International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Stakeholder Engagement and Quality Health Care Service Delivery in Government Hospitals. A Case of Lyantonde Hospital

Fatuma Kyomuhangi[1], Roberts Muriisa[2], Noel Kiiza Kansiime[3]

[1,2,3]Faculty of Business Economics and Governance, Bishop Stuart University, Mbarara-Uganda

ABSTRACT

This study examines the impact of stakeholder involvement on the quality of healthcare service delivery in government hospitals in Lyantonde District, Uganda. The main issue identified is the subpar quality of healthcare services in the district, which is attributed to a lack of adequate stakeholder engagement in the planning, implementation, and monitoring and evaluation (M&E) processes. The study, employing a case study design, involved 257 respondents, including hospital administration, doctors, nurses, Local Council Leaders, the District Health Officer (DHO), a Biostatistician, the Lyantonde Hospital Management Committee, and patients. Data were collected using questionnaires, interviews, and documentary reviews, analyzed through SPSS and content analysis. A key finding is that while stakeholders like local leaders and district officials are actively involved, there is a significant lack of direct engagement from community members and patients, particularly in planning and M&E processes. The study recommends enhancing community involvement through structured consultations and participatory approaches to improve healthcare service delivery. The conclusion underscores that addressing the gaps in stakeholder engagement is crucial for improving the quality of healthcare services and ensuring that community needs are effectively met.

Keywords: Stakeholder Engagement, Quality Health Care Service Delivery, Lyantonde Hospital Uganda.

INTRODUCTION

This study examined the impact of stakeholder engagement, particularly at Lyantonde Hospital on the provision of high-quality healthcare services among medical facilities in Lyantonde district. Walakira (2019) claims that there are still gaps in Uganda's health care and service delivery systems. According to Nabukeera (2016), Lyantonde district is not an exception to Uganda's low health care and status indicators, as it continues to struggle with inadequate health service delivery (Katsigazi, 2017).

Residents of Lyantonde district continue to seek timely, high-quality, easily accessible services, according to Nduhura et al., (2022). The Lyantonde District Development Plan (2012–2016) attributes inadequate health care service delivery to staff negligence as well as a lack of tight oversight and involvement from key stakeholders, including local leaders. This study was motivated by the Lyantonde District Development Plan (2020–2025) Section 6 (c), which stated that all stakeholders, including local leaders, must make sure that the hospital's service delivery quality is significantly enhanced.

Study Background

Historical Background

The early writings of renowned British nurse and public health reformer Florence Nightingale are the source of the history of health care service delivery. Florence became a global celebrity after her nursing mission during the Crimean War in 1854, and she went on to support a more specialized and structured health care system that prioritized hospital treatment (Bates & Memel, 2021).

Louis Pasteur is regarded by historians as one of the "greatest benefactors to humanity of all time." His discovery—which subsequently came to be known as the germ theory—that germs or bacteria were the source of disease was made by a French scientist (Chamberland, 1904). This data prompted medical professionals and hospitals across Europe, and subsequently the United States, to implement antiseptic procedures on a large scale (Sheingold & Hahn, 2014).

In the 19th and 20th centuries, Germany, England, and the United States became the three nations where healthcare payment first appeared. In 1883, German Chancellor Otto Von Bismarck created a state-run health insurance scheme. In Germany, Otto is referred to as the "father of healthcare" with fondness (Sawicki & Bastian, 2008). A government-financed, centrally managed healthcare system was the goal of the Bismarck vision. The healthcare system in Germany is still based on the principles of the Bismarck Era. (Sawicki & Bastian, 2008; European Observatory on Health Care Systems, 2000).

William Beveridge is the British author of the "Beveridge Report," which was released in 1942 in the wake of World War II in the United Kingdom. The paper proposed redesign possibilities for the British healthcare system. A National Health Service with free medical care for everyone as a top priority was established in 1948 as part of this (British Broadcasting Corporation, 2013).

The public health system in the United States was later adopted at the beginning of the 20th century by renowned industrialist Henry Kaiser (Kaiser Permanente History, 2006). Both the Beveridge and Bismarck models of healthcare systems served as the models for universal coverage throughout the rest of Europe, and the Beveridge Model of a National Health Service is still in use today (Sheingold & Hahn, 2014).

By the end of the 19th century, missionary work and colonization had played a major role in introducing formal and organized health care service delivery systems to Africa (Stilson, 2000). There is very little research on the pre-colonial African public health system; however, one detailed study/account (Waite, 1987) suggests that there was a public health system in East Africa that was characterized by witchcraft, sorcery, rainmaking, and traditional healers. She also points out that new institutions and cultural changes, such as those in the health sector, were brought about by colonial authority; local health workers were trained in the emerging field of biotechnology.

However, the usefulness of African medicinal practices for disease prevention on the continent was progressively called into question by the development of politicized colonial states and European germ theory-based biomedicine in the 19th century (Coghe & Berlin, 2022). This significantly weakened Africa's conventional health system, which would later deteriorate.

In colonial Africa, there were other sources of biomedical healthcare than colonial states. Both private businesses and missionary societies operated their own health services with distinct goals, strategies, and logics. Additionally, international agencies like UNICEF and the World Health Organization (WHO) began making larger investments in health campaigns throughout Africa after 1945 (Coghe & Berlin, 2022).

Since the 1940s, health policymakers, professionals, and providers have launched new national and international initiatives every decade to address the health needs and concerns of people, particularly in sub-Saharan Africa (WHO, 2012). However, these efforts have not led to a significant improvement in the overall health of most Africans.

In recognition of the fact that health services all over the world were not responding to the needs of the populations they served, the World Health Organization (WHO), through the Alma-Ata Declaration of 1978 (WHO and UNICEF, 1978; Lawn et al, 2008), launched the Primary Health Care (PHC) approach which focused on the key role of shared commitment and community participation in the delivery of health services.

Through the Alma-Ata Declaration of 1978 (WHO and UNICEF, 1978; Lawn et al., 2008), the World Health Organization (WHO) launched the Primary Health Care (PHC) approach, which focused on the critical role of shared commitment and community participation in the delivery of health services, in recognition that health services around the world were not meeting the needs of the populations they served. The Millennium Development Goals (MDGs) sped up worldwide progress towards achieving population health objectives in low- and middle-income nations between 2000 and 2015. Globally, there was a 53% decrease in infant mortality, a 43% decrease in maternal death, and a more than 38% fall in new HIV infections (22). But improvement was incredibly uneven. Preventable mortality remained high in populations that were poor, rural, and difficult to reach (WHO, 2018).

For instance, based on their assessments of what constitutes a strong health system, governments and the international health community in Africa developed policies, created programs, and allotted funds for the provision of healthcare, strengthened health systems, and MDG indicator monitoring. The opinions and contributions of the health system's end users were absent from all of these attempts (WHO, 2012). The nearly 800 million people residing in the WHO African Region would considerably benefit from growing the body of knowledge about how to build health systems, improving the health workforce, and increasing funding for such efforts (WHO, 2008). Better financial resources, greater inputs into the delivery of health services (including the design and placement of medical facilities), and easier access to medical equipment and medications did not, however, always translate into better health outcomes (Travis et al, 2004; WHO, 2000). High rates of avoidable mortality and morbidity were noted despite the significant improvement in access to vital health services throughout the MDG era (WHO, 2018).

A new development strategy, transforming our world: the 2030 strategy for Sustainable Development, was adopted by the UN General Assembly in 2015. In addition to including a new health goal to “ensure healthy lives and promote well-being for all at all ages,” the SDGs are more comprehensive than the MDGs in terms of economic, social, and environmental goals (WHO, 2018). The provision of healthcare and other services in Uganda's public hospitals is still deficient today. Uganda's health care system and related metrics continue to be deficient (Nabukeera, 2016). As stated in the Lyantonde District Development Plan 2012–2016, the study area of Lyantonde district, for example, faces challenges such as sporadic drug supplies, a 38% understaffing rate, inadequate health equipment, inadequate support for health workers, and a high death and morbidity rate from malaria and other common illnesses. In the Lyantonde area, the prevalence of HIV among adults (15–49 years old) is 10.1%, significantly higher than the 5.4% national prevalence rate (UAC, 2021).

Private-for-profit medical providers are often driven by the incentive to deliver superior medical care to attract higher profits, unlike government medical providers, who do not operate with profit motives. As a result, many patients in various countries prefer these private providers for their healthcare needs. This

preference is reflected in the thriving and expanding private medical sector, which some attribute to the deficiencies in the public health system (Zikusooka & Kyomuhangi, 2008). Patouillard (2007) notes that research indicates private medical practices offer better services, including easier access, shorter wait times, more flexible service hours, better availability of staff and medication, healthcare workers who are more attentive to patient attitudes, and a higher level of patient confidence in the accuracy of diagnoses and treatments.

Uganda offers Primary Health Care through its National Minimum Health Care Package, which intends to give equal access to a list of fundamental services for the entire population in order to promote health, prevent disease, and improve mother and child health (Ssengooba, F. 2004).

Although the Republic of Uganda's government has doubled access to healthcare over the past 20 years through increased funding for the health sector, the development of health infrastructure, the hiring of more medical personnel, and improved access to medications, the standard of care provided in government hospitals has not improved (Ministry of Health, 2016).

According to Mostafa (2005), due to the strong connections between quality service and factors like costs (Crosby, 1979), profitability (Rust & Zahorik, 1993), customer satisfaction (Boulding et al., 1993), service guarantees (Kandampuly & Butler, 2001), and financial performance (Buttle, 1996), quality service has become a crucial area of research. Recent studies have also highlighted the importance of stakeholder participation in this context (Wright, 2008). Wright (2008) notes that the term "stakeholder" was first documented in 1708, originally referring to someone holding a stake in a bet. In contemporary usage, however, the term has evolved to include the concept of involving key interested parties or stakeholders to achieve specific goals and objectives. Given this backdrop, this study explores the still unanswered questions regarding the role of various stakeholders in enhancing the quality of healthcare services in government health facilities. These stakeholders include local leaders, government officials such as the District Health Officer (DHO), and members of the hospital management committee. The study aims to understand the specific roles and contributions of these key stakeholders in the improvement of health services.

Theoretical background

According to Donaldson and Preston (1995), there are three categories of theories on stakeholder management: instrumental, normative, and descriptive theories. As per the descriptive stakeholder theory, stakeholders are determined by virtue of the possession of one or more specific traits. These include the stakeholder's urgency in asserting claims against the firm, the legitimacy of the relationship between the stakeholder and the firm, and the level of influence determined by their power (Mitchell et al., 2007). They also emphasize that the stakeholder theory approach enables corporate organizations to acknowledge that the interests of various stakeholder groups may differ, necessitating the balancing of potential misunderstandings. According to Reynolds et al. (2009, p. 286), there is a need to balance the interests of stakeholders. To harmonize the interests of different stakeholders, it is necessary to assess, weigh, and answer their diverse claims.

For an organization to thrive, it must prioritize the stakeholders who provide essential resources, offer critical support, and facilitate activities that align with the stakeholders' interests. Whether a manager aims to balance the interests of multiple stakeholders simultaneously or focus on one stakeholder group at a time depends on their capacity to allocate organizational resources effectively. Engaging stakeholders helps build strategic alliances, encourages collaborative problem-solving (including power-sharing), and ensures that decisions are broadly supported. According to Savage et al. (2004), the core principles of

stakeholder theory are: the organization engages with a diverse range of parties who either directly or indirectly affect its operations; the focus is on the nature of these relationships concerning processes and outcomes that benefit both the organization and its stakeholders; all legitimate stakeholders' interests are inherently valued; and no single interest is presumed to have priority over the organization as a whole.

Accordingly, "the early and continuing process of building and maintaining interaction that are grounded on mutual trust and respect through conversing with varied parties about multifaceted matters" (Shaw, Ackermann, and Eden, 2003) can be used to define stakeholder engagement. Different academics classify stakeholders in different ways. Primary and secondary stakeholders are the two categories into which we fall (African Development Bank 2011). Primary stakeholders are those who gain from a development initiative, whereas secondary stakeholders are those who have an impact on it. Although secondary stakeholders have less power, the organization is nonetheless impacted by their capacity to provide support (Frooman 2010).

Gibson (2000) distinguished between internal and external stakeholders as another category. On the other hand, Chinyio and Olomolaiye (2010) offered an alternative viewpoint in which they divided them into important and non-key categories. Key stakeholders are individuals whose wants and interests must be taken into consideration for the project to be completed successfully. Conversely, non-key stakeholders are individuals whose wants and interests are not very important. According to this hypothesis, the district health officer, local council leaders, Lyantonde hospital employees, and the community at large are among the many stakeholders in the hospital. Thus, the purpose of this study is to ascertain how these parties contribute to the provision of healthcare services at Lyantonde District Hospital.

Conceptual background

A stakeholder is defined as "any group or individual who can affect or is affected by the achievement of the organization's objectives" (Freeman, 1984, p. 46). Consistent with Freeman’s (1984) definition, Conscannon et al. (2012) describe stakeholders in health as any individuals or groups accountable for or impacted by decisions related to health and healthcare based on research findings. Building on these definitions, stakeholders in this study are defined as people or organizations impacting or impacted by the provision of healthcare services. This includes the community, patients, healthcare professionals, local and federal governments, and statutory organizations like the Ministry of Health, Joint Medical Stores, and National Medical Stores.

Stakeholder engagement, according to Mitchell et al. (2022, p. 77), is "the interaction among a firm and its stakeholders that addresses knowledge problems to improve correspondence in understanding between managers and stakeholders, thereby assisting in resolving ethical challenges faced by managers." Similarly, Leonidou et al. (2020, p. 246) describe it as "procedures, solution development and/or usage, co-creation, interactions and/or relevant, marketing-based forms of service exchange, of all stakeholders within the micro- and macro-environment of an organization." Based on these definitions, this study defines stakeholder engagement as "a systematic process through which stakeholders and managers in a firm interact and relate to achieve the firm's or organization's goals and interests" (Kujala et al., 2022). Moodley (2002) asserts that adequate stakeholder participation is critical to the successful provision of healthcare services and has been recognized as a top priority by eminent medical professionals worldwide (Nutt & Backoff, 1992). Stakeholder engagement improves accountability, fosters responsive, safe, and high-quality service care, and enhances collaboration, ownership, and empowerment of stakeholders in service delivery (Pearce & Robinson, 2011; WHO, 2020). However, there is limited research specifically

identifying the best practices, obstacles, and facilitators for stakeholder engagement in healthcare service delivery.

Healthcare is defined as the organized provision of medical care to individuals or a community. It involves a range of services provided by medical professionals to maintain or improve health through prevention, diagnosis, treatment, and recovery. Healthcare service delivery refers to the mechanism by which healthcare services are provided to patients. It encompasses the entire spectrum of healthcare from preventive care to treatment and rehabilitation, ensuring that individuals receive timely, efficient, and effective health interventions.

Quality healthcare service is defined by the World Health Organization (WHO) (2018) as the degree to which health services for individuals and populations are consistent with current professional knowledge and increase the likelihood of desired health outcomes. Key indicators of quality healthcare include safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. In this study, quality healthcare service will be measured by assessing these indicators through patient surveys, health outcome statistics, and performance metrics of healthcare institutions.

Contextual background

In developed countries, healthcare systems are characterized by advanced infrastructure, substantial financial resources, and comprehensive healthcare policies aimed at ensuring high-quality service delivery. Stakeholder engagement in these countries often involves a collaborative approach, where government bodies, healthcare providers, private sector entities, and patients work together to enhance healthcare outcomes. In nations like the United States, the United Kingdom, and Germany, the focus is on integrating technology, improving patient care, and ensuring accountability through rigorous policy frameworks and regulatory oversight (OECD, 2020). Health care delivery in these regions is facilitated by well-established institutions and mechanisms that promote research, innovation, and continuous quality improvement.

Sub-Saharan Africa faces numerous challenges in healthcare delivery, including limited resources, inadequate infrastructure, and a high burden of infectious diseases. Stakeholder engagement in this context involves a complex network of international organizations, local governments, NGOs, and community-based organizations working to address these challenges. Efforts are focused on improving access to basic health services, enhancing maternal and child health, and combating epidemics such as HIV/AIDS, malaria, and tuberculosis (WHO, 2020). Despite the progress made through initiatives like the Global Fund and Gavi, the Vaccine Alliance, the region still struggles with disparities in healthcare quality and accessibility.

In Uganda, the Ministry of Health (MoH), the Ministry of Local Government (MoLG), the private sector, and non-governmental organizations (NGOs) offer healthcare services. The Ministry of Health (MoH) is tasked with planning and developing health policies and delivering care across all government hospitals, whereas the Ministry of Local Government (MoLG) manages healthcare delivery at the district level and lower (Nabukeera, 2016). Uganda's healthcare system is decentralized, with district health services managed by local governments. Key challenges include limited funding, shortage of healthcare workers, and inadequate medical supplies. Stakeholder engagement is critical in addressing these issues, with various stakeholders collaborating to improve service delivery and health outcomes (MOH, 2021).

Lyantonde District, located in Central Uganda, serves a population of over 90,000 people (UBOS, 2014). The district's healthcare services are provided by government hospitals, private clinics, and NGOs. Lyantonde District Hospital is the main facility, offering both general and specialty medical services. The

hospital faces challenges such as insufficient medical staff, limited resources, and inadequate infrastructure. Stakeholder engagement in Lyantonde involves coordination between local government, healthcare providers, and community organizations to enhance healthcare service delivery. Efforts are focused on improving access to healthcare, ensuring the availability of essential medicines, and promoting community health initiatives (Lyantonde District Local Government, 2020).

Problem statement

In an ideal healthcare system, effective stakeholder engagement is essential for ensuring that healthcare services are timely, high-quality, and accessible to all residents. This includes active participation from local leaders, healthcare providers, and government agencies, coupled with clear communication channels and a robust monitoring and evaluation framework. According to the World Health Organization (2022), such engagement is critical for improving healthcare outcomes and ensuring service sustainability. Currently, Lyantonde District Hospital faces significant challenges in delivering quality healthcare. The hospital has experienced critical shortages of essential drugs, leading to temporary closures and forcing patients to seek costly private care. Communication about these shortages has been insufficient, as notices are primarily in English, a language not understood by over 60% of the district's population (Uganda Bureau of Statistics, 2021). Additionally, a survey by Nduhura, Nansamba, et al. (2022) highlights widespread dissatisfaction among residents due to drug stockouts and delays.

Addressing these issues involves tackling the gaps in stakeholder engagement and communication strategies. The disconnect between hospital administration and the community has resulted in unresolved grievances and unmet needs. With only 30% of health facilities in Uganda having functional monitoring and evaluation systems (Uganda Ministry of Health, 2023), there is a clear need for improvement. This study explored how enhanced stakeholder engagement can improve service delivery at Lyantonde District Hospital, aiming to provide actionable recommendations to bridge these gaps and better meet community needs.

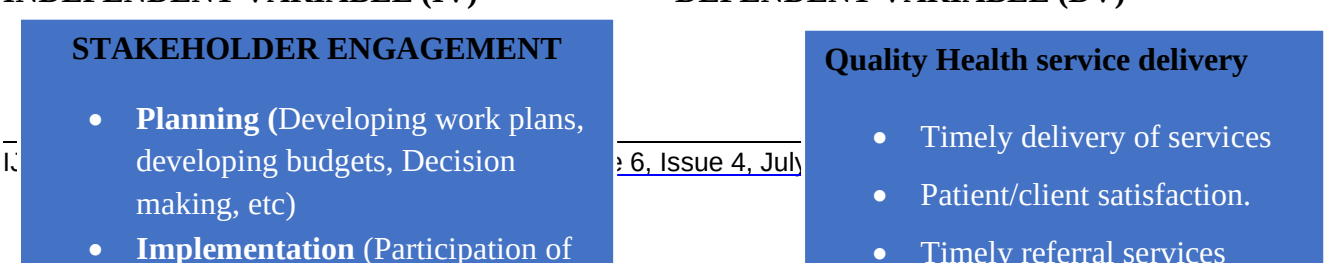
Specific objectives

1. To examine the stakeholders' level of engagement in planning of health care service delivery in Lyantonde district, Uganda.
2. To establish the impact of stakeholder engagement on implementation of quality health care service delivery in government hospitals Lyantonde district, Uganda.
3. To find out the role of stakeholder engagement in Monitoring and Evaluation of care health service delivery in government hospitals a case of Lyantonde district.

Conceptual Framework

A concept is a broad idea derived from specific instances (Kombo and Tromp, 2009). Finchman (2008) defines a conceptual framework as a model of assumptions that categorizes the study's model and the relationship between dependent and independent variables. Figure 1 below illustrates the variables explained in this study. The predictor variable is stakeholder engagement, and the dependent variable is the quality of health service delivery at Lyantonde Hospital. The figure below depicts these relationships.

Figure 1: Conceptual framework illustrating the connection between stakeholder engagement (independent variable) and the quality of healthcare service delivery (dependent variable).



Source: Adapted and modified from (Okot, 2011; Okker, 2014; Opiyo, 2019) and modified by the Researcher.

The conceptual framework explores the relationship between stakeholder engagement and health care service delivery. Stakeholder engagement, as the independent variable (IV), is fundamental in shaping the outcomes of health care service delivery. Effective stakeholder engagement encompasses various aspects such as planning, implementation, and monitoring and evaluation. According to Roberts (2014), effective public involvement extends beyond mere consultation, involving the creation of ideas through discussions, exchanges, and communal education. This collaborative approach, involving multiple entities such as government, nonprofit organizations, community groups, and businesses, plays a significant role in enhancing public value and addressing health care challenges (Innes & Booher, 2010).

Stakeholder engagement is measured through several key activities. In the planning phase, stakeholders are involved in developing work plans, budgets, training programs, and decision-making processes, which directly impact the effectiveness and efficiency of health care services. During implementation, stakeholders participate in executing health services and measuring progress, which influences the quality-of-service delivery. Monitoring and evaluation involve stakeholders in data collection, analysis, and the use of findings to inform improvements in health care services. These activities collectively shape the quality of health care delivery.

Health care service delivery, the dependent variable (DV), is operationalized by examining improvements in public healthcare services, such as reduced waiting times and adequate medical supplies, as defined by Alford (2009). The SERVQUAL model is employed to measure various dimensions of service delivery, including timely service, patient satisfaction, referral services, speed of delivery, responsiveness to patient needs, reliability, and overall service quality. This framework emphasizes how stakeholder engagement influences these aspects, rather than treating quality as an isolated indicator.

Justification of the study

This study was timely and important because health service delivery in Lyantonde District has significantly declined over the years. Assessing the contribution of all relevant stakeholders to quality health service delivery in the district was crucial."

Most studies about Lyantonde District, namely (Seth, 2018; Bukenya & Mutebi, 2019; Katsigazi, 2017), did not focus on stakeholder engagement in the public health sector. These studies primarily addressed

fiscal decentralization and health service delivery, political settlements and the delivery of maternal health services, and NGO performance and health financing. Therefore, this study will fill the knowledge gap in stakeholder engagement in health service delivery. While previous research has explored various aspects of health service delivery, there is a lack of knowledge regarding the role of stakeholder engagement in this context? Some studies have examined stakeholder engagement, but they have not specifically addressed its impact on health service delivery. By focusing on this aspect, this study aims to identify and address these gaps" (Bukenya & Mutebi, 2019; Katsigazi, 2017; Seth, 2018).

Research on health service delivery has been extensive, covering challenges in public-private partnerships, organizational culture, and healthcare improvement systems (BMC Health Services Research, 2023; BMJ Open, 2020). For instance, the study by Nilsen et al. (2020) highlights how organizational culture and leadership behavior affect job satisfaction and, subsequently, health service delivery quality (BioMed Central). Another study emphasizes a systems approach to healthcare improvement, recognizing the interplay of various elements to enhance outcomes (BMJ Open, 2020)

Although there have been studies on stakeholder engagement, they typically focus on collaborative public management and planning rather than its direct impact on health service delivery. For example, the research by Innes and Booher (2010) explores collaborative efforts in public management but does not delve into how these efforts impact specific health outcomes (BMJ Open, 2020).

By examining the role of stakeholder engagement in health service delivery specifically in Lyantonde Hospital, this study aims to fill the identified gaps. This focus will help to better understand how engagement in planning, implementation, and monitoring influences the quality of health services provided, addressing the current lack of detailed insights in this area (Roberts, 2014; Alford, 2009).

Significance of the study

This study aims to derive practical solutions to improve the quality of healthcare service delivery in Lyantonde District through effective stakeholder engagement. By involving key stakeholders in planning, implementation, and monitoring, the study will address existing gaps and enhance the overall effectiveness and responsiveness of health service

The study will contribute to the current body of knowledge on stakeholder engagement and healthcare service delivery in Uganda. This information could be valuable for private and public health providers, non-governmental organizations (NGOs), Civil Society Organizations (CSOs), Community Based Organizations (CBOs) with a focus on healthcare, and academics.

Additionally, the study's findings may help shape policy and be applied for intervention purposes, particularly in similar contexts, or adapted for specific interventions as needed.

Operational terms and definitions

A stakeholder refers to “individuals or groups of individuals who affect or are affected by health care service delivery.” In this study; stakeholders will include; patients and the community, hospital Administration, health workers, Lyantonde District Local Government and elected leaders.

Stakeholder engagement will refer to “a systematic process through which stakeholders partake in the planning, implementation and Monitoring and evaluation of healthcare service delivery.”

Quality health care will refer to “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Healthcare service delivery will refer to the provision and method of making treatment and other related supplies available to patients.

LITERATURE REVIEW

Introduction

This section reviews existing literature related to the influence of stakeholder engagement on the quality of healthcare service delivery in government hospitals, with a specific focus on Lyantonde District, Uganda. The review will address the three specific objectives of the study: examining stakeholder engagement in planning, establishing its impact on implementation, and exploring its role in monitoring and evaluation (M&E) of healthcare service delivery.

Theoretical Review

In the realm of health initiatives, understanding and engaging with stakeholders is crucial for the success of any project. This study is underpinned by Freeman's Stakeholder Theory, first coined by R. Edward Freeman in 1984. According to Freeman, a stakeholder in an organization is any group of people or an individual who can affect or is affected by the achievement of the organization's objectives (Freeman, 1984). This theory posits that stakeholders can have a unidirectional or bidirectional impact on an organization, meaning they can either influence or be influenced by the organization's actions. This perspective excludes only those who have no power to affect the organization and are not impacted by it. Stakeholder Theory is particularly relevant in the context of health projects. Internal stakeholders such as employees and healthcare workers, and external stakeholders including patients, suppliers, and the broader community, all significantly influence an organization's survival and development (Baraldi et al., 2007). Effective stakeholder engagement is essential, as it involves understanding the needs and concerns of all parties involved, ensuring that their voices are heard and integrated into decision-making processes. This approach is vital for the sustainability and success of health initiatives, ensuring they address community needs while fostering trust and collaboration.

The choice of Freeman's Stakeholder Theory for this study is justified by its comprehensive framework for understanding the complex interactions between an organization and its diverse stakeholders. This theory aligns with the study's focus on stakeholder engagement at Lyantonde District Hospital. By applying this theory, the study aims to examine how stakeholder engagement can influence the quality of health service delivery. The stakeholders for Lyantonde Hospital include local council leaders, area members of parliament, the Government of Uganda, specifically the Ministry of Health, and community members who receive services from the hospital. This alignment underscores the importance of managing stakeholder relationships to enhance health care service delivery, making Stakeholder Theory a suitable and robust theoretical foundation for this research.

Analysis of the stakeholders

Reflecting on the importance of stakeholders in health care service delivery at Lyantonde District Hospital, the following table presents an analysis of various actors, their relevance, interests, expectations, potentials to problems, resistance/support levels, and additional comments. This analysis underscores the critical roles played by different stakeholders and aligns with the principles of Stakeholder Theory, which emphasizes the need for effective engagement and management of all parties involved to ensure successful project outcomes.

Actors	Relevance	Interests, Expectations of Actors	Potentials of Actors to Problems	Resistance/Support	Comment

Local Council leaders (I-V)	High	Ensure healthcare services meet community needs, gain political support	Influence local policy, allocate resources, mobilize community	High Support	Critical for grassroots mobilization and policy implementation
Area Members of Parliament (MPs)	High	Advocate for constituency, secure funding, influence national health policy	Leverage national resources, influence legislation	High Support	Key in securing funding and policy advocacy at the national level
Ministry of Health	High	Ensure national health standards, provide funding and resources	Policy formulation, resource allocation, technical support	High Support	Essential for policy guidance and resource provision
District Health Officer	High	Implement health policies, oversee hospital performance	Local health governance, implementation oversight	High Support	Crucial for local health management and oversight
Health Inspector	High	Ensure compliance with health regulations	Enforce health standards, identify areas for improvement	High Support	Vital for maintaining health service quality
Hospital Administration	High	Manage hospital operations, ensure service delivery	Operational management, staff coordination	High Support	Key to daily hospital management and service delivery
Members of the community	High	Receive quality healthcare services,	Provide feedback on services, advocate for improvements	Low Support	Primary recipients of healthcare services, their

		affordable treatment			feedback is crucial
Government of Uganda	High	Improve national health outcomes, ensure efficient use of funds	Provide funding, set national health priorities	High Support	Main provider of funding and policy direction for healthcare services
NGOs	Moderate	Implement health projects, support community health initiatives	Provide additional resources, expertise, and advocacy	Moderate Support	Complement government efforts with specialized projects
Churches	Moderate	Promote community health, support social services	Mobilize community, provide moral and social support	Moderate Support	Important for community mobilization and support services

Source: Freeman, R. E. (1984).

Stakeholder Theory is chosen for this study because it provides a robust framework for analyzing the interactions between Lyantonde District Hospital and its various stakeholders. This theory's emphasis on understanding and managing stakeholder relationships is crucial for addressing the challenges faced in healthcare service delivery. By applying Stakeholder Theory, the study can identify and engage key stakeholders, understand their interests and expectations, and leverage their potential to overcome problems and enhance the quality of health services. This alignment between theory and practice underscores the relevance of Stakeholder Theory in guiding the research and achieving its objectives.

Stakeholder engagement in planning and healthcare service delivery.

Studies have shown that involving stakeholders in planning can lead to improved health outcomes. For example, a study by Seth (2018) indicated that stakeholder involvement in planning led to better resource allocation and prioritization in health projects. However, research by Bukenya and Mutebi (2019) highlights that a lack of stakeholder engagement often results in misaligned priorities and resource wastage, limiting the effectiveness of health interventions.

Stakeholder engagement in planning involves the participation of various stakeholders in setting priorities, developing work plans, and budgeting for healthcare services. Effective engagement ensures that the needs and preferences of the community are considered, leading to more relevant and sustainable healthcare interventions (Roberts, 2014).

Studies have shown that involving stakeholders in planning can lead to improved health outcomes. For example, a study by Seth (2018) indicated that stakeholder involvement in planning led to better resource allocation and prioritization in health projects. However, research by Bukenya and Mutebi (2019)

highlights that a lack of stakeholder engagement often results in misaligned priorities and resource wastage, limiting the effectiveness of health interventions.

Further literature supports these findings. For instance, a study by Kapiriri and Norheim (2004) emphasized the importance of involving stakeholders in setting health priorities to ensure that resource allocation aligns with community needs. Similarly, Nabyonga-Orem et al. (2013) found that stakeholder engagement in the health planning process in Uganda led to more equitable and efficient use of health resources.

Integrating a theory of participation is fundamental for this study, as it adheres to the essential principles suggested by the World Health Organization (WHO) for enhancing health service delivery. Participation is one of the nine key principles outlined by WHO to improve health services (WHO, 2014, as cited in Nayebare, 2020). The report "Delivering quality health services: a global imperative for universal health coverage" emphasizes that involving individuals and communities in the design of health services is crucial for achieving better health outcomes (WHO, 2018).

Arnstein's Ladder of Citizen Participation offers a well-known framework for understanding participation. Introduced by Sherry Arnstein in 1969, this model classifies levels of citizen participation in decision-making processes into eight rungs, ranging from nonparticipation to varying degrees of tokenism and ultimately to degrees of citizen power (Arnstein, 1969). The model highlights that genuine participation occurs only when citizens hold substantial power and influence over decisions impacting their lives.

The WHO report illustrates that models incorporating citizen and community participation in healthcare service design can significantly enhance various health indicators. For example, such participatory approaches have resulted in a 33% reduction in child mortality. This evidence underscores the importance of actively engaging stakeholders, including patients, families, and communities, for the success and sustainability of health initiatives. In this context, Arnstein's Ladder of Citizen Participation is invaluable. It ensures that health programs are designed with the beneficiaries' involvement, actively engaging them in planning and implementation phases. This approach fosters a sense of ownership, accountability, and responsiveness to the community's actual needs and preferences, leading to more effective and sustainable health outcomes.

Engagement, as a form of participation, is particularly pertinent in health service delivery. Stakeholder engagement goes beyond merely involving stakeholders; it entails actively involving them in decision-making processes, ensuring their voices are heard, and their inputs are valued. According to the WHO (2018), stakeholder engagement is essential for fostering collaboration, trust, and shared responsibility in health initiatives. This theoretical understanding emphasizes that stakeholder engagement is not a passive process but an active, dynamic one where stakeholders contribute meaningfully to health service design and delivery.

In this study, stakeholder engagement is examined through the lens of Arnstein's Ladder of Citizen Participation, which provides a structured framework to assess the depth and quality of engagement. By applying this model, the study can differentiate between superficial forms of participation, such as consultation and placation, and more substantive forms, such as partnership and citizen control. This distinction is crucial for evaluating the effectiveness of stakeholder engagement in improving health service delivery at Lyantonde District Hospital.

By integrating Arnstein's Ladder of Citizen Participation, the study can systematically assess the levels of stakeholder engagement and identify areas for improvement. This approach ensures that health programs are designed with meaningful input from all relevant stakeholders, leading to better health outcomes and

more sustainable health services. The alignment of this theoretical framework with the study's objectives underscores the importance of understanding and enhancing stakeholder engagement in health care delivery.

In their study on maternal health in Eastern Uganda, Kananura et al. (2017) found that stakeholder involvement in planning is beneficial for mutual target setting, tracking progress, and identifying challenges. They assert that stakeholder engagement facilitates appropriate decision-making, replanning, and communal risk mitigation. This finding aligns with the argument presented by Lipineux (2005), who emphasizes that stakeholder demands are crucial in today's healthcare environment, where powerful stakeholders have diverse objectives. Similarly, Lapenu and Pierret (2005) highlight that early stakeholder engagement leads to a mutual understanding of project outcomes and interests, timely issue identification, and prevention of costly delays and overruns.

Michelson (2002) emphasizes that stakeholder involvement in planning enhances the effectiveness and sustainability of development projects and programs (David & Lewis, 2007, as cited in Okker, 2014). Delnoij et al. (2010) found that active stakeholder participation in indicator development improves local people's skills and competencies, which can be applied to future community developments.

Nyandemo & Kongero (2010) highlight that stakeholder involvement in planning ensures effective management of resources, community ownership of projects, and achievement of objectives (Bwampu, 2022). Stakeholder involvement in decision-making, planning activities such as meetings, budgeting, and setting project targets enhances project performance (Atwijukire, Kyohairwe & Kiwanuka, 2015). According to Nyabera (2015, as cited in Munina, 2021), lack of stakeholder participation in planning can lead to poor project implementation and performance.

A 2014 study by the Agency for Healthcare Research and Quality in the USA concluded that stakeholder engagement during planning and designing stages leads to early buy-in, successful program design, and long-term support. This study focused on community projects aimed at livelihood improvement, where community members actively participated in decision-making and implementation.

Chirenje, Giliba, and Musamba (2013) note that although local governments in African countries recognize the need for local community participation in resource management, citizens are often excluded from decision-making during planning and budgeting of development programs. Their study found that stakeholders were primarily engaged in program implementation but not in critical decision-making, leading to a lack of program ownership (Ahimbisibwe, 2021).

While existing literature emphasizes the importance of stakeholder engagement in planning, there is limited research specifically focusing on the level of stakeholder engagement in planning within Lyantonde District. Studies by Kananura et al. (2017) highlight the positive outcomes of stakeholder involvement in planning for maternal health in Eastern Uganda, yet they do not delve into the varying degrees of engagement or the impact these levels might have on outcomes.

In Lyantonde District, the level of stakeholder engagement in planning processes remains underexplored. The literature often generalizes the benefits of stakeholder engagement without distinguishing between superficial involvement and deeper, more meaningful participation. According to Arnstein's Ladder of Citizen Participation (1969), different levels of engagement—from tokenism to citizen power—can significantly affect the efficacy and sustainability of healthcare initiatives. Understanding the specific levels of engagement practiced at Lyantonde Hospital could shed light on why certain challenges persist despite efforts to involve stakeholders.

Additionally, the specific mechanisms through which stakeholder engagement influences planning outcomes are not well-documented. While studies such as those by Lipineux (2005) and Lapenu and Pierret (2005) discuss the overall importance of stakeholder demands and early engagement, they do not provide detailed insights into how varying levels of engagement might affect decision-making, resource allocation, or risk mitigation in healthcare settings. Investigating these mechanisms in the context of Lyantonde District could reveal crucial factors that enhance or hinder the effectiveness of stakeholder participation, offering a more nuanced understanding of how to improve planning processes and healthcare service delivery.

By considering the levels of engagement and the specific mechanisms at play, this study aims to fill the existing research gaps and provide a comprehensive analysis of stakeholder engagement in Lyantonde District's healthcare planning. This approach not only builds on the foundational work of earlier studies but also addresses the unique challenges faced by the district, offering practical insights for improving stakeholder participation and healthcare outcomes.

Stakeholder engagement in implementation and quality health care service delivery.

Stakeholder engagement during the implementation phase involves the active participation of stakeholders in executing health plans and interventions. This engagement can enhance the effectiveness and efficiency of healthcare service delivery by ensuring that the services meet the community's needs and are delivered in a timely manner (Innes & Booher, 2010).

Research by Katsigazi (2017) shows that stakeholder engagement in implementation leads to higher accountability and better resource management. However, the study by Nilsen et al. (2020) suggests that the absence of stakeholder engagement during implementation can result in poor adherence to plans, delayed services, and reduced overall quality of healthcare delivery.

Stakeholder engagement during the implementation phase involves the active participation of stakeholders in executing health plans and interventions. This engagement can enhance the effectiveness and efficiency of healthcare service delivery by ensuring that the services meet the community's needs and are delivered in a timely manner (Innes & Booher, 2010).

Other studies corroborate these findings. For example, a study by Maluka et al. (2011) found that engaging community members in the implementation of health interventions in Tanzania improved the relevance and acceptance of these interventions. Additionally, a study by Shayo et al. (2013) demonstrated that stakeholder engagement in the implementation phase led to better health outcomes and increased community trust in health services.

A 2014 study by the Agency for Healthcare Research and Quality in the USA on engaging stakeholders in a Care Management Program found that engaging patients during the implementation and evaluation stages helps program staff understand the program's effects on patient behavior and identify areas for improvement. Engaged patients are also more likely to follow providers' or care managers' recommendations. However, the implementation of similar programs at Lyantonde Hospital is unpredictable due to the different community settings and the lack of sufficient information about healthcare programs and their implementation among the people in Lyantonde.

Brown et al. (2013) argue that community participation in project implementation mobilizes human and material resources, increasing productivity and improving living standards. Fischer & Qaim (2014) recognize community participation as a crucial strategy for enhancing project performance. Genuine participatory elements in development projects increase overall effectiveness, fostering collective action, where beneficiary communities become real resources and experts in their development process (Waweru,

2015, as cited in Ahimbisibwe, 2021). However, in the case of the hospital, the community benefits or suffers from the service quality over which they have no control, with recommendations for improving service quality.

Training stakeholders to acquire knowledge and skills about the project improves their attitudes and interest toward the project (Erina, Ozolina-Ozolanand, Gaile-Sarkane, 2015). Lawman (2020, as cited in Munina, 2021) argues that trained stakeholders can perform tasks effectively, understand project objectives, and fulfill their responsibilities during implementation. However, for the hospital, there is a significant gap in community participation during implementation, as it is primarily carried out by technical staff, with limited input from the community due to a lack of technical skills.

Scholars caution against engaging stakeholders in technical matters during implementation. Khwanja (2014) argues that technical decisions require specific knowledge, especially in poor rural communities where external agencies might better provide design expertise. Tennoya et al. (2015, as cited in Ahimbisibwe, 2021) also assert that professional or technical individuals are crucial for technical decisions. A study in Northern Pakistan (Baltistan) showed that while citizen participation improved outcomes in non-technical decisions, increased community participation in technical decisions led to worse project outcomes (Khwaja, 2014; Ahimbisibwe, 2021).

Other authors advocate for meaningful stakeholder involvement for better service delivery in development programs. Abatena (2015) argues that grassroots contributions to design and implementation are often overlooked by technocrats and policymakers, despite stakeholder participation leading to empowerment (Opiyo, 2019). Kessey (2017) also contends that despite continued advocacy for participation and institutional ownership, there is still heavy reliance on outside specialists during project implementation of community development projects

There is a scarcity of studies examining the specific impact of stakeholder engagement on the implementation of healthcare services in Lyantonde District. Additionally, existing research often overlooks the challenges and barriers to effective stakeholder engagement during implementation.

Stakeholder engagement in Monitoring and Evaluation (M&E) and quality healthcare service delivery.

Monitoring and Evaluation (M&E) involve tracking the progress of health interventions and assessing their outcomes. Stakeholder engagement in M&E can enhance transparency, accountability, and learning, thereby improving the quality of healthcare services (Alford, 2009).

Studies have found that involving stakeholders in M&E processes leads to more accurate data collection, better interpretation of results, and more effective use of findings to improve health services (Roberts, 2014). For instance, the study by BMC Health Services Research (2023) highlights the positive impact of stakeholder engagement in M&E on service delivery in Tanzania.

Additional research supports these conclusions. For example, a study by Ho et al. (2015) found that stakeholder involvement in M&E activities led to improved health service delivery and greater accountability in Vietnam. Similarly, a study by Tsofa et al. (2017) demonstrated that engaging stakeholders in M&E processes in Kenya resulted in better health outcomes and more efficient use of health resources.

The Institute of Development Studies (1998) noted that involving stakeholders in M&E allows development organizations to better focus on improving the lives of the poor, broadening involvement, and gaining a clearer picture of what is happening on the ground. This process is empowering, as it develops the skills of those in charge and demonstrates that their views matter (IDS, 1998). Nyaguthii and

Oyugi (2013) stated that involving local residents in project monitoring increases beneficiary satisfaction (Sulemana et al., 2018).

Nyabera (2015) found a strong relationship between stakeholder participation in M&E and project performance. To ensure good performance, stakeholders must be involved in activities such as knowing schedules, required resources, objectives, and timeframes, and ensuring standard operating procedures are followed for quality outputs (Munina, 2021). Oreyo, Munyua, and Olubandwa (2016) also state that stakeholder involvement in M&E enhances good governance with increased accountability, responsiveness, and transparency.

Ruwa (2016) asserts that stakeholder participation in monitoring acts as a follow-up on implemented activities, assessing whether expected results are achieved based on quality standards. It helps determine if the project is on track and allows stakeholders to develop strategies for better results, leading to good project performance (Munina, 2021).

A study by Rendell et al. (2020) on community monitoring and health service delivery in Uganda found that community monitoring through report cards and joint action planning improved service utilization and health outcomes. Biannual meetings with ministers and permanent secretaries to review health sector performance also increased interest in data quality and use.

Kananura et al. (2021) in Uganda found that involving local management in planning and M&E processes strengthened their capacity to use available data for advocacy.

Different uses and users of M&E findings should be appreciated, as successful communication of these findings ensures accountability, advocacy, learning, and empowerment. The key task is to deliver progress messages to the appropriate audience. Understanding the information needs and preferred delivery methods for all stakeholders is crucial, and the information should be presented clearly (Mpofu et al., 2014).

While the benefits of stakeholder engagement in M&E are well-documented, there is limited research on how this engagement is operationalized in the context of Lyantonde District. Furthermore, there is a need to explore the specific roles and contributions of different stakeholders in the M&E processes.

Summary of literature review.

Stakeholder participation is critical for quality service delivery, including healthcare (Zwane & Matsiliza, 2022; Stel et al., 2012). Most researchers agree that stakeholder engagement enhances the effectiveness of development projects, service quality, accountability, transparency, sustainability, and good governance (Karama & Iravo, 2019; Sulemana et al., 2018; Zwane & Matsiliza, 2022; Stel et al., 2012). This consensus underscores the significant positive impact that effective stakeholder engagement can have on various aspects of service delivery.

However, existing studies have not fully addressed the specific context of stakeholder engagement in Lyantonde District, particularly within the planning and decision-making processes of healthcare service delivery. While scholars like Kananura et al. (2017) have highlighted the benefits of stakeholder involvement in maternal health planning in Eastern Uganda, they did not explore the different levels of engagement or the specific mechanisms through which stakeholder engagement influences outcomes. Moreover, the practical implementation and challenges of stakeholder engagement at the grassroots level remain underexplored. This gap is evident in the operational dynamics at Lyantonde Hospital, where stakeholders are not effectively involved in planning processes, leading to issues such as drug shortages and inadequate service delivery.

Additionally, some scholars caution against involving stakeholders in technical decisions, arguing that it can lead to worse outcomes (Khwanja, 2014; Tennoya et al., 2015). Waheduzzaman (2010) identified obstacles to effective participation, such as lack of awareness and a robust legal framework. These challenges highlight the need for a nuanced understanding of stakeholder engagement, considering both its potential benefits and limitations.

This study aims to address the role of stakeholders, including the District Health Officer (DHO), Health Management Committees, and hospital administrators, in healthcare service delivery at Lyantonde Hospital, building on existing knowledge gaps. By examining the specific levels of engagement, the mechanisms through which stakeholder participation influences service delivery, and the unique challenges faced in this context, this study seeks to provide a comprehensive analysis that can inform more effective and sustainable healthcare practices. This approach will not only fill the existing gaps in the literature but also offer practical insights for improving stakeholder engagement and healthcare service delivery in Lyantonde District.

METHODOLOGY

Introduction

This chapter outlines the methodologies employed in the study. It includes details on the research design, study population, sample size, sampling techniques and procedures, data collection methods and tools, as well as the validity and reliability testing of the research instruments. Additionally, the chapter describes the data collection process, variable measurement, and data analysis methods.

Research design

This study employed a descriptive case study research design, selected for its capacity to offer a thorough, contextual, and detailed analysis of stakeholder engagement and quality healthcare service delivery at Lyantonde Hospital. Yin (2014) notes that case study research is an empirical investigation into current phenomena within their real-life context, making it well-suited for examining complex issues. This method facilitates the use of various data sources, including interviews, observations, and document reviews, to provide a comprehensive perspective. The case study design was preferred over experimental or survey designs because it captures the depth and nuances of stakeholder interactions and their effects on service delivery, which are crucial for understanding the processes, events, and relationships involved in this specific context.

Study Area

The study used Lyantonde Hospital as a case to examine the influence of stakeholder engagement on healthcare service delivery. Lyantonde Hospital was selected because it is a public health facility in Uganda and the main hospital in Lyantonde District, serving a population of over 90,000 people (UBOS, 2014). This selection was strategic for several reasons. Firstly, Lyantonde Hospital typifies the managerial and operational characteristics common to 73.6% of public health facilities in Uganda, as highlighted in the Uganda Demographics and Health Survey report (2016) (Nayebare, 2020). Secondly, a significant proportion of these facilities (67.2%) are located in rural areas, making Lyantonde Hospital representative of rural healthcare challenges and dynamics. Studying this hospital provided insights into the broader context of rural healthcare service delivery in Uganda, especially concerning stakeholder engagement and its impact on service quality. This case was therefore chosen not only for its representativeness but also for its relevance in addressing gaps in understanding how stakeholder involvement can enhance healthcare outcomes in similar settings.

Study Population

The study population included Lyantonde Hospital administrators, doctors, nurses, local council leaders, the District Health Officer (DHO), a biostatistician, the hospital management committee, and patients. Hospital administrators were included because they manage the day-to-day operations of the hospital, led by the senior administrator. Doctors and nurses were selected due to their direct role in providing healthcare services. Local council leaders were involved because they oversee the implementation of government projects in their areas. The hospital management committee was chosen as they are responsible for governing the hospital, setting policies, and establishing goals. The DHO and biostatistician were included for their roles in planning, organizing, supervising, and managing public health functions and ensuring compliance with health regulations. The biostatistician was also chosen for her knowledge of the hospital, while patients were included as direct beneficiaries affected by the quality of healthcare services. Lyantonde Hospital has ten departments and serves an average of 778 patients daily.

For this study, five departments were selected based on the nature of services they provide, as they are crucial for examining stakeholder engagement in healthcare service delivery. The selected departments include Pediatrics, Maternity, Emergency, General Ward, and the Outpatients Department (OPD). These departments were chosen because they handle the highest patient volumes, collectively attending to approximately 454 patients daily, which is more than half of the hospital's total daily patient count.

Sample size determination

The sample size for this study was 257.The researcher used Krejcie and Morgan's (1970) methods as a guide to determine an appropriate sample size, ensuring a small manageable error and a justifiable number of respondents for the quantitative portion of the study. The Krejcie and Morgan formula is as follows:

$$s = \frac{X^2NP(1-P)}{d^2(N-1) + X^2P(1-P)}$$

(See Appendix I: Morgan & Kreije table of sample size determination)

For the qualitative sample, a different approach was used. Purposeful sampling was employed to select participants who could provide in-depth and rich information relevant to the study. This method ensured that the qualitative sample was adequately represented by stakeholders who had significant insights into healthcare service delivery at Lyantonde Hospital.

Therefore, a sample size of 257 respondents was selected as illustrated in the table below;

Category of respondents	Accessible population	Sample	Sampling technique
Hospital Administration (In-charge, department heads, hospital Supretendant)	10	10	Purposive sampling
Doctors	6	06	Simple random sampling
Nurses	16	14	Simple sampling
DHO	1	1	Purposive sampling
Biostatistician	1	1	Purposive sampling
Hospital Management Committee	12	10	Purposive sampling

District Health Department officials	12	10	Purposive sampling
Patients	454	205	Simple random sampling
TOTAL	**512**	**257**	

Source; Researcher obtained primary data from Senior Hospital Administrator and District Health Officer.

Sampling technique and procedure.

Simple random sampling and purposive sampling was utilized to obtain a representative sample.

Simple random sampling.

Simple random sampling is a technique where every sample has an equal probability of being chosen and included in the study (Elfil M, Negida A 2017). The researcher employed this method to select respondents from among patients. It was chosen because it ensures that each unit in the population has an equal opportunity to be selected (Pandley & Pandey, 2015; Nayebare, 2020).

Purposive sampling.

The researcher used purposive sampling to select respondents who were knowledgeable about stakeholder engagement in healthcare service delivery. Hospital administrators were chosen for their oversight of hospital operations and management, providing insights into administrative challenges and engagement strategies. Health workers, including doctors, nurses, and support staff, were selected for their direct involvement in patient care and their perspectives on the impact of stakeholder engagement on service delivery.

Members of the Hospital Management Committee were included due to their role in governance and decision-making, offering views on how engagement influences hospital policies and strategic planning. The biostatistician was selected for their expertise in managing health data and statistics, contributing valuable insights into the effects of stakeholder engagement on healthcare outcomes.

The District Health Officer was chosen for their oversight of health services at the district level, providing a broader context on stakeholder engagement beyond the hospital. Finally, District Health Department officials were included to understand regional healthcare policies and strategies, and how district-level stakeholder engagement influences hospital operations and service delivery.

Data collection methods

The study utilized three methods of data collection namely; questionnaire method, Key informant interview (in-depth interviews) method and document review. Multiple methods were used to reduce bias and to attach more strength to study results (Udoimuk et al, 2013).

Survey

The questionnaire survey method was utilized to gather data from hospital staff and patients because it effectively collects a large amount of standardized information. Self-administered questionnaires were used for staff to collect quantitative data, as they are easy to distribute and complete independently, which helps achieve a higher response rate among busy healthcare professionals. For patients, researcher-administered questionnaires were employed to assist with understanding and completion, considering that patients might need help due to different levels of literacy and health conditions. This approach enabled thorough data collection from the largest respondent group in the study, ensuring robust and reliable information on stakeholder engagement and healthcare service delivery.

Key Informant Interviews

Key informant interviews were carried out with members of the Hospital Management Committee, District Health Department officials, the Biostatistician, and the District Health Officer at Lyantonde Hospital. This method was selected because it allows the researcher to delve deeper into responses, clarify questions, and obtain detailed explanations during data collection. These interviews were essential for gaining an understanding of the specific roles and experiences of these key stakeholders regarding stakeholder engagement and healthcare service delivery. By interacting directly with individuals involved in the hospital's management and oversight, the researcher was able to obtain comprehensive insights and contextual information that would not have been captured through surveys alone.

Document Review

Document review was utilized to complement the data collected through surveys and interviews. This method involved analyzing existing records, reports, and publications relevant to the study. By reviewing documents from the hospital, District Health Department, and other relevant bodies, the researcher was able to verify information provided by respondents, identify trends over time, and gather additional context that informed the overall analysis. Document review thus provided a valuable source of secondary data, enriching the study with comprehensive background information and supporting the triangulation of data collected through other methods.

Data collection instruments

The researcher developed and used two data collection instruments: a questionnaire and an interview guide.

Structured Questionnaire

A structured questionnaire was designed by the researcher in line with the variables, sub-variables and objectives of the study. Self-administered questionnaires were administered to the hospital staff since they are all literate and this was economical and quick (Udoimuk et al, 2013) and researcher administered questionnaire were for the patients as most of them are illiterate. The questionnaire were guided by the Five (5) point Likert scale (1 – Strongly Disagree to 5 – Strongly Agree) in order to be more appealing, easy to answer and comfortable to respondents. The questionnaires were administered to Hospital staff and patients.

Interview guide

The researcher designed and utilized an interview guide with unstructured and semi-structured questions to collect in-depth information from key informants of the study. The instrument was administered to hospital management committee members and District Health Department officials.

Validity and reliability

Reliability and validity enhance the accuracy, precision and reduce optimism to incorporate researcher's predisposition in research. Without evaluating reliability and validity of a study, it is difficult to give an account for the effects of dimension errors on theoretical associations measured by the study (Mohajan,2017: (Nayebare, 2020). Below is how validity and reliability of the proposed data collection instruments in this study will be tested and ensured.

Validity and reliability for quantitative research

Validity

The data collection instruments were proof read by the research supervisor to establish their face validity using the supervisor's expert judgment.

The relevance of the questions was ensured through the calculation of Content Validity (CVI);

Content Validity Index (CVI) = Relevant items by all judges as suitable

Total number of items judged.

If the instrument scores CVI of over 70% then the instrument were declared valid and used in the research. Validity for the interview guide was ensured through seeking truth values, consistency and neutrality and application during both data collection and analysis (Lincoln and Guba, 1993:Walakira, 2019).

Reliability

Reliability refers to the degree to which a research instrument produces consistent results across different items when administered at different times (Sekaran, 2003). To assess reliability, the instruments were piloted twice with the same subjects at two-week intervals. Test-retest reliability was employed to determine how consistently the instrument produces scores when the same group is measured repeatedly under identical conditions (Amin, 2005; Walakira, 2019). The pretest results were used to refine the questions in the instruments.

To ensure the reliability of the quantitative data, the Cronbach's Alpha Reliability Coefficient for Likert-type scales was calculated. Cronbach's alpha is a measure commonly used to assess the internal consistency or reliability of a psychometric test score for a group of respondents. This test was applied to all variables to confirm their reliability.

Validity and reliability of qualitative research

In qualitative research, reliability refers to the consistency of the researcher's approach across various projects, objects, and subjects (Mohajan, 2017), while validity pertains to the credibility, dependability, and usefulness of the research findings (Zohrabi, 2013; Nayebare, 2020). The use of triangulation in this study ensures the validity and reliability of the qualitative section by mitigating bias and establishing trustworthy and well-founded assertions (Golafshani, 2003).

Procedure of data collection and Ethical Consideration

The researcher obtained an introduction letter from Dean Faculty of Business, Economics and Governance of Bishop Stuart University after approval of the study proposal. The researcher then conducts a pilot study; questionnaires were administered to 20 hospital staff and three key informant interviews were conducted.

The researcher sought consent and voluntary participation from all potential respondents before administering the data collection tools. Potential respondents were voluntarily asked to partake in the study and their permission sought. Written consent was obtained as proof that respondents took part in the study voluntarily with a clear and informed mind.

The study-maintained confidentiality and anonymity all at stages of the research. Codes and unique identifiers were used to identify information collected during the study. The researcher ensured anonymity of respondents on request.

After input from the pretest, data collection using questionnaires and interview guides were carried out in one week. Appointments were planned with potential key informants to ease the data collection exercise. All the necessary data was solely collected by the researcher.

Data analysis

Qualitative and quantitative analysis was conducted. The following sub-sections provide further details;

Quantitative data analysis

Statistical Package for Social Scientists (SPSS version 20) was utilized to analyze the collected quantitative data. The first analysis targeted descriptive statistics including measures of central tendency (frequency and mean), followed by the analysis of inferential statistics to help in undertaking correlation and regression analysis. These helped to determine the strength and significant relationship between the Dependent and Independent variables of the study.

Qualitative data analysis

Content analysis was employed to refine and organize the qualitative data into information aligned with the study themes. This technique involves collecting and analyzing various forms of text content, including words, phrases, sentences, paragraphs, pictures, symbols, or ideas. Consequently, Qualitative Data Analysis Software (QDAS) was used to process the qualitative data.

The content was categorized into themes; data were transcribed, synchronized, and organized accordingly. Patterns and connections related to the research questions were identified within these themes, and data interpretation was conducted with reference to the research objectives.

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

Introduction

The chapter presents the research findings and interpretation regarding the study which investigated the influence of stakeholders' engagement on quality health care service delivery in government hospitals in Lyantonde district, Uganda. The study involved a total of 257 respondents and data was collected using both a questionnaire and an interview guide from the respondents. The response rate was 99.23%.

Categories of the respondents

Table 1: Categories of the respondents

Category	Frequency	Percent
Nurses	14	5.4
Doctor	6	2.3
Patients	205	79.8
Hospital Health Management Committee	10	3.9
Hospital Administrators	10	3.9
Biostatistician	1	.4
DHO	1	.4
District Health Department officials	10	3.9
Total	**257**	**100.0**

Source: *Field Data, 2024*

Field findings in table 1 above show that majority of the respondents who participated in the study were patients represented by 205(79.8%) followed by nurses represented by 14 (5.4%).

Stakeholder engagement in planning of healthcare service delivery.

This study examined stakeholder engagement in the planning of healthcare service delivery through a questionnaire administered to community members (patients), health workers, District Health Department officials, the District Health Officer, and the Biostatistician. Table 2 presents the responses categorized by stakeholder groups across various aspects of planning:

Table 2: Stakeholder engagement in planning of healthcare service delivery

Response	SA (%)	A (%)	NS (%)	D (%)	SD (%)	Mean (μ)	Std Deviation (δ)	Decision
We always take part in planning for health service delivery in our area	36(1.7)	69(30.1)	17(7.4)	43(18.8)	64(27.9)	2.87	1.493	Strongly disagree
There are some community representatives that take part in the formulation of the budgeting for the hospital	31(13.5)	77(33.6)	25(10.9)	59(25.8)	37(16.2)	3.03	1.337	Agree
Hospital Management always involves the community members in the meeting of the hospital	15(6.6)	55(24.0)	24(10.5)	91(39.7)	44(19.2)	2.59	1.227	Disagree
Hospital Administration always informs stakeholders about the new changes in the hospital for quality health service delivery	41(17.9)	67(29.3)	15(6.6)	69(30.1)	37(16.2)	3.03	1.402	Agree
Local leaders always consult stakeholders on issues of health	45(19.7)	44(19.2)	24(10.5)	68(29.7)	48(21.0)	2.87	1.451	Disagree

care service delivery								

Note: N= 229, SA = Strongly Agree, A = Agree, NS = Not Sure, D = Disagree, SD = Strongly Disagree, Decision = Weighted Average=2.88.

Source: *Field Data, 2024*

From the results in Table 2, it is evident that stakeholder engagement in planning for healthcare service delivery at Lyantonde District Hospital varies significantly across different categories of respondents. For instance, only 36% strongly agree or agree that they always participate in planning, indicating a lack of consistent involvement. Notably, Hospital Management and Local Leaders scored lower on involving stakeholders in meetings and consultations, reflecting mean scores below the overall weighted average of 2.88. Conversely, there is positive feedback regarding community representatives' involvement in budget formulation and the Hospital Administration's communication of changes, both scoring above the weighted average with means of 3.03.

During interviews with key informants, including the District Health Officer and Biostatistician, it was revealed that planning primarily involves district leaders, technical committees, implementing partners, local leaders, and civil society organizations, neglecting direct input from community members and patients who are the primary recipients of healthcare services.

Respondent 1 (DHO) *"we consider the supervisory role and what makes them important during planning process. The lobbying capacity by implementing partners, civil society organizations and district leaders makes them important"(interviewed on 20th April 2024*

The influence of stakeholders such as the Health Management Committee and influential local leaders underscores their decision-making power and lobbying capabilities in healthcare service delivery improvements.

Stakeholder engagement in implementation of health care service delivery.

This section investigates the extent of stakeholder involvement in the implementation of healthcare services at Lyantonde District Hospital, focusing on perspectives from community members, health workers, District Health Department officials, and the District Health Officer. The aim was to assess the level of engagement among various stakeholders in the operationalization and delivery of quality healthcare services.

Table 3: Stakeholder engagement in implementation of health care service delivery

Response	SA (%)	A (%)	NS (%)	D (%)	SD (%)	Mean (μ)	Std Deviation (δ)	Decision
There are some community members who are employed in the hospital	67 (29.3)	75 (32.8)	23 (10.0)	26 (11.4)	38 (16.6)	3.47	1.437	Agree
Some community members take part in healthcare service delivery	32 (14.0)	88 (38.4)	33 (14.4)	42 (18.3)	34 (14.8)	3.10	1.302	Disagree
Some community members take part in the	48 (21.0)	68 (29.7)	48 (21.0)	40 (17.5)	25 (10.9)	3.32	1.284	Agree

implementation of hospital projects								
Local leaders are always consulted for any activity	45 (19.7)	83 (36.2)	40 (17.5)	39 (17.0)	22 (9.6)	3.39	1.247	Agree
The district is always aware of the hospital activities	33 (14.4)	89 (38.9)	26 (11.4)	50 (21.8)	31 (13.5)	3.19	1.303	Agree
The district leaders and other local leader always take part in hospital activities	42 (18.3)	81 (35.4)	21 (9.2)	44 (19.2)	41 (17.9)	3.17	1.405	Agree
Stakeholders always take part in resource mobilization for the hospital	28 (12.2)	34 (14.8)	45 (19.7)	59 (25.8)	63 (27.5)	2.59	1.353	Disagree
Some stakeholders facilitate in some trainings	13 (5.7)	48 (21.0)	50 (21.8)	63 (27.5)	55 (24.0)	2.57	1.222	Disagree
The presence of local leaders at hospital-organized events consistently influences service delivery	47 (20.5)	95 (41.5)	17 (7.4)	39 (17.0)	31 (13.5)	3.38	1.345	Agree

NB: N= 229, SA = Strongly Agree, A = Agree, NS = Not Sure, D = Disagree, SD = Strongly Disagree, Decision = Weighted Average=3.14.

Source: *Field Data, 2024*

According to the analysis of the findings in table 3 above, majority of the respondents indicated that there are some community members who are employed in the hospital and some community members take part in the implementation of hospital projects. These were presented by a mean (μ) of 3.47 and 3.32 which is greater that the grand mean on 3.14. Furthermore, respondents revealed that the local leaders are always consulted for any activity, the district is always aware of the hospital activities and the district leaders and other local leader always take part in hospital activities. These are represented by means (μ) of 3.39, 3.19 and 3.17 respectively which is greater than the weighted mean on 3.14.

During an interview with one of the key informants (Senior Hospital Administrator), He mentioned "……. *you cannot leave the local leaders behind when you are working on things of the public. They are very influential and can help in convincing the public*". (Interviewed on 19th April 2024) This implied that local leaders are always involved in all activities of the hospital because of their role, power /influence and capacity to mobilize resources from the government.

The analysis reveals a notable lack of community engagement in various aspects of health care service delivery, with mean scores of 3.10 for engagement in service delivery activities and 2.59 for participation in resource mobilization, both falling below the weighted average of 3.14. For targeted service delivery, this highlights the need to identify barriers to engagement, such as lack of awareness or socio-economic challenges, and to develop strategies to increase community involvement through meetings, feedback

mechanisms, and participatory planning sessions. Tailored outreach programs should target underrepresented groups to foster a sense of ownership and responsibility, while efforts to educate the community on the importance of their contributions can enhance resource mobilization. Establishing robust monitoring and feedback systems involving community members will ensure transparency and accountability, and investing in capacity building for healthcare providers and community leaders can facilitate better engagement and collaboration. Addressing these areas will lead to more effective and sustainable healthcare outcomes.

In an interview with the key informants, they revealed that before involving the stakeholders, they consider the activity that is going to be implemented and their role in that activity. This statement underscores the importance of strategic planning and stakeholder assessment before implementation begins, suggesting a structured approach to stakeholder engagement. "Other factors they consider for stakeholder involvement are the capacity of the stakeholder in the planning process and the ability to cascade information to the community about the hospital and government plans. This highlights additional criteria used to determine stakeholder involvement, emphasizing not only capacity but also communication capabilities crucial for community engagement. "This implies that stakeholder involvement in the implementation of hospital activities depends on their influence and power, This insight suggests that stakeholders' influence and power are pivotal in shaping their involvement and effectiveness in driving hospital activities forward, influencing decision-making and community outreach efforts.

Stakeholder engagement in Monitoring and Evaluation (M&E) and quality healthcare service delivery.

The third objective aimed at establishing the effect of stakeholder engagement in monitoring and evaluation of hospital activities on the quality of healthcare service delivery at Lyantonde District Health Care service delivery. This was paused to all the respondents in the study and the responses are as presented in table 4 below.

Table 4: Stakeholder engagement in Monitoring and Evaluation (M&E) and quality healthcare service delivery

Response	SA (%)	A (%)	NS (%)	D (%)	SD (%)	Mean (μ)	Std Deviation (δ)	Decision
Stakeholder engagement results in better transparency and accountability	71 (31.0)	80 (34.9)	28 (12.2)	33 (14.4)	17 (7.4)	3.69	1.257	Agree
Stakeholder engagement in monitoring and Evaluation helps to make sure that the intended beneficiaries receive the service	56 (24.5)	117 (51.1)	26 (11.4)	14 (6.1)	16 (7.0)	3.80	1.094	Disagree
Stakeholder engagement in monitoring and evaluation process helps in ensuring quality service delivery	82 (35.8)	97 (42.4)	14 (6.1)	23 (10.0)	13 (5.7)	3.93	1.154	Agree

Stakeholder involvement helps to reduce errors and mistakes	58 (25.3)	96 (41.9)	22 (9.6)	34 (14.8)	19 (8.3)	3.61	1.243	Strongly Disagree
Stakeholder engagement in monitoring and Evaluation helps Decision Making	75 (32.8)	87 (38.0)	29 (12.7)	20 (8.7)	18 (7.9)	3.79	1.214	Agree
Stakeholder engagement in monitoring and Evaluation helps to make sure that their interests are met	47 (20.5)	103 (45.0)	27 (11.8)	29 (12.7)	23 (10.0)	3.53	1.234	Disagree
Stakeholder engagement in monitoring and evaluation helps in creating public awareness of the programmes	57 (24.9)	90 (39.3)	20 (8.7)	35 (15.3)	27 (11.8)	3.50	1.330	Disagree
Stakeholder engagement in monitoring and Evaluation helps timely completion of the project or activities	69 (30.1)	105 (45.9)	23 (10.0)	22 (9.6)	10 (4.4)	3.88	1.081	Strongly Agree
Stakeholder engagement in monitoring helps in efficient resource utilization	46 (20.1)	97 (42.4)	30 (13.1)	35 (15.3)	21 (9.2)	3.49	1.231	Strongly Disagree

Note: N= 229, SA = Strongly Agree, A = Agree, NS = Not Sure, D = Disagree, SD = Strongly Disagree, Decision = Weighted Average=3.69.

Source: *Field Data, 2024*

The problem idea is that the healthcare delivery in Lyantonde is of poor quality, and there is a need to understand why, hence the need to study stakeholder engagement. Specifically, the focus is on whether stakeholders are engaged in Monitoring and Evaluation (M&E) activities. The study findings in Table 4 reveal that the majority of respondents indicated that stakeholder engagement in M&E positively impacts transparency, accountability, quality service delivery, decision-making, and timely project completion, with mean scores of 3.69, 3.93, 3.79, and 3.88 respectively, all above the weighted mean of 3.69.

Verbatim quotes from the study further support this: *"Stakeholder involvement guides the planning process since stakeholders know what the community needs and can identify areas of prioritization, which helps to create more impact,"* said by the respondent three (Health worker, interviewed on 18th April 2024). This highlights that stakeholders' engagement in M&E is critical for improving healthcare quality by ensuring that community needs are prioritized and that there is better planning, transparency, and accountability.

However, the study findings show that a majority of the respondents indicated that stakeholder engagement in Monitoring and Evaluation (M&E) does not effectively ensure that the intended beneficiaries do not receive services, nor does it help reduce errors and mistakes. This is evidenced by the mean scores of 3.80 and 3.61, which are less than the weighted mean of 3.69

Findings further established that majority of the respondents disagreed to the statement that stakeholder engagement in monitoring and evaluation could help to make sure that their interests are met as it was represented by mean (μ) of 3.53 which was less than grand mean of 3.69. During an interview one of the patients (respondent four, interviewed on 18th April 2024), they stated that the statement *"the hospital doesn't involve us to ask us the challenges we face and even when they are doing things they don't tell us. So we can't tell all their plans. We just see things being done." source* highlights significant communication and engagement issues between the hospital and the community. This lack of involvement suggests a top-down approach where community input is neglected, leading to misaligned priorities and ineffective solutions. Transparency issues arise as the community remains uninformed about hospital plans, breeding mistrust and reducing support for initiatives. The absence of community feedback results in missed opportunities for service improvement, and dissatisfaction may increase as a result. To address these issues, the hospital should adopt participatory approaches, involving the community in planning and decision-making processes to enhance trust, relevance, ownership and effectiveness of healthcare services.

The findings indicate that a majority of respondents, with a mean score of 3.50, disagree that stakeholders are effectively engaged in monitoring and evaluation (M&E) activities related to public awareness programs. Furthermore, they perceive that stakeholder engagement does not significantly contribute to efficient resource utilization, as evidenced by a mean score of 3.49, both of which are below the grand mean of 3.69. This suggests that while stakeholder engagement in M&E is theoretically crucial for improving transparency, accountability, and service delivery, the current practice does not reflect this. As one of the respondent (five, community member, interviewed on 18th April 2024) noted, *"The hospital doesn't involve us in identifying the challenges we face and they don't communicate their plans effectively. We just see things being done without understanding the underlying processes."* This comment underscores the lack of communication and involvement in M&E activities, which hampers effective resource utilization and public awareness. The data highlights the need for improved stakeholder engagement in M&E processes to address these issues more effectively.

Table 5: Indicating stakeholders and their level of involvement in the implementation of hospital activities

Activities	Position of the Respondents	SD	D	NS	A	SA
Take part in planning for health service delivery in our area	Health Workers	5 (35.7%)	4 (28.6%)	0.0%	3 (21.4%)	2 (14.3%)
Hospital Administration	0	0	0	0	10 (100%)	
Doctor	0	0	0	1 (16.7%)	5 (83.3%)	
Hospital Management Committee	0	0	0	0	10 (100%)	

District Health Department	0	0	0	0	10 (100%)	
Patients	88 (42.9%)	54 (26.3%)	19 (9.3%)	35 (17.1%)	9 (4.4%)	
Biostatistician	0	0	0	0	1 (100%)	
DHO	0	0	0	0	1 (100%)	
Take part in the implementation of hospital activities	Health Workers	5 (35.7%)	4 (28.6%)	0.0%	3 (21.4%)	2 (14.3%)
Hospital Administration	0	0	0	0	10 (100%)	
Doctor	0	0	0	1 (16.7%)	5 (83.3%)	
Hospital Management Committee	0	0	0	0	10 (100%)	
District Health Department	0	0	0	0	10 (100%)	
Patients	88 (42.9%)	54 (26.3%)	19 (9.3%)	35 (17.1%)	9 (4.4%)	
Biostatistician	0	0	0	0	1 (100%)	
DHO	0	0	0	0	1 (100%)	
Take part in Monitoring & Evaluation of hospital activities	Health Workers	2 (14.3%)	7 (50.0%)	1 (7.1%)	2 (14.3%)	2 (14.3%)
Hospital Administration	0	0	0	3 (30.0%)	7 (70.0%)	
Doctor	0	0	0	2 (33.3%)	4 (66.7%)	
Hospital Management Committee	0	0	0	0	10 (100%)	
District Health Department	0	0	0	6 (60.0%)	4 (40.0%)	
Patients	40 (19.5%)	37 (18.0%)	38 (18.5%)	57 (27.8%)	33 (16.1%)	
Biostatistician	0	0	0	0	1 (100%)	
DHO	0	0	0	0	1 (100%)	

Source: *Field Data, 2024*

The data in Table 5 reveals varying levels of involvement among different stakeholders in the planning, implementation, and monitoring & evaluation (M&E) of hospital activities at Lyantonde District Hospital. In the planning for health service delivery, high involvement is observed among the hospital administration, the hospital management committee, the district health department, the District Health Officer (DHO), and doctors. In contrast, health workers and patients have low involvement, with health workers at 35.7% SD and 28.6% D, and patients at 42.9% SD and 26.3% D. This indicates that planning

activities are primarily conducted by higher management, while health workers and patients feel largely excluded. This top-down planning approach lacks input from frontline staff and beneficiaries, potentially leading to plans that do not fully address on-the-ground realities and community needs.

Similarly, in the implementation of hospital activities, high involvement is again seen among the hospital administration, the hospital management committee, the district health department, the DHO, and doctors, while health workers and patients show low involvement, with the same percentages as in the planning phase. This pattern suggests that implementation is also dominated by the hospital administration and higher management, with limited involvement from health workers and patients. This could result in a lack of ownership and commitment from those directly involved in delivering and receiving healthcare services, potentially impacting the effectiveness and sustainability of the hospital's activities.

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter examines the findings of a study on the influence of stakeholder engagement on quality healthcare service delivery in government hospitals within Lyantonde district, Uganda. It also presents recommendations aimed at enhancing healthcare service delivery across the district and the country as a whole.

Summary of the findings

The study engaged various stakeholders, predominantly patients (79.8%) and health workers (9.3%), highlighting their critical roles as key respondents.

Discussion of the Findings

Stakeholder engagement in planning and Healthcare Service Delivery

The findings reveal a pronounced gap in stakeholder engagement in the planning of healthcare service delivery at Lyantonde District Hospital. Data from Table 2 indicate that involvement in planning varies significantly among different stakeholder groups. For example, only 36% of respondents strongly agree or agree that they always participate in planning, and mean scores for statements regarding stakeholder involvement in meetings and consultations are below the overall weighted average of 2.88. This suggests that while some community representatives are involved in budget formulation and the Hospital Administration communicates changes, the broader engagement of primary stakeholders such as patients and community members remain limited.

According to WHO (2018) and Nayebare (2020), effective community involvement in health service design is essential for improving health outcomes. However, the data indicates that planning processes at Lyantonde District Hospital primarily involve district leaders, technical committees, and implementing partners, with minimal input from patients and other community members. This is reflected in the interview data, where key informants highlighted that planning often relies on the lobbying capacity of influential stakeholders, which can marginalize the voices of those directly affected by healthcare services. As one key informant noted, “The lobbying capacity by implementing partners, civil society organizations, and district leaders makes them important,” underscoring the preference for engaging influential stakeholders rather than community members who may lack similar influence.

Stakeholder engagement in implementation and quality Healthcare Service Delivery

Results show varying levels of stakeholder involvement in the implementation of healthcare services. Community members and local leaders are reported to have relatively high involvement in certain activities, such as employment in the hospital and participation in hospital projects. However, the data

also reveal low levels of engagement among patients and health workers in service delivery activities and resource mobilization, as indicated by mean scores below the grand mean of 3.14.

Interviews with key informants suggest that local leaders play a crucial role due to their influence and resource mobilization capabilities, which aligns with the higher levels of involvement reported. This involvement is crucial as it ensures that local leaders can advocate for community needs and support hospital activities effectively. However, the lack of engagement from health workers and patients, as shown in Table 5, suggests a top-down approach where higher management drives implementation without sufficient input from those directly involved in or affected by the service delivery. This approach may result in lower ownership and commitment from health workers and patients, potentially affecting the effectiveness and sustainability of healthcare interventions.

Stakeholder engagement in monitoring and evaluation (M&E) and quality Healthcare Service Delivery

Again, study found that stakeholder engagement in M&E activities is perceived to positively impact transparency, accountability, and quality service delivery, with mean scores above the weighted mean of 3.69. However, despite these positive perceptions, there are concerns about the effectiveness of M&E in ensuring that beneficiaries receive services and in reducing errors, with mean scores of 3.80 and 3.61, respectively.

Key informants have reported significant issues in communication and engagement between the hospital and the community. One respondent's comment—"The hospital doesn't involve us in identifying the challenges we face and they don't communicate their plans effectively. We just see things being done without understanding the underlying processes"—highlights the deficiencies in stakeholder engagement in M&E activities. This lack of involvement results in missed opportunities for improving service delivery and transparency, suggesting a need for more inclusive and participatory approaches.

CONCLUSIONS

Assess stakeholder engagement in planning for Healthcare Service Delivery

The study has identified a substantial gap in the engagement of primary stakeholders—specifically community members and patients—in the planning of healthcare service delivery at Lyantonde District Hospital. Analysis of the data shows that while secondary stakeholders such as district leaders and technical committees are regularly consulted, the involvement of those directly affected by healthcare services remains limited. This underrepresentation of primary stakeholders highlights a disconnect between healthcare planning processes and the actual needs and expectations of the community. The low mean scores and high percentage of disagreement from respondents underscore the need for greater inclusivity in planning processes. Recommendations from global health organizations, such as WHO (2018) and Nayebare (2020), advocate for active community involvement to improve service design and health outcomes. Thus, integrating community input more effectively could lead to more responsive and relevant healthcare solutions, addressing the identified disparities.

Evaluate stakeholder engagement in implementing Hospital activities

The findings reveal that community members are partially involved in the implementation of hospital activities, primarily through employment and sporadic consultations. Despite some positive feedback regarding community involvement in hospital projects, the predominant role of secondary stakeholders—such as district leaders and local authorities—suggests an imbalanced engagement approach. This reliance on secondary stakeholders limits the potential for broader community ownership and the effectiveness of

health initiatives. The relatively high mean scores for involvement in certain implementation aspects, contrasted with lower scores in resource mobilization and community engagement, indicate a partial integration of stakeholders into implementation activities. Greater inclusivity of community members in the implementation phase could enhance the effectiveness and sustainability of healthcare programs, as suggested by Fischer and Qaim (2014), who emphasize the importance of broader stakeholder participation in achieving project success.

Analyze stakeholder engagement in Monitoring and Evaluation (M&E) of Hospital activities

Stakeholder engagement in Monitoring and Evaluation (M&E) is crucial for enhancing transparency, accountability, and decision-making in healthcare service delivery. The study indicates that while stakeholder engagement in M&E is positively associated with better project outcomes, there are significant areas needing improvement. The high mean scores related to transparency, accountability, and decision-making reflect the potential benefits of involving stakeholders in M&E processes. However, lower scores regarding the effectiveness of M&E in ensuring beneficiaries receive services and in resource utilization highlight gaps in current practices. These findings suggest that while M&E processes involve stakeholders to some extent, there is room for improvement in ensuring that their engagement translates into effective service delivery and optimal resource use. Previous studies, including those by Lapenu & Pierret (2005) and Kananura et al. (2017), support the notion that early and active stakeholder dialogue can align expectations and mitigate risks, thus enhancing the overall quality of healthcare services.

RECOMMENDATIONS

Enhance community involvement in planning

To address the identified disparity in stakeholder engagement during the planning phase, it is crucial to develop and implement strategies that actively involve community members and patients. This can be achieved through the establishment of regular community consultations, participatory planning sessions, and effective feedback mechanisms. Additionally, forming community advisory boards or focus groups can provide ongoing input and ensure that healthcare plans are more closely aligned with the real needs and priorities of the local population. By incorporating these practices, healthcare planning can become more inclusive and responsive to the needs of those directly affected by the services.

Increase community participation in implementation

The study highlights the need for greater community involvement in the implementation of healthcare activities. To enhance this, it is recommended to expand opportunities for community members to participate through various roles such as employment, volunteer positions, and advisory roles. Building partnerships with local organizations and community leaders can facilitate more effective project implementation and resource mobilization. By actively involving community members in these capacities, healthcare initiatives are likely to benefit from increased ownership, effectiveness, and sustainability.

Strengthen stakeholder engagement in monitoring and evaluation (M&E)

To improve stakeholder engagement in Monitoring and Evaluation (M&E) processes, it is important to enhance communication and transparency between the hospital and the community. This can be achieved by involving stakeholders more comprehensively in M&E activities through regular meetings and feedback sessions. Ensuring that stakeholder concerns are addressed and that M&E findings inform and adjust healthcare strategies is crucial. Furthermore, strengthening stakeholder training and capacity-building initiatives will help ensure that their engagement contributes effectively to resource utilization

and public awareness. By implementing these recommendations, stakeholder engagement in M&E can lead to more transparent, accountable, and responsive healthcare service delivery.

Areas of further research

- The researcher suggests that further research be undertaken to establish stakeholder's knowledge and competences to effectively do monitoring and evaluation of the projects of such nature.
- There is also a need to establish the tools, techniques and the criteria used by the stakeholders in monitoring and evaluation of such projects.
- A study should also be done to establish how different stakeholders are using their power and authority of influence in the implementation of government projects

References

1. African Development Bank Group. (2011). *AfDB Group Annual Report 2011*. Retrieved from African Development Bank Group
2. Arnstein, S. R. (1969). *A ladder of citizen participation.* Journal of the American Institute of Planners, 35(4), 216-224.
3. Bates, C., & Memel, T. (2021). *Florence Nightingale and the history of health care service delivery.* Cambridge University Press.
4. Boulding, W., Kalra, A., Staelin, R., & Zeithaml, V. A. (1993). *A dynamic process model of service quality: From expectations to behavioral intentions.* Journal of Marketing Research, 30(1), 7-27.
5. British Broadcasting Corporation. (2013). *The Beveridge Report and the establishment of the National Health Service.* British Broadcasting Corporation.
6. Chamberland, C. (1904). *Louis Pasteur and the germ theory.* Lippincott.
7. Chinyio, E., & Olomolaiye, P. (2010). *Construction stakeholder management.* Wiley-Blackwell.
8. Coghe, S., & Berlin, D. (2022). *African public health systems and colonial influence.* Palgrave Macmillan.
9. Conscannon, T. W., Meissner, P., Srinivasan, A., Reede, C., Phelps, C., & Mittman, B. (2012*). Engaging stakeholders in comparative effectiveness research: The experience of the Effective Health Care Program.* Journal of Comparative Effectiveness Research, 1(3), 367-370.
10. Crosby, P. B. (1979). *Quality is free: The art of making quality certain.* McGraw-Hill.
11. Donaldson, T., & Preston, L. E. (1995). *The stakeholder theory of the corporation: Concepts, evidence, and implications.* Academy of Management Review, 20(1), 65-91.
12. European Observatory on Health Care Systems. (2000). *Health care systems in transition: Germany.* European Observatory on Health Care Systems.
13. Freeman, R. E. (1984). *Strategic Management: A Stakeholder Approach.* Boston: Pitman.
14. Frooman, J. (2010). *Stakeholder influence strategies.* Academy of Management Review, 24(2), 191-205.
15. Gibson, K. (2000). The moral basis of stakeholder theory. Journal of Business Ethics, 26(3), 245-257.
16. Kaiser Permanente. (2006). Henry J. Kaiser: *America's Health Care Visionary.* Retrieved from https://about.kaiserpermanente.org/who-we-are/our-history/henry-j-kaiser-americas-health-care-visionary.
17. Kananura, R. M., Ekirapa-Kiracho, E., Waiswa, P., Bua, J., Kadobera, D., Nakigudde, J., ... & Tetui, M. (2017). *Participatory monitoring and evaluation approaches that influence stakeholders'*

collaboration and the implementation of rural maternal and newborn health systems in Eastern Uganda. Health Research Policy and Systems, 15(1), 1-14.

18. Kandampully, J., & Butler, L. (2001). *Service guarantees: A strategic mechanism to minimize customers' perceived risk in service organizations.* Managing Service Quality: An International Journal, 11(2), 112-121.
19. Karama, A., & Iravo, M. (2019). *Influence of stakeholder involvement on the performance of road construction projects in Kenya.* International Academic Journal of Information Sciences and Project Management, 3(4), 28-40.
20. Khwanja, J. (2014). *The pitfalls of stakeholder participation in decision-making.* Journal of Health Management, 16(3), 335-350.
21. Kujala, J., Lehtimäki, H., & Mäkelä, M. (2022). *Understanding the Complexity of Stakeholder Engagement in Service Ecosystems.* Journal of Business Ethics, 176(1), 123-141
22. Lapenu, C., & Pierret, D. (2005). *The role of stakeholders in microfinance programs: A case study from the Latin American context.* Savings and Development, 29(2), 167-194.
23. Lawn, J. E., Rohde, J., Rifkin, S., Were, M., Paul, V. K., & Chopra, M. (2008). *Alma-Ata 30 years on: Revolutionary, relevant, and time to revitalize.* The Lancet, 372(9642), 917-927.
24. Leonidou, L. C., Christodoulides, P., Kyrgidou, L. P., & Palihawadana, D. (2020). *Internal drivers and performance consequences of small firm green business strategy: The moderating role of external forces.* Journal of Business Ethics, 151(4), 1009-1029.
25. Lipineux, J. (2005). *Stakeholder theory in the modern healthcare environment.* Health Policy and Planning, 20(3), 178-186.
26. Lyantonde District Local Government. (2014). *District population and health services.* Lyantonde District Local Government.
27. Lyantonde District Local Government. (2020). *Lyantonde District Development Plan (2020–2025).* Lyantonde District Local Government.
28. Lyantonde District Local Government. (2021). *Lyantonde District Approved Budget Estimates FY 2020/2021*. Lyantonde District Local Government
29. Merriam-Webster. (n.d.). Open source. *In Merriam-Webster.com dictionary.* Retrieved from https://www.merriam-webster.com/dictionary/open%20source
30. Ministry of Health (MOH). (2021). *Annual Health Sector Performance Report 2020/2021*. Kampala: Ministry of Health.
31. Ministry of Health. (2016). *Health sector development and improvements.* Government of Uganda.
32. Mitchell, R. K., Agle, B. R., & Wood, D. J. (1997). *Toward a theory of stakeholder identification and salience: Defining the principle of who and what really counts.* Academy of Management Review, 22(4), 853-886.
33. Mitchell, R., Agle, B., & Wood, D. (2022). *Towards a theory of stakeholder identification and salience: Defining the principle of who and what really counts.* Academy of Management Review, 22(4), 853-886.
34. Moodley, K. (2002). *Stakeholder participation in health policy decisions: an analysis of the dynamics of representative democracy.* Journal of Health Politics, Policy and Law, 27(5), 798-812.
35. Mostafa, M. M. (2005). *An empirical study of patients' expectations and satisfactions in Egyptian private hospitals.* International Journal of Health Care Quality Assurance, 18(7), 516-532.

36. Nabukeera, M. (2016). *The effectiveness of health service delivery in Uganda's public hospitals.* Makerere University Press.
37. National Medical Stores. (2019). *Drug supply chain management and distribution.* National Medical Stores
38. Nayebare, P. (2020). *WHO guidelines for improving health service delivery.* Journal of Health Services Research, 15(3), 45-58.
39. Nduhura, M., Nansamba, C., et al. (2022). *Community perspectives on healthcare service delivery in Lyantonde District.* Journal of Health Services Research, 15(3), 45-58.
40. Nutt, P. C., & Backoff, R. W. (1992). *Strategic Management of Public and Third Sector Organizations: A Handbook for Leaders.* San Francisco: Jossey-Bass.
41. OECD. (2020). *Health at a Glance: Europe 2020.* Paris: OECD Publishing.
42. Patouillard, E., Goodman, C. A., Hanson, K. G., & Mills, A. J. (2007). *Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature.* International Journal for Equity in Health, 6(1), 17.
43. Pearce, J. A., & Robinson, R. B. (2011). *Strategic management: Formulation, implementation, and control.* McGraw-Hill.
44. Reynolds, S. J., Schultz, F. C., & Hekman, D. R. (2009). *Stakeholder theory and managerial decision-making: Constraints and implications of balancing stakeholder interests.* Journal of Business Ethics, 64(3), 285-301.
45. Rust, R. T., & Zahorik, A. J. (1993). *Customer satisfaction, customer retention, and market share.* Journal of Retailing, 69(2), 193-215.
46. Savage, G. T., Nix, T. W., Whitehead, C. J., & Blair, J. D. (1991*). Strategies for assessing and managing organizational stakeholders.* Academy of Management Executive, 5(2), 61-75.
47. Sawicki, P. T., & Bastian, H. (2008). *Otto von Bismarck and the development of the German healthcare system.* Springer
48. Shaw, D., Ackermann, F., & Eden, C. (2003). *Approaches to sharing knowledge in group problem structuring.* Journal of the Operational Research Society, 54(9), 936-948.
49. Sheingold, B. H., & Hahn, J. A. (2014). *The history of health care in the United States.* In M. F. Purnell (Ed.), Healthcare System: Fundamentals and Challenges (pp. 45-67). Springer Publishing.
50. Ssengooba, F. (2004). *Primary health care in Uganda.* Makerere University Press.
51. Stel, N., Hilhorst, D., & Van der Haar, G. (2012). *Challenging the State in Central Africa: The influence of informal governance on health service delivery in the Eastern DRC.* Development Policy Review, 30(4), 425-444.
52. Stilson, M. (2000). *Missionary work and the development of health care systems in Africa.* Macmillan.
53. Sulemana, I., James Jr, H. S., & Valdivia, C. B. (2018). *The impact of participation in community development projects on civic attitudes and behaviors in Ghana.* Journal of Rural Studies, 62, 146-158.
54. Tennoya, E., Goudarzi, F., & Wu, H. (2015). *Stakeholder participation in health system governance: A critical review.* Journal of Health Policy and Planning, 30(2), 187-195.
55. The Institute of Internal Auditors. (2006). *Internal audit standards.* Retrieved from https://www.theiia.org/

56. Travis, P., Bennett, S., Haines, A., Pang, T., Bhutta, Z., Hyder, A. A., … & Evans, T. (2004). *Overcoming health-systems constraints to achieve the Millennium Development Goals.* The Lancet, 364(9437), 900-906.
57. Uganda AIDS Commission (UAC). (2021). *HIV prevalence and health metrics in Lyantonde District.* Uganda AIDS Commission.
58. Uganda Bureau of Statistics (UBOS). (2014). *National Population and Housing Census 2014 - Main Report.* Kampala: Uganda Bureau of Statistics.
59. United Nations General Assembly. (2015). *Transforming our world: The 2030 Agenda for Sustainable Development.* United Nations.
60. Waheduzzaman, W. (2010). *Obstacles to effective citizen participation in public administration: The case of Bangladesh.* International Journal of Public Administration, 33(14), 774-786.
61. Waite, L. (1987). *Public health systems in pre-colonial East Africa*. Routledge
62. World Health Organization. (1978). *Alma-Ata Declaration.* World Health Organization Press
63. World Health Organization. (2000). *Health systems: Improving performance.* World Health Report 2000.
64. World Health Organization. (2008). *Primary health care: Now more than ever.* World Health Report 2008.
65. World Health Organization. (2012). *Strengthening health systems in Africa.* World Health Organization Press.
66. World Health Organization. (2018). *Delivering quality health services: A global imperative for universal health coverage.* Geneva: World Health Organization.
67. World Health Organization. (2020). *Naming the coronavirus disease (COVID-19) and the virus that causes it.* Retrieved from https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it
68. Wright, M. (2008). *Stakeholder engagement and organizational performance*. Oxford University Press.
69. Zikusooka, C. M., & Kyomuhangi, R. (2008). *Private medical services in Uganda*. Health Economics Unit, University of Cape Town in the Regional Network for Equity in Health in East and Southern Africa (EQUINET).
70. Zwane, T., & Matsiliza, N. (2022). *Stakeholder engagement and the provision of quality healthcare services in South Africa.* International Journal of Public Administration, 45(6), 459-471.