

RELATIONSHIP BETWEEN COMMUNITY-BASED SUPERVISION AND HEALTH SERVICE DELIVERY IN PAKWACH DISTRICT LOCAL GOVERNMENT. A CROSS-SECTIONAL STUDY.

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Page | 1 **Abstract**

Background

Supervision in healthcare systems can be seen as an integral part of the larger health system. The purpose of the study was to examine the relationship between community-based supervision and health service delivery in Pakwach District Local Government.

Methodology

Mixed research approach using a cross-sectional survey design. Quantitative data was coded and summarized using frequency tables. Descriptive statistics, frequencies, and percentages were used to describe quantitative data. Pearson correlation was used to establish the relationships in line with the study objectives.

Results

63 (63%) were male, while 37 (37%) were female; the majority of respondents fell within the 31–40 years age group, accounting for 43%. Respondents were asked whether community members receive updates on equipment available at health centers. The Majority of the respondents (53%) disagreed. **In-charge, Sub-county Health Centre III said, "The concept of community-based supervision is important, but it's not working well here. Most of the community doesn't feel empowered or informed enough to monitor health services.** Results show a weak positive correlation ($r=0.314$) between community-based supervision and health service delivery, which is statistically significant at the 0.05 level ($p = 0.040$). This indicates the increased involvement of the community in supervising health.

Conclusions

The study reveals a statistically significant but weak positive correlation ($r=0.314$) between community-based supervision and health service delivery, highlighting the potential value of community involvement in enhancing health outcomes. While mechanisms like suggestion boxes and leader visits show some level of activity, the overall low engagement in broader community oversight, like surveys, health committees, and public forums, underscores a critical gap in participatory governance.

Recommendations

Pakwach District local government should revitalize and support health committees at the facility and community levels by providing training, clear roles, and regular engagement opportunities to ensure meaningful participation in planning, monitoring, and feedback processes.

Keywords: Relationship, Community-based supervision, Health service delivery, Pakwach District Local Government.

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Background

Healthcare organizations must be viewed as complex adaptive systems where supervision serves as a crucial component to monitor and guide the functioning of these systems (Ahn et al., 2020). Supervision in healthcare systems can be seen as an integral part of the larger health system. In the context of systems theory, supervision ensures that all parts of the healthcare system, such as human resources, medical equipment, and healthcare policies, are functioning optimally to provide quality care. Supervision can be categorized as direct, supportive, and indirect, all of which influence different parts of the system in various ways.

Effective supervision in healthcare settings leads to improved workforce performance, better utilization of resources, and ultimately, higher quality service delivery (Thiel et al., 2021). This aligns with the systems theory's premise that supervision helps coordinate various system components to achieve desired outcomes, such as better patient care and improved health outcomes. The relationship between supervision and health service delivery can be effectively understood through the lens of systems theory. As part of the healthcare system, supervision ensures that healthcare workers receive the guidance, training, and support they need to deliver quality care. Poor supervision, on the other hand, can result in inefficient practices, resource misallocation, and

ultimately poor health outcomes. For example, Kates et al. (2019) argue that poor supervision can lead to a breakdown in communication within the healthcare system, making it difficult to implement changes or improvements. This inefficiency can create bottlenecks in service delivery, such as long waiting times or stock-outs of essential medications. Systems theory, in this case, highlights how issues in one part of the healthcare system, such as ineffective supervision, can ripple across other parts, leading to systemic inefficiencies.

A study by Osei-Akoto and Duku (2023) further underscores the importance of supervision in fostering accountability in healthcare delivery. Supervisors monitor performance at various levels and ensure that health services meet standards of care. In line with systems theory, supervision acts as a feedback loop that helps identify issues in real time and adjust the system accordingly to prevent negative outcomes. A study by Sarpong and Ofori (2022) found that districts with more robust supervision mechanisms showed better health system performance, as supervision allowed for better resource allocation, improved coordination between different health levels, and enhanced staff motivation. This study suggests that when supervision is effectively integrated into the health system, it helps identify and address inefficiencies that hinder service delivery. The studies reviewed highlight the centrality of supervision in improving health service delivery within local government systems. Supervision plays a key role in ensuring that healthcare workers are adequately trained, motivated, and provided with the necessary resources to perform their duties effectively. The positive effects of regular and supportive supervision are evident in improved workforce performance, higher patient satisfaction, and better health outcomes. However, challenges such as inadequate resources, limited infrastructure, and lack of standardized supervision frameworks continue to undermine the effectiveness of supervision in many local government health systems. The purpose of the study was to examine the relationship between community-based supervision and health service delivery in Pakwach District Local Government.

METHODOLOGY

Study Design

The researcher employed a mixed research approach using a cross-sectional survey design. A mixed research design involved the combination of both quantitative and qualitative research methods to gain a comprehensive understanding of the research problem. In the study, this approach allowed the researcher to explore the measurable aspects of supervision and its impact on health service delivery, as well as the deeper, contextual factors that influenced the effectiveness of supervision at the local government level.

A cross-sectional research methodology was used, which involved collecting data at a single point in time to provide a snapshot of the current state of supervision and health

service delivery in Pakwach District. This was appropriate for studying the relationships between different variables and identifying patterns or trends that could inform future policy and practice.

Study Population

According to the nature of the study, 145 individuals were included in the target population. These individuals included 8 doctors, 66 nurses in various health centers within the district, and 53 patients who were found at the selected health centers within Pakwach District Local Government on the day of data collection. Further, the study included 18 members of the District Health Committee.

Doctors often supervise clinical activities and provide leadership within health centers. Understanding their experiences with supervision and how it impacts their ability to deliver quality healthcare was essential for evaluating the effectiveness of the local government's supervision framework. Including doctors in the study provided insights into the higher levels of supervision and clinical decision-making impact on service quality at the district level.

Nurses in various health centers across Pakwach represented a diverse group working in different environments (urban vs. rural health centers) and provided a broad perspective on the challenges and benefits of supervision in local government health facilities.

Patients in health centers directly observed and experienced the results of effective or ineffective supervision. For example, they noticed long waiting times, the availability of medical supplies, the responsiveness of healthcare workers, and the overall quality of care.

The District Health Committee (DHC) was responsible for guiding and supporting healthcare management decisions, allocating resources, ensuring the quality of care, and overseeing the implementation of health policies. Their perspectives on supervision provided a policy-level view of how health services were managed and how the supervisory framework was designed and executed at the local government level.

Selection of Sample Size

The sample size for this investigation was determined using Sloane's formula (1960). The fact that Sloane's formula is the best method for selecting a sample size in a population with which little is known justifies its use.

Where N=target population
e = 0.05 level of significance
n= sample size

$$n = \frac{145}{1 + 145(0.0025)}$$

= 106 Respondents

Table 1: Sample Dimensions and Sample Choice

Respondents	Target population	Samples size	Sampling Technique
Doctors	08	08	Purposive sampling
Nurses	66	56	Purposive sampling
District Health Committee members	18	08	Convenience sampling
Patients	53	34	Convenience sampling
Total	145	106	

Source: Primary data (2025)

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Therefore the target population of the study constituted 8 doctors, 56 nurses, 08 district health committee members and 34 patients that were willing to participate in the study on day the researcher visited the selected health facilities.

Sampling Procedure

The researcher used purposive sampling to select doctors and nurses at government-aided health centers as respondents to the study. The method was selected because these were key to the study, as they had more knowledge about the study variables.

Also the researcher used convenience sampling to select members of the District Health Committee and Patients who were accessible and willing to engage in the study to give their opinion on quality of services provided by government health workers in the District.

Methods for Collecting Data

Various tools were used to collect for this study and these were; questionnaires, interview guide and document inspection checklists as explained below.

Questionnaires

This is a resource for learning facts, viewpoints, views, beliefs, attitudes, and more (MOH, 2017). These were issued to patients and nurses at the selected health centers within the district. These were filled with the help of the appointed research assistant at the selected health centers and collected immediately. This helped the researcher gain a lot of information about the study variables in a short period.

Interview Guide

This instrument was used to collect more detailed information from doctors, members of the district health committee as they were more involved in supervision of health services within the district.

Validity of Instruments

The validity of instruments was established using expert judgment with the Content Validity Index (CVI). To ensure greater chances of data validity, the questionnaires were reviewed with a Research Expert (other than the research supervisor), who assessed that 18 questions were correct out of 20 questions. A Content Validity Index (CVI) of 0.9 was achieved and compared with 0.7 as

suggested by Amin (2009). Therefore, the researcher continued and used the questionnaire since the Content Validity Index was greater than 0.7.

Reliability of the Study Tools

The Cronbach Alpha method was used to examine the instrument's reliability concerning the variables, and a Cronbach alpha of 0.85 was obtained and compared with 0.7, which indicated that the instruments were reliable. Using the test-and-retest method, the reliability of the research instrument was evaluated. Test and retest reliability describes the consistency of scores obtained by the same people on the same test across time. This method was chosen because it gave proof that test results were consistent when the test was conducted again at a later date (re-test).

Data Processing

To manage quantitative data, it was coded and summarized using frequency tables within in Statistical Package for Social Sciences (SPSS 26.0)

Data Analysis

Descriptive statistics, frequencies, and percentages were used to describe quantitative data. Additionally, Pearson's correlation was used to establish the relationships in line with the study objectives. Regression analysis was used to assess the effect of supervision on health care service delivery in Pakwach District.

A thematic content analysis was used to examine qualitative data. The gathered information was organized to develop frequency tables and percentages that were subsequently used methodically; the data was divided into themes and sub-themes. To maintain the data's original context and the study's objectivity, this was done gradually. Also employed in the study was general content analysis.

Ethics-Related Matters

The Institutional Research and Ethics Committee (IREC) of Team University granted the researcher clearance. The research honored the participants' privacy by omitting the use of a name column, which was done to preserve individuals' identities and maintain the confidentiality of their information.

Informed consent was obtained by asking the subjects to sign a consent form before participating in the research.

The purpose of obtaining respondents consented to demonstrate that their rights were protected during data collection—such as the right to know the purpose, nature, and procedures of the study, to ask questions, to maintain their privacy, to be aware of any potential personal benefits of the study, to have both the researcher and participants sign a consent form indicating an agreement to the study's terms, and to withdraw from the study at any time.

The researcher used codes to reflect the personal and corporate identities of study participants when interpreting the data and producing the final report. This safeguarded the identities of individuals and institutions both during and after the research. To acknowledge all the authors referenced in the study, the researcher included appropriate citations. To protect participant confidentiality and avoid identifying specific individuals, the study's conclusions were generalized.

Consent

RESULTS

Response Rate for the Study

Table 2: Response Rate

Respondents	Questionnaires Issued and Interviews Scheduled	Questionnaires Collected and Interviews Conducted	Response Rate (%)
Doctors	08	05	62.5%
Nurses	56	56	100%
District Health Committee Members	08	05	62.5%
Patients	34	34	100%
Total	106	100	94.3%

Source: Primary Data (2025)

Table 2, The study titled "*Supervision and Health Service Delivery in Pakwach District Local Government*" achieved a high overall response rate of 94.3%, indicating strong participation and reliability of the data collected. Out of the 106 questionnaires issued and interviews scheduled across the various respondent groups, 100 were completed. All 56 nurses and all 34 patients responded, reflecting a 100% response rate for these categories. This full participation by nurses was particularly significant, as they represent a major segment of frontline healthcare providers, and their insights were vital for assessing the practical aspects of supervision in health service delivery.

The respondents' informed consent was requested to obtain their permission to participate in the research.

Confidentiality

The purpose of the study was explained in detail during the introductions made by the researcher and the research assistants. Before the data-gathering activity began, respondents were given ample opportunity to ask questions. Every respondent was treated equally within accepted social norms, regardless of gender, age, status, or level of education. Respect for respondents' cultures, taboos, and economic standing was strictly observed to avoid any violation of their rights and dignity. All information provided was kept confidential and used solely for academic purposes.

Autonomy

The researcher promoted the respondents' freedom of expression by ensuring that they were free to share their views and to choose whether or not to participate in the study.

Among the doctors, 5 out of 8 participated, resulting in a 62.5% response rate. This was also the same for District Health Committee members, with 5 out of 8 responding. While slightly lower, this still provided meaningful qualitative data from those in leadership and policy-making roles, offering critical perspectives on how supervision is structured and overseen at the district level. Overall, the 94.3% response rate signifies a successful data collection effort, with responses sufficiently distributed across various stakeholder groups. This strong turnout ensures that the study's findings are credible, balanced, and reflective of the realities within Pakwach District's local government healthcare system.

Socio-Demographic Characteristics of Respondents

Gender of Respondents

Table 3: Gender of Respondents

Gender	Frequency	Percentage
Male	63	63%
Female	37	37%
Total	100	100%

Table 3 presents the gender distribution of respondents who participated in the study on Supervision and Health Service Delivery in Pakwach District Local Government. Out of the 100 respondents, 63 (63%) were male, while 37 (37%) were female.

This distribution indicates a higher representation of male respondents in the study sample. The predominance of male participants may reflect the gender composition within the healthcare workforce and leadership structures in Pakwach District, particularly in roles such as medical officers and district health officials, where men were more represented. However, the inclusion of a substantial proportion of female respondents (37%) ensured that gendered perspectives, especially those of nurses and female patients, were adequately captured in the study.

Understanding the gender composition of respondents is essential in analyzing how gender dynamics may influence supervision practices and experiences within local government healthcare facilities. For example, differences in supervisory expectations, communication styles, and professional experiences may vary across gender lines and have implications for the effectiveness of health service delivery.

Overall, the gender distribution provided a balanced foundation for analyzing the impact of supervision on healthcare delivery, allowing the study to explore whether gender-related factors played a role in shaping respondents' perceptions and experiences within the local government health system.

Age Group of Respondents

Table 4: Age Group of Respondents

Age Group	Frequency	Percentage
Under 20 years	10	10%
21–30 years	13	13%
31–40 years	43	43%
41–50 years	26	26%
51+ years	8	8%
Total	100	100%

Table 4 illustrates the age distribution of respondents who participated in the study. The majority of respondents fell within the 31–40 years age group, accounting for 43% of the total sample. This suggests that a significant portion of the respondents were in their prime working years, likely representing active healthcare workers such as nurses and mid-level supervisors who are directly involved in day-to-day service delivery.

The second-largest age category was 41–50 years, comprising 26% of the respondents. This group likely included more experienced personnel, such as senior nurses, medical officers, or health committee members, whose insights are critical in understanding the long-term effectiveness and challenges of supervision in healthcare systems.

Respondents aged 21–30 years made up 13% of the sample. This group may have included younger healthcare

professionals or patients, bringing in fresh perspectives on the supervision mechanisms in place.

A smaller proportion of respondents, 10%, were under 20 years, likely consisting of younger patients or student interns. Meanwhile, those aged 51 years and above accounted for 8%, possibly reflecting retired or senior-level committee members, or long-serving healthcare workers.

Overall, the age distribution suggests that the study gathered data from a broad range of age groups, offering a diverse and representative understanding of how supervision is perceived and experienced across different stages of professional and personal life. This diversity enhances the reliability of the study's findings, especially in understanding how age and experience intersect with supervision practices and health service delivery in Pakwach District.

Education Level of Respondents

Table 5: Education Level of Respondents

Education Level	Frequency	Percentage
Primary	6	6%
Certificate	56	56%
Diploma	32	32%
Degree	4	4%
Masters	2	2%
Total	100	100%

Table 5, The majority of respondents have a Certificate level of education, accounting for 56% of the sample (56

out of 100 respondents). This is followed by those with a Diploma, making up 32% of the respondents. A small

number of respondents have only completed Primary education (6%), while even fewer hold a Degree (4%) or a Master's degree (2%).

This data indicates that most respondents have mid-level qualifications (Certificates and Diplomas), suggesting a

fairly skilled population with vocational or technical training. However, the low percentages of those with higher academic qualifications (Degree and Master's) imply limited access to or pursuit of higher education within the sampled group.

Table 6: Marital Status

Marital Status	Frequency	Percentage
Single	15	15%
Married	76	76%
Separated	09	09%
Total	100	100%

The findings in Table 6 present the marital status distribution of the respondents. A large majority of the respondents are married, making up 76% of the sample (76 out of 100 respondents). Single individuals account for 15%, while separated individuals represent 9% of the respondents.

The data suggests that the respondent group is predominantly married, indicating that marital status may play a significant role in the context of the study potentially influencing perspectives, responsibilities, or decision-making patterns. The smaller proportions of single and separated individuals reflect a more limited

representation of other marital statuses within the sample, which might affect how broadly the findings can be generalized to those groups.

Community-Based Supervision of Health Services in Pakwach District

The researcher used Likert format responses to describe the responses of the study participants where; 1- strongly disagree, 2- disagree, 3- Not sure, 4- Agree, 5-Strongly agree.

Table 7: Community-Based Supervision of Health Services in Pakwach District

Statement	Scale	Frequency	Percentage (%)	N	Mean	Std. Deviation
Community members receive updates on equipment available at health centers	Strongly Agree	0	0%	100	2.01	0.87
	Agree	10	10%			
	Not Sure	9	9%			
	Disagree	53	53%			
	Strongly Disagree	28	28%			
Community leaders make timely visits to health centers	Strongly Agree	30	30%	100	4.18	0.65
	Agree	58	58%			
	Not Sure	12	12%			
	Disagree	0	0%			
	Strongly Disagree	0	0%			
Community members participate in surveys to give feedback on health services provided	Strongly Agree	0	0%	100	1.41	0.49
	Agree	0	0%			
	Not Sure	0	0%			
	Disagree	41	41%			
	Strongly Disagree	59	59%			
Community members report any gaps they observe at health centers	Strongly Agree	0	0%	100	2.22	0.91
	Agree	8	8%			

	Not Sure	12	12%			
	Disagree	43	43%			
	Strongly Disagree	37	37%			
Community Health Committees meet regularly to discuss health service delivery	Strongly Agree	4	4%	100	1.72	0.91
	Agree	2	2%			
	Not Sure	0	0%			
	Disagree	52	52%			
	Strongly Disagree	42	42%			
Community Health Boards raise concerns about the services provided	Strongly Agree	0	0%	100	2.03	0.88
	Agree	2	2%			
	Not Sure	21	21%			
	Disagree	45	45%			
	Strongly Disagree	32	32%			
The community takes part in monitoring health facility operations	Strongly Agree	0	0%	100	2.36	0.94
	Agree	10	10%			
	Not Sure	31	31%			
	Disagree	43	43%			
	Strongly Disagree	16	16%			
Leaders organize regular meetings for citizens to speak openly about health care challenges	Strongly Agree	0	0%	100	2.05	0.86
	Agree	5	5%			
	Not Sure	20	20%			
	Disagree	50	50%			
	Strongly Disagree	25	25%			
Community members use suggestion boxes to report issues	Strongly Agree	29	29%	100	4.19	0.63
	Agree	61	61%			
	Not Sure	10	10%			
	Disagree	0	0%			
	Strongly Disagree	0	0%			

Table 7. This chapter presents the findings from a survey conducted to assess the level of community supervision of health care services. Respondents (N = 100) were asked to express their level of agreement with several statements using a five-point Likert scale ranging from *Strongly Agree* (5) to *Strongly Disagree* (1). The mean and standard deviation were calculated to establish central tendencies and variations in responses. The findings are discussed below.

Respondents were asked whether community members receive updates on equipment available at health centers. The majority of the respondents (53%) disagreed, and 28% strongly disagreed with this statement. Only 10% agreed, and none strongly agreed, while 9% remained unsure. The mean score was **2.01**, with a standard deviation of **0.87**, indicating that respondents generally disagreed and showed little variation in responses. This

suggests a significant communication gap between health facilities and the community regarding equipment availability.

When asked if community leaders make timely visits to health centers, 30% strongly agreed and 58% agreed, making a combined total of 88% in support of the statement. Only 12% were unsure, and none disagreed. This item had a high mean score of **4.18** and a low standard deviation of **0.65**, indicating strong agreement and consistency in responses. This finding implies that community leadership is actively engaged in oversight through regular visits to health facilities.

Regarding whether community members participate in surveys to give feedback on health services, 41% disagreed and 59% strongly disagreed. No respondents agreed or strongly agreed. The mean score was notably low at **1.41**, with a standard deviation of **0.49**, indicating

near-unanimous consensus. This reflects a serious lack of mechanisms or opportunities for the community to provide feedback through structured surveys.

Participants were also asked whether community members report gaps they observe at health centers. Only 8% agreed, while 12% were not sure. A large percentage disagreed (43%) and strongly disagreed (37%). The mean score was **2.22**, and the standard deviation was **0.91**, suggesting that most respondents do not report observed gaps and that there is moderate variability in perception. This reflects weak community involvement in identifying and reporting service delivery challenges.

In terms of regular meetings held by community health committees, only 4% strongly agreed and 2% agreed, while 52% disagreed and 42% strongly disagreed. The mean score was **1.72**, with a standard deviation of **0.91**, indicating widespread disagreement. These findings suggest that community health committees are either inactive or non-functional in many areas.

Only 2% of respondents agreed that community health boards raise concerns regarding the services provided. A combined 77% disagreed or strongly disagreed with this assertion. The mean score was **2.03**, and the standard deviation was **0.88**. This implies that while such boards may exist, their advocacy or oversight role is minimal or ineffective.

Respondents were asked if the community participates in monitoring health facility operations. Only 10% agreed, while 43% disagreed and 16% strongly disagreed. A considerable portion (31%) was not sure. The mean was **2.36** and the standard deviation was **0.94**, suggesting low levels of community involvement and a degree of uncertainty about existing monitoring mechanisms.

When asked whether leaders organize regular meetings to discuss health challenges, only 5% agreed, while 50% disagreed and 25% strongly disagreed. The mean score was **2.05**, and the standard deviation was **0.86**. This finding indicates that forums for open community dialogue on health issues are largely lacking.

The use of suggestion boxes to report issues was highly rated, with 29% strongly agreeing and 61% agreeing. Only 10% were unsure, and none disagreed. The mean score was **4.19**, and the standard deviation was **0.63**, indicating widespread use and approval of this feedback mechanism. This suggests that suggestion boxes are a well-established and effective tool for community members to voice their concerns.

During the interview with a **Medical Officer at one of the Health Centre IVs**, he said, "Community supervision in

our facility is almost non-existent. Apart from a few feedback forms and the suggestion box, which many patients don't even use, we rarely get any structured input from the community. Sometimes, local leaders visit during health campaigns, but that's it. I believe if we had active health committees or regular public dialogues, it would help bridge the gap between service providers and community expectations."

Another respondent (In-charge, Sub-county Health Centre III) said "The concept of community-based supervision is important, but it's not working well here. Most of the community doesn't feel empowered or informed enough to monitor health services. Also, there's a perception that healthcare is a technical field and not something they should interfere with. We need community sensitization to help people understand that their input matters."

One Senior Nursing Officer (Health Centre II) said, "Honestly, we only hear from the community when there's a complaint, and even then, it's informal. There are supposed to be health unit management committees, but they're not active. If they were functional, they could help us identify service gaps early, especially things we might overlook from the inside."

One of the Enrolled Nurses said, "Most community feedback we receive is verbal and not documented, so it rarely leads to change. There's a suggestion box at our facility, but I doubt it's open regularly. Sometimes patients complain about long waiting times or drug shortages, but we lack a clear channel to formally report and follow up with them. A more organized approach involving community leaders could help."

One of the District Health Committee Members said, "One of our biggest challenges is that the structures for community supervision exist on paper but are not functional in practice. Many health committees don't meet regularly, and there's a lack of funding to support community engagement activities. Additionally, the community lacks awareness of its role in monitoring health services. We need to strengthen these oversight platforms, train community representatives, and budget for their activities if we want to see change."

Health Service Delivery in Pakwach District

The researcher used Likert format responses to describe the responses of the study participants where; 1- strongly disagree, 2- disagree, 3- Not sure, 4- Agree, 5 strongly disagree.

Table 8: Health Service Delivery in Pakwach District

Statement	Scale	Frequency	Percentage (%)	N	Mean	Std. Deviation
Tasks are streamlined for patient flow within health facilities	Strongly Agree	26	26%	100	4.14	0.58
	Agree	62	62%			
	Not Sure	12	12%			
	Disagree	0	0%			
	Strongly Disagree	0	0%			
Health care services are easily accessible	Strongly Agree	2	2%	100	2.17	1.09
	Agree	3	3%			
	Not Sure	7	7%			
	Disagree	56	56%			
	Strongly Disagree	32	32%			
There is no waiting time for patients at health centers	Strongly Agree	0	0%	100	1.92	0.70
	Agree	4	4%			
	Not Sure	9	9%			
	Disagree	62	62%			
	Strongly Disagree	25	25%			
Health centers provide 24/7 emergency services	Strongly Agree	0	0%	100	1.92	0.72
	Agree	4	4%			
	Not Sure	34	34%			
	Disagree	52	52%			
	Strongly Disagree	10	10%			
Continuous medical education is provided to maintain competency	Strongly Agree	0	0%	100	1.71	0.56
	Agree	0	0%			
	Not Sure	6	6%			
	Disagree	65	65%			
	Strongly Disagree	29	29%			
There is patient-centered care at health centers	Strongly Agree	0	0%	100	1.90	0.66
	Agree	5	5%			
	Not Sure	8	8%			
	Disagree	59	59%			
	Strongly Disagree	28	28%			
Consistent supply of medical commodities	Strongly Agree	3	3%	100	2.39	0.86
	Agree	5	5%			
	Not Sure	20	20%			
	Disagree	72	72%			
	Strongly Disagree	0	0%			
Health workers follow standardized treatment protocols	Strongly Agree	6	6%	100	3.09	0.84
	Agree	23	23%			
	Not Sure	45	45%			
	Disagree	26	26%			

	Strongly Disagree	0	0%			
Timely services extended through outreach/mobile units	Strongly Agree	0	0%	100	1.31	0.47
	Agree	0	0%			
	Not Sure	0	0%			
	Disagree	69	69%			
	Strongly Disagree	31	31%			
Resources are optimally utilized at facilities	Strongly Agree	3	3%	100	2.00	0.72
	Agree	6	6%			
	Not Sure	0	0%			
	Disagree	73	73%			
	Strongly Disagree	15	15%			
Facilities accurately collect and record health data	Strongly Agree	34	34%	100	4.16	0.68
	Agree	48	48%			
	Not Sure	18	18%			
	Disagree	0	0%			
	Strongly Disagree	0	0%			
Health centers have follow-up and referral systems	Strongly Agree	2	2%	100	2.20	0.74
	Agree	8	8%			
	Not Sure	45	45%			
	Disagree	45	45%			
	Strongly Disagree	0	0%			

Table 8. This section presents the perceptions of respondents regarding the quality and organization of health service delivery in Pakwach District. The assessment was based on several indicators such as task organization, accessibility, emergency services, education of staff, supply consistency, and patient-centered care. Respondents provided their views using a five-point Likert scale where: 1 = Strongly Disagree, 2 = Disagree, 3 = Not Sure, 4 = Agree, 5 = Strongly Agree. The results are summarized and discussed below:

The majority of respondents agreed (62%) or strongly agreed (26%) that tasks are streamlined to promote efficient patient flow within health facilities. The mean score was 4.14, and the standard deviation was 0.58, indicating strong consensus and confidence in the organization of clinical tasks. This suggests that most health facilities have implemented internal systems to reduce patient congestion and manage workflow effectively.

Despite streamlined patient flow, only 5% of respondents agreed or strongly agreed that healthcare services are easily accessible. A significant proportion (56%) disagreed, and 32% strongly disagreed. The mean score was 2.17, reflecting a low level of agreement. This suggests that geographic, financial, or infrastructural barriers may limit access to services in the district.

Responses on patient waiting times revealed significant concern: 62% disagreed and 25% strongly disagreed that

there is no waiting time at health centers. Only 4% agreed, and none strongly agreed. The mean score was 1.92, indicating that long queues and delays are a common experience in these facilities. This may be attributed to staff shortages or high patient-to-health-worker ratios.

Only 4% of respondents agreed that health centers provide 24/7 emergency services. More than half (52%) disagreed, and 10% strongly disagreed, with 34% uncertain. The mean of 1.92 suggests that continuous emergency service provision is either limited or absent in most health centers. This raises concern for maternal, neonatal, and other critical care cases, which require round-the-clock attention.

A vast majority of respondents expressed dissatisfaction with ongoing training opportunities for health workers. A total of 65% disagreed and 29% strongly disagreed that there is continuous medical education in their facilities. The mean score was 1.71, indicating very limited in-service training, which may compromise the competency and up-to-date knowledge of health staff.

Patient-centered care was also rated poorly. A combined 87% of respondents disagreed or strongly disagreed that such care is practiced. The mean was 1.90, suggesting that most patients are not actively engaged in decisions about their health, or that respectful, dignified care may not be consistently provided.

Only 3% strongly agreed and 5% agreed that there is a consistent supply of medical commodities. In contrast,

72% disagreed and 20% were not sure. The mean of 2.39 reflects inadequate supply chains and stock-outs, which negatively impact service quality and reliability.

A relatively more balanced view was observed regarding adherence to clinical guidelines. While 29% of respondents agreed or strongly agreed that standardized protocols are followed, 45% were unsure, and 26% disagreed. The mean of 3.09 reflects moderate confidence in protocol adherence, but the high level of uncertainty indicates a need for greater clarity and training on standard procedures.

The statement about outreach clinics and mobile units received the lowest score. All respondents either disagreed (69%) or strongly disagreed (31%) that such services are extended to communities. The mean score was 1.31, showing that outreach services are virtually non-existent. This limits access for remote and marginalized populations and undermines the district's efforts to reach universal health coverage.

Respondents also expressed concern over how resources are utilized. Only 9% agreed or strongly agreed that resources are used optimally, while 73% disagreed and 15% strongly disagreed. The mean was 2.00, reflecting inefficiencies in the allocation and use of physical, financial, and human resources.

Unlike other areas, health data management received a positive rating. A majority of respondents (34% strongly agreed and 48% agreed) confirmed that health-related data is accurately recorded. The mean was 4.16, indicating confidence in the effectiveness of the Health Management Information System (HMIS) and routine data practices in the district.

Correlation Findings of the Study

Table 9: Summary of Correlation Results

Variables	Pearson Correlation (r)	Sig. (2-tailed)	Health service delivery in Pakwach District Local Government
Community-Based Supervision	0.314	0.040	

Table 9, The results show a weak positive correlation ($r=0.314$) between community-based supervision and health service delivery, which is statistically significant at the 0.05 level ($p = 0.040$). This indicates that increased involvement of the community in supervising health services, such as through health committees, feedback mechanisms, or suggestion boxes, is associated with improved health service delivery. However, the strength of this relationship is relatively modest, suggesting that while community oversight contributes to better service delivery, its impact is limited without support from other supervisory structures.

DISCUSSION

Community-Based Supervision and Health Service Delivery in Pakwach District

Opinions on follow-up and referral systems were split. While 10% agreed or strongly agreed that such systems exist, 45% disagreed, and another 45% were not sure. The mean score of 2.20 reflects limited development of referral networks, which are crucial for continuity of care, especially for patients needing specialized services.

During an interview, one nurse said, *"One of our biggest challenges is access many patients travel long distances, often on foot, just to reach the health facility. By the time they arrive, they're exhausted, and sometimes we can't even help them adequately because we lack essential drugs or equipment. It's heartbreaking to send a mother away without antibiotics or to tell a patient we can't run basic lab tests because the equipment is broken or missing."*

Another nurse said, *"We have very limited staff here. Sometimes it's just me and one nursing assistant handling everything from maternity to outpatient to immunization. This leads to long queues and frustrated patients. They wait for hours, and some even leave without being attended to. We do our best, but without more qualified staff and better resources, we are simply overwhelmed."*

Another nurse said, *"We face daily struggles with shortages, especially drugs. Common medicines like paracetamol and amoxicillin run out quickly, and when patients are told to buy from private pharmacies, many can't afford them. Also, we lack diagnostic equipment, so we rely on symptoms to treat conditions that should be confirmed with lab tests. These gaps lower the quality of care and patient trust in the health system. We also need more trained staff, especially clinical officers and midwives, to reduce the workload and improve services."*

The findings align closely with existing literature on community-based supervision (CBS) and its role in enhancing health service delivery within local government systems, particularly in low-resource settings like Uganda.

The weak but statistically significant correlation ($r = 0.314$, $p = 0.040$) between community-based supervision and health service delivery reflects a positive trend, although modest in strength. This aligns with Musoke et al. (2019), who emphasized that CBS mechanisms such as health committees and suggestion boxes can improve responsiveness and accountability in health service provision. The significance of the correlation suggests that while CBS contributes positively, its isolated effect is limited without being integrated into broader, well-resourced supervisory frameworks.

In both the Mitooma District and the Wakiso initiative, regular and supportive supervision—characterized by feedback, training, and logistical support was directly linked to improved CHW motivation, competence, and performance. These findings are echoed in Ludwick et al. (2021) and the Tanzania study, where supportive supervision, especially when integrated with digital tools and capacity-building, was associated with sustained improvements in primary healthcare. The emphasis here is not just on oversight but on *mentorship* and *development*, which appear critical for sustained performance.

Despite the promising findings, the challenges reported in Mukono District (Turyakira et al., 2019) resonate with broader concerns around fragmented supervision, unclear roles, and insufficient funding. These systemic issues limit the potential of CBS, even when effective models are identified. They highlight the need for more consistent and institutionalized supervision structures that go beyond ad-hoc or project-based interventions.

The integration of digital tools, as highlighted in Ludwick et al. (2021), remains underexplored in some local Ugandan contexts, including Pakwach District, but offers a future direction. Digital tools can help bridge gaps in supervision frequency and support real-time feedback, which could address some of the inconsistencies noted in Mukono and Mitooma.

Conclusions

The study reveals a statistically significant but weak positive correlation ($r=0.314$) between community-based supervision and health service delivery, highlighting the potential value of community involvement in enhancing health outcomes. While mechanisms like suggestion boxes and leader visits show some level of activity, the overall low engagement in broader community oversight, such as surveys, health committees, and public forums, underscores a critical gap in participatory governance. These findings suggest that community supervision alone is insufficient to drive substantial improvements in service delivery without complementary support from formal supervisory structures.

Recommendations

Community-Based Supervision and Health Service Delivery in Pakwach District

Revitalize and support health committees at facility and community levels by providing training, clear roles, and regular engagement opportunities to ensure meaningful participation in planning, monitoring, and feedback processes.

Structured platforms such as periodic community dialogue meetings, patient satisfaction surveys, and public forums are used to gather input on service delivery and promote transparency and accountability.

Conduct community sensitization campaigns to educate the public about their rights and roles in health service oversight, and encourage active participation in available supervision channels.

Develop mechanisms to ensure that feedback from community-based supervision is systematically documented, analyzed, and incorporated into facility-level improvement plans and district-level policy decisions.

Enhance the effectiveness of suggestion boxes and complaint mechanisms by ensuring confidentiality, prompt response, and regular reporting back to the community on actions taken.

Establish indicators to track the effectiveness of community oversight mechanisms and regularly evaluate their impact on service delivery outcomes to inform continuous improvement.

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LIST OF ABBREVIATIONS

AIDS	: Acquired Immunodeficiency Syndrome /
DLGs	Local District Government
DV	Dependent variables
FHI	Family Health International
HC	Health Centre
HIV	: Human Immunodeficiency Virus
HMIS	Health Management Information System
HSDP	Health Sector Development Programme
LG	Local Government
MDGs	: Millennium Development Goals
MMR	Maternal Mortality Ratio
MOH	Department of Health
MoLG	Ministry of Local Government
NGOs	Non-Government Organizations
NRM	National Resistance Movement
PHC	First-Line Healthcare
PNFP	Private Not for Profit
QMS	Quality Management System
QoS	Quality of Service
UNDP	United Nations Development Programme
VHTs	Village Health Team

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The study was not funded.

Conflict of interest

The author did not declare any conflict of interest.

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Data availability

Data is available upon request.

Author contributions

Esau Opio collected data and drafted the manuscript of the study

Dr. Benard Nuwatuhaire (Phd) supervised the study

Ethical consideration

The Institutional Research and Ethics Committee (IREC) of Team University granted the researcher clearance. The research honored the participants' privacy by omitting the use of a name column, which was done to preserve individuals' identities and maintain the confidentiality of their information.

Informed consent

Informed consent was obtained by asking the subjects to sign a consent form before participating in the research. The purpose of obtaining respondents consented to demonstrate that their rights were protected during data collection—such as the right to know the purpose, nature, and procedures of the study, to ask questions, to maintain their privacy, to be aware of any potential personal benefits of the study, to have both the researcher and participants sign a consent form indicating an agreement to the study's terms, and to withdraw from the study at any time.

Author Biography

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REFERENCES

1. Aday, L. A., & Anderson, R. (2019). Understanding the role of access to healthcare services. *Journal of Health Care Access*, 25(2), 112-126.
2. Adom, F., Bempong, R. B., & Mensah, A. (2022). Impact of Supervision on Health Workforce Performance in Ghana's Local Government Health Systems. *Journal of Health Systems and Policy*, 13(2), 34-45.
3. Ahn, J., Jeong, D. H., & Shin, H. (2020). Application of Systems Theory to Healthcare Organizations: Improving Supervision and Performance. *Journal of Health Systems and Policy*, 14(3), 47-53.
4. Asimwe, J., & Ouma, M. (2023). Leveraging Data for Effective Supervision of Health Services in Local Governments. *Journal of Health Informatics*, 28(5), 125-139.
5. Baker, S., Hernandez, L., & Williams, P. (2021). Equitable Health Service Delivery: Addressing Disparities in Access and Outcomes. *American Journal of Public Health*, 111(5), 711-720.
6. Barton, M., & Birkhölzer, T. (2017). The Role of Systems Thinking in Healthcare. *Journal of Health Organization and Management*, 31(3), 348-363. <https://doi.org/10.1108/JHOM-02-2017-0037>
7. Berman, P., et al. (2019). Strengthening health systems: The role of the government. *Health Systems and Policy Journal*.
8. Bryce, J., et al. (2019). Improving access to healthcare in low-income countries: A comprehensive approach. *Lancet Global Health*.
9. Buchanan, A., Powell, M., & Richards, K. (2022). Public Sector Supervision: The Role of Local Government Supervisors in Service Delivery. *Public Administration Review*, 49(3), 345-360.
10. Churchman, C. W. (1968). *The Systems Approach*. Delacorte Press.
11. Donabedian, A. (2020). The Definition of Quality and Approaches to Its Assessment. *Health Administration Press*.
12. Epstein, R. M., & Street, R. L. (2020). The Value of Patient-Centered Care. *Journal of Clinical Outcomes Management*, 27(8), 357-368.
13. Frenk, J., & González-Block, M. A. (2020). Health service delivery in the context of integrated care models. *Lancet Public Health*, 5(7), e342-e349.
14. Homer, J. F., & Hirsch, G. (2003). System Dynamics Modeling for Public Health: Background and Opportunities. *American Journal of Public Health*, 93(4), 502-508.
15. Juma, A., Kimani, J., & Makau, P. (2023). How external factors influence service delivery in local government health systems. *International Journal of Health Services*, 53(1), 71-83.
16. Jones, L., Karanja, N., & Mwaniki, T. (2024). Supervision and Community Engagement in Local Government Health Services: Enhancing Public Accountability and Service Delivery. *Global Health Action*, 13(2), 110-119.
17. Kates, R., Wiseman, A., & Ferguson, J. (2019). Systemic Challenges in Health Service Delivery: The Role of Supervision. *Global Health Journal*, 29(5), 71-79.
18. Kibera, S., & Ndungu, K. (2024). Centralized vs decentralized supervision in local government: A comparison of outcomes in service delivery. *Journal of Local Government Studies*, 36(2), 158-174.
19. Kruk, M. E., et al. (2018). Building resilient health systems in low-income countries. *The Lancet*.

20. Lehmann, U., et al. (2018). Health workforce governance and leadership in low- and middle-income countries: A systematic review. *Health Policy and Planning*.
21. Lazlo, E. (1972). *The Systems View of the World*. Harper & Row.
22. Ministry of Health, Uganda. (2019). *Annual Health Sector Performance Report 2019*.
23. Morris, S., & Jackson, P. (2023). Accountability and Supervision in Local Government: Building Transparent and Effective Service Delivery. *Journal of Public Sector Governance*, 34(2), 112-126.
24. Mujinja, P., Kyaddondo, D., & Mukisa, J. (2020). Supervision of Health Services in Local Governments: Improving Quality and Efficiency. *BMC Health Services Research*, 20(1), 400-410.
25. Morgan, K., & Zhang, Y. (2020). Enhancing Health System Performance through Supportive Supervision: A Systems Theory Perspective. *Health Policy Review*, 13(1), 92-102.
26. Osei-Akoto, I., & Duku, S. (2023). Barriers to Effective Supervision in Rural Health Systems: A Case Study from Local Government Health Centers in Ghana. *International Journal of Public Health*, 48(3), 57-63.
27. Osei-Akoto, I., & Duku, S. (2023). The Role of Supervision in Improving Health Service Delivery in Rural Health Systems. *International Journal of Health System Science*, 6(4), 65-72.
28. Poku, E. T., Afari-Asare, A., & Asante, E. A. (2021). Improving Health Outcomes through Supervision in Local Government Health Systems: A Case Study of District Health Services in Ghana. *Global Health Action*, 14(1), 82-90.
29. Saxena, S., et al. (2021). Health system strengthening and disaster preparedness: A global framework. *Journal of Global Health*.
30. Sarpong, D., & Ofori, J. (2022). The Impact of Supervision on Health System Performance: A Systems Approach. *African Journal of Health Systems*, 17(1), 40-49.
31. Simmons, C., & Lee, H. (2021). Supervision in Local Governments: Balancing Accountability and Support for Public Sector Workers. *International Journal of Public Administration*, 44(6), 459-475.
32. Thiel, P., Klein, C., & Chang, L. (2021). Supervision and Organizational Health: A Systems Theory Approach to Healthcare Delivery. *Healthcare Management Review*, 46(2), 124-133.
33. Thomas, R., Liss, R., & Johansson, A. (2024). Supervision and Continuous Improvement in Health Systems: The Role of Feedback Loops. *Journal of Global Health Systems*, 11(2), 118-126.
34. Thompson, S., Henderson, R., & Smith, P. (2020). Logistical Challenges in Health Supervision: The Case of Rural Local Government Health Systems. *Journal of Rural Health*, 36(4), 489-498.
35. Walraven, G., Clarke, J., & Ekwueme, D. (2021). Supervisory Practices in the Health Sector: Ensuring Quality and Performance in Local Government Health Services. *Health Policy and Planning*, 36(7), 891-897.
36. World Health Organization (WHO). (2017). Strengthening health systems to achieve the Sustainable Development Goals. *WHO Report*.
37. World Health Organization (WHO). (2021). Health Systems Strengthening and Service Delivery. *WHO Technical Report Series*, 102(4), 23-30.
38. Uganda Bureau of Statistics. (2020). *Uganda National Population and Housing Census 2020: District Analysis Report*.
39. Uganda Demographic and Health Survey (UDHS). (2016). *Health Service Utilization in Uganda*.
40. Uganda Health Systems Strengthening. (2019). *Health System Challenges in Rural Uganda: A Case Study of Pakwach District*.
41. Uganda Maternal Health Care Initiative. (2018). *Challenges in Maternal Health in Northern Uganda: A Case Study of Pakwach District*.
42. von Bertalanffy, L. (1968). *General System Theory: Foundations, Development, Applications*. George Braziller.
43. Zhang, H., & Morgan, K. (2022). The Role of Supportive Supervision in Improving Health Service Delivery in Local Governments. *International Journal of Health Policy and Management*, 19(4), 301-309.

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