COMMUNITY PARTICIPATION AND MATERNAL AND CHILD HEALTH CARE SERVICE DELIVERY IN SOMALIA: A CASE OFWARTA-NABADA DISTRICT

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A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF POLITICAL SCIENCE AND PUBLIC ADMINISTRATION IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF PUBLIC ADMINISTRATION, UNIVERSITY OF NAIROBI

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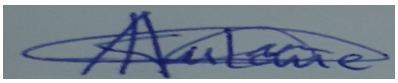
DECLARATION

This research project is my original work and has not been submitted for a degree in any other university.



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This research project has been submitted for examination with my approval as the University of Nairobi supervisor.

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DEDICATION

This project is dedicated to my Mother Ardo Gaas Geedi, for urging me to finish this degree and for her exceptional and steady help. My Children Ardo Safa Liban Abukar and Safwan Liban Abukar this is for you; I trust you will outperform this stamp.

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LIST OF ABBREVIATIONS AND ACRONYMS

ANC	Antenatal care
BRA	Benadir Regional Administration
DHHS	Department of Health and Human Services
FGRS	Federal Government of the Republic of Somalia
HIV/AIDS,	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ILO	International Labor Organization
KI	Key Informant
MCH	Maternal and Child Health
MOF	Ministry of Finance
MOH	Ministry Of Health
MOHDPS	Ministry Of Human Development And Public Services
MOHFMS	Ministry of Health of federal member states
NGO	Non-governmental organizations
NSM	New Social Movement
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Cooperation and Development
PHC	Primary Health Care
PNC	Postnatal care
SDG	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
UMI	Uganda Management Institute
UNDP	United Nations Development Program
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's FundUNSOM United Nations Assistance Mission in Somalia
WHO	World Health Organization

ABSTRACT

In practice, some of the developing and less developed countries like Somalia are characterized by poor maternal and child health care service delivery arising from the past two decades of violence and dysfunctional government. Although such issues of poor maternal and child health care service delivery could be best handled by taking a participatory approach at the community level, there is scanty of literature in the context of Somalia to link community participation and delivery of health service. Thus, the study sought to establish the influence of community participation on maternal and child health care service delivery in Warta-Nabada District. More specifically, the study looked at resource mobilization, community involvement and community empowerment in relation to maternal and child health care service delivery in Warta-Nabada District. The study was guided by participation ladder framework and it had hypotheses that were developed as guided by the reviewed literature. The study adopted descriptive correlational design targeting community members, district adminstrtaors and health care officials from Warta-Nabada district. The study selected 30 community members, 12 district administrators and 12 health care officials. Primary data was collected aided by the questionnaire and the interview guide. The analysis of the collected data was done with Statistical Package for Social Sciences supported by descriptive statistics (frequencies and percentages) and regression analysis as the inferential statistics. Content analysis was utilized during analysis of open-ended questions. The presentation of the findings was done using tables. It was established that community empowerment (β=.648, $p<0.05$) had the largest significant influence on maternal and child health care service delivery in Warta-Nabada District followed by resource mobilization (β=.078, $p<0.05$) and lastly community involvement and (β=.073, $p<0.05$). The study concluded that community participation had significant influence on maternal and child health care service delivery in Warta-Nabada District. The study recommended that policy makers in the Ministry of Health in Warta-Nabada District should focus more on empowerment of the community since this has the largest contribution towards maternal and child health care service delivery. The health care officials in Warta-Nabada should utilize media channels to raise more awareness on the need for the community to be involved in mobilization of resources in support of maternal and child health care service delivery. There is need for more improvement on community involvement so that it may greatly contribute towards maternal and child health care service delivery.

CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

The state of maternal and child health care in the world has been in a deplorable state in most parts of the world over the last decade. According to the report by World Health Organisation (WHO) (2017), 810 women die every day from causes related to childbirth and pregnancy. The report further states that from 2000 to 2017, most maternal deaths occurred in the developing and lower middle-income countries. Southern Asia and sub-Saharan Africa accounted for 86% which translates to more than 250,000 deaths in 2017. This depicts a sad and worrying trend. While the sub-Saharan Africa and the Southern Asia accounted for most of these deaths, the WHO (2017) also reported that there was on overall decline in the deaths in Southern Asia by approximately 38%.

The maternal deaths have been largely attributed to inequalities in terms of access to health care with a variation being evident from the low income and high-income economies. For instance, the WHO report showed that the maternal mortality ratio was 460 for every 100,000 live births in the low-income economies as opposed to 11 for every 100,000 in the high-income economies. Most of the communities specifically in the rural areas are forced to grapple with poor maternal and child health care. It is also evident according to the WHO report (2017) that there are more pregnancies among women in the least developed countries than in the developed countries. Most women die due to complications yet these complications are preventable given a good health care system.

The sustainable development goals (SDGs), targets that by 2030, the maternal mortality rate should have been reduced to less than 70 deaths for every 100000 births yet poor state of maternal and child health care systems is the biggest impediment towards this endeavor. Humanitarian crises, disasters and pandemics have also been cited as the biggest hindrance towards the realization of good maternal and child health care. The outbreak of Covid 19 has also caused a disruption in the health care system.

The concept of community participation in the health care system is increasingly gaining prominence particularly in the least developed countries. Community participation also referred to

as public or citizen participation is an important concept that enables people to get involved in community projects to solve problems facing them. It is intended to increase a sense of ownership by the affected community and the success of an intended intervention (Haldane, 2019). In essence, community participation is seen to increase active and genuine involvement of people in the definition of key issues that are a major concern to them, in taking part in the decision-making process on factors that have a far-reaching influence on their lives as well as in the development of interventions and strategies aimed at improving the level of service delivery (Rifkin, 2014). The underlying argument is that people who are affected by a decision should be involved in the decision-making process.

As a concept, community participation has gained relevance and emerged as a key subject matter for discussion in different disciplines. Indeed, there is a growing of body of literature that is exploring the role played by community participation in fields like health, education, democracy and governance. In health care, public participation has been noted to play a crucial role by involving community representatives with clear responsibilities and roles (Nathan, Braithwaite and Stephenson, 2014). According to a study by Bath and Wakerman (2015) on health care in Australia, community participation facilitates accessibility and utilization of health care services. Community participation can take place at any stage of the health care program (Farmer and Nimegeer, 2014). Noori (2017) argues that involving the community in all the stages of an intervention is a key in fostering sustainability. Accordingly, public participation may take place at the assessment of the needs phase, planning and design phases, execution as well as in monitoring and evaluation phases.

According to Gurtoo (2015), community participation plays an important role in governance by enhancing accountability and transparency and strengthening the level of democracy. Mak, Cheung and Hui (2017) have emphasized the important role played by community participation in decision making processes. For example, Japan is one the countries in the world where community participation allows people to define issues that are of major concern to them while trying to come up with the best way on how to resolve these issues (Herbez, Yasushi and Lee, 2013). Through proper community participation, the local planning authorities are able to make sound planning decisions that would enable the local authority to offer quality and sustainable environment to the members of the community (Zanudin, Ngah and Misnan, 2019).

Community participation is facilitated and provided for through by several legal provisions. In many nations including Somalia, the constitution offers a blueprint through which the citizens, local government and urban centers can be empowered. The link between community participation in health care service delivery is well established in the Alma-Ata declaration of 1978, where primary health care was reaffirmed as a key human right and that achieving the highest health level is regarded as an essential social goal in the world. The Alma-Ata declaration of 1978 places emphasis on the role played by the government in ensuring primary health care and this can best be realized through creation of awareness on the need for community participation. These views are particularly important to a country like Somalia, which is a member State of the World Health Organization (WHO).

Somalia is a fragile State in the Horn of Africa that is trying to recover from civil wars experienced in (1986–1995), that adversely affected key sectors including health care. Its maternal and child health has largely been affected. In fact, the statistics from WHO rank Somalia as one of the countries in the Horn of Africa with the highest child mortality rate in Africa (WHO, 2015). However, the provision of quality health care service delivery will largely be informed by how the community participates in the initiated health interventions at the communal level.

As Vesterinen and Toija (2015) have pointed out, although the level of community participation in Somalia has traditionally been poor, some development organizations like International Solidarity Foundation (ISF) have started operations in Somalia that have changed perceptions of communities in terms of participation in major initiatives. These organizations have opened up new platforms for democracy strengthening the level of participation of the community. However, Abdi and Dirie (2015) have identified several factors that hinder community participation in decision making in Somalia. These factors include security concerns, inadequate training of the local community leaders, lack of resources and mistrust between the government and the community members. These factors according to the study have resulted into weak and poor level of community participation in interventions in Somalia.

Warta-Nabada District is one of the largest districts in Mogadishu. Mogadishu is the capital city of Somalia and it is administratively divided into 17 districts. Warta-Nabada District was initially referred to as Wardhigley District until 2012 when the present name was adopted. Warta-Nabada

District is faced with a various health challenges including malaria among infants, tuberculosis among adults and cholera outbreaks. Furthermore, the quality of health care services delivered to people Warta-Nabada District is very poor as compared with other districts in Somalia (Ministry of Human Development and Public Services [MOHDPS], 2013). In the period before 2015 when community participation was enhanced these challenges had adversely affected the District to a great extent. The available maternity services are limited against the population in Warta-Nabada District resulting into a situation where they are constrained. There is low uptake of immunization among infants with poor malnutrition resulting from inaccessibility to quality food and balanced diets (MOHDPS, 2013).

Due to these challenges, the government of Somalia through the constitution came up with new strategies on how to deal with the challenge of child and maternal health care in Somalia. At the centre of these strategies is community participation where the members within a community are involved in the health care programs through resource mobilization, community involvement and community empowerment. It was from the period 2015 onwards that the concept of community participation became prevalent in the health sector in Somalia as districts like Warta-Nabada began implementing community participation initiatives. With the community participation, the state of maternal and child health care in Somalia is currently going through a rapid transformation as access to the maternal and child health care is improved. Although the government of Somalia has adopted the constitution to empower people and thus allow them to participate in community health related activities, more needs to be done in terms of raising awareness in the community, increased involvement and collaboration with the community. Thus, this is the reason why the study sought to evaluate the influence of community participation on health service delivery in Somalia with major focus on Warta-Nabada District.

1.2 Statement of the Problem

Ideally, the existence of a stable maternal and child health care service delivery system is linked with reduction in maternal and child health care mortality rates in an economy (Bath & Wakerman, 2015). Sound maternal and child health care service delivery results into a healthy and productive labor force that would contribute towards the growth of the economy (WHO, 2015). In practice, some of the developing and less developed countries like Somalia are characterized by poor

maternal and child health care service delivery arising from the past two decades of violence and dysfunctional government. Furthermore, there is a great disparity between the quality of health services provided in the urban areas and those of the rural areas like Warta Nadaba (MOHDPS, 2013).

The maternal and child health care system has been going through a myriad of challenges in spite the efforts of most countries to improve the system. The challenges are evident from the maternal and child deaths that have so far been reported. UNICEF (2020) reports that in the year 2019, more than 6 million children below the age of 15 years died out of which 5 million were children below the age of 5 years. Most of the children were reported to have died within the first month of their lives. In most African countries including Somalia, the health care systems are underfunded and this has occasioned a struggle in the provision of equitable and high-quality health services that can save the lives of children as well as mothers. This has seen organizations like UNICEF establish collaborations and partnerships with governments as well as the communities in health care programmes.

The poor maternal and child health care service delivery in Somalia has led to high mortality rate in the country. Unders-5 age mortality is high (in the scope of 180 to 225 for every 1,000 live births) and there has been next to zero advancement in decreasing youngster death rate over the last 20 years (MOHDPS, 2013). According to WHO (2015), Somalia has one of the highest neonatal death rate in the world whereby 61 out of 1,000 babies die inside of the first month of life. The maternal mortality is equally high with 1,400 deaths for every 1,000,000 live births. Although such issues of poor maternal and child health care service delivery could be best handled by taking a participatory approach at the communal level, there is scanty of literature in the context of Somalia to link community participation and health service delivery. Literature has shown that the community can play an important role in mobilization of resources and through empowerment and involvement in the health care interventions for an improvement in delivery of maternal and child health care service.

The available literature offers mixed and inconclusive results on community participation and health care service delivery, with some of the studies being conducted in other advanced economies like Australia (Bath &Wakerman, 2015) and China (Mak, Cheung & Hui, 2017) and

not in Somalia. Other studies although conducted on community participation, they have related it with other variables like project performance and not health care service delivery. This result into contextual and conceptual gaps that the present study sought to fill by answering the following research question: what is the influence of community participation on health care service delivery in Somalia using a case of Warta-Nabada District?

1.3 Research Questions

Specifically, the study sought to answer the following questions:

i. How does community resource mobilization affect maternal and child health care service delivery in Warta-Nabada District?
ii. How does community involvement affect maternal and child health care service delivery in Warta-Nabada District?
iii. How does community empowerment affect maternal and child health care service delivery in Warta-Nabada District?

1.4 Objective of the Study

The key objective of the study was examining the effect of community participation on maternal and child health care service delivery in Warta-Nabada District. The specific objectives were to:

i. Establish how community resource mobilization affects maternal and child health care service delivery in Warta-Nabada District.
ii. Determine how community involvement affects maternal and child health care service delivery in Warta Nabada District.
iii. Assess how community empowerment affects maternal and child health care service delivery in Warta-Nabada District.

1.5 Justification of the Study

Policy makers in Somalia's ministry of health would use the findings to understand the need to come up with better strategies of increasing community participation in the maternal and child health care. The study would go a long way to informing the available policies on maternal and child health care in Somalia. The administrators in Somalia are also key policy makers who may use the findings to guide and encourage the community to participate in health interventions. The

other policy makers in Somalia government including people in charge of national planning would use these findings to plan on how best to motive people in the community to take part in health service delivery.

There are different organizations including the non-governmental organizations that have initiated health care programs in Somalia. The outcome from the study would be essential to the executives of these organizations in coming up with the best interventions of mobilizing more people in the community to be involved in maternal and child health care activities. The management team of the government health care facilities and institutions in Somalia would use the findings to encourage more people in the community to be actively involved in the initiated activities.

The study would add to the existing knowledge and understanding of community participation and maternal and child health care service delivery. It would add to the current collection of information through an observational examination concerning community participation and its commitment to their results. The study would add towards comprehension of the available theories on community participation for instance the ladder theory. Future scholars would also be able to conduct related studies.

1.6 Scope and Limitations of the Study

The study examined the connection between community participation and health care service delivery. The study was carried out in Warta-Nabada District in Somalia. Warta-Nabada District was selected because it is one of the largest districts in Mogadishu, it is easily accessible and it has major health care challenges that are central to this study. The rate of infant and maternal mortality in Warta-Nabada District was so high which justifies and warrant the need for the current study.

During the field data collection, respondents were busy with their day to day activities. This meant that gathering data within a single day was not possible. Thus, the study adopted a system of drop and pick later in issuance of the questionnaires to respondents. Additionally, some of the respondents were afraid to answer any question citing insecurity. For this reason, the response was not 100 percent. Others feared disclosing all the information for security reason. This challenge notwithstanding the response rate was above 90 percent for the questionnaires and 75 percent for the key informants and this was sufficient for analysis. The researcher also obtained substantial

information relevant to the subject matter. Once the questionnaires had been dropped to respondents, the study recorded their contact information. This information was useful in making follow up with the respondents so as to respond to any issues and challenges that respondents might be facing in responding to the questionnaires.

In terms of the time scope, the study covered a ten-year period from 2011 to 2020. The choice of this period was to facilitate the acquisition of adequate information on the situation prior to the community participation and situation in Warta district after the community participation in the child and maternal health care program. Community participation in Warta District was enhanced in between the period 2015 to 2020 while the period 2011 to 2015 witnessed the centralization of the health care services in Warta District in Somalia.

1.7 Operational Definition of the Key Terms

Community: WHO (2008) defines community as a collection of people that reside together with some cohesion and social aspects. Haldaneet et al. (2020) consider a community as comprising of people that have in common some cultural and social aspects and some interests covering health. In this study, community will be used to refer to beneficiaries of a health care intervention or activity and these may include the number of households who will directly benefit from the intended program.

Community participation: Community participation is a process that can be viewed in social dimensions in which there is some group of people sharing given needs, residing in a well-established area and working together to attain these needs (Woelk, 1992). According to Kahssay and Oakley (1999), community participation is the ability of people in the society to have cooperated or collaborated programs that are sponsored by external agencies and this aims at enhancing the implementation of the program. In this study, community participation will be used to mean allowing the beneficiaries of an intended activity/program to take part in allocation of resources, involvement in exploration of desired issues and empowerment of these beneficiaries to make informed decisions concerning an intended program.

Community involvement: According to WHO (2008), community involvement is the ability of people to have in common responsibilities and opportunities for betterment of health outcomes.

Dennill, King and Swanepoel (1999) consider community involvement as the ability to drift the role of supplying health services from externally established agencies to the people in the area or locality themselves. It is boosting the ability of the local people to actively take part in idea generation, need assessment, planning and implementation of the type of care they receive (Kahssay & Oakley, 1999). According to Rifkin (1990), community involvement seeks to establish a partnering link between the community members and the government to increase the uptake of health interventions. In this study, community involvement will be used to mean working together with the beneficiaries of a health program in order to explore issues of interest to be achieved.

Community empowerment: Community empowerment is the coordinated efforts aimed at enhancing self-determination and self-reliance of people within a given establishment (Mamburu, 2007). According to Ahmad and Talib (2015), community empowerment is enhancing the decision-making ability of people at the community level. In this study, community empowerment will be used to mean enhancement of the skills and capabilities of the beneficiaries in the community so as to make an informed decision and settle on a given choice.

Maternal and Child Health (MCH) care: It refers to the health care which is given to the mothers within child bearing age and their children. According to WHO (2015), maternal health is a state of wellbeing of a woman when she is pregnant, after the birth of the child and the subsequent period. In this study, MCH will be used to refer to any health care services given to women and children living in Warta Nadaba District in Somalia.

Resource mobilization: Resource mobilization is the ability to acquire and utilize the required facilities for realization of the objectives (Shane, 2003). According to Ucbasaran et al. (2001), resource mobilization are efforts made to access various elements covering people, finances, technology and physical material from the owners. In this study, resource mobilization will be used to mean taking part in determination of human, financial, time and the material resources needed for health service delivery.

Service delivery is the act of providing a desired activity to the customers of an organization (Johnston & Clark, 2008). According to OECD (2009), service delivery is carrying out a specific task to another party as one of the bestowed responsibility. In this study, service delivery will be

used to cover key issues including accessibility, availability, utilization and coverage of a given health intervention (activity) to a given community.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviews existing literature by different researchers and writers in the area of the investigation. The chapter consists of the following sub-section; community participation, community resource mobilization, community involvement, community empowerment as well as community participation and health service delivery. The theoretical framework, conceptual framework and research hypotheses are also discussed in this chapter.

2.2 Community Participation

Abbot (1991) defines community participation as the ability to allow people in a social setting to take part in the initiated projects for their own specific benefits like solving their own problems. Vesterinen and Toija (2015) viewed community participation as the willingness of the people in a society to actively be engaged in interventions initiated at the rural or community level. Literature provides four key levels of community participation which can be considered as its key constructs. The first level which is regarded as basis is through provision of information to the community members concerning an intervention or activity to be undertaken (Den-Broeder et al., 2017). The second level is through consultation with the community so as to obtain feedback on the proposed intervention. The third level of community participation is involvement; where the government works with the community members to explore the issues intended to be implemented (Nkwake, 2013). The fourth and highest level of community participation is collaboration which is characterized by a high level of partnership with the community (Howard-Grabman, Miltenburg, Marston & Portela, 2017).

The role played by community participation in decision making processes was recognized by a study conducted in China by Mak, Cheung and Hui (2017); arguing that the ladder theory of citizen participation by Arnstein is key in explaining the expected nature of participation by the community in formulated interventions like health. In India, Narwana (2015) noted the role played by community participation in management of schools through various programs like Lok Jumbish and Sarva Shiksha Abhiyaan. A study conducted in Malaysia by Sulaiman et al. (2014) noted that community participation can also be extended to community policing programs. In Kenya,

Wanyera (2016) noted that community participation is a strong predictor of sustainability at the communal level. The suggestions raised include the fact that members of the community should be involved in participation at the earlier stages of an intervention in the community. These views are consistent with a study conducted by Waithaka, Kisovi and Obando (2016) which noted that community participation in rural development is a key determinant and predictor of improved livelihood of people in the community.

In Somalia, Abdi and Dirie (2015) looked at community participation in decision making and identified some of the factors that hinder community participation to include security concerns, inadequate training of the local community leaders, lack of resources and mistrust between the government and the community members. These factors according to the study have resulted into weak and poor level of community participation in interventions in Somalia. In partial agreement with these views, Vesterinen and Toija (2015) argued that although the level of community participation in Somalia has traditionally been poor, some development organizations like International Solidarity Foundation (ISF) have started operations in Somalia that have changed perceptions of communities in terms of participation in major initiatives. The study noted that these organizations have opened up new platforms for a democracy thus strengthening the level of participation of the community.

However, the above studies had contextual gaps as they were conducted in other countries like China (Mak, Cheung & Hui, 2017) and not in Somalia. The studies also create conceptual gaps as they were conducted relating community participation with other dependent variables like decision making process (Abdi & Dirie, 2015) and not health service delivery. None of the study conducted in Somalia focused on the health care content and these motivates the need for the present study which seeks to link community participation and health service delivery.

2.3 Community Resource Mobilization

Community resource mobilization is the process of bringing together people, finances, facilities and other assets so as to create more awareness among people to demand a given intervention (Wang, Kuan & Chan, 2014). The other definition of community resource mobilization is that they are the activities carried out in order to secure additional and new assets to support realization of

the objectives of a given intervention (Ochieng & Sakwa, 2018). Kyunyu (2014) viewed resource mobilization as the ability to utilize and optimize on the available assets.

There are various resources that are needed for successful implementation of community projects which include financial, material, time and human resources and information (Brann, 2015). Resource mobilization refers to the efforts put in place to acquire a wide range of these facilities from different providers by leveraging on various mechanisms. One of the key resources that are required by any organization is the financial resources (Murray, Kotha & Fisher, 2020). Financial resources can be mobilized and raised from the local members of the community and authorities within the community through different means like donations, grants and fees that can be charged to users. There can also be donations from friends that can be in-kind in nature for instance the material for construction and supplies (Johansson, Eriksson, Sadigh, Rehnberg & Tillgren, 2009).

Ochieng and Sakwa (2018) did a study on participatory resource mobilizations and how this influences the implementation of projects related with water at a communal level. The study was done in the County of Kisumu. The variables covered include sourcing of labour which is an aspect of human resource, mobilization of finances which is part of the financial resources and sourcing of materials for the project which is part of the material resources. From 360 targeted households, stratified sampling was used to select 189 respondents. It was noted from the results that participation in mobilization of resources enhances the efficiency of the implementation phase of the projects. The recommendation raised by the study was the need for agencies that implement projects at a community level to train the community members so that they are prepared with the required skills to help them to run the projects.

A study conducted in Nyeri by Muniu, Gakuu and Rambo (2018) looked at participation of the community in mobilization of resources and how this impacts on sustainability of water projects at the community level. The adopted design was mixed research and from the targeted 1052 beneficiaries, 290 of them were selected. The findings showed that the ability of the members of the community to take part in the mobilization of resources has an influence on the degree which water projects have remained sustainable. In Taiwan, Wang, Kuan and Chan (2014) focused on social established enterprises and did an analysis of the ability to mobilize resources. It was noted

that there are various incentives provided by the government of Taiwan that promote the development of the social enterprises.

Kyunyu (2014) looked at the strategies for mobilizing resources and their influence on ability of community-based organizations (CBOs) to perform. This study was carried out in the County of Kitui. The study variables included the sources of resources, effective communication and the role of the local community. The adopted design was descriptive and sampling of the CBOs was purposively done. It was indicated that sound mobilization of resource is important for sustainability and overall performance of the CBOs. Awuor, Wanjala and Muriithi (2015) paid attention on key strategies that are relevantly used to mobilize financial resources with reference to secondary schools in Homabay County. The specific strategies used to mobilize financial resource which the study focused on include user fee and charges, subsidy from the state and the activities aimed at generating income. The adopted design was descriptive survey where 62 from the entire 72 targeted schools were covered. It was shown that the level of internal efficiency increases with an increase in the availability of financial resources.

From the literature, it is palpable that some of the studies were done in different global regions including Taiwan (Wang, Kuan & Chan, 2014) and not in Somalia which creates a contextual gap. Generally, there is scarcity of literature on community resource mobilization in Somalia context. Other studies cover focus on resource mobilization in reference to other concepts like performance (Kyunyu, 2014) and sustainability (Muniu, Gakuu & Rambo, 2018) and this creates conceptual gap.

2.4 Community Involvement

Community involvement is defined as the extent which the role of managing a given intervention is shifted away from being done by the external parties such that that locally established people takes up that position (Dennill, King & Swanepoel, 1999). According to WHO (1978), community involvement can take various structures, depending on the conditions, explanation of issues and objectives. In primary health care (PHC)community involvement means that the authorities, health providers and the local community have to work together for the success of the health intervention as they each have their area and degree of capacity (Tosun, 1999). In this association, it is thought that health specialists and community constituents will share obligation commitments, essential

initiative and duty to interventions and results to improve the community health (Jabbar & Abelson, 2011).

A study done by WHO (2008) largely focused on involvement of the community in prevention and care of tuberculosis. It was shown that community involvement largely looks at shared responsibilities and partnership with services related to health as opposed to leveraging on the community to bring down the burden linked with health services. Encouraging involvement means that people in the community take part from the start of an intervention with active participation in defining the needs of the problem and coming up with relevant solutions. Involvement is largely established through partnerships and it requires cooperation and synergy from the other community members. Partnership can arise between the institution/government and the local members of the community and its success is shaped and determined by the degree which the actors are committed. Collaborations can either be formal or informal in nature (WHO, 2008).

In Natal, Mchunu and Gwele (2005) looked at community involvement in the health care context. Essentially, the study largely focused on bringing out the understanding of the need to have in place PHC. It was noted that community involvement was differently understood by the community and the various participants. Muthoni (2015) focused on community involvement as far as the management of public learning institutions in the County of Machakos was concerned. It was shown that few members of the community turned up for the meetings that they had received invitations to attend. It was shown that there was little involvement of parents in matters relating with decision making at the school level.

Haldane *et al.* (2019) focused on involvement at a communal level and how it helps in implementation and development of health care was concerned. The study noted that community involvement is positively linked with health care outcomes, especially at a communal level. Ghafar (2014) explored the key factors that brought about lack of involvement of the community in learning institutions. The study identified illiteracy of the members of the community with inadequate understanding of their role in learning institutions as a key factor limiting the community in participating in matters in schools. The other identified factors include low level of awareness, collusion and conflicts between the tutors and the community, societal and environmental challenges as well as low level of awareness.

In Rwanda, Havugimana (2015) looked at the involvement of the community within the planning activities and how this impacts on implementation of projects. The focus of the study was projects relating to sanitation and water. It was shown that there was low level of participation of the community at the stage of planning. However, more people from the community were highly involved at the stage of the implementation. The higher level of community involvement at the implementation phase was attributed to a number of factors including increased awareness among the community created by the agencies charged with the responsibility of implementation of projects. It was shown that there was little involvement of the community in decision relating with the selection of the project activities. There were a number of factors that were found to predict the degree of participation of the community which includes awareness of the community as it regards the project activities and the perceptions on corruption among the locally established leaders.

A study was done in Ghana by Sakeah et al. (2014) to bring out the role played by involvement of the community in planning activities linked with the quality of health care. The study was largely supported by qualitative methods. It was shown that the members of the community have a critical role to play in boosting the level of skilled delivery. It was shown that there were health volunteers at the community level and the traditionally established birth attendants who ensured that there is availability of relevant information on health as far as delivery was concerned. There were a number of factors identified as stumbling blocks for women to access maternal health in the rural setting which include poor transportation, unsteady supply of medicinal drugs and the attitudes displayed by the nurses.

Although the above studies suggest that community involvement is an important component of a stable health system, most of the studies were done in different contexts. For instance, the study by Sakeah*et et al.* (2014) was conducted in Ghana while that of Havugimana (2015) was conducted in Rwanda. This creates a contextual gap that the present study will seek to fill.

2.5 Community Empowerment

Rifkin (1986) defines empowerment as the act of giving people the power and autonomy and information to make decisions on issues affecting their lives. Community empowerment is an activity procedure in which people, community, and associations gain authority over their setting

of changing their social and political condition to enhance value and personal satisfaction (Wallerstein, 1992). Laverack (2001) also differentiate participation from empowerment approaches to ways to deal with unequivocal introduction of empowerment toward social and political change. At the same time, the World Bank established empowerment talk and characterized empowerment as procedure of growing the ability of persons or communities to settle on decisions and to change decisions into wanted actions and results (World Bank, 1993).

According to Montesanti (2013), community empowerment is a process that enables community to recognize their own capabilities and skills to participate through personal and collective reflection on the root causes that impact their health and capacity-building activities, to enhance their views and experiences in the designing of and decision-making about health facilities delivery in terms of primary health care services, health promotion, prevention services and/or programs, and broader population health programs. The rule of empowerment states that individuals take an interest since it's their democratic right to achieve this, and participation also means having power (Wignaraja et al., 1991). As per this idea, contribution is the regular consequence of empowerment. Empowerment isn't always a way to give up but it is the objective of improvement (De-Vos et al., 2018).

In Pakistan, Khalid, Ahmad, Ramayah, Hwang and Kim (2019) did a study focusing on community empowerment and its role in development of the tourism sector. The study was anchored on the social exchange theory. It was shown that community empowerment is a key driver for tourism development in an economic system. It was noted that with a high level of community empowerment, there are higher chances of enhancing the stability and development of the overall tourism sector. Another study was conducted by Wisitcharoen, Boonchieng, Suwanprapisa and Buddhirakkul (2016) on the program aiming at empowerment of the community and its role in prevention of diabetes. It was shown that one of the key ways of increasing community empowerment is through initiation of programs aimed at empowering the community.

Sianipar, Yudoko, Adhiutama and Dowaki (2013) argued that empowerment is a key driver of sustainable development at a community level. In Indonesia, Retnowati and Soeharjoepri (2018) argued that community empowerment increases synergy and cooperation among the members of the community as they work together for a common good. Sumedha (2013) did a study on projects

aimed at empowering the community and their role as far as the ability of women to make decisions was concerned. It was shown that women can be empowered when they are left free to make decision on the daily expenses and the type of health care facility to select.

Although various studies have been conducted, they fail to articulate what community empowerment exactly implies in the health care context. Further, some of the study like Retnowati and Soeharjoepri (2018) and Khalid et al. (2019) were done in different countries like Indonesia and Pakistan respectively and not in Somalia which bring about the contextual gaps.

2.6 Community Participation and Health Care Service Delivery

An inquiry into the role played by community participation in service delivery in Uganda was conducted by Kugonza and Mukobi (2015). According to the study, key factors that influence public participation in matters of health service delivery were identified as accessibility to information, ability to effectively use this information and the level of awareness of responsibilities and rights of community members. The suggestions raised by the study include the need for governments to increase information dissemination to community on their rights, roles and responsibilities and raise more awareness on the need for community to participate in governance of health initiatives. Similar views were shared by a study of Mbyemeire, Byabashaija, Tumwesigye, Mbabazi, Kahara and Afikwu-Abba (2018) in Uganda, which raised the needs for governments to ensure that the community members are empowered to make relevant decisions that would drive health service delivery at the communal level.

A study conducted in Nigeria by Lucky (2016) identified two perspectives of community involvement in health which include decision making processes and benefits related with health. A related study by Usman, Deepali and Kabiru (2018) in Nigeria pointed out the need for more communal enlightenment and awareness through meetings with local leaders and mass media on the need to increasingly get involved in health care services and activities at the communal level. Another study in Malaysia by Zanudin, Ngah and Misnan (2019) focused on the role that community participation plays in decision making processes; indicating that through proper community participation, the local planning authorities are able to make sound planning decisions that would enable the local authority to offer quality and sustainable health care services.

Although the reviewed studies focused on community participation, most of them were however conducted in different contexts. For instance, a study by Lucky (2016) was done in Nigeria while that of Kugonza and Mukobi (2015) was done in Uganda. On account of Somalia, no research work has ever targeted to investigate the relationship between community participation and health service delivery. Existing studies focus on community participation with education and development areas. There is scanty of literature done to link community participation and health care service delivery with reference to maternal and child health care. Therefore, this study will answer the question of whether or not there is a connection between community participation and health service delivery in Somalia, case of Warta-Nabada district in Mogadishu.

2.7 Theoretical Framework

A theoretical framework focuses on the key theories that give anchorage to the objectives of a given inquiry (Bahreldin, 2014). The main theory adopted by this study is that the Sherry Arnstein theory of 1969 and 1971. The theory focuses on community participation which is a major theme of the present study.

2.7.1 Sherry Arnstein's Participation Ladder Framework

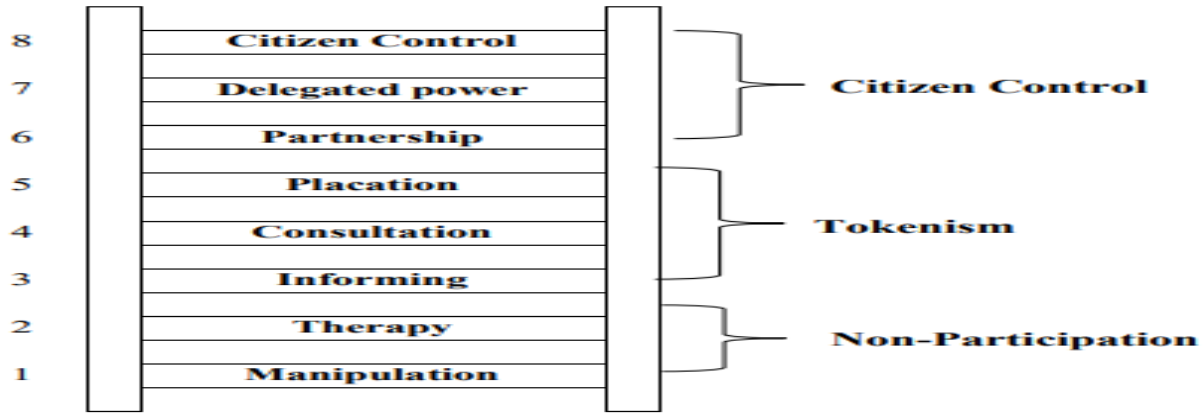
In the late 1960s, Sherry Arnstein alluded to community participation as an absolute term for citizen power. The author explained the concept of community participation by developing a participation ladder. The participation ladder as appeared in Figure 2.1 comprises of 8 rungs with each rung indicating the extent of citizen's power in decision making (Arnstein, 1969). There are three levels within the ladder theory of participation which include non- participation, tokenism and citizen control.

Non-participation comprises of two rungs (manipulation and therapy) and this is a phase where there is no noticeable participation by the community (Arnstein, 1969). In this study manipulation could cover a situation where the beneficiaries of the health and child health initiative get invitation to attend meetings only to rubber stamp the key decisions of the project committee even when they have not taken part in the process of decision making. At the therapy rung, the members of the community are blamed by the project leaders for project failure; they are seen as the problem that should be cured through therapy (Arnstein, 1969).

The second level of this ladder theory is tokenism and it comprises of three rungs (informing, consultation and placation) where the activity initiators ensure that people are informed of the issues and projects that are key to them. Although sensitization is a key process in quality service delivery, it is imperative to note that communication is a two-way process and thus the community members should be given opportunity to share out their views and concerns. Although consultation is an important aspect in health service delivery, it however fails to attain the threshold of active involvement (Arnstein, 1969). It would make no effect if the project leaders seek for opinions of the community members when the same ideas are not implemented. With placation, the project leaders may invite the community members to attend meetings for instance with regard to planning.

The last level of this theory is citizen control and it covers three rungs (partnership, delegated power and citizen control). This is the level where there is active involvement of the community in programs that affect them (Arnstein, 1971). In partnership, there is sharing of planning and the decision-making ability. Negotiations are conducted to distribute power between the community members and those in power. The key tools for sharing responsibilities at this phase include joint committees. In delegation rung, the members of the community are able to have various seats within the committees and they have powers to decide. At this rung, the members of the community are empowered to demand accountability of the project. The last rung is citizen control where even the disadvantaged community members are brought on board in the process of formulation of plans, making of policies and management of the project.

Figure 2.1: Participation Ladder



Source: adapted participation Ladder from (Arnstein,1969).

Arnstein contends that citizen participation is citizen power which lets the citizens hold total control over them however that there is an important distinction between having an empty practice of participation and carrying the real power to affect the final results of the procedure (Bishop & Davis, 2002). The author helps the establishment of a new greater suitable method to community participation, primarily based upon the idea of community power and manipulation (Aman, 2006). At this stage, the local authorities redistribute authority through negotiation with citizens to involve them in basic leadership, engage them with the facility spreading and execute the entire program together (Arnstein, 1969). While the community as a whole, are not given the scope to be engaged, the factional association of individuals can happen in this sort of process. Arnstein (1969) model portrays participation as the methods by which disadvantaged residents can prompt noteworthy social change, which empowers them to partake in the advantages of the rich society. The importance of this model to the study is that it focuses on community involvement and this study will explore how this is related to MCH service delivery.

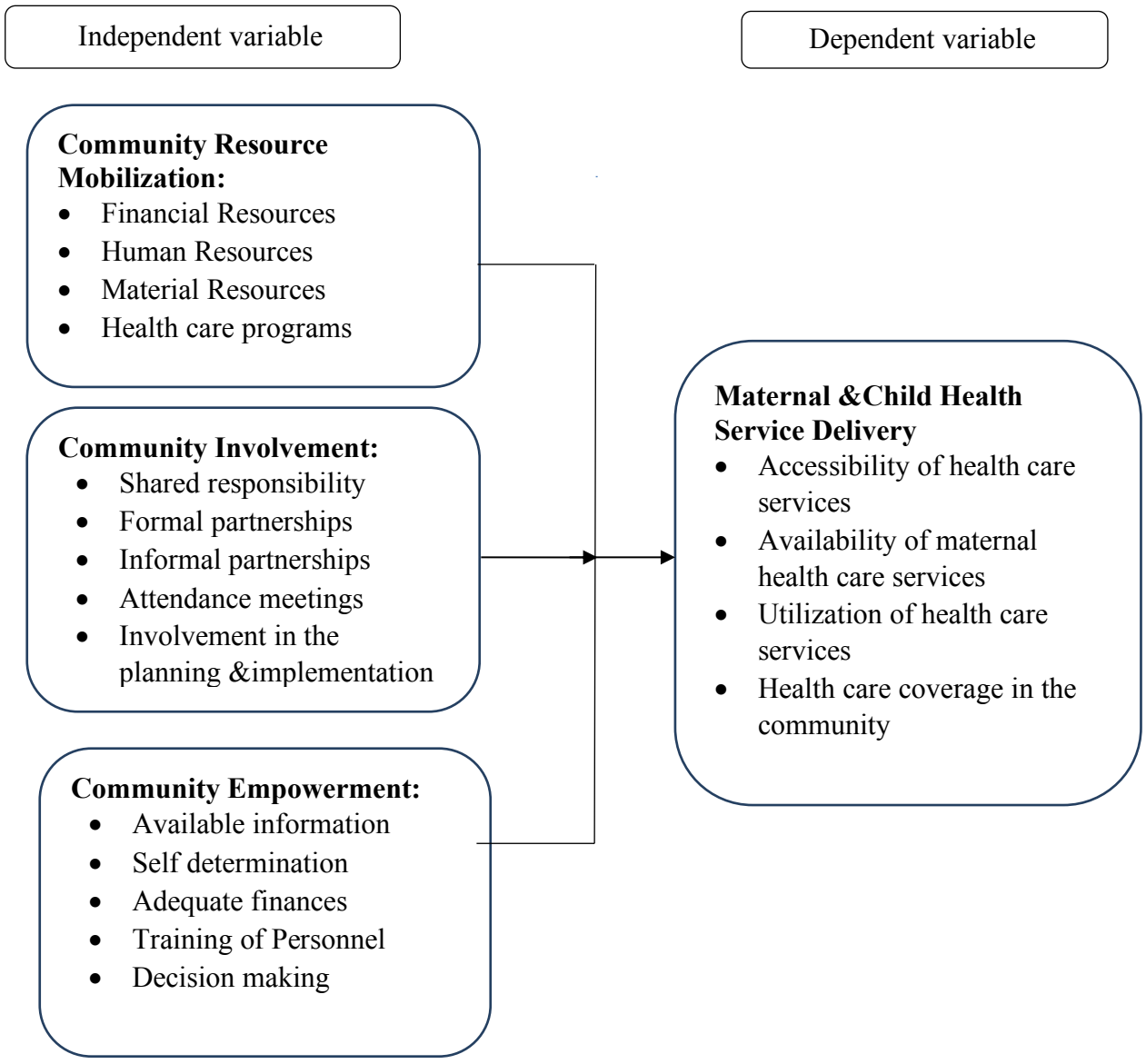
With regard to the state of community participation in health care programs in Warta District in Somalia, it is apparent based on the findings that there is adequate citizen control which is the last stage in the Arnstein participation ladder. From the findings 53.3% of participants stated that there was community involvement in the child and maternal health care service delivery. The respondents for instance stated that they were involved in planning on where to set up the health facilities, regular formal meetings, formal and informal partnerships, decision making and in identification of the health care needs in the district. It also became apparent that there were

community health workers drawn from the local community. Furthermore, the 47.2% of the respondents concurred that there was community empowerment. Community empowerment had been realized through training adequate personnel (community health workers), choice of health facilities, funding, and improved road networks. Lastly the level of citizen control was evident from the participation of the community in resource mobilization. The key informants stated that community helped in resource mobilization through funding and providing technical capacity where needed. This therefore revealed that there was adequate level of citizen control specifically in Warta District.

2.8 Conceptual Framework

A conceptual framework is a structure that diagrammatically illustrates the variables and the associated relationship between them. The rationale of the conceptual framework is to assist the reader in speedily understand the projected relationship (Kumar, 2011). It lays the foundation of the study guiding how the various variables of the study are to be conducted (Kothari, 2004). Figure 1.2 demonstrates the connection between the independent variable and the dependent variable with the consideration of the intervening variables:

Figure 2.2: Conceptual Model



Source: Author, 2021

In this study, the independent variable is the community participation measured by the community resource mobilization; involvement and empowerment. The dependent variable is maternal and child health service delivery measured by accessibility, availability, utilization, and coverage. The intervening variables are derived from the external forces affecting health service delivery in Somalia, denoted by macro-level measures of political climate, infrastructure, social values and culture, economic conditions and population trends in the period covering the study.

The intervening variable consists of certain external factors that also shape the participation of the community to the health services delivery system in the Warta-Nabada district. These forces may consist of the political climate of a nation in terms of stability, security, armed oppositions, interest groups, government policies, rules, and regulations; absence of enough substructure such as education, water, highways, energy, among others. Social and cultural values in terms of traditional practices, clan differences, and social cohesion; economic conditions such as general economy, competition, low standard of living, poor purchasing power and low personal income; population trends such as population growth, age composition, changes in population density, urban-rural movement. If these environmental forces that can negatively or positively deviate the contribution of the community to health service delivery are to be considered, the participation of community members towards health care services in the Warta-Nabada district will change (Qayad, 2007).

2.9 Research Hypotheses

H_1 Community resource mobilization has significant effect on maternal and child health service delivery in Warta-Nabada District.

H_2 Community involvement has significant effect onmaternal and child health service delivery of Warta Nabada District.

H_3Community empowerment has significant effect onmaternal and childhealth service delivery of the Warta-Nabada District.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the procedures and methods used to carry out the study. The chapter consists of the research design; study populace; sample procedures and sample size; data collection instrument; methods of data analysis and validity and reliability of instruments.

3.2 Research Design

The study adopted a descriptive research design to achieve the objectives. The reason for adopting a descriptive design was to allow the researcher to describe the population of the study. The study used mixed methods to collect both the quantitative and qualitative data. Further, the study was cross-sectional since data was carried out at one point in time. The research design helped the researcher to establish the relationship between community participation and health service delivery while testing and determining whether to accept ot reject the formulated hypotheses of the study.

3.3Study Population

The target population of the study comprises of individuals that provide the basis for generalization of the findings (Kothari, 2004). This study targeted the community members, district administrators and health care officials in Warta-Nabada district in Mogadishu.

3.4 Sampling Techniques and Sample Size

As indicated by Singh (2006), sampling is the way toward choosing a few cases from an objective populace to give data that can be utilized to make decisions about a lot bigger number of cases. Sampling techniques can be either probability selection or non-probability selection. With probability selection, each segment has a chance of being included in the sample. With the non-probability selection, the researcher uses his subjective judgment in selecting a sample (Kothari, 2004). The study used non-probability sampling technique specifically a purposive method of sampling in selecting the respondents.

First, the researcher selected three hospitals in Warta-Nabada district in Mogadishu which are Al-

Hayat, Sokorey and Jazira hospitals. Thereafter, the researcher picked community members (women visiting each of these hospitals). The researcher picked 10 women from each of these hospitals thus giving a total of 30 community members. The district administrators included the chiefs and the assistant chiefs. In Warta-Nabada district, there is a chief and 3 assistant chiefs anywhere there is a hospital. Thus, the researcher picked 3 chiefs and 9 assistant chiefs thus giving a total of 12 district administrators. For the health care officials, the researcher selected 2 doctors and 2 nurses per hospital. This means a total of 12 doctors and nurses were selected and included in the study. The role of the district administrators was to give an in-depth information on the subject matter hence they were interviewed as the key informants. On the other hand, community members and health care officials were given questionnaires to answer the specific questions based on the research objectives. Thus, a total of 54 respondents were selected and included as summarized in Table 3.1.

Table 3.1: Sample Size

Category	Sample size
Community members	30
District administrators	12
Health care officials	12
Total	**54**

3.5 Data Collection Instrument

The researcher used a questionnaire and interview guide as the main instruments for gathering data because of the time and accessibility of study people. The questionnaire which was constructed by the researcher had five sections. Section A covered the general information of the respondents, section B had information on resource mobilization, section C covered information on community involvement, and section D had information on community empowerment while section E had information on service delivery. The items on the questionnaire were structured using a five-point Likert scale where 1=strongly disagree and 5=strongly agree. The questionnaire was administered among the community members and the health officials. On the other hand, the interview guide was utilized on the collection of information from the district administrators who were regarded as the key informants (KIs).

3.6 Reliability and Validity of the Instrument

A pilot study was conducted among 10 respondents who were purposively selected from Warta Nadaba District in Somalia. However, the respondents who participated in the pilot study were excluded in the final study to prevent biasness. The essence of the pilot study was to determine reliability and validity of the instrument.

Reliability is used to ascertain how consistent a measure is in evaluating an idea while validity helps in pointing out the nexus between an instrument and the concept that was meant to be covered (Crano & Brewer, 2002). A measure is deemed reliable if the measure remains consistent from the point of perusal to the next level (Cozby & Bates, 2012). The researcher used the values of Cronbach Alpha Coefficient from the questionnaire results obtained in the pilot study. The researcher used 0.7 as a threshold in determining the instrument's reliability. Table 3.2 gives the findings of reliability.

Table 3. 2: Reliability Results

Variable	Cronbach Alpha Coefficient	Remark
Community Resource Mobilization	α=0.765	α >0.7 thus reliable
Community Involvement	α=0.837	α >0.7 thus reliable
Community Empowerment	α=0.733	α >0.7 thus reliable
maternal and child health care service delivery	α=0.725	α >0.7 thus reliable

For validity, the researcher engaged the supervisor who reviewed critically the items on the questionnaire to make certain that they were according to the study objectives. Furthermore, the questionnaire was shared with the experts in the field of public administrative in Warta-Nabada district who reviewed its contents and determined whether it was valid.

3.7 Data Analysis and Presentation

The handling of information incorporates all activities attempted from when a lot of information is gathered until the point when it is prepared to be analyzed either manually or by software (Babikir, 1997). The researcher processed data through editing; coding; classifying and tabulating to run statistical Package for Social Sciences (SPSS) version 24. SPSS was utilized to project correlation and regression analysis of the data to interpret the connection between community participation and health service delivery. A correlation of zero demonstrates no relationship at all,

however, the researcher used the guidelines suggested by Cohen (1988) which will apply both negative and positive correlation as pursues: The following regression model was adopted:

$$Y = B_0 + B_1X_1 + B_2X_2 + B_3X_3 + e$$

Where Y = Maternal and Child Health Care Service Delivery
B_0 = Y Intercept
X_1= Community resource mobilization
X_2 = Community Involvement
X_3 =Community Empowerment
e= Error Term

For qualitative data, the study used content analysis which is a technique that helps in identifying the concepts and themes from the qualitative data.

3.8 Ethical Considerations

Respondents were not compelled to disclose their contact details and names on the tools to safeguard their confidentiality. Respondents were informed in advance that involvement in the study was on voluntary basis and those who were not be free to take part were not forced to do so. Assurance was provided to respondents that information to be gathered was only to be used for academics by including a letter of introduction to the questionnaire. All information reviewed was appropriately referenced using APA style to steer clear of plagiarism.

3.10 Organization of the Study

The study is organized into five chapters. Chapter one focuses on the background of the study, the statement of the problem, research questions, and objectives, the significance of the study, scope, and limitations as well as the operational definition of terms. Chapter two focuses on reviewing the literature in line with the objectives of the study and chapter three covers the methodology. Chapter four discusses the results of the analysis as guided by the objectives while section five summarizes the findings of the study and gives conclusions and recommendations.

CHAPTER FOUR
FINDINGS AND DISCUSSION

4.1 Introduction

The chapter discusses the outcome from the analysis as informed by the objectives of the study. The chapter consists of the response rate, general information of the respondents, descriptive analysis of community participation, community involvement, community empowerment and the results from regression analysis.

4.2 Response Rate

A total of 42questionnaires were issued to heath care officials and community members during data collection from which 38 of them were properly filled and forwarded to the researcher translating into a response rate of 90.5%. For the interview guides, 12 key informants (District administrators) were targeted out of which 9 were interviewed giving a response rate of 75%. This information is presented in Table 4.1.

Table 4.1: Response Rate

Instrument	Total Instrument Issued	Total Instrument returned	Response Rate (%)
Questionnaires	42	38	90.5
Interview Guides	12	9	75.0
Total	**54**	**47**	

Source: Field Data (2020)

The response rate in Table 4.1 was consistent with Mugenda and Mugenda (2003) who stated that a rate of response of above 60% is appropriate for analysis.

4.3 General Information

The information on the respondents of the studying terms of age, gender level of education and years of residency was analyzed and exhibited in Table 4.2.

Table 4.2: General Information

Category	Classification	Frequency	Percentage
Age of Respondents	Less than 30 years	4	10.5
	31-40 years	11	28.9
	41-50 years	18	47.4
	50 and above years	5	13.2
	Total	**38**	**100.0**
Gender Category	Male	10	26.3
	Female	28	73.7
	Total	**38**	**100.0**
Level of Education	Primary	4	10.5
	Secondary	7	18.4
	Diploma	7	18.4
	Bachelor	11	28.9
	Master	9	23.7
	Total	**38**	**100.0**
Years of Residence	Less than 3 years	11	28.9
	3-8 years	16	42.1
	8-15 years	10	26.3
	Over 15 Years	1	2.6
	Total	**38**	**100.0**

Source: Field Data (2020)

Table 4.2 exhibits the respondents' general information. In respect to age, the study established that 10.5% were less than 30 years, 28.9% were 31-40 years, 47.4% were 41-50 years and 13.2% were over 50 years. This implies that the participants had different age categories covering both youths and the adults hence diversity in the views they shared on maternal and child health care.

The findings on gender indicated that 73.7% of the respondents were female while 26.3% were male. This implies that both male and female respondents took part and probably the findings sought from them were representative. However, it should be noted that the study was on maternal health, thus more female than male took part. The participation of women indicates that women are actively involved in health care interventions at the community level.

The findings on education indicated that 28.9% had bachelor's degree, 23.7% had masters, 18.4% had diplomas, 18.4% had secondary education and 10.5% had primary education. This implies that participants were learned and probably they could read and interpret the research questions.

In view of the years of residence, the study established that 42.1% of the respondents had lived in Mogadishu for 3-8 years, 28.9% for less than 3 years, 26.3% for 8-15 years and 2.6% for over 15

years. Thus, it can be inferred that majority of the respondents had lived in Warta Nadaba district for a relatively longer period of time and probably they were knowledgeable on key issues revolving around maternal health care.

4.4 Descriptive Statistics

The study had three specific objective variables as follows; community resource mobilization, community involvement and community empowerment. The specific objective variables guided the formulation of questions on a five-point Likert scale where 1-strongly disagree and 5 meant strongly agree. The values of percentages were generated to interpret this Likert scale as illustrated in the successive sections.

4.4.1 Community Resource Mobilization

To determine the extent to which the community is involved in community resource mobilization, participants were asked to state the extent to which they agreed or disagreed with the various aspects on community mobilizations of financial, human and material resources and whether they were involved. The respondents were also asked to indicate their views on the extent to which community resource mobilization influenced maternal and child service delivery. The findings are as summarized in Tables 4.3 and 4.4.

Table 4.3: Community Resource Mobilization

Statements	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The community mobilizes finances for the child health care initiatives in the community	12.8%	36.9%	6.7%	37.4%	6.1%
The community mobilizes relevant sources of financing the maternal health care interventions	6.7%	32.4%	13.4%	40.8%	6.7%
The community mobilizes human resources for the maternal health care in the community	1.1%	19.6%	12.8%	66.5%	0.0%
The community mobilizes human resources for the child health care providers in the community	6.1%	43%	13.4%	37.4%	0.0%
The community mobilizes material resources to support health care in the community	0.0%	19%	13.4%	53.6%	14.0%
The community is involved in determining timelines of the health care programs in the community	3.4%	17.3%	19.6%	59.8%	0.0%
The community determines the required skills for the child health care interventions in the community	3.4%	19.6%	5.0%	68.7%	3.4%
Average Score	**4.8**%	**26.8**%	**12.0**%	**52.0**%	**4.3**%

Source: Author, 2021

When asked whether the community mobilized finances for the child health care initiatives in the community, the responses as indicated in Table 4.3 established that only 43.5% were of the view that the community was involved in mobilization of finances for the child health care initiatives in the community while 49.7%were of contrary opinion. The remaining 6.7% were neutral. This finding reinforces the fact that mobilizing financial resources for child health care was perhaps undertaken at the national level or by non-governmental organizations not the community. Therefore, close to half of the respondents believed that the community was involved in mobilization of finances for child interventions like vaccinations and nutrition programs. Mobilization of the finances by the community, according to KIs, take various forms including fundraising that ultimately would influence the quality of health services delivered to the community. These findings are supported by Muniu, Gakuu and Rambo (2018) who shared that the ability of the members of the community to take part in the mobilization of resources has an

influence on the sustainability of community projects. As noted by Awuor *et al.* (2015), the strategies used to mobilize financial resource to include user fee and charges, subsidy from the state and the activities aimed at generating income. Since some of the community members failed to pay for user fees in some of the health centers, the available finances were perhaps not adequate to support hiring of more pediatricians to support child health care.

Similarly, the respondents were asked to state whether the community was involved in the mobilization of relevant sources of financing the maternal health care interventions. The study's outcome indicated that 40.8% of the participants agreed that that the community mobilized relevant sources of financing the maternal health care interventions, 32.4% disagreed, 13.4% were neutral with a tie at 6.7% between those who strongly agreed and those who strongly disagreed. This means that less than half of the respondents were of the view that the community did not take part in mobilization of the financial resources for maternal health care. As shared by a KI the community was largely involved in mobilization of in-kind resources like trees that were critical for cutting timbers to construct offices for running maternal and health services in the area. Therefore, in order to raise funds for carrying out maternal and health services, KIs shared that the government and other donors provided the required funds. As noted by Awuor *et al.* (2015), common strategies used to mobilize financial resource include user fee and charges, subsidy from the state and the activities aimed at generating income.

As to whether the community is involved in the mobilization of human resources for the maternal health care in the community the responses indicate that while 66.5% of the respondents agreed that human resources were mobilized by the community, 19.6% disagreed, 12.8% were neutral and 1.1% strongly disagreed. This could be an indication that the health care workers including nurses and doctors who provided health care services at the local clinics and health centres came from the community. This may include health aides who are trained by the project organizations to ensure they are as competent as possible so as to provide quality services. According to the KIs, the community through their representatives in the health centres helped in selecting the required personnel to carry out the maternal and health services in the community. This view is supported by Ochieng and Sakwa (2018) who raised the need for agencies that implement projects at a community level to train the community members so that they are equipped with the required skills

which will help them to run the projects. Since the community mobilized the human resources required, this perhaps influenced the level of service delivery.

The study further established that 43% of the respondents disagreed, 37.4% agreed, 13.4% were neutral and 6.1% strongly disagreed on whether the community mobilized human resources for the child health care providers in the community. Thus, the community seems to play a bigger role in the mobilization human resources for maternal care compared to child health care. This could further be interpreted to mean that the community had more qualified and professional gynecologists as compared to pediatricians and this calls for government interventions to balance this shortage and thus enhance service delivery. These findings were corroborated by KIs who unanimously shared that the community took part in mobilization of the personnel required to carry out the maternal and child health care services.

The outcome further showed that 53.6% of the participants agreed, 19% disagreed, 14.0% strongly agreed and 13.4% were neutral on whether material resources were mobilized by the community. This means that a majority of the respondents were of the opinion that community members took part in mobilizing the material resources relevant in supporting the maternal health care interventions at the community level in Warta Nadaba district. The KIs shared various examples of the materials resources that were mobilized to include trees, roofing timbers, water and cement that helped in putting up structures of health centers and clinics at the community level. These findings are echoed by Johansson *et al.* (2009) who noted that material resources can include donations from friends that can be in-kind in nature for instance the material for construction and supplies.

The study found that 59.8% of the respondents agreed, 19.6% were neutral, 17.3% disagreed and 3.4% strongly disagreed on the statement whether the community was involved in determining timelines of the health care programs in the community. This implies that the community was involved in the planning and implementation of the health care programs. In other words, the community was involved in determining when the health program is to start and end. The KIs shared that public forums and meetings were organized where the community together with the maternal and child health care providers attended to be informed on the upcoming programs. It is at this point that the community is given a platform to give their suggestions on the program and

the timelines. Timelines are important in completion of the program since it saves on costs and other expenses as detailed in the budget as determined by donors. These findings are supported by Muniu, Gakuu and Rambo (2018) who emphasized on the need for the community to participate in community projects.

As to whether the community determines the required skills for the child health care interventions in the community the results show that 68.7% of the respondents agreed, 19.6% disagreed, 5.0% were neutral with a tie at 3.4% between those who strongly disagreed and those who strongly agreed. This implies that the community had a say on the skills that the health care workers get and this is based on the specific maternal and child health care challenges that they face. The KIs also shared that community had clan leaders who provided representation at regional and national level of the maternal and child health services on addition to having a say on the skills based on the community health care challenges.

The results in Table 4.3 indicate that on average, 52.0% of the respondents agreed that mobilization of financial, human and material resources was practiced in their community, 26.8% disagreed, 12.0% were neutral, 4.8% strongly disagreed and 5.3% strongly agreed. These findings are consistent with Brann (2015) and Ochieng and Sakwa (2018) who postulated that for successful implementation of community projects there is a need for mobilization of various resources including financial, material and human resources. Financial resources can be mobilized and raised from the local members of the community and authorities within the community through different means like donations, grants and fees that can be charged to users.

Table 4.4: Extent which Community Resource Mobilization influenced Maternal and Child Service Delivery

	Frequency	Percent
Not at	1	2.6
Little extent	6	15.8
Moderate extent	7	18.4
Great Extent	22	57.9
Very Great Extent	2	5.3
Total	**38**	**100.0**

Source: Author, 2021

The results in Table 4.4 show that 57.9% of the respondents indicated that community resource mobilization influenced maternal and child health service delivery to a great extent, 5.3% indicated

to a very great extent, 18.4% to a moderate extent, and 15.8% to a little extent while 2.6% indicated that there was no influence at all. Overall 63.1% felt that community resource mobilization influences maternal and child care service delivery in the district. These findings are supported by Ochieng and Sakwa (2018) who note that participation in mobilization of resources enhances the efficiency of the implementation phase of the projects.

4.4.2 Community Involvement

To determine the extent to which the community was involved in community health and maternal healthcare programs the participants were asked to show the extent to which they agreed or disagreed with statements on community involvements in planning, formal meetings, formal partnerships, informal partnerships, implementation, and decision making and in defining the health care needs of the community. The respondents were also asked to indicate their views on the extent to which community involvement influenced maternal and child service delivery. The results are as summarized in Table 4.5.

Table 4.5: Community Involvement

Statements	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The community is involved at the planning phase of the maternal health activities in the community	1.7%	15.6%	6.1%	70.4%	6.1%
The community is invited for formal meetings by the child health service providers in the community	1.7%	11.2%	10.1%	65.9%	11.2%
The community has established informal partnerships with the child health care service providers in the community	5.6%	16.8%	11.2%	59.8%	6.7%
The community has formed formal partnerships with the maternal health care service providers in the community	2.2%	17.9%	16.8%	58.7%	4.5%
The community is involved during the implementation of the health care activities in the community	0.6%	21.8%	12.3%	54.2%	11.2%
The community is involved in recommending suggestions to improve maternal health care services in the community	1.1%	20.7%	16.2%	50.3%	11.7%
The community is involved in selecting the suitable child health interventions with health service providers in the community	3.9%	19.6%	24.6%	47.5%	4.5%
The community is involved in making decisions affecting child health care service delivery in the community	1.1%	7.8%	31.3%	36.9%	22.9%
The community is involved in defining the health care needs with the child health service providers in the community	4.5%	37.4%	3.9%	35.8%	18.4%
Average Sore	**2.5%**	**18.8%**	**14.7%**	**53.3%**	**10.8%**

Source: Author, 2021

On whether the community was involved at the planning phase of the maternal health activities in the community, 70.4% of the respondents agreed, 15.6% disagreed, with a tie at 6.1% between those who disagreed and those who strongly agreed and 1.7% strongly disagreed. This implies that the community took part in planning for the maternal healthcare activities. According to the KIs, this could arise from the fact that the community members were invited to attend meetings to plan on how to improve on the available health centers so as to avoid maternal deaths. This is in line

with the WHO (2008) which encourages people in the community to take part from the start of an intervention with active participation in defining the needs of the problem and coming up with relevant solutions.

The results showed that 65.9% of the respondents agreed, 11.2% either disagreed or strongly agreed, 10.1% were neutral and 1.7% strongly disagreed on whether the community was invited for formal meetings by the child health service providers in the community. Thus, it can be inferred that the community attended the meetings to deliberate on issues revolving around maternal and child healthcare in Warta Nadaba district. The KIs shared that public forum were organized to deliberate on the child and maternal health service delivery. This happens especially in cases where there is a disease outbreak in the community like measles. Additionally, through the public forums issues of nutrition were deliberated. The KIs went further and shared that these meetings were successful because the community readily sacrificed their busy schedules to attend. These findings are echoed by Usman, Deepali and Kabiru (2018) in Nigeria who pointed out the need for more communal enlightenment and awareness through meetings with local leaders and mass media on the need to increasingly get involved in health care services and activities at the communal level. Havugimana (2015) indicated that through proper community participation, in the planning activities helps in projects implementation.

The results of the study were that 59.8% of the respondents agreed, 16.8% disagreed, 11.2% were neutral, 5.6% strongly disagreed and 6.7% strongly agreed on whether the community had established informal partnerships with the child health care service providers in the community. This implies that the health care providers worked well together without any written agreement or contract and there are some expectations which are met by each party. The KIs added that since some of the health care staff like nurses and doctors working in some of the community health centers were drawn from other areas, they were not the natives and this was probably a host community. Despite this fact, KIs went further and shared that the host community could have been welcoming providing social support to the health care staff who were working to improve the health care services at the community level. This finding is strongly supported by the citizen control level of the ladder theory that comprises of partnership as one of the rungs. Arnstein (1971) argues that this partnership involves sharing of planning and the decision-making abilities between the community and those implementing the health care interventions.

The study further established that 58.7% of the respondents agreed, 17.9% disagreed, 16.8% were neutral, 4.5% strongly agreed and 2.2% strongly disagreed on whether the community had formed formal partnerships with the maternal health care service providers in the community. The local authorities play a part in fostering this partnership through policies that encourage community involvement. The result was supported by a KI who indicated that through the government and local authorities the host community were working to with doctors and nurses to implement maternal health care interventions. These findings are further supported by the Arnstein (1971) ladder theory of participation that recognizes the role played by partnership in success of any intervention.

On whether the community was involved during the implementation of the health care activities in the community, 54.2% of the respondents agreed, 21.8% disagreed, 12.3% were neutral and 0.6% strongly disagreed. This shows that the community had a role to play in putting into practice the maternal and child health care activities. This is usually done through the involvement of community social workers and trained birth attendants who help the mothers in maternal and child health care. According to the KIs, the implementation phase of a program is one of the challenging tasks since majority of the programs fail at this stage. The key activities carried out during implementation of the program include regular communication including meetings and solving of problems through dialogue and negotiations. These views are supported by the ladder theory advanced by Arnstein (1971) that recognizes the need for negotiations when implementing a program so as to distribute power between the community members and those in power. The importance of community involvement during implementation is also supported by Havugimana (2015) who noted that the more people from the community involved at the stage of the implementation the more likely the success of the project. The higher level of community involvement at the implementation phase was attributed to a number of factors including increased awareness among the community created by the agencies vested with responsibility of execution of projects.

The results further showed that 50.3% of the participants agreed, 20.7% disagreed, 16.2% were neutral, 11.7% strongly agreed and 1.1% strongly disagreed on whether the community was involved in recommending suggestions to improve maternal health care services in the community. The suggestions given by the community include the establishment of the additional health

facilities, additional birth attendants and the location of these facilities. The community also reviews the challenges faced in a given period and suggest the areas for improvements for instance the efficiency of health care workers in service delivery, and specifically in the way they talk to those in need of the health services. In other words, sessions and meetings for improvement of the health care programs were organized and the community attended to suggest the relevant ways of how to improve the health care. There are also suggestion boxes in the centers where the community could give their views. The KIs shared that the community was consulted through meetings by those implementing the health care interventions specifically on the suitability of establishing a health facility, security of locations where the facilities are based and also on issues concerning permits for the establishment of a health facility. Arnstein (1969) brought forth consultation as an important aspect of community participation.

The results were that 47.5% of the respondents agreed, 24.6% were neutral, 19.6% disagreed, 4.5% strongly agreed and 3.9% strongly disagreed on whether the community was involved in selecting the suitable child health interventions with health service providers in the community. By looking at those who agreed and strongly agreed, it can generally be inferred that a most respondents agreed that the community was involved and consulted in the selection of the most suitable program on child and maternal health care from a list of suggested programs. The KI shared some of the parameter's that can be used by the community when selecting suitable child health interventions including cost, affordability and accessibility as well as reputation of the health facility in the community and beyond. These results are consistent with Haldane *et al.* (2019) who noted that community involvement is positively linked with health care outcomes, especially at a communal level.

At the same time, 36.9% of the respondents agreed, 22.9% strongly agreed, 31.3% were neutral, 7.8% disagreed and 1.1% strongly disagreed on whether the community was involved in making decisions affecting child health care service delivery in the community. When focusing on the respondents who agreed and the ones who strongly agreed, it can be deduced that the community made decisions that affected maternal health care interventions in Warta Nadaba District. This includes community making decisions on which parts of the district should be given priority in as far as new child health care programs are concerned. This is usually done at the planning stage in liaison with the local government. Other decisions include trainings of additional birth attendants

and nutrition. The KIs stated that community involvement is deliberately done at the planning stage to ensure that the recommendations from the community are considered in the entire implementation of healthcare programs. These findings are echoed by Rifkin (1986) who define empowerment as the act of involving people in the decision-making process on issues affecting their lives.

The study also noted that while 37.4% of the respondents disagreed, 35.8% agreed, 18.4% strongly agreed, 4.5% strongly disagreed and 3.9% were neutral on whether the community was involved in defining the health care needs with the child health service providers in the community through public forums and formal meetings. The KIs said that involving the community in definition of the health care needs contribute towards enhancing sustainability in maternal and child health care service delivery. Through formal and informal meetings information is collected from the community which helps the doctors and nurses in understanding the state of health and the health needs of the community. Havugimana (2015) looked at the involvement of the community within the planning activities and how these impact on implementation of projects where more people from the community were highly involved at the stage of the implementation. It was shown that there were health volunteers at the community level and the traditionally established birth attendants who ensured that there is availability of relevant information on health as far as delivery was concerned.

The findings in Table 4.5 indicate that on average, 53.3% of the respondents agreed, 18.8%disagreed, 14.7% were neutral, 10.8% strongly disagreed and 2.5% strongly disagreed on whether that there was community involvement as far as maternal and child health care service delivery was concerned. According to WHO (1978), community involvement can take various structures, depending on the conditions, explanation of issues and objectives. In primary health care (PHC) community involvement means that the authorities, health providers and the local community have to work together for the success of the health intervention as they each have their area and degree of capacity (Tosun, 1999).

The study sought to establish the perceptions of the respondents regarding the extent which community involvement influenced maternal and child service delivery in Warta Nabada District. Table 4.6 gives a breakdown of the findings.

Table 4.6: Extent which community involvement influenced maternal and child service delivery

	Frequency	Percent
Not at	1	2.6
Little extent	8	21.1
Moderate extent	4	10.5
Great Extent	23	60.5
Very Great Extent	2	5.3
Total	**38**	**100.0**

Source: Author, 2021

The outcome in Table 4.6 indicate that 60.5% of the respondents noted that community involvement influenced maternal and child service delivery to a great extent. This implies that the role by community involvement in maternal and child health care service delivery cannot be overlooked. These findings are reinforced by WHO (2008) which noted that community involvement largely looks at shared responsibilities and partnership with services related to health as opposed to leveraging on the community to bring down the burden linked with health services. Haldane et al. (2019) noted that community involvement is positively linked with health care outcomes, especially at a communal level.

4.4.3 Community Empowerment

The last specific objective variable of the study was community empowerment and the analysis of the Likert based items is as provided in Table 4.7.

Table 4.7: Community Empowerment

Statements	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The community has adequate personnel to participate in child health care services	0.6%	20.1%	12.8%	66.5%	0.0%
The community is empowered to make decisions relating to the type of child health facility to choose	7.8%	14.0%	6.7%	64.8%	6.7%
The community is self-reliant when it comes to maternal health matters	6.7%	19.0%	13.4%	57.5%	3.4%
The community has adequate finances to fund maternal health care services	6.7%	31.8%	13.4%	41.3%	6.7%
The community is self-determined to ensure quality child health service delivery	12.8%	36.3%	6.7%	38.0%	6.1%
The community has good road network to allow mothers to visit health centers when giving birth	6.1%	44.1%	12.8%	36.3%	0.6%
The community has different hospitals offering maternal health care services	3.4%	36.9%	26.8%	26.3%	6.7%
Average Score	**6.3%**	**28.9%**	**13.2%**	**47.2%**	**4.3%**

Source: Author, 2021

The results showed that 66.5% of the respondents agreed that the community has adequate personnel to provide child health care services, 20.1% disagreed, 12.8% were neutral and 0.6% strongly disagreed. Based on the percentage of those who agreed it can be inferred that most of the health facilities are staffed adequately. However, a significant percentage of 20.1% disagreed and this implies that there are certain hospitals within the district that do not have adequate personnel. The KIs shared that the community had been supplied with doctors including the gynecologists and midwives by the government who were responsible for maternal health care issues at the communal level. Those who disagreed, felt that the government needs to do more facilitation in terms of the doctors and nurses within their parts of the district. This finding is strongly supported by Montesanti (2013) who noted that community empowerment is a process that enables community to recognize their own capabilities and skills to participate through personal and collective reflection on the root causes that impact their health and capacity-building activities.

The study noted that while 64.8% of the respondents agreed that the community was empowered to make decisions relating to the type of child health facility to choose, 14.0% disagreed, 7.8% strongly disagreed and those who were neutral and the ones that strongly agreed were tied at 6.7%. This implies that the community had authority to make decisions on child healthcare. While those who are sick can go to the nearest hospitals, there are those who at their discretion chose to go to other hospitals which they perceive to have adequate health facilities. Others even opt to go to the nearest neighboring locations According to the KIs, the community was given adequate information on the various maternal and child healthcare services in the health facilities and this helps them in making decisions on which health facilities to choose. The finding is supported by Montesanti (2013) who indicated that community empowerment is a process that enhances their views and experiences of the community in the designing of and decision- making about health facilities delivery in terms of primary health care services, health promotion, prevention services and/or programs, and broader population health programs.

It was shown that 57.5% of the respondents agreed, 19.0% disagreed, 13.4% were neutral, 6.7% strongly disagreed and 3.4% strongly agreed on whether the community was self-reliant when it came to maternal health matters. Being self-reliant, it can be inferred that the community was empowered to decide on whether to take part in such programs as ANC or PNC since they had enough information. Additionally, it can be inferred that most health facilities in most parts of the district had adequate resources to run most of their services. This according to the KIs implies that there was adequate information on maternal health care. According to the study by Wisitcharoen, Boonchieng, Suwanprapisa and Buddhirakkul (2016) one of the key ways of increasing community empowerment is through initiation of programs aimed at empowering the community.

The study further established that 41.3% of the respondents agreed, 31.8% disagreed, and 13.4% were neutral while 6.7% either strongly disagreed or strongly agreed on whether the community had adequate finances to fund maternal health care services. This means that financial resources were inadequate at the community level as far as the maternal health care services were concerned. The KIs said that some of the health centers had been supported by donors who may have stopped funding on account that the projects should initiate their own sources of income (user fees and membership charges) for sustainability. However, some of the community members were not probably willing to pay for the services which may have affected the finances as supported by

these findings. Therefore, this calls for more innovative ways of financing including the need to diversify and as shared by Awuor et al. (2015), the level of internal efficiency increases with an increase in the availability of financial resources.

The study established that 38.0% of the respondents agreed, 36.3% disagreed, 12.8% strongly disagreed, 6.7% were neutral and 6.1% strongly agreed on whether the community was self-determined to ensure quality child health service delivery. This means that self-determination was lacking among most of the community members in Warta Nadaba district as far as the matters of maternal and child health care services were concerned. The KIs indicated that some of the members of the community especially women were not able to decide on their own with regard to the relevant health facilities to attend to. Rather, they relied on the decision made by their male counterparts. According to Khalid, Ahmad, Ramayah, Hwang and Kim (2019), community empowerment is the coordinated efforts aimed at enhancing self-determination and self-reliance of people within a given establishment.

It was shown that 44.1% of the respondents disagreed, 36.3% agreed, 12.8% were neutral, 6.1% strongly disagreed and 0.6% strongly agreed on whether the community had good road network to allow mothers to visit health centers when giving birth. This shows that road network was an issue, perhaps the available road networks especially during rainy seasons were not passable and this affected the ability of mothers and their children to access health care services. This could be the other cause of high child and maternal deaths in Somalia. It can further be inferred that some of the financial resources mobilized by the community had largely been utilized in financing health care programs with little focus on improvement of the roads. The KIs said that the available resources were not adequate for improving road infrastructures at the expenses of improving maternal and child health care services in the community. Therefore, according to the KIs, much of the priority was given to improvement of maternal and child health care. As indicated by Wallerstein (1992), community empowerment is an activity procedure in which people, community and associations gain authority over their setting of changing their social and political conditions which could the road networks to enhance value and personal satisfaction.

The study's results were that 36.8% of the respondents disagreed, 26.8% were neutral, 26.3% agreed, 6.7% strongly agreed and 3.4% strongly disagreed on whether the community had different

hospitals offering maternal health care services. This means that there was little diversity in the healthcare facilities that people in Warta Nadaba could access. Thus, it can be inferred that the available health facilities were not adequate to cater for the child and maternal health care needs of the community. The KIs said that existence of limited number of health facilities would have lowered the level of competition and to some extent compromised the quality of services offered to the community. This could also be an opportunity for the limited health centers to establish themselves as monopolies charging relatively higher user fees that probably made the community to shy away from contributing thus affecting their available financial resources (KIs). This finding is reinforced by the report published by the Ministry of Human Development and Public Services [MOHDPS] (2013) which indicated that there is a great disparity between the quality of health services provided in the urban areas and those of the rural areas like Warta Nadaba.

Table 4.7 showed that on average, 47.2% of the respondents agreed that community empowerment was practiced with reference to maternal and child health care services, 28.9% disagreed, 13.2% were neutral, 6.3% strongly disagreed and 4.3% strongly agreed. This implies that over half of the respondents were of the view that communities in Warta-Nabada have the power and autonomy and information to make decisions on issues affecting their lives. This is in line with Wallerstein, (1992) definition which states that community empowerment is the concept in which people, community, and associations gain authority over their setting of changing their social and political condition to enhance value and personal satisfaction.

The study sought to establish overall the extent to which community empowerment influenced maternal and child service delivery in Warta Nabada District. The results are presented in Table 4.8.

Table 4.8: Extent which community empowerment influenced maternal and child service delivery

	Frequency	Percent
Not at	3	7.9
Little extent	7	18.4
Moderate extent	6	15.8
Great Extent	17	44.7
Very Great Extent	5	13.2
Total	**38**	**100.0**

Source: Field Data (2020)

Table 4.8 indicates that 44.7% of the respondents noted that community empowerment influenced maternal and child health care service delivery to a great extent while 13.2% indicated to a very great extent. This finding is consistent with Retnowatiand Soeharjoepri (2018) study that argued that community empowerment increases synergy and cooperation among the members of the community as they work together for a common good.

4.5Regression Results and Hypothesis Testing

Regression analysis is a statistical technique that helps in analyzing the relationship between the independent (community participation) and the dependent variable (maternal and child health care service delivery). There are three key outputs that generated from regression analysis; the model summary and the regression beta coefficients with related significance.

4.5.1 Regression Model Summary

This section presents the findings of regression analysis aimed at testing the formulated hypotheses. The regression model summary gives information of the coefficients of correlation R and coefficient of determination R square as illustrated in Table 4.9.

Table 4.9: Regression Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.878[a]	.772	.768	1.18552

a. Predictors: (Constant), Community Empowerment, Community Resource Mobilization, Community Involvement

Source: Field Data (2020)

The regression analysis was used to measure the relationship between the dependent variable which in this study was maternal and child health care service delivery and the independent variables which were community resource mobilization, community involvement and community empowerment. From the findings in Table 4.9, the value of R (coefficient of correlation) is given

as 0.878, which is interpreted to infer that community participation has a far-reaching influence on maternal and child health care service delivery in Warta Nadaba. Meaning that there is a high degree of correlation between community participation and maternal and the provision of child health care services.

The findings of the R square (coefficient of determinant) indicate its value as 0.772, this infers that 77.2% change in maternal and child health care service delivery in Warta Nadaba District is explained by community participation. This means that community participation is a major factor influencing maternal and child health care service delivery. This finding is consistent with Kugonza and Mukobi (2015) who revealed that the key factors that influence public participation in matters of health service delivery were identified as accessibility to information, ability to effectively use this information and the level of awareness of responsibilities and rights of community members.

4.5.2 Regression Beta Coefficients and Significance

Table 4.10 gives a summary of the findings of the regression beta coefficients and the significance as determined by the p-values.

Table 4.10: Regression Beta Coefficients and Significance

	Unstandardized Coefficients		Standardized Coefficients		
	B	**Std. Error**	**Beta**	**T**	**Sig.**
(Constant)	2.369	.762		3.110	.002
community Resource Mobilization	.078	.026	.134	2.996	.003
Community Involvement	.073	.029	.136	2.519	.013
Community Empowerment	.648	.042	.844	15.392	.000

a. Dependent Variable: Maternal and Child Health Service Delivery
Source: Field Data (2020)

Table 4.1 gives the below predicted model:

$$\mathbf{Y=2.369+.078X_1+.073\ X_2+.648\ X_3}$$

Where Y=Maternal and Child Health Service Delivery

X_1 is Community Resource Mobilization

X_2 is Community Involvement

X_3 is Community Empowerment

The first objective of the study sought to establish how community resource mobilization influences maternal and child health care service delivery in Warta-Nabada District. The results showed that holding other factors constant, a unit change in community resource mobilization would lead to .078 unit improvement in maternal and child health care service delivery in Warta-Nabada District. The first hypothesis of the study wasH_1 community resource mobilization has significant effect on health service delivery in Warta-Nabada District. From the findings, community resource mobilization had p-value of 0.003 ($p<0.05$), which means that it was significant. Thus, hypothesis H_1 was accepted by the study.

The second objective of the study sought to establish how community involvement influences maternal and child health care service delivery in Warta Nadaba District. The study revealed that when all other factors are to be held constant, a unit increase in community involvement would influence maternal and child health care service delivery in Warta Nadaba District by 0.073 units. The second hypothesis of the study was H_2 community involvement has significant effect on health service delivery of Warta Nadaba District. From the findings, community involvement had p-value of .013 which was less than 0.05, and thus it was significant. Thus, the study accepts hypothesis H_2.

The in objective three, study sought to assess how community empowerment influences maternal and child health care service delivery in Warta-Nabada District. The results of the study indicated that when other factors are held constant, a unit increase in community empowerment would influence maternal and child health care service delivery in Warta-Nabada Districtby 0.648 units. The third hypothesis of the study was H_3community empowerment has significant effect on health service delivery of the Warta-Nabada District. The findings showed that the p-value of community empowerment was 0.000 which was less than 0.05 and thus it was significant. Thus, the study accepts hypothesis H_3.

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the analyzed findings as guided by the specific objectives. The conclusions and recommendations as informed by the findings are also presented. The chapter is divided into the following sub-section: summary, conclusions, recommendations and areas for further research.

5.2 Summary

This section summarizes the findings of the study according to the specific objectives. The study sought to examine the influence of community participation on maternal and child health care service delivery in Warta-Nabada District. The specific objectives were to: establish how community resource mobilization influences maternal and child health care service delivery in Warta-Nabada District; determine how community involvement influences maternal and child health care service delivery in Warta Nabada District; and assess how community empowerment influences maternal and child health care service delivery in Warta-Nabada District.

The first objective was to establish how community resource mobilization influences maternal and child health care service delivery in Warta-Nabada District. The study established there was community resource mobilization that influenced maternal and child health service delivery to a great extent. The findings confirmed that the community was involved in the mobilization of financial, human and material resources required for the delivery of both maternal and child health services. The mobilization of financial resources was mainly done through fund raising and cost sharing by the community. The community was also involved in the mobilization of human resources in that most of the staff that worked in health facilities including nurse aides, nurses, clinical officers and doctors came from the community. Furthermore, there were local representatives in the selection boards of the health personnel. Material resources mobilized by the community included water, timber and cement that was used for the construction of buildings. These findings are in line with those of Muniu *et al.* (2018) who pointed out that the ability of members of the community to take part in the mobilization of resources has an influence on the sustainability of community projects.

The second objective was to determine how community involvement influences maternal and child health care service delivery in Warta Nabada District. From the results, there was community involvement and this influenced maternal and child health service delivery to a great extent. Most of the respondents agreed that they were involved in planning of maternal health activities at the community level. Involving the community at the planning phase is an important step towards increasing acceptance of the maternal and child health project and thus overall service delivery. Community involvement was also realized through invitation to formal meetings, where key issues including the need to improve maternal and child health care projects are deliberated in such forums. It was noted that there was both formal and informal partnership between the health care service providers and the local community. The informal partnerships were through involving the community in sharing of resources for instance the financial resources to improve health care services. The formal partnerships happened through partnerships between local authorities and community through policies that allow the community to provide midwives and birth attendants. It was shown that the community was involved in recommendations of suggestions to improve maternal health care services in the community. There was community involvement at the implementation phase of the health care activities and this probably contributed towards improving maternal and child health service delivery.

The third objective of the study was to assess how community empowerment influences maternal and child health care service delivery in Warta-Nabada District. The findings showed that community empowerment influenced child and maternal health care service delivery in Warta-Nabada District albeit relatively lower compared to other indicators of community participation. Most of the respondents said that the community had adequate personnel to participate in providing child health care service delivery. Much of the empowerment at the community level was in regard to decision making ability especially in respect to the types of the child health facilities to select. Furthermore, majority of the respondents agreed that community empowerment was realized through self-reliance when it came to child and maternal health care services. Most respondents also agreed that there were adequate finances to fund maternal health care services. Majority of the respondents also agreed that the community was self-determined to ensure quality child health service delivery. The respondents however felt that the road network in the community was not good to allow mothers to visit health centers when giving birth. Most respondents also disagreed

that the community had different hospitals offering maternal health care services meaning that there was diversity in health care facilities.

5.3 Conclusions

Following the results from the study it was established that community resource mobilization influences maternal and child health care service delivery in Warta-Nabada District. From the results, community resource mobilization had a positive beta coefficient that was significant ($p<0.05$). Thus, the study concludes that community resource mobilization is a significant factor supporting maternal and child health care service delivery in Warta-Nabada District. The study concludes that with community resource mobilization, specifically to contribute financial, material and human resources the implementation of health care services is enhanced since there are no shortages of the needed facilities. It also enhances child and maternal health care by ensuring that the required personnel with relevant skills are available. This helps in enhancing efficiency in the provision of these services.

The second objective of the study sought to establish how community involvement influences maternal and child health care service delivery in Warta Nadaba District. In view of the findings of regression analysis, community involvement had a positive beta coefficient which was significant ($p<0.05$). Thus, this study conclude that community involvement significantly contributes towards maternal and child health care service delivery in Warta Nadaba District. From the study it is concluded that community involvement helps in winning the full cooperation from the community and this ensures the success of the child and maternal health care service delivery. Additionally, it ensures that the health care service delivery is a shared responsibility and this helps in bringing all the participants on board making the health care service delivery successful as opposed to if this was left to the healthcare providers alone.

The study sought to assess how community empowerment influences maternal and child health care service delivery in Warta-Nabada District. Based on the findings of regression analysis, community empowerment had a beta coefficient that was significant ($p<0.05$). Thus, the study conclude that community empowerment significantly influences maternal and child health care service delivery in Warta-Nabada District. This is because; community empowerment helps in

harnessing the skills of the community while giving a leeway for the members of the community to make decisions as to which health care facilities are appropriate for them.

5.4 Recommendations of the Study

Based on the findings of regression analysis, community empowerment had the largest regression beta coefficient which was significant. Thus, this study recommends that policy makers in the Ministry of Health in Warta-Nabada District should focus more on empowerment of the community since this has the largest contribution towards maternal and child health care service delivery. Specifically, the community should be empowered through equipping them with skills on healthcare service delivery. For instance, adequate number of community social workers along with birth attendants need to be trained to ensure that using their skills they are able to complement the work done by professional health care officers. The community should also be able to access adequate information on health care services.

In view of regression results, community resource mobilization had the second largest beta coefficient that was significant. Additionally, a significant percentage of the respondents indicated that the community was not fully involved in resource mobilization. Thus, this study recommends that health care officials in Warta-Nabada should utilize media channels to raise more awareness on the need for the community to be involved in mobilization of resources in support of maternal and child health care service delivery. The community in Warta Nadaba district should take an active role in mobilizing finances to support child and maternal health care services through organization of fund raisers. The community health departments should also mobilize human resources from the community by facilitating trainings of community members on health care needs.

The findings of regression analysis indicated that community involvement had the least but significant beta coefficient. Thus, this study recommends for more improvement on community involvement so that it may greatly contribute towards maternal and child health care service delivery. This can be realized by encouraging all the members of the community irrespective of their gender to actively take part in decisions on maternal and child health care service delivery. On regular basis, the health care departments in the district should seek recommendations from

the community members on the health care priority areas so that their planning can be in tandem with child and maternal the healthcare needs of the community.

5.5 Suggestions for Further Studies

The present study focused on community participation and maternal and child health care service delivery. More specifically, the study looked at community resource mobilization, community involvement and community empowerment with respect to maternal and child health care service delivery. The items of community participation that were covered in this study were only seen to cause77.2% change in maternal and child health care service delivery. This means that aside from the variables examined there are other factors that could influence on maternal and child health care service delivery that future studies should study.

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APPENDICES

Appendix I: Letter of Introduction

Dear Respondent,

RE: **DATA COLLECTION**

I am Liban Abukar Abdikulane, a student at Nairobi University, currently undertaking a research study on **INFLUENCE OF COMMUNITY PARTICIPATION ON MATERNAL AND CHILD HEALTH CARE SERVICE DELIVERY IN SOMALIA: A CASE OF WARTA-NABADA DISTRICT.** You are requested to be involved in this study by honestly and accurately answering the questions raised in the interview guide. The information given herein is meant for academics and will be treated with confidentiality.

Your cooperation is highly appreciated.

Yours Sincerely,

Liban Abukar Abdikulane

Appendix II: Questionnaire for community Members and Health care Officials of Warta Nabada District

Dear Respondent

Kindly provide appropriate responses to the questions below. Note that any information you will share will only be used for academic purpose. Do NOT write your name on the questionnaire.

SECTION A: DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Kindly indicate your age

Less than 30 years ( ) 31-40 ( ) 41-50 ( ) 50 and above ( )

2. Kindly indicate your gender category

Male ( ) Female ( ) Other…….. Specify

3. Kindly indicate your level of education

Primary ( ) Secondary ( ) Diploma ( ) Bachelor ( ) Master ( ) Other…….. Specify

4. Kindly indicate the number of years you have been a resident in Warta Nabada district

Less than 3 years ( ) 3-8 years ( ) 8-15 years ( ) Over 15 Years ( )

SECTION B: MATERNAL AND CHILD HEALTH CARE SERVICE DELIVERY

5. Below are several statements on maternal and child health care service delivery. Kindly indicate the extent of your agreement with each of these statements. Use a scale of 1-5, where 1=strongly disagree and 5=strongly agree.

Statements	**1**	**2**	**3**	**4**	**5**
The health care services are accessible to the community in Warta Nabada district					
The maternal health care services are available to community in Warta Nabada district					
The community is able to utilize the health care services					
The child health care services cover the community in Warta Nabada district					

6. Kindly recommend the best ways that can be adopted to improve Maternal and Child Health Care Service Delivery in Warta Nabada district

……

……

SECTION C: COMMUNITY RESOURCE MOBILIZATION AND MATERNAL AND CHILD HEALTH CARE SERVICE DELIVERY IN WARTA NABADA DISTRICT

7. Please tick the letters in the box that corresponds or characterizes your degree of agreement, where: 1=strongly disagree, 2=disagree, 3=neutral, 4=agree or 5= strongly agree to the following statements by indicating appropriately.

Statements	**1**	**2**	**3**	**4**	**5**
The community mobilizes finances for the child health care initiatives in the community					
The community mobilizes relevant sources of financing the maternal health care interventions					
The community mobilizes human resources for the maternal health care in the community					
The community mobilizes human resources for the child health care providers in the community					
The community mobilizes material resources to support health care in the community					
The community is involved in determining timelines of the health care programs in the community					
The community determines the required skills for the child health care interventions in the community					

8. In general, to what extent does community resource mobilization impact on maternal and child service delivery in Warta Nabada District?

Not at ( )

Little extent ( )

Moderate extent ( )

Great Extent ( )

Very Great Extent ( )

9. Kindly indicate other ways through which the community is involved in resource mobilization

for Maternal and Child Health Care Service Delivery in Warta Nabada district

……
……..

10. Kindly indicate some of the resources that the community has been involved in mobilizing Maternal and Child Health Care Service Delivery in Warta Nabada district

……
……..

SECTION D: COMMUNITY INVOLVEMENT AND MATERNAL AND CHILD HEALTH CARE SERVICE DELIVERY OF WARTA NABADA DISTRICT

11. Below are several statements on community involvement and maternal and child health care service delivery. Kindly indicate the extent of your agreement with each of these statements. Use a scale of 1-5, where 1=strongly disagree and 5=strongly agree.

Statements	**1**	**2**	**3**	**4**	**5**
The community is involved in selecting the suitable child health interventions with health service providers in the community					
The community has formed formal partnerships with the maternal health care service providers in the community					
The community has established informal partnerships with the child health care service providers in the community					
The community is involved in defining the health care needs with the child health service providers in the community					
The community is involved in recommending suggestions to improve maternal health care services in the community					
The community is invited for formal meetings by the child health service providers in the community					
The community is involved in making decisions affecting child health care service delivery in the community					
The community is involved at the planning phase of the maternal health activities in the community					
The community is involved during the implementation of the health care activities in the community					

12. In general, to what extent does community involvement impact on maternal and child service delivery in Warta Nabada District?

Not at ( )

Little extent ( )

Moderate extent ( )

Great Extent ( )

Very Great Extent ( )

13. Kindly identify some of the challenges encountered that affect your involvement in maternal and child health care activities in the community?

……

……

SECTION E: COMMUNITY EMPOWERMENT AND MATERNAL AND CHILD HEALTH CARE SERVICE DELIVERY OF WARTA NABADA DISTRICT

14.Below are several statements on community empowerment and maternal and child health care service delivery. Kindly indicate the extent of your agreement with each of these statements. Use a scale of 1-5, where 1=strongly disagree and 5=strongly agree.

Statements	**1**	**2**	**3**	**4**	**5**
The community is self-reliant when it comes to maternal health matters					
The community is self-determined to ensure quality child health service delivery					
The community has adequate finances to fund maternal health care services					
The community has adequate personnel to participate in child health care services					
The community has good road network to allow mothers to visit health centers when giving birth					
The community has different hospitals offering maternal health care services					
The community is empowered to make decisions relating to the type of child health facility to choose					

15.In general, to what extent does community empowerment impact on maternal and child service delivery in Warta Nabada District?

Not at ( )

Little extent ( )

Moderate extent ( )

Great Extent ( )

Very Great Extent ( )

16. Kindly indicate other ways through which community empowerment impact on maternal and child health care service delivery in Warta Nabada district

……
……..

I thank you very much for your response

Appendix III: Interview Guide for District Administrators of Warta Nabada district

1. Kindly indicate gender

……

2. Kindly indicate your education

……

3. For how long have you worked as a district administrator in Warta Nabada district?

……

4. What is your view on Maternal and Child Health Care Service Delivery in Warta Nabada district in terms of accessibility, availability, utilization and coverage? Kindly explain

……..

5. What is your understanding of the term community resource mobilization in the context of Maternal and Child Health Care Service Delivery?

……

6. What are some of the strategies that are adopted by Warta Nabada district of enhancing community resource mobilization?

……

7. Kindly comment on your understanding of community involvement as a way of enhancing health service delivery in Warta Nabada district

……

8. Kindly identify some of the strategies that are used in Warta Nabada district to ensure there is community involvement?

……

9. Kindly indicate your understanding of community empowerment in the context of Maternal and Child Health Care Service Delivery in Warta Nabada district.

…….

10 What are some of the strategies that are used in Warta Nabada district to ensure there is community empowerment?

…….

Thank you