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Research Article

Community Participation and Health Service Delivery in Mogadishu Municipality- Somalia

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Abstract: The paper discusses the relationship between community participation and health service delivery in Mogadishu Municipality-Somalia. The study was motivated by poor health service delivery in the public sector which might caused by limited participation of respective stakeholders. The specific objectives of this research were intended to examine the relationship among community resource mobilization; community involvement; community empowerment and health service delivery in Municipality. The study used correlation design and the sample was 138 respondents. Simple random and purposive sampling were used as a sampling techniques to collect data. Questionnaires were the main tool used together data. The data was coded, organized, analyzed and interpreted using the Statistical Packages for Social Scientists (SPSS). As regards the relationship between community resource mobilization and health service delivery in Howlwadag and Hodan districts of Mogadishu municipality, the findings generally indicated that there is a small significant relationship between community resource mobilization and health service delivery in two districts ($r = .285$, $n=138$, $p = .001$). As relates to the relationship between community involvement and health service delivery in both districts, the findings shown that there is a small negative relationship between community involvement and health service delivery in two districts although involvement is not significant predictor of the health service delivery ($r= -.006$, $n=138$, $p = .941$). Considering the correlation between community empowerment and health service delivery in districts, the findings revealed that there is a small positive relationship between community empowerment and health service delivery in two districts but empowerment was not a statically significant predictor of the health service delivery because of the sig. level ($r = .144$, $n=138$, $p = .092$). The study found that local communities in Mogadishu municipality are willing to participate in health service delivery at the grassroots level. However, there are many foctors that deviate the associations among variables including urgent needs for sector service delivery reform and implementation of long-term projects that address poor health service delivery. Lak of involvement of community members in health services delivery, insecurity, poor odinances and by-laws concerning local government organizations, limited research and publications about community resources are also exist. The lack of creation of sensitization programs, limited health care management information systems, lack of social security system and health insurance system. Nevertheless, the study revealed that the relationship between community participation and health service delivery in Mogadishu municipality is very limited. Finally, the study concluded that the community participation in health service delivery in Mogadishu is very weak.

Keywords: Community, Participation, Health, Service Delivery, Mogadishu Municipality

1. Introduction

In the view of popular participation in decision-making about health service delivery is a very old one. It emerged throughout the time of the Greek City States, where it had been believed that each citizen ought to be permitted in order to contribute the delivery of health services [45]. With the emergency of community participation, there are various shifts in thought of the idea of participation that was reflective 'a dynamical explanation for participation among the United Nations [2]. In 1955, the international organizations recognized community participation as similar with community development [37]. This perception changed after 20 years once the International Labor Organization (ILO) highlighted that community inputs ought to play a crucial role within the provision of essential needs and as a method for increasing potency and self-sufficiency. Basic necessitates like health, education, water, etc. will solely be provided with efficiency through public endeavors by stressing the role of non-material basic necessitates such as employment and political liberty as means to reach material needs such as shelter and clothing [1].

Historically in the civilian administration, Somalia had elected government led by Somali Youth League Party called SYL to locally manage locality administration such as a village, a city, or any other area smaller than the state to decentralize public bodies to all over the country to enable citizens to popularly elected local councils who will responsible for municipals, circles and district administrations. It was suspended in 1969 when the military led by General Mohamed Siad Barre took over the country in a coup. The military regime centralized power and ruled the country from Mogadishu through their promotion of nationalism, patriotism, and national identity. This centralization led to a brutal civil war that eventually destroyed the state in 1991 [13]. After the civil war for many years which culminated within the collapse of central government organizations and infrastructure throughout the country. As a result, the availability of social services like health, education, water, sanitation, food, and nutrition was seriously discontinuous or abandoned [6].

The Transitional Federal Charter, approved in February [51] with the Provisional Constitution, endorsed by National Constituent Assembly on 1 August FRS [40] defines that Somalia will have a decentralization system of administration relied on federalism which will devolve powers from central government to its sub-national units of governments to enhance community participation at the local level [54]. The adoption of federalism might increase community participation in health service delivery and brought services near to communities in need [17]. Community participation in health service delivery in Mogadishu Municipality is a very important in peace building and post conflict reconstruction of Somalia with the consideration of policy formulation, implementation, monitoring and evaluation of sustainable policies and programs at the locality level.

1.1. Statement of the Problem

The health service delivery has been the focus of intensive research effort in recent times [51]. Efficient, responsive and prompt health service delivery is now an ideal goal for all nations [41]. It is now commonly accepted that health could be a basic right and is outlined by the WHO as a situation of whole physical, social, and mental well-being, and not simply the absence of un-wellness or frailness [48]. The WHO states that all people should have access to basic resources for health which permits people to lead an individually, socially, and economically productive life. Health for all that supported the conception of equity has become a priority of organizations like World Health Organization.

The health of Somali people remains in a very difficult situation with a number of the worst health indicators within the world [34]. Under-5 age mortality is extremely high (in the vary of one hundred eighty to 225 per 1,000 live births) and there has been no progress in minimizing child death rate within the last twenty years [34]. The World Health Organization guessed that sixty one per one thousand newborn infants die among the first month of life, the highest neonatal mortality rate among the globe. Similarly, maternal mortality is among the highest among the globe, at least 1,400 per 1,000,000 live births. Life expectancy is forecasted to be fifty three and fifty six years for male and females, respectively [64]. Recent estimations demonstrate on-going health concerns linked to COVID-19 pandemic, insecurity, floods, lack of administration access and restricted coverage of health care services across most of the districts in Mogadishu-Somalia, and the absence of necessary health, nutrition and water, sanitation and hygiene (WASH) facilities, is resulting in high levels of ill-health and frequent health problem outbreaks [34]. The Somali health sector strategic plan for 2013-2016 identifies that:

> The major determinants of population health are poverty, lack of security, lack of access to health services, poor nutritional status of the population, the low status of women and high rates of female genital mutilation, high fertility, low immunization rates, lack of access to drinkable water and safe sanitation, poor health behaviors and increasingly unhealthy lifestyles [34].

Despite the establishment of the government's health sector strategic plan was focused on to address those determinants, there has not been a scientific analysis that examined its strengths and potential constraints. It's worthy to comprehend that whether or not community participation is cornered in those things as connected in health services delivery. This paper is then stirred up to fill this gap. It intends to assess whether there is any statistically significant relationship between community participation and health service delivery in Mogadishu Municipality-Somalia.

1.2. Objective of the Study

The general objective of this study was to examine the relationship between community participation and health service delivery in Mogadishu Municipality-Somalia.

1.3. Research Questions

The study thought to analysis the following research questions:-

1) What is the relationship between Community Resource Mobilization and health service delivery in Mogadishu Municipality?
2) What is the relationship between Community Involvement and health service delivery in Mogadishu Municipality?
3) What is the relationship between Community Empowerment and health service delivery in Mogadishu Municipality?

1.4. Conceptual Framework of the Study

A conceptual framework is an illustration where the investigator comprehends the previous literature review to present the relationship between two or more variables graphically. The rationale of conceptualization is to assist the person who reads quickly see the projected relationship [21]. In order to analyze the research questions, the researcher adapted the following conceptual framework. The independent variable was the community participation measured by the Community Resource Mobilization; Involvement and Empowerment. The dependent variable was the health service delivery measured by Community-based Health workers, Leadership and Governance, Essential drugs and technologies, Vaccine-preventable diseases and Health Financing Services. The moderating 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 within the period covered the study.

The figure underneath shows the association among the independent variable and the dependent variable with the consideration of the moderating variables:

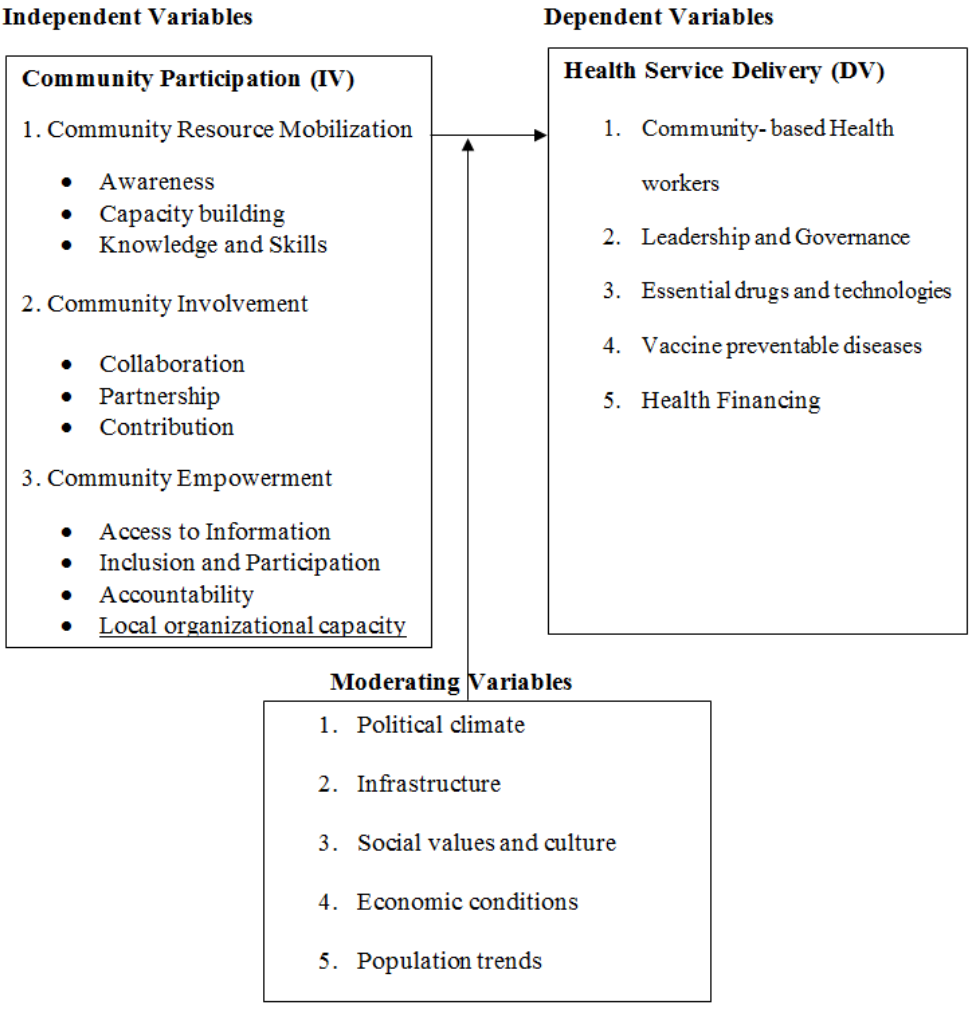

***Figure 1.** 1.*

Source: Developed by the Researcher (2022) based on the references of Ismael et al. (2016); Whitehead et al. (2005); Dennill, King & Swanepoel (2002); World

Bank (2002); WHO (2015); Qayad (2007) and (MOHDPS, 2013).

2. Literature Review

2.1. The Concept of Community Participation

The literature on community participation is diverse and spans several disciplines. There has been considerable analysis and discussion among scholars and practitioners of participation regarding the meaning of the term participation [35]. However [5] defined community participation as an actual act of collaborating within the association of community members in specific community activities. In community participation, the participants ought to be members of an equal community. Moreover [23] suggested that community participation involves purposeful activities in which community members have taken half in government-related activities.

Within this broad field, community participation with health service delivery has been used interchangeably with other labels such as community development, community participatory-action, collaborative decision making, community empowerment, community capacity-building, community organizing, and community governance [35]. In the context of health, a community is often thought-about to be people who are littered with same health problems. The sense of belonging that individuals have in their community might influence their participation in community activities, the however, in modern society, community members add more value to social accountability and participation [12].

The centrality of community and its importance for health were reflected in prominent international statements such as the Ottawa Charter for Health Promotion [31]. The Kazakhstan 1978 Alma-Ata International Conference on Primary health care (PHC) and also the ensuing Alma-Ata Declaration advanced the principle that communities ought to play a job in developing policies and programs that have an effect on their health through a transparent concern of participation [12] by swing community-based physicians mutually of the cornerstones for provision of comprehensive PHC at the local level [32]. However, the real implications of this standard became the topic of intense dialogue [46]. Three decades more later than Alma-Ata, a review of worldwide policies stated that every Declaration's key principles that have most notably didn't stabilize are that of community participation [25]. The basis of community participation lies within health service delivery as defined by the Alma-Ata Declaration of 1978, and health service should emphasize community inputs in whole health core activities [43]. The same scholars stated that the reference to the saying communities having their own voice in tackling health problems, is not new, as in the1950's and 1960's rural and urban community growth programs began to embrace local residents in decision-making processes and control [47]. However, due to the increase in technology and the centralization of National Health Services, it does not only have the possibility of exclusion, but most of the health services shifted to be the responsibility of professional health personnel [64]. Although this reality is noted, community participation in health is still viewed as a valuable approach to improve health outcomes in vulnerable communities [9].

Following the analysis of the health service implementation in Africa, three decades more later than the Alma-Ata Declaration, policymakers advocated for the need to accelerate the achievement of community contribution in African governments, including communities as partners [42]. By means of which members and families have come back to look at health not solely as a right, however additionally as a responsibility that provide people a high degree of responsibility for his or her own health care for example, by adopting a healthy life-style, by applying principles of sufficient nutrition and hygiene, or by using protection services [36]. Moreover WHO explicitly states the role of key stakeholders in policy decision making processes and views stakeholders' participation as of central importance in any dialogue affecting community members' lives or that of the broader society [64].For the sake of that community participation involves minimizing the gap between health professionals and the community so that the health care professionals share some of their tasks with community members. Participation to be successful, maintenance of trust is also needed, because, if trust is lacking, it can lead to the community increasing demand for participation or self-exclusion [50].

2.1.1. Community Resource Mobilization

Community resource mobilization may be described as a method by which we tend to reach resolute totally different sectors of the community to make partnerships that specialize in, and ultimately address, the social, structural and individual problems related to health service delivery [7]. Likewise, community resource mobilization represents an important way, in which the health problems faced by members of poor communities may be addressed, especially young people to be engaged in local government activities that improve their lives, and the lives of others in their communities [56]. These resource mobilizations cover the construct of "helping communities to assist themselves" through capability building, skills development and management which would lead mind shift from the desire to acquire material goods or skills for the community towards focusing on their own ability to contribute to the community health. In addition to that they will empower the community members' victimization them and it permits for the employment of community experience on inward conditions and their social connections with the broader community [59] within the areas of health services, transportation help for accessing health services, health education, and facilitation of employment in programs to purchase health be in mind [28]. The seven major community resources mobilization (outreach) methods employed in service delivery programs included: formation neutral buy-in,

the formation of community coalitions, community engagement, community participation, raises community awareness, the involvement of leaders, and partnership building. Evans and his colleagues have argued activities that focus on and aim to empower individual community members ought to be distinguished from community mobilization efforts that obtain to construct a collective entity out of a bunch of people [14].

2.1.2. Community Involvement

Community involvement towards people's contribution appeared in response to Alma-Ata's decision towards primary health care [66]. By the mid-1980s, Susan Rifkin described 3 completely different approaches toward community involvement: 1st, the medical approach, within which health practitioners foster community contribution so as to diminish individual morbidity and to enhance sanitation; second, the health service approach, within which community participation intends to assemble along folks to participate within the delivery of health services; and third, community development approach, within which community seeks to involve community members in choices that are associated with the progress of the social, economic, and political conditions that have an effect on their health [44]. In the context of health service approach, community involvement in health encouragement and health service provision is a crucial part of the event of health care services to the community [11]. Community involvement describes to a shift of stress from external or governmental agencies activity of health services, to the members of a community turning into active participants in their own health care. Community members become partners in health care by generating their own concepts, assessing their needs, involvement at intervals of the decision-making technique, planning, implementing, and even evaluating the care they acquired [30].

2.1.3. Community Empowerment

Rifkin defined empowerment as a way of promoting chances and motivations to change those while not power and/or influence to realize skills, knowledge, and confidence to organize their own lives [30]. Wallerstein articulated similar concepts to Rifkin by describing empowerment as a lively method through which people, communities, and organizations achieve mastery in excess of their situation of sterilization to their communal and political surroundings to develop fairness and value of life [58]. [24] also differentiate participation from empowerment approaches to an clear orientation of direction toward social and political modification at the same time, the World Bank accepted empowerment debate and outlined as a way of fast the potential of individuals or groups to create choices and to remodel selections into desired actions and outcomes [61]. In addition to that, other scholars also described community empowerment as 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 planning of and decision- making about health services delivery in terms of primary health care services, health promotion, prevention services and/or programs, and broader population health programs [35].

The communities take part meaningfully in health programs commence with the goal of uplifting quality of life, it's imperative that they're encouraged. The principle of empowerment describes that folks partake as a result of it's their democratic duty to try and do this, and contribution additionally suggests that having power [60]. There are numerous service delivery organizations, agencies, and government departments that regard local folks as a decent supply of data. However, these organizations might limit people's participation in consultative role. If this can happen, we have a tendency where we cannot say power ought to accompany participation [53] as a result of that Arnstein [4] affirmed that involvement without a power "is an empty and frustrating process for the powerless". Rifkin [44] explained the empowerment approach as a method of people's participation based upon community power in the areas of getting information, right to use resources and finally organization over their own lives rather being dominated by the authorities essentially the poor by whom they need been exploited too.

2.2. The Concept of Health Service Delivery

The community participation for health service in Somalia is affected by armed conflict that has junction rectifier to the destruction of social services, particularly faculties and health facilities, and a high level of insecurity resulting in population dislocations and fear. As disagreement continued had diode several health facilities ransacked, broken or destroyed. A huge proportion of health professionals who would contribute had left the country; the few who remained were typically inexperienced and poorly skilled [49]. The unfortunate level of health coverage in most components, the high price of providing health provision services in insecure areas, and therefore the weak capability of local authorities have diode to the new levels of morbidity and mortality that created vulnerable teams of girls and youngsters and therefore the elders are most affected. These challenges are combined by a weak and fragmented service delivery system, provided by many totally different associations [32].

In a recovery situation, healthcare in Somalia is the third key priority areas after security and education, Somalia does not have an appearance of even basic public health systems. Community participation is necessary for all facets of public health infrastructure includes putting in place national health policies, regulation and enforcement mechanisms, disease control, and monitoring capabilities as well as community health education and awareness strategies [15].

Health care services in Somalia are responsible for Ministry of Health of Federal government (MoHFG), Ministry of Health of federal member states (MoHFMS), Banadir Regional Administration (BRA) also called Mogadishu

Municipality, NGOs and Private. MoHFG is liable for designing and advancing health policies and for improving health care all told government hospitals whereas the MoHFMS and BRA are accountable for health provision at the regional and district level. The NGOs give services each in hospitals and in smaller medical units [26]. There's no insurance system in any region of the country [22]. The present health system is organized below four levels of health care like fundamental health units, health centers, referral health centers and hospitals [39].

Primary health unit (PHU) is worked by a minimum of one community medical worker (CHW), acknowledged by the home leaders within the organization of health services delivery. PHU services are strengthened by the health centre (HC) reaching support, significantly in services connected with the extended programme on immunization (EPI) & nutrition promotion and education whereas the health clinic (HC), worked by competent nurses and midwives significantly trained on self-report personality inventory and nutrition. Every HC serves the concerned area population of 2 or more PHUs [39]. A serious operate of the HC is that the prerequisite of basic emergency obstetric care (BEmOC) services sustained by variety of delivery beds offered for this reason. Even so, there's variety of Maternal and Children Health (MCH) care services are operational at the district level, wherever technical capacities for setting up HCs don't seem to be offered. MCH centers offer a bundle of services that less than those delivered by the HC [65]. Referral clinic (RHC) or the district hospital is meant to supply necessary referral support functions that embody the entire emergency medicine care (CEmOC) services, entailing the supply of applicable facilities and trained technical workers. The RHC operates the designed area populations of many health centers [33].

The regional hospital is also anticipated to provide for main health care professional services done by variety of competent medical and midlevel health proficiency workers. The PHUs and HCs report back to their grassroots health officers, who in conjunction with the hospital director report back to the regional health officer (RHO). On the top of structure facility structure was freshly supplementary by a community-based program, wherever trained feminine Community physicians (FCHWs) named as “Marwo Caafimad” are utilized applying severe choice criteria with represented age vary, academic level, living at intervals their communities with their acceptance and facilitate. FCHWs work from their homes and carry out home visits to produce those allocated services at the doorstep stage. The FCHWs are observed by specially qualified FCHW supervisors [32].

Before the civil war, national capital nowadays called Mogadishu Municipality had four major hospitals just like the mothers and children Benadir Hospital built by Chinese; the Digfer Teaching Hospital built by the EU; Military Hospital built by the Russian; the Madina Police Hospital; and also Lazareti Forlanini and De Martini Hospital who have been isolated and treated tuberculosis patients. Before the civil war, by the Austrian-based international organization implemented Children’s village hospital called SOS. There have been conjointly various few clinics. All health services were government controlled [63]. Dayniile and Keysaney Hospital are other public Hospitals built during the civil war by Dayniile Community [38]; and Somali Red Crescent Society (SRCS) respectively [16]. Some of these hospitals are not effectively functional [55]. The center of district health, that is staffed by one superior doctor among others, is chargeable for four primary health care units and covers from forty thousand to sixty thousand persons. The center of regional health is predicted to figure with the district health centers at the regional capital which is assisted by the government to curative services both district and regional hospitals [63].

On the other side, the access to primary health care services is low with limited right to use clean water which is a remarkable trait in approximately major areas of Somalia including Mogadishu. Then It is not surprising that acute watery diarrhea (AWD) and cholera are prevalent and regularly at the heart of illness epidemic [8]. The MICS two thousand study initiated that generally solely twenty three percent of the population has right to use to harmless drink throughout the country. Because of unpredictable rainfall which is account for droughts and floods grounded poor sanitation and environmental hygiene that are major causes of diseases like cholera among kids and ladies [29]. The influence of lack environmental sanitation is especially felt within the town with its districts, marketplaces, giant villages, and different places wherever folks reside in shut proximity to every different with devastate disposal neighboring to dwellings. Lack of trash collection services are another issue poignant the urban surroundings and polluting water sources, alongside the large number of plastic refuse baggage [3].

3. Methods of Data Collection

The paper discusses the relationship between community participation and health service delivery in Mogadishu Municipality-Somalia. The study used quantitative non-experimental correlation design. The samples of the study of 138 respondents were got in touch with and all filled the questionnaires. Both simple random and purposive sampling were used as a sampling techniques to collect data. The purposive sampling technique was used in selecting key respondents from health officials, traditional leaders and community members for the reason of their expertise and information. While simple random sampling was used to select respondents from Howlwadag and Hodan districts administration officials and civil society representatives because of their availability and experience of community participation and health service delivery in Mogadishu Municipality. Questionnaires were the main tool used together data. The data was coded, organized, analyzed and interpreted using the Statistical Packages for Social Scientists (SPSS).

The study was conducted in the Mogadishu which is the capital city of Somalia and also referred to as the Benadir regional administration. The city is governed by a mayor, is

divided into seventeen districts, every headed by a district commissioner. However, for the reason of security problems, time and budget limitations, only 2 districts were considered to be a part of the study. The selected districts are Howlwadag and Hodan districts. Those districts were selected because they near the regional administrative Headquarter and the size of the districts as well as their population density compared to other districts. The districts were selected sample representatives including all the below mentioned participant's categories as indicated the following table:

Table 1. *Sample Distribution.*

Category of Respondents	Population	Selected sample	Sampling techniques
Howlwadag and Hodan districts staff	34	27	Simple Random Sampling
Civil society representatives	34	27	Simple Random Sampling
Traditional leaders	34	27	Purposive sampling
Health officials	17	16	Purposive sampling
Community members	46	41	Purposive sampling
Total	165	138	

Source: Primary data (2022).

4. Discussion of the Findings

4.1. Demographic Characteristics of the Respondents

This part provides detailed information regarding the uniqueness and the nature of the participants by age, sex and their level of education. These characteristics were selected because they were more likely related to the relationship between Community Participation and Health Service Delivery in Howlwadag and Hodan districts Mogadishu Municipality-Somalia.

Table 2. *Age of the Respondents.*

		Frequency	Percent
Valid	18-30	79	57.2
	31-40	34	24.6
	41-50	17	12.3
	50 and above	8	5.8
	Total	138	100.0

Source: Primary data (2022).

The above table 2 of age group shows that 57.2% of the respondents of the sample population were in the age group of between 18-30 years, 24.6% of the respondents were between 31-40, and 12.3% of the respondents were in between 41-50 years, while, 5.8% of the respondents were within an age group of 50 & above years. The results of the above table indicates that there were many respondents in the age range of 18-30 years who comprised 57.2% (79) participating in the study. There were others in the age range 31-40 years who also represented 24.6% (34), while considerable numbers of participants were within an age range 41-50 years who represented 12.3% (17). The smallest figures of the respondents were within an age group 50 and above years who represented 5.8% (8) of the total population of the respondents. This means that the respondents were mature people and the information they provided to researcher can be trusted because [20] stated that the study age group is considered as mature when they are 18 years and above who can able to think about a particular aspect of their lives. This means that health service delivery officials in both districts are more experienced enough to provide relevant information about the situation of health service delivery.

Table 3. *Sex of the Respondents.*

		Frequency	Percent
Valid	Male	99	71.7
	Female	39	28.3
	Total	138	100.0

Source: Primary data (2022).

In the table above 3 points out that 71.7% of the respondents who answered questions were males whereas, 28.3% of research participants were females. With the respect of gender, this shows that both males and females were involved within the study to make sure representativeness and therefore the reliability of the data collected as a result of [58] argued that data collected from each gender is reliable than from single-sex sample size.

Table 4. *Level of Education of the Respondents.*

		Frequency	Percent
Valid	Primary	9	6.5
	Secondary	36	26.1
	Diploma	34	24.6
	Bachelor Degree	48	34.8
	Master's Degree	11	8.0
	Total	138	100.0

Source: Primary data (2022).

The findings from above table 4 show that 34.8% (48) of majority of the study participants were holding bachelor degree holders, followed by 26.1% (36) who attained secondary level, 24.6% (34) with diplomas, 8% (11) were master degree level whereas, small proportion 6.5% (9) of the respondents were the primary level of education. The research findings imply that majority of the respondents were educated and knowledgeable enough to provide sufficient evidence regarding community participation and its impact on health service delivery in both districts. However, the information they provided throughout the study is significant

in achieving the academic requirements of the study because [21] stipulated that it is crucial in social research to interact with those that have achieved the acceptable degree of knowledge so as to have the capacity to understand & interpret the content of the research questionnaire.

4.2. Community Resource Mobilization and Health Service Delivery in Mogadishu Municipality

Table 5. *Spearman's Rank Correlations Analysis.*

Community Resource Mobilization			**Health ServiceD elivery**	
Spearman's rho	Community Resource Mobilization	Correlation Coefficient	1.000	.285**
		Sig. (2-tailed)	.	.001
		N	138	138
	Health Service Delivery	Correlation Coefficient	.285**	1.000
		Sig. (2-tailed)	.001	.
		N	138	138

**. Correlation is significant at the 0.01 level (2-tailed).

The table 5 above explains that there's a small positive relationship between community resource mobilization and health service delivery in both districts (r = .285, n=138, p = .001). The remaining.715 is attributed to other factors like central government policies, infrastructure, economic conditions of the country etc. The above results in the above table indicate that there's significant correlation between community resource mobilization and health service delivery carried out within local governments. This is because the value of significance is equal.001 which shows that the results are statistically significant. The research results imply that using community resource mobilization weakly improves (r = .285) on health service delivery in both districts. The findings are also in agreement with that of [56] who revealed that community resource mobilization plays an important role in solving health problems faced by members in poor communities especially young people to be engaged in local government activities to improve their lives, and the lives of others in their communities. In an attempt to test whether community resource mobilization in both districts have an influence in health service care delivery system, the researcher looked at community capacity building, awareness and their knowledge and skills to mobilize resources and participate health service delivery at local governance level. The data of the above table means that if any local government wants to carry out health service delivery, they should concentrate on community resources mobilization at the local level as other things else.

4.3. Community Involvement and Health Service Delivery in Mogadishu Municipality

Table 6. *Spearman's Rank Correlations Analysis.*

			Community Involvement	**Health Service Delivery**
Spearman's rho	Community Involvement	Correlation Coefficient	1.000	-.006
		Sig. (2-tailed)	.	.941
		N	138	138
	Health Service Delivery	Correlation Coefficient	-.006	1.000
		Sig. (2-tailed)	.941	.
		N	138	138

**. Correlation is significant at the 0.01 level (2-tailed).

The above table 6 proves that there's a small negative relationship between community involvement and health service delivery in both districts (r= -.006, n=138, p = .941). The remaining 0.994 is attributed to other factors. The results in above table point out that there's no statistically significant relationships between community involvement and health service delivery in both districts because probability value is greater than 0.005. The research results imply that adopting involvement in terms of community participation does not positively improves on the health service delivery in districts (r= -.006). The study findings are also in line with [18] who revealed that there's an absence of consistency within the effectiveness of community involvement (CI) on improving health service delivery. They found that CI failed to improve health behaviors or health outcomes.

4.4. Community Empowerment and Health Service Delivery in Mogadishu Municipality

Table 7. *Spearman's Rank Correlations Analysis.*

			Community Empowerment	Health Service Delivery
Spearman's rho	Community Empowerment	Correlation Coefficient	1.000	.144
		Sig. (2-tailed)	.	.092
		N	138	138
	Health Service Delivery	Correlation Coefficient	.144	1.000
		Sig. (2-tailed)	.092	.
		N	138	138

**. Correlation is significant at the 0.01 level (2-tailed).

The above table 7 explains that there's a small positive correlation between community empowerment and health service delivery in both districts (r = .144, n=138, p = .092) but community empowerment is not statistically significant predictor of the health service delivery as a result of significance value is greater than 0.005. The remaining 0.856 is attributed to other factors. The findings imply that community empowerment has weakly improved on health service delivery in districts. The results are supported by [27] who argued that community empowerment (CE) in health service delivery failed to have any optimistic impact on mortality, morbidity, health behaviors or health disparities because most of the health programs use 'top-down' CE approaches, as opposed to 'bottom-up' democratic strategies, that limit their effect on health service delivery. In an attempt to test whether community empowerment in both districts have an influence in health service delivery system, the study looked at the right to use to information, inclusion and contribution and therefore the local structure capability to empower indigenous communities in order to participate health service delivery at the local administration level. This is in line with the [44] who explained the empowerment approach as a method of community partaking based upon community power in the areas of getting information, right to use to resources and ultimately management over their own lives instead of being dominated by the authorities primarily the deprived by whom they need been exploited too.

5. Conclusions & Recommendations

5.1. Community Resource Mobilization and Health Service Delivery

It was concluded that community resource mobilization contains a positive influence on health service delivery in districts which implies that if a lot of both districts officers increase the extent of mobilizing their community resource will facilitate the health service delivery system and will increase health service access and coverage. Therefore, from the findings mentioned above, the districts' health service delivery system depends on the extent of how people's resources were mobilized to realize their expectations, needs, and talents prevailing within the locality. Resource mobilization enables community power to influence health provision, through their physical, social, economic, and religious potential. Community resources have not been fully exploited to maximize community participation in health program planning and decision making. Some categories of people such as the poor, elderly, women and people with ill health are more socially excluded than others as also shown previous studies. Community members and their leaders have very limited knowledge of their rights to health. There is a need to improve community sensitization on the rights to health, including their duties to take part into health program planning, choice making, monitoring and implementation in both districts.

In recommendations First, the researcher suggests that districts formulate a transparent by-laws concerning community mobilization in support of the health service delivery system, particularly their role in health and overall community participation. Secondly, community resources are needed to be identified, studied, documented and used in health service delivery. Thirdly, religious scholars ought to be inspired to check the potential economic resources that may be utilized in support of community mobilization, like charity and Waqf to offer health service delivery. Fourth, nongovernmental organizations, pensioners, active community leaders, and friends of health ought to be briefed in concerned health activities of priority areas. Fifth, local government should to develop and encourage totally different kinds of community medical examiners and friends of health in support of health care services and guarantee acceptable coaching and analysis of their contribution. Sixth, Ministries of Health are needed to develop and impart coaching programs for health personnel, particularly executives and managers at the district level to strengthen their capabilities in human activity with communities and developing a partnership with them. Seventh, research publications and approaches for promoting community mobilization that may modification the perceptions of communities and result in their taking bigger responsibility in promoting health are recommended in both districts. The researcher also recommends that the Federal government of Somalia in collaboration with Banadir regional administration also called Mogadishu municipality should develop medium and long term projects to address the health care service in districts by integrating with community members in order to meet equitable service coverage and access especially the poor people and disadvantaged members of the community.

5.2. Community Involvement and Health Service Delivery

As regards the connection between community involvement and health service delivery in both districts, it is ended that there's a tiny low correlation between community involvement & health service delivery which means that limited involvement of community members might be responsible to poor health care services delivery in districts. However, community partnership between community and health service providers and mechanisms available to implement decisions made by community members are to be improved to facilitate members' participation in health service coverage. In recommendations, the decentralization of service delivery provided immense opportunities for communities to participate in health program planning and decision making in their communities and local governments. These opportunities have however not been fully exploited in both districts. Therefore, first, the researcher recommends districts officials to create sensitization programs to increase public awareness of local people so as to promote the community level of inputs during formulating and implementation of health policies. Secondly, in both districts should develop a crucial health care information management system that improves the availability of effectiveness, equity & accessibility of health service delivery. Thirdly, women and youth are need to empowered to efficient and effectively participate in health service delivery initiatives at the local government level. Fourthly, Federal government in partnership with local government and development partners necessity to discover the character and follow of community attachment in health programs.

5.3. Community Empowerment and Health Service Delivery

Based upon the study findings, it was concluded that improving community power will have significant influence on health care service delivery into both districts. The evidence has shown that if districts officials empower their local community, they would automatically play a crucial role in promoting health service delivery system in districts which will also contain a constructive influence on national average standard of health care service coverage. Furthermore, community empowerment served as a great tool in taking action towards the local necessitates of the community because it could address existing problems of the community. The community is empowered to take timely and appropriate decisions for their own well-being and health. By getting awareness and information through the community health workers about various district programs related to health and health facilities, the people in the community are coming out in greater numbers to avail of the health care services. In recommendations, improving health service delivery needs the community to be empowered in order to meet successful partnerships between communities and the districts officials. The both districts need to create social security system that prevents the exploitation of disadvantaged people in order to reduce poverty level at the local communities and promote health care services. Meanwhile, since there's not insurance health system throughout the Somalia, collectively organized insurance health systems are required in order to disburse health expenses that might force them advance into common well-being. Female community health workers are required to be mobilized and empowered to support hygiene and sanitation, early vaccination and health education at the districts level. Outreaching community members to take part in planning based upon democratic approaches in communication that give confidence debate and dialogue lead to accrued information and awareness, and a better level of essential thinking will help joint delivery initiatives of health care services at Howlwadag district. The researcher also recommends holding seminars, workshop and conferences that concentrate on the abstract and sensible problems in building direction adjusted health promotion each in local administrations and country settings. Finally, the development partners are also required to work together with the district officials in order to reach the needy and vulnerable people in the community at the district level to minimize urban poverty level.

6. Areas of Further Research

The research was limited itself towards an urban area by focusing on two small districts which are districts in Mogadishu-Somalia. A replication of this research could be expanded to other sixteen districts in Mogadishu municipality. This study only focused on an urban area in the capital city of Somalia, further research can be done in rural and other urban districts of the country. Moreover, the study was limited the relationship between community participation and health service delivery, further research is required on the overall public sector service delivery capacity in country in terms of education, roads, water and electricity etc. The study also merely covered certain categories of respondents including the administrative staff, small number of community members, civil society, traditional leaders and few number of private health sector in both districts, more research is needed to be covered a larger scope of population involved in the sector by adding the academicians and employees of public and private academic institutions.

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