DECENTRALIZATION AND PRIMARY HEALTH CARE SERVICEDELIVERY IN LOCAL GOVERNMENTS IN UGANDA: A CASE STUDYOF KABALE MUNICIPALITY

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DECLARATION

I, **KISEMBO JULIUS,** do hereby declare that the material presented in this research report titled **"Decentralisation and Primary Health Care Service Delivery in Local Governments in Uganda: A Case Study of Kabale Municipality"** is out my effort and has never been presented to any other institution of higher learning for any academic award.

Signature…… Date……

KISEMBO JULIUS

APPROVAL

This research report titled **"Decentralization and Primary Health Care Service Delivery in Local Governments in Uganda: A Case Study of Kabale Municipality"** has been written under our supervision and it is now ready for submission with our approval.

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DEDICATION

I dedicate this work of the Master's Degree dissertation to my parents, Mr. Phillip Nsekanabo and Ms. Yudita Kyosiimire for laying a solid foundation for my education and shaping my life. I also dedicate it to my wife Ms. Clare Makoha and my son, Alberic Kisembo whose love and efforts have been a source of inspiration and courage.

Lastly, to my siblings, Nickson, Jeniva, Laudel, Christopher, Aron, Oliviah, Caroline, Solomon and Maurence.

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I salute you all.

LIST OF ABBREVIATIONS

LCs:	Local Councils
LGA:	Local Government Act
LGDP:	Local Government Development Programme
MDGs:	Millennium Development Goals
MoH:	Ministry of Health
SDGs:	Sustainable Development Goals
SPSS:	Statistical Package for Social Sciences
UNDP:	United Nations Development Programme

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ABSTRACT

The decentralization policy was introduced in 1993 with the objective of transferring financial and planning powers to local governments so that they could improve service delivery in the five national priority areas. The national priority areas included primary health care, extension of agriculture services, water and sanitation, primary education and feeder roads (Ugandan Local Government Act, 1997). Indeed, decentralization has enabled local governments to carry out their own planning and budgeting with a focus on their local priorities. Local governments have been able to finance some of these priorities using the locally-generated revenue. However, a problem of delivering poor quality primary health care services has remained outstanding. This study was conducted to assess the factors that may have hindered the implementation of financial, political and administrative decentralization and primary health care service delivery in Kabale Municipality so as to establish relevant remedies that have to be applied in improving decentralization and health service delivery in Kabale Municipality and Uganda at large. The study espoused a cross-sectional research design supported by both qualitative and quantitative approaches. A sample size of 112 respondents was used and respondents were selected using simple random and purposive sampling techniques. Data collection methods involved the use of questionnaires and interviews. Data analysis was done using the Statistical Package for Social Sciences Version 20 that helped to generate frequencies, percentages, mean and standard deviation. The study found that some the factors that hampered financial decentralization in Kabale Municipality were lack of enough revenue generation that would have improved provision of primary health care services. More so, it established that local revenue was highly misappropriated and diverted which affected the quality of primary health care service delivery. There was high rate of tax evasion by taxpayers resulting into low revenue to finance the health sector for improved quality primary health care services. Kabale Municipality had high rate of bureaucratic red tape, corruption and fraud by some administrators, delayed implementation of projects and programmes for primary health care services. There was also inadequate human resources in the health sector to deliver quality primary health care services. The study established that strengthening the fight against corruption and embezzlement of funds would impact greatly towards improved delivery of primary health care services. It was established that there was need for the Local Government to recruit adequate primary health care staff to provide

quality health services. The study recommended that the Government should ensure that the budget allocation for drugs is increased to meet the demands of the clients and ensure their satisfaction and that of service providers. Since cases of corruption were found to hinder administrative decentralization and primary health care service delivery, there is need for the government and its anti-corruption agencies to strengthen measures to fight against corruption.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

Decentralization can be described, in general terms, as the 'socio-political process' of 'power-sharing arrangements' between central government and local authorities in planning, management and decision-making. This process is often triggered by a desire to bring politicians and policymakers closer to citizens and also partly to make public services efficient and effective (Muriu, 2012). Decentralization entails the transfer of administrative, financial, and/or political power. The impact of this transfer of power depends on the interaction of three dimensions of decentralization: actors, changes introduced in their powers as a result of decentralization, and the nature of accountability. All three dimensions are critical to understanding decentralization (Akorsu, 2015).

1.1 Background to the Study

1.1.1 Historical Background

World over, decentralization is increasingly becoming one of the key development strategies in the quest to deliver goods and services efficiently and effectively to the citizenry. In the last decades there has been increasing reference to the term "decentralization" as a way of managing the public sector in both the developed and developing countries. All governments in the world, no matter how centralized they are, need at the very least to transfer responsibility for the execution of their centrally decided policies to regional or locally-based branches or organizations (Smoke, 2003). In many countries, the role of local governments has undergone a major shift in the face of new fiscal realities characterized by new severe limitations on financial resources. This situation has led to the downloading of a large number of functions and responsibilities to the local level often unaccompanied by the devolution of fiscal powers and financial resources.

In Africa, many countries have carried out reforms aimed at decentralizing the political, administrative and fiscal structures of the public sector. The need to transform the structure of

governance is informed by the view that decentralization increases the overall efficiency and responsiveness of the public sector in providing services, an outcome that enhances economic development and contributes to a reduction in regional disparities decentralization has advanced considerably in the last two decades (Amusa & Mabugu, 2016). Moreover, many African central governments have initiated or deepened processes to transfer authority, power, responsibilities, and resources to sub-national levels. African countries that have decentralized include Kenya, Botswana, Burkina Faso Ethiopia, Ghana, Mali, Mozambique, Nigeria, South Africa, Tanzania, and Uganda (Dickovick & Riedl, 2017). Despite this, the African evidence on the relationship between devolution and service delivery is very limited. Moreover, much of the available evidence is anecdotal or focused on a specific set of issues, such as participation, empowerment or fiscal autonomy. There is paucity of studies that have examined devolution experiences across the Africa region in a comprehensive and comparative way (Batchelor, Smith, & Fleming, 2014).

Olatona and Olomola (2015) assert that there are three fundamental forms of decentralization. The first form is outlined as deconcentration which refers to shifting of responsibilities to local administrators who are closely supervised by the federal government. It is viewed as the weakest form of decentralization. The second form is delegation which involves transferring of decision-making and administration to semi-autonomous organizations such as public corporations. The third and last form is devolution which is the strongest form and entails transfer of administrative and political powers from central government to lower tiers of government. In devolution, state governments can elect their own leaders, raise their own revenue and make their own investment decisions (Olatona & Olomola, 2015). All in all, regardless the reason of decentralization and the form of decentralization (devolution, delegation or deconcentration), the main aim is to provide efficient and effective local services for human development (Tshukudu, 2014).

In broad terms, decentralization has three fundamental dimensions namely, administrative, political and fiscal. Administrative decentralization implies transfer of civil servants and public functions to the lower level; fiscal decentralization is devolution of fiscal resources and revenue-generating powers; while political decentralization refers to devolution of decision-making powers (Muriu, 2012; Triesman, 2007). As Faust and Barbers (2012) indicate, political decentralization reflects whether sub-national governments are directly elected and thus share in the political functions of governance. Devolution is considered by many theorists and experts as

the best form of political decentralization. In contemporary discourse and practice, political decentralization is often perceived as the only true mode of decentralizing government, bringing with it such benefits as local democracy, participation in local affairs and accountability of local officers.

In general, researchers and scholars across the world have used various constructs to measure decentralization, including financial decentralization, political decentralization and administrative decentralization (Abe & Monisola, 2014; Sow & Razafimahefa, 2015; Tshukudu, 2014). Further, several studies have been carried out on the link between decentralization and service delivery (Kannan, 2013). These studies focus mostly on developed or developing countries of Asia and Latin America. The link between decentralization and public service delivery in the context of Sub-Saharan Africa is scarcely explored. To date, only few studies have evaluated the impact of decentralization on service delivery in the context of Sub-Saharan Africa (Tshukudu, 2014). Additionally, there is imbalance in the attention that has gone into studies on governance decentralization and service delivery. Existing studies tend to measure primary health care service delivery with service accessibility and disregard other dimensions such as quality of primary health care services and citizen satisfaction (Opiyo, 2014; Saavedra, 2010; Sujarwoto, 2012).

Uganda is among the countries in Sub Saharan Africa that are implementing reforms in the Health Sector in the framework of fiscal decentralization. This process started in 1999 when the National Health Policy was launched (Ongodia, 2006). This was done as a way out of the broken health system since the 1970s due to a combination of economic, political and social factors. Before fiscal decentralization was introduced in Uganda by the central government in accordance with Article 176 of the 1995 National Constitution and Sections 78-86 of the Local Governments Act (Cap. 243), Uganda was faced with many problems related to the quality of primary health care services including high infant mortality rates, high maternal mortality rates, poor facilities, inadequate personnel, poor responsiveness and reliability (Ongodia, 2006). The primary health care services were not reliable and responsive and the associated infrastructure was not meeting the standards.

Kabale Municipality started as a township authority and was incorporated by the Royal Charter dated 28th September, 1962. It is a municipal council in accordance with the provisions of section 2 (2) of the Urban Authorities Act. Section 4 o the Act states that every council shall be a body corporate by the name of the municipal council with the addition of the name of the municipality having perpetual succession and power:- a) To sue and be sued in its corporate name; and b) To purchase, acquire, hold manage and dispose of movable and immovable property. And according to section 6 or the said Act, every council shall have a common seal of design approved by such council which shall be kept in custody of the Town Clerk. Section 23 of the Act provides for the appointment of a fit person as a Town Clerk who shall be the Chief Officer of the council and shall have the charge and the custody of and be responsible for all books, deeds, records and other documents of the council. The Town Clerk may, subject to the general directions of the council, exercise the powers of the council and all acts done by him in the exercise of such powers shall be deemed to have been done by the council. Despite the above mentioned powers, the Town Clerk may not perform the duties or exercise the powers of the Treasurer without the consent of the Minister. Under Section 42 of the Urban Authorities Act, the Council has powers to make bye-laws in respect of such matters as are necessary or expedient for the maintenance of health, wellbeing and safety of the inhabitants of the municipality, for the good order and government of the municipality; or for the previous and supervision of nuisances in the municipality. According to Section 29 (1) of the Act, Kabale Municipality Council is vested with the duty of to safeguard public health through the delivery of primary health care services such as immunization, antenatal care, malaria treatment and prevention and family planning.

1.1.2 Theoretical Background

The theories of decentralization are based on the premise that the transfer of responsibility to government units closer to the population has got several advantages including improved delivery and quality of services through greater citizen input, better accountability to the citizenry for public service outcomes (Shah, 2007). Wolman propagated two theories in support of decentralization; efficiency values theory and governance of values theory. Efficiency values theory states that efficiency is an economic value seen as the maximization of social welfare. Tax and service packages should reflect aggregated preferences of community members. Divergence between the preferences of individual community members and the tax and service package

reduces social welfare. Such divergence will be less in smaller jurisdictions (for example sub-counties) and more in heterogeneous areas (the nation). Reduction of this divergence improves customer satisfaction and meets service quality needs (Kee, 2003). The governance of values theory attaches the improvement of service delivery to the governance values. Governance values like responsiveness and accountability, diversity and political participation, foster citizen participation. Decentralization places allocation decision making closer to the people. This fosters greater responsiveness of local officials and greater accountability to citizens thereby improving the quality and volume of service delivery. This is because local decision makers are expected to be more knowledgeable about problems and needs of their local area than centralized decision makers. Further, there is accountability through local elections which are driven by issues of local allocation (Kee, 2003*)*. From the above theories, it is clear that decentralization is built on the assumptions that participation of local decision makers in controlling service delivery improves the service quality. There are four major types of decentralization, namely: Devolution, decongestion, privatization and delegation. Uganda adopted devolution type of decentralization (Banyoya, 2006). In this type of decentralization, powers to plan and raise revenue to finance the approved plans were transferred to the local governments. This study set out to assess the effect of these transferred powers on the provision of primary health care services. These powers include fiscal, administrative and political decision making.

1.1.3 Conceptual Background

Akorsu (2015) contends that financial decentralization is a set of policies designed to increase the revenues or fiscal autonomy of sub-national governments. Fiscal decentralization is the most traceable type of decentralization as it is directly linked to budgetary practices. It necessitates the transfer of powers to raise and retain financial resources to fulfil assigned responsibilities to local level political and administrative organizations. It entails the assignment of functions and responsibilities regarding revenue collections and spending to sub-national government institutions (Yusoff, Sarjoon, Awang, and Efendi, 2016). Rodríguez-Pose and Krøijer (2009) summarized arguments in favour of fiscal decentralization. They claim it promotes high-quality and adequate primary health care service delivery.

Political decentralization refers to the process of giving citizens more power to influence public decision making and the formulation and implementation of policies through elected leaders.

This includes coming up with structures to improve people's participation in local political processes, hence providing a mechanism of checks and balances (Sutiyo, 2014). Political decentralization aims to give more authority to citizens and their elected representatives in decision making and public administration. Political decentralization supports democratization by providing more opportunity for citizens and their elected representatives to affect the creation and implementation of policies (Ozmen, 2016). According to Akorsu (2015), political decentralization is a set of constitutional amendments and electoral reforms designed to open new, or activate existing but dormant or ineffective spaces for the representation of sub-national politics. Obicci (2014) revealed that political decentralization can be used as an instrument to promote the provision of primary health care service delivery. Furthermore, decentralization is shown to have had significant effect on primary health care service delivery in Kabale Municipality. Political decentralization proponents argue that bringing citizens closer to government and allowing them to hold elected officials accountable are an important foundation to achieve better local government and primary health care services (Grindle, 2007).

Administrative decentralization refers to a transfer of power to lower-level central government authorities, or to other local authorities who are upwardly accountable to the central government. This means shifting responsibilities from central government officials in the capital city, to those working in regions, provinces, and districts (Fritzen & Lim, 2016). Administrative decentralization seeks to redistribute authority, and financial responsibility, thereby dampening the employment effect for local residents (Ozmen, 2016).

Akorsu (2015), citing Falleti (2004), argued that administrative decentralization has either a positive or negative impact on the autonomy of sub-national executives. If administrative decentralization improves local and state bureaucracies, fosters training of local officials, or facilitates learning through the practice of delivering new responsibilities, it will likely increase the organizational capacities of sub-national governments in delivering quality primary health care services.

WHO (2015) defines primary health care as essential health care based on practical, scientifically sound and socially acceptable methods, made universally accessible to individuals and families in the community through their full participation at a cost that they can afford.

Zeithaml (1988) defines access to services as being approachable and easy to contact; interpersonal relations such as politeness, respect, consideration and friendliness of contact personnel; effectiveness of care as willingness and ability to perform the promised service dependably and accurately. These concepts are also defined by PAHO (2003): access to services as the removal of geographic, economic, social, organizational or linguistic barriers to care; effectiveness of care as the degree to which the desired health results are achieved; interpersonal relations as effective listening, communication, establishment of trust, respect, responsiveness and confidentiality.

1.1.4 Contextual Background

Before the introduction of decentralization in Uganda, the local governments faced many problems including the low quality of services delivered. In most service delivery sectors of local governments, services were limited by geographical, economic, social and organizational factors (Muwanga, 2016). The services were also ineffective and lacked the existence of trust and respect between the clients and service providers. The local governments had limited powers and resources to make their own plans, execute and monitor them. This meant that there was limited participation, control on the part of the local governments and this compromised quality primary health care service delivery. The decentralization policy was introduced in 1993 with the objective of transferring financial and planning powers to local governments so that they could improve service delivery in the five national priority areas. The national priority areas included primary health care, extension of agriculture services, water and sanitation, primary education and feeder roads (Ugandan Local Government Act, 1997). Indeed, decentralization has enabled local governments to carry out their own planning and budgeting with a focus on their local priorities. Local governments have been able to finance some of these priorities using the locally generated revenue.

Decentralization of health service delivery facilitates decision making and monitoring at districts and lower levels local governments involves community participation. In the process, the District Local Governments (DLGs) become accountable for resources allocated and monitoring the quality of services provided. It is believed that decentralized systems offer opportunities for increased beneficiaries' involvement in the direct decision making process in health service

prioritization, quality, cost and preferences. This is attributed to the fact that DLGs are more acquainted to the beneficiaries' requirements, responsive to new developments and is in contact with communities.

Administratively, this proved attractive to the central government because part of the burden of financing health services could be shifted to sub-national units and private providers. The medium-term policies to improve health service delivery are clearly documented in Uganda's Poverty Reduction Strategic Plan (PRSP, 1997) in which the DLG system has been mandated with the implementation of the national health policy. The National Health Sector Strategic Plan (HSSP) is the major policy framework which documents all the strategies for the provision of public health services within a decentralized system in Uganda. This is in line with the observation in the Poverty Eradication Action Plan (International Monetary Fund, 2003) which states in part that, "ill-health affects productivity and economic activities". Thus, to achieve and maintain sustainable development, Uganda identified health and economic growth as mutually reinforcing.

This means the efficient provision of health services through the decentralized system was identified as an essential prerequisite for sustained development because without good health, the entire productive population (namely: individuals, families, communities and the nation) cannot effectively achieve identified social and economic goals. It is therefore clear that the health sector plays a critical role in poverty eradication and promotion of development. To facilitate health service decentralization initiatives, there has been increased annual budgetary allocation for the provision of Primary Health Care services at the district local government and municipality levels. Whereas the policy has given the district local governments and lower-level local governments central roles in the management of health service delivery, the performance of the decentralized system has run short of expectations in some DLGs, which has widened regional disparities in equity to access quality health services. The poor performance has largely been attributed to local government capacity constraints (GOU, Ministry of Health, 2015).

The Republic of Uganda (2018), for example, notes that although there was an improvement in the national performance in the Health Sector Strategic Plan (HSSP) indicators, there were marked variations in performance between DLGs which have largely been attributed to inadequacy of management capacity in some districts. Obwona (2016) indeed pointed out that

“financial and institutional constraints have adversely affected the ability of the sub-national governments to adequately deliver services of sufficient quality.” The constraints identified include weaknesses in the institutional arrangements for monitoring health service delivery, local capacity to manage social service delivery and poor framework for accountability. This has led to instances where the intended beneficiaries do not get access to the services or, if they do, they are inefficient and of low quality. The central government’s capacity to monitor such services is often undermined by human resource and financial constraints. This study therefore looked at how finance and human resources hindered decentralization and primary health care service delivery in Kabale Municipality.

The demarcation and extension of the boundaries of Kabale Municipality has been carried out several times since its inception as a township authority in 1930. The first and perhaps more precise demarcation was considered and approved by the authority in 1932. The municipal council started as a township authority established under the then township ordinance. The executive powers of the township authorities’ administration were vested in the township authority under the directions of the then protectorate governor who appointed the district commissioner, the district medical officer and the district engineer.

The township authority functioned until it was declared a town board in 1958. The board in addition to its other duties had to ensure that this area grows and develops to the wellbeing and benefit of the residents. The town board continued to function until 1962 when it was elevated to the status of a town council. The council had ten councillors including the chairman with some ex-officio members. In 1985, Kabale town council was elevated to municipal status. Itcurrently comprises three divisions (Northern, Southern and Central Division).

Kabale Municipality has six health centres which are Rutoma Health Centre II, Kabale Municipality Yard Health Centre II, Kabale Barracks Health Centre II, Kamukira Health Centre IV, Ndorwa Prison Health Centre III and Mwanjari Health Centre II. The quality of primary health care service delivery in these health centres was still ineffective despite the financial release by the government injected in them (Kabale Municipality Annual health Status Report, 2018/2019).

Health centres in Kabale Municipality are expected to deliver antenatal care at least four times to increase the likelihood of receiving effective maternal health interventions during antenatal visits, ensure that all women have access to skilled care during pregnancy and childbirth to ensure prevention, detection and management of complications being assisted by properly trained health personnel with adequate equipment in order to lower maternal deaths. Provision of supplementation with vitamin A is considered to be a critically important intervention for child survival owing to the strong evidence that exists for its impact on reducing child mortality (WHO, 2010). However, primary health care service delivery in Uganda, and Kabale Municipality in particular, is often marred by cases in which expenditure does not reflect the quality and outcomes of the health services delivered. This has in part been attributed to weak institutional processes and governance among some DLGs. Poor delivery of services implies that most of the intended beneficiaries do not have access to the service or if they do the quality is not commensurate to the resources invested (Mirmirani & Ilacqua, 2014). It is not uncommon to visit a health facility with no doctor at the duty station to serve clients when the personnel are available; there are no drugs, equipment or even electricity. Although communities are involved in health management and health planning systems to improve primary health care, primary health care services are still poor (Muwanga, 2016). It is against this background that this study was conducted to examine the factors that have hindered decentralization and primary health service delivery in Kabale Municipality.

1.2 Statement of the Problem

Decentralization has enabled local governments to carry out their own budgeting with a focus on their local priorities. The local governments have been able to finance some of these priorities using the locally-generated revenue. However, a problem of delivering poor quality primary health care services remained outstanding. The primary health care services were not easily accessed; the expected heath outputs were not being obtained; and the service lacked trust and respect between the service providers and clients (Muwanga, 2016). A survey conducted in Kabale Municipality by Mbonye, Mohamud & Bagonza (2016) on perceptions and practices for preventing malaria in pregnancy in Kabale peri-urban setting in south-western Uganda found that few women (19%) attended the recommend four antenatal care visits; less than a half (48.8%) accessed two doses of sulfadoxine-pyrimethamine (SP) for malaria prevention in pregnancy

while 16.3 % received at least three doses of SP, as recommended by the current policy. Additionally, the number of pregnant mothers who seek primary health care services in form of antenatal and postnatal care at Kamukira Health Centre dropped from twenty in 2019 to ten in 2020 in a period of one week (Kamukira Health Records Department, 2020). The main reasons for poor antenatal care attendance were: women feel healthy and do not see a need to go for antenatal care; long distances; and long waiting hours at clinics. The reasons given for not taking sulfadoxine-pyrimethamine (SP) for malaria prevention were: women not feeling sick; and they were not aware of the benefits of sulfadoxine-pyrimethamine (SP) in pregnancy. The poor customer care and long waiting hours by patients in government health centres in Kabale Municipality make service seekers prefer seeking primary health care services like antenatal, postnatal, immunization and vaccination from private hospitals and health facilities like Rugarama Hospital and Rushoroza Hospital and other private clinics which are even expensive. The question that therefore arises is: What are issues at play in affecting decentralization and primary health care service delivery in Kabale Municipality?

1.3 Objectives of the Study

1.3.1 General Objective

To examine the influence of decentralization on primary health care service delivery in Kabale Municipality, Kabale District.

1.3.2 Specific Objectives

i. To find out the factors that may have hindered the implementation of financial decentralization towards better primary health care service delivery in Kabale Municipality;
ii. To identify the factors that may have hindered political decentralization towards better primary health care service delivery in Kabale Municipality;
iii. To investigate the factors that may have hindered administrative decentralization towards better primary health care service delivery in Kabale Municipality;
iv. To identify relevant remedies that have to be applied in improving decentralization towards better health service delivery in Kabale Municipality.

1.4 Research Questions

i. What are the factors that may have hindered the implementation of financial decentralization towards better primary health care service delivery in Kabale Municipality?
ii. What are the factors that may have hindered political decentralization towards better primary health care service delivery in Kabale Municipality?
iii. What are the factors that may have hindered administrative decentralization towards better primary health care service delivery in Kabale Municipality?
iv. What are the relevant remedies that have to be applied in improving decentralization towards better health service delivery in Kabale Municipality?

1.5 Scope of the Study

1.5.1 Content Scope

This study was about decentralization and primary health care service delivery in local governments in Uganda. It explored challenges that affected financial, political, administrative decentralization and primary health care service delivery and the remedies that can improve decentralization and health service delivery.

1.5.2 Geographical Scope

This study was conducted in Kabale Municipality due to its proximity to the researcher and state of primary health care service delivery which was still poor despite the introduction of decentralization policy. This was chosen because there were complaints of ineffective primary health care service delivery by service seekers. The whole settlement of Kabale Municipal Council is contained between parallel series of steep hills on either side of the Mugogo-Rwabakazi valley and is terminated at each end by the Kiruruma and Kisumbi swamps.

The municipality is bisected by the river Mugogo and small tributary streams in valleys. It is 408 kilometres from Kampala city and 22km from Uganda-Rwanda border crossing atKatuna and has a total surface area of 47sq km. Kabale municipality shares a border with Kitumba Sub County in the south and west, Bubaare to the north and Kyanamira to the East.

1.5.3 Time Scope

This study considered a period of six years from 2014 to 2019 because it is within this period that there was poor delivery of primary health care services in Kabale Municipality. This period enabled the researcher understand the factors that hindered financial, political and administrative decentralization towards better primary health care service delivery in the study area.

1.6 Significance of the Study

The study findings will help in setting grounds for policy makers like local councils, government, international bodies and other primary health care service providers to see the necessity of initiating projects and policy/laws, by-laws and ordinances aimed at improving primary health care service delivery in the country. More still, the findings from this study will assist policymakers in formulating effective strategies and policies that will enhance healthcare delivery at the county and national level under the devolved systems.

The study provides more information on areas for further research since devolution is a new concept in Uganda and despite other countries having devolved health systems; every country has its own unique challenges and opportunities. Both the sub county governments and national government can make use of the findings to come up with policies and strategic interventions to enhance primary health care service delivery to citizens.

The study will be very significant to the government of Uganda as a whole to see how best it has performed in the implementation of decentralized health service delivery. The study will also help local government authorities and other authorities on how best to address the challenges being faced in primary health care service delivery under a decentralized setting.

It will enlighten the local people to demand for health services since they will have been made aware of the idea behind the policy.

It will be important to academicians or scholars who would wish to carry out further research on fiscal decentralization to identify areas that need further study and exploration.

The study will help local authorities to comprehend the effects of decentralization towards better primary health care service delivery. It will help the lower local governments to strengthen their

financial bases as this study would highlight some identified problems hampering the effective utilization of revenue in the councils.

1.7 Definition of Operational Key Terms

Decentralization: Decentralization presupposes a process or a system of administration in which political, financial and decision-making powers are transferred from the centre to the lower administrative units (local governments).

Financial decentralization: This entails the transfer of financial resources in the form of grants and tax-raising powers to the sub-national units or local governments.

Political decentralization: This refers to the situation where powers and responsibilities are devolved to elected local governments

Administrative decentralization: This indicates the degree to which policy responsibilities are in the hands of sub-national governments.

Community participation: This is a process which provides private individuals an opportunity to influence public decisions and has long been a component of the democratic decision-making process.

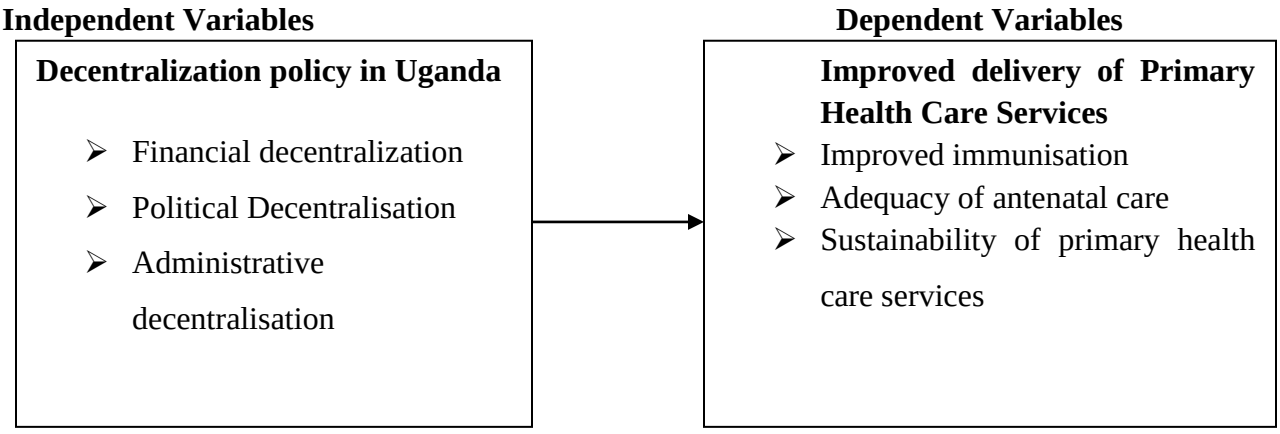
Primary Health Care: Refers to maternal and child health, family planning, BCG and DPT immunization.

Health service delivery: The prevention and management of disease, illness, injury, and other physical and mental impairments in individuals delivered by health care professionals through the health care system and can either be routine health services, or emergency health services.

1.8 Conceptual Framework

The conceptual framework is hinged on the idea of Amin (2005) which advises that a conceptual framework is relevant to adequately present the relationship between the independent and dependent variables in a study.

Figure 1.1: Summary of the Conceptual Framework



Source: Kosec & Mogues (2015) and modified by the researcher 2020

According to the above figure, decentralization with financial, political and administrative dimensions enhances effective primary health care service delivery. More still, decentralization ensures proper allocation of resources so that there is improved immunization and adequacy of antenatal care.

Financial decentralization promotes higher efficiency for better primary health care service and also increases economic efficiency because local governments are better positioned than the national government to deliver public services as a result of proximity and informational advantage. Financial decentralization is an important tool in revenue performance and therefore instrumental in providing services closer to people in large and densely populated economies (Clegg & Greg, 2010).

Effective local political institutions, better informed citizen and transparency, citizen political participation via community programmes, and the presence of social group in community are significant for improving primary healthcare service performance. Obicci (2014) states that political decentralization can be used as an instrument to promote the provision of service delivery. Furthermore, decentralization is shown to have had significant effect on primary health service delivery.

Administrative decentralization redistributes authority, responsibility and financial accountability in order to ensure timely provision of primary health care services. Stanton (2009) asserts administrative decentralization is concerned with the functional tasks of decentralization. It

relates to the assignment of service delivery powers and functions across levels of government and determining where responsibility is situated.

This study considered improved primary health care service delivery in Kabale Municipality as a dependent variable (DV). The primary health care service delivery has dimensions which include improved immunization and adequacy of antenatal care and sustainability of primary health care services. The study assessed the effect of independent variable on the dependent variable.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews literature on decentralization and primary health service delivery in local governments. The literature review was on the factors that may have hindered the implementation of financial decentralization towards better primary health care service delivery; factors that may have hindered political decentralization towards better primary health care service delivery; factors that may have hindered administrative decentralization towards better primary health care service delivery; and relevant remedies that have to be applied in improving decentralization towards better health service delivery. Various sources of literature were reviewed; such as scholarly journals, textbooks, government publications, reports, previous studies, statutory instruments and council minutes were used to provide information for this chapter.

2.1 Financial Decentralization and Primary Health Care Service Delivery in Local Governments

Adam (2015) carried out a study in Europe and America to empirically examine the relationship between fiscal decentralization and public sector efficiency. The study found that irrespective of whether public sector efficiency concerns education or health services, an inverted U-shaped relationship exists between government efficiency in providing these services and fiscal decentralization. In contrast, Elhiraika (2017) used data from nine provinces in South Africa to investigate the impact of fiscal decentralization on basic service delivery, focusing on the role of own-source revenue. The own-source revenue variable was found to have a negative and significant impact on demand for health relative to demand for other public services. The researchers argued for increased fiscal decentralization and greater revenue autonomy in particular if sub-national governments in South Africa are to improve service delivery by enhancing transparency and shifting accountability to the local population rather than the central government. The study by Adam (2015) focused on the relationship between fiscal decentralization and public efficiency in Europe and America and did not look at the hindrance of financial decentralization and primary health care services. More still, it was conducted in

developed world where the situation is different from the situation in Uganda. This explained the need for this investigation by the researcher.

Wei-qing and Shi (2016) undertook an empirical study in China and revealed that fiscal decentralization on expenditure tended to encourage governments to allocate fiscal expenditure in infrastructure, to attract outside capital to develop local economy, but at the same time, reduced provision of public services, such as education. The study also found negative effect of fiscal decentralization on public education provision was highest in Central and West China, and lowest in Northeast China. Similarly, Busemeyer (2018) used a pooled-data of 21 OECD countries analysis, and found that fiscal decentralization decreases public education expenditures at national level but increases public education spending at regional level. The study focused on fiscal decentralization and expenditure on education in China yet our studywais on the effect of decentralization on primary health care in Kabale Municipality, Uganda. Therefore, this gap was filled through conducting a study on the factors hindering financial decentralization and primary health care service delivery in Kabale Municipality, Uganda.

In a related study in Europe, Sow and Razafimahefa (2015) concluded that fiscal decentralization improved the efficiency of public service delivery but only under specific conditions of adequate political and institutional environments and sufficient degree of decentralized expenditures and revenues. The researchers also noted that in the absence of those conditions, fiscal decentralization can worsen the efficiency of primary health care service delivery. This study was conducted to establish the factors that have hindered financial decentralization in Kabale Municipality, Kabale District.

Ghuman and Singh (2016) analysed the impact of decentralization on public service delivery. The study found that the impact of decentralization on public service delivery is contingent on factors such as the design of the decentralization policy; implementation bottlenecks and diluting the model of decentralization for accommodating the dissenting segments of stakeholders including employees; and participatory governance. In particular, the study revealed that decentralization had resulted in improvements in delivery of local services where devolution as a mode of decentralization was accompanied by sound financial resource base of local governments, full autonomy to local governments in human resource management matters,

regular capacity building of local officials, performance-based incentive structures, and participatory governance. However, the study did not look at how capacity building and participation in governance affected primary health care service delivery in Kabale Municipality.

In Russia, Freinkman and Plekhanov (2015) analysed the relationship between fiscal decentralization and the quality of public services in the Russian regions. The study found that fiscal decentralization had no significant effect on the key inputs into secondary education, such as schools, computers, or availability of pre-schooling, but had a significant positive effect on average examination results, controlling for key observable inputs and regional government spending on education. The study also concluded decentralization had a positive impact on the quality of municipal utilities provision. In another study, Oriakhi (2016) examined fiscal decentralization and efficient service delivery in Nigeria. The researcher posited that service delivery by sub-national governments had been poor and attributed it to constraints such as: the mismatch between expenditure assignments and sources of revenue; lopsided vertical allocation formula which favoured the federal government; rent seeking; and ineffective monitoring of public expenditures, among others. The above authors did not talk about how poor community participation in planning and budgeting hinder financial decentralization and primary health care service delivery. This was the essence of our study.

Uchimura and Jütting (2017) analysed the effect of fiscal decentralization on health outcomes in China using panel data set with nationwide county-level data. They found that counties in more fiscally decentralized provinces had lower infant mortality rates than counties where the provincial government remained the main spending authority, if certain conditions were met. The findings supported the common assertion that fiscal decentralization can lead to more efficient production of local public goods, while also highlighting the conditions required for this result to be obtained. More recently, Olatona and Olomola (2015) analysed the influence of fiscal decentralization on health and educational service delivery between 1999 and 2012. The study found that fiscal decentralization had positive link with educational service delivery while a high degree of fiscal decentralization was negatively related to health care delivery. The study by Uchimura and Jütting (2017) was done in China and not in Uganda; therefore, the researcher carried out a study on factors hindering financial decentralization and primary health care service delivery in Kabale Municipality.

In the same context, Ibok (2014) carried a study on local governance and service delivery and stated that lack of funds occasioned by low budgetary allocation, restricted revenue sources available to local government and inability to effectively utilize its internal sources of revenue generation had impacted negatively on the provision of public goods at local level. For Kenya, Simiyu et al. (2014), using a descriptive survey design and a sample of 98 respondents carried out a case study in Kimilili to examine effects of devolved funding on socio- economic welfare services. The study measured socio- economic welfare services by literacy level, access to health facilities, security level, employment level, income levels, water and sanitation and food security. The researchers revealed that the constituency development fund plays an important role in social economic aspects of the lives of the locals and called on policy makers to improve on management of the devolved funds.

Financial resources have been blamed for low level of accessibility to health centres in Uganda. A study by United Nations Development Programme (UNDP) (2018), for example, indicates that the budget for provision of health sector in the country is still low and yet a lot is needed. This means that the government support for health sector is still minimal. Most of the drugs and other medical facilities in public health centres are funded by donor organizations and yet in the health sectors, supplies of medicines are less than half of required amounts. This therefore affects the accessibility of health services to many patients in the country. This factor is of major importance because all activities performed by local governments (LGs) require adequate financial resources.

Additionally, local revenues have been declining and the amount of locally raised revenue as a percentage of total local government funding has fallen each financial year. In some local governments, local revenue accounts for only 3% of the total budget (MoLG, 2016). A critical analysis of local government budgets reveals their dependence on central government, which makes the districts agents of the central government rather than independent local governments as envisaged under Article 176 of the Uganda Constitution, suggesting that Uganda is promoting deconcetration rather than decentralization.

On average, about 80% of the central transfers are conditional − i.e., earmarked by the centre for the provision of specific services, leaving local governments little power to determine local

priorities. The remaining 20% of transfers are composed of unconditional and equalization grants (Entisham, 2017). In practice the unconditional transfers are mostly used to cover administrative costs, including council salaries and allowances, rather than for service delivery. To worsen the situation, conditional and unconditional grants from the central government have continued to decline. For example, in 2011/2012 the unconditional grant for all local governments decreased from USh 156,944 billion (US$63m) to USh 151,155 billion (US$60.5m) (National Budget 2015/2016). Declining revenues and the failure to use unconditional transfers on service provision have weakened the accountability of local authorities to service beneficiaries, and threaten the autonomous functioning of local governments.

Furthermore, Onyach-Olaa (2012) asserts that the central government transfers to LGs are largely earmarked for the services for which they are given. Only a slight degree of flexibility is permissible with restrictions. The unconditional grant from the central government which is the only grant that LGs may use as part of their revenue is mainly used to pay staff salaries. In many districts, the amount from this grant is not adequate to cover the wage bill. LGs have to therefore obtain the rest from their local revenue so as to fund payment of workers' salaries. The conditional grant which is by far the largest source of revenue to LGs finances projects and programmes agreed upon between the central and local government such as primary education, and primary healthcare, including the Local Government Development Programme (LGDP) through which grants are available to lower councils for specific projects identified in development plans. The equalization grant is paid as a special provision based on the extent to which least developed districts lag behind the national average standard for a particular service. These funds are not adequate enough to finance most of the health projects and programmes in the district meant to provide effective health services to citizens. This weakens the implementation of decentralized health care, thus affecting health service delivery.

Uganda's decentralization system empowers local governments to access revenues for effective financing of devolved responsibilities. The local governments execute their functions using resources transferred from the centre, mobilized locally, and directly received from donors. Resource transfer from the centre to local governments takes the form of conditional, unconditional or equalization grants. The Conditional grant (about 80% of transfers from the centre) largely comprises the Poverty Action Fund (PAF), which is to be spent on centrally

determined priorities. Channelling the local development grant through the PAF and the protection of the PAF from any emergency budget cuts has enabled resources to reach local levels without much central bureaucratic hurdles. To fulfil their obligation to finance up to 10% of its budget, local governments exercise their powers to raise revenue locally from the cities, municipalities, town councils and rural areas. In rural areas, local government revenue is collected by sub-county officials, who retain 65% of the revenues and remit the rest to local government headquarters (MoLG, 2018). However, increased political freedom and power at the local level have also affected the revenue base of local governments. For example, tax assessments are reported to have come under undue influence of political leaders who have in some instances placed political supporters in lower graduated tax brackets (Peterson, 2000). In response to inefficiency and corruption in tax administration, local governments have opted to privatize the collection of certain categories of revenue. However, survey evidence shows that the procedure of awarding tax collection contracts is ridden with the very shortcomings that privatization was intended to circumvent, leading to poor local revenue performance (Bahiigwa, 2016). The suspension of graduated tax based on political rather than economic determination of its burden to the citizens has further deteriorated decentralized health service delivery.

The constraints on the workings of local government authorities is evident in that (a) Whereas provincial revenue assignment accounts for about 22% of total expenditure needs of the province, (b) On the average own revenues of local authorities account for less than 60% of total expenditure, varying according to the tax base of the Local Authority. (In respect of small Pradesheeya Sabhas, own revenue may account for as little as 30% of expenditure.) Though decentralization is an institutional arrangement on the part of the government to become responsive to citizen needs and preferences, there are several aspects and ensuing substance of sub-national government such as Small Size, Limited Autonomy, Fragmented Responsibilities, Imbalances in Devolved Expenditure and Revenue, weak Public Expenditure and Management, Inadequate Capacity and Lack of Fiscal Transparency that require change and/or improvements to make use of opportunities that decentralization provides (Ouedraogo, 2017).

More still, there has been growth in the number and diversity of transfer mechanisms from central government and donors and this has been a matter of growing concern in both central and local governments. Many of these mechanisms are not well adapted to the decentralized

framework, with local governments given little real power over the allocation resources, and little involvement of lower-level local governments in the decision-making. Problems with management and financial accountability have arisen from the profusion of different transfer systems and bank accounts. Line ministries are faced with major problems in dealing with quarterly reporting from a growing number of conditional grants and a growing number of districts. In addition, there is concern about the different design and type of conditionalities under the Ministry of Local Government's (MoLG) Local Government Development Programme (LGDP) and the PAF conditional grant regulations, and the bureaucratic load of multiple procedures, bank accounts and lines of reporting. It is against this background that the GoU commissioned the Fiscal Decentralization Study to examine how to streamline and harmonise the present systems and processes of transferring resources to local governments (MFPED, 2016).

Stephen and Rebecca (2016) state that local governments face a challenge of the inability to collect fully the revenue due to them. The huge gaps between reported and projected revenues in local governments is an indication of inability to collect and this is due to: weak administrative capacity to assess taxes and levies and then to enforce revenue laws and bylaws, taxpayers' resistance and low tax morale on the part of citizenry, corruption, including embezzlement of revenue by revenue collectors, external pressure on the local finance department to provide optimistic projections and political pressure on the revenue collectors to relax on revenue collection (Stephen and Rebecca, 2016). Both central government and LGAs are generally expected to provide public service, but it is common to find that the own source revenue raising powers of the latter are not sufficient to meet the costs of providing the services they have been assigned. The resulting gap can be filled by vertical equalization i.e., transfer resources from the central government or by increasing revenue raising powers of LGAs. But increasing local own-source revenue is, more often than not, quite challenging. For example, allowing LGAs to have substantial revenue raising powers reduces central control over the total size of the public sector and raises concerns about macroeconomic stabilization. In addition, appropriate local revenue bases are commonly weak or too administratively complex for LGAs to handle (Stephen and Rebecca, 2016).

2.2Political Decentralization and Primary Health Care Service Delivery in Local Governments

In Indonesia, Sujarwoto (2016) surveyed 8,320 households living in 120 local governments to investigate the association between political decentralization and local public service performance. The study revealed that effective local political institutions, better informed citizen and transparency, citizen political participation via community programmes and the presence of social group in community are significant for improving local public service performance. Enikolopov and Zhuravskaya (2017) conducted an empirical study using both cross-section and panel data from developing and transition countries and found that strong national parties (a form of political centralization) combined with fiscal decentralization significantly improve government quality measured both in terms of government efficiency, regulatory quality, control of corruption and rule of law and in terms of public good provision (health and education outcomes). Enikolopov and Zhuravskaya (2017) used a cross-sectional design in their study but our study espoused a case study design to establish whether the situation would be similar or different. Sujarwoto (2016) also conducted his study from Indonesia where there was a difference in political decentralization and primary health service delivery. This propelled the researcher to carry out this study.

In Spain, Kyriacou and Roca-Sagale (2017), using a sample of 101 countries found a negative impact of political decentralization on the relationship between fiscal decentralization and government quality (control of corruption, rule of law, regulatory quality, and government effectiveness).The researchers concluded that political decentralization, in the form of sub-national elections, bicameralism, and especially federalism and autonomy, tends to mitigate the positive impact of fiscal decentralization on the quality of government. They observed the findings could be as result of the existence of a regionally elected upper house with the power to block the lower house's financial legislation which may be preventing improvements in government performance.

In the context of South Africa, Bogopane (2014) carried out a study on political decentralization and service delivery based on North West provincial government that consists of twelve provincial departments and the legislature. The study revealed the lack of a well-established public bureaucracy that bluntly implements government policies and was also involved in putting

politicians in check against any form of abuse of political power. The study also found lack of political structures which led to errors of judgment which in turn resulted with poor governance and service delivery. In addition, Lambright (2014) found that partisan politics undermines service delivery in Kampala in several ways, including financing, tax policy, and even direct interference in the policies and decisions made by the city council.

Nir and Kafle (2015) evaluated the implications of political stability on educational quality using a sample comprising 47 countries, 26 politically stable and 21 politically unstable during a ten-year period of time (1998-2008).The study revealed that political stability plays a major role in explaining the survival rate in education when used as a single predictor or, when introduced in the analysis with the GDP per capita. In Europe, Diaz-Serrano and Rodriguez-Pose (2014) carried out a study based on analysis of views of 160,000 individuals in 31 European countries and found that political decentralization affects citizens' satisfaction with education and health delivery in different ways. The influence of political decentralization, however, is highly contingent on whether the capacity of the local or regional government to exercise authority over its citizens (self-rule) or to influence policy at the national level (shared-rule). Similarly, Kumar and Prakash (2016) carried out a study in India to investigate the impact of political decentralization and gender quota in local governance on different measures of health outcomes and behaviours. The study found that political decentralization is positively associated with higher probabilities of institutional births, safe delivery, and births in public health facilities. The above authors focused on education and gender and their studies were done in other countries not Uganda. Therefore, the factors hindering political decentralization and primary health care services were not tackled in their studies. Thus, this study was conducted in Kabale Municipality, Uganda to fill the knowledge gap in the literature.

The quality of councillors is affected by their level of education (Natamba etal., 2010). At the moment, there is no minimum education requirement for anyone to hold office as a district councillor, and academic qualifications are not part of the eligibility requirements for the office. There is widespread consensus that councillors with very low levels of education fail to express themselves during plenary sessions, while some cannot make written contributions (Natamba, etal., 2010). Such low levels of education undermine effective debates among councillors with

their educated technical staff and some local politicians have an inferiority complex which has sometimes led to conflicts with technical staff.

In spite of Uganda's initial success in decentralization, widely heralded by the international community, corruption remains widespread at all levels of society and the country faces major challenges (Transparency International, 2015). The survey report of the Inspectorate of Government (2009) noted that corruption in the form of bribery, financial leakages, conflict of interest, embezzlement, false accounting, fraud, influence peddling, and nepotism, theft of public funds or theft of public assets remains nt impediment to development and a barrier to poverty reduction in Uganda at national and local government levels. Public confidence in government officials (politicians and technocrats) is severely undermined by regular corruption scandals.

The majority of citizens surveyed in 2005 by a regional research firm, Afro Barometer, perceived corruption to be rampant. In addition, 36% of respondents to the survey believed that most or all government officials, at central or local level, were involved in corruption. In fact, it is sometimes believed that decentralization in Uganda has led to a dispersion of corruption, 'redefining the character of corruption relationships from those controlled by the centre to those controlled by district level officials' (Steiner, 2010). For example, during the financial year 2009/10, the Office of the Auditor General (2011) conducted a Value for Money Audit on seven districts of Apac, Arua, Bundibugyo, Bushenyi, Kamuli, Moroto and Mukono focusing on procurement of goods and services during 2007/08, 2008/09 and 2009/10, which revealed numerous corruption problems.

Smith (2015) asserts that community participation as reflected under the decentralization programme has been rendered worthless by poverty. He argues that it is not necessarily true to say that local citizens have superior ability – or even any ability at all – for identifying both local needs and the optimal amount of resources and services needed to meet them. He maintains that where there is resource scarcity (as it is in many local governments including Kabale Municipality), local elites or single ethnic or other interest groups have disproportionate power to influence allocation of resources. In addition, Regan (2014) notes that bureaucracy has greatly affected popular participation in Uganda; as a result, there is a problem of creating a balance between, on the one hand, facilitating popular participation and imposing necessary political control over bureaucrats, and respecting their autonomy in carrying out the tasks they are

appointed to do, on the other hand. Basing on experience in many countries, he argues that neither central nor local governments can exert much control over the bureaucracy. Thus, the popular participation dilemma in the planning process of local governments is worsened by Uganda's history of corruption, absenteeism and all–round non-performance in the Civil Service of which Kabale Municipality is not an exception.

Sharpe (2016) argues that limited local democracy and participation makes planning more sensitive to local interests and less dependent on officers in Local Governments but he asserts that there is no evidence to show that the masses really participate. Furthermore, Sharpe (2016) contends that participation in planning as in other parts of the decentralization system in Local Governments was a search for legitimacy rather than means of power sharing or democratic public involvement. He maintains that in as far as participation generates benefits, it is only those with expertise or the resources to command it that are advantaged.

Furthermore, Nathan (2018) identifies three main problems that lead to citizens or voters losing trust in government, especially at the local government level in Africa. Firstly, the government, especially at municipal level, is becoming fundamentally undemocratic and lacks accountability to the citizens through public participation channels. Secondly, the political system and government is hierarchically set up, with those at the top unaccountable to those at the bottom. This opens the opportunity for corruption and mismanagement by those elected or appointed to positions of power. Thirdly, the state has a biased system, serving the long-term interest of the ruling class. This is expressed through neoliberal forms of privatization in the provision of services. All of the above concerns give ordinary citizens reason to use public protest actions as the principle mechanism for expressing their anger, frustration and dissatisfaction about how resources are spent to deliver basic services.

Klaver (2016) asserts that the increased number of local governments has put immense pressure on health service delivery and the capacity to manage new administrations This has resulted in a decline in the number of local government authorities meeting performance-assessment criteria (minimum conditions) from 80% in 2006 to 34% in 2008 (MoLG, 2009). The creation of new local governments is seen by the central government as being in tune with the original objectives of decentralization, but unfortunately service delivery in both new and old districts has declined

due to lack of financial and human capacity, as resourcing has not been increased. As observed by Okidi and Guloba (2006), by creating so many political districts, Uganda runs the risk of excessive decentralization, which could contribute to lowering local-level economic growth.

2.3 Administrative Decentralization and Primary Health Care Service Delivery in Local Governments

Kosec and Mogues (2015) analysed the impact that administrative district-level decentralization on agricultural and rural service delivery. The study used sample data from eight districts in seven regions in Ethiopia, 1,899 individuals and 1,117 households. The study found that administrative decentralization has led to increased access to agricultural extension services, and to greater use of modern agricultural inputs, such as fertilizer and improved seed. In another study in United States, Saavedra (2016) examined the effects of administrative decentralization on access to two key services: health care and improved drinking water sources. The study provided evidence supporting positive and significant effects of administrative decentralization on access to health care, and improved water provision. In another study, Mobarak, Rajkumar, and Cropper (2016), using data from Brazilian municipalities, found that administrative decentralization only provides good results when it is accompanied by good governance. The study by Kosec and Mogues (2015) focused on administrative district-level decentralization on agricultural and rural service delivery and Saavedra (2016) studied the effects of administrative decentralization on access to two key services: health care and improved drinking water sources. Yet our study looked at the factors that have hindered administrative decentralization and primary health care service delivery.

A study in South Africa by Stanton (2017) explored to what extent the problems of providing basic services currently experienced by municipalities were influenced by the administrative configuration of the decentralized system of governance. The study concluded that local councils had the authority to pass by-laws with respect to the implementation of their legally assigned functions and responsibilities. However, municipalities had limited autonomy and need provincial approval when contracting out responsibilities and services. In a related study, Bogopane (2015) explored the impact of perceived erosion of the politics-administration dichotomy on good governance and service delivery. The study concluded that strong visionary political and administrative leadership; vibrant apolitical strong public bureaucracy and

integrated political and administrative structures led to improvement to the functionality and performance of politics-administration dichotomy relations. The above authors' studies were done in South Africa and did not specify which basic services. Our study therefore addressed this by focusing on the factors affecting administrative decentralization towards better primary health care services in Kabale Municipality.

In Ghana, Alornyeku (2016) carried out a case study in Kumasi metropolis on administrative structure and service delivery. The study revealed that even though there was a clear practice of division of labour, there was a departmental lack of technical equipment which resulted in delays in meeting the expectation of citizens, assembly low productivity and excessive bureaucracy negatively impacted on performance of the central government as regards service delivery. In another study in Nigeria, Boris (2015) carried out an empirical study to examine challenges confronting local government administration in effective and efficient social service delivery at the grassroots using secondary data. The study concluded that lack of funds, corruption and undue political interference, amongst others, as major constraints to primary health care service delivery. Although the Alornyeku (2016) and Boris (2015) studies were conducted in relation to the factors that had hindered administrative decentralization and primary health care service delivery, they were done in Ghana and Nigeria where the situation may be different from Uganda's case. This necessitated the carrying out of this study.

There is general agreement that the problem of inadequate capacity of human resource in Uganda's local government continues to exist. The problems highlighted by De Muro, Salvatici and Conforti (2015) as affecting many sub-Saharan African countries also exist in Uganda. These problems include shortages of qualified and experienced staff to deliver services especially in the health sector and a lack of training opportunities to develop professional and technical expertise. The problems noted by the study as constraining staff recruitment and retention in the LG include, among others, low pay and salary payment delays which in turn lead to low staff morale in delivering health care services. In Uganda, the staffing problem is exacerbated by a shortage of equipment and materials.

Narasimban (2016) points out that personnel for health in much of the developing world, particularly in sub-Saharan Africa, are inadequate and poorly distributed; there is a mismatch

between supply and demand; high mobility across local, national, regional and international borders. These challenges pose a serious obstacle to the achievement of improved health. Geographical imbalance in the distribution of health workers aggravates the health personnel crisis. The number of trained health workers in Africa has historically been inadequate; many countries have suffered from serious scarcity of almost all cadres. The expansion of the health facility networks in many African countries has been done in an uncoordinated way, such that the construction and refurbishment of health facilities has not matched with the ability of the national health system to staff and maintain them on a sustainable basis.

Decenzo (2015) stresses that the supply of human resources must be sufficient to ensure the health operation of the organization, whether it is a business firm, a government agency, or university, towards this objective of confirming health operations, requires health workers, acquired through human resource planning, training and development system. The new local government staffing norms which propose an increase in staffing levels of health centres and in particular having two medical officers at health centre IV is a step in the right direction but there is also a high turnover of medical officers in the health centre IVs (Annual Sector Report, October 2005). The above therefore called for a study to find out how administrative decentralization has affected the accessibility to health services in Kabale Municipality health centres. While commenting on the level of health service accessibility in Uganda especially in the areas of family planning and reproductive health, Glenngård, and Hjalte (2016) indicated that the level of accessibility in those services still remains minimal throughout the country. Giving a reason for this cause, the scholars established that shortage in human resource especially in advocacy, to spearhead capacity for health service delivery, sensitization and education as facilities affecting the accessibility level to health services especially in rural areas.

Furthermore, Mossialos and Dixon (2015) noted that one of the major government-supported facilities limiting accessibility to health services in Uganda is the shortage of skilled and experienced personnel like doctors. In his study, the author indicated that many of the patients who seek some medical services in Level II and Level III health centres tend to be referred to Level IV health centres because of lack of highly skilled human resource in those health centres. According to him, even patients found it very hard to access services in those Level IV health

centres they were referred to since they were still poorly facilitated with doctors, hence making accessibility to health services in many parts of the country very hard.

In addition, in a study conducted by Aminuzzaman (2015) in Bangladesh, it was revealed that some of the critical institutional factors constraining effective health service delivery at the level of local authorities include limited manpower and resources. Considering the workload and responsibilities, local authorities were understaffed. The author further clarifies that local authorities also lacked logistic supports like computers and transport and that they also lacked managerial capability and resources to design and run innovative service delivery in areas like health and education. Aminuzzaman further asserts that, there was a problem of lack of coordination between local authorities and extension service delivery workers of the government at the field level. The author noted that there were no formal links even between the standing committees of the local authorities with the extension workers of the corresponding line ministries of the government. Such isolation made lots of the services of local authorities dysfunctional and ineffective. This also deprived the local authorities of getting technical assistance and other professional support from the government line agencies.

Nathan (2018) argues that a lack of accountability is one of the factors that produce improper budget allocation and poor service delivery at the local government level. This lack of accountability by officials to their superiors and to the communities they serve exists because of the hierarchical character of the state, especially on tender deals with private firms. In addition, outright theft of state funds and property is the norm. The majority of services to be provided to communities are executed through tenders but it is known that many times officials use that process to collude with private firms to squander public funds. This is supported by evidence when considering the high number of corruption cases reported against certain officials in government (Public Protector, 2013).

More still, medical facilities that limit the accessibility to health services in Uganda according to Chattoe-Brown and Bitunda (2016), are concerns about accountability and transparency of government spending and other health centre managers or management committees. According to this study, many patients cannot access health services properly because the money meant for procurement of medical facilities sometimes is not appropriately used or is embezzled. Even in

some of the health centres, drugs get lost and many people are not held responsible. It is through this factor that medical facilities in many public health centres are insufficient and many patients fail to access primary health care services.

Glenngård and Hjalte (2016) also had a similar view to that of Chattoe-Brown and Bitunda (2016) especially when trying to establish reasons for low accessibility level of health services to patients in Uganda. Taking into consideration the accessibility to HIV/AIDS services, for example, they strongly blamed the mismanagement of HIV/AIDS funding as a reason for poor medical facilities. A lot of money meant for the provision of services to HIV/AIDS patients normally gets lost and yet many patients fail to access drugs and contraceptives. Many of the research findings were qualitative, and thus could not establish the extent to which financial, political and administrative decentralization affected health service delivery. Thus, this study attempted to address this gap by establishing both quantitative and qualitative approaches to draw a clear picture on the relationships between the research variables with the help of mean values and standard deviation.

2.4 Remedies for Improving Decentralization and Primary Health Care Service Delivery in Local Governments

Financial management and accounting improvements are essential to identify collateral to be pledged to finance projects in the short-term and to help build the credit rating system and replicate initial municipal borrowings over the long term. The support needed here is to instal and train municipal staff on using a double entry accounting system. Initially, a series of municipalities may be identified based on willingness to participate in reforms needed to increase the supply of municipal resources through borrowing. Cash transfer incentives will help them move forward through greater revenue sharing, including a portion to pay for local accounting support. A national resource centre can offer training courses and facilities for training. Focusing resources on a few municipalities to create some initial successes will provide incentives to other municipalities and gather momentum towards replication. Achieving creditworthiness, a credit rating, municipal borrowing, and the construction of a much-needed facility will demonstrate the results of initiating accounting reforms to other municipalities. Operations and maintenance improvements are needed to ensure that the asset's value will not diminish due to physical deterioration. Once substantial human and financial resources are

invested in providing the basic services, they must be operated and maintained properly or the assets' value will diminish due to physical deterioration (Hankla, 2018).

Bossert and Beauvais (2016) observes that the central government should retain some control over expenditure responsibilities for health to achieve equity and specific minimum health outputs. It is more appropriate for the responsibility of redistribution and equity to lie with the central government (Shah, 2015). Another rationale for the conditional grants is that the policy on equity should be set and implemented by one level of government. The extent of inequities in resource allocation across local jurisdictions make a case for the central government to intervene in order to achieve a more equitable distribution of allocated resources for primary health care (Okorafor, 2017).The World Bank (2016), however, notes that accountability for conditional grants may be poor as citizens may not have adequate information on the grants since they are not the specific taxpayers. The study findings, however, showed that the problem of conditional grants lies with their tight conditions and inadequacy and not mismanagement.

Participatory monitoring and evaluation is critical in financial accountability. Therefore the involvement of communities in monitoring and evaluation is essential for accountability and health service delivery. Onyach Ola (2012) argues that continuous monitoring and evaluation over time has promoted a series of refinements of the local government development programmes; leading to substantial improvements in local government planning, resource allocation, investments, management of development resources especially through increased transparency and decision making which have enhanced health services delivery. However, Williamson (2003) argues that multiplicity of funding sources undermines planning and target setting.

Local development grants ensure that health funding decisions are based on a transparent assessment of results against time-bound targets (The Global Fund, 2009). It is therefore important to note that the basis of the disbursement of local development grants is increasingly on the achievement of pre-agreed output performance targets and process benchmarks within an agreed timeframe through monitoring and supervision processes. Based on the aforementioned statement, local development grants have put in place monitoring and reporting mechanisms to measure progress towards the achievement of performance targets set. It is worth noting that local development grants are monitored and evaluated for four major reasons: i.e. as a

management tool; for documenting lessons learned; for policy reforms; and for impact evaluation. The strategy is routine health facility and institution-based monitoring exercises and supervision. Different service delivery parameters are monitored and include: Out-Patient, In-patient, Theatre, Maternity, Laboratory, Medical Supplies Special clinics/projects, Human Resource, Finance and Administration for facilities. For institutions, training facilities, programmes, trainers and enrolment are some of the parameters assessed to ensure quality of the health work force (Jaszczolt, 2016).

2.5 Summary of Gaps in Literature Review

The chapter has presented the conceptualization of the independent and the dependent variables by analysing the relationships between the two sets of variables. The chapter has also discussed factors that have hindered implementation of various decentralization constructs including financial decentralization, political decentralization, administrative decentralization and primary health service delivery and the remedies for challenges hindering decentralization and primary health service delivery. In addition, empirical review, critique of existing studies and research gaps have been discussed.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents a description of the research methodology that was used to carry out the study. It covers the research design, study population, determination of sample size, sampling techniques and procedures, data collection methods, data collection instruments, validity and reliability of research instruments, procedure of data collection, data analysis and measurement of variables.

3.1 Research Design

Kothari (2004) defines research design as an arrangement of conditions for the collection and analysis of data that aims at combining relevance to the research purpose with economy procedure. Cross-sectional design was used in this study because it was appropriate for collecting data from a sample of respondents at one point in time and it allowed the collection of both quantitative and qualitative data. This triangulation assisted the researcher to obtain detailed description of the study variables by use of quantitative approach and the measurement of the relationship between the variables through quantitative techniques (Amin, 2005; Punch, 2006).

3.2 Study Population

Bertram and Christiansen (2013) define study population as the total number of people, groups, or organizations that could be included in a study. In other words, the study population is a group of people, institutions or organizations from which data can be collected. The study population is used in order to determine the eligibility of individuals for a study and also acts as a basis for applying the research results to other relevant populations. The study population was 159 and it involved stakeholders in primary health care service delivery in Kabale Municipality and all its divisions and therefore knew how these services were being delivered. This population was considered because it was directly affected by the problem under study. The researcher selected 16 administrative staff, 69 Division councillors, 38 health workers and 36 Health Unit Management Committee Members from Rutoma Health Centre II, Kabale Municipality Yard Health Centre II, Kabale Barracks Health Centre II, Kamukira Health Centre IV, Ndorwa Prison

Health Centre III and Mwanjari Health Centre II (Kabale Municipality Department of Health Records, 2020).

3.3 Sample Size

A sample size refers to a number of observations taken from a population through which statistical inferences for the whole population are made (Njunwa, 2005). A sample size of 112 respondents was derived from the population of 159 to provide data for the study. Sample size determination was guided by Krejcie and Morgan Table (1970).

Table 1: Population distribution

Local Councils	**Category**	**Population**
Kabale Municipality	Division councillors	27
	Administrators	4
	Health unit management committee members	9
	Health workers at Kabale Municipal Council HCII	7
Northern division	Municipal councillors	14
	Administrators	4
	Health unit management committee members	9
	Health workers at Rutooma HCII	7
Southern division	Division councilors	14
	Administrators	4
	Health unit management committee members	9+9+9=27
	Health workers at Mwanjari HCII, Kamukiira HC IV and Ndorwa HCII	6+8+5=19
Central division	Division councillors	14
	Administrators	4
	Health Unit Management Committee Members	9
	Health workers at Kabale Police Barracks HCII	5
Total		**159**

Kabale District Medical Department, 2020

Table 2: Sample Size Distribution

Category of respondents	Study Population	Sample Size	Sampling techniques
Administrators	16	16	Purposive sampling
Councilors	69	22	Simple random sampling
Health workers	38	38	Purposive sampling
Health Unit Management Members	36	36	Purposive sampling
Total	**159**	**112**	

Kabale District Medical Department, 2020

3.4 Sampling Techniques

The researcher employed both purposive sampling and simple random sampling techniques in the course of this study.

3.4.1 Purposive Sampling

Purposive sampling is a non-probability sampling technique where respondents are selected based on the characteristics of the population and objectives of the study (Kotler, 2013). Purposive sampling technique was used to select key informants or respondents that is, people with technical or specific information on the effect of decentralization on primary health care service delivery. Thus, 16 administrators, 38 health workers and 36 Health Unit Management Committee members were selected from Kabale Municipality because some of these respondents had technical knowledge about the study. Purposive sampling was preferred because it helped the researcher to select respondents who were informants in this study.

3.4.2 Simple Random Sampling

To ensure representation of the councillors, the researcher employed simple random sampling technique to select 22 councillors from Kabale Municipality. The technique was used because the method enabled the researcher to raise the required number without bias.

The names of councilors were got from register at divisions and Kabale Municipality and these names were written on tags that identified elements of the population to be sampled. The tags placed in a container and well mixed up. A tag was then drawn from the container and the process was repeated until the required number of tags was obtained.

3.5 Data Collection Instruments

This study collected both qualitative and quantitative type of data from two sources i.e. primary and secondary sources as discussed below.

3.5.1 Questionnaires

Kothari (2004) defines a questionnaire as a document that consists of a number of questions printed or typed in a definite order on a form or set of forms. A questionnaire is survey method that utilizes a standardized set or list of questions given to individuals or groups, the results of which can be consistently compared and contrasted.. The questionnaires were administered to a sample of health workers, health unit management committees and division councillors. Questionnaires were designed in Likert scale format (strongly agree, agree, undecided and disagree, strongly disagree) in order to gather quantitative data. Questionnaires were used because they catered for confidentiality, collection of a lot of data in a short time with a large number of respondents who were geographically apart. Questionnaires did not call for close supervision and they were cheap and allowed respondents to fill them at a time convenient to them.

3.5.2 Interview Guide

This is an instrument which consists of unstructured questions used for in-depth interviews with key respondents to validate the range of information (Mugenda & Mugenda, 2003)**.**This instrument was used to collect qualitative primary information. Interview is face-to-face interpersonal communication in which an interviewer asks participants questions aimed at eliciting answers related to the research questions. An Interview guide was used because it usually yields richest data, details, new insights and permits face-to-face contact with respondents; provides an opportunity to explore topics in depth and allows the interviewer to experience the affective as well as cognitive aspects of responses; it allows interviewer to explain or clarify questions; increases the likelihood of useful responses and allows the interviewer to be flexible in administering interview to particular individuals or in particular circumstances (Amin, 2005).Therefore, face-to-face interviews with the town clerk and his assistants were conducted because they had key information about how decentralization was being implemented and how primary health service delivery was being done in health centres in Kabale Municipality.

3.5.3 Documentary Review Checklist

The following documents were reviewed during the study: Kabale Municipality reports on primary health care outcomes and finances, health centres' performance reports, Municipal Council budgets and their corresponding final accounts for 2017/2018 financial years, health unit management committee minutes, staff work schedules, primary health care implementation guidelines and health policy, Annual expenditure performance reports, Work plan Revenues and Expenditures by source, 2018/2019, Kabale Municipality Local Government Quarterly Performance Report for Financial Year 2018/2019) and Ministry of Health Annual Health Sector Performance Report Financial Year 2018/2019 and Section 35 of the Local Government Act Cap 243, Amendment (2010). This constituted a secondary source of data for the study. Documentary review checklist was preferred because of advantage in gathering written information to back up primary data collected using questionnaires and interview guide.

3.6 Reliability of the instruments

3.6.1 Reliability

To ensure that the instrument measures what is supposed to be measured, a test for reliability of instrument was done. Reliability entailed identifying a group of ten respondents who were requested to answer the sampled questionnaire. To ensure the effectiveness of the questionnaire, reliability was computed using Alpha Cronbach. Statistical Package for Social Sciences software was used in determining the reliability. The reliability score of 0.5 suggests that the instrument is reliable (Amin, 2005). So, reliability was obtained using Cronbach's Alpha coefficient.

The reliability alpha coefficients for items on the factors that hinder implementation of financial, political, administrative decentralization and primary health care service delivery were as follows: financial decentralization factors, $\alpha = .880$, political decentralization factors, $\alpha = .970$, administrative decentralization factors $\alpha = .975$, remedies of decentralization and primary health care services, $\alpha = .920$. The results showed a Cronbach-alpha coefficient of greater than 0.60, which was used to indicate that the instruments were reliable (Suhr & Shay, 2009).

Table 3: Reliability Statistics

	Number of Items	Cronbach's Alpha
Financial Decentralisation factors	5	.880
Political Decentralisation factors	5	.970
Administrative Decentralisation factors	5	.975
Remedies of decentralisation	5	.920

3.6.2 Validity

Validity refers to the ability of the instrument to measure what it is expected to measure. The study used face, content and constructs validity to ensure validity of the instruments (Questionnaires and interviews). Face validity refers to the appropriateness of the instruments by appearance. Content validity focuses on whether the full content of a conceptual definition is represented in the measure. Thus, two steps are involved in content validation; specifying the content of a definition and developing indicators which sample from all areas of content in the definition (Punch, 2005). Construct validity aims at linking the instruments used and the theories of the study. A validity test was carried out prior to the administration of the research instruments. This was done in order to find out whether the questions were capable of capturing the targeted data. Content validity index of the instruments was determined by giving a list of objectives, research questionnaires and interview guides to experts in the area of study and questionnaire construction. The experts were requested to evaluate each item in the questionnaire to determine the relevant items. It was then calculated using the formula as follows:

$$CVI = \frac{\text{Number of Valid items}}{\text{Total number of items}} \quad CVI = \frac{20}{23} = 0.87$$

The content validity index was 0.87 which was greater than 0.7 according to George and Mallery (2003). Thus the questionnaires were considered valid because the items in the instruments were relevant and sufficient to cover the content validity index.

In determining the validity of the interviews, a pilot test was conducted on ten respondents. The research instrument used in the pilot test was open-ended questions of semi-structured interview which allowed the researcher to not strictly follow a formalised list of questions. The questions were based on the issue related to factors that have hampered financial, political and administrative decentralisationtowards primary health care service delivery in Kabale Municipality.

Table 4: Showing Content Validity Index Ranges

CVI Range	Interpretation
0.9-1	Excellent
0.8-0.89	Good
0.70-0.79	Acceptable
0.60-0.69	Questionable
0.50-0.59	Poor
0.00-.0.5	Unacceptable

3.7 Data Collection Procedure

On commencement of the study, the researcher obtained an introductory letter from the Department of Postgraduate Training at Kabale University. This letter was administered to the Town Clerk who granted permission to the researcher to carry out the research study. The researcher sought consent from respondents through writing a letter that accompanied the questionnaires during data collection.

A field assistant administered the questionnaires to the identified respondents and carried out face-to-face interviews by the help of the interview guide. A review of relevant documents based on the theme of the study was done by the researcher. Respondents were visited at their places of work and given questions and others were interviewed. Data was collected in a period of 2-4 weeks in order to exhaustively collect data.

3.8 Data Analysis

3.8.1 Qualitative Data

Qualitative data is nominal (named) data concerned with qualities and non-numeric characteristics. Qualitative data analysis is the range of processes and procedures from the qualitative data that have been collected into some form of explanation, understanding or interpretation of the people and situations under investigation. Qualitative data responses were transcribed, sorted and classified. The analysis was done manually and responses were summarized in a narrative form of presentation of the major findings of the study. The technique for qualitative data analysis was content analysis.

3.8.2 Quantitative Data

Quantitative data refers to data collected in numerical form. Quantitative analysis is a systematic approach to investigations during which numerical data is collected and/or the researcher transforms what is collected or observed into numerical data (Yin, 2008). Quantitative data was coded and entered into Statistical Programme for Social Scientists (SPSS) version 20.0 software and data was analysed to generate frequencies, percentages, mean and standard deviation to present results.

3.9 Ethical Consideration

The researcher considered ethical issues throughout the period of the research and remained sensitive to the impact of his work on the respondents and stakeholders affected by the study. The researcher obtained introductory letter from Kabale University to the Town Clerk of Kabale Municipality prior to conducting research, seeking permission to conduct research in the Municipality.

The researcher emphasized confidentiality of all his research findings and used research assistants where he anticipated bias during data collection. The researcher ensured that information obtained from respondents remained confidential. Research assistants were warned not to reveal any information provided by respondents.

The researcher sought consent of the respondents before administering the questionnaires. This was aimed at ensuring that respondents participate in the study basing on their own free will.

In addition, the researcher proved the authenticity of the research being conducted and acknowledged all sources where information was got to ensure that there was no plagiarism. The respondents' names were withheld to ensure anonymity and confidentiality in terms of future prospects.

Respondents were assured that the study was voluntary and respondents were free to withdraw any time they wished and their responses remained confidential. At the end of each interview, each respondent was thanked for participation.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter presents the findings of the study on the effect of decentralization on primary health care service delivery in local governments in Uganda; a case study of Kabale Municipality. The findings are interpreted, discussed and presented in relation to the specific objectives of the study outlined in chapter one. In presenting the findings, the researcher used frequency tables. For easy understanding of the results, findings have also been presented with the help of quotations recorded from primary data.

4.1 Response Rate

The total population of this study was 159 from northern division, southern division, central division and Kabale Municipality where a sample of 112 was targeted. A total of 108 questionnaires were delivered to the respondents but 99 questionnaires were filled and returned. This represented a 91.7% response rate, which is quite suitable for the study. This response rate was favourable according to Mugenda and Mugenda (2003) who asserted that a 50% response rate is adequate for analysis and reporting in research; 60% good and above 70% is very good for data analysis and reporting. Based on the above, the response rate of 91.7% was found to be adequate and good for analysis and generalization of the results.

4.2 Background Characteristics of Respondents

This section gives the number of people who responded to the study with regard to the characteristics of the respondents, gender, age and level of education. This was done to enable the researcher have an understanding of the respondents characteristics and form appropriate judgment on the research findings.

4.2.1 Gender of Respondents

The researcher set out to find out the gender distribution of respondents. This was done to establish whether the study was gender sensitive. This was done to find out whether

decentralization and primary health care services involved both men and women. The results are presented in the Table below.

Table 4: Gender of the Respondents

Gender	Frequency	Percentage
Male	52	52.5
Female	47	47.5
Total	99	**100.0**

Source: Field Data, 2020

Table 4.1 shows that most respondents 52(52.5%) were males while 47(47.5%) were females. Males were more than females because formerly females were not empowered and not allowed to occupy positions in government; but currently, females are involved in all kinds of employment and they also participate in decision making. Thus, the study was gender-sensitive.

4.2.2 Age of the Respondents

The age of respondents was important in this study because it would help in understanding whether age matters in primary health care service delivery and decentralization implementation. Frequency table was used to present and analyse data on the age of the respondents and illustrated in Table 4.2 below.

Table 5: Age of the respondents

Age	Frequency	Percentage
21-30	4	4.0
31-40	50	50.5
41-50	37	37.4
51-60	8	8.1
Total	**99**	**100.0**

Source: Field Data, 2020

From Table 4.2, it was revealed that the majority of the respondents 50(50.5%) were between 31-40 years, 37(37.4%) were in the age bracket of 41-50, 8(8.1%) fell in the age range of 51-60 and only 4(4.0%) were between 21-30 years. The results show that most of the respondents were above 31 years. There were no respondents above 61 years because such people exit employment through either voluntary decision or employer-initiated early retirement.

4.2.3 Level of Education of the Respondents

Table 4.3 also provides results of academic qualifications of the sampled respondents. This was investigated in order to find out whether the level of education influences implementation of decentralization and primary health care service delivery. The results of the item on the level of academic qualifications possessed by respondents are indicated in the Table below.

Table 6: Level of Education of the Respondents

Education	**Frequency**	**Percentage**
Certificate	10	10.1
Diploma	39	39.4
Degree	46	46.5
Masters	4	4.0
Total	**99**	**100.0**

Source: Field Data, 2020

From figure 4.3 above, results revealed that most of the respondents; 46(46.5%) were degree holders, 39(39.4%) were diploma holders, 10(10.1%) had certificate while 4(4.0%) had masters. This finding that majority of the respondents had undergraduate degree indicates that Kabale Municipality has made significant progress toward human resource development. The availability of educated people has a positive impact on the effectiveness and efficiency of decentralization and primary health care service delivery.

4.3 Factors that have Hindered Financial Decentralization and Primary Health Care Service Delivery

The study has established the factors that have hindered financial decentralisation and primary health care service delivery and the findings were recorded in table 4.4.

Table 7: Factors that have Hindered Financial Decentralization and Primary Health Care Service Delivery

Statement	SA	A	UD	D	SD	Mean	St.Dev
Kabale Municipality do not generate adequate revenue to improve sustainability of primary health care services	25(25.3%)	29(29.3%)	9(9.1%)	21(21.2%)	15(15.2%)	3.306	1.417
Local revenue is highly misappropriated and diverted which affects the quality of primary health care service delivery	22(22.2%)	25(25.3%)	10(10.1%)	24(24.2%)	18(18.2%)	3.082	1.455
Many tax payers tend to evade the tax resulting into low revenue to finance health sector for improved quality primary health care services	25(25.3%)	30(30.3%)	11(11.1%)	20(20.2%)	13(13.1%)	3.367	1.373
Kabale Municipality has limited finance to pay health workers which leads to inadequate primary health care services delivery	30(30.3%)	28(28.3%)	0(0.0%)	23(23.2%)	18(18.2%)	3.316	1.529
Inadequate central government grants do not contribute towards adequate provision of primary health care services	25(25.3%)	32(32.3%)	0(0.0%)	20(20.2%)	22(22.2%)	3.204	1.538

Source: Field Data, 2020

Table 4.4 reveals that Kabale Municipality did not generate adequate revenue to improve sustainability of primary health care services was strongly agreed by 25(25.3%) of the respondents, 29(29.3%) of the respondents agreed, 9(9.1%) were undecided, 21(21.2%) disagreed, while 15(15.2%) strongly disagreed. From the findings, the majority of the respondents 54(54.5%) agreed, implying that there was no adequate revenue in Kabale Municipality and its divisions to enhance sustainability of primary health care services. This was supported by a mean score of 3.306 and the standard deviation of 1.417 indicated that there was high variation in the respondents' views in relation to the item.

Findings revealed that local revenue was highly misappropriated and diverted which affected the quality of primary health care service delivery was strongly agreed by 22(22.2%) of the respondents, 25(25.3%) of the respondents agreed, 10(10.1%) undecided, 24(24.2%) disagreed while 18(18.2%) strongly disagreed indicating that majority 47(47.5%) of the respondents agreed that there was diversion and misappropriation of local revenue in Kabale Municipality and its divisions meant for providing quality primary health care services. The scored mean value for this sub-construct was 3.082 and standard deviation was 1.455, signifying that there was variation in responses given by respondents.

The findings are consistent with Ibok (2014) who carried out a study on local governance and service delivery and stated that lack of funds occasioned by low budgetary allocation, restricted revenue sources available to local government and inability to effectively utilize its internal sources of revenue generation had impacted negatively on the provision of public goods at local level.

Many taxpayers tended to evade the tax resulting into low revenue to finance health sector for improved quality primary health care services was strongly agreed by 25(25.3%) of the respondents, 30(30.3%) agreed, 11(11.1%) were undecided, 20(20.2%) disagreed while 13(13.1%) strongly disagreed. The scored mean value for this item was 3.367 and standard deviation was 1.373, signifying that many taxpayers evaded paying tax, resulting into low revenue to finance the health sector for improved quality primary health care services. The standard deviation of 2.752 indicates that the participants in the current research had high variation in the way they responded to this item.

Table 4.4 also reveals that 30(30.3%) of the respondents strongly agreed, 28(28.3%) of the respondents agreed, (0.0%) were undecided, 23(23.2%) disagreed while 18(18.2%)strongly disagreed that Kabale Municipality had limited finance to pay health workers which leads to inadequate primary health care services delivery. The findings mean that the majority of the respondents 58(58.6%) agreed with the statement that Kabale Municipality had limited finance to pay health workers which leads to inadequate primary health care services delivery. The scored mean value for this item was 3.316 while the standard deviation was 1.529. This implied that finance to pay health workers was not adequate to provide inadequate primary health care

services in Kabale Municipality and the standard deviation of 1.529 meant that the views of the respondents on this item had high variation.

The above findings concur with a UNDP report (2018) which states that financial resources have been blamed for low level of accessibility to health centres in Uganda. A study by the United Nations Development Programme (UNDP) (2018), for example, indicates that the budget for provision of health sector in the country is still low and yet a lot is needed. This means that the government support for the health sector is still minimal. Most of the drugs and other medical facilities in public health centres are funded by donor organizations and yet in the health sector, supplies of medicines are less than half of required amounts. This therefore affects the accessibility of health services to many patients in the country. This factor is of major importance because all activities performed by local governments (LGs) require adequate financial resources.

More still, inadequate central government grants do not contribute towards adequate provision of primary health care services was strongly agreed by 25(25.3%) of the respondents, 32(32.3%) of the respondents agreed, 0(0.0%) were undecided, 20(20.2%) disagreed while 22(22.2%) strongly disagreed. The majority of the respondents 57(57.6%) agreed that inadequate central government grants did not contribute towards adequate provision of primary health care services. The scored mean value for this item was 3.204 which shows that conditional grants are not satisfactory to contribute towards adequate provision of primary health care services. The standard deviation was 1.538, implying that there was much variation in the views of respondents on this item. In support of the findings, Onyach-Olaa (2012) asserts that the central government transfers to LGs are largely earmarked for the services for which they are given. Only a slight degree of flexibility is permissible with restrictions. The unconditional grant from the central government which is the only grant that LGs may use as part of their revenue is mainly used to pay staff salaries. In many districts, the amount from this grant is not adequate to cover the wage bill. LGs have to therefore obtain the rest from their local revenue so as to pay workers' salaries. The conditional grant which is by far the largest source of revenue to LGs finances projects and programmes agreed upon between the central and local government such as primary education, and primary healthcare, including the Local Government Development Programme (LGDP) through which grants are available to lower councils for specific projects identified in development plans.

In support of the above findings, Stephen and Rebecca (2016) state that local governments face a challenge of the inability to collect fully the revenue due to them. The huge gaps between reported and projected revenues in local governments is an indication of inability to collect and this is due to: weak administrative capacity to assess taxes and levies and then to enforce revenue laws and bylaws, taxpayers' resistance and low morale on the part of citizenry to pay tax, corruption, including embezzlement of revenue by revenue collectors, external pressure on the local finance department to provide optimistic projections and political pressure on the revenue collectors to relax on revenue collection (Stephen and Rebecca, 2016). Both central government and LGAs are generally expected to provide public service, but is common to find that the own source revenue-raising powers of the latter are not sufficient to meet the costs of providing the services they have been assigned. The resulting gap can be filled by vertical equalization, i.e., transfer resources from the central government or by increasing revenue-raising powers of LGAs. But increasing local own-source revenue is, more often than not, quite challenging. For example, allowing LGAs to have substantial revenue-raising powers reduces central control over the total size of the public sector and raises concerns about macroeconomic stabilization. In addition, appropriate local revenue bases are commonly weak or too administratively complex for LGAs to handle (Stephen and Rebecca, 2016).

One respondent reported that "*The funds allocated to us are not adequate to help us establish immunization outreaches in areas where the services are needed because service providers do not get allowances which reduce access, ordering types of drugs mostly needed thereby reducing improving effectiveness and establishment of communication feedback mechanism to capture the feelings of the clients".*

"The planning team at Divisions and the Council has the final decision on the amount of money to be allocated to primary health care sector and nature of programmes to be implemented in certain areas. This at times lead to the delivery of primary health services which are not very essential in the areas".

One of the administrators was quoted saying:

"*Most of our revenues are spent in road improvement plans, health service delivery, installation of safe water in the villages and you have a chance to go and look into our*

strategic plans and documented municipality budgets…we are not like other municipalities because we have always been transparent."

One informant disclosed that "*our local council is largely depends on central government transfers every year but these have been inadequate because we have a lot of activities to be done in the council. Thus, primary health care service delivery is not adequately financed. That is why it is still lacking".*

4.4 Factors that have Hindered Political Decentralization and Primary Health Care Service Delivery

This section of the study analyses the participants' perceptions regarding factors that have hindered political decentralization and primary health care service delivery. Descriptive statistics were used and the findings are presented in Table 4.5.

Table 8: Factors that have Hindered Political Decentralization and Primary Health Care Service Delivery

Statement	SA	A	UD	D	SD	Mean	St.Dev
Health sector is not adequately represented in council and at the technical planning committee meetings to ensure quality primary health care service delivery	18(18.2%)	23(23.2%)	0(0.0%)	30(30.3%)	28(28.3%)	2.745	1.521

There is political influence in allocation of expenditure for primary health care services	25(25.3%)	28(28.3%)	0(0.0%)	20(20.2%)	26(26.3%)	3.082	1.589
There are imbalances in primary health care services	20(20.2%)	25(25.3%)	0(0.0%)	25(25.3%)	29(29.3%)	2.837	1.563
The council do not adequately monitor the management of local revenue for primary health care services	15(15.2%)	20(20.2%)	8(8.1%)	30(30.3%)	26(26.3%)	2.694	1.432
Most councilors have limited education and do not adequately represent their areas which affects the quality of primary health service delivered to people	25(25.3%)	29(29.3%)	10(10.1 %)	20(20.2%)	15(15.2%)	3.194	1.475

Source: Field Data, 2020

Table 4.5 indicates that the health sector was not adequately represented in council and at the technical planning committee meetings to ensure quality primary health care service delivery was strongly agreed by 18(18.2%) of the respondents, 23(23.2%) of the respondents agreed, 0(0.0%) was undecided and 30(30.3%) disagreed while 28(28.3%) strongly disagreed indicating that majority of the respondents disagreed that the health sector was not adequately represented in council and at the technical planning committee meetings to ensure quality primary health care service delivery. The respondents scored mean value was 2.745 while the standard deviation was 1.521. This implies that health sector was adequately represented in council and the technical planning committee but there were still gaps in primary health care service delivery and there was much variation in the responses. The gaps in primary health care service delivery were attributed to political influence and lack of motivation of health workers to provide primary health care services.

Table 4.5 also reveals that there was political influence in allocation of expenditure for primary health care services was strongly agreed by 25(25.3%) of the respondents, 28(28.3%) agreed, 0(0.0%) of the respondents undecided, 20(20.2%) disagreed and 26(26.3%) strongly disagreed with the statement. Since majority of the respondents 53(53.5%) of the respondents agreed, it implied that political influence in allocation of expenditure for primary health care services negative affected primary health care services delivery. The scored mean value for the item was

3.082 while the standard deviation was 1.589, meaning that there was much variation in the responses.

There were imbalances in primary health care services was strongly agreed by 20(20.2%) of the respondents, 25(25.3%) agreed, 0(0.0%) of the respondents undecided, 25(25.3%) disagreed while 29(29.3%) strongly disagreed. From the findings, the majority of the respondents disagreed, implying that there were no imbalances in primary health care service delivery. The scored mean value for this sub-construct was 2.837 which indicates that the majority of the respondents disagreed; and standard deviation of this item was 1.563, implying that there was much variation in the way participants responded on this item. From this, it is possible to deduce that there were no imbalances in primary health care service delivery in Kabale Municipality.

Table 4.5 also reveals that the council do not adequately monitor the management of local revenue for primary health care services was strongly agreed, 15(15.2%) of the respondents, 20(20.2%) agreed, 8(8.1%) of the respondents were undecided, 30(30.3%) disagreed whereas 26(26.3%) strongly disagreed with the statement indicating that 56(56.6%) of the respondents disagreed which implied that the council monitors the management of local revenue but primary health care service delivery is still lacking. This could be attributed to limited finance and inadequate participation in the implementation of primary health care services.

Furthermore, findings indicated that 25(25.3%) of the respondents strongly agreed, 29(29.3%) agreed, 10(10.1%) undecided, 20(20.2%) of the respondents disagreed while 15(15.2%) strongly disagreed that most councillors had limited education and did not adequately represent their people which affected implementation of decentralization and improved immunization and antenatal care. The mean score of this item was 3.194 and this indicates that most respondents agreed that most councillors had limited education that made them not fully represent their areas. The findings concur with Natamba et al. (2010) who stated that the quality of councillors is affected by their level of education. At the moment, there is no minimum education requirement for anyone to hold office as a district councillor, and academic qualifications are not part of the eligibility requirements for the office. There is widespread consensus that councillors with very low levels of education fail to express themselves during plenary sessions, while some cannot make written contributions. Such low levels of education undermine effective debates among

councillors with their educated technical staff and some local politicians have an inferiority complex which sometimes leads to conflicts with technical staff.

In an interview with town clerk, it was reported that;

> *"The performance of every lower local governments is a primary concern to every citizen in the community because there is an expectation that all lower local government resources are to be used efficiently in providing the highest level of public services to the community and in turn, the lower local governments have the responsibility to ensure that the primary health care programs that it provides meet needs of the people.*
>
> *It was noted in an interview that community priorities are implemented after planning and budgeting due to political interest however; most of them are decided at higher levels with authority and not all community priorities are taken into consideration.*

One respondent noted that *"not all activities and/or projects for primary health budgeted for are implemented in a transparent way this is because many stakeholders have different interests in the different activities budgeted for and above all work plans are not shared with other stakeholders. In addition to this, misappropriation of funds is greatly affecting implementation of revenue plan for health service delivery".*

Additionally, most political leaders overwhelmingly complained that they were not being involved in planning. The staff and political leaders agreed that the health unit management committee was dedicating little time to oversee the implementation of primary health care activities. The research also got information from the interviewees that the health unit management committee lacked technical competence to monitor some of the health activities. The interviewees were in agreement that inadequate resources like drugs and other supplies were a constant challenge to achieving decentralization and primary health care service delivery.

4.5 Factors that have Hindered Administrative Decentralization and Primary Health Service Delivery

The table below shows the findings on the factors that have hindered administrative decentralization and primary health service delivery.

Table 9: Factors that have Hindered Administrative Decentralization and Primary Health Service Delivery

Statements	SA	A	UD	D	SD	Mean	St.Dev
There is high rate of bureaucratic red tape in Kabale Municipality which affected the quality of primary health care services delivery	22(22.2%)	28(28.3%)	12(12.1%)	20(20.2%)	17(17.2%)	3.204	1.414
Cases of corruption and fraud by some administrators have affected the delivery of adequate primary health care services	30(30.3%)	34(34.3%)	0(0%)	20(20.2%)	15(15.2%)	3.469	1.458
Delayed implementation of projects and programmes for primary health care has reduced the quality of primary health care services	32(32.3%)	34(34.3%)	0(0%)	20(20.2%)	15(15.2%)	3.592	1.413
Lack of training opportunities to develop professional and technical expertise in health sector affects the delivery of quality primary health care services	20(20.2%)	28(28.3%)	0(0%)	30(30.3%)	21(21.2%)	2.980	1.491
There is inadequate human resources in the health sector to deliver quality health services	28(28.3%)	36(36.3%)	0(0%)	20(20.2%)	15(15.2%)	3.449	1.444

Source: Field Data, 2020

From Table 4.6, there was high rate of bureaucratic red tape in Kabale Municipality which affected the quality of primary health care service delivery was strongly agreed by 22(22.2%)of the respondents, 28(28.3%) agreed, 12(12.1%) were undecided, 20(20.2%) disagreed while 17(17.2%) strongly disagreed. From the findings, it can be seen that the majority of the respondents 50(50.5%) agreed, implying that a high rate of bureaucratic red tape in Kabale Municipality and its divisions affected the quality of primary health care service delivery. The mean score value for this item was 3.204 while the standard deviation was 1.414. This implies that there was much variation in the way participants responded and the majority of the respondents agreed with the view that there was high rate of bureaucratic red tape in Kabale

Municipality which affected the quality of primary health care service delivery. The finding is in harmony with Alornyeku (2016) who carried a case study in Kumasi metropolis in Ghana on administrative structure and service delivery. The study revealed that even though there is a clear practice of division of labour, there is the department's lack of technical equipment which results in delays in meeting the expectation of citizens.

Cases of corruption and fraud by some administrators have affected the delivery of immunization services was strongly agreed by 30(30.3%) of the respondents, 34(34.3%) of the respondents agreed, 0(0%) undecided, 20(20.2%) disagreed while 15(15.2%) strongly disagreed. Findings indicated that the majority 64(64.6%) of the respondents agreed, implying that cases of corruption in Kabale Municipality affected the delivery of primary health care services. This was supported by a mean score of 3.469. The standard deviation of 1.458 indicated that there was much variation in the way participants presented their views on this item.

The findings are in agreement with Boris (2015) who carried out an empirical study to examine challenges confronting local government administration in effective and efficient social service delivery at the grassroots in Nigeria using secondary data and concluded that lack of funds, corruption and undue political interference, amongst others, as major constraints to primary health care service delivery.

From Table 4.6, delayed implementation of projects and programmes for primary health care has reduced the quality of primary health care services was strongly agreed by 32(32.3%) of the respondents, 34(34.3%) of the respondents agreed, 0(0%) were undecided, 20(20.2%) disagreed while 15(15.2%) strongly disagreed. The majority of the respondents 66(66.6%) agreed, implying that there was also delayed implementation of programmes for health care service delivery in Kabale Municipality. The mean score value of 3.592 indicates that the majority of the respondents agreed while the standard deviation indicates much variation in responses, implying that respondents presented different views on delayed implementation of projects and programmes for primary health care and reduced quality of primary health care services.

Furthermore, lack of training opportunities to develop professional and technical expertise in health sector affected the delivery of quality primary health care services was strongly agreed by 20(20.2%) of the respondents, 28(28.3%) agreed, 0(0%) were undecided, 30(30.3%) disagreed

while 21(21.2%) strongly disagreed, indicating that the majority of the respondents disagreed with lack of training opportunities to develop professional and technical expertise in the health sector affected the delivery of quality primary health care services. From the findings, a mean score of 2.980 indicates that there was a majority of respondents who were in disagreement with the statement and a standard deviation of 1.491 indicated that there was high variation in respondents' views on this item.

Additionally, inadequate human resources in the health sector to deliver quality primary health care services was strongly agreed by 28(28.3%) of the respondents, 36(36.3%) of the respondents agreed, 0(0%) undecided, 20(20.2%) of the respondents disagreed while 15(15.2%) strongly disagreed. The above findings indicate that human resources concerned with the delivery of primary health care services were available. The mean score of 3.449 indicates that there was high level of agreement with the item, and a standard deviation of 1.444 indicates a much variation in responses.

In agreement with the above findings, De Muro, Salvatici and Conforti (2015) identify shortages of qualified and experienced staff to deliver services especially in health sector and a lack of training opportunities to develop professional and technical expertise as some of the hindrance of decentralization and primary health care service delivery.

Also, in support of the above findings, Mossialos and Dixon (2015) noted that one of the major government-supported facilities limiting accessibility of health services in Uganda is the shortage of skilled and experienced personnel like doctors. In his study, the author indicated that many of the patients who seek some medical services in Level II and Level III health centres tend to be referred to Level IV health centres because of lack of highly skilled human resource in those health centres. According to him, even patients find it very hard to access services in those Level IV health centres they are referred to since they are still poorly facilitated with doctors, hence making accessibility of health services in many parts of the country very hard.

One informant reported that: *Though Kabale Municipality is mandated to provide primary health services;this is hindered by lack of technical equipment which results in delays in meeting the expectation of citizen's .In addition, assembly low productivity, due to excessive bureaucracy negatively impacted performance of the local government in the*

delivery of primary health care services.Additionally, lack of funds, corruption and undue political interference amongst others were reported to be major constraints to primary health care service delivery in Kabale Municipality.

4.6 Relevant Remedies for Improving Decentralization and Primary Health Care Service Delivery

This section shows the level of agreement on relevant remedies for improving decentralization and primary health care service delivery.

Table 10: Relevant Remedies for Improving Decentralization and Primary Health Care Service Delivery

Statements	SA	A	UD	D	SD	Mean	St.Dev
The government should strengthen the fight against corruption and embezzlement of funds meant to provide primary health care services	30(30.3%)	34(34.3%)	0(0%)	20(20.2%)	15(15.2%)	3.469	1.458
There is need for the local government to recruit adequate primary health care staff to provide quality health services	30(30.3%)	36(36.4%)	0(0%)	20(20.2%)	13(13.1%)	3.531	1.416
Budget allocation for primary health care sector needs to be sufficient	60(60.6%)	39(39.4%)	0(0%)	0(0%)	0(0%)	4.612	0.487
Money allocated for health centers should be properly spent for primary health care service improvement	55(55.6%)	45(45.5%)	0(0%)	0(0%)	0(0%)	4.561	0.496
The Central Government should make adequate policies for primary health care services	39(39.4%)	40(40.4%)	0(0%)	12(12.1%)	8(8.1%)	3.939	1.236

Source: Field Data, 2020

Table 4.7 reveals that the government should strengthen the fight against corruption and embezzlement of funds meant to provide primary health care services was strongly agreed by 30(30.3%) of the respondents, 34(34.3%) of the respondents agreed, 0(0%) undecided, 20(20.2%) disagreed while 15(15.2%) strongly disagreed and the respondent scored mean value

was 3.469. The implication is that the majority of the respondents 64(64.6%) agreed with the view that the government should strengthen the fight against corruption and embezzlement of funds meant to provide primary health care services. The scored mean value of 3.469 implies that government should strengthen the fight against corruption and embezzlement of funds meant to provide primary health care services while the standard deviation of 1.458 implies there was much variation in the responses.

Findings revealed that there is need for the local government to recruit adequate primary health care staff to provide quality health services was strongly agreed 30(30.3%) of the respondents, 36(36.4%) of the respondents agreed, 0(0%) undecided, 20(20.2%) disagreed while 13(13.1%) strongly disagreed. The scored mean value for this sub-construct was 3.531 and the standard deviation was 1.416. Since the majority of the respondents agreed 66(66.7%), it implies that Kabale Municipality needs to recruit adequate primary health care staff to provide quality health services. The mean value of 3.531 implies that recruitment of adequate primary health care staff provides quality health services while the standard deviation of 1.416 implies a higher variation in the responses.

Budget allocation for primary health care sector needs to be sufficient was strongly agreed by 60(60.6%) of the respondents while the remaining 39(39.4%) agreed. The scored mean value for this sub-construct was 4.612 implying that majority of the respondents agreed with the item that budget allocation for primary health care sector needs to be sufficient to improve the quality of primary health care. The standard deviation of this item was 0.487 which means that there was no variation in the views provided by the respondents.

Additionally, 55(55.6%) of the respondents strongly agreed while 45(45.5%) of the respondents agreed that money allocated for health centres should be properly spent for primary health care service improvement. The scored mean value for this item was 4.561 and the standard deviation was 0.496. The findings mean that all the respondents agreed that the proper allocation of money to health centres would improve on primary health care service delivery. The standard deviation of 0.496 implies there no variation in responses.

Furthermore, the central government should make adequate policies for primary health care services was strongly agreed by 39(39.4%) of the respondents, 40(40.4%) of the respondents

agreed, 0(0%) undecided, 12(12.1%) disagreed while 8(8.1%) strongly disagreed. The mean score value for this item was 3.939 which means that the majority of the respondents agreed while the standard deviation of 1.236 implied that respondents gave different views on this item.

A respondent noted that; "*Some of our staff are greedy and try to embezzle government money meant for primary health care service delivery. However, we deal with them through auditing and monitoring to ensure that the money is properly used in the provision of primary health care services*"

Some respondents reported that decentralization has helped improve the quality of PHC services in a number of ways. Examples given by the informants included establishing immunization outreaches in areas where the services are needed, thereby improving the access, ordering types of drugs mostly needed thereby improving effectiveness, and establishment of communication feedback mechanism to capture the feelings of the clients, thereby improving interpersonal relations.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary of the study, discussion of the findings, conclusions and recommendations. It also presents areas for further research. The discussion of the findings, conclusion and recommendations are presented objective by objective.

5.1 Summary of Findings

The study sought to establish the effect of decentralization on primary health care service delivery in Kabale Municipality, Kabale District. The study assessed the factors that have hindered the implementation of financial decentralization and primary health care service delivery; established the factors that may have hindered political decentralization and primary health care service delivery; investigated the factors that may have hindered administrative decentralization and primary health care service delivery; and established relevant remedies that have to be applied to improve decentralization and health service delivery in Kabale Municipality. The major findings for each objective were as follows.

5.1.1 Factors that have hindered the Implementation of Financial Decentralization and Primary Health Care Service Delivery in Kabale Municipality

The first objective of the study was to assess the factors that have hindered the implementation of financial decentralization and primary health care service delivery in Kabale Municipality. It was revealed that 54(54.5%) of the respondents agreed Kabale Municipality did not generate adequate revenue to improve sustainability of primary health care services, 9(9.1%) were undecided, 36(36.4%) disagreed. Findings revealed that local revenue was highly misappropriated and diverted, which affected the quality of primary health care service delivery was agreed by 47(47.5%) of the respondents, 10(10.1%) were undecided, 42(42.4%) disagreed. Many tax payers tended to evade the tax resulting into low revenue to finance health sector for improved quality primary health care services was agreed by 55 (55.6%) of the respondents, 11(11.1%) were undecided, 33(33.3%) disagreed. The findings indicated that 58(58.6%) of the

respondents agreed that Kabale Municipality had limited finance to pay health workers which leads to inadequate primary health care services delivery whereas 41(41.4%) disagreed. Additionally, inadequate central government grants did not contribute towards adequate provision of primary health care services while 42(42.4%) disagreed.

5.1.2 Factors that have hindered Political Decentralization and Primary Health Care Service Delivery

The second objective of the study was to establish the factors that have hindered political decentralization and primary health care service delivery. The findings revealed that 41(41.4%) of the respondents agreed that the health sector was not adequately represented in council and at the technical planning committee meetings to ensure quality primary health care service delivery while 58(58.6%) disagreed. The item that there was political influence in allocation of expenditure for primary health care services was agreed by 53(53.5%) of the respondents, while 46(46.5%) disagreed. There were imbalances in primary health care services was agreed by 45(45.5%) of the respondents whereas 54(54.5%) disagreed. The study further indicated that 35(35.4%) of the respondents agreed while 56(56.6%) disagreed that council did not adequately monitor the management of local revenue for primary health care services. It was also revealed that 54(54.6%) of the respondents agreed, 10(10.1%) wereundecided, 35(35.4%) of the respondents disagreed that most councillors had limited education and did not adequately represent their areas which affected the quality of primary health service delivered to people.

5.1.3 Factors that have hindered Administrative Decentralization and Primary Health Care Service Delivery

The third objective of the study was to investigate the factors that may have hindered administrative decentralization and primary health care service delivery. From the findings, it was indicated that 50(50.5%) of the respondents agreed that there was high rate of bureaucratic red tape in Kabale Municipality which affected the quality of primary health care service delivery, 12(12.1%) were undecided while 37(37.4%) disagreed. Cases of corruption and fraud by some administrators affected the delivery of adequate primary health care services was agreed by 64(64.6%) of the respondents while 35(35.4% disagreed. Delayed implementation of projects and programmes for primary health care has reduced the quality of primary health care services was also agreed by 66(66.7%) of the respondents while 35(35.4%) of the respondents disagreed.

Furthermore, lack of training opportunities to develop professional and technical expertise in health sector affected the delivery of quality primary health care services was agreed by 48(48.5%) of the respondents whereas 51(51.5%) disagreed. Additionally, inadequate human resources in the health sector to deliver quality primary health care services was agreed by 64(64.6%) of the respondents and 35(35.4%) disagreed.

5.1.4 Relevant Remedies that have to be applied in improving Decentralization and Health Service Delivery in Kabale Municipality

The fourth objective was to established relevant remedies that have to be applied in improving decentralization and health service delivery in Kabale Municipality. The study revealed that the government should strengthen the fight against corruption and embezzlement of funds meant to provide primary health care services was agreed by 64(64.6%) of the respondents whereas 35(35.4%) disagreed. There was need for the local government to recruit adequate primary health care staff to provide quality health services was agreed 66(66.7%) while 33(33.3%) disagreed. Budget allocation for primary health care sector needed to be sufficient and money allocated for health centers should be properly spent for primary health care service improvement were all agreed by all the respondents. Furthermore, the central government should make adequate policies for primary health care services was agreed by 79(79.8%) of the respondents while 20(20.2%) disagreed.

5.2 Conclusions

5.2.1 Factors that have hindered the Implementation of Financial Decentralization and Primary Health Care Service Delivery in Kabale Municipality

The study found that some of the factors that hindered implementation of financial decentralization and primary health care service delivery in Kabale Municipality were that Kabale Municipality did not generate adequate revenue to improve sustainability of primary health care services. Local revenue was highly misappropriated and diverted which affected the quality of primary health care service delivery. There was high rate of tax evasion by taxpayers resulting into low revenue to finance health sector for improved quality primary health care services. The study also established that Kabale Municipality had limited finance to pay health workers which led to inadequate primary health care services delivery. Furthermore, there were

inadequate central government grants given to Kabale Municipality to provide primary health care services.

5.2.2 Factors that have hindered Political Decentralization and Primary Health Care Service Delivery

The factors that were found to have hindered political decentralization and primary health care service delivery in Kabale Municipality were political influence in allocation of expenditure for primary health care services, imbalances in primary health care services and limited education for councillors which made them not adequately represent their areas which affected the quality of primary health service delivered to people.

5.2.3 Factors that have hindered Administrative Decentralization and Primary Health Care Service Delivery

Factors that have hindered administrative decentralization and primary health care service delivery in Kabale Municipality were high rate of bureaucratic red tape, corruption and fraud by some administrators, delayed implementation of projects and programmes for primary health care services and inadequate human resources in the health sector to deliver quality primary health care services.

5.2.4 Relevant remedies that have to be applied in improving Decentralization and Health Service Delivery in Kabale Municipality

The study established that there was need to strengthen the fight against corruption and embezzlement of funds meant to provide primary health care services. It was established that there was need for the local government to recruit adequate primary health care staff to provide quality health services. Budget allocation for primary health care sector needed to be sufficient and money allocated for health centres should be properly spent for primary health care service improvement.

5.3 Recommendations

Based on the summary of finds and conclusions, the following recommendations were made:

5.3.1 Factors that have hindered the Implementation of Financial Decentralization and Primary Health Care Service Delivery in Kabale Municipality

The study recommends that the government should put in place a set of deliberate and proactive processes, policies and structures that support financial decentralization and primary health care service delivery.

The Government should ensure that the budget allocation for primary health care service delivery is increased to meet the demands of the clients and meet their satisfaction and that of service providers.

The study recommends that bigger releases should be made to primary health care activities. Kabale Municipality and its divisions should deliberately allocate a specific percentage of its budget to PHC activities and annually evaluate the actual releases made.

5.3.2 Factors that have hindered Political Decentralization and Primary Health Care Service Delivery

There is need to maintain balance in the distribution of primary health care services in Kabale Municipality as this will ensure that all people access primary health care services.

It is recommended that Kabale Municipality in line with its Local Council leaders need consider using community sensitization or community dialogue meetings to elicit information about all available sources of revenue specifically the untapped or silent sources. This will increase the amount of revenue that will be spent on primary health care activities.

5.3.3 Factors that have hindered Administrative Decentralization and Primary Health Care Service Delivery

Since cases of corruption were found to hinder administrative decentralization and primary health care service delivery, there is need for the government and its anti-corruption agencies to strengthen measures to fight against corruption. This will ensure effective primary health service delivery in Kabale Municipality.

There is therefore need to reduce bureaucratic tendencies in Kabale Municipality so as to improve on administrative decentralization and primary health care service delivery.

The salaries and allowances for service providers should be updated to match with the prevailing market conditions so as to attract new entrants, retain the existing personnel and motivate them. The conditions on grants should be revisited to accommodate room for funding of locally raised priorities that support primary health care activities.

The Kabale Municipality leadership should always monitor the implementation of primary health services in order to ensure quality service delivery.

5.3.4 Relevant remedies that have to be applied in improving Decentralization and Health Service Delivery in Kabale Municipality

There should be increased strengthening of the fight against corruption and embezzlement of funds meant to provide primary health care services.

The government should recruit adequate primary health care staff to provide quality health services.

There should be proper budget allocation for primary health care sector needed and funds allocated to primary health sector should be sufficient and properly spent for the delivery of quality primary health care services.

5.4 Areas for Further Research

During the study, the researcher identified three areas that could be considered for future research, basing on the empirical findings of the study.

A study needs to be conducted on the effect of decentralized Monitoring and Quality of primary health care Services delivery in Kabale Municipality.

There is need for a study to be done on the effect of inter-governmental transfers on primary health care service delivery.

There is need for a study on the factors that hinder full participation of stakeholders in primary health care service delivery

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APPENDICES

Appendix A: Introductory Letter

KABALE UNIVERSITY
P.O Box 317
Kabale - Uganda
Email: info@kab.ac.ug
admissions@kab.ac.ug

Tel: 256-392-848355/04864-26463
Mob: 256-782860259
Fax: 256-4864-22803
Website: www.kab.ac.ug

DIRECTORATE OF POSTGRADUATE TRAINING

November 18th, 2020

To whom it may concern

This is to certify that *Mr. Kisembo Julius Reg. No. 2018/MAPAM/1736/W* is a postgraduate student of Kabale University studying for a *Masters of Arts in Public Administration and Management* in the department of *Governance.*

He has successfully defended his Research Proposal for a study entitled,

"Effect of Decentralization on Primary Health Care service delivery in Local Government in Uganda: A case study of Kabale Municipality"

The student is now ready for field work to collect data for his study. Please give the student any assistance you can to enable him accomplish the task.

Thanking you for your assistance,

Yours sincerely

KABALE UNIVERSITY DIRECTORATE OF POSTGRADUATE TRAINING P. O. BOX 317, KABALE 18 NOV 2020

Dr. Sekiwu Denis
DIRECTOR, POSTGRADUATE TRAINING

Appendix B: Questionnaire for Health Workers, Health Unit Management Committee Members and Division Councilors

Dear Respondent

I am **Kisembo Julius** a graduate student of Kabale University undertaking a research leading to the award of a Degree of Master of Arts in Public Administration and Management. My topic of investigation is; **DECENTRALISATION ANDPRIMARY HEALTH CARE SERVICE DELIVERY IN LOCAL GOVERNMENTS IN UGANDA: A CASE STUDY OF KABALE MUNICIPALITY**. This questionnaire has been designed to assist me in collecting data for this research study. The research is purely for academic purposes and the information you will provide will be treated with utmost confidentiality. I kindly request you to provide me the necessary information having been chosen to participate in the study to enable me complete my research work successfully.

Thank you in advance for your co-operation

Note: Please fill in the spaces provided or tick in the Optional Boxes with your responses

SECTION A: BIO DATA OF RESPONDENTS

1. Sex

Male ☐ Female ☐

2. Age

Below 20 Yrs ☐ 21 – 30 Yrs ☐

31 – 40Yrs ☐ 41 – 50Yrs ☐

51-60Yrs ☐ Above 61Yrs ☐

3. Educational qualification

Never went to School ☐ Certificate ☐

DiplomaDegree ☐ ☐

Masters ☐

Other…….

SECTION B: FACTORS THAT HAVE HINDERED FINANCIAL DECENTRALISATION AND PRIMARY HEALTH CARE SERVICE DELIVERY

Statements	**5**	**4**	**3**	**2**	**1**
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
Kabale Municipality do not generate adequate revenue to improve sustainability of primary health care services					
Local revenue is highly misappropriated and diverted which affects the quality of primary health care service delivery					
Many tax payers tend to evade the tax resulting into low revenue to finance health sector for improved quality primary health care services					
Kabale Municipality has limited finance to pay health workers which leads to inadequate primary health care services					
Conditional grants do not contribute towards adequate provision of primary health care services					

SECTION C: FACTORS THAT HAVE HINDERED POLITICAL DECENTRALIZATION AND PRIMARY HEALTH CARE SERVICE DELIVERY

Statement	**5**	**4**	**3**	**2**	**1**
Health sector is not adequately represented in council and at the technical planning committee meetings to ensure quality primary health care service delivery					
There is political influence in allocation of expenditure for primary health care services					
There is regional imbalances in primary health care services					
The council do not monitor the management of local revenue for primary health care services					
Most councilors have limited education and do not adequately represent their areas which affects the quality of primary health service delivered to people					

SECTION D: FACTORS THAT HAVE HINDERED ADMINISTRATIVE DECENTRALIZATION AND PRIMARY HEALTH CARE SERVICE DELIVERY

Statements	**5**	**4**	**3**	**2**	**1**
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
There is high rate of bureaucratic red tape in Kabale Municipality which affect the quality of primary health care services delivery					
Cases of corruption and fraud by some administrators have affected the delivery of adequate primary health care services					
Delayed implementation of projects and programmes for primary health care has reduced the quality of primary health care services.					
Lack of training opportunities to develop professional and technical expertise in health sector affects the delivery of quality primary health care services					
There is inadequate human resources in the health sector to deliver quality health services					

SECTION C: RELEVANT REMEDIES FOR IMPROVING DECENTRALIZATION AND PRIMARY HEALTH CARE SERVICE DELIVERY

Statements	**5**	**4**	**3**	**2**	**1**
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
The government should strengthen the fight against corruption and embezzlement of funds meant to provide primary health care services.					
There is need for the local government to recruit adequate primary health care staff to provide quality health services					
Budget allocation for primary health care sector needs to be sufficient					
Money allocated for health centers should be properly spent for primary health care service improvement					
The Central Government should make adequate policies for primary health care services					

Appendix C: Interview Guide for Town Clerk and his Assistants

Dear Respondent

I am **Kisembo Julius** a graduate student of Kabale University undertaking a research leading to the award of a Degree of Master of Arts in Public Administration and Management. My topic of investigation is; **DECENTRALISATION ANDPRIMARY HEALTH CARE SERVICE DELIVERY IN LOCAL GOVERNMENTS IN UGANDA: A CASE STUDY OF KABALE MUNICIPALITY**. This questionnaire has been designed to assist me in collecting data for this research study. The research is purely for academic purposes and the information you will provide will be treated with utmost confidentiality. I kindly request you to provide me the necessary information having been chosen to participate in the study to enable me complete my research work successfully.

Questions

1. Would you say that the quality of primary health care services delivered in Kabale Municipality has changed since the introduction of decentralization? Please give examples.
2. How effective are primary health careservices delivered in Kabale Municipality?
3. Do you think decentralization contributes towards this effectiveness in any way? Give examples.
4. Are the primary health care services delivered in Kabale Municipality with interpersonal relations? Give description of these interpersonal relations. Would you think these interpersonal relations link to decentralization in any way? Explain.
5. Do you encourage community participation in planning for primary health care services usually? In your view, is decentralized planning effective in improving the quality of health services in Kabale Municipality? (Give attention to quality, adequacy and sustainability)
6. How would do you rate the effectiveness of primary health care (in aspects of access, effectiveness, interpersonal relations) in Kabale Municipality Justify this rate given.
7. What challengesdo you face in implimentingprimary health care services?
8. What can be done to solve the challenges in Kabale Municipality?

Appendix D: Documentary Review Checklist

The following documents were reviewed during data collection;

1) LG Act: Section 35 of the Local Government Act Cap 243, Amendment (2010),

2) Kabale Municipality Auditor reports for Financial Year (2014/15).

3) Kabale Municipality Auditor reports for Financial Year (2015/16).

4) Kabale Municipality Strategic Development Plan (2015/2016-2019/2020)

5) Constitution of the Republic of Uganda (1995)

6) Local Government Finance Accounting Regulations (1998)

7) Workplan Revenues and Expenditures by source, 2018/2019

8) Kabale Municipality Health report 2017

9) Kabale District Response Initiative on HIV/AIDS Action Research report.

10) Kabale Municipality Local Government Quarterly Performance Report for Financial Year 2018/2019)

11) Ministry of Health Annual Health Sector Performance Report Financial Year 2018/2019,

12) Kabale Municipality revenue reports, peer reviewed report on financial reports and

Appendix E: Krejcie and Morgan Table of Sample Size Determination

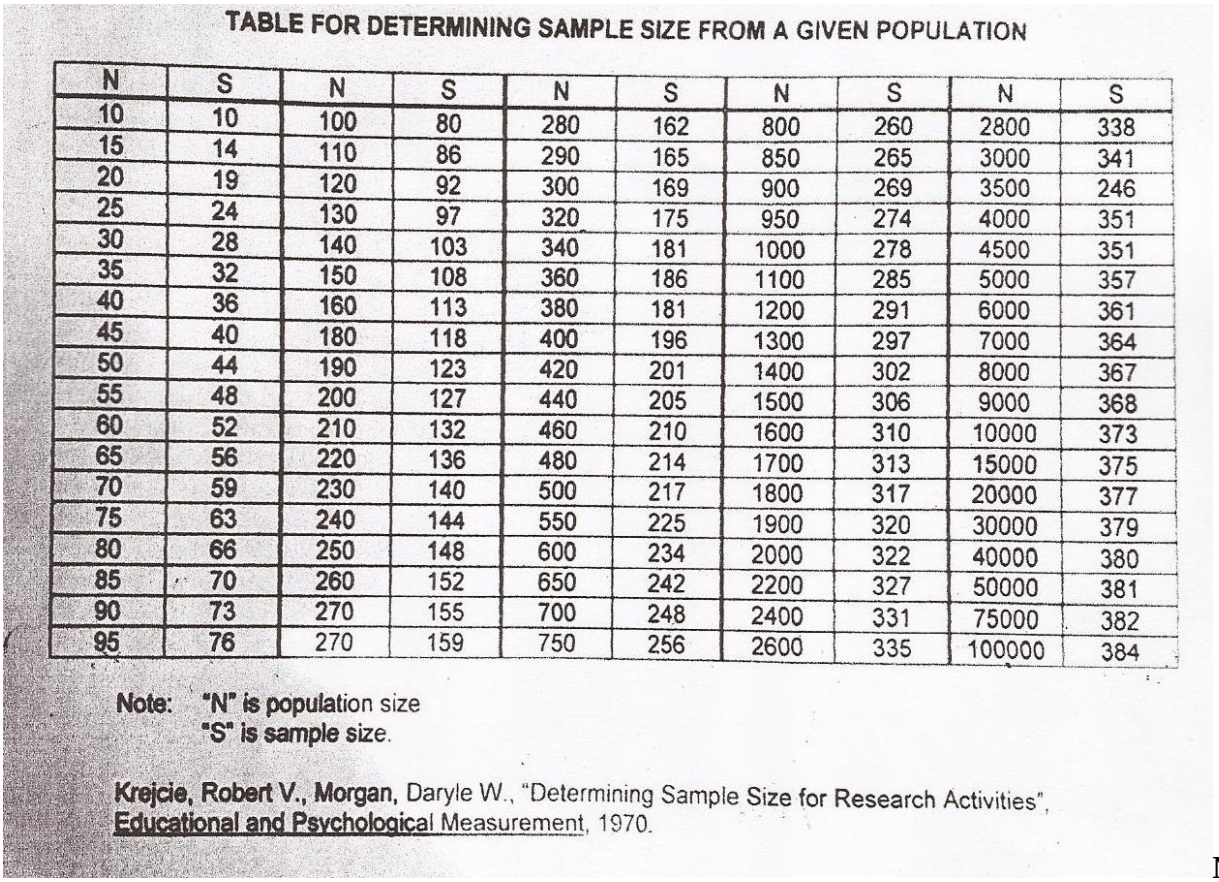

TABLE FOR DETERMINING SAMPLE SIZE FROM A GIVEN POPULATION

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Note: "N" is population size
"S" is sample size.

Krejcie, Robert V., Morgan, Daryle W., "Determining Sample Size for Research Activities", Educational and Psychological Measurement, 1970.

Note: "N" is the population size

"S" is the sample size