DECENTRALIZATION AND PUBLIC HEALTH SERVICES DELIVERY IN KABALE MUNICIPALITY, KABALE DISTRICT, UGANDA

BY

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A RESEARCH DISSERTATION SUBMITTED TO THE DEPARTMENT OF POSTGRADUATE STUDIES OF KABALE UNIVERSITY AS PARTIAL FULFILMENT FOR THE REQUIREMENTS FOR THE AWARD OF A MASTER'S DEGREE IN PUBLIC ADMINISTRATION AND MANAGEMENT OF KABALE UNIVERSITY

MAY, 2022

DECLARATION

I declare that the information in this research dissertation titled *"Decentralization and Public Health Services Delivery: A case of Kabale Municipality, Kabale District, Uganda"*, except where due reference has been made, is my original work and has never been submitted to any other University/Institution of higher learning for any academic award.

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APPROVAL

The Research Dissertation titled *"Decentralization and Public Health Services Delivery: A case of Kabale Municipality, Kabale District, Uganda"*, has been under my guidance and supervision.

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DEDICATION

I dedicate this research dissertation to my wife, Mrs. Pamela Mubangizi, children Trinah and Mark, and my mother, Mrs. Juliet Tumwine.

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ABBREVIATIONS

ADDLD	Africa Day for Decentralization and Local Development
BFP	Budget Framework Paper
BMUs	Beach Management Units
CAO	Chief Administrative Officer
DDEG	District Development Equalization Grant
DEC	District Executive Committee
FDS	Fiscal Decentralization Strategy
FGD	Focus Group Discussion
FY	Financial Year
GoU	Government of Uganda
IFMIS	Integrated Financial Management Information System
KAP	Knowledge, Attitudes and Practices
LED	Local Economic Development
LGA	Local Governments Act
LGSIP	Local Government Sector Investment Plan
LGSSP	Local Government Sector Strategic Plan
LST	Local Service Tax
MDAs	Ministries, Departments and Agencies
MoFPED	Ministry of Finance Planning and Economic Development
MoLG	Ministry of Local Government
NDP	National Development Plan
NGOs	Non-Governmental Organizations
NPA	National Planning Authority
OPM	Office of the Prime Minister
PBC	Performance-based contracting
PFM	Public Financial Management
PPP	Public Private Partnership

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ABSTRACT

This study examined the relationship between decentralization and public health service delivery in Kabale Municipality, Kabale District, Uganda. The objectives of the study were: To establish the relationship between political decentralization and public health service delivery; To determine the relationship between fiscal decentralization and public health service delivery; and, To establish the relationship between administrative decentralization and public health service delivery. A cross-sectional research design was used and both quantitative and qualitative approaches were employed where questionnaire, interviews and observation methods were used. Self-administered questionnaire and interview guide were employed as data collection tools on a sample size of 144 respondents that was determined from a target population of 225 using Yamane's formula of sample size determination. Simple random sampling and purposive sampling techniques were used in selecting respondents. In addition, observation method by use of observation checklist as a data collection tool was also used to supplement on the questionnaire and interview methods. Pearson product moment correlation coefficient was used to test the hypotheses and the study findings revealed a significant relationship between the three decentralization dimensions and public health service delivery. It was therefore concluded that there is a positive significant relationship between political decentralization and public health service delivery, positive significant relationship between fiscal decentralization and public health service delivery and a positive significant relationship between administrative decentralization and public health service delivery in Kabale Municipality. The study recommended that there should be improvement in political decentralization, fiscal decentralization and administrative decentralization through embracing citizen participation in decision making by ensuring public hearings and consultation system and involving them in the budget preparation process; finding out more revenue generating opportunities to widen the tax bases by encouraging entrepreneurial spirit and embracing the qualities of good governance like transparency, responsiveness, and rule of law, accountability, equity and inclusiveness; appreciation of the whistle blowers in the management, regular monitoring and evaluation of Kabale Municipality operations by the responsible Local Government officials and the Central Government should regularly demand for accountability from the Town Council on its performance to instil a sense of seriousness and proper allocation of the funds, proper utilization of the disbursed drugs and other health equipment of machines assigned to it to facilitate in health related operations. This study focused on decentralization in terms of (political, fiscal and administrative) and how the trio relate to public health service delivery. A further study may be carried out to examine the relationship between decentralization and public education service delivery in Kabale Municipality. A similar study may be carried out in other Municipal Councils in the country especially in Eastern and Northern Uganda. More research may also be carried out to investigate the influence of locally generated funds on public health service delivery in the Local Governments of Uganda.

CHAPTER ONE

INTRODUCTION

1.0 Introduction to the Study

Since the introduction of the Decentralization strategy in 1993, one of the governments' health programme initiatives in Uganda has been to provide efficient and effective services, particularly health care. This was done with the intention of delivering appropriate, basic, and inexpensive health services to local communities and within the jurisdiction of local governments. However, little progress has been made in terms of improving community health through local government delivery of public health services. As a result, the focus of this study was on decentralization and health service delivery. This chapter discusses the study's background, problem statement, purpose, specific objectives, hypotheses, scope, and importance.

1.1 Background to the Study

This background is categorized into four perspectives, namely: historical, theoretical, conceptual and contextual perspective.

1.1.1 Historical Perspective

Most African countries have explored decentralization of duties and responsibilities such as planning, policy formation, and execution to lower units and levels of government in the previous two decades. Decentralization began in Uganda on October 2, 1992, following a major presidential policy pronouncement (Nsibambi, 1998).

"The search for effective governance and democratic decentralization administration across the country began in When the National Resistance Movement (NRM) won power in 1986, control and began implementing ideas created and developed during the war," according to Nsibambi (Nsibambi, 1998:1). Following extensive engagement with a variety of stakeholders and individuals, the government published the Constitution of 1995 which says: "All persons shall have access to leadership posts at all levels, pursuant to the constitution," declares National Objectives and Directive Principles of State Policy II (ii). (Uganda's Government, 1995: 2)

Following the passage of Uganda's 1995 Constitution, Parliament wrote, debated, and approved the Local Government Act (1997), which defined the relationship between the

central government and the districts (Government of Uganda, 1997). This Act outlined Uganda's decentralization policy, which aimed to: Transfer actual power to local governments, thereby reducing the workload of Uganda's remote and under-resourced central officials; Transfer service delivery to local communities to increase efficiency and accountability, as well as to foster a sense of community ownership (political, managerial, and administrative) of local government programmes and initiatives. Local government managers should be free of central government limitations, allowing them to build organizational structures that are adapted to the needs of their communities.

Almost a half of the inhabitants in Sub-Saharan Africa live on less than $1.50 per day. $1 per day, adjusted for purchasing power, makes individuals in poor countries like Ghana, Kenya, South Sudan, and the Democratic Republic of the Congo especially vulnerable to disease (World Bank, 2003). Extremely poor people do not have access to safe drinking water, decent housing, proper sanitation, food, education, professional health care, transportation, safe and secure employment, or health information. Inequities in health status are exacerbated by disparities in health care spending, research investment, capacity building, and access to technology and information (WHO, 2000).

In terms of health care, Preventable and treatable diseases, as well as delivery impose a huge toll on the planet. Vaccine-preventable diseases kill at least 300 people per 1000 people each year, according to estimates (Global Alliance on Vaccines and Immunizations, 2003). Furthermore, the divide between affluent and poor countries appears to be widening. For example, between 1970 and 2000, the mortality rate of children under the age of five fell by more than 70% in high-income countries.

According to Baker and Gosh (1994), in Uganda, there are gaps in access to health services, with the poorer regions and families bearing the brunt of the burden. Based on documented discrepancies in health-care benefits among Uganda's communities, the central government would play a prominent role in financing and regulating health-care delivery, and, when practicable, utilize targeting tactics to focus greater attention and health-care benefits towards the poor. The most important aspects of a health-care system's quality are often identified as effectiveness, accessibility, equitability, human relations, continuity, and the availability of facilities. The necessity to offer inexpensive health care services to all residents, particularly the poorest and most vulnerable, is a popular reason for government participation. There was

therefore an interest in this study, to establish how equity, fairness, affordability and accessibility matters have been addressed by health care service delivery in a decentralized framework.

Quality management for a health care service provider means that he or she has the skills, resources, and environment necessary to enhance the health status of communities in accordance with current technical standards and available resources. Technical expertise, effectiveness, and safety are commonly prioritized by service providers.

Both service providers and beneficiaries have wants and demands that must be met through health management. They must also be good stewards of the resources that have been given to them by the government, the business sector, and the society (Government of Uganda, 1995). Health management must consider the need of multiple beneficiaries in addressing questions about resource allocation, fee schedules, staffing patterns and management practices. The multi-dimensional concept of quality is particularly helpful in a social service sector such as health, where access, effectiveness, technical competence, equity and efficiency are the most important dimensions of quality in health care service provision (Government of Uganda, 1997).

Uganda's health care delivery system has been overhauled and reconfigured to improve performance at all levels, particularly in Kabale. The key objectives are to build a system that is efficient and effective enough to handle the government's present reform activities. ACODE (2018).

In terms of local jurisdictions, duties for Central Government and Local Government have been specified under the new Constitution (1995) and Local Government Act (1997). (Government of Uganda, 1997).

Under a decentralized framework, districts and sub-districts (local jurisdictions) prepare their own yearly work plans, human resource recruiting and management of staff for health care services, passing health bylaws, and planning and resource mobilization and allocation for health care services are all things they have control over.

The local jurisdiction council, through the local jurisdiction health committee, is in charge of the framework for managing health services in local jurisdictions. The Principal Health Inspector leads the local jurisdiction's health management staff. The health inspectors and section chiefs make up this group.

1.1.2 Theoretical Perspective

The Sequential Theory of Decentralization drove this research, which looked into the link between decentralization and health service delivery. he researcher bases his findings on Falleti's sequential theory of decentralization, which follows a succession of governmental reforms (2004). Depending on the sort of authority devolved, Falleti (2004) divides decentralization policies into three categories: administrative, fiscal, and political.

The researcher used the sequential theory of decentralization in this dissertation, which is based on a set of state changes presented by Falleti (2004). Depending on the sort of authority devolved, Falleti (2004) divides decentralization policies into three categories: administrative, fiscal, and political. Administrative decentralization is a collection of policies that transfers the administration and delivery of social services to sub-national governments, such as education, health, social welfare, and housing.

Under Decentralization, according to this notion, subnational governments will have more power as a result of this. However, a closer look at the effects of decentralization in different countries demonstrates that the scale of change can range from major to negligible. It has three distinct features: It does it in three ways: (1) it defines decentralization as a process, (2) it considers negotiating players' territorial interests, and (3) it adds policy feedback effects. It claims that the order in which different types of decentralization (fiscal, administrative, and political) are implemented is a critical factor in the evolution of the intergovernmental power balance. It was used in the two extreme situations to measure this evolution in the four main Latin American countries (Colombia and Argentina). It is shown that contrary to popular belief, decentralization does not necessarily boost governors' and mayors' influence.

As a result, the researcher believed that decentralization through Administrative, Fiscal, and Political decentralization could work as key factors in improving public health service delivery in Kabale Municipality, Kabale District, and that improved decentralization in Local Government organizations as per this theory would mark improved health service delivery in Kabale Municipality, Kabale District.

1.1.3 Conceptual Perspective

Decentralization and public health service delivery are two of the study's main topics.

Decentralization, according to Agrawal (2001) as referenced by Falleti (2004), in the context of a certain type of state, is a process of state reform characterized by a collection of public policies that move responsibilities, resources, or authority from higher to lower levels of

government. Decentralization can be territorial, functional, or institutional, according to Ribot (2004), depending on the geographical demarcation, the scope of functions delegated, and the method decision-makers are recruited.

Fiscal decentralization, according to Ribot (2004), is a collection of policies aimed at increasing the revenues or fiscal autonomy of sub-national governments. As a result, fiscal decentralization is the public finance dimension of decentralization in general, outlining how and where expenditures and revenues are distributed between and across different levels of government in a national polity.

Depending on how sub-national government and administration are formed, the nature of intergovernmental fiscal interactions and fiscal decentralization strategy in any particular country differs (Agrawal, Agrawal, Agrawal , (2004).

Political decentralization refers to a reduction in national governments' policy-making authority. This is accomplished by the implementation of reforms that either delegate a certain level of real decision-making authority to subnational tiers of government or provide citizens the ability to elect lower-level officials, such as local or regional representatives.
Citizen engagement and domestic accountability was used to operationalize political decentralization.
The transfer of administrative, fiscal, and political authorities and functions of public service delivery to elected local governments is known as citizen involvement (Rondinelli, 2011., Azfar et al., 2009., Robinson, 2015).

Domestic accountability involves the relationship between the Local Government units and its citizens (people) and the extent to which the Local Government unit is answerable for its actions to its citizens.

Administrative decentralization refers to a set of policies that entrust sub-national governments with the administration and delivery of social services such as education, health, social welfare, and housing (Falleti, 2004).

Delegation and Deconcentration are used to operationalize administrative decentralization in this study.

Deconcentration is typically regarded as the least efficient kind of decentralization, and it is most frequently used in unitary systems.

— redistributes decision-making authority, as well as budgetary and administration responsibilities, throughout the federal government's numerous levels. It can simply transfer responsibilities from central government officials in the capital city to those in regions, provinces, or districts, or it can build strong field administration or local administrative capability under the supervision of central government departments (Falleti, 2010).

Delegation is a type of decentralization that is more extensive. Central governments delegate decision-making and administration of public tasks to semi-autonomous institutions that are not fully controlled by the central government but are ultimately accountable to it through delegation. When governments establish public enterprises or companies, housing authorities, transportation authorities, special service districts, semi-autonomous school districts, regional development corporations, or special project implementation units, they delegate tasks to these entities. In most cases, these institutions have a lot of latitude when it comes to making decisions. They may be immune from the same restrictions that apply to normal civil servants, and they may be permitted to charge users directly for services (Postponement, 2016).

Public health service delivery, the study's other variable, is defined as the provision of health-related products and services to all people (Kotler, 2002). According to Mutabwire (2013), health service delivery relates to the interaction of policymakers, service providers, and service users, and includes both services and their supporting systems. Shenghelia (2003) defines service accessibility as a wide term with many dimensions: complete measurement of access necessitates a systematic assessment of people's ability to use health care on physical, economic, and socio-psychological levels. Shenghelia (2003) defines availability as a component of comprehensiveness that refers to the actual existence or delivery of services that meet a set of basic requirements. However, according to Van (2004), it is defined as citizens' perceptions of the quality of the government's goods and services.

1.1.4 Contextual Perspective

In the context of this investigation, although much progress has been made in Kabale Municipality in several sectors of life, including health service delivery, there is still a long way to go. However, in terms of health service delivery, the municipality continues to lag

behind. Most municipal health centres, for example, lack current technology such as blood count machines, computed tomography (CT) scan machines, and insufficient patient beds, among other things, all of which have had a substantial impact on the delivery of health services to the public (KDLG, 2017).

The failure of local government authorities to provide effective and efficient public health services in all three division areas within Kabale Municipality has raised the question of whether decentralization can help the country overcome its development challenges and achieve the Millennium Development Goals (MDGs) by 2030 through health infrastructure development. This study uses the Kabale Municipality as a case study to investigate the relationship between decentralization and the delivery of public health services.

1.2 Problem Statement

To promote enhanced fair access to public services, timely delivery, service availability, citizen happiness, and adequate services, Uganda's government implemented a decentralized governance system (Economic Policy Research Centre, 2010). Despite the above adoption, the nature of health service delivery in Kabale Municipality remains below the intentions of decentralization, with observable records showing limited access to health services, dissatisfied citizens, a limited number of health workers, with the few available at times off the job, stock outs of medicines, and delayed service delivery (Kabale, Uganda Health Analysis Report, 2017-2018; Auditor General's Report, 2018). It is also said that the sole prominent Kabale Regional Referral Hospital lacks enough competent doctors and nurses, as well as the bulk of necessary medical equipment, and that decentralization efforts in Kabale Municipality are ineffective. This has hampered the efficient and effective delivery of health care, and unless something is done, the government's goal of decentralization to better public service delivery will not be realized, and voters may lose faith in the current government. As a result, the purpose of this research was to look into the relationship between decentralization and public health care delivery in Kabale Municipality.

1.3 Objectives of the Study

1.3.1 General Objective

To examine the effect of Decentralization on public health services delivery in Kabale Municipality

1.3.2 Specific Objectives

Specific objectives of the study were:

i. To examine the effect of Administrative decentralization on public health services delivery in Kabale Municipality;
ii. To establish the effect of Fiscal decentralization on public health services delivery in Kabale Municipality;
iii. To investigate the effect of Political decentralization on public health services delivery in Kabale Municipality.

1.4 Research Hypotheses

The following null hypotheses were posed towards achieving objectives of the study

i. **$H0_1$**.There is no significant relationship between Administrative decentralization and public health services delivery in Kabale Municipality.
ii. **$H0_2$.** There is no significant relationship between Fiscal decentralization and public health service delivery in Kabale Municipality.
iii. **$H0_3$.** There is no significant relationship between Political decentralization and public health service delivery in Kabale Municipality.

1.5 Scope of the study

1.5.1 Content Scope

The study focused on decentralization and its effect on public health service delivery. The sub-variables of decentralization included administrative decentralization, fiscal decentralization, and political decentralization by determining their contribution to public service delivery in terms of adequacy, accessibility, timeliness, availability of health equipment.

1.5.2 Geographical Scope

The study was limited to Kabale Municipality. Kabale Municipality is located in Kabale District which is in Western Uganda. The study was limited to this area because it had sufficient data related to the topic of the study to enable the researcher conduct his research.

1.5.3 Time Scope

This study focused on the years 2009 to 2019, because this is when Kabale Municipality's health service performance did not improve as projected, despite the new Government decentralization system (The KRRH Report, 2020).

1.6 Justification of the Study

Since the introduction of the Decentralization strategy in 1993, one of the governments' health programme initiatives in Uganda has been to provide efficient and effective services, particularly health care. This was done with the intention of delivering appropriate, basic, and inexpensive health services to local communities and within the jurisdiction of local governments. However, little progress has been made in terms of improving community health through local government delivery of public health services. This could be due to the fact that decentralization has not been properly established or utilized in the way it is supposed to be or planned to reach its intended results. As a result, a study on decentralization and public health service delivery in Kabale Municipality was required to establish the extent to which public health service delivery had been achieved as a result of the Decentralization policy, as well as the problems that had been encountered.

1.7 Significance of the Study

This study would enable the central Government and the management of Kabale Municipality to determine the effect of decentralization to public health service delivery. It would also help the district management committee to understand what decentralization practices should be mainly focused on to enhance public health service delivery and contribute to meeting the National Development Goals.

There could be a number of academicians, organizations and researchers who would like to know what decentralization constructs are available in Kabale Municipality and how they relate to public health service delivery which is on a high demand by the citizens.

The study may also guide the Ministry of Health on how to come up with effective policies that can improve on health service delivery across Local Governments without necessarily focusing on decentralization.

The successful execution of this study would enable the researcher to be awarded a Master's Degree in Public Administration and Management of Kabale University.

1.9 Definition of operational term.

Decentralization: This refers to the delegation of decision-making and implementation authority to lower administrative levels in order to increase efficiency and effectiveness (Faguet is a French novelist, 2012).

Administrative decentralization: This means the transfer of responsibility for planning, financing and managing of certain public functions from the central Government and its agencies to field units of Government agencies (Kahkonen, & Lanyi, 2001).

Fiscal decentralization: This simply refers to the transferred expenditure responsibilities and revenue assignments from the central Government to lower levels of Government (Faguet, 2012).

Political decentralization: Allows enterprises, community groups, cooperatives, private voluntary organisations, and other non-government entities to perform services that were formerly solely or mostly the responsibility of government (Egbenya, 2009).

Health: A state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity (Faguet, 2016).

Service Delivery: The act of supplying a client with a service (Chave, 1984).

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter analyses existing literature and insights of other scholars about decentralization and health services delivery under themes of the study that reflect the objectives. Literature review provides a conceptual framework, theoretical framework and a review of related studies. The literature available was mainly drawn from textbooks, research paper reports and internet sources.

2.1 Theoretical Review

The Sequential Theory of Decentralization drove this research which looked into the relationship between decentralization and public health care delivery. Falleti's (2005) Sequential Theory of Decentralization was used as the guiding paradigm for discussing the curves and conducting the research. Decentralization is a notion that refers to a set of state changes that solely involve state actors from the top down, from the federal government to the local government (Falleti, 2005). In line with this, Falleti, a proponent of the sequential theory of decentralization, claims that the order in which various types of decentralization, such as fiscal, administrative and political decentralization occur is a key determinant of the development of the Inter-Governmental balance of powers. The theory's analysis shows that the three dimensions of decentralization are interdependent, and that all three must be operational for decentralization to produce the desired outcomes, namely public health service delivery in terms of accessibility of health equipment, timely service delivery, and availability of health services.

Decentralization, coupled with expenditure and fiscal arrangements, should be adopted to assure service delivery and the exercise of delegated functions in general, according to the notion (Falleti, 2005). Function, finance, and functionaries must all be correctly sequenced. Despite rival theories such as the Principal Agent theory, the theory is pertinent to this study because it was developed by the first scholars to clearly propose and begin developing a theory of Principle and Agency. Odeke (2014) employed the agency principle to explain the influence of local development funds administration on service delivery in local government, as well as the Public-choice theory, which posits that decentralization improves service delivery, and as a mode of governance will enhance speedy delivery of social services used by Mutumba

(2005) in The resource dependency theory, which posits that power is based on control of resources that are considered strategic within the organization and is often expressed in terms of budget and resource allocation, explains the effect of decentralization on the performance of district personnel in Uganda (Pedersen, 2007).

The study used sequence theory to confirm the presence of decentralization and its link with public health service delivery, as well as determine which decentralization feature makes a significant contribution to public health service delivery. However, this hypothesis ignores the social, religious, and environmental variables that have been demonstrated to be present in every decentralized state. Theoretically, decentralization is linked to increased citizen satisfaction because services are delivered in accordance with citizens' needs, service adequacy due to proper planning and budgeting for local needs, and improved service accessibility and timely delivery through the creation of a variety of health systems starting from Village Health Teams (VHTs) to referral hospitals (Batley & Larbi, 2004).

Decentralization, coupled with expenditure and fiscal arrangements, was discovered to be necessary to assure health care delivery and the exercise of devolved authorities (economic powers) in general. Function, finance, and functionaries must all be correctly sequenced.

As a result, it was hypothesized in this study that decentralization through administrative, fiscal, and political decentralization could work as key factors in enabling the government to improve public health service delivery, and the researcher believes that improved decentralization in Local Government organizations, as per this theory, will result in improved health service delivery.

2.2 Conceptual Framework

The study was guided by the conceptual framework below, which depicts the link between decentralization and the delivery of public health services. In research, the framework is intended to identify potential courses of action or recommended approaches to the research topic (Mugenda & Mugenda, 2003).

Fig 2.2: Conceptual framework on Decentralization and Health services Delivery

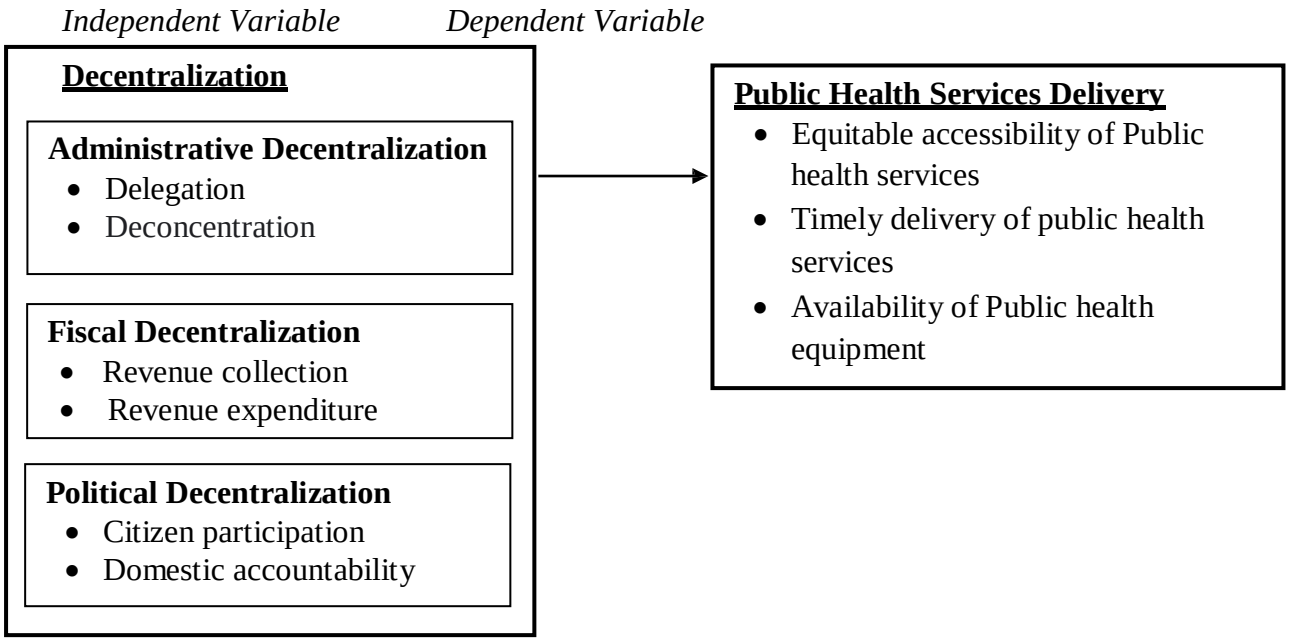


Fig 2.2: *Conceptual framework indicating interplay between Decentralization and Public Health services Delivery.*

Source: Researcher using ideas of Falleti (2005); World Bank (2000).

Figure 2.2 displays the apparent relationship between decentralization and public health care delivery in Kabale Municipality. Administrative decentralization (delegation and deconcentration), fiscal decentralization (revenue collection and revenue expenditure), and political decentralization (citizen participation and domestic accountability) are all conceptualized to have a significant effect on public health service delivery measured in terms of the independent variable (equitable accessibility, timely delivery and availability of health equipment). The study concludes that the government's ability to decentralize services at the municipal level will have a substantial impact on public health service delivery, and the opposite is true.

2.3 Empirical Review

It is worth noting that actual information on the impact of decentralization is scarce and contradictory. There has been little empirical study on the concept that decentralization improves government service responsiveness to demand in developing nations. The majority of the research available focuses on the influence of decentralization on budget allocation or the impact of public services delivered, rather than whether health care matches local demand (Mwangi, 2005).

Uganda is one of the countries that has decentralized government in order to provide better public health services to its citizens. Most services are delivered by local government, according to the Local Government Act of 1997. The goal was to ensure that service delivery was responsive to local needs and that the limited resources available were used efficiently and effectively.(Mwangi, 2005).

Decentralization, according to some authors, resulted in overall improvements in service delivery in Uganda (Kator, 1997). Others, though, suggest otherwise.

"One critical difficulty with decentralization is that public health service delivery has yet to improve significantly" (Saito, 2000). He does, however, ascribe the problem to a perception gap, as health-care staff notice certain changes while patients do not. "Financial and institutional constraints have significantly damaged the ability of sub-national governments to adequately supply public health services of appropriate quality", Obwona et al. (2000) find. The results of executing a decentralization programme and its implications on public health service delivery have been mixed; improvements in health services have been achieved as a result of central government direction rather than local government initiative. This is due to the fact that funding is controlled by numbers. In truth, the Ugandan experience contains all of the aforementioned flaws and obstacles (see Livingstone and Charlton, 2001; Takahebwa, 1998).

This study therefore focused on decentralization and health service delivery in Kabale Municipality, Kabale District, Uganda.

2.4Administrative decentralization and public health service delivery

Administrative decentralization, according to Fan, Lin, and Treisman (2009), is the transfer of planning, financing, and control of certain government services from central agencies to field units, subordinate units, or levels of government. Decentralization is especially common in the delivery and management of social services to the general public, such as health care.

Deconcentration, devolution, delegation, and privatization are the four subcategories of administrative decentralization. Devolution is thought to be the most effective way to speed up the decentralization process and achieve its goals in terms of public service delivery. It entails the government delegating functions and transferring decision-making, financial, and management authority to quasi-autonomous Local Government units with corporate status. These quasi-autonomous subdivisions of Local Governments will be better able to administratively respond to the requirements of the communities as a result of this.

A Local Government entity with corporate standing and the authority to acquire its own resources has the power to decide on public priorities and the autonomy to respond to the demands of local inhabitants (Ferlie & Steane, 2002). They go on to say that a Local Government unit with corporate status has the administrative competence to provide improved public health services to citizens since local officials are closest to the people and understand their requirements as well as the environment.

Administrative decentralization, according to the World Bank (2004), is a more comprehensive transfer of administrative decision-making power to sub-national authorities, granting them legal decision-making authority as well as the ability to create and govern resources, particularly financial resources, hiring and firing sub-national public sector employees, career management, and pay. Furthermore, it often gives local governments the ability to reallocate resources (including personnel) across service sites within their jurisdiction in response to changing conditions. Nonetheless, some central principles must frequently be followed, primarily in order to achieve national objectives in areas such as improving health service delivery.

The Government of Uganda has initiated a number of measures, according to Yawe and Kavuma (2008), to ensure that communities are empowered to take responsibility for their own health and well-being, and to participate actively in the management of their local health services for general health service improvement. These include developed guidelines for community capacity building for effective participation in resource mobilization and monitoring of health activities, and health services and established the national health assembly with adequate representation from the district, civil society, donors and other key partners.

According to Steiner (2005), de-concentration increases the quality of service delivery since authorities at the sub-national level plan and deliver services while staying completely accountable to the appointing central office.

There may be different levels of citizen involvement, but local officials are subject to mandates from above, some of which may contradict the local population's wishes. However, according to Blunt and Turner (2007), de-concentration can meet citizen expectations by assuring resource distribution equity, resource allocation stability and consistency, and highly skilled workforce available to the local community.

Analysis of the movement of administrative power from the centre to the sub-national levels, according to Cohen and Morrison (2007), can be problematic. A wide range of factors must be considered, for example, there are a wide range of projects and functions in which sub-national governments collaborate with line ministries, making the work difficult. However, the quality of public health services can only be improved if staff are held accountable for the results of their activities.

Merino (2012) discovered that when Local Governments are given a range of powers and responsibilities, such as decision space on issues like service organization, hospital autonomy, civil service, access rules, and governance rules, corruption tendencies are minimized, a high level of accountability and transparency in the actions of local officials, and resources are advanced to the Local Governments, the existence of good governance means corruption tendencies are minimized, a high level of accountability and transparency in the actions of local officials, and the resources advanced to the Local Governments The discretion over personnel and decision-making power over facility structure are probably the two factors that have the most impact on how sub-national governments provide services. This suggests that the central government's power was transferred to local governments with the goal of increasing service delivery.

However, according to this study, the intended goal of improving service delivery, such as public health services, has not been achieved because citizens cannot access the services, citing Uganda (Kabale Municipal Council) as an example. As a result, this study sought to establish the relationship between administrative decentralization and public health services. Decentralized service provision, according to Acedo, Gorostiaga, and Senén González (2007), is intended to increase service quality and efficiency through enhanced governance

and resource allocation. According to the agency theory, the proximity of Local Governments helps residents to have more influence over local authorities, increases competition among Local Governments, lowers corruption, and improves accountability, among other things. Decentralization, however, may worsen outcomes, according to some experts, because local governments may lack the competence or incentives to operate as theory predicts.

Administrative decentralization, according to Omolo (2011), is meant to mitigate the disadvantages of excessive centralization, ensure public engagement in management, strike a balance between local services and local demands, and improve productivity or effectiveness in public service delivery. He also claims that delegation, in which the central government delegate service delivery responsibilities to semi-autonomous government agencies or non-state organizations that are fully accountable to the assigning ministry or department, necessitates the sub-national governments' ability to manage funds for efficient and effective service delivery; otherwise, administrative decentralization may not yield positive results in terms of public health service delivery.

Through devolution of tasks previously done by the central government to District Local Governments, administrative decentralization is a vital step in achieving the HSSP's systematic health care service provision objectives. Merino (2012) claims that administrative decentralization can improve public health care delivery by extending clear roles and responsibilities for public service delivery. This was created to enable stakeholders to participate in the planning and budgeting process, allowing clients to hold policymakers and service providers accountable for the quality of the services they deliver. However, despite the fact that administrative decentralization is intended to mitigate the disadvantages of excessive centralization and to ensure public participation in management, the level of citizen participation at the local level is not appealing, as service quality remains low in areas such as health, education, and roads, among others, necessitating the need to establish a link between administrative decentralization and public health service delivery.

2.5Fiscal decentralization and public health service delivery

Fiscal decentralization, according to Bird, Ebel, Wallich, and Otates (2015), consists of fiscal instruments and procedures that devolve fiscal responsibility to lower levels of government in accordance with their local demands and preferences aid in the delivery of public goods. Fiscal decentralization, according to Choi (2012), is defined as the transfer of income collection or expenditure authority from superior offices to subordinate offices for the

purpose of delivering suitable public services and enhancing citizens' welfare. Fiscal decentralization, according to Thiessen (2003), entails proper fiscal transfers from the federal government to local governments. According to him, substantial budgetary transfers enable Local Government units to deliver services that meet the requirements of citizens; however, this can only be accomplished if local authorities are accountable and accountability procedures are in place.

Fiscal decentralization, according to Raghabendra, Chattopadhyay, and Duflo (2001), includes the authority to determine the tax bases from which revenues can be collected at the local council level. They go on to say that having the authority to establish tax bases is not enough; there needs to be a variety of tax bases from which a specific Local Government unit can generate enough money. They go on to say that every local government entity with a diverse tax base can use the money gathered to improve public health care delivery.

According to ACODE (2010), a number of issues confronting health centres, such as inadequate funding for health care services and lack of transparency in the use of drugs and medicines, as well as a chronic shortage of trained workers, particularly at lower-tier health facilities, are among the factors limiting public health service delivery.

As a result, Health care services in rural areas are still inaccessible, and decentralization has not improved things. Where formal monitoring and supervisory methods are not allowed or enforced, and informal processes are insufficient, levels of performance monitoring emerge. This, crucially, comprises both top-down and bottom-up monitoring and oversight. More still in Uganda, for example, formal processes for monitoring and supervision are not followed across the chain of health service delivery.

Local governments in Uganda continue to operate at minimal staffing levels, some as low as 10% of the approved establishment due to limited funds, according to Onyach (2012) in a study on challenges in the implementation of fiscal decentralization and its effects on the health sector in Uganda. This has a direct impact on public health service delivery.

In their study on fiscal decentralization and health service delivery, Omar, Azfar, Satu, Livingston, Meagher, and Rutherford (2000) discovered that only 17% of health-care facility respondents said all of their personnel had the tools they needed to execute their jobs and that 83 percent did not have or had faulty equipment. A major barrier in rural districts like Abim, Kalangala, Kabong, Buvuma, and Bukwo is that some Local Governments, through the

economically focused District Service Commissions (DSC), have negative effects on service quality. According to Parasuraman, Zeithaml, and Berry (2014), a large proportion of local governments lack the managerial, administrative, budgetary, and institutional competence to satisfy the growing needs of their citizens. This situation is exacerbated by the decline between Local Government and tertiary sector. As a result, these Local Governments cannot meet their required performance standards, hence impacting adversely on health service delivery.

However, from this literature, the researcher determined the relationship between fiscal decentralization and health service delivery by concentrating on a single entity.

Faguet (2012) states that The most compelling case for decentralization is that it will improve local government accountability and responsiveness, increasing overall government efficiency through delivering high-quality services. It accomplishes this through modifying governance structures to provide individuals a stronger voice and create incentives for public officials to deliver services.

Decentralization is the fundamental strategy for enhanced service delivery since it increases the accountability and responsiveness of local governments, which in turn improves public services. Recent assessments of the influence of decentralization on service delivery back up this claim. These studies highlight its benefits, indicating that decentralized Local Governments provide higher-quality and more-quantitative public services. While the research indicates mixed results overall, the best quality studies demonstrate the most favourable impacts of decentralization, according to Channa and Faguet (2016) who ranked them according to their strength of evidence.

Martinez and Sacchi (2015) report similar findings, stating that decentralization through sub-national borrowing allows Local Governments to increase financial capacity to meet local needs in terms of health service delivery, but there are more mixed results in the health sector because more funding is required for effective execution of health activities, including evidence of negative effects of decentralization.

Local governments frequently have limited revenue bases and are reliant on fiscal transfers from the federal government, according to Gadenne and Singhal (2014). Sub-national governments raise roughly a third of overall income in rich countries, but only around 14 per cent of total revenues in poor countries. Sub-national governments in developing nations

relied on transfers to fund 62 per cent of their budgets on average in the late 2000s. The amount to which a Local Government is reliant on grants is defined not just by the revenue sources available to it, but also by its spending functions.

Local governments with limited obligations that require finances, such as fundamental municipal activities (e.g. rubbish collection, local roads, and fire protection and control), will only require a modest tax base to be self-financing, according to Bird (2011). When local governments also have substantial budget responsibilities, such as education and health, the situation is very different. Furthermore, inequities between local governments are almost unavoidable as a result of decentralization. Urban local governments with large tax bases are less likely to rely on transfers, whereas poor rural Local Governments are more likely to rely on transfers for the majority of their revenue. As a result, the goal of this research was to determine the impact of fiscal decentralization on public health service delivery and to examine the gaps in the findings of the previous scholars, whether it was due to a lack of financial support from the federal government or a lack of responsibilities such as basic municipal functions.

Local councils should be in charge of overseeing and authorizing annual plans from sector service managers at all levels of government, according to Kahkonen and Lanyi (2001). Fiscal decentralization has been suggested as an ideal technique to improve health service delivery since a Local Government unit with the capacity to decide tax rates can determine the tax bases on which tax is inelastic so that more revenues can be collected.

It has recently been recognized as a critical component of broader Local Government reforms aimed at improving equality, efficiency, quality, and financial stability. According to Batley and Larbi (2004), fiscal decentralization of service provision has resulted in the mandatory establishment of local councils at the state and municipal levels, as well as local access to national funds. These councils have come to play a key role in local politics, becoming important for participation, decision-making, and public accountability for the government's actions. This was in line with the Sequential Theory of Decentralization, which predicted that decentralization as a method of government will improve the pace with which social and public health services are delivered.

Similarly, Onyach (2012) argued that due to scale diseconomies, fiscal decentralization in the health sector is more complicated than in other sectors. He claims that these scale inequities deter sub-national governments from providing expensive curative care and vaccines.

Simultaneously, spillover effects, he claims, tend to hinder national provision of preventive health care, particularly immunization and epidemiological measures.

Furthermore, Lyon (2015) says that there is always some degree of local governments following central government priorities in using its spending authority to provide conditional grants for the purchase of equipment, pharmaceuticals, and the development of Health Centres for improved service supply, and he emphasizes that the establishment of a health budget that is adequate to meet the health needs of a local government unit creates improvements in public health service delivery.

In contrast to the foregoing, excessive central government involvement in local government decision-making biases the system toward centralized outcomes, despite the fact that the grants are designed to assist fiscal decentralized decision-making for health-care delivery. The relationship between fiscal decentralization and public health service delivery was crucial in this regard.

Okecho (2006), who conducted research on the challenges of decentralized health services, found that an examination of community involvement in the delivery of health care revealed that communities were involved in the delivery of decentralized health care to some extent through representation at every facility level in Uganda. Despite the existence of channels, they were frequently inefficient due to a lack of capacity, an insufficient flow of information, and the limited utility of health committees. Insufficient health budgets due to poor economic conditions, combined with expanding health problems such as the global HIV-AIDS epidemic, have resulted in drug and medical supply shortages, it was also found that the effective delivery of health services is being hampered, not forgetting inadequate or non-payment of health workers' salaries, poor quality of care, and inequitable health care.

In the light of the foregoing, various recommendations were made to the Ministry of Health, the Ministry of Local Government's Decentralization Secretariat, and the District's economic and administrative leaders, urging them to adequately fund the health sector and educate the "Wanainchi" and economic leaders about the decentralization policy. Despite such guidelines, the quality of Uganda's public health service delivery remains deficient.

In his research, he employed a case study research design, and this study used a mixed research design that combined qualitative and quantitative approaches. Purposive and simple random sampling were also utilized by the researcher, and this study included both probability and non-probability sampling approaches, as well as purposive and simple random sampling.

2.6 Political decentralization and public health service delivery

Political decentralization provides individuals more authority in public decision-making through their chosen leaders. It is frequently associated with a mixed environment and a representative government. The research suggests that policies governing service delivery at the sub-national level will be more informed and relevant to a wide range of societal interests than those enacted only by national political authorities. Khemani is a character in the film Khemani (2001).

More importantly, political decentralization may aid accountability, which is critical for better public health service delivery (World Bank, 2014). If local elected officials make policy decisions about health care that affect citizens, citizens can hold them accountable and vote them out of office in the next local election. However, most Local Government bodies, including Kabale Municipality, have found this ineffective, necessitating the creation of a link between political decentralization and public health service delivery.

According to Mugabi (2014), devolution and delegation of power to smaller Local Governments would promote community engagement in planning and hold local officials accountable for the quality of health services provided. This entailed delegating authority to improve public health care access, increase participation in decision-making, strengthen local capacity, and increase transparency and accountability.

Political decentralization increases system accountability and may improve health-care delivery. This could be due to the fact that residents have a way to provide feedback on local decision-making processes and hold local decision-makers responsible for their actions. In the context of a decentralized supply of health care, Mc Greevey (2010) believes that political decentralization is necessary to provide accountability and efficiency gains. He claims that educating people about the benefits of decentralization necessitates not only devolving financial and administrative tasks to lower levels of government, but also establishing electoral accountability. However, considering the state of public health service delivery in Kabale Municipality, it is still unclear whether this holds true.

In such circumstances, decentralization through devolution was frequently used, with power being devolved to local governments to provide for better community representation through elected officials and increased accountability of officials to the electorate for improving health service delivery (Khemani, 2004). As a result, politically motivated decentralization of the health system frequently occurred alongside decentralization of the public sector as a whole, sometimes as part of a broader national development agenda. In this aspect, the health sector may not have been a prominent player in decentralization decision-making and planning since political decisions to decentralize were taken outside the realm of the health sector at times, often requiring reluctant acquiescence of health sector supervisors.

Political decentralization, according to Ozmen (2014), is the most advantageous strategy to successful citizen participation in influencing local health service delivery through participation in the budget formulation process. It is the most extensive kind of decentralization since local governments have the ability to make choices and put them into effect within their jurisdiction.

These governments are expected to be horizontally accountable to elected politicians, upwardly accountable to the central government, and downwardly accountable to citizens who will assess their success in terms of service delivery. He goes on to say that the central government's actions affecting local governments must be clear in order for them to be directed rather than politicized.

Goetz (2012) further stressed that political decentralization increases local public awareness of local officials' operations, allowing citizens to monitor and evaluate officials' activities to ensure that they deliver health services that fulfil their requirements while also improving accountability.

Although budgetary and administrative decentralization are important, according to Smoke (2013), they cannot achieve the major aims of decentralization (better health service delivery in terms of accessibility, timeliness, and availability of services) without significant political transformation.

This is because political decentralization fosters quality collaboration between citizens and their representatives or local officials, he explains, and the occurrence of quality collaboration speeds up the process of delivering services that satisfy residents' requirements.

Smoke (2013) goes on to say that political decentralization can provide sub-national governments with enough knowledge to address the requests. This could be as a result of

local leaders being given clear and appropriate tasks and resources, as well as having proper official mechanisms and capability, but efficiency in this context is based on sub-national governments' ability to identify and respond to demands and preferences of local people better than the Central Government because of being familiar with the local information.

According to Schindler (2013), political decentralization can only be beneficial to health service delivery if local elections are free and fair. Such quality local elections allow citizens to empower a specific representative whom they believe will meet their expectations, and also allow elected officials to prioritize the electorates' interests over personal interests, which expand on health service delivery.

It is worth noting that decentralization usually entails a decline in sub-national governments' accountability to the central government. Local leaders may become primarily accountable to themselves and prominent local elites if this is not replaced by a degree of accountability to local people. This means that political decentralization increases the autonomy of sub-national executives, which can be tempered by local accountability.

Therefore, from the findings of these scholars, it was relevant to establish a link between political decentralization and the delivery of public health services.

2.7 Research Gaps

Roca (2011) carried out a study on the effect of decentralization on service delivery in government institutions. However research only focused on two dimensions of decentralization (political decentralization and fiscal decentralization) and left out another essential element of decentralization (economic decentralization).

Agyepong (1999) carried out a study on decentralization and health services delivery in Zambia and his findings indicated that decentralization has negative effect on public health service delivery. During decentralization and health sector reform, access to health care and customer satisfaction actually deteriorated. This research therefore was carried out to establish whether decentralization actually has an effect on public health service delivery in Kabale municipality by finding out the significance of the relationship between the two variables (decentralization) and (public health service delivery).

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter on methodology adopted for the study includes data collection and analysis methodologies, research design, study population, sampling strategy, and sample size.

3.1Research Design

The study was carried out using a cross-sectional research approach. The aforementioned research design was selected since it allowed the researcher to compare diverse factors. The association between decentralization and public health service delivery in Kabale Municipality, Kabale District, was investigated using both quantitative and qualitative methods.

3.2Target Population

Kabale municipality has a total population of 49,667 people (UBOS, 2014). This study considered a target population of 225 individuals comprising Kabale Municipal Council staff (35), Kabale Regional Referral Hospital staff (65), and selected citizens (daily health service users) (125) (KRRH, 2019; KDLG, 2016)

3.3Sample size and selection

Yamane's technique for sample size determination was utilized to come up with a sample size of 144 responders from the target population of 225.

Because each category of respondents plays a big role in establishing the relationship between decentralization and public health service delivery, the total sample size was drawn from the strata that the researcher established from the target population (Kabale Municipal Council staff, Kabale Regional Referral Hospital staff, and the selected service users) as illustrated in the sample frame in Table 3.3 below.

Table 3.3: Sample size selection and sampling technique

Category	Strata Target population	Population	Sample size	Sampling technique
Kabale Municipal Council Headquarters staff	Municipal Council Executive	5	5	Purposive sampling
	Other Town Council officials	30	14	Simple random sampling
Kabale Regional Referral Hospital staff	Top management staff	5	5	Purposive sampling
	Operational management staff	60	52	Simple Random sampling
Citizens (Public Service users/patients)	Selected public health Service users	125	68	Simple Random sampling
Total		**225**	**144**	

Source: *Primary data; 2021, Yamane, (1973)*

The sample size was determined by adopting Yamane's (1973) sample size selection approach. According to Yamane's formula, sample size is determined by:

$$n = \frac{N}{1+N\,(e)^2}$$

Where: n- is a sample size;

N- Is total population; and

e- Is tolerable error.

Given the total population of 225, and the margin of error of 5%, the sample size can be calculated as below.

$$n = \frac{225}{1 + 225 * (0.05)^2}$$

$$n = \frac{225}{1 + (225 * 0.0025)}$$

$$n = \frac{225}{1 + (0.5625)}$$

$$n = \frac{225}{1.5625}$$

$$\mathbf{n = 144}$$

3.3.1 Sampling Techniques

To recruit respondents for this study, the researcher employed both basic random sampling and selective sampling techniques.

Simple random sampling, according to Siegle (2004), is employed when each respondent has an equal probability of being chosen to participate in the study. Simple random sampling was used to choose participants for the study from among the operational management employees of Kabale Regional referral hospital, as well as public health service clients (citizens).

Because the population was small, and the cases in the strata possess crucial information due to their knowledge and experience about the subject under study, the purposive sampling technique was used to select key informants, who included Kabale Municipal Council Executives and top management staff at Kabale Regional Referral Hospital (Cohen & Morrison, 2007). This technique was used by picking the specific respondents who were considered to be more informed about issues under study because of their uniqueness in terms of experience and seniority.

3.4Data Collection Methods and Instruments

Owing to the research questions and objectives of this study, both qualitative and quantitative data was collected from both primary and secondary sources with the help of questionnaires and interviews.

3.4.1Data collection methods

Questionnaire survey

This method of data collection was used to collect data from sampled respondents. Questionnaire survey method of data collection was preferred because it is a simple, straightforward, cost-effective data collection method (Sekaran, 2004).

Observation

The researcher employed all of his senses to gain information about the phenomena under investigation in this data gathering strategy (Sekaran, 2004). Using this method, the researcher collected data on the presence of public health services such as a standby generator, admission wards and beds for admitted patients, the Health Centre's structures in good condition to the minimum standards of a health facility, waiting line, drug stock in store, presence of an ambulance, presence of health workers, presence of basic medical equipment, status of the theatre, Laboratory, and Reports.

Interviews

Interviews were conducted from key informants. These were Kabale District Local Government administrative workers. Questions were limited to decentralization and public health care delivery.

3.4.2 Data collection instruments

Self-Administered Questionnaire

A questionnaire, according to Denscombe (2000), is a properly developed instrument for gathering data in accordance with the specifications of the study questions and hypotheses. This strategy entailed asking respondents who can read and write questions in writing and checking relevant documents for more extensive yet succinct information on decentralization and public health care delivery in Kabale Municipality. The questions were filled out in such a way that most of them had options for which subjects to choose based on their preferences and understanding of the subject area. The questionnaires were semi-structured, with both open-ended and closed-ended items (Appendix I). Questionnaires were utilized in the study because they allowed the researchers to reach a large number of people in a short amount of time and provided accurate data because respondents answered the questions in their own mood, unaffected by the researcher's presence. After an agreed period with the respondents, the researcher collected completed questionnaires for coding and analysis.

Interview guide

To acquire qualitative data from key informants, an interview guide was used. These were Kabale District Local Government administrative workers; data was collected using an interview guide, and questions were limited to decentralization and public health care delivery. (See Appendix II.)

Observation checklist

In order to establish observable items such as health conditions in Kabale municipality, how various public health services had been decentralized, and how decentralization of public health services had benefited people in Kabale Municipality, an observation checklist was used to record observations as a Yes/No option. Without being instructed, the researcher was able to gather first-hand information about the study issue through observation.

3.5 Data Quality Control

3.5.1 Validity of Research Instruments

Validity refers to a research instrument's capacity to measure what is expected of it. A pilot research was conducted, and respondents were given questionnaires to see if the responses provided were appropriate for the topics posed and were not ambiguous. To evaluate the validity of the set questions in obtaining the anticipated findings, the researcher randomly selected 10 respondents from the study area. The researcher was able to confirm whether the prepared questionnaires are valid and reliable for data collection after the pilot test. Because the respondents were chosen for the pilot survey, the researcher verified that they would not participate in the final study. In the event that the questionnaires were discovered to be unreliable and valid, the researcher made the necessary adjustments in order to achieve the desired results.

To determine the authenticity of the content, a Content Validity Index (CVI) was calculated on Self-Administered Questionnaire and interview guide using the formula:

$$\text{Content Validity Index} = \frac{\text{Total number of items rated as valid}}{\text{Total number of items on the instrument}}$$

Content Validity Index computations

	Administrative Decentralization	Fiscal Decentralization	Political decentralization	Public Health service delivery
Number of items rated valid	09	09	07	08
Total number of items on the questionnaire	10	10	10	10

Source: Primary data, 2021

CVI for Administrative $\frac{09}{10} = \mathbf{0.9}$ CVI for Fiscal $\frac{09}{10} = \mathbf{0.9}$ CVI for Political $\frac{07}{10} = \mathbf{0.7}$

CVI for Public Health service delivery

$\frac{08}{10} = \mathbf{0.8}$

Average CVI = $\frac{(0.9 + 0.9 + 0.7 + 0.8)}{} = \frac{2.52}{} = \mathbf{0.825}$

4 4

According to Bakabbulindi (2004), a CVI of 0.7 or higher is considered valid for a data collection instrument. Since the computed CVI was 0.825 above 0.7, the items on the instruments were considered valid by researcher.

3.6.2 Reliability

Reliability refers to the degree to which a research instrument generates consistent results or data after multiple trials (Mugenda & Mugenda, 2012), The test-retest approach was used to determine the instrument's reliability.

Cronbach's Alpha Dependability Coefficient for Likert-Type Scales test was used to evaluate the reliability of quantitative data. Cronbach's alpha is a coefficient of reliability in statistics (Russell, 2011). It is widely employed as a measure of a psychometric test score's internal consistency or reliability for a group of examinees. The instrument was subjected to a pre-test in which ten people from the general public who were not part of the sample size were utilized to test the questionnaire's reliability.

Reliability Statistics

Cronbach's Alpha	N. of Items
.813	40

As it is revealed in the reliability statistics table above, the Cronbach's Alpha value was 0.813 which was above 0.75 and hence indicating that the instrument was reliable (Amin, 2005).

3.7 Data Collection Procedure

Before employing the research tools in the field, the researcher ensured that they were discussed with his supervisor. A note outlining the study's goal was attached to each data collection gadget. The respondents were guaranteed anonymity and secrecy, which encouraged them to be open and honest in their comments. The researcher also acquired permission and an introductory letter from the University administration, which he subsequently presented to the Kabale Municipal Council's authorities for consideration. To conduct the interviews, the researcher scheduled appointments with each respondent.

3.8 Data Processing, Analysis and Presentation

In order to process the data, it was edited, sorted, and coded in preparation for analysis. The data was structured using SPSS (Statistical Package for Social Sciences) version 21 for

Windows, which produced descriptive outputs in line with the study's aims. The use of descriptive statistics in the data analysis allowed for the creation of meaningful description and distribution of scores. The average scores (mean) were calculated using measures of central tendency in order to estimate the average number of responders per item in the questionnaire. The standard deviation, which was used to assess the divergence of scores from the mean in the distribution, was also useful. To examine the relationship between the independent (administrative decentralization, fiscal decentralization and political decentralization) and dependent (Public health service delivery) variables, at 0.05 level of significance Pearson's Correlation was used and this helped to measure the degree and direction of relationship between the variables. Values of correlation between +1.0 and -1.0 reflected positive or negative relationship and the value 0 reflected no relationship and the value obtained was compared with the critical value from the Pearson's correlation table (Amin, 2005; Shafer & Zhang, 2012).

3.9 Ethical Considerations

The ethics of research refers to the morals of the investigation or intervention in terms of minimizing abuse, disregard, and safety, as well as the social and psychological well-being of people, communities, and/or animals, i.e. how the principles of consent, beneficence, and justice are handled in the study. To address the ethical issues, the research proposal was first approved by the research ethics committee of Kabale University.

Furthermore, the researcher began by introducing himself and explicitly stating the topic of his research or study. Before the data gathering activity began, the respondents were given enough opportunity to ask the researcher questions. Within the confines of social conventions, all respondents were treated equally, regardless of gender, age, social rank, or educational attainment. The researcher protected the respondents' privacy by not using their identities and promising them that the information they provided would only be used for research purposes. Finally, informed consent was obtained, and no respondent was coerced into taking part in the study. Study participants were not compensated in any way for the information they gave.

3.10 Limitations of the study

Respondents were difficult to engage in the study due to Covid-19 difficulties. However, the researcher encouraged respondents to follow normal operating protocols outlined by the

Ministry of Health, such as wearing face masks, washing their hands with soap and water, using hand sanitizers, and social separation, among others.

The majority of respondents were skeptical of the survey, believing it to be a ruse to obtain information about the organization's operations. The researcher took a long time to explain to them that the purpose of this study was to help them understand how decentralization affects public health care delivery.

Non-response from respondents who were given questionnaires to fill out was a difficulty for the researcher. The researcher did tell the responders, however, that any information they provided would be treated with the utmost confidentiality.

The researcher also faced a language barrier, with some of the selected service users as respondents unable to communicate in English. This was overcome by translating the questionnaire from English to the local language for those who had difficulty, which was simple given that the researcher and research assistant spoke a variety of languages, including English, Rukiga, and Kifumbira.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

4.0 Introduction

The findings of a study concentrating on the relationship between decentralization and public health care delivery in Uganda, with Kabale Municipality as a case study, are presented in this chapter. The results are given in accordance with the study's aims and hypotheses. The study's specific objectives were to look into the impact of administrative decentralization on public health service delivery in Kabale Municipality, the impact of fiscal decentralization on public health service delivery in Kabale Municipality, and the impact of political decentralization on public health service delivery in Kabale Municipality. The response rate, background information, and empirical outcomes of the study are all included in this chapter.

4.1Response Rate

The target sample size of this study was 144 respondents who were examined through questionnaires and interviews as indicated in table 4.1 below.

Table 4.1: Response rate

Instrument	**Target sample (N)**	**Actual sample (N)**	**Response rate (%)**
Self-Administered Questionnaire	134	124	86.1
Interview guide	10	09	90
Total	**144**		**88.1**

Source: *Primary data, 2022*

Table 4.1 above shows that 88.1 percent of those who took part in the survey responded. The researcher distributed a total of 134 questionnaires to 134 respondents, and a total of 124 questionnaires were fully filled out and returned by the respondents, resulting in an 86.1 percent response rate. Out of a total of 10 interviews planned for 10 respondents, only 9 were actually conducted successfully, resulting in a 90 percent response rate, as shown in Table 4.1

above, which was a good representation to allow the researcher to continue with data analysis (2005), and thus this qualifies the study findings to be more reliable since the highest percentage of the expected participants actually participated in the study.

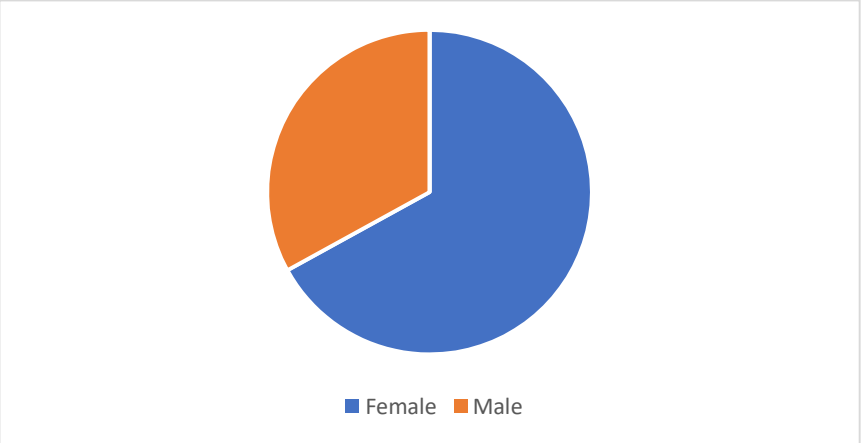
4.2 Background Information

Gender, age group, degree of education, place of work, length of service, and number of times respondents have ever used public health services as patients or patient's attendants were among the background data collected for this study. Such data was critical because it allowed researchers to have a better grasp of respondents' attitudes regarding problems like decentralization and public health service delivery.

4.2.1 Gender distribution

This section aims at establishing the gender of the respondents. A self-administered questionnaire was used to collect this data. The outcomes are shown in Figure 4.2.1 below.

Figure 4.2.1: Gender of the respondents



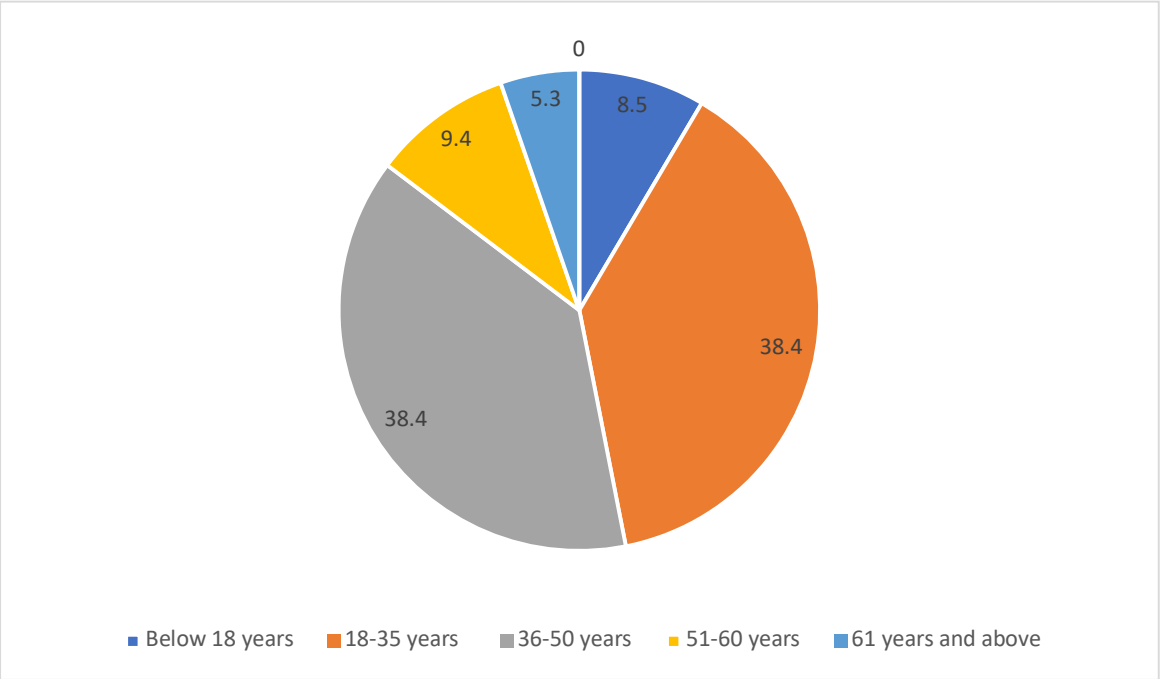
Source: *Primary data, 2021*

Figure 4.2.1 shows that 67 percent of the responders were females, whereas 33 percent were males. This conclusion implies that the study was gender-representative because both females and males were included, which reduced gender-based biases and variances. As a result, females in Kabale Municipality participated more in the delivery and reception of public health services than their male counterparts, despite the fact that they were the ones who most needed them.

4.2.2 Age distribution

Figure 4.2.2 below presents age distribution of respondents.

Figure 4.2.2: Age of the respondents



Source: *Primary data, 2021*

According to the findings in Figure 4.2.2, 38.4 percent of respondents in Kabale Municipality were between the ages of 18 and 35, and 36 and 50, respectively. Because the age group of respondents was considered mature enough to grasp and appreciate the challenges of decentralization and public health service delivery, this conclusion shows that the study was representative and reliable.

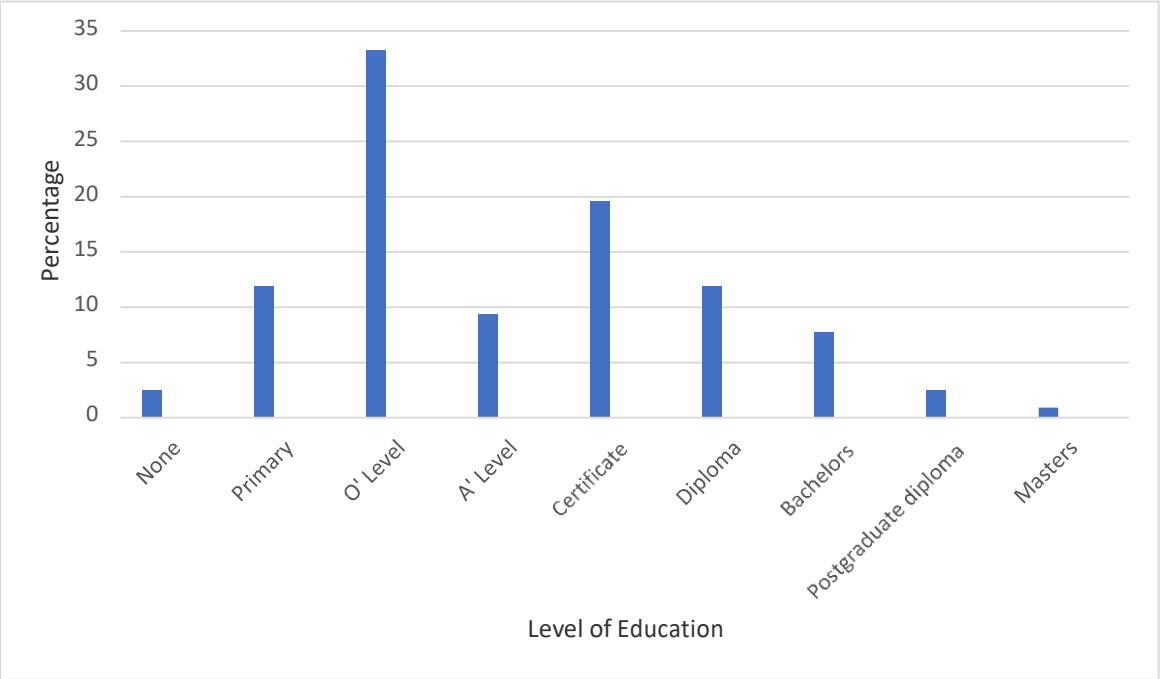
However, despite the fact that 9.4% of respondents were between the ages of 51 and 60, this group was essential since they were mature and had extensive knowledge of decentralization and public health service delivery.

As a result, if age was related to a person's comprehension of the factors under investigation, one might believe that the data presented was accurate and credible.

4.2.3 Highest Level of Education

This aimed at establishing the level of education distribution of the respondents. The findings are illustrated in Figure 4.2.3 below.

Figure 4.2.3: Highest Level of education of the respondents



Source*:* *Primary data, 2021*

Figure 4.2.3 indicates that 33.33 percent of respondents had completed O' Levels, 19.66 percent had a certificate, 7.7 percent had a bachelor's degree, 2.6 percent had postgraduate diplomas, and 0.855 percent had completed education up to Master's level. Although these were small percentages, they played an important role in determining the effect of decentralization on public health service delivery.

The findings indicate that the majority of the respondents in the study (85.4 percent) had at least completed O' Level education, implying that they were literate, capable of correctly interpreting questionnaires, and believed to have provided a reliable and valuable opinion on decentralization and public health service delivery. However, those respondents with the highest level of education were 2.6 percent, while 11.9 percent had at least completed primary school. This could have impacted on their understanding of the instruments administered, but the researcher ensured that such cases were addressed by using a literate research assistant who interpreted the questions in the local languages (Rukiga and Kifumbira) that the respondents best understood while answering the questions.

4.3 To examine the effect of administrative decentralization on public health service delivery in Kabale Municipality

The study's first goal was to look into the impact of administrative decentralization on the delivery of public health services in Kabale Municipality. This report summarizes the results of the above-mentioned objective. The size of the mean score indicates the level of administrative decentralization and public health service delivery in Kabale Municipality, as shown by that measuring indicator. SD=strongly disagreed=disagree=not sure, A=agree, and SA=strongly agree were utilized on a 5-Likert scale ranging from 1 to 5, with 1 representing strongly disagree and 5 representing strongly agree. 4.20-5.00 (very high); 3.4-4.19 (high); 2.60-3.39 (average); 1.80-2.59 (low); and 1.00-1.79 (low) are the mean scores (very low). The results are summarized in Table 4.3.

Table 4.3: Findings on effect of administrative decentralization on public health service delivery in Kabale Municipality N= 124

S/N	Item Variables	Min	Max	Mean	Std. Deviation
AP1	Kabale Municipality has corporate standing and administrative rights, allowing it to obtain its own resources to carry out its tasks. As a result, public health services are easily accessible. .	1	5	3.84	1.066
AP2	The Kabale Municipal Council has prepared standards for community capacity building so that people may participate in and monitor health programs effectively.	1	5	3.93	.872
AP3	The majority of citizens are satisfied with the level of public health services provided since administrative health committees have been established with an acceptable gender balance to manage health-related concerns.	1	5	3.51	.970
AP4	While performing its tasks, Kabale Municipality is fully accountable to the central appointing office, ensuring that the public has access to health services whenever they need them.	1	5	3.23	1.220
AP5	Employees are held accountable for the portion of their work that is directly under their control, which has improved the delivery of public health services.	1	5	3.44	.968

AP6	Kabale Municipal Council officials are held accountable for how public funds are spent, particularly in the area of public health.	1	5	4.00	.900
AP7	Kabale municipality has strengthened administration, and as a result, the necessary public health services are always available.	1	5	3.57	.894
AP8	Because the Town Council has administrative decision-making authority, health services are easily accessible in this Local Government unit.	2	5	3.76	.784
AP9	There is administrative competence to handle monies so that public services may be delivered efficiently and effectively.	1	5	3.74	1.003
AP10	For improved public service delivery, the administrative role and responsibilities are clear.	1	5	3.74	1.003
	Average Mean	**1.1**	**5**	**3.68**	**.652**

Source*:* *Primary data,2022*

According to Table 4.3, the results show a high overall mean of (3.68, SD=0.652), indicating that the majority of respondents believed Kabale Municipality had corporate standing and the authority to obtain its own resources to carry out its tasks. Kabale municipality has established For effective involvement, instructions for community capacity building are provided and monitoring of health activities (3.93, SD=.872) and it enjoys corporate status and powers to secure its own resources to perform its functions (3.84, SD= 1.066), which is higher than the average mean. Despite the high overall mean, the results are unappealing because the Kabale municipality does not remain fully accountable to the central appointing office while performing its functions, as evidenced by a mean score of (3.23, SD= 1. 220), there are no established health committees with an appropriate gender balance to handle health-related issues (3.51, SD= 0.970), and the Kabale municipality does not remain fully accountable to the central appointing office while performing its functions.

One of the key informants was on record saying:

> *"...people must trek vast distances to reach Kabale Regional Referral Hospital, which is the only regional referral hospital in the Kigezi region." Those who live far away from a public health institution must travel lengthy distances. It was discovered that some service users are unable to receive required medication*

due to the small amount of money that is always requested from them, and thus services are reserved for those who can afford to pay, indicating unequal public health service delivery despite the fact that these services are supposed to be free."

4..3.1 Correlation results on the effect between administrative decentralization and public health service delivery

The results of the Pearson correlation product moment approach were used to establish the relationship between administrative decentralization and public health service in Kabale Municipality, as shown in Table 4.3.1 below.

Table 4.3.1 The correlation coefficient results on administrative decentralization and public health public health service delivery

		Administrative decentralization	**Public health service delivery**
Administrative decentralization	Pearson Correlation	1	.319**
	Sig. (2-tailed)		.000
	N	124	124
Public health service delivery	Pearson Correlation	.319**	1
	Sig. (2-tailed)	.000	
	N	124	124
**. Correlation is significant at the 0.01 level (2-tailed).			

Source: *Primary data, 2022*

$H0_1$ Stated that there is no significant relationship between administrative decentralization and public health services delivery in Kabale Municipality

Since the sign. value of 0.00 is less than = 0.01, the results in Table 4.3.1 show a significant relationship between administrative decentralization and public health service delivery in Kabale Municipality. Administrative decentralization has a 0.319 favourable association with the provision of public health services. This suggests that administrative decentralization had a good impact on the delivery of public health services. As a result, the null hypothesis,

which claims that there is no significant association between administrative decentralization and the delivery of public health services in Kabale Municipality, is rejected.

4.4 To establish the effect of fiscal decentralization on public health service delivery in Kabale Municipality

The study's second goal was to determine the impact of administrative decentralization on the delivery of public health services in Kabale Municipality. This report summarizes the results of the above-mentioned objective. The magnitude of the mean score indicates the extent to which Kabale Municipality has fiscal decentralization and provides public health care, as indicated by that measurement indicator. SD=strongly disagreed=disagree=not sure, A=agree, and SA=strongly agree were utilized on a 5-Likert scale ranging from 1 to 5, with 1 representing strongly disagree and 5 representing strongly agree. 4.20-5.00 (very high); 3.4-4.19 (high); 2.60-3.39 (average); 1.80-2.59 (low); and 1.00-1.79 (low) are the mean scores (very low). The results are summarized in Table 4.4.

Table 4.4: Findings on fiscal decentralization and public health service delivery in Kabale Municipality N= 124

S/N	Item variables	Min	Max	Mean	Std. Deviation
FP1	The Kabale Municipality raises tax income from a variety of sources in order to improve public health service delivery.	1	5	2.81	1.245
FP2	The Municipal Council is in charge of revenue expenditures, particularly in the health sector, in order to improve public health services.	1	5	3.45	1.055
FP3	Kabale Municipality receives enough fiscal allocations from the central government.	1	5	3.26	.995
FP4	The tax bases from which the municipality earns revenue are determined by the Municipal Council.	1	5	3.52	1.119
FP5	Kabale Municipal Council has income collecting authority, which aids in the improvement of public health services in Kabale Municipality.	1	5	3.48	1.095

FP6	The Kabale Municipal Council has complete discretion over tax rates.	1	5	3.53	1.200
FP7	Few people are unhappy with the quality of services provided by Kabale Municipality.	1	5	3.39	1.114
FP8	The Town Council's functions are adequately funded.	1	5	2.46	1.063
FP9	Subnational borrowing is used by the Town Council to fund part of its operations.	1	5	2.77	.923
FP10	Kabale municipality's health service providers are constantly ready to give any type of public health service to service seekers.	1	5	2.49	1.096
	Average Mean	**1**	**5**	**3.12**	**.750**

Source: *Primary data, 2022*

The results in Table 4.4 above report an average overall mean of (3.12, SD= 0.750) of the existence of a relationship between fiscal decentralization and public health service delivery in Kabale Municipality.

To back up this claim, Table 4.4 shows that respondents believed that Kabale Municipal Council has autonomy in managing tax rates, with a mean of (3.53, SD=1.200) and a mean of (3.52, SD=1.119) agreeing that Kabale Municipal Council sets the tax bases from which it generates income. Despite such means being higher than the average, the results also showed a lower mean below the average, implying that respondents revealed that there is insufficient funding for Kabale Municipal Council activities (2.46, SD= 1.063), that there is no variety of tax bases from which Kabale Municipal Council can tax revenue (2.81, SD= 1.245), and that there is insufficient funding for Kabale Municipal Council activities (2.46, SD= 1.063). Kabale Municipal Council rarely uses sub-national borrowing to support some of its activities (2.77, SD= 0.923), and Kabale Municipality's health budget is never sufficient to meet health demands (2.49, SD= 1.096).

> *"...The health budget of the Kabale municipal council has been in constant deficit for the past five years, forcing the municipality's health facilities to rely on sub-national borrowing." We've been dealing with that problem for a long time, and I can't say when it'll be over..." ...yeah, we have an ambulance, but the problem is that most of the time these machines aren't equipped with fuel, which forces us to ask patients for*

money during rare crises to cover fuel costs, which has sparked public outrage because we ask them for money..."

4.4 Correlation results on the relationship between fiscal decentralization and public health service delivery

To examine the association between fiscal decentralization and public health care delivery in Kabale Municipality, a Pearson correlation product moment approach (bivariate) was utilized, and the results are provided in Table 4.4 below.

Table 4.4: The correlation coefficient results on fiscal decentralization and public health service delivery

		Fiscal decentralization	**Public health service delivery**
Fiscal decentralization	Pearson Correlation	1	.532**
	Sig. (2-tailed)		.000
	N	124	124
Public health service delivery	Pearson Correlation	.532**	1
	Sig. (2-tailed)	.000	
	N	124	124
**. Correlation is significant at the 0.01 level (2-tailed).			

Source: *Primary data, 2022*

According to H02, in Kabale Municipality, there is no substantial association between fiscal decentralization and the provision of public health services.

Table 4.4 shows that fiscal decentralization and public health care delivery in Kabale Municipality have a favourable significant association. The correlation results of 0.532** at the significance criterion of 0.05 was exceeded by a P-value of 0.000, thus supported this conclusion.

This means that fiscal decentralization and public health service delivery work hand in hand in Kabale Municipality, with improved fiscal decentralization leading to a small improvement in public health service delivery.

Therefore, hypothesis two which stated that there is no significant relationship between fiscal decentralization and public health services delivery in Kabale Municipality is rejected.

When asked about revenue collections, the town clerk said,

> *"Kabale Municipal Council has strong tax administration policies and guidelines, but the only challenge is that there are very few bases on which taxes can be levied because there is low entrepreneurial spirit attributed to Covid-19 effects, limited incomes, and the few tax bases like markets, taxi stages, shops, and others cannot raise enough funds to meet our assignments as a Municipal Council."*

4.5 To investigate the effect of Political decentralization on public health services delivery in Kabale Municipality

Objective three of the study sought to investigate the effect of Political decentralization on public health service delivery in Kabale Municipality.

This research explored the impact of political decentralization on the delivery of public health services in Kabale Municipality. As represented by the measurement indicator, the magnitude of the mean score indicates the extent to which political decentralization affects public health service delivery in Kabale municipality. SD=Strongly (1), D=Disagree (2), NS=Not Sure (3), A=Agree (4), and SA=Strongly Agree (5) were utilized on a 5-Likert scale ranging from 1 to 5, with 1 representing strongly disagree and 5 representing strongly agree (5). 1.00 – 1.79 (very low), 1.80 – 2.59 (low), 2.60 – 3.39 (normal), 3.4 – 4.19 (high), and 4.20 – 5.00 (extremely high) (very high). Table 5 below summarizes the findings.

Table 4.5: Findings on effect of political decentralization on public health services delivery in Kabale municipality N=124

S/N	Item Variables	Min	Max	Mean	Std. Deviation
PP1	The power has been moved from the federal government through the state government to the municipal government to enable better community representation through elected leaders, and as a result, health service providers are always accessible to give any type of public health service to service seekers.	1	5	3.83	1.018
PP2	Because the central government's actions impacting the Town Council are transparent, few individuals complain about the quality of the services provided.	1	5	3.89	.718
PP3	The majority of local inhabitants are aware of the efforts of local officials, ensuring that citizens receive proper health care whenever they require it.	1	5	3.69	.815
PP4	Citizens have more authority in public decision-making through their elected leaders, so anybody can use public health care whenever they need them.	1	5	3.75	.970
PP5	Local citizens have the authority to hold local decision-makers accountable for their acts because there is accountability. Few people are unhappy with the quality of services provided by Kabale Municipality.	1	5	3.99	.753

PP6	Citizens participate in decision-making, and public service providers are always ready to provide any type of public health service to service seekers, particularly through democratic processes.	1	5	3.93	.897
PP7	Local elections are usually held to a high standard, and as a result, the necessary public health equipment is always readily available and in good functioning order.	1	5	3.98	.890
PP8	Residents and municipal officials always have a positive interaction, which has enhanced public health service delivery.	1	5	3.73	1.022
PP9	The Kabale Municipal Council has sufficient information to satisfy the essential demands, ensuring that citizens have access to adequate public health services whenever they need them.	2	5	3.88	.779
PP10	The majority of citizens have access to health care from any government facility within a 5-kilometer radius of their residences.	2	5	3.84	.941
	Average mean	**1.2**	**5**	**3.85**	**.880**

Source: *Primary data, 2022*

Table 4.5 shows the findings on the impact of political decentralization on public health service delivery in Kabale municipality. Ten statements were given to 124 respondents, and the results revealed a high average mean score of (3.85, SD=.0.880) according to respondents' viewpoints. Respondents agreed to items 5 and 7 with mean scores of (3.99, SD= 0.753) and (3.98, SD= 0.890), respectively, greatly beyond the average mean that there is accountability and that quality municipal elections are always held.

Despite the high mean score, the results in Table 4.5 showed that the mean scores for statements 8, 10, 4, and 3 were below the average mean, indicating that there is lower quality interaction between residents and local officials (3.73, SD= 1.022), budget preparations are

not always participatory in nature (3.84, SD= 0.840), citizens through their elected leaders have less power in public decision-making (3.75, SD 0.870), and majority rule is not always the best rule (3.84, SD= 0.840).

In fact, some key informants were in agreement with the quantitative findings as they revealed that:

> *...the majority of individuals are unaware of what their local politicians are supposed to do and have little interaction with them. This is due to the fact that some municipal officials are not constantly on the job, making it difficult for locals to communicate their requirements to them. This has hampered the provision of high-quality public health services, for example, concerns involving some public health employees who fail to show up for work, making it difficult for citizens to receive timely health care.*

Another key respondent from Kabale Municipal Council revealed that:

...there is political autonomy, but it is limited by the fact that political leaders do not have enough time to seek citizens' perspectives on crucial topics, which restricts democratic involvement. This not only limits citizens' democracy, but it also makes it difficult to determine what the citizens' most pressing needs are. These findings suggest that the Kabale Municipality's political decentralization system is still broken...

Table 4.5.1: The correlation coefficient results on political decentralization and public health service delivery in Kabale Municipality

		Political decentralization	**Public health service delivery**
Political decentralization	Pearson Correlation	1	.793**
	Sig. (2-tailed)		.001
	N	124	124
Public health service delivery	Pearson Correlation	.793**	1
	Sig. (2-tailed)	.001	
	N	124	124
**. Correlation is significant at the 0.01 level (2-tailed).			

Source: *Primary data, 2022*

Hypothesis three stated that there is no significant relationship between Political decentralization and public health service delivery in Kabale Municipality.

According to the correlation data in Table 4.5.1, political decentralization and public health care delivery in Kabale Municipality have a favourable significant link. The correlation coefficient of 0.793** at a P-value of 0.001 (below the significance level of 0.05) justified this.

This means that political decentralization and public health service delivery are linked, and that improving political decentralization leads to significant improvements in public health service delivery in Kabale.

As a result, null hypothesis three, that there is no significant link between political decentralization and public health service delivery in Kabale Municipality, is rejected by the research.

Table 4.6: ANOVA results on Decentralization and Public Health Service Delivery

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	9.329	3	3.276	17.436	.000[b]
	Residual	23.548	120	.180		
Total		32.877	123			

a. Dependent Variable: Public health service delivery

b. Predictors: (Constant), Administrative decentralization, Fiscal decentralization, Political decentralization.

Source:*Primary data,2022*

The model's F-Test statistic is 17.436 and the associated probability is 0.000, as shown in Table 4.6. The model's P-value is extremely significant, and the results show that it is jointly significant. This means that administrative decentralization, fiscal decentralization, and political decentralization all play a role in explaining changes in Kabale Municipality's public health service delivery.

CHAPTER FIVE

SUMMARY, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0Introduction

This chapter presents discussion and summary of study findings as presented in chapter four, conclusions and recommendations plus areas for further research.

5.1Summary of findings

5.1.1 Relationship between administrative decentralization and public health service delivery

The research found a significant positive association between administrative decentralization and public health care delivery, with a correlation coefficient of 0.319** and a P-value of 0.00, which was less than 0.01 level of significance. This means that improved administrative decentralization in Kabale Municipality leads to a slight improvement in public health service delivery.

5.1.2 Relationship between fiscal decentralization and public health service delivery

The study found a positive significant link between fiscal decentralization and public health care delivery, with a correlation coefficient of 0.532** and a P-value of 0.000, which was below 0.05 level of significance. This means that fiscal decentralization and public health service delivery go hand in hand in Kabale Municipality, and that improving fiscal decentralization leads to a minor improvement in public health service delivery.

According to the correlation data in table 4.5.1, political decentralization and public health care delivery in Kabale Municipality have a favourable significant link. The correlation coefficient of 0.793** at a P-value of 0.001 (below the significance level of 0.05) justified this.

This implies that political decentralization and public health service delivery go hand in hand and improvement in political decentralization leads to a high improvement in public health service delivery in Kabale Municipality.

5.1.1 Relationship between political decentralization and public health service delivery in Kabale Municipality

The outcomes of the study found that there is a weak positive relationship between political decentralization and public health care delivery, with a correlation coefficient of 0.793** and a P-value of 0.001 (below the 0.05 level of significance), inferring that increased decentralization leads to improved public health service delivery in Kabale Municipality.

5.2Discussion of the research findings

5.2.1 Relationship between administrative decentralization and public health servicedelivery

The findings on this goal revealed a high overall mean of (3.68, SD= 0.652), with the majority of respondents agreeing that Kabale Municipality has developed guidelines for community capacity building for effective participation, monitoring of public health activities, and it has corporate status and powers to secure its own resources to perform its functions, all with the goal of improving public health service delivery.

These findings are consistent with the findings of Yawe and Kavuma (2008), who found that the Government of Uganda has taken a number of steps to ensure communities are empowered to take responsibility for their own health and well-being, and to participate actively in the management of their local health services for general health service improvement, including developing guidelines for community capacity building for effective participation in resolving conflict for their efficient operation.

According to the majority of respondents, the Kabale municipality does not conduct its tasks entirely accountable to the central appointing agency. Administrative decentralization, according to Omolo (2011), is meant to mitigate the disadvantages of excessive centralization. He further claims that delegation, in which the central government delegates service delivery responsibilities to semi-autonomous government agencies or non-state entities that are completely accountable to the ministry or department to which they are assigned, will improve public service delivery.

5.2.2 Relationship between fiscal decentralization and public health service delivery The average overall mean in Table 4.4 was (3.12, SD= 0.750), indicating that Kabale Municipality has autonomy in managing tax rates and determining the tax bases from which it collects money, with the goal of increasing public health care delivery. This finding is

consistent with Choi (2012), who claims that fiscal decentralization occurs when revenue collection or expenditure authority is transferred from higher-ranking authorities to lower-ranking offices in order to provide suitable public services and improving public welfare for residents, and the majority of respondents agreed with Choi.

In Kabale Municipality, the findings in Table 4.4 also revealed that there is insufficient financing for municipal activities, and the health budget is never sufficient to address public health demands. According to ACODE (2010), a persistent scarcity of educated staff, particularly at lower-tier health institutions, was exploited to cover administrative expenditures, as well as poor funding of health care services and minimal transparency in the use of pharmaceuticals and treatments. According to Parasuraman, Zeithaml, and Berry (2014), a large proportion of local governments lack the managerial, administrative, budgetary, and institutional competence to satisfy the growing needs of their citizens. The erosion in the relationship between local government and the tertiary sector is exacerbating the problem. As a result, these Local Governments are unable to satisfy their required performance requirements, which has a negative impact on the delivery of public health services.

5.2.3 Relationship between political decentralization and public health service delivery

According to respondents' opinions, while establishing a link between political decentralization and public health service delivery in Kabale Municipality, a high average mean of (3.85, SD= 0.880) was reported while establishing a relationship between political decentralization and public health service delivery. According to the majority of respondents, there is accountability, and local communities are in a position to hold local decision-makers accountable for their actions, which has resulted in improved public health care delivery. This finding is consistent with a review of the research by the World Bank (2004), which found that political decentralization improves system accountability and may improve health service delivery. This could happen because residents have a conduit through which to contribute feedback on local decision-making processes and hold decision-makers on the ground responsible for their actions.

Table 4.5 also highlighted that the majority of local citizens are unaware of the work of local authorities and that there is always a lack of quality interaction between residents and local officials, making it difficult to achieve high-quality public health care delivery. To connect

this finding to the literature, the World Bank report (2000) stated that the rational and primary assumption of political decentralization is that decisions made with greater participation will be more informed and relevant to a wider range of societal interests than decisions made by national political authorities. However, while political decentralization has this assumption, the procedure of picking representatives, as well as personal disposition and interest influence the level to which they are elected, represent the interest of their constituents; thus, the need of quality interaction between residents and local officials.

5.3Conclusion of the study

According to the findings of the study, there is a favourable substantial association between decentralization and the delivery of public health services in Kabale Municipality. This means that improvements in decentralization, such as administrative, budgetary, and political decentralization, are likely to improve public health service delivery in Kabale Municipality.

5.3.1 Administrative decentralization and public health service delivery

Based on the findings of the study's first objective, it was determined that there is a positive significant relationship between administrative decentralization and public health service delivery in Kabale Municipality, thereby rejecting null hypothesis one, which stated that there is no significant relationship between administrative decentralization and public health service delivery in Kabale Municipality.

5.3.2Fiscal decentralization and public health service delivery

According to the findings of study objective two, there is a positive significant relationship between fiscal decentralization and public health service delivery in Kabale Municipality, so null hypothesis two, that there is no significant relationship between fiscal decentralization and public health service delivery in Kabale Municipality, was rejected.

5.3.3 Political decentralization and public health service delivery

Based on the study's findings, it was determined that there is a positive significant relationship between political decentralization and public health service delivery in Kabale Municipality, and thus null hypothesis three, which stated that there is no significant relationship between political decentralization and public health service delivery in Kabale Municipality, was rejected.

5.4 Recommendations

To improve public health service delivery in Kabale Municipality through decentralization, administrative, fiscal, and political decentralization should be improved to increase citizen participation in decision-making, financial capacity, and good governance, all of which will improve public health service delivery.

5.4.1 Administrative decentralization and public health service delivery

Both the Ministries of Public Service and the Local Government should fully administratively decentralize health service duties to local governments as a matter of policy, not only to reduce the rising cost of public administration but also to close the gaps or overlap between the centre and the LGs. For efficiency, the HR divisions of local governments should thoroughly monitor and oversee recruiting and wage bills, payroll, pensions, and scholarships.

A wage review commission should be established by the Ministry of Public Service and policymakers to ensure adequate remuneration and uniform terms and conditions of service, including the implementation of motivational schemes at all levels of government.

Some Kabale Municipality divisions, such as the Northern, Southern, and Central divisions, should be given high priority so that workers can work there.

The Central Government should hold Kabale Municipal Council accountable for its performance on a regular basis to instil a sense of urgency and proper allocation of funds, as well as proper utilization of disbursed drugs and other health equipment and machines assigned to it to aid in health-related operations.

5.4.2Fiscal decentralization and public health service delivery

The results of the second aim demonstrated a considerable favourable association between fiscal decentralization and public health care delivery.

As a result, this study recommends that continued emphasis on fiscal decentralization be placed on finding more revenue-generating prospects to broaden the tax bases by inspiring the entrepreneurial spirit, as well as looking for more possible sources of local revenue, such as user charges/fees e.g, market dues and parking fees, which can be used to meet health budgets and thus improve health outcomes.

By advocating for a budget increase for Kabale Regional Referral Hospital, it will be able to stock pharmaceuticals, facilitate health staff, and carry out other operations incidental to public health service delivery.

5.4.3 Political decentralization and public health service delivery

The results of goal three demonstrated a good and significant association between political decentralization and the delivery of public health services.

As a result, this study suggests that a continued focus on political decentralization should be made to improve public health service delivery by embracing citizen participation in decision-making by safeguarding public hearings and consultation systems, as well as involving citizens in the budget preparation process.

5.5 Areas for further research

This study focused on decentralization in terms of (political, fiscal and administrative) and how the trio relate to public health service delivery. A further study may be carried out to examine the relationship between decentralization and public education service delivery in Kabale district.

A similar study may be carried out in other municipalities across the country especially in Eastern and Northern Uganda to generalize the findings.

More research may also be carried out to investigate the influence of locally generated funds on public health service delivery in the Local Governments of Uganda.

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APPENDIX I: QUESTIONNAIRE FOR SELECTED RESPONDENTS

Greetings!

I am a student pursuing Master of Public Administration and Management of Kabale University. I am conducting a study titled *Decentralization and Public Health Services Delivery in Kabale Municipality, Kabale District, Uganda*. Because of your unique knowledge, you have been chosen to participate in this study, and I am confident that you will be able to provide reliable and relevant information to help the study succeed.

The information gathered in this study will be used solely for academic reasons and will be kept in strict confidence.

I am looking forward to your cooperation.

Thank you.

Yours sincerely,

Boaz Mubangizi
(Researcher)

SECTION A: Background information (*Kindly tick the appropriate box corresponding to a particular question)*

1.Gender
i) Male ☐ ii) Female ☐

2.Age group (please tick appropriate group)

i) Below 18 years ☐ ii) 18 – 35 years ☐ iii. 36 – 50 years ☐ iv. 51 – 60 years ☐
v. 61 years and above

3.Highest Level of Education (please tick appropriate group)

i).None ☐ ii. Primary ☐ iii. "O" Level ☐ iv. "A" Level ☐ v. Certificate ☐
vi. Diploma ☐ vii. Bachelor's degree ☐ viii. Postgraduate Diploma ☐
ix. Masters ☐ x. PHD ☐

For the following sections B, C, D and E, please tick the appropriate box corresponding to a particular question. The abbreviations to the right hand corner of the questionnaire mean;

SD – Strongly Disagree = 1, **D** – Disagree = 2, **NS** – Not Sure = 3, **A** – Agree = 4 and **SA** – Strongly Agree = 5

SECTION B

ADMINISTRATIVE DECENTRALIZATION		**SD 1**	**D 2**	**NS 3**	**A 4**	**SA 5**
AD1	Kabale Municipality has corporate standing and the authority to obtain its own resources in order to carry out its duties.					
AD2	The Kabale Municipal Council has prepared standards for community capacity building so that health initiatives can be effectively monitored and participated in.					
AD3	To manage health-related concerns, there are established administrative health committees with an acceptable gender balance.					
AD4	While performing its tasks, Kabale Municipality is totally accountable to the central appointing agency.					
AD5	Employees are responsible for and expected to account for the results of the work that is directly under their control.					
AD6	Kabale Municipal Council officials are held to a high standard of accountability when it comes to spending public funds.					
AD7	The Town Council has enhanced its governance.					
AD8	Kabale Municipality has administrative decision-making authority.					
AD9	There is administrative competence to manage monies in order to deliver services efficiently and effectively.					
AD10	The roles and duties for delivering public services are well defined.					

SECTION CFISCAL DECENTRALIZATION		SD 1	D 2	NS 3	A 4	SA 5
FP1	Kabale Municipal Council collects tax revenue from a number of different sources.					
FP2	The Municipal Council has authority over revenue expenditure					
FP3	The central government makes enough fiscal allocations to the Kabale Municipal Council.					
FP4	The tax bases from which the municipality earns revenue are determined by the Municipal Council.					
FP5	The Kabale Municipal Council is in charge of tax collection.					
FP6	The Kabale Municipal Council has complete discretion over tax rates.					
FP7	Only a few people have expressed dissatisfaction with the quality of services provided by Kabale Municipality.					
FP8	The Municipal Council's functions are adequately funded.					
FP9	To fund certain of its operations, the Kabale Municipality uses subnational borrowing.					
FP10	The municipal health budget is always sufficient to satisfy health demands.					

SECTION D

POLITICAL DECENTRALIZATION		SD 1	D 2	NS 3	A 3	SA 5
PP1	To enable greater community representation through elected leaders, power has been moved from the federal government to the local government.					
PP2	The actions of the central government that affect the Town Council are transparent.					
PP3	Budget planning is always a collaborative effort.					
PP4	Citizens have more control in public economic decision-making through their elected officials.					
PP5	Local citizens have the authority to hold local decision-makers accountable for their acts because there is accountability.					
PP6	Citizens can participate in decision-making processes, particularly in the economic process.					

PP7	Local elections of high quality are always held.					
PP8	Residents and local budget officials always have a good time together.					
PP9	In Kabale Municipality, there is sufficient information to address the relevant requests.					
PP10	The majority of local residents are familiar with the work of local politicians.					

SECTION E

PUBLIC HEALTH SERVICE DELIVERY.		**SD 1**	**D 2**	**NS 3**	**A 4**	**SA 5**
PH1	In this Local Government Unit, health services are easily accessible.					
PH2	Health services are available to everybody at any moment they require them.					
PH3	The necessary health services are always available.					
PH4	The majority of citizens are pleased with the level of health care provided.					
PH5	Few people complain about the quality of services provided by the Town Council.					
PH6	The health service providers are constantly ready to supply any type of health service to the people who need it.					
PH7	The necessary health equipment are always readily available and in good working conditions					
PH8	The citizens get adequate health services any time they need them					
PH9	Majority of citizens can seek for health services from any Government facility within a proximity of not more than 5 kilometers away from their homes					
PH10	The public health services can be equitably accessed by all citizens in need of them without any constraint					

APPENDIX II. INTERVIEW GUIDE FOR KEY INFORMANTS

1. Does there exists established administrative health committees with an appropriate gender balance to handle health related issues in Kabale Municipality?

2. Is Kabale Municipality fully accountable to the central appointing office while performing its functions?

3. Is there is administrative capacity to manage funds for efficient and effective public service delivery in Kabale Municipality?

4. Does there exist adequate fiscal transfers from the central Government to Kabale Municipal Council?

5. Does Kabale Municipal Council has autonomy in controlling the tax rates?

6. Do citizens through their elected leaders have more powers in public economic decision-making in Kabale municipality?

7. Is there accountability and local citizens are in position to hold local decision-makers accountable for their actions?

8. Is it easy to access public health services in this Local Government unit?
9. Are health service providers always readily available to deliver any kind of public health service to the service seekers?
10. Are necessary health equipment always readily available and in good working conditions?

Thank you

APPENDIX III: OBSERVATION CHECKLIST

1. Existence of admission wards and beds for admitted patients
2. Is the Hospital's structures in good conditions to the minimum standards of a health facility
3. Waiting line
4. Drugs stock in store
5. Existence of an ambulance
6. Presence of health workers
7. Existence of basic medical equipment
8. Status of the theatre
9. Laboratory
10. Reports

APPENDIX IV. COMPUTATIONS FOR CONTENT VALIDITY INDEX

Content Validity Index = $\frac{\text{Total number of items rated as valid}}{\text{Total number of items on the instrument}}$

Content Validity Index computations

	Administrative Decentralization	Fiscal Decentralization	Political decentralization	Public Health service delivery
Number of items rated valid	09	09	07	08
Total number of items on the questionnaire	10	10	10	10

CVI for AdministrativeCVI for Fiscal

CVI for Political

$\frac{09}{10}$ **= 0.9** $\frac{09}{10}$ **= 0.9** $\frac{07}{10}$ **= 0.7**

CVI for Public Health service delivery

$\frac{08}{10}$ **= 0.8**

Average CVI = $\frac{(0.9 + 0.9 + 0.7 + 0.8)}{4} = \frac{2.52}{4} =$ **0.825**

Since Computed CVI is above 0.7 the items on the instruments were considered valid

APPENDIX IV: LETTER FOR DATA COLLECTION

DIRECTORATE OF POSTGRADUATE TRAINING

December, 14th 2020

To whom it may concern

This is to certify that *Mr. Boaz Mubangizi Reg. No. 2018/MAPAM/1800/W* is a postgraduate student of Kabale University studying for *Masters in Public Administration and Management* in the department of *Governance.*

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

"Decentralization and Public Health Services delivery in Kabale Municipality, Kabale District, Uganda;"

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

Dr. Sekiwu Denis
DIRECTOR, POSTGRADUATE TRAINING