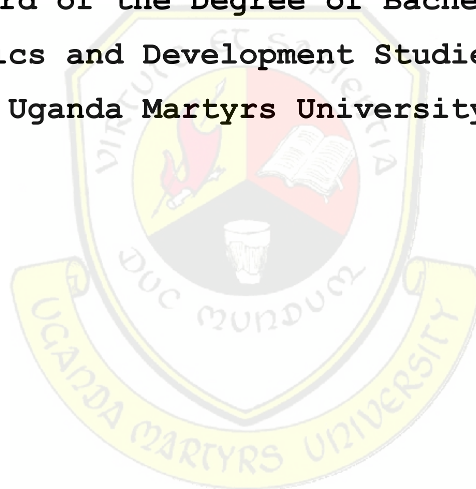
ASSESSING THE EFFECTIVENESS OF DECENTRALISATION IN HEALTH SERVICE DELIVERY IN MPIGI DISTRICT

THE CASE OF BUWAMA HEALTH CENTRE III IN BUWAMA SUB COUNTY

A Dissertation Submitted to the Institute of Ethics and Development Studies in Partial Fulfillment of the Requirements for the Award of the Degree of Bachelors of Arts (Ethics and Development Studies) of Uganda Martyrs University



Apio Vera Amy

2013-B013-10018

May, 2016

Dedication

This dissertation is dedicated to my beloved parents Mr. Bwire Wycliffe and Ms. Nasirumbi Victoria, my beloved siblings Vanessa, Wayne, Wyland, Eunice plus my beloved Aunts Janet, Monica and Nephew Joel.

Acknowledgement

I would like to first of all tremendously thank the Almighty God for the gift of life and good health which helped me do this research.

With great honor, I would like to extend my sincere gratitude to my parents Mr. Bwire Wycliffe and Ms. Nasirumbi Victoria for all the encouragement and financial support they extended to me during the writing of this research work.

I would also like to overwhelmingly thank my supervisor Mr. Eno-Akpa Rene for all his assistance and effort on this research work.

My thanks also go to my dear friends, Shammy, Victor, Bridget, Brenda and Carol for their entire support that they gave me during the writing of this research work.

Table of contents

Dedication.. i

Acknowledgement.................................... ii

Table of contents.................................. iii

List of figures.................................... viii

List of tables..................................... vii

List of abbreviations.............................. ix

Abstract... x

CHAPTER ONE.. **1**

GENERAL INTRODUCTION............................... **1**

1.0 Introduction 1

1.1 Background of the study 1

1.1.1 Historical Background 1

1.2 Statement of the problem 4

1.3 Objectives of the study 6

1.3.1 General objective 6

1.3.2 Specific objectives 6

1.4 Research questions 6

1.5 Scope of the study 6

1.5.1 Geographical scope 6

1.5.2 Time scope 7

1.5.3 Conceptual scope 7

1.6 Significance of the study 7

1.7 Justification of the study 7

1.8 Conceptual framework 8

1.9 Definition of key terms 9
CHAPTER TWO..... 11
LITERATURE REVIEW..... 11
2.0 Introduction 11
2.1 Understanding of decentralization 11
2.2 Health understanding 17
2.2.1 The understanding of Service delivery 19
2.2.2 Fiscal Decentralization and its implication 21
2.3 Delegation of hospital administration 23
2.4 Fiscal decentralization and procurement 25
2.5 Devolution of authority and decision making 27
2.6 Conclusion 30
CHAPTER THREE..... 31
RESEARCH METHODOLOGY..... 31
3.0 Introduction 31
3.1 Research design 31
3.2 Area of study 32
3.3 Study population 32
3.4 Sample size and sampling techniques 33
3.5 Data collection methods 33
3.5.1 Questionnaires 33
3.5.2 Interviews 34
3.5.3 Documentary review 34
3.6 Quality control methods 35
3.6.1 Validity 35
3.6.2 Reliability 35
3.7 Data analysis 35

3.8 Ethical considerations 36
3.9 Limitations 36
CHAPTER FOUR... 37
PRESENTATION, ANALYSIS, INTERPRETATION AND DISCUSSION OF THE FINDINGS... 37
4.0 Introduction 37
4.1 Demographic characteristics 37
4.1.1 Gender of the respondents 38
4.1.2 Age group of the respondents 38
4.1.3 Marital status 39
4.1.4 Academic qualification of the respondents 40
4.1.5 Employment status of the respondents 41
4.1.6 Health services offered 41
4.2 Delegation of hospital administration 42
4.2.1 Roles of the local government 42
4.2.2 Supplied drugs adequate to meet the needs 43
4.3 Fiscal decentralization and delivery of health 44
4.3.1 Annual budget for health centers 44
4.3.2 Raising revenue 44
4.3.3 Determining salaries 45
4.4 Devolution of authority and decision making 46
4.4.1 Full power to make key decisions 46
4.4.2 Involvement of communities that use the facility .. 46
4.4.3 Increased decision making power 47
4.5 Health service delivery 48
4.5.1 Respondents visits to Buwama health centers 48
4.5.2 Availability of drugs 49
4.5.3 Transfer of instruments of power 49

4.5.4 Challenges as a result of decentralization 50

4.5.5 Overcoming the challenges faced 51

CHAPTER FIVE 52

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 52

5.0 Introduction 52

5.1 Summary of the findings 52

5.2 Conclusions 53

5.3 Recommendations 54

5.4 Areas for further study 54

References 55

APPENDICES 63

APPENDIX I: QUESTIONNAIRE: LOCAL OFFICIALS 63

APPENDIX II: QUESTIONNAIRE: RESIDENTS OF BUWAMA 66

APPENDIX III: INTERVIEW GUIDE 68

List of tables

Table 1.1: Age group of the respondents..................... 38

Table 4.2: Marital status of the respondents................ 39

Table 4.3: Academic qualification of the respondents........ 40

Table 4.4: Showing whether supplied drugs adequate.......... 43

Table 4.5: Raising revenue to run health services........... 44

Table 4.6: Full power to make key decisions................. 46

Table 4.7: Increased decision making power.................. 47

List of figures

Figure 1.1: Assessing the effectiveness...................... 8

Figure 4.1: Gender of the Respondents....................... 38

Figure 4.2: Employment status of the respondents............ 41

Figure 4.3: Showing whether central government.............. 45

List of abbreviations

AIDS: Acquired Immune Deficiency Syndrome

DLGs: District Local Governments

GDP: Gross Domestic Product

HSSP: Health Sector Strategic Plan

MOH: Ministry of Health

NGOs: Non-Governmental Organizations

PHC: Primary Health Care

PNFP: Private-Not-For-Profit

PRSP: Poverty Reduction Strategic Plan

RCs: Resistance Councils

SWAP: Sector-Wide Approach

WHO: World Health Organization

Abstract

The study aimed at assessing the effectiveness of decentralization in health service delivery in Mpigi District a case of Buwama Health Centre III in Buwama Sub County. The study objectives were; To find out how the delegation of hospital administration has led to access to drugs in Buwama Sub County; To evaluate how fiscal decentralization has led to delivery of health services in Buwama Sub County and to assess how the devolution of authority on decision making has led to health facility utilization in Buwama Sub County.

The study employed a case study design approach using qualitative research paradigm in which data was collected from 30 (thirty) respondents using questionnaires, and interviews

The study found out that Even though decentralization has faced challenges in Buwama Sub County characterized by shortage of drugs and limited infrastructure, overall the researcher concludes that decentralization policy has had a number of positive effects in the delivery of health services in Mpigi District. This is based on the fact that health centers are beginning to be self-sustaining through fiscal decentralization, in that they can generate their own revenue for operations. Furthermore devolution and delegation have enabled important decisions to be made quicker such as purchase of health needs, recruitment of staff for the health centers and involvement of the local community in decision making.

It was recommended that Fiscal decentralization should be enhanced in order to increase on the revenue generated at local government health facilities if sustainability is to be realized. It was also recommended that monitoring of health workers activities and attendance needs to be addressed. For instance by availing an attendance registers and punishing absenteeism. This will ensure the local population have better health care.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

This study assessed the effectiveness of decentralization in the delivery of health services in Buwama Sub County in Mpigi District. Decentralization is a complex but a fairly preferred strategy for good governance today. Today, many African governments use decentralization as an approach to deliver services to their citizens at the grassroots.

1.1 Background of the study

1.1.1 Historical Background

Since the 1980s, decentralization has had a prominent position in the politics of the world (World Bank, 2001). Due to the transition towards democracy during the 80s and 90s, there were state reforms and this marked the beginning of decentralization which took on two phases (Bank and Fiorilli, 2007).

Today, the reality is that Africa is no exception to either the decentralization trend or the reality of its difficulties and diversity. Decentralization is an effective way of managing delivery of services which are inherently heterogeneous in nature, such as healthcare, which is closely linked to the demographic and societal characteristics of local communities, (Popic Patel 2011). Health service delivery is defined as the provision of public activities, benefits or satisfactions to a citizen or citizens (Fox & Meyer, 1995). It can be either tangible (products) or intangible (services). Decentralization reforms involved three main components: political, administrative, and financial decentralization (Villadsen, 1996). Political decentralization was based on the Resistance Councils (RCs).

Decentralization of health services is undertaken with the assumption that it will improve health service delivery. One assumption is that local communities have better knowledge of local needs and conditions and make better decisions if they are granted the authority to manage resources and organize and supply health services. Decentralization is intended to promote accountability and participation of the local population, make health service providers accountable to the local community, and boost the responsiveness of the providers to the local demand for services. Decentralization is therefore expected to improve the efficiency, equity, and quality of health service delivery and management.

Decentralization and National Health Policy Implementation in Uganda Political and Administrative Levels are accountable to local administration, financial decentralization was carried out in phases with the introduction of an unconditional block-grant to each district in conjunction with the introduction of locally-approved budgets. In the Constitution of the Republic of Uganda (1995), the system of local government was further consolidated, and the process continued with the adoption of the Local Governments Act of 1997. Decentralization has transferred all political and administrative authority from the central government to the local government authorities, including the power to approve district budgets (Kisubi 1996). The function of the central government has thus been directed exclusively to policy formulation, planning, inspection, management of national programmes and projects, security, defense, and foreign policy. The responsibility for the delivery of health services now lies within the districts.

Decentralization is the process of redistributing or dispersing functions, powers, people or things away from a central location or authority. The meaning of decentralization

may vary in part because of the different ways it is applied. Concepts of decentralization have been applied to group dynamics and management science in private businesses and organizations, political science, law and public administration, economics and technology (Fink, 2003).

Decentralization embraces a variety of concepts which must be carefully analyzed in any particular country before determining if projects or programs should support reorganization of financial, administrative, or service delivery systems.

The various types of decentralization include political, administrative, fiscal, and market decentralization. Drawing distinctions between these various concepts is useful for highlighting the many dimensions to successful decentralization and the need for coordination among them. Nevertheless, there is clearly overlap in defining any of these terms and the precise definitions are not as important as the need for a comprehensive approach. Political, administrative, fiscal and market decentralization can also appear in different forms and combinations across countries, within countries and even within sectors (Gutierrez, 2010).

The three major forms of administrative decentralization include deconcentration, delegation, and devolution each has different characteristics.

Health service deliveries are the services provided by health personnel in the health service. These health services can also include access to drugs, procurement of health services and also Health facility utilization (O'donnel, 2008).Decentralization of drug supply functions must be considered along with overall government efforts toward decentralization of health and social services (Murindwa et al., 2003)

Uganda began its health sector decentralization process in 1997 following the enactment of the Local Government Act, 1997. The rationale was to increase both a locative and productive efficiency in health service provision. Decentralization of health services delivery facilitates decision making and monitoring at districts and lower levels local governments involving community participation (O'donnel 2008).

In the process, the District Local Governments (DLGs) became accountable for resources allocated and monitoring the quality of services provided (Nanyonjo and Okot, 2013). The medium-term policies to improve health service delivery are clearly documented in Uganda's Poverty Reduction Strategic Plan (PRSP) in which the DLG system has been mandated with the implementation of the national health policy. The National Health Sector Strategic Plan (HSSP) is the major policy framework which documents all the strategies for the provision of public health services within a decentralized system in Uganda.

The focus of health service delivery was mainly immunization and capital development projects funded under the PHC non-wage grant (Tamale, 2013). Two maternity wards were constructed at Kampiringa Health Center III and Sekiwunga Health Center III. This investment is perhaps responsible for the increased deliveries in health centers which rose from 34% to 72% during the financial year 2012/2013.

1.2 Statement of the problem

All citizens of Uganda should be able to access good health services. This is in line with the sustainable development goal number 3 which intends to ensure healthy lives and promote wellbeing for all at all ages.

Health sector decentralization has drawn advocacy from various international organizations among which is the World Health Organization (WHO), requiring that certain health system functions be transferred to the local levels in order to meet the health needs of the people (World Bank, 2005).The decentralization policy has been used in the health sector in Uganda where by the central government delegates local governments to manage health centres. This is intended to make timely decisions by Health Personnel, easier access to drugs and autonomy at the health facilities. Mpigi District Local Government has a number of health centres delivering health services using the decentralization approach. Among is Buwama Health Centre III which has existed ever since decentralization was introduced in Uganda.

Even though the health centres have continued to deliver health services through decentralization approach, health in Uganda lags behind many other countries but is at par with the countries in the World Health Organization's (WHO) Africa region. As of 2013, life expectancy at birth in Uganda was 58 years, lower than any other country in the East African Community except for Burundi. As of 2015, the probability of a child dying before reaching age five was 5.5 percent (55 deaths for every 1,000 live births). Total health expenditure as a percentage of Gross Domestic Product (GDP) was 9.8 percent in 2013.

These statistics leave one to wonder whether decentralization policy has improved the health services delivery in Uganda. Furthermore, the non availability of decentralization data peculiar to Mpigi District creates a gap for investigation.

It is against this background that the researcher assessed the effectiveness of Decentralization policy in delivering health services in Mpigi District considering Buwama Health Centre III as a case.

1.3 Objectives of the study

1.3.1 General objective

To assess the effectiveness of decentralization in health service delivery in Mpigi District a case of Buwama Health Centre III in Buwama Sub County.

1.3.2 Specific objectives

i. To find out how the delegation of hospital administration has led to access to drugs in Buwama Sub County.

ii. To evaluate how fiscal decentralization has led to delivery of health services in Buwama Sub County.

iii. To assess how the devolution of authority on decision making has led to health facility utilization in Buwama Sub County.

1.4 Research questions

i. How has delegation of hospital administration led to access to drugs in Buwama Sub County?

ii. How has fiscal decentralization led to delivery of health services in Buwama Sub County?

iii. How has the devolution of authority on decision making led to health facility utilization Buwama Sub County?

1.5 Scope of the study

1.5.1 Geographical scope

The research was conducted in Buwama Sub County located in Mpigi District 70km west of Kampala City along the Kampala Masaka highway.

1.5.2 Time scope

The study specifically aimed at assessing the effectiveness of decentralization in the delivery of health services in Buwama Sub County for a period of 5 years from 2011 to 2016. This is so because statistics show quite a systematic improvement in the increased deliveries in health centers which rose from 34% to 72%.

1.5.3 Conceptual scope

This study was limited to how decentralization policy led to outcomes in the Health services delivery in Buwama Sub County.

1.6 Significance of the study

The study will avail a body of knowledge associated with decentralization in the health sector to the Academia.

To Leaders in Mpigi District, this study will inform them of the loopholes in the delivery of health as a service by decentralization and thus calls upon them to be more attentive in observing and monitoring the process of delivering health services to local people.

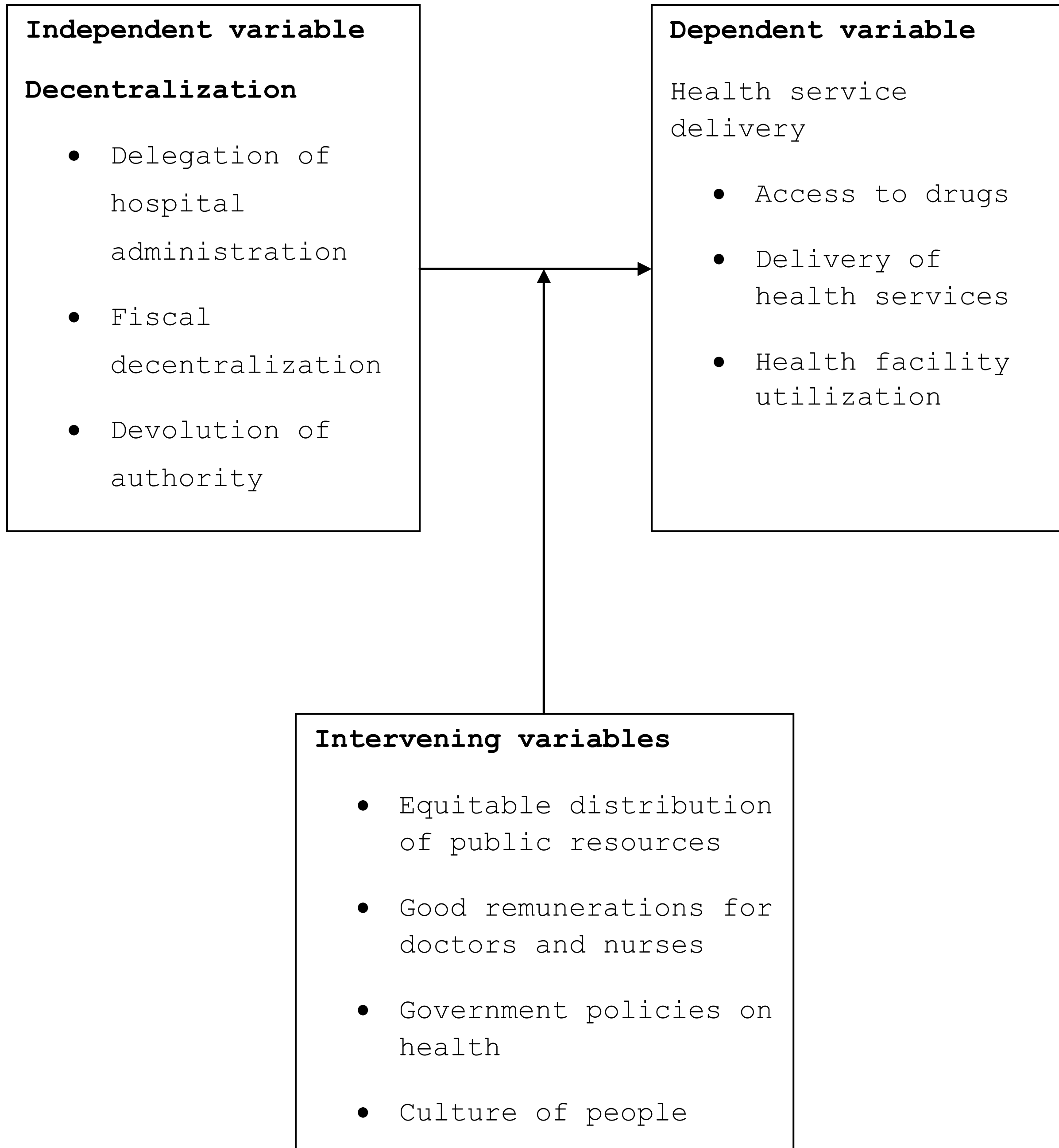
This study will help the Ministry of health make informed and viable policy responses. This is because the study has pointed out some loopholes associated with the decentralization policy.

1.7 Justification of the study

Many governments all over the world have adopted decentralization policy in delivering services to their citizens. However, research on decentralization has not been adequate to inform on its effectiveness. The health sector being a delicate one, in that people’s lives are at risk. It important to study whether decentralization policy can be an avenue in achieving better health for the people.

1.8 Conceptual framework

Figure 1.1: Assessing the effectiveness of decentralization in health service delivery in Mpigi District



The conceptual model provides an illustration of the concepts and how they are related to each other. This study is guided by a combination of independent variables, Dependent variables and intervening variables. This study suggests assessing the effectiveness of decentralization in the delivery of health

services in Buwama Sub County in Mpigi District. The challenges are observed such as poor government policies, planning and monitoring on health services (MOH 2000), (Kahkonenand Lanyi A, 2001). But there is need to understand what causes poor allocation of public resources and study will find out what causes poor government policies, uncivilized people, and lack of enough resources and among others (Popic, Patel 2011). The intervening variables that come into play between the independent and Dependent variables are the possible solution in assessing the effectiveness of decentralization in the delivery of health services in Buwama Sub County in Mpigi District due to the different equal distribution of resource and the government polices.

For the purpose of this study therefore, the independent variable will be the causes of uncivilized people while the dependent will be the challenges of the effectiveness of the decentralization in delivering health services to people as the Dependent variable will the outcome of the Independent variable while the intervening variable of the study will be the solution to the challenges in providing effectiveness of decentralization in health services.

1.9 Definition of key terms

Decentralization: This is a process of transfer of authority and responsibility for public functions from the central government to intermediate and local governments or the private sector (Neven, 2000).

Effectiveness: It is defined as the extent to which stated objectives are met for example the policy achieves what it intended to achieve (Australian government, 2013).

Service delivery: Service delivery is defined as the provision of public activities, benefits or satisfactions to a citizen

or citizens (Fox & Meyer, 1995). It can be either tangible (products) or intangible (services).

Health: Means a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, (Christian Nordqvist, 2015)

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

In recent years, public health reforms in developing and least developed nations have followed a global trend towards decentralization of services from central governments and large hospitals to local governments and district health clinics (Foley, 2008). The idea of this movement was to increase efficiency and citizen participation in health services and improve access to health care and drugs in rural populations (Akin, Hutchinson & Strumpf, 2005).

2.1 Understanding of decentralization

The concept of decentralization has a been defined by various scholars of public administration as the transfer of authority from a higher level of government to a lower level where, delegation of decision making, placement of authority with responsibility allows greatest number of actions to be taken where most of the people reside Rahman, 1996). This implies that decentralization involves delegation of functions from the center to the periphery, a mode of operations involving wider participation of people in the whole range of decision making beginning from plan formulation to implementation,

There are mainly four types of decentralization and these include the political, administrative, and fiscal and market decentralization.

Political Decentralization

It is the transfer of authority to a sub national body. This type of decentralization strives to give citizens or their elected representatives more power in public decision making. It is usually connected with pluralistic and representative

government though it can also support democratization by giving citizens or their representatives more influence in the formulation and implementation of policies (Awal, 1994). Political decentralization often requires constitutional or statutory reforms, the development of pluralistic political parties, the strengthening of legislatures, creation of local political units and the encouragement of effective public interest groups. Political decentralization is often shown through devolution. This implies that the groups at different levels of government–central, meso and local–are empowered to make decisions related to what affects them.

Administrative Decentralization

Administrative decentralization refers to redistribute authority, responsibility and financial resources for providing public services among different levels of government. . It is the transfer of responsibility for the planning, financing and management of certain public functions from the central government and its agencies to field units of government agencies, subordinate units or levels of government, semi-autonomous public authorities or corporations, regional or functional authorities. The sub-systems may be territorial units (federalism) or bodies entitled to self-sufficiency (Holtmann, 2000).

In the researchers view, it implies that the different levels of government administer resources and matters that have been delegated to them, generally through a constitution.

Under administrative decentralization, there are mainly three forms of decentralization and these include; deconcentration, delegation and devolution. In terms of decentralization as a process of change, and according to the level of transfer of responsibilities, it is useful to distinguish between deconcentration, delegation and devolution.

De-concentration

It is in most cases considered to be the weakest form of decentralization and is commonly used in unitary states. It re-allocates decision making authority and financial management of responsibilities among different levels of the central government. This may mean shifting of workload from one ministry to the other or from ministry to its field or local administration (Ali, 1995). This form of administrative decentralization is used by many of the African and Asian countries such as Tanzania, Tunisia, Pakistan, Kenya, Morocco, Algeria, Pakistan, Philippine, Indonesia and Thailand. This implies that one of administrative decentralization which redistributes decision-making authority and financial and management responsibility among levels of the central government.

Delegation

It is a more broad form of decentralization which involves the transfer of responsibility for decision making and administration of public functions from the central government to semi- autonomous organizations that are not wholly controlled by the central government but are eventually accountable to it (Islam, 1997). For example many developing countries utilize this practice in the creation of boards, authorities, corporations or any other separate agencies for carrying out specific functions.

Devolution

Devolution is the transfer of significant power, law making and raising revenue by law to the locally elected bodies (Conyers, 1986). It also involves the transfer of natural resource management to local individuals and institutions located within and outside of government. Devolution usually transfers responsibilities for services to municipalities that

elect their own mayors and councils, raise their own revenues and have independent authority to make investment decisions. In a devolved system, local governments have clear and legally recognized geographical boundaries over which they exercise authority and within which they perform public functions. This type of administrative decentralization is one that brings about political decentralization (Awal, 1994). This implies De-concentration also plays an important role of addressing the difficulties of trying to coordinate disparate HIV/AIDS activities for different regions from a central location.

Fiscal Decentralization

Financial responsibility is the main component of decentralization. Fiscal Decentralization transfers two things to local governments and private organizations, that is, funds to be used in delivering decentralized functions and revenue-generating power and authority to make decisions on expenditures.

There are mainly five forms of decentralization and these include; Self-financing or cost recovery through user charger, Co financing or co production arrangements through which the users participate in providing services and infrastructure through monetary or labor contributions, Expansion of local revenues through property or sales taxes or indirect charges (Awal, 1994). Authorization of municipal borrowing and the mobilization of either national or local government resources through loan guarantees and Inter-governmental transfers that shift general revenues from taxes collected by the government to local governments for general or specific use.

Economic / Market Decentralization

Economic or market decentralization is the passing over the private sector of the functions exclusively performed by government. It is manifested through privatization and deregulation (Awal, 1994). This implies that this type of decentralization promotes the engagement of businesses, community groups, cooperatives, private voluntary associations and other nongovernment organizations.

Privatization

Privatization means the transfer of functions from the public to non-government institutions. In many countries according to Ahmed, (1990), the transfer of some of the planning and administrative responsibilities of public functions from government to private or voluntary agencies facilitated the processes of decentralization.

Deregulation

It reduces the legal constraints on private participation in service provision or allows competition among private suppliers for services that in the past had been provided by government or regulated by monopoly. In recent years privatization and deregulation have become more attractive alternatives to governments in developing countries. Local governments are also privatizing by contracting out service provision or administration (Awal, 1994).

Neven (2000) suggests that there must at least be five conditions in place for decentralization to be successful and the following are the conditions suggested as seen below;

The decentralization framework must link at the margin, local financing and fiscal authority to the service provision responsibilities and functions of the local government so that

local politicians can bear the costs of their decisions and deliver on their promises.

This implies that the local community must be informed about the costs of services and service delivery options involved and the resource envelope and its sources so that the decisions they make are meaningful.

There must be a mechanism by which the community can express its preferences in a way that is binding on the politicians so that there is a credible incentive for people to participate.

There must be a system of accountability that relies on public and transparent information which enables the community to effectively monitor the performance of the local government and react appropriately to that performance so that politicians and local officials have an incentive to be responsive. The instruments of decentralization that is the legal and institutional framework, the structure of service delivery responsibilities and the intergovernmental fiscal system are designed to support the political objectives.

The World Bank Decentralization Thematic Team points out the following as some of the advantages of Decentralization; Decentralization helps lessen the bottlenecks in decision-making that are usually brought about by central government planning and control of important economic and social activities, It can help reduce on the complex bureaucratic procedures and thus help increase government officials sensitivity to local conditions and needs. In the researchers view, it can help national government ministries reach larger numbers of local areas with services and it also allows greater political representation for diverse political, ethnic and cultural groups in decision-making.

2.2 Health understanding

First all, Huber et al., (2012) define Health as the level of functional or metabolic efficiency of a living organism. In humans it is the ability of individuals or communities to adapt and self-manage when facing physical, mental or social challenges. The World Health Organization (WHO) defined health in its broader sense in its 1948 constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization. 2006).

Systematic activities to prevent or cure health problems and promote good health in humans are undertaken by health care providers. Applications with regard to animal health are covered by the veterinary sciences. The term "healthy" is also widely used in the context of many types of non-living organizations and their impacts for the benefit of humans, such as in the sense of healthy communities, healthy cities or healthy environments. In addition to health care interventions and a person's surroundings, a number of other factors are known to influence the health status of individuals, including their background, lifestyle, and economic, social conditions, and spirituality; these are referred to as "determinants of health." Studies have shown that high levels of stress can affect human health (Taylor and Marandi 2008).

Health care or healthcare is the maintenance or improvement of health via the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings. Health care is delivered by health professionals (providers or practitioners) in allied health professions, chiropractic, physicians, physician associates, dentistry, midwifery, nursing, medicine, optometry, pharmacy, psychology, and other health professions.

It includes the work done in providing primary care, secondary care, and tertiary care, as well as in public health.

Access to health care varies across countries, groups, and individuals, largely influenced by social and economic conditions as well as the health policies in place. Countries and jurisdictions have different policies and plans in relation to the personal and population-based health care goals within their societies. Health care systems are organizations established to meet the health needs of target populations. Their exact configuration varies between national and sub national entities. In some countries and jurisdictions, health care planning is distributed among market participants, whereas in others, planning occurs more centrally among governments or other coordinating bodies. In all cases, according to the World Health Organization (WHO), a well-functioning health care system requires a robust financing mechanism; a well-trained and adequately-paid workforce; reliable information on which to base decisions and policies; and well maintained health facilities and logistics to deliver quality medicines and technologies.

As a developing country, health in Uganda lags behind many other countries but is at par with the countries in the World Health Organization's (WHO) Africa region. As of 2013, life expectancy at birth in Uganda was 58 years, lower than any other country in the East African Community except for Burundi (The World Bank, 2016). As of 2015, the probability of a child dying before reaching age five was 5.5 percent (55 deaths for every 1,000 live births). Total health expenditure as a percentage of gross domestic product (GDP) was 9.8 percent in 2013(The World Bank, 2016).

Uganda was hit very hard by the outbreak of the HIV/AIDS epidemic in East Africa. In the early 1990s, 13 percent of Ugandan residents had HIV. This had fallen to 4.1 percent by

the end of 2003, the most effective national response to AIDS of any African country (see AIDS in Africa).

At the beginning of the 21st century, the government of Uganda began implementing a series of health sector reforms that were aimed at improving the poor health indicators prevailing at the time. A Sector-Wide Approach (SWAp) was introduced in 2001 to consolidate health financing (HDPG. 2002) Another demand side reform introduced in the same year was the abolition of user fees at public health facilities, which triggered a surge in outpatient attendances across the country.

Decentralization of health services began in the mid-1990s alongside wider devolution of all public administration, and was sealed in 1998 with the definition of the health sub district. Implementation of the health sub district concept extended into the early 2000s (Murindwa et al, 2006). The aim of decentralization was to improve the management and delivery of health services at the local level.

To improve medicines management and availability, the government of Uganda made medicines available to private-not-for-profit (PNFP) providers. Nabyonga et al. (2005) points out that with decentralization of health services, a "pull" system was instituted in which district and health facility managers were granted autonomy to procure medicines they needed in the required quantities from the national medical stores, within pre-set financial earmarks. The result was better availability of medicines.

2.2.1 The understanding of Service delivery

Service delivery can be termed as the relationship between policy makers, service providers and poor people. It comprises of services and their supporting systems that are normally considered to be a state responsibility. These include social services such as primary education, basic health services,

infrastructure which consists of water and sanitation, roads and bridges and services that promote personal security such as justice, police among others. On the other hand, Pro-poor service delivery refers to interventions that maximize the access and participation of the poor by strengthening the relationships between policy makers, providers and service users (Carlson et al, 2005). This implies that with service delivery, the public should be able to achieve primary education, basic health services, infrastructure which consists of water and sanitation, roads and bridges.

Pro-poor service delivery is laid on the following principles; Principle of universal access and coverage on the basis of right, Principle of commitment to equity, Principle of community participation in defining and delivering services (WHO, 2003).

The state is the main service provider in many countries however we also have other actors such as the NGOs, faith-based organizations, communities and commercially-oriented private entrepreneurs who get involved in the provision of services such as education (Pauline, 2007).

In Uganda during the 1970s and 1980s, Uganda went through a period of political and economic upheaval, resulting in the breakdown of many services. In the health sector this was characterized by general system failure. Funding was grossly insufficient, leading to problems of meager and late salaries for health workers, permanent shortages of medicines and supplies, and dilapidated infrastructure. In the 1990s, in light of these problems, the government initiated the process of preparing a National Health Policy and a Health Sector Strategic Plan.

Uganda has a devolved form of government where local governments have extensive political and administrative powers. The health sector undertook a number of other reforms to improve the delivery of primary health care services in the districts. These included reforms to human resource management and physical infrastructures, and the establishment of appropriate structures and institutions for support supervision and performance monitoring.

With regard to the health sector in Uganda, decentralization has been concerned with changing the way health systems are managed and delivered. Conceptually, it has involved a change in power relations between the central government and other actors of the health sectors such as districts and sub districts, not at least because it led to creation of health sub districts which are mainly responsible for delivery of primary health care services (MOH, 2002). Uganda's reform program has in many ways been more radical and comprehensive, investing democratically elected local governments with the responsibility for service delivery and financial management, not only in the health sector but also in the educational development planning transportation and other social sectors.

2.2.2 Fiscal Decentralization and its implication for health service provision

Financial responsibility is a core component of decentralization. If local governments and private organizations are to carry out decentralized functions effectively, they must have an adequate level of revenues – either raised locally or transferred from the central government– as well as the authority to make decisions about expenditures.

Fiscal decentralization can take many forms, including a) self-financing or cost recovery through user charges, b) co-financing or co-production arrangements through which the users participate in providing services and infrastructure through monetary or labor contributions; c) expansion of local revenues through property or sales taxes, or indirect charges; d) intergovernmental transfers that shift general revenues from taxes collected by the central government to local governments for general or specific uses; and e) authorization of municipal borrowing and the mobilization of either national or local government resources through loan guarantees. In many developing countries local governments or administrative units possess the legal authority to impose taxes, but the tax base is so weak and the dependence on central government subsidies so ingrained that no attempt is made to exercise that authority.

The existence of externalities in health care do not necessarily imply centralized provision as a superior alternative, since there might still be welfare gains from decentralized provision relative to a centrally determined level of health care services (Oates, 2005). Moreover, providing local governments with subsidies may encourage efficient levels of health services to the point where the marginal social benefits for society as a whole from the provision of health care equals marginal costs. Following the fiscal decentralization position the main argument for decentralizing decision making in health is that local decision makers have greater knowledge of the health needs of their populations and of local conditions that affect the production of health care than national policy makers.

2.3 Delegation of hospital administration and access to drugs

Whilst delegations has been found to be ineffective in several instances, Foley, (2008) argues that this is due to other reforms instituted in parallel to decentralization and that delegation in health care is the most realistic method of increasing access to medicines in the developing world right now. This implies that one of the main reasons that centralized medicine is inefficient and inaccessible is because populations are not homogenous but diverse and have different health needs as well as social norms which affect their health treatment choices.

According to Blumenthal & Hsaio, (2005), delegation of hospital administration also indirectly increases access to medicines because it often coincides with the existence of community health insurance through risk pools. The traditional communes that operated under the Cooperative Medical System in China provided risk pooling infrastructure which is simply a voluntary health insurance program.

Effective delegation can also result in increased productivity because several team members are involved in particular tasks or projects at any given time so that more can be achieved than would be possible by one individual (Kourdi 1999). Marquis and Huston (2000) suggest that for many managers the volume of work becomes too much for one person and that delegation is a necessity not an option. They further suggest that in such situations delegation is often regarded as synonymous with productivity.

The development of effective delegation skills can enhance the personal and professional advancement of delegators. For example, delegating allows managers to concentrate on improving their specific skills, including policy making,

managing people, conflict resolution and evaluation (Kourdi 1999).

Delegation of hospital administration can also result in a greater understanding and appreciation of the work of wards and organizations (Uchimura, and Jutting 2010). In undertaking delegated tasks, delegates often have to work with other members of staff and may need to develop further their negotiation and interpersonal skills. It also enables delegates to manage tasks that are of particular interest to them, thereby increasing initiative and enthusiasm (Nelson 1994). This implies that the development of these skills can improve their ability of effectively distributing the medical resources such as drugs.

Delegation of administration can also increase delegates' commitment to carrying out tasks such as drug distribution effectively (Yukl 1998). People, who have been delegated tasks, and the authority to make decisions related to these tasks, try to avoid unsuccessful outcomes because these can reflect poorly on their competence. Therefore, if delegation is regarded as a manipulative strategy by delegators however, it is unlikely that it will improve delegate commitment.

Delegation of patient care is a constant requirement when caring for patients. Delegation is not a mysterious art but a management function that can be learned and improved with practice. Effective delegation gives delegators more time for their other managerial activities, which enables them to focus on doing few tasks well rather than many tasks poorly (Kourdi 1999, Nelson 1994, Yukl 1998). Even if managers believe they can perform tasks better than delegates, it is a more efficient use of managers' time to concentrate on these other managerial activities.

Local decision makers also have more opportunities to reduce costs than central managers. They can tailor staff and procedures to the local context, and have more freedom for experimenting with alternative ways of doing things and implementing them rather than relying on centrally determined procedures (Kourdi 1999). Therefore, decentralization, if properly designed and implemented, is expected to improve equity, efficiency, quality, and access to health care services and ultimately health outcomes.

2.4 Fiscal decentralization and procurement of health services

Fiscal decentralization signifies the public finance dimension of intergovernmental relations. It specifically addresses the reform of the system of expenditure functions and revenue source transfers from the central to sub national governments. It is a key element of any decentralization programme. Without appropriate fiscal empowerment, the autonomy of sub national governments cannot be substantiated and, in this way, the full potential of decentralization cannot be realized.

Efficiency Criteria or Subsidiarity principle: Providing goods and services at the lowest level of government that can efficiently deliver the good or service. Issues of public finance appear in a new light when an economy is divided into several regions. The general functions of the government – to support an efficient allocation of scarce resources (where the private sector fails to do so) and to guarantee a fair income distribution – must first be divided into several components. Once a fundamental line of government policy is chosen, these functions must be assigned to the jurisdictions.

Fiscal decentralization enhanced improved efficiency of the health services: This argument is linked to the notion of improved efficiency in the use of public resources, which is also related to increased competition for better use of public

resources. Specifically, it can be persuasively argued that decisions about public expenditure, that are taken by a level of government closer to the people it is serving, are more likely to reflect the actual demand for local services, and thus appropriate resource allocation, than a one sized fits all approach more typical of a central government (allocative efficiency).

Different sub national governments offer different mixes of tax-expenditures, and local constituencies are supposed to locate themselves accordingly to their preferences (Tiebout, 1956). Therefore, it implies that fiscal decentralization promotes competition among sub national governments for limiting taxing power and maximizing their health service delivery.

There is also improved political and financial accountability: This is related to the notion that increased authority level may increase democratic accountability by giving citizens greater opportunities for input and participation. In addition, to the extent that sub national services are financed through own revenues, the citizens tend to closely monitor sub national authorities.

Improved effectiveness: This argument supportive of decentralization reflects the principle of subsidiarity, which is the view that government functions should be carried out at the lowest level that can perform those functions effectively and efficiently. This is linked to the notion that decentralization can lead to improved health service delivery, because local officials, as compared to the central government, due to their knowledge of local needs and the incentive to use this information, are better equipped to respond to local variations in conditions, standards and requirements for services and infrastructure.

Additionally, in order to meet local needs, fiscal decentralization may also encourage experimentation and innovation in public policy and service delivery, as individual jurisdictions have both the incentive and freedom to develop and implement new approaches or have incentives to copy successful sub national governments.

Fiscal decentralization is essentially a political decision. The key is in the strategy design and implementation. Strategy must be country specific and dynamic. In addition strategy must integrate intergovernmental and intergovernmental (sub national) components to realize the potential benefits of fiscal decentralization.

Fiscal decentralization is argued to assign more financial responsibility for health service provision to lower tiers of government bringing about efficient service provision (Khaleghian, 2004), Robalino (2001)). The beneficial impact of decentralization on health services is based on the assumptions that decentralization can improve the information of local decision makers about local circumstances, stimulating prompt and effective responses to local needs, and is an effective channel for people to express their preferences.

2.5 Devolution of authority and decision making and health facility utilization

Devolution is a third form of decentralization, whereby independent authority and responsibility for certain functions or programs is constitutionally or legally transferred to sub national units of government that are substantially independent from the central government. Examples of devolution are found in the federal or provincial structures of the United States, Nigeria, or Canada, where states or provinces carry independent responsibility for education,

health care, and social welfare programs, for example. The sub national unit of government normally possesses independent constitutional authority to collect taxes and raise revenue to support the services.

Human resource in health care can be defined as the clinical and non clinical staff in charge of public and individual health intervention. The human resources are therefore the stock of all individuals engaged in the promotion, protection or improvement of the health of the population (Coate, 2003). The most important of the health system inputs, the performance that can be recorded depend largely on the knowledge, skills and motivation of those individuals responsible for delivering health services. The human resource function contributes to making strategic choices about the health care that are essential for developing a national health sector.

Decentralization of the health system combined with the Civil Service reform is increasingly prevalent component of the health sector reform. It is however, regrettable that, the implications of decentralization for human resource development in the health sector are mostly neglected. The human resource are the most important component of the health care system in converting available pharmaceutical, medical technology and preventive health information into better health for a nation (Kolehmainen, 1998).

The implication of Decentralization for staff for Health Care Delivery are greatly influenced by numerous factors; the extent of which political/and administrative power is transferred, how the new roles are defined, what skills are available at the local level and what administrative linkages exist between the different management levels and between the Ministry of Health. Human resource and decentralization are closely linked. The ideas of decentralization mostly arise

outside the health sector. Local needs are the main issues in many countries that decentralized substantial control over health service to local government. The most important human resource issues that come up as a result of transfer of power to lower management level are; the adequacy of available information on human resources, the complexity of transferring staff, the impact of professional associations, unions and registration bodies as well as the morale and motivation of health workers(Kolehmainen, 1998).

Devolution has not been a widely used form of decentralization in developing nations. Decentralization brings major changes in the health care structures and in the jobs that staffs perform. Positions at both national and local require transformation to conform to the new division of power and resources. Existing Organizations may need to be redesigned, revised job descriptions and reporting channels as well as terms and conditions of service (Bossert et al, 2000). Therefore, the personnel management process after decentralization must proceed in tendon with the design of organizational structures; salary scales, position levels, recruitment, selection, appointment, performance assessment, staff disciplines etc. will have to be undertaken with some guiding principles from the National level.

Potential gains to be realized from devolution are also conditional on the existence of decentralization of political decision-making authority, and in particular, effective channels for the individuals to express their preferences, and incentives for the policymakers to respond to those preference.

2.6 Conclusion

From the above reviewed literature it can be observed that a lot has been written about decentralization of the health sector and how it affects service delivery. It stipulated that active involvement of all stake holders in the decentralization design, clear national resource allocation standards and health service norms, and an ongoing system for monitoring are essential for guarding equity and quality and for improving service delivery and efficiency. However a few studies have been done on how decentralization of the health sector impacts on the delivery of services in at Buwana Sub County. Therefore that is why this study was undertaken to cover the research gap.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the methodology used in the study. The study adopted a more qualitative approach with a case study design. The study area which is in Buwama Sub County in Mpigi District and the study population which included the health officials, the local people and some local leaders in Buwama Sub County. A purposive sampling was used as the sampling procedure. The data collection methods where questionnaires, interviews and documentary review were used, controlling validity and reliability through a Triangulation study. The analysis procedures was a qualitative method was used, measurements of variables, the ethical considerations and the limitations.

3.1 Research design

Research design is an overall plan which expresses what data is required, what methods were used to collect and examine the data and how all of the above is going to answer your research topic or study.

The researcher used a more qualitative approach and a case study design. A Qualitative approach is one that seeks to interpret a phenomenon from the perspectives, meanings of the local population it involves. The Qualitative approach is concerned with finding meaning embedded within rich sources of information (Denzin and Lincoln, 2005). The case study design focuses on a contemporary phenomenon within its actual life context and the case study allowed the researcher to get in depth information/data about her research topic from the different multiple data sources (Yin Robert, 1994). It also enabled the researcher to closely examine data about the

research topic in question. Purposive sampling and cluster sampling were used to get respondents of the study. The researcher also used the interview guides, questionnaires and observation checklists to collect information from the respondents.

3.2 Area of study

The study was conducted in Buwama Sub County in Mpigi District. The Sub County consists of 10 parishes and 57 villages. There are 2 health centers and 1 sub dispensary. Buwama Health Center III was the researcher's main focus. Economic activities in the Sub County include Fishing, retail trade, entrepreneurship, banking, and market vending. The researcher chose this area because of the ongoing Health service program that goes through a decentralized system of governance.

3.3 Study population

Population of the study is an aggregate or totality of all the objects, subjects or members that conform to a set of specifications or are selected because they are relevant to a researcher's research question (Polit & Hungler, 1999).

The target population of the study is that of some male and females living in Buwama Sub County. Those included the local health officials, residents of the area and some local council leaders. The researcher chose the above groups of people because she believed they have some experience of Health service delivery and majority of them are assumed to be benefiting from decentralization through the Health Service delivery program. Therefore the researcher believes the above three groups of people have the required information necessary for the research study.

3.4 Sample size and sampling techniques

The sample size was 30 respondents. Purposive sampling, also known as judgmental, selective or subjective sampling, is a type of non-probability sampling technique. Non-probability sampling focused on sampling techniques where the units that are investigated are based on the judgment of the researcher. In this study, purposive sampling technique was used to select Staff of Buwama Health Centre III and the Local Council Leaders. The researcher considered these as key respondents. The researcher also employed accidental sampling technique to select the residents of Buwama Sub County who participated in the study. This involved including residents who came to the health facility without prior appointment.

3.5 Data collection methods

Both primary and secondary data collection methods were employed. Whereas Primary data collection methods included questionnaires and interviews, secondary data was collected through documents review.

3.5.1 Questionnaires

The questionnaire was used to collect mainly qualitative data from 18 respondents. A questionnaire is a list of written questions which are either open-ended or close ended. The researcher used a self-administered questionnaire which was semi-structured in nature. The questionnaire data collection method and instrument enabled the researcher to reach her respondents and collect information from them in quite a short period of time. The method also makes it easy for the respondents to express themselves about the different asked questions, which are very essential in helping the researcher know about the attitude of her respondents concerning the research study. The Local Government Administrators, and other local health officials and the residents of the area are the

respondents that were questioned and their information is expected to generate both qualitative data.

3.5.2 Interviews

The interviews collected qualitative data from 12 respondents and these were from Katebo village, Ssango parish, Bangole village, among other chosen places. An interview is any person to person interaction between two or more individuals with a specific purpose in mind (Kumar, 2005). The researcher used an interview guide with some questions which were asked to the respondents face to face while the respondents answered in line with the questions asked. The interviews helped the researcher to be flexible in a way that the researcher directed the interviews and made necessary adjustments that helped to obtain the information that was needed.

3.5.3 Documentary review

Document analysis involved reviewing existing published and unpublished information relating to the topic under investigation. The researcher reviewed publications and reports from the Health centers and other researcher generated documents, journals and reports. References from which data is drawn was recognized in this study. The study used a documentary review checklist to gather information objective by objective, in line with the variables of the study. Medicines and Health Service Delivery monitoring unit Report in Mpigi district were used and Mpigi district score card report 2012/2013 was of a big use in collecting data.

3.6 Quality control methods

3.6.1 Validity

Validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are (Joppe, 2000).

The researcher used Triangulation. The questionnaire method was used to cross-check some findings from the interview method and the interview method was used to cross-check some findings from the observation method. Triangulation is a combination of more than one data collection method in the study of the same phenomenon. It is a method used in qualitative research to cross-check multiple data sources and collection procedures to evaluate the extent to which all evidence converge. This was used to prove the validity of the research instruments used in answering the stated research objectives and questions (Patton, 2002).

3.6.2 Reliability

It is the extent to which results are consistent over time and an accurate representation of the total population under study (Joppe, 2000). Reliability determined whether the questionnaires especially for the local health officials and the residents if they produce the same results as of some questions that were answered by the respondents in line with the research study.

3.7 Data analysis

The researcher used thematic data analysis and content analysis methods. This is so because the goal of qualitative data analysis is to uncover emerging themes, patterns, concepts, insights and understandings. Qualitative research also generates a report of findings that include expressive language and a personal voice. Some of the qualitative data

analysis methods that are to be used include documentation, interpretation of data plus making conclusions.

3.8 Ethical considerations

The following was done to ensure an ethical study;

Informed consent was sought and appropriate documentation kept, and questionnaires were coded to guarantee anonymity as no one of the respondents can be named at any time during the research or in the subsequent study.

The researcher sought an introductory letter from Uganda Martyrs University which was presented to the authorities in Buwama Sub County to seek permission and consent. The data obtained from the respondents was treated purely as academic and confidential for the safety, social and psychological well-being of the respondents.

The respondents were selected for their willingness to participate without compulsion and no risks to the respondents were identified at any stage during the research.

3.9 Limitations

There was limited cooperation from some respondents who were unwilling to provide information for fear of being implicated. They thought the researcher was a government spy. However, the researcher clarified to the respondents that she was a student and the data collected was only for academic purposes.

There was very limited literature on decentralization in Uganda, particularly in the health sector. This made review of literature difficult. However, the researcher relied on reports from multiple sources such as online sources and district reports.

CHAPTER FOUR

PRESENTATION, ANALYSIS, INTERPRETATION AND DISCUSSION OF THE FINDINGS

4.0 Introduction

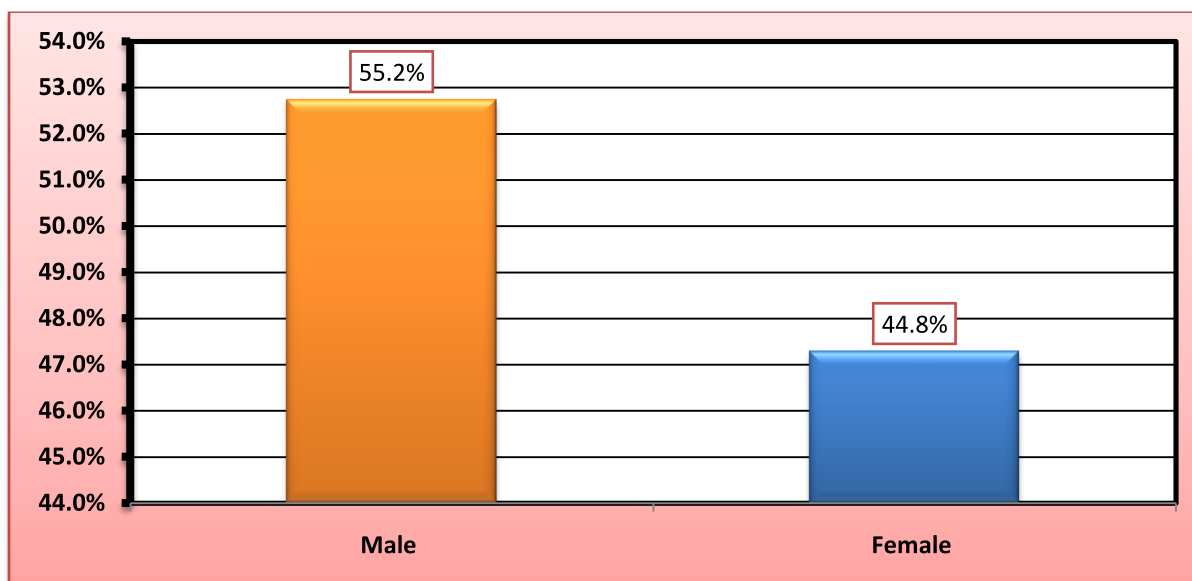
Chapter four presents the findings collected from the field which was Buwama Sub County Mpigi District. Respondents included local health officials, local government administrators and some residents. Data was collected from Buwama Health Center III and all the respondents were from this health center or had a connection with the health center. The researcher presented data using her questionnaires and interview guides while also adding information got using her documentary reviews. Data was presented and analyzed using tables, charts percentages and documentation. Data was collected from 30 respondents. The researcher got information from 18 respondents using the Questionnaire method and 12 respondents using the interview method. Using the documentary reviews, some few things were noted down as per what the researcher saw. Data was discussed using findings got from the field and other authors' input from the literature review (chapter two)

4.1 Demographic characteristics

Demographic characteristics of the respondents were explored as shown in tables and figures below. They included Gender, Age group, Academic qualification, Marital status and Employment status.

4.1.1 Gender of the respondents

Figure 4.1: Gender of the Respondents



Results from figure 4.1 presented that the majority (55.2%) of the respondents were males while the minority (44.8%) of the respondents were females. This implied that Buwama Sub County is a male dominated society. Furthermore, the delegated power from the central government was controlled mostly by men.

4.1.2 Age group of the respondents

Table 1.1: Age group of the respondents

Age group	Frequency (F)	Percent (%)
Below 20 years	0	0.0%
20 - 25 years	6	20.0%
26 - 30 years	10	33.3%
31 - 35years	6	20.0%
36 - 40 Years	5	16.7%
Above 40 years	3	10.0%
Total	**30**	**100.0%**

Table 4.1 above shows that the majority (33.3%) of the respondents had 26-30 years, those were followed by (20.0%)

who had both 20-25 years and 31-35 years, then (16.7%) of the respondents were in the age range of 36 -40 years whereas the minority (10.0%) of the respondents had years above 40. The data implies that Buwama Sub County is mainly comprised of a youthful population that needs to be kept healthy to ensure more productivity. This also assisted the researcher to acquire varying views from distinct age groups.

4.1.3 Marital status

Table 4.2: Marital status of the respondents

Marital status	Frequency (F)	Percent (%)
Single	10	33.3%
Cohabiting	5	16.7%
Married	14	46.7%
Divorced	1	3.3%
Widowed	0	0.0%
Total	**30**	**100.0%**

Table 4.2 above shows that the majority (46.7%) of the respondents were married, these were followed by (33.3%) who were single, then (16.7%) of the respondents were cohabiting, and the minority (3.3%) of the respondents had divorced. This also assisted the researcher to acquire varying views from the various marital groups.

4.1.4 Academic qualification of the respondents

Table 4.3: Academic qualification of the respondents

Academic Qualification	Frequency	Percentage
Never Studied	0	0%
Primary	0	0%
Secondary	4	13.3%
Tertiary	26	86.7%
Total	**30**	**100.0%**

According to table 4.3, it was indicated that the majority (86.7%) of the respondents had attained a tertiary education, these were followed by (13.3%) of respondents had been to secondary education. This implied that most of respondents were highly educated people with high expertise. This also helped the researcher to quickly collect data since the respondents were able to read and write.

4.1.5 Employment status of the respondents

Figure 4.2: Employment status of the respondents

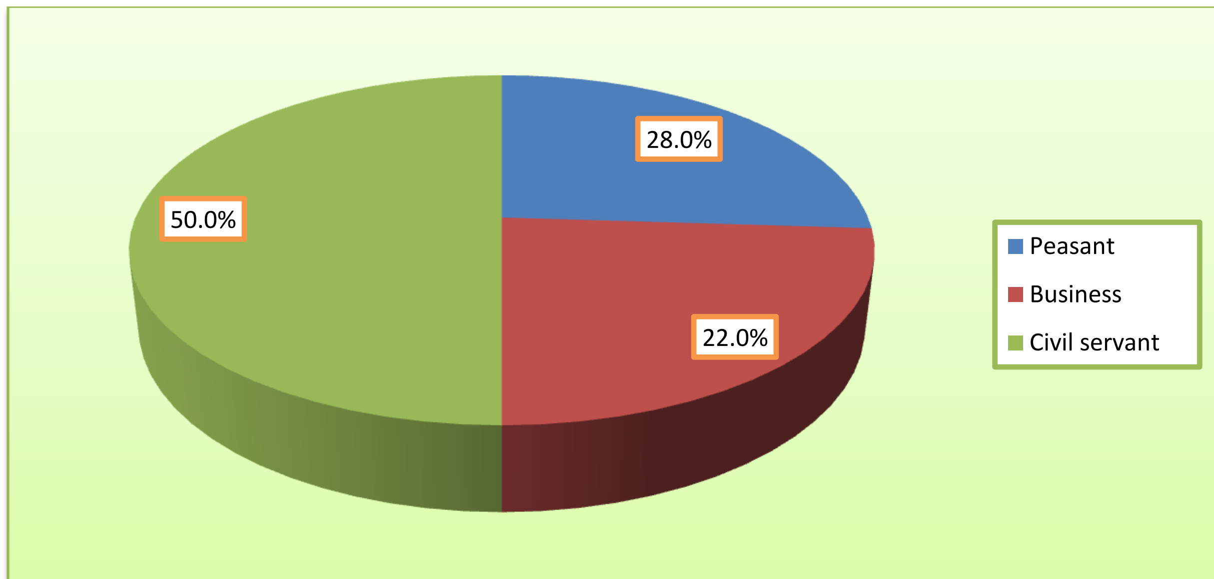


Figure 4.2 above indicates that the majority (50.0%) of the respondents were civil servants, those were followed by (22.0%) who were business men, (28.0%) were peasants. Thus implied that the majority had enough experience with the operations of the Health centre hence they provided relevant information in relation to the topic under study.

4.1.6 Health services offered

The researcher wanted to establish the health services offered at Buwama health centre 3.Health officials and Buwama residents who sought services at the facility were interviewed. In the interviews, the health services mentioned by the respondents include; Mental Health care, paediatric Services, Family planning services, Antenatal care, facility deliveries, and postnatal care among others. As noted by Nanyonjo and Okot, (2013), Uganda's health system is composed of health services delivered in the public sector, by private providers, and by traditional and complementary health practitioners. It also includes community-based health care

and health promotion activities. The aim of Uganda's health system is to deliver the national minimum health care package. Uganda runs a decentralized health system with national and district levels.

4.2 Delegation of hospital administration and access to drugs

Under this section the first objective which was about the effect of Delegation of hospital administration and access to drugs.

4.2.1 Roles of the local government play in the provision of drugs

Asked about the roles played by the local government play in the provision of drugs.

Findings revealed that the local government plays a role of joining up the various health-related functions of district and county councils. It was also noted that the local government protects and advances the interests of society includes the delivery of high-quality health care. The findings were in agreement with Akin, Hutchinson & Strumpf, (2005) who argued that local Government's responsibility to protect and advance the interests of society includes the delivery of high-quality health care. One of the local health officials interviewed said that,

> The local government ensures that the health centre receives all the delivery of equipment and to ensure the delivery of quality health care. (Interview in Buwama Sub County on 28th May 2016).

In addition the respondents said that the local government has a role of developing the health care workforce. It was also revealed from the study that the local government has a role of regulating health care markets, and that it makes proactive use of the powers of both district. One of the local health officials interviewed said that,

> For the past ten years, the government of Uganda through the local governments has embarked on a number of reforms towards enhancing the capacity of the public sector to deliver more efficient and responsive services to the wider population. (Interview in Buwama Sub County on 28th May 2016).

It was also seen from the study that the LG has a role of ensuring access to quality care for vulnerable populations, and forming health care decision makers.

More so Marquis and Huston (2000) pointed out that the ultimate goal of achieving high quality of care will require strong partnerships among federal, state, and local governments and the private sector. Translating general principles regarding the appropriate role of government into specific actions within a rapidly changing, decentralized delivery system will require the combined efforts of the public and private sector because the market alone cannot ensure all Ugandans access to quality health care.

4.2.2 Supplied drugs adequate to meet the needs

Table 4.4: Showing whether supplied drugs adequate to meet the needs

Adequacy	Frequency (F)	Percent (%)
Yes	45	90.0%
No	5	10.0%
Total	**50**	**100.0%**

Most of the respondents (90.0%) point out that supplied drugs adequate to meet the needs of Buwama residents. However the minority of the respondents (10.0%) pointed out that they don't meet the needs adequately. This implies that despite the challenges that are faced in the health centers, the drugs that are supplied are aimed at addressing the needs of the end users.

4.3 Fiscal decentralization and delivery of health services

Under this section, there are findings on the second objective which was about the effect of Fiscal decentralization on procurement of health services are revealed.

4.3.1 Annual budget for health centers

It was revealed for the study that most annual budgets for the health centers are prepared by the financial officers or the accountants. This is because they have vast knowledge regarding finical management and control. In line with Bossert et al, (2000), Proper finical management and Fiscal decentralization can enhance improved efficiency of the health services: This argument is linked to the notion of improved efficiency in the use of public resources, which is also related to increased competition for better use of public resources.

The respondents asked who accounts for the finances at Buwama health centers, they pointed out that the accountant at the health center helps in ensuring that all the finances are accounted for.

4.3.2 Raising revenue

Table 4.5: Raising revenue to run health services

Raising revenue	Frequency (F)	Percent (%)
Yes	30	100.0%
No	0	0.0%
Total	**30**	**100.0%**

It was agreed by all the respondents (100.0%) that Buwama health center raises some revenues to run health services. This is because the revenues that come from the government are normally not enough which necessitates for the health center

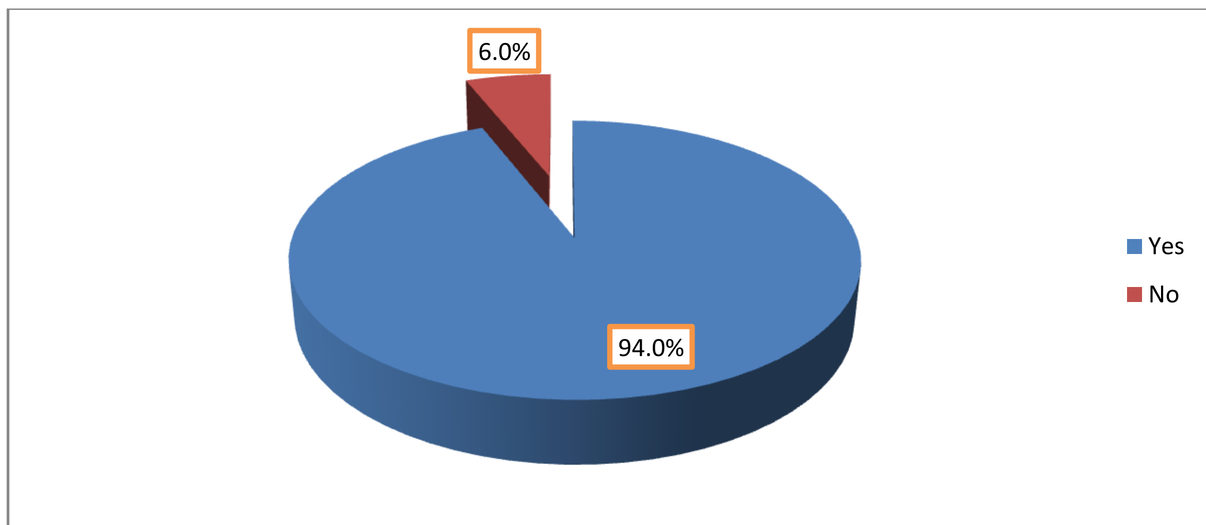
to improvise for extra earning. One of the interviewed respondents said that;

> we normally initiate some side projects that can help the health center to earn extra revenue so that it can supplement the budget that is always constrained such projects include Agaliawamu and also Mildway among others. (Interview in Buwama Sub County on 30th May 2016).

> Some health services are charged for like dental health care services, admissions of patients and some drugs are paid for by the patients through this extra money is got to help run the health centre. (Interview in Buwama Sub County on 30th May 2016).

4.3.3 Determining salaries

Figure 4.3: Showing whether central government determining salaries



It was revealed from the study that majority of the respondents (94.0%) agreed that the local government or health centre determine salaries for Buwama health centers' employees. However minority of the respondents disagreed (6.0%). This could be because some of the employees in Buwama health centers are not on the government payroll and some others are support staff or hired by the health centre its

self. Therefore in such cases, Buwama health centers determine the salaries for such employees.

4.4 Devolution of authority and decision making led to health facility utilization

4.4.1 Full power to make key decisions

Table 4.6: Full power to make key decisions

Full power to make key decisions	Frequency (F)	Percent (%)
Yes	14	46.7%
No	13	43.3%
Total	30	100.0%

It was disagreed on by majority (46.7%) that the central government granted full power to Buwama health center to make key decisions in the provision of health services as compared to the (43.3%) who agreed. In line with the results one of the interviewed respondents said that:

> We are normally told to follow the policies and regulations as provided to us from the central government. There are a few decisions that the health workers make on their own. (Interview in Buwama Sub County on 30th May 2016).

4.4.2 Involvement of communities that use the facility

It was also revealed from the study that Buwama health center normally ensures full involvement of communities that use the facility. As agreed by Villadsen, (1996) one assumption is that local communities should be involved in decision making because they have better knowledge of local needs and conditions and make better decisions if they are granted the authority to manage resources and organize and supply health services.

4.4.3 Increased decision making power

Table 4.7: Increased decision making power

Role of increased decision making power	F	%
It helps in addressing the difficulties of trying to coordinate disparate Health centre activities	6	20.0%
Increased control over specific types of responsibilities including administrative, political or fiscal	3	10.0%
It leads to greater accountability of health workers	2	6.7%
improvement in Health Sector through information asymmetry	8	26.7%
improved efficiency of resource utilization	11	36.7%

Asked about how the increased decision making power at Buwama health centers determined the acquisition of information at the hospital, respondents (36.7%) said that improved efficiency of resource utilization. Still, (20.0%) noted that it helps in addressing the difficulties of trying to coordinate disparate Health centre activities. This was in line with the study findings of Popic, Patel M (2011) pointed out that increased decision making power also plays an important role of addressing the difficulties of trying to coordinate disparate health centre activities for different regions from a central location. Decision-making to the local level can reduce the time required for making decisions, as well as increasing the likelihood that decisions will be made with the benefit of local knowledge of conditions.

From the study, (26.7%) agreed that increased decision making power has led to improvement in Health Sector through information asymmetry and that it has also increased control over specific types of responsibilities including administrative, political or fiscal. In line with the study

findings, Bossert et al, (2000) argued that the Hospital/Health Sector has been improved as a result of increased decision making power through information asymmetry. In this case, the health centres can pursue their own agenda if central MOH is not well informed about their activities.

The findings also revealed that it leads to greater accountability of health workers as agreed by (6.7%). In line with the interview findings one of the respondents said that;

> Increased decision making power can lead to greater accountability of health workers, thereby increasing the quality of health services and the efficiency by which they are produced. (Interview in Buwama Sub County on 30th May 2016).

4.5 Health service delivery

4.5.1 Respondents visits to Buwama health centers

The people are not interested in using health facilities because they have to travel long distances and even when they reach they don't find the drugs there and therefore opt for the local herbs which are easily found. In agreement with the results Grant, (1990) stated that access to health facilities in Africa is greatly affected by culture where by in some cultures, they are not allowed to use artificial medicine they emphasize traditional medicine and especially in developing countries.

It was also revealed from the study that the medical staff at Buwama health centers always available to serve the residents of Buwama. However there were cases where the medical staff were not available.

4.5.2 Availability of drugs

From the results still it was indicated some people were unsure of the situation whether there is lack of drugs in Health Facilities this could be because of the fact that some people often use herbs for treatment as revealed in an interview with one of the residents in Buwama. As one Health official said in an interview,

> Some of the people here are not interested in using health facilities and they opt for traditional medicine. (Interview in Buwama Sub County on 30th May 2016).

These results also justify what a Health official said from an interview that,

> Health centers cannot order for drugs, the government gives the drugs quarterly and decides on the quantity of drugs to be supplied (push system) and by the time they arrive there is much drug shortage. (Interview in Buwama Sub County on 30th May 2016.

This implies that the drugs sent from the government are not enough as compared to the population. This quotation is in line with Castro-Leal et al (2000), states that many individuals by-pass health care facilities within their localities and utilize those outside their place of residence for various reasons which include trust in the services rendered by the facility, availability of qualified staff, availability of required equipment, type of disease and severity of illness.

4.5.3 Transfer of instruments of power

It was revealed that the authority and responsibility for public functions were transferred from the central government to the local level. It was also revealed that the Health sector decentralization policies are now implemented at the

local level, this is in agreement with Green, (1994) who stipulated that decentralization of health services involves the transfer of policies and responsibility to lower health officials, and health service providers from the central government health department.

4.5.4 Challenges as a result of decentralization of health services

It was revealed that Lack of care was among the challenges faced. It was shown that there are few health facilities to cater for the increasing numbers of patients. From the interviews done one Health Official said that;

> Most of the health facilities in Buwama are under staffed which limits the management of the increasing number of patients. (Interview in Buwama Sub County on 31st May 2016.

The Condition of the roads and distance to the health centers has been greatly considered as one of the ways to boost access to health centers and utilization of health services. However, the respondents describe the Condition of the roads and distance to the health centers to be poor and is a challenge to effectively access health services One Health official stressed that;

> This road infrastructure limits the movement of patients from where they stay to the Health facilities because it's dusty when it shines and muddy when it rains. (Interview in Buwama Sub County on 31st May 2016).

These results indicate that the respondents agreed that the legal framework that plans for the health sector service delivery has been shifted to the local level. This indicates that few of the respondents had no knowledge about legal and institutional framework. In line with the findings, some of the local Officials said that;

> The biggest challenge of small number of people managing the local planning but there is an existing legal and institutional framework in Buwama. (Interview in Buwama Sub County on 1stJune 2016).

4.5.5 Overcoming the challenges faced

The study showed that most of the respondents agreed that there is a need to recruit more medical personnel to fill the vacant posts by the local government and also that Health care providers have to be educated on the importance of involving beneficiaries in planning and managing health care delivery

It was also pointed out by the respondents that there is need to have enlightenment to the local people about the importance of participation in health services;

It was also revealed by the respondents that there is a need to have appropriate technical and attitudinal training for service providers. There is also a need to equip the community health centers with better equipment to treat patients.

The study findings indicated that there is need for enlightenment to the local people about the importance of participation in health services like immunization and the benefits of decentralization of health services. Mass education exercise should be organized by bodies like the District Assembly, NGOs and advocates of local participation to create awareness in these people. By doing so, the local people will be equipped with knowledge and ideas on the nature of participation and their roles. This has eliminated the tendencies for local people to drag or hijack the process as complained by some of the health workers at the health centers. The education also instills in local people the zeal to take the move to participate in service delivery rather than always waiting to be brought in my health professionals.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter looks at the summary of the findings, conclusions drawn from the findings and discussions in the previous chapter plus the recommendations for how health as a service can be improved especially in Buwama Health Center III as mentioned in the research study.

5.1 Summary of the findings

The study revealed that delegation of hospital administration has enabled the residents of Buwama Sub County to access drugs. This has been done through, recruiting a workforce to offer health care at Buwama health centre, equipping the health facilities with drug supplies. This is in collaboration with the Ministry of Health and the national drug authority.

The findings revealed that decentralization has to a large extent effectively delivered health services as seen for example by ensuring that supplied drugs are adequate to meet the needs of the people which is done at the district level.

On fiscal decentralization of health facilities in Buwama, the study revealed that the health centre is able to generate revenue to supplement funding from the central government. This is achieved through projects like Agaliawamu and Mildway The health centre is also empowered to charge basic fees for some health services like dental health care, drugs and admission fees among others. The health centre also has the autonomy to decide on how the funds generated should be utilized.

Pertaining devolution, the local community has been able to participate in decision making at Buwama health Centre III. Some of the community members are representatives on the health committee of the health centre. The local community is also empowered through their leaders to demand for better health care.

Some of the challenges that were associated with decentralization of health services in Buwama included shortage of drugs and absence of the health workers at times as mentioned by respondents, inadequate infrastructure and relatively unsatisfactory inspection was another challenge.

The failure by decentralization to deliver Health as a service, to a small extent has led to poor health care of the people. On the other hand, the success of decentralization to a small extent has also led to improvement in the health of the residents of Buwama for instance.

5.2 Conclusions

Even though decentralization has faced challenges in Buwama Sub County characterized by shortage of drugs and limited infrastructure, overall the researcher concludes that decentralization policy has had a number of positive effects in the delivery of health services in Mpigi District. This is based on the fact that health centers are beginning to be self sustaining through fiscal decentralization, in that they can generate their own revenue for operations. Furthermore devolution and delegation have enabled important decisions to be made quicker such as purchase of health needs, recruitment of staff for the health centers and involvement of the local community in decision making.

5.3 Recommendations

Based on this study, the researcher made the following recommendations;

Fiscal decentralization should be enhanced in order to increase on the revenue generated at local government health facilities if sustainability is to be realized.

Monitoring of health workers activities and attendance need to be addressed. For instance by availing an attendance registers and punishing absenteeism. This will ensure the local population have better health care.

There local government health centres should collaborate with the national drug authority and the ministry of Health to ensure timely delivery of drugs to the health centres.

Health care providers should be educated on the importance of involving beneficiaries in planning and managing health care delivery. These providers can be sensitized during training, worships and seminars organized by policy makers, NGOs, and civil society groups. This is because, the health worker is the one close to the user and until he or she sees the need to encourage local level participation; national efforts aim at doing so will be thwarted.

Community participation in health services in the whole rural community should be made official or legal, so that when beneficiaries are denied the opportunity to partake, they will have the power to challenge the operators of the given health delivery system.

5.4 Areas for further study

Therefore there is need for further research on the impact of community participation in enhancing Health Services delivery.

References

Ahmad J., Shantayanan D., Stuti K., Shekhar S., (2005). *"Decentralization and Service Delivery,"* World Bank Policy *Research* Working Paper.

Akin, Hutchinson & Strumpf, (2005). *Decentralization and Primary Health Care*: Some Negative Implications in Developing Countries. International Journal of Health Services.24: 459-75.

Ali, Q. A. (1995). "*Decentralized Administration in Bangladesh*". Dhaka: University Press Limited.

Australian Government. (2013). *Productivity Commission on Efficiency and Effectiveness*: Some Definitions. Staff Research Note.

Awal, (1994). "*Desirable and Undesirable outputs*: a case study of selected district referral hospitals in Uganda", Health policy and Development, Vol. 6.

Bank, W & Fiorilli, J. (2007). *Decentralization and Local Democracy in the World*. Global Report. Barcelona.

Blumenthal & Hsaio, (2005)343
(d4163) http://savenhshomeopathy.org/wp-content/uploads/2012/09/Huber-Definition-Health-BMJ-21.pdf

Bossert et al, (2000). *Decentralizing Public Services:* What Can We Learn from the Theory of the Firm?" Revue d' Economie Politique 106 (Jan.-Feb.): 37-60.

Carlson, C. et al, (2005). *Improving the Delivery of Health and Education Services in Difficult Environments*: Lessons from Case Studies. Health Systems Resource Centre: DFID.

Castro-Leal, Asante, F.A. and Ayee, J.R. (2008). *Decentralization and Poverty reduction.* The economy of Ghana: Analytical perspectives on the stability, growth and poverty.

Christian Nordqvist, (2015). Recentralising while Decentralising: Center-Local Relations and "CEO" Governors in Thailand. *The Asia Pacific Journal of Public Administration*. 26: 33-53.

Coate, (2003). Crossing the Great Divide: Coproduction, Synergy and Development. *World Development*, 1986, 24(6): 1073-1087.

Constitution of the Republic of Uganda (1995).

Conyers, D. (1986). "Future Direction of Development Studies: *The case of Decentralization*". World Development. Vol. 4.

Denzin & Lincoln.(ed). (2005). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.

Desirable and Undesirable outputs: a case study of selected district referral hospitals in Uganda", Health policy and Development, Vol. 6.

Dr Brian, V. WYK. (ND). *Research Design and Methods*. Post-Graduate Enrollment and Throughput: University of the Western Cape.

Fink, A. (2003). *How to Sample in Surveys*. 2nd Edition. Thousand Oaks: Sage.

Foley, (2008). Performance-based financing and changing the district health system: experience from Rwanda. *Bulletin of the World Health Organization*, *84*(11), 884-889.

Fox, W & Meyer. (1995). *Policies for Public Service Transformation*. Eliot Avenue: Creda Press.

Government of Uganda. (2005), "Ministry of Health National Health Policy", Ministry of Health, Kampala.

Grant, (1990). *Health system decentralization:* concepts, issues and country experience.

Green, A. (1994). *Decentralization and primary health care: some negative implications in developing countries.* International journal of Health services, 24(3), pp.459-475.

Greyson, (2009). Performance-based financing and changing the district health system: experience from Rwanda. *Bulletin of the World Health Organization*, *84*(11), 884-889.

Gutierrez, R. A. (2010). "*Implementing decentralization of local services*: a case-study from Mexico", in Mills, A. et al., Health System Decentralization. Concepts, Issues and Country Experience, World Health Organization, Geneva.

HDPG, (2002). *SWAp Mechanisms and Structures*. Mimeo. Health Development Partners Group, Kampala, Uganda.

Holtmann, E. (2000). *"Decentralization/Dezentralisierung".* Politik-Lexikon, 3. völlig überarbeiteteund erweiterte Auflage. München.

Huber, Niederlin, and Frank, A. (2012). *Music playing system with decentralized units.* U.S Patent 5,691,964.

Hutchinson et al, (2000). *Decentralizing Public Services:* What Can We Learn from the Theory of the Firm?" Revue d' EconomieP olitique 106 (Jan.-Feb.): 37-60.

Islam, K.M. (1997). *"Administrative Decentralization: A Conceptual Analysis and Its Implication in Bangladesh:* A journal of mass communication, public Administration and Social Sciences. Center for Social Science Research: University of Rajshahi. Vol. 1.

Joppe, (2000). *The Political Economy of Democratic Decentralization*. World Bank: Washington DC.

Kahkonen, S. and Lanyi, A. (2001). *Decentralization and governance: does decentralization improve public service delivery?* (No. 11382). The World Bank.

Khaleghian, (2004). *Multi-nationalism, democracy and 'asymmetrical federalism', Technical Advisory Network of Burma, working Paper.*

Kisubi, (1996). *Assessing Decentralization Policies in Developing Countries:* The Case for Cautious Optimism." Development Policy Review.1986, 4, 3-23.

Kolehmainen, (1998). *Governance, Administration & Development: Making the State Work*. McMillan Press LTD: Hong Kong.

Kourdi, (1999). *Decentralization of Governance and Development. J. Economic Perspectives*, 16(4): 182-205.

Krejcie, R. V., & Morgan, D. W. 1970. *Determining sample size for research activities*. Educational and psychological measurement, 30(3), 607-610.

Kumar, (2005). "*Decentralization in health care*: lessons from public economics", in: Smith PC, Ginnelly L, Sculpher M (Eds.), Health Policy and Economics, Open University Press, Maidenhead.

Levaggi R, Smith PC (2005): "*Decentralization in health care*: lessons from public economics", in: Smith PC, Ginnelly L, Sculpher M (Eds.), Health Policy and Economics, Open University Press, Maidenhead.

Marquis and Huston, (2000). *Participatory Budgeting in Porto Alegre*: Toward a Redistributive Democracy. Politics & Society, 26 (4), 461-510.

McPake B, Asiimwe D, Mwesigye F, Ofumbi M, Streefland P, Turinde A (1998). *The Economic Behaviour of Health Workers in Uganda*: Implications for Quality and Accessibility of Public Health Services. London School of Hygiene and Tropical Medicine. PHP Departmental Publication No. 27.

Mills, A., Maganu, Vaughal, J. P., Smith, D.L., and Tabibzadeth. (1990), *"Health System Decentralization: Concepts, Issues and Country Experiences"*, World Health Organization: Geneva.

Mirmirani S., Li H.C., and Ilacqua J. A., (2008). *"Health Care Efficiency in Transition".*

Murindwa et al., (2003). *Forces Shaping Centralization and Decentralization in Environmental Policymaking"* In Environmental Governance and Decentralization: Country Studies, eds. Breton.

Murindwa G., Kirunga-Tashobya C., Kyabaggu J. H., Rutebemberwa E., and Nabyonga J. *Meeting the challenges of decentralized health service delivery in Uganda as a component of broader health sector reforms.* In: Kirunga-Tashobya C., Ssengooba F., Cruz V., editors. Health Systems Reforms in Uganda: Processes and Outputs. Health Systems Development Program, London School of Hygiene & Tropical Medicine, UK.2006. Available from http://docs.mak.ac.ug/sites/default/files/Health%20Sytems.pdf

Muyomba- Tamale, L, et al, (2013). *Local Government Councils' Performance and Public Service Delivery in Uganda*: Mpigi District Council score-card Report 2012/2013. ACODE Public Service Delivery and Accountability Report Serries No.2, 2013. Kampala.

Nanyonjo and Okot, (2013). *Abolition of cost-sharing is pro-poor: evidence from Uganda.* Health Policy and Planning, 20 (2): 100–8.

Nelson, (1994). *The Economic Behaviour of Health Workers in Uganda*: Implications for Quality and Accessibility of Public Health Services. London School of Hygiene and Tropical Medicine. PHP Departmental Publication No. 27.

Neven, I. (2000). *Background Paper On "Decentralisation" Contribution To Cost-Action "National Forest Programmes in the European Context*". Green World Research. Wageningen: The Netherland.

O'donnel, (2008). *Decentralization and governance*: does decentralization improve public service delivery?

Oates, (2005). *Governance, Administration & Development: Making the State Work*. McMillan Press LTD: Hong Kong, 1997.

Patton, M.Q. (2002). *Qualitative research and Evaluation Methods.* 3rd Edition. Thousand Oaks, CA: Sage.

Pauline, R. (2007). *Supporting Non-State Providers in Basic Education Service Delivery*: Consortium for Research on Educational Access, Transitions and Equity. Research Monograph 4.

Polit, D. F. & Hungler, B. P. (1999). Nursing Research: *Principles and Methods*. 6th Edition. Philadelphia: J. B.

Popic D, Patel M. (2011). *Decentralization: Equity and sectoral policy implications for UNICEF in East-Asia and the Pacific UNICEF EAPRO, Social Policy and Economic Analysis Unit.*

Rahman, M. S. (1996). "*Decentralization Practices in Bangladesh*: Problems and Potentials": Rajshahi University Studies. Vol. 4.

Robalino, (2001). *Governance gone local*: "*Does decentralization improve accountability.*" In East Asia Decentralizes. World Bank: Washington DC.

Taylor and Marandi, (2008). *Robust Decentralized Detection in Sensor Networks:* Multiple Observations.

The World Bank, Washington, D.C. Yawe B. L. and Kavuma S. N., (2008), "*Technical Efficiency in the presence of Desirable and Undesirable outputs*: a case study of selected district referral hospitals in Uganda", Health policy and Development, Vol. 6.

The World Bank.(2016) *"Life expectancy at birth, total (years)"*. Retrieved 28 February 2016.

Tiebout, (1956). Macroeconomic Management in Decentralized Democracries: The Quest for Hard Budget Constraints in Latin America. In *Development in Latin America and the Caribbean: Decentralization and Accountability of the Public Sector*. World Bank: Washington, DC.

Uchimura and Jutting, (2010). *Rethinking Decentralization in Developing Countries*. World Bank: Washington, DC.

Villadsen, (1996). *The Emergence of Local Capacity*: Lessons From Colombia. In World Development, 25(7): 1029-1043.

Winkler, D. R. (2005). *Public Expenditure Tracking in Education Policy Brief* . Educational Quality Improvement Program (EQUIP2). Washington, D.C.

World Bank (2001), *World Bank Development Report* 2001.

World Health Organization. (2003). *Health Systems*: Principled Integrated Care. Geneva: WHO.

World Health Organization. (2006). *Constitution of the World Health Organization* –Basic Documents, Forty-fifth edition, Supplement, October (2006).

Yin, R.K, (1994). Case Study Research. Design and Methods. Thousand Oaks: Sage.

Yukl, (1998). *Health System Decentralization: Concepts, Issues and Country Experiences"*, World Health Organization: Geneva.

APPENDICES

APPENDIX I: QUESTIONNAIRE: LOCAL OFFICIALS AND HEALTH OFFICIALS

Dear respondent,

My name is **Apio Vera Amy** student of Uganda Martyrs University. I am carrying out a research study entitled: **"Assessing the Effectiveness of Decentralization in Health Service Delivery in Mpigi District".** This questionnaire is therefore intended to seek information on the above subject matter. The information is purely for academic purposes and all the answers will be handled with utmost confidentiality. I therefore humbly request that you complete this questionnaire correctly in the spaces provided or options given (Please, tick the appropriate answers where options are given).

SECTION A: Demographic Characteristics of respondents

Tick / fill in the most appropriate answer.

1. Gender:

    a) Female ☐ b) Male ☐

2. Age

    a) Below 20 years ☐ b) 20 – 25 years ☐

    c) 26 – 30 years ☐ d) 31 – 35years ☐

    e) 36 – 40 Years ☐ f) Above 40 years. ☐

3. Marital status

    a) Single ☐ b) Cohabiting ☐ (c) Married ☐

    c) Divorced ☐ e) Widowed ☐

4. Education level

a) Never studied ☐ b) Primary ☐

c) Secondary ☐ d) Tertiary ☐

5. Employment status

a) Peasant ☐ b) Business ☐ c) Civil servant ☐

6. What health services are offered by Buwama health centers?

....

....

....

7. What roles does the local government play in the provision of drugs at Buwama health centers?

....

....

....

8. Are the supplied drugs adequate to meet the needs of Buwama residents?

....

....

9. Who prepares the annual budget for Buwama health centers?

....

....

....

10. Does Buwama health center raise any revenues to run health services? If yes please explain how?

....

....

....

11. Who accounts for the finances at Buwama health centers?

……

……

……

12. Does the local government or health centre determine salaries for Buwama health centers' employees?

……

……

……

13. In your opinion, has the central government granted full power to Buwama health center to make key decisions in the provision of health services?

……

……

14. How does Buwama health center ensure full involvement of communities that use the facility?

……

……

15. How has the increased decision making power at Buwama health centers determined the acquisition of information at the hospital?

……

……

16. Is there any other information relevant for this study that you would like to provide?

……

……

Thank you for your time

APPENDIX II: QUESTIONNAIRE: RESIDENTS OF BUWAMA

Dear respondent,

My name is **Apio Vera Amy** student of Uganda Martyrs University. I am carrying out a research study entitled: **"Assessing the Effectiveness of Decentralization in Health Service Delivery in Mpigi District".** This questionnaire is therefore intended to seek information on the above subject matter. The information is purely for academic purposes and all the answers will be handled with utmost confidentiality. I therefore humbly request that you complete this questionnaire correctly in the spaces provided or options given (Please, tick the appropriate answers where options are given).

SECTION A: Demographic Characteristics of respondents

Tick / fill in the most appropriate answer.

1. Gender:

   a) Female ☐ b) Male ☐

2. Age

   a) Below 20 years ☐ b) 20 – 25 years ☐

   c) 26 – 30 years ☐ d) 31 – 35years ☐

   e) 36 – 40 Years ☐ f) Above 40 years. ☐

3. Marital status

   a) Single ☐ b) Cohabiting ☐ (c) Married ☐

   c) Divorced ☐ e) Widowed ☐

4. Education level

   a) Never studied ☐ b) Primary ☐ c) Secondary ☐

   d) Tertiary ☐

5. How often do you visit Buwama health centers?

……

……

6. Is the medical staff at Buwama health centers always available to serve the residents of Buwama?

……

……

……

7. Have you experienced drug shortages at Buwama health centers?

……

……

……

8. Are the drugs at Buwama health centers free of charge or you are charged for them?

……

……

……

9. Do the local council leaders often inform you of the health funds received at Buwama health centers?

……

……

……

Thank you for your time

APPENDIX III: INTERVIEW GUIDE

Dear Respondent

My name is **Apio Vera Amy** student of Uganda Martyrs University. I am carrying out a research study entitled: **"Assessing the Effectiveness of Decentralization in Health Service Delivery in Mpigi District.** You have been selected to share with us your experience and make this study successful. The Interview I am conducting is basically aimed at obtaining qualitative information to compliment the quantitative information. Information given will be treated with utmost confidentiality.

1. What do you understand by decentralization
2. Has everyone in the area been able to access drugs?
3. How have the taxes collected in the area led to health service delivery?
4. What instruments of power have been handed down to from the central government?
5. Who accounts for the finances at Buwama health centers?
6. Have you faced any challenges as a result of decentralization of health services?
7. How have you overcome these challenges faced?
8. What recommendations would you give regarding the topic under investigation?

THANKS FOR YOUR TIME