ASSESSING THE ROLE OF ADMINISTRATIVE DECENTRALIZATION IN THE IMPROVEMENT OF HEALTH SERVICES AMONG THE LOW EARNING PEOPLE IN LWENGO DISTRICT

CASE STUDY: KYAZANGA HEALTH CENTRE III,

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

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Dedication

This work is dedicated to my dear parents that have worked hard to make me the person that I am today, especially my father Mr. Mwesigye Alex, my mother Mrs. Nahumuza Fausta Mwesigye, Aunt. Naamara Melidah, and to my sister Kyarimpa Specious and my friends who have supported me in my education.

May God bless you.

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I would like to thank the Almighty God for his Grace up on me that enabled me to come to the accomplishment of this research, Glory be to His Name.

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Much thanks to you all.

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List of abbreviations/Acronyms

ANC:	Antenatal care
AIDS:	Acquired Immune Deficiency Syndrome
HIV:	Human Immune Virus
EMTCT:	Elimination of Mother to Child Transmission
HCIII:	Health Centre III
HC:	Health Centre
HCT:	HIV counseling and testing
PMTCT:	Prevention of mother-to-child transmission
UDHS:	Uganda demographic and health survey
VHTs:	Village health teams
LC:	Local council
LCIII:	Local Council three (Chairperson)
UNDP:	United Nations Development Programme
MDGS:	Millennium Development Goals
UBOS:	Uganda Bureau of Statistics
WHO:	World Health Organization
MOH:	Ministry of health
IMF:	International Monetary Fund
DLG:	District Local Governments
PRSP:	Poverty Reduction Strategic Plan
HSSP:	Health Sector Strategic Plan
PNFPs:	Private Not for Profit Organizations
NRM:	National Resistance Movement
NHS:	National Health System
NMS:	National Medical Stores

Abstract

The study was intended to Assess the role of Administrative Decentralization in the Improvement of Health Services among the low earning people in Uganda, Kyazanga Sub County, and Kyazanga health Centre III as the case study. The study was guided by four research questions as derived from the specific objectives; How has decentralization helped in health service delivery? What is the role played by the sub county in the health service delivery to the local citizens?, What are the services offered to the people at the health Centre III? What challenges have been faced in health decentralization?

In carrying out the study, a descriptive study design employing both qualitative and quantitative approach was used. The study covered a sample size of 54 respondents among whom it targeted the following; the local government leaders at the sub county (councillors), the health administrators and health workers (nurses and clinical officers), and the local people/ the HC III beneficiaries. Some of these respondents were selected using simple random sampling technique while others were selected using purposive sampling technique.

The data was collected using questionnaires and interview guides administered to the sampled population and it was later presented using tables and narratives. Literature from secondary sources such as published books, reports, journals, newspapers and internet services (websites) was used to supplement the primary data. Analysis of data was done using frequency counts, percentages and content analysis for information from the structured interactions with respondents.

It was confirmed that LCIII council plays an important role in health service delivery through planning and financial budgeting for the health sector and sensitization. This has empowered the local people the participants were highly knowledgeable about the health facilities that existed in their community. They access treatment diseases such as malaria, diarrhea, measles, Antenatal care and fighting HIV/AIDS among the rural people. For instance there are Mobile clinic services and community health workers (CHWs) that have been crucial in supplementing services. The people had access to cheap health services.

The low income earners are disadvantaged populations hence accessibility of health services in communities with no public health facilities is burdensome to poor. However they experience challenges such as illiteracy, poverty, under funding of the health sector, corruption, regular stock out for drugs, high costs of services, cultural conservatism, inadequate water and poor sanitation facilities have a big impact on health indicators.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

Chapter one covers the background of the study, statement of the problem, objectives of the study, research questions, scope of the study, significance of the study and its justification, definition of key terms and the conceptual frame work.

1.1 Back ground of the study

Ssonko, (2013) defines Decentralisation as the transfer of power over decision-making and implementation to lower administrative levels for purposes of improving efficiency and effectiveness. Other definitions of decentralisation are many but four types predominate as shown below as stated by Ssonko, (2013),

> Deconcentration – the transfer of administrative responsibilities from the central government to local governments within a central government ministry or agency; Delegation – the transfer of managerial and administrative responsibilities of central ministries for specifically defined functions to organisations that are external to the regular bureaucratic structure; Devolution – the substantial transfer of powers and authority and functions from higher or central government to local units, upon which the local units or governments subsequently acquire significant and autonomous financial and legal powers to function without reference to central government; Privatisation is the transfer of responsibilities to private or individual companies in a process by which service delivery is made by private companies who win tenders through a competitive tendering process administered by the government agency.

According to Bashaasha, (2011) Decentralization initiatives have transferred responsibility of procurement, selection of local projects, and identification of beneficiaries from

central ministries to local governments or community representatives. Such experiments were first introduced in the 1980s in several countries, including Armenia, Albania, Bosnia-Herzegovina, Brazil, China, El Salvador, Georgia, India, Mexico, South Africa, and Uganda among others. The presumed argument in favor of decentralizing delivery systems is that local governments will be subject to electoral pressures from local citizens, who are able to monitor delivery better than a distant central authority.

Ssonko, (2013) still argues that since the 1980s governments in sub-Saharan Africa have been undergoing economic and institutional reforms. Among the many institutional reforms, decentralisation has been instituted to advance political democratisation and to promote socio-economic development. Decentralisation is part of efforts to promote people's participation in decision making processes and development activities which in turn promotes good governance. This is based on the premise that decentralised governance provides a structural arrangement and a level playing field for stakeholders to promote peace, democracy and development. Bashaasha et al, 2011as cited in Ssonko (2013) further supports this that under the decentralisation policy, service delivery institutions and their governance are decentralised in order to improve access to services particularly for the rural poor. Decentralisation therefore transfers administrative and political powers from central to regional or sub-national governments.

The 1995 Constitution and Local Governments Act 1997 provided for the District to be a unit of decentralisation and spelt out the functions devolved to local governments, and the relevant funding mechanisms. The idea was to involve the people in the way they are governed, in decision making, identifying problems, setting priorities, planning

implementation and monitoring, to ensure better utilisation of resources both financial and human, and value for money through participation, transparency and accountability and sensitisation. The World Bank (2000) provide a clear and detailed outline of the perceived merits of decentralisation which include; facilitating good governance by empowering the local population to participate in matters affecting their lives. This allows for the local people to be watchdogs and ensure that public officials deliver quality goods and services.

According to Mayanja, (2005) decentralization of health services in Uganda, driven by the structural adjustment programme of the World Bank, was embraced by government as a means to change the health institutional structure and process delivery of health services in the country. Arising from the decentralization process, the transfer of power concerning functions from the top administrative hierarchy in health service provision to lower levels constitutes a major shift in management, philosophy, infrastructure development, communication as well as other functional roles by actors at various levels of health care. Decentralization was therefore envisaged to contribute to poverty reduction and development through the bottom-up approach to planning and monitoring service delivery as stated in (WHO, 2007).

> Uganda began its health sector decentralization process in 1997 following the enactment of the Local Government Act, 1997. The rationale was to increase both allocate 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. In the process, the District Local Governments (DLGs) become accountable for resources allocated and monitoring the quality of services provided as argued by (Mayanja,2005).

It is believed that decentralized systems offer opportunities for increased beneficiaries' involvement in the direct decision making process in health services prioritization, quality, cost and preferences as argued by (Nannyonjo and okot, 2013). Therefore according to Tidemand, (2010) this attributed to the fact that, DLGs are more acquainted to the beneficiaries' requirements, responsive to new developments and is in contact with communities. Administratively, this proved attractive to the central government because part of the burden of financing health services could be shifted to sub-national units and private providers.

The medium-term policies to improve health service delivery are clearly documented in Uganda's Poverty Reduction Strategic Plan (PRSP). 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(WHO, 2007). This is in line with observation in the Poverty Eradication Action Plan(PEAP 2006).

Thus, to achieve and maintain sustainable development, Ugandan identified health and economic growth as mutually reinforcing means the efficient provision of health services through the decentralized system. This was identified as an essential requirement for sustained development because without good health, the entire productive population cannot effectively achieve identified social and economic goals. It is therefore clear that the health sector plays a critical role in poverty eradication and promotion of development as a way of improving people's incomes.

Furthermore the private sector health care delivery system was introduced as a result of decentralisation. Ministry of health, (2010) states that the private sector plays an important role in the delivery of health services in Uganda

covering about 50% of the reported outputs. The private health system comprises of the Private Not for Profit Organisations (PNFPs), Private Health Practitioners (PHP) and the Traditional and Complementary Medicine Practitioners, the contribution of each sub-sector to the overall health output varies widely. The PNFP sector is more structured and prominently present in rural areas. The PHP is fast growing and most facilities are concentrated in urban areas. Even if the services provided are not consistent and vary from traditional practices in rural areas to imported alternative medicines, mostly in urban areas. This was brought by decentralisation when the government of Uganda decided to privatise the health sector for easy delivery of health services.

Non-government organizations especially church missions such as Kitovu hospital in Masaka, play an important role in the provision of rural health services, while the private for profit sector is very small and remains mostly an urban phenomenon. However, a largely this has also improved on the health service delivery in Uganda as stated in (Okidi and Gulaba, 2006).

The Health infrastructure has also improved under decentralisation. When user fees for government health facilities were abolished in 2001 (except for private facilities in hospitals), the health system was reorganised into a hierarchy that mirrors government structures (Okidi and Gulaba, 2006). The system now comprises national and regional referral hospitals, and Health Centres categorised as level IV, III,II, or I depending on the range of services offered at a given facility level. The operationalization of this structure required the construction of several new facilities leading to growth in the number of health facilities, especially at Health Centre II level to improve on the health

of the people in Uganda. The central, through the Ministry of Health (MOH), is responsible for resource allocation and hospitals. However, it had devolved much of the responsibility of operating the lower health units such as health centres and dispensaries to lower levels of local government under the Ministry of Local Government. This makes it easy for it to monitor and the local government provides what its people need hence improving on the service delivery.

1.2 Statement of the problem

There has been inadequate health service due to high rates of diseases such as malaria in the 1980s and HIV/AIDs in Uganda. Therefore this caused need to extend health services to the local people and most especially the rural people, who are low income earners and experience low standards of living; this has been done through administrative decentralisation.

Administrative Decentralisation of health services was introduced in Uganda to improve service delivery especially at the local level, such as among the poor to improve their health standards. It has made services available for the poor, accessible to the people hence improving the health services and the incomes of the locals there by leading to improved standards of living. Though despite that, the practice of decentralisation has been affected with some problems of corruption, poor financing, and lack of adequate human resource management in this case in the health service delivery there by leading to inefficient service delivery. This has caused poor service delivery in the country at the local level as far as decentralisation of health services is concerned. Therefore there is need to assess the performance of decentralisation in health service delivery to find out and cover the missing gaps in health service delivery. This helps to provide adequate health service delivery to all people

most especially the low income earners, hence promoting good health for economic growth of the low income earning people (the poor).

1.3 Objectives of the study

1.3.1 General objective

To assess the Role of Administrative Decentralisation in the Improvement of Health Service Delivery to the Low Earning People.

1.3.2 Specific objectives

i. To establish the role of administrative decentralisation in health service delivery.

ii. To find out the extent administrative decentralisation has offered health services to the poor.

iii. To assess the challenges countered in health service decentralisation.

1.4 Research questions

i. How has decentralisation helped in health service delivery in this area?

ii. What is the role played by the sub county in the health service delivery to the local citizens?

iii. What are the services offered to the people at the health centre?

iv. What challenges have been faced in health decentralisation?

v. How does it cost you to reach the health centre and how efficient are the services offered?

1.5 Scope of the study

1.5.1 Content scope

The study was focused on significance of Administrative decentralisation in Uganda in promoting health service delivery to the low income earners, improving the local people's income and the standards of living. The study was to counter the role of the local administration to the health service delivery to the poor. The role of health centres in Uganda and their effectiveness, more so looking at the challenges encountered in the programme.

The research included the information from the health centre management and health workers as well, there was need for the concerns and information from the local people in the area and the patients at the health centre. The research had to also analyse and assess how the local councils and sub county officials have helped in improving the access of health services to their subjects as a result of Administrative decentralization.

1.5.2 Geographical scope

The research was restricted to the study of decentralized health service delivery in Kyazanga Sub County, in Lwengo district which is found in the central region of Uganda. Due to the fact that this area is located in a newly created district, we need to find out how the new districts have catch-up to support health decentralization.

1.5.3 Time scope

The study covered the period of about 10years (between 2006-2014) as the time scope it was targeted in order to get appropriate and current information related to administrative health decentralization. This time scope has been used because the Ugandan government system has struggled to improve on the health sector and decentralisation has been effective in this

period for better service delivery. Therefore this time scope was selected as a reliable source for vivid data.

1.6 Significance of the study

The study enlightened the researcher on how much the health centre has helped in the development of the local poor people showing how it has helped the people to attain good health to work and save.

The information found out can be used by the government officials at both the district and sub county level to do the needful for their subjects to improve people's standards of living basically through improved health and standards of living.

The information got from the study shall be used by the board of this health centre to evaluate their performance on the people's livelihoods and health.

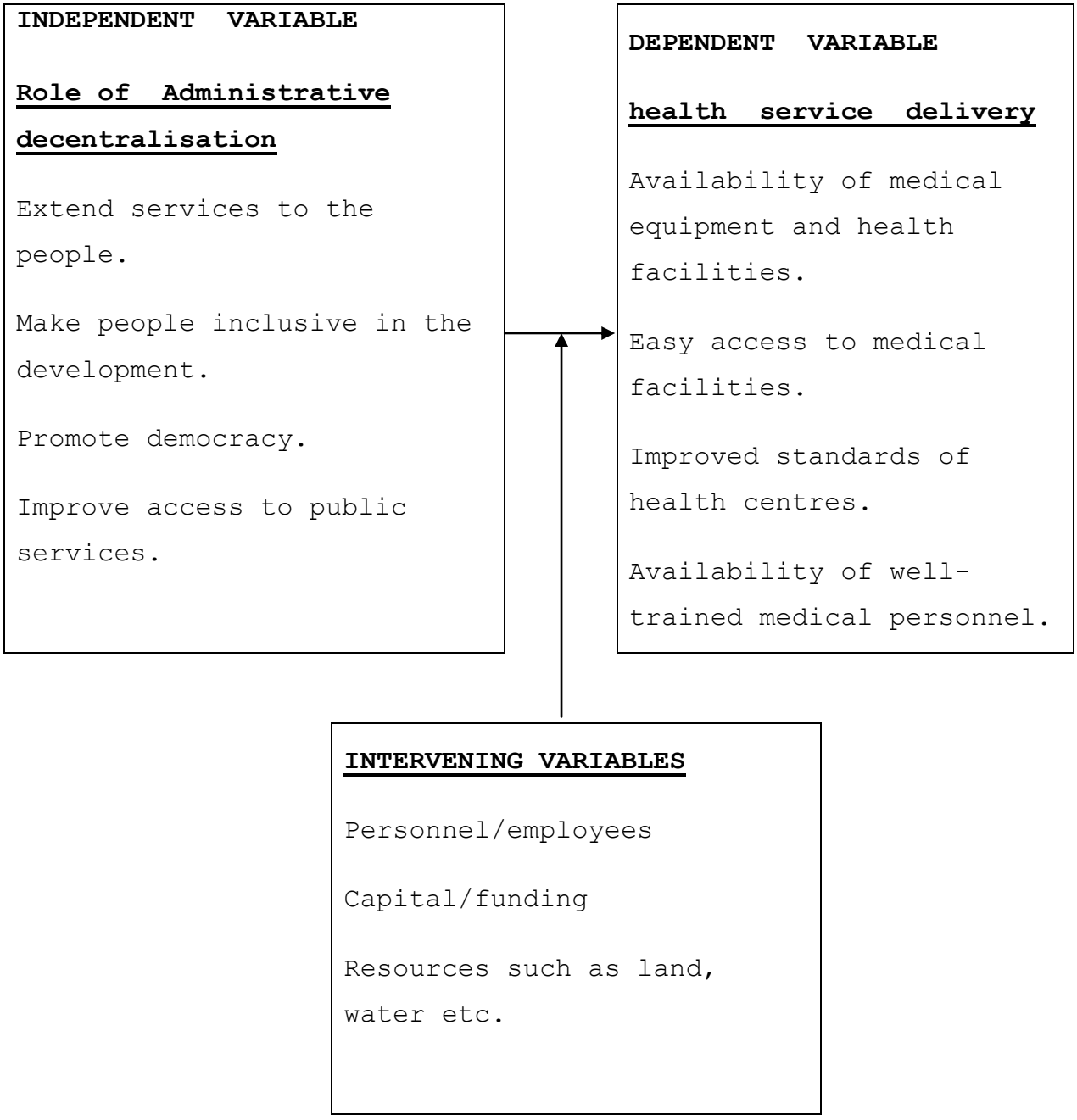
The study found out the missing gaps in the role played by health decentralization and possible recommendations.

The study shall be used to have analysis for critiques and supports for decentralization in Uganda as a democratic way of governance and extension of service delivery to the local people.

1.7 Justification of the study

The reason as to why the researcher decided to carry out this research at this time is because of, the high reports of poor service delivery in government health centres, high practices of creating new districts in Uganda as a form of decentralisation to extend services to the local people who can't access expensive medical care. Therefore the researcher needs to research about this field in this area to have improvements, with both negative and positive solutions to the current situation for the better management.

1.8 Conceptual frame work



The above structure shows that the independent variable are under the role of decentralisation which contains issues like Extended services to the people, make people inclusive in the development, promote democracy, improve access to public services. Therefore if all these are put in the system, they support, promote better service delivery. For that matter these link us to the dependent variable which is health service delivery which contains Availability of medical

equipment, Easy access to medical facilities, improvements in the standards of health centres, availability of well-trained medical personnel. Therefore the dependent and independent variables are supported by the intervening variables which include personnel/employee, financing/capital, Resources such as land, water among others which support the health centre (From the researcher).

1.9 Definition of key terms

Administrative Decentralization: It is a transfer of responsibility for planning, financing and management of certain public functions from central government and its agencies or commissions to field units of government agencies, or local government.

Decentralization: is defined as the transfer of authority and responsibility for public functions from the central government to subordinate or local independent government.

Health Services: This includes all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services. It can also be defined as an activity performed in relation to an individual that is intended or claimed by the individual or the person performing it; to assess, maintain or improve the individual's health.

Low income earning people: Low income earners are people who worker in a range of lower paid occupations. Particularly such people are engaged in areas such as Subsistence agriculture, retail, people earning relatively low wages as well some of these people are seasonally employed, or who are on an aged or disability pension or other government benefit.

1.10 Conclusion

Chapter one presents the background of the study, statement of the problem, objectives of the study, research questions and, scope of the study, significance of the study and its justification, definition of key terms and the conceptual frame work. All these guided the researcher to come up with better tools to use in the field and get better results from the study.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Chapter two presents a review of the existing literature from scholarly works, journals, reports, and topical essays, text books in order to understand and analyse the data, the context and the power of the problem under investigation. It captures an overview of Administrative decentralization of services specifically in the health sector.

2.1 Decentralization

According to Khaleghian, (2003) decentralization refers to the transfer of authority and responsibility for public functions from the central government to intermediate and local governments or quasi-independent government organizations and the private sector. Juma, (2013) defined Decentralization as the transfer of authority and responsibility for public functions from the central government to subordinate or quasi-independent government. Decentralization has been promoted by advocates of health sector reform for decades. Viewed initially as an administrative reform which would improve efficiency and quality of services, and later as a process of promoting democracy and accountability to the local population, decentralization was seen by many advocates as a major reform in and of itself (Bossert, 2014).

2.2 Administration

Hiroshi, (2008) refers "local administrations" to organizations that deliver local administrative services with autonomous authority independent of the central government as "local governments", and the entities that govern and provide services under the command of the central government as "local offices of the central government."

The administrative decentralization is composed of two local authorities that have both council and administrative functions; the District and Village. In rural areas, there are Wards that exist as levels without councils but with standing committees that exist and as well as the level without standing committees but with grass-roots local residents organizations. According to Juma, (2013) a policy of "Decentralization by Devolution" was adopted to devolve political power, financial power and administrative power to local authorities, formally converting the agenda into a government policy document.

> Hiroshi, (2008) states that the institutional pillar of the decentralization reforms in Uganda is the Local Council (LC) system. This is a hierarchy of councils ranging from LC1 (Village) to LC5 (District). The council encompasses both legislative and administrative organs. The origin of the LC system derives from the Resistance Council (RC), which was used by the National Resistance Army (NRA) when they were engaged in a guerrilla war to topple the then government. The RC helped the National Resistance Movement (NRM)/NRA to ease communication with local residents, and it is for this reason that the NRM decided to install the system on a nationwide scale once it took power. As a result, vast improvements have been made in the coordination of functions between the central government and the local authorities, and between the various levels of local authorities (in particular between LC1, LC3 and LC5).

2.3 Administrative Decentralization

According to Hossain, (2008) administrative decentralization refers to redistribute authority, responsibility and financial resources for providing public services among different levels of government. Similarly to Jennie, (2008) argues that Administrative decentralization seeks 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, or area-wide, regional or functional authorities. Whereas according to John and Stephen, (2013) defines "Administrative Decentralization" as a strategy for addressing a number of critical governmental needs. Foremost among these are improved governance, increased transparency and accountability, and more effective and efficient production and delivery of public goods and services.

Furthermore Hossain,(2008)states that "administrative decentralization involves the full or partial transfer of an array of functional responsibilities to the local level such as health care service, the operation of schools, the management service personnel, the building and maintenance of roads and garbage collection. There are three major forms of administrative decentralization- deconcentration, delegation and devolution-each have different characteristics.

Decentralization of health services have taken place through all three main categories of (administrative) Decentralization as argued by; Tidemand (2010)Deconcentration refers to transfer of authority and responsibility from central agencies to field offices of those agencies at a variety of levels regional, provincial, state, and/or local. This is a limited form of decentralization that only marginally may increase local responsiveness of health services and also still retain health staff within the overall central civil service. Deconcentrated units (e.g. "District Administrations") may however have some local autonomy for health planning and budgeting within a framework provided by the central ministry.

Delegation is the transfer of authority and responsibility from central agencies to organizations not directly under the control of those agencies (Tidemand, 2010). In the health sector these typically include semi-autonomous entities such as health boards, hospitals as well as arrangements whereby non-governmental organizations undertake certain service provisions on behalf of the central government (such as implementation of primary health care campaigns).

According to Tidemand (2010) Devolution is the transfer authority for decision making, finance and management to semi-independent local government. Devolution usually transfers responsibilities for services to municipalities that elect their own mayors, collect their own taxes (raise their own revenues locally), and have an independent authority to make investment decisions. In devolved systems, local governments have clear and legally recognized geographical boundaries over which they exercise authority and within which they perform public functions or duties. Importantly Juma, (2013) argues that devolution is therefore a form of decentralization that holds the greatest potential benefits in terms of increasing local responsiveness of health planning and cross sectoral integration.

2.4 Local Administration and the Status of the Local Population

According to Diego, (2009) Local people are prominent people who have lived in an area for an extended period of time. Robert D. (2000) argues that a local community is a group of interacting people sharing an environment. In human communities, intent, belief, resources, preferences, needs, risks, and a number of other conditions may be present and common, affecting the identity of the participants and their degree of cohesiveness. A community has been defined as a group of interacting people living in a common location. The

word is often used to refer to a group that is organized around common values and is attributed with social cohesion within a shared geographical location, generally in social units larger than a household (Robert, 2000).

In relation to the above explanations Miller, (2002) states that local government can be defined as, "A sub-national level of government which has jurisdiction over a limited range of state functions, within a defined geographical area which is part of a larger territory."

Different authors prefer however, to define it as "decentralized administration, democratically controlled by local communities". The term Local Government refers to, structures, which exercises authority or carry out governmental functions at the local level (Miller, 2002). Therefore we should importantly note that the local governance on the other hand, refers to the processes through which public choice is determined, policies formulated and decisions are made and executed at the local level, and to the roles and relationships between the various stakeholders which make up the society. It can be noted as the exercise of political, economic and administrative authority to manage local affairs.

According to Tidemand (2010) "Delegation with participation" A relative autonomous local /district health board or health service commission manage staff deployments locally. Budgets and accounting may be under substantive local scrutiny. In devolution an elected local government is given the responsibility for the recruitment, deployment and discipline of local staff. The local government will have varying degree of local spending and taxing powers. Budget may include some central government scrutiny or even approval. Davila, (2015) clearly asserts that a health care administrator is responsible for establishing health care standards, making strategic policy decisions and implementing the personnel

management procedures necessary to support his vision. In addition to the internal leadership they provide, health care administrators are leaders within the greater community as well. They partner with other health care organizations, comply with government regulations, advocate and testify on behalf of health care policies, and maintain campuses that are significant to communities.

Besides that the local population of Uganda largely consists of income earning people as states the World Bank, (2015) that currently, Uganda is a low income country whose labour force is predominantly employed in the agricultural sector, but mainly at subsistence levels, with 94 percent of agricultural output being derived from small farms of less than one acre. However, up to 75 percent of the labour force derives their primary livelihood from the farm; hence as rural residents spend a large proportion of their incomes on food. If the focus on agricultural transformation results in the achievement of the stated goal, then it will facilitate increased rural incomes, possibly through the application of technological innovations. Abuka, et al (2007) further argues that households with lower levels of human capital are poor. They show that poor households in Uganda suffer from high illiteracy levels. Available data shows that 51 percent in rural areas are illiterate against a national average of 40 percent. These also face lack of physical assets such as land identified as an important factor in poverty determination.

Definitely relating to current issues, for example Busuulwa, (2015)througha proposal by the Kampala City management states that to eliminate slums in favour of high density housing units has raised hopes of significant growth in low-income housing. He states that low income earners live in the slums, high birth rates among low-income families, for example in Kampala. The World Bank (2015) illustrates that vast majority

of Uganda's local rural people live in fragile, dry and sub-humid regions where the variability of rainfall and soil fertility means that farming presents a challenge. Household-level production often falls short of minimum household needs, rendering families particularly vulnerable to food insecurity affecting the rural livelihoods. According to the World Bank, (2015)

> The World Bank reports that people described as being low income earners include workers in a range of lower paid occupations. Particularly such people are engaged in areas such as Subsistence agriculture, retail, as well as people earning relatively low wages as well some of these people are seasonally employed, or who are on an aged or disability pension or other government benefit.

2.5 Local Accountability Arrangements

This section discusses two main issues related to local accountability arrangements within decentralized health system issues related to Local Government Systems. According to Tidemand (2010) he states that the World Development Reports from 2004 have emphasized the importance of effective accountability mechanisms for improved service delivery to the poor.

Accountability framework development introduces a monitoring framework to ensure accountability of the Local Government. Devise Feedback mechanisms so that the local governments are not in a position to abuse their power. Probably engage civil society in an oversight role with regards to service delivery quality, accessibility and afford-ability. This is particularly important for the health sector given it is a public good and core government service to society.

Furthermore it Creates/enhances capacity at all levels to implement the various frameworks required for efficient and effective decentralization. Train government health care

workers and civil servants in planning and managerial skills at the decentralized level, and whole system stewardship at the central level. More so recruit and train health workers to meet shortfalls compromising efficient health service delivery.

2.6 Role of Administrative Decentralization

Administrative decentralization increases local democratic legitimacy by introducing health and wellbeing boards to ensure that health and social care commissioning are joined up across the local area and to provide strategic leadership to commissioning for health and wellbeing, including through pooled budgets. Furthermore, this gives power and responsibility to local authorities to lead on public health provision, resourced by ring-fenced public health budgets according to Greg, (2012).In relation to this, according to WHO, (2007) leadership and governance involves ensuring strategic policy frameworks, effective oversight, coalition-building, regulation, attention to system-design and accountability. The elected local bodies are accountable and responsive to their constituents. A further assumption is that financial resources will be available to support the provision of services at the local level through a combination of central government fiscal transfers and local taxation. Therefore many authors argue that decentralization initiatives assume that local administrative capacity will be adequate to deliver the expected increase in the production of local services.

Juma, (2013)argues that it further creates the existence of 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 World Bank, (2001) reveals that it involves functions such as informed decision making, adherence to local priorities and accountability. However, applying these principles in practice has not proven to be simple. Country circumstances differ, often in complex ways; consequently the policy and institutional instruments that establish decentralization have to be shaped to the specific conditions of individual countries.

2.7 Health service

Basically administrative decentralization leads to improved service delivery for example Hiroshi, (2008)argues that education and health represent the progressive implementation of decentralized service provision in Uganda. More specifically, there have been improvements in the monitoring, supervision and mentoring provided by the line ministries at the centre, and support at the LC5 (District) level for service providers has also improved. Underlying these improvements in services is a mechanism of multi-partnership with collaboration among different layers of government, between the central government and local authorities and between different local authorities (in particular between the LC1, LC3 and LC5 levels).Diana, (2007)says that in India and the state holds primary responsibility for health care delivery. The district acts as a link between the state structures and the local health Centres, and is responsible for coordinating with states governments for implementation of programmes.

According to WHO (2007) a health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. It includes efforts to

influence determinants of health as well as more direct health-improving activities. It more stated that a strong health system has six elements such as health services, health workforce, health information, medical products and technologies, health financing, and leadership and governance. All these elements must function well to ensure that quality health service reaches the entire population with promote preventive, curative and rehabilitative health services.

2.8 Service delivery

Hiroshi, (2008) argues that the process of service delivery involves the terms of effectiveness, efficiency, accountability, and equity in distribution and delivery as explained; Effectiveness is a factor that concerns the level of achievement of the objectives, whereby services are provided based on an accurate assessment of citizens' needs and the local context. Efficiency implies maximizing the efficiency of administrative services that is to say consider a factor that can be equated with "investment effectiveness," whereby services are provided in a prompt and appropriate manner by efficiently utilizing limited resources such as personnel and budgets. Accountability implies a responsibility to provide adequate information and explanations in a manner that can be trusted by the citizens. In the sense that it increases the transparency of service provision and earns the trust of the public/ the people's will. Equity relates to fair distribution to the poor and equality among different regions. While decentralization has the potential to realise a fairer and more strategic distribution of resources to the deprived classes based on the particular conditions and needs of the concerned local society, it also has potential risks to widen disparities among regions. It is therefore important to pay special attention to ensuring equity among different regions. Therefore all these illustrate how useful it affects service

delivery.

According to Greg, (2012) decentralization helps devolving power and responsibility for commissioning services to health care professionals closest to patients by introducing clinical commissioning groups (CCGs) to ensure services are designed by those who know patients best. Greg, (2012) further states that establishing an independent and accountable NHS (national health system) Commissioning Board to support and hold to account new clinical commissioning groups. This will therefore help on reducing bureaucracy by abolishing Strategic Health Authorities and Primary Care Trusts. More so there should be incentivizing providers to improve their quality and efficiency; this will lead to motivation of health workers and administrators.

Health decentralization ensures a focus on improving health outcomes through new outcomes frameworks for the NHS, public health and adult social care, rather than through top-down process targets. Greg, (2012) argues that the NHS Commissioning Board will support CCGs to improve outcomes through the commissioning outcomes framework. Therefore ensuring that people are able to exercise choice and control over their care and support by creating a legal entitlement to a personal budget and by supporting local authorities to shape and develop a strong and diverse local care.

The good health services are those that deliver effective, safe, quality personal and non-personal health interventions, a well performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances. However WHO(2007) argues that there should be equitable access to and use of essential medical products, vaccines and technologies of assured quality, a good health financing system which raises adequate funds for health, and

protects from financial catastrophe or impoverishment. It provides incentives for providers and users to be efficient, hence promoting health service delivery.

2.9 Provision of health services to the poor

Building from John and Stephen, (2013) 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. In the process, the District Local Governments become accountable for resources allocated and monitoring the quality of services provided. It is believed that decentralized systems offer opportunities for increased beneficiaries' involvement in the direct decision making process in health services prioritization, quality, cost and preferences (Mugabi, 2004). Administratively, this proved attractive to the central government because part of the burden of financing health services could be shifted to sub-national units and private providers.

According to Tidemand, (2010) simultaneous decentralization through various modalities such as devolution and user groups may create complimentary and mutually enforcing systems that enhance the voice of (poor) citizens. Citizens may for instance influence the planning and delivery of health services through their local government while also participating in the local health unit committee in a mutually benefitting manner to the low income earners. To further strengthen the decentralized delivery of healthcare in rural areas, the government of India launched the National Rural Health Mission (NRHM) in 2005. NRHM aims to strengthen the health infrastructure at the local and district levels by integrating planning of initiatives related to health, water, sanitation and nutrition. The programme engages Accredited

Social Health Activists (ASHA) to act as an interface between the community and the public health system thereby enhancing the effectiveness of the decentralized model (Diana, 2007).

International Monetary Fund (IMF), (2004) reveals that 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. It is therefore clear that the health sector plays a critical role in poverty eradication and promotion of development. To facilitate health service decentralization initiatives there has been increased annual budgetary allocation for the provision of Primary Health Care at the DLG and sub-county levels. Therefore this policy has given the DLGs and lower level local government's central roles in the management of health service delivery,

In principle, devolution and delegation of power to lower local governments was expected to encourage more community participation in decision making and to hold policy makers accountable for the quality of service provided. This involved delegation of authorities to: improve access to public services; increase participation in decision-making; develop local capacity and enhance transparency and accountability (Mugabi, 2004). Decentralization was therefore envisaged to contribute to poverty reduction and development through the bottom-up approach to planning and monitoring service delivery.

2.10 Challenges countered in health service decentralization

Uganda is one of the few countries where local governments have the authority to hire and fire, although the remuneration is still determined centrally. In particular, since the turn of this century, capacity at the LC3 level appears to have improved both in quantity and quality. However, there are still two challenging issues. Hiroshi, 2008 says that once a majority of the offices are appointed from the same area, the range of experience and knowledge that they can assemble as a technical team is significantly narrowed. Secondly attracting qualified personnel in remote areas continues to be a problem due to the devolution of power which causes local government officials to lose their enthusiasm for self-improvement.

Mark, (2007) states that decentralization may not always be efficient, especially for standardized, routine, network-based services. This can result in the loss of economies of scale and control over scarce financial resources by the central government. Weak administrative or technical capacity at local levels may result in services being delivered less efficiently and effectively in some areas of the country. According to Diana, (2007) administrative responsibilities may be transferred to local levels without adequate financial resources and make equitable distribution or provision of services more difficult. Decentralization can sometimes make coordination of national policies more complex and may allow functions to be captured by local elites. Also, distrust between public and private sectors may undermine cooperation at the local level.

According to Tidemand, (2010) it is noted that some countries have undertaken health sector reform primarily based on delegation, deconcentration or devolution, and some countries have adopted several forms of decentralization simultaneously. This may be mutually supportive but often it is the result of

conflicting approaches that may lead to policy confusion, conflicts and tensions. In Ghana for instance there have for long been unresolved disputes between advocates for health sector reforms based on delegation and advocates for decentralization by devolution to the elected District Assemblies.

Even in a country like Uganda where decentralization by devolution is rather well established in legislation and spelled out in the Constitution we find conflicts with sector policies. For example Tidemand (2010), suggests that in the health sector it has been argued that the desirable health facility hierarchy poorly fits with the overall local government architecture and a new level of sub-district planning is required for the planning of health services. According to Mark, (2007) in relation to that, the lines of accountability are then confused and practical arrangements for service delivery uncoordinated. This is often hampered by unclear assignment of services delivery mandates and interventions by central government in local government decision-making.

According to IMF, (2004) the performance of the decentralized system has run short of expectations in some DLGs, which has widened regional disparities in equity to access quality health services. The poor performance has largely been attributed to local government capacity constraints. The Republic of Uganda (2007) for example, notes that although there was an improvement in the national performance against the Health Sector Strategic Plan (HSSP) indicators, there were marked variations in performance between DLGs, which have largely been attributed to inadequacy of management capacity in some districts.

IMF, (2004) also suggests that public health service delivery in Uganda is often marred by cases in which expenditure does not reflect the quality and outcomes of the services delivered. This has in part been attributed to weak institutional processes and governance among some DLGs. Poor delivery of services implies that most of the intended beneficiaries do not have access to the service or if they do the quality is not commensurate to the resources invested. It is not uncommon to visit a health facility with no doctor at the duty station to serve clients or the personnel are available, there are no drugs, equipment or even electricity. This suggests that there could be weakness in the institutional design and framework for health service delivery. Therefore there is policy evaluation of the institutional arrangements for decentralized health service delivery in Uganda.

According to Diana, (2007) the experience of sub-Saharan Africa is especially disappointing with little improvement in the quality of services provided through local governments, both to poor people and local citizens In the 1980s, the combination of decentralization with structural adjustment and privatization proved disastrous in terms of service delivery outcomes for poorer people and regions. This has been as a result of the centralization of power, weak structures of accountability, and lack of countervailing pressure from civil society. For these reasons, African governments have largely been reluctant to devolve power and finance to local governments, which consequently lack the capacity and resources to deliver improved services.

Importantly Mark, (2007) has also argued that inadequate devolution of power, particularly over finance and staff, Vague/inappropriate systems and procedures, inadequately qualified, underpaid and unmotivated staff, Political

'interference', corruption and abuse of power, and lack of 'downward' accountability have hampered effective and the efficiency of administrative decentralization of health. Besides that, the boards of sub-national health bodies can be appointed by Ministers or elected by local people. Similarly the capacity at local level may be effective or ineffective, and citizens may or may not respect local institutions as much as they respect national ones. With regard to corruption, there are probably as many cases of theft and bribery at local as national levels of health systems.

2.11 Conclusion

This chapter contains the literature reviewed from other authors from different sources in relation with my topic according to its objectives. That is to say it presents information on health decentralization and how the locals get involved in the service delivery, in other words it further illustrates how and where the system has been applied and its benefits to the beneficiaries. This has been done to back up the researcher's findings from the field of study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Chapter three presents the research methods that were used in obtaining the necessary information (data) from the field. It presents a description of the research design, the area of the study, the study population, sampling procedures and sample size, sources of data, quality control methods, data analysis, ethical considerations and limitations of the study.

3.1 Research design

According to Creswell (2009) defines a research design as a plan and the procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis, as well as Bryman (2008), also states that a research design relates to the criteria that are employed when evaluating social research. It is therefore a frame work for the generation of evidence that is suited both to the certain set of criteria and to the research question in which the researcher is interested.

The researcher used qualitative approach. Qualitative research aims at getting a better understanding through first-hand experience, truthful reporting, and quotation of actual conservation (Marshall and Rossman 1995). This approach was used to qualify results while at the same time augmenting them with quality data. Thus, qualitative research has the ability to permit the research to go beyond the statistical results that were reported in quantitative research. Therefore although the research was mainly qualitative, the researcher also applied a few quantitative method as well for the reason of complementarity, elaboration and explanations with illustrations.

The researcher largely used more qualitative data analysis than quantitative to analyse data from interviews and questionnaires held to the administration officers on health at the health Centre, local people in this rural area, the people's representatives in authority such as the local councils (councillors), health Centre managers, nurses and doctors, with patients interviewed.

3.2 Area of study

The study was conducted in Kyazanga Sub County, Lwengo district. Kyazanga Sub County is located in the central Uganda in Lwengo district in greater Masaka. Specifically, Lwengo was chosen for the study because it is one of the newly created district annexed form Masaka in 2010.

Uganda Bureau of statistics (UBOS),(2014) illustrates that Lwengo is located approximately 35 kilometres (22 mi), by road, west of Masaka, the largest town in the sub-region. This location lies approximately 165 kilometres (103 mi), by road, southwest of Kampala, the capital of Uganda and the largest city in that country. Lwengo District is bordered by Sembabule District to the north, Bukomansimbi District to the northeast, Masaka District to the east, Rakai District to the south, and Lyantonde District to the west, west of Masaka, the nearest large town.

3.3 Population of the study

Gomm (2004) argues that a population sample will consider the options and logistics of taking a statistically representative sample from the population of the study. Whereas Odiya (2009) observed that study population is the total number of potential units for observation or an entire group of people, objects, or event having at least one characteristic in common. The researcher used respondents such as the local council(councillors)at the sub county, the health coordinator

at the sub county, managers of the health centre, nurses and doctors, the local people whom services are offered to prove whether they are efficient or not. This is because they were relevant to the study and they have information for the research study.

3.4 Sample size

Crossman, (2014) states that a sample is a subset of the population being studied which represents the larger population and is used to draw inferences about that population. It is a research technique widely used in the social sciences as a way to gather information about a population without having to measure the entire population.

The study population comprised of 54 male and female respondents, including respondents from all sections of concern that is to say from the local people in this rural area, the people's representatives in authority such as the local councils.

The respondents were obtained from the sample population of 54 people. These were then grouped into three groups comprising of the health management team, which includes the health centre in charge and medical staff 15, the local people/ beneficiaries 36, the local government authority 9. The respondents in each group were randomly chosen depending on who was willing to give out the information. This is because all those people were considered potential respondents.

3.4.1 Sampling techniques

According to Bloor and Wood (2006) sampling is the selection of cases from wider populations stating that the units of a sample may be individuals, institutions and communities. The study employed simple random sampling, and purposive sampling to the select the sample. To avoid being biased the researcher

selected a sample from relevant respondents to obtain accurate information about the subject matter.

Simple Random Sampling

Powell, (2014) defines simple random sampling as a format employed to select the 54 respondents who were informed about the topic under discussion without bias from the target population. It was mainly used to select a random sample.

It is preferred for this study because it ensured that each member of the target population has an equal and independent chance of being included in the sample. The study employed sample random techniques and stratified sampling in various departments and others was as well used in a stratum where by it was easy and possible to use that stratum so that the sampling is done well hence getting clear and correct data.

By the use of random sampling method the researcher assigned numbers of various respondents who were selected randomly by their numbers as samples out of the population and as well as organization charts were selected to show the data got. This kind of technique is good in the little time taken hence simplifying work (Powell, 2014).

Purposive sampling

According to Crossman, (2014) purposive (judgmental) sampling is when a researcher chooses specific people within the population to use for a particular study or research project. In this technique the sample is selected based on the knowledge of a population and the purpose of the study. Whereas Trochim, (2006) states that purposive sampling, is referred to as judgment, selective or subjective sampling is a non-probability sampling method that is characterised by a deliberate effort to gain representative samples by including groups or typical areas in a sample. The researcher relies on

his/her own judgments to select sample group members; purposive sampling is mainly popular in qualitative studies.

Unlike random sampling, which deliberately includes a diverse cross section of ages, backgrounds and cultures, the idea behind purposive sampling is to concentrate on people with particular characteristics who will better be able to assist with the relevant research (Crossman, 2014). The researcher will use purposive sampling because it has a wide range of techniques due to several different types of purposive sampling (e.g. homogenous sampling, expert sampling, critical case sampling, etc.), which led to ability to gather large amounts of information by using a range of different techniques. This variety, in turn, gave a better cross-section of information. Furthermore Qualitative research usually involves a number of different phases, with each phase building progressively onwards from the original. This being the case, purposive sampling was useful to a researcher because he was able use the variety of methods available to build and increase their research data (From the researcher).

3.5 Data collection methods

The study applied methods such as oral interviews, questionnaires and observation method. While interviews and observation were flexible research tools, the questionnaires were mostly administered to the elite.

3.5.1 Interview guide

Sarantakos (2011) says that interviewing is a form of questioning characterized by the fact that it employs verbal questioning as its principle technique of data collection.

Oral interview was the relevant method for my research study since it allows a two way communication, the researcher applied this mainly to gather qualitative and few quantitative

information for the study. The oral interview was carried out through a face to face communication or interaction with the respondents. So in this case the researcher was able to ask questions and at the same time note down the information from the respondents.

The researcher interviewed 35 respondents in the field of study in accordance to their departments in health service delivery relating to decentralization. This method was used because it was relevant to the study and it was cheap to carry out.

3.5.2 Questionnaire guide

Oppenheim, (1997) describes a questionnaire as simply a 'tool' for collecting and recording information about a particular issue of interest. It is mainly made up of a list of questions, but should also include clear instructions and space for answers or administrative details.

The researcher developed the questionnaire consistency of both structured and semi-structured questions. The research questionnaires were pretested on a sample of 19 respondents. This was done to certain the relevance of the question to the researcher variables, the logical flows of the questions and considered the time it would take to administer the questionnaires. After the pre-test the questionnaire was adjusted and used for data collection.

Sets of questionnaires were issued to 19 different individuals were by these questionnaires contained questions set by the researcher for the respondents to answer. The questionnaires were given to management team in charge of health service delivery, that is to say the health centre management, local council health management and administrators in the local government, and the local people/ beneficiaries of the health centre. This method was relevant to the study since most of

the respondents knew how to read and write; as well the questionnaire could easily be twisted to any language to make it suitable for the targeted sample population of the study hence making it convenient.

3.5.3 Observation checklist

Observation is the systematic description of events, behaviours and artifacts in the social setting chosen for the study. Therefore here the researcher was able to collect data by observing what takes place in the health Centre and the society, in relation to the local people and how they are accessing health services and how it is improving their standards of living.

3.5.4 Secondary sources

Secondary data was an assessment of the existing literature sources from scholarly works, journals, reports, and topical essays, text books, newspapers, and official records relating to the study. This was done in order to understand the analysis, the context and the gravity of the problem under investigation.

It also enabled the researcher to discuss the gaps that existed between literature and the field study itself.

3.6 Quality control methods

Therefore, the researcher endeavoured to design tools; such as the interview guide, the questionnaire guide, observation checklist related to the study and links them to the research objectives in order to enable a free flow of the research topic.

Validity

Validity is the degree to which an instrument measures what it is supposed to measure. It has got three important aspects (Polite et al 2001). To establish validity, the instruments were designed in accordance to the research objectives. The instruments were then given to two experts: my research supervisor and my academic advisor to evaluate the relevance of each item in the instruments of the research, who then judged, accepted and guided the researcher on how to proceed.

Reliability

Reliability refers to the consistency with which an instrument measures the attribute (Polite et al, 2001). To establish reliability, the instruments were tested whether they could accurately reflect the true score of the attribute under investigation. Therefore, the interview guide, questionnaire guide, observation guide were tested and retested in order to assess their consistence.

3.7 Data Analysis

Techniques of data analysis and criteria for interpretation of results

Qualitative methods of analysing and presenting data were employed and as well as quantitative method for the purpose of statistical information. Data from the field was analysed for accuracy and completeness basing on the research objectives. Data from open-ended interviews, questionnaires and observations was grouped under broad themes and converted into frequency accounts. The results of this study were presented and discussed in the form of narrative, were tables have also been used, SPSS (Statistical Package for Social Sciences) version 16.0 and Microsoft Excel was employed to analyze data and to illustrate field data using relevant figures.

Furthermore the data that the researcher collected through interviews, questionnaires and observations it was analysed and interpreted in qualitative and a descriptive manner, hence tables were also used to facilitate quick understanding.

3.8 Ethical considerations

The researcher provided assurance to the respondents that the findings will help them on how to benefit from health administrative decentralization.

The researcher as well was respectful and sensitive to dignity of the respondents. The researcher did not do anything that can cause physical or emotional discomfort to the respondents. The researcher was careful with the word selection during the interviews.

The researcher ensured that the respondents have an informed consent on the adequate knowledge of the study. The researcher had to explain to the respondents the purpose of the research, the duration, any benefits and consequences such that the respondents had the free will to choose to be part of the research.

Issues to do with confidentiality and conditions of anonymity were emphasized to the respondents.

Seeking approval and permission from the authorities as well as obtaining consent from the respondents was granted to the researcher.

3.9 Limitation of the study

English was a problem to some local respondents. This made it difficult for the researcher to communicate to some respondents. This problem was solved by interpreting the questions into local languages (Luganda / Lunyankole).

High costs of stationary printing and power shortages which led to poor Internet network, while using the computer facilities also affected my research. The researcher therefore had to make personal savings to solve some of these problems.

The high transport costs to and from the targeted field of study were a matter to consider. This was covered by assistance from parents and relatives by offering some extra money to the researcher.

Inadequate skills in research (lack of experience) which made the researcher to spend much time and money in the field. This was solved through the consultations from the supervisor and the academic advisor.

Some respondents such as the local people are illiterate and they didn't know how to read and write, hence filling in the questionnaires was not easy. Therefore the researcher applied oral interviews as he filled the questionnaire for the respondents.

3.10 Conclusion

Chapter three contains almost all of what the research applied in the field, given that it also talks about the limitations faced in the field. Therefore this chapter is a presentation of the research designs the researcher used, the area of the study, the study population, sampling procedures and sample size, sampling techniques, sources of data, quality control methods, data management and processing, data analysis, ethical considerations and limitations during the study.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.0 Introduction

Chapter four presents the analysis and discussion of the findings of the study assessing the Role of Administrative Decentralization in the improvement of Health Services among the low earning people in Uganda. It also describes the respondents' background information, the dependent variable and the verification this chapter also presents study findings as well as the interpretation and discussion of the findings.

4.1 Background characteristics of the respondents

Section 4.1 presents the background of the respondents, according to gender, marital status, and age, highest level of education attained and years of producing coffee as per section A of the questionnaire (Appendix 1).

4.1.1 Respondents by sex

Table 1 shows the frequency distribution of respondents by their gender including the percentages.

Table 1: Distribution of the respondents according to their sex

Sex of respondents	Frequency	Percentage (%)
Male	21	38.9
Female	33	61.1
Total	54	100.0

Source: Primary data, 2016

The study results indicated that majority of the respondents were females 61.1% and only 38.9% were males. This was due to higher expectation from the returns of health service

delivery, females being the most vulnerable in the community and family, and women being submissive to the partners they would respond because they are always the ones who take most responsibility for the sick at home and in the health centre. Despite the fact that males commanded a big say in managing family resources like proceeds.

Table 2: Showing distribution of the respondents according to their marital status

Marital status	Frequency	Percentage (%)
Single	9	16.7
Married	24	44.4
Widowed	8	14.8
Divorced	13	24.1
Total	54	100.0

Source: Primary data, 2016

According to table 2 results on the marital status show that the respondents who were still single are 16.7% and majority of the respondents were married 44.4%, followed by those who are widowed 14.8% and the respondents that had divorced or separated with their partners were 24.1%. 18≡33.35% of the married respondents had amassed some assets including pieces of land where they had established coffee and banana plantations. The married respondents had the biggest percentage 44.4% because it was easier to get clear information from them since they had families to cater for their health unlike the other respondents such as the single and divorced. Therefore this helped the researcher in the gather basic data from the local respondents specifically women in the area

Table 3: Distribution of the respondents according to their age

Age of respondent	Frequency	Percentage (%)
18- 25 years	4	7.4
26-35years	24	44.4
36-45 years	16	29.6
46years and above	10	18.5
Total	54	100.0

Source: Primary data, 2016

Data in table 3 shows that, it was further found out that most respondents 44.4% were aged26-35years, 29.6% were aged between 36-45 years, while 18.5% were aged 46years and above and 7.4% were aged 18-25years. Most of the respondents the researcher corroborated with were old and mature enough to give the researcher related information because they have had quite good experience about the topic. It was however observed that majority (80%) of the young people at the age of 25 and below was not so much engaged in this study because they were at school and others rarely visit the health centre.

Table 4: presents the Distribution of the respondents according to their Education level.

Education level	Frequency	Percentage (%)
PLE	20	37.0
UCE	15	27.8
UACE	12	22.2
University	5	9.3
Tertiary	2	3.7
Total	54	100.0

Source: Primary data, 2016

As shown in table 4, findings indicated that the biggest proportion of respondents 37.0% had attained primary education followed by those with UCE education 27.8%, 22.2% had attained UACE education and Very few respondents indicated that they had attained University education 9.3% because of the high cost of university education. Semaatto a respondent when interviewed stated that, high levels of literacy made it easy for local people to adopt appropriate new health technologies like use of mosquito nets immunisation and sanitation at each house hold hence the people with primary level of education easily adapt to the new techniques of health maintenance.

This further elaborates how the education levels have boosted the health status of the poor people in this area. Therefore good education ensures good health in the area since they are empowered and they know how to maintain and promote health in their homesteads despite the income levels.

Table 5: presents the distribution of respondents according to time spent/lived in the Area of study

Time lived in the Area	Frequency	Percentage (%)
Below 10years	9	16.7
20years	13	24.1
30years	16	29.6
Above 30years	16	29.6
Total	54	100.0

Source: Primary data, 2016

According to table 5, the study findings indicated that some respondents had lived in the area as early as ten (10) years old some in 1980s others in 90s. The statistics showed that the bigger number of respondents 29.6% had an experience over the issues in this area of 30 and over 30 years, followed by those respondents 24.1% who have been in the area for 20 years

and 16.7% of the respondents reported to have spent less than 10years.

4.2 Establishing role of administrative decentralization in health service delivery

Administrative decentralization structure and its involvement in the health service delivery

It was established that Kyazanga sub-county is made up of four parishes and the headquarters are located in Kyazanga town. The sub-county is run by the sub-county chief on the technical side and by an elected local council III (LCIII) chairperson and his/her executive committee. The sub-county also has an LCIII council, with a speaker and deputy speaker. The council consists of elected councilors representing the parishes, other government officials involved in health, development and education, and NGO officials in the sub-county as stated by the chairperson LCIII in the questionnaires.

It was reported by the respondent (councilor) that via the interviews that planning in the local council level is done by the planning committee of the sub-county. The planning committee involves the councilors and the funds are received through government and taxation of the local business owners. The researcher found out through interviews that the budget of the sub-county involves different sectors such as education, health and infrastructure such as roads; this was pointed out by the councilors interviewed in the field. Therefore the health sector at this level has got the public health department committee which is headed by the inspector of health at the sub-county level.

From the four councillors via questionnaires and interviews, it was noted that the financial budget is presented to the council under the chairperson LCIII and they offer what they have for example on the maintenance of the health Centre.

However it was indicated that the budget is always forwarded to the chairperson LC5 since they have little finance and he informed that the district plays the largest role in the offering of drugs and personnel such as nurses and doctors. The respondents also told us that they allocate 8 million to the financial Centre each fiscal year. It was reported through questionnaires, by the LC3 chairperson of the area from the field that;

> There are some NGOs which offer funds and essentials to the health Centre such as Mild May, world vision, which support the health of the people through educating the people about health and offering basic needs. Mild May donated a vehicle to the health centre for ease of accessing drugs and water.

Sources of income for the sub-county include money as tax from the people who carry economic activities such as business owners in Kyazanga sub-county, NGOs and the central government to fund the sub-county every year of the budget (from the field).

Health Decentralization Levels at the Sub County

Health decentralization in its course has led to the process of health service promotion through the creation of more service providers at the sub county level as pointed out below showing the hierarchy of health service delivery, hence providing health service delivery in the area.

Village Health Teams structure in Community Medicine Distributors

The first contact for someone living in a rural area such as Bijjaaba would be a community medicine distributor or a member of a Village Health Team (VHT). Each village is supposed to have these volunteers but in many cases they are either non-existent or they do not have basic drugs for diseases such as

malaria. In Kyazanga, the African Medical and Research Foundation (Amref) project has re-energized the VHT structure through training and giving members bicycles. They still have no medicine, but they can advise patients and refer them to health centres.

Health Centre II

According to the Ugandan government's health policy, every parish is supposed to have one of these centres. A health Centre II facility, serving a few thousand people, should be able to treat common diseases like malaria. It is supposed to be led by an enrolled nurse, working with a midwife, two nursing assistants and a health assistant. It runs an out-patient clinic, treating common diseases and offering antenatal care.

Health Centre III (HCIII)

The respondents reported that a health centre III facility should be found in every sub-county in Uganda. These centres should have about 18 staff, led by a senior clinical officer, who run a general outpatient clinic and a maternity ward. It should also have a functioning laboratory. Reports from the field indicated that Kyazanga health centre III was started in 1998 under the local government from the sub-county as a concern of lack of enough health facilities in the sub-county as a result of decentralization.

> As supported by Thuan., et al. (2008)that in Uganda, health facilities are categorized by the area served and services provided: a) Health Centre II (HC II) serves a parish and provides outpatient, antenatal, immunization and outreach services; b) Health Centre III (HC III) serves a sub-county and additionally provides inpatient care and environmental health.

It was started with one building and later more were constructed in 2000 and 2003 as the number of patients increased in the health centre, informed by the chairperson LCIII. The number of nurses was increased in 2003 from 4to 13 though it was still not enough to sufficiently service the number of patients in the health centre.

Through interview discussions with the respondents it was noted that, this is the only public health centre in the sub-county and the rest of the health service providers are private and performing on a small scale whereas the other hospitals are located far for example Mulago hospital in Masaka district. Therefore it was tiresome and expensive for the people to travel from Kyazanga to other hospital, hence affecting service delivery, though the health Centre III has brought some health services closer to the people.

> It was established from the respondents that a HC III is the highest level health facility in this sub county and provides outpatient services, inpatient services for children, HIV/AIDS counselling and testing (HCT), antenatal care (ANC), maternity and deliveries, PMTCT, immunizations and limited laboratory services hence it has promoted health service delivery in the area.

4.2.1 Role of health Decentralization

Table 6: presents the respondents response on the role of decentralisation in health service delivery

	Frequency	Percentage (%)
Disagree	8	14.8
Not sure	4	7.4
Agree	29	53.7
Strongly agree	13	24.1
Total	54	100.0

Source: Primary data, 2016

Data in table 6 shows that 53.7% respondents agreed that decentralisation of the health service delivery has played a good role on improving people's health status in the area while 14.8% disagreed because the services offered at the health centre are not of good quality and they are sometimes requested to pay for the services which are supposed to be for free hence impacting on their incomes (from the field).This was attributed to the fact that the inspectors of health (head of health department) sit as a committee and discuss on what is needed for the health of the people in the sub-county. This is done from the sanitation level or general cleanliness of the people from their homesteads up to the health Centre level.

Table 7: presents the response on the statement that LCIII plays a role in the health service delivery to the local people

	Frequency	Percentage (%)
Strongly disagree	6	11.1
Disagree	12	22.2
Not sure	10	18.5
Agree	22	40.7
Strongly agree	4	7.5
Total	54	100.0

Source: Primary data, 2016

Data in table 7 shows that 40.7% respondents agreed because the sub county under its committee they plan for the Health Centre III since they have the health department and they also sensitize the people about adapting good health through the promotion of sanitation and putting strict lows for its maintenance etc., 18.5% were not sure but they attain health care services from the HC3 and 22.2% disagreed because the services offered at the health Centre are not of good quality

and they are sometimes requested to pay for the services which are supposed to be for free hence impacting on their incomes and the sub county has done less about such activities (via questionnaires 2016).

In support to the analysis above researcher found out that health Administrative decentralization has partly achieved its objective. That is to say, the respondents in the field pointed that there was so much need for the health centres to be handled by the local people in their areas to easily identify their problems for example diseases in the area. Furthermore they explained that the population was still very low in the area and therefore the resources were enough for the given populations unlike today were there are many people and the medical facilities are quite expensive. In addition the doctor as a head of the health centre stated that the health centre is now accommodating patients beyond its capacity; hence there are plans of expansion (interview 20th may 2016).

The administration informed the researcher as interviewed the chairperson LCIII that the local people have responsibility as they are involved in the planning and budgeting for health services offered at the health centre and possibly other private health centres are given license in the area. This was supported by Juma, (2013) stating that;

> 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.

This has provided good health to the people most especially the poor or low income earners in the area. This is because it provides cheap health services (According to the researcher).

Basically via interviews it was found out that the HCIII was meant for the health service delivery to combat the problem of high malaria out breaks and HIV/AIDS in the area called for the construction of the health centre since there were no close hospitals. It was found out that the sub county is responsible for public health service delivery as mandated by the local government act in the constitution, as stated by Greg, (2012)that giving power and responsibility to local authorities to lead on public health provision, resourced by ring-fenced public health budgets. This has been done through the health centres as per the government programs of extending health services to the grass roots. But as well this is done with the aid of the ministry of health and the district health officer, therefore this has promoted health services in Kyazanga Sub County.

It has helped in monitoring and supervision of the health facilities and the health workers as a form of offering clear supervision of the health sector at the grass roots in the sub county through the health committee headed by the health officer at the sub county.

> For example Hiroshi, (2008) argues that education and health represent the progressive implementation of decentralized service provision in Uganda. More specifically, there have been improvements in the monitoring, supervision and mentoring provided by the line ministries at the centre, and support at the LC5 (District) level for service providers has also improved hence promoting better health services to the local people.

This shows the involvement of the people in decisions upon their health dependency in Kyazanga Sub County.

Utilization

Awareness on health facilities was noted, the participants were highly knowledgeable about the health facilities that existed in their community. This included

those aware of health centres 57.4%, Private health centres and Clinics 31.5% and pharmacies / drug shops 11.1%. The health Centre was the government facility which was health Centre III. Clinics, pharmacies and drug shops were privately owned facilities.

Table 8: showing people who use HCIII and Private health Centre's and clinics

Health Facility	Frequency	Percentage%
HCIII	31	57.4
Private health centres and Clinics	17	31.5
pharmacies / drug shops	6	11.1
Total	54	100.0

Source: Primary data, 2016

As stated in the table above it was established that 57.4% use health Centre III, and 31.5% Private health Centre's and Clinics whereas 11.1% who are the least use pharmacies / drug shops as they seek for their health care in this field study. This illustrates the awareness and utilization of the health facilities.

Therefore the local people being aware of the available health services and resources creates a pending choice for the person to choose where and which facility to go for/to for treatment. According to my observation many of the respondents attended health services from the HCIII because they are cheap and affordable in Kyazanga Sub County.

4.2.2 Promotion of health service delivery

There has been the extension of decision making to the local people, through making the leaders at the sub county accountable to the people. This is via election system which gives the locals the right to vote for the people of their

choice according to their ability and capacity to perform such duties of administration. John and Stephen, (2013)supports this by arguing that the decentralization framework must link, 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 quality services on their promises. The local respondents in the field further informed the researcher that the process of elections makes the sub county council accountable to the people as a form of assessing what they have performed as leaders of the in Kyazanga sub County (Interview reports).

The respondents pointed that, decentralization has helped to promote local people's health through having access to the public funds for the budget of the health sector via their councillors and through free medication from Kyazanga health Centre III.

> Partly this involved delegation of authorities to: improve access to public services; increase participation in decision-making; develop local capacity and enhance transparency and accountability (Mugabi, 2004).

The respondents interviewed informed that the funds from the sources of finance such as taxes and from the central government, therefore the budgeting and planning committee made up of councillors plan and allocate the resources at the sub county depending on the best priority and health has always been among the first priorities there by promoting health service delivery in the sub county.

This further informed the researcher that they encourage the people to have toilets that are in proper conditions and make rack/"Butandaalo" for drying utensils, have water and soap for washing hands after using the toilet. The rules/ bye laws are set by the local government to ensure health in the sub-county

and the fine is put for those who are found without these essentials. The consequence when the fine is not paid is to spend two months in jail; hence the sub county has responsibility to set bye laws that govern health of the people. Probably according to the researcher this has promoted sanitation and good health in the rural areas.

4.3 The extent administrative decentralization has offered health services to the poor.

4.3.1 Role of administrative decentralization in health services

The researcher found out that through the sub county council with the health committee communicates in the health centre III with the doctors and nurses from the health centre they ensure effective service delivery in planning for the health service in the area, and sometimes there should be a representative from the LC5 council (district).

The findings showed that on every first Monday of the month the District provides the Health Centre with medical supplies and the representative from the sub county administration has to be available to take note of the received materials and take records. They provide them with various drugs but mostly Malaria, and HIV/AIDs medication and small amounts of drugs needed to heal common infections or bacteria. It is through the Central government that provides grants that the LCIII is able to finance the availability of drugs. However, according to Mugisha of the Kyazanga HC3, the LCIII doesn't play a big role in providing the health centre with the requirements it needs (from questionnaires). As he was interviewed the researcher found out that the budget per quarter of the Kyazanga health centre is only 5million shillings from the sub county. As one of the respondents stated that;

> The district plays a major role in the service delivery within the Kyazanga HC III as it ensures that drugs and medical supplies are provided every month. The district plans and monitors the way the medical supplies are used so as to ensure that there is efficiency within the health Centre.

As the researcher interviewed some residents from Katuulo parish, It was reported that the local government under the chairperson LC3 and the inspector of health with the use of the parish chief to supervise the people in the parish and educate the people on how to keep sanitation in their homesteads for example they arrest people who don't have toilets and those which are in poor conditions. They educate the people on proper disposal of rubbish and washing their hands so as to avoid diseases. The respondent from Katuulo village council informed that this is monitored by the inspector of health in the sub-county and incentives are given to those who have the best sanitation. Through this they have been able to ensure health in the community. A round 70% of the people in the area have good standard latrines in the area as it was reported from the field hence emphasizing health maintenance and promotion in the sub county.

Respondents reported that there are different Non-Government Organizations (NGOs) that offer services such as the Mild May, Kisumu mostly for the Health Education and how to make 'Ebitoobelo' for feeding young children to prevent kwashiorkor and stunted growth of babies in villages. The researcher observed that this has reduced the number of malnourished children in the families of the poor people there by creating good standards of living among the people in the sub county hence health decentralization plays a greater role(From the field).

The local respondents Hanifah and Sofia through interviews stated that, the local government has tried to help in providing some of the services like provision of mosquito nets to the children and pregnant mothers free of charge and sensitizing the people to construct standard latrines with all equipment as stated by the respondents in the field. The researcher further discovered as he observed that Family planning methods have been educated to the local people via chats and posters, by the locally trained nurses as the VHTs to reduce family size for easy support. It was also observed as the researcher was informed that the LC3 level has advocated for water provision, such as construction of boreholes, piped water and dams to provide safe water which is enough and available even in dry seasons, therefore access to safe water in villages in Kyazanga Sub County has also played a role in health service delivery.

The health services offered at the HCIII level

Table 9: presents the respondents response on whether the health services offered HCIII are adequate to the local people

	Frequency	Percentage (%)
Strongly disagree	5	9.3
Disagree	8	14.8
Not sure	12	22.2
Agree	16	29.6
Strongly agree	13	24.1
Total	54	100.0

Source: Primary data, 2016

Data in table 4 shows that 29.6% of the respondents agreed the health centre offers adequate health services to the local people according to its capacity and what it is supposed to offer according to the ministry of health, 22.2% of the

respondents weren't sure because most of these rarely use this health centre, and 14.8% disagreed because the ever occurring out stocks of the drugs and shortage of the nurses at the health centre.

This has been evidenced with a range of services offered at the health centre and mobile clinics including immunization, laboratory testing, medical consultation and health education as established in this study area, the population has benefit from them.

> It was reported that Antenatal/Maternal health for the pregnant mothers has been carried out, as per the promotion of the government of Uganda in relation to the former Millennium Development Goals (MDGs) and the current Sustainable Development Goals (SDGs) as per the UN under the UNDP in the low income countries.

In the midwifery department the researcher found out that they do offer Antenatal Services to expectant mothers that are to prepare them on how to give birth, how to feed and as well enabling them to have a successful delivery and labour. They also offer HIV testing and counselling to patients who are positive. One of the respondents from the maternal ward told the researcher that they roughly work on 20 mothers each week through interviews. Importantly the researcher noted that this has reduced the infant and maternal death rates in the area hence creating a good health environment among the people.

From the field it was noted interviews and observations that there was treating epidemic diseases such malaria, diarrhoea, measles which have been common among the rural people and most especially the low income earners who have lost their lives over these diseases due to lack of capacity to support their health life and poor feeding. The researcher further found out that they fight and combat HIV/AIDS in the area.

> This establishes the basic health facilities for the HIV/AIDS patients in the area through making easy supply of drugs and other medical facilities to combat and reduce the high prevalence rates and deaths of AIDS casualties.

The HCIII has a responsibility for educating the patients in regards to correct dosages. The researcher learned that often the medication plan is changed and the patients must re-learn the proper dosages. Thus there are struggles that people go through when the dosages are changed as many people are illiterate and have trouble understanding the prescriptions (From the field).

All that presented above shows that to a greater extent the administrative decentralization has offered health services to the poor in Kyazanga sub county hence it has promoted health and social welfare.

Benefits from health Centre III to the Local and the low income earners

The participants were generally low earners based on their average monthly household income. This clearly relates to the high poverty levels in Uganda particularly in rural communities. Such low income levels can affect uptake and utilization of health services particularly in communities with no public health facilities where services are supposed to be offered for free following abolition of user fees in 2001as stated by (Mark 2007).

Despite the availability of many health service providers in Uganda, the poor, being financially constrained, normally have limited choice and often use public services many of which are offered free of charge (Kiwanuka S, et al.(2008). Indeed, there is a significant difference in access to various health care providers between the rich and poor.

Accessibility of the health services in the area the local people have been somehow ensured, as there's ability to acquire good treatment from the health facilities in their area, and if the complication is hard they call the ambulance and the patient is forwarded to the big hospital in Masaka Mulago hence improving services and being accessible. This indicates that despite the challenges encountered in health service delivery to larger extent decentralization has promoted health service delivery in this area (From the field).

Commonly Mobile Clinic Services have been crucial in supplementing services offered at health facilities especially in communities where these are few hence necessitating to travel long distances to seek medical attention. These services are known to be very beneficial to disadvantaged populations such as the poor (including those without health insurance), and where no services are provided. With a range of services offered at these mobile clinics was observed in the field in Katuulo parish and it was noted that they include immunization, laboratory testing, medical consultation and health education as established in this study area, the population has benefit from them (From the field).

Besides that, they also have Community Health Workers (CHWs) in health service delivery as a strategy used in Uganda and other countries that serves as a community's initial point of contact for health. These CHWs are volunteers who carry out community mobilization, drug distribution, health education, and referral of patients to health facilities. Therefore CHWs are known to increase access to health care and facilitate appropriate use of health resources. There have been cheap and affordable health services in the area hence reducing the prevalence rate of some diseases like polio and malaria, tetanus, and HIV therefore reducing the death rates which has

created reduction on the number of orphans and widows/widowers leading to improved standards of living in Kyazanga Sub County.

It was found out that more emphasis in the area is now employed to provision in HC III, antiretroviral drugs for prevention of mother-to-child transmission (PMTCT), statistics from the Health Centre stated that;

> Out of 850 women who had given birth in the 5years prior to survey, 818 (96%) had attended antenatal care (ANC) at least once in the pregnancy leading to their most recent birth; 439 (52%) women attended at least 4 times.

The most common reason for not attending ANC was the husband refusing to accompany them to clinic. Although self-care and use of traditional healers is categorized under health, these are often discouraged by health practitioners, with the emphasis on care encouraging people to opt for conventional channels with medically trained personnel with all that therefore there has been promotion of health service delivery in the Kyazanga sub county (From the field).

From the field the researcher observed promotion of health through counselling and sensitization of the masses about the promotion of good sanitation to overcome diseases related to poor sanitation (diarrhoea, cholera etc.), more so the health officers have helped to sensitizes the people on prevention of diseases such as malaria through sleeping under treated mosquito nets, having protected sex to prevent sexually transmitted diseases and HIV/AIDs. Therefore this has promoted good health among the local people hence leading to good standards of living.

Counselling

There were two counsellors present at Kyazanga Health Centre that are responsible for counselling services. The counsellors that responded to the researcher worked specifically with the HIV/AIDS section. It was stated that there are other counsellors responsible for other aspects of health care and that in total there are 9 counsellors who work at Kyazanga Health Centre III. The counsellors also reported that they are nurses and counsellors who also work in the villages making house calls to patients who are sick and unable to travel to the centre.

The counsellor's responsibilities include education on healthy lifestyle, self-esteem, meal plans. The counsellors also spend a lot of time with HIV/AIDS patients who are overwhelmed with their medication plans. The counsellors help to train the patients on how much and how often to take their drugs. Safe sex practices are also taught, and free condoms are supplied. A surprising element the counsellors brought up was a type of match making service for single HIV positive males and females. The health Centre will match patients in order to stop the spread of HIV. The counsellors work with HIV positive partners in order for them to conceive a child without passing on the disease. The counsellors also work with expecting mothers providing advice on meals plans, breast feeding, prenatal care, and encouraging the mothers to have frequent check-ups. Mental health was an issue that was raised continuously, and the counsellors were passionate about ensuring their patients personal and emotional needs were addressed as much as their physical needs hence promoting a health environment among the communities.

Accessibility of health care

Table 10: below presents the respondents take on the statement that, Health facilities are accessible to all people and services offered are efficient to the low income earners in the area

	Frequency	Percentage (%)
Strongly disagree	8	14.8
Disagree	13	24.1
Not sure	8	14.8
Agree	17	31.5
Strongly agree	8	14.8
Total	54	100.0

Source: Primary data, 2016

Data in table 10 shows that 31.5% of the agreed and 14%strongly agreed since they are close to the health centre and they are educated hence being aware of the services offered at the HCIII. 14.8% of the of the respondents were not sure because they were ignorant about the health centre III most especially they are middle income earners and they prefer private health centres, and 24.8% of the farmers disagreed because they had less knowledge about what is supposed to be offered. As well others reported issues of corruption lack of drugs at the HCIII.

Accessibility of health and medical facilities to the local people, involves making them available, known and affordable to all the people despite their income status to promote good health and productivity of the population. The researcher interviewed a patient by the name of John Dungu, who informed the researcher that he travels, by foot, from Lwempazi to Kyazanga (20km) every month in order to get treatment. When asked how he found his treatment, his response was "It's not

all that bad, though drugs tend to be few sometimes." The respondent pointed that in the past he only had to come every 2 months (From the field).

From the field through questionnaires it was pointed out from the respondents that the administration also plays an important role in sensitization of the masses about the basic of good health in the society and how to access the public health facilities to the poor locals who can't afford costs for private health services in the area. In Kyazanga Sub County this has been done through encouraging and informing via posts and charts, to the local people about the use of maternal health services, sleeping under mosquito nets, sanitation in the households etc., and hence promoting health.

Cost of healthcare

It was found out that the cost of medical services in the area is relatively low because the health centre offers free medication to the people. Whereas if the medicine is not available medical check-up is done and then the medicine needed is written for that patients and they are sent to buy them from private health centres, hence reducing on the cost of medical check-ups and tests in the private wards(From the field).

For the case of the HIV patients via questionnaires and interviews it was found out that, everything is supplied on a free basis for example the ARVs are supplied every after two months the patients hence promoting good health. It was found out that they carry out counselling of the patients most especially the HIV infected people to give them comfort and assurance of their life.

Improved people's health life and productivity

As we interviewed more respondents from the local people or the beneficiaries we found out that public health Centre services have increased productivity of labour. This has been achieved due to assurance of good health and counselling of the sick hence making them comfort to work for their better living. Therefore this has improved the peoples incomes and there standards of living in the area.

Table 11: Administrative decentralization of health has improved people's health life and productivity

	Frequency	Percentage (%)
Strongly disagree	3	5.6
Disagree	10	18.5
Not sure	6	11.1
Agree	27	50
Strongly agree	8	14.8
Total	54	100.0

Source: Primary data, 2016

Data in table 11 shows that 50% of the respondents agreed stating that good health accessibility and provision leads to good health at a cheap price which leads to high productivity in the population and increased saving since less is spent on the health, 18.5% of the respondents disagreed because other factors such as increased corruption, poor health facilities at the HC3, and lack of enough and qualified personnel in health service delivery and 14.8% of the local people weren't sure because they didn't have knowledge about the process of decentralisation. The availability of affordable and accessible health services has therefore promoted people's standards of living hence leading to improved life style and able to produce enough for their incomes and welfare.

All that presented above shows that to a greater extent the administrative decentralization has offered health services to the poor in Kyazanga sub county hence it has promoted health and social welfare.

4.4 To assess the challenges countered in health service decentralization

In many health systems, particularly in developing countries such as Uganda, illiteracy, and poverty, under funding of the health sector, inadequate water and poor sanitation facilities have a big impact on health indicators. In addition, cost of services, limited knowledge on illness and wellbeing, and cultural prescriptions are a barrier to the provision of health services.

Table 12: presents the response from the respondents to the statement that, Decentralization has failed to improve the health services due to some challenges experienced

	Frequency	Percentage (%)
Strongly disagree	2	3.7
Disagree	8	14.8
Not sure	16	29.6
Agree	24	44.4
Strongly agree	4	7.5
Total	54	100.0

Source: Primary data, 2016

Data in table 12 shows that 44.4% of the respondents agreed that the health decentralisation process has not fully improved the health service delivery due to some challenges faced such as high levels of bureaucracy, corruption, and increased population lack of technically skilled labour among others. Which has hampered the efficient service delivery to the people through health centre III's, 14.8% disagreed but a

good number of respondents were not sure making 29.6% since they were less educated and therefore ignorant about such issues saying they are for the educated people (From the field).

In support to the above however it was found out that some of the challenges faced in Kyazanga sub county health service delivery relating to Kyazanga health centre III such as inadequate equipment like surgical tools and drugs. For example the boxes the researcher observed that were in poor storage such as scissors and tongs. The clinical doctors also responded to the researcher that they don't have enough water provisions as the only use the tanks during the rainy season. During the dry season they are forced to use more costs to access clean water.

The researcher found out that under the department of maternal sector, and under the department of HIV/AIDS sector there were only four senior nurses for the entire health centre and were incredibly busy with patients. However the researcher was informed that there is still need to improve, for example issues concerned with more manual labour for the maternal ward as they were very few compared to the number of patients. She also reported that they needed more privacy for the expecting mothers that are more rooms for delivery, the need for more drugs for boosting blood for haemoglobin which she told us was out of stock though they had the vitamin c drug but there is need for more(From the field).

From the HIV section, it was noted that there was only one nurse working in this sector and so she informed us that she is responsible for supplying medication (ARVs) to all HIV patients and giving them guidelines and illustrations on how to use the drugs and when to change to new doses. The respondent went ahead and told the researcher that the AIDs sector works for two days in a week that is Monday and Tuesday

and this is when they offer services to around 300 patients per day.

It was pointed that "occasionally there are shortages because the government fails to supply." It was also reported that sometimes they do find shortage of drugs in some months for example before they would give AIDs patients drugs for two months but now due to shortage they have been forced to give them drugs for one month, hence it becomes tiresome and expensive for the patients in form of transport for those who come from far places (From the field).

One of the respondents stated that drugs are received on free basis, but on occasion, when there are no drugs available, the health centre sends him to a private clinic where his expenses are not covered. He explained that he cannot afford to pay the high fees for drugs so on those months, he goes without drugs. This therefore affects the people's health which may led to body weakening and hence causes death.

There are also inadequate communication skills between some patients who don't know how to interpret prescriptions of the drugs given to them by the nurses.

Accessibility

Challenges of accessing health facilities from the field were noted were the nearest health facilities to the participants' homes were clinics (68%), health centres (21%), and pharmacies / drug shops (11%). The distance of these nearest facilities from the participants' homes is shown in the table below. No hospital existed in the community.

Table 13: showing Distance of nearest health facilities from homes

Distance	Frequency (N = 54)	Percentage (%)
Less than ¼ a kilometer(km)	4	7.4
Between ¼ and ½ of a Kilometer	9	16.7
More than 10 kilometers	41	75.9
Total	54	100

Primary source of data

It was noted that 75.9% of the population live more than 10kms away from any health facility, 7.4% live less than ¼ a kilometre and 16.7% live between ¼ and ½ of a Kilometre a way from any health facility.

Means of transport

"It was reported that while sick, the majority of participants (75%) used commercial motorcycles to travel to health facilities while 18% walked. The rest used either bicycles (5%) or vehicles (2%)."

The problem of distance to health facilities is aggravated by the high poverty levels in rural communities which affects expenditure on transport. Some patients including those that are disabled or pregnant may not attempt long distances to seek health care without adequate means of transport. Although constructing more health facilities in the country could be a long term strategy to address this problem, providing more frequent mobile clinic services would greatly benefit the rural population.

The problem of regular stock out of drugs has been known in the Ugandan health system for a long time. From the field 3 respondents from the health Centre informed the researcher that;

> the reasons for its occurrence include the long procurement process (bureaucracy) for drugs from the main government suppliers (National Medical Stores - NMS), inadequate funding for essential drugs, lack of skills in medicine forecasting, poor selection and quantification of medicines, poor records management and lack of prioritization(From the field).

The continued absence of essential drugs especially at public health facilities has a negative impact on health service utilization, as people ignore health Centre III facilities because of the usual trend of no drugs. This is likely to lead to unfavorable behaviors such as self-medication or use of traditional healers hence leading to poor health services most especially among the low income earners.

High cost of health services in nonpublic facilities and long distances to health facilities were the other main challenges established. Ministry of health (MOH), (2014) supports this by stating that other studies conducted have also indicated that cost is often a barrier to seeking health services especially among the poor. Due to abolition of user fees at public health facilities, rural communities use them frequently. However, due to the limited number of public facilities particularly in rural areas, inhabitants are necessitated to use private health care providers at a cost.

It was confirmed via questionnaires that Corruption has affected the health service delivery in the area at the administration of the sub county were some people recruit the people who are less qualified to work in the health service delivery.

> Some of the respondents also informed us that some funds for the construction of the new block for the health facility was delayed by the sub county administrator(From the field).

It was also found out that some nurses and doctors collect money from some patients before some services are offered to them, for example it was evident from some respondents such as Sofia a resident in Kyazanga town via interviews, who reported that they are sometimes forced to pay some amount of money to the health workers for them to be worked on urgently. Some of the patients at the health centre informed the researcher that the mama kit is offered to every pregnant mother free of change but some rural people from deep in the villages are charged for it hence showing corruption and inequality in the service delivery.

Poor service delivery was also identified via interviews, with the local people in the area. We found out that the services rendered at the health centre III are not of good quality and if the sickness is severe they are referred to private health centres or to Mulago in Masaka which is in a far distance. This is related to lack of enough qualified personnel to work in the health centre since we found that there are cases of were one nurse attends to 5 patients. There is only one doctor and two senior nurses which do not suit the population of the patients in the health centre.

Limited facilities at the health centre such as accommodation, water sources and medicine in the medical stores were we found out that sometimes this health centre runs short of some drugs such as ARVs, anti-malarial drugs and other drugs. This has mostly become an impact due to high population increase. Population in the area has been the problem because the health centre was constructed to hold a relatively small capacity but as of recent the population of people in the sub county has increased hence affecting service delivery.

It was found out that there is Limited funds and finance to support the health sector in the area that is to say the funds are delayed to the sub county hence limiting the service

delivery. This also affects the allowance payments to the employees in this sector hence affecting their motivation. Some clinical officer reported that limited finance is caused by,

> Unfavourable budgets which don't favour the health sector as the first priority to ensure better health services to the people, therefore little funds are allocated to the health sector and this makes it little to support the services that are supposed to be offered.

It was established that there is also a problem of Poor and conservative rural people who don't coup up for the changes introduced for health development and sanitation, such as immunization PMTCT (Stick to traditional healers especially the giving birth mothers and others).

4.5 Conclusion

The findings showed that Decentralization has established better service delivery at the local level. Through its systems such as administrative decentralization, privatization of the health system have supported all the people in the area both the poor and rich hence it has partly reduced the challenges in the health system of Uganda. Despite the existence of issues such as corruption, high levels of illiteracy, poverty, under funding of the health sector, regular stock out, inadequate water and poor sanitation facilities that have a big impact on health development. Therefore all these need specific and regular attention to promote health service delivery to the people hence achieving good deeds of decentralization.

Besides that there has been access to the public health facility at every level of the government administration, such as the health Centre IIIs at Kyazanga Sub County to promote health for all citizens regardless of the social, political and economic differences in Uganda.

CHAPTER FIVE

SUMMARY CONCLUSION AND RECOMMENDATION

5.0 Introduction

Chapter five discusses the findings of the study as presented in chapter four. It also presents the conclusions arising from the study and recommendations, which could improve health service delivery.

5.1 Summary of the findings

Administrative decentralization refers to the redistribution of authority, responsibility and financial resources for providing public services among different levels of government as mandated by the local government act in the constitution. It involves the planning, financing and management of certain public functions and resources.

It was stated that the sub-county is headed by the sub-county chief on the technical side and by an elected local council III (LCIII) chairperson and his/her executive committee, with an LCIII council. As well the council consists of elected councilors representing the parishes. It was confirmed that these play an important role in health service delivery through planning and financial budgeting for the health sector.

The Health decentralization levels at the sub county involve the Village Health Team (VHT) in each village, Health Centre II, and the Health Centre III as the most facility. This has empowered the local people to access health cheaper health services. The participants were highly knowledgeable about the health facilities that existed in their community. They access treatment diseases such as malaria, diarrhoea, measles and preventing HIV/AIDS among the rural people.

Despite the availability of many health service providers in Uganda, the poor being financially constrained, normally have limited choice and often use public services. The low income earners are disadvantaged populations. This is noted that low income levels can affect uptake and utilization of health services particularly in communities with no public health facilities. For instance due to Mobile clinic services and Community Health Workers (CHWs) have been crucial in supplementing services offered at health facilities especially in communities where these are few. Therefore this has made cost of medical services in the area relatively low because the health Centre offers free medication to the people.

In many health systems, particularly in developing countries such as Uganda, they experience challenges such as illiteracy, poverty, under funding of the health sector, corruption, inadequate water and poor sanitation facilities have a big impact on health indicators. The problem of regular stock out has been caused by long procurement process (bureaucracy) for drugs from the main government suppliers and lack of prioritization. In addition, cost of services, limited knowledge on illness and wellbeing, and cultural prescriptions are a barrier to the provision of health services.

5.2 Conclusion

Decentralization at the Local government as amended in the 1997 constitution of Uganda, has established better service delivery at the local level. The systems such as administrative decentralization, privatization of the health system has supported all the people in the area both the poor and rich hence it has partly reduced the challenge in Uganda.

There has been access to the public health facility at every level of the government administration, such as the health Centre IIIs at each sub county to promote health for all

citizens regardless of the social, political and economic differences in Uganda.

Beside that health service delivery at the sub county level has had challenges like partially the whole health system in Uganda has been affected with the same problem even at the national referrals. There are issues of corruption, high levels of illiteracy, poverty, under funding of the health sector, regular stock out, inadequate water and poor sanitation facilities have a big impact on health indicators. Therefore all these need specific and regular attention to promote health service delivery to the people hence achieving good deeds of decentralization.

5.3 Recommendations

Having examined the different aspects from the research carried out in the field, it can be noted that decentralization has played some role in raising the standards of living of its members. However, it has also faced some problems and weaknesses, which have undermined its effectiveness, and efficiency. Hence, there is need for the society members and the management to find ways of rectifying such undesirable conditions. The following are some of the measures the researcher proposes to the society, which could solve some of the problems.

Reduction of the high levels of bureaucracy

Decentralization has led to high levels of bureaucracy in Uganda where access to some public resources has been made little bit difficult and a burden to some people due to high procedures. The problem of regular stock out has sometimes been caused by long procurement process (bureaucracy) for drugs from the main government suppliers hence affecting the service delivery. Therefore the levels of bureaucracy should be reduced to ensure easy access to the resources.

There should be enfaces on accountability, transparency and supervision to reduce misuse of resources and avoid corruption. There should be thorough supervision by the government through the district and sub county authorities especially from the ministry of health well facilitated to effectively inspect, guide, monitor, evaluate and discipline all the health workers and administrators who misuse the public resources. This should be done to ensure accountability and transparency in health service delivery.

Promote education to reduce illiteracy and conservatism

The high levels of illiteracy noted from the area have partly affected people's income capacity and the health status. If the people attain better education levels they will be in position to attain good jobs, improved standards of living and as well the leadership at the local government level will be of competent citizens that can deliver better services. Mostly education will reduce the high levels of conservatism which was noted that the local people hardly adapt to new changes in the area to promote health and sanitation hence some members of the community are rigid and resistant to change due to backward perceptions. This will therefore help on the people's awareness on how to promote good health (immunization, HIV testing, and going for antenatal checks).

Rise people's income:

There should be creation of employment schemes to ensure more jobs for the population to reduce the high levels of dependency and poverty in the area. For example it was noted that most of the people in this area are agriculturalists and others are engaged in Agribusiness which tends to be seasonal and flactuative in nature hence the government should improve on agriculture and also create other employment sectors to improve people's income. Further creation of markets will

also Create employment and improve people's incomes and standards of living to reduce poverty levels.

Accessibility and affordability

Improve accessibility and affordability of the health services. The private health service renders should be given tax holidays and subsidies to reduce on the costs of acquiring health. This will make the health services accessible and affordable for every one despite of their income capacity.

Management to train the non-medical staffs.

Management should ensure that all those dealing with financial resources and VHTs are properly trained and instructed. This will allow the staff to be equipped with all the necessary qualifications and skills to carry out their duties and responsibilities efficiently and effectively.

5.4 Areas of Further research

This study has identified the need to investigate and analyse the effect of government policy and funding of public health centres in Uganda.

This study has identified the need to analyse the effect of high levels of bureaucracy on health delivery to the poor in Uganda.

5.5 Conclusion

The researcher was optimistic that given the trend of event as revealed by the findings and analysis, it was now left to government and other stakeholder as discussed in chapter two of this book to play their part using the means that have been suggested above.

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APPENDICES

Appendix I: Research questionnaire

(To be filled in by the respondents from Kyazanga Sub County)

Dear Mr. / Madam,

I am Tumusiime Richard a student of Uganda Martyrs University pursuing a Bachelor's Degree in Ethics and Development Studies carrying out research on the topic: **Assessing the Role of Administrative Decentralization in the improvement of Health Services among the low earning people in Lwengo district.** Case study: Kyazanga health Centre III, Lwengo District. As a partial fulfilment for the award of this degree, the study is purely for academic purposes and the information given will be treated with utmost confidentiality and a profound manner of professionalism. I therefore, humbly request you to spare some time and answer the following questions.

This questionnaire has two Sections A and B. Please answer all questions.

PART 1

Name (Optional)……

Please tick your choice in the appropriate box provided.

1. Gender

a) Male ☐ b) Female ☐

2. Marital status:

a) Single ☐ b) Married ☐ c) Widow(er) ☐ d) Divorced ☐

3. Age bracket

a) 18-25s ☐ b) 26-35 ☐ c) 36-45 ☐ d) 46 and above ☐

4. Level of education attained (Qualification)

a) UCE ☐ b) UACE ☐ c) Tertiary ☐ d) University ☐

5. For how long have you been in this Area?

a) Below 10years ☐ b) 20years ☐ c) 30years ☐

d) Above 30years ☐

SECTION A

Decentralization refers to the transfer of authority and responsibility for public functions from the central government to intermediate and local governments.

Administrative decentralization refers to the redistribution of authority, responsibility and financial resources for providing public services among different levels of government. It involves the planning, financing and management of certain public functions and resources.

Please tick your appropriate choice in the space provided using the keys given below;

S.A-Strongly Agree, A- Agree, D- Disagree, S.D- Strongly Disagree, N.S- Not Sure

Statement	S.A	A	D	S.D	N.S
1. Decentralization has helped in health service delivery in this area.					
2. The sub county has played a role in the health service delivery to the local citizens.					
3. The health Centre offers adequate health services to the local people.					
4. The health Centre is accessible to all the people and services offered are efficient most especially to the low income earners.					
5. Health administrative decentralization has effectively improved people's health life.					
6. Decentralization has failed to improve the health services due to some challenges experienced.					

SECTION B

1) How has administrative decentralization promoted health service delivery in this area?

……

2) Is the sub county responsible for public health service delivery? If yes, how has the sub county administration played its role in health service delivery?

……

3) What are the services offered at Kyazanga health Centre III?

……

4) What is the cost of attaining treatment in the area?

a) Moderate ☐ b) Low ☐ c) High ☐ d) Affordable ☐

How has the cost affected service utilization?

……

5) How does it cost you to reach /accessibility of the health Centre, is it expensive or cheap?

……

6) What means of transport are used to travel to the health Centre III.

a) Car ☐ b) Motorcycle ☐ c) Bicycle ☐ d) Foot ☐

7) Has health Administrative decentralization achieved its objectives? Yes or no and explain why and how.

……

8) How have the local and the low income earning people benefited from the health Centre services.

……

……

9) Challenges have been faced in health decentralization? Yes or No. then what are some of these challenges.

……

10) If the challenges encountered in health decentralization affect the local people. How does this affect local people's productivity and income?

……

***Thank you for your cooperation**

Appendix II: Interview Guide

My name is Tumusiime Richard a student of Uganda Martyrs University carrying out research on a topic entitled; **Assessing the Role of Administrative Decentralization in the improvement of Health Services among the low earning people in Lwengo district.** Case study: Kyazanga health Centre III, Lwengo District. Please, I kindly want to ask you a few questions and will be grateful for your response.

Findings will be used for academic purposes of this study only.

Section A: Background Information

1) Sex: (a) Male ☐ (b) Female ☐

2) Qualification ☐(a) Degree ☐b) Diploma ☐(c)Certificate ☐ (d)PLE Other ☐

Section B: Questions

1) What is the role played by the sub county in the health service delivery to the local citizens?

……

2) How has the sub county administration played its role in health service delivery?

……

3) How has administrative decentralization promoted health service delivery in this area?

……

4) What are the services offered to the people at the health Centre?

……

5) How does it cost you to reach /access the health Centre and how efficient are the services offered?

……

6) Why was Kyazanga health Centre III constructed in this area, and how has it achieved its goals.

……

7) How have the local and the low income earning people benefited from the health Centre services.

……

8) Is there any challenges that have been faced in health decentralization?

……

***Thank you for your cooperation**