DECENTRALIZATION AND PUBLIC HEALTH SERVICE DELIVERY IN UGANDA: A CASE STUDY OF BULAMBULI TOWN COUNCIL

BY

ERIC WANYAMA

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Declaration

I **Eric Wanyama**, hereby declare that this is an original copy of my dissertation. It has never been submitted to any Tertiary Institution or University for any academic purpose.

Signature:**……** Date**:……**

Name: ERIC WANYAMA

Approval

This dissertation was compiled by **Eric Wanyama** under the Title, "Decentralization and Public Health Service Delivery in Uganda**"**, taking a Case Study of Bulambuli Town Council. It was under our supervision and it meant the requirements for the award of a Master's Degree of Science in Organization and Public Sector Management of Kyambogo University.

1. SIGNED: …… DATE: ……..

DR. REGIS ZOMBEIRE

(SUPERVISOR)

2. SIGNED: …….. DATE: ……..

DR. MADINAH NABUKEERA SEBYALA

(SUPERVISOR)

Dedication

I dedicate this work to my beloved wife Chebet Linet who absolutely stood with me in all situations physically, emotionally, spiritually, economically and socially to see this academic project becomes a success.

May God bless her abundantly.

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First and foremost, I extend my honour and thanks to God, I also extend sincere gratitude to my Supervisors; Dr. Regis Zombeire and Dr. Madinah Nabukeera Sebyala (Lecturers) at Kyambogo University for their guidance and academic support extended to me, and invaluable research experience that they didn't hesitate to share with me. I also thank the entire academic staff of Kyambogo University and my comrades (classmates) for their continuous encouragement and all forms of assistance that they rendered to me in the process of coming up with this research project.

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Acronyms

ACODE: Advocates Coalition for Development and Environment.

H/C IV: Health Centre Four

HIV/AIDS: Human Immunodeficiency Virus infection and Acquired Immune Deficiency Syndrome

MDGs: Millennium Development Goals

NPM: New Public Management

Abstract

This study examined the relationship between decentralization and public health service delivery in Uganda, taking Bulambuli Town Council as a case study. The objectives of the study were; To establish the relationship between political decentralization and public health service delivery, To determine the relationship between fiscal decentralization and public health service delivery, and To establish the relationship between administrative decentralization and public health service delivery. A case study research design was used and quantitative and qualitative approaches were employed where questionnaire, interview and observation methods were used. Self-administered questionnaires and Interview guide were employed as data collection tools on a sample size of 150 respondents that was determined from a target population of 240 using the formula for Yamane and Taro. Purposive and simple random sampling techniques were used in selecting respondents. In addition, observation method by use of observation checklist as a data collection tool was also used to supplement on questionnaire and interview methods. Pearson product moment correlation coefficient was used to test the hypotheses and the study findings revealed a significant relationship between the three decentralization dimensions and public health service delivery. It was therefore concluded that there is a positive significant relationship between political decentralization and public health service delivery, positive significant relationship between fiscal decentralization and public health service delivery and a positive significant relationship between administrative decentralization and public health service delivery in Bulambuli Town Council and the study recommended that there should be improvement in political decentralization, fiscal decentralization and administrative decentralization through embracing citizen participation in decision making by ensuring public hearings and consultation system and also involving them in the budget preparation process, finding out more revenue generating opportunities to widen the tax bases by encouraging entrepreneurial spirit and embracing the qualities of good governance like transparence, responsiveness, and rule of law, accountability, equity and inclusiveness and also appreciation of the whistle blowers in the management, regular monitoring and evaluation of the Town Council operations by the responsible Local Government officials and the Central Government should regularly demand for accountability from the Town Council on its performance to instill a sense of seriousness and proper allocation of the funds, proper utilization of the disbursed drugs and other health equipment of machines assigned to it to facilitate in health related operations. This study focused on decentralization in terms of (political, fiscal and administartive) and how the trio relate to public health service delivery, a further study may be carried out to examine the relationship between decentralization and public education service delivery in Bulambuli district, a similar study may be carried out in other Local Government Town Councils in the country especially in Eastern and Northern Uganda, more research may also be carried out to investigate the influence of locally generated funds on public health service delivery in the Local Governments of Uganda.

CHAPTER ONE
INTRODUCTION

1. Introduction

This study examined the relationship between decentralization and public health service delivery. The independent variable was decentralization with key dimensions that included political decentralization, fiscal decentralization and administrative decentralization while dependent variable was public health service delivery with service indicators such as equitable accessibility, timely delivery, availability of health equipment and citizen satisfaction. This chapter presented the background to the study, statement of the problem, general objective, specific objectives, research hypotheses, conceptual framework, and scope of the study, significance and justification of the study and definition of key terms.

1.1 Background to the study

The background to the study was built on the historical perspective of the problem, theoretical, conceptual and contextual backgrounds which shaded more light on the situation in regard to the problem under study.

1.2 Historical Background

In earlier centuries, when little was known about the causes of diseases, societies tended to attribute illnesses to witch craft and resignation, and on this note, few public health actions were taken (Ferlie & Steane, 2002). As understanding of sources of contagion and means of controlling diseases became more refined, more effective health interventions against health threats were developed and the move towards decentralization started evolving especially with the emergence of the New Public Management (Manning, 2001) and Public organizations and agencies were formed to employ newly discovered interventions against health threats. It is

important to note that the transformation of the territorial structure of Government, its decentralization, particularly the introduction of territorial self-Government was considered an essential task in the process of rebuilding political and administrative systems in Central and Eastern Europe after 1989 and the reforms of the territorial Government followed closely after the collapse of the Communist regimes and after the transformations of the constitutional bodies and Central Governments in 1990 (Batley & Larbi, 2004). This was intensified with intensions of extending power, public services, and generally public administration near to the locals through a scientific approach, through this approach, public authorities expanded to take on new tasks, including sanitation, immunization, regulation, health education, and personal health care (Chave, 1984; Fee, 1987). Since the 1980s, a great number of Countries, developed or developing, have been embarking on improving the quality of public service delivery through decentralization whereby legally Uganda embraced the move in 1997 through the enactment of the Local Government Act, 1997 (The Government of Uganda, 1997). Despite the mentioned move, public services still remain out of reach for many communities with a few exceptions of successful cases (Malaysia, for example), public service delivery remains at a lethargic stage for the middle- and low-income countries Uganda being one of them (Frost, 2012).

It is argued that with a deliberate emphasis on quality of health, nations will be able to make significant progress towards achieving the Sustainable Development Goals and attaining universal health coverage (Marek, 2003). For instance, Mutumba (2005) carried out a study on the effect of decentralization on the performance of district personnel in Uganda: a case-study of Tororo District Health Directorate. Lameck (2017) studied decentralization and the quality of public service delivery in Tanzania. Case study of Morogoro Municipality and Hai District Council. Saavedra (2010) undertook a study on the impact of decentralization on access to service delivery).

In Uganda, service delivery focuses on a defined minimum package of care, the Uganda National Minimum Health Care Package. This minimum package of care is delivered through a network of health units and referral system escalated by the decentralization move. The Local Governments also plan for and oversee health service delivery within the districts (The Government of Uganda, 1997).

However, the challenge is to make the Country's health system functional in order to provide modern health services to the citizens (The Government of Uganda, 1997). In the last two decades, the high levels of maternal mortality, infant mortality, malnutrition, poor sanitation and hygiene are at unacceptable levels (Thynne, 2003). The persistent inadequacy of health service delivery and other health related challenges against common health conditions despite decentralization move triggers the concern to undertake the study to identify the relationship between decentralization and public health service delivery as the Country strategizes through such moves to move towards middle income status.

1.3 Theoretical Background

This study was guided by the Sequential Theory of Decentralization, as the study sought to examine the relationship between decentralization and public health service delivery. The Sequential Theory of Decentralization propounded by Falleti (2005) was used as the directing framework to discuss the curves in conducting the study by specifically focusing on the three decentralization dimensions of political, fiscal and administrative. The concept of decentralization is a set of state reforms which involves exclusively only state actors from the central Government to the lowest Government agencies at the grassroots (Falleti, 2005). In line with that, Falleti the proponent of the sequential theory of decentralization argued that the sequencing of diverse forms of decentralization namely: administrative, fiscal, and political is

a key determinant of the development of the Inter-Governmental balance of powers, increase of locals' participation in decision making and general improvement in public service delivery. The incorporation of this theory in the study was intended to prove the existence of decentralization and its relationship with public health service delivery and which decentralization dimension has a remarkable contribution towards public health service delivery.

However this theory falls short of the society, religion and environmental factors that have proven that they are always in the background of every decentralized state. Theoretically, it is believed that the undertaking of decentralization is associated with the improvement in public service delivery through increased citizen satisfaction since services are delivered in line with the citizens' needs, service adequacy because of proper planning and incorporation of the locals' needs in the budgets, improved service accessibility and timely delivery through the creation of a variety of health systems starting from Village Health Teams (VHTs) to referral hospitals. It is discovered that to ensure service delivery and the exercise of devolved powers (political powers) in general, administrative decentralization should be implemented along with expenditure and fiscal arrangements. So function, finance, and functionaries all need to be sequenced properly. Therefore, in relation to this study, it was believed that decentralization through political, fiscal and administrative could work as key factors that could enhance improvement in the public health service delivery and the researcher thought that improved decentralization in the Local Government organizations as per this theory would mark improved public health service delivery in Bulambuli Town Council.

1.4 Conceptual Background

The key concepts of this study included decentralization and public health service delivery. According to Agrawal (2001) as cited in Falleti (2004) decentralization is a process of state

reform composed by a set of public policies that transfer responsibilities, resources, or authority from higher to lower levels of Government in the context of a specific type of state. According to Ribot (2004) decentralization can be territorial, functional or institutional, depending upon the geographical demarcation, range of functions delegated and the way decision-makers are recruited.

Ribot (2004) defines fiscal decentralization as a set of policies designed to increase the revenues or fiscal autonomy of subnational Governments.

Administrative decentralization comprises the set of policies that transfer the administration and delivery of social services such as education, health, social welfare, or housing to subnational Governments (Falleti, 2004). According to Devas and Delay (2006) political decentralization is the set of constitutional amendments and electoral reforms designed to open new or activate existing but dormant or ineffective spaces for the representation of subnational institutions.

The other variable of this study, public health service delivery can be defined as the provision of health related goods and services to all persons especially those that cannot be provided by the private sector (Kotler, 2002). According to Mutabwire (2013) public health service delivery refers to a relationship between policy makers, service providers, and consumers of those services, and encompasses both services and their supporting systems. Shenghelia (2003) describes accessibility of service as a broad term with varied dimensions: the comprehensive measurement of access requires a systematic assessment of the physical, economic, and socio-psychological aspects of people's ability to make use of health services. Shenghelia (2003) defines availability as an aspect of comprehensiveness and refers to the physical presence or delivery of services that meet a minimum standard. However, according to Van (2004) it is

defined as citizens' perception of the quality of the goods and services that are provided by the Government.

1.5 Contextual background

Important to note is that, studies have been carried out to determine the relevance of decentralization in improving public service delivery but of these, few studies carried out by scholars and researchers focused on the relationship between decentralization and public health service delivery, most studies have focused on the effect of decentralization on public service delivery in general, but this study focused on decentralization and public health service delivery in Bulambuli Town Council.

In the context to this study, it was revealed that Bulambuli district where Bulambuli Town Council follows has directorates for different sectors; typically, these are directorates for finance and planning, education and sports, health services, management support services, production, works and technical services, and community-based services. These district directorates extend public services to the citizen as opted by the Central Government to decentralize public service delivery to the Local Governments. Bulambuli district has 09 sub counties and one Town Council with 25 health facilities; including 14 Health Centre IIIs, 10 Health Centre IIs and one Health Centre IV found in Bulambuli Town Council. Muyembe Health Centre IV is now the only haven for the population within and those from the neighboring districts such as Sironko, Bukedea, Kween, Bukwo and Kapchorwa.

The Town Council has one health facility at a level of Health Centre IV (Muyembe H/C IV) as well serving as a referral point collecting health service seekers from the nine sub-counties in the district and neighboring districts to Bulambuli, hence contrary to the aim of decentralisation

since the too much reliance on Muyembe health Centre for health services has detoriorated the quality of health services (Mugabe & Omagor, 2018).

It was reported that Muyembe H/C IV operates in dilapidated structures, lacks a stand by generator and accommodation for both admitted patients and medical workers. On average Muyembe H/C IV receives approximately 1060 patients per week from within Bulambuli District and the neighborhoods. The in charge of the maternity ward was quoted saying that during power outages the Health Centre is covered in absolute darkness and times Nurses are forced to use torches while administering delivering mothers. All these have negatively affected health service delivery in terms of limited access to services, delayed delivery and stock out of medicines, inadequacy of health services (Bulambuli, Uganda Health Analysis Report, 2017-2018). This highly inconveniences the efficient and effective delivery of health services and if no action is taken, the Government intention of decentralization to improve public service delivery will not be attained and may even make the citizens to lose confidence in the incumbent Government.

The choice for taking Bulambuli Town Council as a case study was attributed to the worrying status of health service situation in the area and yet citizens in this area are low income earners mainly depending on subsistence agriculture and having their hopes in the Government to reach them such crucial services like health, education and among others (Mugabe & Omagor, 2018). Meaning if the Government's move is not realizing the intended health benefits, then such citizens will continue suffering thus the decision to conduct the study on the relationship between decentralization and public health service delivery in Bulambuli Town Council with the aim of finding the mechanisms to enhance decentralization move and improve public health service delivery.

1.6 Statement of the Problem

The Government of Uganda adopted a decentralized system of governance to ensure improved equitable access to public service, timely delivery, service availability, citizen satisfaction, adequate services (Economic Policy Research Centre, 2010). Despite the above adoption, the nature of public health service delivery in Bulambuli Town Council is still below the intentions of decentralization with observable records showing limited access to health services, unsatisfied citizens, limited number of health workers, and the few available are at times off the work, stock out of medicines and delayed service delivery (Bulambuli, Uganda Health Analysis Report, 2017-2018; Auditor General's Report. 2018) it is further asserted that the only prominent Health Centre IV (Muyembe H/C IV) operates in dilapidated structures, lacks a stand by generator and lacks most of the essential medical equipment, some of the few that exist are faulty (Auditor General's Report, 2018) this even led to the closure of the theatre (Muyembe H/C IV Administrators' Report, 2018) and unfortunately the related reviewed literature does not show efforts being made to establish the underlying issues of health service delivery vis-à-vis decentralization move in Bulambuli Town Council. This has continuously inconvenienced the efficient and effective delivery of health services and if no action is taken, the Government intention of decentralization to improve public service delivery will not be attained and may even make the citizens to lose confidence in the incumbent Government. Therefore, it was upon this background that this study sought to examine the relationship between decentralization and public health service delivery in Bulambuli Town Council so as to take the appropriate action.

1.7 General Objective

The purpose of the study was to examine the relationship between decentralization and public health service delivery in Uganda with specific reference to Bulambuli Town Council as a case study.

1.8 Specific Objectives

1. To establish a relationship between political decentralization and public health service delivery in Bulambuli Town Council.
2. To determine the relationship between fiscal decentralization and public health service delivery in Bulambuli Town Council.
3. To establish a relationship between administrative decentralization and public health service delivery in Bulambuli Town Council.

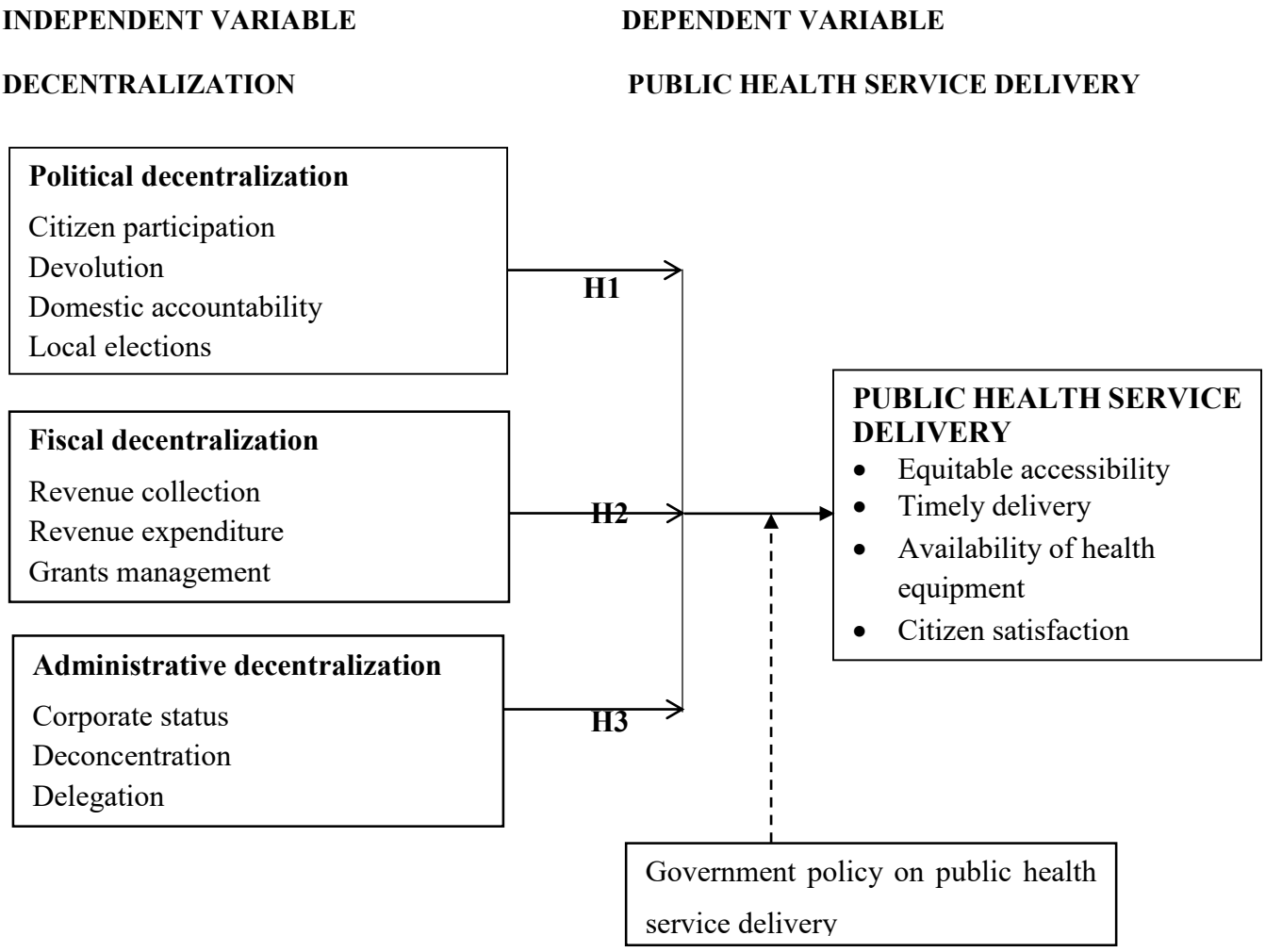
1.9 Research Hypotheses

H_1 There is a significant relationship between political decentralization and public health service delivery in Bulambuli Town Council.

H_2 There is a significant relationship between fiscal decentralization and public health service delivery in Bulambuli Town Council.

H_3 There is a significant relationship between administrative decentralization and public health service delivery in Bulambuli Town Council.

Figure 1: Conceptual Frame Work (CFW)



Source: *Adapted from Falleti (2005); World Bank (2000); constructed from the reviewed literature and modified by the researcher.*

The conceptual frame work above was conceptualized to explain the relationship between decentralization and public health service delivery. Decentralization was conceived as the Independent Variable (IV) while public health service delivery as the Dependent Variable (DV) as illustrated in figure1 above. The independent variable was conceptualized as political decentralization, fiscal decentralization and administrative decentralization. The indicators of political decentralization a sub variable of decentralization included citizen participation, devolution, domestic accountability and local elections.

Administrative decentralization was measured inform of corporate status, decocentration and delegation of authority and responsibility, financial resources, transfer of administration. The dimension of fiscal decentralization was measured inform of autonomy of revenue collection, expenditures, Inter-Governmental transfers, grants management. The dependent variable was public health service delivery disintegrated as equitable access, timely delivery, and availability of health equipment, citizen satisfaction and adequate services. The major intent for this study was to examine the relationship between decentralization and public health service delivery. Therefore, the conceptual framework above was to guide the researcher to examine the relationship between the two main variables (decentralization and public health service delivery) in Bulambuli Town Council.

1.10 Scope of the study

1.1.1 Geographical scope

The study was carried out in Bulambuli Town Council found in Bulambuli District headquarters located approximately 32 kilometers by road, Northeast of Mbale. The main reason for selecting this area as a case study was due to the current health service delivery situation in the Town Council which is not in tandem with the objectives of decentralization move and yet such health services are very crucial to the wellbeing of the citizens in Bulambuli Town Council and the country as a whole.

1.1.2 Content Scope

The study focused on decentralization and how it is related to public health service delivery. The sub variables of decentralization included political decentralization, fiscal decentralization and administrative decentralization by determining their contribution to public health service delivery in terms of adequacy, accessibility, timeliness, availability and citizen satisfaction. The justification for the choice of this scope was that decentralization move was undertaken with

the intentions of improving public service delivery but the results on ground are not in tandem with such intensions given the status of public health service delivery in Bulambuli Town Council.

1.1.3 Time Scope

This study focused on a period from 2009 to 2019 since this is the period, the public health service delivery of Bulambuli Town Council has not improved as expected despite the new Government system of decentralization.

1.11 Significance of the Study

This study would enable the central Government and the management of Bulambuli Town Council to determine the contribution of decentralization to public health service delivery.It would also help the district management committee to understand what decentralization practices should be enhanced to enhance public health service delivery and contribute to meeting the National Development Goals.

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

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

The successful execution of this study will enable the researcher to be awarded a Master's Degree of Science in Organization and Public Sector Management of Kyambogo University.

1.12 Justification of the study

It is the mandate of the Government through its respective agents to deliver public health services to its citizens, and once these services are not delivered as mandated, the poor at the grass root suffer the consequences.

The move towards decentralization was among other factors intended to improve public service delivery, therefore, it is necessary to establish the relationship between the two before Government may continue injecting resources in to the move.

Today, the status of unfriendly health service delivery in the Local Governments specifically in Bulambuli Town Council in Bulambuli district is alarming where such services are inadequate, difficult to access, time consuming which is contrary to the objectives of decentralization of ensuring prompt service delivery and responsive to the locals' needs, hence the move to undertake the study to examine the relationship between decentralization and public health service delivery with the intention to assess the association of the three dimensions of decentralization with public health service delivery in Bulambuli Town Council.

1.13 Definition of key terms

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

Availability of health equipment and services: Is the situation where health inputs like medicines, health equipment, health worker and other health facilities are in existence and can be attained by citizens in need of them.

Citizen participation: this is a process which provides ordinary citizens an opportunity to influence public decisions through a democratic decision-making process.

Citizen satisfaction of health services: this refers to citizens' perception of the quality of health services that are provided by the Government through the established local health units.

Confidence level: refers to the percentage of all possible samples that can be expected to include the true population parameter.

Corporate status: this is the status of a Local Government unit (Bulambuli Town Council) authorized to act as a single entity and recognized as such in law.

Decentralization: this is the process by which the Government activities particularly those regarding planning and decision making, are distributed or delegated away from a central, authoritative location to Local Government units.

Delegation: this is the assignment of any authority by the central Government to the Local Government unit to carry out specific activities.

Devolution: it is the statutory delegation of powers from the central Government of a sovereign state to govern at a Local Government unit and with the power to make legislation relevant to the Local Government unit.

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

Equitable access: this means that all individuals within Bulambuli Town Council have access to affordable, high quality, culturally and linguistically appropriate public health services in a timely manner without any accessibility divergences among such individuals.

Fiscal decentralization: this simply refers to the transferred expenditure responsibilities and revenue assignments from the central Government to lower levels of Government.

Grants management: this is the way the Local Government unit properly and appropriately utilizes the grants received to deliver the objectives of the grants.

InterGovernmental transfers: this refers to the transfer of funds designated from one level of Government to another for a specific purpose aimed at improving public service delivery.

Local elections: this is the election of representatives to a local council or Governmental body by the local people.

Mixed research design: this represents research design that involves collecting, analyzing, and interpreting quantitative and qualitative data in a single study or in a series of studies that investigate the same underlying phenomenon.

Political decentralization: this is a top-down process where powers of control over the social, economic and cultural life of its citizens is moved from the central Government to Local Government unit aimed at giving citizens or their elected representatives more power in public decision-making.

Public Health Service Delivery: this is the organization of people, institutions, and resources that deliver health care services to meet the health needs of the local populations.

Reliability: this is the degree to which the results of measurement, calculation, or specification can be depended on to be accurate.

Revenue collection: this is the process of collecting income of a Government from taxation, excise duties, customs, or other sources, appropriated to the payment of the public expenses.

Revenue expenditure: this is the process by which a Local Government unit spends appropriately the public revenues collected on public service delivery.

Sample size: this is the count of individual samples or observations in any statistical setting, such as a scientific experiment or a public opinion survey.

Target population: this is the total group of individuals from which the sample can be drawn

Timely delivery: this is a situation where the citizens can access public health services promptly the time they need them without any much delay.

Triangulation: this is a way of assuring the validity of research through the use of a variety of methods to collect data on the same topic, which involves different types of samples as well as methods of data collection.

1.14 Summary for chapter one

This introductory chapter discussed the background which was presented under four perspectives, the statement of the problem, purpose of the study, the specific objectives of the study, research questions, conceptual framework, the significance of the study, justification of the study, scope of the study, and operational definitions of terms and concepts and the chapter drew a basis for other chapters.

CHAPTER TWO

LITERATURE REVIEW

2. Introduction

This chapter of the study focused on the review of relevant related literature to the study.

The review was conducted under themes which were formulated in line with the objectives of the study and in an effort to seek affirmation that were raised under the study. The review begun by looking at the theoretical review of the study; it also evaluated the concept of decentralization specifically focusing on three dimensions; political, fiscal and administrative decentralization and their relationship with public health service delivery.

2.1 Theoretical Review

This study was guided by The Sequential Theory of Decentralization as the study was to examine the relationship between decentralization and public health service delivery. The Sequential Theory of Decentralization propounded by Falleti (2005) has been used as the directing framework to discuss the curves in conducting the study. The concept of decentralization is a set of state reforms which involves exclusively only state actors from the central Government to the lowest Government agencies at the grassroots (Falleti, 2005). In line with that, Falleti the proponent of the sequential theory of decentralization argues that the sequencing of diverse types of decentralization namely: administrative, fiscal, and political are key determinants of the development of the Inter-Governmental balance of powers. The analysis of the theory indicates that the three dimensions of Decentralization are interdependent and for decentralization to yield the intended outcomes specifically public health service delivery in terms of accessibility, timely service delivery, availability of services, and citizen satisfaction the three need to be in operation.

The theory explains that to ensure service delivery and the exercise of devolved powers in general, administrative decentralization should be implemented along with expenditure and fiscal arrangements (Falleti, 2005). So function, finance, and functionaries all need to be sequenced properly. The theory is relevant to this study despite other competing theories like the Principal Agent theory, the first scholars to propose explicitly that a theory of Principle and Agency be created, and to actually begin its creation. The agency principle has been used to explain the effect of local development grants management on service delivery in Local Government by (Odeke, 2014), the Public-choice theory which assumes that decentralization, as a mode of governance will enhance speedy delivery of social services used by Mutumba (2005) in explaining the effect of decentralization on the performance of district personnel in Uganda, the resource dependency theory which posits that power is based on control of resources that are considered strategic within the organization and is often expressed in terms of budget and resource allocation (Mudambi & Pedersen, 2007).

The incorporation of sequential theory in the study was intended to prove the existence of decentralization and its relationship with public health service delivery and establish which decentralization dimension has a remarkable contribution towards public health service delivery. However this theory falls short of the society, religion and environmental factors that have proven that they are always in the background of every decentralized state. Theoretically, it is believed that the undertaking of decentralization is associated with the improvement in service delivery through increased citizen satisfaction since services are delivered in line with the citizens' needs, service adequacy because of proper planning and incorporation of the locals' needs in the budgets, improved service accessibility and timely delivery through the creation of a variety of health systems starting from Village Health Teams (VHTs) to referral hospitals (Batley & Larbi, 2004).

It was discovered that to ensure service delivery and the exercise of devolved powers (political powers) in general, administrative decentralization should be implemented along with expenditure and fiscal arrangements. So function, finance, and functionaries all need to be sequenced properly.

Therefore, in relation to this study, it was believed that decentralization through political, fiscal and administrative could work as key factors that could enable Government to improve on public health service delivery and the researcher presupposes that improved decentralization in Local Government organizations as per this theory, will mark improved public health service delivery.

2.2 Conceptual review

According to Berman and Bossert and Berman (2000) decentralization is the transfer of decision making from central Government bodies to local officials to tailor service provision to the needs of local populations. Or it is generally perceived as a reform process designed to reduce central influence and promote local autonomy. Egbenya (2009) states that, decentralization can be in the form of political, administrative, fiscal and market decentralization. According to Hutchinson and LaFond (2004) fiscal decentralization refers to devolving to local levels Government control over financial resources either in terms of expenditure, assignments or revenue generation. It is the situation in which decision about expenditure of revenues raised locally or transferred from central Government are done by the local authority. Administrative decentralization comprises the set of policies that transfer the administration and delivery of social services such as education, health, social welfare, or housing to subnational Governments. Saito (2000) revealed that in Uganda with decentralization, ordinary people have opportunities to participate in decision-making process for the first time since colonial rule was imposed. This is a very significant change because

before decentralization, people felt little relationship with the administrative offices except being asked to pay taxes and other duties. Now the people have the opportunity to exercise their rights.

Mutabwire (2013) defines service delivery as a relationship between policy makers, service providers, and consumers of those services, and encompasses both services and their supporting systems. According to Economic Policy Research Centre (2010) Uganda currently has a complex decentralized health system. It consists of the district health infrastructure consisting of Village Health Teams/Health Centre I (VHTs or HC Is), HCs II, III and IV plus general district hospitals. Government investment in HCs (I - IV) dramatically improved physical access to the health facilities. Today, 72 percent of households live within 5km of a health facility (public or NGO). The challenge is that while physical access improved, effective access to medicines has not and even in some cases it is difficult to access the physical aspect. Evidence shows that utilization is limited because of inadequate medicines and health supplies, worsened by the low functionality of wards at HC IVs, the shortage of qualified health workers, and the demotivation of the few that exist.

This needs intervention to revert the situation hence the need to examine the relationship between decentralization and public health service delivery in Bulambuli Town Council.

2.3 Political decentralization and public health service delivery

According to World Bank (2000) political decentralization involves providing citizens or their representatives with additional public decision making power, in particular through democratic process. The rational and principal assumption of political decentralization is that decisions made with greater participation will be better informed and more relevant to diverse interest in society than those made by national political authorities. The reality however provides some level of variance because though political decentralization has this assumption, the process of

selecting representatives, personal disposition and interest determine the level to which they represent the interest of their constituents.

Khemani (2001) revealed that political decentralization gives citizens through their elected leaders more power in public decision-making. It is often associated with a mixed setting and a representative Government. The premise is that service delivery policies taken at the sub-national level will be better informed and more relevant to diverse interests in society than those taken only by national political authorities.

More importantly, political decentralization may help to strengthen accountability, which is necessary for improved service delivery (World Bank, 2004). If local elected officials make policy decisions about services that affect citizens, they in turn can hold the local officials accountable and remove them from power in the next local elections. However, this has not been effective in most of Local Government councils and Bulambuli in particular thus the need to establish the relationship between political decentralization and public health service delivery. Mugabi (2014) states that devolution and delegation of power to lower Local Governments was expected to encourage more community participation in planning and budgeting and to hold local policy makers accountable for the quality of social services provided, such as health, education, agricultural services, water and infrastructure. This involved delegation of authorities to improve access to public services, increase participation in decision making; develop local capacity and enhance transparency and accountability.

According to World Bank (2004) it is commonly argued that political decentralization brings accountability to the system and may improve health service delivery. This may occur because citizens have a channel to provide input on local decision-making processes and hold local decision-makers accountable for their actions. McGreevey (2000) argues that political

decentralization, in the context of a decentralized provision of health services, is essential to ensure accountability and improvements in efficiency. He argues that the realization of the benefits of decentralization requires not only devolving financial resources and administrative functions to lower tiers of Government but also instituting electoral accountability. However, it is still doubtful as to whether this prevails in Bulambuli Local Government given the status of public health service delivery.

Krasovec and Shaw (2000) accords that decentralization motivated by political concerns has usually been undertaken as part of political transformation in a bid to expand democracy.

Decentralization through devolution was commonly implemented in such instances, characterized by transfer of power to Local Government to enable greater community representation through elected leaders, and greater accountability of officials to the electorate for improving service delivery (Khemani, 2004). Thus, politically motivated decentralization of the health system usually occurred in the context of decentralization of the public sector as a whole, often as part of a national development strategy that extended beyond the health sector. In this regard, the health sector may not have been prominent actor in the decision-making and planning for decentralization because political decisions to decentralize were at times made outside the realm of the health sector, requiring sometimes unwilling compliance of health sector managers.

Ozmen (2014) highlighted that political decentralization is seen as the most conducive approach towards effective citizen participation in influencing local service delivery through participation in budget preparation process. It takes the shape of devolution and is the most far reaching type of decentralization as the Local Governments have the discretionary space to make decisions and implement them within their jurisdiction.

Devas and Delay (2006) stressed that these Governments by design are expected to be downwardly accountable to the citizens, horizontally accountable to the elected officials and upwardly accountable to the central Government to evaluate their performance as far as service delivery is concerned. He further adds that the central Government's acts that affect the Local Government units needs to be transparent for such acts not to be political but channeled towards improving public service delivery

Smoke (2003) asserted that although fiscal and administrative decentralization are critical, they cannot bring about the major goals of decentralization (improved service delivery in terms of accessibility, timeliness and availability of services) without adequate political reform.

This is because the existence of political decentralization establishes an environment for quality interaction between the citizens and their representatives or the local officials, he adds the prevalence of quality interaction expedites the process of delivering services that meet the citizens' needs.

Smoke further states that sub-national Governments through political decentralization can be availed with sufficient information to address the necessary demands. This may be as a result of local leaders being empowered with clear and appropriate functions and resources and they may also have adequate institutional mechanisms and capacity, but in this context, efficiency is predicated on the ability of sub-national Governments to understand and act on the needs and preferences of local people better than the central Government because of being acquainted with the local information.

Cooper and Schindler (2003) stressed that political decentralization can only be fruitful in regard to service delivery if the local elections organized are free and fair, such quality local

elections create a ground for citizenship autonomy to empower a given representative whom they believe will deliver their expectations and also makes it possible for the elected to prioritize the electorates' interests than personal interests, this therefore improves on service delivery through minimizing diversion of public resources meant for delivery of services to private gains.

Goetz and Marie (2002) also asserted that political decentralization makes the local citizens knowledgeable about the works of the local officials and through this, the citizens can be in position to monitor and evaluate the officials' activities to ensure that they deliver services that meet their needs and it also improves on accountability.

It is important to emphasize that decentralization typically implies some reduction in the accountability of sub-national Governments to the central Government. If this is not replaced by a degree of accountability to local people, local officials may become primarily accountable to themselves and influential local elites. This implies that political decentralization increases the autonomy of the sub-national executives, which autonomy can be moderated through accountability to the locals.

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

2.4 Fiscal decentralization and public health service delivery

According to Bird, Ebel, Wallich and Otates (2015) fiscal decentralization refers to the process of devolving fiscal responsibility to lower levels of Governments in accordance with their local needs and preferences, it consists of fiscal instruments and procedures that are aimed at helping in the delivery of public goods. Choi (2012) asserted that fiscal decentralization means the authority of revenue collection or expenditure is transferred from superior offices to subordinate offices for the purposes of producing appropriate public services for improving public welfare

for residents. Thiessen (2003) views fiscal decentralization as entailing adequate fiscal transfers from the central Government to the Local Government unit. He states that adequate fiscal transfers enable the Local Government units to deliver the services that suit the citizens' needs, however, this can only be possible if the local officials are responsible and there are accountability mechanisms in place.

According to Raghabendra, Chattopadhyay and Duflo (2001) fiscal decentralization comes along with the authority to identify the tax bases from which the revenues can be collected at the local council level. They further assert that the authority to identify tax bases alone is not an end in its self but also there must be a variety of tax bases from which a given Local Government unit can raise adequate tax revenue. They add that any Local Government unit that has many tax bases is able to allocate such revenues collected towards improvement of public health service delivery.

According to ACODE (2010) it was found that numerous problems facing health centers, including poor funding of health care services and minimal transparency in the use of drugs and medicines; chronic shortage of trained workers especially at lower tier health facilities were among the limiting factors to public health service delivery.

Consequently, Health care services remain out of reach of the people in the rural areas and decentralization has not led to improved services. Levels of performance monitoring, this emerges where formal process for monitoring and supervision are not allowed or enforced and informal processes are insufficient. Critically, this includes both top-down monitoring and forms of bottom or supervision. More still in Uganda, for example, formal processes for monitoring and supervision are not followed across the chain of health service delivery.

Onyach (2012) in a study on challenges in the implementation of fiscal decentralization and its effects on the health sector in Uganda indicated that Local Governments in Uganda continue to operate at minimal staffing levels; some instances as low as 10% of the approved establishment as a result of limited funds, this has a direct implication on the public health service delivery. Omar, Azfar, Satu, Livingston, Meagher and Rutherford (2000) in their study on fiscal decentralization and health service delivery found that only 17% of health facility respondents reported that all their employees had necessary equipment to do their work and 83% where not having or had faulty equipment. In remote districts such as Abim, Kalangala, Kabong, Buvuma and Bukwo a further constraint is the fact that some Local Governments through the politically oriented District Service Commissions (DSC) has adverse effects on the quality of service provision. Parasuraman, Zeithaml and Berry (2014) adds that significant number of Local Governments do not have the managerial, administrative, financial and institutional capacity to meet the rising needs of local people. This situation is exacerbated by the decline between Local Government and tertiary sector. As a result, these Local Governments cannot meet their required performance standards hence impacting adversely on health service delivery. However, from this literature, the researcher determined the relationship between fiscal decentralization and health service delivery by concentrating on a single entity.

Faguet (2012) states that the strongest argument for decentralization is that it will improve Local Government accountability responsibilities and responsiveness and thereby increase the overall efficiency of Government by delivering quality services. It does this by altering the structures of governance to increase the voice of citizens and strengthen incentives for public officials to deliver services.

The main mechanism for improved service delivery is that decentralization will increase the accountability and responsiveness of Local Government and ultimately improve public

services. This argument is supported by recent reviews of the impact of decentralization on service delivery. These studies emphasize its positive effects, finding that decentralized Local Governments deliver an increased quality and quantity of public services. Channa and Faguet (2016) have ranked these studies according to their strength of evidence and found that, while the studies show mixed results overall, the highest quality studies show the most positive effects of decentralization.

Martinez and Sacchi (2015) report similar findings, they state that decentralization through subnational borrowing enables the Local Governments to increase the financial capacity to address the locals' needs in as far as health service delivery is concerned decentralization improves service delivery, but there are more mixed results in the health sector since more funding is needed for effective execution of health activities, including evidence of negative effects of decentralization on the quality of service delivery.

Gadenne and Singhal (2014) highlighted that Local Governments often have limited revenue bases and are often dependent on fiscal transfers from central Government. In developed countries, around a third of total revenues are raised by subnational Governments, whereas in developing countries the amount raised by subnational Governments is only around 14% of total revenues. In the late 2000s, subnational Governments in developing countries relied on transfers to finance 62% of their budgets on average. The extent to which a Local Government is dependent on grants is determined not only by the sources of revenue available to that Government but also on its expenditure functions.

Bird (2011) also revealed that Local Governments with limited responsibilities that need funds such as basic municipal functions (e.g. waste collection, local roads, and fire prevention and control) will only need a fairly small tax base to be self-financing. The situation is very different when Local Governments also have large expenditure responsibilities such as education and

health. Furthermore, an almost inevitable feature of decentralization is that there will be inequalities between Local Governments. Typically, urban Local Governments with significant tax bases will be somewhat less transfer dependent, whereas poor rural Local Governments are likely to be dependent on transfers for the vast majority of their revenues. Therefore, this study intends to determine the contribution of fiscal decentralization on public health service delivery and review the gap in the findings of the above scholars whether it's about limited financial support from the central Government or limited responsibilities such as basic municipal functions.

Kahkonen and Lanyi (2001) observed that local councils should be responsible for the overseeing and authorizing annual plans from the sector service managers at every Government level. He adds that a Local Government unit having the authority to determine the tax rates can determine the tax bases on which tax is inelastic such that more revenues can be collected through this, fiscal decentralization has been tipped as a perfect mechanism to improve health service delivery. Lately, it has been viewed as a fundamental means of a wider Local Government reform to attain improved equality, efficiency, quality and financial soundness. Batley and Larbi (2004) found out that fiscal decentralization of services provision has also resulted in the mandatory establishment of local councils at state and municipal levels as well as guaranteeing local access to national funds, these councils have come to play a key role in local politics, becoming important for participation, decision making and public accountability for the Government`s actions. This was in agreement with the Sequential Theory of Decentralization as assumed that decentralization as a mode of governance will enhance speedy delivery of social services and public health service delivery.

Likewise, Onyach (2012) stated that fiscal decentralization in the health sector tends to be more complex than in other sectors because of diseconomies of scale. He argues that these

diseconomies of scale tend to discourage sub-national Governments in the provision of costly curative treatment and immunization at the same time scale tend to discourage sub-national Governments in the provision of costly curative treatment and immunization.

At the same time, he argues, spillover effects tend to discourage the national provision of preventive health care, particularly immunization and epidemiological controls.

In addition, Lyon (2015) asserts that there is always some degree of Local Governments to follow priorities established by the central Government to use its spending power in providing conditional grants for the purchase of equipment, drugs and build Health Centres for improved service provision, he stresses that the establishment of a health budget which is adequate enough to meet health needs of a Local Government unit creates improvement in public health service delivery and this is in agreement with resource dependency theory.

Contrary to the above, by central Government overly getting involved in Local Government decision making, this biases the system towards centralized outcomes and yet the grants are intended to facilitate Fiscal decentralized decision making for delivery of health services. In this regard, it was important to determine the relationship between fiscal decentralization and public health service delivery.

Okecho (2006) in his study on the challenges of decentralized health services in Uganda found that an examination on the community involvement in the delivery of health care revealed that to some extent communities are involved in the delivery of decentralized health care through representation at every facility level. However, though the channels existed, they were often ineffective due to lack of capacity, inadequate flow of information and the limited usefulness of health committees. It was further revealed that the effective delivery of health services is being hindered by insufficient health budgets due to deteriorating economic conditions,

combined with the growing health problems such as the global HIV-AIDS pandemic which have led to shortage of drugs and medical supplies, inadequate or non-payment of health worker's salaries, poor quality of care, and inequitable healthcare.

In light of the above, various recommendations were made to Ministry of health, the Decentralization Secretariat in the Ministry of Local Government, the political and administrative leaders at the District, to sufficiently fund the health sector, and sensitize the "Wanainchi" and political leaders about the policy of decentralization. However, despite of such recommendations, the quality of public health service delivery in Uganda still remains wanting.

In his study, he used case study research design and this study used mixed research design where both qualitative and quantitative approaches were applied. The researcher also used purposive and simple random sampling and this study used both probability and non-probability sampling techniques which involved purposive and simple random sampling technique.

2.5 Administrative decentralization and public health service delivery

It is important to note that, Fan, Lin and Treisman (2009) asserts that administrative decentralization deals with the transfer of the responsibility for planning, financing and management of certain public functions from central agencies to field units of Government agencies, subordinate units or levels of Government. This form of decentralization is particularly common in the provision and management of social services to the populace such as health. Administrative decentralization is made up of four sub-categories namely de-concentration, devolution, delegation and privatization. Devolution is considered to be the most prominent that can expedite the whole process of decentralization towards realizing its

objectives in regard to public service delivery. It involves Government devolving functions, transfer authority for decision-making, finance, and management to quasi-autonomous units of Local Government with corporate status. By doing this, these quasi-autonomous units of Local Governments are in the better position to administratively respond to the needs of the locals.

A Local Government unit with corporate status and powers to secure its own resources has the ability to decide on the priorities of the public and also autonomy to address the needs of the local citizens (Ferlie & Steane, 2002). They add that a Local Government unit with corporate status has administrative capacity to deliver improved public health services to the citizens given the closeness of the local officials to the local citizens, they best understand the people's needs and also the environmental needs.

According to World Bank (2004) it is indicated that administrative decentralization is a more complete transfer of administrative decision-making power to sub-national authorities and this empowers them with legal decision-making power and the ability to generate and control resources, including the sub-national public sector employees hiring and firing, career management and pay. Moreover, typically it provides Local Government with the ability to reallocate resources (including staff) across service facilities within their jurisdiction adapting to local circumstances. Often, nevertheless, some central guidelines need to be followed, mainly with the aim of pursuing national objectives in certain areas like improve health service delivery.

Yawe and Kavuma (2008) showed that to ensure communities are empowered to take responsibility for their own health and well-being, and to participate actively in the management of their local health services for general health service improvement, the Government of Uganda has initiated a number of measures which include developed guidelines for community

capacity building for effective participation in resource mobilization and in the monitoring of health activities, promoted the establishment of health committees with an appropriate gender balance at each of the different levels of the Local Government system to handle issues concerning health, established management boards for all publicly owned tertiary hospitals with extensive delegated authority for their efficient operation, developed guidelines for the establishment and operation of facilities, promoted and supported community-based health services and established the national health assembly with adequate representation from the district, civil society, donors and other key partners.

Steiner (2005) noted that de-concentration where the authorities at the sub-national level plan and deliver services while remaining fully accountable to the appointing central office improves the quality of service delivery.

There may be levels of citizen involvement but the local officials are subject to directives from above some of which may disaffirm the preferences of the local population. However, Blunt and Turner (2007) argues that de-concentration can deliver on the citizen expectations by ensuring equity in resource distribution, stability and consistency of resource allocation and highly skilled manpower available to the local population.

Cohen and Morrison (2007) observed that analyzing the shift of administrative power from the center to the subnational levels can be a difficult task. A great variety of elements need to be taken into account for example, there are a great variety of projects and functions in which subnational Governments participate in coordination with line ministries that make that task complex. However, public health service delivery can only be improved if the employees are responsible and accountable for the outcomes of their actions.

It is important to note that Merino (2012) discovered that a range of powers and responsibilities as the decision space given to Local Governments on issues such as service organization, hospital autonomy, civil service, access rules, and governance rules, the existence of good governance implies corruption tendencies are minimized, high level of accountability and transparence in the actions of the local officials and the resources advanced to the Local Governments are appropriately put into use. Probably the ones that make the biggest difference about how sub-national Governments provide services are the discretion on personnel and decision making power on facilities structure. This implies that shifting of power from the central Government to local authority was introduced with the intention of improving service delivery.

However, to this study, it is believed that the intended goal of improving service delivery like public health services has not been attained as citizen cannot access the services given an example of Uganda (Bulambuli Town Council) thus this study sought to establish the relationship between administrative decentralization and public health services.

According to Acedo, Gorostiaga and Senén González (2007) decentralized service provision is expected to enhance the quality and efficiency of service provision through improved governance and resource allocation. The agency theory suggests that the proximity of Local Governments allows citizens more influence over local officials, promotes competition among Local Governments, reduces corruption compared to centralization, and improves accountability, among others. Some analysts, however, argue that decentralization may worsen outcomes because Local Governments may not have the capacity or incentives to act as theory predicts.

Omolo (2011) found that administrative decentralization is intended to minimize the drawbacks of excessive centralization, to ensure public participation in management, to establish a balance

between local services and local needs and to improve productivity or effectiveness in public service delivery. He further asserts that delegation, where the central Government transfers service delivery responsibilities to semi-autonomous Government agencies or non-state organizations that are fully accountable to the assigning ministry or department, the sub-national Governments must have the capacity to manage funds for efficient and effective service delivery otherwise, administrative decentralization may not yield positive results as far as public health service delivery may be concerned.

Administrative decentralization provides a critical step towards attaining systematic health care service provision objectives contained in the HSSP through devolution of functions which used to be performed by the central Government to District Local Governments. Merino (2012) asserts that administrative decentralization through extension of clear roles and responsibilities for public service delivery can enhance public health service delivery. This was designed to allow stakeholder participation in the planning and budgetary decision making process thus, allowing clients to hold policy makers and providers accountable for the quality of services provided. However, the fact that administrative decentralization is intended to minimize the drawbacks of excessive centralization, to ensure public participation in management, the level of citizen participation at the Local Government is not appealing as the quality of service delivery remains low like in the health sector, education, roads among others thus the need to establish the relationship between administrative decentralization and public health service delivery.

2.6 Summary of literature

The above literature stresses that decentralization leads to improved public health service delivery guided by three dimensions of decentralization (political, fiscal and administrative). It is revealed that failing to clarify assigned responsibilities will surely result in poor public health service delivery. The critical connotation established from the reviewed literature is that, for

the Local Government tiers to ensure improvement in public service delivery specifically public health as a result of decentralization, there needs to be implementation of decentralization in its full potential by appreciating the decentralization dimensions of political, fiscal and administrative with their elements in full.

Although the above studies in the literature by different scholars and authors highlight the relevance of decentralization to public health service delivery, most of the literature is faced with contextual and methodological gaps which need to be addressed and specifically taking Bulambuli Town Council as a case study, the facts in the literature are not traceable on ground hence the need for this study to examine the relationship between decentralization and public health service delivery in Bulambuli Town Council.

2.7 Gaps in the literature

From the literature, it can be asserted that different scholars and researchers have studied the effect of decentralization on public health service delivery. However, gaps in the literature have been left which need to be fulfilled. For instance, Onyach (2012) in a study on challenges in the implementation of fiscal decentralization and its effects on the health sector in Uganda indicated that Local Governments in Uganda continue to operate at minimal staffing levels. In his study, he used a survey research design where questionnaire survey was used as a data collection method, relatedly, Mutumba (2005) conducted a study on the Effect of Decentralization on The Performance of District Personnel in Uganda: A Case-Study of Tororo District Health Directotrate and used a descriptive case-study design where he revealed that decentralization has helped to improve on personnel performance and still beneficial to service delivery with need for proportionate facilitation of the system to appropriately deliver the decentralized services.

Another related study was conducted by Nannyonjo and Okot (2013) where they investigated on the impact of decentralization and Local Government capacity on efficiency of health service delivery in Uganda and applied a qualitative analysis, and two stage Data Envelopment Analysis (DEA) on quantitative data covering a sample of 44 districts over the period 2008/09 and 2009/10, and their findings indicated inefficient performance in 13 districts, important to note is of the 44 districts selected in their study, Bulambuli district was not among them.

Anokbonggo, Ogwal, Obua, Aupont and Ross (2004) studied the Impact of decentralization on health services in Uganda: a look at facility utilization, prescribing and availability of essential drugs with focus on two district hospitals in Northern Uganda and they employed a mixed method evaluation design and they discovered that decentralization policy led to increased utilization of health facilities.

However, this study considered a mixed research design where both qualitative and quantitative approaches were adopted and questionnaire survey and interview methods were used coupled with observation method. This intended to fill the methodological gap by introducing an observation method which has not been used by the mentioned researchers, this aims to fill the gap in the literature empirically by observing the current situation in the Local Government public health services by checking the availability of medicine supplies, presence of staff to provide the health services to the citizens, the existence of medical equipment and their working conditions, and the equitable access to the health services to the nearest public Health Centre and among other necessary observable study related elements.

The study also sought to close a theoretical research gap by incorporating in sequential theory of decentralization propounded by Falleti (2005) where emphasis is put on decentralization forms of political, fiscal and administrative decentralization regarding public service delivery (public health service delivery) as services that should be accessible to the citizens, adequate,

timely and yield citizen satisfaction since the previous related studies conducted have been using other theories different from the sequential theory of decentralization.

Contextually, the reviewed literature and other related studies conducted in Uganda indicated no evidence for related study conducted in Bulambuli Town Council and Bulambuli district as a whole by focusing on decentralization and public health service delivery, therefore, this is a new study in Bulambuli Town Council and Bulambuli district as whole. With the identified gaps in the literature, it was justifiably necessary to undertake this study to add new knowledge to the existing knowledge to narrow the identified gaps.

2.8 Summary for chapter two

This chapter was zealous to a detailed literature review and the chapter provided a detailed description of the theory that guided the study. The theory that has been considered is the social exchange theory. The chapter presented the empirical literature that is based on the study objectives and the study variables. The key academic journals examined focused internal mentorship practices of mentorship identification, mentorship programmes and role modeling on employee career growth. Knowledge gaps from literature reviewed were also presented in this chapter

CHAPTER THREE
RESEARCH METHODOLOGY

3. Introduction

This chapter presents the methods and procedures that were used to conduct the study. It included the research design, and target population, sampling selection techniques and sample size, data collection methods, validity and reliability of data, sources of data and data processing, analysis, measurement of variables, measurement of data, ethical consideration and limitation to the study.

3.1 Research design

The study used a case study research design by focusing on a single unit that were issues concerning decentralization and public health service delivery in Bulambuli Town Council were highlighted and investigated. According to Amin (2005) asserts that this research design provides in-depth study of the problem within a limited period of time.

The study involved using both quantitative and qualitative approaches

Quantitative approach involved the use of questionnaires to quantify the data collected in order to describe the current situation and examine the relationship between decentralization and public health service delivery in Uganda. This approach was used because it was flexible and had multiple scale with indices that focus on the same construct that followed different responses from the many respondents' knowledge, attitudes and experiences on the topic (Nunally, 1978). Qualitative approach included the use of interview guide observation checklist to gather data aimed at explaining the narrative and interpretive information to complement on the quantitate approach. The use of both approaches enabled the researcher to minimize the element of bias associated with the application of one research approach (Mugenda & Mugenda, 2003).

3.2 Target Population

This study considered a target population of 240 individuals comprised of Bulambuli Town Council staff (24), Muyembe H/C IV staff (65), and citizens/selected service users (151). Important to note is that according to Muyembe Health Centre IV Management Analysis Report 2017 the average weekly population that visits the Health Centre was estimated at 1060 and the target population of selected service users/citizens was determined by dividing the weekly number of patients who visit the Health Centre IV by 7 days and the target population for service users was determined at 151 respondents daily. Therefore, the day the researcher went for data collection in Bulambuli Town Council expected to encounter 151 patients at the Health Centre from which the sample was selected.

3.3 Sample size and selection

From the target population of 240, a simplified formula for calculating the sample size was used to determine the sample size and used a 95% confidence level and a 5% precision level where a sample size of 150 respondents was selected using the formula for Yamane and Taro (1967) as given below.

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

Where n is the sample size, N is the target population size, and e is the level of precision.

$$n = \frac{240}{1+240(0.05)^2} = \frac{240}{1+240 \times 0.0025} = \frac{240}{1+0.6} = \frac{240}{1.6} = 150 \text{ Sample size}$$

Source: Yamane and Taro (1967)

The total sample size was drawn from the strata that the researcher established from the target population (Town Council staff, Health Centre IV staff and the selected service users) since each category of the respondents plays a big role in establishing the relationship between decentralization and public health service delivery as illustrated in the sample frame in table 1 below.

Table 1: Target population, sample size and sampling technique

S/N	Category	Strata for Target population	Stratum population	Sample size per stratum	Sampling technique
1	Town Council Headquarters staff	Town Council Executive	5	3	Purposive sampling
		Other Town Council officials	19	12	Purposive sampling
2	Muyembe Health Centre IV staff	Top management staff	5	3	Purposive sampling
		Operational management staff	60	38	Simple Random sampling

3	Citizens (service users)	Selected Service users	151	94	Simple Random sampling
TOTAL			**240**	**150**	

Source: *adapted from Bulambuli Town Council provisional management team July 2017; Yamane & Taro (1967) formula for determining sample size and modified by the researcher.*

3.4 Sampling technique

This study employed both simple random and purposive sampling techniques in selecting the sample from the target population. Simple random sampling technique helped to select samples from the strata where each case in the population of the strata had an equal probability of being selected into the sample to minimize on bias (Neuman, 2014).

A total sample of 132 respondents that included operational management staff (38) and service users (94) were selected through simple random sampling technique since it gives equal chance to elements of being selected and limits bias and classification error (Mugenda & Mugenda, 2003). With this technique the researcher randomly selected the service users from the waiting benches and wards and also health workers from their respective health sections.

The purposive sampling technique was used to select 18 respondents who included Town Council Executives (03), other Town Council officials (12), and Muyembe Health Centre IV top management staff (03) since the population is relatively small, and the cases in the strata possess crucial information due to their knowledge and experience about the subject under study (Cohen & Morrison, 2007). This technique was used by picking out the specific respondents who were considered to be more informed about issues under study because of their uniqueness in terms of experience and seniority.

3.5 Study procedure

Using an introduction letter from the Head of Graduate School, the researcher sought permission from the Town Clerk of Bulambuli Town Council to conduct an academic research. The researcher then made contact with the various authorities to whom the letter was addressed to make appointments as to when the study was to be carried out to enable proper planning. On the agreed dates, the researcher went to the various divisions within the Town Council to meet the respondents and collected the data appropriately.

The data collection was carried out for a period of one (01) week. After data collection, data analysis was run upon which interpretations, conclusions and recommendations were presented in a report, which marked the final activity of the research process.

3.6 Data collection approaches

This study utilized both quantitative and qualitative research approaches to collect data from both primary and secondary sources. The primary data was used because it is reliable and dependable with accurate information without bias (Mugenda & Mugenda, 2003). The sources of secondary data was documents which included reports concerning administration and management. Quantitative approach involved the use of close ended questionnaires and qualitative approach involved the use of open ended interviews, and observation method was also used by using the all researcher's senses to create meaning out of the relevant observed aspects.

3.7 Data collection methods

3.7.1 Questionnaire survey method.

The questionnaires were personally administered to the respondents and feedback about the related topic was shared with the researcher easily (Sekaran, 2003). This method was also economical in terms of time management as questionnaires were easy to fill and took less of

the respondents' time and that of the researcher in administering and analyzing them (Amin, 2005). The questionnaires were addressed to a total of 140 respondents who included Town Council officials (12), Muyembe H/C IV operational management staff (38) and service users (90) and a total of 117 respondents returned their questionnaires fully filled and data was fed in to SPSS programme for data analysis.

3.7.2 Interview method

Interview is a data collection method which basically involves the researcher and the respondent, during the process a researcher follows the designed interview guide to help him/her proceed with his/her research (Mugenda & Mugenda, 1999). In this study, face to face interviews were carried out personally with the selected key respondents using semi structured open ended questions with the aim of getting information from respondents and the responses were written down for analysis. The interviews were held with $^{07}/_{10}$ respondents who included Town Council executives (02), Muyembe Health Centre IV top management staff (02) and selected service users (03).

3.7.3 Observation method

This is where the researcher used all of his senses to gather information about the phenomena under study (Sekaran, 2004). With this method, the researcher passively collected data concerning the existence of a standby generator, presence of admission wards and beds for admitted patients, the Health Centre's structures in good conditions to the minimum standards of a health facility, waiting line, drugs stock in store, existence of an ambulance, presence of health workers, existence of basic medical equipment, Status of the theatre, Laboratory and Reports to validate some of the information that was gathered by use of other data collection methods.

3.8 Data collection instruments

Data was collected using three instruments, questionnaires, interview guides, and observation checklist.

3.8.1 Self-Administered Questionnaires

According to Mugenda and Mugenda (1999) use of self-administered questionnaires allowed the researcher to collect data from many respondents in the shortest time and the researcher analyzes all the respondents' answers. Sekaran (2003) asserts that structured questionnaires with closed ended questions are used to collect information from the randomly sampled respondents using a Likert scale questionnaire with a five category response continuum where Strongly Disagree (SD) =1, Disagree (D) =2, Not Sure (NS) =3, Agree (A) =4, and Strongly Agree (SA) =5. The self-administered questionnaires were used because respondents answer at their convenience and the low cost-per-completion makes it an economical method of surveying large samples to collect diversity views on the relationship between decentralization and public health service delivery in Bulambuli Town Council. Refer to Appendix 1 (questionnaire)

3.8.2 Interview Guide

The interview guide was developed by the researcher and guided using semi-structured and unstructured interviews which contained open ended questions. The interview guide was prepared basing on the research objectives. This method allowed the researcher to obtain in depth information and allowed a face to face contact with the respondents. The researcher took lead on the respondents' answers and gauged on how to handle the interview process. Refer to Appendix 2 (interview guide).

3.8.3 Observation checklist

Observation checklist is a directory list used or followed by the researcher during data collection process through observation (Sekaran, 2004). The researcher recorded all the necessary

observable aspects that were vital to enriching the study with the required information and thereafter the data collected was analyzed accordingly in line with the objectives of the study. Refer to Appendix 3 (observation checklist).

3.9 Sources of data

This study used primary data collected from the field by the help of the identified data collection instruments since the study was aiming at collecting the views and opinions of the respondents on the study and also primary data was more reliable and non-subjective in nature. Secondary data was also sought from reports, workers' registers and budgets.

3.10 Validity and reliability

A pilot study was conducted to test the reliability and validity of the research instruments. According to Orodho (2003) a pilot test helps to test the reliability and validity of data collection instruments.

3.10.1 Validity of data

Validity was determined by the use of Content validity Index (CVI). CVI of between 0.7 and 1 shows the instruments to be valid for the study (Orodho, 2003). Content validity ensures that the measures include an adequate and representative set of items that tap the concept or one of its dimensions. To ensure content validity, the researcher sought for expert's opinion on the suitability and accuracy of the questions in the questionnaire.

This was achieved by use of the formulae below;

CVI = Total number of valid questions in the questionnaires

Total number of questions in the questionnaires

CVI= 40/46= **0.869**

Table 2: Validity of the instruments

Type of variable	Current number of items	Previous number of items	Percentage of the current to previous items
Political decentralization	10	12	0.83
Fiscal decentralization	10	12	0.83
Administrative decentralization	10	11	0.90
Public health service delivery	10	11	0.90
Total No. of items/ average percentage	40	46	0.86

Source: *Primary data*

Therefore, this result implies 40 of 46 of items were declared to be valid and the rest were discarded as indicated in Denscombe, (2010) and these were finally considered in the questionnaire for data analysis.

3.10.2 Reliability of data

To measure the reliability of the data collected, an internal consistency technique using Cronbach's alpha was applied to the gathered data (Nunally, 1978). Cronbach's alpha is a coefficient of reliability that gives an unbiased estimate of data generalizability and a minimum coefficient of 0.7 or higher is considered the appropriate as suggested by Nunally (1978) as it indicates that the gathered data is reliable as it has a relatively high internal consistency and can be generalized to reflect opinions of all respondents in the target population.

The reliability was determined per variable items as indicated in the table 2 below.

Table 3: Reliability Test

Reliability Statistics

Item Variables	No. of Items	Cronbach's Alpha
Political decentralization	10	.879
Fiscal decentralization	10	.875
Administration decentralization	10	.879
Public health service delivery	10	.788
Average total reliability of items	**10**	**.855**

Source: *Primary data*

The results in table 3 above indicated that reliability test using Cronbach's Alpha ranges from 0.879 to 0.788 and the average Cronbach's Alpha was 0.855. This implies that items adopted in the questionnaire were deemed highly reliable as recommended by Katamba and Nsubuga (2014) Cronbach's alpha coefficient has to be above 0.70

3.11 Data analysis

Data was analyzed both quantitatively and qualitatively.

3.11.1 Quantitative data analysis

Quantitative data was analyzed using Statistical Package for Social Sciences (SPSS) version 23 where descriptive statistics were represented in the form of descriptive tabulations, percentages, and frequencies. On the other hand, inferential statistics was used to run correlation (Pearson's product moment correlation coefficient) to determine the relationship between decentralization and public health service delivery in Bulambuli Town Council (Mugenda & Mugenda, 1999). It was upon the results from this analysis method that the researcher decided either to accept the research hypotheses or reject them with reference to the significance level of 0.05 (5%).

3.11.2 Qualitative data analysis

Qualitative data collected was compiled, edited, coded, and categorized through finding patterns, trends and relationships from the information gathered. According to Mugenda and Mugenda (1999) the researcher's interest is to analyze information in a systematic manner so

as to come up with meaningful conclusions and recommendations. The qualitative data collected was analyzed by use of content analysis method.

3.12 Measurement of variables

The measurement of variables was conducted using the works of Sekaran (2004). Coding system was used where numbers were assigned to characteristics in order to operate and define the variables. The various types of scales that were used to measure characteristics and this included nominal, ordinal and Likert scales of measurement. The nominal scale was used on the data concerning the bio-data of the respondents like age, academic background, gender, number of years in service, category of respondents, and number of times respondents sought for health services in Bulambuli Town Council (Mugenda & Mugenda, 1999). Ordinal scale was used to report the mean scores of variables from the findings for example the researcher used statements such as very low (1 – 1.79), low (1.80 – 2.59) average (2.6 – 3.39) high (3.4 – 4.19) and very high (4.20 – 5.00) during the reporting of the results (Amin, 2005).

The Likert scale was used to collect opinion data that was used to measure the entire citizens view on the relationship between decentralization and public health service delivery Bulambuli Town Council using five scales: - Strongly Disagree (SD) =1, Disagree (D) =2, Not Sure (NS) =3, Agree (A) =4 and 1 = Strongly Agree (SA) =5.The numbers in the ordinal measured positions among variables (Mugenda & Mugenda, 1999; Amin, 2005).

3.13 Limitations to the study

Most of the respondents were very suspicious of this study, thinking that was a ploy to gain information about the organization's operations. It took a lot of time by the researcher to explain to them that this research was mainly to help them understand how decentralization relates with public health service delivery.

The researcher experienced a problem of non-response from respondents who were given questionnaires to fill. However, the researcher assured the respondents that any information given is to be treated with utmost confidentiality.

The researcher also encountered a challenge of language difficulties where some of the selected service users as respondents could not understand English language; however this was managed through translating questionnaire and interview questions from English to local language for some respondents who had such difficulties, this was easy given the fact that the researcher and the research assistant understood both English and Gishu languages.

3.14 Ethical considerations

Confidentiality of respondents was observed where their details were not disclosed apart from identification where the researcher agreed with some respondents that their photos can be disclosed for as long as their clear identities are not displayed which was adhered to.

All data gathered was used only for the purpose of the study and nothing else.

The research procedures were explained to all the respondents before they took part in the research and their informed consent was obtained.

All the sources of literature were acknowledged throughout the whole study through proper citations and referencing.

3.15 Summary for chapter three

This chapter presented the methodology used in the study. The study employed a mixed research design by use of quantitative and qualitative approaches. A population of 240 respondents was targeted from which 150 respondents were determined as the sample size using

the formula by Yamane and Taro (1967). Primary data was obtained from 124 respondents where 117 were given questionnaires and 07 were subjected to interviews

Reliability and validity tests were conducted for the variables used, measurement of the research variables was made and model specifications were generated. Correlational analysis method was employed by use of descriptive and inferential statistics. Finally ethical considerations and limitations of the study were presented.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

4. Introduction

The chapter presents study findings focusing on the relationship between decentralization and public health service delivery in Uganda with specific reference to Bulambuli Town Council as the case study. The findings are presented basing on the study objectives, and hypothesis. The specific objectives of the study included; to establish a relationship between political decentralization and public health service delivery, to determine the relationship between fiscal decentralization and public health service delivery, to establish a relationship between administrative decentralization and public health service delivery in Bulambuli Town Council. The chapter comprises of the background information, response rate and empirical findings of the study.

4.1 Response Rate

The target sample size of this study was 150 respondents who were examined through questionnaires and interviews as indicated in table 4 below.

Table 4: Response rate per research instrument

Instrument	**Target sample (N)**	**Actual sample (N)**	**Response rate (%)**
Questionnaires	140	117	83.6
Interviews	10	7	70.0
Total	**150**	**124**	**82.67**

Source: *Primary data*

Table 4 above indicates a response rate of 83.6% of the respondents who participated in the study. From this, the researcher distributed a total of 140 questionnaires to 140 respondents and a total of 117 questionnaires were filed and returned by the respondents constituting 83.57%

and interview sessions were held with7 respondents out of the expected 10 respondents giving 70.0% response rate as illustrated in table 4 above. However, the average response rate of 82.67% was good representation to enable the researcher to continue with data analysis because it is above 70% as according to Amin (2005), thus this qualifies the study finding to be more reliable since the highest percenta0ge of the expected participants actually participated in the study.

4.2 Background Information

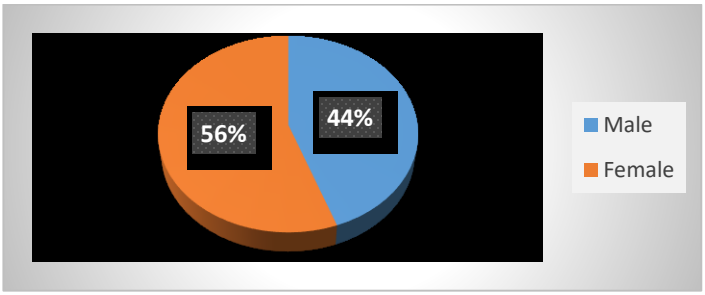
The background information of interest to this study included gender, age group, level of education, place of work, length of service and number of times respondents have ever been in need of health services as either patients or patient's attendants. Such information is vital because it provides an understanding of respondents and the information that influences the attitude towards issues such as decentralisation and public health service delivery.

4.2.1 Gender distribution

The study aimed at establishing the gender of the respondents. This information was gathered using a questionnaire administered to Town Council officials, Muyembe H/C IV operational management staff and service users.

The results are presented in figure 2 below.

Figure 2: Gender of the respondents



Source: *Primary data*

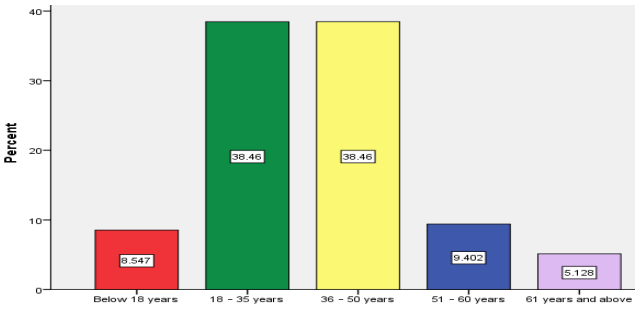
Findings from figure 2 illustrate that 56.0% of the majority respondents were females and 44.0% of the respondents were males. This finding implies that the study was gender representative since both females and males were captured and this minimized the biases and variations that are gender based since there was only a percentage difference of 11%.

Therefore, in this Town Council female participated more in delivering and receiving of public health services than their counter parts since they are the ones that greatly need health services.

4.2.2 Age distribution

The study aimed at establishing the age of the respondents. The findings are presented in figure 3 below;

Figure 3: Age of the respondents



Source: *Primary data*

The findings in figure 3 above illustrates that 38.46% of the respondents in this Town Council were between the age of 18-35 and 36-50 of age respectively. This finding implies that this study was representative and reliable since the age category of respondents was regarded mature

enough to understand and appreciate the issues of decentralisation and public health service delivery.

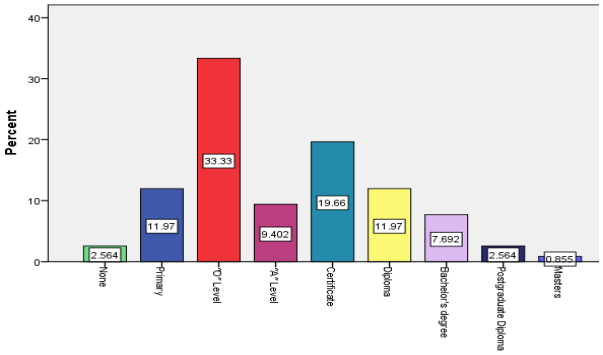
However, much as 9.402% being a small percentage represents respondents between the age of 51-60 years, these are important to reason being they are mature enough and they have vast knowledge on decentralisation and public health service delivery.

Therefore, if age relates to the understanding of variables under study, then one can assume that the information provided was valid and reliable.

4.2.3 Highest Level of Education

This aimed at establishing the level of education distribution of the respondents. The findings are illustrated in figure 4 below.

Figure 4: Highest Level of education of the respondents



Source*: Primary data*

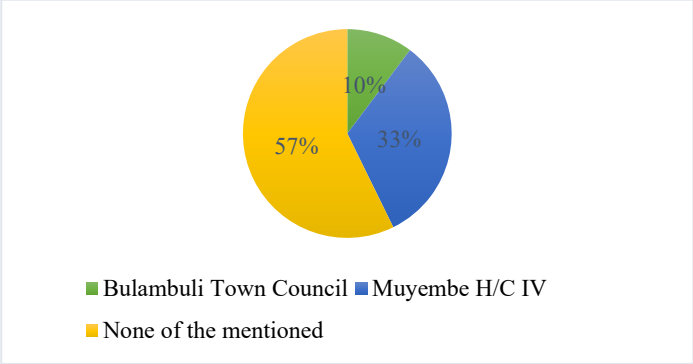
Figure 4 above indicates that 33.33% of the respondents' highest level of education is O' Level, 19.66% at least hold a certificate, 7.692% have at least attained their bachelor's degree, 2.564% hold post graduate diplomas and 0.855% have attained education up to masters level although these are lower percentages but they play a big role in determining the relevance of decentralization on public health service delivery.

The results would mean that the highest percentage of the respondents in the study (85.4%) at least had attained the education level up to O' Level implying they were literate, could interpret the questionnaires as required and believed to have provided their reliable and valuable opinion on decentralization and public health service delivery. However, for those respondents whose highest level of education was none constituted 2.56% and 11.97% of them had at least reached primary, this could have had an effect on the understanding of the instruments administered but good enough the researcher ensured that such cases are catered for by using a literate research assistant who interpreted the questions in the local language (Gishu) the respondents best understood while answering the questions addressed to them.

4.2.4 Place of work.

This aimed at determining the place of work of the respondents. The findings are illustrated in figure 5 below.

Figure 5: Place of work of the respondents



Source: *Primary data*

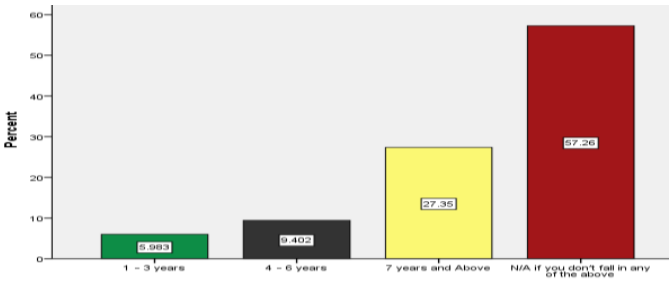
Results from figure 5, indicate that 57.0% of the respondents that participated in this study none of them work neither in Bulambuli Town Council nor Muyembe H/C IV, 33% work with Muyembe H/C IV and only 10% work with Bulambuli Town Council.

However, this finding implies that majority of the respondents who participated in this study are basically the beneficiaries of the public health services who have reliable information concerning the status of public health service delivery in Bulambuli Town Council.

4.2.5 Length of service

This aimed at determining the length of service distribution of the respondents. The findings are illustrated in figure 6 below.

Figure 6: Length of service



Source: *Primary data*

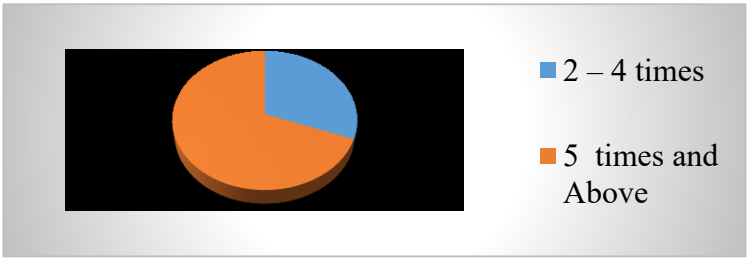
Results from figure 6, indicates that 57.26% of the respondents have not worked with in the Town Council and Health Centre for any of the years mentioned, 27.35% have worked for a period of 7 years and above and 9.402% have worked for a period between 4-6 years. However, although the majority respondents did not follow in any of the mentioned period of work, these could be the non-employees mentioned above and to those who worked for above 7 years being next to the majority are representative to this study of their knowledge about decentralization and public health service delivery and their capability to perform the assigned duties and responsibilities strategically, tactically and operationally.

This finding implies that at least individuals in this Town Council and Health Centre have stayed for period of 7 years and above which gives a good experience on the issues of the problem under study.

4.2.6 Times needed health services either as a patient or patient attendant

This aimed at determining how many times respndents have ever been in need of health services either as patients or attendants to a patient. The findings are illustrated in figure 7 below.

Figure 7: Times needed health services either as a patient or attendant



Source: *Primary data*

Results from figure 7, indicate that 69% of the respondents have needed health services for 5 and above times from Muyembe H/C IV and at least 31% have needed health services for 2-4 times from this Health Centre. This study finding revealed at least majority of the respondents have ever sought for health services from this Health Centre several times being the fact that it is the only Health Centre IV in the Town Council and the neighbouring areas within the district and outside.

4.3 Descriptive findings

4.3.1 Political decentralization in Bulambuli Town Council

This presents descriptive findings on decentralization in Bulambuli Town Council. The magnitude of the mean score suggests the extent to which political decentralization exists in Bulambuli Town Council as it was depicted by the measurement indicator. A 5-Likert scale ranging from 1 which represented strongly disagree to 5 which reflected strongly agree was

used where SD=strongly (1), D=Disagree (2), NS=Not Sure (3), A=Agree (4) and SA=Strongly Agree (5). Mean scores were interpreted as follows: 1.00 – 1.79 (very low), 1.80 – 2.59 (low), 2.60 – 3.39 (average), 3.4 – 4.19 (high), and 4.20-5.00 (very high). The results are presented in table 5 below.

Table 5: Findings on political decentralization in Bulambuli Town Council

S/N	Item Variables	Minimum	Maximum	Mean	Std. Deviation
1	There exists citizens' participation in decision making, in particular through democratic process.	1	5	3.93	.998
2	There is always quality interaction between residents and local officials	1	5	3.73	1.022
3	Budget preparations are always participatory in nature	2	5	3.84	.840
4	Citizens through their elected leaders have more powers in public decision-making	1	5	3.75	.870
5	There exists accountability and local citizens are in position to hold local decision-makers accountable for their actions	1	5	3.99	.793
6	There is transferred power from central to Local Government to enable greater community representation through elected leaders	1	5	3.92	1.018

7	Quality local elections are always organized	1	5	3.98	.890
8	There exist transparency in the central Government's acts affecting the Town Council.	1	5	3.95	.808
9	There is sufficient information with in the Town Council to address the necessary demands	2	5	3.88	.779
10	Majority of the local citizens are knowledgeable about the works of local officials	1	5	3.73	.906
	Average mean	**1.2**	**5**	**3.87**	**.621**
				N=117	

Source: *Primary data*

Table 5 above presents the results on the relationship between political decentralization and public health service delivery in Bulambuli Town Council, to achieve this, ten statements were administered to 117 sampled respondents, and the results revealed a high average mean score of (3.87, SD=.0.621) as per respondents' opinions. To attain this, respondents agreed to statements 5 and 7 at mean scores of (3.99, SD= 0.793) and (3.98, SD= 0.890) respectively which are far above the average mean that there exists accountability and quality local elections are always organized respectively.

However much a high mean score was revealed, the results in table 5 further indicated that the mean scores for statements 2, 3, 4 & 10 were below the average mean, where it was revealed that; there is lower quality interaction between residents and local officials (3.73, SD= 1.022), budget preparations are not always participatory in nature (3.84, SD= 0.840), citizens through their elected leaders have less powers in public decision-making 3.75, SD 0.870), and majority of the local citizens are less knowledgeable about the works of local officials (3.73, SD= 0.906) thus not appealing to attain the quality of public health service delivery.

4.3.2 Fiscal decentralization in Bulambuli Town Council

This presents descriptive findings on decentralization in Bulambuli Town Council. The magnitude of the mean score suggests the level of fiscal decentralization in Bulambuli Town Council as depicted by that measurement indicator. A 5-Likert scale ranging from 1 which represented strongly disagree to 5 which reflected strongly agree was used where SD=Strongly Disagree D= Disagree NS= Not Sure, A=Agree and SA=strongly agree respectively.

Mean scores are interpreted as follows: 1.00 – 1.79 (very low), 1.80 – 2.59 (low), 2.60 – 3.39 (average), 3.40 – 4.19 (high) and 4.20-5.00 (very high). The results are presented in table 7.

Table 6: Findings on fiscal decentralization in Bulambuli Town Council

N= 117

S/N	Item variables	Minimum	Maximum	Mean	Std. Deviation
1	The Town Council has authority over revenue collection	1	5	3.48	1.095
2	The Town Council has authority over revenue expenditure	1	5	3.45	1.055
3	There exists adequate fiscal transfers from the central Government to the Town Council	1	5	3.26	.995
4	The Town Council sets the tax bases from which it generates revenue	1	5	3.52	1.119
5	There exists a variety of tax bases from which the Town Council raises tax revenue	1	5	2.81	1.245
6	The Town Council has autonomy in controlling the tax rates	1	5	3.53	1.200
7	The Town Council has financial accountability responsibilities	1	5	3.39	1.114
8	There exists adequate funding of the Town Council activities	1	5	2.46	1.063
9	The Town Council sometimes undertakes subnational borrowing to fund some of its operations.	1	5	2.77	.923

10	The health budget is always adequate enough to meet health needs in the Town Council	1	5	2.49	1.096
	Average Mean	**1**	**5**	**3.12**	**.750**

Source: *Primary data*

The results in table 6 above report an average overall mean of (3.12, SD= 0.750) of the existence of fiscal decentralization in Bulambuli Town Council.

To support this finding, the results in table 6 indicate that respondents went ahead and agreed at a mean of (3.53, SD=1.200) that the Town Council has autonomy in controlling the tax rates and a mean of (3.52, SD=1.119) as respondents agreed that the Town Council sets the tax bases from which it generates revenue. However, despite such means above the average mean, the results further indicated lower mean below the average implying that respondents revealed that there is no adequate funding of the Town Council activities (2.46, SD= 1.063), there exists no variety of tax bases from which the Town Council can tax revenue (2.81, SD= 1.245), there exists inadequate funding of the Town Council activities (2.46, SD= 1.063), the Town Council rarely undertakes subnational borrowing to fund some of its operations (2.77, SD= 0.923), and the health budget is always not adequate enough to meet health needs in the Town Council (2.49, SD= 1.096).

4.3.3 Administrative decentralization in Bulambuli Town Council

This presents descriptive findings on decentralization in Bulambuli Town Council. The magnitude of the mean score suggests the extent to which administrative decentralization exists in Bulambuli Town Council as depicted by that measurement indicator. A 5-Likert scale ranging from 1 which represented strongly disagree to 5 which reflected strongly agree was used where SD=strongly disagreed=disagree=not sure, A=agree

and SA=strongly agree. Mean scores are interpreted as follows: 4.20-5.00 (very high); 3.4-4.19 (high); 2.60-3.39 (average); 1.80-2.59 (low); and 1.00-1.79 (very low). The results are presented in table 9 below;

Table 7: Findings on administrative decentralization in Bulambuli Town Council.

N= 117

Source*: Primary data*

S/N	Item Variables	Mini mum	maxi mum	Mean	Std. Deviation
1	The Town Council enjoys corporate status and powers to secure its own resources to perform its functions	1	5	3.84	1.066
2	The Town Council has developed guidelines for community capacity building for effective participation and monitoring of health activities	1	5	3.84	.982
3	There exists established health committees with an appropriate gender balance to handle health related issues	1	5	3.51	.970
4	The Town Council remains fully accountable to the central appointing office while performing its functions.	1	5	3.23	1.220
5	Employees are responsible and expected to give an account for outcomes for the portion of the work directly under their control	1	5	3.44	.968
6	The Town Council officials are broadly accountable for how public money is spent	1	5	4.00	.900
7	There is improved governance within the Town Council	1	5	3.57	.894
8	There is administrative decision making authority within the Town Council	2	5	3.76	.784
9	There is capacity to manage funds for efficient and effective service delivery.	1	5	3.74	1.003
10	There exists clarity of the role and responsibilities for public service delivery	1	5	3.74	1.003
	Average Mean	**1.1**	**5**	**3.69**	**.652**

From table7 above, the results indicate a high overall mean of (3.69, SD=0.652) as majority of respondents opined that administrative decentralization in Bulambuli Town Council, this result is however supported at a higher mean of (3.84, SD= 0.982) which is above the average mean as revealed that the Town Council has developed guidelines for community capacity building for effective participation and monitoring of health activities (3.84, SD= 0.982) and it enjoys corporate status and powers to secure its own resources to perform its functions (3.84, SD= 1.066). However, much as an overall high mean was obtained, the results are not appealing as the Town Council does not remain fully accountable to the central appointing office while

performing its functions and this was revealed at a mean score of (3.23, SD= 1. 220), there exists no established health committees with an appropriate gender balance to handle health related issues (3.51, SD= 0.970), the Town Council does not remain fully accountable to the central appointing office while performing its functions (3.23, SD= 1.220), and employees are not always responsible and expected to give an account for outcomes for the portion of the work directly under their control (3.44, SD= 0.968).

4.3.4 Public health Service delivery in Bulambuli Town Council

Descriptive analysis was conducted to measure the existence of public health service delivery. The magnitude of the mean score suggests the level of public health quality depicted by the measurement indicator. A 5-Likert scale ranging from 1 which represented strongly disagree to 5 which reflected strongly agree was used where SD=Strongly Disagreed D=Disagree NS= Not Sure, A= Agree and SA=Strongly Agree. Mean scores are interpreted as follows: 1.00 – 1.79 (very low), 1.80 – 2.59 (low), 2.60 – 3.39 (average), 3.40 – 4.19 (high) and 4.20-5.00 (very high). The results are presented in table 11 below.

Table 8: Findings on public health service delivery in Bulambuli Town Council

N= 117

S/N	Item variables	Mini mum	Maxi mum	Mean	Std. Deviation
1	It is easy to access health services in this Local Government unit.	1	5	1.85	.802
2	Anyone can get health services at any time he/she needs them.	1	4	1.89	.818
3	The health services needed are always available.	1	4	1.90	.781
4	Majority of the citizens are satisfied with the quality of the health services delivered.	1	5	2.09	.900
5	Very few people complain of the nature of the services delivered in the Town Council.	1	5	2.22	.911
6	The health service providers are always readily available to deliver any kind of health service to the service seekers	1	5	2.22	1.001
7	The necessary health equipment are always readily available and in good working conditions	1	4	2.22	.911
8	The citizens get adequate health services any time they need them	1	4	2.03	.742
9	Majority of citizens can seek for health services from any Government facility within a proximity of not more than 5 kilometers away from their homes	1	4	1.97	.787
10	The public health services can be equitably accessed by all citizens in need of them without any constraint	1	4	1.81	.830
	Average mean	**1**	**4.4**	**2.02**	**.500**

Source: *Primary data*

The results in table 8 indicate a low overall or average means of (2.02, SD=0.500) implying low or unpleasant public health service delivery in this Town Council. The low or unpleasant public health service delivery can be confirmed by statements 1, 2, 3, 9 and 10 whose mean scores of (1.85, SD= 0.802), (1.89, SD= 0.818), (1.90, SD= 0.781), (1.97, SD= 0.787) and (1.81, SD= 0.830) respectively are far below the average mean. Specifically, findings revealed that public health service delivery is below the standards characterized by difficulties in accessing health services in the Town Council, not possible for anyone to get health services at any time

he/she needs them , the health services needed are not always available, majority of citizens cannot seek for health services from any Government facility within a proximity of not more than 5 kilometers away from their homes, and the public health services are inequitably accessed by citizens in need of them and with constraints respectively as per the mean scores. Empirically this indicates a bad situation of public health service delivery to the citizens in Bulambuli Town Council.

4.3.5 Interview findings on Public health Service delivery in Bulambuli Town Council

To support the above quantitative findings, the qualitative findings on this variable from key informants revealed that the citizens in this area find it hard to access the health services. They have to walk long distances to the Health Centre and the whole Town Council has only one Health Centre IV. Those who are far from the nearest public health facility move for a distance of 5 km. it was revealed that some service users are not in position to receive the required medication because of the small money that is always being asked from them and thus the services remain for only those who have money to pay thus indicating unequal service delivery yet these services are meant to be for free. This finding implies that there is unequal health service delivery and it's hard to access the services to some citizens.

Other respondents interviewed revealed that most of the health services needed most especially the critical services are never readily available, and for this case people are always referred to Mbale Main Referral Hospital which is far. While conducting an interview with one of Muyembe Health Centre IV staff, it was revealed that the Health Centre does not have most of the necessary health equipment, when asked whether the ambulance and standby generator exist, he replied *"yes, we have an ambulanceand the standby generator, but the only challenge is that most of the times these machines are*

not facilitated with fuel, this compels us to solicit some money from the patients during occasional emergencies to cater for fuel something that has raised public outcry that we solicit money from them, all these arise from budget limitations".

4.3.6 Observation findings on the status of public health service delivery

Findings from the observation method revealed that there are two standby generators at Muyembe HC IV but of the two, one has just been donated by the area Member of Parliament (Hon. Bulondo), and on this note, one of the health workers asserted that most of the times the generators are not used because of lack of funds for fuel and to make it worse power is regularly unstable, This as indicated in figure 8 below.

Figure 8: The standby generators at Muyembe H/C IV

Newly established standby generator Donated by area Member of Parliament

Functional standby generator

Standby generator non-functional

Faulty standby generator

Source: *Primary data*

The researcher discovered that there exists admission wards at the health facility but majority of the patients were sleeping down since beds were not adequate as compared to the population admitted.

Figure 9: Patients in two admission wards sleeping on the floor because of inadequate beds.

Mattresses put on the floor *Patients in admission wards sleeping on the floor*

Source: *Primary data*

The researcher discovered that patients were many in the waiting line especially at the general wing and this was attributed to the limited number of health workers and also given the fact that most of the citizens seek for health services from this health facility.

Figure 10: Patients waiting to be attended to by health workers at the general and immunization section.

Health service seekers in the waiting line

Source: *Primary data*

The ambulance was in place and in good conditions but the challenge is fuel, one of the health official reported that sometimes they are forced to request the patients' attendants to raise money for fuel in instances of critical emergencies or referral of critical cases to Mbale Main Hospital.

It was also observed that health workers were few as compared to the number of health service seekers, and this is the reason as to why people take long in the waiting line and makes the few workers so fatigued to the extent that they rarely give good customer care.

The theatre was in place but closed because of lack of the necessary equipment and also the absence of a qualified Surgeon, The Public Health Officer revealed that the Health Centre last had a qualified Surgeon three years ago, and instantly he resigned and went for further studies from then no replacement has ever been established.

The laboratory was also observed in place but with very few equipment, in fact the Laboratory Attendant reported that critical cases are always referred to Mbale because the Health Centre can only handle minor tests.

Figure 11: A Laboratory Attendant exhibiting some of the few Reagents and laboratory tools available.

Laboratory

Source: *Primary data*

It was also revealed by observation results that most of the medical equipment are not in place some that are available are faulty, to make it more realistic, the researcher requested for some reports concerning the status of health service delivery from the Town Council, and fortunately the Auditor General's report, 2018 on the health situation in Bulambuli Town Council was availed which confirmed the non-existence and faultiness of most of the equipment (see attachment).

4.4 Summary for chapter four

This chapter presented the study response rate, background information about the respondents included in the study were also presented as well as the descriptive statistics on the study variables of political decentralization, fiscal decentralization, administrative decentralization and public health service delivery showing the measures of central tendencies and dispersion minimum and maximum. Inferential analysis by running a Pearson correlation analysis was performed to examine the relationship between decentralization and public health service delivery in Bulambuli Town Council. The qualitative findings from both interviews and observation methods were also accordingly presented to give a backup on the quantitative findings and results were accordingly presented according to the study objectives.

4.5 Inferential findings

This explains the findings in this study as they are presented according to the objectives of the study.

4.5.1 Correlation results on the relationship between political decentralization and public health service delivery.

A Pearson correlation product moment technique (bivariate) was used to produce the correlational results to establish the relationship between political decentralization and public health service delivery in Bulambuli Town Council and the results are as indicated in table 6 below;

Table 9: The correlation coefficient results on political decentralization and public health service delivery in Bulambuli Town Council.

		Political decentralization	Public health service delivery
Political decentralization	Pearson Correlation	1	.244**
	Sig. (2-tailed)		.008
	N	117	117
Public health service delivery	Pearson Correlation	.244**	1
	Sig. (2-tailed)	.008	
	N	117	117
**. Correlation is significant at the 0.01 level (2-tailed).			

Source: *Primary data*

The correlation results in table 9 above indicated that there is a positive weak significant relationship between political decentralization and public health service delivery in Bulambuli Town Council. This was justified by the correlation coefficient of 0.244** at a P-value of 0.008 which was below the significance level of 0.05.

This implies that political decentralization and public health service delivery go hand in hand and improvement in political decentralization leads to a slight improvement in public health service delivery in Bulambuli Town Council.

From the qualitative findings, results from interviews held with some key informants were in agreement with the quantitative findings as revealed that most of the citizens are not knowledgeable on what is meant to be done by their local officials and they interact less with them. This is because some of the local officials are not always on their jobs which makes it hard for the citizens to address their needs to them. This has hindered the deliverance of quality health services for example issues concerning some public health workers who absent themselves from their work makes it difficult for the citizens to get health services timely and in adequacy .

Another key respondent from the Town Council revealed that there is political autonomy but the limiting factor is that, political leaders do not have adequate time to seek for citizens' opinions on certain key issues and this inhibits the aspect of democratic participation. This does not only limit citizens' democracy but also makes it hard to know the priority needs of the citizens.

Another respondent asserted that, the citizens have powers to determine who to represent them through elections though sometimes instances of malpractices are registered, it was further revealed that most of the representatives do not represent the voices of the people instead they present their own voices and this does not manifest the will of people. These findings imply that there is still a problem with the political decentralization system in the Town Council.

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

A Pearson correlation product moment technique (bivariate) was used for to determine the relationship between fiscal decentralization and public health service delivery in Bulambuli Town Council and the results are presented in table 10 below.

		Fiscal decentralization	Public health service delivery
Fiscal decentralization	Pearson Correlation	1	.471**
	Sig. (2-tailed)		.000
	N	117	117
Public health service delivery	Pearson Correlation	.471**	1
	Sig. (2-tailed)	.000	
	N	117	117

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

Table 10: The correlation coefficient results on fiscal decentralisation and public health service delivery.

Source: *Primary data*

The correlation results in table 10 above indicated that there is a positive weak significant relationship between fiscal decentralization and public health service delivery in Bulambuli Town Council. This was justified by the correlation coefficient of 0.471** at a P-value of 0.000 which was below the significance level of 0.05.

This implies that fiscal decentralization and public health service delivery go hand in hand and improvement in fiscal decentralization leads to a slight improvement in public health service delivery in Bulambuli Town Council.

Qualitative findings from interviews were revealed to support the quantitative findings. The findings revealed that the Town Council lacks enough funds to facilitate its activities and Muyembe Health Centre IV struggles to deliver the expected health services to the citizens of the area. The Health Centre IV management used to collect money from patients to fuel the generators but the arrangement was resisted by patients. Thus this has affected the public health service delivery.

It was also revealed that though the Town Council has authority to collect taxes and decide on how to allocate it, the revenues collected are not adequate enough to meet the assignments the Town Council has, when the Tax Officer was asked on the cause of low revenue collections, he replied that *"the Town Council has strong tax administration policies and guidelines but the only challenge is there are very few bases on which taxes can be levied since there is low level of entrepreneurial spirit attributed to limited incomes, the few tax bases like markets, taxi stages, shops and others cannot raise*

enough funds to meet our assignments as a Town Council and the fiscal allocations and grants that we receive are too meagre".

		Administrative decentralization	Public health service delivery
Administrative decentralization	Pearson Correlation	1	.283**
	Sig. (2-tailed)		.002
	N	117	117
Public health service delivery	Pearson Correlation	.283**	1
	Sig. (2-tailed)	.002	
	N	117	117
**. Correlation is significant at the 0.01 level (2-tailed).			

In addition to that, one of the health service providers revealed that Muyembe Health Centre IV is allocated only five million shillings per quarter (5,000,000/=) to cater for all its operations even including the outreach programmes, he stressed that this money is too little in relation to the population that the health facility serves and the necessary health requirements that are needed to be in place.

4.5.3 Correlation results on the relationship between administrative decentralization and public health service delivery.

Source: *Primary data*

A Pearson correlation product moment technique (bivariate) was used to produce the results to establish the relationship between the administrative decentralization and public health service in Bulambuli Town Council and the results are as indicated in table 11 below;

Table 11: The correlation coefficient results on administrative decentralization and public health public health service delivery.

The correlation results in table 11 above indicated that there is a positive weak significant relationship between administrative decentralization and public health service delivery in

Bulambuli Town Council. This was justified by the correlation coefficient of 0.283** at a P-value of 0.002 which was below the significance level of 0.05.

This implies that administrative decentralization and public health service delivery go hand in hand and improvement in administrative decentralization leads to a slight improvement in public health service delivery in Bulambuli Town Council.

To support the above quantitative, qualitative findings were also revealed as one of the key informant revealed that the Town Council does not remain fully accountable to the central appointing office while performing its functions. One of the Senior Medical workers take advantage of the staff accommodation problem to abscond from work. The staff could attend three times in a week which affects the service delivery because their consultation is needed on a daily basis.

Another key informant informed that there are too many patients compared to the number of health workers at the Health Centre. This accuses some of the health personnel of taking advantage of the situation to extort money from patients.

While interviewing some of the key respondents, it was revealed that the Town Council enjoys corporate status and has developed guidelines for effective participation and monitoring of health activities but there is poor governance and limited accountability.

4.6 Research Hypotheses Testing

4.6.1 Hypothesis one

Hypothesis one was that, “There is a significant relationship between political decentralization and public health service delivery in Bulambuli Town Council”.

The results from the correlation analysis revealed a positive weak significant relationship between political decentralization and public health service delivery in Bulambuli Town Council and therefore, research hypothesis one was supported since the relationship between political decentralization and public health service delivery was significant at a P-value of 0.008 which was less than significance level of 0.05.

4.6.2 Hypothesis two

Hypothesis two was that, "There is a significant relationship between fiscal decentralization and public health service delivery in Bulambuli Town Council".

The results from the correlation analysis revealed a positive weak significant relationship between fiscal decentralization and public health service delivery in Bulambuli Town Council and therefore, research hypothesis two was supported since the relationship between political decentralization and public health service delivery was significant at a P-value of 0.000 which was less than significance level of 0.05.

4.6.3 Hypothesis three

Hypothesis three was that, "There is a significant relationship between administrative decentralization and public health service delivery in Bulambuli Town Council".

The results from the correlation analysis revealed a positive weak significant relationship between administrative decentralization and public health service delivery in Bulambuli Town Council and therefore, research hypothesis three was supported since the relationship between political decentralization and public health service delivery was significant at a P-value of 0.002 which was less than significance level of 0.05.

Table 12: Summary of research hypotheses testing

S/N	Hypotheses	P-values	Status
1	There is a significant relationship between political decentralization and public health service delivery	0.008<0.05	Accepted
2	There is a significant relationship between fiscal decentralization and public health service delivery	0.000<0.05	Accepted
3	There is a significant relationship between administrative decentralization and public health service delivery	0.002<0.05	Accepted

Source: *Primary data*

From the summary table 12 of research hypotheses testing above, it indicated that all the three research hypotheses were accepted since their respective P-values were below the significance level of 0.05. Implying that political decentralization, fiscal decentralization and administrative decentralization significantly relate to public health service delivery in Bulambuli Town Council.

Table 13: Model summary table showing analysis results on decentralization and public health service delivery in Bulambuli Town Council.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.544[a]	.296	.278	.425

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

Source: *Primary data*

From the model summary table above, it indicates that there is a moderate relationship between decentralization and public health service delivery. The findings imply that the three dimensions of decentralization (political, fiscal and administrative) studied explain the variation in the dependent variable (public health service delivery) by 54.4% and 45.6% explained by other factors outside this model.

Table 14: ANOVA results on Decentralisation and Public Health Service Delivery

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	8.585	3	2.862	15.873	.000[b]
	Residual	20.372	113	.180		
	Total	28.957	116			

a. Dependent Variable: Public health service delivery
b. Predictors: (Constant), Political decentralization, Administrative decentralization, Fiscal decentralization.
Source: *Primary data*

Results in Table 14 above indicate F-Test statistic of the model is 15.873 and the corresponding probability is 0.000. The P-value is highly significant and the results indicate that the model is jointly significant. This implies that political decentralization, fiscal decentralization, administrative decentralization significantly and adequately explain changes in public health service delivery in Bulambuli Town Council.

CHAPTER FIVE

SUMMARY, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5. Introduction

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

5.1 Summary of findings.

5.1.1 Relationship between political decentralization and public health service delivery

The study findings revealed that there is a positive weak significant relationship between political decentralisation and public health service delivery observed at correlation coefficient of 0.244** with a P-value of 0.008 which was below 0.05 level of significance. Implying that improvement in decentralization leads to a slight improvement in public health service delivery in Bulambuli Town Council.

5.1.2 Relationship between fiscal decentralization and public health service delivery

The study findings revealed that there is a positive weak significant relationship between fiscal decentralization and public health service delivery at a correlation coefficient of 0.471** with a P-value of 0.000 which was below 0.05 level of significance. This meant that improvement in fiscal decentralization leads to a slight improvement in public health service delivery in Bulambuli Town Council.

5.1.3 Relationship between administrative decentralization and public health service delivery.

The study findings revealed that there is a positive weak significant relationship between administrative decentralization and public health service delivery at a correlation coefficient of 0.283** with a P-value of 0.002 which was below 0.05 level of significance. This meant that

improvement in administrative decentralization leads to a slight improvement in public health service delivery in Bulambuli Town Council.

5.2 Discussion of the research findings

5.2.1 Relationship between political decentralization and public health service delivery

The findings in chapter four, on the first objective indicated that while establishing a relationship between political decentralization and public health service delivery in Bulambuli Town Council, a high average mean of (3.87, SD= 0.621) was reported as per respondents' opinions. From the majority respondents, it was revealed that there exists accountability and local citizens are in position to hold local decision-makers accountable for their actions. This finding can be related with literature reviewed by World Bank (2004) revealed that it is commonly argued that political decentralization brings accountability to the system and may improve health service delivery. This may occur because citizens have a channel to provide input on local decision-making processes through their leaders and hold local decision-makers accountable for their actions.

The findings in table 5 further revealed that majority of the local citizens are less knowledgeable about the works of local officials and there is always less quality interaction between residents and local officials thus not appealing to attain the quality of public health service delivery. To relate this finding with the literature, the World Bank report (2000) revealed that the rational and principal assumption of political decentralization is that decisions made with greater participation will be better informed and more relevant to diverse interest in society than those made by national political authorities. The reality however provides some level of variance because though political decentralization has this assumption, the process of selecting representatives, personal disposition and interest determine the level to which they represent

the interest of their constituents. Thus the need of quality interaction between residents and local officials.

5.2.2 Relationship between fiscal decentralization and public health service delivery

The results in table 7 indicated an average overall mean of (3.12, SD= 0.750) as revealed that the Town Council has autonomy in controlling the tax rates and sets the tax bases from which it generates revenue. This finding is in line with Choi (2012) as asserted that fiscal decentralization means the authority of revenue collection or expenditure is transferred from superior offices to subordinate offices for the purposes of producing appropriate public services for improving public welfare for residents thus the majority respondents were in line with Choi.

The findings in table 7 also revealed that there is no adequate funding of the Town Council activities and the health budget is always not adequate enough to meet health needs in the Town Council. This can be confirmed with the literature according to ACODE (2010) as found that numerous problems facing health centers, including poor funding of health care services and minimal transparency in the use of drugs and medicines; chronic shortage of trained workers especially at lower tier health facilities were used for administrative costs. Parasuraman, Zeithaml and Berry (2014) add that significant number of Local Governments do not have the managerial, administrative, financial and institutional capacity to meet the rising needs of local people. This situation is exacerbated by the decline between Local Government and tertiary sector. As a result, these Local Governments cannot meet their required performance standards hence impacting adversely on public health service delivery.

5.2.3 Relationship between administrative decentralization and public health service delivery

The findings on this objective indicated a high overall mean of (3.69, SD= 0.652) where majority of the respondents supported this finding as revealed that the Town Council has

developed guidelines for community capacity building for effective participation, monitoring of health activities and it enjoys corporate status and powers to secure its own resources to perform its functions.

These findings can be correlated with the finding revealed by Yawe and Kavuma (2008) as showed that to ensure communities are empowered to take responsibility for their own health and well-being, and to participate actively in the management of their local health services for general health service improvement, the Government of Uganda has initiated a number of measures which include developed guidelines for community capacity building for effective participation in resource mobilization and in the monitoring of health activities, promoted the establishment of health committees with an appropriate gender balance at each of the different levels of the Local Government system to handle issues concerning health, established management boards for all publicly owned tertiary health facilities with extensive delegated authority for their efficient operation.

From the majority respondents, it was found that the Town Council does not remain fully accountable to the central appointing office while performing its functions. Omolo (2011) found that administrative decentralization is intended to minimize the drawbacks of excessive centralization. He further asserts that delegation, where the central Government transfers service delivery responsibilities to semi-autonomous Government agencies or non-state organizations that are fully accountable to the assigning ministry or department, public service delivery is likely to improve.

5.3 Conclusion of the study

From the findings in chapter four, it was concluded there is positive significant relationship between decentralization and public health service delivery in Bulambuli Town Council. This implies that improvement in decentralization through embracing citizen participation in

decision making is likely to lead to improvement in public health service delivery in Bulambuli Town Council.

5.3.1 Political decentralization and public health service delivery

Basing on study findings in chapter four, it was concluded on objective one that there is a positive weak significant relationship between political decentralization and public health service delivery in Bulambuli Town Council.

5.3.2 Fiscal decentralization and public health service delivery

Basing on study findings in chapter four, it was concluded on objective two that there is a positive weak significant relationship between fiscal decentralization and public health service delivery in Bulambuli Town Council.

5.3.3 Administrative decentralization and public health service delivery

Basing on study findings in chapter four, it was concluded on objective three that there is a positive weak significant relationship between administrative decentralization and public health service delivery in Bulambuli Town Council.

5.4 Recommendations

For public health service delivery to be improved in Bulambuli Town Council through decentralization, there should be improvement in political decentralization, fiscal decentralization and administrative decentralization to enhance citizen participation in decision making, financial capacity and good governance which will improve public health service delivery.

5.4.1 Political decentralization and public health service delivery

The findings under objective one revealed a positive weak significant relationship between political decentralization and public health service delivery.

This study therefore, recommends that there should be continuous emphasis on political decentralization to improve public health service delivery through;

- Embracing citizen participation in decision making through ensuring public hearings and consultation system and also involving them in the budget preparation process.

5.4.2 Fiscal decentralization and public health service delivery

The findings under objective two revealed a positive weak significant relationship between fiscal decentralization and public health service delivery.

This study therefore, recommends that there should be continuous emphasis on fiscal decentralization to improve public health service delivery through;

- Finding out more revenue generating opportunities to widen the tax bases by encouraging entrepreneurial spirit and also looking out for more potential sources for generating local revenue for instance from user charges/ fees including market dues and parking fees which can be used to meet health budget thus improving the health service delivery.
- Undertaking subnational borrowing to improve on its funding and increasing on the health budget to fund health related operations, this can be done through lobbying for budget increment for Muyembe H/C IV for it to be in position to stock drugs, facilitate health workers and undertake other operations incidental to health service delivery.

5.4.3 Administrative decentralization and public health service delivery

The findings under objective three revealed a positive weak significant relationship between administrative decentralization and public health service delivery.

This study therefore, recommends that there should be continuous emphasis on administrative decentralization to improve public health service delivery through;

- Embracing the qualities of good governance like transparence, responsiveness, and rule of law, accountability, equity and inclusiveness and also appreciation of the whistle blowers in the management, regular monitoring and evaluation of the Town Council operations by the responsible Local Government officials, once these pathways of communication are created, officials must be responsive.
- The Central Government should regularly demand for accountability from the Town Council on its performance to instill a sense of seriousness and proper allocation of the funds, proper utilization of the disbursed drugs and other health equipment of machines assigned to it to facilitate in health related operations.

5.5 Areas for further study

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

A similar study may be carried out in other Local Government Town Councils in the country especially in Eastern and Northern Uganda.

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

5.6 Summary for chapter five

This chapter presented the summary of the study findings, discussion of the research findings, conclusion on the study findings, recommendations and suggestion of areas for further research.

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APPENDENCES

APPENDIX I: QUESTIONNAIRE

RESEARCH STUDY FOR MASTERS DEGREE OF SCIENCE IN ORGANIZATION AND PUBLIC SECTOR MANAGEMENT, KYAMBOGO UNIVERSITY

Dear respondent,

I am a Masters student pursuing Master of Science Degree in Organization and Public Sector Management of Kyambogo University. I am conducting a study on the relationship between decentralization and public health service delivery in Uganda a Case Study of Bulambuli Town Council. You have been selected to participate in this survey because of your exclusive knowledge and I believe that you can provide trustworthy and appropriate information to boost the study.

The information collected in this survey is purely for academic purposes and shall be treated with utmost confidentiality.

I am looking forward to your cooperation.

Thank you.

Yours sincerely,

Eric Wanyama

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

1. **Gender**
   1. Male ☐ 2. Female ☐
2. **Age group** ***(please tick appropriate group)***
   1. Below 18 years ☐ 2. 18 – 35 years ☐ 3. 36 – 50 years ☐ 4. 51 – 60 years ☐
   5. 61 years and above ☐
3. **Highest Level of Education** ***(please tick appropriate group)***
   1. None ☐ 2. Primary ☐ 3. "O" Level ☐ 4. "A" Level ☐ 5. Certificate ☐

6. Diploma ☐ 7. Bachelor's degree ☐ 8. Postgraduate Diploma ☐ 9. Masters ☐ 10.PHD ☐

4. **Where do you work?**
   1. Bulambuli Town Council ☐ 2. Muyembe H/C IV ☐ 3. None of the mentioned ☐

5. **Length of service if you are a health worker or Town Council worker *(please tick appropriate group)***
   1. 1 – 3 years ☐ 2. 4 – 6 years ☐ 3. 7 years and Above ☐ 4. N/A if you don't fall in any of the above ☐

6. **How many times have you ever been in need of health services either as a patient or attendant to a patient (*please tick the appropriate box*)**
   1. Once ☐ 2. 2 – 4 times ☐ 3. 5 times and Above ☐ 4. None ☐

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

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

SECTION B

B. POLITICAL DECENTRALIZATION		**SD**	**D**	**NS**	**A**	**SA**
1	There exists citizens' participation in decision making, in particular through democratic process.	1	2	3	4	5
2	There is always quality interaction between residents and local officials	1	2	3	4	5
3	Budget preparations are always participatory in nature	1	2	3	4	5
4	Citizens through their elected leaders have more powers in public decision-making	1	2	3	4	5
5	There exists accountability and local citizens are in position to hold local decision-makers accountable for their actions	1	2	3	4	5
6	There is transferred power from central to Local Government to enable greater community representation through elected leaders	1	2	3	4	5
7	Quality local elections are always organized	1	2	3	4	5
8	There exist transparency in the central Government's acts affecting the Town Council	1	2	3	4	5
9	There is sufficient information with in the Town Council to address the necessary demands	1	2	3	4	5
10	Majority of the local citizens are knowledgeable about the works of local officials	1	2	3	4	5

SECTION C

C. FISCAL DECENTRALIZATION.		SD	D	NS	A	SA
1	The Town Council has authority over revenue collection	1	2	3	4	5
2	The Town Council has authority over revenue expenditure	1	2	3	4	5
3	There exists adequate fiscal transfers from the central Government to the Town Council	1	2	3	4	5
4	The Town Council sets the tax bases from which it generates revenue	1	2	3	4	5
5	There exists a variety of tax bases from which the Town Council raises tax revenue	1	2	3	4	5
6	The Town Council has autonomy in controlling the tax rates	1	2	3	4	5
7	The Town Council has financial accountability responsibilities	1	2	3	4	5
8	There exists adequate funding of the Town Council activities	1	2	3	4	5
9	The Town Council sometimes undertakes subnational borrowing to fund some of its operations.	1	2	3	4	5
10	The health budget is always adequate enough to meet health needs in the Town Council	1	2	3	4	5

SECTION D

D. ADMINISTRATIVE DECENTRALIZATION.		SD	D	NS	A	SA
1	The Town Council enjoys corporate status and powers to secure its own resources to perform its functions	1	2	3	4	5
2	The Town Council has developed guidelines for community capacity building for effective participation and monitoring of health activities	1	2	3	4	5
3	There exists established health committees with an appropriate gender balance to handle health related issues	1	2	3	4	5
4	The Town Council remains fully accountable to the central appointing office while performing its functions.	1	2	3	4	5
5	Employees are responsible and expected to give an account for outcomes for the portion of the work directly under their control	1	2	3	4	5
6	There are many responsibilities assigned from the central Government to this Local Government unit	1	2	3	4	5
7	The Town Council officials are broadly accountable for how public money is spent	1	2	3	4	5
8	There is improved governance within the Town Council	1	2	3	4	5
8	There is administrative decision making authority within the Town Council	1	2	3	4	5
9	There is capacity to manage funds for efficient and effective service delivery.	1	2	3	4	5
10	There exists clarity of the role and responsibilities for public service delivery	1	2	3	4	5

SECTION E

E. PUBLIC HEALTH SERVICE DELIVERY.		**SD**	**D**	**NS**	**A**	**SA**
1	It is easy to access health services in this Local Government unit	1	2	3	4	5
2	Anyone can get health services at any time he/she needs them	1	2	3	4	5
3	The health services needed are always available	1	2	3	4	5
4	Majority of the citizens are satisfied with the quality of the health services delivered	1	2	3	4	5
5	Very few people complain of the nature of the services delivered in the Town Council	1	2	3	4	5
6	The health service providers are always readily available to deliver any kind of health service to the service seekers	1	2	3	4	5
7	The necessary health equipment are always readily available and in good working conditions	1	2	3	4	5
8	The citizens get adequate health services any time they need them	1	2	3	4	5
9	Majority of citizens can seek for health services from any Government facility within a proximity of not more than 5 kilometers away from their homes	1	2	3	4	5
10	The public health services can be equitably accessed by all citizens in need of them without any constraint	1	2	3	4	5

THANK YOU

APPENDIX II

INTERVIEW GUIDE

Dear respondent,

I am Eric Wanyama a master student pursuing a Master of Science Degree in Organization and Public Sector Management of Kyambogo University. I am conducting a study to establish the relationship between decentralization and public health service delivery in Uganda with specific reference to Bulambuli Town Council as a case study. You have been selected to participate in this survey because of your exclusive knowledge and I believe that you can provide trustworthy and appropriate information to boost the study.

The information collected in this survey is purely for academic purposes and shall be treated with utmost confidentiality.

I am looking forward to your cooperation.

Briefly comment on these questions.

Section B: Political decentralization

1. Do you think the locals are knowledgeable on what is to be done by their local officials?
2. Are the citizens given chance to input their opinions in the decisions undertaken by the Town Council?
3. Do citizens have the powers to decide who to represent them and if yes there are interests represented?

Section C: Fiscal decentralization

1. Is the Town Council in position to raise adequate funds to support its operations and most especially health?
2. Does the Town Council have in place tax administration and management gears that enable it collect the needed funds for its operations?
3. Is the health budget adequate enough to meet health needs in the Town Council?

Section D: Administrative decentralization

1. Does Bulambuli Town Council remain fully accountable to the central appointing office while performing its functions?

2. Muyembe Health Centre IV being the major health facility in the Town Council and the district as a whole, does it have the capacity to serve the available population?

3. Is the Town Council solely accountable for its actions?

4. Are there established good governance measures?

Section E: Public health service delivery

1. Do you feel happy and satisfied with the health services rendered in this Town Council? If not why?

2. If one is in need of health services, how easy is it for him/her to get such services?

3. Are Health workers always available and willfully ready to offer health services to any one in need of them?

4. Apart from Muyembe H/C IV, which other health facility can a patient visit to get necessary services within Bulambuli Town Council?

5. How many health facilities exist in Bulambuli Town Council?

APPENDIX III

OBSERVATION CHECKLIST

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