DECENTRALIZATION POLICYAND PUBLIC HEALTH SERVICE DELIVERY IN UGANDA
A CASE STUDY OF MAKINDYE DIVISION, KAMPALA

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A RESEARCH REPORT SUBMITTED TO THE COLLEGE OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF A BACHELOR'S DEGREE OF SOCIAL WORK AND SOCIAL ADMINISTRATION OF KAMPALA INTERNATIONAL UNIVERSITY

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DECLARATION

I, ABWE ILAMBO ELIE Reg. No. BSW/37583/122/DU, hereby declare that this is my original research report and that it has never been published for any award; degree or diploma at any institution.

Signature..... Date.....11th/05/2015.....

ABWE ILAMBO ELIE

APPROVAL

This research report entitled "Decentralization policy and public health service delivery in Uganda. A case study of Makindye division, Kampala" has been submitted to the college of humanities and social sciences for examination with my approval as the student's supervisor.

Signature…… Date…18·5·15……

Dr. Oketch Chrisostom

DEDICATION

I dedicate this piece of work to my parents Mr. Josias ILAMBO LYA LWEBULA and Mrs. Josephine ILOMBWE MAKENE for all their parental affections and supports that saw me completing my education and giving me greater ambitions for higher training.

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I thank the Almighty God for he has been my refugee, rescue mentor and director and a dwelling place through all generations.

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LIST OF ABBREVIATIONS AND ACRONYMS

GPT	Graduated Personal Tax
KCCA	Kampala Capital City Authority
LCV	Local Council Five
LG	Local Government
MFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Heal
NRA	National Resistance Army
NRM	National Resistance Movement
RDC	Resident District Commissioner
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHO	World Health Organisation

ABSTRACT

The study was carried out in Makindye Division, Kampala District and it was carried out on the impact of decentralization on health service delivery in Makindye Division. The objectives of this research was to examine the impact of decentralization on public health service delivery; to examine the challenges faced in delivering public health services and to come up with possible measures to the problems encountered in health service delivery.

The study used a descriptive research design to describe issues relating to decentralization and public health service delivery. The population included the local government officials, local leaders and the local people in the area. Simple random sampling and purposive sampling procedures were used in the study to obtain a sample of 90 respondents. Data was collected from both primary and secondary sources using key informant interviews and interview guides. Data was analyzed qualitatively in themes that reflect the study objectives.

The study found out that decentralization has led to the establishment of mutual public health goals through community collaboration, establishment of new health centres and improvement of primary health care. This impact has made a great improvement in health service delivery to the public. However, findings established various challenges faced by local governments in ensuring delivery of public health services and these included lack of transparency in allocation of resources, lack of enough health equipment, facilities and personnel, lack of funding at the local level and the influence of some politicians with selfish and political ambitions that hinder effective service delivery. Among the solutions, it was suggested that there should be motivation of health workers to enable them serve the public effectively, implement and improve public-private partnerships in health service system and implementation of strict laws to those who misuse funds meant for improving the health standards of the community.

Therefore the study recommended that the government and other stakeholders should step up their efforts to educate the local communities on their rights and obligations in taking part in the growth and development of health service delivery.

CHAPTER ONE
INTRODUCTION

1.0 Introduction

This chapter focused on background information, statement of the problem, purpose of the study, objectives of the study, research questions, hypotheses, scope, and significance of the study and operational definitions of the key terms.

1.1 Background of the Study

Simultaneously, the world has increasingly turned towards the practice of decentralization to assure democratic governance for human development (Robertson, 2010). Decentralization has recently been embraced by a large number of developing countries, especially in Africa, since it has been presented as a powerful tool to reduce poverty and improve governance. The World Bank in particular views it as one of the major reforms on its agenda. In response to the failure of a central state to run the country's development or to limit the risk of civil conflicts in ethnically fragmented countries, decentralization is perceived as a way to ensure political stability, to improve accountability and responsiveness of local leaders, to increase the efficiency of public policy, and ultimately to reduce poverty, (Oates, 2009). Decentralization theorem states that decentralization improves preference matching by offering a greater diversity of public services to a heterogeneous population.

A central theme in decentralization is the difference between a hierarchy, based on: authority: two players in an unequal-power relationship; and an interface: a lateral relationship between two players of roughly equal power. The more decentralized a system is, the more it relies on lateral relationships, and the less it can rely on command or force. In most branches of engineering and economics, decentralization is narrowly defined as the study of markets and interfaces between parts of a system. This is most highly developed as general systems theory and neoclassical political economy.

Decentralization, which officially began in Uganda in 1993, has increased opportunities for citizens to democratically determine how they should be governed and to make choices regarding the type and quality of public services they want.

Health Service Delivery according to World Health Organization (WHO) as the way inputs are combined to allow the delivery of a series of interventions or health actions. As noted in the World Health Report 2000, "the service provision function [of the health system] is the most familiar; the entire health system is often identified with just service delivery." The report states that service provision, or service delivery is the chief function the health system needs to perform World Health Organization (WHO, 2000). Health service delivery can be represented in a system's perspective, with inputs, processes, outputs, and outcomes some of the core inputs that are deemed necessary for health care delivery are financial resources, competent health care staff, adequate physical facilities and equipment, essential medicines and supplies, current clinical guidelines, and operational policies. These inputs must be available and accessible to have an impact. They also must be used to properly carry out the system processes to produce desired health outcomes. World Health Organization, (2008).

In East Africa, health service delivery has been deteriorating as an example, Kenya's health system faces a variety of human resource problems, primarily an overall lack of personnel in key areas, which is worsened by high numbers of trained personnel leaving the health sector to work overseas (WHO, 2012).

Health services in Uganda are decentralized, with local district government employing the health staff and to a considerable extent controlling health budgets and expenditures. The Ministry of Health (MoH) provides national leadership and establishment of health policy. The MoH is seen by almost all interviewed as being effective and well-focused on strengthening Public Health services in Uganda. It has learned to function in a multidisciplinary manner while promoting

the strengths of districts to function in collaboration with local government. Health receives 2% of Uganda's national budget. Of the MoH's budget, 50% of recurrent costs and 80% of capital costs are met by donor funds. Many middle and senior level personnel at the MoH headquarters have received Public Health training at Makerere. People now joining the MoH are largely taken from the ranks of district health services (USAID, 2006). Access to health services is highly variable with large parts of some districts without ready access to health facilities and others having almost universal access. Of health facilities, 30% are operated by private not-for-profit organizations. The for-profit health sector is the most rapidly growing, but is almost entirely composed of outpatient services.

1.2 Statement of the problem

The mission of the health sector of the Government of Uganda is to attain a good standard of health for all people in Uganda (MoH 1999 p.6). The government has tried to bring services closer by bringing health services close to the citizens through its Agents like KCCA in case of Kampala where a number of health centres have been established/constructed. However, the public image of health staff has been eroded and the quality of care provided is perceived as poor and the utilization of health services is low, particularly in the public sector claiming that there are no drugs, understaffing and lack of enough equipment. Many people now first go to a private clinic, hospital or pharmacist as their first option when ill living a high burden of diseases and eventually deaths among the poor who cannot afford private hospital charges. This therefore has prompted the researcher to carryout research on the effect of decentralisation on health service delivery in Makindye division, Kampala Uganda.

1.3 Purpose of the study

This purpose of this study was to assess the impact of decentralization on health service delivery in Makindye Division.

1.4 Specific objectives

i. To examine the impact of decentralization on public health service delivery in Makindye Division
ii. To examine the challenges faced in delivering public health services in Makindye Division
iii. To come up with possible measures to the problems encountered in health service delivery.

1.5 Research questions

i. What is the impact of decentralization on public health service delivery in Makindye Division
ii. What are the challenges faced in delivering public health services in Makindye Division
iii. What are the possible measures to the problems encountered in health service delivery?

1.6 Scope of the study

1.6.1 Geographical scope

Makindye is one of the administrative divisions of Kampala. It is located in the south eastern corner of Kampala bordering Wakiso district to the south and west. The eastern boundary of Makindye division is Murchison bay, a part of lake Victoria, Nakawa division lies to the north east, Kampala central to the north, Lubaga division to the northwest. Makindye is only 6km by road southeast of Kampala central business district.

1.6.2 Content scope.

The study focused mainly on decentralization policy and performance of public health service delivery in Makindye division. Focus was also be put on the elements of decentralization, its impact on public health service delivery, challenges encountered in delivering public health services and then possible measures were suggested.

1.6.3 Time scope

The study was carried out for a period of two months starting from February 2015 to April 2015

1.7 Significance of the study

The study results may help to highlight the failures of decentralisation in regard to public health service delivery and how it affects social service delivery to the poor people hence giving room for remedial strategies to be put in place.

The study findings will help policy makers to always draft policies that are always relevant with less interferences from corrupt officials hence making it easy to make for the policies to reap their objectives with less manipulation.

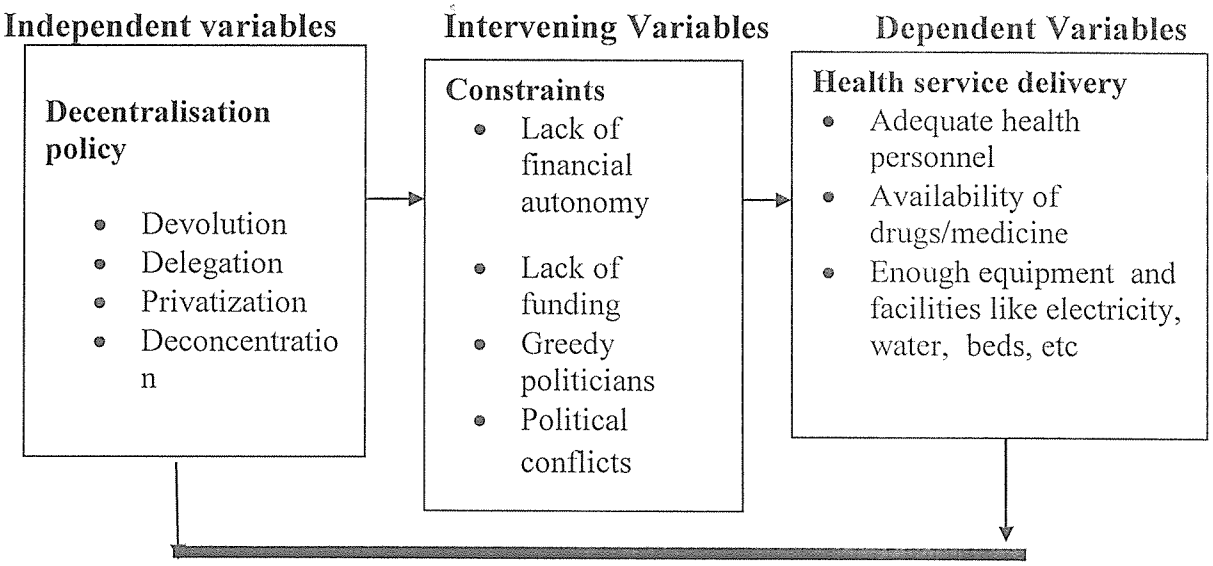
The study is beneficial to the ministry of health for the assessment of appropriate measures and remedies that will be put in place by the researcher to minimize the dysfunctional health operators in Makindye division and Uganda at large.

The study will be useful to the local administrators, local leaders, politicians and health workers who are always responsible the attainment of health service by the needy community of which they work for.

The administrators will be in a position to identify the challenges encountered in health service delivery and mitigation measures suggested in this research will help to avert the problems when adopted effectively.

The study results will be used by future scholars as a source of reference in case scholars want to understand the problem at length.

1.8 Conceptual framework showing the impact of decentralization on public health service delivery Kampala, Makindye division.



Source: Primary data

As illustrated from the figure 1 above (conceptual framework), decentralization system (independent variable) is implemented through four different forms that is devolution of powers, delegation of authority, privatization of public institutions and deconcentration which involves transfer of administrative powers from central to local authorities. This when applied in the health sector and effectively implemented, health service delivery (dependent variable) will be improved by provision of adequate health personnel to run health centres, improved quality of services by having enough drugs and medicine and enough physical facilities and equipment such as beds, electricity, laboratory, well equipped theatre among others. However, there must be enough funding, favourable political environment and controlled corruption within the health service system for decentralization policy to have a great impact on health service delivery. Health service delivery can be represented in a system's perspective, with inputs, processes, outputs, and outcomes some of the core inputs that are deemed necessary for health care delivery are financial resources, competent health care staff, adequate physical facilities and equipment, essential medicines and supplies, current clinical guidelines, and operational policies.

CHAPTER TWO
LITERATURE REVIEW

2. 0 Introduction

This chapter reveals the different literature of scholars and studies that have been done concerning decentralization locally, nationally and internationally. The chapter also presents literature related to health service delivery as will be reflected by this study themes.

2.1 Elements of Decentralization

Uganda's current decentralization was born from both the exigencies of a guerrilla war and ideological conviction. First, in Luweero district which was the initial area occupied by Museveni's guerilla force, a political local people-based infrastructure, named the Resistance Councils, which aimed at cultivating and sustaining support for the National Resistance Army (NRA) was secretly organized in tile areas which the guerrillas captured and occupied. Owing to the size of the area under NRA control, the civilian population was big and NRA could not be everywhere to police them, it (NRA) therefore asked them to elect among themselves people they trusted as their leaders and the first resistance council (RC) to be established was in Kanyanda, (Kuteesa, 2008).

The elements of decentralization can be highlighted below;

Deconcentration – the transfer of administrative responsibilities from the central government to local governments within a central government ministry or agency.

This process of delegating some powers of decision-making processes is moved closer to consumers from the centre to elected officials of its own. It is an administrative decentralization (Daun, 2007) that involves handing over "more routine authority and decision-making powers from a higher level of the central government to lower levels (regional, district, cluster), still accountable to, and staffed by, the central ministry" (Shaeffer, 1994 quoted in Daun, 2007, p. 32).

Delegation – the transfer of managerial and administrative responsibilities of central ministries for specifically defined functions to organizations that are external to the regular bureaucratic structure.
Delegation implies some degree of decision making is given to the local bodies. However, power and authority still with central authority and the power can be withdrawn easily from the local bodies (Daun, H. 2007).

Devolution– the substantial transfer of powers and authority and functions from higher or central government to local units, upon which the local units or governments subsequently acquire significant and autonomous financial and legal powers to function without reference to central government.

Privatization – the transfer of responsibilities to private or individual companies in a process by which service delivery is made by private companies who win tenders through a competitive tendering process administered by the government agency.

The Ugandan Ministry of Finance, Planning and Economic Development (MFPED) argues that devolution features prominently in Uganda (MFPED,1998). One of the main features of devolution is the ability of local governments to exercise both financial and political autonomy. This paper will illustrate that decisions at local government are frequently influenced and/or affected by the financial and political dependence of local governments on the central government. This feature eliminates devolution as a decentralisation practice in Uganda. A close look at the implementation of the decentralisation policy indicates that the decentralisation system in Uganda can well be described as a mixture of delegation, deconcentration and privatisation. Most of the public services are currently being offered by private firms who through competitive bidding are awarded tenders to provide services.

Most advocates of decentralization argue for it not just as an end in itself but rather as a means to enhance development. Many arguments have been put forward in favour of decentralization. It has been argued that decentralization increases citizen/popular participation in political, economic and social activities (Blair 2000, Ribot 2002, Robertson 2002,). The assumption is that as government comes closer to the people, more people will participate and will have a meaningful role in local government decisions that affect them (Blair, 2000).

In recent years, many states in the world have been experiencing rapid decentralization, not only in developed countries but also in transitional and developing countries. One of the strongest arguments for decentralization is that shifting the authority and function of planning and service delivery to the local level would reflect the needs and priorities of the people better, and would deliver services more effectively. However, this argument is based on the assumption that people are guaranteed voice and influence on the decision – making of local governance that affects their daily lives, and that they can hold local governments and councilors accountable. It also assumes that they are actually capable and motivated enough to collectively collaborate to participate in local governance.

Uganda's history of turmoil, mass struggle and reconstruction has a lot to tell us about the nature of decentralization today. The present decentralization is largely based on the Resistance Council system that was first established during the civil war of 1981-1985. The general philosophy of decentralization is then closely related to the 1980s National Resistance Movement (NRM) liberal struggle whose teen point program had the first objective as to create a local government a system that would be democratic participatory, efficient and development oriented, indicating also, that the system would empower communities to take charge of their destiny through local institutions of self-governance and resource mobilization (Nielsen, 1996:2).

The civil war in the 1980s is normally traced to the 1980 elections (Tukaheebwa, 1998), but Ddungu and Wabwire (1991) strongly argue that the fundamental causes of the armed resistance cannot be sought in a single instance of rigging an election. Rather armed insurrection results from the gradual accumulation of contradictions and the level of development of social forces in a given environment broad causes of the armed insurrection in the 180s are traced to the crisis of the post-colonial state manifested in military take- over, state repression and economic crisis.

2.2 Impact of decentralization on health service delivery

Since the launch of the Health Sector Strategic Plan II in 2000, the MoH together with its cooperating partners have directed their efforts towards increasing the staffing levels in various facilities, building the training capacity of health training institutions to improve the quality and quantity of output, as well as providing tools and an enabling environment for improved work performance. These efforts were further enhanced by the Global Health Workforce Alliance Kampala declaration of March 2008 that emphasized the need for collective and sustainable political, structural, systemic and economic interventions to address the global health workforce crisis (MoH 2009c, Musoke & Candia 2009 p.2). In response to this crisis, the Government of Uganda (GoU) has instituted many reforms and initiatives that will be described in this paper including motivation and retention strategies, new incentive programmes, and improved performance management systems.

In health, the immunisation programme shows a marked success through decentralisation. Nsibambi (1998) points out that in Bushenyi district, the *District Three Year Development Plan, 2001–2004* indicated that district service coverage of immunisation was 80 per cent. This programme succeeded largely because of the involvement and participation of local leaders in mobilising local people. The local council officials, especially the local council secretary for women and health, were instrumental in mobilizing people to take children for immunisation.

Similarly, provision of medical care and services has fallen far short of local needs through lack of finances. A survey of health services conducted in 1996 found that the most common problem facing the health sector was that no drugs were being provided to patients. This was because most of the grants transferred to districts for health had been used for salaries In addition, the lower tiers of government lacked the ability to manage public finances and maintain proper accounting procedures. Spending on primary healthcare halved, from 33 per cent to 16 per cent, during decentralization (WHO, 2006). It should be noted that for decentralisation to achieve its targets, there has to be high level of public accountability. However a number of problems with regard to accountability have been registered and therefore the researcher seeks to find out the impact of decentralisation on service delivery as well as the problems encountered plus the possible measures that can be implemented to close the gap.

A recent study of the extent of decentralization among thirty African countries characterizes Uganda's policy of decentralization as among the most advanced on the continent (Ndegwa 2002). In fact, Uganda earned among the highest scores on the indices of political, administrative, and fiscal decentralization (Ndegwa 2002). District councils in Uganda are now responsible for decision making and policy implementation in several important policy areas, including: education policy through secondary school; health policy, especially concerning hospitals in the district; water policy; road policy, excluding major roads for travel between districts; and agricultural extension (Uganda 1997a). Local councils (LCs) have also been given the responsibility to monitor and supervise the activities of civil society organizations (CSOs) in their areas (Uganda 1997a).

2.3 Challenges in public health service delivery in a decentralized system

Decentralization of services and human resources is a challenge in itself, whereby low resourced and unskilled districts are given the responsibility to plan and deliver health services with a constrained human resource structure and budget. Evolution of this system is still in its early stages, as it is undecided

which responsibilities will lie with the districts, and which will remain at the centre.

The inability of health systems to recruit and retain sufficient numbers of health professionals – especially skilled workers – is one of the biggest challenges for the health sector (MoH 2009a). On the other hand, the lack or inadequacy of service providers is due to slow and lengthy recruitment processes, delays encountered in accessing the pay-roll, and high absenteeism. The high absenteeism may be due to lack of accommodation on site but also low morale because of poor remuneration and poor HR management.

Difficulty in attracting and retaining service providers is particularly critical in the remote, rural and insecure difficult-to-reach and difficult-to-stay districts. Many of these districts do not have personnel officers to declare the vacant posts for recruitment in addition to maintaining the personnel records of the health workforce in the districts. In fact, many of these remote districts have no functional District Service Commission (DSC) (which are tasked with recruiting health personnel for the districts) coupled with inadequate resources to recruit skilled personnel (MoH 2009b p.12).

The human resource policy (MoH 2006 p.2) reveals that medical doctors, dentists, pharmacists as well as diagnostic personnel are extremely unequally distributed throughout the country, serving only a fraction of the population. The policy further indicates that the greater majority of Ugandans rely on associate health professionals for clinical, nursing, midwifery, diagnostic, therapeutic and rehabilitative health services. This creates a lot of work pressure on the associate health professionals. The policy further reveals that there is a heavy urban/rural imbalance, with an extremely heavy bias towards the central region.

Other cross-cutting challenges include;

Lack of transparency in the allocation of resources

Lack of transparency in the allocation of resources and weak budgetary procedures with regard to record-keeping and auditing. In education, for example, there was disproportionate distribution of finance to the schools, with the poor schools receiving less or nothing of the capitation grants. Parents and students had little or no information regarding the amount of the capitation grant entitled to them.

Kayizzi-Mugerwa (1999:42) argues that the success of decentralisation will depend on the capacity of districts and urban governments to raise their own revenue and use it efficiently in the provision of services. However, the generation of local revenues is limited, with local governments largely depending on central government financial transfers. In the 1990s, on average, only 13.2 per cent of revenue in Uganda could be generated locally (Saito 1999).

Abolition of graduated tax

A national graduated tax had been operational for many years until 2006. With the introduction of decentralisation, many districts started to charge education, environment and sanitation, and health taxes along with graduated tax. These additional charges specifically targeting certain service sectors substantially contributed to the service delivery in these sectors. Graduated tax, however, was removed in 2006, leaving these districts financially paralysed.

The abolition of the Graduated Personal Tax (GPT) meant that the local and urban governments had limited financial sources to finance public services, as is the case with education and health cited above. As a result there has been an increase in the reliance by local governments on central government.

Lack of financial self-sufficiency

This affects the implementation of development plans and consequently limited service delivery since most of funds are diverted before they reach their final destination.

The Ministry of Finance, Planning and Economic Development survey on health and agricultural service delivery in Uganda (1998) found that there was deficiency in the percolation of funds allocated to these sectors. Despite the bid for financial autonomy implied by decentralisation, the central government still provided funding for major services at local government level. However, provision of funding suffered diversion in the process of allocation to local governments. MFPED and MAFAI (1998) thus reported a shortage of incentives and facilitation for districts. This resulted in the inability to deliver Agricultural Extension Services (AES) to grassroots farmers.

Analysis of most district budget estimates for the 1997/1998 financial year showed that only 1 per cent of the total expenditure was allocated to AES. It should be pointed out that the most daunting challenge facing decentralisation as a framework for service delivery is a lack of capacity and personnel at sub-national government level to exercise responsibility for service delivery. The lower-level governments lacked the ability to manage public finances and maintain proper accounting procedures. As a result, lower levels of funding reached the local level.

Lack of funding at the local levels

In the first instance, decentralisation led to staff retrenchment through civil service reform. In the agricultural sector the Agricultural Extension officer–farmer ratio was 1:1000–3000 in 1998. The wider area covered by each extension officer meant that few farmers had access to these services. On average, the proportion of farmers contacting Agricultural Extension Officer was only 10 per cent. In Tororo district, AE staffs were deployed only up to sub-

county level and had limited direct contact with farmers. In Bushenyi, Muriisa (2001) found that whereas extension workers had motorcycles to use to visit farmers, they only had a monthly allocation of 25 litres of fuel for extension work. Only 1 per cent of farmers were receiving extension services.

The same problems of shortfalls in funding and personnel were observed in health, with limited medical personnel and medicine, and in education with limited teaching staff. Spending on public health, as earlier mentioned, fell from 33 per cent to 16 per cent during decentralisation (Akin, Hutchinson, and Strumpf 2001), while, as also noted, increased enrolment of primary school children during UPE resulted in overcrowding and low staff capacity to handle large classes. The increase in school enrolment was not marched by increased recruitment of new staff (UNDP 2004).

Gap between service providers and beneficiaries

Another challenge of decentralisation to improved service delivery is the perception gap between service receivers and providers about the benefits of the policy. According to Saito (1999), on the one hand, the public service officials perceive that decentralisation improves control and the mobilization of resources, and on the other, the service receivers perceive that services have not improved in recent years.

Greedy politicians

Decentralisation as an approach to service delivery is limited by the failure of politicians to cede political power to the local governments. Golola (2003) maintains that politicians at the centre have little wish to cede power to the local governments. They propose reforms including decentralisation when they expect benefit for themselves. This failure to cede power by politicians at the centre limits democracy and autonomous decision-making at the local level.

One of the objectives of decentralisation is to transfer real power to the district and thus reduce the load on the 'remote' and under-resourced central government

officials. These officers are often remote in terms of geographical distance and frequently unknown to the local people in terms of language, culture, interests and values (Murembe, Mokhawa and Sebudubudu 2005).

Political conflicts with civil servants

Implementation of the decentralisation programme is disfigured by the conflicts between the politicians and the civil servants. Largely, conflicts emerge from the demand for accountability by the civil servants from the politicians. In several districts, there have been conflicts between the Local Council Five (LCV) chairman and the Residence District Commissioner, for example, Ntungamo and Kiruhura districts. In the *Daily Monitor* for 20 August 2007, it was reported that the Ntungamo RDC claimed to be under threat from the LCV chairman because he demanded accountability and had exposed the LCV chairman's corruption practices. In Kiruhura, the acting RDC reportedly resigned, citing corruption and intimidation from elected representatives.

Another limitation of the decentralisation policy comes from the response to externally determined programmes that differ from local needs. In one district, residents argued that funds to implement decentralisation were usually obtained from donors who fund specific projects even when these may not be priorities of the local area. In the district, members cited an example of a road recently constructed in the area, but pointed out that if they were given a choice, they would have preferred equipping the health centres with medicine.

In terms of accountability, the lack of financial autonomy and insufficient funds to facilitate local government officials means that many of the local government officials including councillors have remained voluntary, without compensation. Such people are difficult to hold accountable to the local communities (Golola 2003). There is increased corruption by these officials who try to compensate themselves by misappropriating funds and by extortion from the citizens. In the decentralised framework, I can rightly assert that there is decentralisation of

corruption. This is a big challenge to service delivery because much of the available financial resources end up enriching individuals employed in the public sector, particularly local governments.

In summary, only a handful of studies have examined the effects of decentralization on other aspects of equity, such as equity of access, utilization of health services, or health outcomes. In Ghana, decentralization is believed to have led to more equitable access to care due to increasing budget allocations to districts and more direct control of spending decisions (Agyepong 1999). In Zambia, access to health care and consumer satisfaction actually worsened during decentralization and health sector reform (Blas and Limbambala 2001), Mexico also reported no improvement in equity of access or quality of care (Alvarez-Guttierez 1990). In Uganda, while decentralization was initially associated with declining expenditures on primary health care, the greater fiscal autonomy provided by decentralization increased utilization of all health services – both public and private goods (Hutchinson, Akin, and Ssengooba 2003).

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter presents the research methods the researcher used to collect data. It presents mainly the research design, population of the study, sampling procedure and techniques, sample size, data collection instruments, how data will be analysed and ethical procedures which were followed before collecting data.

3.1 Research Design

The study employed descriptive and comparative designs to generate the desired methods and data for the research process. These designs helped the researcher to generate descriptions on the process of decentralisation and how it affects public health service delivery. The designs employed the use of questionnaires and in-depth interviews which were conducted between the different types of respondents.

3.2 Study population and area of study

The study focused especially on the local people in Makindye division. It also involved the participation of local government officials and health service personnel at health centres III & IV who oversee the performance of public health facilities in Makindye division, Kampala district. This diversity in the study population helped the researcher to generate a wide range of ideas and information which enabled the researcher to make comparison in views possible hence having comprehensive results at the end of the study.

3.3 Sampling procedure and technique

The researcher developed a list of all Parishes and zones in Makindye Division with the help of the Kampala district administration. From each Parish or zone a representative sample was sampled according to the number of occupants. The researcher made a survey of the Division to find out the health centres that provide health services under the local government such that they could also be sampled.

Simple random sampling was used to select a representative number of local people from the selected Parishes and zones. Local people were allocated numbers according to the names on uniform cards which were put into the container, shaken well to mix and the researcher picked the numbers randomly until the sample number is obtained. This was important to avoid bias and give each respondent an equal chance to participate in the study.

3.3.1 Sample Size

A sample size of 90 respondents was obtained from the study population and this was distributed in the ratios of 50 local people, 10 local government officials, 10 LC I chairpersons and 20 health workers including doctors, nurses, midwives and their supervisor in Makindye Division. The local people were distributed according to gender in ratios of 30 women and 20 men. This distribution is adopted because women need access to health facilities more than their male counter parts.

3.4 Sources of data

Data was collected from two sources, the primary source and secondary source.

3.4.1 Primary source

This is the field from which the researcher interacted with the respondents and collected firsthand information. It was helpful to the researcher to obtain data that that was used as findings of the study which were discussed to draw final conclusions and research recommendations.

3.4.2 Secondary source

This is where the researcher obtained the data that was already written about the topic understudy. It helped to review the literature of the study and help the researcher to cite the areas of agreement and disagreements that the authors had and how such existing gaps could be filled by this research.

3.5 Methods and tools of data collection

3.5.1 In-depth interviews

In-depth interviews were used to collect data from local government officials and health workers working in Makindye Division. This was done by the researcher through holding face-to-face conversations with respondents. This method was selected because it catered for collection of data from people who had busy schedules and well versed with issues relating to decentralisation and health service delivery and could serve for the purpose of knowledge questions. It also gave the researcher a chance to seek for clarification and more understanding of the concepts under study and also to observe facial expression from the respondents.

3.5.2 Questionnaire

Questionnaires were used to collect data from local people. These were people who are mobile and could not get enough time to attend interview sessions. It also gives respondents enough time to think about questions before they are answered. Multi choice questions were used to help the researcher carry out the process of data collection within the shortest possible time.

3.6 Data analysis

Data collected was analyzed using descriptive statistics like logical arithmetics, thematic analysis and personal communication to code and edit to group the related data into themes of objectives. This was selected because the research is more of qualitative descriptions which could easily be quantitatively analyzed. Computer packages like Excel were used to group related data into simple percentages to present the data in form of tables and charts.

3.8 Ethical consideration

The researcher obtained a recommendation letter from the KIU-Faculty of Social Sciences allowing him to go for data collection which were presented to the leaders and the general respondents to allow her collect data from their areas and organizations. This assisted the researcher in drawing arrangements with the

local people on the convenient time for holding interviews and dissemination and collection of questionnaires from the respective respondents.

The researcher tried as much as possible to show the highest level of discipline by respecting the respondents irrespective of their ages or social status so as to portray a good image of the researcher and the institution respectively.

The researcher also did his best to get to the field and reach out to every respondent and follow every step of the research so as to avoid forgery and make generalizations about the study based on reality and empirical evidence.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

4.0 Introduction

This chapter presents, analyses and interprets the findings of the study and they are done according to themes of research objectives.

4.1. Biographic feature of respondents

This subsection examines the biographic features of respondents and how they influence the final finding of the study.

Table 1: Biographic data of respondents

Responses	Frequency	Percentage (%)
Gender		
Male	51	57
Female	39	43
Total	**90**	**100**
Age		
Below 25 years	07	08
25-34 years	36	40
35-44 years	21	23
45-54 years	15	17
55 years and above	11	12
Total	**90**	**100**
Marital status		
Single	23	25
Married	44	49
Divorced	08	09
Widowed	15	17
Total	**90**	**100**
Education level		
Never been to school	07	08
Primary level	13	14
Secondary level	26	28
Tertiary	45	50
Total	**90**	**100**
Designation		
Student	08	09
Health worker	06	07
Local leader	14	15
Civil servant	38	42
Business person	24	27
Total	**90**	**100**

Source: Primary data, 2015

Basing on the study findings, 57% of the respondents were male and 43% of the respondents were females. This indicated that men were more active in local government activities than their female counterparts. The local councils had a big number of men than women and women were not active in governance as they opted for family maintenance work. However, since the study is related to health service delivery, the involvement of women in this study was very important because they are the most affected when it comes to health related issues.

Regarding age of respondents, findings showed that 08% of the respondents were below 25 years of age, 40% of the respondents were between the age 25 to 34 years of age, 23% of the respondents were between the age of 35 to 44 years of age, 17% of the respondents were between the age of 45 to 54 years of age and 12% of the respondents were 55 and above of age. This indicates that the study involved basically mature people and their responses were valid to the research problem.

On marital status, results indicated that , 25% of the respondents were single, 49% of the respondents were married, 09% of the respondents were divorced and 17% of the respondents were widowed. This showed the married people were the most active participants and parties in the local government. Married people participated more in than any other categories this was attributed to the fact that people entrusted their votes with people who had responsibility like families because they are mature enough to take constructive decisions regarding health related issues as per this study.

Findings on education level of respondents showed that , 8% of the respondents had never been to school, 14% of the respondents had completed primary level, 28% of the respondents were of secondary level and 50% of the respondents were of tertiary level of education. This showed that people who are concerned more about decentralization were highly educated as they can easily interpret the polices that are put in place.

From the study findings information regarding respondents' designation showed that, 09% of the respondents were students, 07% were health workers while 15% of the respondents were local leaders, 42% were civil servants and 27% were business people. This indicates that the study focused more on the local officials and central government civil servants as they are the ones most equipped with knowledge about decentralization in matters pertaining to delivery of social services in Makindye Division. In this regard, health service delivery was focused on.

4.2 Impact of decentralization on public health service delivery in Makindye division.

The first objective of this study was to examine the impact of decentralization on public health service delivery. This was intended to assess the benefits of decentralization in regard to provision of health services to communities especially in Makindye division. It was also intended to assess how services are delivered and status of health facilities in the area.

Basing on the results, it was indicated that health service delivery has greatly improved due to extension of health facilities at different community levels for example establishment of health centre III managed by KCCA made it easier for community members to access health services at a fair cost that can be afforded by the poor compared to the previous years before their establishment.

Results showed that the government has therefore tried to respond to local people's out cry for the shortage of health services through the following measures as cited by the respondents in Makindye division.

Table 2: Impact of Decentralisation on public health service delivery

Responses	Frequency	Percentages (%)
Emphasis on accountability	34	38
Establish mutual public health goals through community collaboration	15	17
Provision, management and maintenance of primary health care	19	21
Establishment of new health centres	22	24
Total	**90**	**100**

Source: Primary data, 2015

Emphasis on accountability

The respondents (38%) cited that the government has now put more emphasis on the accountability and submission of expected reports in relation to the funds allocated to boost health service delivery to the citizens. This happened after the Ministry of Finance, Planning and Economic Development survey on health service delivery in Uganda (2008) where it was discovered that there was deficiency in the percolation of funds allocated to the sector and provision of funding suffered diversion in the process of allocation to local governments hence government's intervention to ensure proper accountability and allocation of the budgetary funds to the expected destinations hence improving health service delivery.

Establish mutual public health goals through community collaboration

The government is now pushing for community participation and collaboration in the provision of health services. This was submitted by 17% of the respondents. They said that government through its agents like KCCA has established more health facilities and called-upon the public as stakeholders to

participate for examine in the monitoring of performances by the health personnel in their respective communities. Through this initiative, public health services have improved in terms of delivery for example attendance of nurses and doctors at the allocated centres than before when they would absent themselves. There are however complaints that health workers are not well motivated in terms of remuneration which is also a challenge on the side of attending to patients.

Provision, management and maintenance of primary health care

From the study findings, 21% of the respondents showed that improving, management and maintenance of primary healthcare will help to improve public health service delivery. It was attributed that although primary health care was introduced through decentralization, some important decisions and responsibilities remained at the centre. For example, staffing decisions in health are made at the district level but district funding comes largely from the central government in the form of conditional grants with explicitly identified uses.

Provision of reproductive healthcare

The findings (24% of the respondents) attributed that the government has now put more emphasis on the provision of reproductive health care especially to women and children /adolescents with the strategies focusing on eliminating barriers and improving access to health care for both women, children and adolescents. This is also addressed in community collaboratives such as the Children's Mental Health and Family Services collaboratives, children's issues can be discussed, and regular communication and planning by all important community members can influence the community as a whole. Information obtained can be shared with all agencies and community members for improvement.

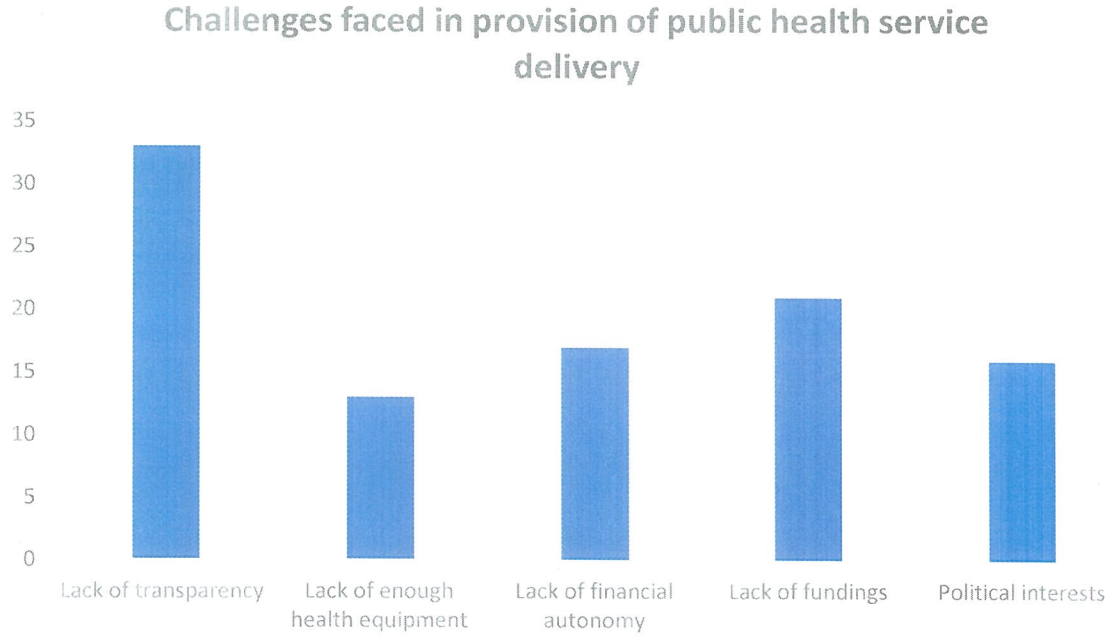
4.3 Challenges faced by local governments in ensuring delivery of public health services to the local communities

This was aimed at examining the challenges faced by local governments in ensuring effective and efficient delivery of health services.

Table 3: Challenges faced by local governments in ensuring delivery of social services to the local communities

Responses	Frequency	Percentages (%)
Lack of transparency in the allocation of resources	30	33
Lack of enough health equipment and personnel	12	13
Lack of financial autonomy	15	17
Lack of funding at the local levels	19	21
Political interests	14	16
Total	**90**	**100**

Source: Primary data, 2015



Source: primary data, 2015

Lack of transparency in the allocation of resources.

Respondents revealed that lack of transparency in allocation of resources (33%) and weak budgetary procedures with regard to record keeping and auditing is one of the challenges faced by decentralization system in provision of health services. This is because at times, health centres do not receive the allocated capitation grants and sometimes the beneficiaries or local communities are not aware of the grants entitled to them hence poor health service delivery.

Lack of enough medical personnel and equipment

Respondents (13%) indicated that although the government tries to allocated doctors/nurses/midwives at health centres through Kampala district, some of them health personnel do not reach at the allocated destinations. At times due to low remuneration from the government, they are hired by private hospitals hence terminating their contracts at the public health centres. This in most cases leaves unprofessional medical personnel to manage health centres and consequently poor service delivery. Respondents added that sometimes health centres do not have enough equipment like beds and at times patients are forced to go and buy drugs from the surrounding private clinics because they are not there at the health centre this does not only affect the patients but also gives a bad impression to the governments decentralized health centres.

Lack of financial autonomy

Respondents attributed that provision of funding to the local government and the private sectors is suffering from diversion in the process of allocation and this resulted into inability to effective running of the health centres. This is why at times there are no drugs at the health centres and sometimes utility bills are not meant which forces service providers like National water and sewerage corporation and Umeme to cut off their services, this is a big threat to the provision of health services at the health centres. The respondents from Mubaraka Makindye west endorsed that their local leaders have failed to extend safe water to the nearest homesteads, and in turn, that's is why there are so many cases of typhoid reported in the area.

Lack of enough funding at the local levels

According to the respondents (21%) submitted that in the decentralized system there is a problem of shortfalls in funding and personnel due to staff retrenchment where this has been observed in some public health centres in Makindye division with limited medical personnel and medicine. Respondents added that lack of enough fundings leads to recruitment of unqualified personnel that can go with any salary and wage payment which leads to poor service delivery and increase in corruption cases because of low wages and salaries.

Political interests

According to the findings, 16% of the respondents established that political interests by some greedy politicians have failed to give up power to the local governments simply because when they propose reforms like decentralisation, they expect benefits for themselves. This was cited by 16% of the respondents with the view that in Makindye division these politicians especially those from the opposition side, fail to support government initiatives to improve health service delivery in Makindye, some of them are fighting for political gains which limits decision making at the local level and as a result poor service delivery. They also added that Implementation of the decentralisation programmes in regard to public health service delivery is spoiled by the conflicts between the politicians and the civil servants. Largely, conflicts emerge from the demand for accountability by the civil servants from the politicians.

Respondents also submitted that lack of access to health insuarance by majority of the people in Makindye division is a big challenge. This limits them from monitoring their health status and prevent the likely health related tragedies that may occur.

4.4 Possible measures that can be implemented to ensure equitable and effective delivery of public health services

This was intended to establish the measures that all stakeholders were putting place to solve the problem of poor public health service delivery in Makindye division.

Table 4: Possible measures that can be implemented to ensure equitable and effective delivery of public health services.

Responses	Frequency	Percentage
Encourage development of regional and community health insurance options for small employers and self-employed individuals.	30	33
Motivation of health workers	12	14
Laws/ punishment to corrupt officials	28	31
Public private partnership	20	22
Total	**90**	**100**

Source: Primary data, 2015

Encourage development of regional and community health insurance options for small employers and self-employed individuals.

The study results, 33% of the respondents showed that there is need for the government to develop a regional and community health insurance options for small employers and self-employed individuals. This will help people to have access to affordable health insurance coverage so that health care costs can be reduced right from household level even congestion in public health centre will be reduced since insurance covers sometimes includes treatment from private health centres.

Motivation of health workers

Basing on the study results, 14% of the responses indicated that the government should make all efforts to increase the salaries of health workers. This will

motivate them thus leading to effective service delivery by reducing on the rate of absenteeism among health workers as well as attracting professional health workers in the system.

Public-private partnerships

in addition to motivation, respondents said that if the government put more emphasis on public-private partnerships in the health sector, it will improve its service delivery because different shareholders will join hands to ensure that all health centres are well facilitated both with human and materials resources and this will lead to improved public health service delivery not only in Makindye division but also the entire country.

Implementation of strict laws

Corruption among local government officials was reported to be among the challenges in the public health service as some funds meant for medicine are diverted to other personal benefits. From the study findings, 31% of the responses showed that laws were being put in place to solve the problem of corruption within the local government in Makindye Division. These were being emphasized with punishing those particular people who violated those laws. Corrupt officials are being interdicted, imprisoned and their properties being confiscated by government to regain the lost funds. Others are being chased from offices such that other officials who thought of getting corrupt would learn a lesson and fear getting involved in the bad practice.

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter gives summary of the research findings and draw conclusions based on the findings. The summary and conclusion have been drawn according to the objectives of this study which were to examine the impact of decentralization on public health services delivery in Makindye division, examine the challenges faced in delivering public health services and to come up with possible measures to the problems encountered in health service delivery. Researcher's recommendations are also indicated.

5.1 Summary of finding

The study found out that decentralization has led to the establishment of mutual public health goals through community collaboration, establishment of new health centres and improvement of primary health care. This impact has made a great improvement in health service delivery to the public. Additionally findings showed that there are different challenges faced by the local government in the implementation and delivery of public health service to the local people which included lack of transparency and accountability to the funds allocated, poor health facilities, lack of medicine/drugs and lack of enough health workers at the facilities, absenteeism among health workers and at times congestion which results in the poor service delivery to the local people.

Due the above challenges the government has tried to respond through putting more emphasis on accountability for the funds granted, establishing primary health care programs, public private partnership which all are intended to improve health service delivery. for the construction and development of health infrastructure /facilities in terms of hospitals and other facilities like water tanks including management and maintenance of primary health care through allocating more grants plus strict regulations on the service providers and

extension health workers.

Different counter measures were being put in place to ensure that decentralized system is effectively and efficiently realized by the local people through improved social service delivery. The measures included, formation legislation and administering punishments to corrupt officials and the installation of IGG offices to monitor the activities and performance of local governments.

Lack of access to affordable health insurance coverage is becoming an increasing reality for many Minnesotans as health care costs rise at double-digit rates. This is particularly true for small business employees or self-employed individuals. Rural areas, where small businesses and self-employment is common and choices are limited, are especially affected. Underinsurance shows up in higher deductibles and co-pays, and limitations on health care options.

5.2 Conclusions

According to objective one of the study which aimed at identifying the challenges faced by decentralization which have significantly affected the system and resulted into poor service delivery. The challenges identified were lack of transparency and accountability, abolition of graduated tax, lack of funding at the local levels where by lack of transparency was the most prominent challenge at 33% of the total responses collected. In line with objective two of the study the government has tried to respond to the challenges through putting more emphasis on accountability, increased the percentage of funding to the social services and transformation of primary health care program which is intended improve on the health status and wellbeing of local people who comprises the biggest percentage of the population.

In accordance with objective three of the study, Strategic measures were being put in place to solve the problems encountered in the implementation and delivery of improved social services to the local people in Makindye division which included decentralization, auditing legislation and punishments and the installation of office of the IGG. However none of the above measures was

working effectively as the problem of corruption still existed in the area. This was being attributed to central government interference into activities of the local governments, ignorance of the local people, corrupt judicial system, political fear and poor law implementation.

Decrease barriers to health care. Women and children who do have insurance through private or Medicaid services continue to face other barriers to receiving preventive health care and early identification of health problems. Transportation, childcare issues, and the inability of a parent to take off work are health care barriers, which families confront. Promoting school-based health centers will decrease some of these concerns for school-aged children.

5.3 Recommendations

The following recommendations have been drawn from the study:

There should be separation of power between the central government and the local government. This will help in making independent decisions hence ensuring accountability.

Local leaders should have good will for the development of the communities. This will help to use government funds carefully to meet the needs of the targeted beneficiaries other than the personal aspirations.

Local communities should be educated on their rights and obligations in taking part in controlling their development. This will help them to identify the corrupt officials and where they can report them.

The government should come up with strict laws and punishment for the corrupt officials so that other people can learn lessons from the corrupt officials who have been punished.

REFERENCES

AMREF (2002). The Cost of Training a Comprehensive Primary Health Worker, Kampala.

Arvessm G and Chatora R (2003). Migration of health professionals in six countries: A synthesis report Draft Report for WHO.

Bardhan, Pranab and Dilip Mookherjee 1998. "Expenditure Decentralization and the Delivery of Public Services in Developing Countries," Department of Economics, University of California, Berkeley, mimeo.

Bardhan, Pranab and Dilip Mookherjee, 2000. 'Decentralising Anti-poverty program delivery in Developing countries,' University of California, Berkeley, Working paper— Web site: http://econ.bu.edu./dilipm/wkpap.htm/wkbpaphmpg.html.

Bataringaya J et al (2002). The framework for Public Partnership in Health, Uganda Health Bulletin, Vol 8 editions 3 & 4: 294-300.

Besley, Timothy and Stephen Coate (1999). "Centralized versus Decentralized Provision of Local Public Goods: A Political Economy Analysis," NBER Working Paper no. 7084.

Crook, Richard, James Manor, 1998, Democracy, Decentralisation in South Asia & West Africa: Participation, Accountability & Performance, Cambridge, Cambridge University Press.

Inbanathan, Anand and D. V. Gopalappa, 2003. Fixers, patronage, `Fixing', And Local Governance in Karnataka, Sociological Bulletin, 52 (2): 164-185.

Johnston, Michael. 1979. "Patrons and Clients, Jobs and Machines: A Case Study of the Uses of Patronage." American Political Science Review 73(2): 385–98.

Karlstrom, Mikael (1996) "Imagining Democracy: Political Culture and Democratisation in Uganda.

Konde-Lule J et al (2006), The potential of the Private Sector to Improve health outcomes in Uganda, Makerere University.

Langseth, Peter (1995) 'Civil Service Reform in Uganda: Lessons Learned,' Public Administration and Development,

Langseth, Peter, J. Katorobo, E. Brett, and J. Munene ed. (1995)Uganda: Landmarks in Rebuilding a Nation (Fountain Publishers,

Matsiko CW (2001). Motivating health workers: Will it improve health care indicators? Uganda Health Bulletin 2001 7 (4); 38-9.

Matsiko CW (2005). Assessing Effectiveness of Standards for Labour Utilization for priority health interventions in Uganda, A dissertation submitted in partial fulfilment for the award of a Ph D, Cambridge Management Institute, Cambridge.

Mbonye A (2001). The Structure of The Ministry of Health: Is there room for democracy and motivation? Uganda Health Bulletin 2001 7 (1); 21-23.

Migdal, J.S. (1995)Strong Societies and Weak States,Ministry of Gender and Community Development, 'Country Report in Preparation for the Fourth World Conference on Women 1995'

Ministry of Health Uganda (1999). The Health Policy of Uganda.

Ministry of Health Uganda (2000), Health Sector Strategic Plan I, 2000/01-2004/05, Kampala, Uganda.

Ministry of Health Uganda (2002a). Health Facilities Inventory, October 2002.

Ministry of Health Uganda (2002b). Nursing Assistant Training Modules, by AMREF and Ireland Aid, 2002.

Ministry of Health Uganda (2004). Human Resources for Health Inventory, Ministry of Health & DANIDA.

Ministry of Health Uganda (2007). Health Management Information System reports. Available at: www.health.go.ug.

Ministry of Health Uganda (2008a). Mapping the Human Resources Management Processes in Uganda.

Ministry of Health Uganda (2008b). Policy for Mainstreaming Occupational Health & Safety in the Health Services Sector

Ministry of Health Uganda (2008c). Motivation and Retention Strategy for Human Resources for Health.

Ministry of Health Uganda (2009a). Bi-annual Report.

Ministry of Health Uganda (2009b). Uganda Health Workforce Satisfaction and Intent to Stay Among Current Health Workers (unpublished).

Mulyampiti, Tabitha (1989) 'Political Empowerment of Women in Uganda: Impact of Resistance Councils and Committees' MA Thesis for the Department of Women Studies, Faculty of Social Sciences, Makerere University Kampala.

Neilsen, Henrik A. 'Decentralisation Experience: From Noakhali to Rakai' in Villadsen and Lubanga ed. (1996)

Obbo, Christine "Healing Cultural Fundamentalism and Syncreticism" Africa 66(2) 1996

Okuonzi, Sam A. and Francis X.K.Lubanga . (1995) 'Decentralization and Health Systems Change in Uganda' A Report on the Study to Establish Links between Decentralization and Changes in the Health System

Ottemoeller, Dan (1998) "Popular Perceptions of Democracy: Elections and Attitudes in Uganda'Comparative Political Studies.

USAID (2006) Public Health Education in Uganda: a Case Assessment, unpublished

WHO (2012). Commission on Macroeconomics and Health: Investing in Health for Economic Development. Geneva.

APPENDIX A

QUESTIONNAIRE FOR LOCAL PEOPLE

KAMPALA INTERNATIONAL UNIVERSITY

FACULTY OF SOCILA SCIENCES

Introduction

I am **ABWE ILAMBO ELIE** a third year student of Kampala International University. I am doing this research study as part of the requirements for the award of a Bachelors degree in social Work and Social Administration. The topic of my research study is related to "Decentralisation and health service delivery in Makindye Division." The provided information will be treated with the highest level of confidentiality and only be used for academic purposes.

You are therefore requested to answer the following questions to the best of your understanding.

SECTION A: BIO DATA

1. Names (optional).....

2. Sex
   a). Male
   b). Female

3. Age
   a). Below 20 years
   b). 20-30 years
   c). 31-40 years
   d). 41-50 years
   e). 51 and above

4. Marital status
   a). Single
   b). Married
   c). Divorced
   d). Widowed

5. Designation.....

6. Level of education a). Never been to school

b). Primary level

c). Secondary level

d). Tertiary level

7. Place of location.....

SECTION B: INFORMATION ON THE DECENTRALISATION AND HEALTH SERVICE PROVISION

1. What do you perceive as Decentralisation?

   .....

   .....

2. Do you know of any forms of decentralisation in Makindye Division local government and what are they?

   .....

   .....

3. What could be the aims of Decentralisation in Makindye Division local governments?

   .....

   .....

   .....

   What type of health services are provided by the public health centres through the local government of Makindye Division?

   .....

   .....H

   ow does decentralisation affect the performance of public health service delivery?

   .....

   .....

   .....

4. What do you think are the achievements of decentralisation in relation to public health service delivery?

.....

.....

.....

What have been the failures of decentralisation system in your area towards health service delivery?

.....

.....

.....

What do you think are the challenges faced by public health facilities/system in an effort to implement equitable service delivery in your area?

.....

.....

.....

What roles have the communities played to support their local governments towards improvement of health services in Makindye division?

.....

.....

.....

What do you think should the government and the local government do to improve public health service delivery in Makindye division

.....

.....

Thank you very much!!

APPENDIX B

INTERVIEW GUIDE KEY INFORMANTS

Introduction

I am **ABWE ILAMBO ELIE** a third year student of Kampala International University. I am doing this research study as part of the requirements for the award of a Bachelors degree in social Work and Social Administration. The topic of my research study is related to "Decentralisation and health service delivery *in Makindye Division.*" The provided information will be treated with the highest level of confidentiality and only be used for academic purposes.

You are therefore requested to answer the following questions to the best of your understanding.

SESCTION A: BIOGRAPHIC FEATURES

1. Names (optional).....
2. Sex.....
3. Age.....
4. Marital status.....
5. Level of education.....
6. Designation.....
7. Level at which you work.....

SECTION B: INFORMATION ON HEALTH SERVICE DELIVERY

8. What type of health services are given in this centre?
9. How effective is the provision of health services in public health centres in your Division?
10. What do you think has the government done through decentralization system to improve health service delivery?
11. What are the main challenges to public health service delivery in Makindye Division?

12. How does decentralisation affect the performance of public health centres in Makindye Division?
13. What are some of the challenges faced by local governments in ensuring delivery of health services to the local communities?
14. What has been the response of the government towards the above mentioned challenges in (Qn 13)?
15. What measures do you think can be put in place to facilitate equitable and effective delivery of public health services delivery to the communities?
16. What is your opinion on the issue of corruption in relation to local government performance?

Thank you very much!!

APPENDIX C: INTRODUCTION LETTER

KAMPALA INTERNATIONAL UNIVERSITY
EXPLORING THE HEIGHTS

Ggaba Road, Kansanga* PO BOX 20000 Kampala, Uganda
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COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
DEPARTMENT OF APPLIED PSYCHOLOGY

Date: ..14th/04/2015...

To:.....MAKINDYE.....DIVISION.....LOCAL.....GOVERMENT.....
.....KAMPALA/UGANDA.....
.....

This is to introduce to you ..ABWE....ILAMBO....ELIE..... Reg. No. .BSW/37.583/122/..DU.... who is a bonafide student of Kampala International University. He/She is working on a research project for a dissertation, which is a partial requirement for the award of a Degree. I here by request you, in the name of the University, to accord him/her all the necessary assistance he/she may require for this work.

I have the pleasure of thanking you in advance for your cooperation!

Yours sincerely,

OMUYA RONALD

HEAD OF DEPARTMENT, APPLIED PSYCHOLOGY

APPENDIX D: MAP SHOWING GEOGRAPHICAL LOCATION OF MAKINDYE DIVISION, KAMPALA