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FISCAL DECENTRALIZATION AND QUALITY OF PRIMARY HEALTH CARE SERVICES IN UGANDA LOCAL GOVERNMENTS: A CASE STUDY OF KIGARAMA SUB-COUNTY, BUSHENYI DISTRICT

By

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DECLARATION

I, Bamanyisa Bwagi Geoffrey, hereby declare that this dissertation is my own work and has not been produced by any previous researcher for any award and no any person is allowed to reproduce it without permission.

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APPROVAL

This dissertation has been submitted after it has been approved by supervisors:

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DEDICATION

To my dear wife Honest Abenawe and my son Vien who endured loneliness and boredom during the period I was busy undertaking the study.

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ABBREVIATIONS

BCG	-	Bacille Calmette Guerin
DPT	-	Diphtheria Pertussis Tetanus
GoU	-	Government of Uganda
GoT	-	Government of Tanzania
HC	-	Health Centre
LGDPII	-	Local Government Development Programme (Phase) II
LGMSD	-	Local Government Management and Service Delivery (Programme)
HSSP	-	Health Sector Strategic Plan
HUMC	-	Health Unit Management Committee
MCH	-	Maternal and Child Health
MHCP	-	Minimum Health Care Package
MoH	-	Ministry of Health
MDG	-	Millennium Development Goal
PAHO	-	Pan American Health Organization
PHC	-	Primary Health Care
VCT	-	Voluntary Counseling and Testing
WHO	-	World Health Organization

ABSTRACT

The purpose of the study was to asses the effect of fiscal decentralization on the quality of PHC services delivered in Kigarama sub-county for the period 2003-2008. The study design used was cross sectional, correlational case study. The study used a questionnaire, interviews, observation and documentary review to collect data.. Validity was tested using face, content and construct validity. Reliability test was done using Cronbach's alpha test-retest method and it yielded 0.89. A sample of 108 PHC clients was selected to participate in the study. The response rate was 89.8%. Pearson product-moment correlation coefficient was used to assess the relationship between the variables, and regression analysis was used to measure the magnitude of the relationship. Decentralized planning reflected a coefficient of .204 (significant at 0.05,2 tailed), decentralized execution had .243 (significant at 0.05 level, 2 tailed), conditional grants had .262 (significant at 0.01 level, 2 tailed), unconditional grants had .309 (significant at 0.01 level, 2 tailed) and government policies had .437 (significant at 0.01 level, 2 tailed). Decentralized monitoring reflected no significant relationship with a coefficient of -.024 (significant at .814 level, 2 tailed). These results imply that there is a significant relationship between fiscal decentralization and quality of PHC services. Basing on the findings, the study concluded that the small budget does allow implementation of locally generated priorities and this limits the participation of the stake holders at the grass root. Conditions attached to the funding from the centre is does not cater for the priorities generated from the beneficiary community. The study recommended that budget allocation for drugs should be increased to ensure the availability of drugs at the health centre all the time. Conditions attached to the PHC conditional grants should be adjusted to allow flexibility for funding of locally generated priorities. Cost sharing should be

reinstated at client-affordable rates to enable the health centre obtain funding to fill the existing gaps for a quality service.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter presents the background to the study, the statement of the problem, the general objective of the study, the specific objectives of the study, research questions, hypotheses of the study, conceptual frame work, significance of the study, justification of the study, scope of the study and operational definitions. This study was intended to establish the relationship between fiscal decentralization and the quality of Primary Health care services in the local governments of Uganda using Kigarama Sub-county in Bushenyi District as a case study. In this study fiscal decentralization was conceived as an independent variable while quality of primary health care services was the dependent variable.

Background to the Study

1.1.1 Historical Background

World wide, in the last three or so decades, there has been increasing reference to the term "Fiscal decentralization" as a way of managing the resources of the Public Sector in both the developed and developing Countries (Smoke, 2003). Indeed, the classification of governments and constitutions into federal (decentralized) and unitary (Centralized) forms has a long and distinguished pedigree (Charlton, 1986). Better provision of public services in general and improving the quality of primary health care services in particular is one of the impetuses for fiscal decentralization.

The Almar Ata Declaration of primary health care in 1978 has fascinated many countries to implement primary health care within the framework of decentralization (WHO, 2003). In India, fiscal decentralization was used as a policy tool of shifting power and resources from central or regional authorities to local governments to achieve quality of public services (Asfaw *etal*, 2004). Fiscal decentralization has been advocated by health care reformists as a powerful means of improving the provision of public services such as primary health care services (Asfaw *etal*, 2004).

In Brazil, decentralized budgeting has been used to capture the views of the citizenry as a means of making government responsive to public interests and also as a means of monitoring the quality of public services (Shah, 2007).

In Africa, many countries have likewise adopted fiscal decentralization at different periods of time. Kauzya (2007) reports that South Africa, Ghana, Nigeria and Rwanda are among the top African countries that have decentralized powers and resources to a great degree in search for an inclusive, involving and participatory governance that is able to enhance quality of public services. In Tanzania fiscal decentralization was implemented with the intention of raising strategies to improve quality of primary health care services and increase equity in health accessibility and utilization (Government of Tanzania, 1994).

Uganda is among the countries in Sub Saharan Africa that are implementing reforms in health Sector in the framework of fiscal decentralization. This process started in 1999 when the

National Health Policy was launched (Ongodia, 2006). This was done as a way out of the broken health system since 1970's due to a combination of economic, political and social factors.

Before the fiscal decentralization was introduced in Uganda by the central government in accordance with Article 176 of the 1995 National Constitution and Sections 78-86 of the Local Governments Act (Cap. 243), Uganda was faced with many problems related to the quality of primary health care services including high infant mortality rates, high maternal mortality rates, poor facilities, inadequate personnel, poor responsiveness and reliability (Ongodia, 2006). The primary health care services were not reliable and responsive and the associated infrastructure was not meeting the standards.

1.1.2 Theoretical Background

The theories of fiscal decentralization are based on the premise that the transfer of responsibility to government units closer to the population has got several advantages including improved delivery and quality of services through greater citizen input, better accountability to the citizenry, for public service outcomes (Shah, 2007).Wolman propagated two theories in support of fiscal decentralization; efficiency values theory and governance of values theory. Efficiency values theory states that efficiency is an economic value seen as the maximization of social welfare. Tax and service packages should reflect aggregated preferences of community members. Divergence between the preferences of individual community members and the tax and service package reduces social welfare. Such divergence will be less in smaller jurisdictions (for example sub-counties) and more in heterogeneous areas (the nation). Reduction of this divergence improves customer satisfaction and meets service quality needs (Kee, 2003). The governance of values theory attaches the improvement of service delivery to the governance values. Governance values like responsiveness and accountability, diversity and political

participation, foster citizen participation. Fiscal decentralization places allocational decision making closer to the people.

This fosters greater responsiveness of local officials and greater accountability to citizens thereby improving the quality and volume of service delivery. This is because local decision makers are expected to be more knowledgeable about problems and needs of their local area than centralized decision makers. Further, there is accountability through local elections which are driven by issues of local allocation (Kee, 2003*)*. From the above theories, it is clear that fiscal decentralization is built on the assumptions that participation of local decision makers in controlling service delivery improves the service quality. There are four major types of decentralization, namely: Devolution, decongestion, privatization and delegation. Uganda adopted devolution type of decentralization (Banyoya, 2006). In this type of decentralization, powers to plan and raise revenue to finance the approved plans were transferred to the local governments. This study set out to assess the effect of these transferred powers on the provision of primary health care services.

1.1.3 Conceptual background

The study focused on fiscal decentralization as an Independent Variable (IV) with two dimensions: Budgeting and intergovernmental transfers. The effect of each dimension on the dependent variable was assessed (many to-one relationship). Budgeting as a dimension was studied under three indicators: Decentralized planning, decentralized execution and decentralized monitoring. Intergovernmental transfers as a dimension was studied under the two indicators of conditional grants and unconditional grants. The quality of primary health care services was the Dependent Variable (DV) of the study with three dimensions: Access to services, effectiveness

of care and interpersonal relations. Government policies on the quality of primary health care services constituted the Moderating Variable (MV).

Fiscal decentralization is defined as the devolution by the central government to local governments of specific functions with administrative authority and revenue to perform those functions *(*Banyoya: 2). Banyoya (2006: 51) defines fiscal decentralization as the systematic arrangements put in place that avail instruments which local governments can use to access financial resources to meet responsibilities and functions that are decentralized to them. This study adopted the definition by Banyoya (2006) with some modifications.

Shah (2007) defines budgeting as the process of planning, adopting, executing, monitoring and auditing the fiscal program for the government for one or more future years. This definition was adopted but modified by the study. Okarafor & Thomas (2007: 9) define intergovernmental transfers as transfer of funds from the central government to lower levels of government. This concept is also defined by Wikipedia Encyclopedia (2009) as the shift of general revenues from taxes collected by the central government to local governments for general and specific uses. For purpose of this study, Okarafor's definition was used.

WHO (1978) defines primary health care as essential health care based on practical, scientifically sound and socially acceptable methods, made universally accessible to individuals and families in the community through their full participation at a cost that they can afford. Wikipedea Encyclopedia defines the same concept as services provided at the first level of basic health care for an individual's health needs including education for health, immunization, maternal and child

health, nutrition, treatment of communicable diseases, locally endemic disease control, safe water and sanitation. This study adopted Wikipedia's definition of the concept with modifications.

Zeithaml *etal* (1988: 2) defines access to services as being approachable and easy to contact; Interpersonal relations as politeness, respect, consideration and friendliness of contact personnel; effectiveness of care as willingness and ability to perform the promised service dependably and accurately. These concepts are also defined by PAHO (2003: 6): access to services as the removal of geographic, economic, social, organizational or linguistic barriers to care; effectiveness of care as the degree to which the desired health results are achieved; interpersonal relations as effective listening, communication, establishment of trust, respect, responsiveness and confidentiality. This study used PAHO's definitions.

1.1.4 Contextual Background

Kigarama Sub-county like any other local government in Uganda derives its mandate to deliver social services from the 2nd Schedule (Part V) of the Local Governments Act (Cap. 243). Like other local governments in the country, Kigarama Sub-county is faced with problems of poor quality in respect of primary health care services. There is limited access to the services by the beneficiaries, ineffectiveness of care and poor interpersonal relations.

Table 1: Some Vital health indicators for three selected years at Kigarama HC III

Health indicator/Year	**2003**	**2004**	**2008**
Mothers who attended Antenatal clinics at the health centre III	1,101	2,419	1,284
Mothers who delivered at the health centre III	56	185	108
%age of mothers who delivered at the health centre against those who attended antenatal	5.09	7.6	8.4
Total population of immunizable children ($\leq$ 5 years)	7,938	8,703	10,481

Children immunized	5,320	6,875	8,700
Percentage of children immunized	67	78.9	83

Source: Kigarama Health Centre III Annual performance Reports.

As indicated in table 1, in 2003 only 5% of the mothers who attended antenatal delivered at the health centre. The performance was at 7.6% and 8.4% for 2004 and 2008, respectively. The percentage of the children that were immunized for the same period were 67%, 79% and 83%, respectively. This indicates very poor performance of service delivery. Kigarama Sub-county adopted fiscal decentralization as provided in the 1995 National Constitution and the Local Governments Act (Cap. 243). Since the promulgation of the Constitution and the enactment of the Local Governments Act, fiscal decentralization has been in implementation.

Although fiscal decentralization has been advocated as a powerful means to improve the quality of primary health care services in developing countries, very little empirical work has been done to systematically analyze the impact of fiscal decentralization on the quality of primary health services. There is no information available to analyze factors enabling or constraining the effect of fiscal decentralization on the quality of primary health care services in Kigarama Sub-county between 2003 and 2008.

1.2 Problem Statement

Before the introduction of fiscal decentralization in Uganda the local governments faced many problems including the low quality of services delivered. In most service delivery sectors of local governments, services were limited by geographical, economic, social and organizational factors. The services were also ineffective and lacked the existence of trust and respect between the clients and service providers. The local governments had limited powers and resources to make their own plans, execute and monitor them. This meant that there was limited participation,

control on the part of the local governments and this compromised quality service delivery. The fiscal decentralization policy was introduced in 1993 with the objective of transferring financial and planning powers to local governments so that they could improve service delivery in the five national priority areas.

The national priority areas included primary health care, extension of agriculture services,, water and sanitation, primary education and feeder roads. (Nsibambi, 1998). Indeed, fiscal decentralization has enabled local governments to carry out their own budgeting with a focus on their local priorities. The local governments have been able to finance some of these priorities using the locally generated revenue.

However, a problem of delivering poor quality primary health care services remained outstanding. The primary health care services were not easily accessed, the expected heath outputs were not being obtained and the service lacked trust and respect between the service providers and clients. Little information was available on the analysis of the effect of the fiscal decentralization operations on the quality of primary health care services delivered. Indeed, no study had been done to establish the effect of fiscal decentralization on the quality of primary health care services delivered in Kigarama Sub-county. This left a gap on the extent to which fiscal decentralization influenced the quality of primary health care services delivered in Kigarama Sub-county. If this trend continued, the desired health results would not be obtained. This would eventually result into unbearable disease burden with unprecedented proportions of life years being lost due to premature deaths. The carrying out of this study was therefore timely, so that the information gap on the extent to which fiscal decentralization affected the quality of primary health care services was filled.

1.3 General Objective

The general objective of this study was to assess the effect of fiscal decentralization on the quality of primary health care services delivered in Kigarama Sub-County for the period 2003-2008.

1.4 Specific Objectives

The following specific objectives guided this study:-

1. To assess the effect of budgeting on the quality of primary health care services delivered in Kigarama Sub-county.
2. To establish the relationship between intergovernmental transfers and the quality of primary health care services delivered in Kigarama Sub-county.
3. To establish the moderating effect of government policies on the relationship between fiscal decentralization and quality of primary health care services rendered in Kigarama sub- county.

1.5 Research Questions

The study answered the following questions:-

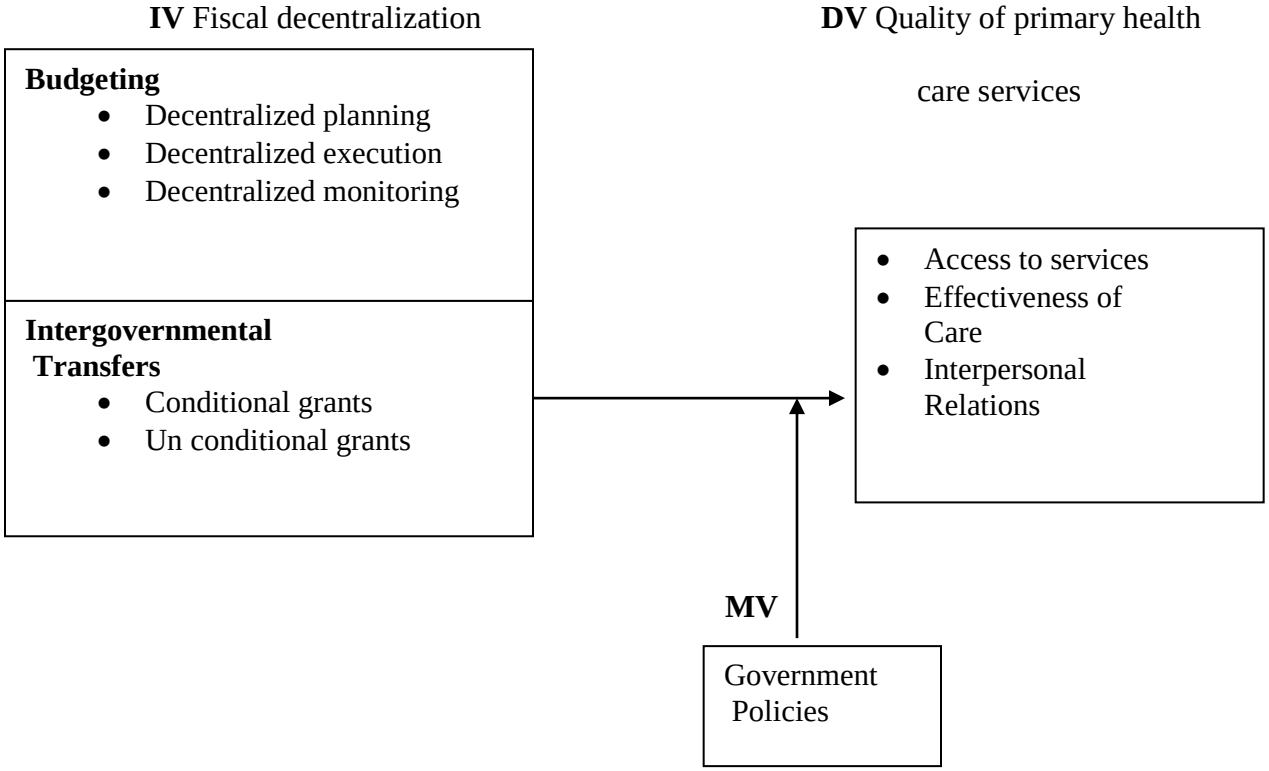
1. To what extent does budgeting affect the quality of primary health care services delivered in Kigarama sub-county?
2. What is the relationship between intergovernmental transfers and the quality of primary health care services delivered in Kigarama sub-county?
3. To what extent do government policies affect the relationship between fiscal decentralization and quality of primary health care services?

1.6 Hypotheses of the Study

The following hypotheses were tested during the study:-

1. Budgeting significantly contributes to the quality of primary health care services delivered in Kigarama sub-county.
2. There is a significant relationship between inter-governmental transfers and quality of primary health care services delivered in Kigarama Sub-County.
3. Government policies significantly affect the relationship between fiscal decentralization and quality of primary health care services.

1.7 Conceptual framework



Adopted and modified from Shah (2007), Ahmed (2005), PAHO (2003) and Zeithaml *etal* (1988).

Fig 1: Schematic diagram showing the relationship between fiscal decentralization and quality of primary health care services.

As presented in Figure 1 above, this study preconceived fiscal decentralization as the Independent Variable (IV) with various dimensions which include budgeting, accounting, cash management, debt administration, revenue administration (Shah, 2007) inter-governmental transfers, monitoring of cash flows, allocation of expenditure responsibilities by the central government (Ahmed, 2005). This study however concentrated on only two dimensions: Budgeting and intergovernmental transfers. The study analyzed budgeting under three indicators of decentralized planning, decentralized execution and decentralized monitoring.

Inter-governmental transfers were analyzed under two indicators of conditional and unconditional grants. Each dimension contributed to the achievement of the overall expectations of fiscal decentralization. Although each dimension has its own processes and procedures, their roles and operations are closely interrelated as part of fiscal decentralization (Shah, 2007). The study analyzed how each dimension impacts on the dependent variable (many -to- one relationship).

On the other hand, this study preconceived the quality of primary health care services delivered in Kigarama sub-county as a dependent variable (DV). The quality of primary health care services has numerous dimensions which include tangibles, access to services, reliability, responsiveness, assurance, empathy (Zeithaml, 1988), effectiveness of care, efficiency of care, interpersonal relations, continuity of services, safety, choice, access to information (PAHO, 2003). This study however limited itself to three dimensions: Access to services, effectiveness of care and interpersonal relations. The study assessed the extent to which this dependent variable is affected by the independent variable. Meanwhile, the above interrelationships were moderated by government policies on primary health care services. Government policies on primary health care services regulate the relationship between the independent variable and dependent variable through designing the normative framework that protects and promotes the quality of health

services and guarantees compliance with the existing policies, laws, rules and guidelines (PAHO, 2003). If there is laxity in the existing policies, then the expected effect of fiscal decentralization on the quality of primary health care services may be less significant. In the study, the quality of PHC services was considered as a variable that is affected by fiscal decentralization. The study considered government policies on PHC services as a variable that moderates the relationship between quality of PHC services and fiscal decentralization.

1.8 Significance of the Study

This study assessed the effect of fiscal decentralization on the quality of primary health care services delivered in Kigarama sub-county. The findings of the study may enable the policy makers in Kigarama sub-county and other local governments in the Country understand the magnitude of the relationship between the fiscal decentralization and the quality of primary health care services. The recommendations of the study can be adopted by policy makers in local governments to significantly improve on the quality of PHC services. The study findings also avail empirical evidence on the effect of fiscal decentralization on quality of PHC services to the academicians and researchers.

1.9 Justification of the Study

The majority of Uganda's population is rural based and heavily depends on primary health care services offered by the local governments' health centers and hospitals. The findings of this study can benefit policy makers and health service managers in their focus on the quality of primary health care services. The study may therefore be useful not only to Kigarama sub-county but also to other local governments, ministry of health and development partners engaged in the health out comes. The study was undertaken as a partial fulfillment of the requirements for the award of a masters' degree at Uganda Management Institute to the researcher.

1.10 Scope of the Study

1.10.1 Geographical Scope

The study was carried out in Kigarama Sub-county, Bushenyi district in the South Western Uganda. Bushenyi district boarders with Rukungiri, Kasese, Kamwenge and Mbarara districts in the South west, North and East, respectively. Kigarama sub-county is located in the Eastern part of Bushenyi district.

1.10.2 Time Scope

The study focused on the period between 2003-2008. This was the period when the implementation of fiscal decentralization was fully in practice.

1.10.3 Content Scope

The study focused on fiscal decentralization as an independent variable (IV). Two dimensions under the independent variable were studied: Budgeting and inter governmental transfers. Quality of primary health care services delivered in Kigarama sub-county was the dependent variable of this study. Three dimensions of quality primary health care services was analyzed: Access to services, effectiveness of care and interpersonal relations. Government policies on the quality of primary health care services constituted the moderating variable (MV).

1.11 Operational Definitions of Concepts

The study was guided by the following operational definitions:

1.11.1 **Fiscal decentralization:-** Refers to the statutory arrangements put in place that avail instruments which local governments can use to access and source financial resources to meet responsibilities and functions that are decentralized to them.

1.11.2 **Budgeting:-** Refers to the process of identifying, ranking and approving funding priorities, mobilizing resources to fund them, implementing them and monitoring the implementation.

1.11.3 **Intergovernmental transfers**:- Refers to the cash flow from the central government to the local governments.

1.11.4 **Primary Health Care:-** Refers to maternal and child health, family planning, BCG and DPT immunization.

1.11.5 **Access to service:-** Refers to absence of geographical, economic, social, organizational or linguistic barriers to primary health care.

1.11.6 **Effectiveness of service:-** Refers to the degree to which the desired primary health care results are achieved.

1.11.7 **Interpersonal relations:-** Refer to effective listening and communication, establishment of trust, respect, responsiveness and confidentiality between the service providers and their clients.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter captures the review of literature related to the study. The chapter identifies and analyses information related to the problem. The sources for this literature include journals, reports, books and periodicals. Some of these sources are primary and others are secondary. It presents theoretical review, actual literature review and summary of the literature review. In theoretical review, key theories guiding the study are identified and analyzed. In the actual literature review, related information is reviewed objective – by – objective. The lessons and gaps identified from the literature review are captured in the summary, at the end of this chapter.

2.1 Theoretical Review

The theoretical case for fiscal decentralization in abid to improve the quality of service delivery dates from the 17^{th} & 18^{th} century philosophers including Rousseau and Montesquieu. Central governments were distrusted and lower unit governments were seen as the hope to preserve liberties for the people. The modern case for decentralized governments to improve the quality of service delivery was articulated by Wolman (in Bennet, 1990) under the efficiency & governance values theories. Efficiency theory states that efficiency is an economic value seen as the

maximization of social welfare. Public sector allocation of goods and services are inherently political, however, as nearly as possible, tax and service packages should reflect the aggregated preferences of community members. Within any political jurisdiction, some people will prefer more, some less, public services. As a result, there is a divergence between the preferences of individual community members and the tax and service packages reflecting the aggregate community preferences.

Since such divergence reduces social welfare, it is desirable to hold those to a minimum and they will be less in smaller communities (for example sub-counties) than in larger, more heterogeneous areas (the nation). Reduction of this divergence improves customer satisfaction and meets service quality needs. (Kee, 2003).

The Governance values theory attaches the improvement of service delivery to the values like responsiveness, accountability, diversity and political participation. The theory asserts that these values foster citizen participation. Fiscal decentralization places decision making closer to the people and this fosters greater responsiveness of the local officials and greater accountability to the citizens thereby improving service delivery. This is because local decision makers are expected to be more knowledgeable about the problems and needs of their local area than centralized decision makers. Further, there is accountability through local elections which are driven by the outputs made (Kee, 2003). This is because as local politicians seek polls for the next term of office, they are tasked to explain the achievements made in the previous period.

Dethier (2000) contends that fiscal decentralization world wide is seen as a way of bringing authorities in more direct contact with the citizens. She further argues that fiscal decentralization is seen as a way of improving the poor quality of public services or to resolve the tensions arising

from the unequal pace of growth and improvement in standards of living in different regions of the country.

Banyoya (2006) asserts that fiscal decentralization is based on the principle of 'subsidiarity' meaning that public services should be provided by the jurisdiction having control over the minimum geographical area that is able to internalize both the benefits and costs of providing such a service. This is intended to achieve both efficiency and effectiveness in service provision.

However, World Bank (2001) analyses that although the general argument for decentralizing delivery of public services is the potential for improved quality and coverage, fiscal decentralization is often politically driven and the theoretical benefits tend to get more attention than the more concrete facts of actual experiences in most countries. Policy makers tend to take advantage of the arguments for fiscal decentralization to meet their selfish individual ends. Moreover, local policy makers and the citizens may not have sufficient information to initiate and formulate good policies and plans that can create the desired effect (Kee, 2003).

It is clear that the World Bank and Kee were giving normative assumptions which may not be holistically applicable in the context of local governments in Uganda because the study findings revealed that fiscal decentralization has a significant bearing on service delivery benefits and that local policy makers know what they want and the benefits accruing from their choice. So, this study assessed the effect of fiscal decentralization on the quality of primary health care services in Kigarama Sub-County and established that fiscal decentralization significantly affects the quality of primary heath care services.

2.2 Budgeting and Quality of Primary Health Care Services

The effect of budgeting on the quality of PHC services is analyzed under the three dimensions of decentralized planning, decentralized execution and decentralized monitoring. This is based on

the idea that the key components of budgeting such as decentralized planning, decentralized execution and decentralized monitoring are central in the relationship between fiscal decentralization and quality of PHC services (Kee, 2003).

2.2.1 Decentralized Planning and Quality of Primary Health Care Services

WHO (1978) declares a new approach for primary health care which advocates for community participation and greater responsiveness to the needs of the community through decentralized planning.

The approach recognizes that there is need to involve the local community in planning so as to promote participation and control for a community- oriented- quality health system (Bhattacharyya & Murray, 1999). The democratic theory considers involvement of the beneficiaries in planning as a social value in an ideal and standard decision environment.

It argues that decision making is improved when there is participation of the beneficiaries, increment in responsiveness and cooperation among stakeholders. This leads to arise in productivity as a result of correct decision making (Colombian Encyclopedia, 2005). Putting decision making in the hands of those who have the information that outsiders lack gives them a strong incentive advantage. Local information can often identify cheaper and more appropriate ways to deliver public services (Dethier, 2000).

However, Bhattacharyya (1999) warns that decentralized planning yields the desired results in communities that have a positive attitude towards the government regime and with a past experience of collective action and group activities. Shah (2007) observes that in local government planning, the citizenry should be involved in each stage of the process, as a means of making government responsive to public interests and as a means of monitoring the results of government programmes. Citizen participation has traditionally been political, that is; involving voting, lobbying, and sometimes testifying at hearings, aimed at influencing public

representatives and officials. However, a new philosophy and system of participatory planning incorporates citizens' views as stakeholders identify and rank priorities. So, citizen input is considered earlier in the process than has been traditionally the case. Participatory planning has been successfully used by local governments in Brazil, the Philippines, Ecuador, India, Indonesia, Serbia, South Africa, Sri Lanka, Tanzania, the United Kingdom and Uruguay.

The World Bank (2004) and GoU (2005) have recognized the value of decentralized planning.

The National Constitution (1995) Article 176 (e) and the Local Governments Act (1997) Cap. 243 Section 36(3) mandate local governments to plan, initiate and execute policies on issues affecting their communities.

Kundishohora (2002) however, observes that poverty and low literacy levels lower the capacity of the community to fully participate in decentralized planning. Dethier (2000) adds that for participation in planning to be operational, it requires a minimum of literacy, basic capabilities and gender equality; which are often not present in very poor areas of developing countries. The study findings did not confirm these observations. Instead, it was found out that participation is hindered by the tight conditions on grants which do not allow funding for the community generated priorities.

2.2.2 Decentralized Execution and Quality of Primary Health Care Services

Bossert & Beauvais (2003) assert that decentralized execution of health sector plans at the local level is an important element of decentralization because the influence held by various stakeholders over decision processes can ensure implementation of local priorities at variance with national priorities and can be a means of holding the local health staff accountable for higher quality care. Dethier (2000) observes that fiscal decentralization and citizen participation can increase accountability. The author notes that there is some evidence that by making local

officials more accountable and placing responsibility for decision making and implementation in the hands of local stakeholders, the quality of public services improves. The United Kingdom Wikipedia (2009) reports that in United Kingdom, community based committees known as trusts are selected and controlled by their respective communities, local residents, employees and patients and have the power to manage their own health budgets and shape their healthcare provision according to local needs and priorities. The trusts also have more access to funds for investment and this can come from the public or the private sector.

The trusts are also responsible for generally improving local health and making sure that the national health service agencies work effectively with local communities.

Daura, *etal* (1998) reports that decentralized implementation of primary health care activities in Mongu District (Zambia) resulted into significant improvements in service quality and drug availability. Hutchinson (1998) reports that Uganda has much more democratic local institutions created to enable citizen participation in health service delivery and administration. Health unit management committees, Sub-County and village health committees are fundamental institutions for implementation of primary health care service activities. The author however, observes that these institutions have not been practically associated with any noteworthy improvement in service quality and have instead been accused of complicity in drug leakage and other abuses. Inke (2001) adds that these institutions are organizationally weak and have no linkage with the community.

The study findings were in agreement with Inke's observation. The health unit management lacks technical competence to monitor some of the health centre's operations. The committee dedicates little time to monitor primary health care services and comes to the health centre only to attend quarterly meetings. The study findings also indicated that the participation of the local

health committee is hampered by having no control over the funding for PHC activities. The conditional grants do not consider their locally generated priorities for funding.

2.2.3 Decentralized Monitoring and Quality of Primary Health Care Services

WHO (2002) contends that appropriate mechanisms need to be established for quality monitoring, assessment and continuous quality improvement at all levels of health care services. The same author however notes that local governments lack appropriate mechanisms for monitoring.

Government of Uganda (1997) in the Local Governments Act Cap. 243 Section 27 (d) & (j) empowers executive committee of a local government to monitor the implementation of policies, programmes and projects and take action where necessary. Section 27 (f) of the Act empowers the executive committee to evaluate the performance of the council against approved work plans and programmes. Government of Uganda (2007) states that monitoring is a continuous function that involves collection and analysis of data about project implementation that will lead to timely decision making, ensuring accountability and quality. The above literature lacks empirical information analyzing the effect of budgeting on the quality of health services. This study set out to fill this gap. The study findings revealed that budgeting significantly affects the quality of primary health care services.

2.3 Intergovernmental Transfers and Quality of Primary Health Care Services

The effect of intergovernmental transfers on the quality of PHC services is analyzed according to two dimensions of conditional grants and unconditional grants.

2.3.1 Conditional Grants and Quality of Primary Health Care Services

Ahmad (1997) argues that with the increased responsibilities under decentralization, there are limits to which local revenues of local government can meet the expenditures. This generates a need for local governments to obtain intergovernmental transfers. Bird & Smart (2002); Fjeldstad (2001) and Shah (2004) agree that the way intergovernmental transfer system is

designed, plays a critical role for quality and equity of local service delivery. To bridge fiscal gaps, grant design should include tax base sharing; to reduce regional disparities, there is need for fiscal capacity equalization; to set national minimum standards block transfers and conditions on service standards are preferable and to influence local priorities there is need for open ended matching.

Bossert & Beauvais (2003) observes that the central government should retain some control over expenditure responsibilities for health to achieve equity and specific minimum health outputs. It is more appropriate for the responsibility of redistribution and equity to lie with the central government (Shah, 2005). Another rationale for the conditional grants is that the policy on equity should be set and implemented by one level of government. The extent of inequities in resource allocation across local jurisdictions make a case for the central government to intervene in order to achieve a more equitable distribution of allocated resources for primary health care (Smith, 1985; Okorafor, 2007).The World Bank (2004) however notes that accountability for conditional grants may be poor as citizens may not have adequate information on the grants since they are not the specific tax payers. The study findings however showed that the problem of conditional grants lies with their tight conditions and inadequacy and not mismanagement.

2.3.2 Unconditional Grants and Quality of Primary Health Care Services

Okorafor (2007), analyses that unconditional grants supply increase the local governments' income without altering their spending priorities, which are dictated by local preferences. Oates (1999) notes that local preferences may vary across jurisdictions and therefore local outputs have to vary accordingly, to maximize overall welfare. The World Bank (2004), reports that the central policies must consider local conditions and capacities. The discrepancies existing amongst local governments can be addressed through unconditional grants to improve service

delivery. Berg (1998) and World Bank (2004) observe that when local governments have access to unconditional grants with powers to adjust the allocations to budget items independently, it enhances the efficiency in the public sector finances and the quality of services delivered.

IMF (2006), however, reports that corruption and poor financial management at local levels in Uganda has called for conditions and stringent requirements and this has weakened the ability of fiscal decentralization to improve quality service delivery.

The government of Uganda (1995) through the National Constitution provides for conditional, unconditional and equalization grants to local governments. From the above, it is clear that no study had been carried out to find out the effect of intergovernmental transfers on the quality of primary health care services. The study assessed the effect of intergovernmental transfers on the quality of primary health care services delivered in Kigarama Sub-County and discovered that intergovernmental transfers had significant effect on the quality of primary health care services.

2.4 Effect of Government Policies on the Relationship between Fiscal Decentralization and Quality of Primary Health care Services

PAHO (2003); WHO (2002) are in harmony on the role of the central government in stewardship, policy making and coordination for PHC services. The centre needs to establish equitable means of allocating resources to districts and to ensure the existence of effective mechanisms for quality control. The author further analyses that depending on policy conditions, decentralization can give rise to equity or inequity. In order to give rise to equity, the programmes of decentralization have to be linked to policies. With increasing enthusiasm for decentralization as a strategy of promising efficiency and public accountability, it is important not to overlook the role of the centre. The centre needs to establish equitable means of allocating resources between districts and to ensure the existence of effective mechanisms for managing the health labor market.

Harvey (2007) reports that in developing countries where the ministries for health have not executed their stewardship roles, provision of basic primary health care packages has failed due to forces of economic crises and market reforms. The government of Uganda (1997) in the Local Governments Act Cap. 243 [2nd Schedule, Part 1(27)] empowers the central government to carry out duties relating to policy making for health outcomes.

This study assessed the influence of government policies on the relationship between fiscal decentralization and quality of primary health care services and found out that government policies had a significant influence on the relationship between fiscal decentralization and the quality of primary health care services.

2.5 Summary of the literature review

The quality of primary health care services advocates for full community participation and greater responsiveness to the needs of the community through decentralized planning. Full participation of the community is however hampered by low levels of literacy and poverty. The influence of the stakeholders on the quality of primary health care services can be made through their participation during the implementation of health activities. The institutions designed for participation of the stakeholders are however still organizationally weak and poorly link with the communities they represent. Monitoring assesses the adherence of programmes, projects and activities to the set standards of performance. Most local governments lack appropriate mechanisms for planning implementation, monitoring and evaluation. Conditional grants are important for the central government to control equity and minimum health standard outputs. Unconditional grants help local governments address specific local preferences and disparities. Grants are mismanaged by the local governments due to lack of ability to manage public finances and keep proper records. Government policies on health outcomes are important for

equity and quality controls. When the centre fails to execute its stewardship roles, primary health care services suffer from the forces of economic crises and market reforms.

The above lessons and gaps captured from the reviewed literature guided the study in its efforts to assess the effect of fiscal decentralization on the quality of PHC services. The study findings revealed that fiscal decentralization had a significant effect on the quality of primary health care services.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the research design, the population of the study, the sample size and selection, sampling techniques and procedure, data collection instruments, pretesting of the instruments, procedure of data collection, data analysis and measurement of variables.

3.1 Research Design

A research design is a general plan for the research project and includes the conceptual structure, measurement of variables, collection and analysis of data (Sekaran, 2003). This study adopted a cross sectional, correlational case study. The study adopted cross sectional design because it was carried out at a particular period of time. Correlational design was used because the study variables were hypothesized to have cause – effect relationship and correlational techniques were therefore appropriate in assessing this relationship. Case study design enabled the study obtaina detailed contextual analysis of the study population in the natural environment. The study employed both qualitative and quantitative approaches. This triangulation assisted the researcher obtain detailed description of the study variables by use of quantitative approach and the

measurement of the relationship between the variables through quantitative techniques (Amin, 2005; Punch, 2006).

3.2 Study Population

The study was carried out in Kigarama Sub-county in Bushenyi district. The target population for this study was composed of the stakeholders of primary health care services delivered in the area of the study.

These stakeholders were categorized into seven groups:

- Administration staff 10
- Medical staff 08
- Political leaders 13
- Health unit management committee 09
- BCG and DPT immunization clients 32
- Antenatal and post natal clients 30
- Family planning clients. 58

Source: Kigarama Sub County Council and HCIII Records

3.3.1 Sample Size Determination

Determination of sample size is a technical matter which essentially involves balancing cost and access against the level of precision required in relation to the variability of the population on the characteristics being measured (Punch, 2006). In reality, the appropriate sample size depends on a number of factors like the size and nature of the population and the research design. In correlation research, it is generally desirable to have a minimum of between 30 or 50 participants (Amin, 2005). In the determination of the sample size for this study, the researcher gave utmost attention to the heterogeneous nature of the target population, control of the chaotic factors, cost,

access and the error margin of the study (0.05). In table 2, the sample size of each category of respondents and the method of its selection are indicated.

Table 2: Sample Size Selection

Category of Respondents	Population	Sample size	Basis	Sampling
Administration staff	10	10	Krejcie & Morgan table formula	Purposive
Medical staff	08	08	Krejcie & Morgan table formula	Purposive
Political leaders	13	13	Krejcie & Morgan table formula	Purposive
Health unit mgt committee	9	9	Krejcie & Morgan table formula	Purposive
DPT & BCG imm. Clients	32	28	Krejcie & Morgan table formula	Purposive
Antenatal/Post natal clients	30	28	Krejcie & Morgan table formula	Purposive
Family planning clients	58	52	Krejcie & Morgan table formula	Simple random

Totals	160	148	Krejcie & Morgan table formula	

Source: *Kigarama HCIII Annual performance Report, 2008*

As presented in table 2, seven categories of respondents were selected. In the categories of administration staff, medical staff, political leaders, and health unit management committee, all the respondents were selected using purposive sampling. These categories constituted the key informants of the study.

In the category of DPT and BCG immunization clients, 28 respondents were selected from 32 using purposive sampling. In the category of antenatal /postnatal clients, 28 respondents were selected from 30 using purposive sampling. In the category of family planning clients, 52 respondents were selected from 58 using simple random sampling. Krejcie and Morgan table guided the study in arriving at the numbers of the selected respondents.

3.3.2 Sampling Techniques and Procedures

3.3.2.1 Purposive Sampling

The respondents in six categories of administration and medical staff, political leaders, health unit management committees, immunization, and antenatal/postnatal were purposively sampled for the study. This enabled the researcher to obtain the data necessary for the study, because these categories are key stakeholders for the services delivered. The year 2008 was selected by the study for the services rendered to the clients in the categories of immunization, antenatal/postnatal, and family planning because it is the most recent complete year of reporting. If interviewing is conducted too long a period after the service delivery, there is a possibility that the respondents ability to answer some items will change due to intervening learning or maturation (Amin, 2005:297). This means that changes in the minds of the respondents after a period of time may make them give different responses as these changes may have affected their

levels of understanding or abilities to interpret given situations. Moreover, some of the respondents could have either migrated or died thereby reducing the sample size and the desired representation.

3.3.2.2 Simple Random Sampling

The respondents in the category of family planning were selected randomly. This is because the study wanted to offer every member of this category an equal chance of participating in the study.

Their names were got from the family planning services register at the Health centre III and these names were written on tags that identify elements of the population to be sampled. The tags were placed in a container and well stirred. A tag would then be drawn from the container and the process would be repeated until the required number of tags was obtained. The 52 names were then randomly picked giving each an equal opportunity to be picked. One month of 2008 (August) was randomly selected for the services to clients. The study selected one month because the performance reports of the health centre are compiled monthly and each month's report tends to be unique. Further, most of the clients get the services every month until they have completed their service cycle. So the clients of this nature keep being repeated in the ensuing month's report.

3.4 Data Collection Methods

During the study, both primary and secondary data was collected. Primary data was collected from the respondents through the use of questionnaires, interviewing and observing. On the other hand, secondary data was collected by the means of documentary review. The study used questionnaires to collect quantitative data because they are the generally acceptable instruments for quantitative data collection (Punch, 2006:52). Questionnaires were used to collect data from the consumers of PHC services. The interviews were conducted among key informants

composed of the sub-county administrative and medical staff, the councilors and members of HUMC. The study also used observation to collect data that had not been obtained from the respondents through the use of other tools. The documentary review was used by the study to collect data from key relevant documents that could support the empirical findings of the study.

3.5 Data Collection Instruments

The study used the following instruments to collect data:-

3.5.1 Questionnaire

A questionnaire on appendix I was administered to the 108 consumers of PHC services. The questionnaire had structured and closed-ended questions to capture quantitative data. The opinions of respondents in structured and closed-ended questionnaire were measured by Likert scale with 5 intervals:(1= Strongly Agree 2= Agree 3= Undecided 4= Disagree 5= Strongly Disagree). The questionnaire was composed of 46 items arranged under 9 sections according to the indicators, viz: Decentralized planning (6 items) decentralized execution (5 items), decentralized monitoring (5 items), conditional grants (5 items), unconditional grants (6 items) government policies (5 items), access to services (5 items), effectiveness of services (4 items) and interpersonal relations (5 items).

3.5.2 Interview Guide

Interview guide was used to capture data from the Sub-County staff, the political leaders and the health unit management committee members. The interview guide as indicated in appendix II had 10 unstructured open-ended questions. The instrument collected detailed qualitative data by giving an opportunity to the respondents to give their individual opinions on the study.

3.5.3 Documentary Review Check list

The following documents were reviewed during the study as indicated in appendix III: local governments reports on health outcomes and finances , health center's performance reports, sub county budgets and their corresponding final accounts for 2002/2003 – 2008/2009 financial years, health unit management committees' minutes, staff work schedules, primary health care implementation guidelines and health policy. This constituted a secondary source of data for the study.

3.5.4 Observation check list

The observation check list on appendix IV included items like numbers of clients coming for services at the health centre, hours spent while getting services, existing infrastructure and equipment, health appearance of the clients, level and mode interaction between the service providers and the clients while at the health centre and the body language of the clients.

3.6 Validity and reliability

The data collection instruments were pre-tested to confirm their validity and reliability and the coefficients of 0.79 and 0.89 were obtained, respectively. This indicated validity and reliability results at acceptable standards for the study.

3.6.1 Validity

Validity refers to the ability of the instrument to measure what it is expected to measure. The study used face, content and construct validity to ensure validity of the instruments. Face validity refers to the appropriateness of the instruments by appearance. Content validity focuses on whether the full content of a conceptual definition is represented in the measure. Thus, two steps are involved in content validation; specifying the content of a definition and developing indicators which sample from all areas of content in the definition (Punch, 2005:97). Construct

validity aims at linking the instruments used and the theories of the study. A validity test was carried out prior to the administration of the research instruments. This was done in order to find out whether the questions were capable of capturing the targeted data. The results indicated 0.79, showing that the questions were capable of capturing the information that was stated in the study objectives (Amin,2005). The researcher then proceeded to administer the questionnaires.

3.6.2 Reliability

This refers to the consistency of the instrument. An instrument is reliable if it produces the same results whenever it is repeatedly used to measure trial or concept from the same respondents even by other researchers (Punch, 2005). The study adopted test-retest to pretest the instruments.

The instruments were administered to a group of 5 respondents and the scores were recorded. After two weeks, the same instruments were administered on the same group and the scores obtained were correlated with the first scores. The resulting alpha co-efficients are indicated in table 3 below.

Table 3: Results of Reliability

Alpha	**Variable**	**No. of items**
.89	All variables, background characteristics of the respondents inclusive.	52
.89	All variables, respondents' background characteristics exclusive.	46
.86	Decentralized planning	6
.85	Decentralized execution	5
.86	Decentralized monitoring	5
.84	Conditional grants	5
.55	Unconditional grants	6
.93	Central government policies	5

Source: Primary data

The results in table 3 indicated high coefficients for all the variables which meant that the instruments had good test re-test reliability (Amin, 2005; 296). The two methods of test-retest and co-efficient alpha tap the two different meanings of reliability; true consistency and internal consistency, but either or both can be used to estimate the reliability of a measuring instrument (Punch 2005: 95-96). The study therefore used both methods.

3.7 Procedure of Data Collection

On getting a letter of introduction from UMI, the researcher proceeded to the Chief Administrative Officer of Bushenyi District and requested him to authorize the carrying out of the study. After this authorization, the researcher recruited and inducted five research assistants to assist in the collection and editing of data from the respondents. The researcher then proceeded to pretest the instruments and to name the sample. The questionnaires were administered by the research assistants at the homesteads of the service clients. The researcher himself collected data from the health management committee members, political leaders and staff at places of their convenience. The observation required the researcher to visit the heath centre during the working hours and observe the attitudes of clients and the personnel, and the existing infrastructure.

3.8 Data Analysis

The study employed two approaches in data collection; qualitative and quantitative. Each of these approaches demanded a unique technique of data analysis. However, both approaches required organizing data, editing it, addressing errors and omissions, after data collection. The

study organized and edited all the data questionnaires collected and sort out errors and omissions.

3.8.1 Quantitative Data Analysis

Quantitative data was coded and entered in the computer using SPSS 16. The study used correlation techniques (Pearson product-moment correlation and Linear regression analysis) to assess the relationship between fiscal decentralization and the quality of primary health care services rendered.

3.8.2 Qualitative Data Analysis

Qualitative data obtained from structured open-ended questions was analyzed through six stages.

Analyzing data into different themes and by source of information, reading through the data to get a general sense and overall meaning, arranging data into categories and labeling those categories for analysis, developing description for each category theme and developing interpretation involving lessons learnt (Amin, 2005:324). Grounded Theory method is another approach that can be used to analyze qualitative data. It involves comparing incidents applicable to each category, understanding similar incidents across respondents because of the common characteristics amongst the respondents and eliminating incidents which relate to a few categories. Incidents which cut across can be identified to form general statements or patterns and link these patterns to the study (Babbie, 2007). The study adopted both Amin's approach and the grounded theory method to analyze qualitative data.

3.9 Measurement of Variables

The questionnaire for service clients was measured on a five interval Likert scale. Ordinal scale and interval scale (with other different intervals) were used to capture personal data of the respondents. The Pearson product-moment correlation was used by the study to assess the effect

of fiscal decentralization on the quality of PHC services. The study also used linear regression analysis to test the hypotheses.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4.0 Introduction

This chapter presents the response rate, background characteristics of respondents, descriptive statistics for the various dimensions of the independent variable and dependent variable. It also presents the detailed empirical results of the study.

4.1 Response Rate

During the study, the number of the sampled respondents who participated in the study was computed to establish their adequacy for the generation of the required study data. The response rate of each category of the study respondents is presented in table 4 below.

Table 4: Response Rate of the Respondents

Category of Respondents	**Population(N)**	**Sample size(s)**	**Response Rate**	**Response %age**
DPT & BCG	32	28	27	96.4%
Antenatal/postnatal	30	28	24	85.7%
Family Planning	58	52	46	88.4%
Totals	**120**	**108**	**97**	**89.8%**

Source: Primary data

As presented in table 4, the sample size of 108 was selected from the three categories of respondents of DPT and BCG, Antenatal/ postnatal and Family Planning. Out of the 108 selected respondents, 97 respondents actually participated in the study (89.9 %).

Neuman (2000), gives the formulae for calculating response rate as:

$$\frac{\text{Total Number of responses}}{\text{Total Number in the sample- (ineligible and unreachable)}}$$

Using the above named formulae, the study obtained the following response rate:

$$= \frac{97}{108 - 0} = \frac{97}{108} = 89.8\%$$

Lin (1976), asserts that a response rate of 50% or higher is adequate while that of above 70% is very good. Therefore the response rate of 89.8% for this study was very good.

4.2 Background Characteristics of the Respondents

These included gender, education levels, type of service obtained and number of visits made to the health centre. This information was presumed by the study to be important because such aspects can influence the opinion of the respondents on the quality of PHC services. Women were strongly represented (99%) compared to men (1 %).

4.2.1 Category of Respondents

The respondents were put into categories of BCG/DPT Immunization clients, Family Planning clients and Antenatal/Post natal clients. This was done to ensure that each section of PHC services clients at Kigarama HC III was given a chance to participate in the study. A summary of this is presented in table 5 below.

Table 5: Category of Respondents

Category	**No. of respondents**	**%**
BCG/DPT Immunization	27	28%
Family Planning	46	47%
Antenatal/Postnatal	24	25%
Total	**97**	**100%**

Source: Primary data

In table 5, of the 28 BCG/DPT clients who constituted the sample, 27 of them responded to the study (28%), Family planning clients sampled were 52 and 46 responded (47%). The

Antenatal/Postnatal services clients sampled were 28 and 24 of these responded to the study (25%).

4.2.2 Gender Distribution of the respondents

The researcher set out to find out the gender distribution of the PHC services' clients at Kigarama HCIII. This was done to establish whether the consumption of PHC services is evenly distributed between male and female clients. The results are presented in the figure II below.

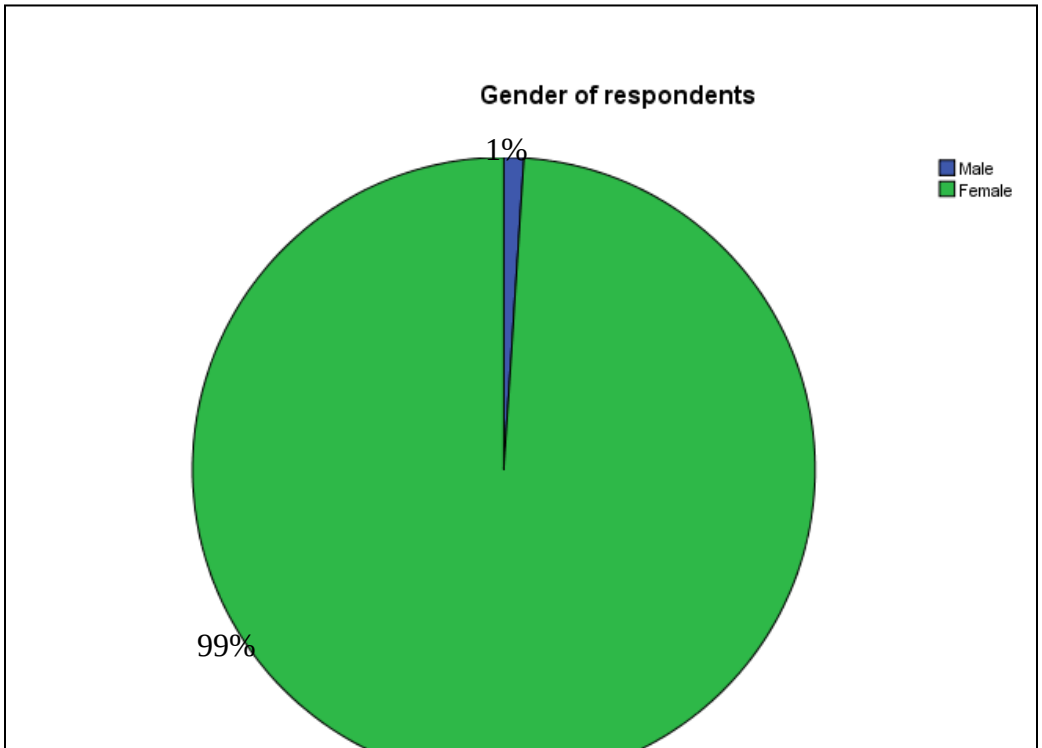


Figure II: Pie Chart Showing the Gender Distribution of the Respondents

Source: Primary data

The findings revealed that 96 of the respondents who took part in the study were female (99%) while 1 client was male (1%). This clearly indicated that PHC services at Kigarama HCIII are consumed mainly by female clients. Culturally, given that many of the demands for family reproductive health are chores taken up by the women, men seem not to see the reason why they should participate in demanding for the services related to the chores that are not their domain. This kind of evidence is further substantiated by the information gathered from the midwife M/S Jane Tukahirwa ‘‘Men are still preoccupied by the stereotype that reproductive health for the family is the core justification for the existence of a wife in a home. They do not see the reason of supporting a woman in what she is socially justified to accomplish”.

This implies that the concerns of female clients have to be captured in the access, effectiveness and interpersonal relations of PHC services if service delivery has to be of quality since females are the majority of the clients. The male’s concern for health seems to come only when his own health is affected.

4.2.4 Education Levels of the Respondents.

The education levels of the respondents were categorized as Postgraduate, Graduate, Diploma, Professional certificate, A’level, O’level and Other. The findings were presented in the table 6 below:

Table 6: Education Levels of the Respondents

Education level	Frequency	%

Post graduate	0	0%
Graduate	0	0%
Diploma	0	0%
Professional Certificate	2	2.1%
A'level	0	0%
O'level	6	6.2%
Other	89	91.8%
Total	**97**	**100%**

Source: Primary data

From table 6, it was found out that none of the respondents had a postgraduate, graduate, diploma or A'level qualification(0%), 2 respondents had a professional certificate (2.1%), 6 respondents had O'level (6.2%) and the rest 89 respondents (91.8%) were below were in the category of other qualifications. This implies that the majority of the respondents were either below O'level or held other qualifications.

The findings also indicated that clients who had attained at least a professional certificate and were in gainful employment were less likely to come for PHC services at Kigarama HC III (Kigarama HCIII patient register).

This evidence is corroborated by the comment from the midwife M/S Tukahirwa Jane "Most of my clients for antenatal and postnatal services are housewives. Some of them walk long distances to the health centre because their husbands do not support them with money for transport. Women who have access to income prefer services from private health facilities because of convenience and privacy". This indicates that the majority of the respondents (91.8%) is either illiterate or hold low levels of education. The mode of communication for these clients

has to match their levels of education in order to capture their needs in order to have interpersonal relations typical of a quality service.

4.2.6 Number of Visits by the Respondents

The researcher set out to establish the number of visits made by the respondents to the health centre in search of PHC services. Table 7 below shows the results.

Table 7: Number of Visits made by the Clients

Number of visits	**Frequency**	**%**
Once	3	3.1%
Twice	2	2.1%
More than twice	92	94.8%
Total	**97**	**100%**

Source: Primary data

From table 7 above, it was found out that the respondents who had visited the health centre for PHC services once were 3 (3.1%), those who had visited the health centre twice were 2 (2.1%).

The respondents that had made more than two visits at the health centre were 92 (94.8%).

This information implies that the majority of the clients who come for PHC services are more likely to make another visit. This implies that the services offered are effective enough to adduce the client consider another visit. This information is supported by the key informants of the study who suggested that apart from inadequate drugs, effectiveness of PHC services is alright.

4.2.5 Type of Service Demanded by the Respondents

The researcher categorized PHC services as BCG/DPT immunization, Family Planning and Antenatal/Postnatal services, in order to establish the type of service demanded by the respondents.

Table 8: Type of Service Demanded by the Respondents

Service	**Frequency**	**%**
BCG/DPT Immunization	27	27.8%
Family Planning	46	47.4%
Antenatal/Postnatal	24	24.7%
Total	**97**	**100%**

Source: Primary data

From the table 8, it is indicated that respondents who sought BCG/DPT Immunization services were 27 (27.8%), Family Planning 46 (47.4 %) and Antenatal/Postnatal 24 (24.7%). This shows the majority of the respondents were coming for Family Planning services. This implies that the access, effectiveness and interpersonal relations of family planning as a service have to be taken care of if the service has to be of quality, since family planning has the biggest number of clients.

4.3 Empirical Findings

In this section, the extent to which budgeting contributes to the quality of PHC services is explored. The relationship between budgeting and quality of PHC services is analyzed under the three indicators: Decentralized Planning, decentralized execution and decentralized monitoring. The effect of Intergovernmental transfers on quality of PHC services is assessed under two indicators: Conditional grants and unconditional grants. The relationship between government policies and quality of PHC is also analyzed. The variables are analyzed using a five likert scale and the results are presented in the descriptive tables showing the percentage of responses, under each variable. The relationships are then assessed using correlations in order to explore their magnitude. Quantitative data is compared with qualitative data. Regression analysis was used to

test the study hypotheses. The study tested three hypotheses using the research findings. The hypotheses tested included: (i) Budgeting significantly contributes to the quality of PHC services delivered in Kigarama Sub County. (ii)There is a significant relationship between intergovernmental transfers and quality of PHC services delivered in Kigarama Sub County. (iii) Government policies significantly affect the relationship between fiscal decentralization and quality of PHC services. Regression analysis was used to test the hypotheses under the Model Summary[b] , ANOVA[b] and Coefficients[a] for each dimension.

4.3.1 Budgeting and Quality of PHC Services

In this section, the relationship between budgeting as one dimension of fiscal decentralization and quality of PHC services was assessed. In this study, elements of budgeting included decentralized planning, decentralized monitoring and decentralized execution. There was consistent consensus among the political leaders, health unit management committee members and staff who participated in the study that decentralized planning, monitoring and execution are effective in fostering the quality of PHC services.

However, the political leaders overwhelmingly complained that they were not being involved in planning. The staff and political leaders agreed that the health unit management committee was dedicating little time to oversee the implementation of PHC activities. The research also got information from the interviewees that the health unit management committee lacked technical competence to monitor some of the health activities. The interviewees were in agreement that inadequate resources like drugs and other supplies were a constant challenge to achieving decentralized planning, execution and monitoring.

4.3.1.1 Decentralized Planning and Quality of PHC Services

In this study, this variable was measured using 6 questions which solicited the respondents' opinions. This was done on the basis of the 5 likert scale. The results are presented in table 9.

Table 9: Respondents' Attitudes on Decentralized Planning and Quality of PHC Services

Item	SA %	A %	UD %	D %	SD %
Your views are considered during planning for PHC services	16.5	47.4	26.8	7.2	2.1
This decentralized planning helps in making correct decisions for PHC services	18.6	63.9	25.5	2.1	0
You usually participate in participatory planning for PHC services directly or through your representatives.	14.4	16.0	3.1	12.4	4.1
This decentralized planning improves access to PHC services	25.8	56.7	14.4	3.1	0
This decentralized planning effectiveness PHC services	23.7	64.9	11.3	0	0
This decentralized planning improves interpersonal relations for PHC services	23.7	51.5	20.6	4.1	0

Source: Primary data

Key: **SA** = Strongly Agree, **A**- Agree = **UD =** Undecided, **D** = Disagree **SD** = Strongly Disagree.

In the study 97 respondents were asked to give their opinions on decentralized planning and the quality of PHC services. As seen in table 9, in item No.1 respondents were asked whether their views were considered during planning for PHC services, out of 97 respondents 16.5% strongly agreed, 16.5% 47.4% agreed, 26.8% were undecided, 7.2 %disagreed and 2.1% strongly disagreed. In item No.2 the respondents were asked if decentralized planning helps in making correct decisions for PHC services, 18.6% of 97 respondents who participated in the study strongly agreed, 63.9% agreed, 15.5% were undecided, and 2.1% disagreed. In item No. 3

respondents were asked if they usually participated in planning directly or through their representatives. 14.4% strongly agreed, 16% agreed, 3.1% were undecided, 12.4% disagreed and 4.1% strongly disagreed. In item No.4 the respondents were asked if decentralized planning improves access to PHC services. 25.8% strongly agreed, 56.7% agreed, 14.4% were undecided and 3.1% disagreed. In item No.5 respondents were asked if decentralized planning improves effectiveness of PHC services. 23.7% strongly agreed, 64.9% agreed and 11.3% were undecided. In the item No.6 the respondents were asked if decentralized planning improves interpersonal relations of PHC services. 23.7% strongly agreed, 51.5% agreed, 20.6% were undecided and 4.1% disagreed.

The results imply that the majority of the respondents agreed that decentralized planning improves the quality of PHC services. This position was in agreement with the information obtained from key informants that decentralized planning has helped improve the quality of PHC services in a number of ways.

Examples given by the informants included establishing immunization outreaches in areas where the services are needed thereby improving the access, ordering types of drugs mostly needed thereby improving effectiveness and establishment of communication feed back mechanism to capture the feelings of the clients thereby improving interpersonal relations.

A correlation of these findings was done in table 10 and revealed a moderate significant relationship of .204 at the 0.05 level of significance (2 tailed).

Table 10: Correlation of Decentralized Planning and Quality of PHC Services

	Decentralized planning	Quality of primary health care services

Decentralized planning	Pearson Correlation	1	.204*
	Sig. (2-tailed)		.045
	N	97	97
Quality of primary health care services	Pearson Correlation	.204*	1
	Sig. (2-tailed)	.045	
	N	97	97

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

*. Correlation is significant at the 0.05 level (2-tailed).

Source: Primary data

A correlation of the findings in table 10 revealed a moderate significant relationship between decentralized planning and quality of PHC services with a coefficient of .204 at the 0.05 level of significance (2 tailed).

A regression of the same findings was done in tables 11-13. The results in table 11 show that a coefficient of determination, R2 (or R square) of 0.042 was obtained which implies that the amount of variation in the dependent variable that is statistically explained by the independent variable (decentralized planning) is 4.2%, obtained with a standard error estimate of 0.44.

Table 11: Model Summary of Decentralized Planning and Quality of PHC Services

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.204[a]	.042	.032	.440

a. Predictors: (Constant), Decentralized planning

b. Dependent Variable: Quality of primary health care services

Source: Primary data

Table 12: ANOVA b of Decentralized Planning and Quality of PHC Services

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.800	1	.800	4.134	.045[a]
	Residual	18.386	95	.194		
	Total	19.186	96			

a. Predictors: (Constant), Decentralized planning

b. Dependent Variable: Quality of primary health care services

Source: Primary data

Analysis of variance (ANOVA) in table 12 shows that the regression results were obtained with an F value of 4.134 which was significant at 95% confidence level (P = 0.045). This implies that the regression coefficient is significantly different from zero and that decentralized planning is a significant predictor of the quality of PHC services.

Table 13: Coefficient of Decentralized Planning and Quality of PHC Services

Coefficients

Model		Un standardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.824	.161		11.341	.000
	Decentralized planning	.151	.074	.204	2.033	.045

a. Dependent Variable: Quality of primary health care services

Source: Primary data

In table 13, the value of calculated *t* is compared with the critical value of *t* with n-2 degrees of freedom, n being the number of respondents. The coefficients show that the calculated value of *t* as 2.033. This is greater than the tabled value of *t* (1.980) with 97-2 = 95 degrees of freedom. And so we reject the null hypothesis that the value of t is zero. We can also arrive at the same conclusion by noticing that the calculated probability of .045 is not greater than .05. The alternative hypothesis is therefore substantiated.

4.3.1.2 Decentralized Execution and Quality of PHC Services

In the study, this section was measured using five questions on a five likert scale. The results of the 97 respondents are presented in table 14.

Table 14: Respondents' Attitudes on Decentralized Execution and Quality of PHC Services

Item	SA%	A%	UD%	D%	SD%
You are usually consulted during the implementation of the approved PHC services directly or through your representatives	10.3	60.8	9.3	12.4	7.2
Your views are considered in the implementation of PHC services.	11.3	50.5	20.6	12.4	5.2
This decentralized execution contributes to	17.5	61.9	11.3	9.3	0

improvement of access to PHC services.					
This decentralized execution contributes to improvement of effectiveness of PHC services	21.6	64.9	9.3	4..1	0
This decentralized execution contributes to improvement of interpersonal relations for PHC services	20.6	49.5	22.7	5.2	2.1

Key: **SA** = Strongly Agree, **A-** Agree = **UD =** Undecided, **D** = Disagree **SD** = Strongly Disagree.

Source: Primary data

As seen from table 14, in item No.1 respondents were asked if they were usually consulted during the implementation of the approved PHC services directly or through their leaders. 10.3% strongly agreed, 60.8% agreed, 9.3% were undecided, 12.4% disagreed and 7.2% strongly disagreed. In item No.2 the respondents were asked if their views were considered in the implementation of PHC services. 1.3% strongly agreed, 50.5% agreed, 20.6% were undecided, 12.4% disagreed, 5.2% strongly disagreed.

In item No.3 the respondents were asked if decentralized execution contributes to improvement of access to PHC services. 17.5% strongly agreed, 61.9% agreed, 11.3% were undecided, 9.3% disagreed. In the 4th item the respondents were asked if decentralized execution contributes to improvement of effectiveness of PHC services. 21.6% strongly agreed, 64.9% agreed, 9.3% were undecided and 4.1% disagreed. In the 5th item the respondents if the decentralized execution contributes to improvement of interpersonal relations for PHC services. 20.6% strongly greed, 49.5% agreed, 22.7% were undecided, 5.2% disagreed and 2% strongly disagreed.

The results indicated that the majority of the respondents agreed that decentralized execution fosters quality of PHC services. Respondents also agreed that their views are captured during implementation. This information is backed by the interviewees who agreed that they participated in decentralized execution in different ways. The administrative staff who participated in the study said they enforce laws on community health for example on immunization campaign. The political leaders who participated in the study showed that they carry out mobilization and sensitization of the communities for PHC services. The HUMC members who participated in the study said they oversee the implementation of PHC related activities and also harmonize relationships of different parties that participate in PHC activities. The medical staffs are charged with clients' disease control.

A correlation analysis of the same results was computed in table 15 to establish the relationship between decentralized execution and quality of PHC services.

Table15: Correlation of Decentralized Execution and Quality of PHC Services

		Decentralized execution	Quality of primary health care services
Decentralized execution	Pearson Correlation	1	.243*
	Sig. (2-tailed)		.017
	N	97	97
Quality of primary health care services	Pearson Correlation	.243*	1
	Sig. (2-tailed)	.017	
	N	97	97

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

*. Correlation is significant at the 0.05 level (2-tailed).

Source: Primary data

The correlation in table 15 revealed that there was a moderate positive relationship between decentralized execution and quality of PHC services with a correlation coefficient of. 243 at 0.05 level of significance. This indicates that with more decentralized execution the quality of PHC services is likely to get better.

Table 16: Model summary of decentralized execution and quality of PHC services

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.243[a]	.059	.049	.436

a. Predictors: (Constant), Decentralized execution

b. Dependent Variable: Quality of primary health care services

Source: Primary data

Table 16 indicates R square of .059. This means that 5.9% of the variations in the dependent variable is statistically explained by the independent variable (decentralized execution)

Table 17: ANOVA b of Decentralized Execution and Quality of PHC Services

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	1.131	1	1.131	5.953	.017[a]
	Residual	18.055	95	.190		
	Total	19.186	96			

a. Predictors: (Constant), Decentralized execution

b. Dependent Variable: Quality of primary health care services

Source: Primary data

Analysis of variance shows a significant value of F statistic of 5.953 significant at the level of 95% (P = .017) in table 17. This implies that the regression coefficient is significant. Hence decentralized execution is a significant predictor of the quality of PHC services.

Table 18: Coefficients of Decentralized Execution and Quality of PHC Services

Coefficients[a]

Model		Un standardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.797	.146		12.269	.000
	Decentralized execution	.152	.062	.243	2.440	.017

a. Dependent Variable: Quality of primary health care services

Source: Primary data

The coefficients in table 18 show a calculated value of *t* 2.440. This is greater than the value of *t* obtained from tables (1.980). We therefore reject the null hypothesis that the value of *b* (un standardized coefficients) is zero. The alternative hypothesis is substantiated.

4.3.1.3 Decentralized Monitoring and Quality of PHC services

In the study, 5 questions were used to measure this indicator. In table 19, the results of the five questions are presented.

Table 19: Respondents' Attitudes on Decentralized Monitoring and Quality of PHC Services

Item	SA%	A%	UD%	D%	SD%
You usually participate in monitoring of PHC	8.2	63.9	7.2	15.5	5.2

services directly or through your representatives					
Your views on monitoring are usually considered by the implementers	13.4	47.4	22.7	12.4	4.1
Monitoring mechanisms in place are appropriate to ensure access to PHC services	15.5	61.9	8.2	11.3	3.1
Monitoring mechanisms in place are appropriate to ensure effectiveness of PHC services	16.5	58.8	16.5	8.2	0
Monitoring mechanisms in place are appropriate to ensure interpersonal relations for PHC services	21.6	45.4	24.7	8.2	0

Key: **SA** = strongly Agree, **A**- Agree = **UD =** Undecided, **D** = Disagree **SD** = strongly Disagree.

Source: Primary data

In table 19, in item No.1, the respondents were asked if they usually participated in monitoring of PHC services directly or through their representatives. 8.2% strongly agreed, 63.9% agreed, 7.2% were undecided, 15.5% disagreed and 5.2% strongly disagreed.

In the 2nd item, the respondents were asked if their views on monitoring were usually considered by the implementers. 13.4% strongly agreed, 47.4% agreed, 22.7% were undecided, 12.4% disagreed and 4.1% strongly disagreed. In the 3rd item, the respondents were asked if monitoring mechanisms in place were appropriate to ensure access to PHC services. 15.5% strongly agreed, 61.9% agreed, 8.2% were undecided, 11.3% disagreed and 3.1% strongly disagreed. In the 4th item, the respondents were asked if monitoring mechanisms in place were appropriate to ensure effectiveness of PHC services. 16.5% strongly agreed, 58.8% agreed, 16.5% were undecided and 8.2 disagreed. In the 5th item, respondents were asked if monitoring mechanisms in place were

appropriate to ensure interpersonal relations for PHC services. 21.6% strongly agreed, 45.4% agreed, 24.7% were undecided and 8.2% disagreed.

The results indicate that decentralized monitoring contributes well to quality of PHC services. The information from the interviewees however suggests that decentralized monitoring is still weak. Those responsible for monitoring dedicate little time to this important activity. The HUMC, a committee charged with overseeing the delivery of PHC services lacks technical competence to monitor some of the activities like drug prescriptions, dosage, etc. Ongodia (2006), observes that HUMCs are technically weak and lack courage to hold the service providers accountable for poor service delivery. The committee also lacks adequate resources to enable it carry out substantive work. During the study, the researcher observed that the HUMC members check on the health centre only when they are invited for the quarterly committee meetings.

A correlation of these results was done in table 20 to determine the relationship between decentralized monitoring and quality of PHC services.

Table 20: Correlation of Decentralized Monitoring and Quality of PHC Services

		Decentralized monitoring	Quality of primary health care services
Decentralized monitoring	Pearson Correlation	1	-.024
	Sig. (2-tailed)		.814
	N	97	97
Quality of primary health care services	Pearson Correlation	-.024	1
	Sig. (2-tailed)	.814	
	N	97	97

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

*. Correlation is significant at the 0.05 level (2-tailed).

Source: Primary data

In table 20, the correlation indicates a negative relationship between decentralized monitoring and quality of PHC services with a coefficient of - .024, which is a low correlation at the level of significance of 0.814. This indicated that the relationship is not significant.

Table 21: Model Summary of Decentralized Monitoring and Quality of PHC Services

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.024[a]	.001	-.010	.449

a. Predictors: (Constant), Decentralized monitoring

b. Dependent Variable: Quality of primary health care services

Source: Primary data

The results in table 21 show a coefficient of determination of .001. This implies that 0.1% of variations in the dependent variable is explained statistically by the independent variable (decentralized monitoring). This indicates a non-significant relationship.

Table 22: ANOVA b of Decentralized Monitoring and Quality of PHC Services

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	.011	1	.011	.056	.814[a]
	Residual	19.175	95	.202		
	Total	19.186	96			

a. Predictors: (Constant), Decentralized monitoring

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	.011	1	.011	.056	.814[a]
	Residual	19.175	95	.202		
	Total	19.186	96			

b. Dependent Variable: Quality of primary health care services

Source: Primary data

Analysis of variance in table 22 shows that the regression results were obtained with an F value of 0.056 at the confidence level of less than 90 % (P = 0.814). This implies that F value statistic was low and was also obtained at a low confidence level; this means that the variation explained by the independent variable could be due to chance.

Table 23: Coefficients of Decentralized Monitoring and Quality of PHC Services

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.171	.149		14.608	.000
	Decentralized monitoring	-.014	.061	-.024	-.236	.814

a. Dependent Variable: Quality of primary health care services

Source: Primary data

The results in table 23 show the calculated value of *t* – 0.236. This value is less than the value of *t* obtained from the tables (1.980). We therefore reject the alternative hypothesis and accept the null hypothesis.

4.3.2 Intergovernmental Transfers and Quality of PHC Services

The relationship between intergovernmental transfers and quality of PHC services was analyzed under the two indicators of conditional grants and unconditional grants. On the whole, intergovernmental transfers were found responsible for procurement of supplies, remuneration of service providers and support towards establishment of infrastructure.

4.3.2.1 Conditional Grants and Quality of PHC Services

The study used 5 questions to measure this indicator on a five likert scale. The results of the 97 respondent's opinions were presented in table 24.

Table 24: Respondents' Attitudes on Conditional Grants and Quality of PHC Services

Item	SA%	A%	UD%	D%	SD%
Local leaders and the citizens have adequate	16.5	29.9	11.3	33	9.3

information about the conditional grants released to the sub-county for PHC activities					
The central government uses conditional grants to regulate the quality of PHC services.	13.4	68	17.5	1	0
Conditional grants contribute towards the improvement of access to PHC services.	14.4	69.1	14.4	2.1	0
Conditional grants contribute towards the improvement of effectiveness of PHC services	17.5	69.1	13.4	0	0
Conditional grants contribute towards the improvement of interpersonal relations for PHC services	20.6	41.2	33	5.2	0

Key: **SA** = strongly Agree, **A**- Agree = **UD =** Undecided, **D** = Disagree **SD** = strongly Disagree.

Source: Primary data

In the item No.1 of table 24, the respondents were asked if the local leaders and citizens have adequate information about the conditional grants released to the sub county for PHC services. 16.5% strongly disagreed, 29.9% agreed, 11.3% were undecided, 33% disagreed, 9.3% strongly disagreed. In the 2nd item, the respondents were asked if the central government uses conditional grants to regulate the quality of PHC services. 13.4% strongly agreed, 68% agreed, 17.5% were undecided and 1% disagreed.

In the 3rd item, respondents were asked if conditional grants contribute towards the improvement of access to PHC services. 14.4% strongly agreed, 69% strongly agreed, 14.4% were undecided,

2.1% disagreed. In item No.4, the respondents were asked if conditional grants contribute towards the improvement of effectiveness of PHC services. 17.5% strongly agreed, 69.1% agreed, 13.4% were undecided. In item No.5, respondents were asked if conditional grants contribute towards the improvement of interpersonal relations to PHC services. 20.6% strongly agreed, 41.2% agreed, 33% were undecided and 5.2% disagreed. The results indicate that the majority of the respondents strongly agreed that conditional grants strongly influence the quality of PHC services.

A correlation of the same findings was done in table 25 to assess the relationship between conditional grants and quality of PHC services.

Table 25: Correlation of Conditional Grants and Quality of PHC Services

		Conditional grants	Quality of primary health care services
Conditional grants	Pearson Correlation	1	.262**
	Sig. (2-tailed)		.009
	N	97	97
Quality of primary health care services	Pearson Correlation	.262**	1
	Sig. (2-tailed)	.009	
	N	97	97

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

*. Correlation is significant at the 0.05 level (2-tailed).

Source: Primary data

In table 25, the relationship between conditional grants and quality of PHC services is moderately significant at 0.01 level if significance with a positive correlation of 0.262.

This implies that an increase in the conditional grants release to the local government is likely to improve the quality of PHC services. This position is consistent with the data obtained from the

study key respondents who all agree that the contribution of conditional grants towards the quality of PHC services can be enhanced if the grants were released timely and that there should be an allocation of flexibility to enable the implementers fund local priorities that may not be taken care of by the centre.

Table 26: Model Summary of Conditional Grants and Quality of PHC Services

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.262[a]	.069	.059	.434

a. Predictors: (Constant), Conditional grants

b. Dependent Variable: Quality of primary health care services

Source: Primary data

The above results in table 26 indicate a coefficient of determination of 0.069. This means that 6.9% of the variations in the dependent variable can be statistically explained by the independent variable (conditional grants).

Table 27: ANOVA b of Conditional Grants and Quality of PHC Services

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	1.321	1	1.321	7.024	.009[a]
	Residual	17.865	95	.188		
	Total	19.186	96			

a. Predictors: (Constant), Conditional grants

b. Dependent Variable: Quality of primary health care services

Source: Primary data

Analysis of variance in table 27 shows that regression results were obtained with an F value of 7.024 significant at 99% confidence level (P = 0.009). This shows a significant coefficient and it implies that conditional grants are a significant indicator of quality of PHC services.

Table 28: Coefficients of Conditional Grants and Quality of PHC Services

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.728	.161		10.746	.000
	Conditional grants	.183	.069	.262	2.650	.009

a. Dependent Variable: Quality of primary health care services

Source: Primary data

The coefficients in table 28 show a calculated value of *t* as 2.650. This value is greater than the value of *t* obtained from the tables (1.980). We therefore reject the null hypothesis that value of *t* is zero. The alternative hypothesis is substantiated.

4.3.2.2. Unconditional Grants and Quality of PHC Services

Table 29: Respondents' Attitudes on Unconditional Grants and Quality of PHC Services

Item	SA%	A%	UD%	D%	SD%
Local leaders and citizens have adequate information about unconditional grants released to the Sub-county for PHC activities	15.5	36.1	14.4	33	1
Unconditional grants have helped Kigarama Sub-county meet its locally preferred PHC priorities.	22.7	44.3	23.7	9.3	0
Sub-county Managers have the required ability to effectively utilize and account for the received unconditional grants.	20.6	36.1	34	9.3	0
Unconditional grants contribute towards improvement of access to PHC services.	20.6	47.4	23.7	8.2	0
Unconditional grants contribute towards the improvement of effectiveness of PHC services	21.6	52.6	16.5	9.3	0
Unconditional grants contribute towards the improvement of interpersonal relations for PHC services	23.7	34	35.1	7.2	0

Key: **SA** = strongly Agree, **A-** Agree = **UD =** Undecided, **D** = Disagree **SD** = strongly Disagree.

Source: Primary data

The study used 6 questions to obtain opinions from the respondents about this indicator. As presented in table 29, in item No.I respondents were asked if local leaders and citizens have adequate information about unconditional grants released to the sub county for PHC activities. 15.5% strongly agreed, 36.1% agreed, 14.4% were undecided, 33% disagreed, and 1% strongly disagreed. In item No.2, respondents were asked if unconditional grants had helped Kigarama sub county meet its locally preferred PHC priorities. 22.7% strongly agreed, 44.3% agreed, 23.7% were undecided, 9.3% disagreed. In the 3rd item, the respondents were asked if the sub county managers have the required ability to effectively utilize and account for the received unconditional grants. 20.6% strongly agreed, 36.1% agreed, 34% were undecided and 9.3% disagreed. In the 4th item, the respondents were asked if unconditional grants contribute towards improvement of access to PHC services. 20.6% strongly agreed, 47.4% agreed, 23.7% were undecided, 8.2% disagreed. In item No.5, the respondents were asked if unconditional grants contribute towards the improvement of effectiveness of PHC services. 21.6% strongly agreed, 52.6% agreed, 16.5% were undecided and 9.3% disagreed. In item No.6 respondents were asked if unconditional grants contribute towards the improvement of interpersonal relations for PHC services. 23.7% strongly agreed, 34% agreed, 35.1% were undecided, 7.2% disagreed.

The above results imply that the majority of the respondents agreed that unconditional grants strongly influence the quality of PHC services.

A correlation of the same findings was done in table 30 to assess the relationship between unconditional grants and quality of PHC services.

Table 30: Correlation of Unconditional Grants and Quality of PHC Services

		Unconditional grants	Quality of primary health care services
	Sig. (2-tailed)	.000	.009
	N	97	97
Unconditional grants	Pearson Correlation	1	.309**
	Sig. (2-tailed)		.002
	N	97	97
Quality of primary health care services	Pearson Correlation	.309**	1
	Sig. (2-tailed)	.002	
	N	97	97

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

*. Correlation is significant at the 0.05 level (2-tailed).

Source: Primary data

In table 30, the relationship between unconditional grants and quality of PHC services is analyzed with a moderate positive significant correlation of .309 at a significance level of 0.01. This implies that an increase in unconditional grants will most likely improve the quality of PHC services. This is in agreement with the data from the key respondents who agreed that unconditional grants help in co-funding capital projects for PHC services like buildings and in maintenance of the existing facilities.

Table 31: Model Summary of Unconditional Grants and Quality of PHC Services

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.309[a]	.096	.086	.427

a. Predictors: (Constant), Unconditional grants

b. Dependent Variable: Quality of primary health care services

Source: Primary data

The results in table 31 show a coefficient of determination of .096. This means that 9.6% of the variations in the dependent variable can be statistically explained by the independent variable (unconditional grants).

Table 32: ANOVA b of Uncondititonal Grants and Quality of PHC Services

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1.834	1	1.834	10.042	.002[a]
	Residual	17.352	95	.183		
	Total	19.186	96			

a. Predictors: (Constant), Unconditional grants

b. Dependent Variable: Quality of primary health care services

Source: Primary data

The regression coefficient shown in table 32 is significantly greater than zero. The significance value of the F statistic is also greater than 0.05. This means that the variation explained by the independent variable is not due to chance.

Table 33: Coefficients of Unconditional Grants and Quality of PHC Services

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.835	.105		17.463	.000
	Unconditional grants	.128	.040	.309	3.169	.002

a. Dependent Variable: Quality of primary health care services

Source: Primary data

The calculated value of *t* is 3.169 in table 33 and is greater than the value of *t* from the tables (1.980). So we reject the null hypothesis that *b* is zero. We can also arrive at the same conclusion by noticing that the calculated probability value of .002 is much less than the level of significance of .05. Alternative hypothesis is therefore substantiated. Therefore, the second study hypothesis was substantiated and null hypothesis rejected.

4.3.3 Government Policies and Quality of PHC Services

The study used 5 items to measure this variable on a five likert scale. The results of the 97 respondents were presented in table 34.

Table 34: Respondents' Attitudes on Government Policies and Quality of PHC Services

Item	SA%	A%	UD%	D%	SD%
Central Government makes adequate policies for PHC services	25.8	52.6	13.4	8.2	0
The existing policies of central government on PHC services are effective in regulating and coordinating PHC services.	22.7	55.7	14.4	7.2	0
Central government policies regulate the access to PHC services.	21.6	58.8	13.4	5.2	1
Central government policies regulate the effectiveness of PHC services	21.6	64.9	10.3	2.1	1
Central government policies regulate the interpersonal relations for PHC services	25.8	35.1	35.1	3.1	1

Key: **SA** = Strongly Agree, **A**=Agree = **UD =** Undecided, **D** = Disagree **SD** = Strongly Disagree.

Source: Primary data

The study used 5 items to measure this variable on a five likert scale. The results of the 97 respondents were presented in table 34. In item No.1, respondents were asked if central government makes adequate policies for PHC services. 25.8% strongly agreed, 52.6% agreed, 13.4% were undecided and 8.2% disagreed. In item No.2, respondents were asked if the existing policies of central government on PHC services are effective in regulating and coordinating PHC services. 22.7% strongly agreed, 55.7% agreed, 14.4% were undecided and 7.2% disagreed. In the 3rd item, respondents were asked if central government policies regulate the access to PHC services. 21.6% strongly agreed, 58.8% agreed, 13.4% were undecided, 5.2%disagreed and 1% strongly disagreed.

In the 4th item, respondents were asked if central government policies regulate the effectiveness of PHC services. 21.6% strongly agreed, 64.9% agreed, 10.3% were undecided, 2.1% disagreed and 1% strongly disagreed. In the 5th item respondents were asked if central government policies regulate the interpersonal relations for PHC services. 25.8% strongly agreed, 35.1% agreed, 35.1% were undecided, 3.1% disagreed and 1% strongly disagreed. In the five items indicated in the table the majority of the respondents agreed with the questions. This implies that central government policies have a significant relationship with the quality of PHC services.

A correlation of the same findings was done in table 35 to assess the influence of government policies on the quality of PHC services.

Table 35: Correlation of Government Policies and Quality of PHC Services

		Central government policies	Quality of primary health care services
	N	97	97
Central government policies	Pearson Correlation	1	.437**
	Sig. (2-tailed)		.000
	N	97	97
Quality of primary health care services	Pearson Correlation	.437**	1
	Sig. (2-tailed)	.000	
	N	97	97

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

*. Correlation is significant at the 0.05 level (2-tailed).

Source: Primary data

The results in table 35 indicate a moderate positive significant relationship between government policies and quality of PHC services with a coefficient of .437 obtained at a significance level of 0.01 (2 tailed).

However, the key respondents pointed out that some of the central government policies on PHC lie idle for example some parishes are far from the nearest health centre and yet they do not have a health centre of their own. The distances are long; and they cited that people travel from the parishes of Katooma and Bwayegamba to Kigarama HC III, a distance of more than 5 kilometers. This makes some of them fail to seek important PHC services because they fear the long distance to be traveled. The interview also indicated that some of the policies that are implemented lack adequate resources to support and make them more meaningful. They cited absence of drugs at the health centre for the common ailments.

The third hypothesis that government policies significantly affect the relationship between fiscal decentralization and quality of primary health care services was tested using regression analysis.

Table 36: Model Summary of Government Policies and Quality of PHC Services

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.437[a]	.191	.183	.404

a. Predictors: (Constant), Central government policies

Source: Primary data

The results in table 36 indicate a coefficient of determination of 0.191. This means that 19.9% of the variations in the dependent variable (quality of PHC services) is statistically explained by the government policies (moderator variable). This implies that the variations in the quality of PHC services explained by the government policies are moderate.

Table 37: ANOVA b of Government Policies and Quality of PHC Services

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	3.670	1	3.670	22.469	.000[a]
	Residual	15.516	95	.163		
	Total	19.186	96			

a. Predictors: (Constant), Central government policies

b. Dependent Variable: Quality of primary health care services

Source: Primary data

The results in table 37 indicate an F statistic value of 22.469 obtained a 99% level of significance. This implies that the variations in the dependent variable explained by the government policies can not be due to chance.

Table 38: Coefficients of Government Policies and Quality of PHC Services

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.580	.125		12.685	.000
	Central government policies	.271	.057	.437	4.740	.000

a. Dependent Variable: Quality of primary health care services

Source: Primary data

The results in table 38 indicate a calculated value of *t* as 4.740 obtained at 99% level of significance. This value is far greater than the value of *t* obtained from the tables (1.980).

We therefore reject the null hypothesis. Therefore the alternative hypothesis is substantiated. We can arrive at the same conclusion by noticing that the level of significance at which *t* was calculated (.000) is far less than .05. The third study hypothesis was therefore substantiated.

The study also used partial correlations to establish the moderating effect on the relationship between fiscal decentralization and quality of PHC services. The results were presented in the table 39.

Table 39: Partial Correlations Showing the Effect of Moderator Variable

Variable	**Quality of PHC services (MV not controlled)**	**Quality of PHC services (MV controlled)**
Decentralized planning	.204	.079
Significance(2 tailed)	.045	.444
df	95	94
Decentralized execution	.243	.093
Significance(2taild)	.017	.369
df	95	94
Decentralized Monitoring	.024	.264
Significance 2 tailed	.814	.009
df	95	94
Conditional grants	.262	.031
Significance 2 tailed	.009	.765
df	95	94
Unconditional grants	.309	.103
Significance 2 tailed	002	.319
df	95	94

Source: Primary data

Table 39 has a middle column with coefficients before controlling the MV (Government policies).

In this column, only one variable (decentralized monitoring) indicates a coefficient that is not significant (- 0.024 obtained at 0.814 level of significance). In the third column with coefficients after controlling the MV, only the variable of decentralized monitoring has a coefficient with a significant relationship (- .264 obtained at a significance level of .009). This indicates that the government policies play a vital role in decentralized monitoring.

CHAPTER FIVE

SUMMARY, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary of the study, discussion of the findings, conclusions and recommendations. It also presents contributions of the study and areas for further research. The discussion of the findings, conclusion and recommendations are presented objective by objective.

5.1 Summary of the Study

5.1.1 Purpose of the Study

The purpose of the study was to assess the effect of fiscal decentralization on the quality of PHC services delivered in Kigarama Sub county for the period 2003-2008. Fiscal decentralization was analyzed under two dimensions of budgeting and intergovernmental transfers. Budgeting was analyzed under three indicators of decentralized planning, decentralized execution and decentralized monitoring.

Intergovernmental transfers were analyzed under the indicators of conditional grants and un conditional grants. Quality of PHC services was studied under three components of access to PHC services, effectiveness of PHC services and interpersonal relations of PHC services. The study moderator variable was government policies on PHC services.

5.1.2 Major Findings of the Study

The study findings revealed that budgeting in general had moderate positive significant relationship with the quality of PHC services, but its indicator of decentralization monitoring showed a negative insignificant relationship. Decentralized planning reflected a correlation of 0.204 (significant at .045, 2 tailed, decentralized execution showed a correlation of 0.243 (significant at 0.17, 2 tailed). Intergovernmental transfers showed a moderate significant positive relationship with the quality of PHC services. Conditional grants showed a correlation of 0.309 (significant at 0.002, 2 tailed). Central Government policies showed a moderate positive significant relationship with quality of PHC services with a correlation of 0.437 (significant at 0.000, 2 tailed). The study also used partial correlations to assess the magnitude of the effect of central government policies on the relationship between fiscal decentralization and the quality of PHC services. The results indicated that when the MV (government policies) is controlled, all variables indicate insignificant relationships apart from decentralized monitoring which shows a significant negative relationship.

5.2 Discussion of the Findings

The discussion of the findings for the study was done according to the study objectives.

5.2.1 Budgeting and Quality of PHC Services

The effect of budgeting on the quality of PHC services was analyzed under three dimensions of decentralized planning, decentralized execution and decentralized monitoring.

5.2.1.1 Decentralized Planning and Quality of PHC Services

Decentralized planning reflected a moderate significant relationship with quality of PHC services. It had a correlation coefficient of 0.204 obtained at the level of significance of 0.045 and it accounted for 4.2% of the variations in the dependent variable.

This is a significant prediction for the dependent variable given the fact that decentralized planning is just one of the indicators under the independent variable. Decentralized planning is perhaps the starting point to achieving quality PHC services. This is because it enables the stakeholders identify the existing gaps in accessing PHC services, rendering PHC services effective and in the interpersonal relationship of PHC services. The stakeholders then prioritize these gaps with an aim of addressing them. This position appears close to the opinion held by the stakeholders who participated in the study through interviews. They revealed that prioritizing the establishment of immunization outreaches in the sub county and actually establishing them has boosted access to PHC immunization services. This priority of establishing the outreaches emanated from the identification of the problem that mothers had to travel long distances to the health centre in need of this service. The study also discovered through interviews that establishment of the communication system that allows a feedback from the clients through the suggestion box was an output of decentralized planning. The practice of the suggestion box had helped improve interpersonal relations. The study through the documentary review discovered that basing on the frequencies of the diseases, the health centre requisitions for drugs in reflection of the commonest diseases through annual and quarterly work plans.

During the study, however, the researcher observed that decentralized planning is not devolved enough to bring out the desired outputs in the quality of PHC services. Although stakeholders prioritize their local needs, these are rarely implemented because the health centers almost have no control over the financial resources. The funding available to them comes in form of conditional grants and it has numerous conditions which do not leave room for the local priorities. This practice looks to be a contravention of the principles of PHC. WHO (2002) asserts that in PHC, people at the local level should be actively involved in planning, implementation and monitoring.

Kirunga, *etal* (2009), observed that the definition of PHC emphasizes local ownership of health services. Health care solutions should be created, owned and sustained by communities. The communities should be involved in decision making. The politicians who were interviewed confessed that they did not participate in planning for health activities because funding and priorities for health are predetermined from the central government. "I do not see the relevance of participating in PHC planning when health annual priorities are determined by the line Ministry". Local Council III councillor for Masheruka parish Mr. Tumwesigye Ezra, commented during the interview.

5.2.1.2 Decentralized Execution and Quality of PHC Services

Decentralized execution reflected a moderate positive significant relationship with the quality of PHC services with a correlation coefficient of 0.243 at 0.017 level of significance. Under the regression analysis the same results revealed that decentralized execution statistically explained 5.9% of the variations in the quality of PHC services. This implied that this indicator is a significant predictor for the variations in the dependent variable as it adds its contribution to that of other indicators. The study through interviews obtained data that each category of the key stakeholders participated in implementation of PHC activities differently. The administrative staffs who participated in the study said they enforce laws on community health for example on immunization campaign. The political leaders who participated in the study showed that they carry out mobilization and sensitization of the communities for PHC services. The HUMC members who participated in the study said they oversee the implementation of PHC related activities and also harmonize relationships of different parties that participate in PHC activities. The medical staffs are charged with clients' disease control.

The review of the HC documents revealed that decentralized execution was being slowed down by inadequate supplies, providers and small range of activities of health services.

This does not go well with decentralization of health services according to WHO. WHO (2002), contends that in decentralization of health services, the lower level has a better opportunity to adapt or translate policy, strategy and targets to suit local needs without too much compromise on quality. Despite many important tasks that should be maintained by the centre, gradually programme implementation in general; should become the main task of the local or lower units. Top-down implementation by a strong central government of a new health policy without due regard for a process of consultation and adaptation should be avoided.

5.2.1.3 Decentralized Monitoring and Quality of PHC Services

The study findings found a very low negative relationship between decentralized monitoring and quality of PHC services, with a correlation of 0.024 obtained at a level of significance of 0.814. Given the fact that this correlation was obtained at a significance level (0.814), and considering that the coefficient is low (-0.024), the implication is that the explanation of the variations in the dependent variable by decentralized monitoring could be by chance. The most interesting aspect with this indicator is that the negligible correlation coefficient indicated reflects a negative relationship. It is more interesting that when the moderating variable (MV) was controlled using partial correlation, this negative relationship was magnified (0.264), obtained at a significance level of 0.009. This becomes a significant negative relationship. This implies that government policies (MV) play a big role in decentralized monitoring. This position is in agreement with the national Constitution of Uganda (1995) which provides that the ministry of health is responsible for conducting monitoring and evaluation of health programmes, among other roles.

5.2.2 Intergovernmental Transfers and Quality of PHC Services

The effect of intergovernmental transfers on the quality of PHC services was analyzed under two indicators of conditional grants and unconditional grants.

5.2.2.1 Conditional Grants and Quality of PHC Services

The study correlations on conditional grants and quality of PHC services indicated a coefficient of 0.262 (at a significance level of 0.05, 2 tailed). This is a moderate positive relationship and it implies that conditional grants statistically explain 6.8% of the variations in the dependent variable. This position is in agreement with the data obtained from the minutes of the health centre which indicated that drugs supplies and equipment used at the health centre are obtained through conditional grant. Availability of drugs at the health centre seemed to the researcher to be taking a key role of quality in the perspective of the client. The findings are in strong agreement with several studies on clients' perception of drug availability.

Opera (1996), observes that many studies show that patients equate availability of drugs with high quality services. In Kenya, one study reported that drug availability in the health facility had a positive impact on demand for services. Another study in Tororo, Uganda also concluded that the availability of drugs in the rural health facilities brought satisfaction not only to the users, but also to the providers. DISH (1999), found out that a reliable supply of drugs was a critical but lacking factor in provision of quality service. This factor needs to be addressed if the demand and utilization of services is to increase. Gilison, *et al* (1994), asserts that drugs are a main reason why people seek care in alternate locations. Nshakira, *et al* (1996), observes that some clients often think that receiving drugs means receiving treatment. Therefore consultation without drugs is a waste of time. As a result, many users will choose a health facility where they expect to find drugs all the time, such as private clinics.

The respondents who participated in the interviews of the study observed that the effectiveness of PHC services heavily depends on the availability of drugs at the health centre.

WHO (2002), stresses that the ministry of health should be responsible for specialized health care services and medical supplies in order to make sure that the population gets equitable access to necessary quality care services. The researcher observed that many clients go home complaining when they fail to get drugs prescribed for their ailments at the health centre.

DISH (1999), reports that clients believe a health facility with good quality service must be equipped with diagnosis equipment like blood testing equipment and laboratory equipment. Others include ambulance, furniture, beds, mattresses and gloves. The study found out in the deliberations of HUMC members that the releases of PHC grant were being made late making it difficult to execute the planned activities timely. The conditional grants were also too tight on conditions leaving no room for the adjustment necessary for peculiar needs. The key informants who participated in the study had a common position on the commitment and dedication of HUMC. They agreed that the committee dedicates very little time to monitoring and overseeing the implementation of PHC activities. Their role was simply described by some of the interviewees as simply attending quarterly committee meetings at the health centre. The study found out in the minutes of the committee meetings that there was a challenge of checks and balances on the drug stocks procured. There was no elaborate procedure of ensuring the safety of these drugs and the committee was not sure whether all the procured drugs were being put to use. This indicates that perhaps the committee was in not in full control. The PHC guidelines issued by the ministry of health in 2005 indicate that control of supplies is the duty of HUMC, but it looks the committee is not exhausting its mandate. The inadequacy of conditional grants does not stop at drugs alone. The facilitation for HUMC appears to be a big challenge. The study established from the proceedings of the committee meetings that on average, each committee member gets Shs. 3,000/=(three thousand) for a quarterly sitting.

On discussion with one of the committee members, the researcher discovered that from the furthest point of the sub county, boarding a motorcycle (*boda boda*) to and from the health centre for a meeting, a committee member would need Shs 5,000/=. This would therefore require this member to make a top up of Shs. 2,000= for every meeting from his/her reserves! Probably this is why they dedicate little time to the activities of the health centre and come to the health centre only to attend quarterly meetings. During the study, it was found out that there was a suggestion box at the health centre to capture the feelings of the clients. The box is emptied at the beginning of the meeting and the contents are discussed in that meeting, according to the HUMC chairperson.

However, the study realized that this method of communication feedback may not be appropriate for a community with low literacy. The respondent's background statistics indicate that 91.8% had education below 0'level (see table 6). It may be difficult to use a suggestion box as a means to capture the perceived needs of the clients in a community with such low levels of literacy. The key informants of the study indicated that the composition of HUMC does not enable it monitor all aspects of service delivery due to lack of professional background in health sciences.

5.2.2.2 Unconditional Grants and Quality of PHC Services

During analysis of the study findings, unconditional grants reflected a correlation coefficient of 0.309 at 95% confidence level, 2 tailed. This means that 9.5% variations in the dependent variable be explained by the unconditional grants. This is a moderate significant positive relationship. The key informants who participated in the study interviews generally reported that the unconditional grants received by the sub county help the health centre by meeting the 10% co-funding obligation required under capital development programmes. These programmes help in health centre infrastructure development. An example of such programmes is LGMSD (Local Government Management & Service Delivery).

The key informants also revealed that part of the unconditional grants also help in meeting operation and maintenance requirements for some of the existing facilities like motorcycle, ambulance, and buildings repairs.

However, documentary review of the sub county's final accounts for the FYs 2003/2004 – 2008/2009 indicated that the figures that are actually released for PHC activities were small considering the health demands of the community, and may hardly create impact.

Table 40: Budgeted Allocations and Actual Releases to PHC Activities from the Unconditional Grants for Kigarama Sub County for the Period 2003/2004 – 2008/2009

Financial year	**Budget (UShs)**	**Actual (UShs)**	**%**
2003/2004	2.820.600=	2.560.000=	90.7**%**
2004/2005	4.620.000=	3.220.000=	69.7**%**
2005/2006	5.762.550=	4.988.099=	86.6**%**
2006/2007	3.989.887=	3.276.928=	84**%**
2007/2008	2.671.000=	662.031=	24.9**%**
2008/2009	7.030.189=	3.835.215=	54.6**%**

Source: Kigarama Sub County final accounts for the period 2003/2004 – 2008/2009.

As indicated in table 40, in 2007/2008 and 2008/2009 periods, only 24.9% and 54.6% of the budgeted funds were actually spent on PHC activities. Besides, very little money of Shs 2,671,000= was budgeted for in 2007/2008. This indicates very small contribution that could hardly create the desired effect in the improvement of health service delivery.

5.2.3 Central Government Policies and Quality of PHC Services

The central government policies on PHC services reflected a correlation coefficient of 0.437 obtained at 99% level of confidence, 2 tailed. This implies that central government policies can explain 19% of the variations in the dependent variable. This is a high significant relationship indicating that central government policies are a significant predictor of quality of PHC services.

The study reviewed central government policies on PHC services like National Health Policy 2000/2001,MHCP, Health Sector strategic Plan (HSSP) 2000/2001 – 2004/2005, conditions on PHC grant 2004/2005, establishment of health centre IIs at every parish, manpower structure at health centers and formation of HUMCs to oversee PHC service delivery. The responses from the study interviews indicated that while the existing policies have good intentions in the perspective of the client, many of them leave a lot desired for their fulfillment. The free minimum health care package policy is hampered by inadequate supplies especially drugs and many clients go back without any drug or with fewer drugs than the prescribed. The health centre has no other source of revenue other than the conditional grants to enable it purchase more drugs to top up what is supplied by the government. The researcher observed that the patient who is in dire need of the prescribed drug is left with either to keep coming back until that drug is procured, which often takes long, or to buy that missing drug from the private pharmacists. The second option is often expensive and a choice of those who can afford, and the first one, of their unable counterparts. This position does not seem to be the vision of the 5 year HSSP 2000/2001 – 2004/2005 which is to ensure quality health services accessible to all Ugandans which are responsive to their needs (MoH, 2006).

Key informants interviewed expressed the need for re-introduction of affordable cost sharing scheme so that the realized revenue can go towards the purchase of additional drugs.

The respondents consistently argued that the problem of the clients was not paying for quality health services but affordability. Brawley (2000) notes that communities are willing to pay for improved quality of PHC services. Their concern is affordability. Patients do desire affordable fees if that is what it demands to have a quality service. The central government efforts to establish HC IIs at every parish has been hampered by small budgets. During the study, documents at Kigarama Health Centre showed that the sub county of seven parishes has only 2 health centres in two parishes. The researcher observed that some clients who come to the health centre walk long distances and arrive when they are exhausted. The conditions attached to the PHC grant are too stringent with a direct focus on supporting key areas of PHC. However, this leaves out funding for the local priorities which target PHC support services for example sanitation and cleanliness at the health centre and yet the health centre has no alternative source for funding for these priorities. The respondents of the study expressed the need for adjusting the conditions of PHC grant to allow flexibility for funding of the local priorities.

The researcher observed low morale among the service providers. Although it is designed that they stay at the health centre to respond to the needs of their clients swiftly, some of them were seen reporting in the morning seemingly from long distances. Brawley (2000), asserts that lack of providers at a health facility has a negative impact on the client's perception of quality. The author also observes that poor pay and lack of allowances are not conducive to the provision of quality care. They cause low morale and motivation for providers. The formation of HUMCs to oversee the delivery of PHC services has met a challenge of lack of technical competence. Most of the interviewees acknowledged that the HUMC lacks technical competence to judge performance standards in the area of medication. The staffs are few in number. Most of them leave the service for better conditions in the private sector. Table 41 indicates staffing position of Kigarama HCIII during the time of the study.

Table 41: Staffing Position at Kigarama HCIII in 2009

Approved post	**No. of Posts Approved**	**No. of Posts Filled**	**%**
Nursing Officer	1	0	0**%**
Enrolled Nurse	3	2	66.7**%**
Enrolled Midwives	2	2	100**%**
Nursing Assistant	3	1	33.3**%**
Senior Clinical Officer	1	0	0**%**
Clinical Officer	1	1	100**%**
Health Assistant	1	1	100**%**
Lab. Technician	1	0	100**%**
Lab. Assistant	1	1	100**%**
Health Information Assistant (Records Officer)	1	1	100**%**
Guards/Askari	2	0	0**%**
Porters	2	0	0**%**
Total	**19**	**9**	**47.4%**

Source: MoH, (2005) and Kigarama HCIII staff list

Although Kigarama HC III was allocated 19 staff in the approved manpower structure, only 9 (47.4%) were attached to the centre at the time of the study, as shown in table 41.

This implies that the staffs work under the stress of workload and this definitely affects their performance and client satisfaction. The problem of low morale seems to be stemming from the low pay offered by government.

5.3 Study Conclusions

The study conclusions have been arranged according to the objectives.

5.3.1 Budgeting and Quality of PHC Services

The conclusions of the study on budgeting and quality of PHC services were drawn under the three indicators of decentralized planning, decentralized execution and decentralized monitoring.

5.3.1.1 Decentralized Planning and Quality of PHC Services

The study established the existence of a moderate significant positive relationship between decentralized planning and quality of PHC services. Decentralized planning was therefore established as a significant predictor of the quality of PHC services. The alternative hypothesis that there is a significant relationship between decentralized planning and the quality of PHC services was substantiated. The study also established that decentralized planning is in practice the starting point to enhance the quality of PHC services. The gaps that hinder the rendering of a quality services in PHC can be identified and prioritized during planning. It was also observed that decentralized planning is not yet decentralized enough to capture the aim of decentralization which is creation of inclusive, involving and participatory governance that is able to enhance quality of public services. Activities for funding are still predetermined from the centre. As a result, the locally prioritized needs that can not be merged with those activities that are centre-selected eventually do not get funding. Some of these priorities are preventive and cost effective. This trend has killed the enthusiasm of local policy makers to actively participate in decentralized planning. The result is that those gaps identified as hindrances to attaining quality service remain unaddressed and quality suffers.

5.3.1.2 Decentralized Execution and Quality of PHC Services

During the study, a moderate positive significant relationship between decentralized execution and quality of PHC services was found. Decentralized execution was therefore a significant predictor of variations in the quality of PHC services. The hypothesis that decentralized execution has a significant relationship with the quality of OHC services was accepted. The study found that different key stakeholders perform different roles in the execution of PHC activities, each role contributing to the overall function of decentralized execution. It was observed during the study that decentralized execution is limited by inadequate supplies, small number of implemented and funded many activities and the small number of service providers deployed at the health centre.

5.3.1.3 Decentralized Monitoring and Quality of PHC Services

During the study, an insignificant relationship between decentralized monitoring and quality of PHC services was reflected. Therefore decentralized monitoring was not found to be a significant predictor for variations in the quality of PHC services. The control of the moderator variable (MV) showed that central government policies play a big part in decentralized monitoring.

It is clear that there is another variable (chaotic) which makes the relationship spurious. To obtain a clear relationship between decentralized monitoring and quality of PHC services, this chaotic variable should be controlled. During the study, it was established that HUMC, a body specifically charged with monitoring of PHC service delivery, lacks technical competence to monitor areas of disease diagnosis and treatment. The committee also dedicates little time to monitoring and visits the health centre only for quarterly meetings.

5.3.2 Intergovernmental Transfers and Quality of PHC Services

The study conclusions under this dimension were presented under the two indicators of conditional grants and unconditional grants.

5.3.2.1 Conditional Grants and Quality of PHC Services

A moderate significant relationship between conditional grants and quality of PHC services was established during the study. The second study hypothesis that conditional grants significantly affect quality of PHC services was tested and accepted. The study found out that the role of conditional grants in quality service delivery is three fold: (i) Provision of supplies especially drugs which are major predictors of effective service delivery in the clients' perspective. (ii) Provision of equipment. (iii)Payment of staff salaries, allowances and operating costs for PHC activities. It was established during the study that the supply of drugs is inadequate and that many clients equate effectiveness of service to the availability of drugs. It was also observed during the study that some basic equipment is either lacking or is obsolete. The study established that PHC grant conditions fail to accommodate locally generated PHC priorities and that the grant is released late. The grant's capacity to motivate and retain staff was found inadequate by the study.

Dehu *et al* (2002), observes that even when PHC money reaches the health centre, the service providers may be poorly paid and ineffectively monitored. Clients, mean while, have limited information to enable them hold the service providers accountable. This situation is common and it brings down efforts to attain a quality service.

5.3.2.2 Unconditional Grants and Quality of PHC Services

The analysis of the relationship between unconditional grants and quality of PHC services reflected a moderate significant one. Unconditional grants therefore were interpreted as a significant predictor for variations in the quality of PHC services.

The second hypothesis of the study that unconditional grants significantly affect quality of PHC services was substantiated. The study found out the role of unconditional grants received by Kigarama Sub County in PHC activities two fold: (i) Co–financing the construction of infrastructure at the health centre under the funding of LGDP II and LGMSD programmes. (ii) Meeting the operation and maintenance costs of the existing facilities at the health centre. During the study, it was however established that the contribution of the unconditional grants towards PHC activities is still small and that serious contribution would cause the desired effect.

5.3.3 Government Policies and Quality of PHC Services

The study established a moderate significant relationship between government policies and quality of PHC services. The third hypothesis of the study that government policies significantly affect the relationship between fiscal decentralization and quality of PHC services was tested and accepted. The study also established that government policies take an upper hand in the function of decentralized monitoring.

During the study, a number of government policies on PHC were reviewed and their effectiveness was found wanting. The budget allocated to the implementation of the policies to cater for the needs of the clients is inadequate. The small budget has also made some of the policies idle and irrelevant. The study also analyzed that there was a need to supplement government's funding to realize a quality service through affordable user fees.

5.4 Study Recommendations

The recommendations of the study were presented under the two dimensions of budgeting ad intergovernmental transfers.

5.4.1 Budgeting and Quality of PHC Services

The study recommendations under this dimension were done under three indicators of decentralized planning, decentralized execution and decentralized monitoring.

5.4.1.1 Decentralized Planning and Quality of PHC Services

The study found out that decentralized planning is not devolved enough to capture and integrate the input of the local communities fully. From the findings, it is evident that there is a need to decentralize planning for PHC services more, by allowing the input of local policy makers and creation of a funding for that input. Local policy makers therefore should be given more opportunities to plan for PHC activities which focus on disease prevention and concerns of the majority clients like female clients and family planning clients. Health centre reports indicated that most diseases treated are preventable. An analysis of the categories of diseases reported between 2003 – 2008 at the health centre was done in table 42.

Table 42: Categories of Disease Cases Registered at Kigarama HC III for the Period 2003 – 2008

Year	NCD	CD	Maternal Health	Family planning	Immunization	PTMCT	Total
2003	2,176	28,076	2513	1,190	5,023	-	38,978
2004	4,532	29038	2,434	1,315	5,685	-	43,004
2005	1,939	27,664	2,431	2,307	5,810	-	40,151
2006	1,166	13,654	1,575	1,006	5,007	-	22,408
2007	1,330	16,464	1,824	1,048	7,120	984	28,770
2008	1,270	12,760	2,023	1,198	5,652	946	23,849

Key:

NCD – Non Communicable diseases

CD – Communicable "

PMTCT – Prevention of mother to child transmission (of HIV)

Source: Kigarama HC III Annual Performance Reports 2003 – 2008

Table 42 indicates that the majority of the cases handled by the centre consist of communicable and non- communicable diseases, which are preventable. Communicable diseases are dominated by intestinal worms, malaria and sexually transmitted diseases, and these are preventable. Kyabaggu (2008), supports this assertion that about 75% of our diseases are preventable; this calls for community participation. This can alleviate the problems associated with high client numbers at the health centre so that the remaining clients are given adequate attention. It would also lessen the burden of educating clients on personal hygiene while at the health centre by the service providers which is perceived in bad faith thereby resulting into poor interpersonal relations. Decentralized planning should be given an opportunity to capture the needs of the clients from the client communities and these needs should be funded and implemented if quality service is to be appreciated.

Brawley (2000), notes that an essential factor to consider when analyzing the quality of PHC services is the perspective of the client. For clients, quality care is something that meets their perceived needs. Client-centered care requires providers to respect a client's point of view, encourage clients to discuss their needs, provide the appropriate medical information to the client and assist them in making decisions rather than telling them what to do.

5.4.1.2 Decentralized Execution and Quality of PHC Services

The study concluded that funding and implementation of locally generated client-centered priorities is hardly done and that this stifles participation of some stakeholders. Funding and implementation of PHC activities should be done for both centre-selected and locally generated activities. This will attract participation of stakeholders in implementation because of a feeling of ownership and implementation of a wide range of activities. The approved staff structure should be implemented by the district, by deploying the remaining needed staff to reduce work load per staff.

The reduction of staff work load is likely to improve interpersonal relation as staff will get more time to attend to the individual clients.

5.4.1.3 Decentralized Monitoring and Quality of PHC Services

During the study it was established that the technical competence of HUMC was lacking for effective monitoring. During the selection of the HUMC, the professional background of the committee members should be considered. All the members of HUMC may not necessarily be qualified in health sciences but the committee should have representatives who can assist to interpret disease treatment procedures to enable the committee assess the level of performance in that particular aspect. The study established that the existing control mechanisms to check drug stocks are weak. The HUMC has mandate to establish a concrete mechanism for drug stock control with adequate checks and balances. The HUMC should take control and adequately control the drug stocks to guard against theft and misuse. During the study it was concluded that the little facilitation offered to HUMC members may not create a conducive environment for them to eagerly dedicate more time to the monitoring task. Facilitation for HUMC members should be increased to enable them meet the costs involved. This will most likely enhance their dedication. The study noted that the suggestion box in place was not capturing the feedback from the majority of the clients because they hold low levels of education. The HUMC should carry out periodic evaluation of client satisfaction levels through opinion survey of the clients who come for PHC services.

5.4.1 Intergovernmental Transfers and Quality of PHC Services

The recommendations of the study on intergovernmental transfers and quality of PHC services have been presented under the two indicators of conditional grants and unconditional grants.

5.4.1.1 Conditional Grants and Quality of PHC Services

The study established that drugs, other supplies, equipment and staff salaries are obtained by the health centre through conditional grants.

The conditional grants do not provide these requirements to the necessary standards. The budget allocation for drugs should be increased to meet the demands of the clients and meet their satisfaction and that of service providers. PAHO (2003), observes that providing quality care leads to higher job satisfaction and esteem derived from excellence of performance. In turn, patient satisfaction increases manifesting itself in appreciation and respect for health workers. Other supplies like gloves and laboratory chemicals should be supplied along with the drugs because they are complimentary. The salaries and allowances for service providers should be updated to match with the prevailing market conditions so as to attract new entrants, retain the existing personnel and motivate them. The conditions on grants should be revisited to accommodate room for funding of locally raised priorities that support PHC activities.

5.4.1.2 Unconditional Grants and Quality of PHC Services

During the study, the actual releases by the sub county to PHC activities for the period 2003/2004 – 2008/2009 were found inadequate to help create a quality service. The study recommends that bigger releases should be made to PHC activities. The sub county council should deliberately allocate a specific percentage of its budget to PHC activities and annually evaluate the actual releases made.

5.4.2 Government Policies and Quality of PHC Services

During the study, it was empirically established that government policies on PHC activities are not effective enough to bring out the intended effect on the ground of small budgets available to implement these policies. Therefore the central government should avail reasonable budgets to run the existing policies. The study also concluded that the problem of the community is not cost sharing for effective health services but affordable rates for cost sharing. The study recommends that cost sharing be introduced at rates affordable by the communities. The communities should be consulted on the rates.

Dehu *et al* (2002), notes that in a context where drug stock-outs are common, an abolition of user fees could have a deleterious impact on the capacity of facilities to deliver services. The writer observes that a considerable proportion of staffs were financed by user fees before its abolition, and wonders what could have happened to these staffs and the subsequent impact on service delivery. The study also recommends that government should exhaust consultations with the communities before making policies.

5.5 Contributions of the Study

5.5.1 Fulfillment of Goals for Government Policies

On top of achieving the primary objectives, this study has in the process of achieving these primary objectives made a humble contribution to the existing body of knowledge in the aspect of government policies on PHC activities. Basing on the empirical findings, the study explored that most of the government policies on PHC activities are initially designed with good targeted goals that would meet the clients' perceived needs but are not practically implemented to the level that would allow these targeted goals be realized. The result of this is that the clients do not live to taste the real intended good intentions of the policies and they end up criticizing the policies. This even makes it harder to evaluate the policies after their intended impact has aborted.

5.5.2 Abolition of User fees at the Health Centers

The study findings revealed that the policy of user fees also known as cost sharing was abolished in 2001 without making adequate evaluation and community consultations. As a result, the quality of PHC services has been affected. Some of the clients go back home without getting the desired health care package they have come for. The concern according to the empirical findings of this study was not the user fees but the affordability by the clients and the management of the collected fees.

5.6 Recommended Areas for Further Study

During the study, the researcher identified three areas that could be considered for future research, basing on the empirical findings of the study.

5.6.1 Decentralized Monitoring and Quality of PHC Services

The findings reflected that there was no significant relationship between the decentralized monitoring and the quality of PHC services. However, the insignificant relationship that was reflected was negative. When the MV was controlled, the relationship became significant but remained in the same direction (negative relationship). Although this was interpreted to mean that government policies (MV) still played a big role in decentralized monitoring, the direction of this relationship was unexpected. It indicates that as more decentralized monitoring is carried out, the quality of PHC services goes lower.

This implies that there is another variable that makes this relationship spurious. Neuman (2006: 171) explains that spuriousness occurs when two variables are associated but are not causally related because there is actually an unseen third factor that is the real cause. This unseen third factor represents a more powerful explanation. This variable needs to be studied and controlled to get the real relationship between decentralized monitoring and quality of PHC services.

5.6.2 The Effect of Private Partnerships on the Quality of PHC Services

During the study, the researcher observed that the private sector was playing a crucial role in PHC service delivery. The researcher noted the existence of strong networks between government facilities and non-governmental and civil society organizations delivering PHC services. Some of them deliver preventive care services that aim at reducing the number of reported cases at government health facilities. The effect of these private partners on the quality of PHC services should be assessed.

5.6.3 The Effect of Abolition of User Fees on the Quality of PHC Services

During the study, the key informants unanimously agreed that the quality of PHC services during the time of user fees was better than afterwards, in their opinion. Their arguments were consistent on the ground that the user fees would enable the health centre top up for the needed drugs, other essential supplies, motivation of staff and catering for operating costs not catered for by the conditional grants. They added that the user fees would reinforce community ownership and control, and thus more involvement. The effect of abolishing the fees on the quality of PHC services should be studied.

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APPENDICES

APPENDIX I

QUESTIONNAIRE

The researcher is conducting a study to assess the effect of fiscal decentralization on the quality of Primary health care services in local governments of Uganda, a case of Kigarama Sub-county. He is a student of UMI and the data collected will be purely used for academic purposes and will be treated with utmost confidentiality. He would be grateful if you could spare a few minutes to complete this questionnaire.

Grateful,

Bamanyisa B. Geoffrey

SECTION A: PERSONAL DATA OF RESPONDENTS

1. Please indicate your gender

a) Male ☐ b) Female ☐

2. Please indicate your age group

a) Below 30 ☐

b) 30-39 ☐

c) 40-49 ☐

d) 50-59 ☐

e) 60 & above ☐

3. What is your current highest formal education?

a) Post graduate ☐

b) Graduate ☐

c) Diploma ☐

d) Professional certificate ☐

e) A' level ☐

f) O'Level ☐

g) Other ☐

4. What is your religion?

a) Catholic ☐

b) Protestant ☐

c) SDA ☐

d) Moslem ☐

c) Others(specify) ☐

5. What type of service did you get from Kigarama Health centre III in 2008?

a) BCG/DPT Immunization ☐

b) Family planning ☐

c) Antenatal/Postnatal ☐

6. How many times did you visit Kigarama Health centre III in 2008 for these services?

a) Once ☐

b) Twice ☐

c) More than twice ☐

Instructions

Please rate the PHC services you were offered at Kigarama Health centre III using this scale.

1= Strongly agree 2 = Agree 3 = Undecided 4 = Disagree

5= Strongly disagree.

SECTION B: Decentralized planning and quality of PHC services

	Scale	**5**	**4**	**3**	**2**	**1**
1	You usually participate in participatory planning for PHC services directly or through your representatives					
2	Your views are considered during planning for PHC services					
3	This decentralized planning helps in making correct decisions for PHC services					
4	This decentralized planning improves access to PHC services					
5	This decentralized planning improves effectiveness of PHC services					
6	This decentralized planning improves interpersonal relations for PHC services					

SECTION C. Decentralized execution and quality of PHC services

	Scale	**5**	**4**	**3**	**2**	**1**
7	You are usually consulted during the implementation of the approved PHC services directly or through your representatives					
8	Your views are considered in the implementation of PHC services.					
9	This decentralized execution contributes to improvement of access to PHC services.					
10	This decentralized execution contributes to improvement of effectiveness of PHC services					
11	This decentralized execution contributes to improvement of interpersonal relations for PHC services					

SECTION D. Decentralized monitoring and quality of PHC services

	Scale	5	4	3	2	1
12	You usually participate in monitoring of PHC services directly or through your representatives					
13	Your views on monitoring are usually considered by the implementers					
14	Monitoring mechanisms in place are appropriate to ensure access to PHC services					
15	Monitoring mechanisms in place are appropriate to ensure effectiveness of PHC services					
16	Monitoring mechanisms in place are appropriate to ensure interpersonal relations for PHC services					

SECTION E. Conditional grants on quality of PHC services

	Scale	5	4	3	2	1
17	Local leaders and the citizens have adequate information about the conditional grants released to the sub-county for PHC activities					
18	The central government uses conditional grants to regulate the quality of PHC services.					
19	Conditional grants contribute towards the improvement of access to PHC services.					
20	Conditional grants contribute towards the improvement of effectiveness of PHC services					
21	Conditional grants contribute towards the improvement of interpersonal relations for PHC services					

SECTION F: Un conditional grants on quality of PHC services

	Scale	5	4	3	2	1
22	Local leaders and citizens have adequate information about unconditional grants released to the Sub-county for PHC activities					
23	Unconditional grants have helped Kigarama Sub-county meet its locally preferred PHC priorities.					
24	Sub-county Managers have the required ability to effectively utilize and account for the received unconditional grants.					
25	Unconditional grants contribute towards improvement of access to PHC services.					
26	Unconditional grants contribute towards the improvement of effectiveness of PHC services					
27	Unconditional grants contribute towards the improvement of interpersonal relations for PHC services					

SECTION G. Government policies on the relationship between fiscal decentralization and quality of PHC services

	Scale	5	4	3	2	1
28	Central Government makes adequate policies for PHC services					
29	The existing policies of central government on PHC services are effective in regulating and coordinating PHC services.					
30	Central government policies regulate the access to PHC services.					
31	Central government policies regulate the effectiveness of PHC Services					
32	Central government policies regulate the interpersonal relations for PHC services					

SECTION H: Access to services for PHC

	Scale	5	4	3	2	1
33	The services are within geographical reach					
34	There is no economic barrier to get the services					
35	There is no social barrier to get the services					
36	There is no barrier created by the health centre personnel to get the services					
37	There is no linguistic barrier to get the services					

SECTION I: Effectiveness of services for PHC

	Scale	5	4	3	2	1
38	The health personnel are usually on duty					
39	The required essential drugs are usually available					
40	The PHC services are delivered as expected					
41	The PHC services are delivered to the consumer's satisfaction					

SECTION J: Interpersonal relations of PHC services

	Scale	5	4	3	2	1
42	You feel you are taken care of when you visit Kigarama HC III for PHC services.					
43	You feel that the medical personnel listen to you and understand your mind.					
44	You feel that you are treated with respect by the medical personnel.					
45	You build trust and confidence in the medical personnel and tell them your health problems.					
46	You find it easy to communicate with the medical personnel					

APPENDIX II

INTERVIEW SCHEDULE

Dear Respondent,

I am in the process of carrying out a study to assess the effect of fiscal decentralization in the quality of primary health care services in local governments of Uganda, a case of Kigarama Sub-County. You have been identified as a key respondent in this study. Your contribution is crucial for the success of this study. The information you give will be treated with utmost confidentiality and will be used for academic purposes.

Personal data of respondents

A) Sex: Male Female ☐

B) Age: Below 30 ☐

30- 39 ☐

40- 49 ☐

50- 59 ☐

60 and above ☐

C) Level of Education:

Graduate and above ☐

Diploma ☐

Certificate ☐

Other ☐

1. Would you say that access to PHC services delivered in Kigarama Sub-County has changed since the introduction of fiscal decentralization? Please give examples.
2. How effective are PHC services delivered in Kigarama Sub-County? Do you think fiscal decentralization contributes towards this effectiveness in any way? Give examples.

3. Are the PHC services delivered in Kigarama Sub-County with interpersonal relations? Give description of these interpersonal relations. Would you think these interpersonal relations link to fiscal decentralization in any way? Explain.
4. Do you personally participate in planning for PHC services usually? In your view, is decentralized planning effective in improving the quality of PHC services in Kigarama Sub-County? (Give attention to access, effectiveness, interpersonal relations.)
5. Do you usually get involved in implementation of PHC activities in some way? Would you say that decentralized execution of PHC activities contributes towards the quality of PHC services (access, effectiveness, interpersonal relations) in Kigarama Sub-County?. Explain.
6. How would do you rate the effectiveness of decentralized monitoring of PHC activities in improving the quality of PHC services (in aspects of access, effectiveness, interpersonal relations) in Kigarama Sub-County? Justify this rate given.
7. Putting conditions on conditional grants by the central government is believed to enhance the quality of PHC services (in the aspects of access, effectiveness, interpersonal relations). What is your opinion about this?
8. Do you think unconditional grants assist Kigarama Sub-County to render better PHC services (in the areas of access, effectiveness, interpersonal relations)? Give examples.
9. Do you think the central government's role of policy making, regulating and coordinating PHC activities is effective in improving the quality of PHC services in Kigarama Sub-County? (Pay attention to access, effectiveness, interpersonal relations).
10. What would you recommend as the most effective strategy to improve quality of PHC services further? (Pay attention to access, effectiveness, interpersonal relations).

I sincerely appreciate your time and cooperation.

Bamanyisa B. Geoffrey – UMI Student

APPENDIX III

DOCUMENTS REVIEW CHECKLIST

1. Local Governments health performance reports 2002 – 2008.
2. Local government's budgets and fiscal accounts 2002/2003 – 2008/2009.
3. HUMC minutes 2003 – 2008
4. Staff work schedules 2003 – 2008
5. Government policies in PHC 2003 – 2008
6. PHC implementation guidelines 2003 – 2008
7. MDG's
8. Journals, papers presented in workshops, symposia on PHC between 2003 and 2008

APPENDIX IV

OBSERVATION CHECKLIST

1. Appearance of PHC facilities at health centers
2. Appearance of employees
3. Level and mode of interaction between employees and service consumers.
4. Hours spent at the health centre while getting the services.
5. Numbers of clients who come for the services at the health centers
6. Appearance and body language of the clients.

APPENDIX V

UGANDA MANAGEMENT INSTITUTE

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Plot 44-52, Jinja Road
P.O. Box 20131
Kampala, Uganda
Website: http://www.umi.ac.ug

Your Ref:

Our Ref: G/35

15 July 2009

TO WHOM IT MAY CONCERN

MASTERS IN MANAGEMENT STUDIES DEGREE RESEARCH

Mr. Bamanyisa Bwagi Geoffrey is a student of the Masters Degree in Management Studies of Uganda Management Institute 17th Intake 2008/2009 specializing in Public Administration and management, Registration Number: **08/MMSPAM/17/059.**

The purpose of this letter is to formally request you to allow this participant to access any information in your custody/organisation, which is relevant to his research.

His Research Topic is: ***Fiscal Decentralization and Quality of Primary Health Care Service in Local Governments of Uganda: A case study of Kigarama Sub County, Bushenyi District.***

Basheka Benon
HEAD, HIGHER DEGREES DEPARTMENT/
PROGRAMME MANAGER, MMS

To whom it may Concern

Please accord him the necessary Co-operation

31/08/09

FOR CHIEF ADMINISTRATIVE OFFICER
BUSHENYI DISTRICT LOCAL GOVERNMENT
P. O. BOX 01 BUSHENYI

APPENDIX VI

Pearson Correlations

		Decentralized planning	Decentralized execution	Decentralized monitoring	Conditional grants	Unconditional grants	Central government policies	Quality of primary health care services
Decentralized planning	Pearson Correlation	1	.337**	.531**	.587**	.436**	.597**	.204*
	Sig. (2-tailed)		.001	.000	.000	.000	.000	.045
	N	97	97	97	97	97	97	97
Decentralized execution	Pearson Correlation	.337**	1	.462**	.262**	.229*	.379**	.243*
	Sig. (2-tailed)	.001		.000	.010	.024	.000	.017
	N	97	97	97	97	97	97	97
Decentralized monitoring	Pearson Correlation	.531**	.462**	1	.500**	.338**	.434**	-.024
	Sig. (2-tailed)	.000	.000		.000	.001	.000	.814
	N	97	97	97	97	97	97	97

Conditional grants	Pearson Correlation	.587**	.262**	.500**	1	.585**	.648**	.262**
	Sig. (2-tailed)	.000	.010	.000		.000	.000	.009
	N	97	97	97	97	97	97	97
Unconditional grants	Pearson Correlation	.436**	.229*	.338**	.585**	1	.527**	.309**
	Sig. (2-tailed)	.000	.024	.001	.000		.000	.002
	N	97	97	97	97	97	97	97
Central government policies	Pearson Correlation	.597**	.379**	.434**	.648**	.527**	1	.437**
	Sig. (2-tailed)	.000	.000	.000	.000	.000		.000
	N	97	97	97	97	97	97	97
Quality of primary health care services	Pearson Correlation	.204*	.243*	-.024	.262**	.309**	.437**	1
	Sig. (2-tailed)	.045	.017	.814	.009	.002	.000	
	N	97	97	97	97	97	97	97

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

*. Correlation is significant at the 0.05 level (2-tailed).

APPENDIX VII

Partial Correlations

Control Variables			Decentralized planning	Decentralized execution	Decentralized monitoring	Conditional grants	Unconditional grants	Quality of primary health care services	Central government policies
-none-[a]	Decentralized planning	Correlation	1.000	.337	.531	.587	.436	.204	.597
		Significance (2-tailed)	.	.001	.000	.000	.000	.045	.000
		df	0	95	95	95	95	95	95
	Decentralized execution	Correlation	.337	1.000	.462	.262	.229	.243	.379
		Significance (2-tailed)	.001	.	.000	.010	.024	.017	.000
		df	95	0	95	95	95	95	95
	Decentralized monitoring	Correlation	.531	.462	1.000	.500	.338	-.024	.434
		Significance (2-tailed)	.000	.000	.	.000	.001	.814	.000
		df	95	95	0	95	95	95	95
	Conditional grants	Correlation	.587	.262	.500	1.000	.585	.262	.648
		Significance (2-tailed)	.000	.010	.000	.	.000	.009	.000
		df	95	95	95	0	95	95	95
	Unconditional grants	Correlation	.436	.229	.338	.585	1.000	.309	.527
		Significance (2-tailed)	.000	.024	.001	.000	.	.002	.000
		df	95	95	95	95	0	95	95

	Quality of primary health care services	Correlation	.204	.243	-.024	.262	.309	1.000	.437
		Significance (2-tailed)	.045	.017	.814	.009	.002	.	.000
		df	95	95	95	95	95	0	95
	Central government policies	Correlation	.597	.379	.434	.648	.527	.437	1.000
		Significance (2-tailed)	.000	.000	.000	.000	.000	.000	.
		df	95	95	95	95	95	95	0
Central government policies	Decentralized planning	Correlation	1.000	.149	.375	.327	.177	-.079	
		Significance (2-tailed)	.	.148	.000	.001	.084	.444	
		df	0	94	94	94	94	94	
	Decentralized execution	Correlation	.149	1.000	.356	.023	.037	.093	
		Significance (2-tailed)	.148	.	.000	.825	.719	.369	
		df	94	0	94	94	94	94	
	Decentralized monitoring	Correlation	.375	.356	1.000	.318	.143	-.264	
		Significance (2-tailed)	.000	.000	.	.002	.166	.009	
		df	94	94	0	94	94	94	
	Conditional grants	Correlation	.327	.023	.318	1.000	.376	-.031	
		Significance (2-tailed)	.001	.825	.002	.	.000	.765	
		df	94	94	94	0	94	94	
	Unconditional grants	Correlation	.177	.037	.143	.376	1.000	.103	
		Significance (2-tailed)	.084	.719	.166	.000	.	.319	
		df	94	94	94	94	0	94	
	Quality of primary health care services	Correlation	-.079	.093	-.264	-.031	.103	1.000	
		Significance (2-tailed)	.444	.369	.009	.765	.319	.	
		df	94	94	94	94	94	0	

a. Cells contain zero-order (Pearson) correlations.