

Fiscal Decentralisation and Primary Health Care Services Delivery in Mbale District, Uganda

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Abstract - This study sought to investigate the Fiscal Decentralization and Primary Health Care Services Delivery in Mbale District. It was guided by three (3) objectives that included the following; (i) to establish the state of fiscal decentralization on Primary Health Care Services Delivery; (ii) To identify the extent of Primary Health Care Services Delivery; (iii) To establish whether there is a significance relationship between fiscal decentralization and Primary Health Care Services Delivery in Mbale district. It was guided by three sampling techniques: stratified sampling, purposive sampling and simple random sampling. A descriptive correlation design was adopted. A researcher made a self-administered questionnaire was administered and interview guides from respondents. Purposive and random sampling procedures were employed. Percentages and frequencies were used to analyze categorical data. Pearson Product moment Correlation was used to find levels and significant relationships, Regression analysis was used to find the effect of fiscal decentralisation on Primary Health Care Services Delivery. The findings indicates that (39.2%) of the respondents were between the ages of 21-29 years. For gender it was revealed that (70.0%) were males and (30.0%) were females. the findings show that majority of the respondents (47.5%) were married, majority of the respondents (36.7%) have Bachelors Degree. working experience (27.5%) have worked with the organization for more than 5years. Thus, the result shows that majority of the respondents have worked with the organization for more than 5years.the findings on Fiscal Decentralization as an independent variable revealed that Allocating Revenue source (mean=2.77, std=.73681), expenditures responsibility (mean=2.74, std=.79673), Revenue administration (mean=2.79, std=.95282), Intergovernmental transfer (mean=2.77, std=.89644) with the overall mean of 2.76. the findings on Primary Health Care Services Delivery revealed that Accountability for service delivery (mean= 2.60, std=.53521) Public Education (mean=2.84, std=.51745) Proper Nutrition

(mean=2.74 std=.79095) Clean Water & Sanitation (mean=2.69, std=.75473) Maternal & Child Health Care (mean= 2.74 std= .79095) Immunization and Local Disease Control (mean=2.69, std=.75473) Accessible Treatment and Drug Provision (mean= 2.73 std=.78126) (mean= 2.72 std=.46278) Results show that Primary Health Care Services Delivery was significantly correlated with Fiscal Decentralisation ($r=0.773$, at $Sig=.000$). The results further indicated that the relationship that exists between Fiscal Decentralization and Primary Health Care Services Delivery is positive and significantly correlated, ($sig.>0.05$). This means that Fiscal Decentralization persuade Primary Health Care Services Delivery and the failure to decide clear Fiscal Decentralization well, the less the Primary Health Care Services Delivery. The Public Choice Theory of James Buchanan and Gordon Tullock (1969), on which this study was based were proved right. it is based on an improved allocation of resources in the public sector. And it has four basic elements;

First, regional or local governments are in a position to adapt outputs of public services to the preferences and particular circumstances of their constituencies, as compared to a central solution which presumes that one size fits all. Second, in a setting of mobile households, individuals can seek out jurisdictions that provide outputs well suited to their tastes, thereby increasing the potential gains from the decentralized provision of public services (Tiebout 1956).

Third, in contrast to the monopolist position of the central government, decentralized levels of government face competition from their neighbors; such competition constrains budgetary growth and provides pressures for the efficient provision of public services. And fourth, decentralization may encourage experimentation and innovation as individual jurisdictions are free to adopt new approaches to public policy; in this way, decentralization can provide a valuable "laboratory" for fiscal experiments.

it was recommended that, In order to generate more local resources sub-national governments should discover more potential sources of revenue for the district administration, and in line with that the central government should devolve more tax levying powers to lower tier governments in order to increase their own sources of revenues, which later will relieve the central government in form of grants transfers, and also restructuring of resource allocation and establishment of resource sharing mechanisms should be re-introduced.

Keywords: Fiscal Decentralization, Primary Health Care Services Delivery.

I. INTRODUCTION

Fiscal decentralisation has gained prominence as an expressed goal or as an actual programmatic pursuit in the context of or as a consequence of two prominent movements affecting the African state (Ndegwa, 2002). These two areas are: the structural adjustment programmes that sought to reform the public sector starting in the 1980s while the other is the ongoing transition toward more democratic and competitive politics that started in the 1990s (Bandie, 2003).

Fiscal decentralization holds great promise for improving the development objective of public service delivery, but the outcomes depend on its design and the institutional arrangements governing its implementation (Adarkwa, *et al.*, 1999). Now, the concept of requirements for achieving development objectives is changing and many countries around the world are now implementing fiscal decentralisation reforms (Bahl, *et al.*, 1992).

Programmes linked to fiscal decentralisation, on the other hand, have been embarked in many African countries to strengthen the role of regional and local government in development (World Bank, 1996). Increased fiscal decentralisation is expected to allow public goods and services to be provided at the level and costs desired by local communities and to enhance citizen participation in government (Bahl, 1999). According to Ebel and Yilmaz (2002) the shift from central to local governance, thus fiscal decentralisation, has resulted in a shift of focus (Bandie, 2003). To them, the concept of requirements for achieving the development objectives is changing and many countries around the world are now implementing fiscal decentralisation reforms (Bandie, 2003).

According to Shah and Thompson (2004) “in the last quarter century, over 75 countries have attempted to transfer responsibilities of the state to lower tiers of government. Significantly, most of these lower-tier governments have been elected, so that the decentralization is not just administrative

or fiscal, but also political (John, 2007). According to Uganda ministry of health there is inadequate funding for health sector activities especially Primary Health Care Services. Only Ushs 41.185bn was allocated as recurrent budget to run health service delivery in 137 LGs with 56 General Hospitals, 61 PNFP Hospitals and 4,205 Lower Level Health Units (Bahl, *et al.*, 1992). Maternal mortality rates were high in Mbale District at 680/100,000 (Bahl, *et al.*, 1992). Inadequate staff was also identified as an overarching challenge. (ACODE: 2013). What therefore remains alarming is whether there is a relationship between fiscal decentralization adopted by Uganda and the delivery of health services in Mbale district, Uganda.

However, while it is possible that in one case all of these aspects of decentralization may operate simultaneously, in another case, it is equally possible that a country may be decentralized in one or two respects, while less so in others (John, 2007). Accountability to local voters is perhaps the most crucial element of a decentralized system of governance. Town Councils (Mbale) must be locally elected, preferably by popular vote of the local population (Asibou, *et al.*, 1994). If the local leadership is appointed by higher levels of government, their accountability will be upwards and not down to the local population. It is almost as important that the local council appoint the local chief officers for example treasurer, chief education officer, among others. Otherwise, implementation will not be locally directed, and services may be delivered as directed by the center (Bahl, R. W. 1999). Other necessary conditions for fiscal decentralization are a significant set of expenditure responsibilities and a significant amount of taxing powers, budget making autonomy, transparency and a hard budget constraint (Boex, *et al.*, 2005).

In 1978, world leaders created the Declaration of Alma-Ata, which reaffirmed access to health as a fundamental human right and identified primary health care as the key to the attainment of the goal of health for all. The 30th anniversary of Alma-Ata coincided with the halfway mark of the United Nations' Millennium Development Goals, stimulating discussion about the role of primary health care in facilitating the achievement of those goals and led to revitalized calls for use of community health workers (CHWs) as a form of community participation. CHWs help individuals and groups in their own communities' access health and social services and educate them about various health issues. Many studies have documented the advantages of CHW programmes, including that such programmes can enhance community participation.

Integrated services' offer a range of integrated primary health care services from sites located in the communities they serve (World Bank. 2003). Their scope is significantly broader

than general practitioner services, but may include coordination with general practitioner services (Bahl, *et al.*, 1992). Integrated services provide single point access to a range of services and sufficient numbers of health professionals to ensure mutual professional support (Asibou, *et al.*, 1994). Because these communities cannot usually sustain necessary allied health and specialist services in a discrete form, this model enables the population to sustain such a service. 'Integrated services', which usually emerge from a community health service or allied health team approach to primary health care services, comprise a variety of models (Bahl, 1999). For example, the 'shared care' model of mental health care addresses access to and co-ordination of service across primary and specialist care (Kokor, *et al.*, 2000). The Multi-Purpose Services (MPS) program provides a specific model of Commonwealth/state financing which allows for the co-location and common administration of acute care, residential aged care, community and allied health services, rehabilitation and health education activities (John, 2007).

Even when it is not explicit, improving service delivery is an implicit motivation behind most of these decentralization efforts (John, 2007). The reasons are twofold (World Bank, 2003). First, these basic services, such as health, education, water and sanitation, all of which are the responsibility of the state, are systematically failing and especially failing poor people (World Bank 2003). In South Africa, promoting local governments was aimed at "rebuilding local communities and environments, as the basis for a democratic, integrated, prosperous and truly non-racial society" following the trauma of apartheid in the country (Shah, 1993). In Rwanda decentralization was to "provide a structural arrangement for government and the people of Rwanda to fight poverty at close range, and to enhance their reconciliation via the empowerment of local populations" following the trauma of the genocide of 1994 (Kokor, *et al.*, 2000). In Uganda decentralization is "a system of governance, which seeks to transfer political, administrative, financial and planning authority from central government to local government councils and to promote popular participation, empower local people to make their own decisions and enhance accountability and responsibility" following the ineffective regimes from (1964 -1986) (John, 2007).

Uganda introduced the decentralization policy in 1997 under the Local Government Act of 1997 that has since undergone four amendments. Prior to the 1990s, Uganda had a highly centralized healthcare system with considerable differences in health services standards between urban and rural areas (Jeppsson and Okuonzi 2000). After decentralization, the central government, through the Ministry of Health (MOH), is responsible for resource allocation and

hospitals (Bandie, 2003). However, it has devolved much of the responsibility of operating the lower health units, such as health centers and dispensaries, to lower levels of local government under the Ministry of Local Government. Health facilities run by faith-based organizations, which constitute 40 percent of the country's healthcare facilities, offer better services than non-faith-based facilities (Jeppsson and Okuonzi 2000). The process of fiscal decentralization in Uganda began in fiscal year 1993/94, when the central government devolved many functions and responsibilities, including the provision of basic health services and the control of medical personnel from the central MOH to the district level (Mensah, *et al.*, 2005). Fiscal decentralization occurred in a phased manner, with some districts being decentralized before others (Akin, Hutchinson, *et al.*, 2005).

Health sector reform was part of an overall reform of the public sector, consisting of liberalization, constitutional reform, civil service reform, and privatization. Public sector reform essentially drove the changes in the health sector. Therefore, health sector decentralization follows and uses the general administrative and political structures of the public sector (Bandie, 2003). At the central level, the MOH's functions were revised to include policy formulation, the setting of service standards, quality assurance, and provision of training and human resource guidelines, provision of technical supervision, responses to epidemics and other disasters, and the monitoring and evaluation of health services (Bandie, 2003). The MOH headquarters divested all service provision to regional and national hospitals and was significantly reorganized and reduced in size (Boex, *et al.*, 2005).

II. MATERIALS AND METHODS

Location of the study area

This study was confined to Mbale district, The District boasts of 48 health facilities of which 43 are government-owned while the rest are private not for profit (PNFPs). OPD utilization in Health facilities in Mbale District in Government and PNFP facilities was 0.9 visits per person per year during 2010/11. In addition, 50% of mothers still delivered without supervision of qualified health professional which put the lives of both the mothers and babies at risk.

The study covered the local government health units, the district health team, and office of the District Director of Health Services (DDHS), the selected health centers are but not limited to; Kapleko health center II, Mukuju health center IV, Chemnet dispensary, immaculate nursing home, Katung child development center, Bison Health center II, Kasoli health center II, and Kwoti health center II.

There is a challenge of the alignment of off-budget funding to sector priorities, there is also skewed input mix in financing health facilities, for instance there have not been commensurate funding for recurrent costs for utilities and/or maintenance arising from the construction of new buildings and equipment especially for hospitals at all levels .there are also institutional weaknesses in capacity of LGs in areas of financial reporting, leadership and financial management (MOH: 2015).

Mbale District is bordered by Sironko District to the north, Bududa District to the northeast, Manafwa District to the south east, Tororo District to the south, Butaleja District to the southwest and Budaka District to the west. Pallisa District and Kumi District lie to the northwest of Mbale District. Mbale, the largest town in the district and the location of the district headquarters, is located approximately 245 kilometres (152 mi), by road, northeast of Kampala, the capital of Uganda, and the largest city in that country. The coordinates of the district are: 00 57N, 34 20E. It has an area of 518.8 square kilometres (200.3 sq mi). The districts of Bududa, Manafwa and Sironko were part of Mbale District before they were split off as independent districts of their own.

Figure 1: Sketch Map of Uganda Showing the Location of Mbale District (Study Area)



Sampling

The researcher used stratified, random and purposive sampling techniques on the village health teams, community members and district health officials respectively. Here the criterion for stratification listed the population according to the defined strata or sub groups, determined the required sample size and lastly the researcher selected the required sample respondents using random numbers from each sub group. This enabled the researcher to achieve the desired representation from various subgroups in the survey population as sample size. With purposive sampling technique, cases that have the required information with respect to study variables were hand-picked following the level of experience as the basic criterion. Purposive sampling technique allowed the researcher to use respondents that have the required and actual information, with respect to his study objectives, questions and hypothesis.

Respondents were selected based on the fact that there are limited resources and time constraints that the researcher experienced. A smaller manageable sample offered the researcher the ideal information needed and at the same time enabled him to timely complete this study. The main concern ensured that all respondents are represented in the study. Areas are chosen using the simple random sampling technique to ensure that each unit in the study population were represented

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Determination of sample size of respondents

The study comprised of a target population of 170, a sample size of 120 was used with respondents from Health workers, community members, and local district health officials. These respondents from health workers were selected because majority of them provide the primary health services to the district population. Community members were selected because they are the consumers of the health services in the district and health administrators are also selected because they are implementers of health service delivery strategies in the district.

While there are several ways of determining a sample size, the researcher adopted the Slovene’s formula which was used to determine the minimum sample size of 120 respondents.

Table 3.3.1: Sample size distribution (HC=Health Center) Morgan and Krejcie (1970)

No	Categories	Target population	Sample population	Percentage (%)
1	Kasoli-HCII	30	20	16.66
2	Kwoti-HC III	30	20	16.66
3	Mukuju-HCIV	25	15	12.5
4	Katung Child Development Center	25	10	8.33
5	Bison HCII	20	10	8.33
6	Keplelko HCII	10	5	4.16
7	Immaculate nursing home	25	20	16.66
8	Local Officials	25	20	16.66
Total		170	120	100%

Source: Primary data (2021/2022)

Instruments

Interviews were conducted during data collection from which the researcher asked questions and respondents answered. The interviews were supplemented with document scrutiny of various sections or branches and assess their Fiscal Decentralization. An interview guide was used especially with the general Fiscal Decentralization and Health Service Delivery which led the interviewer to the respective respondents. The researcher carried a face-to-face interview with these interviewees.

Questionnaires; these are an efficient data collection tools when the researcher knows what was required and how to measure the variable of interest. Only closed ended questions with likert scale were given to the cross section of respondents which in turn facilitated effective data gathering. The researcher adopted this type of questionnaires because questions asked in it are easy to complete, analyze quantitatively and responses obtained through the use of this kind of questionnaire can be compared easily to different items hence making it easy for the researcher to detect a trend just by glancing at the responses. One set of questionnaires were administered to health sector workers and the second one was administered to health administrators, health workers and district's health service administrators. This strategy was expected to make possible to collect adequate information and opinions from the respondents within a short period of time.

III. DATA ANALYSIS

Determining Importance Value Indices (IVIs)

The researcher analysed data using both quantitative and qualitative methods.

All the information from the questionnaires was entered into Microsoft excel spreadsheets and SPSS. The SPSS and the Microsoft excel program was used to generate descriptive statistics, graphics, tables and charts. The interpretation of the descriptive statistics made it possible to formulate appropriate

inferences in terms of determining the influence of fiscal decentralisation to the district's health service delivery performance. The qualitative data was analyzed into themes and concepts. Based on the grounded theory plausible relationships among themes and concepts were identified (Strauss & Carbin, 1998).

Measurement of variables

The researcher used the likert scale. The following mean range was used to arrive at the mean of the individual indicators and interpretation:

Mean Range	Response	Interpretation
3.26 - 4.0	Strongly Agree	Very High
2.51 - 3.25	Agree	High
1.76 - 2.5	Disagree	Moderate
1.0 - 1.75	Strongly disagree	Low

Pearson's linear correlation coefficient and regression analysis was used to establish whether there was a significant relationship between Fiscal Decentralization and Primary Health Care Services Delivery.

IV. RESULTS

The purpose of this thesis investigated the influence of fiscal decentralization on health service delivery and to test whether the fiscal decentralization increases Primary Health Care Services Delivery. The researcher used both quantitative and qualitative methods to collect and analyse data.

Findings about Demographic data of the respondents

This section presents the bio data or information of the respondents, including their Gender, age, marital status, highest educational qualification, and number of years one has served in this District.

The age category of respondents in Table 4.1 indicates that 47 (39.2%) of the respondents were between the ages of 21-29 years, 33 (27.5%) were between the ages of 30-39

years, 30 (25.0%) were between the ages of 40-49 years and 10 (8.3%) were between the ages of 50-59 years. Thus, the result indicates that the active age range of workers is the ages between 21-29 years.

The distribution of respondents by gender reveals that 84 (70.0%) were males and 36 (30.0%) were females. This indicates that a large proportion of those in the work force are males. The data in Table 4.1 also shows that 52 (43.3%) were single, 57 (47.5%) were married, 9 (7.5%) were divorced and 2 (1.7%) were separated. Thus, the result shows that majority of the respondents are married.

In another development, distribution of respondents by their educational qualification reveals that 20 (16.7%) have Certificate, 32 (26.7%) have Diploma, 34 (36.7%) have Bachelor's Degree 19 (15.8%) have Masters Degree and 5 (4.2%) have P.h.D. Thus, the result shows that majority of the respondents had Bachelor's Degree, which implies that at least the respondents had minimum academic requirements to respond to our questions. And also, the data in table 4.1 reveals that 10 (8.3%) have worked with the organization for Less than 6months, 16 (13.3%) have worked with the organization for 6months-1year, 29 (24.2%) have worked with the organization for 1-2years, 32 (26.7%) have worked with the organization for 3-5years and 33 (27.5%) have worked with the organization for more than 5years. Thus, the result shows that majority of the respondents have worked with the organization for more than 5years, an implication is that they have experienced employees who have the potential to provide essential primary health care services to the community.

Fiscal decentralisation

Fiscal Decentralization is the independent variable in this study and was operationalised into four constructs which included Allocating Revenue source with five questions, Expenditures responsibility with five questions, Revenue administration with five questions, and Intergovernmental transfer with five questions in Mbale District, Uganda. Each question was likert scaled between 1-4, where 1=strongly disagree, 2=disagree, 3=agree and 4=strongly agree. Respondents were required to show the extent to which they agree or disagree with each item and their responses were analysed using means as summarized in tables 4.2

Regarding fiscal decentralization the finding (table 4.2) revealed that, five items were measured on allocating Revenue source and all rated high for example; economic efficiency (revenue instruments should be structured to minimize economic distortions in investments, production, consumption and local decisions) (mean=2.85 std=.960); equity (system should be as equitable as possible according either to the ability to pay principle, or to the benefits revenue principle)

(mean=2.80, std. =1.007); administrative feasibility (mean=2.78, std. =.990), All primary Health centres services are catered for in the areas (mean=2.75, std.=.994) political acceptability (acceptable to the various groups in the society, otherwise they will not "voluntarily" pay) (mean=2.65 std.=1.023) with an average mean(mean=2.77, std.= .73681)

Regarding expenditures responsibility and all rated high for example; Most goods do not fit these extreme categories (especially health and education) (mean=2.81 std.= 1.025), Most goods must be evaluated on a multi-dimensional basis (producing a good or delivering a service; providing or administering the service; financing a service; setting standards, regulations or policies guiding the provision of government services) (mean=2.80 std.= 1.018); Focus on core services, then devolve additional responsibilities incrementally (mean=2.72 std.= 1.022), Recognize that the allocation of expenditure responsibilities must be linked to capacity (mean=2.70, std.=.982), Some services, such as education and health, may have a high cultural value and requires more centralized or controlled delivery (mean=2.65, std.= 1.0320 with an average mean (mean=2.74 std.= .79673)

The findings are in agreement with Bahl 1992, who stated that, the practice of fiscal decentralisation cannot do away with a structure to address the fundamental problem of allocating expenditure and revenue responsibilities among levels of government known as Intergovernmental fiscal relations. For example, Bahl and Linn (1992: 82) argue that the central government can, if it wishes, allow regional and local authorities a greater role in regional policy and yet still retain control of the pattern of expenditure by making inter-government grants to regional and local authorities.

Regarding Fiscal Decentralization the finding (table 4.2) revealed that, five items were measured on revenue administration and all rated high for example; administration of all cash inflows Consider citizen credibility (mean=2.86, std.= 2.485) ; Revenue base information: lacking, incomplete or dated (mean=2.81, std.= 1.052), increased authority at the sub-national government level may increase democratic accountability by giving citizens greater opportunities for input and participation (mean=2.76, std.= 1.001); local government do not have control over the tax base, tax rate, tax collection or the sharing rate (mean=2.74, std.= 1.041), all transactions are documented and accountability given (mean=2.72, std.= 1.043) with an average mean (2.79, std.= .95282).

These findings revealed that, Fiscal decentralisation has an added advantage in revenue mobilisation effort. The advantage is that it gives the local people, through their District Assembly, the chance to mobilise internally generated

revenues such as rates, fines, fees, land and licenses. The District Assembly, being familiar with its local economy will be in the best position to mobilise internally generated revenues in the fast-growing parts of their economic base. Through this, the local administration will comparatively mobilise more financial resources at less cost than the Central government. However, the implementation of fiscal decentralisation brings up the following questions: to what extent should the local government be allowed to exercise their right to mobilise financial resources. Should they be allowed to mobilise the financial resources internally and also be in charge of its expenditure or what? What framework should the central government put in place to ensure an efficient and effective fiscal decentralisation process?

Regarding Fiscal Decentralization the finding (table 4.2) revealed that, five items were measured on Intergovernmental transfer and all rated high for example; Introduce output based conditional transfers (mean=2.83 std.=1.002); Develop an institutional arrangement for broad based consultation (mean=2.80 std.=.996); Focus on single transfer objective (mean=2.78 std.=.996); keep the transfer simple (this refers among others to the transfer formula that must be transparent, based on credible factors and as simple as possible) (mean=2.75 std.= 1.016) Introduce fiscal equalization transfers(mean=2.71 std.=.985) as well as an average mean (mean= 2.77 std.=.89644) with the overall mean=2.76.

Intergovernmental fiscal relations and fiscal decentralisation together deal with how public expenditure is organized between these different levels of government and how it is financed. Fiscal decentralisation thus constitutes the public finance dimension of decentralisation, defining how and in what way expenditures and revenues are organized between and across different levels of government in the national polity. However, the precise nature of intergovernmental fiscal relations and fiscal decentralisation policy in any given country varies depending on how sub-national government and administration is organised.

Fiscal decentralisation process provides a framework for a system of locally-controlled development and planning. By this process, District Assemblies were established and charged as the local planning authorities with responsibility for the overall development and governance of their district of jurisdiction.

Primary Health Care Services Delivery

Primary Health Care Services Delivery had Accountability for service delivery with five questions, Public Education with five questions, Proper Nutrition with five questions, Clean Water & Sanitation with five questions, Maternal & Child Health Care with five questions,

Immunization and Local Disease Control with five questions and Accessible Treatment and Drug Provision with five questions among selected Institutions of Higher Learning in Kampala District, Uganda. Each question was likert scaled between 1-4, where 1=strongly disagree, 2=disagree, 3=agree and 4=strongly agree. Respondents were required to show the extent to which they agree or disagree with each item and their responses were analysed using means.

The findings (Table 4.3) on the dependent variable reveal that five items were measured on Accountability for service delivery and four of them rated high as follows: illness care can lower the cost of healthcare significantly by lessening the chance of a major illness landing the patient in the hospital (mean=2.86 std=1.006) we have Comprehensive care spending more time with patients when they are in the office (mean=2.71 std=.900) Providing cost-effective care is crucial to achieve cost savings, part of the triple aim (mean=2.65 std=.1.228); Everyone involved in a patient's wellbeing, from primary care physicians to nurses to specialists (mean=2.64 std=.902)and only one item was rated moderate that is to say, I always sign when drugs are taken in and out at the centre (mean=2.14 std=.1.039) with an average mean of 2.60std=.53521

The findings (Table 4.3) on Primary Health Care Services Delivery shows that five items were measured on Public Education and rated high as follows: Assessing Individual and Community Needs for Health Education(mean=2.92 std=.763); Plan Health Education Strategies, Interventions, and Programs (mean=2.90 std=.994); Implement Health Education Strategies, Interventions, and Programs (mean=2.88 std=.914) Conduct Evaluation and Research Related to Health Education (mean=2.85 std=.888); Communicate and Advocate for Health and Health Education (mean=2.76 std=.819); Assessing Individual and Community Needs for Health Education (mean=2.73 std=.988) with an average mean (2.84 std=.51745)

To be a strong advocate for health education, disease prevention and health promotion directed to individuals, groups and communities in all activities of the Association. To set, maintain, and exemplify the highest ethical principles and standards of practice on the part of all professionals and disciplines whose primary purpose is health education, disease prevention and/or health promotion.

The findings (Table 4.3) on Primary Health Care Services Delivery shows that five items were measured on Proper Nutrition and rated high as follows: Focuses on "total patient care" (mean=2.78 std=.935), Interdisciplinary angle to patient care (mean=2.77 std=.937), Healthy and nutrient-dense foods, such as fruits, vegetables, whole grains and lean proteins,

typically contain fewer calories than sodas, sweets and fast food meals (mean=2.73, std=.940) Proper nutrition increases blood flow to your brain, protecting brain cells and helping to prevent Alzheimer's disease (mean=2.72, std=1.000) Increased energy levels are the immediate benefits of switching to a healthy diet. Eliminating excess fats, sugars and refined carbohydrates helps prevent blood sugar fluctuations (mean=2.68, std=1.010) with an average mean (2.74, std=.79095)

Eating a proper, nutritious diet offers numerous health benefits that keep you mentally and physically well. Proper nutrition doesn't mean starving yourself, but instead means eating a diet balanced in lean proteins, carbs and fats. MayoClinic.com recommends getting between 45 and 65 percent of your daily calories from carbohydrates, between 10 and 35 percent of daily calories from protein and between 20 and 35 percent of daily calories from fats. A diet low in fats, cholesterol and sodium can lower your risk of heart disease. The types of fat in your diet play a major role in your level of risk. Saturated and trans fats commonly found in red meats, fried foods, coconut oils, palm oils, margarines and packaged snack foods increase your risk and should be avoided. Diets that reduce your risk of heart disease are rich in fruits, vegetables, whole grains and low-fat dairy. Aim for four to five servings of fruits and four to five servings of vegetables per day.

The findings (Table 4.3) on Primary Health Care Services Delivery shows that five items were measured on Clean Water & Sanitation and rated high as follows: We have policies on properly disposing of items that cannot be recycled keeps them from making their way to rivers (mean= 2.76, std=.947) All communities Participate in Clean-up Efforts (mean= 2.75, std=.976) There are proper policies on eliminating or minimizing your use of harsh chemicals provides the surest way to protect global waters from chemicals (mean= 2.70, std=.963) There are proper disposal of hazardous materials such as paints, motor oil and pharmaceuticals (mean= 2.62, std=.983) Water that runs down streets after rainfall, or after you wash your car with a hose, carries toxins from streets and yards that eventually may reach waterways (mean=2.61, std=.964) with an average mean=2.69 std=.75473).

Nowhere is the relationship between healthy ecosystems and healthy people more apparent than in the global water system. Clean water is the single most important building block of ecosystems around the world, say the Centers for Disease Control and Prevention (2015). It's also our most valuable resource, the EPA asserts. However, contamination of the world's waters leaves 2.5 billion people without access to sanitized water sources. Because global water conditions

are declining, more people will soon have to rely on polluted water sources unless we make a concerted effort to clean our water supply.

This implies that, fresh water is one of our most vital resources, and when our water is polluted it is not only devastating to the environment, but also to human health. The US relies on public water systems to treat and deliver just over 44 billion gallons of clean water each day to homes, schools and businesses. Much of that water comes from rivers, lakes and other surface water sources. Before it is delivered to homes it is treated to remove chemicals, particulates for example soot and silt and bacteria. This clean, potable water is then used for cooking, drinking, cleaning, bathing, watering our lawns and so forth the findings reveal that, those that are served by public sanitation systems rely on sewers to keep untreated wastewater from being released into the environment where it could potentially contaminate drinking water sources and the natural environment. When the water goes down the drain or is flushed down the toilet, it usually enters a sewer system where it travels to a wastewater treatment plant. The plant treats the wastewater and removes solid waste and other contaminants before releasing the treated water it into the environment. Depending on the type of treatment the wastewater receives, water that is released could have different levels of quality from the water body into which it is released.

The findings (Table 4.3) on Primary Health Care Services Delivery shows that five items were measured on Maternal & Child Health Care and rated high as follows: Emphasize that Kids between the ages of 5 to 12 need 10 to 11 hours of sleep each night (mean= 2.78, std=.935) Learn the benefits of a clean environment, which is the land, the water, and the air we breathe (mean= 2.77, std=.938) Vision and Hearing Tests - It is still important to go for vision exams and hearing tests so that any interventions can begin early if necessary (mean= 2.74, std=.940) Keep current with all vaccinations to ensure protection from serious diseases (mean=2.73, std=1.000) Hygiene is very important- An absolute must, all kids need to wash their hands after they've been outside, before every meal, and when they've played around with pets. Hand washing helps prevent the spread of germs and illness (mean= 2.68, std=1.010) with average (mean= 2.74 std=.79095).

Every parent wants to nourish their children in a loving, caring and secured atmosphere. The parents would want to give proper care and attention to the little ones, especially during their initial stages of development. As far as child care is concerned, everything, starting from their health, hygiene to safety at home and outside the home needs to be considered. We are here to help you with some child care tips. In this chapter, you will learn about how to give baby massage, car

seat safety tips for babies and young children, facing challenges of diapering babies, weaning babies from breast or bottle, soothe a colic baby and to deal with insistent cries of a toddler to be always held. Baby Massage Baby massage is a good old tradition of nurturing the infants, followed by people since centuries. The conventional method of massaging the body parts of the baby with oil helps strengthen the immune system of the infants. The moms take immense pleasure in massaging the soft and delicate skin Apart from being a therapy for strengthening the muscles; baby massage is a nice way to bond with the child. of the infants. However, they should know how to give proper massage, so that the baby gets all the benefits of the therapy. Car safety seats Car safety seats, as the name suggests, are primarily designed to protect the children from the impact of an accident in a car. Such seats shield the child during an accident and reduce injuries on a sudden jerk. Child car safety seats are available in a variety of types, designs and with unique features. It is important to purchase the right type of car seats, so that the children can enjoy a safe ride, every time they get into the vehicle. This is because children placed in the wrong type of seat are more prone to accidents. Colic Soothers Generally, an infant cries when he/she is hungry or unable to sleep. However, if the baby cries for longer hours continuously, probably he/she is suffering from some ailment. One of the most common health problems suffered by babies is colic. It generally occurs in a baby aged between 3 weeks and 3 months. Immature nervous system in the little ones is the prime reason for the occurrence of colic. Learning how to deal with colic babies is very important, because the baby whimpers all the time, which causes frustration, deprivation of sleep and exhaustion in parents. Carrying The Growing Baby Many toddlers, who already know how to walk well, often insist on being carried by their parents. The babies, perhaps, like to view the world at the same height of the elder ones. They might be eager to enjoy a trip to explore the world around them, by resting on the shoulder of their parents. Other factors prompting the babies to be carried by the parents may include insecurity in the presence of strangers.

While carrying the growing baby, the parent should make sure that he/she is held comfortably. Diapering Fidgeting Babies Diapering a baby is one of the intimidating tasks for the parents, especially when the little ones fidget. While many parents know how to hold their babies in the correct position and tie the diaper, others are not adept at doing the job effortlessly.

The findings (Table 4.3) on Primary Health Care Services Delivery shows that five items were measured on Immunization and Local Disease Control and rated high as follows: Dusting sulfur is a great natural way to fend off disease and pests(mean=2.78std=.947) Wash hands since

water is accessible (mean= 2.75, std=.976) All kids are taken for immunization immediately after birth (mean= 2.70, std=.963) Most diseases are caused by poor hygiene (mean= 2.62, std=.983) Even animals are sprayed for controlling diseases resulting from them (mean= 2.61, std=.964) with an Average mean (mean= 2.69, std=.75473).

The findings (Table 4.3) on Primary Health Care Services Delivery shows that five items were measured on Accessible Treatment and Drug Provision and rated high as follows: Have early immunization (mean= 2.78, std=.934) Carry out comprehensive examination whenever I want (mean= 2.74, std=.931) We are given free drugs in health centre (mean= 2.73, std=.914) We have an ambulance to carry patients to referral hospitals (mean= 2.72, std=.963) The road allows easy movement of patients (mean= 2.68, std=1.026) with an average mean of (mean= 2.73, std=.78126) and (overall mean= 2.72, std=.46278).

V. DISCUSSIONS

The discussions of the findings are presented according to the objectives of the study and the various constructs as given below; The results of the relationship between Fiscal Decentralization and Primary Health Care Services Delivery in Mbale District are shown in Table 4.4. Results show that Primary Health Care Services Delivery was significantly correlated with Fiscal decentralisation ($r=0.773$, at $\text{Sig}=.000$). The results further indicated that the relationship that exists between Fiscal Decentralization and Primary Health Care Services Delivery in Mbale District is positive and significantly correlated, ($\text{sig}.>0.05$). This means that Fiscal Decentralization influence Primary Health Care Services Delivery in Mbale district and the failure to decide clear Fiscal Decentralization well, the less the Primary Health Care Services Delivery, therefore basing on the results, the stated null hypothesis was rejected and a conclusion is made that Fiscal Decentralization affects Primary Health Care Services Delivery.

This study sought to investigate the Fiscal Decentralization and Primary Health Care Services Delivery in Mbale District. It was guided by three (3) objectives that included the following;(i) To assess the state of fiscal decentralization in Mbale (ii) To identify the extent of Primary Health Care Services Delivery in Mbale (iii) To establish whether there is a significance relationship between fiscal decentralization and Primary Health Care Services Delivery in Mbale district. It was guided by three sampling techniques: stratified sampling, simple random sampling and purposive sampling on village health teams, community members, and district health officials respectively. A descriptive correlational design was used in the study. A researcher made

a self-administered questionnaire which was administered on to 120 randomly selected respondents to elicit useful data.

Disease prevention and health promotion

These factors outlined have important implications for the delivery of district health services. Inconsistencies and poor understanding of primary care and primary health care raises unrealistic expectations in service delivery and health outcomes, and blame is apportioned when expectations are not met. At the micro level of health delivery, it is important for all health practitioners to consider the contextual influences on health and ill-health and to recognise the role of the underlying determinants of ill-health, namely, social, economic and environmental influences. Comprehensive primary care using strategies of the primary health care approach could focus on integrated health care delivery, where individuals and communities are managed holistically. This includes the recognition that chronic diseases as a result of lifestyle practices, will result in a number of disease presentations for example unhealthy dietary practices are linked to obesity, dental caries, cardiac complications, diabetes, etc. Thus strategies to address the risks to unhealthy lifestyle practices must recognise the role of optimal oral health and nutritional status in improving overall health outcomes. These would include the need to create supportive environments to promote the selection of healthier choices. The primary health care approach provides a strong framework for this delivery but it is not widely applied. The primary health care framework also allows for assessment of the quality, appropriateness and impact of service delivery, the identification of gaps, and research development. Healthy living and family self care initiatives will make significant contributions to foster individual and community empowerment if there is coordinated effort to focus on disease prevention and health promotion.

Fiscal Decentralization

The findings on the state of Fiscal Decentralization revealed that four (4) constructs were measured and all rated high for instance; Allocating Revenue source (average mean= 2.77, std=.73681), expenditures responsibility (average mean= 2.74, std= .79673), Revenue administration (average mean= 2.79, std=.95282), Intergovernmental transfer (average mean= 2.77, std= .89644) with the overall mean of 2.76. Local government spending trends to be directed on services such as primary public goods and basic health care, whereas the central government has significant expenditures in such areas as defense and security, transport and communications infrastructure, public administration. It therefore, follows from the argument that, if it is accepted, that the national government has primary responsibility for horizontal fiscal

equalization, economic stabilisation and management, as well as, significant expenditure responsibilities in such areas as major economic infrastructure, it follows that the centre should exercise control over the most important (lucrative) and flexible, as well as the main redistribute tax sources.

World Bank (1988) and Bahl& Linn (1983) have argued along the lines of what the local government should do. The arguments dwelled on the grounds of efficiency and states that for the sake of efficiency, District Assemblies should distinguish between services based on some characteristics. These characteristics are: (i) pure public goods- which should be financed by user charges, and (ii) externalities financed by intergovernmental transfers.

Gandhi (1983) puts a challenge to this simplified classification of services. Gandhi argues the simplification of the classification has resulted in conflicts in its application. For example, clean water supply can be a public utility which has significant externalities. Public utility includes services such as national defense, mosquito abatement, pollution control, disease control etc. The common characteristics of these services are that once they are made available, separation of those who have paid from those who have not paid is impossible and any number of people can consume the same good at the same time without diminishing the amount of goods available for anyone else to consume.

Oates (1985) argued that fiscal decentralisation would tend to increase total public resource mobilization. An empirical investigation conducted by Oates (1972) for 42 countries reveals a strong and statically significant negative association. The study was done by regressing tax revenue (size of public sector) on a fiscal decentralisation ratio (central revenue as proportion of the total). In another study, Oates (1985) explored the question again for 43 countries (18 industrial and 25 developing). The results proved that for the entire sample, the rank correlation between the size of the public sector and the extent of fiscal decentralization is strong and significantly negative. Meaning a relatively decentralised public sector is typically large.

Primary Health Care Services Delivery

The findings on Primary Health Care Services Delivery revealed that seven (7) constructs were measured and all rated high for instance Accountability for service delivery (average mean=2.60, std=.53521) Public Education (average mean= 2.84, std=.51745) Proper Nutrition (average mean= 2.74 std=.79095) Clean Water & Sanitation (average mean=2.69, std=.75473) Maternal & Child Health Care (average mean=2.74 std=.79095) Immunization and Local Disease Control (average mean=2.69, std=.75473) Accessible

Treatment and Drug Provision (average mean=2.73 std=.78126) (average mean= 2.72 std=.46278).

People living in small rural and remote communities of Mbale face significant health disadvantage. Generally, mortality and illness levels increase with distance from major cities. Moreover, these communities are characterised by higher hospitalization rates and higher prevalence of health risk factors compared with metropolitan areas. These rural and remote communities are further disadvantaged by reduced access to primary health care (PHC) providers and health services (in part a function of health and medical workforce shortages), leading in turn to lower utilisation rates than in urban areas and consequent poorer health status for rural residents.

A dynamic health system that is able to monitor and respond to unforeseen challenges, including demographic transitions and changing health needs, is required. At the macro and meso level of health care delivery, it is important that health system development be coordinated with areas of development, such as social, economic and environmental development. Thus re-engineering of primary health care and the implementation of the National Health Insurance System could provide a mechanism to redress current health inequalities in Mbale. However Sanders et al (2011) argue that the impact of neoliberal economic policies and the broader impact of economic forces on primary health care delivery must be considered. Regulation of the market is required if revitalisation of primary health care and progress towards health equity is to be realized.

Primary health care requires structural re-organisation, multidisciplinary team approach with clear lines of accountability, clear referral patterns in a two-way direction, improved access to health insurance to improve health coverage, and developing effective public-private partnerships. The universal core packages of health care should be evidence-based, cost-effective and appropriate to local needs.

Policy development on integrated health care generally fails to guide the translation of policy rhetoric into health action. The delays in health integration are largely due to the current lack of clear direction and accountability at district and institutional levels. Effective leadership is required in terms of policy formulation and translation into practice, development of monitoring tools for assessment of the health system including the burden of disease, utilization of health services, and effectiveness of health interventions. There is a need for renewed political and policy commitments toward quality primary health care delivery, re-orientation of health care workers, integration of primary health care activities into other

community-based development, improved management skills and effective coordination at all levels of the health system. There should also be optimal capacity building, and skills development in problem-solving, communication, networking and partnership formation. Apart from capacity building, there should be incentives to motivate health personnel and support career development.

Often these isolated rural and remote communities are too small to support traditional models of health delivery locally, so residents must access care from larger urban centres. Unfortunately, access to health services provided in larger centres remains a problem for many residents of isolated settlements. In many cases, their inability to access health services when required results in health needs not being adequately met, lack of continuity of care and an absence of monitoring of the effectiveness of services in terms of health outcomes. It is clear that 'models of care in rural and remote areas must differ from those in metropolitan communities, incorporating strategies to account for these problems'.

Drawing on information about model type, location and service population size, it was evident that in general the different categories of models relate to different geographical contexts, with a notable association with population size and remoteness. While larger rural communities are generally able to support a greater variety of local, discrete, more specialised health care services, increasing remoteness and diminishing population size and density constrain service model options and increase the impetus for the development of more integrated and comprehensive primary health services in order to maximise the economies of scale and use of existing health workforce.

VI. CONCLUSION

Based on the findings of this research, the study has been able to reveal that effective Fiscal Decentralization creates mutual understanding between local government and the community which helps in building genuine relationship among both parties in the organizations. The philosophy of primary health care is an important component for the health transformation process in Mbale District; however, a well-functioning district health system is required for the re-engineering of primary health care. This approach requires strong leadership, strengthening of the current district health system with a greater emphasis on health promotion and prevention, recognition of the role of traditional / complementary health care, together with commitments in intersectoral collaboration, and community participation and empowerment.

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