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Finding out the Relationship Between Financial Decentralization and Quality of Maternal Health Services in Uganda. Sheema Municipality, Sheema District.

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ABSTRACT

The study investigated the relationship between financial decentralization and the quality of maternal health services in Uganda, Sheema Municipality Sheema Municipality. cross-sectional and correlational research designs were adopted on a sample of 235 respondents. Quantitatively data was analyzed by use of descriptive statistics, frequencies and percentage tables and qualitatively, by thematic content analysis. Inferential analysis results indicated that financial decentralization had a strong positive significant relationship with quality of maternal health services. Therefore, it was concluded that financial decentralization as a component of decentralization policy implementation is essential for quality of maternal health services. The study recommended that the Government of Uganda should implement financial decentralization policy in the health sector by granting local government powers and authority to manage and run the health facilities in order to improve the quality of maternal health services.

Keywords: Financial Decentralization and Quality of Maternal Health Services

INTRODUCTION

Improving the quality of maternal and newborn baby health care is critical if maternal and newborn health outcomes are to improve further. This will necessitate a shift in global focus. According to World Health Organization statistics from 2017, 303 000 women die during labor, childbirth, or the postnatal period, 2.6 million infants are stillborn, and 2.7 million babies die within one month after birth. The majority of these deaths occur in low- and middle-income areas and are avoidable (United Nations Report, 2017) and in Financial decentralization dispensation which is the transfer of authority to a sub national body this should not be the case. (Makara, 2000).

Theoretical Review

The study was anchored on the participatory theory. This theory was introduced in the development arena in the early 1980's by Robert Chamber's Rapid Rural Appraisal Methodology. Participatory Theory served as the study's main point of reference for assessing the impact of decentralization policy implementation on the quality of maternal health service delivery. The theory assumes that the participation of stake holders will cause decision making processes to be more inclusive and therefore instigate ownership over development processes and services which in turn lead to more sustainable impact. According to Brett (2018), participatory theory may be used to manage services and programs for maternal health in underdeveloped nations.

REVIEW OF RELATED LITERATURE

Financial Decentralization and Quality of Maternal Health services

Financial decentralization has led to improved efficiency in health service delivery (Golola, 2023) This argument is linked to the notion of improved efficiency in the use of public resources, which is also related to increased competition for better use of public resources. For example, with fiscal decentralization, decisions about public expenditure are taken by a level of government closer to the people it is, serving hence reflecting the actual demand for local services, and thus appropriate resource allocation, then a one size fits all approach more typical of a central government (allocative efficiency). Different sub-national governments offer different mixes of tax-expenditures, and local constituencies are supposed to locate themselves accordingly to their preferences (Felicio and John-Abraham, 2014). Therefore, financial decentralization promotes competition among sub national governments for limiting taxing power and maximizing their service delivery.

Naidoo (2017) investigated Health Sector Decentralization in Sub-Saharan Africa, and the findings show that nations with excellent financial decentralization policies had better resource mobilization in maternal health care delivery. This is demonstrated by the significant financial gains experienced by Municipalitys following decentralization. Decentralization has enhanced the accountability of government services. Because the beneficiaries are involved in the implementation and planning, they can quickly see if the intended activities are being carried out. For example, sub-county revenue and spending are placed on the notice board for all to see. Kapologwe et al. (2019) investigated the implementation of Direct Health Facility Financing and its impact on Tanzanian health system performance: a non-controlled before and after mixed method study protocol, and the findings indicate that Health system responsiveness assessment, accountability, and governance of the Health Facility Government Committee should reduce autonomy and improve patient experiences.

Gasto and Anna (2023) investigated health planning involvement in a decentralized system, and their findings show that decentralized health systems in Sub-Saharan Africa rely on central government funding to operate operations in the provision of health services in their regions of authority. The release of monies is frequently delayed and occurs in four installments. In Uganda, the method is known as the quota system of finance. According to Frumence (2019), this is a barrier to successful health policy implementation and health care delivery. This type of activity has a direct impact on health-care providers, as their pay are also affected by the delays. According to Anna-Karin Hurtig, Gasto et al. (2014), central funding in a decentralized system is not a suitable solution. As a result of the health sector’s decentralization, maternal health care services are now freely available (Frumence, 2014) Despite the fact that researchers have made great efforts to link financial decentralization with the quality of maternal health services, contextual and conceptual gaps have developed. Contextually, none of the research was conducted in Uganda. All previous research focused on financial decentralization as a policy rather than how it is implemented, but the proposed study focuses on how financial decentralization is achieved. Because of these gaps, this study in Uganda must seek to establish the relationship between financial decentralization and the quality of maternal health services.

METHODOLOGY

The cross-sectional and correlational research designs were used in the investigation. A cross-sectional study design, according to Sekara (2003), is one in which data is gathered just once over a period of days, weeks, or months in an effort to address a research issue. The cross-sectional design made it possible to gather data using a variety of methods, including face-to-face interviews and self-administered

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questionnaires (Lavrakas 2008). However, because the research was cross-sectional, the data collected reflected what was happening at a specific point in time, enabling the collection of valuable data in a relatively short amount of time and at a lower cost (Moule& Goodman 2009). Regarding the correlational design, this involves investigating the relationship between the effectiveness of the decentralization strategy and the standard of maternal health (Ingham-Broomfield, 2014). By correlating the independent and dependent variables, statistical inferences were made using quantitative data as the foundation. By giving specific information in the form of remarks from interviews for in-depth examination, qualitative data complemented quantitative data. The study conducted an in-depth investigation and statistical conclusions using both the quantitative and qualitative methodologies (Bernard 2012).

Sample Size and Sampling Technique

The sampling techniques used to select the respondents were simple random and purposive sampling. The simple random offers detailed information on all or most elements in the population involving all the total of a small population. This allowed the use of a questionnaire to collect information (Lavrakas, 2008). Simple random method was used to select the Maternal health users/beneficiaries because although a small population, they were sufficient for providing questionnaire survey data necessary for generalisation of the findings. With purposive sampling, this was used to select particular people to provide in-depth views since the study was both quantitative and qualitative. The method of purposive sampling used was intensity purposive sampling. Intensity sampling allows the researcher to select a small number of rich cases that provide in depth information and knowledge of a phenomenon of interest (Palinkas et al., 2015). As shown in table 1 below.

Table 1: Sample size

Category	**Target Population**	**Selected Population (Sample Size)**	**Sampling Technique**
Maternal health users/beneficiaries	436	178	Simple Random Sampling
Village Health teams	88	36	Simple Random Sampling
District Health Officer	01	01	Purposive Sampling
Municipality/ Town council Health Center in charges	02	02	Purposive Sampling
Chief Administrative Officer.	1	01	Purposive sampling
Mid wives	42	17	Simple Random Sampling
Total	**570**	**235**	

Data Analysis

Quantitatively when data was obtained, there was Coding, Statistical Package for Social Sciences (SPSS) 24.0 computer entry, frequency table summarization to identify problems, and editing to fix errors were all steps in the processing of quantitative data (Greasley 2007). Calculating descriptive statistics and frequencies for descriptive analysis was part of quantitative data analysis. The testing of the hypothesis included correlation analysis using Pearsons Linear Correlation Coefficience and regression analysis for inferential statistics (Simpson, 2015). This generated the data required for the findings to be generalized. Quantitatively, Discursive and thematic methodologies were used to conduct the analysis (Kohlbacher 2006). The discursive approach took into account textual specifics when interpreting the material under

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue VI June 2024

analysis and assigning meaning. Thematic analysis, on the other hand, made sure that groups of text with comparable meanings were displayed together (Attride-Stirling 2001). Quantitative data were complemented by qualitative data, which assisted in elucidating the findings.

RESULTS AND DISCUSSION

Response Rate

At first, the researcher had 235 respondents from whom to gather data. However, 215 respondents provided complete data, which was gathered. There were 215 replies altogether (91.5% of those that were surveyed and interviewed). This response rate was enough since, according to Mellahi and Harris (2016), humanities studies only need a response rate of 50% or above. A questionnaire was used to get quantitative data from 212 respondents, and an interviewing guide was used to gather qualitative data from 3 respondents. The response rate was as presented in Table 2

Table 2. Response rate

	Frequency	Percentage
Response	215	91.5%
Non response	20	8.5%
Total	235	100%

Source: Field Findings 2023

Financial decentralization which is the second aspect of socio-economic development was studied using four items. The results were as presented in Table below 3

Table 3 Descriptive statistics on financial decentralization

	F/%	**SA**	**A**	**N**	D	SD	**Mean**
Central government provides enough funds to the Municipality for provision of maternal health programs	**f**	124	70	–	11	7	3.89
	%	58.3	33.3	–	5	3.3	
Funds at the Municipality are allocated according to health center III' needs	**f**	117	67	–	11	17	3.98
	%	55	31.7	–	5	8.3	3.77
There is proper accountability at all levels for maternal health funds at the Municipality	**f**	42	21	7	99	42	2.33
	%	20	10	3.3	46.7	20	
The Municipality administration normally engages all stakeholders during the allocation of funds to maternal health	**f**	113	53	3	18	25	3.86
	%	53.3	25	1.7	8.3	11.7	
The Municipality and people in the community contribute to funding of maternal health programme	**f**	**117**	**67**	–	**11**	**17**	**3.79**
	%	**55**	**31.7**	–	**5**	**8.3**	

All health center in charges normally make budgets for maternal health funds	**f**	**42**	**21**	**25**	**99**	**42**	**2.03**
	%	**20**	**10**	**3.3**	**46.7**	**20**	
All health centers get materials to use for maternal health services in time	**f**	**113**	**53**	**3**	**17**	**25**	**4.01**
	%	**53.3**	**25**	**1.7**	**8.3**	**11.7**	

Source: Primary Data 2023

According to the findings in Table3, the Municipality receives sufficient funding from the federal government to provide maternal health programs. The majority of respondents (91.6%) agreed, while 8.3% disagreed. The results also showed that businesses were assisting people in their efforts to support their households by helping them generate income. The majority of respondents (78.3%) agreed with the statement, while 20% disagreed and 1.7% were neutral about it, which further supported the conclusion that Municipality funds are provided in accordance with the needs of health center III. The high mean = 3.98 served as confirmation for the findings. Additionally, the data indicated that there is sufficient accountability at all levels for maternal health funding at the Municipality, with the majority of respondents disagreeing (66.7%) and the lower mean = 2.33, while 30% of them agreed and 3.33% of them were neutral. The data also showed that Municipality administration regularly involves all stakeholders when allocating funding for maternal health since the majority of respondents (78.6%) agreed with the statement and the high mean value of 3.86 supported this.

The majority of respondents (55%) strongly agreed to the statement that “the Municipality and individuals in the community contribute to the funding of maternal health programs,” while 31.7 percent agreed, 5% disagreed, and 8.3% strongly disagreed. This meant that the Municipality and the individuals in the neighborhood both contributed to the funding of the maternal health program. (46.7%) of the respondents disputed that every health center in charge generally develop budgets for maternal health funds (20% strongly disagreed, (3.1%) were neutral, (20%) agreed, and (10%) highly agreed, and this finding was confirmed by a lower mean of 2.03 This suggests that health center administrators do not often allocate for maternal health money. Summary statistics for the eight elements assessing financial decentralization were compiled to see how overall respondents viewed financial decentralization as a facet of decentralization policy execution. Table 4 summarizes the findings.

Table 4 Summary of descriptive statistics on financial decentralization

	Descriptive		Statistics	Std.Error
Financial decentralization	Mean		3.48	0.05
	95% Confidence	Lower Bound	3.42	
	Interval for Mean	Upper Bound	3.84	
	5% Trimmed Mean		3.79	
	Median		3.75	
	Variance		0.81	
	Std. Deviation		0.79	
	Minimum		1.20	
	Maximum		5.80	
	Range		3.58	
	Interquartile Range		1.40	
	Skewness		1.87	0.04

	Kurtosis		1.46	0.30

Source: Primary Data, 2023

According to Table 4 findings, the median value of 3.75 was not far from the mean value of 3.48. The findings show that the replies were normally distributed, with a positive skew (skew 1.87). Because of the high mean, the respondents thought their financial decentralization was effective. Low response dispersion was suggested by the low standard deviation of 0.79. When asked how the implementation of the decentralization strategy has aided in raising the caliber of maternal health care in their Municipality, leaders were invited to respond during interviews. One leader responded,

"I am impressed with local government financial activities are connected to the improvement of maternal health and a number of people have picked interest in seeking maternal service but. Still, there is a need to improve on the quality maternal services in the health centres like putting in place quality maternal beds and recruiting enough midwives."

In relation to the above, another local leader remarked,

"In this area we still experience low quality of maternal health services because people largely spend most of their incomes and time in seeking quality services in private facilities. Nevertheless, there is improvement, those who manage to go to government facilities; a few are able to access the services." (Key informant interview, May 2023)

It is clear from the perspectives presented above that more work needs to be done to enhance the standard of maternal health in the Sheema Municipality. The results of the descriptive statistics that showed that financial decentralization is beneficial for enhancing the standard of maternal health are supported by the interview responses.

Quality of maternal health services as the dependent variable and was studied using eight items. The results on the same were as presented in Table 5;

Table 5 Descriptive Statistics on quality of maternal health services

Statements	**F/%**	**SA**	**A**	**N**	D	SD	**Mean**
Traditional birth attendants are trained by the MOH in maternal health conditions and complications in time	**F**	37	15	3	5	60	3.99
	%	66.7	25	5	8.3	5	
Maternal health services are given freely by government at the health centers and referral hospitals on time	**F**	29	20	2	4	60	3.77
	%	48.3	33.3	3.3	6.7	8.3	
Delays in the delivery of items used during delivery of mothers is major barrier to effective delivery of maternal health services	**F**	26	15	1	6	60	3.47
	%	43.3	25	1.7	10	20	
Mothers walk several miles to get antenatal care which affects utilization of maternal health services in time.	**F**	35	11	2	5	60	3.72
	%	58.3	18.3	3.3	8.3	11.7	
Mothers walk several miles to get antenatal care which affects utilization of maternal health services in time.	**F**	33	17	-	4	60	3.81
	%	55	28.3	-	6.7	10	
Well trained midwives are still lackig in health facilities	**F**	28	13	1	6	60	3.67
	%	46.7	21.7	1.7	10	20	
Motivation of the midwives available would improve on the quality of maternal health service provision	**F**	30	11	2	10	7	3.51
	%	50	18.3	3.3	16.7	11.7	

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There are free guidance and counseling services for pregnant mothers living with HIV as well as treatment to avoid mother to child transmission of the virus.	**F**	7	10	3	24	44	2.33
	%	11.7	16.7	5	40	26.7	
Mothers are aware of all the services provided for them by the government	**F**	30	11	2	10	60	1.51
	%	50	18.3	3.3	16.7	11.7	
Pregnant mothers in most cases purchase their own items for delivery	**F**	7	10	3	24	60	4.12
	%	11.7	16.7	5	40	26.7	

Source: Primary Data 2023

Table 5 shows that the majority of respondents (91.7%) agreed that traditional birth attendants are trained by the MOH in maternal health conditions and complications in time, while 13.3% disagreed and 5% were neutral, and that the high mean = 3.99, close to code 4 on the scale used, indicated that traditional birth attendants are trained by the MOH in maternal health conditions and complications in time. The majority of respondents (81.6%) disagreed, 15% agreed, and 3.3% were neutral when asked if the government provided free maternal health services at health centers and referral hospitals on time. This, combined with the high mean value of 1.77, indicated that the government does not provide free maternal health services at health centers and referral hospitals on time. The majority of respondents (68.3%) agreed that delays in the delivery of goods used during childbirth are a significant obstacle to the effective provision of maternal health services, while only 30% disagreed and 1.7% were neutral. This implied, given that the average mean was 3.47, that delays in the delivery of goods used during childbirth are indeed a significant obstacle to the effective provision of maternal health services.

The majority (76.6%) of respondents agreed, 20% disagreed, and 3.3% were neutral on the question of whether mothers walk several miles to get antenatal care, which affects the timely use of maternal health services. This, combined with the high mean of 3.72, indicated that mothers walk several miles to get antenatal care, which affects the timely use of maternal health services. The respondents reported that there are still not enough well-trained midwives in medical institutions, with a high proportion (83.3%) of respondents agreeing and a high mean of 3.81. The results also showed that the availability of midwives would be more motivated, as evidenced by the majority of respondents (83.3%) agreeing and the high mean value of 3.67, which proved that the availability of midwives would be more motivated to provide quality maternal health services.

Whether there are free counseling and advice services available to expectant HIV-positive women, as well as care to prevent mother-to-child virus transmission. 68.3% of respondents said they agreed, 28.4% said they disagreed, and 3.3% said they were indifferent or with it. The average mean was 3.51, which indicated that free counseling and advice were available for expectant moms who were HIV positive as well as treatments to prevent mother-to-child transmission of the virus. The majority of respondents (66.6%) disagreed with the statement that mothers are aware of all services offered to them by the government, while 28.4% agreed and 5% were neutral. This resulted in an average mean of 1.51, which indicated that mothers are not aware of all services offered to them by the government and the high mean of 4.12 indicates that the majority of respondents concur that pregnant women often buy their own supplies for birth. Summary statistics for the eight elements measuring the Community tourism effort were produced in order to determine how the respondents felt overall about it. The outcomes are shown in Table 6 below.

Table 6 Summary of Descriptive Statistics on quality of maternal health services

	Descriptive		Statistics	Std.Error
Quality of maternal health services	Mean		2.69	0.05
	95% Confidence	Lower Bound	2.42	

	Interval for Mean	Upper Bound	2.74	
	5% Trimmed Mean		3.79	
	Median		2.80	
	Variance		0.81	
	Std. Deviation		0.99	
	Minimum		1.60	
	Maximum		4.90	
	Range		3.44	
	Interquartile Range		1.60	
	Skewness		-.78	0.24
	Kurtosis		1.46	0.50

Source: Primary Data 2023

According to Table 6's findings, the median value of 2.80 was not far from the mean value of 2.69. The results revealed that the responses were normally distributed despite the negative skew (skew -0.78). The high mean suggested that the respondents did not think the quality of services for maternal health was good. Low response dispersion was suggested by the low standard deviation of 0.99. Municipality authorities were questioned about the decentralization approach that had been implemented to improve the caliber of maternal health care. One officer responded to this query by saying, *"Not many people take quality maternal services as serious and it requires persuading them to get involved, few people can push themselves."* (Key informants interview, May 2023)

Another Municipality official stated,

"While there are some people who take quality maternal health services serious, this has not contributed much in their quality improvement. Many take maternal services casual and they need to be told that maternal services are more important". (Sheema, May 2023). These views partially supported the descriptive statistics which indicated the quality of maternal health services in Sheema Municipality is still poor.

Correlation of financial decentralization policy implementation and quality of maternal health services

To establish whether financial decentralization policy implementation was related to quality of maternal health services, the researcher carried out correlation analysis. The results were as given in Table 7

Table 7: Correlation Matrix for decentralization policy implementation and quality of maternal health services

	Financial decentralization and quality of maternal services.
	0.77** 0.000
Financial decentralization	1

Source: Primary Data 2023

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According to Table7 findings, financial decentralization (r = 0.77, p = 0.000 <0.05)—had a significant relationship with the quality of maternal health services in sheema municipality. This suggests that the adoption of financial decentralization had a substantial association with the quality of maternal health care.

Regression Model for financial decentralization policy implementation and quality of maternal health services.

At the confirmatory level, to establish whether financial decentralization affect the quality of maternal health services, a regression analysis was carried out. The results were as in Table 7 below

Table 7 Regression Results

	Standardised Coefficients Beta (β)	Significance Beta (β) (p)
Financial decentralization	0.424	0.000
R= 0.87, R^2= 0.76,adjusted		

Source: Primary Data 2023

According to Table 7 findings, there is a strong positive correlation between the application of financial decentralization policy and the caliber of maternal health services (r = 0.87); This suggests that additional variables not taken into account by this model accounted for 24% of the variability in the quality of maternal health services. However, financial decentralization (= 0.424, p = 0.000 <0.05)—have a positive impact on the standard of maternal health services. This indicates that the third hypothesis was accepted. According to the magnitudes of the corresponding betas, Sheema municipality maternal health services are primarily strongly influenced by financial decentralization.

CONCLUSION

Financial decentralization significantly affect the quality of maternal health services which implies that when local governments are in charge of the financial resources, it can improve the quality of maternal health services

RECOMMENDATION

The Researcher recommended that the central government should increase on the funding of health facilities and also release the findings in time to aid in the smooth running of the activities in those health centers in order to improve the quality of maternal health services and those in charge should be able to give proper accountability on funds extended to them. This will encourage the central government and other funders to continue funding since there was value for money.

REFERENCES

1. Bossert, T. J., and J. C. Beauvais (2016). Decentralization of health systems in Ghana, Zambia, Uganda, and the Philippines: A comparative analysis of decision space. *Health Policy and Planning* 17 (1): 14–31.
2. Brett, E.A (2018). "Participation and accountability in development management". *Journal of Development studies*, Vol.40, No.2. Routledge, Part of the Taylor and Francis Group.

3. Bukenya, G. & Ziegler, P (2023). Manual of District Health Management for Uganda. Santa Barbara, California: *Fithian Press.*
4. Bwindi Community Hospital Report *(2018) Project detail*
5. Chandana, Y (2016). Implications of Health sector Reform for Family Planning Logistics in Uganda. Arlington, VA: *Family Planning Logistics Management/John Snow International*.
6. Cheema, G.S and Rondinelli, D.A (2023). 'Implementing decentralization policies: Developing Countries, Beverly Hill: Sage Publications.
7. De Muro, P. &. Conforti. M (2015). An overview of decentralization in sub-Saharan Africa. London: *Longman Publishers*.
8. Dodge P. and Wiebe, P.D (2015). Crisis in Uganda: The Breakdown of Health Services. New York: *Pergamon Press*.
9. Enon, K (2008). *The Triangulation of research designs*. London: Longman Publishers.
10. Gasto, F. & Anna, H (2023). *Participation in health planning in a decentralised system.* Global health action.
11. Gilson, L. and McIntyre, D (2011). Challenging Inequities in Health: From Ethics to Action. New York: *Oxford University Press* p.198.
12. *Golola,* L, M (2023). Decentralization, local Beaurocracies and Service Delivery in Uganda, in Reforming Africa's institution. New York: *United nations University press*.
13. Green, E (2017). District creation and decentralization in Uganda. Working Paper 24. London *School of Economics*.
14. Hickey, S. & Mohan G (2017). *Participation, From Tyranny to Transformation*? Exploring New Approaches to participation in development. London: Zed Books Ltd.
15. Jeppsson, A. and S. A. Okuonzi (2018). Vertical or holistic decentralization of the health Sector? Experiences from Zambia and Uganda. *International Journal of Health Planning and management* 15: 273–289.
16. Kisakye, A. (2015). Health systems factors affecting maternal health service delivery. *Journal of management.*
17. Kyomuhendo, G (2015). Low Use of Rural Maternity Services in Uganda: Impact of Women's Status, Traditional Beliefs and Limited Resources, Reproductive Health Matters
18. Landman, W. A. and Henley, L. D (2017). Equitable rationing of highly specialized health care Services for children*:* A perspective from Uganda. *Journal of medical ethics* 24:268-273.
19. Lavy, V. and Germain, J.M (2014). Quality and Cost in Healthcare Choice in Developing Countries. Living Standards Working Paper No.105. Washington DC: The World Bank.
20. Lubanga, F (2018). The process of decentralization. In Democratic decentralization in Uganda: A new approach to local governance, Kampala, Uganda: *Fountain Publishers*.
21. Makara S (2000) Financial and Administrative relations in Decentralization. Decent. Civ. Soc. Uganda, Kampala. *Fountain publishers*.
22. Mandelli, A. & Kyomuhangi, L (2015). Survey of public health facilities in Uganda. Bethesda, MD, The Partners for Health Reform *plus* Project, *Abt Associates Inc.*
23. Mills, A. and Tabizadeh I (2016). Health System Decentralization, Concerns Issues and Country Experience. Geneva Switzerland: *World Health Organization*.
24. Ministry Of Health (2017). National Supervision Guidelines*: February 2017 Draft*. Uganda: *Ministry of Health Publications.*