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The relationship between financial decentralization and quality of maternal health services

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ABSTRACT

This study aimed at investigating Decentralisation policy implementation and quality of maternal health services in Kihiihi Town Council and Nyanga Sub county-Kanungu District. It was guided by three objectives namely. The objectives were; to determine the relationship between Political decentralization and the quality of maternal health services in Kihiihi town council and Nyanga Sub County - Kanungu district, to find out the relationship between financial decentralization and quality of maternal health services in Kihiihi town council and Nyanga Sub County - Kanungu district and to assess the relationship between administrative decentralization and quality of maternal health services in Kihiihi town council and Nyanga Sub County -Kanungu district. The study adopted descriptive cross-sectional research and correlational designs on a sample of 235 respondents. Data was collected using a questionnaire and an interview guide. Quantitative data were analyzed using frequencies, percentages mean, correlation and regression. Qualitative data were analyzed using thematic analysis. Inferential analysis results indicated that financial decentralisation had a strong positive significant relationship with quality of maternal health services. Therefore, it was concluded that financial decentralisation as components of decentralization policy implementation is essential for quality of maternal health services.

Keywords: financial decentralization, maternal health services, women.

INTRODUCTION

Decentralization policy refers to the process through which control over planning, decision-making, and administrative power is transferred from the central government to its administrative divisions, local governments, and field organizations [1]. Between the formationof a policy (such as the enactment of legislation, the issuance of an executive order, or the promulgation of a regulatory rule) and the effects of the policy on the people it touches, policy implementation is a stage of policy making. However, the definition of decentralization policy implementation used in this study was based on how different academics conceptualized Fiscal/ financial, Administrative, and Political decentralization [2-3]. Fiscal/ Financial decentralization is the transfer of funds, revenue-generating power and authority over expenditure to local government and private organisations. Fiscal decentralisation considers financial accountability to be an essential component of decentralization. If subnational governments are to carry out decentralized functions effectively, they must have adequate revenues,either locally generated or transferred from national governments, as well as the authority to make expenditure decisions [4]. Pre-conception and family planning services, prenatal care, and postnatal care are examples of common maternal health services [5]. Decentralisation policies inmaternal health service delivery are intended to assist improve women's maternal health by facilitating access in terms of transportation, distance between users and health facilities, and enhancing the quality of maternal health services [6]. The degree to which health services for people and groups enhance the likelihood of desired health outcomes and are compatible with current professional knowledge is referred to as service quality.

Research design

The cross-sectional and correlational research designs were used in the investigation.

Study population

The 570 subjects that made up the study population were chosen from Kihiihi Town Council and Nyanga Sub County, respectively. The key informants in this study included VHTs, DHOs, CAOs,and sub county/town council health center in charge) midwives and nurses in Kihihi Town Council and Nyanga Sub County. Out of these, however, the study focused on the following categories: maternal health care users as the beneficiaries of the decentralization policy. The researcher chose 235 respondents from the 570 people that were the subject of her investigation, Using Slovin's formular ($n= N÷(1+Ne^2)$) these were chosen from among various groups of Kihihi Town Council members

Sampling techniques

The researcher employed both purposive sampling and a straightforward random sample strategy in the investigation. To eliminate bias and ensure that consumers of maternal health services had an equal chance of being chosen, the researcher utilized simple random sampling. The researcher was able to acquire information from official documents with the aid of key informants such as DHOs, Town Council/Sub County Health in Charges, Nurses/ Midwives, and VHTs through the use of purposeful sampling. 235 respondents made up the sample size for the study.

Procedure of data collection

Following ethical permission, the researcher requested an introduction letter from Kampala International University's postgraduate school to contact respondents in the study's field. The CAO and DHO of the Kanungu District received the letter from the researcher, who then introduced them to the responders. The researcher conducted interviews and personally delivered study questionnaires. Each questionnaire was accompanied by a permission form that described thestudy's overall goal.

Data processing and analysis

Quantitative Data

The researcher initially processed the data once it had been obtained. Coding, Statistical Packagefor 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. 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. This generated the data required for the findings to be generalized.

Qualitative data

The study goals and emergent themes were used to categorize and organize the qualitative data that was gathered. Discursive and thematic methodologies were used to conduct the analysis.The discursive approach took into account textual specifics when interpreting the material under analysis and assigning meaning. Thematic analysis, on the other hand, made sure that groups of text with comparable meanings were displayed together. Quantitative data were complemented by qualitative data, which assisted in elucidating the findings.

Ethical considerations

No invasive procedures were needed of study participants. When a strong rapport had been built with the informant, personal and delicate topics were probed. The study team was advised and mandated to respect the respondents' cultures while gathering data. In order to promote maternal health care within the area, the researcher made sure that the studywas communicated with the district administration and VHTs. A copy of the study report will be made available to the participants, the researcher further pledged. By using code numbers rather than names on the questionnaire, anonymity was preserved. By doing this, bias will be reduced throughout data collection.

Informed Consent: In order to ensure that her subjects are eager and willing to provide the information, the researcher obtained a consent form from them before beginning to gather data. This was accomplished by including a consent document that was obtained from Kampala

International University with the survey. Each subject gave their free and informed permission before the study ever began. The goal of the study, what participation in the study included, how respondents might decline to participate in the study or withdraw from it without penalty, and the advantages and hazards of participating in the study were all explained to respondents on an informed consent form.

Confidentiality: The researcher gave her respondents her word that the information they submitted would be kept private. This is due to some responders finding it unpleasant to offer certain details. The researcher therefore assured them that the information that was gathered was only to be utilized in this study and not for any other purpose. The questionnaires and other study equipment will be kept in a secure file cabinet, and only those participated in the study had access to the data collected. As a result, seeking information or asking questions that would be unethical was avoided and discouraged. **REC Clearance letter:** A clearance letter was got from KIU REC permitting me to go for data collection

RESULTS

Table 1: Descriptive statistics on financial decentralisation

	F/%	SA	A	N	D	SD	Mean
Central government provides enough funds to the district for provision of maternal health programs	F	124	70	-	11	7	3.89
	%	58.3	33.3	-	5	3.3	
Funds at the district are allocatedaccording 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 thedistrict	F	42	21	7	99	42	2.33
	%	20	10	3.3	46.7	20	
The district administration normally engages all stakeholders during theallocation of funds to maternal health	F	113	53	3	18	25	3.86
	%	53.3	25	1.7	8.3	11.7	
The district and people in the communitycontribute 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**	

According to the findings in Table 1, the district 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 district 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 thedistrict, 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 district administration regularly involves all stakeholders when allocating funding for maternal health sincethe 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 district and individualsin 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 district 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 decentralisation were compiled to see how overall respondents viewed financial decentralisation as a facet of decentralization policy execution. Table 4.6 summarizes the findings.

Table 2: Regression Results

Decentralisation policy implementation	Standardised Coefficients	Significance
	Beta (β)	Beta (β) (p)
Political decentralisation	0.464	0.000
Financial decentralisation	0.424	0.000
Administrative decentralization	0.025	0.124
R= 0.87, R^2= 0.76,adjustedR^2= 0.25, F =102.35, p = 0.000		

According to Table 2's findings, there is a strong positive correlation between the application of decentralization policies and the caliber of maternal health services (r = 0.87); additionally, the components of decentralization policies' application account for 76% of the variation in the caliber of maternal health services (R2 = 0.76). 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, only two aspects of decentralization policy implementation—political decentralization (= 0.464, p = 0.000 <0.05) and financial decentralization (= 0.424, p = 0.000<0.05)—have a positive impact on the standard of maternal health services, while administrative decentralization (= 0.025, p = 0.124 >0.05) had a marginally positive impact. This indicates that the third hypothesis (H3) was disproved and that only hypotheses one and two

(H1 and H2) were accepted. According to the magnitudes of the corresponding betas, Kanungu district's maternal health services are primarily strongly influenced by political decentralization.

DISCUSSION

The study found that financial decentralization has a substantial (p=0.000<0.05) impact on the quality of maternal health care in Kanungu district, and there is a strong positive association (r=0.77) between financial decentralization and the quality of maternal health services. As a result of financial decentralization, maternal health quality improves, because if the Central government provides enough funds to the district for the provision of maternal health programs, funds at the district are allocated according to the needs of health center III, and proper accountability at all levels for maternal health funds at the district. This was confirmed by district authorities who were interviewed. In relation to the above, another district official confirmed that, in this area, there's still 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 service".

The study's findings concur with Naidoo's [7] analysis of the Health Sector Decentralization in Sub-Saharan Africa, which found that nations with excellent financial decentralization policies had better resource mobilization for the provision of maternal health services. The significant financial gains districts experienced following decentralization provide proof of this. The results show that decentralized health systems in sub-Saharan Africa depend on funding from the central government to manage activities in the provision of health services in their areas of jurisdiction, which is in line with Gasto and Anna's [8] analysis of participation in health planning in a decentralized system. The money is often released afterward and in around four payments during the fiscal year. The financing mechanism in Uganda is known only as the quota system. This, in Frumence's opinion, makes it more difficult to carry out sound health policies and provide quality medical care. According to Anna-Karin Hurtig, Gasto et al. [8], central funding in a decentralized system is not the best way to guarantee the effective and efficient operation of local authorities due to obstacles like limited funding disbursement, delays in funding release, and alack of funding from other sources, among others. These obstacles all highlight the need for the introduction of informal coping strategies to deal with the situation.

CONCLUSION

Financial decentralization significantly affects 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

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