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Administrative decentralization and quality of maternal health services: A case of Kihiihi Town Council and Nyanga Sub county-Kanungu District

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ABSTRACT

The primary objective of this investigation was to explore the implementation of decentralization policies and their impact on the quality of maternal health services in Kihiihi Town Council and Nyanga Sub-county, Kanungu District. The study was guided by three specific objectives: (1) to ascertain the connection between political decentralization and the quality of maternal health services in Kihiihi Town Council and Nyanga Sub-county, Kanungu District, (2) to examine the relationship between financial decentralization and the quality of maternal health services in the same areas, and (3) to evaluate the relationship between administrative decentralization and the quality of maternal health services in these regions. The research employed both descriptive cross-sectional and correlational designs and involved a sample of 235 respondents. Data were gathered using questionnaires and interview guides, and quantitative data were analyzed using statistical measures like frequencies, percentages, means, correlation, and regression. Qualitative data were subjected to thematic analysis. The inferential analysis revealed that administrative decentralization exhibited a weak and statistically insignificant positive relationship with the quality of maternal health services. The study recommends that the Government of Uganda should implement decentralization policies in the health sector, granting local governments the necessary authority and funding to manage and operate health facilities, thus enhancing the quality of maternal health services.

Keywords: Administrative, decentralization, maternal healthand services

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 thepromulgation 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]. Administrative decentralization refers to transfer of authority, responsibility, and financial resourcesfor providing public services from national governments to local government agencies, subnational governments, or semi-autonomous public authorities or corporations (deconcentration, devolution, and privatization) [4]. Maternal health refers to a woman's health throughout pregnancy, childbirth, and the postpartum period. Pre-conception and family planning services, prenatal care, and postnatal careare 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].

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 Counciland 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' Formular (n=

$N \div (1+Ne^2)$ these were chosen from among various groups of Kihihi Town Council members shown in table 1 below:

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 themto 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 surethat 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 ratherthan 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

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Table 2: Summary of Descriptive Statistics on administrative decentralization

	Descriptive		Statistics	Std.Error
Administrative decentralisation	Mean		2.39	0.05
	95% Confidence	Lower Bound	2.22	
	Interval for Mean	Upper Bound	3.44	
	5% Trimmed Mean		3.99	
	Median		3.20	
	Variance		0.91	
	Std. Deviation		0.89	
	Minimum		1.50	
	Maximum		4.80	
	Range		3.48	
	Interquartile Range		1.40	
	Skewness		1.57	0.14
	Kurtosis		1.36	0.40

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The findings in Table 2 demonstrate that the median value of 3.20 was not particularly near to the mean value of 2.39. However, the outcomes show that the replies were regularly distributedbecause of a positive skew (skew 1.57). Because of the high mean, the respondents gave their administrative decentralization a poor rating. The opinions expressed above imply that while there were many individuals involved in making sure that there was a need for qualified professionals to deliver qualified maternal health care, there were also a lot of people who were not participating. Therefore, the district leaders' views entirely concur with those who said that their administrative decentralization was poor in their comments. It may be inferred, however, that there was adequate participation of people in administrative decentralization to enhance the standard of maternal health, given that leaders said that a lot of people were active. Quality of maternal health services quality of maternal health services as the dependent variableand was studied using eight items. The results on the same were as presented in Table 3.

Table 3: 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	3	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	5	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	12	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	7	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	6	3.81
	%	55	28.3	-	6.7	10	
Well trained midwives are still lackig in health facilities	**F**	28	13	1	6	12	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	
There are free guidance and counseling	**F**	7	10	3	24	16	2.33
services for pregnant mothers living with HIV as well as treatment to avoid motherto child transmission of the virus.	**%**	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	7	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	16	4.12
	%	11.7	16.7	5	40	26.7	

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Table 3 shows that the majority of respondents (91.7%) agreed that traditional birth attendants aretrained 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 ontime. 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 only30% 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 questionof 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 ofmidwives would be more motivated to provide quality maternal health services.

DISCUSSION

The study found a weak positive association (r=0.402) between administrative decentralization and quality of maternal health care in Kanungu district. The study found that administrative decentralization insignificantly (p=0.124>0.05) affects the quality of maternal health services. The majority of respondents disagreed that there is enough staff in health facilities, the local governmentsupervises the staff in health facilities, health workers are given enough materials to use in providing maternal health services, and Health Center in charge are consulted during recruitment of midwives and motivating health workers, which indicates that the decentralization of administrativepowers has a negligible impact on the quality of maternal health services. The study's findings did not agree with those of Bossert and Beauvais [3], who studied the decentralization of health systems in Ghana, Zambia, Uganda, and the Philippines. Their findings showed that all maternal health activities in public health facilities are monitored under decentralization policy. The activitiescarried out under decentralization to improve the quality of maternal health services are included in the monitoring and evaluation of health programs, according to Cheema and Rondinelli's [7]. Implementing decentralization policies: Developing Countries study. The findings show that under decentralization, the health infrastructure improves. The majority of African nations lack the necessary equipment for providing basic maternal health treatments. The afore mentioned qualitative findings concur with De Muro and Conforti's [8] analysis of decentralization in sub-Saharan Africa, which concluded that decentralization requires educating and raising community awareness of the value of utilizing maternal health care. Both men and women are made aware of the dangers of home or solo childbirths that aren't supported by a trained attendant through seminars and reproductive health campaigns [9]. Demand for health care is predicated on the ability to recognize sickness and the possible advantages of therapy,both of which are significantly influenced by an individual's level of education. The majority of the time, educated women attend for their prenatal exams more frequently than uneducated ones since the latter are unaware of the need of utilizing maternal health care. The health sector often organizeshealth workshops on maternal health through the health in charges and VHTs through a decentralized health system. The village health team has only been trained in the village-level roles of civic education, counseling, and advocacy. This has increased the use of maternal health care [5].

CONCLUSION

Decentralization policy implementation had a significant effect on quality of maternal health services and that it contributes 76% which implies that it's not only decentralisation that contributesto quality of maternal health services but also other factors like fighting corruption as revealed by qualitative findings. Administrative decentralization insignificantly affects the quality of maternal health services and this implies that giving powers to local government to recruit health workers without giving the required resources that not improve the quality of maternal health services.

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