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The relationship between political decentralization and quality of maternal health services in Kanungu District

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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 SubCounty - 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 political decentralisation decentralisation had a strong positive significant relationship with quality of maternal health services. Therefore, it was concluded that political decentralisation as a component of decentralization policy implementation is essential for quality of maternal health services.

Keywords: political decentralization, maternal healthservices, 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]. Political decentralisation refers to the transfer of authority to a sub national body. The formulation and implementation of policies is made more participatory through the involvement of more stake holders. Political Decentralisation strives to give citizens or their elected representatives more influence in making public decisions. Its purpose is to promote more participatory forms of governance by allowing individuals or their representatives' greater say in the development and execution of health policies and strategies [4].

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]. Hemorrhage, infection, and excessive blood pressure are among the leading causes of maternal death [7-9]. By decentralizing maternal health care, we make it easier for consumers to receive these services by shortening the distance between their homes and health facilities. When used properly, decentralized maternal health care are efficient, competent, timely, and cost effective, contributing to a reduction in maternal mortality [10].

Research design

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

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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's
Formular ($n= N \div (1+Ne^2)$ 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 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 Coefficient 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 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

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RESULTS

Table 1: Response rate

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

Source: Field Findings

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 thatwere 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.

Table 2: The data on the background characteristics of respondents

Item	Categories	Frequency	Percent
Gender	Male	98	45.7
	Female	117	54.3
	Total	215	100
Age Brackets	below 20	12	5.7
	21-40 years	108	50
	41-60 years	83	38.6
	Above 60 years	12	5.7
	Total	215	100
Marital status	Married	141	65.5
	Single	34	15.7
	Separated	9	4.3
	Windowed	15	7.1
	Total	215	100
Level of Education	No formal education	31	14.3
	Primary	92	42.9
	Secondary	31	14.3
	Tertiary	55	25.7
	Others	6	2.9
	Total	215	100

Source: Primary Data 2022

According to the findings by gender category, women made up a greater percentage (54.3%) than men, who made up 45.7%. This indicated that a larger proportion of responses were women. However, given the difference between the two groups was just 8.6%, views were representative of both gender groups. According to age categories of the respondents, the majority (50%) of respondents were between the ages of 21 and 40, followed by 38.6% of respondents who were between the ages of 41 and 60, and 5.7% of respondents who were beyond the age of 60. 5.7% of the responders were also under the age of 20. These findings demonstrate that respondents from a range of ages took part in the research. As a result, the opinions expressed accurately representedthe responses from respondents across a range of ages, allowing for generalization. The data on respondents' educational backgrounds revealed that a larger percentage (42.9%) of respondents left school after primary school, followed by 25.7% who completed tertiary level, 14.3% who completed secondary level, and 2.9% who had completed other levels of formal education, while 14.3% had none at all. These findings imply that the respondents' levels of schooling varied. As a result, the opinions represented respondents with various educational backgrounds. Due to the majority of research participants being over the age of 18 and thus eligible to be married, the majority of respondents—65.6%—were married. The remaining respondents—15.7% were single, 7.1% were widowed, and 4.3% were split or divorced.

Table 3: Descriptive statistics on Political decentralisation

	F/%	SA	A	N	D	SD	Mean
authority to local government to managehealth sector	%	63.3	28.3	-	5	3.3	
The local government makes decision onhow to manage health sector	F	124	70	-	7	11	3.87
	%	58.3	33.3	-	3.3	5	
The central government gives guidelines to local government on how to implement maternal health programme	F	21	35	-	110	46	2.07
	%	10	16.7	-	51.9	21.7	
The local governments are concerned on the performance of health centers in relation to provision of maternal health services	F	81	60	7	42	21	3.96
	%	38.3	28.3	3.3	20	10	
There is good coordination between central government and local governments in implementing maternalhealth programme	F	42	35	6	20	60	3.66
	%	20	16.7	1.7	33.3	28.3	
The local government gives feedback on the performance of health centers in relation to provision of maternal health services	F	120	56	-	14	21	4.02
	%	56.7	26.7	-	6.7	10	
Political leaders interfere in theimplementation of maternal health programmes	F	109	64	7	18	14	4.12
	%	51.7	30	3.3	8.3	6.7	
The central government has given	F	134	60	-	11	7	4.03

The findings in Table 3 regarding whether the central government has granted local governments authority to manage the health sector revealed that, overall, the majority of respondents (91.6%) said the central government has granted local governments authority to manage the health sector, while 8.4% said this was untrue. The results showed that respondents believed it was true that local governments had been granted authority by the federal government to handle the health sector, witha high mean of 4.03, which is near to code 4, on the scale being utilized. The respondents agreed that the local government takes decisions on how to administer the health sector since the majority (91.6%) agreed, 8.4% disagreed, and only 1.7% were indifferent. The high mean = 3.87 verified theresults. Furthermore, the majority (73.6%) of respondents disagreed with the low mean = 2.07 that the central government provides guidance to local governments on how to administer the maternal health program. The finding indicated that the local governments are concerned on the performance of health centers in relation to provision of maternal health services because the majority percentage(66.6%) agreed and this was supported by the high mean= 3.87. With a high percentage (76.9%) of the respondents agreeing and a high mean = 3.66, that there is good coordination between central government and local governments in implementing maternal health programme. Furthermore, the respondents indicated that the local government gives feedback on the performance of healthcenters in relation to provision of maternal health services because majority percentage (83.4%) andthe mean = 4.03 was high. However, with the larger percentage (60.3%) of the respondentsdisagreeing that political leaders interfere in the implementation of maternal health programmes with lower mean = 2.01, the results suggested that it was not true that political leaders interfere in the implementation of maternal health programmes.

Table 4: maternal health services

	quality of maternal health services,	Political decentralisation	Financial decentralisation	Administrative decentralization
quality of maternal health services,	1	0.89** 0.000	0.77** 0.000	0.381** 0.11
Political decentralisation		1		
Financial decentralisation			1	
Administrative decentralisation				1

Source: Primary Data 2022

According to Table 4 findings, the two aspects of decentralization policy implementation— political decentralization (r = 0.89, p = 0.000< 0.05) and financial decentralization (r = 0.77, p =0.000 <0.05)—had a significant relationship with the quality of maternal health services in Kanungu district, while administrative decentralization (r = 0.381, p = 0.11 > 0.05) had a positive but unimportant relationship. This indicates that H03 was accepted whereas the null hypotheses (H01&H02) were rejected. This suggests that the adoption of decentralization policies in terms of political and financial decentralization had a substantial association with the quality of maternal health care, but administrative decentralization had a negligible impact.

DISCUSSION

According to the study, the quality of maternal health services in the Kanungu area is considerably (p=0.000<0.05) impacted by political decentralization. Additionally, there was a significant positive correlation between political decentralization and the standard of maternal health care in the Kanungu area (r=0.89). It suggests that political decentralization enhances the standard of the Kanungu district's maternal health care. The district authorities that were questioned backed the aforementioned conclusion and largely agreed that in the past years, leaders in communities of Kanungu district showed low commitment and willingness to work towards improving the qualityof maternal health. However, since the introduction of decentralization especially political decentralization, there has been improvement. This has not been because of lack of avenues to makethem get involved in decision making, but sensitization about the importance and benefits of gettinginvolved in improving the quality of maternal health has been ongoing. And

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"Although the enthusiasm for leaders in Kanungu district is still low, there has been improvement. This can be seen in the increasing numbers of leaders getting involved improving the quality of maternal health.Even though the number are still low, once in a while we get some people joining the campaign of improving the quality of maternal, in this context, the interview also supports that decentralization improves the quality of maternal health services.

The findings are in agreement with Bossert and Beauvais [3], who conducted a study on the decentralization of health systems in Ghana, Zambia, Uganda, and the Philippines. The findings indicate that local communities are involved in mobilizing resources to build health centers and seek to understand how the mobilized resources are used. This becomes a responsibility of every politician to implement, monitor, and supervise the policies to aid better quality of maternal health services. Political decentralization has since resulted in better resource mobilization for the provision of maternal health care in underdeveloped nations additionally, in line with using experiences from Zambia and Uganda, Jeppsson and Okuonzi [11] looked at the vertical or holistic decentralization of the health sector. The findings highlight that political decentralization entails the local population acting as a watchdog over the system and ensuring that public officials provide high-quality goods and services. This is due to the fact that choices about the distribution ofresources are made in consultation with the local communities.

Furthermore, the findings are consistent with the findings of Mookherjee [12], who conducted a study on Combating the Crisis in Government Accountability, and the findings indicate that political decentralization is a critical step toward achieving systematic maternal health care service provision objectives through devolution of functions performed by the central government toDLGs. According to Naidoo [13], who conducted a study on Health Sector Decentralization in Sub-Saharan Africa, political decentralization helps to ensure that communities, particularly mothers, are empowered to take responsibility for their own maternal health and well-being, as wellas to participate actively in the management of their local maternal health services.

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.

Political decentralization significantly influenced quality of maternal health services and this implies that when local governments are given powers and authority to manage their health facilities, there was improvement of quality services

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