

Provision of primary health care service under decentralization: a comparative study of Paidha and Pakwach Urban Authorities

Charles Felix Olarker

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Provision of Primary Health Care Service Under Decentralization

A Comparative study of Paidha and Pakwach Urban Authorities

2000

PROVISION OF PRIMARY HEALTH CARE SERVICE UNDER DECENTRALIZATION: A COMPARATIVE STUDY OF PAIDHA AND PAKWACH URBAN AUTHORITIES

BY

OLARKER CHARLES FELIX

A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT OF THE DEGREE OF MASTER OF PUBLIC ADMINISTRATION AND MANAGEMENT OF MAKERERE UNIVERSITY (MAK)

FEBRUARY, 2000

DECLARATION

I Olarker Charles Felix, do hereby declare that this research work is original and has been purely my own work and that it has never been presented elsewhere for the award of Master of Public Administration and Management.

Signed: .....

Date: 18 - 2 - 2000

Supervisor: DR. YASIN A.A. OLUM

Signed: .....

Date: 19th - 2 - 2000

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DEDICATION

This piece of work is dedicated to my late grandpa Zakary Ngira, my father Anjelo Oyera and my mother Fulumena Acan for having encouraged me to continue with my academic struggle which has stirred me to the level of getting a Master of Arts Degree (MA) in Public Administration and Management. I highly believe that " parents are the most influential teachers, what parents teach their children is more important for their academic success". I'm, therefore, grateful to my parents and to the Austrian Government for supporting my education

May the Almighty God grant me the efforts and blessing to enable me effectively utilize the knowledge I have acquired for the development of my country.

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ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
CMR	-	Child Mortality Rate
DSC	-	District Service Commission
GDP	-	Gross Domestic Product
HMC	-	Health Management Committee
IMR	-	Infant Mortality Rate
LCs	-	Local Councils
LCD	-	Less Developed Countries
LEB	-	Life Expectancy at Birth
MIS	-	Management Information System
MMR	-	Maternal Mortality Rate
MoH	-	Ministry of Health
MGLSD	-	Ministry of Gender, Labour and Social Development
MPED	-	Ministry of Planning and Economic Development
NGOs	-	Non Governmental Organisations
NRM	-	National Resistance Movement
PHC	-	Primary Health Care
SSA	-	Sub-Saharan Africa
STD	-	Sexually Transmitted Diseases
UN	-	United Nations
UPE	-	Universal Primary Education
VHWs	-	Village Health Workers
WES	-	Water and Environmental Sanitation
WHO	-	World Health Organisation
SNV	-	Netherlands Development Organisation

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I wish to apologise and take full responsibility for any mistake that may arise in this work which unfortunately has not been intentional.

ABSTRACT

This comparative study is about the provision of Primary Health Care (PHC) in Paidha and Pakwach Urban councils under the National Resistance Movement's (NRM) decentralization programme. The study specifically pursued the following objectives: the common problems of PHC in the two urban councils; community participation towards improved PHC; the way the available funds and trained personnel are being utilised under decentralization; and examining other factors that influence or constrain PHC in the two urban councils.

The research attempted to examine the delivery of PHC under decentralization with emphasis on the influence of community empowerment: and financial and personnel management on PHC service delivery.

In carrying out the comparative study, qualitative and quantitative research methods were used. While qualitative research method was descriptive in nature thereby exploring the experiences of respondents. quantitative research method provided the tabulated statistical categorisation of responses that were presented in frequencies and percentages. These two methods provided a built-in linkage that made interpretation of findings possible.

The comparative study helps in understanding the importance of community participation in improving the quality of PHC. It further helps community leaders to find ways and means of promoting positive behaviours towards PHC. This therefore provide a basis for understanding how participatory and strategic policy formulation, implementation and adjustments can be improved.

The first chapter deals with introduction to PHC in developing countries and Uganda in particular. It examines Uganda's situation from independence to the current National Resistance Movement (NRM) government. It also defines the key concepts. It further gives the statement of the problem, objectives of the comparative study.

Chapter two looks at the related literature in relation to the study problem. The literature review looks at findings and observations of many scholars about PHC under decentralised system. This review is then linked to Uganda's situation in order to examine how she has been handling PHC under decentralization. The study mainly focused on how the available funds, trained personnel and community participation has been influential in the provision of PHC.

The third chapter stipulates the methodological approaches of data collection, the type of research design used to accomplish the research, the study area and

sample population. Tha approach also indicates the way the data has been analysed and the limitations of the study. This chapter is very important for the study because if appropriate methodological approach is not used, it invalidates the research process and findings.

Chapter 4 presents the study findings. It reveals the analysis of the information as derived from the respondents' views. The findings of the study revealed that improvements of PHC depends on the level of political empowerment of the local community because when the community is empowered politically, the local people are able to make quicker decisions which lead to improvement in service delivery. The study also found out that adequate PHC service delivery depends on the availability of funds and trained personnel. The findings in chapter 4 are therefore the reflection of the situation of the PHC on the ground.

Chapter 5 is the last chapter of the study. It lays down the summary of the findings of the study, the conclusion and the recommendations about the way forward. It also suggests areas for further research because very frequently it has been quite difficult to carry out research very exhaustively due to limited time, funds and other difficulties like appropriate manpower to be used in the field.

DEFINITIONS

The Concept of Primary Health Care

Primary Health Care (PHC) is defined as "essential health care made universally accessible to individuals and families by means acceptable to them, through their full participation and at a cost that the community and country could afford" (WHO 1978).

PHC includes: health education and food quality supervision, sanitation and water, maternal and child health care, immunization, essential drugs, and treatment of common ailments by community workers. At grassroot levels, the PHC service providers are health centres, dispensaries, sub-dispensaries, aid posts and sometimes hospitals.

Infant Mortality Rate (IMR)

Infant mortality rate refers to the number of deaths of infants under one year of age per 1000 live births in a given year (MPED 1998).

Child Mortality Rate (CMR):

Child mortality rate refers to the number of deaths of children between 1 to 5 years of age per 1000 live births.

Life Expectancy at Birth (LEB):

Life expectancy at birth refers to the number of years a newborn infant is expected to live if he or she is subjected to age-specific-death rates in a given year (MGLSD 1998).

Maternal Mortality Rate (MMR):

Maternal mortality rate refers to the number of deaths of mothers while pregnant or within 42 days (6 weeks) of termination of pregnancy for every 100,000 live births (MPED 1998).

Sanitation

Sanitation is defined as personal and environmental cleanliness to promote the well-being of the community. Better sanitation is the promotion of facilities, skills and practises that enables individuals, families and communities to improve their qualities of life through safe and appropriate disposal of human excreta, practising of good personal hygiene, provision of good drinking water, appropriate disposal of solid and liquid waste (School Sanitation Information, July 1999).

The Concept of Decentralization

Decentralization means the transfer of legal, administrative and political authority to make decisions and manage public functions of those agencies with subordinate units of governments, semi- autonomous public corporations; area-wide development authorities; functional authorities, autonomous local government, and non-governmental organisations (Rondinelli 1987:37).

Decentralization policy, as suggested by the World Bank in many countries, argues that local governments can become more responsive, accountable, and effective in service delivery (World Bank 1992). This policy became an important part of development strategies of many Third World governments in the 1970s and 1980s (Rondinelli 1981: 134). Further, Third World countries attempted this policy to create more socially equitable patterns of economic growth and to spread benefits of development to meet the needs of the general population.

According to the Ministry of Local Government's implementation unit, the Decentralization Secretariat (1994:19), decentralization is the transfer of legal, political, administrative and financial authority to plan, make decisions and manage public functions and services. This transfer is normally from the

central government and its agencies to lower level of administration or organisation.

The major types of decentralization are: deconcentration, delegation, devolution and privatization.

Deconcentration

Deconcentration involves the shifting of workload from central ministries to field officers and whose decision-making and implementation is within the guidelines set by the central ministries (Rondinelli 1981:137). An example of deconcentration in Uganda is where the District Medical Officer performs his or her duties within the guidelines set by the Ministry of Health (MOH).

Delegation

Delegation is where the central government transfers responsibility for decision-making and administration of public functions to semi-independent organisations, not wholly controlled by the central government, but ultimately accountable to it (Decentralization Secretariat 1994:21; Rondinelli 1981:138). An example of a delegated function in Uganda is when the Ministry of Transport and Communications gives authority to Uganda Posts

and Telecommunications to plan and implement decisions concerning specific activities of Posts and Telecommunications services.

Devolution

Devolution involves substantial transfer of powers, functions and resources to lower level authorities which are largely independent of central government (Rondinelli 1981:138). An example of devolution of powers in Uganda is the management of separate personnel system which has been transferred from the national capital under the control of the Public Service Commission to local authorities which are body corporates and managed by District Service Commissions (DSCs).

Privatization

Privatization is the transfer of public or parastatal responsibilities to private firms, individuals, NGOs and companies to provide services (Decentralization Secretariat 1994:21). An example of privatization is where markets which belong to districts are hired out to efficient private businessmen.

Manor (1995) argued that privatization is not a form of decentralization because power is actually passed from one major centre to others. However, it should be noted that in privatization, power is passed from the central

government to private firms, and it is the central government which provides the enabling environment and regulates the private sector. The central government has to ensure that appropriate standard of goods and services are maintained due to increases in the choice of goods and services available to the consumers.

CHAPTER ONE

1.0 INTRODUCTION

Chapter 1 explains the problem of health care services in developing countries. It also defines the key concepts namely: PHC, and decentralization. This chapter also deals with the statements of the problem, and the research questions.

This chapter is important because it explains the prevailing situation of PHC in developing countries particularly the experience of Uganda from 1962 to the current National Resistance Movement (NRM) government. It also clearly gives the objectives and significance of the study.

1.1 BACKGROUND OF THE STUDY

The improvement of health care services in developing countries has gradually slowed down during the last two decades. Economic recession, debt burdens, draught, famine and war, have undermined the improvement of health care services. Many countries, especially in sub-Saharan Africa (SSA), have experienced declines in per capita income. In SSA per capita growth between

1980 and 1993 has been negative (-0.8) compared to East Asia which was 6.4, and South Asia which stood at 3.0. Further, life expectancy was at 52 years. This life expectancy was significantly lower than other regions; Illiteracy rate was as high as 50% (World Development Report 1995). The SSA countries have suffered decreases in the availability of food and increased malnutrition as well as increases in the prevalence of communicable diseases such as malaria and acquired immune deficiency syndrome (AIDS).

At the time of independence in 1962, Uganda was one of the countries in SSA with promising economies. This potential was demonstrated during the first 10 years after independence when GDP was growing at an annual average rate of 5.1% (1961 - 1970) in which all sectors had positive and high growth rates (Ochieng 1995). However, the political crisis, economic mismanagement and armed conflicts in the 1970s and 1980s destroyed social and physical structures including health services (Ochieng 1995:4). During the 1970s and 1980s, many trained personnel left the country due to economic hardship and insecurity. This led to the reduction in the number of medical doctors from 978 to 574 and pharmacists from 116 to 15 (Khiddu-Makubuya et.al. 1994:545).

Since 1986, the NRM Government has been trying various measures to build up health services in order to improve on the delivery of health care services by

involving the local people in political and administrative affairs concerning their localities. The local administration system introduced by the NRM in 1986 was based on Resistance Councils (RCs) - today, RCs are called Local Councils (LCs). LCs, because of their participatory approach, made it possible for the government to reach deep in the rural areas. The LCs also allowed for easy information flow. It was, therefore, the structural framework of the LCs which later led to the formulation of the policy or programme of decentralized governance in the 1990s.

1.2 SERVICE DELIVERY

In Uganda the provision of social services such as medical and educational facilities constitute an important aspect of planning and resource allocation. The availability of such services in different parts of the country is influenced by the major factor of the total population and the age structure of the population in a given area. Other factors stemming from the different levels of economic development of a given area, historical and political influences do play a part in the location of these services (Jamal 1972: 75-78).

However, government normally attempts to provide the services according to acceptable guidelines on principle that the greater number of people should benefit from such services. However, under condition of strained resources government has not been in position to extend the services adequately in all areas.

Since the material and social conditions under which people live are constantly changing and people's needs are also changing, policies and programmes designed to promote the welfare of people also require constant review and adjustment (UN 1984: 19-21). In order to cater for the welfare programmes or improve on service delivery of the different groups, there is need for central government to allow local authorities with their available local resources and authority to play a crucial role. Local government agencies should be empowered to run comprehensive programmes and allow smaller agencies or private firms to cater for different interest groups in order to improve on service delivery.

In the field of health, programmes of immunisation, antenatal and delivery services, nutrition, the promotion of breast-feeding, growth monitoring of children, free milk for children, and environmental sanitation help in prolonging life. The PHC approach is seen as a significantly new strategy in health care that has the potential to achieve the aim of adequate health services for the local population. In order to achieve adequate health service delivery, there is need to involve the local population through local authorities.

1.3 DECENTRALIZATION IN UGANDA

The decentralization programme in Uganda was launched on 2nd October, 1992, by His Excellency the President Yoweri Kaguta Museveni. In November 1993,

the National Resistance Council (NCR) debated and passed statute No. 15 of 1993, which became an enabling law for decentralization process and created a framework for autonomous decision-making at District and Urban Councils (Authorities). The statute also devolved powers to lower levels of governments.

Decentralization in Uganda has been further strengthened by the 1995 Constitution and the Local Governments Act of 1997. These reforms aimed to achieve three main objectives. First, it sought to bring political and administrative control over services to the point where they are actually delivered. Second, it aims to free local managers from central constraints. Third, it aimed to improve financial accountability, as well as improve local capacity to plan, finance and manage the delivery of services.

However, it should be noted that due to inadequate funds, skilled labour, and other infrastructures, decentralization programme has been carried out in three phases (Decentralization Secretariat 1994:9). The first phase began in 1993/94 financial year with 13 districts. The second phase commenced in 1994/95 with 12 districts. The third phase was launched in 1995/96.

Despite these phased implementation, local authorities in Uganda continue to experience the problem of inadequate financial resources, trained personnel, and

other infrastructure such as health units, to cope up with the decentralised services in the country. According to the Ministry of Natural Resources (1995:8), one physician attends to 24,700 people, one nurse/midwife attends to 8,900 people, one medical assistant attends to 20,500 people, one health inspector attends to 58,000 people. It is also estimated that 20,000 people share one health unit and 800 people share one health care bed. Khiddu-Makubuya et. al. (1994:545) noted that one doctor attends to between 9000 to 10,000 people. However, this varies from district to district.

In Uganda today, child mortality rate (CMR) is at 147 per 1000 live births, infant mortality rate (IMR) is at 97 per 1000 live births, maternal mortality ratio (MMR) is at 506 per 100,000 live births, life expectancy at birth (LEB) is 48 years (MoH 1998:1). Geographical access to health care is severely limited with only 49% of the population living within 5kms of any type of health service unit. More than 60% of mothers are not attended to by trained health personnel during child birth. About 75% of life years is lost due largely to preventable diseases such as malaria, diarrhoea, pneumonia, tuberculosis, anaemia and meningitis (MoH 1998:1-2).

Considering the population ratio to trained medical personnel and the high child, infant, maternal mortality rates, it is quite clear that there is inadequate distribution of social services and amenities related to health care services. The high death rate due to preventable diseases is an indication of inadequate health care services and low level of literacy and awareness in the local authorities in the country. It is

these difficulties that led to decentralization as the way out to improve on health care services.

1.4 STATEMENT OF THE PROBLEM

Decentralization policy has been introduced in local authorities to improve on service delivery by addressing issues pertaining to financial constraints, health manpower planning requirements, community participation and NGOs. The government of Uganda, through the MoH, has been committed to implementing PHC strategy by involving local authorities, NGOs and the local community at large.

Despite the ongoing decentralization, where every local authority has taken charge of its own development in terms of legal, political, administrative and financial authority so as to carry out plans according to local needs in order to improve on primary health care facilities, urban authorities are still faced with challenges of inadequate financial resources, professional and administrative personnel, lack of community participation due to weak mobilization, poor political leadership, insufficient community outreach and poor accessibility to health units. As a result, urban authorities are continuing to face problems of morbidity and mortality due to increased outbreak of diseases such as meningitis, plague, malaria and other

preventable diseases such as pneumonia, tuberculosis and anaemia. There is still high infant, child and maternal mortality rates.

Although Paidha and Pakwach urban authorities seem to have similar problems related to PHC which include; inadequate number of trained personnel, financial resources and medical equipment, the current trend is that many patients tend to visit Paidha more than Pakwach. In fact, even the people from Pakwach tend to visit Paidha instead of their own health units. This phenomenon shows that there is something wrong in terms of PHC services delivered in the two Urban Authorities under decentralization. Hence, there arises the need for a comparative study between Paidha and Pakwach to establish why Paidha receives more attention from patients than Pakwach in the provision of primary health care services under decentralization, given that the two urban authorities are exposed to similar facilities including; similar political status, management structure and sources of revenue.

1.5 OBJECTIVES

General:

The general objective of this study is to:

- establish the overall pattern of primary health care service delivery being provided by the two urban authorities in relation to available resources under decentralized management.

Specific:

The specific objectives of this study are as follows:

- To find out health problems commonly faced by the communities of Pakwach and Paidha;
- To assess the community's participation towards improvement of primary health care services;
- To establish the extent to which decentralization particularly financial, and personnel, has led to the improvement of PHC service delivery; and
- To examine other factor(s) that influence or constrain the delivery of PHC in the two urban authorities.

1.6 RESEARCH QUESTIONS

The following research questions are considered central to this study:

- Is the improvement of PHC service delivery dependant upon political empowerment of the community?
- Is there a relationship between decentralized management (i.e financial, personnel) and the type of PHC being delivered?
- What other factors influence or constrain PHC delivery?

1.7 JUSTIFICATION OF THE STUDY AREAS OF PAIDHA AND PAKWACH URBAN AUTHORITIES

The following reasons explain why the two Urban Authorities were selected:

1.7.1 PHC forms part of the priority programme area of the central government and the provision of PHC affects the greater part of the urban society in improving their life style, it is therefore necessary to conduct research in these young and developing urban authorities to find how they are providing PHC services for the development of the country.

1.7.2 Because the researcher comes from these areas, it will be easy to access the necessary respondents and data. Also, the researcher is very familiar with the activities that go on not only in the health centres, but the region as well.

1.7.3 Both urban authorities are in an insecure area; since the north is in a war zone, the two authorities become areas of interest because it is important to establish how the two urban authorities are managing the decentralized services, especially health, during this difficult political and economic situation.

1.8 SCOPE OF THE STUDY

The study covered two administrative wards of Paidha and Pakwach respectively and in each Urban Authority the sample size composed of 40 non patients, 20 patients and 18 key informants.

The main variables in the study were PHC service delivery, decentralized finance and personnel functions, other variables included gender in relation to male, female, age group, level of education in provision of PHC.

The researcher assessed the capacity of Paidha and Pakwach in delivering PHC, with the view to establishing the problems or constraints therein. Recommendations were made to alleviate the likely problems or constraints.

1.9 SIGNIFICANCE OF THE STUDY

The study is significant in that:

- It will contribute to the understanding of the local population whose participation is very important in the provision of PHC hence, enabling them to prioritize their needs in relation to available resourses;
- It will aim at providing useful information appropriate to policy formulation that can improve on PHC delivery; and
- It will contribute significantly to the understanding of how PHC services should function under decentralization.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews literature on the theory of (neo)liberalism, decentralization and PHC concepts, and related literature. It looks at observations of different scholars related to the delivery of PHC and how this plays out in the case of Uganda. This is important because the opinion or observations of many scholars on PHC delivery helps in understanding how PHC is being provided under decentralized system, the relationship betwen central government and local government and how local community participate in providing PHC by making use of the available resources. I start with the theory of (neo)liberalism.

2.2 THE THEORY OF (NEO)LIBERALISM

Decentralization in Uganda is largely explained by the liberal perspective (public choice theory) other than theories like Marxism or Nationalism. From Adam Smith to its contemporary proponents, liberal thinkers have shared a coherent set of assumptions and beliefs about the nature of human beings, society and economic activities. All forms of economic liberation, are committed to the

market and the price mechanism as the most efficient means of organising domestic and international relations. In other words, liberal economic theory is committed to free markets and minimal state intervention.

Liberalism is defined as a doctrine and set of principles for organising and managing a market economy in order to achieve maximum efficiency, economic growth, and individual welfare (Gilpin 1988:27). Gilpin notes that the rationale for a market system is that it increases economic efficiency, maximises economic growth and thereby improve human welfare.

There are principally two competing theoretical paradigms on the question of economic growth and development in the realm of development studies (Marshall 1996: 427-430): (neo)liberal and the structuralist schools. Liberalism is ...

> ... an intellectual and moral principle on which social life is organised and which is built on the recognition of political and economic rights of the individual with the limits prescribed by the operation of laws ... In its narrower meaning, liberalism - the ideology and politics of liberal parties - as a whole is oriented to the preservation of the market economy and free competition in conjunction with minimal necessary regulatory role of the state (Weigle 1996: 437).

The liberal school emphasizes that development is attained once domestic elite in state and industry apply growth-generating policies. This school views the world economy as being a neutral space within which liberalisation and privatisation can

succeed. Liberals argue that countries develop solely on their intrinsic merits. Liberals seek to provide a prescriptive, policy-oriented measures suitable for economic growth.

Neo-liberals emphasize capital-intensive industrialisation, heavy infrastructure investment, and the transformation of traditional values as the appropriate formula for achieving self-sustaining economic growth, the benefits of which will 'trickle down' to the masses. The neo-liberal thesis believes that the search for profit is a natural human inclination, and that freedom of choice is critical to the success of economic and, to a certain extent political enterprises. The liberal approach is rooted in the classical liberal framework of Adam Smith and others who privilege the 'invisible hand' of the market in the global economy.

Structuralists, on the other hand, deny that global capitalism provides any ready answer for peripheral countries. They present the law of uneven and restricted development in a fixed way in an attempt to describe today's global power configurations. Structuralists believe that the conditions for 'perfect competition' do not exist in many Third World countries such as the new states of Africa because inequalities in access to resources, information, and technology, impede the clock-work operation of a free-market.

For nearly three decades (i.e., 1945 to mid-1970s), it was structuralism rather than neo-liberalism which served as the major motor in public policy in the developing countries. Structuralism, serving as the dominant paradigm of development, thrust the public nostrum beyond the traditional limits and, towards the elimination of 'poverty, ignorance and disease' (Balogun 1996). In this sense, structuralism resulted in central planning, social engineering and grandiose solutions to problems of poverty and inequality and the tendency to extract resources from potentially productive sectors and transfer them to drain-pipes acting in the guise of public interests, economic regulators and law enforcers.

The polarisation of these theoretical debates into the two extreme denies the Third World countries the opportunity to pursue a 'third way'- i.e., developmentalist path based on a resolve to exercise state power in more dynamic ways. The developmental state perspective represents efforts to arrive at a synthesis within the inside-out (state-centric) or *dirigisme* (state activism) approach. Yet the 'invisible hand' of markets, and good state management accounted for the success of 'late developers' particularly in the Far East. In countries such as those in the Far East, the phenomenon of 'late developer' rests with the strategic role the state played in taming the domestic and international forces and harnessing them to national ends (Onis 1991: 109-121; Johnson 1982). Thus, the role of the state should be seen as 'historical animator' in developmentalist 'catch-ups' (Wade 1990).

Public-choice approach is defined as the application of methodology and behaviourial assumptions of economics to the subject matter of political science (Lane 1987:146). Public-choice theorists such as Buchanan, Tullock and Ostrom advocate for decentralization of powers and services to encourage competition in service delivery. They note that hierarchy in government leads to centralization and the slowing down of decision-making. They, therefore, advocate that authority should be divided into smaller units to limit and control excessive political power (Stocker 1988:244).

Public-choice theorists advocate that local government should be run as business organisations because there will be greater diversity of services provided within a given geographical area. This belief, it is argued, will give all opportunity for individuals to choose rationally by providing the range of goods and services which is more suitable in a particular environment and needs of the people (Harmon and Mayer 1996:251).

In Uganda, the implementation of the Decentralization policy since 1993 clearly shows what public-choice theory advocates. Under this new local government arrangements, body corporates include units such as District Local Councils, urban authorities and sub-county councils. This structure is created to enable quicker decision-making and improvement of service delivery.

The implementation of financial decentralization, which enables the district council and other lower local government councils to 'contract out' services like markets, licence, permit collection, garbage collection in urban councils, hospitals, health centre cleaning and supply of drugs, are all aimed at effective service delivery. The central government normally provides the enabling environment by regulating the private sectors and ensuring that appropriate standard of goods and services are maintained, e.g. Uganda National Drugs Authority (UNDA) and Uganda National Bureau of Standards (UNBS).

Since the NRM is following liberal theory (public choice theory), and the country is faced with major problems in the health sector such as health care organization, management and financing, how does it expect the local authorities, and more especially those with low economic base like Paidha and Pakwach, to be efficient and effective in delivering the decentralized services? In fact, the inadequate funding of health sector coupled with the problem of underdeveloped infrastructure (MoH 1998:31-3), lack of trained personnel, and limited community participation, constrain the implementation of the decentralized services. This study intends to investigate these difficulties related to the provision of PHC service delivery in the two urban authorities of Paidha and Pakwach.

2.3 CONCEPTUAL FRAMEWORK

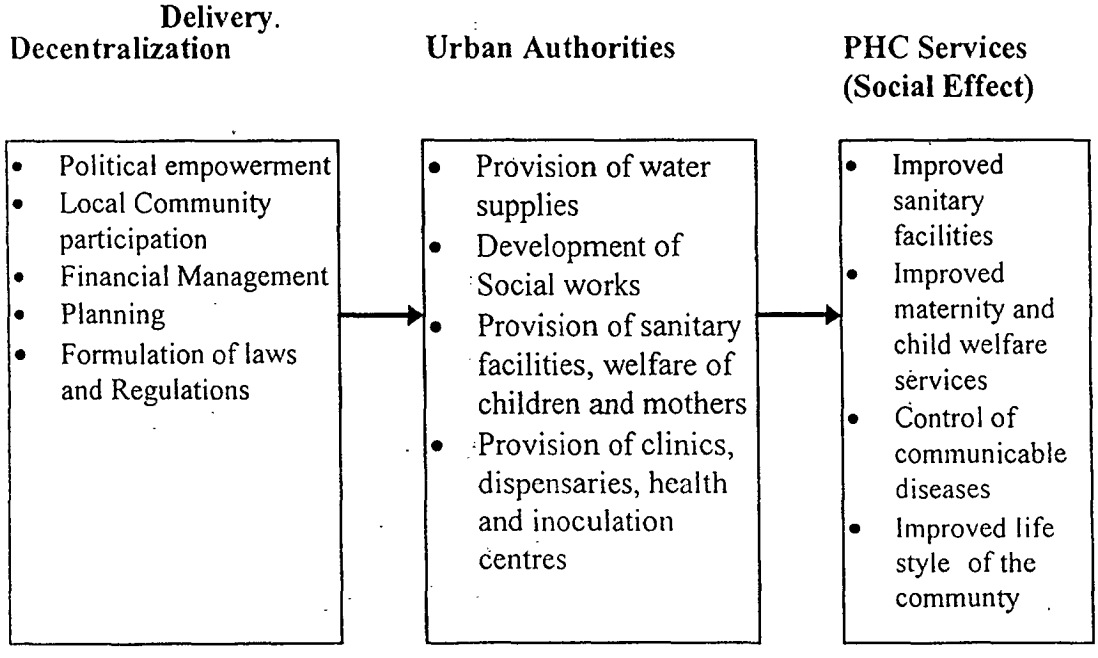
The conceptual framework looks at the accomplishment of PHC service delivery by local authorities or Urban Authorities. It recognizes the need for variables from the part of policy formulation and implementation through decentralization. It helps to examine the degree to which political empowerment enables local authorities (Urban Authorities) to improve on PHC service delivery.

Decentralization, in its context, covers political, financial and personnel, aspects. Political empowerment covers local community participation in decision-making, in which the local community are involved in mobilization of resources, planning and prioritising their local needs in order to improve on service delivery.

Through community participation, the local people make decisions on issues affecting them, they become agents of their own change, rather than being passive recipients of a centrally-driven process. The whole notion of decentralization, and especially devolution of power from the centre to the districts and from the districts to sub-counties/urban councils, to villages and individuals is the creation of political empowerment to the local community to take charge of their own development priorities.

Financial management includes mobilization, allocation and utilization of funds. With regard to planning, each lower local authority is mandated to make a comprehensive plan to be integrated in the District Council by the District Planning Authority. Personnel management requires that every local authority is empowered to recruit, promote, discipline and fire employees through their District Service Commission (DSC). On the question of laws and regulations, local authorities have been empowered to make relevant bye-laws. The ultimate aim of decentralization is to empower the local people so as to enable them to participate in their own affairs in order to shape their own destiny.

Table 1: Conceptual Framework of Decentralization and PHC Service Delivery.



Source:Author

Table 1 indicates that decentralization is a process of transferring political, legislative and personnel or executive powers from the centre to local authorities in form of local community participation in which local people exercise all political, financial and executive function within their areas of jurisdiction. Financial management is whereby local authorities mobilize and manage resources at various levels, including funds from central government and revenues raised locally. Planning has to be people-centred and it should be a bottom-up participatory approach. This is considered the most appropriate to get positive response from the local population. Through personnel decentralization, personnel management has become the responsibility of every local authority. They identify and recruit the relevant required manpower regularly and promptly. Legislative powers is given to local authorities to enable them make their own bye-laws in order to implement their own decisions and make work easier in implementing decentralization programme.

The concept of political autonomy is reflected in local governments by way of local authorities being made body corporates, in which they exercise political, financial, executive and legislative functions in order to help them develop their local potentials and capacities to improve on service delivery. In order to improve on PHC service delivery, central government normally supplements local revenues of local authorities through contributions in form of unconditional, conditional and equalization grants. The central government also plays the role of providing

policy guide lines to local authorities in certain areas which are considered priority programme areas in the country. Central government continues to support local governments in key areas of policy formulation, monitory, supervision, guidance and capacity building.

When the local people are involved in decision-making, they are expected to plan for the future, mobilize and allocate resources, set priorities, monitor and evaluate their performance. Therefore, the conceptual framework helps to explain the fact that through decentralization, local authorities are able to improve on the provision of PHC service delivery. However, the likely difficulties or constraints which young Urban Authorities like Paidha and Pakwach are likely to face in providing PHC are: limited community participation, lack of trained personnel and inadequate funds. This, therefore, implies that local authorities require high level of community participation, sound financial management and personnel management, planning, relevant laws and regulations in order to deliver PHC service to the local population effectively and efficiently.

Although community participation, financial management, personnel management, planning and relevant bye-laws and regulations are all crucial in the delivery of PHC service whether under decentralized or centralized systems, three main areas will be addressed, namely (community participation, financial management and

personnel management) to compare whether Paidha and Pakwach Urban Authorities have the capacity to deliver PHC service effectively and efficiently to the local population.

2.4 RELATED LITERATURE

Rondinelli (1981: 133-134) noted that decentralization became more prominent in developing countries in 1970s and 1980s in order to create political and administrative reform for better service delivery. The World Health Organization (WHO) (1990:1) observes that the decentralization of health system takes many different forms depending largely on overall governmental, political and administrative structures and objectives of the country.

In Uganda, the national health policy is developed within the framework of various national and international declarations and obligations which make the government to concretise its values and interest in the country's long term development vision (MoH 1998:3). Fesler (1965:556) observed that workload is often decentralized to field officials with detailed regulations. In addition, Winkler (1994) observed that under decentralization, central government has a very competent role to play which includes clearly specifying expenditure and revenue assignments.

These observation are being experienced in Uganda where central government grants are transferred to local government in three ways. First, is the case of unconditional grants. Unconditional grant is minimum grant which is paid to local governments to run decentralized services and is calculated using an objective criteria. Local government allocates it in accordance with its priorities but taking into account national priority programme areas.

Second, is conditional grants. This grant is given to local governments to finance programmes agreed upon between the central government and local governments. Local governments have no powers to reallocate it to any other activity without the authority of the sector ministry.

Third, is equalization grants. This is a grant which is paid to local governments as a special subsidy. It is based on the degree to which local government unit is lagging behind the national average standard for a particular service (Local Government Act 1997:60).

The excessive influence of central government on grant allocation, therefore, defeats the purpose of decentralization and this may as well affect the local authorities. The disbursement of funds from the central government to local governments makes the central government so powerful as to dictate and

determine what should be done by local governments. In other words, decentralization does not mean total disengagement by the central government from the activities of local governments.

The introduction of 'conditional grant' for PHC in 1996-1997 was to encourage greater attention to priority health activities. Attempts to compensate for health inequalities between districts by using equalization grants have not been successful till this day (MoH 1997:31). The meeting between MOLG officials and the NRM Secretariat team on 9/11/98 noted that the conditionalities attached to conditional grants makes it difficult for local governments to access these grants.

The financing of health services has become increasingly critical and urgent in many developing countries especially after the declaration of Alma Ata in 1978. This difficulty is because the less developing countries (LDCs) experience persistent health hazards such as malaria, meningitis, plague, pneumonia and other communicable diseases.

Lincoln (1988) noted that the concept of PHC has made a strong positive contribution to the health and wellbeing of people in all nations. However, the major problem has been lack of increased political commitment, including making permanent the principles and spirit of health for all. He observes that from 1960 to

1985, mortality rate fell constantly in major regions of the developing world. Global life expectancy, on the other hand, increased from 49 years to approximately 59 years. This was due to the effective implementation by many LDCs of the resolutions of the Alma Ata conference.

Rondinelli (1981: 139-142) and Smith (1985:191) reported that the poor performance of decentralization in many Third World countries are related to defects in budgeting, staffing, revenue collection, maintenance of work, financial control, inflation, honesty, shortage of trained personnel, difficulties in inter-governmental co-ordination and low levels of managerial and professional capabilities, which are all necessary to make local institutions effective and efficient. What Rondinelli (1981) and Smith (1985) noted explains the current situation in Uganda. There is inadequate funding of the health sector with the per capita health expenditure in the range of US $7 to $12 with only US $ 3.95 attributed to government and donor spending. Furthermore, there is low staff moral, poor co-ordination and weak collaboration between the public and private sectors. All these result in poor health service delivery (MoH 1998:3).

Furthermore, in Uganda only 27% of the population live within 5km away from a health unit while 43% live more than 10km away from any social welfare facility (MPED 1998:35). Faced with the absence of health units within reasonable

walking distance, many poor families rely on self treatment with drugs purchased from nearby shops and traditional healers.

The NGO's Forum (1995:5) observed that many families become rapidly impoverished when members become ill. Assets such as furniture are sold to pay for health fee. Indeed, in Uganda, many patients seek for treatment from traditional healers because they are less expensive and sometimes the traditional healers ask for payment in kind (New Vision 2/11/1998). For instance, items usually asked for include goats and chicken which the patients who live in rural areas normally possess as assets.

The observation by the NGO's Forum and the New Vision explains the health situation in Uganda. Poverty among the population is very high with an income per capita of US$ 300 and approximately 66.3 per cent of the people live under absolute poverty (MoH 1998:1). Attempts by the government to improve on PHC service delivery is being constrained by inadequate financial and manpower resources and the general level of underdeveloped infrastructure.

Makumbi (1991) noted that many deaths are known to occur far from medical care in rural areas and slums where 91 per cent of the population live. He further noted that many maternal deaths would be preventable if women had better access to

antenatal and post-natal care and had enough trained birth attendants and health units. The NGO Forum Adhoc Steering Committee (1995:5) noted that the high illiteracy rate among women in Uganda has direct implication on infant mortality. Hence, education for women has important side effects in improving health of families.

Although the role of women in community programme has been provided for in the Local Governments Act, 1997, in practice, the development of health sector policies and programmes have not responded to gender concerns.

Gender sensitivity will require that gender-related barriers to health care be removed (MoH 1998: 3- 5). There is also need to find out why there is delay in implementing effectively policies related to gender.

The WHO (1998:91) reported that most developing countries have poor data pertaining to health care services. For instance, Tukahebwa (1997:59) found out that Local Councils in Uganda are faced with serious problem of lack of data to carry out effective development planning. Langseth and Mugaju (1996:95) noted that while many districts in Uganda have some kind of district annual plans, most

of these plans are merely listings of activities. This, therefore, indicates that the implementation of decentralization has some weaknesses in that many districts face data and resource limitations.

This is perhaps why the NGO's Forum (1995:5) observed that participation of the poor is vital in policy formulation and implementation. The Forum noted further that it is vital that the government of Uganda and the World Bank decision-making processes become more transparent and help to strengthen civil society. However, Kauzya (1993:21) and Nsibambi (1998:144) noted that civil society in Uganda is still weak because many Ugandans suffer from illiteracy and also lack sophisticated organisational skills. External NGOs which play a key role in civil society have not been well co-ordinated by the state. Yet it is a fact that the poor know their environment and have views on how to address their problems. This potential must be taped, if the delivery of PHC services is to succeed. This involvement of the poor will support the policy of the government which is geared towards promoting the health and well-being of women, men, children, adolescents and specifically mothers in order to reduce the high rates of infant, childhood and maternal mortality and morbidity.

Although community participation is highly recognised, the majority of the NGOs reckon that the beneficiaries have very little access to financial information and

district authorities rarely have access to information themselves (Nsibambi 1998). The Alma Ata Declaration in which Uganda declared "health for all by the year 2000" is a challenging situation for the country despite the fact that the decentralization programme and the well laid down policy on health aims at improving health care service delivery.

The above review is intended to show how decentralization has been seen as an effective and efficient means of delivering PHC and how the available human and financial resources can be used in this provision. Although the central government is supposed to provide critical inputs to enable local governments handle decentralized service delivery, there is lack of: funding to enable local government to effectively execute the policy of PHC, lack of service delivery standard, and a vibrant civil society. All these gaps necessitate a study such as this one.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 3 indicates the methodological approaches used in the data collection and how sample selection was carried out. This chapter is relevant to the study because it indicates the study area and the study population. It further explains how the different sampling procedures were used to ensure that appropriate respondents and key informants in the two Urban Councils, were obtained.

3.2 RESEARCH DESIGN

The research design which was used was mainly exploratory because no study has attempted to investigate the way in which health services are delivered in young Urban Authorities. The creation of young urban authorities which are body corporates is a new administrative arrangement which requires exploratory research design, in order to find more information how PHC services is being provided. Most studies in health service have been mainly carried out at the district local authorities. Districts are much larger than small up-coming Urban Authorities. District local authorities may have adequate resources to provide PHC service, while young Urban authorities may have limited resources. Yet these

young urban authorities are supposed to provide PHC service through decentralization in the same way as the larger district authorities.

The exploratory research design involved examining the information obtained by describing the events, the information gathered were used to explain how PHC is being delivered in the young urban authorities, the information was later categorized, tabulated into frequencies and percentages.

3.3 STUDY AREA

The comparative study was conducted in the urban authorities of Paidha and Pakwach. Administratively, Paidha has two wards namely Paidha East and Paidha West. Pakwach has similar number of wards, namely, Puvungu and Amor.

The two urban councils were chosen for comparative study because they are both situated in Nebbi district. The two authorities have a similar sources of revenue and political status. The comparative study was therefore conducted in the two urban councils to find out how PHC was being provided, and, of the two, which urban council was rendering better services and why there was difference in the delivery of PHC yet both are exposed to similar economic, social and political conditions.

3.4 STUDY POPULATION

The study population comprised of "providers" and "consumers" of PHC. The providers of PHC included policy-makers and implementors such as LC III Councillors, members of Health Management Committee, and civil servants who are Heads of Departments.

Consumers or clients of PHC comprised of the local community which included patients who were admitted in the Health Centres, and non-patients who were selected from four wards, two from each of the urban authorities.

The study population had different parameters and statistics. Some were literate while others were not; some had knowledge of PHC and others did not; and some are employed while others are unemployed. However, a factor common to these authorities is that the majority of the respondents were in the age-group of 21-40 years with their educational background not beyond 'A' level. This reflects the literacy status of the population.

3.5 SAMPLE SELECTION

Different sampling procedures were used to select the area of study in both urban authorities. In order to obtain the respondents who are consumers or clients of

PHC and who are patients, simple random sampling procedure was used to select them from the list of admitted persons in Paidha and Pakwach health centres.

In order to select respondents who are consumers of PHC but who are non-patients from the two wards of Paidha and Pakwach, the 1998 Voters' Registers were used as the sampling frame. The registers were adequate in the sense that they have the identification information like villages, wards, contact address and socio-demographic background information like sex and age. Through systematic random sampling, the potential respondents were identified and contacted to confirm their participation in the interview.

Key informants like providers of PHC were purposively selected in both Paidha and Pakwach urban authorities. Purposive sampling has been used here because the key informants comprised of policy-makers and policy implementors who are knowledgeable about the subject.

In order to obtain the respondents in the two urban councils, selection was done as follows:

3.5.1 Paidha Urban Authority

5 members of Health Management Committee were purposively selected. These were considered representative enough in the area of health management in the urban councils and, secondly, they could easily be reached. 9 Councillors were purposively selected from among the list of LC III Councillors. This was considered representative enough to cover the areas of policy-makers, as the composition of Urban Councillors represents different interest groups like women, youth and persons with disabilities. 4 civil servants who are Heads of Departments (given that there are majorly 4 departments found in most Urban Authorities in Uganda at Town Council level). These are, therefore, considered representative enough to cover the areas of implementors. 20 respondents who were patients were selected from the list of admitted persons in Paidha and Pakwach Health Centres through simple random sampling from the two wards. 40 respondents who were non-patients were selected through systematic random sampling from the 2 wards.

3.5.2 Pakwach Urban Authority

The same procedure used to obtain the respondents in Paidha was also applied in Pakwach Urban council. The only exception is that in Pakwach urban council one key informant who is a councillor did not return his questionnaire as indicated in the sample structure in table 2(b).

Table 2: Sample Structure

(a) Paidha Urban Council

Category A	Category B	Category C
Sample of 40 non-patient respondents selected through systematic random sampling using the 1998 Voters' Register	Sample of 20 patients selected through simple random sampling from the list of persons admitted in Paidha health centre	Key informants
<u>Paidha East Ward</u> Female 10 Male 10 <u>Paidha West Ward</u> Female 12 Male 8	Female 10 Male 10	5 members of Health Management Committees 9 Councillors 4 Civil servants (heads of departments)
Total Respondents 40	Total Respondents 20	Total 18

(b) **Pakwach Urban Council**

Category A	Category B	Category C
Sample of 40 non-patient respondents selected through systematic random sampling using the 1998 Voters' Register	Sample of 20 patients selected through simple random sampling from the list of persons admitted in Paidha health centre	Key informants
<u>Puvungu Ward</u> Female 8 Male 12 <u>Amor Ward</u> Female 10 Male 10	Female 10 Male 10	5 members of Health Management Committees 8 Councillors 4 Civil servants (heads of departments)
Total Respondents 40	Total Respondents 20	Total 17

3.6 METHODS OF DATA COLLECTION

The data collection process involved different research instruments or methods. These included the use of semi-structured interviews, observation, semi-structured questionnaire and documentary analysis. Semi-structured interviews were administered to two categories of respondents comprising of patients and non-patients. Semi-structured questionnaires were administered to key informants who comprised of policy-makers and policy implementors.

The use of semi-structured interview was preferred because it is the responsibility of the researcher to fill in the responses on the interview schedule. This is expected to produce the most accurate result and it is also an easy way of knowing that the person selected is the one responding to the interview.

Semi-structured questionnaire was preferred for the simple reason that the policy-makers and policy implementors are knowledgeable about government policy on PHC and are in position to complete the questionnaires giving their own views on PHC activities.

Observation method was preferred because it can add strength to the interview being carried out because the interviewer can observe the facial expressions of the respondents as well as understand the health situation of the respondents.

Documents were used because they proved useful to the researcher in the sense that he could extract the relevant information about the performance of the two urban councils and problems relating to the provision of PHC.

3.7 STUDY VARIABLES

In this comparative study, the key variables that were considered were PHC service delivery and decentralization. Sub-variables such as gender in terms of male and female, age group, and levels of education were considered in understanding the level of community participation in improving health care services in the two urban councils.

3.8 DATA ANALYSIS

In this comparative study, both quantitative and qualitative data methods were used. Qualitative data analysis was used in explaining the social problems experienced by the respondents. This was descriptive in nature, describing how the respondents are attended to or treated when PHC services are being provided. It also explained the experience of the respondents on issues related to PHC in the two urban councils.

Quantitative data analysis was used. It was well edited to ensure consistency. The data analysis was done by considering the statistical response of the respondents. There was tabulation of the response of the different categories of the respondents

in terms of percentage and frequency. These were later on interpreted to come up with the explanations related to the data and information so gathered.

The qualitative data analysis which explained the problems of PHC and described the experience of respondents in provision of PHC was used to back up the quantitative data analysis.

3.9 RELIABILITY OF THE DATA

The data collected has been generally reliable considering the types of research instruments used in the data collection. The research instruments were pretested and gave reliable and dependable information. During the interview, most respondents gave clear explanation on activities of PHC, all the key informants in Paidha returned their questionnaires. In Pakwach only one key informant did not return his questionnaire. The questionnaires were well answered, majority of the key informants gave additional comments about PHC. The analysis of the data involved tabulation, categorization of responses into frequencies and percentages. This was scientific enough to give the appropriate reliable information.

3.10 LIMITATIONS OF THE STUDY

During the period of carrying out the study, the researcher encountered some limitations as follows:

Conducting research requires one to be patient and resilient because the exercise is time consuming. Hence, the time frame was limited. Yet this was a comparative study which required ample time for a thorough investigation to be conducted.

The ill health of some of the respondents, especially patients, was another limiting factor to the study as some of them were not very interested in responding to the questions being asked.

During the research period, the researcher experienced financial constraints because some of the respondents became more demanding. However, to make the study a success, the researcher made efforts through persuasion and sacrifice.

CHAPTER FOUR

4.0 FINDINGS OF THE STUDY AND DISCUSSIONS

4.1 INTRODUCTION

Chapter 4 is the most important part of the study because it indicates and analyses the findings obtained from the field as depicted by what goes on in the two Urban Authorities. The information obtained from the field survey were analysed and relevant recommendations were made.

4.2 CATEGORIES OF SAMPLE RESPONDENTS

In each of the two Urban Authorities the sample population comprised of category A of 40 respondents who are non-patients, category B comprised of 20 respondents who are patients, and category C of 18 key informants. The information obtained from the 3 categories were analysed using tabulations and calculations of percentages. The statistical information was strengthened by qualitative information which were analysed basing on their contents. This qualitative information was got from the respondents and the views of key informants.

4.3 SOCIAL DEMOGRAPHIC BACKGROUND

In an attempt to find out about social demographic information about the background of the respondents, more attention was paid to the 40 non-patients and 20 patients of Paidha Urban Council and an equivalent number of respondents and categories from Pakwach Urban Council. These respondents are considered the consumers or clients of PHC. For purposes of clarity and easy comparison, sub-headings have been used.

The major social demographic information of the respondents which include sex, age and educational background, are indicated and summarised under tables 3 below. In terms of sex (i.e. male and female) this has been clearly stated in table 3(a).

Table 3(a) Gender Variables of Non-Patient Respondents of Paidha and Pakwach

	Paidha		Pakwach	
Sex	Frequency	%	Frequency	%
No. of females	22	55	18	55
No. of males	18	45	22	45
Total	40	100	40	100

Table 3(c) Educational Level of 40 Non-Patient Respondents of Paidha and 40 Non-Patient Respondents of Pakwach.

	Paidha		Pakwach	
Educational Level	Frequency	%	Frequency	%
Never went to school	15	37.5	11	27.5
Primary Education	22	55.0	14	35.0
Junior Education	-	-	5	12.5
'O' Level	3	7.5	3	7.5
'A' Level	-	-	1	2.5
Tertiary Education	-	-	6	15.0
University education	-	-	-	-
Total	40	100	40	100

Table 3(d) Age-group of 20 Patient Respondents of Paidha and 20 Patient Respondents of Pakwach.

	Paidha		Pakwach	
Age group	Frequency	%	Frequency	%
21-30	8	40.0	5	25.0
31-40	4	20.0	7	35.0
41-50	4	20.0	3	15.0
51-60	-	-	3	15.0
61+	4	20.0	2	10.0
Total	20	100	20	100

Table 3(e) Educational Level of 20 Patient Respondents of Paidha and 20 Patient Respondents of Pakwach.

	Paidha		Pakwach	
Educational Level	Frequency	%	Frequency	%
Never went to school	9	45.0	7	35.0
Primary Education	10	50.0	10	50.0
Junior Education	-	-	2	10.0
'O' Level	-	-	-	-
'A' Level	-	-	1	5.0
Tertiary Education	1	5.0	-	-
University education	-	-	-	-
Total	20	100	20	100

Tables 3 (b) and 3(c) indicate that a big proportion of the respondents in both Urban Councils are young people within 21-40 age bracket. It further indicates that Paidha Urban Council has a slightly lower educational status compared to Pakwach. This can be seen from the proportion of those who never went to school of 45% among patient respondents and 37.5% for non-patient respondents for Paidha Urban Council compared to 35% and 27.5% for Pakwach Urban Councils, respectively.

4.4 FINDINGS AND INTERPRETATION ABOUT COMMON HEALTH PROBLEMS AND COMMUNITY PARTICIPATION TOWARDS THE IMPROVEMENT OF HEALTH CARE SERVICES.

4.4.1 PHC Improvement and Community Empowerment

In relation to the research question about the political empowerment of the community and improvement of PHC, it was important to find out community understanding of decentralization and PHC. The result of the finding is summarised in table 4(a) and 4(b).

Table 4 (a) Response of Non-Patient Respondents.

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Those who know what decentralization means	24	60	37	92.5
Those who don't know what decentralization means	16	40	3	7.5
Total	40	100	40	100

Table 4(b) Response of Patient Respondents.

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Those who know what decentralization means	10	50	12	60
Those who don't know what decentralization means	10	50	8	40
Total	20	100	20	100

Tables 4(a) and 4(b) show that the urban community in Pakwach Urban Council is more knowledgeable about the meaning of decentralization compared to their counterparts in Paidha Urban Council. This is reflected in the low percentage of 7.5% among non-patients and 40% among patients in Pakwach who don't know what decentralization means compared to 40% and 50% respectively in Paidha Urban Council. This finding is a true reflection of the educational background indicated in table 3(c) which shows that there are more respondents in Paidha who did not attend, primary school level of education compared to Pakwach. The finding reveals that on average, the respondents in Pakwach have attained better levels of education than in Paidha and, therefore, are capable of understanding the meaning of the term decentralization.

4.4.2 Decentralization and PHC

4.4.2.1 The Meaning of decentralization

The number of respondents interviewed were 80 non-patient respondents: 40 from Paidha and 40 from Pakwach; and 40 patient respondents: 20 each from Paidha and Pakwach.

4.4.2.2 Understanding the meaning of PHC

Table 5 (i) Response of Non-Patient Respondents.

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	39	97.5	37	92.5
No	1	2.5	3	7.5
Total	40	100	40	100

Table 5 (ii) Response of Patient Respondents.

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	20	100	20	100
No	-	-	-	-
Total	20	100	20	100

Although the community in Pakwach are better educated than those in Paidha, the findings on the understanding of PHC is better in Paidha than in Pakwach (see table 5(i) and 5(ii)). Figures under Paidha show that 97.5% of the respondents understand PHC and are knowledgeable about PHC compared to 92.5% . This statistics was obtained from the respondents with a 'Yes' response for understanding PHC. This is as a result of more involvement of the Urban Community in Paidha in provision of PHC than Pakwach which has led to creation of more awareness among the urban community in Paidha.

The respondents who did not understand the meaning of PHC as shown in table 5(i) indicate that it was the responsibility of the local leaders as policy-makers and policy implementors (technocrats) who should enable them understand the meaning of PHC.

The above revelation agrees with the views of key informants that there is decentralised PHC services in Paidha and Pakwach Urban Councils except that Paidha Urban Council has a workplan for PHC activities which is more effective than that of Pakwach Urban Council. This is shown in table 5. The workplan spells out how PHC programme is to be carried out over a period of time. This programme includes activities such as immunization, water and environmental sanitation (WES) campaign, sensitization of the community especially the risk

group of STD and HIV/AIDS. Video shows about STDs/HIV/AIDS have been conducted in villages in order to change the attitude of the community.

Table 6 Workplan for PHC Activity: 18 Key Informants from Paidha and 17 Key Informants from Pakwach

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	18	100	8	47.0
No	-	-	9	52.9
Total	18	100	17	100

More findings from the key informants from Paidha revealed that there is a general awareness of the existence of a workplan for PHC This has been reflected in the number of springs protected by the Urban Councils, construction of a maternity ward and the effective mobilisation for control of plague and meningitis. The success in implementing the workplan effectively has been done by involving the local community at LCI and LCII in decision-making. This approach of involving lower local government councillors agrees with public-choice theorists such as Buchanan, Tullock and Ostrom who advocate that authority should be divided into smaller units to limit and control the excessive political power from central government.

4.4.2.3 Types of PHC services being provided

The majority of respondents in both urban authorities are aware of the types of PHC services being provided. These include; provision of safe water, immunisation, maternal child health, environmental sanitation, curative services like treatment of illnesses such as intestinal worms, malaria, diarrhoeal diseases, cholera, health education and nutrition education. What has led to the majority of the respondents to be aware of the type of PHC is a result of better understanding of the meaning of PHC as reflected in table 5(i) and 5(ii). This awareness is also a result of decentralised system of decision-making that has responded to the roles and responsibilities of the many local government structures which are body corporates. The structures enable quick decision-making and easy accessibility to information by the local population on issues pertaining to PHC services.

4.4.3 Involvement of local community

Table 7 Involvement of Urban Community in the Provision of PHC

(a) Response of 40 Non-Patient Respondents each from Paidha and Pakwach.

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	40	100	32	80
No	-	-	8	20
Total	40	100	40	100

(b) Response of 20 Patient Respondents each from Paidha and Pakwach

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	19	95	20	100
No	1	5	-	-
Total	20	100	20	100

Table 7 (a & b) clearly shows that there is involvement of urban communities in the provision of PHC. However, the level of involvement of the urban community in Paidha is better than in Pakwach as is indicated in table 6(a) in which all the 40 (100%) non-patient respondents in Paidha indicated that there is total involvement of urban community in the provision of PHC services compared to 32(80%) in Pakwach. This implies that there is more political empowerment in Paidha than in Pakwach as the local community in Paidha is more involved in service demand and supply. This finding shows that participation in PHC activities does provide a sense of belonging to such services. The involvement or participation of the local community was upheld by the key informants in which they expressed the view that the increasing involvement of the community can be attributed to effective mobilisation and positive community perception created by the confidence built in the community by the open nature of operation of the local council system.

4.4.4 The Major Contribution of Urban Community

The major contribution of the urban community towards the provision of PHC has been: collection of local materials like sand, stones, aggregates for construction of safe water sources, provision of local unskilled labour during the construction and maintenance of water sources, construction of sanitary facilities for their homesteads, participation in immunisation through taking their children to static or outreach immunisation posts, mobilisation of the community by local leaders (local councillors), financial contributions collected as and when the need arises and paying the cost-sharing fees for antenatal and laboratory services and use of public latrines.

4.5 RESPONSE OF THE URBAN COMMUNITY TO IMMUNISATION PROGRAMME

Table 8(a) Response of 40 Non-Patient Respondents each from Paidha and Pakwach

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	39	97.5	23	57.5
No	1	2.5	17	42.5
Total	40	100	40	100

Table 8 (b) Response of 20 Patient Respondents each from Paidha and Pakwach

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	20	100	11	55
No	-	-	9	45
Total	20	100	20	100

Table 9 Response of Urban Community on availability of Antenatal and delivery care services

(a) Non-patient Respondents

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	40	100	37	92.5
No	-	-	3	7.5
Total	40	100	40	100

In finding out the common health problems faced by the two Urban Councils, 97.5% non-patients in Paidha reported that immunisation programme is available compared to 57.5% in Pakwach. Meanwhile, the response from patients in Paidha stood at 100% compared to only 55% in Pakwach.

In finding out about the availability of health services such as antenatal and delivery care services, the response rate of 100% and 92.5% among non-patients respondents indicated the availability of such services in Paidha and Pakwach, respectively. This portrayal is partly due to the effective coverage of the services in Paidha than in Pakwach and due to political influence. It was reported that poor leadership without commitment to such services in Pakwach compared to Paidha limits the sensitisation of the public on the availability and need for the services. This reveals that there is minimal community involvement in PHC service delivery in Pakwach than in Paidha. A true indication is the enormous community contribution in Paidha in terms of local materials, unskilled labour and funds for local PHC related activities compared to Pakwach.

4.6 RELATIONSHIP BETWEEN DECENTRALIZED MANAGEMENT AND PHC SERVICES BEING DELIVERED

In finding out whether there was a relationship between decentralized management and the type of PHC services being delivered, it was necessary to examine the level of funds and human resources available and then link the utilisation of the resources to the type of PHC services being delivered.

4.7 HEALTH MANAGEMENT COMMITTEE IN URBAN AUTHORITY

All the key informants from both councils responded that there health management committees existed in their Authorities and were responsible for management of Health Units in the provision of PHC services.

Table 10 Right Type of People who Form the Management Committee: Views of Key Informants in Paidha and Pakwach

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	15	83.5	7	41.2
No	3	16.7	10	58.8
Total	18	100	17	100

Table 10 reveals that the composition of the health management committee (HMC) is by the right people in Paidha (83.5%) than those in Pakwach (41.2%). This high percentage difference of key informants in Paidha and Pakwach was attributed to the fact that the key informants in Pakwach revealed that the composition of the HMC was by politically handpicked individuals. Pakwach Urban Authority did not follow the management and implementation guidelines issued by the MOH in July 1996. The guidelines state that the composition of a

Health Unit Management Committee should comprise of the following people; medical doctor, clinical officer, staff representative, 2 opinion leaders, one teacher, one woman representative, and two religious leaders. This was not followed in Pakwach. This failure, therefore, shows that there is inadequate level of political commitment by leaders in Pakwach as compared to Paidha to elect the right calibre of members of the HMC. Therefore, in order for decentralization policy to succeed, there is need to follow the regulations through political commitment to create a strong civil society.

Table 11 Management Committee Trained on Its Roles And Responsibilities: Views of Key Informants

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	18	100	8	47.1
No	-	-	9	52.9
Total	18	100	17	100

Table 11 indicates that the HMC in Paidha has been trained on their job description than those in Pakwach. The key informants in Paidha further revealed that the management committee is effective in discharging their role. This implies that apart from having the right people, there is need to train personnel in order to improve on their effectiveness.

4.8 AVAILABILITY OF VILLAGE HEALTH WORKERS TO PROVIDE PHC SERVICE.

In both Urban Councils, it was reported that there were a few Village Health Workers (VHWs) who end up being trained on the job. The two Urban Councils, however, expressed their dissatisfaction with the number of available trained personnel indicating the need for a resident doctor, and increasing the number of other established staff.

Table 12 Rate of Performance of Staff Involved in PHC Services: Views of Key Informants

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Excellent	-	-	-	-
Very Good	2	11.1	2	11.8
Good	13	72.2	7	41.2
Poor	3	16.7	8	47.0
Very Poor	-	-	-	-
Total	18	100	17	100

From table 12 key informants confirmed that the performance of health workers was good by 72.2% in Paidha compared to 41.2% in Pakwach. This can be linked to the fact that the training of members of HMC in Paidha contributes to their

supervisory role to the health workers thus enhancing the performance of the latter. Related to this is the fact that the HMC in Pakwach are not in close touch with the health staff, as was revealed by the key informants.

The effectiveness of health workers involved in the provision of PHC has been highly recognised by the respondents of Paidha in terms of reduction of maternal and infant mortality, health education that has promoted a positive attitudinal change, and the improvement in the relationship between health workers and patients. This, therefore, implies that improved work performance of health workers in Paidha is due to the appropriate training being undertaken which leads to improvement in organisational skills and decision-making processes become transparent, well coordinated, thus helping to strengthen the local community.

Table 13 Sex Education and Family Planning Programme being carried in the Community

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	22	55	12	30
No	18	45	28	70
Total	40	100	40	100

Table 13 indicates that sex education and family planning programmes are carried out in the community of the two Urban Councils.The level of current use of family planning is one of the indicators most frequently used to assess the success of family planning. The success of effective use of contraceptives is that it must be accepted by both women and men. However, the lack of effective communication among women and men, cultural norms and limited education normally hamper the community' s access to the use of contraception.

Table 13 shows that there is more provision of sex education and family planning in Paidha (55%) than in Pakwach (30%). This situation is probably due to the fact that Paidha has been selected by the district as a pilot project area for community based distribution agent for condoms and other contraceptives. This has led to the concentration of resources to enhance community awareness, inspire need for and access to sex education and family planning services. This, therefore, confirms that there is a relationship between management and the type of PHC services being provided in the sense that the more the availability of finance and trained manpower the better the service provided.

The study reveals that in both Councils, programmes related to breast feeding, weaning provision, growth monitoring of children and nutrition education is being carried out but at a low level due to limited manpower and lack of effective integration of the community in such delivery system.

This finding agrees with Nsibambi and Kauzya's observations that the civil society in Uganda is still weak because of high illiteracy rate and the society lacks organisational skills to function effectively.

On the adequacy of finance for PHC in both Urban Councils, the opinion of the key informants were as shown in table 14.

Table 14 Budget Allocation for PHC by Urban Authority Corresponding to the Needs of the Community

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
To a very large extent	-	-	-	-
To a large extent	1	5.6	-	-
To a sufficient extent	3	16.6	1	5.9
To a small extent	12	66.7	6	35.3
To a very small extent	2	11.1	1	5.9
Total	18	100	8	100

All the 18 key informants in Paidha returned their questionnaires while in Pakwach only 17 did. From Table 14, the non-response rate for Pakwach is an indicator of not fully understanding budget allocation. A cross-examination on this aspect led to the utilisation of the findings from the non-patient respondents on the adequacy of funding for PHC as is shown in Table 15.

Table 15 Response of Non-patient Respondents on the Adequacy of Funds in the Urban Authorities for PHC.

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	16	40	1	2.5
No	24	60	39	97.5
Total	40	100	40	100

Although there is an under 50% score for the availability of funds for PHC from Table 15, it is evident that there is a substantial funding in Paidha compared to Pakwach. This can be realised from the provision of safe water, purchase of drugs and community sensitisation. This implies that the improved provision of PHC depends on the availability of funds. The more the funds the better the level of PHC services delivery as is reflected in Paidha Urban Council.

The availability of water and environmental sanitation programme is summarised in Table 16.

Table 16 Response of Non-Patient Respondents on the Availability of Water and Environmental Sanitation

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Yes	40	100	34	85
No	-	-	6	15
Total	40	100	40	100

From Table 16, all the respondents in Paidha (100%) acknowledged the availability of water and environmental sanitation compared to 85% in Pakwach.

The documentary analysis reveals that there is a clear budgetary allocation for PHC in Paidha than in Pakwach Urban Council. PHC accounts for 5.4% of the annual council budget for Paidha. However, given the fact that there is a considerably higher revenue base in Paidha than in Pakwach, funding for PHC is better in Paidha than in Pakwach. The fees charged on certain PHC activities confirms the liberal theory and NRM policy of privatisation that the market can provide the appropriate services if one has the ability to pay for the services.

Furthermore, the study found out that the funding contribution by central government towards PHC is inadequate. Both Councils reported that some nominal fees are charged for certain PHC services such as antenatal care, water

point maintenance, use of public latrines, and for treatment in the health centres. The fees charged is used as follows: 50% for staff incentives, 30% for health unit maintenance, 10% for administrative costs and 10% for the District Medical Officer's office. This indicates that much of the fees collected is utilised on welfare of staff other than on providing PHC to the community. There is, therefore, need to revise the utilisation of the fees being collected.

Table 17 indicate how the two urban authorities are implementing PHC outreach services.

Table 17 Urban Authority and PHC Outreach Services: Response of Key Informants.

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
To a very large extent	4	22.2	1	5.6
To a large extent	6	33.3	3	17.6
To a sufficient extent	4	22.2	4	23.5
To a small extent	2	11.1	6	35.3
To a very small extent	2	11.1	3	17.7
Total	18	100	17	100

Table 17 confirms that there are better community outreach services in Paidha than in Pakwach. 22.2% of the key informants in Paidha indicated that to a very large

extent PHC outreach services was provided compared to 5.9% who responded that to a large extent inadequte outreach services are provided by the Council. These figures compare favourably with Pakwach. However, Paidha is better serviced.

Table 18(a) General Provision of PHC: Response of Non-Patients

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Excellent	-	-	-	-
Very Good	1	2.5	-	-
Good	20	50.0	2	5.0
Average	18	45.0	15	37.5
Poor	1	2.5	23	57.5
Total	40	100	40	100

Table 18(b) General Provision of PHC: Response of Patients

	Paidha		Pakwach	
Response	Frequency	%	Frequency	%
Excellent	-	-	-	-
Very Good	-	-	-	-
Good	16	80	15	75
Average	3	15	-	25
Poor	1	5	-	-
Total	20	100	20	100

While 50% of non-patients and 80% of patients in Paidha reported that the provision of PHC was good, the response from Pakwach was only 5% of non-patients and 75% of patients, respectively. The reasons forwarded for these variations were:

- drugs are always available in Paidha health centre since the council has a budgetary allocation for the same;
- safe water coverage is higher in Paidha Urban Council than in Pakwach;
- integrated community mobilisation by both the civil servants (i.e., health workers) and the politicians at all levels within the Council in Paidha is better than in Pakwach;
- the HMC is part-and-parcel of the PHC delivery system. In comparative terms, Paidha provides a better supervision of the technical staff than Pakwach; and
- there are more trained personnel in Paidha than in Pakwach. This contributes positively to outreach programmes that requires technical staff who in the case of Pakwach are more concentrated in the health centre for curative service delivery.

The key informants further revealed that Paidha Urban Council improved the level of funding of PHC through the attraction of all stakeholders. This, therefore, confirms that there is a positive relationship between decentralised management (financial and personnel, among others) and the type of services being delivered. The study reveals that if decentralization is to be effective, there is need for adequate financial, and trained human resources. This adequacy agrees with Rondinnelli (1981) and Smith (1985) who observed that poor performance of decentralization in many developing countries are related to defects in budgeting, staffing, revenue collection, and the shortage of trained personnel thus making local institutions ineffective in service delivery. Hence, effective delivery of PHC services is dependent upon the availability of funds and trained personnel.

4.9 OTHER FACTORS INFLUENCING OR CONSTRAINING PHC DELIVERY

In carrying out a comparative study in Paidha and Pakwach on PHC service delivery under decentralization, it was necessary to examine other factors influencing or constraining this process in the two Urban Councils.

Poverty was found to be one of the major factors influencing or constraining PHC in the two Urban Authorities. Due to social, economic or other deprivations which

affect individual households or communities, this often results into lack of basic necessities to life as well as a feeling of powerlessness. Considering that most of the population are peasants, the communities are generally poor. Because few children attend school, this tends to have a negative effect on the ability to perceive and appreciate some basic concepts of PHC. In addition, lack of education means shortage of trained human resources. This shortage explains the poor staffing level. Some of the health workers such as vaccinators and health educators are limited. Besides, given the rural setting of the two Councils, the attraction of personnel by the DSC has been an uphill task. Many trained personnel do not want to be recruited in areas which lack the basic infrastructural facilities for their upkeep.

Lack of transparency and effective accountability of PHC funds was found to be another factor influencing or constraining PHC service delivery especially in Pakwach Urban Council. Also, due to lack of a workplan, it has been difficult to deliver the services people want. This is worsened by the fact that even the funds sent by central government and those that are generated locally are spent without the knowledge of the public on the kind of services they should expect from their contributions. In Pakwach, the key informants revealed that the weakness of the HMC has further weakened the management including monitoring of collections and expenditures from user-fees. It is the responsibility of the HMC to carry out the exemption of fees. The poor undertaking of this responsibility by the HMC in

Pakwach explains the poor performance of user-fees in Pakwach compared to Paidha. This lack of proper management calls for the immediate training of HMC in Pakwach on their roles and responsibilities.

During the study period, it was revealed that in Pakwach there was no proper budget for the health units. The Urban Council dissolved the HMC in September, 1997 and instituted a new one in August, 1998. The basis of this operation and undertaking has, therefore, created a rift in the health unit's operation and management, and monitoring which has in turn tainted the credibility of the services to the population.

In Pakwach, bad political leadership was also reported by the respondents as being responsible for inadequate PHC service delivery. This is due to the fact that the leadership has antagonised the policy implementors by suspending some officers and sending others on forced leave. Coupled with the poor mobilisation and sensitisation, the response of the population towards PHC services is low. It is this nature of operationalisation that has affected the revenue performance of the Council and the attitude to contribute towards PHC services. For instance, in Pakwach, it was reported that the people have a negative attitude towards the payment of user-fees compared to Paidha; user-fees is one avenue for resource mobilisation for the stimulation of a quality PHC service delivery.

Another pertinent area that was noted was the high rate of illiteracy of the urban community. Apart from the positive role education plays for community mobilisation, it also influences or constrains behaviour and attitude change. It is more difficult for an illiterate community to change, positively, their practice, behaviour and attitude. Education is a pre-requisite for PHC services such as immunisation, safe water and environmental sanitation, family planning, safer sex practise, among others.

CHAPTER FIVE

5.0 SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 INTRODUCTION

The study was carried out with specific objectives of finding out health problems faced by the Urban community of Paidha and Pakwach and to assess the community participation towards the improvement of health care services. The study also aimed to establish the extent to which financial and personnel decentralization has led to the improvement of P.H.C, and to examine other factors that influence or constrain the delivery of PHC in the two Urban Councils.

5.2 SUMMARY OF THE FINDINGS

5.2.1 Social Demographic Background Information of Respondents

The major Social Demographic Information of the respondents were classified under sex, age and educational background. The demographic summary shown in table 2 (a-d) indicates that a big proportion of the population in both Urban

Authorities are still young people; The age group was found to be between 21-30 and 31-40. This shows that both Urban Councils are faced with an expansive population structure and growth pattern that will continue to mount pressure on the available social welfare services including health. Hence, both Urban Councils should come up with appropriate measures to improve PHC service delivery and facilities to cater for the needs of the population.

The demographic information of the respondents pertaining to education indicates that the level of education and especially in Paidha, is still low in both Authorities. This can be attributed to the predominance of agriculture and petty trade as the major source of household income. Besides yielding low income that is inadequate to support education, they tend to rely on family labour that in turn limit access to educational opportunities. Besides, the indication of this level within the respondent age-group is a manifestation of the cultural rigidity against education especially of the girl child, yet they are the majority of the school-going population. However, the success of an effective PHC service delivery requires an educated community for the implementation of PHC activities such as personal and household hygiene.

Interestingly, despite the low level of education in both Urban Councils, a big proportion of the urban community have the knowledge about and type of PHC

services offered in both Councils. This has a positive effect on community mobilisation for and participation in PHC activities. Indeed, the policy of decentralization that has empowered LCs, especially Urban Councils with their self-accounting status, has facilitated the delivery of PHC services. Decentralization has also provided room for improvement of the quality of PHC services to the community.

5.2.2 Common Health Problem and Community Participation

Both Urban Councils face common health problems. They are characterised by out-break of preventable diseases like meningitis, plague, malaria and other killer diseases. The morbidity and mortality indicators in both Councils reveal that the top 5 causes are related to water-borne, water-washed, water-based, and water-related vectors. These are intestinal worms, malaria, diarrhoeal diseases, and cholera. Although a bigger proportion of the community is knowledgeable about PHC, with the low coverage of safe water and environmental sanitation, their effective response to PHC services is questionable.

According to the WES-MIS Inventory Summary Report, 1998, conducted by the District Planning Unit in conjunction with UNICEF and the Directorate of Water Development, the coverage of sanitation (latrines) in Paidha Urban Council was

44.5% and Pakwach was 96.2%. This indicates that regardless of the involvement of the urban community in the decision-making on WES, the implementation at the household level is inadequate. Hence, the people tend to be exposed to diseases that can be prevented by PHC services. This also indicates an increasing PHC cost per capita.

The above situation calls for a concerted effort in community conscientization through sensitisation programmes and follow-up actions which should be geared towards imparting knowledge that promotes attitudinal and behavioural change.

5.2.3 Improvement of PHC due to Financial and Personnel Decentralization

Decentralization has empowered the local authorities to recruit, promote, discipline and dismiss employees through the DSC, to mobilize resources in order to deliver services to the local population. Paidha Town Council gained a self accounting status in 1993 and Pakwach Town Council in 1994. In Nebbi district, both Urban Councils have achieved significant development as a result of the decentralization policy.

Decentralized PHC activities such as immunisation, WES, health education, refuse management, family planning and antenatal care, have brough services nearer to the people. Since LCs are expected to deliver services that the people choose from, the prioritisation in the annual council budget [as well as the mobilisation of external intervention support], has taken a centre stage. The role of the central government towards LCs has been the supply of drug kits, grants (conditional and unconditional), and salaries of the medical staff. However, the contribution has not been adequate to meet the needs of the district even within a limited priority area.

The findings show that in both Authorities, the local community has been involved in decision-making on PHC activities and there is need to encourage more participation of the local community. This participation will achieve the aims of political participation.

The comparative study also reveals that both Urban Councils have inadequate number of trained personnel. Although Paidha has many more trained health personnel for the delivery of PHC than Pakwach, both Councils expressed the need for a Resident Doctor. For example, while Paidha has two Vaccinators, Pakwach has none. This deficiency is, however, attributed to the funding capacity of the Councils. Nevertheless, Paidha has a wider revenue base than Pakwach. The

actual revenue collection of the former increased from Ushs 152 million in 1996/97 to Ushs 189 million in 1998/99 compared to that of Pakwach which only increased from Ushs 98 million in 1996/97 to Ushs 110 million in 1998/99 financial year. This explains why Paidha is able to employ and retain a large workforce whose salaries are regular than Pakwach.

5.2.4 Community Participation

Participation has been upheld in the promotion of local development due to its contribution towards ownership and sustainability for self sustained growth. What gives real meaning to popular participation is the collective effort of the people concerned to pool their efforts and whatever other resources they decide to pool together, to attain objectives they set for themselves. In this regard, participation is viewed as an active process in which the participants take initiatives and actions that is stimulated by their own thinking and deliberation and over which they can exert effective control. The study, however, revealed that there is a greater level of community participation in Paidha than in Pakwach. In Paidha, the community is involved in decision-making at various levels either directly or through their representatives. In this regard, the local leaders have played a great role in ensuring community involvement in the PHC activity, workplan formulation, annual budget process, PHC project implementation and monitoring of PHC activities. In Pakwach, there are neither workplans nor budget allocation for PHC.

The local community participation is characterised by contribution either in kind, cash or both, towards PHC activities. This takes the form of local material collection, provision of unskilled labour, payment of user-fees in the health centres and water points, participation in local committee membership, among others. It is such zeal that has helped in the topping up of government (local and central) and donor contributions towards the provision of safe water points and their maintenance, mobilisation for immunisation, construction of PHC service delivery facilities, among others. Consequently, in Paidha where community participation is fairly higher compared to Pakwach, the coverage of these services is higher.

5.3 THE CRITICAL FACTORS THAT PROMOTE PHC UNDER DECENTRALIZATION

The critical factors that promote PHC under decentralization as being experienced in Paidha urban authority than Pakwach urban authority are:

Creation of political awareness; there is creation of political awareness among the local community of Paidha, this has enabled the local community to participate in developmental issues pertaining to their life style. Community sensitization, community outreach programmes being implemented in Paidha coupled with better communication between the policy makers, service implementors and service consumers has led to greater community and household involvement in

provision of PHC in Paidha than Pakwach. Therefore creation of political awareness is important in provision of PHC.

Capacity building is essential to the development of a more efficient and effective local government system. The training of local leaders in Paidha on issues of policy and decision making in provision of PHC through preparation of local programmes has led to improvement of PHC service delivery. In order for Pakwach to improve on PHC, there is need for more recruitment of trained staff, there is need to organize training for its current policy makers and implementors.

The local politicians of Paidha urban authority are more transparent to the population on utilization of funds. This had led to the encouragement of the local community to provide more resources in cash and kind for PHC activities and the local people have greater faith that their resources including money is being put to good use, this had led to sustainability of PHC activities. In order for Pakwach urban council to improve on provision of PHC there is need for the local politicians to become more transparent on utilization of funds and other resources.

Paidha urban authority is continuing to perform better than Pakwach urban authority in provision of PHC on the ground that the Health management committee is ensuring that the necessary infrastructures like buildings, other

material resources like drugs, human resources are in place. Paidha urban authority continues to provide for most of the essential resources for PHC as per the local needs of the people in its yearly budget while Pakwach does not come up clearly with programme and essential resources for PHC.

5.4 CONCLUSION

By looking at the overall pattern of PHC in the two Urban Councils, the comparative study has realised its stated objectives. The specific objectives which were related to the research questions, investigated whether the improvement of PHC depended on political empowerment of the community, decentralized management (i.e, finance and personnel), and any other factors influencing or constraining PHC delivery.

The findings of the study reveals that, " decentralization policy has led to the improvement of PHC service delivery; and the more the availability of funds and trained personnel supported by an informed community, the better the PHC service delivery.

Although the most appropriate types of respondents and their improvement have been identified, there are yet some areas which have remained fertile for further research. These gaps exist because the comparative study was faced with some

difficulties such as lack of funds, manpower, and types of respondents. However, in order to obtain sufficient information, the researcher relied mainly on the tools used in the field to solicit for information and documentary backups.

5.5 RECOMMENDATIONS

The study recommends that there is need for extensive community out-reach, i.e., the community should be informed of social factors which will affect their life-style; They should also be made aware of their responsibilities.

The study further recommends that there should be persistent sensitization of the local community through health educators because health education helps to develop a dialogue among community members and to enlighten the population on health related matters.

There is need for training additional manpower to beef-up the staffing level and the functional committees on their roles and responsibilities. However, this will require the establishment of committees as stipulated by law. Staff of the health units require skills updating courses while Health Management Committee apart from their roles, require task-oriented training such as in strategic and participatory planning and budgeting.

Due to limited resources, Urban Councils need to improve the effectiveness and efficiency of their manpower as well as the quality of service out-reach by establishing and training village health workers. Traditional midwives should be equipped with the appropriate tools. This will expand service delivery at client points, improve service coverage, ease community mobilisation and hasten community participation.

Central Government should endeavour to direct the local leaders appropriately and should instill managerial skills in local leaders to enable sound decision-making by the different communities; Community decision-making is considered a key to success in PHC because it promotes ownership. This can be done by local leadership training through local seminars or workshops.

It is evident that in the near future, Urban Councils such as Paidha and Pakwach, may not be in position to deliver effective PHC services due to inadequate funding. While the Urban Councils are focussing at conventionally changing and re-directing more efforts towards preventive and promotive health, resource allocation by central government should be revisited. The assumptions underlying resource apportionment based on target population falls short of the flexibility and mobility status and influx into Urban Councils.

In addition, there is need to privatize some of the PHC services. Notable success has been scored with WES programme. This can be emulated into other sections of PHC components. Besides, private practitioners should be encouraged to provide PHC services to the community. This promotion can be through tax exemptions for some activities, sub-contracting arrangements for some specific activities such as construction of water points, health unit infrastructure and community sensitization.

Further, there is need for "twinning of towns" so as to provide avenues for sharing of the limited resources both in skills, funds, and experiences. The Local Governments Act 1997 (second schedule, part 3(29):124) emphasizes that local governments can initiate and contract twinning arrangements with international local governments or local authorities in consultation with the Minister. This will provide room for the expansion of avenues that promote effective resource mobilisation and utilisation for social welfare services such as health.

The revelation of low coverage of WES in the Urban Councils amidst support from UNICEF, SNV, MoH and other donor community, is a clear indication of limited and non-participatory planning and budgeting capacity at the district level. In most cases, WES programme in Nebbi district is centralised at the district level where priority setting does not put into consideration the needs and capacity of the

beneficiaries (i.e., communities). Apart from the need to decentralise WES activities to lower council levels leaving the district unit with quality assurance and supervisory roles, there is need for the donors to re-orient their support to Urban Councils. A direct dealing with Urban Councils is expected to yield more fruitful results.

The researcher recommends that there is need to increase the capacity and role of women in identifying and managing locally prevalent health problems which revolve around their daily activities. Women should be made to understand and appreciate the environment (encompassing water, sanitation, food and communication) which will help improve health status of households.

Education and literacy are preconditions to development and, hence, play a key role in the determination of the status of women and men. Therefore, the findings regarding the low educational level requires a concerted effort of the Councils in enforcing the UPE policy so as to create an environment that provides for access, equity, retention and progression for all children of school-going age. There is need to formulate local by-laws with the involvement of all stakeholders. Besides, adult education programme needs to be promoted to ensure that the adults are able to read and write in areas such as functional numeracy, basic health and improved production skills. This will provide a positive avenue for the understanding, internalisation, appreciation and application of PHC principles as well as paying-for-services under cost-sharing arrangements.

The study was conducted in Urban settings, where the population is sensitive and interested in finding out why such information is being gathered. Therefore, due to little time and resources like funds and manpower, the researcher was not in position to cover other related fields extensively. It is, therefore, recommended that further comparative study be conducted in such young towns to gather more information on health services. The proposed areas are:

1. The types of leadership in the local government in relation to resource utilization and provision of PHC;
2. The risk behaviours of the young population in relation to understanding PHC activities; and
3. Resource allocation and management discipline for PHC service delivery.

REFERENCES

Bert Van Noren, et al (1989) Simplifying the Evaluation of Primary Health Care Programmes Pergamon Press, Great Britain.

Cassels, Andrew (1995) "Health Sector Reform: A Key issue in Less Developed Countries", Journal of International Development, Vol 7, No 3, 329-347, United Kingdom.

Decentralization Secretariat (1994) Decentralization in Uganda, The Policy and its implementations Vol 2. Ministry of Local Government, Kampala.

Decentralization Secretariat (1994). Hand Book for facilitators of Decentralization Sensitization Training, Ministry of Local Government, Kampala.

Ebrahim, G. J. (1976) "A Model of Integrated Community Health Care," Tropical and Geographical Medicine, Vol 28, London.

Fesler, James W. (1965) "Approaches to the understanding of Decentralization" Journal of Politics Vol. 27, No 4 Yale University.

Stocker, Gerry (1988) Politics of Local Governments. Macmillan Education.

Gilpin, Robert (1987). The Political Economy of International Relations. Princeton University Press, New Jersey.

Herman and Mayer M. W. (1986). Organization Theory for Public Adminstration, Toronto little brown and company.

Jamal, G. (1972) Uganda Squared. A Systematic Analysis of Geographic Data on Uganda by Grid-Squares, Department of Geography, Makerere University, Kampala, Occassional Paper No. 24, Chapter IV.

Jan-Erik lane (1987) Bureaucracy and Public Choice, Sage Publications, London.

Johnson, C. (1981) MITI and the Japanese Miracle, Stanford, C.A, Standard University Press.

Kauzya, J.M. (1993) "State, Democratization and Decentralization Conditions of Poverty and Regional Inequalities: Lesson from Uganda" A paper presented in the second International Conference Toluca 27th - 30th July 1993.

Khiddu Makubuya, E. et. al. (1994) Uganda Thirty years of Independence 1962-1992, (pp. 544-545). Makerere University, Kampala.

Korte, R. et. al. (1992) Financing Health Services in sub-Saharan Africa: Options for decision-makers during adjustment. Pergamon Press, Great Britain.

Lincolm, C. Chen (1988) "Ten years after Alma Ata: Balancing different Primary Health Care Strategies" Tropical and Geographical Medicine, Vol 40.

Makumbi J.G.S (1991) "Needs Assessment in Reproductive Health in Uganda". A paper presented at Colline Hotel Mukono November, 4 1991.

Manor, J. (1995) "Decentralization in Africa and Asia". IDS Bulletin, Vol 26, No 2 April.

Mark, Baird and Deborah, Wetzel (1995) "Reduction of Poverty, Lessons from Experience". A paper presented at International Conference Kampala.

Marshall, Don D. (1996) "From the Triangular Trade to (N)AFTA": A Neo-structuralist Insight into Raised Caribbean Opportunities, Third World Quaterly 17(3): 427-453.

Ministry of Health (1998), National Health Policy of the Republic of Uganda, Kampala

Ministry of National Resources (1995) National Environment Action Plan for Uganda, Kampala

Ministry of Planning and Economic Development (1998) Poverty Eradication Action Plan. A National Challenge for Uganda, Kampala Vol.1.

Ministry of Gender, Labour and Social Development (1998), Balancing the Scale, Addressing Gender Concerns in District Development Programmes.

Ministry of Planning and Economic Development (1998), Women and Men in Uganda, Kampala.

Paidha Town Council, Approved Recurrent and Capital Budget Estimates, 1996/97, 1997/98, 1998/99.

Minute of Meeting between Ministry of Local Government and NRM Secretariat Team held on 2 November 1998 at Conference Centre, Kampala.

NGO's Forum adhoc Steering Committee (1995) "The Challenge of Growth and Poverty Reproduction". A paper presented on 6th November 1995, Kampala.

Rondinelli A. D. (1981) "Government Decentralization in Comparative Perspective: Theory and Practice in Developing Countries". International Review of Administrative Science, Vol XLVIII, No 2.

Nsibambi A. R. (1998) Decentralization and Civil Society in Uganda. The Quest for Good Governance. Fountain Publishers Ltd, Kampala.

Nsibambi A. R. (1997) "Making Democratic Decentralization an Instrument of Poverty Eradication: Uganda's challenge". A paper presented at UNDP's Development Forum, Kampala, April 1997.

Ochieng, O. E. (1995) Economic Stabilization and Adjustment Programmes in Uganda 1981-1994. Ministry of Finance and Economic Planning, Kampala.

Onis, Z. (1991), 'The Logic of the Developmental State', Comparative Politics 24(1): 109-121.

Pakwach Town Council, Approved Recurrent and Capital Budget Estimates, 1996/97, 1997/98, 1998/99.

Langseth, Petter and Mugaju Justus, (1996) Post-conflict Uganda. Towards an Effective Civil Service, Fountain Publishers Ltd, Kampala.

Rhodes, Rod A. W. (1995), The New Governance: Governing without Government, E.S.R.C.

Smith B. G. (1985) Decentralization: The Territorial Dimension of the State. George Allen and Unwin, London.

New Vision Paper Vol.13 No 262 of 2/Nov/1998, The New Vision Printing and Publishing Corporation, Kampala.

Republic of Uganda, The Local Governments Act, 1997.

Republic of Uganda, Constitution of Republic of Uganda, 1995.

Tukahebwa G.B (1997) "The Role of District Councils in the Decentralization Programme in Uganda". A Research Report under a MISR Project entitled "The Quest for Good Governance and Civil Society through Decentralization in Uganda".

United Nations (1991) Economic and Social Commission for Asia and the Pacific ST/ESCAP/1005 Bankok.

Wade, R. (1990), Governing the Market: Economic Theory and the Role of Government in East Asian Industrialisation, Princeton, New Jersey, Princeton University Press.

Weigle, Marcia A. (1996), 'Political Liberalisation in Post Communist Russia', The Review of Politics 58(3): 469-503.

Wolfers, Ivan (1986) "Developing World: Limitations of Primary Health Care Model": A case study from Bangladesh. Vol 40, Berlin.

World Bank Annual Report (1998), Washington DC.

Appendix 1: Interview Schedule Applicable to 20 Respondents Selected From Patients Admitted in the Health Centre, 40 Respondents Who Are None Patients Selected From the 2 Wards of Paidha/Pakwach Urban Authority

Introduction: I am interested in finding out how (PHC) service is being provided in Paidha/Pakwach Urban Authority. I would like to establish the various types of problems associated with PHC service. The information you are giving me will be made known to the Urban Community and this will lead to getting solutions to the problems. I am therefore informing you that your contribution is very important to this study, because it will be used to improve on health care situation of the community.

Thank you very much in advance for your co-operation.

1.0 Identification information

1.1 Village/LCI .....

1.2 Ward .....

1.3 Occupation .....

1.4 Contact address .....

2.0 Social demographic background information

2.1 Nationality .....

2.2 Sex ( ) Male 1

( ) Female 2

2.3	Age group	Code
	21 - 30	1
	31 - 40	2
	41 - 50	3
	51 - 60	4
	60+	5

2.4 Education background level

	Code
Never went to school	1
Primary level	2
Junior level	3
'O' Level	4
'A' Level	5
Tertiary Institution	6
University	7

3.0 Decentralization and PHC

3.1 Do you understand what Decentralization is about?

Yes.....1 No.....2

3.1.1 If yes, in your own opinion what does Decentralization mean? .....

.....

.....

3.2 Do you understand what PHC is?

Yes.....1 No.....2

3.2.1 If yes, in your own opinion what does PHC mean?

.....

.....

.....

3.2.2 If no, do you think you should have been informed of what PHC is?

Yes.....1 No.....2

3.3 Who should have informed you?

.....

.....

4.0 Urban Authority and PHC

4.1 Do you see PHC being provided by your Urban Authority?

Yes.....1 No.....2

4.1.1 If yes, explain the types of PHC service being provided by the Urban Authority.....

.....

.....

.....

4.2 Has the Urban Community been involved in provision of PHC?

Yes.....1 No.....2

4.2.1 If yes, what has been the major contribution of the Urban community towards provision of PHC?

.....

.....

.....

4.3 Are there village health workers (VHWs) available to provide PHC service?

Yes.....1 No.....2

4.3.1 If yes are the Village Health Workers (VHWs) trained on their roles/responsibilities of PHC?

Yes.....1 No.....2

4.4 Do you think the Urban Authority has adequate trained personnel such as Doctors, Medical Assistants, Laboratory Assistants, Nurses, Midwives?

Yes.....1 No.....2

4.4.1 If yes, how effectively has the trained personnel available been used in the provision of PHC?

.....

.....

.....

Give 3 examples to show effectiveness of the trained personnel .....

.....

.....

.....

4.4.2 If no, what has been the constraints to having adequate trained personnel?

.....

.....

.....

4.5 In your own opinion has the Urban Authority got adequate finance to provide PHC service?

Yes.....1 No.....2

4.5.1 If yes, how effectively has the adequate finance been used for providing PHC?

.....

.....

.....

Give reasons to show the effectiveness of the finance in providing PHC.

.....

.....

.....

4.5.2 If no, what has been the difficulties in mobilizing adequate finance to provide PHC?

.....

.....

5.0 Provision of PHC and availability of PHC programmes

5.1 Is there expanded programme for immunization for BCG. DPT, Polio, Measles, Tetanus?

Yes.....1 No.....2

5.1.1 If no, why is there no expanded programme for immunization programme?

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.....

.....

5.1.2 If yes, in your own opinion, has the Urban Community been responding well to immunization programme?

Yes.....1 No.....2

5.1.3 If no, why is there poor response?

.....

.....

.....

5.2 Have there been Antenatal, and delivery care services?

Yes.....1 No.....2

5.2.1 If yes, how effective have the services been on the practical life style of the society?

	Code
( ) Very effective	1
( ) Effective	2
( ) Moderately effective	3
( ) A little effective	4
( ) Ineffective	5

Please state reasons for your answer.....

.....

.....

5.3 Have there been breast feeding/weaning promotion, growth monitoring of children and nutritional programmes?

Yes.....1 No.....2

5.3.1 If yes, how effective have the programme been?

	Code
( ) Very effective	1
( ) Effective	2
( ) Moderately effective	3
( ) A little effective	4
( ) Ineffective	5

Give reasons to support your answer.....

.....

.....

5.3.2 Give example (if any) of the effect

.....

.....

.....

5.4 Is sex education and family planning programme being carried out in the community?

Yes.....1 No.....2

5.4.1 If yes, how effective has it been in practical terms in the family life style of the community?

	Code
( ) To a very large extent	1
( ) To a large extent	2
( ) To a sufficient extent	3
( ) To a small extent	4
( ) To a very small extent	5

Give reasons/examples to support your answer.....

.....

.....

5.5 Is there water and environmental sanitation programmes?

Yes.....1 No.....2

5.5.1 If yes, to what extent has the local community been involved in water and environmental sanitation programmes?

		Code
( )	To a very large extent	1
( )	To a large extent	2
( )	To a sufficient extent	3
( )	To a small extent	4
( )	To a very extent	5

5.5.2 What has been the contribution of the local community in practical terms on water and sanitation programmes?

.....

.....

.....

5.6 Is there any fee being levied on PHC service being provided to the community?

Yes.....1 No.....2

5.7 If yes, what are these services?

.....

.....

.....

5.8 What would you say generally about provision of PHC in your Urban Authority compared to neighbouring Urban Authorities in the District?

	Code
( ) Excellent	1
( ) Very good	2
( ) Good	3
( ) Average	4
( ) Poor	5

5.9 Give reasons why you say so .....

.....

.....

.....

5.10 In your own opinion how best can the problems of PHC in growing Urban Authority like Paidha/Pakwach be solved?

.....

Appendix II: Questionnaire For Councillors, Members of Health Management Committee And Civil Servants

Introduction: The purpose of the research is to assess the decentralized PHC activities in Paidha/Pakwach Urban Authority in order to come up with recommendations for improving the provision of PHC.

1.0 Decentralization and PHC

1.1 Is there decentralized PHC service in Paidha/Pakwach you are aware of?

Yes .....1 No.....2

1.1.1 If yes what are those decentralized PHC services being provided to the local population?

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.....

.....

1.1.2 Is there any workplan for the PHC activities you have listed above?

Yes .....1 No.....2

1.1.3 If yes, how effective has the workplan been? .....

.....

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.....

1.2 To what extent do the local people of Paidha/Pakwach Urban Authority contribute or participate in the provision of PHC? Code

( )	To a very large extent	1
( )	To a large extent	2
( )	To a sufficient extent	3
( )	To a small extent	4
( )	To a very small extent	5

Please give reasons for your answer .....

.....

.....

.....

2.0 Personnel and Financial Management of PHC

2.1 Is there Health Management Committee in the Urban Authority?

Yes ..... 1 No.....2

2.1.1 If yes, what is the composition of the Health Management Committee?

.....

.....

.....

2.2 Do you think those are the right type of people to form the Management Committee?

Yes .....1 No.....2

2.2.1 If no, give reasons .....

.....

.....

2.3 Has the Health Management Committee been trained on its roles/responsibilities of PHC services?

Yes.....1 No.....2

2.4 To what extent has the committee been effective in providing PHC services?

	Code
( ) To a very large extent	1
( ) To a large extent	2
( ) To a sufficient extent	3
( ) To a small extent	4
( ) To a very small extent	5

Please give reasons to support your answer.....

.....

.....

.....

2.5 How do you feel about the number of established staff i.e Doctors, Medical Assistants, Nurses, Midwives, Laboratory Assistants responsible for the provision of PHC in your Urban Authority?

	Code
( ) Very satisfied	1
( ) Satisfied	2
( ) Some what satisfied	3
( ) Dissatisfied	4
( ) Very dissatisfied	5

Please give reasons to support your answer

.....

.....

.....

2.6 How would you rate performance of the staff involved in PHC service?

	Code
( ) Excellent	1
( ) Very Good	2
( ) Good	3
( ) Poor	4
( ) Very poor	5

Please give reasons to support your answer

.....

.....

.....

2.7 What is the approximate/total budget allocation for Urban PHC

.....

.....

2.8 What is the proportion of the PHC budget to the overall Urban Authority budget?

.....

.....

2.9 What is the proportion of Urban Authority's Health budget for PHC compared to curative service?

.....

.....

.....

2.10 To what extent do you think the budget allocation for PHC by Urban Authority correspond to the need of the community?

	Code
( ) To a very large extent	1
( ) To a large extent	2
( ) To a sufficient extent	3
( ) To a small extent	4
( ) To a very small extent	5

Please give your comment: .....

.....

.....

.....

2.11 What is the contribution from the central government?

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.....

.....

2.12 How adequate do you consider the central government's contribution to PHC?

( ) Highly adequate

( ) Fairly adequate

( ) Adequate

( ) Moderate

( ) Too inadequate

Please comment .....

.....

.....

2.13 Is there any charge of fee for the PHC services being provided to the Urban Community?

Yes .....1 No.....2

2.14 If Yes, what type of services is fee being charged upon?

.....

.....

.....

2.15 What happens to those who cannot afford the fee charged on services?

.....

.....

.....

2.16 How is the fee which is collected utilized?

.....

.....

.....

3.0 Urban Authority and PHC

3.1 To what extent do you consider the community outreach services in terms of family planning, Health education, Immunization, Nutritional service and other services to be of practical importance to the Urban Community?

	Code
( ) To a very large extent	1
( ) To a large extent	2
( ) To a sufficient extent	3
( ) To a small extent	4
( ) To a very small extent	5

Please state why.....

.....

3.3 Are there difficulties/constraints in the provision of PHC?

Yes .....1 No.....2

3.3.1 If Yes, what are those difficulties/constraints:

.....

.....

.....

3.4 Do you have suggestions on how the difficulties/constraints can be overcome?

Yes .....1 No 2

If Yes, give the suggestions .....

.....

.....

.....

3.5 From your professional/administrative/management point of view, what is your opinion on the overall performance of PHC by your Urban Authority?

	Code
( ) Excellent	1
( ) Very Good	2
( ) Good	3
( ) Average.	4
( ) Poor	5

Please comment/give reasons to support your answer

.....

.....

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3.6 What do you think about the level of PHC services being provided by your Urban Authority compared to the neighbouring Urban authorities in the District?

	Code
( ) Excellent	1
( ) Very Good	2
( ) Good	3
( ) Average	4
( ) Poor	5

Please explain why you think so.....

.....