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Decentralization Policy Implementation and Quality of Maternal Health Services in Bundibugyo District

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Abstract: ***This study investigated Decentralization policy implementation and quality of maternal health services in Bundibugyo District. Specifically, the study aimed at; assessing the relationship between Political decentralization; financial decentralization; administrative decentralization; and quality of maternal health services in Bundibugyo district. A descriptive cross-sectional and correlational research designs was used on a sample of 235 respondents. Data was collected using a questionnaire and an interview guide. The findings revealed that political Decentralization and financial Decentralization had a strong positive significant relationship with quality of maternal health services while administrative decentralization had a positive weak insignificant relationship with quality of maternal health services. The study concluded that political Decentralization and financial Decentralization as components of decentralization policy implementation are essential for quality of maternal health services. The study recommended that the Government of Uganda should also implement Decentralization policy in health sector by giving local government powers and enough funds to manage and run the health facilities in order to improve the quality of maternal health.***

Keywords— ***Decentralization policy; implementation; quality of maternal health services*** **(key words)**

1. INTRODUCTION (*Heading 1*)

Improving the quality of maternal and newborn baby health care is critical if maternal and newborn health outcomes are to improve further. This will necessitate a shift in global focus. According to World Health Organization statistics from 2017, 303 000 women die during labor, childbirth, or the postnatal period, 2.6 million infants are stillborn, and 2.7 million babies die within one month after birth. The majority of these deaths occur in low- and middle-income areas and are avoidable (United Nations Report, 2017). It is critical for maternal and infant survival to provide appropriate health care to both mothers and children throughout this period (Kruk, et.al., 2018). The initial goal of tracking progress toward MDGs 4 and 5—respectively, reducing infant mortality and improving mother wellbeing—was to determine the availability of evidence-based, cost-effective services, such as maternity care, and the qualified birth rate (Boerma, et.al., 2014). A number of instances are given in the research; however, treatment and quality care are both uneven, with the poor quality of care preventing women from using facilities even if they were accessible, close, and reasonably priced. The UN Commission on the Knowledge of Women's and Children's Health was founded in 2011 with the goal of improving state, national, and international transparency for the welfare of women and children (Rahman, et.al., 2016). The World Health Organization's Committee 12 adopted ten recommendations, the first of which was to improve outcomes by requesting countries to improve critical registry and health information systems, focus on a core collection of harmonized infant and maternal health metrics, and invest in information, communication, and technology to strengthen them. The Commission's objectives were ten suggestions that countries should follow (Hogan, et.al., 2018). In recent years, the Countdown to 2018 research have acknowledged that treatment standards must be tracked, intervention coverage is required, and more documentation is required to accomplish so.

In Africa, maternal morbidity and mortality rates are high and the risk of maternal mortality in the region is estimated at one in 38, with an annual average of roughly 530,000 maternal deaths; and Africa accounts for more than 90 percent of all maternal fatalities globally (World Health Organization, 2018). The low availability of important maternal health services, as well as the poor implementation of maternal health policies and initiatives, continue to contribute to the high maternal death ratio (Miller, et.al.,2016). The region's maternal health crisis has resulted in a wide range of programs aimed at improving the quality of reproductive health care and health outcomes (Oliveira-Ciabati, et.al., 2017). According to Comfort et-al. (2013), depending on factors like population size, geographical area, and gross domestic product, African nations including Morocco, Tanzania, Nigeria, Ghana, Kenya, South Africa, and many others see decentralization as a way to achieve national unity. And in Sub-Saharan Africa, a woman's likelihood of dying during delivery is one in sixteen (World Health Report, 2018). The study discovered that poor maternal health and nutrition, as well as the standard of care provided at birth and throughout the neonatal period, are responsible for at least 20% of the illness load in children under the age of five. The prosperity and well-being of our

future generations are greatly influenced by the health of our mothers (WHO, 2018).

In 1993, Uganda adopted a contemporary decentralization strategy. Before, local governments were forced to follow the central government's growth plans. In order to enhance service delivery, the 1995 constitution transferred functions and responsibilities of service provision and resource allocation from the center to the local government located at districts, sub counties, or divisions (Green, 2017). Since 1997, the department of mother and child health and family planning (MCH/FP), which is part of the ministry of health, has placed a primary emphasis on developing districts' capacity to plan, execute, and oversee maternal and child health and family planning services (Golola, 2013).

1.2 Statement of the Problem

Despite the decentralization of health-care service delivery, poor quality of maternal health services in Bundibugyo district has remained persistent. In Bundibugyo district, 60% mothers deliver at home with maternal mortality rate of 1.4% and infant mortality rate of 14% (Bundibugyo community Hospital report, 2020). Maternal mortality, therefore, remains high at 336 deaths per 100,000 live births, and the odds of a woman dying from a pregnancy complication in Uganda are high owing to abortions and the home deliveries of pregnant women without competent attendants (MOH, 2022). In Uganda, the delivery of maternal health services continues to face numerous challenges; there have been reports of problems in health facilities with the quality of health services provided in public health institutions, such as hostile or negligent staff mistreating patients, gender discrimination, drug shortages, insufficient staff numbers, absentee staff, and high costs (Onyach-Olaa, 2023). This has resulted in a poor usage of maternal health facilities. In Uganda, for example, fewer pregnant women give birth at health centers. According to the Uganda Bureau of Statistics' (UBOS) 2016 Uganda Demographic and Health Survey, many women choose to employ traditional birth attendants (UDHS). It was discovered that 41% of births occurred in health facilities in the five years preceding the study, whereas 58% occurred at home (UBOS, 2016). According to 2005 statistics, five direct complications account for more than 70% of maternal deaths: haemorrhage (25%), infection (15%), unsafe abortion (13%), eclampsia (12%), and obstructed labor (8%). While these are the leading causes of maternal mortality, insufficient, inaccessible, costly, or of low-quality treatment is to blame (WHO, 2005). Similarly, Uganda continues to have a high maternal death rate of 343/100,000 live births (Reproductive Health Report, 2005). There is anecdotal evidence of increased usage of alternative therapies such as herbs and reflexology, all of which indicate discontent with traditional health facilities (Kyomuhendo, 2025). As a result, the purpose of this research was to analyze how decentralization policy implementation has influenced the quality of maternal health care in Bundibugyo District.

1.3 Purpose of the study

The purpose of the study was to assess the relationship between decentralization policy implementation and quality of maternal health services in Bundibugyo district.

1.4 Objectives of the Study

i. To determine the relationship between Political decentralization and the quality of maternal health services in Bundibugyo district.
ii. To find out the relationship between financial decentralization and quality of maternal health services in Bundibugyo district.
iii. To assess the relationship between administrative decentralization and quality of maternal health services in Bundibugyo district.

1.5 Null Hypotheses

i. There is no significant relationship between Political decentralization and the quality of maternal health services in Bundibugyo district.
ii. There is no significant relationship between financial decentralization and quality of maternal health services in Bundibugyo district.
iii. There is no significant relationship between administrative decentralization and quality of maternal health services in -Bundibugyo district

2.0 RESEARCH METHODOLOGY

2.1 Research Design

The cross-sectional and correlational research designs was used. The cross-sectional design made it possible to gather data using a variety of methods, including face-to-face interviews and self-administered questionnaires (Lavrakas 2008), the data collected reflected what was happening at a specific point in time, in a relatively short time and at a lower cost (Moule& Goodman 2009). Ccorrelational design, involved investigating the relationship between the effectiveness of the decentralization strategy and the standard of maternal health (Ingham-Broomfield, 2014), statistical inferences were made using quantitative data as the foundation. The study conducted an in-depth investigation and statistical conclusions using both the quantitative and qualitative methodologies (Bernard 2012) were made.

2.2 Study population

The 570 subjects that made up the study population were chosen from Bundibugyo respectively. The key informants in this study included 88 Village Health Teams, 1 District Health Officer, 1 Chief Administrative Officer, and 2 health center IV in-charges), 42 midwives and nurses in Bundibugyo. Out of these, however, the study focused on the following categories: 436 maternal health care users as the beneficiaries of the decentralization policy.

2.3 Sample Size

The researcher chose a sample size of 235 respondents from the population 570 people that were the subject of the investigation, Using Slovin's formula ($n= N/(1+Ne^2)$ these

were chosen from among various groups of Bundibugyo district Slovin (1960).

2.4 Sampling Techniques

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

2.5 Data Collection Methods and Tools

2.5.1 Questionnaires

A self-administered questionnaire (SAQ) created for VHTs and users of maternal health services served as the data gathering tool. The questionnaire had three sections, numbered A through C. The respondents' demographic features were covered in Section A, and the independent variable and dependent variable based on instruments were covered in Sections B, respectively. The technique allowed the researcher to swiftly and affordably cover the responses (Bowling 2005). The respondents were able to fill out the questionnaire more quickly and readily since it was brief, straightforward, and organized using a five-point Likert scale (1 = Strongly disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly agree). Due to the time and space they provide for freeform replies that urge participants to contribute their understandings, experiences, opinions, and interpretations, open questions were placed at the conclusion of each section of the close ended question items. Overall, the survey write-up received measurable and comprehensive data from a mix of closed and open questions. The SAQ-based instrument was also ideal for the sampled group since they were able to reply to the questions with ease due to their fluency with the English language.

2.5.2 Interview Guide

The researcher interviewed DHO, the in-charge of Nyahuka Health Center IV, and CAO Bundibugyo to gather data. The interview gave the researcher the chance to question the respondents when they gave unclear answers. The researcher created a semi-structured interview guide that was applied during in-person interviews with the DHO, the supervisor of the Health Center IV, and the CAO (Bolderston, 2012). There were open-ended interviews conducted.

3.0 PRESENTATION AND ANALYSIS OF FINDINGS

3.1 Response Rate

Table 3.1 Response rate

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

Source: Field Findings

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

3.2 Background Characteristics

This section presents facts about the respondents, namely; gender, age bracket, marital status and education level of the respondents.

Table 3.2 The data on the background characteristics of respondents

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

	Primary	92	42.9
	Secondary	31	14.3
	Tertiary	55	25.7
	Others	6	2.9
	Total	215	100

Source: Primary Data 2025

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

3.3 Decentralization policy implementation

Implementation of the decentralization policy, the independent variable in this study, was conceptualized to include political, financial, and administrative decentralization. The next subsections include the findings on the same.

3.3.1 Political Decentralization and Quality of Maternal Health Services

Political Decentralization which is the first aspect of Decentralization policy implementation was studied using seven items. The results on the same were as presented in Table below

Table 3.3 Descriptive statistics on Political Decentralization

	F/%	**SA**	**A**	**N**	D	SD	**Mean**	**Std. dev**
The central government has given authority to local government to manage health sector	**F**	134	60	-	11	7	4.03	0.81
	%	63.3	28.3	-	5	3.3		1.17
The local government makes decision on how to manage health sector	**F**	124	70	-	7	11	3.87	0.87
	%	58.3	33.3	-	3.3	5		
The central government gives guidelines to local government on how to implement maternal health programmes	**F**	21	35	-	110	46	2.07	1.01
	%	10	16.7	-	51.9	21.7		
The local governments are concerned on the performance of health centers in relation to provision of maternal health services	**F**	81	60	7	42	21	3.96	0.53
	%	38.3	28.3	3.3	20	10		
There is good coordination between central government and local governments in implementing maternal health programmes	**F**	42	35	6	20	60	3.66	0.71
	%	20	16.7	1.7	33.3	28.3		
The local government gives feedback on the performance of health centers in relation to provision of maternal health services	**F**	120	56	-	14	21	4.02	1.02
	%	56.7	26.7	-	6.7	10		

Political leaders interfere in the implementation of maternal health programmes	**F**	109	64	7	18	14	4.12	0.75
	%	51.7	30	3.3	8.3	6.7		

Source: Primary Data 2025

The findings in Table 3.3 regarding whether the central government has granted local governments authority to manage the health sector revealed that, overall, the majority of respondents (91.6%) said the central government has granted local governments authority to manage the health sector, while 8.4% said this was untrue. The results showed that respondents believed it was true that local governments had been granted authority by the federal government to handle the health sector, with a high mean of 4.03, which is near to code 4, on the scale being utilized. The respondents agreed that the local government takes decisions on how to administer the health sector since the majority (91.6%) agreed, 8.4% disagreed, and only 1.7% were indifferent. The high mean = 3.87 verified the results. Furthermore, the majority (73.6%) of respondents disagreed with the low mean = 2.07 that the central government provides guidance to local governments on how to administer the maternal health program. The finding indicated that the local governments are concerned on the performance of health centers in relation to provision of maternal health services because the majority percentage (66.6%) agreed and this was supported by the high mean= 3.87. With a high percentage (76.9%) of the respondents agreeing and a high mean = 3.66, that there is good coordination between central government and local governments in implementing maternal health programme. Furthermore, the respondents indicated that the local government gives feedback on the performance of health centers in relation to provision of maternal health services because majority percentage (83.4%) and the mean = 4.03 was high. However, with the larger percentage (60.3%) of the respondents disagreeing that political leaders interfere in the implementation of maternal health programmes with lower mean = 2.01, the results suggested that it was not true that political leaders interfere in the implementation of maternal health programmes. To find out how overall how respondents rated political Decentralization, summary statistics were calculated for the items measuring political Decentralization. The results were as shown in Table 3.4;

Table 3.4 Summary of Descriptive Statistics on political Decentralization

	Descriptive		Statistics	Std.Error
Political Decentralization	Mean		3.86	0.05
	95% Confidence	Lower Bound	3.52	
	Interval for Mean	Upper Bound	3.94	
	5% Trimmed Mean		3.89	
	Median		3.91	
	Variance		0.61	
	Std. Deviation		0.79	
	Minimum		1.00	
	Maximum		5.00	
	Range		3.88	
	Interquartile Range		1.00	
	Skewness		-0.87	0.24
	Kurtosis		0.46	0.40

Source: Primary Data, 2025

According to Table 3.4's findings, the median value of 3.91 was not far from the mean value of 3.86. Therefore, the outcomes were normally distributed even though the skew was negative (skew -0.87). Due to the high mean, respondents found political decentralization to be satisfactory (high). Low response dispersion was suggested by the low standard deviation of 0.79. Area leaders were questioned about their thoughts on whether political decentralization has aided in enhancing the standard of maternal health in the Bundibugyo district. The district leaders provided various relevant comments in their responses, indicating that political decentralization has helped over time to improve the standard of maternal health in Bundibugyo district. One leader said;

"*In the past years, leaders in communities of Bundibugyo district showed low commitment and willingness to work towards improving the quality of maternal health. However, since the introduction of decentralization especially political decentralization there has been improvement. This has not been because of lack of avenues to make them get involved in decision making, but sensitization about the importance and benefits of getting involved in the improving the quality of maternal health has been ongoing"* (Bundibugyo, May 2025). Another leader said;

"Although the enthusiasm for leaders in Bundibugyo district is still low, there has been improvement. This can be seen in the increasing numbers of leaders getting involved improving the quality of maternal health. Even though the number are still low, once in a while we get some people joining the campaign of improving the quality of maternal health services" (Bundibugyo, May 2022)

The opinions above from the respondents suggest that leaders love to improve the quality of maternal health had improved. This finding is consistent with the results of the descriptive statistics which showed that political decentralization has helped in improving the quality of maternal health for people of Bundibugyo district were improving although it has not yet reached the required level.

3.3.2 Financial Decentralization

Financial Decentralization which is the second aspect of socio-economic development was studied using four items. The results were as presented in Table 3.5

	F/%	SA	A	N	D	SD	Mean	Stad.D
Central government provides enough funds to the district for provision of maternal health programs	F	124	70	-	11	7	3.89	0.82
	%	58.3	33.3	-	5	3.3		
Funds at the district are allocated according to health center IV' needs	F	117	67	-	11	17	3.98	0.98
	%	55	31.7	-	5	8.3	3.77	
There is proper accountability at all levels for maternal health funds at the district	F	42	21	7	99	42	2.33	0.86
	%	20	10	3.3	46.7	20		
The district administration normally engages all stakeholders during the allocation of funds to maternal health	F	113	53	3	18	25	3.86	0.85
	%	53.3	25	1.7	8.3	11.7		
The district and people in the community contribute to funding of maternal health programme	F	**117**	**67**	**-**	**11**	**17**	**3.79**	0.75
	%	**55**	**31.7**	**-**	**5**	**8.3**		
All health center in charges normally make budgets for maternal health funds	F	**42**	**21**	**25**	**99**	**42**	**2.03**	0.95
	%	**20**	**10**	**3.3**	**46.7**	**20**		
All health centers get materials to use for maternal health services in time	F	**113**	**53**	**3**	**17**	**25**	**4.01**	0.67
	%	**53.3**	**25**	**1.7**	**8.3**	**11.7**		

Table 3.5 Descriptive statistics on financial Decentralization
Source: Primary Data 2025

According to the findings in Table 3.5, the district receives sufficient funding from the Central government to provide maternal health programs. The majority of respondents (91.6%) agreed, while 8.3% disagreed. The results also showed that businesses were assisting people in their efforts to support their households by helping them generate income. The majority of respondents (78.3%) agreed with the statement, while 20% disagreed and 1.7% were neutral about it, which further supported the conclusion that district funds are provided in accordance with the needs of health center IV. The high mean = 3.98 served as confirmation for the findings. Additionally, the data indicated that there is sufficient accountability at all levels for maternal health funding at the district, with the majority of respondents disagreeing (66.7%) and the lower mean = 2.33, while 30% of them agreed and 3.33% of them were neutral. The data also showed that district administration regularly involves all stakeholders when allocating funding for maternal health since the majority of respondents (78.6%) agreed with the statement and the high mean value of 3.86 supported this.

The majority of respondents (55%) strongly agreed to the statement that "the district and individuals in the community contribute to the funding of maternal health programs," while 31.7 percent agreed, 5% disagreed, and 8.3% strongly disagreed. This meant that the district and the individuals in the neighborhood both contributed to the funding of the maternal health program. (46.7%) of the respondents disputed that every health center in charge generally develop budgets for maternal health funds (20% strongly disagreed, (3.1%) were neutral, (20%) agreed, and (10%) highly agreed, and this finding was confirmed by a lower mean of 2.03 This suggests that health center administrators do not often allocate for maternal health money. Summary statistics for the eight elements assessing financial Decentralization were compiled to see how overall respondents viewed financial Decentralization as a facet of decentralization policy execution. Table 3.6 summarizes the findings.

Table 3.6 Summary of descriptive statistics on financial Decentralization

	Descriptive		Statistics	Std.Error
Financial Decentralization	Mean		3.48	0.05
	95% Confidence	Lower Bound	3.42	
	Interval for Mean	Upper Bound	3.84	
	5% Trimmed Mean		3.79	
	Median		3.75	
	Variance		0.81	
	Std. Deviation		0.79	
	Minimum		1.20	
	Maximum		5.80	
	Range		3.58	
	Interquartile Range		1.40	
	Skewness		1.87	0.04
	Kurtosis		1.46	0.30

Source: Primary Data, 2025

According to Table 3.6's findings, the median value of 3.75 was not far from the mean value of 3.48. The findings show that the replies were normally distributed, with a positive skew (skew 1.87). Because of the high mean, the respondents thought their financial decentralization was effective. Low response dispersion was suggested by the low standard deviation of 0.79. When asked how the implementation of the decentralization strategy has aided in raising the caliber of maternal health care in their district, leaders were invited to respond during interviews. One leader responded,

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

In relation to the above, another local leader remarked,

"In this area we still experience low quality of maternal health services because people largely spend most of their incomes and time in seeking quality services in private facilities. Nevertheless, there is improvement, those who manage to go to government facilities; a few are able to access the services." (Key informant interview, May 2025)

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

3.3.3 Administrative Decentralization

Administrative decentralization which is the third aspect of decentralization policy implementation was studied using seven items. The results on the same were as presented in Table 4.7 below;

Table 3.7 Descriptive statistics on administrative decentralization

	F/%	**SA**	**A**	**N**	D	SD	**Mean**	**Stad. Dev**
Central government has given local governments powers to appoint staff to provide maternal health services	**F**	106	67	-	18	21	3.69	0.85
	%	50	31.7	-	8.3	10		
There is enough staff in our health facilities	**F**	18	14	7	64	109	1.98	0.81
	%	8.3	6.7	3.3	30	51.7		
The local government supervises the staff in health facilities	**F**	49	21	7	93	42	2.23	1.08
	%	23.3	10	3.3	43.3	20		
The health workers are regularly monitored by the local officials	**F**	124	42	3	18	25	3.85	0.82
	%	58.3	20	1.7	8.3	11.7		
Health workers are given enough materials to use in offering maternal health services	**F**	21	14	-	117	60	1.53	1.23
	%	10	6.7	-	55	28.3		

The health workers are regularly monitored by the local officials	**F**	123	50	5	17	17	3.55	0.61
	%	58	23.6	2.4	8.0	8.0		
Health workers are given enough materials to use in offering maternal health services	**F**	18	14	-	133	47	1.33	1.19
	%	8.5	6.7	-	62.7	22.2		

Source: Primary Data 2025

The results in Table 3.7 regarding the question of whether the central government has given local governments the authority to appoint staff to provide maternal health services revealed that overall, the majority percentage (81.7%) of respondents agreed with the statement while 18.3% disagreed. With the high mean = 3.69 close to code 4, which on the used scale corresponded with agreement, the results suggested that the central government has given local governments the authority to appoint staff. The majority of respondents (81.7%) disagreed with the assertion, 15% agreed, and only 3.3% were indifferent. This indicates that there is adequate personnel in our healthcare institutions. The results were supported by the high mean of 1.98, which indicates that there are not enough personnel at health institutions to serve the public with maternal health care. Additionally, the results revealed that the local government did not oversee the employees at healthcare institutions, as indicated by the majority of respondents (63.3%) disagreeing and the low mean value of 2.23. The majority proportion (78.3%) of respondents agreed with the statement, and the high mean value of 3.85 supported this conclusion, which further suggested that the health professionals are under the regular supervision of the local government. This implies that the local government always keeps an eye on the medical professionals.

The majority of respondents (83.3%) disagreed that health workers are given enough materials to use in providing maternal health services, while 16.7% agreed with the statement and the low mean value of 1.53 suggested that health workers are. Finally, in terms of whether health workers are given enough materials to use in providing maternal health services, the majority of respondents (83.3%) disagreed that health workers are given enough materials to use in offering maternal health services. The majority of respondents (58%) agreed that health inspectors routinely check on healthcare institutions, while just 23.6% disagreed, 2.4% were indifferent, 8.0% strongly agreed, and 8.0% disagreed. This suggests that health inspectors don't frequently check on medical institutions. The majority of respondents—92 (66.2%)—strongly disagreed with the assertion that the Health Center in charge is contacted when hiring midwives; 17.3% disagreed; 18.9% were indifferent; 5 (3.6%) agreed; and none of the respondents—92 (66.2%)—strongly agreed. This meant that while hiring midwives to provide high-quality maternal health care, the district of Bundibugyo did not contact the Health Center in charge. Summary statistics for the seven categories assessing financial decentralization were compiled to see how respondents generally perceived administrative decentralization as a component of decentralization policy execution. The results were as presented in Table 3.8 below;

Table 3.8 Summary of Descriptive Statistics on administrative decentralization

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

Source: Primary Data 2025

The findings in Table 3.8 demonstrate that the median value of 3.20 was not particularly near to the mean value of 2.39.

However, the outcomes show that the replies were regularly distributed because of a positive skew (skew 1.57). Because of the high mean, the respondents gave their administrative decentralization a poor rating. When asked who recruits healthcare workers at health centers and what problems they confront, district officials gave pertinent answers. One local official said, *"There is district service commission that recruits health workers but most times the commission does not have enough resources to recruit enough health workers to help in provision of quality maternal health services."* (Key informants interview, May 2025)

Another district leader said;

"administrative decentralization has helped to allow local government recruit their own health workers but the work of recruitment has been given to the district service commission which limit the local leaders to monitor and supervise the recruitment process and this has promoted corruption and recruitment of less skilled health workers". (Bundibugyo, May 2025)

The opinions expressed above imply that while there were many individuals involved in making sure that there was a need for qualified professionals to deliver qualified maternal health care, there were also a lot of people who were not participating. Therefore, the district leaders' views entirely concur with those who said that their administrative decentralization was poor in their comments. It may be inferred, however, that there was adequate participation of people in administrative decentralization to enhance the standard of maternal health, given that leaders said that a lot of people were active.

4.4 Quality of maternal health services quality of maternal health services as the dependent variable and was studied using eight items. The results on the same were as presented in Table 3.9;

Table 3.9 Descriptive Statistics on quality of maternal health services

Statements	**F/%**	**SA**	**A**	**N**	D	SD	**Mean**	**Stad. Dev**
Traditional birth attendants are trained by the MOH in maternal health conditions and complications in time	**F**	37	15	3	5	3	3.99	0.82
	%	66.7	25	5	8.3	5		
Maternal health services are given freely by government at the health centers and referral hospitals on time	**F**	29	20	2	4	5	3.77	0.98
	%	48.3	33.3	3.3	6.7	8.3		
Delays in the delivery of items used during delivery of mothers is major barrier to effective delivery of maternal health services	**F**	26	15	1	6	12	3.47	0.61
	%	43.3	25	1.7	10	20		
Mothers walk several miles to get antenatal care which affects utilization of maternal health services in time.	**F**	35	11	2	5	7	3.72	1.08
	%	58.3	18.3	3.3	8.3	11.7		
Mothers walk several miles to get antenatal care which affects utilization of maternal health services in time.	**F**	33	17	-	4	6	3.81	0.82
	%	55	28.3	-	6.7	10		
Well trained midwives are still lackig in health facilities	**F**	28	13	1	6	12	3.67	1.19
	%	46.7	21.7	1.7	10	20		
Motivation of the midwives available would improve on the quality of maternal health service provision	**F**	30	11	2	10	7	3.51	0.86
	%	50	18.3	3.3	16.7	11.7		
	F	7	10	3	24	16	2.33	0.85

There are free guidance and counseling services for pregnant mothers living with HIV as well as treatment to avoid mother to child transmission of the virus.	**%**	11.7	16.7	5	40	26.7		
Mothers are aware of all the services provided for them by the government	**F**	30	11	2	10	7	1.51	0.81
	%	50	18.3	3.3	16.7	11.7		
Pregnant mothers in most cases purchase their own items for delivery	**F**	7	10	3	24	16	4.12	1.23
	%	11.7	16.7	5	40	26.7		

Source: Primary Data 2025

Table 3.9 shows that the majority of respondents (91.7%) agreed that traditional birth attendants are trained by the MOH in maternal health conditions and complications in time, while 13.3% disagreed and 5% were neutral, and that the high mean = 3.99, close to code 4 on the scale used, indicated that traditional birth attendants are trained by the MOH in maternal health conditions and complications in time. The majority of respondents (81.6%) disagreed, 15% agreed, and 3.3% were neutral when asked if the government provided free maternal health services at health centers and referral hospitals on time. This, combined with the high mean value of 1.77, indicated that the government does not provide free maternal health services at health centers and referral hospitals on time. The majority of respondents (68.3%) agreed that delays in the delivery of goods used during childbirth are a significant obstacle to the effective provision of maternal health services, while only 30% disagreed and 1.7% were neutral. This implied, given that the average mean was 3.47, that delays in the delivery of goods used during childbirth are indeed a significant obstacle to the effective provision of maternal health services.

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

Whether there are free counseling and advice services available to expectant HIV-positive women, as well as care to prevent mother-to-child virus transmission. 68.3% of respondents said they agreed, 28.4% said they disagreed, and 3.3% said they were indifferent or with it. The average mean was 3.51, which indicated that free counseling and advice were available for expectant mothers who were HIV positive as well as treatments to prevent mother-to-child transmission of the virus. The majority of respondents (66.6%) disagreed with the statement that mothers are aware of all services offered to them by the government, while 28.4% agreed and 5% were neutral. This resulted in an average mean of 1.51, which indicated that mothers are not aware of all services offered to them by the government and the high mean of 4.12 indicates that the majority of respondents concur that pregnant women often buy their own supplies for birth. Summary statistics for the eight elements measuring the Community tourism effort were produced in order to determine how the respondents felt overall about it. The outcomes are shown in Table 3.10 below.

Table 3.10 Summary of Descriptive Statistics on quality of maternal health services

	Descriptive		Statistics	Std.Error
Quality of maternal health services	Mean		2.69	0.05
	95% Confidence	Lower Bound	2.42	
	Interval for Mean	Upper Bound	2.74	
	5% Trimmed Mean		3.79	
	Median		2.80	
	Variance		0.81	
	Std. Deviation		0.99	
	Minimum		1.60	
	Maximum		4.90	
	Range		3.44	

	Interquartile Range		1.60	
	Skewness		-.78	0.24
	Kurtosis		1.46	0.50

According to Table 3.10's findings, the median value of 2.80 was not far from the mean value of 2.69. The results revealed that the responses were normally distributed despite the negative skew (skew -0.78). The high mean suggested that the respondents did not think the quality of services for maternal health was good. Low response dispersion was suggested by the low standard deviation of 0.99. District authorities were questioned about the decentralization approach that had been implemented to improve the caliber of maternal health care. One officer responded to this query by saying, *"Not many people take quality maternal services as serious and it requires persuading them to get involved, few people can push themselves."* (Key informants' interview, May 2025)

Another district official stated,

"While there are some people who take quality maternal health services seriously, this has not contributed much in their quality improvement. Many take maternal services casual and they need to be told that maternal services are more important". (Bundibugyo, May 2025). These views partially supported the descriptive statistics which indicated the quality of maternal health services in Bundibugyo district is still poor.

3.5 Correlation of Decentralization policy implementation and quality of maternal health services

To establish whether Decentralization policy implementation components namely; political Decentralization, financial Decentralization and administrative Decentralization were related to quality of maternal health services, the researcher carried out correlation analysis. The results were as given in Table 3.11;

Table 3.11: **Correlation Matrix for Decentralization policy implementation and quality of maternal health services**

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

Source: Primary Data 2025

According to Table 3.11's findings, the two aspects of decentralization policy implementation—political decentralization ($r = 0.89$, $p = 0.000 < 0.05$) and financial decentralization ($r = 0.77$, $p = 0.000 < 0.05$)—had a significant relationship with the quality of maternal health services in Bundibugyo district, while administrative decentralization ($r = 0.381$, $p = 0.11 > 0.05$) had a positive but unimportant relationship. This indicates that H03 was accepted whereas the null hypotheses (H01&H02) were rejected. This suggests that the adoption of decentralization policies in terms of political and financial decentralization had a substantial association with the quality of maternal health care, but administrative decentralization had a negligible impact.

3.5.1 Regression Model for Decentralization policy implementation and quality of maternal health services.

At the confirmatory level, to establish whether Decentralization policy implementation components namely; political Decentralization, financial Decentralization and administrative decentralization affect the quality of maternal health services, a regression analysis was carried out. The results were as in Table 3.14 below

Table 3.12 Regression Results

Decentralization policy implementation	Standardized Coefficients Beta (β)	Significance Beta (β) (p)
Political Decentralization	0.464	0.000
Financial Decentralization	0.424	0.000
Administrative decentralization	0.025	0.124
R= 0.87, R^2= 0.76, adjusted $R^{2=}$ 0.25, F =102.35, p = 0.000		

Source: Primary Data 2025

According to Table 3.12's findings, there is a strong positive correlation between the application of decentralization policies and the caliber of maternal health services (r = 0.87); additionally, the components of decentralization policies' application account for 76% of the variation in the caliber of maternal health services (R2 = 0.76). This suggests that additional variables not considered by this model accounted for 24% of the variability in the quality of maternal health services. However, only two aspects of decentralization policy implementation—political decentralization (= 0.464, p = 0.000 <0.05) and financial decentralization (= 0.424, p = 0.000 <0.05)—have a positive impact on the standard of maternal health services, while administrative decentralization (= 0.025, p = 0.124 >0.05) had a marginally positive impact. This indicates that the third hypothesis (H3) was disproved and that only hypotheses one and two (H1 and H2) were accepted. According to the magnitudes of the corresponding betas, Bundibugyo district's maternal health services are primarily strongly influenced by political decentralization.

4.0 DISCUSSION CONCLUSIONS AND RECOMMENDATIONS

4.1.1 Political Decentralization and Quality of Maternal Health Services

According to the study, the quality of maternal health services in the Bundibugyo area is considerably (p=0.000<0.05) impacted by political decentralization. Additionally, there was a significant positive correlation between political decentralization and the standard of maternal health care in Bundibugyo area (r=0.89). It suggests that political decentralization enhances the standard of Bundibugyo district's maternal health care. The district authorities that were questioned backed the aforementioned conclusion and largely agreed that In the past years, leaders in communities of Bundibugyo district showed low commitment and willingness to work towards improving the quality of maternal health. However, since the introduction of decentralization especially political decentralization, there has been improvement. This has not been because of lack of avenues to make them get involved in decision making, but sensitization about the importance and benefits of getting involved in improving the quality of maternal health has been ongoing. And "Although the enthusiasm for leaders in Bundibugyo district is still low, there has been improvement. This can be seen in the increasing numbers of leaders getting involved improving the quality of maternal health. Even though the number are still low, once in a while we get some people joining the campaign of improving the quality of maternal, In this context, the interview also support that decentralization improves the quality of maternal health services.

The findings agree with Bossert and Beauvais (2016), who conducted a study on the decentralization of health systems in Ghana, Zambia, Uganda, and the Philippines. The findings indicate that local communities are involved in mobilizing resources to build health centers and seek to understand how the mobilized resources are used. This becomes a responsibility of every politician to implement, monitor, and supervise the policies to aid better quality of maternal health services. Political decentralization has since resulted in better resource mobilization for the provision of maternal health care in underdeveloped nations additionally, in line with Using experiences from Zambia and Uganda, Jeppsson and Okuonzi (2018) looked at the vertical or holistic decentralization of the health sector. The findings highlight that political decentralization entails the local population acting as a watchdog over the system and ensuring that public officials provide high-quality goods and services. This is due to the fact that choices about the distribution of resources are made in consultation with the local communities.

Furthermore, the findings are consistent with the findings of Mookherjee (2016), who conducted a study on Combating the Crisis in Government Accountability, and the findings indicate that political decentralization is a critical step toward achieving systematic maternal health care service provision objectives through devolution of functions performed by the central government to DLGs. According to Naidoo (2017), who conducted a study on Health Sector Decentralization in

Sub-Saharan Africa, political decentralization helps to ensure that communities, particularly mothers, are empowered to take responsibility for their own maternal health and well-being, as well as to participate actively in the management of their local maternal health services.

3.1.2 FINANCIAL DECENTRALIZATION AND QUALITY OF MATERNAL HEALTH SERVICES

The study found that financial decentralization has a substantial ($p=0.000<0.05$) impact on the quality of maternal health care in Bundibugyo district, and there is a strong positive association ($r=0.77$) between financial decentralization and the quality of maternal health services. As a result of financial decentralization, maternal health quality improves, because if the Central government provides enough funds to the district for the provision of maternal health programs, funds at the district are allocated according to the needs of health center III, IV etc. and proper accountability at all levels for maternal health funds at the district. This was confirmed by district authorities who were interviewed. In relation to the above, another district official confirmed that, In this area, there's still low quality of maternal health services because people largely spend most of their incomes and time in seeking quality services in private facilities. Nevertheless, there is improvement, those who manage to go to government facilities; a few are able to access the service".

The study's findings concur with Naidoo's (2017) analysis of the Health Sector Decentralization in Sub-Saharan Africa, which found that nations with excellent financial decentralization policies had better resource mobilization for the provision of maternal health services. The significant financial gains districts experienced following decentralization provide proof of this. In line with Kapologwe, et al. (2019), who examined the implementation of Direct Health Facility Financing and its effect on health system performance in Tanzania: a non-controlled before and after mixed method study protocol, the findings show that Health system responsiveness assessment, accountability, and governance of Health Facility Government Committee should bring autonomy

The results show that decentralized health systems in sub-Saharan Africa depend on funding from the central government to manage activities in the provision of health services in their areas of jurisdiction, which is in line with Gasto and Anna's (2013) analysis of participation in health planning in a decentralized system. The money is often released afterward and in around four payments during the fiscal year. The financing mechanism in Uganda is known only as the quota system. This, in Frumence's opinion, makes it more difficult to carry out sound health policies and provide quality medical care. According to Anna-Karin Hurtig, Gasto et al. (2014), central funding in a decentralized system is not the best way to guarantee the effective and efficient operation of local authorities due to obstacles like limited funding disbursement, delays in funding release, and a lack of funding from other sources, among others. These obstacles all highlight the need for the introduction of informal coping strategies to deal with the situation.

4.1.3 ADMINISTRATIVE DECENTRALIZATION AND QUALITY OF MATERNAL HEALTH SERVICES

The study found a weak positive association ($r=0.402$) between administrative decentralization and quality of maternal health care in Bundibugyo district. The study found that administrative decentralization insignificantly ($p=0.124>0.05$) affects the quality of maternal health services. The majority of respondents disagreed that there is enough staff in health facilities, the local government supervises the staff in health facilities, health workers are given enough materials to use in providing maternal health services, and Health Center in charge are consulted during recruitment of midwives and motivating health workers, which indicates that the decentralization of administrative powers has a negligible impact on the quality of maternal health services. The study's findings did not agree with those of Bossert and Beauvais (2016), who studied the decentralization of health systems in Ghana, Zambia, Uganda, and the Philippines. Their findings showed that all maternal health activities in public health facilities are monitored under decentralization policy. The activities carried out under decentralization to improve the quality of maternal health services are included in the monitoring and evaluation of health programs, according to Cheema and Rondinelli's (2013) Implementing decentralization policies: Developing Countries study. The findings show that under decentralization, the health infrastructure improves. The majority of African nations lack the necessary equipment for providing basic maternal health treatments.

The afore mentioned qualitative findings concur with De Muro and Conforti's (2015) analysis of decentralization in sub-Saharan Africa, which concluded that decentralization requires educating and raising community awareness of the value of utilizing maternal health care. Both men and women are made aware of the dangers of home or solo childbirths that aren't supported by a trained attendant through seminars and reproductive health campaigns (Kyomuhendo, 2015). Demand for health care is predicated on the ability to recognize sickness and the possible advantages of therapy, both of which are significantly influenced by an individual's level of education. The majority of the time, educated women attend for their prenatal exams more frequently than uneducated ones since the latter are unaware of the need of utilizing maternal health care. The health sector often organizes health workshops on maternal health through the health in charges and VHTs through a decentralized health system. The village health team has only been trained in the village-level roles of civic education, counseling, and advocacy. This has increased the use of maternal health care. (MOH, 2018)

4.2 CONCLUSIONS

Decentralization policy implementation had a significant effect on quality of maternal health services and that it contributes 76% which implies that it's not only Decentralization that contributes to quality of maternal health services but also other factors like fighting corruption as revealed by qualitative findings. Political decentralization significantly influenced quality of maternal health services and this implies that when local governments are given powers and authority to manage their health facilities, there was improvement of quality services. Financial decentralization significantly affect the quality of maternal health services which implies that when local governments are in charge of the financial resources, it can improve the quality of maternal health services. Administrative decentralization insignificantly affects the quality of maternal health services and this implies that giving powers to local government to recruit health workers without giving the required resources that not improve the quality of maternal health services

4.3 RECOMMENDATIONS

i The researcher recommend that the Government of Uganda should implement political decentralization policy in the health sector by granting local government powers and authority to manage and run the health facilities in order to improve the quality of maternal health services.

ii Local councils also need to be empowered to monitor the grass root situation of maternal health service delivery especially in rural areas of Bundibugyo

iii The Researcher also recommend that the central government should increase on the funding of health facilities and also release the findings in time to aid in the smooth running of the activities in those health centers in order to improve the quality of maternal health services and those in charge should be able to give proper accountability on funds extended to them.

iv As it was established in this study the district service commission mismanage the recruitment process of health workers, there is a need to monitor their activities by district officials and the central government in order to eliminate corruption.

v Administrative units should be equipped with qualified personnel and they required equipment at all levels.

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