

BISHOP STUART UNIVERSITY



ADMINISTRATIVE DECENTRALIZATION AND MATERNAL HEALTHCARE SERVICE DELIVERY IN RURAL COMMUNITIES OF MITOOMA DISTRICT, UGANDA

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**A DISSERTATION SUBMITTED TO THE DIRECTORATE OF GRADUATE
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AND MANAGEMENT OF BISHOP
STUART UNIVERSITY**

SEPTEMBER, 2025

DECLARATION

I, **Bucureezi Priver**, declare that this dissertation is my original work and has never been submitted to any University or Institution for any award.

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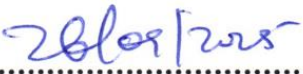
APPROVAL

This dissertation has been done under our supervision as university supervisors and is now ready to be submitted for examination to the Faculty of Business, Economics, and Governance of Bishop Stuart University.

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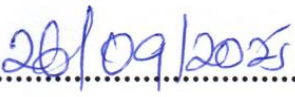
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DEDICATION

I dedicate this dissertation to my husband Eng. Tugume Pathias for his love, encouragement, and financial support throughout my research work

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I am grateful to the Almighty God who has given me life and enabled me to overcome all obstacles.

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANC	Antenatal Care
BMC	Biomedical Council
BSU	Bishop Stuart University
CAO	Chief Administrative officer
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CBO	Community-Based Organization
CDC	Center for Disease Control
CSO	Civil Society Organization
DHO	District Health Officer
DHO	District Health Officer
EMOC	Emergency Obstetric Care
FGD	Focus Group Discussion
HC11	Health Centre II
HC111	Health Centre III
HC1v	Health Centre IV
HIV	Human Immunodeficiency Virus
KII	Key Informant Interview
MGD	Millennium Development Goal
MHC	Mental Health

MMR	Maternal Mortality Ratio
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
NGO	Non-Governmental Organisation
NRM	National Resistance Movement
OPD	Outpatient Department
PNC	Postnatal Care
PNFP	Private Not for Profit
REC	Research Ethics Committee
SAS	Senior Assistant Secretary (Sub County Chief)
SBA	Skilled Birth Attendant
SBA	Skilled Birth Attendants
SDOH	Social Determinants of Health
SGD	Sustainable Global Development
TBA	Traditional Birth Attendant
TC	Town Clerk
UBOS	Uganda Bureau of Statistics
UNCST	Uganda National Council for Science and Technology
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VHT	Village Health Team
WHO	World Health Organization

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ABSTRACT

Decentralization has been promoted globally as a means to improve health service delivery by bringing decision-making closer to communities. In Uganda, the decentralization policy, introduced in 1993, implemented reforms such as the devolution of power to district councils, the delegation of administrative functions to local authorities, and the upgrading of lower-level health facilities (HCII to HCIII) to improve the accessibility of maternal health services. Despite these reforms, maternal health care outcomes remain suboptimal in rural areas, particularly in Mitooma District, where this study was conducted.

An interpretivist phenomenological qualitative design was employed, using in-depth interviews and focus group discussions (FGDs) with key stakeholders, including healthcare workers (Midwives, and nurses), pregnant and lactating mothers, and local government officials. Participants were purposively selected across multiple communities served by four health facilities at the level of HC111, and HC11 within Mitooma districts. Data were transcribed, coded, and thematically analyzed using **ATLAS.ti** software to identify key themes and patterns. Ethical principles were observed throughout the research, including informed consent and confidentiality.

Findings revealed that while decentralization has enhanced local autonomy and community engagement in some districts, significant challenges persist. These include limited financial and human resources, inadequate decision-making capacity at the local level, poor referral systems, and delays in emergency health care for expectant mothers. Participants also highlighted disparities in service availability and quality, particularly in rural and hard to reach communities like Kanyabwanga HC111. Despite these constraints, decentralized structures offered opportunities for locally tailored interventions and improved accountability when adequately supported.

In conclusion, it was observed that decentralization alone is not sufficient to ensure improved maternal health outcomes. Strengthening district-level capacities, enhancing coordination mechanisms, and addressing systemic resource constraints are critical for the success of decentralization reforms. The study recommends targeted policy actions to bridge implementation gaps and promote equitable health care package mostly maternal health for which the gaps were identified in service delivery.

Keywords: decentralization, maternal health, Uganda, health service delivery, Mitooma District

CHAPTER ONE

BACKGROUND OF THE STUDY

1.0 Introduction

This study is about administrative decentralization and maternal healthcare service delivery in rural communities of Uganda with the main focus on Mitooma district. Currently, maternal health care in Mitooma District is inadequate, as women encounter limited services when they visit health centers. These challenges include a lack of adequate ambulance services, understaffing of health workers, high reported, accessibility to the health facilities, and shortages of essential drugs and vaccines. This situation motivated the researcher to conduct the study, focusing on decentralization and service delivery. Decentralization in Uganda is a policy aimed at enhancing local governance and improving public service delivery by redistributing authority and responsibilities from the central government to local governments. This shift was intended to address inefficiencies and promote greater local involvement in decision-making processes (Nabatanzi, 2022). This study aims to assess the health care service delivery under decentralization policy in Uganda focusing on Mitooma district as an example of rural community.

This section covers; background, statement of the problem, objectives, justification, significance, and scope and conceptual framework.

1.1 Background

The background section covers historical, conceptual, theoretical and contextual perspectives

1.1.1 Historical background

This section discusses the history of the study variables, with particular emphasis on the dependent variable (maternal health care service delivery), and less emphasis on decentralization (independent variable). The historical background is examined from global, African, and local (Ugandan) perspectives.

1.1.1.1 History of maternal Health

Global Perspective

The history of maternal health care globally reflects a long journey of progress, determined by scientific advances, policy development, and advocacy. In the early 20th century, maternal mortality was alarmingly high due to limited medical knowledge, poor hygiene practices, and minimal access to skilled birth attendants (CDC, 1999; Loudon, 2000). During the 1930s to 1950s, many developed countries began to improve outcomes by professionalizing midwifery, introducing antiseptics, and shifting births into hospital settings; for example, in the United States, maternal mortality dropped by approximately 71% between 1939 and 1948 (CDC, 1999). A pivotal moment occurred in 1987 when the World Bank, WHO, and UNFPA launched the Safe Motherhood Initiative at a conference in Nairobi, aiming to halve maternal mortality in developing regions within a decade (WHO, 1987; Wikipedia, 2024; Studylib, n.d.). This initiative raised global awareness, mobilized multiple UN agencies, and prompted integrated policy and funding efforts targeting prenatal care, skilled attendance, family planning, and emergency obstetric services.

In the 2000s, maternal health became even more central under Millennium Development Goal 5 (MDG 5), which sought a 75% reduction in maternal mortality from 1990 to 2015 (Engender Health, 2014; BMC Health Services Research, 2019). Although MDG 5 was not fully achieved, it helped refocus global attention on maternal health. With the adoption of Sustainable Development Goal 3.1 in 2015, the target shifted to reducing the global maternal mortality ratio to less than 70 per 100,000 live births by 2030, emphasizing universal health coverage, skilled birth attendance, and emergency obstetric care (WHO, 2015).

African Perspective

Over time, Africa has faced chronic maternal health challenges, though improvements have been made over time. In the pre-colonial and colonial eras, childbirth was largely managed by traditional birth attendants (TBAs), and formal medical support was minimal, especially in rural areas (Krasovec et al., 1991). Following independence in the 1960s, many nations invested in health infrastructure, but gains were undermined by political instability, poverty, and weak health systems. Throughout the 1990s and early 2000s, maternal mortality remained high, exacerbated

by HIV/AIDS, poor access to skilled care, and under-resourced systems (The Guardian, 2013). Yet, nations began embracing WHO-recommended interventions. More recently, the African Union and national governments launched initiatives such as CARMMA (Campaign for Accelerated Reduction of Maternal Mortality in Africa), attempting to reduce the continent's disproportionate burden, sub-Saharan Africa still accounts for approximately two-thirds of global maternal deaths (The Guardian, 2013; WHO, 2023).

Ugandan Perspective

Uganda's maternal health history reflects the broader regional struggle, marked by both challenges and strategic reforms. Prior to its 1962 independence, most childbirths in Uganda occurred at home with Traditional Birth Attendants (TBAs), and formal medical facilities were scarce and concentrated in urban areas (Kyomuhendo, 2003; Ministry of Health Uganda, 2000). In the early 1900s, hospitals were virtually non-existent for the majority of Ugandans, compelling communities, particularly in rural regions, to rely heavily on TBAs, who often practiced without formal training or modern equipment (Kyomuhendo, 2003). After independence, rural facilities expanded and mid-level health personnel were trained, but civil unrest and economic decline in the 1970s–80s hampered sustained progress (BMC Health Services Research, 2019).

In the 2000s, Uganda adopted MDG 5 targets via Health Sector Strategic Plans and focused on expanding community-based health services and skilled birth attendance (BMC Health Services Research, 2019). The Safe Motherhood Strategic Plan, developed after the 1987 Nairobi conference, aimed to upgrade TBAs' skills and strengthen referral systems (Engender Health, 2014; The Lancet, 2013). More recently, under Vision 2040 and SDG frameworks, Uganda has implemented maternal health vouchers, recruited more midwives, and enhanced emergency obstetric care (BMC Health Services Research, 2019). Notwithstanding these efforts, significant challenges persist including understaffing, medicine stock-outs, and inadequate ambulance services remain widespread, particularly in rural areas (The Lancet, 2013).

1.1.1.2 History of decentralization

Global Perspective

The concept of decentralization gained prominence in the mid-20th century, particularly following decolonization. In the post-World War II era, many newly independent nations sought to establish

governance structures that could address local needs and enhance democratic participation. The 1970s and 1980s marked a significant shift toward decentralization as many governments, influenced by the globalization of ideas and practices, began to recognize its potential benefits for enhancing public service delivery, increasing accountability, and promoting local development (Smoke, 2003). International organizations, such as the World Bank, began to advocate for decentralized governance as a strategy for economic development and poverty alleviation. The World Bank's 1988 report on "sub-Saharan Africa" emphasized decentralization as a means to empower local authorities and improve the efficiency of service delivery (World Bank, 1988). This trend continued into the 1990s and 2000s, as countries worldwide implemented various forms of decentralization, from fiscal to political, to enhance governance and citizen participation.

African Perspective

In Africa, the history of decentralization is closely linked to the continent's colonial past. Colonial administrations often implemented centralized systems of governance that marginalized local communities. Following independence, many African nations initially adopted centralized governance models, believing that strong central control was necessary for nation-building (Bardhan & Mookherjee, 2006). However, by the late 20th century, there was a growing recognition of the need for decentralization to address local governance issues and promote development. Many countries began to adopt decentralization policies in the 1990s, spurred by pressure from international financial institutions and civil society. The African Union and various regional bodies also promoted decentralization as a means of enhancing democracy, improving service delivery, and fostering local development (Olowu & Wunsch, 2004).

Countries like South Africa, Ghana, and Kenya implemented serious decentralization reforms during this period, leading to the establishment of local government structures with varying degrees of autonomy and authority (Smoke, 2003).

Ugandan Perspective

In Uganda, decentralization has a distinct history that began in earnest in the late 1980s. After years of political turmoil and civil conflict, the National Resistance Movement (NRM) government, led by President Yoweri Museveni, recognized the need for a new governance approach to rebuild the country. In 1993, Uganda implemented a comprehensive decentralization policy aimed at devolving power and responsibilities to local governments.

The Ugandan model of decentralization was characterized by the establishment of local councils at various levels, enabling communities to participate in decision-making and manage local resources. This approach aimed to improve service delivery, enhance accountability, and empower citizens (Mugerwa, 2011). The decentralization policy also emphasized participatory governance, encouraging community involvement in planning and budgeting processes. Despite its successes, Uganda's decentralization has faced challenges, including capacity issues, political interference, and disparities in resource allocation among regions (Tukahebwa, 2019). Nonetheless, Uganda remains a prominent example of decentralization in Africa, illustrating both the potential benefits and challenges of devolving authority to local governments. Decentralization has evolved significantly over time, influenced by historical, political, and social contexts. Globally, it emerged as a response to the need for better governance and local development. In Africa, it marked a shift from colonial centralized systems to more participatory governance models. Uganda's experience highlights the complexities and potential of decentralization as a tool for enhancing local governance and community empowerment. As countries continue to navigate the challenges of decentralization, ongoing evaluation and adaptation of policies will be crucial to realizing its full potential.

1.1.2 Conceptual Background

This section discusses the key concepts which are derived from the topic and which apply throughout this study. They include; 'Decentralization', 'Maternal Health', 'Service delivery' and 'rural Community'

The Concept of Decentralization

Broadly, decentralization in government service delivery refers to the transfer of authority, responsibility, and resources from central government to lower levels of government or local authorities. This process aims to enhance the efficiency, effectiveness, and responsiveness of public services. Hence, empowering local governments, decentralization seeks to tailor services to better meet the unique needs of communities, ultimately fostering improved governance and public engagement (Ribot, 2002).

1.1.2.1 Types of Decentralization

Decentralization can be categorized into several types, each serving distinct purposes. For example, ‘Political decentralization’ involves distributing decision-making authority to local governments or community organizations, thereby allowing citizens to exert greater influence over governance and local affairs. This can strengthen democratic practices at the grassroots level (Bardhan & Mookherjee, 2006). Similarly, ‘Administrative’ decentralization refers to the redistribution of authority, responsibility, and financial resources among different government levels. This includes deconcentrating, which redistributes authority within central government, delegation to semi-autonomous organizations, and devolution to independent local governments (Olowu & Wunsch, 2004). Finally, ‘fiscal decentralization’ entails allocating financial resources to local governments, granting them the authority to raise revenues and manage budgets for service delivery, which can enhance local accountability (Faguet, 2004).

Administrative Decentralization

Administrative decentralization refers to the redistribution of administrative functions, powers, and responsibilities from a central government to lower levels of government, local authorities, or public entities (Rondinelli, 1981; Smoke, 2003). Its core components typically include devolution, delegation, and deconcentration, as well as local government empowerment, resource allocation, public participation, accountability, and oversight (World Bank, 2001; Ribot, 2002). In this study, administrative decentralization will focus on the following subcomponents: local governance structures, resource allocation, community participation, and service availability.

Devolution refers to the transfer of decision-making authority, resources, and responsibilities to local or regional levels of government. It allows local governments to make decisions and implement policies that directly affect their communities, thereby ensuring that local authorities have the autonomy to manage their own affairs. Recent studies indicate that devolution can lead to more responsive governance and improved service delivery, as it empowers local leaders to tailor solutions to the specific needs of their regions (Bardhan & Mookherjee, 2024; Tavares & Souza, 2023). On the other hand, delegation involves the transfer of specific tasks or powers from the central government to subordinate or regional authorities, while the central government retains ultimate control and oversight. Unlike devolution, the delegated bodies have less autonomy, and responsibilities are usually carried out under the supervision or direction of the central government.

Delegation is often used for technical or specialized tasks, where the central government wants to maintain strategic oversight but requires regional bodies to manage operational aspects (King, 2024; Richards & White, 2023). Similarly, deconcentration refers to the redistribution of administrative functions within the central government, from central ministries or agencies to regional or local offices. The regional offices still report to the central authority and do not have independent policymaking power. This approach primarily aims to improve the efficiency and responsiveness of the central government by delegating operational tasks to local branches, which are expected to implement policies according to central guidelines (Hansen & Fransen, 2024; Ahmed, 2023). Local Government Empowerment involves strengthening the capacity and authority of local governments to perform public administration tasks effectively. It includes providing resources, training, and legal frameworks to enhance the ability of local authorities to deliver public services and manage local development. Empowerment initiatives have been shown to enhance the ability of local governments to better address community needs, especially in developing regions (Thomas & Sanz, 2024; Yeboah & Mensah, 2023).

Resource Allocation is a key element of administrative decentralization, requiring the transfer of financial resources to local authorities to ensure they have the means to implement the powers and responsibilities transferred. This includes fiscal decentralization, where local governments gain financial autonomy through local taxes, grants, or revenue-sharing mechanisms. Studies show that adequate resource allocation is essential for local governments to exercise their newfound powers effectively (Beasley & Hines, 2024; Ortiz & Cruz, 2023). Public Participation implies that decentralization often enhances public participation in decision-making processes. Local governments, being closer to the people, are expected to involve citizens in planning, implementation, and monitoring of public policies. This ensures that local needs are addressed and that citizens have a voice in governance, which leads to more inclusive and democratic processes (Meyer & Higgins, 2024; Liao & Zhang, 2023). Accountability and Oversight are essential for decentralization to be effective. Hence, local authorities must be accountable to their citizens, but there should also be systems for oversight by the central government to ensure that local administrations are functioning properly, efficiently, and in compliance with national laws. Recent research emphasizes the importance of establishing clear accountability mechanisms and independent auditing to safeguard against corruption and mismanagement (Schneider & Thompson, 2024; Clark & Roberts, 2023).

1.1.2.2 The Concept of Maternal Health

Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period, including a wide range of physical, mental, and social well-being considerations. It is a critical aspect of public health that significantly impacts the health of mothers and their newborns, influencing broader family and community health outcomes (World Health Organization, 2021). The focus on maternal health is not only essential for reducing maternal mortality but also for ensuring that women have healthy pregnancies and deliveries, which are foundational for the well-being of future generations.

Key Aspects of Maternal Health include; ‘Prenatal Care’ which is one of the most crucial components of maternal health. It involves regular medical check-ups during pregnancy to monitor the health of both the mother and the developing fetus. Effective prenatal care includes screenings for conditions such as gestational diabetes and preeclampsia, vaccinations, nutritional counseling, and education about pregnancy-related issues (American College of Obstetricians and Gynecologists, 2020). Research has shown that adequate prenatal care can significantly reduce risks of complications and improve outcomes for both mothers and infants (Khan et al., 2019). Additionally, maternal health care has a component of ‘Safe Delivery’ which is another critical element of maternal health. Access to skilled care during childbirth whether in hospitals or birthing centers can dramatically reduce maternal and neonatal mortality rates. The presence of trained healthcare professionals during delivery ensures that complications can be managed swiftly and effectively (WHO, 2018). In contrast, a lack of access to skilled birth attendants can lead to higher rates of preventable deaths and complications, particularly in low-resource settings (Betrán et al., 2016).

Also ‘Postnatal Care’ is a component of maternal health which is vital for the recovery of mothers after childbirth. This phase involves follow-up care to monitor recovery, address any physical or mental health issues, and provide support for breastfeeding and infant care. It is crucial to recognize that mental health is an often-overlooked aspect of maternal health; many women experience postpartum depression or anxiety, which can affect their well-being and their ability to care for their newborns (O'Hara & Swain, 1996).

Access to quality healthcare services is a top need for improving maternal health. This includes not only prenatal and postnatal care but also emergency care during complications. Barriers such

as socioeconomic factors, geographic location, and cultural attitudes can limit access to these essential services, contributing to disparities in maternal health outcomes (Kassebaum et al., 2014).

Maternal health is a multidimensional component that includes various aspects of care and support for women during pregnancy, childbirth, and the postpartum period. Therefore, improving maternal health outcomes is essential for reducing maternal and infant mortality rates and promoting the overall health of families and communities. Efforts to enhance maternal health should focus on ensuring access to quality healthcare, providing comprehensive prenatal and postnatal care, and addressing social determinants of health that influence women's access to necessary services.

1.1.3 Theoretical Background

Academic studies are underpinned by theories which are relevant to the study areas. Hence, this study will be underpinned by the “Social Determinants of Health Theory” which more suitable

1.1.3.1 Social Determinants of Health Theory

The Social Determinants of Health (SDH) theory does not have a single developer but has evolved over time through the contributions of numerous public health scholars, organizations, and policy frameworks. Various thinkers and institutions have shaped its understanding and application, making it a multidimensional concept grounded in the social and political realities affecting health (Solar & Irwin, 2010; Braveman & Gottlieb, 2014). One of the earliest figures associated with the roots of SDH is Rudolf Virchow, a 19th-century German physician often considered a pioneer in the social medicine tradition. Virchow argued that health outcomes are deeply influenced by social conditions such as poverty and inequality. His work emphasized the idea that medicine is a social science and that addressing health inequities requires systemic social and political change (Taylor & Rieger, 1985).

In the modern era, Sir Michael Marmot has played a central role in advancing the SDH framework. He led the influential Whitehall Studies in the United Kingdom, which demonstrated how social class significantly impacts health outcomes, even within relatively affluent populations (Marmot et al., 1991). Marmot later chaired the World Health Organization (WHO) Commission on Social Determinants of Health from 2005 to 2008. The commission's work was pivotal in formalizing and globalizing the SDH approach, placing it at the forefront of global public health discourse (WHO,

2008). The World Health Organization itself has been instrumental in institutionalizing the SDH framework. In its landmark 2008 report, *Closing the Gap in a Generation*, produced under Marmot's leadership, the WHO defined social determinants of health as “the conditions in which people are born, grow, live, work and age,” shaped by the distribution of money, power, and resources (WHO, 2008). This definition highlights the broad scope of factors that influence health and has guided international efforts to address health inequities. Therefore, while no single individual can be credited with developing the Social Determinants of Health theory, Sir Michael Marmot and the World Health Organization are most prominently associated with its contemporary formulation and global influence. Their work has significantly shaped how public health professionals and policymakers understand and address the social factors that impact health outcomes. This theory emphasizes that health outcomes are not solely the result of individual behaviors or medical care but are significantly influenced by a range of social, economic, and environmental factors. This theory posits that these determinants, such as socioeconomic status, education, neighborhood and physical environment, employment, social support networks, and access to healthcare, interact in complex ways to shape the health of individuals and populations (WHO, 2008). The theory shifts the focus from individual-level explanations of health disparities to a broader understanding of how societal structures impact health.

1.1.3.2 The link between Social Determinants of Health Theory and the study

The Social Determinants of Health (SDH) theory helps explain the link between administrative decentralization and maternal healthcare service delivery in rural areas. It shows that health outcomes depend not just on medical care or individual behavior but also on wider social, economic, political, and physical conditions (WHO, 2008). Hence, applying this theory to maternal health highlights how local governance, infrastructure, and community involvement affect women's access to care (Marmot et al., 2012).

Administrative decentralization transfers authority, funding, and responsibility from national to local governments. This shift affects how health services are planned, managed, and delivered (Bossert & Beauvais, 2002). Thus, SDH theory points to governance as a key factor that influences health. Local governments are closer to the communities they serve and often understand their needs better. In rural areas, where women face long travel times, poor roads, and a shortage of skilled staff, local authorities can respond more directly. They might choose to invest in

community health workers, maternity homes, or transport services that help mothers get timely care (Kolehmainen-Aitken, 2004).

Access to services is another concern. SDH theory focuses on how unequal access to healthcare leads to poor outcomes (Solar & Irwin, 2010). Decentralized systems can help fix this by improving service reach in areas that central systems often overlook. If managed well, decentralization supports fairer distribution of health resources. That can reduce the gap between urban and rural care (Worku et al., 2020). But if local governments lack the skills or resources to manage services, or if they distribute resources unfairly, the gap can grow worse. Poor planning, corruption, or political interference can lead to even more unequal access (Saltman et al., 2007).

Community involvement is central to SDH theory. Decentralized health systems usually encourage local participation in decision-making (Atkinson et al., 2000). This means people can influence the services that affect them. In rural areas, women and community leaders can take part in planning health services that match their needs. Local participation also makes it easier to design services that people will use. For example, communities can help choose where to build new health facilities or how to run maternal health education campaigns (Brinkerhoff & Azfar, 2006).

The SDH theory also stresses the role of other sectors like education, roads, and clean water in supporting health. Local governments are often better placed to coordinate across these sectors (WHO, 2010). For maternal health, that might mean improving road networks so women can reach hospitals faster or supporting schools so more girls stay in education, which has a long-term effect on maternal health (Victora et al., 2003). When local authorities work across sectors, they can remove many of the barriers women face during pregnancy and childbirth. In a nutshell, administrative decentralization affects many of the social factors that determine maternal health outcomes. It can bring services closer to rural communities, improve equity, and involve people in decisions about their health. Its success depends on strong local leadership, fair resource use, and coordination across sectors.

1.1.4 Contextual Background

The discussion of the context for this study begins with a summary of the National Health Structure. The purpose is to align this with the decentralization of services to local governments

and communities. However, this study specifically focuses on health services, with particular attention to maternal health.

1.1.4.1 Uganda's health system is structure/Framework

Table 1: Uganda's Health System Structure/Framework

Level	Description / Functions
National (Ministry of Health)	Policy formulation, regulation, supervision, and oversight of referral hospitals.
Regional Level	Regional Referral Hospitals providing specialized services and technical support.
District/Sub-district	District Health Management Teams (DHMTs), General Hospitals, and Health Centre IVs (HCIVs) providing comprehensive emergency obstetric care and supervision of lower facilities.
Health Sub-district (Local level)	Health Centre IIIs (HCIIIs) provide outpatient, maternity, and laboratory services; Health Centre IIs (HCIIIs) offer outpatient services and basic preventive care; Health Centre Is (HCIs), represented by Village Health Teams (VHTs), provide community-based health services and health promotion.
Private/PNFP	Private Not-for-Profit and private providers offering complementary services.
Regulatory/Information Systems	National systems supporting quality assurance, health information management, and accountability.

Source: Adapted from Ministry of Health Uganda (2021).

Uganda still has HCIIIs and HCIs. HCIs are represented by Village Health Teams (VHTs), while HCIIIs and HCIVs remain in the current structure, though some HCIIIs are being upgraded to HCIIIs as part of reforms (MoH, 2021). Despite ongoing efforts to improve health outcomes, Mitooma District, located in Western Uganda, faces several challenges in maternal health care

service delivery. The district has made strides in reducing maternal mortality rates, but barriers remain that impact the quality and accessibility of maternal health services (Uganda Bureau of Statistics, 2021). Mitooma District has several health facilities, including health centers and a general hospital. However, many of these facilities are often under-resourced and struggle with inadequate medical supplies, staff shortages, and insufficient training for healthcare providers (World Health Organization, 2019). The quality of care can vary significantly between rural and urban health centers, with rural areas often facing greater challenges due to limited access to trained professionals and essential medical services (Ministry of Health Uganda, 2016). Access to maternal health services in Mitooma is hampered by geographical and logistical barriers. Many women live in remote areas and may need to travel long distances to reach health facilities (Brett et al., 2020). Poor road conditions, especially during the rainy season, further complicate access (World Bank, 2018). Additionally, the lack of transportation options can deter women from seeking timely care, particularly during emergencies, as reliance on personal or communal transport can be inconsistent and unreliable (Graham et al., 2016).

Cultural beliefs and practices significantly influence maternal health care utilization in Mitooma District. Some communities still hold traditional beliefs about childbirth and prefer to rely on traditional birth attendants rather than seeking help from formal healthcare providers (Khan et al., 2019). This reliance on traditional practices can lead to delays in receiving critical care, particularly in cases of complications during pregnancy or childbirth, which can have severe consequences for both mothers and infants (Mishra et al., 2020). Additionally, there is a general lack of awareness about maternal health services among some segments of the population. Educational initiatives aimed at promoting the importance of antenatal care, skilled birth attendance, and postnatal care have been implemented; however, challenges remain in reaching all community members effectively (Nabyonga-Orem et al., 2019). Efforts to educate women about their reproductive health rights and available services are crucial for improving maternal health outcomes, as informed women are more likely to seek and utilize health services (Hounton et al., 2019).

The Ugandan government, along with various non-governmental organizations (NGOs), has launched several programs to enhance maternal health services in Mitooma District. These initiatives focus on increasing the availability of antenatal care, improving emergency obstetric care, and training health workers. Community health workers also play a critical role in bridging

gaps in service delivery by educating communities and facilitating access to health services. While there have been improvements in maternal health indicators, such as increased rates of facility-based deliveries, the maternal mortality ratio remains a concern. As of recent reports, Uganda's maternal mortality ratio is estimated at around 336 per 100,000 live births, reflecting ongoing challenges in maternal health care access and quality (Uganda Bureau of Statistics, 2021).

In summary, maternal health care service delivery in Mitooma District, Western Uganda, faces several challenges, including inadequate healthcare infrastructure, limited access to services, cultural barriers, and a lack of awareness. While efforts by the government and NGOs are helping to improve the situation, continued investment in healthcare resources, education, and community engagement is essential to further enhance maternal health outcomes in the district.

1.2.0 Statement of the Problem

Antenatal care (ANC) is a vital health service that ensures pregnant women receive essential medical attention throughout pregnancy. Despite its recognized importance, Uganda continues to experience a high maternal mortality ratio, approximately 336 deaths per 100,000 live births (UBOS, 2021; WHO, 2022). This persistently high level has been attributed to systemic healthcare challenges, including limited access to skilled birth attendants (UNFPA, 2023), poor infrastructure, and delays in accessing emergency obstetric care (Atuyambe et al., 2020; Kiwanuka et al., 2008). Most of these indicators are a reflection Mitooma district which is the area of the study

While ANC attendance for at least one visit is relatively high at 97.3%, it significantly drops to 59.9% for the recommended four or more visits (Atuyamuza et al., 2023; WHO, 2016). Barriers such as geographic inaccessibility, workforce shortages, indirect costs, and sociocultural factors continue to hinder full ANC utilization (Kabakyenga et al., 2016; UBOS & ICF, 2022; Nankwanga, 2020; Tann et al., 2007). In Mitooma District, maternal health challenges are particularly acute. Skilled birth attendance (SBA), a proven strategy for reducing maternal mortality, remains inadequate, especially in rural areas (Kungu et al., 2021; MOH Uganda, 2020; WHO, 2019; Benova et al., 2014). Inadequate postnatal care (PNC) is also a growing concern, with contributing factors including low awareness, cultural practices, and weak health infrastructure (Takahashi et al., 2021; Waiswa et al., 2015; Nalwadda et al., 2010; Campbell & Graham, 2006). Systemic barriers compound these issues. More than 55% of Uganda's population

lacks access to primary healthcare services (USAID, 2020; Ngabirano & Igwe, 2024). Health facilities in Mitooma District are often understaffed (no lab technician), poorly equipped (not ambulance services), and located far from the communities they serve. Only 9.7% of the national budget was allocated to healthcare in FY 2019/2020, reflecting chronic underinvestment in maternal health (Mbonye et al., 2022; MOFPED, 2020; World Bank, 2020). Emergency obstetric care (EmOC) remains critically underprovided. Many facilities lack basic services, including operating theatres, trained personnel, and reliable transport systems (Atuyamuza et al., 2023; Nabulo et al., 2023; BMC, 2018; Mitooma District Health Department, 2024). This situation is consistent with recent findings that lower-level health centres across Uganda have limited capacity to manage even essential services, including non-communicable diseases, due to chronic resource and staffing gaps (Turyamureeba, 2025). A lack of maternal health education and weak referral systems further reduce women's ability to seek timely and appropriate care (Musoke et al., 2014; Mukasa et al., 2021).

Given these persistent challenges, this study will explore how Administrative Decentralization can be leveraged to improve maternal health in Mitooma District.

1.3.0 Objectives

1.3.1 General objective

The general objective of this study is to assess the contribution of decentralization in addressing maternal healthcare service delivery in rural communities focusing on Mitooma district in South Western Uganda.

1.3.2 Specific objectives

1. To assess the effectiveness of devolution, delegation and deconcentration, in improving access to maternal health care services in Mitooma District.
2. To examine the barriers women, face in receiving maternal health care service delivery in Mitooma District.
3. To evaluate the local government capacity to improved maternal health care delivery in Mitooma District.

1.4 Research Questions

1. What is the impact of administrative decentralization on access to maternal health care services in Mitooma District?
2. What specific barriers do women face in receiving maternal health care services in Mitooma District?
3. How does the local government's capacity influence the delivery of maternal health care services in Mitooma District?

1.5 Justification/Rationale of the study

Maternal health is a critical component of public health and is directly linked to broader social and economic development. High maternal mortality rates, particularly in rural areas, signify underlying health system weaknesses and inequities in access to care. In Uganda, the maternal mortality ratio remains concerning at approximately 336 deaths per 100,000 live births (Uganda Bureau of Statistics, 2021). This highlights the urgent need for research to identify effective strategies to improve maternal health outcomes, particularly in rural communities like Mitooma District (Khan et al., 2019).

Decentralization has been widely adopted in many countries as a strategy to improve governance, enhance accountability, and increase the responsiveness of public services to local needs. By shifting decision-making power closer to communities, decentralization aims to empower local governments to address specific health challenges more effectively (Faguet, 2014). In the context of maternal healthcare, understanding how decentralization affects service delivery is crucial, as it can potentially improve access to quality care, foster community participation, and tailor health services to the unique needs of rural populations (Bossert, 1998).

Mitooma District presents a unique case for studying the intersection of decentralization and maternal healthcare. The district faces specific challenges, such as inadequate healthcare infrastructure, limited access to skilled care, and cultural barriers that affect service utilization (World Health Organization, 2019; Khan et al., 2019). Investigating how decentralized health systems operate in this context can provide valuable insights into the effectiveness of local

governance structures and their ability to enhance maternal health service delivery (Nabyonga-Orem et al., 2019).

While previous studies have explored the general impacts of decentralization on health outcomes, there is limited empirical evidence specifically focusing on maternal healthcare in rural Ugandan contexts (Mishra et al., 2020). This study will contribute to filling this knowledge gap by providing a detailed examination of how decentralized governance structures influence maternal health services in Mitooma District. The findings can inform policymakers and health practitioners about best practices and potential areas for improvement in decentralized health systems.

The study will have significant policy implications for the Ugandan government and stakeholders involved in health service delivery. Understanding the strengths and weaknesses of the decentralized approach in Mitooma can guide the development of targeted interventions to enhance maternal health services (WHO, 2016). Moreover, the study's findings can be extrapolated to inform broader national health policies aimed at improving maternal health outcomes in similar rural settings across Uganda.

Conducting this study will also promote community engagement and empowerment by involving local stakeholders in the research process. Engaging community members, healthcare providers, and local government officials will ensure that the research captures diverse perspectives and experiences, leading to more nuanced and actionable findings (Cohen et al., 2016). This participatory approach can enhance the ownership of maternal health initiatives and foster a collaborative spirit among stakeholders. Therefore, this study is justified by the critical need to improve maternal health outcomes, the potential of decentralization to enhance service delivery, the context-specific insights it can provide, the opportunity to address existing knowledge gaps, the implications for policy and practice, and the promotion of community engagement. The findings will not only contribute to academic discourse but also offer practical solutions to improve maternal health in rural Uganda, ultimately supporting national health goals.

1.6 Significance of the study

This study will significantly contribute to the existing body of knowledge on decentralization and maternal healthcare, and health care in general by providing empirical evidence from a rural Ugandan context. While much research has focused on urban settings or broader national analyses,

understanding the specific aspects of decentralized healthcare delivery in Mitooma District can reveal unique challenges and opportunities. This context-specific knowledge will fill existing gaps in literature, particularly regarding how local governance structures influence maternal health outcomes. In addition, examining the relationship between decentralization and maternal healthcare service delivery, the study will enhance understanding of local health systems in Mitooma District. It will identify the strengths and weaknesses of decentralized governance in addressing maternal health challenges, thereby informing stakeholders about effective strategies for improving health services. Insights gained from this study can serve as a model for other rural districts facing similar issues.

Important to note is that, the findings of this study will have significant implications for policymakers at both local and national levels. By highlighting the impact of decentralized governance on maternal health service delivery, the study can inform the design and implementation of policies aimed at enhancing healthcare access and quality. Policymakers can utilize the results to develop targeted interventions that address specific barriers faced by rural communities, ultimately leading to improved maternal health outcomes.

This study will promote community engagement by involving local stakeholders in the research process. Engaging healthcare providers, community leaders, and women of reproductive age will ensure that the research reflects the voices and experiences of those directly affected by maternal health issues. This participatory approach can foster a sense of ownership among community members regarding health initiatives and encourage greater involvement in local health governance.

By focusing on maternal healthcare service delivery, the study will contribute to the empowerment of women and local health workers. Understanding the barriers and facilitators to accessing care can lead to more effective women educational programs and community health interventions. As women become more informed about their health rights and available services, they may be more likely to seek care, advocate for their needs, and participate in health decision-making processes.

The study will provide evidence that can guide health practitioners in implementing best practices within decentralized health systems. Hence, understanding what works well in Mitooma District, healthcare providers can adopt successful strategies and adapt them to their specific contexts. This

evidence-based approach can improve the overall quality of maternal healthcare services and contribute to better health outcomes.

The findings of this study will align with the global commitment to achieving the Sustainable Development Goals (SDGs), particularly Goal 3, which aims to ensure healthy lives and promote well-being for all at all ages. Improving maternal health is a critical aspect of this goal, and insights from this research can contribute to national and international efforts to reduce maternal mortality and improve reproductive health services. Therefore, all in all, this study on decentralization and maternal healthcare service delivery in Mitooma District holds significant importance for various stakeholders, including researchers, policymakers, healthcare providers, and the local community. Hence, providing a better understanding of the challenges and opportunities within decentralized health systems, the study aims to contribute to improved maternal health outcomes, empower communities, and advance the broader goals of public health and sustainable development.

1.7 Scope of the study

1.7.1 Geographical Scope

The study focused on Mitooma District, which was purposively selected due to a combination of factors that make it an appropriate case for examining maternal healthcare under decentralization. While many rural districts in Uganda face similar challenges, Mitooma presents particular concerns, including persistent gaps in ambulance services, high reliance on Health Centre IIs and IIIs, poor road infrastructure that affects timely referrals, and cultural practices influencing maternal health-seeking behavior. The district has also recently undergone decentralization reforms aimed at upgrading some HC IIs to HC IIIs, making it a suitable case for studying how administrative decentralization interacts with maternal health service delivery. These unique demographic and service delivery dynamics justified its selection as the focus of this study.

1.7.2 Time Scope

The study evaluated the current state of maternal healthcare service delivery in Mitooma District, with a focus on data collected over the past five years (2020-2024). This timeframe allowed for an

assessment of recent developments in decentralized health governance and their impacts on maternal health outcomes.

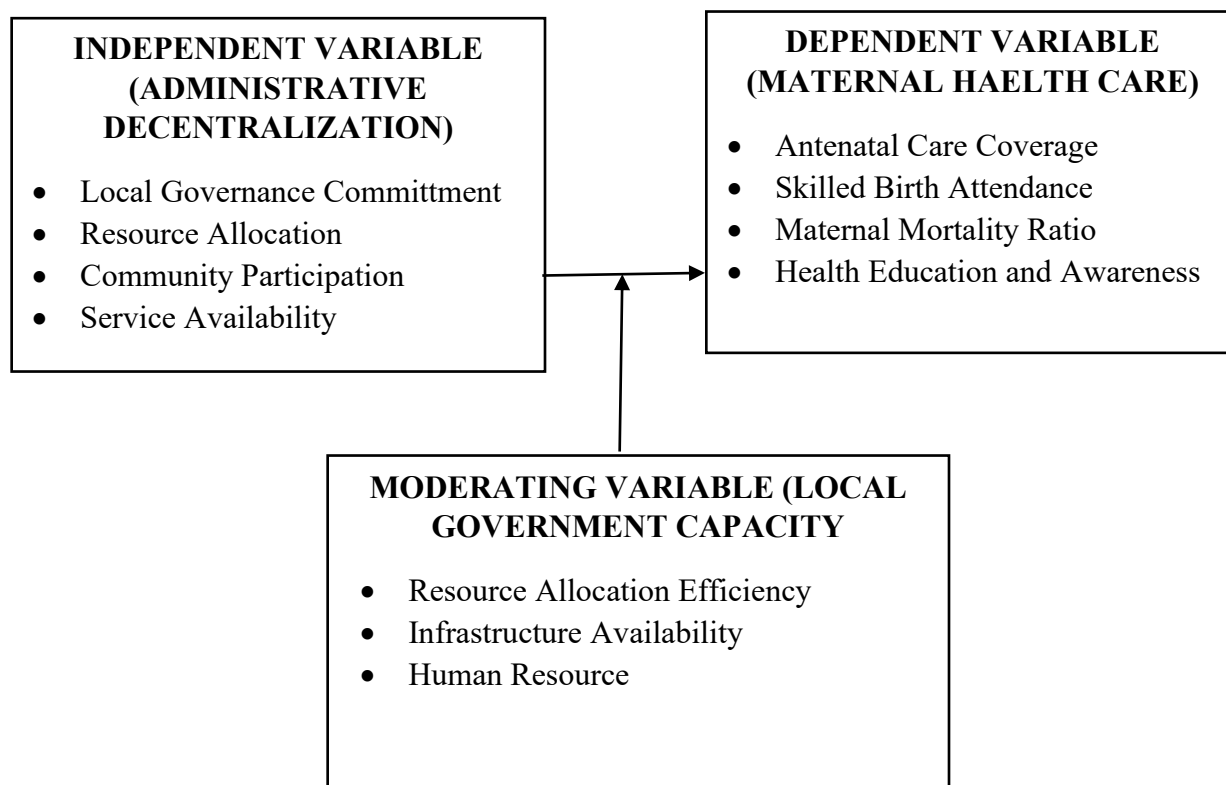
1.7.3 Content Scope

The primary focus of the study was on the intersection of administrative decentralization and maternal healthcare service delivery in Mitooma district considering detailed discussion about (antenatal care coverage, skilled birth attendance, postnatal care, maternal mortality ratio, service coverage rates, quality of care, patient satisfaction in Mitooma district.

1.8 Conceptual framework

In this study, the independent variable is identified as the *Decentralization Policy*, and specifically administrative decentralization (resource allocation, local government structures, community participation and service availability) while the dependent variable is *Maternal Health Care* (*antenatal* care coverage. Skilled birth attendants' maternal mortality ratio health education and awareness). The relationship between these two variables may be influenced by a third variable, termed the *Intervening Variable*, which in this context is the *Local Government Capacity* (resource allocation efficiency, infrastructure availability, data management system).

Fig 1: Conceptual Framework



Source: Researcher (2024)

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The purpose of a literature review is to identify gaps in knowledge, establish the theoretical framework, and justify the need for new research (Booth, Sutton, & Papaioannou, 2016). It also helps to position the current study within the broader academic conversation, showing how it builds upon, challenges, or diverges from previous work (Hart, 1998; Machi & McEvoy, 2016). A well-conducted literature review ensures that the researcher is informed about prior studies, avoids duplication, and contributes meaningfully to the field's ongoing scholarly discourse (Randolph, 2009; Jesson, Matheson, & Lacey, 2011).

2.1.0 Theoretical Review

A theoretical framework refers to the structure that guides research by relying on a formal theory or set of concepts that explain the relationships between variables or phenomena under study. It provides a foundation for understanding, interpreting, and analyzing the research problem by linking it to existing knowledge and theories (Creswell, 2014; Grant & Osanloo, 2014). Theoretical frameworks help researchers clarify definitions, make assumptions, develop hypotheses, and choose appropriate methods (Anfara & Mertz, 2015). Essentially, it serves as a lens through which the research is conducted, ensuring that the study is grounded in established academic thought and contributes meaningfully to scholarly discourse (Swanson, 2013).

2.1.1 Social Determinants of Health Theory

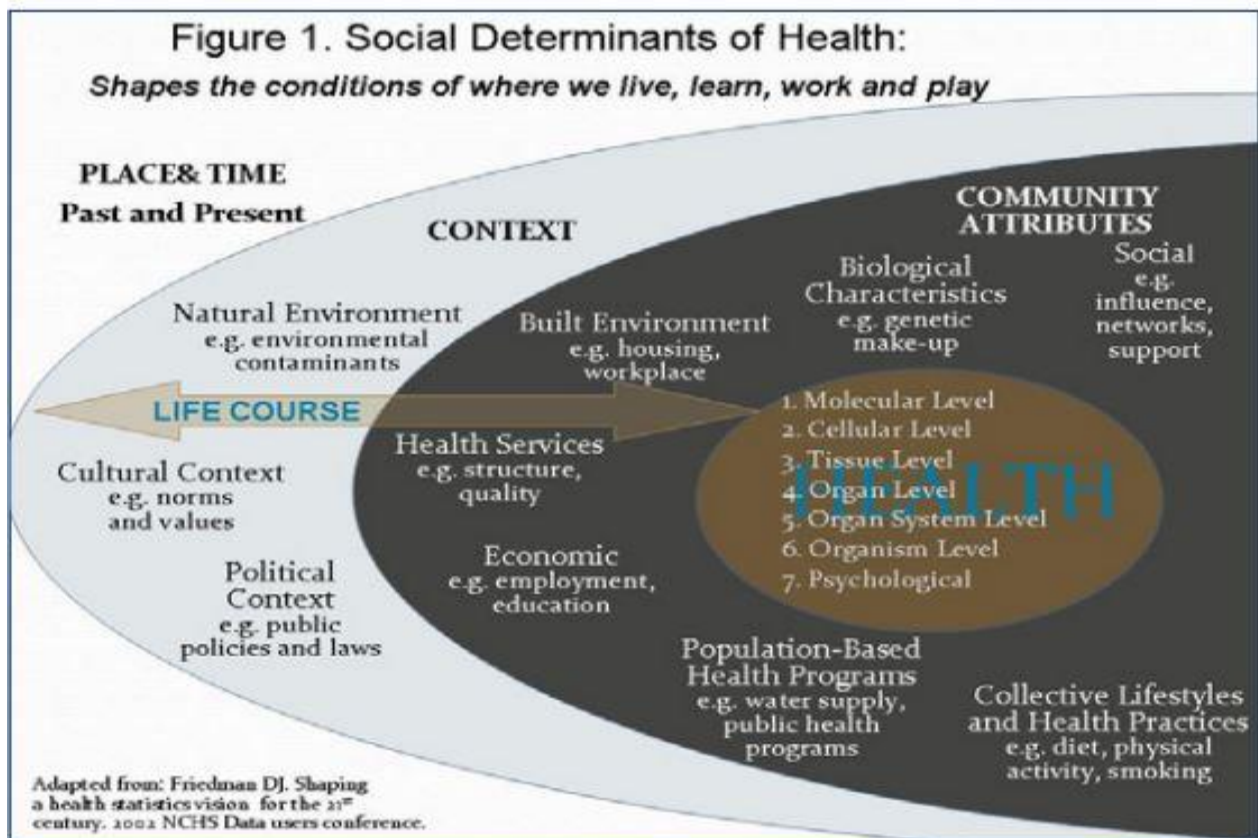


Figure 1: Social Determinants of Health Theory

Source: Maio & Mazzeo (2013)

The Social Determinants of Health (SDH) Theory highlights the broader social, economic, and environmental factors that influence individual and community health outcomes. These determinants include factors such as income, education, employment, housing, access to healthcare, gender equity, and social support networks. SDH Theory asserts that health outcomes are not solely the result of individual behaviors or healthcare access, but are also shaped by structural inequalities and social conditions.

2.1.2 Key Components of the Social Determinants of Health (SDH)

One of the key components include, “Social Inequities” where the SDH emphasizes how poverty, gender inequality, education, and social exclusion impact access to and quality of health care. Women in low-income or rural areas may face multiple barriers that limit their access to maternal health services, such as long distances to health facilities, limited financial resources, and cultural

or gender norms that restrict mobility or decision-making. (Frontiers in Public Health, 2019), (BMJ Open, 2021). Additionally, the SDH theory highlights the “Health Systems and Policy” whereby SDH theory links the role of social policies (such as decentralization) in influencing health care access. Decentralization, if not accompanied by policies that address social determinants like poverty, education, and infrastructure, may worsen health inequities. (Bennett et al., 2020), (De Silva et al., 2021). Finally, the SDH underscores the idea that the way health systems are structured can perpetuate inequalities. For instance, poor health infrastructure, unemployment, or low educational levels in rural areas may undermine decentralization efforts by limiting the effectiveness of local health institutions in delivering quality care. (Kawachi & Berkman, 2020)

Maternal health outcomes are heavily influenced by the broader social determinants of health, especially in decentralized settings (WHO, 2008; Marmot et al., 2012). Issues such as economic inequality, gender-based violence, education levels, and transportation access are critical factors that affect women’s ability to seek and receive timely maternal health care (Gabrysch & Campbell, 2009; Say & Raine, 2007; Bhutta et al., 2010). Hence, decentralization may offer potential to improve access to maternal health services at the local level by bringing decision-making and resource allocation closer to communities (Bossert & Beauvais, 2002; Saltman et al., 2007). However, without addressing underlying social determinants such as poverty, lack of education, and cultural barriers, decentralization may inadvertently exacerbate disparities between urban and rural populations or among different socioeconomic groups (George et al., 2019; Gilson & Raphaely, 2008). On the other hand, when paired with targeted efforts to reduce structural inequalities, decentralization can support more equitable, responsive, and context-specific maternal health interventions (Brinkerhoff & Bossert, 2008).

2.2 Thematic Review

A thematic review in research is a type of literature review that identifies, analyzes, and organizes existing studies or data based on recurring themes or key issues relevant to the research objectives. Instead of reviewing literature chronologically or by author, a thematic review groups information under meaningful topics or patterns that emerge from the materials being studied.

This section is a discussion of the previous literature related to the themes which have been derived from the objectives (1.3.2). This implies that the literature scope is limited to these three thematic areas.

2.2.1 Decentralization and improved Access to Maternal Health Care Services

The effectiveness of administrative decentralization in improving access to maternal health care services has garnered significant attention in recent literature. From a global perspective, decentralization is often viewed as a strategy to enhance health service delivery by transferring authority and resources from central to local governments. In South Sudan, previous studies indicate that this shift can potentially empower local health institutions to address specific community needs more effectively, thereby improving maternal health outcomes (Chol et al., 2023). Research conducted in Bangladesh indicates that decentralization can promote quality and access in health systems by improving efficiency, responsiveness, and accountability, particularly in fragile and post-conflict settings (Miah et al., 2023). However, it is essential to recognize that the relationship between decentralization and improved access to maternal health services is still a challenge, influenced by various factors including governance structures, resource allocation, and local capacity for successful maternal health (Miah & Mia, 1996) in Bangladesh. Furthermore, evidence in Indonesia suggests that while some countries have seen positive progress following decentralization, others have experienced setbacks due to issues such as poor resource management and lack of community engagement (Zon et al., 2023). The researcher concurs with previous in South Sudan, Bangladesh and Indonesia on the aspect of decentralization having improved service delivery, even though more gaps are yet to be bridged especially in the area of study, Mitooma District where the current health concern is focused on maternal health care service delivery.

According to the researcher's analysis following the previous scholars, it is true that one of the critical aspects of decentralization is its impact on the responsiveness of health systems. Indeed, decentralized health systems can lead to improved access to health care by enabling local decision-making that reflects the unique needs of communities as pointed out by (Sparrow, 2022). For instance, in Mitooma District, local authorities may prioritize maternal health initiatives that directly address barriers faced by women in accessing care, such as transportation challenges and

cultural norms. This localized approach can enhance service delivery and ultimately improve health outcomes for mothers and newborns. However, this is not happening and this study is very concerned on how pregnant mothers and the unborn babies can be given the best health care services to ensure their safety.

The role of social determinants of health (SDH) cannot be overlooked when examining the effectiveness of decentralization. The SDH framework emphasizes that factors such as poverty, education, and infrastructure significantly influence health access and outcomes (Wong et al., 2022). In rural areas like Mitooma, where these social determinants are often unfavorable, administrative decentralized type of governance must be accompanied by targeted policies that address these underlying issues. Without such integration, I believe that decentralization efforts may inadvertently exacerbate existing inequalities in maternal health care access.

Evidence from other regions supports the notion that effective administrative decentralization can lead to better maternal health outcomes. For example, research conducted in Indonesia found that decentralized health financing mechanisms significantly increased antenatal care visits and reduced home births (Sparrow, 2022). These findings suggest that when local governments are empowered to manage health resources effectively, they can implement strategies that directly benefit maternal health services. This highlights the importance of not only decentralizing authority but also ensuring adequate funding and training for local health workers.

In addition to financial resources, leadership and managerial capacity within local health systems play a crucial role in the success of decentralized maternal health initiatives. My study aims to indicate that strong leadership at the local level is essential for coordinating services and promoting collaboration among stakeholders (BMC Health Services Research, 2022). In Mitooma District, enhancing leadership skills among health managers could lead to improved organizational performance and better service delivery for mothers and newborns.

Furthermore, I have observed that the effectiveness of decentralized systems is often contingent upon the establishment of clear communication channels between different levels of government. Effective communication ensures that local needs are articulated and addressed within broader national health policies (Chol et al., 2023). In Mitooma, fostering collaboration between local authorities and national agencies could enhance the implementation of maternal health programs tailored to community-specific challenges.

The literature suggests that community engagement is vital for successful decentralization in maternal health care. Engaging communities in decision-making processes can lead to more culturally appropriate interventions and increase trust in health services (Wong et al., 2022). In Mitooma District, involving community leaders and women's groups in planning and implementing maternal health initiatives could improve service uptake and satisfaction.

Moreover, challenges remain regarding the sustainability of decentralized maternal health programs. Factors such as political instability or changes in government priorities can undermine ongoing efforts to improve access to care (Chol et al., 2023). It is crucial for stakeholders in Mitooma District to advocate for sustained commitment from both local and national governments to ensure continuity in maternal health services.

Evaluating the impact of decentralized maternal health initiatives requires robust data collection and monitoring systems. Routine data collection on maternal health indicators can provide insights into the effectiveness of interventions and inform policy adjustments as needed (BMC Health Services Research, 2022). In Mitooma District, establishing a comprehensive monitoring framework could facilitate evidence-based decision-making regarding maternal health programs.

In conclusion, while administrative decentralization holds promise for improving access to maternal health care services in Mitooma District, its success hinges on addressing social determinants, enhancing leadership capacity, fostering community engagement, and ensuring sustainability through effective governance. Continued research is necessary to explore best practices in decentralized maternal health care delivery and identify strategies for overcoming existing barriers.

2.2.2 Barriers Which Women Face in Receiving Maternal Health Care Service Delivery in Mitooma District

Access to maternal health care services remains a significant challenge for women in Mitooma District, Uganda. As a researcher focused on maternal health, I have noticed that various barriers hinder women's ability to receive adequate care, ultimately impacting maternal health outcomes. Understanding these barriers is crucial for developing effective interventions to improve access and quality of maternal health services in the region.

One of the primary barriers the researcher has identified is financial constraints. Many women in Mitooma District face economic hardships that limit their ability to pay for maternal health services. This includes costs associated with transportation to health facilities, fees for medical services, and expenses for necessary medications (Kabia et al., 2023). The lack of financial resources can deter women from seeking timely care, leading to adverse maternal health outcomes. In my discussions with local women, many expressed regrets over their inability to afford essential services, which often resulted in delayed or missed appointments.

Additionally, distance to health facilities poses a significant challenge. Many women in rural areas of Mitooma must travel long distances to access maternal health services, which can be both time-consuming and costly (Macha et al., 2022). Poor road infrastructure exacerbates this issue, making it difficult for women to reach health centers, particularly during adverse weather conditions. During interviews, several women recounted their struggles with transportation, emphasizing how the journey often left them exhausted before they even received care. Another critical barrier is cultural beliefs and practices. In many communities, traditional norms regarding gender roles can restrict women's autonomy in decision-making related to their health (Dahab & Sakellariou, 2020). Women may need permission from male family members to seek care, which can delay or prevent them from accessing necessary maternal health services. I have witnessed firsthand how these cultural dynamics play out in households, where women's health decisions are often secondary to those of male relatives.

The lack of knowledge and awareness about available maternal health services also contributes significantly to the problem. Many women in Mitooma District may not be fully aware of the maternal health services offered or the importance of seeking timely care during pregnancy (Hatt et al., 2013). Educational initiatives are essential to inform women about the significance of regular antenatal visits and skilled delivery. In my outreach efforts, I have encountered numerous women who were unaware of the benefits of prenatal care and how it could improve their pregnancy outcomes. Moreover, stigma and discrimination within healthcare settings can deter women from seeking care. Reports indicate that some women experience disrespect or mistreatment from healthcare providers, which can discourage them from utilizing maternal health services (Kabia et al., 2023). Addressing these issues is vital for creating a supportive environment that encourages

women to seek care. I often emphasize the need for training healthcare providers on respectful maternity care to foster a more welcoming atmosphere for patients.

Inadequate healthcare infrastructure is another barrier affecting access to maternal health services. Many facilities in Mitooma District may lack essential medical supplies or qualified personnel, leading to long waiting times and suboptimal care (Mubyazi et al., 2004). Strengthening healthcare infrastructure is necessary to ensure that women receive timely and adequate care during pregnancy and childbirth. In my assessments of local clinics, I have observed that many are under-resourced and struggle to meet the needs of the community effectively.

The shortage of skilled healthcare providers is a pressing issue that impacts service delivery. In many cases, there may not be enough trained personnel available to provide comprehensive maternal health services (Dahab & Sakellariou, 2020). Increasing the number of qualified healthcare workers in Mitooma District is critical for improving access to quality maternal care. I advocate for targeted recruitment and training programs aimed at building local capacity within the healthcare workforce. Additionally, transportation challenges further complicate access to care. Women often rely on public transport or informal means of transportation to reach health facilities, which may not be reliable or readily available (Macha et al., 2022). Improving transportation options could help mitigate this barrier and facilitate timely access to maternal health services. In my discussions with community leaders, we have explored potential solutions such as community transport initiatives that could assist pregnant women in reaching clinics safely.

Decision-making power within households significantly influences women's access to healthcare. In many cases, women may have limited authority over their own healthcare decisions, often deferring to male family members (Wong et al., 2022). Empowering women through education and community engagement can enhance their ability to make informed decisions about their maternal health. I believe that fostering an environment where women's voices are heard is essential for improving access to care. The lack of community support networks also plays a role in hindering access to maternal health services. Women may feel isolated or unsupported when seeking care, particularly if they lack family or community support during pregnancy (BMC Women's Health, 2024). Establishing support groups for pregnant women could foster a sense of community and encourage service utilization. In my work with local organizations, we are exploring ways to create peer support networks that can provide encouragement and information.

Furthermore, policy-related barriers can impede access to maternal health services. Existing policies may not adequately address the specific needs of women in rural areas like Mitooma District (Chol et al., 2023). Policymakers must consider local contexts when designing interventions aimed at improving maternal health access. I actively engage with policymakers to highlight these issues and advocate for more inclusive policies that reflect the realities faced by women on the ground.

Finally, healthcare system inefficiencies, such as bureaucratic hurdles and inadequate referral systems, can prevent women from receiving timely care. Women may face challenges navigating the healthcare system due to poorly defined referral pathways or lack of coordination among different levels of care (Hatt et al., 2013). Streamlining healthcare processes can enhance women's experiences and outcomes when seeking maternal health services. I emphasize the importance of creating clear guidelines and support systems that assist women in navigating these complexities.

To address the barriers faced by women in receiving maternal health care services in Mitooma District requires a vibrant approach. Interventions must focus on improving financial accessibility, enhancing healthcare infrastructure, empowering women through education and community support, and addressing cultural norms that restrict access. Hence, tackling these challenges comprehensively, it is possible to improve maternal health outcomes for women in the region.

2.2.2.1 Literature synthesis

The researcher acknowledges that Kabia et al. (2023), Macha et al. (2022), Dahab and Sakellariou (2020), Hatt et al. (2013), Mubyazi et al. (2004), Wong et al. (2022), and Chol et al. (2023) all point to key barriers that affect women's access to maternal health care. They agree that financial barriers, poor infrastructure, limited decision-making power, and weak health systems contribute to poor outcomes. Kabia et al. and Macha et al. highlight cost and transport as major challenges, while Dahab and Sakellariou focus more on cultural and gender-related constraints. Hatt et al. and Mubyazi et al. stress weak systems, lack of supplies, and poor staffing. Wong et al. link poor decision-making power to broader social structures, and Chol et al. point to policy-level gaps. Some authors give more weight to structural and systemic causes, while others focus more on personal or cultural factors. Despite these differences, they all agree that improving access requires looking beyond medical care alone.

In my own work in Mitooma District, I have seen how these barriers overlap and make it hard for women to get timely and adequate care. What stands out from the literature is that while each author highlights specific factors, in practice, all of these problems show up together in people's daily lives. Women deal with long distances, high costs, poor service, and limited autonomy all at once. These findings support my view that solutions must be practical, community-based, and grounded in real conditions. Policies and programs that ignore these day-to-day realities often fail. My work aligns with the literature, but I also push for a more hands-on approach that starts with what women say they need and builds from there.

2.2.3 Local Government Capacity to Improved Maternal Health Care Delivery

The capacity of local government ought to play a critical role in improving maternal health care delivery in Uganda. As a researcher focused on maternal health, it is possible that effective governance and resource management are essential for enhancing health outcomes for women and children. This review explores the various dimensions of local government capacity and its impact on maternal health service delivery in the district.

One of the primary components of local government capacity is administrative efficiency. Effective administrative structures enable local governments to plan, implement, and monitor maternal health programs effectively. In Mitooma District, the presence of a District Health Officer (DHO) and a well-organized health department can facilitate better coordination of health services (Mitooma District Health Department, 2024). From my observations, this coordination is vital for ensuring that maternal health initiatives align with national strategies and local needs.

Financial management is another critical aspect of local government capacity. Adequate funding is necessary for the provision of maternal health services, including antenatal care, skilled birth attendance, and emergency obstetric care (Kabia et al., 2023). In Mitooma District, local governments must prioritize budget allocations for maternal health to ensure that resources are available for essential services. I have noted that effective financial management can also enhance transparency and accountability in the use of funds, which is crucial for building trust within the community.

Moreover, human resource capacity significantly influences the quality of maternal health care delivery. A well-trained workforce is essential for providing quality services to pregnant women

(Dahab & Sakellariou, 2020). In Mitooma District, increasing the number of skilled healthcare providers through targeted recruitment and training programs can improve service delivery. My research indicates that strengthening the capacity of existing staff through continuous professional development is equally important to ensure they are equipped with the latest knowledge and skills.

The infrastructure available for maternal health services also reflects local government capacity. In Mitooma, there is one Health Centre IV and several lower-level facilities (Mitooma District Health Department, 2024). However, the adequacy and condition of these facilities can impact service delivery significantly. I have observed that investments in upgrading health infrastructure are necessary to provide a conducive environment for maternal care.

Community engagement is another vital component of local government capacity. Involving community members in planning and implementing maternal health programs can enhance ownership and accountability (Wong et al., 2022). During my fieldwork in Mitooma District, I found that fostering partnerships with community-based organizations helps identify barriers to accessing care and develop targeted interventions to address these challenges effectively.

Furthermore, data collection and management are essential for informed decision-making in maternal health programming. Local governments must establish robust systems for collecting and analyzing data on maternal health indicators (Hatt et al., 2013). In Mitooma District, I have seen that improving data collection processes can facilitate better monitoring of service delivery and outcomes, enabling timely adjustments to programs as needed.

Another critical factor is policy formulation and implementation at the local level. Local governments must develop policies that address the specific needs of their populations regarding maternal health (Chol et al., 2023). In Mitooma District, aligning local policies with national strategies such as the Reproductive, Maternal, Newborn, Child, Adolescent Health (RMNCAH) Sharpened Plan can enhance the effectiveness of interventions aimed at reducing maternal mortality.

The role of leadership within local government structures cannot be underestimated. Strong leadership is necessary to advocate for maternal health priorities within the broader health agenda (Mubyazi et al., 2004). In my experience working with local leaders in Mitooma District, I have

seen how effective leaders can mobilize resources, engage stakeholders, and drive initiatives that improve access to quality maternal care.

Local government capacity also encompasses collaboration with stakeholders, including non-governmental organizations (NGOs) and international development partners. Partnerships can provide additional resources and expertise to enhance maternal health services (Kabia et al., 2023). In Mitooma District, leveraging these partnerships has proven beneficial in implementing innovative solutions to address existing gaps in service delivery.

Moreover, addressing socio-cultural barriers is essential for improving access to maternal health services. Local governments must work with communities to challenge harmful cultural practices that may restrict women's access to care (Dahab & Sakellariou, 2020). Through my advocacy efforts, I emphasize promoting gender equity and empowering women through education and community engagement as key strategies for creating an environment conducive to improved maternal health outcomes. The impact of decentralization on local government capacity is also noteworthy. Decentralization can empower local authorities to make decisions that reflect community needs more accurately (Sparrow et al., 2022). In Mitooma District, effective decentralization requires strengthening local governance structures to ensure they have the authority and resources necessary to implement maternal health initiatives successfully.

Furthermore, monitoring and evaluation mechanisms are vital for assessing the effectiveness of maternal health programs at the local level. Local governments should establish clear indicators for measuring progress toward achieving maternal health goals (Hatt et al., 2013). Regular evaluations can provide insights into what works well and what needs improvement in service delivery. My research emphasizes that establishing a culture of continuous improvement through monitoring can significantly enhance program effectiveness.

In conclusion, enhancing local government capacity is critical for improving maternal health care delivery in Mitooma District. This involves strengthening administrative efficiency, financial management, human resource capacity, infrastructure development, community engagement, data management, policy formulation, leadership roles, stakeholder collaboration, addressing socio-cultural barriers, effective decentralization practices, and robust monitoring mechanisms. By focusing on these areas comprehensively, it is possible to achieve significant improvements in maternal health outcomes in the region.

2.2.3.1 Literature synthesis

Kabia et al. (2023), Dahab and Sakellariou (2020), Hatt et al. (2013), Mubyazi et al. (2004), Wong et al. (2022), Chol et al. (2023), and Sparrow et al. (2022) agree that local government capacity affects maternal health outcomes. They all point to the importance of governance, funding, staffing, and community engagement. Kabia et al. and Chol et al. focus on financial and policy structures. Dahab and Sakellariou highlight cultural factors and human resources, while Hatt et al. and Mubyazi et al. look closely at health system performance and infrastructure. Wong et al. emphasize participation and decision-making power. Sparrow et al. draw attention to decentralization and the local government's ability to adapt services to local needs. Where they differ is in emphasis. Some stress technical aspects like data and finance; others focus on social or political drivers. These differences show that local capacity is complex and shaped by multiple factors working together or pulling apart.

My experience in Mitooma District supports what these authors write, but also adds local depth. What matters most here is not just having plans and policies, but whether people in the system can act on them. I have seen that weak leadership, delayed funding, and staff shortages stall progress even when the plans are clear. At the same time, when local leaders are active, health workers are motivated, and the community is involved, change happens. The literature helps explain what strong capacity looks like on paper, but my study adds real examples of what helps or blocks it on the ground. The best results come when technical tools meet practical action, when local governments are not just given responsibilities, but the means and support to carry them out.

2.4 The Literature Gap

There has been extensive literature on denaturalization and local service delivery, highlighting government efforts to ensure that services effectively reach local communities through decentralization programs. This approach is particularly relevant in the context of maternal health care, where a significant body of research documents the challenges and successes of health systems worldwide. However, this study specifically focuses on the intersection of decentralization and maternal health care service delivery in Mitooma District, Uganda.

The existing literature reveals that while decentralization can enhance service delivery by allowing local governments to tailor health services to community needs, it often faces obstacles such as

inadequate resource allocation and governance challenges (Miah & Mia, 1996) 2. Furthermore, studies have shown that maternal health outcomes are closely linked to social determinants such as education, economic status, and healthcare accessibility, which are often exacerbated in decentralized systems lacking sufficient support (WHO, 2023) 3.

This study aims to fill the gap in literature regarding how decentralization specifically impacts maternal health care in Mitooma District. Hence, addressing this gap, the research will contribute valuable ideas into the effectiveness of decentralization strategies in improving maternal health outcomes and highlight best practices for enhancing service delivery in similar contexts. The findings will be critical for policymakers aiming to refine health systems and ensure that maternal health services are both accessible and effective for local populations (Azugbene et al., 2023) 1.

2.5 How to measure maternal health care

Table 2: Indicators used to measure maternal health care

SN	Area	Detail	Source/Developer
1	Maternal Mortality Ratio (MMR)	Number of maternal deaths per 100,000 live births – measures safety of childbirth and effectiveness of maternal care.	WHO (2023)
2	Antenatal Care (ANC) Coverage	% of women (15–49) with a live birth who received ANC from a skilled provider at least 4 times.	UBOS & ICF (UDHS, 2016; 2022); WHO (2016)
3	Skilled Birth Attendance (SBA)	% of live births attended by doctors, nurses, or midwives.	WHO; UNICEF; UNFPA; UBOS (UDHS)
4	Postnatal Care (PNC) Visits	% of mothers and newborns receiving PNC within 2 days of delivery.	WHO; UBOS (UDHS)
5	Quality of Care Indicators	e.g., proportion of ANC visits where BP was measured.	MOH Uganda (2020); UBOS (UDHS)

6	Access to Emergency Obstetric Care (EmONC)	Availability and readiness of facilities to handle complications.	MOH Uganda (HSDP 2020/21–2024/25); WHO
7	Utilization of Family Planning Services	% of women whose need for FP is met.	UBOS & ICF (UDHS); UNFPA
8	Health Facility Assessments	Presence of skilled staff, medical supplies, and infrastructure.	MOH Uganda; UBOS
9	Community-Based Surveys	Women’s reported experiences, satisfaction, and barriers.	UNICEF; UBOS
10	Health Information Systems	Routine data collection on MMR, ANC, SBA, and PNC.	MOH Uganda (HMIS); WHO
11	Evaluation of Health Policies	Analysis of national maternal health policies and frameworks.	MOH Uganda; UNFPA
12	Patient Outcomes Monitoring	Rates of postpartum complications and neonatal deaths.	WHO; MOH Uganda
13	Equity Measures	Distribution of services by wealth, education, and residence.	WHO (Social Determinants Framework); UBOS (UDHS)

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This study will investigate how administrative decentralization has contributed on the accessibility and quality of maternal healthcare services in rural Uganda focusing on Mitooma district. This study is relevant and timely given the ongoing challenges in maternal health service delivery in decentralized health systems, despite the policy's intention to enhance local governance and improve service access. Therefore, the researcher applied an appropriate methodological design to guide the process of managing data collection.

3.2 Research Design

The study employed a phenomenological qualitative research design suitable for investigating a phenomenon to gain in-depth understanding of the participants lived experiences about given maternal health service deliver under decentralization policy. Hence following an interpretivist phenomenological qualitative approach, the study provided a comprehensive and thorough evaluation of the participants' experiences related to “Decentralization and Maternal Health”. The approach allowed the researcher to find out the underlying constructs associated with these two variables the beneficiaries (pregnant and lactating mothers), health workers, district administrators and Non-Governmental Organisation who are partners in health.

3.3 Study Area

This study was conducted in four health facilities including (Mayanga HC111, Kanyabwanga HC11I, Nyakishwja HC11I, and Kigyende HC11) Mitooma District, covering the communities of Mitoma Town Council, Kashenshero Town Council, Kinyabwanga, Kiyanga, Rurehe, Kabira, Mayanga, Mutara, Katenga, Kagyenda, Nyakishojwa, Bukuba, Bitereko, Kiyanga, Rwoburunga, Kibare, Nyakatsiro, Mayanga, Bikongoro, and Kigyende. The ease of access to resources and locations was crucial for the researchers when selecting the study area and subject matter, as it affected their ability to gather data (Muriisa, 2006). Therefore, the researcher prioritized accessible

areas with minimal obstacles. The selection of these specific study areas was guided by indicators from the National Population and Housing Census (2014). The researcher determined the study areas with the aim of ensuring easy access, which was a vital aspect of the research work. This was because the acquisition of data for the study hinged on the accessibility of the area, considering both physical entry and data retrieval (National Academy of Sciences, 2009). The decision-making process for study area selection was shaped mainly by two critical factors: the availability of resources in terms of time and finances, and the accessibility of data, taking into account variables such as language, participant responsiveness, collaboration with suggested stakeholders, government engagement, and adherence to research protocols.

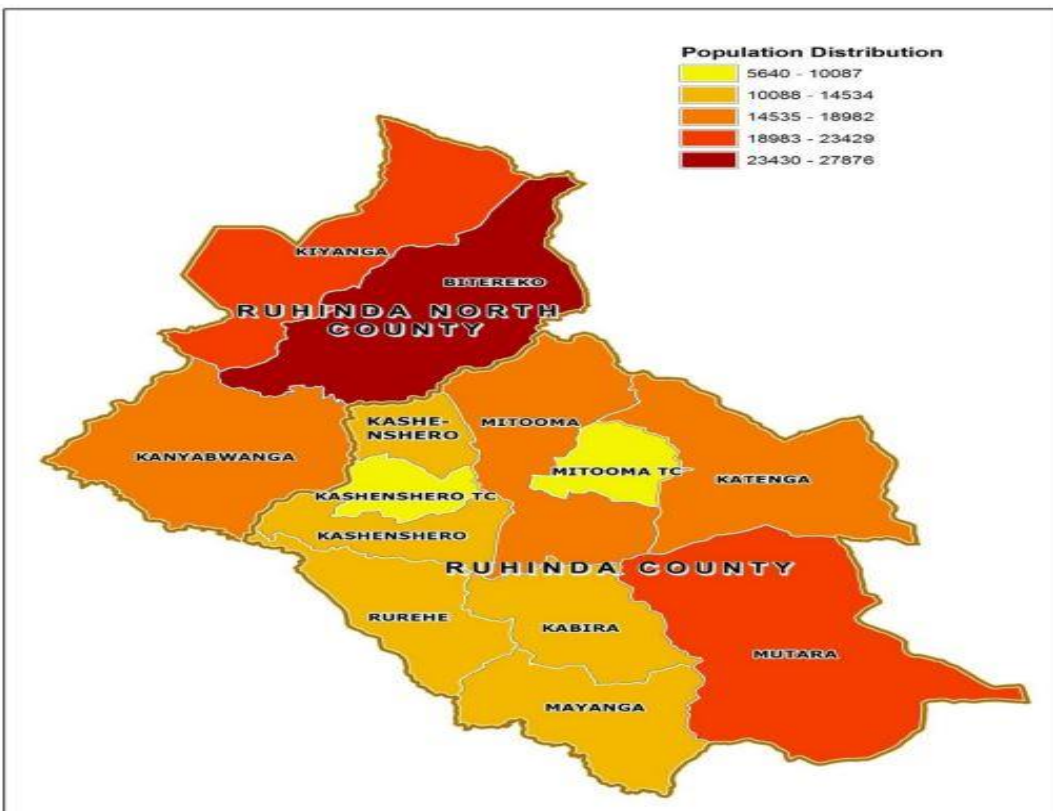


Figure 2: Map of Mitooma District where the study will be conducted

Source: National Population and Housing Census (2014)

3.4 Sources of data

The study utilized both primary and secondary sources of data.

Primary sources included information obtained directly from key stakeholders such as pregnant women, lactating mothers, health workers (midwives, nurses, and facility administrators), local government officials (District Health Officer, sub-county chiefs), and community representatives including Village Health Teams (VHTs).

Secondary sources comprised existing literature and reports relevant to maternal health care, including the Uganda Demographic and Health Survey (UDHS) reports, Mitooma District Health Department records, Ministry of Health policy documents, and international publications by WHO, UNICEF, and UNFPA, as well as scholarly articles.

3.5 Study Population

3.5.1 Target Population

The study considered a variety of population categories that provided comprehensive data about the effects of decentralization on maternal healthcare services in Mitooma District. The most suitable categories of the population included, among others: pregnant women and new mothers, healthcare providers, local government officials, community leaders and elders, health facility administrators, non-governmental organizations (NGOs) and community-based organizations (CBOs), and families of pregnant women.

3.5.2 Inclusion Criteria

Participants in this study were required to be residents of Mitooma District who were directly affected by maternal healthcare service delivery, including pregnant women, lactating mothers, healthcare workers (midwives, nurses, and facility administrators), and local government officials. Eligible participants had to be at least 18 years of age, able to provide informed consent, and possess relevant experiences either as direct beneficiaries of maternal healthcare services or as providers or decision-makers involved in maternal health service delivery. This approach ensured inclusion of participants with practical and lived experiences while avoiding restrictive

requirements, such as prior knowledge of decentralization policy, which are not commonly understood by the general population.

3.5.3 Exclusion Criteria

The study excluded individuals who are under the age of 18, those with unsound mind to make meaningful contributions, people out of Mitooma district except if deemed necessary. All members of the public unwilling to participate in this study were excluded.

3.6 Sampling Strategy

Qualitative researchers often employ respective sampling strategies to choose specific participants, enabling them to concentrate on individuals with particular experiences that relate to the research question. In this study, the sampling strategy will be shaped by the characteristics of the target population.

3.6.1 Purposive Sampling

This strategy involved selecting interviewees based on specific criteria such as their age, experience within local government and health sector. This category provided valuable information about local government and health sections.

3.6.2 Snowball Sampling

Snowball sampling, as a strategy used in qualitative research studies, enabled the researcher to access networks and connect with individuals who possessed specific expertise or experiences relevant to the research question. These referrals assisted the researcher in identifying participants who provided valuable information about the relationship between decentralization and health, particularly those employed at lower-level health facilities within the local government framework. Consequently, snowball sampling not only broadened the participant pool but also ensured the inclusion of individuals with unique or diverse ideas in the study, as pointed out by Biernacki and Waldorf (1981) and Atkinson and Flint (2020).

3.7 Sample Size

Qualitative studies generally utilized smaller sample sizes because of the nature of data collection and analysis (Guest, Bunce, & Johnson, 2006). In this study, a sample size of 20 to 25 participants was deemed appropriate, as it provided enough data to achieve saturation, which is the point at which no new information emerges (Fusch & Ness, 2015). However, the precise sample size was influenced by several factors, including the depth of the interviews (which lasted about 45 to 60 minutes), the range of information the researcher intended to capture, and other challenges such as time and resources, as highlighted by Mason (2010).

3.8 Data collection methods

The investigator employed a double approach in conducting this study, drawing on primary and secondary data sources.

3.8.1 In-depth Interviews

In-depth interviews are suitable qualitative research methods to gather detailed data in the form of stories, case scenarios, and opinions through direct, personal conversations between the interviewer and the participant. This technique was suitable for the study because it allows researchers to explore details about the topics by asking open-ended questions that encourage participants to share their thoughts, feelings, and experiences in a detailed and free manner. In-depth interviews promote a more flexible dialogue between the interviewer and interviewee.

The categories included in the interviews specifically covered population groups such as pregnant women and new mothers, healthcare providers, local government officials, community leaders and elders, health facility administrators, non-governmental organizations (NGOs) and community-based organizations (CBOs), families of pregnant women, and policymakers at the national level. All questions were designed based on the study objectives to remain focused.

3.8.2 Focus Group Discussions

Focus group discussions (FGDs) are essential for exploring the perspectives of participants within the context of “Decentralization and Health.” Ideally, in FGDs, participants had the opportunity to

share their views on a specific topic, even when their opinions varied. This method promotes a deeper understanding of how individuals perceived the issue through group dialogue. Participants articulated their ideas based on their personal experiences and knowledge related to the subjects being studied. Consequently, FGDs served as a valuable data source, as participants expressed themselves in their own language and terms. This approach preserved the authenticity of the discussion, eliminating the need for participants to rephrase their responses in the researcher's terminology (Gregory, Namey, Chrissy, & Taylor, 2020), thus allowing for a more genuine exploration of their opinions.

3.8.3 Categories of the Key Participants

Table 3: Categories of the population of the study

S/N	Key Informant	Sampling Method	Number
1	Pregnant Women	Snowball	4
	New Mothers	Snowball	4
	Health Facility Administrators	Purposive	2
2	Healthcare workers	Purposive	4
3	Local Government Officials	Purposive	4
4	Policy Makers at National Level	Purposive	1
5	Families of Pregnant Women	Purposive	2
6	Community-Based Organizations (CBOs)	Purposive	2
7	Non-Governmental Organizations (NGOs) and	Purposive	2
9	Community Leaders and Elders	Purposive	1
	Total		26

In presenting data from in-depth interviews and focus group discussions, participants were anonymized and assigned unique identifiers. For key informant interviews, codes such as *IDI 1*,

IDI 2, KI 3, etc., were used, followed by the location and date (for example, *IDI 3, Nyakishojwa HCIV, May 2025*). For focus group discussions, references were made as *FGD 1, FGD 2*, etc., along with the location and date (for example, *FGD 1, Pregnant Mothers at Mayanga HCIV, June 2025*). This system ensured clarity, consistency, and anonymity while maintaining contextual accuracy of the data sources.

3.9 Reliability and Validity of the Instruments

Reliability and validation of key instruments for data collection in academic research studies is conducted to avoid bias, criticism, and to ensure comparability with studies by other scholars and the family of academia.

3.9.1 Reliability of data

The researcher followed the guidelines provided by Kothari (2014) for assessing reliability, focusing on the following aspects. To confirm that the tools effectively collect the necessary information, they were tested with a small group of participants. Based on the feedback received, any required modifications were made to the data collection instruments, ensuring that only pertinent questions are included.

3.9.2 Validity

The researcher agrees with previous scholars that in social research, validity refers to the confirmation of the consistency of the study's intended objectives. It pertains to the "correctness or credibility of a description, conclusion, explanation, interpretation, or other types of accounts" (Creswell, 2013; Zina, 2006). Validity does not involve measuring results against an absolute truth; rather, it emphasizes ensuring that the conclusions drawn are credible and meaningful. Establishing validity is sufficient to support the claim that a study offers valuable and trustworthy insights. To evaluate the validity of the research findings, several questions can be considered: Do the tools created for the study accurately measure what they are intended to measure? Are these tools consistent with those used in similar or related research? Do the conclusions align with the research questions? In this study, several strategies were employed to ensure data validity. (a) To draw valid conclusions, the researcher aligned research instruments (Key Informant Interviews

guide, FGD guide, and Participant Observation checklist) with empirically validated tools designed to measure perceptions. Additionally, to further enhance the validity of the conclusions, the researcher incorporated multiple sources of information as part of a triangulation approach.

3.9.3 Trustworthiness

Since this is a qualitative study, the investigator applied a range of strategies to ensure the trustworthiness of the findings (Nyirenda et al., 2020). These strategies included credibility, dependability, transferability, triangulation, confirmability, reflexivity, consistency in data management, and persistent observation.

3.9.4 Credibility

To enhance the credibility of the study, the researcher carried out a thorough, in-depth key informant interviews, providing participants with sufficient time to reflect on and affirm their viewpoints, thereby preventing fatigue. Furthermore, the Principal Investigator and Research Assistants became well-acquainted with the study context, specifically concerning Decentralization and Maternal Health.

3.9.5 Triangulation

To enhance the trustworthiness of the data, the Principal Investigator employed data triangulation by gathering information from various sources (Korstjens & Moser, 2018). This process included conducting in-depth interviews with key informants, particularly targeting staff involved in Decentralization and Health, as well as their supervisors.

3.9.6 Transferability

Transferability, as defined by scholars such as Korstjens and Moser (2018), refers to the degree to which research findings from one context could be applied to another involving a different group of respondents. This detailed account enables other researchers to evaluate whether the findings are applicable to their own contexts. The researcher provided an extensive overview of the research context, including details about the setting, sample size, sampling strategy, study population,

inclusion and exclusion criteria, interview procedures, any modifications made to the interview questions throughout the iterative research process, and relevant excerpts from the interview guide.

3.9.7 Dependability

Dependability refers to the stability of research findings over time. As noted by Bryman (2004) and Trochim (2006), findings are considered dependable if similar results can be replicated over several years within the same context. To ensure dependability, research assistants received thorough training in note-taking and data transcription. The analysis adhered to established qualitative analysis standards to maintain consistency. Additionally, member checking was employed, whereby feedback from peers and supervisors was solicited to verify data quality and refine the findings prior to finalization (Swimberghe et al., 2014).

3.9.8 Confirmability and Reflexivity

Confirmability refers to the extent to which the findings can be validated by the participants or their peers, rather than being shaped by the researcher's personal biases (Cornish et al., 2020). To ensure confirmability, the moderator summarized the responses after each focus group discussion or key informant interview and ask participants to verify whether the summary accurately represents their contributions. Reflexivity is also crucial for preventing the researcher's biases from influencing participants' responses (Cornish et al., 2020). To reduce such biases, the Principal Investigator used bracketing during interviews and while reporting findings. This approach will help ensure that the conclusions drawn reflect the participants' views rather than the researcher's preferences.

3.10 Research Procedure and Protocol

As a required step, the researcher submitted an application to the local Institutional Research Ethics Committee (REC) for protocol review. Once clearance was granted by the Institutional Research Ethics Committee (BSU REC), the researcher received permission to gather data from the field.

3.11 Ethical Considerations

Ethical considerations include the essential guidelines and principles that researchers adhere to conduct their studies in a standardized manner while respecting the rights and privacy of research subjects. These principles ensure that the research process is carried out with integrity, resulting in trustworthy outcomes. One of the most fundamental ethical considerations is obtaining informed consent. Researchers must ensure that participants fully understand the nature, purpose, and potential risks of the study before agreeing to participate. Therefore, the current researcher will provide clear and comprehensive information about the study, enabling participants to make informed decisions regarding their involvement. In the realm of social sciences, ethical principles are particularly crucial. Key considerations include:

Confidentiality which indicates that researchers are responsible for protecting participants' personal information and ensuring data security by preventing unauthorized access and anonymizing identifiers. The researcher also considered the notion of “minimizing Harm” which reduces any physical, emotional, or psychological risks to participants. Researchers should design studies carefully to avoid harm and provide support if issues arise. Additionally, the researcher preserved “integrity” which guides researchers to conduct their studies with honesty and transparency, avoiding fabrication, falsification, and plagiarism to maintain the credibility of their findings. Furthermore, the researcher knows the principal of “respect for participants” because acknowledging the autonomy and dignity of participants is essential, especially for vulnerable groups.

Ethical considerations permeate every stage of the research process from problem formulation to data collection and reporting. Researchers bear the responsibility of safeguarding participants' rights and well-being, particularly for vulnerable populations such as children, women, and individuals with disabilities who may face higher risks. In studies involving sensitive topics, such as decentralization and maternal health, it is crucial to manage participants' expectations regarding any potential emotional or psychological stress that may arise from interview questions. Participants will be informed about the study's objectives and expected outcomes, ensuring they can make informed decisions about their involvement. Participants will also have the option to decline answering any questions that may cause distress, emphasizing the voluntary nature of participation. Strategies will be developed to address any unanswered questions while minimizing

discomfort. Confidentiality remains a priority throughout the study. Participants were assured that their identities will not be disclosed in reports; instead, anonymous references will be used to protect their privacy. The primary ethical considerations for this study focused on obtaining informed consent and safeguarding participant privacy, guiding the researcher in conducting the study ethically while upholding participants' rights throughout the process.

3.12 Informed Consent

Informed consent is an essential process that guarantees participants voluntarily agree to participate in a study. It involves providing participants with detailed information regarding the study's objectives, potential benefits, and any associated risks. Participants need to understand the crucial elements of the research to make an informed decision about their participation, based on the information provided by the researcher. Manti & Likari (2018) define informed consent as a process in which "an individual voluntarily confirms their willingness to participate in a particular trial, after having been informed of all aspects of the trial that are relevant to the individual's decision to participate," according to the International Council for Harmonization Good Clinical Practice guidelines. This procedure ensures that participants make knowledgeable and voluntary decisions regarding their involvement in the research. Researchers can obtain informed consent through various methods, including direct communication to explain the research and gain agreement. Alternatively, consent may be sought from organizations representing the individuals involved, ensuring they safeguard their members from harm and review research proposals, serving as a "filter" before granting permission.

In line with informed consent protocols, this study's research proposal was reviewed and approved by Bishop Stuart Research Ethics Committee (REC). This review process guarantees that ethical standards are upheld and that participants are sufficiently protected.

3.13 Privacy of Respondents

It is the responsibility of investigators to ensure participants' privacy. In case data collection methods carelessly breach privacy, the researcher must take steps to protect participants from any harm. Privacy violations can compromise participants' integrity and lead to emotional, physiological, or psychological distress. Therefore, the researcher must take precautions to avoid

these breaches, even those that may occur unintentionally. Hence, safeguarding the privacy and comfort of participants is a fundamental ethical requirement that the investigator will strictly follow. Also, during data the methods and instruments applied can potentially compromise participants' privacy. This risk is especially possible during interviews, where participants might disclose private information, either intentionally or unintentionally. Additionally, certain observation methods, like hidden cameras, may infringe on participants' privacy by capturing data without explicit consent. To mitigate these risks, the researcher used appropriate instruments and be cautious in protecting participant privacy. This included utilizing user-friendly data collection methods, obtaining explicit consent for sensitive information, and avoiding intrusive techniques that could compromise confidentiality.

3.14 Type of Data Collected

It is essential for the researcher to ensure that all data collected is directly relevant to the research proposal in order to uphold ethical standards. Straying from the originally intended data can jeopardize the integrity and validity of the study. The researcher must adhere closely to the specified research objectives and questions. During open-ended interviews, participants may disclose information that exceeds what is necessary, including personal and sensitive details. To address this, the researcher formulated focused and clear questions that prompt participants to share relevant information without oversharing. This strategy promotes ethical data collection while respecting participants' privacy and boundaries. The researcher ensured that all questions are straightforward and aligned with the study's objectives. To maintain control over the scope of the collected data and ensure it aligns with the study goals, the researcher implemented appropriate techniques that protect participant privacy while remaining within ethical guidelines.

3.15 Data Analysis

Through its robust coding system, ATLAS. it allows the researcher to systematically assign codes to relevant data segments, which are then grouped into categories and broader themes. This structured approach enhances the consistency and depth of thematic analysis by enabling the researcher to track emerging patterns, compare responses across different participant groups, and identify relationships between concepts. The memoing feature in ATLAS. It supports reflexive

analysis by allowing the researcher to document insights, analytical decisions, and evolving interpretations throughout the coding process. Additionally, the software's ability to generate reports and export coded data facilitates transparency, auditability, and integration into the final reporting of findings. Overall, ATLAS.ti plays a central role in ensuring that the qualitative data analysis is both rigorous and methodologically sound.

3.16 Dissemination plan

The researcher will disseminate the outcomes of the study by sharing the reports with the District DHO, and CAO. She will also ask for permission to present to the district health teams. Additionally, the researcher intends to publish the outcomes of this study to capture a wider coverage to share the key outcomes both internally and externally. The social platforms like Twitter, X, TikTok will be used to share the highlights of the study outcomes.

CHAPTER FOUR

DATA PRESENTATION AND INTERPRETATION

4.0 Introduction

This chapter presents and interprets the findings of the study on the effectiveness of administrative decentralization in improving maternal healthcare service delivery in rural communities of Mitooma District.

The chapter analyses and interprets the data collected for the study, framed through thematic analysis, an essential qualitative research tool that enables the systematic identification, organization, and interpretation of themes within the data. Thematic analysis was chosen because it goes beyond surface-level insights, providing deeper meanings and patterns within participants' actual individual narratives derived from both direct and probing questions. Specifically, this study employed inductive thematic analysis, a variant that allows themes to emerge organically from the data.

4.1 Bio data information of study participants

Table 4 Sex of study participants

Sex	Frequency	Percent
Male	5	19.2
female	21	80.8
Total	26	100

The findings in **Table 4** on the sex of study participants indicate that out of the 26 respondents, a majority were female (n = 21, 80.8%), while only a small proportion were male (n = 5, 19.2%). This shows that women were more represented in the study population, suggesting that female perspectives were more dominant in the responses.

Table 5 Age Distribution

Age Group	Frequency	Percentage (%)
18–28 years	6	23.1%
29–38 years	10	38.5%
39–48 years	7	26.9%
49 & above	3	11.5%
Total	26	100%

The findings in **Table 5** on age distribution reveal that the majority of respondents were aged 29–38 years ($n = 10$, 38.5%), followed by those aged 39–48 years ($n = 7$, 26.9%). Respondents aged 18–28 years accounted for 23.1% ($n = 6$), while the least represented age group was 49 years and above ($n = 3$, 11.5%). This implies that most participants were in their economically active years, with fewer older individuals represented.

Table 6 Education Level

Education Level	Frequency	Percentage (%)
Primary	10	38.5%
S.4	2	7.7%
S.6	1	3.8%
Diploma	9	34.6%
Degree	2	7.7%
Masters	2	7.7%
Total	26	100%

The findings in **Table 6** on education levels show that the majority of respondents had attained primary education ($n = 10$, 38.5%) and diploma qualifications ($n = 9$, 34.6%). Fewer respondents had completed secondary education, with 7.7% ($n = 2$) at S.4 and 3.8% ($n = 1$) at S.6. Higher education levels were less represented, with only 7.7% ($n = 2$) holding a degree and another 7.7%

(n = 2) holding a master's degree. This suggests that while most respondents had at least basic education, professional and advanced qualifications were limited.

Table 7 Marital Status

Marital Status	Frequency	Percentage (%)
Married	25	96.2%
Divorced	1	3.8%
Total	26	100%

Results in **Table 7** on marital status demonstrate that nearly all respondents were married (n = 25, 96.2%), with only one participant reporting being divorced (n = 1, 3.8%). This reflects that the majority of respondents came from stable family settings, which may influence their household and community roles.

Table 8 Occupation

Occupation	Frequency	Percentage (%)
Peasants	10	38.5%
Health workers	4	15.4%
Health Admin	4	15.4%
LC Officials	2	7.7%
NGO / Health	1	3.8%
Policy Maker	1	3.8%
Total	26	100%

The results in **Table 8** on occupation reveal that most respondents were peasants (n = 10, 38.5%), followed by health workers (n = 4, 15.4%) and health administrators (n = 4, 15.4%). Other

occupations represented included local council officials (n = 2, 7.7%), NGO/health workers (n = 1, 3.8%), and policy makers (n = 1, 3.8%).

4.2 Data Collection and Analysis Process

The data was collected through Key Informant Interviews (KIIs) with health facility administrators, midwives, and health workers in the district and mothers seeking maternal health services in given health centers. The analysis focuses on understanding of decentralization, encompassing devolution, delegation, and deconcentrating, has influenced access to and the quality of maternal health services. The researcher arranged the data using "Thematic Analysis" of the raw data, based on the themes that surfaced from the data gathered for each objective.

This process involved initial coding, axial coding, selective coding, and thematic coding. Therefore, it was appropriate to develop themes that form the foundation for organized data presentation and interpretation. These themes also align with the study objectives, following the arrangement of the data collected from the field.

After data collection, the data were transcribed from audio to text and were coded using Atlas Ti v.9 software. Coding was done to facilitate the identification of themes and patterns. Themes were identified objective by objective using the thematic analysis methodology. Thematic analysis is a qualitative data analysis method that involves identifying, analyzing, and interpreting patterns (themes) within qualitative data. It provides a systematic yet flexible framework to uncover insights into the lived experiences of study participants. The use of inductive thematic analysis allowed the researcher to derive themes directly from participants' narratives, ensuring that the findings authentically represented their experiences. The process involved coding the data to identify recurring patterns, which were then grouped into broader themes. These themes are presented in alignment with the study objectives, with excerpts from the interviews used to illustrate key points highlighted during the interaction with participants.

4.3 Presentation of Extracts from the Data Analysis

After analyzing the data, the researcher presented and interpreted the findings based on the constructs generated by the tool used to analyze the data (Atlas Ti). The data are presented according to the study's objectives, within the themes identified from the data.

4.3.1 Extracts from objective 1: To assess the effectiveness of devolution, delegation, and deconcentrating in improving access to maternal health care services in Mitooma District.

The findings for this objective are organized into two primary themes: Improvements and Challenges, each supported by direct verbatim quotations from the participants to ensure their voices and experiences are accurately represented. This approach provides a rich, contextual understanding of the multifaceted impact of decentralization on the ground.

Theme 1: Improvements in maternal health service delivery

Decentralization has led to notable improvements in maternal healthcare service delivery in Mitooma District. A major improvement is the increased access to services. Health facilities have been brought closer to the people. This has helped village dwellers save on transport costs and has discouraged home deliveries. Several health centers have been upgraded from Health Centre II to Health Centre III status, which has allowed for the provision of more services, such as admissions, deliveries, and antenatal care. The number of mothers seeking services has increased as a result.

This is observed by a key informant in one of the health facilities as he emphasized how decentralization has brought services closer to the people. The key informant narrated that;

"The services have been brought closer to people e.g., formerly, Mayanga used to be a HC2 and it has been elevated to HC3 status so that services are brought nearer to the people, I confirm that it has helped village dwellers on transport costs, deliveries, and discouraging home deliveries, it has really helped." (IDI 4, Health Worker at Mayanga HCIII, May 2025).

Another respondent, a health worker, noted that patients who once had to travel long distances for care can now access services at nearby health facilities. This shift confirms that decentralization has successfully brought services physically closer to the people, which has helped reduce transport costs for village dwellers and is a key factor in the observed increase in mothers seeking maternal healthcare. The upgrade of health centers, such as Kigyende Health Center II being elevated to a Health Centre III, is a specific example of this process in action, leading to more services being provided locally. Overall, the statement reflects a positive outcome of the policy, directly addressing a common barrier to healthcare access in rural areas.

She stated:

"At first patients used to receive services from far but now services are got from nearby health facilities." (IDI 4, Health Worker at Kigyende HCII, May 2025)

Another vivid remark from a key informant highlights a significant advantage for mothers: the reduction in the distance they must travel to access maternal services. This is a direct positive outcome of decentralization. Bringing health services closer to the people has not only reduced transport costs for village dwellers but has also discouraged home deliveries, which is a major win for maternal healthcare. One key informant directly states, "The number of mothers seeking for MHC services has increased due to bringing services nearer to people". This confirms that a key barrier to healthcare access in rural areas has been addressed, leading to improved health-seeking behavior.

She remarked:

"The number of mothers seeking for MHC services has increased due to bringing services nearer to people." (IDI 4, Health Worker at Mayanga HCIII, May 2025)

Facility-level managers now have more autonomy to respond to maternal healthcare needs. They can make decisions regarding staff deployment, such as relocating a staff member from the Outpatient Department to the maternity section if there is a big turn up of mothers. They can also order for essential drugs and supplies based on patient demand, rather than waiting for whatever is supplied. Some in-charges even have the authority to make temporary recruitments for support staff. Furthermore, communication between the facilities and the district health management team is effective, with monthly reports and a direct forum for in-charges and the District Health Officer (DHO). This has led to the DHO's office responding to calls and addressing challenges, such as the frequent demands that led to the posting of a new midwife at a facility.

As noted by the DHO;

"I take decisions regarding to those who may ignore their duties, make duty roaster, order for supplies in case I anticipate there could be stock outs in the near future."

(KI 4, DHO's Office, April 2025)

Another remark from a health worker demonstrates that the delegation of authority under the decentralized framework. While the respondent acknowledges that they are not completely

autonomous and must consult with the District Health Office (DHO), they possess significant decision-making power at the facility level. Specifically, the key informant can take disciplinary action against staff, such as recommending their dismissal and transfer. They also have the authority to make temporary recruitments for support staff, like a security guard ("Askari"), to ensure the safety of government property. This level of control over personnel and operational decisions allows the facility to respond more effectively to local needs and challenges, such as a security breach⁶. The statement highlights a shift from a centralized, top-down approach to one that empowers local managers to maintain efficient operations and address immediate issues.

As she remarked:

"I take some decisions and not all on behalf of the facility, e.g., if staff don't attend to their duties, I can make a decision on that staff to dismiss and send them to DHO's office... I make temporally recruitment of support staff e.g., Askari to keep the govt property safe." (KI 4, DHO's Office, April 2025)

Another comment highlights a positive shift in the supply chain for health facilities under decentralization. The health worker stated that the facility now has the autonomy to order necessary supplies, such as essential drugs, directly based on the needs of their patients. This is a significant improvement from the previous system where they had to wait for whatever was supplied to them. This delegation of responsibility empowers the health facility to better meet the specific demands of the community, which is crucial for effective service delivery, especially for maternal health.

The health worker noted:

"Like I have already said we can now make orders and not to wait for whatever they will supply." (IDI 2, Health Worker at Mayanga HCIII, May 2025)

A related remark from a health facility administrator demonstrates a key aspect of delegation and local autonomy under the decentralized system. It shows that facility-level managers have the authority to make critical, on-the-spot decisions to address immediate needs. By being able to reallocate supplies from one department (Outpatient Department) to another (maternity) when a stock-out occurs, the manager can ensure that mothers receive the care they need without having to wait for a distant, centralized authority to intervene. This flexibility is crucial for maintaining continuous service delivery and directly responding to patient needs.

The health work narrated that;

"We can relocate supplies from OPD to maternity section in case there are stock outs in the maternity ward." (IDI 2, Health Worker at Mayanga HCIII, May 2025).

Theme 2. Challenges of the decentralized framework

Despite the improvements, some challenges remain under the current decentralized framework. The most prominent issue is severe understaffing. Some health facilities have only a fraction of the recommended number of health workers. This leads to midwives being overworked and managers having to deploy enrolled nurses who have little knowledge on maternal health issues. There is a lack of specialized staff, such as lab technicians, which results in patients missing out on necessary tests and being referred to other facilities. Similarly, the absence of a midwife in some units means no deliveries can be conducted there.

This was highlighted by one of key informants he highlights a critical gap in the effectiveness of administrative decentralization in Mitooma District. While the policy has been successful in establishing and equipping health facilities, it has failed to address the human resources component. The key informant points out a serious challenge: a facility has the necessary physical infrastructure a fully equipped lab but lacks the essential staff to operate it. This reveals a disconnect between infrastructure development and human resource deployment under the current framework. As a result, even though the facilities are closer to the people and may have the equipment to provide certain services, they are forced to refer mothers for tests that could otherwise be conducted on-site. This not only undermines the goal of bringing services closer but also creates inefficiencies in the healthcare system and can lead to patients missing out on care.

In her own words the health facility In-charge narrated that:

"We don't have enough manpower like we don't have a lab person; the lab is there with everything but there is no person." (IDI 3, Health Worker at Kigyende HCII (May 2025))

To emphasize the above, an in-charge of one of the health facilities points to a critical challenge in maternal healthcare service delivery in Mitooma District: severe understaffing. The respondent explains that due to an overwhelming workload, the sole midwife is unable to handle all the mothers. As a result, the in-charge is forced to deploy an enrolled nurse who has "little knowledge on maternal issues," to assist. This practice highlights a significant knowledge gap and potential risk to maternal and child health outcomes, as essential services may be provided by inadequately

trained personnel³. The statement directly illustrates how understaffing compromises the quality of care, a key concern in the decentralized framework.

As she remarked:

"Our midwife is over worked and I end up deploying an enrolled nurse who has little knowledge on maternal issues." (IDI 5, IDI 1, Health Worker at Kanyabwanga HCIII, May 2025)

Similar views were held by one other health facility In-charge; she emphasized the sorry state of staffing not only in the health center that he heads but across the entire subcounty.

She emphasized:

"There has been little positive impact in regard to staffing, we are still understaffed for example, having one midwife attending to all mothers in the sub county and this under staffing may reduce the number of mothers seeking MHC." (IDI 5, IDI 1, Health Worker at Kanyabwanga HCIII, May 2025)

Another major challenge is the poor state of the referral system. Facilities lack ambulances, forcing health workers to use their own personal cars or relying on "boda-bodas" (motorcycle) for emergency transport, which is risky for pregnant mothers. Patients are sometimes required to provide money for fuel, and if they cannot, the in-charge has to support them financially. The lack of ambulance services has contributed to home deliveries and maternal deaths due to complications like over-bleeding. This was elaborated by one health facility administrator as he points to a major failure in the decentralized system's ability to provide a consistent and reliable referral system. The key informant highlighted a critical gap: while some health facilities may have ambulances, others do not. This lack of a dedicated ambulance creates significant challenges, especially during emergencies, and directly compromises patient safety. The statement reveals that the distribution of resources, in this case, emergency transport, is not equitable across all health facilities, which undermines the goal of improving healthcare access for everyone in the district.

As she narrated:

"There are challenges in the referral system, when there are emergencies, we have issues with transport means since we don't have an ambulance here and yet some facilities have." (IDI 1, Health Worker at Kanyabwanga HCIII, May 2025)

This was emphasized by another health facility in charge, elaborating the burden of the unreliable ambulance service which is shared across several health facilities.

In her narrative, she mentioned that;

"Here the referral system is not good, we are supposed to be calling an ambulance from Mitooma health center but not all the time we call the ambulance is available." (IDI 1, Health Worker at Kanyabwanga HCIII, May 2025)

Another health worker exposed a critical flaw in the referral system under the decentralized framework. The participant highlighted the severe lack of reliable transport for emergencies, forcing them to use their personal vehicle to transport referred mothers. When the in-charge is unavailable, a far more dangerous alternative relying on “boda-bodas” (motorcycle taxis) is used to transport expectant mothers. This situation shows that while authority and services have been brought closer to the community, the necessary resources, specifically emergency transport, have not been equitably distributed or adequately provided. The reliance on private cars and risky motorcycle taxis directly compromises the safety of both the mother and child, and undermines the primary goal of improving maternal health outcomes through decentralization.

The in-charge narrated this as follows;

"When I am around, I take the referred mothers with my small car to Mitooma HC IV, if am not around, the boda-bodas are called upon to carry expecting mothers and their caregivers." (IDI 1, Health Worker at Kanyabwanga HCIII, May 2025)

Finally, there are challenges related to supplies and infrastructure. Some facilities experience stock-outs of supplies, particularly for family planning, which is attributed to the withdrawal of a former supplier. There is also a shortage of infrastructure, with some units lacking a maternity ward. This was highlighted by a comment from a health worker who revealed the difficulty of consistently meeting high demand for specific services. While the key informant noted that decentralization has increased the number of mothers seeking family planning, the supply chain cannot keep up. This results in frequent stock-outs, which undermines the positive gains made in improving access. The quote also hints at a previous, more reliable supply system when an external organization, USAID, was involved, suggesting that the current local procurement or distribution channels are not yet fully effective.

She commented:

"The challenge is that we have stock outs of supplies for family planning since the demand is high. Sometime back when USAID was still supplying, we used not to

have such stock outs but ever since USAID withdrew, we have challenges of stock outs." (IDI 3, Health Worker at Kigyende HCIII, May 2025)

Another statement from a key informant discussed a severe failure in the implementation of the decentralized system: the presence of health facilities that are fundamentally unable to deliver essential services. The respondent pointed out a challenge regarding critical deficiencies by having no maternity ward, no midwife, and therefore, no deliveries. This highlights that while decentralization may have brought the *idea* of a health facility closer to the community, the execution is incomplete. Without the basic infrastructure (a maternity ward) and the necessary human resources (a midwife), the facility cannot fulfill its primary function of assisting with births. As a result, expectant mothers are forced to seek care elsewhere, undermining the goal of improved access and potentially leading to unsafe home deliveries. The statement represents a major gap between policy objectives and on-the-ground reality, where a facility's mere existence does not guarantee a functioning service.

She remarks:

"We don't have a maternity ward here, no midwife, and therefore no deliveries are conducted here..." (IDI 6, Health Worker at Nyakishojwa HCIII, May 2025).

4.3.2 Extracts from Objective 2: To examine the barriers women, face in receiving maternal health care service delivery in Mitooma District.

The findings for this objective are based on data from both Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) with pregnant women, new mothers, and family members of the mothers. The analysis focused on understanding the practical, infrastructural, and systemic challenges that women encounter when trying to access and utilize maternal health services. The data was grouped into three major themes, each supported by verbatim quotes from the participants to provide a detailed and authentic account of their experiences.

Theme 1: Shortages of Human Resources and Gaps in Service Quality

This theme highlights the critical challenge of understaffing and the resulting impact on the quality of care. Participants reported a lack of essential personnel, particularly midwives, which leads to overworked staff and compromises the level of care. There are also instances of poor staff attitude,

which has a negative effect on women's trust in the healthcare system. A participant explicitly calls for an increase in personnel to meet the growing demand for maternal health services. This suggests a direct contradiction: while decentralization has successfully brought services closer to the community, resulting in a higher number of mothers seeking care, the human resources have not been scaled up to match this increased demand. This creates a new set of challenges, as overworked staff may struggle to provide quality care, potentially leading to dissatisfaction and a decline in overall service delivery.

The participant explicitly stated:

"The local government should Increase on staff to attend to an increased number of mothers seeking for maternal health services." (IDI 6, Health Worker at Nyakishojwa HCIII, May 2025)

The participant pointed out that due to staffing issues, pregnant women are given appointments for only one day a month. This rigidity creates a major barrier, as missing an appointment for any reason means a woman must wait another full month for care. This not only delays critical antenatal care but also highlights the over-reliance on a limited number of staff, particularly midwives, which directly compromises the accessibility and timeliness of care. In her narrative she noted:

"Due to staffing challenges, and mostly midwives. Because here they give us one visit in a month and in case one misses the appointment, she must wait for the next month." (IDI 3, Health Worker at Kigyende HCII, May 2025)

One of the FGD participant's highlighted that the physical distance to a health center with specialized staff is a significant problem. This revealed a critical imbalance where local facilities may be geographically closer, but their lack of skilled staff forces women to travel to more distant, better-equipped facilities. This undermines the intended benefit of bringing services closer to the community and creates a burden for mothers who must travel further, incurring time and cost, to receive the care they need. The key informant informed the interviewer that;

"There is need to have skilled workers here at Kigyende HCII so that women are relieved of the burden of going to Kanyabwanga HCIII." (FGD 1, Pregnant Mothers at Kigyende HCII, June 2025)



Figure 3: FGD with Mothers at Nyakishojwa HCIV

Another FGD participant highlighted a critical issue related to poor staff attitude and its direct impact on patient trust and care-seeking behavior. The discussion revealed a critical breakdown in service delivery: a health worker failed to respond to a call for help from a pregnant mother in labor. This neglect forced the mother to seek care at a different, more distant facility (Mitooma HCIV), and left her with a negative experience that would likely discourage others from using the first facility. The key informant demonstrates that even when services are physically closer, negative interpersonal experiences can become a major barrier. The perceived lack of empathy and professionalism from health workers can erode a community's confidence in the healthcare system, undermining the positive gains of decentralization and potentially leading to a return to risky practices like home deliveries.

Actual word by the key informant:

"One pregnant mother went to Kanyabwanga HCIII at night to deliver and the care giver called a health worker to conduct a delivery and she did not wake up. A pregnant mother decided to go and deliver from Mitooma HCIV and she was not happy with health workers in Kanyabwanga." (FGD 2, Pregnant Mothers at Muyanga HCV, June 2025)



Figure 4: FGD with Women at Mayanga HC1V

Theme 2: traditional beliefs and religion

Data suggests that some women continue to seek maternal health advice and services from non-medical sources such as their mothers-in-law, elderly women in the community, and traditional healers. Mothers-in-law often share experiences from their own time, claiming that childbirth was manageable without hospital visits. They emphasize the use of herbal remedies and assert that they were able to give birth to healthy children without modern medical intervention. In addition, some women reported visiting traditional healers, who advise them to listen to ancestral spirits for guidance regarding the health of both the unborn child and the mother. These practices are often rooted in long-standing cultural beliefs. Data also revealed that religion also plays a significant role in shaping health-seeking behavior. Some mothers indicated that certain religious leaders, particularly those from newly established "Born Again" Christian churches, actively encourage the community to rely solely on prayer for all forms of support. These leaders preach that God is the ultimate provider and source of healing, thereby discouraging the use of formal maternal health services.

A key informant narrated the story as follow:

“You see, some women still ask their mothers in-laws about maternal health and those in-laws complain to us that we waste money going to the hospitals and yet they were able to produce our husbands without hospital innervations, they tell us to use herbals, “emumbwa”, and steaming to prepare for a healthy delivery” (FGD 3, Pregnant Mother, Kirengye HCII, 2025)

Another mother added:

“Let me tell you another problem. The new religion called “Abalokole” has diverted people from reality to spiritual beliefs. They tell people including mothers to seek everything they want through prayers, and as a result some people die in the churches and nothing is done about them. You doctors should come to the community and educate people about the se churches” (FGD 3, Pregnant Mother, Kirengye HCII, 2025)



Figure 5: FGD with Mothers at Kirengye HC11

2. Inadequate Infrastructure and Lack of Essential Supplies

This theme addresses the physical and material shortcomings that serve as barriers to effective maternal healthcare. Participants noted that even when facilities are available, they may be incomplete or lack essential equipment like lab facilities, ultrasound scans, and even basic supplies like maama kits. A statement from one of the key informants, revealed a gap in maternal health

care services under the decentralization framework. It shows that While services may be closer geographically, they lack the necessary infrastructure and equipment to provide comprehensive care. The key informant explicitly stated the need for a theatre and an ultrasound scan, revealing that without these essential tools, patients are forced to travel to other facilities, such as Bitereeko HCIV, to access crucial diagnostic services. This creates a burden on patients, negates some of the benefits of having a nearby facility, and highlights a disconnect between the policy of bringing services closer and the provision of adequate resources. During the interview, the key informant mentioned;

"We need a theatre and ultra sound scan because if you want scan services you must go to Bitereeko." (IDI 3, Health Worker at Kigyende HCII, May 2025))

Another key informant emphasized the reality that even after facilities have been upgraded, they may not be fully functional. Her statement suggests that some facilities have been physically improved but still lack critical equipment and supplies. This statement underscores a key challenge: a policy of decentralization that focuses on building new structures without fully resourcing them with the necessary tools and services will not fully meet the needs of the community.

She states:

"Finishing and equipping the upgraded HC III and providing laboratory services is crucial, and yet here at our health center, we lack we have many services we offer to mothers but we still lack some equipment even though the facility has been upgraded to HCIII " (IDI 4, Health Worker at Mayanga HCIII (May 2025))

Another FGD participant pointed the discussion to timeliness and consistency of supplies especially mama kits. The lack of timely provision of these kits forces mothers to either purchase them themselves, which presents a financial burden, or go without, which compromises the safety of both mother and child during delivery. This directly contradicts the goal of providing free and accessible services under the decentralized framework.

The participant narrated that:

"They health workers should always give us maama kits in time to get prepared before giving birth but they wait when it is very late and give us maama kit when some women have already wasted money to buy items which are the same time provided in maama ki." (FGD 3, Pregnant Mother, Kirengye HCII, 2025)

Theme 3. Dysfunctional Referral and Transport System

While services have been brought closer to the community, the referral system remains a major barrier, particularly during emergencies. Participants consistently pointed out the lack of ambulances, which forces them to rely on unsafe and costly alternatives for transportation. One of the key informants highlighted two critical and interconnected barriers to effective maternal healthcare: the shortage of staff and the dysfunctional referral system. The request to "increase on the number of staff" directly addresses the issue of understaffing, which is a recurring theme in the provided data. The second part of the request, to "provide an ambulance for transporting women who are referred for operation," underscores the severity of the referral system's failures. This patient-level perspective makes it clear that the lack of a reliable transport system is not just an administrative problem but a direct risk to the health and safety of mothers who require emergency care. The need for both more staff and an ambulance to transport patients for "operation" shows that even with services brought closer to the community, the most critical medical needs cannot be met without these two fundamental resources.

She remarks:

"To increase on the number of staff, and provide an ambulance for transporting women who are referred for operation. This is because our mothers suffer and some can even die on a boda-boda. We request the government to address this problem to save the lives of mothers" (IDI 6, Health Worker at Nyakishojwa HCIII, May 2025)

One of the key informants revealed that it shows that while antenatal care (ANC) may be accessible and satisfactory, the system fails at the most critical moment: the participant's personal story being in labor on a rainy day, a "boda-boda" refusing to take her due to poor roads, and being forced to deliver at a private clinic is a powerful illustration of the failures in the referral and transport system. This experience underscores that even with a nearby health facility, poor infrastructure and the lack of an ambulance can directly compromise a mother's safety.

The emotional impact of her experience is also clear: she was "not happy" because she was unable to complete her journey with government health workers. This points to a loss of trust in the public system. Furthermore, delivering without a "maama kit," which she had been promised, reveals a failure in the supply chain and a direct contradiction of the government's promise to provide essential materials for delivery.

Finally, her comment on postnatal care that only babies are immunized and no other services are provided exposes another critical gap in the continuum of care. This demonstrates that the challenges are not isolated to a single service but exist across different stages of maternal healthcare.

Participant's narrative:

“Very good ANC services, but when it comes to deliver, we meet problems. Like me when I got labour pains, it was a rainy day, boda-boda refused to take me up, to Kanyabwanga HC III due to poor roads, I was forced to deliver from a clinic and I was not happy because I started with government health workers but could not end with them, I even delivered without a maama kit because they had promised to give it to me when I come to deliver. For postnatal, they only immunize babies and no other services are given to them and yet young babies have a lot of complications.” (FGD 3, Pregnant Mother, Kirengye HCII, 2025)

A statement of one of the participant's pointed out that the community is comprised of "subsistence farmers" who have "meager incomes," which means that even small expenses can be a major obstacle. This is especially true for the cost of transport, which is often a financial burden for families. The fact that a woman might be hindered from attending antenatal care because she cannot afford a maternity dress, which "health worker always encourage us to put on," shows a disconnect between the medical advice and the economic reality of the community. This indicates a lack of culturally sensitive and economically appropriate guidance, where a seemingly minor social expectation becomes a major barrier to essential healthcare. This highlights that challenges to maternal healthcare are not only medical but are deeply intertwined with economic and social factors. The participant explained that:

“People here are subsistence farmers and earn meager incomes, husbands can offer some money to their wives in case of need. Lack of maternity dresses can hinder women from attending to ANC since health worker always encourage us to put on maternity dresses.” (IDI 6, Health Worker at Nyakishojwa HCIII, May 2025)

The effects of the financial barriers were further emphasized by other participants as below:

Poverty may hinder some mothers from seeking for services e.g. if someone doesn't have money to buy a pamper for a baby to be taken for immunization, she may skip that visit. Or someone may opt to go and work for money or food when the home is poverty stricken instead of attending to ANC. (IDI 2, Health Worker at Nyakishojwa HCIII, May 2025).

4.3.3. Objective: To evaluate the local government capacity to improve maternal health care delivery in Mitooma District.

This section presents the data for Objective 3 of the study, which examined the role and capacity of the local government in maternal healthcare service delivery in Mitooma District. The analysis was based on data collected through Key Informant Interviews (KIIs) with district-level administrators and health officials. The objective was to understand how the local government perceives its role, what its key functions are, and the challenges it faces in effectively supporting maternal health outcomes under a decentralized framework. The following sections are organized into three major themes, each supported by verbatim quotes from the participants to provide a detailed and authentic account of their experiences.

Theme 1: The Role of Local Governments in Service Provision and Oversight

This theme highlights the perceived and actual responsibilities of the local government under decentralization. The key informants view their role as central to ensuring that maternal health services are accessible, well-supplied, and properly monitored. They see themselves as facilitators of service delivery, responsible for both human resources and logistics. Many statements from key informants illustrate the local government's awareness of its core responsibilities under a decentralized framework. They see themselves as the central administrative body responsible for both the human resources (recruiting staff) and logistics (providing medicine and equipment) that are essential for effective service delivery. The mention of supervision and monitoring also indicates that the local government understands its role in quality assurance and accountability. This narrative was made to confirm that the local government's self-perception aligns with the fundamental principles of decentralization, which is to bring decision-making and resources closer to the point of service delivery. The key informants (CAO) narrated that:

"Our role is to ensure that all staff are recruited and that services are brought nearer to people and it's our role at the helm to supervise and monitor to guarantee that those desired services are delivered by the health workers." (IDI 2, CAO at District HQ, April 2025)

In relation to the health services, another informant pointed out the specific roles of the local government is providing health services. In his words he narrated that:

"We also ensure that the necessary medicine, equipment is all in place, without them we cannot definitely deliver the required services to the public or what we call service beneficiaries. The government provides drugs, health workers, infrastructure development and equipping the health unit " (IDI 2, CAO at District HQ, April 2025)"

2. Gaps in Local Government Capacity and Motivation

This theme addresses the internal challenges and limitations faced by the local government that hinder its ability to effectively support maternal healthcare. The responses revealed that key administrative and supervisory personnel are often demoralized due to salary disparities and a lack of proper facilitation, which directly affects their ability to perform their duties. This was pointed out by one of the participants as he emphasized the demotivating effect of segregation in salary scales for local government staff.

"But the challenge remains because the supervisors appear to be demoralized such as SAS who were not favored by the current salary structure that enhanced the salaries health workers forgetting that a health worker don't work alone..." (IDI 2, CAO at District HQ, April 2025)

Another participant pointed out the issue of inadequate facilitation for key personnel and a lack of resources. The participant mentioned that the Chief Administrative Officer (CAO), despite playing a crucial coordinating role, is "not well facilitated." The most striking example of this is the lack of a dedicated vehicle. Hence, having to "commandeer" the vehicle of the health department, the CAO is forced to compromise the department's ability to conduct its own monitoring and supervision activities. This illustrates a critical resource deficit at the highest level of district administration, which has a ripple effect on the entire health system. Data indicates that the lack of proper tools for key coordinators directly undermines their ability to perform their duties, ultimately hindering the effective implementation of decentralized health services. While narrating, the key informant mentioned that;

"On the other hand, the CAO is not well facilitated and yet he plays a big role as a coordinator of all activities in the whole district. The CAO doesn't have a vehicle, I am commandeering, just using the vehicle of health department therefore I am depriving health department of that vehicle they should be using to monitor." (IDI 2, CAO at District HQ, April 2025)

3. Recommendations for Enhancing Local Government Support

This final theme summarizes the specific recommendations made by the key informants to improve maternal health outcomes. The suggestions focus on addressing the root causes of the challenges,

including a need for increased funding, better infrastructure, and improved human resource management to ensure that the decentralized system can operate at its full potential.

A key informant suggested a list of recommendations;

The first recommendation is to "enhance remuneration of supervisors," specifically mentioning SAS and TCs, who are administrative or supervisory staff. The narrative suggests that the current salary structure is "demoralizing," which directly impacts their motivation and effectiveness. The second recommendation is "infrastructure development" because some facilities are in an "appalling state." This points to a failure in the decentralized system to provide or maintain the necessary physical structures for service delivery. Finally, the key informant asked for "recruitment and ensure all the required staff are posted to the health facility." This underscores the recurring theme of understaffing which is a major barrier identified by all levels of respondents. The call for both recruitment and proper deployment indicates a systemic issue where simply hiring staff is not enough; they must be placed where they are needed to ensure the system functions properly.

The researcher captured the interviewee as mentioning that;

"Enhance remuneration of supervisors i.e., the SAS and TCs, Infrastructure development in that some of them are in appalling state. Recruitment and ensure all the required staff are posted to the health facility." (IDI 2, CAO at District HQ, April 2025)

Another key informant recommended the increase in funding, he presented that; there is a fundamental disconnect between the policy of decentralization and its financial reality. While local governments are tasked with providing essential maternal healthcare services, they are not being given the financial resources required to do so effectively. This funding gap serves as a major barrier, as it affects everything from the recruitment and remuneration of staff to the acquisition of supplies and the maintenance of infrastructure. The statement is a clear call for increased financial support, without which the local government's capacity to deliver on its mandate is severely limited.

The key informant stated that;

"The government must increase on the funding because the current funds are not commensurate with the services that were supposed to deliver." (IDI 2, CAO at District HQ, April 202)

A related key informant emphasized the need to deliver adequate supplies and health workers: The respondent pointed out that for the system to work effectively, the local government must ensure a reliable flow of drugs and equipment to the health facilities. This addresses the frequent stock-outs and lack of necessary infrastructure that were noted by other informants. Secondly, the call for the "deployment of health workers" underscores the pervasive issue of understaffing. This is not just a plea for more personnel but a demand that the staff, once recruited, are actually placed in the facilities where they are desperately needed. The quote serves as a powerful synthesis of the major challenges and provides a clear roadmap for action.

He pointed out:

"Supply of drugs, equipment and deployment of health workers. Recruit and ensure all the required staff are posted to the health facility. Ensure that all sub counties have HC III, Upgrading of HCII s to HC III status. Increase on the funding because the current funds are not commensurate with the services that were supposed to deliver. (IDI 2, CAO at District HQ, April 2025)

CHAPTER FIVE

DISCUSSION OF THE STUDY FINDINGS

5.0 Introduction

This study was guided by three main objectives, and the findings are discussed in line with the data collected from the field. Since the study used a purely qualitative approach, the aim was to explore participants' views, experiences, and opinions on decentralization and its impact on maternal health service delivery. During the analysis, common patterns emerged across different respondents, which were grouped into relevant themes. The data is presented according to these themes, which also structure the discussion of the findings. Each finding is discussed alongside its practical implications, as well as comparisons with existing literature to highlight areas of agreement, contrast, or new contributions. This approach provides a deeper understanding of the issues raised and helps to place the study within the wider body of research on maternal healthcare and decentralization.

5.1 Discussion of Findings for Objective 1: To assess the effectiveness of devolution, delegation, and deconcentration in improving access to maternal health care services in Mitooma District.

According to the data gathered from the field after interacting with participants and analyzing the responses, the findings for Objective One show that decentralization has improved maternal health service delivery in Mitooma District. However, some challenges still remain in the delivery process. The responses from key informants point to two main areas of improvement: better access to services and more effective local decision-making.

5.1.1.1 Improvements in Access to Services

Most key informants noted that general services are now closer to the people. As a result, this has reduced travel distances for patients, especially mothers seeking antenatal care and delivery services. Previously, patients had to travel long distances to access care. Now, health centers such as Mayanga and Kigyende have been upgraded from Health Centre II to Health Centre III. These upgrades have enabled the facilities to offer more services, including deliveries, admissions, and

antenatal care. In regard to maternal health care service accessibility and availability, a key informant confirmed that mothers no longer need to walk long distances or rely on home deliveries. She explained that the new status of health centers has made a big difference in access and has helped village residents save on transport costs. In support of the same outcome, another health worker noted that more mothers are now coming to health centers for services, which confirms that the change has improved service uptake. Therefore, these improvements reflect the effectiveness of devolution and deconcentration in making health services physically available at the local level. When services are near, people are more likely to use them, especially in rural areas where transport is limited and costly.

This finding is supported by the previous scholars on similar study. Hence Namazzi et al. (2015) reported that when lower-level health facilities in rural eastern Uganda received district-led training, supervision, essential equipment, and supply support, facility-based deliveries increased by 30%, rising from 3,151 to 4,115 over two years. This demonstrates that better-equipped and more accessible facilities can lead to greater use of maternal health services. Another study by Waiswa et al. (2014) describes a Health Centre III that lacked delivery beds and clean delivery kits. Once those key items were supplied and the maternity ward reorganized, delivery numbers steadily rose, demonstrating that upgrading facility capacity directly improves maternal service uptake.

5.1.1.2 Increased Local Decision-Making and Responsiveness

Data revealed that decentralization has increased decision-making authority at the facility level, particularly in efforts to improve service delivery in maternal health, which was the main focus of this study. As a result, health facility managers and in-charges now have more control over staffing, supplies, and daily operations. For example, a key informant explained that they can reassign staff between departments depending on patient needs. When many mothers come for services, the in-charge can move staff from the Outpatient Department to maternity to manage the workload. Health Facility managers also have some authority over personnel. A key informant shared that they can take action when staff fail to perform their duties, including recommending dismissal or reporting to the District Health Officer (DHO). In addition, they can recruit temporary support staff, such as security guards, when needed. Hence, this allows facilities to remain functional and secure without delays.

The findings of this study revealed that decentralization has expanded decision-making authority at the facility level, giving managers and in-charges more control over staffing, supplies, and daily operations. This is consistent with Bossert et al. (2021), who used the “decision space” framework in Uganda and established that facility-level managers had gained greater authority over personnel management and supply chain decisions. The ability to discipline staff, reassign them, or recruit temporary workers locally, as seen in this study, directly reflects Bossert et al.(2021) observation that discipline-related decisions are increasingly handled at the facility level, although recruitment and promotion remain centralized

Similarly, the results indicated that facility in-charges could reallocate staff (e.g., moving from OPD to maternity) and order essential drugs directly based on patient demand. This agrees with Onweng Anguzu et al. (2004), who evaluated district hospitals in northern Uganda and found that decentralization enhanced responsiveness and improved maternal service delivery by empowering staff to manage operations effectively. It also resonates with Twesigye et al. (2023) in Sheema District, who reported that financial decentralization improved maternal health quality since local control over budgets allowed facilities to procure supplies in line with real-time needs

The study further showed that decentralization enabled facilities to recruit temporary support staff like security guards to maintain functionality. This reflects Sparrow (2022), who noted that localized decision-making under decentralization allows health managers to prioritize interventions that directly address community challenges, thereby ensuring service continuity

Moreover, improved communication between facilities and the DHO, where monthly reports led to quicker responses such as posting new midwives, demonstrates the responsiveness of decentralized systems. This aligns with Chol et al. (2023) and Miah et al. (2023), who emphasized that decentralization strengthens health systems by improving accountability and responsiveness to local needs

Finally, these results are supported by global evidence. In Bangladesh, decentralization was found to improve efficiency and accountability in maternal service delivery (Miah et al., 2023), while in Indonesia, decentralized financing increased antenatal care visits and reduced home births (Sparrow, 2022). These studies reinforce the current finding that greater autonomy at facility level enhances the ability to respond quickly to patient demands, thereby improving maternal health outcomes.

Ordering essential drugs and supplies based on patient demand is another key improvement. According to data, previously, facilities had to wait for whatever was sent to them. Now, they can place direct orders based on actual needs. A health worker explained that this change helps them avoid stock-outs and better serve patients. In cases where supplies run out, one informant said they can move resources from one department to another, such as transferring supplies from outpatient care to maternity, to keep services running.

There is also improved communication between facilities and the district health team that was noticed through data analysis. In-charges submit monthly reports and receive responses from the DHO. A key informant noted that persistent requests led to the posting of a new midwife at their facility. This shows that the system now allows quicker responses to local problems mostly related to maternal health care.

These findings are backed by previous studies on similar aspects as compared to the current study findings. therefore, the current findings agree that a study by (Bossert et al., 2021) about the “decision space” framework in Uganda found that facility-level managers gained greater authority over specific managerial functions, especially in personnel management and supply chain decisions. As compared to the current study, this study also found out that discipline-related decisions have increasingly fallen under facility-level control, while tasks like recruitment and promotion remain centralized. Hospitals and Health Center IVs were found to have significantly greater autonomy in placing drug orders, suggesting that the push–pull supply system allows facilities to respond to actual demand (Bossert et al., 2021). Increased decision space was also associated with improved performance in areas such as essential drug ordering (Bossert et al., 2021). These findings directly support the observed ability of facility managers to reassign staff, manage supplies dynamically, and avoid stock-outs.

Similarly, an evaluation of two district hospitals in northern Uganda found increased patient attendance and perceived improvements in service delivery, especially in maternal health (Onweng Anguzu et al., 2004). Facility staff reported that decentralization empowered them to manage operations more effectively and enhanced community trust, although logistical and financial challenges still persisted. Another related study in Sheema District indicated that financial decentralization significantly improved the quality of maternal health services, suggesting that greater local control over budgets enhances responsiveness and service outcomes (Twesigye et al.,

2023). This supports findings that health facility managers can now order supplies based on real-time patient demand, reducing stock-outs and service disruptions. Alongside similar studies, this study contributes to a better understanding of how decentralization is perceived to have provided solutions in local service delivery, particularly in relation to maternal health.

5.1.1.3 Implications for objective one findings

The findings suggest that decentralization has made maternal health services more accessible and responsive in Mitooma District. Bringing services closer to rural communities has reduced transport barriers, discouraged home deliveries, and improved the use of health services. This is a positive step toward safer childbirth and better maternal health outcomes. Also, delegation of authority at the facility level has improved how services are managed. Health workers and facility heads can now address issues in real-time without waiting for higher offices. This flexibility helps maintain service continuity and meet the specific needs of the community. However, while the findings show progress, the level of autonomy still varies. Some decisions must go through the DHO, which may limit responsiveness in urgent cases. The system depends on strong coordination and support from district leadership to function well. Therefore, decentralization in Mitooma has improved both access and operational efficiency in maternal health care. Continued support for facility-level autonomy and regular supervision from the district health office will be key to maintaining and building on these milestones.

5.1.2 Theme 2: Challenges of the Decentralized Framework

While decentralization has improved access to maternal health services in Mitooma District, data still revealed that several major challenges continue to affect the quality, consistency, and reliability of care regarding maternal health care service delivery. These challenges relate mainly to staffing shortages, weak referral systems, and supply and infrastructure gaps.

5.1.2.1 Staffing Shortages

According to the data, understaffing in lower health facilities is the most critical issue raised across nearly all health facilities in which this study was conducted. Accordingly, many centers operate with only one midwife, or in some cases, none at all. This forces in-charges to assign enrolled nurses with limited maternal health training to assist with deliveries. This practice puts both mothers and babies at risk, especially when complications arise. The overworking of the few available qualified staff further reduces service quality. Hence, one key informant explained that

their facility has a fully equipped laboratory, but no lab technician to operate it. The equipment is present, but without staff, it sits unused. Mothers are referred elsewhere for basic tests, even when the tools are available on-site. Another participant emphasized that one midwife is expected to serve all mothers in the entire subcounty. This compromises care and discourages mothers from seeking services. Therefore, this mismatch between infrastructure and human resources weakens the intended impact of decentralization. Facilities may exist and be well-equipped, but without skilled staff, they cannot function.

Similar concerns have been raised in other studies conducted in Uganda and sub-Saharan Africa. For instance, Nalwadda et al. (2011) found that the shortage of skilled health personnel, particularly midwives, significantly limited the provision of quality maternal care in rural facilities. Their study reported that health workers were frequently required to perform tasks beyond their training, increasing the risk of poor maternal and neonatal outcomes. Likewise, Tumwine et al. (2021) highlighted that while decentralization has improved infrastructure in many lower-tier facilities, the recruitment and retention of skilled personnel remain major challenges. Facilities often have the necessary equipment but lack trained staff to operate it, leading to underutilization of resources. Moreover, the overburdening of the few available health workers contributes to burnout and poor patient experiences, especially in maternal health services. These systemic gaps suggest that decentralization alone is insufficient unless accompanied by deliberate strategies to strengthen human resource capacity at the local level.

5.1.2.2. Referral and Emergency Transport Gaps

According to the findings, the referral system in the district is unreliable. Most facilities which were visited during the study, lack ambulances and depend on calling vehicles from larger health centers, such as Mitooma Health Centre IV. However, these ambulances are not always available. It was found out that in emergencies, health workers (mid-wives) often use personal cars or boda-bodas (motorcycle taxis) to transport mothers. As a result, this is both unsafe and unsustainable. One key informant explained that they use their small car to transfer patients, when possible, but if unavailable, the mother must risk a boda-boda ride. In other cases, the health worker is forced to give the patient money for fuel or seek support from others. These informal solutions increase the chances of delay, complications, or maternal death during emergencies. Therefore, while decentralization has given more decision-making power at the facility level, it has not ensured

equal distribution of key resources like ambulances. Some centers have transport, others do not, and this creates wide gaps in patient safety across the district.

As compared to this study, other several studies document the unreliability of referral systems and the critical transport challenges faced in Uganda's lower health facilities. A mixed-method study in eastern Uganda found that most health facilities lacked referral transport systems, leading staff to improvise with boda-bodas, an unsafe and suboptimal method, especially for mothers in critical condition (Namazzi et al., 2017). Moreover, at Kamuli and Pallisa districts, health workers recounted using motorcycle taxis during emergencies when ambulances were either unavailable or too distant, causing dangerous delays in referrals (Namazzi et al., 2017). Similarly, a study in south-western Uganda highlighted that, although ambulances existed at primary facilities, they were often non-functional due to mechanical failure or lack of fuel. Referrals required hiring vehicles from town, which led to significant delays and increased risk to patients (Nanyonga et al., 2023). One patient recounted being delayed while the ambulance made multiple unnecessary stops, exacerbating her condition (Nanyonga et al., 2023). Furthermore, a study assessing obstetric inter-facility ambulance transfers at Kawempe National Referral Hospital found that ambulance services were fragmented, with discrepancies in response times depending on whether they were government or non-government operated. The median transfer time for emergencies was 50 minutes; and substantial variation existed in medical care during transport, with many ambulances not meeting consistent staffing and care standards (Tumuhairwe et al., 2023). The lack of standardized protocols further undermined referral system effectiveness.

With reference to previous studies, this study acknowledges the serious problem of ambulance (transportation) services within health facilities, particularly those in communities under local government jurisdiction. As a result, the decentralization framework has not fully operationalized service delivery, especially in critical areas such as ambulance services. These gaps have frequently contributed to maternal and child health complications, including both prenatal and postnatal issues.

5.1.3.1 Supply Chain and Infrastructure Gaps

Another recurring issue according to data was the lack of consistent supplies, particularly for family planning. Health workers mentioned frequent stock-outs, which are linked to the withdrawal of former donors like USAID. The local system has not filled the gap effectively.

Mothers now come for services that cannot be delivered due to missing commodities. In some facilities, the problem is even more basic. There are no maternity wards and no midwives. As one in-charge plainly stated, no deliveries happen at their facility because the infrastructure and staff simply do not exist. This turns the health center into a referral point rather than a service provider. As a result, this failure underlines a key problem: decentralization brought facilities closer to people, but in some cases, only on paper. A building without staff or essential equipment cannot meet maternal healthcare needs.

Previous studies have also found supply chain and infrastructure gaps as compared to the current study. For example, a qualitative case study in Uganda's Rwenzori sub-region highlights how the withdrawal of donor support, such as from USAID, led to a resurgence of medicine and supply shortages. The National Medical Stores (NMS) struggled to meet demand, hampered by centralization, logistical delays, and unsynchronized procurement systems. These challenges resulted in frequent stock-outs after donor exit, undermining continuity in service delivery (Ssegujja et al., 2023). Similarly, a broader scoping review on donor transitions further revealed that in contexts where USAID withdrew, non-governmental organizations (NGOs) were often forced to diversify their service offerings, such as introducing pediatric and dental care to financially sustain core services like family planning (Ssegujja et al., 2023).

In Western Kenya, a mixed-methods study using mystery clients, focus group discussions, and interviews found that contraceptive stock-outs frequently demotivated health providers and eroded community trust. Health workers were often forced to advise clients to purchase supplies from outside the facility, which created delays, increased costs, and discouraged women from seeking care altogether (Tumlinson et al., 2023). In Uganda, the implementation of the "skilled birth attendance" policy encountered major challenges. Although there was notable progress in constructing physical infrastructure, the recruitment of skilled health workers lagged behind. Many facilities remained non-functional due to lack of essential equipment, electricity, water supply, and adequate staffing (Tumlinson et al., 2023). Lower-level health centres often lacked maternity wards, midwives, and even basic medical supplies. One respondent noted that the gaps were not necessarily due to high-cost equipment but rather basic deficits such as gloves or IV fluids. In many cases, facilities were staffed by only one midwife or none at all, rendering them incapable

of handling deliveries. As a result, these health centers acted more as referral points than actual service providers (Tumlinson et al., 2023).

5.1.3.2 Implications for objective one findings

These challenges demonstrate that decentralization alone is not sufficient to improve maternal healthcare. While bringing services closer to communities is an important first step, physical proximity does not automatically translate into access or safety. For decentralization policies to be truly effective, several critical areas require urgent attention. Staffing must be prioritized. Trained health workers, particularly midwives and laboratory technicians, are essential to the functioning of any health facility. Even the best-equipped centers cannot operate effectively without the human resources needed to deliver care. Hence, in many areas, the absence of skilled personnel renders facilities unusable for key maternal health services.

Equally important is investment in the referral system. Every health facility should have access to a reliable ambulance service. Currently, emergency transport is often dependent on personal vehicles or motorcycles, which are unreliable and unsafe in critical maternal emergencies. A functional and well-coordinated referral network is vital to reducing delays that could lead to complications or fatalities. Furthermore, Supply chains also require urgent improvement. Consistent and predictable delivery of medical supplies, particularly for essential services like family planning, is necessary to maintain trust in the health system. When women arrive at health centers and are turned away due to stock-outs, it not only disrupts care but also undermines public confidence in government services. Infrastructure must align with the level of care expected at each facility. A health center without a maternity ward or delivery room cannot meet even the most basic maternal health needs. Planning must go beyond erecting buildings and include equipping them properly and ensuring that they can be staffed and operated to full capacity. Finally, the distribution of resources must be equitable. While some facilities receive adequate support, others operate with minimal capacity or functionality. This uneven distribution creates disparities in access and outcomes, pushing some women to resort to unsafe alternatives such as home deliveries. Ensuring fair allocation of resources is necessary for consistent care across the entire district. Thus, while decentralization has led to visible improvements in the availability of health services, the experiences of health workers highlight serious gaps in implementation. Persistent issues such as understaffing, inadequate emergency transport, supply shortages, and poor

infrastructure continue to limit the effectiveness of the system. Therefore, it is necessary to address these structural challenges as a critical if decentralization is to deliver real and lasting improvements in maternal health outcomes in Mitooma District and other parts of the country as highlighted by this study and other previous studies referred by the researcher.

5.2 Discussion of Findings for Objective 2: Barriers Women Face in Receiving Maternal Health Care in Mitooma District

The findings from interviews and focus group discussions revealed that women in Mitooma District continue to face several serious barriers when trying to access maternal health services. These barriers fall under three key issues: staff shortages, service quality concerns, and poor health worker attitudes.

5.2.1. Staff Shortages and Delays in Service

According to data, women across the district face delays in receiving maternal health services because of a shortage of health workers, especially midwives. Most health centers do not have enough trained staff to match the growing number of mothers seeking care. In some cases, women are given appointments only once a month. If they miss that one visit, they must wait another full month to be seen. This delay creates a real risk for pregnant women who need regular antenatal check-ups. This was observed when a key informant stated that the local government should increase staffing to meet the high demand for antenatal services here at *Mayanga Health Center Iv*. The current staffing levels cannot support the workload, and overburdened midwives cannot provide the attention and adequate care each patient needs. As more women now seek services due to decentralization, the shortage of staff is becoming a bigger issue.

Challenges related to delayed maternal services are common not only in Uganda but in many parts of Africa. Women face delays in getting maternal health care when midwives are in short supply. For example, a study in villages around Addis Ababa, Ethiopia, shows that midwife shortages force health centers to reschedule pregnant women, sometimes delaying their appointments by weeks or even a month. That delay means many women never make it back (Abebe et al., 2021). In rural areas of Uganda, facilities often lack enough staff, and absenteeism is a big problem. Researchers found that doctors often do not show up for work during contracted hours. That absence slows responses, leads to delays in care, and drives up risk for pregnant women and

newborns (Nabudere et al., 2016). In addition, a survey in the Karamoja region in Uganda found health centers missing nearly half of the required midwives. That under-staffing left many women waiting longer and getting less care during visits (Adazu et al., 2015). Also, Midwives themselves describe being stretched thin. In focus groups in Ugandan public hospitals, they talk about working all night without breaks, juggling multiple roles, and losing focus. One midwife said, “when you are tired, you do not give proper services” highlighting how overwork directly affects care quality (Namukwaya et al., 2020). As compared to this study, putting it all together: not enough midwives, frequent absenteeism, and heavy workloads create real delays. Pregnant women cannot get timely check-ups. They may wait a month for the next appointment. That builds risk and frustration. Therefore, this study is very relevant and timely because issues to do with maternal health cut across the country as indicated by previous studies.

5.2.1.1 Limited Skilled Staff at Local Health Centers

While some facilities have been brought closer to communities, they often lack skilled health workers. For example, a participant pointed out that women in Kigyende still have to travel to Kanyabwanga HCIII to access better maternal health services, as their local health center lacks enough qualified personnel. This means that even though decentralization has reduced physical distance to health units, it has not solved the issue of unequal access to skilled care. Hence, without skilled staff, women are forced to travel further or delay treatment. This increases the cost, time, and risk involved in receiving care and can lead to complications that could have been avoided with timely intervention. This is a serious finding which the local government should pay attention while planning to ensure all the lower health facilities get skilled personnel as recommended by the national health guidelines.

A similar situation was reported in a study conducted in rural Tanzania, where decentralization expanded the number of health facilities in remote areas, but most of these centers remained poorly staffed. The study found that although health posts were geographically closer to communities, women continued to bypass them and travel long distances to better-equipped hospitals because the nearby centers lacked trained midwives and nurses. This behavior increased delays in accessing care and raised out-of-pocket costs for families (Kruk et al., 2010). The researchers concluded that improving access alone does not guarantee improved health outcomes unless facilities are staffed

and resourced well enough to provide quality care. This supports the finding that without skilled personnel, decentralization risks becoming a cosmetic reform rather than a functional solution.

5.2.1.2 Poor Staff Attitude and Lack of Trust in Services

Another major barrier according to the data is the poor attitude of some health workers. This was revealed by a woman who explained her experience that a pregnant mother in labor arrived at a health facility (name with-held) at night, but the staff on duty ignored the call. The mother had to travel again to another facility to deliver. This kind of neglect is not just disappointing but dangerous. It also damages trust in local health services. When women lose confidence in health workers, they may stop seeking care altogether or return to home deliveries. These negative experiences spread quickly through communities and undo the progress made in expanding access to care under decentralization framework.

Several previous studies highlight how negative attitudes and neglect by health workers create serious barriers to maternal care. Research from Tanzania found that disrespectful or unresponsive staff behavior discouraged women from using health facilities for delivery, pushing them instead toward home births with traditional attendants (Kruk et al., 2014). Similarly, a study in Kenya reported that women who experienced rude or inattentive care during labor were less likely to return for postnatal services or recommend the facility to others (Mackintosh et al., 2016). In Uganda, accounts from mothers show that such poor treatment not only endangers women physically but also erodes trust in the entire health system (Namatovu et al., 2017). These findings align closely with the data from Mitooma district, emphasizing that improving health worker attitudes is essential for maintaining confidence in decentralized maternal health services and ensuring women seek timely, facility-based care.

5.2.1.3 The influence of traditional beliefs, and religion is health seeking behaviour

The data reveals that traditional beliefs and religious ideologies remain deeply embedded in the maternal health-seeking behavior of some women. Despite the availability of modern healthcare services, several women continue to rely on informal sources such as mothers-in-law, elderly women, and traditional healers for maternal health advice and care. These sources promote herbal remedies and cultural practices such as steaming and the use of *emumbwa* (a traditional herbal mixture), with the belief that they ensure a healthy delivery without the need for hospital intervention. Therefore, the influence of mothers-in-law, in particular, reflects intergenerational

transmission of health practices. This not only sustains traditional norms but also creates a barrier to the uptake of modern maternal health services, especially when young mothers feel pressured to conform to family expectations.

Additionally, traditional healers and ancestral beliefs continue to play a role in maternal care, where women are encouraged to seek spiritual guidance from ancestral spirits for insight into their health and that of the unborn child. This belief system often results in a delay or complete avoidance of seeking skilled care from health facilities. Data also revealed that religious beliefs, particularly among some “Born Again” Christian groups (locally known as *Abalokole*), further complicate the situation. These groups reportedly discourage reliance on medical services and instead advocate for prayer as the sole solution to all health concerns. The data suggests that such teachings have led to preventable maternal deaths, with calls from community members for healthcare professionals to engage more actively in educating the public about the risks associated with this approach. These findings highlight how cultural and religious influences can undermine maternal health initiatives and hinder progress toward improving maternal and child health outcomes.

5.2.1.4 Implications of the staff shortages and delays in service

These findings show that the maternal health care system in Mitooma District still faces serious gaps, even after the implementation of decentralization. While decentralization has led to increased demand for services by bringing them closer to communities, the system has not adequately kept pace with this demand, particularly in terms of staffing. Many health facilities remain critically understaffed, especially with regard to skilled personnel such as midwives. This mismatch has resulted in delays in care and a decline in service quality. As a result, many women continue to travel long distances to reach better-equipped centers, undermining the very goal of decentralization, which is to provide accessible care at the community level.

Compounding these structural issues are deeply rooted cultural, traditional, and religious beliefs that influence maternal health-seeking behavior. In some cases, women may choose to consult traditional healers, elderly women in the community, or rely on guidance from their mothers-in-law, who advocate for herbal remedies and home-based care rooted in past practices. These beliefs, passed down through generations, often discourage women from seeking formal medical attention unless complications arise. The persistence of these practices is often reinforced by the lack of

trust in the health system due to poor staffing, limited equipment, and disrespectful treatment by health workers.

Religious influences also play a significant role, particularly among followers of some "Born Again" churches in the district. These groups often promote the idea that prayer alone can ensure safe delivery, discouraging mothers from attending antenatal visits or delivering in health facilities. In an environment where health services are already strained, such spiritual messaging can further delay or prevent women from seeking necessary care, sometimes with fatal consequences. In addition to these cultural and religious factors, the attitude of health workers significantly shapes whether women feel safe and respected when accessing services. Even when facilities are available and somewhat staffed, negative experiences, such as disrespectful language, dismissive behavior, or lack of empathy can deter women from returning or recommending care to others. Improving professionalism, accountability, and respectful care is therefore just as important as addressing physical infrastructure or staffing shortages.

Moreover, the rigid scheduling of services, such as limiting maternal health appointments to once per month adds another layer of difficulty. For women who have already overcome cultural reluctance and logistical barriers, being turned away due to inflexible schedules can be deeply discouraging. Health centers must explore more patient-centered approaches, such as staggered appointments or extended service hours, to better accommodate expectant mothers.

Ultimately, mothers in Mitooma District face a complex situation of practical, cultural, and human barriers to maternal health care. Addressing these challenges will require more than constructing additional facilities. There must be a concerted effort to invest in human resources, ensure reliable services, engage respectfully with cultural and religious norms, and rebuild trust in the health system. Only then can the promise of decentralization, of accessible, respectful, and quality maternal care, be fully realized.

5.2.2 Theme 2: Inadequate Infrastructure and Lack of Essential Supplies

According to data, health centers across Mitooma District continue to operate with serious infrastructure and supply gaps. Participants reported that even after upgrading certain facilities, many still lack key services and equipment. For example, several health units have no theatres or ultrasound machines, which forces pregnant women to travel to distant facilities like Bitereeko for

essential diagnostic services. This defeats the purpose of decentralization, which aimed to bring services closer to the community. This was narrated by a key informant who called for the immediate provision of both a theatre and an ultrasound scan at the health facility in the community. Another emphasized that despite an upgrade to HCIV level, her facility still lacked laboratory equipment and other critical supplies. This shows that construction alone is not enough. Without equipping these facilities, the system cannot meet the needs of pregnant women or ensure safe delivery. Also, the supply chain for essential items like *maama kits* is also unreliable. A focus group participant explained that these kits are often given out too late, after women have already spent money buying the same items. For women with limited incomes, this creates unnecessary financial pressure and undermines trust in the health system.

Similar challenges with infrastructure and supply gaps have been documented in other low-resource settings. A study in rural Tanzania found that many health centers were upgraded in name but remained poorly equipped, lacking essential tools like ultrasound machines and functioning theatres. This forced women to travel long distances for basic diagnostics and emergency care, increasing risks and costs (Kruk et al., 2016). In Uganda, research showed that health facilities frequently experienced stock-outs of critical supplies such as delivery kits and medications, leading to delays and extra out-of-pocket expenses for patients (Waiswa et al., 2015). These shortages not only hinder safe delivery but also damage community trust in the health system. Both studies highlight that investing in buildings alone does not improve maternal outcomes unless accompanied by reliable equipment, supplies, and effective supply chains, echoing the concerns raised by participants in Mitooma District.

5.2.3 Theme 3: Dysfunctional Referral and Transport System

Lack of a working referral and transport system remains one of the most dangerous weaknesses in maternal health care in Mitooma district. Participants repeatedly mentioned the absence of ambulances and the use of unsafe transport methods during emergencies. A key informant described how mothers are forced to travel on *boda-bodas* or rely on personal vehicles. Data revealed that some health centers share a single ambulance across many units, and in some cases, the ambulance is simply not available when needed. A participant described a personal experience where she went into labor during a rainy day. Poor roads and lack of transport forced her to deliver at a private clinic instead of the government health facility where she had received antenatal care.

She was disappointed that after all the preparation, including being promised a *maama kit*, she had to deliver without any government support. She also reported that postnatal care was limited to baby immunization, with no other follow-up services. This shows that even when antenatal care is available and of good quality, the system often fails when it matters most. The emotional and physical toll of this gap is clear. Mothers feel abandoned and unsafe. When emergency services are unavailable, it puts lives at risk and discourages others from seeking care.

Studies from other regions reflect on these concerns about weak referral and emergency transport systems in maternal health care. In a study conducted in northern Uganda, researchers found that the lack of ambulances and poor road conditions were major contributors to delays in accessing emergency obstetric care. Women often relied on boda-bodas or bicycles, even during labor, which increased the risk of complications and maternal deaths (Wilunda et al., 2014). Another study from rural Ethiopia reported similar findings: despite improvements in antenatal care, the absence of a reliable referral system meant that many women could not reach hospitals in time during emergencies. In some cases, this led to home births or deliveries in private clinics with no trained staff, which undermined the benefits of earlier care (Tura et al., 2017). These studies show that without dependable transport and referral systems, the progress made through antenatal services can be overlooked at the point of delivery, as also seen in Mitooma District.

5.2.3.1 Poverty and Social Barriers

During the study, poverty was identified as major underlying issue among community members especially among the women. Several participants noted that families often lack the money to meet even the smallest costs, such as transport to the health center or buying a *pamper* for postnatal visits. In some cases, women miss antenatal appointments because they cannot afford a maternity dress, which health workers recommend they wear when coming for care. This expectation, while perhaps well-meaning, becomes a real barrier when it does not account for the economic realities of the community. Many households depend on subsistence farming. When women have to choose between going to a clinic or working to provide food for their families, healthcare often loses out. This makes it clear that improving maternal health is not just about having facilities in place. It requires an understanding of the social and financial conditions that determine women's ability to access care.

Poverty as a barrier to maternal health care has been well documented in other settings. A study in eastern Uganda found that indirect costs, such as transportation, clothing, and supplies, often prevented women from attending antenatal care or delivering at health facilities, even when services themselves were officially free. Many women prioritized daily survival needs over health care, especially in farming communities where income is irregular (Ekirapa-Kiracho et al., 2011). Similarly, research in rural Ghana revealed that women delayed or avoided care because they could not afford basic necessities like soap, baby clothing, or even a meal before traveling to a clinic. These non-medical costs created shame, anxiety, and practical barriers that kept women away from services they otherwise valued (Ganle et al., 2015). These studies reinforce the finding from Mitooma district that economic hardship, even in small amounts, has a direct impact on whether women can access maternal health care.

5.2.3.2 Implications for objective two findings

These findings point to four major gaps in maternal healthcare delivery under decentralization in Mitooma District. First, having physical structures without equipment does not improve care. A health center without a theatre, ultrasound scan, or functioning laboratory cannot safely manage maternal health complications. Simply upgrading a facility's status, such as from HCIII to HCIV, is not enough unless it comes with full equipping and adequate staffing. Second, poor transport and referral systems create life-threatening delays. Many women still rely on unsafe methods like boda-bodas or personal cars during labor. Without ambulances and decent roads, they often end up delivering in unsafe conditions or in private clinics far from their original health facility. This not only puts lives at risk but also erodes confidence in the public healthcare system. Third, the supply chain for essential items remains unreliable. Key resources like maama kits do not always reach mothers on time. When supplies arrive late or not at all, it forces families to spend money they may not have, or to go without. These delays waste resources, raise personal costs, and cause mothers to lose trust in health facilities. Fourth, poverty continues to block access to care. Even small costs, like transport, basic baby items, or the maternity dress recommended for antenatal visits, can prevent women from going to health centers. Most families depend on subsistence farming, so healthcare often loses out to more immediate needs like food or work. Advice from health workers and national policies must consider the financial realities rural households face every day.

In Mitooma District, decentralization has improved physical access to some maternal health services, but major gaps remain. Facilities need more than buildings, they need equipment, trained staff, and consistent supplies. The referral system must be strengthened to respond to emergencies in real time. Most importantly, maternal healthcare delivery must be designed around the actual challenges women face, especially poverty and transport. Without addressing these issues, the goal of ensuring safe maternal health for all women in the district will remain out of reach.

5.3 Findings for objective 3: Local Government Capacity to Improve Maternal Health Care in Mitooma District

5.3.1 Theme 1: Role of Local Government in Service Delivery and Oversight

According to the data collected from the field, local government officials understand their responsibility in delivering maternal health care. They see their role as managing staff recruitment, supplying medicine and equipment, supervising health workers, and ensuring service delivery across the district. This shows alignment with the basic principles of decentralization, where authority and accountability shift closer to the community. As a result of this, a key informant (CAO) explained that local leaders are directly responsible for recruiting staff, ensuring services are available, and supervising the work done at health facilities. Another pointed out that the district must also provide medicine and equipment, without which the services cannot be delivered. This shows that local officials are not blind to their duties. However, being aware of these responsibilities does not mean they are in a position to carry them out effectively.

Similar findings have been reported in other countries where decentralization has transferred responsibilities to local governments without always providing the tools or resources needed to fulfill them. A study from Malawi found that while district-level officials clearly understood their roles in health service delivery, including recruitment, supply distribution, and supervision, they struggled to perform these tasks due to budget constraints and delays in receiving central government support (Muula et al., 2011). In Kenya, county health managers expressed similar concerns: despite being tasked with managing personnel and ensuring service delivery under devolution, they often lacked autonomy over funds and faced bureaucratic barriers that limited their effectiveness (Tsofa et al., 2017). These studies reinforce the point that local awareness and commitment to responsibilities do not always translate into effective implementation when

resources and decision-making power remain limited. This situation is similar to the findings of this study in Mitooma district where it was found out that the local government know their role in recruitment of health personnel, provision of medical supplies and general knowledge about their role. Nonetheless, this does imply that decentralization has been very effective in-service delivery considering the current situation in Mitooma district.

5.3.2 Theme 2: Gaps in Capacity and Motivation

Data shows that while district officials know what they should do, they are often limited by lack of resources and poor working conditions. One key informant said that key supervisory staff, such as sub-county chiefs (SAs) and town clerks (TCs), feel demoralized because the government improved salaries for health workers but ignored their own. This has created a situation where people expected to oversee services lack motivation to perform their duties. Similarly, another example is the Chief Administrative Officer (CAO), who coordinates all district-level activities. Despite this central role, the CAO has no official vehicle. Instead, he uses a vehicle meant for the health department. This weakens the health department's ability to carry out its own monitoring and disrupts both coordination and service delivery. Therefore, these issues highlight a clear breakdown in the support systems meant to uphold decentralized service delivery. Hence, local leaders lack the financial support, logistical tools, and recognition needed to manage health care services well. This has a big effect on effective service delivery especially maternal health which was the major concern of this study.

Studies from other settings confirm that decentralization can struggle when local leaders lack the support and resources needed to manage services effectively. In Uganda, a study by Ssenyonjo et al. (2018) found that district health managers were often demotivated due to poor working conditions, lack of transport, and limited operational funds. These challenges made it difficult to carry out essential tasks like supervision, coordination, and service monitoring, especially in rural areas. Similarly, in Ghana, Kwamie et al. (2015) reported that district health administrators faced low morale and logistical constraints, such as the lack of vehicles and office space. This hampered their ability to coordinate health services and support frontline workers. In both cases, as in Mitooma District, decentralization created expectations of local responsibility, but without matching investment in leadership capacity and working conditions, service delivery, especially in maternal health, remained weak.

5.3.3 Theme 3: Recommendations to Strengthen Local Government Support

According to the data from the field, key Informants proposed clear and direct solutions to these problems. First, they called for better salaries for supervisory staff, especially those outside the health sector who still play a big role in service delivery. Poor pay reduces their motivation and lowers accountability. Second, they pointed to the poor state of health infrastructure in some areas. Without decent buildings, equipment, and transport, it becomes impossible to deliver maternal health services safely and consistently. Third, understaffing remains a major concern. Hence, some key informants insisted that recruitment alone is not enough. Staff must also be deployed properly to facilities that need them most. In many cases, health centers have the buildings and equipment but no qualified personnel to operate them. Another key informant pointed to the core of the problem: the government has given responsibilities to local authorities without providing enough money to match those duties. Such disconnect, leaves local governments unable to deliver even basic services. Moreover, a related point was the need for regular supply of drugs and equipment, which continues to fail. The informant also stressed that every sub-county should have at least a functioning HCIII, and that HCII facilities should be upgraded where possible.

Similar challenges and proposed solutions have been reported in other decentralization studies. In Tanzania, a study by Munga et al. (2009) found that while local governments were tasked with managing health services, they lacked sufficient financial resources and struggled with poor infrastructure, understaffing, and irregular supply chains. Local leaders proposed increased funding, better deployment of health workers, and infrastructure upgrades, very similar to the suggestions from officials in Mitooma District. In Nigeria, Abimbola et al. (2015) reported that decentralization created a gap between responsibility and capacity. Local government officials were expected to supervise and deliver services but lacked logistical tools, such as transport and office space, and faced persistent funding delays. These limitations led to poor planning and weak accountability. The studies show that without strong financial backing, better pay for key staff, and consistent drug supplies, decentralization efforts often fall short, especially in maternal health care, where timely and well-equipped services are critical.

5.3.4 Implications for objective three findings

The data shows a local government that understands its responsibilities but lacks the means to carry them out. Decentralization has shifted authority to district leaders, but without enough

money, staff, and tools, the work does not get done. Officials know what needs to happen: health centers need staff, medicines, and proper equipment; services need supervision; and communities expect care to be available when they need it. But they are stuck between expectations and limited resources.

Several problems keep coming up. First, district and sub-county leaders are not well supported. Many lack vehicles, fuel, or even office space to coordinate services. Supervisory staff feel left behind because their salaries have not improved like those of health workers. This creates tension and lowers morale. Second, funding does not match the workload. Health departments are expected to run outreach, staff facilities, and monitor services across large areas, but they often work without the basics. Third, supply chains remain unreliable. Essential items arrive late or not at all. Some facilities have equipment they cannot use because no trained staff were deployed alongside it.

Local leaders in Mitooma are not unaware or unwilling. They are simply under-resourced. They see what needs to be fixed but lack the tools to fix it. Unless the central government increases funding, improves logistics, and fills staffing gaps, decentralization in health care will fall short. Physical structures alone will not improve maternal health. People need trained staff, working systems, and services they can count on. Investing in those areas will help local governments turn authority into real care on the ground.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the conclusions drawn from the study findings and offers some practical recommendations based on the three research objectives. The conclusions summarize the key issues affecting maternal health service delivery under decentralization in Mitooma District. The recommendations aim to guide policymakers, local government leaders, and other stakeholders in improving the effectiveness, accessibility, and quality of maternal health care in the district.

6.1 Conclusions

Objective 1: To examine how decentralization has influenced access to maternal health services in Mitooma District

According to the findings, this study concludes that decentralization has made it easier for people in Mitooma District to reach health facilities. More health facilities have been built closer to where people live, which has reduced the physical distance to care. However, this progress is mostly limited to construction. Many of the health facilities still lack qualified staff, reliable equipment, and working referral systems. Because of this, access to proper maternal health care remains uneven, especially in hard-to-reach or under-resourced areas like Kanyabwanga, Mayanga, Kigyende, and Nyakishojwa, even near the district headquarters. For many women in these areas, the nearest facility may not offer the care they need during pregnancy or childbirth. Some must travel long distances to reach facilities that have the right staff, a functioning lab, or emergency care like ambulances. When complications come up or when labor starts at night or during bad weather, the lack of nearby services forces women to use boda-bodas or private cars if they can afford them. This puts both mothers and babies at risk. So, while decentralization has brought services physically closer, it has not filled the critical gaps that matter most in emergencies. The intention is clear, but the system still falls short where it counts.

Objective 2: To assess the effectiveness of the current health system (under decentralization) in delivering quality maternal care.

The findings indicate that the current decentralized health system in Mitooma District struggles to deliver consistent and high-quality maternal care. Health worker shortages, frequent drug and supply stock-outs, poor infrastructure, and weak referral systems are major barriers. Supervisory structures are in place, but many local officials lack the vehicles, resources, and incentives to monitor services effectively. This limits the quality and consistency of care delivered, especially during emergencies or complicated deliveries. Similarly, the findings clearly indicate that traditional beliefs and religious ideologies significantly affect maternal health-seeking behaviors in the community. While these practices are rooted in long-standing cultural and spiritual norms, they often pose serious risks to maternal and child health by discouraging the use of skilled medical care. The continued reliance on non-medical advice, herbal remedies, and spiritual healing in place of professional healthcare services contributes to maternal morbidity and mortality, especially when complications arise that require immediate medical intervention.

Objective 3: To explore the challenges local government faces in implementing decentralized maternal health services.

Findings revealed that local government officials understand their roles in managing maternal health services but face major constraints in implementation. These include insufficient funding, poor facilitation for supervisory staff, lack of transport, and limited decision-making power in certain areas. Although responsibilities have been devolved, the support needed to carry them out, such as logistics, staffing resources, and operational autonomy, is often missing. This mismatch creates delays, weakens accountability, and affects the quality-of-service delivery.

6.2 Recommendations

Objective 1: To examine how decentralization has influenced access to maternal health services in Mitooma District.

Based on the findings, this study provides several commends for each objective.

To improve maternal health care under decentralization, each sub-county should have at least one fully functional Health Centre III (HCIII) that provides reliable maternity services, including antenatal care, delivery, and postnatal support. These facilities must not only exist in structure but also be adequately staffed and equipped. The deployment of trained midwives, laboratory

technicians, and other essential health workers to these lower-level centers should be treated as a priority, especially in hard-to-reach or underserved areas. Many women currently travel long distances for skilled care because their nearest facilities lack both the personnel and equipment needed to handle pregnancy-related cases. Basic but critical tools like ultrasound machines, delivery beds, and essential drugs should be made available in all health centers providing maternal care. In areas where distance still limits access, the government should invest in regular community outreach programs. These can bring basic services such as antenatal checkups, health education, and follow-up care closer to women who might otherwise go without. Together, these actions can reduce maternal health risks and ensure that decentralization leads to real, usable care, not just more buildings to improve infrastructure without enough human resource personal and adequate drugs, medicines and mother medical equipment to improve maternal health care delivery.

Objective 2: To assess the effectiveness of the current health system (under decentralization) in delivering quality maternal care.

To improve healthcare delivery at the district and sub-county levels, it is critical to increase central government funding to adequately cover operational costs. Many local health facilities in which this study was conducted struggle with limited budgets, which affects their ability to provide consistent and quality services. Therefore, increased financial support would enhance the day-to-day functioning of these facilities, ensuring that basic needs such as utilities, staffing, and maintenance are adequately met.

A critical component of effective healthcare service delivery is the availability of essential medical supplies. Hence, strengthening supply chains is therefore essential to ensure the timely and consistent delivery of key items such as maama kits, essential medicines, and medical equipment. Reliable supply systems reduce stock-outs and interruptions in care, particularly for maternal and child health services.

Regular refresher training for health workers, coupled with systematic support supervision, is vital for maintaining high standards of care. Training helps healthcare providers stay updated with current medical guidelines and practices, while supervision ensures accountability and encourages continuous improvement in service delivery.

Improving the working conditions of health workers is equally important. Ensuring fair and timely salaries, along with providing incentives for those serving in hard-to-reach or underserved areas

like Kanyabwanga HC1V, can help address challenges related to staff motivation, retention, and performance. Well-supported health workers are more likely to deliver better care and remain committed to their roles.

Finally, strengthening referral systems is necessary for efficient healthcare service delivery, especially in emergencies. This involves improving road access to major health facilities and providing reliable ambulance services to ensure timely transportation of patients in need of specialized care. A strong referral system reduces delays in treatment and improves health outcomes, particularly in rural and remote areas.

To address the influence of traditional beliefs and religious ideologies on maternal health-seeking behavior, several key recommendations can be made. First, health authorities and healthcare providers should effectively implement targeted community health education and sensitization programs through the outreach and health camps. These initiatives should focus on educating families, especially influential figures like mothers-in-law and religious leaders, about the importance of antenatal care, skilled birth attendance, and timely access to emergency obstetric services. Educating these key decision-makers can significantly shift community perceptions and encourage greater utilization of formal healthcare services.

Engagement with religious and cultural leaders is equally important. Collaborating with these leaders to become advocates for maternal health can help dismantle harmful narratives while still respecting the spiritual and cultural fabric of the community. By involving them in health promotion activities, they can act as trusted messengers who reinforce accurate information about maternal health. Culturally sensitive health communication should also be prioritized. Health messages must be designed in ways that acknowledge and respect existing traditional and religious beliefs while clearly explaining the risks associated with non-medical practices. The goal should be to find a balance between preserving cultural identity and promoting safe health practices, encouraging the integration of beneficial traditional practices with modern medical care.

In addition, trusted community figures, such as elderly women and traditional birth attendants, should be trained and included in maternal health programs. Their involvement as community health advocates can help bridge the gap between traditional systems and formal healthcare, making medical services more acceptable and accessible to local populations. Strengthening the visibility and trust of the health system within communities is also vital. Healthcare professionals

should be more present in community spaces through regular visits, mobile clinics, and active participation in local events and meetings. This direct engagement helps dispel myths and build trust in the formal health system, particularly in areas where misinformation or skepticism is prevalent.

Finally, there is a need to monitor and, where appropriate, regulate religious teachings that negatively impact public health. Government bodies and local government authorities in particular and relevant stakeholders should work with faith-based organizations to ensure that spiritual guidance does not endanger maternal and child health. Encouraging religious institutions to align their messages with public health priorities can help create a supportive environment for safe maternal health practices.

Objective 3: To explore the challenges local government faces in implementing decentralized maternal health services.

Enhancing the effectiveness of healthcare service delivery requires a comprehensive approach that includes strengthening administrative support systems. One critical step is to improve facilitation for administrative staff by providing adequate transport, office space, and essential supervisory tools. These personnel play a pivotal role in planning, coordination, and oversight of health services, and without proper logistical support, their ability to carry out these responsibilities is severely limited.

Addressing disparities in compensation is also essential. A review of salary structures should be conducted to close the pay gaps between health workers and key administrative staff who are equally integral to the delivery of health services. When administrative personnel are undervalued or underpaid, it can lead to demotivation and high staff turnover which can undermine the overall effectiveness of healthcare programs.

To ensure that service delivery is efficient and sustainable, there must be a clear alignment between national budget allocations and local-level responsibilities. Resources should be distributed in a way that reflects the actual workload, challenges, and population needs at the district and sub-county levels. This alignment helps ensure that health facilities and administrative teams are adequately equipped to meet their mandates.

Furthermore, involving local leaders in health planning and budgeting processes is crucial for promoting accountability and ensuring that policies reflect community-level realities. Local leaders often have a deep understanding of the unique health needs and priorities of their communities. Their participation in decision-making helps tailor interventions that are more relevant, effective, and locally supported.

Finally, establishing a comprehensive performance monitoring framework that includes both health workers and local government supervisors is essential for driving results. This framework should include clear indicators, regular performance reviews, and meaningful incentives that reward accountability and measurable improvements in service delivery. Such a system promotes transparency, strengthens motivation, and ensures that all stakeholders are working collaboratively toward shared health outcomes.

6.3 How the study addressed the main research question

This study provides a grounded and practical understanding of how decentralization has promoted maternal health care service delivery in lower health facilities, particularly in Mitooma District. The findings show that while decentralization has helped bring services physically closer to communities through the construction and upgrading of facilities, it has not fully translated into better maternal health outcomes. This is mainly because critical components, like trained staff, medical equipment, reliable transport, and functional referral systems, are either missing or insufficient at many of the lower-level health centers. The study highlights that the decentralization process has transferred responsibility to local governments, but without matching resources or adequate support. This mismatch has left many health facilities under-equipped and under-staffed, forcing women to either travel long distances or rely on unsafe alternatives during emergencies.

More importantly, the study reveals that decentralization, in its current form, tends to focus more on physical infrastructure and administrative devolution, rather than ensuring that the services delivered at those facilities are complete, reliable, and consistent. Local government officials understand their roles and responsibilities under the decentralized system, but they face serious constraints, such as low funding, poor logistics, and lack of transport, that limit their ability to supervise, support, and deliver essential maternal health services. In practice, this means that while services appear to be closer, the quality and reliability of those services remain weak.

Therefore, the study directly answers the main research question: decentralization alone does not guarantee better maternal health care service delivery to lower-level facilities. For decentralization to contribute meaningfully, it must go beyond shifting authority and must be supported with trained personnel, resources, infrastructure, and accountability systems. Without these elements, the benefits of decentralization are limited, especially for rural women who continue to face delays, poor treatment, and high risks during pregnancy and childbirth. This critical analysis shows that addressing maternal health care at the lower facility level under decentralization requires a more integrated approach that links policy with real investment in service delivery.

6.4 How this study addressed the main research gap

This study addressed the research gap by providing a focused, community-level evaluation of how decentralization affects maternal health care delivery in lower health facilities, a topic that is often overlooked in broader health system research. While many existing studies have explored decentralization in general terms or from national and regional policy perspectives, few have closely examined its practical impact on day-to-day service delivery at the local level, especially in rural and under-resourced districts like Mitooma. This study filled that gap by gathering direct input from health workers, local government officials, and mothers who use the services, offering a clear picture of what is actually happening in lower-level facilities under decentralized management.

Documenting specific challenges, such as staff shortages, equipment gaps, poor transport systems, and unreliable supply chains, the study moved beyond theoretical assumptions and showed the real conditions affecting maternal health care. It also highlighted the disconnect between policy expectations and local realities, such as facilities being upgraded without adequate staffing or supplies. In doing so, the study helped to clarify why maternal health outcomes remain poor in some areas despite efforts to decentralize services. It showed that decentralization, while valuable in principle, cannot succeed without proper funding, skilled personnel, and logistical support. This direct, ground-level perspective provides a much-needed contribution to the body of knowledge and offers practical guidance for policymakers looking to improve maternal health through more effective implementation of decentralization policies.

6.5 How Results are linked to theory

The findings of this study strongly align with the Social Determinants of Health (SDH) theory, which was used to underpin the research. SDH theory emphasizes that health outcomes are not only determined by clinical care or health facility availability, but also by the broader social, economic, and structural conditions in which people live and access services. This study confirms that maternal health in Mitooma District is deeply affected by these non-medical factors, such as poverty, education levels, infrastructure, transport, and governance, which together determine whether women can access timely and quality care. For example, the study found that even where health centers exist, many women are still unable to access safe maternal care due to poor roads, lack of transport, or inability to pay for basic needs like maternity clothing or baby items. These are clear examples of how economic conditions and physical environment, key elements of SDH, directly limit access to health services. Similarly, the shortage of qualified health workers and the poor attitude of some staff show how the health system's social environment (including work conditions, salaries, and supervision) affects the quality-of-care women receive.

Governance and policy which is another domain of SDH, also emerged as a key influence. While decentralization has shifted authority to the district level, local leaders reported that they lack the resources, staffing, and logistical support needed to deliver the services they are responsible for. This gap between responsibility and capacity affects the entire system and leaves women in vulnerable positions, particularly in rural or hard-to-reach areas. Essentially, the results of the study support the SDH framework by demonstrating that maternal health is not only a matter of having health centers nearby, but also of addressing the broader social and economic barriers that prevent women from accessing care. The findings suggest that improving maternal health requires action not only within the health sector but across sectors, transport, finance, education, and local governance, that influence the social conditions of health. Hence the study concludes that the study outcomes are within the scope of the theory which was used to underpin it.

6.6 Limitations of the Study

This study faced several limitations that should be considered when interpreting the findings. First, the research was limited to selected sub-counties within Mitooma District. This means the findings reflect the situation in those specific areas (Kanyabwanga, Mayanga, Kigyende, and Nyakishojwa)

and may not fully represent conditions in other districts or even other parts of Mitooma. The study's geographical scope was narrow, and the findings should therefore be understood as context-specific rather than generalizable across Uganda or other decentralized health systems even though this was supported by the previous studies similar to this.

The study relied purely on qualitative methods, interviews and focus group discussions, to gather data. While this approach allowed for in-depth understanding of local experiences and perceptions, it did not allow for statistical comparisons or measurement of the prevalence of specific issues such as stock-outs, delays, or service uptake. The absence of quantitative data means the findings are descriptive and interpretive, rather than measurable or predictive. This implies that this was a purely evaluation study whose results are subjective to the perceptions of the participants. However, if the quantitative methods were used, the study would have provided information about the implementation process and associated challenges and how they can be mitigated.

The study was conducted as a programmatic evaluation, which focused on assessing how decentralization affects maternal health care delivery. This limits the scope of analysis to outcomes related to service delivery and stakeholder experiences, without exploring broader systemic or policy-level impacts in depth. Because the study was evaluative in nature, it may have missed more complex causal relationships or unintended effects of decentralization. Furthermore, some participants may have hesitated to speak openly due to fear of criticism or job-related consequences, especially health workers and local government officials. Although anonymity was assured, social desirability bias may have influenced some responses. Additionally, the study was conducted over a limited time period, which may not have captured seasonal variations in maternal health service access, for example, how transport challenges worsen during the rainy season.

Finally, while the study explored the impact of decentralization on maternal health care, it did not include voices from central government agencies or national-level policy makers. Their perspective could have helped in understanding the broader context, especially regarding funding, national planning, and policy oversight. Hence, despite these limitations, the study provides valuable information about decentralization and how it affects maternal health service delivery at the community level and highlights important areas for policy improvement.

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Appendices

Appendix 1: Focus Group Discussion (FGD) Guide for Health Facility Administrators and Healthcare Workers



My name is Priver Bucurezi, and I am currently pursuing a Master's Degree in Public Administration and Management at Bishop Stuart University (BSU). As part of my academic requirements, I am conducting research titled: **“Administrative Decentralization and Maternal Healthcare Service Delivery in Rural Communities of Mitooma District”**

I kindly request your participation in this study to facilitate the completion of my course. Please be assured that the information you provide will be used solely for academic purposes and will remain confidential. It will only be accessed by Bishop Stuart University for the evaluation of my academic progress.

Objective 1: To assess the effectiveness of devolution, delegation, and deconcentration in improving access to maternal health care services in Mitooma District.

A. General Access and Service Delivery

1. How easy or difficult is it for women in this area to access maternal health care services (e.g. antenatal, delivery, postnatal)? (prob for more information about access and service delivery)
2. Have you noticed any changes in maternal health services in the last few years? If so, what has improved or worsened?

B. Devolution (Transfer of authority to local governments)

3. Do you think the local government understands the maternal health needs of your community? Why or why not?

4. Have you seen any local initiatives or programs introduced by the district to improve maternal health? If so. Can you mention them?
5. How responsive are local health authorities to issues or complaints related to maternal health services? (*Prob for ambulance, and other services*)

C. Delegation (Transfer of responsibility to semi-autonomous entities or health workers)

6. Are there community health workers or health volunteers (VHTs) supporting pregnant women and new mothers in your area?
7. Do these community volunteers (VHTs) have the knowledge and resources to help with maternal care needs?
8. Can you share any experience where a local health worker (VHT) helped you or someone you know during pregnancy or childbirth?

F. Deconcentration (Dispersing functions within the central government at the district level)

9. Are health services (especially maternal health) available at nearby health facilities, or do mothers have to travel far to access services?
10. How often do district-level health officials visit or inspect local health centers or maternal clinics?
11. Have you noticed any improvement in the availability of supplies (like medicine, delivery kits) at your local health facility? If so, Do you think the service covers all mothers in need?

G. Community Involvement and Satisfaction (VHTs)

12. Do you feel involved or consulted in decisions regarding maternal health services in your community?
13. What challenges do you still face when trying to access maternal health care at the community?
14. Whom do you trust most when it comes to seeking information or support for pregnancy and childbirth?

15. What suggestions would you give to local or district leaders to improve maternal health care services in your community?

Appendix 2: Focus Group Discussion (FGD) Guide For Pregnant Women, New Mothers, And Family Members



FOCUS GROUP DISCUSSION (FGD) GUIDE FOR PREGNANT WOMEN, NEW MOTHERS, AND FAMILY MEMBERS

My name is Priver Bucurezi, and I am currently pursuing a Master's Degree in Public Administration and Management at Bishop Stuart University (BSU). As part of my academic requirements, I am conducting research titled: **“Administrative Decentralization and Maternal Healthcare Service Delivery in Rural Communities of Mitooma District”**

I kindly request your participation in this study to facilitate the completion of my course. Please be assured that the information you provide will be used solely for academic purposes and will remain confidential. It will only be accessed by Bishop Stuart University for the evaluation of my academic progress.

Objective 2: To examine the barriers women, face in receiving maternal health care service delivery in Mitooma District.

A. Awareness and Information Barriers

1. How do women in this community usually learn about maternal health services (antenatal care, delivery services, postnatal care)? *Probe for the role of the VHTs*
2. Are there any challenges women face in understanding or accessing information about maternal health services? *Probe for methods of information sharing*

B. Physical and Geographical Barriers

3. How far is the nearest health facility offering maternal care from your home? *(Probe for the challenges associated with long distance)*

4. What difficulties do women face when trying to reach a health facility, especially during emergencies or labor?

C. Financial and Economic Barriers

5. What are the main costs involved in seeking maternal health care (*probe for transport, medicines, service fees*)?
6. Do these costs prevent some women from accessing care? Can you share any examples?

D. Health System and Facility-Level Barriers

7. Have you or someone you know ever gone to a health facility and failed to get the maternal care needed? *What happened?*
8. Are there enough skilled health workers to assist pregnant women and new mothers at your health facility?
9. How do you perceive the attitudes and behavior of health workers toward women seeking maternal care?

E. Cultural and Social Barriers

10. Are there cultural or traditional beliefs in your community that discourage women from seeking health facility care during pregnancy or childbirth?
11. Do women face pressure from family or community members that affects their decision to seek maternal care?

F. Decision-Making and Gender Barriers

12. Who usually decides whether a woman can go to the health facility for antenatal or delivery care in your household?
13. Do women feel free and empowered to make decisions about their own health care during pregnancy? Why or why not?

G. Trust, Safety, and Personal Experiences

14. Have any women in your community had negative experiences at health facilities that discouraged others from going?
15. What are some things that would make it easier or safer for women in your community to seek maternal health care?

Do you any questions for me? Or do you have any information I can add to this tool to make it better.....

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Appendix 3: Key Informant Interview (KII) Guide for Pregnant Mothers, New Mothers, and Families



My name is Priver Bucurezi, and I am currently pursuing a Master's Degree in Public Administration and Management at Bishop Stuart University (BSU). As part of my academic requirements, I am conducting research titled: **“Administrative Decentralization and Maternal Healthcare Service Delivery in Rural Communities of Mitooma District”**

I kindly request your participation in this study to facilitate the completion of my course. Please be assured that the information you provide will be used solely for academic purposes and will remain confidential. It will only be accessed by Bishop Stuart University for the evaluation of my academic progress.

This interview will last for 45-60 minutes

Section 1: Personal Information

1. Full Name:

[First Name, Middle Name(s), Last Name]

2. Gender:

[Male / Female / Other]

3. Age:

[Years]

4. Marital Status:

[Single / Married / Divorced / Widowed]

5. Highest Level of Education Completed:

[None / Primary / Secondary / Tertiary / Other]

6. Occupation:
[e.g., Farmer, Teacher, Health Worker, Student, etc.]
7. District of Residence:
[Specify District]
8. Sub-county:
[Specify Sub-county]
9. Village/Town:
[Specify Village or Town]

Objective 2: To examine the barriers women, face in receiving maternal health care service delivery in Mitooma District.

A. General Understanding

1. How would you describe the current state of maternal health care service delivery in Mitooma District?
2. What are the most common maternal health services sought by women in this district?

B. Access-Related Barriers

3. What are the main challenges women face in accessing antenatal, delivery, or postnatal care?
4. How does the availability of transportation or road infrastructure affect maternal health service utilization?
5. In your opinion, how do distance and geographic location affect women's ability to access maternal health care?

C. Health System Challenges

6. What are the key limitations in the local health facilities that affect service delivery for pregnant women?
7. Are there enough skilled health workers in your area to meet maternal health care needs? Please elaborate.

8. How do stockouts of essential drugs or supplies impact maternal health outcomes?

D. Socioeconomic and Cultural Barriers

9. In what ways do economic factors (such as poverty or user fees) limit women's ability to seek maternal health care?

10. How do cultural beliefs or traditional practices influence women's decisions about where or when to seek care?

11. What role do male partners or family members play in women's decisions to seek maternal health care?

E. Policy and Governance Issues

12. How does decentralization influence maternal health service delivery at the local level?

13. What support does the local government or health department provide to address maternal health challenges?

F. Community Perceptions and Solutions

14. How does the community perceive the quality and accessibility of maternal health services?

15. What changes would you recommend to improve access and quality of maternal health services for women in Mitooma District?

Provide any other questions to enrich this tool

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Appendix 4: Key Informant Interview (KII) Guide for *Local Government Officials*



Policymakers at the National Level, Community-Based Organizations (CBOs), Non-Governmental Organizations (NGOs), as well as Community Leaders and Elders

My name is Priver Bucurezi, and I am currently pursuing a Master's Degree in Public Administration and Management at Bishop Stuart University (BSU). As part of my academic requirements, I am conducting research titled: **“Administrative Decentralization and Maternal Healthcare Service Delivery in Rural Communities of Mitooma District”**

I kindly request your participation in this study to facilitate the completion of my course. Please be assured that the information you provide will be used solely for academic purposes and will remain confidential. It will only be accessed by Bishop Stuart University for the evaluation of my academic progress.

This interview will last for 45-60 minutes

Section 1: Personal Information

10. Full Name:

[First Name, Middle Name(s), Last Name]

11. Gender:

[Male / Female / Other]

12. Age:

[Years]

13. Marital Status:

[Single / Married / Divorced / Widowed]

14. Highest Level of Education Completed:

[None / Primary / Secondary / Tertiary / Other]

15. Occupation:

[e.g., Farmer, Teacher, Health Worker, Student, etc.]

16. District of Residence:

[Specify District]

17. Sub-county:

[Specify Sub-county]

18. Village/Town:

[Specify Village or Town]

3. Objective: To evaluate the local government capacity to improve maternal health care delivery in Mitooma District.

A. Understanding Governance and Roles

1. What is the role of the local government in maternal health care planning and delivery in Mitooma District?
2. How are maternal health priorities set and funded at the local level?
3. How effectively does the local government coordinate with national health policies and programs on maternal health?

B. Planning and Resource Allocation

4. Does the local government have sufficient financial and human resources to support maternal health care delivery?
5. How are resources for maternal health care distributed across different sub-counties or communities in Mitooma?
6. To what extent are health budgets and plans developed with input from community stakeholders?

C. Service Delivery Capacity

7. How would you assess the current capacity of local health facilities to provide quality maternal health services?

8. What systems are in place to monitor and evaluate maternal health programs at the local level?
9. How has local government support influenced staffing, equipment, and availability of essential maternal health services?
10. What challenges exist in implementing maternal health programs at the grassroots level?

D. Partnerships and Collaboration

11. How does the local government collaborate with NGOs, CBOs, and other partners to improve maternal health outcomes?
12. Can you provide examples of successful joint initiatives between local government and community organizations in maternal health?
13. Are there formal platforms for coordination between local authorities and civil society actors? If yes, how effective are they?

E. Community Engagement and Participation

14. How are community members, especially women, involved in planning and decision-making around maternal health services?
15. What role do community leaders and elders play in supporting or influencing maternal health practices?
16. Are there mechanisms to address cultural or social barriers that prevent women from accessing maternal health care?

F. Policy and Oversight

17. What policies or frameworks guide local government actions in improving maternal health in the district?
18. Is there accountability or oversight in place to ensure local maternal health programs are effective and equitable?

G. Opportunities and Recommendations

19. What opportunities exist to strengthen the local government's role in maternal health care delivery?

20. What recommendations would you make to improve the capacity of local government to support better maternal health outcomes in Mitooma District?

Provide any other questions to enrich this tool

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Appendix 5: Key Informant Interview (KII) Guide for Pregnant Mothers, New Mothers, and Families



Amaziina gangye ndi Priver Bucurezi, hati ninshooma degree yakabiri omu byobutegyeki nokureberera abantu (Public Administration and Management) aha itendekyero Bishop Stuart (BSU). Nka kiimwe ahabyokwentengwa, ninkora okuburiiriza ahari **“okwiha obushoborozi kuruga aha gavumenti ya rwagati kubuta omugavumenti ze byanga nakakwate okukiine aha buhereza bwamagara gabakazi benda,babanibazara, nabaheza kuzara omu byaro ebya Mitooma district”**

Nembabazi nyingi naaba, ninkushaba ngu oyejumbira omukubuririza oku reero kinyambe okuheeza emishomo yangye Ninkuhamiza ngu ebituraganiire nibiza kuguma biri ekihama. Nibiza kokezesiibwa abitendekyero rya Bishop Stuart ahabwemishomo yangye yonka.

Ekiganiiro eki nikiyiiza kumara edakiika 45-60.

Section 1: ebirikukwataho

19. amaziina

[First Name, Middle Name(s), Last Name]

20. obuhangwa:

[Male / Female / Other]

21. oine emyaka engahi?

[Years]

22. oine omukazi/omushaija?

[Single / Married / Divorced / Widowed]

23. obwegyese bwawe obwahiguru nibuha:?

[None / Primary / Secondary / Tertiary / Other]

24. nokora murimo ki:?

[e.g., Farmer, Teacher, Health Worker, Student, etc.]

25. notura omu district eha?

[Specify District]

26. egomborora yawe neha?

[Specify Sub-county]

27. ekyaro kyawe nikiha?

[Specify Village or Town]

Objective 2: okubuza ebirikuteganiisa abakazi benda, abirikuzakuzaara nabaziire juba okutnga obujanjabi/ obuhereza omuri Mitooma District.

A. General Understanding

3. mbwenu okashoborora ota aha mbeera yobuhereza/obujanjabi obukuhwbwa abakazi benda, abarikuzaara, nabaziire juba omuri Mitooma District?
4. Nibujanjabi ki obu bakazi benda, abarikuzaara, nabaziire juba, barikuba nibentega/ nibasherura omu district egi?

B. Access-Related Barriers

6. Nibureemezi ki obu abakaazi bakubugana baaba bagiire kukyebeza enda, baaba nibazaara nababa barugyire kuzaara?
7. Ebyentambura nenguto byiine kakwatekyi nobuherreza bwabakazi benda, abarizakuzaara nabaziire juba?
8. Omuntekateka yawe nogira ngu orugyendo nobuhangwa bwekyanga byiine akakwate nokubaasa kwabakaazi benda, abarikuzakuzaara, nabazire juba okuhiika aha buherreza byebyamagara.

C. Health System Challenges

9. Nibintuki ebirikuteganisa obuhereza bwabakazi benda omumarwariiro gahagombororora?
10. Mwiine abashaho batendekyire, abarikubaasa kuhereza obujanjababi abakazi benda, abarikwenda kuzara, nabaziire juba? Yongyera kunshobororaho.
11. Okubura kwemibaazi eyomugasho omwirwariiro kiine kakwateki nebirikuruga omubuhereza bwabakazi benda, abarikuza kuzaara, nabaziire juba?

D. Socioeconomic and Cultural Barriers

12. Nimumiringo kyi, ebyentyasya nka obworo ninga okushashura akasente kokuraguza, oku birikubaasa kureemesa abakazi benda, abarikuza kuzaara nabaziire juba kutunga obujanjababi?
13. Ebyobunyakaare, nenyikiriza zebiika biine kakwateki nokusharamu kwabakazi ahubarikusherura,, nobwiire bwokusheruramu obujanjababi?
14. Nmugasho ki ugu abashaija, nabeeka biine ahakusharamu kwabakazi benda, abarikuza kuzaara, nabaziire juba ahu barasherure obujanjababi?

E. Policy and Governance Issues

14. Okwiiha obuhereza kurga aha gavumenti yarwagaati kuza omugavumenti zebyanga nikiyambaki ahahuhereza bwabakazi benda, abarikuza kuzaara nabaziire juba omumarwariiro gahagomorora?
15. Nibushagi ki obu gavumenti zebyanga nekitongoore kyebyamagara birikuhereza okumaraho ebiziibu ebyobuhereza bwabakazi benda, abarikuza kuzaara, nabaziire juba?

Community Perceptions and Solutions

16. Abantu bomwaya ugu nibatwara bata omutindo, nokuhikibwa/okuheebwa obujanjababi ahabwa bakaazi benda, abukuza kuzaara nabazire juba?
17. Nimpinduka ki ei mukuhayo ahabwo kutungura omutindo nokuheebwa obujanjababi bwabakazi benda, abarikuza kuzara, nabaziire juba ?

Provide any other questions to enrich this tool

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