

**THE ROLE OF DECENTRALISATION IN PROMOTING HEALTH SERVICE
DELIVERY IN ARUA HILL DIVISION, ARUA CITY, UGANDA**

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DECLARATION

I, **MAKETA FORTUNATE**, do hereby declare that this research report has not been submitted for any academic award to any institution. All sources consulted have been duly acknowledged, and this work is not plagiarised.

Signed *Maketa*

Date *81 May 2026*

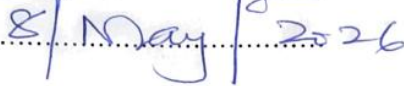
APPROVAL

This is to certify that this research report was done under my supervision as the academic supervisor, and is ready for submission for examination.

Signed



Date



Dr. Martin Kizito
Academic Supervisor

DEDICATION

This is in honor of my family, who have been the foundation, on which all my accomplishments in this life are based. You were with me through all my times of doubt, and all my times of triumph. Your prayers, encouragement and belief in me made me go farther than you will ever know.

To my beloved friends who journeyed this research with me, giving their time, energy, ideas, and helping hands without a second thought, this work is also theirs. Your hospitality of spirit, friendliness and selfless contributions made what would have been an individual venture to be a collective and memorable adventure in the pursuit of knowledge.

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Without the advice, encouragement, and efforts of a number of people and organizations, I cannot say that this research study would have been possible.

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I also want to thank Uganda Christian University to help me enrich my academic environment and also to provide me with the institutional resources that helped me conduct this study. The philosophy of the university to excel in research and Christian scholarship has always been an inspiration.

The glory be to God.

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ABSTRACT

This study examined the role of decentralisation in promoting health service delivery in Arua Hill Division, Arua City, Uganda, covering the period 2020-2025. Guided by three specific objectives assessing the effects of political, administrative, and fiscal decentralisation on health service delivery the study adopted a qualitative case study research design and relied exclusively on secondary documentary sources, including national health sector performance reports, Auditor General reports, local government performance assessments, policy instruments, and peer-reviewed academic literature.

Findings revealed that, while Uganda's decentralisation framework formally transferred governance responsibilities to division-level structures, all three dimensions of decentralisation fell short of generating meaningful improvements in health service delivery. Political decentralisation established formal institutional structures elected councils and citizen participation mechanisms but these did not produce functional downward accountability; no documented corrective responses to a 54% health worker vacancy rate and persistent medicine stockouts were found. Administrative decentralisation devolved management responsibility without a corresponding transfer of authority: division-level structures functioned as administrative relays rather than empowered management units, with staffing, drug procurement, and facility oversight remaining centrally controlled. Fiscal decentralisation operated as a fiscal management arrangement rather than a fiscal empowerment arrangement, with per capita health expenditure of approximately US\$23 falling far below the WHO benchmark of US\$86, transfer predictability

constrained by the Treasury Single Account system, and grant conditionality limiting local expenditure discretion.

The study concludes that decentralisation in Arua Hill Division achieved institutional form without institutional function across all three dimensions. It recommends strengthening political accountability mechanisms, expanding administrative decision space for health workforce and procurement management, revising the health conditional grant formula to reflect demographic pressures from refugee-hosting populations, and increasing the national health budget allocation toward the 15% Abuja Declaration target. The findings contribute to the limited scholarship on decentralised health governance in Uganda's West Nile sub-region and carry policy relevance for similar contexts across different countries.

CHAPTER ONE: INTRODUCTION

The paper was one among the list of such studies which discuss the role of decentralisation in promoting the provision of health services in Arua Hill Division, Arua City, Uganda. The most important governance reform agenda that has been instituted in Uganda since the approval of the Local Governments Act (Cap. 243, 1997). The reform framework in health sector identifies the district and the lower level of local government as the key players in the planning, financing and management of health services. Being an administrative unit to the Arua City Local Government, the Arua Hills Division has health centres which are directly under this form of decentralisation in action and at the local government level.

Chapter One contained the introduction, including the background, problem statement, objectives, research questions, propositions, rationale, scope, conceptual framework and significance. Chapter Two had a summary of theoretical and empirical researches organised under the objectives of the study. In Chapter Three, the methodology of the research was described. In Chapter Four, the outcomes of the documentary analysis were introduced and analyzed. The results, conclusions and recommendations are found in Chapter Five.

1.1. Background to the Study:

1.1.1 Conceptual Background

Decentralisation can be defined as the re-distribution of power, functions and resources between the central government and the lower levels of government or

non-governmental organisations (Rondinelli, 1981). Three forms that are common and developed by researchers are identified in the literature. The process of devolving political power and electoral responsibility, to elected local government bodies and establishing formal means through which communities can determine the priorities of local services, is the political decentralisation (Manor, 1999). The process of transferring planning, management and implementation of the public services to the sub-national administrative units such as district and division health management structures is known as administrative decentralisation (Smoke, 2003). Fiscal decentralisation is associated with delegation of revenue generating and expenditure powers of the local governments including the freedom of the local governments in sharing the health budgets (Bahl & Linn, 1992). The three types are not mutually exclusive; their interplay determines the degree of meaningful local authority over the result of service delivery.

The dependent variable in this study was the health service delivery, which is the organised process through which health services are made available and accessible to a population within a given jurisdiction (WHO, 2010). The operational expression of the authority, resources and accountability structures that local governments have over health facilities in their jurisdiction is referred to as in the context of decentralised governance. It was assessed in three dimensions typical of the health systems literature: accessibility, which is concerned with whether services are accessible to the populations of sub-groups of the population (Penchansky and Thomas, 1981; Levesque et al., 2013); quality, which is concerned with whether services meet clinical and patient-experience standards; and equity, which is

concerned with whether services were distributed fairly across the populations of sub-groups of the population (Penchansky and Thomas, 1981; Levesque et al., 2013).

1.1.2 Historical Background

The period following the 1980s is one in which the world experienced a transformation of the way services were delivered by the centralised form of government led by structural adjustment programmes and democratisation movements as well as recognition of the limitations of the top-down form of service delivery (Rondinelli, 1981; Manor, 1999). The international trend in Africa was translated into waves of decentralisation reform in the 1990s and at the turn of the 2000s with Ghana, Tanzania, Kenya and Uganda leading the ranks of salient reformers in the health sector (Bossert and Beauvais, 2002).

In the Republic of Uganda the policy of decentralisation was enshrined in the 1995 Constitution, and implemented by the Local Governments Act (Cap. The control over the service planning, budgeting as well as implementation was handed over to the District and lower local governments and incorporated the responsibility of primary health care (243, 1997). Later decentralisation of the health sector was formalised in the first Health Sector Strategic Plan (HSSP I, 2000/012004/05), which saw the district health office become the central unit in the management of the deployment of health workers, procurement of drugs and oversight of facilities in Health Centres II, III, and IV. This architecture has been reinforced by the succeeding National Development Plans and Health Sector Development Plans and identified the current implementation challenges (Ministry of Health, 2015; 2022).

The history of African context of decentralisation of health services has left behind it a complex history. Bossert and Beauvais (2002) report that the breadth of the decision space by which the local health authorities would make decisions was highly varied across Uganda, Zambia, Ghana and the Philippines. Uganda Sector Wide Approach as shown by Jeppsson (2002) had formal structures of local health management in Uganda that were limited by the central government control in drug purchasing and the deployment of health workers. It was also established by Saltman, Bankauskaite and Vrangbaek (2007) that decentralisation of fiscal resources, without a corresponding administrative ability is more likely to increase service delivery inequities than it is likely to reduce them.

1.1.3 Contextual Background

Arua Hill Division was one of the administrative divisions of the city Arua that is a part of sub-region of West Nile within the north-western region of Uganda. Health centres were found at Level II and Level III, directly under administrative and fiscal control of the Arua City Local Government. These health centres formed the main health service delivery points of the population of the division and were governed by the local government structures provided by the Local Governments Act (Cap. 243, 1997). Under the Arua City Health Department was the Division Health Management Team, which had the mandate of supervising the activities of the health workers, distributing drugs, maintaining facilities and planning the health services within the division.

The West Nile sub-region has a broader socioeconomic profile, placing Arua Hill Division health service delivery landscape within its context. The impact on the health

infrastructure and service delivery is also significant since the number of refugees is also one of the largest in Uganda (UNHCR, 2022). It was observed in 2021/2022 in the Uganda Annual Health Sector Performance Report 2021/2022 (Ministry of Health, 2022) that a rate of rupture of 54 per cent in Arua, consistent stock-outs of the necessary medicines at lower-level facilities and a rate of outpatient utilisation that was below target were observed. The Uganda National Household Survey (UBOS, 2020) also reported that a high percentage of households in the region reported that they have a problem accessing health services. All these contextual aspects make Arua Hill Division a very interesting case study in as far as an investigation into the dynamics of decentralisation arrangements in the environment of a resource constrained local government health service delivery set up is concerned.

1.2 Problem Statement

The policy of decentralisation of Uganda has been developed to enhance delivery of the community services like the health services through the endowed the local governments with the power, resources and accountability structures to plan and execute services that reflect the needs of the community and the local conditions (Local Governments Act, Cap. 243, 1997; Ministry of Health, 2000). At the normative level, the effective decision-decentralisation of the health sector, according to WHO (2016), should result in the improvement of access to health facilities, staffing of health facilities and adequate supply of drugs, and even distribution of health services to a specific population.

In practice, provision of health services at Arua Hill Division continues to be below these standards. The issue of chronic understaffing inadequacy is a longstanding problem that has affected the division as indicated in the document of the 2021/2022 Annual Health Sector Performance Report which shows a vacancy rate of 54% of the health workers across Arua (Ministry of Health, 2022). In lower level facilities, persistent stockouts of essential medicines, inadequate infrastructure and the lowest outpatient utilisation rates have been observed. Such shortcomings exist even after over 20 years of decentralised health administration and successive Health Sector Development Plan that have placed such shortcomings in the spotlight as areas in which they need to be remedied.

Most of the scholarly knowledge on the subject of decentralisation and the delivery of health services in Uganda has mostly focused on central, eastern and western regions with very little scholarly attention given to Arua City and the West Nile sub-region (Jeppsson, 2002; Kyaddondo & Whyte, 2003; Tumwesigye et al., 2015). Interestingly, none of the published studies had studied the interaction of the three dimensions of decentralisation systematically with the aim of determining the outcomes of health service delivery at the division level in the Arua City. This gap—between the alleged design of the Uganda decentralisation system, the reported inadequacies in service delivery, and the lack of division level empirical research, - is the problem, that this study aimed to resolve.

1.3 General Objective

The purpose of the study was to understand the nature of decentralisation in the promotion of health service delivery within the Arua Hill Division of Arua City, Uganda.

1.4 Specific Objectives

The following three specific objectives guided the study:

- i. The purpose of this study was to unravel the effects of political decentralisation on provision of health services in Arua Hill Division.
- ii. The aim of the study was to determine the effects of the administrative decentralisation on health service delivery in the Arua Hill Division.
- iii. The research question to be answered was: What are the effects of fiscal decentralisation on the provision of health services in Arua Hill Division.

1.5 Research Questions

The research questions below informed the study:

- i. How did political decentralisation contribute to delivery of health services in Arua Hill Division?
- ii. How administrative decentralisation affected the provision of health services in Arua Hill Division?
- iii. What did fiscal decentralisation mean to the provision of the health services in Arua Hill Division?

1.6 Research Propositions

Since this research was based on a qualitative approach to research, propositions rather than hypotheses were used to state what the research was expected to infer after the investigation had been made (Yin, 2018). The following propositions informed the research:

Proposition 1: Political decentralisation in the form of elected local government councils and direct participation of the citizens in the planning of the health services in Arua Hill Division would lead to improved accountability and responsiveness of health service delivery.

Proposition 2: Administrative decentralization, through delegation of management of health workers, purchase of drugs and management of facilities to division level structure had an effect on the quality and availability of health services in Arua Hill Division.

Proposition 3: The transfer of the conditional grants on health services and the power to distribute the local revenue in Arua Hill Division had an impact on the adequacy and equity of the health service delivery in Arua Hill Division.

1.7 Significance Of This Study

1.7.1 Contribution to Policy

The outputs were intended to inform the local government in terms of health and its local governance policy at the local government, sub-regional and national levels. In particular, the description of mechanisms of decentralisation that are in place at the level of divisions in a recently formed city that is to be provided in the analysis was

likely to provide support to the evidence of the policy reforms to improve the relation between decentralisation and health service delivery in similar context in the Ugandan context.

1.7.2 Contribution to Practice

The research yielded results that could be applied to the practice of the practitioners including the administrators of local governments, administrators of health departments, civil society organisations, and development partners working on governance and health in decentralised environment in the West Nile sub-region and Uganda in general.

1.7.3 Contribution to Knowledge

This work contributed to the existing body of literature on the theme of decentralisation in Uganda by providing a documentary analysis at the division level in a newly established unit of analysis in the urban local government in Uganda and a governance context that is otherwise not well represented in the current body of literature on the topic of decentralisation in Uganda.

1.8 Rationale / Justification of the Study

The study was founded on the fact that there has been an existing gap between the objectives of the decentralisation framework in Uganda, and the reality of the situation of the health service provision at the local government. With more than 20 years of history of decentralised health administration, health centres in the Arua Hill Division have remained consistently characterised by serious staffing deficits, chronic

stockouts of crucial medicines and inadequate infrastructure (Ministry of Health, 2022). The implications of these conditions on the accessibility of the population to basic health care is empirically untested, but the role of the mechanisms of decentralisation in these outcomes at the level of divisions is empirically unexplored. The particular history of government in Arua City also supported the study. When Arua was made into a city in 2020, it reorganized the local government structure, with new divisions, including Arua Hill Division as units of their own, with direct responsibility to service delivery (Government of Uganda, 2020). This institutional change was a point of deviation whereby decentralised resources such as health conditional grants, staffing allocations, planning authority started to be deviated to the division as a distinct governance unit. The period after 2020 was hence a critical test whether when operationalised as new local government structures, decentralisation is translated into an improvement in the delivery of health services. This transition provided a solid scholarly rationale because the lack of published studies on this transition at the division level (Tumwesigye et al., 2015).

1.9 Scope of the Study

1.9.1 Geographical Scope

This study was limited to Arua Hill Division, Arua City, West Nile sub-region, north-western Uganda. The decision was arrived at based on three reasons namely, the division had health centres (Level II and III) that are directly under the decentralised governance structure availed by the Local Governments Act (Cap. The fact that the division is located within the West Nile sub-region, which also hosts large numbers of

refugee populations (UNHCR, 2022) was used to provide the analysis of the decentralised health service delivery under the conditions of demographic pressure with evidence-based rationale of investigation (Ministry of Health, 2022); and the fact that the division is located within the West Nile sub-region, which also hosts large numbers of refugee populations (UNHCR, 2022) adds to the analysis of the decentralised health service delivery under the conditions of demographic pressure with evidence-based rationale of investigation (Ministry of Health, 2022).

1.9.2 Content Scope

The three common types of decentralisation which were the focus of the study included: (i) political decentralisation which is the transfer of political power and electoral responsibility in the health sector to the Arua City Health Department and division level health management structures; (ii) administrative decentralisation which is the transfer of planning, management and implementation of health services to the Arua City Health Department and division level health management structures; and (iii) fiscal decentralisation which is the transfer of revenue and expenditure authority in the health sector to the Arua City Health Department and division level health management structures. Quality of service delivery was determined in three dimensions: accessibility, quality, and equity (Penchansky and Thomas, 1981; Levesque et al., 2013).

1.9.3 Time Scope

The research dealt with the years 2020-2025. The starting point was the gazetting of Arua City on 1 July 2020 (Government of Uganda, 2020) that reorganised the local government structures and created Arua Hill Division as a separate administrative unit through which the resources began to flow down. The endpoint was the most recent period that has publicly available documentary evidence, and coincided with the period of implementation of the Health Sector Development Plan III (2020/21-2024/25).

1.10 Conceptual Framework

CONCEPTUAL FRAMEWORK

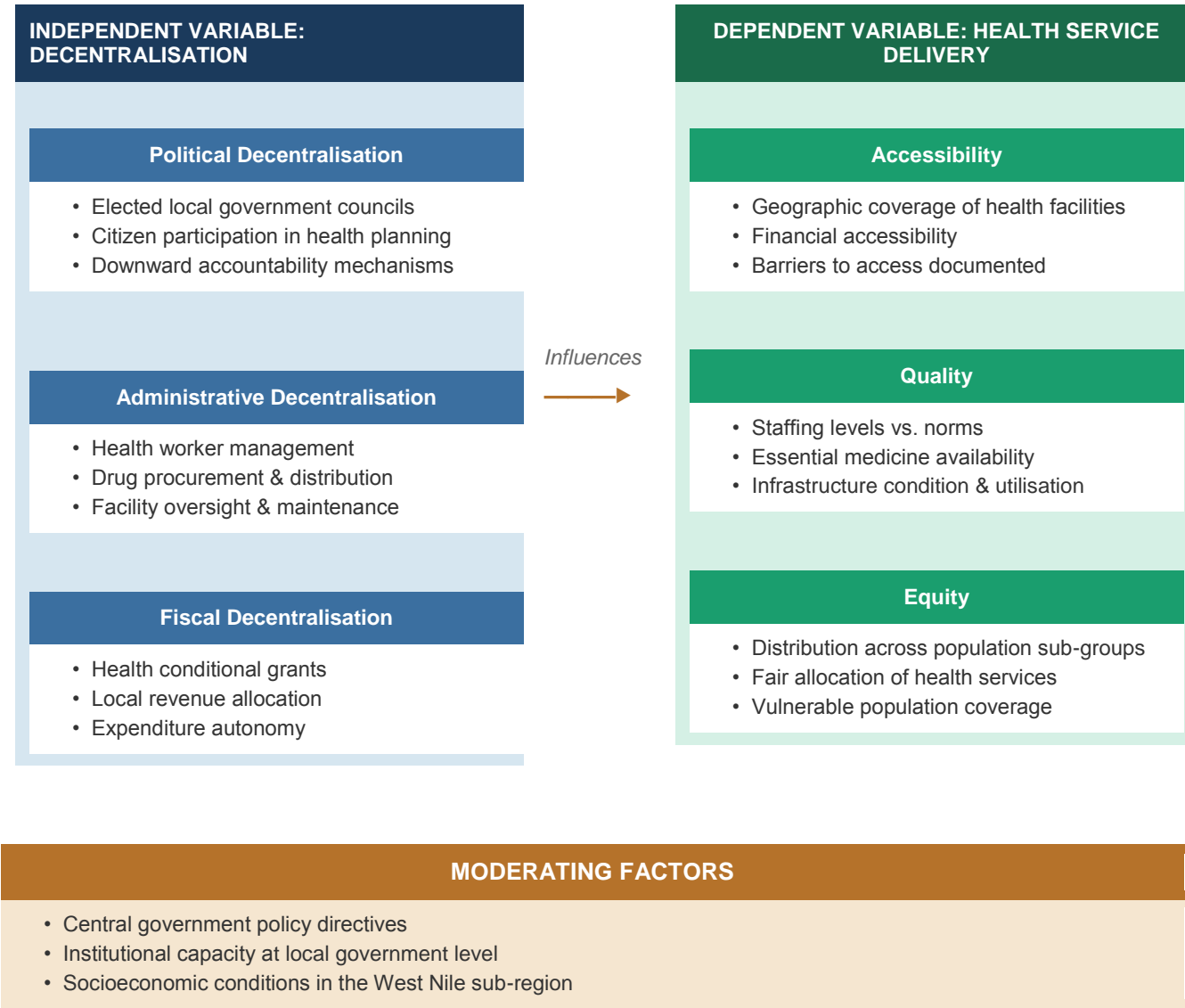


Figure 1

Figure 1 demonstrates the conceptual framework that was used in this study. The independent variable was decentralisation, operationalised into three dimensions which include political decentralisation (elected councils, participation of citizens,

downward accountability); administrative decentralisation (management of health workers, buying of drugs, control of facilities); and fiscal decentralisation (health conditional grants, the allocation of local revenue, the autonomy of expenditure). The dependent variable, which was operationalised in terms of accessibility, quality and equity is health service delivery. The framework posited that the three types of decentralization were interrelated in the determination of the quality and reach of the delivery of health services with moderating factors of being the central government policy directives, institutional capacity at the local government level and the socioeconomic conditions in the West Nile sub-region.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Theoretical and empirical literature that is relevant to the three specific objectives of the study were reviewed in this chapter. In section 2.2 the theoretical framework on which the study was based was presented. Section 2.3 was a review of empirical studies, structured around each objective, of previous research on the relationship between decentralisation and health service delivery within similar contexts.

2.2 Theoretical Framework

Decentralisation Decision Space Framework (Bossert and Beauvais, 2002) and Democratic Decentralisation Theory (Manor, 1999) were the two theoretical frameworks used in this study.

The concept of the Decision Space Framework took into consideration the concept of decentralisation as a set of options available to the local health authorities within the frame of the rules created by the central government. Bossert and Beauvais (2002) differentiate between *de jure* decision space - what is being decided by local authorities who are formally empowered to make decisions - and *de facto* decision space - what it actually decisively decides in practice. The framework looked at the decision space within the following key health system functions: staffing, drug procurement, and finance generation and allocation, and facility management. It was directly applied to this study as it offered tools of analysis in examining whether the decentralisation of health governance in the Arua Hill Division has devolved the true

decision-making authority or simply offered administrative responsibility with the corresponding lack of authority.

The Theory of Democratic Decentralisation as theorized by Manor (1999) was directly based on the assumption that in the quest to improve the effectiveness of service delivery, decentralisation must establish effective downwards accountability i.e. elected representatives must real consequences in cases where service delivery has failed. Manor stated that having elected structures in place is not enough but the structures must offer political incentives that could be utilized to tie health performance results to electoral and accountability results. It was this framework which offered the analytical framework of whether the political component of the decentralisation in Arua Hill Division has brought about the accountability mechanisms which health service delivery improvement requires. The two frameworks combined allowed the study to make approximations on how decentralisation affects things not just as an institutional set up but also as a functional governing practice the outcomes of which or lack of which can be traced through the documentary record.

2.3 Empirical Literature Review

In this section the findings of the previous studies on relationship between the two variables in the various settings were taken into account to identify the relationship between the two variables in the various settings.

2.3.1 How political decentralisation has contributed towards the provision of health services.

A mixed-methods study of the impacts of decentralisation and the provision of public health services across a multitude of Ugandan districts by Tumwesigye et al. (2015) found that districts where the Local Government Council had a greater involvement in health planning had higher prevalence of health facility use and higher levels of community satisfaction with services. The researchers established that the active involvement of the community in the local government was an intervening variable between political decentralisation and outcome of health service delivery which suggests that the formal political structures should be supplemented with active community involvement to bring about improvements in the delivery. The result was directly applicable to the Arua Hill Division where the Division Council and the Arua City Local Government Council are the key political decentralisation machineries to health.

In their comparative research study of local governance in fifteen African countries, Olowu and Wunsch (2004) found that the quality of the political decentralisation i.e. the regularity of elections, competitiveness of local political competition and the ability of councils to scrutinise budgets and performance was a better predictor of the service delivery outcomes than the mere existence of decentralised structures. They find that formal institutional form without functional accountability is inadequate and that political decentralisation should provide actual downward accountability to the citizens to ensure health services at the local government level is enhanced.

In an examination of the governance of the facility in South Africa following the implementation of the political decentralisation reforms it was found that the governance structures that existed in place in the South African context following the introduction of the political decentralisation reforms merely lacked the technical competence, legal mandate as well as community legitimacy to undertake effective oversight of the delivery of the health services (Atkinson et al., 2002). Their results warn that this is not necessarily the case that the formalisation of the local models of governance under the umbrella of decentralisation will automatically translate into the enhanced accountability of service delivery in a facility.

2.3.2 The Effect of the Administrative Decentralisation on the Health Service Delivery.

Bossert and Beauvais (2002) introduced the concept of the decision space as a measure of administrative decentralisation and they found, through their comparative analysis of Uganda, Zambia, Ghana and the Philippines, that the broader decision space in human resource management, and in the procurement of drugs, was correlated with better health outcomes, but only where the administrative capacity was sufficient to exercise that discretion effectively. They found in Uganda, in particular, that, local health management teams had nominal authority over the deployment of health workers but had little practical discretion due to central government control over salary payments and norms of staffing. This observation leads to the analytical question of whether the division-level health management structures at Arua Hill Division has a real administrative discretion in the delivery of health services.

In their study of the effects of administrative decentralisation on health workers in Uganda, Kyaddondo and Whyte (2003) reported how the transfer of human resource management to local government created an environment of professional insecurity, loss of accountability and a sense of demoralisation among the health workers. Absenteeism and low-quality of services at facility level were some of the effects of administrative decentralisation which was employed without adequate resources. Their results show that the quality aspect of health service provision is directly influenced by the way administrative decentralisation handles the health workforce.

In Uganda, Jeppsson (2002) found that though administrative structure of the local health management were formally constituted, practical administrative functions such as the procurement of drugs and maintenance of facilities were subject to administrative procedures in the central ministry and sporadic flow of funds. It has direct consequences about the examination of whether the structures of administration in the Arua Hill Division exercise real administrative discretion in the determination of service delivery decisions.

2.3.3 The Effect of Fiscal Decentralisation to the Health Service Delivery.

Fiscal decentralisation, according to Bahl and Linn (1992), was the most significant dimension in terms of service delivery as ultimately resources will determine whether or not the authority can be exercised in practice. Their conclusions on this are that in order to have meaningfully decentralised fiscal systems, they must have powers over own-source revenue, enough and predictable intergovernmental fiscal transfers, and expenditure autonomy at the local level. Should any of the following factors be wanting, formal political and administrative decentralisation is made a meaningless concept.

Health financing in the form of central government conditional grants supplemented with a very small number of locally generated revenues formed local government health financing in Uganda. According to the records of the Ministry of Finance, Planning and Economic Development (2020), the per capita health expenditure, which is implied by the current levels of grants, was lower than the WHO minimum amount of expenditures required to provide basic health services and that the allocation formula did not reflect the difference in population density, disease burden, or service demand across the local government units in a country adequately. In the case of health centres in the Arua Hill Division, the fiscal constraints were directly translated into the lack of capacity to address the vacancies caused by the health workers, as well as procure medicines and maintain the infrastructure.

In their cross-country analysis, Saltman, Bankauskaite, and Vrangbaek (2007) documented that fiscal decentralisation without the associated administrative capability is likely to amplify inequity in service delivery because the health facilities in poorer or more remote regions have the ability to counter the inequity in service delivery through lack of central transfers through mobilisation of local resources. These findings are supported by the 2021/2022 Annual Health Sector Performance Report by the Ministry of Health: recorded shortages in health worker stations, medicine stock, and maintenance budgets in lower-level facilities in the West Nile sub-region are in line with the trend of fiscal decentralisation acting to generate nominal local authority in a framework of chronic under-funding (Ministry of Health, 2022).

CHAPTER THREE: Research methodology.

3.1 Introduction

This chapter outlined the methodological framework that was adopted in this study. It provided the research design, research approach, data sources, document population and sampling, variable definitions and measurements, method and instruments of data collection, quality and error control, data processing and analysis, ethical considerations and methodological constraints. All methodological decisions were explained in the context of the aims of the study and the epistemological prerequisites of a qualitative documentary study.

3.2 Research Design

A case study research design was adopted in this research paper. According to Yin (2018), case study research refers to a type of empirical study that takes the form of an investigation into a current phenomenon within the context of the real-life situation. The case study design fitted well on four grounds. Firstly, Arua Hill Division is a clearly delineated local government entity where three dimensions of decentralisation are simultaneously effective and can be empirically traced (Yin, 2018). Second, the design had the capacity to address explanatory ‘how’ and ‘what role’ research questions, which are the nature of this study’s questions. Third, the design was based on more than one source of evidence, which made it possible to triangulate data related to policy documents, government performance reports, budget records, and legislative tools in a single analytical frame (Yin, 2018). Fourth,

the design was context-sensitive; it required the researcher to investigate the phenomenon of decentralisation within context-specific institutional, political and socioeconomic context of Arua Hill Division instead of abstracting it out of context.

Its combination of several documentary sources made a holistic institutional narrative was an aspect that distinguished the case study design as opposed to phenomenology, which focuses on the lived experience, and to grounded theory, which aims to form a theory inductively out of data (Creswell and Creswell, 2018).

3.3 Research Approach

This study used a qualitative research approach. The qualitative approach was characterised by the emphasis on the interpretation of meanings, institutional processes, and outcomes of governance within a natural setting and not testing statistical hypotheses or developing numerical measures (Creswell and Creswell, 2018). The key features were an interpretive approach to information and an inductive analysis that proceeds between the concrete textual evidence and the more general themes (Bryman, 2016). The justification of the approach was that the concept of decentralisation as the form of governance is a social construct and depends on the situation. The qualitative approach allowed the researcher to describe the mechanisms of recording political, administrative, and fiscal in official documents and to generate results that are contextually-based and policy-relevant.

3.4 Data Sources

This research was solely based on secondary sources of data. The data which was originally gathered to be used in other purposes other than the one the current study

is concerned with is considered to be the secondary data (Bryman, 2016). Three reasons justified the use of secondary data: the institutional and governance processes are best reliably captured in official records as opposed to the subjective memories of individual informants; the documentary record provides longitudinal data covering the entire period 2020-2025; and the identified sources of secondary data are drawn on the authoritative government publications, NGO reports, and peer-reviewed academic literature, which enhanced credibility and verifiability (Yin, 2018).

The secondary sources consulted were: the Local Governments Act (Cap. 243, 1997); the Health Sector Development Plan III (Ministry of Health, 2020); Uganda Annual Health Sector Performance Reports (Ministry of Health, 2021/22 and 2022/23); Office of the Auditor General reports for Arua City (FY 2020/21 through FY 2022/23); ACODE Local Government Councils Scorecard Assessment reports; Local Government Management and Service Delivery (LGMSD) Performance Assessment reports; the UNICEF Health Budget Brief (2023/24); published peer-reviewed academic studies on decentralisation and health service delivery; relevant extracts from the National Development Plan III (2020/21-2024/25); and PHC Grant Budget and Implementation Guidelines issued by the Ministry of Health.

3.5 Population and Sampling of Documents.

The document population comprised all the official records, reports, policy instruments, and published academic works that document the governance, financing as well as performance of the delivery of health service within Arua Hill Division under the decentralised structure during the period 2020-2025. The process of

selecting documents was based on purposive sampling wherein the documents were directly relevant to the three objectives of the study and how authoritative they are as official or peer-reviewed sources (Bryman, 2016). The type of documents was summarised in Table 1.

Document Category	Source	Est. Quantity	Justification
National health sector performance reports	Ministry of Health	4-5 reports	Annual data on staffing, drug availability, and facility utilisation for Arua
Auditor General reports for Arua City	Office of the Auditor General	3-4 reports (FY 2020/21-2022/23)	Fiscal management, health grant allocations, absorption rates, and expenditure patterns
Local Government Performance Assessment reports	Ministry of Local Government	3-4 reports	Administrative capacity and governance performance of Arua City Local Government
ACODE Local Government Councils Scorecard Assessment	ACODE	1-2 reports	Independent assessment of council governance performance including health oversight
National legislation and policy instruments	Government of Uganda	5-7 documents	Legal and policy framework for

			decentralised health service delivery
Published academic studies	Peer-reviewed journals and books	15-20 publications	Theoretical and empirical context for interpreting documentary findings

Table 1: Document Population, Sampling, and Justification

3.6 Measures and Definitions of the Variables.

The research had one independent variable (decentralisation) and one dependent variable (health service delivery). Since the research employed a qualitative documentary approach, the variables were defined and measured with qualitative indicators based on the documentary record, but not using the numbers.

The independent variable was decentralisation, operationalised with the assistance of three dimensions. Elected council participation in the health planning process, participation mechanisms and accountability actions in response to performance of health services were all indicators of political decentralisation. Administrative decentralisation was expressed in recorded trends of the local authority control of recruitment and assignment of health workers, purchase and distribution of drugs and management of decisions of facilities. Fiscal decentralisation was indicated by the recorded amounts and patterns in the health conditional grant allocations, timeliness of fiscal transfers and the degree of local government spending discretion over health budgets.

The dependent variable was health service delivery, operationalised based on three dimensions. Accessibility was reported by the geographic distribution of health facilities documented and the reported barriers to access. Quality was expressed as the documented staffing rates in relation to the standard staffing rates, availability of necessary medicines, status of infrastructures and any documented utilisation data. Equity was also evidenced by recording the allocation of the health services among the different population sub groups within the division (Penchansky and Thomas, 1981; Levesque et al., 2013).

3.7 Method of Data Collection: Document Review and Analysis

The data collection methodology was document review and analysis: systematic process that involves identification, selection, appraisal and synthesis of data found in the existing documents (Bowen, 2009). The review of documents had several features that made it suitable in the current study: it was unobtrusive, the data existed in isolation of the research process, and the data was unaffected by the presence of the researcher (Bryman, 2016); the data was available in a longitudinal format, allowing the researcher to trace the change of policy, resource allocation and performance of service delivery over time; it utilised data that is produced by authoritative institutions in the course of their functioning; and it allowed conducting a triangulation of various types of documents and strengthen the validity of findings through convergence of evidence (Yin, 2018).

Three reasons explained why document review was appropriate as the only method since it studied the institutional and governance processes in the most reliable

manner of capturing these processes in official records; the documentary record covered the entire period of 2020-2025 and thus it was possible to assess the trends in a systematic manner, which would not have been easy to reconstruct through recall-based methods (Bowen, 2009; Yin, 2018).

3.8 Data Collection Tool: Document Review Checklist.

The tool was a structured document review checklist, which specified, per document category, the types of information to be extracted, the indicators to be recorded, and the study objective(s) to which each of these is related. The checklist guided the extraction of: the figures of health staffing, and the vacancy rates; the availability and stockout records of the essential medicines; the figures of health conditional grants allocation and disbursement; the revenue generated locally that can be allocated to health; the council records of deliberations and decisions that relate to health; the utilisation record of the facility; and the record of the infrastructure condition. Systematic and transparent linkage was made between the study objective and variable dimension and data points that were extracted (Yin, 2018). The checklist was tested on two documents before full implementation to ensure adequacy and to refine extraction categories as needed.

3.9 Data collection Procedure.

The data collection process entailed following a systematic order: (i) identifying and compiling a comprehensive list of all the relevant documents in the categories specified in Table 1; (ii) retrieving documents through government publications and databases, NGO report repository, and peer-reviewed academic databases (PubMed

Central, Google Scholar), including Auditor General reports on Arua City, Ministry of Health Annual Health Sector Performance Reports, Office of the Prime Minister LGMSD Assessment reports, and published studies on decentralisation and health service delivery; (iii) appraising each document on the basis of authenticity, credibility, representativeness, and meaning using the quality criteria provided by Scott (1990); (iv) extracting the data using the structured checklist to a master extraction matrix organised by the objective and variable dimension; and (v) noting gaps, inconsistencies, or areas requiring corroboration by additional sources (Bowen, 2009).

3.10 Quality and Error Control.

Reliability and validity were achieved in a number of ways. Credibility was addressed by the triangulation of documentary sources: information from health sector performance reports was cross-checked with the information presented in the budget records and the findings of the audit reports in order to determine consistency (Lincoln and Guba, 1985). Transferability was addressed through the collaboration of the thick description of the study environment, documentary materials and analytical processes. Dependability was covered by keeping a detailed audit trail of all document selection decisions and extraction procedures (Bryman, 2016). Confirmability was dealt with through entrenching all findings directly in the documentary evidence and presenting specific data points of sources to support analytical claims. Scott's (1990) four criteria were used to evaluate documentary sources: authenticity, credibility, representativeness and meaning.

3.11 Data Processing and Analysis.

The first step in data processing was to arrange all the extracted data in a master extraction matrix that was organised in regards to the study objective, the dimension of the variables and the indicator. The thematic analysis framework of Braun and Clarke (2006) was adapted to documentary data to carry out the analysis of the data. Data analysis was performed in six steps the familiarisation with the extracted data; generation of first codes; identification and development of themes; review and refinement of themes; definition and naming of final themes; and the production of the written analysis. It was thematic, and was designed around the three research questions of the study and provided systematic relationships between the analysis and the conceptual framework. Since it was a qualitative study, the analysis was descriptive and interpretive; findings were represented in form of thematic narratives with certain evidence presented by the documentary record.

3.12 Ethical Considerations

This study relied exclusively on secondary documentary sources and did not involve primary data collection from human participants. Nevertheless, the following ethical principles were observed:

3.12.1 Informed Consent

Informed consent requires that research participants be made aware of a study's nature and purpose and voluntarily agree to participate (Bryman, 2016). The study relied on publicly available government publications, NGO reports, and peer-reviewed literature. No interviews, surveys, or direct contact with the public were carried out,

and as a result, the need for informed consent from individual participants did not arise.

3.12.2 Confidentiality and Anonymity

Confidentiality means that researchers have a duty to keep participant identities and data protected from unauthorised disclosure; anonymity means that data cannot be traced back to specific individuals (Creswell & Creswell, 2018). In this study, no individual health workers, officials, or community members were identified by name. All evidence quoted related to institutional outputs, and findings were shared at the institutional level (e.g., Arua City Local Government, Division Health Management Team) rather than attributed to named individuals.

3.12.3 Proper Attribution and Academic Integrity

Academic integrity involves appropriate acknowledgement of all intellectual contributions through proper referencing (Bryman, 2016). All sources were cited using APA 7th edition conventions in accordance with Uganda Christian University's academic integrity policy, and the research was subjected to plagiarism detection software as required by the university.

3.12.4 Avoidance of Harm (Non-maleficence)

Non-maleficence means that research should not cause physical, psychological, social, or reputational harm (Bryman, 2016). Findings were presented in a balanced, evidence-based manner, and shortcomings in governance, staffing, or fiscal management were noted as institutional patterns rather than individual failings. The

study aimed to contribute constructively to policy improvement rather than to assign blame.

3.12.5 Use of Public Domain Sources

For documentary research to be ethical, data must be accessed through legitimate and authorised means (Scott, 1990). All sources were taken from official government websites, public report repositories, and academic databases (Google Scholar, PubMed Central), and no restricted or classified documents were used. Where potentially relevant internal records were unavailable, this was clearly acknowledged as a methodological limitation.

3.12.6 Institutional Ethics Clearance

Explanation: Ethics clearance is a formal review process ensuring that research meets institutional and national standards (Creswell & Creswell, 2018).

How it was ensured: Ethics clearance was obtained from Uganda Christian University's Research Ethics Committee prior to data collection. The committee confirmed that the study met the university's standards for responsible research conduct.

3.13 Methodological Constraints

The research had a number of methodological limitations. First, the qualitative case study design did not allow statistical generalisability; however, the theoretical frameworks employed in the study were designed to have analytical generalisability (Yin, 2018). Second, the reliance on secondary sources meant that the research was

reliant on the validity, fullness, and accessibility of the records that were created by government institutions; gaps or inaccuracy of the documentary record could affect the completeness of findings. Third, there may be an institutional bias in reports on government performance; triangulation between reports on different types of documents (each independent) can be used to reduce this risk. Fourth, the subjective issues of decentralisation were not captured in this study because of the need to capture the views of users of health services, health workers or local government officials and thus such a study could not explain the subjective aspects of decentralisation. Fifth, the research was limited to Arua Hill Division and the time 20202025. Sixth, the published government sources, NGO publications and academic literature summarize data past the division level; the study counters this by triangulating various sources of data that accumulate Arua level data and West Nile sub-regional data.

3.14 Chapter Conclusion

The chapter outlined the methodological framework of the research, justification of the application of a case study research design and a qualitative documentary research approach. All the aforementioned details in the definition of variables, data collection procedure and data collection instrument, quality control measures, analytical framework and ethical considerations were all intended to lead to valid, reliable and ethically sound results in order to answer the research questions of the study.

CHAPTER FOUR: Presentation and Interpretation of Results.

4.1 Introduction

This chapter presented the results of documentary analysis done on the role of decentralisation in promoting health service delivery in Arua Hill Division, Arua City, Uganda. The findings were concentrated around the three research questions which informed the research and were presented in the form of themes which were developed based on the systematic review of the publicly available policy documents, health sector performance reports, Auditor general reports, local government performance assessment data and peer-reviewed academic studies covering the period 2020-2025. Each theme was supported by documentary evidence and followed by an explanatory commentary of what the finding entails in relation to how decentralisation is correlated with provision of health services in the study area.

It must be stated at the outset of this work that the research was grounded on the governmental publications and reports of the non-governmental organizations and the academic literature that could be reviewed. Internal Arua City Local Government records, such as council minutes, facility-level HMIS data and detailed budget performance reports, on a division-by-division basis, were administrative records that were not in the public domain and were therefore not available to conduct this study. This limitation has been recognised as a methodological limitation with the implications to the depth of analysis discussed under each theme where it is applied and further in chapter five.

4.2 How political decentralisation affects the provision of health services within Arua hill division.

In this part, the results on the role of political decentralisation, in the form of elected local government councils, the participation of the citizen in health planning and the mechanisms of downward accountability have played a part in the provision of health services in Arua Hill Division. After examining the document, 4 key themes were identified.

4.2.1 Institutionalization of Political Governance Formulations of Health.

The documentary analysis confirmed that the political governance structure of how it delivers health services in Arua Hill Division was formally constituted as prescribed in the Local Governments Act (Cap. 243, 1997). The Act gave elected councils in the city and division the legislative and oversight powers on the provision of services such as health. The Arua City Council and the Arua Hill Division Council were formed as the primary political units of decentralisation through which health planning and oversight is done following the gazetting of Arua City on 1 July 2020. As is established in the review of the National Development Plan III (2020/21-2024/25) these structures were obliged to take part in the planning of the health sector, approve annual health workplans, and review health budget allocations within their jurisdictions (National Planning Authority, 2020). The Health Sector Development Plan III also lists local government councils as stakeholders in the annual health sector planning cycle, and the expectation that council resolutions would reflect locally identified health priorities (Ministry of Health, 2020). This observation confirmed that formal

institutional structures of political decentralisation of the health sector existed in Arua Hill Division. However, the existence of structures in itself was not an indicator of an active political role.

4.2.2 Council involvement in Health Planning and Oversight.

The documentary evidence accessible to this study did not cover the Arua City Council minutes as they were not in the public domain. In the absence of this primary evidence, the research was also based on two proxy sources, that is, on the ACODE Local Government Councils Scorecard Assessments and the reports of the Office of the Auditor General on behalf of Arua City. The ACODE Local Government Councils Scorecard Assessment (2016/17), which included Arua District prior to the formation of Arua City, had an average local government performance score of 53 out of 100 across the assessed districts, which demonstrated that much remained to be done to improve the way that the governance and service delivery oversight is undertaken across the assessed districts (Bogere et al., 2017). The ACODE scorecard approach rates the councillors based on their legislative roles like budgetary scrutiny, committee work and use of council resolutions as a means of guiding service delivery improvements. The 53 suggested that in the districts measured, the control of the council over the execution of its services, and those of the health service in particular, was below the threshold of effective governance.

The LGMSD Performance Assessment of 2023 recorded that overall improvement in the local government performance in the country was improved by 57% of the 2023 performance compared to the 51% of the 2022 performance (Office of the Prime Minister, 2024). Nonetheless, the publicly available national synthesis reports did not

provide division-level disaggregated scores of Arua Hill Division. The reports of the Auditor General of Arua City (FY 2020/21 through FY 2022/23) report on recurring findings such as delayed accountabilities on funds advanced to staff, poor performance in local revenue collection against targets, and conditional grant absorption rates below 100% in several categories such as health (Office of the Auditor General, 2022, 2023). The consistency of the results of the different financial years was that council oversight mechanisms had not been able to create sufficient corrective pressure. This kind of finding indicated that political decentralisation had given rise to the formal means through which council are involved in health governance but the available evidence was that the content of such involvement fell short of generating any measurable corrective influences upon health service delivery.

4.2.3 The Citizen involvement in the Health planning.

The documentary framework provided for citizen involvement in different forms. The Local Governments Act (Cap. Prior to the finalisation of annual workplans, (it is a requirement of 243, 1997) that there be public budget consultations at parish and division levels. Community health needs assessment is one of the required activities of district and city health departments as per the Health Sector Development Plan III (Ministry of Health, 2020). The facility-level governance structures through which community voice was expected to influence health service delivery were Health Unit Management Committees (HUMCs) in each of the health centres. Neither evidence of community health needs assessment in Arua Hill Division during the study period nor minutes of HUMC meetings were in the public domain.

In a study of the local government in Arua District (Maractho, 2017), it was found that, although decentralisation created formal structures of citizen participation, 75% of the assessed districts reported that their reliance on the central government acted as an inhibitor of the usefulness of local participation. The randomised controlled trial (Bjorkman and Svensson, 2009) to demonstrate that community participation by organising information provision and interface meetings was actively facilitated led to a measurable improvement in the health outcomes that followed, including reduced infant mortality and increased service utilisation. The disparity between this demonstrated potential and the absence of recorded outputs of the community engagement practice in Arua Hill Division suggested that the aspect of citizen participation of the political decentralisation process was an unrealised institutional potential rather than a functional governance practice in the study area.

4.2.4 Downward Responsibility of Health Performance.

In the analysis of Uganda Annual Health Sector Performance Reports, the indicators of health service delivery for Arua were reported at the district/city level. The health worker vacancy rate was registered as 54% in Arua, frequent stockouts of necessary medicines in the facilities of lower levels, and the rates of outpatient utilisation were below target (Ministry of Health, 2022). The 2022/2023 report also observed that the West Nile sub-region continued to face challenges in staffing and availability of commodities (Ministry of Health, 2023). The publicly available record contained no evidence with evidence that the political accountability mechanisms have resulted in corrective action. The study found no published evidence of any council resolutions that direct the Arua City health department to respond to particular failures in

service delivery, the initiation of oversight measures by HUMC in Arua Hill Division or the demands of citizens that results in documented policy or resource allocation changes. A qualitative study of health accountability meetings with local politicians in Ugandan districts by Kabuye et al. (2024) found that such meetings did not often result in tangible follow-up action, and that politicians tended to use such meetings as a form of information sharing, rather than as an accountability mechanism involving binding commitments.

A significant finding was that no published evidence existed that the political accountability mechanisms have had a corrective effect to documented health service delivery deficits. It demonstrates that the process of decentralisation of politics within the Arua Hill Division had created institutional frameworks that were formal in nature and which did not bring to life the functional downward accountability which Manor (1999) identified as the pre-requisite of decentralisation to translate into better service provision. The recorded 54 percent vacancy rate, continuing drug stock outs and a below target utilisation rate had not improved over the years of multiple financial years with no evidence of a politically driven remediation and indicated that the accountability loop between health performance data, political oversight and corrective action was not functioning in the manner that the decentralisation framework envisaged.

4.3 The Impact of Administrative Decentralisation on the Health Service Delivery in Arua Hill Division.

This section presents the findings of the effect of administrative decentralisation, by delegating the management of health workers, drug procurement and facility management to structures at division level, on the delivery of health services. When reviewing the documents, the five main themes that can be identified.

4.3.1 Staffing of Health Workforce and Vacancy Patterns.

The documentary data on the staffing of health workers in Arua indicated a persistent trend of persistent understaffing in the study period. In 2021/2022, the Annual Health Sector Performance Report reported a 54% health worker vacancy rate within Arua (Ministry of Health, 2022). The report of the Ministry of Public Service, 2024, the State of Human Resource in the Public Service 2024 report, recorded an overall fill rate public service nationally of 54% with particularly severe shortages being faced in the health sector and it is further noted that recruitment was halted in FY 2022/23 except on a replacement basis further limiting the potential staffing improvement (Ministry of Public Service, 2024).

Facility-specific staffing of individual health centres in Arua Hill Division were not reported in national health sector performance reports, which were aggregated at the city level. However, the 54 percent vacancy rate in the city level was a legitimate measure of the staffing situation in which the health centres in the division were located. The national WISN assessment showed that across Uganda, only 56% of the approved health worker positions were filled with maldistribution being worst in

favour of the central region; Kampala employed 71% of all medical doctors and 64% of all nurses and midwives despite only serving 27% of the national population (Hagopian et al., 2015). The West Nile sub-region remained below the national staffing average, a fact further worsened by the population pressures that were associated with accommodating a large population of refugees (Orach et al., 2019). The researchers (Luyimbazi et al., 2017) demonstrated that local health managers saw themselves as the executors of centrally-determined staffing models, but not as the decision-makers, who could influence the composition of the workforce. This observation indicated that the administrative decentralisation had devolved the formal mandate of management of health workers to local government institutions while the practical capacity to recruit, deploy, and retain health workers was limited by central control of the wage bill and appointment of the Health Service Commission.

4.3.2 Procurement and Distribution of Drugs.

In the documentary, it was shown that the supply of necessary medicine to health centres in Arua Hill Division was managed through the National Medical Stores (NMS) push system. In this system, centrally calculated allocations of medicines are sent to HC IIs and HC IIIs as predetermined consignments of medicines, instead of facility-level ordering of medicines based on local demand patterns. The annual report on the performance of the health sector of 2022/2023 shows that the proportion of the national budget on health and supplies is reduced by 34% in 2021/22 compared to 34% in 2019/20 (Ministry of Health, 2023).

The Orach et al. (2023) study on health service provision in the West Nile sub-region, confirmed that drug stockouts were a chronic problem in the lower-level health

facilities within the region and that the push system was a structural factor that contributed to supply mismatches. An analysis of the Ugandan healthcare facility using a decision space analysis of the Ugandan healthcare facilities in the Ssenyonjo et al. (2021) study found that the larger-scale public-run healthcare facilities reported significantly higher levels of drug-ordering autonomy than smaller facilities which operated based on the push system. Since Arua Hill Division has to manage health centres at Level II and Level III, the facilities with the smallest decision space in the national system, administrative decentralisation in the procurement and ordering of medicines was nominal: the administrative responsibility of ensuring the availability of medicine but the lack of the decision making authority to procure or order medicines independently, which created a gap between administrative responsibility and administrative discretion that had a direct effect on the quality of health services.

4.3.3 Infrastructure and service preparedness of health facilities.

As reported by Komakech et al. (2019), the range of the access to health facilities in the 5 kilometres area in Arua was 24-68 which indicated significant geographic variation in access to health facilities in the district. This difference was directly pertinent to the dimension of accessibility of health service delivery and implied that the distribution of health infrastructure did not offer homogenous geographical coverage. To compare progression of the facilities at the facility level against national standards, Lutalo et al. (2025) found that the imbalanced capacity in the facilities was observed through the number of lower-level health centres failing to meet the

basic expectations regarding the service readiness in terms of infrastructure, equipment, and staffing.

The Auditor General has provided Arua City reports that capture capital development expenditure where construction projects are related to health. In line with the overall national result that local government level capital development of the health sector was challenged by implementation delays and variances between the planned and actual capital expenditures at the local government level (Office of the Auditor General, 2022), the FY 2021/22 report reported cases of project implementation delays and variances between the planned and actual capital expenditures at the local government level (Office of the Auditor General, 2022). This observation implied that infrastructure management in the West Nile sub-region was below national levels as a result of administrative decentralisation. The difference in geographic access of 2468% reported by Komakech et al. (2019) indicated that spatial distribution of health infrastructure had not been responsive enough to the needs of the population - a role that ought to have been facilitated under administrative decentralisation through locally informed planning.

4.3.4 Division Health Management Team Functionality

The documentary evidence did not include internal Arua City health department reports, supervisory records of the HMIS and the Division health management team (DHMT) meeting records because they were internal administrative records, not publicly available. DHMT functionality was therefore evaluated on the basis of the research at the national level and literature on the administrative decentralisation. According to Jeppsson (2002), administrative structures to local health management

were formally constituted in Uganda, but actual administrative functions such drug procurement and facility maintenance were subject to central ministry procedures and irregular funding flows with DHMTs acting as reporting intermediaries rather than autonomous management units capable of driving improvements in service delivery.

The analysis of the Ssenyonjo et al. (2021) case based on the decision space analysis confirmed this pattern 20 years later, with the DHMTs exercising discretion in the primary functions of the HMIS data management and community health outreach coordination, with higher-impact management functions, such as staffing, procurement, capital investment etc., under the control of higher-level structures. This finding suggested that the Division Health Management Team within the Arua Hill Division operated within a national trend whereby administrative decentralisation resulted in management structures at the division level but did not entail the transfer of the decisional authority, fiscal resources or supervisory independence, that would be required to make the management structures operate as true units of management of health services.

4.3.5 Decision Space on the Division Level.

The de jure decision space available by the Arua Hill Division health management structures according to the documentary analysis included health worker supervision, facility-level planning, community health outreach coordination and the HMIS data management space. However, the de facto space of decisions, the real discretion that is exercised, was limited in the areas that most directly determine the outcomes of service delivery: staffing decisions were controlled by the District Service Commission and the Health Service Commission; drug procurement was controlled by NMS; and

capital investments were controlled by the Ministry of Health and UgIFT. According to a study by Ssenyonjo et al. (2021) using the Bossert decision space framework to the Ugandan healthcare facilities in particular, the de facto decision space were found to be smaller at lower-level facilities where the managers stated that they had limited influence over the three most significant resource inputs: staff, medicines, and capital. The Jordanwood et al. (2022) study on the impact of decentralisation and health financing in Uganda reported that the guidelines of conditional grants dictated the type of spending to the extent that locally-identified priorities that were not falling within the pre-determined categories could not be funded.

The trend was consistent with the finding that administrative decentralisation in Arua Hill Division saw administrative responsibility transferred down the line leaving the administrative responsibility retained up the line creating an accountability gap.

4.4 How Fiscal Decentralisation affects the provision of Health Services at Arua Hill Division.

The results of how the fiscal decentralisation, by transferring the health conditional grants and the local revenue allocation authority to Arua City Local Government has affected the adequacy and equity of health service delivery were presented in this section. The documentary analysis identified five important themes.

4.4.1 Allocations and Adequacy of Health Conditional Grant Allocations.

The PHC NWR and the PHC Wage Grant, and periodic development grants, under programmes such as UgIFT, were implemented with conditional grants transferred by central government. The PHC Grant Budget and Implementation Guidelines of the

Ministry of Health (Ministry of Health, 2020) presented the formula of allocation and the permissible expenditures. Auditor General Reports to Arua City indicated that the rates of absorption among the grant categories varied though the conditional grants had been received and the rates captured as budgeted in the nominal terms. The health sector recorded a lower absorption rate than 100 percent in at least one of the financial years and unspent balances could be attributed to late releases, delay in procurements, and administrative constraint of operating within strictly defined expenditure categories (Office of the Auditor General, 2022, 2023).

The UNICEF Health Budget Brief (2023/24) reported that the per capita expenditure on health in Uganda was around US23 in the approved national budget of 2023/24 which was way below the international standard of US86 which was recommended, to be used to provide access to basic health services. The health sector spending in the national budget as a percentage of the national budget was 7.7 percent which is a long way short of the 15 percent target of Abuja Declaration. The share of funds spent on pharmaceuticals and supplies has decreased to 34% in 2021/22 compared to 42 in 2019/20 (UNICEF, 2023). This finding suggested that a national allocation system where the overall amount of quantum is inadequate to provide the minimum package of health care determined the fiscal resources flowing to the Arua City Local Government on health. The fiscal decentralisation placed the burden of management of health expenditure on the local government but the fiscal envelope was determined centrally and did not meet the requirements of quality health service delivery standards.

4.4.2 Local Revenue Sharing to Health.

According to the reports by the Auditor General of Arua City document, the revenue collection was consistently below budgeted amounts, and the FY 2021/22 report indicated persistent shortfalls in the revenue collection compared to the budgeted amount (Office of the Auditor General, 2022). The local revenue composition and its allocation across the various sectors such as health was reported in aggregate form in the OAG reports but was not disaggregated to show the exact percentage allocated to the health services. In a research conducted by ActionAid (2019) into the local government structures in Uganda found that the administrative costs were eating up the greater part of the locally generated revenues across the councils that were studied and left only some margin to the social service sectors such as health. The study by Kinyata and Siraje (2018) which recorded that, though there was an increase in the local revenue collection, the health departments across the local governments were getting insignificant shares with the rest of the shares going to council operations, supervisions and administrative overheads. According to the Maractho (2017) Arua District study, local revenue was a small share of overall district funds as compared to the central government transfers and donor funds. This line of evidence was a solid indicator that a similar trend also applied in Arua City: the locally generated revenue though on the rise was not being channelled toward health in relative amounts that would be of great supplementary value to conditional grant allocations.

4.4.3 Promptness and predictability of transfer of finances.

Included in the Auditor General reported to Arua City are certain findings relating to the quarterly release schedule of the conditional grants with some instances of delayed releases or timing constraints of release schedules that created cash flow constraints in the service delivery planning (Office of the Auditor General, 2022, 2023). There were also reports of instances when funds advanced to the staff to implement some specified activity had not been recovered even after the staff had ended the specified accountability periods. In a research conducted by Jordanwood et al. (2022) reported grave delays of the fiscal transfer to local governments in Uganda, with the local revenue to the Treasury Single Account (TSA) not returned in many years, paralyzing health outreaches and payment of utility at health centres. The authors, Kinyata and Siraje (2018) found out that one of the primary bottlenecks to the provision of health services at the subnational level was identified as making erratic disbursement by the central government.

On this finding, it would be implied that fiscal decentralisation has decentralised the spending account without the guarantee of the fiscal predictability to the health services provision. When health facilities are run under some uncertainty conditions of cash flow, the health facilities cannot plan and/or provide services at a steady rate, irrespective of whether the facilities adequately provided the services and/or the formal sufficiency of the allocations on paper. The TSA system of requiring generated revenue by local governments to be remitted to a central account and requisition funds per activity further streamline the revenue generation by local governments to a single account as centrally mediated and as the delays in release

associated with conditional grants, effectively further reduces the decentralisation of fiscal matters.

4.4.4 Autonomy and Conditionality of Expenditure

The PHC Grant Budget and Implementation Guidelines confirmed that the grants to local governments were heavily conditional, with the Ministry of Health specifying the type of expenditures that could be made, the conditions of reporting on the issue, and the performance conditions (Ministry of Health, 2020). Legal provision had been restricted by local governments to reallocate conditional grant funds to respond to locally identified priorities not within the specified categories. The effects of this conditionality were indirectly evidenced in the reports of the Arua City by the Auditor General which recorded expenditure patterns in compliance with the specified categories of conditional grant, with little evidence of locally-initiated decisions on health expenditure choices that were not in compliance with the conditional framework (Office of the Auditor General, 2022, 2023). The practical impact of this conditionality on expenditure in categories were recorded in the Jordanwood et al. (2022) study: the heads of the health departments noted the impact of the given conditionality on the expenditure in categories.

The Bahl and Linn (1992) benchmark of meaningful fiscal decentralisation has the following characteristics: own-source generation of revenue, adequate intergovernmental transfers, and expenditure autonomy. The three factors are wanting as proposed by the documentary evidence of Arua City i.e. the distribution of own-source revenue to health is marginal, intergovernmental transfers are inadequate relative to need (per capita expenditure of US23 against the US86 benchmark) and

expenditure autonomy is restricted due to conditionality. Fiscal decentralisation is a fiscal managerial arrangement in these circumstances as opposed to a fiscal empowerment arrangement - the local government manages spending as it sees fit in accordance with centrally determined rules and not in accordance with a true fiscal discretion determination of the health service delivery priority.

4.5 Chapter Conclusion

The chapter has given the findings of the documentary analysis that was organized based on the three research questions. A uniform pattern appeared across all three dimensions of decentralisation that the institutional form of the devolved health administration was present in Arua Hill Division, but the functional content of that form, i.e. political accountability, which corrects failures in service delivery, administrative discretion, which facilitates responsive control of the administrative facilities, and fiscal resources adequate to the task which the institutional form of the devolved health administration was present in Arua Hill Division, but the functional content of that form, i.e. political accountability, which corrects failures in service delivery, administrative discretion, which facilitates responsive control of the administrative facilities, and fiscal resources adequate to the task which the institutional form of the devolved health administration was present in Arua Hill Division, but which functional content of that form i.e. political accountability, which corrects failures in service delivery, administrative discretion, which facilitates responsive control of the administrative facilities and fiscal resources adequate to the task was all inadequate to the task to which the institutional form of the devolved

health administration was expected to apply itself. In a political decentralisation, the structures of governance are constituted though did not produce corrective accountability of the health performance. Under administrative decentralisation the management structures were at the division level but with a small decision space. The conditional grant program, which allocated resources to health service delivery, was not adequately funded under the fiscal decentralisation which allocated resources to health service delivery, but the amount was not sufficient, local revenues were distributed to health marginally, predictability of transfers was compromised and expenditure autonomy was constrained by conditionality. Based on these findings, Chapter Five discussed the findings in relation to existing literature, drew conclusions, identified limitations, and made recommendations.

CHAPTER FIVE: Results discussion, Conclusions and recommendations.

5.1 Introduction

Regarding the literature review that was conducted on each of the three purposes of the study, the findings were discussed in this chapter. The documentary analysis and existing literature on decentralisation and delivery of health services showed points of convergence, divergence, and extension. The chapter concluded with conclusions through organisation by objective, recognition of limitations of the study, policy and practice recommendations which was organised by objective and finally giving a concluding reflection on the contribution made by the study.

5.2 Discussion of Study Findings

This section discusses the findings in relation to the literature reviewed in Chapter Two. Under each objective, key findings are examined for agreement, contradiction, or extension of existing scholarship.

5.2.1 Political Decentralisation and Health Service Delivery

Finding 1: Formal governance structures were present but did not generate corrective accountability for health outcomes.

This finding agreed with Manor (1999), who argued that political decentralisation improves service delivery only when it generates functional downward accountability. A lack of corrective health interventions by Arua City Council, despite a 54% vacancy rate and persistent drug stockouts, confirmed that the accountability mechanism Manor identified was not operational. The finding also aligned with the ACODE

Scorecard (2016/17), which showed an average performance score of 53/100 across assessed districts (Bogere et al., 2017), and with Olowu and Wunsch (2004), who found that the quality of political decentralisation predicted service delivery outcomes more strongly than structural existence alone.

Existing literature attributed weak political decentralisation to insufficient capacity or political will, but this study identified a specific mechanism: the failure of health performance data to reach division-level actors in usable forms. This extended Maractho's (2017) finding by identifying information opacity as a distinct constraint on political accountability.

Finding 2: Citizen participation in health planning remained unrealised.

This was consistent with Maractho (2017), who reported that 75% of assessed districts found central government dependence constrained meaningful local participation, and with Boadu et al. (2024), who found public participation in Ugandan local government health delivery was frequently tokenistic.

Björkman and Svensson (2009) showed that actively facilitated community participation produced significant health improvements. The contrast showed that the conditions for effective participation—structured information access, facilitation, and accountability interfaces—had not been created in Arua Hill Division.

Finding 3: Downward accountability for health performance was not functioning.

This was in line with Kabuye et al. (2024), who found that health accountability meetings with local politicians in Ugandan districts rarely led to concrete follow-up actions. It also aligned with Atkinson et al. (2002), who cautioned that formal local

governance structures do not automatically translate into improved service accountability.

5.2.2 Administrative Decentralisation and Health Service Delivery

Finding 1: Health worker vacancy rates remained at 54%, with staffing responsibility devolved but authority retained centrally.

This was in line with the national WISN assessment, which found that only 56% of approved positions were filled nationally, with severe maldistribution favouring Kampala (Hagopian et al., 2015). It also agreed with Luyimbazi et al. (2017), who confirmed that local managers saw themselves as implementers rather than decision-makers, and with Kyaddondo and Whyte (2003), who documented demoralisation and absenteeism resulting from under-resourced administrative decentralisation.

The study built on existing evidence by showing that this pattern continued into the 2020-2025 period, including a recruitment freeze in FY 2022/23 (Ministry of Public Service, 2024), confirming the gap as a durable structural feature rather than a transitional phenomenon.

Finding 2: Drug procurement was centrally controlled, leaving division-level structures with responsibility but no procurement authority.

This was consistent with Ssenyonjo et al. (2021), who found that de facto decision space in drug procurement was smallest at lower-level facilities, and with Orach et al. (2023), who confirmed that persistent drug stockouts in West Nile were linked to the push system. It also aligned with Jeppsson (2002), who found drug procurement remained subject to central ministry procedures.

Finding 3: The gap between de jure and de facto decision space was structural, not transitional.

This directly agreed with the Decision Space Framework (Bossert & Beauvais, 2002). The consistency of this finding over more than twenty years—from Jeppsson (2002) through Ssenyonjo et al. (2021) to the present study—confirmed the gap as a lasting structural feature.

Jordanwood et al. (2022) reported that conditional grant guidelines dictated expenditure categories to the extent that locally identified priorities outside prescribed categories could not be funded, further confirming that administrative discretion was limited across staffing, procurement, and resource allocation.

5.2.3 Fiscal Decentralisation and Health Service Delivery

Finding 1: Per capita health expenditure (US\$23) fell far below the WHO benchmark (US\$86).

The UNICEF Health Budget Brief (2023/24) confirmed that health sector spending stood at 7.7% of the national budget, well below the 15% Abuja Declaration target. The finding was consistent with Bahl and Linn (1992), who identified adequate transfers as a prerequisite for meaningful fiscal decentralisation, and with Williamson and Okole (2021) and Kinyata and Siraje (2018), who documented the effects of fiscal inadequacy on local health delivery.

The study traced the downstream consequences of fiscal inadequacy through the conditional grant framework to specific service delivery failures in Arua Hill Division,

showing that fiscal decentralisation transferred the burden of managing an insufficient envelope to the local level.

Finding 2: Locally generated revenue was not meaningfully directed toward health.

This was consistent with Kinyata and Siraje (2018), ActionAid (2019), and Maractho (2017), all of whom documented that health departments received very small shares of local revenue, with the bulk directed toward administrative overhead.

Finding 3: The conditional grant framework and TSA system constrained expenditure autonomy and fiscal predictability.

This was in accordance with Jordanwood et al. (2022), who documented severe transfer delays and the TSA's conversion of local revenue into a centrally mediated resource, and with Saltman, Bankauskaite, and Vrangbaek (2007), who found that fiscal decentralisation without administrative capacity deepens service delivery inequities.

Against Bahl and Linn's (1992) three prerequisites—own-source revenue authority, adequate transfers, and expenditure autonomy—none of the three were met, leading the study to characterise Arua Hill Division's fiscal arrangement as a fiscal management arrangement rather than a fiscal empowerment arrangement.

5.3 Conclusions

5.3.1 Conclusion on Political Decentralisation and Health Service Delivery

The findings and discussion led to the following conclusions:

- i. Political decentralisation put in place the formal institutional framework for health governance in Arua Hill Division, including elected councils, citizen participation mechanisms, and downward accountability structures as mandated by the Local Governments Act (Cap. 243, 1997).
- ii. Citizen participation in health planning remained an unrealised institutional capability. No documented outputs of participation processes were found for Arua Hill Division during the study period.
- iii. No published evidence was found that political governance structures generated corrective responses to documented health deficits, including the 54% vacancy rate, persistent drug stockouts, and below-target utilisation rates.
- iv. The accountability loop between health performance data, political oversight, and corrective action was not functioning. Information asymmetry—health data reported at city level without flowing to division-level actors—was a key constraint.
- v. Political decentralisation achieved institutional form without institutional function, confirming Manor's (1999) theoretical expectation that formal structures alone are insufficient without information access, citizen engagement facilitation, and consequence mechanisms.

5.3.2 Conclusion on Administrative Decentralisation and Health Service Delivery

The following conclusions were drawn:

- i. Administrative decentralisation transferred formal responsibility for health service management to division-level structures but did not transfer the corresponding authority needed for responsive management.
- ii. The 54% health worker vacancy rate reflected a national pattern in which staffing decisions were controlled centrally (District Service Commission, Health Service Commission, central wage bill), while local structures bore management responsibility without recruitment authority.
- iii. Drug procurement through the NMS push system operated as a centralised function, with division-level structures bearing responsibility for medicine availability without authority to procure based on local demand.
- iv. The Division Health Management Team operated within a constrained decision space, functioning as an administrative relay rather than an empowered management unit—a pattern consistent with findings spanning over two decades (Jeppsson, 2002; Ssenyonjo et al., 2021).
- v. Health facility readiness in the West Nile sub-region fell below national standards, with geographic access to facilities within 5 km ranging between 24% and 68% (Komakech et al., 2019).
- vi. The gap between administrative responsibility and authority was a durable structural feature of the decentralisation framework, not a transitional challenge.

5.3.3 Conclusion on Fiscal Decentralisation and Health Service Delivery

The following conclusions were drawn:

- i. Fiscal decentralisation operated as a fiscal management arrangement rather than a fiscal empowerment arrangement: local government managed expenditure according to centrally determined rules rather than exercising genuine fiscal discretion.
- ii. All three prerequisites for meaningful fiscal decentralisation (Bahl & Linn, 1992)—own-source revenue authority, adequate transfers, and expenditure autonomy—were unmet. Per capita health expenditure of approximately US\$23 fell far below the WHO benchmark of US\$86.
- iii. Transfer predictability was compromised by delayed fiscal releases and TSA dynamics, which converted local revenue from a flexible resource into a centrally mediated one.
- iv. Local revenue allocation to health was marginal, with the bulk directed toward council operations and administrative overhead.
- v. Expenditure autonomy was constrained by grant conditionality, limiting the capacity to respond to locally identified health priorities.
- vi. The combined effect was a fiscal architecture in which local government bore the consequences of health service delivery failures while lacking the resources, discretion, and predictability needed to address them.

5.5 Recommendations

5.5.1 Recommendations on Political Decentralisation

- i. Arua City Local Government ought to make it a practice to publish council resolutions, committee reports, and health-related oversight actions in publicly accessible formats to address the information gap that constrained political accountability.
- ii. Local government councils need to be supported to create health-specific standing committees with clear terms of reference for health budget scrutiny, facility oversight, and monitoring of health performance indicators.
- iii. Structured community participation mechanisms, based on the approach shown by Björkman and Svensson (2009), should be set up, including provision of health performance information to citizens and structured interface meetings between service users and decision-makers.
- iv. The Ministry of Health, together with the Ministry of Local Government, should make sure that HMIS health performance data is disaggregated and made available at the division level to enable informed local oversight.

5.5.2 Recommendations on Administrative Decentralisation

- i. The central government ought to review the allocation of administrative authority in health, granting local structures more influence over recruitment, deployment, and retention of health workers within approved establishment ceilings.
- ii. Recruitment restrictions in the health sector should be lifted, and PHC wage bill allocations adjusted to reflect demographic pressures in sub-regions such as

the West Nile, where refugee hosting created demands not captured by the standard formula.

- iii. The Ministry of Health should continue to extend the pull system for drug procurement to HC III-level facilities, enabling facility-level ordering based on local demand.
- iv. Division Health Management Teams should be given dedicated operational budgets and clear performance benchmarks to function as genuine management units.

5.5.3 Recommendations on Fiscal Decentralisation

- i. The Government of Uganda needs to speed up efforts toward the Abuja Declaration target of 15% of the national budget allocated to health, to bring per capita expenditure closer to the WHO-recommended minimum of US\$86.
- ii. Local government councils should allocate a guaranteed minimum percentage of locally generated revenue to health service delivery in each financial year.
- iii. The conditional grant framework should include a discretionary allocation within health grants for locally identified priorities in categories not already prescribed.
- iv. The Ministry of Finance should look at the impact of the TSA system on local government health service delivery, weighing efficiency gains against service delivery costs from local revenue access delays.
- v. The health grant allocation formula should be changed to account for conditions in refugee-hosting sub-regions where population pressure on health infrastructure exceeds the current formula's assumptions.

APPENDIX: DOCUMENT REVIEW CHECKLIST

The following structured document review checklist was used as the data collection instrument. It set out, for each document category, the information to be extracted, the indicators to be recorded, and the corresponding study objective(s). The instrument was piloted on two documents before full deployment (Yin, 2018).

Study Title: The Role of Decentralisation in Promoting Health Service Delivery in Arua Hill Division, Arua City, Uganda

Researcher: Maketa Fortunate (S23B56/038)

Date of Review: _____

Document Being Reviewed: _____

Document Category	Information to Extract	Indicator(s)	Study Objective	Data Present (Y/N)	Notes / Source Reference
National health sector performance reports (MoH)	Health worker staffing; vacancy rates; medicine availability; OPD utilisation; facility readiness	Filled vs. approved positions; vacancy %; tracer medicines in stock; OPD rate per capita; facility readiness score	Obj 2 (Admin); cross-cutting		
Auditor General reports for Arua City	Health grant allocation/disbursement; local revenue to health; transfer timeliness; staff accountability	Allocated vs. disbursed (UGX); absorption %; LGR to health %; release delays	Obj 3 (Fiscal); cross-cutting		
LG Performance Assessment reports (OPM)	LG performance scores; admin capacity indicators	Overall score %; health sub-scores; planning compliance; supervisory visits	Obj 1, 2 (cross-cutting)		
ACODE LG Councils Scorecard	Council oversight scores; councillor legislative performance	Scorecard total (/100); budget scrutiny; health-related motions/resolutions	Obj 1 (Political)		
National legislation and policy instruments	Legal framework; grant guidelines and conditionality	Council authority provisions; HUMC mandates; expenditure categories; local discretion	Obj 1, 2, 3 (framework)		

Published academic studies	Empirical findings; citizen participation evidence	Decision space breadth; staffing patterns; accountability findings; HUMC functionality	All three objectives		
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Instructions for Use:

1. One copy of this checklist was filled out for each document reviewed.
2. Specific data points found were recorded under “Information to Extract.”
3. “Data Present (Y/N)” showed whether or not the document included the specified information.
4. Page numbers, table numbers, or section references were recorded under “Notes / Source Reference.”
5. All extracted data was transferred to a master extraction matrix organised by objective and variable dimension.
6. Where information was absent, “N” was recorded with relevant observations about the gap.
7. Each document was appraised for authenticity, credibility, representativeness, and meaning according to Scott’s (1990) criteria before extraction.

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