

Effects of Allocations of Revenue Collected Locally by Kampala Capital City Authority on the Provision of Quality Maternal Health Care

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ABSTRACT

The study focused on the effects of revenue allocations collected locally by Kampala City Authority in Uganda on the provision of quality maternal health care. A case study design was used. A quantitative approach was adopted with a population of 300 and a sample size of 172. Questionnaires were used to collect information from the respondents. Data were analyzed using the mean and standard deviation and correlation methods. The findings showed that there were no tangible effects of the expenditure of locally collected revenue by KCCA on the quality of maternal health care, as the quality of maternal health care in KCCA health facilities was poor (mean score of 1.93). Poor quality maternal health care was associated with mismanagement, corruption, and poor planning of locally collected revenue. The study also concluded that if locally collected revenue was used well for maternal health care, then there would be significant positive effects on the provision of quality maternal health care since the correlation coefficient was 0.788, indicating a strong relationship. The study recommended that KCCA administration adopt best practices such as anti-corruption strategies. Leadership of health facilities and the KCCA to implement best planning methods, good governance and transparency.

Keyword: - Revenue Allocation, Maternal Health Care, Kampala Capital City Authority

1. INTRODUCTION

Many African countries have carried out reforms aimed at decentralizing government administrative and fiscal structures. This has given local government authorities the power to collect revenue in their areas of jurisdiction. The need for these reforms has been pushed by the view that decentralization of services to local authorities improves the efficiency of the public sector in providing services [1]. Some African countries that have fiscal devolved functions to local authorities include; Mozambique, Kenya, Burkina Faso, Botswana, Ghana, Mali, Nigeria, South Africa, Ethiopia, Tanzania, and Uganda [2]. In Kenya, for instance, fiscal decentralization of health was adopted in 2010. Health management was shifted to 47 counties (local authorities). This devolvement of services to local authorities has seen improved infrastructure in hospitals, and it has also witnessed health service, which had not been done before in some local hospitals such as C-section [3]. In Uganda, when the National Resistance Movement took power in 1986, a number of reforms were pursued to mitigate some health sector problems, partially through the government's broader decentralization policy [4]. Since then, several reforms have been introduced to strengthen decentralization in Uganda. These include introduction of the Sector Wide Approach (SWAp), public-private partnership, abolition of user fees, introduction of the Uganda National Minimum Health Care Package (UNMHCP), autonomy for the National Medical Stores (NMS), and decentralization of the responsibility of delivering health services to local authorities. In Uganda, maternal mortality is 343 per 100,000 live births (WHO, 2018). According to Benova et al. [5], the quality of Antenatal Care (ANC) in Kampala is poor. The quality of maternal health care in Uganda must reflect the World Health Organization (WHO) standards for maternal health care. The link between devolved services to local authorities and Maternal Health Care (MHC) service delivery has been scarcely explored. To date, only a few studies have evaluated the impact of local authority local collected revenue on MHC [6]. In recent years, scholars and practitioners have produced much research on devolution, covering a vast array of issues. Unfortunately, the evidence on the link between local authority collected revenue and the provision of maternal health care is highly inconclusive. The existing empirical literature focuses on the merits and drawbacks of decentralization. Therefore, this study was set to assess the effects of revenue allocations collected locally by the Kampala Capital City Authority on the provision of quality maternal health care.

1.1 Literature Review

The theoretical foundation of this study was the Sequential Theory of Decentralization. The Sequential theory of decentralization was proposed by Falleti [7]. This theory observes that decentralization is a set of state reforms. Therefore, decentralization excludes transfers of authority to non-state actors. Falleti [7] noted that decentralization reforms may occur in both authoritarian and democratic contexts, meaning that the concepts of decentralization and democratization should not be conflated. Notably, Falleti [7] asserted that the sequential theory of decentralization classifies territorial decentralization into political, administrative, and fiscal dimensions. Awortwi [8] argued that the sequential theory of decentralization is based on three propositions: First, the institutional design of decentralization policies is highly dependent on when those policies occur within the sequence of reforms. According to Falleti [7], fiscal decentralization policies that occur early in the sequence tend to increase the power of local government actors, whereas early administrative decentralization reforms tend to negatively affect their power. Second, a set of national and sub national actors' preferences regarding types of decentralization. National politicians and executives prefer administrative decentralization (A) over fiscal decentralization (F), which in turn prefers political decentralization (P). Lastly, the origin or state context in which the decentralization process occurs and the timing of each reform is crucial [8].

The Sequential theory of decentralization is relevant to this study because it portends that territorial decentralization takes political, administrative, or fiscal dimensions. This study examines fiscal decentralization variables namely; expenditure decisions, revenue decisions, and revenue collected based on the sequential theory of decentralization. The sequential theory of decentralization has three main assumptions: assumes decentralization is a process; it is underpinned to territorial interests of bargaining actors and incorporates policy feedback effects. In this study, the research opined that since decentralization is a dictate of the Ugandan constitution, there is no doubt that it is a process in which the central government gives powers and management responsibilities to local governments such as the Kampala City Local Government. Falleti [7] supports the idea that decentralization embraces a series of actions or steps taken to achieve a particular end. The series of actions is political, administrative, and fiscal. Because local government power is portend in the constitution, the territorial interests of the bargaining are guaranteed. However, the policies undertaken by the local government may have received feedback from the residents; it is difficult to understand how the Kampala City Local Government. This study provided more knowledge on the sequential theory of decentralization in that it demonstrated whether decentralization is a set of state reforms intended to improve service delivery. On the other hand, the study improved the theory by understanding how policy feedback advocated by the theory could be operational to enhance service delivery in the local government, specifically maternal health care in Kampala City Local Government. Bourbonnais [9] supported this by suggesting that for quality service delivery, considerate and structured policy feedback action.

2. METHODOLOGY

The study was conducted at the Kampala Capital City Authority (KCCA). The hospitals selected were; Kiswa Health Center and Komamboga Health Centers. The case study design was adopted because it explains the situation in depth [10]. The population was 300, including mothers (200), employees of Kiswa and Komamboga Health Centers (50), and KCCA (management staff) (50). The sample size was 172 as calculated using the Yumane formula of 1967. Purposive sampling was used to select the hospitals and staff of KCCA, whereas random sampling was used to select the mothers who attended the hospitals. The data collection methods were questionnaire and interview. Data were analyzed using the mean and standard deviation. The correlation was also used to determine the relationship between revenue collected by KCCA and the provision of quality healthcare.

3. FINDINGS AND DISCUSSION

3.1 Findings

Profile of Respondents

The characteristics analyzed were gender, age, and academic qualifications.

Table 1: Gender of Respondents

Gender	Frequency	Percentage (%)
Male	35	21.3
Female	129	78.7

The study found that 129 (78.7%) were female and 35 (21.3%) were male. The proportion of female participants was greater than that of male participants because the study was squarely investigating quality of maternal health care and was biased to mothers who had sought treatment at the health facilities.

Table 2: Respondent Age

Variable	Frequency	Percentage
20-30 years	45	27.4
31-40 years	80	48.8
41-50 years	25	15.3
55-60 years	12	7.3
Over 60 years	2	1.2

The findings show respondents of ages 31-40 years were 80 (48.8%), 20-30 years were 45 (27.4%), 41-50 years were 25 (15.3%), 55-60 were 12 (7.3%) and over 60 near shore only 2 (1.2%). Respondents of ages 31-30 years and 31-40 were many because this is the child-bearing age for the mothers.

Table 3: Education of Respondents

Education	Frequency	Percentage
Secondary Education	6	3.7
Secondary Level	60	36.6
Diploma Level	50	30.5
University Degree	40	24.4
Post Graduate	8	4.8

Table 3 shows that the secondary level had 60 (36.6%) respondents, diploma had 50 (30.5%), university degree had 40 (24.4%), and postgraduate had 8 (4.8%), and below secondary had 6 (3.7%) respondents.

Effects of revenue allocations collected locally by KCCA on the provision of quality maternal health care

The respondents were given statements depicting the effects of local revenue allocation by KCCA on the provision of quality maternal health care. Table 4 presents the results.

Table 4: Response regarding the effects of revenue allocations collected locally by KCCA on the provision of quality maternal health care

Statement	N	Mean	Standard Deviation
The health facility has enough medicine because of revenue collected locally by Kampala city.	164	2.14	0.33
The Kampala City's locally collected revenue allocation provides for adequately trained personnel in health facilities.	164	3.10	0.47
Kampala collected locally collected revenue contributes toward adequate medical equipment related to the provision of quality maternal health in health facilities.	164	2.14	0.52
Kampala collected revenue locally and has provided the hospital with enough beds to cater for mothers seeking maternal health.	164	3.12	0.36
Kampala City's locally collected revenue contributes toward all consumables available to patients.	164	1.74	0.12

The results in Table 4 indicate that statements; the health facility has enough medicine as a result of revenue collected locally by Kampala city had a mean score of 2.14, which means the health facilities had few medicines, the

Kampala city locally collected revenue allocation provides for adequately trained personnel in the health facility had a mean score of 3.10, which means allocation from KCCA provides or contributes moderately toward training of personnel in the hospitals. The statement that Kampala City locally collected revenue contributes toward adequate medical equipment related to provision of quality maternal health in the health facility had a mean score of 2.14, which means that the KCCA locally collected revenue contributes to little or no medical equipment toward maternal health care. Lastly, the statement; the Kampala city locally collected revenue has provided the hospital with enough beds to cater for mothers seeking maternal health had a mean score of 3.12, which means the KCCA Locally collected revenue contributes moderately in provision of beds for mothers seeking maternal health care in the health facilities and Kampala city locally collected revenue contributes toward all consumables availed to patients had a mean score of 1.74, which means KCCA locally collected revenue contributes very little of very few toward consumables given to patients in the health facilities.

Correlation between the expenditure of locally collected KCCA revenue and quality maternal health care

Alternatively, a correlation analysis between the expenditure of locally collected revenue allocated to KCCA and quality maternal health care was conducted, and the results are presented in Table 5.

Table 5. Correlation between KCCA expenditure of locally collected revenue allocation and quality of maternal health care

		Expenditure of locally collected KCCA revenue	Quality maternal health care
Expenditure of locally collected KCCA revenue	Pearson Correlation	1	.788**
	Sig. (2-tailed)		.000
	N	164	164
Quality maternal health care	Pearson Correlation	.788**	1
	Sig. (2-tailed)	.000	
	N	164	164

** . The correlation is significant at the 0.01 level (2-tailed).

Results in Table 5 clearly demonstrate that the relationship between the expenditure of KCCA locally collected revenue allocation and quality health service delivery is significant, as demonstrated by the Pearson Correlation coefficient result of 0.788. The *correlation coefficient* is a statistical measure of the strength of the relationship between the relative movements of two variables. The values ranged from 1.0 to 1.0. The more the *coefficient approaches 1.0, the more the strength of the relationship. Thus, the coefficient of the study is 0.788, which is closer to 1.0.* This shows a strong relationship. This result implies that the expenditure of locally collected revenue allocation from KCCA affects quality health service delivery.

3.2 Discussion

The study found that the health facilities had few medicines despite the Kampala City locally collected revenue allocation, allocation from KCCA provides or contributes moderately toward training of personnel in the hospitals, KCCA locally collected revenue contributes to little or few medical equipment toward maternal health care, KCCA Locally collected revenue contributes moderately in provision of beds for mothers seeking maternal health care in the health facilities and KCCA locally collected revenue contributes very little or very few toward consumables given to patients in the health facilities. Generally, KCCA locally collected revenue has little impact toward provision of quality maternal health care as responses point to poor maternal health care given to mothers. The results concur with those of Bethany et al. [11], who found that provision of maternal care was poor because collected revenue was diverted to COVID-19. This action neglected mothers seeking maternal health care in hospitals. The World Health Organization [12] also emphasized that in some countries, poor quality maternal care is attributed to poor use of revenue collected by authorities. This gave the researcher an insight into Uganda, where the local government authority (KCCA) could be collecting huge revenues; however, mismanagement causes poor health services delivery, including maternal health care. The findings of this current study could not facilitate quality maternal health care as dictated by the WHO [13] standards of quality maternal health care, especially quality Standard No. 1: Every woman and newborn receive routine, evidence-based care and management of complications during labor, childbirth, and the early postnatal period.

The researchers' association with locally collected KCCA did not have an impact on quality maternal health care in Uganda due to mismanagement, corruption, and poor planning. This position was also taken by the World Health Organization [14] in their study on making pregnancy safer: the critical role of the skilled attendant and found out that mismanagement, corruption, and poor planning lead to the non-employment of skilled manpower. This implies that KCCA locally collected revenue had little impact on the provision of quality maternal health care as responses point to poor maternal health care given to mothers. This is because if the KCCA locally collected revenue was properly used toward quality maternal health care, then the above mothers could have responded positively, and the mean score from the respondents would have been high. The results were similar to Samwel and Kerry [15], who found that some devolved units (Counties) in Kenya e.g. Garissa, Kilifi, and Madera, had poor quality of maternal health despite the counties having the power to collect revenue locally. The correlation analysis showed that the relationship between the expenditure of KCCA locally collected revenue allocation and quality health service delivery would be significant, as demonstrated by the Pearson Correlation Coefficient of 0.788 if the revenues were put in good use toward maternal health care. In fact, the coefficient depicted a strong relationship that the expenditure of KCCA locally collected revenue allocation affects quality healthcare service delivery.

4. CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

The study concluded that the expenditure of locally collected revenue by KCCA had no tangible effects on the quality of maternal health care. This was associated with mismanagement, corruption, and poor planning of locally collected revenue. The study also concludes that if locally collected revenue was used well for maternal health care, then there would be significant positive effects on the provision of quality maternal health care since the correlation coefficient was 0.788, signifying a strong relationship.

4.2 Recommendations

The study recommended that KCCA administration adopt best practices such as anti-corruption strategies. Leadership of health facilities and the KCCA to implement best planning methods, good governance and transparency

5. REFERENCES

- [1]. Amusa, H., & Mabugu, R. (2016). The effects of fiscal decentralization on public health outcomes in Africa. *African Journal of Health Economics*, 12(3), 14-27.
- [2]. Speer, P. (2012). Local government fiscal decentralization in Africa: An overview of practices and challenges. *Journal of African Economies*, 21(1), 217-244. <https://doi.org/10.1093/jae/ejr016>
- [3]. Kenya Ministry of Health Report. (2019). *Improving health services through fiscal decentralization in Kenya*. Nairobi, Kenya: Author.
- [4]. Otieno, F., et al. (2020). The impact of decentralization on health service delivery in Uganda: A case study of the Kampala Capital City Authority. *BMC Health Services Research*, 20(1), 1-10. <https://doi.org/10.1186/s12913-020-05821-2>
- [5]. Benova, L., et al. (2018). Quality of antenatal care in low- and middle-income countries: A systematic review. *International Journal of Gynaecology and Obstetrics*, 142(5), 533-542. <https://doi.org/10.1002/ijgo.12771>
- [6]. Makokha, A. (2017). Decentralization and its impacts on local health care delivery in Kenya: A review of the literature. *Health Policy and Planning*, 32(3), 319-326. <https://doi.org/10.1093/heapol/czx014>
- [7]. Falleti T.G (2004) A sequential theory of decentralization and its effects on the intergovernmental balance of power: Latin American cases in comparative perspective *American Political Science Association* 99(03):327 – 346 DOI: 10.1017/S0003055405051695.
- [8]. Awortwi, N. (2011). A comparative study of decentralization and local government development trajectories in Ghana and Uganda. *International Review of Administrative Sciences Quarterly*, 77(2), 347–377
- [9]. Bourbonnais, J. (2013). Policy feedback and quality service delivery in local governments: Evidence from the health sector. *Public Administration Review*, 73(6), 847-855. <https://doi.org/10.1111/puar.12058>
- [10]. Mugenda, O. M., & Mugenda, A. G. (2003). *Research methods: Qualitative and quantitative approaches*. Nairobi, Kenya: African Centre for Technology Studies Press.

- [11]. Bethany, K., Emily, G., Sophia, P., Ana L. & Henning T. (2021). The impact of the COVID-19 pandemic on maternal and perinatal health: a scope. 2018; article number: 10. <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-021-01070-6>
- [12]. World Health Organization. (2018). *Global health estimates: Maternal mortality ratio (per 100,000 live births)*. Geneva, Switzerland: Author.
- [13]. World Health Organization. (2016). Standards for improving quality of maternal and newborn care in health facilities. *WHO Guidelines*. <https://www.who.int/publications/i/item/9789241511217>
- [14]. World Health Organization. (2004). *Making pregnancy safer: The critical role of the skilled attendant*. Geneva, Switzerland: Author.
- [15]. Samwel, I., & Kerry, H. (2018). Decentralization and the quality of maternal health care in Kenya: Lessons from selected counties. *Kenya Journal of Health Services*, 3(1), 45-61.

