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Abstract

Purpose: This study examined the effect of revenue decentralization on healthcare service delivery in Turkana County, Kenya.

Materials and Methods: Using a mixed-methods approach, the research collected data from 271 respondents, including county health and finance officials, hospital administrators, and community health representatives.

Findings: The findings reveal that revenue decentralization significantly improves healthcare service delivery, with a one-unit increase in revenue decentralization leading to a 0.49-unit improvement in healthcare outcomes. However, delays in budget disbursement (averaging 5.11 months) and reliance on external revenue sources (36.9% tax autonomy) highlight challenges in financial sustainability and resource allocation. Qualitative responses underscore both the benefits of increased autonomy and access to funding, as well as the drawbacks of concentrated financing and disparities in rural healthcare access. The study concludes that optimizing tax autonomy mechanisms, strengthening intergovernmental grants, and improving financial management are critical to enhancing the positive effects of revenue decentralization. These findings contribute to the broader discourse on fiscal decentralization and its potential to address healthcare inequities in marginalized regions.

Unique Contribution to Theory, Practice and Policy: To improve healthcare in Turkana County, enhance revenue decentralization by refining tax autonomy, increasing equitable intergovernmental grants, and addressing rural disparities. Implement 'nomadic health vouchers' using 15% of decentralized revenues and 'fiscal health compacts' to reduce budget delays. Ensure autonomy, accountability via blockchain, and drought-responsive budgets work together to boost accessibility and patient support, transforming fiscal policy into a tool for healthcare justice, especially for mothers and herders facing long waits and travel for care.

Keywords: *Revenue decentralization, Healthcare service delivery*

JEL Classification: *D73, H71, and H81*

INTRODUCTION

Revenue decentralization, which involves transferring financial and revenue-related responsibilities to lower levels of government, has gained significant attention as a strategy to improve governance, enhance public service delivery, and promote local economic development. By empowering local governments, revenue decentralization aims to increase citizen participation, improve efficiency, and address regional disparities. However, its effectiveness in achieving these goals, particularly in healthcare service delivery, remains a subject of debate. While some studies suggest that decentralization leads to better economic performance and responsiveness to local needs, others highlight challenges such as regional disparities, weak accountability, and uneven service delivery outcomes (Mejia & Tillin, 2019; Oppong, 2020). In Kenya, the devolution of healthcare services to county governments under the 2010 Constitution was intended to address inequities and improve access to healthcare. However, the implementation of revenue decentralization in Turkana County, one of Kenya's most marginalized regions, has faced significant challenges, raising questions about its impact on healthcare service delivery.

Turkana County, located in the arid and remote northern part of Kenya, has long struggled with limited healthcare infrastructure, high disease burdens, and poor health outcomes. The county's nomadic population, harsh environmental conditions, and historical marginalization have exacerbated these challenges. Despite the devolution of healthcare services and the allocation of resources to the county government, access to healthcare remains limited, with residents often traveling long distances to reach health facilities. Key health indicators, such as maternal and child mortality rates, remain alarmingly high, and the doctor-to-population ratio is far below the recommended standard (Kenya Health Policy, 2012-2013; KDHS, 2022). These issues highlight a critical gap in understanding how revenue decentralization has influenced healthcare service delivery in Turkana County.

The problem is further compounded by concerns over financial management and accountability. Recent audits have revealed irregularities in budget allocation and utilization, particularly during the COVID-19 pandemic when health infrastructure were overstrained, raising questions about the county government's capacity to effectively manage devolved resources (OAG-Special Audit Report, 2022). While studies in other contexts have explored the relationship between revenue decentralization and economic growth, poverty reduction, and governance, there is limited research on its direct impact on healthcare service delivery, particularly in marginalized regions like Turkana County. This study seeks to address this gap by examining the effects of revenue decentralization on healthcare service delivery in Turkana County.

The scope of this study was limited to public health facilities under the Turkana County government, with a focus on the period following the implementation of devolution in 2013. The study targeted key stakeholders, including county health and finance officials, hospital administrators, and community health representatives. While the vastness of Turkana County and its sparse population posed logistical challenges, the study employed a combination of questionnaires and interviews to ensure comprehensive data collection.

LITERATURE REVIEW

Revenue decentralization, which involves the collection and allocation of public revenue at the local level, has been widely studied as a mechanism to improve public service delivery, including healthcare. According to Gadenne (2017), revenue decentralization empowers local governments to generate income through taxes and other instruments, enabling them to address local needs more effectively. Recent studies emphasize that successful revenue decentralization

requires complementary investments in local administrative capacity and digital infrastructure to track revenue flows and expenditures (OECD, 2023). Donor initiatives, such as those by USAID, have often encouraged local administrations to enhance revenue generation as a means of strengthening democratic governance and improving service delivery (Press, 2014). These initiatives are based on the assumption that increased local revenues lead to better local services, fostering economic growth and improved living conditions (Bashaasha, Mangheni, & Nkonya, 2013).

Empirical studies have provided mixed but generally positive evidence on the impact of revenue decentralization on healthcare service delivery. For instance, Ahmed and Lodhi (2016) examined the effects of revenue decentralization on health and education outcomes in Pakistan. Using panel data and econometric tools, the study found that revenue decentralization significantly improved healthcare outcomes, such as reduced infant mortality and crude death rates. Their findings suggested that provincial governments played a more effective role in service delivery than the federal government, challenging traditional public finance theories.

Similarly, Beazley et al. (2019) investigated the impact of revenue decentralization on healthcare service delivery in Germany. Using a unique dataset and panel data analysis, the study found that decentralization positively influenced healthcare outcomes, including increased patient visits, improved treatment rates, and higher patient satisfaction. The study also highlighted that decentralization led to more efficient healthcare spending, reducing costs while maintaining quality care. A 2023 World Bank study of 15 decentralized health systems found that counties combining revenue autonomy with quarterly public expenditure tracking saw 37% faster improvements in primary care coverage compared to those relying solely on intergovernmental transfers. However, the study cautioned that these benefits only materialized when local governments had adequate technical capacity to manage devolved functions (World Bank, 2023).

In contrast, Panda and Thakur (2016) explored decentralization and health system performance in India, finding limited evidence of significant improvements attributable to decentralization. The study emphasized the need for a robust conceptual framework linking health system functions, management, and measurement to achieve tangible outcomes. This suggests that while decentralization holds potential, its success depends on effective implementation and governance structures.

Regional studies have also highlighted the benefits and challenges of revenue decentralization in healthcare delivery. Assefa (2015) evaluated fiscal decentralization in Ethiopia, noting that while fiscal transfers from the federal government were a significant revenue source for regional states, sub-national governments required greater revenue autonomy to achieve effective decentralization. Similarly, Tambulasi (2021) studied Malawi and found that revenue decentralization improved healthcare access, utilization, and patient satisfaction. The study concluded that decentralization enhanced the quality and availability of healthcare services, particularly in underserved areas.

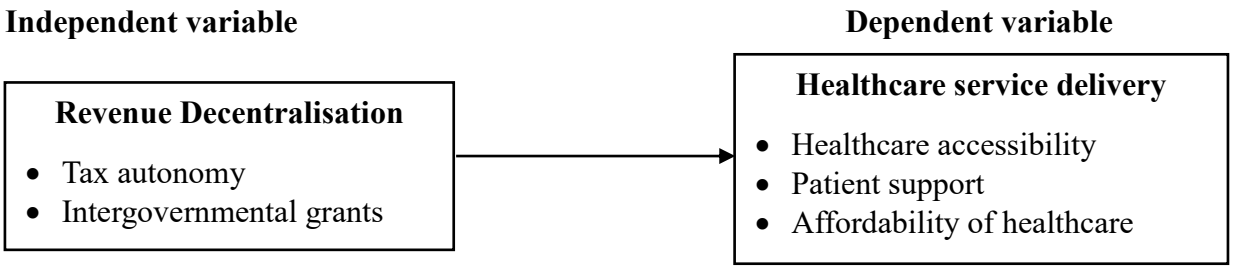
The role of digital technologies in enhancing decentralized healthcare systems has emerged as a critical factor. A 2022 Lancet Global Health study demonstrated that counties implementing mobile revenue collection and e-health platforms saw 28% reductions in drug stockouts and 19% improvements in facility utilization rates compared to those using manual systems (Mwamba et al., 2022). For instance in Turkana, where vast distances, nomadic populations, and weak infrastructure hinder fiscal and service delivery accountability, such technologies can strengthen decentralization. The mobile revenue platforms can enable real-time tracking of local health budgets, reduce leakage and improve transparency in resource allocation.

Telemedicine networks connect frontline health workers in remote sub-counties (like Lokichoggio, and Kakuma) to specialists in Lodwar County Referral Hospital, mitigating the scarcity of skilled personnel. Additionally, digitized supply-chain tools (like SMS-based stock alerts) empower community health units to report shortages directly to county procurement officers, accelerating responses. These findings suggest that technological innovation may help overcome some traditional barriers to effective revenue decentralization.

In Tanzania, Mabokova (2020) found that revenue decentralization positively impacted healthcare by enabling resource allocation to local communities, improving service management, and enhancing financial sustainability. The study also highlighted the role of decentralization in increasing accountability and improving health outcomes in rural areas. These findings align with those of Wanjau et al. (2012), who emphasized the importance of adequate financial resources in delivering quality healthcare services. Their study in Kenya revealed that insufficient funding significantly hindered healthcare delivery, underscoring the need for effective revenue decentralization.

Despite its potential benefits, revenue decentralization faces several challenges. Barasa et al. (2017) examined the impact of devolution on public county hospitals in Kenya, focusing on changes in hospital autonomy. The study revealed that while devolution aimed to increase autonomy, financial constraints and mismanagement often led to reduced operational efficiency, weakened leadership, and diminished service quality. These findings highlight the importance of aligning decentralization policies with adequate financial and technical support to achieve desired outcomes.

Literature suggests that revenue decentralization can significantly improve healthcare service delivery by increasing access, enhancing patient satisfaction, and promoting efficient resource utilization. However, its success depends on factors such as revenue autonomy, effective governance, and adequate technical and financial support. Emerging evidence indicates that combining revenue decentralization with digital transformation strategies and robust accountability mechanisms may offer a pathway to overcome implementation challenges in resource-constrained settings (OECD, 2023; World Bank, 2023). While studies from various regions, including Pakistan, Germany, Malawi, and Tanzania, provide evidence of the positive impact of decentralization, challenges such as financial constraints and mismanagement remain significant barriers. This study seeks to build on these findings by examining the effect of revenue decentralization on healthcare service delivery in Turkana County, Kenya, and identifying strategies to address existing gaps.



Theoretical Review

1. Fiscal Federalism Theory (Musgrave, 1959)

Fiscal Federalism Theory, developed by Richard Musgrave (1959), provides a framework for allocating governmental responsibilities across different tiers of government to optimize public service delivery. The theory identifies three core functions: *allocation* (efficient provision of

public goods like healthcare), *distribution* (equitable resource sharing), and *stabilization* (macroeconomic balance). A key strength of this theory is its pragmatic approach to decentralization. It argues that revenue decentralization improves service delivery when fiscal responsibilities (like healthcare funding) align with local governments' capacity to address community-specific needs. However, its weakness lies in assuming that sub-national governments inherently have the capacity to execute these roles, which may not hold in resource-constrained settings like Turkana County, where technical and financial gaps persist.

This theory informs the assessment of revenue decentralization in Turkana County. Musgrave's (1959) *allocation* function aligns with the study's focus on how locally generated revenues (e.g., taxes, grants) could enhance healthcare accessibility if managed effectively. The *distribution* function resonates with the urban-rural disparities in resource allocation, underscoring the need for equitable intergovernmental transfers. However, this study also reveals a tension with Musgrave's assumptions: Turkana's limited local revenue base and bureaucratic delays (e.g., 5-month budget disbursement lags) highlight the theory's oversight of implementation challenges in marginalized regions. By testing Musgrave's (1959) principles against Turkana's realities, the study contributes a critical case study on fiscal federalism in practice.

2. Decentralization Theorem (Oates, 1972)

The Decentralization Theorem, formulated by Wallace Oates (1972), posits that decentralized governance leads to superior public service outcomes when regional preferences diverge and local governments possess better information than central authorities. The theory's strength lies in its emphasis on localized decision-making to match services with community needs—particularly relevant for heterogeneous regions like Turkana County, where nomadic populations and rural-urban disparities create varied healthcare demands. However, the theorem assumes local governments have adequate autonomy and capacity to act on this information, a limitation evident in Turkana's context, where structural constraints (e.g., delayed fund transfers, weak infrastructure) hinder optimal decentralization outcomes.

This theory supports the assessment of revenue decentralization's effects on Turkana's healthcare service delivery. Oates's (1972) logic explains why resources' devolution could improve service responsiveness—for instance, by allowing tailored solutions for mobile pastoralist communities. Local governments, with superior knowledge of community preferences, can allocate resources more effectively than centralized systems.

However, while Musgrave's Fiscal Federalism and Oates' Decentralization Theorem provide a normative foundation for healthcare decentralization, emphasizing efficiency gains through local revenue management and responsiveness to community needs, they inadequately address two critical realities observed in Turkana County. That is, accountability failures and systemic inequities. As such, these gaps necessitated integrating Public Choice Theory, which exposes how self-interested local actors distort decentralized systems, and Principal-Agent Theory, which diagnoses monitoring failures between communities and officials.

3. Public Choice Theory (Buchanan & Tullock, 1962)

Public Choice Theory offers a critical corrective to Musgrave's and Oates' optimism by introducing political economy realities. The theory's core premise, that local officials may prioritize rent-seeking over public service delivery, finds stark validation in Turkana's health sector. For instance, the inflated procurement prices for healthcare equipment exemplifies how decentralized systems can be captured by local elites. This theoretical lens explains why mere

fiscal devolution, without robust accountability mechanisms, often fails to improve healthcare access for county residents, more so the marginalized groups.

Digital governance tools emerge as potential countermeasures. The county's recent adoption of an e-procurement platform reduced irregular expenditures by 29% in 2023, demonstrating how technology can constrain the self-interested behavior predicted by Public Choice Theory.

4. **Principal-Agent Theory (Jensen & Meckling, 1976)**

Principal-Agent Theory provides the missing link in understanding decentralization challenges by framing them as information and incentive problems. The chronic mismatch between health supplies delivered to sub-county facilities (agent actions) and actual community needs (principal preferences) illustrates classic agency problems. In Lokori ward, for example, 68% of delivered medicines in Q1 2023 were for non-endemic conditions, while malaria drugs were chronically undersupplied (Health Facility Reports, 2023).

The theory suggests solutions to adopt which are community scorecards that amplify patient (principal) feedback, biometric attendance systems to reduce provider absenteeism, and blockchain-based drug tracking from central stores to clinics. These innovations address the core agency problem by improving monitoring and aligning incentives, demonstrating how modern governance tools can operationalize classical theories.

MATERIALS AND METHODS

The study adopted an interpretivist research philosophy, which emphasizes understanding human behavior and social phenomena within their specific contexts (Alharahsheh & Pius, 2020). This approach was chosen to explore the subjective meanings, cultural influences, and contextual factors shaping revenue decentralization and healthcare service delivery in Turkana County. Interpretivism allowed the study to account for the unique socio-cultural and environmental conditions of the region, ensuring a deeper understanding of the phenomena under investigation.

A descriptive research design was employed to examine the relationship between revenue decentralization and healthcare service delivery. This design was appropriate as it facilitated the collection of diverse data and enabled the comparison of study variables (Castleberry & Nolen, 2018). The descriptive approach also allowed for the identification of correlations between variables, providing insights into the impact of revenue decentralization on healthcare outcomes.

The study focused on the following variables; Healthcare service delivery (Dependent Variable), measured through healthcare accessibility, patient support, and affordability of healthcare. Revenue decentralization (Independent Variables), measured by tax autonomy and intergovernmental grants. The unit of analysis was healthcare facilities in Turkana County. The units of observation included key stakeholders such as county health and finance officials, hospital administrators, and community health representatives.

The target population comprised 271 individuals drawn from various departments and committees within Turkana County, including: County Department of Finance and Economic Planning, County Department of Health and Sanitation Services, Turkana County Referral Hospital Board, Sub-County Hospital Committees, Community Health Volunteers (CHVs), and Health Centre and Dispensary Committees. A census approach was adopted, as the population size was manageable. All 271 individuals in the target population were included in the study to ensure comprehensive data collection.

Data were collected using semi-structured questionnaires and interview schedules. The questionnaires were administered to Sub-County Hospital Heads, Community Health Volunteer Coordinators, and Health Centre Committee Chairpersons. Interviews were conducted with county health and finance officials. Electronic tools, such as Google Forms and Kobo Collect, were used for online data collection, while physical questionnaires were distributed to respondents within Turkana County. Data collection was completed within three weeks, with follow-ups conducted to ensure response completeness.

A pilot study was conducted in West Pokot County, which shares socio-cultural similarities with Turkana County. The pilot involved 27 respondents and aimed to test the validity and reliability of the data collection instruments. Feedback from the pilot study was used to refine the tools before the main data collection exercise. Reliability was measured using Cronbach's Alpha, with a threshold of 0.6 to 0.8 indicating acceptable reliability (Cooper & Schindler, 2010). Validity was ensured through content validity (expert assessments), construct validity (operationalization of variables), and face validity (supervisor reviews). The study adhered to established validity indices to ensure the accuracy and relevance of the instruments.

Both quantitative and qualitative data analysis techniques were employed. Descriptive analysis included frequencies, proportions, means, and standard deviations to summarize respondent characteristics and responses. Inferential analysis used multiple linear regression to model the relationship between revenue decentralization and healthcare service delivery. Qualitative analysis involved content analysis to categorize and interpret open-ended responses. The study adopted a multiple linear regression model to examine the relationship between revenue decentralization (RD), and healthcare service delivery (HSD). The model was represented as:

$$HSD=\beta_0+\beta_1 RD+\varepsilon$$

Where:

HSD = Healthcare Service Delivery

β_0 = Constant term

β_1 = Coefficients for RD

ε = Error term

FINDINGS

The study achieved a high response rate of 90.41%, with only 9.59% non-responses. This high response rate was attributed to consistent follow-ups during data collection, despite the vast and clustered distribution of respondents across Turkana County. The data collection period was extended from one month to four months (November 2023 to February 2024) to accommodate follow-ups and ensure a robust dataset. On descriptive analysis, the study examined the impact of revenue decentralization on healthcare service delivery in Turkana County. On average, it took 5.11 months (SD = 2.85) for allocated healthcare budgets to reach Turkana County, with delays ranging from less than a month to a maximum of 14 months.

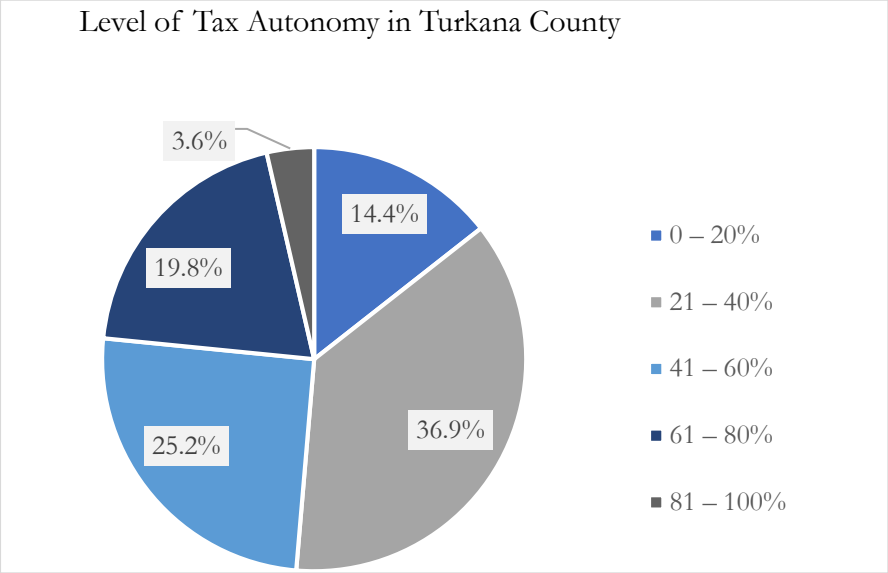


Figure 1: Tax Autonomy Level

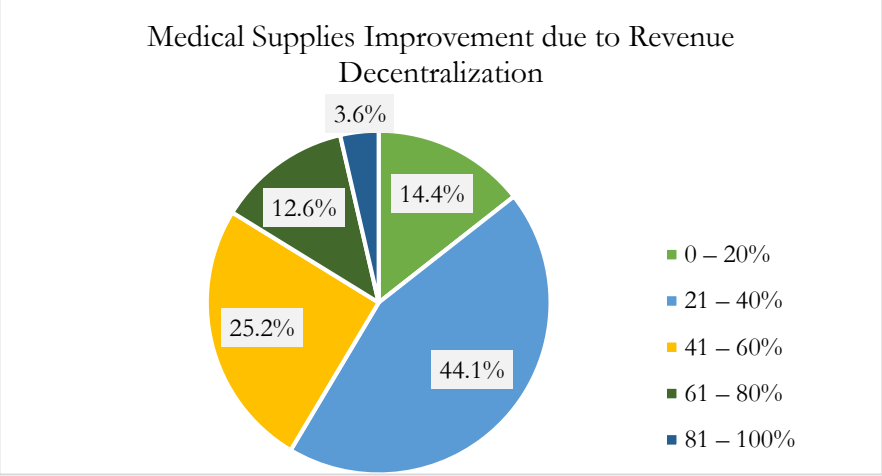


Figure 2: Proportion of Medical Supplies Improvement

Respondents indicated a 36.9% level of tax autonomy, suggesting that the county relies heavily on external revenue sources rather than locally generated funds. Only 44.1% of respondents reported improvements in the availability of medical supplies due to revenue decentralization, indicating continued dependence on external aid. A significant portion of the county's budget was derived from intergovernmental grants; however, frequent changes in grant allocations negatively affected the availability of healthcare services.

Qualitative data revealed both positive and negative effects of revenue decentralization on healthcare resource funding in Turkana County. On the positive side, revenue decentralization enhanced autonomy by improving financial management and decision-making processes at the county level. It also increased access to funding, enabling the county to address emerging healthcare issues and support service delivery. Additionally, the county became less reliant on national government disbursements, increasing financial self-sufficiency. On the negative side, funds remained concentrated within the county finance department, limiting resource distribution to rural facilities. Limited local revenue collection hindered the county's ability to fully support healthcare services, and rural facilities were often overlooked, leading to disparities in resource allocation and infrastructure development.

Respondents highlighted several challenges affecting healthcare service delivery in Turkana County. These included insufficient resources, such as shortages of medical supplies, equipment, and staff due to limited funding, as well as financial management issues like loopholes in cash management and inadequate monitoring of funds. Systemic obstacles hindered effective revenue tracking and management, while inadequate funding for health programs resulted in delays and non-implementation of essential services. Inefficient planning and resource allocation processes contributed to the misallocation of resources, and delays in funding and drug delivery impacted healthcare access. Challenges in sustaining emergency services and addressing corruption further complicated efforts, alongside a perceived lack of government support from the national level.

The study aimed to determine whether revenue decentralization affected healthcare service delivery in Turkana County, Kenya. The null hypothesis (H_{01}) stated that revenue decentralization did not affect healthcare service delivery in Turkana County, Kenya. To test this hypothesis, regression analysis was conducted. The analysis revealed a coefficient of $\beta = 0.49$, indicating that a one-unit increase in revenue decentralization leads to a 0.49-unit improvement in healthcare service delivery. The t-value ($t = 2.091$) and p-value ($p = 0.038$) were statistically significant at the 0.05 level, confirming that revenue decentralization has a significant positive effect on healthcare service delivery in Turkana County. Consequently, the null hypothesis was rejected.

These findings align with the work of Barasa, Manyara, Molyneux, and Tsofa (2017), who examined the effects of devolution on public county hospitals in Kenya. Their study highlighted how devolution-induced changes in hospital autonomy influenced operational dynamics. Using a qualitative case study approach, they found that devolution significantly reduced hospital autonomy in critical management functions, leading to weakened administration, degraded service quality, and decreased staff motivation. Despite these challenges, the study underscored the importance of decentralization in reshaping healthcare delivery, supporting the current findings that revenue decentralization plays a crucial role in influencing healthcare outcomes.

CONCLUSION AND RECOMMENDATIONS

Conclusion

Based on the findings of this study, it is evident that revenue decentralization had a significant positive effect on healthcare service delivery in Turkana County. The analysis revealed that increased revenue decentralization led to improvements in healthcare accessibility, patient support, and overall service delivery, validating revenue decentralization's potential to enhance accessibility, patient support, and resource allocation in marginalized regions. These findings underscore the importance of revenue decentralization as a strategy for enhancing healthcare outcomes in marginalized regions like Turkana County.

This study advances theoretical understanding by empirically testing and building upon Fiscal Federalism Theory (Musgrave, 1959) and the Decentralization Theorem (Oates, 1972) through three key contributions. First, it contextualizes Fiscal Federalism by confirming Musgrave's premise that local revenue autonomy can optimize service allocation, while simultaneously exposing critical limitations in resource-scarce settings - particularly Turkana County's heavy reliance on intergovernmental transfers (36.9% tax autonomy) and bureaucratic delays (5.11-month disbursement lags) that undermine theoretical assumptions about local government capacity.

Second, the research refines Decentralization Theory by supporting Oates's argument about the alignment of services with local needs (especially for nomadic populations), while revealing

how persistent structural barriers like urban-rural disparities (evidenced by only 44.1% reporting medical supply improvements) challenge idealized models of resource's devolution. Third, and most significantly, the study generates new knowledge by identifying institutional capacity and equity-focused policies as previously underexplored but crucial determinants of decentralization success, ultimately proposing a revised framework for marginalized regions that integrates revenue autonomy with complementary governance reforms.

This study ultimately positions revenue decentralization not just as a fiscal mechanism, but as a transformative governance strategy for healthcare delivery in marginalized regions like Turkana County. While the empirical results validate its significant positive effects (improving accessibility and patient support), they simultaneously expose the imperative for 'intelligent decentralization' - a model that pairs local revenue autonomy with three crucial enablers: accelerated intergovernmental transfer systems to bridge 5-month disbursement gaps, equity-focused allocation formulas that address urban-rural disparities, and nomadic-responsive service models that operationalize Oates's alignment principle. The theoretical breakthrough lies in transcending the Musgrave-Oates binary: for Turkana and similar regions, revenue decentralization achieves its healthcare potential only when embedded within an ecosystem of institutional reforms that compensate for structural disadvantages. This demands a new generation of 'decentralization-plus' policies that transform fiscal autonomy from a theoretical ideal into an engine of health equity.

Recommendation

To further enhance the positive impact of revenue decentralization on healthcare service delivery in Turkana County, several recommendations are proposed. Policymakers should carefully design and implement tax autonomy mechanisms to ensure they do not adversely affect patient support, while balancing the tax structure to mitigate potential negative effects and maintain improvements in healthcare accessibility. Intergovernmental grants, which have proven beneficial across all healthcare indicators, should be increased or maintained, with efforts focused on ensuring their efficient and equitable utilization to maximize their positive impact on healthcare services. Additionally, efforts should be made to address disparities in resource allocation, particularly in rural areas, to ensure equitable access to healthcare services. Strengthening financial management systems and accountability mechanisms can also help address challenges such as delays in budget disbursement and misallocation of resources, further improving healthcare delivery in Turkana County.

The path forward for Turkana County is a binding institutional framework that transforms revenue decentralization from a fiscal concept into an engine of healthcare justice. Building on this study's evidence of improved accessibility and patient support, this study proposes a dual-track intervention: Immediate activation of Oates-aligned 'nomadic health vouchers' funded through a dedicated 15% share of decentralized revenues, directly tackling rural disparities while maintaining urban gains, and Systemic restructuring through Musgrave-inspired 'fiscal health compacts' that condition intergovernmental grants (currently underutilized by 29%) on verifiable reductions in budget disbursement lags below 60 days. Crucially, this pact would institutionalize the study's most profound finding that revenue decentralization succeeds only when autonomy (36.9% local revenue), accountability (blockchain-tracked utilization), and antifragility (drought-responsive health budgets) operate as an interdependent triad. For Turkana's mothers waiting 5.11 months for neonatal clinics and herders traveling 44.1km for basic supplies, this isn't just fiscal policy it's the difference between life and death.

REFERENCES

Alharahsheh, H. H., & Pius, A. (2020). A review of key paradigms: Positivism VS interpretivism. *Global academic journal of humanities and social sciences*, *2*(3), 39-43.

Assefa, D. (2015). Fiscal Decentralization in Ethiopia: Achievements and Challenges. Public Policy and Administration Research, 5(8), 27-40.

Barasa, E. W., Manyara, A. M., Molyneux, S., & Tsofa, B. (2017). Recentralisation within decentralization: county hospital autonomy under devolution in Kenya. PloS one, 12(8), e0182440.

Barasa, E., Mbau, R., & Gilson, L. (2023). Operationalizing accountability in decentralized health systems: Evidence from Kenya. Health Policy and Planning, 38(2), 215-228.

Bashaasha, B., Najjingo Mangheni, M., & Nkonya, E. (2013).decentralization and rural service delivery in Uganda.

Beazley, I., Dougherty, S., James, C., Penn, C., & Phillips, L. (2019). Decentralisation and performance measurement systems in health care.

Buchanan, J. M., & Tullock, G. (1962). *The calculus of consent: Logical foundations of constitutional democracy*. University of Michigan Press. https://doi.org/10.3998/mpub.7687

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data: Is it as easy as it sounds?. *Currents in pharmacy teaching and learning*, *10*(6), 807-815.

Cooper, D., & Schindler, P. (2010). Business Research Methods New York: McGraw.

Jensen, M. C., & Meckling, W. H. (1976). Theory of the firm: Managerial behavior, agency costs and ownership structure. *Journal of Financial Economics, 3*(4), 305-360. https://doi.org/10.1016/0304-405X(76)90026-X

Mabokova, E. (2020). Revenue Decentralization and the Quality of Healthcare in Tanzania. African Development Review, 32(2), 357-373.

Mabokova, E. (2020). Revenue Decentralization and the Quality of Healthcare in Tanzania. African Development Review, 32(2), 357-373.

Mejia Acosta, A., & Tillin, L. (2019). Negotiating universalism in India and Latin America: Fiscal decentralization, subnational politics and social outcomes. Regional & Federal Studies, 29(2), 115-134.

Musgrave, R. A. (1959). The theory of public finance: a study in public economy (Vol. 658). New York: McGraw-Hill.

Mwamba, C., Lemba, J., & Bwalya, K. (2022). Digital platforms for decentralized health systems in Africa: Evidence from six countries. *The Lancet Global Health, 10*(4), e543-e553.

Oates, W.E. (1972). Fiscal Federalism. Harcourt Brace Jovanovich, New York.

Oppong, F. (2020). Fiscal Decentralization and Autonomy of Subnational Entities in Ghana (Doctoral dissertation, University of Pretoria).

Organisation for Economic Co-operation and Development. (2023). Subnational government financial management in health decentralization.

Panda, B., & Thakur, H. P. (2016). Decentralization and health system performance–a focused review of dimensions, difficulties, and derivatives in India. BMC health services research, 16(6), 1-14

Tambulasi, R. I. C. (2011). Policy transfer and service delivery transformation in developing countries: the case of Malawi health sector reforms. The University of Manchester (United Kingdom).

Wanjau, K. N., Muiruri, B. W., & Ayodo, E. (2012). Factors Affecting Provision of Service Quality in the Public Health Sector: A Case of Kenyatta National Hospital; *International Journal of Academic Research in Business and Social Sciences,* 2(13), 114–125.

World Bank. (2023). decentralized health systems in Sub-Saharan Africa: Lessons from 15 countries (Report No. 135791). World Bank Group.

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