AfroGlobal Perspectives
Vol. 3 No. 11 (2026): November 2026 issue
https://doi.org/10.70572/955gdz85
Original article

Revenue mobilization and access to health service delivery in Ibanda Municipality, Uganda. A cross-sectional study.

Alex Nuwagaba*, Dr. Muhammad Sendagi, Edmand Bakashaba
School of graduate studies and research, Team University

Abstract

Background:

Revenue mobilisation determines how much discretionary funding local governments have for services such as health. This study examined the relationship between revenue mobilisation and access to health service delivery.

Methods:

A correlational study used a convergent parallel mixed-methods design. Questionnaires were completed by 89 officials, councillors, health workers, and Health Unit Management Committee (HUMC) members. Exit interviews were held with 247 service users at one Health Centre (HC) IV and four HC IIIs. Four key informants were interviewed, and records for 2020/21 to 2024/25 were reviewed. Data were analysed in SPSS using descriptive statistics, Pearson's correlation, t-tests, and thematic analysis.

Results:

Among staff respondents, 53.9% were male, and 68.6% were aged 30-49 years. Among service users, 68.4% were female, and 41.7% were farmers. Revenue mobilisation was rated moderate (mean = 2.65). Access to health services was rated moderate by officials (2.69) but low by service users (2.57). Records showed the collection ratio stayed between 61.8% and 63.1% every year, and 26.7% to 38.3% of planned outreach sessions were not held. Revenue mobilisation correlated positively and significantly with access ($r = 0.488$, $p < 0.001$). The relationship was stronger at the HC IIIs ($r = 0.675$) than at the HC IV ($r = 0.455$). Access was significantly better at the HC IV.

Conclusion:

Revenue mobilisation has a moderate, positive relationship with access to health service delivery. Mobilisation is weakened by incomplete enumeration of revenue sources, an outdated valuation roll, irregular sensitisation, and unrealistic targets.

Recommendation:

The municipality should enumerate all revenue sources, update the valuation roll, and base targets on the results. It should also sensitise taxpayers continuously and involve the health department in revenue planning.

Keywords: *Revenue mobilisation, access to health service delivery, local government, Health Centre, Ibanda Municipality.*
Submitted: *November 01, 2026* ***Accepted:*** *November 10, 2026* ***Published:*** *November 19, 2026*
Corresponding author: *Alex Nuwagaba*
Email: *nuwagaba5060@gmail.com*
School of graduate studies and research, Team University

Background.

Revenue mobilisation refers to a local government's efforts to raise own-source revenue from a broad and growing base (Bahl & Bird, 2008; MoLG, 2020). It determines how much discretionary revenue a local government has to fund local services. Bahl and Bird (2008) argue that local governments in developing countries mobilise far less revenue than their potential, particularly from property taxes, because of narrow bases, outdated valuations and political reluctance to tax. In a review of property taxation across Africa, Franzsen and McCluskey (2017) found that most countries collect very little property tax relative to their potential. This leaves urban local governments short of a revenue source that could fund local services.

Fjeldstad et al. (2014) found that African local governments rely on many small revenue sources, such as market dues and licences, which are costly to collect and yield little. They also found that mobilisation is often undermined by political decisions to suspend or reduce taxes before elections. Moore et al. (2018) argue that broadening the local tax base, especially through property taxes, is one of the most promising ways for African cities to finance services. In Uganda, the Local Government Finance Commission (2019) attributed low local revenue mobilisation to the abolition of graduated tax, outdated property valuation rolls, and weak exploitation of new revenue sources.

Access to health service delivery refers to the extent to which residents can obtain and use needed health services of acceptable quality when they need them (Penchansky & Thomas, 1981; Levesque et al., 2013). Evidence suggests that local revenue performance is linked to it. Tumusiime and Ainebyoona (2021) found that growth in local revenue collections in Mbarara City was associated with higher allocations to health and sanitation services. Ochieng and Otieno (2019) found that Kenyan counties with higher own-source revenue growth had better availability of medicines and staff in primary health facilities. However, these studies were conducted in large cities and counties, not in newly created municipalities such as Ibanda.

Ibanda Municipality is in Ibanda District, western Uganda, about 70 km northwest of Mbarara and 290 km southwest of Kampala. It has three divisions (Kagongo, Bisheshe and

Bufunda), 21 wards and 236 villages, and a population of 126,088 (UBOS, 2024). As the commercial and administrative centre of the district, it has growing markets, trading centres and residential areas that provide a potential local revenue base. Public health services are delivered mainly through one Health Centre IV and four Health Centre IIIs, supported by Health Centre IIs, private not-for-profit facilities and private clinics. The public facilities are funded mainly by central primary health care grants and partly by municipal local revenue (IMC Health Department, 2024).

Despite this potential, revenue mobilisation in the municipality is weak. In 2023/24, the municipality collected about UGX 1.31 billion of a budgeted UGX 2.12 billion in local revenue, a collection rate of 62%. This is well outside the 10% variance from plan expected under the LGMSD assessment (MoLG, 2020). Local revenue financed only about 6% of the municipal budget, leaving the municipality heavily dependent on central transfers (IMC, 2024). It is therefore unclear whether, and to what extent, revenue mobilisation influences access to health service delivery in the municipality. This study examined the relationship between revenue mobilisation and access to health service delivery.

Methodology.

Research Design

The study adopted a correlational research design. A correlational design examines the strength and direction of the relationship between two or more variables without manipulating them (Creswell & Creswell, 2018; Amin, 2005). Data were collected at one point in time from municipal officials, elected councillors, health workers, Health Unit Management Committee members and health service users, making the design cross-sectional in nature (Sekaran & Bougie, 2016).

Research Approach

The study used a mixed-methods approach, specifically a convergent parallel design in which quantitative and qualitative data were collected at the same time, analysed separately and then merged during interpretation (Creswell & Plano Clark, 2018). The quantitative strand, based on questionnaires administered to officials, councillors, health workers, HUMC members and service users, measured the relationships between the dimensions of revenue management and access to health service delivery. The qualitative strand, based on key informant interviews and document review, explained those relationships by capturing how revenue is raised, collected, and spent in practice, how the Health Centre IV and Health Centre III experience the availability or absence of local revenue, and the reasons behind low collections and cancelled outreach. Combining the strands strengthened the validity of the findings through triangulation and addressed Fiscal Federalism Theory's limited attention to local capacity.

Study Area

The study was conducted in Ibanda Municipality in Ibanda District, western Uganda, about 70 km northwest of Mbarara. The municipality became a municipal council on 1 July 2016 and comprises Kagongo, Bisheshe and Bufunda divisions, with 21 wards, 236 villages and a population of 126,088 (UBOS, 2024; IMC, 2024). The municipality was selected because its local revenue collections had fallen short of targets, it allocated a small share of local revenue to health, and its residents, especially in peri-urban wards, faced gaps in access to health services (IMC, 2024; OAG, 2023).

Within the municipality, the study covered five public health facilities at Health Centre IV and Health Centre III levels, namely Kyegegwa Health Centre IV and four Health Centre IIIs: Kyegegwa Town Council Health Centre III, Kakabara Health Centre III, Mpara Health Centre III and Rwentuha Health Centre III. The two levels were selected because they are important public providers of primary health care and receive funding and support from the municipal council for medicine top-ups, outreach activities, and facility maintenance. A Health Centre IV serves a health sub-district and offers wider services, including admissions, emergency surgery, blood transfusion and comprehensive maternity care, while a Health Centre III serves a sub-county or division-level population and offers outpatient, maternity, immunisation and laboratory services (MoH, 2023). Covering both levels allowed the study to compare how revenue management relates to access to health services at each level. Health Centre IIs, private not-for-profit facilities and private clinics were excluded because they are either smaller in-service scope or do not fall within the study's focus on municipal council financing.

Study Population

The study population was made up of two groups.

Officials, councillors, health workers and HUMC members: This group comprised 170 people who are directly involved in revenue management or in the delivery and oversight of health services in Ibanda Municipality (IMC, 2024). They included top management (the Town Clerk, Deputy Town Clerk, Principal Treasurer and Municipal Medical Officer of Health), revenue officers and collectors, finance and accounts staff, elected councillors of the Municipal Council and Division Councils, division administrative officers, health workers in the Health Centre IV and Health Centre IIIs, and members of their Health Unit Management Committees (HUMCs). There were 55 health workers, of whom 30 worked in the Health Centre IV and 25 in the Health Centre IIIs, and 34 HUMC members, of whom 10 served the Health Centre IV and 24 the Health Centre IIIs (IMC Health Department, 2024).

Health service users: These were adult clients (aged 18 years and above) and caretakers of children who received services at the selected health facilities. They were included because they experience access to health services directly and could report on the availability of medicines, waiting times, staff

attendance, distance, and outreach. The population of service users was taken as the average weekly number of adult outpatient attendances at the selected facilities, which stood at 800: 400 at the Health Centre IV and 400 at the Health Centre IIIs, according to the facilities' Health Management Information System (HMIS) records (IMC Health Department, 2024).

Sample Size and Selection

The sample size for each group was determined using Yamane's (1967) formula, as cited by Israel (1992):

$n = N / (1 + N(e)^2)$

Where n is the sample size, N is the population size, and e is the margin of error (0.05). For officials, councillors, health workers and HUMC members (N = 170): $n = 170 / (1 + 170 \times 0.0025) = 170 / 1.425 = 119.3$, giving 119 respondents. For health service users (N = 800): $n = 800 / (1 + 800 \times 0.0025) = 800 / 3 = 266.7$, giving 267 service users.

The total sample was therefore 386 respondents. Within each group, the sample was distributed across categories in proportion to their populations, using the formula $n_i = (N_i / N) \times n$, where n_i and N_i are the sample and population of each category. The four members of top management were all included because each holds a unique office.

Table 1: Population, sample size and sampling techniques

Category of respondents	Population (N)	Sample size (n)	Sampling technique
A. Officials, councillors, health workers and HUMC members			
Top management (Town Clerk, Deputy Town Clerk, Principal Treasurer, Municipal Medical Officer of Health)	4	4	Purposive
Revenue officers and collectors	26	18	Simple random
Finance and accounts staff	12	8	Simple random
Elected councillors (Municipal Council and Division Councils)	30	21	Simple random
Division administrative officers	9	6	Simple random
Health workers, Health Centre IV	30	21	Stratified random
Health workers, Health Centre III	25	17	Stratified random
HUMC members, Health Centre IV	10	7	Stratified random
HUMC members, Health Centre III	24	17	Stratified random
Sub-total A	170	119	
B. Health service users			
Service users, Health Centre IV	400	134	Systematic random
Service users, Health Centre III	400	133	Systematic random
Sub-total B	800	267	
Grand total	970	386	

Source: Ibanda Municipal Council staff and council records (2025), HMIS records of the selected facilities (2026), and Yamane (1967).

The service users' sample for the Health Centre IIIs was shared among the individual Health Centre IIIs in proportion to each facility's average weekly outpatient attendance.

Sampling Techniques

The study used both probability and non-probability sampling techniques.

Purposive Sampling

Purposive sampling was used to select the four members of top management as key informants, because they hold strategic knowledge of revenue planning, collection, spending, and health service management in the municipality (Creswell & Plano Clark, 2018).

Simple Random Sampling

Simple random sampling was used to select revenue officers and collectors, finance and accounts staff, elected councillors and division administrative officers. Staff lists were obtained from the Principal Human Resource Officer and the list of councillors from the Clerk to Council. Each name was given a number, and the required number of respondents was selected using a table of random numbers, giving each person an equal chance of selection and reducing bias (Amin, 2005).

Stratified Random Sampling

Stratified random sampling was used for health workers and HUMC members, with the level of health facility (Health Centre IV and Health Centre III) as the strata. The staff and HUMC lists of each facility were obtained from the facility in-charges, and respondents were selected randomly from each stratum in proportion to its size. Stratifying by facility level ensured that both levels were represented and allowed the findings to be reported separately for the Health Centre IV and the Health Centre IIIs.

Systematic Random Sampling of Service Users

Service users were selected using systematic random sampling through exit interviews at each selected facility. The sampling interval (k) was obtained by dividing the weekly population by the sample ($800 \div 267 \approx 3$), so every third adult client leaving the outpatient, maternity, or immunisation section after receiving services was approached. The first client was chosen randomly from the first three clients of the day, and every third client thereafter

was invited to participate. Data were collected over five working days at each facility, covering different days of the week, until the facility's share of the sample was reached. Only clients aged 18 years and above, or caretakers of children, who gave informed consent were interviewed, and very sick clients were excluded.

Data Collection Methods

Questionnaire Survey

A self-administered questionnaire was used to collect quantitative data from 115 officials, councillors, health workers and HUMC members (all sampled respondents in group A except the four key informants). The method was chosen because it allows data to be collected from many respondents in a short time, ensures that all respondents answer the same questions, and produces data suitable for correlation and regression analysis (Sekaran & Bougie, 2016).

Service User Exit Interviews

An interviewer-administered questionnaire was used to collect data from the 267 sampled service users at the selected facilities. The questionnaire was read to respondents in Runyankore or English by trained research assistants, because some service users could not read and write. This method captured the users' experience of access to health services directly at the point of care.

Key Informant Interviews

Face-to-face interviews were held with four key informants: the Town Clerk, Deputy Town Clerk, Principal Treasurer, and Municipal Medical Officer of Health. The interviews provided in-depth explanations of how local revenue is mobilised, administered, enforced, and spent, the challenges faced, and how these affect the Health Centre IV, the Health Centre IIIs, and outreach services, allowing the researcher to probe and clarify responses.

Document Review

Document review was used to collect secondary data. The documents reviewed included the municipality's approved budget estimates and budget performance reports, IRAS and revenue registers, the valuation roll, the staff establishment list, final accounts, Auditor General's reports, council minutes, quarterly release reports, municipal health department reports, and HMIS/DHIS2 data for the Health Centre IV and Health Centre III for the period 2020/21 to 2024/25. Document review provided objective, standard local government indicators, such as the revenue collection ratio, annual growth in own-source revenue, arrears, the share of local revenue allocated and released to health, medicine stock-outs, staffing levels, outpatient attendance, antenatal and immunisation coverage, and outreach sessions held, recorded separately for each facility level, to corroborate the questionnaire and interview data.

Data Collection Instruments

Self-Administered Questionnaire for Officials and Health Workers

A structured questionnaire had five sections: respondents' background characteristics, revenue mobilisation and access to health service delivery. Revenue mobilisation was measured by five items, revenue administration and enforcement by eight items, revenue expenditure control by six items, and access to health service delivery by eight items, all on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Items were developed from the definitions and local government indicators of each variable.

Service Users' Questionnaire

A structured interviewer-administered questionnaire collected the service users' background characteristics, distance to the facility, means of transport, waiting time and number of visits, and their experience of access to health services through eleven items covering availability of medicines and laboratory tests, health workers, waiting time, cost, distance, transport, outreach and overall satisfaction, using a five-point Likert scale.

Interview Guide

A semi-structured interview guide was used for key informant interviews. The questions were derived from the three specific objectives and the indicators of each variable in the conceptual framework, and were organised into sections on revenue mobilisation, revenue administration and enforcement, revenue expenditure control, the link between local revenue and health services at Health Centre IV and Health Centre III, and recommendations. Open-ended questions with probes allowed respondents to give examples and explanations. The draft guide was reviewed by the supervisor and two experts in public finance and health management and pre-tested before data collection.

Document Review Checklist

A document review checklist guided the systematic extraction of revenue and health service indicators from official records, with health indicators recorded separately for the Health Centre IV and the Health Centre IIIs.

Validity and Reliability

Validity

Validity is the extent to which an instrument measures what it is intended to measure (Amin, 2005). Content validity was established by giving both questionnaires to the supervisor and two experts in public finance and health management, who rated each item as relevant or not relevant to the study objectives. The Content Validity Index (CVI=0.86) was computed as the number of items rated relevant by all judges divided by the total number of items in the instrument, and a CVI of 0.70 or above was considered acceptable (Amin, 2005). Items rated irrelevant were revised or removed before data collection.

Reliability

Reliability is the consistency with which an instrument measures a variable (Cronbach, 1951). The instruments were pre-tested in the neighbouring Bushenyi-Ishaka Municipality, which has similar characteristics but is outside the study area, and internal consistency was confirmed on the main study data using Cronbach's alpha for each scale. A coefficient of 0.70 or higher was considered acceptable (Sekaran & Bougie, 2016).

Table 2: Reliability of the research instruments (Cronbach's alpha)

Scale	Instrument	No. of items	Cronbach's alpha	Decision
Revenue mobilization	Officials' questionnaire	5	0.907	Reliable
Access to health service delivery	Officials' questionnaire	8	0.937	Reliable
Access to health service delivery	Service users' questionnaire	11	0.920	Reliable

Source: Primary data, 2026.

All three scales returned alpha coefficients between 0.907 and 0.937, well above the 0.70 threshold, indicating that the items in each scale consistently measured the same construct and that the instruments were reliable.

Trustworthiness of Qualitative Data

The credibility of qualitative data was enhanced through triangulation of interview, questionnaire, and document data, and by sharing summaries of interview responses with key informants for confirmation. Dependability was ensured by recording interviews with permission and keeping a clear record of coding decisions (Creswell & Plano Clark, 2018).

Procedure for Data Collection

The researcher obtained an introductory letter from the School of Graduate Studies and Research of Team University and sought permission from the Town Clerk of Ibanda Municipal Council and the Municipal Medical Officer of Health, who introduced the researcher to the in-charges of the selected Health Centre IV and Health Centre IIIs.

A pilot study was conducted in Bushenyi-Ishaka Municipality, and the instruments were revised accordingly. Two research assistants were recruited and trained on the instruments, the sampling of service users, informed consent, and confidentiality.

Staff, councillor, and HUMC lists were obtained, and respondents were selected.

Questionnaires were delivered to the selected officials, councillors, health workers and HUMC members at the municipal headquarters, division offices and health facilities, and collected after an agreed period.

Exit interviews with service users were conducted at each selected facility over five working days.

Interviews with the four key informants were held at their convenience and lasted about 45 minutes each.

Documents were reviewed at the municipal finance, planning and health departments and at the selected facilities using the document review checklist.

Data Management and Analysis

Completed questionnaires were checked for completeness, coded, and entered into the Statistical Package for the Social Sciences (SPSSV26). Each record carried a code for the level of health facility (Health Centre IV or Health Centre III) so that results could be analysed and reported separately. Interview recordings were transcribed and stored securely.

Quantitative Data Analysis

Descriptive statistics, including frequencies, percentages, means and standard deviations, were used to describe respondents' characteristics and their views on each dimension of revenue management and on access to health service delivery. To answer the three research questions, Pearson's product-moment correlation coefficient was used to establish the strength and direction of the relationship between each dimension of revenue management and access to health service delivery, with significance tested at the 0.05 level. Correlation coefficients were interpreted following Cohen (1988): 0.10–0.29 weak, 0.30–0.49 moderate, and 0.50 and above strong. Trends in revenue and health indicators from document review were presented in tables and charts.

Reporting Findings by Facility Level

Findings were presented separately for the Health Centre IV and the Health Centre IIIs. Mean scores on access to health service delivery from health workers, HUMC members and service users were presented for each facility level, and an independent samples t-test was used to establish whether the mean scores of the two levels differed significantly. The correlation analysis was also run separately for each facility level, and document review indicators such as stock-outs, staffing, antenatal care, immunisation and outreach were tabulated for each level.

Qualitative Data Analysis

Interview and document data were analysed using thematic analysis following Braun and Clarke (2006): familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and reporting. Themes were organised by the three specific

objectives, and selected verbatim quotations were used to explain and illustrate the quantitative results. A theme raised by three or more key informants was treated as dominant, by two as recurring, and by one as an isolated view. The quantitative, qualitative, and documentary findings were merged in a joint display to show where they agree, differ, or add explanation.

Measurement of Variables

The independent variable, revenue management, was measured through mobilization. The dependent variable, access to health service delivery, was measured through eight items in the officials' questionnaire and eleven items in the service users' questionnaire. All items used a five-point Likert scale (1 = strongly disagree, 2 = disagree, 3 = not sure, 4 = agree, 5 = strongly agree). Composite scores were computed as the mean of each scale's items. Mean scores were interpreted as follows: 1.00–1.80 very low, 1.81–2.60 low, 2.61–3.40 moderate, 3.41–4.20 high, and 4.21–5.00 very high. The questionnaire results were corroborated by the standard local government indicators obtained through document review.

Ethical Considerations

The researcher obtained approval from Team University and permission from Ibanda Municipal Council and the Municipal Health Department. Respondents were informed of the purpose of the study, and their informed consent was obtained before participation; for service users who could not write, consent was recorded by thumbprint in the presence of a witness. Participation was voluntary, and respondents were free to withdraw at any stage without penalty. Exit interviews were conducted only after clients had received services, so that the study did not delay care. Names were not recorded on questionnaires, and interview data were anonymised using codes (KI-01 to KI-04) so that no individual service user, health worker or councillor can be identified; key informants are referred to by office only with their consent. Revenue and health records were used only in aggregate form, and no individual taxpayer or patient clinical information was collected. All data were stored securely and used strictly for academic purposes, and sources consulted have been acknowledged.

Results

Response Rate

Table 3: Response rate by category of respondents

Category of respondents	Instrument	Sample size	Responses	Response rate (%)
Top management (key informants)	Interview guide	4	4	100.0
Revenue officers and collectors	Questionnaire	18	15	83.3
Finance and accounts staff	Questionnaire	8	6	75.0
Elected councilors	Questionnaire	21	17	81.0
Division administrative officers	Questionnaire	6	6	100.0
Health workers, Health Centre IV	Questionnaire	21	15	71.4
Health workers, Health Centre III	Questionnaire	17	12	70.6
HUMC members, Health Centre IV	Questionnaire	7	5	71.4
HUMC members, Health Centre III	Questionnaire	17	13	76.5
Service users, Health Centre IV	Exit questionnaire	134	124	92.5
Service users, Health Centre III	Exit questionnaire	133	123	92.5
Sub-total A (officials, councillors, health workers, HUMC)		119	93	78.2
Sub-total B (service users)		267	247	92.5
Grand total		386	340	88.1

Source: Primary data, 2026.

Table 3 shows that 340 of the 386 sampled respondents took part in the study, an overall response rate of 88.1%. All four key informants were interviewed (100%), 89 of the 115 questionnaires issued to officials, councillors, health workers and HUMC members were returned fully completed (77.4%), and 247 of the 267 sampled service users completed the exit interview (92.5%). The lowest response rates were among health workers at the Health Centre IIIs (70.6%) and at the Health Centre IV (71.4%), mainly because they were busy with clinical duties. Mugenda and Mugenda (2003) regard a response rate of 70% and above as very good for analysis, and every category met this threshold. The data were therefore adequate for drawing conclusions.

Background Characteristics of Respondents

Table 4: Background characteristics of officials, councillors, health workers and HUMC members (n = 89)

Characteristic	Category	Frequency	Percent (%)
Gender	Male	48	53.9
	Female	41	46.1
Age group (years)	18–29	15	16.9
	30–39	29	32.6
	40–49	32	36.0
	50 and above	13	14.6
Highest qualification	Secondary (O/A level)	11	12.4
	Certificate	18	20.2
	Diploma	32	36.0
	Bachelor's degree	24	27.0
	Postgraduate	4	4.5
Years of service	Less than 2 years	17	19.1
	2–5 years	22	24.7
	6–10 years	21	23.6
	Over 10 years	29	32.6
Category	Revenue officers and collectors	15	16.9
	Finance and accounts staff	6	6.7
	Elected councillors	17	19.1
	Division administrative officers	6	6.7
	Health workers	27	30.3
	HUMC members	18	20.2
Facility level	Health Centre IV	20	22.5
	Health Centre III	25	28.1
	Not applicable (non-health staff)	44	49.4

Source: Primary data, 2026.

Table 4 shows that slightly more respondents were male (53.9%) than female (46.1%), so the views of both sexes were captured. Most respondents were aged 30–49 years (68.6%), and 32.6% had worked in Ibanda Municipality for over ten years, while a further 23.6% had served for six to ten years, meaning that most respondents had observed revenue management and health services in the municipality across the whole study period. Two-thirds held a diploma or higher qualification (67.4%), indicating that they were able to understand and respond to the questionnaire items. Health workers (30.3%) and HUMC members (20.2%) formed the largest categories, followed by elected councillors (19.1%) and revenue officers and collectors (16.9%). Of the 45 health workers and HUMC members, 20 were attached to the Health Centre IV and 25 to the Health Centre IIIs, allowing findings to be compared across the two facility levels.

Health Service Users

Table 5: Background characteristics of health service users (n = 247)

Characteristic	Category	Frequency	Percent (%)
Health facility	Kyegegwa Health Centre IV	124	50.2
	Kyegegwa Town Council Health Centre III	37	15.0
	Kakabara Health Centre III	30	12.1
	Mpara Health Centre III	30	12.1
	Rwentuha Health Centre III	26	10.5
Service received	Outpatient	162	65.6
	Maternity/ANC	39	15.8
	Immunisation	46	18.6
Gender	Female	169	68.4
	Male	78	31.6
Age group (years)	18–24	37	15.0
	25–34	69	27.9
	35–44	56	22.7
	45–54	42	17.0
	55 and above	43	17.4
Education	Primary	92	37.2
	Secondary	87	35.2
	Tertiary	36	14.6
	Not stated	32	13.0
Occupation	Farmer	103	41.7
	Trader/business	46	18.6
	Housewife/homemaker	34	13.8
	Casual labourer	33	13.4
	Salaried employee	21	8.5
	Student	10	4.0
Division of residence	Kagongo	118	47.8
	Bisheshe	70	28.3
	Bufunda	59	23.9
Means of transport	Walking	120	48.6
	Boda boda	62	25.1
	Taxi/matatu	33	13.4
	Bicycle	32	13.0
Distance to facility	Less than 2 km	66	26.7
	2–5 km	117	47.4
	More than 5 km	64	25.9
Waiting time	30 minutes or less	21	8.5
	31–60 minutes	31	12.6
	61–120 minutes	145	58.7
	More than 120 minutes	50	20.2

Source: Primary data, 2026.

Table 5 shows that the service users were almost equally divided between the Health Centre IV (50.2%) and the four Health Centre IIIs (49.8%). Most were female (68.4%), reflecting the fact that women are the main users of maternal and child health services and usually accompany children for treatment and immunisation. Most users were farmers (41.7%) and had only primary (37.2%) or secondary (35.2%) education. Nearly half lived in Kagongo division (47.8%), where the municipal centre is located, while 28.3% came from Bisheshe and 23.9% from Bufunda. Almost half walked to the facility (48.6%), and about one quarter (25.9%) lived more than 5 km away. The mean distance travelled was 3.9 km (SD = 2.7). Waiting times were long: 78.9% of users waited more than an hour before being served, with a mean of 90.4 minutes (SD = 38.6). Users at the Health Centre IV waited longer on average (99.4 minutes) than those at the Health Centre III (81.3 minutes), which is consistent with the higher patient load at the Health Centre IV.

Access to Health Service Delivery

Table 6: Views of officials, health workers and HUMC members on access to health service delivery (n = 89)

No.	Statement	Disagree (%)	Not sure (%)	Agree (%)	Mean	Std. dev.	Interpretation
AHS 1	Essential medicines are available at the health facilities throughout the year	49.4	22.5	28.1	2.67	1.04	Moderate
AHS 2	The health facilities have adequate health workers	39.3	39.3	21.3	2.71	1.07	Moderate
AHS 3	Health facility buildings and equipment are well maintained	46.1	32.6	21.3	2.66	1.05	Moderate
AHS 4	Clients are attended to within a reasonable waiting time	39.3	41.6	19.1	2.73	0.96	Moderate
AHS 5	Most expectant mothers complete four antenatal visits	39.3	43.8	16.9	2.71	0.94	Moderate
AHS 6	Immunisation coverage targets are achieved	37.1	48.3	14.6	2.66	0.94	Moderate
AHS 7	Immunisation and antenatal outreach sessions are held as planned	43.8	36.0	20.2	2.67	1.07	Moderate
AHS 8	Residents of peri-urban wards can easily reach health services	39.3	40.4	20.2	2.70	1.06	Moderate
	Average				2.69	0.85	Moderate

Source: Primary data, 2026. Disagree = strongly disagree + disagree; Agree = agree + strongly agree.

Table 6 shows that access to health service delivery was rated moderate, with an overall mean of 2.69. No item was rated high, and on every item fewer than three in ten respondents agreed. The weakest item was the availability of essential medicines throughout the year: almost half of the respondents (49.4%) disagreed that medicines were available all year round. Fewer than one in five agreed that immunisation coverage targets were achieved (14.6%) or that most expectant mothers completed four antenatal visits (16.9%), and about 44% disagreed that outreach sessions were held as planned. The large share of "not sure" responses on the utilisation items (43.8% on antenatal care and 48.3% on immunisation) reflects the fact that revenue staff and councillors are less familiar with clinical indicators than health workers. Overall, the officials' ratings show that access to health services in the municipality was only fair, and weakest on medicines and outreach.

Views of Health Service Users

Table 7: Service users' views on access to health service delivery by facility level (n = 247)

No.	Statement	Disagree (%)	Agree (%)	Mean HC IV (n=124)	Mean HC III (n=123)	Overall mean	Std. dev.	Interpretation
SU1	The medicines I was prescribed were available at this facility	49.4	18.2	2.79	2.40	2.60	1.03	Low
SU2	Laboratory tests I needed were done at this facility	43.7	21.5	2.81	2.47	2.64	1.04	Moderate
SU3	I was attended to by a qualified health worker	43.7	19.0	2.89	2.36	2.62	1.08	Moderate
SU4	Health workers were present at their duty stations when I arrived	47.0	21.9	2.97	2.39	2.68	1.03	Moderate
SU5	I was attended to within a reasonable time	55.5	17.4	2.60	2.41	2.51	0.99	Low
SU6	I did not pay any money for services at this facility	46.6	17.8	2.72	2.49	2.60	1.01	Moderate
SU7	I did not have to buy prescribed medicines from a private drug shop	40.1	19.8	2.94	2.48	2.71	1.02	Moderate
SU8	This facility is within a reasonable distance of my home	60.3	12.6	2.57	2.25	2.41	0.95	Low
SU9	The cost of transport to this facility is affordable for me	46.2	15.0	2.68	2.46	2.57	0.93	Low
SU10	Immunisation/antenatal outreach is regularly conducted in my village	61.9	14.2	2.39	2.15	2.27	1.02	Low
SU11	Overall, I am satisfied with my access to health services at this facility	45.3	23.5	2.88	2.51	2.70	1.09	Moderate
	Average			2.75	2.40	2.57	0.76	Low

Source: Primary data, 2026.

Table 7 shows that service users rated their access to health services as low, with an overall mean of 2.57. The poorest-rated aspect was outreach: 61.9% of users disagreed that immunisation and antenatal outreach were regularly conducted in their village (mean = 2.27). Distance was the second weakest aspect, with 60.3% disagreeing that the facility was within a reasonable distance of their home (mean = 2.41), followed by waiting time (mean = 2.51) and the availability of prescribed medicines (mean = 2.60). Only 23.5% of users said they were satisfied overall with their access to services.

Users of the Health Centre IIIs rated access lower than users of the Health Centre IV on every one of the eleven items. The gaps were largest in the presence of health workers at their duty stations (2.97 against 2.39), being attended to by a qualified health worker (2.89 against 2.36) and not having to buy prescribed medicines from a private drug shop (2.94 against 2.48). These are the items most directly affected by staffing levels and medicine supply, which the facility records show are weaker at the Health Centre IIIs.

Documentary Evidence on Access to Health Services

Table 8: Access to health service indicators by facility level, 2020/21–2024/25

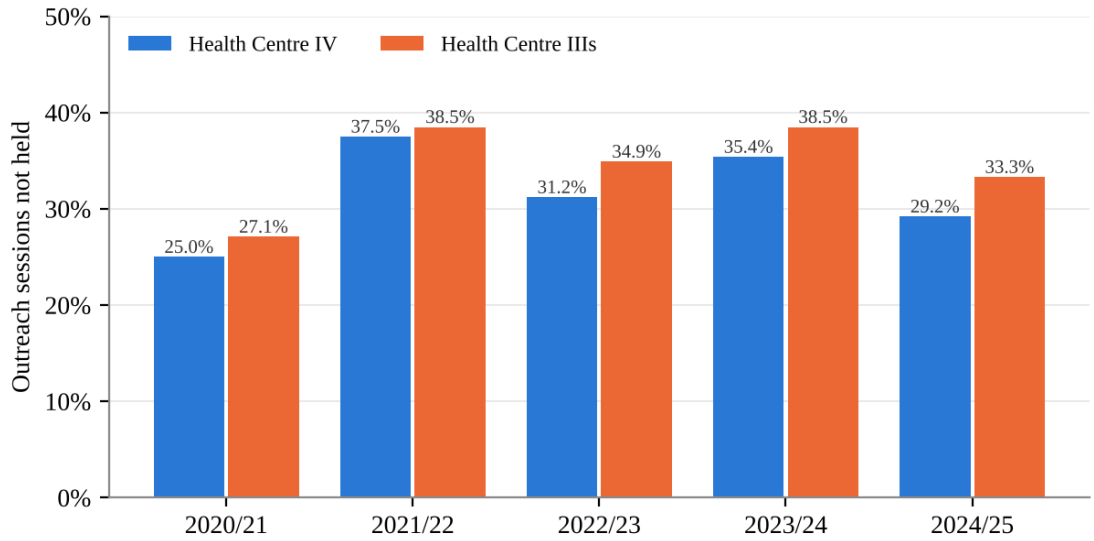
Indicator	Level	2020/21	2021/22	2022/23	2023/24	2024/25
Months with stock-out of ≥1 tracer medicine (of 12)	HC IV	4	5	4	5	4
	HC III	5	6	5	5	5
Staffing (% of approved norm)	HC IV	66	64	65	63	64
	HC III	60	58	59	59	60
New OPD attendances (annual)	HC IV	19,800	21,100	20,400	20,900	21,300
	HC IIIs	19,500	20,200	20,600	20,700	21,000
ANC4 completion rate (%)	HC IV	54	55	53	55	56
	HC IIIs	48	50	49	50	51
DPT3 coverage (%)	HC IV	88	84	86	85	87
	HC IIIs	82	78	80	79	81
Outreach sessions planned	HC IV	48	48	48	48	48
	HC IIIs	192	192	192	192	192
Outreach sessions held	HC IV	36	30	33	31	34
	HC III	140	118	125	118	128
Outreach sessions not held (%)	HC IV	25.0	37.5	31.2	35.4	29.2
	HC IIIs	27.1	38.5	34.9	38.5	33.3
Outreach sessions not held (%)	Combined	26.7	38.3	34.2	37.9	32.5

Source: Municipal health department reports and HMIS/DHIS2 records, 2020/21–2024/25.

Table 8 shows that access to health services remained constrained throughout the five years, with little improvement. Both facility levels experienced stock-outs of at least one tracer medicine in four to six months of every year, and staffing never exceeded two-thirds of the approved norm, standing at 63–66% at the Health Centre IV and 58–60% at the Health Centre IIIs. Only about half of the mothers who started antenatal care completed four visits, with completion at the Health Centre IIIs (48–51%) consistently below that at the Health Centre IV (53–56%). Immunization coverage (DPT3) was higher at the Health Centre IV (84–88%) than at the Health Centre IIIs (78–82%), and both remained below the national target of 90%.

The clearest gap was in community-level delivery. Of 240 outreach sessions planned each year, between 64 and 92 were not held.

Figure 1: Proportion of planned outreach sessions not held by facility level, 2020/21–2024/25



Source: Municipal health department reports and HMIS/DHIS2, 2020/21–2024/25.

Figure 1 shows that the proportion of outreach sessions not held rose from about a quarter in 2020/21 to over a third in 2021/22 and remained above 29% in every subsequent year. In 2023/24, 37.9% of all planned sessions were not held, and the Health Centre IIIs lost a higher share of sessions than the Health Centre IVs in every year. Outpatient attendance was stable at about 380–410 new attendances a week at each level, showing that demand for services was steady while the services reaching communities fluctuated.

Key Informant Views on Access to Health Services

The key informants linked the gaps in access directly to local revenue. The Municipal Medical Officer of Health confirmed the stock-outs, staffing levels, and cancelled outreach found in the records, and explained the effect on mothers in peri-urban wards:

Mothers from Bufunda had to come to town because we could not go to them. (KI-04, Municipal Medical Officer of Health)

The Town Clerk said that outreach was the first activity to suffer when collections fell, while the Deputy Town Clerk noted that repairs requested by HUMCs waited for months:

When collections drop, the first thing we cut is outreach. (KI-01, Town Clerk)

HUMCs request small repairs, but the money comes after months. (KI-02, Deputy Town Clerk)

These accounts explain why outreach and distance were the lowest-rated aspects of access among service users: outreach is the service most dependent on locally raised funds for fuel and allowances, and when it is cancelled, mothers and caretakers must travel to the facility instead.

Comparison of Access by Facility Level

An independent samples t-test was used to establish whether access to health service delivery differed significantly between the Health Centre IV and the Health Centre IIIs.

Table 9: Independent samples t-test of access to health service delivery by facility level

Respondents	Facility level	n	Mean	Std. dev.	t	df	Sig. (2-tailed)	Levene's Sig.
Health workers and HUMC members	Health Centre IV	20	3.08	0.97	2.63	43	0.012	0.259
	Health Centre IIIs	25	2.40	0.77				
Service users	Health Centre IV	124	2.75	0.79	3.75	245	<0.001	0.136
	Health Centre IIIs	123	2.40	0.68				

Source: Primary data, 2026.

Table 9 shows that access to health service delivery was significantly better at the Health Centre IV than at the Health Centre III, according to both health workers and HUMC members ($t = 2.63$, $p = 0.012$) and service users ($t = 3.75$, $p < 0.001$). Levene's test was not significant in either case ($p > 0.05$), so equal variances were assumed. The difference is consistent with the facility records, which show higher staffing, fewer stock-out months, higher antenatal completion, and higher immunisation coverage at the Health Centre IV. Among the Health Centre IIIs, users of Rwentuha Health Centre III gave the lowest rating (mean = 2.14), followed by Kyegegwa Town Council Health Centre III (2.42), Mpara Health Centre III (2.48) and Kakabara Health Centre III (2.51), against 2.75 at Kyegegwa Health Centre IV.

Revenue Mobilization and Access to Health Service Delivery

Table 10: Respondents' views on revenue mobilization (n = 89)

No.	Statement	Disagree (%)	Not sure (%)	Agree (%)	Mean	Std. dev.	Interpretation
RM1	The municipality has identified and registered all its potential local revenue sources	40.4	42.7	16.9	2.65	1.00	Moderate
RM2	The local revenue enhancement plan is implemented as approved	46.1	31.5	22.5	2.65	1.02	Moderate
RM3	Taxpayers are regularly sensitised on the importance of paying local revenue	51.7	29.2	19.1	2.63	1.09	Moderate
RM4	The property valuation roll and rates register are up to date	47.2	33.7	19.1	2.65	1.01	Moderate
RM5	Local revenue targets set by the council are realistic and achieved	49.4	29.2	21.3	2.66	1.02	Moderate
	Average				2.65	0.88	Moderate

Source: Primary data, 2026.

Table 10 shows that revenue mobilisation was rated moderate, with an overall mean of 2.65, but at the lower edge of the moderate band. On all five items, the share of respondents who disagreed (40.4%–51.7%) was more than double the share who agreed (16.9%–22.5%). Just over half (51.7%) disagreed that taxpayers were regularly sensitised on the importance of paying local revenue, and 49.4% disagreed that the council's revenue targets were realistic and achieved. Only 16.9% agreed that the municipality had identified and registered all its potential revenue sources, while 42.7% were not sure, suggesting that many officials themselves did not know the full extent of the revenue base.

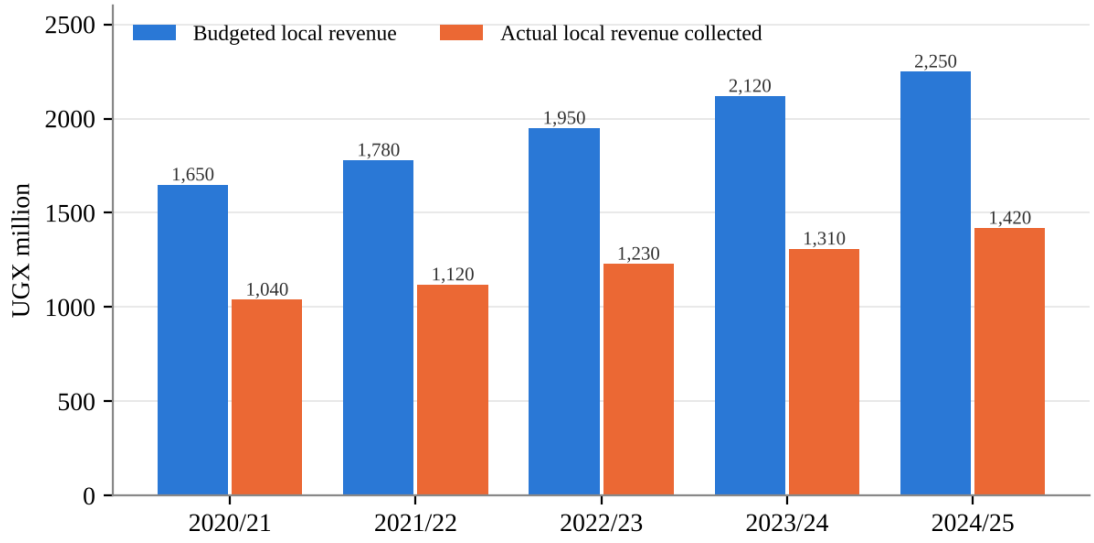
Documentary Evidence on Revenue Mobilisation

Table 11: Local revenue mobilisation indicators, Ibanda Municipal Council, 2020/21–2024/25

Indicator	2020/21	2021/22	2022/23	2023/24	2024/25
Budgeted local revenue (UGX million)	1,650	1,780	1,950	2,120	2,250
Actual local revenue collected (UGX million)	1,040	1,120	1,230	1,310	1,420
Revenue shortfall (UGX million)	610	660	720	810	830
Collection ratio (actual ÷ budget, %)	63.0	62.9	63.1	61.8	63.1
Annual growth in local revenue (%)	–	7.7	9.8	6.5	8.4
Total municipal budget (UGX million)	17,900	19,200	20,500	21,840	23,100
Local revenue as % of total budget	5.8	5.8	6.0	6.0	6.1

Source: Approved budget estimates and budget performance reports, 2020/21–2024/25.

Figure 2: Budgeted and actual local revenue of Ibanda Municipal Council, 2020/21–2024/25 (UGX million)



Source: Approved budget estimates and budget performance reports, 2020/21–2024/25.

Table 11 and Figure 2 show that local revenue collections grew every year, from UGX 1,040 million in 2020/21 to UGX 1,420 million in 2024/25, an increase of 36.5% over the period and annual growth of between 6.5% and 9.8%. However, the budget grew at almost exactly the same pace, so the collection ratio did not improve: the municipality collected between 61.8% and 63.1% of its budgeted local revenue in every year, far outside the LGMSD standard of collecting within 10% of the plan. The revenue shortfall widened from UGX 610 million to UGX 830 million, and local revenue financed only about 6% of the total municipal budget in every year, confirming the municipality's heavy dependence on central government transfers.

Table 12: Local revenue performance by source, 2023/24 (UGX million)

Revenue source	Budget	Actual	Performance (%)	Share of actual (%)
Property rates	520	285	54.8	21.8
Trading licences	330	240	72.7	18.3
Market dues	450	310	68.9	23.7
Ground rent	150	95	63.3	7.3
Parking and taxi park fees	260	180	69.2	13.7
Building plan fees	120	70	58.3	5.3
Other fees and charges	290	130	44.8	9.9
Total	2,120	1,310	61.8	100.0

Source: Budget performance report, 2023/24.

Table 12 shows that in 2023/24 no single source met its target. Property rates, which carry the largest budget (UGX 520 million), performed worst among the major sources at 54.8%, consistent with the incomplete valuation roll. Market dues (23.7% of actual collections), property rates (21.8%) and trading licences (18.3%) together provided almost two-thirds of local revenue. Trading licences performed best (72.7%), the only major source already administered through IRAS.

Key Informant Findings on Revenue Mobilisation

The key informants explained the persistent gap between budgeted and actual revenue in three recurring themes: incomplete enumeration of the revenue base, unrealistic targets, and dependence on central transfers. The Town Clerk explained that targets are not based on a revenue survey:

We budget for over two billion, but we have never done a full enumeration since we became a municipality. (KI-01, Town Clerk)

The Principal Treasurer confirmed the 62% collection ratio found in the documents and linked it to transfer dependence: Local revenue is about six percent of our budget, so we live on transfers. (KI-03, Principal Treasurer)

The Deputy Town Clerk added that sensitisation was irregular and concentrated in the town centre, leaving traders in Bisheshe and Bufunda the least registered, and that "most of our radio talk shows are only done when the financial year starts" (KI-02). The Municipal Medical Officer of Health noted that the health department was excluded from revenue planning: "We are told our ceiling; we do not take part in mobilising" (KI-04). Together, these accounts explain the questionnaire finding that officials were unsure whether all revenue sources had been identified, and the documentary finding that the collection ratio stayed flat as budgets grew.

Relationship between Revenue Mobilisation and Access to Health Service Delivery

Table 13: Correlation between revenue mobilisation and access to health service delivery

Variable	Statistic	Access to health service delivery
Revenue mobilisation	Pearson correlation (r)	0.488
	Sig. (2-tailed)	<0.001
	N	89
	Coefficient of determination (r^2)	0.239

Source: Primary data, 2026. Correlation is significant at the 0.01 level (2-tailed).

Table 13 shows a moderate, positive, and statistically significant relationship between revenue mobilisation and access to health service delivery ($r = 0.488$, $p < 0.001$, $n = 89$). The coefficient of determination ($r^2 = 0.239$) indicates that revenue mobilisation alone accounted for 23.9% of the variation in access to health service delivery. The positive relationship means that respondents who rated revenue mobilisation higher also rated access to health services higher. The relationship was stronger among respondents attached to the Health Centre IIIs ($r = 0.675$, $p < 0.001$) than among those attached to the Health Centre IV ($r = 0.455$, $p = 0.044$), suggesting that the smaller facilities, which have fewer alternative sources of support, are more sensitive to the municipality's ability to raise revenue.

The three sources of evidence therefore converge: revenue mobilisation was rated only moderate; the documents show a collection ratio stuck at about 62% and local revenue financing only 6% of the budget; the key informants traced this to the absence of an enumeration and to unrealistic targets, and revenue mobilization was significantly and positively related to access to health service delivery.

Discussion

Revenue Mobilization and Access to Health Service Delivery

The first objective was to establish the relationship between revenue mobilisation and access to health service delivery in Ibanda Municipality. The study found a moderate,

positive, and significant relationship ($r = 0.488$, $p < 0.001$). Revenue mobilisation itself was rated only moderate (mean = 2.65). Documents showed that collections grew by 6.5–9.8% a year but that the collection ratio remained at about 62% throughout 2020/21–2024/25, far outside the LGMSD standard of collecting within 10% of the budget, and that local revenue financed only about 6% of the municipal budget.

These findings agree with Tumusiime and Ainebyoona (2021), who found a moderate positive relationship between local revenue performance and service delivery in Mbarara City, and with Ochieng and Otieno (2019), who found that Kenyan counties with stronger own-source revenue growth had better availability of medicines and staff. The finding that property rates performed worst among the major sources (54.8% of target) and that the valuation roll had never been fully updated supports Bahl and Bird (2008) and Franzsen and McCluskey (2017), who identified narrow bases and outdated valuations as the main reasons for low property tax yields. The key informants' accounts of targets set from past budgets rather than an enumeration, and of sensitisation limited to the town centre, are consistent with the Local Government Finance Commission's (2019) explanation of low mobilisation in Ugandan local governments.

The study adds two findings to this literature. First, growth in collections did not translate into a better collection ratio, because budgets grew at the same pace; the municipality's mobilisation problem is therefore one of realistic targeting and base coverage, not only of effort. Second, the relationship was stronger at the Health Centre IIIs ($r = 0.675$) than at the Health Centre IV ($r = 0.455$), which suggests that smaller facilities with fewer alternative sources of support depend more on what the municipality is able to raise. In terms of Fiscal Federalism Theory, the finding supports the argument of Oates (1999) and Bahl and Bird (2008) that the benefits of decentralised service delivery depend on local governments raising a meaningful share of their own revenue; at 6% of the budget, Ibanda's own revenue gives it little discretion to respond to local health needs, which is the situation Weingast (2009) describes as weak fiscal incentives under transfer dependence.

Conclusion

The study established that revenue mobilisation has a moderate, positive and significant relationship with access to health service delivery in Ibanda Municipality. Mobilisation is held back by the absence of a full enumeration of the revenue base, an outdated valuation roll, irregular sensitisation, and targets that are not based on revenue potential, so that the municipality collects only about half of its budgeted local revenue and remains dependent on transfers. Improving mobilisation is likely to improve access, particularly at the Health Centre IIIs.

Recommendation

Ibanda Municipal Council, through the Finance Department, should carry out a full enumeration of revenue sources in all three divisions and update the property valuation roll, and should base annual local revenue targets on the results so that the collection ratio becomes a meaningful measure of performance.

The municipality should run continuous taxpayer sensitisation throughout the year, with particular attention to traders and property owners in Bisheshe and Bufunda divisions, using radio, notice boards, division meetings and barazas.

The Municipal Health Department should be included in the revenue planning and budget process so that the health needs that local revenue is expected to finance are considered when targets and allocations are set.

A longitudinal study linking facility-level releases of local revenue to monthly outreach and stock-out records over a longer period, to test the direction of the relationship found in this study.

The Ministry of Local Government and the Local Government Finance Commission should support new municipalities with revenue enumeration, valuation, and IRAS roll-out, and should consider including the share of local revenue allocated and released to health as an indicator in the LGMSD performance assessment.

Acknowledgement

I thank the Almighty God for the gift of life, good health, and the strength to complete this study.

I am deeply grateful to my supervisor, Dr. Sendagi Muhammad, for his guidance, constructive criticism, and patience from the development of the proposal to the completion of this dissertation. I also thank the lecturers and staff of the School of Graduate Studies and Research of Team University for the knowledge and support they gave me during the Master of Public Administration and Management programme.

I sincerely thank the Town Clerk, the Deputy Town Clerk, the Principal Treasurer and the Municipal Medical Officer of Health of Ibanda Municipal Council for granting me permission to carry out this study and for sharing their time and insights. I am equally grateful to the revenue and finance staff, councillors, division administrative officers, health workers, Health Unit Management Committee members and health service users who responded to the questionnaires, and to the research assistants who helped with data collection.

I thank my classmates for the encouragement and shared learning, and my family for their moral and financial support throughout the course. May God bless you all.

List of abbreviations.

HC: Health Centre
HUMC: Health Unit Management Committee
SPSS: Statistical Package for the Social Sciences
UGX: Ugandan Shillings

Informed Consent.
Written informed consent was obtained from all participants prior to their inclusion in the study. Participants were informed about the purpose of the study, procedures involved, potential risks and benefits, and their right to withdraw at any time without penalty.

Source of funding.
The study was not funded.

Conflict of interest.
There is no conflict of interest.

Availability of data.
Data used in this study are available upon request from the corresponding author.

Authors contribution.
BA conceptualized the study, developed the methodology, carried out the investigation, and wrote the original draft.
MS: supervision, validation, writing, review, and editing
EB: supervision, validation, writing, review, and editing.
All authors approved the final version of the manuscript and agreed to be accountable for the work.

Authors biography
Alex Nuwagaba is a researcher at the School of Graduate Studies and Research, Team University
Dr. Muhammad Sendagi is a research supervisor at the School of Graduate Studies and Research, Team University
Edmond Bakashaba is a research supervisor at the School of Graduate Studies and Research, Team University

References.
1. Amin, M. E. (2005). Social science research: Conception, methodology and analysis. Makerere University Printery.
2. Bahl, R., & Bird, R. (2008). Subnational taxes in developing countries: The way forward. Public Budgeting & Finance, 28(4), 1-25. https://doi.org/10.1111/j.1540-5850.2008.00914.x
3. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101. https://doi.org/10.1191/1478088706qp063oa
4. Cohen, J. (1988). Statistical power analysis for the behavioral sciences (2nd ed.). Lawrence Erlbaum Associates.
5. Creswell, J. W., & Creswell, J. D. (2018). Research design: Qualitative, quantitative, and mixed methods approach (5th ed.). Sage.
6. Creswell, J. W., & Plano Clark, V. L. (2018). Designing and conducting mixed methods research (3rd ed.). Sage.
7. Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. Psychometrika, 16(3), 297-334. https://doi.org/10.1007/BF02310555
8. Fjeldstad, O.-H., Chambas, G., & Brun, J.-F. (2014). Local government taxation in sub-Saharan Africa: A review and an agenda for research (CMI Working Paper WP 2014:2). Chr. Michelsen Institute.
9. Franzsen, R., & McCluskey, W. (Eds.). (2017). Property tax in Africa: Status, challenges, and prospects. Lincoln Institute of Land Policy.
10. Ibanda Municipal Council. (2024). Annual budget performance report and local revenue enhancement plan, FY 2023/24. IMC.
11. Ibanda Municipal Council Health Department. (2024). Annual health sector performance report, FY 2023/24. IMC.
12. Israel, G. D. (1992). Determining sample size (Fact Sheet PEOD-6). University of Florida.
13. Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. International Journal for Equity in Health, 12, 18. https://doi.org/10.1186/1475-9276-12-18
14. Local Government Finance Commission. (2019). Local revenue performance and enhancement strategies for local governments in Uganda. LGFC.
15. Ministry of Health. (2023). Annual health sector performance report, FY 2022/23. Government of Uganda.
16. Ministry of Local Government. (2020). Local Government Management of Service Delivery performance assessment manual. Government of Uganda.
17. Moore, M., Prichard, W., & Fjeldstad, O.-H. (2018). Taxing Africa: Coercion, reform and development. Zed Books. https://doi.org/10.5040/9781350222861
18. Mugenda, O. M., & Mugenda, A. G. (2003). Research methods: Quantitative and qualitative approaches. African Centre for Technology Studies.
19. Oates, W. E. (1999). An essay on fiscal federalism. Journal of Economic Literature, 37(3), 1120-1149. https://doi.org/10.1257/jel.37.3.1120
20. Ochieng, J., & Otieno, B. (2019). Own-source revenue and primary health care service delivery in selected county governments in Kenya. International Journal of Public Policy and Administration, 1(2), 60-78.
21. Office of the Auditor General. (2023). Report of the Auditor General on the financial statements of Ibanda Municipal Council for the year ended 30th June 2023. OAG.

22. Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. Medical Care, 19(2), 127-140. https://doi.org/10.1097/00005650-198102000-00001
23. Sekaran, U., & Bougie, R. (2016). Research methods for business: A skill-building approach (7th ed.). Wiley.
24. Tumusiime, E., & Ainebyoona, G. (2021). Local revenue performance and service delivery in Mbarara City. Journal of Public Administration and Governance in Africa, 3(2), 22-39.
25. Uganda Bureau of Statistics. (2024). National population and housing census 2024: Final results. UBOS.
26. Weingast, B. R. (2009). Second generation fiscal federalism: The implications of fiscal incentives. Journal of Urban Economics, 65(3), 279-293. https://doi.org/10.1016/j.jue.2008.12.005
27. Yamane, T. (1967). Statistics: An introductory analysis (2nd ed.). Harper & Row.

PUBLISHER DETAILS

AfroGlobal Press

AfroGlobal Press
Amplifying Voices Worldwide

Contact: +256 763 123 847

Email: afroglobalpress@gmail.com

Website: https://afroglobalpress.com

Address: Scholar's Summit, Nakigalala, East Africa