

# Decentralization and Socio-Economic Development: Assessing Primary Health Care Service Delivery in Bo District

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**Abstract:** This study examines the impact of decentralization on socio-economic development in the chiefdoms of Bo District, Sierra Leone, with particular attention to primary health care services. Following the reintroduction of decentralization in 2004 after the civil war, local councils and chiefdom administrations were expected to improve service delivery and strengthen community participation in governance.

A mixed-method approach was adopted, combining quantitative survey data and structured interviews. A total of 414 respondents were selected across sixteen chiefdoms using stratified sampling techniques. Data were analyzed using SPSS, employing descriptive statistics and Pearson's chi-square tests to assess associations between decentralization and selected health indicators, including malaria, enteric fever, labour pain-related deaths, HIV/AIDS, and anaemia.

The findings reveal mixed outcomes regarding the impact of decentralization on health service delivery and socio-economic development. While decentralization has improved local participation and awareness of health-related issues, significant challenges persist in the provision, accessibility, and effectiveness of primary health care services. Inferential statistical results indicate varying degrees of association between decentralized governance structures and health outcomes within the district. The study concludes that although decentralization has created opportunities for local involvement in governance and development, institutional, financial, and administrative constraints continue to limit its full potential in enhancing socio-economic development in the chiefdoms of Bo District.

**Keywords:** *Decentralization, Socio-economic Development, Primary Health Care, Chiefdom Councils, District Councils, Local Governance, Bo District, Malaria, HIV/AIDS, Enteric fever, Maternal Death, Anemia.*

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## Introduction

Primary health care focuses mainly on the prevention of diseases and disabilities through interventions such as immunization programmes, family planning services, malaria prevention and treatment, maternity care, public health awareness campaigns, and first aid services (Giovannella, 2018; HAKI ZETU ESC, 2012). It represents the first point of contact between individuals, families, communities, and the national health system. Primary health care brings medical services closer to the people through Peripheral Health Units (PHUs), where community health workers, nurses, and paramedics provide treatment for common but potentially life-threatening illnesses. This level of care is particularly important in rural communities where access to advanced medical facilities is limited.

Secondary health care, on the other hand, deals with the treatment of more serious medical conditions such as tuberculosis, bronchitis, and physical injuries including fractures. Services at this level are provided in hospitals and specialized clinics by nurses, paramedics, medical officers, and other health specialists. Secondary health care facilities are therefore more equipped than primary health care centres and serve as referral points for cases that cannot be adequately managed at the community level.

The tertiary level constitutes the most advanced stage of health care delivery. It provides specialized treatment for highly complex medical conditions, including cancer management, kidney-related illnesses, cardiovascular diseases, and complicated surgical operations. Tertiary health care services are usually delivered in referral hospitals or university teaching hospitals by highly trained medical specialists using sophisticated medical technologies (HAKI ZETU ESC, 2012; 2021).

However, this study focuses specifically on primary health care because it is the most accessible and operational level of health service delivery within the chiefdoms of Sierra Leone. Since decentralization reforms were introduced through the Local Government Act of 2004, primary health care services have increasingly become an important area through which local councils and chiefdom authorities interact with rural communities. Examining the effectiveness of primary health care delivery therefore provides a useful basis for assessing the extent to which decentralization has contributed to socio-economic development in the chiefdoms of Bo District.

**The Concept of Socio-Economic Development**

The concept of socio-economic development cannot be adequately discussed without first understanding the broader notion of development itself. Development is a multidimensional concept that has been defined differently by various scholars and practitioners. According to Adam Szirmai (5005, P.6), development reflects the unequal conditions existing between nations, where some countries are characterized by extreme poverty while others enjoy high levels of prosperity. In a similar vein, Palvia, Baqir, and Hamid (2018) describe development as a progressive process of growth and transformation within society.

However, Amartya Kuma Sen argues that development should not merely be equated with economic growth alone (Sen, 1988). He contends that while economics focuses on the engineering and organization of society’s resources, development evaluates the extent to which such arrangements improve human wellbeing and living standards. In this regard, development is concerned with expanding human capabilities, freedoms, and opportunities rather than only increasing national income.

Similarly, Walter Rodney (1974) conceptualizes development as a multidimensional process operating at both individual and societal levels. At the individual level, development involves increased skills, creativity, self-discipline, freedom, responsibility, and material wellbeing. At the societal level, it refers to the capacity of social groups to manage internal and external relationships effectively while safeguarding collective independence and welfare. Rodney’s perspective underscores the importance of social organization, institutional capacity, and collective advancement in the development process.

Dudley Seers (1969), on the contrary challenges the narrow interpretation of development as mere economic growth measured by per-capita income. According to Seers, true development must also involve poverty reduction, employment creation, and equality

of opportunity. He argues that economic growth alone may benefit only a privileged minority if there are no mechanisms for equitable distribution of resources and opportunities. Consequently, development should be assessed through improvements in education, political participation, freedom of expression, and the overall fulfillment of human potential.

While development is certainly a polysemic word, the phrase socio-economic development came about as a result of questions around how development benefits qualitatively trickle down to people in various ways more than economics alone (Fourcade et al, 2023). Subsequently, from the collective point of view, socio-economic development came to mean the creation of qualitative conditions for the existence of all members of community through the provision of material resources and public goods (Kravchenko et al, 2021.p478). This definition helps to sharpen the concept of development as a distributional logic and applicability of growth (Ashford 2004, p 8). In this regard, development is socio-economic when there is a sound mechanism for the distribution of wealth and opportunities to all.

Based on the fore-going analyses, socio-economic development was succinctly defined by Szirmai (2005) as quoted in Palvia et al (2018), “development in income, education, human capabilities, politics, culture, ecology, nutrition, health, life expectancy, personal dignity, freedom of association, personal safety, and freedom from fear of physical harm, and the extent of participation in the civil society part of development” (See table 1 in Palvia et al 2018).

Among others, this definition seems quite appropriate for this study, and against which backdrop this study adapted Madon’s theoretical model quoted by Palvia et al (2018), which graphically depicted socio-economic development as a four sided component. The diagram below shows physical environment, social wellbeing, economic growth and political wellbeing.

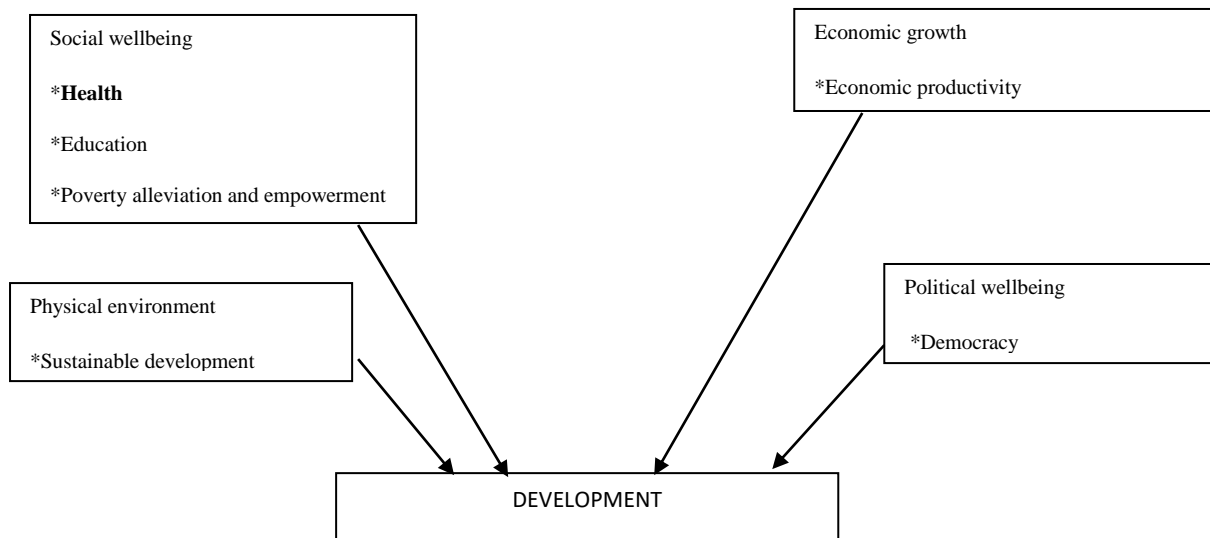


Fig. 1: Socio-economic Development adapted from Palvia (2018, fig 1).

**Objectives of the Study**

**General Objective**

The study sought to examine the impact of decentralization on the socio-economic development of chiefdoms in Bo District, with particular emphasis on primary healthcare delivery.

**Specific Objectives**

1. To assess the extent to which decentralization has influenced the delivery of primary health care services in the chiefdoms.

2. To examine the availability, accessibility, and functionality of health facilities across the chiefdoms under the decentralization framework.
3. To analyse the perceptions of community members on the quality and affordability of health care services before and during decentralization.

## Method

### Study Design

This study adopted a mixed method research approach in which data were collected through structured questionnaires administered by trained field enumerators. Face-to-face interviews were conducted with respondents across the study area in order to ensure clarity, accuracy, and completeness of responses. A total of 414 respondents were interviewed across all sixteen chiefdoms in Bo District. Respondents were engaged at locations convenient to them, including their residences, workplaces, and local communities.

In addition to the mixed method approach, the study employed a phenomenological case study design to examine stakeholders' perspectives on the administrative interactions between chiefdom councils and district councils within the decentralization process, and how such interactions influence socio-economic development, particularly in relation to primary health care delivery. According to Heath Williams (2021, p.369), phenomenology focuses on the description and interpretation of lived experiences associated with a particular phenomenon.

The phenomenological case study approach was considered appropriate for this research because it enabled the study to capture the lived experiences of ordinary citizens, local authorities, and other stakeholders regarding health service delivery within the decentralized governance system. In this regard, the approach provided an opportunity to explore how decentralization has affected access to and delivery of primary health care services in the chiefdoms of Bo District.

### Description of the Study Area

Bo District is one of the principal districts in the Southern Province of Sierra Leone and hosts the country's second-largest city, Bo. The district shares boundaries with Kenema District to the east, Tonkolili District to the north, Moyamba District to the west, Bonthe District to the southwest, and Pujehun District to the south. The strategic central location of Bo District has historically provided it with significant administrative and commercial advantages from the colonial era to the present day.

According to the 2021 midterm population census, Bo District has an estimated population of 756,975 people, making it the second most populous district in the country after the Western Urban Area. The district derives its name from the city of Bo, which serves simultaneously as the provincial headquarters of the Southern Province, the district headquarters, and the headquarters town of Kakua Chiefdom. Due to these administrative advantages, Bo has evolved into a highly cosmopolitan urban centre inhabited by diverse ethnic groups and foreign nationals.

Traditional accounts from local authorities in Kakua Chiefdom provide two explanations regarding the origin of the name "Bo." The first narrative attributes the name to the clayey nature of the soil around the present-day Shengay Market area, where early settlers referred to the location as "Bowui," meaning clay soil in the Mende language. The second and more widely known narrative relates to a hunter who killed an elephant and shared portions of the meat with surrounding communities in accordance with local customs. Recipients were reportedly told "Bi-wo-loy," meaning "This is yours" in Mende, a phrase that gradually evolved into the present name "Bo."

The district comprises sixteen chiefdoms, namely: Kakua, Baoma, Badja, Bagbwe, Bongor, Jaiama, Selenga, Tinkoko, Ngao, Lugbu, Niawa-Lenga, Bagbo, Gbo, Valunia, Komboya, and Wonde. Some of the notable towns within the district include Baoma, Bumpeh, Damballa, Mandu, Mongere, Jerihun, Njala, Serabu, and Tinkoko.

The economy of Bo District is predominantly agrarian, with farming constituting the major source of livelihood for the population. Agricultural activities include the cultivation of rice, cassava, coffee, kola nut, oil palm, and cocoa on a relatively limited scale. Mining activities involving gold, diamonds, and sand also contribute to the district's economy. In addition, trade in imported manufactured goods from Freetown, Conakry, and Monrovia forms part of local commercial activities, often exchanged for agricultural and forest products.

In terms of social development indicators, the Multi-Dimensional Poverty Index (MPI) for Bo District in 2023 stood at 0.29, placing the district among the moderately poor districts in the country alongside Bombali and Kenema districts. The district also recorded a net primary school enrolment rate of 77.6 percent, reflecting moderate progress in educational access and human development. These socio-economic characteristics make Bo District an appropriate case study for examining the relationship between decentralization and socio-economic development, particularly in the area of primary health care delivery.

### Study Population

The study population comprised residents and stakeholders within Bo District's chiefdoms. Respondents were categorized into two main groups: (1) government and administrative stakeholders, including paramount chiefs, councillors, and local administrators; and (2) beneficiary groups, including farmers, traders, health workers, teachers, patients, and other community members directly affected by service delivery.

### Sample Size and Sampling Procedure

A total sample of 414 respondents was selected from an estimated population of 971 individuals using Krejcie and Morgan's (1970) sample determination table. Stratified sampling was employed to ensure representation across chiefdoms and stakeholder categories, followed by purposive and convenience sampling to select key informants based on relevance and accessibility.

**Sample frame**

Table 1: Categorization of study participants

Category	Targeted Population (N)	Sample size ( S )	Percentage
Paramount chiefs / speakers	16	14	3.4%
Bo District Council administration	30	28	6.8%
Bo City Council administration	20	18	4.3%
Chieftdom administrative clerks	16	14	3.4%
DHMT	35	32	7.7%
MBSSE	55	48	11.6%
Field questionnaires	800	260	62.8%
Total	971	414	100%

**Data Analysis**

Quantitative data were coded and analyzed using SPSS software. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize respondent characteristics and perceptions. Inferential analysis was conducted using Pearson’s chi-square test to examine associations between decentralization and selected health indicators, including malaria, enteric fever, labour-related deaths, HIV/AIDS, and anaemia. Cramer’s V was used to determine the strength of association between variables.

Qualitative data from interviews were coded and thematically analyzed to complement and interpret quantitative findings, particularly regarding perceptions of service delivery, governance effectiveness, and socio-economic impacts.

**Ethical Considerations**

Ethical clearance was obtained prior to data collection. Informed consent was sought from all participants, and confidentiality and anonymity were strictly maintained throughout the study.

**Result**

**Sex Distribution of Respondents**

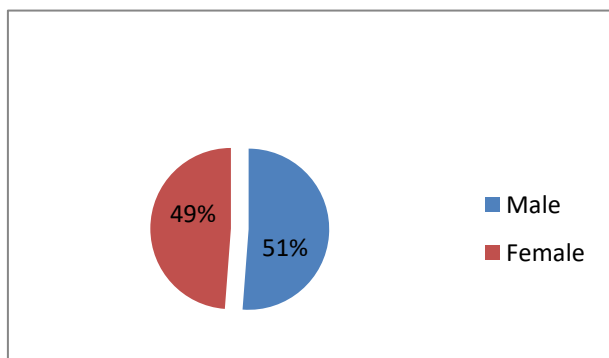


Figure 2: Sex Distribution of Respondents

According to Figure 2, females constituted 51 percent of the respondents, while males accounted for 49 percent. This indicates that the majority of respondents in the study were women. Although women were not deliberately targeted during the sampling process, their slightly higher representation may reflect the increasing level of women’s participation and assertiveness in matters relating to community development and social welfare in Sierra Leone.

The relatively high participation of women is particularly significant given that issues relating to health, education, and family wellbeing are often closely associated with women’s everyday experiences and responsibilities within society.

**Age Distribution of Respondents**

Table 2: Age distribution of respondents

Age	Frequency	Percent
18-27	46	17.7
28-37	64	24.6
38-47	68	26.2
48-57	54	20.8
58-67	18	6.9
68 and above	10	3.8
Total	260	100.0

Data presented in Table 2 indicate that the respondents had a mean age score of 2.86, a median of 3.00, a standard deviation of 1.33, and a range of 5. These statistics suggest that the majority of respondents were within the youthful and middle-aged categories. Specifically, 26.2 percent of respondents were within the age bracket of 38–47 years, representing the largest proportion of the sample population. This was followed by respondents aged 28–37 years, who accounted for 24.6 percent, while those within the age range of 48–57 years constituted 20.8 percent of the respondents.

In addition, 17.7 percent of respondents fell within the category of teenagers and young adults, whereas respondents of retirement age and above accounted for 6.9 percent and 3.8 percent respectively. The distribution demonstrates that the study largely captured the views of economically active and socially engaged individuals who are likely to possess substantial knowledge and experience regarding governance and service delivery within their communities.

Furthermore, the age composition of respondents strengthens the reliability of the findings because the majority was

mature enough to provide informed assessments of the decentralization programme in Sierra Leone. Since the current decentralization arrangement was reintroduced in 2004, the fact that approximately 82.3 percent of respondents were older than the programme itself implies that they had lived through both the centralized and decentralized governance systems. Their responses therefore provide valuable experiential insights into the extent to which decentralization has influenced socio-economic development and primary health care delivery in the chiefdoms of Bo District.

**Occupational Distribution of Respondents**

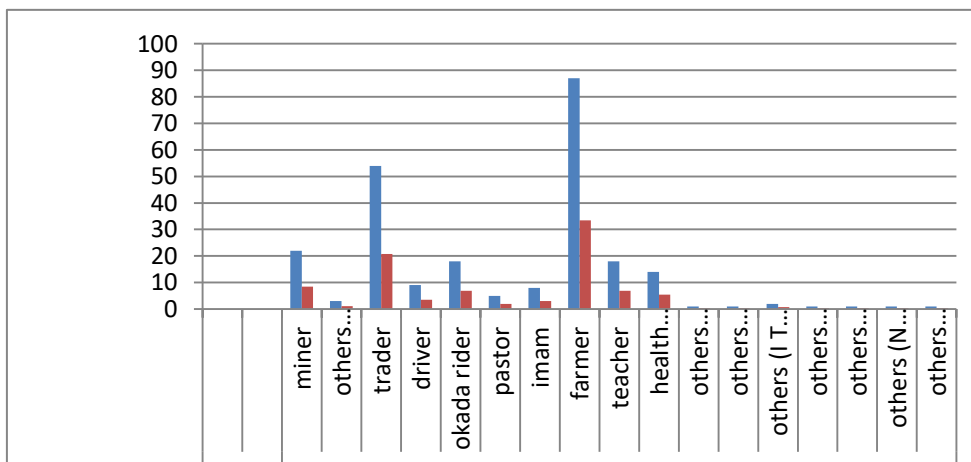


Figure 3: Respondents' occupation

The study engaged respondents from diverse occupational backgrounds in order to capture a wide range of perspectives on decentralization and socio-economic development within the chiefdoms of Bo District. The occupational composition of respondents therefore reflects the demographic and socio-economic characteristics of the study population.

According to Figure 3, farmers constituted the largest occupational category, representing 33.5 percent of the respondents. Traders accounted for 20.8 percent, while miners represented 8.5 percent of the sample population. These three occupational groups formed the majority of respondents, with farming ranking as the dominant occupation. This finding is consistent with the predominantly agrarian nature of Bo District, where agriculture remains the principal source of livelihood for many rural households.

Teachers and commercial motorbike riders ("okada" riders) each accounted for 6.9 percent of respondents, making them the fourth most represented occupational groups in the study. Health workers ranked as the sixth largest category of respondents, an important inclusion given the study's focus on primary health care delivery and decentralization.

Furthermore, vehicle drivers and students each represented 3.5 percent of the respondents, while imams accounted for 3.1 percent. Pastors constituted 1.9 percent of the sample population. Respondents categorized as "others" represented 1.2 percent, whereas Information Technology (IT) students and tailors each accounted for 0.8 percent of respondents.

The least represented occupational category consisted of six respondents, each accounting for 0.4 percent of the sample

population. These respondents identified themselves respectively as a mason, mechanic, Native Administration (NA) police officer, retired head teacher, retired military officer, and traditional healer. Although these occupations recorded the lowest frequencies, their inclusion contributed to the diversity of opinions and experiences represented in the study.

Overall, the broad range of occupations represented among respondents enhanced the comprehensiveness and inclusiveness of the research findings. It demonstrates that the study captured views from different segments of society, including agriculture, trade, mining, education, transportation, religion, health services, security, and traditional community structures. This diversity strengthened the study's ability to assess how decentralization and primary health care delivery affect various socio-economic groups within the chiefdoms of Bo District.

**Social Status of Respondents**

Table 3: Social status of respondents

	Frequency	Percent
youth leader	34	13.1
Chairman	10	3.8
chair lady	9	3.5
ordinary citizen	72	27.7
business person	32	12.3
Town chief	12	4.6
community elder	46	17.7

<b>agricultural group member</b>	28	10.8
<b>senior citizen</b>	16	6.2
<b>Total</b>	260	100%

Data presented in Table 3 indicate that 27.7 percent of the respondents identified themselves as ordinary citizens, representing the largest category within the study population. Community elders accounted for 17.7 percent of respondents, while youth leaders constituted 13.1 percent. Business persons represented 12.3 percent of the respondents, whereas members of agricultural groups accounted for 10.8 percent.

In addition, 6.2 percent of respondents identified themselves as senior citizens. Chairmen of various social groups constituted 3.8 percent of the respondents, while chairladies of

social groups represented 3.5 percent. The presence of respondents occupying leadership and community-based positions suggests that many participants possessed substantial knowledge of local governance structures and development activities within their respective chiefdoms.

The distribution of respondents according to social status therefore enhanced the reliability of the study because the participants were well positioned to assess and evaluate the impact of decentralization and socio-economic service delivery in their communities. Their experiences and community roles provided informed perspectives on the effectiveness of local governance structures, particularly in relation to primary health care services and broader socio-economic development initiatives in the district.

**Level of Education of Respondents**

Table 4: Educational levels of respondents

	Frequency	Percent
Graduate certificate/diploma	12	4.6
senior school leaver	38	14.6
junior school leaver	69	26.5
primary school	51	19.6
no formal education	34	13.1
Arabic	47	18.2
Total	9	3.5
	260	100%

Table 4 presents the educational attainment of respondents involved in the study. The findings indicate that respondents possessed varying levels of formal and informal education, reflecting the diverse educational background of the population within the chiefdoms of Bo District.

According to the data, the largest proportion of respondents, representing 26.5 percent, were senior secondary school leavers. This was followed by junior secondary school leavers, who accounted for 19.6 percent of the respondents. Respondents with no formal education constituted the third largest category, representing 18.1 percent of the study population.

Furthermore, respondents who indicated that they possessed certificates or diploma qualifications are 14.6 percent of the sample population. Those who attained only primary school education represented 13.1 percent, while respondents with university education accounted for 4.6 percent. The least represented educational category comprised respondents who had attained various levels of Arabic education, accounting for 3.5 percent of the respondents.

The educational diversity among respondents suggests that participants were reasonably equipped to provide informed opinions and experiences regarding decentralization and service delivery systems within their communities. The relatively high proportion of respondents with secondary, certificate, diploma, and university education enhanced the reliability of the data collected, while the inclusion of respondents with little or no formal education ensured that the perspectives of ordinary rural citizens were adequately represented in the study.

Overall, the mixture of educational backgrounds strengthened the comprehensiveness of the research by capturing

views from respondents with different levels of literacy, knowledge, and social experiences concerning governance, socio-economic development, and primary health care delivery under the decentralization framework in Sierra Leone.

**Chiefdom Contribution to the Operations of Health Facilities**

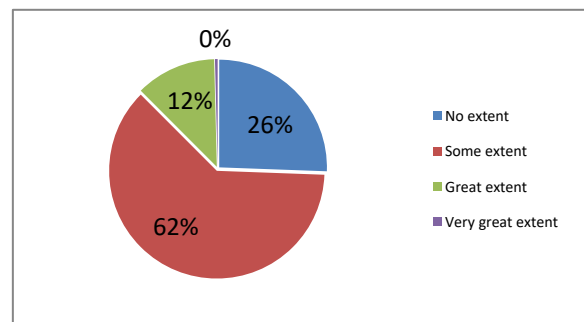


Figure 4: Chiefdom contribution to the operations of health facilities

The study further examined the extent to which chiefdom administrations, within the framework of decentralization, contributed to the operation of health facilities in their respective chiefdoms. Findings presented in Figure 4 indicate that 61.5 percent of respondents believed that chiefdom authorities contributed to the functioning of health centres to *some extent*. In contrast, 25.4 percent reported that chiefdom administrations contributed to *no extent*, while 12.7 percent perceived the contribution to be to a *great extent*. Only 0.4 percent of respondents indicated that chiefdom authorities contributed to a *very great extent*.

These findings suggest that respondents generally perceived the role of chiefdom administrations in health service

delivery as moderate rather than substantial. The responses also reflect the subjective experiences of community members regarding the effectiveness of chiefdom authorities in supporting decentralized health governance within Sierra Leone.

The relatively low proportion of respondents who perceived chiefdom contributions as “great” or “very great” may be associated with the limited statutory powers and operational capacities of chiefdom councils within the decentralization framework. Although the Local Government Act 2021 provides a legal basis for cooperation between local councils and chiefdom councils, the specific functions and operational responsibilities of chiefdom authorities in the decentralization process remain relatively constrained and sometimes unclear in practice.

In particular, Section 20 of Part V of the Act requires local councils to delegate certain responsibilities to chiefdom councils while encouraging cooperation in promoting devolution, inclusive participation, human rights, and good governance. However, the

effectiveness of such collaboration often depends on several contextual factors, including the quality of local leadership, the commitment of chiefdom authorities to community welfare, the size and administrative capacity of the chiefdom, and the availability of natural and economic resources within the locality.

Consequently, the ability of chiefdom administrations to support health facilities varies considerably across communities. In some chiefdoms, capable leadership and community mobilization may facilitate stronger support for health centres through local initiatives and cooperation with district councils. In others, limited resources, weak institutional coordination, and inadequate administrative capacity may constrain meaningful contributions to primary health care delivery. These disparities help explain the varied perceptions expressed by respondents regarding the extent of chiefdom involvement in the operation of health facilities in Bo District.

**Respondents’ Perceptions of Chiefdom Contributions to Health Centre Operations**

**Table 5: Reasons for respondents’ scores**

Category	Examples	Counts	Percentages
<b>Facility Management Committee</b>	FMC oversees the day to day running of the hospital.	30	12%
<b>Health condition slowly improving</b>	Health workers ready to work at all times. / We now have electricity at the centre	37	14%
<b>Chiefdom is helping</b>	Chiefdom helps to construct new labour room.	28	11%
<b>Health centre available</b>	Health centre is available.	34	13%
<b>No help from chiefdom</b>	I have neither seen nor heard of anything done by them in the community.	21	8%
<b>No health centre</b>	We walk miles to access clinic in another community.	69	27%
<b>Poor treatment</b>	Essential drugs not enough.	19	7%
<b>Sensitization meetings</b>	Sensitization meetings with chiefdom authorities	22	8%
<b>Total</b>		260	100%

Table 5 further presents the reasons advanced by respondents to justify their perceptions regarding the extent to which chiefdom administrations contribute to the operations of health centres within their communities in Bo District. The responses reveal both positive and negative assessments of the role of chiefdom authorities in supporting primary health care delivery.

According to the findings, “health condition slowly improving” received 37 counts, representing 14 percent of responses, while “health centre available” accounted for 34 counts or 13 percent. In addition, “Facility Management Committee” received 30 counts (12 percent), and respondents who stated that the “chiefdom is helping” accounted for 28 counts (11 percent). These responses suggest that some communities acknowledge the efforts of chiefdom administrations and local structures in supporting the functioning of health facilities and improving access to health services.

Furthermore, “sensitization meetings” accounted for 25 counts or 8 percent of responses, indicating that awareness campaigns and community mobilization activities were recognized as part of chiefdom contributions to local health governance. However, 21 respondents (8 percent) indicated that there was “no help from chiefdom,” while 19 respondents (7 percent) complained of “poor treatment” within the health facilities.

Most significantly, the largest proportion of responses, representing 66 counts or 27 percent, indicated that there were “no health centres” in their communities. This finding is particularly important because it highlights the inadequacy of primary health care infrastructure within several chiefdoms in the district. The absence of health facilities in more than one-quarter of the surveyed communities underscores the persistent challenges facing decentralized health service delivery in Sierra Leone.

The findings therefore suggest that although decentralization and chiefdom participation may have contributed to some improvements in health service delivery, substantial gaps remain in terms of infrastructure, accessibility, and quality of care. The high percentage of respondents reporting the absence of health centres serves as a strong indication that access to primary health care remains uneven and inadequate across some chiefdoms. This situation calls for greater intervention from local councils, chiefdom authorities, and the central government to strengthen rural health infrastructure, improve service delivery, and ensure equitable access to health facilities within the decentralized governance framework.

**Affordability of Health Care**

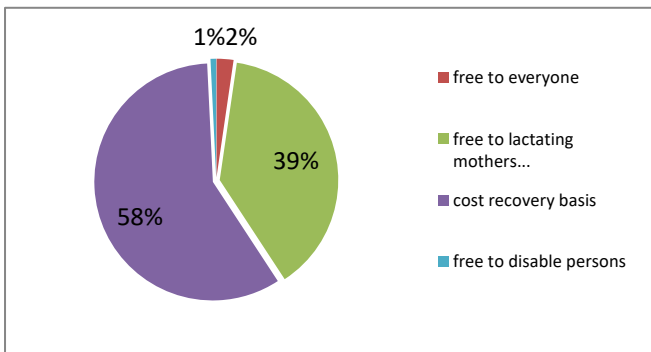


Figure 5: Affordability of health care

The study also examined respondents’ perceptions regarding the affordability of health care services within their communities in Bo District. Findings presented in Figure 5 indicate that the majority of respondents, representing 58 percent, reported that health care services were provided on a cost-recovery basis. This implies that patients are generally required to make payments for medical consultations, drugs, or other health-related services before receiving treatment.

In addition, 39 percent of respondents indicated that free health care services were available only to lactating mothers. This finding reflects the implementation of targeted government health policies aimed at supporting vulnerable groups, particularly women

**Rating of Health Care Services**

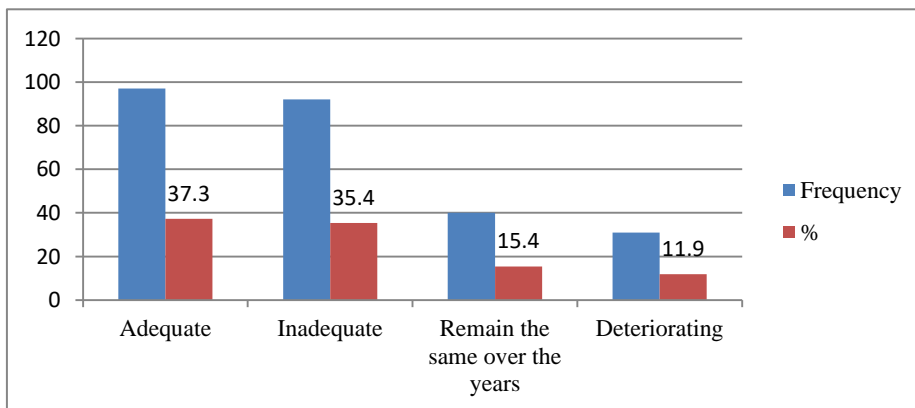


Figure 6: Rating health services

The study further assessed respondents’ perceptions regarding the quality and adequacy of health care service provision across the chiefdoms of Bo District. The findings reveal mixed opinions concerning the effectiveness of primary health care delivery under the decentralization framework.

According to the data, 37.3 percent of respondents rated health care services as adequate, while 35.4 percent considered the services to be inadequate. In addition, 15.4 percent of respondents stated that health care services had remained the same over the years, whereas 11.9 percent believed that the services were deteriorating.

The narrow difference between respondents who viewed health services as adequate and those who perceived them as inadequate suggests a divided level of public confidence in the health care system. Similarly, the relatively close percentages between respondents who believed services had remained

and children, within the primary health care system of Sierra Leone.

However, only 2.3 percent of respondents stated that health care services were free for everyone, while an even smaller proportion, 0.8 percent, indicated that free services were specifically available for persons with disabilities. These findings suggest that access to free health care remains limited and selective within many communities.

The results further imply that there may be inadequate public awareness regarding the categories of beneficiaries entitled to free medical services and the range of services available at local health facilities. In some cases, respondents may not fully understand government health policies or the provisions attached to primary health care centres within their chiefdoms.

Moreover, the dominance of cost-recovery responses raises concerns about affordability and equitable access to health care services among rural populations, particularly low-income households. It also points to persistent challenges within the decentralized health sector, including allegations of informal charges, weak monitoring mechanisms, and corruption in health service delivery. Consequently, the findings highlight the need for stronger public sensitization, improved accountability, and enhanced government intervention to ensure that health care services become more accessible, transparent, and affordable for local communities.

unchanged and those who perceived a decline in service quality indicate that many community members are uncertain about the extent of progress achieved in the health sector since the introduction of decentralization in Sierra Leone.

These findings imply that although some improvements may have been recorded in primary health care delivery, significant challenges continue to affect the efficiency, accessibility, and quality of services provided in the chiefdoms. The perceptions of inadequacy and deterioration may be linked to factors such as shortages of drugs and medical personnel, poor infrastructure, limited equipment, long distances to health facilities, and inadequate administrative support.

Furthermore, the findings highlight the need for service providers, local councils, chiefdom administrations, and central government authorities to adopt more strategic and community-centered interventions aimed at strengthening public confidence in

the health sector. This may include improving health infrastructure, enhancing staff capacity, ensuring regular supply of essential drugs, strengthening accountability mechanisms, and increasing community engagement and sensitization programmes.

Overall, the results demonstrate that while decentralization has created opportunities for localized health service delivery, considerable efforts are still required to improve the effectiveness and public perception of health care services across the chiefdoms of Bo District.

**Reasons for Respondents’ Ratings of Health Care Services**

Table 6: Reasons for rating health services in the chiefdoms

Category	Examples	Count	Percentage
Money/affordable service	Pregnant and lactating mothers still pay money. Medical treatments are based on one’s financial strength.	55	21%
Outreached sessions	We received medical service during outreached sessions	30	12%
Adequate health care service	There is reduction of maternal death. Health workers are very accommodating and ready to work at any time.	69	27%
Inadequate health care service	Shortage of drugs. Adult patients usually don’t receive good attention.	55	21%
No available clinic	If we don’t go to Bo we will die	51	19%
<b>Total</b>		<b>260</b>	<b>100%</b>

Following the assessments presented in Figure 6, Table 6 provides further explanations advanced by respondents to justify their ratings of health care service provision within their communities in Bo District. The responses reveal both positive and negative experiences regarding access to and quality of primary health care services.

According to the findings, the issue of “money for medical treatment” received 55 counts, representing 21 percent of respondents’ responses. This suggests that the cost of obtaining medical care remains a major concern for many community members and may limit access to essential health services, particularly among low-income households.

In addition, respondents who stated that they received medical services only during outreach sessions in their communities accounted for 30 counts or 12 percent of the responses. This indicates that some communities rely heavily on periodic outreach programmes rather than having consistent access to permanent and fully operational health facilities. While outreach services may help bridge temporary gaps in health care delivery, they may not adequately address the regular medical needs of the population.

Furthermore, 51 counts, representing 19 percent of the respondents, reported that there were no available clinics in their communities. This finding reinforces earlier concerns regarding the

inadequate distribution of health infrastructure across some chiefdoms and highlights the continuing challenges associated with accessibility to primary health care services in rural areas.

On the other hand, respondents who believed that their communities had adequate health care services are 69 counts or 27 percent of the responses, representing the largest single category in the table. Nevertheless, an equally significant proportion of respondents, represented by 55 counts or 21 percent, indicated that health care services in their communities were inadequate.

The findings therefore demonstrate that perceptions of health care service delivery remain mixed among community members. While some respondents acknowledged improvements and availability of services, many others expressed dissatisfaction arising from financial barriers, absence of clinics, and dependence on occasional outreach programmes. These varying experiences suggest that decentralization has produced uneven outcomes in the delivery of primary health care services across the chiefdoms of Sierra Leone.

Overall, the results underscore the need for stronger investments in rural health infrastructure, increased accessibility to affordable medical services, and sustained community-based health programmes in order to improve public confidence and enhance socio-economic wellbeing within the decentralized governance framework.

**Comparative Health Status Before and During Decentralization**

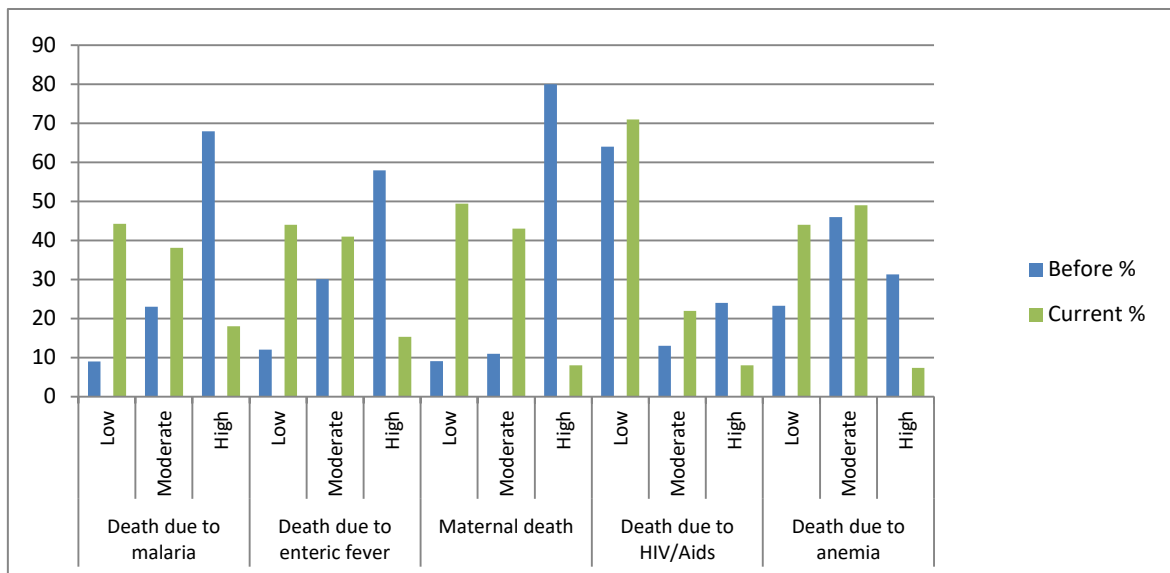


Figure 7: Comparative health status

Data presented in Figure 7 illustrate the comparative health status of people in the study area during the period before decentralization and the current era of decentralization. The analysis is based on respondents’ perceptions as well as information gathered from community health centres within the chiefdoms of Bo District. The findings reveal varying degrees of improvement in selected public health conditions following the implementation of decentralization reforms in Sierra Leone.

The findings indicate that deaths associated with malaria were perceived to be considerably higher before decentralization, with 63.1 percent of respondents reporting high occurrence during that period. In contrast, 43.5 percent of respondents described the current occurrence of malaria-related deaths as low, reflecting a reduction of approximately 19.6 percent. This suggests a notable improvement in malaria prevention, treatment, and public health awareness within local communities.

Similarly, deaths associated with enteric fever were perceived to be high before decentralization, accounting for 55 percent of responses. Under the current decentralized system, 43.8 percent of respondents described the occurrence as low, representing an estimated reduction of 11.2 percent. This improvement may be associated with increased access to primary health care services, community sensitization programmes, and better disease surveillance mechanisms.

Furthermore, maternal deaths and deaths resulting from labour complications were reported to be significantly high before decentralization, with 70 percent of respondents indicating high occurrence. However, under the current decentralization era, 50 percent of respondents considered such occurrences to be low, suggesting a substantial reduction of 20 percent. This improvement may reflect enhanced maternal health interventions, increased availability of maternity services, and expanded outreach activities within rural communities.

In the case of HIV/AIDS, respondents reported relatively low occurrence both before and during decentralization. Before

decentralization, 55.4 percent described HIV/AIDS-related deaths as low, while 65.4 percent currently perceived such occurrences to remain low, indicating an estimated reduction of 10 percent. The findings suggest that HIV/AIDS prevalence and mortality may have been comparatively limited within the study communities, possibly due to sustained awareness campaigns and the availability of Direct Observation Therapy (DOT) and related treatment services.

Similarly, deaths associated with Anemia were perceived as moderate before decentralization, accounting for 46.2 percent of responses, and remained moderate during the current era at 48.8 percent. This reflects only a marginal reduction of approximately 2.6 percent, indicating that anemia continues to pose a health challenge within some communities despite existing interventions.

Overall, the findings suggest that decentralization may have contributed positively to improvements in several key health indicators, particularly malaria control and maternal health outcomes. However, the relatively limited changes observed in conditions such as anemia indicate that certain health challenges remain persistent and require further intervention. Respondents and health facilities also noted that diseases such as HIV/AIDS and anemia occur relatively less frequently within their areas of operation, partly due to the role played by health centres equipped with Direct Observation Therapy facilities and related support services.

The study therefore demonstrates that while decentralization has contributed to improvements in primary health care delivery and community health outcomes, progress remains uneven across different health conditions. To further assess the relationship between decentralization and socio-economic service delivery, subsequent sections of the study employ inferential statistical analyses, particularly chi-square tests, to determine the strength of association between decentralization and selected services such as health, education, and road infrastructure.

**Respondents’ suggestions on health service delivery:**

Table 7: Respondents’ suggestions on health service

Category of suggestions	Examples	Counts	Percentages
<b>Supply of more drugs</b>	We want government to bring more medicines for us. We want more medicines in our clinics.	120	46%
<b>More clinics and more nurses</b>	We don’t have clinic here, we want government to provide us clinics. More nurses for our children and women so that we will stop going to Bo.	62	24%
<b>Have free medical</b>	Let the council expand the free medical to us the poor people	78	30%
<b>Total</b>		260	100%

In table 6: above, are the respondents’ suggestions on how to improve on the health services in their areas. In the category of suggestions, “supply of more drugs” scored 120 counts (46%) of respondents’ suggestions that government provides more drugs to the health centres. Demand for “more clinic and more nurses” scored 62 counts (24%) of the suggestions and to “have free medical” reaching out to more people scored 78 counts (30%) of the respondents’ suggestions. Indicating that drug shortage is more wide spread, followed by paying money for treatment in the clinics and lastly is shortages of personnel (nurses) in the health sectors to be addressed. The reasons proffered below are pointers to the fact that the tendency of centralization of medical services in Bo city is lingering around and has the tendency of taking over again.

**Pearson’s Chi square analyses on the effects of decentralization on health in Bo district, southern province of Sierra Leone.**

To assess the impact of decentralization on socio-economic development in the chiefdoms of Bo District, chi-square tests were conducted on key health indicators. The analysis examined whether significant associations exist between the pre-decentralization period and the current decentralization era in relation to major health outcomes.

The study focused on categorical health variables, including deaths due to malaria, enteric fever, maternal complications, HIV/AIDS, and Anemia. The chi-square test, supported by Cramer’s V, was used to determine the strength and significance of associations between decentralization and observed health changes.

Overall, the analysis provides statistical evidence to complement descriptive findings, indicating whether changes in health outcomes can be significantly associated with decentralization reforms in Sierra Leone.

**Deaths Due to Malaria**

A chi-square test of association was conducted to examine whether there is a statistically significant relationship between the rate of deaths due to malaria before decentralization and during the current decentralization era in the chiefdoms of Bo District.

**Hypotheses**

- **H<sub>0</sub>:** There is no statistically significant association in malaria-related deaths between the pre-decentralization and decentralization periods.
- **H<sub>a</sub>:** There is a statistically significant association in malaria-related deaths between the two periods.

**Result:**

The chi square test conducted shows that a significant difference exists in the rate of deaths due to malaria between the era before decentralization and in the current era of decentralization rejecting the Null hypothesis with a significant level of  $p \leq 0.01$  and a Cramer’s value of 0.239 also indicates a meaningful level of association between decentralization and changes in malaria-related deaths.

$$X^2 (4) = 29.58, p \leq 0.01$$

$$\text{Cramer’s V } 0.239, p \leq 0.01$$

**Chi-Square Tests**

	Value	df	Asymptotic Significance (2-sided)
ears n Chi-Square	29.580 <sup>a</sup>	4	.000
Likelihood Ratio	40.62	4	.00
L near-by-Linear Association	15.524	1	.000
N of Valid Cases	260		

a. 1 cells (11.1%) have expected count less than 5. The minimum expected count is 2.56.

**Symmetric Measures**

	Value	Approximate Significance
Nominal by Phi	.337	.000
Nominal Cramer's V	.239	.000
N of Valid Cases	260	

**Deaths Due to Enteric Fever**

A chi-square test of association was conducted to determine whether there is a statistically significant relationship between deaths due to enteric fever before decentralization and in the current decentralization era.

**Hypotheses**

- **H<sub>0</sub>:** There is no statistically significant association in deaths due to enteric fever between the pre-decentralization period and the current decentralization period.
- **H<sub>a</sub>:** There is a statistically significant association in deaths due to enteric fever between the two periods.

**Result**

The chi square test conducted shows that a significant difference exists in the rate of deaths due to enteric fever between the era before decentralization and in the current era of decentralization, rejecting the null hypothesis with a significant level of  $p \leq 0.01$  and a Cramer's V 0.326,  $p \leq 0.01$ . This indicates that a moderate association exists in the rate of deaths due to enteric fever between the era before decentralization and now; which means that the decrease in the rate in the deaths due to enteric fever is dependent on decentralization.

$$X^2(4) = 55.10, p \leq 0.01$$

$$\text{Cramer's V } 0.326, p \leq 0.01$$

**Chi-Square Tests**

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	55.102 <sup>a</sup>	4	.000
Likelihood Ratio	65.749	4	.000
Linear-by-Linear Association	20.964	1	.000
N of Valid Cases	260		

a. 1 cells (11.1%) have expected count less than 5. The minimum expected count is 3.43.

**Symmetric Measures**

		Value	Approximate Significance
Nominal by Nominal	Phi	.460	.000
	Cramer's V	.326	.000
N of Valid Cases		260	

**Level of Maternal Mortality**

A chi-square test of association was conducted to examine whether there is a statistically significant relationship between levels of maternal mortality before decentralization and during the current decentralization era in the chiefdoms of Bo District.

**Hypotheses**

- **H<sub>0</sub>:** There is no statistically significant association in maternal mortality levels between the pre-decentralization and current decentralization periods.
- **H<sub>a</sub>:** There is a statistically significant association in maternal mortality levels between the two periods.

**Result**

The chi square test shows that a significant difference exists in the levels of maternal mortality between the era before decentralization and in the current era of decentralization rejecting the null hypothesis with a significant level of  $p \leq 0.01$  and a Cramer's V  $p \leq 0.01$  probability. This shows that a perfect association exists in the levels of maternal mortality between the era before decentralization and now; the current era of decentralization. It suggests that the reduction in the levels of maternal mortality is dependent on decentralization.

$$X^2(4) = 24.84, p \leq 0.001$$

$$\text{Cramer's V } 0.219, p \leq 0.001$$

**Chi-Square Tests**

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	24.848 <sup>a</sup>	4	.000
Likelihood Ratio	30.156	4	.000
Linear-by-Linear Association	12.544	1	.000
N of Valid Cases	259		

a. 2 cells (22.2%) have expected count less than 5. The minimum expected count is 1.78.

**Symmetric Measures**

		Value	Approximate Significance
Nominal by Nominal	Phi	.310	.000
	Cramer's V	.219	.000
N of Valid Cases		259	

**Deaths Due to HIV/AIDS**

A chi-square test of association was conducted to examine whether there is a statistically significant relationship between deaths due to HIV/AIDS before decentralization and during the current decentralization era in the chiefdoms of Bo District.

**Hypotheses**

- **H<sub>0</sub>**: There is no statistically significant association in deaths due to HIV/AIDS between the pre-decentralization and current decentralization periods.
- **H<sub>a</sub>**: There is a statistically significant association in deaths due to HIV/AIDS between the two periods.

**Result:**

The chi square test shows that difference exists between the rates of deaths due to HIV/Aids before decentralization and in the rate of death in the current era of decentralization rejecting the null hypothesis with a significant level of  $p \leq 0.01$  and a Cramer's value of 0.553;  $p \leq 0.01$  probability shows a weak relationship. This shows that the rate of deaths due to HIV/Aids before the era of decentralization and in the era of decentralization is a dependent on other variables rather than on decentralization.

$$X^2(4) = 158.9, P \leq 0.01$$

$$\text{Cramer's } V = 0.553, p \leq 0.01$$

**Chi-Square Tests**

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	158.976 <sup>a</sup>	4	.000
Likelihood Ratio	159.770	4	.000
Linear-by-Linear Association	108.207	1	.000
N of Valid Cases	260		

a. 1 cells (11.1%) have expected count less than 5. The minimum expected count is 3.92.

**Symmetric Measures**

		Value	Approximate Significance
Nominal by Nominal	Phi	.782	.000
	Cramer's V	.553	.000
N of Valid Cases		260	

**Deaths Due to Anemia**

A chi-square test of association was conducted to examine whether there is a statistically significant relationship between deaths due to anemia before decentralization and during the current era of decentralization in the chiefdoms of Bo District.

**Hypotheses**

- **H<sub>0</sub>**: There is no statistically significant association between deaths due to anemia before decentralization and in the current decentralization period.
- **H<sub>a</sub>**: There is a statistically significant association between deaths due to anemia before decentralization and in the current decentralization period.

**Result**

The chi square test reveals that a difference exists between the rates of death due to anemia before decentralization and in the rate of death due to anemia in the current era of decentralization rejecting the null hypothesis with a significance of  $p \leq 0.01$  but the Cramer's value of 0.551,  $p \leq 0.01$  shows a weak relationship between decentralization and the rate of death due to anemia.

$$X^2(4) = 157.94, p \leq 0.01$$

$$\text{Cramer's } V = 0.551, p \leq 0.01$$

**Chi-Square Tests**

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	157.946 <sup>a</sup>	4	.000

Likelihood Ratio	177.866	4	.000
Linear-by-Linear Association	92.016	1	.000
N of Valid Cases	260		

a. 1 cells (11.1%) have expected count less than 5. The minimum expected count is 4.92.

**Symmetric Measures**

		Value	Approximate Significance
Nominal by Nominal	Phi	.779	.000
	Cramer's V	.551	.000
N of Valid Cases		260	

**Discussion**

The findings of this study indicate that the impact of decentralization on the socio-economic status of people in the chiefdoms of Bo District presents a mixed pattern of achievements and continuing challenges, particularly within the health sector.

Statistically significant improvements were observed in key health indicators such as malaria, enteric fever, and maternal-related (labour pain) death. These results suggest that decentralization has contributed positively to strengthening primary health care delivery in Sierra Leone, particularly through improved access to community-level health services, increased health awareness, and expanded outreach activities. The reductions in mortality rates for these conditions imply that decentralized health governance may have enhanced preventive and basic curative health interventions at the local level.

However, the study also reveals that little or no noticeable changes were recorded in relation to deaths due to HIV/AIDS and Anemia. This may be explained by the relatively low prevalence and more stable occurrence of these conditions in the district even prior to the introduction of decentralization. Nonetheless, their persistence highlights the fact that they remain important components of the broader primary health care system and require sustained attention beyond governance reforms alone.

Overall, the findings suggest that while decentralization has contributed to improvements in certain priority health outcomes, its impact is uneven across different disease categories. The variation in outcomes reflects both the strengths and limitations of decentralized service delivery systems, particularly in rural and resource-constrained settings.

In addition, respondents consistently emphasized the need for government and relevant authorities to expand the number of health centres in remote communities in order to improve geographical access to health services. They also highlighted the importance of ensuring a consistent supply of essential drugs to existing health facilities, as shortages were identified as a major barrier to effective service delivery.

These suggestions point to the need for further strengthening of the decentralized health system through improved infrastructural development, enhanced supply chain management, and equitable distribution of health resources. Addressing these gaps is essential for translating decentralization reforms into

sustained improvements in socio-economic wellbeing at the community level.

**Conclusion**

This study concludes that decentralization has had a generally positive but uneven impact on the socio-economic development of chiefdoms in Bo District, particularly in the area of primary health care service delivery. The findings show that decentralized governance has contributed to noticeable improvements in the management and reduction of diseases such as malaria, enteric fever, and maternal-related deaths through enhanced community-based health services, improved health awareness, and expanded access to primary health care facilities.

However, the study also reveals that decentralization has not significantly influenced outcomes related to HIV/AIDS and anemia, indicating that some health challenges require more specialized interventions beyond administrative reforms alone. The mixed nature of the findings demonstrates that while decentralization has strengthened certain aspects of local health service delivery, important gaps still exist in infrastructure, medical supplies, and equitable access to health care services, especially in remote communities.

Furthermore, the study highlights that inadequate health centres and shortages of essential drugs continue to limit the effectiveness of decentralized health systems. Therefore, for decentralization to achieve its full developmental potential, greater government commitment is required in expanding rural health infrastructure, improving supply chain management, and ensuring equitable distribution of health resources.

Overall, the study establishes that decentralization remains an important mechanism for promoting socio-economic development and improving primary health care delivery in Sierra Leone. Nevertheless, its long-term success depends on sustained institutional support, adequate funding, and continuous strengthening of local governance and health systems at the chiefdom level.

**Recommendations**

Based on the findings of the study on decentralization and socio-economic development in the chiefdoms of Bo District, the following recommendations are made to strengthen primary health care delivery and improve overall community wellbeing in Sierra Leone:

1. **Expansion of health infrastructure:** Government, through the Ministry of Health and Sanitation and local councils, should increase the number of health centres in underserved and remote communities. This will reduce geographical barriers and improve timely access to primary health care services.
2. **Improved supply of essential drugs and medical consumables:** A more efficient and transparent drug supply chain should be established to ensure that health facilities are consistently stocked with essential medicines. This will reduce the high incidence of out-of-pocket payments and improve treatment outcomes.
3. **Recruitment and deployment of health personnel:** There is a need for increased recruitment and equitable deployment of qualified nurses, midwives, and community health workers, particularly in rural chiefdoms where staff shortages are more pronounced.
4. **Strengthening free health care implementation:** The Free Health Care Initiative should be expanded and more effectively implemented to cover a wider category of vulnerable groups, while ensuring strict monitoring to reduce informal charges and improve accountability.
5. **Enhanced decentralization coordination:** Clearer functional collaboration between chiefdom councils and district councils should be strengthened in line with the Local Government framework to avoid duplication, improve coordination, and enhance service delivery efficiency.
6. **Community sensitization and health education:** Continuous public awareness campaigns should be intensified to educate communities on available health services, eligibility for free care, and preventive health practices.
7. **Strengthening monitoring and accountability systems:** Stronger supervision mechanisms should be introduced at local and district levels to reduce corruption, improve service quality, and ensure that resources intended for health facilities are effectively utilized.
8. **Targeted interventions for persistent health conditions:** Although decentralization has improved some health indicators, sustained national-level interventions are needed to address persistent conditions such as anemia and HIV/AIDS, which require broader public health strategies beyond local governance structures.

Overall, these measures will help consolidate the gains of decentralization while addressing the persistent gaps in health service delivery, thereby improving socio-economic development outcomes across the chiefdoms.

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