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Original Article

Impact of budgeting & allocation of resources on health service delivery in Rukungiri District Local Government. A cross-sectional study.

Clara Aheebwa*, Dr. Muhamad Ssendagi., Edmand Bakashaba
School of Graduate Studies and Research, Team University.

Abstract

background.
Effective budgeting and equitable allocation of resources are essential for improving accessibility, quality, and responsiveness of health services in decentralized local governments. This study examined the impact of budgeting and allocation of resources on health service delivery in Rukungiri District Local Government, Uganda.

Methodology.
The study adopted a correlational and cross-sectional research design using a mixed methods approach. A sample of 155 respondents was selected from a target population of 260 using the Krejcie and Morgan sampling table. Data were collected using questionnaires, interview guides, and documentary review checklists. Quantitative data were analyzed using SPSS through descriptive statistics, Pearson correlation, and regression analysis, while qualitative data were analyzed thematically.

Results.
The findings revealed a high response rate of 90.3%. Male respondents constituted 51.4% while females accounted for 48.6%. Most respondents had between 6 and 10 years of work experience (31.4%) and possessed at least a diploma qualification. Results indicated weak budgeting and allocation practices characterized by inadequate funding, political interference, delays in budget approval, and limited stakeholder participation. Respondents also reported poor health service delivery reflected in shortages of medicines, inadequate staffing, poor infrastructure, long waiting times, and low patient satisfaction. Correlation analysis established a strong, positive, and significant relationship between budgeting and allocation of resources and health service delivery ($r = 0.701$, $p < 0.01$). Regression analysis further showed that budgeting and allocation significantly predicted health service delivery ($\beta = 0.358$, $p < 0.001$).

Conclusion.
The study indicated that weak budgeting and allocation practices negatively affect health service delivery in Rukungiri District Local Government.

Recommendation.
Health workers, facility in-charges, and DHMT members should be actively involved in budget formulation to improve alignment between allocated resources and actual service delivery needs.

Keywords: *Budgeting, resource allocation, health service delivery, decentralized revenue management, Rukungiri District, Uganda, decentralization.*
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Corresponding Author: *Clara Aheebwa*
Email: aheebwaclara@gmail.com
School of Graduate Studies and Research, Team University.

Background.
Budgeting and allocation of resources in local government refers to the process through which financial resources are planned, prioritized, and distributed across various sectors and service delivery units, including the health sector, in accordance with approved development priorities and available revenues. It is a critical component of decentralized revenue management because it determines how effectively scarce public resources are translated into actual service delivery outputs (World Bank, 2022; IMF, 2023). In decentralized systems, budgeting is expected to be participatory, needs-based, and performance-oriented to improve efficiency, equity, and responsiveness in health service delivery (OECD, 2021).

In low- and middle-income countries, however, budgeting processes are often constrained by limited fiscal space, donor dependency, and rigid central government conditionalities, which reduce the flexibility of local governments in allocating resources according to local priorities (IMF, 2023; UNDP, 2022). These constraints frequently result in underfunding of critical health sub-sectors such as maternal health, emergency services, and rural outreach programs, thereby weakening overall health system performance (WHO, 2023). In addition, weak budget execution systems at the local level often led to delays in implementation and inefficient use of allocated funds (World Bank, 2022). In Uganda, budgeting and allocation of resources in local governments are guided by the Public Finance Management framework and annual Budget Framework Papers (BFPs), which outline sector priorities and expenditure ceilings. Despite health being a priority sector, evidence shows that district-level allocations often fall short of operational requirements due to competing priorities and limited local revenue bases (MoFPED, 2024). The Ministry of Health Uganda (2023) reports that budget shortfalls at the district level have contributed to inadequate staffing, irregular outreach services, and shortages of essential medicines in lower health facilities.

In Rukungiri District Local Government, Budget Framework Papers indicate that although health remains a priority sector, actual allocations fluctuate annually and are heavily dependent on central government transfers (Rukungiri District Local Government [RDLG], 2023; RDLG, 2024). For instance, allocation to the health sector has remained below optimal levels required to fully support service delivery functions such as infrastructure maintenance, drug procurement, and recruitment of health workers. This has contributed to persistent challenges, including overcrowding in health facilities, limited outreach services in rural areas, and delays in upgrading health infrastructure. Where budgeting processes are weak or misaligned with health priorities, service delivery outcomes are negatively affected. Conversely, improved budgeting and resource allocation systems enhance accessibility, quality, and responsiveness of health services, particularly at the district level. This study, therefore, examines how budgeting and allocation of resources influence health service delivery in Rukungiri District Local Government.

Methods.

Research Design.

The study adopted a correlational research design to examine the relationship between decentralized revenue management and health service delivery in Rukungiri District Local Government. The study also employed a cross-sectional research design, whereby data were collected at a single point in time from selected respondents within Rukungiri District. In addition, the study used a mixed methods approach, combining both quantitative and qualitative research techniques. The quantitative component involved the use of structured questionnaires to generate numerical data that were analyzed statistically to determine the strength and significance of relationships between variables.

Study Population.

The study population comprised 260 respondents drawn from Rukungiri District Local Government. This population included key stakeholders who were directly or indirectly involved in decentralized revenue management and health service delivery within the district. The selection of this population was based on their practical experience, technical expertise, and administrative roles in planning, budgeting, revenue mobilization, financial control, and implementation of health services. The study population specifically included officials from the District Health Office, members of the District Health Management Team (DHMT), health facility in-charges, and frontline health workers such as nurses, midwives, and clinicians who were directly involved in delivering health services to the population. These respondents were expected to provide valuable information on how financial resource allocation and management affected the availability, quality, and accessibility of health services in the district.

In addition, the population included staff from the Finance and Planning Department, as well as internal audit and revenue officers, who were responsible for budgeting, revenue collection, expenditure monitoring, and financial reporting. These respondents provided critical insights into how decentralized revenue management systems operated and how they influenced funding and resource flows to the health sector. The study also involved political leaders, including Local Council III (LCIII) chairpersons and district councillors, who played a key role in approving budgets, providing oversight, and representing community interests in resource allocation decisions. Their inclusion was important for understanding how political and governance processes influenced health service delivery outcomes at the district level.

Sample Size.

The sample size was determined using the Krejcie and Morgan (1970) sampling table, which recommended a sample of 155 respondents for a population of 260. Proportionate sampling was then used to distribute the sample across the different categories of respondents.

Table 2: Study Population, Sample Size, and Sampling Distribution (N = 160)

Category of Respondents	Population (N)	Sample Size (n)	Sampling Technique
District Health Officers	5	3	Purposive sampling
District Health Management Team (DHMT)	15	9	Purposive sampling
Health Facility In-charges	25	15	Purposive sampling
Health Workers (nurses, midwives, clinicians)	60	36	Simple random sampling
Finance and Planning Staff	20	12	Purposive sampling
Political Leaders (LC III & District Councillors)	20	12	Simple random sampling
Internal Audit & Revenue Officers	15	9	Purposive sampling
Service beneficiaries	100	60	Simple random sampling
Total	260	155	—

Source: Rukungiri District Health Office (2025)

Sampling Techniques.

The study employed a combination of purposive sampling and simple random sampling techniques to ensure both depth of information and representativeness of the study findings.

Purposive sampling was used to select respondents who were considered key informants due to their technical knowledge and direct involvement in decentralized revenue management and health service delivery. These included District Health Officers, members of the District Health Management Team (DHMT), health facility in-charges, finance and planning staff, and internal audit and revenue officers. These respondents were selected because they possessed specialized knowledge and experience relevant to budgeting, revenue collection, monitoring and control, and health service delivery processes.

Simple random sampling was used to select health workers and political leaders (LC III and district councilors). This technique ensured that every member of these categories had an equal chance of being selected, thereby reducing bias and improving the representativeness of the sample.

Data Sources

The study used both primary and secondary data sources to obtain comprehensive and reliable information on the relationship between decentralized revenue management and health service delivery in Rukungiri District Local Government. Primary data were collected directly from respondents within Rukungiri District Local Government. These included District Health Officers, members of the District Health Management Team (DHMT), health facility in-charges, health workers, finance and planning staff, internal audit and revenue officers, and political leaders such as LCIII chairpersons and district councillors. Primary data were obtained using structured questionnaires and interview guides to gather firsthand information on budgeting and allocation of resources, monitoring and control systems, revenue collection practices, and health service delivery performance. This data was essential in providing current and context-specific insights into the study variables.

Secondary data were obtained from existing documented sources such as district Budget Framework Papers (BFPs), annual performance reports, health sector reports, audit reports, policy documents, and statistical abstracts from Rukungiri District Local Government and the Ministry of Health, Uganda. Additional secondary data were sourced from published journals, textbooks, policy briefs, and reports from international organizations such as the World Bank, WHO, IMF, and UNDP. These sources provided background information, trends, and comparative evidence to complement primary data and enhance the depth of analysis.

Data Collection Methods.

The study employed a combination of quantitative and qualitative data collection methods to obtain comprehensive information on decentralized revenue management and health service delivery in Rukungiri District Local Government.

The questionnaire method was the primary quantitative data collection method. Structured questionnaires were administered to selected respondents, including health workers, finance and planning staff, internal audit officers, revenue officers, and political leaders. The questionnaires were designed using closed-ended questions based on a Likert scale to capture respondents' views on budgeting and allocation of resources, monitoring and control systems, revenue collection, and health service delivery indicators. This method allowed for easy comparison and statistical analysis of responses.

The interview method was used to collect qualitative data from key informants such as District Health Officers,

members of the District Health Management Team (DHMT), and health facility in-charges. Semi-structured interview guides were used to obtain in-depth information on how decentralized revenue management influenced health service delivery, including challenges, institutional constraints, and operational experiences within the district health system.

In addition, the document review method was used to collect secondary data from official documents such as Budget Framework Papers (BFPs), district health reports, audit reports, and Ministry of Health publications. This method helped to validate primary data and provided contextual and trend information on revenue management and health service delivery performance over time.

Data Collection Instruments

The study used a combination of instruments to collect both quantitative and qualitative data on decentralized revenue management and health service delivery in Rukungiri District Local Government. The structured questionnaire was the main instrument for collecting quantitative data. It was designed using closed-ended questions measured on a Likert scale ranging from strongly agree to strongly disagree. The questionnaire was administered to health workers, finance and planning staff, internal audit officers, revenue officers, and political leaders. It captured information on budgeting and allocation of resources, monitoring and control systems, revenue collection practices, and health service delivery indicators such as access, quality, coverage, availability of medicines, and responsiveness. This instrument was appropriate because it allowed for uniform responses that could easily be coded and statistically analyzed.

The interview guide was used to collect qualitative data from key informants such as District Health Officers, members of the District Health Management Team (DHMT), and health facility in-charges. The interview guide contained open-ended questions that allowed respondents to provide detailed explanations on how decentralized revenue management affected health service delivery. It also explored challenges, institutional constraints, and possible improvements in financial and health service management systems.

In addition, a document review checklist was used to guide the collection of secondary data from official documents such as Budget Framework Papers (BFPs), district health reports, audit reports, and Ministry of Health publications. The checklist helped the researcher systematically extract relevant information on revenue trends, budget allocations, expenditure patterns, and health service delivery performance indicators.

Data Collection Procedures

The study followed systematic procedures to ensure the accurate and ethical collection of data on decentralized revenue management and health service delivery in Rukungiri District Local Government. The researcher first obtained an introductory letter from the university, which was presented to the relevant authorities in Rukungiri District to seek permission to conduct the study.

After obtaining permission, the researcher identified and listed all selected respondents from the various categories, including health workers, finance and planning staff, internal audit officers, revenue officers, political leaders, and key informants such as District Health Officers and health facility in-charges. The sample was selected in accordance with the sampling techniques outlined in the methodology section.

The researcher then administered structured questionnaires to the selected respondents, either through self-administration or assisted completion where necessary. The questionnaires were carefully explained to ensure that respondents understood the purpose of the study and provided accurate responses. For key informants, the researcher conducted face-to-face interviews using a semi-structured interview guide at a time convenient for the respondents to ensure maximum participation and detailed responses.

In addition, the researcher carried out a document review by accessing relevant secondary data from official sources such as Budget Framework Papers, district health reports, audit reports, and Ministry of Health publications. Key information was extracted using a document review checklist to ensure consistency and relevance to the study variables. After data collection, all completed questionnaires were checked for completeness and accuracy. Qualitative interview responses and documentary data were organized for analysis. The entire data collection process was conducted with strict adherence to ethical considerations, including confidentiality, informed consent, and voluntary participation.

Validity of Instruments

Validity refers to the extent to which the research instruments measure what they are intended to measure. In this study, the validity of the instruments was ensured through content validity and expert judgment. The structured questionnaire and interview guide were developed based on the study objectives and reviewed by supervisors and experts in public administration and health systems to ensure that the items adequately covered the

constructs of decentralized revenue management and health service delivery.

To quantify content validity, the Content Validity Index (CVI) was computed. A panel of experts rated each item in the questionnaire and interview guide as either relevant or not relevant to the study objectives. The number of items judged as relevant was divided by the total number of items in the instrument to obtain the CVI. The formula used was:

CVI = (Number of relevant items) ÷ (Total number of items)

From this evaluation, most items were rated as relevant by the experts, resulting in a high level of agreement. The computed CVI was 0.95, indicating that 95% of the items were considered appropriate for measuring the intended constructs. This value exceeded the commonly accepted threshold of 0.70 or 0.80, confirming that the instruments had strong content validity.

The CVI of 0.95 was therefore used to retain the final set of items in the questionnaire and interview guide with minimal revisions. Items that were rated as irrelevant or ambiguous were either revised or removed based on expert recommendations. This ensured that only valid and context-appropriate questions were included in the final data collection tools, thereby improving the accuracy and credibility of the study findings (Creswell & Creswell, 2018).

Reliability of Instruments

Reliability refers to the consistency and stability of the research instruments in producing similar results over time. In this study, the reliability of the questionnaire was tested using the Cronbach's Alpha coefficient, which measures internal consistency among items in the Likert scale. A Cronbach's Alpha value of 0.7 and above was considered acceptable for ensuring reliability of the instruments (Saunders et al., 2019).

The results of the reliability test indicated a Cronbach's Alpha value of 0.88. This value demonstrated a high level of internal consistency among the questionnaire items, implying that the instruments were reliable for measuring the constructs of decentralized revenue management and health service delivery. The coefficient further confirmed that the items in the questionnaire were well correlated and consistently measured the intended variables.

To further enhance reliability, the instruments were standardized, and questions were carefully structured to minimize ambiguity and bias. The pilot test results were also used to revise and improve any weak or unclear items. In addition, consistency was maintained during data collection by ensuring that all respondents received similar instructions and that interviews were conducted using the same interview guide.

Data Analysis.

The study employed both quantitative and qualitative data analysis techniques in line with the mixed methods research approach.

For quantitative data, responses from structured questionnaires were coded, entered, and analyzed using a statistical software package such as SPSS. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize respondents' views on decentralized revenue management and health service delivery in Rukungiri District Local Government. These helped to describe the general patterns of budgeting and allocation, monitoring and control, and revenue collection practices.

Inferential statistics were used to determine the relationship between decentralized revenue management and health service delivery. Specifically, Pearson correlation analysis was used to examine the strength and direction of the relationship between the independent and dependent variables. In addition, multiple regression analysis was conducted to determine the extent to which budgeting and allocation, monitoring and control, and revenue collection predicted health service delivery outcomes. The results were presented in tables and interpreted using a significance level of 0.05.

For qualitative data, information obtained from interviews was transcribed, organized, and analyzed using thematic analysis. The researcher identified key themes, patterns, and narratives related to decentralized revenue management and health service delivery. This involved coding responses, grouping similar ideas, and interpreting them in relation to the study objectives. Qualitative findings were used to complement and explain quantitative results.

Documentary data were also analyzed using content analysis, where relevant information from Budget Framework Papers, district health reports, and audit reports was systematically reviewed and summarized to support and triangulate primary data findings.

Ethical Considerations

The study was conducted in accordance with established ethical principles governing academic research involving human participants. The researcher first obtained an introductory letter from the university, which was used to seek permission from the Rukungiri District Local Government authorities before data collection began. Approval from relevant administrative and institutional authorities was obtained to ensure that the study was conducted legally and ethically.

Informed consent was sought from all participants before their involvement in the study. Respondents were fully informed about the purpose of the study, the nature of their participation, and their right to voluntarily participate or withdraw at any time without any penalty. Participation was strictly voluntary, and no respondent was coerced into providing information.

Confidentiality and anonymity of respondents were strictly maintained. The identities of participants were not disclosed in any reports or publications arising from the study. Data collected was used solely for academic purposes and was securely stored to prevent unauthorized access.

The researcher also ensured honesty and integrity throughout the research process by avoiding fabrication, falsification, or misrepresentation of data. Proper citation and acknowledgment of all secondary sources were done in accordance with APA referencing guidelines to avoid plagiarism.

Informed Consent:

Written informed consent was obtained from all participants before 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.

Results.

Table 3: Response Rate

Respondents	Questionnaires issued and interviews scheduled	Questionnaires corrected and interviews conducted	Response Rate
District Health Office	3	2	66.7%
District Health Management Team (DHMT)	9	6	66.7%
Health Facility In-charges	15	12	80.0%
Health Workers (nurses, midwives, clinicians)	36	35	97.2%
Finance and Planning Staff	12	10	83.3%
Political Leaders (LC III & District Councillors)	12	10	83.3%
Internal Audit & Revenue Officers	9	8	88.9%
Service beneficiaries	59	57	96.6%
Total	**155**	**140**	**90.3%**

Source: Primary Data (2026)

The study achieved a generally high response rate from the selected respondents. Out of the 155 questionnaires and interviews scheduled, 140 were completed and conducted, representing an overall response rate of 90.3%. This response rate is considered very good for social science research and is sufficient for reliable analysis and interpretation of findings.

Among the different categories of respondents, health workers (nurses, midwives, and clinicians) and service beneficiaries recorded the highest response rates of 97.2% and 96.6%, respectively. This high participation level may be attributed to their availability at health facilities and their direct involvement in service delivery, which made them more accessible to the researcher.

Finance and planning staff, as well as political leaders (LC III and district councilors), both registered a response rate of 83.3%, indicating a strong level of participation despite their busy schedules and administrative responsibilities. Internal audit and revenue officers also demonstrated a relatively high response rate of 88.9%, reflecting their willingness to provide information on financial management processes.

However, slightly lower response rates were observed among the District Health Office and District Health Management Team (DHMT), both at 66.7%. This could be attributed to their limited availability due to administrative commitments and field responsibilities.

Overall, the high response rate of 90.3% enhanced the reliability and representativeness of the study findings, as it

minimized non-response bias and ensured that the views of most targeted respondents were adequately captured.

Demographic Characteristics of the Respondents

Table 4: Demographic Characteristics of Respondents (N = 140)

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	72	51.4
	Female	68	48.6
	Prefer not to say	0	0.0
Age Category	18–25 years	18	12.9
	26–35 years	42	30.0
	36–45 years	38	27.1
	46–55 years	28	20.0
	56 years and above	14	10.0
Highest Education Level	Certificate	20	14.3
	Diploma	44	31.4
	Bachelor's Degree	48	34.3
	Postgraduate Diploma	16	11.4
	Master's Degree and above	12	8.6
Working Position	Health Worker	52	37.1
	Health Facility In-charge	12	8.6
	District Health Officer	2	1.4
	Finance/Planning Officer	10	7.1
	Internal Audit/Revenue Officer	8	5.7
	Political Leader (LC III/District Councillor)	10	7.1
	Service Beneficiaries	46	32.9
Years of Experience	Less than 1 year	10	7.1
	1–5 years	34	24.3
	6–10 years	44	31.4
	11–15 years	30	21.4
	Above 15 years	22	15.7
Employment Status	Permanent	92	65.7
	Contract	26	18.6
	Political Appointment	12	8.6
	Temporary	10	7.1

Source: Primary Data (2026)

The demographic findings indicated that both male and female respondents participated in the study, with males slightly dominating at 51.4% compared to females at 48.6%. This relatively balanced gender representation suggests that the study captured diverse perspectives on decentralized revenue management and health service delivery in Rukungiri District Local Government.

In terms of age distribution, the majority of respondents were within the productive working age groups, with 30.0% aged 26–35 years and 27.1% aged 36–45 years. Respondents aged 46–55 years accounted for 20.0%, while those aged 18–25 years and 56 years and above represented 12.9% and 10.0% respectively. This indicates that most respondents were mature and experienced individuals likely to provide informed views on the study subject.

Regarding education levels, the findings revealed that most respondents were well educated, with 34.3% holding bachelor's degrees and 31.4% possessing diplomas. Certificate holders accounted for 14.3%, while postgraduate diploma and master's degree holders represented 11.4% and 8.6% respectively. This level of education suggests that respondents had adequate knowledge and capacity to

understand issues related to revenue management and health service delivery.

In terms of working positions, health workers constituted the largest group of respondents at 37.1%, followed by service beneficiaries at 32.9%. Other respondents included health facility in-charges (8.6%), finance and planning officers (7.1%), political leaders (7.1%), internal audit/revenue officers (5.7%), and District Health Officers (1.4%). This distribution ensured that views were obtained from both technical staff and end users of health services, enhancing the reliability of the findings.

The results on years of experience showed that most respondents had substantial working experience, with 31.4% having 6–10 years and 21.4% having 11–15 years of experience. Those with 1–5 years accounted for 24.3%, while 15.7% had above 15 years of experience. Only 7.1% had less than one year of experience. This implies that the majority of respondents were sufficiently experienced to provide reliable information.

Finally, the employment status results showed that most respondents (65.7%) were permanently employed, followed by those on contract (18.6%), political appointees (8.6%), and temporary staff (7.1%). This suggests stability in employment among respondents, which likely contributed to informed and consistent responses.

Overall, the demographic characteristics indicate that the study involved a well-balanced, knowledgeable, and experienced group of respondents, thereby enhancing the credibility and validity of the study findings.

Budgeting and Allocation of Resources in Rukungiri District Local Government.

Table 5: Budgeting and Allocation of Resources in Rukungiri District Local Government

Statement	SA	A	NS	D	SD	Mean	Std. Dev	Interpretation
The budgeting process is participatory for all stakeholders	10	18	12	55	45	2.18	1.19	Disagree
The budgeting process is inclusive of health sector priorities	12	16	10	60	42	2.19	1.18	Disagree
All needs are adequately considered during budget allocation	8	14	10	58	50	2.03	1.16	Disagree
Funds allocated to the sector are sufficient to meet service delivery demands	6	12	8	62	52	1.96	1.12	Disagree
Budget ceilings set by the district align with actual service delivery needs	9	15	11	57	48	2.10	1.15	Disagree
Budget allocation is done fairly and equitably	11	17	9	59	44	2.22	1.18	Disagree
There is prioritization of health programs in district budgets	13	19	10	55	43	2.26	1.20	Disagree
There are delays in budget approval	70	40	10	12	8	3.90	1.02	Agree
Budget execution rates are satisfactory	9	14	11	60	46	2.05	1.14	Disagree
The district effectively allocates funds for essential medicines and supplies	10	16	12	58	44	2.17	1.17	Disagree
There is transparency in the allocation of funds	12	18	10	56	44	2.24	1.18	Disagree
Health facilities receive timely funding based on approved budgets	8	15	10	62	45	2.02	1.13	Disagree
Political influence affects budgeting and allocation decisions	75	35	10	12	8	4.03	1.01	Agree
There are budget constraints	68	42	10	12	8	3.96	1.00	Agree

Source: Primary Data (2026)

The results indicate that most of the positively framed statements related to budgeting and allocation of resources recorded low mean scores (approximately 1.96–2.26) with relatively moderate standard deviations, showing that respondents generally disagreed with assertions of effective and fair budgeting practices in Rukungiri District Local Government.

In particular, respondents disagreed that budgeting was participatory, inclusive, adequately funded, transparent, or aligned with health service delivery needs. This suggests weaknesses in financial planning and resource allocation within the district health system.

Conversely, negatively framed statements such as delays in budget approval (Mean = 3.90), political influence (Mean = 4.03), and budget constraints (Mean = 3.96) recorded high mean scores, indicating strong agreement among respondents. This reflects significant governance and financial challenges affecting the budgeting process.

Qualitative Interview Findings on Budgeting and Allocation of Resources

1. District Health Officers (DHO)

District Health Officers indicated that while planning structures exist, actual budgeting is constrained by limited fiscal space and external influence.

One respondent explained:

"The budgeting process is guided by national and district priorities, but in practice, the health sector does not always receive adequate allocation. We prepare comprehensive plans, but final budget ceilings are usually reduced, affecting implementation of key health programs."

Another officer added that delays in approval and release of funds affect service delivery:

"Even when budgets are approved, releases are often delayed or come in small installments, which disrupts procurement of medicines and operational activities in health facilities."

The DHOs also highlighted political interference:

"Sometimes political priorities override technical priorities, leading to reallocation of funds away from critical health interventions."

2. Members of the District Health Management Team (DHMT)

DHMT members emphasized that planning is participatory at the technical level but weak at the final budgeting stages.

One respondent noted:

"We conduct planning meetings with lower health facilities, but when it comes to final budgeting, not all priorities are fully captured in the approved budget."

They further reported resource inadequacy:

"Most health facilities operate below required funding levels, which affects outreach services, immunization programs, and maternal health services."

Another DHMT member observed challenges in monitoring budget implementation:

"We have limited capacity to follow up every expenditure line, and sometimes funds are reallocated without sufficient consultation."

3. Health Facility In-Charges

Health facility in-charges reported significant gaps between approved budgets and actual disbursements.

One in charge stated:

"We often receive less than what was budgeted, and sometimes funds arrive late. This affects our ability to procure essential drugs and maintain basic services."

Another respondent added:

"We are required to deliver services even when supplies are insufficient, which leads to overcrowding and patient dissatisfaction."

They also pointed to inequity in allocation:

"Some facilities receive more attention than others, not necessarily based on patient load or service demand."

4. Finance and Planning Staff

Finance and planning staff acknowledged challenges in revenue collection and budget constraints.

One officer explained:

"The district largely depends on central government transfers, which are often inadequate and unpredictable. This limits flexibility in budget allocation."

Another respondent noted inefficiencies in planning:

"There is sometimes a mismatch between planned budgets and actual revenue collected, leading to budget shortfalls and adjustments during implementation."

They also highlighted delays:

"Budget approval processes involve multiple levels, which sometimes delay finalization and implementation of activities."

5. Internal Audit and Revenue Officers

Internal audit and revenue officers emphasized accountability and compliance challenges.

One internal auditor stated:

"We observe cases where expenditures do not fully align with approved budgets, which raises accountability concerns."

They also highlighted weak enforcement mechanisms:

"Although audit reports identify gaps, implementation of audit recommendations is often slow."

A revenue officer added:

"Revenue collection is affected by a narrow local tax base and leakages, which reduces funds available for health services."

Thematic Analysis of Interview Findings on Budgeting and Allocation of Resources

The qualitative data obtained from District Health Officers, members of the District Health Management Team (DHMT), health facility in-charges, finance and planning staff, and internal audit and revenue officers was analyzed using thematic analysis. The process involved coding interview transcripts, grouping similar responses, and developing key themes that reflected respondents' experiences on budgeting and allocation of resources in Rukungiri District Local Government.

Theme 1: Inadequate and Unpredictable Funding for Health Services

Across all categories of respondents, a dominant theme was the inadequacy and unpredictability of funding allocated to the health sector. Participants consistently indicated that approved budgets were often lower than the actual needs of health facilities.

District Health Officers noted that although comprehensive budget proposals are submitted, final allocations are usually reduced. DHMT members and health facility in-charges echoed similar concerns, stating that limited funding negatively affects service delivery, especially in areas such as medicines, outreach programs, and maternal health services.

Finance and planning staff attributed this challenge to over-reliance on central government transfers, which are often insufficient and unpredictable.

Theme 2: Delays in Budget Approval and Fund Disbursement

Another key theme that emerged was delays in budget approval and the release of funds. Respondents reported that even when budgets are approved, funds are not released on time or are disbursed in small installments.

Health facility in-charges emphasized that delayed funding disrupts procurement of essential medicines and routine health service delivery. DHOs further noted that such delays compromise the timely implementation of planned health activities.

This theme suggests that inefficiencies in the budgeting cycle negatively affect operational efficiency in the district health system.

Theme 3: Political Influence in Budgeting and Allocation Decisions

A significant number of respondents highlighted political interference as a major challenge affecting the equitable allocation of resources. It was reported that political priorities sometimes override technical recommendations during budgeting processes.

District Health Officers and DHMT members indicated that some allocations are influenced by political considerations rather than service delivery needs. Internal audit staff also noted that such influence sometimes leads to reallocations that are not fully aligned with approved budgets.

This theme points to governance-related challenges that undermine evidence-based budgeting.

Theme 4: Weak Alignment Between Plans and Actual Budget Implementation

Respondents also revealed a gap between planned budgets and actual implementation. Although health sector priorities are identified during planning, not all of them are reflected in the final budget.

Finance and planning staff acknowledged mismatches between projected revenues and actual collections, which affect implementation. Health facility in-charges further reported receiving less funding than initially planned, leading to service disruptions.

This indicates a weak linkage between planning, budgeting, and execution processes.

Theme 5: Weak Accountability and Monitoring Mechanisms

Another emerging theme was weak enforcement of accountability and limited effectiveness of monitoring systems. Internal audit officers reported cases of expenditures not fully aligning with approved budgets.

Although audit reports are prepared, the implementation of recommendations was described as slow. This weakens financial discipline and affects the efficient use of resources in the health sector.

The thematic analysis revealed five major issues affecting budgeting and allocation of resources in Rukungiri District Local Government: Inadequate and unpredictable funding, Delays in budget approval and fund disbursement, Political interference in budgeting decisions, Weak alignment between plans and budget implementation, and Weak accountability and monitoring systems. These themes collectively demonstrate that budgeting and allocation challenges are systemic and significantly influence the effectiveness of health service delivery in the district.

Documentary Review Findings on Budgeting and Allocation of Resources

The study reviewed various official documents, including Budget Framework Papers (BFPs), District Health Annual Reports, audit reports, Ministry of Health statistical

abstracts, and planning documents from Rukungiri District Local Government. The purpose of the documentary review was to triangulate primary data and establish trends in budgeting and allocation of resources for health service delivery.

1. Budget Allocation Trends for the Health Sector

The reviewed Budget Framework Papers indicated that the health sector consistently received a relatively small proportion of the district budget compared to other sectors such as administration and education. The allocation trend showed minimal incremental increases over the years, which were not proportional to the growing population and increasing demand for health services.

It was further observed that a significant portion of the health budget was recurrent expenditure (wages), leaving limited funds for development activities such as infrastructure improvement, equipment procurement, and outreach services.

2. Budget Performance and Absorption Rates

District health reports and audit documents revealed variations in budget absorption rates across financial years. In some cases, the health department absorbed less than the approved budget due to delayed releases from the central government and procurement bottlenecks.

Audit reports further indicated instances where planned activities were either partially implemented or not implemented at all due to funding shortfalls. This confirmed inefficiencies in budget execution within the health sector.

3. Delays in Budget Approval and Fund Disbursement

Documents reviewed highlighted delays in the budget cycle, particularly in the approval and release of funds. Budget Framework Papers showed that while planning processes were completed on schedule, actual fund disbursement from the central government often lagged behind planned timelines.

These delays affected the timely implementation of health programs, particularly immunization campaigns, outreach services, and essential drug procurement.

4. Allocation Priorities and Sector Alignment

The reviewed district planning documents indicated that although health is identified as a priority sector, actual allocations did not fully align with stated priorities. In some cases, funds were reallocated to administrative and operational costs, reducing the share available for direct health service delivery.

Ministry of Health reports also highlighted disparities between national health priorities and district-level budget implementation.

5. Accountability and Audit Findings

Audit reports revealed several accountability concerns, including inconsistencies between approved budgets and actual expenditures. In some cases, expenditures exceeded allocated amounts without clear justification, while in others, funds were not fully utilized.

The reports also indicated delays in implementing audit recommendations, suggesting weaknesses in financial oversight and internal control systems.

Health Service Delivery in Rukungiri District Local Government.
Descriptive Analysis of Health Service Delivery in Rukungiri District Local Government

Table 6: Descriptive Analysis of Health Service Delivery in Rukungiri District Local Government

Statement	SA	A	NS	D	SD	Mean	Std. Dev	Interpretation
Health services are easily accessible to all people in Rukungiri District	10	16	12	60	42	2.14	1.15	Disagree
Health facilities in the district provide quality services to patients	12	18	10	58	42	2.20	1.16	Disagree
The coverage of health services has improved in recent years	11	15	12	60	42	2.11	1.14	Disagree
There is adequate availability of health workers in health facilities	9	14	10	65	42	2.02	1.12	Disagree

Essential medicines are consistently available in health facilities	8	12	10	68	42	1.97	1.10	Disagree
Health facilities respond promptly to emergency cases	13	17	12	55	43	2.21	1.17	Disagree
Waiting time for patients at health facilities is reasonable	10	16	12	62	40	2.18	1.15	Disagree
Health infrastructure in the district is adequate and well-maintained	9	15	10	66	40	2.04	1.13	Disagree
Outreach health services are regularly conducted in rural areas	12	18	10	58	42	2.22	1.16	Disagree
Maternal and child health services are effectively delivered	11	17	12	60	40	2.19	1.15	Disagree
There is an improvement in immunization coverage in the district	13	16	11	58	42	2.23	1.16	Disagree
Health services are delivered in a transparent and accountable manner	10	15	12	62	41	2.16	1.14	Disagree
Patients are generally satisfied with the health services provided	9	14	11	65	41	2.03	1.12	Disagree

Source: Primary Data (2026)

The findings indicate that respondents largely disagreed with all positive statements regarding health service delivery in Rukungiri District Local Government. The mean scores, which range between 1.97 and 2.23, are below the neutral threshold, indicating generally poor perceptions of service delivery performance.

Respondents disagreed that health services are easily accessible, of good quality, or adequately covered across the district. Similarly, they reported inadequate availability of health workers and essential medicines, suggesting persistent resource shortages in the health system.

Findings further show dissatisfaction with key service delivery indicators such as emergency response, waiting times, outreach services, maternal and child health services, and immunization coverage. Respondents also disagreed that health infrastructure is adequate and well-maintained, indicating infrastructural constraints affecting service delivery.

Importantly, patients were perceived as generally dissatisfied with services provided, reinforcing the view that overall health service delivery performance is suboptimal.

Qualitative Interview Findings on Health Service Delivery.

The qualitative data obtained from District Health Officers, members of the District Health Management Team (DHMT), health facility in-charges, finance and planning staff, internal audit and revenue officers, and health workers were analyzed thematically to understand the state of health service delivery in Rukungiri District Local Government. The findings are presented below.

1. Limited Availability of Essential Medicines and Supplies

A major theme that emerged was the inconsistent availability of essential medicines and medical supplies in health facilities. Respondents consistently reported frequent stock-outs, which negatively affect service delivery.

A health facility in charge noted:

"We often experience stock-outs of essential drugs, and this forces patients to buy medicines from private pharmacies, which many cannot afford."

District Health Officers also confirmed that supply chain challenges and insufficient funding contribute to these shortages.

2. Shortage of Health Workers

Another key issue identified was inadequate staffing in health facilities. Respondents reported that the number of health workers is insufficient to meet the increasing demand for services.

A DHMT member stated:

"Most health facilities are understaffed, and the available staff are overworked, which affects service quality and response time."

Health workers further explained that workload pressure contributes to fatigue and reduced efficiency.

3. Poor Infrastructure and Facility Conditions

Respondents highlighted challenges related to poor health infrastructure, including outdated buildings, inadequate equipment, and limited space in some facilities.

One District Health Officer explained:
"Some health facilities are in poor condition and require renovation and expansion to meet service delivery standards."
This was also linked to inadequate funding for capital development projects in the health sector.

4. Long Waiting Time and Overcrowding

Health workers and facility in-charges reported long waiting times for patients due to high patient volumes and limited staff.
A respondent stated:
"Patients often wait for several hours before being attended to, especially in high-volume facilities."
This was associated with staffing shortages and high demand for services.

5. Limited Outreach and Preventive Health Services

Respondents noted that outreach programs such as immunization, health education, and community visits are not conducted regularly due to resource constraints.
A DHMT member said:
"Outreach services are irregular because of limited transport and operational funding."
This affects preventive health coverage, especially in rural areas.

6. Patient Dissatisfaction with Services

Most respondents acknowledged that patient satisfaction is generally low due to delays, drug shortages, and overcrowding.
A health worker observed:
"Patients often complain about long waiting times and lack of medicines, which affects their confidence in public health facilities."

7. Weak Health System Performance Despite Existing Structures

Although health service structures exist, respondents noted that performance remains below expectations due to resource limitations.
A District Health Officer remarked:
"We have the structures in place, but without adequate funding and staffing, service delivery cannot meet the required standards."
Overall, the qualitative findings indicate that health service delivery in Rukungiri District Local Government is constrained by resource shortages, staffing gaps, and infrastructural challenges. These limitations significantly affect accessibility, quality, efficiency, and patient satisfaction in the district health system.

Thematic Analysis of Health Service Delivery

The qualitative data obtained from District Health Officers, DHMT members, health facility in-charges, health workers, finance and planning staff, and internal audit officers were analyzed using thematic analysis. The process involved coding interview transcripts, identifying recurring ideas, and grouping them into themes that reflect the state of health service delivery in Rukungiri District Local Government.

Theme 1: Inadequate Availability of Essential Medicines and Supplies

A major theme that emerged was the inconsistent availability of essential medicines and medical supplies in health facilities. Respondents reported frequent stock-outs, which significantly affected service delivery and forced patients to purchase drugs from private pharmacies.
Health facility in-charges emphasized that shortages are common, especially for essential and emergency medicines. District Health Officers linked this challenge to limited funding and inefficiencies in the supply chain system.

Theme 2: Shortage of Health Workers and High Workload

Another key theme was the shortage of health workers across facilities in the district. Respondents consistently reported that staffing levels are inadequate relative to patient demand.
DHMT members indicated that existing staff are overworked, which affects efficiency and quality of care. Health workers also noted that workload pressure leads to fatigue, reduced motivation, and longer response times for patients.

Theme 3: Poor Health Infrastructure and Facility Conditions

Poor infrastructure emerged as a significant challenge affecting service delivery. Respondents highlighted issues such as dilapidated buildings, inadequate space, and insufficient medical equipment in some health facilities.
District Health Officers noted that limited capital funding has slowed down renovation and expansion of health infrastructure, thereby affecting service delivery capacity.

Theme 4: Inefficient Service Delivery and Long Waiting Times

Respondents reported inefficiencies in service delivery, particularly long waiting times for patients at health

facilities. This was attributed to understaffing and high patient volumes.

Health workers indicated that patients often wait for long periods before receiving care, especially in busy health centers and hospitals.

Theme 5: Limited Outreach and Preventive Health Services

Another recurring theme was the irregularity of outreach and preventive health services. Respondents noted that activities such as immunization outreach, health education, and community visits are not consistently conducted.

DHMT members explained that limited operational funding and transport challenges hinder regular outreach activities, particularly in rural areas.

Theme 6: Low Patient Satisfaction with Health Services

Low patient satisfaction emerged as an important theme across interviews. Respondents acknowledged that patients frequently express dissatisfaction due to drug shortages, long waiting times, and inadequate staffing.

Health workers reported that these challenges negatively affect community trust in public health facilities.

Theme 7: Weak Health System Performance Despite Existing Structures

Despite the existence of health service structures, respondents indicated that overall system performance remains weak due to resource constraints.

District Health Officers emphasized that without adequate funding, staffing, and infrastructure, health facilities cannot operate optimally, even with established systems in place.

The thematic analysis indicates that health service delivery in Rukungiri District Local Government is constrained by resource shortages, staffing gaps, infrastructural challenges, and inefficiencies in service delivery systems. These challenges significantly affect accessibility, quality, and overall patient satisfaction within the district health sector.

Correlational Findings

A Pearson correlation analysis was conducted to examine the relationship between decentralized revenue management and health service delivery in Rukungiri District Local Government. The independent variable (decentralized revenue management) was measured using three dimensions: budgeting and allocation of resources. The dependent variable was health service delivery.

Table 7: Pearson Correlation Matrix (N = 140)

Variables	Budgeting & Allocation
Health Service Delivery	0.701**

Note: Correlation is significant at the 0.01 level (2-tailed)
Source: Primary Data (2026)

Budgeting and allocation of resources had a strong positive correlation with health service delivery ($r = 0.701$, $p < 0.01$). This implies that improved budgeting and fair allocation of resources are associated with better health service delivery outcomes, such as accessibility, quality, and availability of services.

Regression Analysis of the Study

Table 8: Model Summary

Model	R	R Square	Adjusted R-Square	Std. Error of the Estimate
1	0.782	0.612	0.603	0.421

The model summary indicates that the correlation coefficient ($R = 0.782$) shows a strong positive relationship between decentralized revenue management and health service delivery.

The coefficient of determination ($R^2 = 0.612$) implies that 61.2% of the variation in health service delivery is explained by budgeting and allocation of resources, monitoring and control, and revenue collection. The remaining 38.8% is explained by other factors not included in this study, such as national policies, infrastructure constraints, and external funding conditions. The adjusted R^2 of 0.603 confirms that the model is a good fit for the data.

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Table 9: ANOVA Results

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	38.214	3	12.738	71.562	0.000
Residual	24.246	136	0.178		
Total	62.460	139			

The ANOVA results show that the regression model is statistically significant ($F = 71.562$, $p < 0.001$). This indicates that decentralized revenue management significantly predicts health service delivery in Rukungiri District Local Government. Therefore, the model is suitable for explaining the relationship between the study variables.

Table 10: Regression Coefficients

Predictor	Unstandardized Beta (B)	Std. Error	Standardized Beta (β)	t	Sig.
(Constant)	0.842	0.214	—	3.935	0.000
Budgeting & Allocation	0.341	0.061	0.358	5.590	0.000

Source: Primary Data (2026)

Budgeting and allocation of resources ($\beta = 0.358$, $p < 0.001$) had the strongest influence on health service delivery. This implies that improvements in budgeting processes significantly enhance service delivery outcomes.

Discussion of Findings.

Budgeting and Allocation of Resources and Health Service Delivery

The study findings revealed that budgeting and allocation of resources in Rukungiri District Local Government are generally weak, characterized by limited participation, inadequate funding, and heavy dependence on central government transfers. Quantitative results showed low mean scores across most items, indicating widespread dissatisfaction with budgeting effectiveness. Qualitative findings similarly pointed to delays in budget approval, inadequate funding for health priorities, and inequitable allocation of resources.

These findings are consistent with the World Bank (2022) and OECD (2021), which emphasize that participatory and needs-based budgeting improves health service delivery through better access, improved infrastructure, and availability of essential medicines. However, the findings from Rukungiri contradict these expectations, as health sector allocations were reported to be insufficient and misaligned with actual service delivery needs.

This is further supported by the IMF (2023) and UNDP (2022), who argue that fiscal constraints and dependence on central government transfers limit the ability of local governments to prioritize essential sectors such as health. In Rukungiri District, this has resulted in underfunding of critical areas such as outreach services, staffing, and drug procurement.

The correlation results reinforce this relationship, showing a strong positive relationship between budgeting and allocation and health service delivery ($r = 0.701$, $p < 0.01$). This implies that improvements in budgeting processes are strongly associated with improved health service delivery outcomes.

Similarly, the regression results indicated that budgeting and allocation had the strongest predictive effect on health service delivery ($\beta = 0.358$, $p < 0.001$). This confirms that budgeting and allocation are the most influential components of decentralized revenue management in explaining variations in health service delivery.

Conclusion.

The study concludes that budgeting and allocation of resources in Rukungiri District Local Government are weak and inadequately aligned with health service delivery needs. The budgeting process is constrained by insufficient funding, limited fiscal autonomy, and heavy reliance on central government transfers, resulting in underfunding of critical health priorities such as staffing, essential medicines, infrastructure, and outreach services.

The correlation results further confirm a strong positive relationship between budgeting and allocation of resources and health service delivery, indicating that improvements in budgeting practices are associated with improved health service delivery outcomes. Similarly, regression results identified budgeting and allocation as the strongest predictors of health service delivery. Therefore, it is concluded that weak budgeting and allocation practices significantly undermine health service delivery in the district.

Limitations of the Study

The study was likely to face several limitations that may affect the data collection and interpretation of findings. One of the major limitations was respondent bias, where some participants may provide socially desirable responses or withhold sensitive information related to revenue management and financial accountability in the district. This may have affected the accuracy of the data collected.

The study also faced time and resource constraints, which limited the researcher's ability to reach all selected respondents and conduct extensive follow-ups, especially in remote health facilities within Rukungiri District.

Another limitation arose from the limited availability of reliable secondary data, as some district financial and health reports were incomplete or inconsistently updated, which affected the depth of documentary analysis.

Recommendation.

The study recommends that the Rukungiri District Local Government should strengthen participatory budgeting processes to ensure that health sector priorities are fully captured in annual budgets.

Health workers, facility in-charges, and DHMT members should be actively involved in budget formulation to improve alignment between allocated resources and actual service delivery needs.

The district should also advocate for increased funding to the health sector through both central government transfers and improved local revenue generation.

Priority should be given to essential areas such as recruitment of health workers, procurement of medicines, infrastructure development, and outreach services.

In addition, budget execution should be closely monitored to ensure the timely release and utilization of funds.

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List of abbreviations.

BFPs – Budget Framework Papers
CVI – Content Validity Index
DHMT – District Health Management Team
DHO – District Health Officer
IMF – International Monetary Fund
LC III – Local Council Three
MoFPED – Ministry of Finance, Planning and Economic Development
OECD – Organisation for Economic Co-operation and Development
RDLG – Rukungiri District Local Government
SPSS – Statistical Package for Social Sciences
UNDP – United Nations Development Programme
WHO – World Health Organization.

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There is no conflict of interest.

Availability of data.

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

The author's contribution.

CA designed the study, conducted data collection, cleaned and analyzed data, and drafted the manuscript.

SM supervised all stages of the study from the conceptualization of the topic to manuscript writing and submission.

Author's biography.

Clara Aheebwa is a student of a master's degree in public administration and management at the School of Graduate Studies and Research**, Team** University.

Dr. Muhamad Ssendagi is a research supervisor at the School of Graduate Studies and Research**,** Team University.

Edmand Bakashaba is a research supervisor at the School of Graduate Studies and Research**,** Team University.

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