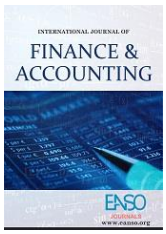
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Original Article

Budget Preparation and the Quality of Service Delivery in Health Facilities: A Case of Public Health Facilities in Kasese District

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Budget Preparation, Quality of Service Delivery, Healthy Facilities.

ABSTRACT

This study examines the effect of budget preparation on the quality of service delivery in public health facilities in Kasese District, Uganda. Budget preparation is conceptualised as a participatory planning process, while service delivery is assessed across dimensions of tangibility, reliability, responsiveness, assurance, and empathy. A cross-sectional design employing both quantitative and qualitative approaches was used, with data collected from 336 Participants. Findings reveal a weak and statistically insignificant relationship between budget preparation and service delivery ($r = -0.176$, $p > 0.05$). Qualitative findings suggest that although budget preparation structures exist, they are often characterised by limited stakeholder participation, weak responsiveness to local needs, and centralised decision-making processes. The study concludes that budget preparation alone does not significantly influence service delivery outcomes in public health facilities. It recommends strengthening participatory and evidence-based budgeting practices to enhance alignment between planning processes and service delivery priorities. The study contributes to ongoing discussions on public financial management and health system performance in decentralised settings.

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INTRODUCTION

Public health facilities play a central role in delivering essential healthcare services within decentralised governance systems where planning and resource allocation responsibilities are devolved to lower administrative levels (Ministry of Health, 2022; WHO, 2023). Effective budgeting is a key managerial function that ensures efficient allocation of scarce resources, strengthens accountability, and enhances service delivery outcomes in public health systems (MOFPED, 2015; World Bank, 2021). In Uganda, public health financing continues to rely heavily on government budgetary allocations, although inefficiencies in planning and resource utilisation remain a major constraint to health system performance (Ministry of Finance, 2023; Uganda Bureau of Statistics, 2022).

The budgeting process in public health facilities typically involves budget preparation, implementation, monitoring, and review, all of which collectively influence service delivery outcomes (Allen & Tommasi, 2021; OECD, 2022). Among these stages, budget preparation is particularly critical because it determines whether resource allocations are aligned with actual service delivery priorities (UNICEF, 2021; World Bank, 2022). Weak budget preparation often results in misallocation of resources, poor prioritisation of health needs, and inefficiencies in service delivery that undermine healthcare quality (WHO, 2023; Ministry of Health, Uganda, 2022).

Recent empirical evidence indicates persistent inefficiencies in health service delivery across Uganda despite continued fiscal allocations to the health sector (Ministry of Health, 2022; World Bank, 2023). Studies show that many public health facilities experience shortages of essential medicines, inadequate staffing levels, infrastructure breakdowns, and inconsistent service availability, particularly at lower-level health centres (Uganda Health System Assessment, 2023; WHO Africa, 2022). These challenges are partly attributed to weaknesses in planning and budgeting systems that limit the effective translation of financial resources into service delivery outputs (World Bank, 2022; Ministry of Health, 2022).

Empirical studies further confirm the link between budgeting practices and health service outcomes in Uganda and similar contexts (Apuuli et al., 2021; Odoch & Kato, 2022). For instance, budget performance studies in public health facilities in northern Uganda reveal that weaknesses in budget planning significantly affect the availability of medicines, staffing adequacy, and overall service responsiveness (Apuuli et al., 2021; Lira University Research Reports, 2022). Similarly, findings from primary health facilities indicate that poor budget formulation processes contribute to delays in service delivery, inefficient procurement processes, and reduced quality of care (Odoch & Kato, 2022).

Despite these insights, most existing studies emphasise budget execution and general financial management rather than isolating budget preparation as a distinct determinant of service delivery quality (World Bank, 2023; OECD, 2022). In addition, limited district-specific evidence exists for Kasese District, creating a contextual and empirical gap in understanding how budget preparation influences service delivery outcomes at the local level (Uganda Bureau of Statistics, 2022; Ministry of Health, 2022).

This study is anchored in the Resource-Based View (RBV) theory, which argues that organisational performance depends on the effective acquisition, allocation, and utilisation of resources (Barney, 1991; Wernerfelt, 1984). In this context, budget preparation represents a

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strategic planning process through which resources are identified, prioritised, and aligned with service delivery objectives (Barney et al., 2020; Grant, 2021). Ineffective budget preparation may therefore lead to suboptimal resource utilisation and reduced quality of healthcare services (World Bank, 2022; WHO, 2023).

Based on this theoretical foundation and empirical gap, the study tests the following hypothesis;

> **H_0:** *Budget preparation has no significant effect on the quality of service delivery in public health facilities in Kasese District.*
>
> **H_1:** *Budget preparation significantly affects the quality of service delivery in public health facilities in Kasese District.*

Accordingly, this study examines the effect of budget preparation on the quality of service delivery in public health facilities in Kasese District (Uganda Bureau of Statistics, 2022; Ministry of Health, 2022).

LITERATURE REVIEW

Concept of Budget Preparation and Health Service Delivery

Budget preparation is a critical stage of the budgeting process that involves setting priorities, estimating resource needs, and allocating funds to planned activities in organisations, including public health facilities (Allen & Tommasi, 2021; OECD, 2022). In the health sector, effective budget preparation ensures that financial plans are aligned with service delivery requirements, thereby improving efficiency and accountability in resource use (WHO, 2023; MOFPED, 2015). Recent evidence shows that weaknesses in budget preparation often result in misalignment between allocated resources and actual facility needs, ultimately affecting service delivery performance (Ministry of Health, Uganda, 2022; World Bank, 2023).

Quality of service delivery in health facilities is commonly assessed in terms of availability of medicines, responsiveness of staff, waiting time, patient satisfaction, and adequacy of infrastructure (WHO, 2023; Uganda National Health System Assessment, 2023). In low-resource settings, these indicators are highly sensitive to how well budgets are planned and structured at the beginning of the fiscal cycle (World Bank, 2022; OECD, 2022).

Budget Preparation and Health Service Delivery Outcomes

Empirical studies increasingly show that budget preparation significantly influences health service delivery outcomes. For example, studies in Uganda indicate that poor budget planning is associated with drug stock-outs, inadequate staffing levels, and reduced service responsiveness in public health facilities (Apuuli et al., 2021; Odoch & Kato, 2022). These findings suggest that deficiencies in early budgeting stages translate into operational inefficiencies during service delivery.

A recent study on budget allocation and healthcare performance at Mulago National Referral Hospital found a strong positive relationship between financial planning and service delivery efficiency, particularly in areas of staffing, medical supplies, and infrastructure development (Kaweesa, 2025). The study further revealed that up to 61.5% of variations in service performance were explained by budget-related factors, highlighting the importance of effective budgeting processes in public hospitals (Kaweesa, 2025).

Similarly, budget execution studies in northern Uganda demonstrate that weak financial planning and monitoring systems negatively affect service availability and health outcomes in lower-level facilities (Ejang et al., 2022). These studies collectively suggest that budget preparation is not only an administrative function but also a determinant of health system performance.

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Empirical Evidence from Uganda and Comparable Contexts

In Uganda, health facilities continue to face persistent operational challenges, including shortages of essential medicines, inadequate staffing, and infrastructure breakdowns (Ministry of Health, 2022; Uganda Bureau of Statistics, 2022). These challenges are more pronounced in lower-level facilities such as Health Centre II, III, and IVs, where budget constraints and planning inefficiencies are most evident.

A study conducted in Kasese District revealed that limited financial planning capacity and weak budget participation negatively affect the delivery of healthcare services in public facilities (Namirimu, 2019). Similarly, research on decentralisation and health service delivery in Kasese highlights that inefficiencies in resource allocation at the planning stage contribute to delays in service provision and reduced service quality (Afribary, 2021).

Recent regional studies further confirm that budget planning and monitoring are significant predictors of organisational performance in health institutions, accounting for up to 78.4% of variations in budget performance outcomes (Kizza et al., 2022). These findings reinforce the argument that budget preparation is central to effective health service delivery.

Theoretical Review

This study is anchored in the Resource-Based View (RBV) theory, which posits that organisational performance depends on the effective acquisition, allocation, and utilisation of resources (Barney, 1991; Wernerfelt, 1984). In the context of public health facilities, budget preparation represents a strategic resource planning process through which financial and material inputs are identified and allocated to priority service areas (Grant, 2021; Barney et al., 2020).

From an RBV perspective, inefficient budget preparation leads to suboptimal resource allocation, which weakens the ability of health facilities to deliver quality services. Conversely, well-structured budget preparation enhances resource alignment, improves efficiency, and strengthens service delivery outcomes (World Bank, 2023; WHO, 2023).

METHODOLOGY

Research Design

The study employed a cross-sectional survey design using a mixed-methods approach to examine the relationship between budget preparation and quality of service delivery in public health facilities. A cross-sectional design was appropriate because it enables the collection of data from multiple respondents at a single point in time, allowing efficient analysis of relationships between variables (Kothari, 2004; Creswell & Creswell, 2018). The mixed-methods approach combined quantitative and qualitative techniques to enhance depth, triangulation, and validity of findings (Creswell & Plano Clark, 2018).

Quantitative data were collected using structured questionnaires to facilitate statistical analysis, while qualitative data were obtained through interviews to provide contextual explanations of budgeting and service delivery practices (Patton, 2015).

Study Area

The study was conducted in Kasese District, located in Western Uganda. The district comprises a network of public health facilities, including Bwera Hospital, Kilembe Hospital, Health Centre IIIs, and IIs that provide primary and secondary healthcare services (Kasese District Local Government, 2022).

Study Population

The study population consisted of 27 public health facilities and key stakeholders involved in

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service delivery within Kasese District. According to Sarantakos (2015), a population refers to a complete set of units possessing common characteristics relevant to a research study.

Table 1: Distribution of Health Facilities

Category	Government
H/C IV	2
H/C III	11
H/C II	14
Total	**27**

Source: *Kasese District Local Government Statistical Abstract, 2022.*

Sample Size and Sampling Technique

A sample of 24 health facilities was selected from the accessible population using Krejcie and Morgan's (1970) sample size determination table as cited by Amin (2010). From these facilities, 120 health workers and 240 patients participated in the study.

A two-stage cluster random sampling technique was used. First, health facilities were grouped by level (HC II, HC III, HC IV, and hospital). Second, respondents were randomly selected within each cluster to ensure proportional representation across facility types (Enon, 2008; Gurinova, 2011).

Data Collection Methods

Questionnaire Survey

Structured questionnaires were administered to health workers and patients to collect quantitative data. The instruments were translated into Lukonzo to improve comprehension among respondents. Questionnaires were appropriate due to their efficiency, standardisation, and suitability for statistical analysis (Bryman, 2016).

Key Informant Interviews

Face-to-face interviews were conducted with selected health facility in-charges and patients. This method allowed the researcher to obtain in-depth qualitative insights and observe non-verbal communication cues, enhancing data richness and validity (Irvine et al., 2013; Kvale & Brinkmann, 2015).

Research Instruments

Questionnaires

Closed-ended questionnaires were used to collect quantitative data. Health workers provided information on budget preparation practices, while patients evaluated service delivery quality. This separation minimised bias and improved construct measurement accuracy.

Interview Guide

A structured interview guide was used to ensure consistency across respondents while allowing probing for deeper insights. The guide focused on experiences related to budgeting practices and service delivery challenges among Healthy centres in Kasese District (Sarantakos, 2005).

Validity and Reliability

Validity

Content validity was established through expert review by supervisors and research consultants to ensure relevance, clarity, and adequacy of items (Zamanzadeh et al., 2014).

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Table 1: Content Validity Results

Construct	Total Items	Relevant Items	CVI	Interpretation
Budget Preparation	26	21	0.81	Good content validity
Quality of Service Delivery	22	21	0.95	Excellent content validity
Overall Instrument	**48**	**42**	**0.88**	**Excellent content validity**

Source: *Pilot Study, 2026*

The findings indicate that the budget preparation scale attained a CVI of 0.81, while the quality of service delivery scale achieved a CVI of 0.95. The overall instrument yielded a CVI of 0.88, demonstrating that the questionnaire possessed high content validity.

These results exceed the minimum acceptable threshold of 0.70 recommended for social science research (Polit & Beck, 2006) and are well above the minimum agreement level proposed by Lawshe (1975). According to Lynn (1986), a CVI greater than 0.80 indicates that the instrument adequately represents the content domain of the construct being measured. Therefore, the research instruments were considered sufficiently valid to collect data for the study, providing confidence that the questionnaire items appropriately captured the dimensions of budget preparation and quality of service delivery.

Reliability

Reliability was assessed using Cronbach's Alpha to determine internal consistency. A pilot study involving 10 respondents was conducted prior to the main study. Cronbach's Alpha values above 0.70 were considered acceptable (Cronbach, 1951; Nunnally & Bernstein, 1994; Tavakol & Dennick, 2011). The instruments demonstrated acceptable reliability, confirming their suitability for data collection.

Data Analysis

Quantitative data were analysed using SPSS Version 30, employing descriptive statistics (frequencies, means, and percentages) and inferential statistics with only correlation to examine the relationship between budget preparation and service delivery quality (Field, 2018; Pallant, 2020).

Qualitative data were analysed thematically through coding, categorisation, and interpretation of patterns and meanings emerging from interviews (Braun & Clarke, 2019).

Ethical Considerations

Ethical clearance was obtained from relevant institutional authorities like the District Health Officer and the Chief Administrative Officer of Kasese District prior to data collection. Participation was voluntary, and informed consent was obtained from all respondents. Confidentiality and anonymity were maintained throughout the study, and participants were assured of their right to withdraw at any time without penalty (Israel & Hay, 2006; Wiles, 2013).

Study Limitations

The study was limited by reliance on self-reported data, which may introduce response bias. Additionally, the cross-sectional design limits causal inference; however, it remains appropriate for assessing associations between variables under study (Creswell & Creswell, 2018).

ANALYSIS AND RESULTS

Budget Preparation and the Quality of Service Delivery in Health Facilities

Descriptive statistics were computed to examine respondents' perceptions of budget preparation practices in public health facilities within Kasese District.

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Table 2: Descriptive Statistics on Budget Preparation

Descriptive Statistics

	N	Min	Max	Mean	Std. Deviation
Do you think Health facilities have the knowledge and skills needed to prepare the budget?	336	1	5	4.17	.756
Health facilities take time to identify budget needs before budgeting is done	336	1	5	4.18	.837
Health facilities set desired objectives of the budget	336	1	5	4.03	.801
There is enough information required to facilitate public health facility budgets	336	1	5	4.05	.885
Health facilities involve community leaders in budget preparations	336	1	5	3.24	1.144
All departments are involved in the facility budgeting	336	1	5	3.52	1.190
Health facilities hold budget conferences to solicit ideas from stakeholders	336	1	5	2.88	1.231
Health facilities make reference to historical budgets when preparing the current budget	336	1	5	3.99	.839
Valid N (listwise)	336				

Source: *Primary Data, 2026.*

From the table above, results indicated generally high levels of agreement that health facilities possess adequate technical capacity for budget preparation. For instance, respondents agreed that health facilities have the necessary knowledge and skills for budget preparation (M = 4.17, SD = 0.756) and that they take time to identify budget needs before budgeting is undertaken (M = 4.18, SD = 0.837). One health worker under one health centre IV had this to say,

> *"I can't do a budget before I list what is necessary to run my activities, and depending on the money I have received, I can tell that this money is enough to run my activities."* (Health Centre III In-charge, Female, 41 years, June 2025).

> *"Look at what the needs for the community are. Also look at the historical records and consider planning for these activities early."* (Health Centre II In-charge, Male, 46 years, June 2025).

Similarly, respondents agreed that health facilities set clear budget objectives (M = 4.03, SD = 0.801) and make use of sufficient information during budget formulation (M = 4.05, SD = 0.885). However, participatory budgeting practices were relatively weak. Involvement of community leaders recorded a moderate rating (M = 3.24, SD = 1.144), while departmental involvement in budgeting was also moderate (M = 3.52, SD = 1.190). The lowest mean score was observed for holding budget conferences to solicit stakeholder input (M = 2.88, SD = 1.231), indicating limited stakeholder engagement. Use of historical budgets in current planning was relatively high (M = 3.99, SD = 0.839). The findings suggest that while technical aspects of budget preparation are strong, participatory budgeting practices remain weak in public health facilities.

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Table 3: Descriptive Statistics on Quality of Service Delivery

Descriptive Statistics

	N	Min	Max	Mean	Std. Deviation
Physical facilities are virtually appealing	336	2	5	3.71	.731
Employees are well dressed and appear neat.	336	1	5	4.10	.590
The physical environment of the health facility is clean	336	1	5	2.67	1.117
When they promise to do something by a certain time, they do it	336	1	5	3.34	1.000
When Patients has a problem, they should show sincere interest in solving the problem	336	1	5	3.19	1.050
Health facility perform the service right the first time	336	1	5	2.91	1.054
Health facility provide their services at the time they promise to do so	336	2	5	3.39	.950
Health Facility maintain accurate records	336	2	5	3.99	.374
Employees make information easily obtainable by patients	336	2	5	3.78	.693
Employees give prompt services to patients	336	1	5	3.59	.870
Employees are always willing to help patients	336	1	5	2.85	1.066
Employees are never too busy to respond to patients' requests	336	1	5	3.50	.920
Employees instil confidence in patients	336	1	5	3.38	1.013
Patients feel safe in their engagements with the employees	336	1	5	3.41	.994
Employees are polite to patients	336	1	5	2.87	1.170
Employees have the knowledge to answer patients' questions.	336	1	5	3.99	.445
Health facility gives patients individual attention	336	1	5	3.73	.793
Operating hours of the health facility are convenient for patients.	336	1	5	2.77	1.148
Employees give patients personal service.	336	1	5	1.90	.821
Health Facility has their patients' interest at heart.	336	1	5	3.30	1.023
Employees understand the specific needs of their patients	336	2	5	3.71	.753
Valid N (listwise)	336				

Source: *Primary Data, 2026.*

The descriptive statistics indicate that the quality of service delivery in public health facilities is generally moderate, with noticeable variation across different dimensions of care. Respondents rated the physical appearance of facilities relatively positively (M = 3.71), and staff appearance was rated highly (M = 4.10), suggesting that outward presentation and professional dress code are reasonably maintained. Similarly, staff knowledge to respond to patients' questions (M = 3.99) and maintenance of accurate records (M = 3.99) were rated highly, reflecting relatively strong administrative competence and technical capacity within the health facilities.

However, several important weaknesses are evident. The cleanliness of the physical environment received a relatively low rating (M = 2.67), indicating challenges in maintaining hygiene standards, which are critical for effective healthcare delivery. Service reliability also shows inconsistencies, as reflected in the lower rating for performing services correctly the first time (M = 2.91), suggesting potential inefficiencies or errors in service execution.

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Responsiveness indicators present a mixed picture. While prompt service delivery (M = 3.59) and ease of obtaining information (M = 3.78) were rated moderately well, aspects such as willingness to help patients (M = 2.85) and politeness of employees (M = 2.87) were rated lower. This points to gaps in staff attitude and patient-centred responsiveness, which are essential for perceived service quality.

Similarly, assurance-related aspects such as instilling confidence in patients (M = 3.38) and patients feeling safe during interactions (M = 3.41) indicate moderate performance, suggesting that while staff are knowledgeable, the transfer of confidence to patients is not consistently strong.

The weakest performance is observed in the empathy dimension. Personalised service received the lowest mean score (M = 1.90), indicating a significant deficiency in individualised patient care. In addition, operating hours' convenience (M = 2.77) and willingness to assist (M = 2.85) further highlight limited flexibility and attentiveness to patient needs.

Overall, the findings suggest that although public health facilities demonstrate relative strength in technical competence and administrative processes, significant gaps remain in cleanliness, responsiveness, and especially empathy. This imbalance indicates that service delivery quality is stronger in structural and procedural aspects but weaker in interpersonal and patient-centred care, which may negatively affect patient satisfaction and overall perceptions of healthcare quality.

Some of the respondents expressed their disagreement as follows;

> *"Also, the health workers report late for work. They come at around 10:00 am. This means if the patient is very ill, more complications may come up."* (Patient, Female, 34 years, May 2025).

> *"The health workers come really late to work, like today we have waited up to 11:00 am. We come early and expect them to be around, however, no one is here. What happens if someone is unconscious? Does she or he just pass away?"* (Patient, Male, 52 years, May 2025).

> *"Some health workers need to be counselled and advised to come early. We normally come here by 7:00 am, and the health workers arrive at 10:00 am, and yet they don't even start work right away."* (Patient, Female, 45 years, June 2025).

Correlation Results

Pearson correlation analysis was conducted to examine the relationship between budget preparation and quality of service delivery in public health facilities. The results indicate a weak negative relationship between budget preparation and quality of service delivery ($r = -0.176$, $p = 0.081$, $N = 336$).

The negative correlation coefficient suggests that improvements in budget preparation are associated with a slight decline in perceived quality of service delivery; however, the strength of this relationship is weak, indicating a minimal linear association between the two variables. This implies that budget preparation, in isolation, does not strongly correspond with variations in service delivery quality within the studied health facilities.

More importantly, the relationship is not statistically significant at the 0.05 level ($p = 0.081 > 0.05$). This indicates that the observed association may have occurred by chance, and therefore there is insufficient evidence to conclude a statistically significant linear relationship between budget preparation and quality of service delivery in public health facilities in Kasese District.

Accordingly, the null hypothesis (H_0), which states that budget preparation has no significant relationship with quality of service delivery, is not rejected based on the correlation results alone.

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The findings further suggest that service delivery quality may be influenced more strongly by other organisational and operational factors not captured in the bivariate correlation model, such as budget execution efficiency, staffing adequacy, procurement systems, and availability of medical supplies.

Table 4: Correlation Results for Budget Preparation and the Quality of Service Delivery in Health Facilities.

Correlations

		Budget Preparation	Quality of service delivery
Budget Preparation	Pearson Correlation	1	-.176
	Sig. (2-tailed)		.081
	N	336	336
Quality of service delivery	Pearson Correlation	-.176	1
	Sig. (2-tailed)	.081	
	N	336	336

Source: *Primary Data, 2026.*

DISCUSSION OF RESULTS

The findings of this study largely align with the reviewed literature, which portrays public health facilities as possessing relatively strong technical and administrative capacity but facing persistent weaknesses in patient-centred service delivery. From the perspective of the Resource-Based View (RBV), organisational performance depends not merely on the possession of resources but on how effectively they are deployed to create value (Barney, 1991; Barney et al., 2020). Accordingly, competent staff, budgeting expertise, and administrative systems constitute strategic organisational resources that should enhance service delivery when effectively utilised.

The high ratings for staff knowledge and record management are consistent with the World Health Organization (2023) and the Ministry of Health (2022), which report that public health workers in Uganda generally possess adequate technical competence supported by standardised training and established administrative systems. These findings support the RBV proposition that human capital and organisational capabilities are valuable internal resources that contribute to organisational performance. Similarly, OECD (2022) argues that standardised administrative procedures strengthen institutional efficiency through effective resource utilisation.

Conversely, the low rating for environmental cleanliness supports the findings of the World Bank (2023), which attributes poor facility conditions to inadequate financial and infrastructural resources. From the RBV perspective, physical infrastructure represents a strategic organisational resource whose inadequate availability or utilisation constrains service quality despite the presence of skilled personnel. This demonstrates that the mere existence of human resources is insufficient when complementary organisational resources are lacking.

The mixed performance in service reliability is consistent with the Uganda National Health System Assessment (2023) and WHO (2023), which identify staffing shortages, excessive workload, and operational inefficiencies as barriers to consistent service delivery. RBV suggests that organisational resources must be effectively coordinated and integrated to generate superior performance. Therefore, weaknesses in planning, resource allocation, and operational management reduce the ability of health facilities

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to transform available resources into reliable healthcare services.

Similarly, the findings on responsiveness and assurance mirror those reported by OECD (2022) and the World Bank (2022), which emphasise that technical competence alone does not guarantee high-quality service delivery. Although employees possess the knowledge required to perform their duties, lower ratings for willingness to assist patients, politeness, and patient confidence indicate underutilization of intangible resources such as organisational culture, communication skills, and employee commitment. RBV recognises these intangible capabilities as critical sources of sustained organisational performance because they are difficult to imitate and directly influence client satisfaction.

The very low rating for empathy, particularly personalised care, further supports the literature reviewed. The World Bank (2023) attributes weak patient-centred care to staffing constraints and increasing patient workloads. Consistent with RBV, these findings suggest that health facilities have not fully leveraged their human resources to deliver value beyond technical competence. Without supportive organisational systems that encourage teamwork, motivation, and patient-centred practices, valuable human resources cannot be transformed into improved service delivery outcomes.

The findings reinforce both the reviewed literature and the Resource-Based View theory by demonstrating that while public health facilities possess important organisational resources, including competent personnel and administrative systems, these resources are not being optimally integrated and utilised to improve service quality. The study therefore suggests that strengthening budgeting capabilities should be accompanied by investments in organisational culture, infrastructure, staff motivation, and patient-centred management practices to enable public health facilities to convert their internal resources into sustained improvements in service delivery.

CONCLUSION

This study assessed the effect of budget preparation on the quality of service delivery in public health facilities in Kasese District. The findings show that while health facilities demonstrate relatively strong technical capacity in budget preparation, overall service delivery quality remains moderate, with notable weaknesses in cleanliness, responsiveness, and especially empathy.

Correlation results indicate a weak and statistically insignificant relationship between budget preparation and service delivery quality, suggesting that budget preparation alone does not directly translate into improved service outcomes.

The study concludes that budget preparation is an important but insufficient determinant of service delivery quality. Its effectiveness is largely dependent on how well it is complemented by budget implementation, monitoring, and broader institutional factors such as staffing and resource availability.

Recommendations

The study makes the following key recommendations. First, public health facilities should improve budget preparation by strengthening stakeholder involvement to ensure that budgets reflect actual service delivery needs.

Second, health facilities should base budget preparation on accurate and timely data to enhance prioritisation and resource allocation.

Third, the Ministry of Health and local governments should provide targeted training in results-based budgeting to improve planning capacity at the facility level.

Fourth, supervision of budget implementation should be strengthened to ensure adherence to approved budgets and improve service delivery efficiency.

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Finally, health facilities should enhance patient-centred care by improving staff responsiveness, communication, and empathy to improve overall service quality.

Conflict of Interest Declaration

The authors declare no conflict of interest regarding this study.

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