MAKERERE UNIVERSITY

MAKERERE UNIVERSITY BUSINESS SCHOOL

PARTICIPATORY BUDGETING, INTERNAL CONTROLS AND SERVICE DELIVERY PERFORMANCE IN SELECTED PUBLIC HEALTH FACILITIES A CASE OF WAKISO DISTRICT

BY

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PLAN A

OCTOBER 2021

DECLARATION

I declare that this dissertation is my original work and it has never been presented anywhere for academic purposes.

Signed.....Date: 26 | Oct | 2021

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APPROVAL

This is to confirm that this dissertation has been submitted with our approval as university academic supervisors.

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DEDICATION

I dedicate my dissertation work to my family and many friends. A special feeling of gratitude to my loving parents, Echongu Henry and Ayebazibwe Janice whose words of encouragement and push for tenacity ring in my ears. My brother Agaba Sedrick who never left my side and is very special.

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LIST OF ABBREVIATIONS

WHO	World Health Organization
MOH	Ministry of Health
UBOS	Uganda Bureau of Statistics
RBV	Resource Based View Theory
EMHS	Essential Medicines and Health Supplies
CSOs	Civil society organizations
HUMCs	Health Unit Management Committees
WMO	World Meteorological Organization
ACHS	Australian Council of Healthcare Standards
RPJMD	Regional Medium Term Development Plan
COSO	Committee of Sponsoring Organization

ABSTRACT

This study aimed to establish the relationship between participatory budgeting, internal controls and the service delivery performance in selected public health facilities in Uganda. The specific objectives were to establish the relationship between participatory budgeting and service delivery performance in selected public health facilities in Uganda, to examine the relationship between internal controls and service delivery performance in selected public health facilities in Uganda and to examine the contribution of participatory budgeting and internal controls on service delivery performance in selected public health facilities in Uganda

The research adopted a cross-sectional survey design. A self-administered quantitative questionnaire was used to collect data from 59 public health facility staff and 118 community members. Purposive sampling technique was used to select the respondents. Statistical package for social science (SPSS version 23.0) was used to analyze the data. The study findings revealed that there was a positive significant relationship between participatory budgeting and service delivery performance in the selected Public health facilities. It was also found out that there was a negative relationship between internal controls and service delivery performance in the selected public health facilities.

Furthermore, using the hierarchical regression model, the study found out that participatory budgeting and internal controls combined contributed 48.2% of the variance in service delivery performance in the selected public health facilities. The study recommends that Participatory budgeting can be improved through engaging citizen's participation, resource allocation and ensuring transparency. Therefore, government's effort to improve service delivery in Public Health facilities should focus on engagement of the communities in the budgeting process.

CHAPTER ONE

INTRODUCTION

1.1. Background

Attaining service gratification in the whole world demands that governments improve on the quality of services they offer (Makanyeza et al., 2017). Service quality particularly in the health sector is linked with improved human wellbeing and in return, enhances productivity of life (Kimenyi, 2018). Effective health service delivery in any country is concerned with bringing about an acceptable level of coherent programs that will assist the country to provide health care to populations having insufficient or no access to health services (Krishna, 2019). The government should employ effective resources allocation, systems analysis and management methods capable of implementing the decisions taken (Ejumudo, 2018). Therefore, when assessing service delivery performance in the health sector it's important to focus on access to health services, sustainability of such services, quality of the services offered and accountability (WHO, 2018).

In a bid to improve service delivery performance in the public health facilities, it becomes important to involve key stakeholders while preparing budgets for the health sector (Hutama and Yudianto, 2019). It offers citizens at large an opportunity to learn about government operations and to deliberate, and influence the allocation of public resources (Cabannes, 2015). The enhanced transparency, citizen participation and resource allocation that participatory budgeting creates can help reduce government inefficiency, patronage, corruption and improve service sustainability, (Campbell, Fenton and Craig, 2018).

However, not only participatory budgeting relates to service delivery performance, internal control has been regarded a distinctive factor to enhanced health quality service delivery (Wane and Gayle, 2015; Ntongo, 2017). Internal control is a system that is guided by a framework

invented to reliably assure the government that its purpose for existence will be achieved (COSO, 2015). The rationale is that the stakeholders are demanded to provide a framework that safeguard resources, promote consistent information, enhance adherence to recommended laws and meet effectively the operations of the service delivery performance. The effective implementation of internal controls safeguard resources against loss, misuse and damage (Otieno and Kalenzi, 2019).

The relationship between internal control and quality health service delivery is well explained by stakeholder theory (Freeman, 1984). This theory assumes that an organization is comprised of different stakeholders and each stakeholder has differing interests which need to be taken into account if the organization is to achieve its purpose (Shao, 2010). The Resource Based View theory focuses attention on the internal resources or strengths within an organization to manage uncertainty, rather than capitalizing on the opportunities presented by the changing external environment (Rosner, 1968)

For the case of Uganda, the country has an organized national health system and health delivery in place within the strategic frame work and focus. The national health system is comprised of both private and public sectors (Global Health Corps report, 2018). The private sectors contribute about 50% of the Health care delivery. The public sectors include Government Health facilities; Health services departments of different Ministries. Health services delivery is decentralized within national, districts and health sub districts (Ministry of Health, 2019). Despite government efforts to improvements service delivery performance in the public health facilities, these facilities continue to suffer from corruption, theft of medicines, neglect of duty and absenteeism by staff, diversion of funds to private clinics, ineffective planning and budgeting among others (MOH, 2019). The continued poor service delivery in the health sector could be attributed to the lack participatory budgeting and weak internal control system.

1.2. Statement of the problem

The government of Uganda has put in place mechanism for transparency and accountability in a bid to improve service delivery in the health sector. This has seen an improvement in major services delivered in the public health facilities. Some of the interventions include; access to health facilities, availability of drugs, trained medical workers and access to health-related information and improved life expectancy rates (MOH, 2018). Despite these efforts the high levels of maternal mortality, infant mortality, malnutrition, poor sanitation and hygiene remain at an acceptable levels (WHO, 2019). The inadequacy of interventions against common health conditions, inefficient use of available health resources, low response to quality and safety of services, social and financial risk and concerns of the community being inadequate, leading to public outcry (MOH, 2018). The poor service delivery in public health facilities could be attributed to the failure to involve the citizens in participatory budgeting and weak internal control systems in the public health facilities. Therefore, the study intends to understand the relationship between participatory budgeting and internal controls and how they can improve service delivery in the public health sector.

1.3. Purpose of the study

The purpose of the study is to establish the relationship between participatory budgeting, internal controls and the service delivery performance in selected public health facilities in Uganda.

1.4. Research Objectives

i. To establish the relationship between participatory budgeting and service delivery performance in selected public health facilities in Uganda

ii. To examine the relationship between internal controls and service delivery performance in selected public health facilities in Uganda iii. To examine the contribution of

participatory budgeting and internal controls on service delivery performance in selected public health facilities in Uganda

1.5. Research Questions

i. What is the relationship between participatory budgeting and service delivery performance in selected public health facilities in Uganda?
ii. What is the relationship between internal controls and service delivery performance in selected public health facilities in Uganda?
iii. What is the contribution of participatory budgeting, internal controls on service delivery performance in selected public health facilities in Uganda?

1.6. Scope of the study

1.6.1. Content scope

The study will focus on participatory budgeting, internal controls as independent variables whereas the dependent variable will be service delivery. Participatory budgeting is limited to citizen participation, resource allocation and transparency (Campbell et al, 2018). Internal Controls is limited to risk assessment, control environment, control activities, information and communication and monitoring activities (Otieno and Kalenzi, 2019) and Service delivery performance is limited to access to health services, sustainability of services, quality of services, accountability (WHO

Report, 2019).

1.6.2. Geographical Scope

The study was conducted in the selected public health facilities/ health centres III and IV in Wakiso District. Wakiso district was selected because it is the second most populated district in Uganda with a population of over 2 million people (UBOS 2018) and has the highest number of public health facilities/ Health centres (MOH, 2018).

1.6.3. Time Scope

The study will focus on the service delivery performance in the public health facilities from 2010 to 2020. The study will also consider literature review for the period 2004 to 2019 because service delivery performance in the health sector has been on a continuous improvement since the early 90s which would give the researcher access to a wide scope of empirical literature.

1.7. Significance of the Study

i. This study will help to inform policy makers on the role of participatory budgeting, internal controls and service delivery performance in the public health facilities in Uganda. ii. To the policy makers the knowledge will help them in formulating policies that would improve participatory budgeting and internal controls for service delivery performance the Ministry of Health.

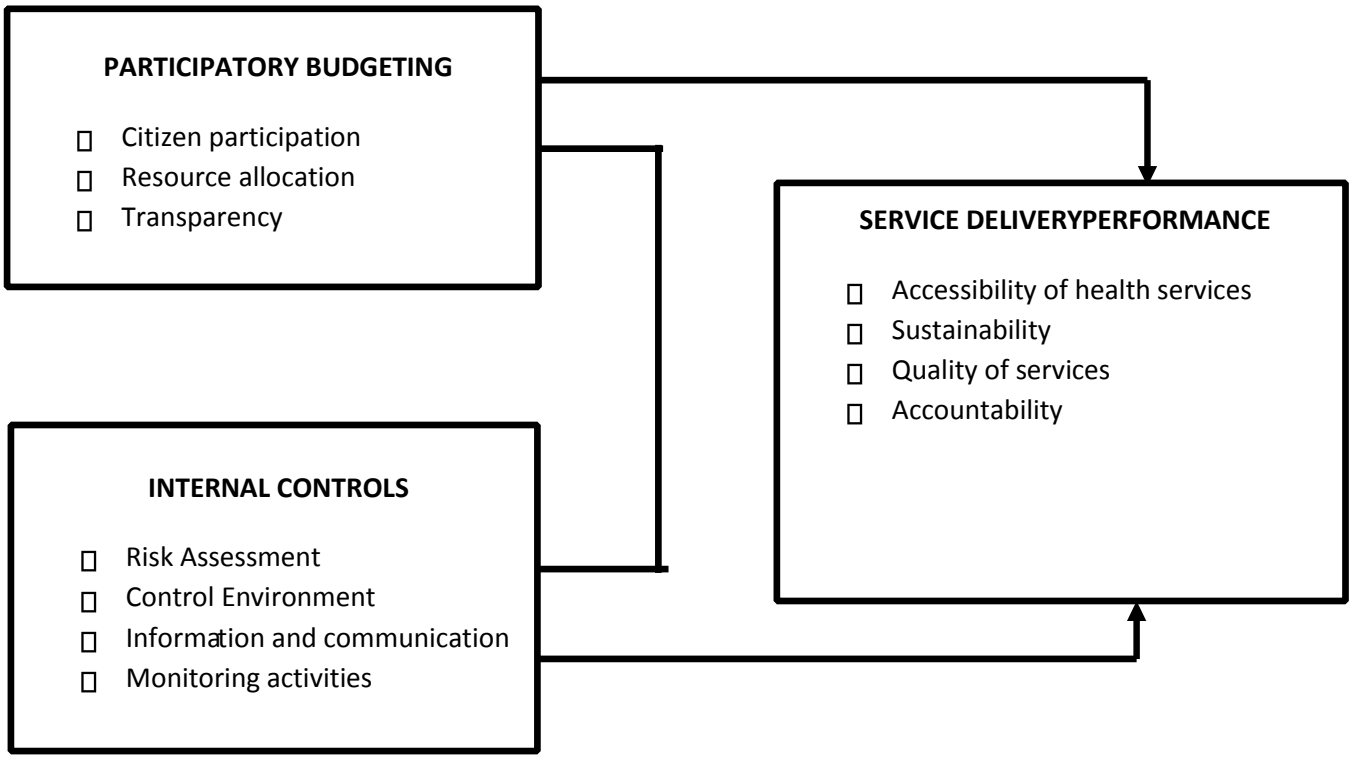
iii. The study will help the staff of public health facilities to appreciate the need for community involvement in participatory budgeting and the advantage of strong internal controls to improve service delivery performance.

iv. The researcher intends to make a contribution to the existing research done in the area of participatory budgeting, internal controls and service delivery performance to enable future researchers have a wide reference.

1.7. Conceptual Framework

The conceptual framework intends to create a relationship between the variables. It hypothesizes that there is a relationship between participatory budgeting and service deliver performance (H1). There is a relationship between internal controls and service delivery performance (H2) and there is a combined contribution of participatory budgeting and internal control towards service delivery performance (H3).

Conceptual Framework



Adopted from the literature of (World Health Organization report, 2010; Campbell, Fenton & Craig, 2018 and Otieno & Kalenzi, 2019) and modified by the researcher.

CHAPTER TWO

LITERATURE REVIEW

2.1. Theoretical review

The concept of citizen participation has emerged highly in democratic processes and is supported by the stakeholder theory (Acerete, Royo, and Yetano, 2010). Stakeholder theory has been discussed in e-government contexts (Flak, and Rose, 2005). For citizen participation, stakeholder theory argues on inclusion of stakeholders in innovation and management and thus satisfying their needs. The theory further argues on accountability, satisfaction and efficiency of management and decision making processes through actual inclusion of stakeholders (Acerete et al. 2010). Citizen participation is where the citizens are actively involved in decision making processes to achieve more accountability and good governance (Ackerman, 2004). Originating in strategic management, the Resource Based View of the Firm theorizes organizations comprise a mix of tangible and intangible resources, including physical, human and organizational capital (Barney,

1991). The 'imperfect distribution' of these resources across firms, or organizations within a similar market is thought to account for variation in performance, usually in terms of market share. RBV focuses on resources that have Value, Rarity, are difficult to Imitate, and are Nonsubstitutable (VRIN) and explain an organization's competitive advantage relative to others (Barney and Clarke, 2007). RBV focuses attention on the internal resources or strengths within an organization to manage uncertainty, rather than capitalizing on the opportunities presented by the changing external environment. Addressing these opportunities depends on both the scope to invest in improvement work (Rosner, 1968) and organizational slack, or free resources, to support learning and innovation within the organization (Bate, Mendel and Robert, 2008). The ability to recognize, mobilize and exploit these resources is key, and this may present a particular

challenge for health service managers. Obtaining sustained benefits from these resources also requires some capacity of a healthcare organization to re-engineer new resources as the strategic environments in which they are operating change over time. These organizational capacities may be evident in activities which consolidate, replicate or extend resources across an organization; learning; and the creative integration of resources. In these ways, a healthcare organization has the potential to increase the impact of improvement capability and learning, and strategic potential. However, and within healthcare, these strategic environments comprise a complex mix of policy; public expectations; predictable and unpredictable demands; demographics; and shifts in the technical capacity of modern healthcare.

The DCT adds to the resource based view by attempting to improve theory by explaining the nature of sustainable competitive advantage, while also intending to inform managerial practices (Teece et al., 1997). In essence the DCT tries to make use of competences that are unique to firms to gain competitive advantage and explains how these competences are developed, deployed and protected (Teece et al., 1997). The approach takes into account three classes of factors that help explain where competitive advantages derives, namely; processes, which describe the way things are done in an organization: positions, which represent the types of assets, and relations of an organization: and paths, which refer to the organizations strategic direction. In essence the accumulation of competitive advantage and DC's is attributed to the processes of an organization, the positions of its assets and its past and future paths (Teece et al., 1997)

2.2. Service delivery performance in Public Health Facilities

Undeniable worldwide health improvements have been observed in recent history. In two centuries, world life expectancy rose from 25 to 65 years for men and to 70 years for women.

Before 1950, reductions in death rates at younger ages explained most of the gain in life expectancy. Survival improvements after age 65 drove life expectancy, lengthening in the second half of the 20th century (Oeppen and Vaupel 2017). Improvements in health systems' performance drove such reductions in mortality and morbidity. Nevertheless, large inequalities remain. Africa has the lowest worldwide life expectancy, although it rose significantly from 38 years in 1950 to

56 years in 2012. Mortality reduction among children under-five represents 59% of Africa's life expectancy gains since 1950, while 12% of the gain is due to better survival rates of children aged 5 to 14 (African Development Bank 2013). In country inequalities also prevail with the poorest quintile suffering from higher infant and under-five mortality rates than any other quintile in low and middle income countries (Wagstaff 2015).

Health service delivery remains at the core of government activities upon which the majority of citizens of a particular country depend. Failure of a health delivery system at any level of government legitimizes accusations about the incapacity of governments. Public Health Facilities are often located some distance from the national referral hospitals. Over the past few decades, health has attained worldwide recognition as a crucial component of human development and poverty eradication. In this regard, improvement of health is a critical governance issue. However, there is a realization that one third of the world population lacks access to essential medicines, and this critically contributes to further poverty, mortality and morbidity (WHO, 2019). The 2019 Report of the Special United Nations Rapporteur on the Right to Health observed that the disease of the poor – that is maternal, per-natal and nutritional diseases, among others – still account for 50% of the burden of diseases in developing countries. Improving access to medicines alone can save ten million lives a year – four million in Africa and South Asia (WHO, 2018 Report).

Effective health service delivery depends on other determinants of health, which include the availability of highly motivated healthcare workers, well equipped infrastructure, access to roads, sanitation and to clean water (WHO, 2018). In Africa, health service delivery has continued to face many challenges, most of which are similar across the continent. According to the WHO 2018 Report, in Mali for example, medical facilities are very limited and medicines are in short supply most of the time. The health care system in Niger suffers a chronic lack of resources and a small number of health providers relative to the population. Most essential medicines are in short supply or unavailable. Similarly, the health system in Zimbabwe has more or less collapsed, and due to the political and economic crises, many doctors and other health personnel have migrated, hence resulting in very poor health service delivery (WHO, 2018).

According to Nabyonga, Desmet & Karamagi, (2017), patients tend to visit health facilities in large numbers when they have information that drugs are available. A review of literature from Tanzania suggests that people considered the availability of essential drugs a prerequisite to the credibility of health services, (Mamdani & Bangser, 2016). According to Wabwire-Mangen, Amuge & Pariyo, (2017), in Rakai District, some of the reasons why patients choose to go to a health facility include a short distance, cheap and free treatment, availability of drugs and quick service to patients. Therefore, essential medicines and health supplies (EMHS) contribute to delivery of health services at health facilities.

Over the past decade, the Ugandan Government has focused on expanding its health infrastructure through construction of more health facilities in an effort to bring services closer to the people. However, a number of these health facilities are neither manned with the right cadre of healthcare workers nor adequately equipped, (MOH, 2018). Although 72% of the households in Uganda live within five kilometers from a health facility, utilization is limited due to poor infrastructure, lack of medicines and other health supplies, a shortage of human resources, low

salaries, a lack of accommodation for staff at the health facilities and other factors that further constrain access to quality service delivery (MOH, 2018). Besides, maintenance of health infrastructure and medical equipment remains a major challenge coupled with inadequate supervision and monitoring of health facility functions (MOH, 2018). There are also variations with regard to access, ranging from as low as 7% of the population within five kilometers of a health facility in Kotido, to 100% in Jinja, Tororo and Kampala districts.

2.3. Participatory Budgeting

Participation is understood as a process of communication between local communities and development agencies, in which local people assume the lead role in analyzing their current situation to identify the need or problem requiring attention in order to plan, implement and evaluate development activities, and even implement and evaluate the quality of participation itself (Center for African Policy, 2017). Participation is thus concerned with who plays the leading role in development activities; who ultimately influences the planning process and/or decisions; and whether development plans reflect the priorities of the local people.

Participatory budgeting represents a direct-democracy approach to budgeting. It offers citizens at large an opportunity to learn about government operations and to deliberate, debate, and influence the allocation of public resources (Mkude, 2018). It is a tool for educating, engaging, and empowering citizens and strengthening demand for good governance (Tembo, 2016). The enhanced transparency and accountability that participatory budgeting creates can help reduce government inefficiency and curb clienteles, patronage, and corruption avoidance.

Participatory budgeting also strengthens inclusive governance by giving marginalized and excluded groups the opportunity to have their voices heard and to influence public decision making vital to their interests (Mansuri and Rao, 2017). Done right, it has the potential to make governments more responsive to citizens' needs and preferences and more accountable to them

for performance in resource allocation and service delivery. In doing so, participatory budgeting can improve government performance and enhance the quality of democratic participation.

Public participation in decision-making is a mechanism that serves to entrench democracy and promote social cohesion between government and citizens, particularly as relates to the provision of quality and sustainable services and goods (Malena, Forster, & Singh, 2014). It is just that people – both in their capacity as citizens and consumers of public services and goods provided in terms of the law – should be allowed and encouraged to express their views on governance and service delivery matters pertaining to them (Center for African Policy, 2017).

Citizen participation in budgeting takes different forms: indirect participation involves representation through elected leadership, e.g. local councils, which can be targeted at special interest groups such as women, youth, the elderly, and persons with disability, many of whom may be marginalized (socially, economically, etc.) (Chrispine, 2015). Direct participation involves personal engagement through platforms such as village meetings, local council meetings, budget conferences and Barazas, which are intended to facilitate direct citizen participation in decision making processes such as for example government budgeting and development planning cycles (

Mansuri & Rao, 2016)

2.4. Internal Controls

Internal controls are systems within an organization that design methods and procedures to produce effective operations, establish reliable financial reporting, avoid fraud and maintain compliance with regulations and laws (Amudo and Angella, 2018). Internal controls evaluation is meant to help institutions review and assess the structure of accountability within the organization. An effective system of internal controls gives assurance regarding the integrity of financial reporting and safeguarding of assets of the entity. Fraud can easily be detected through

internal controls (Asare, 2016). Internal controls are used by organizations to make sure financial information is accurate and valid. The existences of internal financial controls are important because they protect the integrity of an organization's financial information and allow stakeholders a measure of financial health. Strong internal controls can also increase the profitability of a company (Krishnan, 2017)

Internal control has been pointed out as unique and essential to the success of organizations (Pillai, 2017). Internal control is a process guided by the organization's framework that reliably assures the entity that its purpose for existence will be achieved (COSO, 2015). The rationale is that the stakeholders are demanded to provide framework that safeguard resources, promote consistent information, enhance adherence to recommended laws and meet effectively the operations of the organization. Conceptually, internal control is comprised of five interconnected components. These are control: environment, risk assessment, control activities, information and communication, and monitoring activities (COSO, 2015). There effective implementation safeguard resources against loss, misuse and damage (Long and Jeremy, 2018). This requires each organization to adopt internal control that is appropriate to its particular needs and activities (MWE, 2018).

The control environment is the component of internal controls which includes factors such as integrity, ethical values, competence of the workers and the management's philosophy in the organization. It is the component that provides the foundation needed for the other components to build on in internal financial controls systems (COSO, 2015). Risk assessment is that component which is used for identifying risks in the system. For risk assessment to be effective, preventative measures are put into place by establishing clear objectives. This component identifies and analyzes possible risks internally and externally. This component manages risk by developing precise procedures to achieve consistent objectives within the organization. Risk

assessment always takes change into consideration within the objectives set forth by Enterprise Risk Management – Integrated Framework (2017).

Organizations develop control activities to assist in monitoring. Control activities include policies, procedures and practices developed to increase risk management strategies (COSO, 2015). Specific control activities include separation of duties, verifications, reconciliations and physical security of assets. These policies are designed to ensure that management directives are fulfilled. Information must be identified, captured and communicated timely and effectively and is achieved through this internal control component (Doyle, Ge, and McVay, 2016). This component is designed to allow employees the ability to carry out their responsibilities in the best manner possible. Information must be communicated externally as well to all parties involved in the company. Information that is communicated in this fashion allows control activities and employee responsibilities to be more effectively. Monitoring includes assessing the performance of internal control components, ensuring they are operating effectively. This component includes allowing managers clear responsibility guidelines so that they are able to effectively do their jobs. It also includes performing evaluations through audits and other independent parties, ensuring that the company is handling the operations of the business correctly (Doyle, Ge, and McVay, 2016).

2.5. The relationship between participatory budgeting and service delivery performance in selected public health facilities in Uganda

Participatory budgeting, as an important aspect of accountability, is also necessary for the effective implementation of service delivery mechanisms, optimizing the benefits of any given mechanism (Center for African Policy, 2017). Decision-making and civil, social and cultural life characterized by an absence or paucity of civilian participation is recognized as a cause and central defining feature of poverty, as opposed to merely the consequence thereof (Devas &

Grant, 2018). It has further been noted that the purpose of participatory programs is to enhance the involvement of the poor and the marginalized in community-level decision-making in order to give citizens greater say in decisions affecting their lives (Mansuri & Rao, 2017) Local participation is viewed as a way to achieve a variety of goals, including improved poverty and benefits targeting, building community-level social capital, and increasing the demand for good governance. Participation is also expected to lead to better-designed development projects, and more effective service delivery (Tembo, 2017).

Wampler (2018) argues that political and social actors have different motivations for promoting and participating in participatory budgeting. Local governments implement participatory budgeting programs in order to build a base of political support, achieve a more equitable distribution of scarce resources, foster public learning, and promote transparency in government. Citizens participate in participatory budgeting programs in order to increase access to public decision-making activities, gain access to information, and improve the quality of services provided under a participatory budgeting system. Civil society organizations (CSOs) participate in order to build broader networks of supporters and enhance their ability to influence policies

Participatory budgeting comes with significant risks. Participatory processes can be captured by interest groups. Such processes can mask the undemocratic, exclusive, or elite nature of public decision making, giving the appearance of broader participation and inclusive governance while using public funds to advance the interests of powerful elites (Oloka, 2017). Participatory processes can conceal and reinforce existing injustices. Participatory budgeting can be abused to facilitate the illegitimate and unjust exercise of power. It can be used to deprive marginalized and excluded groups of having a say in public affairs.

Takawira (2016) observed that it can do so by unleashing the “tyranny of decision making and control” by overriding existing legitimate decision-making processes—by limiting the role of

elected local councils in budgetary decisions, for example. The “tyranny of group dynamics” can allow manipulative facilitators to preserve and protect the interests of the governing elites. The “tyranny of method” can be used to exclude more inclusive methods of democratic voice and exit, such as parental choice in school finance, under which both government and nongovernment schools are publicly financed based on enrollments (Cooke and Kothari 2015). To prevent these abuses, participatory process must fully recognize local politics and formal and informal power relations, so that the processes yield outcomes desired by the median voter.

Public participation in decision-making is a mechanism that serves to entrench democracy and promote social cohesion between government and citizens, particularly as relates to the provision of quality and sustainable services and goods (Sudarman, 2019). It is just that people – both in their capacity as citizens and consumers of public services and goods provided in terms of the law – should be allowed and encouraged to express their views on governance and service delivery matters pertaining to them. The imperative of accountability and community participation at local government level is vested in the district leadership. Public engagement in the planning and prioritization of service offerings is essential for efficient and effective government functioning. Government should be citizen-centered both in respect of planning and implementation of policies and programs.

The Public Health Act 1935 vests powers in the minister of Health to establish any number of sanitary boards by statutory instrument; 89 however, such boards are not mandatory and may be created at the discretion of the minister. S.8 also gives the minister powers to establish an Advisory board of Health whose composition affords citizens the opportunity to participate where appointed by the minister. The Act confers excessive powers upon the minister, who is empowered to make rules and appointments diluting citizen participation since the public do not have a say regarding who represents them on the Health Advisory Board.

To supplement the public Health Act, The Guidelines on Health Unit Management Committees (HUMCs) for Health Centre II and Health Centre III as well as the Guidelines on Hospital Management Boards for Referral Hospitals and District Hospitals, 2003 were passed by the Ministry of Health to serve as institutional structures for participation in Health governance. The ministry of Health Guidelines explicitly state that the mandate of HUMCs is to monitor and govern the health facilities on behalf of the respective local governments and foster improved communication with the public thereby encouraging community participation in health activities within and outside the unit (Ragnhild, Muriaas and Vibeke, 2017). The functions of Health Management Boards include providing strategic vision and direction to hospitals; making inputs to health policy; examining and approving the annual work plans, budget and funding reallocations proposed by hospital management teams; monitoring implementation of annual work plans and budget performance; fixing the ceiling for single item expenditure; monitoring, on behalf of the ministry of health, tender awards and performance (World Health Organization, 2018). Given the different findings from the literature, it is important to establish the status of the relationship between participatory budgeting and service delivery performance in the Ugandan context specifically in Wakiso district.

2.6. The relationship between internal controls and service delivery performance in selected public health facilities in Uganda

Attaining service gratification in the whole world demands that government health facilities improve on the quality of health services they offer (Makanyeza et al., 2018). Service quality particularly in the health sector is linked with improved human well-being and in return, enhances productivity of life (Kimenyi, 2017).

With the continuous development and improvement of the health facilities in the new era, health facilities management plays an increasingly important role in the development of the health

sector. Under the premise of the separation of ownership and management rights, the structure of health facilities governance is formed to cope with the relationship between all stakeholders in the hospital. Internal controls are important measures for the improvement of service delivery performance in health facilities. It is also a key basis to enhance the reliability and compliance of public health facilities. There is a close relationship between the public health facilities governance structure and the internal controls, whose high correlation directly affects service delivery performance in public health facilities (MoH, 2017). Effective internal control system can not only guarantee the safety of health facilities' assets, improve the efficiency of health facilities' management and operation, but also improve the quality of services offered and ensure the advantages of health facilities in the communities. On this basis, the public health facilities should raise the importance of the internal control system building ideologically and make an in-depth analysis based on the current problems in the internal control of the health sector. With the scientific management concept, corresponding solutions should be put forward to combine short-term interests and long-term interests together to achieve the strategic objectives of improved service delivery performance (African Development Bank, 2018).

Xiancheng (2018) exhibits the significant role of internal control in quality service delivery. Effective internal control enhances desired service quality (Ntongo, 2017). In this regard, organizations with well-structured internal control improves performance and meets client's expectations (Oppong et al., 2016; Umar et al., 2018). This translates into quality service delivery.

Internal control promotes efficiency in utilization of organization resources whereby jobs are carried out as described, employees available at work at all times, and equitable allocation of resources and hence, timely service quality delivery (MWE, 2018). Similarly, internal control has a potential to ensure usage of funds on planned organizational activities, investment of idle

funds, and regular monitoring of utility (Oppong et al., 2016). Monitoring is an important driver to quality service delivery. It provides vital feedback on the extent of service delivery and whether delivery of those services make any difference both to clients and organization (Rossi, 2016). Besides, it provides insights which are useful for detecting changes in performance and understanding trends over time (Woodall et al., 2015). The objective is to ensure that organizations are functioning as envisioned and that their systems are enhanced to proactively respond to variations to gain competitive advantage (Long and Jeremy, 2017). Comprehensively, monitoring measure if the core objective spelt out in the description of the organization core existence is being achieved (Long and Jeremy, 2017).

Similarly, organization's aptitude to make better resolutions that reciprocate desired outcome is influenced by the good information (COSO, 2015), thus, information must be suitable, well-time, up-to-date, exact, and available (COSO, 2015). Moreover, for information to meet its purpose, it must be communicated to the intended persons (Long and Jeremy, 2017). As communication is enhanced, there is a possibility that service quality will improve as organizations become more focused on client's requirements and needs (Musenze et al., 2016; Mwazo et al., 2017). This positions communication as a unique predictor of quality service delivery performance (Musenze et al., 2016; Mwazo et al., 2017). Furthermore, communication is seen to be important in all quality service delivery practices. Complete and timely communication, simplifies employees tasks thereby incorporating their needs and meet them as required (Musenze et al., 2016). This means that all communication practices must be controlled in order to realize better outcome.

Effective control activities have been positioned as a key to performance (QSD) (Oppong et al., 2016). Service quality is reliant on insight of organizational control activities. Effective and efficient processes (internal activities) directly impact quality of service delivery (World

Meteorological Organization (WMO), 2018). In this view, control activities are considered as activities that provide evidence on the status of the organization and actions to be taken. The said actions must be supported by internal control objectives, procedures and policies that enable managers to address risk timely, effectively and efficiently (COSO, 2015) as cited by Oppong et al. (2016). According to Australian Council of Healthcare Standards (ACHS, 2018), COSO (2015), and Long and Jeremy, (2013), risk assessment is important in mitigating risks towards realization of service quality. Risk assessment and service quality, are not isolated processes (Mwazo et al., 2017). They provide a system through which organization's operations are assessed, the processes involved examined, and enhance its performance in an effort to foster service quality (COSO, 2015; ACHS, 2018). Evidence showed that organizations that have successfully implemented risk management reciprocated quality improvements scenario (Umar et al., 2018; ACHS, 2018; Mwazo et al., 2017). This program to be functional, organizations Local governments need to exhibit allegiance to the procedures stipulated and define the objectives of all participants. Similarly, governing authority must allocate adequate resources to proficiently lessen, regulate and govern all risk in the organization (ACHS, 2018; COSO, 2015). The reviewed literature demonstrates internal control as a considerable indicator of quality service delivery in organization (Mwazo et al., 2017).

In a study conducted by Otieno and Kalenzi (2019), assessing the relationship between internal control and service delivery in public health facilities in greater Iganga Local Government. The study established that the link between internal control and quality service delivery was positive and significant. This finding is in consonant with Ntongo (2015), Oppong et al. (2016) and Umar et al (2018), who suggested that as organizations enforce policies and procedures such as the presence of the frameworks that safeguard resource, compliance to the stipulated laws, better reporting systems, risk assessment, proactive monitoring and evaluation and regular auditing

exercises, the quality of healthcare is likely to recuperate as organizations aim to meet the requirements of their esteemed clients, they will quickly respond to arising issues proactively in an effort to realize exceptional outputs, processes and inputs. Given the different findings from the literature, it is important to establish the status of the relationship between internal controls and service delivery performance in the Ugandan context specifically in Wakiso district.

2.7. The contribution of participatory budgeting and internal controls on service delivery performance in selected public health facilities in Uganda

The community is now starting to highlight the performance of government for services carried out by the government to the public. The assessment of the government's public services began to be questioned by the public so that the government must make every effort to improve service delivery performance of in order to gain trust from the community by providing satisfactory services to the community (Fauzan, 2017). Sometimes service delivery performance is not achieved due to the inefficiencies in budget allocations. Budget performance only looks at the aspect of budget planning and budget realization without focusing on the outcomes that will benefit the community on an ongoing basis (Negara, 2018).

Preparation of budget goals must be clear and not confusing budget implementers in carrying out government activities, and realization of the prepared budget is expected to reach the goals so that it will have an impact on performance appraisal. In preparing a budget, it is, of course, necessary to involve the parties to participate in the preparation of the budget so that budget preparation can be targeted and in accordance with the provisions based on the strategic plan, Regional Medium Term Development Plan (RPJMD), Key Performance Indicators (IKU) and other documents as reference in budgeting based on the strategic objectives to be achieved.

Internal control is carried out on all government activities to avoid fraud and supervise and direct every activity carried out by the government to be effective and efficient use of resources.

Internal control also has an important role in motivating employees to achieve organizational goals. With the existence of internal control, each program/activity can run as expected and will have implications for the performance of employees and the government as a whole (Ministry of Industry, 2011).

Budget participation is the responsibility of a manager involved in budgeting and its influence on budget goals in an organization (Kenis, 2017). In budget participation, there are two different understandings about who participates in budget preparation and determination. The first understanding states that participatory budgeting involves the community in preparing budgets as a form of democratization and accountability (Wampler, 2017). While the other understanding, according to (Kenis, 2017) states that budget participation involves government officials in preparing budgets in accordance with the main tasks and functions in the government. This is due to the different needs and preferences of each other and the diversity in the types of services that are given and prioritized in development planning that is planned and budgeted annually.

Kewo (2017) states that budget participation has several benefits, namely: 1) can reduce a person's pressure in making a budget; 2) can strengthen relations and cooperation between members in a group to achieve goals; 3) can reduce unfairness between parts of an organization in allocating resources. The results of Kewo's study (2017) concluded that participatory budgeting positively affected service delivery performance of local governments. Gul, et al (2015) stated that in high participation budgeting has a positive effect on the performance of organizations that implement decentralization. Abata and Mathew (2018) state that there is a positive but weak relationship between participatory budgeting and service delivery performance in Nigeria. Furthermore, Owusu, et al (2018) in his study concluded that budgetary participation has a positive effect on employee performance. Nasser et al (2017) that the characteristics of the

budget (participatory budgeting) influence the performance of the department. Brownell, Peter (2015) concludes that there is a positive influence between managerial participation and performance and motivation as an intervening variable.

According to the COSO (Committee of Sponsoring Organization Treadway Commission) in Redding (2015), internal control is the design for conducting control activities compiled by all ranks in the company that formulate the objectives that can be achieved and all company activities must comply with regulations following statutory regulations applicable laws. The purpose of implementing an internal control system in the government environment according to Mardiasmo (2017), namely: 1) Maintaining security of state assets; 2) Accounting information is tested and examined carefully; 3) Efficiency of operational costs can be increased; 4) Management policies that have been determined can be maintained properly.

Various studies on the effect of the implementation of the internal control system on performance have been carried out, the results show that the implementation of the internal control system has a positive effect on performance (Erica Magdalena (2014), Taufan Dharmawan (2016), Darmawan (2016), Kewo (2017)). Then the research of Silalahi (2017) concluded that internal control has a positive effect on the performance accountability of government agencies. Furthermore, the research of Hoitash et al. (2009) concluded that good governance affects internal control and reasonable internal control will improve performance better.

Although in Africa participatory budgeting is gaining ground in central and local governments and other institutions, many countries are still plagued by poor transparency and weak accountability (Mwazo, Weda, Omondi & Njenga, 2017). This is due to a closed-door budget process, weak accounting and reporting systems, ineffective audits and exclusion of civil society from dialogue (Mwazo et al., 2017). The past two decades have seen growing interest in

promoting public access to government budget information. Access to information on government budgets and financial activities is essential to ensuring that governments are accountable to their citizens. Timely access to such information enables citizen to participate in, and understand, policy decisions that have profound impacts on their daily lives. Given the different findings from the literature, it is important to establish the contribution of participatory budgeting and internal controls on service delivery performance in the Ugandan context specifically in Wakiso district.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0. Introduction

This section describes how the study was conducted and it focuses on the Research design, Target population, Sample size and selection, Sampling techniques and Procedures, Data sources, data collection methods, Data collection instruments, Reliability and validity, Measurement of variables, Ethical procedure, Data processing, Presentation and data analysis.

3.1 Research Design

The study followed a cross sectional survey (Amin, 2005). The researcher used a cross-sectional survey because it was effective when gathering data of a sample population at a particular point in time. The study used a quantitative approach. The study employed a descriptive and analytical research design to examine the relationship between variables. The unit of analysis was the selected health facilities and the unit of inquiry were the administrator or in charge at the healthy facility and community members preferably a local leader. The administrator at the health facilities were selected because they are the managers while community members are the direct beneficiaries of the services offered by the health facilities.

3.2 Study Population

The population of the study was constituted of the 67 public health facilities in Wakiso district (District health report, 2018/19). Wakiso district was selected because it has the highest population in Uganda with a high number of public health facilities yet the quality of health service delivery is still lacking (UBOS Survey, 2018).

3.3 Sample Size and sampling techniques

Out of the population of 67 public health facilities, 59 health facilities were selected using the Krejcie and Morgan sampling table 1970. Simple random sampling technique was used to select

the public health facilities. From within the health facility one respondent was selected and this was the in charge of the facility or the administrator. These respondents were selected using purposive sampling technique because they oversee the day to day operations of the facilities and are the key decision makers. From the community Two (2) respondents will be selected. These were selected using purposive sampling technique. Administrators/ in charge and community members constituted the unit of inquiry and the public health facilities were the unit of inquiry

3.4 Data Collection methods

Primary data source was used for this study. The researcher went to the field and collected the data using the appropriate instrument that was selected. Primary data was used since this was a new study to enable the researcher attain first-hand information.

3.5 Data collection instrument

The source of data was primary. Quantitative data was obtained through the use of self-administered questionnaire anchored on a five-point Likert-type scale ranging from 5(strongly agree) to 1(strongly disagree) Vagias, Wade. (2006). The scales were adopted since it is most recommended by the researchers that it would reduce the frustration level of respondents and increase response rate and response quality. Two data collection instruments were issued. One was for the in charge / administrator of the health facility and one for the community members. The respondents answered basing on the extent to which they agree or disagree with the statements in the questionnaire.

3.6 Measurement of variables

Each dimension was measured basing on the works of other scholars and were modified to match the Ugandan study context. Participatory budgeting was measured using citizen participation, resource allocation and transparency (Campbell et al, 2018). Internal Controls was measured using risk assessment, control environment, control activities, information and communication

and monitoring activities (Otieno and Kalenzi, 2019) and Service delivery performance was measured based on access to health services, sustainability of services, quality of services, accountability (WHO Report, 2019).

3.7 Reliability and Validity of instrument

Validity of the instrument was measured through seeking for views from experts both academicians and practitioners in the area of accounting and finance who assisted on the relevance of the scales in the instrument. A content validity index (CVI) of 0.7 will be established. Reliability of the items were done with the application of the Cronbach Coefficient Alpha for the computation to check for the internal consistency of the items that conform to a Cronbach Alpha Coefficient of

0.7++ were retained.

3.8 Data Processing and Analysis

Once data is collected through the questionnaire, it was edited, coded and entered into the computer software Statistical Package for Social Scientists (SPSS V.21). The researcher presented demographic characteristics using percentages. The researcher used correlation analysis to test the relationship between the variables and the dependent variable. Regression analysis was used to show the combined effect of the independent variables on the dependent variable.

3.9 Ethical Procedure

In order to ensure ethical research principles, the researcher obtained an introductory letter from Makerere University Business School and sought permission to undertake the research in Health facilities. Appointments were arranged to determine the proper time for questionnaires to be submitted and picked. The research instruments which were used to collect the data delivered

and collected by the researcher after being filled by the respondents. The research was purely academic and confidentiality and anonymity of the respondents will be strongly protected.

CHAPTER FOUR

PRESENTATION AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter presents analysis and interprets the study findings. It is divided into three sections. The first section presents the response rate; the second section presents analysis and interprets the results about the background information. The third section presents, analysis and interpretation of the results according to research objectives namely;

i. To establish the relationship between participatory budgeting and service delivery performance in selected public health facilities in Uganda ii. To examine the relationship between internal controls and service delivery performance in selected public health facilities in Uganda iii. To examine the contribution of participatory budgeting and internal controls on service delivery performance in selected public health facilities in Uganda

4.2 Demographic characteristics of the respondents

4.2.1 Response rate

Out of a targeted sample of 118 respondents from the community, only 92 provided information, giving a response rate of 78%. Out of the sample of 59 respondents from the public health facility staff, only 49 provided information giving a response rate of 83.1%. Details of the responses are presented in the subsequent tables.

Table 4.1. Showing demographic characteristics of the Community respondents

Variable	Category	Frequency	Percent
Gender	Male	39	42.4
	Female	53	57.6
	Total	92	100
Age of the respondent	Below 25	5	5.4
	26 – 35 years	54	58.7
	36-45 years	22	23.9
	46-55 years	8	8.7
	Above 56 years	3	3.3
	Total	92	100
Level of education	Secondary	9	9.8
	Tertiary	56	60.9
	Degree	27	29.3
	Total	92	100
Position in the community	Local Leader	29	28.3
	Community Member	66	71.7
	Total	92	100
How often do you visit the public health facility?	Never	12	13.0
	A few times a month	33	35.9
	A few times a year	25	27.2
	More often	22	23.9
	Total	92	100

Source: Primary data

Regarding the background characteristics of the respondents from the community, the table above indicates that majority of the respondents were female, out of the 92 respondents, 57.6% were female, while 42.4% males. This implies that female visit the public health facilities more than male. Regarding the age of the respondents 58.7% of the respondents were aged between 26-35 years, 23.9% were aged between 36-45 years while 8.7% of the respondents were aged between 46-55 years, 5.4% of respondents were below the age of 25 years, and the minority were aged above 56 years (3.3%). Majority of the respondents being in the age between 26 to 45 implies that they could be having families and responsibilities that would necessitate them to visit public health facilities. The results also indicate that the majority of the respondents had attained at least a

Tertiary level of education 60.9%, while 29.3%, of respondents had attained a bachelor's degree. This implies that researcher was able to get reliable and valid responses considering their education background. The table illustrates that 71.7% of the respondents were Community Member, and 28.3% were local leaders. The results also depict that 35.9% of respondents visit the public health facility a few times a month, 27.2% a few times a year, 23.9% more often and 13% never visits the public health facility in the community. This implies that majority of the respondents have at least visited the Public Health Facility.

Table 4.2. Showing demographic characteristics of the public health facility staff respondents

Variable	Category	Frequency	Percent
Gender	Male	25	51
	Female	24	49
	Total	49	100
Age of the respondent	Below 25	3	6.1
	26 – 35 years	26	53.1
	36-45 years	18	36.7
	46-55 years	2	4.1
	Total	49	100
Level of education	Degree	29	59.2
	Masters	20	40.8
	Total	49	100
Position in the health facility	In charge	24	49
	Administrator	25	51
	Total	49	100
How long have you worked at the health facility	Less than 5 years	28	57.1
	5-10 years	16	32.7
	More than 10 years	5	10.2
	Total	49	100

Source: Primary data

According to the findings, regarding the demographic characteristics of the public health facility staff, 51% of the respondents were male and 49% were female. This implies that there was no gender bias in the study. The study findings indicated that 53.1% of the respondents were 26-35 years, 36.7% were 36-45 years, 6.1% were below 25 years, and 4.1% were 46-55 years old. This indicates that respondents were mature enough to answer questions in the questionnaires. It was established that 59.2% had degree, and 40.8% had masters. This implies that the public health

staff are well trained and qualified. Regarding the position of the respondents, 51% of the respondents were administrators, while 49% were in charge of the health facilities. The results also showed that respondents who have worked for less than 5 years were 57.1%, 5-10 years had 32.7%, and more than 10 years had 10.2%. This implies that staff do not work for long in the same public health facilities.

4.3. Correlations analysis

A bi-variable Pearson correlation analysis was conducted in order to establish the relationship between the variables under study as summarized in table 4.3. Correlation analysis is important to establish the strength of the relationship between the variables under study. This analysis was particularly important in addressing the study objectives

Table 4.3 showing correlation analysis results

	1	2	3	4	5	6	7	8	9	10
1. Participatory Budgeting	1									
2. Citizen participation	.860**	1								
3. Transparency	.861**	.558**	1							
4. Resource allocation	.907**	.737**	.660**	1						
5. **Internal Controls**	**-.227**	**-.220**	**-.239**	**-.118**	**1**					
6. Risk Assessment	-.102**	-.183	-.012	-.071	.670	1				
7. Control environment	.567**	1	-.214	-.205	-.007	.828				
8. Information and communication	-.083	-.039	-.163	-.005	.860**	.416**	.582**	1		
9. Monitoring activities	-.334**	-.242	-.336	-.567	.754**	.172	.441**	.669**	1	
10. Service delivery performance	**.767****	**.589****	**.783****	**.624****	**-.268**	**-.077**	**-.246**	**-.231**	**-.266**	**1**

**. Correlation is significant at the 0.01 level (2-tailed)

4.3.1. Relationship between Participatory Budgeting and service delivery performance.

The results in table above further revealed that participatory budgeting and service delivery performance were positively and significantly correlated (r=.767**, p<.01). This implies that a unit change in participatory budgeting is likely to result to a 0.767 change in service delivery performance.

4.3.2. Relationship between internal controls and service delivery performance.

From the table above, findings show that there is a negative insignificant relationship between Internal Controls and Service Delivery Performance with a Spearman correlation coefficient ($r=0.268$, $p>0.05$). This implies that a unit change in Internal Controls is likely to cause a negative change of -0.268 in service delivery performance.

4.4. Regression Analysis

The Multiple Regression model was used to examine the predictive power of participatory budgeting, internal controls on service delivery improvement. The regression analysis results explained the variance in service delivery as a result of change in participatory budgeting and internal controls using coefficient of determination (r 2). The multiple regression analysis was used to combine the results from the two tools that were used to collect the data. The results of the regression analysis are presented in the table below:

Table 4.4 Showing Hierarchical Regression analysis results

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.886	.457		1.937	.059
	Participatory Budgeting	.759	.112	**.702**	6.764	**.000**
2	(Constant)	1.345	.753		1.787	.081
	Participatory Budgeting	1.182	.336	1.094	3.519	.001
	Citizen Participation	-.176	.195	-.184	-.900	.373
	Resource Allocation	-.263	.207	-.289	-1.272	.210
	Internal Controls	-.106	.122	**-.094**	-.870	**.389**
R=.702, R Square=.493, Adjusted R Square=.482, F=45.748, Sig=.000						

a. Dependent Variable: Service delivery performance

4.4.1. To examine the contribution of participatory budgeting and internal controls on service delivery performance in selected public health facilities in Uganda

The multiple regression model presented in table 4.4 indicates that Participatory Budgeting and Internal Controls combined predict 48.2% of the variance in Service delivery performance. (Adjusted R Square = .482). This means that there are other factors which explain the remaining 51.8 percent of the variance in service delivery. Adjusted R2 gives the idea of how well the regression model generalizes the study variables and ideally every researcher would like its value to be the same, or very close to the value of R2. But since R2 is very sensitive to sample size, the adjusted r2 was used as a better goodness of fit measurer (Field, 2009)

In this study it was found out that there is a shrinkage (loss of predictive power) of 1.1% (0.493-0.482=0.11) between R2 and Adjusted R2. Meaning that if the model was derived from the population rather than a sample it would account for approximately 1.1% less variance in service delivery. The results further confirmed that participatory budgeting is the only significant predictor of service delivery at 5% significance level or better. Thus, H1 was further supported, this is in agreement with the stakeholder theory which suggests that inclusion of stakeholder satisfy their needs and may result into improved service delivery performance. however internal controls were not a significant predictor of service delivery performance, hence H2 was not held. This implies that the resource best theory did not well explain the relationship between internal controls and service delivery performance.

Multiple regression Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	1.500	.732		2.048	.046
	Internal Controls	-.129	.120	-.114	-1.073	.289
	Participatory Budgeting	.731	.115	.676	6.353	.000
	R	.711				
	R Square	.506				
	Adjusted R Square	.484				
	F	23.524				
	Sig	.000				

a. Dependent Variable: Service delivery performance

The results in table 4.5 above show that the predictor variables explain at least 48.4% of the variance in Service delivery performance (Adjusted R Square = .484). The results further indicated that Internal Controls (Beta =. -114, Sig. = 0.289), was not a better predictor followed by Participatory Budgeting (Beta = .676, Sig. = .000 which was a better predictor. It means that a change in Internal Controls leads to -0.114 negative changes in Service delivery performance while Participatory Budgeting contributes 0.676 positive changes in Service delivery performance. The regression model was also observed to be significant (F= 23.524, Sig. <.01) and could thus be used to reliably make recommendations in selected public health facilities in Uganda.

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This Chapter presents discussions of the study findings and recommendations for further research based on the study. The chapter then draws conclusions from the research objectives and provides recommendations for improvement as well as future studies. The study was guided by the following objectives;

i. To establish the relationship between participatory budgeting and service delivery performance in selected public health facilities in Uganda
ii. To examine the relationship between internal controls and service delivery performance in selected public health facilities in Uganda
iii. To examine the contribution of participatory budgeting and internal controls on service delivery performance in selected public health facilities in Uganda

5.2. Discussion of findings

The study focused on the relationship between participatory budgeting and service delivery, internal controls and service delivery and the contribution of participatory budgeting and internal controls on service delivery performance as discussed below;

5.2.1. The relationship between participatory Budgeting and service delivery performance

The study revealed that there is a significant positive relationship between participatory budgeting and service delivery performance. It indicates that if citizens participate in the budgetary process, take part in resource allocation and ensure transparency, the level of service delivery performance will improve. These findings are in agreement with the works of Mansuri & Rao, (2017) who observed that the purpose of participatory programs is to enhance the involvement of the poor and the marginalized in community-level decision-making in order to

give citizens greater say in decisions affecting their lives. Tembo, (2017) also agreed that Local participation is viewed as a way to achieve a variety of goals, including improved poverty and benefits targeting, building community-level social capital, increasing the demand for good governance which we infer will result into improved service delivery.

5.2.2. The relationship between internal controls and service delivery performance

The study revealed that there is an insignificant negative relationship between internal controls and service delivery performance. This implies that regardless of the nature of internal controls, the impact on service delivery is very insignificant and may not be realized. The findings are contrary to the reports from MoH, (2017) where it was observed that effective internal control system can not only guarantee the safety of health facilities' assets, improve the efficiency of health facilities' management and operation, but also improve the quality of services offered and ensure the advantages of health facilities in the communities.

5.2.3. To examine the contribution of participatory budgeting and internal controls on service delivery performance in selected public health facilities in Uganda

Regarding the contribution of participatory budgeting and internal controls on service delivery performance, the study indicated that both participatory budgeting and internal controls combined have a positive contribution to service delivery performance. However, participatory budgeting contributes significantly while internal controls have an insignificant contribution. These findings are in agreement with studies of Kewo (2017) who stated that budget participation has several benefits, namely: 1) can reduce a person's pressure in making a budget; 2) can strengthen relations and cooperation between members in a group to achieve goals; 3) can reduce unfairness between parts of an organization in allocating resources. The findings also contradict with the works of Abata and Mathew (2018) who stated that there is a positive but weak relationship between participatory budgeting and service delivery performance in Nigeria.

5.3. Conclusion

From the study which was guided by three objectives which included to establish the relationship between participatory budgeting and service delivery performance in public health facilities, examining the relationship between internal controls and service delivery performance and the combined contribution of participatory budgeting and internal controls towards service delivery performance, it was clearly observed that participatory budgeting has a positive correlation with service delivery. Therefore, Participatory budgeting ensures that citizen participation, resource allocation and transparency in service delivery performance. It was further noted that internal controls has a negative correlation with service delivery performance. Therefore, while internal controls play a role of risk assessment, control environment, information and communication and monitoring activities, their contribution to service delivery improvement remains insignificant. It was however observed that when combined participatory budgeting and internal controls contribute to service delivery performance by less than 50% implying that there are other factors affecting service delivery performance in public health facilities.

5.4. Recommendations

In light of the research findings, the following recommendations are made;

i. To improve service delivery performance in public health facilities, it's important to ensure an effective participatory budgeting process is done through consultations and involvement of the communities in identifying priority service delivery areas. Therefore, government need to design policies that ensure the involvement and participation of local communities in the budgeting process.

ii. Citizens need to be sensitized on how public health facilities operate and the level of service delivery expected. This makes staff in the public health facilities accountable to the communities they serve. Therefore, the Ministry of health should organize

sensitization outreach activities to ensure citizen involvement in public health facilities activities.

iii. Participatory budgeting and Internal Controls combined contribute 48.2% towards the improvement of service delivery. Therefore, other factors other than participatory budgeting and Internal controls contribute 51.2% and should be identified and considered to improve service delivery performance.

iv. The administrators in Public health facilities need to design and implement community engagement programs to enable community members to contribute towards the improvement of service delivery performance in these public health facilities.

5.5. Limitations of the study

The study was conducted during the time of the Covid-19 pandemic which made it difficult to find the officers/ respondents in their offices. This was however managed by identifying the respondents and scheduling appointments with them

The study was limited to public health facilities in Wakiso district yet public health facilities are spread across the country. Despite the stated limitations above I was able to conduct the study and get the appropriate evidence.

5.6. Areas for further studies

Further studies need to focus on the effectiveness of the internal control in government institutions.

Further studies should establish the level of participatory budgeting in government institutions.

Further studies should be carried out using different variables other than participatory budgeting and internal controls to establish their relationship with service delivery performance in public health facilities.

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APPENDICIES

Appendix 1

QUESTIONNAIRE FOR PUBLIC HEALTH FACILITY STAFF

PARTICIPATORY BUDGETING, INTERNAL CONTROLS AND SERVICE DELIVERY

PERFORMANCE IN PUBLIC HEALTH FACILITIES

Dear respondent,

I am a student pursuing a Masters of Business Administration of Makerere University Business School. My study is on participatory budgeting, internal controls and service delivery performance in public health facilities. You have been identified as a respondent, and I therefore request you to kindly spare a few minutes of your busy time to fill this questionnaire. This study is purely for an academic research. Your honest answer and sincere responses are highly appreciated and shall be treated with outmost confidentiality.

Section A

1) Gender: Male ☐ Female ☐

2) Age of the respondent

Below 25years ☐ 26-35years ☐ 36-45years ☐ 46-55years ☐ above 56years ☐

3) Level of education attained:

Degree level ☐ Masters ☐ Others specify…….

4) Position in the health facility

In charge ☐ Administrator

5) How long have you worked at the health facility

Less than 5 years ☐ 5-10 years ☐ More than 10 years ☐

SECTION B

For the statements below, please rate the extent of your agreement or disagreement with each by ticking one of the options provided

Degrees: 5. Strongly Agree, 4. Agree, 3. Not Sure, 2. Disagree, 1. Strongly disagree

C	**Internal Controls**	**SA**	**A**	**NS**	**D**	**SD**
	Risk Assessment					
C1	There is a well-established internal control system at all health facilities	5	4	3	2	1
C2	All the health facilities assets are safe guarded against all risks	5	4	3	2	1
C3	There is a well-established inventory management system to safe guard drugs	5	4	3	2	1
C4	There is a well-established risk register at all health facilities	5	4	3	2	1
C5	There are systems to check the professionalism of the health workers at the health facilities	5	4	3	2	1

C6	Risk assessment exercise is often conducted to identify new risks	5	4	3	2	1
C7	Risk evaluation is an ongoing activity at all health facilities	5	4	3	2	1
	Control Environment					
C8	There are clear guidelines that patients follow to access health facility services each time they visit the health centers	5	4	3	2	1
C9	The health workers adhere to ethical values of their profession	5	4	3	2	1
C10	The local leaders play an oversight role to ensure that the locals access quality services	5	4	3	2	1
C11	There is a clear organizational structure at each health facility	5	4	3	2	1

C12	There is clear assignment of responsibilities among the staff at the health facilities	5	4	3	2	1
C13	Health workers perform their role with commitment to competence	5	4	3	2	1
C14	There clear human resource polices that are followed at all public health facilities	5	4	3	2	1

	Information and Communication					
C15	Necessary information is always shared on the notice boards at the health facilities	5	4	3	2	1
C16	The information needs of all the people visiting the health facilities are well understood	5	4	3	2	1
C17	There exists an information system at the public health facilities used by the health workers	5	4	3	2	1
C18	The existing information systems are very effective	5	4	3	2	1
C19	There is effective communication within the health facilities	5	4	3	2	1
C20	There is good communication between the health facility staff with the general public	5	4	3	2	1
C21	Information at the health facilities is well controlled	5	4	3	2	1
	Monitoring activities					
C22	Monitoring of activities at the health facilities is an ongoing activity	5	4	3	2	1
C23	The community carries out separate evaluations of the health facility activities	5	4	3	2	1

C24	Performance evaluations of the health facility staff are regularly conducted	5	4	3	2	1
C25	Deficiencies in performance are always reported to the concerned authorities	5	4	3	2	1
C26	There are checks at all health facilities to ensure that health workers report to work as required	5	4	3	2	1
	Service delivery performance					
	Accessibility of health services					
D1	Community members can access a public health facility within a distance of 5 kilo meters	5	4	3	2	1
D2	Patients can access any kind of medication from the public health facility near by	5	4	3	2	1
D3	Health workers are always available to attend to the patients	5	4	3	2	1
	Sustainability					
D4	There is a good relationship between the health workers at the public health facilities and the local communities	5	4	3	2	1
D5	The wage bill provision caters for all the existing health workers	5	4	3	2	1
D6	There are village health teams that support the locals in the communities	5	4	3	2	1

	Quality of services					
D7	Our public health facility offers services that are comparable with services offered in the private health facilities	5	4	3	2	1
D8	Our public health facility has well trained qualified health workers	5	4	3	2	1
D9	The health facility offers quality treatment services	5	4	3	2	1
	Accountability					
D10	Health services are responsive to locals needs	5	4	3	2	1
D11	The health facility staff are always accountable to the community	5	4	3	2	1
D12	Health facility reports are published on the notice boards for the community to access	5	4	3	2	1

THANK YOU VERY MUCH

Appendix 2

QUESTIONNAIRE FOR LOCAL COMMUNITY MEMBERS

PARTICIPATORY BUDGETING, INTERNAL CONTROLS AND SERVICE DELIVERY PERFORMANCE IN PUBLIC HEALTH FACILITIES

Dear respondent,

I am a student pursuing a Masters of Business Administration of Makerere University Business School. My study is on participatory budgeting, internal controls and service delivery performance in public health facilities. You have been identified as a respondent, and I therefore request you to kindly spare a few minutes of your busy time to fill this questionnaire. This study is purely for an academic research. Your honest answer and sincere responses are highly appreciated and shall be treated with outmost confidentiality.

Section A

1) Gender: Male ☐ Female ☐

2) Age of the respondent

Below 25years ☐ 26-35years ☐ 36-45years ☐ 46-55years ☐ above 56years ☐

3) Level of education attained:

Secondary level ☐ Tertiary level ☐ Degree level ☐ Masters ☐

Others specify…….

4) Position in the community;

Local leader ☐ Community Member

5) How often do you visit the public health facility in your community?

Never ☐ A few times a month ☐ A few times a year ☐ More Often ☐

SECTION B For the statements below, please rate the extent of your agreement or disagreement with each by ticking one of the options provided Degrees: 5. Strongly Agree, 4. Agree, 3. Not Sure, 2. Disagree, 1. Strongly disagree

	Participatory Budgeting	**SA**	**A**	**NS**	**D**	**SD**
	Citizen Participation					
B1.	The local are always involved in identifying the requirements of the health facilities in their areas	5	4	3	2	1
B2.	The locals have influence on the budget allocations for their health facilities	5	4	3	2	1
B3.	The locals are always consulted during the budgeting cycle to ensure that they have an input in the health center budgets	5	4	3	2	1
B4.	Community members are well knowledgeable about public affairs	5	4	3	2	1
B5.	Community members are empowered to negotiate for priority areas during the budgeting process	5	4	3	2	1
B6	The locals are always informed on the resources that have been associated to their health centers	5	4	3	2	1
B7	The locals are always informed on the plans of their health facilities	5	4	3	2	1
	Resource Allocation					
B8	The local leaders play a role in ensuring that community health needs are given priority while budgeting	5	4	3	2	1
B9	Resources in health facilities are allocated with consultation from citizens	5	4	3	2	1
B10	Citizens identify the priority areas where the resources should be allocated	5	4	3	2	1
B11	Community members take part in deciding how the resources should be utilized efficiently	5	4	3	2	1
B12	Resources allocated to health facilities are always increasing with a focus of improving the quality of services offered	5	4	3	2	1

B13	Budget allocations to health facilities is based on the population served by the health facilities	5	4	3	2	1
	Transparency					
B14	The public plays a role in reducing inefficiencies of health workers	5	4	3	2	1
B15	The Citizens are working so hard to ensure that they fight corruption in health facilities	5	4	3	2	1
B16	The community members are well informed of the resources allocated to the health facilities in their areas	5	4	3	2	1
B17	The public ensures that they monitor the use of resources allocated to the health facility	5	4	3	2	1
B18	The community is vigilant to identify health officers who misuse the health facility resources	5	4	3	2	1
	Service delivery performance					
	Accessibility of health services					
D1	Community members can access a public health facility within a distance of 5 kilo meters	5	4	3	2	1
D2	Patients can access any kind of medication from the public health facility near by	5	4	3	2	1
D3	Health workers are always available to attend to the patients	5	4	3	2	1
	Sustainability					
D4	There is a good relationship between the health workers at the public health facilities and the local communities	5	4	3	2	1
D5	The wage bill provision caters for all the existing health workers	5	4	3	2	1

D6	There are village health teams that support the locals in the communities	5	4	3	2	1
	Quality of services					
D7	Our public health facility offers services that are comparable with services offered in the private health facilities	5	4	3	2	1
D8	Our public health facility has well trained qualified health workers	5	4	3	2	1
D9	The health facility offers quality treatment services	5	4	3	2	1
	Accountability					
D10	Health services are responsive to locals needs	5	4	3	2	1
D11	The health facility staff are always accountable to the community	5	4	3	2	1
D12	Health facility reports are published on the notice boards for the community to access	5	4	3	2	1

THANK YOU VERY MUCH