CORRUPTION AND HEALTH CARE SERVICE DELIVERY IN BUVUMA DISTRICT, UGANDA

By

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MARCH, 2019

DECLARATION

I hereby declare to the best of my knowledge that this research report has been prepared as a result of my own effort and that it has never been submitted to any other institution of higher learning before for academic award.

Sign: ..... Date: 04-04-2024.

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APPROVAL

I hereby confirm under my signature that I was personally involved in supervising this project research and therefore it is his original effort.

Signature: ..... Date: 09-04-2019

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I thank the almighty God for the gift of my life and for having brought me thus this far to enable me accomplish this research project.

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DEDICATION

I dedicate this research project to my beloved parents, brothers and my only sister who have been so supportive and guided me to fulfil my dreams.

Thank you for your courageous words and your prayers, which taught me to live a blessed life.

LIST OF ACRONYMS

CHSS	College of Humanities and Social Sciences
GHF	Global Health Fund
NPM	New Public Management
SPSS	Statistical Package for Social Scientists
UMSR	Uganda Medical Survey Report
USAID	United States Agency for International Development

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ABSTRACT

The study investigated corruption and health care service delivery in Buvuma district, Uganda, it was guided by the following objectives, To assess perceptions of corruption in process of receiving health services, To determine factors driving corruption in health service delivery in Buvuma District, To assess the quality or levels of health service delivery in Buvuma District and To examine the relationship between corruption and health service delivery in Buvuma District. This study employed a cross-sectional research design. The study population was 71 respondents who were chosen from the leadership structure of Buvuma District and directly mandated to manage health care service delivery who will include, Health departmental leaders, staff civil society organizations, youth groups and community based organization. A sample size of (60 people) was selected from the study population of (71) respondents using Krejcie & Morgan, (1970). The study made the following Conclusions, It is apparent that most local government authorities are not functional. With the exception of few local governments in the country, others are mere shadow of themselves. Monitoring systems specifically looked for evidence of overcharging, informal payment, ghost patients, and inflation of statistics, and used this information to address specific problems and make systematic changes. Fighting corruption is a complex undertaking, but there are things policy makers and citizens can do to prevent corruption. These corruption types can be prevalent in both high-income and low-and middle-income countries. Regulators in all health systems must implement measures to minimise the risks of prevalent types of corruption in healthcare service delivery. The study recommended that the local governments in Uganda should be scrapped. The circumstance that has characterized poor service delivery at the grass root in Nigeria has been a colossal tales of one corrupt case to the other. The Financial Crime regulatory institutions should conclude all the outstanding financial fraud cases on the past district bosses that are all over the courts in Buvuma district. This would help to some extent serve as a guide to upcoming politicians whom would be at the helms of affairs. Stringent measures should be taken to deal with corrupt health workers who are caught in one corrupt act or the other so that they can serve as deterrence to other potential perpetrators in the health sector. Avenues within the public hospitals that encourage corruptions should be curbed by making sure that receipts are issued and payments made at the appropriate quarters.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter includes background to the study, the problem statement, the purpose of the study, research objectives, the research questions, the scope and the significance of the study and definition of key terms.

1.1 Background to the study

1.1.1 Historical perspective

Among the many challenges facing public service institutions in developing countries, corruption remains one of the most pervasive and the least confronted. Historically, donor agencies and their clients accepted the inevitability of corruption in public service delivery; it was at worst a necessary evil and at best the ''grease'' essential to move the wheels of economic development (Lui, 1985). In recent years, however, consensus has emerged that corruption is a central challenge to equitable and sustainable development. A growing body of research suggests that corruption and rent-seeking shrink the range of opportunities available to developing countries as investments become less productive, the cost of capital increases, and private investment, foreign direct investment, and foreign aid all decline (Mauro, 1995; Tanzi & Davoodi, 1997; Wei, 1999). Donors are increasingly sponsoring research on corruption (including in their own projects), and many have created units dedicated to providing assistance to developing countries for assessing and responding to corruption-related problems. Anticorruption programs sponsored by development agencies emphasize macro-level initiatives such as economic and sector policy reforms (e.g., liberalizing trade and reducing subsidies) and transformation of critical institutions such as the judiciary (Kaufmann, 2005; Huther and Shah, 2000; Reinikka and Svensson, 2005). Large-scale reforms are, of course, critical in reducing corruption, but they also require time and considerable political will to implement (DiIulio, Garvey, & Kettl, 1993). Much of the anti corruption advice at the organizational level, however, implicitly assumes that a backdrop of such macro-reforms is in place. The result is a set of recommendations drawn from ''New Public Management (NPM)'' tenets that are generally infeasible in the highly constrained institutional environment of many developing countries (Hood, 1991).

In Africa, eradicating corruption has been a major concern of successive government in the country because of its negative impact on good governance and effective service delivery. According to Adamu (2007), corruption exists in one form or the order in all societies. The major difference in the case of Africa is the extent of its pervasiveness and its implication for good governance, its value system and political culture in particular. Adamu (2007), an average African has accepted corruption as inevitable and uncontrollable, believing that the society as a whole is corrupt and beyond remedy.

In Uganda, Corruption is the greatest evil in ethics and public management. (Pellegrini & Gerlagh, 2007) Uganda's Corruption in health became legendary when some Government Officials stole funds from the Global Health Fund (GHF). Uganda Medical Survey Report (UMSR) (2004) found the median availability of the essential medicine surveyed to be 55% at the public sector facilities. The health service sector is rated the second most corrupt institution in Uganda (Deininger and Mpuga, 2005).The research still shows that corruption in health service delivery in local governments, especially in Buvuma District , a semi-urban area of Buvuma district persists unabated at an alarming rate (Hunt, 2010). For instance, the Ministry of Health in 1998 started a new policy to promote Decentralization of health. This was in reference to the New Constitution (1995) where the Local Government act was later enacted in 1997 (Yerindabo, 2010).

1.1.2 Theoretical perspective

The study is based on Principal-Agent theory adopted from Batley (2004:38). The adoption of theoretical framework in the management and social sciences greatly helps in the analysis and even understanding of concepts from some theoretical point of view and/or orientation. Therefore, the theoretical framework of analysis adopted in this study is the Principal-Agent theory. The Principal-Agent theory adopted from Batley (2004:38) examines organisational relationships as a tension between the "Principal" who demands a service and the "Agent" who provides it. The model assumes that actors are motivated by rational self interest. The issue in connection with this paper is how the Principal (in this case, the Nigerian citizens) can manage the self interest of those empowered to act on their behalf (i.e. the Agents: government officials, politicians, legislators, bureaucrats etc) so that it is aligned with the purposes that they (the Principal) wish to achieve.

The problem arises not just from conflict of interest but also from the privileged access of the agents to information- the problem of asymmetric information. The agents who have been employed to provide a service will tend to use their superior knowledge to divert benefits in their own direction.

Hague (1996) here asserts that Public Administration itself is susceptible to corruption, since officials exercise a substantial amount of power. There are possibilities for acquiring improper benefits by interpreting or bending rules in favour of certain groups or individuals. All government seek to have in place a number of safeguards for deterring and dealing with corruption within administrative agencies. At the same time, Public Administration has to develop ways and means to prevent and detect corruption in other section of society. Much of the benefit of rapid economic growth or a stable political order may be lost in the growing tide of corruption.

In a democratic polity, the ultimate Principals are the citizens who are the consumers of specific services provided by the government. In the Principal -Agent theory, they are Principal in the sense that politicians as Agents seek their mandate from and act as the representatives of the public. In their turn, appointed officials (Public Servants) are in theory, the agents of political leaders in executing the programmes and policies of the government. Each of these players has a measure of autonomy and their own interests to advance.

The likelihood of the Principal effectively controlling the Agent depends on how much information the Principal has about the performance of the Agent, and how far the Principal can structure the relationship so as to control the Agent or give incentives so as to make the Agents' interest correspond to the Principals.

1.1.3 Conceptual perspective

The concept of corruption can be seen from various perspectives and depends on how it is being perpetuated or practiced. According to Adisa (2003) corruption or corrupt practices has to do with fraudulent activities especially siphoning of funds that are meant for the general populace for ones aggrandisement only. In line with this, Osoba (1996) defines corruption as an anti-social behaviour conferring improper benefits contrary to legal and moral norms and which undermines the authority's ability to improve the living condition of the people. A concise definition is given by USAID (2003:3) that corruption is the misuse of entrusted

power for private gain. Operationally, corruption is a selfish and dishonest act that deprives a vast majority (apart from the perpetrators and their cohorts) of desire benefits i.e. social, economic, political, and other legitimate benefits.

Operation definition of corruption has emphasis on personal interest as against the public interest/good. The Principal -Agent theory thus will help in espousing how the perpetration of this selfish interest has affected the ability of the Agent (government, bureaucracy) in providing the necessary services to the consumers (i.e. Principals/Public), in an effective and efficient manner, in the right quantity and quality, in the right place and as at when necessary. Thus, corruption is looked at here from the political and bureaucratic perspective. Political corruption occurs at the highest level of political authority amongst politicians and political decision makers, who are entitle to formulate, establish and implement the laws in the name of the people.

These people thus make and formulate policies and legislated laws that are intended to benefit themselves. It is characterised by greed because it affects the manner in which decisions are made, as it manipulate political institutions, rules of procedure and distorts the institutions of government. The bureaucratic corruption on the other hand, occurs in the Public Administration or the implementation end of politics. In Uganda, this type of corruption occurs daily in places like the hospitals, schools, local licensing offices, police, and tax offices etc where citizens must have to offer bribes to access what they are legally entitled to.

Service delivery implies tangible and intangible goods and services provided by the government in order to improve the well being of the citizenry. Carlson et al., (2005) conceptualised service delivery as the relationship between policy makers, service providers and poor people. According to Carlson et al., (2005), service delivery encompasses services and their supporting systems that are typically regarded as a state responsibility. These include social services (primary education and basic health services), infrastructure (water, sanitation, roads and bridges) and services that promote personal security (justice, police etc).

In Uganda, government constitutes the major service provider through the Public Service. The Public Service refers to all organisations that exist as part of government machinery for

implementing policy decisions and delivering services that are of value to the citizens. It is a mandatory institution of the state under the 1999 Constitution of Uganda. (Yerindabo, 2010)

1.1.4 Contextual perspective

Is one of urban centres in Buvuma district, and its service delivery in terms of health is corrupted. This is indicated by many health officials requesting for tea to attend to some ones patient. The majority of people in Buvuma, district, live in rural areas and are dependent on the public health system. A big proportion of the population lives below the poverty line with 31.1% (2006) of population living in absolute poverty, this means that many people can not afford private medical services and therefore require free medical services provided by Governmental.(GoU, 2017) User-charges abolished in 2001 in all government health facilities in Uganda.

The health sector in Buvuma, district, unfortunately suffers from high level corruption.(MoH Uganda Annual Report, 2017) This has implications for the health of the citizens especially the poorest citizens. The evidence on the link between institutions and heath has largely relied on analyzing the cross-country relationships between corruption and health outcome measures. Evidence from 89 countries including Uganda for 2016 and 2017 show corruption indicators negatively associated with child and infant mortality, the likelihood of unattended birth, immunization coverage and low birth weight. A research undertaken in Uganda on the link between leakages of drugs and health outcomes has likewise demonstrated the negative implications of drug leakages on the quality and accessibility of care in public health facilities. People are not using the health care facilities when medicine is not available. This has prompted the research to conduct a study.

1.2 Statement of the problem

Buvuma district has a total of 10 Health Centres which include one Health Centre IV, six Grade Three Centres and a number of clinics a number of these have been abandoned following the resignation of 20 medical workers from the district. They are Buvuma Health Center IV, Busamuzi, Bugaya and Namatare Health Centre III, Buwoya, Lwajje, Nkata, Lubya Bweema and Lingira health center II. Health Center IVs attends to about 130 – 160, Health Center III attent to about 80 – 100 patients a day, Health Center II attend to 40 – 70 patients a day. These Health Centers to a greater extent have not been performing to their expectations due to lack of enough facilities like medical personnel and availability of drugs.

Though anti-corruption programs have been established to improve service delivery, the performance of the public service is still low (Reinikka and Svensson, 2005).The health sector in Buvuma , district, unfortunately suffers from high level corruption and this is basically indicated by different health employees asking for bribes, kickbacks, theft (for personal use) or diversion (for private sector resale) of drugs/supplies at storage and distribution points, sale of drugs or supplies that were supposed to be free and unnecessary referrals to private practice or privately owned ancillary services. In 2016 there were a number of cases which were cited in Buvuma health centres where medical personnel's steal medical equipments and take them to their private clinics (New vision, 16, 2016).therefore It is upon this that the researcher has been prompted to conduct a study on corruption and service delivery.

1.3 Purpose of the study

The purpose of the study was to investigate the effect of Corruption on Health Service Delivery in Local Governments in Buvuma District.

1.4 Research objectives

(i) To assess perceptions of corruption in process of receiving health services

(ii) To determine factors driving corruption in health service delivery in Buvuma District

(iii)To assess the quality or levels of health service delivery in Buvuma District

(iv)To examine the relationship between corruption and health service delivery in Buvuma District.

1.5 Research questions

(i) What is the perceptions of corruption in in process of receiving health services?

(ii) What is the factors driving corruption in health service delivery in Buvuma District?

(iii)What is the quality or levels of health service delivery in Buvuma District?

(iv)What is the relationship between corruption and health service delivery in Buvuma District?

1.6 Scope of study

1.6.1 Geographical scope

The study was carried out in Buvuma district, Uganda. found in Lake victoria situated 15 kilometers from the district head quarters. It's neighbored by Mayuge district, Jinja, Buikwe

and Kalangala The selection of this area was based on the following reasons; is faced with a lot of problems of health due to corruption. Many people have died as a result of lack access to health services and also the few hospitals which are there are located far, besides that there are no ambulances to transport the patients to the health centers for them to get better treatment.

1.6.2 Content scope

In terms of content, the study will focus on service users' perceptions of corruption and factors driving corruption in health service delivery in Buvuma District, quality or levels of health service delivery in and relationship between corruption and health service delivery in Buvuma District .

1.6.3 Time scope

The study period will be from 2012 to 2017 because this is the period when there was high cases of corruption in Buvuma District. This period will generate rich information to be used by all stakeholders in corruption and health care service delivery in Buvuma District Uganda. This study will be conducted from June 2018 to September, 2018

1.7 Significance of the study

The aim of this study will be to determine the relationship between corruption and health service delivery in local governments in Buvuma District. This research work is useful to researchers, public policy makers and analysts, students, health workers, NGO's and civil societies interested in curbing corruption.

The study may help the community in Buvuma District to identify better Corruption prevention measures and improve health care service delivery. As it will teach them means and methods of adopting modern technologies of curbing corruption in the district.

The study may help policy makers to design workable solutions to better health care service delivery following the results to bridge the gaps in the existing legal structures.

The study will also add value to the existing body of knowledge by stimulating new areas for further research through the findings and subsequent recommendations for corruption and health care service delivery.

1.8 Operational definition of key terms

Corruption:

Corruption is a form of dishonesty or criminal activity undertaken by a person or organization entrusted with a position of authority, often to acquire illicit benefit. Corruption may include many activities including bribery and embezzlement, though it may also involve practices that are legal in many countries. Political corruption occurs when an office-holder or other governmental employee acts in an official capacity for personal gain.

Service Delivery, Service here implies tangible and intangible goods and services provided by the government in order to improve the well being of the citizenry. is a set of principles, standards, policies and constraints to be used to guide the designs, development, deployment, operation and retirement of services delivered by a service provider with a view to offering a consistent service experience to a specific user community in a specific business context.

Kickbacks: Money paid illegally to someone for a service meant to be free

Health care

healthcare is the maintenance or improvement of health via the prevention, diagnosis, and treatment of disease, illness, injury, and other physical and mental impairments in human beings. ... Physicians and physician associates are a part of these health professionals.

CHAPTER TWO
LITERATURE REVIEW

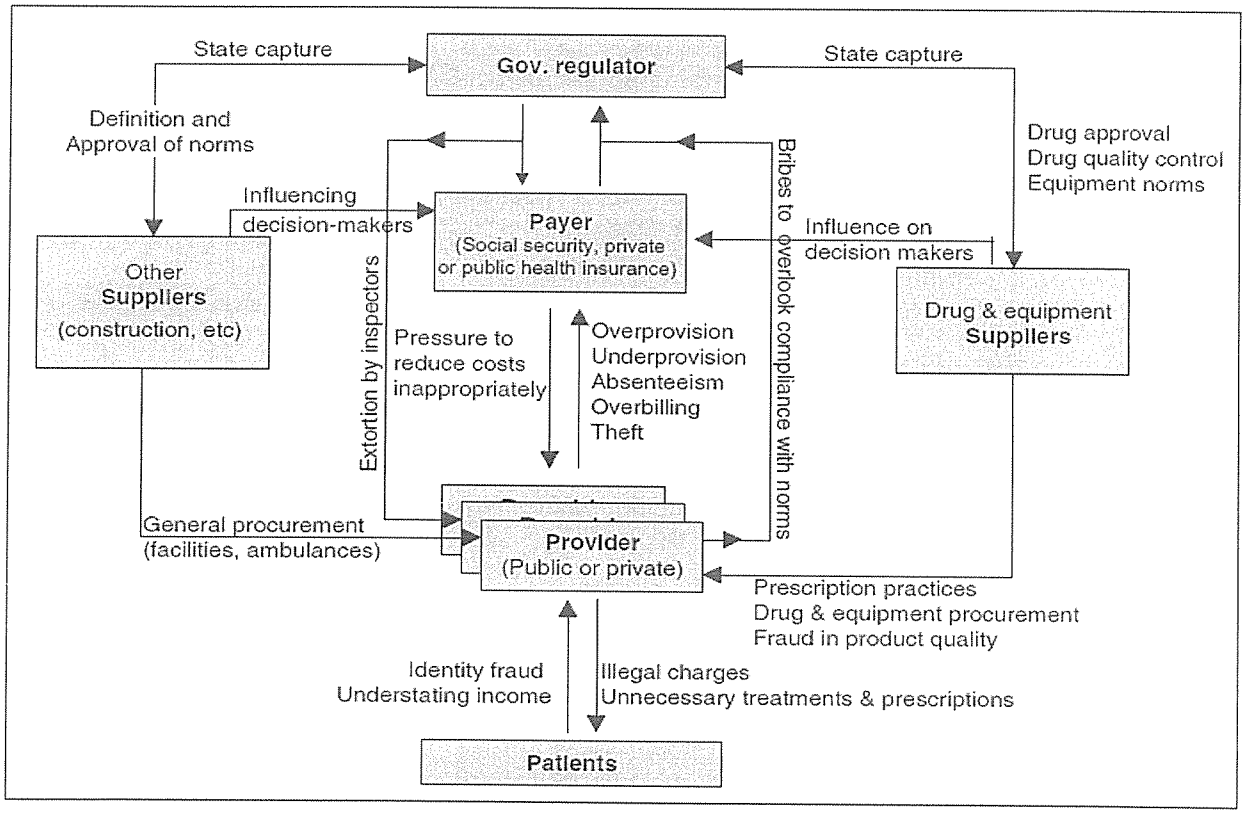
2.0 Introduction

This chapter will present different subjects that include concept of corruption, theoretical review, conceptual framework, service delivery and forms/manifestations of corruption.

2.1 Corruption

According to Transparency International (2006) corruption is defined as 'misuse of entrusted power for private gain', corruption occurs when public officials who have been given the authority to carry out goals which further the public good, instead use their position and power to benefit themselves and others close to them. Corruption in the health sector may be viewed by examining the roles and relationships among the different players to identify potential abuses that are likely to occur (Ensor and Antonio, 2002; Savedoff, 2006). Such an organizational view is shown in Figure 2.1.

Figure 2.1: Roles and relationships among the different players



Source: Savedoff and Hussmann, 2006.

Risks of corruption in the health sector are uniquely influenced by several organizational factors. As Savedoff (2006) explains, the health sector is particularly vulnerable to corruption

due to: uncertainty surrounding the demand for services (who will fall ill, when, and what will they need); many dispersed actors including regulators, payers, providers, consumers and suppliers interacting in complex ways; and asymmetric information among the different actors, making it difficult to identify and control for diverging interests. In addition, the health care sector is unusual in the extent to which private providers are entrusted with important public roles, and the large amount of public money allocated to health spending in many countries (Savedoff, 2006).

Expensive hospital construction, high tech equipment and the increasing arsenal of drugs needed for treatment, combined with a powerful market of vendors and pharmaceutical companies, present risks of bribery and conflict of interest in the health sector (Lantham, 2001; Kassirer, 2006). Government officials use discretion to license and accredit health facilities, providers, services and products, opening risk of abuse of power and use of resources. The patient-provider relationship is also marked by risks stemming from imbalances in information and inelastic demand for services. Resulting corruption problems include, among others, inappropriate ordering of tests and procedures to increase financial gain; under-the-table payments for care; absenteeism; and use of government resources for private practice (Di Tella and Savedoff, 2001).

It must be noted that definitions of corruption will vary by country and even within areas of a country (Werner, 2000). Often there is not a clear line between bribe and gift, and some forms of reciprocity which are seen as normal in one country will be illegal in another (Gaal and McKee,2005). An area where this is especially apparent is informal payments, or unofficial payments given to medical personnel for services that are supposed to be provided free of charge at the point of delivery. Recent research has explored this problem in some detail (Lewis, 2002; Allin*et al.,* 2006; Lewis, 2007; Tatar *et al.,* 2007).

2.1.1 Factors influencing corruption

According to economic theory, officials weigh the costs and benefits of acting corruptly against the costs and benefits of acting with integrity, and choose to act in the way that maximizes their self-interest (Jaen and Paravisini, 2001). Opportunities for corruption are greater in situations where the government agent has *monopoly power* over clients; officials have a great deal of *discretion*, or autonomous authority to make decisions, without adequate

control on that discretion; and there is not enough *accountability* for decisions or results (Klitgaard, 1988).

Monopoly creates opportunities for corruption by limiting the ability of citizens to choose other providers of services. If the government is the only provider offering medical services, for example, patients could be compelled to pay bribes to access those services. General strategies to reduce monopoly include health reforms to separate payer and provider, privatization or contracting of services with many providers, and increasing the number of government agents providing particular services (Klitgaard*et al.*, 2000). In one of the few studies that has tested the relationship between monopoly and corruption in the health sector, researchers in Bolivia found that the existence of alternatives to government services (competition) was associated with lower informal payments (Gray-Molina *et al.*, 2001).

Discretion refers to the autonomous power of a government official to make decisions, such as hiring staff or deciding what medicines are needed and in what quantities to procure them. Clinical care providers also exercise discretion by making decisions about the amount and types of health care services a patient should have. High amounts of discretion without adequate controls can create opportunities for corruption. For example, a department head can choose to hire an unqualified relative, or a procurement agent can decide to procure a new, high priced drug in quantities that greatly exceed need, in order to obtain a promised kickback. The goal of anti-corruption strategies is to increase appropriate control on discretion without creating dysfunctional bureaucracy. Strategies can include dividing tasks between individuals to create checks and balances; clarifying the decision-making process through standard operating policies and procedures; and strengthening information systems such as personnel management, drug inventory control and internal financial control systems. To control discretion in drug warehouses, for example, one South African distribution agency strictly segregates duties for order fulfilment, order checking and transport; staff working in each area have access only to the information needed to fulfil their own task, thus minimizing chances for collusion and drug diversion (Vian, 2006).

Reforms to improve control on discretion may not be possible if there are so few health workers available that tasks cannot be separated and there is no time for control, and it is of limited use when there is extensive collusion among health workers at different levels in the hierarchy.

Accountability is government's obligation to demonstrate effectiveness in carrying out goals and producing the types of services that the public wants and needs (Segal and Summers, 2002). Lack of accountability creates opportunities for corruption. Brinkerhoff (2004) identifies three key components of accountability, including the measurement of goals and results, the justification or explanation of those results to internal or external monitors, and punishment or sanctions for non-performance or corrupt behaviour. Strategies to help increase accountability include information systems which measure how inputs are used to produce outputs; watchdog organizations, health boards or other civic organizations to demand explanation of results; performance incentives to reward good performance; and sanctions for poor performance. In South Africa, a district health planning and reporting system was used to improve management control and hold government agents accountable for their decisions. By combining financial and service data, the reporting system drew attention to clinics and programmes that had unusual indicators, and helped officials to explore root causes for performance differences, including possible corruption (Vian and Collins, 2006).

Citizen voice refers to the channels and means for active participation by stakeholders in planning and provision of services (Thompson, 2005; Lewis, 2006; Milewa, 2006). One purpose of citizen voice is to increase external accountability of government. Strategies to promote citizen voice include local health boards where citizens can have input into the budgeting and planning processes; patient surveys to provide feedback on satisfaction; and complaint offices to record and mediate reports of unethical or corrupt conduct. Research conducted by the Center for Civic Education (http://www.civiced.org), in countries such as Russia, Latvia and Indonesia, suggests that civic education can be effective in increasing citizens' willingness to participate in civic and political life, and their skills in explaining their problems. In Bolivia, citizen health board activism was an important deterrent of informal payments and was associated with lower prices in government procurement of essential supplies (Gray-Molina *et al.,* 2001). However, increasing citizen voice is not always easy; in countries where citizen participation was repressed for many years, there may be limited experience with non-governmental organizations and other forms of civic activism, and more work may be needed to develop effective approaches. In addition, incentives must be structured, and the nature of accountability defined, so that local committees have power to influence the actions of centrally managed staff (Lewis, 2007).

Transparency is another concept which is closely related to accountability. The idea behind transparency is that by actively disclosing information on how decisions are made, as well as measures of performance, we can improve public deliberation, reinforce accountability and inform citizen choice. In addition, transparency helps to document and disseminate information on the scope and consequences of corruption, information which can help build support for anti-corruption programmes and target enforcement efforts.

Transparency policies may include government-mandated disclosure of information, or may involve external agents such as civil society or the media (Fung *et al.,* 2007). Strategies to increase transparency include public service 'report cards', price monitoring and release of government documents or decisions through web sites, public databases, public meetings and the media (World Bank, 2003). Examples of transparency initiatives in Argentina, Morocco and Uganda show the range of interventions possible. The Ministry of Health in Argentina created a price monitoring system that tracked prices paid by 33 public hospitals for common drugs, sharing this data with the reporting hospitals. The effect of the transparency policy was that purchase prices fell immediately by an average of 12%, and stayed below the baseline for over a year (Schargrodsky*et al.,* 2001). In Croatia, regulations have been proposed which will require hospitals to make waiting lists public, to reduce the practice of patients bribing doctors to jump ahead of the queue (Transparency International, 2006). In Uganda, an information strategy was used to reduce leakage of central government education grants to local governments (a problem first identified through a Public Expenditure Tracking Survey). Before the grant transfer amounts were publicized in newspapers and posted in schools, only 13% of grant allocations reached the schools; after the reforms, 80–90% of grant funds were reaching recipients (Reinikka and Svensson, 2002).

Detection and enforcement includes steps taken to collect evidence that corruption has occurred, and to punish those who engage in corruption. The goal of detection and enforcement is both to get rid of bad agents, i.e. those government officials abusing their power, and to deter others from engaging in corruption in the future. Mechanisms of enforcement can function within the Ministry of Health bureaucracy (for example, an Inspector General's Office or Internal Auditor) or externally through policing and the criminal justice system. Enforcement includes such activities as surveillance, internal security, fraud control, investigation (including investigative journalism), whistle-blowing and punishment. Effective disciplinary systems can increase accountability and deter

corruption, although they may require difficult changes in organizational culture. While a hospital in Cambodia found it hard to punish employees, it was able to withhold bonus payments from poorly performing employees (Barber *et al.,* 2004). This is a start at changing incentives.

Rationalization: in addition to the institutional or organizational factors described above, which collectively affect the opportunities for corruption, behavioural scientists have studied the ways in which individual beliefs, attitudes and social norms influence corruption. Although a sense of moral obligation and concern for others is an important influence on behaviour, especially in the medical professions and among public servants (Randall and Gibson, 1991; Kurland, 1995; Raats*et al.,* 1995), researchers point to eroding public service values which create a vacuum in which corruption appears justified (Miller *et al.,* 2001). Miller *et al., (*2001) hypothesize that severe economic and political disruption, such as that which has occurred in post-communist Europe and Central Asia since 1991, can contribute to the problem by creating confusion over values: for example, capitalism suggests that 'everything has its price', which seems to endorse aggressive pursuit of self-interest even within government institutions. Officials may not even perceive themselves to be morally conflicted, in their government role, when they pursue self-interest instead of the interests of others.

Other social scientists have called attention to 'practical logic', which helps explain corruption in cultural settings. According to anthropologist Paul Brodwin, when an unexpected bounty of resources became available to Haitian communities through a donor-funded health programme, the community leaders used these resources to advance their own economic position and reputation actions that were logical, sensible and effective ways to act by this community's own cultural norms (Brodwin, 1997). In a similar way, Olivier de Sardan explores social norms which permit African societies to justify corruption, arguing that these "logics" of negotiation, gift-giving, solidarity, predatory authority, and redistributive accumulation' allow corruption to become 'socially embedded', and must be considered in developing anti-corruption policies and interventions (Olivier de Sardan, 1999).

Very little research exists to link these concepts to corruption in the health sector, but it is an important area for future study. A clearer understanding of these factors can help in crafting professional education programmes, codes of conduct, information campaigns to correct misinformation which may be influencing beliefs, and to promote effective role modelling.

Personality character traits and demographic characteristics may also be important in explaining corruption. Hessing*et al.,* (1988) studied the relationship between personality traits and tax evasion, observing that traits reflecting a 'self-serving personality', such as a tolerance of illegal behaviour and a competitive orientation, were associated with tax evasion (Hessing*et al.,* 1988). Strategies to carefully select and train government agents may mitigate these types of influences. Gender and marital status may also be associated with corruption, as was suggested by Giedion*et al.*,(2001) in their study of irregularities in Bogota hospitals. Their study found that procurement prices were lower when the purchasing agent was unmarried or a woman (Giedion*et al.,* 2001).

Pressures to abuse: a government agent may feel pressure to embezzle to pay-off personal financial debt, or may accept informal payments because government salaries are too low to make a living. One strategy to address such pressures is to perform credit checks during the hiring process or periodically during employment (Vian, 2006). Increasing salaries is often suggested as a strategy to reduce financial pressure leading to corruption (Van Lerbergh*eet al.,* 2002; Ferrinho*et al.,* 2004); yet higher salaries alone will not reduce risk of abuse if opportunities and incentives do not also change. Accordingly, some reforms have tried to link compensation to achievement of targets for quality and/or productivity, or to exert professional or peer pressure for performance. Performance-based incentives have been studied and used in some low-income countries, including Haiti, the Philippines and Cambodia (Eichler*et al.,* 2000; Management Sciences for Health, 2001; Soeters and Griffiths, 2003; Dugger, 2006).

Government agents may also feel pressured by clients to accept bribes. This is especially true in situations where people are sick and suffering, and feel that bribes are the only way to ensure they receive the best possible treatment (Vian*et al.,* 2006). Pressure may also be exerted by suppliers, or by other agents involved in corruption.

2.1.2Forms of Corruption in Health Sector

According to Vian (2008),corruption in the health sector may be viewed by examining the types of corruption by reviewing the functions of the health care delivery process, and examine the potential abuses that can occur at each step. This view is shown in Table 2.1.

Table 2.1: Types of corruption in the health sector

Area or process	Types of corruption and problems	Results
Construction and rehabilitation of health facilities	• Bribes, kickbacks and political considerations influencing the contracting process • Contractors fail to perform and are not held accountable	• High cost, low quality facilities and construction work • Location of facilities that does not correspond to need, resulting in inequities in access • Biased distribution of infrastructure favouring urban-and elite-focused services, high technology
Purchase of equipment and supplies, including drugs	• Bribes, kickbacks and political considerations influence specifications and winners of bids • Collusion or bid rigging during procurement • Lack of incentives to choose low cost and high quality suppliers •	• High cost, inappropriate or duplicative drugs and equipment • Inappropriate equipment located without consideration of true need • Sub-standard equipment and drugs • Inequities due to inadequate funds left to provide for all needs
Distribution and use of drugs and supplies in service delivery	• Theft (for personal use) or diversion (for private sector resale) of drugs/supplies at storage and distribution points • Sale of drugs or supplies that were supposed to be free	• Lower utilization • Patients do not get proper treatment • Patients must make informal payments to obtain drugs •
Regulation of quality in products, services, facilities and professionals	• Bribes to speed process or gain approval for drug registration, drug quality inspection, or certification of good manufacturing practices • Bribes or political considerations influence results of inspections or suppress findings •	• Sub-therapeutic or fake drugs allowed on market • Marginal suppliers are allowed to continue participating in bids, getting government work • Increased incidence of food poisoning • Spread of infectious and communicable diseases
Education of health professionals	• Bribes to gain place in medical school or other pre-service training • Bribes to obtain passing grades • Political influence, nepotism in selection of candidates for training opportunities	• Incompetent professionals practicing medicine or working in health professions • Loss of faith and freedom due to unfair system
Medical research	• Pseudo-trials funded by drug companies that are really for marketing • Misunderstanding of informed consent and other issues of adequate standards in developing countries	• Violation of individual rights • Biases and inequities in research
Provision of services by medical personnel and other health workers	• Use of public facilities and equipment to see private patients • Unnecessary referrals to private practice or privately owned ancillary services • Absenteeism • Informal payments required from patients for services • Theft of user fee revenue, other diversion of budget allocations	• Government loses value of investments without adequate compensation • Employees are not available to serve patients, leading to lower volume of services and unmet needs, and higher unit costs for health services actually delivered • Reduced utilization of services by patients who cannot pay • Impoverishment as citizens use income and sell assets to pay for

2.2 Health Care Service Delivery

Strengthening health service delivery is crucial to the achievement of the health-related Millennium Development Goals (MDGs), which include the delivery of interventions to reduce child mortality, maternal mortality and the burden of HIV/AIDS, tuberculosis and malaria. Health service provision or delivery is an immediate output of the inputs into the health system, such as the health workforce, procurement and supplies, and financing. Increased inputs should lead to improved health service delivery and enhanced access to health services. Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system.

To monitor progress in strengthening health service delivery, it is necessary to determine the dimensions along which progress would be measured. According to Van Lerberghe (2008), there are eight key characteristics of good service delivery in a health system. These ideal characteristics describe the nature of the health services that would exist in a strong health system based on primary health care, as set out in the 2008 World Health Report (Lerberghe, 2008).

Lerberghe (2008) further contend that the process of building evidence for the strengthening of health service delivery must therefore proceed alongside efforts to restructure service delivery in accordance with the values of eight key characteristics of good service delivery. Health sector leaders and policy-makers who are tasked with assessing their health systems should participate in the process to deliberate on ways to assess these key characteristics in their countries. Researchers should continue to experiment with methods and measures that would allow progress to be assessed over time, along these important dimensions (World Health Organization, 2017).

For some of the dimensions of service delivery, such as quality of care, widely accepted methods and indicators for assessment are available, although research to refine these continues. For other characteristics in the list, such as person-centredness, research and dialogue on what and how to measure it is in the early stages.

Some concepts that have frequently been used to measure health services remain extremely relevant and are part of the key characteristics. For example, terms such as access, availability, utilization and coverage have often been used interchangeably to reveal whether

people are receiving the services, they need (Tanahashi, 1978, Shengelia, Murray and Adams, 2003). *Access* is a broad term with varied dimensions: the comprehensive measurement of access requires a systematic assessment of the physical, economic, and socio-psychological aspects of people's ability to make use of health services. *Availability* is an aspect of *comprehensiveness* and refers to the physical presence or delivery of services that meet a minimum standard. *Utilization*is often defined as the quantity of health care services used. *Coverage* of interventions is defined as the proportion of people who receive a specific intervention or service among those who need it.

2.2.1 Dimensions of health service delivery

Good service delivery is a vital element of any health system. Service delivery is a fundamental input to population health status, along with other factors, including social determinants of health. The precise organization and content of health services will differ from one country to another, but in any well-functioning health system, the network of service delivery should have the following key characteristics.

Key characteristics of good Service Delivery

According to Adams, (2003) below are the characteristics of good service delivery **Comprehensiveness** A comprehensive range of health services is provided, appropriate to the needs of the target population, including preventative, curative, palliative and rehabilitative services and health promotion activities.

Accessibility Services are directly and permanently accessible with no undue barriers of cost, language, culture, or geography. Health services are close to the people, with a routine point of entry to the service network at primary care level (not at the specialist or hospital level). Services may be provided in the home, the community, the workplace, or health facilities as appropriate.

Coverage Service delivery is designed so that all people in a defined target population are covered, i.e. the sick and the healthy, all income groups and all social groups.

Continuity Service delivery is organized to provide an individual with continuity of care across the network of services, health conditions, levels of care, and over the life-cycle.

Quality Health services are of high quality, i.e. they are effective, safe, centred on the patient's needs and given in a timely fashion

Person-centredness Services are organized around the person, not the disease or the financing. Users perceive health services to be responsive and acceptable to them. There is participation from the target population in service delivery design and assessment. People are partners in their own health care. (Adams, 2003)

Coordination Local area health service networks are actively coordinated, across types of provider, types of care, levels of service delivery, and for both routine and emergency preparedness. The patient's primary care provider facilitates the route through the needed services, and works in collaboration with other levels and types of provider. Coordination also takes place with other sectors (e.g. social services) and partners (e.g. community organizations).

Accountability and efficiency Health services are well managed so as to achieve the core elements described above with a minimum wastage of resources. Managers are allocated the necessary authority to achieve planned objectives and held accountable for overall performance and results. Assessment includes appropriate mechanisms for the participation of the target population and civil society. (Adams, 2003)

2.3 Related literature

2.3.1 Effect of Corruption on Health Service Delivery

Corruption, as defined by Transparency International, is the "abuse of entrusted power for private gain"(Robinson, 2006). With health care expenditures totalling 3 trillion US dollars globally, this sector is particularly vulnerable to corruption (Robinson, 2006). In health care, there is a significant diversity of services offered, and a large scale and expense associated with procurement (Vian, 2002). In addition, the nature of health care is such that the demand is not fully predictable and often exceeds supply (Vian, 2002). Health care systems also tend to have weak or non-existent rules and regulations, lack of accountability, information imbalances between providers and patients and suppliers and providers, and low salaries for health care professionals and public officials (Kohler, 2011). These characteristics of the health sector make it susceptible to corruption. Corruption has been well documented in the health sector in Uganda. A study in Uganda reported that the resale of pharmaceuticals is the

greatest source of income for health care workers (Ferrinho and Van Lerberghe, 2002). In Uganda, it is estimated that over two-thirds of drugs meant for free distribution in the public sector were lost due to theft or went unaccounted for, and that 68-77% of formal user charges were misappropriated or pocketed by workers (McPake, Asiimwe, Mwesigye, Ofumbi, Ortenblad, Streefland and Turinde, 1999). In 2005, the Global Fund for HIV/AIDS, Malaria and Tuberculosis suspended all donations to Uganda when over 1.6 million US dollars of grants went missing (Somali Press, 2009). In 2009, two Ugandan officials have been accused and sentenced for the embezzlement of Global Fund monies (Kelly, 2009).

Theft, diversion and resale of drugs are other sources of corruption documented to occur at the distribution point of pharmaceutical supply chain (Vian, 2002). For example, there can be theft without falsification of inventory records, dispensing of drugs to patients who did not actually attend the pharmacy or clinic, recording of drugs as dispensed to legitimate patients but the patients do not receive them, and dispensing of drugs to patients who pay for them but the health care provider keeps the funds for themselves (World Bank, 2005).Corruption in orthopaedics was an uncommon topic in academic literature and non-medical media until the announcement of a large-scale lawsuit in the United States in 2005. The Department of Justice's U.S. State Attorney for the District of New Jersey brought forth allegations against the five largest orthopaedic device manufacturers for illegal kickbacks to surgeons and false claims allegations. Physicians were allegedly awarded vacations, gifts and annual "consulting fees" as high as $200,000 in return for physician endorsements of their implants or use of them in operations (Healy and Peterson, 2009). The false claims were concerning illegal promotions of off-label uses for a certain product. These five companies control 95% of the orthopaedic medical de-vice market (Healy and Peterson, 2009). Four of those companies paid 311 million US dollars to settle the case (Healy and Peterson, 2009). Many of the individual orthopaedic surgeons are the subjects of investigations as well. The medical device industry, especially in orthopaedics, is an area where there are relatively large sums of money involved and thus a susceptibility to corruption (Vian, 2002). Corruption within orthopaedic services and industry may inflate prices of equipment, lower the quality of care and products, and impede the necessary response to alleviating the growing global injury burden.

2.4 Conceptual model of Corruption in the Health Sector

Figure 2.2 presents a conceptual framework of corruption in the health sector which consolidates some of the concepts and models that have been developed previously

(Klitgaard, 1988; Di Tella and Savedoff, 2001; Miller *et al.,* 2001; Duncan, 2003; Ramos, 2003; Brinkerhoff, 2004; Oliver, 2004; Lewis, 2006; Fung *et al.,* 2007). Looking at corruption from the viewpoint of the government agent, the framework suggests that corruption is driven by three main forces: government agents who abuse public power and position for private gain do so because they feel pressured to abuse (financially or by clients), because they are able to rationalize their behaviour or feel justified (attitudes and social norms support their decision), and because they have the opportunity to abuse power. The factors involved, and the application of this model to the health sector, are discussed below, looking in most detail at the opportunities to abuse.

Figure 2.2: Conceptual framework of corruption in the health care sector

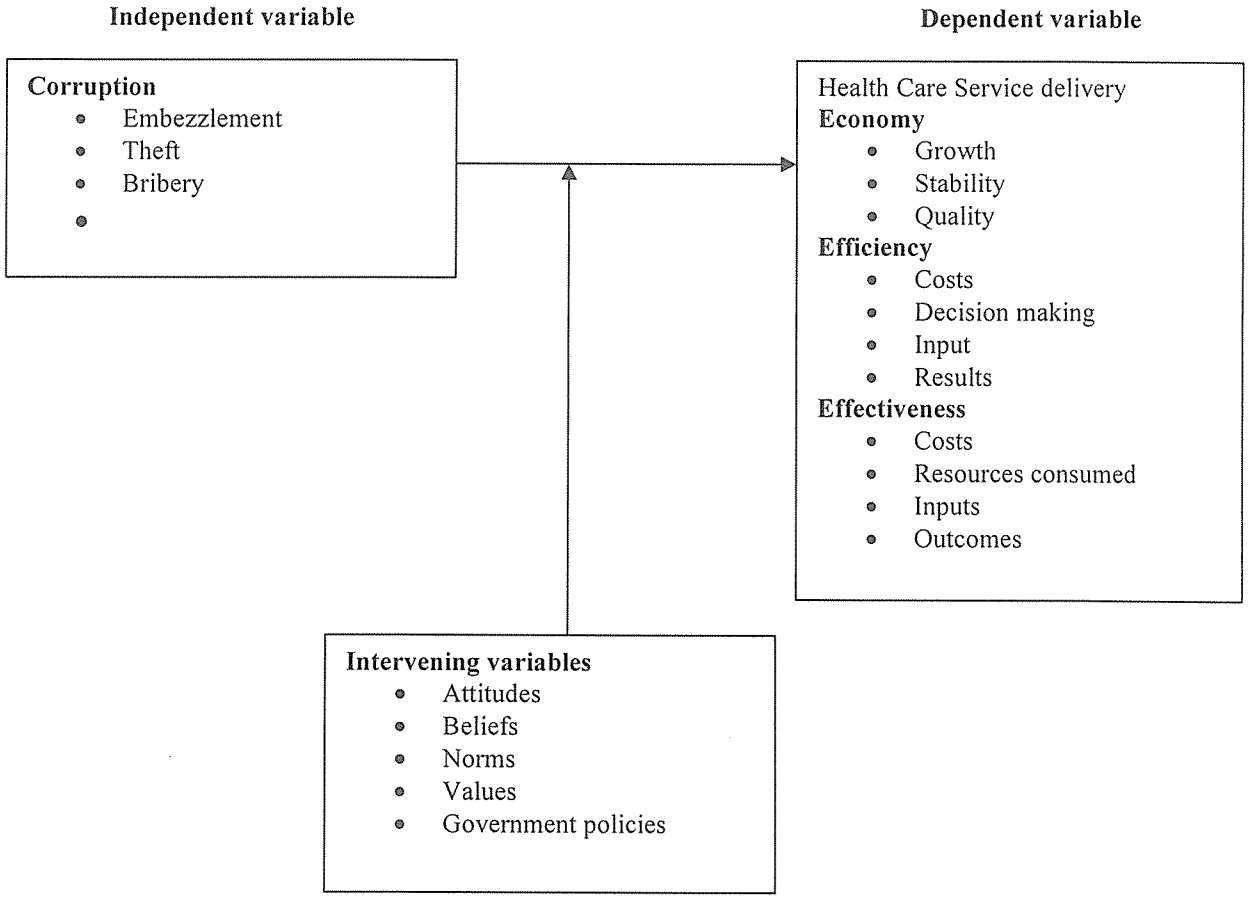


Figure 1. 1: Shows the relationship between corruption and health care service delivery in Buvuma District.

Source: (Mugaga 2006; Schubeler, 1996; Thomas, 1998; Rand & Marxen, 2000) and modified by the researcher

2.5 Gaps in the literature

Previous studies were conducted in public sectors (Barr, Lindelow and Serneels, 2009) and none has been conducted in different health centres at ago. Therefore this study will help in filling this gap. Also Gupta (2000) conducted a study in health care and education services whereas this study will entirely focus on health service delivery. In Uganda, Deininger and Mpuga (2005) assessed the effect of accountability on quality of public service delivery but this never tackled well on the effect of corruption on health service delivery. The researcher intends to fulfil this gap.

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter summarizes the methodology that will be adopted by the study; it consists of research design, target population, data collection, variables and measurement, and ethical considerations.

3.1 Research design

This study will employ a cross-sectional research design. The research design will be preferred for the study since it provides a quick, efficient and accurate means of accessing information about the population. This design will use both qualitative and quantitative approaches. The quantitative research approach will be used because of the desire to solicit and present data numerically whereas qualitative approach will be used to analyse qualitative data about the variable under study. The justification for using the descriptive cross sectional survey is that it provides a meaningful picture of events and seeks to explain people's perception and behaviour based on data gathered at a point in time.

3.2 Population of the study

The study population will be 71 respondents who will be chosen from the leadership structure of Buvuma District and directly mandated to manage health care service delivery who will include, Health departmental leaders, staff civil society organizations, youth groups and community based organization (Primary data, 2018).

3.3 Sample size

Due to limited time and resources, a sample size of (60 people) will be selected from the study population of (71) respondents (Krejcie & Morgan, 1970) divided as seen in Table 1 below. This study will use Purposive sampling for those in the Civil society organizations Departmental leaders, Community Based Organizations. Simple random sampling is good for in-depth analysis, it enables high representation of the population, less bias, and simplifies data interpretation and analysis of results (Black, 1999). While purposive sampling will be used for staff, youth groups because it will allow for probing more on public health.

Table 1: Sample Size

Category	Population	Sample	Sampling technique
Staff	50	44	Purposive sampling
Civil society organizations	5	4	Simple Random sampling
Youth groups	6	4	Purposive sampling
Departmental leaders	5	4	Simple Random sampling
Community Based Organizations	5	4	Simple Random sampling
Total	**71**	**60**	

Source: Primary Data 2018

3.4 Sampling techniques

The district was chosen because it ranks the highest in corruption and poor health care service delivery (GoU, 2017). In addition it was accessible to the researcher in terms of cost, time and information (Cressswell, 1994).

3.5.1 Simple Random Sampling

The participants in the study were selected through simple random sampling method for respondents among them Civil society organizations, Departmental leaders, Community Based Organizations to have an equal chance of being selected to be part of the study. Simple random sampling is best because it is easy to collect data when the population members are similar to one another on important variable (Gay, 1996). It also ensured a high degree of representativeness and ease of assembling the sample (Thompson, 2002; Levy& Lemeshow, 2008).

3.5.2 Purposive Sampling

Purposive sampling was used for selecting the particular groups of people in the population especially health care staff and youth groups. This sampling procedure was used for its cost efficiency and effectiveness to collect specific information and allowed for probing for clarity (Kothari, 2004).

3.5 Data collection instruments

3.5.1 Questionnaires

A questionnaire was the major tool used for data collection. The questionnaires were preferred for the study because they enabled the researcher to reach a larger number of respondents within a short possible time which therefore made it easier for researcher to collect relevant information. The questionnaires were designed into three sections of bio data, corruption and health service delivery. The corruption and health service delivery sections boar questions designed on a five point Likert scale ranging from 1= strongly disagree, 2 = disagree, 3 = not sure, 4 = agree, and 5 = strongly agree. The questionnaires contained close-ended questions to collect quantifiable data relevant for specific variables under study. These were preferred to save respondent's time in terms of filling and are meant to them focus on the subject and objective of the study.

3.6 Validity and reliability of the instrument

A pilot test was carried out before the main study. The study involved about 10 per cent (6 of the respondents) of the target population. There were 6 respondents who participated in the pilot test. These respondents were randomly selected and participants of the pilot study were excluded from the main study in order to avoid compromising the study findings of the main study. The rationale for pilot testing was to establish any potential weaknesses in the research instrument. This was to be achieved by determining both the reliability and validity of the research instrument.

3.7 Data gathering procedures

An introductory letter was obtained from the CHSS to conduct the study. In addition, the questionnaires for actual distribution were prepared and coded accordingly.

The researcher requested respondents to answer the questionnaires as objectively as possible and not to leave any question unanswered. Furthermore, the researcher emphasized respondents to pick the questionnaires after three days from the date of distribution and all returned questionnaires were checked to see if all were fully answered.

After the collection of primary data through questionnaires, the researcher analyzed it and completed questionnaires were coded, edited, categorized and entered into a computer for the Statistical Package for Social Scientists (SPSS) for data processing and analysis.

3.8 Data analysis

The frequency and percentage distribution were used to determine the demographic characteristics of the respondents. Data obtained was summarized using descriptive statistics that included mean and standard deviation to arrive at the interpretation of the corruption and health service delivery. The computed mean was interpreted as shown in table below;

Table 3.2: Mean interpretation guide

Mean ranges	Response mode	Interpretation
4.21-5.00	Strongly agree	Very high
3.41-4.20	Agree	High
2.61-3.40	Not sure	Moderate
1.81-2.60	Disagree	Low
1.00-1.80	Strongly disagree	Very low

3.9 Ethical considerations

To ensure confidentiality of the information provided by the respondents and to ascertain the practice of ethics in this study, the researcher obtained an introductory letter from CHSS of Kampala International University that introduced him to the concerned respondents for permission to collect data for this study. The researcher acknowledged the authors quoted in this study through citations and referencing and the researcher presented the findings in a generalized manner.

CHAPTER FOUR
DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter presents the information on the background information of respondents including; gender, age, marital status, highest level of education, occupation position of the respondent and duration of service. Further, the chapter reports on quantitative and qualitative data, presents summery, discussions, conclusion, recommendations, limitation of the study, contribution of the study and areas recommended for further research all done objective by objective as;

4.2 Respondents' Background Information

This section involved the description of the background information of the respondents because it gave a clear view of the respondents' ability to give adequate and accurate information on how corruption relates to health service delivery in Buvuma district.

4.2.1 Gender of respondents

The respondents were asked to give their gender. This enabled the researcher to have a proportionate representation of both the females and males.

Table 1: Showing gender of respondents

Gender	Frequency	Percentage
Male	45	75
Female	15	25
Total	60	100

Source: Primary data 2018

The table above shows that the majority of the respondents represented by (75%) were male and the females followed with (15%). This implies that the study was gender sensitive and collected views from both males and females since both sexes have adequate information on corruption and health service delivery in Buvuma district.

4.2.2 Age of respondents

The respondents were asked to give their age. This enabled the researcher to have a proportionate representation of the age of the respondents.

Table 2: Showing Age of respondents

Age	Frequency	Percentage
20 – 30	10	16.7
31 – 40	30	50
41 – 50	10	16.7
51 – 60	5	8
61 and above	5	8
Total	60	100

Source: Primary data 2018

The table above shows that the majority of the respondents represented by (50%) were in the age bracket of 31 – 40 followed by those in the age bracket of 20 – 30 years and 41 – 50 years

with (16.7%) and the least were in the age bracket of 51 – 60, 61 and above . This implies that the study was age sensitive and collected views from all ages since all age brackets had adequate information on corruption and health service delivery in Buvuma district.

4.2.3 Marital status of respondents

The respondents were asked to give their marital status. This enabled the researcher to have a proportionate representation of the marital status of the respondents.

Table 3: Showing marital status of respondents

Marital Status	Frequency	Percentage
Single	20	33.3
Married	30	50
Divorced	10	16.7
Widowed	-	-
Total	60	100

Source: Primary data 2018

The table above shows that the majority of the respondents represented by (50%) were married followed by singles with (33.3%) and the least were divorced with (16.7%) response. This implies that the study collected views from all categories of marital status.

4.2.4 Highest level of education of respondents

The respondents were asked to give their highest level of education. This enabled the researcher to have a proportionate representation of the level of education of the respondents.

Table 4: Showing level of education of respondents

Level of education	Frequency	Percentage
Never went to school	-	-
Certificate	5	8
Diploma	15	25
Bachelor's Degree	30	50
Master's Degree	10	16.7
PhD	5	8
Total	60	100

Source: Primary data 2018

The table above shows that the majority of the respondents represented by (50%) had bachelor's degree followed by diploma holders with (25%), master's holders with (16.7%) and the least were PhD and Certificate holders with (8%) response. This implies that the study collected views from all levels of education.

4.2.5 Occupation of respondents

The respondents were asked to give their occupation. This enabled the researcher to have a proportionate representation of the occupation of the respondents.

Table 5: Showing the occupation of respondents

Occupation	Frequency	Percentage
Farmer/Peasant	-	-
Businessman/women	-	-
Public servant	55	92
Other	5	8
Total	60	100

Source: Primary data 2018

The table above shows that the majority of the respondents represented by (92%) were public servants followed by others with (8%), response. This implies that the study collected views from all mainly public servants in Buvuma district who had adequate knowledge on corruption and health service delivery.

4.2.6 Where do you mostly get health services?

The respondents were asked to give their responses on where they mostly get health services. This enabled the researcher to have a proportionate representation of where respondents get their health services.

Table 6: Showing where respondents mostly get health services

Occupation	Frequency	Percentage
District hospital	10	17
Clinic	5	8
Health centre	40	67
Other	5	8
Total	60	100

Source: Primary data 2018

The table above shows that the majority of the respondents represented by (67%) get their health services from health centres followed by those who get them from the district hospitals with (17%), and lastly those who get from clinics and other health centres with (8%) response. This implies that the majority of the respondents get their health services from health services as represented by 67% response.

4.3 To assess perceptions of corruption in process of receiving health services

Do you think corruption occurs at the point of health services?

4.3.1 Clients perception of corruption

The respondents were asked to give their perceptions of corruption.

Table 7: Showing Clients perception of corruption

Clients perception of corruption	Frequency	Percentage
Yes	45	75
No	15	25
Total	60	100

Source: Primary data 2018

The table 7 above shows that the majority of the respondents represented by (75%) said yes and the minority said No with (15%). This implies that the majority of the respondents had knowledge on corruption and health service delivery in Buvuma district.

4.3.2 If yes, what types of corrupt practices are common in your area?

The respondents were asked to give type of corruption practices. This enabled the researcher to have a proportionate representation of the types of corrupt practices are common in Buvuma District.

Table 8: Showing the types of corrupt practices

types of corrupt practices	Frequency	Percentage
Absenteeism of health service providers	5	8
Theft of medical supplies	30	50
Informal payments	15	25
Nepotism	5	8
Embezzlement of health care funds	10	16.7
other	-	-
Total	60	100

Source: Primary data 2018

The table 8 above shows that the majority of the respondents represented by (50%) said that the major type of corruption practice in Buvuma District was Theft of medical supplies followed by informal payments with (25%), embezzlement of health care funds with (16.7%) and the least were Absenteeism of health service providers and Nepotism with (8%) response. This implies there are a number of corruption practices in Buvuma district but the major one is Theft of medical supplies.

4.3.3 To assess perceptions of corruption in process of receiving health services

The first objective was to assess perceptions of corruption in process of receiving health services. All the aspects of the perception of corruption in process of receiving health services were measured using six qualitative questions in which respondents were requested to indicate the extent to which they agree or disagree with the statement by writing the number that best describes their perception. All the six items on the perceptions of corruption in process of receiving health services. were likert scaled using four points ranging between 1= Strongly Disagree, 2= Disagree, 3= Agree and 4= Strongly Agree. Their responses were analyzed and described using Means as summarized in table 9 below.

Table 9: Showing the perceptions of corruption in process of receiving health services

N = 60

№	Statement	Mean	Interpretation	Rank
1.	Bribery control health services delivery	2.92	High	1
2.	Bribes help to receive information on the process of health service	2.86	High	2
3.	Corruption reduces long health service procedure which are too costly and time wasting	2.75	High	3
4.	Corruption gives unfair health treatment among clients	2.66	High	4
5.	Corruption helps to reduce the existing uncertainty of health services	2.13	Low	5
6.	Unofficial payment guarantee reliability of services	2.67	High	
7.	**Average mean**	**2.67**	**High**	

Source: Primary data 2018

The means in table 9 indicate that the perceptions of corruption in process of receiving health services were rated at different levels. Out of the items, five (5) were rated high equivalent to agree meaning that respondents agreed with the statement. The remaining one item was rated low (equivalent to disagree) meaning that the respondents disagreed to the statement with.

The overall average mean is (2.67) which is equivalent to agree on the rating scale used and thus basing on these results, it can be concluded the perceptions of corruption in process of receiving health services is moderate.

Items which were rated High among others included, Bribery control health services delivery (Mean = 2.92), Bribes help to receive information on the process of health service (Mean = 2.86), Corruption reduces long health service procedure which are too costly and time wasting (Mean = 2.75), Corruption gives unfair health treatment among clients (Mean = 2.66) and Unofficial payment guarantee reliability of services (Mean = 2.67) respectively.
Item which was rated low among others included Corruption helps to reduce the existing uncertainty of health services (Mean = 2.13) respectively.

4.4 To determine factors driving corruption in health service delivery

The second objective was to determine factors driving corruption in health service delivery. Their responses were analyzed and described using percentages as summarized in table 10 below.

Table 10: Showing the factors driving corruption in health service delivery

	Motive for being involved in corruption	Frequency	Percentage
1.	Wanted to avoid a long queue	10	17
2.	It was a pressure from medical workers	5	8
3.	Quest to get good quality health services	20	33
4.	Poor responsibility among medical workers	5	8
5.	Wanted to avoid long bureaucratic procedures	10	17
6.	Poor living standards among medical workers	5	8
7.	Poor access to information about my health service rights	5	8
	Total	**60**	**100**

Source: Primary data 2018

The findings in the table 10 above revealed that the majority with (33%) of the respondents said that Quest to get good quality health services is what motivated them to being involved in corruption followed by those who said that Wanted to avoid a long queue and Wanted to avoid long bureaucratic procedures with (17%), the rest of the respondents with(8%) said that It was a pressure from medical workers, Poor responsibility among medical workers, Poor living standards among medical workers and Poor access to information about my health service rights is what motivates them for being involved in corruption. This implies that the majority of the respondents are motivated by the quest to get good quality health services to involve themselves in corruption.

4.5 To assess the quality or levels of health service delivery

The third objective was to assess the quality or levels of health service delivery. Their responses were analyzed and described using percentages and means as summarized in table 11 below.

4.5.1 For your opinion, how does corruption affect the quality of health service delivery?

Table 11: Showing how corruption affects the quality of health service delivery

Response	Frequency	Percentage
To a greater extent	40	67
To some extent	8	13
To a small extent	5	8
Not a problem at all	5	8
Don't know/ not sure	2	3
other	-	-
Total	**60**	**100**

Source: Primary data 2018

The findings in table 11 above revealed that the majority of the respondents with 67% said that corruption affects the quality of health service delivery to a great extent while 13% of the

respondents said it affects to some extent followed by those who said to a small extent, and not a problem at all with 8% response and lastly the minority said that they don't know or were not sure that corruption affects the quality of health service delivery in Buvuma district. This implies that the corruption to a great extent affects the quality of health service delivery since the majority of the respondents agreed.

The third objective was to assess the quality or levels of health service delivery in Buvuma. All the aspects of the quality or levels of health service delivery were measured using seventeen (17) qualitative questions in which respondents were requested to indicate the extent to which they agree or disagree with the statement by writing the number that best describes their perception. All the six items on the quality or levels of health service delivery were likert scaled using four points ranging between 1= Strongly Disagree, 2= Disagree, 3= Agree and 4= Strongly Agree. Their responses were analyzed and described using Means as summarized in table 12 below.

Table 12: Showing the quality or levels of health service delivery in Buvuma

Statement	**Mean**	**Interpretation**	**Rank**
Patients are waiting for a long time to get health service	2.92	High	
The demand of tips before services builds trust between health workers and patients	2.86	High	
Patients are denied their rights due to practices of friendliness	2.75	High	
Only rich patients receive high respect and favour from health service providers	2.66	High	
Patients financial resources are depleted to get attentiveness from service providers	2.13	Low	
Patients are satisfied with the services provided at the health care center	2.67	High	
Health service providers pay more attention to patients privacy	2.79	high	
Patients get the necessary treatment according to their sickness	3.12	High	1
Patients are not satisfied with the services provided	2.55	High	
Patients kept waiting for a short time to get health service	2.44	Low	
Patients lose faith to health workers due to the demand of tips before	2.97	High	2
Patients gets their right due to the practices of friendliness	2.76	High	
Poor patients are disrespected from health service providers	2.95	High	3
Health service providers give attentiveness to the patients regardless of financial resources	2.66	High	
Patients privacy are not paid attention by health services providers	2.88	high	5
To get the necessary treatment patients must pay more than it is required	2.67	High	
Professionals tend to claim to have provided services which they did	2.25	low	
Average mean	**2.54**	**High**	

Source: Primary data 2018

The means in table 12 indicate that the quality or levels of health service delivery in Buvuma was rated at different levels. Out of the items, fourteen (14) were rated high equivalent to agree meaning that respondents agreed with the statement. The remaining three (3) item were rated low (equivalent to disagree) meaning that the respondents disagreed to the statement with.

When you sum up all the seventeen categories, the overall average mean is (2.54) which is equivalent to agree on the rating scale used and thus basing on these results, it can be concluded that the quality or levels of health service delivery in Buvuma stands at a moderate scale.

Items which was rated low among others included Patients financial resources are depleted to get attentiveness from service providers (Mean = 2.13), Patients kept waiting for a short time to get health service (Mean = 2.44), and Professionals tend to claim to have provided services which they did (Mean = 2.25).

4.6 The relationship between corruption and health service delivery in Buvuma District

The fourth objective was to examine the relationship between corruption and health service delivery in Buvuma.

The researcher studied the relationship of corruption and health service delivery in Buvuma District. A null hypothesis: "corruption has no significant relationship on health service delivery in Buvuma District" was developed.

Table 13: The correlation of corruption on health service Delivery in Buvuma District

		health service delivery	**Corruption**
Health service delivery	Pearson Correlation	1	0.864
	Sig. (2-tailed)		0.036
Corruption	Pearson Correlation	0.864	1
	Sig. (2-tailed)	0.036	

Table 13.above revealed that corruption has significant relationship on health service delivery in Buvuma District since the p-value (0.036) is less than the level of significance. The

correlation coefficient is strong (0.864) which showed that corruption has strong relationship on corruption and health service delivery in Buvuma District. In order to determine the magnitude of the relationship, regression analysis was conducted.

4.4.2 Regression of corruption on health service delivery in Buvuma district.

Table 14: Regression of corruption on health service delivery in Buvuma District.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	0.864	0.747	0.621	0.49839	0.747	5.912	1	2	0.136

According to table 14 above, the factors affecting corruption were regressed on factors under health service delivery in Buvuma District. The findings revealed that factors studied under corruption explain 74.7% of the factors leading to health service delivery in Buvuma District. The correlation coefficient 0.864 is strong and showed that corruption has a significant strong relationship on health service delivery in Buvuma district.

CHAPTER FIVE
DISCUSSIONS, CONCLUSION AND RECOMMADATIONS

5.0 Introduction

This chapter discusses the findings from the field reported in chapter four. In addition it composed of the, discussions of the findings, conclusion and recommendations which are presented objective by objective and the further areas of study.

5.1 Discussion

The findings revealed that that the majority of the respondents represented by (75%) were male and the females followed with (15%). The majority of the respondents represented by (50%) were in the age bracket of 31 – 40 followed by those in the age bracket of 20 – 30 years and 41 – 50 years with (16.7%) and the least were in the age bracket of 51 – 60, 61 and above . The majority of the respondents represented by (50%) were married followed by singles with (33.3%) and the least were divorced with (16.7%) response. The majority of the respondents represented by (50%) had bachelor's degree followed by diploma holders with (25%), master's holders with (16.7%) and the least were PhD and Certificate holders with (8%) response. The majority of the respondents represented by (92%) were public servants followed by others with (8%), response. the majority of the respondents represented by (67%) get their health services from health centres followed by those who get them from the district hospitals with (17%), and lastly those who get from clinics and other health centres with (8%) response. This implies that the majority of the respondents get their health services from health services as represented by 67% response.

These were in line of those of Klitgaard*et al.*, 2000, where In one of the few studies that has tested the relationship between monopoly and corruption in the health sector, researchers in Bolivia found that the existence of alternatives to government services (competition) was associated with lower informal payments.

5.1.1 To assess perceptions of corruption in process of receiving health services

The majority of the respondents represented by (75%) said yes and the minority said No with (15%). The majority of the respondents represented by (50%) said that the major type of corruption practice in Buvuma District was Theft of medical supplies followed by informal payments with (25%), embezzlement of health care funds with (16.7%) and the least were Absenteeism of health service providers and Nepotism with (8%) response.

That the perceptions of corruption in process of receiving health services were rated at different levels. Out of the items, five (5) were rated high equivalent to agree meaning that respondents agreed with the statement. The remaining one item was rated low (equivalent to disagree) meaning that the respondents disagreed to the statement with. The overall average mean is (2.67) which is equivalent to agree on the rating scale used and thus basing on these results, it can be concluded the perceptions of corruption in process of receiving health services is moderate.

These findings were in line with those of Hessing*et al.,* (1988) who studied the relationship between personality traits and tax evasion, observing that traits reflecting a 'self-serving personality', such as a tolerance of illegal behaviour and a competitive orientation, were associated with tax evasion (Hessing*et al.,* 1988). Strategies to carefully select and train government agents may mitigate these types of influences. Gender and marital status may also be associated with corruption, as was suggested by Giedion*et al.*,(2001) in their study of irregularities in Bogota hospitals. Their study found that procurement prices were lower when the purchasing agent was unmarried or a woman (Giedion*et al.,* 2001).

Pressures to abuse: a government agent may feel pressure to embezzle to pay-off personal financial debt, or may accept informal payments because government salaries are too low to make a living. One strategy to address such pressures is to perform credit checks during the hiring process or periodically during employment (Vian, 2006). Increasing salaries is often suggested as a strategy to reduce financial pressure leading to corruption (Van Lerbergh*et al.,* 2002; Ferrinho*et al.,* 2004); yet higher salaries alone will not reduce risk of abuse if opportunities and incentives do not also change.

5.1.2 To determine factors driving corruption in health service delivery

The majority with (33%) of the respondents said that Quest to get good quality health services is what motivated them to being involved in corruption followed by those who said that Wanted to avoid a long queue and Wanted to avoid long bureaucratic procedures with (17%), the rest of the respondents with(8%) said that It was a pressure from medical workers, Poor responsibility among medical workers, Poor living standards among medical workers and Poor access to information about my health service rights is what motivates them for being involved in corruption.

These findings were in line with those of Arowolo (2008) in Adeyemi (2012) who opined that, hard earned and limited resources accrued to and raised by local government are always mismanaged. Priorities are misplaced; projects are done not according to or as demanded by the people but regrettable in tune with the selfish end and aggrandizement of political leadership in collaboration with senior bureaucrats at the local government level of Administration. Generally wide-scale embezzlement by officials of the grassroots has made the need development of grassroots a tall dream and has rendered them financially incapable to discharge their constitutionally assigned responsibility.

This is in line with the findings of Lewis (2006), Crape, Demirchyan, Grigoryan, Martirosyan, Petrosyan and Truzyan (2011) and Oluwabamide (2014) when they explained that the impact of corruption on maternal and infant mortality is high most especially in developing countries such as Nigeria. Evidences (Lewis, 2006; Oyejide, 2008) revealed that reducing corruption can improve health outcomes by increasing the effectiveness of public expenditures in the public hospitals for the betterment of the poor masses. Lewis (2006) and Adegboyega and Abdulkareem (2012) further opined that corruption in the public health sector affects health outcome by reducing government funding available for health services. Besides this have also lead to private companies who are reluctant to invest in countries with high level of corruption, and this has led to an overtime effect of an overall low economic productivity and growth. This in turn leads to a lesser revenue available to the health sector in the country.

5.1.3 To assess the quality or levels of health service delivery

1The findings revealed that the majority of the respondents with 67% said that corruption affects the quality of health service delivery to a great extent while 13% of the respondents said it affects to some extent followed by those who said to a small extent, and not a problem at all with 8% response and lastly the minority said that they don't know or were not sure that corruption affects the quality of health service delivery in Buvuma district. This implies that the corruption to a great extent affects the quality of health service delivery since the majority of the respondents agreed.

The quality or levels of health service delivery in Buvuma was rated at different levels. Out of the items, fourteen (14) were rated high equivalent to agree meaning that respondents

agreed with the statement. The remaining three (3) item were rated low (equivalent to disagree) meaning that the respondents disagreed to the statement with.

These were in line with the findings of Randall and Gibson, 1991; Kurland, 1995; Raats*et al.*, 1995), who point to eroding public service values which create a vacuum in which corruption appears justified (Miller *et al.*, 2001). Miller *et al.*, (2001) hypothesize that severe economic and political disruption, such as that which has occurred in post-communist Europe and Central Asia since 1991, can contribute to the problem by creating confusion over values: for example, capitalism suggests that 'everything has its price', which seems to endorse aggressive pursuit of self-interest even within government institutions. Officials may not even perceive themselves to be morally conflicted, in their government role, when they pursue self-interest instead of the interests of others.

5.1.4 The relationship between corruption and health service delivery in Buvuma District

The findings revealed that corruption has significant relationship on health service delivery in Buvuma District since the p-value (0.036) is less than the level of significance. The correlation coefficient is strong (0.864) which showed that corruption has strong relationship on corruption and health service delivery in Buvuma District. The factors affecting corruption were regressed on factors under health service delivery in Buvuma District. The findings revealed that factors studied under corruption explain 74.7% of the factors leading to health service delivery in Buvuma District. The correlation coefficient 0.864 is strong and showed that corruption has a significant strong relationship on health service delivery in Buvuma district.

These were in line with the findings of Hessing*et al.*, (1988) studied the relationship between personality traits and tax evasion, observing that traits reflecting a 'self-serving personality', such as a tolerance of illegal behaviour and a competitive orientation, were associated with tax evasion (Hessing*et al.*, 1988). Strategies to carefully select and train government agents may mitigate these types of influences. Gender and marital status may also be associated with corruption, as was suggested by Giedion*et al.*,(2001) in their study of irregularities in Bogota hospitals. Their study found that procurement prices were lower when the purchasing agent was unmarried or a woman (Giedion*et al.*, 2001). *Pressures to abuse*: a government agent may feel pressure to embezzle to pay-off personal financial debt, or may accept informal

payments because government salaries are too low to make a living. One strategy to address such pressures is to perform credit checks during the hiring process or periodically during employment (Vian, 2006). Increasing salaries is often suggested as a strategy to reduce financial pressure leading to corruption (Van Lerbergh*et al.,* 2002; Ferrinho*et al.,* 2004); yet higher salaries alone will not reduce risk of abuse if opportunities and incentives do not also change. Accordingly, some reforms have tried to link compensation to achievement of targets for quality and/or productivity, or to exert professional or peer pressure for performance. Performance-based incentives have been studied and used in some low-income countries, including Haiti, the Philippines and Cambodia (Eichler*et al.,* 2000; Management Sciences for Health, 2001; Soeters and Griffiths, 2003; Dugger, 2006).

Hague (1996) quoted in Kayode et al (2013) argue that Public Administration itself is prone to corruption, since officials exercise a substantial amount of power. There are possibilities for acquiring improper benefits by interpreting or bending rules in favour of certain groups or individual.

In a democratic polity, the ultimate principals are the citizens who are the consumers of specific service provided by the government. In the Political-Agent theory, they are Principal in the sense that politicians as Agents seek their mandate from and act as the representatives of the public.

The likely hood of the principal effectively controlling the Agent depends on how much information the principal has about the performance of the Agent, and how far the principal can structure the relationship so as to control the Agent or give incentives so as to make the Agents interest correspond to the Principals.

5.2 Conclusion

It is apparent that most local government authorities are not functional. With the exception of few local governments in the country, others are mere shadow of themselves. In terms of meeting their core mandate they have been largely ineffective and inefficient. This explains why after many years of comprehensive and democratically minded local government reform of 1976, little social dividends can be found in most local government. There is no doubt that the high rate of corruption in the local government has great implication on service delivery. It is rather unfortunate that the citizens that are supposed to enjoy the benefits of these services are rather subjected to all forms of ridicule and frustration.

Monitoring systems specifically looked for evidence of overcharging, informal payment, ghost patients, and inflation of statistics, and used this information to address specific problems and make systematic changes. This type of integration of anticorruption tools and approaches into the traditional health reform process is perhaps the best strategy for preventing corruption

Monitoring systems specifically looked for evidence of overcharging, informal payment, ghost patients, and inflation of statistics, and used this information to address specific problems and make systematic changes. This type of integration of anticorruption tools and approaches into the traditional health reform process is perhaps the best strategy for preventing corruption

Fighting corruption is a complex undertaking, but there are things policy makers and citizens can do to prevent corruption. Applied research is needed in several areas: policy research to evaluate which types of health reforms are most likely to reduce corruption; studies of the effectiveness of alternative roles for civil society in promoting transparency and accountability in health governance; and refinement of tools and methods to diagnose vulnerability to corruption in health systems and to reduce risk. By closing opportunities for corruption while building ethical standards so that people are less inclined to abuse public power for personal gain, we can begin to curb corruption in the health sector.

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Corruption in the Buvuma district includes but not limited to mismanagement and misappropriation of public fund but also not doing what one is supposed to do including coming late to work and leaving the office before the specified closing time. Corruption in the health sector still includes pilfering office materials, drugs, injections and equipment among others. Corruption, which is endemic in the health sector, cuts across the administrative officers, doctors, nurses to the pharmacists and even the patients. Deficiencies of assessment, evaluation, monitoring policies, epileptic power supply and lack of transportation means are the major inconsistencies in procurement and distribution of drugs.

Mismanagement and diversion of public funds are the major factors responsible for poor management/administration of funding in the health sector.

Service delivery is the part of a health system where patients receive the treatment and supplies they are entitled to. All the other parts of the health system examined in this map support the delivery of healthcare services and, as a result, corruption in these other areas will indirectly impact on the quality of delivery. For example, unpublished harms data from clinical trials could lead to healthcare providers basing the treatments they give on unsound medical knowledge.

However, there are multiple forms that corruption can take specifically in the delivery of healthcare services. Corruption here has a negative impact on access to services, compromising the ability of governments to provide healthcare to citizens. Likewise the quality of care can be diminished as patients receive needless treatments. Vulnerable populations will be most affected as they struggle to meet unofficial or unnecessary payments and instead may choose to forgo treatment or seek treatment from unauthorised providers.

Some experts suggest that low wages and poor working conditions for healthcare workers are the causes of corruption in this part of the health system. For example, doctors may demand informal payments from patients and provide private practices using public resources, as they seek to subsidise their wages with other or higher payments. Others have suggested that these corruption types should be seen as an effect of wider governance failures in the health systems including limited oversight of worker performance and minimal sanctions for malpractice. However, in other instances it may simply be an abuse of power to satisfy greed. These corruption types can be prevalent in both high-income and low-and middle-income countries. Regulators in all health systems must implement measures to minimise the risks of prevalent types of corruption in healthcare service delivery.

5.3 Recommendation

We thus, recommend that the local governments in Uganda should be scrapped. The circumstance that has characterized poor service delivery at the grass root in Nigeria has been a colossal tales of one corrupt case to the other. The position here is in line with the opinion of the delegates in the just concluded National Conference. The idea is that since the creation of the third tier of government, the situation of grassroot development has gone from bad to worst. It is thus suggested that the local government should be made an administrative arm of

the State Government rather than leaving it in the current situation where even the conduct of a free and fair democratically elected functionaries has become almost impossible. The few areas where elections are conducted, they seem not to be performing.

Again, the Financial Crime regulatory institutions should conclude all the outstanding financial fraud cases on the past district bosses that are all over the courts in Buvuma district. This would help to some extent serve as a guide to upcoming politicians whom would be at the helms of affairs.

The following recommendations were proposed in order to curb corruption in the health sector and improve quality of service been delivered in Buvuma district. They are as follows:

1. Stringent measures should be taken to deal with corrupt health workers who are caught in one corrupt act or the other so that they can serve as deterrence to other potential perpetrators in the health sector.
2. Seminars, symposiums and convention programs to enlighten health workers/officials on the dangers and negative impacts of corruption on their image as a person and its effects on sick poor masses citizens who are always on the receiving end should be conducted from time to time.
3. Avenues within the public hospitals that encourage corruptions should be curbed by making sure that receipts are issued and payments made at the appropriate quarters.
4. The ministry of health should be decisive and swift in procuring and distributing drugs, vaccinations, medical equipment and materials needed in public hospitals. There should also be public awareness to ensure that masses have knowledge of drugs that are free.
5. Ambulances, vehicles and other logistics should be provided for easy and faster mobility in terms of emergencies, procurement and distribution of drugs/medical materials to public hospitals in Buvuma district. This will further address some shady corrupt practices in procurement and distribution of drugs; hence it will enhance better and quality healthcare services outputs.

5.4 Area of further study

The researcher recommends that further study be done on

Corruption and service delivery in local government systems

Corruption and the Consequences for Public Health

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APPENDIX

APPENDIX A

QUESTIONNAIRE

Dear Respondents;

I am KIGONGO HERMAN, a student of Kampala international University, College of Humanities and Social Sciences pursuing a Degree in Bachelor of Public Administration. As part of my requirement for the Degree award, I am conducting a study on Corruption and Health Service Delivery in Local Governments: A Case Study of Buvuma District.

You are requested to answer these questions as honestly as possible. This questionnaire will be treated with the strictest confidentiality. The information gathered from this questionnaire will be used purely for academic purposes. Thank you for taking the time and effort to complete this questionnaire.

SECTION A: BIO DATA

1. **Gender: Please tick (√)**

   Male ☐ Female ☐

2. **Age (in years): Please tick (√)**

   20 – 30 ☐ 31 – 40 ☐ 41 – 50 ☐

   51 – 60 ☐ 61 and above ☐

3. **Marital status: Please tick (√)**

   Single ☐ Married ☐ Divorced ☐ Widowed ☐

4. **Highest level of education: Please tick (√)**

   Never went to school ☐ Certificate ☐ Diploma ☐

   Bachelor's Degree ☐ Master's Degree ☐ PhD ☐

5. **What is your main occupation?**

   Farmer/Peasant ☐ Businessman/women ☐ Public servant ☐

   Other specify.....

6. **Where do you mostly get health services?**

   District hospital ☐ Clinic ☐ Health centre ☐

   Others specify.....

SECTION B: Clients' Perceptions of Corruption

7. Do you think corruption occurs at the point of health services? 1= Yes 2=No
8. If yes, what types of corrupt practices are common in your area? 1= Absenteeism of health service providers, 2=Theft of medical supplies, 3=Informal payments, 4=Nepotism, 5=Embezzlement of health care funds, 6=other (specify)
9. On the following statements, Please indicate the extent to which you disagree or agree with corruption. Using a scale ranging from 1= Strongly Disagree (SD), 2 = Disagree (D), 3 = Not Sure (NS), 4 = Agree (A), and 5 = Strongly Agree (SA), please indicate your preference by marking with a tick (√) in the appropriate block provided.

№	Statement	SD	D	NS	A	SA
8.	Bribery control health services delivery					
9.	Bribes help to receive information on the process of health service					
10.	Corruption reduces long health service procedure which are too costly and time wasting					
11.	Corruption gives unfair health treatment among clients					
12.	Corruption helps to reduce the existing uncertainty of health services					
13.	Unofficial payment guarantee reliability of services					

SECTION C: Factors driving corruption

10. If you have been involved in any form of corruption with medical workers in the previous 12 months, what was the major motive behind? [Tick only one major motive]

S/N	Motive for being involved in corruption	Yes	No
8.	Wanted to avoid a long queue		
9.	It was a pressure from medical workers		
10.	Quest to get good quality health services		
11.	Poor responsibility among medical workers		
12.	Wanted to avoid long bureaucratic procedures		
13.	Poor living standards among medical workers		
14.	Poor access to information about my health service rights		

SECTION D: Perceived Quality of Health Service Delivery

11. For your opinion, how does corruption affect the quality of health service delivery?
    1= to a greater extent, 2= to some extent, 3= to a small extent, 4= not a problem at all, 5= don't know/ not sure, 6= other (specify)
12. On the following statements, please indicate the extent to which you disagree or agree with the quality of health services received. Using a scale ranging from 1= Strongly Disagree (SD), 2 = Disagree (D), 3 = Not Sure (NS), 4 = Agree (A), and 5 = Strongly Agree (SA), please indicate your preference by marking with a tick (√) in the appropriate block provided.

№	Statement	SD	D	NS	A	SA
1.	Patients are waiting for a long time to get health service					
2.	The demand of tips before services builds trust between health workers and patients					
3.	Patients are denied their rights due to practices of friendliness					
4.	Only rich patients receive high respect and favour from health service providers					
5.	Patients financial resources are depleted to get attentiveness from service providers					
6.	Patients are satisfied with the services provided at the health care center					

7. Health service providers pay more attention to patients privacy
8. Patients get the necessary treatment according to their sickness
9. Patients are not satisfied with the services provided
10. Patients kept waiting for a short time to get health service
11. Patients lose faith to health workers due to the demand of tips before
12. Patients gets their right due to the practices of friendliness
13. Poor patients are disrespected from health service providers
14. Health service providers give attentiveness to the patients regardless of financial resources
15. Patients privacy are not paid attention by health services providers
16. To get the necessary treatment patients must pay more than it is required
17. Professionals tend to claim to have provided services which they did

SECTION E: Perceived Effect of Corruption on Health Service Delivery

13. On the following statements, you are asked about the perceived effect of corruption on the health service delivery. Using a scale ranging from 1= Strongly Disagree (SD), 2 = Disagree (D), 3 = Not Sure (NS), 4 = Agree (A), and 5 = Strongly Agree (SA), please indicate your preference by marking with a tick (√) in the appropriate block provided.

№	Statement	SD	D	NS	A	SA
1.	Leads to lack of drugs, equipment or other materials					
2.	Leads to poor quality care					
3.	Patients die or maimed due to poor quality care					
4.	Charges are made high in order to cover charges					
5.	Patients condition get worse due to delay of service					
6.	Patients do not get proper treatment					
7.	Workers lack motivation and interest in patient care					
8.	Patients distrust the health system					
9.	Doctors and nurses respects patients during delivery of services					
10.	Doctors treat patient in a genuine interest during delivery of service					

"Thank you for taking the time and effort to complete this questionnaire"

Appendix D: Table for Determining Sample Size from a Given Population

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Note: "N" is population size

"S" is sample size.

Source: (Krejcie & Morgan, 1970)

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COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

DEPARTMENT OF POLITICAL AND ADMINISTRATIVE STUDIES

March 22, 2019

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: INTRODUCTION LETTER FOR KIGONGO HERMAN
REG NO. 1153-06404-01538

The above mentioned candidate is a bonafide student of Kampala International University pursuing a Bachelor's Degree in International Relations.

He is currently conducting a field Research for his Dissertation entitled, **"Corruption and Health Care Service Delivery in Buvuma District, Uganda."**

Your organisation has been identified as a valuable source of information pertaining to his Research Project. The purpose of this letter then is to request you to accept and avail him with the pertinent information he may need.

Any data shared with him will be used for academic purposes only and shall be kept with utmost confidentiality.

Any assistance rendered to him will be highly appreciated.

Yours faithfully,

KAMPALA INTERNATIONAL UNIVERSITY
COLLEGE OF HUMANITIES & SOCIAL SCIENCES
P.O. BOX 20000 KAMPALA
12 MAR 2019

Gerald Muzaare
HOD, Political and Administrative Studies