CORRUPTION AND HEALTH SERVICE DELIVERY IN KISMAYO DISTRICT, SOMALIA

BY

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A RESEARCH DISSERTATION SUBMITTED TO THE COLLEGE OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTERS DEGREE OF DEVELOPMENT STUDIES OF KAMPALA INTERNATIONAL UNIVERSITY

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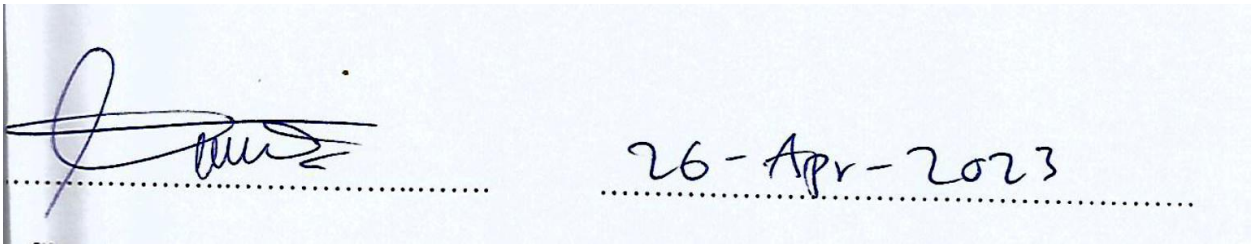
DECLARATION

I, **Ahmed Dek Ahmed**, hereby declare that this proposal is my original work to the best of my knowledge and has not been submitted to any other university for the purpose of awarding a Master's Degree in Development Studies.



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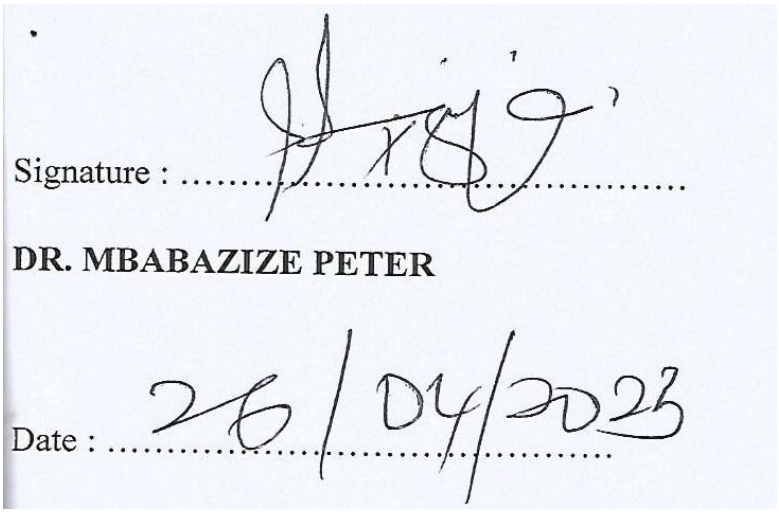
APPROVAL

This research proposal has been prepared under my supervision and is now ready for progress review by the College of Humanities and Social Sciences of Kampala International University.



(Research Supervisor)

DEDICATION

First of all, I would like to dedicate this piece of work to the Almighty Allah who has enabled me to carry out this research successfully and to my beloved parents without forgetting my dear siblings. May the Almighty God bless you all.

ACKNOWLEDGEMENTS

I thank Almighty Allah who has given me the strength, wisdom, protection and provision in all situations. I give him all the glory.

Formulating a research topic, coming up with literature review, compiling the information gathered with a research proposal and finally writing a dissertation involves a lot of consultations. There are special people who have greatly assisted me in the production of this report. It is practically impossible to individually thank everyone. However, a few of them deserve special mention.

I humbly express my gratitude to my supervisor Dr. Peter Mbabazi Mbabazize for her invaluable advice and correction, patience, effective guidance and understanding in the course of writing this research, I am grateful to Kampala International University for admitting me to their Master's program. Special thanks to my dear friends and fellow MSW students of Kampala International University for their total support.

I am grateful to my beloved parents, my brothers and sisters and other relatives who contributed tremendously and for their patience, prayers and support throughout the long journey of sacking knowledge towards completion of this report.

Finally I will love to give a Special thanks to all my family, friends and relatives who have come to love me for who I am and fight with me throughout this journey, thank you and may Allah bless you All.

I once again thank all, including the categories not mentioned above, who encouraged and contributed to the completion of this work.

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ABSTRACT

The study assessed the effect of corruption on health service delivery at Kismayo district Health Centers. The objectives of the study included; to find out how bureaucratic dishonesty affects health service delivery at Kismayo district health centers, to examine how conflict of interest in health centers affects health service delivery at Kismayo district health centers and to find out how bribery in health centers affects the delivery of health services at Kismayo district health centers.. A case study research design was adopted employing both qualitative and quantitative approaches. Out of the targeted sample size of 400 respondents, 365 respondents participated in the study, which was equivalent to a response rate of 91%. The quantitative data was analyzed using descriptive statistics, Spearman correlation and regression analysis techniques. Qualitative data was summarized and presented using verbatim statements. The findings showed that, bureaucratic corruption affected service delivery by 23.9%, conflict of interest had 38.9% effect on health service delivery while bribery affected health service delivery by 18.9%. The results therefore mean that conflict of interest had the greatest effect on service delivery. In conclusion, the researcher observed that bureaucratic corruption which results into low morale among the health workers significantly contributes to poor health service delivery. Conflict of interest contributed to poor service delivery since it compromises the recruitment process and cheats the health centers of would-be competent and committed staff. Solicitation for bribes from the patients was also contributed to poor service delivery. The study recommended that Kismayo district should come up with strategies to motivate its workers, especially in the health department; streamline the recruitment system to minimize conflict of interest and seriously revise and emphasize the work ethics and code of conduct.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

Corruption in the health sector can be a matter of life and death, especially for poor people in developing countries. Corruption in the health sector can have severe consequences on access, quality, equity and effectiveness of health care services. Bribes to avoid government regulation of drugs have contributed to the rising problem of counterfeit drugs which can lead to increased disease resistance and death (DFID, 2010). Although corruption is an ancient problem, it has in the last decade attracted considerable attention of academicians and policy makers. There are efforts in many countries to clean-up politics and bureaucracy. In less developed countries, corruption is seen as one of the reasons for underdevelopment. In literature, there is almost consensus that corruption by public officers discourages entrepreneurs, causes inefficiencies and wastes resources, discourages foreign investment, distorts income distribution and harms democracy and ethics (Bayar, 2003).

Throughout the world, corruption in vital service sectors like health and education undermines public policies aimed at assuring equitable development. Corruption especially in the health sector hits the poor and rural communities the hardest (Transparency international, Global Corruption Report 2006). Achievement of one of the millennium development goals of combating HIV/ AIDS, malaria, and other diseases is likely to be undermined due to the seemingly high rate of corruption in the health services sector in developing economies.

This study examined corruption and service delivery in Kismayo district health Units. The independent variable in the study was corruption, which was further conceptualized as; bureaucratic dishonesty, conflict of interest and bribery. The dependent variable was service delivery, in terms of timeliness of service, staff efficiency and service quality. This chapter presents the introduction, background to the study, statement of the problem, general objectives, specific objectives, research questions, hypotheses, significance, justification, scope of the study and operational definitions.

1.1 Background to the Study

1.1.1 Historical background

The word “Corruption” has its origin in a Latin verb “corruptus” meaning “to break”. Literally, it means “a broken object”. In simple words, corruption means “the misuse of entrusted power for private benefit” (Turocy, 2001). Corruption is said to be as old as mankind. It can be traced back to the story of the disobedience of man; Adam to God when the former’s mind was corrupted by the serpent to eat the forbidden fruit in the Garden of Eden (Sebutinde, 2000).

Among the many challenges facing public service institutions in developing countries, corruption remains one of the most pervasive and the least confronted (Kauflnann, 1998). Transparency International (2018) considers corruption as one of the greatest challenges of the contemporary world. It undermines good government, fundamentally distorts public policy, leads to the misallocation of resources, harms the private sector and private sector development and particularly hurts the poor.

Amundsen (2019) argues that corruption is found almost everywhere, though it is stubbornly entrenched in the poor countries of Sub-Saharan Africa, while it is widespread in Latin America. In addition, Agbu (2001) further asserts that corruption as a phenomenon, is a global problem and exists in varying degrees in different countries. Corruption is a word with broad meanings in every day speech. tied to both designating facts and passing of moral judgement and condemnation. Social scientist understands corruption as the misuse of public office or a comparable position of trust for private purpose (Cremer (2018). Hence Upset and Lenz (2010) conclusion that corrupt practices are not an issue that just begins today; but the history is as old as the world.

History shows that this phenomenon has generally been manifesting in different kinds of cultures and societies starting with the most ancient times. Today corruption is still a reality, generated by the particular economic, cultural and political conditions in both developing and developed countries. In East Africa for a country like Uganda, corruption has existed since the pre-colonial era, and thus, it is not a new phenomenon. Chiefs could arbitrarily deprive subjects of their property, wives and labor. Subjects could also bribe chiefs to have their cases adjudicated in their favor. Collaborators of the colonial government in Somalia were rewarded with administrative

positions for their alliances with the colonial administration like Semei Kakungulu attained in Buganda (Tumwesigye, 2001).

In Somalia due to a breakdown of the system of control, accountability and management in Somalia in the 1960s and 1970s the anti-corruption legal framework was instituted. This saw the subsequent enactment of the legislations like the Prevention of Corruption Act, the Penal code Act and the Leadership Code Act. The establishment of corruption institutions like Auditor General's office, Inspectorate of Government, Public Accounts Committees of parliament and districts and Directorate of Public Prosecutions are clear manifestation of the existence of corruption in the public sector including health. In the recent past, the media has been awash with various reports of corruption in Kismayo district health centers, which had culminated into poor health service delivery. Pregnant mothers have lost their lives due to failure to raise the fees as required by the service providers, prior to facilitating their delivery, while many HIV/AIDS clients have missed out on ARVs, which are meant to be freely given, but due to corruption, some health staff choose to sell them off.

While the government has tried to set up facilities countrywide to improve the general health service delivery, a 2019/2020 report, Somalia Local Government Councils Score Card by ACODE, shows that improvements are only in infrastructure. However, the major problems such as understaffing, unavailability of drugs and equipment, absenteeism of health workers, and weak accountability mechanisms remain (The Observer, 2021). Such practices have enormously affected the health sector to a point of rendering it nearly dysfunctional.

1.1.2 Theoretical background

This study was guided by the Economic Theory by Adam Smith 1723 to 1790 and the Principal-Agency theory developed by Lupia (1998).

The Economic Theory of Adam Smith wrote at a time when the concept of corruption, under pressure from two broad and related historical fronts, was undergoing a refinement in its meaning. The first was the expansion of commercialism and British domestic and foreign markets. As Britain's empire and economy grew so did the opportunities and scope for corruption. This, in turn, hastened the emergence of new understandings of the relationship between private interests and public duties. The second set of pressures was brought about by the

birth of the modern state, which was expanding rapidly and becoming more organized (Paul, 2002). With that expansion and increasing organization, the line between private market and state affairs began to sharpen. Corresponding to these changes was the emergence of protoliberal sensibilities that nurtured and promoted such values as neutrality, impartiality, merit, and egalitarianism and pitted them against the absolutism, nepotism, particularism, and patronage perceived to be attendant on feudal and aristocratic forms of governance. Although most eighteenth-century thinkers continued to employ the term "corruption" in its classical sense, (Albert, 1977), reformers increasingly drew attention to practices and institutions that would now qualify as sins against modern sensibilities.

Furthermore 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 & 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). If the government is the only provider offering medical services, for example, patients could be compelled to pay bribes to access those services. In Somalia, while there are a number of private players offering medical services, the government is constitutionally mandated to take care of the health of its nationals and consequently, the low income earners (who form majority of the populace), are compelled to seek services in government facilities. Therefore, due to the sensitivity of health related matters, many people find themselves with no choice but to offer bribes once they are cornered into that state to secure their health or that of a beloved one.

The study was further guided by the Principal-agency theory developed by Lupia (1998) which denoted that the analysis and evaluation of service delivery requires a specification of who is (or is supposed to be) accountable to whom. Principal- agency theory is more accurately described as a family of formal models addressing related concerns with similar styles of analysis. It is not much of a stretch to suppose that for any given actors labeled "principal" and "agent," and any pattern of interaction between the two, a principal-agent model can be written down with that pattern as an equilibrium outcome and modelers might consider it a parlor game of sorts to do it (Sasser, 2011). The Principal-Agency theory, adopted from Batley (2004) examines

organizational relationships between the "Principal" who demands a service and the "Agent" who provides it. The model assumes that actors are motivated by rational self-interest. In the operational definitions, corruption was looked at as having emphasis on personal interest as against the public interest/good. The Principal- Agent theory helped in espousing how the perpetration of this selfish interest has affected the ability of the Agent (Kismayo district health service providers) in providing the necessary services to the consumers (i.e. Public), in an effective and efficient manner, in the right quantity and quality, in the right place and as at when necessary. In connection with this study, the Principal (in this case, the Kismayo district administrative authority) can manage the self-interest of those empowered to act on their behalf (i.e. the Agents: Kismayo district health service providers) so that it is aligned with the purposes that they (the Principal) wish to achieve. However, the challenge lies in the privileged access of the agents to information and the manipulation of such information by the agents compared to other agents and health service consumers. In majority of the cases, the Kismayo district health service providers who deal directly with the principal (Kismayo district administrative authority) and at the same time deal directly with the health service consumers (the public) who actually not aware of their rights and obligations. Consequently, those who have been employed to provide a service (the agents or Kismayo district health service providers) will tend to use their superior knowledge to divert benefits in their own direction.

1.1.3 Conceptual background

Corruption is a complex problem which threatens health care access, equity and outcomes (Grownendijk, 1997). The menace of corruption has links to a multitude of vices. Its roots are linked to injustice, mistrust, suspicion, extremism and terrorist activities. It creates a sense of insecurity, exacerbates poverty and adds to the misfortune of the vulnerable segments of the society. It also instils a sense of hopelessness and despondency and threatens the strength of good values which have been established over centuries of civilized struggle.

The term corruption has various definitions. The United Nations Manual on Anti- Corruption, the Transparency International, and the multilateral financial institutions like the World Bank and Asian Development Bank define corruption as, "abuse of public office for private gains" (Jamal, 2013; Simitko, 2013). In defining corruption, Transparency International focuses on it as "the abuse of entrusted power for private gain". The National Anti-Corruption Strategy (NACS)

has defined corruption as behavior on the part of office holders in the public or private sector whereby they improperly and unlawfully enrich themselves and/or those close to them, or induce others to do so, by misusing the position in which they are placed (Don Quichotte 2013).

For Somalia, the definition contained in the Laws of Somalia, Section 1, of the Inspectorate of Government Act (2002), refers to "abuse of public office for private gain and includes but is not limited to embezzlement, bribery, nepotism, influence peddling, theft of public funds or assets, fraud, forgery, causing financial or property loss, and false accounting in public affairs (Inspectorate of Government, 2008; Owor, 2012).

Corruption can be categorized as petty or survival corruption practiced by poorly paid public servants, and grand corruption which involves theft of vast amounts of public resources. It can also be categorized into political, corporate and even moral corruption. In whatever way it is looked at, corruption has an element of moral breakdown; the corrupt ignore acceptable practice and put their needs above the needs of the public (Transparency International, 2013).

Some of the forms in which corruption is manifested include embezzlement: The act of dishonestly taking or using resources by persons entrusted with authority and control over those resources. It is theft of public resources (softened by calling it "misappropriation of funds) (Yuksel, 2013). Bribery: The promise, offer or giving of any benefit that improperly affects the actions or decisions of a public official. A bribe may be money, inside information, gifts, entertainment, sexual or other favors, a job, company shares, and such related inducements to achieve personal gains. Nepotism: The act of giving unfair consideration to family members and/or relatives for appointment to the public service, award of contracts from public resources and the benefit resources at the expense of other members of the public. Cronyism (favoring friends) and Patronage: (favoring supporters) closely relate to this. Influence Peddling: Participation by public officials – in the course of their official work – in a decision in which they have private interest or from which they stand to gain (directly or indirectly) and fraud: Deliberate deception and this is usually through forgery (Yuksel, 2013).

Health service is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in humans. Health care is delivered by practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health, and other care providers. It

refers to the work done in providing primary care, secondary care and tertiary care, as well as in public health (Auditor General, 2006).

Access to health care varies across countries, groups and individuals, largely influenced by social and economic conditions as well as the health policies in place. Countries and jurisdictions have different policies and plans in relation to the personal and population- based health care goals within their societies. Health care systems are organizations established to meet the health needs of target populations. Their exact configuration varies from country to country. In some countries and jurisdictions, health care planning is distributed among market participants, whereas in others planning is made more centrally among governments or other coordinating bodies. In all cases, according to the World Health Organization (WHO), a well-functioning health care system requires a robust financing mechanism; a well-trained and adequately-paid workforce; reliable information on which to base decisions and policies; and well maintained facilities and logistics to deliver quality medicines and technologies (WHO, 2002).

1.1.4 Contextual background

In Somalia, public health care may be delivered from facilities which are run by the Somali authorities and international NGOs with external donor financing (HIPS & City University of Mogadishu, 2020).

Most of the services provided at the public healthcare facilities, including hospitals, are within primary health care, especially maternal and child health.86 The six core programmes in Somali public health facilities are i) Maternal, reproductive health, neonatal health and nutrition; ii) child health and nutrition; iii) CDC (center for disease control), surveillance and WATSAN (water and sanitation); iv) first aid and care of critically ill and injured; v) treatment of common illnesses; and vi) HIV, sexually transmitted infections (STI) and tuberculosis (TB) (HIPS & City University of Mogadishu, 2020).

Health service delivery is the constitutional mandate of the Federal Ministry of Health and Human Resources (FMoH). This ministry is responsible for the regulation of the health sector across Somalia, including quality control of health services and medicine distribution and policy, oversight of human resource capacity development as well as coordination between the different health sector actors (WHO, 2016). The Ministry has developed a roadmap towards Universal

Health Coverage and the Ministry is also in the process of reviewing the existing essential package of health services (EPHS) so that it becomes better aligned with the Universal Health Coverage. This review is, according to information on the Ministry's website, undertaken in collaboration with the federal member states (Ministry of Health Somalia, Programmes).

According to the HIPS & City University of Mogadishu there were in 2019 a total of 661 operational public health facilities across the federal states of Somalia: 305 in Puntland, 92 in Galmudug, 93 in Jubbaland, 81 in Hirshabelle, 61 in Banadir and 29 in the Southwest. As illustrated by the map below, and as recognised by the FMoH, the number of functional health services is unequally distributed across the country and is particularly low in the southern and central regions.93 Health infrastructure, private as well as public, is concentrated in the capital and in major towns where security is better compared to rural areas which may be under mixed control or al-Shabaab control.

Furthermore in response to the effectiveness of the decentralized governance on health services, community participation has been limited to support in the form of manpower for the development of health programs through the role of "health promoters". Community leaders and some users have participated in the monitoring of some health programs, but the community has been reluctant to make economic contributions directly towards health financing. The community has chosen representatives as members of the local health committees (integrated by suppliers and users), whose main task is designing and supervising health programs according to the main epidemiological problems at state and municipal levels. Kismayo hospitals were selected as a study area because it was among the first 13 communities that were decentralized in the 2013/15 financial year, and thus an evaluation of it is more appropriate than an evaluation of districts that were decentralized later. Therefore, in this study sought to examine the effect of decentralized governance on health services delivery in Kismayo city of Puntland.

More so in Kismayo, health service delivery is an obligation of the Ministry of Health (MoH) which gives the priority areas of health service system development, health technology and medicines, health human resource development and health care delivery (Health, 2015). Generally, the Ministry of Health is responsible for improving the health and wellbeing of all citizens of Kismayo. Therefore Health services are delivered under decentralized governance in Kismayo. The Ministry of Local Government and Rural Development (MLGRD) has full

responsibility of supervising the implementation plans and activities of District Councils of Kismayo (DCP) which include; delivering essential needs such as healthcare. (M.O.L.G.R.D., 2015).

In 1990s Kismayo had only one hospital before decentralization. However, after decentralization in Kismayo, Kismayo city council achieved four hospitals which include; Kismayo general hospital, TB hospital, Somaal hospital, Qaran hospital and Nine (9) Maternal Child Health services to enhance service delivery. This reveals the level of health services delivery under decentralization strategy (Kismayo District Development Framework, 2011). Whereas decentralization was implemented in Puntland to bring about better service delivery, Kismayo District Development Framework (2011) revealed that there were very poor and deplorable health services in Kismayo. In rural areas, many people are reported not to have sufficient health care (Health Strategic Plan of Kismayo, 2013-2015).

Despite all the above efforts, Uganda, once internationally recognized for its anti-Aids programmes, has come under intense criticism for allegedly backsliding in its commitment to help the sufferers of the disease and reduce its dissemination. The criticism comes because of the high levels of corruption that is biting hard on the country´s health sector (Mboizi, 2008). These include under-the-table payments, absenteeism from public health centers, private practice in public facilities, and pocketing of official fee revenue. Other forms reported in the health sector were giving bribes from a private supplier to win a government procurement contract and misappropriation of public resources for private gain. From health centers across Uganda, various forms of corruption, especially during provider-patient interactions, have been reported

In fighting corruption in the health sector, Somalia has adopted a pursuant approach to the zero-tolerance policy on corruption where the Anti-Corruption Coalition in Somalia calls for more vigilant action against corrupt officials in the health sector (Mboizi, 2008). There is also a parallel health structure directly under the office of the president to monitor the health sector. In doing this, Somalia has seen corrupt officials in the health sector taken to court, including health ministers who were in charge of the GAVI funds; large financial resources earmarked by the donor countries for fighting Aids, malaria and tuberculosis. On several occasions, arrests have been made of health Officials who have taken drugs from Public health Centers for their personal

gains and have been ordered to pay back what they had taken (the Ogaal Newspaper, January 14, 2008). On January, 14, 2008, the Daily Monitor reported the arrest of three Health workers from Kismayo health centre who had stolen drugs worth 72 million Uganda shillings. On 17 January the Puntland Post and the Ogaal Newspaper both ran stories of 10 doctors and nurses who had taken medicines from the National referral hospital, to have been arrested and demanded to hand the medicines back. Similar arrests have taken place in all parts of the country and served to reduce the loss of public drugs to health officials´ thefts. The actions of such health workers have played a part in the inadequate availability of drugs to different health centers which in turn has led to the death of a number of patients too poor to afford buying drugs off the shelves in pharmacies.

In Kismayo, health service delivery is an obligation of the Ministry of Health (MoH) which gives the priority areas of health service system development, health technology and medicines, health human resource development and health care delivery (Ministry health of Kismayo, 2013). Generally, the Ministry of Health is responsible for improving the health and wellbeing of all citizens of Kismayo. Therefore Health services are delivered under decentralized governance in Kismayo.

1.2 Problem Statement

Corruption in the health sector is a concern in all countries, but it is an especially critical problem in developing and transitional economies where public resources are already scarce (Ahimbisibwe, 2011; Mwanje, 2011; Juuko, 2020; Vian 2012). According to the Inspector General of Governments Office (2021), Kismayo district government institutions are complained against rampant corruption. The Kismayo district health center processes are riddled with corruption, embezzlement and fraudulent activity. Corruption at Kismayo district is manifested in mismanagement, fraud and lack of financial accountability by both staff and political leaders (Kismayo district Office of the Executive Director, 2013). Lack of a system of accountability manifested in inflated claims, forgery of documents and outright fraud including payments for undelivered services (Kismayo district Office of the Executive Director, 2013).

Despite efforts made to improve health service delivery at and district level, service delivery has remained poor (Lambright, 2012). For instance, Kismayo district health centers have failed to provide essential health services to the local community (Lambright, 2011; Okidi & Guloba, 2008). Ahmad et al. (2006) cast doubts on the reach and quality of health services. The researcher cites the worsening of mortality indicators to support his argument. Further, the Kismayo Office of the Executive Director (2013) and Azfar et al. (2007) highlight the lack of transparency in service provisions and corruption by health workers although a lot of money has been put in the sector. If this situation continues then it will undermine GoS's efforts to combat HIV/ AIDS, malaria, and other diseases to achieve the Millennium Development Goals (MDG) in health. This study therefore seeks to examine the effects of corruption on health service delivery at Kismayo district health centers.

1.3 Purpose of the Study

The purpose of this study was to examine the effect of corruption on health service delivery at Kismayo district health centers.

1.4 Objectives of the study

The objectives of this study were:

1. To find out how bureaucratic dishonesty affects health service delivery at Kismayo district health centers.

2. To examine how conflict of interest in health centers affects health service delivery at Kismayo district health centers.

3. To find out how bribery in health centers affects the delivery of health services at Kismayo district health centers.

1.5 Research Questions

This study was guided by the following research questions:

1. To what extent does bureaucratic dishonesty in health centers affect health service delivery at Kismayo district health centers?

2. How does conflict of interest in health centers affect health service delivery at Kismayo district health centers?

3. To what extent does bribery in health centers affect health service delivery at Kismayo district health centers?

1.6 Research Hypotheses

This study was guided by the following research hypotheses:

1. Bureaucratic dishonesty significantly affects health service delivery.

2. Conflict of interest has a significant effect on health service delivery.

3. Bribery has a significant effect on health service delivery.

1.7 Scope of the Study

1.7.1 Geographical scope

The study was carried out from Kismayo District, Kismayo District is a district in the southern Jubbada Hoose region of Somalia. Its capital is Kismayo. The city is situated 528 kilometres (328 miles) southwest of Mogadishu, near the mouth of the Jubba River, where the waters empty into the Indian Ocean. According to the United Nations Development Programme, the city of Kismayo had a population of around 89,333 in 2005. During the Middle Ages, Kismayo and its surrounding area was part of the Ajuran Empire that governed much of southern Somalia and eastern Ethiopia, with its domain extending from Hobyo in the north, to Qelafo in the west, to Kismayo in the south.

1.7.2 Content scope

This study examined corruption and service delivery in Kismayo district health units. Relating to corruption, the study was limited to bureaucratic dishonesty, conflict of interest, and bribery while service delivery was limited to timeliness (speed) of service, staff efficiency and service quality.

1.7.3 Time scope

The study covered information from 2010-2019. This study was justifiable at that time because government and the international community has been committing enormous sums of money to the health sector which had been lost to the corrupt. This led to the suspension of budgetary support to the health sector making to local people suffer the consequences of unethical individual actions from the health sector. The corruption scandal involving the siphoning off of some $13 million in donor funds had already led Britain - Somalia's biggest donor - to suspend aid to Kismayo. Denmark, Norway and Ireland followed suit. Therefore, health center staff and patients that will be interviewed provided information limited to the stated period.

1.8 Significance of the Study

The study of corruption and service delivery was important at this time because the findings will expose the dimensions and magnitude of corruption that will highlight the problem in Kismayo district.

It could enable management and policy makers to prescribe and adopt measures that could reduce corruption tendencies at Kismayo district.

It could result into cost savings from possible loss of public funds to the corrupt health workers and protect citizens from losing money through bribery.

1.9 Definitions of Key Terms

The operational terms in this study were defined as follows:

Corruption: Any action done in private or public that diverts resources from the intended and wider public good for private purposes. In other words, you do not have to be caught or seen to commit that act. Osoba (1996) defines corruption as an antisocial behavior conferring improper benefits contrary to legal and moral norms and which undermines the authority's ability to improve the living condition of the people.

Bureaucratic Dishonesty. Refers to those forms of corruption that are clearly committed by public administrators in their political capacity. Furthermore, I have distinguished bureaucratic corruption from maladministration, may not be fault of bureaucratic corruption.

A **conflict of interest** (**COI**) is a situation in which a person or organization is involved in multiple interests, financial or otherwise, and serving one interest could involve working against another. Typically, this relates to situations in which the personal interest of an individual or organization might adversely affect a duty owed to make decisions for the benefit of a third party.

Bribery is defined by Black's Law Dictionary as the offering, giving, receiving, or soliciting of any item of value to influence the actions of an official, or other person, in charge of a public or legal duty (Black's Law Dictionary, 2011). With regard to governmental operations, essentially, bribery is "Corrupt solicitation, acceptance, or transfer of value in exchange for official action."

Service delivery: Tangible and intangible goods and services provided by the government in order to improve the wellbeing of the citizenry.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter covers the review of literature on corruption and service delivery. It begins with introduction to the arrangement of the chapter then, review of theories related to the subject of study and the literature review objective by objective.

2.1 Theoretical Review

2.1.1 Principal-agent theory

Majorly, the study was underpinned by the Principal-agency theory developed by Lupia (1998) which denoted that the analysis and evaluation of service delivery requires a specification of who is (or is supposed to be) accountable to whom. Principal- agency theory is more accurately described as a family of formal models addressing related concerns with similar styles of analysis. It is not much of a stretch to suppose that for any given actors labeled "principal" and "agent," and any pattern of interaction between the two, a principal-agent model can be written down with that pattern as an equilibrium outcome and modelers might consider it a parlor game of sorts to do it (Sasser, 2011). One of the standard frameworks used in the theoretical analysis of corruption is the Principal-Agent model. Using this model researchers have investigated the trade-offs between the expected costs and benefits of corrupt acts (Bardhan, 1997; Klitgaard, 1988; Rose-Ackerman, 1978). One of the findings resulting from this work is that lower wages increase the likelihood of corruption by reducing the cost associated with being caught (Becker and Stigler, 1974; Chand & Moene, 1999; Mookherjee & Png, 1995) and through adverse selection (Besley & McLaren, 1993).

The principal-agent model assumes that if a country would like quality health services to be delivered throughout the country, the Ministry officials recruit doctors to work in hospitals. If doctors care as much about quality health-care delivery as the Ministry of Health/society, then quality service delivery is straightforward, and in a sense, this is the ideal scenario. However, this may not necessarily be the case, that is, unless the government finds some other way of motivating doctors, tastes for quality health-care diverge between the government/society and the

health service provider. Thus, through the model, optimal delivery of public services in a principal-agent framework shows that the policy maker (the principal) can induce a service provider (the agent) to deliver high quality services under the assumption that explicit performance pay is based on service delivery outcomes (Bold et al, 2019). The situation in Somalia is to the effect that most of the health service providers work in environments that do not befit their status and to make matters even worse, their pay is not considered to be commensurate with their effort, a situation that serves to encourage corruption in health service delivery.

2.1.2 Economic Theory

Further, the study was guided by the economic theory. The Economic Theory of Adam Smith wrote at a time when the concept of corruption, under pressure from two broad and related historical fronts, was undergoing a refinement in its meaning. The first was the expansion of commercialism and British domestic and foreign markets. As Britain's empire and economy grew so did the opportunities and scope for corruption. This, in turn, hastened the emergence of new understandings of the relationship between private interests and public duties. The second set of pressures was brought about by the birth of the modern state, which was expanding rapidly and becoming more organized (Paul, 2002). With that expansion and increasing organization, the line between private market and state affairs began to sharpen. Corresponding to these changes was the emergence of protoliberal sensibilities that nurtured and promoted such values as neutrality, impartiality, merit, and egalitarianism and pitted them against the absolutism, nepotism, particularism, and patronage perceived to be attendant on feudal and aristocratic forms of governance. Although most eighteenth-century thinkers continued to employ the term "corruption" in its classical sense, (Albert, 1977), reformers increasingly drew attention to practices and institutions that would now qualify as sins against modern sensibilities.

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 & 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 fulfillment, order checking and transport; staff working in each area has access only to the information needed to fulfill 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 & Summers, 2002). Lack

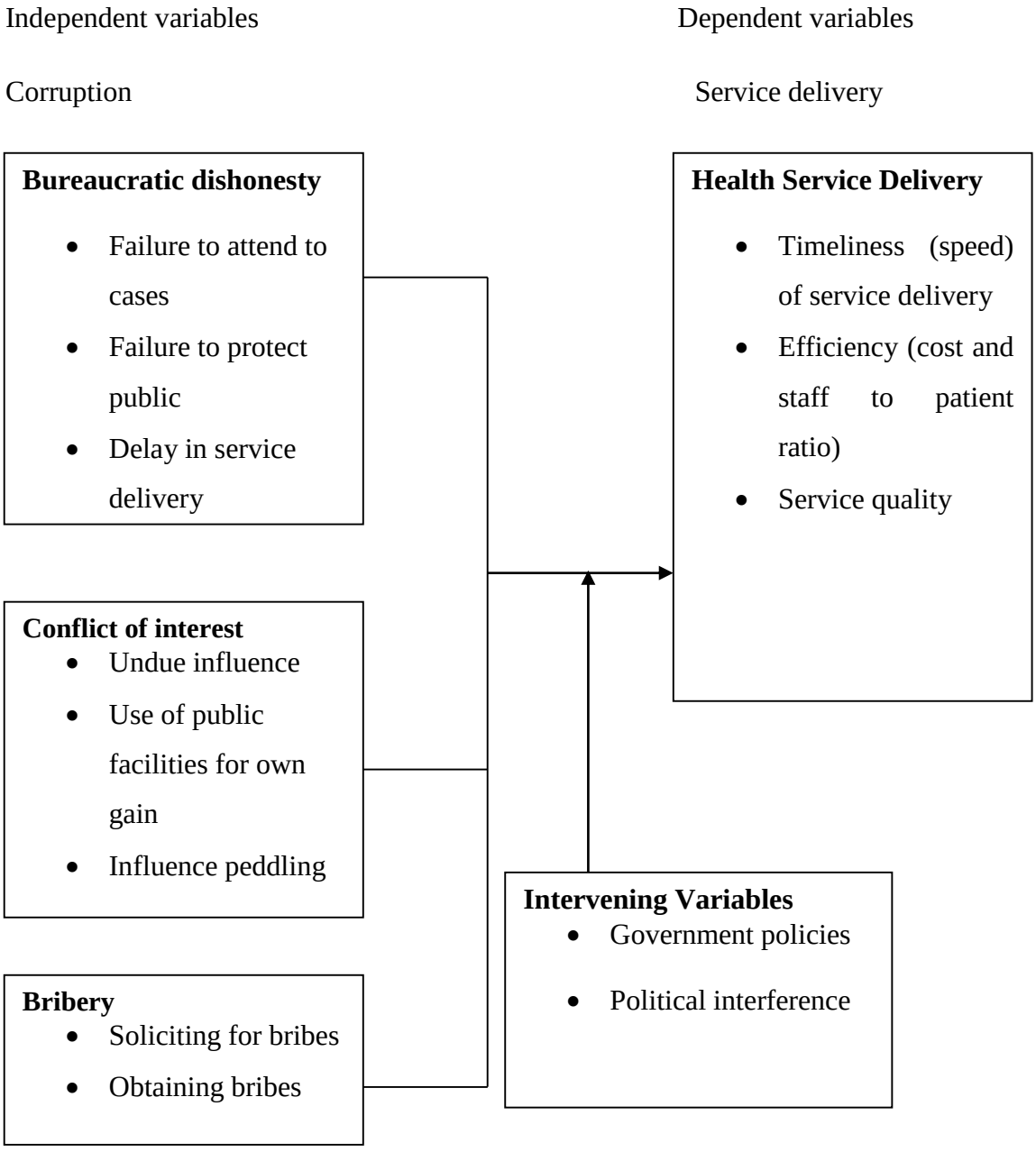
of accountability creates opportunities for corruption. Brinkerhoff (2004) identifies three key components of accountability, including the measurement of goals and results, the justification or explanation of those results to internal or external monitors, and punishment or sanctions for non-performance or corrupt behavior. 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 programs that had unusual indicators, and helped officials to explore root causes for performance differences, including possible corruption (Vian & Collins, 2006).

Though Smith was keenly aware of "the disadvantages of a commercial spirit," he seems more convinced that commercialization is natural, inevitable, and basically positive. His views are ultimately those of an early liberal political economist whereby corruption is seen to consist in deviations from a natural (broadly liberal) state. In a sense, most early liberalism was, almost by definition, an implicit reaction to corruption (understood here in its modern sense), and Smith can be safely bracketed in the modern camp due to his sustained defense of such standard liberal values as impartiality, universalism, neutrality, liberty, formal equality of opportunity, and rule of law. At the same time, he comprehends—but does not show much interest in—the typical concerns of modern corruption reformers.

2.2 Conceptual Framework

The following conceptual framework shows how corruption affects service delivery. Corruption is the independent variable while service delivery is the dependent variable.

Figure: Showing the Effect of corruption on service delivery



Source: Based on the Economic Theory (Jean & Paravisini, 2001) and Principal-Agent theory (Batley, 2004)

Corruption is categorized as bureaucratic dishonesty (failure to attend to cases, failure to protect public assets and delay in service delivery), conflict of interest (undue influence, use of public facilities for own gain and influence peddling) and bribery (soliciting for bribes, obtaining bribes). Health Service delivery categorized is timeliness (speed) of service delivery, staff efficiency (cost and staff to patient ratio) and service quality. It is conceptualized more corruption (bureaucratic dishonesty, conflict of interest and bribery) will contribute to poor health service delivery and less corruption (bureaucratic dishonesty, conflict of interest and bribery) will contribute to better health service delivery.

2.3 Review of Related Literature

2.3.1 Bureaucratic dishonesty and health service delivery

Bureaucratic dishonesty is linked with the activities of bureaucrats. Traditionally, the concept was used to denote the practice of buying favor from bureaucrats who formulate and implement governments' economic and political policies. The concept however transcends the buying of favor; it refers to the violation of public duty by bureaucrats or public officials (Lawal & Tobi, 2006).

These general factors affect the extent of corruption in any sector, but the health sector has a number of dimensions that make it particularly vulnerable to abuse. No other sector has the specific mix of uncertainty, asymmetric information and large numbers of dispersed actors that characterize the health sector. As a result, susceptibility to corruption is a systemic feature of health systems, and controlling it requires policies that address the sector as a whole. Two other factors that contribute to corruption in health care are worth mentioning.

First, the scope of corruption in the health sector may be wider than in other sectors because society frequently entrusts private actors in health with important public roles. When private pharmaceutical companies, hospitals or insurers act dishonestly to enrich themselves, they are not formally abusing 'public office for private gain'. Nevertheless, they are abusing the public's trust in the sense that people and organizations engaged in health service delivery are held to a higher standard in the interests of protecting people's health. The medical profession, in particular, is given great latitude in most countries to police itself in return for assuming professional responsibility to act in the best interests of patients Yuksel, D. (2013).

Second, the health sector is an attractive target for corruption because so much public money is involved. The world spends more than US $3.1 trillion on health services each year, most of it financed by governments. European members of the OECD collectively spend more than US $1 trillion per year and the United States alone spends US $1.6 trillion. In Latin America, around 7 percent of GDP, or about US $136 billion, is consumed by health care annually, of which half is publicly financed. In lower income countries, private health spending is often greater than public health spending, although the latter is still a significant amount. The share of total government revenues spent on health care ranges from under 5 per cent in Ethiopia, Egypt, Indonesia and Pakistan to more than 15 per cent in Ireland, Germany, the United States and Costa Rica. These large flows of funds represent an attractive target for abuse Vian, T. (2002).

According to Kahkonnen *et al.,* (1997), corruption raises the cost of doing business. This may occur when public officials introduce delays and unnecessary requirements to force the transfer of bribes raising these costs in addition to the monetary value of the corruption payment. They add that health officials may add to administrative delays to attract bribes, their arguments however, lack details on how delays introduce bribes in cases where there are no set standards on completion of certain tasks. Nevertheless, it is invaluable in understanding abuse of office and service delivery.

According to Lui (1985), time has different value. For different individuals depending on their level of income and opportunity cost of their time. Those for whom time is valuable will offer bribes to public officials to be allowed to economize on time by jumping in front of the line-getting decisions more quickly. Thus, corruption could lead to efficiency because it saves time for those whom time has the greatest value. Lui (1996) argue that while corruption may improve resource allocation, it reducers growth because it provides individuals the incentive to acquire the kind of human capital that can be used to improve corruption opportunities.

According to Gunnar Myrdal. in underdeveloped countries “a bribe to a person holding a public position is not clearly differentiated from the ‘gifts,’ tributes, and other burdens sanctioned in traditional, pit-capitalist society or the special obligations attached to a favour given at any social level” (Myrdal, 1970). When giving presents to officials can be defended as accepted etiquette, businessmen are likely to have fewer scruples about seeking favors in return.

Various conjectures link the supply of corrupt services to characteristics of countries' security systems and state structure. Some scholars suggest a simple positive relationship between state size and corruption or rent-seeking (Tanzi 1994. Buchanan 1980). They argue that the greater the share of (lOP redistributed by government, the greater the spoils for corrupt allocation.

Similarly, the more officials there are in public office, the more potential bribes available. Industrial organization arguments suggest that the internal structure of the state may also influence the supply of corrupt services. When bureaucracies are more decentralized, with less internal discipline, bureaucrats may compete to extract maximal rents (Shleifer and Vishny 1993).

Low civil service salaries and poor working conditions, with few incentives and rewards for efficient and effective performance, are strong incentives for corruption as found in Nigeria by Abiodun (2007). Other factors which were found included: less effective government works with slow budget procedures, lack of transparency, inadequate strategic vision and weak monitoring mechanisms make Nigeria a fertile environment For corrupt practice. This study thus investigated whether the same factors account For corrupt practices in Kismayo district.

In more decentralized or federal states, the burden of corruption may thus be greater. According to James Q. Wilson, one cause of corruption in the system is "the need to exchange favours to overcome decentralized authority" (Wilson 1970). Another security scientist argues that "decentralized security systems are more corrtiptible, because the potential corrupter needs to influence only a segment of the government, and because in a lIagmented system there are fewer centralized forces and agencies to enforce honesty." In addition, a number of economists also suggest that corruption is more widespread at the local level, perhaps because of the greater intimacy and frequency of interactions between private individuals and local officials (tanzi 1995. prud'I~omme, 1995). In this study, the link between the various causes of corruption in the Somalia sense was investigated more so in the local governments.

2.3.2 Conflict of interest and health service delivery

Unethical drug promotion and conflict of interest among physicians can have negative effects on health outcomes as well. Kassirer (2006) observed that promotional activities and other interactions between pharmaceutical companies and physicians, if not tightly regulated, could influence physicians to engage in unethical practices. Studies have shown that these interactions can lead to non-rational prescribing (Wazana, 2000), and increased costs with little or no additional health benefit. Patients' health can be endangered as some doctors enroll unqualified patients in trials or prescribe unnecessary or potentially harmful treatments, in order to maximize profit (Kassirer, 2005).

Providers have a high degree of discretion when they choose services for patients, which can put patients in a vulnerable position. In most countries, healthcare providers have assumed a cultural role as trusted healers who are above suspicion. We don't like to believe that providers could have conflicts of interest that affect their judgment, but in fact this can be the case Yuksel,D.(2013). Systems with direct public provision are prone to low productivity when insulated from competition or external accountability. Services are also highly decentralized and individualized, making it difficult to standardize and monitor service provision and procurement.

According to Sedigh and Mugenda (1999), as conflict of interest becomes more widespread, the decisions of corrupt public servants which are made in defiance of official regulations and stated priorities irrevocably undermine the efficient management of public affairs. Ruzindana et al., (1998) also observed that corruption leads to economic waste and inefficiency because of its effects on allocation of resources. He however does not substantiated how conflict of interest leads to inefficiency hence a gap in literature. Tumwesigye (2004) observes that corruption promotes inefficiency in the use of public resources. He asserts that corruption undermines the quality of service delivery resulting in adverse effects on the needy poor.

Health or sometimes referred to grand corruption takes place at the highest levels of health authority. It was when the politicians and health decision-makers (heads of state, ministers and top officials), who are entitled to formulate, establish and implement the laws in the name of the people, are themselves corrupt. Corruption in health is fUrthermore when policy formulation and

legislation are tailored to benefit health officials and legislators (Moody-Stuart 1997; Doig and Theobald 2000).

Corruption in health might take place on arenas without the general public coming across it in their daily life, or even knowing about it. It might be incidental, controlled or concealed, as in most consolidated liberal democracies. In Uganda, this seems not true instead corruption among health officers has become the order of the day. This study investigated the cause of such health corruption tendencies in local governments.

More broadly, the cultures of distrust and private-spiritedness have been found to foster higher rates of venality than occur in communities where generalized trust and civic engagement are strong (Putnam, 1993). Distrust and suspicion boost the demand for corrupt services on the part of private agents. The greater perceived uncertainty of entering into partnerships with strangers may impede legitimate private business activity (Ia porta et al, 1997). This may render transactions with family members and close acquaintances (including corrupt exchanges with friends in public office) relatively more attractive thus causing one-side to bribe the other.

Corruption has also been linked to ethnic polarization. It is held that in deeply divided societies, the demand for corrupt services tends o be higher at any given price. Generalized trust is likely to be lower. Members of ethnic groups tend to feel that demanding favors from co-ethnics in a given office is the only effective way to obtain public services. Additionally, the supply of corrupt services tends to be increased by the social leverage that ethnic leaders have over officials of their ethnicity: fear of social ostracism makes them reluctant to refuse their co ethnics' demands. Various scholars have argued that competition between different ethnic groups within the same state has at times fostered patronage politics and bureaucratic predation (Easterly and Levine 1997).

2.3.3 Bribery and Health Service Delivery

The healthcare sector appears to be particularly vulnerable to corruption. The large amounts of money involved and the complexities of many healthcare systems play a role as well as the fact that there are many processes with high risks of bribery, Fraud and corruption occurs in all systems. Fraud and corruption occur whether systems are predominantly public or private, well-funded or poorly funded, and technically simple or sophisticated Simitko, E.G (2013).

According to Kohkonen et al (1997), bribery leads to reduction in the quality of goods and services. Bribes are used to induce regulatory officials to overlook procedures and to permit firms to reduce quality. Tumwesigye (2004) argues that corruption also leads to wrong choices of projects where the quality of service is undermined. Some observers have however argued that bribery can have positive effects under certain circumstance by giving firms and individuals a means of avoiding burdensome regulations and ineffective legal systems. However, their argument ignores competition that many politician and bureaucrats have over the creation and interpretation of counterproductive regulations.

Fraud and corruption activities can take place in any area of healthcare delivery. The following processes stand out as having a high inherent risk of corruption: provision of services by medical personnel, human resources management, drug selection and use, procurement of drugs and medical equipment, distribution and storage of drugs, regulatory systems, and budgeting and pricing.

Van Lerberghe *et al*., (2002) observed that health workers respond to inadequate salaries and difficult living and working conditions by developing individual coping strategies, many of which can be seen as "survival corruption. Patients pay unofficial fees to gain access to health services, which are supposed to be free of charge, to reduce waiting time, receive drugs, treatment or hospital meals, as well as to ensure better attention and improved quality of treatment. Such practices are widespread in developing and transition countries. Informal payments have been consistently associated with massive reduction in the use of services in Poland and Somalia, due to financial accessibility of care. In the long run, they also compromise the quality of the health system by channeling out-of- pocket payments outside of the public health system. Many studies have been conducted in the past several years exploring the motivations behind informal payments, which is an essential step in order to design effective strategies to prevent them (Vian *et al*., 2004).

Rajkumar and Swaroop (2001) reported that reducing corruption (or, improving the quality of government) improves education outcomes largely by improving the effectiveness of public expenditures. This means that if corruption leads to large leakages in public funds allocated to education, public expenditure on education is likely to be less effective, in this we find that the more the public servants fail to a bid by the regulations of managing public finances allocated to

them, thereby giving way for security peddling, there is a high risk of compromising service delivery.

2.4 Empirical Review

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.

Unregulated medicines which are of sub-therapeutic value can contribute to the development of drug resistant organisms, increase the threat of pandemic disease spread, and severely damage patients' health as counterfeit drugs might have the wrong ingredients or include no active ingredients at all and undermine public trust in important medicines according to WHO IMPACT (2006). In addition to fake and sub-therapeutic drugs on the market, corruption can lead to shortages of drugs available in government facilities, due to theft and diversion to private pharmacies. This in turn leads to reduced utilization of public facilities. Procurement corruption can lead to inferior public infrastructure as well as increased prices paid for inputs, resulting in less money available for service provision.

Corruption flourishes at the service delivery points affecting the interaction between health workers and patients when the following conditions arise: staffs is underpaid as a result of constrained health budgets, when exceptional performance of health providers is not noticed or adequately rewarded, and when rules and sanctions are not enforced due to lack of oversight and supervision. Most common abuses include informal charging of patients, theft of drugs and medical supplies, illegal use of public facilities for private practices, self-referral of patients, and absenteeism. All these practices undermine the quality, access and use of health services. In an interview with CIET International in Somalia, one respondent noted that because he was too

poor, his child was immunized with water, since he did not have the money to pay the health worker an extra fee (CMI, 2008).

2.5 Gaps in the literature

This study will examine the relationship between corruption and health service delivery at Kismayo District Health Centers. The gaps identified in literature in previous studies include failure to explicitly relate how corruption affects staff efficiency. Few studies if any have been carried out in Kismayo district under its current autonomous status.

Majority of previous empirical studies on decentralization and healthy service delivery have been conducted in developed or developing countries of Asia and Latin America (Kyriacou & Roca-Sagale's, 2011; Wei-qing & Shi, 2020). There is relatively small body of work and attempts to systematically examine the evidence on the impact of decentralization on service delivery in Sub-Saharan Africa. Consequently, the link between decentralization and public service delivery in the context of Sub-Saharan Africa is scarcely explored. Only a limited number of studies have so far examined the impact of decentralization on service delivery in the context of Sub-Saharan Africa (Balunywa et al., 2014; Tshukudu, 2014).The near absence of research in Africa in this area raise a question as to whether decentralization influences healthy service delivery in Africa. Empirical findings in developed countries may not be generalized in developing countries due to different cultural and political context. Further, there is also the need to test if decentralization frameworks, models or theories developed in western countries are applicable in poor African countries suffering high unemployment rates. Moreover, it has been argued that people‘s attitudes, beliefs and values vary across countries, cultures and continents. Hence, this study to bridge the knowledge gap by establishing the impact of decentralization on health service delivery in a less developed, non-Western context like the Somalia context.

Additionally, literature reviewed indicates there is imbalance on the attention that has gone into studies on decentralization and health service delivery. In measuring service delivery, most studies tends to concentrate on service accessibility and disregards other dimensions of service delivery such as quality of service and citizens satisfaction (Kosec & Mogues, 2015; Sujarwoto, 2012). Empirical evidence on the links between decentralization and service delivery measured by quality of service and citizen satisfaction is evidently lacking. One notable exception is a study in India by Nayak and Samanta (2014) which examined the role of participation in public

service delivery. The researchers used accessibility, availability, reliability and quality of services as a measure of public service delivery. However, the findings of this study could not be generalized due to different cultural and political contexts. It would therefore be prudent for other researchers to make a remarkable contribution in this field by establishing the impact of decentralization on service delivery (measured by accessibility, citizen satisfaction and quality of services)

Moreover, there is need to question the veracity of the link between decentralized governance and health service delivery. Analysis of previous research relating to the question of a link between decentralized governance and health service delivery reveals there is uncertainty as to the direction of the link. Empirical evidence on the impact of decentralized governance and health service delivery is mixed and inconclusive. Cross sections of studies provide evidence that decentralization leads to improved service delivery (Balunywa et al., 2014; Freinkman & Plekhanov, 2019). In contrast, other studies found that decentralization negatively influences service delivery (Elhiraika, 2017; Olatona & Olomola, 2015). The inconclusive nature of evidence suggests that more empirical work is required on the relationship between decentralized governance and health service delivery.

The limited character of research findings in this area suggests that there is need to further investigate the nature of the relationship between corruption and health service delivery.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methodology that guided the researcher in the process of carrying out the research. It includes a brief introduction to the chapter and a description of how the chapter is arranged, research design for the study, the study population, sample size and selection, data collection methods and instruments, validity and reliability, procedure of data collection, data analysis and measurement variables.

3.2 Research Design

This study adopted cross-sectional research designs. The cross-sectional research design facilitated an in depth investigation (Amin, 2005) into corruption and service delivery at Kismayo health units. The research involved cross-sectional survey to enable data collection was carried out only once within a short period of time (Amin, 2005). Further, the study adopted both qualitative and quantitative approaches for data collection and analysis, in order to triangulate the findings. Quantitative data is any data that is in numerical form like number of Medical Officers in a health unit. The researcher asked questions and collect data from participants. Qualitative data on the other hand is non- quantified data. Due to the perceived subjective nature of this method of research, it can be argued that quantitative research provided better findings. The two approaches complemented each other in the investigations. The researcher collected data from medical officers in each health unit.

3.3 Study Population

A study population is the population to which the researcher ultimately wants to generalize the results (Amin, 2005). According to Kismaayo metro population area from 1950-2022 the trend shows that the area in 2020 was 471,000, a 4.2% increase from 2019. However this study comprised of a total population of 471,000 which include staff of the health units and patients that attended treatment.

3.4 Sample Size

Out of the total population of the study, the researcher selected a sample of 400 respondents who were identified from the total population of 471,000.This number was arrived at by use of the Slovene's formula as illustrated below.

$$n = \frac{N}{1 + N(e)^2}$$

Equation 3.1: Slovene's Formula

$$n = \frac{471,000}{1+471,000\ (0.05)2}$$

$$n = \frac{471,000}{1+471,000\ (0.0025)}$$

$$n = \frac{471,000}{1178.5}$$

= 399.6 =400 respondents

Table 3.1: Sample size and selection

Category	Accessible Population	Sample size	Sampling technique
Hospital management committees (of the four health units, 11 members each)	51810	44	Purposive
Medical officers	4710	4	Purposive
Nurses and midwives	69473	59	Purposive
Patients	317925	270	Simple random
Hospital Attendants	27083	23	Simple random
Total	**471,000**	**400**	

Source: Kismayo HR Health Department (2022).

3.5 Sampling Technique

Random and non-random sampling techniques were adopted in this study. To determine respondent health workers in the survey, a list of health unit staff was obtained from the Personnel Officer at each health unit. The list was from the sampling frame. The staffs were categorized into strata like nurses and medical officers to enable inclusion of each category in the sample. After stratification, the relative proportion of each stratum was computed

and sample size was determined based on proportion. Random numbers were then generated from computer and assigned to each staff and selection was done by randomly selecting the numbers until the sample size is obtained.

Selections of patients that attend treatment were done by assigning random numbers to the list of patients. The numbers that corresponded to each patient was randomly selected until the sample size was obtained. Key informants constitute the management team at headquarters. Community leaders constituted key informants. They were expected to have and be able to provide responses to interviews with the researcher. No systematic sampling was therefore necessary since the respondents in this category were purposively selected.

3.5 Data Collection Methods

Data collection methods included questionnaire survey, interviews, and document review. The combination of these methods helped to improve the overall attributes of the data that was collected.

3.5.1 Questionnaire

The researcher administered questionnaire which was closed ended questions to be answered by the respondents. According to McLeod (2018), a questionnaire is research instrument consisting of a series of questions for the purpose of gathering information from respondents. This mainly was applied to the district councilors and health officials.

Questionnaires were used because it enables a large amount of information to be collected from a large number of study populations in a short period of time and in a relatively cost effective way. Additionally, researcher employed the questionnaire because its results can easily be quantified.

Questionnaire survey was conducted with patients and health unit staff using questionnaires. Survey questionnaires were used to gather information from people. They are one of the most convenient and popular methods of collecting survey data in social research (Amin, 2005). This method involved collecting information from a sample of patients and health unit staff in a systematic way. Questionnaire survey were used for these category of respondents to save on time because their number was big to interview.

3.5.2 Interviews

Interviews involved obtaining information from a resident who is in a position to know the community or the particular portion in which one is interested (Mugenda & Mugenda, 1999). These were used to solicit information from key informants who included the 4 medical officers.

The face to face interviews enabled the researcher to establish rapport with these categories of respondents and therefore gain their cooperation. They also allowed the researcher to clarify ambiguous answers and obtain in-depth information through probing. Semi structured-interviews were designed to collect data for this study. Open-ended questions were used so that other valuable questions might emerge from the dialogue between interviewer and interviewee. Semi-structured interviews are the most widely used interviewing formats for qualitative research (DiCicco-Bloom & Crabtree, 2006). In this study, the probing interviewing tactic was used extensively to obtain a deeper explanation of the issue at hand from the Hospital management committees (of the four health units, 11 members each), Medical officers, Nurses and midwives. This was largely due to the fact that the respondents often needed stimuli to expand or clarify their own answers and ideas more broadly, so that a broader understanding was more easily reached later on in the findings of this study.

3.5.3 Documentary review

Data collection involved review of documents to gather information that was used in the research. Documentary methods refer to the analysis of documents that contain information about the phenomenon we wish to study (Bailey, 1994). Payne and Payne (2004) describe the documentary review methods as the techniques used to categorize, investigate, interpret and identify the limitations of physical sources like human behavior. The documents that were reviewed include annual, quarterly and monthly reports of each health unit.

3.6 Validity and Reliability

3.6.1 Validity

An instrument is valid if it measures what is intended to measure and accurately achieves the purpose for which it was designed (Patten, 2004; Wallen & Fraenkel, 2001). Patten (2004) emphasizes that validity is a matter of degree and discussions should focus on how valid a test is and not whether it is valid or not. According to Patten (2004), no test is valid. The researcher needed assurance that the instrument being used would result in accurate conclusions (Wallen & Fraenkel, 2001). Validity involves the appropriateness, meaningfulness, and usefulness of inferences made by the researcher on the basis of the data collected (Wallen & Fraenkel, 2001). Validity can often be thought of as judgmental. According to Patten (2004), content validity is determined by judgments on the appropriateness of the instrument's content. He identifies three

principles to improve content validity namely; use a broad content rather than a narrow one, emphasize important material, and write questions to measure the appropriate skill. The three principals were addressed when writing the survey instruments. To provide additional content validity of the survey instrument, the researcher used the expertise of his two supervisors who provided input and suggestive feedback on survey instruments. The Coefficient of Validity Index (CVI) was used to compute the validity of the research instrument from the following formula.

$$CVI = \frac{\text{Items rated relevant}}{\text{Total number of items in questionnaire}}$$

A CVI was acceptable if it is above 0.7 (Amin, 2005). Rating used in the formula are presented in the following table.

Table 3.2: Validity of questionnaire

Raters	Items rated relevant	Items rated not relevant	Total
Rater	29	8	37
Rater	23	14	37
Total	52	22	74

Thus, applying the formula $CVI = \frac{52}{64} \approx .8125$

Results showed a CVI of .8125, and since it was above 0.7 as recommended by Amin (2005), the instrument was considered valid and could therefore be depended upon to produce accurate results.

3.6.2 Reliability

Reliability of a data collection instrument relates to the consistency with which it collected data if successively used to collect data (Mugenda & Mugenda, 2005). Reliability of an instrument can be improved by pilot testing. This will enable the researcher to review questions that were ambiguous and need focusing in addition to ensuring it captures all the required spectrum of the required information. Cronbach's coefficient alpha was used to determine the internal reliability of the instrument. The Cronbach's Alpha test will be used in testing the consistency of data that was collected. Cronbach's alpha reliability coefficient ranges between 0 and 1; the closer the coefficient to 1.0, the greater the internal consistency of the items in the scale and vice versa. Based on the formula Alpha = rk / [1 + (k -1) r] where k is the number of items considered and r, the mean of the inter-item correlations. The size of alpha was

determined by both the number of items in the scale and the mean inter-item correlations. The survey instrument was tested in its entirety, while the subscales of the instrument were tested independently.

Table 3.3: Reliability of variables in questionnaire

Variable	Alpha crombach	No. of items
Bureaucratic corruption	.749	12
Conflict of interest	.712	6
Bribery	.703	5
Service Delivery	.734	14

The alpha coefficients were above the recommended .70 (Amin, 2005). Thus, the questionnaire was suitable for data collection.

3.7 Procedure of Data Collection

An informal pilot study was conducted with a small group of respondents in Health center. Conducting a local pilot study allowed the researcher to ask participants for suggestive feedback on the survey and help eliminate author bias. A letter introducing the researcher to the health centers management was obtained from Kampala International University in Kampala Main Campus. The researcher then met the Health center management to explain the research objective and ask management to participate. The introduction was also attached on the questionnaire to give a brief introduction to the subject matter.

3.8 Data Analysis

3.8.1 Qualitative data analysis

This involved content analysis, which was used to edit qualitative data and reorganize it into meaningful shorter sentences. A thematic approach was used to analyze qualitative data where themes, categories and patterns were identified. The recurrent themes, which emerged in relation to each guiding question from the interviews, were presented in the results, with selected direct quotations from participants presented as illustrations.

3.8.2 Quantitative data analysis

Coded (quantitative) data was entered in a computer program known as a Special Package for Social Scientists (SPSS version 13) for analysis. Descriptive statistics was used to determine the distribution of respondents on personal information and on the questions under each of the

variables. Inferential statistics was used to test the hypothesis. Spearman rank order correlation and coefficient of determination was used to test the hypothesis given that the scale used in the questionnaire was ordinal (Sekaran, 2003). Spearman rank order correlation determined the strength of the relationship between the independent and dependent variables. The coefficient of determination was used to determine the effect of independent variable on dependent variable. The significance of the coefficient (p) was used to test the hypothesis by comparing p to the critical significance level at (0.05). The data was organized and presented by charts and tables.

3.9 Measurement variables

There were variables measured at nominal and ordinal levels depending on the items in the instrument. Nominal scale was largely used to measure the demographic characteristics of the respondents. The ordinal scale was using a five likert scale measure of Strongly Agree=5, Agree =4, Not sure =3, 2= Disagree and 1 strongly disagree. Ahuja (2001) maintains that this type of scale is often referred to as a "Likert Scale named after one of its originators.

3.10 Limitation of the study

As a result of other academic work coupled with shortness of time given for completion of this research work, the researcher had to battle with the limited time available to him in combining traveling to the place of case study and attending lectures.

The other limitation was the belief that the research would never be read, thus people might not get the benefit of the study. It was therefore the Intention of the Researcher to write papers out of the research and present the min conferences.

The attitude of some of the respondent and some library attendant probably due to ignorance were also constituted to its own limitation.

Numerous expenses were involved in this work, hence the limited resources available to the research due to poor economic condition may be not enough to take care of the high transportation cost, stationeries, public relations and cost of typing this work and binding it.

The study focused on corruption at Kismayo district health centers. There are many other sections of health centers which should be looked at. Again the challenges faced by one municipality may be unique to all other municipalities, and therefore it may not be easy to generalize the findings.

CHAPTER FOUR
PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4.1Introduction

In this chapter, the results are presented, analyzed and then interpreted. The chapter highlights the response rate, demographic characteristics of the respondents and empirical findings based on the objectives of the study. It also focuses on the bureaucratic corruption, Conflict of interest, bribery and extortion and health service delivery at Kismayo district health centers.

4.2 Response Rate

This section presents the response rate per category of respondents that were included in this study.

Table 4.1: Response Rate

Category	Population	Sample size	% of Return	Data Collection Instruments
Hospital management committee	44	39	89%	Simple random
Medical officers	4	4	100%	Purposive
Nurses and midwives	59	56	95%	Simple random
Patients	270	250	93%	Simple random
Attendants	23	16	70%	Simple random
Total	**400**	**365**	91%	

Source: Primary data, 2022

The study targeted a sample of 400 respondents. Of these sampled respondents, a total of 365 participated in the study. This was 91.3% response rate. A low response rate can give rise to sampling bias if the non-response is unequal among the participants regarding exposure and/or outcome. According to Amin (2005) and Mugenda and Mugenda (1999), a 67% response is acceptable. According to Mundy (2002), a study of a general population which aims to describe knowledge or behaviors, a 60% response rate might be acceptable, although 70% would be preferable. Thus, a 91% response rate in this study was considered acceptable given that it falls within the recommended response rates.

4.3 Background Information

To establish the background characteristics of the respondents the study focused on gender of respondent, Age of respondent, highest level of Education, How long have you worked in the organization and Terms of employment.

4.3.1 Gender of the respondents

Gender of the respondents was categorized as male and female. A question about gender of respondent was administered to find out the influence of health service delivery at Kismayo district health centers and the results were analyzed using descriptive statistics.

Table 4.2: Gender of Respondents

Gender of Respondents	Frequency	Percentage
Male	152	42%
Female	213	58%
Total	**365**	**100.0**

Source: Primary Data, 2022

The study findings show that (213) 58% of respondents were females and (152) 42% were males. This is attributed to the fact that female patients and health staff are dominant at Kismayo district health centers and as result, it is expected that when a study is conducted out at Kismayo district health centers, one is likely to have more female participants compared to male participants. Thus, the implication of these findings is that information obtained about corruption and service delivery using the sample was not gender biased.

4.1.2 Age Bracket

Table 4.3: Age bracket of Respondents

Age bracket of Respondents	Frequency	Percentage
18-30 Years	75	21%
31-40 Years	66	18%
41-45 years	120	33%
46-50 years	83	23%
51 and above	21	6%
Total	**365**	**100.0**

Source: Primary Data, 2022

The results of the study in terms of age bracket, also showed that out of the approached respondents, 75 (21%) were between 18-30years, 66 (18%) were from 31-40 years, 120 (33%) were of age bracket 41-45 years while those who were aged between 46-50 years were 83 representing 23%. The remaining percentage of the respondents were aged 51 and above years and they were 6% of the total percentage of the respondents. On average, most of the respondents were aged 41-45 years. The results imply that majority of the respondents were mature and having adequate and critical understanding of the corruption. It is possible that age imply experience and critical understanding of concepts an avenue for experience and undoubtable data by the researcher.

4.3.3 Highest level of education

The education level of the respondents was categorized as bachelors, post grad diploma, masters and professional courses. A question about education level of respondents was administered and the results were analyzed using descriptive statistics and are presented in the following table.

Table 4.4: Education Level of Respondents

Education Level of Respondents	**Frequency**	**Percentage**
Professional courses	146	40%
Masters	53	15%
Post graduate diploma	63	17%
Bachelor's Degree	103	28%
Total	**365**	**100.0**

Source: Primary Data, 2022

The study findings in the table above showed that most of respondents had completed Professional Courses at (146) 40% followed by Bachelors holders at 103% (28), Masters holders had (53) 15% and (63) 17% had completed Post Grad Diploma. Thus, the implication of these findings is that the education background of the respondents suggested that they should ably respond to the questions. In other words, most respondents who participated in the study were literate and understood issues that were asked. Thus, information obtained was reliable.

4.3.4 Duration of period of respondents associating with Kismayo district health centers

This section looked at how long someone had associated with Kismayo district health centers, which was categorized as 1-3 years, 3-5 years, 5-8 years and 8 and above years. The results were analyzed using descriptive statistics and findings are presented in the following table.

Table 4.5: Duration of period of respondents associating with Kismayo district health centers

Education Level of Respondents	**Frequency**	**Percentage**
1-3 years	107	29%
3-5 years	172	47%
5-8 years	43	12%
8 and above years	43	12%
Total	**365**	**100.0**

Source: Primary Data, 2022

The study findings show that a good number of respondents (172) 47% had associated with Kismayo district health centers for 3-5 years followed by (107) 29% who had associated with Kismayo district health centers for 1-3 years and (43) 12% had associated with Kismayo district health centers for 8 and above years. The findings show that most of respondents had associated with Kismayo district health centers for 3-5 years. This implies that most of the respondents had been associated with Kismayo district health centers for quite some time to be conversant with the issues the study sought to obtain. Therefore, the respondents who participated in this study provided dependable information about corruption and service delivery at Kismayo district health centers.

4.3.5 Main nursing unit

This section looked at main nursing unit respondents belong to, which was categorized as medical-surgical unit, children's (Paediatrics), emergency holding area, intensive care unit and maternity (OBS). A question about main nursing unit was administered and the results were analyzed using descriptive statistics. Below was the distribution of responses;

Table 4.6: Main nursing unit of Respondents

Education Level of Respondents	Frequency	Percentage
Maternity (OBS)	99	27%
Intensive care Unit	33	9%
Emergency Holding Area	117	32%
Children's (Paediatrics)	69	19%
Medical-Surgical Unit	47	13%
Total	**365**	**100.0**

Source: Primary Data, 2022

The study findings show that (39) 32% of respondents were employed in emergency holding area, (33) 27% were employed in maternity, (23) 19% were employed in children's, (16) 13% were employed in medical-surgical unit and 9% (11) were employed in intensive care unit. This means that at emergency holding area there is need for services because of the high numbers of the patients so possibility of corruption can occur here, it also implies that due to scarcity of personnel it tends to lead to bribery, nepotism, .

4.4 Empirical Findings on Corruption and Service Delivery at Kismayo district health centers

This study looked at the effect of corruption on health service delivery at Kismayo district health centers. While analyzing the data, a five point likert scale was used by assigning levels; "Strongly Agree = 5"", "Agree = 4", "Not Sure = 3", "Disagree = 2" and "Strongly disagree = 1". However, it is recommended that before testing hypotheses, descriptive statistics should be first computed for each of the variables (Plonsky, 2007). Thus, descriptive statistics approach was adopted using frequencies and percentages.

4.4.1 Service delivery

Patients and health workers were requested to respond to 14 items about service delivery by indicating their agreement using a five-point Likert scale as shown in Table 5. The items are presented in the first column and the proportion of patients and health workers to the responses on each of the items is presented in form of frequencies and percentages in columns 2 to 6. The analysis and interpretation of the findings about bureaucratic corruption follows the

presentation of findings in Table 4.7.

Table 4.7: Service Delivery

Timeliness	**SD**	**D**	**NS**	**A**	**SA**	**Mean**	**Interpretation**	**Rank**
Patients take long to obtain drugs	16% (58)	9% (33)	7% (27)	57% (207)	11% (40)	3.26	Very Satisfactory	1
Patients take long to be examined treatment	14% (54)	8% (30)	3% (12)	53% (192)	22% (79)	2.62	Satisfactory	2
Health workers are not competent	15% (53)	3% (12)	10% (34)	50% (187)	22% (79)	2. 51	Satisfactory	3
Health workers are few	18% (66)	4% (16)	11% (40)	47% (170)	20% (73)	2.47	Unsatisfactory	4
Health workers are often away from health units	12% (42)	6% (23)	11% (40)	52% (191)	19% (69)	2.71	Satisfactory	
Staff efficiency	**SD**	**D**	**NS**	**A**	**SA**	**Mean**	**Interpretation**	**Rank**
Health workers are so many but do little work	21% (75)	7% (27)	6% (23)	43% (157)	23% (83)	3.04	Satisfactory	1
It takes long for staff to see a patient	21% (75)	10% (36)	4% (16)	49% (180)	16% (58)	2.52	Satisfactory	2
Medical records are not often kept	21% (75)	10% (36)	4% (16)	39% (143)	26% (95)	2.48	Unsatisfactory	3
Medical records often take long to trace	20% (73)	8% (30)	14% (54)	31% (112)	27% (96)	1.53	Unsatisfactory	4
Service quality	**SD**	**D**	**NS**	**A**	**SA**	**Mean**	**Interpretation**	**Rank**
Service quality is low	12% (42)	9% (33)	7% (27)	57% (207)	15% (53)	2.39	Unsatisfactory	
Customer care is lacking	9% (33)	8% (30)	3% (12)	53% (192)	27% (96)	3.26	Very Satisfactory	1
Treatment is often in adequate	13% (47)	3% (12)	10% (36)	51% (187)	23% (83)	2.62	Satisfactory	2
Prescribed drugs are often not available	16% (58)	4% (16)	11% (40)	46% (168)	23% (83)	2. 51	Satisfactory	3
Customers are delayed	11% (40)	4% (16)	11% (40)	49% (180)	25% (89)	2.47	Unsatisfactory	4
Average mean						**2.58**	**Satisfactory**	

Source: Primary data, 20222

To analyze the findings, patients and health workers who strongly disagreed and those who disagreed were combined into one category who "opposed" the items and in addition, patients and health workers who strongly agreed and those who agreed were combined into another category who "concurred" with the items. Thus, three categories of patients and health workers were compared, which included "Patients and health workers who opposed the items", "Patients and health workers who were not sure about the items" and "Patients and health workers who concurred with the items". Interpretation was then drawn from the comparisons of the three categories as shown in the following paragraph.

Finding show that more patients and health workers were concurred to all the 14 items about service delivery. For example, relating to timeliness, more patients and health workers (68%) concurred that patients take long to obtain drugs compared to 25% who opposed while 7% were not sure. More patients and health workers (75%) concurred that patients took long to be examined treatment compared to 22% who opposed while 3% were not sure. More patients and health workers (72%) concurred that health workers were not competent compared to 18% who opposed while 10% were not sure. More patients and health workers (67%) concurred that health workers were few compared to 22% who opposed while 11% were not sure. More patients and health workers (71%) concurred that health workers were often away from health units compared to 18% who opposed while 11% were not sure. These findings show there was delayed service delivery at Kismayo health centers. Interviews findings about Kismayo health centers' service delivery were supportive of findings obtained using questionnaires as they also showed that all the four interviewees were dissatisfied with it.

Regarding staff efficiency, it is shown that more patients and health workers (66%) concurred that health workers were so many but do little work compared to 28% who opposed while 6% were not sure. More patients and health workers (65%) concurred that it took long for staff to see a patient compared to 31% who opposed while 4% were not sure. More patients and health workers (65%) concurred that medical records were not often kept compared to 31% who opposed while 4% were not sure. More patients and health workers (58%) concurred that medical records often took long to trace compared to 28% who opposed while 14% were not sure. Thus, these findings show staff inefficiency at Kismayo district health centers. In

support of these findings were interview findings from four medical officers. Inefficiencies in health service provision were the most cited during interviews.

In relation with service quality, it is shown that more patients and health workers (72%) concurred that service quality was low compared to 21% who opposed while 7% were not sure. More patients and health workers (80%) concurred that customer care was lacking compared to 17% who opposed while 3% were not sure. More patients and health workers (74%) concurred that treatment was often in adequate compared to 16% who opposed while 10% were not sure. More patients and health workers (69%) concurred that prescribed drugs were often not available compared to 20% who opposed while 11% were not sure. More patients and health workers (74%) concurred that customers were delayed compared to 15% who opposed while 11% were not sure. Therefore, these findings show that service quality in Kismayo district health center was poor. Interviews with four medical officers also revealed in the same. Interview findings revealed that there remained significant challenges in matching Kismayo district health centers' services with local community needs. It was established that most the service that Kismayo district health centers services were insufficient and of poor quality.

Overall, these findings show the following. In most cases, Kismayo district health centers' service delivery was inefficient and ineffective, had no value for money and was of poor quality services. In addition, in most cases, KCCA health centers' services were not easily accessed and Kismayo district health centers' responsiveness in service delivery and service coverage were unsatisfactory. Lastly, Kismayo district health centers offered unreliable service to the community. Thus, the implication of these findings is that Kismayo district health centers' service delivery was poor.

4.4.2 Bureaucratic corruption

Patients and health workers were requested to respond to 12 items about bureaucratic corruption by indicating their agreement using a five-point Likert scale as shown in Table 6. The items are presented in the first column and the proportion of patients and health workers to the responses on each of the items is presented in form of frequencies and percentages in columns 2 to 6. The analysis and interpretation of the findings about bureaucratic corruption follows the presentation of findings in Table 4.8.

Table 4.8: Bureaucratic corruption at Kismayo district health center

Bureaucratic corruption	SD	D	NS	A	SA	Mean	Std. D	Interpretation
Health workers engage in corrupt practices	3.3% (12)	4.1% (16)	10.7% (41)	46.7% (170)	35.2% (126)	2.47	1.36	Low
Use public health facilities for own use	4.9% (19)	13.9% (50)	15.6% (57)	51.6% (189)	13.9% (50)	2.50	1.38	Low
There is misappropriate public funds meant for health services	4.1% (16)	5.7% (23)	13.9% (50)	48.4% (175)	27.9% (101)	2.95	1.37	Moderately high
Only the rich received quality services	1.6% (9)	8.2% (29)	9.8% (36)	45.1% (165)	35.2% (126)	2.73	1.35	Moderately high
Health workers often do not attend to patients because corrupt practices	2.5% (12)	16.4% (59)	18.0% (66)	41.0% (149)	22.1% (79)	2.96	1.27	Moderately high
There are mishandle cases because corrupt practices	0.8% (2)	2.5% (10)	5.7% (23)	61.5% (225)	29.5% (107)	2.95	1.19	Moderately high
Patients' conditions get worse due to delay because corrupt practices	1.6% (9)	13.9% (50)	16.4% (59)	53.3% (192)	14.8% (55)	3.55	1.42	Moderately high
Patients do not get needed treatment	5.7% (23)	1.6% (9)	4.9% (19)	50.8% (187)	35.0% (127)	3.47	1.23	Moderately high
Workers lack motivation and interest in patient care because corrupt practices	4.1% (16)	0.8% (2)	22.1% (80)	50.8% (187)	22.1% (80)	3.50	1.221	Moderately high
There is misuse public assets	4.1% (16)	2.5% (12)	13.9% (50)	52.5% (192)	26.0% (95)	3.09	1.12	Moderately high
There is low morale and lack of commitment from staff because corrupt practices	0.8% (2)	8.2% (29)	21.3% (77)	44.3% (160)	25.4% (97)	3.27	1.27	Moderately high
Health centers do not protect assets satisfactorily because corrupt practices	5.7% (23)	6.6% (27)	8.0% (28)	52.5% (192)	26.2% (95)	3.65	1.26	Moderately high
Average Mean						**3.075**	**.446**	**Moderately high**

Source: Primary data, 2022

Finding show that more patients and health workers were concurred to all the 12 items about bureaucratic corruption compared to those who opposed the items and those who were not sure about the items. A comparison on these items shows that the percentages of patients and health workers that opposed ranged from 4.9% to 18.9% while the percentages of patients and health workers that were not sure ranged from 4.9% to 22.1% and the percentages of patients and health workers that concurred ranged from 63.1% to 91%.

From these comparisons, it can be seen that the percentages that opposed the items and the percentages were not sure were lower compared to the percentages that concurred. Thus, from this analysis, the following is the interpretation. Health workers engaged in corrupt practices, health workers used public health facilities for own interest, there was misappropriate public funds meant for health services, only the rich received quality services and health workers often did not attend to patients. In addition, findings show that there were mishandle cases due to corruption, patients' conditions got worse due to delay because corrupt practices, patients did not get needed treatment because corrupt practices and workers lack motivation and interest in patient care because corrupt practices. Lastly, it is shown that there was misuse public assets, low morale and lack of commitment from staff because corrupt practices and health centers did not protect assets satisfactorily because corrupt practices.

Interview findings shed some light about bureaucratic corruption at Kismayo district health centers. For example, all key informants considered absenteeism of health workers as the most prevalent administrative malpractice. Other administrative malpractices mentioned included unnecessary referral of patients to private clinics, unofficial/informal payments for services and theft of drugs. One key informant had this to say when asked about bureaucratic corruption at Kismayo district health centers:

> *Bureaucratic corruption in the Kismayo district health centers is in the form of mainly absenteeism of staff, informal payments required from patients and unnecessary patient referrals to private clinics and informal payments for services supposed to be free. Other forms include theft of drugs, and use of public facilities for private issues.*

Further probing focused on two forms of irregular conduct - theft of drugs and unjustified failure of health staff to fulfill their contracted working hours - that were considered too serious affect the ability of Kismayo district health centers to provide timely and good quality services. Most key informants blamed high absenteeism and theft of drugs on weak supervision and control mechanisms. When further questioned the primary cause for health staff absenteeism, 3 out of the 4 key informants identified ineffective supervisory and control measures, 2 of 4 key informants blamed tolerance of these situations in the health centers and low pay.

After establishing patients and health workers' views on each of the variables under the first objective, the next step was to test the first hypothesis using inferential statistics. Findings are

presented in section 4.4.2.2.

4.4.2.2 Testing first hypothesis

The first research question was "*To what extent does bureaucratic corruption in health centers affect service delivery at Kismayo district health centers*?" and first alternative hypothesis stated, "*Bureaucratic corruption significantly affects service delivery*". Spearman rank order correlation coefficient (*rho*) was used to determine the strength of the relationship between bureaucratic corruption and service delivery. The coefficient of determination was used to determine the effect of bureaucratic corruption on service delivery. The significance of the coefficient (p) was used to test the hypothesis by comparing p to the critical significance level at (0.05). This procedure was applied in testing the other hypotheses and thus, a length introduction is not repeated in the subsequent section of hypothesis testing. Table 11 presents the test results for the first hypothesis.

Table 4.9: Correlation between bureaucratic corruption and service delivery

	Bureaucratic corruption
Service delivery	*rho* = -.495 rho^2 = 245 p = .000 n =365

Source: Data from field, 2022

Findings show that there was a moderate negative correlation (*rho* = .495) between bureaucratic corruption and service delivery. Since the correlation does imply causal- effect as stated in the first objective, the coefficient of determination, which is a square of the correlation coefficient (rho^2 = .245), was computed and expressed as a percentage to determine the change in service delivery due to bureaucratic corruption. Thus, findings show that bureaucratic corruption accounted for 24.5% change in service delivery. These findings were subjected to a test of significance (p) and it is shown that the significance of the correlation (p = .000) is less than the recommended critical significance at 0.05. Thus, the effect was significant. Because of this, the null hypothesis "*Bureaucratic corruption significantly affects service delivery*" was accepted.

The implication of these findings is that the moderate correlation implied that a change in

bureaucratic corruption contributed to moderate change in service delivery. The negative nature of the correlation implied that the change in bureaucratic corruption and service delivery was in the opposite direction whereby more bureaucratic corruption contributed to poor service delivery and less bureaucratic corruption contributed to better service delivery.

4.4.3 Conflict of Interest and Health Service Delivery at Kismayo district health center

The effect conflict of interest on health service delivery at Kismayo district health center was examined.

4.4.3.1 Conflict of interest at Kismayo district health centers

Before establishing the effect, there was need to first find out the respondents' views on conflict of interest using descriptive statistics. Respondents were requested to respond to 6 items about conflict of interest dimensions using a five point Likert scale of (5) = strongly agree (4) = agree, (3) = not sure (2) = disagree (1) = strongly disagree and the findings are displayed in Table 4.10.

Table 4.10: Conflict of interest and Health service delivery in Kismayo district health centers

Conflict of interest and service delivery	**SD**	**D**	**NS**	**A**	**SA**	**Mean**	**Std. D**	**Interpre**
Health workers pay more attention to relatives and acquaintances	2.5% (12)	4.1% (16)	11.5% (44)	57.4% (207)	24.6% (86)	3.27	1.82	Very Good
Health administrative staff hire relatives and friends	0.8% (2)	1.6% (9)	4.9% (19)	47.5% (170)	45.1% (165)	3.21	1.79	Good
Health workers segregate patients in service delivery	2.5% (12)	10.7% (39)	13.1% (46)	41.0% (149)	32.8% (119)	2.82	1.68	Good
Health administrative staff influence procurement process for personal gain	4.1% (16)	9.0% (33)	10.7% (39)	54.9% (200)	21.3% (77)	2.18	1.48	Poor
Health administrative staff award contracts relatives and friends	6.6% (27)	7.4% (27)	17.2% (61)	48.4% (175)	20.5% (75)	2.87	1.69	Good
Quality of procurement is low because of conflict of interest	6.6% (27)	18.0% (64)	26.2% (95)	39.3% (143)	9.8% (36)	3.10	1.76	Good
Average mean						**2.60**	**1.49**	**Good**

Source: Data from field, 2022

Finding show that more patients and health workers were concurred to all the six items about conflict of interest compared to those who opposed the items and those who were not sure about the items. A comparison on these items shows that the percentages of patients and health workers that opposed ranged from 2.4% to 24.6% while the percentages of patients and health workers that were not sure ranged from 4.9% to 26.2% and the percentages of patients and health workers that concurred ranged from 68.9% to 92.6%. From these comparisons, it can be seen that the percentages that opposed the items and the percentages were not sure were lower compared to the percentages that concurred. Thus, these findings show that health workers paid more attention to relatives and acquaintances, the health center administrative staff hired relatives and friends, health workers segregated patients in service delivery, health staff administrative influenced procurement process for personal gain, health administrative staff awarded contracts relatives and friends and the quality of procurement low because of conflict of interest. Thus, these findings obtained from patients and health staff suggests that there was conflict of interest at Kismayo district health centers.

Interview findings shed some light about conflict of interest at Kismayo district health centers. Key informants were asked about conflict of interest and one of them summarized all others key informants as shown in the following:

> *Pecuniary gains have influenced health workers' decisions, especially in administrative positions, because of the remunerative aspects of some health center activities. This has raised the questionable relationship between some health workers and firms that have been characterized with manipulation of tenders, misappropriation of supplies, poor quality drugs, hoarding of supplies and payment of non-delivered goods.*

After establishing patients and health workers' views on each of the variables under the first objective, the next step was to test the first hypothesis using inferential statistics. Findings are presented in section 4.4.3.2.

4.4.3.2 Testing second hypothesis

The second research question was "*How does conflict of interest in health centers affect service delivery at Kismayo health centers?*" and second alternative hypothesis stated, "*Conflict of interest significantly affects service delivery*". Spearman rank order correlation coefficient and coefficient of determination were computed. Table 4.11 presents the test results for the first hypothesis.

Table 4.11: Correlation between conflict of interest and service delivery

	Conflict of interest
Service delivery	*rho* = -.628 rho^2 = 394 p = .000 n =365

Source: Data from field, 2022

Findings show that there was a strong negative correlation (*rho* = -.628) between conflict of interest and service delivery. The coefficient of determination, which is a square of the correlation coefficient (rho^2 = .394) show that conflict of interest accounted for 39.4% change in service delivery. These findings were subjected to a test of significance (p) and it is shown that the significance of the correlation (p = .000) is less than the recommended critical significance at 0.05. Thus, the effect was significant. Because of this, the null hypothesis "*Conflict of interest significantly affects service delivery*" was accepted.

The implication of these findings is that the strong correlation implied that a change in conflict of interest contributed to big change in service delivery. The negative nature of the correlation implied that the change in conflict of interest and service delivery was in the opposite direction whereby more conflict of interest contributed to poor service delivery and less conflict of interest contributed to better service delivery.

4.4.3 Bribery and Health Service Delivery at Kismayo district health center

This section analyzed the relationship between bribery and health service delivery at Kismayo district health centers. Before testing the hypothesis, respondents' views on bribery were established.

4.4.3.1 Bribery at Kismayo district health centers

Bribery dimensions consisted of soliciting for bribes and obtaining bribes measured using five point Likert scale of (5) = strongly agree (4) = agree, (3) = not sure (2) = disagree (1) = strongly disagree and the findings are displayed in the table below.

Table 4.12: Soliciting for Bribes and Health Service Delivery at Kismayo district health center

Bribery and service delivery	**SD**	**D**	**NS**	**A**	**SA**	**Mean**	**Std. D**	**Interpretation**
Health workers:	1.6% (9)	8.2% (29)	32.0% (116)	45.1% (165)	13.1% (46)	2.87	1.69	Good
Ask for bribes for services provided	5.7% (23)	3.3% (12	9.0% (33)	48.4% (175)	33.6% (122)	3.10	1.76	Good
Delay treating patients to attract inducements	0.8% (2)	2.5% (12	5.7% (23)	45.1% (165)	45.9% (163)	2.99	1.54	Good
Sell drugs to patients	3.3% (12)	10.7% (13)	15.6% (19)	54.1% (66)	16.4% (20)	3.10	1.76	Good
Charge patients for use of ambulances	9.0% (33)	10.7% (39)	11.5% (44)	46.7% (170)	22.1% (79)	2.93	1.71	Good
Average						**2.60**	**1.49**	**Good**

Source: Primary data, 2022

Finding show that more patients and health workers were concurred to all the five items about bribery compared to those who opposed the items and those who were not sure about the items. A comparison on these items shows that the percentages of patients and health workers that opposed ranged from 2.5% to 10.7% while the percentages of patients and health workers that were not sure ranged from 5.7% to 32.0% and the percentages of patients and health workers that concurred ranged from 58.2% to 91.0%. From these comparisons, it can be seen that the percentages that opposed the items and the percentages were not sure were lower compared to the percentages that concurred. Thus, these findings show that health workers engaged in bribery , health workers asked for bribes for services provided, health workers delayed treating patients to attract inducements, health workers sold drugs to patients

and health workers charged patients for use of ambulances. Thus, these findings obtained from patients and health staff suggests that that there was bribery at Kismayo district health centers.

Interview findings shed some light about bribery at Kismayo district health centers. For example, all for key respondents expressed dissatisfaction when were asked whether they were satisfied with the process involved in the provision of health services in Kismayo district health center. When asked to explain their dissatisfaction, interview findings revealed that there was bribery as one key informant asserted thus;

> *There is high level of corruption at Kismayo district health centers. Three medical workers of were arrested for soliciting bribes from patients. The suspects included a clinical office and two laboratory technicians at Kismayo health center. They were picked up by Kismayo district law enforcements officers for allegedly collecting between shillings 5000 and 20,000 from patients at the health center. I have been receiving numerous complaints from patients that they are charged to access health services at Kismayo district health centers yet health services at all health centers operated by Kismayo district are meant to be free of charge.*

Similarly, another key informant had this to say about corruption in Kismayo district health center:

> *The general perception is that it is true corruption is influencing provision of at Kismayo district health centers allegations of health workers soliciting bribes are on the rise. The Kismayo district officials are corrupt because they are greedy.*

A third key informant revealed the following about bribery at Kismayo district health centers:

> *Complaints about corruption in health centers include staff charging patients. Patients bribe to advance on health centers' waiting lists, and hospitalized patients bribe to obtain the attention of medical staff, particularly a consultation with the doctor and to have surgery.*

The above perception is influenced by the belief that the provision of bribes persists at Kismayo district health centers. According to key informants during the interviews, bribery

was the most prevalent form of corruption. Almost all interviews indicated that medical attention at *Kismayo district* health units could only be obtained in exchange for payment despite the official abolition of user fees at health units. They stated that patients have to bribe to attract the attention of medical staff. The impression conveyed by the interviews is one of individual bad apples within a particular facility than of facility-wide policies to extort bribes. In one interview, it was revealed that while patients accuse Kismayo district health center staff of demanding bribes, Kismayo district health center staff also accused patients of inducing them with bribes. In this study, it therefore be deduced that corruption in health center procurement is a two way thing: patients dangling bribes in front of Kismayo district health center staff and the latter encouraging corruption.

After establishing patients and health workers' views on each of the variables under the first objective, the next step was to test the first hypothesis using inferential statistics. Findings are presented in section 4.4.3.2.

4.4.3.2 Testing third hypothesis

The third research question was "*To what extent do bribery in health centers affect service delivery at Kismayo district health centers?*" and the third alternative hypothesis stated, "*Bribery significantly affects service delivery*". Spearman rank order correlation coefficient and coefficient of determination were computed. Table 4.13 presents the test results for the first hypothesis.

Table 4.13: Correlation between bribery and service delivery

	Bribery
Service delivery	*rho* = -.442 rho^2 = 195 p = .000 n = 365

Source: Data from field, 2022

Findings show that there was a moderate negative correlation (rho = -.442) between bribery and service delivery. The coefficient of determination, which is a square of the correlation coefficient (rho^2 = .195) show that bribery and extortion accounted for 19.5% change in service delivery. These findings were subjected to a test of significance (p) and it is shown that the significance of the correlation (p = .000) is less than the recommended critical significance at 0.05. Thus, the effect was significant. Because of this, the null hypothesis "*Bribery significantly affects service delivery*" was accepted.

The implication of these findings is that the moderate correlation implied that a change in bribery contributed to moderate change in service delivery. The negative nature of the correlation implied that the change in bribery and service delivery was in the opposite direction whereby more bribery contributed to poor service delivery and less bribery contributed to better service delivery.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The purpose of the study was to examine the relationship between corruption and health service delivery at Kismayo district health centers. This chapter presents the summary, discussion, conclusions and recommendations of the findings; they are presented objective by objective.

5.2 Discussions

5.2.1 Bureaucratic corruption and Health service delivery at Kismayo district health centers

The study findings showed that there is a relative positive significant relationship between Bureaucratic corruption and health service delivery at Kismayo district health center. Bureaucratic corruption was found to have Spearman correlation *rho* = 0.495**, which was significant. Hence, the study accepted the stated hypothesis that "Bureaucratic corruption affects health service delivery". The study showed that Bureaucratic corruption influences health service delivery at Kismayo district health center by 24.5%.

The findings revealed that patients' conditions get worse due to delay. This view was shared by Kahkonnen et al., (1997) corruption raises the cost of doing business which may occur when public officials introduce delays and unnecessary requirements to force the transfer of bribes raising these costs in addition to the monetary value of the corruption payment.

In line with the findings, Lui, (1985) asserts that time has different value. This view was agreed by respondents who asserted that workers lack motivation and interest in patient care, for whom time is valuable will offer bribes to public officials to be allowed to economize on time by jumping in front of the line- getting decisions more quickly.

The findings revealed that patients' conditions get worse due to delay Lui (1996) argues that while corruption may improve resource allocation, it reducers growth because it provides

individuals the incentive to acquire the kind of human capital that can be used to improve corruption opportunities this was further agreed by respondents who not that only the rich received quality.

5.2.2 Conflict of interest and Health service delivery at Kismayo district health centers

The study findings showed that there is a strong positive significant relationship between conflict of interest and health service delivery at Kismayo district health centers. Conflict of interest was found to have Spearman correlation r = 0.628**, which was significant. Thus, the study accepted the stated hypothesis that "Conflict of interest affects health service delivery". The study also showed that conflict of interest influences health service delivery at Kismayo district health centers by only 39.4%.

It was established that there was conflict of interest at Kismayo district health centers, which negatively affected service delivery. As Pellegrino and Relman (1999) have written, "too often, ethical goals have been commingled with protection of self-interest, privilege, and prerogative. Yet, effacement of self-interest is the distinguishing feature of a true profession that sets it apart from other occupations" (p. 984). The findings of this concur with Jamal (2013) who argued that a conflict of interest in a health care organization may negatively influence health service delivery and argued that because it influences a health care provider to perhaps alter his or her treatment of a patient based on a prior allegiance, either to a company or another individual. The findings of this study agree with Ensor & Duran-Moreno (2005) who emphasized that the effects of medical conflicts of interest can be harmful for patients.

Basing on Simitko (2013) observation, it is argued in this study that conflicts of interest arise from the ways in which health workers are paid for their services. This is because public health have complained about poor and irregular salaries for a long time to the present day and no much change has taken place (Orem, Mugisha, Kirunga, Macq & Criel, 2011). Many studies have concluded that paying health workers for each service that they provide creates incentives for health workers to increase the volume of services, which also increases their income and society's spending for health care (Smith, 1992; Hsiao et al., 1993). In addition, the appropriate pricing of specific services and categories of services is a concern (Ginsburg &

Grossman, 2005; Bodenheimer et al., 200).

The findings revealed that conflict of interest becomes more widespread if more attention paid to relatives and acquaintances, the decisions of corrupt public servants which are made in defiance of official regulations and stated priorities irrevocably undermine the efficient management of public affairs this view was also supported by Sedigh and Mugenda (1999). Findings of the study concur with Owor (2012) who observed that in the health care system, conflicts of interest could range from doctors having close ties with other companies or groups of people outside the health care system and recommending their products in cases that would not be best for patients. This is because this study established that KCCA health administrative staff influence procurement process for personal gain and awarded contracts relatives and friends. Ruzindana et al., (1998) also observed that corruption leads to economic waste and inefficiency because of its effects on allocation of resources. He however does not substantiated how conflict of interest leads to inefficiency.

The study findings revealed that quality of procurement was low since corruption promotes inefficiency in the use of public resources. This is in line with Tumwesigye (2004) assertion that corruption undermines the quality of service delivery resulting in adverse effects on the needy poor. In addition, Ensor & Duran-Moreno (2005) argues that the use of power and influence by health practitioners, officials and organizations for self- enrichment conflicts with their public roles, which undermine health service delivery. They further argued that corrupt activity is likely to damage the ability of the health care system to deliver high quality, effective care to the people who can benefit most.

5.2.3 Bribery and Health service delivery at Kismayo district health centers

The study findings showed that there is a relative positive significant relationship between bribery and health service delivery at Kismayo district health centers. Bribery was found to have a Spearman correlation rho = 0.442**, which was significant. Therefore, the study accepted the stated hypothesis which was stated “Bribery affects health service delivery”. The study also showed that bribery development influences health service delivery at Kismayo district health centers by 18.9%. The study findings showed that there is a relative positive

significant relationship between bribery and health service delivery at Kismayo district health centers. Bribery was found to have a Spearman correlation rho = 0.442**, which was significant. Therefore, the study accepted the stated hypothesis which was stated "Bribery affects health service delivery". The study also showed that bribery development influences health service delivery at Kismayo district health centers by 18.9%.

The study agreed with Kohkonen et al (1997) who argues that bribery leads to reduction in the quality of goods and services, the study revealed that works ask for bribes for services provided and also works sell drugs to patients hence bribes are used to induce regulatory officials to overlook procedures and to permit firms to reduce quality. According to Tumwesigye (2004) corruption leads to wrong choices of projects where the quality of service is undermined, the study showed that works charge patients for use of ambulances.

Findings of this study are supported by Kanyane (2010) who emphasized on the negative effects of corruption and wrote that the effect of fraud and corruption is eating away at the tax collected from the public, simultaneously in the process also eating away at the moral fabric of society. In turn, corrupt practices result in non-delivery of essential public services, thus denying communities their right to a better life.

In addition, the findings of this study are similar to the view is espoused by Webb, (2008) claiming that corruption impede service delivery. Webb (2008) continues by stating that the existence of corruption in a state is an indication that the management of its public institutions is weak; and that tolerating corruption of some could lead to the spiraling of malfeasance to a systemic level.

In an attempt to quantify the cost of corruption and its impacts on service delivery, Ruhiiga, (2000) observed that bribery are grouped together as these involve the receipt of illegal benefits by public officials from individuals and entities in return for favors. According to Ruhiiga, the immediate effect of is that the costs of providing services become higher.

5.3 Conclusions

Conclusions of the study were based on the study findings.

5.3.1 Bureaucratic corruption and Health service delivery at Kismayo district health centers

The study concluded that patients' conditions get worse due to delay in providing health service delivery at Kismayo district health centers. This was reflected when most of respondents agreed that workers misappropriate public funds meant for health services. The study also concluded that there was bureaucratic corruption. This could be due to low morale and lack of commitment from staff. This was further echoed when respondents were asked if workers lack motivation and interest in patient care were most of respondents agreed. This study concludes that abuse of office significantly influences health service delivery at Kismayo district health centers. This was due to the fact most of respondents agreed with this fact.

5.3.2 Conflict of interest and Health service delivery at Kismayo district health centers

This study concludes that conflict of interest significantly influences health service delivery at Kismayo district health centers. This was due to the fact most of respondents agreed with this fact. This study concludes that workers pay more attention to relatives and acquaintances. This was due to the fact that Kismayo district health centers hire relatives and friends, which was agreed by most respondents. The study further concluded that quality of procurement was low. This was due to the fact that contracts were awarded to relatives and friends, which was also agreed by most respondents.

5.3.3 Bribery and Health service delivery at Kismayo district health centers

This study concludes that bribery significantly influences health service delivery at Kismayo district health centers. This was due to the fact that most of respondents agreed. This study concludes that workers ask for bribes for services provided, which was the reason for delay in treating patients. The study further concluded that workers sell drugs to patients.

5.4 Recommendations

Recommendations of the study were based on the study findings.

5.4.1 Bureaucratic corruption and Health service delivery at Kismayo district health centers

The researcher recommends that health centers should motivate its workers this was due to the fact that most respondents agreed that workers lack motivation and interest in patient care; this can be done through providing incentives to workers. The researcher also recommends that administrators of health centers should establish better accountability system since most of respondents noted that public funds meant for health services are misappropriated.

5.4.2 Conflict of interest and Health service delivery at Kismayo district health centers

The researcher recommends that health centers should establish recruitment systems to avoid hiring relatives and friends. The study also recommends that health centers should establish procurement guidelines to avoid influence in procurement process for personal gain which will reduce awarding contracts to relatives and friends.

5.4.4 Bribery and Health service delivery at Kismayo district health centers

The researcher recommends that Kismayo district health centers should have a code of conduct which includes punishments to deter workers from asking for bribes for services provided. The researcher furthermore recommends that quick response to patients should be encouraged since most of respondents agreed that there was delay treating patients to attract inducements.

5.5 Areas for Further Research

This study focused on a few dimensions of corruption and their effect on service delivery. Other studies may be conducted focusing on other dimensions of corruption, which include political corruption, systemic corruption, sporadic (individual) corruption, grand corruption, petty corruption to mention some.

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APPENDICES

APPENDIX I: INFORMED CONSENT

I am giving my consent to be part of the research study carried out by Ahmed Dek Ahmed that will focus on "Corruption and Health Service Delivery in Kismayo District, Somalia".

I shall be assured of privacy, anonymity and confidentiality and that I were given the option to refuse participation and right to withdraw my participation any time.

……..

Signature

APPENDIX II: QUESTIONNAIRE

Please do not write your name anywhere on this questionnaire as all your responses is confidential. If you are answering on behalf of someone else, answer for the patient.

A. Background information

Qn 1. What is your Gender?

1) Male ☐ 2) Female ☐

Qn 3. What is your highest level of education?

1) Bachelors ☐ 2) Post Grad Diploma ☐

3) Masters ☐ 4) Professional Courses ☐

Qn 4. How long have you worked in the organization?

1) 1-3 years ☐ 2) 3-5 years ☐

3) 5-8 years ☐ 4) 8 and above years ☐

Qn5. Which main nursing unit do you belong too?

1) Medical-Surgical Unit ☐ 2) Children's (Paediatrics) ☐

3) Emergency Holding Area ☐ 4) Intensive Care Unit ☐ 5) Maternity (OBS) ☐

Please tick the appropriate box relating to each question below. (SA = Strongly agree, A = Agree, NS = Not sure, D = Disagree, SD = Strongly disagree).

B. Corruption

1	**Bureaucratic dishonesty**	**SA**	**A**	**NS**	**D**	**SD**
W1	Health workers:					
W2	use public health facilities for own use					
W3	Misappropriate public funds meant for health Services					
W4	Only the rich received quality					
W5	Often do not attend to patients					
W6	Mishandle cases					
W7	Patients' conditions get worse due to delay					
W8	Patients do not get needed treatment					
W9	Workers lack motivation and interest in patient care					
W10	Misuse public assets					
W11	Low morale, and lack of commitment from staff					
W12	Do not protect assets satisfactorily					

2	**Conflict of interest**	**SA**	**A**	**NS**	**D**	**SD**
A1	Pay more attention to relatives and acquaintances					
A2	Hire relatives and friends					
A3	Segregate patients in service delivery					
A4	Influence procurement process for personal gain					
A5	Award contracts relatives and friends					
A6	Quality of procurement low					

3	**Bribery**	**SA**	**A**	**NS**	**D**	**SD**
B1B	Health workers:					
B2B	Ask for bribes for services provided					
B3B	Delay treating patients to attract inducements					
B4B	Sell drugs to patients					
B5B	Charge patients for use of ambulances					

C. Service delivery

4	**Timeliness**	**SA**	**A**	**NS**	**D**	**SD**
C4C1	Patients take long to obtain drugs					
C4C2	Patients take long to be examined treatment					
C4C3	Health workers are not competent					
C4C4	Health workers are few					
	Health workers are often away from health					
5	**Efficiency**					
D5D1	Health workers are so many but do little work					
D5D2	It takes long for staff to see a patient					
D5D3	Medical records are not often kept					
D5D4	Medical records often take long to trace					
6	**Service quality**					
E6E1	Service quality is low					
E6E2	Customer care is lacking					
E6E3	Treatment is often in adequate					
E6E4	Prescribed drugs are often not available					
E6E5	Customers are delayed					

Thank you

APPENDIX III: INTERVIEW GUIDE

1. What do you have to say about bureaucratic dishonesty at Kismayo health Centers?
2. How has bureaucratic dishonesty at Kismayo health Centers affected service delivery?
3. What do you have to say about conflict of interest at Kismayo health Centers?
4. How has conflict of interest at Kismayo health Centers affected service delivery?
5. What do you have to say about bribery at Kismayo health Centers?
6. How has bribery at Kismayo health Centers affected service delivery?

Thanks for your cooperation

APPENDIX IV: BUDGET ESTIMATE

The study costs will total up to Ushs 1, 260, 000/=

ITEM	COST PER UNIT	TOTAL COST (UGX)
Library	50,000	50,000
Transport	200,000	600,000
Communication	50,000	50,000
Photocopy	100,000	100,000
Printing	150.000	150,000
Binding	50,000	50,000
Internet	50,000	50,000
Miscellaneous	200.000	200,000
Total		1,260,000

APPENDIX V: WORK PLAN 2022

ACTIVITY	TIME IN MONTHS				
	DECEMBER	JAN	FEB	MARCH	APRIL
Proposal writing					
Questionnaire design					
Data collection					
Coding and analysis					
Submission					

APPENDIX VI: A MAP OF KISMAYO LOWER JUBA REGION