The Importance of Payback Method in Capital Budgeting Decisions

Article by Jones Stamelevi

MBA in Financial Management, Texila American University
Email:- stamelevi@yahoo.com

Abstract

Purpose – To investigate the importance of using payback method in making capital budget decisions in relation to other appraisal techniques used for capital budgeting decision in organizations. The paper also included the examination of the importance of the payback method in relation to simplicity, manager incentive compensation and the size of the company.

Design/methodology/approach – The author used conceptual analysis using theories on payback period in which secondary data from past research in African, European and American companies were analyzed to determine the importance of the payback method in capital budgeting.

Findings – The analysis show that the payback method is preferred in appraising capital budget decisions in various organizations because of its simplicity, liquidity and risk assessment among many other advantages. Managers should complement payback method with other methods in order to make a sound investment decisions.

Keywords: Capital Budgeting, Payback Method, Payback Period, Net Present Value, Internal Rate of Return, Real Options Approach

Introduction

Capital budgeting involves allocating the firm's capital resources between competing project and investments. This valuation requires estimating the size and timing of all the incremental cash flows from the project. This reflects the riskiness of the investment and is measured by the volatility of cash flows and take into account the financing mix.

Ideally, businesses should pursue projects and opportunities that enhance shareholder value. However, because the amount of capital available at any given time for new projects is limited, management needs to use capital budgeting techniques to determine which projects will yield the most return over an applicable period of time. The author has discussed popular methods of capital budgeting which include net present value (NPV), internal rate of return (IRR), Real Option and payback period.

In this thesis work, the author examined the reasons why major decision makers in organizations still use payback period method despite its critics’ objections. The results of analysis conducted in Europe, America and Africa have confirmed the widely acceptance of this method because of its simplicity, liquidity and the manager's incentives packages among others.

Body

The real value of capital budgeting is to rank projects. Most organizations have many projects that could potentially be financially rewarding. Once it has been determined that a particular project has exceeded its hurdle, then it is ranked against peer projects. The highest ranking projects are implemented until the budgeted capital has been expended. The author has discussed four capital budgeting tools in this article

The value added by this thesis is twofold. Firstly, according to the author’s knowledge a similar comprehensive study in the manufacturing industry currently has not been much done especially in Africa. Secondly, the thesis is not limited to just discussing financial criteria of investment project evaluation. The thesis project has also considered the investment decision process in general.
The author has focused on the capital budgeting decision making in corporate organizations. He applied four common capital budgeting decision tools to analyze past research data on companies in Africa, Europe and America. The tools discussed include the payback period, net present value (NPV) method, the internal rate of return (IRR) method and Real Options to substantiate the importance of using payback method in making capital budget decisions in relation to other appraisal techniques.

**Payback Period** - The payback period is the most basic and simple decision tool. T. Lucy (1992) on page 303 defined payback period as the period, usually expressed in years which it takes for the project’s net cash inflows to recoup the original investment. The usual decisions rule is to accept the project with the shortest payback period.

Payback method does not measure overall project worth because it does not consider cash flows after the payback period. According to T. Lucy, (1992) payback period provides only a crude measure of the timing of project cash flows. The payback period is probably best served when dealing with small and simple investment projects. The author observed that the simplicity of payback period method should not be interpreted as ineffective. If the business is generating healthy levels of cash flow that allow a project to recoup its investment in a few short years, the payback period can be a highly effective and efficient way to evaluate a project. When dealing with mutually exclusive projects, the project with the shorter payback period is selected.

**Net Present Value (NPV)** - The net present value decision tool is a more common and more effective process of evaluating a project which the author has also analyzed. The article revealed that the NPV tool is effective because it uses discounted cash flow analysis, where future cash flows are discounted at a discount rate to compensate for the uncertainty of those future cash flows. He concluded that the independent projects are accepted when NPV is positive and rejected when NPV is negative. In the case of mutually exclusive projects, the project with the highest NPV is accepted.

Despite a strong academic preference for NPV, surveys indicate that executives prefer IRR over NPV although they should be used in concert. In a budget-constrained environment, efficiency measures should be used to maximize the overall NPV of the firm.

From a purely financial viewpoint, the NPV rule is consistent with the shareholder’s objective of wealth maximization, because it exclusively uses cash flows in the calculations as well as considers the time value of money. It evaluates investment projects in the way as investors do (Shapiro, 2005). The NPV has several strengths and weaknesses. Though the method has a number of strength (Brealey, 2006, Shapiro, 2005, Ansari, 2000) the concept may be hardly understood due to its complexity (Shapiro, 2005). Selecting a suitable discount rate based on assumptions about a potential investment and considering an investment’s risk may be difficult to comprehend for individuals without any financial training, background or experience (Ansari, 2000). The model gives a false sense of accuracy, since the computed present value is based on estimated and uncertain cash flows (Ansari, 2000)

**Internal Rate of Return (IRR)** - From the literature, the author defined that the internal rate of return is discounted rate that is commonly used to determine how much of a return an investor can expect to realize from a particular project. The author further stated that the internal rate of return is the discount rate that occurs when a project is break even, or when the NPV equals 0 and the decision rule is to choose the project where the IRR is higher than the cost of financing. The greater the difference between the financing cost and the IRR, the more attractive the project becomes.

The authors assertion confirms Brealey, 2006, p93 statement which states that internal rate of return rule is to accept an investment project if the opportunity cost of capital is less than the internal rate of return.” The rationale behind this statement is that an investment project yielding more than its opportunity cost of capital has a positive NPV, thus it is worthwhile investing.

It's possible that two mutually exclusive projects can have conflicting IRRs and NPVs, meaning that one project has lower IRR but higher NPV than another project. These issues can arise when initial investments between two projects are not equal. Just as it is the case with the NPV, one of the
disadvantages of the IRR is the fact that the model gives a false sense of accuracy, since the computed present value is based on estimated and uncertain cash flows. The advantages of using the IRR are (Ansari, 2000)

**Real options** - Real options analysis values the choices - the option value - that the managers will have in the future and adds these values to the NPV. Real option analysis has become important since the 1970s as option pricing. The model is more sophisticated as mentioned by the author in his article. It provides flexibility to management – i.e. the actual "real options" – generally, will relate to project size, project timing, and the operation of the project once established.

It is noted that discounted cash flow and other methods essentially value projects as if they are risky projects/bonds, with the promised cash flows known. Using this model, managers have many choices of how to increase future cash inflows, or to decrease future cash outflows.

The analysis has shown that managers can use models such as the CAP or the APT to estimate a discount rate appropriate for each particular project, and use the weighted average cost of capital (\(WACC\)) to reflect the financing mix selected. A common practice in choosing a discount rate for a project is to apply a WACC that applies to the entire firm. However, a higher discount rate is more appropriate when a project's risk is higher than the risk of the firm as a whole.

**Hypotheses**

The hypothesis have been confirmed for the most general methods and criteria. These methods and criteria are that companies prefer the use of the payback method when they evaluate investment opportunities because of its simplicity and that the companies have to do with financial flexibility. The method chosen are related to the pecking order theory and budget. This confirms that companies apply both financial evaluation criteria and non-financial. In addition, the article reveals that both risk and uncertainty are considered when evaluating investment projects and that well-defined investment decision processes are employed when appraising projects.

**Data Source and Method of Collection**

The author used theories on payback period method and past research work which companies used in appraising investment and he has used it as secondary data in order to be able to answer the questions raised in the research hypothesis.

The author used empirical studies and personal judgment to analyze data from the selected countries on how often the countries use the payback and other methods to reach a conclusion on why the country or the continent used the method in question. Furthermore the analyzed data has shown how each continent has favored the use of the payback method.

**Method of Analysis**

The most suitable approach to prove the article objective and to gain insights into firm’s investments is to collect and evaluate information from firms based on a combination of quantitative methods and qualitative methods. This combination allows for proving or rejecting the thesis’ hypothesis and in addition to that provides a deeper understanding of firm’s investment project analysis and investment decision making. Grönhaug (2005) states that quantitative methods allow for accepting or rejecting hypotheses in a logical and consistent manner. In addition, for inductive and exploratory research objectives of the thesis, qualitative methods are suitable (Grönhaug, 2005).

To agree with the above statement, the author analyzed secondary data from the result of the survey conducted among firms in Africa, Europe and America. Due to the number of expected results from the hypothesis, the author used a combination of quantitative and qualitative methods to provide the best possible result from the analysis.
Findings

As the information in the article indicates, the author involved a formal process to provide guidance for evaluating investment projects and reaching decisions. This process and its application reflect the level of quality both companies want to be perceived with not only internally, but also by external stakeholders such as customers, suppliers and investors though the result of the research benefited mostly financial managers.

The author has managed to establish why payback method is often used indifferent continents and he managed to trace the reason why some particular continents prefer payback method, which is primarily based on the kind of industry that run the economy of such countries, a common example is the manufacturing industry.

The author noted that companies in advanced countries often use the payback method because of the capital structure while companies in Africa mostly tend to use the payback method mainly because of the availability of the internal funding

Further analysis of the research shows that the prevalent use of the payback period is more pronounced in the Europe, followed by North America and then Africa. The results show that European companies most often use the payback method followed by American companies and lastly the African companies.

There as on the African companies were rated last is due to the fact that one of the African countries (i.e. Nigeria) showed a high rate in the use of the payback method while the other African country (i.e. South Africa) showed a very low rate in the use of the payback method.

The article has revealed that from the past reports how is that manufacturing companies in Europe and American companies often used the payback period, compared to other sector of the economy. The author concluded that the issue of the relevance of the use of the payback method is motivated by the importance of the payback method which includes the size of the business, the goal function, the management attitude to the pecking order theory and the simplicity of using the method.

Also from the data obtained, the simplicity of the payback period has motivated the use of the method. Managers normally will want to use a very simple formula to make their investment decision. Although developed countries are now more interested in using some complicated formulas like real option, NPV, IRR but the conclusion is that the simplicity of the payback method made it to be easily understood and this has motivated the general use of the payback method. The risk taking of the finance manager also indicate why the payback method is often used.

The above observation by the author confirms what (T. Lucy, 1992) on page 303 where he noted that payback method favors quick return projects which may produce faster growth for the company and enhance liquidity. He further observed that choosing projects which payback quickest will tend to minimize those risks facing the company which are related to time. However, not all risks are related to time.

The author also pointed out that the size of company also motivated the use of the payback method. The companies that are small survive mainly on investment that can generate immediate liquidity and the major investment method that supports this idea is the payback method which also confirms (T. Lucy, 1992) observations.

The valuation of managers has also motivated the use of payback method. From the article and personal judgment, managers are biased on the investments that generate immediate cash flows, because this is what their bonuses are attached to. The major reason for this kind of attitude is that most businesses are run on loan and overdraft. The exorbitant interest rate most especially in African (Nigeria) will make managers use appraisal method that consider liquidity first before profit.

Reviewer/Author Arguments

Different scholars have conducted research on the usage of different financial evaluation method of investment projects in firms throughout the world. The surveys indicated a clear trend towards the application of the more sophisticated discounted cash flow methods such as the NPV and the IRR.
Bierman (2007) calls the increasing popularity of applying discounted cash flow methods and thereby replacing the payback period and the ARR as the first revolution in capital budgeting. However, (Shapiro, 2005) observed that the payback period still remains popular, especially as a secondary method to evaluate a potential investment project and this confirms the findings of this article. The observation of (Shapiro, 2005) confirms (T. Luncy, 1992) on page 303 that in spite of any theoretical disadvantages, payback is undoubtedly the most popular appraisal criterion in practice.

In his article (Kayali, 2006) argues that the pure usage of the traditional investment project evaluation metrics (payback period, ARR, IRR, NPV) assume that the management of a firm is passive, not reacting to any changes that may occur. As more information about an investment project becomes available, management could revise the investment project. Kayali (2006) therefore promotes the usage of real options in combination with the conventional project evaluation metrics “to account for the opportunities arising as the uncertainty about the project under consideration is resolved” (Kayali, 2006, p286).

The above statement by Kayali (2006) suggest that the choice of investment project evaluation techniques depends on a number of factors, for example, the survey conducted in Nigeria shows how investment methods are combined together, it was observed that the payback method was often used, which accounted for 98.9%. The author failed to generalize the conclusion on how the methods are being usedintheAfricancountriesincebothsurveyconductedinAfricarevealedcontradictory rates(i.e. the result of the survey done in Nigeria had a very high rate while that conducted in South Africa had a very low rate).

We can draw lessons from Kayali (2006) that some project evaluation requires combination of a number of methods to avoid conflicting results.(T. Lucy, 1992) page 303 acknowledged that numerous survey have shown that payback is a popular technique for appraising projects either on its or in conjunction with other methods.

The evidence of the data from the South Africa survey has only shown when the payback period is used only as an investment appraisal and the author could not conclude based on that because if the payback period is considered as additional method the percentages would have been higher.

Shapiro (2005) argues that the ultimate aim of capital budgeting is the market value maximization of a firm’s common stock, thereby maximizing the wealth of a firm’s shareholders.

In conclusion based on the assumptions above, it must mean that a firm must never accept any potential investment project that does not maximize the market value of a firm’s shares. As a consequence each individual investment project has to illustrate if the investment maximizes shareholder’s wealth and thereby considers shareholder’s interests irrespective of the method applied.

In addition to financial evaluation methods for project appraisal discussed by the author in this article, the evaluation of investment projects should also consider criteria of a nonfinancial nature. However, as these criteria are mainly intangible, it is hard to value them in financial terms making it difficult to determine their effect on the success or failure of investment projects. These criteria are difficult to quantify and to measure (Ansari, 2000)

It is apparent from the surveys shown in Exhibit 9.4 page 242 of (Colin Drury, 2005) that firms use a combination of appraisal methods. The study of Pike (1996) indicates a trend in the increasing usage of discount rates. The Drury et al, (1993) study suggests that larger organizations use net present value and internal rate of return to greater extent than the smaller organizations. The Dry et al. study also asked the respondents to rank the appraisal methods in order of importance for evaluating major projects. The larger organizations ranked internal rate of return first followed by payback and net present value where the smaller organization ranked payback first, internal rate of return second and intuitive management judgment third. Based on these past research findings, managers should complement payback method with other methods in order to make a sound investment decisions.
Future Research

The research conducted is not without its limitations or shortcomings as noted by the author. This suggests that there are areas in which work presented here can be advanced and improved upon. One such area is to extend the sample size as only two countries were tested in each of the three continents. This thesis has focused on only corporate manufacturing firms and ignored the small firms and other industries. This suggests several areas for additional work. One such area is investigating of other firms rather than manufacturing with a bigger sample size. Though this is a limitation of this study but it is not thought to colour the results presented.

Conclusion

In conclusion, putting all these analyses together, it is evident that companies prefer the use of payback method and also the empirical analyses indicate how this method has gained patronage among other investment methods in the industry. The analysis show that the payback method is preferred in appraising capital budget decisions in various organizations because of its simplicity, liquidity and risk assessment among many other advantages. The manager's incentives packages has been another reason why managers has retain this old method in practice since managers will always want to use appraisal method that will support their incentive plan which it always link to accounting earning.

The author has also demonstrated that managers should consider both risk and uncertainty when evaluating investment projects. Managers should complement payback method with other methods in order to make a sound investment decisions.

In addition to financial evaluation methods for project appraisal discussed by the author in this article, the evaluation of investment projects should also consider criteria of a nonfinancial nature though it is hard to value them in financial terms.

Acknowledgement

I would like to thank Anne Brunnette and Mr Manesh for their support and guidance in writing this article review.

Furthermore I want to thank Dr. Rogaia our UNFPA country representative for giving me time to concentrate on my studies.

Literature Cited

[6.] M. M. Kayali, ‘Real Options as a Tool for Making Strategic Investment
[7.] T.Lucy (1992) 3rd edition, Management Accounting
Performance Appraisal as an Employee Evaluation Tool in an Organization like the Integrity Commission of Guyana

Article by Amanda Jaisingh  
Ph.D in Management, Texila American University  
ajaisingh@texilacconnect.com

Abstract

To evaluate an employee is a management task and a tool that is constantly used is Performance Appraisal. The business dictionary.com define Performance Appraisal in three parts that is, it is the process where managers/consultant 1) examines and evaluates an employee’s work behavior by comparing it with present standards, 2) documents the results of the comparison, and 3) uses the results to provide feedback to the employee to show where improvements are needed and why. An efficient and effective organization will constantly performed evaluation on its employees to measure their work performance on the job. An organization must understand that Performance Appraisal is not the only tool to measure an employee performance. Employees’ evaluation is an assessment/review of an employee job performance. Performance Appraisal is a formal/objective assessment of an employee’s job performance. This Performance Appraisal at the Integrity Commission is an evaluation tool that will identify employees that are performing from the one that is not. An organization Performance Appraisal must have a clear purpose and measurable objective. The most common errors in the evaluation process are the halo and horn effect or a poorly designed Performance Appraisal. To overcome these errors, manager/supervisors should have discussions with the employees when designing the Performance Appraisal so that their goals and objective can also be incorporated with the position goals and objectives. The Performance Appraisal is presented as an evaluation tool used at the Integrity Commission in Guyana. The Commission had taken into consideration Milan Fekete research in which he said that Van and Dan den Berglie (2004) said that organizational performance is “the measurement and reporting system/tools that qualifies the degree to which managers achieve their objectives”. At the Office of the Integrity Commission evaluation of employee is done every six (6) months using the Performance Appraisal to see whether an employee was performing on the job in order to be eligible for the payment of his/her gratuity, to identify areas that need training. In designing the Performance Appraisal for the Integrity Commission, it adopted the following questions poses by Milan in his research to make it an effective evaluation tool:

1. Who should design the evaluation process?  
2. Who should evaluate whom?  
3. Who should review the evaluation results?  
4. How these results could be exploited?

In adopting these questions the performance appraisal as an evaluation tool at the Integrity Commission was a success.

Keywords: Employees Evaluation, Performance Appraisal.

1. Introduction

Evaluating an employee is a full time management task. The Integrity Commission as an efficient and effective organization will constantly performed evaluation on its employees to measure their work performance on the job. In other words every organization practices some form of evaluation to achieve the specified objectives. This organization Performance Appraisal
tool to measure employee performance is a very critical area in that managers will be able to tell if their employees are performing and also how the organization is performing. Whether it is on the right track to achieve its goals and objectives or if the organization have to adjust its objectives. Also an employee will be able to tell at what level he or she is performing and/or if additional training is required. A tool that is constantly used is Performance Appraisal. An organization must understand that Performance Appraisal is not the only tool to measure an employee performance. Employees’ evaluation is an assessment/review of an employee job performance. Performance Appraisal is a formal/objective assessment of an employee’s job performance. According to Armstrong (2006) Performance Management is a systematic process for improving organization by developing the performance of individuals and teams. A performance evaluation form have measurable goals and objective in each area of a job/position and this evaluation is mostly conducted on a six (6) month period especially in the Government Ministries and Agencies like the Office of the Integrity Commission. At the Office of the Integrity Commission evaluation of employee is done every six (6) months using the Performance Appraisal to see whether an employee was performing on the job in order to be eligible for the payment of his/her gratuity. This Performance Appraisal at the Commission will identify employees that are performing from the one that is not.

2. Performance Appraisal at Organizations like the Office of the Integrity Commission

2.1 Purpose of Performing Appraisal

1. Payment of gratuity and vacation allowance.
2. Identify areas where employees needs training and enable career development.
3. Provides data for promotion, transfers, layoffs and even demotion.

2.2 Objectives of Performance Appraisal

1. Assist employee to overcome their weakness, improve his/her strengths so as to improve his/her performance.
2. Have constant feedback and guidance from managers to an employee working under him.
3. Contribute to the growth & development of an employee by helping him/her in realistic goal setting.
4. Creating a desirable culture & tradition in the org.
5. Employees are identified for the purpose of motivating, training and developing them.
6. Gather factual information about employees.

A Performance Appraisal has several designs in which an organization can choose from and can design it to suit the needs of the organization. An organization must also take into consideration the different errors that can occurred when conducting their evaluation using the performance appraisal especially when it is poorly designed and the halo and horn effects. At the Integrity Commission, the approach that is adopted is more of a result centered approach and was designed based on the characteristics of the Job and not the holder of the Job.

2.3 Successful Performance Appraisal Evaluation.

1. Top management needs to review their job description and set specific goals and objective measures base on the job description.
2. Proper training of the evaluator - managers/supervisors conducting these evaluations must be properly trained to do so. It is sometimes better to have an independent person or agency to conduct these evaluations so as to avoid biases. Biases/ favoritism will
always be a problem in Performance Appraisal since the organization is a social network and everyone knows each other.

3. Performance Appraisal should be conducted at different periods or at a time the employees do not expect evaluation to be conducted. This will give a manager the true performance of an employee performance.

4. Cover the entire evaluating process and period and not just a recent performance.

5. Managers should have discussions with the employees when designing the Performance Appraisal so that their goals and objective can also be incorporated with the position goals and objectives. Before conducting the evaluation process began, the manager/supervisor must discuss the Performance Appraisal, after completion again a discussion must take place about whether the employee agree with the evaluation process or if there is any area of concern.

6. Managers/supervisors with employees together must set the goals and objective for the next evaluation period. This will give the employee a chance to be heard and have a say in his or her performance evaluation process.

7. Employers can request employees to conduct their own Performance Appraisal since they will know more about the task they perform. This is called self evaluation.

8. Get feedback from colleagues who are working closely with the evaluated employee, that is, use the 360 degree feedback.

9. Spend more time on the positive aspect of employee’s performance than on the negative aspects.

10. Avoid horns and halo effect

2.4 Performance Appraisal as an evaluation tool use at the Office of the Integrity Commission

The Performance Appraisal is presented as an evaluation tool used at the Office of the Integrity Commission in Guyana. The Performance Appraisal is used by Commission to inform employees of their expected performance and also to provide employees with feedback especially areas that needs training. The Commission had taken into consideration Milan Fekete research in which he said that Van and Dan den Berglie (2004) said that organizational performance is “the measurement and reporting system/tools that qualifies the degree to which managers achieve their objectives”. It also stated that the two roles employees’ evaluation plays in the organization making administrative decisions employees (compensation, promotion, dismissal, downsizing, layoff) and rectifying and planning employees growth opportunities (identifying strength areas for growth, coach, develop career). Milan further stated that when developing an employee evaluation system, management should think about these questions which also adopted by the Office of the Integrity Commission when developing their Performance Appraisal:–

1. Who should design the evaluation process? Whether the Secretary/ C.E.O of the Commission, the Commission board member or the employees themselves.
2. Who should evaluate whom? The board members, the Secretary/ C.E.O or the employees themselves.
3. Who should review the evaluation results? The Secretary/ C.E.O or the board members.
4. How these results could be exploited? Use the information at the Commission for promotions, sent on training, revise the organization goals and objectives if current one is not reached, use in the payment of gratuity and vocation allowance.

The Commission further went on to ask how often these evaluations should take place, once or twice per year.
The Performance Appraisal used at the Commission consist of a covering section page which covers the employees’ personal data and leave record and time section. The other section covers the following areas:

Section 1- Review of previously agreed objectives
Section 2- Performance requirement
Section 3- Overall performance assessment
Section 4- Assessment of training and development needs
Section 5- Assessment of potential
Section 6- Objectives for the next review period
Section 7- Reporting officers’ comments
Section 8- Job holders’ comments
Section 9- Commission/ reviewing officers’ comments

The five criteria used to describe the levels of achievement as keys is listed below and is given a weight score from 1-5. Key is:

5- Superior performance
4- Effective performance
3- Good performance
2- Performance requires improvement
1- Unsatisfactory performance

This performance evaluation is done every 6 months of the employees’ contractual period. It should be mentioned that this evaluation is done during this period to:

Constantly remind employees of what is expected of them in their work environment.

1. Provides information to the employee when making an employment decision (eg) for promotion, demotion, layoff, pay raise such as payment of gratuity and vacation allowance,
2. Empowering and motivation employees to do their best on the job or increase employees effectiveness.
3. Determine the gap between employee actual performance and organization expected performance.
4. Identifying skills for training and development.

3. Conclusion

Employees’ evaluation is an important to employers in that you can identify a performing worker from one that is not. Designing and adopting the right evaluation tool can achieve this purpose. One tool that can be used is the Performance Appraisal. In adopting Milan points, the evaluation process at the Office of the Integrity Commission, designing and using the Performance Appraisal was a success.

4. Acknowledgements

I would like to take this opportunity in thanking my family especially my husband Jaigobin Jaisingh in assisting me in the completion of this Article.
I would also like to thank my staff in assisting me with the typing and gathering of information and not forgetting Texila American University for giving me this opportunity.
5. References

Moral Standards and Corporation’s Moral Responsibility

Article Damianus Abun
Divine Word College of Vigan, Ilocos Sur, Philippines
Email: frdamy@yahoo.com

Abstract

It has been an old argument that Business Corporation is a legal entity, separate entity and separate from the owner. It has blanket to protect itself from being sued. Corporate veil has been used as shield to protect itself from prosecution. With such protection, how can it be morally responsible for its act? Moral responsibility is only applied to human, not to any other things. However, this paper will argue otherwise. Based on paper reviews, it is found that one of the requirements in determining moral responsibility is the presence or the absence of knowledge and free will in a certain act. Such requirement clearly strengthen the idea that corporation, though it is a separate entity from the owner may not completely out of hand, wash its hands and can just do what it wants but it has to be also guided by moral standards and take moral responsibility to its immoral actions. The reason is that a corporation as an entity is still composed of rational beings that have knowledge and free will in pursuing their objectives. Therefore, when things go wrong in the corporation, it is not only individual employees who committed the crime are taking the moral blame but also the corporation as a whole including the owner.

Key words: Moral responsibility, moral standards, element of moral standards, individualism methodology, the nature of corporation, knowledge and freewill.

Introduction

We are trying to understand moral responsibility of a corporation. The concern of this particular subject is: who is responsible for what is going on in a corporation when things are going wrong? Is it individual person or the corporation to be blamed? This question is raised based on the nature of corporation itself, that a corporation is not the same as individual person who has the reason or knowledge and freedom because moral responsibility is referring to human only, not to anything other than human. Now who is then to be responsible when things go wrong in a corporation? Is it only the man who has reason taking the responsibility? How about the corporation? This is the main issue that we need to understand in this topic. To help us understand this issue, we need to understand the nature of corporation. However, before going further, one needs to know about the morality of certain act. Are there moral standards to be followed? Are there moral standards being violated? Are these violations intentional or not intentional? What are the elements to be considered intentional? It is assumed that the judgment of certain act, either to be moral or immoral, is always based on criteria or moral standards, not on anything else. A certain act must be evaluated against those moral standards. However, moral standards elements may not be enough as basis for moral judgment and for someone to take the responsibility. Responsibility involves knowledge/reason and freewill. Therefore, reason and free will may be used as the starting point in any moral investigation, be it to the individual person or the corporation. After knowing the element of moral responsibility, then, we proceed to evaluate whether an organization or corporation is subject to moral evaluation, and if so, then what qualifies it to be treated as a human person so that it can be held morally responsible for its actions and what disqualifies it in order not to be held morally responsible.
The purpose of this article is to enlighten everyone on the nature of Business Corporation and its moral responsibility. We would like to know if a corporation, as a legal entity, not as a person, has the moral responsibility over the crime it has committed. The area of concern is corporate veil. Corporate veil has been used as shield to protect itself from prosecution. The question here is: is corporation protected from moral responsibility? In this paper, I would like to show that corporations cannot hide behind their corporate veil and wash its hand. To support my stand, careful readings on certain authorities related to the topic are the basis of the arguments presented in this paper. The paper will only limit its argument on the main element in determining moral responsibility of a corporation. The writer realizes the difficulty in writing this topic because it does not accommodate the idea of moral relativism. He assumes that the readers are believer of universal morality.

Moral Standards

The meaning of Moral Standards and the Law

Moral standards are bases for moral behavior and bases for determining whether a certain act is moral or immoral and for someone to be responsible or not. These are the guides of human behavior and decision making. These standards are not only applied to individual persons but also to a group or corporation. Something is unethical if it does not conform to a particular standard of morality. They may not be written but observed and they are assumed norms of moral conduct (Articulo, 2005). These norms are point for checking if certain action is good or bad. The concerns of moral standards are norms, not theory which explains why certain act is good or bad. Moral standards are not the same with social norms but they are beyond social norms. Though social norms are code of conduct within a particular society but they are not moral standards. Moral standards are beyond borders or may be called universal that are accepted by all rational being everywhere. The coverage of social norms is local, while the coverage of moral standards is universal. Therefore, the function of moral standards is to check if the social norms are moral or immoral. Example, certain society allows killing in the name of God or offers human as a form sacrificial lamb to God. Moral standards will tell us that it is immoral, though social custom declares that it is accepted.

Based on the above understanding, it is clear that ethical standards guide individuals to act in a good manner in dealing with other humans, society and the environment. These standards should encourage individuals to make the right decisions for their actions, and give them the courage to come forward should they notice dishonest and unethical behavior. Individuals need to follow the norms prescribed by all rational agents. Therefore, in deontological systems, being morally good is defined as obeying certain moral rules (Harris1986). When you follow those rules and do your duty, then you are good — regardless of any other considerations like whether the consequences of that obedience lead to suffering or happiness. On the other hand, if you ignore or break any of those rules then you are not doing your duty and are morally bad — once again, regardless of any consequences. These moral duties are absolute and unconditional duties such as telling the truth, being honest, being fair, etc. They apply whatever consequences might follow from obeying them. Example is the order not to steal. It is our duty not to steal, though the consequences of stealing would save the life the one who is stealing. It does not explain why one should not steal because it is the concern of moral philosophy.

One should remember that moral standards are not the same with legal standards. Following laws does not make one ethical. Abortion in a certain country is legal but it does not mean that abortion is moral because it involves killing a human being. While this practice is certainly legal, the unethical nature of it is quite clear. Another example is euthanasia. Some countries are legalizing euthanasia in which one can terminates one’s life on the basis of mercy or other reasons. Though it is legal but such action is immoral because it is considered killing. Thus Legal
is following the law and may include exploiting holes in the legal system but it may contradict morality. Ethics is doing the morally right thing. Some laws may not even have any ethical connotations whatsoever. Some moral acts may be legal but it may be also illegal. The legality of an action does not guarantee that the action is morally right. Many issues in life that cannot be resolved by appeal to law alone. Thus Shaw, Williams (1999) argued that law codifies a society’s customs, ideals, norms and moral values and changes in laws undoubtedly reflect changes in what society considers right, wrong, good and bad. However, he further emphasized that it is a mistake to see law as a sufficient to establish moral standards that should guide an individual, a profession, an organization or society. Law cannot cover all individual and group conduct. Thus conformity to law does not necessarily mean that the act is immoral or non-conformity to the law does not mean that the act is immoral.

**Sources of Moral Standards**

Related to moral standards issue, one may ask question, “Where are the sources of these standards or where do we get those standards? If our ethics are not based on feelings, religion, law, accepted social practice, or science, and then what are their sources? Many philosophers and ethicists have helped us answer this critical question. They have suggested at least five different sources of ethical standards we should use.

**Common Good**

Common good principle would argue that certain act may be considered good if it promotes the interest of the majority over individual interest. This principle is originated from the utilitarianism theory. Utilitarianism emphasizes that the ethical action is the one that produces most good for the greatest majority interest and does the least harm for all who are affected (Velasquez, 2014). One should not act if it does not bring good to the majority of the society, though it might violate to one’s individual interest. If we apply it in the business setting, an ethical corporate action is the one that produces the greatest good for the stockholders, stakeholders and the environment. All actions are analyzed from its consequences, if the consequences are good for the majority, then such act can be pursued.

**The Rights Doctrine**

Immanuel Kant classified rights as natural and positive rights. Natural right is inborn right while positive or statutory right is what proceeds from the will of a legislator. From the two classifications of rights, thus we have innate rights and acquired rights. Innate right is that right which belongs to everyone by nature, independent of all juridical acts of experience. Acquired right is that right which is founded upon such juridical acts. Innate right may also be called the “internal mine and thine” (meumveltuuminternum), for external right must always be acquired (Kant, 1790). Kant argued that there is only one innate right such as birth right of freedom, while other rights are originated from right to freedom such as right to property and other rights. For Kant, freedom is independence of the compulsory will of another; and in so far as it can coexist with the freedom of all according to a universal law, it is the one sole original, inborn right belonging to every man in virtue of his humanity. This is a right to be independent and of being coerced by external force. The limit of this freedom is the freedom of others, in the sense that the exercise of freedom is limited by the freedom of others. Emanated from freedom is the right to property. It is believed that each one is free to own a property. He/she has the right to property if he/she is connected to it and that if any other person should make use of it with the owner’s consent and if they do it without the consent of the owner, then they do an injury to the person or the owner. The subjective condition of the use of anything is possession of it as Immanuel Kant puts it, “Anything is “Mine” by right, or is rightfully mine, when I am so connected with it, that if any other person should make use of it without my consent, he would do me a lesion or injury”.
Thus anyone who would assert the right to a thing as his must be in possession of it as an object. According to Robert Nozick (1974) as cited by Shaw (1999) argued that property rights is considered sacrosanct. It grows out of one’s basic moral right. Such right is either reflecting ones’ initial creation or appropriation of the product, some sort of exchange or transfer between consenting individuals or a combination of the two. However, Nozick, as quoted by Shaw argued that property rights exist prior to any social arrangement and are morally antecedent to any legislative decision that a state could make.

Reading the argument of Kant and Nozick, it can be said that there are two kinds of rights and they are moral natural rights and legal rights. Moral natural rights are possessed by man by virtue of their human nature; they are born with those rights, not conferred by the state. While legal rights are those conferred and recognized by the law. That’s why we have constitutional rights which are conferred and protected by law. They cannot be altered by the state. While statutory rights are derived from legislation which are drawn by the people’s representative such as right to minimum wage and right to just compensation to additional work (Articulo, 2005).

Thus the ethicists agree that the ethical action is the one that best protects and respects the moral rights of those affected. This approach starts from the belief that humans have a dignity based on their human nature per se or on their ability to choose freely what they do with their lives. On the basis of such dignity, they have a right to be treated as ends and not merely as means to other ends (Kant, cited by Stanford Encyclopedia of Philosophy, 2004). The exercise of any moral rights is limited to the moral rights of others, the sense that while the bearer of the right has the right to exercise his/her freedom but at the same time the bearer should not violate the rights of others. Others have the duty to protect our rights and we have the duty to protect the right of others.

The Justice Doctrine

Plato as cited by Velasquez (1996) argued that in a society that lacks norms of justice, he suggests, people inflict injustices on each other. People quickly conclude that they will be better off if everyone adheres to norms of justice. People consequently agree to cooperate in mutual adherence to norms of justice. It is along this line of reason, we take justice as one sources of moral standards, a standard of moral behavior. All know that just action is considered to be ethical. Therefore, the principles of justice are some portion of the total principles that make up ethics. There are a lot of different ideas about justice. Aristotle and other Greek philosophers have contributed to the idea that all equals should be treated equally. Today we use this idea to say that ethical actions treat all human beings equally—or if unequally. This kind of definition refers to fair treatment. But the question here is: who does the treatment and who are to be treated? The answer to this question leads us to think of individual justice and social justice or group justice. Justice is not only fair treatment from other people toward the person but how the person treats other people justly. Therefore justice becomes individual virtue and social virtue. A just person always treats other people justly and a just society is always treating its community members justly. As a just individual, I pay people more based on their work, based on the amount they have contributed to the organization and so the greater the amount that they contribute to an organization, the greater they receive. Just society, just government, just organization would treat individual justly as how the individual treat each other. In this case justice means giving what is due to a person fairly deserves. An act is ethical if it gives a person his proper due, otherwise the act is unethical. Giving what is due indicates that all persons must always be treated equally.

Velasquez (2014) argues that there are two kinds of justice and they are distributive and retributive justice. Distributive justice is dealing with the way how the wealth is distributed to members of the society. Thus distributive justice refers to fair distribution of society’s benefits and burdens. The benefits should be distributed according to the contribution or the burden.
Someone should not expect more if he/she has not contributed anything to the production of the output. Thus, pursuing society’s benefits but avoiding burdens is unethical because it is unfair for anyone to benefit from society’s economic pool without working hard for it. Such idea of justice falls within what Aristotle called formal justice. Formal justice is the requirement that we should treat similar people similarly. If two persons have the same qualifications, the same amount of contribution to the organization, they should be treated equally or similarly. This kind justice would contradict with what Karl Marx meant by justice. For him justice is to share benefits according to the needs but the burden is shared according to the capability. While retributive justice refers to the punishment given to a person who committed a crime and punishment must be equal to the crime she/he committed. Not accepting the punishment is considered unethical because such act would mean that the person avoids what is due him. In relation to this idea, it is the same when someone destroys the property of other people, then it is his due to pay or replace it. When he violated the law, then it is his due to be jailed.

There are other views of justice when we talk about society as a whole (Velasquez, 2014). When a person thinks that talents, education qualification, ability, experience are the basis for job distribution and salary structure, would understand justice in terms of merit. This what we have mentioned above that justice means giving what is due to the person who deserve. Such idea is originated in the idea of Plato. Plato believes that people are classified not based on their family background but based on their talents and abilities and with such talents and abilities, those persons can play their social role. Further, when a person considers that the government should provide free education to all, would think that justice is about equality. This is rooted in the belief that all men are created equally or the same. Therefore treatment should not be based on religion, gender, race, and nationality and all should be given the same opportunity. Therefore, since all human are the same, they should be given equal shares of benefits and burdens. Next, if a person believes that business is importance to the common welfare of society and they should be given tax break, then they view justice as utility. For this group justice means what promote the common good or common welfare of the citizens. In this case, a business is just when it promotes the welfare of majority of people.

Natural Law and Virtue Doctrine

Humans are born good, they are given the natural knowledge, capability of knowing what is good and bad which is already built in the reason. Such concept would emphasize the point that human are rational being and moral being. This is true to all human beings. Peter Singer as cited by Arneson (1998) argued that human have special moral privilege based on the superior cognitive abilities. Though his argument has been criticized by some for it leads to conclusion that there are different capacities among human and so there must be different level of moralities among human. Beside the point of different argument but the common point in the argument is that all human are moral being. All actions are commanded by reason which makes a different from the animal and therefore actions motivated by reason are necessarily good or moral. It makes a different from animal. Such concept leads us to categorize acts as have human act and act of man. The human act is calculated by reason, while act of man is calculated by instinct which is the same with animal. Therefore, an act is good if it reflects the nature of man as a rational being and a moral being and these are first basis for moral evaluation of human acts.

Since human are moral being, then definitely human must possess moral character or virtues. Therefore human are necessarily virtues human being. Aristotle argued that that a virtuous person is someone who has ideal character traits. These traits derive from natural internal tendencies, but need to be nurtured; however, once established, they will become stable. Virtue ethics emphasize the role of character and virtue in moral philosophy rather than either doing one’s duty or acting in order to bring about good consequences. A virtue ethicist is likely to give us this kind of moral
advice: “Act as a virtuous person would act in your situation.” Or virtue ethicists would advise us, “act always as honest person”. Honesty here is not refereeing to certain dealings or transactions but the honesty is a character of the person. Human transactions must always be honest because honesty is a reflection of human as a moral being, a virtuous human being. If transactions are not honest, then it is immoral because it does not reflect a character of human being as virtuous human being. A virtuous person is someone who is kind across many situations over a lifetime because that is her character and not because she wants to maximize utility or gain favors or simply do her duty (Athanassoulis, 2013).

Moral Responsibility

After knowing that someone has done something wrong based on either one or all of those moral standards, then that person should take the responsibility. Responsibility means something for which one is responsible to one’s act or the state or fact of being responsible, answerable, or accountable for something within one's power, control, or management. Related to the topic of ethics, responsibility would mean being accountable for what we are doing knowingly and freely. It is the extent to which the person or group deserves blame or punishment for what he/she has done or the group has done. In other words, she/he should not wash his/her hands and throw his/her moral responsibility to other people after he/she committed certain action. Be responsible and take the blame. Why? The person who performs an act knows why he acts and freely commits it, even though he knows his act is wrong but he/she does it and therefore she/he must take the full responsibility for his/her actions. Consequently the person deserves blame or punishment. Thus moral responsibility involves the notion of guilt or innocence (Articulo, 2005). Take an example, the employer was found to be violating the right of employees to privacy. The investigation committee recommend to the management that certain employer has to take the responsibility. As a result, the employer was punished and the employer was ordered to pay for moral damages.

The example mentioned above is a case of individual act, in a sense that the act was done by an individual person, not authorized by the management. Now our concern is, how if such act was done out of duty or she/he was authorized by the management as prescribed in his job description? Should the individual employee or the corporation take the responsibility? Should both wash their hands? The contention here is related to the extent of moral responsibility. Moral responsibility refers to both, individual and collective moral responsibility (Risser, 2014) because immoral act may be done either by individual person authorized by corporation or a group as a corporation. There can be a situation in which as a group knowingly and freely plans certain activity which brings disaster to a community. Moral responsibility becomes complicated here because it involves corporation which is not considered a human person or rational being. Corporation is only a legal entity created by law which is not an individual person that has no reason, knowledge and freedom or free will. How can it be imposed with moral responsibility? Therefore, we have the reason to argue that the person or a group who has committed certain immoral act is not always responsible for their wrongful act. It might have been the idea behind why some individual prefer to form a corporation than single proprietorship because it has a veil to protect from moral responsibility. It is a veil given by law. It has a limited liability. Now, what happen if certain corporation committed a crime? Who is the one taking the blame? Let us be clear that morality and law are two different things, in a sense that what is legal may not be always moral and what is moral may not be always legal. The issue on hand is moral issue and as a moral issue, there are simple requirements to be met if certain act is moral or immoral. In this regard, there must be criteria or requirements to be fulfilled for one or a group to be morally responsible, and thus we need to know when the person is morally responsible and when they are not. In order to determine moral responsibility, we need to know what makes an act right or
wrong morally. This is important criteria to determine on which we can base our judgment and moral theories will help us in determining the extent of moral responsibility.

**Element of Moral Responsibility: Knowledge and freedom**

Moral standards are the guide of our moral behavior. Everyone including corporations should be guided by those moral standards. However, in determining moral responsibility of certain act, moral standards may not be a good starting point. Therefore, evaluating certain act and their moral responsibility merely based on the moral standards would not be enough or sufficient. The issue of moral responsibility is framed within the nature of persons. Persons are classified as unique because of the reason, minds (McKenna & Widerker, 2006). Thus the starting point to be investigated is knowledge and freedom. Thus, we need to see if the violation of those moral standards were intentional or not intentional. In other words, evaluation may continue if the element of knowledge and free will are found. Thus, the primary step to be taken before a judgement can be done is to find out if there was the presence or absence of knowledge and freedom or free will (Sandel, 2014, cited from Immanuel Kant). If there was a sign that knowledge and freedom were present in the act, then the question remains: to what extent is the presence of knowledge and free will? This is relevant to the issue because it will determine the level of moral responsibility. But we will not go deeper into it because our main purpose here is to find out if corporation can be morally responsible for its action. A judgement on certain act can be made if it is found that there is presence of mind or reason and free will, if the act was done knowingly and freely. In other words, the person can be blamed if the person is acting out of his knowledge and free will. The person acts knowingly and willingly despite the fact that he knows that such act will destroy common good, the right of people, justice, the doctrine of his religion, and dignity of other people. Despite of that knowledge in mind, however he still commits it.

Reason allows us to act with a purpose and guide us to pursue the objective. With such reason, one can identify or differentiate right from wrong or good from bad and one can avoid it. Thus the absence of reason, depending on the situation or circumstance, can reduce or mitigate the moral burden of the person who committed the act. It is the reality that many times a person acts out of fear or anger or external force. In other words, the person is not in full control of his acts. In such situation the person may or may not be morally responsible. When the person acts without being aware of the consequences or the wrongness of his act, cannot take full responsibility of his act.

Knowledge and free will are the first bases for moral judgement of certain act because we believe that only knowledge and freedom belong to human as a rational being. Consequently all acts performed by human must be based on his reason or knowledge and free will. This is what we call human act; the acts are specifically belonged to human, a rational being who has a freedom. Knowledge and freedom are the only things belong to human and the acts that are belonged to human act are the only the acts we can judge. Human should act based on the knowledge and his free will (Widerker and Mckenna, 2006). This is to emphasize that there are other acts which we call act of man. The act of man does not necessarily belong to human but also belong to animal which is not necessarily motivated by reason but by instinct like animal. Example, eating, drinking, sleeping, is acts that are also belonged to animal. These acts are neutral to moral judgment. Therefore, we emphasize that it is only human act that we can judge morally. Before we judge certain whether it is immoral or immoral based on the motive, the means, the ends and consequence, we need to determine first if the act was done knowingly and freely (Widerker & Mckenna, 2006).
Taking Full Responsibility, Not Full Responsibility and Exempted.

Based on the discussion on the determining factors of moral responsibilities, then we have the idea that not all wrong act are done knowingly and freely. There are certain situations or circumstance that a certain person committed a certain act either with full knowledge and freedom or incomplete knowledge. It is here we need to examine when someone can be full responsible of his /her action or not fully responsible for his /her actions (Widerker and Mckenna, 2006).

Someone is judged to be morally wrong and fully responsible for his/her actions when she/he does it with full knowledge and freedom. In other words, he/she does it knowingly and freely. The person has a complete knowledge of the wrongness of that act but he/she chooses to commit that act at his own choice and free will. In other words, the person committed such act intentionally, voluntarily and is a product of contemplation and deliberation. After establishing facts and determining that such act is done knowingly and freely, then the person has full responsibility and that person should be punished according to the crime he/she has committed.

Example a manager knows that bribery is immoral, however, despite of such knowledge, he/she committed it.

However, there are circumstances in which a person commits certain act not because he/she has full knowledge. Despite of her lack of knowledge, she/he committed it because she /he might be pushed or forced by a certain circumstance that he/she has no choice but to do it. This is the case that we cannot throw all the responsibility and blame over that person. Given that situation, in the case of lack of knowledge of the correctness or rightness of the act, however, the person cannot also be removed from all moral responsibilities. The responsibility and blame are still with the person, however, to a lesser extent, not totally exempted because lack of knowledge is not sufficient enough to exempt the person from moral responsibility because he/she could still find ways to get information but he/she did not.

A person can be exempted totally if the person acts out of complete ignorance of the moral wrongness of the act, unintended result of a rightful act, result of an accident, coercion to the extent that the person’s reason cannot work and when such person has no capability to know if such act is right or wrong, good or bad. The first and the last is the case of a child or a crazy person who burn the house of their neighbor because of excitement to the see the beautiful fire. The case of unintended result is the case of double effect of certain act. This is the case in which a person performs certain act that lead to, either good or bad outcome. Example a doctor examines a pregnant mother who has cancer. The only way to deliver the baby is through caesarean; however, the result was the mother’s death.

Corporate Moral Responsibility

The Nature of Business Corporation

In order to determine moral responsibility of corporation, first, we need to know the nature of corporation. Proper understanding is needed for us to determine if a corporation is morally responsible for their actions. This is due to the fact that corporation is not human, it is a legal entity created by law but what qualifies it to be like human and therefore be responsible morally. It is commonly known that a business entity is an entity that is a group of people organized for some profitable or charitable purpose. Business entities include organizations such as corporations, partnerships, charities, trusts, and other forms of organization. Generally speaking, entrepreneurs incorporate their business in the state where they conduct their business (Perez, 2015). After incorporation, then the business is considered legal and it is now recognized as a legal business entity. It has a legal personality and now can legally pursue its business objectives as prescribed in their constitution and bylaws as approved by the Security of Exchange Commission. Thus the treatment to a corporation is now the same treatment to a person. Business
entities, just like individual persons, are subject to taxation and must file a tax return. Some business entities are exempt from federal income tax. These include non-profit charities, non-profit corporations. Business entities may be subjected to state income tax, depending on the laws of the state or states where they conduct business.

There are different types of businesses and knowing different types of businesses could help us understand the nature of business. The classification of business is depending on the objective that it pursues. Therefore, first, we have sole proprietor. Sole proprietor is unincorporated businesses and it is usually owned by a single individual. There are no forms we need to fill out to start this type of business. The only thing you need to do is report your business income and expense. This is the easiest form of business to set up, and the easiest to dissolve. A Sole Proprietorship in the Philippines is also known as a "single proprietorship, A sole proprietorship is the most simple form of business and the easiest to register in the Philippines, through the Bureau of Trade Regulation and Consumer Protection (BTRCP) of the Department of Trade and Industry (DTI). It is owned by an individual who has full control or authority over all the assets, as well as personally answers all liabilities or losses. The fact that it is run by the individual means that it is highly flexible in which the owner retains absolute control. In relation to liability, the sole proprietorship has an unlimited liability as compared to corporation. This is in case if the owner put up his/her business not by her/his own capital but from loans either from individual person or from the banks. When the business bankrupt, then the owner has to pay all the money that he/she has loaned from other people or creditors. The creditors can also file case against the owner and run after the owner and can proceed not only against the assets and property of the business but also the properties of the owner. Therefore the laws do not differentiate between the owner and the business, both are the same.

Second is corporation. A corporation is an entity which is separate from its owners. Therefore, unlike sole proprietorship, corporation has limited liability protection. The Corporation is formed under the laws of the state in which it is operating, with Articles of Incorporation. It has shareholders, and the shares may be privately or closely held, or they may be offered for sale to the public. Corporations are taxed separately from their owners at the corporate tax rate. Since corporations are separate entities, the debts and liabilities of the corporations are also separate from those of the owners. This separation is sometimes called a “corporate shield” or “corporate veil”. Corporate veil is a term used to describe the separation of the corporations from its owners. As a separate entity, the corporation is set up to shield its owners from personal liability for the debts and negligence of the business. Since it is a separate entity, when the corporation is sued, the individual shareholders and officers cannot be brought into the lawsuit. But there are cases in which the corporation's officers and shareholders could be sued for negligence or for debts; the action of bringing in these shareholders to be sued is called "piercing the corporate veil" or "lifting the corporate veil. "There are two instances when a corporation can be sued: first, in the case of fraud, in which the corporation was found to be a sham that was set up for the purpose of carrying on fraudulent deals or for fraudulent purposes. In this case they knowingly and freely pursue immoral objectives. Second, in the case of egregious and willful activity by corporate shareholders or officers who put corporate gain over public good (Murray, 2015). Again they knowingly and freely pursue immoral intention even though they know that the common good will be violated.

Third is partnership. It is a legal relationship formed by the agreement between two or more individuals to carry on a business as co-owners. Unlike Corporation, partnership is not a separate entity from its owner. Since it is not a separate entity from its owners, then the owners must take the responsibility in case of business going bankrupt. Partnership must have at least one general partner who assumes unlimited liability for the business, for actions of the partnership. It may also include limited partners who are merely investors and who do not share in the day-to-day
operations of the business and who do not share in liability. Partnership must have at least two partners. Partnerships are usually registered with the state in which they do business, but the requirement to register varies from state to state. Partnerships use a partnership agreement to clarify the relationship between the partners, roles and responsibilities of the partners, and their respective shares in the profits or losses of the partnership (Murray, 2015).

Fourth is Trust. Trust is usually formed upon the death of an individual and is designed to provide continuity of the investments and business activities of the deceased individual (Perez, 2015). Fifth is called non-stock nonprofit corporation. Their purpose is not for profit but it is for service or for charity. Such kind of business is exempted from tax but it needs to report its activities and income and assets to ensure that it complies with the government laws with charitable institution or corporations. We use the term nonprofit because these organizations are not set up for the sole purpose of making a profit. Rather, they pursue public benefit purpose that is recognized by the constitution. What makes an organization a nonprofit is that: first its mission. Its mission is to undertake activities whose goal is not primarily for profit. Second, no person owns shares of the corporation or interests in its property. Third, the property and income of the nonprofit corporation are never distributed to any owners, but are recycled back into the nonprofit corporation's public benefit mission and activities. In terms of ownership, it is owned by the public, it belongs to no private person and no one person controls the corporation. All its assets are dedicated to service or charity. The cash, equipment, and other property of a nonprofit cannot be given to anyone or used for anyone's private benefit without fair market compensation to the nonprofit organization (Fritz, 2015). In terms of control, it is controlled and governed by Board of Trustees and their function is to see to it that the organization serves the purpose and the founder does not own or control the nonprofit. Board of Trustees does not act as individual persons but act as a group. Nonprofit is only accountable to the public and it is therefore, it must file annual information return to the appropriate office of the government (Fritz, 2015).

After understanding the nature of business, now we have idea how business are working. Some are taking full responsibility and others are avoiding responsibility which is allowed by law by creating a corporation. However, setting aside the discussion on the different kinds of business organization, from the definition, it gives us a clear view of what business organization is all about. Depending on the kind of business, each business has different set up and has different level of liability. Some have unlimited liabilities, while others have limited liabilities. In the case of unlimited liabilities, then such business cannot cover itself from legal charges and assume the damage. However, our concern in this particular topic is corporate moral responsibility. A corporation has a limited liability because it is a separate entity from its owners. The concern is: who is taking the moral responsibility or who is going to take the blame?

**Corporate Moral Responsibility and Individual Responsibility**

The starting point of discussion is: is a corporation not morally or morally responsible for its actions? This question is raised because of the fact that corporation has a limited liability. Such nature of corporation has brought controversies between theorists whether a corporation is morally responsible or only the individual person, not the corporation. Answering the above question would be simple if we follow the previous argument on the determining factor of moral responsibility, then we can give immediate answer to this question. As long as the act was done knowingly and willingly by the corporation, the organization is morally responsible. However, problem becomes complicated because it is not a matter of applying such principle but the theory of corporation makes it complicated. The idea of corporate veil makes things harder. Pursuing this idea, we encounter a problem and the problem is a corporation has no reason and free will because it is a legal entity created by law that can carry out a business for a certain objectives. It is not an individual person who acts knowingly and freely. Corporation is a separate entity from
its owners and thus it has a limited liability, in the sense that it cannot take all the blame for its actions. Why? Two opposing groups present their views. Those who use the individualism methodology would argue that "corporations don't commit offences; people do (Bodenheimer, 1980). The strategy of Individualism, as revived by numerous commentators in recent years, is to abolish corporate criminal liability and to rely instead on individual criminal liability (Lederman, 1985). He continued that theoretical basis for imposing criminal liability on the corporation remains unclear. And such situation has encouraged the trend toward a slight restriction in the scope of corporate criminal liability.

How can we apply moral responsibility and blame to a corporation? Friedman (1967) as cited by Lederman (1985) argued that many debates have come out to discuss issues related to moral responsibility of the corporations. Indeed, the very substance of the corporate body is controversial and various views concerning it have emerged. There are those who treat the corporate body as a mere legal fiction devoid of the ability to function independently and requiring permanent representation by human beings. Others treat corporations as real entities claiming that the law merely recognizes the existence of corporate bodies rather than creates the corporate entities. A third group of jurists rejects both these approaches and offers additional explanations. For the upholders of the theory of individual responsibility rooted in methodological individualism and its related metaphysics, argue that one cannot ascribe moral responsibility to a corporation but only to a “flesh and blood” individuals who are moral person but Soarez (2003) argued that corporations have sufficient structural complexity to be agents whom it makes sense to call to account for their actions and the consequences of those actions. It may not be possible for corporations to be responsible in the way that the individual can be but they can be responsible appropriate to corporations. J. Braithwite and B. Fisse, (1998) in an article, “The Allocation of Responsibility for Corporate Crime: Individualism, Collectivism and Accountability” as cited by Soarez (2003) argue that methodological individualism amounts to a dualistic ontology. On the one side are individuals and on the other are corporations. Individuals are observable and therefore, real, while corporations are abstractions without the possibility of direct observations. If it is so, it is not possible to ascribe to moral responsibility to a corporation and ideas such as agency, autonomy and rationality do not apply to a corporation. Therefore we cannot expect formal organization or their representative to take the moral blame. It is along such line of argument, Soarez (2003) lamented that moral responsibility is a word without meaning. Amidst those conflicting discussions, however, debate along such idea never ends because of the desire to settle the score on who is holding the moral responsibility. The question of who is holding the responsibility remains alive because different interpretation of the nature of corporation. Trying to settle the interpretation, Lederman (19850 suggested that that distinctions must be made between human beings and corporate bodies. Those distinctions are not to clear one and punish one but to clear the responsibility in terms of the extent to which both are responsible morally. Some argue that even assuming that the individual desires of a group of people working in concert can form a "collective will" as a result of the interdependence and mutual influence within the group, and even assuming that this synthesis of desires is distinct from the separate wills forming it (Braithwite &b Fisse, 1998), the problem of personifying the corporate body is not thereby brought to a clear-cut solution. The corporate entity is an enterprise devoid of the physical ability characteristics of the human race. Man possesses consciousness and physical aptitude, as well as the power to exercise them. Corporate bodies, in contrast, are bereft of those capacities and depend totally on a human source in order to function.

To clear such issue, Soarez (2003) presented two arguments from two contestants: Nominalists and realists. For the Nominalists, corporations are collections of individuals or aggregations of human beings. While the Realists argue that a corporations has its own existence and a meaning as well as moral/legal personality of its own. He further emphasized that both of these views have
implications for moral and legal responsibility. In the Nominalists view, corporations do not exist apart from its members; any blame worthiness or responsibility can only be obtained from the culpability of an individual employee. Therefore, in line with this Nominalists view, corporations are moral persons in the sense that they are entities and they are intentional actors. Corporations are entities with dominant role to play in our society. Corporations are more than mere collection of individuals which means that they are capable of moral decisions and therefore susceptible to moral blame. However, this would leave one with the problem of deciding whether the corporations should be responsible for the behavior of its employees or only for some of them. Definitely if employees or employee acts on behalf of the corporation because they are or he/she is carrying out their duty or her/his duty authorized by corporation, then in this case the corporation has to take the blame. On the realists view, corporations represent something beyond individuals which means that following this point of view, it may be possible to find a new candidate for attributing responsibility. In the realists view, the corporation is not morally responsible. However, Lederman (1985) settles this issue by using the conspirator theory. He said that the theory of conspiracy holds any conspirator liable for crimes committed by fellow conspirators in the furtherance of the conspiracy, even if the conspirator was not capable of committing the offense himself. The analogy to the theory of corporate criminal liability suggests that each breach of law the corporate body has been accused of is in furtherance of an offense previously plotted between the corporation and the perpetrator. Hence, the corporation is criminally liable for the acts of the perpetrator in execution of the plan of the conspiracy.

Based on those arguments presented in the discussion, we can settle our case on the question of “who is taking the blame?” Following the argument, the traditionalist and the nominalists definitely would answer that the one who is taking the blame is an individual person or employees because they are the ones who have reasons and freedom. They have the knowledge of what is right and what is wrong and the knowledge of what is good and what is bad. Therefore using their freedom, individual employee or employees could refuse to carry out a job which is not moral, even though they or she/he is authorized to do so. Further they argue that individuals had to carry out the particular actions that brought about the corporate act. Contrary to the traditionalists and nominalists’ view, French (1979) as cited by Velasquez (1998) claimed that when an organized group such as corporation acts together, their corporate acts may be described as the act of a group and consequently the corporate group and not the individuals who make up the group must be held responsible for the act. Take an example, the defective product of a beauty product cannot be attributed to the individual person but it is attributed to the corporation or the company where the product is made, so long the cause of defective product was not caused by individual employee but a consequence of following the order of the company. Velasquez pointed out that more often than not, employees of large corporation cannot be accused of “knowingly and freely” join their actions together to pursue corporate objectives. Often time they may not be aware of the intention and the ends/objective of the corporation’s act because they are not involved in the discussion during the planning process and they have no way of finding it out and are not capable of stopping it. In this case, the excusing factor is ignorance and inability.

However there are situations wherein employees know that the corporation’s plan is immoral, however, they just ignore about it because they have no power and no choice to do otherwise except to follow the order. They have the capability to question and to withdraw their cooperation but they choose to go along because of the fear and pressure that they might be fired. However, such situation could not be used as an excuse by the employees or employee from their moral responsibility. Velasques (1998) claimed that following orders out of fear of his/her boss cannot absolve the employees/employee from moral responsibility. Unwillingly cooperate with the corporation to do a certain crime cannot excused him/her from moral accountability because such reason is not serious enough to cause his/her mind goes blank but she/he is still in full control of
her knowledge about the wrongness of her/his action. Example, an employee was authorized by his/her employer to put a bump near the gate of their business competitors. The employee cannot claim that he/she is just following orders because the employee knows that it is wrong but still doing it. Doing a certain crime because of fear, threat, and uncertainties may lessen or mitigate the moral responsibility of the employees. The employees/employee can only be exempted from moral responsibility if the employees/employee is found to be in complete ignorance about the wrongness of their act and if he/she was coerced by his/her boss to commit a certain crime, however, such reason can only be accepted if the coercion was very serious up to the point that her reason cannot function well. Moral responsibility requires merely that one acts knowingly and freely and it is irrelevant to use the reason of “following orders only”. Following orders because of pressures may only mitigate the employee’s moral responsibility over the crime.

**Conclusion**

Moral standards are applied to all who are called rational being, be it an individual person or a corporation. Consequently all must take the responsibility if they are found to violate moral standards. We conclude that employees and corporations are morally responsible to the crime they have committed. However moral responsibility depends on the circumstance in which how the crime is committed. The determining factors of moral responsibility of corporation are knowledge and freedom or freewill. Though a corporation is separate legal entity from the owner, and not considered as an individual person, however, a corporation is composed of rational human beings who have knowledge and freedom. There are situations in which, as a group, it knowingly and freely pursues objectives that are in violations of moral standards. When they violated the ethical standards, they are acting as a group with full knowledge and free will. Employees are acting on behalf of the corporation. They are authorized by the corporation to carry out their job as prescribed by the organization or in other words, they are just doing their job. However, employees cannot just wash their hands and throw the blame to the corporation because the element of reason and free will are retained with them. Thus as individual employees, he/she has still the freedom to choose to follow or not to follow if the order is not moral.

It is based on such argument, we conclude that both: employees and corporation are morally responsible to the crime committed by the corporation. This position may be opposed by those who are using the argument of individualism methodology; however our determining factor is knowledge and free will. As long as these two factors are present in certain act, then corporation is morally responsible. In this regard we have group and individual moral responsibility. Individual responsibility maintains that only individual human agents can be held morally responsible, and group responsibility maintains that groups, such as corporation, can be held morally responsible as group, independently of their members. These opposing positions rest on a deeper conflict between methodological individualists, for whom all social phenomena, such as group activities, can be explained by reference only to facts about individual humans, and methodological holists who defend the ontological position that there are social groups capable of actions that cannot be reduced to the actions and interests of their individual members. Though they are using different approach but the two approach lead to the same conclusion that both individual employees and corporation are morally responsible because both are still considered rational being who have knowledge and freewill.
References


Improving Access to HIV and Aids Services for Key Populations in Jinja District – Uganda

Article by Balidawa John
Ph.D in Management, Texila American University
Email: balidawajohn@gmail.com

Abstract

Background: This paper details the application of knowledge and skills gained from Total Quality Management, Management Information Systems and Research Methodologies trainings from TAU in increasing access to HIV and AIDS services to key populations in Jinja district. Uganda has continued to suffer from the adverse effects of HIV and AIDS for almost three decades now, with the HIV prevalence rising from 6.4% in 2005 to 7.3 in 2011%, (UAIS 2011 Report). This was attributed to the increase in the rate of occurrence of new HIV infections, even when access to Ante Retroviral Therapy (ART) for the general population was increasing. The Uganda Ministry of Health noted that the major sources of new infections are the Key Populations.

Key Populations’ are those categories of people who are most likely to be exposed to HIV infection and or most likely to transmit HIV to their sexual partners. According to studies, Key Populations in Uganda have higher HIV prevalence rates above the National HIV prevalence rate of 7.3%, sometimes often more than twice the national average. Key Populations in Uganda include; Fisher folk, Sex workers and their partners, Uniformed personnel, Long distance drivers and Men who have Sex with Men (MSM).

Methods: A PLACE (Priorities for Local AIDS Control Efforts) study conducted by Makerere University and Jinja District Local Government revealed that there were limited interventions in the district to address the challenges of access to HIV and AIDS services for the Key Populations yet they existed in the district. The Jinja district health team came up with interventions to address such challenges faced by Key Populations starting September 2015. The goal of the interventions is to reduce new HIV infections in Jinja district by providing universal access to HIV prevention, care and treatment services to Key Populations in the Jinja district. The specific objectives are; To provide factual information on issues related to HIV and AIDS among Key Populations to the general population including the health workers. To mitigate specific drivers increased HIV infection/transmission among Key Populations. To scale up delivery of comprehensive HIV prevention and treatment services to Key Populations. To build a strong enabling environment for equitable and sustainable delivery of HIV prevention and treatment services to Key Populations, and lastly is to strengthen the strategic information system for program and policy improvement for Key Populations.

Achievements: The project identified a few key populations for consultations on how best they would access and or be provided healthcare services. Venues where Key populations could be found were identified and sensitization of 60 managers in these venues about the intended interventions for the key populations was done. 90 leaders of the different categories of the key population were also identified for orientation and easy mobilization of their peers for services that we offer. The project also prepared 120 health workers to provide services to the key populations. Special clinics for key populations were created for easy access to the different services and to reduce stigma and discrimination. Logistical support is very vital and there was budgeting and procurement of condom dispensers, information and communication posters, and
drugs. HIV Counselling and Testing outreaches conducted and 510 key populations have been tested for HIV. Data collection tools were modified to suit the project information demands. The challenges expected when serving key populations in Uganda are mainly security agencies interference, ethical dilemmas, lack of legal framework to provide such services to key population and limited finances to meet the created demands.

**Conclusion:** HIV prevention, care and treatment interventions have been limited in the Uganda health care system and introduction of such services have been observed to be key in reducing HIV transmission among the population.

**Introduction**

The Uganda AIDS Indicator Survey (UAIS) report 2011 revealed increased HIV prevalence in the general population in Uganda from 6.4% in 2005 to 7.3% in 2011. The report also indicated a higher HIV prevalence among women (8.3%) than among men (6.1%) and that Ugandans living in urban areas like Jinja district are more likely to be HIV-positive than those living in rural areas (8.7% versus 7.0%). The PLACE research report revealed that the urban areas of Jinja had an HIV prevalence of 7.5% compared to the rural areas of 2%. This means that interventions to address HIV transmission in the district needed to be concentrated more in the urban areas than in the rural areas.

Through application of Kaoru Ishikawa’s cause and effect analysis to understand the causes, risk factors, and effects of a high HIV prevalence in the urban areas, the district health team came up with interventions to address HIV prevention, care and treatment among the key population.

**Understanding of key populations and their HIV prevalence rates**

The term ‘Key Populations (KPs)’ refers to those populations that carry a higher chance of contracting or transmitting the HIV infection because of the high risky sexual behaviours they often engage in such as; high rates of unprotected sexual practices often with multiple sex partners, engagement in high risky anal sexual practices, involvement in sexual practices for monetary benefits or other benefits, and alcohol and substance abuse, (UAC, HIV prevention strategy 2015). Key populations are defined by a high burden of HIV and sometimes they engage in stigmatizing and often illegal activities. Some of the key populations like men who have sex with men are often marginalized in ways that make access to HIV and AIDS prevention, care and treatment more difficult compared to the general populations.

According to UNAIDS, Key Populations include; men who have sex with men, sex workers, persons who inject drugs and transgender people but also recognizes prisoners as particularly vulnerable to HIV and frequently lack adequate access to services. The Uganda HIV prevention strategy defines key populations as female sex workers and their clients, uniformed forces, fisher folk, long distance truck drivers, Injection drug users and Men who have Sex with Men (MSM).

In Uganda, key populations are more at risk of HIV infection and therefore bear a disproportionate burden of HIV above the National prevalence rate. According to a 2014 Ugandan Ministry of Health and Uganda AIDS Commission report, there are an estimated 10533 MSM, 54549 sex workers, 2 million fisher folk, 0.65 million uniformed personnel, and 31588 truckers in Uganda. The HIV prevalence among Key Populations is as follows; 13.7% in MSM, 33% in Female Sex Workers, 27-40% in Fisher folks, 25-32% in long distance drivers, and 18.2% in Uniformed services, (Crane Survey report, 2008/09).

**Project interventions**

During the development of intervention to address the challenges of limited access to HIV and AIDS services by the key population, we applied the philosophies of Joseph M. Juran that included; identifying the targeted population, determining their needs, development of the
project goal and objectives, developing services and products that respond to their needs, establishment of infrastructure, establishment of project teams, providing the team with resources, training and having strategies for evaluating performance.

The Jinja district key populations project was as a result of the PLACE study and interventions were developed by the district health team. With support from Global Fund through Uganda AIDS Commission, the district received US $900 to support the interventions.

**Project goal and objectives**

The goal of the interventions is to reduce new HIV infections in Jinja district by providing universal access to HIV prevention, care and treatment services to Key Populations in the district. The specific objectives were;

- To provide factual information on issues related to HIV and AIDS among Key Populations to the general population including the health workers.
- To mitigate specific drivers of increased HIV infection/transmission among Key Populations.
- To scale up delivery of comprehensive HIV prevention and treatment services to Key Populations.
- To build a strong enabling environment for equitable and sustainable delivery of HIV prevention and treatment services to Key Populations, and to strengthen the strategic information system for program and policy improvement for Key Populations in Jinja district.

**Implementation of project activities**

The project identified a few key populations for consultations on how best they would access and or be provided healthcare services, what type of services they want to access and others. This was aimed at determining the needs and kind of services to be provided to the targeted population. Venues where Key populations could easy be found were identified and sensitization of 60 managers in these venues about the intended interventions for the key populations was done. 90 leaders of the different categories of the key population were also identified for orientation and easy mobilization of their peers for services that we offer. This was aimed at establishing structures and teams for the interventions. The project also prepared the health workers to provide services to the key populations. This included training of 120 health workers from Jinja central, Walukuba, Bugembe, and Kakira health units. There was also identification of special areas to act as special clinics within the health units where key populations would access the different services from. This was aimed at reducing stigma and discrimination for the key populations. Logistical support is very vital and there was budgeting and procurement of the required drugs and other supplies. There was supply of condom dispensers and information and communication posters at places where key populations normally stay. HIV Counselling and Testing outreaches are being conducted in the places where key populations stay and 510 of them have been tested for HIV.

**Information management**

Information management is key and we planned not to increase on the reporting tools as this would look to be a burden to the health workers. We put some modifications on the already existing tools to capture information as noted below;

In an effort to collect quality data on the key population programme implementation, Jinja district decided to generate data using the standard Ministry of Health tools. The tools had no areas were key population information can be indicated. The project team had to modify the existing as follows. To record the category of key population served, the following abbreviations/codes were to be used;
The programme also utilized the following source documents for data generation:

- HIV Counselling and Testing (HCT) Card
- HIV Counselling and Testing (HCT) Register
- ART Client Card
- ART Register

**HCT Card:** The key populations identified are filled in the **HCT entry point** section and the documented as follows: Tick sub section (h) and specify the category of the key population as elaborated in table one.

<table>
<thead>
<tr>
<th>Category of Key Population (KP)</th>
<th>Codes to be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fisher Folks</td>
<td>FF</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>MSM</td>
</tr>
<tr>
<td>Sex Workers</td>
<td>SW</td>
</tr>
<tr>
<td>Uniformed Personnel</td>
<td>UP</td>
</tr>
<tr>
<td>Long Distance Truck Drivers</td>
<td>TD</td>
</tr>
<tr>
<td>Others (like; Transgender, lesbian)</td>
<td>Others</td>
</tr>
</tbody>
</table>

**Figure 1:** HCT Register: Check section column 17 and indicate as per examples here under; MARPs-SW, MARPs-TD

**Figure 2:** ART Client Card: Check section of entry care point, tick others and specify the as per examples here under; KP-SW, KP-TD
Figure 3: ART Register: Use column 3 written in as TI/eMTCT. Document as indicated in the ART Client Card above

Figure 4: The documentation has helped us to monitor progress and achievements of the project.

Using the management information systems skills a web based reporting of ministry of health called the District Health Information System 2 (DHIS2) is being used and advocacy for any modifications in the system and the tools has started.

Challenges

Health workers are seen as unfriendly and judgmental towards some key populations like the sex workers and MSM. Some health workers do not provide accurate specific information to different categories of key populations because of their religious briefs. Lastly some health workers do not respect clients’ confidentiality due to negative attitude toward the MSM. The laws in Uganda condemns the sexual acts of MSMs and this affects access and legal framework to provision of health care services to such individuals.

Other challenges include; Interference by security agencies as some times we provide services at night, limited finances to meet the created demands, lack of transport means for movement of staff and logistics during outreaches.

Conclusion

Application of learnt skills is key but challenging given the environment we work in. Key populations project interventions were meant to address the challenges of limited access to HIV and AIDS services to key population. The goal of the interventions in Jinja is to reduce new HIV infections in Jinja district by providing universal access to HIV prevention, care and treatment services to Key Populations in the district. Situational analysis was done and interventions that address the challenges of access to health care for the key population were identified and implemented. Over 500 key populations have access such services and capacity and structure establishment have been made. Information management is key, and data collection tools were
modified to suit the project information demands. The challenges expected when serving key populations in Uganda are mainly security agencies interference, ethical dilemmas, lack of legal framework to provide such services to key population and limited finances to meet the created demands. The project is still ongoing and more results will be communicated in the subsequent reports.

Acknowledgements

The following individuals have been acknowledge for their support in the implementation and reviews of the paper; Dr. Dyogo Peter, District Health Officer Jinja and Mutiibwa Tonny health educator Buwenge General Hospital

References

Analysis of Effects of Working Capital Management on Profitability of Manufacturing Companies: A Case Study of Listed Manufacturing Companies on Nairobi Security Exchange

Article Review by Jones Stamalevi
MBA in Financial Management, Texila American University
Email:- stamalevi@yahoo.com

Abstract

The purpose of this paper is to analyze the effect of working capital management on profitability of manufacturing companies for a sample of Nine firms listed on Nairobi Securities Exchange.

Design/methodology/approach – The paper includes a conceptual as well as empirical analysis, in which data from a sample of listed firms for the period from 2006 to 2010 are analyzed to examine the effect of working capital management on profitability of manufacturing firms. The author used OLS regression techniques to test assumptions and several different models were also run.

Findings – The study reveals that effective working capital management has great impact on profitability. He suggested that managers should focus on managing working capital components to achieve profitability of their companies

Originality/value – The paper's originality and value lies in suggesting that financial managers should pay more attention to working capital management of manufacturing firms and other companies in general to optimize the value of the share holders and maintain a favorable trade-off between liquidity and profitability

Keywords: Working Capital Management; Profitability; Average Collection Period; Average Payment Period; Cash Conversion Cycle, Inventory turnover in Days

Introduction

Some background about this issue is useful. Working capital management is a very important component of corporate finance and it ensures a company to have sufficient cash flow in order to meet its short-term debt obligations and operating expenses. It deals with the management of current assets and current liabilities and directly affects the liquidity and profitability of the company (Deloof, 2003; Eljelly, 2004; Rahemanand Nasri, 2007; Appuhami, 2008; Christopher and Kamalavalli, 2009; Dashand Ravipati, 2009). Working capital management is essential for the long-term success of a business. No business can survive if it cannot meet its day-to-day obligations.

A business must therefore have clear policies for the management of each component of working capital. This research aimed at providing an analysis on the effects of working capital management on profitability of listed manufacturing firms trading on the Nairobi Securities Exchange. The study reveals that effective working capital management has great impact on profitability.

Body

Working Capital Management is a very sensitive area in the field of financial management (Joshi, 1994). It involves the decision on the amount and composition of current assets and the financing of these assets. Steven Kirwa Kimeli discussed the effects of working capital management on profitability of listed manufacturing firms trading on the Nairobi Securities Exchange.
Exchange. An optimal working capital management is expected to contribute positively to the creation of firm’s value (Howorth & Weshead, 2003; Deloof, 2003; Afza & Nazir, 2007).

Steven Kirwa Kimeli pointed out that Working Capital Management has its effect on liquidity as well as on profitability of the firm. The study analyzed the relationship between different variables of working capital management including the Average collection period, Inventory turnover in days, Average payment period, Cash conversion cycle and Current ratio and the gross operating profit. Debtratio, size of the firm and financial assets to total assets ratio were used as control variables.

While the author acknowledges prior scholars studies (for example, Lazaridis and Tryfonidis, 2006; Demirgunes and Samiloglu, 2008 and Mathuva, 2010), their studies were done in developed countries other than Kenya. Steven Kirwa Kimeli focused his research on companies in developing country actively trading on the NSE where limited research has been conducted. This study will help managers and bridges the gap by examining the effect of working capital Management on profitability of companies actively trading on the NSE and that of developed countries.

**Hypotheses**

The author explicitly stated the hypotheses. Some of his expectations were that there is no statistically significant relationship between average collection period, inventory turnover in days, payment period, cash conversion cycle and the profitability of listed manufacturing firms.

**Data Source and Method of Collection**

The author used secondary data from document analysis of consolidated financial reports of year sending 2006 to 2010 of the 6 companies actively trading on the NSE. In consistent with Lazaridis and Tryfonidis (2006) and Mathuva (2010) who collected financial data of firms listed on respective stock exchanges, the author could have exclusively collected data only from NSE for credibility of the data and resist collecting data through document analysis to avoid biased results from data being collected. Furthermore, firms listed on the stock exchange present true operational results in comparison with unlisted companies (Lazaridis and Tryfonidis, 2006).

**Variables**

Steven Kirwa Kimeli used 4 models to analyze the relationship between the variables. The independent variables measured whether there was relation between Average collection period and profitability, another test model measured the relation between Average payment period and profitability. Furthermore the third hypothesis test model measured the relation between Inventory turnover in days (ITID) and profitability and the fourth hypothesis test model measured the relation between Cash Conversion Cycle and profitability. Three control variables were used in order to make its effect on profitability neutral which includes company liquidity, company size and Financial Assets.

The selected variables assisted the author in the analysis of the required results. However, inclusion of other variables like capital structure and market conditions could have made his results different from prior studies which did not include such variables in their studies on the effect on profitability. (for example, Lazaridis and Tryfonidis, 2006; Demirgunes and Samiloglu, 2008 and Mathuva, 2010), their studies are primarily on companies working capital components in geographic jurisdictions and they have not done much on relationship between company profitability and capital structure or market conditions.

As stated by Firer et al (2008), three core areas of corporate finance are capital budgeting, which encapsulates the process of planning and managing a firm’s long-term investments; capital structure, which outlines the specific mixture of long-term debt and equity maintained by a firm and lastly working capital management, which deals with management of a firm’s short-term
assets and liabilities. Therefore, inclusion and analysis of effect of capital structure on profitability would be a plus.

**Method of Analysis**

The author analyzed the relationship between different variables of working capital management including the Average collection period, Inventory turnover in days, Average payment period, Cash conversion cycle and Current ratio and the gross operating profit. While Debtratio, size of the firm (measured in terms of natural logarithm of sales) and financial assets to total assets ratio were used as control variables.

He used OLS regression techniques to test his assumptions. Several different models were run. The tables were well organized. The dependent variable was clearly stated in all tables. As control variables, Liquidity(CR); Company Size (Natural logarithm of sales (LOS) and Financial Assets/Total Assets ratio (FATA) were used while the Debt Ratio (DR) was used to proxy for leverage.

Though the author did not mention the base of his research, this research is built upon theories and frameworks of Lazaridis and Tryfonidis (2006). Several prior research findings by different scholars were also acknowledged and quoted in the article to support certain aspects of the article.

**Findings**

The author offers substantial, detailed evidence by using a variety of statistical methods to support his argument which has assisted him to demonstrate a number of interesting findings. The results are valid and reliable. He established that an increase in the number of days that companies collect and settle bills affect negatively company’s profitability. The findings confirms Hyder, Niaz, Falahuddin & Ghulam (2007); and Rahemanand Nasr (2007) who reported that profitability was inversely related to receivable collection period, but contradicted Ghosh and Maji (2003) who found a positive relationship between collection period and EBIT, indicating that credit facility increases sales of firms which ultimately increases profitability.

Some of the past studies used similar methods and/or subjects, but different results and implications were obtained. For example, in his research, Mathuva (2010) finds that there exists a highly significant positive relationship between the period taken to convert inventories into sales and profitability, this finding is contrary to that of Deloof (2003) whose study findings conclude that there is a negative relationship between day’s sales in inventory and profitability.

However, the results on page 33 of Steven Kirwa Kimeli article revealed that Inventory turnover in days (ITID) had an insignificant effect on gross operating profit and his findings were consistent with those of Roumiantsev and Netessine (2005b), but contradicted the findings of Chenetal. (2005, 2007) who reported that firms with abnormally high inventories have abnormally poor long-terms to ck returns.

The author further established that an increase in average payment period led to an increase in gross operating profit. These findings agreed with Lazaridis and Tryfonidis (2005) and Ramachandran and Janakirama (2006) who also found that there was positive relationship between payment period and profitability, meaning that profitable firms delay their payments. However, the findings contrasted those of Falope and Ajilore (2009) found a significant negative relationship between net operating profit and the average payment period.

Furthermore, the study also established that profitability is negatively affected by increasing cash conversion cycle. The findings concurred with those of Ejelly (2004), who reported that cash conversion cycle is a better measure of liquidity than current ratio and liquidity has a negative relation with profitability. The findings also agreed with those of Ramachandran and Janakirama (2006); Nobanee (2009); Chaterjee (2010); Nobaneetal (2010); Akgunand Meltem (2010) and
Rezazade and Heidarian (2010) all of whom had earlier reported a negative relationship between CCC’s components with profitability. The author also observed that the economic order quantity model can be used to determine an optimum order size and directs attention to the cost of holding and ordering and ordering stock. However, there is growing trend for companies to minimize the use of stock.

**Reviewer/Author Arguments**

The article has shown that the author included adequate background information by citing several prior research works of other scholars. The data is well presented, analyzed with sufficient supporting arguments in comparison to similar cases of different scholars. Although all of the articles cited in the article offer well-supported arguments, they also have weaknesses. At times some of them appear to lack solid solutions to the problem, tend to conflict each other on their findings – for example, the author findings contrasted those of Falope and Ajilore(2009) which makes it very hard for the average reader to understand the solution to the problem. A reader can easily get frustrated when trying to decipher the author’s meaning due to overly referenced scholars.

The author has offered a number of impressive recommendations to managers of the manufacturing companies in Kenya on page 35 of his article based on his research findings and also suggested future areas for further studies. A lack of solid solutions appears to exist in Steven Kirwa Kimeli's article. The author, in particular, fails to offer a solid solution as to how to incorporate more variables like capital structure and economic condition or other variables to bring new knowledge on the existing body of knowledge which other researchers have never talked. The author has acknowledged this in his suggestion for further research on page 35 of his article to include such variables.

The significance of this study is that most of similar studies were mainly carried in developed countries which have different capital structure and economic conditions as opposed to developing countries like Kenya. While we a proud his valid findings, no significant differences existed with the findings of other scholars and his article. Similar studies were carried before to find the effect of working capital on profit. The same results were obtained.

Finally, the impressive analysis of the data has addressed all the four hypotheses with proposed solution inform of advice to the financial managers on the way they can make decisions in regards to managing components of working capital to achieve profitability. However, the author in his article has failed to address the effect of rapidly increase on turnover (overtrading) without having sufficient capital backing and its effect on profitability in his stock turn over analysis.

Denzil Watson and Antony Head, (2007) page 74 observed that overtrading can be caused by a rapid increase in turnover, perhaps as a result of a successful marketing campaign where provision for the necessary associated investment in fixed and current assets was not made. Overtrading is risky because short-term finance can be withdrawn relatively quickly if creditors lose confidence in the business or if there is a general tighten in the economy. The problem with overtrading is not that the company is unprofitable it is that the company has simply run out of cash. This could have been explained by using liquidity ratios which can assist the financial managers to make right decisions. Denzil Watson and Antony Head, (2007) page 87 noted that corrective measures for overtrading include introducing new capital, improving working capital management and reducing business activity.

**Future Research**

The author has suggested similar study to be done on the same topic with different companies over an extended sample period of financial years including a study on the impact of external factors on working capital management in manufacturing companies. He further suggested
similar study with an extended scope to cover other components of working capital management including cash and marketable securities.

**Conclusion**

In this paper, four models were developed to make an empirical research on the effect of working capital management on profitability of manufacturing companies. According to results of the regression analysis the author has concluded that there are significant relations between working capital management and firm profitability.

The results show that collection period of account receivables and cash conversion cycle is negatively related with firm’s profitability and this means by shortening collection period and cash conversion cycle firms can increase their profitability. The author concludes that there is a relationship between the various components of working capital indicating that effective working capital management has great impact on profitability. I suggest that Future studies should also investigate the effect of capital structure and economic conditions on profitability of companies.

**Acknowledgement**

I would like to thank Anne Brunnette and Mr Manesh for their support and guidance in writing this article review.

Furthermore I want to thank Dr. Rogaia our UNFPA country representative for giving me time to concentrate on my studies.

**Literature Cited by the Author**


Civil Service Reforms and National Development in Nigeria

Article by Ogochukwu E.S. Nebo1 and Nnamani, Desmond Okechukwu2
Personnel Unit, Godfrey Okoye University Enugu Nigeria1
Dept of Public Administration and Local Government University of Nigeria, Nsukka2
Email:- connectogoo@yahoo.com

Abstract

Civil service is an executive arm of government that implements the programmes and policies of government efficiently and effectively to enhance national development. Civil servants are crops of technocrat at federal, state and local level who assist government of the day with their wealth of knowledge and experience to carry out their legitimate business. Nigerian civil service has been in dilemma of partisan politics, red-tapism, leakages, wastage, non professionalism, unproductive, redundancy and over-bloated ghost workers from one administration to another since independence of 1960. Civil service revolves around people to achieve result, this prompted why successive regimes have bent on reforming to improve the machinery of government; yet the effort remain obsolescence, no enthusiasm to execute government policies. The paper examines various reforms in Nigeria civil service and finalize that nothing has been done for better service delivery. The lacuna experienced in Nigerian civil service is not far from the structure of Nigerian state coupled with socio-cultural factors on the aegis of federal character principle and quota system all this floored national development. To ameliorate this persistent deterioration of bureaucratic bottleneck, inefficiency and unaccountability, this demands meritocracy in the altar of mediocrity during appointment to enhance national development. The bureaucratic theory of Max Webber should be in place in the context of civil service reform in Nigeria to achieve result. The paper concludes that civil service reform in Nigeria will build human capacity to improve institutional structures and achieve the goal of national development.

Keywords: Civil Service, Reforms, Commission, panels, Red-tapism, service delivery

Introduction

Civil service is a wide organization that is controlled and funded by the government, it involves bureaucrats and technocrats of the state not of political or judicial office holders employed in civil capacity with their remunerations paid wholly from money voted in the parliament (Omoruyi, 1991). Civil service is the executive branch of the government machinery exists to effect government policies. The effectiveness of government machinery depends on the efficiency of civil service ability to policy decisions. Consequently, civil service is the custodian of government reputation to carry out policies efficiently, this undermine government position and stability in power. Civil service is structured into administrative class; executive class; professional class and junior cadre class. Civil service reform is the modification of government human capacity system to maximize administrative values. It is a colonial creation; this model was inherited in Nigeria from our colonial master (Britain) in structure (Adewumi, 1988). It was structured in a way that colonial masters extract the much coveted financial and material resources needed to control metropolitan powers. Nigerian state was in charge of administrative leadership in 1960 to restructure civil service to suit our development needs. The bureaucrats that occupied leadership position in civil service imbibed colonial mentality of wealth acquisition for self-aggrandizement and self-superiority (Tagowa, 1999). Instead of improving the lot of Nigerians, they were colonial masters in black man skin. This abysmal performance necessitated the clamour for civil service reforms in Nigeria. According to Anazodo (2009), the Harragin
commission was the first commission set up to assess manpower problem in civil service and discontent among European members for poor financial reward. Gorsuch commission attempt regional administrative bureaucratic structure. After independence, Nigeria embarks on many reforms such as Adebo commission (1971), Udoji commission (1974), Dotun Philips (1985), Decree 48 reform (1988), Ayida panel (1995). According to World Bank (2002), developing nations struggle to better their existence through the process of reforms for efficient and effective service delivery. When Nigeria got independence in 1960, civil service structure was the way colonial master left it, no development or innovations in the system. Nigerians that take over from the colonial masters adopted their style of management to exploit the masses. Consequently, Nigerians clamoured for Nigerianizing the system to reduce expatriate predominance and introduce regionalization in the civil service. The Northern region was given much attention in recruitment whether qualified or not, it was the same in East and Western regions of Nigeria. This culminated sectionalism in Nigerian civil service, every region vigorously practiced regionalizing their respective zones. The military take-over in 1966 and 1983 was a big blow in the system. Nigerians experienced 35 years military rule with short periods of civilian rule. The military regime exhibit non skilled capacity expert to manage the economy and this development disbanded legislative and elected representatives from the people. Ogunna (1999) states that government functioned without elected legislative, yet policies made were implemented, laws enacted were enforced. The military co-opted politicians, academic experts and career civil servants for ministerial appointment; these initiate economic, social, and political policies at the same time breed unaccountability and probity in the service. Ogunna (1999) stated that military brought insecurity into the civil service, there was massive purge in the public service during Murtala regime of 1975 and 1976, Buhari and Babangida regimes retrench massively in the system retirement, termination and dismissal generated fear, insecurity, dehumanization and frustration in the service. The galloping inflation among civil servant left average bureaucrats in misery and apathy. The low morale, embezzlement, and corruption, ineffectiveness, low productivity; assume more political powers without responsible to the people. The selfish and sectional interests in the system impaired discipline to achieve goals, they are bent on feathering their own nests to neglect societal needs. Riggs (1974) assert that the result of civil service in Nigeria is poor performance, this has not been dealt with and so the problem still lingers. It is against this backdrop that the paper limits the review of previous civil service reforms from post independence era to date and examine the dynamics of transformational change that has shaped civil service in most of these reforms to proffer solutions.

**Conceptual Clarifications**

**Civil Service**

Adamolekun (2002) states that civil service is the machinery of government; this is so in Britain and most common wealth countries of Sub-Saharan Africa. In the British conception, the civil service is used to refer to the body of permanent officials appointed to assist the decision makers. Section 318 sub-section 1 of the 1999 constitution define civil service is service rendered to the federation, state or even local level in a civil capacity, staff to the office of the president, vice president, governor, deputy governor, ministries, departments and agencies of the federation and state with the responsibility to business of the government of the federation or state (FRN, 1999). The civil service is the body of men and women employed in a civil capacity and non-political career basis by the federal and state governments primarily to render and effect government decisions and implementation (Ipinlaiye, 2001). Such career officers got their appointment from civil service commission, and exercise power of delegating duties and responsibilities to ministries, department and agencies of government in accordance with laid down rules. Presently, civil service is an institution bequeathed to mankind in the process of
revolutionizing an efficient way of organizing large human organization. It is in this respect that the civil service is regarded as bureaucracy. Civil service is a complex body of permanent officials appointed to assist the political executives in formulating, executing and implementing government policies in ministries and extra-ministerial departments within which government business is carried out. The new Encyclopedia Britannica (2004), states that civil service is the body of government officials employed in civil occupations that are neither political nor judicial. Bezzina (1994) assert that civil service is the employees selected and promoted on the basis of merit and seniority system, which include examination. World Book Encyclopedia (2004) noted that civil service consists of people employed by state to run public institution of a country. Abba and Anazodo (2006), argue that civil service in Nigeria comprises workers in various ministries, departments and agencies apart from political office holders.

Civil Service Reforms

Olaleye (2001) sees civil service reforms as an attempt to reconstruct administrative structure and revamp operational machinery and techniques capable of improving organizational effectiveness and efficiency. This definition shows that civil service reforms may occur for the purpose of addressing problems arising in operation, structure and organization of an institution. Civil service reforms refer to purposeful change introduced to improve the capacity of a given organization to respond to changing demands. Adewumi (1988) state that civil service reform is embarked on the assumption that it is feasible to reach the optional level in the working of a given organization if the administrative process is equipped to provide such support. Civil service reform is purposeful or goal oriented changes designed to improve the skills as well as the preparedness of members to satisfy the organizational set goals or objectives. Summarily, civil service reform involves identifying an existing problem and attempting to solve it, this has to do with policies formulated to restructure and transform an organization from bad to a better condition in analyzing the civil service reforms and national development in Nigeria.

National Development

Some scholars have attempted to explore the definitions of national development for the purpose of this study. National development refers to a sustainable growth and development of a nation to a desirable one. National development is people oriented and its success is evaluated on the impact to improve the lot of the masses (FGN, 1980). Wood hall (1985) defined national development as the improvement of a country’s productive capacity through changes in social attitude, values and behaviour and finally, changes toward social and political equality and eradication of poverty. Onabanjo and M, Bayo (2009), states that national development is human oriented, that is individually in collectiveness and not individual. Elugbe (1994) view national development as the growth of nation in terms of unity, education, economic well-being and mass participation in government. National development entails the provision of all the necessary materials and equipments that will guarantee man in every society to make a living.

Todaro and Smith (2003) identified the objectives of national development as increase in availability of basic life sustaining goods such as food, shelter health and protection. The levels of living like high incomes, employment, better education and greater attention to cultural and human values. The expansion of economic and social choices available to individuals and nation by freeing them from servitude and dependence, forces of ignorance and human misery. Okpata (2004) agrees that national development is the cornerstone of every economic growth for sustainable development, this may mean “growth, change or planned growth of a nation” Abah (2000) states that development exists in a tri-dimensional concept, development has consumatory dimension connotes increase in the quantity of usable items available to man in the society. The national development is a multi-dimensional process involving organization and re-orientation of the entire socio-economic system, an improvement of income and output, radical changes in
institution, social and administrative structures as well as popular attitudes, customs and beliefs, such as physical (societal), a state of mind (psychological) and transformation of institution. This argues that development is a state of the mind or an issue bordering on the society; it is paramount to note that development is anchored on human resources.

Civil Service Reforms in Nigeria

Since the independence era, Nigerian Civil service has undergone series of reforms aimed at tackling institutional problems to reposition development challenges of the 21st century. From 1960 to date, the table below summarizes the successive reforms of civil service in Nigeria.

Table 1: Civil Service reforms in Nigeria

<table>
<thead>
<tr>
<th>Reforms, Commissions and Panels</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morgan Commission</td>
<td>1963</td>
</tr>
<tr>
<td>Eldwood Commission</td>
<td>1966</td>
</tr>
<tr>
<td>Adebo Commission</td>
<td>1971</td>
</tr>
<tr>
<td>Udoji Commission</td>
<td>1972</td>
</tr>
<tr>
<td>Dotun Philips Commission</td>
<td>1985</td>
</tr>
<tr>
<td>Decree No. 43</td>
<td>1988</td>
</tr>
<tr>
<td>Ayida Review Panel</td>
<td>1994</td>
</tr>
<tr>
<td>Obasanjo Civil Service Reform</td>
<td>1999-2007</td>
</tr>
<tr>
<td>Steven Oronsaye Panel</td>
<td>147</td>
</tr>
</tbody>
</table>


Morgan Commission (1963)/Elwood Grading Team (1966) The nationalist movement that ushered independence in 1960 used indigenization of civil service as part of its campaign. Shortly after the colonial rule, prescient Nigerian leaders at that time introduced and implemented Nigerianization policy where British officials in the civil service were replaced with Nigerians. The fallout of this policy came with attendant problems such as shortage of skilled manpower, inefficiency, politicization and complaint about wages. The general strike of September 27, 1963 put intensive pressure on the government and was forced to set up Morgan commission to look into the agitations of trade unions for increases in wages. Morgan commission not only revised salaries and wages of junior staff of the Federal government but introduced for the first time a minimum wage for each region of the country (El-Rufai, 2008). The Morgan Report metamorphosed into the Elwood Grading Team. The Elwood commission was appointed to identify and investigate anomalies in the grading and other conditions relating to all posts in the Public Service of the Federation, with a view to determining an appropriate grading system and achieving uniformity in the salaries of officers performing identical duties (Collins, 1980:324).

Adebo Commission (1971) was commissioned to ‘review the existing wages and salaries at all level in the public services and in the statutory corporations and state-owned companies’ (Collins, 1980). The commission observed that low remuneration package is responsible for shortage of senior civil servants. The Adebo commission recommends setting up public service review commission to examine several fundamental issues, such as the role of public service commission, the structure of civil service, and its conditions of service and training arrangements. The acceptance of the commission led to the setting up of Udoji public service review commission.

Udoji Commission Of 1974 was set up during General Yakubu Gowon administration to review and over-haul the entire public service, and to ensure development and optimum utilization of manpower for efficiency and effectiveness in the service (Anazodo et al, 2012). The major thrust of the commission is to carry out holistic reform of the civil service in terms of ‘organization, structure and management of the public service; investigate and evaluate methods
of recruitment and conditions of employment; examine all legislation relating to pension, as regarding all post; establish scale of salaries corresponding to each grade as a result of job evaluation. The commission recommended a coordinated salary structure that would be universally applicable to the federal and state civil services, the local government services, the armed forces, the Nigeria police, judiciary, Universities, teaching services and parastatals. The commission recommended the introduction of an open reporting system for performance evaluation, and suggested the creation of a senior management group, comprising administrative and professional cadres (Salisu 2001). The relevance of Udoji Commission is particularly salient in its proposition of modern management style, techniques and procedures that enhance the efficient functioning of the institution (such as the adoption of “New Style Public Service based on Project Management, management by objective (MBO) and Planning Programming and Budgeting System (PPBS). Added to this is the recommendation that encourage the mobility of manpower between the private and public sectors. Udoji commission is credited with providing a comprehensive review of quality service delivery, and compensation in the entire system (Dibie, 2003)

**Dotun Phillips Commission** (1985) was set up by the Military regime of General Ibrahim Babangida to review the structure, composition and methods of operation to cope with the demands of government in the 1980s and beyond, (Omoruyi, 1991). The commission looked into the problems of inefficiency, lapses and inadequacies in the civil service and attempt to introduce structural changes to ensure swiftness in administrative practices and eliminate red-tapism. Dotun Philips commission recommended the position of Permanent secretary be replaced by more politically oriented position of Director-General (Jain 2004). The overview of the commission report, as Anazodo et al (2012) observed, suggest that ‘the minister was made both the chief executive and the accounting officer of his ministry. But before the reform the permanent secretary was the accounting officer of the ministry. The permanent secretary’s appointment was made political as its duration was left for the pleasure of the president or governor by making their position non-permanent any longer. The Dotun Philips reforms properly and correctly aligned the civil service structure with the constitution and presidential system of government, designating permanent secretaries as directors-general and deputy ministers. They were meant to retire with the president or governor. The permanent secretary had a choice whether or not to accept the post. The review commission professionalized the civil service, because every officer whether a specialist or generalist made his career entirely in the ministry or department of his choice. Each ministry was made to undertake the appointment, discipline and promotions of its staff and the ministries of finance and national planning were merged. The acceptance of some of the recommendations of Dotun Philips Commission report led to the civil service

**Reform Decree No. 43 of 1988:** was implemented under the Military regime of General Ibrahim Babangida in 1988. The reform which was widely termed ‘Decree No. 43’ was a military fiat to reposition civil service without input and democratic discussion from the public. The 1988 reforms formally recognized the politicization of the upper echelons of the civil service and brought about major changes in other areas. The main highlights of 1998 reforms are: the merging of ministerial responsibilities and administrative controls and their investment in the Minister as chief executive and accounting officers, replacement of the designation of permanent secretary with ‘Director-General’ whose tenure will terminate with the government that appointed him/her and who will serve as Deputy Minister; greater ministerial responsibility in the appointment, promotion, training and discipline of staff; vertical and horizontal restructuring of ministries to ensure overall management efficiency and effectiveness; permanency of appointment, as every officer, is to make his/her career entirely in one ministry; abolition of the office of the head of civil service; and abolition of the pool system (Igbuzor, 1998). The reform established new administrative department called the Presidency with retinue of top government
officials, purposely to coordinate the formulation of policies and monitor their execution, and serve as the bridge between the government and the civil service (federal ministries and departments). However, the 1988 civil service reforms despite its lofty ideals of efficiency, professionalism, accountability, and checks and balances, did not achieve its desired objectives.

**Alison Ayida Panel of 1994** The Ayida review panel on civil service reforms was inaugurated on 10th November 1994 to re-examine the 1988 reforms. The report of the panel was highly and constructively critical of the 1988 reforms. It reversed most of the reforms of 1988, namely, that the: civil service should revert to the system that is guided by the relevant provisions of the constitution, civil service rules, financial regulations and circulars; the ministers should continue to be the head of the ministry and should be responsible for its general direction but he/she should not be the accounting officer (Fatile and Adejuwon 2010). Instead, the permanent secretary should be the accounting officer of the ministry; the title of permanent secretary should be restored. She/he should be a career officer and should not be asked to retire with the regime that appointed him/her; the position of head of civil service should be re-established as a separate office under the President and a career civil servant should be appointed to head the office; the pool system be restored for those professional and sub-professional cadres that commonly exist in ministries/extra ministerial departments; ministries/extra-ministerial departments should be structured according to their objectives, functions and sizes and not according to a uniform pattern as prescribed by the 1988 reforms. Each could have between two (2) to six(6) departments; personnel management functions in the civil service should be left to the federal civil service commission with delegated powers to ministries; financial accountability in the civil service should be enhanced through strict observance of financial rules and regulations; recruitment into the federal civil service at the entry point should be based on a combination of merit and federal character, but further progression should be based on merit; Decree 17 of 1984 which empowers government to retire civil servants arbitrarily should be abrogated; the retirement age in civil service should be sixty (60) years irrespective of the length of service; government should harmonize the pension rates of those who retired before 1991 and those who retire after 1991; and salaries, allowances and welfare packages of civil servants should be substantially reviewed upwards and should be adjusted annually to ameliorate the effects of inflation, and discourage corruption (Anazodo et al, 2012).

**President Obasanjo Civil Service Reform (1999-2007)** The inception of transition to civilian rule that ushered the emergence of President Olusegun Obasanjo as the Nigerian Head of state came with fulfilling ‘electioneering’ promise of reforming the civil service and other public institutions with a view to expunging extant rules, procedures and regulations that frustrate effective service delivery consistent with modern systems in the civil service. The economic philosophy under which civil service reform under Obasanjo regime hinge was on market: ‘that government has no business. All the existing government projects, plants, enterprises, refineries and shareholdings in industries, trade, banking, finance and agriculture must be privatized and sold, so that government, particularly the Federal Government, can concentrate on governance. So, the Bureau of Public Enterprises (BPE) has been very active, since the present regime came on board on May 29, 1999, in selling off enterprises, including houses and other landed properties owned by the Government.13 The major thrust of civil service reform under Obasanjo regime can be summarized in five ways:

**Pension Reform** In 2004, President Obasanjo regime enacted a law to decentralize and privatize pension administration in Nigeria through the pension reform act 2004. The national pension commission (PENCOM) was constituted as a regulatory body to oversee and check the activities of 25 registered pension fund administrators (PFAs). This new pension scheme is in line with the regime's neo-liberal policies in all areas of life. Before the 2004 new scheme, there had been in existence the Nigeria social insurance trust fund (NSITF) and in 1962 the creation of
national provident fund as compulsory savings for workers in both public and private sectors. This old pension scheme was inherited from British colonialism, which purposely designed it for expatriates. It later accommodated local public sector workers and was in operation until the 2004 decentralized and privatized scheme. Although, in 1974, a little amendment was made which retained the private sector within the national provident fund, the public sector was withdrawn from it. And in 1993, another amendment was made with NSITF re-established and converted from a provident fund into a limited social insurance scheme. The pension scheme of 1962, as amended in 1974 and 1993, was very relatively favourable to workers (Elekwa et al 2011). It was a non-contributory benefit scheme that allowed government to allocate specific resources to the consolidated revenue meant to pay pensioners. This made public sector attractive to workers since their old age could be guaranteed after quitting service, especially in a country where there is no social benefit for the unemployed and senior citizens. The contributory pension reform is one of the key elements in the public service reforms ensure that persons who have worked in the public and private sectors receive their retirement benefits as and when due. Under this new scheme, a compulsory contribution of 7.5% of workers' basic salary and 7.5% of same from employers of labour will now become pension of workers after retirement. The scheme accommodates workers in both public and private sectors with minimum of five employees, and only pensioners and those with 3 years to retirement as from 2004 are exempted (Salami and Odeyemi 2012). The new scheme, therefore applies only to the workers from 2008. The analysis of the Pension reform act suggests that the new pension scheme is not uniform to all categories of workers. While 7.5% of every worker salary is deducted as his/her contribution to pension with the employers remitting 7.5%, totaling 15%, only 2.5% is deducted from armed forces workers while their employer-government-remits 12.5% totaling 15%. Again, judiciary workers under Section 8 (2) of the 2004 pension reform act are exempted from the new scheme entirely. This contributory pension scheme adopted the chilean pension system put in place by military dictatorship of Augusto Pinochet in 1974.

Monetization Policy is one of the elements in the public service reforms that will help to ascertain the true cost of spending that government official used in maintaining governmental positions. The fundamental aim of the policy is to prevent and thwart government officials from using the Public or tax-payers money for personal gain. Prior to the implementation of this policy, public office holders and civil servants had numerous fringe benefits attached to the condition of service and remuneration of package. For most civil servants and public officials, residential quarters were provided, furnished and maintained by government. Utility bills for these quarters, including electricity, water and telephone services, were also picked up by government at minimal cost to the officers. In a similar manner, government facilitated procurement of vehicles by these officers at generous rates that could be conveniently deducted from their salaries. The domestic servants were hired for them at government expense while their medical bills as well as those of their spouses and children were also defrayed from public purse. However, with the new monetization policy passed into law vis-à-vis passage of certain political and judicial office holders acts 2002, it is legally stated that monetization of the salaries and allowances of all categories of federal public servants that were formally paid in kinds be converted to cash by the salary and wage commission (Stephen 2011). Under this scheme, ‘the government’s houses, cars, furniture etc which were for the use of bureaucrats and other Political Office Holders were to be converted into private property. The policy makers believed that the scheme will encourage private initiatives and facilitate creativity and motivation and most importantly, improve the service of quality delivery, promote patriotism and efficiency among civil servants. The monetization policy of Obasanjo regime which was borrowed from the United States primarily to curb excesses and save money for solid development purposes, noted for cutting unnecessary and unproductive spending by the political office holders and top echelon of the civil servant as well
as reducing the burden of providing basic amenities for political office holders have contributed significantly to the continued increase in government recurrent expenditure. What turn out to be the greatest undoing of the policy is that it was characterized by fraud and corruption. For instance, House of Representatives paid almost N500 million above the showroom price of 380 units of Peugeot 407 cars acquired at a princely N2.3 billion. The leadership of Nigerian parliament sold their official government houses to themselves at give away prices.

Restructuring of Pilot Ministries, Departments and Agencies (MDAs) is one cardinal policy in public service reform of Obasanjo administration to re-organize MDAs for effective service delivery. The regime observed that federal bureaucracies have number of duplicating and overlapping functions between agencies, and tiers and arms of government. In doing this, the federal government established Bureau of Public Service Reforms (BPSR) in September 2003 as an independent agency in the Presidency to ensure the re-organization and re-assigning of all Ministries, Departments and Agencies (MDAs) of all arms and branches of the federal government (El- Rufai, 2011). The restructuring policy ensures that all MDAs structure to have between 4 and 8 departments and 2-4 divisions per department. These were approved by the Executive Council of the Federation on May 16th, 2007 and applicable to all MDAs immediately.

Down-sizing and payroll reform one of the complaints about Nigerian civil service is that it is over-bloated largely as many workers perform a duty that should have be done by few people. In correcting this, Obasanjo regime began down-sizing of staff across all MDAs following the review of three critical questions: how many people do we need to do the job and what type and with what skills? What is the best way to get this work done? (Eme and Ugwu, 2011). During the down-sizing process, it was observed that ‘the civil service was rapidly ageing, mostly untrained and largely uneducated. Their average age then was 42 years, and over 60% were 40 years. Less than 12% of the public servants held university degrees or equivalent. Over 70% of the services were junior grades 01-06, of sub-clerical and equivalent skills (El-Rufai, 2011). The cleaning up of civil service vis-à-vis down-sizing began with the headcount of all civil servants across all MDAs. About 45,000 names were prepared by MDAs and forwarded to BPSR for removal. Eme and Ugwu (2011) noted that ‘the first batch of officers that were retired total 35,700 officers. The federal civil service commission issued 20,000 disengagement letters to the affected officers. In compliance with the directives of President Olusegun Obasanjo, social pre-retirement training was organized for the disengaged officers at the conclusion of which cheques covering severance payments were issued to the retirees. In terms of payroll reform, it was discovered that 20% of the public service employees were ghost workers-non-existent people on the payroll which goes to staff of personnel and accounts departments (El-Rufai, 2011). In rectifying this anomaly, the executive council of the federation approved the implementation of Integrated Payroll and Personnel Information System (IPPIS) to all MDAs in February 2006. IPPIS is computerized and biometric database to capture all the bio-data of employees during the headcount process and eliminate payroll fraud. El-Rufai (2011) noted that ‘in federal capital territory (FCT), out of an initial headcount of 26,000, we found 3,000 ghosts in the first round of audit. By the time biometric ID is introduced and centralized, computerized payroll, we found nearly 2,500 who failed to show up for documentation.

Theoretical Framework

The theoretical framework for this paper is “New Public Management theory” as propounded by theorist like Shah, 2006, Pollit, 1996, Hood, 1991 Larbi 1998. The new public management theory is the transition from process and procedure to an arrangement that is workable, practicable and result oriented. The theory emphasize on good governance as a result of the recent globalizaton of the economy, technological and innovation. As a conceptualization of the effective service, new public management theory is a relentless movement in the direction of
greater transparency in resource allocation, decentralization of management authority and performance management through service quality (Pollit, 1996). New Public Management theory captures the basis of institutional and organization restructuring as an attempt to raise its performance by improving the quality of service delivery. It is focused rather than the process of result. The theory is concerned primarily with how to deliver public goods efficiently and equitably (Shah, 2006). The theory came up with different concepts for performance and principles to achieve it (Hood, 1991). The principles of accountability and efficiency; reduction of public sector expenditure; improvement in resource use through labour discipline; flexibility in decision making; competition in the public sector through decentralization and emphasis on result not procedure. Jones and Thompson (1999) interpret new public management as five Rs, restructuring to focus on competences, reengineering of work process, radical organization reinvention, realignment activity based costing and responsibility budgeting, rethinking by reconceptualizing public sector bureaucracies. They conceptualized four categories as efficiency model, downsizing and decentralization model, management of change model and public service orientation to change model. These models engender effective service delivery. Larbi (1998), states that the theory centers on accountability, transparency, democratization and citizens participation. This theory was an effort to improve government service delivery to the citizenry because of the expectations of the people. In many developing countries new public management was a paradigm shift from autocracy to democracy in the dawn of political pluralism. It is an avenue to transform governance that will lead to public policies that are technically efficient and effective and responsive to the needs of the citizenry. The new public management argues for an incentive environment in which leaders are given flexibility in the use of resources but held accountable for results (Shah, 2006). The emerging focus on client orientation and results-based accountability is encouraging civil service to innovate in many parts of the world. In line with the principles of new public management, civil service abysmal performance in Nigeria can be viewed and understood as a carryover effect of this deviation. This captured vividly the reason for the ‘procedure without result of civil service operation in Nigeria. It can be noted that various civil service reforms in Nigeria did not consider the option of new public management as alternative to excessiveness, policies are good on paper but the implementation and workability is a tall dream. Civil service in Nigeria is still an old school bureaucracy that depends on degree rigidity of rules, formal structuring and inefficiency, and this affect sustainable development at all levels of government in Nigeria.

**Analysis of Civil Service and National Development in Nigeria**

Since earliest times, strong recognition has been accorded a permanent body of officials for the sole purpose of implementing governmental decisions. With the emergencies of modern states, the civil service of a state is a derivation of the political system within which it operates. The primary functions of civil service include, advising political office holders on policy formulation on all aspects of governmental activities to ensure formulation of policies that are in line with the objectives of the incumbent government and that are relevant to peoples’ needs, implementation of governmental policy decision, sustenance of continuity of the state, regulation of business activities and provision of social services, the civil service also plays a dominant role in socio-economic development of any country, especially in Nigeria where the public sector plays a direct role in national development (Ajayi, 1997). Civil service in Nigeria occupies a unique position in formulating and implementing national development plans.

The public service Review Commission report of (2004) is primarily with development and the use of public service for this purpose. The report argued that we must understand and articulate our objectives and define appropriate means to achieve them. The commission affirmed that a trend in social change in Nigeria is the increasing role of government in sustainable development.
This required that public services, especially the civil service increasingly adopts management methods, development requisite managerial skills and acquires a new approach that include project management that will ensure and assure sustainable development. Civil service has been affected by the nature and politics of Nigeria since independence. During the colonial era, the civil service was mainly concerned with the maintenance of law and order and existence of a peaceful climate suitable to the colonial masters. After independence, the emphasis was on social and economic development. The civil service had to adapt its basic role to the new challenges. With the advent of the military government in January, 1966 and the suspension of the constitution, the civil service became exposed to functions essentially incompatible with its traditional roles (Olagunju, 2000).

After the civil war of 1967-1970, the role of the civil service shifted to preserving national unity, nation reconciliation, rehabilitation and reconstruction. With increase in oil revenue, emphasis shifted to the development of infrastructures and provision of social services. From early 1979, the role of the civil service has had to adopt to modern challenges of managing an ailing economy through structural adjustment programme (SAP), rationalization, nationalization and recent privatization, poverty alleviation, empowerment. It should be noted that series of reforms have been carried out in the civil service over the years. These reforms are put in place to bring sanity to the system and position civil service for effective service delivery capable of ensuring sustainable development in Nigeria. Most of these reforms are also implemented at state and local level so as to generate development in the grassroots.

Challenges of Civil Service and National Development in Nigeria

Civil service in Nigeria is faced with myriads of problems over the years and this has made it difficult for the system to function effectively as a vehicle for national development. Since independent era, the structure and composition of Nigerian civil service has changed and witnessed significant transformation. Immediately after independence, the Civil Service comprises the federal civil service and other civil services in three regions (West, East and North) and later between federal civil service and that of twelve states of the federation. The Nigerian civil service comprises the federal civil service, the thirty-six autonomous state civil services, the unified local government service, and several federal and state government agencies, including parastatals and corporations.

The federal and state civil services were organized around government departments, ministries and extra ministerial departments headed by ministers (federal) and commissioners (state), appointed by the president and governors respectively to take of policy matters. The administrative heads of the ministry were the permanent secretaries formerly called Director-General. The chief Director General was the secretary to the government and the 2nd republic doubled as head of the civil service. As chief adviser to the government, the head of the civil service liaise between government and civil service. The service is divided into administrative, executive, professional, clerical and messenger class who function as a catalyst to crystallize the shared goals of the society and machinery for policy formulation and implementation. Despite its contributions to national development, civil service over the years has been plagued by numerous problems.

**Politicization:** The Nigerian civil service had been politicized to the extent that most top officials openly supported the government of the day. The introduction of quota system in recruitment and promotion, adherence to federal-character principle, and the constant interference of government in the activities of civil service especially through frequent changes in top officials and massive purges meant that political factors rather than merit alone played a key role in civil service. Eme and Ugwu (2011) noted that ‘the enthronement of federal character principle in recruitment and other spoilt system techniques have sacrificed efficiency and effectiveness in
Nigerian public service. Salisu (2001) posits that considerable political interference in the process of personnel administration has led to improper delegation of power, ineffective supervision and corruption. Thus, result in official apathy that has so far culminated into unauthorized and unreasonable absenteeism, lateness and idleness and, notably, poor workmanship. Strong institutions cannot emerge from present day Nigerian civil service where top echelons of these bureaucracies are handpicked on the basis of ethnicity, religion and class.

The disgruntled elements within and outside civil service politicize the activities of state by reading meanings and prejudice on government policies and programmes on the basis of primordial, religious, ethnic and regional sentiments. For instance, the recent government policy that limit the tenure of permanent secretaries to eight years regardless of the persons age or service generated huge controversy as the affected officials used religion, ethnic and parochial sentiments to fight back. The policy stipulated that two terms of four years each for permanent secretaries with officials only allowed to commence the second tranche after being evaluated on completion of the first and found worthy. This implies that whatever effort that calls for more accountability in spending and the reduction of waste in carrying out government’s activities or attempts at preventing corruption and underhand dealing will be blackmailed and politicized by the affected officials in order to maintain the status quo (Okotoni 2003).

**High level of corruption:** is a major problem limiting public bureaucracies in Nigeria. Corrupt practices occur nearly in all ministries, departments, and agencies where virtually all members of the upper and lower levels of bureaucracy are involved. The graft corruption include bribery, extortion and nepotism characterized by subordination of public interests to private aims and violating duty norms and welfare, accompanied by secrecy, betrayal, deception and callous disregard for any consequences suffered by the public. The public considers graft and corruption to be widespread and persistent in Nigerian civil service (Ogunrotifa 2012).

**Fraught and Discontents:** lack of measurable objectives; inadequate evaluations; mismanagement of time; inadequate facilities; disorganization; personnel mismanagement; and over centralization. These internal weaknesses led many public organizations to define their output as money disbursed rather than service delivered, produce many low-return observable outputs, glossy reports and frameworks and few high-return less observable activities like ex post evaluation, engage in obfuscation, spin control, and official amnesia exhibiting little learning from the past, and putting enormous demands on administrative and technical skills (Easterly, 2002). This culminates in marring of government’s laudable policies vis-a-vis poor implementation strategies (bureaucratic procedures) adopted by the civil service, effecting unworkable solutions, putting obstacles in the way of policies formulated by the political officials (Okotoni, 1996). Most civil servant has no genuine interest for development because it is no mans business. They are not committed to the course of development; rather they are interested in what will benefit them and their immediate family. They are less concerned on the overall development of the country. However, these problems stems from Max Weber model (western) of bureaucracy that Nigerian civil service lack political will especially ruling elite and the nature of economic system in Nigeria-capitalism emphasizes primitive and excessive accumulation of wealth.

**Poor remuneration:** Despite the increment in salary, the civil service salary in Nigeria is still very low because of the poor salary remuneration, most civil servants engage in sharp practices, most of them keep business letter headed papers, invoices receipts of various companies owned by them and because suppliers and contractors even to their own offices. This affects their contribution to development. Most of the civil servants are living above board as it concerns their income (Omotoso, 2001).

**Over bloated civil service:** The Nigerian civil service is over bloated with many redundant staff, as many are employed without doing anything. The incessant state creation exercise contribute to the problem, when new state is created, civil service is expanded, therefore, the urge
to fill the necessary position in civil service by the new state always lead to urgent and compulsory promotion in this process, many civil servants are promoted above their efficiency and productivity.

Inadequate training and retraining: This affect productivity of the civil service and consequently development of the nation. Training is not adequate in the civil service, even when it is carried out, it is politicized.

The use of obsolete equipments: Most government MDAs at federal, state and local government levels are still working with manual typewriting machine in this computer age 21st century. The worst of it is that most civil servants are not computer literate. They are not acquainted with the knowledge of operating new and modern machines, this affect efficiency and productivity. These factors together contributed to the failure of the numerous attempts to reform the civil service from post independence period to date (Expo 1979).

Conclusion and Recommendations

Civil service has failed to deliver efficient service to the people as it suffers from obsolescence, lethargy and lack of enthusiasm in carrying out government policies. Most reforms failed due to non political will to implement the reforms on the side of political office holders, sentiments and mediocrity undermined the recommendations of several committees, government attempt to reform civil service out of the way of its capitalistic foundation without taking a break from the status quo, and conscious attempt to ignore democratic practice in managing civil service. The ongoing civil service reform is not going to achieve desire result unless the problem associated with lack of democratic practice in the administration of civil service is addressed, this will curb weak governance structure, red-tapism, weak accountability, low professional standards, wasteage corruption, poor productivity and redundancy that characterise the affairs in civil service.

The reform of Nigerian civil service will help to build institutional capability that will improve institutional structures and processes, and enhance public institutions to perform specific activities to achieve its goals for sustainable development and societal expectations.

There is need to embark on realistic, workable and practical reforms that have human face rather than the usual cosmetic approaches. There is need for government to create enabling conditions of service; this has to do with adequate pay package and other economic incentives. If this is duly implemented, civil servants will be discouraged from using unethical means in getting economic benefits from clients and public in general, The current national minimum wage of N18,000.00, should be increased to N50,000 as a starting point.

The reform process should focus on the restructuring of the public service sector to avoid unnecessary duplication of ministries, departments and agencies of government. This would definitely prevent waste of resources in the system. Finally, there is also the need to promote sound policies on recruitment, training and retraining of civil servants for effective service delivery. These polices will contribute immensely to enhancing and promoting professionalism, and ethical, values of honesty, integrity, confidentiality, political neutrality, accountability, discipline and transparency in the conduct of government business. Recruitment and promotion or advancement on the job should be strictly based on meritocracy, performance and achievement.


References


Mobilizing deposits; the role of Commercial Banks in Ghana

Article by Bright Adu-Gyamfi Antwi
MBA in Investment Management, Texila American University
Email: gastybright@yahoo.co.uk

Abstract

Commercial banks are the main controller of the financial system in Ghana performing financial intermediation. They control greater portion of the investment funds from domestic deposits and are the main creditors of the corporate bodies, SMEs and individual investors. However, the amount of domestic funds that commercial banks receive is far below the level sustainable for self-sufficiency. Huge volumes of loanable funds are left out of the banking system and it needs the efforts of the commercial banks to tap them into productive uses. The purpose of this study therefore is to identify the most effective and efficient ways commercial banks in Ghana should employ to maximize the volume of domestic deposits in the environment of high rural population, dominant informal sector employment and macroeconomic instability. Thus, the study aims to evaluate the design of bank products and services, assess their effectiveness of harnessing domestic deposits and challenges they face in mobilizing deposits. This research is based on relevant books, journals, articles and other publications. In addition, data from commercial banks in Ghana on deposits they received from 2000 to 2004 were studied to make recommendations. Results from the analysis indicated that deposits mobilization of Commercial Banks in Ghana though, has an upward trend, it increases at a decreasing rate hence, the present level of deposits as a ratio of the total amount of money in circulation is woefully inadequate. The study also reveals certain basic facts about commercial banks in Ghana. Their concentration in the cities and a few urban areas as well as their product design and services are targeted to the literate formal sector employees. In addition, unfavourable macroeconomic conditions have resulted in negative real interest rate on deposits while unnecessary government intervention has reduced the confidence in the banking sector. The effects of these factors are the low deposits that commercial banks receive. The study concluded with recommendations for commercial banks such as; the need to redefine their product target, increase their scope to include the large majority etc. in order to ensure improvements in their operations.

Keywords: Commercial banks, mobilization of deposits, products and services, macroeconomic conditions, capital growth and investment, and interest rate.

Introduction

There has been a major interest in eradicating poverty in Ghana. The leaders of the developed countries in the various G8 summits pledged their support about debt cancellation and aid increments as their quota towards realizing this objective. Much still depends on the ability to mobilise domestic resources to achieve self-sufficiency. The financial sector is one major sector of Ghanaian economy that needs to be revitalized constantly in mobilising domestic deposits to increase investment funds.

The financial system in every economy is composed of the Bank-based system where provision and monitoring of investments funds are made through the banks on one hand and the stock market where investors (surplus units) enter directly through ownership of securities. Banks play an intermediary role of mobilising funds from savers and subsequently lend them to investors-individual/corporations as mostly the case in Germany and Japan. On the other hand, investment funds can also be mobilized by floating shares (equity) in the stock exchange market (Market-
Based system) where investors with surplus funds directly own part of the company (shareholder). The major players in the market-Based system are the institutional investors such as pension, mutual funds and insurance companies. In the United States and the United Kingdom economies where these institutional investors are well developed coupled with the high accounting standards and corporate laws, the role of commercial banks in mobilizing deposits has greatly reduced. According to Rajan (2005) the share of commercial banks assets as a ratio of the total assets of the financial institutions has declined from 70% to 30% in the United States while banks share of corporate debt has reduced from 19.6% in 1979 to 14.5% in 1994. This demonstrates the efficiency at which the stock market mobilizes funds/deposits for investments.

The stock markets in Ghana are not matured to the extent of mobilizing sufficient funds/deposits for investments (Kenny et al. 1998). This is due to the problem of information asymmetry, inappropriate accounting methods, low level of risk management, underdeveloped institutional investors such as insurance companies, pension and mutual funds, inappropriate corporate regulations and independent judiciary that must exist to ensure and articulate stock market capable of protecting investors and investment funds (Ross and Levine, 2000), (Beim and Calomiris, 2001). Though Kenny and Moss (1998) acknowledge growth of stock markets in Africa with the onset of certain institutional reforms like the Financial Sector Adjustment Program (FINSAP), the stock market contribution of 13.30% to GDP in Ghana is still too low to provide sufficient credits in the economy (Global Stock Markets Facts book, 2003). While efforts are underway in these economies to provide the necessary macroeconomic environment and institutions conducive for a market-based system of financing investment there is the need to strengthen the banks alongside due to the vital role they still have to play in the agriculture, Small and Medium Scale Enterprises (SMEs).

The function of the commercial banks in Ghana regarding deposits mobilization has not yielded maximum results. Banks deposit mobilization has tended to concentrate more in the urban areas. This covers the rich with regular incomes and a few large reputable companies who have the ability to save. Needless to say, most of the rural folks and small scale businessmen have limited access to the commercial banks. In many instances these people resort to “susu” collectors and rotational savers for their saving services. As far as these services may achieve their purpose of mobilizing deposits, they face threats of frauds and subsequent mistrust of operators. The benefits of extending bank services to these areas would be enormous either extending bank branches where profitable or bank personnel making periodic visits and training of local group leaders capable of using bank expertise to mobilize deposits.

In Ghana there are limited sources of funds to investors and looking at the dominance of the commercial banks operating in 277 areas and commanding 70% of the banking business (Embassy of Ghana in Washington DC) there is the need for bank reforms that devise more effective ways of mobilizing deposits from these small scale enterprises and subsistent farmers and widens their scope to meet the entire population with bank products and services. The more banking services are extended to the rural savers, the more deposits will increase and “all other things being equal” supply of loanable funds will increase proportionately.

**Methodology**

This study mainly had an explanatory research purpose since it aimed to establish the effect of methods used by commercial banks on deposits mobilization.

According to Yin (1994), there are five major research strategies used to answer research questions which are experiments, surveys, archival analysis, histories and case studies. This study adopted a case study approach (i.e. commercial banks in Ghana as a case). Yin (1994) suggests that a case study methodology is a preferred research approach where the research question to be addressed is a type of how-why; control of the researcher over the research is none or very insig-
nificant and the focus is on a contemporary phenomenon. Because of these differentiating characteristics, no approach could have answered and achieved the research questions and objectives respectively than the case study method. In the case study methodology, the focus is not on a limited number of predetermined independent variables, but on factors, which are helpful in explaining the observed phenomena.

The population of the study is commercial banks in Ghana. Out of the twenty-seven (27) commercial banks, nine (9) have been selected as the sample size because of access to ready data. In addition, some of the banks were not in operation during the periods under consideration (2000 -2004). The sample include the Ghana Commercial Bank Limited, Barclays Bank (Ghana) Ltd, Standard Chartered Bank (Ghana) Ltd, SG-SSB Bank Limited, Trust Bank, Prudential Bank Ltd, Stanbic Bank (GH) Ltd, HFC Bank (Ghana) Ltd, International Commercial Bank, listed in descending order of rank in accordance with the standards set up by both Fitch and Standard and Poor (S&P) Credit Rating Agencies (Bank scope, 2005). Banks’ ratings largely depend on the strength of both their capital adequacy ratio and the volatility to credit and interest rate risks. The larger a bank’s capital adequacy ratio, the less vulnerable it is to crisis and other things being equal the more solvent it becomes. Due to the small sample size, it is recommended that interpretation of the results from the study should be done with some degree of caution.

The secondary data source used included audited and published financial statements for the years 2000 to 2004. The websites of the various banks, annual reports, brochures, past research work, publications of Ghana statistical service, books as well as print media were also scrutinised for information. The periods were chosen because of access to ready data. The data was sourced from nine (9) commercial banks and was basically from the Annual Financial Reports which were gathered through contacts of their Managing Directors.

Analysis and Discussions

Commercial banks in Ghana through their various products have embarked on an intensive marketing drive to enhance deposit mobilisation. The mechanism has always been product design. These products must be designed to be customer focused. Indeed, they must be designed to either target their corporate customers such as Unilever Ghana Ltd, Guinness Ghana Ltd, Ghana Brewery Ltd, Small and Medium Scale Enterprises (SMEs) and/or individuals saving through current and/or saving accounts. Above all, the products must attract and retain valuable customers to be able to generate the required profits.

4.2 Trend of Deposit Mobilisation in Ghana

A study of deposit mobilisation in Ghana from the year 2000 to 2004 reveals an upward trend. A sample of nine(9) out of the twenty-seven(27) commercial banks involving the top rated banks by Fitch and Standard & Poor Rating Agencies indicates an average yearly increase of 32.1% calculated from the yearly percentage increase in deposits. Theoretically, a growth rate of 32.1% in deposits may be considered sufficient to increase supply of loanable funds. However, the present level of deposits as a ratio of the total amount of money in circulation is woefully inadequate (Chapter one).

There is a wide disparity in the rate of deposit growth among commercial banks. The newly established commercial banks for instance Stanbic Bank (Gh) Ltd, Prudential Bank and International Commercial Bank have higher deposit growth rates than the traditional commercial banks such as the Ghana Commercial Bank, Barclays Bank (Gh) Ltd and the Standard Chartered Bank (Table 4.1 and figure 4.1). Over the years studied, Stanbic Bank has more than doubled its deposits yearly while International Commercial Bank and Prudential Bank almost doubled their deposits receipts in 2001. However, Standard Chartered Bank fell behind its deposits in the previous year. This is likely to be the effect of the high rate of inflation in early 2001 as discussed in chap-
ter two. Though there were increases in the deposits received by all the other commercial banks in the year in question (2001), the rates were comparatively minimal.

The data presented in table 4.1 and figure 4.1 below only gives an idea about the amount and the rate of increase over the years studied. There is no distinction as to the proportion of annual deposits mobilized domestically. Evidence from the ownership structure as given in (Acquah, 2003) indicates that foreigners own a greater percentage of commercial banks in Ghana. This suggests that more of their deposits may rather come from foreign sources instead of the domestic country. If the latter scenario holds, then in the event of macroeconomic instability as has been the case in the previous years (chapter two) with its related capital flight, the Ghanaian commercial banks may be prone to financial crises.

**Table 4.1 Commercial Banks (Ghana) Deposits (2000-2004)**

<table>
<thead>
<tr>
<th>Bank</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>Total</th>
<th>Average Growth Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana Commercial Bank Ltd</td>
<td>1,693,283.0</td>
<td>1,720,419.0</td>
<td>2,470,177.0</td>
<td>3,183,830.0</td>
<td>4,321,166.0</td>
<td>13,388,875.0</td>
<td>21.9</td>
</tr>
<tr>
<td>SG-SSB Bank Ltd</td>
<td>748,435.0</td>
<td>879,000.0</td>
<td>1,273,180.0</td>
<td>1,491,561.0</td>
<td>1,821,854.0</td>
<td>6,214,040.0</td>
<td>24.7</td>
</tr>
<tr>
<td>Barclays Bank Ltd</td>
<td>1,344,383.0</td>
<td>1,819,836.0</td>
<td>2,075,643.0</td>
<td>2,912,024.0</td>
<td>3,511,465.0</td>
<td>11,663,351.0</td>
<td>22.0</td>
</tr>
<tr>
<td>Standard Chartered Bank</td>
<td>2,053,668.0</td>
<td>2,262,199.0</td>
<td>3,077,375.0</td>
<td>3,494,800.0</td>
<td>12,671,042.0</td>
<td>29.6</td>
<td></td>
</tr>
<tr>
<td>The Trust Bank</td>
<td>186,613.6</td>
<td>227,158.1</td>
<td>317,845.1</td>
<td>452,847.7</td>
<td>652,760.1</td>
<td>1,837,224.6</td>
<td>29.6</td>
</tr>
<tr>
<td>International Commercial Bank</td>
<td>261,278.9</td>
<td>50,976.6</td>
<td>91,998.2</td>
<td>166,441.9</td>
<td>257,516.0</td>
<td>596,211.6</td>
<td>47.2</td>
</tr>
<tr>
<td>Stanbic Bank (Gh) Ltd</td>
<td>26,825.1</td>
<td>67,408.0</td>
<td>90,832.3</td>
<td>308,690.4</td>
<td>610,446.6</td>
<td>1,204,202.4</td>
<td>98.8</td>
</tr>
<tr>
<td>Prudential Bank</td>
<td>80,664.5</td>
<td>145,693.2</td>
<td>234,062.0</td>
<td>305,914.0</td>
<td>503,950.0</td>
<td>1,189,619.2</td>
<td>47.3</td>
</tr>
<tr>
<td>HFC Bank (Gh) Ltd</td>
<td>164,409.0</td>
<td>201,889.6</td>
<td>224,307.2</td>
<td>213,753.0</td>
<td>230,539.0</td>
<td>1,034,897.8</td>
<td>7.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,246,895.6</strong></td>
<td><strong>6,895,390.5</strong></td>
<td><strong>9,140,243.8</strong></td>
<td><strong>12,112,437.0</strong></td>
<td><strong>15,404,496.7</strong></td>
<td><strong>49,799,463.6</strong></td>
<td><strong>32.1</strong></td>
</tr>
</tbody>
</table>

**Source:** Bank scope; annual deposits figures were extracted from the balance sheets and used to calculate the growth rates.
Figure 4.1 shows the Trend of Commercial Deposits Average Growth Rate

Source: Bank scope; annual deposits figures were extracted from the balance sheet.

The figure 4.1 above, though, review upward trend, the average deposits growth rates were comparatively minimal. Considering the individual commercial banks’ strength of mobilising deposits, the study reveals that the amount of deposits gathered over the five year period is directly related to the number of branches. The larger the number of branches the larger the volume of deposits received. The Ghana Commercial Bank has the highest number of branches and total deposits as well as Barclays Bank and Standard Chartered Bank in that order. However, SG-SSB Bank ranks second in branches but fourth in total deposits. This must be due to over concentration on pension funds and students loan schemes previously. In all, total deposits commercial banks receive increase yearly. Figure 4.1 illustrates the total deposits of individual banks and total deposits in each year over the five year period respectively.

**Figure 4.1.1** shows the Yearly Total deposits from (2000 – 2004)


From figure 4.1.1 above, the percentage of the commercial banks yearly total deposits increased from 13% in 2000 to 31% in 2004.

Deposits form a major proportion of commercial banks’ liabilities (Bank scope, 2004) and are the main source of loanable funds to individual investors and corporate customers. In the year 2004 alone the share of deposits (from table 4.1) as a percentage of Ghana Commercial Banks’ liabilities was 77.0% while Barclays Bank (Gh) Ltd, Standard Chartered Bank (Gh) Ltd and SG-SSB Bank recorded 73.3%, 79.5%, 74.7% respectively. This underscores the over dependency of
commercial banks in Ghana on deposits and the issue of their efficient mobilisation needs to be addressed.

**Instruments of Deposit Mobilisation in Ghana**

Generally, commercial banks in Ghana use common tools to attract deposits. These tools have dual functions. Primarily, they are means of mobilizing deposits from customers. Secondly, they are media through which other financial products and services are sold to the customers. These tools are in the form of products and services and may have different names in the various commercial banks; however, they have similar modes of operation and effectiveness. The mechanisms discussed below are the general and specific products designed to meet their wide range of targets. Indeed, the mechanisms or methods help to satisfy the achievement of objective two of the study.

**Savings Accounts**

Savings accounts enable customers to deposit their money for investment and/or future use. This account is a provision for future convenience. Customers have the benefit of accumulating funds from their own occasional savings and earning interest. Depending on the type of commercial bank in Ghana operators of this account may have twenty-four hour access to their money or a specific time with limited amount to be withdrawn. Savings accounts are available to all customers, personal individuals, groups, corporate bodies and societies. Unlike the developed countries like the United Kingdom savings account in Ghana demand initial deposits and a minimum balance to be retained in the account to make it operational.

Aside, the standard savings account explained above, some commercial banks have specific savings accounts for specific customers with specific needs. These may include Trustee/High rate savings for children and people with liabilities, Fixed Deposit which in itself is an investment hedge against time. Fixed deposits are available in 3months, 6months and one year with negotiated interest rates and a Flexsave account which has flexible withdrawals. The minimum balance requirement as a condition for savings account favours regular income earners who have the ability to meet this minimum balance. Savings accounts are made attractive differently in the various commercial banks with different accompanying products which will be discussed in the subsequent sections.

**Current Account**

A current account is the type of account which operators have access to their money at all times. There are no restrictions as to the number of times a current account holder can withdraw provided there is sufficient balance in the account and the maximum daily withdrawal limit of the account is not exceeded.

Current accounts are cheque guaranteed and depending on the bank that operates them as well as the outstanding balance left may or may not attract interest. It enables customers (enterprises, societies, individuals and corporate bodies) to transact business and pay for them later. Current accounts in Ghana are normally operated by worthy individuals, cooperate bodies who wants to attract interest on their deposits while enjoying flexibility regarding withdrawals (call account). Current account holders in Ghana must earn regular and specific minimum incomes to qualify. Banks provide other services in connection with current account for instance bill payments to make them attractive to customers respectively. This underscores the over dependency of commercial banks in Ghana on deposits and the issue of their efficient mobilisation needs to be addressed.
Accompanying Products and Services to Customers

Savings and Current account holders enjoy a wide range of other services that are cross sold by the banks. These products and services have dual benefits to both the banks through the fees paid and to customers’ access to smooth income. The most popular ones normally used by commercial banks in Ghana are overdraft facility where worthy customers are allowed to overdraw their accounts in the short term (maximum of 12 months), medium term (3-5 years) and long term (over 5 years) loans payable by monthly instalments. Others include consumer credit schemes which allow regular income customers to hire purchase domestic appliances and communication gadgets and Comments purposely designed for corporate customers to access their accounts and request for other services at the comfort of their offices.

Kudi Nkosuo Account

The Kudi Nkosuo is a “Susu” saving scheme for the informal sector designed to encourage members of this sector to save and have access to credit facilities to expand their businesses. The different currents and savings accounts with their inherent benefits favour regular income earners in the formal sector. The informal sector which employs the highest proportion of the labour force is excluded. Kudi Nkosuo targets petty traders, artisans, market women and men (www.gcb.com). Bank personnel are deployed to the door steps of the savers to collect their daily savings. The door to door services enable to benefit from loans, overdrafts and other financial services. This type of account is unique to the Ghana Commercial Bank in its efforts to reduce financial exclusion on both the informal sector and the rural savers. Huge sums of rural deposits are harnessed through this service.

Fodem Account /Foreign Currency Account

Commercial banks efforts to expand deposits they have been extended beyond the borders of the country to entice Ghanaians abroad. Coupled with their money transfer services commercial banks are used as a medium through which huge sums of remittances from Ghanaians abroad are received. Most of these deposits are retained in the accounts of customers, hence increasing deposit liabilities of the banks.

Innovative Marketing Strategies towards Deposit Mobilisation

The greatest challenge facing the banking industry in recent times is competition among the banks. All the commercial banks have similar products designed to attract the same customers. It is therefore imperative to adopt the best customer care services to attract and retain valuable customers.

The innovative marketing strategies currently used by commercial banks are the use of automated teller machines (ATM) to facilitate cash withdrawals, telephone banking, net working of bank branches to speed up credit deliveries and computerisation of banks to encourage inter-bank transactions.

Problems of Deposit Mobilisation in Ghana

Outreaching Rural Savers

In Ghana, Commercial Banks are faced with many challenges in their desire to mobilise more deposits. As observed in the previous chapters, more than 60% of the population live in the rural areas in isolated villages. It therefore become cost ineffective to have bank branches that can conveniently provide door step financial services to the rural inhabitants hence, their concentration in the urban and the southern part of the country (Jones et al, 2000). In many instances bank are forced to close down their branches. Gockel (2003) observed that between 1989 and 1998, then SSB closed down 32 rural branches and Barclays and GCB closed down16 each for the purpose
of cost reduction. He further observed that none of the newly established banks in the 1990s had branches outside the cities of Accra, Kumasi or Tarkoradi. Commercial Banks therefore battle with the problem of how to effectively harness the large volume of deposits left in the rural areas.

**Regaining Confidence in the Banking Sector**

The Banking sector in Ghana has not fully regained the confidence that many customers lost; thus making deposit attraction difficult. This could be due to partly the attitude of bank staff towards customers and the government action of controlling the operations of the banks. In the early 1980s most depositors had their deposits frozen because of the government’s decision to withdraw fifty cedi notes from the money in circulation. Depositors are therefore reluctant to deposit in the banks for the fear of suffering similar action. In other instances depositors have been subjected to bank officials’ brutalities in their attempt to withdraw their own deposits in times of need. The net effects of loss of confidence in the bank system are the low deposits that commercial banks receive in Ghana.

**Unstable Macroeconomic Conditions**

Another problem militating against deposit mobilisation in Ghana is the unfavourable macroeconomic environment with high inflation and reserve requirement and their associated low returns on deposits. In a period of high inflation, hedging is inevitably a prudent measure depositors pursue in order to enjoy future appreciation of value. Thus, more deposits are redirected into the purchase of real estate properties. The high reserve requirement of 44% (BOG Statistical Bulletin- Up to January 2005, Table 7) compose of both secondary and primary reserves in addition to high tax and a 10% development levy reduced the volume of loanable funds which subsequently reduce returns on investment and deposits. Currently, the reduction of reserve requirement to 15% still has the tendency to erode loanable funds and reduce interest payments, thereby discouraging deposit mobilisation. Deposits are withheld in a period of unstable macroeconomic environment.

**Insufficient Instruments**

Currently, the main instruments used to attract deposits in Ghana range from the simple savings and current accounts that require unaffordable initial deposits, money remittances business, branch expansion, corporate imaging, negotiable interest rates, promotion and advertisements, overdrafts and loan facilities to complex internet, telephone and ATMs. These instruments in the first place are not sufficient to cater for the financial needs of all the settlements. Secondly, they favour regular and formal service income earners than the informal workers such as artisans, farmers and other small scale operators who are the majority. Thirdly, customers require literacy to utilise these instruments which majority of the population especially the rural inhabitants do not have.

**Summary of Findings, Conclusions and Recommendations**

**Summary of Findings**

The study reveals certain basic facts about commercial banks in Ghana in their struggle to mobilize greater domestic deposits. Firstly, Commercial banks deposits mobilization in Ghana from 2000 to 2004 indicates an upward trend however, the present level of deposits as a ratio of the total amount of money in circulation is woefully inadequate. Secondly, the methods or the design of product and services, like initial deposits as a precondition for bank account as well as ways of promoting products, have tended to benefit formal sector workers who earn regular income than the informal workers such as artisans, farmers and other small scale operators who are the majority. Thirdly, the concentration of commercial banks in urban areas couple with the insufficient
instruments used for deposit mobilization make them battle with the problem of how to effectively harness the volume of deposits left in the rural areas. Also, the attitude of bank personnel towards rural savers in Ghana has not been customer friendly to entice more depositors. Finally, even though there is a significant difference as far as the banks general deposits growth rate is concerned, in terms of annual average deposit growth rate, there is no significant difference.

Conclusion

Commercial Banks are absolutely essential in the development of the financial system in Ghana. At the moment they are the major mobilizes of local resources in the form of deposits. They are indeed the appropriate media to secure investment funds in these economies where the market is yet to develop. The deposits they attract over the years keep increasing, but are insufficient for self sustainability and form a meagre proportion of the money in circulation. The implication is that large unproductive deposits are left to be squeezed into loanable funds for investment. The onus rests on the commercial banks in collaboration with all other formal and informal financial service providers and government to introduce immediate reforms towards achieving these goals. They strive towards self sufficiency in the financial sector should embrace all calibre of people in Ghana to make the Millennium Development Goals achievable.

Recommendations

1 Extending Banking services to the rural savers.

Commercial banks should now target the rural majority. Where the usual way of extending bank branches has not been helpful, there could be formation of Self Help Groups (SHGs) made of members with similar occupations. Bank personnel can then be deployed periodically to train them simple book keeping, account maintenance and depositing and other related business advice. This is likely to develop rapport between banks and savers. On the other way round, rural saving mobilizes such as mutual fund operators, ROSCA, credit unions, rural banks and “susu” collectors should be commissioned and monitored to ensure savers safety.

2 Restoring Confidence in the Banking Sector

The banking sector has been unnecessarily controlled by government where depositors suffered losses through account freeze and interest rate ceilings. Depositors are reluctant to save. Making the Central Bank independent in taking monetary policy regulations while, government concentrate on fiscal and infrastructural development would be helpful to restore savers confidence. Prudent macroeconomic policies to subduing inflation to a reasonable level will ensure positive real income.

3 Removal of High Initial Deposits and Minimum Balance.

Basic bank products and services such as opening bank account and withdrawals should be made absolutely unconditional. Initial deposits and minimum balance requirements squeeze out savers available income. Depositors should have their money as and when needed through ATMs and Retail shops. This will do away with the habit of keeping money under pillows. Efforts should be made to ensure employees in the formal and informal sector receive their wages through the banks.

4. Strengthening the Financial Sector Regulations

The legal system in Ghana is weak and subject to manipulation from both the government and the opinion leaders. Investors/depositors are not protected in such a situation to invest their money. Good accounting methods, auditing and other checks and balances would ensure smooth
interpretations of the law. Enforcing regulations to guide and protect depositors would provide a safe environment for depositors to increase their savings.

5. Bank Personnel Direct Contact Promotions

Commercial banks should form the habit of reaching savers with their products and service in vantage areas like shopping malls, super markets and other similar places. The usual trend of waiting to receive depositors in the banking halls need to be extended. In such cases, telephone and internet banking would help in the urban areas while other resources would be left for personal contact between bank officers and rural savers. Detailed education on product benefits to customers should be promoted and advertised.

6. Direct Rural Development

Commercial banks in Ghana do not usually commit part of their profits into village development. In many cases the huge profits declared are only paid as dividends. The rural savers therefore see commercial banks as institutions belonging to the rich. However, evidence from the GCB Quarterly Economic Review, (2003) confirms that banks which are used as media for micro projects in the villages increase their rural customers. Commercial banks would increase deposits should they combine with the government in developmental projects at the community level.

References

Journal Article

Book
[18.] Rajan, G. R. (2005): Do We Still Need Commercial Banks?
[19.] Ross, L. (2000): “Bank-Based or Market-Based Financial System; which is Better?”
[27.] Tanzi, V. (1991): “Public Finance in Developing Countries”.

**Chapter in a Book**


**Conference Proceedings**


**Patent**

[9.] Trade Union Congress (Ghana), (2004): “Incomes in Ghana”.

12
Patients and Health Workers' Engagement in Patient Safety in Healthcare in Kitgum General Hospital

Article by Omona Kizito
PhD in Healthcare Management, Texila American University
E-mail: kizitoomona@gmail.com

Abstract

Introduction: The delivery of health care is known to involve potential safety risks for the patients who are supposed to benefit from medical treatment and care. Over the years, efforts have been put in place to reduce the occurrence of safety risks and improve on patient quality of care. Both the health care providers and patients have their respective roles to play. Bringing on board patients in efforts to minimise safety risks, also known as patient engagement, proved effective.

Objectives: The objectives of the study were; to ascertain the level of awareness about patient safety in healthcare among patients and health workers, to determine the level of health workers engagement in patient safety in healthcare, assess the level of patient engagement in patient safety, as well as to determine the factors affecting patients and health workers engagement in patient safety in healthcare in Kitgum General Hospital.

Methods: This was a descriptive, cross sectional study of patients and health workers’ engagement in patient safety in healthcare in Kitgum General Hospital (KGH). The study took both qualitative and quantitative dimensions. A probability sample of 384 patients was interviewed using structured questionnaires and 103 health workers were studied by observation and key informant interviews. Documentation review of previous patient files (50 files) was carried out to assess the depth of patient identification, as a measure to minimize medical errors. Pre-testing of the questionnaires and training of research Assistants were done prior to the study to ensure quality of the research. Ethical considerations in research were strictly adhered to.

Results: The level of awareness about patient safety among patients and health workers was found to be 46.5% and 51% respectively.

The level of health workers engagement in patient safety was found to be 51.4% while engagement of patients in patient safety was at 52.1%

The factors affecting patients and health workers engagement were mainly demographic factors such as age and level of education, among others.

Conclusion: In conclusion, health workers in KGH were 4.5% more aware about patient safety than the patients. However, patients in KGH are 0.7% more engaged in patient safety than the health workers.

1. Introduction

The introduction to the study topic and background of the study area have discussed under this section. The problem statement, research questions, research objectives and justification for this study have also been discussed in this section.

1.1: Introduction to the study topic

The delivery of health care is known to involve potential safety risks for the patients who are supposed to benefit from medical treatment and care (Helle and Larsen., 2012). Over the years, efforts have been put in place to reduce the occurrence of safety risks. Both the health care providers and patients have their respective roles to play. Bringing on board patients in efforts to
minimise safety risks, also known as patient engagement, has proven effective. Therefore, patient engagement means engagement in one’s own health, care and treatment (Parsons et al., 2010). It is used to describe patients’ involvement in primary care consultations regarding their own health, care and treatment. According to Gruman et al. (2010, p.66), patient engagement refers to actions patients must take to obtain the greatest benefit from the health care services available to them. It encompasses a number of potential strategies for patient involvement in patient safety that entails “speaking up” in the case of safety concerns, awareness and knowledge of safety risks, close observation of medication and treatment, coordination of care, contributing to hygienic practices, and self-management and compliance. Efforts to engage patients in safety efforts have focused on three areas: enlisting patients in detecting adverse events, empowering patients to ensure safe care, and emphasizing patient involvement as a means of improving the culture of safety (PSNet, 2007, p.61). Patient engagement also means fostering an effective collaboration in which patients and clinicians work together to help the patient progress towards mutually agreed-upon health goals (Helle and Larsen, 2012).

Patient safety according to WHO (2004) refers to the prevention of errors and adverse effects to patients associated with health care. Similarly, the National Patient Safety Foundation (NPSF, 2010 p.36), defines patient safety as the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the processes of health care. Vigar (2009, p.58) also defines patient safety as the reduction and mitigation of unsafe acts within the health-care system through the use of best practices shown to lead to optimal patient outcomes. He argues that patient safety is all about working persistently to avoid, manage and reduce unsafe acts within the health care system. Again, Helle and Larsen. (2012, p.59) define patient safety as freedom for a patient from unnecessary harm or potential harm associated with healthcare.

Adverse events are poor patient outcomes that are due to medical error. They are unexpected and unwanted events that can take place in any setting where health care is delivered (primary, secondary and tertiary care, community care, social and private care, acute and chronic care) (Forster et al., 2004). The Harvard study of 1991 found that 4% of patients suffer some kind of harm in hospital; 70% of the adverse events result in short-lived disability, but 14% of the incidents lead to death (WHO, 2004). Errors that occur either do or do not harm patients and reflect numerous problems in the health care system, such as a culture not driven toward safety and the presence of unfavourable working conditions for nurses (Wolf and Hughes, 2008).

Beckett et al. (2012, p.11) reported that an estimated 1-10% of medication errors can lead to patient harm. All patients are vulnerable to the detrimental effects of these errors. A study done by Forster et al. (2004) indicates that of the 12.7% patients with an adverse event 4.8% had a preventable event and 0.6%, died because of an adverse event. Most adverse events were due to drug treatment, operative complications or nosocomial infections. The study also report that 61% of adverse events happen before patient hospitalization. Valentin et al. (2006) reported that 20% of adult patients experience at least one medical event among hospitalised patients, with the highest (7.1%) being medication related events. In their study, Valentin et al. (2013) also reported that among 795 observed patients, a total of 641 errors affecting 269 patients were reported i.e. a rate of 49.8 errors per 100 patient days related to the administration of medication, loss of artificial airways, and unplanned dislodgement of lines, catheters and drains. Weingart et al. (2005) demonstrated that about 8% experienced adverse events and 4% experienced near misses of which 5 were serious or life threatening. The National Patient Safety Foundation (NPSF) categorizes medical errors as either diagnostic; (errors such as wrong diagnoses, delayed diagnoses, omitted diagnoses, inappropriate investigation or failure to use results), dose related which include; wrong doses, polypharmacy, wrong route and wrong patient among others, Surgical errors which include no consent, omitted pre-operative investigations, wrong site of surgery, forgotten material in patient’s body and omitted post-operative care (NPSF, 2010).
Studies show that medication errors are the most prevalent category of medical errors that considerably endanger the patient safety (Bahadori et al., 2013). Medication errors are costly from human, economic, and societal perspectives (Dennison, 2005). Similarly, Friedman et al. (2009) argue that adverse safety events in the hospital can impose extra costs not only due to longer stays and corrective treatments, but also due to deaths and re-admissions. The authors suggest that the 3-month re-admission rate was about 17% for those with no safety event compared to 25% for those where a safety event was recorded. The corresponding rates for re-admission within one month were 11% and 16% respectively. The in-hospital death rate was 1.3% with no safety event and 9.2% with a safety event. These findings were consistent with those of Yu et al. (2012), who found out that Multiple patients safety events (MPSEs) occurred in approximately 1 in every 1,000 hospitalizations, and compared with all admissions, the average length of stay for MPSE admissions was 4 times longer, and the average charge for MPSE admissions was 8 times greater.

Medical errors may be less obvious to the care providers but more apparent to patients but little is known about how well patients, especially the hospitalized one, can identify errors or injuries in their care (Weingart et al., 2005). A number of factors affect the willingness of patients to report medical errors. For example the research conducted in Boston teaching hospital by Greenwald et al. (2010) shows that patients with 3 or more drug allergies are more likely to report medical errors compared to those without drug allergies and that only 86% of hospitalized patients were willing to participate in medical events related study. Yves et al. (2010) reported a number of factors that affect the patients’ willingness to report medical errors. The barriers include; lack of patients’ awareness of the healthcare risks, unwillingness to challenge healthcare provider knowledge and authority, lack of awareness of patients’ role in preventing errors (self-efficacy) and fear of legal/technical implication that might arise. The facilitators included healthcare provider modelling, provider perception of risks involved if patients are engaged and lastly, healthcare provider willingness to participate in ensuring patients safety. According to WHO, Patients and family members who are alert to the risk of errors can be more vigilant in monitoring what happens to them while in the hospital. By being informed and alert to their medication regimens, by ensuring medication accuracy on all orders, and by providing all pertinent information to staff, patients can be part of the team effort to reduce errors (WHO, 2013).

Therefore medical errors can be reduced through active engagement of patients and family caregivers with the care team, the use of patient safety checklists, and increased awareness of publicly reported hospital safety records (NEHI, 2011). Similarly, EvidenceScan (2013) suggests efforts to help patients take an active role in their own safety that includes educational leaflets, videos or posters to help patients feel more confident questioning professionals about issues such as hand hygiene, comment cards to help identify individual safety issues and encouragement to tell staff if the patient has any concerns.

1.2: Background to the study area

The research was done in Kitgum district in Northern Uganda. The town centre (Kitgum town) is located approximately 452 kilometres (281 miles), by road, north of Uganda’s capital, Kampala. The district is bordered by South Sudan to the north, Kaabong District to the East, Kotido District to the Southeast, Agago District to the South, Pader District to the Southwest and Lamwo District to the Northwest. The district is composed of one county, that is, Chua County. It is a constituent part of Acholiland, home to an estimated 1.1 million Acholi, according to the 2002 national census. The annual population growth rate of the district was estimated at 3.5% in the year 2010, with the estimated population of approximately 220,000. The main economic activity is agriculture, practiced on subsistence scale. Raring animal, such as cattle is not common.
Kitgum General Hospital (KGH) is located in the heart of the town, adjacent to Kitgum District Administration Headquarters (Southwest to the hospital), in Kitgum town council. The hospital was built in 1938 by the British government. It is a 200 bed capacity public hospital, currently administered by the Uganda Ministry of Health (MoH).

1.3: Statement of the problem

Despite the evidence that there are significant levels of medical errors in Ugandan health facilities, little has been done to analyze the impact of both patient and health worker engagement in patient safety. In Ugandan healthcare settings, the involvement of both the health workers and patients in patient safety strategies is poorly documented. Even if the health care workers seem to be engaged, their level of engagement is less often checked by the patients as majority of patients are not aware that they have roles to play in their own safety issues in healthcare settings. As a result, there has been presumed increase in adverse events, jeopardizing patients’ safety.

The gap in reporting medical errors ultimately results in a rampant increase in medico-legal issues, and the associated direct and indirect costs. Secondly as the patients are less involved in the mitigation of patient safety issues, they tend to hold health workers more responsible for any error(s) that might occur, a factor that greatly affects subsequent health seeking behaviours. If this problem is not handled with the seriousness it deserves, and its increase curbed, more preventable harm will keep coming up. This may result into more loss of lives and medico-legal issues are also likely to increase exponentially in future and health facilities will continue to incur unnecessary resultant associated costs. This in the long run will make health facilities less desirable to the clients and financially impossible to run, a serious blow to the principle of Primary Health care. Directly or indirectly the quality of health care delivery may be compromised if this problem is not handled seriously.

Just like any other health facility in Uganda, Kitgum General Hospital (KGH) is presumed to be having similar challenges in term engagement in patient safety issues. This called for the need to do this research and ascertain the actual fact on ground.

1.4: Research Questions

This study sought answers to the following questions;

I. What was the level of awareness about patient safety in healthcare among patients and health workers in Kitgum general hospital?

II. To what level were health workers engaged in patient safety in healthcare in Kitgum general hospital?

III. To what level were patients engaged in patient safety in healthcare in Kitgum general hospital?

IV. What were the factors affecting health workers and patient engagement in health care in Kitgum general hospital?

1.5: Conceptual Framework

The main problem is poor engagement in patient safety, shown in the Centre of the conceptual model. The problem results in poor error reporting and probably documentation by health workers. Factors such as lack of awareness, fear of legal issues, demographic (for example age difference) and settings as well as severity of illness are some of the common factors known to bar patient engagement. On the other hand, provider modeling, willingness to participate patient education about their roles and risk perceptions are known to facilitate the engagement.
1.6: Objectives of the study

Both the general and specific objectives of the study were developed. They are laid down below, in that order.

1.6.1: General Objective: The general objective of the study was to generate information about health workers and patient involvement in patient safety and hoped to contribute to the best practices of engaging patients in order to improve patient safety in Kitgum general hospital.

1.6.2: Specific Objectives: The specific objectives of the study were;

I. To ascertain the level of awareness about patient safety in healthcare among patients and health workers in Kitgum General Hospital.
II. To determine the level of health workers engagement in patient safety in healthcare in Kitgum General Hospital (KGH).
III. To assess the level of patient engagement in patient safety in healthcare in Kitgum General Hospital (KGH).
IV. To determine the factors affecting patients and health workers engagement in patient safety in healthcare in Kitgum General Hospital.

1.7: Justifications of the study

The study was conducted as a need to assess various engagement levels of health workers and patients in the said hospital (KGH).

However the study findings, if utilized, could also enable the hospital management, Ministry of Health (MoH) and other stakeholders redress the need for prioritizing patients’ engagement in patient safety issues in healthcare facilities. This may call for increase in health education during healthcare service delivery with the view to improving Patient safety at healthcare facility level. At national level, policies that encourage health education and the accompanying financial aspect might be formulated.

Similarly, if utilizes, it would help the government/stakeholders appreciate the existing level of engagement of health workers and patients in patient safety issues in healthcare settings. Improved/adequate level of engagement of both patients and health workers will help to create harmony and build trust among healthcare providers, healthcare institutions and the patients. It is viewed that this would reduce the level of medico-legal issues and unnecessary costs incurred by healthcare institutions and providers in meeting these legal issues and adverse events. This might, also, improve on the willingness of both patients and health workers to engage in patient safety.

The study results and recommendations will, if utilized, add to the existing body of knowledge as a future reference material. They are meant to help other researchers due to the fact that very
few researches have been conducted in Uganda in the line with patients and health workers’ engagement in patients’ safety in healthcare. The healthcare institutions, hospital managers and the general hospital might use the results to identify gaps in the healthcare system that needs to be addressed by regular or further health workers’ training. In this way, if such results are implemented, healthcare would be made much safer and therefore reliable to the users.

2. Literature Review

2.1: Introduction

Medication errors are costly from human, economic, and societal perspectives and all patients are vulnerable to the detrimental effects of these errors (Dennison, 2005). One in 10 patients admitted to hospital will suffer an adverse event as a result of their medical treatment. A reduction in adverse events could happen if patients could be engaged successfully in monitoring their care (Davis et al., 2008). However several studies point out that little is known about patients’ willingness and ability to adopt patient safety promoting behaviors (Longtin et al., 2010). Furthermore, considering that information about concrete methods in primary care is scarce, providing a definite answer to the question ‘what are the potentials and weaknesses of these methods in relation to patient involvement?’ is not possible. These concerns are equally shared by Davis et al. (2011) who argues that despite growing recognition internationally that patients can help to promote their own safety, little evidence exists on how willing patients are to take on an active role. However, a number of factors that are assumed to determine the extent and character of patient involvement in patient safety have been identified.

Davis et al. (2007) and Longtin et al. (2010) argue that patient involvement relies on factors related to the following; patient demographics, type of illness and co-morbidity, health care professionals’ approach and abilities, health care setting and the nature of involvement/health care task. Similarly, Dennison (2005) acknowledges that any interventions to prevent medical errors can be described by the patient safety taxonomy, which includes; patient participation, education regarding medication safety, non-punitive approach to reporting of errors and near misses, teamwork, communication, collaboration and administration support.

This chapter critically examines and compares the various research findings alongside theories put forward by various authors regarding the extent and factors affecting patient engagement and its effects in patient safety. Factors will be put into five categories and these are: patient demographics, illness-related, health-care professional-related, health care setting-related and task-related.

2.2: Level of Health worker’ engagement in patient safety

Health worker’s engagements/involvements in patient safety are the set of actions or attitude or behaviour of health care providers toward reduction of medical associated risks to patients (Vigar, 2009). According to Kammerlind, et al (2004), employee engagement forms the basis of patient-centered care. Well engaged employees were found to lead to shortened lengths of stay for patients and lower variable costs (Harmon, et al., 2003) Furthermore, in their study, they found the effects of higher engagement on patients were improved quality of care, increased patient satisfaction and increased patient loyalty, among others.

According to Ministry of health (MOH), under the patient charter, when health workers engage and respect patients’ rights, they themselves also get engaged (MOH, 2009).

There are variations among the levels of health worker engagement in patient safety strategies and this ultimately has a toll on the level of patient engagement. In support to this claim, Albolino et al. (2010) whose study looked at patient safety and incident reporting among Italian healthcare workers, reported that only 70% of respondents confirmed involvement in a patient safety initiatives.
Some studies report health practitioners’ involvement as playing an important role in enhancing patient safety. For instance a study done by Davis et al. (2007) found that by health workers involving themselves in encouraging questions, patient willingness to ask questions was significantly increased. Thus, physician instruction and education surrounding the reasons why patients should ask questions may have a significant impact on patient error prevention behaviors.

In an evaluative study of a program to increase medication safety by providing patients drug safety information, Chwappach and Wernli (2010) found that good health workers’ (nurses) relationships with patients play a vital role in patients’ safety.

2.3: Level of Patients’ engagement in patient safety

According to Gruman et al. (2010, p.66), patient engagement refers to actions patients must take to obtain the greatest benefit from the health care services available to them. It encompasses a number of potential strategies for patient involvement in patient safety that entails “speaking up” in the case of safety concerns, awareness and knowledge of safety risks, close observation of medication and treatment, coordination of care, contributing to hygienic practices, and self-management and compliance. Efforts to engage patients in safety efforts have focused on three areas: enlisting patients in detecting adverse events, empowering patients to ensure safe care, and emphasizing patient involvement as a means of improving the culture of safety (PSNet, 2007, p.61). Patient engagement also means fostering an effective collaboration in which patients and clinicians work together to help the patient progress towards mutually agreed-upon health goals (Helle and Larsen., 2012).

Just as Longtin et al. (2010) note, patient engagement in health care has gained momentum over recent years. According to their study, momentum is driven primarily from the logical argument that delivery of any service must take into account the user’s needs and perceptions. The study reports that patient engagement has been effective in areas of patient care such as decision-making particularly in the management of chronic diseases. Though in agreement with these assertions and further acknowledgement of the fact that patients are safety buffers for their care, Davis et al. (2007) stresses that the ultimate responsibility for their safety must remain in the hands of health care professionals. Literature reviews have shown that no measures of the extent to which healthcare professionals involve patients in decisions within clinical consultations exist, despite the increasing interest in the benefits or otherwise of patient participation in these decisions (Elwyn et al., 2003).

A number of studies have explored the extent to which patients and professionals feel comfortable with involving patients in safety. A key finding is that patients may feel more comfortable when they do not need to speak directly to a health professional about their concerns because they do not want to appear to be challenging professionals or to be seen as difficult. The attitudes and support of professionals can go a long way to make patients more confident. Strategies to involve patients further may therefore need to concentrate on: ensuring that professionals have positive attitudes, are supportive and ask for feedback; that the infrastructure is in place to do something about patients’ comments and that patients feel able and encouraged to take part. In short, greater patient involvement may require changing the culture of healthcare so that patients and professionals are working as partners in a joint team. (EvidenceScan, 2013)

Hibbard et al. (2005) found that the majority of respondents had moderate self-efficacy and that this was related to the presence of family members in the hospital and having previously read about medical errors. The authors also established that moderate to high perceived health efficacy was strongly related to the likelihood of getting involved in patient safety.

2.4: Factors affecting level of patient engagement

A number of factors have been discussed about patient engagement in patient safety. These include, among others; patient demographics, patient’s level of awareness, task related factors,
health facility setting, provider modeling and severity of the illness. Others factors are patient’s willingness to participate, patients’ self-efficacy, Communication and the role of a caretaker or parent

2.4.1: Patient demographics: Demographic factors have been suggested as key in influencing the willingness of patients in engaging in patient safety initiatives. This theory is supported by Lu and Roughhead (2011) whose study shows that age especially old age, cross-country heterogeneity, household income, level of education are factors influencing patients’ willingness to engage in patient safety. A study by Kommune (2010) which focused exclusively on elderly patients confirms this argument. In contrast to these findings, however, Waterman et al. (2006) found that older patients were less likely to ask the purpose of a medication when compared to other groups. These assertions are supported by Davis et al. (2007) whose study findings demonstrate that younger patients are more likely than older patients to get involved in patients safety initiatives. Davis study also demonstrates that women were more involved than males and highly educated patients opted for a more active role in patients’ safety initiatives than the less educated. Davis et al. (2011) also acknowledged that patients who are less educated or unemployed are less willing to challenge healthcare staff regarding their care than to ask healthcare staff factual questions. Age is also mentioned in the study by Longtin et al. (2010) and Howe (2006) along with personality, low health literacy, little education, lack of assertiveness in consultation as factors influencing patient involvement in patient safety activities.

2.4.2: Patient’s level of awareness: As Hibbard et al. (2007) observed, low patient awareness is a key barrier to patient engagement in patient safety practices. This is because lack of awareness and understanding of what patient safety is, presents a major obstacle to patients’ involvement in patients’ safety initiatives. According to Peters et al. (2006), patient safety awareness can be best achieved through an increased perception of risk and preventability by both patients and health care providers. The authors also argue that if patients are not aware that medical errors constitute a risk for them while receiving treatment, then patient engagement is unlikely to occur. In terms of perception about risk, patients do not feel like their actions can prevent errors from occurring and are, therefore unlikely to become active participants in error prevention strategies

2.4.3: Task related factors: A patient’s level of engagement in medical error prevention strategies vary with the specific action a patient is required to take. This theory is supported by Waterman et al. (2006) whose study demonstrate that patients were very comfortable asking a medication's purpose, general medical questions, and confirming their identity, but were uncomfortable asking medical providers whether they had washed their hands. This study also revealed that patients who felt very comfortable with error prevention were significantly more likely to take 6 of the 7 error-prevention actions compared with uncomfortable patients. These findings were consistent with those of Delbanco et al. (2005) whose study shows that most patients preferred to be informed about important aspects of their care, but their preferences for involvement in care varied widely.

2.4.4: Health facility setting: The health facility climate plays a key role in influencing patient engagement in medical error prevention strategies. In support of this theory Schwappach (2011), assert that hospitals should educate patients on how to prevent errors. The patients’ intentions to engage in safety are significantly predicted by behavioral control, subjective norms, attitudes, safety behaviors during hospitalization and experiences with taking action by the health facility staff. Similarly, Bahadori et al. (2013) argue that managerial factors have the greatest role in the refusal to reporting medication errors by both health care providers and patients. Their study further stresses that managerial factors in question include factors related to the process of reporting and fear of the consequences of reporting. This study also reports a significant relationship between employment status and fear of the consequences of reporting on medication
errors in the case of hospital staff. These assertions are consistent with the findings by Chiang et al. (2012), whose study among Taiwan hospitals, found out that the reporting culture, willingness to report, tenure of work, and reporting rate, significantly contribute positively to behavioural involvement in patient safety (BIPS).

It has also been argued by Clarke (2006) that an ideal health system setting facilitates capture of adverse events, when care harms patients, and near misses and when errors occur without any harm. This study also reported that near misses signal system weaknesses and that medical error can be linked to patient and team characteristics. It further postulates that analysis and feedback are critical and that reporting systems need to be linked to organizational leaders who can act on the conclusions of reports. Similarly, in a study by Lu and Roughead, (2011) about determinants of patient reported medical errors among seven countries of Australia, Canada, New Zealand, UK, US, Germany and Netherlands, it was found out that poor coordination of care was a shared concern of all seven countries. Cost-related barriers to medical services were also a predictor in six of the above countries.

The traditional patient-provider relationship has also been identified as an impediment to greater patient participation in patient safety. Three major patient safety studies in the United States (Marella et al., 2007; Waterman et al., 2005; Davis et al., 2008) identified that patients feel less comfortable asking direct and confrontational questions of their providers, such as, “Did you wash your hands?” or asking if the physician could mark their surgical site. Davis et al. (2008) also found that patients are less willing to adhere to patient safety practices that they view as challenging to the healthcare staff’s clinical abilities. This was somewhat mitigated by the healthcare professional’s designation, with more individuals willing to ask challenging questions of nurses than of physicians (Marella et al., 2007). Waterman et al. (2005) reported similar results with only 45.5% of the respondents indicating that they would feel comfortable asking medical personnel whether they had washed their hands. Even more shocking was the fact that only 4.5% of respondents actually did ask their care provider if they had washed their hands, indicating a large discrepancy between feeling comfortable to perform an error prevention action and actually performing that action. The traditional patient-physician relationship, in which the physician is perceived to have more knowledge about individual health concerns, is an impediment to patients asking questions of their physician, even if they feel that that their safety might be compromised and that they could play a role in preventing an error. This disconnect might point to broader organizational and cultural issues.

2.4.5: Healthcare provider modeling: One of the key facilitators of patient engagement in patient safety is provider behavior or physician modeling. Patients are less likely to engage in behavior that they perceive to be confrontational or challenging. Davis et al. (2007) found that when patients were instructed by a doctor to ask challenging questions of themselves and nurses, patient willingness to ask was significantly increased. Thus, physician instruction and education surrounding the reasons why patients should ask questions may have a significant impact on patient error prevention behaviors. Waterman et al. (2006) report similar results with their survey and suggest physician modeling as an integral part of patient education of patient safety practices. The authors propose that patient safety programs should target patient fears about challenging and insulting their healthcare provider by posting education material in hospital and waiting rooms encouraging patients to ask questions or having providers wear reminder buttons that encourage patients to ask them if they’ve washed their hands. Fundamentally, provider modeling and education surrounding the acceptability of asking healthcare providers questions should ultimately lead to greater patient comfort in engaging in these behaviors. Likewise Hibbard et al. (2005) also suggest that training patients to be more assertive in their encounters with healthcare providers may lead to greater involvement in error prevention behaviors, as it has previously been shown to enhance patient involvement in their own care and improve care outcomes.
2.4.6: Severity of the illness: The severity of illness has been suggested to play an important role in influencing the patients’ involvement in patient safety. As Marella et al. (2007) note, patients are more eager to engage in patient safety practices, particularly when it involved gaining additional information about their health and treatment, certain sub-populations of patients, such as those with chronic diseases and those who were terminally ill, were more inclined to engage in error prevention strategies than their counterparts. However in contrast, Waterman et al. (2006) note that even if the patients had the will, those who are critically ill lack the capacity to fully participate in patient safety. Waterman et al. (2006) further note that inpatients are more likely to report medical errors compared to the patients in the outpatient clinics.

2.4.7: Patient’s willingness to participate: It has been believed that patients are generally interested in engaging in error prevention strategies, but as noted by Waterman et al. (2006) most patients’ willingness is affected by the health care providers. This study found out that the majority of respondents agreed that hospitals should educate patients about error prevention in order to boost patient engagement. However, other studies have found out that patients' perceived willingness to participate is affected by the task required by the patient and whether the patient was engaging in the specific action with a doctor or nurse (Davis et al., 2011). The authors found that patients were less willing to participate in challenging behaviours. Doctors' and nurses' encouragement appeared to increase patient-reported willingness to ask challenging questions. Surgical patients, particularly the men, less educated or unemployed are less willing to challenge healthcare staff regarding their care than to ask healthcare staff factual questions. In another study Davis et al. (2012) argue that control beliefs, normative beliefs and perceived severity of errors were the strongest predictors of patients' intentions to participate in both behaviours. Their study reports a smaller percentage of the variance in patients' intentions to ask doctors/nurses if they have washed their hands than notifying staff if they were not wearing an identification bracelet.

2.4.8: Patients’ self-efficacy: A study by Hibbard et al. (2005) found that the majority of respondents had moderate self-efficacy and that this was related to the presence of family members in the hospital and having previously read about medical errors. The authors also established that moderate to high perceived health efficacy was strongly related to the likelihood of getting involved in patient safety.

2.4.9: The role of a caretaker or parent: Parents or other care givers may become involved in critical incidents as contributors or detectors of critical incidents or they may be affected by critical incidents (Forster et al., 2004). This argument is supported by (Frey et al., 2009) who demonstrate that the most vulnerable categories regarding contribution and detection by parents were drugs, line/drain disconnection, trauma and hygiene. Though their study observed that while it is not the parents' duty to guarantee the safety for their children, it acknowledges that parents should be encouraged to report anything that worries them. This researcher also emphasizes the fact that only an established safety culture allows parents to articulate their concerns.

2.4.10: Communication: Just as Helle and Larsen. (2012) demonstrate, communication is considered to be a potential source of misunderstandings, misinformation, and conflict, as well as key to patient involvement in patient safety. Sandars (2007) says that patients need to be enrolled into the ‘please ask initiative’, which highlights the active role of patients in safe care and encourages patients to offer information on side effects, to question treatment and to report on safety concerns. Entwistle et al. (2010) also points out that one of the most common ways of encouraging patients to play an active role in patient safety is asking them to speak up if they have concerns about their own safety. In contrast however, two studies looking at patients’ perspectives on voicing safety concerns to health providers (Entwistle et al., 2010, Ocloo, 2010), found out that speaking up was generally considered difficult by the patients included in the study and influenced by how professionals behave and relate to the patients. In consistence with Entwistle et al., (2010) findings, Ocloo (2010) demonstrate that a number of factors influence the
patients’ willingness to speak up or not. These factors are; patient’s situational assessment, personal ability to assess problems, personal judgment about responsibilities and the patient’s judgment of consequences of speaking up. These authors further acknowledge the fact that it cannot be assumed that an encouragement to speak up will produce the desired sharing of information and dialogue on errors in all cases. Contextual factors such as health condition, knowledge, and the patient-provider relationship also determine patients’ communication practices.

In another study by (Ocloo, 2010) an action research conducted among medically harmed patients, most patients reported experiences of professional resentment when they addressed their concern, by both individual doctors and health care organizations. The participants had the impression that professionals routinely covered up medical harm and treated the patient as the problem. The patients did not feel included in patient safety reforms, were met with a culture of denial when tackling safety issues and that the regulatory bodies failed them after the adverse event. Ocloo concludes that the patient-professional relationship and health professionals' attitudes shape patients' confidence in speaking up and raising concerns and thus whether some patient safety issues are ignored or go undetected. ‘Concurrently with speaking up campaigns, listening up campaigns for health care workers is suggested’.

However, according to the authors little is known about patients’ experiences of this recommended behavior.

2.5: The effects of patient engagement

It is a general observation in several studies (Coulter and Ellins, 2006, Hall et al., 2010, Longtin et al., 2010), that there exists a weak evidence on the effectiveness of patient involvement in patient safety although a few exceptions are mentioned (Helle and Larsen., 2012). For example Hall et al. (2010) noted that the only evidence of effectiveness regarding patient participation in patient safety was found in self-management of medication. Similarly Coulter and Ellins (2006) revealed that patient involvement in infection campaigns proved effective. The authors however warn that of other strategies, the most effective is simplifying dosing regimens and demonstrate that educational interventions alone are unlikely to be effective. Similarly, Longtin et al. (2010) study reported patients’ participation benefits of up to 10 years later by educating health care workers in patient involvement.

Several studies mention patient involvement in the hand hygiene practices but the evidence of its effect on safety is unclear (Coulter and Ellins, 2007, Davis et al., 2007, Hall et al., 2010, Longtin et al., 2010).

The pilot project on home care by Kommune (2010) showed that medication errors were significantly reduced by the systematic account during home visits, but could not confirm that it motivated the patient to acquire knowledge about treatment and use of medication. Similarly, it could not be measured whether health care workers in other units acquired knowledge about the patient's health status, as a systematic review of this was not possible.

Pearson and Aromataris (2009) argue that the provision of leaflets encourages patients to raise queries concerning treatment, but despite a patient satisfaction outcome, no patient safety improvement was measured. Likewise, little impact was found in encouraging patients to monitor treatment and report incidents, unless combined with a national scheme. Howe (2006) asserts that one of the greatest benefits of patient involvement in safety is the potential to increase professionals' awareness that their actions have consequences. This can moderate professionals' risk taking behavior and may lead to error-prevention, development of a stronger organizational safety culture, professional behavior change, enhanced adherence to advice and improved self-management. Interventions would be most effective, the author believes, if they include patients and all professional disciplines and aim to change professional attitudes and behaviors.
Coulter and Ellins (2007) noted that patient safety can only be improved if patients’ involvement in their care is valued and supported. Likewise Davis et al. (2007) conclude that patient involvement requires a positive safety culture.

In wrapping up the subject matter of factors affecting level of patient engagement, evidence on the effectiveness of patient involvement in patient safety in primary care is scarce and inconclusive. Therefore, there is need for more systematic research on how patient involvement methods work in practice. This study is intended to fill part of that gap.

2.6: Conclusion

Despite the lack of strong evidence and the acknowledgement of various barriers, the majority of the publications are generally positive about the overall idea of applying patient involvement to patient safety. The study from the Municipality of Copenhagen by Kommune (2010) is the one exception. Almost all of the literature point to the need for more research, particularly on the effectiveness of interventions and patients ability and willingness, before a full overview of strengths and weaknesses of patient involvement in patient safety is better understood.

In an analysis of the patient role in safety work, Schwappach (2010) points out that while patients who are sick and under treatment will always be concerned about the risks related to treatment and care, it is not naturally given that such concerns for safety translate into willingness to engage for safety. The author also argues that we must not take for granted that the ability to identify errors enables patients to act in a timely and effective way to intercept these errors. The author further points out that although patient involvement in patient safety seems a logical and promising next step there is so far no enough scientific knowledge that have explored systematically and in detail to what extent and with what means patients may contribute to improving patient safety and how this will change the patient role.

The study from the King’s Fund by Parsons et al. (2010) makes two central points. At first, both the patient and the general practitioner may feel uncertain about what precisely is expected and demanded of them when patients are supposed to play a more active part in the consultation. This is certainly an issue to take into account when applying patient involvement methods not only in general practice, but in other primary care sites where the encounter between patient and health provider may be less clearly defined. Secondly, both doctor and patient may feel that patient involvement is a potential threat to the doctor-patient relationship.

Indeed, studies by Coulter and Ellins, (2006), Entwistle et al., (2010), Howe, (2006), Kingston-Riechers et al., (2009) and Longtin et al., (2010) mentioned the importance of the doctor-patient relationship. They did not provide any details about how patient involvement in patient safety may have an impact on it. The attitude of health care providers is mentioned as having an impact on the way the patients experience involvement or view the potential for involvement as two studies in this review have shown (Entwistle et al., 2010, Ocloo, 2010). However, several other studies have discussed the impact on the trust between patient and health care provider if safety issues are openly voiced and patient vigilance encouraged. Some of these studies point out that both patients and health care providers may see patient involvement in safety work as a threat to the professional authority and identity of the provider. On the same note, Schwappach (2010) argues that patient involvement methods could erode trust. On the other hand, Entwistle and Quick (2006) state that patients are well aware that health care also implies risk and that openness about this is trustworthy in itself. Certainly, the lack of insights into the implications of patient involvement in patient safety for the patient-provider relationship needs calls for further studies because this may have an impact on the effectiveness of involvement methods.

This is even more pertinent when the diversity of primary care patients is taken into account. Several vulnerable groups have already been mentioned; the elderly, women and people with poor communication skills. The study by Kommune (2010) made the point that the elderly
patients who were visited by a home nurse were neither able nor willing to become involved in their own care and treatment. Thus, given the diversity of the patients and health care sites in primary care we may assume that this creates both limitations and opportunities for patient involvement in safety. It might be fruitful to consider the possibilities of a more individualized approach to the concretization of involvement strategies and the testing and implementation of involvement methods.

Another big concern is that of the patient safety culture, which is mentioned in several of the reviewed literature as crucial to patient involvement and patient safety (Davis et al., 2007, Howe, 2006, Ocloo, 2010, Sandars, 2007, Woodward, 2005). Patient safety culture is promoted by influential institutions such as the Institute for Health Care Improvement (IHI). Only the reference guide from Australia provides information about what this implies in practice and defines it as a culture where individuals in organizations and teams have a constant and active awareness of the potential for things to go wrong (Woodward, 2005). In organizations with a safety culture, it is assumed that health staff would not display negative attitudes to patients voicing their concern, but would rather be supportive and encouraging (Howe, 2006). If we once more consider the character of primary care and diversity of sites that are part of it, it becomes obvious that creating a culture of safety across these sites and the health professions represented in them presents a significant challenge. For instance primary care facilities are often different in terms of size, location and organization. There is a dire need to determine to what extent the range of institutions in primary care are prepared to adequately respond to patients’ activities in relation to patient safety, and the kinds of institutional adaption that are necessary for patient involvement to work (Schwappach, 2010).

Finally, if patient involvement is to play its part in patient safety in primary health care, there is a need for interventions and research to test and evaluate the potentials, weaknesses and general viability of involvement, to assess the perspective of professionals and patients on the implications of patient involvement in practice, and to assess the basic organizational requirements in the various primary care sites.

3. Research Methodology

3.1: Introduction

This chapter illustrates the procedures used to carry out data collection. It comprises of; study area, study design, study population, study unit, sample size estimation, sampling techniques, the variables for the objectives and their indicators. It further demonstrates how data collection was carried out and study instruments used. How data was analyzed and how it was presented are further discussed herein. The quality controls used, ethical considerations undertaken, limitations faced during data collection, plans for dissemination of results are indicated.

3.2: The study area

The research was carried out in Kitgum General Hospital (KGH), Kitgum district found in Northern Uganda.

3.3: The study type/design

This was a descriptive, cross-sectional study of patients and health workers’ engagement in patient safety in healthcare. The study took both qualitative and quantitative dimensions.

3.4: Study Population

The study population was all the health workers and patients in Kitgum General Hospital, Kitgum district.
3.5: Study Units

These were clients that had visited Kitgum general Hospital during the study period and a health worker in the health facility.

3.5.1: Inclusion Criteria: The following categories were considered;
1. All health workers present in the respective hospital departments at the time of the study. They were free to participate in the study.
2. All patients who are 18years and above and present in the health facility at the time of the study. This is because clients who are 18 years and above are able to provide legally bound personal information in Uganda
3. The patients who were conscious or not severely ill at the time of the study. They, as well, had no history of present or past (5years) mental illness.

3.5.2: Exclusion Criteria: The following categories were excluded;
1. Any health worker who was unwilling to participate in the study.
2. All patients who were less than 18 years, as they are legally considered children in Uganda. It would, therefore, be difficult to obtain information from them.
3. Patients who were unconscious or severely ill at the time of the study, as well as those with present or past (5years) history of mental illness.

3.6: Sample size estimation

Sample size for both respondent patient/clients and health workers were determined as below. For respondent patients, formula for calculating sample size from unknown population size (N) was used. For respondent health worker, formula for calculating sample size from known population size (N) was used.

3.6.1: Respondent patient sample size: Since the population size of patients who were to seek treatment from the hospital during the study period was not known, Cochran formula for large sample size estimation was used (Cochran, 1963). The desired level of precision was taken at positive / negative five percent (+ / - 5%), that is, e = 5% = ± 0.05. The desired confidence interval was 95% and the degree of variability in the attributes of the population to be measured was assumed to be 50% (0.5), that is, maximum variability. In their revised edition (2009), Glenn and Israel noted that the use of the level of maximum variability (P = 0.5) in the calculation of the sample size for the proportion, generally, produced a more conservative sample size (i.e. a larger one) than was calculated by the sample size of the mean.

Therefore, the sample size was calculated as;

\[ n_0 = \frac{Z^2pq}{e^2} \]

Where, \( n_0 \) is the Sample Size, \( Z \) is the abscissa of the normal curve that cuts off an area \( \alpha \) at the tails (1 – \( \alpha \) equals the desired confidence level, e.g., 95%). The value for \( Z \) is found in statistical tables which contain the area under the normal curve. \( e \) is the desired level of precision (Sampling error), \( p \) is the estimated proportion of an attribute that is present in the population, and \( q \) is (1-p).

Therefore,
\[
\begin{align*}
  n_0 &= \frac{Z^2pq}{e^2} = (1.96^2) \times (0.5) \times (0.5) / (0.05^2) \\
  &= 0.9604 / 0.0025 \\
  &= 384.16 \\
  &\approx 384
\end{align*}
\]

3.6.2: Health workers sample size: As the number of health workers was known (139 health workers on record in Kitgum general hospital), a formula for calculation of sample size was used;

\[ n = \frac{N}{1 + N \ (e)^2} \]
Where $n$ is the sample size, $N$ is the population size, and $e$ is the level of precision. 
Therefore, $n = 139 \div (1 + 139 \times 0.052)$ 
$= 103.15$ 
$\approx 103$

3.7: Sampling Techniques

Both probability and non-probability sampling techniques were used in this study.

3.7.1: The Hospital: Kitgum General Hospital was conveniently sampled based on its availability for this study as the only government hospital in the district. Departments visited by the researcher were Out-patient and In-patient departments, theatre, the hospital compound and administration block.

3.7.2: The Respondents: The respondents were patients and health workers in the health facility. Both simple random sampling and systematic sampling techniques were used to identify and select the respondents.

For respondent patients, both simple random sampling and systematic sampling techniques were used to identify and select the patients. The entry (start) point into the hospital was selected by simple random technique. Prior to the entry into the hospital, all the entry point (Hospital compound, the various Out-patient and the In-patient departments) were identified, randomly assigned numbers and rolled up in many pieces of paper according to the number of the departments. The uniformly rolled pieces of paper were then vigorously shaken in a closed hand and later picked with the researcher’s eyes closed. They were then given to a research assistant to open and read it to the rest of the research team. The first paper picked was the department of first entry. The order of picking was maintained such that the first department got in the paper was the first to be visited by the research team, until all the departments were visited in that order. Systematic sampling technique was then employed. Every third patient the researcher/research assistant came across was to be interviewed, except where he/she did not meet the inclusion criteria above.

For respondent health workers simple random sampling technique was used just as for the patient respondent above to get the entry point/start point. Similarly, for every patient respondents interviewed, the health worker who attended to him/her or the health worker who would attend to him/her was to be included except where the health worker had already been involved or he/she did not meet the inclusion criteria. The top level managers (Medical superintendent, the hospital administrator, the matron) and middle level managers (departmental heads) were conveniently selected as key informants.

3.8: Variables and Indicators for the objectives

The variables for the specific objectives are described below. The dependent and independent variables have been documented, as well as their indicators.

3.8.1: Variables and Indicators for objective I: Objective I is divided into two parts, that is, to ascertain the level of awareness about patient safety in healthcare among patients and among health workers in KGH. Sub-sections below have taken care of both parts.

For variables and indicator for awareness about patient safety among patients, the dependent variable used was level of awareness about patient safety. The independent variables used to assess the level of awareness were; hearing about patient safety, experiencing safety incident, reporting an adverse event, being told when to resume normal activities, being told danger signs to watch for while at home after getting health care and being taught about error prevention by health workers. Respondent patients who acknowledged having heard about patient safety, having experienced safety incident, having been taught about error prevention or told when to resume normal duty after getting health care or told danger signs to watch for were considered to be aware. The mean percentages of the variables, under ‘YES’ categories, were used to compute
the level of awareness. The indicators were the number of ‘YES’ categories of responses given on patient safety awareness by the respondent patients.

For variables and indicator for awareness about patient safety among health workers, the dependent variable used was level of awareness about patient safety. The independent variables used were; hearing about patient safety by the health worker and level of completeness of patient identification particulars on fifty randomly selected patient files. Those who heard about patient safety before the study time were considered to be aware about patient safety. Similarly, completely filled files, where there were names, age, sex and full address (Village, parish, sub-county, county and district) of the patient were all filled, for year 2013, were considered aware about patient safety. Half-filled files were considered as not aware. The mean percentage of the independent variables under ‘YES’ category for hearing about patient safety and completely filled file was used to conclude on level of awareness about patient safety by health workers in KGH. The indicators were the number of ‘YES’ responses given for hearing about patient safety and the completed files for the identification variable.

3.8.2: Variables and indicators for objective II: The dependent variable for this objective was level of health workers’ engagement in patient safety. In assessing health workers engagement in patient safety, responses were sought about the following independent variables; clients seeing the health care provider washes hands before offering a service, clients asking if the health worker had washed his/her hands before offering a service, clients told how much pain to expect during surgery and clients provided with enough information concerning side effects of the medication dispensed to them. These were used for assessing health workers’ engagement from patient perspective.

On the other hand engagements, from health workers’ perspective, were assessed using the independent variables such as; health worker ever experienced/encountered a patient safety incident and ever reported patient safety incidents.

Seeing health worker wash hand or asking if they had washed before offering a service or patient told about level of pain to expect before or during or after operation were regarded, by the researcher, as engagement in patient safety issues. Similarly, being given information about side effects of medication, experiencing and reporting incidents by H/W was also viewed as engagement in patient safety from the H/W perspective. The indicators were ‘YES’ or ‘NO’ responses given by either the patient or the health worker.

The variables and indicators for objective II are as summarized in table 1 below;

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>Independent variables</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of health workers engagement in patient safety</td>
<td>Clients seeing the health care provider washes hands before offering a service</td>
<td>Number of ‘YES’ or NO’ responses given</td>
</tr>
<tr>
<td></td>
<td>Clients asking if the health worker has washed his/her hands before offering a service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clients told how much pain to expect during surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clients provided with enough information concerning side effects of the medication dispensed to them.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>etc</td>
<td></td>
</tr>
</tbody>
</table>
3.8.3: Variables and Indicators for objective III: The dependent variable for this objective was level of awareness about patient safety among the respondent patients. The independent variables used to assess awareness were; hearing about patient safety, education about patient safety and error prevention undertaken, being told when to resume normal activities after healthcare, being told danger signs to watch for while at home, reporting an adverse event and experiencing a safety incident, among others. The mean percentages of the variables under ‘YES’ categories were then used to conclude on the level of awareness about patient safety in KGH. The indicators were number of ‘YES’ or ‘NO’ categories given.

The variables and indicators for objective III are as summarized in table 2 below;

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>Independent variables</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| Level of patients’ engagement in patient safety in healthcare | • Hearing about patient safety  
• Patient safety experiences  
• Reporting safety incident  
• Etc | Number of ‘YES’ or ‘NO’ responses given |

3.8.4: Variables and Indicators for objective IV: Objective IV was to determine the factors affecting patients and health workers’ engagement in patient safety in healthcare in KGH.

The variable for this objective were factors that prevent/hinder engagement in safety issues. The indicators are the number of factors mentioned by either the health worker or the patient.

The health workers related factors intended to study as per the reviewed literature were; Support from the institution, Perception of lack of time, H/w professional category, beliefs and demographic variables among others.

The patient related factor intended to study were; acceptance of new patient role, relevance of the issue, health literacy and knowledge, disease severity and demographic variables among others.

3.9: Data collection tools and techniques

The following tools and techniques were used;

3.9.1: Data collection tools: The tools used were; questionnaires, observation checklist, key informant interview guide and documents review guide

3.9.2: Data collection techniques: The following data collection techniques were used in the study;

I. Self-administered semi-structured questionnaires were given to the respondent clients who were able to read and write. For those who were not able to read and write, the research assistant took them through and filled together with them

II. Observation checks were done as the respondent health workers did their routine duties. This was to observe patient safety practices carried, such as hand washing practices among health workers.

III. Key informant interviews were conducted with the top and middle level managers.

IV. Documentation review of previous patient files. Some key documents (patient files) for the year 2013 were retrieved and reviewed. This was to assess the depth of patient identification by H/Ws as a measure to minimize errors.

3.10: Data entry, analysis and presentation methods

The data entry, analysis and presentation used in this research are as below;

3.10.1: Data Entry and Analysis: Computer software, Statistical Package for Social Sciences (SPSS) and Microsoft excel were used for the entry and analysis of the data collected. A team of two well trained and experienced data entrants were used for this purpose.
Chi-square tests and t-tests were carried out to test the significance of difference in the different study variables.

3.10.2: Data Presentation Methods: The data presentation methods used were pie charts, tables, bar graphs and descriptive method for the qualitative components. Simple frequency tables and cross tabulations were drawn to present the results.

3.11: Quality controls

For quality assurance purpose the researcher employed the following quality control measures;
I. Pre-testing of the questionnaires was carried out prior to the study. A pilot survey was carried out to pre-test the tools and ensure that they capture the intended information. This was carried out in KGH. The pilot survey checked the suitability of all the procedures and changes to the questionnaire were consequently made.
II. A number of other ways were used to improve quality of data collection which included; Intensive training of research Assistants, Pretesting of tools, close field supervision of research Assistants, comprehensive training of data entrants and double data entry.

3.12: Ethical considerations

In this study, the following ethical considerations were taken care of;
I. Introductory letter as well as permission was also sought from office of the medical superintendent. This was done in conformity with the requirement to undertake this research.
II. Informed consent was sought from the respondents. Confidentiality aspect of this research, as well as its benefits was explained to the respondents. To re-enforce confidentiality, respondent name were not captured in the questionnaire.
III. Voluntary participation/involvement of the respondents was observed by the researcher. Respondents were free to pull out of the study, for whatever reason(s) and their decision would be highly respected.

3.13: Limitations to the study

This study was faced with the following limitations; Time, funds and logistics constraints, given the big sample size, were great concern although they did not affect the validity and reliability of the study.

3.14: Plan for Dissemination of Results.

The copy this research work was shared with the office of the medical superintendent of KGH, the office of District Health Officer (DHO) and the office of Chief Administrative officer (CAO) of Kitgum district. The findings were also shared with the necessary stakeholders including patients and health workers on ground.

4. Results, Analysis and Presentation

4.1: Introduction

The results of the analysis of the study have been discussed as below. Tables, pie charts and bar graphs were used. The respondents were clients and health workers (health care providers) in KGH at the time of the study. Respondent clients/patients were both in-patient and out-patients who had visited Kitgum general hospital for medical care in the year 2013. A total of three hundred and eighty four clients were interviewed with a response rate of one hundred percent.

4.1.1: Socio-demographic characteristics of the respondent clients/patients: The respondent clients/patients were 173(45.1%) males and 211(54.9%) females. Their mean age was 35.1(SD=11.6), 18years minimum and 71 years maximum. The majority (52.9%) were in the
young age category (17-35yrs). The middle age (36-55yrs) was the second constituting 41.1% and the old age category (≥56yrs) was the smallest with 6.0%.

One third (33.9%) of the respondents never went to school, 29.2% finished primary, 20.6% finished secondary while only 16.4% finished tertiary education.

4.1.2: Respondent health care providers: A study was made on 103 health workers (74.1%) out of the total 139 health workers in the health facility. The greatest category of cadre studied were Enrolled Nurses (19.3%) followed by Registered Nurses (14.5%). The lowest categories were medical officers, Askaries and laboratory staffs, all accounting for 1.2% per category.

4.2: Health seeking behaviour of respondent clients/patients

The health seeking behaviour of client/patient respondents was assessed with the view to see whether or not they would influence patient engagement. The researcher thought that frequent visit to health care facility would increase chances of the patient engaging in patient safety, as well as their level of awareness on patient safety.

Result showed that 10% of the patients visited the hospital more than once a month, 22% visited the hospital once in a year and 38% visited the hospital at least twice in a year while 30% visited once a month.

4.3: Reasons for respondent patients visiting the hospital

The researcher needed to know what category of medical/disease conditions, could bring the patients more frequently to the hospital, as this may affect their engagement and awareness in patient safety.

When the patient respondents were asked why they visited the hospital, the reasons for visiting the hospital varied among simple conditions, chronic conditions and different conditions. Simple conditions were mainly OPD cases which did not require them to be admitted while chronic conditions were chronic illnesses which required the respondent to regularly visit the hospital, at least once in a month. Different conditions were those respondent patients who had both chronic and simple cases.

This study found that the most of these respondent patients had different conditions (37%), followed by those with simple conditions (35%). Respondents with chronic conditions were at 28 percent.

4.4: Level of awareness about patient safety among respondent clients/patients

The study examined the level of awareness about patient safety among the respondent clients. The independent variables used to assess awareness were; hearing about patient safety, education about patient safety and error prevention undertaken, resumption of normal activities after healthcare, being told danger signs to watch for while at home, reporting an adverse event and experiencing a safety incident, among others.

The mean percentages of these constructs were then used to conclude the level of awareness about patient safety in KGH. This stood at 46.5%, which is quite low as the majority (53.5%) of the respondent patients were not aware of patient safety. The sections below show each of the findings for each of the constructs used
Table 3: Summary of findings on awareness about patient safety among patients in KGH

<table>
<thead>
<tr>
<th>Constructs Used</th>
<th>Results (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing about patient safety</td>
<td>38%</td>
</tr>
<tr>
<td>Experiencing safety incident</td>
<td>53%</td>
</tr>
<tr>
<td>Reporting an adverse event</td>
<td>45%</td>
</tr>
<tr>
<td>Being taught about error prevention</td>
<td>66%</td>
</tr>
<tr>
<td>Told danger signs to watch for while at home</td>
<td>39.3%</td>
</tr>
<tr>
<td>Told when to resume normal activities after getting health care</td>
<td>37.8%</td>
</tr>
</tbody>
</table>

Source: Primary

4.4.1: Respondent client/patient hearing about patient safety: Two hundred and thirty eight (62%) of respondents reported to have never heard about patient safety as opposed to 148 (38%) who reported that it was not the first time they were hearing about patient safety. In other words, 38% of them heard about patient safety. Of the respondents who reported to have heard about patient safety before the time of the interview, twenty two percent heard from the radio, thirty seven from a health facility while 6% heard from school.

However, of the 62% who had not heard about patient safety before, all of them were able to understand it from the research assistants’ explanation.

4.4.2: Has the respondent patient ever experienced a safety incident?: According to the researcher, experiencing a safety incident would make one more aware about health care risks and subsequently the patients become more when seeking health care.

Fifty three percent (53%) of respondents reported to have ever experienced a medical related incident while seeking health care at KGH, while forty seven percent (47%) have not. Of the respondents who experienced an incident, 5% had an under dose of a certain medicine, 10% had wrong medicine, 26% had some medicines omitted, 4.9% were not consulted for a surgical procedure while 13% had delayed treatment.

4.4.3: Reporting an adverse event: Reporting adverse event by the patient could mean that he/she is quiet aware of patient safety concept. Those who reported it were considered, by the researcher, to be aware.

Of the respondents patients who had an incident only 45% had the courage to report it, the rest (55%) did not. The reasons fronted for not reporting the experienced incident were as follows; 22% of the respondents did not know where to report the incident, 20% did not know how to report while 15% feared for the probable consequences.

4.4.4: Clients ever been taught about error prevention: Being taught about patient safety would make one more aware on the subject matter. The researcher, therefore, considered those patients who were taught to be aware and those who were not taught not to be aware.

Two hundred and fifty four (66%) respondents reported to have never been educated about medical error prevention as opposed to 130 (34%) who have ever been educated.

In an interview with a health worker (key informant), the health worker had this to say about the subject matter, ‘We have little time to teach every patient who come to the hospital. We are understaffed to do all these’ – narrates a health worker on 18/08/2013.

A two way tabulation of number of hospital visits a client made in the year versus the likelihood of being educated about error prevention was done. The result is as shown in figure 2 below;
4.4.5: Danger signs to watch for while at home: Patients told about danger signs to watch for while at home after getting medical care, was looked at, by the researcher, as having made them aware about patient safety. Therefore, those who were told about any danger sign to watch for were considered to be aware as opposed to those who were not.

Finding showed that only one hundred and fifty one (39.3%) of respondents were told, by the health workers, of what danger signs to watch for at home while on medication, compared to 233 (60.7%) that were not.

4.4.6: When to resume normal activities after getting health care: Being told about when to resume normal duty by a health care provider after getting health care, was considered by the researcher, as having made the patients aware of safety concept. Finding showed that out of the total 384 respondents, only 145 (37.8%) were told of the time they should take to resume normal duties, compared to 239 (62.2%) who were not. Similarly only 36.7% of respondents were told of which activities to avoid while taking medications at home the rest were not.

4.5: Patient engagement in patient safety

Patient engagement in patient safety in health care, as has been defined by many authors, is too broad and comprised of various components (Refer to literature review and chapter one of this study). Similarly, for this study, the researcher chose a set of factors/independent variables, when combined, to define patient engagement in patient safety. These variables were; patient involvement in decision making, ability of patients to ask questions, patient’s ability to identify an incident and patient’s ability to report the incident, among others. The dependent variable used was patient engagement.

Patients who were involved in any decision making concerning their care, were considered to have been engaged. Similarly, those who ever experienced a safety incident or ask a doctor/health care provider question concerning their treatment plan were considered to have been engaged. Analysis was done on those who always ask questions and those who do so only to some extent. Finding showed that 23.6% always ask questions while 54.2% only did so to some extent, the rest never ask any question. Out of all these independent variables used, identifying an incident and patient’s ability to report the incident did not show any significant result during the analysis and were, therefore, not used in this study to conclude anything in patient engagement.

Below is a summary table of significant variables used to conclude patient engagement in patient safety in KGH.
Table 4: Summary findings on patient engagement in patient safety

<table>
<thead>
<tr>
<th>Constructs</th>
<th>Results (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision involvement</td>
<td>62.4</td>
</tr>
<tr>
<td>Safety experiences of patients</td>
<td>59.8</td>
</tr>
<tr>
<td>Patient ask doctor/health worker about treatment plan</td>
<td>34</td>
</tr>
<tr>
<td>Patient asking H/W questions</td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>23.6</td>
</tr>
<tr>
<td>To some extend</td>
<td>54.2</td>
</tr>
</tbody>
</table>

The mean percentage of decision involvement, safety experiences and patient asking doctor/health worker about treatment plan was found to be 52.1%. The level of patient engagement in patient safety was, based on these, and therefore concluded to be 52.1% in KGH.

4.5.1: Patient involvement in decision making: According to the researcher, complete/definite involvement and involvement to some extent in decision making meant the patient was engaged. Percentage of those who were never involved was not considered. The following constructs/independent variables gave significant findings; disease conditions, educational levels, sex and number of hospital visits. Mean percentage showed that 62.4% of the respondents were involved in decision making to some extend while 17.7% have always/completely been involved. Refer to table 4 below for detail findings.

Table 5: Summary of findings on involvement in decision making

<table>
<thead>
<tr>
<th>Constructs</th>
<th>To some extend involved</th>
<th>Definitely/completely involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>65%</td>
<td>10%</td>
</tr>
<tr>
<td>Female</td>
<td>60%</td>
<td>24%</td>
</tr>
<tr>
<td>Number of hospital visits</td>
<td>64%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Educational levels</td>
<td>61%</td>
<td>18.75%</td>
</tr>
<tr>
<td>Disease conditions</td>
<td>62%</td>
<td>17.67%</td>
</tr>
</tbody>
</table>

Factors influencing involvement in decision making were examined. A number of variables (both demographic and other variables) were examined to determine their effects on client involvement in decision making concerning their care and treatment. These variables were; age of the respondent, sex of the respondent, number of hospital visits per year, level of education, disease condition and how often the respondent asks questions to the health worker, among others. Sub-sections below show the variability of these independent variables used.

Age of the respondent patients disease conditions, level of education, number of hospital visits per year as well as sex of respondents were analyse to ascertain the extent to which they influenced decision making involvement/engagement. Results obtained were as presented in the respective graphs below;
Figure 3: Age of respondents versus involvement in decision making

The majority of clients, across all the age categories, were involved to some extent in decision making. Patients/client in the older age group felt more definitely involved (22%) compared to their counterparts. However, these findings were not statistically significant ($X^2 = .83$ (df 4) $p$ value = .93) suggesting lack of association between age of the client and involvement in decision making.

However, responses from staff interviews revealed that health care workers often tend to involve older patients in decision making as opposed to the younger ones whose concentration of health issues is never definite.

Figure 4: Sex of respondents versus involvement in decision making

The majority of respondents in both sex categories have been involved in decision making regarding their care and treatment. However, males were less likely to be definitely involved in decision making compared to their female counterparts. The finding was statistically significant, ($X^2 = 19.4$ (df 4), $p$ value <0.01). This highlights the fact that males visit the hospital less frequently compared to females and less the chances of being involved.

Figure 5: Number of hospital visits versus decision making involvement
Fewer clients (5%) among those that visited the hospital once a year are less likely to be involved in decision making compared to their counterparts, hence a strong relationship between hospital visits and involvement in decision making. ($X^2 = 21.4$, (df 6), p value = .002). These findings are statistically significant meaning that clients who visit the hospital less frequent are more likely to be engaged in decision making. This is because these clients are not used to the hospital environment as opposed to their counterparts who visit the hospital more often. Their counter parts are, therefore, relatively less willing to get involved especially in asking questions about their conditions, they already know what to do.

Key informants also mentioned that clients who visit hospital more frequently, know well about their conditions and usually interested in picking the medications and go away.

![Figure 6: Level of education versus decision making involvement](image)

The majority of the respondents across all education categories have been involved in decision making concerning their care and treatment. These findings are statistically significant, ($X^2 = 12.3$, (df 6), p value = .05) although the association seems to be weak.

![Figure 7: Disease conditions versus decision making involvement](image)

The majority of clients across all disease condition categories had been involved in decision making concerning their care and treatment options. However, patients who visit the hospital with different conditions were more likely to be involved to some extent in decision making compared to their counterparts, ($X^2 = 11.295$, (df 4), p value = .023). This means that there is an association between the type of disease the client/patient presents with and the extent of involvement in decision making. ‘Clients who visit the hospital with different conditions take time to ask the health care providers as opposed to those with chronic and simple conditions’ -narrates a health care provider on 18/08/2013.
The researcher, through his research assistants observed the health workers for the time they take when interacting with patients of various disease conditions. Interacting with patients for longer duration, more than 5 minutes, was thought to give better chances of engagement in patient safety.

Finding showed that majority of the health workers (up to 56.6%) were found to interact for longer times (more than 5 minutes) with patients with different conditions. In so doing, this category of patients had better opportunity of getting involved in decision making than other categories.

4.5.2: How often the respondent patients ask questions to the health workers: In terms of asking questions, the researcher wanted to know what factors affected patient ability to ask questions. The following independent variables were used; age of respondent, sex of the respondent, educational level, number of hospital visit and disease conditions of the patient. Of all these variables, only sex and educational level of the respondents were significant and hence these were used to determine the level to which questions were asked.

The study found the mean percentage of those who asked questions to some extend were found to be 54.2%, while those who always ask questions were 23.6%.

Table 6 below shows summary of the significant findings on this subject matter.

<table>
<thead>
<tr>
<th>Constructs</th>
<th>To some extend</th>
<th>Yes, Definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>48%</td>
<td>34%</td>
</tr>
<tr>
<td>Female</td>
<td>59%</td>
<td>15%</td>
</tr>
<tr>
<td>Level of education</td>
<td>55.5%</td>
<td>21.8%</td>
</tr>
</tbody>
</table>

A number of factors influencing the client/patients’ ability to ask questions during hospital visits were examined in this study. Each of the variables used to conclude on ability to ask questions were analysed and results displayed in the graphs below.

**Figure 8:** Age of the respondents versus willingness to ask question

The majority of clients across all age groups rarely ask questions while visiting the hospital. However, it’s also clear that clients in the old age category are less likely to ask question compared to their counterparts. These findings are not statistically significant, ($X^2 = 1.5$, (df 4), $p$ value = .85), meaning that there is no association between age of a client (>18) and the willingness to ask questions while seeking medical care.
The majority of clients in both sex categories rarely ask questions, but men were more likely to ask questions sometimes, compared to their female counterparts. This finding was statistically significant hence an association between sex of a client and the willingness to ask questions, \( (X^2 = 18.6 \text{ (df 2), } p \text{ value} < .01) \).

The majority of clients rarely ask questions concerning their health across all the three categories. Patients who have attained tertiary education were more likely never to ask questions (30%) compared to their counterparts. Similarly clients with primary education are more likely to ask questions sometimes (38%) compared to their counterparts in the other education level categories. These findings are statistically significant, \( (X^2 = 35 \text{ (df 6), } p \text{ value} < .01) \). This means that possibly clients with no education at all find it hard to figure out what questions to ask, and conversely client who have attained tertiary level of education do understand the basic issues about the common diseases and therefore ask less questions. ‘It is up to the health care provider to diagnose and treat me, so how can I start asking questions’ -narrates one client who arguably never went to school. Another one said, ‘For me I fear health workers because they don’t listen to us’.
The majority of clients in all the three categories by disease condition rarely asked questions. Respondents with simple conditions were more likely to ask questions sometimes (29%) during their hospital visits compared to their counterparts. It is also clear that clients with different conditions are more likely to ask questions more than the client with a chronic condition. The finding was not statistically significant (p value = .085).

![Figure 11: Disease conditions versus willingness to ask questions](image)

**Figure 12:** Number of hospital visits versus likelihood to ask questions

The majority of respondents across all the categories rarely ask questions while seeking medical care. Respondents who visited the hospital more than once a month was more likely to sometimes ask questions compared to their counterparts. This finding was not statistically significant, ($X^2 = 5.8$, (df 6), p value =.44), suggesting a very weak association between number of hospital visits and the likelihood of asking questions.

4.5.3: **Factors influencing the clients ability to ask questions during hospital visits from health workers perspective:** Patient ability to ask questions was also assessed from health workers perspective. This was done through key informant interviews with top level and middle level managers. For patient responses, data was collected using questionnaires. Paragraph below shows the result of some of the analysis.

Respondent patients were asked whether they ask their doctor question about treatment plan while at home. Finding showed that 67% of respondent patients never asked the doctor about their treatment plan while at home, as opposed to 33% who did.

A tabulation of age of the respondent versus the ability to ask the doctor about their treatment plan while at home was done. See table 7 below;
Table 7: Age of the respondent versus the ability to ask the doctor about their treatment plan while at home

<table>
<thead>
<tr>
<th>Age category</th>
<th>Don’t ask for treatment plan</th>
<th>Asks for treatment plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young (17-35)</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle age (36-55)</td>
<td>63%</td>
<td>37%</td>
</tr>
<tr>
<td>Old (56-up)</td>
<td>65%</td>
<td>35%</td>
</tr>
</tbody>
</table>

The majority of clients in all the three age categories never asked for the treatment plan while at home. The table also illustrates that more clients in the young age group are less likely to ask the health workers, compared to individuals in the other two categories. Further analysis showed that this result was not statistically significant ($X^2 = 2.4$ (df 2), p value = .35).

4.5.4. Respondent patient experiences of patient safety incidents: Experiencing safety incident was thought by the researcher, as making respondent patient not only aware about patient safety and also more engaged than other patients who never experienced it.

The following independent variables were used; number of hospital visit, disease condition, acknowledging encounter of safety incident and educational level of respondents. Finding showed that fifty three percent (53%) of respondents patient reported to have experienced a health care related incident and 47% have never. Of the incidents experienced, 72% were in OPD, 16% in maternity ward while 12% were in other in-patient departments. These incidents were mainly diagnostic, medication (dose related) prescription, communication and surgical errors.

However, when the study sought to determine the factors commonly associated with experiencing safety incident, the number of hospital visit, educational level and disease conditions of the patient were statistically significant. The findings are illustrated in table below.

Table 8: Summary findings on respondent patients who experienced safety incident in KGH

<table>
<thead>
<tr>
<th>Constructs</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospital visit</td>
<td>63%</td>
<td>37%</td>
</tr>
<tr>
<td>Educational level</td>
<td>61%</td>
<td>29%</td>
</tr>
<tr>
<td>Disease condition</td>
<td>62%</td>
<td>38%</td>
</tr>
<tr>
<td>Acknowledging encounter of safety incident</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>Source: Primary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Factors which influence patient/clients’ likelihood to experiencing medical related incidents were examined. Experiencing safety incident was thought to vary with the following independent variables; number of hospital visit, disease condition, acknowledging encounter of safety incident and educational level of respondents, among others.

Graphs below illustrate the results of the analysis.
Respondents, who visited the hospital at least once a month, were more likely to experience medical related incidents compared to their counterparts who visit the hospital fewer times in a year. The finding was statistical significance, (p value < .01.) hence an association exist between the frequency of hospital visits and the chances of experiencing an incident.

![Figure 14: Disease conditions versus likelihood to experience incident](image)

Respondents who visited the hospital with chronic conditions were more likely to experience safety incidents compared to their counterparts. The findings are statistically significant, (X2 = 81, (df 2), p value < .0, highlighting an association between the nature of the disease condition and the chances of experiencing an incident. ‘When a client has multiple disease conditions, the health care provider has increased chances of making a mistake, as this require so many investigations before diagnosis could be made’ - narrated one health care provider on 19/08/2014

![Figure 15: Educational level versus likelihood to experience incident](image)

Finding showed that those clients with highest level of education (tertiary) were more likely of experiencing safety incident than other categories. Although this findings was statistically significant, (X2 = 9, (df 3), p value = .03), the reason is not very clear. Probably, this could mean that the more educated a client is, the more s/he is aware of safety risks and therefore able to recognise whether a safety risk has happened or not. For those in the lower education category, they may not quickly know whether or not they experienced an incident and they therefore tend to under report as well.

4.6: Factors affecting patient engagement in patient safety in KGH

The study investigated the factors affecting patient engagement in patient safety. Findings were divided into demographic factors and other factors.
The demographic factors, quantitatively, proved to be significant were; age, sex and educational levels of the respondent patients.

Others factors, other than demographic factors, were; lack of awareness about their roles in patient safety, disease condition of the patients and the number of hospital visit the respondent made, as well as the negative attitude of health worker. Health workers reported worker overload (31.9%) hence limited time to engage patient in patient safety issues.

4.7: Level of awareness about patient safety among health workers

The level of aware about patient safety in health care among the health workers was assessed. The constructs/independent variables used were; hearing about patient safety and level of completeness of patient particulars on patient files. A documentation review of previous patient files (50 files) was made to ascertain the level of completeness of the identification particulars. The identification particulars looked at was patient name, age, sex and complete address (Village, Parish, Sub-county, county, district and country)

The study found that only 20% of the health workers heard about patient safety concept and 82% of the reviewed files were completed. The mean percentage was found to be 51%, which was taken as the overall level of awareness about patient safety among health workers in KGH. Refer to sub-sections below for each of the constructs/variables used.

4.7.1: Whether the health care provider ever heard of patient safety concept in health care: Health workers were asked whether or not they have ever heard about patient safety. Responses were divided into ‘YES’ or ‘NO’ categories.

Finding showed that only twenty percent (20%) of health care workers at KGH acknowledged having heard about patient safety concept. The majority, accounting for 80% did not hear about patient safety concept, except at the time of the study.

4.7.2: Level of completeness of patient particulars: The researcher believed that that when one is aware about patient concept, he/she would fill all the require identification details of the patients. It is thought that this minimise chances safety incidents such as giving right medicine/care to a wrong patient due to missing identification details.

A review of previous patient files (50 files), randomly selected, for the year 2013 was made. Finding revealed that 41 files (82%) were completed while 9 files (18%) were half way filled. Of the 18% of the files which were not completely filled, 33.3% had no sub-county and county on them.

Completion of patient identification particulars were considered as health workers being aware about patient safety hence minimising associated safety risks that could occur due to non-completion. The identification particulars looked at was patient name, age, sex and complete address (Village, Parish, Sub-county, county, district and country) in course rendering health care during the admission period.

4.7.3: Cadre of staff versus their awareness on patient safety: The researcher went ahead to analyse, with the view to see whether cadre of staffs would significantly vary. Tabulation was done about cadre of staffs versus their awareness on patient safety. Figure 16 presents cross tabulation results of cadre of the staff versus awareness of patient safety initiatives.
Doctors and nurses are more likely to be aware of patient safety initiatives, compared to the clinical officers. However the same trend is not replicated as we go down the staff cascade. The findings do not show a clear association between the cadre of the staff at KGH and the likelihood of awareness of patient safety initiatives, (X^2 = 31, (df 4), p value = .001.

4.8: Level of health workers engagement in patient safety

In assessing health workers engagement in patient safety, responses were sought about the following variables; clients seeing the health care provider washes hands before offering a service, clients asking if the health worker has washed his/her hands before offering a service, clients told how much pain to expect during surgery and clients provided with enough information concerning side effects of the medication dispensed to them. Other variables looked at were; health worker experience/encounter with patient safety incident and reporting patient safety incidents.

Seeing health worker wash hand or asking if they had washed before offering a service or patient told about level of pain to expect before or during or after operation were regarded by the researcher as engagement in patient safety issues. These were from patient perspective. Similarly, being given information about side effects of medication, experiencing and reporting incidents by H/W was also viewed as engagement in patient safety from the H/W perspective.

Of these, patients seeing health worker wash hand before offering a service was not statistically significant. Table below shows the findings used to approximate health workers engagement in patient safety.

Table 9: Summary findings on constructs used to approximate health workers engagement in patient safety.

<table>
<thead>
<tr>
<th>Constructs</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients told about pain to expect after procedure/surgery</td>
<td>43%</td>
<td>57%</td>
</tr>
<tr>
<td>H/Ws provided information about side effect of drugs</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>H/W experienced safety incidences</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>H/W reported safety incident</td>
<td>22.7%</td>
<td>77.3%</td>
</tr>
</tbody>
</table>

Source: Primary

The study found the mean percentage of the “YES” category was 51.4%. Therefore, the level of health workers engagement in patient safety was found (concluded) to be 51.4%.
The sub-sections below reveal the details of the constructs/variables used for this approximation.

4.8.1: Clients seeing the health care providers wash hands before offering a service: Respondent patients were asked whether or not they have ever seen a health worker wash hand before offering them a service. Only twenty five percent (25%) of the clients reported having ever seen a health care provider wash hands before providing a service. The researcher then wanted to see how frequency of hospital visit affected seeing H/W wash hand. Tabulation results of frequency of facility visits versus seeing the health workers wash hands before providing a service was done. The result was reflected below;

**Table 10:** Frequency of facility visits versus clients seeing the health workers wash hands before providing a service

<table>
<thead>
<tr>
<th>Construct</th>
<th>Has the client ever seen the health worker wash hands before offering a service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of hospital visits</td>
<td>Yes</td>
</tr>
<tr>
<td>Once a year</td>
<td>25%</td>
</tr>
<tr>
<td>At least twice a year</td>
<td>21%</td>
</tr>
<tr>
<td>Once a month</td>
<td>32%</td>
</tr>
<tr>
<td>More than once a month</td>
<td>18%</td>
</tr>
</tbody>
</table>

**Source:** Primary

The majority of patient respondents in all the categories have never seen a health care provider wash hands before offering a service. Clients who visited the facility once a month were more likely to see a health care provider wash hands compare to their counterparts. However, the finding was not statistically significant, (X^2 =4.7, (df 3), p value = .19), meaning there is no association between the frequency of hospital visits and the likelihood of seeing a health care provider wash hands before providing a service.

4.8.2: Client asking if the health worker has washed his/her hands before offering a service: Responses were sought from patients as to whether or not they ask their health care providers about washing hand before offering them a service. This was viewed as a strong engagement in of the H/W in patient safety. Analysis was done on frequency of responses, level of education and cadre of staffs. The results are as below;

**Table 11:** How often the respondent asks the health worker if he/she has washed hands before offering a service

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>never</td>
<td>34</td>
<td>11.7</td>
<td>11.7</td>
<td>11.7</td>
</tr>
<tr>
<td>rarely</td>
<td>47</td>
<td>16.1</td>
<td>16.1</td>
<td>27.9</td>
</tr>
<tr>
<td>sometimes</td>
<td>186</td>
<td>64.8</td>
<td>64.8</td>
<td>92.7</td>
</tr>
<tr>
<td>Always</td>
<td>21</td>
<td>7.3</td>
<td>7.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>288</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Primary

Only 7.3% of clients who had never seen a health care provider wash hands before providing a service, always ask if he/she has washed hands before offering a service. However, the majority do sometimes ask and up to 28% rarely or never bother to ask.
Figure 17: Level of education versus ability to ask whether health care provider has washed hands before providing a service.

The majority in all education categories do sometimes ask the health care providers if they had washed their hands. Clients who attained tertiary education were more likely to ask questions compared to their counterparts. These findings are statistically significant, (P value = .002), suggesting an association between level of education and the likelihood to ask if the health care provider has washed hands. The more one is educated, the more the likelihood to ask such question.

Figure 18: Cadre of staff versus hands washing before offering a medical service

Registered nurses/midwives were more likely to wash their hands every time they offer a medical service (57%). The allied health professions were less likely to wash their hands. These findings are statistically significant, ($X^2 = 17$, (df 4), p value = .002, suggesting an association between cadre of staff and observation on hygienic practices.

In the study, up to sixty seven percent (70%) of the interviewed health care providers agreed not to wash hands every time they offer a medical service.

The health workers were asked why they do not always wash hand before offering a service. Thirty nine percent (39%) of the staff which do not wash hands always before offering a service because of lack of constant supply of water, 51% attributed it to work overload while 10% usually forget.

4.8.3: Client told how much pain to expect during surgery/painful procedure: Patients were asked as to whether H/W told them the amount/degree of pain to expect before a painful procedure. Being told about pain to expect was viewed as H/W engaging in patient safety. Out of all the clients who had conditions that required surgical intervention/painful procedure, only 43% of them were told, by the health care provider, how much pain to expect before the operation/procedure and the rest (57%) were not.

4.8.4: Whether the health workers provided enough information concerning side effects of the medication dispensed to you: Again, patients were asked whether or not they were given enough information about side effects of drugs dispensed to them. Being told the side effect of the drug by the health worker was considered as an engagement on the H/W side. Up to seventy seven percent (70%) of respondent clients said that health care providers gave enough
information about the side effects of the medications dispensed to them. “We do give those information to our clients” – narrates a health worker

4.8.5: Whether the health care provider ever experienced/encountered a patient safety incident: Experiencing a safety incident was viewed as having aware about patient safety and hence likelihood of engaging much higher than in those had never experienced it. Thirty four percent (34%) of staff had ever experienced a medical incident and of those, only 23% reported the incident while the rest (77%) did not.

Cadre of staff and experiencing a medical incident was then tabulated. Figure 19 present cross tabulation results of cadre of staff versus experiencing a patient safety incident.

![Figure 19: cadre of staff versus experiencing a patient safety incident.](image)

Being a doctor, nurse or clinical officer was more likely to have experienced an incident than being an allied health professional or support staff, (X2 = 23, (df 4), p value < .001), hence a significant finding. This may be due limited encounter with patient among the allied health professionals, or being more careful as compared with the former category.

4.8.6: Health workers reporting patient safety incidents: Reporting an incident by a health worker was viewed, by the researcher, as having engaged in patient safety. Health workers were asked whether or not they reported safety incidents they experienced. Table 12 below shows whether or not the incidents were reported, out of the 34% (35) staffs that have ever experienced/encountered patient safety incident.

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8</td>
<td>22.7</td>
<td>22.7</td>
<td>22.7</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>77.3</td>
<td>77.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

The majority (Valid responses only) of staffs (77.3%) did not report the incidents they encountered. When they were asked why they did not report, the responses were given as in table 13 below;
Table 13: Why staffs who experienced the incident never reported them

<table>
<thead>
<tr>
<th>Reasons for not reporting incidences</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feared for the consequences</td>
<td>10</td>
<td>38.8</td>
<td>38.8</td>
</tr>
<tr>
<td>I did not know how to report</td>
<td>3</td>
<td>10.4</td>
<td>49.2</td>
</tr>
<tr>
<td>I did not know where to report</td>
<td>14</td>
<td>50.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

The majority of health workers (77.3%) who never reported the incidents did not know where to report (50.8%). The fear of the consequences of reporting ranked second on the list, showing that the hospital management does not encourage the staff to report the incidents once they happen. ‘We are very busy and have a lot of other things to do. Reporting of patient safety incidents will be handled gradually’ – narrates a key informant/manager on 19/08/2013

Duration of stay (staff experiences) at KGH was analysed against their failure to report medical incidents. Figure 20 presents cross tabulation results of duration of staff stay at KGH versus failure to report the experienced medical incident.

Figure 20: Duration of staff stay at KGH versus failure to report the experienced incidents

The new staffs (less experienced) were less likely to know where to report, 2-5 years category were more likely to fear of consequences while the longest serving were less likely to know where to report the experienced incident. The findings were statistically significant demonstrating an association between the duration of staff stay at KGH and the reasons of not reporting the incidents.

4.9: Factors affecting health workers engagement

The factors affecting health workers’ engagement in KGH was investigated. They were ranging from the perception of lack of time, weak institutional support toward patient safety and fear of likely consequences of engaging patients.

5. Discussion, Conclusion and Recommendations

5.1: Introduction

To explore patients and health workers’ engagement in patient safety in health care, the researcher collected and analysed data from three hundred and eighty four clients (384) and 103 health care workers from KGH. The data also revealed the lived experiences of clients while seeking health care service from KGH.

5.2: Discussion of the findings

In discussing the study findings, the areas looked at include; level of awareness about patient safety among patients and health workers, level of health workers engagement in patient safety in healthcare, level of patient engagement in patient safety. The factors were discussed concurrently.
5.2.1: Level of awareness about patient safety among patients and health workers:
According to Albolino et al. (2010) whose study looked at patient safety and incident reporting among Italian healthcare workers, 70% of respondents confirmed involvement in patient safety initiatives. Data analysis from this study, found level of awareness about patient safety to be 46.5% among patients and 51% among health workers. This level is still quite low.

5.2.2: Level of health workers engagement in patients’ safety and factors affecting the engagement:
Davis et al. (2007) found that when patients were instructed by a doctor to ask challenging questions of themselves and nurses, patient willingness to ask question was significantly increased. Thus, physician instruction and education surrounding the reasons why patients should ask questions may have a significant impact on patient error prevention behaviors. In a similar way, Schwappach (2011), assert that hospitals should educate patients on how to prevent errors and that the patients’ intentions to engage in safety are significantly predicted by behavioral control, subjective norms, attitudes, safety behaviors during hospitalization and experiences with taking action by the health facility staff. Similarly,

For this study, a number of constructs was used to approximate health care workers’ engagement in patient safety. They included; health care workers ability to recognise an incident, ability to report the incident, hand washing culture and health worker’s ability to encourage the client to speak up in case of an incident, among others.

In their advocacy, for respect for patient rights, through the patient charter, Ministry of health (MOH) asserts that all health workers must observe these rights. In this way, the engagement of both patients and health workers in patient safety would improve (MOH, 2009)

Data analysis demonstrated an association between cadre of staff and experiencing a medical incident but could not demonstrate the same for the duration of employment in years of staff at the current workplace.

This study showed that 77.3% of the staffs at KGH did not report the incidents they encountered. There was, however, an association between the duration of stay of staff at KGH with failure to report an incident. Duration of stay in KGH is, therefore, a big contributing factor to that effect. This findings are similar those of Albino et al. (2010) and Charles et al. (1994).

There was statistically significant association between cadre of staff and hand washing culture. Many times the staffs forgot to wash hand, a factor attributed due to heavy workload.

A study done by Davis et al. (2007), however, found that by health workers involving themselves in encouraging questions, patient willingness to ask questions was significantly increased. However, data analysis from this study showed that a small percentage of health care workers always encourage patients to speak up in case of a medical incident.

Entwistle et al. (2010) also points out that one of the most common ways of encouraging patients to play an active role in patient safety is asking them to speak up if they have concerns about their own safety.

5.2.3: Level of patient engagement in patients’ safety and the factors affecting the engagement:
Here some elements were chosen to define patient engagement and these included; patient involvement in decision making, ability of patients to ask questions, patient encouragement by the health workers to participate, patient’s ability to identify an incident and patient’s ability to report the incident among others. These were done in comparison with the reviewed literature as below;

Data analysis indicated that about a quarter of clients were definitely involved in decision making concerning care and treatment. Analysis also demonstrated an association between sex and involvement in decision making, a finding earlier demonstrated by Davis et al. (2011) whose study showed that women were more involved than males.

Other factors that significantly influenced involvement in decision making of clients included hospital visits per year, level of education and the disease condition the client presents with in the
hospital. These findings are in consonance with earlier study findings by Davis et al. (2011), who demonstrated an association between level of education and involvement in decision making. However in contrast to the study findings by Davis et al. (2007) who demonstrated a significant association between young age group and involvement in patient safety initiatives, this study could not establish a significant association between age of a client and involvement in decision making.

Data analysis also showed only a small number (23%) of clients sometimes asked questions during care and treatment. Factors that significantly influenced asking questions to a health worker included; client’s sex, level of education and the feeling involved enough in decision making process. These findings rhyme with those of Davis et al. (2011), Longtin et al. (2010) and Howe (2006) which demonstrated that highly educated patients opted for a more active role in patients’ safety initiatives than the less educated. Data analysis could not however demonstrate an association between age of the client and the willingness to ask questions as earlier asserted by Longtin et al. (2010) and Howe (2006).

Data analysis also showed that significant number of health workers had ever experienced or recognised a medical incident happening to them or to a person in their care. This shows that the majority of clients are able to recognise a medical error or a near miss.

A small percentage (34%) of respondents has been educated about error prevention while seeking medical care at KGH. Factors that significantly influence a client’s likelihood of being educated according to this study include; sex of respondent. The hospital administration needs to intensify its efforts in educating the clients about patient safety initiatives as a whole.

The findings of this study mirror those of Waterman et al. (2006) who demonstrated that more clients were uncomfortable asking hospital staff if they washed their hands.

Fewer respondents (25%) reported having ever witnessed a hospital staff wash hands before providing a medical service such as examining a patient or giving an injection. In fact, less than 10% of respondents that never saw the staff wash their hands actually had the courage to ask if they did wash their hands.

5.3: Conclusions

In conclusion, health workers in KGH were 4.5% more aware about patient safety in health care than the patients. Similarly, patients in KGH were 0.7% more engaged in patient safety than the health workers. The level of health workers’ engagement in KGH is not up to the desired standard, considering the findings from the various factors that approximate, when combined, health care workers’ engagement.

Similarly, the level of patient engagement in patient is also not adequate. Patients have put in some initiatives, following the study findings, which need to be encouraged so that their engagement can go up.

Level of awareness about patient safety among both patients and health workers, was found to be low as well in KGH. The findings suggest that patient safety initiatives have not been enforced well enough. Those who knew about the concept probably could have learnt it from school other than from the hospital.

5.4: Recommendations

Based on the study findings, I would make the following recommendations;

I. The hospital administration needs to put in place strategies to introduce and improve on the implementation of patient safety initiatives. The hospital need to embrace the patient charter which was launched by MOH in 2009, if patient engagement is to improve.

II. The researcher recommends further research to be done in the area of patient safety both in the same hospital (KGH) and in other health facilities. The results may need to be compared.
6. Acknowledgement

I wish to thank all the academic staffs of Faculty of Health Sciences Uganda Martyrs University for all the guidance offered to me during this research development. In a very special way, I want to express my sincere thanks and appreciation to my supervisor, Mr. Simon Peter Katongole, who has been fully available for me at every stage of the development of this work.

Many thanks, also, go to my other professional colleagues who have been very corporative to me during the course of this research work. In a special way I want to extend my sincere gratitude to my colleague Dr. Moses Twinomujuni for his technical guidance and review of this work.

May God bless them all!

7. References

7.1: Journal Article


7.2: Journal Article


7.3: Journal Article


7.4: Newsletter


7.5: Journal Article


7.6: Journal Article


7.7: Journal Article

7.8: Journal Article


7.9: Journal Article


7.10: Newsletter


7.11: Newsletter


7.12: Project Report


7.13: Web page


7.14: Chapter in a Book


7.15: Chapter in a Book


7.16: Presentation

7.17: Journal Article

7.18: Book

7.19: Book

7.20: Journal Article

7.21: Journal Article

7.22: Journal Article

7.23: Journal Article

7.24: Journal Article

7.25: Journal Article

7.26: Web Page
7.27: Web Page


7.28: Journal Article


7.29: Journal Article


7.30: Journal Article


7.31: Journal Article


7.32: Journal Article


7.33: Journal Article


7.34: Journal Article


7.35: Journal Article

7.36: Journal Article


7.37: Journal Article


7.38: Journal Article


7.39: Journal Article


7.40: Journal Article


7.41: Presentation


7.42: Journal Article


7.43: Web Page


7.44: Report

7.45: Journal Article

7.46: Journal Article

7.47: Journal Article

7.48: Journal Article

7.49: Project Report

7.50: Chapter in a Book

7.51: Journal Article

7.52: Newsletter
7.53: Journal Article


7.54: Journal Article


7.55: Book


7.56: Web Page

Dynamics of Savings Culture in Ghana

Article by Isaac Tandoh¹, Victor Tandoh²
¹PhD in Management, Texila American University
²Snr. Accounts Officer, Sinapi Aba Savings and Loans Limited
Email:- iketandy@yahoo.com

Abstract

In Ghana and most developing parts of the world, families feel that it’s troublesome or skirting on hard to save as a result of low levels of wages (Boateng, 1994). The low profit of Ghanaian families is a result of the low levels of budgetary improvement consolidated with distinctive components, for instance, unlucky deficiency of training. The purpose of the study was to find out the determinants of savings culture in Kumasi, the second capital of Ghana. Quantitative methodology was used and sample was obtained from selected households in Kumasi. The study assembled and made utilization of primary data through the organization of organized surveys. Questionnaires were used as a data collection tool and SPSS a statically tool was used to analyze the data. It was discovered in the study that, relatively high level of savings culture among the people of Kumasi metropolis. Respondents preferred to save more for the future, they planned life ahead of time, saving money was a virtue, respondents paid close attention to how much money they spend, and before they purchased anything, they compared prices on similar items. The study recommends that financial institutions improve their operational and marketing strategies to attract all persons in the qualified age bracket being it male and female and also governing bodies like the Bank of Ghana, must take drastic measures to close down all these illegal financial institutions in the system that is dragging the reputation of the rest into the mud.

Objectives of the Study

i. To ascertain the determinants of savings within the Kumasi metropolis.
ii. To identify the savings culture among the residents of the Kumasi metropolis.

Research Questions

i. What are the determinants of savings within the Kumasi metropolis?
ii. What is the savings culture among the residents of the Kumasi metropolis?

Literature Review

Defining Savings

Saving is a typical word utilized by people on everyday schedule. It just means setting something aside for future utilization or what will be considered as conceded use. A few meanings of funds exist as there are numerous individuals who compose on the theme. As indicated by Miller and VanHoose (2001), a saving is a sworn off utilization. They clarify renounced utilization as when one does not spend all the pay that is earned inside of a given period. To them, once a piece of what is earned today is left for future utilization, there is a saving. On his part, Ahmed (2002) place it in a straightforward dialect as 'setting cash aside for future utilization'. He contends that saving is the consequence of cautious administration of wage and consumption, with the goal that there is something left to be set aside for future utilization.

Clayton and Brown (1983) in characterizing funds, took a gander at the idea simply from the financial analysts' perspective. They clarify reserve funds as the unlucky deficiency of spending. Different authors on the point, for example, Smith (1991), endeavored to clarify the idea of reserve funds scientifically as: Income – Consumption = Savings. This implies that saving is the
measure of cash left from one's income after all utilizations are deducted. This implies, for case, if a family gets two hundred and fifty Ghana cedis (GH₵250 GH) a month and burns through two hundred Ghana cedis (GH₵200 GH) for that month, the staying fifty Ghana cedis (GH₵50 GH) speaks to the family's funds for that specific month.

All the above definitions point to one certainty that investment funds speak to cash that is earned today however kept for utilization later on. It is, on the other hand, worth to note that saving is not generally an aftereffect of abundance of consumption, but rather now and then it comes as a consequence of planned choice of an individual or family to put some piece of what is earned today aside for future utilization.

**Determinants of Household Savings**

Family units' saving conduct is to a great extent impacted by a few variables like the view of saving of the individuals who save, their capacity, ability, goals or inspirations for saving and the chance to spare. This intentional choice with respect to the family units to spare keeping in mind the end goal to address future issues relies on upon various components. The components typically considered as the determinants of saving incorporate every one of the variables that influence the capacity to spare, the will to spare and the chance to save.

**Income**

One of the fundamental determinants of investment funds which every one of the studies in the territory of reserve funds have attempted to study is pay. Distinctive studies utilizing diverse routines have been directed in diverse parts of the world and all have discovered a positive relationship in the middle of salary and investment funds. In view of the discoveries, a few researchers have propounded certain hypotheses. The Keynesian Savings capacity and the Friedman Permanent Income hypothesize a positive relationship in the middle of reserve funds and wage. Friedman Permanent Income theory recognizes perpetual and short lived parts of wage in which case families have a tendency to devour the changeless pay while the temporary pay is directed into investment funds with a negligible penchant to spare from this pay drawing closer solidarity (Quarcey and Blankson, 2008). Studies led by different researchers have additionally discovered comparative results. Case in point, Collins (1989) inspected the saving conduct in nine Asian creating nations in addition to Turkey since the mid 1960s. Utilizing a times-arrangement information, the outcomes show patterns and contrasts in saving crosswise over nations and inside of nations after some time. In any case, amidst every one of the distinctions in reserve funds rate and investment funds conduct, the outcomes from every one of the nations affirmed that increment in wage have a beneficial outcome on family funds.

Proof from Sub-Saharan Africa and other creating nations, though for the most part from center to upper-wage families, recommends that wage absolutely impacts saving and in routes reliable with Keynesian Savings capacity and the Friedman Permanent Income. In Kenya, family unit wage was observed to be a measurably noteworthy indicator of reserve funds among rustic agriculturists, business people, and instructors (Kibet et al., 2009).

**Interest rate, inflation rate and government policies**

In a static methodology, expanding tariff, if direct, lessens accessible salary to family and if roundabout, brings down the obtaining force of existing individual livelihoods. Restricted or alternate, investment funds potential and inclination are adversely influenced, subsequent to the utilization penchant is for the most part exceedingly unbending concerning pay and African nations normal individual salary is becoming gradually and sometimes is about stable. For this situation a quicker increment in levy would avert family unit reserve funds as well as reason contrary individual investment funds if some salary workers were instigated to disinvest collected
riches with a specific end goal to balance the diminishment in pay (real or in buying influence) distributed to current utilization use (Mottura, 1972).

Mottura (1972) trusts that the aggregate to be picked up by premium rate, regardless of the possibility that it is high, typically has minimal financial criticalness to savers, who store or put sums in a little normal volume. In this manner the saving conduct is not only inspired by the interest rate and savers don't appear to be especially intrigue delicate. Maybe the definition and collection of reserve funds at the family unit level gives off an impression of being emphatically roused by the accompanying elements: the requirement for protection, the requirement for credit, the sentiment social commitment, and the arranging of future use (utilization and speculation). Once more, this is in a roundabout way demonstrated by the execution of indigenous affiliations (both the investment funds and common guide kind) and by the conduct of disciples. In such a domain, it gets to be reasonable that the premium rate can't give an adequate inspiration to spare or to store reserve funds into a bank. Indeed, by saving with an indigenous affiliation (or even a credit union) the family acquires security, credit and social remaining inside the neighborhood group.

**Expectation of future changes in salary**

People over the planet are intermittently confronted with the test of vulnerability. Whiles the rich are confronted with the vulnerability of future changes in wage because of a few progressions in both microeconomic and macroeconomic arrangements, the poor are likewise confronted with instability in meeting present and future consumptions. In this manner, both the rich and poor people family units are usually confronted with the issue of instability. Lusardi (1998) in her examination of the significance of preparatory saving noticed that people confronting higher pay danger spare more. In a comparative vein, Guariglia (2001) likewise discovered a noteworthy relationship between income vulnerability and saving. The outcomes inferred that family units spare more in the event that they anticipate that their budgetary circumstance will break down. Cocoa and Taylor (2006) have noticed that despite the fact that money related desire impacts investment funds, they are likewise affected by individual qualities, (for example, age and instruction) and by business-cycle impacts.

**Incentives**

A few banks give contractual saving arrangement whereby the saver is obliged to frequently store a given entirety of cash, even little, in return for a premium installment or ideally, for the privilege to acquire certain money related administrations (credit and protection). Some of these plans have as of now been effectively presented in a couple African nations (case is the Mit Ghamr bank, now Nasser Social Bank, in Egypt). For example, the contractual savers may be without a doubt, upon specific conditions, advance for different purposes (to fund the building they could call their own home, to back the buy of specific homestead inputs, to pay for their youngsters' training, to meet unanticipated costs, for example, funerals, medicinal treatment and so forth) (Mottura, 1972).

Additionally rather than credit, savers could get at their decision a multi-reason protection strategy, whereby they are secured against specific dangers, for example, characteristic passing, demise coincidentally, powerlessness ensuing to illness or mishap and so forth for a sum corresponding to the entirety kept. In addition, under specific conditions, savers may appreciate the help of a 'social administration subsidize', the primary motivation behind which ought to be bailing followers out of troublesome circumstances, brought on by unanticipated occasions not secured by the protection administration. This type of reserve funds motivation had been tested by Mit Ghamr in Egypt and had turned out to be effective. At long last savers may get, upon solicitation, monetary and specialized exhortation from the bank on issues entirely concerning
either financial action or the administration of their family unit spending plan (in the same place, 1972).

**Demographic Characteristics**

**Gender**

Quartey and Blankson (2008) in the investigation of the GLSS 4 information watched the accompanying. To start with the quantity of individuals who did not have bank account were more than the individuals who had. Just 12.1% of the aggregate example held bank account and out of this extent, females held a bigger number of investment account than guys (53.5% against 46.5%). It was watched that contrasting this figure with that of 1991/2, the extent of guys with bank account declined. It was additionally noticed that of the aggregate individuals who held investment accounts, dominant part of them were children and girls of family head took after by family unit heads themselves and afterward the companions of family heads and the slightest was the grandchildren of family heads.

Denizer et al. (2000) in the investigation of the family unit funds in the Transition utilizing information from Bulgaria, Hungary, and Poland noticed that families headed by ladies show fundamentally higher reserve funds rates than that of men in these three nations. Dupas and Robinson (2013) worked as a team with the Bumala town bank in Kenya to arbitrarily furnish little entrepreneurs with access to investment accounts. Four to six months after record opening; ladies in the treatment gathering had 45 percent higher day by day interest in their organizations than ladies in the correlation bunch. In this way ladies have the ability to spare however were confronted with various obstructions.

**Age**

It was additionally watched that family individuals who are under 18 years held more prominent extent of the bank account including susu. Despite the fact that the individuals underneath held a vast extent of investment account, those matured 60 years or more had the most noteworthy mean reserve funds equalization took after by the individuals who are under 18 years. This outcome repudiates the Life Cycle Hypothesis (LCH) which predicts that working populace collect investment funds whiles the youthful and the old expend past reserve funds (Quartey and Blankson, 2008).

Thus, Chakrabarty et al (2008) in their examination of the saving execution of Australia discovered results predictable to that of Quartey and Blankson (2008). The coefficients on age shams recommend that family units spare more as heads get to be more seasoned. For instance, the saving rates for family units with heads matured 41–50, 51–60, and matured 61 or above were higher than those with heads matured 30 or underneath. One may contend that family units with resigned heads have distinctive saving propensities than those with non-resigned ones however their discoveries demonstrated that whether the leader of the family unit is resigned or not does not seem to influence investment funds. This confirmation runs in opposition to the lifecycle hypothesis of utilization. Lifecycle hypothesis predicts that family units ought to begin dissaving as they age. Chakrabarty et al (2008) additionally trusted that investment funds of the family units with heads beyond 61 years old could be higher because of liberal tax cuts of superannuation commitments.

**Education**

It was likewise watched that in 1991/2, more elevated amounts of training (tertiary) essentially expanded the likelihood of reserve funds yet this couldn't hold for 1998/9. Along these lines 'the likelihood of investment funds increments as one accomplishes tertiary instruction yet the peripheral impact was not noteworthy'. Educating may empower individuals to value the better
things in life or to be more productive in settling on utilization choices (Solmon, 1975). By and large it has been contended that one motivation behind training is to impart a diagnostic capacity in underestimates. "Comes back to saving will be high when the saver can gauge and investigate the impacts of present and future costs of merchandise, present and anticipated that profits would different budgetary resources, the speculation options accessible, and present and future states of different parts of the economy. It is conceivable that individuals with the same salary can buy similarly great venture information and exhortation. On the other hand, no doubt an informed individual can do whatever the less scientific individual can do and that's just the beginning" (Solmon, 1975).

**Place of Residence**

In the territory of settlement, it was watched that the likelihood of funds was likewise reliant on the sort of family convenience. Families living in leased or without rent convenience are prone to have a greater number of funds than those living in their own homes. Quartey and Blankson (2008) watched that in Ghana, those living in leased convenience are more prone to have budgetary reserve funds maybe to pay for rent development (store) or to set up their own homes than those living in their own homes. Those living in their own homes may have utilized their reserve funds to set up houses - a type of investment funds'. As opposed to desire, family size was likewise found to essentially build the likelihood of family unit reserve funds. Along these lines the bigger the family measure the more reserve funds the family has.

**Occupation**

The measure of salary one makes generally rely on upon his or her occupation and as being what is indicated, it has proposed that individuals whose occupations acquire them higher livelihoods have the capacity to have higher reserve funds than the individuals who are into modest employments. In Ghana, Quartey and Blankson (2008) analyzed that greater part of the families who recovery were occupied with agribusiness yet their mean investment funds were low. However those occupied with account, protection, land and business administrations had the most astounding mean current estimation of investment funds.

**Low Savings in Ghana**

As indicated by Dovi (2008), just around 20 for every penny of African families own bank accounts. For instance, in Ghana, only 33% of all families own savings accounts; Two-fifth of these saving records are claimed by urban households, and just 22 for every penny of these records are possessed by rural households or the casual area (Ghana Statistical Service, 2008).The low rate of reserve funds in Ghana when contrasted with a nation like China suggests that Ghanaian money related middle people (e.g. banks) just hold a minute portion of the nation's capital, and consequently, would not have the capacity to efficiently apportion cash amongst the different divisions of the economy. Financial intermediaries, for example, banks are in charge of apportioning money between the distinctive monetary divisions in any economy to boost commerce and make wealth (Morawski, 2007). This responsibility involves moving overabundance cash from the surplus divisions of the economy to deficiency parts with a specific end goal to improve financial development and advancement. For example, a neighborhood Ghanaian rancher may have an extensive stretch of area for farming. Be that as it may, because of inaccessibility of satisfactory capital he may not be ready to add to the entire stretch of area. Then again, a financial researcher may have abundance capital and no practical venture to put resources into. In order for there to be a gainful relationship between these two individuals, the riches creation nature of banks ought to come to play; by the financial researcher keeping his cash with the bank and the rancher applying for a credit from the bank, the need of both people are satisfied. The farmer gets cash to build up the stretch of area and the speculator discovers a safe place to
keep his cash while getting profits for his cash. In this situation, the financial researcher has wiped out the danger included with managing with the agriculturist specifically; the speculator is no more agonized over default risk since he gave his cash to a bank (i.e. spared his cash with the bank).

How well the connecting of the shortfall area to the surplus part is being done relies upon the effectiveness level of a nation's monetary business and the degree to which its nationals spare (Uremadu, 2007). Overabundance money collected from the surplus segment as reserve funds gets to be capital for private or national improvements as credits sourced from banks. The present state of Ghana's capital-starved monetary sector may suggest that people who need cash for money generating investment (shortage area) would keep on staying in need, whilst those individuals with abundance capital (surplus part) would proceed to keep money to themselves. This is to a vast degree impacted by the unattractive premium rates set by most banks and specifically, the boundless between the premium rate charged on credits and the profits on funds. Savers get next to no enthusiasm on their investment funds while borrowers pay very much an immense measure of enthusiasm on credits. Henceforth, people in the surplus area don't have any inspiration for saving their cash with banks, and people in the deficiency segment discover it practically incomprehensible to obtain credits as a result of the high going with premium related with these advances. However in more created nations like China or the United States where the managing an account framework works productively, the spread between acquiring and loaning rate is little.

Regardless of the late uptick in gross saving, all levels of saving rates stay low by recorded norms. Could these low rates exhibit a close term hazard for shopper spending? Macroeconomic information that reflect family money related conditions and are apropos to spending reveal, most strikingly, the momentous recuperation in total family unit wealth recently. As indicated by the

Research Methodology and Profile of Study Area

Research Design

The primary target of this study was to research the determinants and savings culture of people living in Kumai the second capital of Ghana. This design was viewed as most suitable on the grounds that as saw by Anderson (1995), the enlightening outline offers the researcher the chance to get the perspectives of the populace concerning some issue of interest and pertinence to the study. The study likewise included discovering responses to research inquiries and the outcome broke down utilizing factual instruments. It is taking into account the previously stated, that the researcher regarded it fit to utilize the quantitative design for the study.

Population, Sample and Sampling Procedures

The people for this study contained all families in the Kumasi city. The study embraced a comfort inspecting procedure. Respondents were inspected helpfully from their places of living arrangement inside of the city.

Data Collection Method

The study assembled and made utilization of primary data through the organization of organized surveys. Questionnaire was suitable for the study in light of the fact that Saunders et al. (2009) showed that both experiment and case study research techniques can make utilization of this examination instrument. It was likewise utilized on the grounds that information gathered utilizing inquiries can be steady, consistent and has uniform measure without variety. It additionally diminishes predisposition created by the analysts' presentation of issues. The questionnaire was separated into three segments, to be specific, demographics, society of savings
and intentions of funds. There were however some open ended questions to address the challenges of savings.

**Data Analysis and Discussion of Results**

Demographics of the Respondents

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Options</th>
<th>Frequencies (N)</th>
<th>Percentages (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of dwelling</td>
<td>Own house</td>
<td>69</td>
<td>53.5</td>
</tr>
<tr>
<td></td>
<td>Rented apartment</td>
<td>48</td>
<td>37.2</td>
</tr>
<tr>
<td></td>
<td>Rent-free</td>
<td>12</td>
<td>9.3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>129</td>
<td>100.0</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>63</td>
<td>48.8</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>66</td>
<td>51.2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>129</td>
<td>100.0</td>
</tr>
<tr>
<td>Age</td>
<td>18-25yrs</td>
<td>42</td>
<td>32.6</td>
</tr>
<tr>
<td></td>
<td>26-35yrs</td>
<td>54</td>
<td>41.9</td>
</tr>
<tr>
<td></td>
<td>36-45yrs</td>
<td>24</td>
<td>18.6</td>
</tr>
<tr>
<td></td>
<td>46-55yrs</td>
<td>9</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>129</td>
<td>100.0</td>
</tr>
<tr>
<td>Education level</td>
<td>No formal education</td>
<td>6</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>Basic education</td>
<td>3</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>2nd Cycle</td>
<td>9</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>Tertiary</td>
<td>111</td>
<td>86.0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>129</td>
<td>100.0</td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>42</td>
<td>32.6</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>6</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>81</td>
<td>62.8</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>129</td>
<td>100.0</td>
</tr>
<tr>
<td>Dependents</td>
<td>Less than 5</td>
<td>54</td>
<td>41.9</td>
</tr>
<tr>
<td></td>
<td>5-10</td>
<td>57</td>
<td>44.2</td>
</tr>
<tr>
<td></td>
<td>11-15</td>
<td>9</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>16-20</td>
<td>9</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>129</td>
<td>100.0</td>
</tr>
<tr>
<td>Employment status</td>
<td>Full-time</td>
<td>81</td>
<td>62.8</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
<td>12</td>
<td>9.3</td>
</tr>
<tr>
<td></td>
<td>Self-employed</td>
<td>18</td>
<td>14.0</td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
<td>3</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td>15</td>
<td>11.6</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>129</td>
<td>100.0</td>
</tr>
<tr>
<td>Nature of work</td>
<td>Professional</td>
<td>66</td>
<td>51.2</td>
</tr>
<tr>
<td></td>
<td>Clerical</td>
<td>3</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>Administrative</td>
<td>18</td>
<td>14.0</td>
</tr>
<tr>
<td></td>
<td>Sales work</td>
<td>36</td>
<td>27.9</td>
</tr>
<tr>
<td></td>
<td>Transport</td>
<td>3</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>Agriculture</td>
<td>3</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>129</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Source: Field work, 2015.*
The above demographics were selected because previous studies like Schultz (2004), Amu (2008) and Kodom (2013) found them as determinants of savings.

The place of dwelling sought to find out whether respondents lived in their own homes or rented apartment. The analysis indicated that 53.5% of the respondents lived in their own houses, 37.2% rented their apartment, and 9.3% were staying in rent-free apartment which does not belong to them. It was evident that the majority of the respondents were staying in their own houses.

The gender distribution showed that 48.8% of the respondents were male and 51.2% females. This showed a fairly distributed gender for the study.

The age of the respondents indicates that, 32.6% were aged 18-25 years, 41.9% were aged 26-35 years, 18.6% were aged 36-45 years, and 7% were aged 46-55 years. This indicated the youth dominated the study.

From the analysis, 4.7% of the respondents had no formal education, 2.3% had basic education, 7% had a second cycle education, and the majority 86% had a tertiary education (Diploma, HND, Professional certificate, Degrees, Masters, PhD, etc.).

Whether someone is married or not, could influence its savings ability. Out of the respondents, 32.6% were married, 4.7% divorced, and 62.8% were single. The distribution on the number of dependents indicated that, 41.9% had less than 5 dependents, 44.2% had 5-10 dependents, 7% had 11-15 dependents and 7% also had 16-20%. Most of the respondents therefore had up to 10 dependents.

The distribution on employment status indicates that, 68.2% were employed on a fulltime basis, 9.3% were employed on a part-time basis, 14% were self-employed, 2.3% were unemployed, and 11.6% were students. The majority of the respondents were therefore gainfully employed.

Concerning the nature of work, 51.2% were into professional work like nursing, teaching, law, etc. 2.3% were into clerical work, 14% into administrative work, 27.9% were into sales work (trading), 2.3% into transportation business and 2.3% into agriculture businesses.

<table>
<thead>
<tr>
<th>Table 1.2 Determinants of savings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent variable</strong></td>
</tr>
<tr>
<td><strong>(Constant)</strong></td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Place of dwelling</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Dependents</td>
</tr>
<tr>
<td>Income</td>
</tr>
<tr>
<td>Marital status</td>
</tr>
<tr>
<td>Nature of employment</td>
</tr>
<tr>
<td>Employment status</td>
</tr>
</tbody>
</table>

Dependent variable: Percentage of Income Saved

Source: Field work, 2015.

Note:

R represents the correction or relationship between the dependent and the independent variables.

R^2 represents how much of the dependent variable can be explained by the independent variables.

B represents the coefficients of the independent variables.

Sig. represents the statistical significance level of the model (the acceptable level of significance for this research was 0.05).
From the regression output presented in table 1.2, there existed a moderate relationship between the determinants of savings and the percentage of income saved. The result was positive (.640), meaning both dependent and independent variables move in the same direction. As a rule of thumb, any correlation (R) that falls within ±0 to .3 is weak, ±.3 to .7 is moderate, and ±.7 to 1 as strong. The $R^2$ showed that 40.9% change that occurs in percentage of income saved was attributed to or explained by the determinants of savings. The percentage is large enough for conclusions to be drawn as there are macro environmental factors to explain the remaining percentage, but are not the focus of this study.

Although previous studies like Schultz (2004), Amu (2008) and Kodom (2013) altogether found the above 9 factors as the determinants of savings, this study only proved 6 determinants. The regression equation was therefore: $Savings = -4.142 + 0.852(gender) + 0.773(age) + 0.727(place) + 0.659(education) - 0.745(depends) + 0.040(income)$.

The regression analysis indicates that gender significantly impacted savings. The p-value was .026. The coefficient (B) indicates that being a male or female causes a change in savings by 85.2%. The findings by Fisher (2010) showed that women were less likely than men to have saved, while the proportion of the male and female samples reporting to save regularly was similar. On the other hand, some researchers have concluded that no gender difference in savings and investment behavior exists. For example, Zhong and Xiao (1995) found no gender difference in the dollar holdings of stocks.

The coefficient of .773 for age showed that a change in age group impacts the changes in savings by 77.3%. The change was positive indicating the percentage of income increases as age increases and the vice versa. Similarly, Chakrabarty et al. (2008) in their analysis of the saving performance of Australia found the coefficients on age dummies to suggest that households save more as heads become older. This evidence runs contrary to the lifecycle theory of consumption. Lifecycle theory predicts that households should start dissaving as they age. Attanasio (1998) in his examination of the relationship between age cohort and personal savings in the United States using data from the Consumer Expenditure Surveys (CEX) from 1980 to 1991 found that age-savings profile is humped-shaped with the peak of savings occurring around age 57.

Staying in one’s own apartment or renting, or rent-free apartment also significantly impacted the saving ability of respondents. The place of residence determines 72.7% of the changes that occur in the ability of one to save. Quartey and Blankson (2008) observed that in Ghana, those living in rented accommodation are more likely to have financial savings perhaps to pay for rent advance (deposit) or to put up their own houses than those living in their own houses.

Level of education also significantly impacted the ability of one to save. The coefficient of .659 indicates that moving from one educational level to another increased the chance of saving more by 65.9%. This was positive, meaning as people climb the academic ladder, they have a higher tendency to save, and the vice versa. Schooling may enable people to appreciate the finer things in life or to be more efficient in developing consumption decisions. It is possible that people with the same income can purchase equally good investment data and advice. However, it would seem that an educated person can do whatever the less analytical person can do and more (Solmon, 1975).

The number of dependents one has significantly impacted the savings ability. The coefficient was -.745, indicating that the number of dependents had a negative relationship with the ability to save. So as the number of dependents increases, the ability to save was also reducing, and the vice versa. All things being equal, expenditure increases when the number of dependents increases, but with basically same income level. This therefore reduces the amount that would be available to save. Elfindri (1990) conducted a study to examine the demographic impact of family size on household savings in some part of central Sumatra in Indonesia. Using data from the 1987 Indonesian census, the results from the regression analysis show that the size of the household
and the number of children at school going age negatively affect household savings. In contrast to the findings of Elfindri, Browning and Lusardi (1996) who analysed micro theories and data on household savings found that household size can have a positive effect on savings according to economies of scale. However, the composition of the family, rather than the size of the family per se, has a greater impact on savings.

The level of income one receives also significantly and positively impacted the level of savings. Although this study showed a minimal impact of 0.04 (4%). The small level of effect could be attributed to the fact that, a large number of respondents refused to disclose their source and amount of income received. They considered it too sensitive a question to be answered. However, this result showed at least that, when one’s income increases, the ability to save also increases, and the vice versa. The Keynesian Savings function and the Friedman Permanent Income postulate a positive relationship between savings and income. Collins (1989) examined the saving behaviour in nine Asian developing countries plus Turkey since the early 1960s. In the midst of all the differences in savings rate and savings behavior, the results from all the countries confirmed that increase in income have a positive effect on household savings.

Although marital status, nature of employment, and employment status affected the savings pattern of the individual, these relationships were not statistically significant at 0.05. However, Quartey and Blankson (2008) examined that majority of the households who save were engaged in agriculture but their mean savings were low. However those engaged in finance, insurance, real estate and business services had the highest mean current value of savings. Unlike Ghana, the findings from Dupas and Robinson (2013) work show that in Kenya, potential savers were market vendors, bicycle taxi drivers and self-employed artisans who did not have a savings account but were interested in opening one.

**Culture of Savings in Kumasi Metropolis**

From table 1.3 analysis was done using mean, standard deviation, and t-test. These sections of the questionnaire sought to give respondents the opportunity to show by indicating on a five point Likert scale their level of agreement with the statement provided. They were to use a scale of 1=strongly agree, 2=agree, 3=neutral, 4=disagree, and 5=strongly disagree.

A statistical test of the mean was done to decide whether the population considered a particular variable to be important or not using t-test. The one sample t-test was used to ascertain the relative significance of the variables. For a single sample test, the hypothesis was set as Ho: U > or = Uo, Ha: U < Uo. With Ho representing the null hypothesis, Ha representing the alternative hypothesis and Uo representing the hypothesized mean (in this case 2.5).

The mean ranking (in descending order) of each criterion was compiled to in order to articulate the decisions that the respondents expressed. Moreover, the mean for each variable with its corresponding standard deviation are presented. In this research, the higher ratings of 1 and 2 were chosen for the rating scale as ‘strongly agree’ and ‘agree’ respectively while the Uo was set at 2.5. 95% was set as the significance level in accordance with the levels of influence (Field, 2005).

Standard Deviation (SD) provides an indication of how far the individual responses to a question vary or “deviate” from the mean. SD tells how spread out the responses are; are they concentrated around the mean, or scattered far and wide? SD generally does not indicate “right or wrong” or “better or worse”, so a lower SD is not necessarily more desirable. In a normal distribution, 68.26 percent of all scores will lie within one standard deviation of the mean; 95.34 percent of all scores will lie within two standard deviations of the mean; and 99.74 percent of all scores will lie within three standard deviations of the mean.
Table 1.3 Culture of savings in Kumasi metropolis

<table>
<thead>
<tr>
<th>Culture of savings</th>
<th>Test Value = 2.5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
</tr>
<tr>
<td>I prefer to save more for the future</td>
<td>1.7436</td>
</tr>
<tr>
<td>I plan my life ahead of time</td>
<td>1.7692</td>
</tr>
<tr>
<td>Saving money is a virtue</td>
<td>1.77</td>
</tr>
<tr>
<td>I pay close attention to how much money I spend</td>
<td>1.9744</td>
</tr>
<tr>
<td>Before I buy something, I compare prices on similar items</td>
<td>2.0769</td>
</tr>
<tr>
<td>I save money for things I might need later</td>
<td>2.3077</td>
</tr>
<tr>
<td>I live more from day to day</td>
<td>2.8205</td>
</tr>
<tr>
<td>One should never be in debt</td>
<td>2.9487</td>
</tr>
<tr>
<td>I prefer to spend my money and enjoy life today</td>
<td>3.9744</td>
</tr>
</tbody>
</table>

Source: Field work, 2015.

From table 1.3, respondents agreed to 7 out of 9 items, however, only the first 6 were statistically significant at 0.05. The respondents agreed that they preferred to save more for the future. The mean was 1.7436 (approximately 2=agree). From table, 34.3% (the minority), saved up to 10%. The remaining respondents (the majority) saved up to 70%. 17.1% saved from 11-20% of their monthly income, 20% saved from 21-30% of their income, 5.7% saved 31-40%, 17.1% saved 41-50% of their monthly income, 2.9% saved from 51-60% of their income, and 2.9% also saved from 61-70%.

As shown in table 1.3, the respondents plan their life ahead of time. By planning ahead of time means their prepared also for future financial needs through savings. They also agreed that savings is a virtue. The ability to save comes with financial discipline, and the respondents agreed they pay close attention to how much they spend. This is to enable them increase the leftover for savings. Before purchase is made, respondents compare prices on similar items. This is to enable them get the best possible value for their money spent. They saved money for future needs like purchasing car, building, hospital bills, school fees, etc.

The respondents were indifferent that they lived more from day to day. Meaning they were indifferent that they didn’t plan towards the future. But this was not statistically significant at 0.05. They were also indifferent that one shouldn’t be in debt. The respondents disagreed they preferred to spend money and enjoy life today.

Although this current study showed a good savings culture among the people of Ghana, other studies proved otherwise. Savings as a percentage of Gross Domestic Product (GDP) in Ghana is low as compared to that of several African countries. It averaged 37.4% in Botswana, 21.4% in Cameroon, 21.6% in Nigeria but only 6.4% in Ghana between 1980 and 2001 (World Bank, 2003). The apparent low savings in Ghana has been attributed to political as well as macroeconomic factors (Zorklui & Barbie, 2003).

Summary of Findings, Conclusion and Recommendations

Determinants of savings

Multiple regressions was conducted to ascertain the effect of the nine independents variables on savings pattern. The study found six of them to have been the determinants of savings. These were gender, age, and place of dwelling, education, dependents and income.
Culture of savings in Kumasi Metropolis

Contrary to other findings, this study found a relatively high level of savings culture among the people of Kumasi metropolis. Respondents preferred to save more for the future, they planned life ahead of time, saving money was a virtue, respondents paid close attention to how much money they spend, and before they purchased anything, they compared prices on similar items.

Conclusion

The study sought to assess the determinants and consequences of low savings in Ghana, but with special focus on Kumasi metropolis. A thorough review of literature was conducted, to have a better appreciation of concepts understudy. After the study, six major factors determined savings ability in Ghana. These were gender, age, and place of dwelling, education, dependents and income. There was a relatively high culture of savings in the metropolis. Respondents preferred to save more for the future, they planned life ahead of time, saving money was a virtue, respondents paid close attention to how much money they spend, and before they purchased anything, they compared prices on similar items. The major reasons of savings as identified from the study were, against unforeseen contingencies (illness, home repairs, etc., for children, to invest in business, to enjoy a gradually improving standard of living over time, and to be financially independent and to have the power to do things. The factors that limited savings ability were external family pressure and high dependency; inadequate income; unexpected occurrence in course of the month; high cost of living in Ghana; inflation and depreciation of the cedi; unlimited needs from little income; low productivity; financial indiscipline; lack of education on financial savings and benefits; unemployment; and business investments.

Recommendations

After undertaking the study, the following recommendations were made;

Lack of confidence in financial institutions also affected the abilities of people to save. This is as a result of the fact that there are so much proliferation of savings and loans and microfinance institutions, with some operating even without the due permit. And no time, some of these institutions collapse, causing people to lose their savings. Noble Dreams microfinance, Eden microfinance, Mizpah microfinance and Atobiase rural Bank have collapsed in recent years. It is recommended that, governing bodies like the Bank of Ghana, must take drastic measures to close down all these illegal financial institutions in the system that is dragging the reputation of the rest into the mud. The macro environmental factors like inflation, currency depreciation, unemployment, etc. also affected ability to save. To the political leaders, it is recommended that measures be put in place to improve the macro environmental factors. This would intern affect savings ability positively. Age was found to be a significant determinant of savings. As people advance in age, they turn to have the tendency of saving more. It is therefore recommended to the financial institutions to develop financial or savings packages that would attract the aged. On the other hand, financial products must be tailored to encourage the youth to increase their tendencies to save since it was found that younger people saved less.

Gender also significantly affected savings, and therefore, promotional packages must not be on a mass approach, but tailored to a specific gender. With that, the financial institutions could maximize the returns on clients' savings.

The macro environmental factors like inflation, currency depreciation, unemployment, etc. also affected ability to save. To the political leaders, it is recommended that measures be put in place to improve the macro environmental factors. This would intern affect savings ability positively.
Limitations of the Study

The study was limited to only selected families in Kumasi, the second largest capital of Ghana and could not cover the entire country due to funds and time constraints.

References

TEXILA AMERICAN UNIVERSITY

Lot A, Goedverwagting, Sparendaam, East Coast Demerara, Guyana, South America.
Telephone: (+592) 2225224 / (+592) 2225225
E-mail: ejournal.assist@tau.edu.org