PETTY CORRUPTION IN THE HEALTH SERVICES IN DAR ES SALAAM AND COAST REGIONS.

A RESEARCH REPORT SUBMITTED TO YOUTH ACTION VOLUNTEERS.

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List of Abbreviations and Acronyms

1. ADOs = Assistant Dental Officers
2. AMOs = Assistant Medical Officers
3. FGDs = Focus Group Discussions
4. MUHAS = Muhimbili University of Health and Allied Sciences
5. REPOA = Research on Poverty Alleviation
6. ToR = Terms of Reference
7. TI = Transparency International
8. URT = United Republic of Tanzania
9. YAV = Youth Action Volunteer

Acknowledgement:

This study, on factors which influence petty corruption in the health services in Ilala, Kibaha, Kinondoni and Temeke districts, was commissioned by YAV (Youth Action Volunteer). The authors acknowledge with gratitude the interest that YAV showed in the proposal that the authors submitted.

Special thanks are due to the Executive Director, Mr.Irenei Kiria, for both his assistance and patience that enabled fruitful completion of the assignment.

The main interest of the authors stems from their professional interest in health care ethics. The first author is on the team of facilitators in courses of Medical Ethics for undergraduates and Bioethics for postgraduates at MUHAS. It was hoped that the research experience would enrich his repertoire of ethics cases for use in his teaching. To this end this expectation has been realized, and much gratitude is owed to YAV for the opportunity to undertake this study.

The authors would also like to record their gratitude to the study respondents – health workers, patients, and community members – for spending their precious time in answering questions posed to them. Municipal/ district health administrators and Ward Executive Officers are all acknowledged for their logistical support.

Last, but not least, the study team is grateful to the research assistants – Dr. Seni Jeremiah, Dr. Lazaro Mbale, Ms.Adella Sariah, and Ms. Lilian Mretta.

Executive Summary

This is a report of a study which was commissioned by Youth Action Volunteers, a civil service organization which operates in areas of social development

Corruption is a concern in all sectors, but it is an especially critical problem in the health sector. This is because it reduces the resources effectively available for health; lowers the quality, equity and effectiveness of health care services; and increases the cost of provided services. It undermines equity of access to health care by discouraging people who have to pay in order to use health services. Ultimately it has a corrosive impact on the population's level of health.

The Warioba report (URT 1996) revealed that corruption in the health sector is a serious problem. The Terms of Reference for the proposed study (YAV 2007) however, state that there is lack of current research on corruption in health service systems, particularly in Dar es Salaam and Coast regions which constitute the organization's sit of operation. Research-based information is needed to provide an understanding of the factors associated with corruption and to strengthen the mechanisms for preventing and combating corruption in the health services system.

The broad objective of the study was to examine the state of corruption in the health service provision in the four districts in Kinondoni, Temeke, Ilala and Kibaha, and to make recommendations that will reduce it.
Specifically the study sought:-

1. To examine awareness and roles of service users in the corruption that takes place in public health facilities.
2. To examine the service users' experience and practice of corruption in public health facilities.
3. To examine the effects of corruption on the health care seeking behavior of service users
4. To examine the awareness of, and involvement in corruption by service providers
5. To make recommendations of effective ways of preventing and combating corruption in the public health services.

    a) A multi-method approach was used. It comprised:
    b) A survey of community health health workers in selected health facilities in the districts of Ilala, Kinondoni, Temeke and Kibaha;
    c) A survey of in-patients and ambulatory patients in the same selected health facilities
    d) A survey of community members in the catchments of the selected health facilities;
    e) Two Focus Group Discussions involving men and women in each district;
    f) Mystery Clients who were primed to seek health care in each of the major public hospitals in these districts.

The results from each of these components are presented and discussed in separate chapters. These are then synthesized in another chapter in accordance with the requirement that results of a multi-method study have to be triangulated.

These results show how entrenched corruption in the public health services is, in that it involves all cadres of health workers whose motives are varied, that the same health workers who demand bribes from patients are often required to pay bribes both within their own sector in order to obtain favourable postings or opportunities for further studies, and to other sectors in order to obtain different services.

Patients, their relatives and the general population are not mere objects who suffer the consequences of the corrupt system, rather they also sustain the system by offering, even when not asked for bribes because of the social norm which appear to have emerged, that one cannot obtain high quality care unless one knows or is known to the health workers, failing which one has to pay a bribe as an incentive for the health workers to do what they were trained to do, and are paid to do. This social norm is associated with mutual definition of situations in which bribes are deemed to be appropriate.

Both health workers and the general public recognize the negative impacts of corruption but feel trapped in a system from which they cannot escape. Thus not only do health workers who are not inclined to take bribes find themselves unable to take action against their colleagues who do, relatives of patients will fail to pay up and fatalistically accept the consequences, which include deaths of their relatives for lack of timely medical or nursing interventions due to non payment of bribes.

Three recommendations are derived from this study. The first is for strategic approaches to combating corruption in a systemic manner, and involving forging alliances with other players taking into account the recent awakening in the country that people engaged in corrupt practices ca actually be held to account. The second is for formulating prototype policies which are realistic and costed. These should serve as the advocacy material with which to engage the Government in all its organs. This should be coupled with public education which could be facilitated by adapting and improving the model which Haki Elimu has established. The third is for a follow up study which is well funded and can meet all the criteria for sound social scientific surveys, in order to validate the indicative findings of this study, and provide the necessary statistical evidence for associations and correlations in order to guide highly focused measures to be taken in specific health service operations.

CHAPTER 1: BACKGROUND TO THE STUDY

1.1. Introduction

This is a report of a study which was commissioned by Youth Action Volunteers, a civil organization which works to improve policy and governance of health sector in Tanzania This introductory chapter reviews the objectives of the study its design, and how it was actually conducted.

1.2: Overview

There is no doubt that corruption is rampant in all sectors of the economy and public services in the country. It has become part and parcel of daily life in many countries including Tanzania. According to Warioba report (URT 1996) there is evidence that even those officers of the government organs vested with the responsibility of administration of justice, namely; the department of national security, the police, the judiciary and the anti-corruption bureau are themselves immersed in corruption. Consequently, as years go by, both people who give bribes and those who receive them have accepted it as normal behavior. And a significant proportion of the population believes that without bribing, they will not get fair treatment. The widespread nature of real corruption is evidenced by a variety of terms that are used to connote 'bribes'. The terminology and the way it changes over time makes corruption more socially acceptable. There are three Kiswahili terms that are commonly used to mean "corruption" and/or "bribes." These are *rushwa*, *hongo* and *mulungula.* These terms have been in use for many years, and they continue to be used today. However, those who solicit and receive bribes do not use these words. They use other terms that are more polite. Such terms include *kitu kidogo (*something small), *chai* (tea) *and mshiko* (something that greases the palm)

Corruption is a concern in all sectors, but it is an especially critical problem in the health sector. This is because it reduces the resources effectively available for health; lowers the quality, equity and effectiveness of health care services; and increases the cost of provided services. It undermines equity of access to health care by discouraging people who have to pay in order to use health services. Ultimately it has a corrosive impact on the population's level of health.

The health sector appears to be particularly vulnerable to corruption. It is marked by a high degree of imbalances of information and an inelastic demand for services.

The high degree of discretion given to providers in deciding on what constitutes appropriate care for patients puts patients in a vulnerable position. In most countries health professionals have assumed a cultural role as trusted healers who are above suspicion. Providers are not expected to have conflicts of interest that may affect their judgment.

Services are also highly decentralized and individualized making it difficult to standardize and monitor service provision and procurement. Limited regulatory capacity in many developing countries adds to the problem

1.2 Corruption in the health sector in Tanzania.

In Tanzania there is both petty and grand corruption in the health sector, and the poor are worst affected by the resultant increase in costs and reduced quality of service. Corruption in the health sector takes different forms and health workers collaborate in facilitating it. Paying bribes to get privileged access to public care is one of the common forms of corruption. In some countries, such bribes are socially acceptable and excused as a way to compensate poorly paid, public sector health professionals, or as an understandable response by people who may be in dire need of care. When such bribes become 'institutionalized', however, it creates a situation in which wealthier people are likely to get better attention than those who are poorer and unable to pay bribes.

According to Warioba report (URT, 1996), many people complained that even after paying the preliminary fees so that a patient can see a doctor, there are many other unofficial conditions for seeing the doctor, which are advised by the nurses and attendants. For instance when it is the patient's turn to see the doctor, he may be told that the doctor is out when he actually is in his room.

The main causes of corruption in the health sector include: chronic shortages both human and non-human resources; excessive red tape; poor salaries; poor management and supervision; lack of information for clients (Mwaffisi, 1999).

According to Warioba report (URT 1996), health workers claim that poor salaries are the main cause of corruption in the health sector. However, Warioba's commission was of the opinion that the real problem is not salaries, but the collapse of health professionals' work ethics.

2.0 The Research Problem:

The Warioba report (URT 1996) revealed that corruption in the health sector is a serious problem. The Terms of Reference for the proposed study (YAV 2007) however, state that there is lack of current research on corruption in public health service systems, particularly in Dar es Salaam and Coast regions which constitute the organization's sit of operation. Research-based information is needed to provide an understanding of the factors associated with corruption and to strengthen the mechanisms for preventing and combating corruption in the health services system.

4.0 Review of the literature.

A systematic review of the literature was undertaken in order to highlight the gaps in knowledge which the study would seek to fill.

A number of research reports and other papers which address the issue of corruption in different sectors of the Tanzania economy including the public health services were identified and reviewed. They indicate that corruption in the public services is fueled by social, cultural, political and economic factors within the society. One of these papers (Kamuzora 2004) advocates for examining the phenomenon of corruption in the health services within this wider context. This review as well as the study itself adopt this broad perspective even though the focus remains on corruption within the public health services.

The first, and arguably a landmark report on corruption in Tanzania, is the famous Warioba Report, formally known as the Repor
t of the Presidential Commission of Inquiry against Corruption (URT 1996). The report provides the findings of the investigations carried out by a Commission chaired by Judge Warioba. The Commission was appointed by President Benjamin William Mkapa. It examined the phenomenon of corruption in all the sectors of the economy, including the health sector.

The highlights of the findings of the Warioba Report about corruption in the health services are:

- Corruption was reported to be rampant in all sectors of the economy, public services and politics in the country;
    - Specific examples of corrupt practices were given from the sectors of Education, Health, Home Affairs, Finance, The Judiciary, Office of the Attorney General, Ministry of Industries and Trade, Ministries of Works and Communications, Employment, Ministry of Labour, Lands and Housing, Natural Resource and Tourism, Media Institutions, Energy, Minerals and Water, and in Local Government.
- The growth of corruption in the 1990s was said to have been heightened by the close relationship between politicians and government leaders with corrupt businessmen.
- Corruption became widespread beginning with the economic crisis of the early 1970s that forced the Government to take various political, legal and economic measures to combat the situation. These measures, in turn, created loopholes for corruption.
- With specific reference to public health services:
    - The cost sharing policy which was instituted to overcome the burden of provision of free public health services was not well understood, and patients were required to give bribes so as to qualify for service.
    - Under-funding of health services resulted in shortage of medicine, equipment and essential working gear. The little medicine was given to patients after they had given a bribe.

- Allowing health workers to establish their own private health facilities to augment the poor salaries which did not enable them to meet basic needs. Some took secondary jobs in private hospitals. Consequently unfaithful employees enhanced their private financial interests in total disregard of the interests of patients.
- The report singled out Nurses and attendants for creating conditions and procedure for providing services which allowed them to solicit for bribes from patients.
- Poor leadership and supervision by managerial staff that spent much time in their own private practice. This left them with little time for the administration of government hospitals. Consequently the subordinates operated as they wish, including harassing patients, organizing gangs for selling medicines and demanding bribes from patients.
- Ethics which govern the medical and nursing professions were no longer valued; greed for money became the criterion for delivery of services.
- The patient flow at Muhimbili Hospital is described in order to show the typical loopholes at each stage for corrupt practices. The report asserts that
    - *"The situation is worse for those without the ability to bribe because they are not given the service of the required standard. Where such service is given, this is done reluctantly and accompanied by derogative pronouncements contrary to the vows taken to serve patients with all their hearts." (Op.cit. p. 449)*

This report makes a distinction between grand and petty corruption. Petty corruption is fueled by low incomes of the civil servants. It allows them to make ends meet. This form of corruption however is very rampant, and is what greatly bothers ordinary people. Grand corruption in turn is practiced by high level leaders and senior public servants. According to the report this form of corruption is due to excessive greed for money and wealth.

It is noteworthy that the Commission's investigations did not constitute social scientific research, and the Warioba report is not a formal research report. The investigation did not follow the tenets of social scientific research. People with information of relevance to the subject matter were invited to testify before the Commission. They did not constitute a representative sample of the Tanzanian population. Even the health workers who appeared before the Commission did not constitute a random sample of health workers or managers.

Another important study was conducted by Kamuzora, and is the subject of two published papers (Kamuzora 2004, 2005). The study focused on corruption in public health systems in Tanzania. The first paper gives an account of the study and major findings, while the second paper discusses strategies for preventing corruption.

The study covered 16 hospitals in six regions. These were selected using different sampling procedures, both random and purposive. It employed qualitative and quantitative research methods:

> *"Quantitative data came from questionnaires administered with users (outpatients through 'Exit Interviews,' and outpatients), and providers (health workers) of hospital services. Qualitative data came from in-depth interviews with 43 people including the hospital managers, branch leaders of the Trade Union of Government and Health Employees (TUGHE), and regional government administration offices." (Kamuzora 2004: 34).*

The quantitative component of the study had three samples of health workers, outpatients and inpatients. The sample sizes involved were 156, 160, and 208 respectively. How these sample sizes were determined and the sample populations actually selected are not described.

Highlights of the findings are:

- Corruption was reported as taking place at almost every stage in the service seeking process. Service areas which were ranked highly on the basis of the proportion of respondents' responses are surgical theatres (50%), laboratories (44%), X-Ray (42%), medical records – reception (38%), labour wards (34%), consultation (31%), and maternity wards (28%).
- Health workers used a number of loopholes, or devised various tactics during the service delivery to exact bribes from patients: These included unnecessary delays in service delivery – reported by 34% of respondents, taking advantage of the shortage of material and human resources – (28%), taking advantage cost sharing measures – (16%), taking advantage of patients' ignorance of service delivery procedures – (11%), and improper provision of services – (10%).
- The main reasons why health workers take bribes were found to be"
    - Low salaries and inadequate incentives – mentioned by 81% of the respondents;
    - Greed by health workers – (34%);
    - Patients entice staff to accept bribes – (24%)
    - Perception by health workers of corruption as the norm – (18%).

It is noteworthy that Kamuzora's findings corroborate those of the Warioba Report, and they advance knowledge about corruption in the health services by indicating the magnitude of corruption in various service areas, as well as the reasons for corruption. The main drawback of the method for ranking corrupt service areas and reasons for corruption is that it is the sum of the numbers of respondents in different sub samples who may not have the same level of knowledge of health service delivery.

Kamuzora's second paper (Kamuzora 2005) reports on the strategies for combating corruption. The main respondents whose responses provide the basis for this report are

health workers because *"the study considered health workers to be more knowledgeable about the kind of measures introduced" (Op.cit. p. 116).*
Five main anti-corruption measures were reported:

- Workers awareness raising meetings – reported by 38% of health workers;
- Posters indicating that corruption is a menace – 36%;
- Staff required to wear name tags – 33%;
- Warning and punishing corrupt individuals – 17%;
- Putting up suggestion boxes for patients to report corrupt health workers – 16%.

Measures which were recommended by health workers for combating corruption included:

- Improving availability of medical equipment and supplies – mentioned by 27% of health workers;
- Improving staffing levels and recruiting qualified personnel – 26%;
- Improving the salaries of health workers – 25%;
- Strengthening inspection of hospitals and supervision of health workers – 19%;
- Putting in place sound incentive systems – 12%.

Kamuzora argues that underdevelopment and economic liberalization are the root cause of corruption. This argument however is not borne out by history, especially when he takes the emergence of the New Right in Britain and in the USA in the 1980s as the genesis of this economic liberalization which spurred corruption. Many analysts (URT 1996, Shellukindo & Baguma 1993, Yahaya 1993, Aboud 1993) however have gone back to at least a few years after independence, and Ake (1993) has even gone back to the colonial period.

Claude Ake's paper (Ake 1993), merits a brief review because it has a unique perspective. The paper notes that the logic and demands of the colonial state were so different from those of the indigenous societies, that it was disconnected from their experience. In essence Ake argues that the colonial government leaders cared less about the wellbeing of the indigenous people. They (the colonial administrators) promoted and defended they own interests for power and wealth.

With independence came national leaders but they did not transform the state in accordance with nationalist aspirations. They in effect inherited it and they took over the role of the colonial authority. This, according to Ake, isolated them, and they became increasingly dependent on force to suppress a population that was inclined to revolt against what they perceived as their betrayal.

> Under the circumstances, argues Ake, the independent state did not really become the quintessential public institution. It was at best the state of some, and its administrative apparatus was not really a public service.

Thus, Ake argues, corruption in public service is not a problem of psychological dispositions, character deficiency, or even one of morality. Rather it is a problem of the character of the state and its relation with the people, a relationship which reproduces not a public but a plurality of publics that struggle for the appropriation of state power. It is also a problem of conflicting claims for the legitimacy of the political and administrative leadership.

For Ake the way forward lies in creating and developing a public to which the state is responsive. Only then will the notions of public service, civic virtues and political morality make sense. He contends further that the pressures of economics on public servants should be removed. It is unreasonable to expect much from public servants under the current economic realities. The wages of junior public servants lag far behind what is necessary for self-reproduction. Consequently they have to reproduce at lower levels of welfare, while others bridge the gap between wages and self-reproduction by keeping their wives in the village as farmers, some become urban peasants cultivating small plots, while others do so by using their official positions as economic leverage. This is survival strategy; it is not so much as a case of immorality as a clash of moralities. Even senior public servants are under economic pressure to abuse office as they struggle to maintain living standards in the face of declining real incomes. He says that

> *"Those who hang on stubbornly to their integrity can expect that poverty and its indignities will be staring them in the face when they retire. Worse still, not many people, including their relatives, are likely to honour them for their virtue" (Op.cit.p.22).*

Shellukindo and Baguma writing within the Tanzanian context identified three factors which influenced corruption in the civil service: the political factor, the economic factor, and the cultural factor.

With specific reference to the political factor, they trace its influence to 1964 when it was made obligatory for civil servants in the staff grade to become members of the ruling party. Politics became the most important state activity and entrenched political supremacy over administrative values. As a consequence bureaucratic principles were flouted in order to facilitate political decisions. Senior civil servants who acquiesced to the demands of political leaders driven by gluttony were seen as the most cooperative, while those who resisted corruption were seen as dangerous. In good time, according to these authors, corruption became habitual and percolated through out the system.

By the economic factor Shellukindo and Baguma refer to what they regard as the sheer economic need for survival in the face of the ever worsening economic situation of the African economies. This has led to the erosion of the official incomes public officials, and has triggered a chain of negative responses in order to survive. They assert that:

> *"One has to use the very system which denies one adequate income, to compensate oneself. Given one's position and access to illegal (unethical) opportunities for extra income, there evolves operational behaviours by members of the Civil Service, such as favoritism in the offer of tenders, contracts, over invoicing of stores, engaging in sideline business during official hours,*

moonlighting , embezzlement of public funds, use of public property for personal use, etc." (Op. cit. p.37)

The cultural factor, in turn, has to do with the cultural bonds to which public officials are tied, and refers to the cultural obligations they have. They are constantly called upon to violate laid down rules, and hence ethical standards, in order to accommodate demands arising out of their cultural attachments. Shellukindo and Baguma maintain that:

"The moment therefore one becomes a senior public official, his kinship and tribesmen will come to look for favours. If he clings on the established procedures of operation, and thus refuses to accommodate their demands and expectations, he will be cursed by the members of society for betraying their trust, and his acceptability by them will be in doubt. Hence in order not to betray the trust of his tribesmen, he may try to manipulate the procedures and the system so as to accommodate their demands" (Op. cit. P.37).

Another study of corruption in the Tanzanian public health services is that by Makeula which was conducted in the health facilities of Kilombero district in 1996 – 1997 (Makeula 2000). It sought to identify the causes of corruption. Participants in the study were health workers of all cadres working in public and private health facilities.

The report provides information on the perception of the health workers about the causes of corruption, and the major ones are reported to be:

- Inequity in promotion
- Blind schemes of service
- High expectation of health workers
- Low income of health workers
- High living costs
- Poor working environment
- Poor leadership at the workplace.

The main drawback of the report is that it does not explain how each of these causes actually operates. Even though some recommendations are given for the fight against corruption these are not directly linked to the identified causes. For instance he recommends that Health/Medical Association should act as pressure groups for health workers as one approach towards reducing corruption, and yet health care ethics are not an issue which is discussed in the paper.

There is also an interesting paper by Kinemo (Kinemo 2000). The paper is an analysis of the relationship of corruption with the health sector reform, and appears to be informed by personal experience and reflection rather than an empirical study of the phenomenon.

The paper examines corruption within a legal and ethical perspective. It asserts that Tanzania has a specific statute which proscribes corruption both in government and in private dealings. It is a criminal offence for a doctor or nurse to solicit, receive or agree to receive any gift, loan, fee, reward, consideration or advantage as an inducement. It also

prohibits corrupt transactions with agents or by agents in order to show favour or disfavour in relation to a doctor's and nurse's affair. He observes however that this legislation is silent about tips or 'speed money'. Besides this legal requirement not to engage in corrupt practices the paper asserts that doctors, nurses and pharmacists are governed by professional ethics which discourage doctors, nurses, and pharmacists and others in the profession from engaging in corruption.

Concerning the health sector reforms the paper notes that these were initiated as a response to the poor performance of the health sector whose manifestation included corrupt practices. The reforms sought to create conditions which facilitate adherence to procedures, rules, and regulations within the health sector in a transparent manner. The paper notes however that the health sector reforms as such did not put in place measures to curb corruption, rather, some of the measures instituted as part of the reform actually created loopholes for corruption. These include allowing doctors who are employees of the government to own private health facilities, and the cost sharing system whose administration allows a measure of discretion in collecting cost sharing revenue.

The ethical perspective which Kinemo operates with is an important facet especially in the health services which are bound by ethics. Corruption is unethical behaviour. This is also the position which Yahaya takes (Yahaya 1993). He maintains that when unethical behaviour becomes institutionalized it acquires a degree of acceptance, and becomes the standard of behaviour for accomplishing any goal. Officials and clients operate within the same unethical process. When services are rendered there is an illegal standing fee, and these illegal takings are shared up and down the hierarchy.

This is also the view expressed by Mohamed Aboud in his paper that examines what appeared to him as an ineffective watch dog role played by organizations in Tanzania (Aboud 1993). He asserts that a war against corruption cannot succeed if the community has come to accept corruption as a way of life. Conditions have to be created to support the training of public officials in ethics, and for the training to have impact in their professional behaviour. He contends that it is futile to teach ethics unless they are practiced in society in general. There is no need to teach ethics of good government if images of good government are not demonstrated.

The Afrobarometer Briefing Papers, Numbers 33 and 34 (REPOA and MSU 2006) are rich sources of information about corruption in Tanzania. REPOA is the Tanzanian collaborator in this international research enterprise which has been tracking public attitudes about the prevalence of corruption in Tanzania, and their ratings of the government's efforts to combat this problem since 2001.

Studies were conducted in 2001, 2003, and 2005. The 2005 study is the subject of the two briefing reports referred to above. It was carried out from July 18th to August 13th, 2005. It was based on a nationally representative random sample of 1,304 Tanzanians – 650 men and 654 women – above the age of 18, and was conducted in all regions of the country.
Highlights of the findings include the following:

- In 2003, 80% of the respondents thought that “some”, “most” or “all” police were involved in corrupt practices, but this dropped to 72% in 2005.
- In 2003, 58% of the respondents thought that some/most/all elected officials engaged in corruption, but in 2005, only 38% thought MPs were corrupt, and that 44% thought elected local government officials were corrupt.
- 58% of the respondents thought that health workers were corrupt. No similar figures are reported for the previous years.
- 39% of the respondents reported that “some” health workers are involved in corruption, and that 20% believe that “most” or “all of them” are involved in corruption.
- 29% of the respondents reported that they had encountered demands for illegal payments at their local clinic or hospital.
- 15% of the respondents reported that they had actually made such payments.
- 7% of the respondents reported that they had to make illegal payments “once or twice”, and 5% did so “a few times”, while 3% said they were forced to do so “often”.
- 18% of the respondents reported that they had “no experience with this in the past year.”
- 73% of the respondents thought that an official who demands an additional payment for some service that is part of his job is violating his responsibility to the public.
- When asked to identify up to three of the country’s most important problems that the government should address, only 3% of the respondents named corruption as a priority problem.

An important contribution of this report to knowledge about corruption in Tanzania generally, and in the health service in particular is the distinction between respondents’ perception of corruption and their actual involvement in corruption. Perception can be formed in response to rumours or media coverage and may exaggerate the magnitude of the problem. This appears to have been the case when compared with respondents’ own experience of being asked for and giving bribes.

Another important contribution of the report to knowledge is its exploration into the definition Tanzanians have of corruption in the public service. Tanzanians are reported to eschew corruption in public services. The survey asked about three potential acts by government officials, and invited respondents to indicate whether they considered the acts “not wrong at all,” “wrong but understandable”, or “wrong and punishable.” The acts in question were

- Locating a development project in an area where his friends and supporters live;
- Giving a job to a family member who does not have the necessary qualifications;

- Demanding a favour or additional payment for some service that is part of his job.

The findings show that 55 percent of the respondents stated that locating a development project as indicated was wrong and punishable; while 34 per cent said it was wrong but understandable. Only seven percent said it was not wrong at all. Some 70 percent said giving a job to an unqualified family member was wrong and punishable; while 23 per cent said it was wrong but understandable. Only four percent said it was not wrong at all. Another 73 per cent said demanding a favour or additional payment for some service that is part of the official's job was wrong and punishable. Some 21 per cent said it was wrong but understandable; while a miniscule one per cent said it was not wrong at all. The conclusion is clear:

> *"Clearly, Tanzanians for the most part share international perceptions of how public officials are supposed to behave in executing their responsibilities. Traditional cultural practices, whether of gift giving or other varieties, do not, in the eyes of the Tanzanian public, entitle government officials to take advantage of them" (REPOA & MSU 2006: 7).*

A major weakness of the reports is that they do not identify the specific sections of the health service in which respondents were asked for, and those in which they actually gave bribes. Targeted interventions against corruption within the health services need to be informed by such knowledge.

It would also be desirable to have information about the profiles of the peoples who were asked for, and those who gave bribes. These might be the most vulnerable groups who could not seek care from private health services.

The papers deal with what the Warioba Report categorizes as petty corruption. Admittedly this is the type of corruption which arouses public discontent. The papers do not explore for other forms of corruption which might be ravaging the public health services.

The Global Corruption Report 2006 of Transparency International (TI 2006) is another interesting source of information about corruption in the public health services generally, and is of relevance to Tanzania. Tanzania was not among the countries for which the report has country reports. The report is particularly useful for the contribution it makes about the forms that corruption takes in public and private health services, its perpetrators who include drug companies and manufacturers of medical equipment and for the factors that make the health sector prone to corruption.

The report defines corruption as the "abuse of entrusted power for private gain." Examples in the health services include "bribery of regulators and medical professionals, manipulation of information on drug trials, the diversion of medicines and supplies, and corruption in procurement." The perpetrators of corruption in the health services in the health sector include private actors and medical professionals. In countries like Tanzania which the report categorizes as developing or transitional economies, corruption in health

systems is largely in the form of informal or illegal payments for services. The next is theft by employees, self-referral of patients, absenteeism, and the illicit use of public facilities for private practice. There are also kickbacks and graft in the purchase of medical supplies, drugs and equipment. Prevalent abuses relate to counterfeit drugs, selling faulty equipment, misrepresenting the quality or necessity of medical supplies, and conflict of interests between purchasers, providers, suppliers and researchers.

According to the report corruption in the health sector prevails because of an imbalance of information. Health professional have more information about illness than patients, and pharmaceutical and medical device companies know more about their products than the public officials entrusted with procurement decisions. Furthermore there is uncertainty in health markets; this makes it difficult for policy makers to manage resources. This is compounded by emergence of humanitarian emergencies when medical care is needed urgently and oversight mechanisms have to be bypassed. The fact that the health care systems are complex and they involve a large number of parties makes it difficult to have transparency.

This review of the literature indicated to the investigators that there were many questions about corruption in the public service generally and the public health services in Tanzania which still needed to be examined. These included

- Perceived reasons/causes of, and loopholes for corruption in public health services;
- Public perception of corruption, the magnitude of corruption, and their personal experience of corruption;
- The forms of corruption engaged by different cadres of health workers;
- Public officials' own experience of being subjected to corruption;
- Whistle blowing by health workers who do not engage in corrupt practices.

This study was therefore not designed to examine the obvious. It was expected to make a contribution to knowledge, and to inform the formulation of more focused anti-corruption measures within the health services.

5.0 Objectives of the study

The broad objective of the study is to examine the state of corruption in the health service provision in the four districts in Kinondoni, Temeke, Ilala and Kibaha, and to make recommendations that will reduce it.

The specific objectives are:

1. To examine awareness and roles of service users in the corruption that takes place in public health facilities.
2. To examine the service users' experience and practice of corruption in public health facilities.
3. To examine the effects of corruption on the health care seeking behavior of service users

4. To examine the awareness of, and involvement in corruption by service providers
5. To make recommendations of effective ways of preventing and combating corruption in the public health services.

6.0 Methodology:

6.1. Design

A cross-sectional design was employed. Both qualitative and quantitative approaches of data collection were used.

6. 2. Data Collection:

6.2.1. Sources and Methods

Both qualitative and quantitative methods of data collection were used and this was in accordance to the study objectives stipulated in the TOR:

S/N	**Study objective**	**Target population**	**Data collection method**
1.	Examine awareness and roles of service users on corruption at public health facility level.	Community members residing in the catchments areas of the health facilities	FDGs, Key Informant interviews
		Health workers in the hospitals, health centres and dispensaries	Key informant interviews
2.	Critically examine the experience and practice of corruption at the health facility level.	Community members residing in the catchment areas of the health facilities	Semi structured interviews
		Health workers in the hospitals, health centres and dispensaries	Semi structured interviews
		Admitted and out-patients	Semi structured interviews
3.	Examine the effects of corruption to service users	Patients at the health facilities	Semi-structured questionnaire , Key Informant Interviews
		Community members residing in the catchment areas of the health Facilities	FGDs
		Mystery clients	Simulation

4	Examine service providers' awareness on corruption at their health facility level	Health workers in the hospitals, health centres and dispensaries	Semi-structured questionnaire
5	Discuss critically (basing on respondents and key informants' recommendations) effective ways of preventing and combating corruption in the health service delivery systems	Administrators at the health at the health facilities	Key Informant interviews
		Health workers	Key Informant Interviews
		Community members and patients	Semi-structured questionnaire, FGDs

6.2.2. Description of Methods:

6.2.2.1 Semi-structured questionnaire

This consisted of a mixture of close and open ended questions. That is, the tool was, to a large extent, highly structured (eliciting choices between alternative answers to -pre-formulated questions); but had also open ended questions that gave the respondent the opportunity to express in his or her own way any views and experience she or he may have on the issues raised.

6.2.2.2 Key informant interview:

This was basically an unstructured interview with administrative officials of the hospitals covered by the study. That is use was made of a guide that consisted of a list of open ended questions in an attempt to find out the nature (forms, experiences, practices, and enhancing circumstances) of corruption in the health facilities. It was a conversation with a purpose of finding out what kinds of things exist, and why, with regard to corruption in the health facilities. Unfortunately we were able to do it with only one leader. The rest did not honour the appointments we agreed upon despite repeated rescheduling, and those who deputized them insisted that only the substantive incumbents could talk with authority on the subject matter.

6.2.2.3 Focus Group Discussions (FGDs):

This is a qualitative research method that involved two facilitators – one being a moderator and the other a note taker (recorder) engaging a group of 6 – 8 participants in a discussion of the research topic (corruption in the health care system).
The participants were purposively selected to represent a mix of female and male participants by age, and socioeconomic status. The FGDs took about one and half hours, and they were conducted at a place where privacy could be assured.

6.2.2.4 Mystery Clients:

Three persons, a man and two women, were primed to perform the role of mystery clients. Their role was to act as patients. They sought health care, and, hence, were able to experience and to closely observe the state of affairs with regard to the forms, practices, and circumstances associated with corruption in the health facilities.

6.3. Sample size estimations:

The sample size for quantitative data collection method was determined by using the following formula:

$$n = \frac{z^2 pq}{d^2}$$

Where:

n = the desired sample size

z = the standard normal deviate, set at 2

p = Proportion of health workers/ service users involved in or affected by corruption practices This was put at 50% because of lack of a reliable estimate.

q = 1 – p

d = degree of accuracy desired, set at 0.05

Thus, $n = \frac{2^2 \times 0.5 \times 0.5}{(0.07)^2}$

n = 204

Thus, a minimum sample size of 204 for each stratum of health workers and users of health services in each of the four study districts, namely 816 was determined.

For qualitative data a total of 8 FGDs, two in each municipal/district, were conducted. One group was with men and the second one was with women.

6.4. Sampling techniques:

The study involved successive stages of sampling. In the first stage ten wards in each of the three Municipals in Dar es Salaam and five wards in Kibaha District were selected randomly. Subsequently the streets/ villages were selected randomly. However, purposive sampling was applied in selecting health facilities. Thus all health facilities found in the selected wards were included in the sample, as were all Municipal Hospitals and Tumbi Hospital (Kibaha District).

Upon arriving at the selected streets and health facilities a stratified and systematic sampling technique was employed. That is, the study population (health workers and users of health services) were divided into two relatively homogeneous sub-groups (strata) followed by application of systematic sampling within each stratum. At each study site the first thing which was done was to establish the total number of health workers by cadre and then calculate proportions of each cadre of health professionals. The respective proportions were multiplied by the pre-determined sample size to get the

size of the sample in each stratum. In line with systematic sampling the sample was drawn by listing the registered health workers and selecting every nth case – starting with a randomly selected number on the list. The same procedure was used in selecting community members. Sub-ward [street] leaders provided the researchers with a list of residents for establishing the sampling frame.

6.5. Data Management:

Data collection instruments were checked for completeness on daily basis. The responses were coded and entered into a computer, cleaned and subjected to analysis. FGD outputs were tape recorded and transcribed before being analyzed.

6.6. Permission to conduct the study

The proposal for this study was subjected to the ethical review by the Research and Publication Committee of the Muhimbili University College of Health Sciences, and permission to conduct the study was obtained from the respective authorities in the study sites.

6.7. Statement of Ethical Considerations:

6.7.1 Maintenance of confidentiality:

FGD, key informant interview, and survey data was collected without taking down the names or other unique identifiers of the participants.

6.7.2 Introducing the study:

Each potential respondent was adequately informed of the objectives, significance, methods, anticipated benefits, and potential hazards.

6.7.3. Benefits:

Each potential respondent was informed that his/her participation in this study would give him/her the opportunity to reflect on the problem of corruption. Sharing of ideas with others in a discussion may be an opportunity for learning and change of attitudes towards corruption might ensue.

6.7.4. Risk of participating:

Each potential respondent was informed that there were no serious risks involved in participating in this study, except that there might be intrusion into one’s privacy due to being asked to share some information which might a secret, or things they would not like to be reminded of. In this connection one was at liberty to refrain from answering any questions that makes him/her uncomfortable.

6.7.5. Informed Consent

Potential respondents were at liberty to turn down the request or to withdraw from the study in the course of the interview/discussion. Those who agreed to participate in the study made verbal consent.

6.7.6. Limitations of the Study:

Since corruption is a sensitive and despite all assurances given about the harmless nature of the study to individual participants, it is quite clear that many health workers did not disclose the extent of their personal involvement in corruption.

The minimum sample size for health workers was not realized due to funding constraints coupled with problems of scheduling of appointments for interviews with workers on shifts and with those who could only be interviewed after office hours because of heavy workloads.

CHAPTER 2: SURVEY RESULTS ABOUT HEALTH WORKERS' INVOLVEMENT IN CORRUPTION

1: Introduction

This chapter presents the results of the component of the survey which covered health workers.

Some 364 workers were interviewed. They were seen in health facilities in the three districts of Dar es Salaam and in Kibaha district. Table 1 shows the distribution of respondents by district.

Table 1: The distribution of respondents by district

District	Number	Percentage
Ilala	91	25.0
Kinondoni	99	27.2
Temeke	103	28.3
Kibaha	71	19.5
TOTAL	**364**	**100**

It is clear from the table that the problem of reaching the required sample size was particularly serious in Kibaha, where slightly more than a quarter of the respondents could not be obtained.

A total of 20 health facilities were covered in the three districts of Dar es Salaam, and 12 health facilities in Kibaha. The health facilities covered included hospitals, health centres and dispensaries.

And in those health facilities the specific sections which were selected and whose staffs were interviewed included:

Reproductive and Child Health Reception

Laboratory

X-ray

Out patient department

Pharmacy

Specific wards

2: The demographic and socioeconomic characteristics of respondents

Among the staff members interviewed 240 or 65.9% were females, and the remaining 124 or 34.1% were males

Their ages ranged from 20 – 59. Table 2 shows the age distribution of the respondents

Table 2: The age distribution of respondents

Age	Number	Percentage
20 – 39	39	10.7
30 – 39	142	39.0
40 – 49	134	36.8
50 – 59	49	13.5

It is clear that the large majority (75.8%) of the staff members interviewed were in the two age categories of 30 – 39 and 40 – 49years.

The professional affiliation of the staff members interviewed included the medical, nursing, dentistry, pharmacy and laboratory professions. The distribution of the staff members according to their professional affiliation is shown in Table 3.

Table 3: The professional affiliation of respondents

Profession		**Number**
Medical	Doctors	12
	AMOs	16
	Clinical Officer	54
Nursing	Registered Nurses	98
	Enrolled Nurses	30
	Nurse Assistants	72
Dentistry	Dentist	4
	ADOs	4
Pharmacy	Pharmacists	7
	Pharmaceutical Technician	4
	Pharmaceutical Assistant	4
Laboratory	Laboratory Technicians	28
	Radiographer	4
Others	Receptionists	27
Total		**364**

The Medical and Nursing staff constituted slightly more than three quarters (77.5%) of the respondents interviewed. Nurses on their own made up 54.9% of the sample.

The staff members reported having been in service for periods ranging from one year to 39 years. The distribution of staff in terms of their years of services is shown in Table 4.

Table 4: Years of service of the staff members interviewed

Years	**Number of respondents**	**Percent**
1 – 2	40	11.5
3 – 10	85	24.5
11 – 20	113	32.6
21+	111	32.0

The large majority of respondents had been in service for more than ten years. This sample therefore comprised staff members who had considerable years of experience and who knew what went on in the health services.

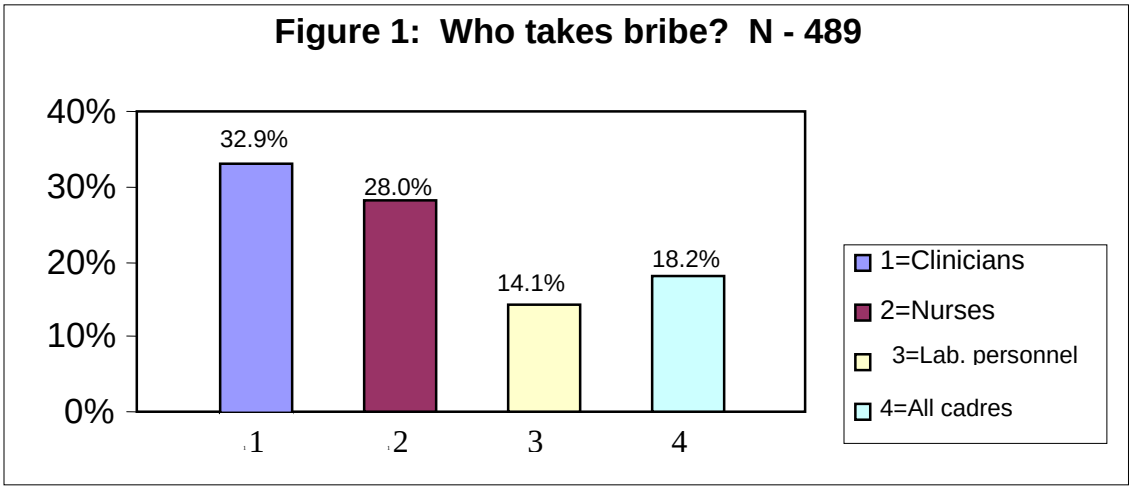
Health workers in the public health service are transferred from one health facility to another quite frequently. In this sample only a third of the respondents reported having been in the health facility where they were interviewed for more than five years.

3: Respondents' involvement with corruption in the course of providing health services

The first substantive issue which was taken up in the interview was the health workers' involvement in corruption.

Respondents were asked which cadre took bribes. They were allowed to give multiple responses, and on the basis of these responses the medical personnel came on top, having been mentioned in 32.9% of the responses. Nurses came second having featured in 28% of the responses. The laboratory personnel came third and featured in 14.1% of the responses. Interestingly some 18.2 percent of the responses claimed that all cadres took bribes. Figure 1 gives a graphic display of these findings.

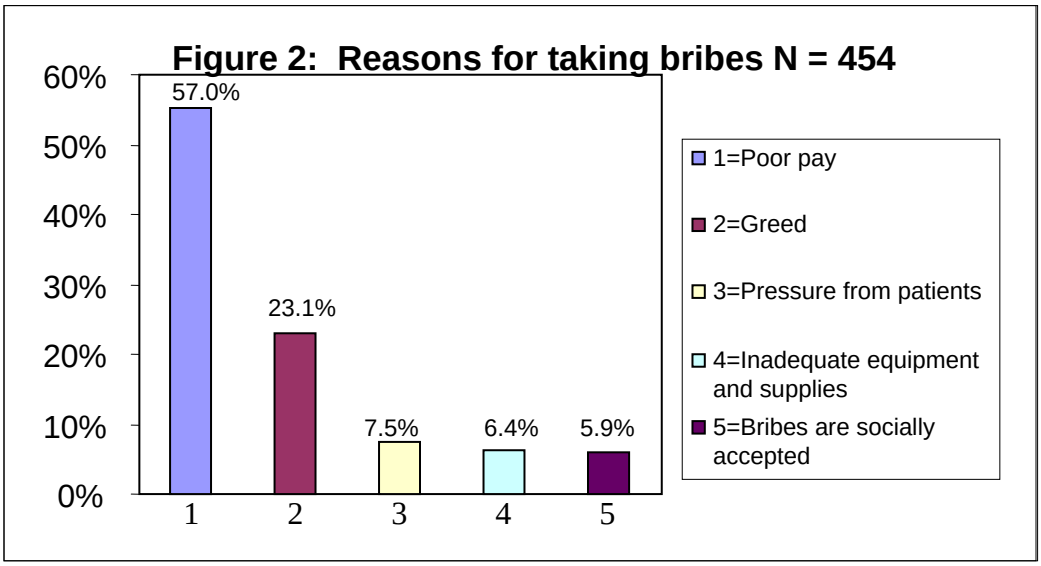
Figure 1: Who takes bribe? N - 489



It appears that while all cadres may be taking bribes the prevailing perception among the health personnel is that it is the medical personnel: Doctors, AMOs and Clinical Officers who take bribes, with the nursing personnel following from behind. Whether this reflects

the fact that nurses contributed more than half of the respondents and hence a tendency to blame others cannot be discounted.

Respondents gave a number of reasons why health workers take bribes. These clustered into five major categories. Figure 2 shows these categories and the proportion of responses which fell into those categories.



The overwhelming number of responses has to do with poor pay. The other category with almost a quarter of the responses is about greed. It is noteworthy that there are respondents who believe that taking bribes has become an acceptable social norm for providing health care. The specific responses in these category included statements that clients expect to give a bribe in order to ensure that they receive good quality care, and that health workers feel that it is alright to take money from patients either before or after providing health care.

The kind of patients who, or whose relatives give bribes were describes as:-

- people of high socio-economic status, in 23.7% of the responses;
- patients whose illness condition was not serious, in 7.0% of the responses;
- poor people, in 10.0% of the responses.

The overwhelming proportion (64.2%) of responses had it that all kinds of patients, regardless of their socioeconomic status and illness condition were asked for, and gave bribes.

The forms in which bribes are paid include the following:

- money, mentioned in 80.9% of responses;
- gifts in terms of commodities, mentioned in 11.0% of responses,
- sex between clients and service providers, mentioned in 8.0% of responses.

It appears from these findings that it is money which changes hands during payment of bribes

A number of words were used to connote bribes. The following were mentioned:-

1. CCD meaning Chakula Cha Daktari (doctor's food), mentioned in 58.5% of responses;
2. Kitu kidogo (a small thing), mentioned in 11.9% of responses;
3. Chochote (anything/something), mentioned in 4.1% of responses;
4. Takrima/Asante (appreciation), mentioned in 18.0% of responses
5. Kalangiza (roast), mentioned in 4.1% of responses;
6. Kusqueeze (to squeeze), mentioned in 3.4% of responses.

Given the previous finding that the medical personnel constitute the main category of health workers who are said to take bribes it does not appear to be incidental even the bribe is termed mainly the doctor's food.

The large majority of respondents (67.8%) reported that corruption, in terms of taking bribes was rampant within the health services. Some 14% of the respondents were evasive in their responses, with 26 of them actually dismissing the allegation about corruption being pervasive in the health services as a lie.

Most of the respondents (75.8%) reported that for them accepting gifts given by patients did not constitute corruption. Only 17.3% regarded it as corruption, *"particularly when patients feel obliged to give something when all indications are that they are very poor,"* as one of them put it.

This finding was confirmed in responses to a subsequent question which required respondents to indicate what among the exchanges between patients and staff did not

constitute corruption. In response to this specific question 56.6% said whatever is given by patients after receiving good care, was a mark of appreciation and did not constitute a bribe. *"It is a mark of appreciation, a way of saying Thank you for a job well done" in the words of one respondent.*

Only 74 or 20.3% respondents admitted to have ever taken a bribe.

And since this was an aspect of self disclosure in an interview situation rather than in answering an anonymous self administered questionnaire, this is an important finding. If one adds the other 8 respondents who exercised their ethical right not to answer the question to this group the figure comes to 82, which is close to a quarter of all the respondents.

In an attempt to profile this group, the following characteristics emerged:

1. Bribe takers tended to be males (Table 5)
2. Bribe takers tended to be primarily medical personnel, followed by laboratory personnel (X-ray and ultrasound personnel are included in the category of laboratory personnel). (Table 6).
3. Bribe takers tended to come mainly from Ilala district followed by Kinondoni district. (Table 7).

Table 5: A cross-tabulation of the variable about taking bribes and gender.

Takes Bribes	**Yes**	**No**	**Total**
Male	38 (51.4%)	82 (29.1%)	120
Female	36 (48.6%)	200 (70.9)	236
Total	74 (100%)	282 (100%)	356

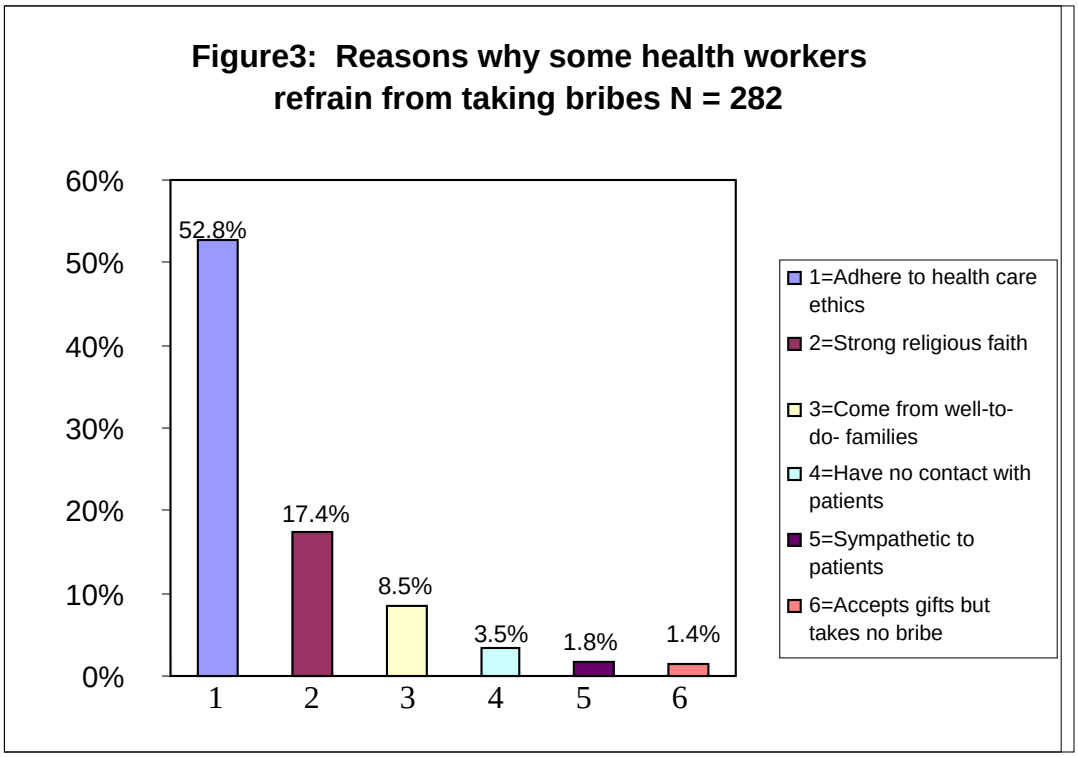
Table 6: A cross-tabulation of the variable about taking bribes and professional affiliation

Takes Bribes	Yes	No	Total
Medics	29 (35.4%)	53 (64.6%)	82
Nurses	27 (13.2%)	173 (86.5%)	200
Laboratory personnel	11 (34.4%)	21 (65.6%)	32
Pharmacists	2 (13.3%)	13 (86.7%)	15
Other	5 (18.5%)	22 (81.5%)	27
Total	74	282	356

Table 7: A cross-tabulation of the variable about taking bribes by district

Takes Bribes	Yes	No	Total
Ilala	26 (28.9%)	64 (71.1%)	90
Kinondoni	21 (21.9%)	75 (78.1%)	96
Temeke	17 (16.8%)	84 (83.2%)	101
Kibaha	10 (14.5%)	59 (85.5%)	69
Total	74	282	356

Those who said they had never taken bribes were asked how they had managed to refrain from taking bribes if this was such a common practice. Figure 3 shows the frequency distribution of the reason given.



Slightly over a half (52.8%) of the said they adhered to the health care ethics which prescribe such behaviour. Next was a subgroup of 17.4% of the members who said they were believers whose strong religious faith proscribed taking bribes. Some 8.5% said they had no opportunity for taking bribes because their professional activities do not bring them in contact with patients. There was a small group of 24 people or 8.5% who said they come for well to do families or have supplementary income generating activities and did not have to take bribes. There were four respondents who said they do not take bribes but only gifts given by satisfied patients. Another two said they never took bribes because there were no bribes in the health services.

The groups of people which admitted to have ever taken bribes were asked to think back to the last time they took a bribe and to describe the circumstances which led to their accepting/taking the bribe.

The circumstances involved

- Giving preferential treatment to the patients: such as jumping the queue for ultrasound examination,
- Getting patients on the operation list out of turn,
- Expediting medical and/or nursing care.

4: Respondents as givers of bribes in their own health sector

With regard to corruption within the health sector some 141 respondents or 38.7 percent reported that they knew of colleagues who had to pay a bribe to higher officials in order to obtain what they wanted. Surprisingly only 31 or 8.5 percent admitted to have ever paid this kind of bribe. This shows that not only do health workers find themselves being victims of corruption in other sectors; some times they may also become victims of corruption in their own sector.

Furthermore only 25 of them were willing to divulge the circumstance surrounding their payment of bribes to senior officials in the health sector. They paid bribes:

- In order to be employed.
- In order to be transferred to health facilities in the urban area.
- In order to be considered to go for in-service-training.

An interesting finding which demonstrates the extent to which corruption is entrenched in the health services is that 36 respondents, or 9.9 percent reported that they had to give a relative of theirs some money towards paying a bribe in order to obtain good quality health care in other health facilities where they had no personal influence.

A good 141 or 38.7 percent respondents reported being in a situation where they thought a colleague was trying to solicit a bribe when should not. Surprisingly only 42 or 11.5% said they tried to prevent that colleague from doing so., and only 12 or 3.3% said they reported the incident to higher officials.

Many of those who simply stood by without attempting to stop their colleague said they did not want to interfere in other people's affairs as this might create enemies for them.

5: Respondents' involvement with corruption during their training

Out of a total of 364 respondents, 95 (26.1%) reported that while they were in the pre-service training institution they got to know of colleagues who were involved in some form of corruption. This invariably involved paying money to, or having sexual relation with tutors.

Predictably only five admitted to have been involved in such corrupt activities. Three were males and two were females. Two were Clinical Officers, and one was a Registered Nurse, another one was an Enrolled Nurse. The fifth one was in the unspecified professional category.

6: Respondents' awareness of grand corruption in the health sector

These health workers were asked if they knew of any grand corruption schemes or deals which bring huge benefits to high officials in the health sector.

Only 23.1% of the respondents reported that they did. Most of the respondents reported that they did not, while 3.6% chose to exercise their ethical right not to answer the question.

An attempt at profiling the group of respondents who knew about grand corruption revealed the following:

1. they tended to be men (Table 8).
2. they were mainly medics followed by Laboratory personnel (Table 9).
3. they came mainly from Temeke and Kinondoni (Table 10).

Table 8: Cross-tabulation of knowing about grand corruption schemes and gender

Knows about grand corruption	**Yes**	**No**	**Total**
Male	35 (41.7%)	86 (374%)	121
Female	49 (58.3%)	181 (78.7%)	230
Total	84 (100%)	267 (100%)	351

Table 9: Cross-tabulation of the variable about knowledge of grand corruption and professional affiliation

Knows about grand corruption	**Yes**	**No**	**Total**
Medics	29 (34.5%)	59 (22.3%)	88
Nurses	42 (50.0%)	149 (56.2%)	191
Laboratory	5 (6.0%)	26 (9.8%)	31
Pharmacists	5 (6.0%)	10 (3.8%)	15
Other	3 (3.6%)	21 (9.8)	24
Total	84	265 (00%)	349

Table 10: Cross-tabulation of the variable about knowledge of grand corruption and district

Knows about grand corruption	Yes	No	Total
Ilala	16 (19.0%)	71 (26.6%)	87
Kinondoni	25 (29.8%)	70 (26.2%)	95
Temeke	30 (35.7%)	71 (26.6%)	101
Kibaha	13 (15.5%)	55 (20.6)	68
Total	84 (100%)	267 (100%0	351

Asked about who was involved in the grand corruption, the responses revealed the following:

- 23 (27.3%) said this involved officials in hospital administration.
- 18 (21.4%) said this involved officials in the Ministry of Health or the Municipal Council.
- 14 (16.7%) said this involved senior doctors.

- 8 (9.5%) said they involve the surgery department.
- 6 (7.1%) said this involved the continuing education department.
- 4 (4.8%) said this involved officials handling tenders.
- 2 (2.4%) said this involved human resource section.

Most of those respondents said they had never reported this form of corruption to anybody because they did not feel that it was their responsibility, or that doing so could get them into trouble.

7: Respondents' involvement with corruption in other sectors

Out of a total of 364 respondents,138 or 37.9% admitted to having offered a bribe to officials in other sectors in order to obtain a service to which they have eligible. The service sectors where they paid bribes were listed as:-

- ARIDHI.
- TANESCO.
- Traffic Police.
- The Law Courts.
- Local Government.
- TRA.

This is essentially a confirmation of the finding of the Warioba Report that corruption is endemic in many sectors of Tanzania's economy. But it also shows that the very people who take bribes in their own sector are also givers of bribes in other service sectors.

This question was followed by a series of interrelated question which sought to determine the circumstances surrounding payment of bribes in these service sectors.

- 52 out of 364 respondents (14.3%) paid a bribe in order to obtain a permit or some certificate. Eight of them reported having to do this more than once.

- 27 out of 364 respondents (7.4%) paid bribe in order to get their children admitted in what they considered to be good schools. Eight of them reported having to do this more than once.

- 62 out of 364 respondents (17%) paid a bribe in order to obtain some domestic utility: water, electricity or a landline telephone connection. In this particular case twenty four respondents reported having to do so more than once.

- 59 out 364 respondents (16.2%) reported paying a bribe to the police in order to avoid being apprehended. Nineteen of them said they did so more than once.

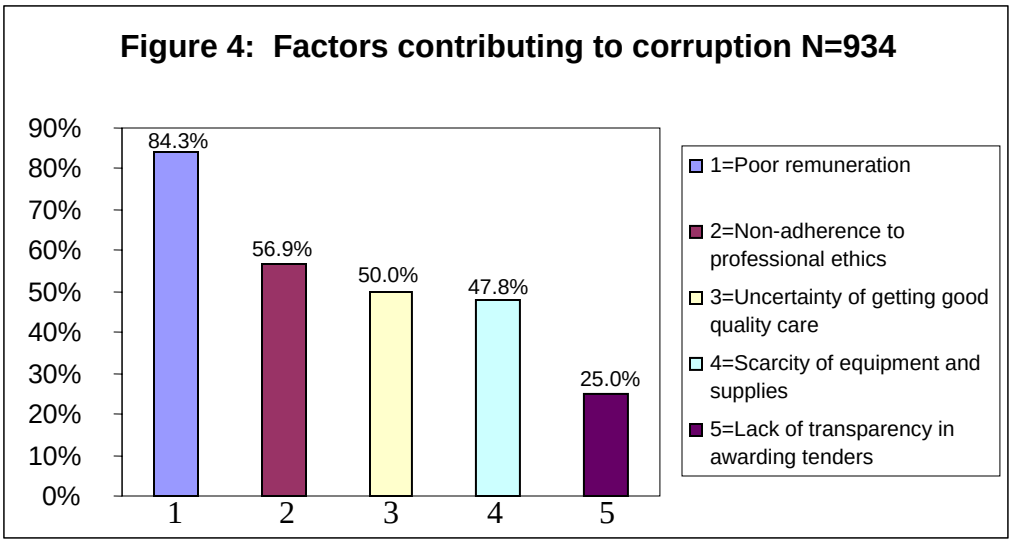
8: Respondents' perception of the causes of corruption in the health sector

How does this differ with what is on page 23?

The respondents attributed the sources of corruption in the health services to the following:-

- inadequate remuneration for health workers: - 307 or 84.3%
- health workers not adhering to professional ethics: 207 or 56.9%.
- Patients prompting health workers to take a bribe because of uncertainty of getting good quality health care: 182 or 50.0%.
- scarcity of equipment and reagents for such services as X-ray, Ultrasound: 147 or 40.4%
- lack of transparency in awarding tenders: %- 91 or 25.0%

Figure 4 depicts this information graphically. The total is greater than 364 because respondents gave more than one factor.

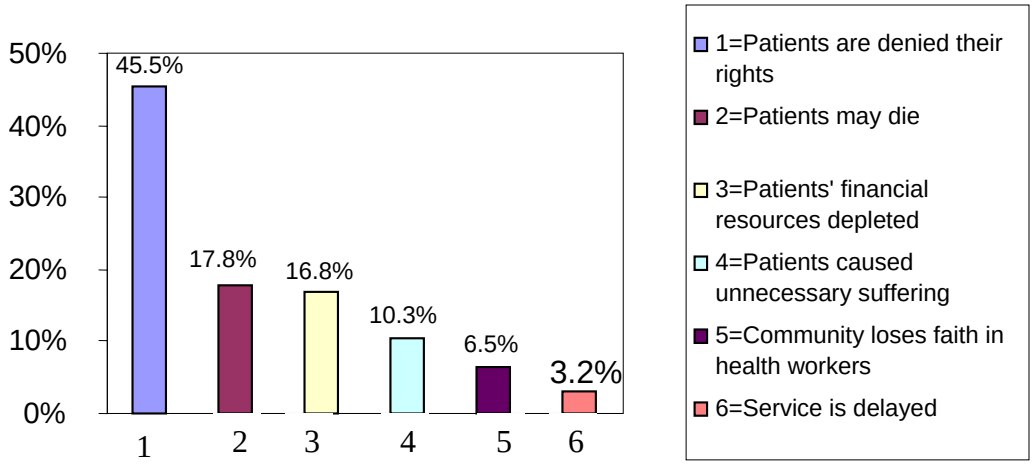


It is clear that health workers attribute their own corrupt practices to what they consider to be poor pay. The fact that non adherence to professional ethics is also given as an important factor, it is an admission on their part that they do not measure up to the standards of the professions of their choice.

9: Respondents' awareness of the negative impacts of corruption within the health sector.

Almost all respondents (98.9%) recognized that corruption had serious negative consequences. Because some of them were able to mention more than one such negative consequence the analysis took the total number of responses as the denominator which was used to rank the negative consequences on the basis of the number of responses in which they featured. Figure 5 shows the frequency distribution of the negative consequences of corruption which the respondents came up with.

Figure 5: The acknowledged consequences of corruption N=495



The prominence of the factor about denial of human rights is noteworthy. It reflects their own experiences in the other service sectors or within their own sector when they find themselves being victims of corruption.

10: Respondents' awareness of anti corruption measures being implemented in the health sector.

Some 278 respondents said they were aware of anti-corruption measures which were being implemented within the health services. These comprised

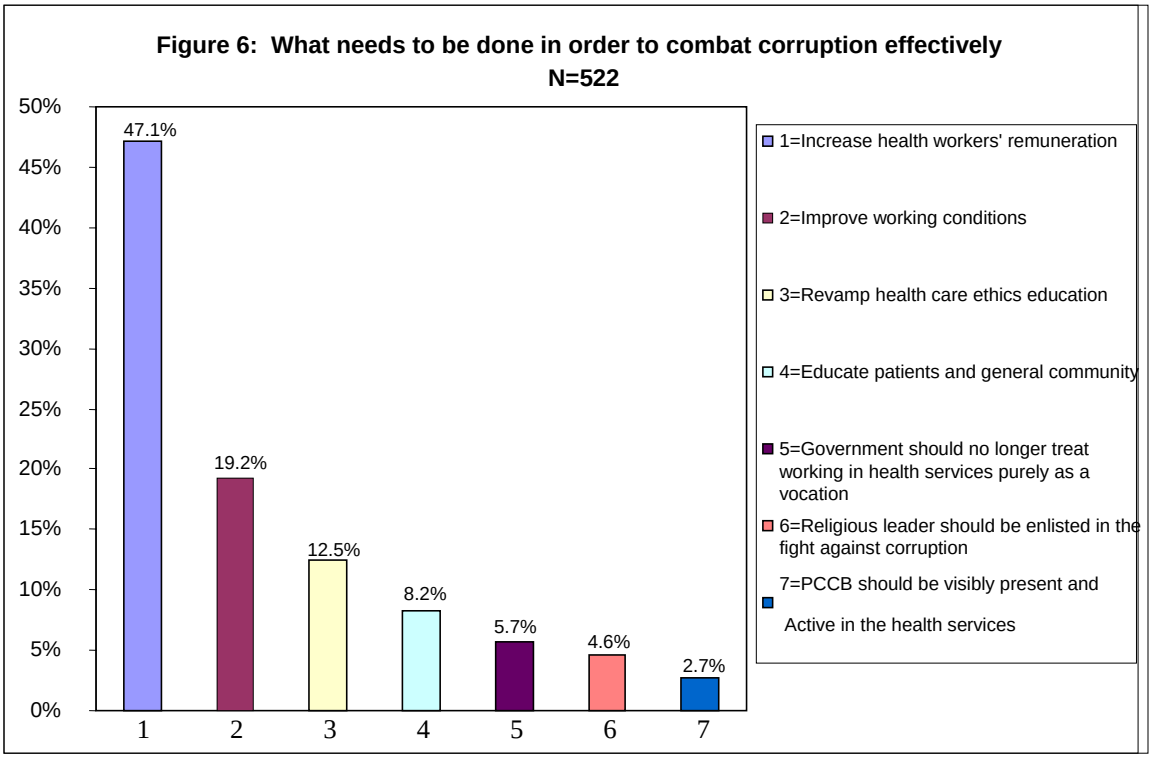
- Seminars, meetings and notices on the board/wall (69.5%)
- Having an opinion box or a specific office for dealing with patients' complaints (14.1%)
- Issuing receipts for payments made (14.1%)

Most of them did not think that these measures were having the desired impact because they did not address what they saw as the real causes of corruption in the health sector.

11: Respondents' suggestions of anti corruption measures which might be more effective.

When asked about what other measures that needed to be implemented in order to combat corruption effectively in the health services, 317 (87.1%) out of 364 respondents, offered their suggestions.

Because some of these respondents gave more than one suggestion the analysis took the total number of responses as the denominator. The rank order of the suggested measures is shown in Figure 6.



Naturally given what the respondents saw as the causes of corruption even the suggestions they gave addressed these factors, with improvement in pay getting the most attention.

12: Discussion

Perception of the prevalence of corruption in the health services can be based on rumours or actual experience of corruption. What this chapter shows is much more than rumours about the extent of corrupt practices in the health services, coming as they do from the very people who provide health care. It is noteworthy that more reported of knowing others who solicit and accept bribes than those admitting to involvement in such practices. The common method of handling such reports is to treat them as indicative of projection of one's own behaviour to other people in order to please the interviewer.

It is also noteworthy that despite the perception that many health workers are involved in corrupt practices, many reveal some antipathy to the practice and are willing to make suggestions of what they consider to be effective methods of combating corruption. Such methods include: increasing health workers' remuneration, improving working conditions, and revamping health care ethics education. Similar measures were reported by Kamuzora (2005).

A finding worth of notice is that some health workers have a history of involvement in corrupt practices that goes back to their pre-service training days. This implies that anti-corruption measures also need to be directed in the training institutions. However, Aboud (1993) cautions that it is futile to teach ethics unless they are practiced in the society in general.

Furthermore the finding that some of them have to give bribes to senior officials in order to obtain some desired outcome may serve to normalize their own corrupt practices with patients. This coupled with their knowledge or belief about the involvement of senior officials in grand corruption mean that anti-corruption measures have to be targeted to different sections, taking into account their differential opportunities for involvement in different forms of corrupt practices. Involvement of senior officials in corruption has also been reported by the Warioba Commission (1996).

A disturbing finding is the tendency to look the other way in the face of corrupt practices. Perhaps the statement that this is to avoid getting into trouble is an indication of two major factors that hinder effective prevention and combating of corruption in the public health facilities. Firstly, health workers –like professionals in other sectors- seem to have a tendency of guarding friendly interpersonal relations (collegiality) at the expense of the public welfare. Consequently, they are less concerned when colleagues do injustice to the clients. Secondly, health workers may not be aware of the existence of the law, which protects whistle-blowers. The Prevention and Combating of Corruption Act No. 11 of 2007 section 51 (1) states that:

> No information relating to commission of an offence under this Act shall be admitted in evidence in any civil or criminal proceedings and no witness in any civil or criminal proceedings shall be obliged to:
> (a) disclose the name or address of any informer who has given information to the Bureau with respect to an offence under this Act or the name or address of any

person who has assisted the Bureau in any way in relation to such an offence; or

(b) answer any question if the answer to such question would lead, or would tend to lead, to discovery of the name or address of such informer or person.

Lack of awareness of the law may be attributed to the fact that the Prevention and Combating of Corruption Act has not been mainstreamed in the health policy.

The third factor that hinders effective prevention and combating of corruption in the public health facilities is the fact that, as the findings indicates, senior officials in administration are themselves not clean and therefore they cannot ensure effective enforcement of the law.

The finding that health workers find themselves having to give bribes in other service sectors may enhance the feeling that they too should take bribes in the course of providing health care.

CHAPTER 3: SURVEY RESULTS ABOUT THE INVOLVEMENT OF PATIENTS WITH CORRUPTION

1: Introduction:

This chapter presents the results of the component of the survey which covered patients.

Some 192 patients were interviewed. They were seen in health facilities in the three districts of Dar es Salaam and in Kibaha district. Table 1 shows the distribution of respondents by district.

Table 1: The distribution of respondents by district

District	Number	Percentage
Ilala	42	21.9
Kinondoni	51	26.6
Temeke	51	26.6
Kibaha	48	25.0
TOTAL	**192**	**100.0**

The table shows that almost equal number of patients was obtained from each district.

The socio-demographic characteristics of patients covered by the study

As Table 2 shows the majority of the respondents were females (71.4%). It further shows that majority had ages that that ranged from 15 -36 years. About two thirds of the respondents had primary education and were Muslims.

Table 2: Socio-demographic Characteristics:

S/N	Characteristics	Frequency	%
1.	Sex: ❖ Male ❖ Female	 55 137	 28.6 71.4
2.	Age Group		
	15-25	62	32.3
	26-36	72	37.5
	37 -47	35	18.2
	48 – 58	10	5.2
	59 – 69	11	5.7
	70 – 80	01	0.5
3	Religious Denominations:		
	Christian (Mainstream)	58	30.2
	Christian (born again)	13	6.8

	Muslim	117	60.9
	Traditional	4	2.1
4	Education level:		
	Primary Education	132	68.8
	Secondary Education	41	21.4
	Vocational Training	6	3.1
	Post, Secondary Education Training	2	1.0
	Missing	11	5.7
	Total	N = 192	

Tables 3, 4, and 5 show the economic conditions of the sample of patients covered by the study.

Table 3: Distribution of patients by employment

EMPLOYMENT STATUS	FREQUENCY	PERCENT
Self- Employed	101	52.6
Employed	24	12.5
Dependent (e.g. Retired, orphan, elderly)	40	20.8
Unemployed (e.g. Looking for work	26	13.5
Missing	1	0.5
Total	192	100.0

Table 3 indicates majority (52.6%) of the respondents were self-employed. And 13.5% were unemployed.

TABLE 4: **Patients responses on whether they have any other source of livelihood**

SOURCE OF LIVELIHOOD	FREQUENCY	PERSENT
None	153	79.7
Small Scale business	28	14.6
Craftsmanship (ufundi/kazi za mkono	1	0.5
Casual labour	13	6.8
Peasantry	6	3.1
Missing	2	1.0
Total	192	100.0

Table 4 indicates that most (79.7%) of the respondents reported that they had no any other source of livelihood, apart from their primary occupation. It also shows that 14.6% had small scale businesses.

Table 5: Patients' responses on how often they take all the three common daily meals (breakfast, lunch, supper) in a week

NUMBER OF DAYS	FREQUENCY	PERSENT
Less than three days	11	5.7
3-5 days	14	22.9
All 7 days	136	70.8
Missing	1	0.5
Total	192	100.00

Table 5 indicates that slightly less than a third (22.9%) of the respondents admitted that they could take all the three common daily meals for 3 – 5 days. Indeed, the table shows that 5.7% could manage to have all the three common daily meals for less than three days.

3: Patients' involvement with corruption

Tables 6 – 10 show the respondents' extent of involvement in corruption and their views about different aspects of corruption.

Table 6: Their responses on whether they have been asked for a bribe in health facility

RESPONSE	FREQUENCY	PERCENT
YES	34	17.7
NO	158	82.3
TOTAL	192	100.0

Table 6 indicates that only 17.7% of the respondents admitted that they had been asked for a bribe.

Table 7: Whether they paid a bribe if they agreed that they were asked for it.

RESPONSE	FREQUENCY	PERCENT
YES	21	61.8
NO	10	29.4
MISSING	3	8.8
TOTAL	34	100.0

Table 7 shows that about two thirds (61.8) of the respondents who were asked for a bribe paid.

Table 8: Patient's responses on whether/not they have ever persuaded a service provider to accept a bribe from them in order to be favoured in accessing health care

RESPONSE	FREQUENCY	PERCENT
YES	18	9.4
NO	174	90.6
TOTAL	192	100.0

Table 8 indicates that most (90.6%) of the respondents denied to have ever persuaded a service provider to accept a bribe from them in order to be favoured in accessing health care.

Table 9: The extent to which they think corruption is a serious problem in delivery of health services in the health facility

THE EXTENT OF THE PROBLEM	FREQUENCY	PERCENT
To a greater Extent	72	37.5
To some extent	20	10.4
To a small extent	13	6.8
Not at all	28	14.6
Don't know/Not sure	56	29.2
Missing	3	1.6
Total	192	100.0

Table 9 shows that slightly more than half (54.7%) of the respondents said that corruption is a problem in the delivery of health services. It is worth noting, however, that about a third (29.2%) of the respondents were not sure of how serious the problem of corruption was.

Table 10: The effects of corruption they have experienced in the health facility

EFFECT EXPERIENCED	FREQUENCY	PERCENT
Have not experienced any effect (none)	129	67.2
Not being attended (a doctor/nurse by passing a patient)	22	11.5
Purchasing medicines without a receipt	2	1.0
Health workers having a non-caring attitude (not friendly)	4	2.1
Being asked to purchase some equipment/materials that are expected to be available at the health facility	9	4.7
Not given all the prescribed drugs because I do not have money	1	0.5
Others	16	8.3
Missing	9	4.7
Total	192	100.0

Table 10 shows that two thirds (67.2%) of the respondents denied to have experienced any effect of corruption at the health facility in which they were getting medical care. It in essence shows that only the minority pointed out effects of corruption they had experienced. For instance, 11.5% said they were not being attended (a doctor/nurse bypassing a patient). And 4.7% were asked to purchase some equipment/materials that are expected to be available at the health facility.

4: Discussion:

The study shows that the respondents were basically poor. Majority were self-employed. This suggests that they are struggling in the informal sector and given the known obstacle of lack of capital, achievement is minimal. They are barely surviving

The findings show that only 17.7% of the patients interviewed admitted that they had been asked for a bribe. This is a small but a significant number bearing in mind two points. Firstly, the interviewees were poor patients who were aware of the problem of corruption in almost all the public sectors, but had no way out except to seek medical care in the public health facilities where they were being interviewed. Secondly, they were probably aware of hegemonic power that the medical professionals have over patients. That is, there is a norm especially in poor countries that the medical professionals are the ones who know everything on disease causation and management and thus whatever kind of care they offer is perhaps what one deserves. No questioning, lest you be neglected altogether. Thus it is possible that, despite assurance of confidentiality from the researchers, they were afraid to say the truth fearing to worsen their relationship with the staff and thereby jeopardize chances of being attended or of getting satisfactory care.

It is therefore not surprising that only about a third of the respondents said that corruption in the delivery of health services is a serious problem to a great extent. Indeed, another third of the respondents were not sure of how serious the problem of corruption was. This suggests that somehow corruption has been accepted as one of those normal bureaucratic obstacles to accessing health care. Likewise when they were asked to point the effects of corruption they had experienced, two thirds of the respondents were unable to mention the effects they experienced This suggests that corrupt practices have become so common that they are have become part and parcel of the system. Thus, it is difficult for poor men and women who know little about how the health care system works to isolate the effects of corruption from other structural problems of the system.

CHAPTER 4: SURVEY RESULTS OF COMMUNITY MEMBERS

Introduction

This chapter presents the results of the component of the survey which covered community members. Some 413 community members were interviewed. Two wards in

each of the three districts of Dar es Salaam and in Kibaha district were involved. Table 1 shows the distribution of respondents by district.

Table 1: The distribution of respondents by district

District	Number	Percentage
Ilala	103	24.9
Kinondoni	117	28.3
Temeke	101	24.5
Kibaha	92	22.3
TOTAL	**413**	**100.0**

The table shows that an average of 100 respondents in each district participated in the study.

1. Socio-demographic Characteristics:

Among the community members interviewed, 61.7% were males and 38.3% were females. Their ages ranged from 15 – 91 years. Table 2 shows the age distribution of the respondents.

Table 2: The age distribution of respondents

Age	Number	Percentage
15 -25	92	22
26 – 36	142	34
37 – 47	96	23
48 – 58	42	10
59 – 69	22	05
70 – 80	16	4
81 -91	3	1
TOTAL	413	100

Table 2 shows that the majority (57%) of the community members interviewed were in the two age categories of 26 – 36 and 37 – 47 years. Their education attainment also ranged from “never been to school” to post-secondary. Table 3 shows distribution of the community member interviewed by level of education.

Table 3 the education level of the respondents

Education level	Number	Percentage
Never been to school	42	10.2
Primary	257	62.2
Secondary	80	19.4
Vocational Training	13	3.1
Post –Secondary	20	4.8
Missing	01	0.2
TOTAL	413	100

The respondents who had never been to school and those who attained the primary level of education constituted about three quarters (72.4%) of the community members interviewed. Primary school leavers on their own made up 62.2% of the sample.

From the religion point of view, the community members interviewed belonged to various denominations. These included: Islam, Christianity (mainstream and born again) and traditional religion. The distribution of respondents by religion is indicated in table 4.

Table 4. The distribution of respondents by religion

Religion	Number	Percentage
Christian (mainstream)	104	33.9
Christian (born again)	26	6.3
Islam	243	58.8
Traditional religion	1	2
Others	2	5
Missing	1	2
TOTAL	413	100

It is clear that the majority of interviewees were Muslims.

2. Socioeconomic Characteristics:

Apart from the desire for maximum attention, readiness to offer a bribe or a tendency to prompt health workers to receive it is a function one's socioeconomic status. The status of employment of the community members ranged from being self-employed to unemployed (looking for a job). The distribution of respondents by their employment status is shown in table 5.

Table 5. The distribution of respondents by employment status

Employment status	Number	Percentage
Self-employed	284	68.8
Employed	38	9.2
Dependent	53	12.8
Unemployed (looking for work)	32	7.7
Missing	6	1.5
TOTAL	413	100

The table indicates that the majority (68.8%) of the respondents were self-employed. Further assessment of the respondents' socio-economic status revealed that less than half (46.4%) were the owners of the houses in which they lived. And the observation made by the interviewers indicated that 72.2% of the houses were located in the slum areas.

Besides, the study sought to determine the extent to which the community members interviewed afforded to have all the three common meals (that is, breakfast, lunch, and supper) in a week. Table 6 shows their responses to the question.

Table 6: Participants' Responses on how often they take all the Three Common Daily Meals (Break Fast, Lunch, Supper) in a Week.

Number of days in a week	Number	Percentage
Less than 3 days	23	5.6
3 -5 days	83	20.1
All 7 days	302	73.1
Never gets all 3 daily meals	1	0.2
Less than 3 days	23	5.6
TOTAL	413	100

The table indicates that about three quarters (73.1%) of the respondents reported to be taking all the three common meals (break fast, lunch, supper) for all the seven days of the week. However, slightly less than a third (20.1%) of the respondents admitted that they could take all the three common daily meals for 3 – 5 days. Indeed, the table further

shows that 5.6% could manage to have all the three common daily meals for less than three days of the week.

3. Awareness of corruption at the public health facility

One of the key issues that were addressed in the interview was the community members' awareness of corruption. They were asked whether they knew that corruption existed in the health facilities. The results are displayed in table 7.

Table 7. Knowledge of existence of corruption in the public health facility:

Response	Number	Percentage
Yes	339	82.1
No	63	15.3
Missing	11	2.6
TOTAL	413	100

Table 7 indicates that most (82.1%) of the participants reported that corruption existed in the public health facilities. This evidence of awareness was backed up by their responses to the question that required them to indicate whether they have ever involved themselves as patients or caretakers in circumstances [scenarios] that were created by health workers to signal a demand for a bribe. The scenarios included:

- Staff taking advantage of shortage of resources to press for bribery, endorsed in 58% of the responses
- Improper provision of service (e.g. Midwife not sensitive to women in labor pain), endorse in 60.6% of the responses
- Doctors absenting themselves causing congestion outside the consultation rooms, endorsed in 69.8% of the responses
- Staff telling patient lies that a certain service is unavailable, endorsed in 68.8% of the responses
- Staff behaviors of extending favors to some patients (their friends/ relatives or friends/ relatives of their colleagues, endorsed in 77.3% of the responses.
- Staff taking advantage of patient ignorance of the services delivery processes, endorsed in 47.7% of the responses.

It appears from these findings that a clear majority of the community members interviewed knew that the health care staffs do create circumstances for corruption to happen. A cross tabulation (see table 8) shows that almost equal proportions of men and women said they were aware of existence of corruption in public health facilities.

Table 8: Cross tabulation of the variable on knowledge of existence of corruption in the public health facility and sex:

Sex	**Knows about existence of corruption in a public health facility**		**Total**
	Yes	No	
Male	138 (87.3%)	20 (12.7%)	158
Female	212 (83.1%)	43 (16.9%)	255
Total	339	63	413

The respondents were then asked which cadre took bribes.
They were allowed to give multiple responses, and on the basis of these responses the nurses came on top, having been mentioned in 49.8% of the responses. Medical personnel came second having featured in 41.9% of the responses. The radiology personnel came third and featured in 2.9% of the responses. And, lastly, the receptionists were mentioned in 0.5% of the response. See the findings in table 9.

Table 9: The cadre of health workers mostly involved in corruption in the public health facilities they usually visit:

Cadre	**Number**	**Percentage**
Clinicians	173	41.9
Nurses	205	49.8
Laboratory personnel	8	1.9
Pharmaceutical personnel	6	1.5
Radiology personnel	12	2.9
Receptionists	2	0.5
Missing	6	1.5
TOTAL	413	100

It appears that while all cadres may be taking bribes the prevailing perception among the community members is that it is the nurses who take bribes, with the medical personnel: Doctors, AMOs and Clinical Officers following closely from behind.

To ascertain the community members' awareness of corruption they were asked to mention the forms in which bribes are offered. Table 10 displays the forms of corruption that medical personnel engage in.

Table 10: Forms of corruption that medical personnel engage in

Form of corruption	Number	Percentage
Cash	350	84.7
Sex	56	13.6
Don't know	7	1.7
TOTAL	413	100

The table indicates that most (84.7%) of the participants were of the opinion that doctors receive a bribe in the form of cash. In addition, it shows that 13.6% pointed out that doctors are engaged in sexual corruption.

Still on awareness, the respondents were asked on the extent to which corruption is a serious problem in the delivery of health services. The results are shown in table 11.

Table 11: Perception of seriousness of the problem of corruption in the Delivery of Health Services

Extent of the problem	Number	Percentage
To a greater extent	207	50.1
To some extent	45	10.9
To a small extent	39	9.4
Not a problem at all	34	8.2
Don't Know/ Not Sure	78	19
Missing	10	2.3
TOTAL	413	100

The table shows that about three quarters (70.4%) of the respondents reported that corruption is a problem in the delivery of health services. Interestingly, 19% of the respondents were not sure of the extent to which corruption was a serious problem in the delivery of health services. Indeed, 8.2% of the respondents said corruption was not a problem at all.

It is worth noting that a relatively higher proportion of men had the perception that corruption is a serious problem in the delivery of health services at the at the public health facility that they usually visit. See table 12.

Table 12: Cross tabulation of the variable on perception of seriousness of the problem of corruption and sex

Sex	The extent to which corruption is a serious problem					**Total**
	Great extent	Some extent	Small extent	Not a problem at all	Don't know/ Not sure	
Male	81 (52.9%)	26 (17%)	15 (9.8%)	8 (5.2%)	23 (15%)	153
Female	126 (50.4%)	19 (7.6)	24 (9.6%)	26 (10.4%)	55 (22%)	250
Total	207	45	39	34	58	403

Table 13: Cross tabulation of the variable on perception of seriousness of the problem of corruption and education.

Education level	The extent to which corruption is a serious problem					**Total**
	Great extent	Some extent	Small extent	Not a problem at all	Don't know/ Not sure	
Never been to school	15 (44.1%)	2 (5.9%)	1 2.9%)	4 (11.8%)	12 (35.3%)	34
Primary education	132 (51.6%)	23 (9%)	28 (10.9%)	22 (8.6%)	51 19.9%	256
Vocational training	7 (58.3%)	3 (25%)	1 (8.3%)	1 (8.3%)	0	12
Secondary education	44 (52.4)	12 (14.3%)	7 (8.3%)	7 (8.3%)	14 (16.6%)	84
Post-Secondary education	9 (52.9%)	5 (29.4%)	2 (11.8%)	0	1 (5.9%)	17
Total	207	45	39	34	78	403

Table 13 shows that if the proportions for the "great extent" and "some extent" responses are added up a pattern emerges that indicates that the tendency to perceive corruption as being a serious problem in the delivery of health services increased with the level of education.

4. Community Members Involvement in Corruption:

The study sought to determine the extent to which the interviewed community members were involved in corruption. They were asked whether they have ever been required to pay a bribe and if they complied or not. Tables 14,15,16,17 & 19 display the responses.

Table 14: **Whether the respondent has ever been asked for a bribe in any of the health facility:**

Response	Number	Percent
Yes	227	55.0
No	186	45.0
TOTAL	413	100

Table 14 indicates that more than half (55%) of the participants reported that they were asked for a bribe in at least one of the health facilities.

This finding was confirmed in responses to a question which required respondents to indicate whether they have ever involved themselves as patients or caretakers in a situation whereby the health care staff demanded a bribe as a condition for rendering the service. The situations [scenarios] included:

- Doctors demanding bribes from patients before prescribing drugs for them, endorsed in 39.9% of the responses
- Nurses demanding bribes before allocating a bed to the patient, endorsed in 32.9% of the responses
- Nurses demanding and receiving bribes on behalf of the doctor (commonly known as chakula cha doctor – CCD), endorsed in 24.5% the responses
- Nurse Attendants/ Assistants demanding bribes before giving a bedpan/ urinal to a bedridden patient, endorsed in 23.3% of the responses.
- A patient/ caretaker being required to pay a bribe to have investigations (e.g. x-ray, blood examination) done, endorsed in 41.5% of the responses.
- A patient being required to pay a bribe before being operated, endorsed in 29.3% of the responses.

In essence, endorsement of the scenarios by about a third of the interviewed community members is a testimony that corruption really exists in various domains of health care.

Table 15: Cross tabulation of the variable about whether the respondent has ever been asked for a bribe in any of the health facility and sex

	Whether asked for a bribe		
Sex	Yes	No	Total
Male	100 (63.3%)	58 (36.7%)	158
Female	127 (49.8%)	128 (50.2%)	255
TOTAL	227	186	413

Table 15 shows that majority (63.3%) of those who were asked for a bribe were men.

Table 16: Whether the respondents gave a bribe asked for

Response	**Number**	**Percent**
Yes	159	70
No	68	30
TOTAL	**227**	**100**

Table 16 indicates that about three quarters (70%) gave the bribe asked for.

Table 17: Cross tabulation of the variable about whether the respondents gave a bribe asked for and sex

Sex	**Gave a bribe asked for**		**Total**
	Yes	No	
Male	69 (71.9%)	27 (28.1%)	96
Female	90 (68.7%)	41 (31.3%)	131
Total	159	68	227

Table 17 clearly shows that a higher proportion of men (than that of women) gave the bribe asked for.

5. Respondents' involvement with corruption in other sectors

The respondents were asked whether they had ever paid a bribe when struggling to access services in other sectors, besides health. It was an attempt to confirm the assumption that corruption in the health sector is just part of the bigger problem in country at large. The results are displayed in table 18.

Table 18: Whether the respondents themselves had had to pay a bribe in order to get some services in other sectors (apart from health):

Response	Number	Percent
Yes	172	41.6
No	241	58.4
TOTAL	413	100

Table 18 indicates that more than a third (41.6%) of the participants reported that they had had to pay a bribe in order to get some service in other sectors apart from health services:

Table 19: Circumstances which compelled them to pay a bribe in other sectors:

Circumstance	Number	Percent
Police services (bail, arresting the suspect, traffic)	93	54.1
Court Services (bail and other legal rights)	19	11.1
Land problems	6	3.5
School problems (enrollment, transfers)	10	5.8
Birth certificate	20	11.6
Electricity	24	14.0
Total	172	100.0

Table 19 shows that majority (54.1%) of the respondents were compelled to pay a bribe when seeking Police services (bail, arresting the suspect, traffic).Others (14%) said they had to pay a bribe when seeking electricity services.

Table 20: Cross tabulation of the variable about whether the respondents themselves had had to pay a bribe in order to get some services in other sectors apart from health services and education level:

	Whether had had to pay a bribe in order to get some services in other sectors		
Education level	**Yes**	**No**	**Total**
Primary education	93 (36.2%)	164 (63.8%)	257
Secondary education	46 (57.5)	34 (42.5%)	80
Vocational Training	7 (53.9%)	6 (46.2%)	13
Post- Secondary	10 (50%)	10 (50%)	20
Never been to school	15 (35.7%)	27 (64.3%)	42
Total	**171**	**241**	**412**

Table 20 roughly shows likelihood of paying a bribe increased with level of education.

6. Problems encountered by respondents the last time they sought health care

Respondents faced many problems when they went to seek health care. Some of these problems constitute conditions in which corruption thrives. Table 21 shows the kinds of problems faced, and the number of respondents who perceived these problems as major, minor, or no problem.

Table 21: The nature of problems that people encounter when seeking health care

		Problem	No problem	Missing	Total
1.	If you family member have ever gone to the health facility in the last one month, did the time waiting to the served constitute big or minor problems or no problem at all.	246 (59.6%)	161 (39.0 %)	6 (1.5%)	413 (100%)
2.	If you/family member have ever gone to the health facility in the last one month, did the politeness of the health staff constitute big or minor problems or no problems at all?	178 (43.1%)	226 (54.7 %)	9 (2.2%)	413 (100%)
3.	If you/family member have ever gone to the health facility in the last one month, did the cost of investigation constitute big or minor problems or no problems at all?	179 (43.3%)	232 (56.2 %)	2 (0.5%)	413 (100%)
4	If you/family member have ever gone to the health facility in the last one month, did the cost of drugs constitute big or minor problems or no problem at all?	243 (58.8%)	166 (40.2 %)	4 (1%)	413 (100%)
5	If you/family member have ever gone to the health facility in the last one month, did the consultation cost constitute big or minor problems or no problems at all?	94 (22.8%)	315 (76.3 %)	4 (1%)	413 (100%)

Table 21 shows that waiting time was a matter of deep concern to more than half (59.6%) of the respondents. It also shows that only 40.2% of the respondents said that the cost of drugs was not a problem. In essence, the majority (58.8%) of the respondents said cost was a stumbling block.

7. Respondents' awareness of the negative impacts of corruption within the health sector.

The study sought to determine the effects of corruption from the respondents' point of view. They were asked to express their views on how corruption affects women, youth, and people who do not know anybody at the health facility. Tables 21, 22, & 23 show the frequency distribution of the negative consequences of corruption which the respondents came up with.

Table 21: Participants responses on how corruption affects women:

The negative consequences of corruption	Number	Percent
Not receiving maximum attention during delivery	208	50.4
Poor women can not afford to buy medication	86	20.8
Maternal mortality for poor pregnant women who can not offer Bribe	12	2.9
Infant mortality for poor women who can not offer bribe	13	3.1
Forced to have sexual relationship as a bribe	14	3.4
Long waiting time as a bribe	7	1.7
No friendly care	6	1.5
Poor women suffer from various illnesses for a long time because they can not get services on time	52	12.6
Others	10	2.4
Total	**413**	**100.0**

Table 21 indicates that half (50.4%) of the participants said that because of corruption women do not receive maximum attention during delivery. It also shows that 20.8% of the respondents said that as a result of corruption poor women cannot afford to buy medication. The table further shows that 12.6% of the respondents reported that poor women suffer from various illnesses for a long time because they cannot get services on time.

Table 22: Participants responses on how corruption affects youth:

The way corruption affects them	Number	Percent
Poor youth cannot afford to buy medication	153	37.1
Do not get appropriate attention from the health workers	165	40.0
Female youth offer sexual bribe	17	4.1
Youth become weakened economically as they offer money as bribe to get medication	58	14
Difficulty to get services from public facilities, hence decide to go for private services.	11	2.7
Don't know	9	3.2
Total	413	100

Table 22 indicates that 40% of the respondents pointed out one consequence of corruption on the youth as being that: they do not get appropriate attention from the health workers. Furthermore, others (37.1%) said that as a result of corruption poor youth can not afford to buy medication 37.1%.

Table 23: Participants responses on how corruption affects those who do not know any body at the health facility:

The way corruption affects them	Number	Percent
Sometimes do not get medication at all	73	17.7
Stay in the queue for a long time/ Delay in getting services	224	54.8
Experience unfriendly care from health personnel	116	28.1
Total	413	100

Table 23 shows that more than half (54.8%) of the respondents said people who do not know anybody at the health facility stay in the queue for a long time. In addition, others (28.1%) said such persons experience unfriendly care from health personnel.

8. Respondents' assessment of effectiveness of government in fighting corruption in the health sector.

The respondents were asked to assess the extent to which the current government was effective in the fight against corruption in the health sector. Their responses are displayed in table 24.

Table 24: Assessment of the current government actions against corruption in the health sector.

Government Action	Number	Percent
The government is very effective in the fight against corruption in the health sector.	140	33.9
The government is fairly effective in the fight against corruption in the health sector.	126	**30.9**
The government is not effective in the fight against corruption in the health sector.	84	**20.3**
The government does not fight corruption in the health sector	47	11.4
The government encourages corruption in the health sector	16	3.9
Total	413	100.0

Table 24 shows that only a third (33.9%) of the respondents assessed the government as being very effective in the fight against corruption in the health sector. Basically, the majority (51.2%) said not enough is being done – whereby 30.9 % said the government is fairly effective and 20.3% said the government is not effective in the fight against corruption in the health sector.

The respondents were then asked to provide explanation in favor of their assessment. The analysis revealed that their arguments essentially favored two main positions: the government is effective Vs the government is not effective. The specific arguments are displayed in table 25.

Table 25 How the participants argued in favour of their assessment regarding government actions against corruption in the health sector.

Position	Arguments in favor of the position	Number	Percent
The government is effective in the fight against corruption in the health sector:	Corruption has declined (some improvement) unlike in the past	20	4.8
	The government is keen, it is the citizens who condone the practice	76	18.4
	The government rebukes health workers for accepting bribes and they are now fearful	9	2.2
	Improved quality of services	7	1.7
The government is not effective in the fight against corruption in the health sector:	Corruption is rampant despite some efforts	107	25.9
	The government is paying leap service, not keen on implementation	81	19.6
	Some workers have been dubiously employed by the management itself, it is difficult to control them	30	7.3
	The government officials are themselves engaged in corruption	34	8.2
	The government pays low salaries to its workers who in turn get prompted to solicit and/or accept bribes due difficult economic situation	5	1.2
	People, particularly the poor, are complaining, but corruption is still rampant	44	10.7
	Total	**413**	**100.0**

Table 25 shows that many people put forward several arguments in favor of the position that the government is not effective in the fight against corruption in the health sector.

9. Respondents' suggestions of anti corruption measures which might be more effective.

Finally, the community members interviewed were given the opportunity to suggest effective ways to combat corruption. Their opinions are summarized in table 26.

Table 26: Participants' opinions about effective ways to prevent and combat corruption in the health services.

Opinion	Number	Percent
Severe punishment	32	7.7
Intelligence officials should identify corrupt individuals	54	13.1
Government should continue rebuking health workers	28	6.8
Religious teaching to the students in the health sciences in order to restore a sense of human dignity and ethics	48	11.6
Members of the public not to condone bribery	36	8.7
Phone numbers of anti-corruption officials anticorruption officials should be made public	24	5.8
Procedure for accessing services for free (cost sharing) and exemption mechanisms should be made known	94	22.8
Government should increase salaries for health workers	50	12.1
Employers should ensure adherence to professional ethics	3	0.7
There should be special offices at particular health facilities for reporting corruption allegations	19	4.6
The government should ensure security of informers of corruption scandals	21	5.1
I do not know	4	0.9
Total	413	100.0

Table 26 shows several suggestions that were put forward as effective ways to prevent and combat corruption in the health services. While all of them (except the "I do not know") sound sensible, none was supported by a clear majority.

10. Discussion:

Socioeconomic characteristics:

Generally these findings suggest that the households in which the respondents lived were poor. People could barely survive. Indeed, about a third (26.9%) of the respondents admitted that they are unable to take all the three common meals (breakfast, lunch, supper) for all the seven days of the week. This matches well with a national data that show that in the year 2000/01 19% of Tanzanians lived below food poverty line (URT, 2005). Since majority of people in the study sites are poor they depend, to a great extent, on services provided by the public health facilities. Thus corruption that was acknowledged to exist by 82.1% of respondents is bound to have serious negative effects on health of the people.

Major problems encountered by the respondents:

The findings indicate that waiting time constituted a major problem among about half (47.2%) of the respondents. This is typical of a health care system that is stifled with a number of problems, including corruption. Under such circumstances health workers spend much time attending patients that are willing to pay a bribe or attending their friends/ relatives. Consequently, as indicated in the findings of this study, poor patients and/or those who do not know anybody at the health facility are mostly affected.

The results also show that even after being attended, cost of medication is often a stumbling block to the poor. The situation becomes worse when patients are advised to go and buy medicines from private pharmacies as often government facilities run short of the drugs.

And, as indicated in the Warioba Commission Report, there are allegations that owners of some of these pharmacies, who are civil servants, might be taking [stealing] drugs from government health facilities.

Circumstances leading to issuance of a bribe:

The study results show that most of the participants reported that corruption existed in the public health facilities. This implies, as indicated in the Warioba Commission Report, that corruption is rampant in the country, including the study sites. It is not surprising, therefore, that more than half of the participants reported that they were asked for a bribe in at least one of the health facilities.

Participants were asked on the manner in which health workers engage in corruption, the findings show that about two thirds of the respondents pointed out that health workers use delay tactics in providing services to the patients. These tactics are manifested in a number of ways as experienced by the respondents as patients or caretakers. The tactics include: doctors absenting themselves causing congestion outside the consultation rooms; staff telling patient lies that a certain service is unavailable; Staff behaviors of extending favors to some patients (their friends/ relatives or friends/ relatives of their colleagues).

Similar findings were reported by Kamuzora (2004). The findings suggest that circumstances leading to issuance of a bribe are multifaceted, requiring a multidimensional approach in addressing them.

The Cadre of Health Workers involved in Corruption:

The findings show that about half of the participants were of the opinion that nurses constituted a cadre of health workers mostly involved in corruption in the public health facilities. This could be explained in two ways: one, nurses are corrupt in their own right as health workers and two, nurses sometime act as middle men between patients and doctors. That is, patients or their relatives convey bribes to doctors through nurses. The study has also found out that the next corrupt cadre was that of doctors. This was expected. There is scarcity of doctors in the country and their demand is very high. This scarcity creates an environment which is conducive for corruption in two ways. Firstly, the patients or their relatives are anxious over whether they will be attended or not. And if they get attended, they are concerned about the quality of care they will receive. So they themselves may prompt doctors to receive a bribe. Secondly, doctors exploit the opportunity provided by the scarcity and sensitivity of medical care to explicitly or implicitly press for a bribe.

Consequences of corruption:

The results show that half of the participants said that because of corruption women do not receive maximum attention during delivery. This is a critical area with respect to achieving the millennium development goals (MDGs). Lack of maximum attention during delivery leads to unnecessary delays in providing essential interventions. This contributes to loss of the lives of mothers and babies. Apart from mortality, persistence of morbidity among poor women is also a serious concern. As a result of corruption poor women suffer from various illnesses for a long time and cannot afford to buy medication. Hence, achieving the MDGs requires intensification of the war against corruption in the health facilities.

Similarly, the findings of this study show that more than a third of the participants pointed out that as a consequence of corruption, youth do not get appropriate attention from the health workers. This implies that being poor, youth hardly attract maximum attention of health workers. Most of youth are dependent on their parents/ guardians for survival. While some of them are still students at primary and secondary levels, others are out –of school and jobless. Thus, they have literary nothing to offer as a bribe. However, it is worth mentioning at this juncture that it is from this context that some female youth opt to offer an alternative bribe – sex, as a matter of necessity. As with other sexual-related matters, sexual bribe is spoken with a low tone. It is, therefore, not surprising that only 4.1% of the respondents reported that female youth do offer sexual bribe.

Another category of people that experience consequences of corruption is that of the really poor. These are people who are poor both socially and economically. That is, they do not only lack income but also have no personal relationship with any health workers.

Consequently, as reported in this study, those who do not know anybody at the health facility stay in the queue for a long time or get delayed in getting services. In fact, in a corrupt health care system, such people are more often than not attended last as they have no body to speak and "fight" for them. Kamuzora (2004) reported similar findings.

Corruption in the wider community:

The results show that corruption in the health sector is just part of the problem in the wider community. More than a third of the participants reported that they themselves had had to pay a bribe in order to get some services in other sectors apart from health. This implies that as part of diagnosing the depth of corruption in health, we need to appreciate the fact that since corruption is widespread in the society, the mind sets of both users (patients/ caretakers) and providers of health services have been affected. It like a norm has been established that without a bribe [something small] no service or at most you get a poor one – be it in health, education, police, or legal sectors. The approach of assessing corruption in all sectors was also applied the Warioba Commission ((URT, 1996)

Ineffectiveness of the government:

The study findings show that only a third of the respondents assessed the government as being very effective in the fight against corruption in the health sector. In essence, the majority of respondents held the general position that the government is not effective in the fight against corruption. When asked to give reasons for their stance, they pointed out that corruption is rampant despite some efforts. They further concluded that the government is paying a leap service, not keen on implementation. This is not surprising. The recent events on grand corruption scandals that implicated the top government figures including the boss of anti-corruption bureau are a testimony that very little is being done to fight corruption in the society in general and in the health sector in particular. The top leadership is itself engulfed in corruption, thereby lacking moral authority to rebuke health workers at facility levels. Besides, health workers at local [facility] levels see no role models to emulate. These findings are different from those reported by REPOA (2006) which indicated that the government was doing fairly in handling corruption in the public sector.

CHAPTER 5: Results of the Focus Group Discussions

1: Introduction

A total of eight FGDs were held in the three districts of Dar es Salaam, namely Ilala, Temeke, and Kinondoni and in Kibaha district. Two FGDs were conducted in each district, and involved men and women separately. This chapter presents and discusses the findings from these discussions. Invariably findings are in terms of the views which participants in the discussion groups expressed. These are summarized and the best expressions are quoted in order to provide a sense of the passion and sentiments of those opinions

2: Perceived extent of corruption in the health sector

Discussants in all the groups expressed the opinion that corruption was rampant in the health sector.

A participant in a male group in Kibaha aptly expressed this opinion by stating that corruption had become so endemic one could not avoid it at all. "When you go to the hospital you have to be prepared for it by taking extra money":

> *"…rushwa ni tatizo sugu. Kufikia sasa hivi haliepukiki kabisa. Ukishaingia pale hospitali lazima ulitambue. Unapotoka tu nyumbani utambue kabisa lazima ubebe pesa ya ziada."*

Another discussant- a woman also in Kibaha- expressed the feeling that not only was the problem of corruption rampant in the health sector, "it has come to be accepted as a fact of life, and people have got used to it":

> *"Ni tatizo lililokithiri katika sekta ya afya, lakini ni tatizo la kawaida ambalo tayari wananchi wamelizoea."*

3: Terms and terminologies that connote corruption.

It appears that corruption has become part of mainstream culture, and different terms are used to refer to it or to different aspects of it. The following terms were given by the participants in different study areas:

- Kitu kidogo – something small
- Mlungula – bribe
- Chai – tea
- Soda –fizzy soft drink
- Mshiko – something to hold
- Kuzunguuka mbuyu – to go round a baobab tree
- Chochote –anything
- Tumboni street – stomach street

It is apparent that most of these terms refer to petty crime in the form of the giving and taking bribes in exchange of some service. Furthermore the reference to a food item and

to the stomach underlies the negligible quantitative characteristic of the bribe which any body can give, even though what one might demand as tea could amount to a huge dinner for the person giving it.

4: How bribes are solicited and given.

Another culture has also developed concerning how bribes are solicited, the terms used and the different circumstances in which bribes are solicited and paid. As with any form of communication if the parties do not use codes which are familiar to both parties they will not be able to understand each other. The following scenarios were narrated and all of them convey the message that a bribe is required or is to be given.

- A patient or a relative of the patient who senses that no service is forthcoming and that a bribe is required in order to get things moving will request the health care provider that they should greet each other – usually with a handshake: *"Tusalimiane." T*he health worker will approach the person and offer his or her hand for the hand shake. The person will already have folded a currency note- for 5,000/= or 10,000/= in his or her palm, and as they grasp each other's hand the currency note will change hands.

- You are in the queue at the Out Patient Department. When you hand in your card to the nurse who takes it inside you attach a currency note to the card. When the nurse takes it she realizes that you have paid up and deserve preferential treatment. You should shortly be called in to see the doctor.

- A patient or relative who has been waiting for attention to no avail will be told by other patients, especially in the ward, or by a health worker, that a hand which has not been dipped into some edible thing does not get licked: *"Mkono mtupu haulambwi."* And if he or she does not appear to be willing to give a bribe she or he will be admonished against being mean by having a hand which is bent like the spout of a kettle: *"Usiwe na mkono wa birika,"* or like the cashew nut: : *"Usiwe na mkono wa korosho,"* because the patient might suffer the consequences of such meanness.

- A patient who has been waiting for a service for a long time will be told by fellow patients, or by a health worker, that he or she should talk nicely, other wise the service may not be provided: *"Ongea vizuri; bila kuongea vizuri unafikiriri motto atafanyiwa nini?*

- A mother requests a nurse to change the sheets on the bed of her hospitalized child who is passing urine frequently because of the medication he is receiving. Mothers are not allowed to stay with their children in the ward. In response the nurse says *"TKK."* The mother does not know what TKK means and is told that it means *"Toa Kitu Kidogo."*

- A health worker will take a patient who has asked for preferential treatment to a colleague who is providing the service and tell him to milk the patient a full glass or half a glass depending on his estimation of how much the patient can pay: *"Kamua maziwa glasi ijae, au nusu glasi.*

- A patient will be told to come back the next day for the results of the laboratory investigations but if she or he wants the results the same day she or he should talk using capital letters: *"Njoo kesho kufuata majibu, au uongee kwa herufi kubwa"*

It is interesting to note the role played by other patients in alerting the affected individual to a situation that require that a bribe be paid, because that individual may not have defined the situation in the same way. People do not share similar experiences, and it is normal for someone who is facing an unfamiliar situation to learn from others.

It is also noteworthy that it is the rather inexplicable delay in obtaining a service that underlies the willingness to pay bribes. This is made more manifest in the scenarios described in the following section.

5: How patients or their relatives get to know for sure when they have to give a bribe.

- You find yourself in a slow moving queue because some people coming after you jump the queue.
- You are in the X-ray section. They tell you the machine is not working and that you should go to another hospital. They will be quick to add however, that they can get someone to help you.
- You have gone to get the cast of Plaster of Paris removed from your injured leg or arm. They tell you that they have no pair of scissors.
- You will see the doctor coming in and going out without attending to you. He or she might even tell you that you cannot get attention *"just like that" – "hivi hivi tu?"*
- You can tell from their actions or inaction. They simply ignore you. They know that they are supposed to take and to process specimen for laboratory investigations so that you may ultimately get a prescription, but they simply go about their business. You should then realize that you are required to give a bribe.
- You might be asked by the health worker who is going to attend to you if you are complete: *"Umekamilika?*
- They keep rescheduling your appointments. Every time you go they ask you to come back at a later date. Then you realize that they want you to give them a bribe.
- The doctor will ask you to meet him at a particular bar. When you meet him at the bar you give him whatever he asks you. When you go to the hospital the next day you get prompt and excellent service.
- The doctor will tell you to go with a particular nurse who will give you instructions concerning your medication.

- You are at the mortuary. They may tell you that there is no room in the freezer for the body of your relative. Alternatively they will tell you that they cannot find the body of your relative and they may keep showing you other bodies in order to frighten you. You should then realize that they want a bribe. And if you give a bribe the body will be found in no time.
- Some health workers are quite blunt about bribes. They will ask you to give it to them in person there and then. Others will be circumspect and ask you to put it in an envelope and to take it to a particular shop so that they can collect it at a later time.

Once again not only is the delay in obtain a service an important factor; it is also clear that health workers play a proactive role in creating the conditions under which payment of bribes appear to be the rational choice. The audacity health workers display can only be explained by their conviction that nothing can happen to them as a result of their corrupt practices – a conviction which comes from experience that such unethical behaviour by many others around them and by them bring no retribution.

6: The different forms which corruption takes

Participants were agreed that there were two main forms of bribes: money and sex.

When it is money the health worker wants he or she will be acting in a manner that lets you know that you are supposed to give a bribe. She or he may actually ask you to pay a specific amount of money, or you may be asked how much money you have, which provides you with the opportunity to bargain.

When it is sex, particularly if your condition is not serious he the doctor will be winking at you as he talks. You are then left with no uncertainty as to what the bribe being demanded is, the question becomes when it is to be paid. Alternatively the female relative that accompanied the patient and whom the doctor fancies will be asked for her telephone number. Later on she will receive a call asking her to meet the caller at a particular place.

Other forms were also mentioned:

- Small presents, such as cake of fizzy drinks taken to nurses in the ward or to the doctor on the pretext that they are from a birthday party of a particular patient of theirs.
- Being forced to buy items from health workers. Women going to deliver are asked to take their own supplies such as gloves. But midwives will still insist that the mothers buy them from them. They will always find fault with what the mothers brought or tell them that what they brought were not enough: *"Don't expect that you will buy only one pair of gloves. Every time she comes to check on you she needs a new pair of gloves which you have to buy from her." [usitegemee utanunua moja, kwa sababu kila akipita anataka nyingine.]*
- The doctor will insist that you should go to a particular laboratory with whom they have some deal for the investigation she or he has ordered. If

you bring results from other laboratories you will be told that they are not correct.

- The dispensaries and drug stores which doctors operate are also a form of corruption: *"Doctors misappropriate hospital drugs and and other supplies and sell them in their dispensaries, and some of them operate pharmacies If what you need is not available in the hospital you just walk into their eastablishments and you will find it." […vidispensari vingi ni vya hawa madaktari wenyewe, madaktari wanachukua madawa wanakuja kuweka, wanachukua vifaa wanakuja kuweka„… kitu kikikosekana vuka barabara pale kanuue. Ni wenyewe wanatuwekea viduka duka fulani au pharmacy fulani ni za kwao.]*
- Children are supposed to receive free medical care, but you will be told that there is no medicine. He or she will direct you to go to his or her own drug store or clinic to go and buy it. Alternatively you will be told to go to buy the medicine at some drug store, but before you set out to go the health worker will tell you that she or he has their own medicine which they are willing to sell to you.

7: Corruption ridden sections of the health services

Even though participants were agreed that there is no corruption free section in the health services, they identified the more notorious sections.

- **The reception**: You get to the reception, but instead of paying attention to you they will go on as if you are not there. Sometimes the condition can get worse while you are still standing there.
- **The Out Patient Department**: You may not leave the queue without giving a bribe to the nurse who ushers patients in, and of course when you get to see the doctor she or he may make his or her own demands.
- **The laboratory, including X-ray and Ultrasound sections**: You may be told that there are no reagents, or the machine is broken or there is no film, but the condition will change if you give a bribe. Alternatively you will be told that you cannot get the results for a number of days, but the condition will change when you pay a bribe. In other cases you will be told that the results are nowhere to be seen, but they will be retrieved upon paying a bribe.
- **The ward**: nursing care - be it giving medication to patients at the predetermined times, administration of a nursing procedure, or assistance with aspects of daily living - will often be contingent upon giving bribes.
- **The surgical department**. Scheduling an operation is often mediated by payment of bribes.
- **The labour ward**: an expectant mother is expected to take her own supply of essentials, but will be told they are not the correct ones, or she has to have more. But they will demand that she pays up so that they can give her the right ones – usually from their own stock. They may also demand a bribe in order to perform routine checkups periodically.

8: The cadres of health workers reputed to be heavily involved in corruption.

As with sections of health services which re perceived to be corruption ridden, participants expressed the view that all cadres of health workers take bribes, even though some of them are more notorious than others. It was said by a participant in the women group in Kibaha that even the watch man will demand a bribe before telling you where to go for a particular service for taking you there.

A point was made by a participant in the men group in Ilala that health officials in the higher echelons use lower cadres to collect bribes for them. *"The nurse will tell you your problem is very serious and for this kind of problem the doctor charges say 80,000/=. You do not give the doctor that much money but you give the nurse. Whether the doctor pockets it all or they share the money between them is immaterial. All you know is that you will soon be scheduled for the procedure you wanted."*

Nurses including midwives were singled out for mention. Nurses were said to play the intermediary role. She is the one who tells you how much the doctor wants, and she is the one who takes you to the doctor when you have paid up. Midwives will demand that you bribe them for them to check the progress of your condition, besides selling you their own supplies even if you took your own as you had been instructed at the antenatal clinic.

The role of nurses as intermediaries was very well described by a participant in a men's group in Ilala. He said *"…you cannot get in to see the doctor. The nurse stands at the door and stops people from going in to see the doctor. She readily allows someone who is far behind in the queue to get in upon payment of a bribe. You feel you have to pay some small thing in order to be allowed in. Otherwise you can stay there from morning until 2 00 PM. It is nurses who create these obstacles, as do Health Attendants." [huwezi kumwona daktari [nesi] anakuzuia mlangoni…Lakini mtu mwingine atamchomoa kule nyuma, akishampakitu,…unaona mpaka umpe kitu kidogo ndio uingie …bila hivyo umeingia asubuhi mpaka saa nane uko pale umeganda kwenye benchi. Manesi ndio wanatuwekea vikwazo, na wale wanaovaa nguo za orange.]* This was echoed by another male participant in Kinondoni: *"It is nurses who come to negotiate with you. They are intermediaries. They will tell you want to be attended without delay and you have some money they will talk to the doctor and you will be attended promptly. The nurse goes to talk to the doctor, pockets half of what you paid and hands the rest to the doctor. They do the same with laboratory investigations. For tests which cost 500/= you will be asked to pay 2000/=. 500/= will be the official payment, the nurse will packet 500/=, and hand over 1000/= to the Laboratory Technician. Nurses are the catalysts for corruption." [manesi ndio … wanakuja kuongea, wewe unataka huduma haraka, ngoja nikaongee na daktari, kama una kitu kidogo ngoja sasa hivi. Yeye dnio anakwenda kuongea na daktari…wakati huo yeye chake kishachukua na nusuanampelekea daktari, maana yeye ndio mtu wa kati. Hata ukienda maabara …atapeleka vipimo, kama ilikuwa ulipe 500/= utaambiwa 2000/=. Kwa hiyo 500/= atachukua yeye, 500/= itawekwa pale, mtu wa vipimo atapewa 1000/=.Manesi ndio chachu hasa wa mambo ya rushwa]*

Next to the nurses were the doctors. Clinical Assistants, Clinical Officers and Assistant Medical Officers are all regarded as doctors. For one participant in the women group in Kinondoni the cadre which takes more bribes and in large quantities is that of doctors. According to one participant *"Much as nurses might be in the forefront the doctor takes a big cut. A nurse might ask for 500/=, but a doctor may not attend you until you give him some money. And this will not be 1000/=, or 2000/= but 5000/=and above, depending on the nature of your illness." [Pamoja na manesi kuhusika na rushwa, daktari mwenyewe ana rushwa kubwa.. Nesi anaweza akakuomba 500/= lakini daktari hakupi tiba mpaka umpe hela ya maana tena, sio 1000/= au 2000/=, ni 5000/= na kwenda juu, inategemea na ugonjwa wako…]*

Laboratories were also said to be notorious for corruption. *"You may be told that your test results cannot be seen…and yet laboratories are supposed to be secure, and the people who work there is in their right mind; how comes that test results should not be seen? People who work in laboratories are also involved in corruption." [unaweza kuwa na vipimo vyako kule ukaambiwa vipimo havionekani…kule ni sehemu ya usalama na watu wanaofanya kazi kule ni watu wenye akili timamu, havionekani vipi? …maabara pia wanahusika]*

9: Why participants in the discussions thought corruption was rampant

A number of factors fueling corruption in the health sector were identified and described.

- Meager incomes of health workers: *"Their incomes are small. Asking for and being paid a bribe helps." [kipato wanachopata ni kidogo, kwa hiyo akiomba rushwa zile anazopata zinamsaidia.]*
- Making a habit of taking bribes: *"I can't go home without anything. Therefore I go back home with 10,000/= or 15,000/= with my salary untouched. This is a habit they have formed." [siwezi kurudi nyumbani bila kitu. Kwa hiyo natoka na shillingi 10,000/=, au 15,000/= na mshahara wangu uko pale pale. Kwa hiyo haya ni mazowea wamejiwekea wenyewe.]*
- Being greedy: *"Some one may be greedy. The salary may be good, and there may be other allowances, but they are not content with official income, and will decide to take bribes." [mwingine anakuwa na tama, mshahara mzuri, malupulupu anapata, lakini kutokana na kutoridhika na kile kipato chake anachopata, basi anaamua aendeleze mtindo wa rushwa…]*
- Some people do not appear to be bothered by corruption: *"Suppose you go to the hospital and you are asked to give a small thing for you to get treated. In stead of going to the relevant authorities who will set a trap for those asking for a bribe so that they can be apprehended, you decide to pay up. This way corruption will continue for ever." [Kwa mfano wewe unaenda hospitali unaambiwa hapa kutibiwa utoe kitu kidogo. Unakwenda sehemu husika, …mnaweza mkatengeneza mchongo wale*

watu wakashikwa, lakini unaenda kutoa rushwa, basi itaendelea milele na milele…]

- Scarcity of equipment and supplies. The little which is available is rationed out through preferential treatment to those who can pay bribes.
- Breakdown of health care ethics: health workers have no qualms in engaging in unethical practices, and people are quite willing to give bribes.
- Lack of patriotism, instead is serving the people a person in position of providing a service takes as the opportunity to enrich him or herself.
- Shortage of health workers: You have one doctor being shunted around to attend to patients in different sections. He knows that if you want his attention you have to wait because there is no alternative. You are therefore tempted to try and influence him by paying a bribe.
- One participant in a male group in Temeke saw corruption as being rooted in the political economy of the country *"You have leaders who get to their positions through corruption, right from ward level leaders to national level leaders. Why should this corruption not be in the health sector?" [Kama viongozi wa serikali wanapata uongozi kwa njia ya rushwa, tangu kata hadi kitaifa, kwa nini hiyo rushwa isiwe katika sekta ya afya?"]*
- One participant in a men's group in Kinondoni described it as an issue of supply and demand: *"The one who gives a bribe is in hurry and wants prompt attention without following the set procedure, and the person who takes the bribe is not well paid and can do with some supplementary income" [Mtoa rushwa anahitaji huduma haraka na bila kufuata utaratibu. Mpokea rushwa mshahara wake haumtoshi."]*

It is noteworthy that participants cast a blame for corruption also on the general public. They expressed the view that it is people who appear to be in a hurry who are responsible for the corruption in the health services. Such people do not want to follow the set procedures like everyone else. A participant in a men's group in Kibaha put it very well when he said: *"We are supposed to get health care by following the laid down regulations. But some of us find these regulations to be too cumbersome and we want short cuts. That is when we entice the health workers to take bribes and give us preferential treatment."* And a participant in a women's group put the point in a different way. For her it is not just people who are in a hurry but people with money: *["Wenye hela ndio wenye vishawishi."]*.

Some participants recounted harrowing experiences of involvement with corruption:

- A participant in the male group in Kibaha said he was asked to pay 300,000/= so that his father could have the surgical operation he needed. It took him and his relatives to raise the money. His father died before they could raise the money.

- A participant in the women group also in Kibaha explained what she had to endure before the fetus which had already died could be removed. She was in the

ward for three weeks without anything being done. She paid 6,000/= for ultrasound examination, and even after she had been prepared for the evacuation procedure nothing was done until her husband paid a bribe.

- A participant in the women group in Temeke told of a mother who had a sick child in the ward. She was told that the child needed blood transfusion, and her husband paid for the procurement of blood. Even when the blood was brought the nurse did not proceed to set the drip, she wanted a bribe, and the mother had no money. In the meantime the condition of the child was deteriorating, but the nurse stuck to her demands. A couple hours later the nurse started saying that "Israili" (the angel messenger of death) would soon be coming around. In no time the child died. It appears that the nurse new the condition of the child was irreversible, but she still wanted to be paid a bribe to do something which would still be ineffectual.

- Another participant in the same group (women group in Temeke) recounted about what happened when she took her own mother to the hospital. Even though the doctor knew that the patient was my mother and that I was distraught because her condition was very serious. Instead of doing the needful the doctor started to seduce me. He gave me an appointment to meet him at a particular bar that evening. So I pleaded with him to attend to my mother and agreed to meet him as requested. I wanted my mother to be attended, even if the price was by meeting the sexual demands of the doctor. She did not say what happened in the end, and neither was she asked about it.

These personal experience do corroborate the sentiments expressed earlier about the breakdown of health care ethics in the health services and about lack of patriotism on the part of health workers who will put their own needs instead of serving the people in need. They also demonstrate an element of impunity with which health workers go about performing the corrupt practices. It is incomprehensible for the medical and nursing professions whose professional ethics have the principles of nonmaleficence and beneficence not to police themselves diligently amidst the loud public outcry concerning the unethical behaviour of their members. There is no doubt that the few acts of malpractice which grab the attention of the media, and are acted upon by the Medical and Nursing Councils are only the tip of the iceberg.

10: The negative impact of corruption

Obviously it takes two to tango. Even the giver of a bribe benefits some how, even if this is simply by getting a service promptly, or getting the kind of service she or he perceives to be of the best quality care. Participants who had themselves invariably paid bribes once in a while were nevertheless united in condemning corruption for its negative consequences

The negative consequences described included:

- Loss of life for those who are unable to give bribes, or those who are poor and cannot raise the amount demanded.
- Ending up with crippling disabilities due to delays in getting care while trying to raise the requisite bribe.
- Living with unnecessary illnesses for lack of money for paying bribes if one were to go to the hospital.
- Economic loss necessitated by having to spend hard earned money which should have gone into making more money by paying bribes.
- Denial of basic human rights.
- Economic loss for the government which bus equipment and supplies which are misappropriated by health workers so that they can sell them for their own gains.

11: Anti – corruption measures

Participants were asked if they knew of any measures which the government was taking to combat corruption and what they made of them. The following were the outcomes:

- There were posters and bill boards urging people to hate bribes and not to pay bribes. But as a participant in the women group in Ilala put it "there are all these posters and leaflets urging people not to pay bribes and to demand receipts for the payments they make. These however are ineffectual, you still have to make some extra payment: ["Kuna mabango na makaratasi. Usitoe rushwa, hakikisha unapewa risiti kwa malipo yako. Lakini haya hayasaidii. Lazima ikutoke senti nyingine za ziada."]
- Many seminars have been organized about the evils of corruption. A participant in the male group in Kibaha said that even the Focus Group Discussion they were participating in was a seminar of sorts, and yet corruption continues unabated.
- Another man in the same group (men's group in Kibaha) saw the President's initiative to send billions of shillings to the regions so that people can obtain loans for undertaking economic ventures was an ant – corruption measure. The initiative would enable everyone to afford private health and to avoid the humiliation of having to bribe someone in order to get medical care.
- Discussants in most groups were skeptical about the effectiveness of the measures put in place. A discussant in the men's group in Temeke dismissed all the measures as mere pretence. For him no concerted efforts to fight corruption had been made. He was not optimistic about the future: *"If the politicians get into power through corruption you should expect everyone in position of authority to have his or her own way of obtaining bribes." ["Kama hao wanasiasa wamepata madaraka ki-rushwa bas kila mmoja atakuwa na njia yake ya kupata rushwa."]*

A sense of despondency pervades the description of the anti – corruption measures. They are not perceived to be effective.

12: Can corruption in the health sector be eliminated?

One discussant in the women group in Ilala was definite that corruption in the health sector cannot be eliminated. She was of the opinion that poor people have no choice but to sit on the bench and wait for service. This was not the case with those who have money. For one thing they do not want to wait in the queue, and for another the health workers have developed this habit of going home having made some money. These two interrelated factors serve to perpetuate corruption.

Another discussant in the same group however, was not so pessimistic. She was of the opinion that it is possible for all people to act with a common purpose and to refuse to give bribes. Any health worker who asked for bribe could be reported to the relevant authorities. This way corruption could be minimized if not eliminated.

These two opinions were voiced in different forms in all the groups when discussing this theme. In other words some people, perhaps the majority of the people, have come to regard corruption as inevitable, while others are still hopeful that something can be done about it – the question for them is what can that something be?

13: The way forward in combating corruption.

Participants put forward different suggestions as to what needed to be done in order to combat corruption in the health sector effectively. The point made earlier that the situation had reached such levels of complexity that it was doubtful whether any one measure directed to one sector can really eliminate corruption, was quite evident even when the participants tried to force themselves to come up with realistic suggestions. Naturally in desperation some participants made what could be regarded as outrageous and draconian proposals which cannot be implemented in a society ruled by a democratic government which seeks to uphold the rule of law and to protect human rights.

Measures suggested included:

- The Government should pay good salaries to the health workers.
- There should be a person whose identity is not known to the doctors to receive complaints from patients about corruption and the reports submitted should be acted upon.
- The government organ responsible for spearheading the fight against corruption should make a habit of sending officers to check on what goes on in health facilities on a regular basis. Such officials should be able to verify if indeed drugs and reagents are out of stock or the machines are not working in order to foil the ploy used to exact bribes from patients.
- Health facilities should be flooded with medicines.
- The shortage of health professionals should be addressed by training more of them and putting in place conducive working conditions in order to retain them.
- Serious efforts should be made to educate people about their rights. They should feel empowered to overcome the fear of reporting any wrong

doing, and there should be mechanism to protect them and to act on their reports.

- When individuals lodge complaints or provide information about perpetrators of corrupt practice such information should be acted upon without necessarily disclosing the identity of the source of the information.
- If a health worker is proved to have engaged in corrupt practices he or she should be paraded in the streets and mocked by the people.
- No drug stores should be allowed in or near the premises of health facilities. These only serve as conduits for siphoning off the drug supplies of the health facilities.
- Health workers should declare their property when they take up their posts. This should make it possible to gauge the legality of the property which the health worker amasses in a particular time period.

A plea was made by a participant in a women group in Temeke, which shows the desperation which many discussants felt. She said *"My suggestion is that you called us here today and asked us to discuss at length about corruption, the impact it has, and what could be done to combat it. We have told you. These ideas should not end here. We ask you to make sure that they are acted upon. We ask you to go and work on them. Help us fight this scourge, and may the Almighty God hear our cry."* This was a sobering request that any researcher into social problems can get from research participants.

Perhaps ending with a somber note is not necessarily a defeatist stance. If anything it is a plea to the Government and a challenge to the organization which commissioned this study not to pay lip service to the fight against corruption because the people are watching every move. This is provided by a male participant from Temeke. He said *"I don't know the medicine for eliminating corruption particularly when the current government remains in power. We saw what happened when the ruling party was holding its own elections. Some members of Parliament were apprehended by PCCB for engaging in corrupt practices. Was any of them taken to court, found guilty and sentenced?" ["Nchi hii kuwepo dawa ya kuondoa rushwa sijui, labda serikali iliyopo madarakani isiwepo. Kwa sababu chama tawala kilipofanya uchaguzi kuna wabunge walikamatwa na TAKUKURU. Je, kuna yeyote kapelekwa mahakamani*

CHAPTER 6: Results of the Mystery Clients component of the study

1: Introduction

Mystery clients – herein after referred as MCs - were sent to Temeke hospital, Amana hospital, and Mwananyamal hospital in Dar es Salaam and to Tumbi hospital in Kibaha district.

The MCs were primed to seek health care for specific conditions, and to observe what was going around them and to themselves as patients. They were specifically instructed to take note of sexual advances and to find out how poor people and the elderly who are not in position to give bribes are treated.

2: **Scenario for MC 1**

MC 1 was primed to present himself as a poor adult person who dressed shabbily.
And was to seek health care for fever, profuse sweating at night, productive cough, and body weakness which has lasted for about one month.

3: Scenario for MC 2

MC 2 was primed to present herself as a smart and beautiful lady, and to seek health care for painful menstrual period accompanied with heavy and prolonged bleeding, a condition which has persisted for :a couple of months. She was to inform the doctor that she needed treatment as she was expecting the next menstrual period in two weeks time.

Scenario for MC 3

MC 3 was a young lady of 23 years, and she was primed to present herself with the same condition as MC 2 who was in her early 40s: menstrual problems.

4: The experience of MC 1 in Hospital A.

MC 1 went to Hospital A around 8:30. He joined the queue for registration. The queue was very long and moved slowly. He managed to get the registration card after paying the statutory fee of TS 300/= after one hour. He was given a receipt for the fees paid.

After getting the card, he went to consult a doctor. For this he had to join another queue which was also very long very long.

While in that slow moving queue he saw patients who were jumping the queue despite the loud complaints of those like him who were in the queue. He noted that some nurses took patients directly to the doctor’s room without getting into the queue. There were also patients who appeared to know the doctor and walked straight into the consulting room without joining the queue. Neither the doctor nor the nurses took notice of the complaints which those in the queue were voicing.

It was around 12:00 noon when MC 1 was able to get into the consulting room.

The doctor was talking on the telephone when MC 1 entered. The telephone rang after a short interlude, and the telephone conversation lasted for about ten minutes. This was followed by another call which went on for about three minutes.

In the course of the consultation two men appeared at the window. They looked like car mechanics. The doctor went to see them at the window. They talked briefly and the doctor handed them some money and came to continue with the consultation.

MC 1 noticed that after the initial presentation of his condition the doctor did not have any questions to ask. He simply gave him a note to go for sputum examination at the laboratory, to have an X-ray examination, and to go for voluntary counseling and testing for HIV infection.

The doctor told MC 1 that the cost of the investigations was TS 5,000/= MC 1 told the doctor that he was not in position to pay that much money, but the doctor simply said that he could not provide him any help.

MC 1 went for the X-ray. There was no long queue there, and he entered to room after 10 minutes only. He found two doctors to whom he explained his medical condition and the fact that he did not have the money which the first doctor said would be required for the investigation. The two doctors looked at each other and one of them told MC 1 to go home, get the money and come back for the X-ray. The doctor explained that they were mere employees who were require to remit any fees we collect to the Accounts Office and could not help him in way.

From the X-ray department MC 1 went to try his luck at the laboratory for sputum investigations.

The queue at the laboratory was also not very long and it took him twenty minutes to see the doctor. He explained why he was there and the doctor gave him a container for collecting the sputum. MC 1 was not asked for any fees, and left the hospital around 2:30 in the afternoon.

5: The experience of MC 2 in Hospital A

MC 2 arrived at Hospital A around 9:30 in the morning. She joined the registration queue, and was in the queue for half an hour. She was given the card after paying TS 300/=.

She joined another queue heading to the doctor's consulting room. She was in this queue for three and half hours. There were two doctors other doctors in the room. And so she went o the table of the doctor who had no patient at the time. She stood there for some time before the doctor took any notice of her. Finally the doctor asked her what her

problem was, and all this time she was still standing up. When MC 2 began to describe her condition the doctor said he was sorry, and asked her to sit down on the chair and wait for a little bit.

This time the doctor was listening very carefully, and at the end of her statement the doctor prescribed some medicine for her and the following exchange between them ensued:

> **Doctor:** *"You have to pay fifteen thousand shillings for a procedure called D & C"*
> **MC 2**: *"Sorry doctor I don't have that kind of money today."*
> **Doctor**: *"Ok, let me write my telephone number for you on your receipt. If you don't find me in the office you give me a call."*

MC 2 agreed with the doctor and left the hospital at around 2:00 PM.

The next day MC 2 wrote an SMS message to the doctor on the number given to her the previous day. The message read:

> "I'm sorry doctor; I couldn't come for the procedure because I failed to get five thousand shillings. When I get that money I will come"

In response, the doctor said:

> "I am sorry for you, but you can come with the ten thousand shillings and ca bring the rest later"

When MC 2 got the message from the doctor she sent a reply to say that this was public call telephone in an office, and the lady to whom the message was meant had left after sending her message.

MC 2 made two conclusions from her experience:

a) it was possible that the service was free but the doctor needed money for his own use
b) or the doctor wanted to help her so that later on he could try to seduce her.

6: The experience of MC 1 in Hospital B

MC 1 arrived at Hospital B around 9:00 and joined the registration queue. It took 40 minutes to get the card and was charged 500 shillings

Thereafter, he joined another queue for men and waited to be called in to see the doctor. All the patients' cards were collected and names were called for the individuals to get into the consulting room. The system was for people to be called according to the order in which their cards were collected. MC.1 was called at around 12:30

The doctor appeared to be very familiar with MC 1's condition because he did not pay attention but proceeded to write something on the card. When he finished writing he directed him to go to test for malaria first. MC 1 tried to explain to the doctor that he had just recently finished a course of anti malaria medicine without any improvement. The doctor insisted that it was important for MC 1 to have the malaria test done in the hospital before anything else can be done for him

MC 1 explained to the doctor that he had no money for the malaria test because he is very poor and that even the money he used to obtain the card was given by a good Samaritan. The doctor said he was sorry but could not help him.

Then the doctor went out of his office while MC 1 lingered on for five minutes without any help. MC 1 went straight to the malaria laboratory. The process required one to pay first before the test could be done. Once again MC 1 explained to the Technician that he had no money. The technician told him he could not help him:

> *"I cannot help you because everything has already been set in the computer. If I had money I could pay for you. You should go back to the doctor who prescribed the test and ask him to allow you to be tested for free. I cannot do anything."*

MC 1 left the laboratory and went away.

7. The Experience of MC 2 at Hospital B

MC 2 reached Hospital B at around 9:15 AM. It took her some 30 minutes to get the card after paying 500 shillings. She was directed to go to Room Number X to see the doctor.

When MC 2 got to the doctor's door it was written Gynecologist. At the door there was a nurse with a light green dress who collected the cards and handed them to the doctor.

MC 2 was still waiting for her turn to see the doctor until 12:00 noon. While waiting, she saw nurses taking their patients inside without waiting in the queue. Some exchanges among the patients waiting in the queue ensued concerning this form of favoritism and queue jumping:

> **Patient A:-** *"Nurses are the first to break the system which they set themselves"*
> **Patient B:-** *"Blessed are those with relatives who are nurses"*
> **Patient C:-** *"Do you think all of them are their relatives? If you have five thousand shillings find one to hold your hand and see if you cannot be served immediately*"
> **MC 2*:-*** *But five thousand shillings is a lot of money.*
> **Patient D:-** *"Five thousands? Even two thousands you can be taken to see the doctor. Even if you have only one thousand they will not leave you, they are very hungry"*

MC 2 left to go to the reception. On the way she met a nurse in a light green dress, she greeted her nicely, and the nurse replied in the same way. After the exchange of greetings MC 2 told the nurse:

"I am sorry sister, I have been here since morning, my card was taken inside to the doctor but I have not been attended till now, can you help me please? Here is some money for a drink of soda please."

MC 2 gave the nurse two thousand shillings. The nurse closed her hand with money and asked MC 2 for her name and directed her to go back and wait.

MC 2 thanked the nurse and rejoined the queue.

After three minutes the nurse entered in the Gynecologist room, and two minutes later MC 2's name was called. MC 2 entered the room, and then the nurse went out.

Two women doctors were in the room, and a number of nurses in light green dresses who appeared to be sitting aimlessly. MC 2 approached one doctor who was writing prescriptions on three cards which had been brought by a nurse.

When she finished she asked MC 2 for her problem following which the doctor directed her to go for ultrasound examination. It is on the basis of the ultrasound examination that the doctor would prescribe the treatment.

MC 2 left the hospital around 12:45 having experienced conditions which make people give bribes, and having done so herself..

8: Experience of MC 1 at Hospital C

MC 1 arrived at Hospital C around 8:45AM. He joined the registration queue. He was in the queue for one hour and obtained the card after 300 shillings. Thereafter he went to queue at the doctor's room. He managed to get into the doctor's room at around 10:30 AM.

MC 1 explained his problems. The doctor asked him how long he had had the problem to which he replied it was two months. The doctor directed him to go to Room Y to see the chest specialist.

When MC 2 got to Room Y he found a long queue. While in the queue he saw was that the hospital workers were taking patients inside without letting them join the queue. Patients who were in the queue complained but no one took any notice.

MC 1 decided to leave the queue and went to stand at the door waiting to bulge in as soon as a patient came out. When he was at the door one doctor who was passing at the corridor asked him not to stand there but to get in the queue. The following exchange ensued:

MC 1:- *"I have decided to stand at the door to wait for a patient to come out so that I can go in. Hospital staffs keep taking those they know directly into the doctor's room without any regard for those of us who are in the queue.*
Patient X: - *"They don't even ask us, they just enter.*

Patient Y:- *"Ah, some of us are used to these things, those are the owners of the hospital"*

The doctor did not make any comment and went away. When a patient came out MC 1 walked in the doctor's room.

The doctor seemed to be a good person who cared for his patients. He welcomed him and asked for his problem. The doctor prescribed sputum investigation, and explained to him that he might have TB, and could be transmitting it to other people. He also assured him that the test was free of charge. The doctor explained further that some patients do not bother to get the test done, or they do not collect their test results. Therefore the doctor took MC 1's name and the name of his cell man down, so that if he does not seen he can be followed up.

MC 1 got out of the doctor's room and went straight to the laboratory. At the laboratory there was no queue, and that was around 12:15 noon. The researcher was given a small plastic container to put his sputum. He gave the container to the laboratory technician and left the hospital around 12:45. No charges were raised for the sputum test.

9: Experience of MC 2 at Hospital C

MC 2 arrived at Hospital C around 10:00 AM. It took her 30 minutes only to get to the head of the queue and pay her registration fee of three hundred shillings. Thereafter, she went to join the queue to see the doctor. She entered the doctor's room at around 11:30.

In the doctor's room she was attended by a male doctor who listened to her problems carefully. The following exchange ensued:

Doctor: "You must go to the laboratory and have two tests, the first one is for vagina discharge and the second one is for ultra sound."
MC 2: Are the tests free?
Doctor: "They are not free sister; but you need to pay only three thousand shillings.
MC 2: "I shall have to come back later because I don't have that much money."
Doctor: "don't make a joke sister Z, don't you have three thousand shillings? OK I shall give you the money. I want you to get well"

MC 2 took the three thousand shillings from the doctor and thanked her. The doctor insisted that she should take the results to him so that he can write the prescription for medicine.

MC 2 left the hospital at around 12:00 noon

10: Experience of MC 1 at Hospital D

MC 1 arrived at Hospital D around 9:00AM. He went straight to the Reception for the registration card as there was hardly and queue. MV 1 was not asked to pay anything after telling the Receptionist that he was a poor man and did not have any money.

It took MC 1 to get to the head of the queue at the doctor's room. The doctor appeared very attentive to his explanation of his illness condition to him.

Then the doctor directed him to the TB specialist.

MC 1 found a short queue at the TB specialist. He managed to see the doctor at 11.00. The doctor prescribed tests for malaria and TB. MC 1 explained that he could not afford to pay for the tests but the doctor told him the tests would be for free

First, MC 1 went to test for malaria, and the test was free. From there he went to test for TB. He was given a container for sputum and told to bring it on early on Monday for the test. He left hospital at around 12:00 noon.

11: Experience of MC 2 at Hospital D

MC 2 arrived at Hospital D at around 10:00 AM. She was in the registration queue for only. There were only 20 patients but the queue progressed very slowly. When she got close to the window she discovered why the queue was moving very slowly. The clerk who was registering the patients was also selling air time vouchers. Also beside her there was a woman who was selling chapatti. She was heard instructing the clerk to take chapatti to the doctors who had placed an order.

When the time for the researcher to obtain the card arrived, she registered and took her card after paying five hundred shillings. She also asked for TTCL air time, and was told that there were no TTCL vouchers left. MC 2 left to join another queue to see the doctor at around 11:10AM

The doctor listened carefully and wrote in her card. He told her to go for ultra sound test which would cost her six thousand shillings. She thanked the doctor and left the hospital.

12: Experience of MC 3 at Hospital A.

MC 3 arrived at Hospital A at 9.30 AM. She was in the registration queue for half an hour and left having paid the 300/= fees. The queue to the doctor's room took another 20 minutes.

There were three doctors in the room. She went to one of the two doctors who had no patients at the time. The other doctor without a patient called her to him and the following exchange ensued between the doctors:

Doctor 1: "Come over here beautiful girl so that I may attend you."

Doctor 2: Please let her come to me."

Doctor 3, his patient having left: "Let her come to me so as to end the squabble."

MC 3 went to be attended by Doctor 3. The doctor listened to her attentively and wrote down on her card. He explained to her that she needed to have the ultrasound examination for which she has to pay 5,000/=. MC 3 told the doctor that she did not have that much money and would have to come back the next day. The doctor told her if money was a problem she should not worry. He called Doctor 2 to them. He came over and asked what the problem was. The following exchange ensued:

Doctor 3: *"Miss X, this is the 'pedeshee' of this hospital. Don't worry, he will give you the money for the ultrasound examination.*

Doctor 2: *"Let me take you for the ultrasound examination."*

MC 3*:* *"Thanks doctor. I am not prepared for that examination tody. I shall have to come back tomorrow.*

Doctor 2: *"OK, when you come tomorrow come directly to me. The offer still stands.*

MC 3 stood up, thanked all the doctors and walked out. That was around 11.30 AM.

13. Experience of MC 3 at Hospital C

MC 3 arrived at Hospital C at 10.00AM. She stayed in the registration queue for 15 minutes only and left having paid 300/= for the card. The queue to the doctor's room was rather slow. After some time a doctor passing by saw her and asked her if she wanted to see the doctor. She replied in the affirmative, and the doctor asked to get in. MC 3 rose to get into the doctor's room feeling rather embarrassed for jumping the queue. The doctor took her in. A doctor who was in the room asked to go to him, but the doctor who had brought her in said he would attend her. MC 3 decided to go to the female doctor who was in the room.

MC 3 was attended by the female doctor, At the end of the consultation her doctor told her that her medical condition was common, and that she would get over it. She directed her to go to the laboratory for investigations.

MC 3 got out the doctor's room at around 11.40 and decided to go home.

14: Discussion

As expected the experiences of the mystery clients bring into sharp focus the conditions which underlie involvement in corruption in public health facilities.

- Delays in obtaining the service one went for due to other patients jumping the queue, either because they know the doctors or are willing to pay a bribe to nurses.
- The inconsistency across hospitals in applying the policy for exempting or waiving cost sharing fees to the indigent or those with TB.
- The inconsistency in the amount of fees charged for registration and other standard tests.
- Even though payment of bribes in the form of sex was not experienced the female mystery clients were given or promised favors which could be interpreted as sexual innuendoes.
- The younger lady mystery client experienced what amounted to harassment meant to soften her to requests for sexual favours in return for the good turn done for her.

CHAPTER 7: Synthesis of the study results

1: Introduction

This chapter presents a synthesis of the results of the different components of the study. This is done against the backdrop of the study objectives to which all the components sought to make a contribution.

2: First Objective

> *"To examine awareness and roles of service users in the corruption that takes place in public health facilities."*

The findings indicate that members of the general community as represented by the sample of community members and by participants in the FGDs are aware that corruption takes place in public health facilities.

They mentioned the different term used to refer to bribes, the context in which bribes are demanded and paid, and much more important the shared definition of the situation which enables individuals to know for sure when the delay in obtaining care means a bribe is required and the role which other patients play in alerting an individual to the necessity of paying a bribe.

The interviews with service providers in turn indicate that sometimes service users will press a service provider to accept a bribe, and indeed the distinction between a bribe and a gift implies that there are cases when the initiative is taken by service users.

3: Second Objective

> *"To examine the service users' experience and practice of corruption in public health facilities."*

The mystery clients component of the study (chapter 7) was designed to meet this particular objective. The Focus Group Discussions (chapter 5) also provided information about the experiences which participants had with corrupt practices in the health sector.
Interviews with patients (chapter 3) and community members (chapter 4), give quantitative information about the proportion of respondents who reported as having paid bribes at one time or another.

A very small proportion of patients reported having been asked to pay a bribe (17.7%). The fact that these patients felt vulnerable to serious repercussions should their report be disclosed to the health workers to whom they still depended for health care despite assurance to the contrary, coupled with the fact that personal identifiers were not recorded explain the low proportion of patients who were willing to own up. This is in

contrast to the higher proportion of the sample of community members who admitted to having ever been asked to pay a bribe (55%).

Harrowing stories of the experiences with bribes were given by participants in FGDs. These referred to the negative consequence of the denial of health care due to inability to pay a bribe.

Mystery clients in turn exemplified how time can be wasted in the process of seeking health care if one is unable or unwilling to give a bribe.

All these serve to underlie the unethical nature of corrupt practices and the denial of the human rights of individuals who are not in position to pay a bribe.

4: Third Objective

> *"To examine the effects of corruption on the health care seeking behavior of service users."*

Service providers indicated that loss of confidence in service providers was one of the negative impacts of corruption in the health sector, and that paying bribes depleted the meager resources of poor people (chapter 2) Such resources could have been spent on other livelihood needs. The outcome can only be inability to seek health care, or to seek alternative care.

The findings from interviews with community members (chapter 4), and of Focus Group Discussions (chapter 5), show that considerations of bribes force prospective service users to take extra money when they go to seek care in public health facilities, even when the person who is sick may be a child who is exempted from having to pay. The implication is clear; one has to have enough money for statutory fees and more money for the illegal payments. Those without money have to think twice before trying to seek care, as the experience of the poor man among the mystery clients (Chapter 7).

5: Fourth Objective

> ***"To examine the awareness of, and involvement in corruption by service providers."***

The study component which involved a survey of health workers was designed specifically to meet this objective, and is the subject of the second chapter of this report.

The sample of health workers interviewed during the survey were aware that corruption was rampant in the health services, and about one-fifth of them admitted to having taken a bribe at one time or another.

There is still some confusion in the minds of some health workers about what exactly constitutes bribery. Some think that what a patient gives, ostensibly as a mark of

appreciation for good quality care received – a gift in cash or in the form of other items/commodities - do not constitute corruption. What this point of view ignores is that some give this so called gift in anticipation of getting even 'better' quality care next time round. Furthermore it is ironical that one should expect appreciation and back shish for service rendered when one is engaged and formally paid to render such a service. And since for some poor patients as the results of the survey with patients (chapter 3) show, the monetary gift given by such poor persons may actually amount to a sizeable proportion of their disposable income. This practice cannot be condoned.

The findings also indicate that some of the service providers started getting involved in corruption during their pre-service training days, that they themselves paid bribes to senior officials in the health sector in order to influence outcomes of bureaucratic processes in their favour, and to pay bribes for services in other sectors. An even more marked is the admission of some of them to give money to relatives to pay bribes in health care delivery situation where they have no influence. All these mean that corruption, especially in the form of soliciting and accepting bribes have become a social norm which service providers have come to accept and can justify to themselves.

This justification of bribes is best expressed in the reasons providers give for the practice: poor pay. Other reasons which connote failure on their part are not given as much prominence as that of poor pay. It is of no surprise that even members of the general public accept/give this reason for corruption in the health service. This came out in the reasons the sample of patients gave for bribes (chapter 3), the reasons which the sample of community members gave (chapter 4) and what participants in Focus Group Discussions said,(chapter 5).In other words poor pay is now a sufficient justification for demanding bribes by service providers , and by service users for giving bribes.
Service providers are aware of the negative impacts of bribes, but they seem to see it as a necessary evil. Consequently even those who do not engage in such corrupt practice do not appear to view it with moral indignation when they see colleagues involved in it, and 'looking the other way' in the face of corrupt practices by colleagues hence they do nothing about it. It is this high level of tolerance for corrupt practice which is manifest in the experience of the young mystery client (chapter 7). A doctor refers to a colleague as "pedeshee" who has no problem giving money to beautiful ladies in anticipation of getting sexual favours, as if it was an endearing adjective.

The main reason given for not reporting such individuals is not to get into trouble. This is essentially an indictment of the management system which does not punish wrong doers or reward outstanding behaviour. And such a system is indicative of moral depravity to which management is party.

The service providers' views about how to combat corruption in the health sector are in line with their views about its causes. Because corruption is caused by poor pay, in order to combat corruption effectively health workers' pay should be increased.

CHAPTER 8: Recommendations

The caveats for the recommendations

The conclusions and recommendations of any research report have to take into account the limitations of the research particularly when these have to do with the validity of the results. The major limitations of the results of this study have to do with the small samples of the respondents covered by the three surveys involving health workers, patients and community members. In view of the fact that the study was a straight forward sample survey and not an interventions study these small sample sizes do not render the findings worthless. Larger samples are more likely to confirm the indications arising from the findings of this survey.

This problem has its roots in the financial constraints and was foreseen from the outset. It is clear that when sample sizes are too small, if the sampling was made following standard random sampling procedures and ethical principles were observed in the conduct of the results can be taken to be indicative as opposed to conclusive and have value. This is the case in this situation, and this stance is reinforced by the way the results from the surveys were corroborated by the qualitative components of the study, namely the FGD and the Mystery Clients.

It follows therefore that because of the indicative nature of the findings of this study the recommendations made are of a strategic nature rather than of specific operational measures. It is fortuitous that this report is being submitted when corruption in high places is topical. It clearly is the opportune time to raise the issue of dealing with grand corruption by senior officials so that even when it comes to fighting petty corruption one can count on establishing and enforcing regulatory and supervisory measures which can be enforced by senior leaders who are seen to be credible and have the moral authority to take the culprits to account. It is futile to expect workers to inform on the corrupt practices of their colleagues to senior officials who cannot act on such accusations.

Three recommendations are given for strategic action by YAV:

First, bearing in mind that corruption is pervasive extending from training institutions, and involves bribe takers themselves having to pay bribes within their own sector and to other sector; YAV needs to join forces with other players in the field to advocate for addressing the root cause of corruption. The study findings point to inadequate remuneration, non observance of professional ethics, and weak or nominal religious faith which tolerates wrong doing.

The usual response of the government in the face of demands for higher pay is that no sector can be paid out of context of the pay made in other sectors. This is not born out by the facts on the ground. When it is realized that poor pay may not attract conscientious people, and may not even retain some of those who join the profession there is need to open the debate to the general community and let them say why doctors and nurses should not be paid well.

With regards to health care ethics YAV needs to put pressure on the Medical and Nursing Associations to take the upholding of these ethics among their members as an important cause, while also working on the social welfare aspects of their members. YAV should

also put pressure on the Medical and Nursing Councils to be tough on breaches of ordinary health care ethics which invariably affect the quality of health care, and not to concentrate on high profile cases of malpractices only. Equally important is the need for the Councils to recognize and reward exemplary ethical conduct, a practice which would go a long way in creating an enabling environment for role models to and mentors to function. But even more important is for the government to provide adequate resources in terms of human resources in order to overcome shortages of staff which lead to heavy workloads, equipment and supplies. This would eliminate the unjust rationing system that health workers operate with in which the ability and willingness to pay bribes introduces inequity when such rationing has to be made, such as in scheduling operations – which was a case in point given by some of the health workers who admitted to having taken bribes.

Religious faith is a personal issue but its manifestation has impact in administering justice. It is noteworthy that a Bishop of one of the churches has made the claim that his training institutions would strive to produce leaders who will not engage in corrupt practices. But as Ake (1993) says with regards to leaders who misappropriate public funds in order to make contributions to parochial projects, the Bishop did not say anything about corrupt believers which the churches embrace and to which such corrupt believers give offerings and even bend the procedures and rules in order to benefit the churches or its leaders. A case in mind has been the misuse of the exemption from paying import duty which churches have enjoyed until recently.

The strategic action we are recommending is for YAV to forge alliances with different players in working for societal transformation. Advocacy needs to be directed to all the pillars of the Government. But there is need for concerted education of the general public. The model provided by Haki Elimu is worth studying and adapting it for this purpose.

The second recommendation is for YAV to formulate prototype policies for the kind of positions it seeks to advance, in the area of selection of students for entry into institutions for training health workers, and of appointment into health care jobs. The issue here is how do you recognize people whose motive is selfless service to humanity rather than self aggrandizement by using the opportunities for fair and foul means which the health care job presents? What system of differential pay is needed to take into account the sensitive nature of health care occupations? What whistle blowing mechanism would provide protection to the whistle blower while upholding the right of the accused for self defence? It is these prototypical and costed policies which would be helpful in engaging with people who have become so despondent that they cannot think of a corrupt free health services system.

The third recommendation is for YAV to commission and fund adequately another study which would meet the standards of statistical rigour which would provide the quantitative estimates which were sought by this study. That would then provide specific areas for

concerted action once the momentum for the societal transformation gains momentum as a result of the two strategies outlined above. It is in effect a recommendation for a follow-up study which would be designed and implemented to validate the findings of this study.

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Annex 1

DATA ANALYSIS ON SOME KEY VARIABLES BY DISTRICT

A: Health Workers

Table 1: Responses of health workers about whether they hade ever taken a bribe by district

	Ever Taken Bribe		
District	**Yes**	**No**	**Total**
Ilala	26 (28.9%)	64 (71.1%)	90
Kinondoni	21 (21.9%)	75 (78.1%)	96
Temeke	17 (16.8%)	84 (83.2%)	101
Kibaha	10 (14.5%)	59 (85.5%)	69
Total	74	282	356

Table 1 shows that less than a third of the respondents across the districts admitted to have ever taken a bribe. Nevertheless, bribe takers tended to come mainly from Ilala district followed by Kinondoni district.

B: Community Members:

Table 2:Perception of community members on existence of corruption in the public health facilities by district:

District	Whether corruption exists		
	Yes	No	Total
Ilala	85 (85.9%)	14(14.1%)	99
Temeke	87 (87.9%)	12(12.1%)	99
Kinondoni	102 (87.9%)	14(12.1%)	116
Kibaha	65 (73.9%)	23 (26.1%)	88
TOTAL	339	63	402

Table 2 indicates that generally corruption is high across all study districts. However, the rate of corruption is relatively lower in Kibaha district.

Table 3: Responses of community members whether they have ever been asked to pay a bribe by district.

District	Ever been asked to pay a bribe		
	Yes	No	Total
Ilala	55 (53.4%)	48(46.6%)	103
Temeke	63 (62.4%)	38(37.6%)	101
Kinondoni	62 (53%)	55 (47%)	117
Kibaha	47 (51.1%)	45 (48.9%)	92
TOTAL	227	186	413

Table 3 shows that slightly more than half of the respondents in the three study districts (Ilala, Kinondoni, and Kibaha) acknowledged to have been asked to pay a bribe. However, the situation was different in Temeke district where about two thirds of the respondents acknowledged to have been asked to pay a bribe.

Table 4: Community members' perception of seriousness of the problem of corruption by district.

	The extent to which corruption is a serious problem in delivery of health services.					**Total**
	Greater extent	Some extent	Small extent	Not at all	Not sure	
Ilala	56 (54.9%)	10 (9.8%)	11(10.8%)	4 (3.9%)	21 (20.6%)	102
Kinondoni	62 (56.9%)	18 (16.5%)	13 (11.9%)	4 (3.7%)	12 (11%)	109
Temeke	67 (65%)	11 (10.7%)	4 (3.9%)	0	21 (20.4%)	103
Kibaha	22 (24.7%)	6 (6.7%)	11 (12.4%)	26 (29.2%)	24 (27%)	89
Total	207	45	39	34	78	403

Combining "greater extent" and "some extent" responses in table 4 gives an impression that about three quarters of the respondents in three districts (Temeke, Kinondoni, and Ilala) had the perception that corruption is a serious problem. However, two thirds of respondents in Kibaha district ("small extent", "not at all", "and not sure" responses combined together) basically had the opinion that corruption is not a serious problem.