INSTITUTIONAL FACTORS INFLUENCING PETTY CORRUPTION IN PUBLIC HEALTH SERVICES IN TANZANIA

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Abstract

General objective

This study seeks to explore the institutional factors at public health facilities that induce service providers to solicit bribes from health service users, and the impact of such practices on quality and utilization of health services.

Methodology

A cross-sectional design was employed, using both qualitative and quantitative approaches for data collection. This is in accordance with the study objectives stipulated in the terms of reference (ToR). Specifically, data were collected through: semi-structured questionnaires, key informant interviews, Focus Group Discussions (FGDs) and observations.

Findings

The findings from the interviews with community members indicated that problems in governance play a great role in enhancing corruption practices. The factors rated to be the most significant, in descending order, are: absence of/limited accountability (50.9%); failure to abide by professional ethics (49.3%); and absence of/limited supervision (47.3%).

Regarding the role of supply side constraints, the study found that drugs shortages are perceived to be a factor influencing the engagement in corruption practices. About two thirds of interviewed community members indicated that they were aware that health staff sell medicines and equipment meant for users at public health facilities. Where the impact of corruption on health-seeking behaviour is concerned, both out- and in-patients showed that more than two thirds of respondents would opt to return to the same public health facility, concerns about corruption notwithstanding. This attitude was attributed to the high cost of services in private health facilities which would be the alternative available to patients.

The findings from interviews with community members revealed that the effectiveness of the Health Facility Governing Committee (HFGC) is very limited.The overwhelming majority (85.7%) of community members

indicated that they did not report their complaints about corruption to the HFGC because they did not know its members.

Conclusion

These findings underscore a need to strengthen governance systems in health facilities in order to combat corruption effectively and improve the quality of services at large.

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List of Abbreviations

HFGC	=	Health Facility Governing Committee
LGAs	=	Local Government Authorities
NGO	=	Non-Governmental Organization
PLHIV	=	People living with HIV and Aids
TI	=	Transparency International
UNDP	=	United Nations Development Programme
URT	=	United Republic of Tanzania
WHO	=	World Health Organization
YAV	=	Youth Action Volunteers

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Executive Summary

Background

The current study was carried out, primarily, in response research gaps emanating from a previous study commissioned by Sikika (then YAV). The original study focused on corruption in Tanzanian health services but failed to address the following issues adequately: the role of scarcity of resources; functionality of redress mechanisms; institutional factors that support corrupt behaviour; supply side constraints that promote corruption; impact of corruption on health-seeking behaviour; and the role of health facility governing committees in fighting corruption.

General objective

This study seeks to explore the institutional factors that induce service providers to solicit bribes from health service users at public health facilities, and the impact of such practices on the quality and utilization of health services.

Methodology

A cross-sectional design was employed, using both qualitative and quantitative approaches for data collection. This is in accordance with the study objectives stipulated in the ToR. Specifically, data were collected through: semi-structured questionnaires, key informant interviews, Focus Group Discussions (FGDs); and on-site observations.

Findings

The study used multiple methods to generate information that synergistically responds to the study objectives and hypotheses.

Hypothesis 1: Corrupt activities are supported by various institutional factors.

The findings from interviews with community members indicated that problems in governance-related institutional factors play a very large role in enhancing corruption practices. The factors rated to be most significant,

in descending order are: absence of/limited accountability (50.9%); failure to abide to professional ethics (49.3%); and absence of/limited supervision (47.3%). There was a statistically significant association between institutional factors that were tested (lack of/limited supervision and lack of/limited accountability) and the likelihood that a patient/carerhad paid a bribe to the health worker ($p < 0.001$). Overall, therefore, the study findings support the hypothesis, implying that institutional factors related to governance create an environment in which corrupt activities can thrive.

Hypothesis 2:Supply side constraints create incentives to exchange quality services for (black) market prices that are above the regulated (standard) price scheme.

Regarding the role of supply side constraints, the study found that drugs shortages are perceived to be a factor influencing engagement in corruption practices. About two thirds of interviewed community members indicated that they were aware that health staff sell medicines and equipment meant for users at the public health facilities.

This was attested to by FGD participants as illustrated by quotations. Moreover, in-depth interviews with managers of health facilities also revealed that patients are dissatisfied with a situation whereby they have to buy drugs from health workers instead of getting them from a pharmacy. Patients suspect that health staff steal from health facilities the very drugs that they sell to patients. Overall, therefore, the study findings support the hypothesis that the shortage of resources creates incentives for health workers to render services at higher costs which do not conform to standard pricing schemes.

Hypothesis 3: Corrupt behaviour at public health facilities affects users' preferences over health service providers.

This hypothesis was tested by examining the responses of service users to the question of how the experience of corruption would influence their decision on where to seek care in the future. The responses by both out- and in-patients showed that more than two thirds of respondents would opt to go to the same public health facility, concerns about corruption notwithstanding.

In essence, the study has shown that the experience of corruption does not change service users' preferences for particular health facilities or care. When they were asked to justify their preferences, most of the respondents referred to affordability, implying that, because of poverty, most users see public health facilities as the first choice in spite of corruption. Indeed, it was argued that the cost of a bribe in a public health facility is lower than the actual medical cost in a private health facility. Nonetheless, findings from FGDs revealed that health workers' corrupt behaviour such as theft of drugs, which creates shortages and non-compassionate care (quiet corruption), were reported to deflect patients away from public health facilities.

It can, therefore, be concluded that bribery per se [a tendency in health workers to solicit bribe(s) as a condition for rendering service(s)] does not change people's health-seeking behaviour but, when corruption causes shortages or an absence of medicines and other materials, patients/carers are compelled to look for alternative sources of care.

Hypothesis 4: Health Facility Governing Committees effectively follow up citizens' complaints about corrupt behaviour at the health facilities in question.

The findings from interviews with community members revealed that the effectiveness of HFGCs is very limited. The overwhelming majority (85.7%) of community members indicated that they did not report their complaints about corruption to the HFGC because they did not know its members. Failure to report corruption complaints to the HFGC was associated with the perception that the efforts made were no adequate for fighting corruption ($p = 0.002$).

In addition, in-depth interviews with members of HFGCs themselves indicated that many of them (62.2%) admitted that they did not follow up patients' complaints about corruption. This deficiency was attributed to the unwillingness on the part of facility management to cooperate. Overall, these findings lead to a rejection of the above-stated hypothesis. In other words, *Health Facility Governing Committees **do not** effectively follow up citizens' complaints about corrupt behaviour at the health facilities in question.*

Conclusion

These findings underscore a need for strengthening governance systems in health facilities in order to combat corruption effectively and improve the quality of services at large. The intervention strategy should be multi-dimensional, involving all the key stakeholders – the government/councils, facility management, civil society organizations and communities.

1 Background of the study

1.1 Introduction

This is the report of a study which was commissioned by Sikika, a civil society organization which works to improve policy and governance of the health sector in Tanzania. It builds on the first petty corruption study commissioned by the same organization (then Youth Action Volunteers – YAV) with the same consultants. Thus, most of the text in the sections that follow has been borrowed from the report on the earlier study (Sikika 2010).

1.2 Overview

Corruption has become part and parcel of daily life in many countries including Tanzania. According to the Warioba report (URT 1996), almost all sectors in Tanzania are engulfed in corruption. Indeed, as the years go by, both the bribe givers and those who solicit bribes have come to recognize corruption as normal behaviour. The ubiquity of corruption is evidenced by the words which are used to imply 'a bribe'. Those who solicit and receive them use polite and euphemistic terms such as *kitu kidogo* (something small), chai (tea) and *mshiko* (something that greases the palm). The Kiswahili words for corruption: *rushwa, hongo* and *mulungula* are commonly used but not during a corrupt exchange.

While corruption is a problem in all sectors, it is of particularly critical concern in the health sector. Corruption can mean life or death for an individual patient. Its consequences include: lessening of resources aimed at improving health; diminishing of quality, equity and effectiveness of health care services, and an increased cost in service provision.

Tanzania's health sector is choked with both petty and grand corruption. However, it is the former that is generally experienced by services users. Petty corruption is practiced in different forms. For instance, it might be in the form of a health worker soliciting a bribe or a patient/carer prompting a health worker to receive a bribe meant to induce him or her to provide better quality care to the patient. In Tanzania, as in other poor countries, bribes are socially acceptable and are justified as a way of compensating poorly paid health professionals working for government health facilities.

According to Mwafisi (1999), the main reasons for the existence of corruption in the Tanzanian health sector include: chronic shortages of both human and non-human resources, excessive red tape, poor salaries, poor management and supervision and a lack of information for clients.

A rapid appraisal that was conducted by the national commission on corruption revealed opposing perspectives on the 'real' causes of corruption. On the one hand, health workers asserted that disproportionately low salaries constitute the central cause of corruption in the health sector. On the other hand, the national commission itself was of the opinion that the actual problem lay in the failure of health workers to adhere to health professionals' ethics.

1.3 The research problem

The ToR for this study (Sikika 2013) were informed by the findings of the previous petty corruption study (Sikika 2010). The 2010 study examined the awareness and practices of corrupt activities at public health facilities by health service providers and users.

Specific gaps were identified in the original study and these constitute the research problem for this study. The gaps relate to: motivation of agents, scarcity of resources, functionality of redress mechanisms,institutional factors that support corrupt behaviours,

strategies (non-prescriptive behaviour): who does what, when and where; supply side constraints that promote corruption; impact of corruption on health-seeking behaviour; and the role of HFGCs in fighting corruption. The current study seeks to address some of these gaps.

1.4 General objective

To explore the institutional factors at public health facilities that induce service providers to solicit bribes from health service users, and the impact of such practices on the quality and utilization of health services.

1.5 Specific objectives

1. To assess the extent to which institutional governance factors (accountability, transparency, supervision and ethical standards) are perceived to induce service providers to solicit bribes from health service users.

2. To explore to what extent health workers are perceived to take advantage of the shortage of resources (health workers, medicines, medical equipment and medical supplies) at public health facilities by offering services, medicines and supplies to solvent patients under the counter or through private pharmacies.

3. To examine the effects of petty corruption on the quality of public health services and how it affects the health-seeking behaviour of service users in both urban and rural areas.

4. To examine how effectively health facility governing committees act upon information about corrupt practices at the health facilities in question. In particular, to analyze which methods for enforcing prevailing service quality standards are available to and effectively applied by the committees.

1.6 Hypotheses

1. Corrupt activities are supported by various institutional factors (the 'rules of the game').
2. Supply side constraints create incentives to exchange quality services for (black) market prices that are above the regulated (standard) price scheme.
3. Corrupt behaviour at public health facilities affects users' preferences for health service providers.
4. HFGCs effectively follow up citizens' complaints about corrupt behaviour at the concerned health facilities.

1.7 Significance of the study

The first petty corruption study shed light on the magnitude of corruption and how health staffs engage in it. The current [second] study takes a step further by examining the role of governance in addressing corruption in public health facilities. The study examines both the supply and demand sides of governance. Therefore, its findings can be expected to inform the design of appropriate and comprehensive interventions.

1.8 Conceptual definitions

The key concepts used in this study are defined as follows:

Corruption in the health sector — refers to the situation in which health workers, as civil servants, abuse their roles or public resources for personal gain (Carrin 2009).

Petty corruption — refers to a specific form of corruption in the health sector whereby health workers demand bribes or speed money before performing their public duties (Carrin 2009).

Governance — refers to "the exercise of economic, political and administrative authority to manage a country's affairs at all levels. It

comprises mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences" (UNDP 1997, p.4).

Good governance — refers to a system which is, among other things, "participatory, transparent and accountable, effective and equitable, and it promotes the rule of law. It ensures that political, social and economic priorities are based on broad consensus in society and that the voices of the poorest and the most vulnerable are heard in decision-making over the allocation of development resources" (Sakiko and Richard 2003, p.4).

The UNDP has listed core elements of good governance. These include: participation, rule of law, transparency, responsiveness, consensus orientation, equity, effectiveness and efficiency, accountability and strategic vision (Abdellatif 2003)

Accountability — refers to the obligation of an individual or organization to account for its activities, accept responsibility for them, and to disclose the results in a transparent manner. It also includes the responsibility for money and other entrusted property. In terms of public accountability, the authorities themselves are being held accountable by their citizens (Bovens 2007).

Where a system of accountability prevails, it is expected that authorities will enable citizens to raise concerns and objections, perhaps through suggestion boxes in health facilities or by offering service users direct access to health managers in order for them to submit their complaints regarding services.

2 Review of the literature

2.1 Introduction

This literature review borrows heavily from text found in Sikika's previous study report (2010) – particularly on the causes and consequences of corruption. However, a new section on the role of governance structures on corruption has been added.

2.2 Causes and consequences of corruption

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

The first, and arguably a landmark report on corruption in Tanzania, is the famous Warioba Report, formally known as the Report of the Presidential Commission of Inquiry against Corruption (URT 1996). The report lays out the findings of 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 sectors of the economy, including the health sector.

The most significant findings in the Warioba Report regarding corruption in health services are that:

- 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 after 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 services.

  - Under-funding of health services resulted in a shortage of medicine and equipment. What little medicine was available was given to patients after they had given a bribe.

  - Health workers were allowed to establish their own private health facilities to augment their 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 bribes from patients.

- There was poor leadership and supervision by managerial staff who spent much of their time in their own private practices. This left them with little time for the administration of government hospitals. Consequently the subordinates operated in whatever manner they chose, sometimes 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 main criterion for service delivery.

- The patient flow at Muhimbili Hospital was described in order to show the typical loopholes at each stage for corrupt practices. The report asserted 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 fuelled primarily by the low incomes of civil servants. It allows them to make ends meet. This form of corruption, however, is very rampant, and is what affects ordinary people on a day to day basis. Grand corruption 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.

Kamuzora (2005) argues that underdevelopment and economic liberalization are the root cause of corruption. This argument, however, is not borne out by history, particularly in the light of Kamuzora's analysis of the emergence of the New Right in Britain and 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) have begun their analyses a few years after independence, and Ake (1993) has even looked back at the colonial period to try and find answers.

Claude Ake's paper (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 they were disconnected from their experience. In essence, Ake argues that the colonial government leaders cared less about the wellbeing of the indigenous people and that they (the colonial administrators) promoted and defended their own interests in power and wealth.

With independence came national leaders but they did not transform the state in accordance with nationalist aspirations. When they inherited it, in effect, 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 relationship 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 to support a family. Consequently they have to start families with lower levels of welfare, while others bridge the gap between wages and the cost of family life by keeping their wives in the village as farmers. Some become urban peasants cultivating small plots, while others use their official positions as economic leverage. This is a survival strategy; it is not so much 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.

Ake 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 (1993), writing in the context of Tanzanian, 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 throughout the system.

The sheer economic need for survival in the face of an ever worsening economic situation for the African economies characterised the economic factor according to Shellukindo and Baguma. This has led to the erosion of the official incomes of public officials, and has triggered a chain of negative responses for survival. The authors 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 favouritism 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 relates to the cultural bonds to which public officials are tied, and refers to the cultural obligations they have. They are constantly called upon to violate rules, and hence ethical standards, in order to accommodate demands arising from 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 Tanzanian public health services is that by Makeula which was conducted in health facilities in Kilombero District between 1996 and 1997 (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 health workers about the causes of corruption. The most significant of these were 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 in the workplace.

The main drawback of the report is that it does not explain how each of these causes operates in practice. Even though some recommendations are given for the fight against corruption, these are not directly linked to the identified causes. For instance, Makeula recommends that health/medical associations 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 (2000). It is an analysis of the relationship of corruption with 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 the affairs of a doctor or nurse.

Kinemo 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 them and others in health professions from engaging in corruption.

Concerning health sector reforms, the paper notes that these were initiated as a response to the poor performance of the health sector which had manifested itself in 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 health sector reforms as such did not put in place measures to curb corruption, rather, some of the reform measures actually created loopholes for corruption. These included allowing doctors who are employees of the government to own private health facilities, and the cost sharing system the administration which allows a measure of discretion in collecting cost sharing revenue.

The ethical perspective through which Kinemo views the issue is an important facet, especially in the context of health services which

are bound by ethics. Corruption is unethical behaviour. This is also the position which Yahaya takes (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 the view which is also expressed by Mohamed Aboud in his paper examining what appeared to him to be an ineffective watchdog 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 on their professional behaviour. He contends that it is futile to teach ethics unless they are practiced in society in general. There is no point in teaching the 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 to the prevalence of corruption in Tanzania and 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 between July 18th and August 13th, 2005 and was based on a nationally representative random sample of 1,304 Tanzanians – 650 men and 654 women – over the age of 18; it was conducted in all regions of the country.

Highlights of the findings include the following:

- In 2003, 80% of respondents thought that "some", "most" or "all" police were involved in corrupt practices, but this dropped to 72% in 2005.

- In 2003, 58% of respondents thought that "some" "most" or "all" elected officials engaged in corruption, but in 2005, only 38% thought MPs were corrupt, and 44% thought elected local government officials were corrupt.

- 58% of respondents thought that health workers were corrupt. No similar figures are reported for the previous years.

- 39% of respondents reported that "some" health workers are involved in corruption, and 20% believed that "most" or "all of them" are involved in corruption.

- 29% of respondents reported that they had encountered demands for illegal payments at their local clinic or hospital.

- 15% of respondents reported that they had actually made such payments.

- 7% of 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 respondents reported that they had "no experience with this in the past year."

- 73% of 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 is the distinction between respondents' perception of corruption and their actual involvement with it. A 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 of the definition Tanzanians have of corruption in public services. 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 or her 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 or her job.

The findings show that 55% of respondents stated that locating a development project as indicated was wrong and punishable, while 34% said it was wrong but understandable. Only 7% said it was not wrong at all. Some 70% said giving a job to an unqualified family member was wrong and punishable, while 23% said it was wrong but understandable. Only 4% said it was not wrong at all. 73% said demanding a favour or additional payment for some service that is

part of the official's job was wrong and punishable. Some 21% said it was wrong but understandable, while a miniscule 1% 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 in 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 health services need to be informed by such knowledge.

It would also be desirable to have information about the profiles of the people 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 other forms of corruption which might be ravaging public health services.

The Global Corruption Report 2006 of Transparency International (TI) (2006) is another interesting source of information about corruption in public health services generally, and is of relevance to Tanzania. Tanzania was not one of the focus countries of the report but it 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 about 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 health services in the health sector include private actors and medical professionals. In countries like Tanzania, which the report categorizes as having a developing or transitional economy, corruption in health systems occurs largely in the form of informal or illegal payments for services.

The next most significant form of corruption 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 a conflict of interest between purchasers, providers, suppliers and researchers.

According to the report, corruption in the health sector prevails because of an imbalance of information. Health professionals 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 problem is compounded by the emergence of humanitarian emergencies when medical care is needed urgently and oversight mechanisms have to be bypassed. The fact that health care systems are complex and involve a large number of parties makes it difficult to achieve transparency.

The 2009 implementation report of the Tanzania's National Anti-Corruption Strategy and Action Plan - II (NACSAP II) revealed that all Local Government Authorities (LGAs) have put in place suggestion

boxes and complaint officers, have signboards at their headquarters and service outlets including dispensaries and health centres with the words *"This is a Corruption Free Zone"*. Furthermore, all LGAs have put in place, at the Council, Ward and Village/Mtaa levels, notice boards displaying the amount of funds received as grants and the expenditure reports. However, this report does not show details of the extent to which institutional factors, both at the LGAs and their service outlets, hinder or facilitate the fight against corruption.

2.3 Indicators of poor governance in health service delivery

Lewis (2006) notes that corruption is high in health institutions in developing countries because the role of good governance in health service delivery has not been given adequate attention.It is argued that indicators of poor governance — which fuel corruption — include: mismanagement; absenteeism of staff; informal payment from patients; weak information systems; limited accountability; and mis-procurement.

Mismanagement and Inadequate Training

Core governance problems include mismanagement in the areas of human resource management and supervision, basic subsystem operations (e.g. procurement, drug distribution, logistics) and input availability (Lewis, 2006). It has been documented that public hospitals are inefficient largely because the managers of these facilities lack the required skills — clinical training substitutes for management skills. However, very little has been done to examine the association between occurence of staff with management skills and the extent of corruption.

Rawe et al. (2005) reviewed a number of studies and found that lack of or inadequate supervision of health workers leaves them unchecked and able to act in any manner they choose. In such circumstances, they may not adhere to professional standards, thereby compromising the quality of care. However, the studies reviewed by Rawe et al. did not

analyze the ways in which a lack of supervision may fuel engagement in bribery by health staff. Anecdotal evidence in Dar es Salaam suggests that limited supervision may lead to clinics opening very late, thereby causing long queues and a loss of hope among patients. A study is needed to examine this situation systematically.

WHO (2006) notes that in a poorly managed health facility there is theft or "leakage" of drugs and supplies.Drugs and other medical supplies in a public health facility may be stolen and sold on the private market. Shortage of drugs has repeatedly been found to discourage patients from utilizing government owned health facilities. Furthermore, studies (Erhun et al., 2001; WHO, 2006; The Associated Press, 2012) have established that, due to limited accountability, about a third of drug supplies in public facilities have either expired or are counterfeit.

Again, as a result of mismanagement, many public health facilities do ask for in-kind supplies from patients. This involves requiring patients to bring or purchase basic items such as pairs of gloves, bed sheets, bandages, cotton wool, drugs, syringes or even kerosene (WHO, 2006). Asking for in-kind supplies from patients or their relatives implies a shortage of these items in public health facilities. The extent to which patients associate this with corruption is not well understood.

Absenteeism

Absenteeism of health staff is a common phenomenon in many developing countries. It results in: closed public clinics, limited patient access to services, lower quality and, ultimately, corruption (Sadananda and Bhat 2010). However, sometimes absenteeism occurs for legitimate reasons. For instance, rural health workers often need to travel to larger towns to receive their salary and may be delayed by unreliable transport and/or bad roads. Unfortunately, in some circumstances, doctors or nurses come to the clinic very late or

don't show up at all. Sadananda and Bhat, however, did not document managerial responses to address the problem of absenteeism in the context of combating corruption.

2.4 Conclusion

This review of the literature indicates that there are many questions about institutional constraints contributing to corruption in public health services in Tanzania which still need to be examined. These include:

- How a lack of or limited supervision creates the opportunity for engagement in corruption
- Linkage between possession of management skills and effectiveness in fighting corruption
- The extent to which a lack of accountability limits the effort to combat corruption
- The extent to which a lack of transparency limits the effort to combat corruption
- The extent to which absenteeism of health staff creates circumstances for bribery
- The extent and effectiveness of institutions' enforcement efforts against corruption
- Institutions' capacity for conducting investigation on corruption.

The proposed study is expected to make a contribution to knowledge and to inform the formulation of more focused anti-corruption measures within health services.

2.5 Conceptual fra mework on the institutional factors influencing petty corruption in the health services

This conceptual framework is based on a formula C = M +D – A, which has been suggested by Klitgaard (1998). According to this simple model, corruption (C) thrives if an individual has monopoly power (M) over a good or service, discretion (D) to decide who will receive it, and is not accountable (A) for his or her decision.

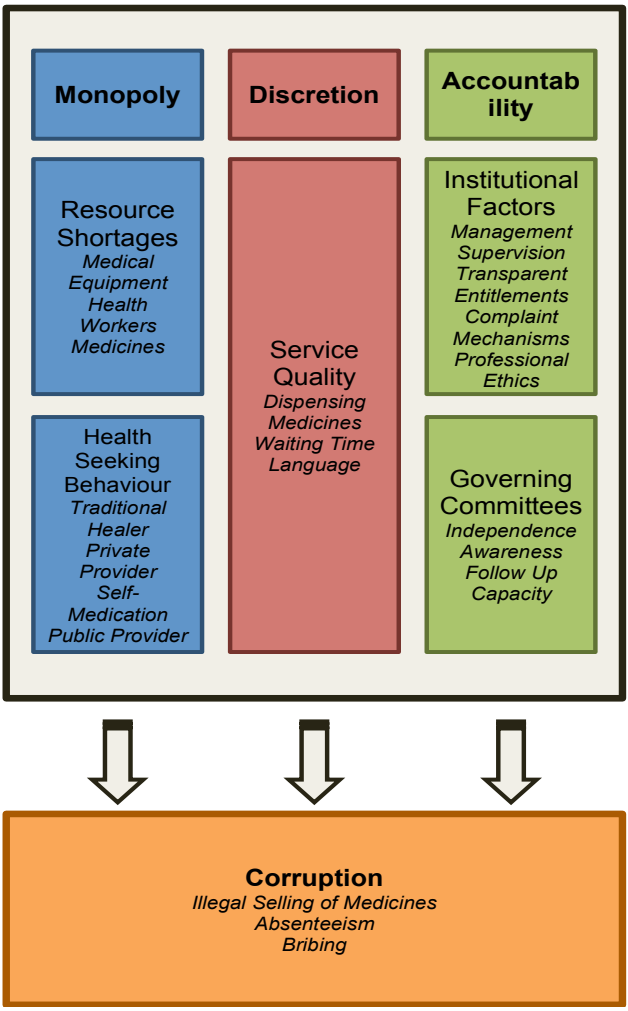

Figure 1: Conceptual framework

Public health workers have significant discretion over the quality of health services offered when they prescribe and dispense medicines, when they decide who needs immediate attention and whether they use respectful language towards patients.

The Tanzanian health system suffers from a severe shortage of human resources for health and a lack of medicines and medical equipment. Facing such shortages, desperate citizens may be forced to pay bribes in order to receive immediate medical attention. The study examined the relevance of resource shortages by testing the hypothesis: Supply side constraints create incentives to exchange quality services for (black) market prices that are above the regulated (standard) price scheme.

The bargaining power of health service providers is limited where citizens have alternative public or private service providers, traditional healers, or the possibility of self-treatment. The study examined the relevance of health-seeking behaviour by testing the hypothesis: Corrupt behaviour at public health facilities affects users' preferences over health service providers.

Health workers may use their discretion to exploit monopoly power if the institutional factors for holding them accountable for their actions and decisions are missing. To detect misconduct, the health facility management is responsible for supervising its staff. Where management is not onsite for monitoring, they can rely on citizens who are aware of their service entitlements and use complaint mechanisms to report transgressions. Moreover, all health workers share medical ethics to which they can be held accountable by the management. The study examined the relevance of institutional factors by testing the hypothesis: Corrupt activities are supported by various institutional factors.

Each health facility has a governing committee which is in place to oversee compliance with professional duties. To perform this role effectively, these committees need to be aware of misconduct,

be independent to avoid conflicts of interest, have the necessary capacity to assess allegations and to follow up remedial actions. The study examined the relevance of HFGCs by testing the hypothesis: Health Facility Governing Committees effectively follow up citizens' complaints about corrupt behaviour at the health facilities in question.

Where the use of monopoly power and discretion is not monitored and sanctioned, corruption in the form of illegal selling of medicines, absenteeism and bribing is expected to thrive.

3 Methodology

3.1 Design

A cross-sectional design was employed, using both qualitative and quantitative approaches for data collection.

3.2 The study population

The study targeted four categories of population, namely: community members, out- and in-patients, heads of health facilities and members of HFGCs.

3.3 Description of data collection methods

Semi-structured questionnaire

This consisted of a mixture of closed and open-ended questions. The tool was, to a large extent, highly structured and elicited choices between pre-formulated alternative answers to set questions, but it also contained open-ended questions which gave respondents an opportunity to express, in their own words, their views on and experiences of the issues raised.

Key informant interview

This was an unstructured interview with administrative officials of the hospitals. The interview guidelines consisted of a list of open-ended questions in an attempt to discover the institutional causes of corruption in health facilities. The interviews were, essentially, conversations with the purpose of finding out what factors contribute to institutional corruption and make combating corruption a difficult undertaking.

Focus Group Discussions (FGDs)

This qualitative research method involved two facilitators – one being a moderator and the other a note taker (recorder) — engaging a group

of 6 – 8 participants in a discussion about the effects of corruption on access to health services. The participants were purposively selected to represent a mix of female and male community members of different ages and socioeconomic status. The FGDs took about one and a half hours and were conducted at a location where privacy could be assured.

Observation

A non-participant observation method was employed to enable objective assessment of governance related factors that influence corruption in health facilities. Three facilities were selected in each of the ten districts. These facilities were: the district hospital, one health centre and a dispensary. Observations were conducted at the out-patient department/section of each of the three facilities.

Sample size estimations

The sample size for the 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 service users and health workers involved in or affected by corruption practices (this will be put at 18% (YAV 2008)),

q = 1 – p, and

d = degree of accuracy desired, set at 0.05.

Thus, for service users [patients], p = 18% (proportion of patients who admitted that they had been asked for a bribe (YAV 2008)).Thus, the sample

size = $\frac{2^2 \quad 0.18 \quad 0.82}{(0.05)^2}$ = 236. Including an adjustment of 10% for non-response

(24), the final sample size amounts to **260 patients** in each of the ten study districts that were involved in the study.

For service users [community members], p = 55% (the proportion of community members who admitted that they had been asked for a bribe (YAV 2008)).Thus,

the sample size = $\frac{2^2 \quad 0.55 \quad 0.45}{(0.05)^2} = \frac{0.99}{0.0025}$ = 396. Including an adjustment of 10% for non-response (40), the final sample size amounts to **436 community members** in each of the ten study districts that were involved in the study.

Sampling techniques for service users: patients

The study employed a multistage sampling technique. Firstly, the district hospital was purposefully selected, and secondly, one health centre and two dispensaries in the district were randomly selected. Thirdly, several patient care units were selected for the study depending on the level of the health facility. At the district hospital, four key units were involved, namely: medicine, surgery, paediatrics and reproductive and child health. Both out-patient (OPD) and in-patient sections of these units were visited. At the health centre and dispensary levels only out-patients were involved.

Fourthly, for each selected health facility unit, a probability proportional to size approach was used to recruit a sample of 436 respondents using systematic sampling techniques. A sampling frame was established through the support of officials who were incharge of the respective units. For the actual sample selection, the number of patients who attended each unit (OPD patients and discharged patients) was established and then divided by the desired sample size, yielding a sampling interval. Then, the sample was drawn by listing the names of patients in an arbitrary order and selecting every nth case — starting with a randomly selected number between one and.

Sampling techniques for service users: community members

The study employed a multistage sampling technique. Firstly, two wards in each district were randomly selected. Secondly, out of the selected wards, two villages were randomly selected. Thirdly, from each selected village a probability proportional to size approach was used to recruit a sample of 436 respondents using systematic sampling techniques. A sampling frame was established through the support of village and hamlet leaders. For this, the number of persons aged 15 and above in each hamlet was established and then divided by the desired sample size, yielding a sampling interval .Then, the sample was drawn by listing the names of eligible persons in the households constituting a hamlet, in an arbitrary order, and selecting every nth case — starting with a randomly selected number between one and .

3.4 Data management and analysis

Quantitative data collection records were checked for completeness on a daily basis. Afterwards, coding data were entered into a computer, checked, cleaned and analyzed by SPSS statistical software. Tables and descriptive statistics have been used to summarize the data. Differences between proportions were assessed using the Chi square test.

In addition, qualitative data were transcribed verbatim and handled using a thematic analysis approach. For this, data were analyzed by examination and categorization of respondents' opinions. Major categories were identified and data were unpacked accordingly. Concepts or quotations were cut and pasted into their appropriate categories. Finally, the information under major and sub-categories was presented through summaries and narrative text (quotations).

3.5 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 of

Health and Allied Sciences, and permission to conduct the study was obtained from the respective authorities in the study sites.

3.6 Maintenance of confidentiality

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

3.7 Introducing the study

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

3.8 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 would provide the opportunity to learn about and, hopefully, change attitudes towards corruption.

3.9 Risks of participating

Each potential respondent was informed that there were no serious risks involved in participating in this study. It was identified that there might be intrusion into individual's privacy due to participants being asked to share some information which might be secret, or to divulge things they would rather not be reminded of. In this circumstance, participants would be at liberty to refrain from answering any questions that might make them uncomfortable.

3.10 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 gave verbal consent.

4 Perceived Influence of institutional factors on corruption

This chapter presents findings and a related discussion on hypothesis *1: corrupt activities are supported by various institutional factors.* The extent to which institutional governance factors induce health service providers to solicit bribes was assessed through respondents' experiences (semi-structured interviews) and objective information through observation. Thus, the results supporting this hypothesis are presented in four parts. Part one relates to respondents' views (through interviews), part two refers to complementary FGD findings, part three is the result of observation and the fourth part analyses the views of health facility managers.

4.1 How institutional factors influence corruption from the respondents' perspective

4.1.1 The role of governance factors

Community members were asked to rate the extent to which weaknesses related to governance factors influence engagement in corruption. The results in table 4.1 show that almost half of the respondents indicated that problems in governance play a great role in enhancing corruption practices. The most significant factors, rated in descending order are: absence of/limited accountability for health workers' actions (50.9%); failure to abide by professional ethics (49.3%); and absence of/limited supervision (47.3%).The least rated factor was ignorance of entitlements by service users (41.3%).

S/N	Factor	The extent of contribution to corruption			
		Great extent	Some extent	Small extent	Not at all
1	Absence of/Limited supervision	1837 (47.3%)	909 (23.4%)	328 (8.4%)	812 (20.9%)
2	Absence of/Limited accountability	1979 (50.9%)	842 (21.7%)	344 (8.9%)	721 (18.6%)
3	Failure to abide to professional ethics	1916 (49.3%)	832 (21.4%)	336 (8.6%)	802 (20.6%)
4	Ignorance of entitlements by service users	1604 (41.3%)	959 (24.7%)	438 (11.3%)	885 (22.8%)

Table 1. Governance factors influencing engagement in corruption practices

The respondents were then asked their opinions on the extent to which the management of the health facility which they usually attend had succeeded in preventing and combating corruption. The opinions of the study's respondents are indicated in figure 4.1.

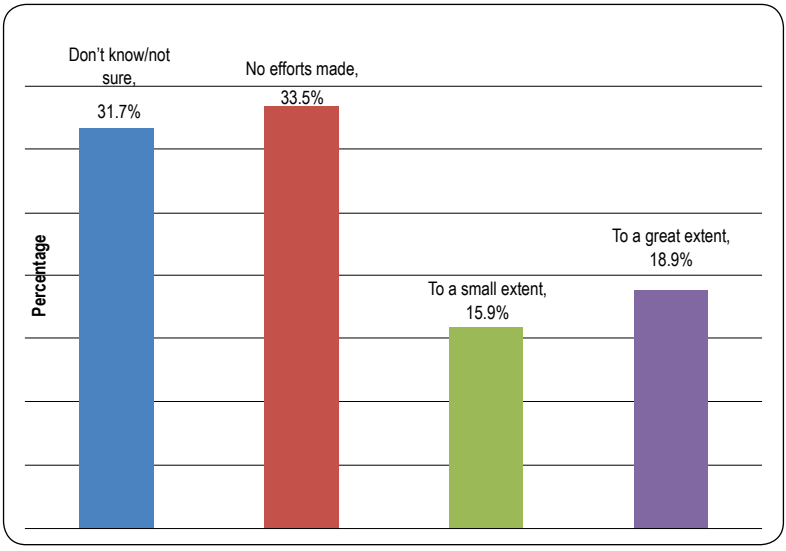

Figure 2. Efforts of facility management in prevention of and combating corruption (n = 3886)

Figure 4.1 shows that, whereas a third (33.5%) of respondents categorically said that no efforts are made by the management at the health facility in preventing and combating corruption, another third (31.7%) did not know or were not sure if there were any efforts being made.

4.1.2 Perception of quality of care

An assessment of the linkages between institutional factors and discretion was also carried out by examining out-patients' perceptions about the quality of care. The key question related to waiting times. As indicated in figure 4.2, more than half (58.4%) of the respondents thought that they had waited for too long before being ushered into the doctor's consultation room.

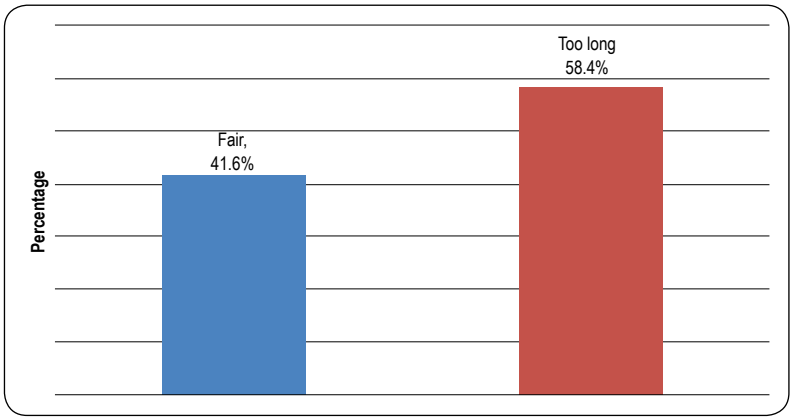

Figure 3. Perception of waiting time (n =1854)

4.1.3 Perceived reasons for long waiting times

Those respondents who claimed that they had waited for too long were asked to givepossible reasons for the delay. Their responses are shown in figure 4.3.

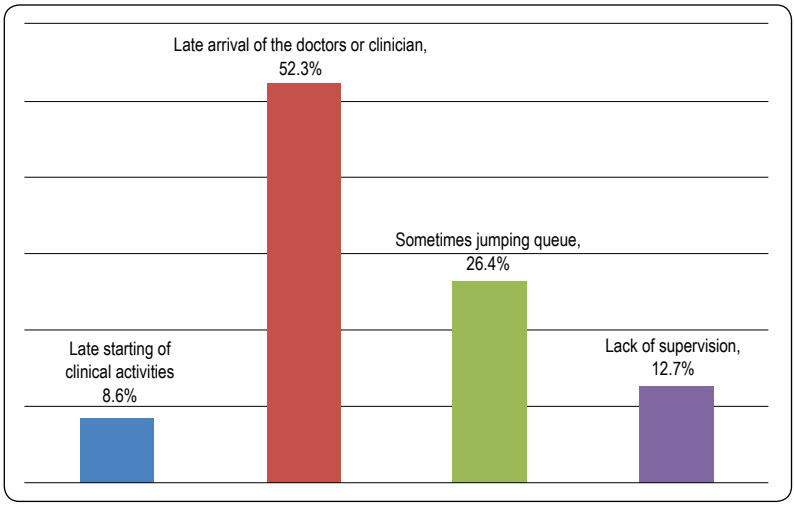

Figure 4. Perceived reasons for long waiting time (n = 1083)

Figure 4.3 shows that respondents identified reasons related to problems in the governance of the health facility: the late arrival of the doctor or clinician (52.3%); some patients jumping the queue (26.4%); and a lack of supervision (12.7%).

Although the results shown in Figure 4.3 reveal that a lack of supervision was identified by only a minority of patients, FGD participants in the community unanimously identified it as an important institutional factor that fuels corruption. The following quotes are illustrative:

"Mi naamini tatizo ni ukosefu wa usimamizi…mfumo toka juuumekaa vibaya…" (Mlandizi man).

(I believe the problem is with lack of supervision. The programme of supervision is faulty right from above.)

"Sisi tunafikiri kwamba maoni yetu makubwa ni usimamizi uwe mkubwa ili mradi hizi kero ndogondogo zisiwepo" (Mlandizi man).

(Our major recommendation is that supervision should be enhanced. This will remove these petty infringements.)

The FGD participants further elaborated on how limited or lack of supervision influences engagement in corruption. It was argued that a lack of supervision encourages service providers to violate professional service delivery norms like: "first come, first served". Patients who are known by the health staff (their friend(s)/relative(s)) are attended to first without regard to their position in the queue. One of the participants aptly remarked:

"Tatizo linatokana na madoctor kukaa mda mrefu kwenye kituo… wengine wamejaza marafiki sana…mkiwa mumekaa kwenye foleni, akija anawahudumia kwanza marafiki zake, wakiisha ndio mnakwenda wengine." (Mpwapwa woman).

(The problem is caused by doctors staying in one duty station for a very long time. They end up having many friends. Consequently, when you are in the queue and he comes along he starts by attending his friends before he can attend the rest of you).

Similarly, it was asserted that a doctor may call a person in and allow him/her to jump the queue because he knows that the individual is likely to offer some money in return for a favour rendered. This was well put by one participant:

"Nakuta doctor akifika pale (wakati mko kwenye foleni) kwa kuwa ni mwenyeji anajua huyu nikimwita tu ndani atatoa hela. Akishajua kuwa wewe hakujui atamwita yule anayepata faida kwake kwanza, wewe… basi anakuruka." (Mpwapwa woman).

(You will find that when the doctor arrives and finds people in the queue, he knows which one will give him a bribe if he calls him in. He does so thereby bypassing you because the doctor does not know you and is not sure if he can get anything from you).

4.2 The influence of institutional governance factors in corruption practices as per the study observations

4.2.1 Introduction

This section presents findings from observations that were conducted to examine the extent to which institutional governance factors promote engagement in corruption practices. The findings relate to: limited supervision; limited accountability mechanisms; and limited efforts to promote engagement of patients/carers in fighting corruption.

4.2.2 Limited supervision

In 20 out of 30 health facilities, the observers did not see an officer who could be regarded as a supervisor. Moreover, out of 10 health facilities in which supervisors were seen passing around, only 4 had supervisors who were seen interacting with patients in order to understand their concerns.

4.2.3 Limited accountability mechanisms

The observers sought to learn if there were complaints expressed by patients and if structures existed for making health staff answer for their actions or inactions. The findings show that in 16 (53.3%) out of 30 health facilities patients were heard complaining. Their complaints were about: long waiting times (12); impolite language (2); jumping the queue (1); and the high cost of medicines (1). In one of the facilities, the observer noted that patients/carers who were complaining did not seem to know where to report their concerns.

This observation was supported by another finding that in two thirds of the facilities (19 out of 30) there was no specific officer (apart from the in-charge) for handling clients' complaints. Likewise, about three quarters of the facilities (21 out 30) did not have a special office for handling clients' complaints.

4.2.4 Limited efforts to involve patients in the fight against corruption

It was noted that there are limited efforts to encourage active participation by the patients or carers in the fight against corruption. It was observed that, although suggestion boxes existed in 22 out of 30 facilities, there are some factors that limit their effective utilization. These include: proximity to the nurses' office, and an absence of pen and paper. Suggestion boxes may deter corruption as they provide an avenue for service users to mention the names of corrupt health workers and even describe associated circumstances without fear. Moreover, a functional client charter was seen in only one health facility. Likewise, posters bearing anti-corruption messages like: "corruption free zone" or "I hate corruption, do you" were seen in only 6 (20%) out of 30 observed health facilities.

4.3 Health facility managers' admission of existence of corruption and other cases of professional misconduct

Health facility managers were asked if there were any cases of professional misconduct in the past three years. The results in figure 4.4 show that 43.5%, 31.4% and 29.4% of the health managers, from the hospital, health centres and dispensary respectively, admitted that cases of professional misconduct had occurred in their facilities.

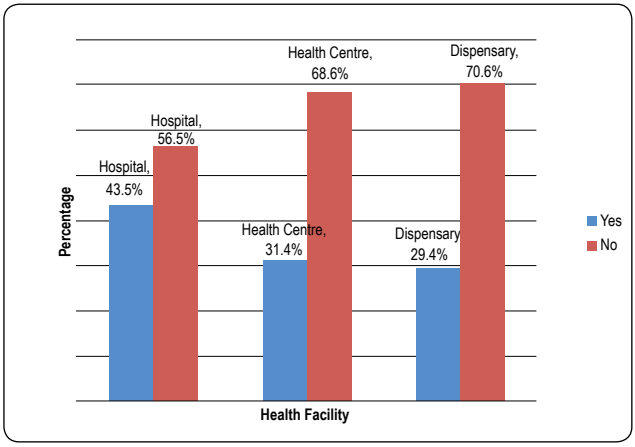

Figure 5. Occurrence of cases of professional misconduct at the facility level

When asked to mention the nature of cases of professional misconduct, the majority of respondents at the hospital level reported corruption and the use of harsh language towards service users. At the health centre level, use of harsh language, arriving late for work and absenteeism from work were the most common cases of professional misconduct while at the dispensary level, late arrival at the facility and absenteeism from work constituted the most common cases of professional misconduct.

Three categories of professional misconduct were common at all three levels of health facility: the use of harsh language towards service users, late arrival for work by staff and absenteeism by staff. Table 4.2 provides more details about these cases by facility level.

Nature of the professional misconduct	Level of facility where cases occurred		
	Hospital	Health centre	Dispensary
Involvement in corruption	√	√	X
Use of harsh language towards service users	√	√	√
Receiving payments without giving a receipt	√	X	X
Arriving late for work	√	√	√
Absenteeism	√	√	√
Drunkenness	√	√	X
Late commencement of provision of health services to patients	√	√	X
Theft	√	X	X
Charging a service fee higher than theofficial rate	√	X	X
Refusing to provide service to patients	√	X	X
Exposing patients' information to others	√	√	X
Threatening patients with withdrawal of services	X	√	X
Fighting with co-workers	√	X	X
Delaying calling a doctor in an emergencyand delaying an operation	√	X	X
Giving an overdose to a patient (negligence)	X	√	X
Involvement in abortion	X	X	√
Being contemptuous of patients and other co-workers	X	√	X
Receiving an unofficial payment	X	X	√
Delaying attending to a pregnant mother resulting in delivery before arrival at the labour ward	X	√	X

Table 2. Nature of cases of professional misconduct by level of health facility

Keys:

√ = case was mentioned in this facility

X = case was not mentioned in this facility

4.4 Ambivalence among service users on handling complaints about corruption

The study sought to understand whether respondents shared the perception that: most complaints about corruption relate to corruption that inconveniences people directly, and people will cover up corruption that gives them underserved benefits. The results show that about half of the respondents [1759 out of 3886 (45.3%)] agreed that the perception that people endorse corruption when it benefits them is common in their communities. This was corroborated by the results in figure 4.5 which shows that virtually half (49.6%) of the respondents agreed that corruption is accepted as a rule of the game in the delivery of health care.

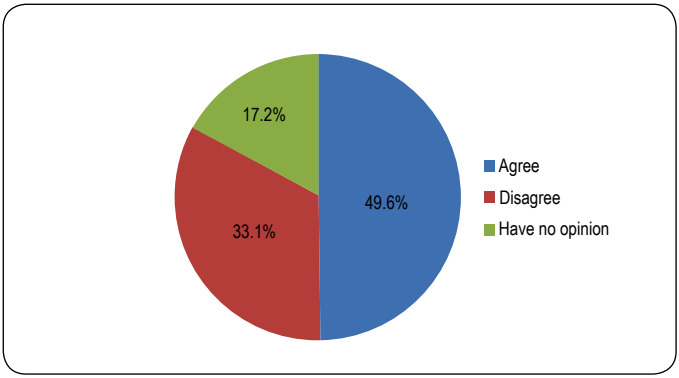

Figure 6. Corruption is accepted as rule of the game in health care delivery (n = 3886)

The endorsement of the belief that corruption is accepted as a rule of the game in health care delivery was corroborated by the finding in figure 4.6 that most (80.4%) of the respondents who admitted to having been asked to pay a bribe by a health worker in the past year never reported the incident(s) to the facility administration for disciplinary action.

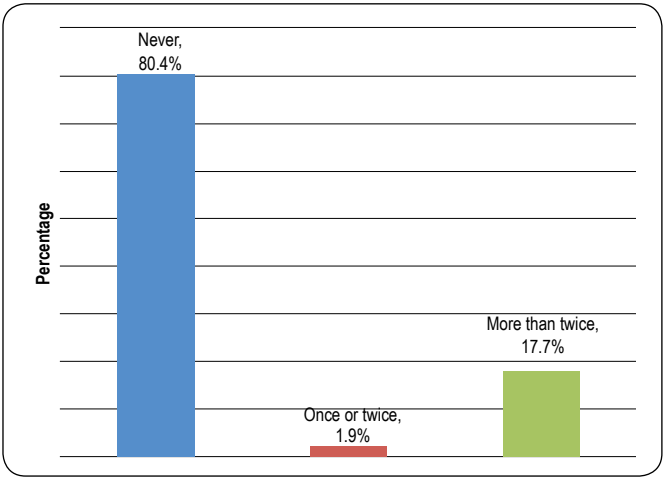

Figure 7. How often complaints about a corrupt health worker were reported (n = 1020)

4.5 Testing hypothesis 1: corrupt activities are supported by various institutional factors

This hypothesis was tested by cross tabulating the perceived influence of institutional constraints and the payment of bribes.

Question		Have you [community member], during the last one year, paid a bribe to a Health Worker at any Health Facility?			P value
		Yes	n (%)	Total	
To what extent does lack of / limited supervision contribute to corruption?	Great	619 (83.1%)	2109 (67.1%)	2728	P< 0.001
	Small	126 (16.9%)	1032 (32.9%)	1158	
	Total	745	3141	3886	
To what extent doeslack of / limited accountability contribute to corruption?	Great	683(91.7%	2108 (67.1%)	2791	P< 0.001
	Small	62 (8.3%)	1033 (32.9%)	1095	
	Total	745	3141	3886	

Table 3. Cross tabulation between the perceived influence of institutional constraints and payment of bribes

Table 4.3 shows that there was a statistically significant relationship between the perceived influence of institutional factors that were tested (lack of/limited supervision and lack of/limited accountability) and the likelihood of having paid a bribe to a health worker ($p < 0.001$).

4.6 Discussion

The study revealed that, as proposed in the conceptual framework (figure 1.1), problems in governance, as perceived by service users, play a great role in enhancing corruption practices. The significant factors rated in descending order are: absence of/limited accountability (50.9%); failure to abide by professional ethics (49.3%); and absence of/limited supervision (47.3%).This implies that, if health workers are not supervised and the system for making them answer for their actions or inactions is weak, health workers are less likely to adhere to professional ethics.

These findings confirm observations made by Lewis (2006) that corruption is high in health institutions in developing countries because the role of good governance in health service delivery has not been given adequate attention. The weaknesses in governing health facilities encourage health staff to engage in corrupt practices. For instance, Rawe et al. (2005), who reviewed a number of studies, noted that lack of or inadequate supervision of health workers leaves them unchecked and consequently free to do whatever they choose.

Weaknesses in the governance of health facilities were further illuminated by a third (33.5%) of community members who said that no efforts were made by the management at the health facility to prevent and combat corruption. Another third (31.7%) did not know or were not sure if there were any efforts being made. These findings suggest that there is a glaring failure among managers of health facilities to combat corruption. Service users experience corruption and its effects but corrective measures are not taken.

The findings from the study observation provide much more solid evidence regarding how weaknesses in governance systems induce engagement in corruption. They complement findings from other sub-components of this major study whose data have been generated through interviews. The investigators exploited the advantage of the observation method in that they were able to observe what managers

of health facilities did from the governance perspective rather than relying merely on what they said they did (CDC 2008).

With regard to perceptions about health workers' **discretion over servicequality**, the study has shown that about two thirds of the respondents felt that they had waited too long for treatment at health facilities. This finding is important as it provides the evidence for the existence of quiet corruption – a form of corruption that does not involve monetary transactions, but results in services not being provided according to set quality standards. Indeed, delivery of a poor quality of services may be an intentional strategy to induce payment from service users who would like to enjoy a higher standard of care.

Many times, quiet corruption is a reflection of governance failure (Lewis 2007). It is not surprising that about half of the respondents who complained about long waiting times attributed their wait to the late arrival of the clinician.Late arrival of clinicians is an indication of governance failure to supervise health workers and ensure that workers' regulations including a timely arrival at work are not violated.

5 Exchange of quality services for unofficial paments

This chapter presents findings and a related discussion on hypothesis 2: *supply side constraints create incentives to exchange quality services for (black) market prices that are above the regulated (standard) price scheme.* Research findings for this hypothesis were obtained by asking questions of patients who had recent memories of health care transactions and community members who recalled their experience of interacting with the health care system. Thus, in the sections that follow, we present the results relating to informal payments made by patients and the views of community members on the extent to which a shortage of resources influences corruption practices.

5.1 Engagement in informal payments

The following information was obtained from patients and community members. The study examined covert and overt payments of bribes by patients. Overt bribing hereinafter refers to a situation in which the patient is asked very directly to pay a certain amount of money to enable him or her to access care or get better care. Covert bribing, in contrast, refers to a situation in which informal payments are made, knowingly or unknowingly. In such cases, the amount paid may be higher or lower than the official rate for accessing a particular service (e.g. diagnostic test, medical/surgical procedure) and a receipt is deliberately not issued.

5.1.1 Overt bribing

Out-patients were questioned about whether they were asked for a bribe directly. Figure 5.1 shows that about a quarter [402 (21.6%)] of respondents reported that they were asked for a bribe.

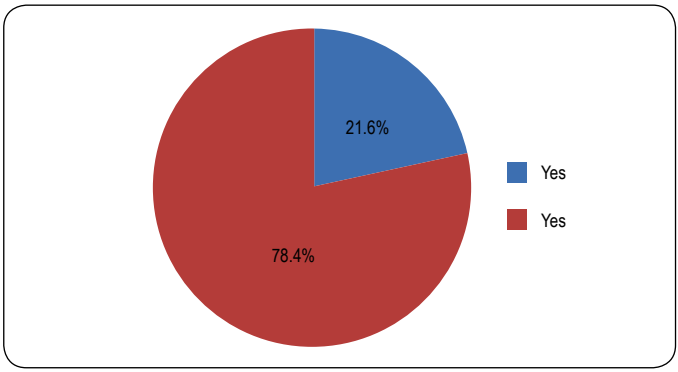

Table 4. Out-patients who acknowledged having been asked to pay a bribe (n = 1854)

Among the out-patients who reported being asked for a bribe, 196 (48.7%) actually paid.

5.2 Experience of people living with HIV (PLHIV)

The study sought to understand the experience of PLHIV on corruption. PLHIV constituted about a quarter (18.3%) of the total sample, 1854 outpatients who took part in the study. The distribution of their responses on whether they were asked to pay a bribe is indicated in figure 5.2.

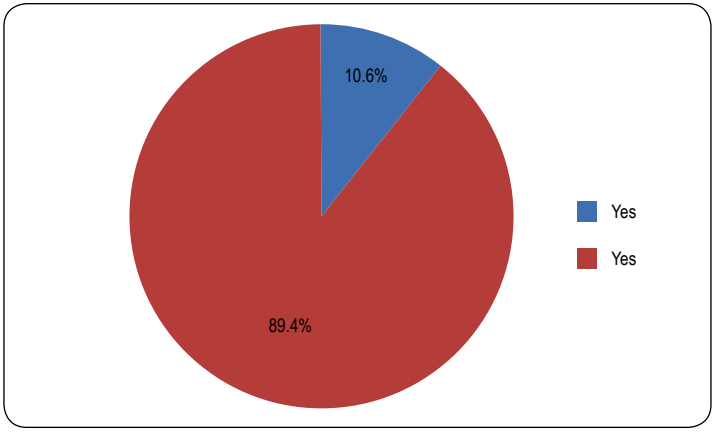

Figure 8. Distribution of PLHIV on whether they were asked for a bribe

Figure 5.2 shows that about 11% of PLHIV reported that they were asked for a bribe.

5.2.1 Covert bribing

Participating out-patients were asked if they engaged in covert bribing. In order to ascertain this, they were firstly asked if they paid for services rendered to them. The results show that two thirds of the out-patients [1260 out of 1854 (67.9%)] agreed that they paid for services that were rendered to them or their family members.

Moreover, out of those who said they had paid for treatment, slightly fewer than a quarter [230 out of 1260 (18.3%)] of them made informal paymentsfor which they were not given a receipt. The out-patients were then asked about the nature of the informal payments that they made. The results in Table 5.1 show that three quarters (76.5%) of the interviewed out-patients did not receive a receipt and did not know if there were receipts available.

Response	**Number (%) (n = 230)**
Receipt available but not issued	30 (13%)
Receipt not available at all	24 (10.4%)
"I did not get receipt and I do not know if there were receipts"	176 (76.5%)

Table 5. Informality of receipt issuance

The out-patients were probed further regarding the amount of money paid informally. The study sought information on factors that motivatedengagement in informal payments. The results in table 5.2 indicate clearly that more than a third of the out-patients (40.4%) paid more than the official amount for the services they received under the influence of the service provider.

Table 5.2 further shows that about a third (29.6%) of out-patients paid more than the official amount as a result of the patient's request to have preferential treatment. Overall, there is evidence that the majority

(70%) of out-patients who made an informal payment paid an amount exceeding the official regulated level.

Response	Number (%) (n = 230)
Paid less than official amount as a result of the patient's request	26 (11.3%)
Paid less than official amount under the influence of the service provider	43 (18.6%)
Paid more than the official amount as a result of the patient's request to have preferential treatment	68 (29.6%)
Paid more than the official amount under the influence of the service provider	93 (40.4%)

Table 6. Informal payments made

5.3 Payments for health services rendered to in-patients

Out of 485 interviewed in-patients, 262 (54%) paid for the services rendered to them.

Among the 262 in-patients, payments were made for the services indicated in table 5.3.

Service paid for	Number of patients Involved (n = 262)	%
Surgery	103	39.3
Medicine	139	53.1
Investigation	115	43.8

Table 7. Services paid for by in-patients

Out of 103 in-patients who paid for surgery, 15 (14.6%) said that they paid more than the official rate and 34 (33%) did not receive receipts after paying for surgery services.

An additional point of note is that, while most respondents in the sample of community members could not remember particular drugs and investigations and the amounts of money they paid, those [84 (2.2%)] who had received surgical treatment were able to remember.

About a third [27 (32.1%)] of these claimed that they paid more than the government fixed prices for surgical procedures at the district hospital.

5.4 Perceived linkage between shortage of resources and engagement in corruption practices

This information was sought from community members. Table 5.4 displays how factors related to a shortage of resources were rated in terms of the extent to which they influence engagement in corruption practices.Two thirds (64.9%) of respondents indicated thata shortage of medicine contributes to corruption to a great extent.The contribution of other factors in descending order is as follows: shortage of equipment and supplies (51.9%); shortage of staff (48.7%); and poor remuneration (46.8%).

S/N	Factor	The extent of contribution to corruption			
		Great extent	Some extent	Small extent	Not at all
1	Shortage of medicine	2521 (64.9%)	703 (18.1%)	147 (3.8%)	514 (13.2)
2	Shortage of equipment and supplies	2015 (51.9%)	751 (19.3%)	327 (8.4%)	793 (20.4%)
3	Poor remuneration	1820 (46.8%)	869 (22.4%)	346 (8.9%)	851 (21.9%)
4	Shortage of staff (doctor/nurses)	1892 (48.7%)	824 (21.2%)	393 (10.1%)	777 (20.0%)

Table 8. Perceived factors influencing engagement in corruption practices

The contribution of a shortage of equipment and supplies in fuelling corruption was also echoed by FGD participants who argued that sometimes the patient may be informed that a certain procedure/ treatment is not being offered routinely because of a shortage of necessary materials. Furthermore, individuals were informed that what little material was available was being reserved for special purposes or for more vulnerable groups of patients. One of the FGD participants shared her experience of health care workers creating a

"false" story about a shortage of HIV test kits in order to make money out of an otherwise free service.

She said:

"Vipimo vya virusi vya ukimwi unaweza ukaambiwa hapa hamna vimebaki vya wajawazito tuu, sasa unaambiwa unaweza ukatoa rushwa kidogo tu ili uweze kupimwa" (Iramba woman).

(You might be told that they have no tests for HIV, and that they only have them for pregnant women. They say that if you pay a small bribe they will test you).

Shortage of staff — disproportionately few staff and an overwhelming number of patients — was also highlighted by FGD participants as being a central driver of corruption in public health facilities.

The following quotes are illustrative:

"Kuna kitu kimoja ambacho kitaendeleza rushwa, wahudumu wachache wahudumiwa wengi. Sasa pindi wahudumiwa wanapokuwa wengi, rushwa lazima itakuwepo…" (Kondoa man).

(There is one thing which will perpetuate corruption, namely a shortage of care givers and a multitude of care seekers. When there are too many care seekers, corruption will be there).

It was argued that when there are too many patients, each one of them gets anxious about whether or not he/she will be attended to by the overwhelmed staff. This situation prompts the patient or carer to search for "means" of ensuring that he/she is attended to.

"Wewe unapouguliwa ndio kitu kinachokutachi, daktari umuingize kwenye rushwa. Leo kuna wagonjwa hawa wote wanamuangalia daktari mmoja, hata Muhimbili, hata wapi, ipo hiyo sasa foleni iliyopo hapa huyu daktari anataka kupima (hawa wote) sasa wako karibu ishirini sasa kwa wepesi wangu mimi nataka tuonane aweze kunisaidia kuliko hawa walioko kwenye foleni" (Mlandizi man).

(When you have a sick relative, that touches you, you will get the doctor to accept a bribe so that your sick relative may be attended. You reason that all these sick people are expecting this one doctor to attend them. Anywhere, even at Muhimbili where you find this situation you will find a way to see the doctor to help you).

Additionally, respondents were asked if they knew that corrupt health workers sell medicines and equipment to service users for personal benefit. Their responses are displayed in figure 5.3, which shows thatmore than half (57.2%) of the respondents indicated that they were aware that sometimes health workers do take medicines and equipment and sell them to users for personal benefit.

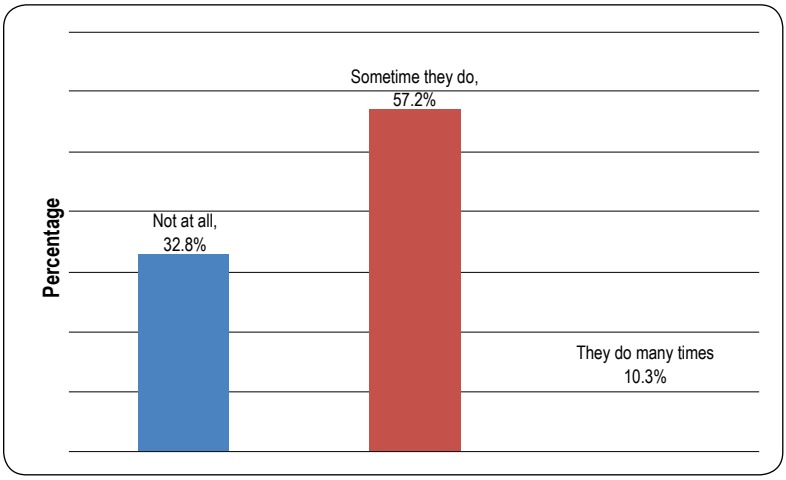

Figure 9. Perceived extent to which health staff sell medicines and equipment

This finding was corroborated by participants in the FGDs. It was asserted that the patient or carer may be informed that a certain medicine is out of stock, but he/she is quickly advised to go to a particular shop which has the medicine.In such cases, the shop is owned by a doctor working at the very deficient public facility. One of the participants said:

"Mimi naona watumishi wanajinufaisha kwa sababu ukienda unaambiwa hiyo dawa hamna lakini unaelekezwa nenda duka Fulani la doctor Fulani ambaye huyo doctor yupo pale hospitali. Kwa hiyo tunahisi vitu vinachukuliwa kwenda kujinufaisha" (Kinondoni woman)

(I think health workers benefit themselves, because when you get there you are told there are no drugs, but you are directed to go to a particular shop which belongs to a doctor who works in that very hospital. We therefore suspect that materials are taken from the hospital for personal benefit).

Indeed, one of the FGD participants asked whether it is ethically right for a doctor working in a government health facility to own a medical store [Pharmacy] and why they behave differently when the patient goes to their private facilities as opposed to when the patient meets them at the government health facility. She said:

"Kwanini kila doctor ana duka la madawa? Ukimkuta kwenye duka lake anakutibu vizuri, anakunyenyekea.Ngoja siku umwendee serikalini". (Simanjiro woman).

(Why does each doctor have a drug store? If you find him at his shop he will treat you well, but when he is at the public hospital it is a different matter).

5.5 Health workers taking advantage of both a shortage of resources and discretion over service quality

Since the study question relating tothe effects of corruption was open ended(see figure 5.5), we were able to acquire additional qualitative information. It was reported by some respondents that when health workers see that a patient is seriously sick they [the staff] sometimes tell the patient or carer that there is a very important medication that would be suitable for the patient which is out of stock. In order to get hold of it, the patient or carer has to hand over money to the staff member who knows "where to purchase it quickly" for the patient. The following quote is illustrative:

"Madaktari na manesi wana mamlaka makubwa mno juu ya afya zetu. Nilipokuja hapa asubuhi mwanangu alikuwa na hali mbaya, wakatuambia kuna dawa muhimu sana ambayo inahitajika ili mgonjwa apate tiba. Lakini wakasema dawa hiyo wameishiwa. Wakasema tutoe elfu kumi watusaidie tuipate haraka. Ilibidi tuwape, bora uzima" (female carer, Temeke).

(Doctors and nurses have great authority over our health. When I came here this morning, my child was seriously sick. We were told there is a very important medicine that was required for the child to be treated. But they said that medicine was out of stock. So they told us to give them Tsh.10,000 so that they could get it from elsewhere quickly. We had to give it to them. Saving life is all we care about.)

A very similar scenario was described in one of the FGDs, in which the patient or careris told that certain medicines are out of stock, but the staff may claim to have a personal stock that he/she offers to sell to the needy for the sake of saving time. This situation was well expressed by one of the participants:

"Mimi mwenyewe nililazwa na nikaambiwa umwambie ndugu yako umtume akanunue, lakini baadae nikatoa shs 38000/=, na daktari alizitoa (hizo dawa) yeye mwenyewe". (Temeke man).

(When I was hospitalized, I was told to ask my relative to go and buy drugs, but when I produced 38000/= the doctor himself brought the drugs.)

5.6 Corrupt referral of patients

The FGD findings threw up another scenario in which health workers create and/or use the shortage of resources for personal benefit. It was argued that it is as if there is a conspiracy between the health workers rendering a particular service in the public health facility and the nearby private providers. Patients are sometimes falsely told that there is no service at the public facility but that they could go to the nearby provider whose equipment is almost always functional; the cost is very high. One of the FGD participants had this to say:

"Hakuna kitu kinachonikera kama kama vipimo…x-ray ukienda ni lazima utoe rushwa ndio upatiwe huduma…nafikiri ni mchezo mchafu pale unafanyika, kwani wanasema nenda kwa Masawe, x-ray Temeke ni shs 3000/=, wakati ukienda kwa Masawe x-ray ni shs 15000/=". (Temeke man).

(Nothing annoys me like the shortage of supplies for investigations. For x-ray when you go there, you have to be prepared to give a bribe before you can get the service. There is a dirty game going on. They tell you to go to Masawe for x-ray where it costs shs 15000/= instead of the usual shs 3000/= at Temeke).

5.7 Discussion

Downsizing of the magnitude of corruption

The findings indicate that only about a quarter of out-patients who were involved in the study admitted that they were asked directly to pay a bribe. This is a small but significant proportion bearing in mind two points. Firstly, the interviewees were poor patients who were aware of the problem of corruption in almost all public sectors, but they 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 the hegemonic power that the medical professionals have over patients. In other words, there appears to be a norm, especially in poor countries,characterised by the perception that the medical professionals are the ones who know everything about disease causation and management and, thus, whatever care they offer is perhaps what the patient deserves.

Questioning of the professionals' actions may lead to the patient being neglected altogether. Thus, it is possible that, despite the assurance of confidentiality from the researchers, some respondents may have been afraid to tell the truth for fear of worsening their relationship with staff and thereby jeopardizing their chances of being attended to or of getting satisfactory care.

In addition to the above findings, the researchpointed to the use of informal payments in order to procure quality health services.This finding implies that corruption is condoned by both service providers and users. The latter's involvement in corruption might be a reflection of an inability to meet high medical costs which leads users to plead with service providers so that they unofficially accept a lower payment. This kind of a scenario benefits both the providers and users of health services and the latter has no incentiveto make a noise about this given the personal benefits.

A study by Maestad (2007) showed similar findings about how health service users in Tanzania are ready to make unofficial payments so as to access quality services including shorter waiting times. Maestad reported further that service providers may sometimes create artificial shortages of medicines so that they can get additional payments from the service seekers.

This study also found that shortages of medicines, medical equipment and reagents for investigations are major problems that cause in-patients to have to stay on the ward for long periods, thus providing an environment conducive to corrupt practices in public health facilities. A study on corruption in the Ghanaian healthcare system (Agbenorku 2012) reports similar findings, stating that health facility staff demand unofficial payments from patients before they can access quality care, particularly appointments with a doctor,drugs and other investigations.

Health workers' abuse of discretion over service quality

The study findings on the effects of corruption indicate that health workers not only take advantage of a shortage of resources but also abuse their professional power. Since the question of accessing health care can sometimes mean life or death, health care workers can easily abuse their positions as providers of care and opt to make money out of patients' and carers' desperation.

6 The influence of corruption on health seeking behaviour

This chapter presents findings and a related discussion on hypothesis 3: corrupt behaviour at public health facilities affects users' preferences over health service providers.

The information relating to this hypothesis was obtained by asking questions tocommunity members who had sought care previously and to patients who had recent memories of corruption practices at the health facilities that were involved in the study. The community members were asked to indicate how their own experience of corruption would influence their choice of health facility or source of health care when sick themselves or caring for a sick family member. The results are shown in figure 6.1.

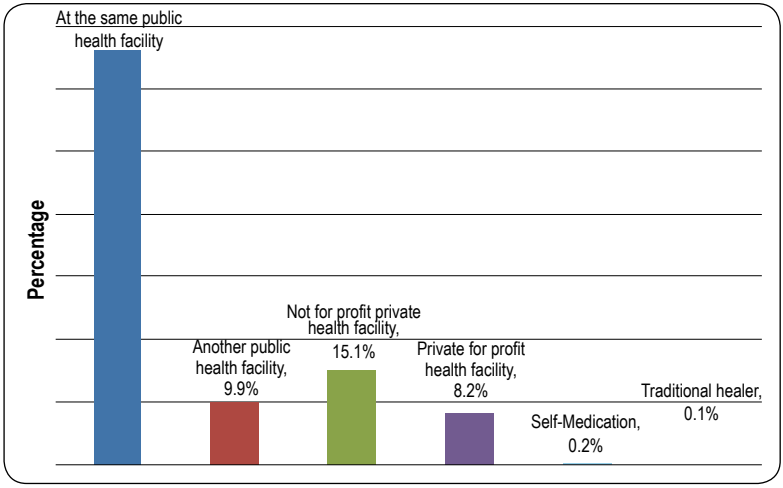

Figure 10. Community members' perceived influence of corruption on next choice of health facility/source of care

Figure 6.1 shows clearly that two thirds (66.4%) of the respondents would go to the same public health facility. The figure further shows that alternative sources of care were indicated by the minority of respondents. These are, in descending order: not for profit private

health facility; another public health facility; and private for profit health facility.

Similar results were found when patients at the out-patient department were interviewed.They were asked to reflect on their experience of corruption at the health facility where they were being interviewed and to indicate where they would go next time when they needed health services. Interestingly, as indicated in figure 6.2, about three quarters said they would return to the same public health facility.

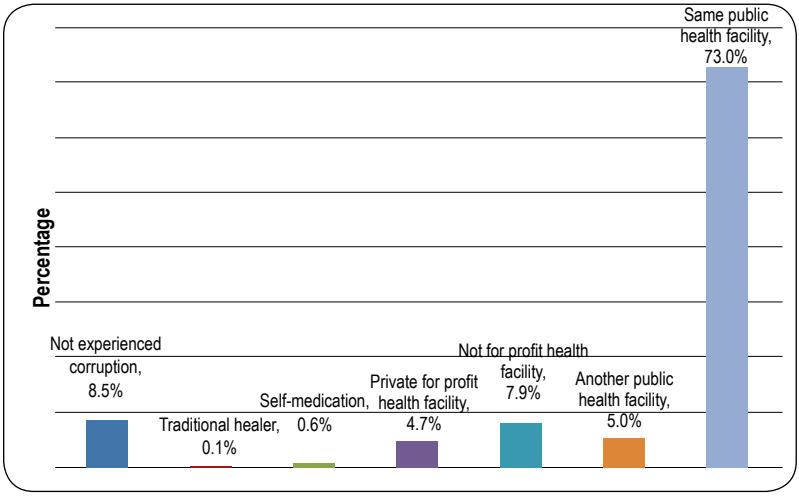

Figure 11. Out-patients' perceived influence of corruption on next choice of health facility/source of care(n = 1854)

Again, these findings were corroborated by those from hospitalized patients. Participants were asked to state how corruption may have affected their decision about where to go for treatment next time they need it.Out of 485 interviewed respondents, 77.9% said that they will use the same public health facilities while 8.0%, 7.2% and 4.1% claimed that they will seek health services at another public health facility, a private not forprofit health facility and private for profit health facility respectively (figure 6.3). When asked why they prefer to use the same public health facilities compared to other facilities, 74.2% of the interviewed in-patients claimed that it is cheaper to

pay bribes at public health facilities than to seek health services at private health facilities whose cost of services is prohibitively high. Furthermore, 3.7% reported that they have nowhere to go because services provided by private health facilities are too expensive for them to afford.

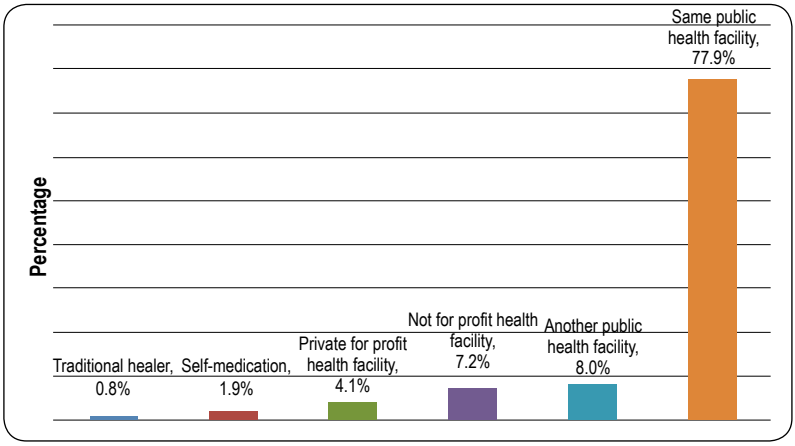

Figure 12. Hospitalized patients' perceived influence of corruption on next choice of health facility/source of care

6.1 Gender dimension to the impact of corruption on health-seeking behaviour

An attempt was made to explore gender differences in the responses of community members who answered the question about where they would seek care next time they needed it, given their experience of corruption in public health facilities.

	Source of care/Type of health facility	Sex		
		Male	**Female**	**Total**
1	At the same health facility	973 (62.9%)	1609 (68.7%)	2582 (66.4%)
2	At another public health facility	178 (11.5%)	207 (8.8%)	385 (9.9%)
3	At a private not-for–profit health facility	240 (15.5%)	350 (14.9%)	590 (15.1%)
4	At a private-for–profit health facility	150 (9.7%)	166 (7.1%)	316 (8.2%)
5	Self-medication	1 (0.06%)	7 (0.2%)	8 (0.2%)
6	Traditional healing	3 (0.2%)	2 (0.09%)	5 (0.1%)
	Total	**1545**	**2341**	**3886**

Table 9. The influence of corruption on next choice of health facility – distribution by sex

Table 6.1 shows that a relatively higher proportion of women indicated they would go to the same public health facility – existence of corruption notwithstanding. The difference was statistically significant (p = 0.002).

6.2 Rural –urban differences on the impact of corruption on health-seeking behaviour

Examination of the differences between rural and urban districts with regard tothe impact of corruption on health-seeking behaviour revealed that there is no significant difference among the districts. As indicated in table 6.2, across almost all rural and urban districts involved in the study, more than half of the respondents indicated that they would go to the same health facility, notwithstanding corruption concerns. However, Simanjiro was an exception. In this district, only 46.4% indicated that they would seek care from the same public health facility. The majority of respondents in Simanjiro indicated that they would go to alternative health facilities, particularly the private notforprofit ones.

Alternative sources of care	*Kinond-oni*	*Temeke*	*Ilala*	*Kibaha*	*Mpwa-Pwa*	*Kondoa*	*Kiteto*	*Sima-njiro*	*Singida*	*Iramba*
At the same health facility	*227 (56.4%)*	*311 (75.8%)*	*386 (97.7%)*	*239 (59.8%)*	*204 (52.9%)*	*258 (64.2%)*	*222 (61.8%)*	*177 (46.4%)*	*238 (68.2%)*	*320 (79.4%)*
At another public health facility	*38 (9.5%)*	*31 (7.6%)*	*2 (0.5%)*	*33 (8.3%)*	*63 (16.3%)*	*110 (27.4%)*	*27 (7.5%)*	*15 (3.9%)*	*40 (11.5%)*	*26 (6.5%)*
At a private not for profit health facility	*62 (15.4%)*	*44 (10.7%)*	*0*	*77 (19.5%)*	*93 (24.2%)*	*25 (0.6%)*	*21 (5.8%)*	*168 (44.1%)*	*58 (16.6%)*	*57 (14.1%)*
At a private for profit health facility	*74 (18.4%)*	*24 (5.9%)*	*6 (1.5%)*	*51 (12.8%)*	*19 (4.9%)*	*8 (0.2)*	*88 (24.5%)*	*19 (3.9%)*	*12 (3.4%)*	*0*
Self-medication	*0*	*0*	*1 (0.3%)*	*0*	*3 (0.8%)*	*0*	*1 (0.03%)*	*2 (0.05%)*	*1*	
Traditional healing	*(0.03%)*	*0*	*0*	*0*	*3 (0.8%)*	*1 (0.02%)*	*0*	*0*	*0*	*0*
Total	*402*	*410*	*395*	*400*	*385*	*402*	*359*	*381*	*349*	*403*

Table 10. The impact of corruption on health-seeking behaviour – distribution of responses by district

Testing hypothesis 3: Corrupt behaviour at public health facilities affects users' preferences over health service providers.

This hypothesis was tested by examining the responses of respondents with regard to how the experience of corruption would influence their decision on where to seek care next time they need it. The hypothesis was not supported as the findings from both out- and in-patients and from community members showed that more than two thirds of respondents would opt to go to the same public health facility, concerns about corruption notwithstanding.Cross-tabulation of the variables with regard to the experience of corruption and health-seeking behaviour is shown in table 6.3.

		Given your experience of corruption where would you seek care next time?			
		At the same public health facility	Other alternative sources of health care	Total	P-value
Do you think corruption exists at the public health facility where you access care?	Yes	1621 (64.2%)	903 (35.7%)	2524	<0.001
	No	962 (70.6%)	400 (29.3%)	1362	

Table 11. Cross-tabulation between experience of corruption and health-seeking behaviour

Table 6.3 shows that,of those who do not think that corruption exists at the public health facility where they access care, 70.6% indicated that they would seek care from the same public health facility the next time they needed it. The other 29.3% would seek care at an alternative health care facility despite having no corruption concerns. This amount increases to 35.7% if respondents do think that corruption exists at the accessed health facility. While the increase from 29.3% to 35.7% is statistically significant ($p < 0.001$), the results show that the majority of respondents who would seek services with another service provider is not motivated by corruption concerns; most of them seem to have other reasons for expressing their intent to change the service provider.

In essence, the study has shown that the experience of corruption has only a small, though statistically significant, effect on users' preferences over health service providers. Most respondents who think that corruption exists at the accessed facility explained that they would return to the same facility because of better affordability. This means that, because of poverty, most health services users see public health facilities as their first choice in spite of corruption and its related effects. Indeed, it was argued that the cost of a bribe in a public health facility is lower than the actual medical costs in a private health facility.

However, FGD data indicate that corrupt practices that involve theft of medicine and other supplies creates scarcity and affects quality of services. Consequently, patients/carers are compelled to seek care from alternative sources including private forprofit facilities owned by senior staff from the poorly stocked public facilities. The following quote from one FGD conducted in Kondoa district is illustrative:

"Uzalendo unapungua, inakuwa ni sababu ya wahudumu kuanzisha vituo vingine.Ukifika pale Kondoa kuna hospitali nyingi za watumishi wa afya, ukienda hospitali za serikali unakuta dawa hazipolakini kwao ziwepo... Wagonjwa wengi wengi wanakwenda hospitali za private kwa sababu zinatoa huduma nzuri, lakini ni wale wale wahudumu wa afya ndio wanakuwa hapo. Kwa hiyohuu mwanya wa kuwa na vifaa vichache unasababisha kusema kwamba huku [private] ni bora". (Kondoa man).

(The level of patriotism has declined. This is the reason that health workers are opening their own centres. If you go to Kondoa you will find many private hospitals belonging to health workers, but when you go to the public hospital you find that it has no drugs while theirs are well stocked. Many patients flock to private hospitals because they provide good quality health care, even though it is the very health workers of the public hospitals whom you find there. It follows, therefore, that the shortage of supplies in the public hospital makes private hospitals attractive.)

As an additional issue,FGD participants argued that non-monetary corruption practices scare patients away from health facilities. They particularly referred to a lack of compassion and empathy which negatively affects the quality of care.

"Hasa kwenye wodi ya kina mama wajawazito ndio kuna shida sana. Kwa mfano ..mimi mwenyewe nnimefika pale usiku (nikiwa na uchungu) nimegonga wananifungulia wanagomba, una vifaa,, umekujaje, mimba ya ngapi? Nikamwambia ananigombeza sio kwamba anataka kunisaidia. Yaani huna Imani na yule anaekuhudumia. Basi huduma

ile inakuwa ngumu. Ndio maana wengi wanajifungulia nyumbani wanasema nikienda kule naenda kutukanwa". (Kiteto woman).

(Things are terrible in the maternity ward. I went there at night when I was in labour. When I knocked, they opened and asked me if I had the supplies. They wanted to know how I got there and how many times I had ever been pregnant. I asked her if her objective was to give me the necessary assistance or to abuse me. Under such circumstances you cannot have faith in the midwife. That is why many deliver at home. They fear that going there is to end up being abused.)

The use of harsh language by nurses was particularly identified as being scary, as illustrated in the following quotes:

"Mimi nafikiri wauguzi wetu …wanakuwa hawana kauli, hata kama kile kitu hakipo ukiuliza utajua kuwakweli hamna, lakini kauli zao. unaweza usimwelewe amekujibu nini". (Mlandizi woman).

(I find that our nurses have no good language. They should be able to tell you politely if something is out of stock. As it is you can never understand what the real situation is.)

"Nikiangalia zile adha za manesi, nina haja gani kwenda kutibiwa pale". (Mpwapwa woman).

(When I think of the aggravations of the nurses, I find that I have no reason to go for health care there.)

"…wengine akili zao ni fyatu…wana lugha chafu… wanakuambia uende tu sisi hatubembelezi, hata ukifa utajua mwenyewe". (Mpwapwa man).

(Some of them are not in their right mind. They have foul language. They will tell you that they do not cajole patients, and that if you die it is your own business.)

6.3 Discussion

This element of the study has shown that the experience of corruption did not change service users' preference for particular health facilities

or care options. This is contrary to the initial conceptualization as indicated in figure 1.1, which predicted that the existence of corruption may change the health-seeking behaviour of health service consumers. The finding suggests that, because of poverty, most users of health services see public health facilities as the first choice, notwithstanding the experience of corruption. Indeed, it was argued that the cost of a bribe in a public health facility is lower than the actual medical costs in a private health facility.

Consequently, as indicated in this study, most people do not report incidents of corruption for fear of jeopardizing relationships with service providers – resulting in what one may call corruption tolerance. Apart from poverty, the finding that the majority of respondents indicated that they would go to the same public health facility the next time can be explained by what might be termed the role of established relationship (partners in crime – they are both guilty!). That is, once an individual has paid some money, then he/she has established a long lasting relationship that makes it easier for the service user to approach the same provider next time he/she needs services.

It is worth noting, however, that one third of the interviewed service users would change health-seeking behaviour because of the existence of corruption in public health facilities. These findings, therefore, underscore the need to fight corruption within the public health sector as it is the primary source of care for the overwhelming majority. Additionally, fighting corruption in the public health sector will reduce the number of service users who are compelled to seek alternative care in private health facilities.

7 Role of health facility governing committee members in combating and prevention of corruption

7.1 Introduction

This chapter presents results and a related discussion on the fourth hypothesis:Health facility governing committees effectively follow up citizens' complaints about corrupt behaviour at the concerned health facility. This hypothesis addresses efforts to combat corruption in public health facilities. The results emanate from in-depth interviews conducted with members of HFGCs, from semi-structured interviews conducted with community members, and from FGDs. The chapter is organized into three main sections, namely: socio-demographic characteristics of the respondents; the role of HFGCs in fighting corruption; and discussion.

7.2 Socio-demographic characteristics of the respondents

Table 7.1 shows socio-demographic characteristics of the respondents.The table shows that about two thirds (62.2%) of the members of HFGCs were males. Furthermore, the majority of the respondents (37.8%) belonged in the age group 34 - 55 years. Regarding education, the majority (37.8%) had completed primary level education.

S/N	Characteristic	Frequency (%) [n = 111]
1	**Sex**	
	Female	42 (37.8%)
	Male	69 (62.2%)
2	**Age**	
	23 – 33	10 (9%)
	34 – 44	37 (33.3%)
	45 – 55	42 (37.8%)
	56 – 66	18 (16.2%)
	67 – 77	2 (1.8%)
	78 – 88	2 (1.8%)

3	**Education:** Primary education Secondary education Vocational training Post-secondary education Never been to school	 42 (37.8%) 40 (36%) 1 (0.9%) 27 (24.3%) 1(9%)

Table 12. Socio-demographic characteristics of the respondents

7.3 Challenges facing HFGCs in combating corruption

7.3.1 Limited awareness about HFGCs among community members

The first finding to note is thatthe overwhelming majority of respondents (85.7%) indicated that they did not know members of HFGCs. Secondly, out of those (555 respondents) who claimed that they knew the members of their local HFGC, only (44.9%) indicated they could easily reach committee members.

7.3.2 HFGCs are non-functional or ineffectual

The results from interviews with members of HFGCs and FGDs with community members revealed that HFGCs are non-functional. This is partly because, as stated above, most community members (85.7%) did not know the members of their local HFGC. Table 7.2 shows that only (2.3%) of respondents indicated that they reported corrupt practices to their HFGC.

Response	Number (%)(n = 3886)
Yes	89 (2.3%)
No	466 (11.9%)
I don't know members of HFGC	3331 (85.7%)

Table 13. Whether respondents do report corrupt practices to the HFGC

According to the FGD data, community members perceive HFGCs to have a role in verifying the delivery of medicines and other medical supplies. One of the FGD participants said:

"(Kuhusu kamati ya kijiji inayosimamia inayosimamia huduma za afya) mimi ninachojua kuna kamati fulani … inayohakiki madawa yanapoletwa, ila sijua wanafanya kazi gani wale kweli. Lakini kama kamati nyingine sijawahi kusikia". (Kinondoni woman).

(What I know is that there is a certain committee which verifies the drugs and supplies delivered at the health facility, but I don't know what they actually do. I don't know of any other committee.)

Even this role of verifying the supply of medicines from the government is limited in the sense that it effectively requires committee members to witness the arrival of medicine and nothing more. Members of HFGCs are incapable of following up on subsequent use of the received. The FGD participants attributed this to the asymmetry ofpower between professional health staff and members of HFGCs, who are lay persons. One of them said:

"Kamati ya huduma ya kijiji hawa nao utendaji wao wa kazi ni mdogo. Yaani kamati zile zote kama jinsi ilivyo taratibu zipo ila kinashindikana si wale ndowataalam.Hawezi akaenda labda utendaji wa kazi asimamie, anakwambia mimi ni mtaalam na niliyesomea hii kazi, na wewe ambae uko kijijini umeteuliwa tu, sasa utaelewaje kazi". (Mpwapwa man).

(The village committee for social services does not do much. All the statutory committees are present, but they cannot confront the professional. The health worker simply tells them that he is the professional and that as laymen they cannot question his performance.)

Another FGD participant contributed by arguing that even verification of consignments on arrival is not being carried out nowadays. Consequently, the likelihood of health staff abusing their power and engaging in theft of medicines is very high. He asserted:

"Kuna udhibiti gani? Mtu akitaka kutoa madawa huku na kupeleka huku kuna mtu atamzuia? Kwa sababu yeye ndiye anayepokea na ndiye anaekaa nazo na ndiye anayesema zimekwisha, kwa hiyo akisema dawa zimekwisha hakuna mtu atakayekuja kuangalia. Zamani palikuwa na utaratibu mzuri, serikali inajua kwamba leo tumeletewa

kiasi gani natunajua kwamba ni baada ya muda gani dawa hizi zitakuwa zimekwisha. Sasa hili halipo siku hizi". (Kondoa man).

(What control is there? If a person decides to take some drugs from here to take them some place who can stop him? He is the one who receives the drugs and supplies when they are delivered; he keeps them, and ultimately says they have run out. Therefore, when he says there are no drugsnobody can go and check. Sometimes back there was a good system whereby the village government knew how much drugs and supplies were delivered. They knew how long the drugs would last, but that system is no longer operational.)

7.3.3 Absence of corruption on the agenda of HFGC meetings

The study sought to understand the role the local HFGC plays in the combating and prevention of corruption by raising a number of issues with members of the HFGC, including: the extent to which corruption features on the agenda of the HFGC. Table 7.3 shows that about half (47.7%) of the respondents said that corruption does not feature at all on the agenda of meetings.

Response	Number (%) (n = 111)
Does not feature at all	53 (47.7%)
To some extent (once in 3 months as we discuss issues related to supervision and/or accountability)	35 (31.5%)
To a reasonable extent (twice in 3 months as we discuss issues related to supervision and/or accountability)	6 (5.4%)
To a great extent (monthly, as we discuss issues related to supervision and/or accountability)	17 (15.3%)

Table 14. The extent to which corruption features on the agenda of HFGC meetings

7.3.4 7HFGCs' limited authority to take corrective measures against corruption

The respondents (members of HFGCs) were asked if they receive complaints from patients regarding the quality of care, and the majority of them (73.9%) agreed that they did. One of the respondents said:

"Hatukutani, ila inatakiwa tukutane mara nne kwa mwaka. Agenda zinatokana na malalamiko tunayopokea kutoka kwa wananchi na matatizo ya kituo chetu, lakini tukimwambia mganga pale hataki tukutane. Hivyo hamna utekelezaji."

(We do not meet, although we are supposed to meet four times in a year. The agenda arises from complaints that we receive from community members and problems at our health facility, but when we tell the clinician in-charge about the need of having a meeting, he doesn't comply.)

However, a number of respondents said they do not take any corrective measures as they lack powers in pursuing such matters. They argued that they are not responsible for convening meetings. It is the facility in-charge who calls meetings when he/she deems fit. The following remarks are illustrative:

"Hatujapewa nguvu na uongozi wa Zahanati, na uongozi wake hawataki tuwe na majukumu yoyote katika kituo cha Afya."

(We have not been empowered by the leadership of the dispensary, and its leadership does not want us to have any role at the health facility.)

"Sina uwezo wa kutambua na kutatua matatizo ya utoaji wa huduma kwasababu sishirikishwi katika kitu chochote kuhusu kituo chetu. Naitwa tu mwanakamatikwa jina tu lakini lakini utendaji sina."

(I do not have the capacity to identify and solve problems related to delivery of services because I am not involved in anything concerning our health facility. I am called a member of the health facility governing committee just passively; I do not play any active role.)

7.3.5 Limited independence from the facility management

In addition to the questions above, respondents were asked if they follow up patients' complaints about corruption. The majority of them (62.2%) said that they don't.This deficiency was attributed to an unwillingness of the facility management to work in collaboration with

HFGCs to address patients' complaints on corruption, as explained by one of the respondents:

"Hatufuatilii malalamiko ya rushwa kwa sababu hatuna ushirikano mzuri na uongozi wa kituo chetu. Hivyo wao hawatupi taarifa yoyote, pia hatujadili malalamiko ikiwa tunakutana"

(We do not follow up patients' complaints about corruption because we are not on good working terms with our facility's management. Consequently, they do not provide us with any information, and when we meet we do not discuss complaints.)

7.3.6 Suggestion boxes are not used

A lack of cooperation from health facility management was further supported by the finding that the majority (61.3%) of respondents [HFGC members] admitted that they do not use suggestion boxes in order to gather information about patients' complaints. They attributed this either to an absence of suggestions boxes or not being involved in the whole process of handling information collected in the boxes. Nevertheless, the FGD participants reported that service users do not use the suggestion boxes as they fear they might be victimized if they become known as having put in "offensive" remarks. One the participants said:

"Sanduku la maoni watu wanaogopa kutumbukiza kuwa ikijulikana ni mimi watanigeuzia kibao." (Mpwapwa woman).

(People are afraid to put anything in the box, because if you are known to have put your complaint in it they will deal with you.)

7.3.7 People are afraid of reprisals for speaking out against corruption

FGDparticipants argued that the ineffectiveness of the HFGC is partly due to the fact that people are fearful of expressing their concerns to members of the committee lest they be victimized. One of the participants said:

"Ukipeleka malalamiko utapigwa singano mbaya Yesu na Maria." (Kiteto woman).

(If you lodge complaints you will get a lethal injection – honest to god.)

Another participant went further and pleaded with the researchers:

"Tunayowaambia haya (ninyi watafiti) yawekwe kwenye mabano. Kwa sababu mtu akisimama kwenye mkutano na unaoongelea hili hatendewi haki. Utachukiwa. Ndio maana visa vinaanza hapo.Niende nikachomwe sindano ya maji hapo hospitali? Si inabidi kila mmoja ajilinde, inabidi unyamaze ." (Kinondoni woman).

(We plead with you researchers to treat what we tell you in strict confidence. If anyone stands out in a meeting and speaks out about corruption he never gets treated fairly. He is hated. Feuds start there. People are afraid to go to the hospital lest they get injected with water. Each one has to protect oneself, and therefore, you have to keep quiet.)

7.3.8 Limited capacity of HFGC members in handling corruption issues

The study assessed the capacity of members of the HFGCsto handle corruption issues.About two thirds of the respondents (61.3%) admitted that they lacked essential competencies to inquire about and sanction misconduct at the health facilities. When probed further, more than half of the respondents said frankly that they lacked formal training or orientation on how to handle misconduct in health care settings. The remark made by one of them is illustrative:

"Kwa kweli sina ujuzi maalum, natumia busara zangu tu. Bado hatujapewa elimu ya kutosha kuhusu maadili ya taaluma ya utabibu na namna ya kufuatilia uzingatiwaji wake."

(Frankly, I do not have a special training, I just use common sense. We are yet to get adequate education on medical ethics and how to monitor adherence to them.)

7.3.9 Negative perception of the role played by HFGCs in fighting corruption

As indicated in table 7.3, when asked about the role played by HFGCs in preventing corruption, the majority of respondents were of the view that the committee has a minimal or weak role.

Perception	Number (%) (n = 111)
Weak role	72 (64.9%)
Satisfying role	29 (26.1%)
Strong role	10 (9%)

Table 15. Perception of the role the HFGC plays in the prevention of corruption

7.3.10 Lack of guidance from the government

The respondents were asked to elaborate on why they perceived their role to be minor. They pointed out a lack of guidance and commitment on the side of the government. This concern was well summed up by one of the respondents:

"Serikali bado haijatoa mwongozo wa kutuwezesha kupambana na rushwa. Kwa hiyo sasa hivi hatuna majukumu ambayo tumepewa rasmi kupambana na rushwa kwa utaratibu mzuri wa kisheria. Serikali itupe semina za kutosha na kutuwekea utaratibu mzuri sana ulio wazi wa kupambana na rushwa ambao utakuwa ukiratibiwa kila baada ya muda fulani na mamlaka ya serikali ." (male 56 years, Mpwapwa).

(The government is yet to provide us with a guideline for enabling us to combat corruption. Thus, as of now we have not been formally and legally given responsibilities for fighting corruption. The government should conduct seminars among members of the HFGC, and provide us with a very good and transparent system for fighting corruption. The system should be closely monitored by the government authority.)

7.3.11 The Government appears to have abrogated its responsibility to combating corruption

The FGD participants asserted that the rampant nature of corruption in public health facilities reflects failure on the part of the government itself. The HFGC exists but it is has not been facilitated and connected to the service users.One of the participants said:

"Ninachoona serikali yetu ni kama vile imetusahau…panahitajika mtu wa wa kuangalia hapo kituoni, anaangalia haki inatendeka… vongozi wetu wangetuita wote (tukaelezwa) kwmba tuna kamati ya kuangalia wananchi wanapata huduma kweli, au wanazipataje huduma hizi. Mimi naona serikali ndio imebaki nyuma kuelimisha watu." (Kinondoni woman).

(It appears to me that the Government has forgotten about us. There has to be a person right in the health facility to ensure that justice is done. Our local leaders should call us to uniform us of the measures taken to enforce anti-corruption measures. I think the Government has lagged behind when it comes to educating the citizens on this issue.)

Another participant added:

"Tunaomba serikali itujali. Serikali ianzishe vituo au ofisi twende kupeleka matatizo yetu.Tunaomba tutendewe haki. Tunaomba usimamizi na hata tume za uchunguzi na kusimamia ziwepo, kwani labda wataboresha. Usimamizi ndio si mzuri." (Kinondoni woman).

(We request that the Government should be concerned about us. The Government should open centres where we can report our problems. We ask that justice be done. There should be supervision as well as commissions of inquiry. Maybe in this way the situation will improve. It is supervision which is lacking.)

Furthermore, it was argued by FGD participants that the war against corruption should be well coordinated and involve all the stakeholders. It is unfortunate that the government has not positively acknowledged the contribution of civil society organizations in playing the role of

watchdog, unearthing how public governance structures engage in or fail to fight corruption. One of the FGD participants said:

"Serikali haitaki kukubali kuwa wafanyakazi wake wana mapungufu, kuna shirika moja lisilokuwa la serikali lilikuja kufanya utafiti wilaya ya Mpwapwa kuhusu huduma za afya. Shirika linaitwa SIKIKA. Baadae walikuja kutoa ripoti yao. Baadae wameambiwa hawa watu ni wazushi….wakaja watu kutoka mkoani wanapita sehemu zote ambapo watu wa SIKIKA walipita kuhoji, wanasema nyie mnawasikiliza wale watu, hawaelewi chochote…Sasa tunakwenda wapi Wizara haitaki kukubaliana na ukweli …kwa hiyo inabidi kwanza wakubaliane na ukweli." (Mpwapwa man).

(The Government does not want to admit that its workers have shortcomings. One NGO called SIKIKA came to carry out investigations in Mpwapwa district about health services and later issued their report. Subsequently they were vilified and accused of lying by Regional Government Officials. They went around telling people not to pay attention to what the report said because they were said to be ignorant. Where does this lead us? The Ministry does not want to be told the truth. In order to combat corruption they have to start by accepting the truth.)

Testing hypothesis 4: HFGCs effectively follow up citizens' complaints about corrupt behaviour at the concerned health facility:

This hypothesis was tested by cross tabulating an independent variable related to whether a community member reports corruption complaints to the HFGC and a dependent variable regarding whether or not efforts made by the facility management to fight corruption are adequate.

Question		Do you think efforts to fight corruption at the health facility where you usually seek care are adequate?		P value
		Yes	No	
Reporting corruption cases to HFGCs	Yes	26 (29.5%)	469 (12.3%)	P = 0.002
	No	62 (70.5%)	3329 (87.6%)	
	Total	88	3798	

Table 16. Reporting of corruption cases to HFGCs and perception of anti-corruption efforts

Table 7.5 shows that non-reporting of corruption complaints to the HFGC was associated with the perception that there are no adequate efforts made to fight corruption (p = 0.002).

7.4 Discussion

The findings presented above provide evidence that rejects the hypothesis that:

Health facility governing committees effectively follow up citizens' complaints about corrupt behaviour at the concerned health facility.

In essence, the findings have demonstrated that health facility governing committees do not effectively follow up citizens' complaints about corrupt behaviour at the concerned health facilities as was initially proposed in the conceptual framework (Figure 1.1).

In this study about half (47.7%) of the respondents said that corruption does not feature at all in the agenda of HFGC meetings. This suggests that, in most facilities, HFGCs do not play a role in combating and prevention of corruption. A major drawback is that HFGCs are not autonomous in discharging their duties. This is corroborated by the finding that although members of the HFGC claimed that they do receive complaints from community members, they do not take any corrective measures. It is the facility in-charge who calls meetings when he/she deems fit and he/she is the one who determines the

agenda. Under such circumstances, it is obvious that HFGC members cannot effectively represent the voice of service users particularly those who question the credibility of facility staff.

Furthermore, this study has found that only 24.3% of the members of HFGCs had post-secondary or primary level education. Two thirds of the respondents were almost equally divided between those who were primary schools leavers and those who had a secondary level of education. Thus, unless deliberate efforts are made to improve the knowledge of the members of HFGCs on issues related to monitoring of service delivery, the intended purpose of establishing these committees may not be fully realized. According to the Ministry of Health and Social Welfare (2001), the roles of the HFGC are to:

- Develop the plans and budget of the facility;
- Mobilise the community to contribute to the CHF and ensure the availability of drugs and equipment;
- Be responsible for reporting health provider employment and training needs to the district council, and ensuring their availability at the facility;
- Liaising with Dispensary Management Teams (DMT) and other actors to ensure the delivery of quality health services.

The accomplishment of these roles requires a special training programme beyond the basic education attained by the majority of the members of HFGCs.

Regarding the role to ensurethe delivery of quality health services, this study has documented that the HFGC plays an insignificant role or none at all. If the HFGCs have to make a meaningful contribution to ensuring quality delivery of health care including fighting corruption,their roles, their composition and linkages to others administrative structures within the district should be redefined.

8 Synthesis of the findings

This study has sought to explore the institutional factors at public health facilities that induce service providers to solicit bribes from health service users and the impact of such practices on the quality and utilization of health services. It was a multi-method study and was guided by four hypotheses about institutional factors and how they influence corruption.

The findings are presented according to the hypotheses with a view to drawing out the salient institutional factors. This approach has the advantage of focusing on each hypothesis through the process of triangulation of the research methods used. An additional advantage of this is that it demonstrates how the findings of each of the hypotheses lend support to each other.

This study has shown that institutional factors are central to the control of corruption in public health facilities. Thus, as the findings related to the first hypothesis show, weaknesses in supervision and accountability, lack of transparency and neglect of professional ethics are perceived to contribute to corruption in the dimensions highlighted by all the hypotheses. The first hypothesis highlights the dimension focusing on how health staff exploit the lack of accountability to solicit bribes from patients. Similarly, the respondents associate weak accountability with a permissive work environment in which the management of health facilities fails to check theft which results in a shortage of medicines.

The findings related to the second hypothesis showed that shortages of medicines were associated with the likelihood of a patient paying an amount of money for treatment which exceeds the official rate. The association between a shortage of drugs and theft by health staff emanates from reported evidence that health staff sell medicines to patients after telling them that such medicines are out of stock. Again, engagement in selling medicines by health staff, within the premises of the government health facility,may reflect a failure on the part of managers of health facilities to enforce professional rules.

The findings related to the third hypothesis indicate that weak institutions have implications for quality of services accessed by poor people. This is because poor citizens do not have the option of seeking alternative (private) services. Theyoftenobtain poor quality health services, have to pay a bribe, and make informal payments above the approved standard prices.

Finally, the existence of poor institutions as a driver of corruption in public health facilities is compounded by the lack of a citizens' voice in the management of service delivery. Citizens' representatives in HFGCs lack the means and power to hold corrupt health workers accountable. About two third of the members of HFGCs admitted that they do not effectively follow up citizens' complaints about corrupt behaviour at concerned health facilities. This problem was attributed to managerial bottlenecks.

In conclusion, health workers are perceived to exploit their discretionary powers to abuse their monopoly because of an absence of accountability through monitoring of rules and an absence of effective enforcement through governing committees. The absence of alternative service providers may have led to a stable behaviour pattern characterised by petty corruption as a social norm.

9 Limitations of the study

This study was not without its limitations. The following methodological factors may have affected the validity of the findings:

The study relied on self-reports which provided subjective information on experiences of corruption. However, the impact of self-reports was mitigated by triangulation of findings obtained from the different research methods used involving different sub-samples (community members, out-patients, in-patients, managers of health facilities and members of HFGCs).

The study was cross-sectional in nature. That is, it involved collection of data at one point in time – thereby minimizing the strength of the associations found and consequently the ability to demonstrate causality.Nevertheless, the use of both quantitative and qualitative methods has generated credible evidence on the basis of which interventions may be formulated.

In addition, the sampled districts were not selected randomly and are, therefore, not representative. This prevented a generalization beyond the scope of the studied areas.

10 Conclusion and Recommendations

10.1 Conclusion

These findings underscore a need to strengthen governance systems in health facilities in order to combat corruption effectively and improve quality of services at large. The intervention strategy should be multi-dimensional, involving all the key stakeholders – the government/councils, facility management, civil society organizations and communities.

10.2 Recommendations

Based on the study findings, the following measures are recommended:

On the influence of institutional factors on corruption:

1. The fight against corruption in public health facilities has to be spearheaded by the government itself, particularly local government authorities (LGAs), and other structures can only derive their punch from this.

2. The government (district/municipal council) should task the management of each public health facility to ensure supervision and accountability.

3. The Council Health Management Team (CHMT) should have an explicit objective for prevention and combating of corruption in its scope of work. Guidelines for this should be developed.

4. The government ought to pay health workers well, and flood the facilities with diagnostic equipment, supplies and drugs. The government has to take stern measures against those who do, or are presumed to solicit and take bribes. Such health workers should not simply be transferred from one facility to another.

5. Those who have been given leadership positions in health services should lead by example and feel empowered to take disciplinary measures against health workers whose behaviour falls short of health care ethical standards, including those who use foul language when communicating with patients, let alone those who solicit and take bribes.

On the exchange of quality services for unofficial payments

1. The Management of health facilities should establish or strengthen a system for checking theft and/or misuse of medicines by the staff. The government may wish to hire experts to design such a system and to train managers of health facilities.

On the impact of corruption on health-seeking behaviour

1. The government should invest heavily in combating corruption in public health facilities as the majority of service users, who are poor, do not regard private facilities to be a realistic alternative source of care.

2. Service users should be made aware of the standards of care they can expect in public health facilities.

On the contribution of HFGCs:

1. The roles and composition of the HFGCs and their linkages to others administrative structures (e.g. health services board) within the district should be redefined in order to make them more effective.

2. HFGCs should be seen and accepted to be legitimate instruments for monitoring conduct of service providers and users as far as corruption as well as anti-corruption measures are concerned. Additionally, members of the HFGCs should not be intimidated by corrupt health personnel.

3. HFGCs should also take a monitoring role by collecting citizens' complaints (anonymously) and reporting them to both CHMT, which is to enforce rules, and the full council, which is to monitor and sanction the CHMT's enforcement performance.

4. People should be educated and empowered to report to HFGCs about corrupt behaviour, and be protected from undue and vindictive reprisals by health personnel when they have to exercise their human rights in accessing health care for themselves or for members of their families.

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