

Strengthening accountability for better health outcomes through understanding health-system bottlenecks: insights from Tanzania

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Acronyms

AMO	Assistant Medical Officer
CCHP	Council Community Health Plans
CFS	Consolidate Fund Services
CHF	Community Health Fund
CHMT	Council Health Management Team
CPI	Corruption Perception Index
CSC	Community score card
DHFF	Direct health facility financing
GDP	Gross domestic product
HBF	Health Basket Fund
HCMIS	Human Capital Management Information System
HFGC	Health Facility Governing Committee
HFS	Health financing strategy
HRH	Human resources for health
HSSP	Health Sector Strategic Plan
IHI	Ifakara Health Institute
ICHF	Improved community health fund
LGA	Local government authority
MCH	Maternal and child health
MoHCDGC	Ministry of Health Community Development Gender and Children
MoHSW	Ministry of Health and Social Welfare
MSD	Medical stores department
NGO	Non-governmental organisation
NHIF	National Health Insurance Fund
P4P	Pay for Performance

PBF	Performance-based financing
PCCB	Prevention and Combating of Corruption Bureau
PHC	Primary health care
PORALG	Presidents Office Regional Administration and Local Government
RBF	Result-based financing
RCH	Reproductive and child health
REPOA	Research on Poverty Alleviation
RMNCAH	Reproductive, maternal, neonatal, child and adolescent health
SAM	Social Accountability Monitoring
SNHI	Single National Health Insurance Fund
THE	Total health expenditure
Tshs	Tanzanian shillings
URT	United Republic of Tanzania
WDC	Ward Development Committee

Executive summary

Corruption is a worldwide concern. Within Tanzania, the landmark Warioba report (URT, 1996) confirmed the existence of extensive corruption across all sectors of the country, including in the public health sector where corruption has been reported at almost every stage of care-seeking.

Based on an in-depth review of peer reviewed and grey literature, and complemented by key informant discussions with selected health-system stakeholders, this study seeks to deepen our understanding of informal practices amongst frontline public health providers in mainland Tanzania's health sector, to explore the incentives that give rise to such practices, and to identify current formal and informal accountability and system-strengthening measures. Taken together, this evidence can be used to inform policy and practice in order to constrain such informal practices.

Tanzania is a low-income country. The majority of mainland Tanzania's estimated population of 56 million people live in rural areas and are dependent on underdeveloped, smallholder primary agricultural production. Despite strong and sustained high rates of growth – with gross domestic product (GDP) having remained stable at around 7% for over a decade – the overpowering public perception is that growth has been unequal. A large share of the population relies on accessing public-sector services for their health care.

Over the last decade, Tanzania has witnessed remarkable achievements in reducing infant and child mortality. However, maternal mortality ratios remain unacceptably high against a backdrop of low facility-based deliveries. Tanzania's public health system is stretched: financing is fragmented and reliant on external support, with increasing out-of-pocket payments; worker motivation is low coupled with severe shortages of staff, medicines and supplies; health facilities receive inadequate funds with limited financial autonomy (till recently); and local government authorities – the most important administrative and implementation units for public services in the decentralised health care system – are inadequately financed and equally challenged.

In spite of a robust anti-corruption legal framework – including numerous laws to deal with ethics, integrity and anti-corruption, and measures to curb corruption, unethical behaviour and abuse of power – corruption has been endemic in many public health systems and facilities across the country. This has been observed by the Quality Improvement Framework in Health Care (2011-16) (URT, 2011) and the most recent draft revised National Health Policy (MoHCDGEC, 2017).

Of particular concern to health-system stakeholders, including policy-makers, is the practice of petty corruption and health-provider absenteeism, but also low productivity among public health providers. The underlying reasons incentivising such informal practices are complex and overlapping – evidence to date underscores that they are a consequence of unmet expectations and needs of both providers and health users.

Such informal practices have come about as coping mechanisms amidst a weak and stretched health system that is grappling with scarcity and inadequate and inequitable financing of facilities and local government authorities across the country; insufficient support to health providers; highly challenging working environments and inadequate quality of services available to the public; lack of an effective social safety net within the context of poverty; high costs of living and inflation; and poor coordination and alignment of external actors and financiers to national priorities. Such adverse conditions are further aggravated by weak institutions and governance structures.

Irrespective of the underlying reasons, corruption in the health sector can have severe negative consequences for patients, resulting in catastrophic out-of-pocket expenditures and further impoverishment of marginalised groups, inequality and discriminatory access to services and high-quality care, loss of public confidence in public health care, and inequality in health outcomes. These consequences not only hurt the individual, but also affect entire communities and the national economy, and demand that the government deliver and fulfil its functions and obligations in resource allocation, policies and service delivery.

Since October 2015, Tanzania has seen an unprecedented effort by the current government in fighting corruption. The need to contain inefficiencies and misuse of public funds, and to ensure the wellbeing of every Tanzanian are at the forefront of these efforts. The government has adopted various interventions to strengthen overall institutional arrangements and specifically to improve health-system performance. Attention is focused on strengthening delivery of quality primary health services to optimise use of scarce resources, as well as to ensure equitable access to essential care. Attention is also focused on exploring feasible incentive schemes to motivate trained personnel to work in rural areas.

This review explores the potential of the following five interventions that are currently being implemented and that seek to directly or indirectly mitigate the practice of corruption in the health sector: 1) performance-based financing; 2) direct health-facility financing; 3) improved community health funds; 4) health facility governing committees; and 5) social-accountability initiatives.

To conclude, corruption is a critical issue and a concern across all sectors, including health, but Tanzania is committed to change. Achieving universal health coverage has been a key priority post-independence and has been further stipulated in several policies and strategies in the country. Vision 2020 made the promise to achieve 'health for all'. There is no single initiative that will address the constraints and challenges facing the health system in Tanzania, however, and that will mitigate informal practices amongst public health providers. The central question then becomes: what is practically feasible and will work best within the Tanzanian context – what mix of strategies and initiatives will result in improved service use and quality, health outcomes and equity to have more meaningful accountability for health-user rights and entitlements?

1. Introduction

1.1. Background: overview of corruption

Corruption is a worldwide concern (Ensor, 2004; Transparency International, 2006, 2015). And yet there is no comprehensive and universally agreed definition of it. Transparency International,¹ a watchdog on these matters, defines corruption as the abuse of entrusted power for private gain. While Jain et al. (2014) describe corruption in terms of the informal payments or the use of influential connections to get ‘a little ahead, a little extra, a little quicker’ and suggest that these have become the norm.

The practice of corruption is detrimental to economic growth. It hinders developmental objectives across sectors (Kaufmann, 1997; Gray and Kaufmann, 1998), increases the costs of doing business (Bardhan, 1997; Anderson and Tverdova, 2003; Akcay, 2006; Clausen et al., 2011; Sullivan and Shkolnikov, 2008) and erodes legitimacy and public trust in various institutions (Clausen et al., 2011; Hussmann, 2011). Evidence from Afrobarometer surveys periodically conducted across sub-Saharan African countries to capture public attitudes on the prevalence of corruption suggest that corruption and mistrust in institutions feed each other, such that they reinforce vicious circles (Cho and Kirwin, 2007; Lavallée et al., 2008).

With annual global spending on health care amounting to over US\$7 trillion each year (Jain et al., 2014), the health sector is often ranked as one of the most corrupt sectors in many countries (Lewis, 2006; Transparency International, 2006; Savedoff, 2007; Berger, 2014; Haroon, 2014). An estimated 10%- 25% of global spending on public procurement of health is lost through corruption (Jain, 2014). Health systems are particularly susceptible to corruption. This is in part because of the uncertainty in health care markets (not knowing who will fall ill, when illnesses will occur, what kinds of illnesses people get and how effective treatments are), but also because of information asymmetry and poor coordination among the many different actors that shape the health system which hinders transparency and accountability (Lewis, 2006, 2014; Savedoff, 2007; Hussmann, 2011).

Addressing corrupt practices is difficult, however. What is considered an acceptable or an unacceptable corrupt behaviour cannot be generalised to other cultures, societies, countries and even across different areas within a country: it requires context-specific understanding (Werner, 2000; Vian, 2008). Certain forms of grand corruption may be considered criminal or unethical universally, but the lines between formal or informal practices are often blurred with respect to petty corruption – are they gifts, socially accepted favours, or bribes? It should also be noted that the different acts of corruption usually do not occur in isolation. Grand corruption at the macro level will have implications at the micro-level, and so on. A distinction is helpful, however, because the drivers and motivations of the actors involved often vary and require different policy responses.

¹ www.transparency.org

1.2. Corruption in Tanzania

Concerns about corruption are widespread in Tanzania, which ranked 103 out of 180 countries in Transparency International's 2017 index of least corrupt countries, with a score of 36/100.² The landmark Warioba report (URT, 1996),³ confirmed the existence of extensive corruption across all sectors of the country, ranging from 'grand/political corruption' (e.g. involving public tenders, practiced by high-level leaders and senior public servants and usually due to excessive greed for money and wealth)⁴ to 'petty corruption', which is rampant and affects ordinary people on a day-to-day basis (e.g. involving public servants trying to make ends meet, fuelled primarily by low salaries). According to a recent survey conducted by the Prevention and Combating of Corruption Bureau (PCCB) in urban Tanzania, the most common and recurring practices of petty corruption are bribery (40.8%) and favouritism (15.1%), followed by sexual corruption (7%) and *takrima* (5.6%) (i.e. 'traditional hospitality' which involves reciprocal gift-giving) (PCCB, 2017 quoted in Baez Camargo et al., 2017). In the same survey, 56.5% of urban citizens reported having been asked for a bribe, and 36.4% admitted to having paid a bribe when accessing public services during 2016. In another perception survey conducted in 2006, ordinary citizens in Tanzania were ranked as the number one perpetrators of corrupt behaviours, followed by local government officials, police and health workers (Fjeldstad et al., 2008).

In the public health sector, corruption has been reported at almost every stage of care-seeking (URT, 2007a, 2011; SIKIKA, 2010; Anon, n.d.). With specific reference to public health services, the Warioba report (URT, 1996) singled out nurses and attendants for creating conditions and procedures for providing services that allowed them to solicit bribes from patients (SIKIKA, 2014). Indeed, around 58% of the respondents from an earlier Afrobarometer survey (2005)⁵ thought that health workers were the third most corrupt after the police, judges and magistrates, with 29% reported to have encountered demands for illegal payments at their local health facilities (REPOA, 2006a). Aiko (2015) reports that corruption, in its different forms, is prominent in accessing treatment from public hospitals.

However, the most recent Afrobarometer perception survey from 2017 suggests some improvements to overall governance and the rule of the law: close to three quarters (72%) of the respondents believed the level of corruption to have decreased over the past year, compared to only 13% in 2014 (Olan'g and Msami, 2017).

² Perceptions of corruption as measured by Transparency International's Corruption Perceptions Index (CPI) score, a composite index which relates to perceptions of the degree of corruption as seen by business people, academics and risk analysts; CPI is of less relevance to the majority of the population who are not directly affected by the kind of business-related corruption the measurement reflects. Within the CPI, ranking number 1 is deemed the least corrupt and number 180 is the most corrupt.

³ In October 1995, former President Benjamin Mkapa appointed a special commission that was chaired by Judge Warioba to assess the state of corruption in Tanzania.

⁴ See, for example, Lindner (2014) for examples on incidences of high-profile grand corruption. Gray (2015) details the political economy of grand corruption in Tanzania by using four grand corruption cases that occurred over the period of higher economic growth from the end of the 1990s until 2014.

⁵ Based on a nationally representative random sample of 1,304 Tanzanians – 650 men and 654 women – over the age of 18.

1.3. Objectives

Drawing on a political economy analysis of vulnerabilities to abuse, this background review seeks to deepen our understanding of informal practices amongst frontline public health providers in mainland Tanzania's health sector – what motivates individual health workers to engage in informal practices, and what might incentivise them not to? We aim to identify novel approaches to addressing informal practices within health systems, with a focus on uncovering the informal systems and also the relationships between formal and informal institutions that can make the system work. More specifically, the review aims to:

- 1 Identify patterns of informal practices among frontline public health providers and their managers and potential effects on health service users.
- 2 Explore the incentives that give rise to inappropriate and ineffective care by public health care workers.
- 3 Identify current formal and informal accountability and system-strengthening measures, with the potential to constrain informal practices among front line public health providers and their managers.

2. Methods

We conducted an in-depth desk review of published peer reviewed and grey literature (institutional reports, working papers, evaluation studies and reports, country-specific commissioned reports, media coverage), including key Ministry of Health policy and strategic documents, as well as overall government reports and documents related to corruption in Tanzania with a particular focus on the health sector. The documents were accessed using the electronic databases of Google Scholar, Google, HINARI PubMed, through websites of various national and international institutions and organisations, and the media. Documents were also recommended by technical advisers and potential key informants.

Literature was included if it: 1) focused on the broader health context and policy landscape; 2) provided information on the types/forms/practices of corruption in the health sector (using specific key words – informal practices, informal payments, bribery, health worker absenteeism, under productivity); 3) reported on the causes/determinants of corruption in the health sector; 4) reported the consequences/effects of corruption in the health sector; 5) identified/proposed strategies for mitigating service-provider corruption (using specific key words – system-strengthening measures, performance-based financing, direct facility financing, improved community health fund, human resource for health shortages, health worker motivation), including social accountability measures (using specific key words – community monitoring, score cards, citizen engagement, health facility governing committees); 6) covered Tanzania; and 7) was published in English. The documents reviewed dated from 1995 to 2018. Open access documents as well as subscribed content were included.

We excluded all literature that did not meet the above inclusion guidelines, duplicate results, that was considered not relevant for the review objectives, or where the source could not be verified.

The review is complemented by key informant evidence from 30 public health providers and other health-system stakeholders in Tanzania.⁶ This is not an exhaustive review.

⁶ We held two group meetings with a total of 30 key informants including representatives from the research community, national and international organisations, and health providers and policy-makers from national (Presidents' Office Regional Administration and Local Government, PORALG), regional and local government to explore detrimental and common informal practices that can be changed.

3. The national context: country profile and health system

3.1. Socioeconomic and health status

Tanzania is a low-income country with a per capita GDP of around US\$879.2⁷ (World Bank, 2017) (see Appendix Table A1). Close to three quarters (70%) of mainland Tanzania's estimated population of 56 million (2016) live in rural areas, where they are dependent on underdeveloped, smallholder primary agricultural production. Despite a strong and sustained high rate of GDP growth – which has remained stable at around 7% for over a decade and which is higher than the average of around 3% for sub-Saharan Africa – the overpowering public perception is that growth has been unequal (REPOA, 2006b). Income poverty is high, signalling persistent income inequality (Loewenson et al., 2018), and a large share of the population relies on accessing public-sector services for their health care.

Demographic and health survey estimates from 1999 to 2015 suggests some remarkable achievements, with significant declines in infant and child mortality in particular (Masanja et al., 2008; Afnan-Holmes et al., 2015). However, Tanzania continues to face shortfalls in meeting key health and health service goals linked to poor outcomes in child nutrition, maternal health and communicable diseases, and is seeing rapidly rising levels of non-communicable diseases (Todd et al., 2017). The reported maternal mortality ratio remains unacceptably high at 556 deaths per 100,000 live births against a backdrop of low facility deliveries. Weaknesses in the health system have had a direct impact on the delivery of maternal and newborn services.

Though the 'right to health' has still not yet been enshrined in Tanzania's new constitution, the government recognises that all citizens have the right to a healthy and safe environment (SIKIKI, 2014). When analysing data on access to health services, however, Mtei and Makawia's (2014) findings suggest that health is not universal; access to health care is not equal and service quality varies, which leads to inequitable life outcomes across socioeconomic groups.

3.2. National development and health policy context

Health and wellbeing are addressed as priorities in various global commitments such as the Sustainable Development Goals (SDGs) (UN, 2015), as well as in national commitments like Tanzania's 2025 Development Vision (URT, 1995), which was adopted in 1999 and sets the country's long-term development agenda. The Vision identifies five key priorities for Tanzania's growth: 1) high-quality livelihoods; 2) peace, security and unity; 3) good governance; 4) education; and 5) a competitive economy, with wellbeing and universal

⁷ All figures in United States dollars in this report reflect current/nominal US dollar unless otherwise indicated.

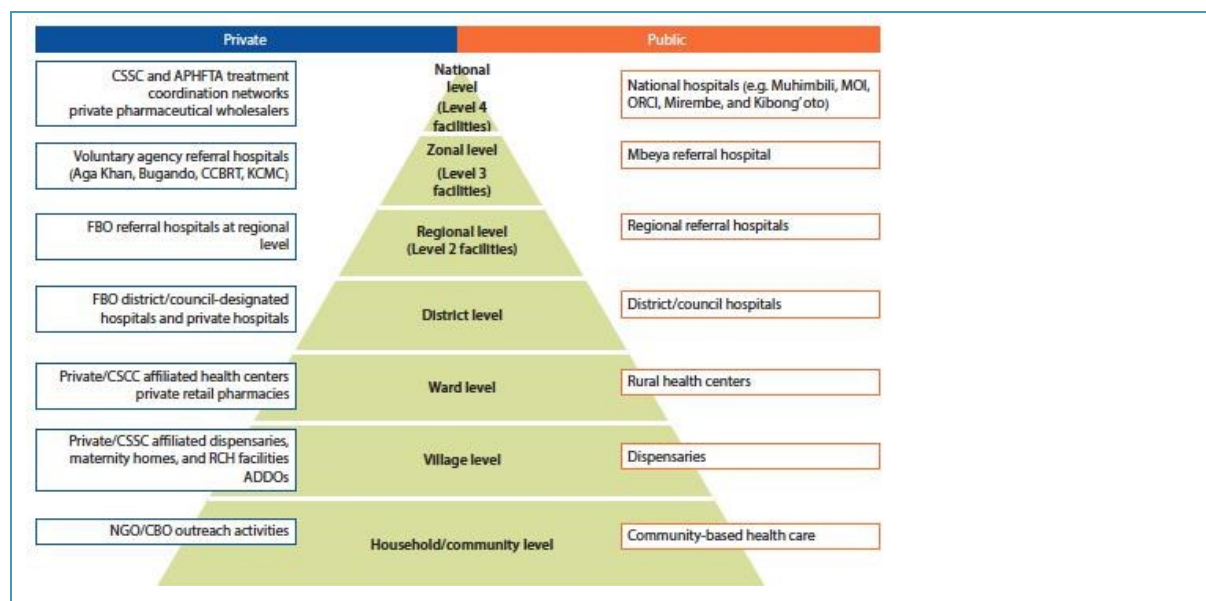
access to good quality health care an underlying theme. It emphasises a government system that is transparent, responsive and accountable, and that is free from corruption of every kind (ibid.).

Achieving universal health coverage has been a key priority since post-independence and is further reiterated in the national health policy and Health Sector Strategic Plans (HSSP). Overtime, national strategies have been set to achieve such goals – from the National Strategy for Growth and Poverty Reduction (2005-2010 and 2010-2015) (URT, 2005, 2010) to the Primary Health Services Development Plan (URT, 2007b) and the 2007 revised National Health Policy (URT, 2007a).

3.3. Health-sector context

Health care services in the public sector are provided through Tanzania’s decentralised health system, across an extensive and interacting network of services at community, primary, secondary, tertiary and quaternary care level (see Figure 1). The public sector is the largest sector within Tanzania’s health system, complemented by private not-for-profit (faith-based and non-governmental organization (NGO)) services and private for-profit services⁸ (see Appendix Table A2).

Figure 1: Tanzania’s decentralised health system



Source: URT (2015).

⁸ There are about 7,400 health facilities, of which 75% are owned by the public sector (2018). Almost 85% of the population receive health services from primary health care facilities. The dispensary is the most peripheral level of service delivery, catering for between 6,000 and 10,000 people. Health centres are expected to serve about 50,000 people, which is equivalent to approximately the population of one administrative division, and provides in-patient services for patients referred from lower levels. Higher up the service pyramid, each district is supposed to have a district hospital. Where there is no government hospital, an available faith-based or NGO hospital is often designated as the district hospital. The regional hospital offers services similar to those at district level but has specialists in various fields and offers additional services not available at district hospitals. The national referral hospital is the highest level of in-patient services.

A World Bank (2015) report points to a range of serious health-system challenges that contribute to poor health outcomes, and identifies three critical supply-side challenges that still stand, namely: shortfalls in health funding, shortage and inequitable distribution of key human resources of health cadres, and constrained local government authorities (LGAs) and facilities. We consider each of these in turn in the remainder of this section.

3.3.1. Shortfalls in health funding

Tanzania faces shortfalls in health funding, and is making slow progress towards meeting the Abuja commitment⁹ of 15% of government financing or 5% of GDP funding for health care. For the 2017/18 financial year, the Government of Tanzania allocated 7% of the national budget (inclusive of Consolidated Fund Services (CFS)) or 10% (exclusive of CFS) to the health sector; this estimate includes all on-budget funding from development partners (see Appendix Figure A1; Lee and Tarimo, 2018). However, the health system is stretched with health financing pools segmented across programmes and providers and it being reliant on external support (which accounted for about 41% of total health expenditure on health in 2015), and with a significant share being off-budget.¹⁰

The community has become an important health care financier. Out-of-pocket payments increased from 18% of total health expenditure in 2008 to 22% in 2015, and the government set a target of enrolling 45% of the population in prepayment schemes by 2015 in an effort towards raising additional revenue for the health sector and providing flexible funding to health facilities (MoHSW, 2013). To date, formal and informal health insurance mechanisms have had limited success, however, covering only a minority of the population:¹¹ by March 2018, around 32% of the population was covered by formal and informal insurance schemes.¹²

⁹ In April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. At the same time, they urged the donor countries to “fulfill the yet to be met target of 0.7% of their GNP as official Development Assistance to developing countries, drawing attention to the shortage of resources necessary to improve health in low income countries (WHO 2011)

¹⁰ Health Basket Funds (HBF), the preferred mode of financing by many development partners (of which there were seven HBF partners in FY2016/17), is intended to supplement the low level of domestic financing for the health sector in order to expand access to high-quality primary health care. HBF accounted for 10% of total on-budget sector spending in FY2015/16 and 6% of the budget in FY2016/17 (DANIDA, 2018). At the level of LGAs, 75% of non-salary recurrent funding (excluding cost-sharing) was recorded as HBF in FY2015/16, and 22% of total funding. In 2016/17, a highly complex system of performance element was introduced, with a proportion of funds allocated based on the previous year’s progress with an indicator set. Late disbursement by some HBF partners continues to be an issue. The combination of weak coordination from the development partner side and capacity gaps within the government have reduced the efficiency of HBF governance mechanisms.

¹¹ A key part of the HSSP III for financing the health sector was to increase complementary funding, consisting of Community Health Fund (CHF) membership fees, user fees, and insurance reimbursements including a National Health Insurance Fund (NHIF) and Social Health Insurance Benefit (SHIB) (MoHSW, 2013). The NHIF was introduced in 1999 to cover public servants (later coverage was extended to employees from the formal sector); followed by establishment of CHF, a voluntary community insurance scheme for the informal sector in 2001. The CHF faces structural problems with respect to design, enrolment, servicing and sustainability, and has had limited success, covering only a fraction of the population, as noted earlier. By 2014 CHF enrolment was 6.7%, far below the national target of 30%.

¹² Health Financing TWG 3 meeting, 19/10/2018 (NHIF 7% and CHF 25%).

The Ministry of Health has a draft health financing strategy (HFS) (2016-2025) in place, that awaits Cabinet approval.. It highlights the guiding principles of equity, solidarity, transparency, sustainability and efficiency. The Strategy aims at improving health insurance coverage (see section 6.1), especially in the informal sector to find a better way of protecting the poor against catastrophic health care payments and of promoting universal access according to a nationally defined minimum benefit package (Mtei et al., 2012).

3.3.2. The shortage and inequitable distribution of skilled health workers

The health sector is challenged with both a shortage of and an imbalance in certain cadres, as well as inequitable distribution of its key health workers (Manzi et al., 2012; MoHSW, 2013; Sue et al., 2016; Buguzi, 2017; Sirili, 2018; Sirili et al., 2018).¹³

Available data suggests a low density of key health workers: the national average ratio of doctors, nurses and midwives per 10,000 population is 7.74, which is well below the ratio recommended by the World Health Organization (WHO) of a minimum of 23 doctors, nurses and midwives per 10,000 population density needed to deliver essential maternal and child health services (Loewenson et al., 2018). The Council Community Health Plans (CCHP) 2017/18 data reports an overall shortage of 55% in staff across all main cadres, especially clinicians, nurses, pharmaceutical technicians, laboratory technicians, radiographers, therapists, health officers and health administration (with shortages of 57% for skilled workers and 51% for unskilled workers) (see Appendix Table A2).

The introduction of the decentralised health-sector administration system following the 1990s health-sector reforms (which gave LGAs/districts the mandates for hiring and firing of health providers within the districts) failed to address the geographic imbalance of health providers – for doctors in particular and to ensure their retention at district level (Sue et al., 2016; Sirili et al., 2018).¹⁴ Rural staffing challenges included lack of attractive retention schemes, poor remuneration, and insufficient equipment and medicines to do the work. Doctors preferred practising in urban settings where they could ‘moonlight’, or work at multiple hospitals and clinics, to supplement low salaries. A partially centralised system of management of human resources for health (HRH) was introduced in 2006: the central government’s role was to fill the vacancies identified by the local government (Sirili et al., 2018). Also, an increase in salaries for doctors and other public health workers in 2006 attracted many private-sector health workers back to the public sector, resulting in HRH shortages and potentially the provision of substandard care in the private sector as a

¹³ The workforce shortage reached emergency levels in 2005, with only 16% (3,836/23,474) health care professionals who had been trained over the previous decade hired to work for the government (Sue et al., 2016).

¹⁴ Tanzania had a decentralised system of monitoring health care workers and limited information on where trainees actually went. Many new doctors simply did not show up: for example, according to a 2014 MoH report, only 63% of doctors reported to their assigned station, and of those who went to their post, 13% left within one year due to quality of life, delays clearing hardship claims, moving costs, bad roads, and lack of social services (quoted in Sue et al., 2016). Between 2005 and 2008, the President’s Office of Public Service Management approved over 12,000 new health positions to try to recruit these workers back into Tanzania’s public sector. Many positions remained unfilled. Filling vacant health care posts involves bureaucratic processes across several ministries, with complex and unwieldy coordination between local and central government bodies that prolonged the process.

consequence (Sue et al., 2016). The second five-year HRH strategic plan was adopted in 2008 and recognised mid-level cadres, such as Assistant Medical Officers (AMOs), as critical for ‘task-shifting’ duties from doctors or taking on some of their work. In 2010, the government passed the Public-Private-Partnership (PPP) Act to encourage more public-private collaborations.¹⁵ The Ministry of Health also established recommendations for staffing levels¹⁶ in the different types of health facility (Manzi et al., 2012).

District hospitals, as well as other lower-level health facilities, continue to suffer an acute shortage of medical doctors. Retention of health providers – and particularly doctors – at district level remains a big challenge, with only 31% of the country’s doctors serving the rural population in 2012, which accounted for over 75% of the total population. Estimates from a 2013 qualitative study carried out in three districts of Tanzania suggest that this ratio subsequently decreased to 26% (Buguzi, 2017). The same study described the unfavourable working conditions that doctors face, and the council managers who are also financially constrained who endeavour to retain doctors using different strategies, including career development plans, minimum financial incentive packages and avenues for doctors to practise privately within their hospitals (ibid.).

3.3.3. Constrained LGAs and facilities

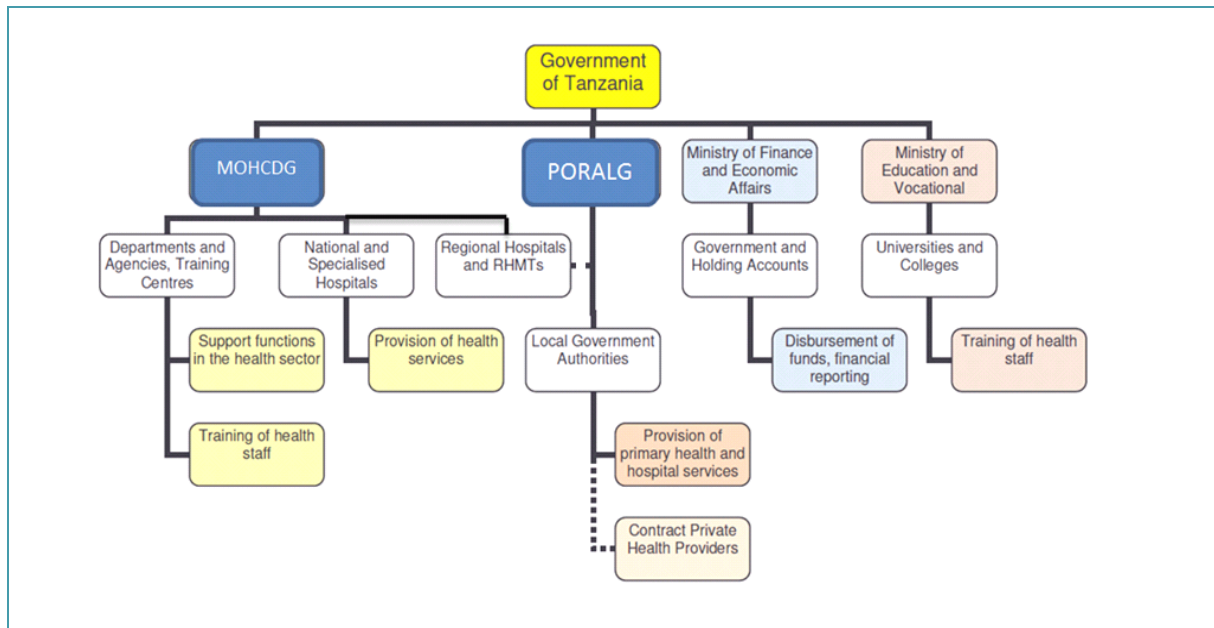
Within the framework of ongoing reforms,¹⁷ the current 167 LGAs are the most important administrative and implementation units for public services (see Figure 2). They are responsible for preparing annual health-sector plans to implement health programmes in their facilities, and for generating and managing resources for the district.

¹⁵ The second five-year HRH strategic plan involved renewed efforts in planning, policy development, education, training, workforce management and utilisation, partnership creation, research and development, and promotion of adequate financing and leadership.

¹⁶ Two clinicians and two nurses for each dispensary and four clinicians and nine nurses for each rural health centre. Health workers delivering the majority of care in rural primary health facilities (dispensaries and health centres) are generally ‘clinical staff’ (AMOs or Clinical Officers or Assistant Clinical Officers) or nurses; there are no medical doctors. However, because of health-worker shortages, it is not uncommon to find auxiliary nursing staff with only basic primary education of seven years and only a one-year introduction to nursing course performing the tasks of a trained nurse [Manzi et al., 2012].

¹⁷ The current 25 regional and 167 local government authorities (LGAs, or councils) are responsible for delivering health services, and report administratively to the President’s Office – Regional Administration and Local Government (PO-RALG); the Ministry of Health, Community Development, Gender and Children (MOHCDGC) is responsible for policy formulation, supervision and regulation for all health services throughout the country, as well as playing a direct role in the management of tertiary health services.

Figure 2: Decentralised health systems structure



Source: Adapted from HSSP III (2010-2015) (MoHSW, 2013).

The aim of decentralisation was to foster economic growth in order to improve efficiency, equity and resource mobilisation, through leadership, accountability and partnership at all levels (Maluka et al., 2011). However, the process of decentralisation by devolution has not been fully realised, hindering the operation of health facilities. Most LGAs face inadequate and unreliable financing for public service provision (Frumence et al., 2013), which impacts negatively on their managerial duties, including providing timely supportive supervision to the facilities under their jurisdiction. LGAs remain dependent on central government grants, and face delays in the disbursement of these funds from the central government (ibid.; Nyamhanga et al., 2013). To deal with these delays, district councils complement funds from their own budgets (e.g. from cost-sharing) and with 'loans' from other ongoing council projects (Frumence et al., 2014). Also, until very recently, most public-sector primary health care (PHC) facilities had limited financial autonomy to utilise their own funds; many did not even have bank accounts. Funding for PHC was thus channeled through LGAs that could limit resources reaching lower levels (MoHSW, n.d.). To overcome some of these shortcomings, the government introduced performance-based financing of facilities in some districts (see section 6.1) and direct health facility financing (see section 6.2).

4. Corruption: the policy context

Tanzania's political, legal and economic measures in response to the economic crisis of the early 1970s resulted in severe budget constraints. It also created several loopholes and a fertile ground for corruption in many sectors, including health (URT, 1996). Deliberate efforts to address corruption have been part of the political agenda in all regimes since independence,¹⁸ as evidenced by the passing of a Prevention of Corruption Act No. 16 in 1971; and forming the Anti-corruption Squad in 1975.¹⁹

Following the release of the Warioba report in 1996, Tanzania adopted a policy of zero tolerance to corruption, and in 2001 enacted the Finance Act and the Public Procurement Act which focused on mitigating corruption risks in management of public finance and procurement.²⁰ Around the same time, the government embarked on a focused institutional strengthening initiative to increase public service efficiency and to address corruption as a national agenda, involving both government and non-government actors.

To govern actions of civil servants, the Public Service Act No. 8 of 2002 gives mandates to the Public Service Management to oversee public service ethics in government ministries, independent departments and executive agencies by coordinating and monitoring ethical conduct at workplaces. Under the Public Service reforms (PSR), which were guided by a comprehensive PSR programme (1999-2004),²¹ a rational pay reform policy was adopted in the 1990s to raise the minimum wage and other compensation benefits. The PSR reforms intended to reduce the scope of government operations to affordable levels; rationalise the machinery of government to improve efficiency and effectiveness; develop an open, objective and competitive pay structure; and decentralise executive responsibilities to local government, executive agencies, NGOs and the private sector. Other key strategies/systems/Acts adopted or passed in an attempt to curb corruption include:

- the National Anti-Corruption Strategy and Action Plan (NACSAP) in 1999 and a Good Governance Coordination Unit (GGCU) in the President's Office to oversee all activities aimed at combating corruption.
- the Human Resources Management and Employment Policy in 1999 and the passing of the Public Service Act of 2002 and its subsidiary regulations in an effort to reinstate meritocracy in the management of human resources in public service.

¹⁸ The ruling party's manifesto indicated the need for deliberate efforts to address corruption (<http://ccmchama.blogspot.com/2016/02/ilani-ya-uchaguzi-ya-ccm-2015-2020.html>)

¹⁹ www.acaauthorities.org

²⁰ Other laws to deal with ethics, integrity and anti-corruption measures included: The Permanent Commission of Enquiry Act (1966) (to check on abuse of power by government officials and its agencies), The Economic Sabotage Act (1983), The Economic and Organized Crimes Control Act of 1984 (incorporated offences under the Prevention of Corruption Act as economic offences), The Economic and Organized Crimes Control Act (Amendment) 1998, The Public Leadership Code of Ethics (Amendment) Act 2001, the Human Rights and Good Governance Commission Act 2001 (Nkinga, 2003).

²¹ <http://unpan1.un.org/intradoc/groups/public/documents/CAFRAD/UNPAN010583.pdf>

- the Open Performance Review and Appraisal System (OPRAS)²² in July 2004, through Circular No.2 of 2004, to facilitate the identification of training needs of civil servants.

In addition, several structures were established towards strengthening national accountability systems (Mutahaba, 2005; URT, 2005; REPOA, 2006a). For example:

- Establishment of the Permanent Commission of Enquiry in 1966 to check the abuse of powers by government officials and agencies.
- Establishment of the Prevention and Combating of Corruption Bureau (PCCB) under the prevention and combating of corruption Act No.11 of 2007, with the aim of investigating corruption complaints from various sources, and to educate and motivate citizens to participate in the fight against corruption.
- Transforming the Permanent Commission of Enquiry into Commission for Human Rights and Good Governance in 2001.

In spite of the existence of a robust legal anti-corruption framework – including numerous laws to deal with ethics, integrity and anti-corruption measures to curb corruption, unethical behaviour and abuse of power – corruption has been endemic, with the public health sector noted to be among one of the most corrupt sectors. The Quality Improvement Framework in Health care (2011-2016) notes that corruption is likely to be one of the major barriers in providing quality health services in the public sector (URT, 2011). The National Health Policy (MoHCDGEC 2017) reiterates that corruption persists in many public health systems and facilities all over the country, despite implementation of various national anti-corruption strategies and measures for preventing corruption in the health sector in the last ten years (efforts have included capacity-building training on good governance and anti-corruption programmes, dealing with complaints and handling mechanisms and training on ethics and integrity committees).

Since October 2015, Tanzania has seen an unprecedented effort by the current government towards fighting corruption (Baez Camargo et al., 2017). Amongst key health-sector leaders within Tanzania, there is growing recognition of the adverse effects and the urgent need to address the practice of corruption that not only threatens equity but also health outcomes. And this is not withstanding the need for effective and efficient use of scarce resources in the face of increased demands to meet existing health needs.

²² OPRAS replaced the Confidential Performance Appraisal System.

5. Rule-breaking and rule-bending: the types, determinants and effects of informal practices among frontline public health providers

This review has identified three common acts of informal practices amongst frontline public health providers, namely: petty corruption, absenteeism and under-productivity, with the former two being more prolific and of increasing concern to policy-makers. Also of concern are practices linked to budget leakages at various levels of the health system (for example fraudulent claims, payroll irregularities and mismanagement), which have the potential to directly or indirectly influence provider and service-user behaviour at primary care level. The following sections detail some of these practices.

5.1. Types of informal practices

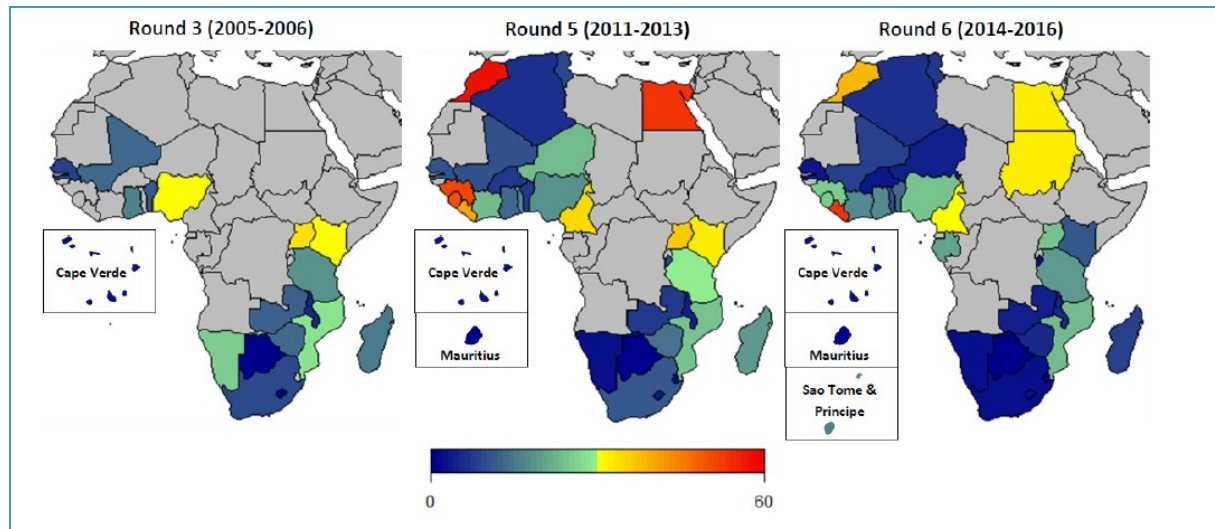
5.1.1. *Petty corruption*

Petty corruption in this instance refers to everyday abuse of entrusted power by public health providers at primary care level in their interactions with citizens trying to access basic health services (Lewis, 2006; Transparency International, 2006; Seppänen and Virtanen, 2008; Hussmann, 2011; Peiffer and Rose, 2014). While there is no universal definition, it includes unofficial in-kind or cash payments from health service users to providers in exchange for a certain favour, with attitudes and perceptions towards informal payments very much shaped by different cultural and social norms.

At a broad level, between 10% and 45% of total out-of-pocket payments in low-income countries are reported to be informal transactions (Aryankhesal, 2017). Using Afrobarometer survey data (rounds three, five and six),²³ Figure 3 presents the level and evolution of informal payments in public hospitals and health centres in Africa in 2005-2006, 2011-2013 and 2014-2016, and suggests that informal payments are almost non-existent in some countries, while they are a real problem in others. With the exception of a few countries, the author notes a general downward trend between round five (2011-2013) and round six (2014-2016), however.

²³ Since 1999, Afrobarometer surveys have been conducted every two to four years (depending on the country), with samples ranging from 1,200 to 2,400 respondents and primarily aimed at producing data on national public attitudes on democracy and governance in Africa in order to measure the social, political and economic atmosphere in those countries.

Figure 3: Percentage of individuals who had to pay a bribe at least once in their local public hospital/clinic during the last 12 months



Source: Kankeu (2013).

In Tanzania, petty corruption is documented to be one of the most commonly encountered informal practices in both urban and rural areas (URT, 1996; Kamuzora, 2005; Mamdani and Bangser, 2005; Manzi et al., 2005; Lewis, 2006; Transparency International, 2006, 2015; REPOA, 2006a; Kruk et al., 2008; Seppänen and Virtanen, 2008; Stringhini et al., 2009; SIKIKA, 2010, 2014; Mæstad and Mwisongo, 2011; Lindkvist, 2013; Peiffer and Rose, 2014; Binyaruka et al., 2015; Kankeu and Ventelou, 2016; Baez Camargo et al., 2017; Kassa and Baez Camargo 2017; Anders and Makene, 2018). Acts of petty corruption include, but are not restricted to, fees for basic health services or supplies (including drugs) meant to be provided free of charge; to obtain specific favours such as expedited or extra services (favouritism); as insurance for receiving better future care from the health provider(s); and unsolicited gift-giving and unofficial payments as a means to establish a personal relationship with the provider, or as an expression of gratitude or sign of appreciation.

Transparency International's data from 2015 suggests high bribery rates in public hospitals in Tanzania (20%) and Uganda (25%), compared to Burundi (2%) and Rwanda (11%). According to the 2005 Afrobarometer survey, about 29% of respondents reported that demands were made of them to engage in illegal payments at their health facilities, with 15% making such payments (REPOA, 2006a). A 2013 phone survey carried out by TWAVEZA,²⁴ revealed that patients are more likely to pay bribes in government health facilities, where staff shortages and long waiting times put pressure on staff and patients alike (TWAVEZA, 2013a), while a more recent study from 2016 suggests that more than 30% of respondents had experienced at least one health worker demanding an informal payment of them (Kankeu and Ventelou, 2016). Stringhini et al. (2009) note that informal payments are frequently initiated by the patient, however, because of the risk for health workers to directly ask for them.

The findings detailed below from a survey conducted by Maestaad and Mwisongo (2011) are quite illustrative of the practice of informal payments in mainland Tanzania. The authors found that health workers at all levels received informal payments/bribes in a number of different contexts, including:

- when patients want to reduce waiting times and bypass a queue – often the lower cadres seek bribes and help patients bypass the queue by presenting the patient to the doctor as a relative;
- when patients are in need of drugs and other medical supplies that they are supposed to get for free – health workers reportedly pretend that there are shortages of drugs and supplies, and ask patients to ‘buy’ the missing supplies from the private market, or from clinicians who are running private pharmacies within consultation rooms, despite their being pharmacies at the health facility;
- for small services that are meant to be free, as well as in the case of major surgeries;
- as gifts of appreciation, but which may involve expectations of better treatment in the future.

The same study reports that the amounts paid as bribes or informal payments varied substantially from place to place, depending on the type of service provided. The payments ranged from 500 up to a few thousand Tanzanian shillings (Tshs) for typical nurse-related work; and up to Tshs 50,000 in relation to surgery and other time-intensive work carried out by doctors.²⁵ Though doctors may typically be involved in the largest transactions, the lower cadres are likely to encounter patients more frequently and therefore have the potential to extract a larger number of smaller bribes. It was reported that health workers sometimes share the payments received, but only partially, and more rarely within than across cadres. Finally, the main reasons given for health workers taking bribes were reported to be: low salaries and inadequate incentives (mentioned by 81% of respondents), greed (34%), patients enticing staff to accept bribes (24%), and a perception by health workers that corruption is the norm (18%) (ibid.).

Pregnant women, children below the age of five years and adults aged 60 years or over are eligible for free outpatient services in government health facilities, but rarely receive free treatment (Mamdani and Bangser, 2005; Manzi et al., 2005; Kruk et al., 2008; Twaweza, 2013b; Binyaruka et al., 2015). There is evidence that health providers often take advantage of the shortages of drugs, supplies and health workers, and of patients’ ignorance regarding cost-sharing measures and service-delivery procedures (SIKKA, 2010). Accessibility to health care is usually not straightforward either, with the ease of receiving medical care sometimes being associated with whether the patient knows the health provider in charge (relatives are considered first), or whether the service seeker can afford a bribe (which tends to increase,

²⁵ Since 1999, Afrobarometer surveys have been conducted every two to four years (depending on the country), with samples ranging from 1,200 to 2,400 respondents and primarily aimed at producing data on national public attitudes on democracy and governance in Africa in order to measure the social, political and economic atmosphere in those countries.

²⁵ 1,000 Tsh = 0.8 US\$.

the more distant the relationship with the health provider and the more urgent the situation) (Kassa and Baez Camargo, 2017).

5.1.2. *Health-provider absenteeism*

Health-provider absenteeism is reported to be a chronic – although often undocumented and unmeasured – problem in developing countries (Lewis, 2006; Seppänen and Virtanen, 2008; Diestel et al., 2014), including in Tanzania (URT, 1996; Transparency International, 2006; Manzi et al., 2012; TWaweza, 2013b; SIKIKA, 2014). Health providers do not report to work for various reasons, some of which are legitimate (such as to attend seminars and trainings or to collect their salaries, vaccines or other supplies from the district capitals), and others not so (i.e. unauthorised absences by health workers during all or part of their paid working hours).

Findings from a survey of 133 health facilities carried out in five districts in southern Tanzania revealed that almost half of clinical staff (40/82) and nurses (45/81) surveyed, were absent from their place of work on the day of the survey. Almost all were reported to be ‘officially’ out: attending seminars (38%), on long trainings (8%), on an official trip (25%), or on leave (20%) (Manzi et al., 2012). The same survey reports that only 14% (122/854) of the recommended number of nurses and 20% (90/441) of the clinical staff had been employed at the facilities, less than the national average of 35%. In addition, although reproductive and child health clinic nurses were present for seven hours a day, they only worked productively for a little over half (57%) of the time they were present at the facility – so-called ‘silent’ absenteeism. This was possibly a result of infrequent and unsupportive supervision and oversight, as almost two-thirds of the facilities had received fewer than three supervisory visits from their managers (council health management teams) during the six months preceding the survey. It should be noted that these managers in turn face genuine challenges themselves, often times being financially constrained and having competing priorities at the district level.²⁶

‘Moonlighting’ amongst doctors – whereby clinicians work in private practices when they are supposed to be attending clinics at public facilities – is also a common and accepted practice in Tanzania, particularly in urban areas (Theisen, 2006). This is an unorthodox form of corruption, however, as it is not usually identified with theft or the use of public office or resources for private gain.

Overall, in a context of a shortage of health providers, the absence of a significant number of health workers from their place of work (be it official or unofficial) can result in overburdened and unmotivated health workers, as well as providing fertile grounds for informal practices. The absence of adequate and timely supervision further aggravates the situation.

²⁶ In the decentralised Tanzanian health system, the district Council Health Management Team (CHMT) is responsible for the health services provided in its district. The persons in-charge of primary facilities are responsible for overseeing the day-to-day activities of their facilities and communicating with CHMTs on various requirements related to drugs, supplies and equipment. CHMT members are supposed to visit each facility on a monthly basis to supply commodities, review Health Management Information System (HMIS) data and support frontline staff.

5.1.3. Underproductivity: the 'know-do gap in providers' performance

Poor productivity of health workers is noted to be another common phenomenon in Tanzania (Leonard and Masatu, 2010; Lindkvist, 2013; Mæstad, 2006; Manzi et al., 2012), as well as in other developing countries (Lewis, 2006).

Health providers perform below their capacity/knowledge for various reasons, including: 1) the absence of an enabling and supportive environment (such as lack of essential supplies, drugs, equipment or referral services) which deters health workers from performing to their professional satisfaction; 2) where facilities are inadequately staffed, overworked health workers are simply not able to deliver to par – Manzi et al. (2012) note that severe shortages in frontline health workers results in the available health staff being overburdened as they end up working extra hours to attend to many patients on a daily basis; and 3) when it is intentionally practiced, a 'go slow' approach is used as a means of eliciting informal payments from patients for better services. Only the latter is an act of corruption, as well as a sign of unprofessionalism.

Several papers report on the practice of health providers intentionally lowering their efforts as a means of extracting informal payments from patients (Kamuzora, 2005; SIKIKA, 2010; Mæstad and Mwisongo, 2011; Lindkvist, 2013). Findings from SIKIKA's (2010) survey suggest that health workers found loopholes and devised creative tactics to extract bribes from patients including by imposing unnecessary delays in service delivery (reported by 34% of respondents). In another instance, based on findings from focus groups with 58 health workers representing different cadres and levels of care in one rural and one urban district in Tanzania, Maestad and Mwisongo (2011) note that 'health workers are involved in "rent-seeking" activities, such as creating artificial shortages and deliberately lowering the quality of service, in order to extract extra payments from patients or to bargain for a higher share of the payments received by their colleagues'.

A report from the Ministry of Health and Social Welfare (MoHSW, 2013) notes that poor human resource management and weak enforcement of policies and regulations have fueled the shortage of health service providers and have led to low productivity.

5.1.4. Budget leakages in the health system

Underfunding of the health sector is further aggravated by system bottlenecks, which result in leakages of public funds that are intended for facilities.

Resources allocated to the health sector flow through various layers of national and local government institutions on their way to health facilities. Budget leakages due to fraud, abuse and corrupt practices may occur at multiple points in the health system, at national, regional and district levels. They also occur for various reasons, including inadequate monitoring, oversight and controls; poorly managed expenditure systems; lack of effective auditing and supervision; and organisational deficiencies over the flow of public funds. Such practices can directly or indirectly influence provider and consumer behaviour at primary care level, including their delivery of, and access to, quality health care. To quote a few examples –

- **Weak institutions** have posed serious challenges in the procurement and distribution of essential drugs. The drug supply chain is extremely complex, with several parties involved before the product reaches end users. Subsequently it is susceptible to mismanagement and corruption at every and any stage of the regulatory process. For example, in January 2016, the Medical Stores Department (MSD) director reported a TShs 500 billion drug shortage for FY2015/16 (Buguzi, 2016a), which limited the agency's capacity to meet the increasing demand for medicines in the country. An MSD audit of Global Fund grants in mainland Tanzania found the governance, oversight and management of grant implementation arrangements to be ineffective. Shortly after, the Health Minister suspended four MSD directors for alleged misuse of TShs 1.5 billion (Kayera, 2016).²⁷
- **Parallel off-budget financing:** a considerable share of donor funds to the health sector continues to be channelled off-budget through international and NGOs. This means the funds remain outside the review of regular budget allocation, discipline and oversight processes, with an inherent risk of corruption, especially if they need to be spent quickly.
- **Payroll irregularities,** in particular the existence of ghost workers, constitutes a serious problem, with the health and education sector topping the list of institutions harbouring the most ghost workers (Buguzi, 2016b).²⁸ Until recently, appropriate management, accountability and personnel information systems on even simple things such as attendance were often lacking. A recent national verification exercise noted that the number of public ghost workers had reached 19,708 by 31 January 2017, enabling the government to save close to US\$10 million of taxpayers' money that would have been spent on their salaries every month (*Standard Digital*, 2017). It is noteworthy that Tanzania's public-sector wage bill has escalated sharply over the past few years, accounting for more than half of government revenues, partly because of the numbers of people registering fake names to collect extra wages (Buguzi, 2016b). It is equally important to note that despite the shortage of health workers in public health facilities, a majority of medical graduates trained locally and abroad were not recruited (Buguzi 2017; Sirili et al., 2018).²⁹ As noted by the Minister of Health, '*the Wage Bill is the determining factor*' (Buguzi 2016b). Payroll clean-up and management of the public workforce is a key priority. Since 2012, the government has started using the Human Capital Management Information System (HCMIS) that enables officers to eliminate workers who do not qualify to remain on the payroll (Buguzi, 2016b).

²⁷ The Global Fund audit found stock-outs of varying magnitudes and differences between stock dispatched by the Global Fund's Pooled Procurement Mechanism and received at the central medical store valued at US\$1.55 million. The Office of the Inspector General also identified a lack of proper records at regional/district medical offices that distribute 50% of all health commodities. There were also unexplained differences ranging between 40% and 50% for the quantity of malaria and HIV test kits and anti-malaria medicines reported as delivered by the Medical Stores Department and accounted for by the district medical offices/facilities.

²⁸ The public-sector health workforce represents the largest single group of civil servants in Tanzania. On average, the government spends about TSh5.5 trillion annually on salaries, equivalent to 51% of the country's revenues. In 2015/16, the government was spending an estimated US\$260 million per month to pay salaries of its more than 550,000 civil servants – equivalent to more than half of government revenues taken in over the same period [US\$1 = 2,182.0000 Tsh].

²⁹ The government may have lost billions on training doctors it is not able to absorb; the cost of training one doctor is estimated at US\$25,000 (TSh 55 million) (Buguzi, 2016b).

- **Fraudulent payment claims** by NHIF-accredited health facilities that provide low-cost health services to clients can result in losses in billions of shillings, and hamper the NHIF's efforts to achieve a higher health insurance coverage (Oforo, 2017).³⁰ As of 2018, the NHIF introduced advanced electronic cards for its members in an effort to seal loopholes of corruption and mismanagement and to curb the misuse of funds.

The literature from Tanzania also reports on unnecessary referrals (SIKIKI, 2014) and on grand corruption that includes public scandals or cases (Gray, 2015; Mpambije, 2017).

5.2. Determinants of informal practices

Evidence to date suggests that, on the whole, informal practices amongst public health providers are a consequence of the unmet expectations and needs of health providers and service users. As such, many behaviours are coping mechanisms, amidst a weak and stretched health system that is grappling with inadequate and inequitable financing of facilities and local government authorities across the country, insufficient support to health providers, and poor coordination and alignment of external actors and financiers to national priorities.

The 1996 Warioba report (URT, 1996) noted that the increasing practice of corruption was a result of inadequate public understanding of the cost-sharing policy that was instituted to overcome the burden of providing free public health services. This policy and the underfunding of health services resulted in patients bribing health providers to qualify for services; a shortage of medicine and equipment with better-off patients more likely to access limited stocks as they could afford to pay bribes; the establishment of private facilities by health service providers or individuals taking up secondary jobs in private hospitals to augment their poor salaries; poor leadership and supervision by managerial staff; and weak ethics governing the medical and nursing professions overall (SIKIKI, 2014).

This subsection summarises some of the key reported causes or underlying determinants of the most common informal practices among Tanzania's public health providers at primary care level.

5.2.1. Health worker (dis)incentives

Health-worker motivation is low due to severe shortages of staff, medicines and supplies, while health facilities receive inadequate funds and have limited financial autonomy (Mæstad, 2006; Leonard and Masatu, 2010; Manzi et al., 2012; Olafsdottir et al., 2014; SIKIKI, 2014; Buguzi, 2017; Todd et al., 2017). The immense health needs in Tanzania dwarf the available resources and the fragile, overloaded systems.

³⁰ Figures from 2017 suggest that only 28% of Tanzanians are enrolled in health insurance schemes, and the NHIF is struggling to ensure that at least 50% of all Tanzanians are on medical cover by 2020 (Oforo, 2017).

Even basic infrastructure is often lacking, meaning that health workers can perform only limited tasks. They are challenged by unfavourable working conditions (i.e. inadequate supplies/drugs, an inability to attend to patients in critical conditions, lack of reliable means to transport patients to higher facilities for referral health care); poor prospects for career progression; inadequate salaries and delays in payment of financial allowances with no standardised financial incentive system across districts; and an unsupportive broader environment characterized by difficulties in securing houses for rent and lack of alternative opportunities to earn extra income. Such conditions incentivise health providers to seek informal payments or bribes (Makeula, 2000; Kamuzora, 2005; Stringhini et al., 2009; Songora Makene and Mpango, 2017) or to ‘moonlight’ (running an ‘unofficial’ private facility/clinic besides their official job in the public sector).

The culture of per diems and allowances often linked to externally funded seminars, trainings and capacity-building workshops has also been used in many countries as a coping strategy to compensate for low public-sector wages. Such practices have proved to be extremely costly for developing-country governments, including in Tanzania, where the amount allocated for allowances for FY2009/2010 represented 59% of the total wage bill³¹, for example (Policy Forum, 2009). The Policy Forum (2009) notes that when allowances are ‘only loosely related to actual cost incurred and when they are high relative to basic salaries, they become an incentive instead of a reimbursement’, and they are ‘likely to induce and reward behaviour that is counterproductive to the provision of quality services by public servants’ (p1/2). Such uncoordinated practices that bypass national planning mechanisms can at times pull many workers from their place of work and have negative consequences for service delivery: they can ‘pay 3 days wages for one day’s attendance. It pays people not to do their work’ (Policy Forum, 2009, p10).

Despite the widespread corruption and poor quality of services delivered, Anders and Makene (2018), Lindkvist (2013) and Strong (2017) show that health professionals in Tanzania work very hard, however, and use a range of ‘practical norms’ to get their job done and provide essential public services to the poorer sections of the population. Furthermore, they often go beyond the call of duty to assist patients by using personal funds and working overtime or double duty. Indeed, a follow-up phone survey by TWAVEZA32 in August 2016 was very positive, citing improvements in certain headline indicators such as the presence of health workers and their manners and attention to detail (although complaints about poor facilities, lack of equipment and shortages of medicine remained significant). Problems arise, therefore, due to the informality and clandestine nature of many transactions, as funds can easily be diverted by civil servants who invoke practical norms.

³¹ Pensionable and non-pensionable basic salaries plus pensions

³² data were collected from 1,836 respondents from the second *Sauti za Wananchi* panel, conducted between 2 and 17 May 2016.

5.2.2. *Drugs stock-outs*

Reliable information and analysis on stock-outs of essential drugs remains relatively scarce, however a study covering 923 public health facilities (hospitals, health centres and dispensaries) conducted by the Ifakara Health Institute in 2012 found high levels of stock-outs, with an average of only 37% of public facilities being in stock for any given drug from a set of 14 essential tracer medicines. The study found considerable variation between districts and across medicine types, with somewhat better levels of availability in private facilities and urban areas (IHI and MoHSW, 2013). The 2012 Afrobarometer survey noted that 88% of Tanzanians reported experiencing shortages of medicines and other medical supplies at a public health facility in the preceding year (REPOA, 2012).

5.2.3. *Institutional and legislative constraints*

Institutional constraints – including lack of or limited supervision, weak enforcement of accountability, lack of transparency and limited capacity for investigating corruption – also contribute to petty corruption in public health services (SIKIKA, 2014). A survey of community members found a statistically significant association between institutional factors that were tested (i.e. lack of limited supervision and accountability) and the likelihood that a patient or carer had paid a bribe to a health worker ($p < 0.001$) (Kassa and Baez-Camargo, 2017).

According to SIKIKA's (2011) facility-based research of 390 health service users across six districts, existing complaint mechanisms are not effective either, mainly due to absence of confidentiality (with complaint boxes in open visible areas); illiteracy, as the majority of service users do not know how to read and write; and complaints rarely being addressed. These findings are further reiterated in interviews with community members that reveal the limited effectiveness of Health Facility Governing Committees (HFGCs)³³ (SIKIKA, 2014). In-depth interviews with HFGC members themselves indicated that a majority (62%) admitted that they did not follow up patients' complaints about corruption, partly due to the unwillingness of facility management to cooperate. Generally, rural community members are concerned about the negative consequences of denouncing corrupt perpetrators, and are therefore unwilling to do so (Kassa and Baez Camargo, 2017).

Overall, Tanzania's legal and regulatory frameworks have not been strong enough to fight corruption either (URT, 1996; Ngware, 2005; SIKIKA, 2014). Some of the identified weaknesses include:

- Inadequate administrative and public control mechanisms, with systems lacking in transparency and political or public oversight.

³³ Tanzania has a policy commitment to involve communities in prioritising and planning local health services through HFGCs that were introduced in 1999, albeit without being uniformly implemented. HFGCs were introduced alongside the CHF, and as part of the government's efforts to implement a bottom-up planning approach in the development and implementation of Council Community Health Plans (CCHPs) (IHI, 2011).

- Lack of clear standards of performance for providers, coupled with weak organisational and poor management structures.
- Lack of effective auditing and supervision.
- Limited enforcement of rules/no sanctions, where abuse prevails and good performance goes unnoticed.
- Lack of accountability systems and political or public oversight (resulting in provider absenteeism, moonlighting, informal payments, poor quality of care, irregularities in purchasing practices, etc.).
- Lack of citizen involvement and oversight, weak public participation in decision-making, and patients being unsure of their rights.

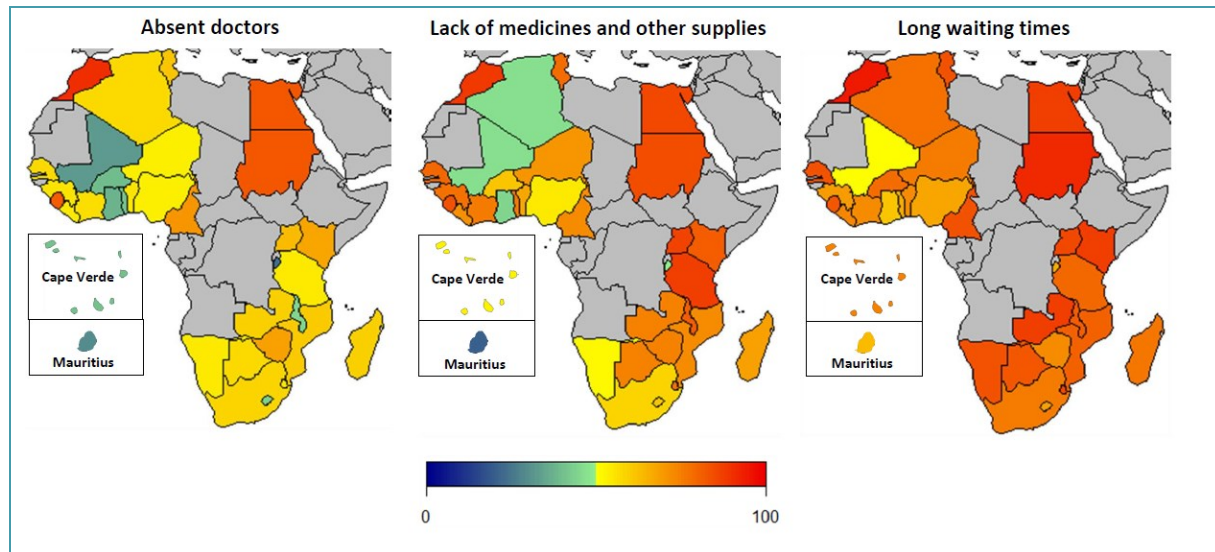
5.2.4. Summary

Kankeu (2018) explores the coexistence of informal payments in public health facilities of several African countries with other failures in health care provision (see Figure 3, Kankeu 2013).

Figure 4 below presents data from round five (2011-2013) of the Afrobarometer survey (Kankeu, 2018), where people were interviewed about other problems they have faced in public health facilities besides informal payments. Commonly reported problems include absenteeism of doctors, stock-outs of medicines and other medical supplies, long waiting times in public health facilities, lack of attention or respect from health staff, and dirty hospitals and health centres.

Reporting on an earlier individual-level analysis, Kankeu (2018) notes that people who report having faced these dysfunctions were also more likely to report having had to pay bribes. Similar patterns emerge when the data is aggregated at the national level. Though not causal, according to Kankeu the analysis suggests that countries with high proportions of individuals reporting having paid bribes in public hospitals and health centres are also those where high proportions report: a) having faced doctors' absenteeism ($r = 0.62$, $p\text{-value} = 0.0001$); b) having faced stock outs of drugs and other medical supplies ($r = 0.56$, $p\text{-value} = 0.0006$); c) having experienced long waiting times ($r = 0.30$, $p\text{-value} = 0.0825$); d) having faced lack of attention/respect from medical staff ($r = 0.58$, $p\text{-value} = 0.0003$); e) having faced insalubrity in these health facilities ($r = 0.61$, $p\text{-value} = 0.0001$). The author concludes that, 'actual or fictitious shortages of human and material resources [in the face of patient needs] create incentives for patients to pay more for the services they are seeking, including paying informally'.

Figure 4: Percentage of individuals who have faced some problems in their local public hospital/clinic during the last 12 months (2011–2013)



Source: Kankeu (2018).

Research findings underscore that practices of petty corruption are fundamentally motivated by adverse conditions involving scarcity, inadequate quality of services available to the public and the lack of an effective social safety net. This is corroborated by the 2017 PCCB survey (quoted in Kassa and Baez Camargo, 2017), where most respondents named poverty, high costs of living, inflation and inefficient bureaucracy/public service delivery as key drivers of corruption.

In sum, the underlying reasons incentivising the many forms of corruption are complex and overlapping. Existing governance structures in Tanzania are not strong enough to fight all forms of corruption. Some performance problems, including absenteeism, stem from weak governance systems that fail to reward good performance and to discipline workers who are under-performing or are absent. Poor remuneration and inadequate or unattractive working conditions are also potential determinants of corruption, along with social pressures from family or peers to engage in corrupt behaviour in order to progress professionally or to support one's family. The mistrust of public institutions is a further determinant (Cho and Kirwin, 2007).

5.3. The effects of informal practices

Informal practices undermine the quality of health care delivered, which has a central role in shaping health outcomes. Several studies report on the disproportionate negative effects of petty corruption on the most vulnerable groups – the disabled, pregnant women and the elderly, as well as the poor, uneducated and the marginalised – who are unable to seek timely and appropriate care (Tibandebage and Mackintosh, 2002; Mamdani and Bangser, 2004; Manzi et al., 2005; Ngware, 2005; Cho and Kirwin, 2007; Kruk et al., 2008; Lavallée et al., 2008; Mboera et al., 2009; SIKIKA, 2010, 2014; Mæstad and Mwisongo, 2011; Peiffer and Rose, 2014; Binyaruka et al., 2015; Kankeu and Ventelou, 2016; Ngata, 2016; Baez Carrago et

al., 2017; Kabote, 2017). Indeed, the poor and the most vulnerable need more health care, but often get less (Smithson, 2006).

Through rent-seeking behaviour, health providers are focused more on maximising income from bribes, giving less attention to their performance, and consequently are less sensitive to patients' medical conditions and needs (Lindkvist, 2013). For providers with dual public and private practices, patients are often encouraged to seek care from their private facilities, possibly incurring higher fees (SIKIKI, 2014). When the poor have money, they often seek care from mission hospitals due to perceived staff commitment and readily available medicines, equipment and other medical supplies (Mamdani and Bangser, 2004; Leonard et al., 2002). In general, the availability and (official or unofficial) cost of medicine, distances to health facilities and provider–user relationships influence care-seeking behaviour and utilization of health services.

It is also important to note that the very practice of being unethical and soliciting informal payments can lead to poor self-esteem amongst health providers and can impact negatively on the quality of their work: aside from the fear of being found out and reported, Stringhini et al. (2009) report on the increasing vulnerability of health providers who engage in informal practices.

Petty corruption leads to wastage of patients' resources (both time and money), which impoverishes them further and deepens their vulnerability (Mamdani and Bangser, 2004; Transparency International, 2006; SIKIKI, 2010;). One study notes that about 41% of Tanzanian households reported having cut down other spending and 37% borrowed money/sold household assets to finance health care (Kruk et al., 2008).

Aside from undermining service provision, health provider absenteeism and poor productivity also results in wastage of resources, and possibly closure of public health facilities (Manzi et al., 2012). Further, grand corruption that involves misuse of public funds has implications for efficient use of available resources and for the implementation of effective policies, strategies and programmes to ensure the wellbeing of all Tanzanians (Mpambije, 2017).

Thus, irrespective of the underlying reasons, corruption in the health sector can have severe negative consequences for patients, resulting in catastrophic out-of-pocket expenditures, inequality in access to services and high-quality care, loss of confidence in public health care, and inequality in health outcomes. These consequences not only hurt individuals, but also affect entire communities and the national economy. Further, corruption poses an obstacle for the government to deliver or fulfil its functions and obligations in terms of resource allocation, policies and service delivery.

6. Potential initiatives to mitigate informal practices among frontline public health providers

The Government of Tanzania has adapted various interventions to strengthen overall institutional arrangements and to specifically improve health-system performance. This includes addressing inefficiencies, containing misuse of public funds, reducing recurrent expenditure and reorienting public expenditure towards development spending, and intensifying efforts to mobilise domestic revenue. Attention is focused on strengthening delivery of quality primary health services to optimise the use of scarce resources, as well as to ensure equitable access to essential care, in line with the HSSP IV on social accountability, improved governance and strengthened systems (MoHSW, 2015b).

This section summarises the following five interventions that are currently being implemented, and that have the potential to directly/indirectly mitigate against corruption in the health sector: 1) performance-based financing; 2) direct health-facility financing; 3) improved community health fund; 4) Health Facility Governing Committees; and 5) social accountability initiatives.

6.1. Performance-based financing

To address longstanding system constraints towards better health outcomes, the Government of Tanzania introduced a Pay for Performance (P4P) pilot in Pwani region in 2011. This pilot was designed to motivate health workers towards providing better quality reproductive and child health (RCH) care: health providers and their managers were financially rewarded for attaining pre-defined performance targets on coverage and quality of RCH health services (Borghi et al., 2013; Binyaruka et al., 2015). Analysis of pilot data collected over an 18-month period suggests the strong enforcement of a fee-exemption policy for pregnant women and children under five years using maternal and child health (MCH) services in the P4P intervention districts, with the chances of paying informal payments for MCH services reduced over time (ibid.). In an effort to increase service utilisation for rewards through P4P, providers are more likely to reduce/remove user charges in order to attract more clients.

Additional financial resources at the facility level for 'performing' facilities helped address some of the supply-side barriers (e.g. infrastructure, drugs and supplies) in the short run, with the potential for improved service quality also (Olafsdottir et al., 2014; Binyaruka and Borghi, 2017). Overall, though the pilot findings were mixed and inconclusive, they do suggest that in the short-run P4P can incentivise health providers to be more responsive to service users (for example, by changing their manner, 'being kinder' or by extending opening hours; Binyaruka et al., 2015), as well as strengthening both external and internal accountability, and enhancing transparency and responsiveness to service users (Mayumana et al., 2017). This is

notwithstanding any concerns for potential displacement of non-incentivised services and the consequences for team work in larger facilities (Mamdani et al., 2012). Analysis of data from another Tanzanian study also suggests that by using performance incentives, health providers are incentivised to exert more effort and to perform to their maximum capacity/knowledge (i.e. the ‘know-do gap’ is reduced and productivity improves) (Mæstad, 2006; Leonard and Masatu, 2010; Gertler and Vermeersch, 2013).

The Pwani P4P pilot has since been redesigned and transformed into a results-based financing (RBF) initiative (MoHSW, 2015b, 2015c), which aims to enhance provider accountability for results and encompasses broader health-system strengthening measures. RBF incentivises multiple levels of the health system for both quality and quantity of PHC services at dispensaries, health centres and district hospitals (ibid.). The scheme has been rolled-out to the seven regions, those with poorer health outcomes and higher poverty levels. A midterm review of the programme shows consistent increases in quality scores across nearly all indicators (World Bank, 2018). A useful exercise will be of use to see if the P4P pilot findings can be further validated by the ongoing evaluation of the national RBF intervention;³⁴ i.e. to ascertain the potential of RBF to strengthen accountability and eventually reduce the incidence of petty corruption, staff absenteeism and poor productivity among front-line providers, as well as on fostering system-wide reforms. PBF interventions in sub-Saharan Africa have been largely externally financed; sustaining motivation as well as the overall intervention is a core concern (Paul et al., 2018).

6.2. Expanding the scope of fiscal decentralisation in the health sector: direct health facility financing

Since the inception of health-sector reforms in Tanzania in 1999, health planning and its implementation was decentralised to CHMTs that were responsible for managing local authority funds disbursed from the central government. However, available evidence indicates that this decentralisation arrangement did not improve health-services delivery at council level as expected. Health facilities were often cash-strapped due to inadequate and late receipt of funds from the council, which ultimately hampered effective and efficient service delivery (see section 3.3.3). In 2016/17, Tanzania revised this health-sector decentralisation arrangement by extending fiscal decentralisation to health-facility level: direct health facility financing (DHFF) was adapted to facilitate quick disbursement of funds³⁵ to all public health facilities across mainland Tanzania (URT, 2017).

DHFF signals a shift towards performance-based, output-based payments. The aim is to improve service delivery through increased flexibility and autonomy, to build local ownership and accountability, to ensure efficiency and effectiveness of basket funding and to improve public financial management (ibid.). All facilities now operate a single DHFF bank

³⁴ Conducted by IHI in collaboration with London School of Hygiene and Tropical Medicine and the Chr. Michelsen Institute.

³⁵ Health Basket Funds are transferred directly to more than 5,000 service-provider accounts according to a transparent formula. HBF disbursements are performance-based, monitoring 19 performance indicators including child survival rates, out-of-pocket expenditures, and incidence levels for diseases such as HIV, tuberculosis, and malaria.

account and by February 2018 two rounds of payments had been directly disbursed into all facility bank accounts by the Treasury.³⁶ Previous facility-based multiple accounts have been closed and cost-sharing revenue has been consolidated at the regional level. The financial management arrangements under DHFF are set in such a way that all health facilities have to use electronic accounting systems for reporting expenditure. A recent update on the status of DHFF implementation shows poor reporting of financial resources by health facilities, however, which is largely attributed to poor coverage of facility supervision by district council managers. For the DHFF initiative to work in a complex and resource constrained sector, it will require good planning and coordination amongst the many actors that finance, manage and therefore influence the sector systems.

6.3. Formalising payment: an improved community health fund

The strategy of strengthening existing pre-payment schemes (such as the community health fund (CHF)) and enforcement of an exemption and waiver policy (using vouchers) has long been suggested as one way of limiting rent-seeking behaviour among health providers in Tanzania (Manzi et al., 2005; Kankeu and Ventelou, 2016), as well as in other settings (Balabanova and McKee, 2002).

The government is in the process of finalising its comprehensive health financing strategy (HFS) as a means to end fragmentation of health insurance coverage, to increase resources for health, to provide a minimum benefits package for all, and to increase the efficiency of health spending. The ultimate goal of the health insurance reform agenda is the establishment of a single national health insurer (SNHI). The proposed SNHI legislation is expected to be considered by the National Assembly in November 2018. If the bill is passed, implementation is not expected to begin until 2019 or 2020. In the interim, the plan is to have two concurrent schemes: the NHIF for the formal sector³⁷ and the improved CHF (the iCHF) intended to cover the informal sector and rural households. Scaling-up the iCHF, under the NHIF's oversight, is considered an essential step in promoting access to health care while national health insurance reforms continue to be deliberated (MoHCDGEC, 2018). A portion of iCHF enrolment for the poor³⁸ is expected to be subsidised by the Government of Tanzania (Lee et al., 2018).

According to Lee et al. (2018), two issues warrant attention as the iCHF scales up. The first is the challenge of keeping administrative and operational costs reasonable below 11% of

³⁶ Dr Anna Nswilla. Assist Director HS, PORALG. 'Updates in implementation status of DHFF'. Presented at Basket Funders Committee (BFC) meeting, 9 February 2018.

³⁷ The NHIF is expected to cover the formal sector; funds will continue to be pooled nationally. A proposed legislative amendment would make enrolment automatic and mandatory for all formal-sector workers (the formal public sector comprising civil servants, other government workers, and their dependents; and the formal private sector).

³⁸ Those living on an income that is below the national poverty line, equivalent to about US\$1 per capita per day using 2005 purchasing power parity estimates (World Bank, 2015). A household budget survey estimated that 28% of Tanzania's total population will be eligible for the subsidy (MoHCDGEC, 2018).

contribution income for the iCHF to be sustainable. For this, the iCHF will need to achieve economies of scale: enrolment must remain at 70% in order to ensure an adequate pool of resources to pay for services (MoHCDGEC, 2018). The second issue is whether iCHF capitation payments will be sufficient to finance facilities to provide necessary services. Lee et al. (2018) also point to the potential of the ongoing RBF and DHFF to improve quality of service delivery at public facilities, which should then help to improve the quality and availability of services at iCHF-financed facilities – a factor that is critical to encourage beneficiaries to re-enroll.

Lessons can be learnt from two existing initiatives to help turn the CHF into a viable and sustainable micro-insurance scheme, namely: a public-private iCHF scheme that has been implemented in the Northern zone since November 2014 with support from PharmAccess and the Dutch government³⁹ (Ngowi, 2016, Lambrecht, 2017); and the CHF-Iliyoboreshwa scheme that has been implemented in Dodoma region since 2012 with support from the Swiss government (Stoermer et al., 2013; Kalolo et al., 2018).

Faced with a large informal economy and a small tax-base, the Government of Tanzania has been searching for alternative mechanisms to redesign their health-financing system, like the use of a public-private partnership. The iCHF, a voluntary, district-owned health insurance scheme, was launched in November 2014 in Northern Tanzania with the aim to increase access to quality health care for people in the informal sector, mostly rural and low-income groups. The iCHF is built on a strong partnership between the NHIF (which administers the scheme at regional level),⁴⁰ the district councils (local government), public and private health care facilities and PharmAccess.⁴¹ Under the iCHF, people can enroll at public and private facilities that are being supported to offer better quality services through training, equipment provision and the upgrading of infrastructure. Enrolment is reportedly high and far above original projections, which is partly attributed to access to care at private providers. The endorsement by local districts, regional authorities and the national government (including NHIF), has reportedly been instrumental.⁴² However, a descriptive cross-sectional survey conducted in the Kilimanjaro region notes that while the iCHF programme is making a modest contribution to universal health coverage when considering equity and financial protection, it is falling behind on quality (Lambrecht, 2017).

³⁹ <https://www.pharmaccess.org/update/ichf-health-insurance-program-now-covers-over-100000-people-in-tanzania/>

⁴⁰ NHIF pays health care facilities directly into their bank accounts for each household enrolled in the iCHF, adding an incentive for facilities to improve their quality and attract more registrants. The iCHF offers a more extensive benefits package, covering primary care and referral for inpatient care for up to five days of admission; the co-premium is Tsh 30,000 (less than US\$14) per household per year, and the Government of Tanzania matches this amount in order to cover costs and ensure sustainability of the scheme. The premium is thus 100% locally funded.

⁴¹ PharmAccess designed the iCHF package and with the support of the Dutch Ministry of Foreign Affairs, provides actuarial expertise, technical assistance and funding for support on marketing, administration and quality improvement using the SafeCare standards.

⁴² With financial support from PharmAccess, the NHIF set up a website – www.chfiliyoboreshwa.co.tz – that provides information regarding the iCHF and will also enable clients to pay for their relatives and friends online from anywhere in the country (Ngowi, 2016).

The redesigned CHF-Iliyoboreshwa has been implemented in the seven district and municipal councils of Dodoma Region since 2012 and is fully integrated in the structures of LGAs. It is part of the Health Promotion and System Strengthening Project that has been funded by the Swiss government since 2011. After one year of operation, the CHF-Iliyoboreshwa reportedly covered 20% of the population, which is well above the national average of 7.9% of the previous CHF system (Stoermer et al., 2013) (see Appendix Table A3 for details of the differences between the standard and the redesigned CHF-Iliyoboreshwa).

6.4. Strengthening Health Facility Government Committees

Introduced in 1999, Health Facility Government Committees (HFGCs) were designed to operate in all public primary health facilities as a mechanism to improve accountability between health care providers and communities. In theory, their role is extensive: to receive, discuss and approve facility annual plans and budgets; to ensure the availability of drugs and equipment in the facility; to identify and solicit financial resources for running the facility; to report health-provider employment and training needs to the district council; to be available at the facility and liaise with facility management teams and other actors to ensure the delivery of quality health services; to assist facility management teams in planning and managing community-based health initiatives within its catchment area in the context of the Ward Development Committee (WDC); and to support the WDC in sensitising the community to join the CHF.⁴³ The HFGC is supposed to be politically independent, however members of the village government have been found to represent 21% of committee membership (IHI, 2011).

Evidence to date suggests that despite their achievements and potential for strengthening accountability, HFGC members might not be capable of fulfilling all their responsibilities (SIKIKA, 2014). According to studies undertaken in several District Councils, various factors hinder the effective participation of HFGCs in the development of CCHPs (for Manyoni district see Kilewo and Frumence, 2015; for Musoma district see Vedastus, 2016; for Ulanga district see IHI, 2011), including: inadequate knowledge and weak management capacity, especially amongst those members with only primary education; weak communication and information-sharing strategies between the Council and HFGC members; limited community awareness of the roles and responsibilities of the HFGCs; and inadequate financial resources for implementing their activities. As noted earlier, HFGC members do not have the mandate and the capacity to take corrective measures against corruption (SIKIKA, 2014). In addition, communities do not believe that HFGCs can represent their concerns at facility level: 'trust' remains an issue (IHI, 2011; Vedastus, 2016). HFGC meetings that are held at facility level are usually controlled by the facility representative, which has the potential to limit representation of community issues (IHI, 2011). Further, only the village government has the authority to call village meetings and to communicate directly with the community.

⁴³ The HFGCs typically consist of five elected community members and three appointed members, with representation from the WDC, the village government committee and the health facility. (IHI 2011)

In short, HFGCs have the potential to serve as bridges between health facilities and their communities, but improvements need to be made in terms of resourcing, capacity and autonomy to participate in planning and managing CCHPs in general and health-facility plans in particular. They also need to have the means and mandate to hold corrupt health workers to account. Equally, communities need to be sensitised on the roles and responsibilities of HFGC members and steps need to be taken towards building trust between HFGCs and the communities they serve. Encouragingly, steps are already being taken to strengthen HFGCs, and for greater involvement of community leaders through HFGCs.

6.5. Social accountability initiatives

Much of the current focus on accountability has been with regards to top-down, mostly administrative accountability, where CHMTs report progress on a quarterly basis to higher authorities regarding the use of funds to implement health plans at council level (i.e. performance-based basket funds, DHFF and PBF, all of which are focused on Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH)-related indicators, or factors affecting RMNCAH service delivery. The current HSSP IV aims to broaden the scope of accountability by prioritising engagement between health providers and the communities they serve. Increasingly, attention is being paid to social accountability mechanisms, including the use of community score cards and social accountability mapping (MoHSW, 2015a).

6.5.1. Community score cards (CSC)

To promote greater community participation and strengthen two-way accountability between health facilities and communities, lessons can be learned from a number of NGOs that have been working closely with their communities in developing and implementing Community score card (CSC) initiatives.⁴⁴

CARE Tanzania's CSC programme has reportedly contributed to strengthening service provision and community-provider relations (Wales and Wile, 2015). The initiative has facilitated improvements in mobilising and focusing resources on key health-systems priorities; in identifying corrupt providers and, over time, reducing unethical practices; in improving provider behaviour; and in improving respect and collaboration between health professionals, communities and district administrators. Save the Children's CSC initiative that was implemented in a remote area in the country's southeast region suggests that citizens were empowered to understand that they have the right to health and entitlements in regard to maternal, newborn and child health. Anecdotal evidence from the Chukua Hatua programme by Oxfam (UK) and its implementing partners suggests some successes in creating active citizenship; that is, citizens who know their rights and responsibilities, and are able and willing to demand them (Green, 2015).

⁴⁴ CSCs can be defined as a participatory tool that (i) is conducted at micro/local level and uses the community as the unit of analysis; (ii) generates information through focus group interactions and enables maximum participation of the local community; (iii) provides immediate feedback to service providers and emphasises immediate response and joint decision-making; and (iv) allows for mutual dialogue between users and providers, and can be followed by joint monitoring (CARE Malawi, 2013).

6.5.2. Social accountability mapping

SIKIKI adopted the social accountability mapping (SAM) tool⁴⁵ and approach to reinforce accountability in health resources management and to provide space/opportunities for citizens to participate in public resource management. For 2016-2020, SIKIKI's focus is on strengthening local government systems and working around systemic issues/constraints (such as availability of health commodities, human resources for health, health governance, finance systems and structures, health infrastructures, and amenities) that affect health service delivery. SIKIKI's SAM approach at both central and local levels has reportedly contributed to the reinforcement of accountability, promoted governance and enhanced better public resource management and delivery of quality health services (SIKIKI, 2016). Noted achievements include: citizen awareness of their rights and responsibilities; improved functionality of HFGCs in 28 facilities in Simanjiro in 2014; aiding facilities' access to and use of their community health fund contributions by activating their dormant bank (Singida rural district); supporting the capacity of councillors to monitor and interpret council plans and budgets at LGA level and taking measures towards council staff engaging in unethical actions; and increasing collaboration between councillors and LGAs, including increasing transparency and accountability amongst councillors. SAM is a resource-intensive approach, and ongoing challenges include the need for timely access to information, coping with occasional resistance from LGAs, and the commitment of SAM members.

Citizen involvement is noted to be central to addressing inappropriate practices and ensuring services meet their needs. A combination of strategies to promote increased interactions between citizens, providers and their managers need to be employed to address informal payments, with attention given to ensuring equitable access to quality care by the poor. Strategies include:

- increasing providers' awareness of forms, consequences and dangers of corrupt practices through poster displays and provider meetings (e.g. health providers to wear name tags for easy identification and reporting) (Kamuzora, 2005)
- training public officials on the ethics of good governance and explicitly establishing and enforcing ethical standards of conduct among providers and their supervisors (ibid.; SIKIKI, 2014)
- rewarding good performance and honest behaviour, and enforcing law and punishment to health providers involved in corrupt practices (Kamuzora, 2005; REPOA 2006a; Fjeldstad et al., 2008; Gaitonde et al., 2016)
- frequent supportive supervision of health providers by their managers to help address the problems of absenteeism and low productivity amongst health workers (Kamuzora, 2005; Manzi et al., 2012; Olafsdottir et al., 2014).
- simple and effective channels (such as complaint boxes, raising community awareness, hotlines, etc.) with appropriate legal support to enable citizens to raise concerns without fear of retaliation (Kamuzora, 2005; Olan'g and Msami, 2017).

⁴⁵ SAM is a tool and approach for monitoring public services at both central and local government levels, through assessment of plans and resource allocations, expenditure management, performance management, and public integrity and oversight functions (Mkani, 2016).

7. Discussion

Tanzania is committed to combat corruption. Tanzania's Vision 2020 made the promise to achieve 'health for all', which has been a key priority since post-independence and is further reiterated in the national health policy. Indeed, increasing domestic resource mobilisation through the establishment of sustainable financing mechanisms for health is an important component of the universal health coverage agenda.

Yet corruption has become part and parcel of daily life in Tanzania, as in many developing countries. Despite institutional and legal transformation to fight corruption, the phenomenon continues to challenge developmental objectives in various sectors, particularly the health sector. Common problems such as petty corruption, staff absenteeism and under productivity, unacceptably long waiting times and frequent essential drug stock-outs at public health facility level are the most commonly documented forms at primary care level. Other forms of corruption also exist but are less frequently researched and/or cited – probably due to measurement difficulties – such as those linked to theft or misuse of public property and resources, unnecessary referrals of patients, and regulation/procedure and procurement.

The many forms of informal practices that occur throughout a health system are often inter-dependent. Some types are easy to identify, while others are implicit and more complex. Preliminary discussions with health stakeholders in Tanzania suggest that informal payments and health-provider absenteeism are of most concern and are prevalent forms of rule-breaking and rule-bending practices by public health providers. Whatever the corrupt behaviour, they all have one thing in common – they negatively impact health systems and health outcomes (Petkov and Cohen, 2016).

Acts of petty corruption – for example **informal payments and bribery** – are highly reported because they happen during the interaction between health providers and clients, and often reflect weakly enforced or inadequately financed user fee-exemption and waiver policies that were introduced alongside cost-sharing policies to protect the most vulnerable groups (i.e. pregnant women, children under five years, elders above 60 years, and patients suffering from tuberculosis and HIV/AIDS) and the poorest to facilitate access to essential outpatient health services (Manzi et al., 2005; Maluka, 2013; Mayumana et al., 2013; Mtei et al., 2014). As a result, many of the most vulnerable and the poorest are paying out of pocket (Binyaruka et al., 2015; Kruk et al., 2008; Mamdani and Bangser, 2004; Manzi et al., 2005), with important implications for inequity in access to and use of health services (Smithson, 2006). Additionally, if supply-side preparation and complementary measures are not in place, exemption policies may lead to disruptive effects (Ridde et al., 2012), which create loopholes for health providers to either seek or receive informal/unofficial payments. Thus, informal payments not only deter poor patients from seeking and accessing care, but they also undermine implementation and the intended objectives of exemption and waiver policies.

The frequency of informal payments offers an important indicator of underlying governance failures because it means fraudulent behaviour is being tolerated, that controls are weak and ineffective, that patients are unsure of their rights, and accountability is not enforced. When the probability of being detected and penalised is very low, informal payments tend to be more widespread. Evidence from two pilot programmes in Kyrgyz Republic and Cambodia suggests that informal payments can be limited through the setting up of alternative sources of funding, however. In these two contexts patient payments and utilisation improved: patient spending reduced by 20% for drugs and 50% for supplies (Haroon, 2014).

Absenteeism among health providers and their managers – be it legitimate and officially authorised (for example, when attending meetings, seminars, trainings, or on leave (Manzi et al., 2012), or unauthorised decisions not to report to work – undermines service provision, especially within the context of health-worker shortages. Distinguishing between the two forms of absenteeism can be quite difficult, but voluntary absenteeism is often characterised by high frequency of absences with long durations (Davey et al., 2009; Belita et al., 2013). From a systems perspective, factors influencing absenteeism revolve around three themes – workplace/context, personal, and organisational/cultural factors (ibid.), as evidenced in South African hospitals (Mudaly and Nkosi, 2015). The specific forms of and underlying reasons for absenteeism remain context-specific. In Uganda, for example, absenteeism has resulted from family conflicts, overstay in one workstation, drug abuse, poor remuneration, inadequate supervision and poor performance management practices (Wananda et al., 2015; Nyamweya et al., 2017). The location of ones workplace has also been shown to have influenced absenteeism in Kenya, such that absenteeism was higher in urban than in rural facilities (Muthama et al., 2008).

Poor health-provider productivity is also a common phenomenon in many low-income countries, including in Tanzania, and results in inefficiencies in the health system. The decision to underdeliver is based on multifaceted factors ranging from rent-seeking behaviour to lack of motivation, overburdened providers and the absence of an enabling environment (Lindkvist, 2013).

Improving the job satisfaction of health providers by fostering enabling work environments and charging official fees with better performance-based (financial and non-financial) incentive packages have also been reported as a possible strategy to make health workers less vulnerable to corruption and bribery (Haroon, 2014; Lewis, 2004). Other studies suggest that such an approach would improve health-worker motivation and their overall productivity at the same time (Mæstad, 2006; Leonard and Masatu, 2010; Meessen et al., 2011; Gertler and Vermeersch, 2013).

The **effectiveness of performance-based financing** at local government and facility level in curbing informal provider practices will in part depend on the underlying reasons for engaging in such practices. For example, are informal payments a voluntary contribution by patients to cover the cost of a service or as a ‘thank you’ for services delivered under difficult conditions; or are they seen as an abuse of power by the provider? Do such payments constitute a significant share of health providers’ income? Will performance-based

payments make up for any short-falls and sustain motivation amongst service providers over the longer term? Does PBF need to be complemented by a standard comprehensive benefit package, such as career development opportunities, a good work environment, safe housing and transport, or other incentives?

Strengthening institutional arrangements through improved good governance and accountability, coupled with transparent policy- and decision-making processes that involve all stakeholders and interest groups (e.g. politicians, policy-makers, health care providers, non-state actors and especially citizens) is one of the most cited measures against corruption (Lewis, 2006; Cho and Kirwin, 2007; Vian, 2008; Hussmann, 2011; Aryankhesal, 2017; Haroon, 2014; SIKIKA, 2014; Gaitonde et al., 2016). Financial incentives in an environment of impunity will fall short of expectations – they have to be accompanied by a combination of accountability mechanisms as well.

Yet **accountability processes within the health sector are dynamic and complex**. There are political challenges to accountability – not limited to poorly functioning or corrupt ministries of health or quality-of-care issues in remote health posts – but rather they include a much broader set of global health systems actors and initiatives that are intertwined with government-sponsored health services at multiple levels, and that influence health outcomes (Joshi and Houtzager, 2012; Bruen et al., 2014; IDS, 2018; Nelson et al., 2018).

The **implementation of community scorecards** in the health sector has shown considerable potential for promoting citizenship engagement. However, evidence from Mozambique suggests that the use of CSCs resulted in transfer of roles and responsibilities for public health-system functioning from state to citizens, and runs the risk of ‘overburdening’ communities at the point of service delivery (Haroon, 2014). Long-term social accountability work done by a group of NGOs suggests multi-stakeholder accountability mechanisms – that facilitate the cycle of monitoring, review and remedial action, and advance the principles of human rights, transparency, and participation – are a pre-requisite for determining the needs of marginalised and vulnerable communities, to attain the goal of universal health coverage (IDS, 2018).

Increasingly, discussions in Tanzania centre around **adequate financing of the health sector, coupled with a range of system-strengthening initiatives** to lower informal practices amongst public health providers. These include: curbing misuse of the wage bill and addressing health-worker shortages and needs-based allocation across the country; improved remuneration of health workers, including a standard comprehensive benefit package and fair opportunities for professional growth; timely and adequate performance-based disbursements to councils and facilities for an enabling work environment (appropriate supervision, infrastructure, drugs and supplies, housing, safety and security); enforcement of improved prepayment health insurance schemes; and improved supervision and community-level accountability through, for example, greater involvement of community leaders with attention to patient rights and ensuring transparency (Mæstad, 2006; Kruk et al., 2008; Mæstad and Mwisongo, 2011; Manzi et al., 2012; Lindkvist, 2013; Buguzi, 2016b, 2017; Kabote, 2017).

The **ongoing challenge of recruiting, retaining and appropriately distributing skilled human resources** remains a risk to the effectiveness and impact of such investments. Attention is currently focused on a critical review of the way health providers are trained, deployed, rewarded, monitored and held accountable. According to Manzi et al. (2012), to increase access and client confidence in the health service requires better availability of skilled health workers, improved service management, and support to reduce absenteeism. The authors stress:

- the importance of improved health services management to reduce health workers in rural facilities being pulled in different directions – to attend seminars and trainings, and to collect their salaries and sometimes vaccines or other supplies from the district capitals. Such distractions further undermine their ability to provide services.
- the need for adequate support to district health management teams (timely disbursement of funds, sufficient staff, prior notification of visits, appropriate training for supervision and improved supervision of CHMTs by regional- and national-level staff) to facilitate their timely supervision and execution of other duties (which could reduce absenteeism and mitigate some of the factors that reduce health workers' productivity). They suggest that consideration should be given to integrated supervision to improve the efficiency of supervisory visits as observed in the Tanzania Essential Health Intervention Programme (TEHIP).
- the need for more training in health facilities and fewer seminars in district head quarters in order to increase health workers' time for patient care and to increase the relevance of trainings.

To conclude, corruption is a critical issue and a concern across all sectors, including health. Tanzania is a diverse country, therefore it is difficult to generalise on the nature and underlying determinants of corruption, and how to effectively contain the practice amongst frontline health providers. Understanding the forms, causes and consequences of informal practices is a first step towards informing context-specific anti-corruption policies or interventions, however. Reducing opportunities and incentives to engage in informal practices is also important, but these need to be matched with improvements in detection of abuse and by enforcement of appropriate anti-corruption sanctions, laws and regulation (which requires a functioning judicial system). Efforts to tackle informal practices should aim to strengthen good governance in aspects of accountability, transparency and supervision, and a well-resourced health system is a pre-requisite. Suggested recommendations for controlling petty corruption include both supply- and demand-side measures.

Yet there remain several unanswered questions: How can we improve the functioning of internal accountability mechanisms and the functioning of oversight structures higher up the system (e.g. for priority-setting and human resource allocation), as well as external accountability mechanisms for the public (e.g. HFGCs and community monitoring systems)? How do these mechanisms overlap, complement or compete with each other? What are the effects of structural interventions (DHFF, PBF) on issues of high absenteeism, low productivity and leakages, and on patient-centred services? Can CSCs be used to monitor the presence of health workers – to identify and address management and performance issues such as absenteeism, access to services and informal payments? What are feasible options

for attracting and retaining skilled health providers to work in rural areas, and for their improved performance and management?

There is no one-size-fits-all initiative that will address all of the constraints and challenges facing the system and mitigate informal practices amongst public health providers. The central question becomes then, what will work best within the Tanzanian context – what mix of strategies and initiatives will result in improved service use and quality, health outcomes and equity, to have more meaningful accountability on health-user rights and entitlements?

References

- Afnan-Holmes, H., Magoma, M., John, T. et al. (2015) 'Tanzania's countdown to 2015: an analysis of two decades of progress and gaps for reproductive, maternal, newborn, and child health, to inform priorities for post-2015', *Lancet Global Health* 3: e396-409.
- Aiko, R. (2015) 'Tanzanians perceive ineffective fight against corruption; say citizens have a role to play'. Afrobarometer Dispatch No. 48. Dar es Salaam: REPOA.
- Akcaý, S. (2006) 'Corruption and human development', *The Cato Journal* 26: 29.
- Anders, G. and Makene, F.S. (2018) *The importance of practical norms in government health and education services in Tanzania*. Dar es Salaam: ESRF.
- Anderson, C.J. and Tverdova, Y.V. (2003) 'Corruption, political allegiances, and attitudes toward government in contemporary democracies', *American Journal of Political Science* 47: 91-109.
- Anon. (n.d.) 'Tanzania's national anti-corruption strategy: executive summary'. Paper presented at the 9th International Anti-Corruption Conference, 10-15 October 1999, Durban.
- Aryankhesal, A.J.R. (2017) 'Factors influencing on informal payments in healthcare systems: a systematic review', *Journal of Medical Ethics* 11 (40): 73-92.
- Baez Camargo, R.S., Kamanyi, E., Stahl, C. and Kassa S. (2017) 'Behavioural influences on attitudes towards petty corruption. A study of social norms and mental models in Tanzania'. Basel: Basel Institute on Governance.
- Balabanova, D. and McKee, M. (2002) 'Understanding informal payments for health care: the example of Bulgaria', *Health Policy* 62: 243-273.
- Bardhan, P. (1997) 'Corruption and development: a review of issues', *Journal of economic literature* 35: 1320-1346.
- Belita, A., Mbindyo, P. and English, M. (2013) 'Absenteeism amongst health workers: developing a typology to support empiric work in low-income countries and characterizing reported associations', *Human Resources for Health* 11: 34.
- Berger, D. (2014) 'Corruption ruins the doctor-patient relationship in India', *BMJ* 348: g3169.
- Binyaruka, P. and Borghi, J. (2017) 'Improving quality of care through payment for performance: examining effects on the availability and stock-out of essential medical commodities in Tanzania', *Tropical Medicine and International Health* 22: 92-102.
- Binyaruka, P., Patouillard, E., Powell-Jackson, T., et al. (2015) 'Effect of paying for performance on utilisation, quality, and user costs of health services in Tanzania: a controlled before and after study', *PLoS One* 10: e0135013.
- Borghi, Josephine, Iddy Mayumana, Irene Mashasi, Peter Binyaruka, Edith Patouillard, Ikunda Njau, Ottar Maestad, Salim Abdulla, and Masuma Mamdani (2013) 'Protocol for the evaluation of a pay for performance programme in Pwani region in Tanzania: A controlled before and after study', *Implementation Science* 8 (80).
- Bruen, C., Brugha, R., Kageni, A. and Wafula, F. (2014) 'A Concept in Flux: Questioning Accountability in the Context of Global Health Cooperation', *Globalization and Health* 10: 73
- Buguzi, S. (2017) 'Half of young doctors to quit by 2025: report', *The Citizen*, 20 March.
- Buguzi, S. (2016a) 'Tanzania: we have a Tsh500 billion drug shortage – MSD', *The Citizen*, 5 January.
- Buguzi, S. (2016b) 'Tanzania's Sh387m ghost workers wage bill', *Daily Nation*, 7 April.
- CARE Malawi (2013) 'The Community Score Card (CSC): a generic guide for implementing CARE's CSC process to improve quality of services', Lilongwe: Cooperative for Assistance and Relief Everywhere, Inc.
- Chene, M. (2015) 'Corruption and anti-corruption practices in human resource management in the public sector', U4 Expert Answer. Bergen: Chr. Michelsen Institute.

- Cho, W. and Kirwin, M.F. (2007) *A vicious circle of corruption and mistrust in institutions in sub-Saharan Africa: a micro-level analysis*. AfroBarometer Working Paper 71. Cape Town: Afrobarometer.
- Clausen, B., Kraay, A. and Nyiri, Z. (2011) 'Corruption and confidence in public institutions: evidence from a global survey', *World Bank Economic Review* 25: 212-249.
- DANIDA (2018) *Tanzania country programme mid-term review report*. Dar es Salaam: Ministry of Foreign Affairs of Denmark.
- Davey, M.M., Cummings, G., Newburn-Cook, C.V. and Lo, E.A. (2009) 'Predictors of nurse absenteeism in hospitals: a systematic review', *Journal of Nursing Management* 17: 312-30.
- Diestel, S., Wegge, J. and Schmidt, K.-H. (2014) 'The impact of social context on the relationship between individual job satisfaction and absenteeism: the roles of different foci of job satisfaction and work-unit absenteeism', *Academy of Management Journal* 57: 353-382.
- Green, D. (2015) *The Chukua Hatua Accountability Programme in Tanzania*. Oxford: Oxfam International.
- Ensor, T. (2004) 'Informal payments for health care in transition economies', *Social Science and Medicine* 58: 237-246.
- Fjeldstad, O.-H., Ngalewa, E. and Katera, L. (2008) 'Citizens demand tougher action on corruption'. REPOA Brief. Dar es Salaam: REPOA.
- Franco, L.M., Bennett, S. and Kanfer, R. (2002) 'Health sector reform and public sector health worker motivation: a conceptual framework', *Social Science and Medicine* 54: 1255-1266.
- Frumence, G., Nyamhanga, T., Mwangu, M. and Hurtig, A.K. (2014) 'The dependency on central government funding of decentralised health systems: experiences of the challenges and coping strategies in the Kongwa District, Tanzania', *BMC Health Services Research* 14: 39.
- Frumence, G., Nyamhanga, T., Mwangu, M. and Hurtig, A.K. (2013) 'Challenges to the implementation of health sector decentralization in Tanzania: experiences from Kongwa district council', *Global Health Action* 6: 20983.
- Gaitonde, R., Oxman, A.D., Okebukola, P.O. and Rada, G. (2016) 'Interventions to reduce corruption in the health sector', *Cochrane Database Systematic Review* Cd008856.
- Gertler P. and Vermeersch, C. (2013) *Using performance incentives to improve health outcomes*. NBER Working Paper No. 19046. Cambridge, MA: NBER.
- Gray, H.S. (2015) 'The political economy of grand corruption in Tanzania', *African Affairs* 114: 382-403.
- Gray, C.W. and Kaufmann, D. (1998) 'Corruption and development', *Finance and Development* 35: 7.
- Haroon, M.Z. (2014) 'Editorial – Corruption in healthcare system: an obstacle in achieving optimal outcome', *Journal of Ayub Medical College, Abbottabad* 26 (2).
- Hussmann, K. (2011) 'Addressing corruption in the health sector: securing equitable access to health care for everyone'. U4 Issue No 1. Bergen: Chr. Michelsen Institute.
- IDS (Institute of Development Studies) (2018) 'Accountability for Health Equity: Galvanising a Movement for Universal Health Coverage', *IDS Bulletin* 49 (2): 147-158.
- Joshi, A. and Houtzager, P. (2012) 'Widgets or watchdogs. Conceptual explorations in social accountability', *Public Management Review, Special Issue: The Politics and Governance of Public Services in Developing Countries* 14 (2): 145-162.
- IHI (Ifakara Health Institute) (2009)
- IHI (2011) Health facility committees: are they working? Spotlight Issue 7. Authored by Jane Macha and Josephine Borghi. www.ihl.or.tz
- IHI and MoHSW (Ministry of Health and Social Welfare) (2013) *Tanzania Service Availability and Readiness Assessment (SARA) 2012: Final Report*. Dar es Salaam: IHI.
- Jain, A., Nundy, S. and Abbasi, K. (2014) 'Corruption: medicine's dirty open secret. Doctors must fight back against kickbacks', *BMJ* 348: g4184.

- Kabote, S.J. (2017) 'Perceived corruption and quality of health services in Mbeya Urban District, Mbeya Region Tanzania', *International Journal of Social Science Research* 5 (1): 150-164.
- Kalolo, A., Gautier, L., Radermachers, R., Stoermer, M., Jahn, A., Meshack, M. and de Allgri, M. (2018) 'Implementation of the redesigned CommunityHealth Fund in the Dodoma region of Tanzania: a qualitative study of views from rural communities', *International Journal of Health Planning and Management* 33:121–135.
- Kamuzora, P. (2005) 'Strategies for public sector corruption prevention: experience from public health systems in Tanzania', *Tanzania Journal of Development Studies* 5: 33-51.
- Kankeu, H. (2018) 'Informal payments and other failures in health care provision in public facilities: more than just an association?', *Health Financing Africa*, 3 July (<http://www.healthfinancingafrica.org/home/informal-payments-and-other-failures-in-health-care-provision-in-public-facilities-more-than-just-an-association0.>)
- Kankeu, H.T. and Ventelou, B. (2016) 'Socioeconomic inequalities in informal payments for health care: an assessment of the 'Robin Hood' hypothesis in 33 African countries', *Social Science and Medicine* 151: 173-186.
- Kassa, S. and Baez Camargo, C. (2017) 'Social norms, mental models and other behavioural drivers of petty corruption – the case of Tanzania'. Policy Brief No.4. Basel: Basel Institute of Governance.
- Kaufmann, D. (1997) 'Corruption: the facts', *Foreign Policy* 107: 114-131.
- Kayera, M. (2016) 'Tanzania: Health Minister suspends four MSD directors', *The Citizen*, 15 February.
- Kilewo, E.G. and Frumence, G. (2015) 'Factors that hinder community participation in developing and implementing comprehensive council health plans in Manyoni District, Tanzania', *Global Health Action* 8:26461.
- Kruk, M.E., Mbaruku, G., Rockers, P.C. and Galea, S. (2008) 'User fee exemptions are not enough: out-of-pocket payments for "free" delivery services in rural Tanzania', *Tropical Medicine and International Health* 13: 1442-51.
- Lambrecht, J. (2017) 'Evaluating the potential of a public-private partnership in Tanzania's health financing system'. Masters thesis (https://www.scriptiebank.be/sites/default/files/thesis/2017-10/Masterproef_Jon_Lambrecht.pdf).
- Lavallée, E., Razafindrakoto, M. and Roubaud, F. (2008) 'Corruption and trust in political institutions in sub-Saharan Africa'. CSAE Conference 2008 – Economic Development in Africa, 18-20 March, Oxford, UK.
- Lee, B. and Tarimo, K. (2018) 'Analysis of the government of Tanzania's budget allocation to the health sector for fiscal year 2017/18'. HP+ policy brief. Washington, DC: Health Policy Plus.
- Lee, B., Tarimo, K. and Dutta, A. (2018) 'Tanzania's improved community health fund. an analysis of scale-up plans and design'. HP+ Policy Brief. Washington, DC: Health Policy Plus.
- Lee, B., Tarimo, K., Dutta, A. and Prabhakaran, S. (2018) *Mainstreaming HIV services in Tanzanian health insurance*. Washington, DC: Palladium, Health Policy Plus.
- Leonard, K.L. and Masatu, M.C. (2010) 'Professionalism and the know-do gap: exploring intrinsic motivation among health workers in Tanzania', *Health Economics* 19: 1461-77.
- Leonard, K.L., Mliga, G. and Mariam, D. (2002) 'Bypassing health centres in Tanzania: revealed preferences for quality', *Journal of African Economics* 11 (4): 441-471.
- Lewis, M. (2014) 'Corruption and health in developing and transition economies'. Washington, DC: World Bank.
- Lewis, M. (2006) *Governance and corruption in public health care systems*. CGD Working paper no 78. Washington, DC: Center for Global Development.
- Lindkvist, I. (2013) 'Informal payments and health worker effort: a quantitative study from Tanzania', *Health Economics* 22: 1250-71.
- Lindner, S. (2014) 'Tanzania: overview of corruption and anti-corruption'. U4Expert Answer. Bergen: Chr.Michelsen Institute).
- Loewenson, R., Mamdani, M., Todd, G., Kadowa, I., Nswilla, A., Kisanga, O., Luwabelwa, M., Banda, P., Palale, M. and Magagula, S. (2018) *The role of an essential health benefit in health systems in east and southern Africa: learning from regional research*. EQUINET discussion paper 113. Harare: EQUINET.

- Mæstad, O. (2006) *Human resources for health in Tanzania: challenges, policy options and knowledge gaps*. CMI report. Bergen: Chr. Michelsen Institute.
- Mæstad, O. and Mwisongo, A. (2011) 'Informal payments and the quality of health care: Mechanisms revealed by Tanzanian health workers', *Health Policy* 99: 107-15.
- Makeula, D. (2000) 'Factors influencing corruption in health services delivery', Proceedings of the 18th TPHA Scientific Conference. Dar es Salaam: Tanzania Public Health Association.
- Maluka, S.O., Hurtig, A.K., Sebastian, M.S., et al. (2011) 'Decentralization and health care prioritization process in Tanzania: from national rhetoric to local reality', *International Journal of Health Planning and Management* 26: e102-120.
- Mamdani, M. and Bangser, M. (2004) 'Poor people's experiences of health services in Tanzania: a literature review', *Reproductive Health Matters* 12 (24): 148-153.
- Mamdani, M., Mayumana, I., Mashasi, I., et al. (2012) 'The role of P4P scheme in motivating health workers at different levels of the PHC system in Tanzania'. Poster presented at Health Systems Global Conference, Beijing, November.
- Manzi, F., Schellenberg, J.A., Adam, T. et al. (2005) 'Out-of-pocket payments for under-five health care in rural southern Tanzania', *Health Policy and Planning* 20 Suppl 1: i85-i93.
- Manzi, F., Schellenberg, J.A., Hutton, G. et al. (2012) 'Human resources for health care delivery in Tanzania: a multifaceted problem', *Human Resources for Health* 10: 3.
- Masanja, H., de Savigny, D., Smithson, P. et al. (2008) 'Child survival gains in Tanzania: analysis of data from demographic and health surveys', *Lancet* 371: 1276-83.
- Mayumana, I., Borghi, J., Anselmi, L., Mamdani, M. and Lange, S. (2017) 'Effects of Payment for Performance on accountability mechanisms: evidence from Pwani, Tanzania', *Social Science and Medicine* 179: 61-73.
- Mboera, L.E.G., Shayo, E.H., Senkoro, K.P., Rumisha, S.F., Mlozi, M.R.S. and Mayala, B.K. (2009) 'Knowledge, perceptions and practices of farming communities on linkages between malaria and agriculture', *Acta Tropica* 13 (2): 139-144.
- Meessen, B., Soucat, A. and Sekabaraga, C. (2011) 'Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform?', *Bulletin of the World Health Organization* 89: 153-6.
- Mkani, B. (2016) 'SIKKA's SAM experience: strategic plan 2011-15'. Presented by Beatrice Mkani, July 2016.
- MoHCDGEC (Ministry of Health, Community Development, Gender, Equity and Children) (2018) *Improved CHF design document*. Dar es Salaam: Government of Tanzania.
- MoHCDGEC, HRH (Human Resources for Health) Technical Working Group (14 November 2018) 'Human Resources for Health Situation in the country'. Presented at Health Sector Technical Review Meeting, Dodoma.
- MoHCDGEC (2017) *The National Health Policy*. 6th Draft. Dodoma: MoHCDGEC.
- MoHSW (Ministry of Health and Social Welfare) (n.d.) Results Based Financing. Operational manual. Dar es Salaam: MoHSW, United Republic of Tanzania.
- MoHSW (2015a) *Tanzania Health Sector Strategic Plan (HSSP IV) 2015-2020*. Dar es Salaam: MoHSW.
- MoHSW (2015b) 'RBF for health in Tanzania'. Health financing TWG presentation, 28 August.
- MoHSW (2015c) *Results-based financing (RBF): design document*. Dar es Salaam: MoHSW.
- MoHSW (2014) *Human Resource for Health and Social Welfare Strategic Plan 2014-2019*. Dar es Salaam: Ministry of Health and Social Welfare (MoHSW).
- MoHSW (2013) *Mid-term review of the health sector strategic plan III: 2009-2015*. Dar es Salaam: MoHSW.
- Mpambije, C.J. (2017) 'Poor maternal and child health in Tanzania amidst plenty: review from Tanzania's grand corruption scandals from 2005-2015'. Dar es Salaam: Department of Development Studies, University of Dar es Salaam.

- Mtei, G. and Makawia, S. (2014) 'Universal health coverage assessment: Tanzania,' Global Network for Health Equity (GNHE), December.
- Mtei, G., Makawia, S., Ally, M., Kuwawenaruwa, A., Meheus, F. and Borghi, J. (2012) 'Who pays and who benefits from health care? An assessment of equity in health care financing and benefit distribution in Tanzania', *Health Policy and Planning* 27: 23-34.
- Mudaly P. and Nkosi Z. (2015) 'Factors influencing nurse absenteeism in a general hospital in Durban, South Africa'. *Journal of nursing management*, 23: 623-631.
- Mutahaba, G. (2005) 'Pay reforms and corruption in Tanzania's public service'. Paper presented at seminar 'Potential for public service pay reform to eradicate corruption among civil servants in Tanzania', 26 May, ESRF, Dar es Salaam.
- Muthama, T.M., Maina, T.M., Mwanje, J.I. and Kibua, T.N. (2008) 'Absenteeism of health care providers in Machakos District, Kenya'. Nairobi: Institute of Policy Analysis and Research.
- Nelson, E., Bloom, G. and Shankland, A. (eds) (2018) 'Introduction: accountability for health equity: galvanising a movement for universal health coverage', *IDS Bulletin* 49 (2): 1-16.
- Ngata, A. (2016) 'Perceived effect of corruption on the quality of public health services in Mbeya Urban District, Tanzania'. Sokoine University of Agriculture.
- Ngowi, D. (2016) 'Tanzania: iCHF in Kilimanjaro and Manyara goes online', *Tanzania Daily News*, 17 December.
- Ngware, S. (2005) 'Strategic studies on corruption-corruption in local authorities in Tanzania', Final Report. Dar es Salaam: PCB in collaboration with UNDP.
- Nkinga, N.S.D. (2003) 'Public procurement reform – the Tanzanian experience'. Paper presented at the Joint WTO – World Bank Regional Workshop on Procurement Reforms and Public Procurement for the English-Speaking African Countries, Dar Es Salaam, 14-17 January.
- Nyamhanga, T., Fruemnce, G., Mwangu, M. and Hurtig, A.K. (2013) 'Achievements and challenges of resource allocation for health in a decentralized system in Tanzania: perspectives of national and district level officers', *East African Journal of Public Health* 10: 416-27.
- Nyamweya, N.N., Yekka, P., Mubutu, R.D., Kasozi, K.I. and Muhindo, J. (2017) 'Staff absenteeism in public health facilities of Uganda: a study in Bushenyi District on Contributing factors', *Open Journal of Nursing* 7: 1115.
- Oforo, V. (2017) 'NHIF accuses health facilities of fraud', *The Citizen*, 1 September 2017.
- Olafsdottir, A.E., Mayumana, I., Mashasi, I. et al. (2014) 'Pay for performance: an analysis of the context of implementation in a pilot project in Tanzania', *BMC Health Services Research* 14: 392.
- Olan'g, L. and Msami, J. (2017) 'In Tanzania, anti-corruption efforts seen as paying dividends, need citizen engagement'. Afrobarometer Brief. Dar es Salaam: REPOA.
- Paul E, Albert L, Bisala BN¹ S, et al. (2018) 'Performancebased financing in low-income and middle-income countries: isn't it time for a rethink?' *BMJ Glob Health* 2018;3:e000664. doi:10.1136/bmjgh-2017-000664
- Peiffer, C. and Rose, R. (2014) 'Why do some Africans pay bribes while other Africans don't?'. Cape Town: Afrobarometer.
- Petkov, M. and Cohen, D. (2016) *Diagnosing corruption in healthcare*. London: Transparency International.
- Policy Forum (2009) Reforming Allowances: A win-win approach to improved service delivery, higher salaries for civil servants and saving money. Policy brief 9.09. www.policyforum-tz.org
- REPOA (2006a) 'Combating corruption in Tanzania: perception and experience'. Afrobarometer Briefing Paper No.33. Cape Town: Afrobarometer.
- REPOA (2006b) 'Despite economic growth, Tanzanians still dissatisfied'. Afrobarometer Briefing Paper No.36. Cape Town: Afrobarometer.
- Ridde, V., Robert, E. and Meessen, B. (2012) 'A literature review of the disruptive effects of user fee exemption policies on health systems', *BMC Public Health* 12: 289.

- Save the Children (2013) *Tanzania community score card transparency and accountability project (TAP) interim report for Results for Development Institute*. Westport, CT: Save the Children.
- Savedoff, W.D. (2007) *Transparency and corruption in the health sector: a conceptual framework and ideas for action in Latin American and the Caribbean*. Washington, DC: Inter-American Development Bank.
- Seppänen, M. and Virtanen, P. (2008) *Corruption, poverty and gender, with case studies of Nicaragua and Tanzania*. Helsinki: Ministry for Foreign Affairs of Finland.
- SIKIKI (2016) *Annual Report*. Dar es Salaam: SIKIKI.
- SIKIKI (2014) 'Institutional factors influencing petty corruption in public health services in Tanzania'. Dar es Salaam: SIKIKI.
- SIKIKI (2011) 'The ineffectiveness of complaints mechanisms in the Tanzanian health sector. Experiences from health service users in selected health facilities'. SIKIKI Brief No 2. Dar es Salaam: SIKIKI.
- SIKIKI (2010) 'Petty corruption in health services in Dar es Salaam and Coast Regions'. SIKIKI Policy Brief 02.10. Dar es Salaam: SIKIKI.
- Sirili, N. (2018) 'Doctors are quitting district hospitals in Tanzania. Times have changed, tactics must change', *Medico*, 2 May.
- Sirili, N., Frumence, G., Kiwara, A., Mwangi, M., Anaeli, A., Nyamhanga, T., Goicolea, I. and Hurtig, A.K. (2018) 'Retention of medical doctors at the district level: a qualitative study of experiences from Tanzania', *BMC Health Services Research* 18: 260.
- Smithson, P. (2006) 'Fair's fair: Health inequities and equity in Tanzania'. Dar es Salaam: Women's Dignity Project and Ifakara Centre for Health Research and Development.
- Songora Makene, F. and Mpango, H. (2017) 'Informal practices among Tanzania's public sector health workers - determinants and policy implications'. ESRF Policy Brief No 9/2017. Dar es Salaam: ESRF.
- Standard Digital* (2017) 'Tanzania's public ghost workers surpass 19,000', *Standard Digital*, 8 February.
- Stoermer, M., Meshack, M., Radermacher, R., Chilunda, F. and Gelister, Y. (2013) 'Health insurance for rural population – the re-organisation of community health funds in Tanzania'. Geneva: Geneva Health Forum.
- Stringhini, S., Thomas, S., Bidwell, P., Mtui, T. and Mwisongo, A. (2009) 'Understanding informal payments in health care: motivation of health workers in Tanzania', *Human Resources for Health* 7: 53.
- Strong, A. (2017) 'Working in scarcity: effects on social interactions and biomedical care in a Tanzanian hospital', *Social Science and Medicine* 187: 217-224.
- Sue, K., Rosenberg, J. and Weintraub, R. (2016) 'Cases in global health delivery: Tanzania's health workforce crisis through a public-private partnership. The case of TTCIH'. Boston, MA: Harvard Medical School/Brigham and Women's Hospital.
- Sullivan, J.D. and Shkolnikov, A. (2008) 'Changing perspectives: how donors can work with the private sector to reduce corruption'. U4 Brief. Bergen: Chr. Michelsen Institute.
- Theisen, T. (2006) 'Multiple-job-holding in Africa: the case of Tanzania'. Kristiansand and Grimstad: Department of Economics and Business Administration, Agder University College.
- Tibandebage, P. and Mackintosh, M. (2002) 'Institutional cultures and regulatory relationships in liberalising health care system: a Tanzanian case study', in J. Heyer, F. Stewart and R. Thorp (eds) *Group behaviour and development: Is the market destroying cooperation?* (pp. 271–289). Oxford: Oxford University Press.
- Todd, G., Nswilla, A., Kisanga, O. and Mamdani, M. (2017) *A case study of the Essential Health Benefit in Tanzania mainland*. EQUINET discussion paper 109. Dar es Salaam: EQUINET.
- Transparency International (2006) *Global Corruption Report: Special Focus: Corruption and Health*. London: Pluto Press.
- Transparency International (2015) *People and corruption: Africa survey 2015 global corruption barometer*. London: Transparency International.

- TWAVEZA (2016) 'Sauti za Wananchi. Signs of recovery? Citizens' views on health service provision by the new government'. Brief No. 34. Dar es salaam: TWAVEZA.
- TWAVEZA (2013a) 'Stock out or in stock? Access to medicines in Tanzania'. Brief No. 5. Dar es Salaam: TWAVEZA.
- TWAVEZA (2013b) 'Sauti za Wananchi: Do health facilities work for people?'. Brief No 7. Dar es Salaam: TWAVEZA.
- Vedastus, P. (2016) 'Effectiveness of HFGCs in Tanzania: a case study of Musoma District Council'. Dissertation submitted to the School of Public Administration and Management, Mzumbe University.
- UN (United Nations) (2015) *Transforming our world: the 2030 agenda for sustainable development*. New York: UN.
- URT (United Republic of Tanzania) (2017) 'Decentralised direct facility financing: concept note and road map (draft)'. Dodoma: PO-RALG.
- URT (2015) *Health sector strategic plan IV: reaching all households with quality care: July 2015-June 2020*. Dar es Salaam: Ministry of Health and Social Welfare.
- URT (2011) *The Tanzania quality improvement framework in health care 2011 – 2016*. Dar es Salaam: Ministry of Health and Social Welfare.
- URT (2010) *National strategy for growth and reduction of poverty II*. Dodoma: Ministry of Finance and Economic Affairs.
- URT (2007a) *National health policy*. Dar es Salaam: Ministry of Health and Social Welfare.
- URT (2007b) *Primary health services development programme: MMAM 2007-2017*. Dar es Salaam: Ministry of Health and Social Welfare.
- URT (2005) *National strategy for growth and reduction of poverty*. Dodoma: Ministry of Finance and Economic Affairs.
- URT (1996) *Report on the commission on corruption (The Warioba Report)*. Dodoma: Government of Tanzania.
- URT (1995) *The Tanzania Development Vision 2025*. Dodoma: Ministry of Finance and Planning.
- Vian, T. (2008) 'Review of corruption in the health sector: theory, methods and interventions', *Health Policy and Planning* 23: 83-94.
- Wales, J. and Wild, L. (2015) 'CARE's experience with community score cards: what works and why?', Project Briefing. London: ODI.
- Wananda, I., Byansi, P., Govule, P., et al. (2015) 'Relationship between management practices and employee absenteeism in public general hospitals of East-Central Uganda', *International Journal of Public Health Research* 3 (6): 374-383.
- Werner, C. (2000) 'Gifts, bribes, and development in post-Soviet Kazakstan', *Human Organization* 59: 11-22.
- World Bank (2018) *Strengthening primary health care for results: implementation status and results*. Report seq. no: 6. Washington, DC: World Bank.
- World Bank (2017) 'Tanzania country profile'. Washington, DC: World Bank (<https://data.worldbank.org/country/tanzania>).
- World Bank (2015) 'Tanzania strengthening primary health care for results'. Report no. PID0024197. Washington, DC: World Bank.
- World Health Organisation (2011) 'The Abuja Declaration: Ten years on '. Geneva: WHO.

Appendix

Table A1. Key economic, health status and health systems indicators for mainland Tanzania

Economic indicators	
Population (million), 2016	55.56
Annual GDP growth (%), 2016	7% (stable for a decade)
GDP/capita US\$, 2016	879.2
% below national poverty line, 2016	28.2
Health status indicators	
Average life expectancy at birth (yrs) 2015/16	64.9
Under-five mortality per 1,000 births, 2016	67
Infant mortality per 1,000 live births, 2016	40
Neonatal mortality per 1,000 live births, 2016	22
Maternal mortality ratio per 100,000 live births, 2015	556
Health financing indicators⁴⁶	
Total health expenditure as % GDP, 2015/16	4.7
Government health expenditure per capita, current, US\$, 2015/16	21
Total health expenditure (THE) per capita, US\$ 2015/16	45
Health Insurance contribution as % THE, 2013-15	5-8
Out-of-pocket payments as % THE, 2015	22
External resources for health as % THE, 2015	41

Source: Todd et al. (2017); World Bank (2017); National Health Accounts 2015/16⁴⁷

Table A2. Facility distribution (2016/17)

	Government (Public)	FBOs/NGOs	Private for profit	Total
Dispensarie	4,900	654	779	6,333
Health centres	525	162	115	802
Hospitals ⁴⁸	124	98	43	265
Total	5,549	914	937	7,400
%	75.0	12.4	12.7	100

Note: Government owns 75% of all health facilities; FBOs = Faith Based Organisations.

Source: MoHCDGEC, HRH (Human Resources for Health) Technical Working Group, 14 November 2018

⁴⁶ Financing data from NHA 2015/16 data; total health sector financing includes on-budget and off-budget support

⁴⁷ NHA data presented during session on ‘Resource tracking in the health sector’, 19th Joint Annual Health Sector Technical Review Meeting, 14-15 November 2018, Dodoma.

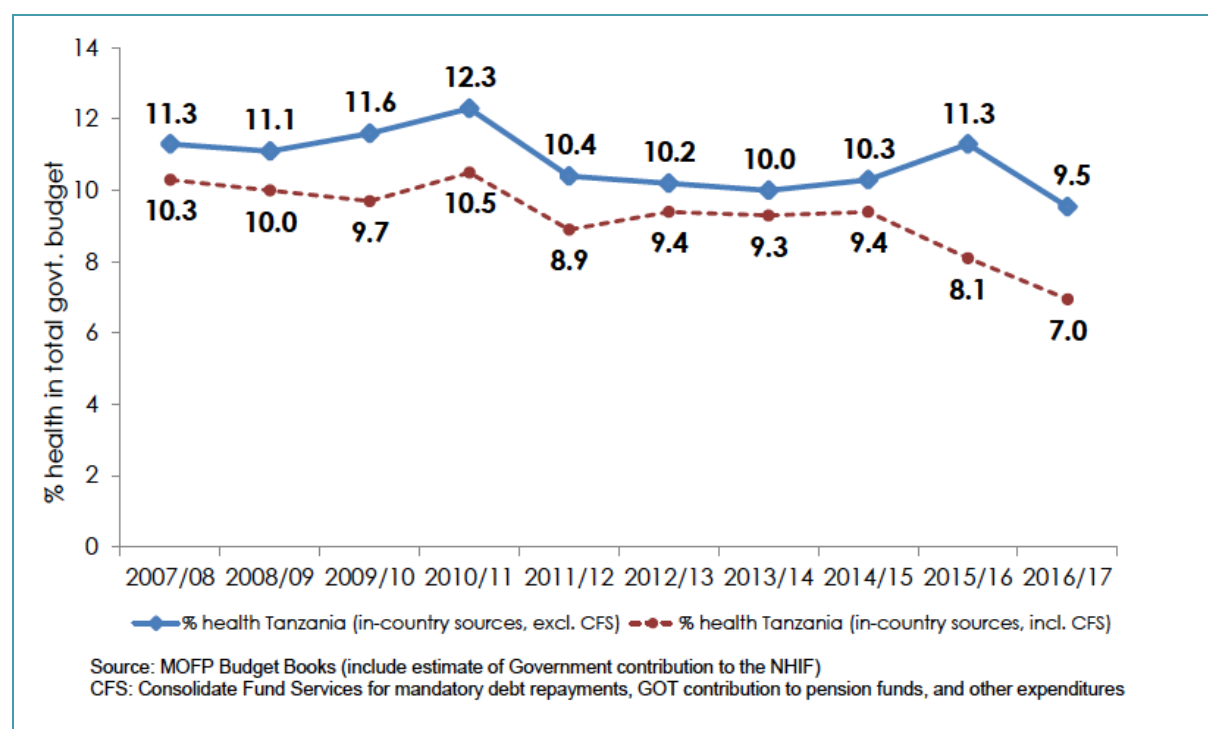
⁴⁸ Hospitals includes all hospitals in the country district, regional, national, zonal, special and other hospitals

Table A3. Differences between the standard CHF and iCHF (Dodoma region)

Standard (old) CHF	Redesigned CHF
No separation between purchaser and provider of health services, that is, the Council Health Service Board represents both the interests of CHF members and health care providers (health facilities)	Reorganised structure that displays the different roles of purchaser (CHF) and health care provider (health facilities)
Weak data management system	Reform of data management system by installation and use of an insurance management system with a central server with online and offline modes
Passive enrolment strategy based on health facilities	Active door-to-door strategy with village-level enrolment officers
Restricted benefit package with card applicable at the enrolled facility and rarely involving hospital services	Expanded range of services to include hospitalisation and portability of CHF cards within the region
Passive to no community sensitisation campaigns	Active mobilisation campaigns with social marketing strategies that involve both community-based campaigns and mass media campaigns
Identity card given to head of the household (only one card for the household)	Each member of the household is given individual membership cards

Source: Kalolo et al. (2018).

Figure A1. Percentage of Tanzania's National Budget Allocation to Health 2007–2017



Note: for FY 2017/18, the Government of Tanzania allocated 7% of the national budget (inclusive of CFS) or 10% (exclusive of CFS) to the health sector; this estimate includes all on-budget funding from development partners.

Source: Lee and Tarimo (2018).

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