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CORRUPTION AND OTHER CHALLENGES FACING HEALTH CARE DELIVERY AT THE GRASSROOTS LEVEL IN NIGERIA

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Introduction

Nigeria is the most populous black nation in the world that is richly endowed with immense natural resources but incidentally manifests poor socio-economic development indicators. Perhaps the absence of good leadership partly might explain why Nigeria has an incurable endemic corruption. No Nigerian leader, past or present, has been able to address the problem of corruption head-on which has made Nigeria to remain in about the lowest rung of the ladder of development. This reflects in numerous problems of poverty and misery of a large segment of the Nigerian populace. It contributes to societal problems as acute power shortage, dilapidated and inadequate infrastructures, unsafe aviation, unavailability of clean pipe-borne water, alarming graduate unemployment, high crime rate, violence, religious conflicts, ethnic tension, galloping inflation, untold hardship, ever widening gap between the rich and the poor and massive institutional failure. The health sector is not exempted from this effect of corruption.

Corruption is a threat to growth and development of a nation. According to African Human Development Report (2012), Nigeria is among the very few countries that have the highest percentage (27%) of corruption victims who faced a bribe situation in 2008. The Transparency International Corruption Perception Index 2011 placed Nigeria almost at the bottom of the ladder, 143rd country out of a global total of 182 countries, with a score value of 2.4 out of 10, which represents a country perceived as highly corrupt. Corruption impacts negatively on individual or group behaviour such as bribery, nepotism, and misappropriation of funds (Lipset and Lenz, 2000). It also include unethical activities such as fraud, disloyalty, breach of confidentiality, falsification and many more. According to Ike (2009), corruption is probably the main means to accumulate quick wealth in Nigeria. Corruption may be defined generally as the misuse or abuse of position, power or procedures for personal or group interests' needs and wants. "It involves the violation of established rules, practices and procedures for personal and group interests. It is concerned with actions directed towards securing wealth, power, authority, influence, relevance or advantage through illegal means. Corruption seems to be everywhere afflicting both profit and non-profit organisations themselves" (Osuagwu, 2008). In health sector, it manifests in several ways such as drug diversion, illegal charges, and fraud in product quality, purchase of substandard products, overbilling, theft, diversion and misappropriation of health funds for other items.

Corruption reduces the resources effectively available for health, lowers the quality, equity and effectiveness of health care services, decreases the volume and increases the cost of provision of services. It discourages people to use and pay for health services and ultimately has a corrosive impact on the population's level of health. Therefore, preventing abuse and reducing corruption is important to increase resources available for health, to make more efficient use of existing resources and, ultimately, to improve the general health status of the population.

The irony in Nigeria's development trend is that situations have failed to improve but rather deteriorated. For instance, the health sector which once had robust primary health care (PHC) in early years of existence is almost on the verge of extinction. Despite the enormous income from oil in the last four decades, huge number of Nigerians is still having the badge of poverty. Many sources have reported that the percentage of population below or at purchasing power parity US$1.25 a day is 64.4 (UNDP, 2010; African Human Development Report, 2012). Access to quality and affordable health services and other basic amenities including safe drinking water and improved sanitation facilities is limited and economic opportunities remain

poor for many citizens.

According to UNDP and Human Development Report (2011), Nigeria bears witness to some of t worst health-care statistics in the world and comes close to the bottom of virtually every development ind For instance, Nigeria's life expectancy at birth is 51.9 years, under-five mortality rate is 138 per 1000 liv births, births attended by skilled personnel is 39%, and maternal mortality ratio is 840 (UNDP, 2010; HD 2011; UNICEF, 2012). About one million Nigerian children die of preventable diseases each year before th fifth birthday. What is more the Nigerian government at all levels spends 3.46% of her budget expenditure health in 2010 (CBN, 2010), despite being signatory to the 2000 Abuja Deceleration which agreed that heal budget should be increased to 15%. Also over the last decade, Nigeria's exponential growth in population h equally put immense pressure on the country's resources and on already overstretched public services a infrastructure. With children under 15 years of age accounting for about 45 percent of the country's populati (FGN, 2004), the burden of health sector has become overwhelming and even stretched further by prevalence of corrupt practices.

Comparatively there has been an increase on the health budget over the last ten years in Nigeria, 20 2009 accounting for 3.30% and 4.59% respectively when compared to that of 1998 budget figure of 2.6 (CBN, 2010). The challenges faced by this sector, in spite of this increased financial input into health sec have been enormous , the output in terms of service provision at all the three tiers of government has been ve discouraging. Perhaps some of these budgets might have entered into personal pockets. Hence, it has place great need for a critical appraisal of corruption and its effects on the health delivery services vis-a-vis liv standard of the people. Thus, this study provides policy-makers with current and relevant information a equips them to pay much-needed attention to reducing corruption, a strong antidote towards better health c services particularly in rural areas.

Concept of Primary health care

The concept of Primary Health Care (PHC) was formulated in Russia on 12th September 1978 by countries that met at the Alma Ata conference organized under the auspices of the World Health Organizati (WHO) and the United Nations Children's Fund (UNICEF). According to World Health Organization, P means essential health care based on practical, scientifically, sound and socially acceptable methods a technology, made universally accessible to individuals and families in the community through their f participation and at a cost which the country can afford to maintain at every stage of their development in spirit of self reliance and self determination. The aim of PHC is essentially to promote health, prevent and cu disease, and rehabilitate people after an illness or disability particularly at the grassroots level (WHO a UNICEF, 1978).

Rationale

Corruption re-enforces a poorly structured health care services bequeathed by a visionless leaders makes the provision and delivery of health services chaotic and unrealistic to the lower levels where i needed most. Each component of the three-tier governance structure through the federal, state and lo government plays a role in the provision of healthcare and corrupt practices and poor accountability impa on development and delivery of health care. We see great manifestations of corruption in health sector leadi to lacks even in basic health care needs in health care service provision at grassroots (PHCs). These needs p a challenge in healthcare delivery services particularly at the local government tier governance level.

The Nigerian PHC system is in a state of total collapse. Primary health care's centres are dilapida structures decorated with expired drugs and cob webs and have become habitat for domestic animals. In ma secondary and tertiary health centres, ordinary water supply is not available, not to talk of availability of pow supply and essential drugs. The poor situation of health care provision has been corroborated by Fede Ministry of Health (FMOH) (2007). According to FMOH (2007), up to 64 percent of the PHC facilities ha not received any drugs from government in the past 2 years. This has resulted in the selling of drugs by hea staff. The objectives of this paper are to examine the manifestations of corruption within the PHC structu which pose challenge to better delivery of health care services and to suggest ways in which the influence corruption in health sector can be curbed. The hypothesis formulated, being that health care facility variab

are significantly related to corrupt practices.

Theoretical framework

Corrupt practices are exacerbated by poverty, nonpayment of salary and gross retrenchment among others. Corruption flourishes where distortions in the policy exist and law enforcement agencies are weak to their responsibility. Corruption being a complex phenomenon has to do within public and private, the giver, taker, why, how, causes, consequences and existing government policies and institutions. Even accountability, moral and ethical values are eroded in a corruption environment. Therefore, a theoretical framework for combating corruption has to be robust enough to accommodate all these dimensions.

There are several frameworks for studying corruption depending on the perspective of the researcher such as Banerjee et al (2012); Pappas et al (2009); Gunnar and Henrik (1999), World Bank (1997) and Klitgaard (1988) among others, but that of Klitgaard is more applicable for the current study. The framework states that corruption thrives due to poor governance and management leading to misdirection in spending of funds intended to improve the health status of the population. It also emphasizes on sound institutions and good governance with strong internal control measures and leaves little room for discretion. It holds administrative and bureaucratic inefficiencies as well as petty corrupt practices. The framework encourages accountability and transparency which are core values in reducing corruption in the health sector.

The Legal framework on corruption in Nigeria

Nigeria has a framework of laws and institutions to deal with corruption though the execution of these laws are yet to be translated into reduction in the level of corruption. With the enthronement of the civilian administration in 1999, some of these laws and institutions came on board and old ones were reinforced to combat corruption. Some of them include, the Corrupt Practices Decree 1975, National Drug Law Enforcement Agency (NDLEA) Act, 1990, the Public Complaints Commission Act Cap 377, Laws of the Federation 1990, Banks and Other Financial Institutions Act 1990, Failed Banks Acts No 16 of 1996, Advanced Fee Fraud and Other Related Offences Act No 13 of 1995, The Money Laundering Act No 3 of 1995, National Food and Drug Administration and Control (NAFDAC), Standard Organization of Nigeria (SON), Economic and Financial Crimes Commission (EFCC) Act 2002; amended Act of 2004, the Independent Corrupt Practices Commission (ICPC), the Code of Conduct Bureau (CCB), and the Budget Monitoring and Price Intelligent Unit (Due Process).

Review of related Literature

The Transparency International corruption perception index 2007 describes Nigeria as the most corrupt country in the world occupying 143 out of 182 positions with a score value of 2.4, a value perceived as highly corrupt. The common man's concept of corruption covers all instances of bribery, kickbacks, favouritism, nepotism and the use of value influence in running of public affairs. According to Dike (2005), corruption is not only found in democratic and dictatorial policies but also in feudal, capitalist, and socialist economies. Christian, Muslim, Hindu, and Buddhist cultures are equally bedevilled by corruption. It is a canker worm that has eaten deep in the fabric of the country and had stunted growth in all sectors. It has been the primary reason behind the country's difficulties in developing fast. Corruption has to do with fraudulent activity especially siphoning funds that are meant for the general populace for one's own. It swallows a junk proportion of Nigeria's annual oil income. Corruption has a culture of pervasiveness and profound neglect. Corruption also affects government choices on how to invest revenue, with corrupt governments more likely to invest in infrastructure-intensive sectors such as transport and military, where procurement contracts offer potential to extract larger bribes, rather than social sectors like health and education.

Within the health sector, investments may also tend to favor construction of hospitals and purchase of expensive, high tech equipment over primary health care programs such as cold chain for immunization and family planning items for the same reason. Corruption in the health sector also has a direct negative effect on access and quality of patient care. As resources are drained from health budgets through embezzlement and procurement fraud, less funding is available to pay salaries, fund operations and maintenance, leading to de-motivated staff, lower quality of care, and reduced service availability and use (Magnus and Pieter, 2005). Studies have shown that corruption has a significant, negative effect on health indicators such as infant and

child mortality (Gupta et al., 2002). There is evidence that reducing corruption can improve health out increasing the effectiveness of public expenditures (Omar, 2005).

A review of research in Eastern Europe and Central Asia found evidence that corruption in the fo informal payments for care reduces access to services, especially for the poor, and causes delays in c seeking behaviour (Lewis, 2000). In Azerbaijan, studies have shown that about 35% of births in rural areas ta place at home, in part because of high charges for care in facilities where care was supposed to be free (Worl Bank, 2005). In many countries, families are forced to sell livestock or assets, or borrow money from extende family and community members, in order to make the necessary informal payments to receive care. Accordin to FMOH (2007) many PHC facilities are not functional due to lack of equipment, essential supplies an qualified staff. The poor performance of health workers cannot be dissociated from the irregular or non payment of salaries. Besides informal payments, other types of corruption which clearly affect healt outcomes are bribes to avoid government regulation of drugs and medicines, which resulted in the dilution o vaccines in Uganda (Omar, 2005), and has contributed to the rising problem of counterfeit drugs in the worl including Nigeria. Dora Akunyili, former Director General of the National Agency for Food and Dru Administration and Control in Nigeria, wrote eloquently about her struggle to lead Nigeria's battle again counterfeit drugs (Akunyili, 2006). Unregulated medicines which are of sub-therapeutic value can contribu to the development of drug resistant organisms and increase the threat of pandemic disease spread. In additio to fake and sub-therapeutic drugs in the market, corruption can lead to shortages of drugs available i government facilities, due to theft and diversion to private pharmacies. This in turn leads to reduced utilizatio of public facilities. Procurement corruption can lead to inferior public infrastructure as well as increased price paid for inputs, resulting in less money available for service provision.

PHC is the first level contact of the individual and community in the national health system, thu bringing health care as close as possible to where people live and work, contributes the first element of continuing health care process (Akinsola, 1993). It is pertinent to note that due to shortage of personnel, ment and dental health care is not presently available at PHCs in Nigeria, an oil rich exporting country. Sever studies conducted to appraise the implementation of PHC in Nigeria have identified funding as the maj limitation of the operation of PHC (Adeyemo, 2005).

In measuring the impact of corruption on the effectiveness of health spending Rajkumar and Swaro (2002) analyzed data for 1990 and 1997 controlling for GDP per capita, female educational attainment, ethn linguistic fractionalization, urbanization among other factors, and found that the effectiveness of public heal spending in reducing child mortality hinged on the integrity rating (1-5 range based on level of perceiv corruption), with higher integrity associated with reduced mortality. Perhaps the lack of enforcement a accountability encourage irregularities in the running practices of health care facilities. Results from surveys physicians and nurses in Argentina (Schargrodsky, Mera and Weinschelbaum, 2001), Colombia (Giedio Morales and Acosta, 2001) and Venezuela (Jaén and Paravisini, 2001) show that corruption within facilit leads to overpayment of suppliers, combined with the lack of punishment and the low probability of getti caught make it possible. In Latvia a recent World Bank survey found that more than 40 percent of househo and enterprises agreed that "corruption is a natural part of our lives and helps solve many problems" (Shah a Schacter 2004: 40). In Tanzania service delivery survey data suggest that bribes paid to officials in the poli courts, tax services, and land offices amounted to 62 percent of official public expenditures in these areas the Philippines the Commission on Audit estimates that $4 billion is diverted annually because of public se corruption (Tapales, 2001).

In a survey study of Lagos and Kogi states in Nigeria it was found that among primary he services that public resources do not appear to be reaching their intended destinations, with evidence of scale leakage in public resources in Kogi, away from original budget allocations. They also reveale problem of accountability at the local government level in the use of public resources that are transferred higher tiers of government (Gupta and Khemani 2003). Khemani (2005) found evidence of li accountability at local levels, which reflected in the non-payment of salaries of health workers, variati which cannot be explained by appealing to lack of resources available to local governments. In a recent s Onuche, Adejoh and Akoh (2011) also revealed that resource constraints did not explain the nonpayme salaries. The effect of nonpayment of salaries included increase in home visits, dirtiness of work place

tial drugs from the facilities and increment in private ownership of essential drugs by facility

Data Collection

ne study was carried out in Ado-Odo/Ota Local Government Area (LGA) in Ogun State, Nigeria. h made use of extensive survey methods in eliciting information. Ado-Odo/Ota local government irposively chosen from the 20 local government areas in the first phase. In the second phase, all the wards in the local government were listed and 11 of them were randomly selected. And finally one ity such as PHCs, health clinic or health post in these 11 wards was selected from each of the ward. e are more than one health facilities in a ward, one was also randomly selected. Respondents were i women health personnel in each health facility and women attending antenatal clinic within the i of the selected health facility. They were interviewed using the questionnaire instrument. A total of 440 questionnaires representing about 90.9 percent of the distributed questionnaires were returned. cal package for social sciences (SPSS) software aided data analysis.

d Discussions

ne results of the analysis were based on a few selected socio-demographic variables, to examine the which plausible might have resulted from persistent corrupt practices and bad governance in the health sector. Descriptive statistics (Table 1) showed that 36% of the respondents fall within 18-30 years. This is followed by those in the age bracket of 31-40 years (26.2%) and 41-50 years spectively. However, respondents above 51 years registered least proportion (17.5%). The l attainment of the respondents revealed that respondents were literates with secondary school ccounting for an overwhelming proportion (45%). This is followed by respondents having primary (23.3%) and tertiary or professional qualification (22%) respectively. Respondents with no egistered lowest proportion (9.7%), emphasizing the need to maximize universal basic education the study area. Occupation of the respondents showed that majority of them belong to ading community (35%), followed by artisans/civil servants (28.5%). It is interesting to note that are into farming and unemployed/housewife not working registered 25 percent and 19.5 percent y. The farming proportion is expected as overwhelming proportion of the respondents were rural i respect to the location of the wards, those that fall within the rural area account for as much as twice oportion compared to that of urban wards (35%).

Socio -Demographic Characteristics of Respondents

s	Frequency	Percentage	Variables	Frequency	Percentage
pondents			**Occupation**		
ears	144	36	Unemployed/		
ars	105	26.2	house wife	78	19.5
ars	81	20.3	Trading/business	140	35
s	70	17.5	Farming	100	25
	400	100.0	Artisan/civil serv.	82	28.5
onal Attainment			**Total**	400	100.0
ation	39	9.7	**Location/Residence**		
	93	23.3	Urban	140	35
ry	180	45	Rural	260	65
ondary/			**Total**	400	100.0
onal	88	22			
	400	100.0			

: Field Survey, 2011

When perception of respondents on corruption and the state of health facility services at the variou were considered (Table 2), an interesting outcome emerged. An overwhelming proportion of the resp (72.3%) stated their knowledge of corrupt practices in the health care sector as against those whose po were contrary (27.7%). The general feeling of respondents about the services at the health facility important bearing to service utilization. Respondents who felt satisfied with the services account for 47 p cent and those who felt otherwise account for bothersome proportion (53%). Feeling may probably serve as a internal mechanism that drives one to his or her directional behaviour. When the feeling is not right of a healt facility, the propensity to patronize same may be lacking. Cost is a major determinant of demand for gooc and services. Slightly less than one-fifth (17.8%) of the respondents agreed that what they spent at healt centres was convenient (cheap) for them. However, 21.7 per cent and 60.5 per cent stated moderate an expensive charges respectively. Cost may reduce the use of health care services, from having hospital-base deliveries or seeking care even when complications arise. Omotoso (2010) observed a similar finding in hi study among rural dwellers in Ekiti State, Nigeria. He found low patronage in medical care as a result of hig costs among rural people. The increased cost might be either due to little budget at the disposal of the facilit management or offset money already misappropriated.

The respondents expressed their feelings on the poor state of amenities in the various health facilitie About three-fifths of them (59.7%) stated that health facility amenities were poor and only 23.5 percent an 16.8 percent indicated the situation to be fair and good respectively. The health facility amenities, equipme and infrastructural facilities are deplorable. The situation of facility buildings were really in bad shape as mo of them was anxiously calling for attention. The room space and furniture were grossly inadequate wit amenities like water, electricity being absolute serious issues. The inadequacy of equipment was confirmed b slightly less than three-fourth (72.2%) of respondents and those that perceived the equipment to be adequat account for 27.8 per cent.

The non-availability of drugs and consumables posed another big challenge in delivery of health care service in the study area. Overwhelming proportion of respondents accented to the non-availability of drugs an consumable in most centers (64.2%) and only 35.8 percent responded in the affirmative. This is in line wit Federal Ministry of Health (2007) assertion that up to 64% of the PHC facilities have not received any drug from government in the past two years, resulting in the selling of drugs by health stuff. The state of funding health centre was perceived to be very poor (49.5%), followed by those who belong to fair category (12%) an finally those who retorted the current level to be good (38.5%). The opinion of respondents on whethe corruption affects staff development and welfare responsibility towards health facility personnel is ver fascinating. Slightly above three-fifths of the respondents (61%) opined that corruption affects sta development and welfare at the grassroots levels. This was followed by those with contrary opinion (25.5% and indifferent feeling (13.5%) respectively. Overwhelming respondents registered their unhappiness wit respect to the decaying infrastructure being due to corruption (46.7%). Those that believed in the contrar registered 53.3 per cent

2.Perception of Respondents on Corruption and State of Health facility

iables	Frequency	Percentage	Variables	Frequency	Percentage
rception of existence of corruption			Perception that corruption affect supply of		
ractices in health care sector			consumablesdrugs, etc. to health facility		
es	289	72.3	Yes	257	64.2
o	88	22	No	143	35.8
ndifferent	23	5.7	Total	400	100.0
otal	400	100.0	Perception on state of funding of PHCs by		
erception of health facility services			Federal and State		
atisfactory	188	47	Good	154	38.5
nsatisfactory	155	38.7	Fair	48	12
ndifferent	57	14.3	Poor	198	49.5
otal	400	100.0	Total	400	100.0
erception of Cost of health facility services			Perception that corruption affects staff		
xpensive	242	60.5	development and welfare		
loderate	87	21.7	Yes	244	61
heap	71	17.8	No	02	25.5
otal	400	100.0	Indifferent	54	13.5
erception of corruption on health facility amenities			Total	400	100.0
Good	67	16.8	Perception that corruption affects		
air	94	23.5	infrastructural facilities		
oor	239	59.7	Yes	187	46.7
otal	400	100.0	No	213	53.3
erception on equipment adequacy			Total	400	100.0
dequate	111	27.8			
ot adequate	289	72.2			
otal	400	100.0			

ource: Field Survey, 2011

egression Analysis Results

Regression analysis was carried out to find the significant relationship between selected health ility variables and perception of existence of corruption (as a proxy to corruption) in health care sector. ible 3), The results revealed that cost of health facility services, equipment inadequacy, supply of drugs and isumables and staff development/welfare were positively associated with the existence of corrupt practices. wever, health facility amenities, state of infrastructural facility, funding and status of health facility services e negatively related to corruption. This means that corruption impacts on normal operations and intenance of health care services at the grassroots (PHC) by draining on health budget. Magnus and Pieter 05) corroborate with the direct negative effect of corruption on access to and quality of patient care in their ly. The non-availability of adequate fund may likely manifests in poor quality services, infrastructural ilities and supply of basic necessities leading to increase tendency to patronize alternative care among ers. Furthermore, since the F- statistics calculated is greater than the F- tabulated the hypothesis that health e variables (challenges) are significantly related to corruption is upheld.

Table 3: Regression Analysis

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	-2.787	1.213		-2.298	.024
	Cost of health facility services	.287	.083	.332	3.457	.001
	Health facility amenities	-.208	.100	-.159	-2.087	.039
	Equipment inadequacy	.922	.210	.593	4.386	.000
	State of drug and consumables	3.437	.499	1.415	6.891	.000
	State of infrastructural facility	-1.908	.323	-.833	-5.910	.000
	Status of health facility services	-.772	.217	-.391	-3.555	.001
	Staff development/welfare	.877	.180	.578	4.860	.000
	Funding of the health facility	-.583	.202	-.264	-2.883	.005

R square= 0.440 Adjusted R square = 0.395 F=9.811

Dependent Variable : perception of existence of corruption

Conclusion and Recommendations

Corruption manifests itself in health sector leading to poor provision of services. Th carried out in Ado-Odo/Ota Local Government Area (LGA) in Ogun State, Nigeria. The study re above two-fifths of the respondents had secondary school education (45%). The knowledge o practices in the health sector was confirmed by overwhelming proportion of respondents (72.3%). A respondents confirmed the existence of infrastructural decay (59.7%), low level satisfaction of s (53%), inadequate supply of equipment (72.2%),unfriendly and unaffordable cost of health care ser (60.5%) and lack of drugs and consumables (60.8%) among other factors inhibiting the service delivery a grassroots. To ensure quality health care services, the study recommends intensive health education (IHE beyond secondary school level education for meaningful impact among the people. In addition, governm must not only increase health budget but equally promote moral values, check and punish perpetrato fraudulent practices in health sector, increase emoluments of health workers, ensure capacity developme health personnel and reward good performance among health workers to boost efficiency and better se delivery.

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