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The Anatomy of Grand Corruption and its Impact on Healthcare Delivery: A Review of Ten-year Experience in Tanzania, 2005–2015

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Abstract

Literature on the corruption menace in Tanzania are not in short supply. There are two levels of corruption, depending on how it manifests: grand and petty. In Tanzania, the former has been on the rise since the neoliberal era. Some past government regimes attempted to squarely fight the vice, while others exerted withered efforts toward fighting it. For instance, the epitome of grand corruption was highly evident between 2005 and 2015, and this resulted in the dwindling provision of social services, including health. Drawing from the state capture theory, and through synthesized literature, this article catalogues major grand corruption scandals of the time in Tanzania, and their far-reaching impacts on health service delivery. The article argues that the perverted grand corruption impairs national budget funds. It was observed that grand corruption affected the health system in terms of shortages of human resources for health and acute out-of-stock medicines and medical supplies. The vice also accelerated petty corruption and community mistrust of the health system. This necessitates solid mechanisms to curb it. It is thus inevitable that the leadership in power needs to continue sharpening the existing strategies that are in place to fight corruption, and designing new measures to curb new venues of corruption. It is suggested that legal instruments be strengthened to back up the strategies that are designed to tackle grand corruption.

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1. Introduction

The provision of social services such as health, amongst other utilities, is a priority of many democratically elected governments. However, in low and middle income countries (LMICs), the provision of health services is unsatisfactory, thereby threatening the attainment of universal health coverage (UHC) (Kodali, 2023; Rudasingwa et al., 2022; Ranabhat et al., 2020). In particular, the provision of health services in Sub-Saharan African Countries (SSA) is acutely low, such that diverse indicators of well-functioning health systems are largely poor. For instance, the maternal mortality rate (MMR) stands at 567 per 100,000 live births in SSA against the 2030 targets of achieving 70 per 100,000 MMR per live births as stipulated in targets 3.1 of the Sustainable Development Goals (SDGs) (WHO, 2016). More so, the shortage of health workforce is also very high, standing at only 5 health professionals per 100,000 people against the global threshold of 21 per

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10000 (Gichaga et al., 2021). Over time, Tanzania has also persistently displayed poor health indicators. For instance, maternal death stood at 578 per 100,000 live births, then dropped to 454 per 100,000 live births in 2010; and rose to 556 per 100,000 live births in 2016, before plummeting to 104 per 100,000 in 2022 (TNBS, 2005; 2011; 2015; 2022). The country is also among the top 10 countries with the highest neonatal mortality worldwide ranging between 26 and 40 deaths per 1000 live births during the last three decades (Mpambije & Maluka, 2023; Lawn et al., 2014). Again, the Tanzania government maintained the lowest ratio of health workforce, standing at 0.9 per 10,000 medical doctors and assistant medical officers; 4.9/10000 nurses and midwives; and 0.12 per 10,000 pharmacists (West-Stevin et al., 2015). In healthcare financing, the government remains off-target to reach the Abuja Declaration of allocating 15 percent of its budget to health expenditure. Of interest is that for over the ten-year period, extending from 2008 to 2018, the proportional allocation of expenditure to the health sector has remained consistently low, around 8.9 percent (Lee & Tarimo, 2018). The status quo is indicative of something amiss in the health sector.

One of the insurmountable deterrents to achieving diverse health-related goals at the local and global levels has always been persistent perennial corruption, mostly grand corruption. Compelling evidence hints that corruption, in whatever form, has seriously contributed to the deterioration of health service provision (Vian, 2008; Lewis, 2006; Savedoff, 2007; Li et al., 2018; Achim & Borlea, 2018). This assertion implies that some reprobates misappropriate a significant chunk of funds that could have been spent in the health sector, leaving the sector dilapidated. Evidence on how corruption has affected health globally was revealed by Mackey (2018) who estimated that, of the USD5.7tr spent on health worldwide in 2018, about USD415bn (7.3 percent) was fraudulently lost among corrupt individuals, health administrators, and pharmaceutical companies through the procurement of medicine and medical supplies. For instance, data from a global corruption report found that between 5 and 10 percent of Cambodia's health funds disappeared in 2006 before reaching the country's Ministry of Health (Dryer, 2006; Sommer, 2019). Likewise, a study by Azfar and Gurgur (2005) in the Philippines revealed that corruption devastatingly delayed the uptake of the vaccination of infants, thereby reducing the uptake of public health clinics, while deterring the community's satisfaction with healthcare provision. In his study in Sub-Saharan Africa, Lewis (2006) asserts that the leakage of health funds is around 70 percent or higher. This data corroborates the findings of the Transparency International in Ghana, which revealed that the health sector is the most corrupt-prone area, with evidence of bribery and fraud across the breadth of medical services (Agbenorku, 2012).

While scholarly works on the effects of grand corruption have been widely available (Gerring & Thacker, 2019; Gray, 2015; Kenny & Soreide, 2008), still the area seems to require further deliberations and articulation since the effect of grand corruption has continued to haunt the health sector, especially in the Global South. In addition, the study of grand corruption and its practices, and specifically in Tanzania, has not

received a fair share of attention in the literature, especially on how it has contributed to the deterioration of health service delivery. Some studies that have addressed the impact of grand corruption in Tanzania include that of Gray (2015), which surveyed the general impacts of corruption in Tanzania. On the other hand, Mpambije (2016) sheds light on grand corruption in Tanzania, confining his source from the reports of the Controller and Auditor General (CAG) in a span of not less than five years, which unearthed how the leakage of funds and squandering by unethical officials have deterred the provision of social service. As Mpambije's study dwelt on the CAG's reports alone, it did not typically make a clear corroboration of the impact of corruption on health service delivery. Thus, anchoring its arguments in the state capture theory, and by synthesizing the literature on the matter, this article attempts to uncover how grand corruption practices in Tanzania contributed to poor health services in the period between 2005 and 2015. This was the period when the severity and practice of the structural adjustment programmes (SAPs) [1] rose to an unprecedented level. Cataloguing major grand corruptions in Tanzania from 2005–2015, this article clearly advances that if the misappropriated funds had been utilized in the health sector, services could have been better. It also calls for policy-makers to consider that the health sector is so critical; and when robbed of funds, this devastatingly affects the poorest and disadvantaged groups.

The rest of the paper is structured as follows. Section two examines how grand corruption explicitly manifests in SSA countries' health systems. Section three covers the theoretical underpinnings of this study, followed by the details on the methodology in section four. Section five dissects incidences of grand corruption practices that engulfed Tanzania in the period 2005–2015; followed by section six that shows how corruption depreciated the provision of healthcare. Finally, a conclusion is provided in section seven to recap the concern of the study, while offering suggestions and practical solutions to the vice.

2. Grand Corruption and Healthcare System in Sub-Saharan Africa

Grand corruption, also called political corruption, is haunting Africa, particularly Sub-Saharan Africa (SSA). The depth and breadth of corruption practices in SSA are measured in different corruption indexes, including Transparency International, the Corruption Perception Index (CPI), the International Country Risk Guide (ICRG), Mo Ibrahim Foundation's Governance in Africa reports and the Afro Barometer. All these indexes place SSA among the highly corruption-prone and corruption-breeding regions (Ganahl, 2013). Empirical evidence shows that 80 percent of SSA countries continued to lag behind in the war against corruption in the last decade (Kitimo, 2022). In 2010, the Global Financial Integrity estimated that financial leakages of illicit financial flows from SSA alone amounted to USD358bn between 2000 and 2008 (Mills, 2012). Notably, the Luanda Leaks scandal in Angola revealed that from 1997 to 2002, the country recorded the disappearance of USD4.22bn, amounting to

[1] The SAP opened the window for market economy in which the introduction of privatisation policy witnessed increased of corruption.

9.25 percent of the country's GDP (HRW, 2004). Grand corruption practices have also flourished in Nigeria since independence. For instance, about USD400bn from Nigeria was stashed away in foreign banks by past corrupt leaders before the institutionalisation of the so-called democratic rule in 1999 (Ayodeji, 2019). On its part, Zimbabwe lost approximately USD2bn, equalling nearly one-sixth of its GDP in 2012 (Bonga, 2021). According to Bonga, the embezzlement became popular following a series of corruption scandals, including the so-called 'Salary Gate', which involved 78 parastatals. Similarly, in 2009, Zambia witnessed a health scandal in which top government officials stole SEK7m (aid from Sweden) from the health ministry (ibid.). These few pieces of evidence of fraudulent practices (out of the many unreported) show how corruption is deeply ingrained in the bloodstream of SSA governments.

Given the complex nature of grand corruption, studies on the underlying reasons for rampant corruption in SSA, and developing countries in general, are not unanimously underscored. Instead, studies accord multifaceted factors to rampant grand corruption due to each country's diverse socio-economic and political context that trigger embezzlement of public funds. Reportedly, rampant corruption in SSA results from micro, meso- and macro-interactions (Bicchieri & Ganegonda, 2016; Dimant & Schulte, 2016). Nevertheless, evidence shows that countries—whose law-enforcing institutions are weak, understaffed and with little freedom from government—suffer significantly from rampant corruption (Diminant & Tosato, 2017). Such a view corroborates Lawali's (2007) observation that corruption vices are even worse in countries where institutions, such as the legislature and the judiciary, are weak; where the rule of law and adherence to formal rules are easily bent, political patronage is standard practice, and the professionalism of the public sector has been eroded. It is noted that corruption has also escalated to a worst scale in countries that have evolved from centralized to liberal economies, and which have upheld the structural adjustment measures since the 1990s (Williams, 1994). It is argued that when the parliament does not ensure financial integrity and effective government spending, automatically the fight against corruption becomes a misnomer (Lukiko, 2022). Also, corruption is rated high in countries with incapacitated oversight bodies, including parliaments, control and auditor generals' offices, and other anti-corruption bureaus and bodies tasked to curb corruption. Such is the case in Tanzania, a country that brags about having the so-called Prevention and Combating Corruption Bureau (PCCB) and a Director of Criminal Investigation (DCI); but where corruption scandals are "… pardoned, and corrupt leaders outsmart law enforcers" (Policy Forum, 2018).

In SSA, corruption stringently impacts healthcare delivery among other public services. The vice has percolated in all health systems directly and indirectly to the level of withering healthcare provision in the region (Sommer, 2019). Accordingly, Gupta et al. (2001) argue that health services in SSA have lagged behind for decades due to corrupt practices. Such a view resonates with the 2000–2004 World Health Survey data, which ascertains that corruption in Africa is consistently associated with

poor health services among adults in twenty African countries (Witvliet et al., 2013). Evidence from Pinzon-Rondon et al. (2015) indicates that African countries with a higher level of corruption also have higher infant and maternal mortality rates. For instance, Siera Leone is one of the countries with the highest maternal mortality rate (MMR) and infant mortality in the world, standing at 1165 deaths per 100,000 live births, which is mostly associated with limited funding in the healthcare system due to corruption (Appiah & Sanny, 2020).[2] Also, based on Uganda's orthopaedic healthcare, Bouchard et al. (2012) reported that corruption practices reduce the quality of care and products, increase equipment prices, and reduce access to healthcare. Again, because of corruption, nearly two-thirds of drugs meant for free public distribution are stolen, and are unaccounted for by public officials; affecting access to, and the quality of, the health care provided to the general public (ibid.). Overall, corruption deeds in SSA have also resulted in lower life expectancy, lower levels of subjective health, low immunisation rates and poorer management of chronic conditions (Mostert et al., 2015; Hsiao et al., 2020).

3. Theoretical Framework

This study evokes the state capture theory (SCT) as propounded by Hellman, Jones and Kaufmann in 2000. The SCT is ascribed to a new dimension of corruption that was rooted in Eastern Europe in the late 1990s as countries in the region were moving from a planned economy to a state economy (Helman & Jones, 2000). The theory explains how actions of minority individuals, groups, and oligarchies in the public and private sectors influence and intervene in forming and implementing laws, regulations, decrees and other government regulatory tools for their benefit, thereby affecting the majority of citizens (Martin & Solomon, 2016). The theory holds that perpetrators who intervene in governance procedures have political and economic powers to alter and even hijack daily government business (Gajić et al., 2021). Such a state capture allows patronage networks to thrive; hence, illegal dealing infiltrates the governments so much that it becomes impossible for the perpetrators to face the legal consequences of their actions since they have people in higher offices who shield their evil deeds (Martin & Solomon, 2016). This allows the dominance of rent-seeking actors in service provision.

The ideas put forth by the state capture theory can be categorized into three schools of thoughts, namely: neo-liberal, neo-institutional economics, and Marxist strands. Under the neo-liberal perspectives, state capture happens as policymakers are inherently corrupt such that they use state power to influence rent allocation and patronage (Robinson & Hdi, 2004). Neo-liberals postulate that a self-regulatory economic system, which gives the market force power to determine the demand and supply of commodities, gives loopholes for powerful policymakers to bend rules (Srouji, 2005). For neo-institution economists, state capture occurs when institutions are weak in enforcing laws; thus, influential individuals and companies

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[2]Other causes of poor maternal and child health in Sierra Leone include prolonged Ebola, political instability and coup d'états.

lobby policymakers to bend rules, and in return, they get rewarded to the detriment of the larger society (Bardhan, 2001). Under the Marxist strand, state capture occurs due to the inherent struggles among capitalists who vie to influence the country's economic policy. As such, the state machinery makes rules that give capitalists exclusive power to manipulate state power, thereby increasing profits at the expense of the poor mass (Srouiji, 2005).

From the three perspectives of the SCT, it is apparent that Tanzania experienced different forms of state capture from 2005 to 2015, which resulted into the breeding space of grand corruption. This period was characterized by bending of rules, regulations and standard procedures; incidents that benefited few individuals and their companies that had the power to influence the legislative process (Gray, 2015). In fact, the policy-making structures of the state were commoditized. During this regime, various grand corruption deals were concluded like the External Payment Arrears, the Twin Tower Scam at the Bank of Tanzania, the Richmond LLC Scandal, and the Tegeta Escrow Account Saga (Mpambije & Magesa, 2017). For instance, during the parliamentary session of March 2014, the then Member of Parliament, Zitto Kabwe,[3] commented about the Tegeta Escrow saga in which he noted that the government operation procedures were almost paralyzed as transfers of money through different banks were conducted (Policy Forum, 2014). Powerful groups in the country successfully hijacked legal frameworks and manipulated the implementation of rules and regulations set by the state to extract undue economic and political benefits (Zinyama, 2021). This was a manifestation of neo-liberal state capture. Eventually, high-profiled business figures and politicians conspired to influence decision-making processes to advance their interests (Lukiko, 2017). This signifies that neo-institutionalism also took precedence. The state's law enforcement mechanisms and agencies entrusted to crack down on corruption were weakened and neutralized (Carmago, 2017), a manifestation of the Marxist state capture. Notably, one form of state capture can contribute to another. Also, more than one form of capture may occur concurrently.

4. Methodology

This study is anchored on an extensive literature review covering two major horizons: grand corruption, and the state of health services provision in Tanzania. The literature reviewed targeted Tanzania from 2005–2015, given that cases and narratives of grand corruption and investigations concerning the vice were mostly reported during the specified time. Grand corruption is undertaken in a secretive circumstance that does not allow people to speak openly and accurately of the figures stashed through corruption (Amizede, 2015). However, figures can easily be obtained from secondary sources, as such a literature review was a convenient

[3] Zitto Kabwe is a senior member and a former leader of the Alliance for Change and Transparency Party, popularly known as ACT-Wazalendo. During the Escrow Saga, he was actively involved in the whole process as he was serving in the parliament as a member of the Parliamentary Committee for Public Accounts.

data source in this study. More so, for security reasons, people prefer not to talk about corrupt figures since such people have the power to strike back when their interests are threatened. Thus, an analysis of books, articles, government reports, and newspapers informed this paper's empirical findings.

Concerning newspapers, evidence shows that as the neoliberal era took its roots in Tanzania, the freedom of expression increased such that different feature articles were dedicated to wide corrupt deeds. Such a fact is evidenced by the booming of new independent Swahili and English newspapers that exposed several incidents of grand corruption that allegedly happened in the period under study. The insightful English newspapers that were reviewed include *The Guardian, The Citizen, The East Africa, This Day* and *The Express;* while Swahili newspapers encompassed *Nipashe, Mwananchi, Rai, Raia Mwema, Tanzania Daima,* and *Mwanahalisi.* Regarding government reports, the article surveyed CAG reports to triangulate different grand corruption scandals that pervaded Tanzania during the study period. Parliamentary reports, including the Hansard, were accessed since all the grand corrupt scandals were extensively discussed during parliamentary sessions. For further triangulation of data, different YouTube[4] videos were viewed as members of parliaments were, at different times, dissecting the state over the mounting grand corruption during the studied period. More so, the levels of corruption at the global and regional levels were extracted from international reports and trusted databases maintained by Transparency International, Mo Ibrahim, and the World Bank.

Regarding health service provision in Tanzania, the researcher extensively surveyed literature, including government reports within the last two decades. These reports mainly included budget speeches from the Ministry of Health spanning from 2005 to 2015, the Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP), and the Health Policies of 2003 and 2007. Others sources were the Health Sector Public Expenditure Review (2014 and 2015), the Health Sector Strategic Plan of July 2015 to June 2020 (HSSP-IV), the Midterm Review of the Health Sector Strategic Plan, the Health Sector Strategic Plan of July 2021 to June 2026 (HSSP-V), and the National Package of Essential Health Intervention Reports. In addition, a thorough analysis of relevant journal articles on the state of the art of healthcare provision was conducted based on trusted databases, including the Google Scholar, EQUINET, PubMed, Scopus, Web of Science, and the Cochrane Library. For more information on health service provision, the WHO Statistical Information System (WHOSIS) was also consulted. Data was analysed by determining different themes as they emerged in diverse sources in which qualitative analysis procedures governed the process. Thematic analysis included collecting the data, transcribing it, and determining similar patterns of emerging themes. The scrutiny of findings from the intensive literature

[4] These sources from YouTube were instrumental in getting data from the parliament https:// www. youtube.com/ watch?v=Ma-pTh3HDDQ, https://www.youtube.com/watch?v=WqL5wnBqCdM.

involved an analysis of the status of health service provision in Tanzania since the post-colonial period; followed by grand corruptions that implicated the country from 2005 to 2015, and their implications on health service delivery.

5. Cataloguing Major Grand Corruption Practices in Tanzania, 2005–2015

Literature on the history of grand corruption in Tanzania holds that the vice started gaining a stronghold in the late 1980s through the 1990s. This was after the state dismantled the socialist era and ushered in the neo-liberal export-oriented development strategies with private enterprises, open markets and foreign investments taking roots in the country. Kilian (2009) argues, for instance, that during Ally H. Mwinyi's presidency (1985–1995), an unprecedented number of complaints against corruption and tax evasions were rampant. A noteworthy example of a corruption that occurred during Mwinyi's administration involved the Chavda family, which obtained a USD3.5m loan under a debt conversion programme; while promising to revive a sisal plantation in Tanga to create 1400 jobs and to generate USD42m. Contrarily, the family diverted the funds outside the country and covered this up by buying fictitious machineries and spare parts (Heilman & Ndumbaro, 2002).

When Benjamin Mkapa took over from Mwinyi from 1995 to 2005, he inherited a corrupt government such that even donors withdrew aids and loans as the country was listed as a highly indebted poor country. Thus, to root out corruption, Mkapa formed the Warioba Commission to probe the severity of corruption. Nevertheless, even Mkapa's government was marred by grand corruption scandals, one of them that tarnished his government image being the deal between Tanzania and the British Aerospace Engineering (BAE) firm, in which Tanzania purchased a civil aviation radar system. The deal became an international corruption scandal in 1999 when investigators from the British Serious Fraud Office identified it as an embodiment of grand corruption. As a result, the BAE was fined £30m (Gray, 2015). The deal's principal architects were high-ranking officials, notably the BoT ex-governor, Dr Idris Rashid; and Mr Andrew Chenge, the then Minister of Infrastructure and former Attorney-General. The investigation uncovered that the latter stashed USD1m in an offshore bank account (Aminzade, 2015).

From 2005–2015, when Jakaya Kikwete took over, many people thought he could heighten the fight against grand corruption but, to their dismay, he did not. Ironically, history inked that significant incidents of grand corruption pervaded the leadership such that in 2013, Transparency International ranked Tanzania as one of the fourteen most corrupt countries in the world (Mpambije, 2015). Again, in 2014 Tanzania was ranked high in the corruption perception index at 119 out of 175 countries by Transparency International, before dropping to 87 out of 180 countries in 2022.[5] Table 1 shows the country's corruption trends from 2010–2015 to 2019–2022.

[5] https://tradingeconomics.com/tanzania/corruption-rank. This was an important source which provided the rank of corruption

Table 1: Tanzania Corruption Index (2010/2015–2020/2021)

Year	Position	Point Secured	Countries Covered
2010	116	27	178
2011	100	30	182
2012	102	35	174
2013	111	33	177
2014	119	31	175
2015	117	30	168
2020	94	38	180
2021	87	39	180

Source: Mpambije, 2016; Mahuni, 2023

Table 1 shows how Tanzania experienced high levels of corruption from 2010 to 2015, before slowing down in 2021. The fact that corruption in Tanzania was high from 2010 to 2015 has also been confirmed by other sources. For instance, the Legal and Human Rights Centre (LHRC) reported in 2016 that corruption in Tanzania had increased, particularly in the past 10 years as evidenced by high-profile grand corruption scandals (LHRC, 2016). The ensuing analysis catalogues the major grand corruption scandals experienced in Tanzania from 2005 to 2015.

5.1 External Payment Arrears (EPA)

A series of grand corruption scandals started unfolding one after another since 2005 after the new administration under Jakaya Kikwete. The first in the series was the External Payment Arrears (EPA) in 2006, which astonishingly costed Tanzanians TZS133bn. The scandal involved the Bank of Tanzania (BoT) as the bank's commercial external account set up to help service the country's balance of payments. This process involved almost 22 local firms that received dubious funds from the BoT (Gray, 2015). The EPA account at the BoT was initially meant to help service balance of payments, under which local importers would pay into the EPA account in TZS, while foreign companies would then be paid by the BOT in foreign currency (Andreon, 2017). Surprisingly, the recipients of money from the EPA were mostly ghost companies that used invalid and fraudulent supporting documents (Cooksy, 2011). These included the Kagoda Agriculture Ltd, and Deep Green Finance: all fraudulently registered in 2005. Following pressure from international partners demanding the country to be audited by international auditing firms, it was confirmed that the funds were recklessly embezzled; and the culprits resigned. Overall, the EPA scandal shook the nation and eroded the credibility of the government, and that of the Central Bank (Mtulya, 2015).

5.2 Twin Tower Scam at the Bank of Tanzania

Before the EPA saga was fully resolved, the Twin Tower Scam shook the BoT, costing the country TZS221bn. This appalling scam resulted from fleecing the construction of a 17 storey building at the BoT main office. The scam broke the

record set by other scandals in the procurement proceedings. Evidence disclosed that the construction cost increased from USD37m in 1997 to USD70m in 2000, and finally to USD345m at its completion in 2006 (Andreon, 2017). Andreon further notes that building this tower in Dar es Salaam was more expensive than having the same building constructed in cities like Tokyo, New York or London (ibid.). On the other hand, Coosky (2011) opines that the project should have cost no more than USD80m. The assertion marks a loss of more than USD220m. The local media further alleged that the BoT's former Director of Personnel and Administration, hired family members of top-ranking politicians to serve in the BOT,[6] making the saga even more prominent. Investigations on the matter implicated the Twin Tower project manager for causing a loss of more than USD170m, resulting in court action against the BOT's director of finance and administration. During the saga's court proceeding, the accused informed the court that the board of directors and the governor made decisions that put the country into a loss of TZS221bn (*Tanzanian Affairs*, 2010).

5.3 Richmond LLC Saga

From 2006 through 2008, Tanzania recorded prolonged severe drought periods that culminated in acute electricity shortages. As a country entirely relying on hydropower, Tanzania thus endured sporadic power cuts and unbearable power-shedding routines. This natural calamity made Tanzania vulnerable to another episode of grand corruption, dubbed as the Richmond saga. As Amizende (2015) reported, the government eventually invited a foreign multinational corporation to produce and supply over 100 megawatts of electricity. Although the US-based Richmond LLC won the tender, it was uncovered that procurement or bidding irregularities marred the whole process, allegedly costing over TZS172bn, the money whooped from Tanzania taxpayers. Such a realisation came following the company's failure to produce the anticipated megawatts of electricity. To address this conundrum, the parliament intervened and formed a committee of inquiry, chaired by the then member of parliament, Dr Harrison Mwakyembe, to investigate the saga. The cabinet was informed how the tendering processes had been conducted, and how the cartel of embezzlers bypassed the cabinet's advice in awarding the tender (Amizende, 2015). The inquiry revealed that Richmond PLC, allegedly registered in the US and Tanzania, was fictitious: a briefcase-based sort of company falling short of experience and expertise. More so, the Mwakyembe Committee learnt that the bidding process was dubious in the government circle (*Tanzania Affairs*, May-September, 2008). As a result, high-ranking government officials, including the Prime Minister,[7] Minister for Energy and Minerals, and the Minister for Infrastructures: all of whom were implicated in engineering the scandal, were forced to resign (Mtulya, 2015).

[6] "Bank of Tanzania Gave Jobs to Kin of Former Presidents Mkapa, Mwinyi," *East African (*Kenya), May 19, 2008. Available at http://www.africafiles.org/article.asp?ID=18026.

[7] Edward Lowasa, who served as the prime minister from 2006–2008, resigned after being implicated with involvement in the Richmond Saga. Other ministers were the then Minister of Energy and Minerals, Msabaha, and Minister for Infrastructure, Naziri Karamagi.

5.4 Tanzania Railway Limited and the Purchase of Defective Wagons

Corruption blows infiltrated the Tanzania Railway Limited (TRL)[8] as well in 2013 through 2015. Through TRL, unethical government leaders purchased defective and substandard wagons worth TZS60bn (*The Guardian*, 2015). The scandal stemmed from the signing of two contracts between Tanzania and an Indian firm—the Hindustan Engineering and Industries—to manufacture 25 freight wagons and 274 cargo wagons. Upon the importation of the wagons, their quality was suspiciously doubted, enticing scrutiny. Hence, the government formed a task force to probe whether the wagons were of the required standards. Disturbingly, the task force discovered that the wagons were an emblem of the highest level of sub-standard, and unfit for ferrying passengers. Even the purchasing signalled gross irregularities and violation of government procurement laws (Mpambije & Magesa, 2017). The task force uncovered further that TRL had paid in cash an amount of TZS60bn instead of paying in instalments as stipulated in the contract (Masare, 2015). After this indicative sabotage, five top TRL officials were sacked, including the managing director, chief engineer, chief accountant, internal auditor and chief procurement manager (*The Guardian*, 2016). However, despite these measures, it is still unclear whether the stashed money was recovered by the government (Mpambije & Magesa, 2017).

5.5 Tegeta Escrow Account Saga

Perhaps the most widely discussed corruption scandal during the 2005–2015 period was the Tegeta Escrow Account (TEA) in 2014, which witnessed the syphoning of Tanzanian tax payers' monies worth TZS306bn. The money was in lieu of capacity charges payable by the Tanzania Electricity Supply Company (TANESCO) to the Independent Power Tanzania Limited (IPTL). The money was held in the Tegeta Escrow Bank Account, awaiting the settlement of pending disputes between the parties at the International Centre for Settlement of Investment Disputes (ICSID) (Lukiko, 2022). With time, the account was subjected to parliament scrutiny following a realisation that there were suspicious withdrawal transactions from the account. It was later unearthed that the whole process of withdrawing the cash was outright fraudulent, involving high collusion of corrupt and highly profiled civil servants from the Ministry of Energy and Minerals, and from public organisations such as TANESCO, and even government officials (e.g., the Attorney General) (Policy Forum, 2014). The scandal raised hot debates in the 2014/2015 parliamentary sessions, where members of parliament argued that the payment was shrouded in fraud, corruption and gross negligence[9] (Kaniki, 2021). Given the parliamentary and public pressure, the saga ended with the resignations of the then Attorney General and the Minister for Energy and Minerals (Bunge la Tanzania, 2014; National Audit Office of Tanzania, 2014). Also, the then Minister for Lands,

[8] Formally, the Tanzania Railway Limited (TRL) was named as Tanzania Railway Corporation (TRC) after the government entered into a contract with an Indian-based firm, RITES to run the TRL. After ending the contract with the Indian company, the name TRC was resumed to date.
[9] See Parliament of Tanzania, Hansard - Parliamentary Debates, 28th November, 2014, pp. 64–328; and 29th November, 2014, pp. 2–28.

Housing and Human Settlement Development proved to have received almost USD1m, a lucrative amount but diminutively referred to as a 'token from her brother', one of the IPTL shareholder (AfriMAP, 2016). The Tegeta Escrow saga prompted Tanzania development partners to suspend budget and programme support until the issue was resolved. The World Bank, for example, stopped the issuance of USD558m, a budget support planned for the financial year 2014–2015 (Bonga, 2021).

6. Implication of Grand Corruption on Tanzania's Health Services Provision

Despite their catastrophic consequences, the grand corruption practices during the 2005–2015 were a window of opportunity to several corrupt politicians, executive government officials, businessmen and their closest allies. As evident in the five analysed grand corruption scandals, the county lost over TZS892bn. Apart from the reported grand corruption during this time, there are other corruption scandals that were reported, and others unreported, worth above TZS1bn, the very cut-off point for what could be termed a grand corruption. It is important to concede that unethical leaders embezzled money that could have been used to improve citizen's life standards, including improving health services. Consequently, the provision of health and other services deteriorated. This section expounds on how the government's failure to invest in the health sector is partly linked to the reported and unreported corruption scandals in the country. The section elaborates outcomes such as underfunding of the public health sector, crises of human health resources, looming petty corruption in the healthcare sector, out-of-stock and theft of medicine and medical appliances, and community mistrust of the health system.

6.1 Gross Underinvestment in the Health Sector

The amount of funds lost through grand corruptions resulted into the government's failure to invest in its citizens' healthcare. Over time, the government of Tanzania has failed to abide by the Abuja Declaration of setting aside 15 percent of national budgets for healthcare services. Data shows that there has been a consistent decline in healthcare financing from the government and, instead, the burden has been shouldered to donor funding. For instance, in the fiscal year 2005/2006, development partners contributed 44 percent of the health finance, while the rest was given by the public sector (28 percent), households (25 percent) and the private sector (3 percent) (Kitole et al., 2022). Contrarily, in the FY 2009/2010, development partners contributed 40 percent, households 32 percent, the public sector 26 percent, and the private 2 percent (Andrew, 2019). On the other hand, in the financial year 2011/2012, development partners contributed 48 percent, households 25 percent, the public sector 22 percent, and the private sector 4 percent (Kitole et al., 2022). This trend of poor government funding of the health sector culminated in the dwindling of finances for health-related projects such as the construction of dispensaries and health centres. For instance, by December 2015, out of 12545 villages, there existed only 4554 (36 percent) government-owned dispensaries, while there were only 513 (11.6 percent) government-owned health centres in 420 wards (Kapologwe et al., 2020).

Worse still, most existing health facilities were offering sub-optimal quality healthcare services, as their amenities were not up to the required standards. For instance, only 33 percent of the health facilities in the country had running water, and only 5.1 percent had telecommunication systems (Kaplogwe, 2020). This fact envisions how poor hygiene and sanitation jeopardise healthcare provision, with poor communication limiting proper implementation of referral systems between healthcare facilities and providers. This acute shortage of health facilities would have been handled if the funds that were withered through grand corruption were to be invested in the healthcare system. For instance, empirical evidence shows that one health centre can be constructed, be fully furnished and with the required medical requirements for TZS500m. Impliedly, the money lost through a single corruption scandal, such as the Tegeta Escrow (TZS306bn), could have constructed almost 600 health centres. On the other hand, if a complete district hospital can cost TZS2bn, then nearly 150 district hospitals could have been constructed with all the money embezzled in the Escrow swindle.

6.2 Crisis of Human Health Resources

In addition to being a country with a high poverty-related disease burden, Tanzania is among the developing countries with an acute shortage of health workforce. As of 2012, the Tanzania's health sector was operating with less than half of the required number of health workforce, with a single doctor serving a population ratio of 0.3 per 10,000 individuals nationwide (Sirill et al., 2019). The situation is even worse in rural areas where the healthcare system is operating with a 65 percent shortage of the required workforce (Narketer et al., 2010); as was the case with the Kilolo rural district, in the Iringa region, that faced a 65 percent deficit in its health workforce, which undermined healthcare delivery (Maluka et al., 2020; 2023). The billions of money looted through grand corruptions could have been invested in the construction of medical colleges, expansion of health service infrastructure, and hiring medical personnel. Data shows that, until 2015, Tanzania Mainland had only three public universities admitting medical students; namely the Muhimbili University of Health and Allied Sciences (MUHAS), the University of Dodoma (UDOM), and the University of Dar es Salaam (UDSM). Even so, the enrolment capacity of these institutions remained disproportionally low: it increased from 175 undergraduates in 2011 to 225 in 2015 for the MUHAS; 120 in 2011 to 175 for the UDOM; and only 100 medical students in 2015 for the UDSM[10] (Mkony, 2016). Moreover, even the number of those who successfully graduated as medical doctors remained acutely low. For instance, the number of graduates at the MUHAS stood at 134, 175, and 201 in 2006, 2007 and 2008, respectively (Mwakigonja, 2006).

Despite such low output of medical personnel, many of them migrate abroad due to poor government emoluments in the health sector, causing a brain drain conundrum which further worsened the health crisis. For instance, 52 percent of

[10] UDSM started enrolling medical students in 2015

Tanzanian doctors worked outside the country in 2006 (Emmanuel, Elo & Piekkari, 2019). Sikika and Mat (2013) further reported that, in 2013, some 26 percent of Tanzanian medical doctors worked abroad. Notably, while the embezzled money reported in this paper through grand corruption is just a tip of an iceberg of the enormous amount lost through corrupt deals, if this had been invested in the health sector, it could have reinforced the retention of the health workforce. The major causes of the brain drain of medical personnel are low salaries, poor working environment and inadequate facilities to perform expected tasks (ibid.), which are mainly caused by underfunding of the healthcare system.

6.3 Booming Petty Corruption in the Healthcare Sector

It is also logical to argue that the engagement of health workers in petty corruption is also chiefly fuelled by grand corruption, whose impact replicates through low salaries and inadequate incentives for workers. More so, the spiral effects of the vice goads greed among the health workers to work for their own interests, invites patients to entice staff to accept bribery, and the leads to the normalisation of corruption among unethical health workers (Kamuzora, 2005; Mpambije & Magessa, 2017). The stolen money through grand corruption would have improved the working conditions of health workers. Instead turn the workers get demoralised serving in the public health sector, hence goading them to indulge in petty corruption (Mkandala & Gunning, 2018; Manyerere & Mpambije, 2022).

According to Neupane et al. (2014), there are different forms of petty corruption in the healthcare system, including bribery, absenteeism, theft, embezzlement, abuse of discretion, favouritism, exploiting conflict, putting private interest ahead of public interest, and improper political interference. The PCCB (2017) also adds other forms of corruption to include sexual corruption, which is another form of bribing to get a 'favour' in healthcare services. A study by Sambaiga et al. (2017) quoted one respondent as stating: *"Money is everything nowadays, [if] you do not have money, go stand in the queue."* The incidence of favouritism in the healthcare system attests to systemic corruption: that one can hardly access quality health services unless s/he has some form of connection with healthcare providers. Regarding the severity of favouritism in the healthcare system, Sambaiga et al. (ibid.) further attested that the proportion of accessing healthcare services is described as a function of whether a patient knows the healthcare provider in charge. Thus, overall, under informal premises, relatives and those with some form of acquaintances are considered first, especially in the event of drug shortages. (ibid.).

Evidence shows that prolonged absenteeism is among the forms of petty corruption prevalent in the Tanzania's health system. For instance, a study by Manzi et al. (2012)—which covered five districts in Tanzania—revealed a high level of absenteeism among employed staff, with 44 percent of clinical staff and 49 percent of nurses absenting themselves from their work station on the survey day. Amongst other reasons, acute absenteeism happens when health workers chase opportunities

to undertake other income-generating activities (Msafiri & Katera, 2020). Absenteeism severely undermines the reliability of a health system, potentially and negatively affecting health behaviour and outcomes (Fujii, 2019).

6.4 Unavailable Medical Supplies

Contrary to the sustainable development goals, which emphasize the right to medical care for all, Tanzania is far from attaining such a goal. This is because empirical evidence portrays a disproportionate shortage of medicine and medical equipment among health facilities mostly in rural areas (Makoka, 2019; Damian et al., 2018). The reasons factored for perennial medicine stock-out include limited government allocations (Frumence, 2014), limited facility planning and forecasting capabilities (Sikika, 2014), lack of accountability in the medical supply system (Damian et al., 2016), and a heavy reliance on donor funding (Wales et al., 2014). Of all these reasons, government underfunding of medicine and medical supplies has been hotly debated since more than a third of the total health budget serves to purchase medicine and medical supplies (URT, 2007). Evidence suggests that during the 2005–2015 period, only a small amount of the budget was apportioned to purchase medicine and medical supplies as the percentage of government funding to medical care dropped from 53 percent in 2007 to 39 percent in 2011. Meanwhile, development partners, including the Global Fund, increased their funding from 47 percent in 2007 to 61 percent in 2011 (Sikika, 2011; URT, 2011). If the funds lost through grand corruption were to be allocated to the purchase of medical supplies, not only could the reliance on donor funding be lessened, but medical supplies could have improved.

Worse still, the few procured medicines by the government and donors get lost through theft in the hands of healthcare providers. For instance, an internal audit of the Medical Store Department (MSD) reported missing medicines, whose value was USD133,000 in October 2007 alone (Ishabakaki & Kaijage, 2015). Evidencing the severity of the acute shortage of medicine and medical supplies, Sikika (2013) revealed that 94 percent of hospitals experienced a stock-out of more than one type medicine and medical supply, with almost 60 to 70 percent of clients leaving facilities without any medical relief. This indicates that a significant loss of purchased medicines and medical supplies is linked to gross mismanagement and weak logistical systems that breed further corrupt practices of theft of medicine and medical supplies and overbilling of health facilities, which further worsens the situation (Wales, 2014).

6.5 Public Mistrust of the Health System

The overall poor provision of health services in public health facilities has made the public lose trust in the health system. For instance, as communities grapple with disproportionate shortages of health workers and medicines, which is partly caused by grand and petty corruption, they devise new options for seeking healthcare in private facilities. This reality, in turn, discourages people from using public health services, which ultimately have a corrosive impact on the population's health level

(Nordberg & Vian, 2008). As Shayo (2016) succinctly puts it, as communities continue experiencing rampant levels of irresponsibility and weak accountability in healthcare provision, they begin to regard the state and its organs with fear, suspicion and cynicism; hence driving some who can afford it to seek for medical care in privately-owned hospitals. In the same study, Shayo found out that many other community members opted for traditional healers rather than seeking services in modern health facilities (ibid.). Moreover, in a study conducted in Arusha Region by Mackdonald (2011), respondents revealed how corruption deters the provision of social services, including health services. The respondents complained that people pay for their health rights, which are supposed to be free; and that government leaders invest money in big projects that do not benefit ordinary Tanzanians, thereby escalating the continued dissatisfaction among those seeking healthcare services in public facilities (ibid.).

Notably, community dissatisfaction with health services provided by public facilities surged the magnitude of home birth delivery, which by 2015 reached 37 percent, with 96 percent of these births being attended by unskilled service providers such as traditional birth attendants (TBAs) or relatives (Moshi & Mbotwa, 2020). As per empirical evidence, low utilisation of health facilities for childbirth is influenced by its unavailability (Konj et al., 2020), inaccessibility (Wong et al., 2017), affordability (Krung et al., 2008), and the quality of the existing modern care (Maselle, 2013). Hence, if the government fully invests in the provision of healthcare services, there would be no reasons for people to be reluctant to use health care services for delivery. Moreover, the stagnant uptake of voluntary health insurance is attributed to the perceived poor quality of health services, which is chiefly attributed to low trust in the health services provided in public health facilities (Mpambije, 2016; Joseph & Maluka, 2017). In 2015, for instance, the government targeted to enrol 30 percent of the population under the Community Health Fund (CHF); however, only 16.4 percent was enrolled (Msele et al., 2022). Given the dire conditions permeating the health sector, one sees that there could be higher investment in healthcare in the absence of grand corruptions that have emaciated taxpayers' money. In turn, this would have equally restored community trust and use of public health services.

7. Conclusion and Recommendations

By drawing from state capture theory, this study has explained how grand corruption negatively impacted health service provision in Tanzania. Specifically, the article has depicted how grand corruption thrives in a country with slack laws and rules that are circumvented by greedy business personnel and high-profile government officials. The article advances that while Tanzania has experienced a handful of incidences of grand corruption since the introduction of the neoliberal policy, the situation worsened during the 2005–2015 period when several grand scandals unfolded. Such high-profile levels of corruption detrimentally affected the quality of healthcare provision. Specifically, the high practice of grand corruption in Tanzania resulted in inadequate budget allocation for health service delivery, which ultimately led to the

country's high dependency on donors to fund health services. It also led to human resource crisis in the health sector, community mistrust in public health services, and increased level of petty corruption in the health system.

Incidences of grand corruption are now deeply ingrained in the society, where the corrupt are revered as successful people; thus making corruption practises be an acceptable norm in the government administrative system in general, and the health sector in particular. This worrisome tradition has been evident in Tanzania for decades, and it is time that substantial changes be made with a view to addressing the vice in offices and in the community at large. It is proposed that concerted efforts be made by the government to appoint people who can fight corruption with determination; hence the vetting of the heads of the bodies entrusted to fight corruption should be done with outmost care. Again, top leaders in ministries responsible for healthcare and good governance should exercise strong leadership, high morality and integrity, as these could help weed out public servants' desire to indulge in whatever form of corruption. This move must go hand in hand with sacking of those in public offices who deliberately indulge in petty corruption, including healthcare providers, and patients who perceive corruption as a tolerable norm in the health system. Above all, the funds saved from corrupt practices should be used to increase health funding to reduce donor apathy, increase medicines and medical supplies, as well as the number of the health workforce for a better and robust healthcare system.

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