Journal of Advance in Social Science and Humanities **ISSN: 2395-6542**
CrossRef DOI: http://dx.doi.org/10.15520/jassh301168

Poor Maternal and Child Health in Tanzania amidst Plenty: Review from Tanzania's Grand Corruption Scandals from 2005-2015

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Accepted 2017-01-3; Published 2017-1-30

Abstract: Maternal and Child Health (MCH) in Tanzania like other Sub Saharan African countries is in a gloomy state. The country has failed to achieve the Millennium Development Goals (MDG). Sadly, maternal mortality rate (MMR) stand at 454 per 100,000 against MDG target of 133 per 100,000. Similarly, under five mortality rates (U5MR) stand at 81 per 1000 against MDG target of 19 per 1000.The government's efforts to address MCH problems have not been successful mainly due to funds lost through grand corruption. The paper argues that the lost amount of money through grand corruption scandals could have been used to fix poor maternal and child health problems in Tanzania if it were invested in the MCH policy and programes. Instead, the MCH policy and programmes are marred by several problems including continued dwindling of human resource for health, increase of petty corruption in the MCH sector, declining of MCH budget that gravely impact on availability of medicine and medical supplies. Other impacts of grand corruption to MCH include declining motivation to health workers and overall poor quality health care that impact community trust of the health system. The paper is of the view that fighting grand corruption can result into improving MCH policy programmes. This will be made possible if unwavering efforts will be exerted toward the said problems such as instilling ethical behaviour, strengthening anti-corruption agencies and imposing harsh penalties to grand corruption perpetrators.

Keywords: Maternal and Child health, Grand corruption, Tanzania

Introduction

When looked by the international standard, the state of Maternal and Child Health (MCH) in Tanzania gives disheartening figures. Most poor pregnant mothers find themselves in conditions where they can't be sure of safe delivery, not to speak of staying alive after delivery. Maternal Mortality Ratio (MMR) stood at 454 per 100,000 in 2010 (NBS, 2011). While under five children hardly do celebrate their 5th birthday as under five mortality rate (U5MR) stood at 81 per 1000 in 2010 whereas neonatal death accounted for 40% of all deaths among under five due to mostly preventable diseases like asphyxia (31% of all neonatal deaths) prematurity (25%) and sepsis (20%) (Dutta, *et al*, 2015; Samuelsen, *et al*, 2013,). All these happen while possibilities to prevent such maternal and child death lie within the reach of human being. History has revealed that developed countries have managed to fix MCH problem far above the MDGs yardstick. For instance, while MMR in developed countries stands at 16 per 100,000 with 2300 deaths annually, the trend in Sub Saharan Africa is

shocking as MMR stands at 510 per 100,000 with annual MMR of 179,000 (WHO, 2014). Although efforts to fight the MCH problems have been underway through different strategies like National Strategy for Growth and Reduction of Poverty (NSGPR I&II) popularly known as MKUKUTA I&II etc, still the situation remains poor. This paper is of the view that, in Tanzania, grand corruption[1] has had devastating consequences to the MCH. If the money that has been squandered, abused and diverted through grand corruption were to be invested in the MCH programme, indeed, the MDG yardstick could have been surpassed. As Nnamuchi (2012: 9) convincingly asserts "most cases of large scale or massive human suffering, morbidity and mortality are man-made. They are not the result of accident or force majeure; instead they flow directly from deliberate human action".

Evidences from around the world indicate that corruption, fraud, and abuse results in significant losses of public money and denial of good quality health and sanitation services to millions of people (Vian, 2008). The link between corruption and the severity of maternal and child death has been revealed in a study conducted by Hanf, *et al,* (2011) in which it found a strong pejorative link between perceived corruption and death rate at national level. Their findings implies that 140,000 (1.6%) out of 8.7 million children death in the world results from corruption.

As Tanzania continues to recover from the demonstrably effects of grand corruption to the MCH, the area is still uneplored as far as the relationship between maternal and child death and grand corruption is concerned. Instead, a lot of studies have been associated with the impacts of grand corruption on economic growth; industries and human right (see for example, Gyimah-Brempong, 2002; Gray, 2015; Lofchie, 1995; Fjeldastad, 2003; Standing, 2007). The MCH seems to receive a little attention as far as connection to grand corruption is concerned. To underscore this, the paper employs documentary analysis to establish this relationship. The rest of the paper is composed of the following sections: section two establishes the state of MCH in Tanzania as well as initiatives that have been undertaken by the government of Tanzania in tackling the MCH problem. This is then followed by critical analysis on how different grand corruption scandals that have been officially documented from 2005-2015 in Tanzania. Following this, section four examines the implication of grand corruption to the existing MCH problems in the health system. Given the multifaceted nature of MCH, the analysis of implications of grand corruption will either be direct or indirect depending on a particular consequence. Some suggestions for the way forward are given at the end.

The State of Maternal and Child Health in Tanzania: A Harsh Reality or Just Euphemized?

As maternal and child death continue to threaten the world through existing large scale preventable death, the same is happening in Tanzania. At the global level, for instance, by 2013 total of 289,000 women died due to pregnancy related complication and child birth (WHO, 2014). Again, each year 6.3 million children below 5 years die from preventable diseases (UNICEF, 2014). Out of these deaths, developing countries account for 15 times of all deaths, (Maucheraud*, et al.,* 2015). The situation is dreadfully high in Sub Saharan Africa where women have 1 in 31 chances of dying from pregnancy related causes (Toure *et al.,* 2012).

[1] Grand corruption often entails powerful players who traverse the globe causing havoc wherever they go, and as such, local or domestic mechanisms may sometimes prove inadequate to respond to crimes of such a magnitude.

Sadly, most of these deaths are either preventable or treatable as they include such disease as respiratory infections, diarrhoea, malaria, measles, malnutrition and neonatal condition from children (Olusegun, *et al.,* 2012).

Tanzania, on its part depicts the same worst indicators to MCH as it is among the 21 countries with the highest MMR in Africa (WHO, 2010). It is estimated that 13,000 women die each year due to labour and pregnancy related causes (WHO, 2007). Tanzania is also among 10 countries that accounted for 58% of global maternal death reported in 2013 with 7900 equal to 3% (WHO, 2014). Furthermore, up to 2010 the country was off track to meet targeted goal of 133/100,000 as MMR stood at 454 per 100,000 live births (NBS, 2011) In the same realm, most maternal and child deaths occur at home as women deliver with no trained health workers. For example in 2010, 50% of all pregnant women gave birth at home where 29.1% were assisted by relatives, 14.7% by Traditional Birth Attendants (TBA) and 28.5% delivered without any assistant (NBS, 2011). Moreover, Antenatal (ANC) and Postnatal (POC) are below bar as 65% of women did not receive POC checkup at the health facility. Also, only 15% of women make their first ANC visit before the 4th month of pregnancy whereas about 13% of home delivery access POC checkup (Shija, 2011*).*

Though Child death status is reported to have improved from U5MR of 137 per 1000 live birth in 1996 to 81 per 1000 in 2010, the fact is that this is still unsatisfactory given the MDG yardstick of 19 per 1000 (NBS, 2011). Still, the highest trend of mortality is highly felt in rural areas and among poorest wealth quintile (URT, 2008; Pandey, 2009). For instance, the nutritional base in urban areas is better where the stunted growth is 32% compared to 45% in rural areas (NBS, 2011). It needs to be noted that malnutrition is among the chronic cause for child mortality in the country. Given the high rates of maternal and child mortality in Tanzania, it becomes imperative to ask what the government has been and is doing about it.

Tracking Government Efforts to the Reduction of Maternal and Child Deaths 2005-2015

The MCH problem has not been left to prolong unaddressed. From 2005 to 2015 the government took several initiatives to curb the problem. Promising results were recorded, for instance, the maternal death dropped from 529/100,000 in 1996 to 454/100,000 in 2010. Such initiatives are stipulated in different policy documents and programmes. From 2005 to 2010 the government introduced the Reproductive and Child Health Strategy which focused at improving the quality of reproductive and child health services that are accessible, affordable, sustainable, and which are provided through an efficient and effective support system. The key priority areas identified included antenatal care, skilled care during childbirth, care for obstetric emergencies, postpartum care, post-abortion care, family planning and prevention of harmful practices (MoH, 2004).

Again, the government came out with the National Strategy for Growth and Reduction of Poverty I and II (NSGPR I&II) from 2005 to 2010 that was developed in line with the Tanzania Vision 2025. The two documents aimed to improve quality of life and social welfare by providing two indicators to monitor reduction of maternal mortality from 454 per 100,000 to 133 per 100,000 live birth and increase coverage of birth attended by trained personnel from 50% to 80% by 2010 (Shija, *et al.,* 2011). Moreover, in 2007, the government launched the Primary Health Service Development Programme 2007-2017, aiming at providing health care to all Tanzanians by 2017 focusing on a number of areas; these include strengthening the health system, rehabilitation of health facilities, human resource development and strengthening the referral system, equipment and supplies. Also the programme aimed at ensuring access to emergency

obstetric care (EmOC) services by providing ambulances, motorcycle especially to rural health facilities (MoHSW, 2007).

In 2008, the Health Sector Support Programme III (2008–2012) was launched. This was a cross cutting strategic plan across the health sector to guide development of council and hospital strategic plans and annual implementation plan. In the same year, The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child deaths in Tanzania 2008-2015 was developed aiming at improving coordination of interventions and delivery of services across the continuum of care. The programmes that were integrated in Maternal and Child Health services include Safe motherhood; Family Planning; Prevention of Mother to Child Transmission; Malaria; Expanded Programme on Immunisation; Adolescent Health and Nutrition (Shija et al, 2011). On average, the policy guideline and programmes that were introduced assisted in reducing maternal and child death but not as per the MDG, NSGPR and Vision 2025.

The above initiatives to reduce MCH problems have faced several challenges, chief of which being inadequate financial resources to run the initiatives. According to URT (2008) shortage of financial resources worsens other health system factors in accelerating MCH as it leads to weak health infrastructure, limited access to quality health services, long distance to access health facility, lack of equipment and supplies and inadequate human resources. To prove that inadequate financial resources have been the main problem behind poor MCH, in the fiscal year 2013/2014 to 2014/2015 the National Institute for Medical Research (NIMR; 2014) estimated the cost for essential medicine and medical supplies at TZS 549.5 billion for 2013/2014 and TZS 577 billion for 2014/15. Surprisingly, the allocation was TZS 64 billion and TZS 45 billion respectively. This allocation covers only 11.6% and 7.7% of the demand for the two years respectively (SIKIKA, 2014). While shortage of financial resource seems to have been the main challenge in the funding of MCH programmes in the period 20015-2015, it is during this same period that recorded quite a number of grand corrupt scandals compared to the former government phases (LRHC, 2016).

Severity of Grand Corruption in Tanzania, 2005-2015

When the former president Jakaya Kikwete was elected president of Tanzania, he was quick to declare corruption a number one enemy (Makoye, 2013). In his inaugural speech to parliament in 2005, he asserted that "we will accelerate the war on corruption in a more scientific way and by addressing its root causes" (PCCB, 2009:28). Unfortunately, however, Kikwete seem to have fought the lost war as corruption rose to unprecedented levels during his regime. All indicators show that corruption in Tanzania is on the rise showing dismal sign of slowing down. Table 1 extracted from International Perception Index from 2010-2015 shows the level of corruption for six consecutive years

Table 1. The Trend of Corruption in Tanzania from the International Perception Index

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

Source: Compiled from Transparent International Corruption Perception Index 2010, 2011, 2012, 2013, 2014, 2016.

Table 1 above reveals that Tanzania level of corruption has for 6 years been higher with record of three digits, i.e., 100-119 in which in the year 2014 it recorded the highest level as corrupt

country by occupying 119th position among 175 covered countries. Such findings resonate with the findings by Transparency International Kenya (2015) which proved that despite government initiative, corruption in Tanzania continued to increase. The study found that in 2012, 48% of respondents perceived corruption being higher and 40% attested that it is medium. In 2013, 68% respondents argued that corruption was higher and 17% attested that it was medium while in 2014, 68% labelled corruption to be higher and 18% said it was medium (Transparency International Kenya,2015). Moreover, according to the LHRC (2016), corruption in Tanzania has increased, particularly in the past 10 years where by the country has witnessed some high profile grand corruption scandals. Such deep seated corruption scandals that deserve more critical analysis have greatly affected the provision of public service notably being MCH service.

The series of grand corruption scandals in Tanzania started hardly a year when the former president Jakaya Kikwete assumed higher office in 2005. The government was hit hard by the External Payment Arrears Scandal (EPA) where a total amount of TZS. 133 billion was dubiously paid to local firms. Gray (2015) argues that at the heart of the scandal was Bank's commercial external debt account, set up to help service the balance of payments. Local importers could pay into the account in Tanzanian shillings and foreign companies could then be paid by the Bank of Tanzania in foreign currency. Rumors of corruption started circulating on the internet and, following pressure from development partners, the government through Controller and Auditor General (CAG) called for special audit in which Ernst and Young Firm was tasked to undertake the audit. Findings revealed that about TZS 133 billion had been wrongly and dubiously paid to some 22 local companies (Mtulya, 2015). The EPA scandal shook the nation and eroded the credibility of both the government and the Central Bank (Mtulya, 2015).

Misuse of public fund through grand corruption also circled the Bank of Tanzania and this time around the construction of Twin Tower made the headline. According to Cooksey (2011) the Bank of Tanzania Twin Tower was the biggest and most overpriced construction Tanzania has ever seen. The cost of the project increased from USD 37 million in 1997 to USD 70 million in 2000 and over USD 350 million on completion. The report states further that measured in USD/square foot the BOT project costs a multiple of high rise structures in Tokyo, New York or London. Taking inclusive New York cost of USD 2,000 per square meter the project should have cost no more that USD 80 million, a loss of more than USD 220 million. When the former Bank Director of personnel and administration Amatus Lyumba was charged for causing over TZS 221 billion loss to the government, he told the court that the decision was made by the Board of Directors and the Bank's Governor, not him (Tanzanian Affairs, 2010).

Richmond Corruption Scandal remains historic as, apart from scooping a huge amount of money it also destabilized Kikwete's regime. Mtulya (2015) eloquently analyzes how the scandal came into being. In 2006, as the nation faced serious power shortages due to drought the government invited investors to apply for the production and supply of over 100 megawatt. A US based Richmond LLC won the tender before it was realized that the whole process was marred with irregularities costing the country over TZS 172 billion. The parliamentary committee chaired by Dr Harrison Mwakyembe found out that Richmond was but a briefcase company. Consequently, in February 2008 Edward Lowasa resigned from his position as the Prime Minister. (Mtulya, 2015).

By the year 2013 through 2015 the country was again caught by the scandal that claimed the

country's TZS. 60 billion ($28million) through a controversial purchase of the defected and substandard wagon (The Guardian, 2015). Tanzania Railway Limited in 2013 signed two contracts with Indian company for purchasing 25 freight wagon and 274 passenger wagons. Soon after realizing that part of the passenger wagon that had been imported was substandard, the government formed a task force to probe the matter. Findings by the task force was really shocking. According to the former Minister of Transport Mr Samuel Sitta the task force realized, among others that there was irregularities in the procurement process, some wagon were found to be defective. Again, instead of paying for the wagon in installment as agreed in the contract, the supplier had already been paid the entire cash, TZS 60 billion (Masare, 2015). Though five top officials were suspended by the Minister stating clearly that what was done by all definition was nothing other than sabotage to the company and to the government (Daily News, 2015). Already the Kikwete regime had suffered through such grand corruption, since the money was paid and nowhere is mentioned that the money was remitted to the government.

Contrary to the PCCB's opinion that grand corruption is on the wane, in 2013 another historic grand corruptions surfaced and dubbed Tegeta Escrow Account (AfriMAP, 2016). The scandal started with the withdrawal of about $120 (approximately TZS 306 billion) from the Tegeta Escrow Account at the Bank of Tanzania (BoT) in 2013 by Pan-African Power Plant (PAP). This account was jointly opened by Tanzania Electric Supply Company (TANESCO) and Independent Power Tanzania Limited (IPTL), pending a tussle over capacity charges between the two in local and international courts (Mtulya, 2015). The reason behind the opening of the account was the dispute between TANESCO and IPTL over the capacity charge where it was said TANESCO was over paying IPTL so until the dispute was solved the money had to be kept in that account (AfriMAP, 2016). It was proven that the whole process of withdrawing such whooping amount was fraudulent despite the fact that the Attorney General had authorized. In fact there was high collusion of the senior government officials in the matter including Tanesco's Board of Directors, the Business Registrations and Licensing Agency (BRELA**)** and private banks (Policy Forum, 2014). Due to parliamentary and public pressure the Attorney General Fredrick Werema resigned while the cabinet Minister Anna Tibaijuka was dismissed after having been allegedly reported to have pocketed about TZS 1.4 billion and 1.6 billion (approximately $1 million) from a former shareholder of IPTL Mr James Lugemarila (AfriMAP, 2016).

Since grand corruption starts from $ 1 million that equals to TZS 2 billion and above, it is quite true that from 2005-2015 Tanzania has experienced a loss of exorbitant amount of money siphoned through this malpractice. The discussed scandals can be tabulated as follows

Table 2 Financial Resource routed through Grand Corruption

Year	**Kind of corruption**	**Amount of money lost (**TZS)
2006	External Payment Arrears (EPA)	133 billion
2007	Twin Tower at Bank of Tanzania (BoT)	221 billion
2008	Richmond	172 billion
2013	Purchase of defected wagon	60 billion
2014	Tegeta Escrow Account	306 billion
TOTAL		**892 billion**

Source: Compiled by the authors, 2016

Though it might be very hard to reliably establish the actual figure lost through grand corruption, the above table points a grim picture over the extent of grand corruption that has impacted the country from 2005-2015. The above data from Table (2) is in line with AfriMAP's (2016) revelation that grand corruption scandals which occurred between 2001 to 2008, have cost the country about USD 1 billion (TZS 1.6 trillion). It may be argued that if the lost amount through grand corruption were to be fully invested in the MCH policy programmes, maternal and child death could have not been as bad as it is now. Such a statement resonates quite well with the Rome Statutes which equated grand corruption as particularly odious offenses in that it constitute a serious attack on human dignity or grave humiliation or a degradation of human beings (Kiefer, 2009).

Grand Corruption[2] and the Failure to Lower Maternal and Child Mortality in Tanzania

Being regarded as bane to development with toxic consequence to socio-economic growth, grand corruption has not left health systems and MCH stable in Tanzania in particular. Its scale, susceptibility and effects of grand corruption on MCH are real. This is because through grand corruption government officials allocate more public funds on opportunities for private gain than on public welfare. It is no wonder that to date Tanzania has not managed to allocate 15% of the national budget on health expenditure as agreed during the Abuja Declaration[3]. The burden of this is felt more on maternal and child health, among others. This is to say, grand corruption has strong direct and indirect consequences on paralyzing and impairing good policies, strategies and programmes geared at reducing MCH problem. Specifically, grand corruption in Tanzania devours success of MCH programmes, policies and strategies in a number of ways.

Through increased grand corruption the country was turned into a breeding place of petty corruption that has compounded the problem of MCH. UNDP (2008) argues that petty corruption occurs when citizens interact with low to mid-level public officials in places like hospitals, schools, and other bureaucratic agencies. The UNDP report states further that the scale of monetary transaction in petty corruption is small and primarily impact individual and disproportionally the poor. This is true with those who seek MCH in public hospitals. A study by Kamuzora (2005) which covered 16 hospitals in 6 regions revealed that corruption was taking place at almost every stage in the service seeking process. According to Kamuzora, service areas which were ranked highly on the basis of the proportion of respondents are surgical threats (50%), laboratory (44%), x-ray (42%), medical record receptions (38%), labour wards (34%), consultation (31%) and maternity wards (31%). To prove that petty corruption is rampant in Tanzanian health system, Chilumba, (2013) quoted one respondent who stated that "if you don't have money to bribe a nurse or any medical staff, nobody will attend you. I spend 1 to 5 hours asking for a help in the hospital but I was never attended to because I had no money. In the reproductive and Child Health Department (RCH) in public hospitals the situation might be even so worse as pregnant mothers are even forced to buy clinic cards which are supposed to be given free of charge (Finlayson and Downe, 2013; Gross, *et al,* 2012). As for Kamuzora (2005), reasons given as to why health

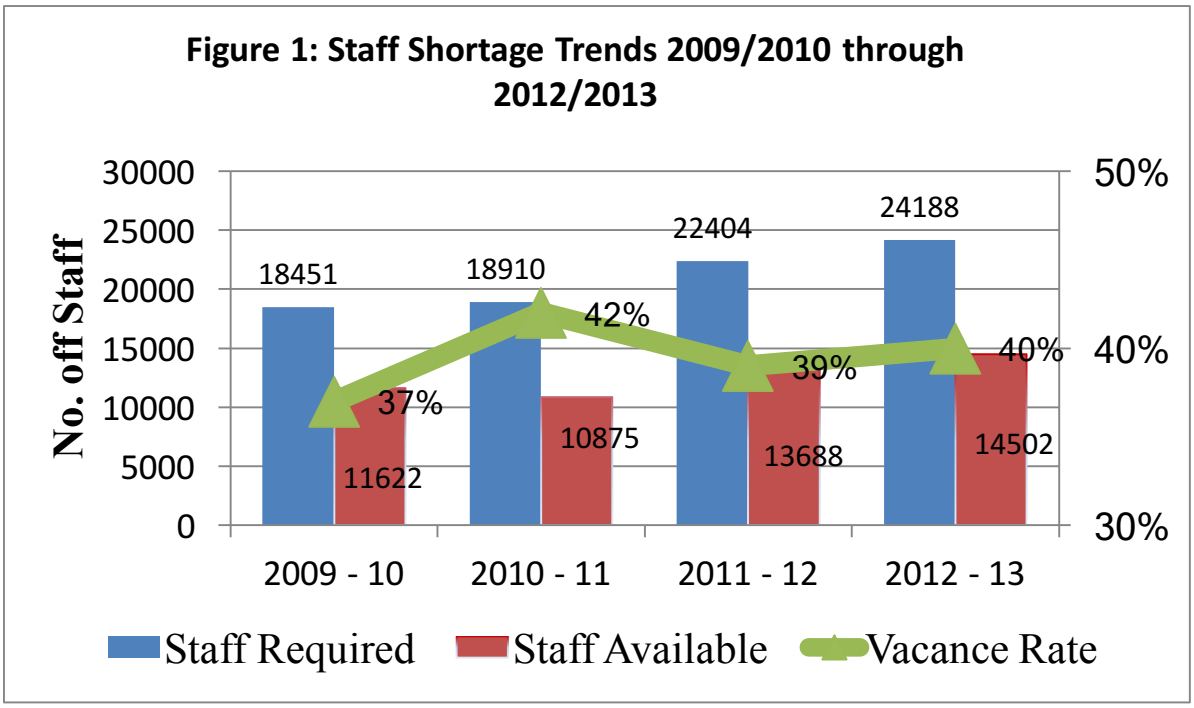
[2] Grand corruption as a vice usually checks the administration of our inherent humanity, by curtailing rights that flow wherefrom, has imprisoned, enslaved many people by condemning them to silence ignorance and ultimate death

[3] Abuja Declaration; Refers to the declaration by heads of African Union countries who met in April 2001 in Abuja Nigeria and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector.

workers indulge in taking bribes have close link with grand corruption at the higher level. The reasons mentioned include low salaries and inadequate incentives mentioned by (81%) of respondents, greed by health workers (34%) patients entice staff to accept bribery (24%) and perception by health workers of corruption as the norm (18%).

The ratio of health workers to population has a direct relationship with survival of women during childbirth and children in early infancy: as the number of health workers decline, survivals decline proportionally (Barnighausen, 2004). This is absolutely true taking the Tanzanian case. Indeed, the country is facing acute shortage of health personnel who could have saved mothers and children's life. According to the new staffing level guideline (2014) the minimum number of health workers required to provide quality health service in the 6,876 available health facilities is 145,454, the actual number of health workers available is 63,447 and shortage is 82,007 which is about 56.38% (URT, 2014). Moreover, according to Macian and Mwijarubi (2013), shortage of health workers was as follows; 2009-10 (37%), 2010-11 (42%), 2011-2012 (39%) and 2012-13 (40%) as figure 1 below reveals

Figure 1: Staff Shortage Trends 2009/2010 through 2012/2013



Source: Macian and Mwijarubi (2013)

The cause for the critical shortage of health personnel in health sector is well documented, (Siril, *et al,* 2014; Manzi, 2013), however, the problem of chronic underinvestment is worsened by among other things money being looted through grand corruption. As a result, the country faces fewer graduates in health sectors and the few available are poorly retained and so leave the sectors soon after graduation (Bryan *et al.,* 2010). For instance, by 2014 among 4812 health workers who were posted to their stations 1780 (47%) did not report; and 13% of those who reported left the stations (MoHS, 2014). In a study by Siril, *et al.,* (2014) it is well established how medical doctors are not fully integrated in the health system after graduation, Table 4 below clearly reveals the situation in Tanzania.

CrossRef DOI: http://dx.doi.org/10.15520/jassh301168

Table 4: Recruitment of Medical Doctors and Dental Surgeons for the recent past four years

year	Cadre	No of graduates	No joined internship	No permitted for retention	No (%) lost
2006	Medical Doctor	218	192	80 (2007/2008)	138(63.3%)
2007	Medical Doctor	310	311	265(2009-2010)	45(14.52%)
2008	Medical Doctor	330	273	190 (201/2011)	140 (42.52)
2009	Medical Doctor	408	424	249(2011-2012)	159 (38.9)

Source: Siril *et al.,* 2014

Table (4) above reveals clearly how the country has been deprived of well trained staff in the health sector. The country is really in shortage of staff; such that those few available are overworked as a result mothers and children under-five do not get adequate and quality health care. This was, for instance, vividly revealed at Amana Referral Hospital which has two labour wards and each is manned by 3 nurses' per shift instead of 6 because of manpower shortage and there are times when one doctor handles 12 operations in a shift (Barozi, 2016).

In order to provide quality health care and mostly the MCH, the budget allocated need to meet the set national and international standard. This has not been the case in Tanzania due to among other things, the problem of grand corruption. In 2001, Tanzania ratified the Abuja Declaration that obliged each country to set aside 15% of its total budget for health service provision (Semkwiji, 2012). Unfortunately, for over 10 years period 2006, to 2015 Tanzania health sector allocations have averaged only around 10.8% (Lee *et al,* 2015). Table 4 below analyzes the health budget trend for 6 years from 2010 to 2015.

Table 5: Trend of the allocated Budget to the health sector

Year	Budget (Billion shillings)	Total Health Expenditure as % of the national budget
2010/2011	1288.7	10%
2011/2012	1209.1	10%
2012/2013	1206.0	12%
2013/2014	1497.8	8.9%
2014/2015	1588.2	9.1%
2015/206	1821.0	11.3%

Source URT, 2014; Lee, *et al.,* 2015

From Table 5 above, it is realized that the government has for the past 6 years failed to reach the Abuja declaration target of 15% of its total estimated budget let alone the actual fund that reach the people at the grassroots. This, in turn, has had a far reaching impact to the health sector and particularly MCH in the country, among others, being inadequate supply of essential medicine and medical supplies in the health facilities. According to Sikika (2015), in the financial year 2012/2013 to 2013/2014, the budget of essential medicine and medical supplies went down by TZS 20.5 from 80.5 billion to TZS 64 billion. For the year 2014 to 2015 the budget went further down and reached TZS 45.8 billion making (28.4%) decrease. The 2015 Sikika report on the decrease of medical supplies is correctly reflected in the 2012 Sikika findings from the 54 surveyed hospitals across Tanzania that established clearly how medicine and medical supplies are insufficient. Result from the report revealed that from the health facilities in which the study were undertaken, a majority,

(94%) of hospitals reported being out of stock of one or more essential medicines. The specific items commonly out of stock were gloves (in 83% of the hospitals), sutures (48%) gauze (39%) for medical supplies and quinine (43%) and metrodazole (31%) for medicine (Sikika, 2013). The critical lack of essential medicine and medical supplies is constrained by slimming health budget affects the success of MCH programmes greatly (Save the Children, 2011). This state of affair could have been lessened if grand corruption with all its repercussion were to be fully addressed.

Health care delivery is highly labour intensive which demands highest service quality, efficiency, and equity. These qualities are directly mediated by workers' willingness to accomplish their task (Weldegebriel, *et al.,* 2016). This may be attained if financial and non-financial incentives like salaries, bonus, allowances, housing, work environment and recognition are predictably provided (Matheauer&Imhoff, 2006). In Tanzania, this is not the case (Munga and Mestad, 2009). As a result, health workers become unresponsive, inequitable, inefficient even unsafe (WHO, 2006). In the maternal and child health care this problem is mostly pervasive as can be evidenced through usage of distrustful and abusive treatment in the labor room (Mamdan&Bangster, 2004; Gerein *et al.,* 2006). In a study by Tibandebage, *et al.,* (2013) from four districts in Tanzania, it is confirmed that there is widespread experiences of rudeness and abuse. One director in one of the district is quoted in the study by Tibandebange *et al,* (2013) saying "you can't blame the nurses…At the moment we deliver 40-70 cases in 24 hours with only 3 nurses [per shift]. They will burn out" (Tibandebange, *et al,* 2013). Thus poor incentive to health workers in all its form result perhaps in retaliation by health workers to patients in labor room. Such mistreatment range from, but not limited to, physical abuse, verbal abuse, stigma and discrimination and poor rapport between women and health workers. Other forms of mistreatments include health systems conditions and constraints, as well as failure to meet professional standard (Bohren, *et al,* 2015). The amount lost through grand corruption if were to be invested to improve working condition of health workers then such mistreatment in the labor room by health workers would have been least experienced or not experienced at all.

There is agreement that provision of quality clinical services is essential if high rates of maternal death are to be reduced (Kinney, *et al.*, 2010). In a country like Tanzania which is characterized by underfunding in the health care due to grand corruption, quality care is unlikely to be awesomely high. As a result, once quality of services is perceived to be of low standard diminish the likelihood of seeking ANC and PNC service among the community (URT, 2007). This, in turn, leads to diminishing of trust to the health system due to bad experiences from public health systems (Silal, *et al.,* 2012). The phenomenon of 50% of all pregnant women who give birth at home being assisted by relatives, traditional birth attendants (TBAs), and themselves (NBS, 2011) might attest to this truth. Moreover, Corno, (2014) states that, of those who fall sick in Tanzania, 68% of them do not seek health care and only 27% choose formal health facilities such as hospitals, health centres and clinic. A study that was conducted in Kongwa district in Tanzania confirmed that unpleasant experiences with services discourage women from seeking services, discouraged potential users and affected the degree of compliance with referral (Mahiti, *et al.,* 2015). The study found further that in a situation where women perceived that good quality was only available for those who are able to pay bribes, their trust to a particular health facility diminished (Mahiti, *et al.,* ibd). This state of affair of existing distrust can be deepened to the whole social fabric of the community if remedies are not taken quite early.

Conclusion

While MCH service delivery relies heavily on effective allocation of financial resources, personnel in transparent manner; the existence of grand corruption halts such a possibility to highest level. This paper has established how grand corruption has undermined possible success of MCH policies, programmes and guidelines from 2005-2015. Specifically, grand corruption permeated the MCH policy programmes and strategies through infiltrating the increase of petty corruption which affects mostly the poor, and the critical shortage of health work force highly attributed to grand corruption. Above all, grand corruption has resulted into underfunding in the sector since the health budget has persistently dwindled. Diminishing motivation of the health workers caused mainly by inconsistence and inadequacy of financial and non-financial incentives has markedly affected the MCH sector which has seen people loosing trust on the MCH service provided. This is compounded by poor quality of MCH service which has a correlation with grand corruption in the country.

If left unchecked, grand corruption can reach a staggering scale and magnitude which reaches into every facet of life, into the highest level of government and taints nearly every industry and institution in the country (Fischer, 1995). Thus, measures to solve the atrocity are of urgency as Omwanza (n.d) puts it: "grand corruption as a vice that threatens our development, that accelerates our deaths; the sole cause of misery must be fought arduously, with all resources at our disposal". This paper offers three suggestions worth to be taken into consideration to solve the atrocity which is considered a crime to humanity.

As long as grand corruption is mostly spearheaded by personal greed (Bauhr&Nasitousi, 2011), a possible way to avert it is through instilling ethical behavior among public servants. It is anticipated that through ethics the blatant corrupt individuals will perhaps start feeling the pinch for millions of citizen around them who bears the consequence of their action in poverty, deprivation, burden of disease that leads into maternal and child death and, of course hopelessness. In a country which witnesses people amassing public wealth to a point of madness or some form of obsessive or compulsive psychiatric disorder, (BBC, 2009), it is evident that corrupt behaviour has permeated the whole social fabric of which a permanent solution can be attained through extoling ethical standards. Through cultivated ethical standards then words articulated by Dr Salim Ahmed Salim in his Keynote address *at the occasion of the Africa Vision Awards* may find the right avenue: "We need to live in a continent where corruption is loathed and effectively combated and not accommodated" (Salim, 2015:7).

In waging war against grand corruption, the anti-corruption agencies need to be more strong and powerful than those who indulge in corrupt practices. This is because grand corruption often entails powerful players who traverse the globe causing havoc wherever they go, and as such, local or domestic mechanisms may sometimes prove inadequate to respond to crimes of such a magnitude (Omwanza n.d). More often, the perpetrators of grand corruption may paralyze the system and at times can fix whistle blowers and make it difficult to trace them. In circumstances such as this, anti-corruption agencies need to command public respect, be credible, transparent and fearless. Pope and Vogl (2000) argue that the need to have strong and politically independent anti-corrupt agencies rest in the truth that some agency may be held to their political masters that they dare not to investigate even the most corrupt officials, they may lack power to prosecute and they may also be poorly staffed.

Grand corruption is so grave with its effects on human life and human dignity being so catastrophic as it results into large scale morbidity and mortality (Maharaj, 2014). Thus, its retaliation should be of equal force. Punitive laws need to be put in place and sharpened for the perpetrators who are found guilty to face the same consequences they have caused to innocent people. Appreciating this line of argument the president of Afghanistan Ashraf Ghan (2016) stated that even with improved planning, clearer rule and heightened oversight corruption will keep occurring until the likelihood of punishment reaches a level that makes perpetrators decide that it is no longer worth the risk. Indeed, if potentially corrupt people know they will get off with a light sentence, they are more likely to take the chance of committing corruption than if they know they will be sent to jail for a long time and of course their properties forfeited. Once harsh punishment will be imposed to the culprits, corrupt practices will recede.

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