

Sociological Enquiry about Perceived Corruption in Health Facilities in the Tamale Metropolis of Ghana

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ABSTRACT

Corruption and abuse of office are serious social cankers and are becoming daily affairs in most Ghanaian public health facilities. This paper focuses on health sector corruption and abuse of office in the public health facilities in Tamale Metropolis in Northern Region of Ghana. The paper seeks to contribute to the ongoing debate of alleged corruptions and diversion of patients by doctors and nurses to their private facilities. Corruption in health care tends to increase the social and economic burden of health care and scares away many poor and vulnerable people from accessing health care in the hospitals. It denies the poor access to health care and also compels people to resort to self-medication which is dangerous to their well being. Poor citizens travel from very far places after paying for high cost of transportation, are asked to pay more charges for drugs and services even though they may be on the National Health Insurance Scheme. This study was conducted in some selected public health facilities and communities in Tamale, the Northern Regional Capital. Data was gathered using interviews, focus group discussions and observations in these facilities. The paper identified that petty corruption is well grounded in most of the health facilities and most departments and persons working in the hospitals are engaged in various forms of corruption. The paper concludes that to effectively fight health service corruption and abuse of office by health workers, there must be a form of interplay of awareness, prevention, detection and sanctions of corrupt officials.

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I. INTRODUCTION

Corruption and abuse of office are taking various shapes and seems to be pervasive across many public institutions. This phenomenon is rather endemic in all governments' institutions (Nye, 1997), to the extent that CDD-Ghana (2007) claimed that no region, and hardly any country, has been immune from corruption. In the health sector, it is said to be pervasive, ranging from administrative or petty to grand (Hussmann, 2011). The former, according to Hussmann (2011), is a situation where public servants demand bribes before performing their public duties. Although considered by some policy makers as less serious, petty corruption affects the poor considerably and can undermine service delivery and has an especially detrimental impact on the poor. It also damages public morale and the legitimacy of the state (Hussmann, 2011).

According to Mary Robinson, former UN High Commissioner for Human Rights and also former President of the Republic of Ireland, it is also a human rights problem: "Corruption literally violates human rights, as people are denied the care that their governments are obligated to provide" (Global Corruption Report 2006, p. xiv)

Despite its perceived pervasiveness and iniquitousness, there is no generally accepted definition for corruption. This is because what constitutes an act of corruption differs from state to state and culture to culture (UN, 2001). However, the United Nations (UN) still defines corruption as: "An abuse of public power for private gain that hampers the public interest. This gain may be direct or indirect. In essence, corrupt practices involve public officials acting in the best interest of private concerns (their own or those of others) regardless of, or against, the public interest" (UN, 2001).

Transparency International (TI) defines corruption as "Behaviour on the part of officials in public sector, whether politicians or civil servants, in which they improperly and unlawfully enrich themselves, or those close to them by abuse of public power entrusted to them. This would include embezzlement of funds, theft of corporate or public property, as well as corrupt practices such as bribery, extortion or influence peddling".

The World Bank, on the other hand, defines corruption as that ("Corruption "behaviour on the part of officials in the public and private sectors in which they [public and private officials] improperly and unlawfully enrich themselves and/or those close to them, or induce others to do so, by misusing the position in which they are placed").

Corrupt practices have direct impact on the welfare of shareholders and society in general. The best approach to the debate on what constitutes corruption will be to consider it as what society thinks it is, at a particular point in time. In other words, we should be seeking “to clarify the essence of corruption by looking straight at reality without any particular local or traditional legal lenses” (Gyimah-Boadi, 2002).

Corruption is principally a governance issue – a failure of institutions and a lack of capacity to manage society by means of a framework of social, judicial, political and economic checks and balances. When these formal and informal systems break down, it becomes difficult to implement and enforce laws and policies that ensure accountability and transparency. From an institutional perspective, corruption arises when public officials have wide authority, little accountability and perverse incentive, or when their accountability responds to informal rather than formal forms of regulation (UNDP, 2004).

Though debatable, inadequate public-sector wage/remuneration is also considered as one of the factors that contributes to the high rate of corruption in the public sector in Africa. In Ghana, 80 percent of public officials regard low salaries as the leading cause of corruption, in addition to a culture of gift giving, absence of positive incentives, weak corruption reporting systems and poor internal management practices (The Ghana Governance and Corruption Survey Report, 2007).

Despite its universal prevalence, corruption has proven to be harmful to the developing world, in general and Africa, in particular. As observed by former UN Secretary-General, Kofi Annan at the UN General Assembly Convention against Corruption in 2008, “Corruption hurts the poor disproportionately by diverting funds intended for development, undermining a government’s ability to provide basic services, feeding inequality and injustice, and discouraging foreign investment and aid.” The Economic Commission for Africa (2010) has also observed that corruption in Africa has resulted in the diversion of scarce state resources for wasteful or inefficient purposes; widespread unemployment; inequitable distribution of wealth; the corrosion of societal morality as well as private sector corruption in the form of money laundering and tax evasion. End with the research gap this study seeks to address.

1.2 The Problem: Corruption in the Health Sector

Corruption surveys in recent times point to a significant deterioration in citizens’ perceptions of corruption in Ghana. The overall trends point to the negative direction, because corruption has become endemic across all levels of government institutions and petty corruption has worsened particularly for citizens seeking to access public goods and services (UNDP, 2011). Public perceptions also reflect a growing awareness of, and concern about, corruption in the health sector.

It is observed that, in the health facilities, clients/patients frequently complained of corruption, in the form of unauthorised, illegal and unproved charges being handed down to them by health workers in health facilities. This makes accessing and utilization of medical services out of reach of many poor people. While this canker is raging on, authorities seem to be tight-lipped or simply not taking serious actions and always sweep complaints under the carpet. It is not clear whether they are aware of this corrupt practice or are net beneficiaries of this.

The paper provides an insight into the basis for various forms of corruption and how they manifest in health facilities in the Tamale Metropolis of Northern Region of Ghana for a clear understanding of the phenomena and its implication on accessing health care in the hospitals, and also how it compels people to resort to dangerous self-medication. Others are denied treatment for non-payment of these exorbitant fees. In some instances, poor citizens travel from very far places after paying for high cost of transportation, are asked to pay more charges for drugs and services even though they may be on the National Health Insurance Scheme.

Objectives of the Paper

The overall objective of this paper is to investigate acts of corruption and abuse of office by health workers in Tamale Metropolis and how these practices could be mitigated in the health facilities.

The specific objectives of the paper are as follows:

- i. To determine the magnitude of and perception about corruption in the health facilities;
- ii. To examine the nature and forms of these corrupt practices;
- iii. To determine how corruption manifests in the health facilities;
- iv. To establish the extent of these corrupt practices in the health facilities; and
- v. To identify individual(s), groups of people and departments involved in these practices. (and)

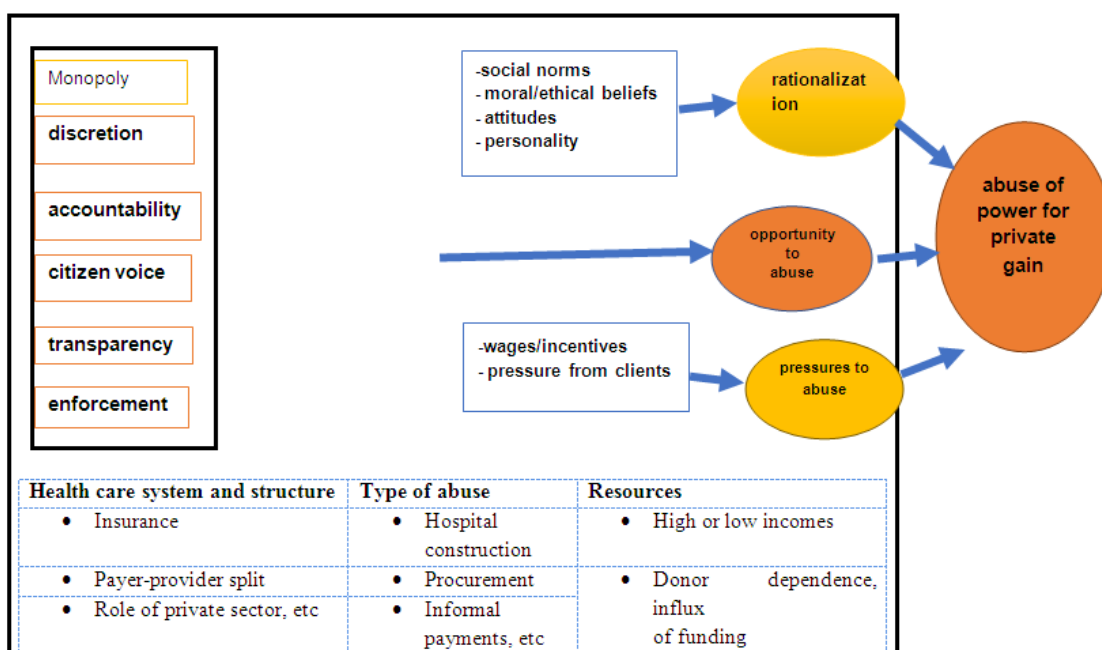
Framework to Understand and Fight Corruption in the Health Facilities

Corruption as public health issue that will neither disappear by itself, nor can it be ignored. Health advisors should recognize that it is possible to confront corruption by changing the conditions that allow it to happen and support it. Efforts to tackle corruption need to translate the main principles of good governance

(information, transparency, integrity, accountability, participation) into action. It is particularly important to close opportunities for corruption by creating mechanisms for transparency and ensuring accountability for results. However, reducing opportunities for corruption is not sufficient: it also necessary to increase the likelihood of detection and appropriate enforceable sanctions when corruption occurs, be they of administrative, criminal or social nature.

In order to design strategies to prevent or control corruption, it is important to understand the factors that explain the patterns of corrupt practices. Figure 1 presents a conceptual framework of corruption in the health sector. People generally cross the line between honest and corrupt behaviour when they have an opportunity to misuse their power and when they feel pressured to do so. They then devise rationalizations to justify their behaviour.

Opportunities for corruption are greater in situations where the government agent has monopoly powers (e.g. the only provider of health services); where officials have discretion without adequate control of this decision-making authority; where there is not enough accountability for decisions or results (including measurement of results and punishment for non-performance or corruption); where transparency (active disclosure of and access to information) is lacking and citizen voice (means for active participation) does not allow for external control; and where abuse or corruption is not detected or punished (enforcement). Individual beliefs, attitudes and social value systems influence corruption and provide the basis for how those engaged in corrupt practices rationalize or justify their behaviour. Finally, government agents may feel pressured to engage in corruption. These pressures can be political, financial or social.



Source: Vian (2008)

Figure 1: Framework to understand and Fight Corruption in the Health Facilities

II. METHODOLOGY AND APPROACH

The study was conducted in the Tamale Metropolis of Northern Region, Ghana involving household/community, patients, facility and institution levels surveys. The communities covered were seven. They are: i). Tisugu, ii). Dagbandaba Fong, iii). Zogbeili, iv). Lamashegu, v) Dohinayili, vi) Changli, viii) Dabopka, and vii) The health facilities covered included three major health facilities in Tamale. These are: Tamale Teaching Hospital (TTH), Tamale Central Hospital and The Tamale West Hospital. It also covered both patients at OPD and those on admissions including women in the maternity wards. Finally, the institutions covered were the National Health Insurance offices at the regional and Tamale Metropolis and Ghana Health Service staff.

Categories of Respondents and Sampling Techniques

The target population were household respondents drawn from the seven communities that were randomly selected out of 21 communities in Tamale. In each community, at least 30 households were further selected at random. In each household, one respondent of at least 18 years, and who had attended any of the

above mentioned health facilities in the last 12 months was selected for the survey. In all, 230 household respondents participated in the survey(what was the period of survey).

At the facility level, the initial aim was to interview a representative percentage of all categories of health workers. However, most of the health workers declined to respond to the questions. All attempt to interview doctors and pharmacists failed. However, nurses, record keepers, ICT, technicians were ready to respond to our questions. In all, 25 health workers participated in the survey. These were 10 respondents from Tamale West Hospital (TWH), eight from Tamale Central Hospital (TCH) and seven from Tamale Teaching Hospital (TTH).

Convenient sampling was used to select and interview patients at OPD and in the wards. This covered only patients who were willing and ready to participate in the survey. In all, 128 patients participated in the survey; TWH 34, TCH, 41 and TTH 53. Finally, the National Health Insurance Scheme (NHIS) and Ghana Health Service (GHS) were picked purposively. They were the only health-related institutions in the survey area. Seven staff; four from NHI and three from GHS participated in the survey.

Table 1: Category and Number of Respondents

Category	Number
Household/community level	230
Health workers	25
Patients/care takers	128
NHIS and GHS	7
Total	300

Data Collection Techniques

Face-to-Face Interviews

A semi-structured questionnaire with mostly closed-ended questions were used to carry out face-to-face interviews with key stakeholders such as the health workers and clients at OPD, wards, theatre, pharmacies, and other departments. This was to determine whether patients had been charged unapproved fees or not and to get their perception about corruption in the health facilities. The details of what circumstances they paid such monies/gave such favours were ascertained. This technique also helped to get detailed information about whether or not some clients were being referred to doctors and nurses' private facilities for further examination and treatment or to their pharmacies and drug store to buy drugs.

Questionnaire

At the community level, copies of a questionnaire were administered to household respondents. In most instances, especially where the respondent could not read or write, the questionnaire was used as interview guide.

Receipts Analysis

The research team, consisting of the researcher and the enumerators also examined receipts given to clients for payment of services, drugs and materials they bought to assist the team determine their authenticity or otherwise. The values of the receipts were examined and weighed against the amount of money clients paid and further questions and clarifications made from both the patient and the service provider. This technique enabled us determine the genuineness of the receipts and authenticated the sources and reasons behind their issuance.

Direct Observation

Direct observation involves seeing and recording what was spontaneously happening at the time of collecting data. This approach is commonly used by sociologists and anthropologists when undertaking attitudinal and community surveys. This method was an important technique for collecting data when the information on sensitive issues and where a high degree of reliability and accuracy was desired. Thus, observations were made at OPD, wards, theatre, pharmacies, consulting rooms, and all other departments. It was used to gather information about jumping of queues, receipts or no receipts for payment made, the location of private facilities such as clinics and pharmacies patients were referred to and items bought at the maternity wards to assist delivery.

Data Analysis

The data collected comprised of both qualitative and quantitative. An expert was engaged to use SPSS and Microsoft Excel to analyse the quantitative data. The qualitative data were analysed by establishing patterns and identifying common themes and issues developed and provided detailed descriptions. Perspectives on the various themes and issues were compared and contrasted. These themes and perspectives were also compared

and contrasted with findings from other respondents. This comparison produced a number of consistent, logical findings that were carried forward to formulate recommendations.

III. FINDINGS AND DISCUSSIONS

Demographic Profile of Respondents

The study involved seven communities and 230 household respondents. Eighty of the respondents, constituting 34.8% were male while 65.2% or 150 were female. Apart from Dagbandaba-Fong where equal number of male and female were involved, more females than males were involved in the rest of the communities, thus more females than males were involved in the survey.

Table 2: Community level Respondents

Name of community	Respondents			
	Frequency	Percent	Male	Female
Changli	30	13.0	11	19
Dabokpa	30	13.0	8	22
Dohinayili	30	13.0	9	21
Lamashegu	30	13.0	8	22
Zogbeli	40	17.4	11	29
Tisugu	34	14.8	15	19
Dagbandaba-Fong	36	15.7	18	18
Total	230	100	80	150

Source:

In addition to the above mentioned, 128 patients/care givers were interviewed at the various health facilities. Out of this figure, 104 (81%) were female and 19% male. Furthermore, 76 or 59.3% were those on admission, while 40.6% were OPD attendants. This implies that, more females than males attend hospital. Perhaps, because women are care givers, they are those who send their children to hospital.

With regard to the health workers, the survey covered 25 as follows: eight nurses of all categories, four records staff, three pharmacy technicians, three Information Technology and Communication(ITC), two morgue attendants, two laboratory technicians and three cleaners/casual workers.

The Magnitude and Perception about Corruption in the Health Facilities

The health facilities are widely perceived to engage in practices that have corrupt undertones. The survey reports that clients/patients generally held the view that most health workers are corrupt. The survey at the community level covered 230 respondents, and out of this figure, 223, or 97% attended the three health facilities in the last 12 months. The respondents claimed that corrupt practices are endemic in the health facilities. This view was corroborated by those interviewed at these health facilities. Out of 128 patients/care givers interviewed, 89(59.3%)claimed that there are corrupt practices in the health facilities. The survey further found that 10.4% of the respondents claimed they have ever paid money to influence health workers before.

The survey found that corruption in the health facilities is a reflection of the structural challenges also administrative and supervisory weaknesses as indicated by 65% of the health workers. Furthermore,58% of the health workers and 78% of the patients and 69% of the community respondents also mentioned respectively claimed that corruption in health sector is as a result of weak or ineffective rules and regulations, as well as lack of accountability, low salaries, low doctor/nurses ratio, (i.e., more demand than supply).

Thus, the magnitude of corruption identified ranges from ‘petty’, ‘serious’ to ‘grand’ corruption. It is the petty corruption that is widely practiced at almost all the departments at the health facilities. Detailed examples of these scales of corruption are given in the next section.

The Nature and Forms of Corrupt Practices

If corruption is defined as “abuse of public or entrusted power for private gain”, then corruption in the public sector occurs when a government agent who has been given authority to carry out public service goals instead uses his or her position to achieve personal interests. The types of corruption or abuse of power which were identified and most prevalent in the health sector include the following:

The survey found various types of corruption and abuse of office as mentioned by all categories of respondents. These include: Informal or unreceipted payments between health workers and patients, paying bribes to get health service, absenteeism and lateness, bribes and kickbacks especially in NHIS claims.

Magnitude/ scale of corruption	Examples or instances are:
1. Petty corruption	<ul style="list-style-type: none"> i. Jumping queues with the help of health workers; ii. Turning of folders in favour of some patients; iii. Collecting money and releasing corpses at the morgue iv. Selling of soap and detergents v. Collecting soap and detergents from women in labour
2. Serious corruption	<ul style="list-style-type: none"> i. Informal or unreceipted payments between health workers and patients, ii. Giving less quantity of drugs; iii. Giving money or materials to nurses to motivate them attend to patients on admission; iv. Selling drugs and herbal mixtures to patients; v. Theft of medicines or other property, vi. Directing patients to private facilities for medical care, laboratory test, scanning, buying of drugs, etc;
3. Grand corruption	<ul style="list-style-type: none"> i. Procurement fraud, ii. Fraud (including insurance fraud, “ghost” patients, etc.), iii. Embezzlement of user fees iv. Mixing water with detergents for cleaning of floors and equipment.

The survey found that, the first and second magnitude/scale of corruption(i.e., the petty and the serious corruptions) are usually perpetrated by individual health workers or sometimes in connivance with other colleagues. The third level (grand corruption) is often done by two or more parties or groups of people in authority.

How Does Corruption Manifest in the Health Facilities?

With regards to how corruption manifests in the health facilities, the study found that 85% of the community respondents, and 56% of the patients respectively mentioned that some health workers do take money and gifts to support patients to get folders on time. Similarly, 35% of the health workers confirmed that these do happen.

In the consulting rooms, corruption manifests in the form of nurses turning folders or rearranging them to favour friends, relatives and bribe givers to be served first. In the survey, 75.4% of the respondents at the community and 68% of the patients indicated this as a practice by some of the nurses. However, only 13% of the health workers agreed to this claim.

Another manifestation of corruption is the situation where health workers encourage, refer or redirect patients to their private facilities for medical treatment, laboratory test or scanning. The majority (87.6%) of the respondents claim this happens often. Fifteen private places were frequently cited, but anonymity is assured to protect them.

The survey further found that, even morgue attendants sometimes deliberately post impediments on their way to collect corpses of their dead relatives and love ones. More than quarter of the (38.3%) claimed that they had ever paid money or witnessed people given money to morgue attendants to release their dead relatives. “One of the interviewee at TTH in an interview stated:

The following should be italics

“We Muslims do not keep our dead people for long. We always want to burry as a soon as possible. However, the bureaucratic bottlenecks in the hospital are too much for a bereaved family to go through. Sometime we arrange with the morgue attendants to release the body to us. In some cases, the morgue attendants will openly ask for money before bodies are given out” (Mr. Johnson).

Four of the health workers confirmed that they have also heard such allegations. However, 45% of the patients also claimed morgue attendants do collect money form bereaved families.

It is frequently alleged that health workers do sell drugs, herbal mixtures and other consumables such as bandages, cotton, syringes, plasters, etc, to patients. Some health workers carry these items in their bags or in their cars, especially, food supplements and virtually force or convenience patients to buy them. The survey found that 69.5% of the community- level respondents as well as 70% of those interviewed at the hospital confirmed this. Forty-eight(48%)percent of the health workers also believed that health workers do sell drugs to patients.

The survey further found that in many (state %age)instances, services and goods are sold to patients without receipts. Almost sixty-four percent (63.9%) of the community -level respondents and 45.4% of the patients respectively indicated that they have been confronted this situation many times. The respondents mentioned instances such as buying of drugs, provision of scanning services, laboratory testing and even antenatal services are sometimes charged without receipts being issued to patients/clients.

Closely linked to under-received payments are situations where receipts are given but less than the value of the amount paid. Over a quarter of the respondents (26.5%) at the community level claimed, while 37.3% of the patients confirmed that. However, 89% of the health workers denied this.

About a quarter (25.7%) of the respondents also claimed that, patients on admission sometimes bribe nurses with money, gifts and other incentives to get their attention to attend to them. This assertion was corroborated by 65.8% of the patients. One of the women at TTH stated that:

“You will have to call them several times and they respond retractably. However, when you make friends with them, by giving them something, they will take good care of your patient”(Madam Sarah)

Another form of corruption and abuse of office is the situation where health providers, especially doctors and nurses, refer patients to their private clinics and laboratories or their relatives and friends for treatment at a fee. The survey found that 35.7% of the community respondents and 78% of the patients claimed this happens often. Almost all the health workers acknowledged that some health workers owned hospitals, clinics, pharmacies, laboratories, etc, in the Metropolis and they suspect they can re-direct clients/patients to these private facilities. Again, one of the respondents at TTH claimed that,

“The frequent breakdown of scanning machines and laboratory machines is due to sabotage. Sometimes it is done deliberately to divert patients to private ones for services. Why is that the private laboratories and scanners do not frequently breakdown” he rhetorically asked? (Mr. Fatwa)

The Extent of Corrupt Practices in the Health Facilities

The majority (75%) of the community -level respondents and 89% of those interviewed at the facilities were of the view that corrupt practices are daily affairs in the health facilities. The study further found that hospital supplies such as detergents are adulterated with water as claimed by 12% of the health workers.

Individual(s), Groups of People and Departments Involved in these Corrupt Practices

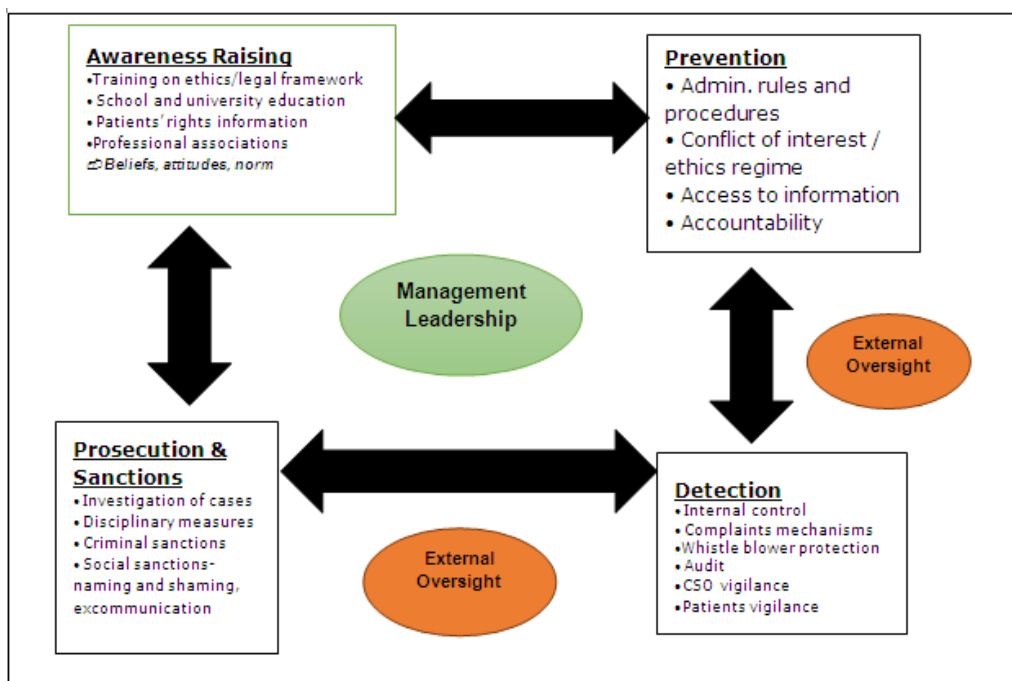
Respondents declined to specifically mention names of health workers who collected bribes from them. However, the survey found that the following departments were frequently mentioned in order of (importance) ranking as the most corrupt (departments):

- i. Maternity/Labour ward 38%
- ii.
- iii. OPD/Consulting rooms 21%
- iv. Male, Female and Children wards 20%
- v. Intensive Care Unit (ICU) 8%
- vi. Theatre 3%
- vii. Pharmacy 3%
- viii. Morgue 2%
- ix. Others such as emergency, blood, scanning unit, etc 5%

Additionally, almost all the patients interviewed at the various health facilities claimed all the departments are corrupt. They also mentioned some of the conduct of the health workers which are worrying to them. These include shouting at patients, ignoring their complaints and snubbing.

Strategies to Fight Health Service Corruption

To effectively fight health service corruption and abuse of office by health workers, there must be a form of interplay of awareness, prevention, detection and sanctions of corrupt officials.



Source: UNDP (2011) with author modification

Figure 2: Strategies to Fight Health Service Corruption

It is important to focus on prevention which is key in fighting corruption. However, credible control systems and enforceable sanctions, including regular and thorough audits, internal and external complaints handling mechanisms must be put in place. Civil Society Organizations' interventions should also look at levers that help impact on grand corruption, e.g. that will help deter senior health officials from embezzling larger sums of money and also given contract to people in anticipation of kickbacks. These include (leads to) adulteration of large quantity of detergents with water (These levers include), monitoring of assets, interests and life-styles of key senior health sector officials and scrutiny of the acquisition and movement of assets by such figures. It may involve asset declarations, scrutiny of contracts and procurements etc.

Corruption prevention and control also require authentic political commitment, sufficient knowledge of the health sector, and resources to implement strategies and interventions. It also requires patients' vigilance, education and awareness creations. The following specific measures could be taken to fight corruption and abuse of office:

- i. Effective public education or awareness creation is necessary to inform unsuspecting clients from becoming victims.
- ii. Naming and shaming of health workers by authority and the general public can also help mitigate the situation.
- iii. In worst-case scenario, dismissal of those found to engage in corrupt practices can be detrimental to others.
- iv. Suggestion boxes should be introduced and taken seriously by authorities. They should be open at management meetings and culprits should be made to answer queries.
- v. Introduce numbering system for patients to follow on first come first serve basis to avoid jumping of queues
- vi. One point of payment for all services should be encouraged or a number of effective well-coordinated payment service system should be put in place.
- vii. Advocacy by CSO can help mitigate the situation.
- viii. Excess materials bought by women in labour and not used should be returned to them.

IV. CONCLUSIONS

Perceived corruption and other unprofessional practices are widely held views of the general populace and patients within Tamale Metropolis. They are daily affairs in the public hospitals. These affect quality health service delivery, increase medical expenditure, frustrate some patients, leading to loss of confidence in the health system, and in some instances denial of health care to clients. It reduces access to care; undermines equity in access; and also increases financial burden on patients.

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