

# Effects of Corruption on Health Care Processes and Outcomes in Nigeria

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**DOI: 10.36108/NJSA/3102/11(0130)**

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## **Abstract**

*Corruption remains the most pervasive social problem in Nigeria. In this paper corruption is viewed as the root cause of non-improvement in the health status of Nigerians produced by comparative failures of huge public health expenditures to achieve the objective of reducing epidemic diseases with the attendant high mortalities. The gap between public health investment and public health outcome is largely accounted for by wasteful public health expenditure which is corruption. Merton's Structural Functionalist Theory of Anomie is used to analyze health policy and legislation, health procurement, availability and access of health care, budgetary appropriation and release in relations to overall health dysfunctions. The paper concludes that the prevailing high level of corruption in health care processes of Nigeria is a function of decades of moral laxity and weak social structures, and it is only a strong political leadership backed by adequate legal and political structures that will halt the impunity of public corrupt practices and catalyze significant improvement in health outcomes.*

**Keywords:** mortality, health status, corruption, fraud, development

## **Introduction**

Corruption remains the most endemic social problem in Nigeria. It is acknowledged by Yakubu (2005) in a succinct review of reports of past anti-corruption committees, panels and workshops to be the major cause of poor public service delivery, fraud, general social laxity and indiscipline in the society. In the past two decades, especially from the annulment of June 12, 1993 election, it is widely noted that the level and dimension of corruption have increased in both public and private life of the people especially among the class of bureaucrats, professionals and politicians. These manifest in all spheres especially with collapse of the financial sector not directly related to the global economic recession of the 2005-2010, scandals in handling public contracts and procurement, embarrassing disappearance, embezzlement and diversion of government money, diversion of public property for private use, money laundering, and the notoriety of financial fraud and slashing of billions of public money into foreign accounts.

In 2012 alone, the Honourable Farouk Lawan's \$620 million bribery scam and the ₦32.8 billion Police Pension Fraud are worth more than some state governments' annual revenue (Leadership Newspaper, 2012). Given the magnitude of corruption in Nigeria, the task of controlling it should be the responsibility of everyone. According to Afrobarometer (2005) and the Transparency International reports, all institutions of government are infected, producing low public confidence in democratic governance. From the Nigerian Corruption Index for 2007 the Police, legislators, and the judicial officers were found to be most corrupt (UNDP 2009). Combating corruption therefore demands strategic planning and focused attention rather than grand public programmes. This made President Olusegun Obasanjo to establish both the Independent Corrupt Practices Commission (ICPC) in 2000 and the Economic Fraud and Crime Commission (EFCC) in 2004 and with the aim of strengthening the 1999 Constitution in the fight against corruption in Nigeria (Omotoso, 2008).

Health sector constitutes three out of the seven Millennium Development Goals (MDGs) to be achieved in 2015 and according to Nigeria Millennium Development Goals Report of 2010, Nigeria has not significantly attained most of the health targets. Other related goals that are equally critical to healthy living are also trailing far behind the health goals. Nigeria has one of the worst health indexes, and this has persisted notwithstanding the huge international fund injected into the sector and the billions of naira either budgeted or spent by various governments. According to Hadi (2007: 1):

*Over 50,000 Nigerian women die from child birth every year (equivalent to a plane carrying 140 people crashing every single day). Nigeria accounts for 10% of the world's maternal deaths in child birth whereas the country represents 2% of the world's population. One in five Nigerian children dies before his/her 5th birthday. About a million Nigerian children die of preventable causes every year. Only 18% of Nigerian children are fully immunized by their first birthday. Malaria kills more Nigerians than any other disease, and yet less than 5% of its population have access to insecticide treated nets proven to be effective in preventing malaria.*

The major reason for this dismal health sector performance is corruption. Since both governments and the people have a natural responsibility to maintain health or improve it at individual, group and societal levels, any deviation from this responsibility is unacceptable. The effect is enormous and the burden falls disproportionately on the poor, with children, women, rural dwellers and other vulnerable groups disproportionately bearing the burden of corruption in the health sector which is partly responsible for Nigeria's high mortality rates ([www.unicef.org/infobycountry/nigeria](http://www.unicef.org/infobycountry/nigeria), 2012).

This paper is founded upon the premise that the most important social structures in any modern society like Nigeria are health, education and security. It is when corruption in these sectors is eliminated or reduced through evidence-based policy framework and public programmes that social progress will be accelerated in the areas of manpower resources, food security, national economy and the international integrity of the nation. This paper therefore has the following specific objectives: analyze corruption with reference to the health care delivery system of the nation; describe the effects of corrupt tendencies and practices in the health care delivery system; attempt a net balance of the returns of anti-corruption programmes on health outcomes of the people and to recommend more workable state-specific actions that will block corrupt tendencies and practices in the health. For the purpose of delineating the scope of this paper, the concepts of corruption, health care, health process, and health outcomes in the context of Nigeria are briefly discussed.

Corruption is defined by Transparency International as the misuse of entrusted power for private gain (Bardham, 1997). In practice corruption occurs when public officials who have been given the authority to carry out goals which further the public good, instead, use their position and power to enrich themselves and those close to them. Given this definition, Nigeria was rated by Transparency International (TI) 2012, as one of the most corrupt nations in the world, placing 139<sup>th</sup> out of 176 nations. While it is agreed there is corruption in virtually all nations, the nature, dimension and impact of corruption vary from country to country. According to Olaleye (2008), corruption is a global menace and not peculiar to Nigeria.

Explaining the phenomenon of corruption in Nigeria, Yakubu (2005) described the menace as an inducement by means of an improper consideration to violate some duty. He also identified corrupt manifestations as including fraud, gratification, and use of office for pecuniary advantage, influence peddling, underserved pay, tardiness and slovenliness. The flux in the specific definition of corruption globally is reflected in the no-specific definition of corruption in the United Nations Convention against Corruption (2005). But, in the African Union (AU)'s Convention on prevention and combating corruption which was adopted in 2003 and enforced in 2006, corruption "means the acts and practices including related offences proscribed in this convention" and the scope of application includes nine offences:

- a. the solicitation or acceptance, directly or indirectly, by a public official or any other person....in exchange for any act or omission in the performance of his or her public functions;
- b. the offering or granting, directly or indirectly,...in exchange for any act or omission in the performance of his or her public functions;
- c. any act or omission in the exchange of his or her duties...for the purpose of illicitly obtaining benefits for himself or for a third party;
- d. the diversion by a public official or public official...of any property belonging to the state or its agencies...such official has received by virtue of his or her position;

- e. the offering or giving, promising, solicitation or acceptance, directly or indirectly, of any undue advantage or by any person who directly or works for...or refrain from acting, in breach of his or her duties;
- f. the offering, giving, solicitation or acceptance directly or indirectly, or promising of any undue advantage to or by any person who asserts or confirms that he or she is able to exert any improper influence over the decision making of any person performing functions in the public or private sectors....;
- g. illicit enrichment;
- h. the use of concealment of proceeds derived from any of the acts referred to in this Article; and
- i. participation as a principal, co-principal, agent, instigator, accomplice or accessory after the fact ...(pages 7-10)

This definition is all encompassing and Nigeria ratified it on 29th December 2006. By 2009 ICPC self-assessed itself and affirmed progress because, “In 2008 Transparency International’s Corruption Perception Index (TI CPI), Nigeria scored 2.7 (on a scale of 0-10 with 0 being very corrupt and 10 being very clean). With that Nigeria place 121 out of 180 countries covered by the index in 2008. In comparison in 2005 Nigeria scored 1.9 and was placed 152 out of 159 countries covered.” Again notwithstanding the reduced CPI ranking, which implies a slow improvement in anti-corruption perception, Nigeria still remains one of the most corrupt nations after Somalia and North Korea (Transparency International CPI, 2012).

Human Rights Watch (2007) also showed that Nigeria lost about USD380 billion out of total revenue of USD500 billion accrued from 1960 and 1999 (UNDP, 2009). This is about 76 percent loss of revenue in four decades. It was also emphasized that corruption is related to wasteful public investment, lower government revenues, and lower quality of public infrastructure. Corruption has underdeveloped Nigeria. In more specific terms corruption has limited the growth potentials of the country and more importantly, initiatives against poverty and inequality. While agreeing that there is a reduced trend of corruption, according to this UNDP report, 1996-2004 corresponded to a period of marginal improvement in the control of corruption and also to a rise in the GDP and reduction in poverty.

In this paper, health care system refers to the whole structure and dynamics of federal government’s coordinated policy, legislation and finance of all tiers which direct people’s behaviors, public and private sector’s actions to improve health status of individuals, groups of people and the nation at large. The health process includes all issues and actions among individuals, group of individuals and governments having responsibilities to promote good health, reduce deaths, prevent diseases and cure ill-health of the people. This will start with public policies framework and related activities, service delivery, and personnel dispositions. Health outcome is the result expected at the individual, family and community levels in both private and public lives due to the

application of strategic public policy, programs and other related interventions. Specifically, health outcomes include measurable indicators such as reduced mortality rates, reduced disease prevalence rates and overall improved life expectancy at births. These and other indicators measure the positive results of composite health inputs like finance, health manpower, health infrastructure and facilities. Generally profile of good availability and access to health care of a nation produce positive health outcomes for the people.

### **Theoretical Framework of Health Corruption**

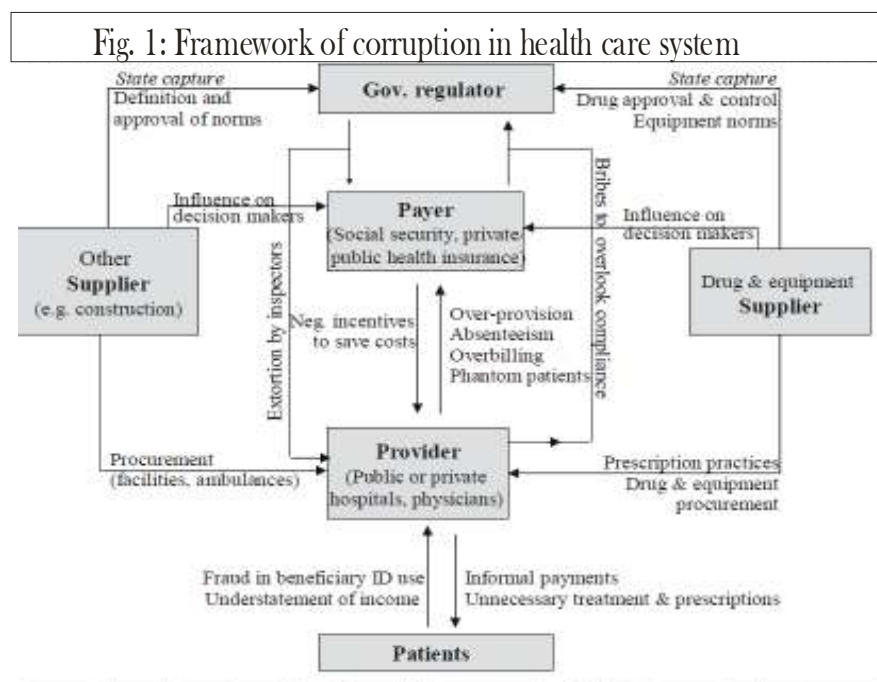
While classical Marxism condemned emerging capitalist nations of the 18<sup>th</sup> Century Europe as corruption of the social order, Max Weber idealized capitalism notwithstanding the obvious weaknesses of its social and political structures. R.K. Merton did his sociology learning from these two orientations by exploring their weak points. But Merton was directly influenced by Talcot Parson's maiden works in the American structural functionalism (Ray, 2008). The structural functionalist theory of Merton guides this paper because the model was developed at an epoch (1930s-1960s) that served as the slow transition from modern to "postmodern" society in America.

Nigeria seems to be in the nascent stage of this socio-political development. Scrambler (2002) identified major characteristics of the latter to postmodernist society to include: material identities replacing class positions, consumerism replacing production forces, decentralization, fundamentalism, cultural glocalisation and unitication, expiration of universal reason, intellectual interpretation rather than legislation, and decentering of intellectual authority. Ritzer (1988) identified the greatest strength of Merton's structural functionalism as: his emphasis on the use of empirical evidence rather than theoretical assertion in functional analysis, and the focus on structural analysis rather than individual motives (Ritzer, 1988). Further explanation was provided by Giddens' view (1993) that dysfunctions refer to aspects of social activity which tend to produce change because they threaten social cohesion, that is, 'features of social life which challenges the existing order of things.' This study focuses on the aspects of corrupt practices which threaten the optimum health care delivery and by implication or consequence produce poor health for the people.

There are also the concepts of *nonfunction* which means that a particular consequence of a structure could be irrelevant to other structures. In the final analysis, there is the et analysis or net balance which is the synthesis or conclusion of dysfunction, *eufunction* and *nonfunction*. Unlike the grand analysis of other functionalists, Merton focused on the application of his analysis to organization, institution and group and he equally put forward the use of levels of analysis in the sense of specific scope, direction or depth of the analysis. For the purpose of this study, corruption is analyzed in specific relations to health care system in Nigeria. Equally important is the use of the concepts of latent and manifest functions. Here corruption could have latent function in the sense of unintended consequences on health care while manifest

functions include direct and intended impact or consequences on health care. This study goes beyond the manifest to latent consequences of corruption to health care in Nigeria (Ritzer, 1988; Berger, 1963).

In order to identify and explain the functions of corruption, and arrive at the net balance or conclusion, the framework (Fig.1) developed by Savedoff (2007) and variously adopted by various development and academic analysts (in WHO, 2006; UNDP, 2011) was adapted. It shows how corruption manifests in the health system (Vian, 2007; DFID, 2010), and the relationship among five health sub-structures with patients at the bottom and government regulator on top of the framework. There are two types of suppliers; the left hand as construction of facilities and structures like hospitals and other buildings, while the right hand sub-structure include beneficiaries of procurement of drugs, reagents, laboratory and medical materials, equipments and machines. The most central in the health corruption model is the payer, here the health care consumers, for the two suppliers ("government regulators" or policy makers and political leaders on one hand and the professional health care providers on the other hand). The two arms of health suppliers influence or actually receive bribes and in the process distort quality health care. The payers (health care consumers) also influence the work and quality of health care providers through discrete or direct corrupt practices.



Source: Savedoff, W.D. (2007: 3)

Department for International Development (DFID), using the above framework, identified eight health issues or processes that fall into three categories; (regulation, human resource management and service delivery) of health service delivery. This categorization was further used to describe the types and nature of corruption in each of the process. The above model guides this paper in identifying and explaining corruption and its effect in the health care delivery system of Nigeria (DFID, 2010).

### **Corruption in Health Care Process and Outcomes**

#### ***Effects of Corruption on Health Regulations***

The democratic government in 1999 started the health sector reform which includes the review of 1988 health policy. The reviewed document became the 2004 health policy and it specifically set the overall goal as “improve the health status of Nigerians through the achievement of health related millennium development goals (MDGs)” (FMOH, 2005). The policy later transformed to a health bill which was passed into law in order to make the reform programme a sustained health development model. During the process, allegation of financial fraud against all the principal players in both legislative and executive arms was rife. It accounted for the removal of the Federal Minister of Health and later prosecution with other top policy makers in the health ministry. Though the bill was passed as an Act of the Senate on the 15th May 2008, Oluwadare (2010) identified the weaknesses of the policy in achieving its stated goal. It is therefore not surprising that when the bill was finally sent for President’s assent, the assent was withheld. Notwithstanding, most of the indicators entrenched in the Health Policy remain unachieved.

The most feasible success story in this millennium is the work of the National Agency for Food and Drug Administration and Control (NAFDAC) which was established by Decree no. 15 of 1993 and amended by an Act as a department in Federal Ministry of Health. The agency by policy is to regulate and control quality standards for foods, drugs, cosmetics, medical devices, chemicals, detergents and packaged water imported, manufactured locally and distributed in Nigeria (Adegun, 2008). According to NAFDAC, counterfeit drugs were first noticed in Nigeria by 1968 and by 1980s, only 25 percent of drugs sampled were genuine, it did not get better by 2000s. But NAFDAC has done creditably well through various innovative and proactive measures to prevent importation of sub-standard drugs and confiscation and destruction of seized consignment and warehousing of drugs and related products (PATHS, 2008b; WHO, 2008).

Related to the above is the notoriety of fraudulent dealings in procurement of medical products, contract outcomes, poor execution of contracts and compromise in quality assurance and inspectorate services. UNICEF (2010) showed Nigeria still having one of the worst health indexes with under-five mortality of 143 per 1000 and maternal mortality rate of 550 per 100,000. These high mortality rates are great impediments in meeting the health MDG targets. The annual one billion naira earmarked as MDG intervention projects

for health since 2006 has not yielded much of gains. The 2010 MDG Monitoring Team's Report showed that different ministries, departments and agencies, (including health) mismanaged a larger chunk of the N320 billion allocated to achieving the MDGs between 2007 and 2010. (*Premium Times* online, July 20, 2012, 20:19pm).

In 1996 Pfizer conducted trovafloxacin trial involving 100 children in Kano, five of whom died, with many others suffering blindness, deafness, and cognitive damage, life-altering injuries characteristic of meningitis. In the incident, the Federal Ministry of Health officials were indicted by the court for issuing fake ethics approval for the trial. The trial scandalously ended in 2009 with out-of-court settlement and agreement to pay compensations to the victims of the trials and Kano State government. Kano State, hospital staff, Ministers, judicial and health officials were fingered for compromise in handling the case. This scandal produced widespread aversion to immunization and federal government's coordinated health inputs (Wikipedia, 2012).

According to Jegede (2007) and Sogunro *et al.* (2007), the aversion to routine immunization and wide polio virus vaccination in Nigerian states of Katsina, Kano, Kaduna, Jigawa and Bauchi was significantly due to loss of public trust in the sincerity of any USA sourced intervention as a result of the Pfizer's vaccination trial scandal. By September 2012, a total of 236 million naira compensation had been paid by Pfizer to victims of the trial process (Businessdayonline, 2012). But it is still a national burden to convince the affected northern States about the veracity of western health care, not only immunization.

### ***Effects of Corruption on Health Manpower Resources***

It was documented in Nworah (2005) that over 8,000 Nigerian medical doctors practice abroad, while The Guardian Newspaper (2013) estimated the number to be over 15,000. Most of this number would have been in the country to contribute to the development of the health sector if adequate level of probity has been achieved in managing health resources. It is also an aspect of corruption for political leaders and top bureaucrats to travel abroad for treatment for all manners of illnesses using public fund while the majority of the population do not have access to quality health care at home.

A raging moral argument is the medical doctors' use of public paid time for private practice (PP). This is however less documented but it is a frequent question which the proprietors of public hospitals and tax payers are unable to answer. Related to this is the insensitivity of health workers to emergency calls both in urban and rural facilities. All these are factors explaining in part the poor access of the people to quality service and the intransigent use of deplorable health facility. The 2003 and 2008 Demographic and Health surveys showed that 66 percent and 65 percent respectively of all deliveries take place outside of quality health facilities, and the improvement in maternal health is only a marginal three percent within the same period (NPC, 2003; 2008).



Oluwadare (2012) observed that the medical system of Anambra State was paralyzed for about eight months in 2011 due to health workers' strike and government's insensitivity to patients, people and health workers' welfare. The incessant health workers and doctors' strike at the federal and state levels are a menace. But worse is the uncommitted stand of political leaders to the incessant strike actions of medical professionals. It bothers on poor health governance system.

### ***Corruption at the Health Facility Level***

Corrupt practices at this level involve extortion by cadres of health workers in the clinics or hospitals for various services like laboratory tests, drugs, emergency consultation, and blood donations. These practices add to the out-of-pocket cost of treatment and discourage uptake of services. It also involves nepotism and favoritism in booking appointment and waiting for consultation. These facility-level corruptions crystallize to structural decay and loss of confidence in modern medical facility.

PATHS (2008a) in a review of drug supply system in Nigeria identified lack of transparency and accountability as major challenges accounting for the poor supply of drugs and needed consumables in public hospitals and clinics. This laxity encourages stealing and reselling of drugs and other supplies. In the same review, The 1996 Petroleum Trust Fund drug supply system could not achieve 50% cost recovery due to pilfering and diversion of supplies. The introduction of drug revolving scheme in Ekiti, Jigawa, Kaduna, Benue and Enugu states from 2003 was to assure availability, affordability of quality drugs in health facilities in Nigeria. It was also to block holes of corruption in the procurement, distribution and prescription of drugs to the end users. While the scheme has been adjudged to be successful, its sustainability remains a challenge since it was initiated and implemented wholly with foreign aid (PATHS, 2008b).

It is stressed here that from 1999 there has been huge international investment into the health sector and more than 80 percent of all expenditure to improve health in Nigeria is donor fund from especially USA, Britain, European Union and World Bank. Global Fund injected \$225 million to fight malaria in 2012. The report of National AIDS Spending Assessment (NASA) for 2007 and 2008 shows that, the total spending for HIV and AIDS tracked by funding sources was above \$299 million (above N34 billion) and \$394 million (N45 billion) respectively. The percentage of public funds in 2007 and 2008 was 14.6% and 7.6% respectively; the percentage of private funds was 0.0% and 0.1% respectively, while respectively 85.4% and 92.3% of the funding was external (FRN, 2010). Nigeria annually has inadequate budgetary allocation for the health sector, one of the least in Africa (Babayemi, 2012), less than 30 percent of the budget is equally released and more of the actual health expenditure is mismanaged. Independent reports of health expenditure indicate widespread corruption and weaknesses in meeting targets (Global Fund, 2011).

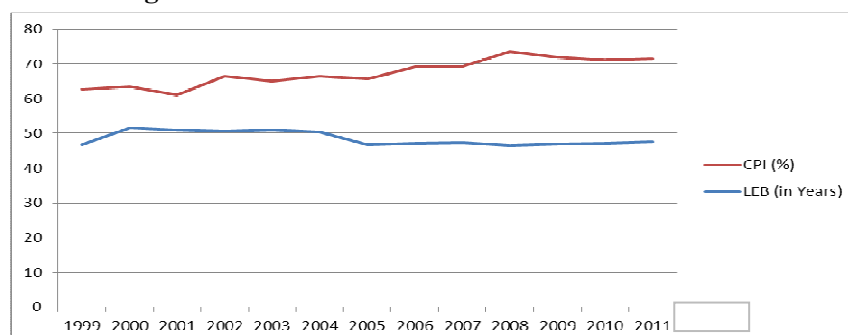
From all of these huge foreign and national investments in the health sector, less is achieved.

### Conclusion

From the above description of the infection of corruption into the health care system in Nigeria since 1999, it is evident that virtually all the three aspects of the health care process are affected. The health human resources are grossly unproductive due to corrupt management and ill-motivated personnel accounting for incessant strike actions and poor uptake of public health facilities. But the most direct impact of corruption is felt at the facility level where doctors, nurses and other health personnel engage in various patterns of fraud, bribe-taking, stealing and pilfering of public properties and other forms of indiscipline. The management framework is weak to checkmate them. In the final analysis, a national system of health care, significantly driven and funded by Western nations and multilateral agencies, cannot achieve much for the citizenry.

Figure 2 compares trends in corruption level and life expectancy at birth in Nigeria from 1999 to 2011. Corruption perception index (CPI) surveys by Transparency International were used to represent the level of corrupt practices.

**Fig 2: Corruption Perception Index (CPI)\* and Life Expectancy at Birth of Nigeria 1999-2011**



**Sources:** 1. Transparency International (TI), 2012. Corruption Perception Index (CPI) cited in [www.transparency.org/research/cpi/overview](http://www.transparency.org/research/cpi/overview) 25th September, 2012, 11.05pm, 2. [www.indexmundi.com](http://www.indexmundi.com) 2012. Life expectancy at birth (years), cited on 26th September, 2012 11.05 pm

Fig 2 clearly shows that Nigeria has gained little from all policy, legal and other institutional framework put in place from 1999 to 2011 to combat corruption. There is only eight percent improvement in corruption rating within

\* For the purpose of comparative analysis, CPI is presented in percentage rather than to the original highest point of 10. According to TI, the lower the score, the higher the corruption perception score.

12 years while life expectancy at birth shows an improvement of one year in the 12 years interval. It shows also that both anti-corruption practices and life expectancy improved gradually till 2007 and started to plummet. No doubt the zeal to work on health reform and also to ensure institutional transparency and prosecute public fraud started to reduce after the tenure of General Obasanjo due to weak leadership, especially the long period of health incapacitation of former President, Mallam Y'aradua, and the resultant political bewilderment. The government of Goodluck Jonathan cannot be rated to be doing better in anti-corruption drive compounded by the entanglement of national insecurity affecting all the facets of health care system in Nigeria.

### **Recommendations**

From the above, this paper affirms that the present leadership and consequent ones should convince the people that strengthening health institutional process in order to improve health outcomes is their priority. In particular, the following issues should be given priority:

1. Political leaders should show practical commitment to work the health policy and programs. Policy backed up with visionary actions is better than plethora of soft laws and legislations. The 2004 health policy is enough to show the sincerity of governments to achieve the health goals rather than politicizing the legislation of the policy which is diversionary.
2. Equally from the policy level to facility level, there are loopholes that allow diversion and use of public resources for private gains. Since anti-corruption agencies have thresholds of operations, internal audit mechanism should be put in place at all levels to identify possible areas of fraud and abuse of office. For instance, monthly evaluation checklist for all supervising health officers to be presented in meetings should be introduced.
3. A need to include the end users of medicine in all decision making process from the policy initiation to service delivery level. This will incorporate the principle of social democracy in health governance. Civil society bodies and community representatives should be incorporated as members of all health committees
4. Above all, political leaders should lead by examples; belief in local content of health delivery structures and initiate policies and health programs that meet the cultural environment rather than Eurocentric health programs. This will start with the obvious promotion of indigenous medicine and legislation to reduce capital flight due to foreign medical treatment.

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