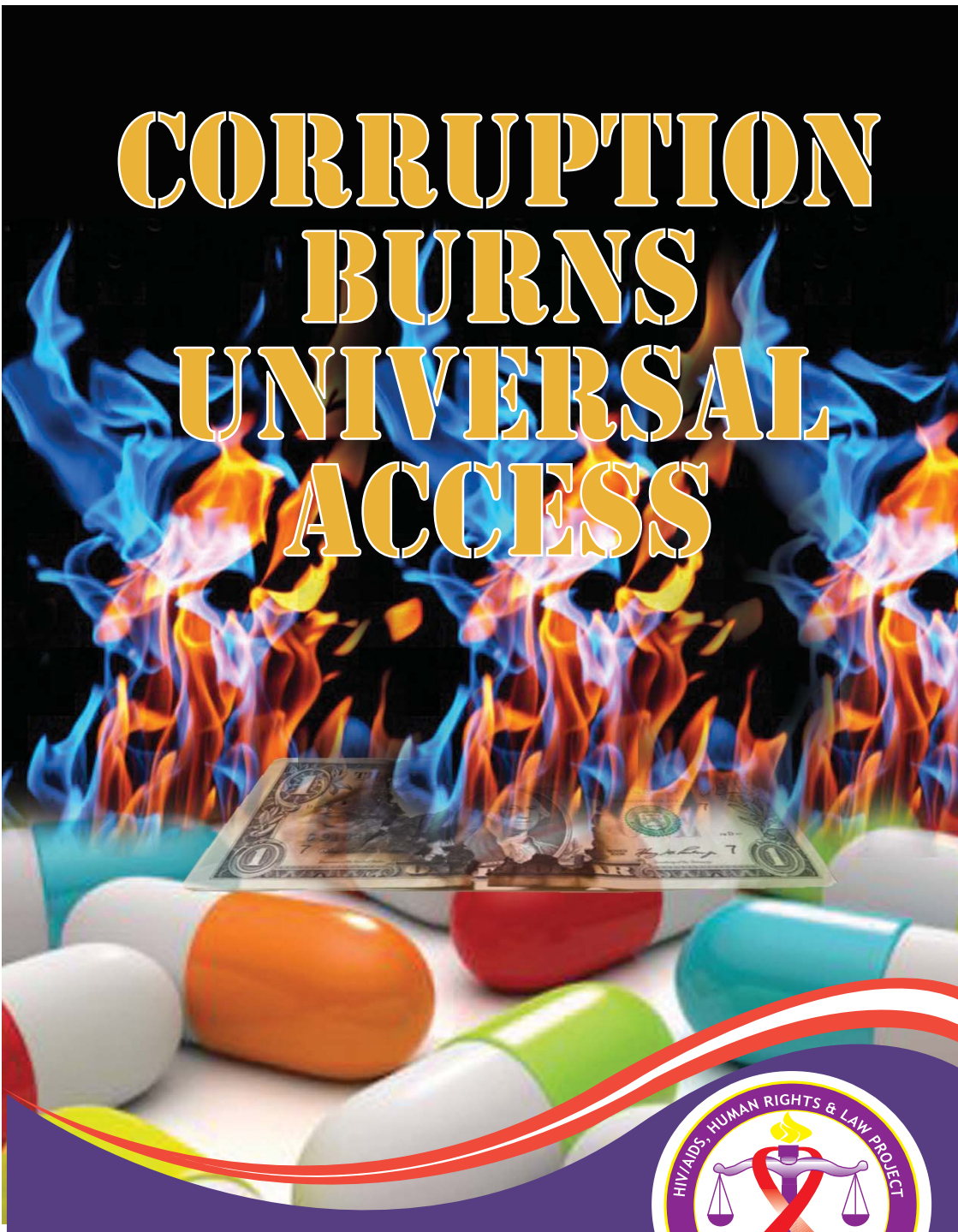
CORRUPTION BURNS UNIVERSAL ACCESS



REPORT ON CORRUPTION AND ACCESS TO TREATMENT

by the HIV/AIDS, Human Rights & Law Project

A project of Zimbabwe Lawyers For Human Rights

HIV/AIDS, HUMAN RIGHTS & LAW PROJECT

ZIMBABWE

Corruption Burns Universal Access

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LIST OF ABBREVIATIONS

The following abbreviations appear throughout this document:

ACCZ	Anti-Corruption Commission of Zimbabwe
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
AU	African Union
FBC	Full Blood Count
FGDs	Focus Group Discussions
HIV	Human Immunodeficiency Virus
NAC	National Aids Council
OI	Opportunistic Infection
PLHIV	People Living with HIV
SADC	Southern Africa Development Community
TI	Transparency International
UN	United Nations
UNCAC	United Nations Convention against Corruption
WHO	World Health Organisation
ZLHR	Zimbabwe Lawyers for Human Rights
ZNNP+	Zimbabwe Network of People Living with HIV
ZRP	Zimbabwe Republic Police

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Heartfelt appreciation is due to People Living with HIV in Zimbabwe, who took their time to interact and respond in this exercise; network contacts and coordinators from the Zimbabwe Network of PLHIV (ZNNP+) for providing us with a mobilised platform for discussion; Oscar Manduku for his software development and data entry efforts; and colleagues John Hreno and Joshua Mavundu.

Irene Petras
Executive Director
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FOREWORD

It has unfortunately become routine to say that corruption is a curse for developing countries on their way out of poverty. Corruption diverts highly needed public monies from their initial use into private hands, leads to inefficient public investment, and causes a lack of private investment. Corruption in the health sector is probably one of the most detrimental faces of the problem because life is directly at stake. If treatment is made conditional to corrupt practices, it could well be that the lives of those who cannot afford paying bribes will be endangered. In the case of HIV/AIDS, the danger is even higher, as there is no cure for the disease, despite the mitigation effect of anti-retroviral treatments. This issue is even more pressing in a country like Zimbabwe - one of the countries affected the most by the pandemic.

This is why a study like this is extremely important, both from a health perspective, and a governance perspective. Various corruption practices have been found in the interaction between people living with HIV/AIDS and hospital personnel. Results are shocking: the majority of respondents of the survey acknowledge being forced to pay bribes, either to be enrolled in the treatment scheme, or to receive ARVs. The mere fact that 10% of the patients who refuse to pay bribes are being taken care of is an encouraging sign in this dark picture.

The figures shown in this study definitely call for action. One can argue that informal payments are being solicited as a livelihood strategy by poorly paid health personnel. This certainly holds true to a large extent. However this assumption does not prevent a government from taking action within a health sector reform process.

Systemic change is needed in order to allocate existing resources more efficiently, to possibly increase the share of the health budget in the total state budget, and eventually to pay better salaries.

Accountability mechanisms must be put in place and monitored; ethics training must become part of the health curriculum and jobs terms of references.

At the other end of the spectrum, civic action and human rights advocacy groups can hold the authorities and the health staff accountable for their results and practices. By repeating the urgency of the situation, civil society organisations can certainly help in moving the anti-corruption agenda within the health sector forward and make people more aware of the serious consequences on health of governance deficiencies. To that end, well-researched and grounded work, such as what has been produced here by the Zimbabwe Lawyers for Human Rights, is needed. Hard facts, as those presented here, widely distributed among the health community, will hopefully create momentum for changing mindsets and practices.

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EXECUTIVE SUMMARY

In March 2010 the Zimbabwe Lawyers for Human Rights, through its HIV/AIDS, Human Rights and Law Project, conducted a research on corruption and access to treatment for PLHIV. The research was done in the provinces of Masvingo, Harare, Bulawayo and Manicaland. A sample population of 1,024 PLHIV was interviewed. Seventy-seven percent of respondents were female and 23% were male. The urban population provided 83% of respondents, with the remaining 17% of respondents coming from rural areas. Four major types of corruption in the roll out of essential medicines and services for PLHIV were identified. These were informal payments, bribes for enrolment, bribes for services, and conflict of interest/self-referral.

Corruption has been defined by Transparency International as "*misuse of power for private gain*". The research sought to assess the patterns, effects and forms of corruption with regards to PLHIV enrolled in the government roll out plan accessing essential medicines and diagnostic services in Zimbabwe hospitals. The research findings reinforced the view that corruption in health care discourages treatment, testing, and other health-seeking behaviour. In these circumstances, the general attitude has been observed to shift towards resentment and resignation by PLHIV who then give up on accessing essential medicines and diagnostic services.

Seventy-three percent of the respondents in this research have been asked to pay a bribe by health officials. This is a sizable number of people, and there is every reason to be concerned with such figures, given that most PLHIV in Zimbabwe live in extreme poverty, with 89% of respondents living with a family income of below USD100 per month.

Forty-five percent of respondents have between 2 and 5 dependents, and 27% have more than five dependents. The strain of corruption on household economies cannot be underestimated considering more than half of health care financing in Africa is out of pocket and Zimbabwe is not an exception.

An out of pocket payment is when a patient or a member of their family pays money directly to the service provider without a third party (insurer or government) assisting. In addition to meeting their personal health care expenses, PLHIV have to contend with health care expenses for dependents, including paying for school fees, food, rentals and rates.

Most cases of corruption were reported at Government hospitals and Council clinics. There were no significant cases reported at Mission hospitals. Corruption cases were mainly perpetrated by nurses and support staff at the hospitals and clinics. Eighty-eight percent of respondents identified nurses and support staff like nurse aides and administrative staff as the chief culprits. Direct evidence implicating doctors was very thin and sporadic. There were cases cited in discussions where doctors were said to be giving unnecessary prescriptions for drugs and ordering further diagnostic tests on the basis of their own financial interests rather than on the basis of the patient's needs. Interactions with hospital staff revealed that low salaries have driven health care workers into corrupt activities as coping strategies.

Bribes for services, bribes for enrolment and requests for informal payments were identified as the dominant practices of this corruption regime. The danger of these practices is that they create disincentives to investment in public health.

Accessing HIV drugs in public hospitals was identified as an everyday challenge for PLHIV. Focus group discussions (FGDs) revealed that drug stock-outs have become commonplace, especially for those on second-line treatment who are at times given prescriptions to buy over the counter at their own expense. At times, these stock-outs are engineered by health personnel in an attempt to source bribes or promote their private enterprises by referring patients to buy from their own pharmacies.

Fifty-seven percent of PLHIV who paid bribes needed access to drugs, 24% needed diagnostic services, and 19% paid a bribe for initial enrolment. Sixty-three percent of those who were asked to pay a bribe at one point were declined access to drugs or services. This resulted in people defaulting or outsourcing for drugs or the required services.

FGDs further revealed that drug stock-outs have also become commonplace because drugs are diverted to the black market through covert fraud and dispensing to ghost patients. From the perspective of civil society, this is a worrying trend and calls for urgent measures to curb corruption in the health sector in Zimbabwe. These measures require the commitment of the Ministry of Health and Central Government. The feeling among stakeholders is that the problem of corruption in the health sector is perpetuated by a moribund health system that is underwritten by phony accountability mechanisms and a tired bureaucracy.

Good governance indicators for the Ministry of Health in Zimbabwe are currently absent or unknown by most stakeholders. This study recommends that the levels of corruption should be considered as a proxy indicator to measure good governance in our health system.

The absence of a functional code of conduct that is strictly adhered to as an accountability mechanism in the health care system in Zimbabwe has contributed to the increase in incidences of corruption. Standards, ethical codes and mechanisms should be aimed at deterring corruption. Evidence of the enforcement and monitoring of existing ethical and conduct codes remain anecdotal. Discussions with PLHIV indicate that absenteeism by senior doctors usually impairs monitoring of these codes. As a result, junior staff and nurses are given enormous latitude to police themselves.

The respondents submitted names of health personnel involved in corruption. Because the objective of this study was to produce an advocacy paper as a basis for reform action, we have withheld the names of officials implicated.

BACKGROUND

Located in Southern Africa, Zimbabwe is home to about 12.2 million people. A total of 1,102,864 people are estimated to be HIV positive; 997,123 are adults above the age of 15, and 594,847 of these are females. At least 343,460 adults are in urgent need of anti-retroviral therapy.

One hundred and fifty thousand people are currently receiving free ARVs from the government programme[1] and thousands more are obtaining them from medical aid societies and over the counter. According to UNICEF, there are more HIV/AIDS orphans in Zimbabwe in proportion to its population than any other country. As many as 1 in 4 children in Zimbabwe are orphaned as a result of parents dying from AIDS-related complications. An estimated 1.3 million Zimbabwean children are orphaned and vulnerable. About 100,000 of them live on their own, while others live with their extended families.[2]

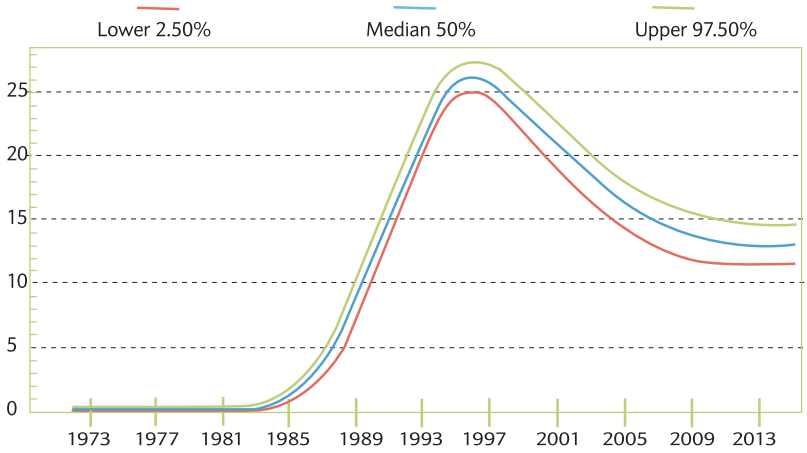
[1] Statistics from the Zimbabwe National HIV and AIDS Estimates 2009- It should be noted that this number keeps changing in presentations by the National Aids Council and the Ministry of Health. Usually presentations vary from 150, 000 to 190, 000. Therefore this should be submitted as the range. Statistics from the Zimbabwe National HIV and AIDS Estimates 2009

[2] *The Standard*: March 21, 2010

Table 1: Adult and Child HIV prevalence[3]

	2007	2008	2009
Adult prevalence 15-49	14.7% (12.8 - 16.0)	14.1% (12.1 - 16.0)	13.7% (11.9 - 15.0)
Prevalence males 15-24	3.4% (2.6 - 4.0)	3.4% (2.7- 4.0)	3.5% (2.8 -5.0)
Prevalence females 15-24	7.5% (6.2 -10.0)	7.3% (6.0 - 10.0)	7.5% (6.1 - 10.0)
Prevalence chn 0 -14	2.1% (1.3 -3.0)	2.1% (1.3 -3.0)	2.1% (1.3 -3.0)

[3]Zimbabwe National HIV and AIDS Estimates 2009



Lower 2.50%		0.04	0.24	1.38	7.11	20.35	23.57	19.13	14.27	11.86	11.45
Median 50%	0.02	0.08	0.37	1.82	8.18	21.81	25.33	21.14	16.32	13.71	13.16
Upper 97.50%	0.02	0.12	0.53	2.39	9.64	23.33	27.08	22.89	18.06	15.40	14.86

Corruption and the Law

Until recently, the Zimbabwean government had never taken any legislative steps to combat corruption. There has been a lack of resolve to fight corruption and the government has remained largely disinterested beyond cosmetic sloganeering. This is has been further exacerbated by the political crisis in the past decade which has seen various amendments to key policies and institutions.

Constitution of Zimbabwe (Amendment No.16) was promulgated in 2000 to introduce, amongst other things, an Anti-Corruption Commission for Zimbabwe (ACCZ), but legislation to operationalise the ACCZ was delayed until four years later, at the end of 2004. Section 108A of the Constitution, as created by Amendment 16 (Reproduced in **Annex C**), catered for the ACCZ, which came into being in September 2005 and reported to Parliament through a Minister of State in the President's Office. Within this framework, the Commission carried out its work through the Anti-Corruption Commission Act [*Chapter 9:22*]. Its mandate therefore was drawn from the provisions of both the Constitution and the Act (see **Annex A** for relevant sections of the Anti-Corruption Commission Act and **Annex B** for the Criminal Law on Bribery and Corruption).

The coming of the Inclusive Government in 2009 saw the introduction of the Constitutional Amendment 19 which established the Zimbabwe Anti-Corruption Commission (ZACC) to replace the ACCZ. However, the provisions for the constitution of the ZACC are drawn from the Kariba Draft Constitution which is yet to be reconstituted. Furthermore, there is lack of clarity whether the Anti-Corruption Commission Act [*Chapter 9:22*] will still apply if the Kariba Draft is adopted.

The ACCZ is signatory to such regional and international protocols as the Southern Africa Development Community (SADC) Protocol against Corruption (2001) as well as the African Union (AU) Convention on Preventing and Combating Corruption and Related Offences and United Nations Convention against Corruption (UNCAC).

While Zimbabwe has conformed to Article 6 of the UNCAC, which requires states to ensure the existence of a body or bodies to prevent corruption, the ACCZ has not met expectations. The ACCZ has been inefficient and unaccountable, largely silent, and has failed to accomplish its mission in a society riddled with corruption. Sadly, the health sector in Zimbabwe has been greatly affected by the ACCZ's ineffectiveness.

Access to Treatment and Corruption – A Literature Review

"Access" is a broad concept that measures three dimensions of key health sector interventions: availability, coverage and/or outcome impact[4]. Availability is defined in terms of reachability (physical access), affordability (economic access) and acceptability (socio-cultural access) of services that meet a minimum standard of quality. Coverage is described as the proportion of the people needing and intervention who receive it while outcome and impact refer to the medium term effects of such an intervention such as high survival rates. Success in providing access is dependent on the efficiency and effectiveness of the interventions that is availability and coverage.

Bevan, McCabeb & Yudkina (2008) emphasize that access to treatment is not sorely focused on the supply of medicine but expands to other factors that also affect patient care and outcomes. These elements may include the availability of diagnostic tools and the presence of trained health-care workers who are able to interpret laboratory test results,

[4] WHO, UNAIDS, UNICEF. 2009. Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector.

formulate treatment and refer patients for specialized attention. This process must take place in a health system with the appropriate infrastructure required to guarantee continued supply of medicines and continuing care for chronic conditions. In addition to these requirements, a positive policy environment and the involvement of the family and community are also necessary.[5]

Corruption, which is defined as "*use of public office for private gain*"[6] or "*the sale by government officials of government property for personal gain*"[7], upsets the achievement of access as defined above. Whilst it is accepted that developing countries face a number of challenges in facilitating access to treatment as a result of poverty, stigma, tariffs, financing, customs, and 'red tape' in government, the scourge of corruption is what threatens to reverse progress made towards universal access. In a 2006 report on health, Transparency International (TI) reported that, "*Corruption is depriving people of needed medical care and promoting the development of drug-resistant disease, creating an ever-spiralling cycle of worsening health conditions.*"[8]

There are different types of corruption that affect the health delivery systems and/or sector irrespective of whether a country is a developed or a developing country. Suppliers, consumers and service providers may encounter or facilitate corruption at different levels, such as within supply chains of pharmaceuticals, theft of pharmaceutical supplies in hospitals, procurement at the hospital and government level, and billing or payment systems.

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[5] Beran D, McCabeb A, Yudkina, J.S., 2008. Access to Medicines Versus Access to Treatment. Bulletin of the World Health Organisation.

[6] Bardhan, P. (1997) "Corruption and Development: A Review of Issues" *Journal of Economic Literature* 35(3) 1310-1346

[7] Shleifer, A. and Vishny, R. W. (1993) "Corruption" *Quarterly Journal of Economics* 108(3): 599-617

[8] *The Global Corruption Report*: Transparency International (2006)

This research dealt with the issue of corruption at the point of contact between a patient and a health service. The research targeted PLHIV who are on a government roll out programme to ascertain the level of corruption and how it was impacting their lives in relation to access to essential medicines and services.

Access to treatment in Zimbabwe has continued to be a critical as well as a priority issue for both the Ministry of Health and advocacy groups. Whilst figures differ in terms of the exact number of people on treatment and those who urgently need it, there is general agreement that less than half of the persons in urgent need of life-prolonging ART are receiving it. As a result, many people are chasing the limited supply of drugs available.

The demand for ARVs in the provinces is extensive. "*We have between 200 and 300 people on the waiting list for antiretroviral drugs and we can only cater for a few people. We fear it might take up to a year before a patient is put on ARV drug therapy,*" said an official from Mutare Provincial hospital in an interview with *The Zimbabwean* newspaper.[9]

Access to safe and affordable medicines in developing countries is hampered by corruption. Research informs that, "*... in many cases, medical supplies are diverted from the public health system for resale by medical staff running their own private practices. Findings from a UN report* [2008] *of the MDG Gap Task Force, for example show that the availability of medicines in 30 countries is far from optimal, reaching only 34.9% availability in the public sector and 63.2% in the private sector.*"[10] Due to corruption, essential medicines and services become more costly and unaffordable, with millions of people – especially the poor who cannot afford paying or bribing for medicine - lacking access to treatment. Current estimates

[9] http://www.thezimbabwean.co.uk Accessed on 17/03/2010

[10] http://www.u4.no/ Accessed on 23/05/2010

from the World Health Organisation indicate that not less than 2 billion people and about 30% of the world population lack regular access to medicine due to insufficient resources.[11]

Corruption that is driven by senior personnel in health systems like doctors usually takes the form of self-referral. Doctors in public health systems are usually allowed to open their own private practices. This has resulted in doctors spending official time in their private practices, utilising public facilities to treat private patients, or merely channelling public health system patients to their own private practice. This is not a purely Zimbabwean phenomenon: ". *In Bangladesh, unannounced visits to public health facilities showed that doctors were absent more than 40% of the time.*"[12] corruption among senior health personnel has resulted in high rates of absenteeism which represents a significant loss of funds and public resources.

Unbundling - where a patient is asked to come again a second time in order to charge them twice - and upcoding- where a doctor performs one procedure but then charges the patient or donor for another more profitable one - are other forms of corruption prevalent in developing countries.[13]

Accessing health care services through out-of-pocket financing diminishes the quality of services in the public health system. Between 1996 and 2005, evidence shows that individuals were being forced to part with money from their own pockets more and more. Shamu *et al*[2006] observed that:

[11] Nordberg, C. and Vyan, T. (2008): "Corruption in the Health Sector" *U4 Issue 2008:10*, accessible at http://www.u4.no/document publication.cfm?3208=corruption-in-the-health-sector

[12] Chaudhury and Hammer, (2003)"Ghost Doctors: Absenteeism in Bangladeshi Health Facilities" *World Bank Research Paper* 3065, p. 17

[13] Anne Lugon Moulin, (2006) "Barriers to Access to Medication: The Role of Corruption in Poverty Conference «Access to Life-Saving Medication – Innovative Solutions»| September 7 2006 | UBS Training- and Conference Center Basel

"The consistent increase in out-of-pocket spending is of concern, given the increased the [sic] *burdens on households at a time of severe economic difficulty… The out-of-pocket share of the private expenditures is shown to have risen to above 53% by 2003, indicating decline of the welfare system and a likely burden on low income households.*

"The falling private pre-paid share of private expenditure and a corresponding increase in out-of-pocket payments reflects a picture where one can conclude it is mostly the unemployed and the informal sectors using [sic] this form of payment for accessing health care."[14]

Pharmaceutical fraud is another form of corruption that goes unnoticed, as it occurs behind walls and counters. This type of corruption involves the dispensing of diluted, substituted, recycled, counterfeit/falsified or expired medicines and the theft of inventory due to poor controls.

Doctors also refer patients to private pharmacies due to stock-outs in the pharmacies at public hospitals.[15]

[14] Adapted from Munyuki E and Jasi S (2009) 'Capital flows in the health care sector in Zimbabwe: Trends and implications for the health system' *EQUINET Discussion Paper Series 79.* Rhodes University, Training and Research Support Centre, SEATINI, York University, EQUINET: Harare

[15] Anne Lugon Moulin *op cit*

RESEARCH METHOD

Objectives

- To identify hospitals and clinics where corruption occurs and is widespread
- To identify the various aspects and/or patterns of corruption on access to ARVs and related diagnostic services
- To identify the effects of corruption on access to treatment in Zimbabwe
- To facilitate a basis for action as a remedy to the findings of the survey

Description of the Study Area

The areas covered in this study consisted of Harare, Bulawayo, Manicaland and Masvingo provinces. Harare and Bulawayo are predominantly urban areas while Masvingo and Manicaland provinces are made up of both urban and rural areas.

Study Population

The study population consisted of PLHIV (both male and female) who are on the free drug roll out by government at government hospitals, municipal clinics and mission hospitals.

Sampling

The objectives and purpose of the research inform on the need to use specific sampling methods. The method of sampling chosen for this study was **purposive sampling**, which was therefore used as a tool

for informant selection. Purposive sampling has the advantage that it can be used with both qualitative and quantitative techniques. The type of purposive sampling used was **criterion sampling,** where people to be interviewed are PLHIV on the free ARV therapy roll out programme at municipal, mission and government hospitals. The fact that an already identified group of people with specific characteristics become informants contributes to its efficiency.

Sample Size

A total of 1,024 respondents were interviewed through questionnaires and 120 participated in FGDs.

Data Collection

The research used a structured questionnaire, key informant interviews and FGDs. Before the questionnaires were used, they were pre-tested to see if they could adequately be used to collect the required information. Not more than one person was interviewed per household.

Limitations of the Research

Corruption is difficult to measure mainly because corruption is, by definition, a hidden practice, and this difficulty has been well documented. Another problem is that interviewees may be reluctant to acknowledge having to pay bribes because they feel ashamed. As a result of this, bias in answering can arise. This research is precise in that it used questionnaires and interviews on a single activity (access to essential medicines and diagnostic testing for PLHIV) and was focused on a specific agency (the health system). The identified target group strengthened the quality and relevance of the data collected.

The research is limited in that it does not cover the whole health sector in Zimbabwe. It does not look at issues of corruption in drug procurement and distribution tariffs. However, corruption in the treatment of HIV is not very different from corruption in other areas of the health sector.

Another limitation was the bias on respondents from urban areas compared to rural areas. This was partly due to the fact that most government hospitals dispensing ARVs are based in urban areas and most people in rural areas obtain their medication at the nearest provincial hospital.

RESEARCH FINDINGS

Demographic and Socio-Economic Characteristics of Respondents

These characteristics of the respondents include age, sex, place of residence, educational level, employment, wealth and status. Information derived from these characteristics forms the basis for understanding how corruption affects PLHIV as a group, individuals and communities. **Table 2** presents the various characteristics of the PLHIV interviewed during this study.

Profile of Respondents

The distribution of respondents according to sex shows a significant difference between the number of male and female respondents. Women make up 77% of the total respondents with the largest proportion of these found within the 40 and above age bracket. The number of respondents by age group significantly increases with age, with the highest numbers for both males and females located among those who are 40 years and above.

Of the 1,024 respondents, two-thirds reside in urban areas whilst one-third is located in peri-urban and rural areas. Similarly, the proportion of women in urban areas is much higher than that of men. For every 5 women respondents in urban areas, there is only one man. The situation is similar to that of the rural areas, where there are twice as many women respondents than their male counterparts.

Education plays a key role in the type of employment one holds and the level of income. The higher the level of education attained by an individual, the more likely they are to have a decent income which can afford them the basics and a few luxuries that crucial for those on

treatment. The number of respondents who attained high levels of education significantly decrease at each level. Most of the respondents only attended primary and secondary school, whilst very few managed to attain diplomas and degrees.

In this study, all respondents had attended school for at least a few years. However, 54% of these did not reach Ordinary Level. In this characteristic, only 25 and 34 respondents reached Advanced and Diploma/Degree Level respectively. For all levels, women out-number men, though the variance decreases as the level of education increases.

An estimated 67% of the respondents interviewed are unemployed whilst the remainder are either formally or informally employed and the greater proportions of these are women.

The research also found that approximately 75% of the respondents have an average monthly income ranging from 0 – 50 United States Dollars, with the percentages decreasing as one goes up the range. As such, 83% of the PLHIV interviewed highlighted that they could not afford basic necessities for their day-to-day lives. This is further exacerbated by the fact that most PLHIV interviewed have a large number of dependants with 71% having 3 or more dependants to look after on less than 50 United States Dollars per month.

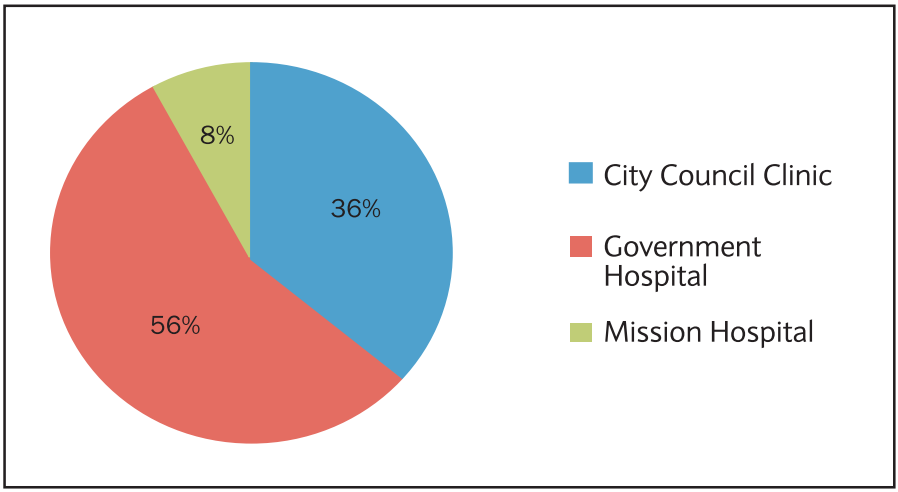
TABLE 2: PROFILE OF RESPONDENTS						
AGE	**Female**	**Male**	**Total**	**% Female**	**% Male**	**% Total**
Below 18	1	0	1	0.098	0	0.098
19-24	23	5	28	2.25	0.49	2.74
25-29	106	39	145	10.35	3.8	14.15
30-39	265	86	351	25.88	8.4	34.28
>40	386	104	490	37.7	10.16	47.86
not indicated	7	2	9	0.68	0.20	0.88
Totals	**788**	**236**	**1024**	**76.96**	**23.05**	**100**

TABLE 2: PROFILE OF RESPONDENTS						
EDUCATION LEVEL	**Female**	**Male**	**Total**	**% Female**	**% Male**	**% Total**
Below o' level	459	88	547	44.83	8.59	53.42
O ' level	289	129	418	28.22	12.6	40.82
A' level	16	9	25	1.56	0.88	2.44
Degree/diploma	18	16	34	1.76	1.56	3.32
Other	-	-	-	-	-	-
EDUCATION LEVEL	**Female**	**Male**	**Total**	**% Female**	**% Male**	**% Total**
Formally Employed	49	25	74	4.79	2.44	7.23
Informal employment	207	61	268	20.21.	6	26.17
Unemployed	524	158	682	51.17	15.43	66.6
Not indicated	-	-	-	-	-	-
Average Monthly income (USD)	**Female**	**Male**	**Total**	**% Female**	**% Male**	**% Total**
Less than 50	599	170	769	58.49	16.6	75.09
51 – 100	102	37	139	9.96	3.6	13.56
101 – 200	59	16	75	5.76	1.56	7.32
201 – 300	13	6	19	1.27	0.59	1.86
301 – 400	6	4	10	0.59	0.39	0.98
401 – 500	3	5	8	0.29	0.49	0.78
More than 500	3	1	4	0.29	0.098	0.39
Not indicated	-	-	-	-	-	-

TABLE 2: PROFILE OF RESPONDENTS						
ASSESSMENT OF INCOME POVERTY LEVELS	**Female**	**Male**	**Total**	**% Female**	**% Male**	**% Total**
Cannot afford basics	655	196	851	63.96	19.14	83.10
Can afford basics	56	15	71	5.47	1.47	6.94
Sometimes affords basics	67	26	93	6.54	2.54	9.08
Can afford basics + luxuries	6	3	9	0.59	0.29	0.88
ASSESSMENT OF FAMILY SIZE	**Female**	**Male**	**Total**	**% Female**	**% Male**	**% Total**
1 -2 dependents	220	76	296	21.48	7.42	28.91
3-5 dependents	341	114	455	33.3	11.13	44.43
More than 5	221	52	273	21.58	5.08	26.66
Not indicated	-	-	-	-	-	-

TREATMENT INFORMATION

Where do you access treatment?

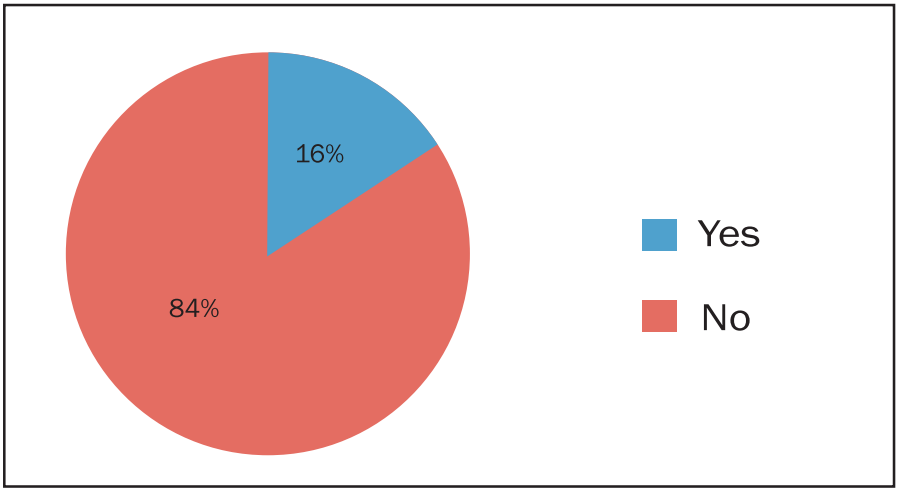


Government hospitals cater for more than half of the patients enrolled in the programme. Decentralisation of the programme has seen municipal clinics coming in to play a major part.

Fifty-six percent (56%) or 568 PLHIV interviewed are enrolled at government hospitals and thirty-six percent (36%) or 367 PLHIV are enrolled at city council clinics.

Eight percent (8%) or 79 people interviewed are enrolled at mission hospitals, which are usually well-resourced. Of the 1,024 PLHIV interviewed ten (10) people had either not commenced treatment or had private sources for drugs.

Have you received expired drugs?



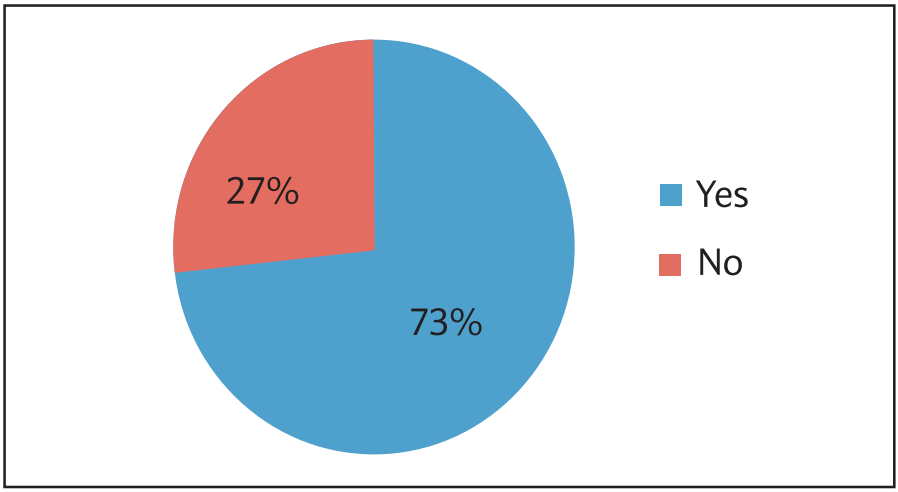
The research showed that dispensing of expired drugs was not widespread.

Eighty-four percent (84%) of PLHIV interviewed had never received expired drugs. Only sixteen percent (16%) had at one point received expired drugs.

Common among these expired drugs were Triviro, Aluvia, Kaletra, Combivir, Cotrimoxazole and Nevirapine.

BRIBES: INCIDENCE, FREQUENCY AND SIZE

Have you been asked to pay a bribe?



Seventy-three percent (73%) or 747 respondents reported that they had experienced encounters with health personnel where bribes were requested.

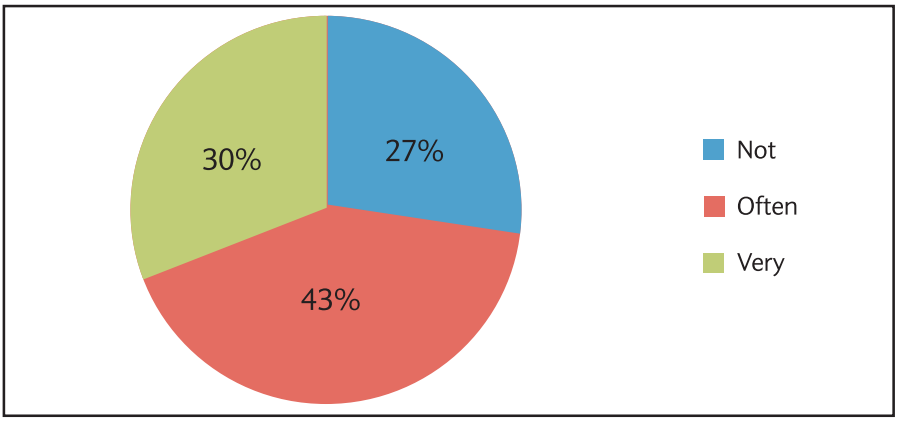
Usually, the requests were explicit.

The admissibility of corruption, i.e. the attitude of PLHIV towards corruption, may have cultivated the acceptability of the practice at the point of contact with health personnel.

Twenty-seven percent (27%) or 277 respondents had never experienced an encounter where bribes were requested from them.

How frequently have you been asked to pay a bribe?

[Asked of the 747 respondents who confirmed having been asked to pay a bribe]



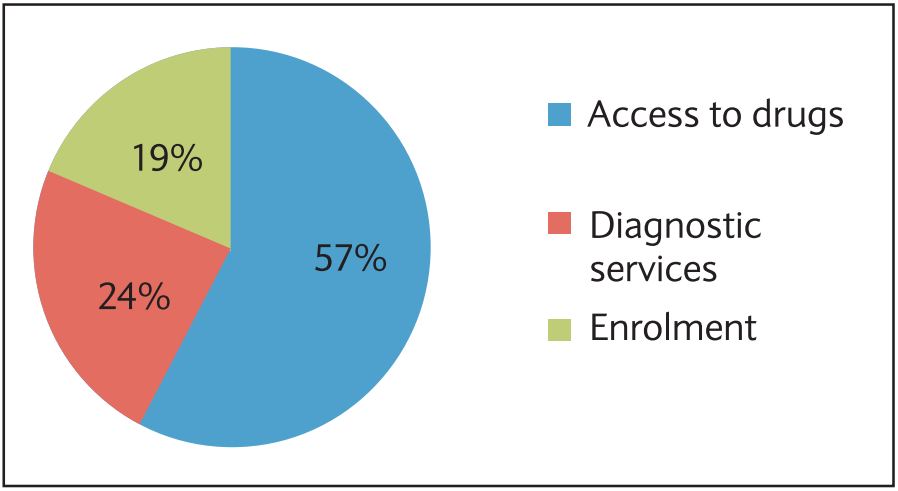
When asked about the frequency of bribe requests, respondents were given the option of answering "often", "very often", or "not often". "Very often" meant every time one attends a hospital or clinic and for every service required, i.e. a bribe is a pre-requisite for accessing service. "Often" meant that bribes are requested sometimes.

Thirty percent or 220 of the category of respondents informed that bribes are required very often and are common practice. Forty-two percent (42%) or 311 said that requests for bribes are often demanded, but not always. Twenty-seven percent (27%) or 199 informed that requests for bribes were occasional but not common practice. Two percent (2%) or 17 people had unstated responses.

An analysis of the frequency of the incidence of bribery and the size of bribes demanded, juxtaposed with limited household incomes, indicate that bribery can take up a sizable share of the average monthly income. This negatively impacts other demands on income, including nutrition and other living expenses like rentals and school fees.

For what type of health services were bribes requested?

[Asked of the 747 respondents who confirmed having been asked to pay a bribe]



It is important to note that, despite the scaling up of treatment, a majority of people in urgent need of treatment for HIV in Zimbabwe are unable to access it. When demand exceeds supply, corruption creeps in, affording those who can pay kickbacks the chance to be considered before others.

Of the 747 people who were asked to pay a bribe, a majority of fifty-seven percent (57%) or 426 respondents had bribes demanded of them for access to drugs, mainly ARVs, Cotrimoxazole and other OI drugs. Twenty-four percent (24%) or 179 people encountered corruption when trying to access diagnostic services, including X-rays, FBC and

liver function tests; and nineteen percent (19%) or 142 people were asked to pay money to be enrolled on the government programme.

Waiting lists at the different hospitals for enrolment are very long, and they drive desperate patients to pay "something" to access a service. Bribes for enrolment at an identified hospital in Bulawayo can be as high as 700 Rands as reported by one respondent.

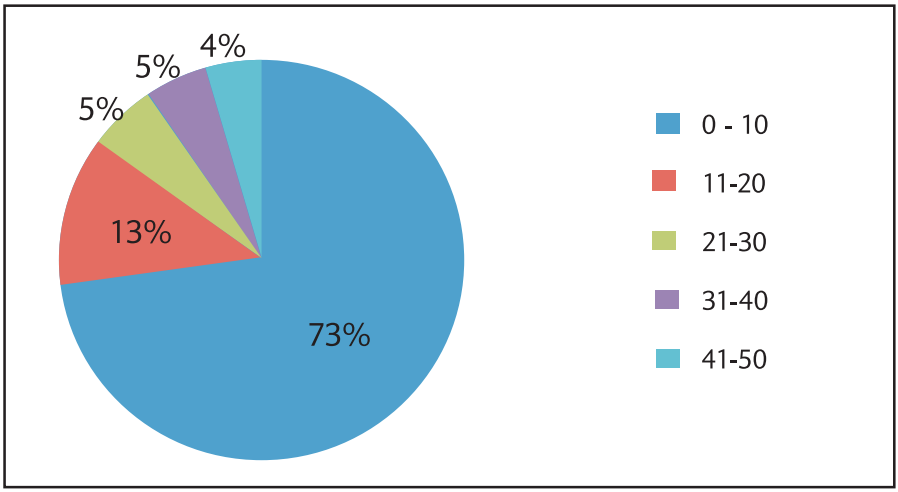
FGD participants mostly from Bulawayo informed that those who pay for enrolment will also have to contend with other bribes in accessing the drugs in future instances of artificial shortages and drug stock-outs. In these circumstances, respondents informed that patients are often told there are no drugs to be dispensed but nurse "so and so" may be able to assist them if they pay something.

These drugs are often dispensed through nurse aides or other support staff such as security guards. These transactions usually take place in closed offices or in the public toilets of hospitals. In extreme circumstances, patients have to source drugs from private residences of health personnel staff.

In some provinces, FGDs informed that diagnostic equipment and machines may be declared as "broken down." However, upon payment to certain individuals, they are declared functional, and services are given.

How much are you asked to pay as a bribe?

[Asked of the 747 respondents who confirmed having been asked to pay a bribe]



Seventy-three percent (73%) or 535 of the respondents who were asked to pay a bribe were asked to pay between USD1 and USD10.

Thirteen percent (13%) or 92 PLHIV were asked to pay betweenUSD11 and USD20. Five percent (5%) of respondents were asked to pay between USD21 and USD30, and another five percent (5%) were asked to pay from USD31 to USD40. Four percent were asked to pay more than USD50.

Given the performance of the economy in Zimbabwe and average household income, no amount can be a small sum in the prevailing corruption narrative.

From the FGDs, it was observed that diagnostic services and enrolment demand the biggest bribes, usually above USD10. This is because PLHIV are usually aware of the inhibiting costs of the alternatives in the private sector.

One can only deduce that people without the means to pay the bribes requested are left to die at home with no alternative.

Ten people did not know the amount requested, and they indicated that the amount was not stated.

Hospital staff usually adopts a lackadaisical attitude in serving patients. For example, PLHIV may queue from 6.00 am for drugs and will only start to be served at 11.00 am. By this time, they will be hungry and eager to go home. For them to jump the queue or to be served, they will have to pay a small bribe to the health personnel.

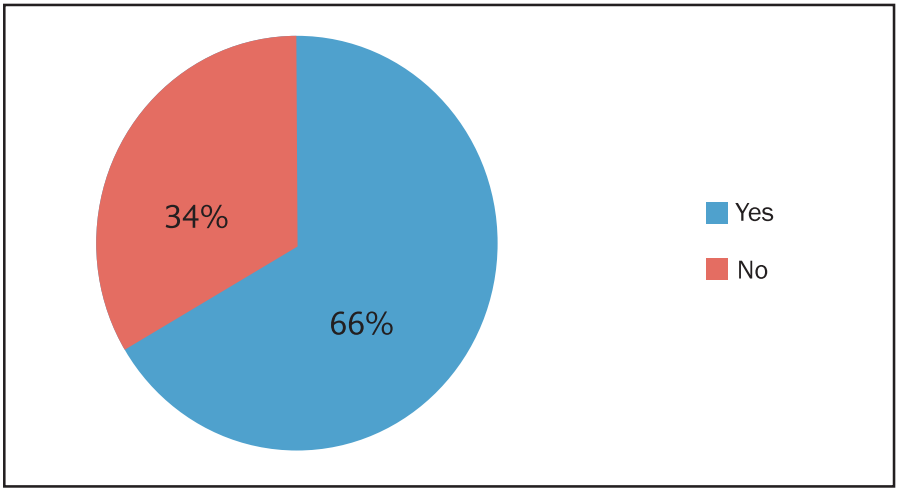
Dispensing drugs to ghost patients or defaulting patients is suspected by PLHIV to be providing an outlet for drugs to be sold on the open market in the cities. These open markets have thrived because most people who are HIV positive live in fear of stigma and discrimination. As a result, they get backdoor prescriptions, and drugs are dispensed by unqualified people who act on behalf of the hospital personnel.

Drugs dispensed in these instances are fake or expired, and may be unrelated to the treatment sought. This may also lead to a situation where adherence is compromised and people develop drug resistance.

BRIBES: CONSEQUENCES

Did you pay the bribe upon request?

[Asked of the 747 respondents who confirmed having been asked to pay a bribe]



Of the 747 respondents who had been asked to pay a bribe, sixty-six percent (66%) or 493 of the respondents informed that they paid the bribe upon request to do so.

Thirty-four percent (34%) or 254 did not pay the bribe, and they had to either default or outsource. Failure to pay the bribe was largely due to poverty. FGDs indicated that most people would rather pay the bribes than default on the required treatment.

Those who declined to pay bribes may have done so as a matter of principle or because they did not have money on that particular day.

It is difficult to ascertain whether fees prescribed by hospitals to PLHIV are actually deposited and accounted for at the provincial and national level Treasury, because sometimes patients are asked to pay whatever they have at that time and settle the balance later.

In some cases, if a patient insists that they have no money, s/he is attended to but is told to bring the money later.

FGDs informed that government receipts might be issued sometimes, and at other times they might not be and instead are only noted in a counter book. This is a clear case of a warped accountability mechanism.

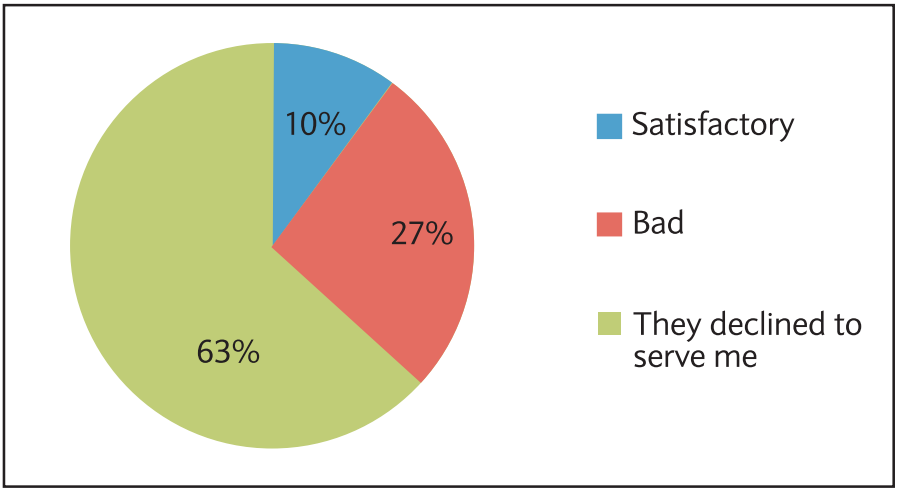
Uptake of medical services is reduced because the ability to pay is diminished in the populace, which affects equity.

Unofficial and informal payments or bribes are the most widespread form of corruption in Zimbabwe confronting PLHIV seeking treatment. For example, in some provinces, PLHIV pay administration fees for the stamping of their cards, whilst in other provinces such as Masvingo, there is a Circular from the Ministry of Health clarifying that PLHIV are not supposed to pay this fee.

PLHIV are asked to pay money for services that are supposed to be free – for example enrolment on a government programme, but most people in urgent need of treatment are forced to pay a fee to hospital personnel.

What were the consequences of refusing to pay bribe?

[Asked of the 254 respondents who refused to pay a bribe upon request]



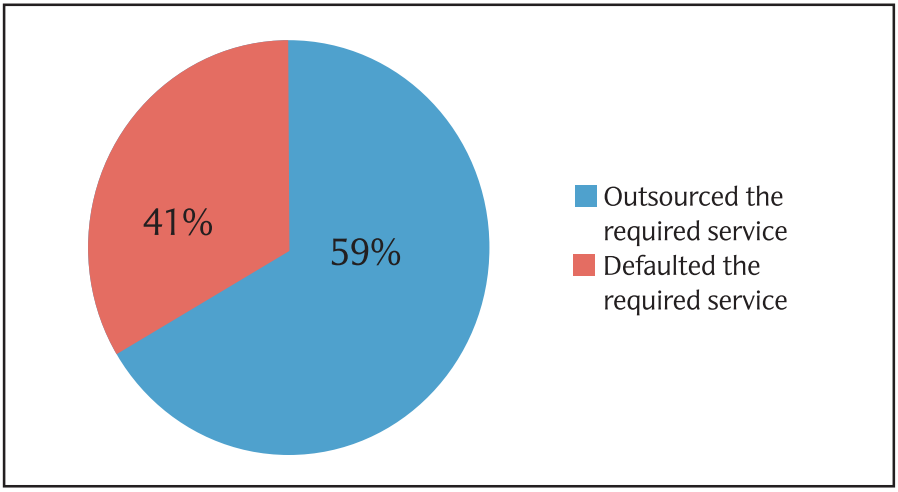
Sixty-three percent (63%) or 161 of the 254 respondents who refused to pay a bribe were denied the required service.

Twenty-seven percent (27%) were provided with service, but the service was bad. Bad service would include such things as being served four or five hours after attending to the hospital or clinic; or being given inadequate pills; or being subjected to verbal abuse and psychological torture. Ten percent (10%) received satisfactory service even after refusing to pay the bribe.

The general feeling amongst participants of the FGDs was that the quality of services improved if bribes were paid. The drugs dispensed are usually adequate and responses or results are usually quick. This compromises equity and leaves patients with no option but to bribe when they are able to.

What happened after the service was denied to you?

[Asked of the 161 respondents who were refused service after refusing to pay a bribe]



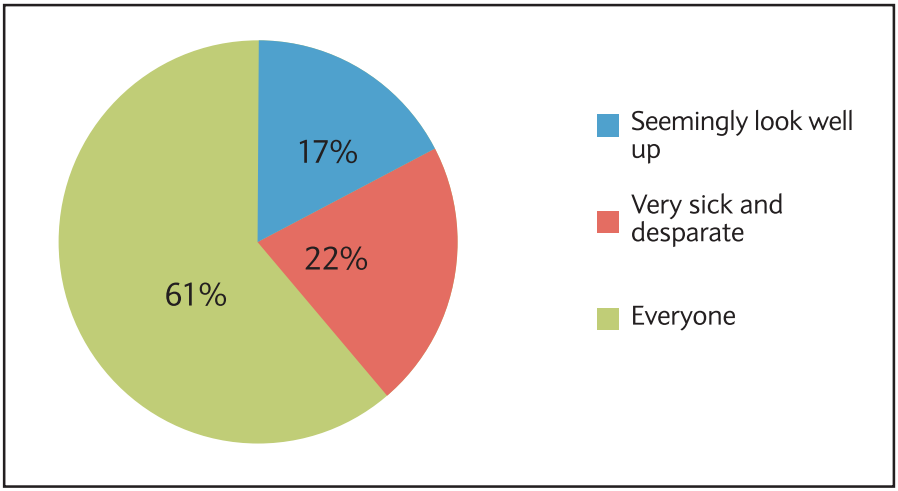
Fifty-nine percent (59%) of the 161 respondents who refused to pay any bribe ended up defaulting on the required service.

Forty-one percent (41%) out-sourced the required service (drugs or diagnostic services). Outsourcing in some instances involves going to the black market for the drugs or buying from a middleman, who often works in tandem with the same people who denied the service in the first place.

BRIBES: PATTERNS AND TRENDS

What types of people are asked to pay bribes?

[Asked of the 747 respondents who confirmed having been asked to pay a bribe]



The majority of persons interviewed informed that there are no identifiable criteria in terms of who is asked to pay a bribe.

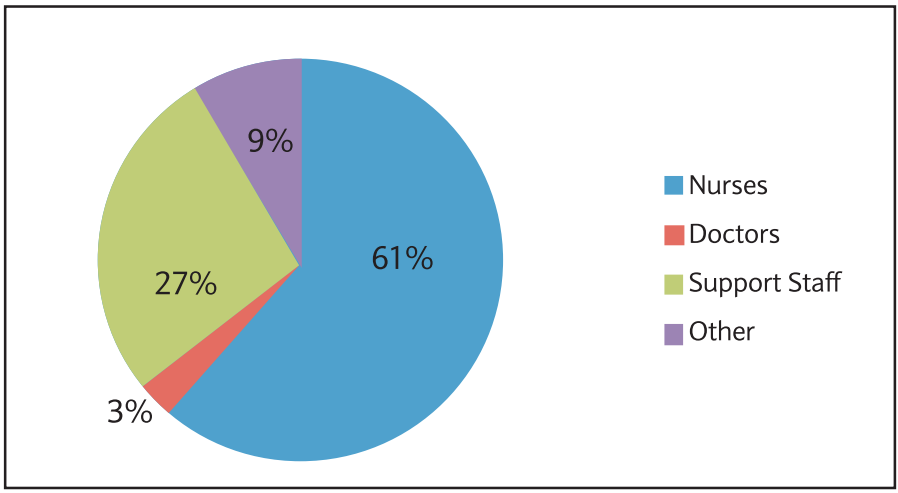
Sixty-one (61%) said that everyone is asked to pay a bribe to access services and drugs regardless of whether they are desperately sick or look well up economically.

Twenty-two percent (22%) said that those who look sick and desperate are considered likely to pay.

Seventeen percent (17%) said that a person would likely be asked to pay a bribe if s/he looked well up and capable to pay.

Who asks for bribes?

[Asked of the 747 respondents who confirmed having been asked to pay a bribe]



Sixty-one percent (61%) of respondents claimed that nurses requested a bribe from them while twenty-seven percent (27%) identified support staff.

Three percent (3%) said doctors are involved, and nine percent (9%) could not state a defined category.

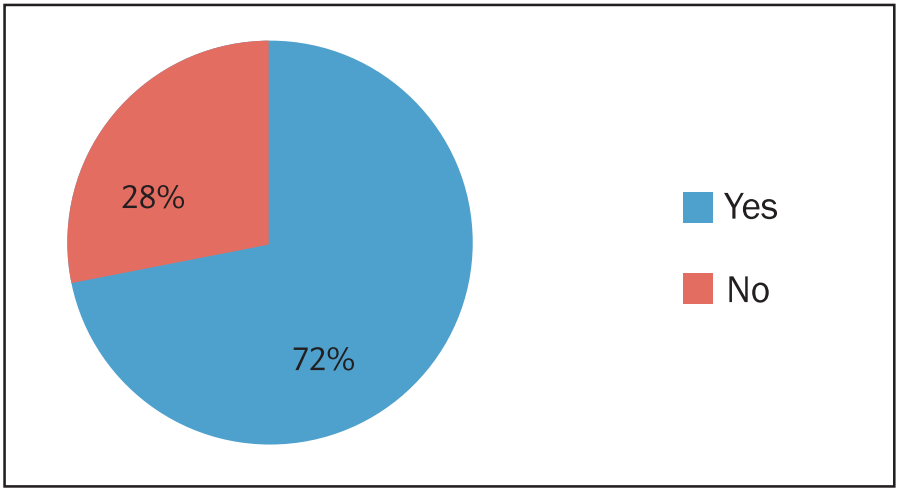
FGDs informed that some hospital corruption rings are syndicates involving nurses, support staff and outside individuals.

Whilst doctors have not been named as key drivers of corruption, isolated incidences were cited where doctors encouraged outsourcing of services - particularly diagnostic testing services - to parallel providers where they were known to have a financial interest, thus representing a *prima facie* case of conflict of interests.

IDENTIFYING PERPETRATORS

Can you identify those involved in corrupt activities?

[Asked of the 747 respondents who confirmed having been asked to pay a bribe]

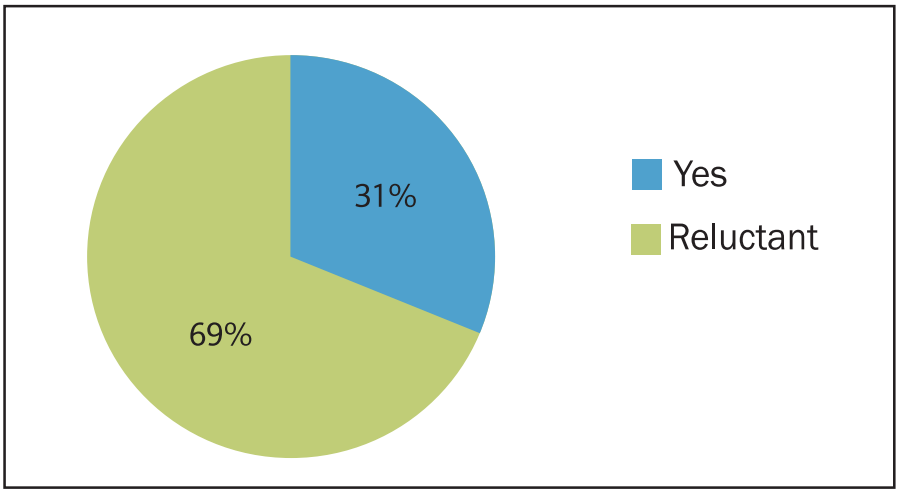


Seventy-two percent (72%) or 536 respondents of the 747 who confirmed having been asked to pay a bribe said they could identify those involved in corrupt activities and know them. These are likely to be nurses and support staff with whom they interact whenever they visit the hospital or clinic.

Twenty-eight percent (28%) said they could not identify those involved in corrupt activities.

Are you able to provide details of the staff involved?

[Asked of the 536 respondents who confirmed that they can identify those involved in corrupt activities]



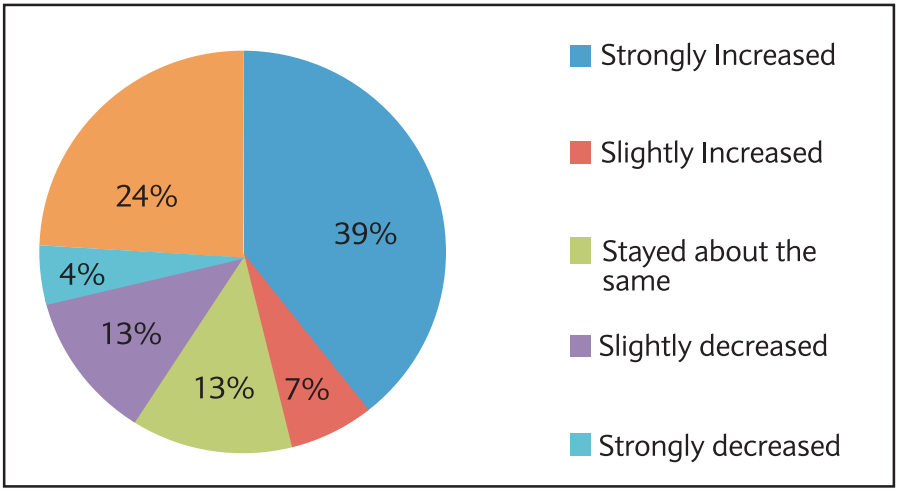
Thirty-one percent (31%) of the 536 respondents who confirmed that they could identify those involved in corrupt activities were able to name the staff involved.

Many respondents were prepared to name them, and the enumerators recorded many identities.

Sixty-nine percent (69%) of the 536 respondents responding to this section of the research were reluctant to name the officials involved. This may have been due to fear of retribution or refusal of service if it became known who had named the corrupt officials.

PERCEPTION

Corruption trends in the past twelve months



CONCLUSIONS AND RECOMMENDATIONS

Corrupt activities are rife within medical facilities throughout the provinces targeted under this research project. PLHIV seeking health services in Zimbabwe are at the mercy of health professionals, particularly nurses and other support staff. This is due to a multitude of factors including socio-economic circumstances; lack of efficient oversight and public accountability mechanisms (including criminal sanctions); the vulnerability of people requiring urgent treatment; and because the management structures in public hospitals provides the latitude and opportunities for engagement in corrupt activities with impunity.

Heightened efforts are urgently required from government, local authorities, and civic society to address this scourge.

Access to life-prolonging drugs is a human rights issue and PLHIV (claim holders) should demand accountability from government and health personnel (duty-bearers). They can only do so where they can be assured that they can safely report corrupt activities without threat to access (and consequently their survival), and where confidence can be instilled that further action will be swiftly and diligently pursued by the authorities.

Corruption devalues investment in health, is responsible for the perpetual collapse of health infrastructure and decreases the uptake of health services and goods by the poor, thereby facilitating underdevelopment.

Application of criminal law on corrupt persons and institutions should not be restricted.

GENERAL VIEWS AND RECOMMENDATIONS

It is generally agreed that there is need to comprehensively address the root causes of generalised and specific corruption at the policy level. Even where cases of corruption vary, certain characteristics appear in most detected cases and need attention, namely:[16]

- "**Motivation**"
  - The individual has an incentive (or cause) to commit fraud[17] or corruption.
- "**Opportunity**"
  - The individual can identify an opportunity to commit fraud.
- "**Justification**"
  - The individual is able to rationalise the reason for committing fraud or corruption.

Preventive Measures:

These are measures which reduce, minimise and/or eradicate the three key factors mentioned above (namely motivation, opportunity and justification). One way to reduce motivation is through the improvement of remuneration for health workers across the board (both professionals and support staff). Justification can be addressed by the adoption and implementation of ethical standards, peer pressure, and a generally agreed and accepted Code of Conduct. To reduce the opportunity at a hospital or clinic, a common understanding of clearly defined internal processes is necessary:

- Universal awareness of the applied procedures.

[16]The following were adapted with permission from Lugon-Moulin in her paper on barriers to access to medication-2006

[17] Fraud is the intentional use of deceit to deprive another of money, property or a legal right

- Identification of weak points and risks in every domain of the organisation (personnel & procedures) from the management to the employees, as well as external persons[18].
- Evaluation and appraisal of the risks, their occurrence probability and the possible impact.
- Implementation and communication of appropriate control mechanisms in the entire Hospital.
- Create awareness to warning signals and open a possibility to report concerns, rumours, observations etc. to an independent entity (e.g. Health Board, audit committee, Internal audit, Board of management, internal hotline, Zimbabwe Lawyers for Human Rights hotline or Anti-Corruption Commission).

In general, there is a correlation between a higher number of controls and a higher chance of detecting fraud and corruption. A higher risk to be detected decreases the "opportunity" and has consequently a preventive impact.

Control measures & mechanisms:

The most commonly instituted control measures are, external audits, internal audits, and internal control[19] mechanisms. Other thinkable but not widely incorporated measures are corporate security, whistle-blowing, hotlines, regular personnel rotation, specific training on fraud or fraud risk management systems. Also, codes of conduct, procurement guidelines, transparency, conflict of interest rules, monitoring procedures and rigorous prosecution are seen as trigger mechanisms to fight corruption.

[18] e.g. high volumes or high risks as well as areas of high complexity

[19] e.g. computer security (access, back up), account reconciliations, segregation of duties

RECOMMENDATIONS FOR CENTRAL GOVERNMENT

1.1 Central government needs to put in place reformed and tightened structures for drug procurement, storage, supply and distribution which will promote accountable systems and ethical environments in hospitals and other treatment facilities.

1.2 The national coordinating body – the National Aids Council (NAC), through its provincial and district coordinators, needs to take a proactive role in monitoring the distribution and dispensing of drugs around the country through a system of participatory monitoring.

1.3 The parent Ministry of Health, together with NAC and civic organisations, need to undertake awareness programmes against corruption that are rights-based and grounded on the right of PLHIV to access treatment and diagnostic services. Awareness will ensure that every person takes up a watchdog role against corrupt activities in health care.

1.4 Central government, through the Ministry of Health, must recruit qualified personnel who know their work. Anti-corruption mechanisms deliver better when applied by people who perform as required in their respective jobs.

1.5 Central government through the Ministry of Health should develop an anti-corruption strategy on drug procurement, supply and distribution that embraces corporate good governance and tight enforcement mechanisms.

RECOMMENDATIONS FOR THE ZIMBABWE ANTI-CORRUPTION COMMISSION

1.1 There is need for government to put in place measurable objectives and indicators for the Anti-Corruption Commission. Besides full and guaranteed independence, the ZACC should be staffed with experienced and skilled personnel to carry out its objectives. At the structural level, government needs to promote the rule of law and desist from arbitrary actions. Only then will the ZACC function normally and gain public confidence.

1.2 The Zimbabwe Republic Police (ZRP) should take an active role in fighting corruption. The ZRP needs to work with the ZACC to stamp out corruption. An ineffective police system effectively makes anti-corruption work a mirage.

1.3 In line with the Anti-Corruption Act, Section 11, the ZACC should investigate all cases of corruption diligently without fear or favour.

1.4 In line with the Anti-Corruption Act, Section 12, the ZACC should professionally carry out its function of monitoring and examining the practices, systems and procurement procedures of public and private institutions.

1.5 In line with the Anti-Corruption Act, Section 11, the ZACC should assist the Ministry of Health in the formulation of practices, systems and procurement procedures of essential medicines and equipment that are corruption free.

RECOMMENDATIONS FOR CIVIC SOCIETY ORGANISATIONS

For civic society, fighting corruption should be prioritised as part of crucial developmental intervention in communities. Accountability is a core value in rights-based programming and anti–corruption efforts should be seen as a key component of enforcing and demanding accountability.

1.1 Local level advocacy and monitoring done by or facilitated through civics should be encouraged to curb corruption.

1.2 Periodic review reports on access to treatment by CSOs should pay deliberate attention to the issue of corruption as a key element of reviewing performance of health systems in the country.

1.3 Citizen participation in reform. There is need for CSOs to work with the public to facilitate information flow on corruption and also mobilize for institutional reform to promote anti-corruption. Such institutional reform efforts will focus on health systems and curbing corruption.

1.4 CSOs need to undertake behavioural change advocacy targeting health personnel and other professionals in the health sector who are involved in the supply and distribution of drugs and provision of diagnostic services.

1.5 Media as civic society needs to play a significant role in investigating and exposing corruption including corrupt individuals. Failure to report corruption will lead to increased incidences of corruption.

Annexes

Annex A – Excerpt of the Anti-Corruption Commission Act

Published in Government *Gazette* 26th November 2004 as Act 13/2004 (General Notice 548/2004)

CHAPTER 9:22

ANTI-CORRUPTION COMMISSION ACT
SECTIONS 11, 12, and 13 (with added SCHEDULE)

SECTIONS 11, 12, and 13 (with SCHEDULE)

11 Objects of Commission

Subject to this Act, the objects of the Commission shall be—

(a) to promote the investigation of serious cases of corruption and fraud;

(b) to make proposals for the elimination of corruption in the public and private sectors;

(c) to promote awareness among the public of the causes of corruption and its effects on society;

(d) to propose new or more effective procedures for the administration of the Commission.

12 Functions of Commission

In addition to its functions under the Constitution, the Commission shall have the following functions—

(a) to monitor and examine the practices, systems and procurement procedures of public and private institutions; and

(b) to enlist and foster public support in combating corruption in society; and

(c) to educate the public on the dangers of corruption in society; and

(d) to instruct, advise and assist any officer, agency or institution in the elimination or minimisation of corruption; and

(e) to receive and investigate any complaints alleging any form of corruption; and

(f) to investigate any conduct of any person whom the Commission has reason to believe is connected with activities involving corruption; and

(g) to assist in the formulation of practices, systems and procurement procedures of public and private institutions with a view to the elimination of corrupt practices; and

(h) to advise on ways of strengthening anti-corruption legislation; and

(i) to recommend to the Government that it ratify and domesticate relevant international legal instruments aimed at combating corruption.

13 Powers of Commission

(1) Subject to this Act, for the better exercise of its functions the Commission shall have power to do or cause to be done, either by itself or through its agents, all or any of the things specified in the Schedule, either absolutely or conditionally and either solely or jointly with others.

(2) The Commission shall exercise its powers concurrently with those of the police.

(3) In exercising its powers, the Commission shall be governed by the relevant provisions of the Criminal Procedure and Evidence Act [*Chapter 9:07*] which govern the police.

(4) An officer who intends to make any search, entry or seizure for the purposes of this section shall—

(a) notify the officer commanding the police district in which the officer intends to make the search, entry or seizure; and

(b) be accompanied by a police officer assigned to him or her or by the police officer referred to in paragraph (a):

Provided that where an officer has reason for believing that any delay involved in obtaining the accompaniment of a police officer would defeat the object of the search, entry or seizure, he or she may make such search, entry or seizure without such police officer.

(5) In the event of any conflict arising in the exercise of their powers between the Commission and the Zimbabwe Republic Police, the Attorney-General shall have the power to intervene and direct the parties to do anything that in his or her opinion must be done to resolve the conflict.

SCHEDULE (*Section 13*)

POWERS OF COMMISSION

1. To make recommendations to the police to arrest and detain any persons reasonably suspected of committing any of the following offences and communicate any such recommendation to the Attorney-General—

(a) any offence related to corruption;

(b) contravening section 63 (“Money-laundering”) of the Serious Offences (Confiscation of Profits) Act [*Chapter 9:17*];

(c) the sale, removal or disposal outside Zimbabwe of any controlled product in contravention of the Grain Marketing Act [*Chapter 18:14*];

(d) any offence under any enactment relating to the unlawful possession of, or dealing in, precious metals or precious stones;

(e) any contravention of section 42 ("Offences relating to banknotes") of the Reserve Bank of Zimbabwe Act [*Chapter 22:15*] or committing any offence relating to the coinage;

(f) contravening subparagraph (i) of paragraph (a) of subsection (1) of section 5 of the Exchange Control Act [*Chapter 22:05*] as read with –

(i) subsection (1) of section 4 of the Exchange Control Regulations, 1996, published in Statutory Instrument 109 of 1996, (in this subparagraph and subparagraph (g) called "the Exchange Control Regulations"), by dealing in any foreign currency in contravention of paragraph (a) or (b) of that section of the Regulations without the permission of an exchange control authority;

(ii) subsection (1) of section 10 of the Exchange Control Regulations, by unlawfully making any payment, placing any money or accepting any payment in contravention of paragraph (a), (b), (c) or (d) of that section of the Regulations;

(iii) paragraph (a) or (b) of subsection (1) of section 11 of the Exchange Control Regulations, by unlawfully making any payment outside Zimbabwe or incurring an obligation to make any payment outside Zimbabwe;

(iv) paragraph (b). (e) or (f) of subsection (1) of section 20 of the Exchange Control Regulations, by unlawfully exporting any foreign currency, gold, silver or platinum, or any article manufactured from or containing gold, silver or platinum, or any precious or semiprecious stone or pearl from Zimbabwe;

(v) subsection (2) of section 21 of the Exchange Control Regulations, by unlawfully exporting any goods from Zimbabwe in contravention of that provision of the Regulations;

(vi) any amendment or replacement of any provision of the Exchange Control Regulations substantially corresponding to any of the provisions mentioned in subparagraphs (i) to (v).

(g) contravening paragraph (b) of subsection (1) of section 5 of the Exchange Control Act [*Chapter 22:05*] by making any false statement or producing any false document in connection with a contravention of subsection (2) of section 21 of the Exchange Control Regulations;

(h) theft of a motor vehicle as defined in section 2 of the Road Traffic Act [*Chapter 13:11*].

(i) theft or forgery of –

(i) a document issued to a person in terms of subsection (1) or (2) of section 7 of the National Registration Act [*Chapter 10:17*], or a passport or drivers licence issued by or on behalf of the Government of Zimbabwe; or

(ii) any visitors entry certificate or other certificate or permit issued to a person in terms of the Immigration Act [*Chapter 4:02*], or in terms of any enactment relating to refugees; or

(iii) any passport, identity document or drivers licence issued by a foreign government; or

(iv) a vehicle registration plate; or

(v) any documentation relating to the registration or insurance of a motor vehicle.

(j) A conspiracy, incitement or attempt to commit any offence referred to in paragraphs 1 to 9.

2. To obtain search warrants from a magistrate or justice of the peace.

3. To seize any travel documents or anything which is reasonably believed to contain evidence of the commission of an offence related to corruption.

4. To seek through the Attorney-General's Office court orders for the freezing of any assets or accounts of persons suspected to be involved in any offence related to corruption.

5. To protect and safeguard any persons assisting in investigations involving any offence related to corruption.

6. To enter any public or private premises and require any public officer or agent of a public officer (as defined in section 2 of the Prevention of Corruption Act [*Chapter 9:16*]) therein to answer any questions related to the investigation of any offence related to corruption.

7. To cause to be prosecuted through the Attorney-General's Office, any person reasonably believed to have committed any offence related to corruption.

8. To seek court orders through the Attorney-General's Office for confiscation of proceeds of corruption.

9. To recommend that any public officer, agency or institution follow a recommended system to improve administrative efficiency.

10. To make standing orders related to the control and administration of the Commission, the discipline, training, classification of and promotion of officers, the duties of officers and the financial regulation of the Commission and any other matters expedient or necessary for preventing the abuse or neglect of duty and for upholding the integrity of the Commission.

Annex B – Bribery and Corruption Criminal Law (9:23)

CRIMINAL LAW (CODIFICATION AND REFORM) ACT [*CHAPTER 9:23*]

Act 23/2004

CHAPTER IX

BRIBERY AND CORRUPTION

169 Interpretation in Chapter IX

In this Chapter –

"agent" means a person employed by or acting for another person in any capacity whatsoever and, without limiting this definition in any way, includes –

(a) a director or secretary of a company;

(b) the trustee of an insolvent estate;

(c) the assignee of an estate that has been assigned for the benefit or with the consent of creditors;

(d) the liquidator of a company or other body corporate that is being wound up or dissolved;

(e) the executor of the estate of a deceased person;

(f) the legal representative of a person who is a minor or of unsound mind or who is otherwise under legal disability;

(g) a public officer;

(h) a member of a board, committee or other authority which is responsible for administering the affairs or business of a body corporate or association other than a statutory body or local authority;

(i) a person who voluntarily –

(i) manages the affairs or business of another person; or

(ii) takes care of the property of another person;

without the knowledge or consent of that other person;

"consideration" means any right, interest, profit, indemnity, benefit or advantage of any kind whatsoever;

"local authority" means a city, municipality, town council, town board, provincial council, rural district council or any similar body established by or in terms of any enactment;

"principal" means the employer or other person for whom an agent acts and, in relation to –

(a) a trustee, assignee, liquidator, executor or legal representative referred to in the definition of "agent", includes –

(i) all persons represented by the trustee, assignee, liquidator, executor or legal representative, as the case may be, or in relation to whom he or she stands in a position of trust; and

(ii) any public officer who is responsible for supervising the activities of the trustee, assignee, liquidator, executor or legal representative;

(b) a public officer who is a Minister and a member of the Cabinet, includes both the State andthe Cabinet;

(c) a member of a council, board, committee or authority which is responsible for administering the affairs or business of a statutory body, local authority, body corporate or association, includes both such council, board, committee or authority and the statutory body, local authority, body corporate or association for whose affairs or business it is responsible;

"public officer" means –

(a) a Vice-President, Minister or Deputy Minister; or

(b) a governor appointed in terms of an Act referred to in section 111A of the Constitution; or

(c) a member of a council, board, committee or other authority which is a statutory body or local authority or which is responsible for administering the affairs or business of a statutory body or local authority; or

(d) a person holding or acting in a paid office in the service of the State, a statutory body or a local authority; or

(e) a judicial officer;

"statutory body" means –

(a) any Commission established by the Constitution; or

(b) any body corporate established directly by or under an Act for special purposes specified in that Act.

170 Bribery

(1) Any–

(a) agent who obtains or agrees to obtain or solicits or agrees to accept for himself or herself or any other person any gift or consideration as an inducement or reward¾

(i) for doing or omitting to do, or having done or omitted to do, any act in relation to his or her principal's affairs or business; or

(ii) for showing or not showing, or having shown or not shown, any favour or disfavour to any person or thing in relation to his or her principal's affairs or business;

knowing or realising that there is a real risk or possibility that such gift or consideration is not due to him or her in terms of any agreement or arrangement between himself or herself and his or her principal;

or

(b) person who, for himself or herself or any other person, gives or agrees to give or offers to an agent any gift or consideration as an inducement or reward

(i) for doing or omitting to do, or having done or omitted to do, any act in relation to his or her principal's affairs or business; or

(ii) for showing or not showing, or having shown or not shown, any favour or disfavour to any person or thing in relation to his or her principal's affairs or business;

knowing or realising that there is a real risk or possibility that such gift or consideration is not due to the agent in terms of any agreement or arrangement between the agent and his or her principal;

shall be guilty of bribery and liable to

A. a fine not exceeding level fourteen or not exceeding three times the value of any consideration obtained or given in the course of the crime, whichever is the greater; or

B. imprisonment for a period not exceeding twenty years;

or both.

(2) If it is proved, in any prosecution for bribery, that –

(a) an agent has obtained, agreed to obtain or solicited any benefit or advantage, whether for himself or herself or for another person; or

(b) any person has given, agreed to give or offered any benefit or advantage¾

(i) to an agent, whether for himself or herself or for another person; or

(ii) to any other person, after agreeing with an agent to do so;

it shall be presumed, unless the contrary is proved, that he or she did so in contravention of this section.

171 Corruptly using a false document

(1) Any –

(a) agent, who, in connection with his or her principal's affairs or business, uses a document which contains a false statement –

(i) knowing that the document contains a false statement or realising that there is a real risk or possibility that it may do so; and

(ii) intending by the use of the document to deceive his or her principal, or realising that there is a real risk or possibility that his or her use of the document may deceive his or her principal;

or

(b) person who gives an agent a document which contains a false statement –

(i) knowing that the document contains a false statement or realising that there is a real risk or possibility that it may do so; and

(ii) intending to deceive the agent or the agent's principal or realising that there is a real risk or possibility that by his or her use of the document the agent or the agent's principal may be deceived;

shall be guilty of corruptly using a false document and liable to a fine up to or exceeding level fourteen or imprisonment for a period not exceeding twenty years or both.

(2) For the purposes of paragraph (b) of subsection (1), where a person gives an agent a false document, intending to deceive the agent or the agent's principal in the conduct of his or her principal's affairs or business or realising that there is a real risk or possibility that the agent or the agent's principal may be so deceived, the person shall be presumed, unless the contrary is proved, to intend to deceive the agent's principal as well as the agent, or to realise that there is a real risk or possibility that the agent's principal as well as the agent may be deceived, as the case may be.

172 Corruptly concealing a transaction from a principal

(1) Any –

(a) agent who, having carried out any transaction in connection with his or her principal's affairs or business, fails to disclose to the principal the full nature of the transaction –

(i) intending to deceive the principal or realising that there is a real risk or possibility that the principal may be deceived; or

(ii) intending to obtain a consideration knowing or realising that there is a real risk or possibility that such consideration is not

due to him or her in terms of any agreement or arrangement between himself or herself and the principal; or

(b) person who –

(i) carries out any transaction with an agent in connection with the affairs or business of the agent's principal; or

(ii) assists an agent to carry out any such transaction;

knowing that the agent does not intend to disclose to the principal the full nature of the transaction;

shall be guilty of corruptly concealing a transaction from a principal and liable to a fine up to or exceeding level fourteen or imprisonment for a period not exceeding twenty years or both.

(2) Where an agent agrees or arranges with another person or a person agrees or arranges with an agent not to disclose to the agent's principal the full nature of any transaction which the agent has carried out or will carry out in connection with the principal's affairs or business, and the agent or person so agreed or arranged –

(a) intending to deceive the principal or realising that there is a real risk or possibility that the principal may be deceived; or

(b) intending that the agent should obtain a consideration knowing or realising that there is a real risk or possibility that such consideration is not due to the agent in terms of any agreement or arrangement between the agent and the principal;

the competent charge shall be conspiracy to commit the crime of corruptly concealing a transaction from a principal.

(3) If it is proved, in any prosecution for corruptly concealing a transaction from a principal, that –

(a) an agent –

(i) agreed or arranged with another person that the full nature of any transaction should not be disclosed to the agent's principal; or

(ii) failed to disclose to his or her principal the full nature of any transaction;

the agent shall be presumed, unless the contrary is proved, to have done so intending to deceive the principal, or to obtain a consideration for himself or herself knowing or realising that there is a real risk or possibility that such consideration is not due to him or her in terms of any agreement or arrangement between himself or herself and the principal, as the case may be;

(b) any person agreed or arranged with an agent that the full nature of any transaction should not be disclosed to the agent's principal, that person shall be presumed, unless the contrary is proved, to have done so intending to deceive the agent's principal;

(c) any person carried out a transaction with an agent or assisted an agent to carry out a transaction the full nature of which was not disclosed to the agent's principal, that person shall be presumed, unless the contrary is proved, to have known that the agent did not intend to disclose to the principal the full nature of the transaction.

173 Corruptly concealing from a principal a personal interest in a transaction

(1) Any –

(a) agent who carries out any transaction in connection with his or her principal's affairs or business without disclosing to the principal that he or she holds a personal interest in the subject-matter of the transaction –

(i) intending to deceive the principal or realising that there is a real risk or possibility that the principal may be deceived; or

(ii) intending to obtain a consideration knowing or realising that there is a real risk or possibility that such consideration is not due to him or her in terms of any agreement or arrangement between himself or herself and the principal;

or

(b) person who –

(i) carries out any transaction with an agent in connection with the affairs or business of the agent's principal; or

(ii) assists an agent to carry out any such transaction;

knowing that the agent does not intend to disclose to the principal a personal interest which he or she or the agent holds in the subject-matter of the transaction;

shall be guilty of corruptly concealing from a principal a personal interest in a transaction and liable to a fine up to or exceeding level fourteen or imprisonment for a period not exceeding twenty years or both.

(2) Where an agent agrees or arranges with another person or a person agrees or arranges with the agent not to disclose to the agent's principal any personal interest held by the agent in the subject-matter of any transaction which the agent has carried out or will carry out in connection with the principal's affairs or business, and the agent or person so agreed or arranged –

(a) intending to deceive the principal or realising that there is a real risk or possibility that the principal may be deceived; or

(b) intending that the agent should obtain a consideration knowing or realising that there is a real risk or possibility that such consideration

is not due to the agent in terms of any agreement or arrangement between the agent and the principal;

the competent charge shall be conspiracy to commit the crime of corruptly concealing from a principal a personal interest in a transaction.

(3) If it is proved, in any prosecution for the crime of corruptly concealing from a principal a personal interest in a transaction, that –

(a) an agent –

(i) agreed or arranged with another person that a personal interest held by the agent in the subject-matter of any transaction should not be disclosed to the agent's principal;

(ii) failed to disclose to his or her principal a personal interest held by him or her in the subject-matter of any transaction;

the agent shall be presumed, unless the contrary is proved, to have done so intending to deceive the principal or to obtain a consideration for himself or herself knowing or realising that there is a real risk or possibility that such consideration is not due to him or her in terms of any agreement or arrangement between himself or herself and the principal, as the case may be;

(b) any person agreed or arranged with an agent that a personal interest held by the agent in the subject-matter of any transaction should not be disclosed to the agent's principal, that person shall be presumed, unless the contrary is proved, to have done so intending to deceive the agent's principal;

(c) any person carried out a transaction with an agent or assisted an agent to carry out a transaction in the subject-matter of which the agent had a personal interest which was not disclosed to the agent's principal, that person shall be presumed, unless the contrary is proved, to have known of the personal interest and that the agent did not

intend to disclose to the principal the personal interest held by him or her in the subject-matter of the transaction.

174 Criminal abuse of duty as public officer

(1) If a public officer, in the exercise of his or her functions as such, intentionally –

(a) does anything that is contrary to or inconsistent with his or her duty as a public officer; or

(b) omits to do anything which it is his or her duty as a public officer to do;

for the purpose of showing favour or disfavour to any person, he or she shall be guilty of criminal abuse of duty as a public officer and liable to a fine not exceeding level thirteen or imprisonment for period not exceeding fifteen years or both.

(2) If it is proved, in any prosecution for criminal abuse of duty as a public officer, that a public officer, in breach of his or her duty as such, did or omitted to do anything to the favour or prejudice of any person, it shall be presumed, unless the contrary is proved, that he or she did or omitted to do the thing for the purpose of showing favour or disfavour, as the case may be, to that person.

(3) For the avoidance of doubt it is declared that the crime of criminal abuse of duty as a public officer is not committed by a public officer who does or omits to do anything in the exercise of his or her functions as such for the purpose of favouring any person on the grounds of race or gender, if the act or omission arises from the implementation by the public officer of any Government policy aimed at the advancement of persons who have been historically disadvantaged by discriminatory laws or practices.

Annex C – Amendment 19 of the Constitution

THE CONSTITUTION OF ZIMBABWE

As amended to No.19 of 2009

CHAPTER XB

OTHER INDEPENDENT COMMISSIONS

(INSERTED S11 OF ACT 1 OF 2009)

PART II

ZIMBABWE ANTI-CORRUPTION COMMISSION

100K Establishment and composition of Zimbabwe Anti-Corruption Commission

(1) There is a Zimbabwe Anti-Corruption Commission consisting of at least four and not more than nine members appointed by the President in consultation with the Committee on Standing Rules and Orders.

(2) Persons appointed to the Zimbabwe Anti-Corruption Commission must be persons of integrity chosen for their knowledge of and experience in administration or the prosecution or investigation of crime or for their general suitability for appointment, and—

(a) at least one must be entitled to practise as a legal practitioner; and

(b) at least one must be entitled to practise as an auditor or public accountant in Zimbabwe; and

(c) at least one shall have had at least ten years' experience in the investigation of crime.

100L Functions of Zimbabwe Anti-Corruption Commission

The Zimbabwe Anti-Corruption Commission has the following functions—

(a) to combat corruption, theft, misappropriation, abuse of power and other improprieties in the conduct of affairs in both the public and private sectors; and

(b) to make recommendations to the Government and to organisations in the private sector on measures to enhance integrity and accountability and to prevent improprieties; and

(c) to exercise any other functions that may be conferred or imposed on the Commission by or under an Act of Parliament.

100M Powers of Zimbabwe Anti-Corruption Commission

An Act of Parliament may confer powers on the Anti-Corruption Commission, including power—

(a) to conduct investigations and inquiries on its own initiative or on receipt of complaints; and

(b) to require assistance from members of the Police Force and other investigative agencies of the State; and

(c) through the Attorney-General, to secure the prosecution of persons guilty of corruption, theft, misappropriation, abuse of power and other improprieties

Annex D –Questionnaire on Access to Treatment

Questionnaire on Access to Treatment in Zimbabwe

(Reformatted for the purposes of this publication)

Hallo, my name is .....I am a researcher with the HIV/ AIDS and Law Project. We are carrying out a study on corruption and its impact on access to treatment. The results of the study will be used to introduce new proposals to combat corruption in the health sector in Zimbabwe.

Province..... Place of Interview.....

Part A: Respondent Information

(Please tick where appropriate)

1. Age:

Age group	
Below 18	
18 – 24	
25 – 29	
30 – 39	
>40	

2. Sex: **Male** ☐ **Female** ☐

3. Place of residence:

Location	
Urban	
Rural	
Peri-urban	

4. Education level

Education Level	
Below O' Level	
O' Level	
A' LevelDegree/Diploma	

5. Employment Status

Type of Employment	
Formally employed	
Informally employed	
Unemployed	

6. What is your family income?

USD$	
0 - 50	
51 – 100	
101 – 200	
201 – 300	
301 – 400	
401 – 500	
More than 500	

7. How would you assess your family income?

Cannot afford the basics	
Can afford the basics	
Sometimes gets enough to afford the basics	
Can afford the basics plus luxuries	

8. How many dependents do you have?

1 – 2	
3 – 5	
5 +	

9. From which clinic do you..... collect your medication?

10. Have you received expired drugs? Yes ☐ No ☐