Integrity Practices and the Performance of Public Health Care: A Case of Mnazimmoja Hospital, Tanzania

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Abstract

Integrity, characterized by honesty, adherence to rules, and ethical conduct, is a cornerstone of trust and quality in healthcare delivery. This study assessed the influence of integrity practices on the performance of public health care at Mnazimmoja Hospital in Dar es Salaam, Tanzania. A descriptive cross-sectional design was employed, collecting data from 139 participants, including 83 patients and 56 healthcare staff, using structured questionnaires and in-depth interviews. Quantitative data were analyzed using descriptive statistics (frequencies, percentages, mean, standard deviation), while qualitative data were analyzed thematically. The study revealed a generally positive perception of integrity practices. A majority of patients (58.9%) agreed that observed ethical breaches were addressed promptly (Mean=2.10). Similarly, staff demonstrated a high level of self-reported integrity, with all respondents (100%) affirming they do not misuse hospital resources and follow rules even when unsupervised (67.9% agreed, Mean=1.71). However, significant uncertainty was noted in areas of reporting unethical behavior. Among staff, 60.7% were undecided about reporting a colleague's misconduct, and 58.9% were hesitant to report their own errors, indicating potential fear of retaliation or a lack of psychological safety. While Mnazimmoja Hospital has a strong foundation in rule compliance and resource ethics, critical gaps exist in the systems that support transparency and whistleblowing. To enhance performance and patient trust, the hospital should strengthen its integrity framework by reinforcing whistleblower protection mechanisms, fostering a culture of open disclosure, and enhancing patient awareness of ethical standards.

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Keywords: Integrity, Workplace Ethics, Public Health Care, Quality of Care, Tanzania, Whistleblowing, Health Systems Performance

Introduction

The pursuit of universal health coverage and the provision of quality healthcare are central pillars of global public health agendas. The performance of health systems in achieving these goals, however, is not solely dependent on financial investment or medical technology but is profoundly influenced by the ethical fabric of the institutions themselves (World Health Organization, 2021). Workplace ethics, encompassing the moral principles and standards that guide the behaviour and decisions of healthcare workers, are critical determinants of service quality, patient safety, and public trust (Kuhumba et al., 2024). Within this ethical framework, integrity characterized by honesty, consistency, adherence to rules, and the courageous act of accountability serves as a foundational virtue. It is the bedrock upon which trust between patients and providers is built and is indispensable for the efficient and equitable functioning of healthcare organizations (Huberts, 2018).

In developed nations, robust regulatory frameworks and professional bodies, such as the American Medical Association (AMA) and the UK's General Medical Council (GMC), provide structured guidance on ethical conduct, which is correlated with higher employee satisfaction and improved patient outcomes (Brown et al., 2018). However, public health systems in many developing countries, including Tanzania, face a more complex landscape. They are often plagued by systemic challenges such as resource constraints, weak governance, and systemic corruption, which create a fertile ground for ethical breaches (Sirili et al., 2018; Kuwawenaruwa et al., 2020). In this context, unethical practices including bribery for services, theft of medical supplies, absenteeism, and negligence are not merely individual failings but symptomatic of broader institutional weaknesses. These practices directly undermine the quality of care, erode public confidence, and pose a significant barrier to accessing essential health services (Mwandakatare & Massawe, 2022; Mnana, 2022).

The Tanzanian government has recognized this challenge, implementing several initiatives to bolster ethical conduct within the public service. These include the Public Service Code of Ethics and Conduct, the Public Leadership Code of Ethics Act, and the Health Sector Strategic Plan IV, which emphasizes good governance and ethical behaviour (Ministry of Health and Social Welfare, 2015; PO-PSMGG, 2020). Despite these efforts, a decline in public trust has been observed, with a national survey revealing confidence in the healthcare system dropping from 55% in 2012 to 35% in 2019 (National Bureau of Statistics, 2019). This erosion of trust is closely linked to persistent reports of unethical conduct, suggesting a gap between policy and practice at the facility level.

Mnazimmoja Hospital, a major public referral facility in Dar es Salaam, epitomizes this crisis. A Ministry of Health report (2023) documented that out of 82 cases of unethical conduct reported in the Dar es Salaam City Council from 2021 to 2023, 36 (approximately 44%) originated from Mnazimmoja Hospital. This concentration of issues, including bribery, poor customer care, and theft of medical supplies, has led to considerable public outcry and underscores the hospital as a critical case for investigating the real-world influence of workplace ethics on service quality. While the existence of ethical codes is a necessary first step, understanding how integrity is practiced, perceived, and enforced within the daily operations of a specific institution like Mnazimmoja is crucial.

Literature Review

The theoretical foundation of this study was grounded in Rest's (1986) Ethical Decision-Making Theory and Freeman's (1984) Stakeholder Theory, which together guided the conceptualization, variables operationalization, and analytical design of the research. Rest's framework posits that ethical behavior in public healthcare delivery is a multi-stage cognitive process shaped by individual values and organizational culture, explaining how medical professionals navigate complex moral dilemmas when balancing institutional resource constraints against urgent patient needs. Complementing this micro-level perspective, Freeman's Stakeholder Theory establishes that public institutions bear deep-seated ethical obligations to a diverse network of actors, notably frontline healthcare employees and patients, rather than just administrative or regulatory authorities. Integrating these two models in this study was structured to operationalize intergrity practice as a multi-dimensional independent variable directly driving the quality of public healthcare services. This dual framework systematically guided the empirical inquiry to investigate whether documented service quality deficiencies at Mnazi Mmoja Hospital stem from individual ethical breakdowns or systemic failures in institutional stakeholder management.

Empirical literature globally, regionally, and locally underscores that institutional integrity practices manifested through operational transparency, organizational honesty, and systemic fairness form the cornerstone of public health delivery, patient safety, and clinical governance. Globally, scholarly inquiries have established a direct causal nexus between micro-level integrity compliance and macro-level health systems performance. Kuhlmann et al. (2016) demonstrated a significant positive correlation between robust integrity practices and institutional patient trust in Germany, noting that transparent administrative frameworks directly improve patient adherence to complex clinical treatment protocols. This structural benefit is echoed by Kearns (2018) in the United States, whose empirical analysis proved that deep-seated integrity practices dramatically reduce the occurrence of workplace ethical dilemmas, thereby optimizing managerial decision-making speeds. In Northern Europe, Kivimäki et al. (2019) verified that explicit organizational honesty minimizes healthcare worker misconduct while concurrently boosting employee morale in Finland. Furthermore, systematic observations by West et al. (2020) in the United Kingdom revealed that hospitals with transparent medical auditing procedures have significantly lower clinical error rates, a finding supported by Dubois et al. (2021) in France, who argued that systemic fairness in resource distribution directly mitigates administrative negligence. In the same vein, a longitudinal study by Hansen and Jensen (2021) in Denmark concluded that open accountability models protect public health facilities against the structural depreciation of service quality, while Martinez and Silva (2022) found in Spain that institutionalized anti-corruption compliance frameworks are the strongest non-clinical predictors of public patient safety and healthcare equity.

Regionally, African health systems research heavily emphasizes integrity as a foundational element necessary to counter systemic operational vulnerabilities. In Uganda, Okello et al. (2021) observed that clear integrity baselines among healthcare professionals bolster frontline accountability, directly translating to superior clinical outcomes and reduced medication errors. In Kenya, Njuguna and Were (2020) analyzed the execution of clinical governance frameworks, finding that operational transparency is inversely related to petty corruption and illicit billing practices. Similarly, Mensah and Amoah (2019) demonstrated in Ghana that when public hospital administrations implement rigorous fairness protocols in treating patients, overall public clinical trust increases. In Southern Africa, Maponya (2021) noted that deficiencies in institutional

honesty within South African rural clinics act as a primary catalyst for resource diversion and extended patient wait times, while Chimwaza et al. (2022) discovered in Malawi that low administrative integrity directly compromises maternal and child health initiatives due to sub-optimal medical material management. Additionally, a comparative evaluation by Diallo and Traoré (2023) in Senegal highlighted that decentralized public healthcare centers prioritizing transparency experience higher patient turnaround and higher satisfaction indices than those lacking explicit integrity tracking mechanisms.

Within the United Republic of Tanzania, the discourse around health-sector integrity centers on balancing regulatory policies with practical delivery at the frontline. Msuya et al. (2020) confirmed that establishing an uncompromised ethical climate within Tanzanian regional hospitals significantly mitigates employee misconduct, curbs drug leakages, and enhances public patient satisfaction. This is structurally reinforced by Kuwawenaruwa et al. (2020), who asserted that systemic resource mismanagement and inadequate patient responsiveness in municipal health facilities are primarily driven by weak internal integrity enforcement mechanisms. Moreover, Frumence et al. (2021) observed that cultivating institutional ethics and active accountability frameworks directly improves leadership efficacy in district healthcare boards. Conversely, empirical investigations by Mwandakatare and Massawe (2022) revealed that a breakdown in personal honesty and compliance among public medical staff accounts for a one-fifth surge in localized service delivery complaints. Finally, the broader baseline assessments by Hassanal and Sospeter (2024) indicated that rampant ethical infractions, such as bribery and hostile language, remain major operational barriers that compromise the quality of care and erode the legitimacy of public health institutions in Dar es Salaam.

Therefore, a significant knowledge gap existed. Previous studies in Tanzania have focused on broad health system inefficiencies or national-level policy (e.g., National Bureau of Statistics, 2019), with limited empirical research examining the specific nexus between measurable integrity practices and healthcare performance at the facility level. While regional and local scholars have evaluated institutional accountability (Frumence et al., 2021), corruption mechanisms (Kuwawenaruwa et al., 2020), and general ethical climates (Msuya et al., 2020), existing literature remains constrained by heavy reliance on methodologies vulnerable to social desirability bias (Okello et al., 2021) and a heavy concentration on Western, high-income healthcare systems (Kuhlmann et al., 2016; Kivimäki et al., 2019; West et al., 2020). This study aimed to fill these geographical, methodological, and analytical gaps by zooming in on the micro-level interactions and institutional culture of a single, high-profile hospital. Its primary objective was to assess the influence of integrity practices operationalized alongside responsibility and professionalism under the intervening framework of the Public Service Code of Ethics and Conduct on the performance of public healthcare at Mnazi Mmoja Hospital. By elucidating the strengths and weaknesses of its integrity framework from the dual perspectives of patients and staff through an innovative combination of overt and covert parameters, this research generated evidence-based insights that informed targeted interventions to rebuild trust, enhance accountability, and ultimately improve the quality of healthcare delivery in Tanzania's public health system.

Methods

Study Design

This study employed a convergent parallel mixed-methods design. This approach was selected to provide a comprehensive understanding of the research problem by combining the strengths of both quantitative and qualitative methodologies (Creswell & Creswell, 2018). The quantitative component provided numerical data to measure the prevalence and perceptions of integrity practices, while the qualitative component offered rich, contextual insights into the underlying reasons, experiences, and institutional mechanisms. Data collection for both strands occurred concurrently during the same data collection phase, and the results were integrated during the interpretation and discussion to provide a more complete analysis.

A descriptive cross-sectional survey was used for the quantitative strand. This design was appropriate for capturing a snapshot of the perceptions and experiences of patients and staff at a specific point in time (February to September 2025), allowing for the description of variables and their relationships without manipulating them.

Study Setting

The study was conducted at Mnazimmoja Hospital, a public referral hospital located in the Ilala District of Dar es Salaam, Tanzania. As a major healthcare facility under the Dar es Salaam City Council, it serves a large and diverse urban population. The selection of this site was purposive, justified by a report from the Tanzanian Ministry of Health (2023) which indicated that the hospital accounted for 44% (36 out of 82) of documented unethical conduct cases in the council between 2021 and 2023. This high prevalence of reported ethical challenges made it an ideal setting for an in-depth investigation into integrity practices.

Study Population and Sampling

The study targeted two distinct groups: healthcare staff at Mnazimmoja Hospital, including doctors, nurses, pharmacists, administrative, and support personnel, totaling 85 individuals, and adult patients or guardians seeking services during the data collection period, with a target population of 127. Using Sloven's formula for a finite population, a minimum sample size of 139 was determined, based on a total population of 212, a 5% margin of error, and appropriate sampling calculations. For staff, a stratified random sampling approach was employed, dividing them into medical (51), administrative (29), and support (5) cadres, with proportional allocation resulting in 32 medical, 19 administrative, and 5 support staff participants, selected randomly from each stratum. Patients were sampled systematically by selecting every k-th patient exiting consultation rooms until the sample size was met, with an estimated daily outpatient flow guiding the interval. Additionally, five senior management staff members Hospital Director, Medical Officer in Charge, Head of Nursing, Human Resources Manager, and Senior Administrator were purposively selected for in-depth interviews due to their strategic roles in hospital policies and workplace culture.

Data Collection Methods and Tools

Data were collected using two primary methods: quantitative and qualitative. Quantitative data were gathered through structured, self-administered questionnaires for both staff and patients, adapted from established tools like the WHO Ethics Questionnaires and Ethical Compliance Audit guides to ensure relevance and validity. The staff questionnaire included sections on demographics and closed-ended Likert-scale questions (1=Strongly Agree to 5=Strongly Disagree) to assess perceptions of integrity, responsibility,

professionalism, and ethical conduct, while the patient questionnaire captured their experiences and observations regarding staff behavior and hospital environment. For qualitative data, semi-structured in-depth interviews were conducted with five senior management staff using an interview guide with open-ended questions exploring themes such as how integrity is promoted and enforced, institutional mechanisms for addressing unethical behavior, and challenges and successes in maintaining ethical standards. Each interview lasted 25-40 minutes, was conducted in private, audio-recorded with permission, and transcribed verbatim for analysis.

Data Analysis

For data analysis, quantitative data from the questionnaires were first cleaned, coded, and entered into SPSS version 26.0, where descriptive statistics such as frequencies, percentages, means, and standard deviations were computed to summarize demographic information and Likert-scale responses. The mean scores were interpreted using a predefined scale to facilitate understanding, and results were presented in tables and figures. Qualitative data from the transcribed interviews were analyzed through thematic analysis based on Braun and Clarke's (2006) methodology, involving familiarization with the data, coding key phrases, identifying and refining themes, and producing a detailed report with illustrative examples. This process was conducted manually to ensure a thorough immersion in the data. During the discussion phase, the quantitative and qualitative findings were integrated: the quantitative results highlighted prevailing perceptions and patterns, such as hesitancy to report misconduct, while the qualitative data provided contextual explanations, like fears of retaliation and cultural barriers, enabling a nuanced and comprehensive interpretation of the findings.

Results

The findings on integrity practices at Mnazimmoja Hospital, drawn from 83 patients and 56 staff members, reveal a complex picture of strong foundational ethics coupled with significant areas of concern, particularly regarding transparency and reporting mechanisms.

Patients' Perceptions of Integrity Practices

Patients generally held a positive, though cautiously optimistic, view of the integrity practices at the hospital. Their perceptions varied depending on the specific aspect of integrity in question, as detailed in Table 1.

Table 1: Patients' Perceptions of Integrity Practices at Mnazimmoja Hospital (n=83)

S/N	Description	Strongly Agree/ Agree (%)	Undecided (%)	Disagree / Strongly Disagree (%)	Mean	Std. Deviation
1	Any ethical breaches I've witnessed are addressed promptly by hospital staff.	66 (58.9%)	1 (0.9%)	7 (6.3%)	2.10	0.806
2	The hospital staff follow rules and regulations, even when no one is watching.	45 (40.1%)	31 (27.7%)	7 (6.3%)	2.47	0.888

3	I feel that staff are honest and maintain integrity in their interactions with patients.	31 (27.7%)	49 (43.8%)	3 (2.7%)	2.65	0.572
4	I believe that staff would report unethical behavior when observed	33 (29.4%)	35 (31.3%)	15 (13.4%)	2.80	1.145
5	I feel that hospital resources are used only for their intended purposes.	31 (27.7%)	43 (38.4%)	9 (8.1%)	2.75	0.730

The most positively viewed area was the hospital's responsiveness to ethical breaches, with 58.9% of patients agreeing that issues were addressed promptly (Mean=2.10). This suggests a perception of active institutional accountability. However, a notable level of uncertainty was evident in other critical areas. For instance, 43.8% of patients were undecided about the honesty of staff in direct interactions, and 38.4% were uncertain about the proper use of hospital resources. Most strikingly, only 29.4% of patients believed that staff would report unethical behaviour, with 31.3% being undecided, indicating a significant lack of confidence in the internal whistleblowing culture.

Staff's Self-Reported Integrity Practices

In contrast to patient perceptions, hospital staff reported a very high degree of personal integrity, particularly concerning rule compliance and resource use. However, this confidence did not extend to actions involving their peers, as shown in Table 2.

Table 2: Staff's Self-Reported Integrity Practices at Mnazimmoja Hospital (n=56)

S/N	Description	Strongly Agree / Agree (%)	Undecided (%)	Disagree / Strongly Disagree (%)	Mean	SD
1	I have never taken anything from work without permission, and I use hospital resources only for their intended purposes.	56 (100%)	0 (0%)	0 (0%)	2.00	0.000
2	I believe in following rules and regulations, even when no one is watching and I am comfortable admitting my mistakes.	55 (98.2%)	1 (1.8%)	0 (0%)	1.71	0.495
3	I can't tolerate my colleagues or supervisor if I knew he/she is engaging in misconduct for personal gain.	56 (100%)	0 (0%)	0 (0%)	2.00	0.000
4	I can report to my supervisor immediately when I realize that I have administered the wrong medicine or treatment.	23 (41.1%)	33 (58.9%)	0 (0%)	2.57	0.535
5	I would report a colleague if I knew they are engaging in unethical behavior and I am aware of the procedures for reporting without fear of retaliation.	13 (23.2%)	34 (60.7%)	9 (16.1%)	3.05	0.942

Staff demonstrated unanimous agreement (100%) on the appropriate use of resources and their intolerance for misconduct by colleagues. A near-unanimous 98.2% also agreed they follow rules and admit mistakes unsupervised (Mean=1.71). However, this strong personal ethical stance was not matched by a willingness to act on the misconduct of others. A significant majority, 60.7%, were undecided about reporting a colleague's unethical behavior, and only 23.2% agreed they would do so. Furthermore, 58.9% were undecided about reporting their own errors, such as administering wrong medication, indicating a pervasive hesitancy linked to fear or institutional barriers.

Qualitative Findings: The Institutional Perspective on Integrity

The in-depth interviews with senior management provided context to the quantitative findings, highlighting both the institutional efforts and the persistent challenges.

Management affirmed a strong commitment to promoting integrity. One senior manager stated, *"We promote integrity through ongoing training, clear codes of conduct, and leading by example, ensuring patient interests are prioritized over personal gain."* They acknowledged past problems but pointed to concrete improvements, noting, *"The management has taken important steps, like introducing the Q management system and installing CCTV cameras throughout the hospital. These changes have significantly reduced unethical actions."*

However, the interviews also directly identified the barriers that explain the staff's hesitancy. A manager explicitly confirmed, *"The biggest challenges in promoting ethics include fear of retaliation among staff who report misconduct..."* This fear creates a critical gap between the existence of reporting procedures and their safe utilization. Another manager described the "inquiry triangle" initiative, which allows patients to question staff instructions, as a step towards building external accountability and trust. Despite these efforts, the qualitative data confirms that a culture of full transparency and psychological safety for staff has not yet been fully realized, directly corroborating the uncertainty seen in the survey responses.

Discussion

This study set out to assess the influence of integrity practices on the performance of public health care at Mnazimmoja Hospital. The findings reveal a critical dissonance within the hospital's ethical landscape: a strong foundation of *personal* integrity among staff coexists with a significant weakness in *systemic* integrity mechanisms, particularly those that enable transparency and accountability. This discussion interprets these findings through the lens of the Ethical Decision-Making and Stakeholder theories.

The Facade of Rule-Compliance and the Reality of Fear

The near-unanimous agreement among staff on using resources appropriately and following rules unsupervised (Table 2) indicates a robust understanding and acceptance of basic ethical conduct. This aligns with the expectations set by the Ethical Decision-Making Theory, where individual moral recognition is the first step (Rest, 1986). The hospital's institutional efforts, such as CCTV and the Q-management system mentioned by management, appear effective in reinforcing this level of compliance. This creates a visible "façade of integrity" that likely contributes to the moderate level of patient trust in rule-following (Table 1, Mean=2.47).

However, this façade cracks when ethical dilemmas require moral courage specifically, reporting the misconduct of peers or admitting one's own errors. Here, the findings are stark. The fact that 60.7% of staff were undecided about reporting a colleague, and 58.9% hesitated to report their own mistakes, points to a profound failure in the organizational and contextual factors of the Ethical Decision-Making model. The theory posits that ethical action is not just about individual morality but is heavily influenced by the organizational culture (Trevino, 1986). The qualitative data confirms that the dominant cultural factor is "fear of retaliation." This fear effectively short-circuits the ethical decision-making process, preventing staff from progressing from moral judgment to moral action. This finding is consistent with global healthcare literature identifying fear as a primary barrier to open disclosure and whistleblowing (Jones et al., 2016; Ferguson et al., 2019). The consequence is a silent, collusive culture where wrongdoing is tolerated, undermining the very performance and safety metrics the hospital seeks to improve.

The Stakeholder Trust Deficit

The Stakeholder Theory (Freeman, 1984) provides a crucial lens for understanding the broader implications of this internal ethical failure. The theory emphasizes that an organization must balance the interests of all its stakeholders, with patients being the primary beneficiaries. The significant uncertainty among patients with over 40% undecided about staff honesty and resource use reveals a critical "trust deficit." Patients, as key stakeholders, are perceptive; their inability to confidently affirm the hospital's integrity reflects the opacity of its internal ethical climate.

This trust deficit has direct consequences for healthcare performance. Patients who are uncertain if resources are being used properly may lose faith in the system's equity. Those who doubt staff will report errors may be less likely to speak up about their own safety concerns, hindering patient engagement and potentially leading to adverse outcomes. The hospital's performance is thus not merely a function of clinical efficiency but is intrinsically tied to its ability to build and maintain trust with its patient stakeholders through demonstrably ethical practices.

Bridging the Gap: From Individual Virtue to Systemic Safety

The most telling finding is the disconnect between staff's personal intolerance for misconduct (100% agreed they "can't tolerate" it) and their practical unwillingness to act (only 23.2% would report it). This chasm highlights that a culture of integrity requires more than virtuous individuals; it requires a *system* that protects and empowers them.

Management's initiatives, such as the "inquiry triangle" for patients, are a step in the right direction as they engage an external stakeholder in the accountability loop. However, our findings suggest that internal systems for staff are insufficient. A robust integrity framework must include strong, transparent, and enforced whistleblower protection policies. Without this, ethical codes and training remain theoretical, and the hospital's performance will continue to be hampered by unaddressed misconduct, medical errors that go unreported, and a pervasive erosion of trust from both within and outside the organization.

Generally, the performance of public health care at Mnazimmoja Hospital is positively influenced by the strong personal integrity of its staff in adhering to rules and managing resources. However, this positive influence is severely undermined by a systemic failure to cultivate a psychologically safe environment for transparency and accountability. The hospital's performance is caught in a paradox: it has ethical staff but

an unethical culture of silence. Future interventions must move beyond rule-setting and focus on building trust and safety for staff, thereby aligning the hospital's internal ethical climate with its mission to provide high-quality, trustworthy care to its patients.

Conclusion

This study provides a nuanced diagnosis of the state of integrity at Mnazimmoja Hospital, moving beyond a simplistic assessment of ethical failure to identify a critical systemic gap. The conclusion is twofold. First, the hospital demonstrates a strong, commendable foundation in what can be termed "procedural integrity" - the adherence to formal rules, responsible resource management, and the prompt handling of reported breaches. This is evidenced by the near-unanimous staff compliance and moderate patient trust in these areas. However, and more critically, the study reveals a profound deficiency in "cultural integrity" - the deeply embedded values, psychological safety, and institutional courage that empower individuals to act ethically in the face of complexity and potential risk. The pervasive hesitancy among staff to report peer misconduct or personal errors, driven by a documented fear of retaliation, signifies that the hospital's ethical infrastructure is incomplete. The ethical code of conduct, while likely present on paper, has not been fully operationalized into a safe and enabling environment. Consequently, the hospital's performance and the quality of its healthcare services are potentially compromised by unaddressed ethical lapses and a failure to leverage full transparency as a tool for continuous quality improvement. The trust of its primary stakeholders, the patients, remains conditional and fragile, held back by this internal culture of silence.

Recommendations

To bridge the gap between procedural and cultural integrity within Mnazimmoja Hospital, several evidence-based recommendations are proposed. These interventions are tailored to address the specific weaknesses identified in this study and aim to foster a more ethical and transparent healthcare environment.

For hospital management and the Dar es Salaam City Council, establishing a robust and protected whistleblowing system is essential. Moving beyond merely having a reporting policy, the hospital should implement an anonymous, multi-channel reporting mechanism such as a hotline, digital platform, or secure drop-box managed by an independent officer or external ombudsman. This system should be widely publicized, and a non-retaliation clause must be incorporated into staff contracts, with strict disciplinary measures for those who victimize whistleblowers. Additionally, instituting a "just culture" framework for error reporting is crucial. This approach shifts the focus from a punitive "blame culture" to one that recognizes human error, at-risk behaviors, and reckless conduct separately. It encourages open disclosure of mistakes as learning opportunities, which is vital for improving patient safety and reducing staff fears about reporting errors. Furthermore, integrating ethical leadership and psychological safety into performance metrics is recommended. Training middle and senior managers to foster an environment where staff feel safe to speak up, and including related indicators in performance reviews, can reinforce a culture of transparency and accountability.

At the national level, policymakers such as the Ministry of Health and PO-PSMGG should develop a comprehensive national framework for protecting healthcare whistleblowers. Enacting specific policies or strengthening existing legislation will provide clear, government-backed protections for healthcare workers reporting corruption, malpractice, or ethical breaches, offering a safety net beyond hospital-level measures. Additionally, mandating and funding regular, interactive ethics training is essential. Moving away from

one-time orientation sessions, these modules should engage health workers with real-world Tanzanian case studies to enhance ethical decision-making and moral courage continuously.

Future research should focus on evaluating the long-term impact of these interventions. Conducting a longitudinal study at Mnazimmoja Hospital to assess how implementing the "just culture" framework affects error reporting rates, staff morale, and patient safety indicators over 12-24 months would provide valuable insights. Additionally, exploring the socio-cultural barriers to whistleblowing in Tanzania through dedicated qualitative research could shed light on norms like hierarchy respect and "ubuntu," which may hinder open ethical practice. Understanding these cultural factors can help design more culturally sensitive interventions that promote ethical behavior.

By adopting these targeted recommendations, Mnazimmoja Hospital can move beyond merely having an ethical code to cultivating an authentic ethical culture. This transformation is a strategic imperative, vital for rebuilding public trust, enhancing patient safety, and ensuring sustainable improvements in healthcare quality and performance.

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