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EFFICIENT AND TRANSPARENT SERVICE DELIVERY IN PUBLIC HEALTH FACILITIES IN BENIN, MOZAMBIQUE AND TANZANIA

VOLUME I: COMPARATIVE REPORT

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This study was conducted by Management Systems International in close coordination with our subcontractor, HLSP.

ACRONYMS

CHD	*Centres Hospitaliers Départementaux*
CHF	Community Health Fund
CNHU	*Centre National Hospitalier et Universitaire*
COGECS	*Comité pour la gestion du centre de santé*
CPIA	Country Policy and Institutional Assessment
CRC	Citizen Report Card
CSO	Civil Society Organization
DDS	D*irections départementales de la santé*
DFID	Department for International Development
DHS	Demographic and Health Survey
FY	Fiscal Year
FGDs	Focus group discussions
GDP	Gross domestic product
HR	Human resource(s)
HSBF	Health Sector Basket Fund
LICS	Low income countries
MoH	Ministry of Health
MSI	Management Systems International
MTEF	Medium Term Expenditure Framework
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIF	National Health Insurance Fund
PBB	Performance-based Budgeting
PER	Public Expenditure Reviews
PETS	Public Expenditure Tracking Survey
PPP	Purchasing Power Parity
PRS	Poverty Reduction Strategy
QSDS	Quantitative Service Delivery Survey
SDS	Service Delivery Survey
SIGFiP	*Système Intégré de Gestion des Finances Publiques*
SNIGS	*Système National d'Information et de Gestion Sanitaires*
SWAP	Sector-wide approach
TI	Transparency International
TORs	Terms of Reference
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

In recent years, a global consensus has emerged regarding the importance of good governance and corruption-free national institutions to building foundations for sustainable growth and development. Official USAID policy stresses that corruption undermines social cohesion and broad participation in economic and political life by distorting the allocation of resources and delivery of public services, usually in ways that damage the poor in particular.[1] USAID Africa Bureau's Office of Sustainability Development requested this study. Its objectives are to provide USAID missions, Ministries of Health, and hospitals and clinics in the region with a detailed analysis of vulnerabilities in healthcare delivery and practical recommendations to improve efficiency, transparency and accountability in healthcare services. This report presents the major comparative findings and analyses of the study which was conducted in Benin, Mozambique and Tanzania during 2006. Companion reports have also been developed that provide more in depth analyses for these three countries in particular.

In this study, corruption is defined as "the use of public office for private gain" and the health system is broken down into four dimensions: the service delivery process (the provision of health care) including the interaction with the public/users; human resource management; procurement, supply chain and logistic management; and health financing and financial management. Using this analytical foundation, research was designed to investigate the vulnerabilities to corruption in each of these four dimensions. Not surprisingly, the findings of this study emphasize the importance of a systems-based approach to understanding, and eventually combating, corruption in the health sector.

The study methodology involved a preliminary phase to identify key issues for the study, including a document and literature review, followed by elaboration of the appropriate research tools. The next phase was broadly that of information gathering and initial stakeholder meetings, including household surveys (users and community data collection), facility surveys, and stakeholder interviews. Finally, draft country reports were written and presented to USAID mission staff for feedback, with the study culminating in this document.

It must be noted at the outset that assessing the extent of corruption and degree of transparency and accountability in the health sector is challenging. Performance indicators are problematic, partly due to the nature of the health sector, where services are of a personal and usually confidential nature and demand is unpredictable. A further challenge is the general sensitivity of corruption as a topic, which makes it difficult to investigate or measure in a precise, quantifiable manner.

In order for a study such as this to be successfully undertaken and for the findings to be acted upon, it is important to understand the readiness of the political and leadership environment to act. The varied pace and scope of the research in the three countries illustrated this lesson. For instance, in Benin, the study was facilitated by a very favorable political context as the new government was specifically elected to combat the endemic corruption of the previous ruling elites and had set about doing just that. As a result, research activities in Benin proceeded more smoothly than in other countries. Studies such as this benefit from initially identifying actors who may be willing to champion, or potentially benefit from, the findings of the study.

A related issue is the extent to which implementation can be expected to be successful if the reforms aim at least in part to undermine the vested interests of those in charge of the design and/or implementation

[1] USAID Anticorruption Strategy, January 2005.

processes – not an uncommon situation with reforms to promote transparency, accountability and anti-corruption. The difficulty in implementing reforms may also be connected with sensitivities around these issues, which tend to discourage explicit consideration or mention of them in public or official discussions.

The upshot of all these comments is that while we conclude with a wide range of action-oriented recommendations, there are not likely to be any quick fixes or magic formulae for resolving the problems identified in the healthcare field. Only through persistence and oversight of reform initiatives will gradual improvements become visible and meaningful.

The main findings specifically relating to the four dimensions investigated are as follows.

Service delivery and interaction with users. From the household surveys, it was found that although the proportions vary from just over 30 percent of respondents in Tanzania to well over 50 percent in Benin, it is clear that sizeable numbers of respondents in all countries do not appear to be aware of which health services are free as opposed to those that are available for a fee. This presumably makes people more vulnerable to informal and illegal charges. Also, a majority of respondents do not consider paying a gift necessary to obtain good quality care, although on further analysis, it seemed that the respondents were probably trying to say something else more obvious, namely that people are not turned away from health facilities because they did not pay a 'gift,' such 'gifts' being necessary rather to obtain better care than would otherwise be the case. At the same time, in at least two of the countries, offering and accepting gifts is not considered corruption by the majority of respondents. This appears to be related to practices widespread in these societies where gifts are frequently given in return for good services. Interestingly, nurses are considered the most corrupt, least transparent health care providers, although this is likely due to the fact that nurses are the frontline of the health delivery process and most patients come into contact with them more frequently. Nurses are also notoriously poorly paid and so are perhaps more exposed to the temptations of corruption. On the other extreme, in all of the surveys, private providers are consistently perceived as less corrupt than public ones. Although there will be many constraints to the public sector adopting similar practices, it may nevertheless be able to learn useful lessons and borrow at least some techniques from how the private sector is able to maintain this reputation.

Other significant findings related to service delivery and patient-health worker interactions from the other elements of the study include: frequent misuse of public facilities; staff soliciting under-the-table payments or bribes; the fee-for-service payment system also facilitates corruption; and low or no community participation in the management of health services exacerbates the situation.

Human Resource Management. There are several findings on this issue area. First, low salaries and lack of motivation are a principal driving force behind corruption. Second, recruitment processes are often complicated, not under the control of the Ministry of Health, and often rely upon acquaintances and paying bribes to people in authority. Finally, the systems for enforcing sanctions, discipline, rules and regulations are generally weak. This includes the lack of authority for local managers to enforce discipline and appropriate sanctions and is reinforced by an atmosphere of impunity. It was also reported that inefficient, non-transparent and unaccountable practices are sometimes perpetuated by the actions of professional bodies of staff who seek to defend the corporate and individual interests of their members.

Procurement, Supply Chain and Logistics Management. It was found that commodity policy and management are considerably less than optimal. The areas of greatest weakness tend to be related to procurement and stock management, especially regarding transparency of the processes involved, quality control and monitoring, inventory and stock management systems. The procurement and tendering processes were found to be prone to a lack of transparency and corruption, including favoritism, kick-backs, circumvention of established procedures, non-competitive bidding and similar issues. The study also found that country supply chain systems were often characterized by a lack of reliable systems for

forecasting and anticipating demand, due to poor information flow, dysfunctional inventory and stock control management systems, and lack of coordination between different actors in the system. Supply chain problems were further aggravated by poor infrastructure (transport, roads, and computer systems). The contractual and administrative processes involved in construction, maintenance, rehabilitation and repairs also offer opportunities for corrupt officials and suppliers/contractors through kick-backs, over- and under-invoicing, provision of low quality services or defective equipment, parts and materials.

Health financing and financial management: Reports from the countries show that the lack of computerization and reliable recordkeeping systems (absence of audit trails) open the way to corrupt practices that are difficult to detect or punish. Health institutions are put under pressure because the Government does not or is unable to pay its debts to those institutions. The study also concluded that external audits are not regularly done as required by statutes, or not properly done, or if they are well done, their findings and recommendations may not be followed up. This appears to be related to shortages of relevant experts, capacity issues with public audit institutions and political and other interference with auditors' work. Financial procedures are also sometimes non-existent or not followed, a reflection of poor public administration in countries.

Reflecting the financial difficulties of low income countries such as these, low budget execution rates are frequently cited, due to factors within the sector Ministry or at the level of the Finance Ministry. Closely related is the problem of long delays in releasing funds for activities at the operational levels such as districts and health institutions, with large sums often getting released only towards the end of the fiscal year, but which cannot be carried over to the next fiscal year. As a consequence, normal procedures may be circumvented, checks and controls that may have been in place in normal times may be temporarily suspended and similar deviations from good practice all add up to create opportunities for corrupt officials to line their pockets and engage in other abuses.

On the other hand, the study also found examples of good practice worth emulation: The *Clinique Homel* in Benin was widely acclaimed as an example of successful reform involving the application of simple management and administrative techniques to facilitate transparent and accountable management. Similarly, in Mozambique, mention has been made of past initiatives taken to improve the link between health units and communities. These included exit interviews at health facilities, management and leadership activities provided at health facilities to empower staff, and training of staff to monitor each others' activities.

Finally, the study presents several tables of country-specific, as well as more general, recommendations for improving efficiency, transparency and accountability in the health sector, distinguishing between short and long term measures. The study emphasized that successful implementation of anti-corruption reforms would require: political leadership and commitment, a comprehensive multi-sectoral approach, donor harmonization and coordination of approaches, promotional activities to build commitment and support, proper attention to effective targeting and sequencing of strategies for preventing and combating corruption in the health sector, and identification of the forces for change and/or influential stakeholders who might benefit from, support or even oppose the proposed reforms.

1.0 INTRODUCTION: GENERAL CONTEXT AND SCOPE OF THE STUDY

A global consensus has emerged over recent years regarding the importance of good governance and corruption-free national institutions for building the foundations of sustained growth and development. In that context, most international agencies and development partners have been increasingly emphasizing the importance of good governance and accountability in public institutions and in the management of public and donor resources.

Official USAID policy stresses that corruption undermines social cohesion and broad participation in economic and political life by distorting the allocation of resources and delivery of public services, usually in ways that damage the poor in particular (USAID, 2005). It is against this general background that USAID approved and funded a three-country study in Africa on efficient and transparent delivery of services in the health sector.

This report presents the main cross-country findings and analyses of the study conducted for USAID in Benin, Mozambique and Tanzania during the course of 2006. The overall objective of the study was to build consensus within the three countries, between the USAID missions, Ministries of Health (MoH) and other stakeholders on opportunities for strengthening health systems delivery to provide more responsive, efficient, transparent and accountable healthcare services, with the intent to ensure a better utilization of available health sector resources.[2]

The immediate purpose of the study was to provide USAID missions, Ministries of Health, and hospitals and clinics in Benin, Mozambique and Tanzania with a detailed analysis of vulnerabilities in healthcare delivery and to offer practical recommendations for improvements in efficient, transparent and accountable healthcare services. The study examined the delivery of healthcare services from a health systems point of view, explored the perceptions of service users regarding barriers to accessing transparent and responsive services, and evaluated system weaknesses in providing these services.

As part of the Terms of Reference (TORs), it was suggested that the study look critically at systems, procedures and implementation practices at national, sub-national and facility level which support services delivery. This suggested approach therefore encompassed both large and small challenges to efficiency in the healthcare system, particularly as they impact on service delivery and costs to consumers of these services. The overall report thus compares the analytical findings from each of the three countries, and provides common, as well as country-specific recommendations on how to improve management procedures, hospital and clinic systems and other gaps that weaken transparency, accountability, and efficiency in the targeted facilities.

The reader will note that the discussion and study results all hinge around the issue of 'corruption in health care systems,' for want of a better term. This was inevitable, as much of the discussion, both at the study design stage and subsequently in the field, about how to strengthen health systems delivery to "provide more responsive, efficient, transparent and accountable healthcare services" in fact turned around ways to reduce or eliminate corruption at various levels of the health system.[3] This was considered

[2] See Appendix 6.1 for the contractual Statement of Work (or TORs) for the study.

[3] This is obviously a highly sensitive subject in most countries of the world, including in the study countries. Where such sensitivity on the part of officials was detected and considered important for carrying out the study, our

to be a key issue in greatly reducing the efficiency of resource use, hindering transparency and accountability in the functioning of the system, and generally undermining the capacity of the health system to achieve key sector goals.

However, in the course of the study, including the literature review, broader issues of governance, institutions and accountability to local communities also arose and were considered by some as at least equally important for achieving "responsive, efficient, transparent and accountable health services." Though we do not address these broader issues directly or in much depth in the country studies, we discuss them briefly and try to place them in context in the analytical section of the report below.[4]

2.0 ANALYTICAL FRAMEWORK, LITERATURE REVIEW AND METHODOLOGY OF STUDY

In this section, we discuss the analytical framework and methodology that guided the study, including the tools used. There is also a discussion of the main limitations of the study.

2.1 ANALYTICAL FRAMEWORK AND SOME LESSONS FROM LITERATURE REVIEW

A review of literature on the issue of corruption and its impact on economic growth and health outcomes was conducted, leading to the selection of four sub-components of the health system for our investigation.

It should be noted from the start that analysis of corruption is often complicated by difficulties in separating out 'corrupt' practices from other forms of malfeasance, inefficiency or simple mismanagement. For instance, it has been noted elsewhere that provider and other surveys in Mozambique, Nigeria and Uganda indicated that "the level of mismanagement, vague and poorly understood performance expectations and the singular lack of accountability to anyone or any institution makes haphazard and corrupt practices difficult to identify, separate or control" (Lewis 2006; *see also* Lindelow, Ward and Zorzi, 2004; Lindelow, Reinikka and Svensson, 2003; Das Gupta, Gauri and Khemani, 2003; McPake et. al., 1999). For the sake of simplicity, these issues are addressed together in the analysis that follows.

'Corruption' is defined in the literature as "the use of public office for private gains" (Bardhan, 1997) or "the sale by government officials of government property for personal gain" (Shleifer and Vishny, 1993).[5]

approach took this into account and as a result of this, the reader may find some variations in the presentation of country findings in terms of depth and scope. This also underlies the delays encountered during some of the country studies, as further explained in the study limitations below.

[4] A discussion of country contexts and background information is also provided at the beginning of section 3 on study findings.

[5] Transparency International too has an operational definition of the term that is quite similar: "Corruption is operationally defined as the misuse of entrusted power for private gain. TI further differentiates between "according

The emphasis in these definitions is on office holders and people entrusted with power or authority in the public domain, although it should be noted that, at least in the context of this study, this does not necessarily refer only to higher-up officials or decision makers, although some arguments encountered during this study concerning motivation, causation and impact seemed to make a distinction between the role of those higher up and those lower down the hierarchy of decision making and authority.[6]

- to rule" corruption and "against the rule" corruption. Facilitation payments, where a bribe is paid to receive preferential treatment for something that the bribe receiver is required to do by law, constitute the former. The latter, on the other hand, is a bribe paid to obtain services the bribe receiver is prohibited from providing." (See http://www.transparency.org/news_room/faq/corruption_faq#faqcorr1.)

[6] See also the distinction drawn in Section 2.1.3 below between incidental and systemic corruption. It is important to note that, in the country studies, there was strong tendency by all level of respondents to broaden the scope of what is understood as corruption in the literature and especially to emphasise the moral aspects of the phenomenon: almost any dishonest behavior by an official or employee, or whatever smacks of a lack of honesty or integrity, was considered as corrupt behavior, and indeed whether in the public or private sector. The definition we have adopted focuses on the economic dimensions of corruption, which is consistent with the overall objectives of the study described earlier.

DEFINING ACCOUNTABILITY, TRANSPARENCY AND INTEGRITY

Accountability and transparency are indispensable pillars of democratic governance that enable the state, private sector and civil society to focus on results, seek clear objectives, develop effective strategies, and monitor and report on performance. Through public accountability and transparency, governments (together with civil society and the private sector) can achieve congruence between public policy, its implementation and the efficient allocation of resources.

ACCOUNTABILITY implies holding individuals and organizations responsible for performance measured as objectively as possible. Accountability stands on four pillars:

1. **Financial accountability** is the obligation of anyone responsible for administering public resources, to consistently and accurately report on the intended and actual use of those resources. This includes ensuring transparency in the policies and procedures designed to satisfy that obligation.

2. **Administrative accountability** includes systems of internal control in government institutions, which complement and ensure the proper functioning of checks and balances among the three branches of a democratic government and an engaged citizenry. These include civil service standards, ethics codes, criminal penalties and administrative review. Administrative accountability should be vertical and horizontal to be effective.

3. **Political accountability** begins with free and transparent elections. In a democracy elections are a means for holding public officials accountable for their leadership—a mechanism for rewarding or sanctioning them. Separation of powers among the legislative, executive and judicial branches of government also ensure political accountability.

4. **Social accountability** is a demand-driven process that relies on civic engagement involving ordinary citizens, the private sector and civil society insisting on greater accountability for public-sector actions and outcomes.

TRANSPARENCY comprises all means for facilitating public access to reliable information about decision making and the results of those decisions. Public-sector transparency begins with the clear and consistent application of standards for access to government information.

INTEGRITY is central to accountability and transparency. It is defined as "incorruptibility" and is synonymous with honesty. In terms of public service, integrity requires that public-office holders not place themselves under financial and other obligation to outside interests that may influence them in the performance of their official duties. Integrity with accountability and transparency lays the foundation for effective delivery of public services and performance of other functions, which the public is entitled to expect from those who govern them.

Source: Country Assessment in Accountability and Transparency (CONTACT) guidelines, UNDP, 2002 (http://www.undp.org/governance/contact_2001.htm)

Transparency International also defines 'transparency' as "a principle that allows those affected by administrative decisions, business transactions or charitable work to know not only the basic facts and figures but also the mechanisms and processes. It is the duty of civil servants, managers and trustees to act visibly, predictably and understandably" (TI, http://www.transparency.org/news_room/faq/corruption_faq#faqcorr1).

From the point of view of the objectives of this study, the importance of the theme is underlined by findings in the literature that have shown strong links between corruption and economic growth on the one hand, and between corruption and health sector outcomes, on the other. We now proceed to examine these links in turn.

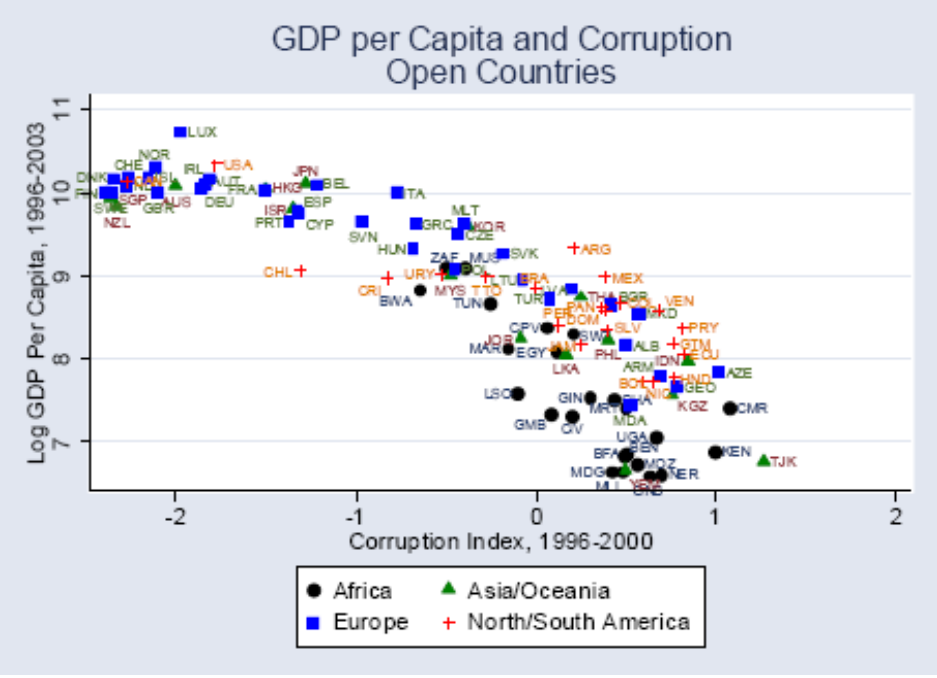
2.1.1 CORRUPTION AND ECONOMIC GROWTH

There has long been a debate about whether, and to what extent, corruption harms economic growth. It is safe to say that the predominant view is that pervasive corruption does undermine a country's economic growth, principally by distorting the efficient allocation of resources in the economy (Murphy et al, 1993; Shleifer and Vishny, 1993; Zvika Neeman et al, 2004; Mauro 1995). But 'predominant' is not unanimous. For instance, others have argued that, by 'oiling the wheels' of bureaucracy, corruption is also sometimes beneficial for the economy (see Bardhan, 1997; Mauro 1998; Mironov 2005).

In one of the most frequently cited contributions to this debate, Mauro (1995) constructed a corruption index for 67 countries, and showed that corruption is indeed negatively associated with investment and growth. Mauro's findings have been supported in more recent work by Kaufmann and Kraay (2002), Hall and Jones (1999) and La Porta et al. (1999). It has also been observed that even the mere perception that a country is prone to corruption can adversely affect inward private investment, and conversely, that countries which are perceived as less corrupt and politically stable may be more attractive to foreign investors and donors (Kaufmann, Kraay and Mastruzzi, 2005).

In an intriguing study, Zvika Neeman et al (2004) found that the relationship between corruption and output per capita is strongly related to a country's degree of openness, as shown in the figures below. Openness is measured by free movement of capital. The authors note that when openness is measured "either by the volume of trade or by the level of barriers to trade, there is no distinction between open and closed countries in the corruption-output relationship. Only when openness is measured by the black market premium, a proxy for free capital movements, do we find that the negative correlation between corruption and output is limited to open economies" (Neeman et al 2004).

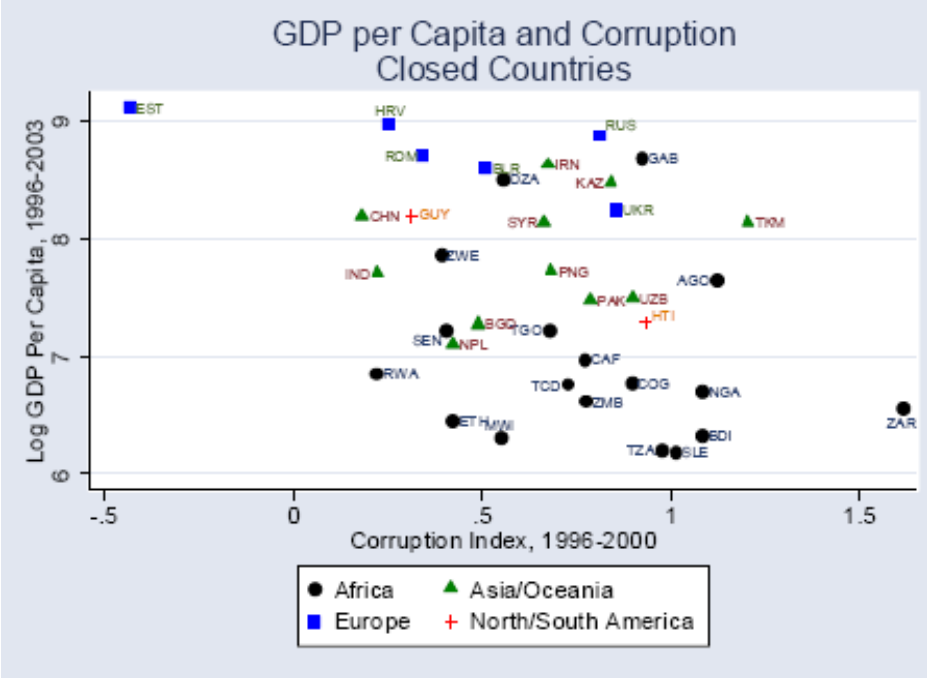
Figure 2.1a: Corruption and Economic Development – Open Countries[7]



Source: Zvika Neeman et al (2004)

[7] Countries are classified as open or closed based on the Wacziarg and Welch (2003) openness index.

Figure 2.1b: Corruption and Economic Development – Closed Countries



Source: Zvika Neeman et al (2004)

Figure 2.1a presents a scatter plot of log GDP per capita in the 1996-2003 period on an index of corruption[8] for open countries. The figure shows clearly that output per capita is strongly negatively correlated with corruption in open economies. The same plot is repeated for closed economies and the results are depicted in Figure 2.1b. No clear relationship emerges from that plot, but there is an apparent continent effect (i.e. clustering by continents). The authors find however, controlling for continent dummies, the relationship between corruption and output disappears in closed countries, while it persists in open ones (Neeman et al 2004).

The explanation offered by the authors for these observations is that corrupt officials have an incentive to transfer the proceeds of their illegal activities abroad, which depletes the country's capital stock, and slows down economic development. In economies with lower barriers to capital movement, it is easier to transfer illegally obtained money abroad. In financially closed economies, illegally obtained capital is more likely to remain within the country. In other words, in open economies corruption affects income by inducing "capital drain." In contrast, in closed economies the adverse effect of corruption on output is mitigated because capital drain plays a less important role. The results therefore suggest that an important channel through which corruption impedes economic development is the transfer of illegally obtained capital abroad (Neeman et al 2004).

However, in the health sector, the focus of this study, there is near-unanimity that corrupt behavior has a negative impact on the achievement of sector objectives (see Lewis 2006 for a survey of the literature).[9]

[8] The corruption index is taken from Kaufmann, Kraay and Mastruzzi (2003).

[9] It is also arguable that there is a strong relationship between health outcomes and economic growth, as in the human capital literature where bad health outcomes have a negative impact on economic growth.

2.1.2 CORRUPTION AND HEALTH

In a highly-acclaimed article particularly relevant for our theme, Lewis (2006) looks at governance and corruption in the public health sector of developing countries in terms of the production function. This may be represented simply as:

Health Outcomes = *f*(L, K, G)

Where L= labor, K = capital and G = governance represents some measure of institutional quality or governance. In this function, outcomes can be improved by increases in labor and capital, but G may dampen or enhance these effects.

In this model used by Lewis (2006), corruption emerges as a proxy for governance in the health sector. Labor includes management, doctors, nurses, laboratory technicians and other staff. Capital is made up of infrastructure, equipment and other fixed assets, and financing as embodied in government transfers for local purchase, in-kind provision of drugs and supplies, and third party and user payments. The manner in which the public health system functions and its results are then determined by the incentives facing the various actors in the system, how inputs are managed and the way in which the incentive structure affects accountability. Accountability can be to a central government, local government, communities or patients, or some combination of these (Lewis, 2006*)*.

As noted by Lewis (2006), measures to assess performance of public systems are lacking. Infant mortality, although a readily available and commonly used measure of outcome, tends to reflect more aggregate measures of well being (such as income and education) than health system performance.[10] Inputs such as hiring, existence of appropriate policies, purchase of drugs, building of clinics and procurement practices are easier to monitor. But much better measures of health system performance would be indicators such as "staff output, drug and medical supply availability, regularity of funding transfers, state of physical infrastructure, inventory and functionality of equipment, and existence of patient records, factors which reflect whether health systems are meeting minimal efficiency and quality standards" (Lewis, 2006). Yet these are also the more complex and difficult measures to capture.

However, utilization data and patient satisfaction can offer complementary metrics of health system effectiveness, as further argued by Lewis (2006), since under-utilized public facilities or their by-passing by target groups suggest implementation problems. In the absence of comparable indicators this kind of information can inform policymakers about performance and the pressure points of health systems development before large scale data collection is in place. Such data are, however, rarely or not at all collected on a routine basis in developing countries.

Kaufman, Kraay and Mastruzzi (2005) identified six dimensions, or indicators, of good governance, namely: voice and accountability; political stability and lack of violence; government effectiveness; regulatory quality; rule of law; and, control of corruption. Lewis (2006) notes that all of these affect the environment within which health care services function, but she identifies three of them specifically as the elements of particular relevance to service delivery – voice and accountability, government effectiveness and control of corruption.

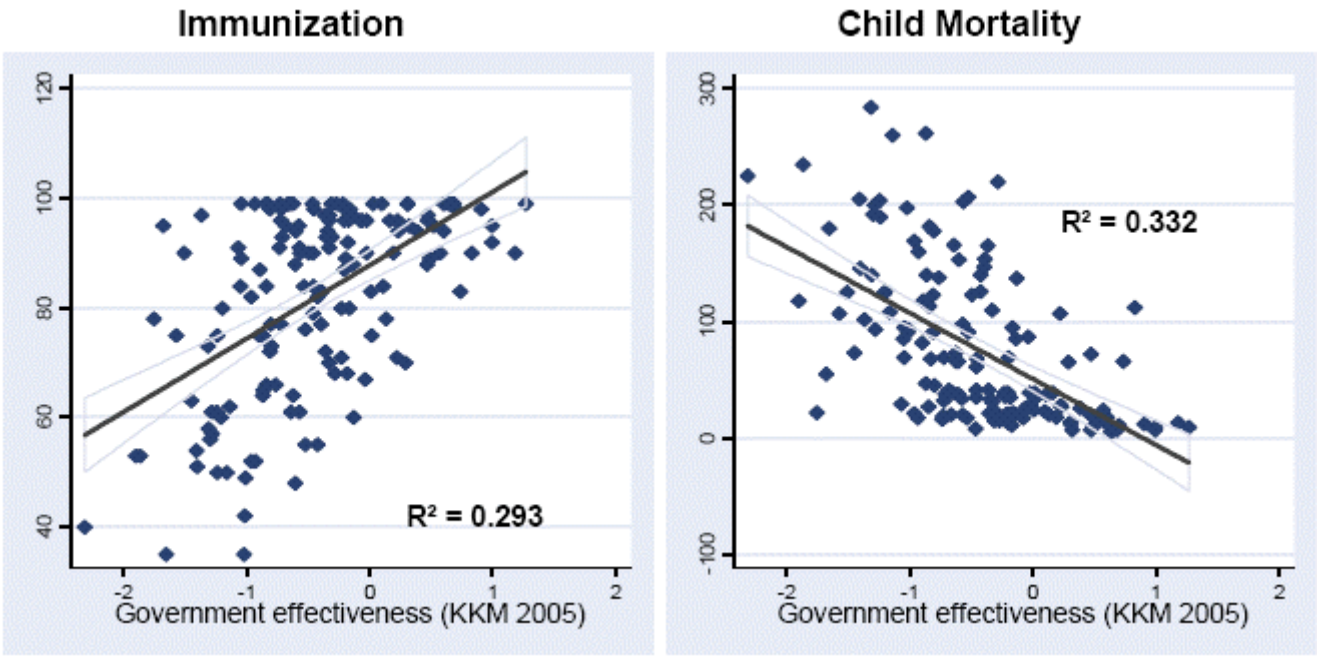
Still according to Lewis (2006), v*oice and accountability* reflect external accountability, the effectiveness of citizen and institutional influences on government action. Voice and accountability permit communities to be involved in decisions and oversight of health care services. *Government effectiveness* encompasses efficiency of the bureaucracy and public servants, roles and responsibilities of local and

[10] Although once the IMR drops below 25-30 per 1000 it better captures the quality and extent of medical interventions (which would therefore appear most relevant for developed rather than developing country contexts).

regional governments, including the administrative and technical skills of government, effectiveness of policy and program formulation, governing capacity, and effective use of resources. Extending the example above, decentralization that comes without funding or local authority undermines potential effectiveness of local jurisdictions as they have no power to affect resource allocations or decision-making and can be the victim of "provider capture" where centrally deployed staff determine service, organization and delivery. And finally, *control of corruption* captures the extent and nature of corruption among public officials, including tracking the incidence of nepotism, cronyism and bribes among civil servants, irregularities in public purchasing and oversight, and the nature and extent to which government manages corruption.

The correlation between these three factors and some select health outcomes were examined by Lewis (2006) through a series of regression analyses, depicted in the figures below.[11]

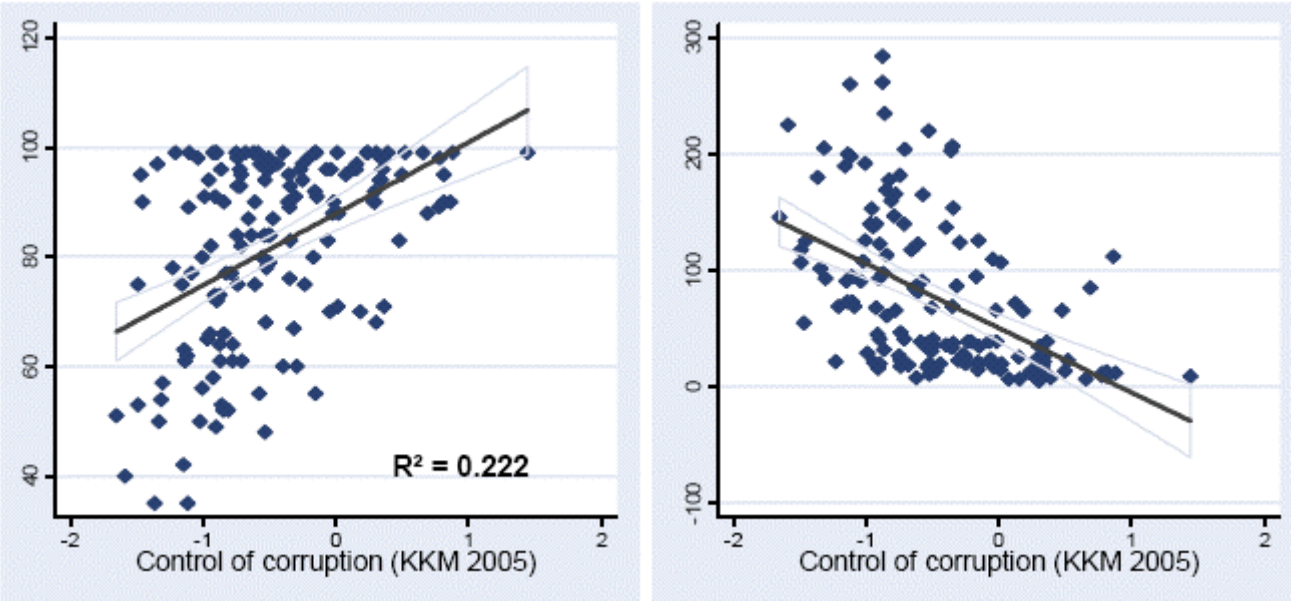
Figure 2.2 a,b: Government Effectiveness Versus (a) Immunization and (b) Child Mortality



(a) Immunization (b) Child mortality

[11] The indices of governance and corruption are those constructed by Kaufman, Kraay and Mastruzzi (2005), indicated on the figures as KKM 2005.

Figure 2.3 a,b: Control of Corruption Versus (a) Measles Immunization on the Left Panel, and (b) Child Mortality on the Right Panel



Figures 2.2 and 2.3 demonstrate the relationship between governance indices and two measures of health performance and outcomes – measles immunization and child mortality. Measles immunization coverage provides a robust measure of public service performance as it reflects government's ability to perform a critical and basic health service. Child mortality is a standard variable for measuring health outcomes, though it is influenced by factors beyond the quality and extent of health care services, but it has the advantage that it is readily available for most countries.

The four panels in Figures 2.2 and 2.3 show the scatter plots for the two indicators (immunization and child mortality) and two components of the KKM governance index: government effectiveness, and control of corruption. Voice and accountability were found to have the least explanatory power and are left out here.[12] Note that, based on the smaller variation conveyed in the adjusted R^2, it is government effectiveness that best correlates here with poor outcomes and performance in health care.[13]

2.1.3 TYPES OF CORRUPTION IN THE HEALTH SECTOR

Some observers also distinguish between *incidental corruption*, which encompasses petty graft, small-scale embezzlement, and favoritism, and *systemic corruption*, encompassing large scale embezzlement and misappropriation (Brinkerhoff, 1999). The latter type is also sometimes referred to as *endemic* corruption, although the two are not exactly the same. The distinction between the *incidental* and *systemic*

[12] Lewis (2006) explains this finding by noting that immunization programs are typically the responsibility of central governments because it is a preventive measure for which demand tends to be low among all but the most educated. The non-significant finding for the role of voice and accountability is consistent with that fact.

[13] For similar analyses, see for example: Filmer and Pritchett (1999) who found a lack of association between public health expenditures and infant and child mortality; Wagstaff and Claeson (2005) who found that spending reduces under five mortality, but only where governance, as measured by the World Bank's CPIA score is sound. CPIA stands for the Country Policy and Institutional Assessment measure that is scored between 1-5 depending on performance, part of which regards corruption and governance; a CPIA above 3.25 is considered sound.

types of corruption is important because, it is argued, it is easier to combat the former than it is to root out the latter. For instance, Brinkerhoff (1999) contends that the political determination required to undertake anti-corruption reform is dependent on the magnitude of the stakes involved. Thus:

> Politicians may not be highly motivated to act against systemic corruption; indeed, they may perceive themselves to be relatively powerless in the face of its immensity and complexity. Successful reform strategies may not be immediately apparent and the political costs of reform, including coping with an uncooperative civil service or a hostile military, may appear prohibitive. Further, the relatively short time horizon of most politicians does not encourage devotion to long-term issues like systemic and ingrained corruption. Other things being equal, it may be easier to generate political will to tackle incidental corrupt practices than to take on endemic corruption, which entails a larger challenge to the status quo. (Brinkerhoff, 1999)

These observations are particularly important for anti-corruption program design and implementation.

In terms of vulnerabilities to corruption in the health sector, Table 2.1.3.1 below, adapted from Vian (2005), presents a summary of health system dimensions or processes and the types of corruption to which they may be vulnerable, as well as indicators of the potential impact of such corruption on the system.

Table 2.1.3.1: Types of Corruption in the Health Sector[14]

Dimension or Process	Types of Corruption and Problems	Indicators or Results
Provision of services by frontline health workers	• Use of public facilities and equipment to see private patients • Unnecessary referrals to private practice or privately owned ancillary services • Absenteeism, shirking • Informal payments required from patients for services • Theft of user fee revenue, other diversion of budget allocations[15]	• Government loses value of investments without adequate compensation • Employees are not available to serve patients • Reduced utilization of services by patients who cannot pay • Impoverishment as citizens use income and sell assets to pay for health care • Reduced quality of care from loss of revenue • Loss of citizen faith in government

[14] Table adapted from Taryn Vian. *2005*. "Health Sector," in Bertram I. Spector, editor, *Fighting Corruption in Developing Countries* (Bloomfield, CT: Kumarian Press).

[15] Vian (2005) notes the following: "Diversion of budgets and resource-flow problems have been documented by Riitva Reinikka and Jakob Svensson in the World Bank-supported study "Assessing Frontline Service Delivery" (Washington, DC: World Bank, Development Research Group, Public Services. Draft, January 23, 2002). Reinikka and Svensson use data from two types of surveys, the public expenditure tracking survey (PETS) and the quantitative service delivery survey (QSDS) to quantify resource leakage and other problems in Uganda, Tanzania, Ghana and Honduras. Findings include 41% leakage of the non-wage health budget in Tanzania as it passes from the central level down to the facility level; in Ghana the situation was even worse with only 20% of non-wage health spending reaching the frontline facilities where it was intended to be spent."

Dimension or Process	Types of Corruption and Problems	Indicators or Results
Health financing and financial management	• Leakage of (non-salary) funds from central level to lower levels and operational units • Misappropriation or misuse of funds received from budget or donor sources • Accounting and bookkeeping fraud • User fee revenues not properly accounted for • Auditing fraud	• Chronic shortage of operational funds for facilities • Frequent stock-outs of drugs and supplies • Low quality of health offered • Bad health outcomes
Purchase of equipment & supplies, including drugs	• Bribes, kickbacks and political considerations influence specifications and winners of bids • Collusion or bid rigging during procurement • Lack of incentives to choose low cost and high quality suppliers • Unethical drug promotion • Suppliers fail to deliver and are not held accountable	• High cost, inappropriate or duplicative drugs and equipment • Inappropriate equipment located without consideration of true need • Sub-standard equipment and drugs • Inequities due to inadequate funds left to provide for all needs
Construction and rehabilitation of health facilities	• Bribes, kickbacks and political considerations influencing the contracting process • Contractors fail to perform and are not held accountable	• High cost, low quality facilities and construction work • Location of facilities that does not correspond to need, resulting in inequities in access • Biased distribution of infrastructure favoring urban- and elite-focused services, high technology
Distribution and use of drugs and supplies in service delivery	• Theft (for personal use) or diversion (for private sector resale) of drugs/supplies at storage and distribution points • Sale of drugs or supplies that were supposed to be free	• Lower utilization • Patients do not get proper treatment • Patients must make informal payments to obtain drugs • Interruption of treatment or incomplete treatment, leading to development of anti-microbial resistance
Regulation of quality in products, services, facilities and professionals	• Bribes to speed process or gain approval for drug registration, drug quality inspection, or certification of good manufacturing practices • Bribes or political considerations influence results of inspections or suppress findings • Biased application of sanitary regulations for restaurants, food production and cosmetics • Biased application of accreditation, certification or licensing procedures and standards	• Sub-therapeutic or fake drugs allowed on market • Marginal suppliers are allowed to continue participating in bids, getting government work • Increased incidence of food poisoning • Spread of infectious and communicable diseases • Poor quality facilities continue to function • Incompetent or fake professionals continue to practice
Human resource management	• Bribes to obtain jobs • Using influence to place favorites in positions, including political interference, nepotism • Unfair application of disciplinary rules and sanctions	• Incompetent staff in sector • Undisciplined behavior and impunity • Productivity losses • Loss of confidence in management and low morale

Dimension or Process	Types of Corruption and Problems	Indicators or Results
Education of health professionals	• Bribes to gain place in medical school or other pre-service training • Bribes to obtain passing grades • Political influence, nepotism in selection of candidates for training opportunities	• Incompetent professionals practicing medicine or working in health professions • Loss of faith and freedom due to unfair system
Medical research	• Pseudo-trials funded by drug companies that are really for marketing • Misunderstanding of informed consent and other issues of adequate standards in developing countries	• Violation of individual rights • Biases and inequities in research

2.1.4 HEALTH SYSTEM FACTORS AFFECTING TRANSPARENT, EFFICIENT AND ACCOUNTABLE SERVICE DELIVERY

At least two key issues seem to emerge from the foregoing analysis: first, corruption appears to be negatively associated with economic growth, even if this is contested in some of the literature; second, whatever the impact on economic growth may be, control of corruption would seem to be positively correlated with good health outcomes.[16] This latter point further suggests that it might be useful to identify and analyze the nodal points of the health system which are most vulnerable to corruption, to explore the mechanisms through which such corruption may occur and thereby contribute to an informed discussion of measures to minimize or eliminate this unhealthy phenomenon.

The key system sub-components or dimensions vulnerable to corruption and explored in this study are depicted in Figure 2.4: the health service delivery process (the provision of health care) including the interaction with the public/users; human resource management issues; procurement of equipment/drugs/other supplies/supply chain and logistic management; and health financing/management and flow of funds.[17]

The boxes at the extreme (left and right) ends of the main sub-components contain further breakdowns of elements that help to make up the sub-component or dimension concerned and which helped to identify the possible indicators (or proxies) required for field data collection and interview guides.

The study then sought evidence from various actors in the health system – policymakers, civil servants, facility staff and managers, users, community members, civil society organizations, other stakeholders – in order to better understand the mechanisms and weaknesses that facilitate or encourage corruption, and how they might be addressed.

[16] In the light of this analysis, it is also interesting to re-visit our initial observation at the beginning of this chapter regarding views on the motivation, causes and impact of the corrupt behavior of people at different levels of authority and decision making. In terms of opportunities for corruption in the health sector and its potential impact, the actions and decisions of top civil servants, doctors, higher functionaries of bodies such as drug procurement agencies, in addition to those of junior staff such as nurses, lab assistants, clerks, kitchen staff, mortuary attendants, and receptionists can be literally life or death for patients. However, in terms of the direct impact on the *macro* economy, and in so far as it can be argued that most corruption at the lower levels of the hierarchy are probably of the *incidental* type, corruption at different levels may still have different consequences.

[17] These are not exhaustive of the various areas of the health system that are vulnerable to corruption. For instance, research, teaching, quality assurance, accreditation processes, interface with traditional medicine, and other areas ay also be vulnerable, but for analytical purposes, we identified the four here as the key ones for investigation. See Table 2.1.3.1 for more areas or processes of the health system that are vulnerable to corruption.

FIGURE 2.4: SOME KEY HEALTH SYSTEM FACTORS INFLUENCING TRANSPARENT AND EFFICIENT DELIVERY OF HEALTH CARE

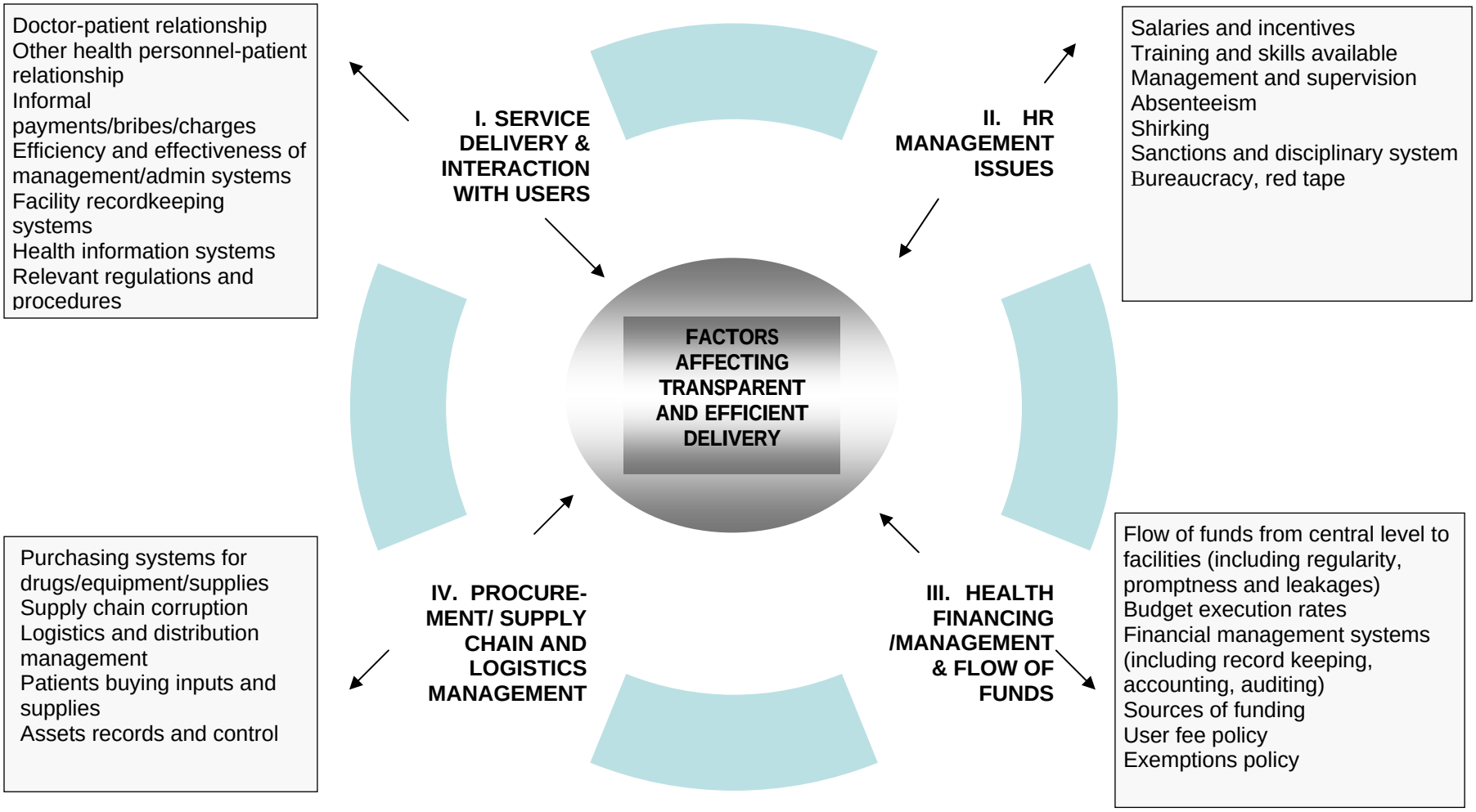
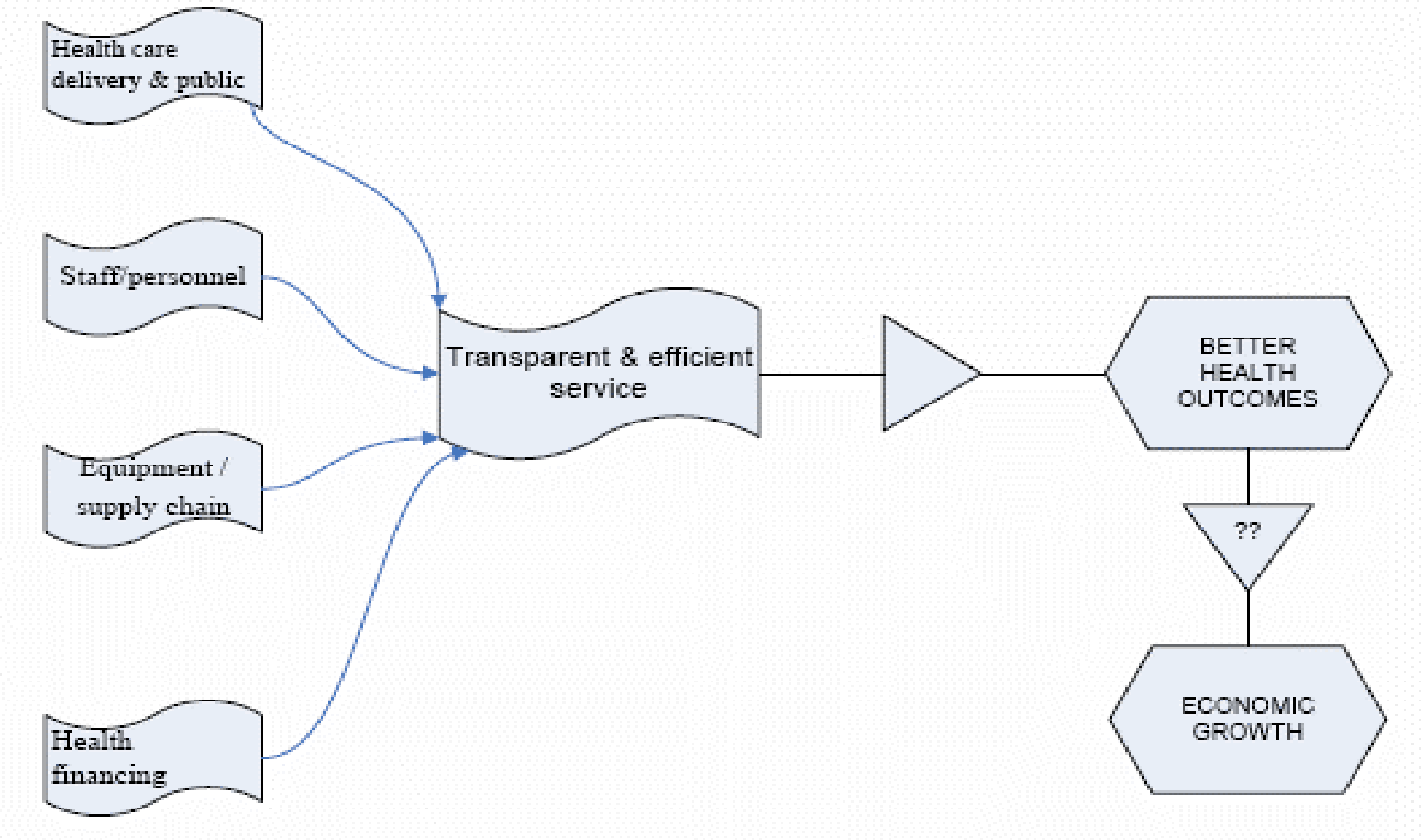


Figure 2.5: How the four health system sub-components relate to the main objectives of the study and potentially with sector and macro-economic objectives



2.2 METHODOLOGY

The study was conducted in four broad phases, although the actual process differed in each country, as described in the individual country studies.

1. The first phase involved the identification of the key issues for the study (including document and literature review), followed by elaboration of the appropriate research tools.
2. The second phase entailed information gathering and initial stakeholder meetings, including household surveys (users and community data collection), facility surveys, and stakeholder interviews.
3. The third phase was that of analysis and draft report preparation.
4. The final one was that of stakeholder briefings, feedback, and revisions.

In two of the three countries (Mozambique and Tanzania), the last three phases were more of a functional distinction than a temporal one, since all three phases had to be carried out in one country visit. And, in the case of Tanzania, the process was further compressed to the household survey of user and community perceptions due to complications in obtaining the necessary government authorizations. The results were then discussed with selected civil society organizations before producing the country report.

Table 2.2.1 below shows the survey tools that were designed for the health system sub-components, as well as the target stakeholders of these tools.

Table 2.2.1: Survey Tools and Health System Sub-Component for which designed

Health System Sub-Component	Survey tools designed to investigate	Countries where tools applied	Targets /Sources of information [18] *(*See footnote below for stakeholder codes*)*
Service Delivery and Interaction with Public/Users	Household survey in target communities	All three countries	Stratified samples of community members in catchment areas of selected health facilities
	Focus group discussions	Benin, Mozambique	Selected community members in catchment areas of selected health facilities (Benin); participants chosen from people waiting for consultations at the health units and randomly from persons passing by in the neighborhood (Mozambique)
	Interviews with MoH and facility staff	Benin, Mozambique	FM, RKD, DOD, NOD, MOH staff/senior policy makers, OS, PA, P&DS
	Civil society interviews	Benin, Tanzania	Executives of organizations concerned
Human Resource Management	MoH and Facility interviews	Benin, Mozambique	IA, FM, RD, MOH, PH, DOD, NOD, P&DS
Procurement/Logistics	MoH and facility interviews	Benin, Mozambique	PA, ST, PH, RKD, FM, P&DS

[18] ***Stakeholder code for above table (column 4)***
ACC=accountant or head of finance department; DOD=doctor on duty; FM=facility manager; IA= insurance agency/mutuelle/community-based insurance/company insurance or employee cover; MoH= Ministry of Health; NOD=nurse on duty; OS = other staff; PA=procurement agency; P&DS = Provincial and/or district staff; PH=pharmacy (facility or outside); RKD= record keeping department; ST=stores/purchasing Department.

and Supply Chain Management	Drugs procurement agency interviews	Benin, Mozambique	
Health Financing, Financial Management	MoH and facility interviews	Benin, Mozambique	ACC, FM, RKD, MOH, IA, P&DS

As indicated in Table 2.2.1, the stakeholder interviews targeted senior policy makers in the Ministries of Health, including staff working in the inspectorate divisions, procurement agencies, hospital and facility oversight, and managers and key staff of the two health facilities selected for the study in each country. Similarly, representatives of civil society organizations involved in promotion of transparency and efficiency, particularly in relation to the health sector, participated in interviews. Table 2.2.1 shows the slight variations in our detailed study methodology from country to country depending on political access and authorization.. Only in Benin was it possible to apply all the tools designed for the research.

Brief description of field survey methodology

The methodology of the household surveys including the sampling frameworks used is described in detail in each of the country reports. The following is a brief description of the process.

In all study countries, random probability surveys were conducted with the purpose of examining attitudes toward, and experiences with, the health-care delivery system in two public health facilities (usually hospitals) selected by the USAID host missions in consultation with national stakeholders. The survey instrument was designed to elicit information on the use of the two chosen facilities as compared to other health service providers (private, uncertified, traditional). Additionally, the survey sought to examine reasons for use or non-use of the health facility, public perceptions and actual experiences of hospital efficiency in resource use, management compliance, and accountability and transparency among users and non-users.

Given the heterogeneous character of the households involved, multi-stage (cluster) stratification sampling techniques were employed to obtain homogenous samples of respondents based on income level. Then, probability proportional to size was employed to obtain samples in each stratum and cumulative systematic random selection was used to get respondents. Three steps were used in order to achieve the unbiased representative sample for individuals: selection of enumeration areas, identification of households in each stratum, and the selection of individuals in each chosen household. A sample size of at least 400 households was obtained in each country. The margin of error for each sample was +/- 5 percent.

2.3 LIMITATIONS OF STUDY

The differential conditions of research in the study countries are related to the varying macro contexts under which the research was carried out, as further discussed in Section 3.1.4 below. Differing conditions to some extent affect the comparability of the findings and the extent to which we could make a comparative analyze. However, wherever possible, we have tried to complement the findings, especially for Mozambique and Tanzania, with relevant literature review and secondary data.

The above factors also partly explain the somewhat lop-sided character of the quantity of data for each of the four dimensions of the health system studied. There is considerably more data, and hence analysis, of the first dimension, i.e. service delivery and user interaction, than for the other three, since the household surveys were the only tool common to all countries and, together with focus group results where these were conducted, they provided a lot more primary material for analysis of this area.

3.0 CROSS-COUNTRY STUDY RESULTS AND LESSONS

This section presents and compares the findings for each country, beginning with basic information on country contexts, indicators and health systems. The discussion then proceeds with a comparative analysis per health system dimension or sub-component based on the analytical framework diagrams shown in Figures 2.4 and 2.5.

Section 3.1 presents and discusses the country contexts and background data. Section 3.2 discusses country findings relating to the first dimension of the analysis, i.e. service delivery and interaction with the users/public; Section 3.3 analyses the findings related to the second dimension, namely human resources/staffing/personnel issues; Section 3.4 discusses the findings regarding procurement, supply chain, and logistics; while Section 3.5 analyses the findings concerning the health financing and financial management dimension.

Section 3.2.1 is based on the household surveys while Sections 3.2.2 to 3.5 are based on the stakeholder interviews, focus groups where relevant and document reviews.

3.1 COUNTRY CONTEXTS: BASIC INDICATORS AND GENERAL BACKGROUND INFORMATION

Table 3.1.1 presents basic parameters on the three countries as background information.

Table 3.1.1: Basic parameters on the three countries

Parameter	Benin	Mozambique	Tanzania
Area: total sq km	112,620	799,380	945,087
Population (July 2006 est.)	7,862,944	19.3 million	37,445,392
Infant mortality rate deaths/1,000 live births (2006 est.)	79.56	129.24	96.48
Life expectancy at birth, years	53.04	36.45	45.64
GDP (purchasing power parity) (2005 est.)	$8.419 billion	$26.18 billion	$27.11 billion
GDP (official exchange rate) (2005 est.)	$4.34 billion	$5.73 billion	$12.12 billion
GDP - per capita (PPP) (2005 est.)	$1,100	$1,300	$700
GDP - real growth rate (2005 est.)	3.5%	7.5%	6.8%
Total health expenditure per capita (Intl $, 2003)	36	45	29
Total health expenditure as % of GDP (2003)	4.4%	4.7%	4.3&

Source: WHO and various country Government sources

The following sub-sections present a brief description of the health system of each of the three study countries, and highlight contextual factors that arguably favor corruption or create an atmosphere where such practices may thrive.

3.1.1 BENIN

The health system in Benin is organized in a pyramidal fashion like those of most other countries. At the top of the pyramid is the central or national level, comprised of the Minister of Health, the central directorates and the '*centre national hospitalier et universitaire*' (CNHU). This top level is responsible for developing and overseeing the implementation of health policy, as well as overall supervision and coordination of the other levels of the system.

The next, or intermediary, level of the health system pyramid is made up of the six departmental health directorates (DDS) and five departmental hospitals (CHD). The DDS are responsible for implementing national health policy, health planning and coordination as well as epidemiological surveillance within their departments.

The bottom, or peripheral, level of the pyramid is made up of 34 health zones, with a reference hospital, satellite heath centers, and other facilities constituting the operational and most decentralized entities of the health system. Each zone serves between 100,000 and 200,000 persons.

There is a private health sector, including the missionary health institutions, but these are not well-integrated into the public system. The for-profit private system is mainly located in the urban areas.

A number of organs have been put in place to involve local communities and development partners in the planning and budgeting of health services. These include the health centre management committees (COGECS), the 'Comité de Santé de la Zone Sanitaire' and the 'Organe paritaire.' The 'Système National d'Information et de Gestion Sanitaires' (SNIGS) provides data and information to facilitate the planning processes.

Since 2000, the Ministry of Health has been engaged in reforming its budget process with the aim of moving from an inputs-based to a performance-based budget. Though still far from successful, elements of this reform include:

- Improving the efficiency of public resource use
- Implementing a common basket fund where all funds – national and donor – are placed into the national treasury
- Unifying the investment and recurrent budgets into one
- Elaboration of a medium term expenditure framework (MTEF)
- Delegation of procurement and payments for goods and services to sector ministries

These budget reforms have so far led to:

- Elaborating an MTEF
- Establishing monitoring and evaluation units in the Ministry
- Establishing public procurement units
- Reinforcing external auditing by the "Chambre des Comptes"
- Delegating procurement and payment for goods and services to sector ministries
- Simplifying expenditure procedures and installing a new integrated financial management system (Système Intégré de Gestion des Finances Publiques (SIGFiP))

As part of the reforms, health facilities are allowed to retain the fees charged for their services. However, analysis of household health spending has shown that most such expenditures go towards direct, self-medicating purchases of drugs from private pharmacies, not to the public health care institutions.

Some of the weaknesses of the health care system in Benin have been described as:

- Bad reception and attitude of personnel towards patients
- Frequent shortages of drugs and medical supplies, often leading to illegal sales of these items
- Poor quality of care
- A lack of sense of responsibility in the management of public property by staff
- Absence of sanctions for wrong-doing by staff (i.e. impunity)

These weaknesses lead to great dissatisfaction with the state of health facilities and health care in the country, opening the door to corrupt practices. However, few studies examine the subject of efficiency and transparency in Benin's health sector. But various internal reports of the Ministry of Health attest to illegal and illicit sales of drugs, demands by health personnel for payments by patients for services, and misappropriation of drugs purchased by patients. Public expenditure reviews as well as reports by Transparency International reinforce these observations. Moreover, no significant initiatives have been undertaken to stop these abuses in the health system.

3.1.2 MOZAMBIQUE

The national health system of Mozambique is organized in four levels according to increasing levels of complexity of care provided. Levels III and IV, at the apex of the system, are made up of the most specialized referral units. Provincial hospitals, at level III, are referral facilities that attend to cases of medium complexity. They can refer patients to the national Central Hospitals which see the most complex cases. Levels I and II include the more peripheral units providing primary health care and first-level referral services. Within these two levels, level II (district or rural hospitals) is made up of referral units providing support for level I, and this latter level (PHC clinics) is where the first interaction between the community and basic health care providers occurs.

The Ministry of Health has five Directorates, each of which has several departments. The General Inspection Directorate is in charge of developing systems to ensure accountability, supervision, discipline and to contribute to the application of discipline and sanctions. The Directorate for Medical Assistance is responsible for the management of all public hospitals, including management of their laboratories. The Directorate for Administration and Management is tasked with forecasting, planning, distribution and warehousing of all non-drug items.

The main health care provider in Mozambique is the public sector assisted by the for-profit and non-profit private systems. The private system is predominantly found in Maputo and Beira, and is developing and expanding in other towns of the country. After national independence in 1975, private medicine was abolished, reappearing approximately 15 years ago when private companies or institutions would contract with doctors on a part-time basis, two to three days a week, to see their staff and in some cases their families. This was considered illegal but became accepted and widespread, giving way to private practice through clinics and hospitals.

Health care in the public health system is free with a symbolic rate equivalent to less than five cents, paid by users at the entrance if they are not considered indigents. Children and emergency care seekers do not pay.

The main sources of public health sector financing are:

- The government budget
- Ministry of Health funds obtained through the Common Fund (PROSAÚDE) which are made up of donor, Sector Wide Approach (SWAP), contributions
- Fee payments made by patients which are retained (100 percent) by the health facilities
- "Special Clinic" in Maputo Central Hospital. The "special clinic" was set up as a kind of private health care system within the public hospitals as a means for increasing the revenue of these units. The Maputo Central Hospital still has the "special clinic" working, where users have to pay higher prices for "special consultations" or services delivered.

Some weaknesses noted about the Mozambican health system which make it vulnerable to corrupt practices are similar to those mentioned in relation to Benin:

- Low salaries in the public sector
- Shortage of resources and medical supplies
- Lack of regular management controls and audit processes
- Lack of supervision and weak enforcement of sanctions.

"…[i]t has become common for state officials to demand payment to provide normal services—a school official demanding "a thank you" for enrolling a pupil, a nurse demanding a "small envelope" before treating a patient, or a policeman demanding a "beer" in exchange for giving the driver back their driving license."

President Joaquim Chissano, in a speech, June 25, 2002

A 'culture of silence' or fear on the part of the public to complain about or confront public officials for abusing their positions or public property was also highlighted during the study in Mozambique as one of the problems in this regard.

Another study for USAID in Mozambique (Casals & Associates, Inc., undated) found that problems of corruption in Mozambique's health sector included:

- Diverting, stealing and/or reselling drugs and supplies
- Using public facilities for private gain
- Requests for unofficial payments for services that are supposed to be provided at no cost.

That study also concluded that citizens paid an average of MT 1,700[19] for services.

3.1.3 TANZANIA

The structure of the health care system is pyramidal with three levels of care.

The primary level consists of dispensaries, health centers and district hospitals. Dispensaries and health centers are the entry points for almost 80 percent of the population. Tanzania, in the mid-1990s, initiated a health sector reform program aimed at creating structures and institutional arrangements to increase transparency in decision-making and cultivate local ownership of health services. Under the health sector reforms primary level health facilities are placed under local government and managed by health facility boards.

The secondary level of health care is comprised of 21 regional hospitals. Regional hospitals are referral points for lower level health facilities, including the district hospitals for specialized services like pediatrics, surgery and technical supervision. Also, the regional level coordinates supplies to the district hospitals. In terms of health system management, the regional level is responsible for coordinating and supervising the lower level under the health sector reforms. Like the district facilities, regional hospitals are under the local government authority.

[19] Just over 60 US cents at the exchange rates in force as at December 2006.

The tertiary level is comprised of four specialized hospitals which include Bugando, Kilimanjaro Christian Medical Centre (KCMC), Muhimbili National Hospital and Mbeya referral hospital. These four hospitals handle referrals from regional hospitals for specialized care unavailable from lower levels. There are also four other hospitals that do not fit strictly into the above structure but which provide specific specialist services for cancer (Ocean Road hospital in Dar es Salaam), psychiatry (Mirembe hospital in Dodoma), orthopedics (Muhimbili Orthopedic Institute) and tuberculosis (Kibongoto hospital in Kilimanjaro). The tertiary level and specialized health institutions are under the Ministry of Health's direct management.

Financing of public health sector services is covered through annual budgetary allocations from the central government, contributions from development partners, and from local government sources including community insurance and cost recovery schemes. Central government allocations are spent on recurring costs (payment of staff salaries, utilities, supplies and equipment) and for development costs (construction and purchase of capital goods). Development partners provide financing for the health sector at the national, regional and district levels. In 1998 the Ministry of Health established the health sector basket fund (HSBF) which some development partners have joined. Through the central Ministry of Health, the HSBF finances an agreed annual plan of action and generally follows government financial rules and procedures. Ministry of Health expenditures increased in nominal terms from Tanzanian shillings (Tshs) 141 billion in FY 2001/02 to Tshs 220.01 billion in FY 2003/04 (See table 3.1.3.1 below).

Table 3.1.3.1: Tanzania - Total Health Expenditure 2001/02 to 2003/04 (in Billion Tshs)

Budget Item	2001/02	2002/03	2003/04	2004/05 (budget)
Recurrent	117.15	143.14	173.31	241.04
Development	23.86	33.21	46.79	71.77
Total	**141.01**	**176.35**	**220.10**	**312.81**

Source: Ministry of Health, Appraisal Report 2nd Health Rehabilitation Report

HSBF funding to district councils, which prepare an annual health plan including all recurrent and development expenditures and indicating the source of funding including HSBF, is restricted to recurrent expenditure excluding personnel compensation. In FY 2000, allocation to district councils was 50 US cents per capita.

To broaden the resource base for health care financing, the government has introduced a number of mechanisms for generating resources for health facilities – Drug Revolving Fund and Cost Sharing at all hospitals and Community Health Schemes – with due attention paid to the indigent and vulnerable. The government has also implemented a medium term expenditure framework as well as reforms aimed at replacing inputs-based with performance-based budgeting.

Information on inefficiency in the health sector is mostly anecdotal. However, the government often acknowledges the existence of inefficiency and lack of transparency in the public sector. For example, a statement issued by the President's Office on the National Anti-Corruption Strategy noted the following:

> Corruption is still a major problem in the country. Corruption, defined as the use of public office for private gain is not only a question of individual criminal acts but is also a result of failure in public administration systems. Weak public administration and financial management systems do contribute significantly to spread of corruption in a country. Corruption is also caused by inadequate and weak laws and sanctions, a weak institutional framework for good governance,

> oversight and accountability. Furthermore, corruption thrives due to low levels of literacy, ignorance, lack of confidence among the population to demand their rights, the public's ambivalence to the misuse of public funds and also the lack of action against those who enrich themselves through misuse of public resources.[20]

Recently, the government estimated annual losses of Tshs 4,703 million through dubious procurement.[21]

The above quote from the government clearly indicates that the problems underlying corruption in the health sector are somewhat similar to those discussed for Benin and Mozambique, especially with regard to weak management controls such as auditing and the prevailing environment of impunity/weak enforcement of sanctions. In addition, the Tanzanian government highlights "low levels of literacy, ignorance, lack of confidence among the population to demand their rights, the public's ambivalence to the misuse of public funds" as some of the underlying reasons for these practices, which may be compared with the 'culture of silence' or fear that was highlighted in Mozambique. Finally, as in the other countries, low salaries and poor working environment for healthcare providers was sited as one of the motivating factors of corruption in the Tanzania study.

A study of public expenditure management in Tanzania in 2003 has findings that are very useful to our understanding of some of the reasons why public sector reforms often fail to achieve several of their key objectives. This study looked at reasons why the budget process showed little responsiveness to results, and also why the MTEF and the performance budgeting approach would not necessarily solve this problem (World Bank and Members of Tanzania PER Working Group, 2003). In the words of the authors of that report:

> (T)here are at least two sources of tension between the objective of creating a stronger link between performance and allocations. The first is the inherent political nature of the budget process. The second is more subtle and derives from the identification of priority sectors in the Poverty Reduction Strategy (PRS). There is pressure from both domestic and international constituencies to increase spending in the priority sectors. Given the complexities in assessing performance and the fact that budgetary allocations are the easiest to monitor indicator of government's commitment to poverty reduction, there is little scope for punishing poor performance in the priority sectors with lower budget allocations. Another important constraint of the results orientation of the budget process is the often complex relationship between budgetary inputs and outputs and outcomes and only very limited knowledge on the production function for achieving certain targets. However, greater use of well defined and objective performance indicators (incidence effects and measures of efficiency) could inform and constrain pressures to spend on ex-ante notions of priority and likely impact and assist to improve the design of programs." (World Bank and Members of Tanzania PER Working Group, 2003)

By the "political nature of the budget process," the report suggests diplomatically that an exclusive focus on technical tools for leveraging efficiency improvements through appropriate budget allocations is often in conflict with politically-driven spending imperatives, thus limiting the impact of well-intentioned and well-designed reforms based on technical solutions. It is also important that the report draws attention to the pressures ("from both domestic and international constituencies") to increase spending in priority areas determined *a priori*. These pressures also limit the room for utilizing budgetary allocations to leverage efficiency gains. These lessons are important to bear in mind especially when it comes to the conclusions to be drawn from the study and recommendations from it.

[20] URT/President's Office. "The National Anti-Corruption Strategy and Sector Specific Action Plans for All Ministries, Independent Government Departments, Executive Agencies and Local Authorities (2006-2010)," pg 1.
[21] The Guardian, Wednesday December 13, 2006.

3.1.4 IMMEDIATE CONTEXTS OF THE STUDY IN THE THREE COUNTRIES

The above descriptions of the health systems and some of their existing constraints show that all three countries share similar problems when it comes to the issues of transparency and efficiency in their health sectors. In Benin, a conjunction of factors worked strongly in favor of the study from the start until the end. The most important of these factors was the election of a new president from outside the traditional political parties and elites of the country, occasioned by a fundamental public disillusionment with those parties and elites, and, consequently, a strong desire for a new leadership willing to battle with the endemic corruption among the elites.

The new government in Benin has made transparency, accountability and especially anti-corruption high priorities on its agenda.[22] There was therefore total cooperation from nearly all stakeholders in that country, and there is some encouraging evidence that the findings might be used to help advance the on-going anti-corruption process in that country. The fact that civil society organizations played a key role in bringing about the changes and developments described above, as well as in sustaining them, is also significant in terms of identifying the forces for change that might be willing to champion, and/or potentially benefit from, the findings of a study such as this.

It is also interesting that in Mozambique and Tanzania the current governments ostensibly had on-going anti-corruption drives.[23] As relates to Tanzania, the present research builds upon a study investigating health sector efficiency in the Mara, Mtwara and Tabora regions. Benin, however, appears to have a unique conjunction of factors absent in the other two countries. Nevertheless, it appears that several stakeholders encountered in those countries strongly supported the objectives of the study, and showed every intention of using the findings to help improve health service delivery in their countries.

It is important to note that many other low income countries in Africa and elsewhere around the world have ostensible programs on anti-corruption. This is arguably due, at least in part, to international pressure and the agenda of good governance currently promoted by external development partners and international agencies. It appears that consistent campaigns to root out corruption exist only in countries where the anti-corruption agenda coincides with the interests of the local leadership, influential stakeholders, or agents of change.[24]

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[22] As evidence, see the Communiqué issued after the Extraordinary Meeting of the Council of Ministers on 18 November 2006 (the relevant excerpts are reproduced here in Annex C: Excerpt from the Communiqué issued by the Council of Ministers of the Republic of Benin). Briefly, the document states that the Council of Ministers examined some communication from the Minister of Finance relating to the various ministries, the presidency, and the Directorate of the Treasury and Public Accounts under the previous regime and concluded that public sector administration had been characterized by serious mismanagement, including: corruption which had attained unacceptable levels, lack of respect for established procedures, lack of respect for public property, lack of transparency in public expenditure, and non-justified expenditures over and above the budgets allocated.

[23] As an example, in 2001, the Tanzanian government with the support of the UNDP and other development partners launched the project 'Strengthening Capacities to Combat Corruption in Tanzania.' The project was aimed at supporting the Tanzanian government in its efforts to raise the standard of good governance in the country and in supporting the implementation of the National Anti-Corruption Strategy and Action Plan. This strategy is still pursued under the current government. (See the Tanzania Report in Vol. 3 of this study.)

[24] It is also fair to mention that, in cases where there might not have been much support for a study such as this from country policymakers, this is not always a sign of lack of vigor or commitment in their anti-corruption drive. There is at least anecdotal evidence that some people see this issue (of anti-corruption) as a sensitive domestic issue and might not have appreciated the ways in which an externally-sponsored study could help. For instance, the Minister of Health of one of the study countries stated to the present author that they regarded this issue as one of "sovereignty."

The context of the study also showed that corruption is generally a very sensitive issue in countries, inherently difficult to investigate and measure in a precise quantifiable manner. For instance, despite careful assurances to various stakeholders throughout the study about the anonymity of the process as well as an approach emphasizing vulnerabilities in systems and procedures rather than individual or specific actions, doubts and suspicions appeared to persist and it proved difficult to obtain reliable information on certain subjects (e.g. commodity procurement and distribution).

3.2 HEALTH CARE DELIVERY SYSTEMS AND INTERACTIONS WITH PUBLIC

3.2.1 COMMUNITY AND USER PERCEPTIONS

This section compares and analyses some key findings of the household survey of community and user perceptions about corruption in the health sector of each target country.

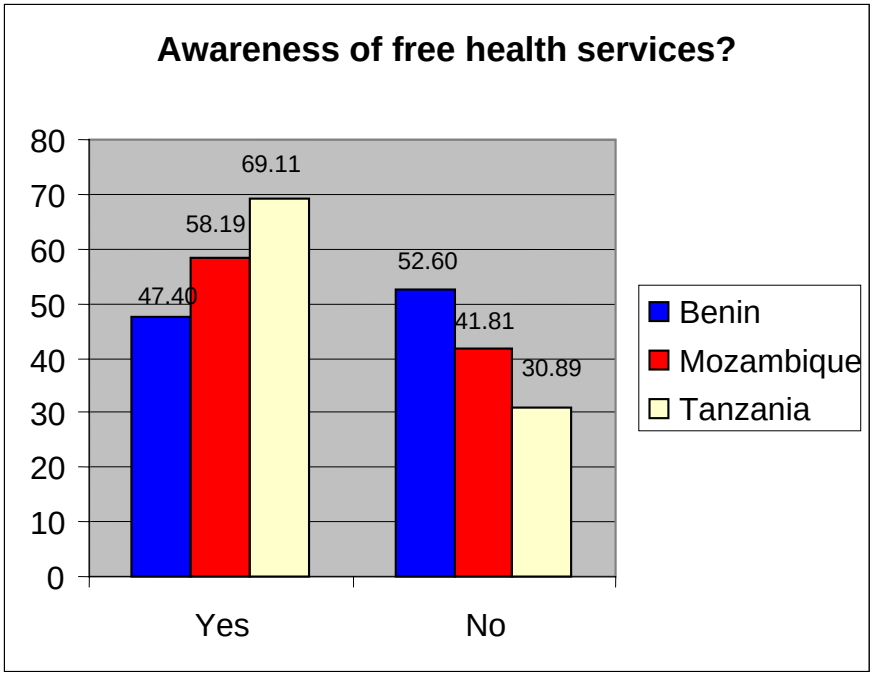
Awareness of free health services

The survey asked individuals if they were aware that certain medical services were free. Analysis of the responses to this question, displayed in Figure 3.1, showed that in Benin a majority stated they were not aware of such services. For respondents in Mozambique, however, the same chart shows a significant majority were aware of such services. Similarly, the Tanzanian data indicate a large majority knew of these services.

The results for the three countries may reflect political and social factors related to their differential historical experiences. It should be noted that while all three countries have espoused some form of 'socialism' at some stage of their post-independence history, such a development path was more vigorously pursued in Tanzania and Mozambique than in Benin. In Tanzania, the philosophy of 'Ujamaa' promoted by the ruling party after independence involved large scale rural mobilization and even an ill-advised and very unpopular physical re-grouping of villages in order to facilitate the provision of state social services such as health education on a free basis. Arguably, this kind of mobilization, whatever its other effects, raises public consciousness about state-provided services even among an illiterate population. Similarly, free social services, including health services, were a key promise of the liberation movement that won independence for Mozambique. The mobilization that accompanied that country's armed independence movement may therefore have ingrained free health care in the consciousness of the population. In Benin, however, a supposedly 'socialist' era in the 1970s and 80s was imposed by a *coup d'état* and neither was accompanied by a similar mobilization nor led to any serious impact on social provision.

We should note here, however, that widespread ignorance concerning free health services (exceeding 30 percent of respondents in each of the countries) would tend to make community persons vulnerable to informal and illegal charges.

Figure 3.1: Percentage of the respondents who answered "yes" or "no"



Likelihood of being asked to pay for free service

For those who said they were aware of free services, overwhelming majorities in Benin were never asked for payment by doctors or hospitals (Table 3.2.1.1).

Table 3.2.1.1: Benin: Likelihood of being asked to pay for free service by doctors or hospitals (Percent)

	Doctors	Hospitals
Always	2.5	3.5
Most of the times	3.0	3.0
Frequently	1.0	1.5
Sometimes	8.0	8.0
Seldom	6.5	6.0
Never	79.1	78.1

In Mozambique, substantial majorities also expressed the opinion that they were never asked for payment by free doctors or hospitals.[25]

It should come as no particular surprise that people who were aware of free health services should report that they were generally not asked to pay for such services. While more interesting, information on the extent to which people who are ignorant of such services were asked to pay for them would be markedly more difficult to collect.[26]

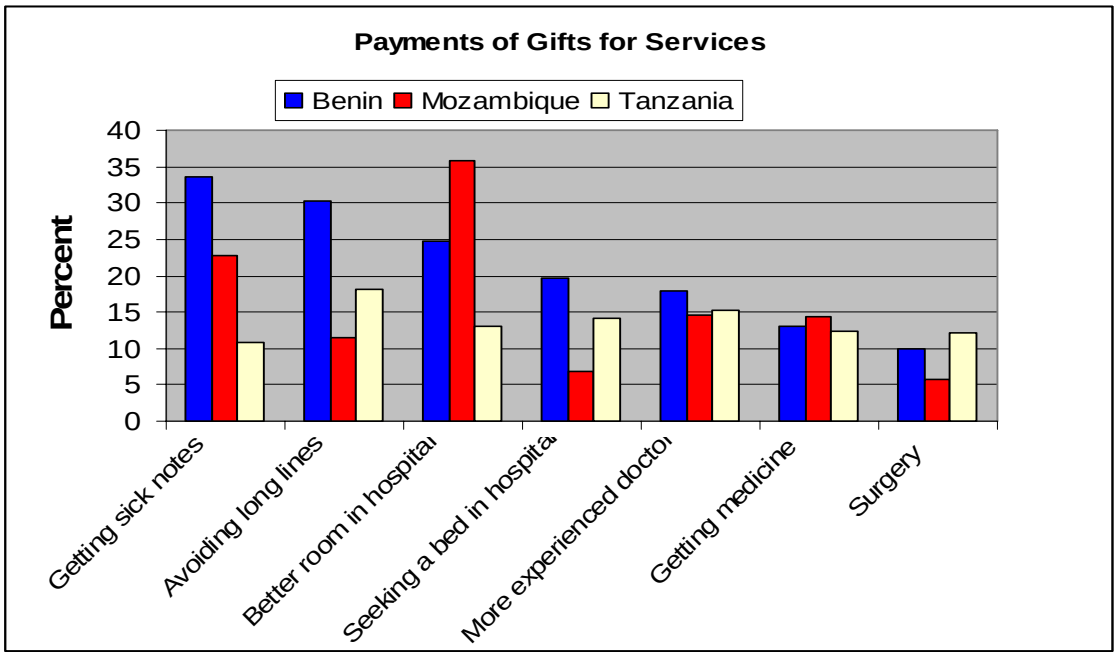
[25] Source: Orlando J. Pérez, MSI Survey Expert. "Report: Survey of Transparency and Accountability in the Health Sector Mozambique," December 2006.

[26] This information would be inherently difficult to collect, since the victims arguably cannot distinguish between legitimate and illegal payments, and the perpetrators are not likely to be a reliable source either.

Likelihood of having to pay a 'gift'

Respondents were also asked about the likelihood of having to pay a 'gift' in various health care situations. Figure 3.2. below presents comparative findings for the three countries.[27] The service for which people are most willing to pay a gift (or possibly, for which there are more demands for 'gift' payments), differs from one country to the next. In Benin, the service that requires the most 'gifts' is getting sick notes. Slightly more than a third of respondents said they had to offer 'gifts' to acquire sick notes. In Mozambique, sick notes rank second in terms of services requiring the most "gift-giving." Rather than a systematic pattern of health care providers asking for such gifts in return for sick notes, these results probably reflect the fact that individuals in Mozambique offer 'gifts' to acquire sick notes in order to avoid going to work or school. According to Mozambican respondents, the service that requires the most 'gifts' is getting a better room for a hospitalized patient. In the case of Tanzanian respondents, people gave the most 'gifts' to avoid long waiting lines. In Benin, this latter service reflected the second largest amount of 'gifts' given. The service that requires the least amount of gifts in all countries is surgery, perhaps reflecting the fact that surgery is usually a service available only upon referral, and patients probably have fewer opportunities to influence how the service is provided.

Figure 3.2



Overall, it seems fair to conclude from these findings that patients in these countries tend most frequently to value payments for getting sick notes, obtaining a better room in hospital, and avoiding waiting queues before receiving treatment.[28]

What actions constitute corruption?

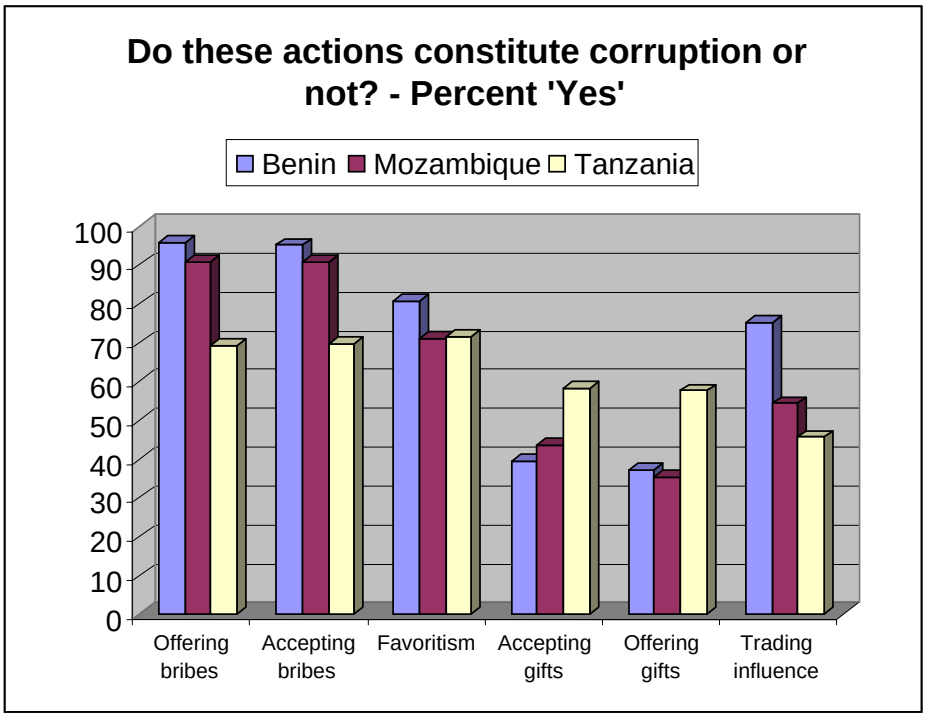
The survey asked respondents to evaluate whether various actions constitute corruption. The results, summarized in Figure 3.3, are interesting and revealing. The chart shows that, for all countries, the overwhelming majority of respondents characterize offering and accepting bribes and favoritism as

[27] See also the detailed country survey reports for the detailed original charts from which the summary comparative figures in this section have been derived.

[28] Supplemental data analyses accompanying the detailed survey reports provide statistical significance tests (p-values and confidence intervals) that enable us to make some broad statements from the generalizable findings.

corrupt. Trading influence is also considered corrupt by a large majority of respondents in Benin, and by a bare majority in Tanzania. However, only a minority of respondents in Benin and Mozambique consider accepting and offering gifts to be corruption, although well over half of the Tanzanians see it as such. Both Beninois and Mozambicans appear to make a clear distinction between bribes and gifts; the latter are acceptable and not considered a corrupt practice.

Figure 3.3



Are gifts necessary to receive good services?

Figure 3.4

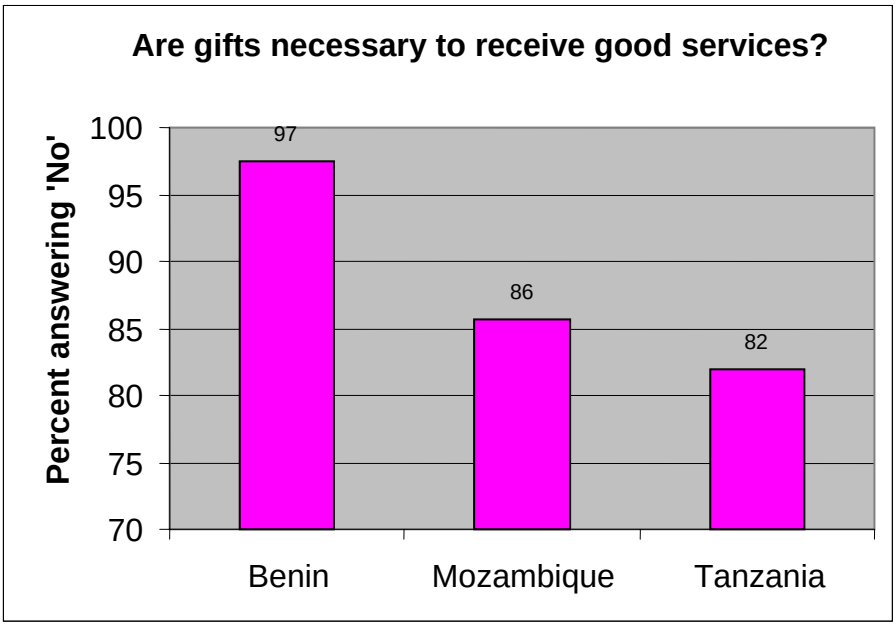


Figure 3.4 summarizes the findings in the three countries concerning whether respondents thought that making a gift was necessary to receive health services. When asked if gifts are necessary to get good services, 97.4 percent of Beninois respondents said no. For Mozambican respondents, 85.6 percent said no when posed this question. Similarly, most Tanzanians interviewed, 82 percent, do not believe it is necessary to offer gifts in order to obtain good services.

Clearly, overwhelming majorities in all countries do not perceive that giving gifts is necessary for obtaining good health care. This appears to contradict all the other evidence gathered in this and other studies (including the data of Figure 3.2 above) and does not fit with the fact that the practice (of paying 'gifts' or bribes for certain services) appears to be widespread. This can be explained by postulating that respondents did not actually catch the nuance about *good* health care, but were trying to answer whether gifts were necessary to obtain *any* health care services. In that case, it can be argued that respondents were very likely stating an obvious truth, namely that people are not turned away from health services because they refused to pay a gift (hence the 'no' responses to this survey question). Rather, as the results displayed in Figure 3.2 above seem to indicate, people pay, or are asked to pay, gifts to obtain *better* health care than what would otherwise be available. This interpretation would also be consistent with the results of other studies indicating that people are often more willing to pay for quality health care when it is available (Creese and Kutzin, 1995).

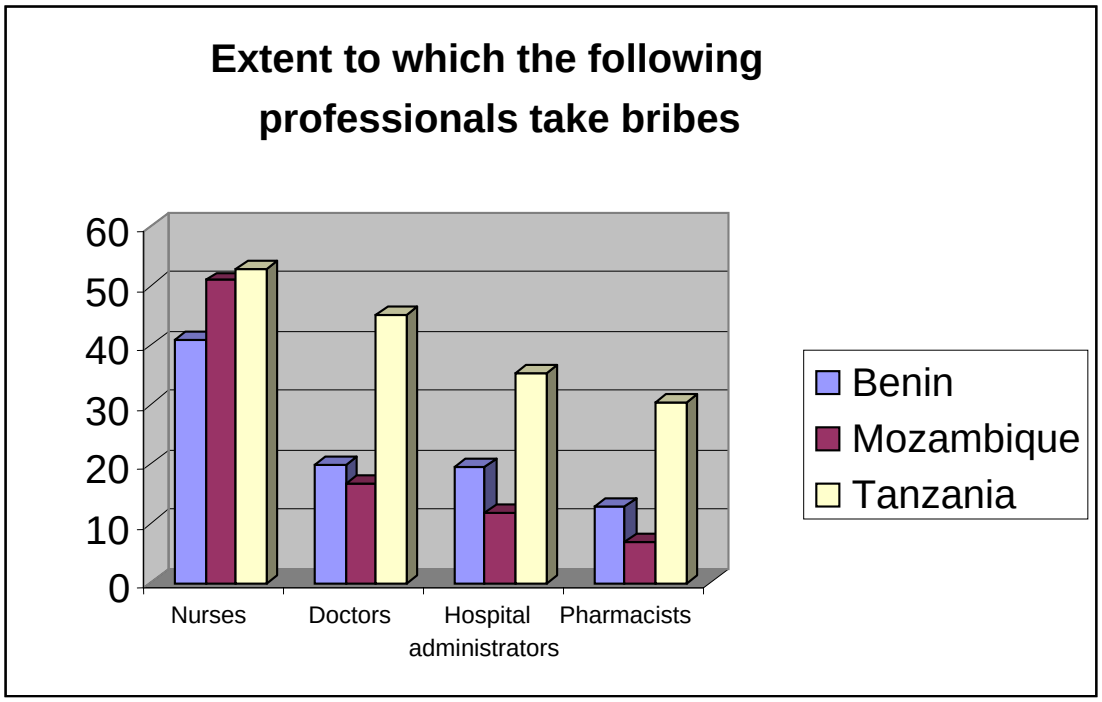
Prevalence of bribe-taking by health care professionals

The survey also asked about prevalence of bribe taking by several health care providers and the results are summarized in Figure 3.5. Remarkably, in all countries, it is clear that respondents perceive that nurses are the most corrupt health care professionals, substantially more likely to accept bribes than doctors, administrators or pharmacists in Benin and Mozambique. While the same trend is true of Tanzania, there is a more gradual decline in the percentages of respondents who consider that the other health

professionals take bribes (i.e. substantially more people consider doctors, hospital administrators and pharmacists as corrupt).

The above results may simply reflect the fact that nurses are at the frontline of service delivery and most patients may only have (or have more) contact with nurses, thus increasing the likelihood that they would need to pay bribes to nurses more often than to other professionals (a "proximity effect"). Additionally, nurses are likely to be the least well paid health care workers and thus more inclined to need to supplement their income by taking bribes.

Figure 3.5



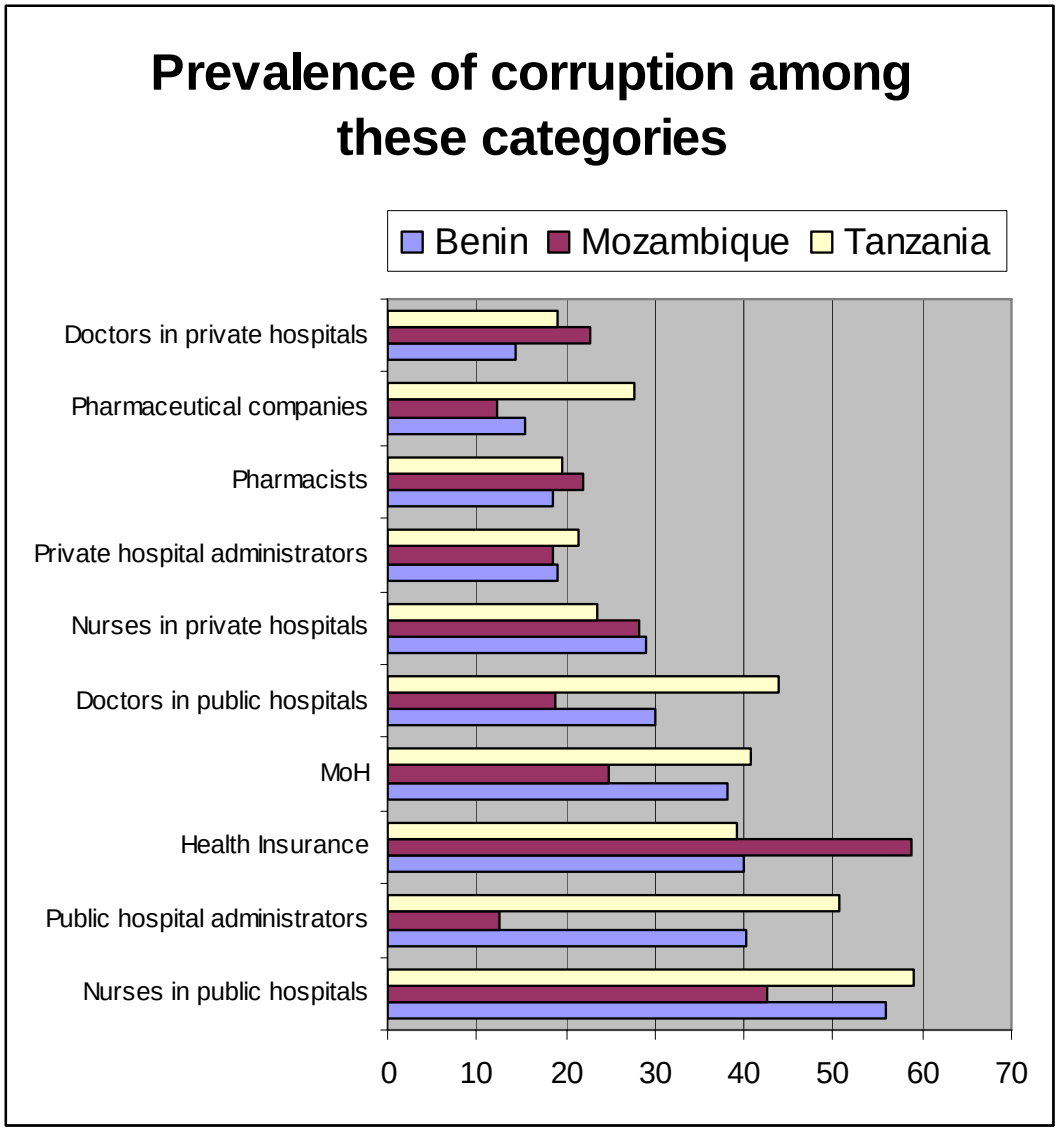
Prevalence of bribe-taking by health care providers/institutions

The above findings are reinforced by the results for this related question. Figure 3.6 shows the summary results for the prevalence of corruption among various categories of health care provider and institution in all three countries. We can safely ignore the health insurance results for Mozambique, because very few in the survey had ever heard of or had any dealings with such systems, as they hardly exist in that country. The high percentage of respondents (i.e. of those few who had had contact with them) claiming health insurance to be most corrupt is therefore misleading in this case.

Controlling for the lack of health insurance in Mozambique, nurses in public hospitals are again considered the most corrupt in all countries, significantly more so than any of the other professionals or institutions including hospital administrators, considered the second most corrupt, and nurses in private hospitals or doctors in both public and private facilities. It is worth noting that doctors in private hospitals are perceived as the least corrupt and that pharmaceutical corporations are viewed as the second least corrupt. This result clearly indicates that findings based on public perceptions must be taken with some caution, as the public is only able to form strong opinions about those professionals and institutions with whom they come into direct and frequent. This analysis is strengthened by the fact that pharmaceutical companies and health insurance each received a substantial number of 'don't know' responses in Benin (where these institutions are somewhat more active than in Mozambique), with 63.3 percent and 79.8

percent respectively refusing to venture an answer on those institutions. The latter is especially not surprising given the fact that over 80 percent in Benin do not have health care insurance coverage and, therefore, have little direct contact with insurance providers. The category considered least corrupt would appear to be doctors in private hospitals, and so once again, the private sector is perceived as less corrupt than the public one.

Figure 3.6

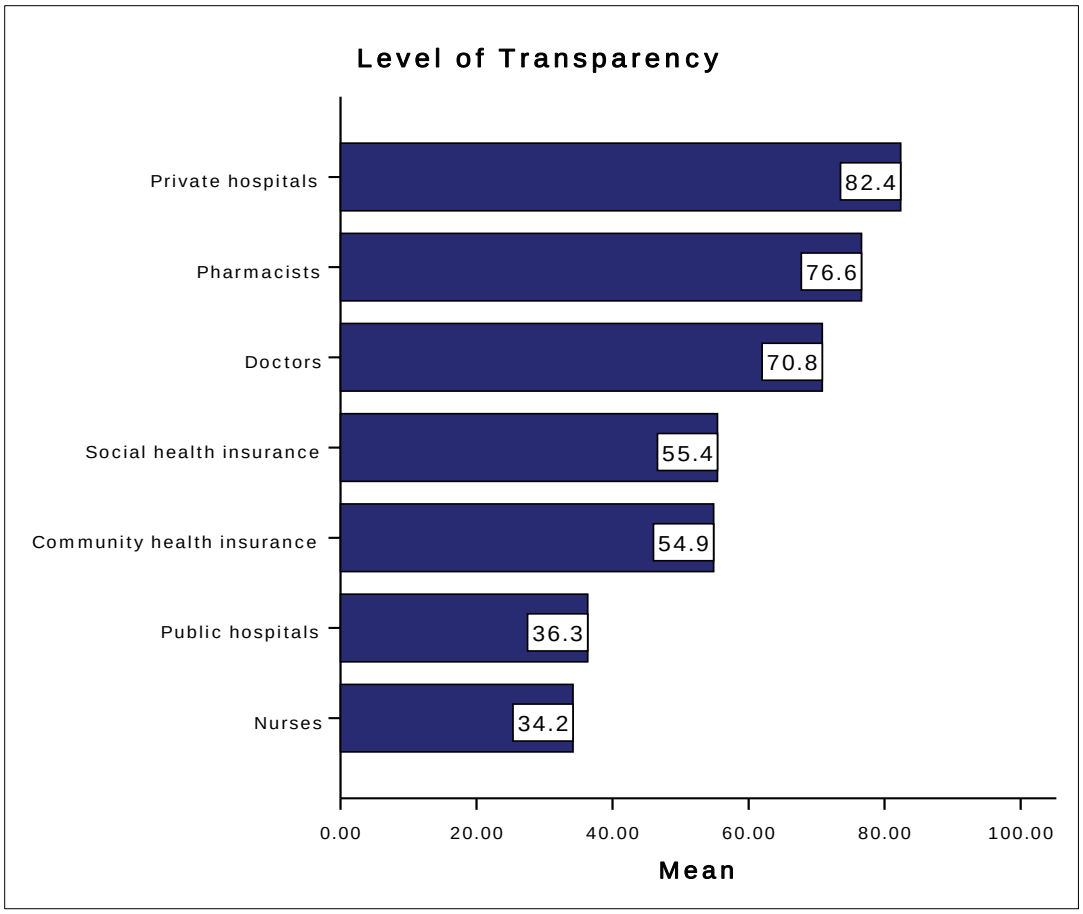


Levels of Transparency

"Levels of transparency" in this context measures *to what extent* the health care institution or professional category indicated on the charts (3.7a-c) was regarded by interviewees as acting transparently in their professional work. The analysis in this section is not strictly comparable across countries, particularly for doctors and nurses, which are disaggregated into public and private categories for Mozambique and

Tanzania,[29] but not so for Benin. We can see from Figure 3.7a from the Benin findings that, as far as transparency is concerned, nurses again score at the bottom. Nurses are considered the least transparent health professionals. Private hospitals are considered the most transparent followed by pharmacists and doctors. The second least transparent institution is public hospitals.

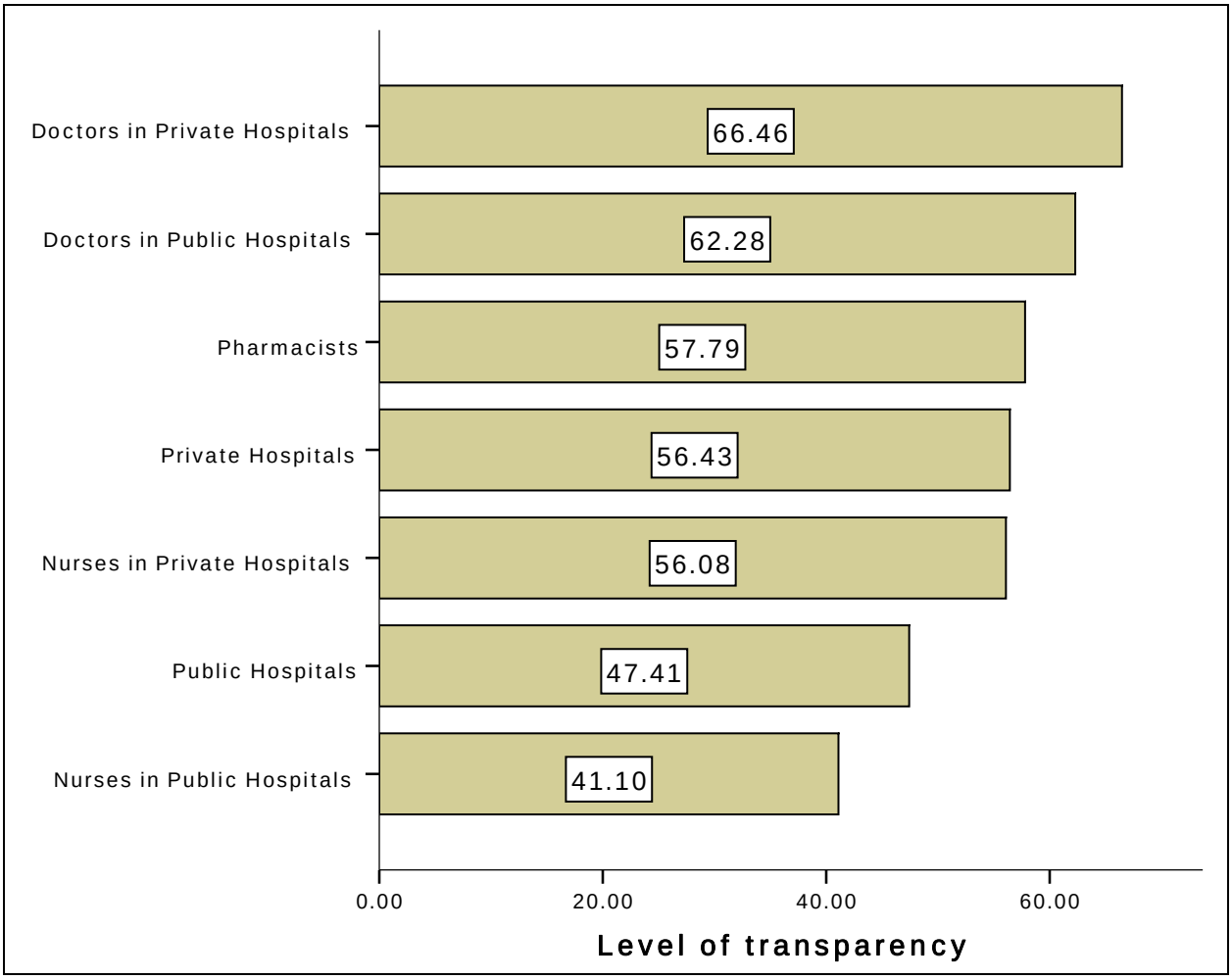
Figure 3.7a



[29] In particular, for Tanzania, the responses are very different depending on whether it is the private or public sector that the question was about.

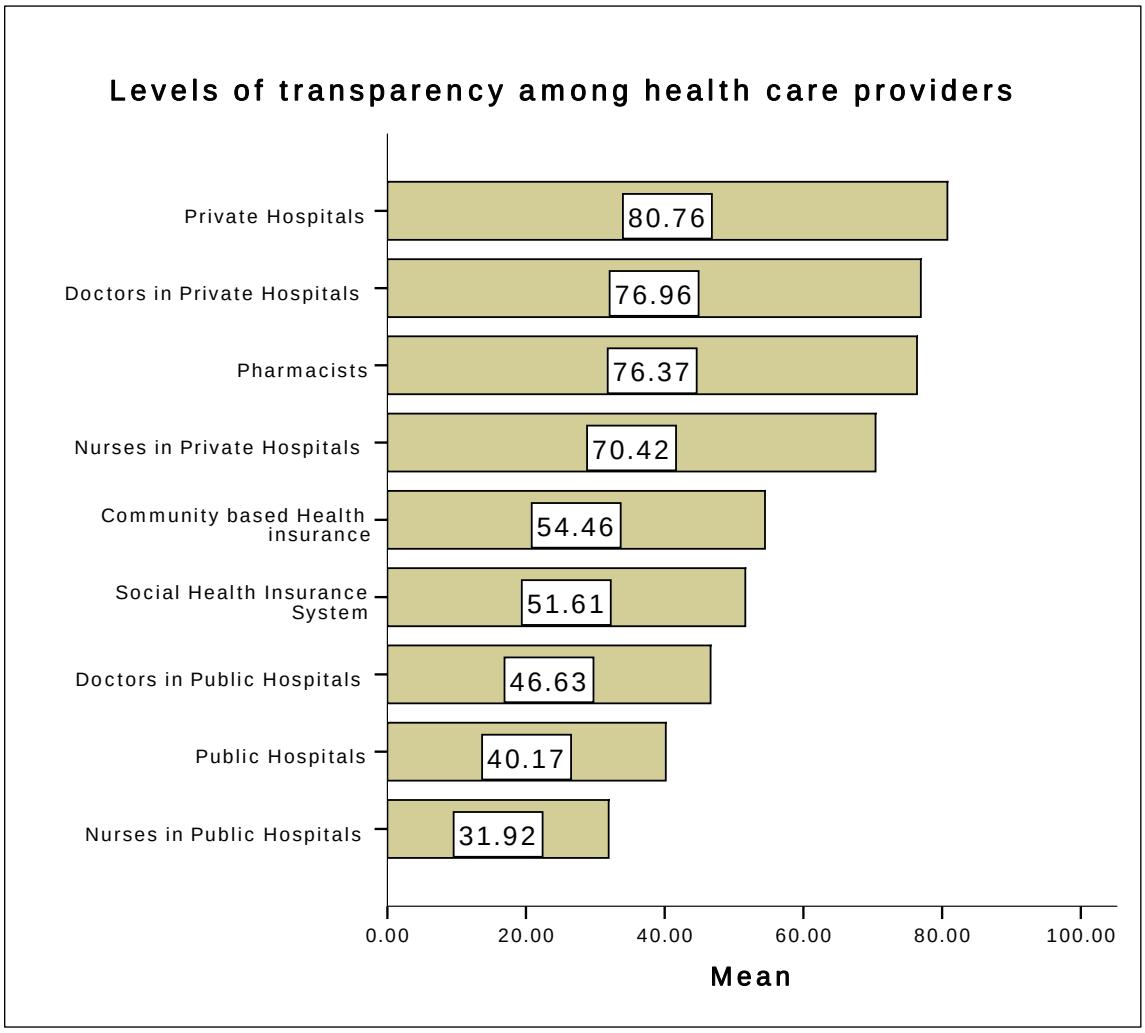
For Mozambique (Figure 3.7b), nurses are again perceived as the least transparent health professional. Doctors in private hospitals are the most transparent followed by doctors in public hospitals and pharmacists.

Figure 3.7b



The findings from Tanzania (Figure 3.7c) show that the most transparent providers are private hospitals followed by doctors at private facilities. The least transparent are nurses at public hospitals followed by public hospitals in general.

Figure 3.7c



These results support the previous findings that doctors at private hospitals (and private providers generally) are considered the least corrupt and nurses at public hospitals the most corrupt, although this may, again, be explained by the more frequent and close interactions between patients and nurses.

3.2.2 FINDINGS FROM INTERVIEWS, FOCUS GROUPS AND DOCUMENT REVIEWS ON SERVICE DELIVERY AND INTERACTION WITH PUBLIC

In the area of health care provision or delivery systems, the country findings from interviews, focus groups and document reviews brought out a number of problems relating to corruption in the health sector, which are categorized as follows:

- **Lack of transparency and responsibility in the management and delivery of health services**
  Interviewees in both Benin and Tanzania highlighted this as an important problem manifested as: unclear regulations and procedures, the selective and often unfair application of rules and procedures, lack of enforcement of rules or disciplinary codes, and the abdication by management of their supervisory duties. This situation facilitates acts of corruption by

making them difficult to detect, or if detected, letting them go unpunished. In Mozambique, imperfect understanding or information about fees as well as procedures or channels for making complaints were highlighted as a significant problem.

- **Misuse of public facilities**
  Respondents in Tanzania note that the most common manifestation of corruption is the use of health facilities by care providers during official and un-official hours to conduct activities for which they receive private payment. A typical example: Doctors conducting laboratory tests in a public hospital and then use the tests result in a private clinic for the treatment of the patient. In this way the patient feels that she has been favored by the doctor and, to the public, the payment does not constitute corruption. This was also found to be a problem in the Benin study. The Mozambique study points out that a reticence by people to talk openly about their experience of corruption in the health sector helps to facilitate the misuse of public facilities.

  A different but potentially more serious issue reported in Benin is that of unqualified facility staff practicing medicine or offering health care in a private capacity.

- **Staff soliciting under-the-table payments or bribes**
  The Benin interviews find that solicitation of illicit payments is common and is a condition before quality care is delivered in a timely fashion to patients, while patients who do not (or cannot because of limited means) submit to such pressure are denied quality care (e.g. long waiting times and no access to drugs). Related to this is the intimidation of patients; for example, subjecting them to long delays in the provision of care. These conditions are exacerbated by bad reception and attitudes of staff upon arrival at the health facility. All of these factors become pretexts for demanding, or encouraging, illicit payments.

  The Tanzania study notes that health care providers use covert means to demand gifts in cash or in kind from patients and their relatives. Some use euphemisms like 'sijanywa chai' – 'I have not taken my tea' – while others just make it inconvenient for the patient to access service. A common practice among doctors is giving future referral dates for situations that need immediate attention. In the laboratory, providers may falsely report breakage of equipment and machines or shortage of expendable supplies as excuses for not providing adequate care until under-the-table payments are made.

- **Fee for service payment system facilitates corruption**
  The Benin report argues that the widely practiced fee-for-service payment system at health facilities leads to numerous cash transactions with attendant problems of accountability, apart from giving providers an incentive to provide unnecessary services and increase their revenues that way.

- **Lack of access to health insurance exacerbates problems of accountability**
  The Benin report also argues that lack of access to health insurance forces most patients to maintain direct cash relations with health providers and multiplies the opportunities for corruption. Furthermore, because individuals directly pay health care staff, they are more easily intimidated or pressured into making illegal payments. A third party, such as an insurance organization, could more effectively check these practices by demanding more accountability or applying counter-pressures on providers. In Benin, 85 percent of the population has no access to health insurance.

  In Tanzania, on the other hand, the government has promoted a National Health Insurance Fund (NHIF), covering public sector employees, and Community Health Funds (CHFs), to

offer some health care coverage to rural communities. Results appear to be mixed at best. It is not clear that the NHIF has solved the transparency problems associated with the institutions where it operates,[30] and the CHFs have not been able to attract large numbers of enrollees (some studies show around five percent of districts signing up). (PHRplus Project, 2006)

- **Low or no community participation in the management of health services**
  The Tanzanian report identified low participation by communities in managing their health services as a factor that reinforces low accountability and fosters abuses. Low community participation is a feature of the health services in all three countries, even where official government policy is to decentralize the management of services and involve the community in such management. The forms of participation so far encountered have been ineffective.

3.3 HUMAN RESOURCE MANAGEMENT ISSUES

Human resource management in the health sector includes recruitment for training in health institutions, deployment of trainees, staff recruitment, discipline, posting and promotion. The main issues brought out by the country studies in this area include:

- **Low salaries and lack of motivation**
  In all three study countries, very low salaries and lack of personnel motivation were identified as a key underlying cause of corruption because staff seek to supplement meager salaries by activities described as corrupt. An example of discontent is mentioned in Figure 3.5.1, which summarizes survey data for Mozambique and found, among other things, that there were "low levels of health worker satisfaction, in particular in rural areas" and that 75 percent of staff in rural facilities wanted to transfer. The Benin study indicates that, because salaries are calculated on the basis of qualification plus years of work, actual job performance does not seem to play a part. This practice does not encourage accountability and probity in work.

  Only the Benin study compared health sector salaries with those in other sectors (in this case favorably). Data from the Benin case also showed that corruption was not limited only to low salaried staff, therefore, additional factors also play a role in leading to corruption. For example, interviewees in all countries pointed to breakdowns in morals as a key issue. Respondents in Benin also said that a lack of leadership role models and bad examples from such persons contributed to the prevalence of corruption.

- **Recruitment**
  The case of Benin illustrates some of the important issues with regard to health sector recruitment and transparency. In 1986, Benin froze public service recruitment and the MoH has not engaged in any systematic recruitment since that time. Instead, each year, the number and types of persons that the Ministry would like to recruit are determined by the Ministry's total available budget. The Ministry of Public Service, however, formally does the recruiting.

  Based on written regulations and recruitment/selection procedures, the recruitment process is ostensibly transparent. It is, however, commonly reported that other criteria are used to recruit personnel that are not in the written texts. For example, closeness to an influential person may be more important than the paper requirements. It also reported that recruitment by the Public Service is determined from a list of individuals drawn up in advance by higher

[30] As civil servants previously used to enjoy some state support for their health care anyway, the replacement of that coverage with the NHIF has arguably only displaced the locus of the actual cash transaction from one state bureaucracy to another.

ranking officials in the MoH and not subject to the nominal recruitment criteria or procedures.

Due to high levels of unemployment, competition for the few jobs is fierce, a situation too easily and, according to the testimonies in our survey, frequently exploited by people in authority or in charge of recruitment in order to enrich themselves or obtain other favors. The Tanzanian study also points out that corruption in the health sector's recruitment processes can take various forms, including demands for sexual favors. In this environment, the benefits of implementing the WHO's recommendation of "recruit, train and retain" are debatable. (WHO, 2006)

- **Sanctions, discipline, rules and regulations**
  The widespread indiscipline and impunity reported in the three study countries is, in turn, the result of other factors that are best illustrated by the situation in Benin:

  In Benin, state employees are covered by Law 86013 which governs employees' rights, duties and the sanctions which accompany various kinds of faults or actions. The method of applying the sanctions is often long and onerous, and the manager on the ground, who usually has to apply the sanction, is frequently not involved in the final decision making process. It is the Minister alone who can decide on certain sanctions – warning, blame and transfer of office. To suspend or dismiss a member of staff two Ministries (the MoH and the Ministry of Public Service) are involved. The process begins with a disciplinary council that must be convened at the Ministry of Public Service and can take as long as 5 years to conclude. According to the interlocutors in Benin, this onerous procedure explains why nobody wants to undertake such an action. Sometimes, a report on the behavior of an employee which is sent to the latter's head of service or manager is simply made available to the employee but without any subsequent action taken.

  In addition, the following problems were also noted in Benin:

  - Written rules and regulations exist but are ineffective because it is not possible to discipline employees at the actual place where they work.
  - The practice of hiring close friends or relations or members of the same region/ethnic group complicates issues of discipline, among other ills.
  - Above a certain level, all initiative is inhibited.
  - Routine working behaviors (without close monitoring or evaluation) means that both good and bad practices are continually repeated.

  The findings from Mozambique also noted that staff absences, late arrivals and early departures from work were a major problem in the health sector (see additional evidence presented in Figure 3.5.1 below).

- **Institutional inertia and resistance to change**
  Results from the Benin study indicate that the professional bodies of doctors, nurses and workers – professional associations and trade unions – help maintain, defend and rationalize practices and systems that perpetuate the lack of transparency and accountability. Some interviewees commented that any changes aimed at improving productivity and transparency, or rooting out corruption would likely encounter resistance from the corporate and individual sides of professional groups, which would oppose the changes and try to prevent their implementation. A case cited as an example was the on-going controversy and

misinterpretation surrounding innovative reforms, such as contractualization, that are designed to help check the abuses under investigation in this study.

It was also contended that disciplinary actions against members of staff for clear wrongdoing might also be opposed by professional groups, thus helping to perpetuate the atmosphere of impunity.

3.4 PROCUREMENT OF GOODS AND SERVICES, SUPPLY CHAIN AND LOGISTICS MANAGEMENT

The procurement process and the supply chain are recognized in many countries as areas where the scope and opportunities for corruption can be very high. It is also arguable that corrupt practices and decisions in the human resource management process can have repercussions on quality of service delivery, user satisfaction, procurement management, financial management and other aspects of the health care system.

The country studies identified the following problems related to this area:

- **Commodity policy and management**
  Many studies, and all anecdotal evidence, have shown that the general public tends to equate the availability of drugs with the quality of health care. Confidence can fall drastically if drug stock-outs are a frequent occurrence at a facility. Areas of commodity management that might be of interest include licensing, registration, drug selection, generic drug policy, procurement, quality control, and distribution.

  The literature review and in-country interviews with officials show that many countries tend to rely principally on the WHO's pre-certification process for licensing and approving pharmaceutical products, but that pressure from pharmaceutical companies, including direct marketing to medical personnel, can be a decisive factor in the process. The same sources also indicate that, in general, study countries have successfully implemented generic drug policies, as shown by the inventories of health facilities and prescription policies dominated by that category of drugs (adequate and reliable stocks are another issue). The areas of greatest weakness tend to be related to procurement and stock management (discussed below), especially regarding transparency of the supply processes, quality control and monitoring, inventory and stock management systems. Anecdotal evidence points to a lack of effective systems in the three study countries for controlling problems such as the importation of inferior quality drugs, repackaging of products, substitution of lower cost or quality drugs for the prescribed drugs, rampant pilfering of supplies, and the proliferation and sale of expired and counterfeit drugs by market traders.

  A study in Tanzania noted that the commodity management system was characterized by "late deliveries, shortages, uncompromising rules, and critically a system that does not encourage flexibility based on burden of disease and population" (Management Services Corporation International, 2003).[31] The studies from Benin and Mozambique identify over-prescription and misappropriation of drugs by personnel as a problem bedeviling health care facilities in those countries. Staff may over-prescribe drugs and other supplies to patients, and then deduct the excess supplies for their own ends. Findings in Mozambique revealed that as a result of the leakage of drugs and supplies, some of the drugs find their way to public

[31] These findings are further amplified below under "The supply chain" section.

markets where they are sold by unqualified traders. It the case of Benin the existence of user fees for drugs, as well as frequent drug stock-outs, creates incentives for parallel markets.[32]

- **The tendering process**
  The tendering process can be prone to a lack of transparency and corruption, including favoritism, kick-backs, circumvention of enumerated procedures and non-competitive bidding. An interlocutor in one of the study countries asserted that a frequent mechanism for avoiding competitive bids is to break down the procurement into quantities or amounts that are just below the ceilings where competitive lists are mandatory.

  The Tanzanian study reports that the procurement of goods and services is undertaken at all levels of the system. The largest procurements occur at the central level – by the Ministry and its specialized departments and institutions. Significant procurement of goods also is undertaken at the regional and district levels. The smallest number of procurements occur at health centers and dispensaries. At all levels, government procurement procedures are expected to be used in the award of tenders. Nevertheless, opportunities for corruption exist within the system, i.e. the corrupt solicitation and award of tenders in return for illicit payments or a share of the contract. Moreover, the quantity and/or quality of goods and services procured may be lower than the amount of money charged with the difference entering into private pockets. The problems have become so serious that some donors have started to demand a tightening of government procedures. For example, in FY 1999/2000, Health Sector Basket Fund (HSBF) donors in Tanzania were unwilling to use MoH procurement procedures for HSBF funds. Thus decentralization of procurement systems does not seem to have solved the core problems, but has dispersed them to all levels of the system.

  Similarly, in Benin, some donors refuse to use the national drug procurement agency's procedures for procuring drugs or other supplies funded by them in favor of better systems. The procurement processes in the Mozambican health sector were also criticized in an external audit report by Ernst and Young on the use of donor funds.

- **The supply chain**
  The complexities of many supply chain systems mean that countries tend to face particular challenges in this area, such as matching commodity supply to demand (involving reliable forecasting and procurement systems as well as adequate infrastructure among other things), managing stocks and inventories, and ensuring adequate information flow at all levels. In addition to these challenges, the fact that drugs and other supplies have to constantly be replenished to keep the health system functioning, and that such replenishment usually goes through a long chain from the central level in the national capital to the operational levels of the system, also offers opportunities for corruption and similar abuses.

  The study found that country supply chain systems were often characterized by a lack of reliable systems for forecasting and anticipating demand due to poor information flow, dysfunctional inventory and stock control management systems, and lack of coordination between different actors in the system. A Tanzanian study cited previously in this report

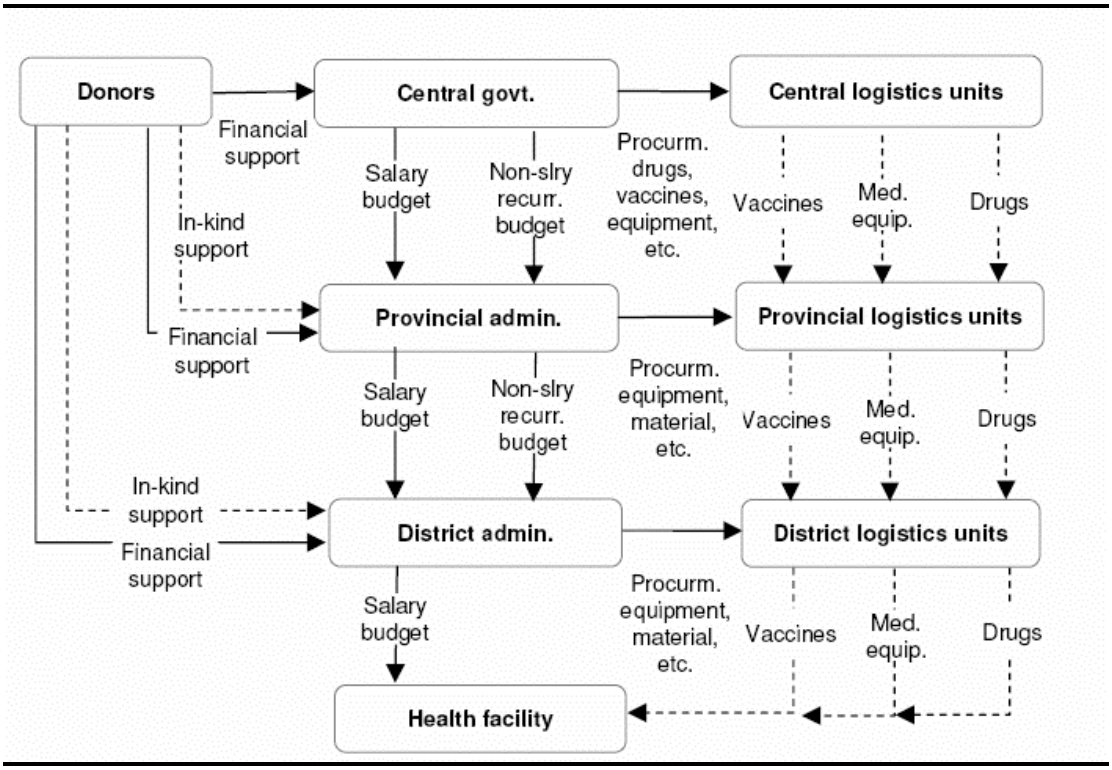
[32] It is quite an irony that field experience seems to point to strong links between corruption and user fees in the public health sector since one of the original arguments for such fees was that by replacing informal with formal charges, the incentives for under-the-table, informal payments would be removed. But evidence that such a measure only appears to displace the locus of corruption from one level to another appears to undermine that argument. For instance, misappropriation of fee revenue was estimated to be as high as 68-77 percent in Uganda (Vian, 2005). In the case of rural communities for example, this would also represent a transfer of resources from vulnerable persons to a more privileged group – public servants.

found that existing drug kits had remained static for several years and were consequently not representative of long term changes in pharmaceutical usage patterns and that, in addition, there was "no existing methodology to vary the contents to be more reflective of significant burden of disease differences and variations in morbidity between Regions or even Districts within a Region and further, the Kits are not population based." Similarly, the methodology "did not permit reaction to an immediate need such as an outbreak of contagious disease." As a result, "some facilities were continuously stocked-out of certain products and overstocked in others," with data showing stock-out levels between 10-30 percent at the average health facility. (Management Services Corporation International, 2003)

Figure 3.8, depicts the flow of financial and other resources within the Mozambican health system and provides an insight into the supply chain and commodity logistics dimension of that system. At all the different organizational levels, it is not difficult to envision that opportunities exist for the leakage of some of those resources. There is, however, no direct evidence of the scale of the problem, or how systematically it happens in Mozambique.

Findings shown in Figure 3.9 do, however, point to delays in drug distribution and frequent drug stock-outs as a problem. Moreover, a further sign of inefficiency is that of "considerable discrepancies in the number of tablets distributed per patient for six tracer drugs." The example provided reported that between 1.1 and 16 tablets of aspirin were given per patient episode. Another sign of inefficiency is that individual drugs, instead of more efficient drug kits, comprised a large share of drugs to facilities.

Figure 3.8: Financial and resource flows to primary level facilities in Mozambique. ***Source: Lindelow, 2006***



- **The abuse of official position and misuse of public property and equipment for personal ends**
  The contractual and administrative processes involved in construction, maintenance, rehabilitation and repairs to facilities and equipment also offer opportunities for corrupt officials and suppliers/contractors through kick-backs, over- and under-invoicing, provision of low quality services or defective equipment/parts/materials. Some interviewees alluded to such practices in study countries, although only in the most general terms.

  The Benin report also noted that some medical staff at public facilities used property and equipment there for some of their private consults.

- **Absence of standard schedule of prices for goods and services**
  Similarly, the Benin report argues that the lack of a standard schedule of prices for goods and services supplied from central stores to public agencies around the country creates opportunities for corruption. A similar problem arises from the variation in prices of drugs from one health facility to another.

3.5 HEALTH FINANCING AND FINANCIAL MANAGEMENT

Health financing and financial management systems, like procurement, are particularly prone to the problems of corruption and the lack of accountability that are examined in this study. The flow of funds and attendant management problems often transcend the health sector, typically involving at least the Ministry of Finance. Those problems are often exacerbated by a situation where health managers are often medical personnel who have not had any specific financial management training. Similarly, it is worth noting that corruption or mismanagement in health financing and financial management will have consequences on resource availability and management within other areas of the health care system. The following issues were highlighted by the country reports relating to this area:

- **Lack of transparency and specifically 'traceability' (i.e. no audit trails) in the management of public resources**
  The country report from Benin noted that corruption is fostered by a lack of either paper trails or computer records of transactions in the sector. Among the kinds of problems identified were those of 'cooking the books,' or accounting and book-keeping forgeries. The Mozambique report also notes that, although this problem is starting to be addressed, a lack of computerization contributes to lack of transparency and facilitates corrupt behavior without leaving traces.

- **Lack of regular audits of public spending**
  All the country studies seem to agree that auditing of public institutions including the health sector is very poor. They are not regularly done as required by statutes, not properly done, or if they are well done, there is no follow-up of their findings and recommendations.

- **Delayed release of funds**
  A problem found in the studies in Benin and Mozambique is that of long delays in releasing funds for activities at the operational levels such as districts and health institutions (for Mozambique, see Figure 3.9 below). Funds meant to be released in the first quarter may be available only in the third or fourth quarter of the fiscal year. As finance regulations usually require that budgets cannot be carried over to the next fiscal year, the consequence of this is that operational units are compelled suddenly to spend considerable sums of money (compared to their normal cash flow situation) over a relatively short period of time. As a

further result, normal procedures may be circumvented, checks and controls that may have been in place in normal times may be temporarily suspended and similar deviations from good practice all add up to create opportunities for corrupt officials to line their pockets and engage in other abuses. The health facilities surveyed in Benin cited delays in releasing budget allocations as a key problem undermining systems put in place to foster accountability and transparency.

- **Delayed payment of debts owed to hospitals by the state (for care given to its employees)**
  Interlocutors in Benin noted that hospitals are put under great pressure because the government does not, or is unable to, pay its debts to those institutions. These debts arise from health care provided to public employees for which the government guarantees to pay about 80 percent of the cost. Although not directly connected with corruption, such pressures force hospitals to use unorthodox methods to keep their institutions running, and these methods may include illegal charges. Further, it is contended that such a situation puts the government at a disadvantage in requiring or enforcing strict accountability, transparency and efficiency in resource utilization within health care institutions.

- **Various reports of misuse and misappropriation of public funds, including donor pool monies**
  In all the study countries there were reports of the misappropriation of public funds at health facilities and even at higher levels in the health system. The Tanzanian report noted a problem related to project funds provided by government and development partners to NGOs and CSOs. It has been observed that some project officials demand commissions from the recipients in return for the grant. Those NGOs and CSOs which do not comply are refused funding. In some cases projects came to an end without spending all the money earmarked for the NGOs because of lack of complying partners. It is also reported that NGOs and CSOs are the preferred channels for such corruption because they have less stringent accountability systems and it is easier to misappropriate funds that way than directly from public sector institutions.

- **Financial procedures sometimes non-existent, unclear or not followed**
  Even where procedures exist, as is the case with procurement, sometimes they are not followed, giving rise to opportunities for undesirable behavior without much chance of penalty.

- **Budget execution and flow of funds**
  A frequent problem in low income countries is that of low budget execution rates, where a sector Ministry is unable to spend the entire budget that has been allocated by the Finance Ministry in the course of a year. The reasons may vary, and can be due to factors within the sector Ministry or at the level of the Finance Ministry e.g. long and complex procedures or staff capacity issues. Donors tend to characterize this problem as one of “low absorptive capacity,” managerial incompetence or delays that have their source in corrupt practices. When this happens, the problems cascade all the way down to the operational levels of the sector Ministry.

  The typical technique for uncovering whether there is a leakage of resources in a sector is to carry out a public expenditure tracking survey (PETS). Figure 3.9 shows some of the findings from such a survey in Mozambique. This figure also serves to bring together issues from different dimensions of the health system that we have examined in this study.

Figure 3.9: Key Findings from an Expenditure Tracking Survey in Mozambique
Source: Lindelow, 2006

Non-wage recurrent budget	• Delays in the execution of the non-wage recurrent budget (in many districts the initial budget transfer to districts, due in January, was only made in March or April, and monthly replenishments were frequently delayed by several months) • Delays and other factors resulted in low levels of budget execution at district level, with an average execution rate of 80 percent, and some districts executing only 35 percent of the original allocation • Dramatic disparities in district spending per capita, and that these disparities can not be adequately accounted for by differences in population or infrastructure
Drugs	• Delays in drug distribution and evidence of stock-outs • Individual drugs comprise large share of drugs used in health centers and health posts, even though drug kits are supposed to be adequate • Despite explicit aim of need-based distribution of drugs to facilities, there was considerable discrepancies in the number of tablets distributed per patient for six tracer drugs (e.g. aspirin between 1.1 and 16 per patient episode)
Human resources	• Delays in salary payments (60 percent of staff report receive salaries late 'often' or 'almost always') • Absenteeism (19 percent of staff were not present at time of visit) • Low levels of health worker satisfaction, in particular in rural areas (75 percent of staff in rural facilities wanted to transfer
User fees	• Despite existence of national policy, fees charged for consultations and medicines vary considerably between province, districts and facilities. Similarly, rules for exempting specific user groups or services from payment for consultation or medicines vary greatly across districts and facilities. • Sizeable share of user fee revenues not recorded by facilities (68 percent of the total consultation fees paid and 80 percent of medicine payments , based on a comparison of expected total facility receipts given patient volume and reported payment, and amounts reported by the facilities)

SOME SUGGESTED CAUSES OF PROBLEMS IDENTIFIED

Of all the issues identified in the country studies, which of them did interlocutors consider causes and which manifestations of the problem of corruption in the health sector? Interviewees across target countries seemed to identify similar issues as causes, as can be seen from the following selections from the country reports:

Benin

The main causes identified were:

- Impunity and weak enforcement of sanctions and disciplinary rules
- Low salaries in poor working environment
- Irregular audits
- Moral degeneracy and
- Lack of public role models or good leadership examples

Mozambique

The main systemic weaknesses seen as contributing to the problems include:

- Low salaries in the public sector
- Lack of management controls or supervision and weak enforcement of sanctions

- Lack of computerization of records and data; although this is a problem that is being addressed progressively in some provinces
- Breakdown of morals

Tanzania

Respondents suggested that the causes of corruption in the health care delivery system arose from:

- Moral degeneration
- Impunity associated with a high degree of tolerance for corruption and weakness of systems
- Low salaries in poor working environment and
- Low community participation in the management of health services.

4.0 GENERAL DISCUSSION, FINDINGS AND LESSONS

The findings of this study emphasize the importance of a systems approach to understanding and, therefore, eventually combating corruption in the health sector. These results illustrate the many and complex ways in which corruption and transparency issues are manifested and inter-linked throughout the various dimensions of the health sector and even in other sectors.

For example, within the health sector human resource decisions impact service delivery, procurement, and financial management. Beyond the health system, corruption reflects, at least in part, weak public administration and institutions, low levels of literacy, critical human resources and financial management decisions/sources that lie outside of the health sector, and low levels of leadership commitment to reform. Therefore mismanagement or abuses in one dimension of the health system or sector of the economy can have repercussions in others making the solution of these problems more difficult.

As a result, and further complicating the picture, assessing the extent of corruption and the degree of transparency and accountability in the health sector poses major challenges. There is a problem of appropriate performance indicators, partly due to the nature of the sector, where services are of a personal and usually private, confidential nature, agency is rife, and demand is unpredictable. A further challenge is that the subject of corruption is generally very sensitive, inherently difficult to investigate or measure in a precise quantifiable manner.

The country-specific analyses revealed the importance of understanding the broader political and leadership context, as well as commitment, to anti-corruption initiatives in order for a study such as this to be successfully undertaken and, subsequently, for the findings to be acted upon. The varied pace and scope of the research in the three countries illustrate this lesson.

Background information on each of the three countries revealed a variety of reforms and initiatives, some of them on-going, which could contribute to addressing the problems of corruption and lack of transparency identified in the study. In Benin, for instance, the Ministry of Health has been engaged in a budget reform process with the aim of moving from an inputs-based to a performance-based budget. However, although some reforms, such as instituting an MTEF and sector-level procurement, have been successfully implemented, the impact of these reforms on the specific issues of immediate interest in this

study do not appear to have been particularly dramatic. The MoH is also currently promoting the contractual approach although this seems to be meeting resistance from vested interests.

Beginning in the early 1990s, the MoH in Tanzania also implemented an MTEF, a performance-based budget approach, and a health financing reform which have culminated in a National Health Insurance Fund for formal sector employees and Community Health Funds for rural districts. An issue debated among observers of the Tanzanian health financing reforms is whether accountability and transparency have been enhanced, or these issues have been displaced to a different level in the health system.[33]

Indeed, given that the development landscape in these and many other countries is littered with reforms that failed to achieve the original high purposes and intentions of their designers, it is worth asking what the reasons are for little to no improvement in to transparency, accountability and anti-corruption.

As cited in the Tanzania case study, a previous study of public expenditure management in Tanzania bears repeating here. According to that report efficiency improvements via budget allocations were difficult to achieve because of (i) the "political nature of the budget process," in other words, an exclusive focus on technical tools for leveraging efficiency improvements through appropriate budget allocations (e.g. rewarding good performance and punishing inefficiency) is often in conflict with politically-driven spending imperatives, and (ii) the pressures "from both domestic and international constituencies" to increase spending in priority areas is determined *a priori*.

These two factors tend to limit the ability of officials or managers to use budget allocations to leverage efficiency gains in different sectors of the economy. But these examples merely illustrate a wider problem, namely that the objectives of key reforms can frequently clash with other objectives or imperatives championed by powerful stakeholders or interest groups.

A related issue is the extent to which implementation can be expected to proceed as designed or intended if the reforms aim, at least partly, to undermine the interests of those in charge of the design and/or implementation processes, which is not uncommon with reforms to promote transparency, accountability and anti-corruption. It may also be partly connected with sensitivities around these issues highlighted earlier, which tend to discourage explicit consideration or mention of them in public or official discussions. There are not likely to be any quick fixes or magic formulae for resolving the problems identified in this study.

4.1 SUMMARY OF GENERAL FINDINGS

The field research and the ensuing country reports have highlighted specific findings related to the health systems of the study countries. We summarize these below as the conclusions of the study, presented according to the dimensions of the health system investigated.

Service Delivery and Interaction with Public/Users

The household surveys provide some important conclusions about community and user perceptions of health facilities in their countries.

- Although varying by country, many respondents, including an absolute majority in Benin, do not appear to be aware of which health services are free, presumably making them more vulnerable to informal and illegal charges. The evidence also indicates that the country results

[33] It should be noted Rwanda, and arguably some other African countries, seem to have been more successful at implementing similar reforms.

here seemed to correlate with the history of popular mobilization around state-provided social services.

- Majorities of the respondents do not consider the payment of a gift as necessary to obtain good health care. We interpret this as a situation where respondents may have been answering another question altogether, not paying any attention to the nuance about *good* as opposed to standard health services. If so, the responses would be consistent with the fact that payment of gifts are not required to obtain health care in general, but are apparently regularly given for the purpose of getting better quality health care than would otherwise be the case. These results would also be consistent with well-founded observations in the literature which indicate that people tend to be willing to pay for quality health services.
- Nurses are considered in nearly all surveys and countries as the most corrupt, and least transparent, health care providers although it is arguable that this is due to the position of nurses on the frontline of the health delivery process. Most patients come into contact with nurses more frequently than other health care providers. Nurses also earn less and so are perhaps more exposed to the temptations of corruption. However, because perceptions matter, this finding cannot and should not be disregarded by members of the nursing profession in these countries. The findings show that there is clearly an urgent need for nurses' professional bodies to examine ways to improve the image of their profession among the public.
- Private providers are perceived as less corrupt than public ones. This finding shows that the public sector may have something to learn from the private sector in terms of how they are able to maintain a good image with the public. Although there are constraints to the public sector adopting similar practices, it may nevertheless be able to learn useful lessons and borrow at least some techniques from the private sector. The study did not investigate the factors involved here, but it is an area for further enquiry.
- In at least two of the countries, offering and accepting gifts is not considered corruption by a majority of respondents. The public, at least in those two countries, appears more receptive to the notion that it is alright to show voluntarily one's appreciation to another person either in advance or after they have performed a service for them. This appears to be related to practices widespread in these societies where gifts are frequently given in return for good services offered.

From the other components of the country studies, the following issues relating to service delivery seem to stand out:

- Lack of transparency and responsibility in the management and delivery of health services: Corruption is facilitated by unclear regulations and procedures, their selective and often unfair application where they exist, lack of enforcement of rules or disciplinary codes, and a situation akin to 'absentee' management where staff are not regularly held accountable in a fair, impartial but strict manner for their actions.
- Misuse of public facilities: This is often manifested as medical staff using the public health facilities (e.g. lab, radiography) to perform diagnostic or other procedures for patients they are seeing in private practice. There were also reports of some unqualified staff setting up their own medical practices in communities and charging unsuspecting patients for these illegal activities.
- Staff solicitation of under-the-table payments or bribes: It is apparently quite common in the study countries for personnel to ask for bribes or illicit payments as a condition for offering better quality care to patients than they would otherwise give.
- Lack of access to health insurance exacerbates problems of accountability: This forces most patients to maintain direct cash relations with health providers and multiplies the opportunities for corruption. Furthermore, individuals who directly pay health care staff are more easily intimidated or pressured into making illegal payments whereas a third party, such

as an insurance organization, could more effectively check these practices and demand more accountability or apply some counter-pressures on providers. This argument is especially relevant in Benin, but the evidence from Tanzania, where social health insurance has been actively promoted by the government, does not so far show a dramatic effect on the problems of transparency, although that experience does not directly refute the above points made by interlocutors in Benin. By contrast, Rwanda appears to have succeeded much better in implementing an attractive community based health insurance system, with district memberships well over 60 percent.

- The fee for service payment system also facilitates corruption: The argument here, again from Benin, is similar to that for health insurance above, namely that numerous individual cash transactions with providers offer many more opportunities for corruption. It is certainly well-attested that the fee for service payment system is among the least effective for achieving low costs and promoting good clinical practice, such as rational drug use, since it gives incentives to provide unnecessary care.[34]
- Low or no community participation in the management of health services: Even when governments have ostensibly undertaken decentralization programs with community participation in management as one of the objectives, the experience shows that effective participation is very low, and certainly does not entail communities actually being able to hold providers to account for local services. More effective forms of community participation are suggested in the recommendations below.

Human Resource Management Issues

- Low salaries and low levels of worker satisfaction/motivation were identified in all three countries as one of the main causes of corruption and lack of transparency in the health sector. However, it was also pointed out that the issues here may be more complex than this, as there is no evidence that higher paid staff are necessarily less corrupt. It seems likely that these factors are important but not sufficient in themselves to explain the scale and depth of the problems noted.
- Recruitment processes are often complicated, not under the control of the Ministry of Health, and frequently reliant upon acquaintances and the payment of bribes to people in authority. It is arguable that because of high unemployment in these countries, competition for the few vacancies among the army of unemployed is fierce, a situation too easily and frequently exploited by people in authority or in charge of recruitment in order to enrich themselves or obtain other favors.
- Weak systems for enforcing sanctions, discipline, rules and regulations: This is manifested in lack of authority for local managers to enforce discipline and appropriate sanctions. Widespread impunity was highlighted in all country studies as a key underlying cause of corrupt practices and other abuses. This situation appears to be fostered by people in authority unable to check the abuses taking place, either because they have no adequate powers to do so, or because they may be setting the worst examples themselves.
- Institutional inertia and resistance to change: This finding pertains to the role of professional bodies of doctors, nurses and workers (professional associations and trade unions) in maintaining, defending and rationalizing practices and systems that perpetuate lack of transparency and accountability.

[34] For instance, a study in Peru showed that private sector doctors carried out unnecessary, and potential risky, Caesarean operations at abnormally high rates when paid by fee for service, compared to public doctors not paid by this system (although even the latter's Caesarean ops were above usual norms): Caesareans constituted between 59 to 78 percent of all deliveries at the private hospitals, compared to 21 to 29 percent at the public hospitals (Tella and Savedoff, 2001).

Procurement of Goods and Services, Supply Chain and Logistics Management

- Commodity policy and management considerably less than optimal: The study found that countries have generally implemented generic drugs policies, although adequate and reliable stocks are another issue. The areas of greatest weakness tend to be related to procurement and stock management, especially with regard to the transparency of the processes involved, quality control and monitoring, inventory and stock management systems.
- Corruption in tendering and procurement processes: The procurement and tendering processes were found to be prone to lack of transparency and corruption, including favoritism, kick-backs, circumvention of laid-down procedures, non-competitive bidding and similar issues. In Benin and Tanzania, some donors lost confidence in the public procurement systems due to such problems.
- Supply chain corruption: The study found that the complexities of many supply chain systems mean that countries tend to face particular challenges in this area, and that country supply chain systems were often characterized by a lack of reliable systems for forecasting and anticipating demand, due to poor information flow, dysfunctional inventory and stock control management systems and lack of coordination between different actors in the system. These problems are aggravated by poor infrastructure (computer systems, transport and roads). In addition to these challenges, the fact that drugs and other supplies have to be constantly replenished to keep the health system functioning, and that such replenishment usually goes through a long chain from the central level in the national capital to the operational levels of the system, also offers opportunities where leakages can occur along the way.
- The contractual and administrative processes involved in construction, maintenance, rehabilitation and repairs also offer opportunities for corrupt officials and suppliers/contractors through kick-backs, over- and under-invoicing, provision of low quality services or defective equipment/parts/materials.

Health financing and financial management

- Absence of audit trails facilitates corrupt behavior and impunity: Reports from the countries show that the lack of computerization and reliable recordkeeping systems open the way to corrupt practices that are difficult to detect.
- Delayed release of funds and payments of debts owed to hospitals by the state: Health institutions are put under pressure because the government does not or is unable to release budgeted funds or pay its debts to those institutions in a timely manner and, sometimes, even at all. These debts arise from health care provided to public employees for which the government guarantees to pay at least some of the cost. Closely related is the problem of long delays in releasing funds for activities at the operational levels such as districts and health institutions, with large sums often getting released only towards the end of the fiscal year. This puts pressure on facilities to spend considerable sums of money over a relatively short period of time, as budgets cannot be carried over to the next fiscal year. As a consequence, normal procedures might be circumvented, checks and controls that might have been in place in normal times may be temporarily suspended and similar deviations from good practice all add up to create opportunities for corrupt officials to line their pockets and engage in other abuses.
- Lack of regular audits of public spending: The study concluded that external audits are not regularly conducted as required by statutes, not properly done, or if they are well done, their findings and recommendations may not be followed up. This appears to be related to shortages of relevant experts, capacity issues with public audit institutions and political and other interference with auditors' work.

- Various reports of misuse of public funds, including donor pool monies: In all the study countries, there were reports of misappropriation of public funds at health facilities and even at higher levels.
- Financial procedures sometimes non-existent or not followed: It is a reflection of poor public administration in countries that such an observation was frequently made.
- Budget execution and flow of funds: Reflecting the financial difficulties of low income countries such as the study countries, low budget execution rates are frequently cited as a problem. This may be due to factors within the sector Ministry or at the level of the Finance Ministry, e.g. long and complex procedures or staff capacity issues. The funding problems then cascade all the way down to the operational levels of the sector Ministry.

4.2 SOME POSITIVE LESSONS FROM COUNTRY FINDINGS

The experience of the Clinique HOMEL, Benin

It has been noted that both quality improvements and an efficient administrative system were achieved at the *Clinique HOMEL* after the setting up and enforcement of a number of very simple measures by the managers.

- The pharmaceutical management system was computerized and networked. The wholesale department and the retail points were placed on a network to facilitate control over the movements of stocks of drugs and supplies (traceability);
- There is a computer for cashiers to enter receipts/payments. The principal cashier is responsible for paying all the day's receipts into the bank account every day without fail;
- It is strictly forbidden to use daily receipts directly for paying for any expenses;
- Whenever the proposed expenditure exceeds 50,000 FCFA, the facility must adhere to the following procedure: identify the needs, contact the suppliers, establish a purchase requisition order (*bon de commande*), reception of the order by a small 'reception' committee, approval of the delivery note by the reception committee (after verification with the order received) and writing up the minutes of the meeting.

Examples from Mozambique

- In order to address the well-known problem of 'ghost workers', all public officials are required to show 'proof of life' annually, by appearing in person at the government department responsible for issuing identity documents.
- Another significant initiative aimed at addressing problems of transparency, among other things, are government-held meetings to solicit communities' views and discuss their complaints regarding local services and other issues.
- Mention has been made of past initiatives taken to improve the link between health units and communities. These include exit interviews at health facilities, management and leadership activities provided at health facilities to empower staff, and training staff to monitor each others' activities. Unfortunately there was no evaluation of the impact of these past initiatives available, but they certainly appear to be quite interesting and worthwhile in themselves.

5.0 GENERAL AND COUNTRY RECOMMENDATIONS

The following recommendations are offered not as cure-alls but as a contribution to a more complete package of solutions which should include appropriate steps to tackle the contextual factors mentioned previously. An exclusive focus on technical solutions, without taking into account the broader context of political, social and institutional dynamics, is likely to lead only to disappointment. While these factors are generally beyond the scope of this study, an indication of some of the institutions involved can be found towards the end of this report in (and the reader is urged to consult) Annex B: General Overview of Key Actors Involved in Combating Corruption and their Roles. The country recommendations are presented in tabular format according to the four dimensions of the health system studied.

5.1 GENERAL RECOMMENDATIONS

The set of recommendations in this section constitutes our main suggested actions to address key problems identified in the study, but is also designed to complement the country-specific recommendations. They are based on insights drawn not only from the country studies but also from broader international experience and the literature review concerning anti-corruption and promotion of transparency, accountability and efficiency in the health sector. Though presented broadly in accordance with the four dimensions of the health system investigated in the study, they are not meant to be an exhaustive response to all the problems identified in the study. These recommendations were selected on the basis of their potential applicability to the study countries and/or their having been tried or tested in some practical situations. Most also share the additional feature that their successful implementation is expected to impact positively on at least another dimension of the health system.

It is important to emphasize that the recommendations here should not be considered as merely technical solutions, but as part of comprehensive anti-corruption strategies transcending one sector. Therefore, they require a high level of political and leadership commitment at the national level.

It is also vital to seek donor harmonization and coordination of approaches. Suggestions from an earlier USAID-sponsored study on the subject of corruption in the health sector are germane to this study:

> Where improved financial management or inventory management systems are to be tested, donors should agree on a common approach and support it fully. A strategy of increasing the participation of civil society in oversight structures, for example, holds more chance of success if multiple donors support the initiative and share the costs of developing capacity and evaluating implementation.
>
> Finally any corruption prevention strategy must plan on conducting promotional activities to build commitment and support. To do this, USAID and other donors must first show commitment to rooting out corruption and corrupting influences in their own agencies…. The World Bank has included self-analysis as one of the central tenets of its corruption prevention strategy. To demonstrate commitment to an anti-corruption strategy, USAID must show a willingness to examine its own practices in a similar fashion. Other promotional strategies could include educational seminars and dissemination of research findings. (Vian, 2005)

Targeting and Sequencing of Anti-Corruption Strategies

The recommendations of this report have not focused on the effective targeting and sequencing of strategies for preventing and combating corruption in the health sector. These are, to some extent, context and country-specific and, for that reason, may be more fruitfully explored by various stakeholders in the context of implementation workshops to discuss the findings and recommendations of the study. Vian (2006) has raised some questions about targeting and sequencing that might be adapted to guide such discussions. These include:

> Should anti-corruption strategies be targeted to the youth who may be more willing to change? What are the key factors that influence people's behavior vis-à-vis corruption and adopting anti-corruption behaviors? Behavioral change models can be used to identify how much people are influenced by personal beliefs, perceptions of what others are doing, and beliefs about personal control. This information can then inform the targeting and sequencing of anti-corruption efforts. (Vian, 2006)

Some important additional issues to be discussed in such a framework should include the identification of the forces for change or influential stakeholders who might benefit from and/or support the proposed reforms, as well as those that can be expected to oppose them. Such an exercise will permit the right strategies to be drawn up for ensuring the implementation of anti-corruption reforms.

KEY RECOMMENDATIONS FOR IMPROVING HEALTH SYSTEM EFFICIENCY, TRANSPARENCY AND ACCOUNTABILITY

The key recommendations of the study are presented on the following pages in tables representing each of the four health system dimensions investigated.

Service Delivery/ Public Interaction

Note: Timing codes are: ***ST*** *= Short term measure;* ***M/LT*** *= medium to long term measure*

Recommended Action	Timing	Likely effects	Additional remarks[35]
Oversight role of civil society and service users			
Community oversight through increased role of community committees, local health board activism	(ST)	Oversight can make managers accountable to local communities for services Improves accountability by providing ways for users to voice approval and disapproval, increases chances corruption will be caught	Such oversight is one option to make local services accountable to those they serve. But to do this, oversight bodies must have real teeth. Some methods to accomplish this include empowering these bodies with real authority to hold managers accountable and equipping them with Citizen Report Card (CRC) and Service Delivery Survey tools (SDS) In Ceara, Brazil the state instituted a health worker outreach program with hired health outreach workers contracted to the state and handed responsibility for supervision to municipalities. Local control led to better health in the communities covered by the new state program. In Bolivia corruption was lower where local organizing groups were active and oversight existed (Gatti, Gray-Molina and Klugman, 2003).
Use Citizen Report	(ST)	Additional way	Laura Bureš. 2002. "Citizen Report Cards" (Washington, DC:

[35] Includes possible implementation issues, countries /places where previously tested/tried, and known results.

Recommended Action	Timing	Likely effects	Additional remarks[35]
Cards for local services and provide results to management and community oversight bodies		to help build accountability Provides tools for community and other stakeholder oversight to be more effective	World Bank). Http://worldbank.org/poverty/empowerment/toolsprac/tools16.pdf. Report cards have been used in Bangalore, India, Ukraine and the Philippines, in addition to the U.S. and other Western countries.
Consumer satisfaction surveys, using exit surveys, mini-household surveys or focus groups	(ST)	Consumer surveys can replace or complement the tools mentioned above if those are seen as impractical, as they help gauge the strengths and weaknesses of public services	
Provide more information publicly to citizens about resource flows from central and local governments as well as ensure clarity on the roles and responsibilities of local authorities	(ST)	Increases quality, user confidence and staff accountability	Reinikka and Svensson (2002) note that when survey data from Uganda documenting leakages of funds became public knowledge, government officials implemented a number of reforms including the publishing of monthly transfers of public funds to the districts in the mass media, and requiring facilities to post information on inflowing funds, thus increasing transparency and public accountability. The Uganda Health Consumers' Organization is also working with district facilities to implement similar measures in the health sector, with reportedly good results.
Analysis and dissemination to management, community oversight bodies and public of results of surveys and data collection (such as standards of living surveys, PETS, QSDS, and DHS)	(M/LT)	Improves transparency and accountability; helps detect gaps between what the service statistics say and what patients report	
Discouraging informal payments			
Public education on health facility procedures and charges, e.g. using radio and putting up posters explaining what fees are and which services are free	(ST)	Will improve transparency, limit informal payments, and empower community members in dealing with	Radio is most powerful medium of communication in most rural communities; where available TV is even more powerful. Posters in the local language have been shown to work very well too – e.g. in Uganda in education sector

Recommended Action	Timing	Likely effects	Additional remarks[35]
		local providers	
Standardize quality and access (e.g., standardizing waiting times; using automatic numbered ticket dispensing machines to control patient queuing)	(ST to M/LT)	Increases quality, user confidence and staff accountability	Predictability in waiting times and fairer queuing systems will do a lot to raise user confidence, and can be done in the short term. Other measures to standardize quality may take longer.
Promote contracting with private sector for provision of non-core services e.g. kitchen, laundry, in some cases even some laboratory/radiological services	(M/LT)	Bring private sector efficiency to running public services; if competition encouraged (e.g. through franchising), quality improvements may also be leveraged Competition from private providers increases clients' exit options Could be politically difficult to implement as resistance to change from vested interests likely to be strong	Not simply a technical solution but requires high level of leadership commitment as well as socio-cultural changes among facility staff.
Actively promote alternative financing mechanisms such as community health insurance schemes	(M/LT)	Reduce cash transactions at facilities, improve accountability Patients empowered through insurance organization to negotiate better with providers	Rwanda and Senegal are good examples of how community schemes are helping to make a difference.

Human Resources

Note: Timing codes are: **ST** = Short term measure; **M/LT** = medium to long term measure

Recommended Action	Timing	Likely effects	Additional remarks[36]
Nurses and corruption			
Nursing organizations and health providers should sensitize members of the nursing profession on their public image and its possible consequences	ST	Will improve public relations by equipping nurses better in their interactions with the public	Nurses need to be made aware that even if most of the public impressions are unjust, such perceptions do matter and can affect their ability to win public trust to be able to discharge their work well.
Members of the public should also be targeted with appropriately designed campaigns – led by providers and nurses	ST	If accompanied by genuine efforts to change behaviors, public could learn to place things in better perspective	Public should be educated to understand that their frustrations in their daily contacts with the front line service deliverers should not blind them to the common interest to win each other's trust. Public could be recruited, through civil society organizations and other means, to help campaign for improved conditions and incentives for nurses.
Replace informal payments with more transparent, officially approved incentives, i.e. improved working conditions	M/LT	Better motivated nurses, less inclination to demand 'gifts'	The general public is likely to overwhelmingly favor improvement of nurses' working conditions and nursing organizations could take full advantage of this.
Improving staff salaries is clearly important, but even if not possible in the short to medium term, staff incentives can be changed by certain measures: e.g. offering management the right to hire and discipline locally; increasing the visibility (transparency) of staff behavior and activities at work	(M/LT)	Improved accountability and incentives	As an example, an experiment among doctors in Tanzania to assess the role of salaries, training and other factors in reducing corruption found that training and salary increases were indeed important, but more important than these individual incentives were institutional ones, above all, the right to recruit and discipline staff locally. These latter incentives produced a better response in reducing corruption among doctors (Leonard, 2005). A second experiment was conducted in Ethiopia, this time among health personnel, in order to assess the temptations for corrupt behavior. The main findings were that: Increasing salaries diminished the temptation and level of corruption but only slightly compared to other factors. The greatest reduction was found when there was a high visibility or transparency of staff behavior and activities at work, i.e. when the staff knew that their actions were being observed, and hence the possibility of detection was high. The conclusion was that the potential of

[36] Includes possible implementation issues, countries /places where previously tested/tried, and known results.

Recommended Action	Timing	Likely effects	Additional remarks[36]
			being detected and punished for infringements or corruption were the strongest incentives against such behavior.[37]
Set up a nationwide database for data matching and payment controls to identify and correct abuses resulting in paying "ghost" workers, among other problems. Combine with a multimedia campaign informing citizens of their rights and obligations under the newly reformed system.	(M/LT)	Should result in better oversight and involvement of citizens Reduce or eliminate phenomenon of 'ghost workers' on public payrolls	In response to extensive corruption and mismanagement in reporting and record keeping in public programs, Colombia's Ministry of Health set up a nationwide database for data matching and payment controls to identify and correct abuses that were resulting in paying "ghost" workers, among other problems. That combined with a multimedia campaign informing citizens of their rights and obligations under the newly reformed system resulted in better oversight and involvement of citizens (Soto, 2002).
See also under "Financial and Management" below for recommendations on performance-based management systems which are also relevant to this category			

[37] However, a note of caution is in order here. This should not be read as an argument against salary increases, because in many of the situations encountered in low income countries like our three study countries, salaries are such low levels that it may be unrealistic to expect staff to discharge their duties fully without looking out for other ways to supplement those salaries. The main lesson is that salary increases are not the magic bullet for ending corruption, and perhaps the best strategy is a combination of different kinds of incentives (carrot and stick).

Procurement/Logistics & Supply Chain[38]

Note: Timing codes are: **ST** = Short term measure; **M/LT** = medium to long term measure

Recommended Action	Timing	Likely effects	Additional remarks[39]
Drug Selection and Promotion:			
Promotion of Essential Drugs Lists (EDL) at national and sub-national levels	(M/LT)	Limits influence of interest groups Limits discretion of drug selection committees	Promoted by many countries in the world
Use standard treatment guidelines as a basis for EDL and revise guidelines regularly	(ST) (M/LT)	Promotes transparency and accountability	Also commonly practiced, but many low income countries do not regularly update these to take account of epidemiological, population and technological changes
Enforceable codes of ethics in marketing promoted through trade and professional associations	(M/LT)	May reduce unethical promotion activities	
Pharmacy & therapeutic committees at facility level	(M/LT)	Provides vehicle for public oversight, increasing accountability	
Drug and Equipment Procurement:			
Technical assistance to help develop governments' capacity to manage competitive procurements	(ST)	Clarifies authority of government officials Promotes competition	Similar to Medicines Transparency Alliance (MeTA, supported by UK's DFID) The World Health Organization (WHO) and Health Action International for Africa (HAI Africa) have published reports of findings from medicine price surveys undertaken in 2004 and 2005, using the WHO/HAI price survey methodology.[40] The medicine price survey reports for Chad, Ethiopia, Ghana, Kenya, Mali, Nigeria, Senegal, Tanzania, Uganda and a multi-country comparison of the Member States of the East African Community are now available at www.afro.who.int/dsd/index.html. Medicine price survey reports from other countries are expected to be posted on the website in due course.
Changes in how procurement officers and quality inspectors are held accountable or paid	(M/LT)	Provides better incentives, linked to performance	
Public disclosure of inspection findings	(ST)	Increases transparency	
Rosters with performance ratings or white lists of suppliers and greater availability of price information	(ST)	Improves accountability by increasing access to information Limits discretion	
Drug Distribution:			

[38] This section is adapted from Vian (2005).

[39] Includes possible implementation issues, countries /places where previously tested/tried, and known results.

[40] The major survey findings were discussed at various national and inter-country workshops which made recommendations on strategic approaches to make medicine prices more affordable. Among these are: improving availability of medicines in the public sector; promoting generic prescription and substitution of medicines; improving availability and appropriate use of generic medicines; providing reliable information on medicine prices; improving efficiency of medicine supply and procurement systems; undertaking continuous monitoring of procurement and prices paid by patients and regularly providing governments and consumers with up-to-date information on the prices of medicine.

Recommended Action	Timing	Likely effects	Additional remarks[39]
Central medical stores reforms to introduce and promote business-like incentives	(M/LT)	Clarifies lines of authority Increases accountability and incentives	"Drug procurement poses multiple challenges and Chile's experience is instructive in how to institute reforms that serve multiple objectives. Chile's drug and medical supply system run by the government, CENEBAST, was plagued with poor management, frequent stock outs and overstocks of other medicines. The reform was built around a shift from a rules-based system to one grounded in transparency and good incentive structures. Its main components were: (1) introducing electronic bidding for pharmaceuticals; (2) reform of CENEBAST to change its mandate to procurement agent for hospitals and other providers who define drug priorities; and (3) information dissemination that let it be known that pharmaceutical procurement would be under scrutiny. An important element of the institutional reform was allowing other agencies and the private sector to purchase, store and transport drugs, removing CENEBAST's monopoly position" (Lewis 2006). The reform reduced information asymmetries between providers and the procurers of pharmaceuticals. and produced clear and fair rules resulting in bids from a broader spectrum of companies and lower prices for government hospitals and clinics. Overall in 1997, US$ 4 million was saved just in pharmaceutical purchases (Cohen and Montoya, 2001).
Transportation contracting and resource management systems, transfer pricing	(M/LT)	Increases accountability and improves incentives	
Improved drug management logistics information systems, indicator-based assessments	(M/LT)	Increases accountability where systems are used (not just a technical solution, but requires the will to implement)	
Set up local health boards, community oversight, if not already in place	(M/LT)	Limits discretion Improves accountability and transparency	

Health Financing & Management

Note: Timing codes are: **ST** = Short term measure; **M/LT** = medium to long term measure

Recommended Action	Timing	Likely effects	Additional remarks[41]
Auditing institutions and legal framework			
Ensure regular audits, follow up recommendations, and apply sanctions strictly and impartially	(M/LT)	Regular auditing will improve accountability and encourage better bookkeeping	In Madagascar, ensuring regular audits and strict application of sanctions for misappropriation of funds led to improved following of financial procedures by personnel. And multivariate analysis in Philippines showed that the frequency of audits by the central level, accompanied by effective decentralization of management, was strongly correlated with an increase in the rate of immunization (Lewis 2006) See also the Anti-Corruption Resource Centre: http://www.u4.no
Ensure independence and competence of audit institutions	(M/LT)	Audit institutions will be better able to serve the public interest	
Put in place a legal framework strong enough to be able to oblige implementation of public expenditure procedures And government must also be legally obliged to respect the fiscal rules governing relations between the central and lower or operational levels.	(M/LT)	The judiciary will be able to enforce public expenditure regulations	
Promoting budget transparency			
Ensure public education on the budget	(ST)	Public will be better able to participate in budget debates and hold government to account for its promises	
Develop the competence of Parliamentarians on the budget process	(ST)	This will enable Parliamentarians to: Analyze and criticize the budget proposals Monitor public expenditures against budget commitments Evaluate the achievements at the end of the fiscal year in relation to the budget provided Request supplementary and relevant info and initiate	

[41] Includes possible implementation issues, countries /places where previously tested/tried, and known results.

Recommended Action	Timing	Likely effects	Additional remarks[41]
		investigations where necessary	
Public Expenditure Tracking			
Carry out regular public expenditure reviews (PER) and expenditure tracking surveys (PETS)	(M/LT)	Will show where public funds are going and whether they reach their intended destination, if not why not Enable matching of expenditure to results obtained	
Corruption and the Global Health Funds			
Evaluate and reinforce existing mechanisms to address the potential for corruption in global funds e.g. Country Coordination Mechanisms, Inter-Country Coordinating Committees, Local Fund Agents.	(ST)	Increased transparency and accountability of these global health funds in the interaction with countries	Global funds have a major impact on the budgets of many low income countries and will need special vigilance. Measures to evaluate the effectiveness of these different initiatives over time need to be agreed.
Changing the institutional incentives facing health providers and staff[42]			
Develop performance-based management systems and provider payment systems e.g. Performance-based budgeting (PBB), where a provider receives funding based on agreed performance targets.	(M/LT)	Increases accountability and provides better incentives, since performance is rewarded There is a risk that performance-based financing may result in health care needs not being met, or too much focus on easy-to-quantify indicators to the exclusion of important health activities that are harder to measure	PBB is being piloted in Benin, Tanzania, Rwanda, Burundi, often in the context of the 'contractual approach' The note in column 3 shows that the health sector faces particular challenges in applying performance-based mechanisms.
Institute a prospective payment system: This option involves paying the health facility in advance for defined care within a defined catchment area. Examples are capitation and global budgets	(M/LT)	If well implemented, prospective system can encourage providers to invest in promotional and preventive care, but it may also give providers an incentive to offer bad (or reduced) quality of care, especially where controls are not strict or competition is absent. Prospective payment could also be a solution to the problem identified in the study, where health facilities	Prospective payment resolves problem of late debt payments since the government must pay in advance for the care of its employees. Under prospective payment system, government provides funding upfront for the care of its employees, otherwise the facilities might choose ask such employees to pay directly for care. Capitation payments are being implemented in Rwanda in the community health insurance context, which allows for external control by third party (the insurance scheme).

[42] These may be seen as cross-cutting solutions that potentially and arguably could change incentives and behavior across nearly all dimensions of the health system.

Recommended Action	Timing	Likely effects	Additional remarks[41]
		have been put under pressure by late transfers or government payment for care given to public employees.	

5.2: COUNTRY-SPECIFIC RECOMMENDATIONS

The country recommendations in this section have been adapted from the country reports, and are not presented here to the same level of detail as the General Recommendations. The latter constitute the main recommendations of this overall, comparative report. (For more on the country recommendations, the reader is urged to consult the corresponding country reports which form part of this study.)

5.2.1 BENIN COUNTRY RECOMMENDATIONS[43]

(NB: These recommendations should be read with the general ones in Section 5.1)
NB: ST = short term; M/LT = medium to long term.

Health system dimension or sub-component	Related Recommendations
Service Delivery/ Public	• Computerize the administration of health facilities (M/LT) • Training, advice and sensitization of all personnel on the importance of good patient reception, a job well done, respect for patients and honesty in work (ST) • Good models by people in leadership (M/LT) • Harmonize the prices of services across facilities (ST) • Ensure close supervision of the night duty staff (ST) • Re-institute civic education (ST) • Provide free health care for emergencies (M/LT) • Ensure full-time presence of qualified personnel to handle patients in the professionally appropriate fashion when they need care *(M/LT)*
Human Resources	• Institute a system of incentives including the sharing of decision-making, work load and rewards with the personnel (M/LT) • Inculcate a greater sense of responsibility in staff by making them accountable for their work/actions (M/LT) • Institute appropriate sanctions, positive as well as negative i.e. 'carrot and stick', but decentralized so that local managers can enforce them (M/LT) • Improve the remuneration of personnel (M/LT) • Identify and implement the real incentive measures that would motivate health personnel appropriately (M/LT) • Reinforce the authority of local managers and give them free hand to act and sanction where necessary, with appropriate avenues for staff to appeal or seek redress in cases of sanctions deemed unjust (M/LT) • Strict application of the disciplinary code (ST)
Procurement/Logistics & Supply Chain	• Elicit ideas from staff on how to improve management of property and equipment of health facilities (ST)

[43] See Annex 6.2B for a table of these recommendations presented as possible solutions to specific problems identified in the study.

Health system dimension or sub-component	Related Recommendations
	• Ensure permanent availability of essential drugs (M/LT) • Introduce a standard catalogue of prices for suppliers of the health sector (ST) • Subsidize or abolish fees for first line drugs and supplies for all patients admitted for emergency care (M/LT)
Health Financing & Management	• Employ independent auditors to suggest management controls to be put in place at the health facilities (ST) • Cancel the fee for service payment system and encourage community health insurance schemes and other health insurance systems so as to reduce the circulation of cash at various points during health service delivery (M/LT) • Simplify bureaucratic management procedures and ensure the existence of audit trails in the management and use of financial and other resources (M/LT) • Ensure debts owed by the state are paid to the health facilities (M/LT)

5.2.2 MOZAMBIQUE COUNTRY RECOMMENDATIONS

(NB: These recommendations should be read with the general ones in Section 5.1.)
NB: ST = short term; M/LT = medium to long term.

Health system dimension or sub-component	Related Recommendations
Service Delivery/ Public	• Reinforce social control and the role of civil society in helping to check abuses. Local communities and civil society organizations could be given a formal oversight role over local services. (ST) • The role of civil society can be further enhanced by making certain tools available to them to use in their oversight responsibilities.[44] (M/LT)
Human Resources	• Institute career development plans for public officials and associate it with a log book system as it is done in South Africa with Continual Medical Education. (M/LT) • Build commitment by demonstrating how reducing corruption can result in better health outcomes, improved quality and expanded access. (M/LT) • Institutionalize technical procedure manuals, ensure the health staff are fully acquainted with them and that they are used at the health facilities' level. (ST) • Elaborate and formalize internal control of the Ministry of Health, using the already existing inspectors with manuals of procedures and routine tasks to be developed. (M/LT) • Create a training and educational plan for health under internal control and according to the needs of the institutions and/or departments. (M/LT)
Procurement/Logistics & Supply Chain	• Establish a new national formulary of drugs and an essential drugs list keeping the generic names as has been in the previous formulary to increase the objectivity and transparency of the pharmaceutical selection process and to guide professionals in their prescriptions. (ST)
Health Financing & Management	• Complete the computerization process, and especially ensure that the national systems of procurement, storage and maintenance are computerized (M/LT) • Call on the assistance of development partners to make use of the tools of public expenditure management such as the Public Expenditure Tracking Survey (PETS) as a means of improving efficiency and transparency of public spending. (M/LT)

[44] See the General Recommendations in Section 5.1 of this study for further details of these tools.

5.2.3 TANZANIA COUNTRY RECOMMENDATIONS

(NB: These recommendations should be read with the general ones in Section 5.1)
NB: ST = short term; M/LT = medium to long term.

Health system dimension or sub-component	Related Recommendations
Service Delivery/ Public	• Adopt a holistic approach to the problem: Given the view that no sector is corruption-free, some respondents recommended an approach that should go beyond political statements to examples at all levels of leadership. (M/LT) • Develop moral integrity among care providers and customers: Without targeting individuals, no matter how strong regulative and anti-corruption institutions are, they are bound to have limited success. (M/LT) • Considering that some members of the public do not perceive corruption as bad, it is recommended that efforts should be directed at improving the public image and awareness of the different forms that corruption assumes. For example, developing a TV spot advocating patient's rights similar to "Haki Elimu" which has been used to promote rights in education. (ST) • Drawing inspiration from the private sector, it is recommended that public health care delivery points should be put in place to make service convenient to customers. Examples include use of numbers when queuing to see a doctor. (ST) • Because the existing 'culture of silence' is, in part, a product of existing vertical relationship between care providers and customers, increased participation of the public in the management of health services is recommended. Specific activities include establishment of suggestion boxes in health facilities to collect public opinion. (ST)
Human Resources	• Low salaries and poor working environment for healthcare providers was sited as one of the motivating factors although some attribute the practice to individual behavior. Those ascribing to the environment as the main problem recommended an improvement of working environment including pay package and supply of equipment and medical supplies. (M/LT)
Procurement/Logistics & Supply Chain	• Carry out operational research on procurement and supply chain to identify problems and propose specific solutions to rampant drug stock-outs and overstocking (M/LT) • Revise and update drug kits (ST) • Revise drug management system to enable distribution to be more reflective of burden of disease differences and variations in morbidity between regions and districts. (M/LT)
Health Financing & Management	• Undertake stakeholder analyses of budget and other reforms (MTEF, performance budgeting, contractual approach) to demonstrate for each reform objective and proposed implementation approach what are the likely interests of each stakeholder and who is in favor of, or opposed to reform; then design advocacy and other measures to address likely opposition or lack of commitment to reforms by key stakeholders and mobilizing assistance of reform supporters. (ST) • Harmonize processes and indicators related to PRS and assign institutional responsibilities for deciding targets and monitoring achievements. (M/LT)

ANNEX A: TERMS OF REFERENCE

STATEMENT OF WORK

Study of Efficient and Transparent Service Delivery in Public Hospitals in Benin, Mozambique and Tanzania

Terms of Reference for HLSP

The purpose of this study will be to build consensus within the specified countries, between the USAID missions, MoH and other stakeholders on opportunities for strengthening health systems delivery to provide more responsive, efficient, transparent and accountable healthcare services MSI and USAID will work together to provide USA.ID missions, Ministries of Health, and hospitals and clinics in Benin, Mozambique and Tanzania with a detailed analysis of vulnerabilities in healthcare delivery and practical recommendations to improve efficient, transparent and accountable healthcare services. The study will examine the delivery of healthcare services from a health systems point of view that explores the perceptions of services

users of barriers to accessing transparent and responsive services, and evaluates system weaknesses, including in the national expenditure process from which health facilities derive their budgets, in providing these services.

The study will look at systems, procedures and implementation practices at national, sub-national and facility level which support services delivery. In this way, the study will encompass both large and small challenges to efficiency in the healthcare system, particularly as they impact on service delivery and costs to consumers of these services. Problems detected will be analyzed, recommendations developed, and dialogues among all stakeholders (authorities, healthcare providers, consumers, donors) initiated around various solution paths to facilitate follow-up action and commitments to move forward.

The study will be conducted in three phases:

- Phase 1: Identification of possible key issues
- Phase 2: Information Gathering and Initial Stakeholder Meetings
- Phase 3: Systems Analysis
- Phase 4: Stakeholder Briefings

The final deliverable will be a report that compares the analytical findings from each of the three countries, and provides common, as well as country-specific recommendations on how to improve management procedures, hospital and clinic systems and other gaps that weaken transparency, accountability, and efficiency in the targeted facilities.

Phase 1: Identification o/possible key issues

Prior to any travel, the MSI team and the USAID missions will work together to determine the study timeline and identify possible issues to be studied, the main official contacts and, as appropriate, important stakeholders in other government offices and civil society. This will be supported by a literature review by the MSI health systems consultant. Issues to be considered might include financial management systems, user fees, procurement, storage and distribution of drugs and other supplies, and

HR management issues which have an impact on the availability of staff, and financial management. MoH and USAID mission will be asked to support the MSI national consultant in gathering up relevant documents, which will then be analyzed by MSl's Health Systems Expert as part of the literature review.

At the same time systematic representative surveys will be conducted by the MSI survey team among service users to identify areas of systems failure that impact on their ability to access services. The surveys will be designed by MSl's Survey Expert, with input from the Health Systems Expert and will be implemented by experienced local survey organizations under the supervision and coordination of MSl's Survey Expert, so that valid comparisons can be made across the three targeted countries. The survey data will be analyzed by the Survey Expert.

Findings will feed into the selection of key issues for consideration.

Phase 2: Information Gathering and Initial Stakeholder Meetings

MSl's Health Systems Expert will travel to Benin, Mozambique and Tanzania and will be supported by national consultants in each country. Meetings will be held with USAID Health and D&G team members, Ministry of Health representatives, and any facilities to be involved to discuss objectives of the study and what all parties expect from the study and hope to ultimately achieve. The key issues to be reviewed will also be agreed upon. The MSI consultant, with introductions initiated by USAID and/or Ministry of Health representatives, will speak with facility administrators about the study and gather any additional available written management procedures and similar documents from each of those facilities. A process for assessment will be agreed with the relevant facilities. The Health Systems Expert and the national consultant will meet with the systems assessment team who will be carrying out the evaluation of the agreed upon issues in order to design a workplan and approach.

Phase 3: Systems Analysis

The third phase of the study will focus on conducting assessments of systems issues from the point of procedures and how these are implemented in practice. The national consultant will coordinate a systems assessment team which will visit key facilities to discuss policies and procedures in the areas specified in the previous phase. They will meet with local service implementers, focusing on capacity of local healthcare providers to implement the systems as they are designed.

Phase 4: Stakeholder Briefings

Phase 3 takes the focus group survey responses and the systems analysis back to the constituents in each country to begin a serious dialogue among all stakeholders about improving efficiency in the health care delivery system, the factors that reduce effective service delivery, and opportunities to mitigate these problems. Focus groups will be held with service users to discuss the survey results, the systems assessment findings and possible solutions to problems. The Health Systems Expert will facilitate a series of meetings (or workshops) in each country for policy makers, service providers, other officials, donors and stakeholders with the assistance of the systems assessment team and our national consultants. The aim will be to assess how systemic inefficiencies, transparency and accountability problems can be resolved and the types of institutional and governance reforms required to accomplish these goals. Throughout all of these meetings, dialogue among stakeholders will be encouraged to generate strong commitment on their part to follow through on positive initiatives. USAID mission representatives will also be encouraged to participate in these meetings. Before leaving each country, the MSI Health Systems Expert will hold an exit briefing with the USAID mission to present findings and recommendations for future programming options.

Deliverable: Comparative Report with Recommendations

Phases 1-3 will conclude with the drafting of a report that describes the findings from each of the three countries, including those that result from the phase 4 meetings, compares the results across countries, and offers common and country-specific recommendations for practical programming options.

ANNEX B: GENERAL OVERVIEW OF KEY ACTORS INVOLVED IN COMBATING CORRUPTION AND THEIR ROLES

(Source: UNDP: Anti-Corruption Practice Note, 2004.)

KEY ACTORS	ROLE IN COMBATING CORRUPTION
Freely elected Parliament or National Assembly	One of the principal functions of the people's representatives is to hold the executive accountable. Regular public scrutiny, through debate and question time, promotes both transparency and accountability. Parliaments also enact anti-corruption legislation that helps to establish a value system that contributes to the creation of an anti-corruption culture in the country. The Global Organization of Parliamentarians Against Corruption is a good network for legislators working against corruption http://www.parlcent.ca/gopac/index_e.php
Leadership at central & local levels	Strong, consistent and coherent political commitment and determination to combat corruption. An example of local accountability initiatives is the Seoul OPEN system to give citizens ability to track online the progress of their application for services http://english.metro.seoul.kr/government/policies/anti/civilapplications/
Central government	Economic growth, resulting from sound macro-economic and industrial policies is a key condition for reducing corruption. The supply or oversupply of regulations may create or eliminate opportunities for corruption. Central government is also responsible for creating the necessary space and conditions for civil society (and the press) to operate.
Managers (public sector) at all levels	They need to adhere to the key principles of administrative law: "Selflessness, Integrity, Objectivity, Accountability, Transparency, Honesty and Leadership excellence through leading by example." For an example of disclosure systems, see Mexico Declaranet http://www.declaranet.gob.mx, efforts to improve civil service ethics and integrity, visit UNPAN http://www.unpan.org/EthicsWebSite/inc/ethicspg.htm
Public administration at large	A meritocratic and responsive public service is a sine qua non for minimizing the opportunities for corruption. Through their moral attitude, service-oriented conduct and culture of information sharing, the public service helps to instill in society values of honesty, sincerity and integrity that help to prevent corruption. Some examples of work by these actors: Transparencia en la Gestión Publica http://www.cristal.gov.ar/Englishindex.html
Ministry of Education	Educates younger generations on the values that underpin good governance. Promote a culture of positive engagement and respect and skills for constructive debate. Education and training in ethics: http://www.iipe.org/resourcedocs/training.html
The judiciary	Ensures enhanced predictability in society by providing legal protection of contracts and property rights, and, in general, ensuring the protection of basic human rights, frequently violated by corrupt activities.
Enforcement Agencies	There role is to ensure the consistent and objective enforcement of the anti-corruption legislation and the protection of whistleblowers and watchdog organizations. An example is the Lithuania Special Investigations Service http://64.49.225.236/rc_Lithuania.htm

KEY ACTORS	ROLE IN COMBATING CORRUPTION
Anti-Corruption Commissions or Offices	Usually accountable to the legislature or the head of government, it normally has a role that is three-fold: (1) prevention and education, (2) investigation and (3) repression and legal enforcement. Some examples: Hong Kong Independent Commission against Corruption http://www.icac.org.hk/eng/main/index.html, Central Vigilance Commission Indica http://cvc.nic.in, Botswana Directorate on Corruption and Economic Crime http://www.gov.bw/government/directorate_on_corruption_and_economic_crime.html
The Auditor-General	Responsible for auditing government income and expenditure in order to effectively reduce the incidence of corruption and increase the likelihood of its detection. The work of the OAG in Canada is a useful example http://www.oag-bvg.gc.ca/domino/oag-bvg.nsf/html/menue.html
Ombudsperson	Receives and investigates allegations of mal-administration, including issues of corruption and lack of accountability and transparency. Not usually vested with powers to make binding decisions, but has moral authority and public impact.
The Accountant General	Responsible for providing accurate and transparent accounts of public revenues and expenditures. See example of support to Tanzania http://www.u4.no/projects/project.cfm?id=480
Public Procurement Body	To provide independent oversight of government procurement, contracting and performance. Some examples of e-procurement initiatives to improve transparency and efficiency: Philippines http://www1.worldbank.org/publicsector/egov/philippines_eproc.htm, Chile http://www1.worldbank.org/public sector/egov/eprocurement_chile.htm
The media	Play an important role in exposing corruption and in building support for efforts to combat it. It has the responsibility to keep the legislature, the executive and the judiciary carefully monitored against corruption. In turn, it can help to improve credibility in state institutions, and as such, help to re-instill a culture of loyalty to the nation and to society. See for illustration Philippine Center for Investigative Journalism: http://www.pcij.org/
Electoral Management	Crucial to ensure independence and transparency of electoral systems and impartiality of elections. The ACE –Administration and Cost of Elections project is an important resource http://www.aceproject.org/main/english/et/et.htm
Civil society	Vital role in re-shaping attitudes, reverse public apathy and tolerance for corruption and monitoring the social and ethical performance of the public officials. It exerts pressure on government and the private sector for greater transparency and accountability. Civil society also ensures that reform measures to combat corruption match the perceptions and expectations of the people. An important resource is Transparency International http://www.transparency.org
The private sector	Participates actively in securing the success of the government's anti-corruption strategy by practicing sound business and accepting to submit their social and ethical performance to public monitoring and scrutiny (corporate accountability). It can be an important check on the government's arbitrary exercise of its discretionary powers. The Wolfsberg Principles is an effort by private companies to fight corruption http://www.wolfsberg-principles.com/

ANNEX C: EXCERPT FROM THE COMMUNIQUÉ ISSUED BY THE COUNCIL OF MINISTERS OF THE REPUBLIC OF BENIN

After its Extraordinary Meeting of Saturday 18 November 2006, under the Chairmanship of the President of the Republic:

« … Au cours de la même séance, le Conseil des Ministres a examiné une communication du Ministre du Développement, de l'Economie et des Finances relative à l'état des lieux des anciens Ministères, de la Présidence de la République et de la Direction Générale du Trésor et de la Comptabilité Publique.

De cette communication, il ressort que de graves dysfonctionnements ont marqué la gestion de notre Administration publique. Ces dysfonctionnements ont pour nom :

- la corruption qui a atteint un niveau préoccupant ;
- l'inobservance des procédures en vigueur, caractérisée par :
- le fractionnement des commandes de l'Administration Publique en violation des dispositions du code des marchés publics dans la plupart des ministères ;
- l'exécution de dépenses en l'absence de tout contrat, marché ou bon de commande.
- le manque de respect du bien public caractérisé par la dissimulation de matériels roulants, les cessions abusives de biens meubles et immeubles (véhicules administratifs, terrains et autres matériels) et l'utilisation abusive des matériels et véhicules administratifs ;
- le manque de transparence dans la gestion des dépenses publiques ;
- la pratique des prix exorbitants ;
- le non respect des dispositions du décret portant régime des frais de missions à l'intérieur du territoire national ;
- le paiement indu de primes trimestrielles à certaines catégories du personnel de l'Etat ;
- le dépassement non justifié de certains crédits budgétaires alloués ; »

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ANNEX E: BENIN COUNTRY REPORT

USAID
FROM THE AMERICAN PEOPLE

REPORT ON TRANSPARENCY AND ACCOUNTABILITY IN THE HEALTH CARE SYSTEM, BENIN

JANUARY 2007

This publication was produced for review by the United States Agency for International Development. It was prepared by Chris Atim, Ph.D., of HLSP (a subcontractor to Management Systems International), with contributions from Orlando J. Perez and Leon Kessou.

REPORT ON TRANSPARENCY AND ACCOUNTABILITY IN THE HEALTH CARE SYSTEM, BENIN

Management Systems International
Corporate Offices
600 Water Street, SW
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CONTENTS

ACRONYMS AND ABBREVIATIONS

APE	Agent permanent d'État (permanent government employee)
CHD	Centre hospitalier départemental (departmental hospital center)
CNHU	Centre national hospitalier et universitaire (national university hospital center)
CS	Centre de santé (health care center)
DDS	Direction départementale de la Santé (departmental health directorate)
DIVI	Direction de l'inspection et de la vérification interne (inspection and internal audit directorate)
DRFM	Direction des ressources financières et du matériel (financial and material resources directorate)
EDS2001	Enquête démographique et de santé, édition 2001 (health and demographic census, 2001 edition)
FGDs	focus group discussions
LME	Liste des médicaments essentiels (list of essential medications)
MS	Ministère de la Santé (Ministry of Health)
SMI	Soins maternels et infantiles (maternal and infant care)
SMIG	Salaire interprofessionnel garanti (interprofessional guaranteed salary)
ZS	Zone sanitaire (health zone)

SUMMARY

This study examines the causes and manifestations of corruption and a lack of transparency in the heath care system and in two hospitals in Cotonou and Parakou in particular, and suggests possible solutions to these problems. Aspects of the system and facilities studied are:

- Delivery of health care services and interaction with the public,
- Human resources and personnel,
- Procurement of goods and services, procurement and management of equipment, medications and other supplies, and the distribution chain,
- Health care funding and the expenditure cycle.

Health care service beneficiaries are of the opinion that hospitals and health care centers lack transparency and accountability in their management and delivery of health care services and that corrupt practices are real and occur in the two hospitals visited in Cotonou and Parakou. Health care service beneficiaries believe that paramedical personnel are those most responsible for such corruption and lack of transparency. Their response most likely provides only a partial image of the situation, as they do not have sufficient contact with administrative and non-technical employees to really be able to determine which types of employees are the most "corrupt". They believe that doctors are less likely to engage in corrupt practices.

Close examination of the issue reveals that corrupt practices and lack of transparency are the response of health care providers and other health care system employees to the struggles of daily life and the difficulty of meeting basic needs on low salaries. The ensuing negative behavior hinders timely treatment of patients and leads or contributes to the poor quality of care and subsequently to a higher rate of mortality. Poor and vulnerable people who cannot pay extra are virtually abandoned, left to their resignation and death. Clients become fearful and mistrustful of hospitals. However, there is no indication that women are more likely than men to be victims of corruption, which affects both genders equally.

Public satisfaction with health care is high overall. The level of satisfaction reported shows a significant correlation with the level of wealth. While satisfaction is highest with respect to prescriptions, ironically, it is lowest with respect to the side effects of the medications prescribed. There is no difference in the satisfaction rate reported between the two hospitals. The two main problems with health care services are the cost and the poor treatment of patients by health care personnel.

Private health care is considered better than public health care. Paramedical personnel are considered to be the most corrupt and the least transparent. Private health care providers are perceived as being less corrupt than their public counterparts. Most respondents do not consider that giving or receiving a gift is a form of corruption.

Representatives of the health authorities, employees, administrators and managers at the central, regional and peripheral levels all acknowledge that corruption and lack of transparency are real, undeniable and seriously affecting the health care system and the quality of care. They are unanimous that the current system facilitates corruption, extortion and misappropriation. They also agree on the absence of traceability in public resource management.

The wide variety of employees interviewed all agreed on evidence of corruption and the lack of transparency and accountability in the health care sector, as well as on their causes and possible solutions.

Corruption takes various forms, including the implicit influence and intimidation of health care clients, long delays in care, extortion, spontaneous offers by patients to health care employees, influence peddling, overprescription or misappropriation of medications and supplies, the use of public facilities/equipment for personal gain, the use of hospital equipment or supplies in treating patients at private clinics, and the use of false documents and accounting entries, which are all exacerbated by the sale of medications at health care facilities and frequent shortages of stock, thus encouraging the cross-selling of medications.

The causes of corrupt practices include poverty, lack of ethics, poor morale, unbounded ambition, lengthy and ponderous administrative procedures, a lack of role models and permissiveness.

While corrupt practices are evident and regularly reported by health care beneficiaries and the public, no appropriate steps to deal with the issue have been taken by decision-makers.

The consequences of the situation are visible and the effects evident in the poor quality of patient care and higher rates of mortality. Solutions to these problems must take into account the factors which determine and encourage corruption. A number of solutions are suggested which could help to eliminate the problems: streamlined management procedures which facilitate tracking of material and financial resources, independent management audits, greater accountability and reporting requirements for employees, consistent availability of essential medications, elimination of payment upon treatment and establishment of health care insurance plans and a health insurance system, systematic procedures to treat all emergency and non-emergency patients, automated health care facility management, establishment of decentralized positive and negative sanctions, identification of role models, and appropriate means of employee motivation, including shared decision-making, responsibilities and benefits.

This study resulted in the following main recommendations being made to the State:

- Intensify action against poverty, social inequality and lack of fairness;
- Combat unemployment and precarious employment;
- Strengthen and diversify the national economy in order to promote higher work wages;
- Reinforce and integrate the efforts of community organizations which work for transparency and against corruption;
- Review health care funding and motivate employees in order to minimize corruption and maximize transparency.

With respect to administration and systems, in order to improve poor internal controls:

- Develop and formalize internal audits for the Ministry of Health;
- Establish an employee training plan for internal auditing;
- Create a guide to internal audit procedures.

With respect to personnel:

- Increase salaries in the health care sector; it is suggested that supplementary remuneration be tied to performance;
- Develop specific means of motivating employees;
- Encourage a healthy work ethic;
- Decentralize the sanctioning system and the systematic application of positive and negative sanctions.

With respect to billing, collection and management of hospital funds:

- Eliminate the use of cash in hospital financial transactions;
- Establish a universal billing system for health care.

With respect to health care funding:

- Promote group and health insurance plans;
- Establish results-based budgets;
- Promote budget transparency.

With respect to delivery of health care services:

- Ensure consistent availability of medications in hospitals for hospitalized patients;
- Eliminate the need for prescriptions for hospitalized patients;
- Integrate medications and supplies into the kits provided to hospitalized patients.

BACKGROUND AND RATIONALE

Benin has a pyramidal health care system divided along regional delimitations and a goal of improving family health and:

- Improving the quality of and access to health care;
- Increasing community participation in and utilization of health care services;
- Increasing availability of health care for citizens and particularly for the poor.

This fairly de-concentrated system is aiming to be decentralized and is comprised of three levels:

- The central or national level is responsible for the development and implementation of health policies, which include the Ministry of Health, the directorates and the national university hospital center (CNHU);
- The regional or departmental level, which includes 6 departmental health directorates (DDS) and 5 departmental hospital centers (CHD), in which departmental health directorates are responsible for the implementation of the health policies established by the government, as well as the planning, coordination of activities and care, and epidemiological monitoring.
- The peripheral level comprises 34 health zones, which are the most decentralized operational units in the system. These health zones include a network of initial health care providers supported by a first impact public or private hospital (zone hospital) serving an area of 100,000 to 200,000 inhabitants.

Objectives for the health zones since their establishment in 2004 are:

- To ensure access to health care and to quality basic care from initial contact;
- To ensure rational and effective management of available resources;
- To contribute to the decentralization process;
- To strengthen community participation;
- To develop a partnership between the public and private sectors.

The supervision of all services (public and private) in the zone therefore falls to the health zones. Community and other partners participate in managing health care facilities through management committees established at each level of the health care pyramid. Health zones directly manage credits allocated to them at the central level.

The health care infrastructure in Benin has improved, from 80% coverage at December 31, 2001 to 89% at June 30, 2005. This rate is generally considered adequate, although its distribution is uneven since Zou has only 69% coverage when all other departments are above 80%. Unfairness has been noted in the establishment of new infrastructures in some areas. Furthermore, compared to national

standards for infrastructures and equipment, the rate falls to less than 50%. Of 34 planned hospitals, 23 have been completed, i.e. 68%. While all health zones have at least one ambulance, the referral system is not comprehensive and the aerial communications system (RAC) is not country-wide.

Policy formulation and strategic planning in the health care sector are based on the following factors:

- An epidemiological profile with minimal variation;
- Increasing population and urbanization;
- Effective interaction between the public health care and other sectors (economy, environment, education);
- Ever increasing public demands for health care access, availability and quality of services;
- The necessity to strengthen partnerships between the public and private sectors.

The five main focuses of current Ministry policies are:

- the reorganization of the base of the health care system pyramid and increased health coverage;
- the funding for the sector and improved resource management;
- the prevention of and fight against major illnesses and improvement in the quality of care;
- the prevention of and fight against of priority illnesses: HIV/AIDS, malaria and tuberculosis;
- the promotion of family health.

Mechanisms are in place to encourage the involvement of development and community partners (COGECS, zone health committees, joint partnerships) in policy and budget planning processes. The national health care information and management system (SNIGS) provides the data required for policy development.

Analysis of family health expenditures reveals that most are directed not to the health care sector but to pharmacies for the direct purchase of medications. Since 2000, the public Ministry of Health is one of the first to reform its budgetary system, shifting from a means-based budget to one based on performance and poverty reduction, focusing on:

- Improved efficiency in the use of public resources (national and foreign);
- Fungibility of all foreign aid in a common treasury board fund;
- Budget consolidation (operating budget and investment budget);
- Development of program budget and medium-term expenditure plan;
- Delegation of commitment and authorization to sector ministries.

The above-mentioned budget reform has resulted in the:

- Establishment and development of the CDMT (medium-term expenditure framework);
- Establishment of monitoring/evaluation units;
- Establishment of public procurement units;
- Strengthened external audits by the *Chambre des Comptes*;
- Delegation of commitment and authorization to sector ministries;
- Streamlining of the expenditure cycle and establishment of the integrated public finance management system (SIGFiP).

A budget-based bottom-up financial planning system allows for the retention of revenue from the delivery of health care services.

The main stakeholders in modern health care in Benin are the State, the public, management committees and outside partners. The main health care providers are private and public hospitals and health care centers and the main health care services are pharmacies and public health care centers. The health care sector receives coordinated aid from numerous partners in addition to the traditional international partners (WHO, UNFPA, UNICEF and the World Bank). Benin receives assistance

from the Global Fund, the Global Alliance for Vaccines and Immunizations (GAVI), and the African Development Bank. Donors of multilateral and bilateral funds include the United States, the European Union, Switzerland, Belgium, China, Japan, Canada, France and Germany. The World Bank and the European Union also provide financial support.

Outside of vaccination breakthroughs for women and children, according to performance indicators (maternal and infant mortality rates, etc.), the health care sector performance remains inadequate and is not developing as rapidly as intended by health policy-makers.

Health and social indicators still show a high rate of morbidity in a constantly deteriorating environment, and various tropical diseases presenting predominantly endemic/epidemic conditions, particularly malaria, which alone accounts for 37% of infectious or parasitic conditions. Diarrhea and gastroenteritis linked to hydrofecal pollution or poor sanitation, and acute respiratory infections (ARI) accounted for 16% of reported illnesses, were the other causes of death in Benin in 2004. Women and children are the worst affected, as indicated by extremely high rates of maternal and infant/child mortality.

Table.: Health indicators in Benin (recent changes)

INDICATORS	2002	2004 Estimate
Gross Birth Rate (GBR)	41.2%	39.9%
Gross Mortality Rate (GDR)	12.3%	10.8%
Infant Mortality Rate (IMR)	90%	66.8%
Infant and Child Mortality Rate (ICMR)	146.4%	105.1%
Maternal Mortality Rate (MMR) in 2002	474.4 deaths per 100 000 births	-
Life expectancy at birth (years)	59.2	59.7
Life expectancy at birth for males (years)	57.2	57.4
Life expectancy at birth for females (years) in 2002	61.3	61.9
Average age at maternity (years)…….....	30.3	-
Total fertility rate (TFR)…	5.53 children per woman	5.38 children per woman

Sources: INSAE (Benin National Statistical Institute) /DED (German Development Service)/ RGPH3 2002 (General Population and Habitat Census) & 2003 Demographic Projections

Weaknesses noted in health care delivery generally include:

- Poor reception;
- Shortages of essential medications and supplies, encouraging parallel sales of medications;
- Poor quality of services;
- Poor control of supplies used by employees;
- Lack of accountability.

In addition to the problematic requirement for payment upon treatment for health care services, these weaknesses are the result or the cause of client dissatisfaction, as they create opportunities and a favorable environment for corrupt practices. As a result, clients of the health care system almost unanimously report that they have witnessed or been the victims of corruption and the phenomenon is endemic, widespread and a daily occurrence in the hospitals and public health care centers of Benin.

Very little work has been done to describe efficiency and transparency in the Benin health care system. However, various internal Ministry of Health reports refer to the illicit sale of medications, the extortion of patients and the misappropriation of medications prescribed for them. A review of public expenditures and reports from Transparency International in Benin confirm these complaints. Furthermore, no initiatives of note have been undertaken to counter corruption and its possible effects.

These facts substantiate USAID's decision to commission a study in order to better understand the forms, extent and causes of corruption in the health care sector. This knowledge should assist in the search for key actors in the countries involved to obtain consensus on possible solutions to the problem.

GOAL AND OBJECTIVES OF THE STUDY

GOAL

The goal of the study is to facilitate a more effective use of the resources allocated to the health care sector in order to meet the objectives of that sector.

SPECIFIC OBJECTIVES

To achieve this goal, the Benin study had the following objectives[1]:

- To conduct interviews on transparency and accountability in the health care sector with its decision-makers, and discussions with focus groups (FGD) comprising health care beneficiaries;
- To discuss policies and procedures currently observed in the main hospitals to ensure transparency and accountability; and
- To present the results of the survey during a national workshop attended by government officials, health care providers and other administrators, donors and other decision-makers.

This country-specific report was produced as part of a broader cross-national comparative study of transparency, accountability, and efficiency in health service delivery in Benin, Mozambique and Tanzania. It is intended as an analysis of information compiled during literature reviews and in-country surveys and interviews, and represents an initial examination of corruption in the country's health system. This report should serve as a foundation and building block for future, more in-depth reports. While it can be read as a standalone piece, the comparative report provides a larger examination of the causes of corruption and recommendations for more transparent and efficient health service provision.

METHODOLOGY

TYPE OF STUDY

The study investigated and described transparency and accountability in the Benin health care sector.

[1] See general report on the three countries participating in the study for overall objectives of the study.

INFORMATION GATHERING METHODS

Three main data gathering methods were used to collect the necessary information:

- Review of documents;
- Surveys conducted by a local firm through interviews with decision-makers and focus group discussions with potential health service beneficiaries; and
- Survey of public attitudes regarding health care delivery conducted in several phases and subpopulations with samplings proportionate to the size of the target groups, with a total of 430 persons, of which 176 were in Parakou and 254, in Cotonou. Most of the target population resides in an urban environment, and 41.6 speak French, 35.6 speak Fon and 12.1 speak Dendi. 46% of the respondents were men and 54% were women. Half of them had a monthly income of between 20 and 80,000 CFAF. The respondents' average education level was 8.8 years of schooling, the equivalent of completing elementary education. Close to one-third of the respondents had visited both the Cotonou hospital and the Parakou hospital. 85% of respondents had no health insurance. Among the 15% who reported having insurance, 81% were covered through their employers.

The data, findings and results were validated.

TARGETS OF THE STUDY

The study examined two main hospitals, one in the capital of Cotonou in the south of the country and the other, in the city of Parakou in the north. Government officials, administrators, managers and health care providers were interviewed.

In addition, Benin's health authorities, health care system representatives, goods and services procurement administrators, distribution chain personnel, community representatives and users of the two hospitals were interviewed as part of the study, as was the general population in the hospital area.

PERIOD STUDIED

This study was carried out in two major phases:

- The hospital phase, with information collection in hospitals and among clients, was conducted from April 2006 to August 2006.
- Public surveys were carried out from May 24 to 30, 2006.

BENIN HEALTH CARE DELIVERY SYSTEM: BA AND SA[2] HOSPITAL CARE

Health care services in Benin are divided into two groups: basic activities (BA) and supplementary activities (SA). Basic activities include basic vaccinations, major endemic disease control, prenatal and postnatal care, infant medical care, childbirth, family planning and basic medical care. Supplementary activities include basic referral facility medical care, specialized and/or referral facility care, laboratory tests, etc. Preventive care services (vaccinations, control of major endemic diseases) fall under the government's responsibility and are provided primarily by public health organizations, and supplemented by significant preventive activities carried out for the most part by private companies in outer regions. No reliable figures are available for those services.

Close examination reveals that primary services do not meet quality standards, as primary health care centers do not have standardized treatment schedules and "employee performance standards" are not always met due to a lack of continuous professional training.

Hospital care includes emergency and non-emergency medical treatments provided in hospitals which require intensive monitoring of vital signs, technical procedures, specialized care and laboratory culture tests. Services are provided by Departmental Hospital Centers (CHD), the national reference center being the Cotonou National University Hospital Center (CNHU)) and by private health care providers. Studies were not conducted to determine the exact volume of health care services provided by the various hospital care providers. At most, approximations may be made by comparing and deducting volumes of activities reported by the National Health Information and Management System (SNIGS, see Appendix 6.2(b)).

An analysis of Benin's national hospital capacity in Benin (for the public sector and confessional hospitals) reveals an average of 0.55 beds per 1000 inhabitants. Although this figure is less than the WHO recommendation of one bed per 1000 inhabitants, a large number of beds remain unused. The bed occupation rate is 30% in health care centers, 39% in departmental hospital centers, 53% in health zone public hospitals, 65% in CNHU hospitals and 81% in confessional hospitals. CNHU hospitals represent 15% of the national hospital capacity, departmental hospital center beds represent 29%, and the remaining 28% is spread among confessional and health zone hospitals. Due to the higher occupancy rate in confessional hospitals, these hospitals account for 36% of hospitalizations, compared to 21% for health zone hospitals. Only 67% of health zones have a specific referral hospital and only 47% of those hospitals have an obstetrician-gynecologist on staff, 52% have a surgeon and 23% a pediatrician.

Initial results of the study on health care facilities carried out at the end of 2005 in four health zones in different regions of the country reveal that 85% of the facilities have electricity, 90% have running water and 87% have isolation units, but only 37% have any means of communication (telephone or radio network).

A percentage of 84% of the population has access to health care services (particularly in the public sector), which is equally distributed and corresponds to that of the Ministry of Health's figure of 86%

[2] The expression Basic activities (BA) refers to the series of preventive, promotional and basic curative services provided in an integrated and continuous manner at primary care establishments in the health care pyramid system. Such services are delivered at UVS, CSA and CSC levels.
The expression Supplementary activities (SA) refers to activities that complement BA services and are performed on a referral basis. Such services are delivered in referred establishments such as health zone hospitals and some community hospitals having the appropriate technical and personnel resources.

for health coverage (number of neighborhoods which have a health care center). However, access to maternal and infant health care, pharmacies and private services is not equitable, with a very low access rate in the case of rural populations.

According to this study, location is not the main obstacle to accessibility. Cost, means of payment and perception of quality of the care provided (medications, laboratory tests, relationship between patient and service provider, and the presence of qualified personnel) are the key factors considered when medical care is sought. Another factor often expressed is a preference for traditional medicine. According to results of the 2001 health and demographic census, the main reasons (list of three possible reasons) for not seeking care are: the cost of medication (42%), the distance of health care facilities (42%), the absence of health care facilities (30%), the absence of health care personnel (25%), the lack of equipment (24%), the exceedingly high cost of consultations (16%), the unsatisfactory relationship between the service provider and the patient (12%) and the shortage of medication (10%).

Prenatal care was sought by 92% of pregnant women, measured by the average number of prenatal consultations carried out in relation to the number of anticipated pregnancies. The figure ranged from 66% in the Atacora region to 179% in the coastal area. 76% of women sought assisted childbirth, ranging from 47% in the Atacora to 91% in the coastal area. Results of the health and demographic census indicate that 87% of women had at least one prenatal consultation, with little difference being noted between women from rural areas and those from urban areas, although 71% of urban women had four prenatal visits, compared with 57% of rural women. 72% of women gave birth in a modern facility, ranging from 98% in Cotonou to 54% in Atacora. The use of contraceptives in 2004 *(annual report on health statistics)* was 16.4%, with a low of 1% in the Plateau region to 23% in Zou.

Significant concern and particular attention have allowed the creation in Benin of a system of reference and cross-reference between the different levels of the health care system. In fact, the health zone system was established in order to close the gaps by creating an operating referral hospital for a health zone. In theory, all health care centers should be linked to the zone hospital by a radio network (RAC) and the health zone must have working ambulances available to pick up patients and deliver them to the hospital. Standards and protocols are in place for nursing care, the care delivered by midwives and for family health (including reproductive health, maternal health, infant health, basic and emergency obstetrical care, integrated treatment of childhood illnesses (IMCI), malaria, diarrhea, acute respiratory insufficiency (ARI), treatment and prevention of HIV/AIDS and tuberculosis).

The private sector is dynamic and diversified. It includes medical offices, private clinics and hospitals, and confessional clinics and hospitals. This network of health care facilities assists the Ministry of Health in achieving its objectives. Private health care facilities observe in principle, the standards and procedures established by the Ministry of Health. Confessional hospitals certified as zone hospitals provide monthly statistics to the Ministry of Health on the services provided and are subject to periodic audits by the Ministry of Health. A framework for public/private sector consultation and a public-private partnership (OPP) were recently established by the Ministry of Health.

Practitioners of traditional medicine account for 8% of health care service providers. Benin anticipates setting up a college of traditional practitioners which would be similar to those for doctors, midwives and pharmacists. The Ministry of Health is reviewing the matter to better understand the size and scope of activity in the traditional medicine segment.

USER OBSERVATIONS

USER PERCEPTIONS REGARDING ACCOUNTABILITY AND TRANSPARENCY IN HEALTH CARE, SYMPTOMS AND FORMS OF CORRUPTION

Opinions of health service beneficiaries noted during focus group discussions are that hospitals and health care centers lack accountability and transparency in their delivery and management of health care services. Corrupt practices are real and exist in both hospitals visited. Corruption progressively becomes established in two phases: users are conditioned to expect corruption, and actual corrupt practices occurring.

CONDITIONING USERS TO EXPECT CORRUPTION

This occurs through incidences of extortion, which demoralize, weaken, prepare and even force patients and their companions to expect corrupt practices. Users report:

- Poor reception characterized by neglect, indifference and deliberate neglect of patients by the health care employee;
- Careless observation of patients: indifferent treatments, inappropriate language, verbal threats or harassment of patients or their companions;
- Deliberate absences of competent staff;
- Delivery of multiple prescriptions to patients;
- Deliberately poor quality of services during evenings and weekends.

CORRUPT PRACTICES OR EXTORTION

Once patients and their companions have been conditioned to expect corrupt practices, various corrupt practices are observed:

- Over-prescription of medications by employees in order to steal the excess (extremely high number of daily prescriptions; 52,000, 45,000, 25,000);
- Theft of products prescribed and acquired by patients or their companions; fraudulent removal of items from surgical kits;
- Fraudulent and unsubstantiated amounts charged to patients or their parents/companions (extortion);
- Private treatment of patients in public hospitals with no payment being made to the hospitals.

USER PERCEPTION REGARDING THE QUALITY AND AVAILABILITY OF MEDICATIONS AND IMPACT ON CORRUPT PRACTICES AND ON THE IMAGE OF THE HEALTH CARE FACILITIES STUDIED

Clients of the two hospitals perceive no risk to the quality of the medications, since these are generally purchased at private pharmacies. At the CNHU and the Borgou health care center, medications and medical supplies are prescribed, these prescriptions are given to patients and their companions who have no choice but have them filled before the patient can be treated. Non-availability of medications in hospitals and the resulting systematic prescription of products and their purchase by patients facilitates the overprescription trend and thereby the misappropriation of medical products from the patients;

INFORMAL PAYMENTS AND QUALITY OF SERVICES

From interviews with health service beneficiaries, it becomes apparent that the acceptance and payment of bribes results in an expectation of quality care provided promptly. Unfortunately, beneficiaries report that despite resorting to bribery, they ultimately still do not receive the expected quality of care.

INFORMAL PAYMENTS AND GENDER

Users interviewed believe that men and women are equally targeted as victims of corrupt practices; however, most of the women present added that women tend to be more resistant than men to corruption and accept it less. There is no evidence that women are more subject to corrupt practices than men.

INFLUENCE OF INFORMAL PAYMENTS AND OF THE LACK OF TRANSPARENCY ON THE POOR AND VULNERABLE (OLDER PEOPLE, CHILDREN AND PREGNANT WOMEN)

They report that when a patient does not accept corruption, his or her treatments are delayed or inappropriate. As the poor and the vulnerable have nothing extra to offer, they are generally ignored, left to their resignation and death.

IMPACT OF CORRUPT PRACTICES/EXTORTION ON HEALTH CARE SERVICES AND COMMUNITY DEVELOPMENT

These practices compromise the quality of care through delays which hinder the timely treatment of patients, and lead to neglect and lack of follow-up. Despite the collection of money by employees from patients and their companions, care is of poor quality, leading to a higher rate of mortality. People are frightened and avoid hospitals, losing not only their trust in hospitals but also their health, which is needed for local economic prosperity and development.

Clients would like doctors (less inclined to follow corrupt practices and to be more competent) to ensure continuity of care in order to guarantee better quality of treatment in the event of problems.

All of the factors evoked hinder or reduce the effective delivery of services. In addition, victims of these practices generally seem not to have any valid recourse. This is impression is probably due to the fact that management hears complaints but, due to its inability to impose sanctions, cannot guarantee that problems are addressed.

UNDERLYING REASONS FOR CORRUPT PRACTICES

In interviews of beneficiaries at these two hospitals, several reasons account for the existence of these practices:

- The lack of medications in stock in hospitals (in fact, incomplete surgical kits) and the resulting systematic prescription of and purchase by patients of products;
- Lack of training or awareness;
- Lack of concern for public welfare;
- Unhappiness with low salaries (SMIG=27,500 CFAF) and employees' overweening ambition (seeking easy gain);
- Weak national socioeconomic situation;
- Guaranteed public employment and salaries regardless of performance;
- Weakening of authority and permissiveness;
- Creation and operation of private medical offices which are often unauthorized by relevant permanent government hospital employees, facilitated by a lack of rigor in the application of Law 97-020 governing the private practice of medicine;

- Avoidance of procedures;
- Inadequate controls;
- Frequent shortages of medications and essential products, which encourages the illicit sale of medications to patients, due to difficulties of the CAME (Benin's central cooperative for essential drugs and medical consumables) in providing regular supplies to hospitals;
- Shortages of medications in private pharmacies;
- Delivery of private medical treatments by hospital employees;
- Low level of education and information prevents the public from distinguishing between paid care, non-paid care and other rights.

STRATEGIES AND OPPORTUNITIES TO ELIMINATE CORRUPT PRACTICES

The following strategies were suggested to eliminate these practices, based on the forms of corruption reported by the beneficiaries interviewed:

- Training and awareness-building sessions and guidelines for all employees regarding the concepts of reception, good work, respect of patients, honesty;
- Ensure efficient management of hospital property;
- Encourage health insurance and health care insurance plans to avoid the exchange of money in hospitals;
- Conduct regular audits and ensure observance of procedures;
- Establish sanctions (positive and negative);
- Harmonize medication prices;
- Produce a price list for suppliers;
- Supervise security personnel;
- Ensure the full-time presence of qualified personnel in reception and emergency areas to ensure appropriate patient treatment;
- Subsidize emergency treatments;
- Provide first aid products at no cost to all patients admitted;
- Increase employee salaries;
- Identify elements to motivate employees;
- Strengthen the authority of managers and allow them to perform their duties;
- Make medications consistently available through CAME and hospitals at a reasonable cost;
- Reinstate civic education;
- Rigorously follow disciplinary rules;
- Contract out management of food services to private firms and offer a discount to permanent employees and security personnel;
- Treat public employees' hospital charges as loans to them;
- Sanction those who profit from illicit activities.

In summary, health service beneficiaries primarily accuse paramedical employees of corruption. Their view most likely provides only a partial image of the situation, as they do not have sufficient contact with administrative and non-technical employees to really be able to determine which types of employees are the most "corrupt". In fact, they do not have close contact with hospital administrators, nor with head office personnel, who have been reported to be involved in other types of corrupt practices linked to the procurement of goods or services.

Considering the reality of corrupt practices and the lack of transparency, links are identified between the weaknesses observed (in financial management, the procurement system and controls), and the behavior of health care employees. That is to say, corruption and lack of transparency are the response of health care providers and other health care system employees to the realities of dissatisfaction and the general daily struggle.

Observations made by managers and clients of the two hospitals are quite revealing and staggering. Perhaps they have always existed in the modern history of the Benin health care system, but never to such an extent. Thorough analysis of the results of the interviews and focus group discussions goes beyond observations in an attempt to describe their causes. The development, indeed, the spread of corruption in other sectors has finally reached the health care sector, against the honesty and humanity that must prevail.

Two types of factors contribute to the lack of transparency and the emergence of corruption:

- Incentives:
  - The legitimate desire for a better life with improved living conditions;
  - The overall context of poverty which tests all morals and honesty;
  - Poorly paid hospital work in health care centers, at odds with the numerous needs and the every-increasing cost of living, leads most service providers to develop ways to obtain extra income from the system. Others seek and develop parallel or related activities with which to supplement their salaries.

- Facilitating factors:
  - The numerous cases of mismanagement by administrators and authorities, which are never prosecuted, judged or punished, constitute, in our opinion, the major factor fostering widespread corruption;
  - Admiration of those who enrich themselves through misappropriation of public resources, fraud and illegal acts;
  - The reward and acclaim of mediocre employees, at the expense of merit and good work. This trend must have provoked a reaction among the more honest employees, who adapted to the situation and finally also took the easy option of enriching themselves through questionable practices;
  - Delays by the State in releasing credits allocated to health administration and health care facilities;
  - Delays in paying hospital employee salaries.

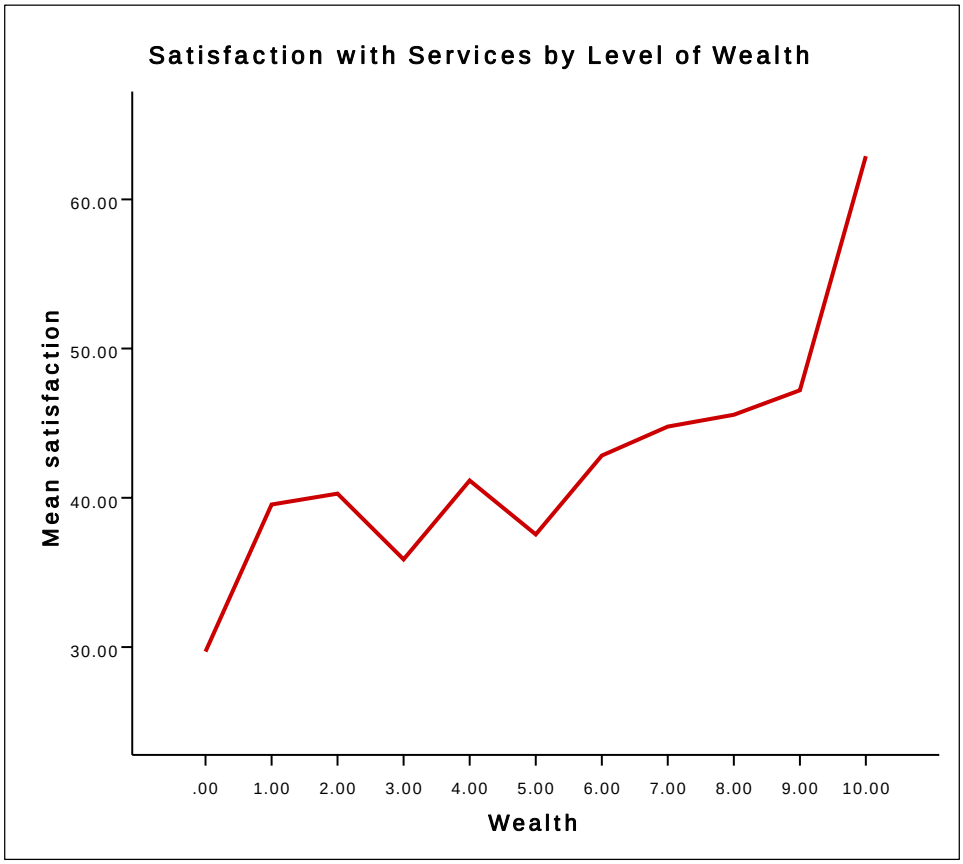
Permissive tolerance of these bad examples has made them reference points for daily practices. Enriching oneself through immorality even arouses public admiration.

We are observing the results of a profound moral void, ever exacerbated by growing poverty. The solutions to these ills must address the factors contributing to this reality...

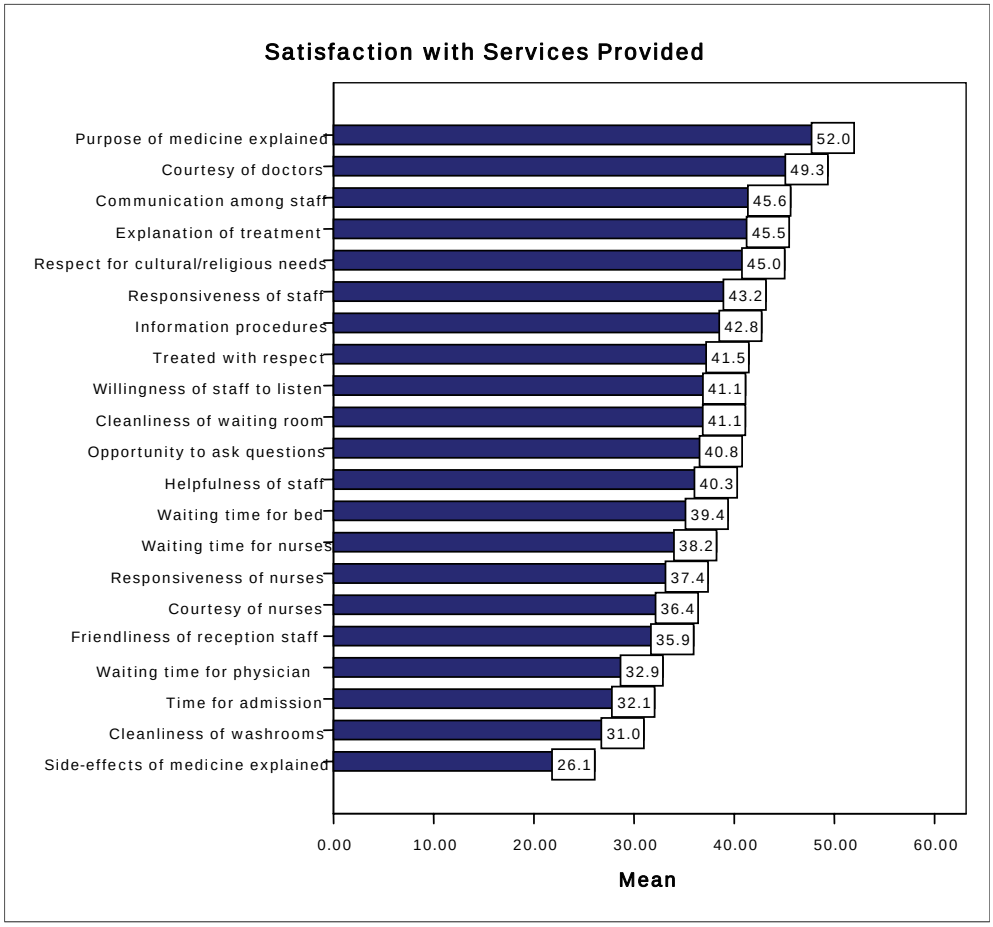
PUBLIC OPINION: IMPRESSION OF THE HEALTH CARE DELIVERY SYSTEM

Field surveys were conducted in the two cities of Cotonou and Parakou to determine public opinion.

Examination of the relation between the level of wealth and the level of satisfaction with health care services reveals that the wealthier the respondent, the significantly greater his or her satisfaction with the care received.



With respect to satisfaction with the services received, 39.3% of respondents state they are satisfied, 47.8% are somewhat satisfied and 12.9 % are not satisfied or very dissatisfied. Overall, the level of satisfaction is the same in Cotonou and Parakou, but care provided by private health care facilities is consistently rated as more satisfactory than that dispensed in public hospitals.

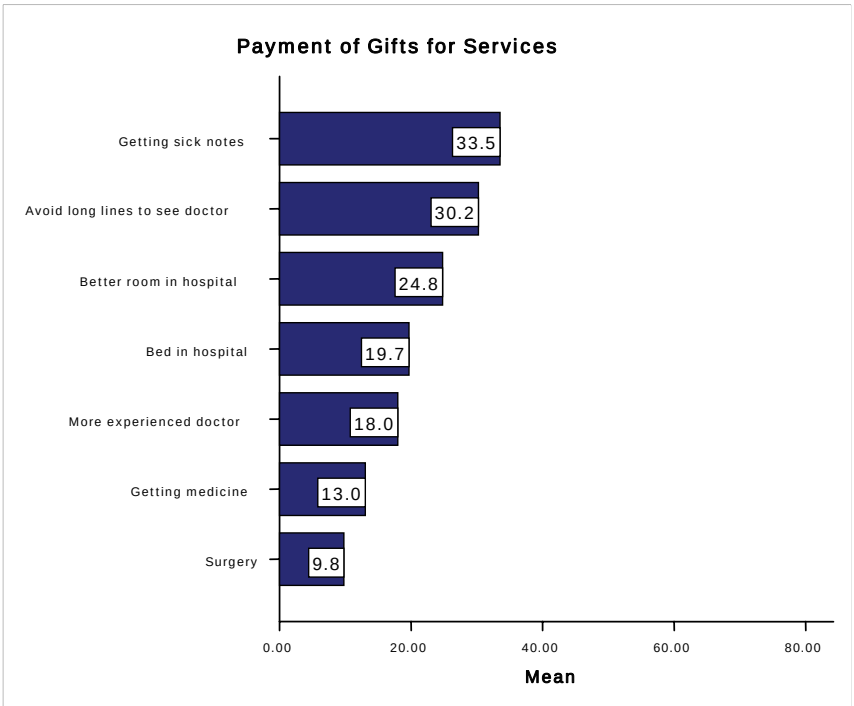


Public interviews reveal that several problems characterize the health care system in Benin. The three main problems are: the cost of health care services goes to the top of the list, second is the lack of respect for patients, and third, employee incompetence.

With respect to corrupt practices in the health care sector, it is reported that beneficiaries are inclined to pay something in the following situations:

- to quickly receive prescriptions and other papers;
- to avoid long lineups and waiting periods;
- to obtain a good hospital room;
- etc.

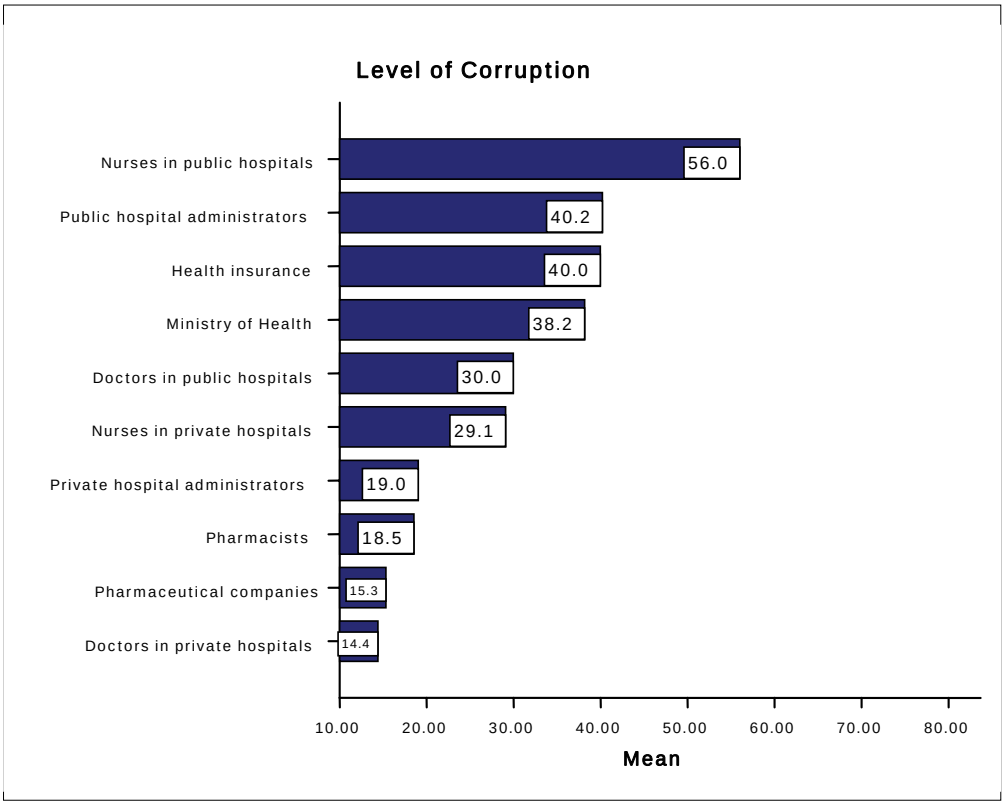
Very clearly, people reported that paramedical personnel were the most corrupt professionals, the most likely to demand bribes, in any case more so than doctors, administrative personnel and pharmacists. This viewpoint may be explained by the fact that paramedical employees are on the front lines and have the most contact with patients and clients. It may, however, be due to the fact that they are paid less. Also, seeking to supplement their monthly income, they tend to request cash under the table for the various reasons which follow.



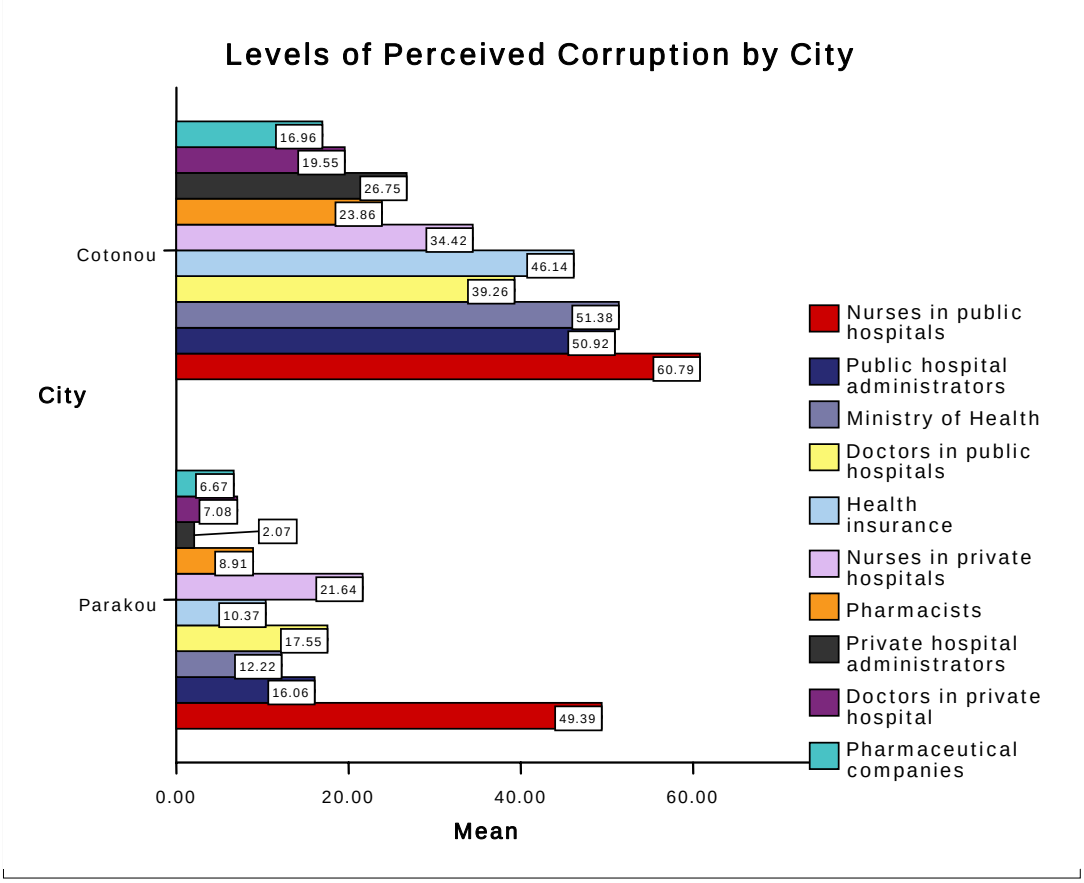
94.1% of users who have paid under the table paid in cash and the amount paid was 5,532 FCFA. For most respondents, the reason for paying was to obtain good care.

For most respondents, giving or accepting bribes, showing favoritism or being swayed by influence peddling are forms of corruption. However, offering or accepting “donations” for services is not considered a corrupt practice.

Graph: Level of corruption among professionals in public and private institutions



The following graph reveals that corruption appears to be more prevalent in Cotonou than in Parakou. In the two cities, paramedical employees in public facilities are considered to be the most corrupt, particularly in Cotonou. Doctors in general and those in the private sector in particular are considered the least corrupt.



Likewise, with respect to the lack of transparency, paramedical employees and public hospitals are considered the least transparent while private hospitals appear to be the most transparent.

OBSERVATIONS ON THE HEALTH CARE SYSTEM: FUNDING AND FINANCIAL MANAGEMENT, CURRENT POLICIES AND PROCEDURES, CONTROL SYSTEMS

The Ministry of Finance overseeing common expenditures directly handles the salaries of public employees and investments. The Ministry of Health takes care of common expenditures, ministerial cabinet expenses, and central directorate projects/programs. At the regional and peripheral levels, departmental health directorates and health zones are now fully responsible for managing allocated credits.

From the reports of various health authorities and administrators at the central level, and those of various administrators, managers and health care employees in hospitals and health care centers, it is revealed that the lack of transparency and accountability, and corrupt practices, are real, undeniable and seriously affect the health care system and the quality of care. Respondents are unanimous that the current system facilitates corruption, extortion and misappropriation, and that there is no traceability of public resources. Some respondents believe that the State itself organizes and supports corruption (the State is behind it).They have provided examples of persistent activities which are harmful to the social order.

According to respondents, corruption takes various forms, depending on the domain or service concerned:

- In administrative services: extortion of users, lack of transparency in awarding contracts, excessively high performance bonuses set by some administrators and non-observance of legislation;
- In procurement services: falsified purchases and reports of undelivered articles,
- In pharmacy services: delivery of damaged medical products or partial deliveries of local purchases, illicit sale of medications;
- In laboratories: unjustified reagents remaining unused after analyses and lack of control of reagents used by employees, utilization of CNHU reagents to analyze samples from private clinics;
- In health care services: open and regular misuse by hospital employees of hospital products for use in private medical offices;
- In the kitchen (Economat): misappropriation of food and provisions, theft of kitchen utensils, overstatement of number of people to be fed, reduced quantities of ingredients used in cooking, reduced number of meals served, in order to use inventory for other purposes;
- At the administration level: false documents, false accounting entries, demands for bribes, manipulation of invitations to tender for public contracts.

Overall, however, corruption takes the following forms:

- Extortion, where a service provider demands that the client pay an amount he or she is not legally required to pay;
- Implicit pressure on the patient to offer money before care is provided;

- Delays in the delivery of care (deliberate on the part of the health care employee) which oblige the patient/companions to motivate the employee to provide more timely care;
- Compelling a service provider by the spontaneous offer of a bribe by a patient;
- Influence peddling: by virtue of his social position, one patient exercises influence over the service provider at other patients' expense;
- Sale of medications in health care facilities and shortages of stock, encouraging the cross-selling of medications;
- Overprescription rather than direct extortion, where the patient is being prescribed more medications and supplies than needed and the employee misappropriates the balance;
- Use of public facilities/equipment for personal gain: in an examining room constructed and equipped by the State, some service providers admit, examine and charge patients, and keep the proceeds;
- Use of hospital equipment or supplies for treatments at private clinics;

There are many causes for the noted corruption and lack of transparency and accountability:

- Poverty due to decreased employment and productivity, in combination with excessive consumption in relation to production;
- Benin's prevalent poor morale and despair (boundless ambition of employees seeking quick gains): one sees and adopts questionable practices to increase one's income rather than seek to improve through acceptable means;
- Overly long and cumbersome administrative procedures;
- Absence of role models (inappropriate use of public resources by management; unionized employees who do not work but still claim an increasing proportion of public resources);
- Lack of deterrents to such behaviors.

Respondents believe the following solutions/suggestions would be useful in eliminating the activities they report:

- Streamlining of management procedures to facilitate traceability of material and financial resources;
- Implementation of management controls by an independent auditor;
- Empowerment of employees and making them more accountable;
- Ensuring a consistent supply of essential goods;
- Elimination of payment upon treatment and establishment of installment payment plans or health care insurance plans/health insurance system;
- Systematic treatment without emergency requirement;
- Automation of the health care facility management system;
- Implementation of sanctions – the problem is not a lack of sanctions but that those who apply sanctions also acknowledge and motivate good performance;
- Decentralization of sanctions;
- Identification of role models: any person susceptible to act as a role model must consistently set an example for others;
- Motivation – not a question of training or increased salary, but rather through sharing with the team of decision-making activities, responsibilities and benefits.

According to authorities and managers interviewed, an appropriate approach to greater transparency in the health care sector has not been identified (lack of reliable data needed to undertake concrete actions). The recommended actions in this study should facilitate auditing and community involvement. Ultimately, it must be assured that funds invested in the health care sector by the Beninese government and its partners are well-managed.

Respondents were unanimous on the issues of transparency, accountability and corruption in the health care sector. Despite their diversity, all stakeholders agree on the causes and possible solutions.

FUNDING AND FINANCIAL MANAGEMENT OF HEALTH CARE SERVICES

Funding of public health offices (Ministry of Health, departmental health directorates, and health zones) is the main responsibility of the central State. As for health care facilities (hospitals and public health care centers), despite State subsidization, basic operations still depend on the funds (community funding) generated from services and managed at the peripheral level by the facilities that generate them. These health care facilities are also financed partly with public funds. Resources provided by the State are used primarily to pay employee salaries, investments (equipment and supplies) and State employee training. The third, equally important, source of funding of public health care and facilities is foreign partners. Other sources (various donations) constitute a small portion of funding.

With 4.6% of the GDP allocated to health care, Benin is slightly below the average investment of 5.24% for sub-Saharan African countries. Overall health care expenditures per inhabitant total 26 dollars at the current rate of exchange, or 43 dollars in purchasing power parity. It therefore appears that households are by far the major source and agent of funding for the health care sector. Private expenditures represent 51.2% of total expenditures and approximately 99% of private expenditures. The government is the second largest source of funding at 31% and donors are third 16.5% for the health care sector. Public hospitals receive funding from various sources and from all funding agencies.

The financial and material resources directorate (DRFM) is responsible for central management of public funds. After a State budget is voted on, each sector ministry is notified of the credits it will be allocated and the Ministry of Health then distributes the credits allocated and advises departmental health directorates and health zones accordingly. Once allocated, the standard procedure is used to make them available for use: commitment, liquidation, authorization and payment.

Unfortunately, the notification and availability of allocated credits is often greatly delayed, thereby compromising timely expenditures and ultimately encouraging large year-end expenditures. Credits have been made available as late as six months after their scheduled disbursement.

With the health care sector having shifted from budgetary deconcentration to budgetary decentralization, health zones are now fully responsible for their operating budgets. They are notified directly of their allocations and manage their budgets without intermediaries. All peripheral health zones and regional health directorates manage their allocated credits exclusively. Regional hospitals, peripheral hospitals and health care centers have their own management teams. Through the allocation of credits which has now been in effect for two years, the operations of all hospitals and health care centers are subsidized by the central State through “allocated credits”.

Management of credits in hospitals and health care centers is generally subject to regulations governing the management of public funds, particularly regarding the use of credits allocated to health zones. At the peripheral level, the State has for a long had difficulty financing health care services. The public contributes significantly, in collaboration with health care employees. However, regulations and management of the funds are inconsistent and poorly monitored, due to a lack of regular audits (internal or external).

PROCUREMENT, WAREHOUSING AND DISTRIBUTION SYSTEM FOR MEDICATIONS AND MEDICAL SUPPLIES: IMPRESSION OF ACCOUNTABILITY AND TRANSPARENCY

At the central level (equipment and supplies), procurement is executed in accordance with public fund management regulations passed by the Ministry of Finance and invitations to tender are issued. Due to competition requirements, purchases require three supplier offers. However, Benin does not have a current scale and as a result, lacks a base price list with which to contain costs. An analysis of successively prohibitive proposals for a first offer (or product) and then preferential proposals for the next offer (or product) seems to reveal, as indicated in the Ministry of Health's internal audit systems, two realities: "either there is no actual competition between suppliers, or suppliers agree to each have an opportunity to profit from public procurement". In these circumstances, it is impossible to ensure that the administration is obtaining the best price.

Where medications are concerned, the Beninese pharmaceutical industry seems fairly well organized: laws, decrees and fairly comprehensive policies concerning pharmaceuticals have been developed and documentation is available. An appropriate system is in place to select essential medications as well as revise and update the list of essential medications (LME). Procurement methods for the public sector are well-defined and comply with international standards. Benin's central cooperative for essential drugs and medical consumables (CAME) currently generates sufficient funds to sustain its daily operations. Stock management tools, such as inventory files and records for stock used in health care facilities, have been developed and distributed. Co-management, monitoring and control of medications are standard and execute more or less regularly by management committees. It is noted that there is a parallel market for the illicit sale of medications and medical supplies. The Ministry of Health is currently attempting to remedy this problem.

With respect to hospitals, health zones and health care centers, it was hoped that decentralization would encourage effective management by streamlining management activities, consolidating the resources of stakeholders in the field, and thereby directly provide the means to quickly implement strategies and programs. From a managerial point of view, it was hoped that once adequate human resources were provided to health zones, they would be managed professionally. Today, decentralization is under way and most health zones have sufficient personnel with the required skills to manage the resources allocated. However, we cannot state that the management of health zones and health care facilities is more transparent, pending evaluation of the decentralized management process. While reports from beneficiaries indicate that the lack of transparency persists in hospital management, there is still insufficient information to measure the degree of transparency in the decentralized management of health zones.

There is no choice but to admit that these are the same regulations governing the execution of public expenditures, using the same operating model. As a result, the situation is quite similar to that of the central model. However, in decentralized facilities, expenditures of local and community funds do not often comply with these principles and are not subject to any rigorous control. It is therefore highly likely that community and public funds are improperly managed.

While using appropriate management tools, the inventory system used at the central level, as well as in hospitals and health care centers, is not subject to regular monitoring and audits. Complaints are made regularly by various sources regarding poor management and even cases of embezzlement.

The inventory of materials, equipment and supplies is not systematized. While some services and facilities (notably those supported by foreign partners) have fairly current records, most Ministry of Health facilities do not. An overall inventory system is recommended for Ministry of Health equipment and materials and those of public health care facilities.

Overall, transparency and accountability for the procurement, inventory and distribution systems for medical supplies and medications are rather flawed and in need of improvement.

CONTROLS

At the central level, it is clear that controls are not systematic. According to the final internal audit report of the Ministry of Health regarding the control systems commissioned by the delegation of the European Commission in Cotonou (August 2005), "the concept of internal controls has not been assimilated, and as a result, the current administrative structures are not appropriate to accomplish this goal."

There is no organization or formalization of the control system, nor any internal audit guide. Instead of procedure documents specific to the Ministry of Health's internal auditing, there are general documents which are not intended as guides to carrying out systematic internal audits. There are Ministry of Finance guides, general Ministry of Health manuals, and the following guides and manuals produced by departments:

- Procedure manual for execution of public expenditures, intended for credit managers and directors of State institutions and ministries (June 1996) issued by the Ministry of Finance;
- The annual Ministry of Finance circular listing credits available in the general State budget, which supports execution processes of public expenditures;
- The manual for execution of public expenditures in health zones;
- Instruction guide regarding the tools of the national health care information and management systems (December 1996), the content of which is not used when conducting internal audits.

According to the above-mentioned audit, "these guides cannot be used as internal audit manuals", as they do not address items specific to the Ministry of Health or take into account the inherent risks in health care services.

Instead of efficient and effective internal controls, one notes the existence of a Ministry of Finance employee responsible for financial controls who is mandated to conduct regular financial audits.

According to an order issued by the Ministry of Health on April 30, 2003, the financial and material resources directorate (DRFM) has jurisdiction in these matters, although it does not itself establish the regulations, standards and procedures in question. At best, it relies on those of the Ministry of Finance. Furthermore, it has not identified/evaluated risks specific to the health care sector, nor established objectives and procedures for internal audits.

Audits of hospitals and health care centers are conducted externally and initiated by line management (departmental health directorates and health zones) and basically consist of supervision presented as a control mechanism for various health care services and centers. It is the "other form of control" which only applies to services outside of the Ministry of Health.

The DIVI (inspection and internal audit directorate), which theoretically has jurisdiction and limitless intervention powers for both technical and management inspections, should in principle be responsible for administrative, financial and material management of all Ministry of Health services and establishments. However, it has not established an internal audit mechanism and seems to be passive, inefficient and not really intimidating. In cases of suspected embezzlement, particularly within deconcentrated services and peripheral health care facilities, the DIVI is rarely dispatched to conduct an investigation which is then generally not followed upon.

ROLES OF OTHER STAKEHOLDERS

Community organizations do not directly influence management of the Ministry of Health and its departments. At most, they may report observations from a distance which the health authorities have

no obligation to consider. It is the same for consumer associations, from which the health care sector seldom hears. However, it is noted that Beninese civil society is one of the strong pillars which may be relied upon in the fight against corruption. It is clear that it may be highly influential in promoting administrative transparancy and fighting corruption in the health care sector. Community organizations have demonstrated their power by achieving the unheard-of goal of prosecuting and jailing almost two-fifth of Beninese judges involved in the misappropriation of public funds in the case known as “criminal court costs”. They proved that they could mobilize and motivate the public, and their effectiveness at ensuring that the law was respected during presidential elections and in other matters serves as an example of what is possible. Given such effectiveness, it seems that community organizations should be encouraged and developed to defend the rights of health care beneficiaries.

Health care committees, for their part, may only act under the supervision and control of management at their health care facility; however, most of the time they lack the level and breadth of knowledge required to be effective.

Parliamentarians are responsible for legislation and the control of governmental actions. As a result, they can exert significant influence in the fight against corruption and the lack of transparency, but they are actually too politicized to do so effectively and efficiently.

THIRD-PARTY PAYMENT MANAGEMENT: PROVISIONS AND ARRANGEMENTS

Health care insurance plans are not widespread, but are increasing in number in Benin, from 11 health care insurance plans listed in 1997 to 90 in 2003, two-thirds of which were operational. It is hoped that 120 health care insurance plans will be registered in 2006. The Beninese government and its development partners agree that health care insurance plans are a promising idea. Health insurance also exists, but remains accessible only to official groups and employees of large private businesses. It remains unavailable to individuals, even those who have the ability to pay regular premiums. Insured members prefer to use private services when they have the choice. Insured patients still account for only a small portion of hospital revenues. As a result, corrupt practices related to procurement of third-party payers are not common.

PREVIOUS SOLUTIONS AND CURRENT POSITIVE EXPERIMENTS

Health authorities and health care management interviewed mentioned some solutions stemming from the positive experience with HOMEL (*e.g. Maternité lagune*) (mother and child hospital in Cotonou) which could be extended to other centers and from which are extracted the following recommendations:

- Medication management automated network. Wholesalers and retailers are connected to the network so that movements of medications and medical supplies may be tracked;
- Adoption of management software for cash revenues. The main cashier makes daily bank deposits of all payments received;
- Expenses are never paid directly from revenues. When the cost of an expenditure exceeds fifty thousand francs, the normal procedure is to be followed: identification of need, contact of suppliers, establishment of a purchase order, receipt of the order by a limited group of receivers, approval of delivery document, recording of receipt, etc.

FUNDING AND MANAGEMENT OF DONOR FUNDS

The health care sector in Benin is supported by foreign partners (donors) as follows:

- Bilateral cooperation, which includes:
  - Bilateral cooperation partners involved primarily on the peripheral level: USAID, and Swiss, Belgian and German partners (ending year-end 2005);
  - Bilateral cooperation partners involved primarily at the regional level: French, Chinese and Egyptian partners;
  - Bilateral cooperation partners involved primarily at the central level: Canadian and Japanese partners.
- Multilateral cooperation includes the European Union, UNICEF, UNFPA and WHO, involved at all levels of the health care pyramid.
- Financial institutions, including: WB (World Bank), DAB (Development Assistance Bank), IDB (International Development Bank), ABEDA (Arab Bank for Economic Development in Africa), etc.
- Non-governmental organizations (NGOs), notably: the Raoul Follereau Foundation, the Family Planning Association of Benin (ABPF), the French Association Of Volunteers for Progress (AFVP), Doctors Without Borders, Plan International, etc.

The actions and activities of various partners have the common characteristic of involvement in development strategies for the Benin health care sector and may be classified as follows:

- Institutional support of infrastructures and equipment, system reorganization and decentralization, resource management and support of service operations (A3), quality of care, reinforcement of capacity, technical assistance and provision of services;
- *La Santé Familiale: Santé de la Mère et de l'Enfant*, family planning;
- Priority diseases: fight against STDs/HIV/AIDS and malaria;
- Major diseases: fight against tuberculosis, leprosy and Buruli ulcer.

Bilateral donors contribute to the development of health care services through two main funding categories: common funds to support the budget and separate funds:

COMMON FUNDS: BUDGET SUPPORT

Through Budget Support[3], some partners are involved in financing the health care sector's operating budget. The European Union, Denmark, the Netherlands, Switzerland and the World Bank though the PRSC program (Poverty Reduction Support Credit), known as CARP in French, are members of a **joint budget support program** to support the Poverty Reduction Strategy (ABC-RP). ABC-RP is a non-specific contribution to the national budget to finance overall expenditures for the year. It is managed according to domestic procedures and has specific immediate objectives[4].

Support expected from the joint program for the period 2003-2006 totals approximately 43.2 billion CFAF, comprising 36 billion from the European Union, 7.5 billion from Denmark; 2.1 billion from Switzerland and 3.6 billion from the Netherlands. Since 2004, annual joint missions have evaluated the budget support program.

[3] Budget support: support from a development partner to provide funding according to national procedures for activities within the National Budget. Expenditures are transacted through the account of the Public Treasury.

[4] Immediate objectives of the ABC-RP are:

a. to support government policies to maintain macroeconomic stability and continue structural reforms under way;
b. to contribute to real and more significant economic growth;
c. to increase government budget options in order to reduce poverty, notably by allocating accrued resources to priority sectors and cross-sector items; and
d. to facilitate the budget reform process in order to ensure an effective, efficient, durable management of public funds.

SEPARATE FUNDS:

These are contributions from bilateral donors managed directly, outside of the public budget, by the donor, such as the donations from Germany and France.

INSTITUTIONAL AND GOVERNANCE PROVISIONS FOR THE SECTOR

Outside of reforms to streamline the use of resources, governance of Benin's health care system suffers from a lack of organization and procedures for treating and validating accounting information. As a result, regardless of the measures of the central or departmental health administration, internal auditing is neither organized in theory nor in practice. Peripheral supervision missions carried out of deconcentrated facilities do not meet internal control objectives.

Actually, there is no effective expenditure tracking system in place, so it is difficult to monitor the actual use of public resources or contributions from foreign partners. The lack of regular audits (internal or external) does not contribute to resolve this weakness in health care facilities.

The lack of effective procedures does nothing to shelter public expenditures from error or fraud or to safeguard assets.

OTHER MANAGEMENT ISSUES

PERSONNEL-RELATED ISSUES

Benin's health care system lacks personnel in certain area and their scarcity, in contrast to the strong demand, creates a foundation for embezzlement, extortion or redirection of patients to private clinics. Personnel falls under one of four main categories:

- permanent State employees (APE);
- contract State employees (ACE), whose contracts may be for a short or long term and who may become APE after four years of service;
- employees contracted through a special program called "Social Means" (CMS); and
- contract employees paid through community funds (CFC).

Recruitment of permanent and contract State employees is centralized, while employees in the other two categories are hired through a decentralized process (local recruitment and management).

Observations of employees currently working in the two hospitals, where the situation is very similar to that of other health care facilities in Benin, reveal a predominant number of employees working in precarious positions: these are contract State employees recruited through the "Social Means" program and employees paid through community funding, who live with the permanent specter of loss of employment and an uncertain future. Their insecure employment and precarious situation are likely to lead to negative behavior and may easily induce the desire to make substantially greater income while the opportunity presents itself, in order to be prepared for the difficulties of possible unemployment.

There are few specialists in key services of the public health care sector, such as surgery (35), obstetrics and gynecology (33), pediatrics (22), internal medicine (2), dental surgery (2), anesthesia (2), cardiology (1), and psychiatry (34), particularly when one considers the 34 health zones which need the services of surgeons, obstetrician-gynecologists and pediatricians. Such scarcity provides opportunities for various illicit activities. On the other hand, there are many public health specialists (60).

Specialties	Needs (number)	Existing (care providers)	Needed in 2003
Gynecology	78	33	45
Surgery	111	24	87
Pediatrics	111	22	89
Anesthesia	98	2	96
Internal medicine	98	2	96
Gastroenterology	30	1	29

The cause for the shortage is well-known. Since 1986, recruitment of doctors has not been carried out systematically. Young doctors who graduate are not encouraged, nor frankly supported, in making the effort to specialize. Training is often offered to APE doctors, the same doctors who cannot do everything at once. Based on the budget, the Ministry of Health identifies the number and type of employees to recruit, but the number is always low. The Ministry of Civil Service takes care of recruitment, with some relative transparency. The selection criteria include some that are not documented and compensate for other factors. Sometimes a list of recommended candidates is provided, thereby avoiding the use of established criteria.

Another human resource problem to be considered in the country is an aging workforce (specialists in particular). More than 60% of specialists will retire within five years.

Professional development is carried out within certain departmental health directorates (DDS) and other programs.

RECAPITULATION OF OBSERVATIONS AND SOLUTIONS

Observations made by different stakeholders encountered in the health care system naturally suggest a number of solutions, which are reviewed here.

Table: Summary on observations and proposed solutions by health care system stakeholders

PROBLEMS OBSERVED	SOLUTIONS PROPOSED
Lack of transparency and accountability in management and delivery of care	• Establishment of management controls by independent auditors • Automation of health care facility management
	• Systematic treatment of emergency and non-emergency patients
Lack of traceability in State resource management	• Streamlining procedures to promote traceability of material and financial resources
Intimidation of patients, delays in treatment	• Systematic treatment of patients even if not urgent • Establishment of appropriate motivation including sharing with the team: decision-making, responsibilities and benefits • Training, guidance and sensitization of all employees to the concept of reception, good work, respect for patients, honesty
Influence peddling	• Identification of role models
Overprescription and misappropriation of medications and medical supplies	• Establishment of management controls by independent auditors • Greater employee accountability and increased reporting requirements • Automation of health care facility management, • Establishment of decentralized positive and negative sanctions • Ensuring effective management of hospital property
Misuse of State installations/equipment for personal gain	
Use of hospital equipment or supplies for private clinic procedures	
Falsification of documents and accounting entries	
Sale of medications in health care facilities and frequent shortages of stock, encouraging the cross-selling of medications	• Consistent availability of essential medications
85% of the population do not have health insurance and therefore cash is used to purchase services	• Elimination of payment upon treatment practice; establishment of health insurance plans and health insurance system
Payment per treatment	• Promote health care insurance plans to avoid circulating money in hospitals
Inconsistent medication pricing between health care facilities	• Harmonize medication prices
Lack of reference prices for goods and services purchased by the State	• Provide a price list to health care system suppliers
Poor reception and extortion upon admission, particularly in emergency situations	• Supervise security employees • Ensuring full-time presence of qualified personnel at reception and in emergency services for the appropriate treatment of patients • Subsidize or provide "free" first aid supplies to all patients admitted to the emergency ward
Employees' low wages and demotivation	• Increase employee salaries • Identify actual elements which motivate employees
Lack of discipline or accountability	• Reinforce authority of administrators and allow them to do their jobs and sanction employees, with the possibility of

PROBLEMS OBSERVED	SOLUTIONS PROPOSED
	appeals in the case of sanctions considered unfair • Rigorously follow disciplinary rules • Reinstate civic education
Delayed provision of credits due to hospitals by the State	• Treat hospital bills of permanent State employees as loans to them • Review funding methods for health care facilities (see following)

CONCLUSIONS

Based on this study and user opinions collected during focus group discussions, a number of major observations emerged which are summarized as follows.

Hospitals and health care centers lack accountability and transparency in their management and provision of health care services. Corrupt practices are real and exist in both hospitals visited. They develop progressively in two stages: patients are conditioned to expect corruption, and subsequently actual events of corruption occur. In technical services, it was found that paramedical employees are, above all, those responsible for corruption and the lack of transparency. Doctors are less likely to behave objectionably.

With the acceptance and payment of bribes, patients expect to receive quality service provided promptly. Women and men are equally victims of corruption. Poor and vulnerable people cannot pay extra and so are virtually abandoned, and resign themselves to die. Such negative behavior (deliberate delays, neglect, lack of follow-up) hinders the prompt management of patients and leads to or encourages poor quality of care. Goods unlawfully taken by employees from patients and their companions do not, unfortunately, improve the poor quality of the care provided, which results in a higher rate of mortality. Patients become fearful and mistrustful of hospitals.

85% of the population do not have access to health insurance and therefore pay cash to health care service providers. The level of satisfaction expressed correlates significantly with level of wealth. While the highest satisfaction level is reported with respect to prescriptions ironically, the lowest level of satisfaction reported is with respect to the secondary effects of prescribed medications. There is no difference between degrees of satisfaction between the two hospitals. The two main problems with the health care system are the costs of care and the poor treatment of patients by health personnel.

Care provided by private health care facilities is considered more satisfactory than that of public health care facilities. Paramedical employees are considered to be the most corrupt and the least transparent. Private health care providers are considered to be less corrupt than public providers.

Many people say they have never given a gift in order to obtain services. Most respondents do not consider giving or receiving a gift to be a demonstration of corruption.

Various health authorities and administrators at the central level and various administrators, managers and health care employees in hospitals and health care centers report the lack of transparency and accountability and events of corruption which are real, undeniable and severely compromise the health care system and quality of care. They unanimously acknowledge that the current system facilitates corruption, extortion and misappropriation, and that there is no traceability in the management of State

resources. Some believe that the State itself organizes and supports corruption (the State is behind it). They provide examples of persistent behaviors which affect social order.

They are unanimous regarding evidence of corruption, lack of transparency and accountability in the health care sector. Despite their diversity, the different stakeholders are unanimous on the existence of corruption, its causes and possible solutions.

Its forms are varied and include implicit pressure and intimidation of patients, delays in care, extortion, compelling of employees by spontaneous offer made by patients, influence peddling, the overprescription and misappropriation of medications and supplies, misuse of State installations/equipment for personal gain, use of hospital equipment or supplies to treat patients in private clinics, and the falsification of documents and accounting entries, all exacerbated by frequent inventory shortages, which encourages the cross-selling of medications.

Causes for the phenomenon are varied: poverty, ethical crisis, despair, unbounded ambition, overly lengthy and cumbersome administrative procedures, absence of role models, permissiveness. Internal controls are weak or nonexistent both within the Ministry of Health and its departments as well as in hospitals and health care centers. At these different levels, there is no entity specifically responsible for internal controls.

A number of solutions are suggested which could help eliminate corruption as described, which include streamlined management procedures to encourage traceability of material and financial resources, establishment of management controls by independent auditors, greater accountability and reporting requirements for employees, consistent availability of essential medications, elimination of payment upon treatment, establishment of health insurance plans and a health insurance system, systematic admission of emergency and non-emergency patients, decentralized positive and negative sanctions, identification of role models, establishment of appropriate employee motivation, including the sharing the team of three elements: decision-making, responsibilities and benefits.

While acts of corruption have become open and regularly reported by patients and the public, there is still no appropriate response by decision-makers to the size and severity of the problem, in order to eliminate it. As a result, few solutions have been attempted in the past or are in the process of being implemented to resolve the problems identified. Unfortunately, the consequences of the situation are visible and the impact is evident every day in the poor treatment of patients and higher rates of mortality.

Finally, corruption and the lack of transparency are realities deeply implanted in the two hospitals investigated, in health care centers and in the overall health care system in Benin. They are a phenomenon with multiple dimensions and multiple causes. Therefore, multiple solutions of various types should be contemplated.

RECOMMENDATIONS

Upon concluding this study, which is particularly revealing with respect to transparency, accountability and corruption in the health care sector, it is clear that a fierce battle, that will require much patience, must be launched against this profound, insidious problem. Resolving it shall take a great deal of time.

Consideration of the following recommendations, which are primarily addressed to the State and health authorities, could assist in eliminating corruption.

TO THE STATE:

Intensify measures against poverty, social inequality and lack of fairness.
Undertake subsequent action against unemployment and precarious employment.
Strengthen and diversity the national economy to be able to promote better work wages.

Reinforce and rely on community organizations that promote transparency and struggle to eliminate corruption.

AT ADMINISTRATIVE AND SYSTEMIC LEVELS:

With respect to weak internal controls:

- formulate and formalize internal controls within the Ministry of Health;
- develop an employee training program for internal auditing;
- develop procedural guides for internal audits.

With respect to employees:

- Increase salaries for health employees, it is suggested that supplementary amounts be linked to performance;
- Implement specific measures to motivate employees;
- Encourage healthy work ethics;
- Systematically apply positive and negative sanctions.

With respect to billing, collection and management of hospital funds:

- Eliminate cash from hospital financial transactions;
- Systematically invoice health care services.

With respect to funding health care services:

- Promote health insurance plans and a health insurance system;
- Prepare budgets based on results;
- Promote budgetary transparency.

Regarding the delivery of health care services:

- Ensure a constant supply at hospitals of medications for hospitalized patients;
- Eliminate prescriptions for hospitalized patients;
- Include medications and medical supplies in the care kit provided to hospitalized patients.

ANNEX F: MOZAMBIQUE COUNTRY REPORT

USAID
FROM THE AMERICAN PEOPLE

EFFICIENT AND TRANSPARENT SERVICE DELIVERY IN PUBLIC HOSPITALS – A CASE STUDY OF MOZAMBIQUE

JANUARY 2007

This publication was produced for review by the United States Agency for International Development. It was prepared by Isabel Lourenco and Chris Atim, Ph.D. of HLSP (a subcontractor to Management Systems International), with contributions from Orlando J. Perez.

EFFICIENT AND TRANSPARENT SERVICE DELIVERY IN PUBLIC HOSPITALS – A CASE STUDY OF MOZAMBIQUE

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CONTENTS

ABSTRACT

The study examined the manifestations, causes, strengths and possible solutions relating to problems impeding the efficient and transparent delivery of health services at the national health system level as well as specifically at the Maputo Central Hospital and two health facilities in Chimoio. The study focused on systems, procedures and vulnerabilities relating to:

- the health care delivery system and its interaction with the public
- the human resources /staffing /personnel issues
- procurement, the supply chain, distribution and logistics management
- health financing, management and flow of funds

The main problems related to the theme that came to light from the interviews, focus groups, field survey and document reviews in the course of this study were:

- Low budget of the public health sector;
- Low salaries in the public sector;
- Existence of corruption manifest as informal payments and deviation of public resources;
- Misconduct of some public employees;
- Bureaucratic and uncontrolled processes of health care; taking too long to fill forms in, too many departments and staff to go through and long waiting times;
- Mismanagement and misuse of public funds; using some of those funds to acquire minor or unnecessary equipment or medicines considered urgent without analysis;
- Lack of communication within the health sector and with the communities;
- Shortage of resources and medical supplies;
- Lack of regular management controls and audit processes;
- Lack of supervision and weak enforcement of sanctions;
- Lack of computerised systems for storage and record of data and management.

The main causes of these problems lack of policy to simulate workers with suitable wages, lack of routine, control and discipline procedures and punishments and shortage of funds.

The main recommendations arising from this study are as follows.

- Sensitize relevant Government officials on the health issues and problems and what is required to resolve them;
- Address the problem of low salaries for public sector employees;
- Reinforce social control and the role of civil society towards the public health system, establishing and regulating their participation contributing to improve and develop efficiency and transparency ;
- Institute career development plans for health workers;
- Complete the computerization process specially of the sensitive departments;
- Develop and reinforce public expenditure management and control;
- Reinforce discipline and improve staff behaviour by establishing specific codes of conduct for health personnel.

The Mozambican system has some points worth noting. For instance, in order to address the well-known problem of 'ghost workers', all public officials are required to attend 'proof of life' procedure annually, by showing up in person at the relevant Government department. Another significant initiative aimed at addressing problems of transparency is the new practice of holding meetings with communities by Government officials to solicit their views and discuss their complaints regarding local services and other issues. Attention is being dedicated to discipline and control of working practices in the MOH (Ministry of Health) through implementing of public employee's codes of conduct and reactivating inspection cabinets. MOH has started to computerize sensitive areas as procurement and finance and is investing in those sectors.

PURPOSE OF STUDY

The purpose of this study was to identify opportunities for strengthening health systems delivery in order to provide more responsive, efficient, transparent and accountable health services, based on data collected on the field within the study developed in Maputo and Chimoio. The study looked at vulnerabilities in health care delivery, according to key informants which were interviewed and based on the perceptions of service users.

It examined the manifestations, causes, strengths and possible solutions relating to problems impeding the efficient and transparent delivery of health services at the national health system level as well as specifically at the Maputo Central Hospital (HCM) and two health facilities in Chimoio.

It focused on systems, procedures and vulnerabilities relating to:

- the health care delivery system and its interaction with the public;
- the human resources /staffing /personnel issues;
- procurement, the supply chain, distribution and logistics management;
- health financing, management and flow of funds.

This country-specific report was produced as part of a broader cross-national comparative study of transparency, accountability, and efficiency in health service delivery in Benin, Mozambique and Tanzania. It is intended as an analysis of information compiled during literature reviews and in-country surveys and interviews, and represents an initial examination of corruption in the country's health system. This report should serve as a foundation and building block for future, more in-depth reports. While it can be read as a standalone piece, the comparative report provides a larger examination of the causes of corruption and recommendations for more transparent and efficient health service provision.

METHODOLOGY

An extensive bibliographic review was done on the themes presented above aiming to provide background information and set a context for the findings in order to understand the health development process in Mozambique. The information was collected in Maputo at the Documentation Centre of the Ministry of Health and also included documents supplied by USAID.

The study used ethnographic methodology with information collected from key informants, semi open interviews, focal group discussions and direct observation. Information, collected from informal conversations in hospitals, clinics and MOH were used to indicate pertinent areas to observe and approach, and to set the guide lines of focal group discussions.

In Maputo, twelve interviews were done with National Directors and Heads of Departments of the Ministry of Health and with four Directors of the Central Hospital of Maputo, the highest complexity health unit in Mozambique. Seven health leaders were interviewed in Chimoio including Provincial and Hospital Directors. Each interview took an average of 60 minutes. The questions for the interviews were translated and written in Portuguese from the survey tools supplied. Before each interview the objectives of the study were presented and the questionnaire was shown to the respondents. Each respondent was also asked if there was any inconvenience in answering the questions. Nobody refused to answer any question.

In the focus groups, the health care system transparency and quality were discussed with thirty-three people from the community of Chimoio, 10 selected at the provincial hospital, 10 at one of the clinics and 13 in one of the neighborhoods. These discussions took place at the provincial hospital, at the clinic and in the neighborhood. Participants were chosen among the people waiting for consultations at the health units and randomly from persons passing by in the neighborhood.

Focus group discussions lasted 2 h 45 m, in the hospital, 2 h 30 m at the health centre and 3h 30 m in the neighborhood. All the participants were over 18 years of age. In the health units they were half female half males and in the neighborhood there were 8 men and 5 women.

The focus group technique turned out to be a suitable method for stimulating people to talk and generating dynamic interactions between participants, allowing open statements and exemplifications of situations lived by them. The agenda and the guide lines scripts for the focal groups were based upon the guide lines for the survey, the questions of the interviews and a pilot test of some inpatients of Maputo Central Hospital.

HCM, two health clinics and the provincial hospital in Chimoio were visited. These visits occurred after being introduced to their superintendents and directors and the presentation of the research goals.

Before the interviews and focus groups started, the objectives and methodology of the study were explained. At the end, participants were asked to give their opinion about the process of the interview or focal group, and about the study. Anonymity was assured to everybody participating in this study.

This report also presents results of a random probability survey conducted in Mozambique with the purpose of examining attitudes toward the health-care delivery system in Chimoio City, Manica Province. The survey instrument was designed to elicit information on the use of the Chimoio City Hospital and Centro de Saude Eduardo Mondlane as compared to other health service providers (private, uncertified, traditional). Additionally, examine reasons for use or non-use of the hospital, public perceptions and actual experiences of hospital efficiency in resource use, management compliance, and accountability and transparency among users and non-users.

BACKGROUND

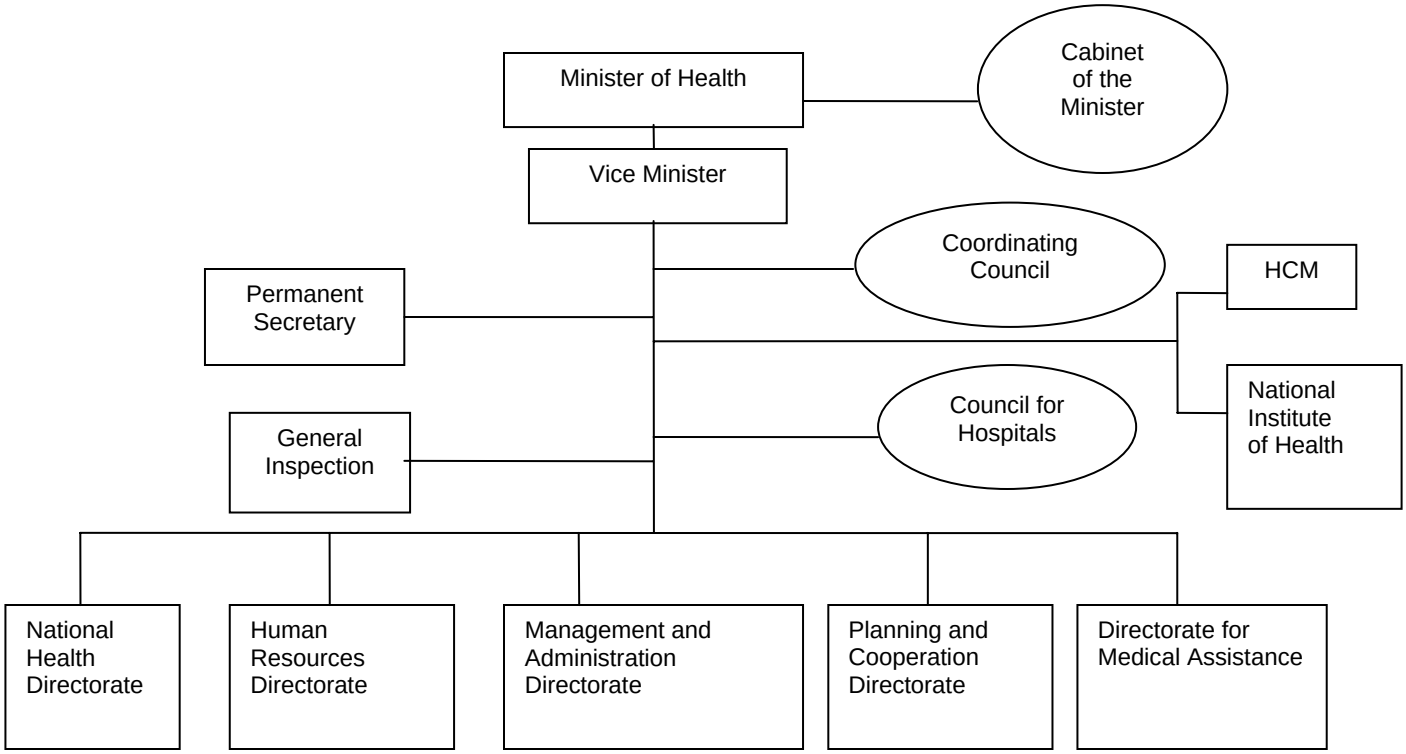
A. COUNTRY PERFORMANCE ACCORDING TO INDICATORS OF HEALTH SYSTEM

Mozambique's population is around 19 million, of which 25% are children from 0 to 14 years of age. Fifty percent of Mozambicans are considered to live in absolute poverty. According to the Strategic Plan for Health Sector, health expenditure per capita is US$14.4, of which 60% are from funds donated by development partners. According to the Strategic Plan for the Health Sector (PESS) 2005-2010, the percentage of the population living in rural areas is 73%. In 2005 only 41% of the people living in rural areas and 37% of those in urban agglomerates had access to potable water. Thirty-six percent of the population has access to a health unit within 30 minutes of walking from their homes (PESS 2005-2010).

Health indicators show that general mortality rate, per thousand people, went from 21.2 in 1997 to 17.2 in 2003. Life expectancy at birth went from 42.3 in 1997 to 46.3 in 2003. In 2005 only 49% of baby deliveries were in health units. In 2003, maternal mortality was 408 per 100.000 births. The incidence rate of measles was 139 per 100.000 and chronic malnutrition (low height for age) had a prevalence of 41% in children less than 5 years of age. Malaria in 2001 killed 7% of patients. The prevalence of tuberculosis in 2004 was 636/100.000. Mozambique occupies the 18th position on the list of countries with high prevalence of tuberculosis. There are 500 individuals infected with HIV every day according to statistics based on diagnoses done through tests, at health units. The main cause of mortality and morbidity in the country is malaria and in 2005, it affected 5.8 million people (PESS 2005).

B. HEALTH STRUCTURE AND HEALTH SYSTEM

The MOH is developing its administrative structure and undergoing modifications to become more operational and efficient. The organizational chart based on the one published in 2000 and as it was understood, is represented below indicating the main directorates. This same structure is reproduced at provincial level. Updated organizational charts were not available.



Each of these Directorates has several departments and the report makes reference to some of them. The General Inspection Directorate is in charge of creating a system to ensure accountability, supervision, discipline and to contribute to the application of discipline and sanctions. The Directorate for Medical Assistance is responsible for the management of all public hospitals, including management of their laboratories. The Directorate for Administration and Management is tasked with forecasting, planning, distribution and warehousing of all non-drug items. It is divided into general procurement and finance departments. Connected to these departments are the maintenance section for routine maintenance and repair of installations and equipment, and the internal administration section. The Center for Medicines and Medical Supplies (CMAM – Central de Medicamentos e Artigos Medicos) reports to the Pharmacy Department which reports to the Director of National Health.

The main health care provider in Mozambique is the public sector assisted by the for-profit and non-profit private systems (PESS 2005-2010). The private system, is predominantly found in Maputo and Beira, and is developing and expanding in other towns of the country. After national independence in 1975, private medicine was abolished and started again around 15 years ago when some doctors would be contracted by private companies or institutions to medically consult their staff and in some cases their direct family, on a part time basis, 2 to 3 days a week. This was then considered illegal but became accepted and generalized giving way to private practice through clinics and hospitals.

The National Health System is organized in 4 levels of care. Levels I and II include the more peripheral units supplying basic health care. The first interaction between the community and basic health care providers occurs at level I. Level II gives support as referral units for level I. Levels III and IV are referral units with specialties and increasing complexities. In other words we can say that the national health system has the primary health care clinics as the entry door. These clinics can refer patients to district or rural hospitals. The difference lies between the location of these hospitals being at the district headquarters or out of it. Provincial hospitals are referral services considered of medium level of

complexity as the rural hospitals, and may refer patients to Central Hospitals, the highest complexity health units in the country.

Health care in the public health system is free with a symbolic rate equivalent to less than 5 cents of a dollar, paid by users at the entrance if they are not considered indigents. Children and emergency care seekers do not pay.

The country has 1500 health units and there is one health unit per 15 000 inhabitants. Only 3% are hospitals, meaning 1 hospital per 420 000 inhabitants. These indicators available in the Strategic Plan for Health Sector, should be associated with those of beds per inhabitants as it has a more significant relationship with the real availability of in hospital care associated with the geographical area coverage per hospital, indicating population's accessibility. Between 2000 and 2004 the number of health units increased less than 3% and the population grew 12%. Around 30% of the health units have no access to water (PESS 2005).

Mozambique has not developed health insurance or medical aid schemes. It was noted that Mozambicans interviewed didn't have any direct dealings with insurance providers and most had no opinion on this question.

C. KEY PLAYERS AND PARTNERS IN HEALTH

According to information received, between 2006 and 2009, Mozambique's Government will be counting on contributions of cooperation partners to finance around 49% of the State Budget annually.
The Mozambique sector wide approach to programming for health (SWAP) exists since 2000 and has been cited as an advantage to enhance government leadership, improve sector policy and strategic focus, creating a more effective use of aid to the health sector and lower transaction costs. Public expenditure for health has more than doubled between 2001 and 2004, due to the increase in the volume of "common funds" (donor's basket) and moderately increasing government expenditure.

The SWAP focuses on developing an open and inclusive arrangement where the MOH and its development partners can share a set of common principles, objectives and working arrangements that include:

- the health sector strategic plan endorsed by all development partners and including a set of indicators to evaluate policy implementation and health sector progress;
- a code of conduct setting rules of engagement for MOH and its partners;
- means to enable structured dialogue and consensus building between the MOH and development partners;
- a sector financing framework highlighting the expectations of the Government in relation to aid modalities and financial instruments to be used by development partners in the health sector ;
- a set of review mechanisms to evaluate health sector progress and commitment to the objectives of the strategic plan.

Through its methodology of work SWAP contributes to the transparency and accountability in the health sector. This group of partners seats regularly to discuss program's objectives, financing methods and control procedures.

Some examples of the key partners involved with SWAP and supporting different areas of the MOH are United States Agency for International Development, World Bank, World Health Organization and other United Nations agencies, Health Alliance International, Swiss Cooperation, Norwegian Kingdom,

European Union, Canadian International Development Agency, among others. There are 15 donors contributing into a common fund (a donor's basket), to support health sector development.

D. HUMAN RESOURCES IN THE COUNTRY

The public health sector has a total of 24.042 workers as technicians for specific areas and general and support workers. The structural base of human resources is dominated by personnel of low qualifications and a marked lack of qualified staff. These factors contribute to the problems of providing quality health care. According to the Strategic Plan of the Health Sector, this personnel shortage situation is the result of inadequate production of the educational institutions, in qualitative and quantitative terms, which are unable to respond to the increasing human resources needs of the country.

Mozambique is a country with less than 800 medical national doctors. Medical doctors are trained in 2 medical schools of the country, but receive specialization or training in specific fields abroad, with exception for pediatricians and physicians who are generally trained in the country. Once these professionals and nurses have qualified they have to work in the provinces and are allocated to their places of work by the MOH.

E. BUDGETS AND FINANCIAL MANAGEMENT

In 2006, the proportion of Government expenditures assigned to the health sector was 12.8%. The objective is to reach 15% following the stipulations of the Abuja meeting.

The finances for health departments and hospitals derive mainly from:

- Government budget;
- Ministry of Health funds given through the COMMON FUND and PROSAÚDE which are made up of donor contributions;
- Funds arising from revenues originated on tributes and taxes on public workers salaries;
- Earmarked revenue, derived from fee payments made by patients that look for medical care in the hospitals and health units and returned to the hospital in its totality;
- "Special Clinic" in Maputo Central Hospital. Special Clinic was a set up of paid care given in the public hospitals as a source for improving the income of these units. The Maputo Central Hospital still has the "special clinic" working, where users have to pay for the services delivered. These "special services" in the Central Hospital of Maputo constitute a differentiated hospital working as a private system. In there, users may be seen at "special consultations" or receive from medical to surgical treatment.

RESULTS

This study was very welcomed by various stakeholders encountered. There were generalized remarks made about its pertinence and need. A number of people showed interest in knowing about how the results would be used and if there would be some follow-up to the findings.

A. HEALTH CARE DELIVERY SYSTEMS AND USER PERCEPTIONS

Maputo has a population of over 2 million people. The Central Hospital of Maputo has around 1000 beds and 210 doctors, including foreign professionals. and is the highest medical reference in Mozambique. Manica has a population of 1.360.000 people and 34 medical doctors. From these, 16 are working at the provincial hospital, 9 in health clinics and at the health educational center in Chimoio. There are 9 doctors placed at the districts. Most of these doctors have cumulative functions as heads of health administrative departments. There are also 66 basic elementary midwives, 10 technicians of different medical fields such as surgery, ophthalmology, medicine or anesthesiology, 44 qualified nurses, 5 midwife-nurses and 26 mother and child care nurses. Chimoio, a town of 289 000 inhabitants, is the capital of Manica Province and has the Provincial Hospital of Chimoio with 200 beds. In this town, people enter the health system through the primary health care units, usually health posts, or where there aren't qualified nurses, at health centers i.e. clinics, some of which have consulting doctors. From these health units, depending on the complexity of care needed, patients can be referred to the provincial hospital.

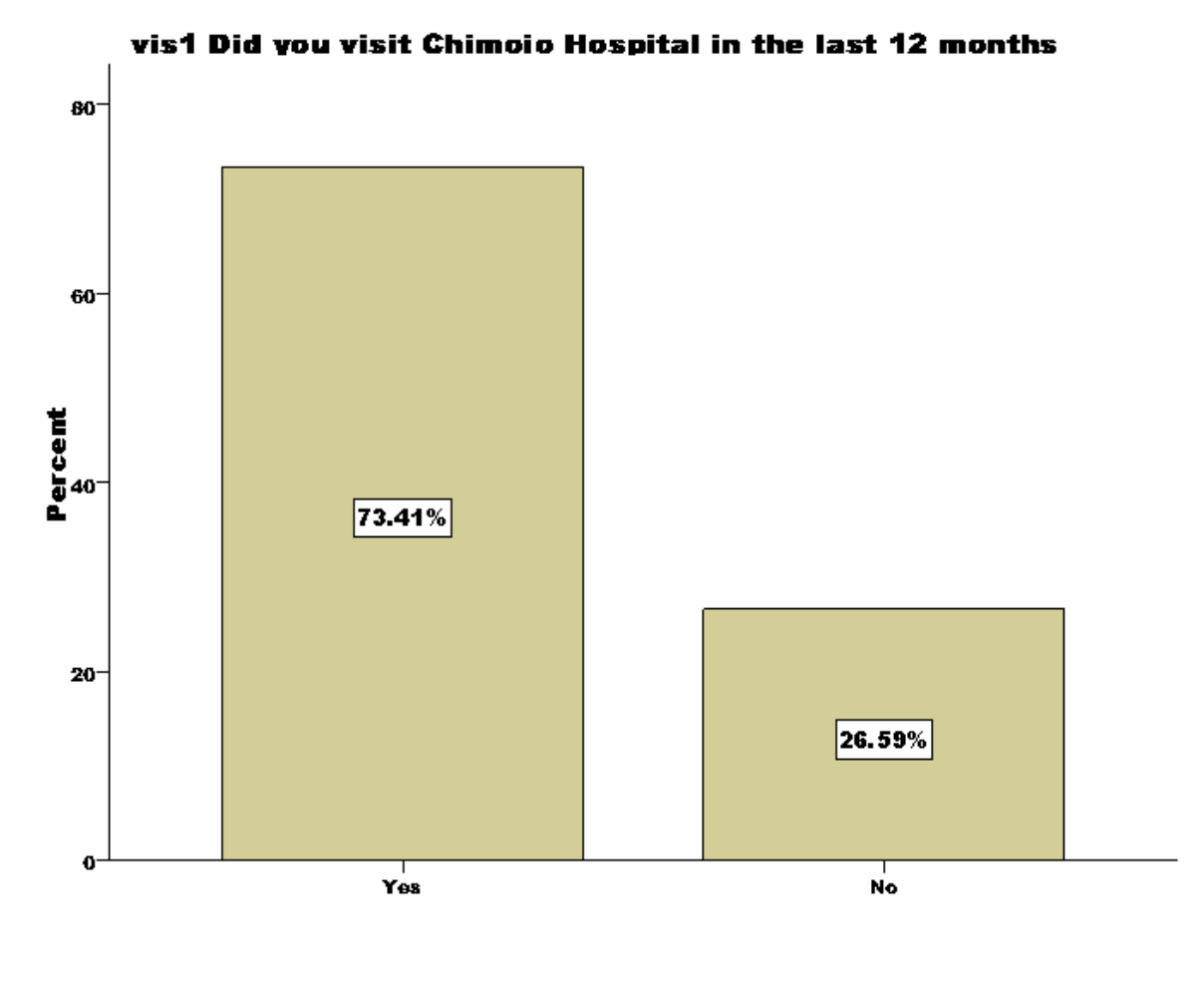
The health system has had a few set backs and has not functioned as it would be desired and needed. Qualifications of personnel are low, there are frequent shortages of medicines and inadequate infra structure. Patients looking for better services tend to ignore the lower levels of care and address themselves straight to hospitals causing overcrowding and inefficiency at these levels.

In Chimoio, there are six health centers, four for the general population, one for the army and one in the prison. The clinics have no admissions or in ward facilities, only delivery rooms. One of the health centers visited does an average of 6 deliveries per day.

Also, in this town, there is a private clinic with 12 beds and a new one to be inaugurated. All the technical staff in the private sector works for the national health system and is supposed to do private work after hours. Users have stated that they are accustomed with health care to be given for free and have demonstrated their dislike for health private services and their inability to pay for its costs.

Since September 2006, in Chimoio, there are no more "special consultations", as they were abolished at provincial level. It was a system of paid care given in the public hospitals as a source for improving the income of these units. The Maputo Central Hospital still has the system "special clinics" working, where users have to pay for the services delivered. These "special services" in HCM constitute a differentiated hospital working as a private system. Some of the directors interviewed disagree with having this type of private practice inside public hospitals and consider it as a disturbing factor for the public service and a cause of competition and elitism among doctors and nurses who are selected to work there and get better payments. According to reports it contributes to frictions and discontentment among health workers from the hospital.

The population prefers to seek care at the provincial hospitals, considered as having a better quality service and with more qualified professionals. It is a reason for discontentment to be referred back to a clinic. Most of the people spoken with in Chimoio had been to the provincial hospital and said that they would rather be seen or treated in this facility. Some had been at the clinics as the target facility, but there was a minority that had never been to the primary health care units due to acquaintances in the hospital that would book them there. In the focus groups there wasn't any one that had been to a private consultation or clinic.



The population often goes to the health unit with sick children and has to walk long distances to get there. This was an issue that aroused in the neighborhood. There is priority and sense of urgency if a child is ill. But if an adult is not sick enough to require immediate care they would rather postpone the visit to the health centre that is considered uncomfortable and unpleasant. Though there were examples of staff's kindness and dedication, when queried why they had that opinion, the majority answered that besides the trouble of being ill, they didn't like the environment and/or the staff manners in great part of the health units.

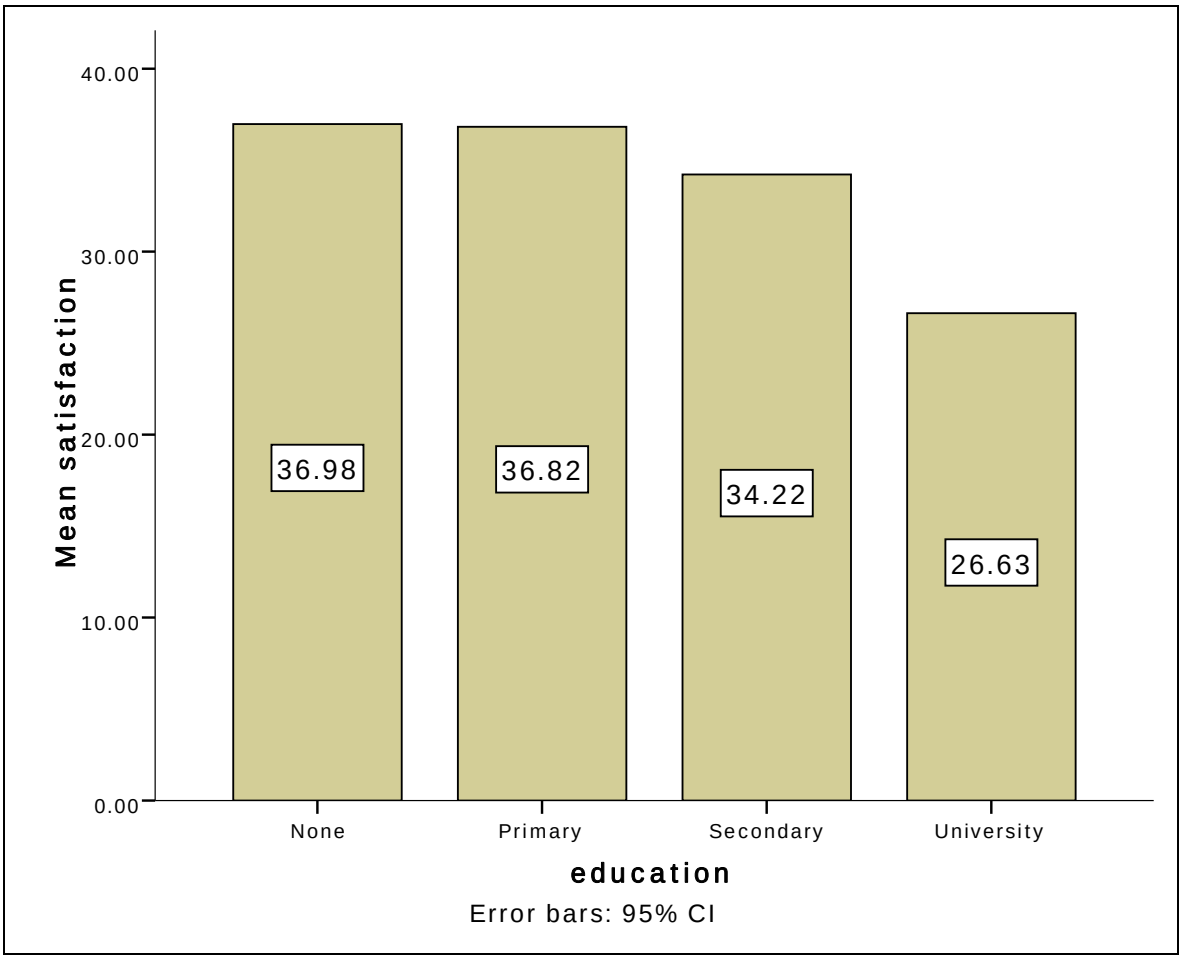
At the HCM those that are not referred to emergency services and directly or voluntarily look for attention at this department will have to pay 1 500 MZN for the service rendered after their condition was considered to be suitable for attention in peripheral health units. With this type of measure the hospital expects to promote a better channeling of patients, to narrow public access and to decrease the staff's work loads.

The overwhelming majority of the people said their names were "recorded" when they entered a facility (91%), when they saw a nurse (95%) and when they visited a doctor (91%). Some said their name was reregistered when they paid. Mostly it was done in the consulting or treatment rooms. Most of our interlocutors were given a "receipt" when they made payment for services. It was a "ticket" that "every body gets" when they arrive at the clinic to be attended. As it was explained, this "voucher" works as a receipt. With the investigation done it was ascertained that in the provincial hospital patients do have files and significantly, they can be retrieved on following visits though some get lost and patients have to open

new ones. In the clinics, patients are registered on a consultation book where name, sex, age, diagnose and summarized treatment are noted and this information feeds the statistical information process on prevalence and incidence of diseases.

It was understood that most of the focus group participants belonged to lower income brackets and possessed low levels of education. The participants associated these factors with the poor services received. The majority said that their incomes weren't sufficient to satisfy their "normal" needs considered as food, clothing, kids schooling and medical care.

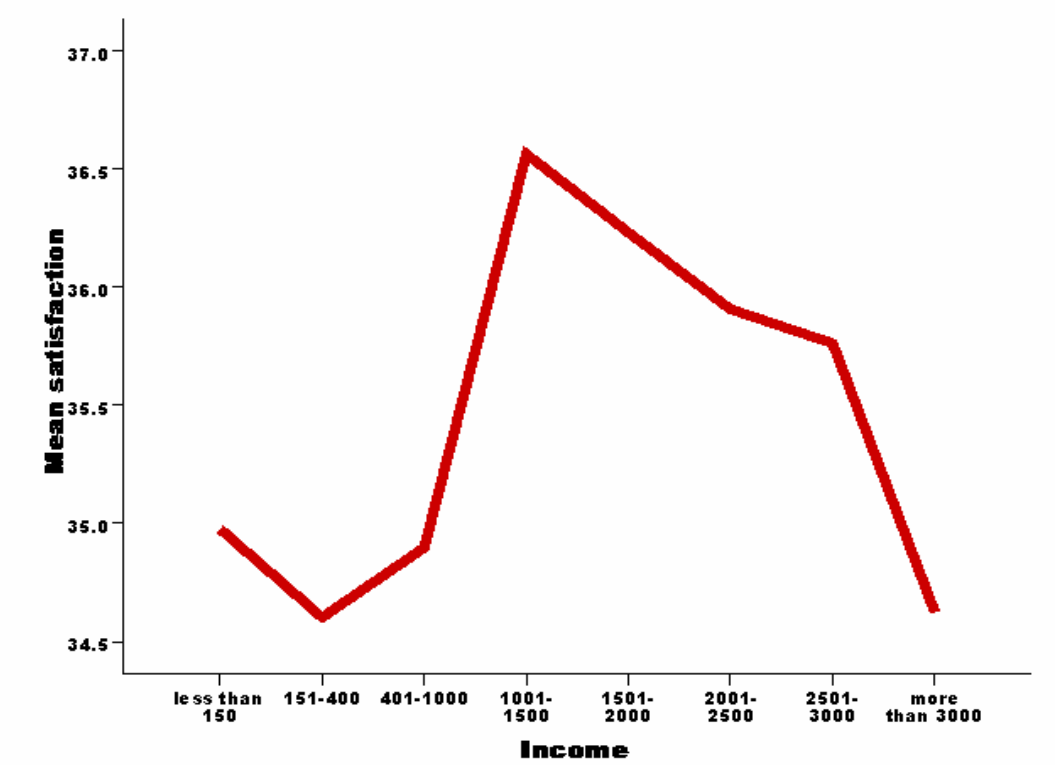
Interestingly, the survey data suggested that the level of satisfaction with health services decreased as education level increased.[1]



The survey data also suggests that as a respondent's level of income increases, his/her level of satisfaction with the services provided increased. The relationship is curvilinear. After a small decrease in satisfaction between those earning less than 150 meticais and those making 151-400, the levels of satisfaction with services increase significantly until respondents earn 1001-1500 meticais. Above 1500

[1] For purposes of better illustrating results and comparing responses across questions, the survey questions were mathematically transformed into a 0-100 scale, and then an overall measure of "satisfaction" was created by adding responses to the series. The graph belowshows the mean level of satisfaction for respondents with various education backgrounds. The way to examine this chart is to consider that each question now ranges from 0 representing poor and 100 meaning excellent service.

meticais levels of satisfaction decline so that the upper income range exhibits nearly the same level of satisfaction as those with the lowest income.



Users noticed the absence of general and clear information on posters and public notice boards about ways, procedures and channels to obtain health care and about fees, medicine prices and availability. There are complaint books in all public health services, but people interviewed said that they are not used. Patients would like to have, as a routine in consultations, an explanation of their diagnosis, treatment and its side effects.

Users of the health services complain of lack of kindness, good manners and consideration in the relationship between health personal and community. They refer sharp and aggressive commands and some cases of rudeness.

In the groups, participants showed no inhibition or reticence to talk about traditional healers or local medicine providers. Everybody had partaken of these services and expressed satisfaction from it. They would return to them any time and some noted that they go to the local traditional healer before seeking care at the clinics or hospitals. In Mozambique traditional health practitioners, including witch doctors and traditional healers, are widespread and part of the national culture. The population in general looks for their services and advice.

When asked about **corruption,** none of the people interviewed denied it. Interviewees stated that offering and accepting bribes was corruption. For health service beneficiaries bribery is the way to access public health care services. All the leaders and directors spoken to also recognized the existence of this problem and justified it as a result of the very low salaries in the health sector and the lack of morality and/or dignity. From the interviews, it was gathered that the health sector is not a stronghold for corruption, classified between light and medium in its magnitude. There haven't been any studies, surveys or investigations on this subject, done by the MOH. Corruptions existence is general knowledge, and people,

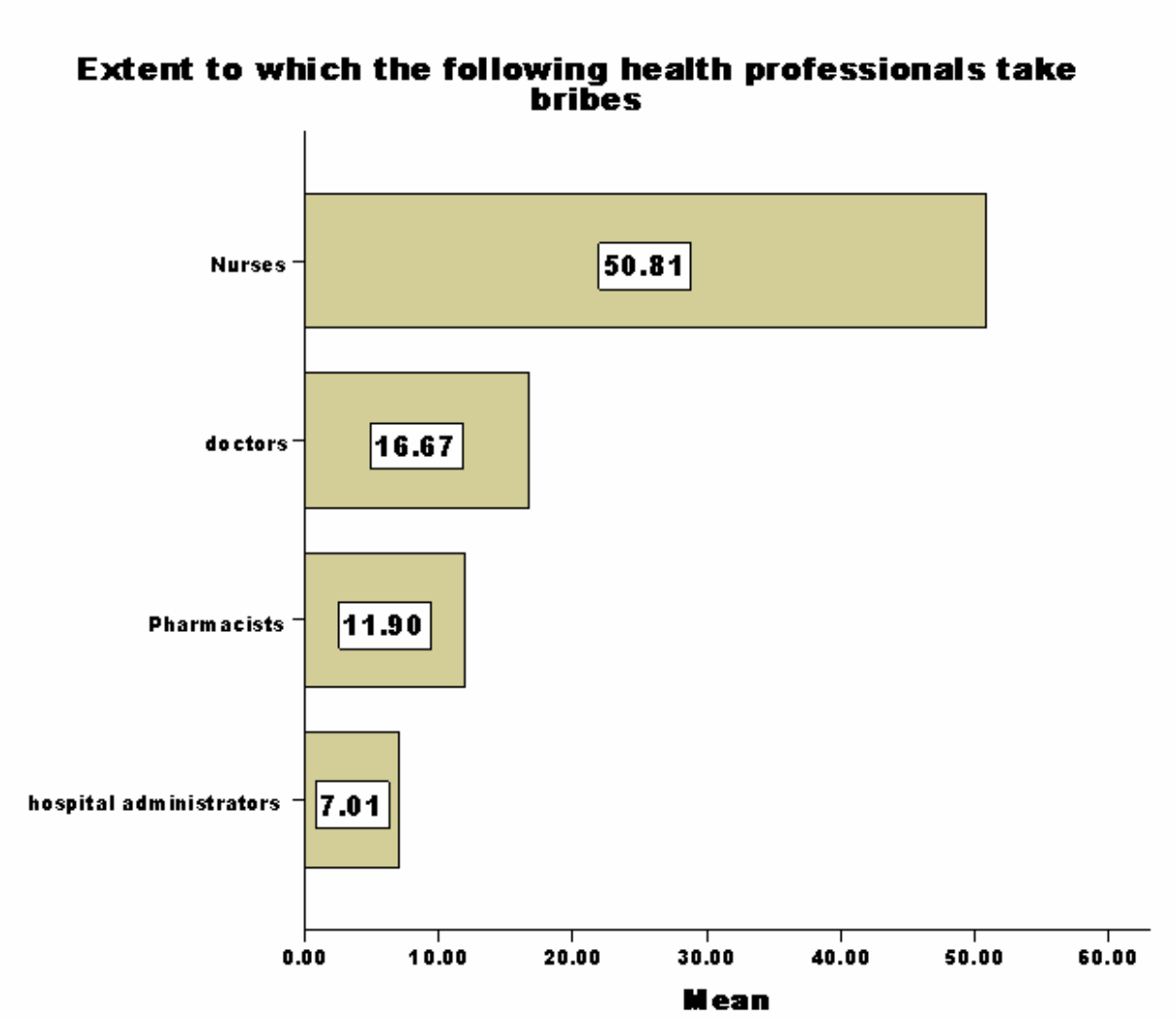
at first, talk about corruption with some reticence for fear of repercussions. Interviewed community members specified that there is fear of retaliation and revenge from health workers involved.

Cultural and political changes associated with loss of moral references were, besides low salaries, another cause indicated for corruption. Interviewed leaders mentioned that during colonial period morality was different and that church and religion had strong influences and surveillance on behaviours. After that period, revolutionary principles and socialistic ideology took over and abolished religious practices, initiating a strict and disciplined period on what concerned people's behaviour and morality. The democratization of the country allowed the population to regain or to acquire new values and principles. In some cases they were lost and these changes and lack of references allowed deviations and practices that turned out to constitute corruption. This type of analysis was done by several individuals showing that somehow, this subject must have been approached collectively.

In the public health sector, corruption is manifest on service providers mainly health units where workers are paid "under the table" to counteract the long waiting times and queues that patients have to endure to be able to set appointments, to see doctors or to be attended. It is particularly marked at the delivery services and at the pharmacies. It was frequently mentioned that in the pharmacies if extra payments are not made, most of the medicines will be lacking and the prescriptions are changed to other medicines of easier and greater availability "on behalf of being as good and much cheaper". It was reported that some of the drugs often find their way to public markets where they are sold by unqualified traders. It is possible to acquire diuretics and antibiotics among other medical goods at local markets. This seems to be the result of diversion, for private sector resale, of drugs/supplies at storage and distribution points. Theft of medicines and medical articles such as thermometers, gauze, and others, for personal use or for resale, has been mentioned.

Many respondents placed emphasis on moral and social aspects, in a wider sense than the economic but it was generalized knowledge and accepted that to be assisted in the delivery rooms, payments have to be made in amounts varying from 50 to 150 MZN. It is recognized that there is need to pay, in a non official manner, workers in delivery rooms and at the pharmacies in order to obtain services and medicines. Informal payments have also facilitated medical consultations. These payments are made especially, but not exclusively, to nurses. It was noticed that this practice is often not called corruption but rather gifts, though it fits the definition of abuse of public roles or resources and reflects the fact that corruption is not yet widely recognized among health professionals as a controllable problem or one that can be openly discussed. Some health workers refer to them as presents that the community offers since salaries are too low.

Our respondents have considered that nurses were more corrupt than other health care professionals, substantially more likely to accept bribes than doctors or administrators. Pharmacists or employees dispensing at the pharmacies were also considered very corrupt. As the field survey done in Chimoio concluded, this may reflect the fact that nurses are at the frontline of health services and most patients may only have contact with nurses, increasing the likelihood that they would need to pay bribes to nurses more often than to other professionals. The same applies to the pharmacies where patients always have to fill in their prescriptions to do the treatment and get better. Additionally, among care workers, these are less paid and more inclined to supplement their income by taking bribes.



Analysis was often complicated by difficulty of separating corruption from inefficiency, bad management or incompetence. Within the focal groups there was disagreement on events considered corruption by some participants and incompetence or gifts by others. What classified the payment as not being a gift was the fact that if assistance in the delivery room had been paid and the mother's conditions complicated to the extreme of having to be referred to a higher complexity health unit, the money given had to be returned. From these discussions it can be concluded that the population differentiates informal or corrupt payments from gifts of appreciation. It was given examples of gifts as material to dress up, goats, jewelry or food as it is practiced in Mozambican culture. It was stressed that, in the maternity wards and pharmacies, such gifts in kind weren't welcome and the payments had to be done in currency even if, for those with smaller incomes, the amounts were less than "stipulated". However, no one said that offering and accepting gifts was corruption and clarified this by explaining "how, where and .when gifts should be given".

When asked why payment was made a plurality said it was to thank the health provider for their services. However, the discussions would end with statements like "it is the way we got used with health service and we want to have the best care they can give us, so we have to pay" or "we are scared that they will leave us alone to die". About the frequency, of the need to pay to be able to get the service, respondents said that it is "much stronger now a days than before", indicating a possible increase of corruption.

Some **positive aspects** came out from the interviews and focus group discussions, worth mentioning. In the public health sector there is an effort to break down corruption and build transparency. There have been meetings, held with the communities where complaints and problems are discussed and space is given for them to be presented. Health ministry leaders gather with the population when they go to the provinces and when they go to work out of their cabinets. This policy doesn't have a regular basis and is not regulated or established as routine practice but it is seen as a way of social control. Respondents are very enthusiastic about this practice and regret that is not done on a regular and more frequent schedule. Few people had been to more than two of these meetings and most of them had participated in one. There were 6 out of 33 people that had not been to any of these events and had not heard of them.

There are special control departments where allocated inspectors evaluate and verify the application of codes of conduct, rules and the implementation of the Public Worker Statute dispositions. They don't have a working plan or a specific guide and their procedures are frequently based on what is decided by superior staff or on their own initiatives. In the Ministry of Health, this sector is valued and there are demands on the inspectors to visit health units, departments and to identify and perceive eventual irregularities. The inspectors are also present at provincial levels, although are often used for tasks other than their attributions because there is no one else available for them.

USAID by contributing to computerisation of specific systems like SIGM, an integrated management information system, has thus, improved the efficiency of management preventing events of absence of data and reduced opportunities for corruption through falsifying records.

The Mozambican State is undergoing the so called reform aimed at making the public sector become more efficient, orderly and organized. Inspection initiatives fall under the reform process and are particularly stimulated in the MOH. In Chimoio there is an effort to decrease bureaucracy in the departments, to operate quicker when issuing certificates and documents, to decrease the length of time spent with dispatch in general and with channeling and circulation of files between departments. At the MOH most people talked about the importance of the reform and their diligences to achieve better performances. The objectives of the public sector's reform are:

- To restructure public sector;
- To manage and develop human resources;
- To decentralize decision taking processes;
- To manage public finances; and
- To achieve good government of public sector.

Due to the Ministry of Health initiative and support of civil organizations, the letter with the rights and obligations of patients has been published recently and will be publicized in health units;

B. HUMAN RESOURCES / STAFF / PERSONNEL ISSUES

All interviewed people mentioned the **shortage of personnel** that the health sector experiences. It is felt by all levels and departments. Foreign cooperation has been a source of professionals to work in Mozambique. The country has foreign doctors among other superior technicians. With the new rules for the application and utilization of foreign finances conceded to the country, some areas under went restrictions. Leaders from the HCM stated that the hospital had to decrease the number of foreign medical doctors. This institution had to terminate the contracts of Russian doctors, paid around US$ 3000 a month by the Swiss Cooperation.

The subject of late arrivals and earlier departures of workers of health units was approached. It was a generalized complaint in Chimoio that doctors do not go to the health clinics and that it is difficult to have

a consultation with them. To overcome this problem in Chimoio, a roster was created for doctors to attend at health clinics. However, due to several excuses such as not being paid for fuel spent to travel to the clinics, doctors do not attend to these duties. In the focus groups people mentioned that they didn't expect to be seen by a doctor and that most of the consultations are done by nurses. Respondents generally find it difficult to schedule a doctor's appointment but if a consultation is booked with a doctor he is generally on time and does not miss his appointments. It was mentioned that other staff arrive late at work and some times leave early.

It was said that recruitment of health workers is done by contests, exams or interviews, and applicants have to contest before a board or fulfill requirements established for the post, but it is not applicable for most of the technical positions as there is a shortage of qualified people and technical staff. These professionals are fully absorbed and assigned to posts as they finish their training. A few informants stated that there are ways to go around the bureaucratic processes of contracts. As said, in hospitals and provincial directorates some workers are recruited and their salaries paid with external funds until the bureaucratic process of assignment by the state is completed.

At the national level in the health departments, most of the high level personnel, particularly those that accumulate tasks in the administration areas of work, have had management training and administrators and heads of department have attended tertiary education and have master's degrees in their fields.

It is a general perception that low salaries determine weak commitment, low quality and bad functioning of health services, and are the main cause for the amount of staff looking for work outside of the public departments and services and for corruption. It is considered that the salaries are lower in the health sector, taking in account the social content and the commitment required. It was pointed out that education and agriculture departments should also have better remuneration and that it could create motivation for technicians to work in the provinces. Doctors are "forced" by law and tradition, to work outside of Maputo and other capitals, in the provinces "to acquire experience and have contact with the country reality". Some of the interviewed mentioned that the wages are particularly low for health workers with no superior qualifications, i.e. basic, elementary and medium levels. It was also mentioned by most of the leaders interviewed that lawyers have salaries between 1000 and 1500 US dollars when they graduate and start working. The majority of the interviewed staff considers that to battle corruption amongst the health workers it would be fundamental to increase their salaries. Salaries in the public health sector are of the equivalent of 500 US dollars for a general practitioner and a specialized doctor has a monthly income equivalent to 700 US dollars. A considerable part of their salaries, near half of it, is given as subsidies. Qualified nurses have incomes per month, per person around the equivalent to 100 dollars.

Personnel salaries are paid regularly, and on time. Salary payments were illustrated with examples of technicians that while waiting for formal contracts to be established with the public service, were paid with donor's funds or finances assigned to different projects, until their contractual process was accomplished.

To **supplement their incomes**, doctors, nurses and technical health staff, work privately, in hospitals, clinics, consulting rooms and some at home on a half time or after hours basis, getting extra wages. Never the less, the large majority of the people we contacted see a doctor at public hospitals. Very few references were made about extra payments made to doctors. It was indicated several times that nurses do see patients outside of health units and charge different amounts according to the type of complaint and care required. There are professionals that refer patients to private clinics but it is dependent on the ability of patients to pay for these services.

In the Ministry of Health there were technicians paid extra "top ups" for their tasks in special programs or projects (e.g. HIV/AIDS, TB, among others) by funds of these projects. Because it was considered a non formal practice and fomenting negligence towards the main occupation of these technicians it was

abolished. It led to retirement or some technicians leaving public service to become full time freelance consultants.

At the central hospital of Maputo there are extra incomes, subsidies or "top ups" paid to the staff that work at the **"**special clinic". The profit made by these services also pays salaries of staff contracted directly by the hospital. The funds for these payments arise from the profit made by these special services that function on a private establishment basis and as a business making arrangement. Those professionals working at the "special clinic" are paid for the services rendered according to their professional qualifications and the procedures undergone by patients/clients.

It was mentioned that there have been cases of **non-qualified and non-medical people from hospitals providing health care** at home. It was stressed that it is a rare event, not generalized and not happening inside the institutions. It was said that there have been, in the past, twio or three cases of doctors that came to work in Mozambique and weren't formally qualified. Interviewed people said that this kind of occurrence is no longer possible as there are mechanisms in place to prevent it.

The health sector has in place the control system to prevent **ghost workers.** In public service there is a procedure called "proof of life" where every single worker has to present himself every year to the public notary relevant government department to demonstrate that he is alive. At the health institutions, ministry and provincial directorates, the department of human resources does the control of the personnel allocations, their transfers within the services as well as their retirement processes. The last identified cases of ghost workers happened some years ago at the central hospital of Maputo.

Respondents confirmed that there are **absences** without justification, which sometimes is given when back at work. Common excuses are death in the family or sickness. Late arrivals or early departures from work were also mentioned mainly among nurses and elementary staff. Doctors were indicated as punctual and as the professionals that most fulfill their time tables. At the central hospital of Maputo and in Chimoio this behavior was indicated as a cause for disciplinary measures.

The **disciplinary measures** applied are processes legislated by the Public Workers Statute, which go from punishments like suspension of bonus and/or salaries, to expulsion from the services. It is variable the way different departments according to who is leading them, follow and obey the rules of the statute. People interviewed refer to this code of behavior and to its application as a leading tool to apply sanctions to public workers. It was stated that there are situations of tighter control with strict referral to the rules and laws and others of benevolence or indifference. According to informants at the Central Hospital of Maputo and leaders of the Provincial Directorate of Manica the application of the statute is subjective. It could be understood from the information collected that the disciplinary control system is difficult to set in place in a regular and uniform manner and also that there is an "institutional culture" of lack of control. The application of disciplinary measures depends on who is in control. It was referred by most of the interviewed as a main purpose of the MOH in order to combat corruption and improve performances in the public service.

It is a common opinion that lack of technical and qualified staff determines precarious services. **Motivation** in the form of incentives, subsidies or bonuses, are considered weak stimuli since they are not taken into account for retirement though they are very well come and appreciated by the workers in general. People interviewed in Maputo have taken courses, received training, and specialized and received post graduate degrees overseas, as a career development support, which is considered a strong motivation by the health personnel in the health ministry. It is also assumed that these opportunities constitute a reason for staff attachment to the public health service. Working for the state in Mozambique, particularly in the health sector, is considered an opportunity to receive good education and training, with access to renowned schools and centers. In the province this practice is not as widespread. It was regretted that

these kind of motivational practices are not regulated, organized or systematic and that these opportunities appear on an *ad hoc* basis.

Most of the health workers have "incentives" in the form of subsidies. Some of them fall under the following designations: shift subsidy, risk subsidy both belonging to the public service establishment. Within the health sector there is the "food subsidy" generated by the contribution of donors. The new allocated personnel in the provinces have a "settling kit" supplied when they arrive, consisting of a radio, batteries, plates, food as chicken, fish, beans, rice, among other things. There is the isolation subsidy for staff placed out of town. Leaders that are heads of department or service, have the "chief subsidy". Those that are not in these positions, can be paid for extra hours of work on an overtime allowance, if they stay "after hours" and it is required by the work. These payments are made up to a maximum of 58 hours of total time worked in a week. People interviewed have called attention to the need for support and stimuli for medical staff working in the districts, supplying them with transport, so the ambulances are not used for such needs, with televisions as an entertaining commodity and allowing and planning their participation in courses and training.

C. HEALTH FINANCING AND FINANCIAL MANAGEMENT

According to the MOH the financial performance has to be improved considerably as well as collection, control and performance of sector revenues. The financing by different organizations that used to be done directly by projects or programs is now done in a centralized manner into a Ministry of Health fund. Funds are then distributed according to priorities and needs. MOH assumes that this prevents the use of funds for top-up payments to technicians, or for the acquisition of equipment, vehicles or on procedures considered unnecessary, illegal and unofficial.

The budget of the Central Hospital of Maputo is funded 60% by the state budget. The remaining 40% comes from the Ministry of Health, which provides support as it is able and this year made a great contribution, from donor support directly to the hospital or to specific projects, as for example the rehabilitation of pathology and biochemistry laboratories. Another source of income is the "special clinic". Funds also come from the symbolic fees paid by patients. This earmarked revenue is around 5% of Chimoio Provincial Hospital's budget. Close to one third of total health expenditure is provided through earmarked and vertical funding arrangements. The Central Hospital of Maputo has variable revenue originated on payments made by individuals that look for care in this institution without being referred to it through the appropriate channels. One of the leaders interviewed stated that the institution's budget is so small for the health unit's needs that it was embarrassing to say the amount stipulated to run the institution for a full year.

Through the MOH departments and at the provincial level, donors and financing agents require justifications for services using their finances. Users of these monies will require bank checks from the finance departments to pay for their expenses, after which they will bring receipts and suitable justifications for the expenditures.

Recently, a computerized accounts system, SISTAFE-State Financial Administration System was installed to replace the manual processing of accounts, making it more reliable and efficient. According to informants a few provinces are still undergoing training and it should be available throughout the country next year.

At the provincial level, financial data is processed until the 10^{th} of each month. There are three main books : one that registers all the requisitions presented to the financial department, one where the follow up of the budget is registered allowing knowledge of how much money is available and a third book,

where all the payments made are annotated. These are the books that are audited. Once the SISTAFE has fully been implemented, the audits will be done every three months.

There are no routine audits done at the Central Hospital of Maputo. They are performed when ordered by the directors of the hospital and applied to pertinent departments or to the institution as a whole. In the provinces these audits are done annually to the different departments from pharmacy to accounts and in Chimoio they recently had the audit done by the administrative court to check on the legality and to follow up on regulations for expenditures as well as to verify if the equipment indicated in the invoices and other documents had been acquired and were in use. Generally these audits are done by the MOH. Recently there was a controversial audit done by an external company "Ernest & Young" and the newspaper "Canal de Moçambique" published an article on the 24th of November about this subject. According to this publication there were severe irregularities with the accounts of the donor's funds and in the "PROSAUDE" fund. However, that report appears to be controversial in some quarters because others contend that it was released prematurely to the media before the MOH had the chance to comment on it and was therefore politicized. This illustrates the potential dangers of such a process failing to achieve all the intended objectives if it is not handled very carefully.

D. PROCUREMENT, PURCHASING AND DISTRIBUTION SYSTEMS FOR SUPPLIES AND EQUIPMENT

The Center for Medicines and Medical Supplies (CMAM) is responsible for implementing or managing most logistic activities related to drugs and medical articles. CMAM currently reports to the Pharmacy Department which reports to the Director for National Health, who in turn reports to the Minister of Health.

The Minister of Health has announced potential reorganization of MOH that would place CMAM under de Directorate for Medical Assistance (DAM). Since DAM reports directly to the Minister of Health, this future change would be beneficial to the overall program management.

CMAM is tasked with forecasting drug needs, directing the procurement of these drugs through Medimoc, a public-private partnership[2] that CMAM has outsourced for the procurement, clearance, central level storage and in country distribution. CMAM has around 40 staff members. Many of these positions were held by a group of "technical assistants" that were not civil servants, who worked under contract to MOH. The Minister of Health determined that these positions should be fulfilled by civil servants as all CMAM employees.

There are norms and guidelines established by the state to acquire goods, medicines and services. The acquisition has to go through specific tenders and bids. According to ruling order 54/2005, at least three quotations have to be presented. Invitation letters are elaborated and there are specific entities to which those letters are addressed as for example pharmaceutical companies. Goods and medicines acquired are sent to the health care unit's through the Provincial Health Directorates that have supplied the information on their demands. These orders are not made regularly. There are frequent stock outs and there is no feedback on what is available, missing or delayed to be supplied.

At the hospitals and provincial directorates there are several warehouses for medical and surgical material and a specific one for medicines. These goods are delivered to pertinent departments following administrative criteria like requisitions on standard models and remittance or delivery bills. In the storehouses, there are card indexes for the management of these goods, including shelve records and stock

[2]Medimoc used to be a state-owned enterprise which was privatised in the 1990s, with the Government retaining 30% ownership.

records, to allow the physical and financial control of these materials. Inventories to determine existing stock are taken every three, six and twelve months. Threshold levels indicate at what point orders should be placed and monthly information on availability of drugs is given to the Provincial Pharmacy Department. All of these procedures are done manually. Informants stressed out that they are also not done on a steady and regular basis allowing frequent stock outs of materials and medicines.

The national drugs formulary has not been updated and does not correspond with the availability of medicines. It is more than 20 years old. There are not studies on what drugs should be purchased regularly or seasonally. People interviewed pointed out that a computerized system existed to control medicines called STK that turned out to be fragile, inconsistent and unable to hold the amount of information supplied. It is no longer used and the MOH has introduced a new system, SIGM (Integrated System of Management of Medicines), which is being tested at the central level and several provinces. In Chimoio they have acquired the package. Informants revealed that a need for new computers able to host this system and trained personnel to operate it.

SIGM is an integrated management information system to manage procurement, stock across multiple stores and distribution among and between levels in the supply chain. The modules of the software include planning, procurement, distribution and warehousing. It should also manage financial transactions related to stock management. This system would be able to track the stock level of any drug at any facility making it possible to estimate consumption of any drug based on issues from the lowest computerized level in the system. This project is sponsored and supported by USAID and will prevent most of the problems related to medicine management. It is divided into two phases with the first one near its end.

Health facilities in Chimoio do not have suitable storage conditions for medicines. They are adapted without shelves and acclimatization. The medicine boxes are piled up and some have been damaged. Interviewees also complain about the lack of transport and qualified and trained personnel. In Chimoio there is one pharmacist and two pharmacy technicians. Chimoio was out of second line malaria treatment drugs and oral quinine due to central stock outs. One of the focus group members said that he had to interrupt his ARV treatment due to lack of medicines.

CONCLUSIONS

The main problems that came to light in the course of this study were:

- Low salaries in the public sector are a cause for corruption. Subsidies and bonuses do not constitute sufficient stimuli to discourage corruption or even to significantly improve working methods, quality and efficiency because they are not taken into account in calculating pensions at retirement;
- Prevalence of corrupt and illegal practices, including widespread informal payments;
- Staff shortage in health facilities; lack of qualified and specialized professionals;
- Insufficient health budget
- Lack of regular and effective control mechanisms particularly of management and weak enforcement of discipline and sanctions;
- Lack of computerized systems for management, records and data (but this is being addressed);
- Lack of clear information to users, including lack of communication with users of the health system as well as public notices;
- Lack of regular audits of public spending;
- Frequent stock outs and precarious storage of medicines;

The Mozambican system has some points worth noting. For instance, in order to address the well-known problem of 'ghost workers', all public officials are required to attend 'proof of life' annually, by showing up in person at the relevant Government department. Another significant initiative aimed at addressing problems of transparency and break down corruption is the new practice of holding meetings with communities by Government officials to solicit their views and discuss their complaints regarding local services and other issues. Attention is being dedicated to discipline and control working practices in the MOH through implementing public employee's codes of conduct and reactivating inspection cabinets. MOH has started to computerize sensitive areas as procurement and finance and is investing in those sectors.

RECOMMENDATIONS

The main recommendations arising from this study are as follows:

- Health authorities should develop regular communication with members of the government and parliamentarians about the health situation, problems and difficulties, priorities and budget executions.
- To prevent corruption in the health sector, strategies and more effective control is needed and users should have their space to present complaints. These spaces should be regulated and assumed as a right of the communities. Commitment could also be built by demonstrating how reducing corruption can result in better health outcomes, improved quality and expanded access. It is part of the strategies to reinforce social control and the role of civil society in helping to check abuses. Create a way to denunciate events of corruption or informal activities. Local communities and civil society organizations could be given a formal oversight role over local services either through popular councils that have their representatives sitting in the regular evaluation meetings and participating in the decision taking processes. Brazil has legislated Health Councils that work at local, provincial and national levels where communities participate regularly in the health management processes. The role of civil society can be enhanced by making certain tools available to use in their oversight responsibilities. Two of such tools are the Citizens' Report Card (CRC) and the Service Delivery Survey (SDS). These tools allow clarification about the destination of public funds and transparency of the budget, giving at the same time empowerment to the communities. The population is supplied with survey data on facility performance and uses this data to engage with facility management, offering local oversight. It is a powerful tool for ensuring transparency and accountability to local communities. NGOs and civil society groups fighting for transparence and against corruption should be involved.
- Address the problem of low salaries for public sector employees promoting better remuneration for work and connect incentives and extra salaries to the performance of employees. Low salaries are a temptation for corruption and their improvement has an easier and direct role on understanding and fighting corruption. Some portion of personnel remuneration can be tied to performance. This performance can be evaluated by putting into place mechanisms of collective and democratic systems with attribution of points by co-workers and others involved.
- Reduction of corruption level can also be obtained by creating or increasing visibility or transparency of staff behavior and activities at work. When staff have their actions observed and this practice is institutionalized the possibility of detection of irregularities is higher. The potential of being punished for infringement or corruption are strong incentives against such behavior, particularly when associated to salary increases.

- Complete the computerization process, develop electronic archives .and ensure the national systems of procurement, storage and maintenance to be electronically operated. It would allow control and follow up of management issues and budgets promoting efficiency and quality. When there are working conditions to improve performances, employees become less prone to negligent behaviors and get more involved and compliant with obligations and tasks, gain respect for correct procedures and accuracy. It would also facilitate immensely the audit trails.
- Call on the assistance of development partners to make use of the tools of public expenditure management such as the Public Expenditure Tracking Survey (PETS) as a means of improving efficiency and transparency of public spending. Institutionalize regular internal and external audits, ensuring independence and competency of audit institutions. Implant strict application of sanctions for misappropriation which will also facilitate the process of decentralization of management.
- Encourage investments in the public health sector as a mean to develop the sector, ameliorate resources and to improve the quality of health care.
- Within the context of PARPA (Absolute Poverty Reduction Plan) in Mozambique, and to improve management of the budget and public expenditures, encourage greater transparency and make financial information available to the public in a systematic and comprehensible manner, ensuring public education on budgets and using methodology that makes it easier to understand.
- Procedure manuals are important standardizing and controlling tools. Institutionalize technical procedure manuals and make use of them at the health facilities and known by the health staff. With these manuals work tasks become standardized and agile. It is also a support to over loaded staff.
- Elaborate and formalize internal control of the MOH using the already existing inspectors with manuals of procedures and routine tasks to be developed. Institutionalize procedure manuals for public funds execution with regular and formal control.
- Institute career development plans for public officials and associate it to a log book system as it is done in South Africa with *Continual Medical Education*.
- Create a training and educational plan for health professionals under internal control and according to the needs of the institutions and/or departments.
- Develop a new national formulary of drugs and an essential drugs list keeping the generic names to increase the objectivity and transparency of the pharmaceutical selection process and to guide professionals in their prescriptions.

ANNEX G: TANZANIA COUNTRY REPORT

USAID
FROM THE AMERICAN PEOPLE

EFFICIENT AND TRANSPARENT SERVICE DELIVERY IN PUBLIC HOSPITALS – A CASE STUDY OF TANZANIA

JANUARY 2007

This publication was produced for review by the United States Agency for International Development. It was prepared by Peter Riwa of HLSP, with contributions from Orlando J. Perez with Management Systems International.

EFFICIENT AND TRANSPARENT SERVICE DELIVERY IN PUBLIC HOSPITALS – A CASE STUDY OF TANZANIA

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CONTENTS

ACRONYMS AND ABBREVIATIONS

ARVs	Anti-Retroviral
CSO	Civil Society Organization
DANIDA	Danish International Development Agency
DFID	United Kingdom Department of International Development
EAs	Enumeration Areas
FY	Financial Year
GTZ	German International Cooperation Enterprise
HSBF	Health Sector Basket Fund
NACSAP	National Anti-Corruption Strategy and Action Plan
NGO	Non Governmental Organization
NORAD	Norwegian Agency for Development Cooperation
PRINMAT	Private Nurses and Midwives Tanzania
REPOA	Research on Poverty Alleviation
SWAP	Sector–wide Approach
SDC	Swiss Agency for Development and Cooperation
TPHA	Tanzania Public Health Association
TAMWA	Tanzania Media Women Association
US	United States
WAMATA	Walio katika Mapamabano ya UKIMWI Tanzania

PURPOSE OF THE STUDY

The study was conducted for the purpose of exploring practical opportunities for strengthening the health care delivery system in Tanzania to provide more responsive, efficient, transparent and accountable healthcare services. The study examined the delivery of healthcare services from a health systems point of view that explores perceptions of service users' of barriers to accessing transparent and responsive services, and evaluates system weaknesses and the national expenditure process from which health facilities derive their budgets to provide services.

This country-specific report was produced as part of a broader cross-national comparative study of transparency, accountability, and efficiency in health service delivery in Benin, Mozambique and Tanzania. It is intended as an analysis of information compiled during literature reviews and in-country surveys and interviews, and represents an initial examination of corruption in the country's health system. This report should serve as a foundation and building block for future, more in-depth reports. While it can be read as a standalone piece, the comparative report provides a larger examination of the causes of corruption and recommendations for more transparent and efficient health service provision.

METHODOLOGY

Data for this study was collected through an extensive literature review and a household survey followed by in-depth interviews with representatives of selected non-governmental organizations (NGOs)[1] to validate survey results and develop recommendations. Due to complications in obtaining the necessary authorizations, the study team did not have the opportunity to meet with national stakeholders such as target facility administrators or personnel. For the surveys, the study team used the MSI standardized questionnaire as a tool for this assignment. The study was conducted in two regions of Tanzania mainland, Dar es Salaam and Arusha, with one major hospital in each -- Muhimbili National Hospital and Mt Meru Regional Hospital respectively. The information gathered in the 2002 Population and Housing Census (households) about the wards surrounding these establishments was used as a Master Sampling Frame for this survey. The sampling frame included both individuals who use the aforementioned facilities and those who do not.

TRAINING

Before field work, training was conducted for three days to cover the objectives of the study, questionnaire design, and interpretation of questions to be asked. As part of the training, attendees participated in a role play exercise to hone their questioning skills.

CONTEXT

Tanzania is the largest member of the East African Community covering a surface area of 947,000 square kilometres with a population of about 34,569,232 and growing at an average rate of 2.9 percent annually.

[1] TPHA, WAMATA, REPOA, PRIMAT, TANA and TAMWA

After introducing economic reforms in the past decade, Tanzania has achieved an impressive level of macro-economic stability and growth. Tanzania is among ten sub-Saharan Africa countries with the fastest growing economies. Overall GDP growth rate has steadily risen from 4.0 percent in 1998 to 6.8 percent in 2005. Inflation rate has consistently declined in the recent past from an average of 30 percent in 1995 to 4 percent in 2004.

Over the past decade a Health Sector Reform Programme was initiated to put in place structures and institutional arrangements such as the Health Service Board and Health Facility Governing Committees which are geared at increasing transparency in decision-making and ownership of health services among the local authorities. The results include:

- 34 Boards have been inaugurated, 103 Councils have been sensitized and are at various levels of establishing such Boards and Committees.
- The supply of medical and diagnostic supplies as well as equipment in public health centers and hospitals has been improved by modernizing the Medical Stores Department.
- Strengthening of the MSD's capacity has led to the improvement in service delivery to regional and district health centers, curbed the inefficiency of middle men in drug procurement; effective and efficient delivery of drugs, and improved quality of drugs.
- Introduction of (1) Community Health Fund (CHF), a prepayment financing mechanism for mobilizing additional resources through community involvement.

HEALTH POLICY

The national health policy is considered a sectoral strategy for achieving the Tanzania Development Vision 2025. The policy states that "the role of the Ministry of Health is to raise and improve the health status and life expectancy of the people of Tanzania by ensuring "effective, efficient and quality curative, preventive, promotive and rehabilitative health services at all levels".[2]

FORMAL HEALTH SYSTEM AND STRUCTURE

Tanzania has a total of 4,990 service delivery points[3] under public, NGO and private sector management. The type and quality of health services provided depend on the technical competence of staff and the supply environment for health care. The structure of the health care delivery is pyramidal with three levels of care.

PRIMARY LEVEL HEALTH CARE

The primary level consists of dispensaries, health centers and district hospitals. Dispensaries and health centers are the most numerous type of health care facilities and they are entry points for almost 80 percent of the population. According to the national health policy, a dispensary serves 5,000 people and a health center serves about 50,000 people. According to establishment regulations, facilities are supposed to be staffed by a clinical officer, who treats and refers cases, two nurses and an auxiliary. However, these positions remain unfilled in many facilities due to challenges of recruiting and posting by the local government. Under the health sector reforms, primary level health facilities fall under the purview of local government and are managed by health facility boards.

[2] Ministry of Health, National Health Policy, October 2003 pg 4
[3] Ministry of Health, Health Statistics Abstract, 2002 pg 5

SECONDARY LEVEL HEALTH CARE

The secondary level of health care is comprised of 21 regional hospitals, which are referral points for lower level health facilities, for specialized services like pediatrics, surgery and technical supervision. Also, the regional level coordinates supplies to the district hospitals. In terms of health system management, the regional level is charged with coordination and supervision of the lower level of health care. Like the district facilities, regional hospitals are under the local government authority.

TERTIARY LEVEL OF HEALTH CARE

The tertiary level is comprised of four specialised hospitals, which include Bugando, KCMC, Muhimbili National Hospital and Mbeya referral hospital. These four hospitals handle referrals from regional hospitals for specialized care unavailable at lower levels. There are additional hospitals that do not fit strictly into the above structure but which provide specific services for oncology (Ocean road hospital in Dar es Salaam), psychiatry (Mirembe hospital in Dodoma), orthopedic (Muhimbili Orthopaedic Institute) and tuberculosis (Kibongoto hospital in Kilimanjaro) patients. The tertiary level and specialized health institutions are under the Ministry of Health's direct management.

Table 1. Total Number of Health Facilities by Type and Ownership

	Type of facility	Public	Voluntary	Parastatal	Private	Total
1	Dispensaries	2,683	598	187	912	4,380
2	Health Centres	292	69	5	36	402
3	Hospitals	85	81	13	29	208
	Total	3,060	748	205	977	4,990

Source: Health Statistics Abstract 2002

HEALTH SECTOR FINANCING

Financing of public health sector services is covered through annual budgetary allocations from the central government, contributions from development partners and from local government sources including community insurance and cost recovery schemes. Central government allocations are spent on recurring costs (staff salaries, utilities, supplies and equipment) and for development costs (construction and purchase of capital goods). Development partners provide financing at the national, regional and district level. In 1998, the Ministry of Health and donors established a sector-wide joint funding mechanism to increase coording between government and donor health programs. Eight donors namely DANIDA, DFID, GTZ/KfW, Irish Aid, Netherlands, NORAD, SDC and the World Bank chose to use this Health Sector Basket Fund (HSBF) to deliver aid to the health sector.[3] The HSBF to the central Ministry of Health finances an agreed annual plan of action and generally follows government financial rules and procedures. Ministry of Health expenditures have increased significantly from Tshs 141 billion in FY 2001/02 to Tshs 220.01 billion in FY 2003/04. See table 2 below.

[3] Graham Hobbs ESRF, The Health Sector –Wide Approach and the Health Sector Basket Fund, Final Report, February 2001 pg 5

Table 2. Total Health Expenditure 2001/02 to 2003/04 (in Billion Tshs)

Budget Item	2001/02	2002/03	2003/04	2004/05 (budget)
Recurrent	117.15	143.14	173.31	241.04
Develop	23.86	33.21	46.79	71.77
Total	141.01	176.35	220.10	312.81

Source: Ministry of Health, Appraisal Report 2nd Health Rehabilitation Report

HSBF funding to district councils is restricted to recurrent expenditures, excluding personnel compensation. Councils prepare an annual health plan, which includes all recurrent and development expenditures, and indicates the source of funding. In FY 2000 allocation to district councils was 50 US cents per capita.

To broaden the resource base for health care financing, the government has introduced a number of mechanisms to generate additional funding for health facilities such as Drug Revolving Fund, Cost Sharing at all hospitals, and Community Health Schemes, with due attention paid to the indigent and vulnerable.

KEY PLAYERS AND PARTNERS IN THE HEALTH SECTOR

The public remains dominant in health care delivery. About 60 percent of health services are provided by public health facilities and the remaining 40 percent is provided by voluntary agencies predominantly, faith-based organizations. Private sector contributions have increased recently following deregulation of private sector.

HEALTH STATUS INDICATORS

Tanzania health indicators are poor and the situation has recently deteriorated due to the HIV/AIDS epidemic. According to the Tanzania Demographic and Health Surveys 2004-2005 life expectancy at birth is estimated at 54 and 56 years for males and females respectively. The low expectation of life at birth underscores high levels of infant (69/1000 live births) and under 5 mortality (112 per 1000). Maternal mortality is unacceptably high. The 2004-05 TDHS estimated the level of maternal mortality at 578/100,000 live births.

SOUCES OF INEFFICIENCY IN THE HEALTH SECTOR

Corruption in Tanzania is viewed as a problem cutting across all sectors and walks of life. Some use words such as systemic, endemic or norm just to underscore the extent to which corruption is entrenched in public life. Corruption appears to be publicly condemned and denounced but privately tolerated by many and acceptable to some. Institutions have rules and regulations in place to fight corruption. Nevertheless, opportunities for corruption or inefficiencies in the health sector present themselves in many ways.

While information on health sector efficiency is mostly anecdotal, the government acknowledges the existence of inefficiency and lack of transparency in the public sector.

> Corruption is still a major problem in the country. Corruption, defined as the use of public office for private gain, is not only a question of individual criminal acts but is also a result of failure in public administration systems. Weak public administration and financial management systems do contribute significantly to spread of corruption in a country. Corruption is also caused by inadequate and weak laws and sanctions, a weak institutional framework for good governance, oversight and accountability. Furthermore, corruption thrives due to low levels of literacy, ignorance, lack of confidence among the population to demand their rights, the public's ambivalence to the misuse of public funds and also the lack of action against those who enrich themselves through misuse of public resources.[4] Corruption frustrates any efforts to provide the public with efficient basic services including health services.

Recently, the government estimated annual losses of Tshs 4,703 million through dubious procurement.[5]

Talking to individuals one hears many stories of corruption. Here we present only the most common types.

USE OF PUBLIC FACILITIES FOR PRIVATE GAIN

This is most common and not considered by many as a form of corruption. However, by definition corruption is use of any public utility for private gain. In the health sector this manifests itself in many forms. The most common is the use of health facilities by care providers during official and un-official hours to conduct activities for which they receive private payment. Typical examples: Doctors conducting laboratory tests in a public hospital and ending up using the test results in a private clinic to treat the patient. In this way the patient feels favored by the doctor and in the eyes of the public the payment does not constitute corruption.

PROCUREMENT OF GOODS AND SERVICES

Anecdotes in this area relayed that the quantity and or quality of goods and services procured was lower than the amount of money charged warranted. The difference enters into private hands.

While procurement of goods and services is undertaken at all levels of the system, the difference lies in the size of procurement at each level. The biggest procurements occur at the central level – the Ministry and its specialized departments and institutions. Significant procurement of goods also is undertaken at the regional and district level. The least amount of procurement occurs at health centers and dispensaries. At all levels of government procurement procedures are used in the award of tenders. However, opportunities for corruption exist within the framework ranging from solicitation to award of tenders. Still some donors demand stronger government procedures. For example in FY 1999/2000, HSBF-donors were unwilling to use MoH procurement procedures for HSBF funds.[6]

[4] URT/President's Office The National Anti-Corruption Strategy and Sector Specific Action Plans for All Ministries, Independent Government Departments, Executive Agencies and Local Authorities (2006-2010) pg 1
[5] The Guardian, Wednesday December 13, 2006.
[6] Graham Hobbs, op cit pg 36

SOLICITATION FOR GIFT OR "CHAI /TEA" FOR SERVICE

A health care provider asks for gifts from patients and their relatives. Euphemistically providers tell the victim "I have not taken my cup of tea" or "lunch" to solicit a gift. Patients are reported to give out gifts to solicit convenient or better service.

DEMAND AND ACCEPTANCE OF GIFTS IN CASH AND IN KIND

It is reported that health care providers use indirect means to demand gifts in cash or in kind from patients and their relatives. Some use euphemisms described above like "*sijanywa chai"* – I have not taken my tea -while other just make it inconvenient for the patient to access service. Common among doctors is giving a referral date too far in the future for situations that clearly need immediate attention. In the laboratory, providers report a false equipment and machine breakdown or shortage of expendable supplies. If the patient in turn offers a gift service is provided sometimes claiming the supplies are from his own source.

COMMISSION ON GRANTS

Agents administering grants to NGOs and Civil Society Organisations (CSOs) ask for a commission on the grant. In many cases the commission is contingent to the grant itself. Use of CSO is a preference because they have weak financial systems used for accounting for the loss. One NGO lamented that they were informed that "they can not be funded because they behaved like born again." On one occasion a CSO had to give a granting officer Tshs30 million from a grant of 70million. It is believed the CSO had to drop some training activities.

HUMAN RESOURCE MANAGEMENT

Human resource management in the health sector includes recruitment for training in health institutions, deployment of trainees, staff recruitment, posting and promotion. Cash demands and in kind requests including sex are reported in the human resource management process.

GOVERNMENT ACTION

The Government of Tanzania regards corruption as one of the worst impediments to economic development and has abundantly made it clear that corruption in all its manifestations is not acceptable. Government policy on corruption is zero tolerance.

Former President Benjamin William Mkapa formed the Presidential Commission of Inquiry against Corruption in 1996**,** to undertake a study on corruption in the country. The Commission's findings and recommendations constituted a major advance in the country's efforts to fight corruption in recent years. The Commission's report, commonly known as the Warioba Commission Report, also provided a vision for dealing with the problem of corruption in the short, medium and long terms. The recommendations called for cleaning up among leadership ranks and strengthening ethics in the public service. It also called for the strengthening of appointment and recruitment procedures, enhancing accountability, and strengthening institutions charged with combating corruption.

The report was made public and all ministries and government leaders were directed to implement the recommendations that affected their areas of jurisdiction. They were to use administrative steps and apply regulations in order to control corruption in ministries, regional administrations and local government authorities. Since then, implementation of the recommendations of the Warioba Commission has been ongoing.

In 1999, the Government prepared, and operationalized the National Anti-Corruption Strategy and Action Plan for Tanzania (NACSAP). The document acknowledged that progress in the battle against corruption is dependant on a combination of several factors. These factors were supposed to reduce both the opportunity and motivation for corruption. In order to increase chances for success, a coherent and holistic approach was required. Thus, the strategy took a multi-pronged approach and was guided by four principles - prevention, law enforcement, public awareness and institutional building. Specifically, NACSAP called for coordinated efforts to achieve the following:

- Reforming government institutions to institute financial discipline and improve service delivery.
- Raising public awareness to combat corruption.
- Increasing transparency, accountability and integrity in government business.
- Involving civil society and the private sector in the fight against corruption.
- Coordinating, monitoring and evaluating the progress of anti-corruption efforts.
- Enacting and enforcing laws aimed at fighting corruption and enhancing good governance.

In 2001, the Government with the support of the United Nations Development Programme (UNDP) and other Development Partners, launched the project Strengthening Capacities to Combat Corruption in Tanzania. The project was aimed at supporting the Government of Tanzania in its efforts to raise the standard of good governance in the country and supporting implementation of the National Anti-Corruption Strategy and Action Plan. The immediate objectives of the project included:

- Ministry, independent government department and agecy assisting in the coordination and monitoring of the implementation of anti-corruption sectoral plans.
- Supporting, involving and promoting NGOs, civil society and the media to participate in the fight against corruption.
- Publicizing efforts to combat corruption and raise public awareness.

The project was executed under the Office of the President and implemented through the Corruption Prevention Bureau, the UNDP and ministries, independent departments and agencies. Generally, this project is applauded for establishing the GGCU, producing the 2002 annual state of corruption report, producing the PCB newsletter and training PCB and MDA personnel.

FACILITY LEVEL ISSUES

KEY FINDINGS

CORRUPTION IN THE HEALTH CARE DELIVERY SYSTEM

The survey asked a number of questions related to issues of corruption and transparency in the health care system. The questions focused on payment fraud and payment of “gifts” or bribes, perceptions of corruption among various health care workers, and levels of transparency among institutions associated with the health care system.

Respondents were asked about the likelihood of having to pay a "gift" in various health care situations.[7] Figure 1 shows the results. On a 0-100 scale, where 0 means never and 100 always, the service that requires the most gifts is to avoid waiting in long lines before treatment by a doctor.

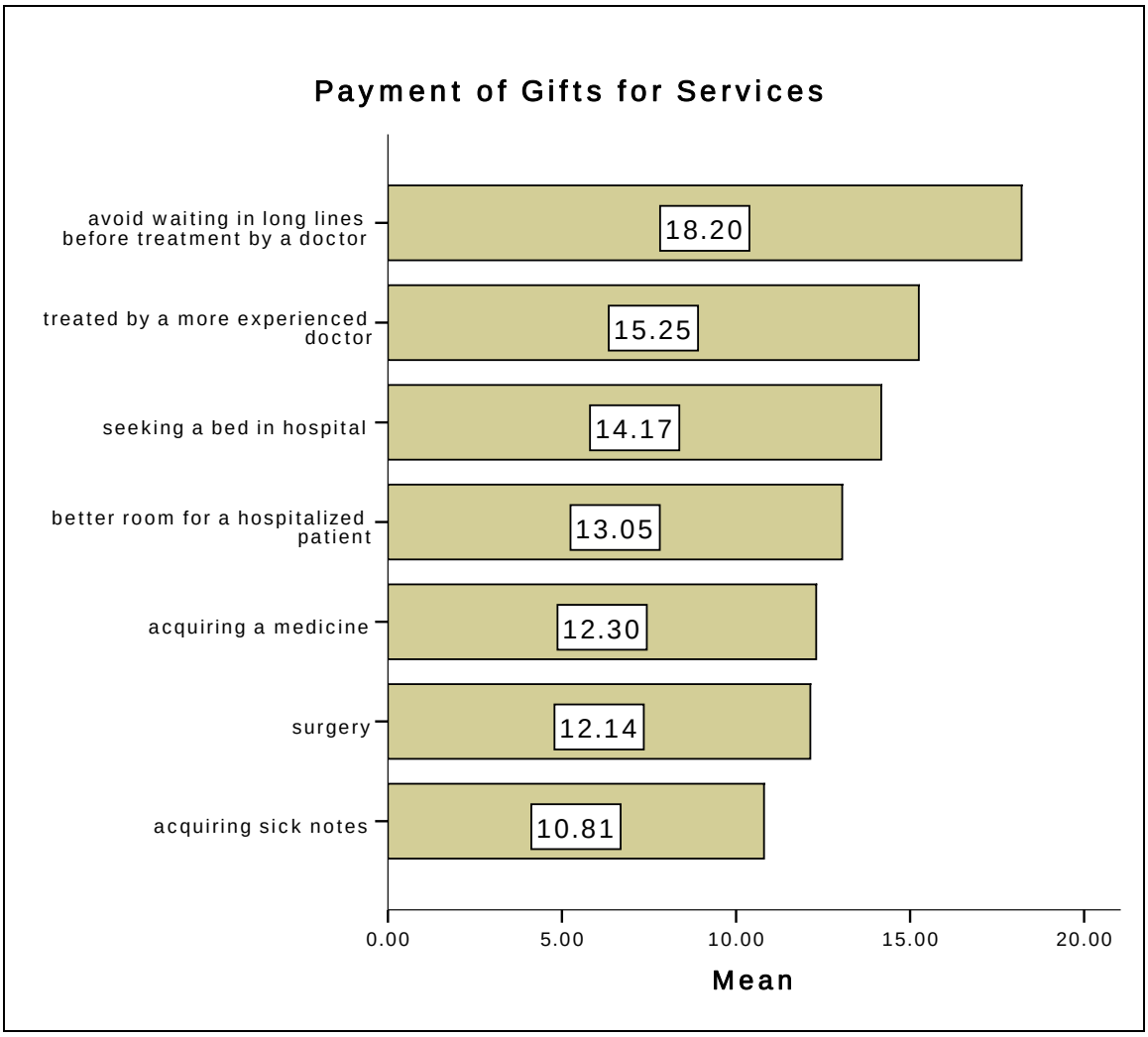


Figure 1

Using the same scale the survey asked about prevalence of bribe taking by several health care providers. Survey data suggests that respondents perceive that nurses are the most corrupt health care professionals, substantially more likely to accept bribes than doctors, administrators or pharmacists. This may reflect the fact that nurses are at the frontline of service delivery and most patients may only have contact with nurses, thus increasing the likelihood that they would need to pay bribes to nurses more often than to other professionals. Additionally, nurses are likely the least paid of these health care workers and thus more inclined to need to supplement their income by taking bribes.

[7] These questions were asked using a 1-7 scale, where 1 represents that "gifts" are not ever necessary and 7 that they are always necessary. For purposes of analysis and presentation, the scales have been transformed into a 0-100 metric.

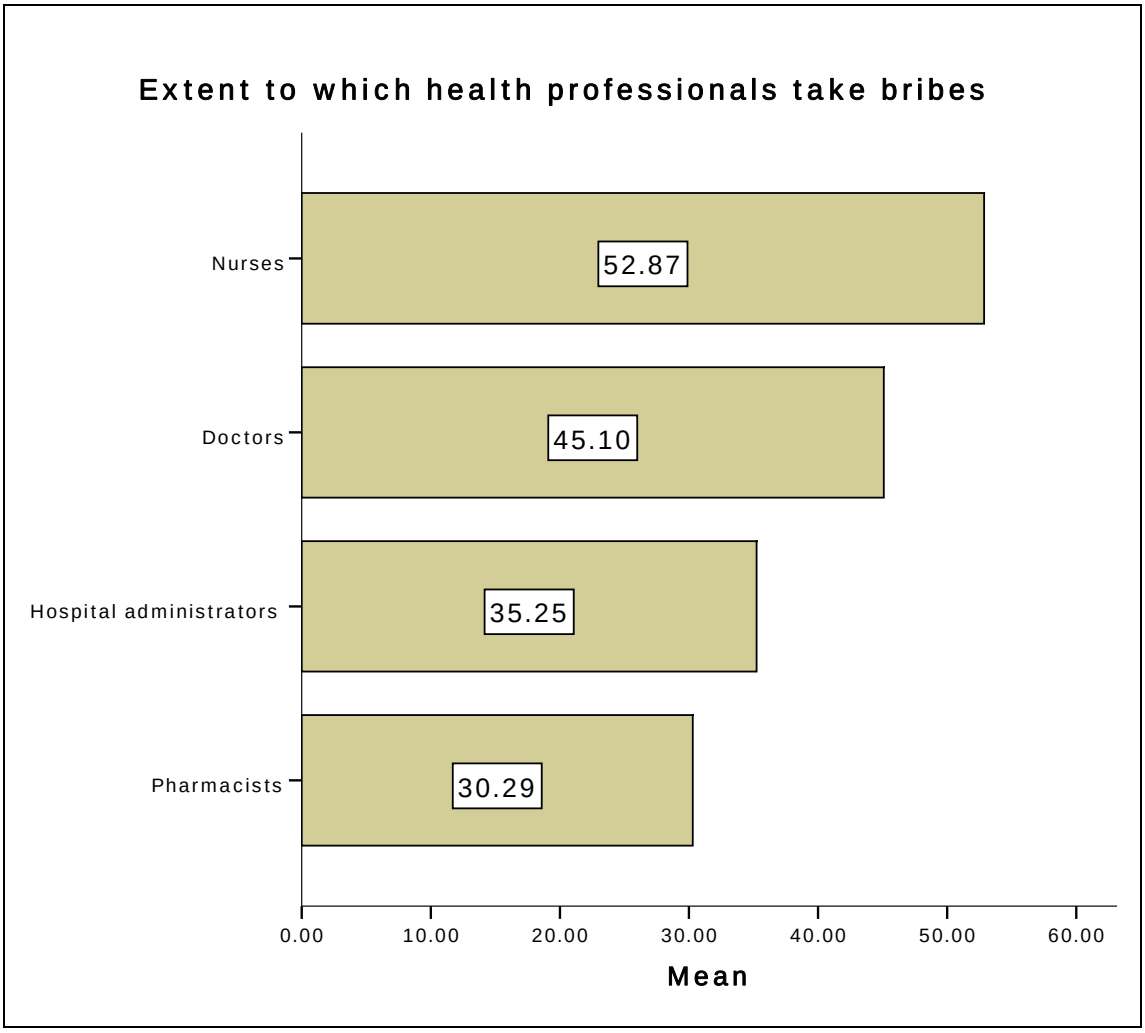


Figure 2

The questionnaire then asked whether a series of actions are considered corrupt or not. The following chart shows the specified actions were perceived as corrupt.

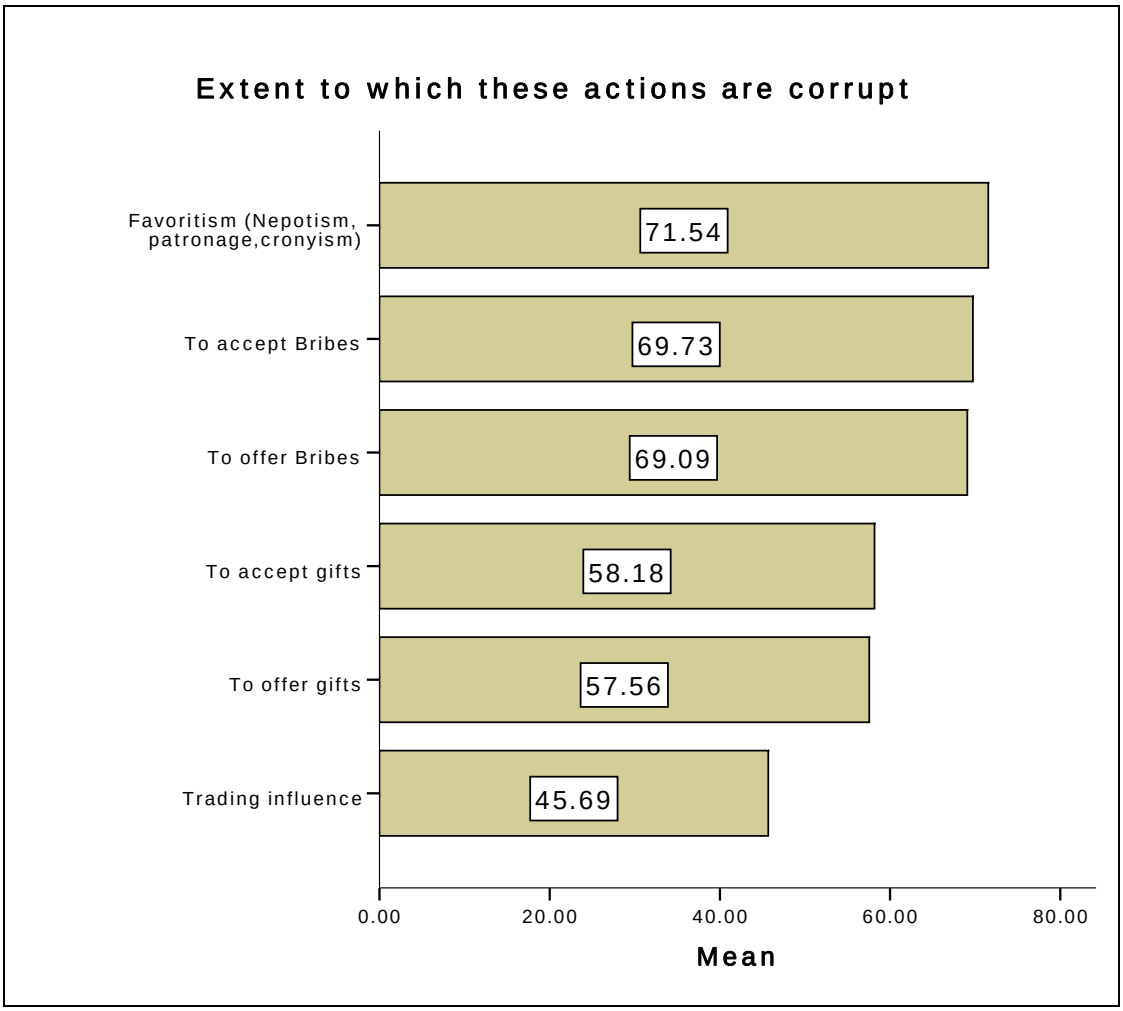
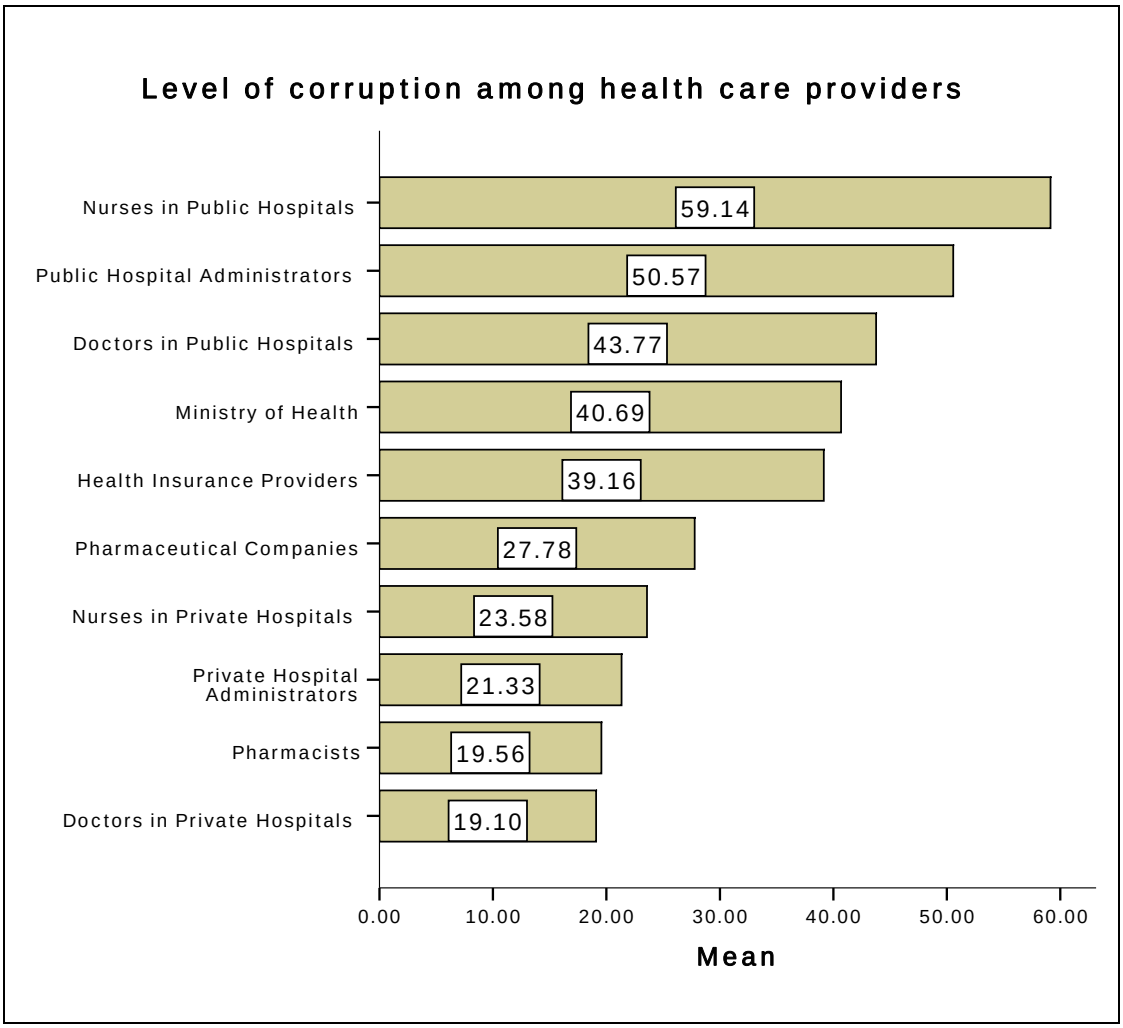


Figure 3

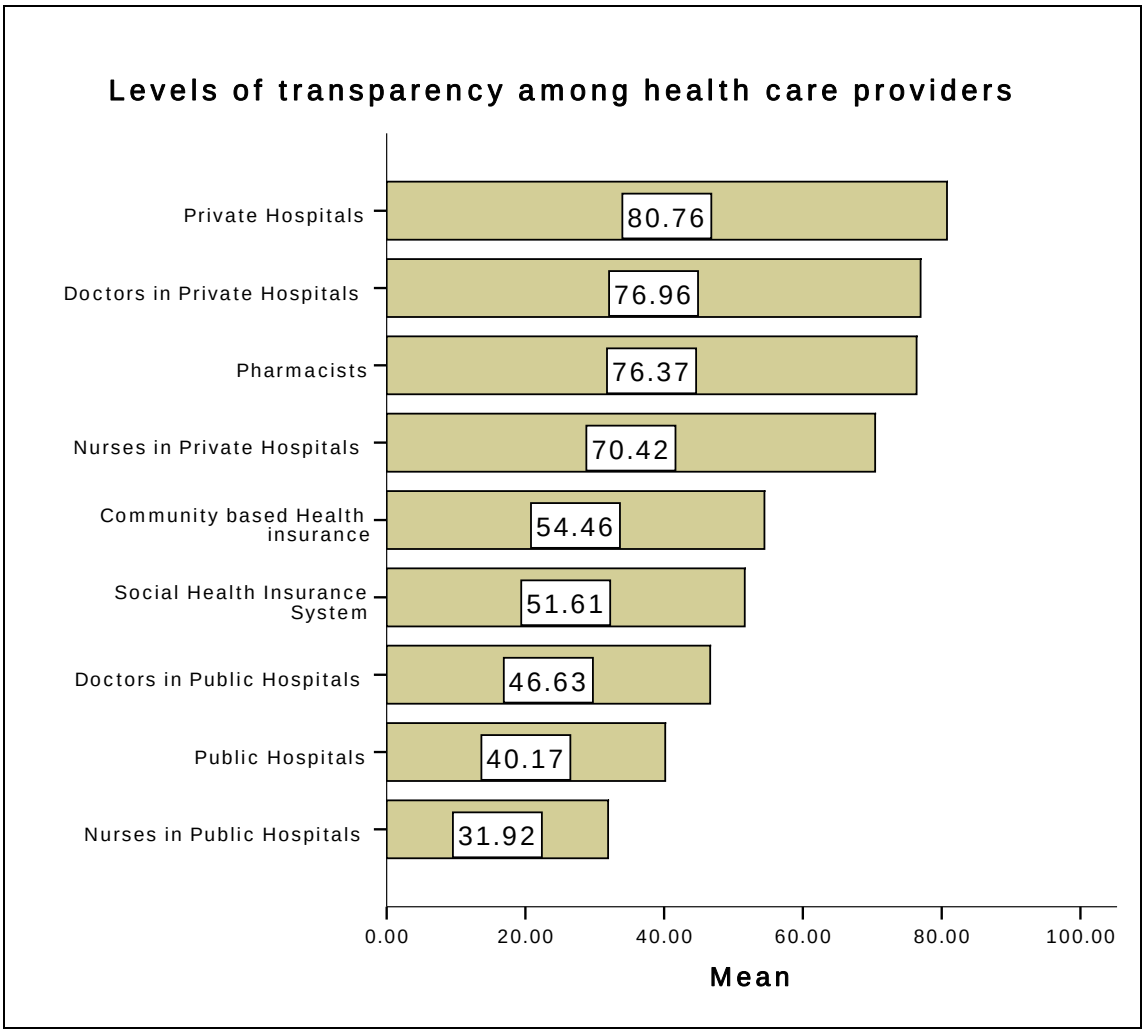
Figure 3 indicates that "favoritism" is considered the most corrupt action, with "trading influence" the least. In all cases, except trading influence, majorities believe that the actions are corrupt.

The survey asked individuals whether they personally made gifts in order to receive better health care. Most respondents, 85%, said they had not made a gift.



We find that nurses in public hospitals are perceived as the most corrupt followed by public hospital administrators and doctors. The least corrupt are doctors in private hospitals.

Finally, in terms of corruption, the survey asked respondents to evaluate the level of transparency in various institutions involved in the health care system. The questions were transformed into a 0-100 metric where 0 represents total lack of transparency and 100 very transparent



The most transparent providers are private hospitals followed by doctors at private facilities. The least transparent are nurses at public hospitals followed by public hospitals in general. These results support the previous finding that doctors at private hospitals are considered the least corrupt and nurses at public hospitals the most corrupt.

CONCLUSIONS AND RECOMMENDATIONS

KEY SURVEY FINDINGS ON CORRUPTION

- Public perceives favoritism as the most corrupt practice when compared to giving or acceptance of bribes or gifts.
- Nurses are perceived as the most corrupt health care professionals, substantially more likely to accept bribes than doctors, administrators or pharmacists.
- Nurses in public hospitals are perceived as the most corrupt followed by public hospital administrators and doctors. The least corrupt are doctors in private hospitals.
- Most individuals (85 percent) said they had not given a gift in order to receive better health care.
- Most people interviewed (81.9 percent) believe it is not necessary to offer gifts to obtain good services.

KEY SURVEY FINDINGS ON TRANPARENCY

The most transparent providers are private hospitals followed by doctors at private facilities. The least transparent are nurses at public hospitals followed by public hospitals in general. These results support the previous finding that doctors at private hospitals are considered the least corrupt and nurses at public hospitals the most corrupt.

FINDINGS FROM INTERVIEWS

Interviews were conducted with six selected NGOs. The selected NGOs included professional health organizations and associations of health care providers. Discussions validated the survey data while some interviewees were of the opinion that inefficiency in the system was underestimated due to the narrow definition used in the survey, which did explicitly list the use of public health facilities and official hours for private gain.

Respondents attributed corruption in the health care delivery system to moral degeneration, impunity associated with a high degree of tolerance for corruption and weakness of systems, low salaries in poor working environment and low community participation in the management of health services.

RECOMMENDATIONS

DEVELOP MORAL INTEGRITY AMONG CARE PROVIDERS AND CUSTOMERS

One view expressed during the interviews is that corruption is inherent human behavior, and therefore a change must be focused on moral development and professional integrity first. The rationale for this idea is grounded in the fact that all institutions fighting corruption are managed by human beings and without targeting human beings no matter how strong regulation and anti-corruption institution are, they are bound to have limited success.

PUBLIC EDUCATION

Closely related to the above, considering that some members of the public do not perceive corruption as a bad thing, it is recommended that efforts be directed at improving public awareness of the different forms corruption assumes and its impact on society. A concrete example recommended is a television program advocating patient's rights similar to "Haki Elimu" which has been used to promote rights in education.

HOLISTIC APPROACH

Given the view that a single sector is corruption free some respondents recommended a holistic approach. Following from the above it would start with development of moral and professional integrity and cover all sectors in public life. Some respondents said it should go beyond political statements to examples by all levels of leadership. Impunity was often mentioned as a driving force.

INCREASE TRANSPARENCY AT FACILITIES

Drawing inspiration from the private sector where customer care is observed, it is recommended that systems be put in place in public health care delivery points to make services more transparent to customers. One recommendation would be to institute a system whereby patients receive a number upon arrival at the facility which lets them know up-front their position in the waiting queue. This system complicates favoritism and seeing patients out of order.

IMPROVE WORKING CONDITIONS

Low salaries and poor working environment for healthcare providers was sited as one of the motivating factors an improvement of working environment was recommended, including increasing salaries, the amount of equipment and medical supplies.

INCREASE PUBLIC PARTICIPATION

Considering that the existing 'culture of silence' is in part a product of vertical relationship between care providers and customers, increased participation by the public in the management of health services is recommended. Specific activities include establishment of suggestion boxes in health facilities to collect public opinion.

ANNEX A: SURVEY ENUMERATION AREAS

Selected Enumeration Areas (EAs) for Dar es Salaam Region													
Reg. Code	**Reg. Name**	**Dist. Code**	**Dist. Name**	**Ward Code**	**Ward Name**	**EA Code**	**EA. Name**	**Population**			**No. of HHS**	**Average HHs Size**	**Income Status of EA**
								Male	**Female**	**Total**			
07	Dar es Salaam	03	Temeke	152	Keko	014	Keko Mwanga 'B'	162	141	303	88	3.4	low
07	Dar es Salaam	03	Temeke	202	Chang'ombe	056	Bora	101	137	238	52	4.6	middle
07	Dar es Salaam	03	Temeke	162	Kurasini	053	Kurasini	129	122	251	62	4.0	high
07	Dar es salaam	02	Ilala	082	Vingunguti	001	Kombo	306	306	612	136	4.5	low
07	Dar es salaam	02	Ilala	142	Kisutu	002	Kisutu	182	186	368	97	3.8	middle
07	Dar es salaam	02	Ilala	182	Kivukoni	006	Sea View	143	180	323	58	5.6	high
07	Dar es salaam	01	Kinondoni	112	Manzese	137	Madizini	248	253	501	124	4.0	low
07	Dar es salaam	01	Kinondoni	012	Magomeni	027	Idrisa	105	94	199	42	4.7	middle
07	Dar es salaam	01	Kinondoni	062	Msasani	078	Masaki	149	179	328	64	5.1	high
07	Dar es salaam	01	Kinondoni	072	Kinondoni	058	Ada Estate	113	110	223	74	3.0	high

Selected Enumeration Areas (EAs) for Arusha Region

Reg. Code	Reg. Name	Dist. Code	Dist. Name	Ward Code	Ward Name	EA Code	EA. Name	Population			No. of HHS	Average HHs Size	Income Status of EA
								Male	Female	Total			
02	Arusha	03	Arusha	122	Unga Ltd	002	Oster Bay	180	216	396	109	3.6	Low
02	Arusha	03	Arusha	032	Sekei	001	Sanawari	259	257	516	144	3.6	Low
02	Arusha	03	Arusha	042	Kimandolu	028	Kiteangare	190	195	385	78	4.9	Middle
02	Arusha	03	Arusha	112	Daraja Mbili	017	Mtaa wa Kati	129	126	255	77	3.3	Middle
02	Arusha	03	Arusha	072	Themi	007	A.I.C.C - Flats	242	257	499	120	4.2	High
02	Arusha	03	Arusha	072	Themi	015	Corridor Area	297	235	532	153	3.5	High

ANNEX B: REFERENCES

1. URT, Ministry of Health : National Health Policy , October 2003

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