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CORRUPTION ASSESSMENT OF RWANDAN HEALTH SECTOR

DECEMBER 23, 2008

This publication was produced for review by the United States Agency for International Development. It was prepared by Management Systems International.

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A subsidiary of Coffey International, Ltd.
Management Systems International
Corporate Offices
600 Water Street, SW
Washington, DC 20024

Contracted under DFD-I-01-03-00144, Task Order #01

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ACRONYMS

ARBEF	Association Rwandaise du Bién-Etre Familiale
ART	Anti-Retroviral Treatment
AVEGA	Association des Veuves du Genocide Avega-Agahozo
CAMERWA	Central Office for Procuring Essential Drugs, Medical Equipments and Supplies in Rwanda
CB	Capacity Building
CBNA	Capacity Building Needs Assessment
CBO	Community Based Organization
CCOAIB	Conseil de Concertation des Organisations d'Appui aux Initiatives de Base.
CDF	Community Development Fund
CLADHO	Collectif des Associations de Défense des Droits de l'Homme.
CHK	Centre Hospitalier de Kigali
CHW	Community Health Worker
CNLS	Commission Nationale de la Lutte Contre le Sida/ National AIDS Commission
CSO	Civil Society Organization
CTB	Coopération Technique Belge
DDP	District Development Plan
DFID	Department for International Development (GB)
DIP	Decentralization Implementation Program
EDPRS	Economic Development and Poverty Reduction Strategy
EU	European Union
FP	Family Planning
FSP	Fédération du Secteur Privé.
GBS	General Budget Support
GOR	Government of Rwanda
GTZ	Deutsche Gesellschaft fur technische Zusammenarbeit
HC	Health Center
HIV	Human Immunodeficiency Virus
HP	Health Post (Dispensary)
IEC	Information, Education and Communication
LG	Local Government
LP	Liberal Party
MDG	Millennium Development Goals
MIFOTRA	Ministère de la Fonction Publique et du Travail.
MINALOC	Ministry of Local Government and Good Governance
MINECOFIN	Ministère de l'Economie et des Finances
MINIJUST	Ministry of Justice
MINISANTÉ	Ministry of Health
MMI	Military Medical Insurance
MOH	Ministry of Health
NEPAD	New Partnership for African Development
NGO	Non Government Organization
NTB	National Tender Board
OAF	Office of Auditor General
OPHAR	National Pharmaceutical Laboratory
PBF	Performance Based Financing
PEPFAR	President's Emergency Plan for AIDS Relief

PETS	Public Expenditure Tracking Survey
PHC	Primary Health Care
PMI	Presidential Malaria Initiative
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategic Paper.
RALGA	Rwandan Association of Local Government Authorities
RPF	Rwanda Patriotic Front
RPA	Rwanda Patriotic Army
RRA	Rwanda Revenue Authority
RPPA	Rwanda Public Procurement Agency
RPSF	Rwandan Private Sector Federation
RSDF	Rwandan Strategic Decentralization Framework
RURA	Rwanda Utility and Regulatory Agency.
RWF	Rwanda Franc
SCMS	Supply Chain Management System
SD	Service Delivery
SDP	Social Democratic Party
SIDA	Swedish International Development Agency.
SNI	Système National d'Intégrité.
SWAP	Sector Wide Approach
TA	Technical Assistance
TBA	Traditional Birth Attendant
TI	Transparency International.
TNA	Transitional National Assembly
TR	Transparency Rwanda.
UNDP	United Nations Development Program
USG	United States Government
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

Unlike most country corruption assessments that address broader political and economic forces and provide a review of corruption vulnerabilities in several sectors, this report and its recommendations focus primarily on the Rwandan health sector. But to put the situation of the health sector into proper context, the report starts with an analysis of Rwanda's political dynamics, general corruption characteristics, key national anti-corruption institutions and stakeholders, and the country's track record in fighting corruption over time.

The post-genocide regime which assumed power in 1994 stressed security, national unity, and reconciliation, and the rebuilding of state infrastructure during its early years in power. Since 1998, it has given greater priority to fighting corruption, implementing decentralization reforms, and improving public services than to promoting political freedoms and civil liberties. Thus, political power is extremely concentrated in the hands of President Paul Kagame, and the RPF, political parties, competitive elections, and freedom of the press are tightly controlled, and civil society and the private sector remain relatively weak and timid forces.

Corruption in Rwanda

Rwanda's corruption is built on networks of diverse elites who share major benefits among themselves while staving off political and economic competitors.[1] Corruption is moderate, tightly controlled from above and marked more by collusion than outright theft and violence. Spoils are shared among the elite and used to ensure political stability and public consensus. Although an alternative to more violent forms of corruption, Rwanda's type of corruption delays the growth of genuine political competition.

But unlike many other regimes with similar corruption characteristics, in which the president and high ranking government officials pay lip service to fighting corruption while continuing to use public funds to enrich themselves, Rwanda has demonstrated a strong commitment to fighting corruption, starting with President Kagame's Zero Toleration policies and personal example, the establishment of national anti-corruption institutions like the Rwandan Public Procurement Authority, Office of the Auditor-General, Ombudsman, and the Rwanda Revenue Authority, and the passage of the 2003 anti-corruption law and the 2007 law requiring high ranking public officials to make annual declarations of wealth and property. Thanks to these policies, institutions, and laws, Rwanda has made striking gains in controlling corruption over the past decade and has scored better than its neighbors.

Despite a sharp decline in open corruption, corruption persists but in more subterranean forms. Corruption has been forced underground and hence, is more difficult to uncover and prosecute. A climate of fear and shame, reinforced by a zero toleration policy, has dampened open discussion of corruption. The main impetus for fighting corruption still comes from above and more needs to be done to get citizens, civil society, the media, and the private sector more involved.

Analysis of Corruption in the Health Sector

The evolution of post-genocide health sector institutions has parallels with broader institutional changes at the national level designed to control corruption, decentralize political institutions and technical services, and make government service delivery more efficient. As an institution, the MOH is highly committed to fighting corruption and to modernizing and improving health services. Since 2004, the

[1] This description corresponds primarily to the Type 2 corruption syndrome in the *USAID Corruption Assessment Handbook* (2008).

MOH has adopted a demand-driven health policy that has succeeded in dramatically increasing access to and use of Rwandan health facilities.

Acceleration of the pace of decentralization and the rapid establishment of new institutions, procedures, and responsibilities for citizens has put heavy strains on the health sector. The newness of these institutions, the lack of experience in working in them and severe limitations in the capacity of existing human and financial resources are constraints and challenges which need to be addressed and which foster corruption vulnerabilities.

Health sector spending in 2008 was well over $300 million with donors providing 80% of the funds. The proliferation of donor programs and INGO health implementers with different management systems, pay scales and agendas, the skewing of donor funding towards fighting AIDs and malaria at the expense of other programs, and the lack of donor coordination have made it more difficult for the MOH to ensure the compatibility of donor and national health sector programs.

This report focuses on analyzing corruption vulnerabilities and corruptive practices in the health sector in six areas (1) Procurement; (2) Warehousing, Stocking, and Distribution of Drugs and Medical Equipment (3) Recruitment, Personnel Relations, and dealing with the Public; (4) Financial. Material, and Human Resource Management; (5) Functioning of the Mutuelle Community Based health Insurance System; and (6) Community Health Workers and Citizen Participation and Oversight.

CAMERWA, the national institution controlling 50% of the procurement and distribution of drugs, has the most advanced techniques and procedures to control corruption in procurement and distribution of drugs and medical equipment, warehousing and stocking. In the event of a rupture of stocks and emergency situations, standard procurement procedures do not need to be followed, thus providing opportunities for corruption. Procurement mechanisms were less effective and procurement rules were less likely to be followed at the district level than at the national level. Efforts to apply sound financial management techniques and inventory controls have also contributed to lowering leakage and corruptive practices in dispensing drugs at the District Hospital level.

Although recruitment procedures have been tightened and based more on merit criteria, opportunities for corruptive practices persist as recruitment decisions may be made on the basis of friendship, gender and social discrimination, and receptivity of decision-makers to accepting kickbacks to those getting jobs. Possibilities for favoritism also exist in offering scholarships, trips to national and international seminars, and assignment to donor projects offering higher salaries and benefits. Improvements need to be made in the workplace to reduce tensions, conflicts and harassment and to build trust and better relations among health sector personnel as well as to promote better treatment of patients by health sector personnel.

While impressive efforts have taken place at the national level to put into place modern managerial systems and technology to improve efficiency and control corruption, the MOH has been less successful at the district and grassroots level of the health system in this area. Major deficits in capacity, especially in financial management, the lack of knowledge and complexity of national regulations and data collection techniques, the weakness of monitoring mechanisms, and the difficulty of integrating local government and health sector institutions and functions explain in part, the non-application of rules and procedures designed to control corruption in the health sector. District level auditors have too many institutions to monitor while members of procurement committees do not always understand and enforce procurement rules and regulations or choose the best firm for the contract. Performance Based Financing (PBF) has recently been introduced as a mechanism for providing rewards and incentives to health officials and communities that have met targets and improved results.

The CBHI (Mutuelle) program has seen phenomenal growth in a short period of time. More than 80% of the population are members of Mutuelles. Use of local health facilities has also jumped sharply in the past

three or four years to over 75%. Mutuelle managers have been overwhelmed with work and lack the means to supervise and monitor the village mobilization committees who collect the premiums. Thus funds and premiums do not always go to Mutuelle coffers. The practice of identifying and placing indigents who do not have the means to pay for health insurance on the rolls without paying provides an opportunity for corruption when the genuinely needy do not get on the rolls while some of those who can afford it do.

The National Community Health Policy relies heavily upon volunteer CHWs to provide basic primary health care services at the village level and calls for the full involvement of communities in planning, implementation and evaluation processes. The absence of material incentives and a heavy workload provides temptations for CHWs to charge for services which ought to be free or to accept gifts for services. The MOH now proposes to introduce a c-PBF incentive system to reward CHWs. However, these incentives won't go to individuals but to cooperatives. The GOR is putting pressure on CHWs to form cooperatives to engage in income generating activities as an alternative to granting CHWs salaries. However, cooperatives imposed from above rarely succeed. The organization of cooperatives will add to CHW burdens and create opportunities for misallocation of cooperative c-PBF incentive funds.

The limited presence and passive role of local civil society and private sector representation in district level health management, planning, and monitoring institutions diminishes citizen oversight of health sector actors. The GOR's emphasis on community participation is a step in the right direction. But it will take some time to change top down mobilization traditions and to engage citizens, civil society, and the private sector to become more actively involved.

Recommendations for Anticorruption Action

The report offers a list of tactical reform recommendations in all six of the above areas. It concludes with a table of the broad anti-corruption programmatic options to reflect a more general and strategic approach to reforms in the health sector for USAID/Rwanda and the MOH, which gives priority to four areas:

- **Enhance transparency at all levels and areas of the health system,** especially. procurement, distribution of drugs and medical equipment, recruitment, and information-sharing
- **Strengthen financial management capacity at all levels and areas of the health system** through training, simplification of rules and procedures and adaptation of financial management systems to international, national, and local conditions
- **Strengthen the capacity of decentralized health sector institutions at all levels** and work with local government to ensure more effective collaboration and partnerships between local government units, elected officials, and decentralized health sector institutions and personnel
- **Increase citizen participation and oversight** at all levels of the health system, especially at the local and community levels.

The strategic recommendations reflect the team's consensus that national level anti-corruption institutions and rules are relatively strong. The future success of the GOR's ambitious health sector policies and programs will depend heavily upon the effective implementation of its decentralization reforms and greater citizen participation, oversight, and ownership of health sector policies and reforms, hence the saliency of our recommendations in this area. USAID has considerable experience in these areas and can make a major contribution to strengthening decentralization institutions and greater citizen input in decision-making.

Methodology

The four-person Rwanda Health Sector Corruption Assessment Team reviewed and adapted the methodology elaborated in USAID's evolving Corruption Assessment Handbook.[2] The methodology underscores the following factors:

- Understanding corruption and its different manifestations
- Understanding the context in which corrupt practices and tolerance have developed within the country which includes an assessment of the country's legal-administrative framework and analysis of the political-economic dynamics guiding the country's development
- Developing an accurate description of the specific corruption syndromes which provides guidance for defining the corruption problem statement and strategies for combating corruption.
- Examining the country's anticorruption program track record over time
- Providing specific anticorruption recommendations tailored to country contexts and political and economic realities rather than general boilerplate recommendations –e.g. strengthen civil society, reinforce independence of judiciary, etc.

Unlike most country corruption assessments which give the bulk of attention to broader political and economic forces affecting corruption and provide a brief review of corruption vulnerabilities in several key sectors, this report and its recommendations focuses primarily on the health sector.[3] Concentration on the health sector reflects the fact that the Health Sector Corruption Assessment was commissioned by USAID/Rwanda and the Rwanda MOH as a tool for designing and implementing more effective public health programs and for providing guidelines to USAID/Rwanda for integrating good governance techniques and anti-corruption safeguards in the next round of health sector programs beginning in 2009 and 2010.

The team was in Rwanda from September 7-September 23. The short period of time in-country necessitated an intensive interview schedule. The team met with representatives of USAID/Rwanda, implementers of USAID programs, officials from the MOH, CAMERWA, and representatives of key national anti-corruption institutions, Parliament, the media, civil society, and private sector health providers.[4] The team also met with representatives of the donor community working in the health sector. Given the importance of decentralization, the team made an all day field trip to Ruhango District to look at decentralized District level health institutions and services and the role of local government officials in planning and implementing health services. The team also visited the CHK and discussed governance issues with the director and other hospital officials. Based on initial interviews and concerns expressed in these interviews, the existing literature, and documentation provided by USAID/Rwanda, the MOH, MINALOC, national anti-corruption institutions, and donors, the team decided to focus on corruption vulnerabilities in the following areas:

[2] The methodology and illustrative materials in the Corruption *Assessment Handbook* were prepared by Bertram I. Spector, Michael Johnston, and Svetlana Winbourne of Management Systems International for USAID. The methodology has been tested, improved, and updated since first being presented in 2005.

[3] The team reviewed the growing literature on health governance and corruption in the health sector. Key articles from the literature are cited in the references section of the report. Three of the four members of the team also had experience working on health governance issues in Cameroon, Senegal, Benin, and Rwanda.

[4] See the List of Persons Contacted for names and affiliations of those interviewed by the team.

- Procurement
- Distribution of drugs and medical equipment
- Recruitment
- Fiscal Management
- Functioning of the Mutuelle Health Insurance System
- Citizen Participation and Oversight in Decentralized Health Institutions

The team provided specific and practical recommendations to address key corruption *vulnerabilities* in the above areas.

The team also looked at an important issue raised in the Terms of Reference concerning the apparent gap between the public's perception of corruption and the reality of corruption in the health sector. Responses given in a wide range of interviews, Transparency International documents, and the press provided valuable insights concerning the subterranean nature of corruption, attitudes towards corruption, and the reluctance to openly discuss corruption in Rwandan society.

INTRODUCTION: THE HISTORICAL CONTEXT

From Genocide to Institutional Stability and Modernization: Corruption in Historical Context

From 1959 until 1994, post-colonial Rwanda was ruled by a small autocratic Hutu elite that assumed and maintained power by mobilizing the Hutu majority against the Tutsi. During the early 1960s, at least 25,000 Tutsis were massacred and 40 to 70 percent of the surviving Tutsi fled the country.[5] The regime led by Kayibanda (1962-73) killed or expelled most of the Tutsi leadership and cadres as well as many Hutu moderates. Habyarimana, who came to power in a coup in 1973, killed many of the Hutu cadres associated with the Kayibanda regime and installed a military dictatorship which ruthlessly repressed political opponents. In 1990, the Rwanda Patriotic Front (RPF), led by exiles operating from Uganda invaded Rwanda. The invasion increased tensions within the regime as Hutu extremists stepped up their media attacks and demonized Tutsi and Hutu moderates calling for peace. After Habyarimana's plane was shot down in April 1994, Hutu extremists took over and carried out a systematic genocide campaign which led to the murder of 800,000 Tutsi and Hutu moderates. Led by Paul Kagame, the RPF responded by launching a military offensive that succeeded in defeating the Hutu armies and militias, installing a new government, and launching a new era in Rwandan history.

In 1962 when Rwanda obtained its independence from Belgium, the Rwandan state had a minute number of African cadres with post-secondary education because of Belgium's colonial education policy based on primary education and an unwillingness to train Africans for leadership roles A tiny bureaucratic ruling class carefully controlled access to secondary and higher education and to key government posts, thus providing opportunities for advancement and self-enrichment. Corruption was endemic and part of the normal functioning of the Rwandan state. Few controls existed within the executive branch to control corruption. Taxes were rarely collected. Public contracts were issued without set procedures and competitive bidding. Given the absence of a dynamic private sector, control over state institutions was the main road to wealth.

The destruction from the 1994 genocide and civil war led to the collapse of state institutions and infrastructure and aggravated the deficit in skilled personnel needed to run a modern state. After its decisive military victory, the RPF emerged as the dominant political force in the country. Despite its willingness to share some power with other political movements not tainted by its participation in genocide, the RPF took the lion's share of political and government offices. Paul Kagame emerged as the strong man of the new régime and eventually became president in 2000.

Since 1994, the Rwandan state has gone through three phases marked by different levels and modes of corruption and an evolution towards greater efforts to control corruption through the establishment of anti-corruption policies and institutions.

Phase 1: Restoring Security and Working for Unity and Reconciliation (1994-1999)

During this period, the RPF gave priority to restoring security and promoting national unity and reconciliation. It also established a transitional regime clearly dominated by the RPF and its supporters. For two years (1994-1996), the GOR received little international aid. A new influx of international aid from 1997-1999 enabled the GOR to rehabilitate the state apparatus and basic infrastructure, resettle returnees from the Congo, and stabilize the country.

[5] Peter Uvin, *L'Aide complice?: Coopération International et Violence au Rwanda* (Paris: L'Harmattan, 1998), pp.22-23.

From 1996 onwards, the RPF accelerated its business enterprises which had been created in the Diaspora to provide a financial base to support its political and military activities.[6] Many of these new business activities were opaque and provided opportunities for corrupt practices fueled by large political loans. Some RPF political and military leaders took advantage of the situation to enrich themselves as did members of the former political opposition to the Habyarimana regime in the government coalition aligned with the RPF. Some political leaders fostered a version of reconciliation that overlooked involvement in genocide against some of their colleagues in government or their business partners. The RPF Congress in the summer of 1998 sharply attacked corruption on the part of leading political and military leaders. Following the Congress, Paul Kagame consolidated his hold over the RPF, gained almost total control over the army, sidelined many of his political and military rivals suspected of corruption, and prohibited military personnel from engaging in business.

The public outcry against corruption and nepotism led to the establishment of new regulatory institutions and efforts to increase transparency in government and private sector financial transactions. In 1997, the National Tender Board (NTB) became Rwanda's first major post-genocide anti-corruption institution. The NTB established clear-cut procedures for firms and government to follow in offering and bidding on government contracts. Three other major regulatory and anti-corruption institutions were created over the next two years:

- Office of the General Auditor (1998)
- Rwanda Revenue Authority (1998)
- The National Police, which replaced the Gendarmerie (1999).

Although a step in the right direction, these new institutions needed time to evolve into effective anti-corruption institutions.

Phase 2: Transitional Period (2000-2003): Purging of Corrupt Officials, Decentralization, and a New Constitution

Many important officials, including Prime Minister Rwigema, President Bizimungu, and government ministers accused of corruption or tolerating corruption resigned during 1999 and 2000. Most of them were affiliated with the former political opposition to the Habyarimana regime. Following the resignation of President Bizimungu, Paul Kagame assumed the presidency in April 2000.

In May 2000, the GOR made decentralization a major cornerstone of institutional reform and a vehicle for good governance by making local leaders directly accountable to the communities they serve and empowering local populations to participate in planning and management of their development process.[7] Decentralization was also motivated by the desire to reform the hierarchical, centralized structures that had facilitated the 1994 genocide. District elections were held in March 2001.

The GOR worked with the Transitional National Assembly (TNA) to establish a new constitution for Rwanda in 2003. This was followed by presidential and parliamentary elections, which Kagame and the RPF won handily, gaining 95 percent and over 75 percent of the vote respectively.

[6] This practice was also adopted by the Liberal Party (LP) and the Social Democratic Party (SDP) who were also members of the ruling coalition. One of the distinct features of the Rwandan political system is the creation of private enterprises by political parties whose profits are used at least partially to finance party activities.

[7] For more details concerning the rationale behind and organization of Rwanda's original decentralization program, see Ministry of Local Government and Social Affairs, *National Decentralization Policy* (Kigali, May 2000).

Phase 3 (2003-2008): Acceleration of Anti-Corruption Campaigns, Consolidation of Anti-Corruption Institutions and Implementation of Decentralization Policies

One of the last acts of the TNA was to promulgate a strong anti-corruption law in July 2003 designed to prevent, fight, and suppress corruption within government agencies, the private sector, and NGOs. After the 2003 national elections, the government created the Office of the Ombudsman. Headed by a trusted confidant of the president, the Office of the Ombudsman emerged as the most prominent government institution engaged in anti-corruption campaigns.

During this period, President Kagame pursued a zero tolerance policy and took action against several high profile officials accused of embezzling public funds, firing the Prosecutor General, several ambassadors, and the head of the National Police. National Tender Board regulations and procedures were tightened and ministers and other top public sector officials forbidden to become directly involved in tendering processes. [8]The Office of the Auditor General (OAG) also stepped up its activities as did the Rwanda Revenue Authority (RRA) which fought against tax fraud and instituted effective mechanisms to fight against corruption within its own agency.

This phase also saw the rapid implementation of the GOR's decentralization reforms characterized by the following developments:

- the redeployment of state resources and personnel to the District level on an unprecedented scale
- the elaboration of District Development Plans responding to local needs
- An effort to radically improve service delivery at the local level, particularly in the health sector
- the mobilization of the local populations and local civil society organizations (CSOs) to participate in frequent meetings and forums at the District, Sector, and Community levels and the recruitment of local citizens to serve as Community Health Workers (CHWs) and as volunteers in collecting taxes and dues for the rapidly expanding Mutuelle health insurance program
- The decentralization of tendering procedures and controls which were transferred to district level committees and officials.

[8] The March 27, 2007 Procurement law lays down rigorous guidelines for government agencies and private firms to follow in public bidding for government contracts

OVERVIEW OF CORRUPTION IN RWANDA

Political and Economic Dynamics

Although post-genocide Rwanda has held national presidential and legislative elections since 2003 and made progress on various indicators of democratization, Freedom House in 2007 still classified Rwanda as an unfree country.[9] Extreme power remains concentrated in the hands of the president, political parties and competitive elections carefully controlled, freedom of the press limited, and civil society timid. Nonetheless, the régime has made important strides towards democratization of the political system and society. Although the RPF continued to dominate in the September 2008 legislative elections, the electoral process was a marked improvement over 2003.[10] Decentralization reforms have transferred more power and resources to the district level and provided forums for local citizens and CSOs to express their views.[11] The GOR has also promoted gender equality. With stability ensured, the régime has been gradually reducing its restrictions on political and civil liberties and freedom of expression. Efforts have been made to improve the legal system.

While moving more slowly on democratic reforms, the GOR has accelerated its efforts to ensure greater transparency, fight corruption, and improve its delivery of public goods and services. As a result, Rwanda scores much higher on indicators reflecting government efficiency and control of corruption.[12] Although Rwanda scores better than its neighbors and many other African countries, the 2007 TI report listed Rwanda as 111 out of 179 countries. The GOR has contested this evaluation as not accurately reflecting Rwanda's anti-corruption efforts.

Three important political dynamics are in play in Rwanda and explain why Rwanda has not moved more decisively in increasing political freedoms and civil liberties. The first is the desire of those in power to retain their power. The second is the legacy of genocide and the fear that the perpetuators of genocide and their sympathizers could return to power through the ballot box if allowed to compete freely in the political arena before national unity and reconciliation are fully achieved. The third is a long legacy of autocratic and top-down rule dating back to pre-colonial times, German and Belgian colonial rule, and post-colonial Hutu-dominated regimes.

Key characteristics of the Rwanda political system affecting its political dynamics include:

- The extreme concentration of executive power and moral authority in the hands of Paul Kagame, the leader of the RPA and RPF who overthrew the Hutu genocide regime.
- The great political and moral authority of the president as a powerful motor for mobilizing and modernizing Rwandan society
- A strong sense of nationalism and unwillingness to accept donor imposition of policies incompatible with those of the government

[9] For a critical analysis of the low level of political freedoms and civil liberties in Rwanda, see Jennie Burnet, "Rwanda", in Freedom House, *Countries at the Crossroads 2007* (Washington, DC, 2008), 1-26.
[10] European Union Election Observation Mission, "2008 Elections prove a sound basis for further reform."(Kigali: 17 September 2008).
[11] Freedom House concentrates primarily on national level institutions, thus often undervaluing the importance of changes in democratization processes taking place at the local level through decentralization.
[12] The 2007 World Bank governance indicators indicate a more favorable evaluation of Rwanda, especially since 2002. On the other hand, the WB continues to give low scores in the voice and accountability categories.

- RPF domination of government institutions
- The trend towards sharing power and providing access to political office, government jobs, and higher education to members of all groups
- A strong emphasis on education, youth, and gender equality as instruments for enhancing support for the regime
- Restrictions on freedom of the press and expression which preclude public discussion, and criticism of certain topics—e.g. criticism of the president and ethnic tensions/conflicts as issues.
- The use of Gacaca trials at the local level to deal with genocide cases, the incapacity of the modern legal system to deal with this issue, and weak legal institutions
- A relatively weak and non-autonomous civil society
- Unresolved traumas and tensions as a legacy of genocide
- Top-down decision-making and mobilization of government officials, technicians, and populations to rapidly implement government policies
- Priority given to decentralization reforms, efficient government, and anti-corruption institutions over increasing the pace of democratization
- A shortage of skilled personnel needed to implement the GOR's ambitious development programs
- A disciplined society willing to carry out directives emanating from above
- Absence of local government traditions involving full participation of citizens and local groups in decision-making processes

Rwanda is one of the world's poorest countries and traditionally has lacked a dynamic and autonomous private sector. Since independence, government has been the main economic actor in the Rwandan economy which is based heavily on coffee and tea exports. Government remains the main source of employment for Rwandans.

Rwanda exiles in the Diaspora created a wide range of financial and economic institutions which provided monetary assistance to the RPF in its efforts to overthrow the Hutu regime. With the return of stability, other political parties have followed this path. As a result, political and economic elites are closely intertwined in Rwanda and government contracts remain a major source of income for private sector enterprises, a situation which enhances the potential for corruption.

The Kagame regime has placed great emphasis on modernizing the Rwandan economy to become more competitive in the global marketplace and a financial development pole for the Great Lakes region.

MCC indicators show that Rwanda has done well in Investing in People, especially in the health and primary education sector and has also moved towards greater economic freedom and improved economic management through its trade and fiscal policies, quality of its regulatory institutions, and efforts to reduce the time needed for new business startups.[13] Rwanda has achieved impressive growth rates over the past few years averaging over 6 percent annually. These growth rates have been helped by a massive influx of donor funding over the past five years, especially in the health sector.

[13] MCC Scorecard, Rwanda FY2008.

Rwanda has performed better than most African countries in terms of corruption in dealing with the private sector. The 2006 Work Bank Enterprise Survey indicated that only 4.4% of the firms surveyed identified corruption as a major constraint to doing business. Although 20% of the firms reported having to make unofficial payments to get things done, this was well under half the average of 48% in other African countries.

Overview of Corruption in Rwanda: Type II Corruption Syndrome

Rwanda today most closely resembles the Type II Corruption syndrome described in the USAID *Corruption Assessment Handbook*. Type II corruption builds upon *networks* of diverse elites who share major benefits among themselves while staving off political and economic competitors. Corruption in this case is generally moderate to extensive, but tightly controlled from above. The spoils are shared among the elite and used to unite members of the elite network. Type II corruption is often characterized by ineffective legislatures, extensive state presence in the economy and mutual colonization of political parties, the bureaucracy, and the private sector. Corruption can be used to ensure political stability and consensus, a situation which can prove to be attractive to international investors and foreign donors. Type II corruption offers an alternative to more disruptive and violent forms of corruption in the short to middle term but delays the growth of genuine political competition. Type II corruption is often marked by collusion than outright theft or violence.

Despite the presence of the above traits associated with Type II corruption in Rwanda, the Rwandan case has certain features usually not found in most Type II regimes where the President and high ranking government officials often pay lip service to fighting corruption while continuing to use public funds for private use and to enrich themselves. In Rwanda, President Kagame has introduced a policy of zero tolerance of corruption, put into place strong anti-corruption laws and regulations and institutions to fight corruption. He has also removed and punished corrupt officials. President Kagame has presented himself and his government as a model for honesty and good government and is seeking to create an anti-corruption culture. The GOR has placed greater emphasis on controlling corruption than on promoting political freedoms and civil liberties and an independent press and vibrant civil society which in other societies serve as watchdogs against other societies. [14]

The presence of features connected with the Type II corruption syndrome highlights corruption vulnerabilities in a society where corruption was open and rampant before the 1994 genocide and during the early years of the post-genocide regime.[15] Has corruption been sharply reduced or has it merely been pushed underground? Is political will on the part of President Kagame and the GOR in the absence of checks and balances on executive power sufficient to radically reduce corruption? World Bank governance indicators show that Rwanda has made striking gains in controlling corruption since 1998 and has done better on this score than Burundi, the Democratic Republic of the Congo, Tanzania, and Uganda.

Gaps between Perceptions of Corruption and Reality

Noting the strong linkages between the President, RPF party leaders, and businesses closely associated with the RPF, some elements in the press have assumed that the GOR has unfairly favored RPF businesses in allocating government contracts without presenting much evidence to support their allegations. While not questioning the honesty and integrity of the President, some political observers have assumed that the regime has often stopped short of cracking down on certain corrupt elements

[14] For example, in African countries like Senegal, Ghana, Benin, and Nigeria, Kenya, and Zambia, civil society and the media have taken the lead in exposing corruption and orchestrating anti-corruption campaigns.

[15] During the early years of the post-genocide regime, corruption in Rwanda had much in common with Type III corruption which is marked by pervasive insecurity, violence, and weak institutions.

among the elite in order to reduce conflict within the RPF and maintain cohesion with its allies. On the other hand, other observers have argued that the GOR has established sufficient safeguards to combat collusion, favoritism, and outright corruption and that private sector enterprises closely affiliated with the RPF win more government contracts because they are more efficient than the competition.

The gap between public perceptions of corruption and the reality is not so easily ascertained. Most corruption indices are based on perceptions of corruption by the general public, the private sector civil society, and the media rather than hard evidence. For example in one survey taken in Rwanda a few years ago, 65% of the respondents replied that Rwanda was moderately corrupt while 35% of the respondents maintained that corruption was rampant. In a recent survey concerning corruption among customs officials in Rwanda and neighboring countries, only four percent of the Rwandans interviewed believed that corruption was prevalent among Rwandan customs officials while none of the Rwandan respondents believed that there was any corruption in cross border health sector transactions.[16] Most surveys also indicate that Rwandans believe that petty corruption is not widespread in Rwanda.

Several factors have affected public perceptions of corruption since 2000:

- The strong political will on the part of President Kagame and the GOR to publicly denounce corruption, create anti-corruption laws and institutions, impose sanctions on lawbreakers, and provide an example to be emulated by the people.
- Corruption is not socially acceptable, a sentiment which has been reinforced by the government's anti-corruption stance and tendency of Rwandans to follow the instructions of their leaders.
- A sharp decline in open corruption.

The factors listed above have contributed to driving corruption underground. A climate of fear, and shame reinforced by a zero tolerance policy have resulted in an unwillingness to openly discuss corruption. Yet corruption persists. Even under the best of circumstances, it is impossible to totally eliminate corruption.

Large segments of the public still believe that corruption in the form of bribes, kickbacks, favoritism, and nepotism are still prevalent in the judiciary, local administration, and procurement.[17] A recent Transparency Rwandan report indicated that 95 percent of the persons interviewed believe that corruption exists in the court system.[18] Moreover, a third of the respondents said that they would be willing to resort to corruption to gain a favorable decision because that was a common practice.

The gap between public perceptions of corruption and the realities of corruption can be reduced by giving the public greater access to information concerning corruption cases and promoting more open public discussion of corruption and dialogue between the government, civil society, and the private sector on this issue.

Policy and Legal Framework to Fight Corruption

The GOR has a policy of zero toleration towards corruption and has passed legislation and created new national institutions to control corruption.

[16] The Steadman Group, *Report on the Assessment Study on Corruption at the Northern Road Corridor Transit Points(Baseline Study, July 2007)*

[17] The 2007 Ombudsman report indicates that corruption is especially high in local administration.

[18] Jean Damascène Biziman and Paul Kananura, *Etude et Proposition d'un Projet de Prévention, lute et Repression de la Corruption dans la Magistrature Rwandaise*. Kigali: Transparency Rwanda, December 2006.

Key laws controlling corruption include the following:

- Civil Service and Penal Codes (2002-2006) which define infractions, conflicts of interest, and sanctions for abusing authority and violating the law
- August 2003 Anti-Corruption Law which applies to government officials, judges, the private sector, and NGOs establishes procedural manuals, rules for recruiting government officials on the basis of merit criteria, internal audits, regular reporting, and proper tender procedures; promotes and monitors codes of conducts and professional ethics; and imposes heavy sanctions in the form of fines and jail sentences for violating the law
- August 18, 2005 Law requiring judges, higher civil servants, and elected officials to make a declaration of wealth and property to the Office of the Ombudsman established in an August 15, 2003 law which the Ombudsman the. Power to look into complaints concerning corruption and abuse of authority by government officials
- The March 27, 2007 law establishing more coherent and precise rules for public procurement procedures and the transformation of the National Tender Board (NTB) into the Rwandan Public Procurement Authority (RPPA).
- The 2003 Rwandan Constitution insuring the establishment of the Office of the Auditor-General (OAG)

Parliament is currently considering new laws to fight corruption and to give government institutions greater teeth in prosecuting violators of the law—e.g. an anti-money laundering law, a law to give the Office of the Ombudsman the power to start legal procedures against law violators.

One of the main critiques of the government campaign against corruption has been the passivity of the National Police and the judiciary branch in trying alleged violators of the law. Some jurists have explained the lack of action of these institutions to the fact that the rules of evidence for convicting alleged violators are more rigorous than those used by the Office of the Auditor-General and the Ombudsman. Other observers have attributed this passivity to such factors as weak institutional capacity, low public confidence in legal institutions, or lack of political will on the part of the GOR to systematically prosecute lawbreakers. The courts and prosecutor's office remain two of the weakest links in anti-corruption institutions.

The GOR has strengthened the main national level anti-corruption institutions – e.g. RPPA, OAG, Office of the Ombudsman, and Rwanda Revenue Authority—by tightening procedures to ensure the integrity of officials working for these agencies and creating new offices within these agencies such as the legal office of the RPPA which keeps track of infractions in tendering procedures or the National Independent Review Panel for Public Procurement (CRI) established in 2007 to permit dissatisfied bidders on public contracts to appeal the decisions made by the RPPA.

Some of these oversight institutions lack the personnel and funding to operate as effectively outside the capital. Thus tax collection is more lax in the rural areas; members of district tender boards often lack the skills and understanding of public procurement procedures and quality standards; a shortage of qualified auditors in the country and limited funding may hinder the quality and frequency of district level audits of government institutions. The imposition of the same rigorous national regulations and oversight procedures at the local government level with the implementation of decentralization reforms places a heavy burden on local officials and oversight committees whose members have had little or no training and experience in this area.

The rapid pace of decentralization presents a major challenge to elected officials and sectoral services to effectively manage these newly created local government institutions and their human and financial resources. But decentralization also provides an opportunity for local government to raise the technical and managerial skills of local officials and to serve as a school for democracy and good governance by enhancing citizen participation.

Anti-Corruption Stakeholders

This section will briefly look at some of the major stakeholders in Rwanda and their stance towards and relative importance in promoting good governance and fighting corruption:

- *The President*[19] *and the four or five key national anti-corruption institutions listed above.* To be popular and effective, President Kagame's ambitious modernization and antipoverty programs require that corruption be tightly controlled. GOR success in providing better health and educational services to the people can contribute to reinforcing the legitimacy of the regime. Rwanda's reputation for having an honest and effective administration has attracted large scale financial and technical assistance from the international donor community.

- *The Ministry of Health*. The MOH has been a staunch champion of good governance and has worked hard to sharply reduce diverse forms of corruption. It is also one of the major recipients of foreign assistance.

- *The Ministry of Local Government and District Councils.* MINALOC is a key player because of its relationships and responsibilities concerning all levels of local government and local administration. At the present time, there are no local anti-corruption agencies although national anticorruption agencies like the Office of the Ombudsman and the OAG visit local districts without having permanent representation there. Decentralization has reinforced the fight against corruption by establishing district councils which hold the mayors and executive branch of local government accountable and providing for an internal audit of local government spending. Corruption remains a reality in procurement procedures, the handling of documents by the local administration, and Gacaca proceedings. MINALOC also plays an important role in certifying and regulating civil society organizations (CSOs) and NGOs.

- *Parliament.* The OAG now sends its annual report directly to the parliament, a change which has strengthened parliament's oversight over the executive branch's spending. Members of parliament have also taken the initiative to ask the state to prosecute embezzlers and other financial misdeeds. Members of Parliament have established a Rwandan branch and joined the African Parliamentarians Network Against Corruption (APNAC). Its members are primarily concerned with promoting anti-corruption legislation. However, initiative for formulating new laws generally comes from the executive branch of government. Domination of the parliament by the RPF and its political allies tempers public criticism of government policies since there is no real political opposition. To date senators and deputies have no obligation to declare their ties with lobbyists and interest groups. On the other hand, members of parliament can not engage in businesses dealings.

- *The Prosecutor's Office and Court System.* Although logically a cornerstone of the fight against corruption, the judicial branch in Rwanda has not fully played its role of applying the law and sanctioning law violators. As a result, relatively few individuals have actually been tried, fined

[19] The President is not accountable to any other government institution. The office of the Presidency is held in high respect and criticism of the president is not easily tolerated.

and/or sent to prison for violating anti-corruption. Moreover, public opinion generally has a low view of this branch of government which it regards as corruptible.

- *Media.* In most democracies, the press plays an important watchdog role in looking into government activities. Until 1994, the media in Rwanda was essentially an appendage of the state. Although freer than in the past, the media exercises a high degree of self-censorship in avoiding controversial issues and criticism of state policies. While the GOR encourages reporting about anti-corruption cases, it has demonstrated its opposition to investigative reporting that implicates high-ranking government officials and harassed members of the press engaging in these practices. A low degree of professionalism has led to reporting based on assumptions and circumstantial evidence rather than hard facts and testimonies from reliable sources. This practice has undermined the credibility of the media as an instrument for uncovering corruption.

- *Civil Society*. The *Conseil de Concertation des Organisations d'Appui aux Initiatives de Base* (CCOAIB), an umbrella organization of development-oriented NGOs created in the 1990s, in the past had been the only major CSO to closely follow the issue of corruption. In July 2004, a group of CSOs organized a network called the Civil Society Platform to coordinate anti-corruption activities and to help groups at the district level gather credible information on corruptive practices and citizen complaints concerning corruption. Transparency Rwanda (TR) is the only CSO organization to specialize in studying and monitoring corruption in Rwanda and has organized conferences and produced studies on this theme. Civil society in Rwanda in general is relatively weak, highly dependent on foreign financing and involved more in service delivery activities than in advocacy for reforms or criticism of government policies. Some of the most important CSOs like Pro Femmes, Avega, COCAIB, and CLADHO have been involved in policy advocacy but in close collaboration with the GOR.

- *Private Sector*. Given the general weakness of Rwanda's private sector, its dependency on financial support from the government. and the importance of private enterprises closely related to the RPF, the Rwanda Private Sector Federation, an umbrella group of Rwandan businesses is not a major player in the fight against corruption. Collusion between government officials and private enterprises in procurement is one of the major forms of corruption in Rwanda. Money laundering to avoid paying taxes constitutes another major corruptive practice. Rwanda's privatization of parastatal operations if done without sufficient safeguards and transparent procedures provides new opportunities for corruption as does the formation of powerful investment groups dependent on government support and contracts to implement large-scale projects.

- *Citizens*. Decentralization is providing new opportunities for citizens to elect local government officials accountable to them, participate in oversight committees, and to express their views in the elaboration of District Development Plans (DDPs). Citizens also have the right to report incidents of corruption to various anti-corruption institutions. Lacking a tradition of participating in decision making in Rwanda, the ordinary citizen remains reluctant to take the initiative in advocating changes in government policies or challenging government authority. The GOR has demonstrated its willingness to consult with citizens, to establish mechanisms for citizens to express their concerns and grievances, and to mobilize the people in collective action to improve health and educational services. It remains to be seen whether citizens will be allowed to challenge, contradict, and change government policies elaborated at the national level and to develop their own modes of organizing and monitoring anti-corruption activities. It may take some time for citizens to actively take the initiative in participating in public affairs.

The first half of the report has focused on an analysis of the historical context in which anti-corruption activities have taken place, Rwanda's legal-administrative framework, the specific features of Rwanda's

Type II corruption syndrome, the country's most prominent anti-corruption institutions and the relative importance of diverse anti-corruption activities. Unlike most traditional corruption assessments, this report will not offer general recommendations to improve the overall system at the national level. Instead, specific recommendations will be directed towards fighting corruption and improving good governance practices and institutions in the health sector only.

HEALTH SECTOR GOVERNANCE ISSUES AND CORRUPTION VULNERABILITIES

The second part of the report directly addresses the need for a comprehensive analysis of corruption vulnerabilities in the health sector as a necessary tool for designing and implementing effective public health programs. The evolution of post-genocide health sector institutions had parallels with broader institutional changes at the national level designed to control corruption, make government service delivery more efficient, and decentralize political institutions and technical services. Over the past decade, the MOH has emerged as an important force in introducing and expanding good governance practices, fighting corruption, and in improving the quality and scope of health services. But more remains to be done.

Evolution of the Post-Genocide Health System in Rwanda: The WHO Model Phase (1994-2003)

In 1994, the health sector in Rwanda was in shambles. The new regime at first tried to rebuild the health sector based on the World Health Organization (WHO) model which gave priority to supply side provision of services. Resources and personnel were concentrated in the capital where the MOH elaborated programs with little consultation with the beneficiaries. Implementation structures of national programs to fight endemic diseases were extensions of national services within the MOH based in Kigali. Although the WHO model called for high standards for health personnel and services, the MOH lacked the human and financial resources to meet these standards. Following the WHO model, the GOR established Health Districts throughout the country. The health districts did not necessarily correspond with administrative districts and were not integrated with local government. Although the health districts reflected a modest effort to decentralize, their health personnel remained accountable primarily to the MOH.

The Rwandan Pharmaceutical Office (OPHAR) dominated the distribution of essential drugs until replaced by CAMERWA in 1998. OPHAR had been plagued by management problems, erratic and untimely distribution and leakage of drugs. In Africa, highly centralized state pharmaceutical agencies have often been major centers of corruption. The GOR established CAMERWA (Central Office for Procuring Essential Drugs, Medical Equipment and Supplies in Rwanda) to rationalize the distribution circuit and procurement procedures to increase efficiency and reduce corruption. CAMERWA operated much like a private enterprise and enjoyed managerial autonomy. Its creation paralleled the establishment of the NTB. In their early years, both CAMERWA and the NTB had limited human and financial resources to carry out their respective mandates. Nonetheless, their existence marked an important step forward and signaled the GOR's intention to establish anti-corruption mechanisms.

The absence of effective national anti-corruption institutions to oversee governmental institutions during the early-post-genocide period left these institutions vulnerable to corruption as did the absence of internal control mechanisms and procedures within Ministries. MOH officials interviewed by the team stated that corruption was rampant in the past within the health sector. For example, budget officers had easy access to the resources they controlled and diverted funds to amass wealth and buy big houses. At the health district level, nurses often pocketed funds they collected when dispensing drugs, overcharged, or diverted drugs to the black market because of lack of internal controls.

A New Orientation and Strategy Based on Decentralization, Rigorous Management, and Demand-Driven Service Provision (2004-2008)

Following the passage of the Constitution and presidential and legislative elections in 2003, the transitional period ended. Since then, the GOR has vigorously acted to implement institutional reforms, anti-corruption measures, and rapidly increase the scope and quality of service delivery, particularly in the health sector.

The WHO service delivery model was replaced by a new approach based on the following elements:

- Priority given to increasing public demand for health services
- Elimination of the old health districts and alignment of new ones with the 30 local government districts and greater accountability of health service facilities and personnel to local government institutions
- Large-scale redeployment of health personnel and financial resources to district level
- Rapid expansion of health structures at Sector level
- Mobilization of citizens to join community-based Mutuelles
- Establishment and rapid expansion of a community health worker system based on volunteers
- Introduction of Performance Based Financing (PBF) to provide incentives to health facilities, personnel, and communities achieving results.

Sharp increases in donor funding, especially to support campaigns to fight HIV/AIDS, malaria, and other endemic diseases, have made it more difficult for the MOH to control and coordinate donor health activities to ensure that their programs are compatible with GOR priorities. The proliferation of aid partners having different approaches, control mechanisms, salary scales and agendas have been a mixed blessing. On one hand, the influx of hundreds of millions of dollars has contributed to the modernization of the MOH and its ability to attain striking results in reaching people and improving health indicators. On the other hand, the influx of external resources reflecting donor priorities and conditions has led to a disproportionate expenditure of funding to fight AIDS while leaving other areas such as preventive and curative health underfunded. Higher salaries and access to more resources given to MOH personnel assigned to donor-funded projects risk creating resentment on the part of MOH personnel not receiving extra benefits through their seconding to donor projects. Massive donor funding has also permitted the MOH to put into place structures which it would be hard-pressed to maintain in the event that donor funding levels would significantly decline.

The MOH has succeeded in promoting its demand-driven approach. Over 80 percent of the population is covered by the community-based mutual health insurance program. More people are using public health facilities at all levels. And the MOH has sharply expanded the number of health personnel working at the sector and community levels and is planning to increase the number of personnel.

During this period, the MOH and CAMERWA have also tightened procurement rules and regulations, improved financial management, recruitment procedures, and controls over distribution of drugs and medical equipment. The results have been a sharp decline in overt corruption and improvements in the quality of services.

The measures listed above have been applied more rigorously at the national level and to a somewhat lesser extent at the district level. Fewer controls to control corruption exist below the district level,

especially at the community level where the functioning of the health system depends upon volunteers who often put in long hours with no compensation and where the formal and complex rules and regulations laid down by the national echelons of the health system make implementation more difficult because of cultural differences and different skill levels.

The rapid pace and expansion of the decentralized health system coupled with efforts to have district level and sub-district level conform with the directives and complex anti-corruption regulations elaborated at the national level have also placed heavy pressure on district and sub-district local government and health structures and personnel.

Health Sector Vulnerabilities to Corruption and Recommendations for Action

Rather than looking at specific programs, this section will focus primarily on six major areas of corruption vulnerabilities, the kinds of corruptive practices in these areas, what has been done to control corruption, and finally specific recommendations for improving health governance in these areas. Before zeroing in on specific health sector areas, it would be helpful to list the some of the broader developments and human resource and cultural constraints that put strains on the health sector system:

- Massive influx of foreign aid. Eighty percent of health sector funding comes from foreign aid which in 2008 will provide over $260 million, double the 2004 level. With all this money flowing in so rapidly come corruption vulnerabilities especially in recruitment, and procurement.
- Rapid pace of implementing ambitious programs to implement decentralization reforms, create and expand new health sector institutions, and improve the quality and scope of health services.
- The limited human resources and institutional capacity available to manage the new programs and institutions. The rapid expansion of the health sector requires expanding the numbers and improving the professional and financial management skill levels of health sector workers and local government officials and providing the financial resources and infrastructure to keep up with a rapidly expanding health system.
- The newness of many of the institutions and the time needed for officials and the public to fully understand the rules and regulations governing these new systems and the negative consequences of not following sound procedures.
- Fear to openly discuss corruption because of Zero Tolerance policies and cultural traditions discouraging citizens from confronting authority which has driven corruption underground and made it more difficult to uncover.
- The accelerated pace of change in the health sector is not isolated, but takes place in the context of rapid change throughout all sectors and levels of government. While these are positive developments, the massive number of changes combined with low skills levels poses a vulnerability for corrupt practices.
- As in many countries, asymmetries of information between health sector officials and providers vis à vis patients is another vulnerability

Procurement

As in many countries, procurement has been widely recognized as one of the major areas of corruption vulnerability in Rwanda. Drug procurement is particularly subject to corruption vulnerabilities.

Although rules and procedures have been put in place to ensure open public bidding and competition, these rules are bypassed in the case of an emergency when stocks of essential drugs are exhausted or when the demand for drugs suddenly increases because of the outbreak of an epidemic. This situation enables Rwandan health institutions to buy drugs from suppliers who can provide them quickly without going through a long process of public bidding. At the national level CAMERWA maintains that this situation does not pose much of a problem because it uses reliable providers which meet international drug standards, have been certified for at least three years, and sell at competitive prices. CAMERWA has also recently revamped its administrative structure to create a separate procurement department which has been working at tightening and revising procurement rules and increasing the number of people on procurement committees to include members from different CAMERWA divisions as well as members outside of CAMERWA to ensure greater transparency.

Opportunities for corruption can occur once a particular international firm has gained the market. If there is not sufficient vigilance and transparency, on the part of the purchaser, the international supplier could lower the quality of the product or raise its price. CAMERWA is now taking the initiative to create a major pharmaceutical factory that will produce a good deal of Rwanda's needs in essential drugs and reduce the need to depend on foreign imports and ensure drug quality.

Problems may also arise when only a few private firms dominate the market. These firms can collude on price bidding and take turns in bidding on and winning contracts. The drug procurement issue is more acute at the district level where the rigorous procedures laid down by the RPPA are less known, understood, and likely to be followed in drug procurement and other contracts. Moreover, inferior drugs are more likely to circulate in the rural areas because they are usually cheaper than those provided by CAMERWA which has higher standards. The complexity of the rules and regulations found in the RPPA and the 2007 procurement law places a heavy burden on members of the district level procurement committees with little experience in this area to fully apply them.

Procurement issues also arise on construction contracts and purchase of medical equipment. For example, the 2007 General Audit report which described the situation up to the end of 2006 noted that the CHUB in Butare did not have an accurate set of books before 2005, did not engage in competitive bidding and did not follow the rules in giving one firm a large advance of 20% without receiving any guaranties.

At the district level, lack of knowledge of national construction and drug quality standards may lead to poor choices by district procurement committee members who may give contracts to low bid vendors offering sub-standard materials and drugs at lower prices. Insufficient technical expertise on the part of procurement committee members can also lead to problems in preparing technical specifications, evaluating bids, and paying too much for the products offered.

Overt corruption can take place when individuals elaborate technical specifications to favor a particular company, leak incoming competitive bids so that a favored firm can offer a lower bid to win the contract, and knowingly accept the bid of a firm that does not have the capacity to meet its contractual obligations, offers inferior products, and overcharges. These acts reflect forms of corruption which can be motivated by favoritism, nepotism, or the desire to receive monetary compensation. Corruption also occurs when those winning a contract provide a kickback or "gift" to officials involved in procurement process

Recommendations to fight procurement corruption and ensure better health governance include:

- Increase transparency mechanisms at all levels of health system, particularly those where financial transactions occur (to reduce vulnerabilities to financial corruption) and those where services are delivered (to better empower citizens of their rights to services - scope, rates, hours - and to reduce the potential for abuse of power that derives of information asymmetry.

- Simplify, stabilize, and disseminate procurement rules to health sector personnel and procurement committee members, especially at district and sector levels. Current manuals are voluminous and complex. A simple brochure or a two page summary and/or check list of basic procurement principles and processes would enhance the ability of personnel to understand and better follow proper procedures. Such documents, publicized in the media and available for pick up at a government offices or health centers would also provide the public with information that would enable them to better understand how decisions are made and to monitor, procurement processes.

- Provide training in procurement procedures and standards to members of health sector procurement committee members at district level.

- Work on annual and longer-term procurement plans to avoid running out of stock and having to resort to emergency measures. This is practice is currently being done by CAMERWA and could also be applied by district level hospitals.

- Create an autonomous national agency to regulate and ensure drug quality akin to the American Federal Drug Agency.

- Establish MOH mechanisms to monitor procurement of medicines and medical equipment at district and health center levels in collaboration with MINALOC.

- Offer and improve appeal mechanisms for firms contesting the fairness of the procurement process and make results public.

- Get more input from private sector pharmacists and drug producers concerning improving drug procurement procedures

- Place firms consistently violating contractual obligations on a black list

- Enforce sanctions to penalize those knowingly violating the rules and standard procedures.

Warehousing, Stocking, and Distribution of Drugs

In the past, corruption vulnerabilities were particularly high in storing and distributing essential drugs. Those responsible for managing warehouses and pharmacies had few safeguards to prevent them from taking drugs for personal use, selling them on the black market, or giving them out to friends and family.

As in procurement, the main initiative for modernizing and fighting corruption in the drug distribution chain has come from the top and is most advanced in national level institutions like CAMERWA which has been expanding at a torrid pace in the past five years. In 2006 the GOR turned over assets and land to CAMERWA which enabled CAMERWA to enlarge its facilities and to establish a modern central warehouse. SCMS is providing training in specialized warehousing skills. To enhance security and rational management, CAMERWA has placed TVs in the warehouse, locked in personnel, elaborated a dispatcher system to keep track of drugs leaving the warehouse and being picked up by other units in the drug distribution chain, and strengthened its audit system.

The warehousing system has also been improved in the major hospitals in Kigali and even at the district hospital levels. While hospitals do not have the resources to replicate the methods used by CAMERWA, they are moving to improve control mechanisms. Lax monitoring mechanisms and poor bookkeeping on the part of hospital administrators had enabled those dispensing drugs to avoid accountability by not turning in their receipt books. As a result, hospital officials didn't know how much was actually collected for the sale of drugs, thus giving those dispensing drugs the possibility of keeping the money they collected for themselves or overcharging customers and keeping the difference for themselves. This

practice had been even more rampant at the district level where the personnel distributing the medicine to the patients also collected payment for medicines and kept the records. The absence of checks and monitoring mechanisms provided temptations for corruptive practices. The situation has improved at all levels thanks to the practice of separating dispensation functions from collecting money. The health personnel still gives out the prescribed drugs, but the money is collected by someone else who is accountable to hospital management. In one district hospital visited by the team, hospital officials asserted that this reform seems to have practically eliminated corruption in this area. Although still present, petty corruption in the form of asking patients to pay extra for obtaining drugs seems to be dwindling.

Another area offering possibilities for petty corruption concerns the shelf life of drugs. Expired drugs need to be taken off the shelf. If there are no mechanisms in place to ensure that they are disposed of, then unscrupulous health personnel can keep the drugs, remove the expiry dates and sell these drugs to unsuspecting clients at different levels of the distribution chain.[20]

One area which the team did not have the time to explore was the warehousing and stocking practices and drug distribution circuits organized by BUFMAR, the faith-based umbrella organization of church groups controlling 40% of drug distribution in Rwanda. This is an area which should be explored.

Recommendations for controlling corruption in warehousing and the distribution of medical equipment include the following:

- Computerize warehouse and pharmacy record-keeping systems in District Hospitals and eventually in Health Centers and improve monitoring of drug sales and stocks. This may be too expensive to implement at the present time, especially at the HC level.
- Separate responsibilities in ordering, payment, inventory, storage and distribution tasks at warehouse to control leakages
- Provide training to improve procurement planning and techniques to more efficiently control distribution of ARVs, bed nets, and other drugs and supplies associated with major programs to fight AIDS and malaria.
- Ensure posting of prices of drugs where drugs are dispensed, provide receipts to customers, and encourage feedback from customers when official prices not respected
- Improve tracking of expired drugs and launch campaign against distribution and use of expired drugs

Recruitment, Personnel Relationships, and Dealing with the Public

In the past few years, the GOR in general and the MOH in particular has tightened recruitment procedures and standards to enhance transparency, hiring based on merit criteria, and to upgrade health sector skill levels. Job requirements are listed—e.g., educational degrees, areas of specialization, experience, recommendations of previous employers and supervisors, etc. Candidates not meeting requirements are often disqualified. Moreover, recruitment is often decided on the results of competitive exams or school records.

While improved standards are essential, the recent upgrading of requirement criteria may encourage some candidates to falsify their records and recommendations. The need to fill a post or to maintain services may push officials to hire candidates not meeting the official requirements. Subjective criteria often affect

[20] This practice seems to be less widespread in Rwanda than in other neighboring African countries.

hiring—friendship, nepotism, gender and social discrimination. Old practices persist, though on a smaller scale. Applicants may seek to influence members of recruiting committees. In some cases, successful candidates may give a month's salary even when not solicited. The power to assign scholarships and participation in national and international seminars also opens up opportunities for favoritism and other forms of corruption.

One nebulous area that offers up possibilities for corruption is the often large differential in salaries, per diem, and other benefits between health personnel working directly in the MOH and those seconded to donor projects. Some MOH personnel may pull strings to get assigned to these projects. On the other hand, donors, especially implementing NGOs, may offer higher salaries and benefits to lure competent MOH personnel to work for them, thus depriving the MOH of key personnel and undermining morale. Some MOH officials may be tempted to give special treatment to certain INGOs with the expectation of getting payoffs or future employment. The differential in salaries and benefits creates tensions between MOH personnel and Rwandans and technical assistance expatriates in donor health sector projects and can be detrimental to effective collaboration.

Some of the tensions and conflicts within the health sector work place reflect similar problems in society. Focus groups have brought up issues such as sexual harassment, real and perceived gender and social discrimination, and poor communications. These problems are rarely discussed openly and if unattended can foster distrust, undermine morale, and adversely affect health personnel performance. Another area to be considered is improving communications between professional health managers at the district and sector levels and CHWs. For example, sector managers are often young university graduates with little experience in rural areas while most rural CHWs generally have much lower levels of formal education and little understanding of the formal rules and regulations elaborated at the national level to control corruption.

Much can also be done to improve relationships between MOH health personnel and the public. For example, a recent study of different forms of violence in health facilities documented a significant degree of verbal abuse (27%) and harassment (16%), some physical violence (4%) and sexual harassment (7%) and aggression (4%).[21] Another area to be considered is improving communications between professional health personnel, especially doctors and administrators working at the district level and the rural communities. Although the MOH, Health Districts, and Sectors have established complaint and suggestion boxes, these are not used very much by the community.

Major recommendations to improve good governance and reduce corruption vulnerabilities and corruptive practices in recruitment and the health sector workplace include the following:

- Greater transparency in recruitment procedures. Job requirements and hiring processes should be public and transparent as should the qualifications for obtaining scholarships and nomination to participate in national and international seminars.

  Develop joint donor-MOH ethics codes, standards, and policies for recruitment of MOH personnel for donor projects to reduce favoritism in assignments to donor projects and loss of key MOH personnel to implementing partners offering higher salaries and benefits.

- Offer higher salaries and long-term benefits to encourage high performance health sector personnel to stay with MOH. This may not be feasible without a broader civil service reform and significant increases in GOR revenues coming from domestic sources rather than international funding.

[21] USAID Capacity Project, *Etude sur la Violence en milieu de Travail dans le Secteur de la Sant´au Rwanda, Rapport Final* (Kigali, July 2008).

- Develop mechanisms for better communications and relationships between health providers and patients such as suggestion boxes, question and answer sessions, procedures for processing patient complaints, etc. Build upon and adapt the PAQ mechanism that has been developed by the Twubakane project.

- Provide training to improve transparency, open discussion and trust among health personnel in the workplace taking into consideration gender, social, and cultural differences.

- Integrate measures to stop violence and discrimination in general and gender violence and discrimination in particular in the workplace and in treatment of patients as a key component of the MOH's Human Resources Strategy. These measures could include a MOH conduct code concerning patient rights and health personnel obligations stressing the need to fight against gender discrimination and violence, workshops to bring these issues out in the open and to find solutions, and the enforcement of sanctions on those blatantly engaging in these practices.

Financial, Material, and Human Resource Management

The rapid expansion of the health sector and its ambitious goals to improve the quality and scope of health services and control corruption has placed heavy strains on the system. At the central level, the MOH may not have enough skilled and experienced personnel to engage in long-term planning and to evaluate the impact of introducing new plans, management systems, and institutions at a breakneck pace. The GOR in general and the MOH in particular has opted to move rapidly to implement nation-wide programs rather than to experiment on pilot projects in selected areas.

While impressive efforts have taken place at the national level to put into place modern managerial systems and anticorruption controls—e.g. computerization systems to track personnel and expenditures,[22] rationalization of recruitment and procurement procedures, higher skill levels for health sector personnel, and improved data collection systems—these efforts have been less successful at the district and grassroots level of the health system because of major deficits in capacity due to shortages of skilled personnel, the complexity of national level management systems, regulations and data collection techniques , lack of experience and difficulty of integrating local government and health sector institutions and functions, and the limited effectiveness of monitoring and other control mechanisms.

The General Audit report indicates that officials still use health sector vehicles, gasoline, and supplies for personal use. Thus, one finds examples of District level MOH vehicles being registered by private individuals. Bookkeeping procedures, particularly by those responsible for collecting money for services, have been lax. In the past, health professional technicians, such as doctors and nurses with little managerial experience had the responsibility for financial management of district and sector level health facilities. Before the implementation of decentralization reforms, local government and district level health officials had little involvement in formulating plans at the local level since planning was top down, reflected national priorities, and was implemented in vertical national programs. The elaboration of District Development Plans (DDPs) gave more initiative and autonomy to district level officials both elected and technical and required that they learn planning skills.

A 2008 District Capacity Building Assessment highlighted the major challenges in the system---lack of knowledge and understanding of the legal framework, especially at the lower levels; ministries not

[22] For example, the MOH now has the capacity to produce a computerized list of its 9,727 employees and provide a breakdown by category and geographical distribution. Computerization has drastically reduced the possibility of inflated numbers of personnel on the payroll who collect salaries without actually working. The National Health Account (NHA) system also provides the MOH with a useful tool for tracking actual health sector expenditures rather than budgetary projections.

honoring pledges to transfer resources in time, service delivery and monitoring of staff at the sector, cell, and community hampered by lack of adequate transport for staff to travel; weak public financial management in budget execution, accounting, procurement, internal auditing, and financial management; weaknesses in procurement systems, no monitoring systems to monitor implementation of DDPs; and little consultation by national level institutions in elaborating policies [23]

The DCBA also reported that the district level auditor was overburdened and unable to audit all the institutions in the districts, including hospital, health center, and health post facilities. Frequent meetings and demands for reports and a myriad of requests to collect data and indicators in accordance with complicated systems conceived by donors and sectoral ministries also contributed to overburdening local managers and staffs, especially when there were no original baseline studies to build upon.

While commendable in providing incentives to reward good performance, PBF programs also were open to corruption vulnerabilities to the extent that data might be falsified in the absence of reliable data to demonstrate that District Hospital and health center facilities, CHWs, and local communities had improved performance in delivering services or in lowering morbidity and mortality rates.

Inadequate human, financial, and material resources to manage and monitor funds, supervise personnel, provide the quality and quantity of services called for in planning documents, and collect reliable data creates situations which the increase the possibility of corruptive practices to go unnoticed and unpunished. These situations can also encourage managers and staff to break rules in order to meet sectoral objectives and to ignore safeguards designed to curb corruption. This can lead to corruptive practices that misreport results and indicators, divert funds from intended uses, and hide private use of public funds and equipment

Recommendations to reduce corruption vulnerabilities and improve good governance practices in the health sector include the following:

- Provide more training in fiscal management and health administration at all levels of the system
- Increase transparency in sharing information concerning national and district health accounts to better assess leakages of financial resources by the MOH's disseminating this information to District Hospitals, Health Centers, local government units, civil society organizations concerned with health issues, and private sector health providers.
- Simplify data collection systems and reduce the number of core indicators to measure results in the health sector. Each donor agency has its own set of core indicators, thus placing a heavy burden on MOH officials to provide many sets of data. Fortunately, donors and the MOH are aware of this issue and have formed a group to explore ways of reducing the number of core indicators and harmonize data collection. These efforts should be strongly supported.
- Simplify reporting systems and reduce frequency of reports.
- Strengthen efficiency and credibility of district level tender boards by providing training to members, simplifying rules and procedures, and getting the private sector and civil society more involved in overseeing these institutions
- Provide mechanisms for documenting, archiving, and sharing information concerning lessons learned and best practices concerning financial and human resource management, anti-corruption institutions, planning, customer relationships, and IEC.

[23] See MINALOC/MIFOTRA, *District Capacity Building Needs Assessment, Findings and Recommendations* (Kigali, 17 March 2008).

- Provide sufficient offices, equipment, and transport facilities to enable health personnel to meet its reporting and monitoring requirements and to supervise field personnel. The absence of sufficient funds for gasoline and vehicle maintenance and replacement hinders the capacity of local level health units to monitor and supervise grassroots operations and health personnel.

- Hire more personnel and provide training to fill gaps in key areas where there are shortages. For example, there is a chronic shortage of gynecologists, midwives, and adequately trained TBAs which are needed to reduce maternal and infant mortality rates.

- Reorient donor programs to support MOH efforts to recruit, retain, and expand health and managerial staff in critical areas which need more and better trained personnel

- Provide opportunities for existing health staff to upgrade skills to prevent losing experienced personnel. For example, new rules call for hiring A0 and A1 nurses to replace A2 nurses who currently constitute the core foundation of the health system at the grassroots level. Many A2 nurses are leaving for lack of incentives to stay. Since it takes 3 years to train an AO level nurse, it might be more efficient and less disruptive to offer A2 nurses training programs to upgrade their skills to A1 or A0 levels.

Functioning of the Community-Based Health Insurance (CBHI) system (Mutuelles)

The creation of a Community-Based Health Insurance (CBHI) system covering all Rwandans has been a major policy objective of the GOR and MOH since 1999 and a cornerstone of its demand-driven health program. With the implementation of decentralization reforms, Mutuelles were established in all 30 Districts. By 2008, 80% of the population were members and had access to health care facilities, up from 27% in 2004. Before the establishment of the new system, chronically ill persons in disproportionate numbers tended to join thus severely undermining the viability of the system. The voluntary nature of the system and widespread poverty kept enrollments down. Changes in the law to make membership compulsory combined with a system of relatively affordable premiums (1000 FRW per family member) and co-payments (10% or 200FRW) sparked the rapid and massive increase in enrollment. Provisions for the needy to get on the insurance rolls without paying also contributed to increasing membership.

A sharp increase in the use of basic health facilities followed as the percentage of those using health services rose from only 21% in 2001 to 75% by the end of 2007. While the enlarged membership pumped additional funds into the health system, the drastic increase in health service use also put tremendous strains on the system to meet the new demand.

The CBHI system is exposed to corruption vulnerabilities due to a number of factors including: the rapid growth and newness of the system; the insufficient numbers, lack of experience, and low salaries of Mutuelle officials and managers; inadequate office space and equipment, the lack of understanding of and conformity with Mutuelle rules on the part of community mobilization committees and sectional management committees; limited transport resources available to Mutuelle managers to make field visits to supervise and monitor community volunteers; discretionary powers in naming needy individuals to obtain insurance free of cost; and lack of transparency concerning billing. These challenges are compounded by weak fiscal management skills, the lack of computers and well defined procedures to track the flow of money and to conduct effective audits. There also seems to be a shortage of national level Mutuelle officials and limited mechanisms to supervise district and lower level Mutuelle staff.

Records indicate that premiums collected at the community level do not always arrive at the Mutuelle offices. It is difficult to allocate blame because of poor bookkeeping records. For example, corruption could take place at the community level in several ways. First, the person charged with collecting

premiums might give an individual a receipt for payment without actually collecting any money as a favor or in exchange for a bribe or a gift. Second, the collector could collect the money, give a receipt to the individual, and keep the money. In this instance, the person who paid the premium would not be adversely affected because he would have the receipt entitling him to access to health services. It would also be possible for Mutuelle managers to manipulate accounts to show that his office received less money than actually received.

The designation of those capable of paying premiums as indigent constitutes a corruptive practice as does the non-designation of the needy as indigent.[24] The first deprives the system of funds and gives the beneficiary a free ride. The second deprives access to health care facilities for needy persons not on the list. Two other corruptive practices fostered by weak control mechanisms consists of health service facilities and providers overcharging for services paid for by the insurance program and prescribing more drugs to patients than actually needed since the cost will be paid by the insurance program. Low salaries, an avalanche of paperwork, and weak control mechanisms also provide temptations for Mutuelle managers to cut corners in reporting, falsifying records, and misappropriating funds.

The MOH has recently attempted to address some of these issues by increasing the number of Mutuelle officials working at the sector level from one to three to reduce workloads and recruiting individuals with accounting and fiscal management skills to handle financial management tasks. In May 2008, the MOH also came out with a new manual of procedures concerning financial management which spells out procedures.

Recommendations to improve governance and control and reduce corruptive practices in the CBHI-system include the following:

- Reduce paperwork of Mutuelle section managers and explore the feasibility of raising their salaries when revenues generated by CBHI programs increases.

- Provide training to Mutuelle personnel and section managers in using new Mutuelle fiscal management manuals to learn proper procedures for registering members, collecting premiums, giving receipts controlling rights to services of members, billing of health providers, etc.

- Train community auditors to monitor payment of premiums, bills, and transfer of funds and ensure that external District level Mutuelle auditors check sectional and community level Mutuelle accounts at least once a year to reduce misallocation and embezzlement of funds

- Provide training to community mobilization committees and section management committees concerning Mutuelle rules and regulations and their responsibilities as members of these committees.

- Provide sufficient logistical support- vehicles, motorbikes, gasoline, -- to enable sector personnel to make field visits to communities and supervise community level volunteers and committees. Traditionally, donors are reluctant to fund these expenditures after their projects are completed or in areas where they are not working. Donors may need to rethink their traditional opposition to financing “recurrent costs” and create a joint resource pool in collaboration with the MOH and MINALOC to help fund these essential expenditures needed to insure proper monitoring and supervision of grassroots operations. Over time, as Rwanda experiences economic growth and its capacity to increase government revenues, support for recurrent costs could gradually be phased

[24] The Global Fund is providing $34 million dollars over a four year period to cover the costs of the 800,000 Rwandans listed as indigents who are covered but not paying dues.

out. For its part, GOR will also need to make a greater effort to provide more funding for grassroots operational costs.

- Use "Ubudehe" cells at the community level to compile lists of indigents based on the "Ubudehe" method of identifying indigents in the health Mutuelles[25]
- Limit premium subsidies only to indigents and eliminate those capable of paying from indigent list
- Place a Mutuelle agent at the DH level to verify and monitor billing at DHs to reduce overbilling and over prescription of medicines to CBHI patients
- Integrate Mutuelle management and community mobilization committees and Mutuelle employees to benefit from PBF and c-PBF incentive systems

Community Health Workers and Citizen Participation and Oversight in Decentralized Health Institutions

The MOH defines Community Health "as a holistic and integrated approach that takes into account the full involvement of communities in planning, implementation and evaluation processes."[26] It sees communities as an essential determinant of health and an indispensable ingredient for effective public health practice. In elaborating Community Health policies, the MOH notes the need to take into account local culture, norms, belief systems, institutions, and politics.

One of the major innovations of the new National Community Health Policy, a high priority for the GOR, involves the mobilization of volunteer CHWs at the community level to provide primary health care services. The absence of material incentives combined with a heavy workload for volunteers opens the system to corruption vulnerabilities and temptations for CHWs to engage in charging for services which are free or covered by CBHI and/or accepting gifts from clients for services rendered. Many at the community level do not this as a form of corruption, but rather as part of a traditional pattern of exchange based on reciprocity.

The MOH proposes to improve CHW performance by introducing a community PBF system which will be financed by the World Bank, Global Fund, and MOH and have clear guidelines and indicators to measure performance such as mutuelle enrollment, reduction of maternal and child mortality rates and malaria-caused deaths; and accurate and timely reporting by CHWs.

Incentives will go to CHW cooperatives rather than to individuals. Thus, CHWs will be encouraged to organize cooperatives to generate incomes and as a pre-condition for receiving c-PBF incentives. Sound cooperative principles affirm that voluntary organizations organized at the initiative of its members who pool their resources to engage in common economic activities are usually the most successful. The MOH sees cooperatives as a an instrument for providing financial support to CHWs and a substitute for paying CHWs. Top-down approaches to organizing cooperatives usually do not succeed when members have little ownership of these institutions and join because of government pressures and/or benefits provided by the government rather than as a spontaneous response to market incentives. Members of economic cooperatives usually engage in full-time economic activities. CHWs working long hours under the current

[25] The Ubudehe method trains community members to work together to define and analyze local problems, come up with solutions, and take collective action to resolve the problem. The methodology was introduced in Rwanda by Action-Aid and can be applied to deal with all kinds of problems, not just those involving health services. For more on the methodology, see Ubudehe Policy Group, Ubudehe *in Rwanda: Community Collective Action* (Kigali, nd).
[26] Ministry of Health, *National Community Health Policy* (Kigali, March 2007), 2.

CHW program may not have much spare time or energy to engage in income-generating activity. Nor do CHW members necessarily share similar or adequate skills to earn a profit from their economic activities. Though CHWs are trained to be health service providers, they are asked to earn money through other activities. It remains to be seen whether c-PBF incentives will be sufficient to keep CHWs motivated.

The establishment of a nation-wide CHW-based cooperative system also offers opportunities for corruption on the part of cooperative officials chosen by the community who will assume responsibility for managing cooperative finances and allocating PBF incentive payments to cooperative members. Moreover to the extent that incentive payments will be based on key indicators, those collecting data may be tempted to inflate results.

More needs to be learned about the recruitment process for CHWs at the community level who are said to be elected on the basis of personal character, literacy, prior service, and the cleanliness of their homes. CHW volunteers often see their service as a stepping stone to a salaried job. The expansion of the basket of primary health care services at the community level will require the acquisition of new skills. Moreover, it is not clear that the A2 nurses who staff the HCs have advanced training in midwifery, social work, nutrition, hygiene, and other aspects of public health now deemed as essential skills for health personnel providing services to rural communities. A2 nurses also often lack the skills needed to supervise CHWs.

Although the GOR often speaks of the need for participatory planning, in fact, the elaboration of health policies is usually taken at the national level with little consultation of district level health and local government officials. While citizens participate in Joint Action Development Forums (JADFs), these are usually initiated by GOR officials. The centralization of national policy planning in the health sector with an emphasis on uniform approaches and priorities may clash with local health priorities which are bound to be different because of different economic, ecological, social, and cultural differences across districts. Donor projects reflect local priorities even less than MOH policies. For example, the huge funding given to fight AIDs, though commendable, does not correspond with local priorities and concerns in many districts to reduce maternal and infant mortality.

The limited presence and passive role of local civil society and private sector representatives in district level health management, planning, and monitoring institutions also limits citizen oversight of health sector activities. The GOR's emphasis on the need for community participation is an important step in the right direction. But it will take some time to change top-down mobilization traditions and to engage citizens and civil society to become more actively involved in planning, monitoring, and overseeing health sector activities.

Recommendations to enhance citizen participation and good governance in the community health sector and address corruption vulnerabilities include the following:

- Develop consultative mechanisms such as national and local level workshops on specific topics related to the health sector, town meetings, Question and Answer Sessions, etc. These mechanisms should ensure greater participation and inputs of local government officials (RALGA), citizens, civil society, and the private sector in National and Local Community Health policy decision-making and improve communications between the Community Health Desk and District level and Community level health institutions.

- Simplify data collection procedures and develop performance indicators which are more relevant to health conditions and needs in specific Districts by reducing the number of data indicators elaborating indicators which address the major health issues and MOH and citizen rather than donor priorities in specific districts.

- Explore the possibility of building upon and adapting cultural traditions and institutions based on community solidarity and reciprocity norms traditionally used by the community to manage community affairs to monitor and sanction corruptive practices in the community today.

- Replicate the Twubakane Project's PAQ (*Partenariat pour l'Amélioration de Qualité*) model for community involvement in health sector activities which fosters collaboration between local government representatives and civil society groups to set up commissions to deal with health issues decided by the group. This kind of collaboration increases transparency, builds trust, and provides the community with opportunities to monitor health service delivery and influence community health sector priorities.

- Provide more training in human resource and fiscal management skills to directors of HCs charged with supervising CHWs

- Rethink the policy of mandating CHWs to organize cooperatives as a precondition for receiving c-PBF incentive payments. If cooperatives are formed, provide training to cooperative members in financial management, elaboration of business plans and feasibility studies, and the skills needed to engage in specific income generating activities.

- Provide training to community members involved with district administration in basic skills in health governance and financial and administrative management as citizen responsibilities and oversight functions increase with the next phase in the implementation of decentralization reforms.

STRATEGIC RECOMMENDATIONS

In the sections above, we have analyzed six key areas of health sector governance where corruption vulnerabilities are present. The recommendations offer a "shopping" list of very specific measures to take for each area. These recommendations are more tactical than strategic. The table that follows provides four major strategic anticorruption and good governance reform options which offer a more strategic approach for the GOR and donors in the health sector to follow:

SUMMARY OF STRATEGIC ANTICORRUPTION PROGRAM OPTIONS FOR RWANDA PUBLIC HEALTH SECTOR

Area or Function	Anticorruption Program Option	Major Counterparts	Potential Obstacles	Potential Impact on Corruption	Short-term Success	Impact Timing
Transparency	Enhance transparency at all levels+areas of health sys. Procurement Distribution of Meds + Equip Recruitment Info. Sharing	MOH, donors, MINILOC, CAMERWA, CNLS CHUs,DHs, HCs, BUFMAR Private drug firms Local Govt. + Natl. +District Procurement Committees Mutuelles +CH systems Media +Public	Interference by corrupt stakeholders Transparency rules not applied Corruption driven underground Reluctance to share info Restrictions on Press and lack of professional	Could reduce corruption, improve health standards + service delivery Develop trust within MOH and public confidence in health system	Potentially significant	Short-to-medium term
Financial Management	Strengthen financial Man. Capacity at all levels and areas thru training, simplification of procedures, and adaption of systems to local conditions	Management Institutes, MOH, donors MINILOC, CAMERWA, BUFMAR,CNLS Local Govt. CHUs,DH, HCs, Mutuelles, CHWs Local health CSOs	Limited number of trained personnel, Complexity of rules and application of same rules to all levels of the system Resistance by stakeholders benefitting by laxity in FM	Could prevent leakages and waste of resources, Reduce opportunities for corruption	Potentially significant	Short-to medium term
Decentralization.	Strengthen capacity of decentralized health sector	MOH, DHs,HCs, Mutuelles,, and community health	Newness of Dec. system	Could improve quality and quantity of	Potentially Significant	Medium to Long-term,

Area or Function	Anticorruption Program Option	Major Counterparts	Potential Obstacles	Potential Impact on Corruption	Short-term Success	Impact Timing
	institutions at all levels + harmonious integration with LG institutions	system MINALOC, mayors, DCs, sectors, cells, local CSOs District Planning Committees Implementing NGOs	Politicization L.G. lack of understanding of technical issues Conflicts between health sector +LG officials	health services Could contribute to consolidating decentralized institutions and building democracy at the grassroots		Will require time
Citizen Part. + Oversight	Increase citizen participation and oversight at all levels of Health system especially at local and community levels	MOH, CHUs, DHs, HCs, Mutuelles, Community primary health care systems, MINALOC, DCs, Mayors, Health Sector procurement and planning committees Joint Development Forums, DDP committees Private sector CBOs, CSOs, Ubudehe groups	Top-down decision-making traditions Desire of GOR to move quickly to make + implement health policy with little consultation with people Weakness and timidity of civil society + private sect Low understanding of how LG and health sector work Limited capacity of citizens to oversee health and L.G. institutions	Could reduce corruption and improve efficiency of health institutions Stimulate greater mobilization of local resources to contribute to support of health system	Potentially significant	Medium to Long-term

Many of the problems and issued raised in the health sector as in other sectors are due to the low capacity of the GOR in human, financial and material resources rather than to rampant corruption. Good governance calls for a high degree of transparency and accountability. These two governance practices provide two important safeguards against corruption. Efficiency depends upon professional technical and managerial skills to get the most out of existing resources and raising the capacity of health sector institutions. The GOR and the MOH deserve much credit for working hard to implement decentralization reforms and improve the living standards and health of their people by insuring greater access to public

services and preventing the squandering of limited resources through corruptive practices. It remains to be seen whether the rapid pace of change can be sustained and serious mistakes avoided in the future. This assessment concludes that the GOR would benefit from soliciting more feedback from the people and giving citizens more leeway to develop their own solutions and modes of organizing to solve their problems at the local level.

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REFERENCES

Azfar, Omar, "Corruption and the Delivery of Health and Education Services," in Bertram I. Spector (Ed.) *Fighting Corruption in Developing Countries; Strategies and Analysis* (Bloomfield, CT: Kumarian Press, Inc., 2005), 181-212).

Bizimana, Jean Damascène and Paul Kananura, *Etude et Proposition d'un Projet de Prévention, Lutte et Repression de la Corruption dans la Magistrature Rwandaise* (Kigali, transparence Rwanda, December, 2006).

Bossert, Thomas J., "Decentralization and Governance in Health," www.HealthSystems2020.org, (June, 2008),1-16.

Brinkerhoff, Derick, "Health Governance: Concepts, Experience, and Programming Options," www.HealthSystems2020.org, (February 2008), 1-30.

Burnett, Jennie E., "Rwanda," in Freedom House, *Countries at the Crossroads 2007*(Washington, DC: 2008), 1-26.

Casals & Associates, *Anti-Corruption Workshop and Technical Assistance, USAID/Rwanda.Health Sector, February25-29,2007, Final Report.* Alexandria, VA, n.d.

Checchi and Company Consulting, Inc., *Africa Bureau Anti-Corruption Initiative (ACI) Mid-Term Evaluation, Final Report* (Washington, DC, USAID, July 2006).

Chr. Michelsen Institute, "Corruption in the Health Sector," www.U4.no, U4 issue 1:2006.

Chr. Michelsen Institute, "Overview of Corruption in Rwanda," www.U4.no, April 16, 2008.

Cross, Peter, *Strengthening CAMERWA's Financing and Financial Management Systems* (Kigali, SCMS, May 28, 2008).

European Union Election Observation Mission, "2008 elections prove a sound basis for further reform" (Kigali, September 17, 2008).

Friday, Barbara, *Corruption: What is corruption, why does it matter, what can we do? Local Governments Workshops, Kigali, Rwanda, March 9 and 10, 2007* (Kigali. 2007).

Gellar, Sheldon, Anicet Kayigema, and Sharon Moris, C*ivil Society in Rwanda: Assessment and Options* (Burlington, VT, ARD, 2001).

*In*yarubuga, Hertilan, Les *Mutuelles de Santé au Rwanda*, (Powerpoint Presentation). Kigali, n.d.

Kayira, Fidèle, *Using Ubudehe (Local Collective action) to identity poor households to enter Mutuelles* (Powerpoint Presentation, Kigali, 2008).

Kimonyo, Jean-Paul, Rwanda*, Un génocide populaire* (Paris: Karthala, 2008).

Kolstad, Ivar and Odd-Helge Fjeldstad, "Fiscal decentralization and corruption: A brief overview of the issues," *U4issue, e3:2006*

Manning, Judy, Kamden Hoffmann, and Jessica Forest, *Rwanda Community Health Needs Assessment* (Kigali: USAID/Washington, September 10, 2008)

MCC Scorecard, *Rwanda FY2008.*

MINALOC/MIFOTRA, *District Capacity Building Needs Assessment, Findings and Recommendations* (Kigali, March 17, 2008).

Republic of Rwanda, Ministry of Local Government, Good Governance, Community Development and Social Affairs, *Rwanda Decentralization Strategic Framework: Towards a sector-wide approach for Decentralization implementation* (Kigali, August, 2007)

Republic of Rwanda, Ministry of Local Government and Social Affairs, *National Decentralization Policy* (Kigali, May, 2000).

Republic of Rwanda, The Office of the Ombudsman, Summary *Report of the Activities of the Office of the Ombudsman in 2007*. Kigali, January 2008.

Republic of Rwanda, Rwanda Revenue Authority, *Annual Report 2006*, Kigali, May, 2007

Republic of Rwanda, Ministry of Health, *National Community Health Policy* (Kigali, March, 2007)

Republic of Rwanda, *Rwanda Health Strategic Plan, HSSP I, 2005-2009, Evaluation Report* (Kigali, July 24, 2008).

République du Rwanda, Ministère de la Santé *Plan Stratégique de Santé Communautaire* (Kigali, February-March, 2006).

République Rwandaise, Ministère de la Santé, *Document de Politique de la Décentralisation du Ministère de la Santé* (Kigali, April 2003).

République du Rwanda, Ministère de la Santé *Politique de Développement des Mutuelles de Santé au Rwanda* (Kigali, 2004).

République du Rwanda, Ministère de la Santé, *Procedures de Gestion Financiére d'une Mutuelle de Santé* (Kigali, May, 2008).

Smith, Zeric, Timothy Longman, Jean Paul Kimonyo, and Théoneste Rutagengwa, *Rwanda Democracy and Governance Assessment* (Washington, MSI, November 2002)

Spector, Bertram I., Michael Johnston, and Svetlana Winbourne, *Corruption Assessment Handbook, Final Report* (Washington DC: USAID, May 16, 2008).

Spector, Bertram I. (Ed), *Fighting Corruption in Developing Countries: Strategies and Analysis* (Bloomfield, CT: Kumarian Press, Inc., 2005).

The Steadman Group, *Report on the assessment Study on Corruption at the Northern Road Corridor Transit Points* (Kigali, July 2007).

Transparency Rwanda, *Rwanda, Etude du Système National d'Intégrité* (Kigali, January, 2008)

Transparency Rwanda, *Séminaire atelier sur "la lutte contre la corruption dans les marchés publics," Kigali, Serena Hotel, July 25, 2008. (Kigali, 2008/*

Ubudehe Policy Group, *Ubudehe in Rwanda, Community Collective Action* (Kigali, n.d.)

USAID, *A Rapid Anti-Corruption Assessment Technique for USAID/Africa: Developing a Practical Checklist for USAID Missions in Africa* (Management Systems International, Washington, DC: January 23, 2007).

USAID Capacity Project, *Etude sur la Violence en milieu du travail dans le secteur de la Santé au Rwanda, Rapport Final*(Kigali, July 2008)

USAID/Rwanda, *Rwanda HMIS Assessment Report* (Kigali, May 9, 2006).

Uvin, Peter, *L'Aide Complice? Coopération International et Violence au Rwanda* (Paris: L'Harmattan, 1998).

Vian, Taryn, "Health Care," in Bertram I. Spector (Ed.), *Fighting Corruption in Developing Countries: Strategies and Analysis."* (Bloomfield, CT: Kumarian Press, Inc., 2005), 43-63.