



United Nations Development Programme

FIGHTING CORRUPTION IN THE HEALTH SECTOR

METHODS, TOOLS AND GOOD PRACTICES

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UNDP is the UN's global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. UNDP is on the ground in 135 developing countries, working with them on their own solutions to global and national development challenges.

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Over the past decade, impressive progress has been made towards meeting the global commitments outlined in the Millennium Development Goals (MDGs). Legal frameworks, systems and processes are in place, and aggregate public spending on social services such as education, health, water and sanitation has increased in many countries. However, disaggregated data on MDG achievements present a picture of uneven progress across regions, between and within countries.

The reason for insufficient progress is not just due to a failure to address entrenched disparities and inequalities or the lack of financial resources generated within and/or flowing to developing countries, but also from the major bottlenecks such as systemic corruption that result in diversion of valuable resources. The poor and vulnerable sections of the society are ultimately the ones to suffer the consequences of corruption.

The outcome document of the 2010 MDGs Review Summit has identified corruption as the major barrier for achieving the MDGs. It calls for decisive steps to be taken to combat corruption in all its manifestations. This requires an understanding on how corruption manifests itself and where corruption risks exist in different sectors, in order to devise strategies to address the underlying governance and anti-corruption bottlenecks impeding MDG progress.

This UNDP-sponsored study presents methods, tools and good practices to map corruption risks, develop strategies and sustain partnerships to address challenges and tackle corruption in the health sector. It complements UNDP's MDG Acceleration Framework (MAF), which has been endorsed by the UN Development Group and enables governments and development partners, within established national processes, to identify and systematically prioritize the bottlenecks to progress toward achieving the MDGs, and then devise ways to overcome them.

The study brings together UNDP's efforts to support countries to develop frameworks to accelerate their efforts to meet the MDGs as well as successfully meet the commitments of the UN Convention against Corruption. It also specifically takes forward UNDP's agenda to develop sectoral approaches to address corruption in different sectors.

MDGs 4, 5 and 6 set basic targets to promote complete physical, mental and social well-being in order to expand capabilities and enlarge the choices people have in fulfilling their lives. This report considers several quantitative and qualitative studies that analyse and present evidence of the negative impact of corruption on health outcomes. This study goes one step further, however. It acknowledges the complex nature of the sector and the information asymmetry that exists within the system. Additionally, within this framework, the report reviews existing literature and discusses methods, tools and good practices on how to address corruption at various levels in the health sector. The study presents concrete evidence for building multi-stakeholder partnerships, including with direct beneficiaries of the public health sector, to promote accountability and improve service delivery.



FOREWORD

We sincerely hope that this study will inspire further country level analysis of corruption risks in the health sector. We also expect that the methods, approaches and good practices presented in this study will serve as a resource for developing country-level interventions and building sustainable partnerships.

Sincerely,

A handwritten signature in black ink, appearing to read "Geraldine J. Fraser-Moleketi".

Geraldine Fraser-Moleketi
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A handwritten signature in black ink, appearing to read "Selim Jahan".

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ACRONYMS AND ABBREVIATIONS



CSO	Civil society organization
DFID	UK Department for International Development
GGM	Good Governance for Medicines programme (of WHO)
IMF	International Monetary Fund
MDG	Millennium Development Goal
MeTA	Medicines Transparency Alliance
MoH	Ministry of Health
NGO	Non-governmental organization
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHO	World Health Organization



EXECUTIVE SUMMARY



UN Photo/Evan Schneider

Several quantitative and qualitative studies highlight the fact that the burden of corruption in the health sector impacts the poor most heavily, given their limited access to resources. Poor women, for example, may not get critical health care services simply because they are unable to pay informal fees: a recent study by Amnesty International on maternal health in Burkina Faso found that one of the primary causes of the deaths of thousands of pregnant women annually (including during childbirth) is due to corruption by health professionals. Further evidence from the International Monetary Fund (IMF) shows that corruption has a significant, negative effect on health indicators such as infant and child mortality, even after adjusting for income, female education, health spending, and level of urbanization. Corruption lowers the immunization rate of children and discourages the use of public health clinics. In many countries, its pervasiveness impedes improvement in health outcomes and therefore is a serious barrier to the achievement of the Millennium Development Goals (MDGs).

This study highlights where and how corruption is a threat in the health sector, and how it can be diagnosed and tackled. Some of the common corrupt practices in the health sector identified include absenteeism, theft of medical supplies, informal payments, fraud, weak regulatory procedures, opaque and improperly designed procurement procedures, diversion of supplies in the distribution system for private gains and embezzlement of health care funds. Each of these practices alone represents a major challenge in many developing countries.



Effective interventions addressing such vulnerabilities need to be designed so that health goals are more likely to be achieved. This study provides examples of anti-corruption interventions that can help policy makers and practitioners to determine what may be most appropriate for their situation. For example, the public posting of medical supply prices can help prevent collusion; regular external and internal audits can help ensure budgets are allocated and spent appropriately; and citizen scorecards can help decision makers identify where potential problems lie. Stand-alone anti-corruption interventions cannot eliminate all risks, however. Instead, what is needed is a multi-pronged approach that includes a variety of supporting interventions mainstreamed across sectors.

The study concludes with some considerations for UNDP staff and others working on health-related projects. The following 10 key lessons are identified and discussed:

- Health policy goals should include anti-corruption considerations.
- There is no 'one size fits all' approach to combating corruption in the health sector.
- More than one anti-corruption intervention should be employed to deal with one risk.
- Prioritization is essential: based on evidence, governments and others involved in health projects and programming should prioritize areas of the health system that are most susceptible to corruption and implement appropriate interventions.
- It is important to work with other sectors.
- Prevention is the best strategy: therefore, it is best not to wait for corruption to happen before beginning to deal with it.
- Numerous empirical diagnostic tools should be employed.
- Partners with experience in implementing anti-corruption strategies and tactics should be identified for technical support.
- Broad participation in health policy and planning helps.
- Good behaviour should be rewarded, and bad behaviour punished.



EXECUTIVE SUMMARY



UN Photo/Sophia Paris

1.1 Purpose of report

Commissioned by the Democratic Governance Group of the United Nations Development Programme (UNDP), this study is a review of corruption assessment tools and anti-corruption interventions relevant for the health sector¹. Its intended audience is UNDP staff as well as health policy makers and others who have an interest in how corruption can have an impact on the health sector. This study aims to serve as background for further work by UNDP to develop a methodology to mainstream anti-corruption initiatives in the health sector.

The amount of existing knowledge that is relevant and related to corruption (including examples from outside of the health sector) and health systems strengthening is extensive. This study therefore seeks to summarize critical knowledge and provide limited examples and references that illuminate some of the common themes and interventions.

¹ The definition of corruption used in this study is the abuse of entrusted position for private gain.

1. SETTING THE CONTEXT: BACKGROUND AND OVERVIEW



1.2 Methodology and structure of study

The study is based on a selection of mainly public policy reports and research on health and corruption relevant to developing countries. The documents were drawn from an initial body of literature included in the terms of reference as well as a literature search using 'health and corruption' as the search term. Commonly cited studies from this initial pool of resources were then included, as well as documents suggested by members of an advisory committee.

The consultant has drawn heavily on a number of informative studies, most of which were published in the past five years. Several notable studies are listed below. All are recommended for those seeking further knowledge about issues related to health and corruption:

- Vian, Savedoff & Mathisen 2010²;
- Lewis & Pettersson 2009³;
- Vian 2008⁴;
- Cohen et al 2007⁵;
- Lewis 2006⁶; and
- Di Tella & Savedoff (2001)⁷.

The study is organized as follows:

- summaries of the impact of corruption on development and how and why the health sector is susceptible to corruption (Sections 1.4 through 1.5);
- examples of existing international health sector diagnostics and international initiatives (Section 2);
- analysis of specific corruption risks in the health sector, along with good practice examples and tables outlining relevant anti-corruption interventions (Section 3); and
- key lessons from the study that may help UNDP staff and others engaged in health policy (Section 4).

Limitations

There are a number of study limitations important to acknowledge at the outset. First, the study is based on documents and health policy research that are publicly available (with a few exceptions); because of resource and time restraints, it does not include richer contextual information that could

2 Vian, T., Sayedoff, W. & Mathisen, H. (2010) *Anticorruption in the Health Sector: Strategies for Transparency and Accountability*, Kumarian Press, West Hartford, CT (USA).

3 Lewis, M. & Pettersson, G. (2009), 'Governance in health care delivery: raising performance'. World Bank Policy Research Working Paper 5074.

4 Vian, T. (2008). 'Review of corruption in the health sector: theory, methods and interventions'. *Health Policy and Planning*, 23(2), 83-94.

5 Cohen, J., Mrazek, M., & Hawkins, L. (2007). 'Corruption and pharmaceuticals: strengthening good governance to improve access' in Campos, J. E., & Pradhan, S., eds., *The Many Faces of Corruption: Tracking Vulnerabilities at the Sector Level*. World Bank, Washington, DC (USA).

6 Ibid.

7 Di Tella, R. & Savedoff, W., eds., (2001). *Diagnosis Corruption: Fraud in Latin America's Public Hospitals*. Latin American Research Network, Inter-American Development Bank, Washington, DC (USA).



1. SETTING THE CONTEXT: BACKGROUND AND OVERVIEW

be gained by probing key informants. Second, the empirical evidence to back up what interventions work best and why is limited. Subsequent country case studies by UNDP country and regional offices will help build much needed empirical data documenting which interventions may work most effectively for health outcomes.

1.3 Global recognition of the impact of corruption on human development

The impact of corruption on human development is an increasingly important focus area for the United Nations and others⁸. For example, the United Nations Convention against Corruption (UNCAC), which was adopted by the UN General Assembly in October 2003 and came into force in 2005, raised the importance of fighting corruption worldwide.

UNDP is the lead agency on democratic governance in the UN system. The agency has been engaged in anti-corruption work since the early 1990s, within its mandate of ‘fighting corruption to improve governance’.⁹ This initiative, which is supported through UNDP’s Global Thematic Programme on Anti-Corruption for Development Effectiveness (PACDE), will help regional, national and local governments implement anti-corruption initiatives.

Other UN agencies and international, financial institutions are also engaged in anti-corruption work. The World Health Organization (WHO) Medicines Strategy 2004-2007 included corruption as a priority issue and led to the launch of its Good Governance for Medicines (GGM) programme. The United Nations Children’s Fund (UNICEF) recognizes the relationship between child mortality and corruption and has linked its promotion of the rights of the child to good governance. The United Nations Population Fund (UNFPA) and UN Women (formerly UNIFEM) are helping to publicize the linkage between gender and corruption. In the health sector, women are more affected by corruption given their need for more specialized and generally more frequent health care services. Also, the World Bank’s Public Resource and Economic Management Group is the central clearinghouse for its institutional anti-corruption work. Another core initiative is the U4 Anti-Corruption Resource Centre¹⁰, which is funded by a number of donors and is a repository of information on health and corruption for development specialists and policy makers¹¹.

⁸ The development community is increasingly recognising the importance of implementing good governance projects to achieve health goals. Two examples are the UNDP project on Strengthening Ethics and Integrity for Good Governance in the Health Sector of Mongolia and the Basel Institute of Governance research project Governance of Health Systems, which examines governance inputs, processes and outcomes in Tajikistan and the United Republic of Tanzania.

⁹ Following the UN resolution A/RES/51/59 adopted on 28 January 1997.

¹⁰ See www.u4.no/index.cfm.

¹¹ U4 Anti-Corruption Resource Centre donors include Norad (Norway), DFID (United Kingdom), CIDA (Canada), GTZ (Germany), MinBuZa (the Netherlands), SIDA (Sweden), BTC (Belgium) and AusAID (Australia).

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1.4 Corruption, health and the Millennium Development Goals

The Millennium Development Goals (MDGs)¹² consist of eight global development objectives that member-states have pledged to achieve by 2015. The eight goals—three of which (numbers 4, 5 and 6) are health-specific—are listed below. Each goal has specific measures that indicate progress:

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Create a global partnership for development

Corruption in the health sector is a reflection of the structural challenges in the health care system as well as where it takes place within the health care sector.

The achievement of the MDGs is contingent on a number of conditions including the presence of good governance, which until recently was little discussed in relation to them¹³. In 2009, however, UN Secretary-General Ban Ki-moon highlighted the impact of corruption on the MDGs. He emphasized that corruption can kill development and may very well impede efforts to achieve the MDGs¹⁴. Thus, designing MDG action plans that effectively integrate governance and anti-corruption interventions is critical for achieving desired goals. This is supported by evidence. An analysis by Transparency International in 2010 showed that increasing transparency, accountability and integrity in 48 countries has a robust correlation to better outcomes in health, education and water.¹⁵ This finding holds true irrespective of a country's wealth or how much it spends in a specific sector.

1.5 How and why the health sector is susceptible to corruption

Corruption in the health sector is a reflection of the structural challenges in the health care system as well as where it takes place within the health care sector. Among the key reasons for corruption in the health sector are weak or non-existent rules and regulations, over-regulation, lack of accountability, low salaries and limited offer of services (i.e., more demand than supply). The scale of corruption also varies: it may be 'petty' (as with bureaucratic or administrative corruption that takes place at

¹² The MDGs directly related to health are numbers 4, 5 and 6. Other MDGs also are indirectly related to health yet are nonetheless important for the sector. For example, one target under MDG 8 specifies that "in cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries."

¹³ For a comprehensive overview, see Wagstaff, A., & Claeson, M. (2004). 'The Millennium Development Goals for health: rising to the challenges'. World Bank, Washington, DC (USA).

¹⁴ UN Secretary-General's speech on the International Anti-Corruption Day, 9 December 2009. Online: www.un.org/News/Press/docs/2009/gsm12660.doc.htm.

¹⁵ See Transparency International (2010). 'The anti-corruption catalyst: realising the MDGs by 2015', Berlin, Germany, p. 1.



1. SETTING THE CONTEXT: BACKGROUND AND OVERVIEW

the implementation level where the people (recipients of services) interact with public officials) or 'grand' (corruption at a higher level, notably at the policy level).

Whatever the reason or type, there is little doubt that corruption hurts health. Several quantitative and qualitative studies illustrate how the burden of corruption impacts the poor most heavily given their limited ability to meet demands imposed by corruption. For example, poor and marginalized individuals can be denied access to necessary care if payments are required for health care services¹⁶. In Bulgaria, high-income urbanized patients were more likely to make informal payments and thus receive care they needed in contrast to low-income patients¹⁷. A recent study by Amnesty International on maternal health in Burkina Faso found that one of the primary cause of the deaths of thousands of pregnant women annually (including during childbirth) is due to corruption by health professionals. Poor women may not get critical health care services simply because they are unable to pay informal fees¹⁸. Further evidence comes from an International Monetary Fund (IMF) report showing that corruption has a significant, negative effect on health indicators such as infant and child mortality, even after adjusting for income, female education, health spending, and level of urbanization¹⁹. Corruption lowers the immunization rate of children; can prevent the provision of necessary treatment, particularly for the poor; and discourages the use of public health clinics²⁰. The two clear and related conclusions are that corruption hurts health outcomes and it is the poor who are affected the most.

As noted in Diagram 1 below, the health sector is susceptible to corruption for a number of reasons related to its organization. First, it is a complex sector, even more so than many others. Uncertainty prevails within the sector: it is not possible to know who will get sick or when, and therefore it is often challenging to predict what supplies and services are needed, when they are needed, and in what quantities. It is also a sector that has asymmetric information, with significant information imbalances between providers and patients and suppliers and providers. For example, physicians prescribe medicines to patients and patients assume that they are being prescribed the right drug for their conditions. However, physicians may prescribe a particular product because a pharmaceutical company is offering him or her an incentive to do so—or that particular product may be recommended by developers of national health guidelines for the same reason, which has nothing to do with its effectiveness or safety.

In addition, a large number of stakeholders with limited and/or indirect accountability exist throughout the sector and they interact in complex ways²¹. Health professionals should be accountable to regulatory bodies, but the enforcement of standards—and sanctions for deviations

16 Lewis, M. (2000). 'Who is paying for health care in Eastern Europe and Central Asia?' International Bank for Reconstruction/World Bank Publications, Washington, DC (USA).

17 Ibid., quoted from Balabanova, D. (1999). 'Informal payments for health care in Bulgaria', observatory case study. London School of Economics, London, UK.

18 See www.amnesty.org/en/news-and-updates/report/pregnant-women-burkina-faso-dying-because-discrimination-20100127.

19 Gupta, S., Davoodi, H. & Tiongron, E. (2000). 'Corruption and the provision of health care and education services', IMF Working Paper 00/116, Appendix Table 9, p.27.

20 Azfar, O. & Tugrul, G. (2005). 'Does corruption affect health and education outcomes in the Philippines?'. Available at Social Science Research Network: <http://ssrn.com/abstract=723702>.

21 Savedoff, W. & Hussmann, K. (2006). 'Why are health systems prone to corruption?'. Global Corruption Report, Transparency International.

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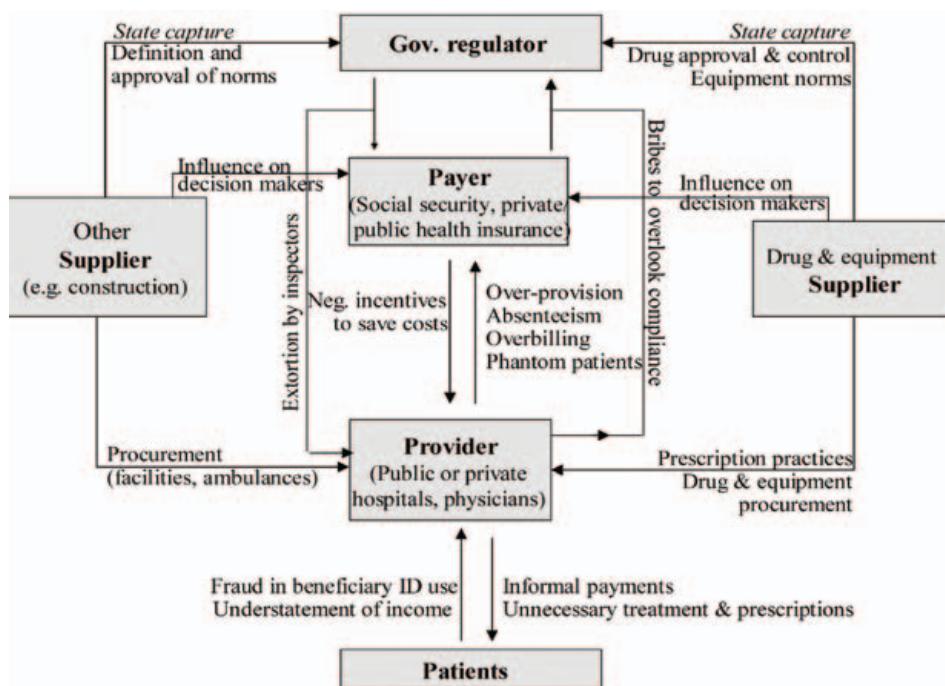


from standards—are sometimes limited or non-existent due to limited financial and human resources. Furthermore, regulatory agencies are not always impartial and can be inappropriately influenced by those they are charged with regulating. Finally, in the health sector the distinction between corruption and inefficiency is often difficult to discern due to poor management/administration²².

Another challenge is that although the issue of accountability is a relatively new area of enquiry in the health sector, desired health gains—whether linked to the MDGs or not—may be hindered or obstructed completely unless efforts are made to improve accountability and transparency and understand how to prevent corruption within the health system.,

Diagram 1 below provides a framework for the analysis of risks and actors that can help anti-corruption actors understand the main issues and design the right response strategies.

Diagram 1. Core areas of health sector and corruption risks



Source: Hussmann, K., 'How-to-note: Addressing corruption in the health sector. A DFID Practice Paper', November 2010.
Online: www.dfid.gov.uk/Documents/publications1/How-to-Note-corruption-health.pdf

22 Lewis, M. (2006). 'Governance and corruption in public health care systems'. Working Paper 78, Center for Global Development, Washington, DC (USA)



2. DIAGNOSTIC TOOLS RELEVANT FOR ASSESSING THE HEALTH SECTOR'S VULNERABILITY TO CORRUPTION²³



This section discusses some key diagnostic/assessment methodologies that donors, governments and non-governmental organizations (NGOs) can use to assess the health sector's vulnerability to corruption. Ideally diagnostics can help practitioners and policy makers design appropriate anti-corruption strategies.

The tools identified as relevant for corruption and the health sector fall into two categories. Those such as the WHO and World Bank risk assessment tools described in detail in Sections 2.1 and 2.2 are designed to identify any weak points in a given health sector (and in the cases below focus specifically on the pharmaceutical sector). Other tools, such as Transparency International's Corruption Perceptions Index and household surveys, are designed more specifically to measure the level of corruption in a country at the national, regional or local levels. However, because the latter tools rely on perceptions they should be used in combination with other tools to ensure their validity.

Both types of methodologies have their strengths in terms of helping to understand how corruption affects the health sector and where anti-corruption interventions might be needed. All of the tools are important as they provide benchmark standards against which interventions can be measured in

23 In addition to initiatives and programmes mentioned in this section, it is worthwhile to also refer to accountability assessments developed by UNDP for Mongolia, the Basel Institute on Governance, the World Bank, etc.

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time, however imperfectly. (Annex 1 of this report includes an overview of key tools to identify, track and measure corruption risks and corruption, including the tools discussed in greater detail below.)

2.1 WHO's Good Governance for Medicines programme

As a core part of its Good Governance for Medicines (GGM) programme launched in 2004, WHO has developed an assessment tool to identify areas in the pharmaceutical sector that are vulnerable to corruption²⁴. The GGM programme relies on two core strategies. The first is a 'top-down' discipline-based strategy that seeks to help governments establish anti-corruption laws and improve legislation and regulation governing the pharmaceutical sector. The second is a 'bottom-up' values-based strategy that aims to help governments build institutional integrity through the promotion of ethical practices.

Implementation occurs in three phases:

- Phase I: national assessment of the level of transparency and potential vulnerability to corruption of the national pharmaceutical system through the implementation of an assessment instrument (described below and the focus of this review).
- Phase II: development of a national GGM framework through a consultation process involving key stakeholders. Once officially adopted, the GGM framework document usually includes an ethical framework and code of conduct, regulations and administrative procedures, collaboration mechanisms with other good governance and anticorruption initiatives, whistleblowing mechanisms, and sanctions for corrupt acts.
- Phase III: implementation of the national GGM programme. This includes the training of government officials and health professionals, as well as communications and advocacy campaigns.

The GGM assessment instrument was based on an earlier diagnostic developed in 2002 for the World Bank's work in the Costa Rican health sector²⁵. The World Bank methodology has also been applied in Macedonia and served as the basis for a United States Agency for International Development (USAID) study of Bulgaria's health system in 2004.

The national assessment undertaken through Phase I of the GGM can potentially examine up to eight core functions: medicines registration, licensing and inspection of pharmaceutical establishments, promotion, clinical trials, selection, procurement, and distribution. The end result is a baseline to monitor the country's progress over time in terms of governance in the pharmaceutical sector (e.g., level of accountability, transparency in the various processes in the pharmaceutical sector). Baseline data is a common goal of many of the diagnostics that seek to understand potential weakness to corruption or level of corruption in the health sector.

24 WHO Assessment Instrument WHO/EMP/MAR/2009.4, 'Measuring transparency in the public transparency sector'. Online: www.who.int/medicines/areas/policy/goodgovernance/AssessmentInstrumentMeastranspENG.PDF.

25 Cohen, J., Cercone, J., & Macaya, R. (2002). 'Improving transparency in pharmaceutical systems: strengthening critical decision points against corruption: a case study of Costa Rica'. Human Development Network, Latin America and Caribbean Region, World Bank, Washington, DC (USA).



2. DIAGNOSTIC TOOLS RELEVANT FOR ASSESSING THE HEALTH SECTOR'S VULNERABILITY TO CORRUPTION

A minimum of two national assessors are responsible for the assessment. They should be from credible organizations, be independent of the Ministry of Health (MoH) and the private sector, and have good knowledge of the country's pharmaceutical sector. For this process to work effectively, government support is vital. Information found on government public websites and other relevant sources are used to check the availability and dissemination of guidelines and procedures. The document analysis is backed up by interviews with key informants.

At least 10 key informants are interviewed for each core function of the pharmaceutical sector or until 'saturation' is reached. The informants represent the various stakeholders: the government, public hospitals, private sector (pharmacies, companies, wholesalers and manufacturers), professional associations, civil society, and non-governmental and international organizations. This helps to ensure different perspectives are represented and a comprehensive overview of the sector is prepared. Binary 'yes/no' and open-ended questions are used. In some cases, the key informants may be asked to justify some of their answers with evidence. Once all the information is compiled, answers are scored and converted to a simple 1 to 10 scale representing the vulnerability of the decision point to corruption from minimum to maximum potential.

The national assessors analyse the results and prepare a report that includes recommendations based on the findings that are presented to government officials and validated in national and regional workshops by key stakeholders. The value of a national assessment is based on and reflects the system's actual structure, particularly the mechanisms to prevent unethical practices and the administrative procedures to measure transparency and accountability. It also provides an opportunity to examine how different stakeholders understand and make use of existing procedures and mechanisms in the pharmaceutical sector. The national assessment also indicates flaws with existing policies and procedures. The downside of this assessment instrument is that it is time-consuming to implement and there is a risk of acquiring information that is flawed given that some key informants may feel threatened by the questions and answer them according to what they perceive is the 'right' answer rather than the true answer.

The GGM framework is then defined through nationwide consultation with key stakeholders. This process includes developing ethical frameworks and codes of conduct, regulations and administration procedures, collaboration mechanisms with other good governance and anti-corruption initiatives, whistleblowing mechanisms, and sanctions for breaches. Lastly, the application of new administrative procedures for increased transparency and accountability and leadership in this area are developed.

The assessment instrument has been applied in over 26 countries to date and some of the reports are publicly available on the GGM website²⁶. It is a good starting point for a more comprehensive investigation of the pharmaceutical sector's vulnerability to corruption. However, the tool is limited insofar as the key informants may be reluctant to reveal the real level of corruption. The tool also demands sufficient knowledge of the local pharmaceutical and health sector and requires government buy-in to ensure access to public officials.

26 See www.who.int/medicines/areas/policy/goodgovernance/documents/en/index.html (accessed 24 August 2010).

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Based on national assessments undertaken to date, drug promotion is often identified as the function most vulnerable to corruption, while distribution is often the strongest or most transparent of all functions studied²⁷. The studies generally illuminate that there is a uniform lack of access to public information about the pharmaceutical sector (e.g., regarding regulations, legislation and written procedures). Also, in many countries there is either a lack of conflict of interest policies or poor implementation of them, as well as a lack of selection criteria for decision makers (such as persons involved in the drug selection process) in the pharmaceutical sector. The limited access stems from the fact that such information did not exist in some cases, while in others it was not made available to the public²⁸.

Since its inception, the GGM programme has had a positive impact on pharmaceutical systems in many of the 26 countries where it has been implemented. National drug procurement practices have improved, pharmaceutical legislation and regulations have been revised to ensure better governance in the sector and to strengthen pharmaceutical systems, and more transparent procedures for pharmaceutical licensing and registration procedures are in place and publicly available on Ministry MoH websites. Annex 2 contains specific country examples of outcomes from the GGM programme from countries in either Phase II or Phase III²⁹.

2.2 World Bank Framework for Rapid Assessment in the Pharmaceutical Sector

The World Bank Framework for Rapid Assessment in the Pharmaceutical Sector is a diagnostic tool that aims to help policy makers and development specialists organize information about the pharmaceutical sector³⁰. The downside of this tool is that it demands assimilation of a lot of varied information pertaining to the pharmaceutical sector and is thus rather time-consuming to implement even if the person using the tool has significant experience in the pharmaceutical sector of the country under study. The advantage of this tool is that it helps to organize information which can serve as a benchmark exercise against which interventions in the pharmaceutical sector can be measured.

The assessment tool can be used as a stand-alone mechanism or as part of an overall analysis of country health systems. The main areas covered are the following: the pharmaceutical market, drug policy and regulation, public and private drug expenditure, drug pricing, purchasing, procurement, reimbursement, service delivery and logistics, industry and trade, and the rational use of drugs. A World Bank Working Paper publication details how this assessment tool has been applied in a variety of different countries and related outcomes³¹. General findings from the assessments include the dominant role of the private sector in the provision of pharmaceuticals, ineffective drug regulation and a lack of consumer power.

²⁷ It should noted, however, that the assessment instrument does not cover the entire distribution chain. Thus the impact of this positive finding regarding distribution is somewhat limited.

²⁸ Kohler, J. & Bagdadhi-Sabetti, G. (forthcoming). 'Good governance for pharmaceuticals' in WHO World Medicine Situation.

²⁹ The results in the annex are from WHO GGM programme, 'An innovative approach to prevent corruption in the pharmaceutical sector', background paper for World Health Report 2010 (in preparation).

³⁰ See Diack, et al, 'Assessment of governance and corruption in the pharmaceutical sector: lessons learned from low- and middle-income countries', HNP discussion paper. World Bank Human Development Network, Washington, DC (USA).

³¹ Ibid.



2. DIAGNOSTIC TOOLS RELEVANT FOR ASSESSING THE HEALTH SECTOR'S VULNERABILITY TO CORRUPTION

2.3 USAID methodology to test for corruption in the health sector

A good example of USAID's work in this area is based on a study of corruption in the Bulgarian health system completed in 2005³². The project used a framework of transparency, accountability, prevention, enforcement and education (TAPEE) as institutional requirements of integrity to examine key areas in the country's health care system. In particular, the project examined drug selection in the public health system and hospital drug procurement. Its methodology focused on processes and was qualitative (focus groups and key informant interviews) and quantitative (a survey of hospitals across the country). Over 30 semi-structured interviews with key informants were held with representatives from the government and the private sector. The quantitative part of the project was the survey of the drug purchasing practices of 148 hospitals. Data were based on suppliers' reports regarding corruption, doctors' and nurses' reports regarding corruption, audit reports, and procurement prices.

USAID also has produced an anti-corruption assessment handbook that includes a diagnostic for the health sector³³. It provides some key questions for provisions of services by front-line health workers; health care fraud; procurement and management of equipment of supplies; regulation of quality in products, services, facilities and professionals; education of health professionals; and hiring and promotion. The health sector diagnostic can be used with others (such as one focusing



UN Photo/Olivier Chassot

32 Iris Center for USAID (2005). 'Governance in Bulgaria's pharmaceutical sector: a synthesis of research findings'. Iris Center, Baltimore, MD (USA).

33 USAID (2009), 'Anti-corruption assessment handbook'.

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on procurement) provided in the handbook. It aims to help the user ask the right questions when conducting an assessment in a country. The diagnostic is limited because it does not allow for a comprehensive examination of the risks³⁴. However, it can be used as a guide for key informant questions and as a starting point for further data collection.

2.4 International partnerships: the example of MeTA

The Medicines Transparency Alliance (MeTA) is a multi-stakeholder alliance led by the UK Department for International Development (DFID) and with the participation of the World Bank and WHO. It examines issues related to drug prices, quality, availability, promotion, transparency and accountability, and multi-stakeholder relationships. MeTA aims primarily to improve access to and affordability of medicines, and the alliance operates under the assumption that lack of access to essential medicines is a result of weak governance and a lack of transparency in the selection, regulation, procurement, distribution and promotion of medicines.

MeTA uses a large arsenal of diagnostic tools to gather information. Such tools may include a pharmaceutical sector scan; review of data availability about price, registration and policies on promotion; and a stakeholder mapping. It also uses the WHO/HAI pricing methodology, which measures medicine price, availability, affordability and component costs³⁵. Priority information sought includes the quality and registration status of medicines, availability of medicines; price of medicines; and policies, practices and data on the promotion of medicines. Also investigated is the specific policy context as well as how supply chain operations work, affordability of medicines, access and their rational use.

MeTA is currently operating in seven countries globally: Ghana, Jordan, Kyrgyzstan, Peru, the Philippines, Uganda and Zambia³⁶. All seven MeTA pilot countries have set up multi-stakeholder groups known as councils that have agreed on work plans that include proposals to generate and disclose information relating to price, quality, availability and promotion of medicines. Countries set their own priorities in each area and they focus on information relating to the prices in the chain. However, there is growing recognition of the need to go beyond pricing issues.

MeTA interventions have to date resulted in i) increased participation in policy dialogue (Philippines); ii) the detection of sub-standard drugs (Ghana, Kyrgyzstan); iii) improvements in the drug selection process (Jordan); and iv) pricing and other transparency measures (Peru, Uganda, Zambia). This section focuses on core areas of the health sector that are at particular risk for corruption: providers (Section 3.1), government regulators in the pharmaceutical market (Section 3.2), procurement of pharmaceuticals and medical supplies (Section 3.3), distribution and storage of drugs (Section 3.4), and payers (Section 3.5). Each core area includes a problem analysis, evidence of the risk, and example(s) of good practice. Possible interventions for each area are included in tables at the end of this document.

34 See www.irisprojects.umd.edu/anticorruption/Files/IRIS_Assessment_Handbook.pdf.

35 World Health Organization and Health Action International (2008). *Measuring Medicine Prices, Availability, Affordability and Price Components* (2nd ed.). Geneva, Switzerland.

36 See Ollier, E. (2010). 'Evaluation of the medicines transparency alliance: phase 1 2008-2010' and Medicines Transparency Alliance (2010). 'Affecting change: the MeTA annual review 2009-2010'.



3. CORRUPTION RISKS IN THE HEALTH SECTOR AND SELECT INTERVENTIONS



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3.1 Health care providers

This sub-section examines corruption among health care providers such as physicians, nurses and pharmacists. Petty corruption associated with health providers includes absenteeism (not showing up for work yet claiming a salary), theft (of medical supplies or pharmaceuticals), and demand for informal payments for services that are supposed to be free. Petty corruption of this sort has a direct impact on the poor by denying them access to services and thereby jeopardizing their health.

3.1.1 Absenteeism

Problem analysis and evidence

As in other public sectors such as education, absenteeism in the health sector is a common occurrence in developing countries. In Argentina it was found to be the most common form of

3. CORRUPTION RISKS IN THE HEALTH SECTOR AND SELECT INTERVENTIONS



corruption among doctors and nurses in public hospitals³⁷. A survey in Costa Rica found that more than two-thirds of doctors and nurses indicated high levels of absenteeism in their hospital³⁸.

Extensive absenteeism can result in lower volume of health care, poor quality of care, and increased costs to the health system³⁹. Yet absenteeism may not always be perceived as corruption. Studies have pointed out that it can be understood as a means of survival or a 'coping mechanism' associated with low salaries and the need for more than one source of employment for livelihood. A UNDP study on Mongolia noted that most respondents perceived the primary cause of corruption in the health sector was indeed due to the low wage of doctors and health workers⁴⁰. But even though salary increases were later implemented, they were insufficient measures against corruption in the long term. This suggests multiple factors are at play which can create opportunities for corruption and that it cannot be attributed to one variable⁴¹.

However, low salary levels do not sufficiently explain why corruption may happen at the level of service provider. The reasons for absenteeism are more complex: they may include a lack of motivation, poor quality of health worker education, lack of qualifications or understanding of one's own role/responsibilities as a health worker, parallel accountability structures, and a lack of merit-based hiring practices.

Petty corruption has a direct impact on the poor by denying them access to services and thereby jeopardizing their health.

Good practice examples

- A study of health workers in four Peruvian hospitals found that physicians with permanent contracts and good job security were more likely to be absent than physicians under temporary contracts. This suggests that accountability (from employer to employee) may be one way to help reduce absenteeism and improve performance.

37 Schargrodsky, E., Mera, J., & Weinschelbaum, F. (2001). 'Transparency and accountability in Argentina's hospitals' in Di Tella, R. & Savedoff, W., eds., (2001). Diagnosis Corruption: Fraud in Latin America's Public Hospitals. Latin American Research Network, Inter-American Development Bank, Washington, DC (USA).

38 Savedoff W. (2007). 'Transparency and corruption in the health sector: a conceptual framework and ideas for action in Latin America and the Caribbean' Inter-American Development Bank, Health Technical Note.

39 Lewis & Petterson 2009.

40 De Jaegere, S. & Finley, S. (2009). 'Mapping accountability in the health sector and developing a sectoral assessment framework'; UNDP mission report.

41 Nordberg, C., & Vian, T. (2008). 'Corruption in the health sector' U4 Brief 10, Chr. Michelsen Institute, Bergen, Norway.



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3.1.2 Theft of drugs and medical supplies

Problem analysis and evidence

Theft of drugs and medical supplies by health care professionals is common globally. In Venezuela, approximately two-thirds of hospital personnel surveyed were aware of theft of medical supplies and medications. Similarly, in Costa Rica, 71 percent of doctors and 83 percent of nurses reported that equipment or materials had been stolen in their hospital⁴². One study in Uganda found that the resale of drugs represented the greatest single source of income for health care personnel⁴³.

Theft has been found to increase when the potential benefit from theft is high, when the probability of detection is low, and when the expected penalty is minor⁴⁴.

Good practice example

- The involvement of citizens as ‘watchdogs’ of the public good can detect corruption in provider services. For example, in Bolivia, local health directorates (which included local government officials and citizen representatives) were set up to oversee most health facilities⁴⁵. Citizen scrutiny of health care services and provisions can act as a deterrent to corrupt actions.

3.1.3 Informal payments

Problem analysis and evidence

Why people ask for informal payments and why people are willing to pay for them are important questions to consider. It is well known that informal payments for medical services are more common in low-income countries than high-income countries, which suggests barriers to services for patients with limited resources⁴⁶. A study of informal payments in the United Republic of Tanzania found that patients commonly make informal payments for better health care services (in other words, patients do not always perceive them as bribes). Health workers in Tanzania took advantage of the population’s ‘willingness’ to pay for services by deliberately creating shortages in order to gain

42 Di Tella, R. & Savedoff, W. (2001). ‘Shining light in dark corners’ in Di Tella, R. & Savedoff, W., eds., (2001). Diagnosis Corruption: Fraud in Latin America’s Public Hospitals. Latin American Research Network, Inter-American Development Bank, Washington, DC (USA).

43 Ferrinho, P. & Van Lerberghe, W. (2002). ‘Managing health professionals in the context of limited resources: a fine line between corruption and the need for moonlighting’. World Bank Publications, Washington, DC (USA).

44 Jaén, M., & Paravisini, D. (2001). ‘Wages, capture, and penalties in Venezuela’s public hospitals’ in Di Tella, R. & Savedoff, W., eds., (2001). Diagnosis Corruption: Fraud in Latin America’s Public Hospitals. Latin American Research Network, Inter-American Development Bank, Washington, DC (USA).

45 Lewis, M., & Pettersson, G. (2009). ‘Governance in health care delivery: raising performance’. World Bank Policy Research Working Paper 5074.

46 Nordberg, C., & Vian, T. (2008). ‘Corruption in the health sector’. U4 Brief 10, Chr. Michelsen Institute, Bergen, Norway.

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surplus payments from patients⁴⁷. In a study on public hospitals in Latin America, most fees paid for public health services were found to be for illegal charges⁴⁸.

Whether informal payments are viewed as an accepted part of health care services or as a form of corruption, the imposition of a ‘tax’ on public health care services that should be free of charge has a negative impact on health care provision.⁴⁹ The end result is that poor people will be denied access to health services.

Good practice examples

- In Hungary, the introduction of an official co-payment was intended to decrease informal payments, but it was not sufficient on its own to change the behaviour of patients paying informally⁵⁰.
- Official co-payments could be complemented by another intervention such as performance-based financing (PBF) to help create incentives for better behaviour. PBF is most likely to work well when there is strong political and management support, flexibilities to make changes when needed to maximize efficiencies, and strong health information and reporting system⁵¹. Performance-based financing has recently been implemented in Rwanda, among other places⁵².
- As part of a UNDP project in Mongolia, hospitals have begun awarding performance bonuses to promote better service delivery and ethical behaviour⁵³.

47 Mæstad, O., & Mwisongo, A. (2007). 'Informal pay and the quality of health care: lessons from Tanzania'. U4 Brief 9, Chr. Michelsen Institute, Bergen, Norway.

48 Di Tella, R. & Savedoff, W. (2001). 'Shining light in dark corners' in Di Tella, R. & Savedoff, W., eds., (2001). Diagnosis Corruption: Fraud in Latin America's Public Hospitals. Latin American Research Network, Inter-American Development Bank, Washington, DC (USA).

49 Rose, R. (2006). 'Corruption is bad for your health: findings from Central and Eastern Europe', in Global Corruption Annual Report: Corruption and Health. Transparency International, Berlin, Germany.

50 Baji, P., Pavlova, M., Gulasci, L. & Groot, W. (2010). 'Short-term effects of the introduction of official patient fees on informal payments: the case of Hungary'. Presentation, ECHE 2010, Helsinki, Finland

51 For more on outcomes of PBF, see Eldridge, C. & Palmer, N. (2009), 'Performance-based financing: some reflections on the discourse, evidence and unanswered questions', *Health Policy and Planning* 24: 160-166.

52 See USAID (2008). 'Corruption assessment of Rwanda health sector'.

53 Lkhagvasuren, N. (2009). 'Integrity in the health sector: Mongolia project assessment'. UNDP, New York, NY (USA).



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Box 1. Anti-Corruption Participatory Monitoring (ACPM) in Armenia

The implementation of the Anti-Corruption Participatory Monitoring (ACPM) project in Armenia aimed to assess the impact of anti-corruption initiatives and measures in the health care sector through community monitoring.

The effort consisted of a three-tiered monitoring system that tracked and evaluated systemic issues, corruption risks and manifestations of corruption through four intertwined and complementary aspects: quality of access to services, finances and shadow monetary circulations, rights and legality, and administration and functions.

While community monitoring principles are well known, the project first needed to develop specific tools to ensure quality control, such as guidelines on responsibilities of a community group's members, norms of ethics, and ground rules and instruments for conducting observations, expert interviews, focus groups and in-depth interviews. Community groups engaged to carry out the monitoring were thus equipped with the necessary tools and knowledge to undertake the effort, even if some of them had no previous relevant experience.

The monitoring was carried out from April to October 2007 in Yerevan, the capital, and 10 other towns and cities in different regions of the country. A total of 22 outpatient clinics and hospitals were reviewed.

The project outputs described the baseline situation in the health care sector, in particular corruption risks and manifestations in various aspects and levels of health care system, according to functional categories (human resources, drugs, medical technologies and financial issues). On this basis, recommendations for systemic changes were developed and communicated to the responsible State authorities and the Prime Minister's Office. In the end, the majority of the project recommendations were accepted and included in the new national anti-corruption strategy.

Source: <http://europeandcis.undp.org/uploads/public1/files/ACPN/I%20Report%20Findings%20of%20the%20Anti-Corruption%20Participatory%20Monitoring%20conducted%20in%20the%20health%20and%20education%20sectors%20by%20civil%20society%20anti-corruption%20groups%5B1%5D.pdf>

3.1.4 Fraud

Problem analysis and evidence

An average of 5.59 percent of annual global health spending is lost to fraud, which is an intentional deception that can lead to an unwarranted benefit to the person perpetuating the fraud⁵⁴. Based on WHO estimates that global health care expenditure is about US\$4.7 trillion, this translates into about US\$260 billion lost globally to fraud and error.

54 European Healthcare Fraud and Corruption Network (2009). 'The financial costs of health care fraud'



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Fraud in the health care system includes the pocketing of user fees by a service provider or the overcharging of a health insurance agency by a physician. In a hospital, it could involve the diversion of patient fees or collusion between a hospital administrator and a purchasing agent. For instance, in Liberia the country's General Auditing Commission found that accounting irregularities by staff in the Ministry of Health and Social Welfare accounted for as much as US\$4 million in unaccounted funds⁵⁵.

Good practice examples

- Institutional checks and balances such as the division of functions between cashiers and accountants can help control against fraud.
- The comparison of actual and expected revenue and regular internal and external audits are recommended measures to prevent fraud.
- The Inter-American Development Bank (IDB) conducted an external audit of public hospitals in Bogota, Colombia. This external review provided Bogota's Secretariat of Health with evidence that fraud was taking place, and in response measures were taken to reduce theft and improper billing in hospitals⁵⁶. This example shows how transparency and auditing tools are effective measures to fight fraud.

UN Photo/Evan Schneider



55 See www.liberianobserver.com/node/5767.

56 Savedoff W. (2007). 'Transparency and corruption in the health sector: a conceptual framework and ideas for action in Latin America and the Caribbean' Inter-American Development Bank, Health Technical Note, p. 11.



3. CORRUPTION RISKS IN THE HEALTH SECTOR AND SELECT INTERVENTIONS

Table 1. Select interventions to improve provider performance⁵⁷

Intervention	Type	Comment
Performance-based financing	Managerial	Financial rewards have helped to ensure better performance. Domain of national or regional government depending on health system structure.
Wage increases	Managerial	Works only if other measures are applied along with it such as 'tough' sanctions for breaches of professional conduct and match market rates. Domain of local or national government depending on health system structure.
Legislation that makes managers legally responsible for actions of subordinates	Managerial	May help deter corruption by ensuring that monitoring of practices is more effectively enforced. Domain of national government.
Prosecuting or establishing administrative sanctions for individual breaches	Accountability/oversight	Helps to set an example but also demands a well-functioning judiciary system ¹ . This needs to be initiated at the facility level but supported by the national government.
Introducing or improving internal control mechanisms	Accountability/oversight	This can help minimize theft of medical supplies in hospitals and public health clinics, including oversight from management ² . Needs to be done at the facility level.
Introducing and enforcing a code of conduct for public officials and professionals that specifies expectations and also requires public officials to disclose their assets ³	Managerial and transparency	Requires oversight and support from management systems
Conduct external reviews including unannounced visits to health facilities and evaluation of services by clients and beneficiaries	Accountability/oversight	Domain of national, regional or local government.

⁵⁷ References in this table: 1. Nordberg, C., & Vian, T. (2008). 'Corruption in the health sector' U4 Brief 10, Chr. Michelsen Institute, Bergen, Norway, p. 55. 2. Ibid. p. 92. 3. Ibid.

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Intervention	Type	Comment
Set up a secure anti-corruption hotline for citizens and professionals	Accountability/oversight	Needs to be linked to adequate follow up, feedback and whistle-blower protection. Domain of national, regional or local government.
Monitor job performance and ensure performance expectations; standardize job descriptions; and implement and enforce transparent rules, behaviour standards, and merit-based promotion policies ⁴	Managerial	Facility level responsibility
Formalize user fees with exemption schemes for the poor	Transparency	Demonstrated as effective in Albania, Cambodia and Kyrgyzstan. Increased payments for facility, supplemented staff salaries, helped in purchase of supplies and to phase out donor support. Also needs a strong public education plan ⁵ . Domain of national government.

3.2 Government regulators in the pharmaceutical market

This section focuses on the role of government in the regulation of the pharmaceutical market and, more specifically, the selection of drugs⁵⁸. The pharmaceutical selection process involves the registration and market authorization of drugs in a pharmaceutical market; this government process also specifies which drugs are included in a public formulary and thus are subject to reimbursement policies.

Drug registration and market authorization are the responsibility of national drug agencies. Unfortunately, these agencies are often poorly funded and have limited staff and institutional capacity. If the legislative and regulatory environments are weak and there is a lack of transparency and accountability in the processes, suppliers may bribe government officials to register their drugs without the requisite information, or government officials may deliberately delay the registration process to solicit an illegal payment or to favour another supplier. This can create openings in the market for counterfeit and substandard medicines.

57 References in this table: 4. Lewis, M., & Pettersson, G. (2009). 'Governance in health care delivery: raising performance'. World Bank Policy Research Working Paper 5074. 5. Miller, K. & Vian, T. (2010). 'Strategies for reducing informal payments' in Vian, T., Savedoff, W. & Mathisen, H. (2010). Anticorruption in the Health Sector: Strategies for Transparency and Accountability, Kumarian Press, West Hartford, CT (USA), p. 64.

58 This section is based on prior work that the consultant did on the topic. See Cohen, J., Mrazek, M., & Hawkins, L. (2007). 'Corruption and pharmaceuticals: strengthening good governance to improve access' in Campos, J. E., & Pradhan, S., eds, The Many Faces of Corruption: Tracking Vulnerabilities at the Sector Level. World Bank, Washington, DC (USA).



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WHO defines a counterfeit medicine as one “which is deliberately and fraudulently mislabelled with respect to identity and/or source. Counterfeiting can apply to both branded and generic products and counterfeit products may include products with the correct ingredients or with the wrong ingredients, without active ingredients, with insufficient active ingredients or with fake packaging.”⁵⁹

Regulation of health sector goods and services is a core function of government. Governments are responsible for ensuring that health professionals are licensed properly and that health products are safe and effective.

Problemsatically, the medicines used to treat some of the most prevalent diseases of the world, such as malaria, tuberculosis and bacterial infections, are the most commonly counterfeited⁶⁰. All of the above point to the extreme health risks that are associated when counterfeit and fake medicines are available in a pharmaceutical market due to lack of good governance and weak health systems.

A key function in the pharmaceutical selection process is whether drugs that are registered and have received market approval should actually be available on a drug formulary. Risks in the selection process include kickbacks from suppliers and payoffs so that

drugs on the formularies are not necessarily appropriate for the health needs of the population or cost-effective. A USAID study on corruption in the pharmaceutical system in Bulgaria found that the national drug formulary had instances of the selection of newer (usually more expensive) pharmaceutical agents and the exclusion of older agents that were equally effective in treating the relevant condition and also comparatively cost-effective⁶¹.

Essential drug lists can prevent corruption in the drug selection process because they usually include drugs that are reviewed by WHO as necessary for most common diseases. But the use of an essential drug list must be accompanied by other anti-corruption initiatives further along in the drug supply chain. For example, in the Balkans the dosage specified for a product in the essential drugs list was set up so that a local manufacturer could win the procurement bid⁶².

59 See WHO website: www.who.int/medicines/services/counterfeit/faqs/05/en/.

60 Pincock, S. (2003). 'WHO tries to tackle problem of counterfeit medicines in Asia'. British Medical Journal 327, (7424), 1126.

61 Iris Center for USAID (2005). 'Governance in Bulgaria's pharmaceutical sector: a synthesis of research findings'. Iris Center, Baltimore, MD (USA).

62 Cohen, J., Mrazek, M., & Hawkins, L. (2007). 'Corruption and pharmaceuticals: strengthening good governance to improve access' in Campos, J. E., & Pradhan, S., eds., *The Many Faces of Corruption: Tracking Vulnerabilities at the Sector Level*. World Bank, Washington, DC (USA).

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Good practice examples

- WHO has since 1977 has published an Essential Drugs List that can be used as a guideline for countries. Each edition establishes a limited list of priority medicines; included are common diseases along with the pharmaceutical products that are most effective and affordable for most countries.
- Transparency helps prevent corruption in the drug selection process.
- The Government of Mongolia has developed an online public database for drug registration. The database has reduced the number of unregistered drugs in the market as well as helped expedite the registration process.
- Even when countries do not have the resources or the size to justify a full-scale drug agency, assessing the quality, safety and efficacy of the drugs entering their markets is possible without comprehensive testing. For example, an applicant product may already have market authorization through a recognized drug agency of another country (e.g., the United States Food and Drug Administration or the European Medicines Agency). In such cases, some countries may accept the documentation submitted to these agencies as sufficient. If documentation is not available, the country may out-source the required testing to a third-party laboratory or may engage in its own testing⁶³.

Table 2. Select interventions to improve government regulator function⁶⁴

Intervention	Type	Comment
Set up a well resourced independent drug agency	Managerial	Needs to be done by national government.
Ensure registration and marketing approval procedures are applied uniformly, are current for all suppliers, and are publicly available through a government website	Transparency	Nigeria's registration guidelines were updated as part of an anti-corruption strategy ¹ . Domain of national government.
Ensure that the regulatory agency publicly provides justification for decisions	Transparency	This includes the regular publishing on a government website of drug registration and market authorization decisions. The process should be complemented by a formal appeals process. Domain of national government.

⁶³ Ibid., p. 43.

⁶⁴ References used in this table: 1. Ibid., p. 41.



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Intervention	Type	Comment
Require that staff of regulatory agency and any supplemental committee members involved in registration and market approval decisions sign a conflict of interest document that is publicly disseminated	Transparency	Public dissemination of conflict of interest should also be part of this strategy. Domain of national government.
Institute a body to manage conflicts of interest.	Accountability/oversight	Must include a process for reporting and reviewing conflicts of interest and determining appropriate course of action. Such a process should ensure that individuals with real or apparent conflicts of interest are not involved in decision-making. Domain of national government
Implement and sustain ongoing market surveillance of drugs with a complementary public education campaign to help educate consumers about how to identify a counterfeit product ² .	Accountability/oversight	Include random batch testing and reporting streams for users and patients so that any potential problems are identified. In Azerbaijan, for example, drugs that passed government inspection were given a hologram sticker so that they were easily identifiable. Domain of national government.

3.3 Procurement of pharmaceuticals and medical supplies⁶⁴

Problem analysis and evidence

The goal of procurement for drugs or medical supplies is to ensure that the right quantity of a product is purchased with the right quality at a cost-effective price. Procurement may take place at the national level of government or it may be decentralized and take place at the facility level. There is no clear evidence about which approach is less prone to corruption. It is not the procurement level that matters but rather how the procurement process is set up.

Procurement of publicly funded drugs is particularly susceptible to corruption because drug volumes are typically large and the contracts are usually quite lucrative; this motivates some actors

64 References used in this table: 2. Ibid., p. 42.

65 This section is based on Cohen, J., Mrazek, M., & Hawkins, L. (2007). 'Corruption and pharmaceuticals: strengthening good governance to improve access' in Campos, J. E., & Pradhan, S., eds., *The Many Faces of Corruption: Tracking Vulnerabilities at the Sector Level*. World Bank, Washington, DC (USA).



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to undertake corrupt actions. Specifications may be manipulated to favour one supplier; suppliers may bribe procurement officials to gain advantage in the procurement tender process; overpayment of products may happen; and procurement of products may occur when there is no justifiable health reason for it.

In Albania, for example, instances of corruption in pharmaceutical procurement included private financial interests determining what drugs to procure for the public health system, kickbacks or bribes that enabled bidders to gain access to confidential information, and use of direct procurement instead of competitive bidding without sound justification⁶⁶. Procurement fraud is particularly risky in hospitals as almost all capital expenses involve procurement and often time and technical expertise is limited⁶⁷.

Procurement of publicly funded drugs is particularly susceptible to corruption because drug volumes are typically large and the contracts are usually quite lucrative; this motivates some actors to undertake corrupt actions.

Box 2. World Bank and corruption in procurement: health projects in India

The World Bank's Detailed Implementation Review of India FY 2007-2008 included a broad-based review of procurement practices in five World Bank health projects that included procurement. Fraud and corruption were found in all projects and included collusion, bribery and manipulated bid prices, deficient civil works certified as complete, broken or damaged equipment certified as compliant with specifications, under-delivery of services, inadequate project audit and control systems⁶⁸.

Anti-corruption interventions are now in place. They include procurement audits, community oversight and monitoring, community social cards and social audits, online publication of all procurement processes, more rigorous terms for NGO and contract awards, and procurement audits. Two companies, Nestor Pharmaceuticals Ltd. and Pure Pharma Ltd., both of which were found guilty of collusive behaviour under the Reproductive and Child Health Project I in India, were also barred from participating in World Bank procurement tenders for a set period of time.

⁶⁶ Vian, T. (2003). 'Corruption in the health sector in Albania'. USAID/Albanian Civil Society Corruption Reduction Project.

⁶⁷ Vian, T. (2006). 'Corruption in hospital administration'. Transparency International, Berlin, Germany.

⁶⁸ World Bank Group (2008), 'Annual integrity report: protecting development's potential'.



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Good practice examples

- Procurement procedures and systems should guarantee that the drugs purchased are of high quality and meet international standards because products can vary substantially in formulation and bioavailability, depending on the supplier. When this difference is therapeutically significant, regular changes in suppliers can have consequences for product quality. Even when new products are completely equivalent in content and effect, changes in a dosage form can be problematic, requiring patient and provider re-education.
- Effective quality assurance systems include the selection of reliable suppliers using existing mechanisms such as the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce; establishing a programme of product defect reporting; and performing targeted quality control testing.
- The selection of suppliers with a proven record of providing high-quality products can contribute to quality assurance, so long as the appropriate checks are in place.
- Pricing transparency in procurement helps to curb price gouging and overpayment for products, and can be fairly inexpensive to implement. One example in this regard is the public posting of medical supplies purchased by public hospitals by the city government of Buenos Aires, Argentina. Authorities informed all purchasing managers of the city government's decision to post prices; as a result, prices fell within the first few months of this intervention in anticipation of price reporting. But the price decline did not stick, thereby suggesting the lack of staying power of this initiative and the need for complementary interventions such as the imposition of sanctions for unethical behaviour.
- USAID's Supply Chain Management System (SCMS) creates a procurement system (in line with US government federal acquisition guidelines) that publicly lists tenders and price information⁶⁹.
- E-procurement as done in the Chilean procurement system is often cited as an effective tool to prevent corruption in drug procurement. Through the use of electronic bidding and information dissemination about procurement procedures and results, corruption has been curbed substantially. These anti-corruption interventions helped even more when a wide range of suppliers competed for each product so that price competition was fostered and opportunities for collusion reduced⁷⁰.
- Researchers at Boston University in the United States have developed two potential transparency tools to help drug purchasers (e.g., governments and NGOs) limit corruption in procurement⁷¹. The first tool is the high price outlier analysis, which examines each antiretroviral drug (used to treat HIV infection) and allows users to assess whether prices paid are excessively higher than the global distribution of prices paid

69 Vian, T. (2010). 'Preventing drug diversion through supply chain management'. U4 Brief 4, Chr. Michelsen Institute, Bergen, Norway

70 See Cohen, J., & Montoya, J. (2001). 'Using technology to fight corruption in pharmaceutical purchasing: lessons from the Chilean experience'. World Bank Institute, Washington, DC (USA).

71 Wanng, B., & Vian, T. (2010). 'Transparency and accountability in an electronic era: the case of pharmaceutical procurement' in T. Vian, 'Preventing drug diversion through supply chain management'. U4 Brief 4, Chr. Michelsen Institute, Bergen, Norway.

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for the same product. This tool can be used internally to identify where problems may exist in the procurement process and then followed up with case studies to detail more information about the procurement process. The second tool allows for the comparison of prices paid in a country to the global median prices paid for identical products. The researchers benchmarked 90 countries and point out that countries should aim to have most of their procurements fall into the 25th to 50th percentile. This would indicate that their products are at the same level or below global median prices.

**Table 3. Select interventions to improve drug and equipment suppliers:
procurement⁷²**

Intervention	Type	Comments
Ensure clear policy on quantification methodology for supplies	Transparency	Limits individual discretion and approval by an unbiased expert committee. Depending on procurement location, will be domain of national, regional or local government or health care facility
Ensure that closing date of all procurement bids is adhered to; that all bids are recorded; and that all awards and adjudication decisions are made by the procurement committee or tender board	Transparency and managerial	This sets into place clear criteria for the procurement process. Domain of national, regional, local government or health care facility.
Publish all procurement tender bids and results of contract awards online	Transparency	Publicly posting prices paid for drugs or other supplies can help ensure that prices are transparent and prevent price manipulation. Domain of national, regional, local government or health care facility.
Use electronic bidding where possible	Transparency	Can be done at any level in the health care system where procurement is taking place

72 References used in this table: 1. Available at www.msh.org/resource-center/international-drug-price-indicator-guide-electronic.cfm (accessed 24 August 2010).



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Intervention	Type	Comments
Prequalify suppliers (e.g., through the WHO Prequalification Programme)	Managerial	Helps to increase likelihood of credible suppliers. Domain of national, regional, local government or health care facility.
Monitor prices of supplies	Transparency	This helps uncover hidden costs caused by poor product quality, poor supplier performance or short shelf life. Domain of national, regional, local government or health care facility.
Check prices against international benchmarks	Accountability/oversight	Management Sciences for Health's International Drug Price Indicators Guide ¹ and Boston University tools cited in Section 3.3 can help with price comparisons. Domain of national, regional, local government or health care facility.
Use international guidelines for health supply procurement practices	Managerial	For example the World Bank, Standard Bidding Document for the Procurement of Health Sector Goods (May 2004) and WHO Operational Principles for Good Pharmaceutical Procurement (1999). Domain of national, regional, local government or health care facility.
Mandate regular reporting of key procurement performance indicators	Accountability/oversight	Domain of reporting will depend on where procurement takes place.
Commission expert committee with oversight over all procurement	Accountability/oversight	Broad-based participation is an effective anti-corruption tool. Domain of national, regional, local government or health care facility.
Provide technical assistance and training of procurement officers ²	Managerial	Procurement officers should ideally sign a contract to remain in their positions for a set amount of years. This can be reinforced particularly by donors if funding is provided to help build up procurement capacity. Domain of national, regional, local government or health care facility.

72 References used in this table: 2. Nordberg, C., & Vian, T. (2008). 'Corruption in the health sector'. U4 Brief 10, Chr. Michelsen Institute, Bergen, Norway.

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3.4 Distribution and storage of drugs⁷³

Problem analysis and evidence

Poor storage conditions can lead to losses either through the mismanagement of pharmaceuticals (leading to their expiration) or plain corruption (theft of medicines). Shipments can be stolen at many points in the delivery system, including by port personnel, crime syndicates that organize large-scale thefts from warehouses, and by drivers along the delivery route. Even if drugs reach their intended destination, government officials and health facility workers may steal them for their own use or profit.

It is unsurprising that drug diversion increases health care costs, given that medicines can account for about between 10 and 30 percent of recurrent health budgets in low-income countries⁷⁴. Thus, stock loss obviously has an impact on a population's access to medicines. Incentives for diversion may be more of a risk in the distribution and storage of expensive medicines such as antiretroviral drugs. Large-scale commitment to treatment puts pressure on health officials to spend funds rapidly, which means there is less time to monitor the supply chain or provide sufficient controls on the supply⁷⁵.

Good practice examples

- The US President's Emergency Plan for AIDS Relief (PEPFAR) and the related Supply Chain Management System (SCMS) are good examples of supply chain management that increases accountability and oversight in drug delivery by separating functions. In these models, private suppliers are contracted by the public sector to deliver drugs to specific points in the health system.
- PHD, a company based in South Africa⁷⁶, has a contract with the government to deliver drugs to government and private-sector service delivery points. It has 9,000 delivery and supplies products from 30 manufacturers. Services include secure warehousing, inventory management, and drug distribution to individual wholesalers, retailers, hospitals, clinics, and physicians' offices across South Africa.

⁷³ This sub-section is based on Cohen, J., Mrazek, M., & Hawkins, L. (2007). 'Corruption and pharmaceuticals: strengthening good governance to improve access' in Campos, J. E., & Pradhan, S., eds., *The Many Faces of Corruption: Tracking Vulnerabilities at the Sector Level*. World Bank, Washington, DC (USA).

⁷⁴ Vian, T. (2010). 'Preventing drug diversion through supply chain management'. U4 Brief 4, Chr. Michelsen Institute, Bergen, Norway, p. 10.

⁷⁵ Information drawn from Vian, T. (2010). 'Preventing drug diversion through supply chain management'. U4 Brief 4, Chr. Michelsen Institute, Bergen, Norway.

⁷⁶ See www.phdist.co.za (accessed 24 August 2010).



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Table 4. Select interventions to improve drug and other equipment supplies: distribution⁷⁷

Intervention	Type	Comment
Keep track of shipments in real time to detect diversion across the entire distribution and storage system through the use of computerized and automated information systems	Accountability/oversight	Optimal systems use bar coding and scanners or radio-frequency identification (RFID) technology.
Create systems for electronic monitoring of transport vehicles and checking of inventory (each batch)	Accountability/oversight	May be a higher cost intervention.
Implement a public expenditure tracking survey (PETS) to validate delivery and financing of drugs	Accountability/oversight	Also relevant to other areas in health sector.
Implement physical facility protection and security measures including hiring of security staff, screening of all employees prior to employment (then annually) for credit history and criminal record, annual polygraphs, and surveillance	Managerial	A core component but often overlooked.
Mandate and enforce separation of work force and functions	Managerial	At PHD in South Africa, warehouses are divided into three units, each of which has separate physical areas, personnel policies, and operating procedures.
Involve civil society groups in monitoring drug delivery systems	Accountability/oversight	Involvement of civil society organizations (CSOs) as 'watchdogs' of the public good is a low-cost and effective intervention.
Run regular risk analyses for transportation and delivery	Accountability/oversight	The risk of theft during transport and delivery is reduced through risk analysis of delivery routes with accompanying appropriate measures.
Create health boards that are charged with distribution and regular monitoring of stocks at the facility level	Accountability/oversight	Health board members must be screened well for no potential conflict of interest.

⁷⁷ Government domain will depend on which level(s) of government (national, state/provincial or municipal) is involved in overseeing the distribution of medicines.

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3.5 Health budgets

Problem analysis and evidence

Health budgets, like all other areas of public sector financing, may be subject to corruption if oversight is lacking. Budget management systems are limited in many developing countries in particular; in such contexts, monitoring of budgets is difficult, critical data are missing and financial information on expenditures may be flawed. The budget formulation process is often an area of weakness and vulnerable to interest politics. Some important steps have been taken to improve such situations: most notably, health budgets in many developing countries now benefit from support provided by global institutions and financing mechanisms such as the GAVI Alliance and the Global Fund to Fight AIDS, TB and Malaria.

Budget processes and corresponding vulnerabilities to corruption will differ depending on the extent to which a budget is managed at the national level and/or is supported by traditional bilateral programmes or global initiatives. This differentiation should be considered when determining what measures are most appropriate to employ to prevent corruption.

Donor financing can be highly vulnerable to corruption. Two main reasons are that funding from that source may be considerably higher than a national health budget and have a shorter time period for disbursement. With shorter timelines, monitoring of disbursements may not take place or be insufficient. Also, donor funding may be more difficult to track when it is converted into local currency; a similar challenge may occur because transactions are often cash-based in resource-poor settings (and thus less easy to track)⁷⁸.

Zambia is a case of donor funding for health that was subject to corruption. The country is the recipient of a large number of donor funds for health, many of which were pooled through a sector-wide approach (SWAp)⁷⁹. Even though Zambia's high potential for corruption was well known, donors did not take necessary measures to ensure that sufficient anti-corruption and good governance processes were in place prior to the granting of funds. In 2009, Zambia's Anti-Corruption Commission found that high-level officials in the Ministry of Health and Social Welfare had embezzled US\$1.4 million. The officials were paid as consultants for workshops that did not take place⁸⁰. As soon as corruption was discovered in the health sector, donor support, which represented half of the national health budget, was frozen, which led to a disruption in health care services. Following the corruption scandal, a number of measures were advocated by donors. They include ensuring transparency in budgetary decisions, strengthening financial management systems, mandating regular financial reports and audits, and prioritizing follow-up to ensure governments implement audit recommendations.

⁷⁸ Semrau, K., Scott, N., & Vian, T. (2010). 'Embezzlement of donor funding in health projects' in Vian, T., Preventing Drug Diversion Through Supply Chain Management. U4 Brief 4, Chr. Michelsen Institute, Bergen, Norway. p. 25.

⁷⁹ See www.who.int/trade/glossary/story081/en/ for more information about SWAps.

⁸⁰ For more information see Pereira, J. (2009). 'Zambia aid effectiveness in the health sector', Action for Global Health.



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Good practice examples

- The government and donors have set up a social control fund in Colombia. Under terms of the fund, citizens monitor funding for key sectors including health. It is estimated that as much as US\$5.4 million would otherwise have been lost due to corruption⁸¹.
- Sector expenditure tracking surveys can help to identify potential budget leakages as well as how well money is being spent. One important caveat, however, is that the tracking of overall health expenditures is often challenging because there are multiple sources and mechanisms for funding⁸².
- It is useful to know what funds are being used in the health sector (core budget, donor, etc.) to ensure their consistency in disbursement and financial management along with appropriate spending at the clinic and hospital levels⁸³.

Table 5. Select interventions to improve payer performance⁸⁴

Intervention	Type	Comments
Apply and enforce IMF's Revised Code of Good Practices on Fiscal Transparency (2007) ¹ .	Transparency	Role of national government to set as a standard. Donors could also ensure this is included in health development projects.
Implement Public Expenditure and Financial Accountability (PEFA) framework.	Accountability/oversight	PEFA indicators relevant to the health sector are: i) aggregate expenditure compared to original approved budget; ii) effectiveness of payroll controls; and iii) availability of information on resources received by service delivery units ² .
Initiate and sustain public expenditure tracking surveys and public expenditure reviews	Accountability/oversight	Commonly used by institutions like the World Bank to determine if public funding is reaching its objective.
Audit institutions or anti-fraud units	Accountability/oversight	A good example of an independent audit institution is the UK Counter Fraud Service, which aims to protect the National Health Service from fraud and corruption ³ .

81 Transparency International (2010). 'The anti-corruption catalyst: realising the MDGs by 2015'; Berlin, Germany, p. 7.

82 See Azfar, O., & Gurgur, T. (2006). 'Local-level corruption hits health service delivery in the Philippines', from Transparency International Annual Report.

83 Lewis, M., & Pettersson, G. (2009). 'Governance in health care delivery: raising performance'. World Bank Policy Research Working Paper 5074.

84 The interventions outlined in Table 5 are from Lewis, M., & Pettersson, G. (2009). 'Governance in health care delivery: raising performance'. World Bank Policy Research Working Paper 5074. References used in this table: 1. The manual can be downloaded from the IMF's website: www.imf.org/external/np/fad/trans/manual.htm (accessed 25 August 2010). 2. Lewis, M., & Pettersson, G. (2009). 'Governance in health care delivery: raising performance'. World Bank Policy Research Working Paper 5074. 3. Gee, J. (2006). 'Fighting fraud and corruption in Britain's National Health Service'. Transparency International, Berlin, Germany.

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Intervention	Type	Comments
Use national health accounts (NHAs)	Transparency	NHAs measure and track the use of total health care expenditures in a country. Some key observers argue that the need for transparency for NHAs makes it an anti-corruption tool if implemented regularly ⁴ .
Increase public participation in the budget process	Transparency	Broad-based participation is an effective tool.
Establish a system for citizen scorecards	Accountability/oversight	Effective means of checking health service delivery.
Promote and enhance budget monitoring by NGOs	Transparency	Allows for greater scrutiny of government budget and increases public awareness.
Implement performance-based budgeting	Managerial	Helps to ensure ethical behaviour.
Ensure training of core staff in relevant areas, such as financial management, budgeting, accounting, and risk management	Managerial	Can be enforced by management in the health sector as well as donors if health projects contain a training component. Domain of donors and the government.
Improve internal control through better oversight, audits and streamlined processes.	Accountability/oversight	Recommended controls include segregation of duties, comparing actual and expected revenue, internal/external audits, and investing in fraud control ⁵ .
Use quantitative service delivery surveys (QSDS) ⁶ .	Accountability/oversight	Investigates the efficiency of public spending and the associated incentive structure.
Simplify reporting systems	Managerial	By keeping reports simple there is less chance of hiding information.
Outsource disbursement of funds to an independent third-party	Accountability/oversight	To be effective, this step also demands appropriate safety measures such as transparency, regular reporting, etc.

84 References used in this table: 4. Lewis, M., & Pettersson, G. (2009). 'Governance in health care delivery: raising performance' World Bank Policy Research Working Paper 5074. 5. Semrau, K., Scott, N., & Vian, T. (2010). 'Embezzlement of donor funding in health projects' in Vian, T., Preventing Drug Diversion Through Supply Chain Management. U4 Brief 4, Chr. Michelsen Institute, Bergen, Norway. 6. See for example: www.gaportal.org/tools/quantitative-service-delivery-surveys-qsdss.



4. TOP TEN LESSONS FROM THIS STUDY



UN Photo/Michel Szwarc-Kryzanowski

The drive to reach the MDGs by 2015 has helped raise awareness among the global community about the need for anti-corruption interventions to be integral elements of health sector policy and planning. This study has explained why the health sector is prone to corruption, provided examples of instances of corruption in the health sector, and discussed select diagnostics and anti-corruption interventions. It has also highlighted a set of lessons that may assist any stakeholder (policy makers, development practitioners, citizens, etc.) to design anti-corruption interventions in the health sector. Ten of the most important lessons are summarized below.

Lesson one. There is no 'one size fits all' approach to mitigating corruption in the health sector. Practitioners need to give careful attention as to what potential strategy or strategies would work most effectively in view of the specific risks identified by use of diagnostics.

Lesson two. More than one anti-corruption intervention should be employed to deal with one risk. For example, wage increases may help to curb the likelihood of absenteeism, but they are likely to be more effective when there are systems in place to document absentee rates and when sanctions for absence are imposed.

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Lesson three. Prioritization is key: governments and others involved in health projects and programming should prioritize areas of the health system that are most susceptible to corruption and implement appropriate interventions. Often even ‘low hanging fruit’ can produce significant anti-corruption impacts. For example, the act of posting medical supply and pharmaceutical product pricing can help deter price gouging. The identification of priority areas is particularly important when resources are scarce.

Lesson four. It is important to work with other sectors. Corruption cannot be curbed in the health sector without the involvement of other critical sectors, such as infrastructure and finance.

Lesson five. Health policy goals should include anti-corruption considerations. Investments in health may be wasted unless anti-corruption strategies are built into all health projects. Preventative interventions can protect investments made.

Lesson six. Prevention is the best strategy: therefore, it is best not to wait for corruption to happen before beginning to deal with it. One of the biggest failings in the health sector is the implementation of anti-corruption interventions only after corruption is suspected or confirmed. Regular monitoring of the health sector for discrepancies in standards is vital.

Lesson seven. Numerous empirical diagnostic tools should be employed. Given the complexity of the health sector, more than one diagnostic tool may be of value to ensure accurate information. This also requires proper measuring and re-measuring. Regular ‘check-ups’ can measure how effectively anti-corruption strategies are working in a given point in the health care system.

Lesson eight. Partners with experience in implementing anti-corruption strategies and tactics should be identified and contacted for technical support. This study has identified a number of NGOs, international development institutions, research groups and experts involved in implementing anti-corruption strategies and tactics in the health sector.

Lesson nine. Broad participation in health policy and planning helps. Involving NGOs, citizens and designated experts in health budgeting, monitoring, and consulting, as a few examples, can help heighten transparency and lessen the likelihood of corruption.

Lesson ten. Good behaviour should be rewarded, and bad behaviour punished. This can be done by setting up appropriate incentive structures that help promote adherence to good behaviour, such as performance-based financing. It is also important to sanction those individuals who are engaged in corrupt activities where possible. This sends an important message that corruption is not tolerated.

There is a growing body of evidence documenting which anti-corruption strategies work in the health sector. What is needed, however, is more information about the impact anti-corruption strategies have on health outcomes, who should be involved in the process, which conditions are most likely to achieve successes, and how to sustain positive results. Also of importance is the need to understand whether good practices are transferable—and if not, why? What should be done at the local, regional or national level to minimize the risk of corruption in the health sector? This study ideally will help set into motion empirical work in response to these questions and more.



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ANNEX 1. OVERVIEW OF KEY TOOLS TO IDENTIFY, TRACK AND MEASURE CORRUPTION RISKS AND CORRUPTION

Area	Issue	Tools to identify and track problems
General	Cross-cutting	Vulnerability to corruption assessments Value chain analysis Sectoral accountability assessment Analysis of governance in health care systems
Budget And Resource Management	Budget processes	Public Expenditure and Financial Accountability (PEFA) indicators Focus groups and interviews with public officials, recipient institutions, and civil society
	Payroll leakages	Public expenditure tracking surveys and reviews Household surveys Focus groups with public officials and health workers
	In-kind leakages	Public expenditure tracking surveys Quantitative service delivery surveys Facility surveys Focus groups with public officials, recipient institutions, and health workers
Individual Providers	Job purchasing	Official administrative records combined with facility surveys Interviews with public officials and former officials Governance and anti-corruption country diagnostic surveys
	Health worker absenteeism	Quantitative service delivery surveys Surprise visits Direct observation Facility records Focus groups or interviews with facility heads and patients
Informal Payments	Informal payments	Household surveys (e.g., World Bank living standards measurement surveys and demographic and health surveys) Facility exit surveys and score cards Focus groups/interviews with providers/patients and health staff Governance and anti-corruption country diagnostic surveys (World Bank)
Corruption Perceptions & Experience	Perceptions of Corruption	Governance and anti-corruption country diagnostic surveys (World Bank) National level perception surveys by CSOs and others
	Experience with corruption	AfroBarometer, LatinBarometer, EuroBarometer, national experience-based surveys Patient satisfaction surveys and report cards Focus group surveys /studies

Source: Hussmann, K (2010). Adapted from Lewis, M., & Pettersson, G. (2009). 'Governance in health care delivery: raising performance' World Bank Policy Research Working Paper 5074.



ANNEX 2. SELECT RESULTS FROM WHO'S GOOD GOVERNANCE FOR MEDICINES (GGM) PROGRAMME

Lebanon

The Phase I assessment recommended that the national Good Manufacturing Practices (GMP) be updated given they had not been revised since 1983. As a result, a national GMP committee was formed in 2008, and it revised the GMP standards in 2009. The Ministry of Health (MoH) recently adopted the GGM framework to include a national code of conduct, compilation of regulations and administrative procedures, mechanisms for collaboration with other good governance and anti-corruption initiatives, whistleblowing mechanisms and sanctions for breaches of standards.

Malaysia

Outcomes from the GGM include the development of public promotional activities to increase awareness on the potential of corruption in the pharmaceutical sector. There is also more publicly available information about the pharmaceutical legislation and process available on the MoH website.

Moldova

The National Medicines Agency is leading the implementation of actions related to the GGM including working with pharmacists to correct any regulatory gaps, and writing standard operating procedures for each function that the assessment instrument deemed as weak. The MoH has since approved a guide for pharmaceutical procurement, a code of ethics for health professionals, and monitoring of drug promotion.

Mongolia

Since Phase I there have been more transparent procedures in the MoH and regulations as well as the development of guidelines such as national standards on drug registration. Also, general principles for pharmacies and for drug procurement agencies have been reviewed and updated. In collaboration with UNDP, the MoH and the Pharmaceuticals and Medical Devices Department set up an online registration system to improve licensing and monitoring of drugs and medical devices.

Philippines

The Government of the Philippines has developed a technical manual for good governance dealing with the registration, selection and procurement of medicines. In August 2008, the government launched a GGM awards system, in collaboration with MeTA (Medicines Transparency Alliance). It encourages local government units, national health facilities or the private sector to develop innovative initiatives that provide models for good governance.

Thailand

There has been an increase in the number of public hospitals that have adopted best practices in medicines procurement. The hospitals have established a pooled purchasing scheme with an agreed list of medicines and suppliers, resulting in more cost-effective procurement. The national pharmaceutical laws and regulations have been reviewed to assess whether they reflect current best practice.

Communication with the public has increased through the use of media, brochures and websites. Minutes from the National Medicine Committee meetings are now publicly available and the topic of good governance has been added to the curriculum of 15 faculties of pharmacy. The National Health Assembly is also focused on policy issues such unethical drug promotion and curbing the influence of pharmaceutical companies on medical doctors.

ANNEX 3. CITED PARTNERS FOR HEALTH AND ANTI-CORRUPTION



Basel Institute on Governance: www.baselgovernance.org/

European Healthcare Fraud & Corruption Network: www.ehfcn.org

Medicines Transparency Alliance (MeTA): www.medicinestransparency.org/

Poverty Reduction and Economic Management (PREM) network, World Bank: www1.worldbank.org/prem

Supply Chain Management System (SCMS): <http://scms.pfscm.org/scms/working/partnerships>

Transparency International: www.transparency.org/

UK Counter Fraud Service: www.nhsbsa.nhs.uk/fraud

WHO Good Governance for Medicines (GGM) programme: www.who.int/medicines/ggm/en/index.html



ANNEX 4. PROPOSED TERMS OF REFERENCE FOR COUNTRY CASE STUDIES ON ANTI-CORRUPTION IN THE HEALTH SECTOR

Background

Corruption in the health care sector exacerbates any existing challenges health systems may face and limits access of the population, particularly the poor and vulnerable, to essential health care services. Absence of rules and regulations, lack of accountability, low salaries and limited offer of services (i.e., more demand than supply) are among the key reasons for corruption in the health sector. The type of corruption found in the health sector is a by-product of the structure of the health care system and its location within it (for example, drug procurement collusion or paying bribes to health professionals for public health services). The scale of corruption is either petty (informal payments levied on public health services) or grand (the manufacture of counterfeit medicines for wide distribution), both types have adverse impacts on health care outcomes. Despite the widespread recognition of the importance of addressing corruption to meet health goals, such as the MDGs, there is not a large body of empirical evidence which documents good practices.

Objective

The field research will investigate select corruption risks in the health sector, and what anti-corruption interventions have been applied at the local and/or national levels to address risks. Attention will be given to what factors help and/or hinder anti-corruption interventions.

Methodology

First step: document review

Documents that are relevant to corruption and/or health specific to the country under investigation should be compiled and analysed for key themes. These may include reports from UN agencies, governments, donors, civil society organizations (particularly Transparency International), academia and the media. Common themes, particularly areas of strengths and weakness in the health sector, should be identified. The purpose of this step is to provide background information on the health sector and to understand why an anti-corruption intervention was warranted. Target areas include: health professionals, drug supply and distribution, finance, and budget allocation.

Second step: identify priority anti-corruption interventions

Based on the findings from the document analysis, anti-corruption interventions in priority areas may be identified for further examination by conducting semi-structured interviews with key informants. Here, questions relevant for the health sector and corruption can be drawn from documents such as the USAID Anti-Corruption Assessment Handbook and the WHO Measuring Transparency in the Public Pharmaceutical Sector.

Third step: key informant interviews

Key informants in the health sector should be identified that would be knowledgeable about the anti-corruption intervention and the health sector in general. These may include representatives from the Ministries of Health, Finance, and Justice, anti-corruption institutions, hospitals, pharmaceutical companies, local drug manufacturers and wholesalers, community health care facilities, international

ANNEX 4. PROPOSED TERMS OF REFERENCE FOR COUNTRY CASE STUDIES ON ANTI-CORRUPTION IN THE HEALTH SECTOR



development agencies, donors, NGOs, media, and patients. The snowball technique (asking a key informant for his/her suggestion about who to interview) may also be helpful here.

Questions for key informants may be based on existing documents to ensure appropriateness to the anti-corruption intervention and health care sector target area. Questions should also include general ones such as:

- Why was the anti-corruption intervention initiated?
- What was your role in the anti-corruption intervention?
- What function or functions in the health sector is/are a target(s)?
- What specific corruption risks were addressed?
- What type of approach was used in this anti-corruption intervention?
- Who participated in the intervention (e.g., national government, local government, UN agency, donor)?
- What other sectors were addressed as part of this anti-corruption intervention?
- What are the results of the anti-corruption intervention? What evidence can back it up?
- What have been the enabling and hindering factors of the anti-corruption intervention's results?
- How were constraints dealt with?
- What sustainability mechanisms were built into the anti-corruption intervention?
- Have these been effective?
- What lessons can be drawn from the anti-corruption intervention?
- Can this intervention be repeated? If so, how?

Fourth step: mapping risks and anti-corruption interventions

Based on the document analysis and key informant interviews, map corruption risks in the health sector. Analyse each risk and try to assess whether the risk for corruption is high or low. In addition to mapping corruption risk, map anti-corruption intervention as below. Information for each anti-corruption intervention should include:

Health function	
Corruption risk	
Length of intervention	
Results	
Success/failure factors	
Hindering/fostering factors	
Enabling policy and context characteristics	
Sustainability of intervention	



ANNEX 4. PROPOSED TERMS OF REFERENCE FOR COUNTRY CASE STUDIES ON ANTI-CORRUPTION IN THE HEALTH SECTOR

Fifth step: final product

The case study should address each step listed in the above focusing particularly on good practices, as well as an analysis about the generalizability of the findings. It should be limited to no more than 30 pages.

Team composition:

- Team leader: solid experience in the area of corruption and development and experience in preparing policy documents
- Finance specialist: strong background in health financing
- Procurement specialist: knowledge of operational issues related to health supplies
- Health specialist: expertise of health system issues and strong knowledge of the structure and functions of the health system under investigation
- Qualitative methods specialist: experience in compiling information from document analysis and conducting key informant interviews as well as preparing case studies
- Research assistant: experience with project management and good organizational skills



1. Objectives and Methodology

This annex presents the findings, conclusions, lessons and recommendations on good anti-corruption practices in the health sector in sub-Saharan Africa. Specific case studies are drawn from Malawi, Tanzania and Uganda, which like most others in the region have faced governance challenges in the health sector that have contributed to high levels of corruption in various sub-sectors including drugs supply and management, human resource management, and procurement. The three countries are all implementing one or more good governance and anti-corruption programmes in the health sector that are discussed elsewhere in this report.

Documents reviewed included reports from UN agencies, governments, donors, civil society organizations, academia and the media. Common themes, particularly areas of strengths and weakness in the health sector, were identified. The purpose of this step was to provide background information on the health sector and to understand why an anti-corruption intervention was warranted. Target areas included health professionals, drug supply and distribution, finance, and budget allocation.

The study was somewhat limited in scope given that it was largely desk-based and there is a paucity of information online (especially updated information). It is key that this process be taken forward later on through in country assessments and evaluations of identified case studies. Additional questions relevant for the health sector and corruption can be drawn from documents such as the USAID Anti-Corruption Assessment Handbook and the WHO Measuring Transparency in the Public Pharmaceutical Sector should. Key informants in the health sector should include representatives from the Ministries of Health, Finance, and Justice as well as anti-corruption institutions, hospitals, pharmaceutical companies, local drug manufacturers and wholesalers, community health care facilities, international development agencies, donors, NGOs, media, and patients.

2. Uganda Case Study: Increasing Public Awareness and Debate on Corruption in the Health Sector through the 'Stop Stock-outs' Campaign

2.1 Introduction

According to the Third Progress Report on MDGs in Uganda (prepared by the Ministry of Finance, Planning and Economic Development in 2010), Uganda is not on track to meet the health-related MDGs. Progress toward achieving several of the health targets, including those related to child and maternal mortality, access to reproductive health, and the incidence of malaria and other diseases, have progressed slowly. Infant mortality remains at 85 per 1,000 live births while maternal mortality is at 435 per 100,000 live births and it is estimated that 16 women die daily due to maternal complications. After declining for years, adult HIV prevalence has stabilized at about 6.4 percent, and annual new infections have risen among older age groups and those that are married/cohabitating.

⁸⁵ These cases studies were commissioned by UNDP and prepared by AVID Development Ltd. in March 2011. The desk research was conducted by Allen Asiimwe with assistant from Ashaba Ahebwa and Victor Agaba.



ANNEX 5. CASE STUDIES FROM UGANDA, MALAWI AND TANZANIA: MAPPING GOOD ANTI-CORRUPTION PRACTICES IN SUB-SAHARAN AFRICA



World Bank / Yosef Hadar

Rapid population growth at 3.2 percent per annum continues to place stress on the health system while the global financial and economic meltdown is likely to result in reduced development assistance to Uganda.

Compounding these challenges is a heavily underfunded health sector in comparison to what is needed for implementing the National Health Policy (NHP) and Health Sector Strategic Plan (HSSP), and achieving the targets outlined in the MDGs. Government budget expenditure in the health sector currently stands 11.6 percent (FY 2008/09), a level still below the Abuja target of 15 percent. Funding gaps for individual health service provision with per capita expenditure are at US\$25 (of which only US\$7 is from government source) compared to HSSP II target of US\$28 and WHO target of US\$40. In the 2009/10 budget, pharmaceutical supplies including medical drugs were allocated 301 billion Ugandan shillings (US\$105 million), which accounted for 47 percent of the total budget allocation to the health sector. Only 2 percent of the health sector budget is apportioned to Monitoring and Evaluation.

2.2 Corruption in the health sector

A big portion of the amount allocated to drugs and supplies is however wasted through leakages and pilferage; according to one analysis, an estimated 22.3 billion shillings (US\$7.9 million) was lost in FY 2006/07 (Bjorkman and Svenson). As a result, access to essential medicines and supplies in Uganda including anti-malarials, antiretroviral drugs (ARVs), contraceptives, gloves and mama kits remains low. Currently, there is an unmet need of 41 percent for contraceptives (UBOS- UDHS, 2006) and it has been reported that 300 people die daily of malaria-related complications. According to the Public Expenditure Review (PER) on the health sector in 2008, the availability of drugs is the most significant determinant of whether people attend public health facilities.



There is lack of credible data on distribution and use of essential medicines but several studies indicate high levels of drug leakage and massive stock-outs. The 2008 PER on the health sector noted that data on drugs released by the National Medical Stores (NMS) explained only 7 percent of the data on drugs received by facilities while the Financial Management Programme (FINMAP) Review (November 2009) found low levels of recording and stock updates in all health facilities visited.

In the recent past, the health sector has been hit by a wave of high-profile corruption scandals involving the direct pilferage of drugs and misuse of resources. Millions of dollars have been lost resulting in the suspension of funding from global initiatives such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the GAVI Alliance. Investigations and prosecutions of accused officials are ongoing; however, follow-up and enforcement remain weak.

Within districts and at health facilities, corruption is largely manifested through bribes and informal payments for services and drugs; pilferage and misuse of health facilities and equipment; and absenteeism. For example, absenteeism across the sector is around 40 percent in all facilities, and nears 50 percent for midwives and nurses⁸⁶.

2.3 Risks that exacerbate inefficiencies and corruption in the health sector

- The existing policy and institutional framework⁸⁷ for drugs management lends itself to potential overlaps and duplicity and potentially provides opportunity and a conducive environment for mismanagement, corruption and pilferage
- Difficulties in tracking drugs among the MoH, districts and health centres⁸⁸
- Weaknesses in procurement planning (e.g., some procurements were not approved by the contract committees, and irregularities in the procurement of ARVS)
- Inconsistencies in drug storage and distribution (e.g., regarding transportation of drugs, reconciling of ledgers, collection of drugs from districts by health centres)
- Drug shortages and stock-outs, inadequate storage facilities and expired drugs
- Poor supervision and monitoring

The impact includes wastage of medical equipment and massive stock-outs of essential drugs, vaccines and contraceptives. Empty medicine cupboards are the norm and vaccine stocks are not updated by health centres. Millions of Ugandans are still unable to access essential medicines in government health facilities and Uganda's efforts to meet its commitments to improving the health rights of its citizens are hampered. In some cases, drug stock-outs have resulted in the loss of lives—e.g., where drugs are not accessible to treat diseases like malaria.

86 Uganda Ministry of Health, Uganda Service Provision Assessment Survey 2007.

87 Drugs management has a broad net work of interdependent institutional entities including the Ministry of Health, the National Medical Stores (NMS), the National Drug Authority (NDA), the Ministry of Finance, Planning and Economic Development, local governments, private-sector organizations, donor organizations, third party programmes (such as the Global Fund and PEPFAR), and NGOs. Also of relevance are existing policies, laws and regulations including the Public Procurement and Disposal of Public Assets Act of 2003 (PPDA).

88 Audit by the Office of the Auditor General in the management of health programmes in the health sector (March 2009).



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2.4 Ongoing reforms

In a bid to enhance drugs management and minimize leakages, the Government of Uganda in November 2009 centralized all medicines funding in the National Medical Stores (NMS). Funds for the purchase of drugs are now channelled directly from the Ministry of Finance, Planning and Economic Development (MoFPED) to NMS as opposed to the previous system of channelling funds directly to the districts and health facilities. This translates to 75 billion shillings (US\$27 million) being transferred to NMS for FY 2009/10, an amount that has increased to 110 billion shillings (US\$39 million) in the FY 2010/11 FY. A review of recommendations by previous studies⁸⁹ indicates that centralization of funding and procurement for drugs and essential medicines supplies has been a longstanding recommendation that may address some of the concerns in the sector.

Several studies/reviews⁹⁰ of NMS have highlighted key challenges and constraints that affect its effective performance and contribute to the existing governance weaknesses. NMS has been newly restructured and is under new management; nevertheless, it has made commitments to addressing gaps and to a zero policy on corruption. Internal reforms⁹¹ are under way with a new priority product list of 256 items developed, an operational manual revised, and a pricing survey undertaken to revisit overpriced items.

Proposals are under way to establish a list of essential drugs and items that must be available at each Health Centre II and III, including anti-malarials, contraceptives, drugs and mama kits. NMS intends to pilot delivery of drugs down to the lower level sub-district health centres, unlike the current policy of delivery to the district level. It NMS has also developed a procurement policy and processes manual, with required modifications expected to address specific peculiarities of procurement of drugs and to reduce bottlenecks in implementing the regulations and provisions of the Public Procurement and Disposal of Public Assets Act of 2003 (PPDA) act. The revised manual was submitted to PPDA for accreditation in February, 2010.

The Medicines Transparency Alliance (MeTA) is working through a multi-stakeholder group (the MeTA Council⁹²) to implement a work plan aimed at bringing information into the public domain—e.g., on the cost of medicines at point of entry and recognition of essential drugs. MeTA is also undertaking a pricing survey for drugs in Uganda and mapping the medicine supply chain.

Loopholes, however, still exist in the value chain as evidenced by the various studies, audits and media reports.

89 Including the technical review of NMS by Euro Health Group Consultants (May 2004) and a World Bank study (August 2006) on the role of NMS in the public and private health care system in Uganda.

90 Including the NMS Task Force Report (2008); and a USAID-supported assessment of warehouses, distribution and management information (October 2007).

91 NMS Progress Report (July-December 2009).

92 The MeTA Council comprises representatives from the MoH, the private sector (including pharmaceutical companies), the National Drug Authority, the Pharmaceutical Society of Uganda, and civil society groups including the Uganda National Health Users Organisation (UNCHCO), HEPS and the Uganda Protestant Medical Bureau. Also involved are development partners such as the World Bank and WHO.



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2.5 Massive stock-outs in health facilities

Despite these reforms, health centres at all levels continue to face massive stock-outs of essential medicines. These medicines were originally defined by the World Health Organization (WHO)⁹³ as those which satisfy the needs of the majority of the population and therefore should be available at all times, in adequate amounts, in appropriate dosage forms and at a price the individual and community can afford. Exactly which medicines are regarded as essential remains a national responsibility but unfortunately corruption greatly interferes with this process.

When a pharmacy (in a medical store or health facility) temporarily has no medicine on the shelf, it is known as a 'stock-out'. It may affect one medicine or many medicines, or in the worst case, all medicines. A stock-out can be documented at one point in time or over a period of days, weeks or months. When there is good stock management systems in place, the stock-out duration will be minimal or, ideally, never. In Uganda, it is not clear what percentage of stock-outs are a result of corruption or poor management.

In 2010 the health minister said the following: "Only 26 percent of public facilities were able to get through the last year without a stock-out of any of the six sector tracer medicines....Factors range from inadequate financing for medicines, low levels of appropriately skilled human resources for health in the health facilities and more especially low management capabilities at the different levels and inefficiencies."⁹⁴

2.6 The Stop Stock-outs campaign: involving the public in oversight

The Stop Stock-outs campaign is a regional campaign in six countries in Africa including Kenya, Madagascar, Malawi, Uganda, Zambia and Zimbabwe aimed at ending stock-outs of essential medicines in public health facilities. At the regional level, the campaign is spearheaded by Health Action International (HAI)-Africa and Oxfam and supported by other stakeholders such as MeTA, the Open Society Foundations and national civil society organizations (CSOs).

In Uganda, the campaign was coordinated by a consortium of five CSOs (HEPS Uganda, AGHA, AIDE, ACFODE, and NAFOPAHU)⁹⁵ and launched in March 2009 for one year.⁹⁶ The Stop Stock-outs campaign was crafted as a public media campaign aimed at putting the issue onto the national agenda. Based on information generated from previous studies undertaken by consortium members⁹⁷, a baseline was established on the availability and affordability of medicines in public health facilities and in the private sector, including mission hospitals. The analysis indicated that certain specific and commonly used medicines were available only an average of 50 percent of the time in public health

93 See www.who.int/medicines/publications/essentialmedicines/en/.

94 Excerpt from a speech by then-Minister of Health Stephen Mallinga at a pharmaceutical policy options workshop supported by USAID in Kampala, 15 April 2010.

95 The Coalition for Health Promotion and Social Development in Uganda (HEPS), the Action Group for Health, Human Rights and HIV/AIDS (AGHA), the National Forum for People Living with HIV/AIDS in Uganda (NAFOPAHU), Action for Development (ACFODE) and the Alliance for Integrated Development and Empowerment (AIDE).

96 The campaign though launched for a period of one year continues to run. The Ushandi website- www.stopstockouts.org/ushaidi is still operational showing status of stock-outs in the different countries

97 HEPS had undertaken numerous studies from 2005 on the availability and affordability of medicines and the data were contained in its quarterly progress reports



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facilities. The comparable figure in the private sector was more than 70 percent, but the drugs were more expensive in that sector and thus not affordable to many.

The campaign was started with a series of capacity building workshops for CSOs and the media working on health-related issues. The training was essential in simplifying health issues and creating understanding among CSOs and media of medicines-related issues and monitoring. In addition, clear, simple and well defined messages were crafted to be used in media advocacy.

Following the training, the consortium undertook a 'Pill Check Week'⁹⁸. This involved a spot check of medicine stock-outs in public health facilities. It was carried out in 11 of the country's 81 districts, each of which was represented by one government facility. The check covered 10 key essential medicines and found that stock-outs, especially of paediatric preparations and anti-malarials, were still a major problem.⁹⁹

After visiting the various clinics and pharmacies, activists reported their results using mobile phones through structured, coded text messages (SMS) that were uploaded on a website called Ushahidi, which means 'testimony' in Swahili¹⁰⁰. The website used Google Maps to show specific locations of up to 250 stock-outs of essential medicines. Based on the results of the Pill Check Week, the Uganda coalition issued a press statement and called upon the Ugandan Government to:¹⁰¹

- Give financial and operational autonomy to NMS, the national medicines procurement and supply agency
- Install civil society representation on the board of NMS.
- End corruption in the medicine supply chain
- Stop theft and diversion of essential medicines
- Take a proactive role in strengthening the watchdog role of accountability mechanisms such as Parliament, the Inspectorate of Government (IGG), the Directorate of Public Prosecutions (DPP) and CSOs by meaningfully involving them in decision making and monitoring the delivery of health care and use of resources for health
- Provide a dedicated budget line for essential medicines
- Fulfil commitments to spend 15 percent of the national budget on health care
- Provide free essential medicines at all public health institutions

The Uganda campaign used a variety of approaches largely aimed at increasing public awareness and generating debate on key issues relating to drugs stock-outs. These approaches have included the use of publicity materials like t-shirts, banners, fact sheets, fliers and policy briefs and identifying champions including a local artist and female Member of Parliament. Press statements and conferences, public rallies, radio talk shows and media articles were used to generate public debate in the media.

98 The Pill Check Week took place in all five of the African countries participating in Stop Stock-out campaigns and used a Google map to identify where the stock-outs were a reality. Online: <http://stopstockouts.org/ushahidi/>.

99 See www.heps.or.ug. The Pill Check Week took place in June 2009.

100 Ushahidi is a website that was first developed to map reports of violence in Kenya after the post-election fallout at the beginning of 2008. Online: <http://stopstockouts.org/ushahidi/>.

101 See <http://stopstockouts.org/2009/08/26/narrative-report-stop-the-stock-outs-campaign/>



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Box 1. Use of Frontline SMS¹⁰²

FrontlineSMS is free open source software that turns a laptop and a mobile phone into a central communications hub. Once installed, the programme enables users to exchange text messages with large groups of people through mobile phones. It was invaluable to the Stop Stock-outs campaign by encouraging the public to volunteer information on the status of drugs in health centres because it is so easy and affordable to use.

Frontline SMS was used during the Pill Check Week campaign where SMS text messages were sent by data collectors on the status of stock-outs of essential medicines. The messages were received on phones in Malawi, Kenya, Uganda and Zambia where computers running Frontline SMS processed and validated the data before sending it to an Ushahidi interface to be visualized on the Web. After visiting clinics and pharmacies, activists reported their results using their mobile phones through structured, coded text messages that were uploaded on Ushahidi. Data were reflected on a map on the website showing specific location of up to 250 stock-outs of essential medicines.

2.7 Achievements of the campaign and lessons identified¹⁰³

The Stop Stock-outs campaign was initially intended for one year starting from March 2009, but was renewed in July 2010 and continues to run to date because of its successes. The campaign has been widely reported in the media including radio, television, print and internet. It has prompted responses from wide sections of society and generated public debate on medicine stock-outs, their causes and possible solutions. Articles and stories continue to appear regarding medicine stock-outs in public health facilities, including about arrests and prosecution of health workers caught stealing drugs.

The campaign also attracted the attention of the key government agencies. For instance, NMS responded to the media reports with a statement and personnel were cited in newspaper articles explaining the causes of stock-outs (including the challenges); many also blamed other players, particularly health facilities, for delayed orders. Members of the Social Services Committee of Parliament made an unannounced visit to NMS to ascertain the stock levels and causes of stock-outs.

The campaign is also credited with contributing to influencing the government's decision to centralize procurement and distribution of drugs under NMS and limit the responsibility of district governments for procurement of drugs. On 31 August 2009, Parliament passed the 2009-2010 national budget, approving a separate budget line for NMS for the first time ever. This means that money for medicines will no longer go through the MoH. It is expected that the decision will reduce bureaucracy and fragmentation and increase resources for medicine procurement on a timely basis.

In October 2009, the President's Office announced the establishment of the Medicines and Health service Delivery Monitoring Unit of State House, with a mandate to investigate and curb theft of

102 See www.frontlinesms.com and <http://stopstockouts.org/partners/>.

103 Interview with Rosette Mutambi, executive director of HEPS, who coordinated the CSO consortium that developed and implemented the Stop Stock-Outs campaign in Uganda



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medicines in government hospitals and enhance smooth delivery of medicines and health services to the people of Uganda. Several medical practitioners and officials (including doctors, nursing aides, clinical officers) have been arrested, mainly those at a low level in the drugs supply chain. A report presented by the Medicines Unit in September 2010 stated that some 5 billion shillings (US\$1.77 million) worth of stolen drugs had been recovered. As many as 80 cases have been brought to court to date across the country, with at least five convictions secured so far.

Overall, the Stop Stock-outs campaign has raised more awareness about the right to health and to access essential medicines in Uganda and increased public participation in the health system. The public are becoming more active in debating the issues, reporting stock-outs and holding institutions to account while the government is responding to the campaign in a positive way and changes are taking place at policy and implementation level.

Lessons identified:

- The Stop Stock-Outs campaign was a concerted effort of several stakeholders. The capacity-building workshop (supported by MeTA) at the start of the campaign was critical in creating understanding among CSOs and the media of medicines-related issues and establishing benchmarks for monitoring.
- The consortium relied on existing data and information by the members and by the MoH which was used to create sufficient material and evidence for the campaign. The MeTA Council (a consortium of stakeholders in the health sector) was used as a platform to provide input and debate materials used for the campaign, thereby enhancing stakeholder support. This support helped build success for the campaign.
- The consortium of CSOs also worked through its networks at the community level in various communities (including Kisenyi and Kawempe), thereby enhancing community ownership of the campaign. By using clear, simple, well defined and consistent messages, the consortium was able to simplify health related issues and endear the local population to the campaign.
- Through use of simple and affordable social media tools such as text messaging, CSOs were able to get the public engaged in identifying gaps and fighting corruption in the drugs supply chain. The public support garnered through the campaign was critical in propelling duty bearers to initiate reforms to address the pilferage of drugs.
- The need to enhance the effectiveness of the campaign especially in following up and sanctioning cases of corruption was noted. Existing laws are weak, leading to poor or ineffective sanctions for those that are arrested and convicted, while the capacity of law enforcement officers to investigate and prosecute drug related crimes is also limited. In addition, strong leadership and political will are needed to enforce management and institutional reforms that will minimize inefficiencies and reduce opportunities for corruption and theft of drugs.



UN Photo/Evan Schneider



3. Malawi Case Study: Measuring Levels of Transparency and Vulnerability in the Health System through the Good Governance for Medicines Programme

3.1 Introduction

Malawi's health indicators are overall extremely poor. Life expectancy declined from 48 to 39 years between 1990 and 2000, mainly as a result of AIDS. Maternal mortality is shockingly high and has worsened since 1990, suggesting a significant decline in the overall health infrastructure and ability to deliver accessible emergency obstetric services. Achieving the MDGs in Malawi is a major challenge in the face of increasing levels of poverty. Sixty-five percent of the population is unable to meet their daily nutritional needs. Fertility rates are high and the HIV/AIDS epidemic has increased demand for health services, while reducing the health sector capacity.

Access to health services is modest and skewed in favour of non-poor and urban populations. Only 54 percent of the rural population has access to a health facility within five kilometres. Only 10 percent of all health facilities have the capacity to deliver the essential health package. Front-line health services suffer from lack of drugs, poor staff-client relations, and poor quality diagnosis and treatment. Public services are free of charge at the point of delivery, but out-of-pocket expenditure accounts for 26 percent of total health spending, with the poorest households spending up to 10 percent of their annual consumption on health care. The poor have the greatest burden of ill health and are the least likely to access health services¹⁰⁴.

¹⁰⁴ DFID Programme Memorandum, 'Improving health in Malawi: a sector-wide approach including essential health package and emergency human resources programme' (2005/06 – 2010/11). Online: www.u4.no/themes/health/dfidmalawifinalreport.pdf.



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3.2 Corruption in the health system

Malawi has in the past been ranked as a highly corrupt country and corruption has been a major problem in drugs procurement and the supply chain. The World Bank assessed the risk as high when it conducted a Country Procurement Assessment Review in 2004, following a procurement capacity assessment of the Ministry of Health (MoH) and Central Medical Stores in December 2003.

Box 1. Governance risks and challenges in the health system in Malawi

- Chronic under-funding of the health sector leading to provision of poor quality services
- Inefficient procurement and distribution systems
- Unethical practices that include corruption and pilferage
- Consistent shortage of essential drugs and medical supplies at service delivery points
- Limited pharmaceutical manufacturing base and over-dependence on the importation of medicines from foreign manufacturers
- Inadequate capacity of the Pharmacy, Medicine and Poisons Board to enforce legislation and regulations relating to control of medicines in Malawi
- High poverty rates and high costs of quality drugs lead the poor to seek cheaper and often unsafe options

3.3 Ongoing reforms:

Malawi has in the last decade introduced greater fiscal discipline and fiduciary reforms. A new public procurement system is being implemented. Donors are supporting government plans to institutionalize political reform in the hope that stronger institutions will make backsliding more difficult. Financial management and procurement procedures have been developed for the sector-wide approach (SWAp), offering safeguards while simultaneously building capacity at central and district levels. These include time-bound financial management and procurement improvement plans, a commitment to fill accountant vacancies, independent financial and procurement audits, and long-term technical assistants with mentoring, management and supervisory responsibilities¹⁰⁵.

Several strategies have been designed, especially by development partners, to improve the operations of the health system and to combat corruption in the sector. In December 2004 DFID agreed to provide £100 million (US\$158 million) to the Government of Malawi to support the health sector over a period of six years (2005 through 2011). DFID is pooling its contribution to the SWAp in health with the World Bank and some other bilateral partners. Other bilateral donors and the Global Fund support the health sector through project funding.

105 See www.u4.no/themes/health/healthgoodpracticeex5.cfm.



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3.4 Assessing vulnerability in the health system through the Good Governance for Medicines programme

In implementing the Good Governance for Medicines (GGM) programme at country level, two strategies¹⁰⁶ were identified to fight corruption:

- Discipline-based strategy: establishing anti-corruption laws, as well as legislation and regulation for the management of the pharmaceutical sector.
- Values-based strategy: building institutional integrity through the promotion of moral and ethical practices.

A three-phase approach was identified by WHO as follows¹⁰⁷:

Phase I: National assessment of transparency and potential vulnerability to corruption using the WHO standardized assessment instrument which focuses on the following central functions of the pharmaceutical sector:

- registration of medicines and control of their promotion
- inspection and licensing of establishments
- selection, procurement and distribution of essential medicines
- control of clinical trials

Phase II: Development of a national framework for promoting Good Governance for Medicines in the public pharmaceutical sector. Once the assessment is done, defining the basic components of the GGM framework will be undertaken through a nationwide consultation process with key stakeholders. These components might include: an ethical framework and code of conduct, regulations and administrative procedures, collaboration mechanisms with other good governance and anti-corruption initiatives, whistleblowing mechanisms, sanctions for reprehensible acts and a GGM implementing task force.

Phase III: Implementing the national Good Governance for Medicines programme, an effort that incorporates a fully-integrated institutional learning process in the application of new administrative procedures for increased transparency/accountability and the development of leadership capabilities.

¹⁰⁶ WHO (2010), 'Good governance for medicines: curbing corruption in medicines regulation and supply'. Online: www.who.int/medicines/areas/policy/goodgovernance/ENCurbingCorruption4May2010.pdf.

¹⁰⁷ Ibid.



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Table 3. GGM Three-step approach¹⁰⁸

MoH clearance		
Phase I	Phase II	Phase III
National transparency assessment	Development of a national GGM programme	Implementation of national GGM programme
Assessment report	GGM framework officially adopted	GGM integrated in the MoH plan

3.5 Implementation of GGM Phase I and II in Malawi¹⁰⁹

Malawi was the first African country to start implementing the GGM programme. Two government officials were nominated as well as two assessors from the local Management Sciences for Health (MSH) office. They were trained on the transparency assessment methodology in March 2007, after which a national assessment was undertaken to assist in measuring the level of corruption in the pharmaceutical sector. This entailed an assessment of the level of transparency and potential vulnerability to corruption in a few key functions in the health sector—i.e., medicines registration, control of medicine promotion, inspection of establishments, selection of essential medicines, and procurement of medicines.

An assessment report and recommendations were prepared and adopted by a national workshop in July 2007. In May 2008, the Malawi MoH authorized WHO to publish the report; the report was formally launched in July 2009. The assessment showed that key functions of the pharmaceutical sector in Malawi are very vulnerable to corruption, mainly because of a number of lapses in the good governance for medicines mechanisms. The functions found most vulnerable to corruption in Malawi's pharmaceutical sector were drug promotion, followed by drug selection, procurement and registration¹¹⁰.

Assessing the level of transparency and potential vulnerability to corruption is not an end in itself but rather the beginning of a long process intended to generate good governance in the pharmaceutical sector. Following the adoption of the report at the highest levels of government, a national GGM team was nominated by the MoH, responsible for i) the development and finalization of the framework document in consultation with all key stakeholders and ii) the overall management, coordination and evaluation of the GGM programme. The report authorizes the GGM team to implement and promote good governance in the pharmaceutical sector. GGM training for Phases II and III was organized to kick-start implementation¹¹¹.

108 Ibid.

109 WHO Good Governance for Medicines programme progress report , February 2009. Online: <http://jmsc.asia/6047/wp-content/uploads/2009/11/s16218e1.pdf>.

110 WHO (2008), 'Measuring transparency to improve good governance in the public pharmaceutical sector in Malawi', p. vii.

111 See <http://infooperation.org/hss/documents/s16777e/s16777e.pdf>.



3.6 Achievements and lessons from the GGM programme in Malawi

The methodology used is key to ensure objectivity and accuracy of information. In Malawi, the national assessment was carried out by independent national assessors, using the standardized WHO assessment instrument. The national assessors collected information through a combination of desk research and semi-structured interviews with 57 key informants and then organized and analysed the data to generate the results presented in a report. This report showed that Malawi has a daunting task in combating corruption and bribery in the pharmaceutical sector. The study results indicate that generally the sector suffers from extreme vulnerability to corruption (i.e., a score of 3.36 on a 1.00 to 10.00 rating scale). Some key functional areas exhibit very low levels of transparency due to poor good governance mechanisms while other areas barely have any mechanisms for transparency and good governance¹¹².

- The assessment came up with key recommendations intended to provide guidance in the fight against corruption in the health sector in Malawi. These include¹¹³:
- The need for increased information-sharing within the pharmaceutical sector through training and motivation of those directly or indirectly involved with medicines.
- The government should provide standard operating procedures and guidelines on conflict of interest (COI) in written form (including procedures to be followed in the process of declaring COI and clear, simple forms to be completed by those involved).
- These prerequisites should be publicly available and easily accessible.
- The government should ensure the promotion of proper, publicly available and speedy public tendering procedures for medicines.
- The government should ensure that there is improved communication with all institutions involved in medicine registration, promotion, inspection, selection, procurement and distribution.

As a result of this transparency study, the Government of Malawi has a better idea of the vulnerability areas in the health system and may be able to identify effective strategies to stamp out corruption and provide better quality health services to the population. As part of the reforms, the government has begun to put in place mechanisms to ensure the availability and accessibility of essential drugs and strengthening institutional capacity for monitoring of drugs distribution and quality. Following the successful conclusion of the assessment stage, GGM training for Phases II and III was organized and is under way.

Lessons identified include the following¹¹⁴:

- The GGM assessment/process is not a one off but a long term intervention that requires commitment at all levels. In Malawi, the process between the assessment in 2007 and its adoption in 2009 was lengthy and it is important to acknowledge that some countries need

112 Ibid.

113 Ibid.

114 WHO Good Governance for Medicines programme progress report , February 2009. Online: <http://jmsc.asia/6047/wp-content/uploads/2009/11/s16218e1.pdf>.



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more time than others, depending on their political situation and the availability of human resources to carry out GGM activities.

- High-level commitment and political buy-in and ownership at the highest levels of government is crucial for the success of the programme. In Malawi, the health minister and president invited WHO to implement this programme and took interest to ensure a credible assessment was conducted. High-level commitment has proved to be beneficial, not only for raising the profile of such a sensitive programme, but also for ensuring its sustainability.
- Partnering with national anti-corruption or good governance bodies is extremely valuable, together with constant communication and discussion of issues and staff training. In Malawi, the teams undertook a series of trainings both in-country and elsewhere.



4. Tanzania Case Study: Strengthening Institutional Capacity of the Tanzanian Food and Drug Authority through the WHO-HAI Africa Regional Collaboration for Action on Essential Medicines

4.1 Overview of the pharmaceutical sector

The total medicine budget for the Tanzania public sector for the year 2000 was US\$14.1 million, but the annual amount had nearly tripled by 2008, to US\$44 million. The procurement, supply and distribution systems in the public sector are organized through the Medical Stores Department (MSD), which receives orders from regional, district and mission hospitals. Procurement is done



through a competitive tender system, and MSD procures at prices that are below international reference prices. Overall medicines availability in the public sector is around 70 percent. Major problems include poor transportation and infrastructure, which affect the distribution process. Local manufacturing of pharmaceuticals remains inadequate to meet national demand. About 70 percent of the country's needs for medicines are imported¹¹⁵.

The Tanzania Food and Drugs Authority (TFDA), established in 2003, regulates various aspects of pharmaceutical sector activities, food, cosmetics and medical devices. The Pharmacy Council, established in 2002, regulates pharmacists, pharmaceutical technicians and pharmaceutical assistants. The number of pharmaceutical personnel in both the private and public sectors is grossly inadequate. The overall enrolment capacity of the five existing training institutions is about 90 students for degree course, 40 for diploma and 20 for certificate.

4.2 Status of corruption in the health sector

The Tanzanian health sector is one of the areas that is prone to corruption and several years ago was ranked third¹¹⁶ in the list of sectors with the highest incidence of corruption. Corruption is often manifested at the lower level involving staff of public health facilities who receive bribes as a supplement to their meagre income. Individuals are often forced to pay small amounts of money in order to get services that they deserve to get free or with a little payment. Patients pay bribes in almost all hospital departments; the outpatient, laboratory, X-ray, labour ward and mortuary service areas are particularly notorious. The pharmacy and the general wards are also not free from corruption. In fact, there is no 'corruption free zone' as is often claimed¹¹⁷.

At the higher level, corruption in the health sector mainly involves the payment of big sums of money by rich individuals and institutions to some corrupt government officials in order to win tenders for the supply of pharmaceuticals, medical equipment and supplies. As a result of this unfair competition among bidders, the government does not receive supplies worth the money it pays¹¹⁸.

The key corruption risks and challenges in the Tanzanian health sector include¹¹⁹:

- Shortage in medicines and other medical supplies as a result of a small budget allocation.
- Surgical operations At some stage, hospitals were forced to do away with elective surgery and perform emergency operations only, and this makes room for corruption.
- Excessive red tape and long queues. Some of the processes and procedures that patients must go through are unnecessary. These procedures combined with shortages and inefficiency result in long queues that create an environment for soliciting and giving bribes.
- Poor salaries for health workers. At one point, the government decided to allow doctors working

115 WHO (2009), United Republic of Tanzania Country Pharmaceutical Profile and NPO.

116 The Presidential Commission of Inquiry against Corruption (Warioba Commission), December 1996.

117 Ibid.

118 As cited in a presentation by Mwaffisi, M.J., a permanent secretary in the MoH, during the 9th International Anti-Corruption Conference in 1999. Online: http://9iacc.org/papers/day4/ws7/dnld/d4ws7_mjmwaffisi.pdf.

119 Ibid.



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in the public sector to open private clinics and engage in private medical practice after their official hours of service in a bid to increase their income while retaining them in government service. However, this move has had some negative consequences:

- Doctors spend some official hours in their private clinics, leaving patients in public service facilities unattended.
- Doctors use public facilities and medical supplies to treat their private patients who often get priority service over others
- Doctors use public facilities as a conduit to channel clients to their private facilities.
- Doctors prescribe medicines that they know are not available in government facilities and advise patients to procure them in their facilities.
- There has been increasing incidences of theft of medicines and equipment from public health facilities. Due to these unwanted consequences, the government is now rethinking this policy decision.
- Poor management and supervision of health workers leaves them unchecked to do whatever they want to do. There is a general breakdown of moral ethics that is making professionals feel comfortable even while breaking their own code of ethics that gave them their credibility and identity.
- Lack of information regarding what services are provided, where and when they are provided, who provides them and procedures to be followed creates an environment for soliciting and paying a bribe.
- Weak institutional capacity for monitoring and enforcement.

4.3 Strengthening institutional capacity through the WHO HAI-Africa regional collaboration

The WHO HAI-Africa Regional Collaboration for Action on Essential Medicines in Africa 2002–2008 programme¹²⁰ was financed by DFID through a contribution of £6 million (US\$9.5 million). The programme has reached 15 countries: Cameroon, the Central African Republic, Chad, the Congo, the Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Mali, Nigeria, Rwanda, Senegal, Tanzania, Uganda and Zambia. In three countries (Ghana, Kenya and Uganda), an even closer collaboration with civil society has been implemented.

The programme uses a model of cross-sector partnership building to make progress in the five areas that are vital for securing safe and accessible medicines: implementation and monitoring of medicines policies; advocacy for fair financing and affordability; well-functioning medicine supply systems; safety regulations and quality assurance; and promoting rational use of medicines. In addition to supporting country policies and programmes, increasing the mutual engagement of government

120 WHO-HAI Africa Regional Collaboration for Action on Essential Medicines in Africa 2002-2008. Evaluation report to DFID, August 2009.



and civil society, the collaboration has also created a network of national professional officers (NPOs) who provide technical support and pharmaceutical expertise in each of the 15 countries¹²¹.

In Tanzania, focus has been on strengthening capacity for implementation and performance in the major agencies responsible for procurement and supply management (Medical Stores Department), and for product quality and safety (TFDA). Data collection and the evidence base for the sector have been strengthened: for the first time there have been methodologically sound assessments conducted of the pharmaceutical situation, of procurement systems, and of medicine availability and affordability. The programme has prioritized capacity-building and technical inputs to policy, regulation, procurement and supply management, pharmaceutical situation assessment and research to improve the evidence base for access (availability, affordability and price surveys)¹²².

Further, Tanzania is the only NPO country without specific funding for civil society collaboration to have started medicines price and availability monitoring activities with HAI-Africa, a project delivered by the pharmacy department at Muhimbili University and the faith-based sector's co-ordinating body and supported by HAI-Africa and WHO.

4.4 Tanzanian Food and Drug Authority (TFDA)

Tanzania's fight against corruption in the health sector has been aided by WHO's contribution to the successful reform of the regulatory bodies, with the separation of the Pharmacy Board into the Pharmacy Council and the Tanzanian Food and Drug Authority (TFDA) under the Tanzania Food, Drugs and Cosmetics Act of 2003. The regulatory agency, TFDA, demonstrates much improved performance and transparency, through for example its new quality management system and website. Medicines are now routinely tested at borders and importation sites, and facilities inspected for GMP (good manufacturing practice). Industry clients (e.g., represented by the Tanzanian Association of Pharmaceutical Industries) report improved services, in terms of both quality and efficiency, of the registration process¹²³.

WHO and others such as MSH through its SEAM programme have contributed to developing capacity within TFDA, which is now regarded as one of the strongest in the East African Community. Processes are supported with WHO's normative guidance on the regulatory function, training and technical assistance. Tanzanian inspectors are now participating in WHO Geneva's team, in the pre-qualification programme. Training has included effective drug registration (focus on bioequivalence), guidance on drug donations and safe disposal of medicines, quality assurance for drug inspectors. Quality assurance monitoring systems have been introduced for ARVs and anti-malarials and a new quality management system for product registration, clinical trials and procurement. Commercial clients report better satisfaction with the process, although some delays still occur¹²⁴.

121 See www.who.int/medicines/areas/coordination/who_hai_partnership/en/index.html.

122 WHO-HAI Africa Regional Collaboration for Action on Essential Medicines in Africa 2002-2008. Evaluation report to DFID, August 2009, p. 26.

123 Ibid., p. 37.

124 Ibid



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By setting up TFDA and strengthening its internal systems, Tanzania made a major effort to strengthen its regulatory capacity in pharmaceuticals. Local products as well as imports now must be registered. Registration is for five years, after which products must be re-registered¹²⁵. There is also increased transparency with all bid documents publicly displayed online. TFDA also keeps an updated list of all registered manufacturers which list is available online.

TFDA's strengthening of the registration system based on plant inspection has substantially improved the quality of privately marketed drugs¹²⁶. Some of the international traders who used to get products manufactured from abroad on contract basis have disappeared. Both local and foreign manufacturers have been forced to upgrade. Problems do persist, though, as TFDA's resources are limited and its standards are not as elaborate as in the United States and Europe.

There is also need to strengthen TFDA's capacity to monitor not just specification of standards, but whether the manufacturers are following procedures and abiding by safeguards intended to ensure the production of drugs which are safe and effective. Its enforcement capacity also remains uncertain.

Nevertheless, the structure and functions of TFDA make it a potentially effective body that is able to carry out its mandate and not simply exist as a paper tiger. This is manifested by the directives it publicizes in various press releases such as the one posted on its website on 17 January 2011 in which it announced it was temporarily suspending the manufacturing, importation, distribution, sale and use of certain substandard medicines¹²⁷.

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126 Ibid.

127 See www.tFDA.or.tz/.

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