



**KENYA ANTI - CORRUPTION
COMMISSION**

Sectoral Perspectives on Corruption in Kenya: The Case of the Public Health Care Delivery

Research & Policy Department
Directorate of Preventive Services

February 2010



On the Frontline against Corruption



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MISSION STATEMENT

OUR MANDATE

To combat corruption and economic crimes in Kenya through law enforcement, prevention and public education as stipulated in The Anti-Corruption and Economic Crimes Act, 2003

OUR VISION

To be a world class institution fostering zero tolerance to corruption in Kenya

OUR MISSION

To combat corruption and economic crimes in Kenya through law enforcement, prevention and public education

OUR CORE VALUES

Courage
Integrity
Teamwork
Professionalism
Fidelity to the law
Excellence in service

FOREWORD

Corruption undermines government efforts in realizing its vision of providing equitable and affordable health care to all Kenyans. It compromises the quality, effectiveness and equity of the health care system. More particularly, it drains the scarce financial resources available to the sector thereby leaving little to fund operations and maintenance, especially the procurement of essential supplies. For these reasons, it is imperative to combat corruption within public health facilities so as to increase efficiency and maximize the quality of health care provided.

The government has undertaken various initiatives that are indirectly aimed at addressing corruption in the health sector. Most of the anti-corruption efforts initiated by the government in this sector have been geared towards improving transparency and efficiency of revenue administration, procurement and financial transactions. To compliment the efforts of the government, the Kenya Anti-Corruption Commission has also implemented various corruption prevention programmes targeting this sector (as well as other sectors of the Kenyan economy).

The Commission has examined policies and operational practices in selected health care institutions and trained various health care personnel under the Public Service Integrity Programme (PSIP) besides investigating various reported cases of corruption in the sector. In order to ensure that these efforts and indeed all our corruption efforts are properly targeted, there was need to develop clear systems for assessing and analyzing the trends and practices of corruption and how they affect key sectors of the economy. This study therefore aimed at fulfilling this requirement.

The findings of various surveys on corruption by the Commission depict varying trends of corruption with the health sector. This called for a more critical and in-depth study of the public health care system in Kenya so as to understand the extent, nature and causes of corruption within the sub-sector. While fulfilling these requirements, this study also sought to assess policy, legal, institutional and operational frameworks of the health sub-sector and explored on how they impact on the state of corruption and governance. The findings of this study provide valuable information for combating corruption and enhancing efficiency within the health sub sector. I therefore call upon all the stakeholders in this sector and members of the public to read and utilise the information in preventing all forms of corruption within the sector.

Finally, I wish to express my gratitude and appreciation for all the members of the Public and Public officers who provided the information used in this study as well as Researchers who undertook this study.



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Kenya Anti-Corruption Commission

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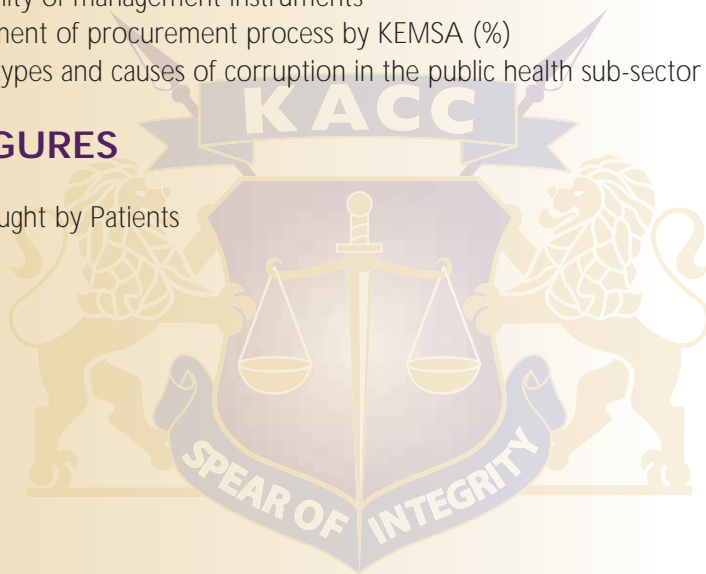


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ACRONYMS

AOP	-	Annual Operation Plan
CBH	-	Central Board of Health
CDF	-	Constituency Development Fund
DMOs	-	District Medical Officers
ERSWEC	-	Economic Recovery Strategy for Wealth and Employment Creation
FY	-	Financial Year
HMIS	-	Health Management Information Systems
ICT	-	Information and Communication Technology
KACC	-	Kenya Anti-Corruption Commission
KEMSA	-	Kenya Medical Supply Agency
KNH	-	Kenyatta National Hospital
LATF	-	Local Authority Transfer Fund
MDGs	-	Millennium Development Goals
MoH	-	Ministry of Health
MP&DB	-	Medical Practitioners & Dentists Board
MPH&S	-	Ministry of Public Health & Sanitation
MTP	-	Medium Term Plan
NACC	-	National Aids Control Council
NHSSPI	-	National Health Sector Strategic Plan I
NHSSPII	-	National Health Sector Strategic Plan II
PMOs	-	Provincial Medical Officers
PPB	-	Pharmacy and Poisons Board
PPPs	-	Public-Private Partnerships
TI	-	Transparency International

EXECUTIVE SUMMARY

The government of Kenya underscores the importance of affordable and equitable health care systems in realisation of the set social goals. Good health and nutrition boosts the human capacity and productivity thus enhancing economic growth and eradication of poverty. Consequently, the government continues to target the improvement of the healthcare system in its development agenda. The Economic Recovery Strategy for Wealth and Employment Creation 2003-7 (ERSWEC) and the Vision 2030 stipulates that the government's vision for health is to provide ***"equitable and affordable health care at the highest affordable standard"*** to her citizens. It is believed that good health plays an important role in boosting of the economic growth, poverty reduction and the realisation of other social goals. However, corruption poses serious challenge to the provision of health care. It compromises the quality, effectiveness and equity in service delivery while raising the cost of discharging the same besides reducing economic growth. Ineffective and inefficient health care systems that are deficient in transparency and accountability lend room to corrupt practices.

It is against this background that this study sought to assess the magnitude, nature and impact of corruption in the Kenya's public health care sector and the healthcare systems. The specific objectives were to:

- i. Identify the areas and processes that are vulnerable to corruption;
- ii. Establish the types of corrupt practices in the various processes in the health care system;
- iii. Identify the causes of corruption in the sector;
- iv. Determine the impact of corruption in the provision of healthcare; and
- v. Propose anti-corruption policies and strategies for the public health care sector.

The study involved desk research where relevant literature were collected and reviewed. In addition to reviewing relevant literature, quantitative and qualitative data were collected from targeted respondents and key informants within the health care sector.

Some of the findings of the study include:

- Performance monitoring is a major challenge for the sector. The survey was informed that the sector's strategic plan is not output based but, rather input based hence not result oriented with no periodic outputs. There are no targets and clear job descriptions for the health workers. The basic tools for monitoring the staff such as registers or clocking system are limited or not utilized. The situation is exacerbated by the weak disciplinary measures especially for personnel at the district level who error since there are no human resources functions at the district and provincial levels.
- It was noted that the procurement process is compromised. Centralization of procurement has led to inflation of prices of supplies, which is further compounded by conflicts of interest resulting from responsibilities of offices like the Chief Pharmacist and the Poisons and pharmacy Board (PPB) in the procurement process.

- While the policy on the standardization of biomedical equipment has been developed, it has not been fully implemented due to lack of resources, supervision and follow up. The policy on the standardization of fixtures and vehicles has not been developed. This is attributed to inadequate capacity and structural problems especially at the provincial level.
- None operationalization of the policies formulated was identified as a major challenge. This is attributed to the centralized structure of the ministry and also inadequate resources, both financial and human. It is further indicated that the development and policy generation process is too reliant on consultants, thus most solutions arrived at are not homegrown therefore lacking ownership thereby presenting challenges at implementation. Misinterpretation of policies at the provincial and district level is also a major weakness; this was attributed to the poor dissemination channels and supervision.
- Over 56 percent of patients indicated that they do not know the official gazetted fees to be paid while seeking medical services. Similarly, over 45 percent indicated that they do not know the kind of health services that are to be offered freely by the government.
- In the survey, over 62 percent of the patients indicated that doctors absconded from duty to attend to private matters.
- In the survey, 24.8 percent of the health providers cited procurement of sub-standard/poor quality drugs. Similarly, 34.2 percent cited manipulation of tender documents, 31.7 percent mentioned misappropriation of supplies, 11.8 percent cited hoarding of supplies while 6.8 percent cited unnecessary procurements that are paid for but not supplied. It is also important to mention that 8.4 percent cited direct bribery of facility heads by supply companies.
- Health officers indicated that public health facilities are only equipped with the minimum tools to implement supervision and control, but are ineffectively applied. When further questioned the primary causes for doctors' absenteeism, 46 percent identified *"ineffective supervisory and control measures"*; 33 percent blamed *"tolerance of these situations in the public health sector"*; only 12 percent indicated *"low pay"*.
- Management of public health systems, hospitals and dispensaries typically fall to trained physicians, with little or no training as managers to run health facilities as autonomous entities. The vague and poorly understood policies, uneven record-keeping and minimal use of such information contribute to poor management.

Key recommendations include:

i) Policy, legal and regulatory framework

- Policy development should encompass capacity development needs to ensure strong implementation and monitoring and evaluation framework.
- Various Acts of Parliament, Regulations, and Codes of conducts governing various practices and conduct of healthcare professionals should be examined, reviewed, harmonized and enforced to improve sector governance and to stem corrupt and unethical conduct.

- All institutions and statutory bodies connected with health care provision should be examined to identify loopholes for corruption and to initiate measures to strengthen the policies, systems and procedures of governance so as to prevent corruption, improve corporate governance and improve equity, access, affordability and quality of health care services.
- Introduced and enforce stringent human resources, financial and facilities management policies and regulations at all levels (national, provincial, districts, health centers and dispensaries) to enhance staff performance, increase efficiency of resource utilization and eliminate wastage and mis-management of health facilities.
- Put in place policies and systems for User Fees collection, appropriation and accounting to facilitate efficiency of administration of the fees and enhance transparency and accountability.
- Create a framework for greater community oversight and involvement in service management, procurement and distribution, and health care reform initiatives. This requires effective implementation of the programmes proposed under the MTP for Vision 2030. The challenges posed by the events and effects of the 2007 post election violence call for a redefinition and re-prioritisation of the scope and coverage of policy interventions.
- Enhance coordination of implementation of all healthcare programmes from government and donors to eliminate duplication, overlaps and wastage and to minimize over-commitment of the scarce human resource capacity on administrative and none aspects of service delivery.
- De-link the central government from health care provision and let it play the policy and regulatory role.
- Review and harmonize the legal framework to address the latest developments in the sector and set up a body to manage healthcare provision.

ii) Human resource issues

- Define clear, transparent and enforced rules and behaviour standards as well as implementing merit based promotion policies.
- Define and set clear performance standards and targets for all healthcare institutions and personnel including specifications of jobs for each cadre of staff.
- Enforce performance management policies and systems for all cadre of staff in headquarters and field offices.
- Ensure equity, fairness and merit in deployment, training and promotions of healthcare staff;
- Modernize and decentralize human resource records management systems to all levels of service provision to facilitate effective monitoring of staff complement and planning for recruitment, training, deployment, promotions etc.
- Deal decisively with persistent and prevalent staff absenteeism through strict enforcement of service regulations and codes of conduct and ethics.
- De-concentrate financial, procurement, administration and operational decision making and empower field managers with the right tools and instruments for operational decision making
- Develop and enforce policies and regulations on private practice to facilitate informed decision and choice between public service and private practice for health care professionals.
- Deliberate measures to decentralize the operations and structures at the Ministry should be undertaken, especially targeting Human resources, finance and procurement.
- Establish effective disciplinary mechanisms at the provincial and district levels.
- Review the remuneration arrangement.

iii) Planning and cost control measures

- Institutionalize regular monitoring and evaluation of healthcare policies and programmes to measure outcomes and impact of healthcare reform initiatives.
- Complement and enhance internal supervision with regular external audits, unannounced visits to health facilities and evaluation of services by clients and beneficiaries. External monitoring can be improved by providing channels for whistle blowing and legal support to citizens who feel they have been treated unfairly.
- The relevant ministry within the sector should coordinate and streamline the government and donor funded activities to ensure harmony of programmes.
- Raise awareness of patients of the cross referral policy so that they know of their rights through the service charter and other instruments.
- Liberalize the sector by accrediting more facilities to the ministry and also allow doctors to advertise and market their services.
- Innovative technology and management procedures at the facility level can also enhance efficiency and quality of service provision; reduce lead-times and opportunities of bribery to gain or speed up access to medical care.

iv) Procurement

- Enhance the human resources capacity to ensure quality and monitoring of the market in view of diversity and dynamism of the market and technology since generation of the various specifications is a major challenge.
- Develop and operationalise a clear policy on capitalization of KEMSA so that it can discharge its intended responsibilities.
- Enforce the policy on rehabilitation and disposal of premises, furniture and fittings within the ministry and the government at large.
- Establish a clear logistic and distribution information management system for distribution of essential drugs and supplies.
- Enforce the provisions of the Public Procurement and Disposal Act, 2005 on the proper disposals of stores to ensure that set procedure and criteria for declaring stores unsuitable by the designated authority is adhered to.
- Enforce procurement regulations on specialized procurement for medical and non-medical supplies so that the set specifications and quality standards are maintained.
- Review the role of the MOH and other institutions involved in procurement of medical and non-medical supplies with a view to providing KEMSA the mandate and authority to execute medical supplies procurements. This will minimize conflict of interest among various stakeholders.
- A clear procurement policy needs to be adopted on whether a push system or a pull system is appropriate. In view of the complicated nature of the commodities mainly used, the current processes of procurement should be reviewed to reduce wastage and enhance transparency and accountability among the stakeholders.
- Liberalize the commodity supply sector by accrediting more commodity suppliers such as the Catholic Medical Board (MEDs)¹ and allow them to compete with KEMSA. However, the accredited players should be adequately regulated. Therefore, this call for a clear and comprehensive framework.

¹ An agency by the Catholic Mission which distributes both pharmaceutical and non pharmaceutical commodities

v) Financial management

- The MoH should ensure that all financial resources are allocated on the basis of an approved budget. During budgeting, priority should be given to areas/items considered critical for the effective and efficient delivery of services to the public. No re-allocation of funds should be allowed except with the prior authorization of the Treasury. Budget variances (both positive and negative) in excess of 15 percent between the actual and budgeted expenditure should be investigated and appropriate action taken.
- The MoH should establish amount of funds necessary for effective supervision in the Districts/ Provinces and ensure that no more than the amount is allocated for the item. The practice of giving blanket allocation in percentages should be discontinued. All allocated funds should be fully and properly accounted for. Subsequent disbursements in this account should be withheld until all the previous allocations have been fully and properly accounted for.
- The MoH headquarters should conduct frequent audits and financial needs assessments for the individual health facilities, to ensure that requests made by the facility managers are justified. Defined standards of quality care within strict cost limits should also be set. The continuous internal audit systems should advise on internal control systems and risk management systems in all management processes.
- The MoH should conduct periodic reconciliations in order to match requests by individual facilities, projected requests and the services/items bought.
- The ministry should employ the services of a cost and management accountant to ascertain costs of various services in order to obtain realistic information for planning purposes.
- The MoH should review and harmonize the accounting process for various projects which use similar facilities and with similar project outputs to avoid duplication of resource inputs.
- There is need to strengthen the Treasury and the Ministry links so that activities and programmes are streamlined to enhance planning efficiency and funds utilization. Since the itemized budgetary allocation has proved inefficient, there is need to review the allocation procedure.
- Implement fiscal and administrative decentralization as envisaged in the decentralization policy to avert governance and corruption challenges, that previously, and could still prove an obstacle to the effective execution of this policy at the Ministry level.

vi) Corruption prevention measures

- Examine policies, systems and procedures of all institutions connected with healthcare provision to identify and seal corruption loopholes.
- Conduct public service integrity and assurance training for all health service providers.
- Sensitize the public on the dangers of corruption in the healthcare delivery systems and the rights to quality, affordable and accessible healthcare.
- Initiate sector-wide investigations into alleged corruption in procurement, distribution and use of medical and non-medical supplies.

1. BACKGROUND

1.1 Introduction

The global community recognize that health is central to the global agenda of reducing poverty as well as an important measure of human well-being. Better health contributes not only to broad economic development, but also to the achievement of the Millennium Development Goals (MDGs). Three of the eight MDGs – reducing child mortality; improving maternal health; and enhancing the fight against HIV/AIDS, malaria and other diseases – are health specific. In addition, good health makes an acknowledged contribution to the achievement of all the other goals, in particular those related to the eradication of extreme poverty and hunger, education, and gender equality. Most importantly, the health goals also focus on problems which disproportionately affect the poor. Building and strengthening health systems are therefore crucial to make progress towards the MDGs and other national goals.

Most developing countries, including Kenya recognize that good health is a prerequisite to socioeconomic development. Since independence the government of Kenya has designed and implemented policies aimed at promoting access to modern healthcare in an attempt to attain its long-term objective of health for all. In a number of policy documents, it has set forth that the provision of health services should meet the basic needs of the population, be geared to providing health services within easy reach of Kenyans and place emphasis upon preventive, promotive and rehabilitative services without ignoring curative services. As stated in the Economic Recovery Strategy for Wealth and Employment Creation (ERSWEC 2003-7) and Vision 2030, the government is determined to provide “equitable and affordable health care at the highest affordable standard” to her citizens. It is important to note that good health plays an important role in boosting the human capacity to be productive thus enhancing economic growth, eradication of poverty and the realisation of other social goals.

Unfortunately, provision of adequate healthcare in Sub-Saharan Africa (SSA) countries, and Kenya in particular, has been compromised by a number of factors including poor governance and corruption. Corruption affects all health systems, whether public or private, whether via embezzlement from health budgets or bribes extorted at the point of health service delivery, the effect is enormous and the burden falls disproportionately on the poor. Overall, corruption reduces the resources effectively available for health, lowers the quality, equity and effectiveness of health care services, decreases the volume and increases the cost of providing services. Moreover, it discourages people to use and pay for health services and ultimately has a corrosive impact on the population's level of health. The situation calls for the need to design appropriate prevention programmes targeted at the sector.

In recent years public sector allocations for financing health have significantly increased; however, corruption stands as a key impediment to the impact of well-intentioned spending on health. Without addressing this issue, the commitment to meet goals articulated in the Millennium Declaration as well as others embodied within indigenous policy instruments such as the ERSWEC and Vision 2030 are unlikely to be met. It is for this reason that the government should accord high priority to the issue because of the potential it has to compromise public investments in a highly constrained

environment. The purpose of this study is to determine the challenges facing the public health sector, but more important is the need to understand and prioritize corruption risks by corruption mapping and analyzing incentives and disincentives. The findings of the survey will guide the strengthening of anti-corruption measures.

1.2 Statement of the problem

The National Corruption Perception Survey (KACC 2005) found that most Kenyans experienced some form of corruption in the Ministry of Health. At least 41.3 percent of the respondents rated the Ministry of Health as the second most corrupt to the Ministry of Provincial Administration and Internal Affairs. The government hospitals were fourth most corrupt public institutions, 27.5 percent. A similar observation was made again in the 2006 Survey with a large number of the respondents 41.3 percent believing that the Ministry of Health is the second most corrupt ministry, further, 22.9 percent of the respondents ranked health facilities as the third most corrupt public institutions. Correspondingly, 27.5 percent of the respondents perceived government hospitals as the fourth most corrupt public institutions in the same survey. The 2007 survey results were no different, 27.5 percent of the respondents who were surveyed perceive the Ministry of Health as the second most corrupt Ministry with the Government hospitals being rated as the third most corrupt government department, 26.5 percent. In addition, the Global Corruption Report (TI 2006) that emphasised on corruption in the Health sector revealed that corruption leads to the haemorrhage of the health system, results to market distortions and counterfeit drugs, undermines the fight against disease in particular HIV/Aids and also threatens the achievement of the MDGs.

Examination of systems, policies and procedures at Kenyatta National Hospital (KNH) unearthed loopholes for corruption and corrupt practices and recommended measures to seal the loopholes and weaknesses in operational areas within KNH². Subsequent assessments and reviews conducted within the health sector³ also confirmed discrepancies in the procurement of pharmaceuticals and non pharmaceuticals and general malpractices in the operations of key institutions. Reports by other institutions highlight the same concerns. The 2005 Transparency International Report⁴ on corruption in Kenya's National Aids Control Council (NACC) revealed cases of gross office abuse.

Further, the Global Corruption Report (2006) cites Kenya's health care system as lacking accountability mechanisms resulting to abuse and misappropriation of the funds meant to alleviate disease. Some of the areas or processes identified in the report as vulnerable to corruption include: construction and rehabilitation of health facilities; purchase of equipment and supplies including drugs; distribution and use of drugs and supplies in service delivery; regulation of quality in products, services, facilities and professionals; medical research and provision of services by frontline health workers⁵. The money lost through these vulnerable areas is colossal. Addressing such vulnerability would lead to savings that can be directed to health care improvement and other poverty reducing programmes for Kenyans.

2 Examination Report, 2003: The Management of Kenyatta National Hospital; Anti-corruption Police Unit

3 Corruption Risk Assessment Report, 2005: Procurement and Distribution of Drugs and Other medical Supplies by the Ministry of Health and Kenya Medical Supplies Agency

4 This is a working paper on corruption and HIV/AIDS

5 Taryn Vian, Sectoral Perspectives on Corruption: Corruption and the Health Sector (2002)

It is indicated in the 2006 Global Corruption Report by Transparency International (TI) that more than US\$ 3.1 trillion is spent worldwide on health services annually with the bulk of these financing being provided by governments. Rapid increases in health care financing have also been witnessed in Kenya over the immediate past. The 2005 MDGs Status Report indicates that the government increased its overall funding for health care in the financial year (FY) 2005/006 by 30 percent, increasing the sector's share as a percentage of total government expenditure from 8.6 percent in FY2004/2005 to 9.9 percent in the FY 2005/2006. It is important to also note that within the Kenyan context, even programmes that are not directly related to the health sector have components targeting this sector. A recent survey by the government of Kenya on the use of Constituency Development Fund (CDF) for example indicated that over 60 percent of financial resources under this Fund are spent on health, water and education in a given constituency at any one time. The 2005 MDG Status Report further indicates that 20 percent of LATF funds were to be spent on core poverty programmes which are essentially MDGs - related programmes. It is however being argued that the rapid increases in funding to the sector has not been matched by rapid improvement in service delivery, a situation that has been blamed on corruption. The sector is still characterised by inadequate health care facilities and lack of appropriate drugs.

The aforementioned findings generated concern and provoked the need to undertake a more critical and in-depth study of the health care system in Kenya so as to understand the extent, nature and causes of corruption within the sub-sector. The findings also call for urgent implementation of comprehensive corruption intervention measures, which can only be arrived at after an in-depth assessment of existing anti-corruption initiatives within the public health care sector. Besides, the increased attention on corruption in the health care sector has elicited a number of questions that have aroused the concern of anti-corruption advocates including among others: which areas and processes are vulnerable to corruption? What types of corrupt practices are prevalent? What is the cause of the malfeasance in the sector? How effective are the existing strategies and interventions? And what new policy and strategic interventions are needed to combat the vice? This study sought to find answers to these concerns.

1.3 Objectives of the Study

The main objective of this study was to assess the magnitude, nature and impact of corruption in the Kenya's public health care sector and the healthcare systems. Specific objectives were to:

- i. Identify the areas and processes that are vulnerable to corruption;
- ii. Establish the types of corrupt practices in the various processes in the health care system;
- iii. Identify the causes of corruption in the sector;
- iv. Determine the impact of corruption in the provision of healthcare; and
- v. Propose anti-corruption policies and strategies for the public health care sector.

1.4 Scope of the Study

The study assessed the policy, legal, institutional and operational environment of the health sub-sector and explored on how this environment impacts on the state of corruption and governance. Areas of special focus included corruption in procurement of drugs and equipment, corruption affecting provider-patient interaction, and financing within the public health sector. Furthermore, the study attempted to establish the extent to which the anti-corruption strategies being used in the

health sector relate to national anti-corruption strategies. To a larger extent the study also sought to identify areas or issues requiring action of the policy makers.

1.5 Methodology

1.5.1 Research Design

The study involved desk research where relevant and related literature was reviewed. In addition, quantitative and qualitative data was collected from targeted respondents and key informants within the health care sector. The findings of the study discussed herein are thus a product of three related approaches:

- i. Review of policy and related documents to establish the channels, types, causes of corruption and the policies and regulation governing the sector and affiliate sectors;
- ii. Review and analysis of information from three diagnostic surveys by KACC and Examination and Assessments reports on KEMSA, Kenyatta National Hospital and Moi Teaching and Referral Hospital (MTRH); and
- iii. Analysis of information collected through interviews with consumers, providers, key informants and other stakeholders within the public healthcare sector.

1.5.2 Targeted Respondents and Sample Size

During the survey, 240 facility managers, 791 health care staff and 2,567 exit-patients were interviewed. Discussions were also held with key informants for in-depth understanding of health care issues. Table 1 below provides the broad areas from where the respondents and key informants were drawn, nature of information that was sought and the methods that were used in collecting this information.

Table 1: Targeted Respondents

Respondents	Type of information sought	Method of data collection
<ol style="list-style-type: none"> 1. Government Hospitals (<i>Referral institutions, provincial and district hospitals, health centers & dispensaries</i>) 2. End-users of public health harmonization of rules, care services 3. Ministry of Health Officials 	<ol style="list-style-type: none"> 1. Quantitative and qualitative data on types, causes, impact and areas prone to corruption 2. Status of reforms on regulations and policies in the health care industry 3. Aspects of the training to aspiring medical personnel 	<ol style="list-style-type: none"> 1. Semi-structured questionnaire through face to face interview 2. Review of statutes, policies, regulations & other documents

1.5.3 Research Instruments, Analysis and Reporting

This study relied on information generated through interviews with various stakeholders, key informants and consumers of the health services. A semi-structured questionnaire and discussion guide were developed and used to gather relevant information from the targeted respondents. These tools were pre-tested to ensure consistency, language appropriateness, flow and sequencing of questions, length of interview, and clarity of questions, ethical considerations and general appropriateness. All the information gathered from the interviews was analyzed and used together with information obtained by reviewing relevant documents to prepare this report.

1.6 Organization of the Report

The report has four sections. The first section is the background of the study and also describes the methodology used in the study. Section two discusses the policy, legal and institutional framework, covering the national health policy and the health sub sector policy framework within the tenets of corruption and governance. Section three addresses corruption in the healthcare delivery and management. It discusses areas, processes and activities prone to corruption within the sector. It further addresses the causes and impact of corruption as evidenced by the respondents.



2. POLICY, LEGAL AND INSTITUTIONAL FRAMEWORK

2.1 Introduction

This section details policy, legal and institutional framework supporting healthcare provision in Kenya. Reform measures and strategies being implemented to realise specific targets are also presented and assessed so as to identify particular weaknesses which if addressed could help in preventing corruption and realising the national vision of providing adequate and affordable health care to all Kenyans by 2030.

2.2 The Policy framework for Health Care Provision

The government's intention to enhance healthcare delivery is well stated in various national and sectoral policy documents, past and present, underscoring the importance of adequate health care systems and their contribution to the quality of life, productivity of the workforce and economic and social development of the country (Vision 2030; MTP 2008-2012; ERSWEC, 2003-2007). Specifically, the Kenya Health Policy Framework (KHPF) formulated in 1994 has been the sector's development blue print implemented through health sector Strategic Plans (the National Health Sector Strategic Plan I (NHSSPI) 1999-2004; and the NHSSPII 2005-2010).

Despite the effort to promulgate these policy and strategic frameworks, it is argued that implementation remains weak and there are no clear and comprehensive monitoring and evaluation systems to facilitate tracking and assessment of the efficacy of the strategic objectives and policies (PETS, 2007). Furthermore, the KHPF is found to be more clinically focused, dwelling more on disease and not adequately addressing the myriad challenges facing healthcare delivery in Kenya. Inadequate implementation and a lack of proper monitoring and evaluation and governance framework of the health sector have greatly hampered service delivery and encouraged corruption to thrive in the sector.

However, it is notable that Kenya made significant gains in healthcare provision immediately after independence progressively up to early 1990s, attributable mainly to heavy government financing and effective supervision of the sector. Thereafter there was observed progressive deterioration of health of Kenyans due to poor governance of institutions mandated to coordinate and provide services coupled with the maturing problems related to the introduction of structural adjustments programmes (SAPs) in the 1980s that introduced cost sharing in the provision of essential services including health.

The thrust of policy interventions thereafter shifted to the need to enhance equity, access, affordability and quality in the provision of basic health services, particularly for the poor. In policy implementation, the government progressively increased budgetary allocation in the health sector. This, however, did not translate into improved access, affordability and quality in the provision of basic health services. In fact, the general health of Kenyans continued to deteriorate. This is attributable to the fact that the policy interventions were not clear and did not lay emphasis on improving governance in the sector, and in cases where such interventions exist, they were not implemented. Weak systems, policies and procedures of governance of health sector institutions have created and nurtured loopholes for corruption to thrive in the sector.

The Vision 2030 and its first Medium Term Plan (MTP2008-2012) now outline reforms measures that seek to infuse efficiency, effectiveness, transparency and accountability in the management of the sector. These include restructuring of healthcare delivery system, enhancing the regulatory regime, creation of an enabling environment to ensure increased private sector participation, greater community involvement in service management, procurement and distribution of drugs reform, restructuring of KEMSA and introduction of devolution in the allocation of funds and responsibility for the delivery of health care to district hospitals, and clinics.

In addition, these reforms will be accompanied by improved capacity for health care delivery through introduction of qualified health facility managers, separation of the regulatory function from the health service delivery; and development of a Public Private Partnerships (PPPs). There will also be financial management reforms aimed at creating fiscal space through efficient use of resources. The delivery of the health service is to be enhanced by de-linking the Ministry of Health from service delivery and focus on regulation and supervision. The overall goal is to improve governance and decentralise health management so as to enhance equity, access, quality and affordability of healthcare services.

In spite of the far reaching reform intentions in the medium to long term, measures to track progress in implementation and evaluation of results are still not adequately addressed. Besides, the effects of 2007 post election violence revealed deep seated problems related to among others equity of service delivery and the capacity of the healthcare system to cope with similar if not greater problems. These challenges call for a redefinition and re-prioritisation of the scope and coverage of policy interventions. Furthermore, no specific interventions are provided for dealing with weakness in policy implementation and monitoring.

2.3 Institutional framework for Healthcare Delivery

The government has put in place an elaborate institutional framework for health care provision from the national level to the grassroots. In addition, there are statutory institutions with the mandate to regulate specific aspects of healthcare provision. This is to ensure that there is an enabling environment for efficient, sufficient and equitable healthcare provision. The government is also involved in the direct provision of health care.

The overall government agency responsible for policy, overall regulation and service provision in the healthcare delivery system in Kenya is the Ministry of Health (MoH). Among other functions, the MoH is mandated to formulate and implement the national health policy and to review health related Acts and regulations. Challenges remain whether the ministry has adequate capacity to implement this mandate since serious governance and efficiency challenges have been noted.

It is noted that there is lack of proper enforcement of the rules and regulations governing the conduct of medical personnel directly working under the ministry and those in auxiliary institutions. This has translated in poor services such procurement and distribution of expired medical and non-medical supplies, inadequate attention to service seekers, high cost associated with informal charges and extortion among others. There are no effective monitoring and evaluation systems for healthcare programmes being implemented.

Other statutory bodies that exercise oversight and regulations in the sector include Medical

Practitioners and Dentists Board (MP&DB), Central Board of Health (CBH), Nursing Council of Kenya Clinical Officers Council and the Pharmacy and Poisons Board. In addition, non governmental organizations and the community play key roles in the regulatory and healthcare provision. In the recent past, there have been reports of gross misconduct of healthcare professionals especially in public medical facilities, thus revealing seriously inadequacies or negligence on the part of institutions enforcing codes of ethics and laws governing various professional groups.

The responsible institutions have not offered comprehensive and robust solutions to the issues affecting governance of the sector. Where some measures have been spelt out, no serious implementation and follow-up mechanism have been made. As revealed in PETS (2007), there is a problem with tracking and analysis of flow of commodities and funds since there is no firm position or agreement on tracer drugs and supplies or proper information system capturing real time data on the actual flow of funds (disbursements or expenditures). This hampers effective decision making on the efficiency and effectiveness of the use of commodities and funds while providing serious corruption loophole besides abating poor governance of the sector.

2.4 Specific issues affecting Sector Governance and Service Delivery

The study established that there are issues related to the policy and institutional framework that significantly affect governance and management of the health sector leading to corruption and poor service delivery to Kenyans. The issues touch on human resource management, health infrastructure development and management, decentralization, financial management and other issues.

2.4.1 Human Resource, Planning and Cost Control measures

The focus of improved healthcare service delivery is the need to increase the cost effectiveness and efficiency of resource allocation and use. This entails attracting and retaining qualified personnel with the right skills and attitudes towards work. The KHPF outlines the need to establish staffing norms that define an appropriate mix of personnel, operations and maintenance inputs at all levels in order to obtain optimal performance and efficiency. It also emphasizes the need to control and contain the unit costs of service delivery through sound management practice, including the contracting of some services to the private or mission sector where those providers are known to be most cost effective.

This study sought to establish the measures that the ministry had put in place to improve staffing norms required to enhance efficiency, quality control and waste reduction healthcare delivery to Kenyans.

a) Personnel management & planning

The focus of KHPF was to ensure that all health professionals underwent reorientation, retraining and redeployment so as to meet the manpower demand and resource availability, particularly at the central level - MoH headquarters. Despite the deliberate efforts to enhance capacity of health professionals, a number of challenges were identified, that require attention. The key issues that stood out during this study included:

- ***Absenteeism of personnel from duty:*** Medical personnel were absent from their workstations either attending workshops or seminars which are donor funded or government-run. The too

many workshops and the poor coordination of government and donor funded programmes which run these workshops and seminars further compounded the problem by ensuring the core personnel were persistently absent. Other senior personnel were either attending to planning or management meetings. This hampers service delivery as non core staffs were often found in the health facilities. It is necessary to enhance coordination of all programmes and monitor staff absence with a view to ensuring that service provision is not affected.

- **Inadequate qualified personnel:** Both patients and health providers (medical personnel) indicated that health facilities experience shortage of staff and lack of qualified personnel.
- **Procrastination:** Patients indicated lateness and laxity by the medical personnel in attending to them. This results to long queues and overcrowding.
- **Poor systems for performance management:** Productivity monitoring is a major challenge for the sector. This is due to the fact that there poor performance management systems. The sector's strategic plan is not result based and lacks clear performance targets and accountability framework. Consequently, health workers are of the view that there are no performance targets and clear job descriptions. The basic tools for monitoring staff such as registers or clocking system are limited. The situation is exacerbated by the weak disciplinary measures especially for personnel at the district level who error since there are no human resources functions at the district and provincial levels. It is acknowledged within the sector that the provincial and district advisory committees or the disciplinary agents are weak and therefore lack capacity to address disciplinary issue.
- **Multiple codes of conduct for health personnel:** There are numerous Code of Conduct and Ethics, coupled with numerous Acts for the various professionals within the sector. This causes confusion and challenges in the implementation. There is need to streamline and harmonize the Codes.
- **Terms and conditions of employment for some health personnel:** The contractual engagement of the nurses and other medical personnel under NASCOP was also perceived as ambiguous. According to Health Providers, this could result in negative financial and human resources implications. These personnel are not captured in the Ministry's personnel records. Therefore, it is difficult to ascertain their exact numbers, cost implication and their performance levels. The manner in which they are engaged and retained in the service is not consistent with established employment regulations in the public service and thus compromise transparency and accountability. Moreover, the expense of hiring of additional staff accounts for 39 percent of revenues at the health centre level and 51 percent at the dispensary level, and thus presenting serious implications for human resources strategy (PETS, 2007). This human resource management strategy could lend room to corruption in implementation of human resource policies and plans in the ministry at large.

b) National manpower and training policy

The policy focuses on issues of priority in resource deployment particularly personnel and supplies, District Health Management Teams, redeployment, and basic education of health professionals. According to key informants, linkage between the human resources department and planning to the health priority needs is lacking at the Ministry. The policy is not clear on the criteria for consideration for training, and, there is no documentation to support the policy leading to compromised training considerations. Medical personnel interviewed suggested the need to increase staff, provide more training and improve the staff welfare as being key to improving performance and quality of service.

Training in governance has not been a priority, though it has finally been earmarked in the current Annual Operation Plan (AOP) 4 covering the financial year 2008/09.

c) Procurement and supply of pharmaceutical and non pharmaceutical commodities

The protracted procurement process, which sometimes stretch to unusually long periods results in expiry and the short life span for some of the drugs supplied. Moreover, the distribution system is weak with no clear distribution policy. It was established that procurement and delivery delays result to short life and eventual expiry of the supplies. Inadequate logistical support and resources is also responsible for challenges experienced in the distribution and transport of the supplies. As reported by health personnel, the procurement process is marred with corrupt practices such as manipulation of tendering systems; misappropriation of supplies; procurement of sub-standard/poor quality of supplies; hoarding of supplies and inflation of prices. Respondents attributed these practices to the following factors:

- **Centralization of procurement**, leading to lack of transparency in the process and inflation of prices of supplies.
- **Conflicts of interest**, resulting from responsibilities of offices like the Chief Pharmacist and the Poisons and Pharmacy Board (PPB) in the procurement process.
- **A push system of procurement**: Medical personnel interviewed indicated that the “push system” does not take cognizance of the disease patterns in the region therefore resulting to facilities receiving drugs that do not address the disease problems⁶. The respondent further indicated that there is limited research on the disease patterns for the various regions. Another reason cited for the shortage of drugs was the fact that KEMSA does not cater for all diseases or supply to the particular facilities. The need to introduce a system that addresses the demands and unique requirements of regions was found to be necessary.
- **Procurement of drugs with short expiry**: Some of the drugs naturally have a short life span thereby requiring an efficient procurement and distribution process. The medical personnel attribute the problem drugs with short expiry to the bureaucratic procurement procedures; delayed distribution of supplies by KEMSA; the push system that results to supply of drugs with low demand and irregular/corrupt procurement practices. To avert wastage, the health facilities redistribute the supplies to other facilities in need of the same or return to KEMSA or lodge complaints.
- **Failure to agree on tracer drugs and supplies**: Further examination indicated the failure to agree on tracer drugs and supplies. This significantly hampers the analysis of flow of commodities, while the absence of any information on actual flows of funds (disbursements or expenditures) precluded the drawing of any conclusions on actual rather than paper leakages and shortfalls. Other studies (PETS, 2007) also established that about 25 percent of health facilities experience stock outs of key drugs, kits and other commodities; stock outs of key medical supplies and contraceptives and stock outs of non-pharmaceutical items therefore prompting the facilities to engage in direct purchase of the out of stock items. The duration for these stock outs averaged one month to six months. This could have far reaching implications on service delivery, procurement and supplies process in the ministry thus impacting on governance and corruption in the sector.

⁶ There is limited research on the disease patterns for the various regions. KEMSA which was supposed to alleviate this problem lacks both technical and financial capacity, and therefore has failed in addressing this challenge.

- **Poor Human Resource Management practices:** Causes of corruption in the procurement process, as identified by the health personnel surveyed, are as a result of low salaries; greed; lack of strict supervision of staff; and poor/lack of systems of accountability and lack of political will to fight corruption. Major problems faced when procuring drugs from KEMSA were mentioned as: delays in delivery; inadequate supplies of required drugs; drugs not specific to the disease patterns of the region; poor quality of drugs and supply of drugs with short expiry periods or expired drugs. In terms of manpower, the health facilities are incapacitated and the pharmacists double up as stock managers and controllers in most facilities. The department of pharmacy lacks the necessary capacity in terms of human resources (with the technical know how) and infrastructure (storage capacity) to ensure efficient operations.

The MoH and the KEMSA should facilitate reforms so as to make the process more efficient and transparent. The noble notion of the economies of scale does not hold in this case. The Ministry is aware of the need to change the disbursement process of supplies from the “push system” of drugs, where medical supply kits are distributed to the health facilities regardless of the disease patterns and area population size. It was established that the “pull system” which is demand and resource driven and which seeks to enhance KEMSA’s compliance with the provisions of the Public Procurement and Disposal Act, had been piloted in the Coast and Eastern Region with Donor support. This system provides for demand-driven and region specific annual procurement plan showing requirements from the health institutions. It also reduces incidences of drugs expiring in the stores. However, the idea became a cropper when the pilot programme in the Coast and Eastern provinces experienced governance challenges prompting the donors to withdraw. It was also not implemented within the budget framework so that the procurement plans are consistent with budgetary provisions. Currently, the “push system” is still in use.

d) Management of non-core functions and resource allocation

Health care provision depends on efficiently combining financial resources, human resources, supplies, and delivering services in a timely fashion distributed spatially throughout the country. The survey established that allocation of resource, both financial and human, is not need-based. Moreover, there is no defined criterion for resource allocation though the Ministry was expected to have institutionalized management tools for cost containment and cost control for health facilities. Related to this policy objective, Coast General Hospital has been the only health facility that has attempted at some point to concentrate on core functions and outsource the non-core functions such as laundry and catering. Unfortunately, this initiative failed due to vested interests from the stakeholders.

e) Policy on establishment of new health facilities and upgrades

Previously, establishment of new health facilities and upgrades has been subjective and haphazard. However, a policy document, the Norms and Standards, has been formulated to address this discrepancy. The document refers to the minimum and appropriate mix of human resources and infrastructure that is required to serve the expected population at different levels of the health care system. While the document provides a clear criterion, implementation is poor due to capacity and resource constraints.

The survey further established that the Ministry does not have a policy on rehabilitation of facilities, equipment and other fixtures. Moreover, there is no policy direction on priority areas and guidelines to be followed and adhered to. Currently, rehabilitation is ad hoc and the problem is grave at the central level of management. It was suggested that the issue be addressed at government level.

f) Policy on standardization of biomedical equipment, fixtures and vehicles

While the policy on the standardization of biomedical equipment has been developed, it has not been fully implemented due to lack of resources, supervision and follow-up; the policy on the standardization of fixtures and vehicles has not been developed. This is attributed to inadequate capacity and structural problems especially at the provincial level. Another factor cited for the failure to formulate and implement the policy are incentives associated with the procurement process. It was also noted that the Ministry lacks the capacity to do market surveillance in order to ensure quality of commodities in view of the diversity and dynamism of the market. Hence, the Ministry experiences challenges in the formulation of specifications for some of these equipment, fixtures and vehicles. This can lead to manipulation in favor of certain suppliers.

g) The Cross Referral Policy

The policy was meant to provide guidelines for referrals between the government and private providers. This policy has not been implemented despite having been identified in the health sector policy framework. As such, there is a likelihood of unnecessary referrals to privately run clinics and pharmacies by the medical personnel with vested interests. Moreover, fee policies between the providers are inconsistent. When asked to state the kind of malpractices experienced, patients indicated unnecessary referrals of patients to private facilities as major malpractice.

h) Part Time Private Practice (PTPP) Policy

The Medical Practitioners and Dentists Board (MPDB) is mandated to regulate medical and dental practice so as to achieve the highest standards of quality health care for all. The Board ensures the provision of high quality health care that is safe and ethical, placing high premium on quality of human life through appropriate regulation of training, professional practice and services. The PTPP policy addresses the issue of public health care officials' engagement in both public and private practice. However, the survey established that there is no criterion for determining abuse of the policy. A number of respondents felt that the policy should be scraped since it is based on a weak operational framework thus presenting challenges in governance. This policy has not been addressed by the Medical Practitioners and Dentists Act.

i) Health systems performance

Intervention measures and capacity for the management teams entrusted with quality control and assurance in the sector is not well-defined. Establishment of Boards at the hospitals, at the district and provincial level was noble as they will oversee the running of the facilities and represent the community to ensure transparency and accountability in order to improve services. The survey established that the management teams are not conversant with their functions and their terms of reference. Moreover, there are no clear performance benchmarks for monitoring and evaluation. It has thus not been possible to carry out performance evaluations due to lack of capacity. In this case, the management teams end up being mere rubber stamps in the decision making process.

The health care personnel stated that they expect the supervising authority to carry out physical observation of work, check records, carry out performance appraisals, assess operational/work plan and carry out quality standard checks.

2.4.2 Decentralization Policy

The KHPF established that the local health planning has no reference to a realistic resource framework, and that plans are rarely taken into consideration in national planning and budgeting, with the headquarters not always providing any feedback to districts on their submissions. Hence, it stated that there is limited correlation between plans and available funds and actual implementations thus a decentralization policy was established.

The survey confirmed that the decentralization policy is in place but has not been fully implemented. The objectives of decentralization are to improve management, efficiency, accountability, and responsiveness of healthcare services, and control of modern healthcare. Kenya has decentralized her health care system through restructuring and strengthening of the Ministry's district level management capacity; creation of District Health Management Teams (DHMT) and District Health Management Boards (DHMB) to represent community interest in health planning and coordinate and monitor the implementation of healthcare projects at the district level; and granting of autonomy to KNH. According to Obonyo and Owino (1997) decentralization in Kenya has helped reduce the users' cost of travel to the health care facilities, provided more time for policy analysis and formulation, and increased their performance in financial respect.

Regarding decentralization of commodity procurement and management, it was established that KEMSA is not fully independent since the budget/vote is still domiciled within the MoH Headquarters. Respondents indicated that the structure is highly centralized and no effort is being made to decentralize the structure. Vouchers have to be approved and signed by officers at the Ministry Headquarters. But, some attempt has been made on the fiscal decentralization, but without corresponding administrative decentralization thus posing governance challenges. The cost-sharing funds have raised accountability, transparency concerns and created loopholes for corruption. As illustrated in table 2 below, there is a significant gap between the original amount as budgeted in the printed estimates and the District Allocation Budget (DAB), and the intended devolution as per the AIE. The reason for this shortfall is not known, but is contrary to the stated policy priority of improving funding to this critical level (PETS 2007).

Table 2: AIEs for DMOHs under R11 113 335, FY2005/06 (Ksh)

a DMOH (Account holder)	b Original printed estimates		c Imputed quarterly devolved allocation	e Actual quarterly devolved allocations as per AIEs				h Funding actually devolved to DMOH	j AIE as % Original devolved estimates
	Total	Devolved		Q1	Q2	Q3	Q4		
Kiambu	27,697,354	3,476,939	869,235	354,721	554,721	554,721	554,721	2,018,884	58%
Kwale	26,024,996	3,259,922	814,981	554,556	554,556		554,556	1,663,668	51%
Meru C	22,695,560	2,849,070	712,268	509,840	509,840	509,840		1,529,520	54%
Garissa	23,186,401	2,521,625	630,406	521,329	521,329	521,329	521,329	2,085,316	83%
Kisii C	27,127,864	3,405,471	851,368	538,423	538,423	538,423	538,423	2,153,692	63%
Kajiado	25,177,303	3,160,613	790,153					-	0%
Koibatek	12,597,203	1,581,382	395,346	250,832	250,832	250,832	250,832	1,003,328	63%
Bungoma	43,418,967	5,450,865	1,362,716	976,223	976,223		976,223	2,928,669	54%
Total	207,925,648	25,705,887	6,426,472					13,383,077	

Source: PETS (2007)

The *dialogue policy*, though having been mentioned in the KHPF of 1994, has not been formulated but its being implemented through a deliberate consultative process adopted by the Ministry.

2.4.3 Financial Management

a) Budgeting

The policy framework indicated that to improve financial planning and budgeting, it was necessary to implement financial and accounting systems to provide data needed to generate meaningful financial management and cost control information. It further proposed the setting of limits on local expenditures so as to encourage more effective management, which should seek to maintain defined standards of quality of care within strict cost limits.

The survey however, established that financial resource allocation is not linked to the planning/budgeting process. Consequently funds are not necessarily allocated in order of the priorities set out in the budget. This could lead to under-funding of critical activities, while over-funding less important ones. Key informant information noted that funds from different sources, channeled towards the same cost/expenditure items are not banked and accounted for separately. This mix up of funds inhibits transparency and accountability, and can create opportunities for misuse, misallocation or misappropriation. A review of the PETS (2007) indicates that the DMOH and the hospital respondents could not in many cases provide values of commodities provided by, and/or buildings constructed with funding from Constituency Development Funds (CDF), Local Authorities Transfer Funds (LATF) and development partners. Respondents were not able to clearly identify a breakdown of operations and management spending on behalf of specific facilities within their jurisdiction.

b) Cost-sharing

The cost-sharing programme was mooted in the 1984/88 Development Plan and implemented in 1989 to supplement and complement government resources allocated to the public health sector within the framework of the Structural Adjustment Programme (SAPs). The main objective of the

policy was to encourage increased cost recovery from users of public health facilities, to generate additional revenue, and augment the financing of the under-funded non-wage recurrent expenditure items, reduce excessive use of services, improve the functioning of the referral system, and improve access by the poor to health services (Collins et al. 1996). The rationale was to charge those who make most use of the curative care and those who are most able to pay and channel the subsidies to those least able to pay (Owino & Were 1997).

Even though the cost-sharing programme has had some positive impact on the health sector, it still experiences numerous problems. As shown in Table 3, the programme's contribution to healthcare financing has been on the decline; meanwhile the collections as a proportion of set targets of the MoH total and recurrent budget have gradually declined since 1993. The poor performance of the programme can be attributed to several factors – institutional and implementation weakness, vested interests, reluctance by the center to cede financial control to the districts or facilities, and the ineffectiveness of district treasurers in overseeing the maintenance of correct accounting procedures (Owino & Munga 1997).

Table 3: Cost sharing programme: facility performance and contributions to the health care financing

General performance	Facilities in the decentralized zones ⁷	Facilities in the centralized zones		
Collections (% of target)	42%	38%		
Reporting on collections	30% - 71%	0% - 12%		
Reporting on banking reconciliation – July 1996 – June 1997	0% - 45%	7% - 39%		
Collections from the cost-sharing programme	1993/94	1994/95	1995/96	1996/97
As % of target	31.4%	26.1%	18.1%	32%
As % of MoH recurrent expenditure	2.49% (5.29%)	2.61% (5.59%)	2.58% (5.58%)	2.48% (5.65%)
As % MoH budget	1.75% (3.71%)	2.19% (4.7%)	2.1% (4.55%)	1.48% (3.39%)

Note: The figures in parenthesis include contributions from Kenyatta National Hospital.

Source: IEA 2001.

As a principle, revenue-collecting institutions are allowed to use 75 percent of the revenue they collect to improve health services in their respective institutions while the balance, 25 percent is to be used in financing promotive and preventive services in the district (MoH 1994). The PMOs and the DMOs are allowed to spend up to 5 percent of revenue collected from income generating/cost sharing activities on supervision, in addition to the allocations that are normally received from the exchequer for the same purpose. For some facilities, this translates into millions of shillings, which is

⁷ The cost-sharing programme has only been decentralized in Western, Coast and Eastern provinces. The other provinces remain fully under the control of the Health Care Financing Division of the MoH.

always fully spent. So far the Ministry has not managed to carry out audits and needs assessments for individual health facilities to compare with projections and requests from the facility managers. This leads to arbitrary requests that could lead to wastage of funds. It is thus not possible at the moment to state with certainty the cost of running any particular health facility due to lack of proper cost and management accounting systems. According to health facility administrators, the key challenges experienced include inadequate or non-allocation of funds from the Ministry; inadequate generation of funds from cost sharing, loss of revenue due to waivers, low user fee and delays in disbursement of funds.

According to PETS (2007), the DMOH retains responsibility for all rural health facilities. However, there is no clear distinction in the budget to separate administrative, supervisory and management costs of the DHMT from the service delivery and operational costs of the actual health facilities. The lack of a clear distinction makes it very difficult to both identify and monitor the extent to which funds flow and/or actual spending on behalf of the rural health facilities. Furthermore, the report indicates that not all funding from development partners is captured in the Development Budget. It is thus difficult to indicate whether such funding is available to MoH agencies or spent on their behalf. In addition, the reporting of off-budget development partner spending, that could be cash or in kind, is variable in completeness and quality both at central and local levels.

It is imperative for the Ministry to establish the items, quantity and cost necessary to render efficient services in these facilities. Currently operations are input-based supported by arbitrary financing estimates. To mitigate some of the challenges and problems experienced, the health care providers suggested the involvement of the heads of departments in the formulation of budgets, conduct needs assessment in the facilities to establish gaps, the allocation of adequate funds directly to health facilities and the reduction of bureaucracy in the utilization of cost sharing funds.

2.4.4 Other Weaknesses

a) Policy and operational framework

Non-operationalization of the policies formulated was identified as a major challenge. This could be attributed to the centralized structure of the ministry and inadequate resources, both financial and human. The over-reliance on consultants in the policy development process produces solutions that lack ownership because they are regarded as not homegrown, thereby presenting challenges at implementation. Misinterpretation of policies at the provincial and district level is also a major weakness that was attributed to the poor dissemination channels and supervision.

b) Regulatory and legal framework

The dual role of the government in service provision and regulation was perceived as presenting conflicting roles and interests. The numerous Acts within the sector are not in harmony yet sometimes they basically address similar issues. It was indicated that various government agencies within the sector lack the capacity to discharge their mandates. They lack the competences and financial resources to operate optimally. There is need to amend the Acts so as to recognize the two ministries and spell out the responsibilities of each ministry.

The health sector has expanded rapidly since independence. However, due to a myriad of constraints and challenges, the government has not been able to adequately cater for the increased demand for healthcare. Inequities and inefficiencies have bedeviled the health care delivery system. Therefore, healthcare policy reforms have adopted a strategy of supplementing government budget to revitalize health care system. However, the KHPF does not provide explicit strategies for ensuring efficiencies, good governance and combating corruption in the health care sector.

The Medium Term Plan (MTP, 2008-2012) has highlighted numerous policy, legal and institutional reforms as being necessary for the effective delivery of services. These will cover areas of health infrastructure, service delivery, health care financing and public private partnership (PPP). The identified reforms in the public health sub-sector will include development of an integrated health infrastructure plan to guide investments in the health sector, strengthening and facilitation of the timely procurement and distribution of medical supplies, and fast tracking of the Community Strategy Framework to promote participation of individuals and community. The mentioned reforms on service delivery include the review of the Public Health Act to allow for the establishment of a Health Service Commission, development of a policy to encourage local manufacturers to produce drugs and commodities locally to reduce the cost of health care, development of a policy on PPPs to ensure a well-coordinated approach to health care delivery; and, development of a human resource strategy to link demand and supply for human resources. The Public Health Act is to be reviewed to allow for the disbursement of funds as grants directly to health facilities as part of the reforms in the health care financing. The health facility boards are to be empowered to manage and supervise resources generated locally and those of the central government.



3. CORRUPTION IN HEALTH CARE DELIVERY AND MANAGEMENT

3.1 Introduction

This section addresses study findings on issues of corruption prone areas, activities and processes. It further covers the types, causes and impact of corruption in delivery of health care services.

3.2 Areas, Processes and Activities prone to Corruption

The survey sought to establish the areas, processes and activities within the public health sub-sector that are most prone to corruption. Health facility managers and the staff identified procurement department as the most corrupt area/process. This is closely followed by pharmacy, personnel management, out-patient department, laboratories, administration and stores in that order. Subsequently, the most prevalent corrupt practices under the procurement process include manipulation of the tendering system, misappropriation of supplies, procurement of sub-standard/poor quality commodities and equipment, hoarding of supplies and inflation of prices. Other malpractices include bribery, embezzlement of funds, favoritism/tribalism/nepotism/cronyism, unnecessary referrals to private clinics, extortion and misappropriation of procurement funds.

Exemption and waivers is another area that was mentioned. Furthermore, PETS (2007) established that health facility staff are usually not expected to be granted exemption from payments yet majority of the rural health facilities stated that they exempt them, thus resulting in leakage of potential revenue. In particular, the report indicates that Health Management Board members accounted for a third of the cases and politicians in a small but a significant number.

3.3 Types of Corruption

Corruption manifests itself in the public health care sector in various ways. During the survey, exit-patients were asked to identify malpractices they experienced in the process when seeking medical care. A significant number of patients (41.1%) considered absenteeism of medical staff as the most prevalent malpractice (Table 4). Other malpractices mentioned include unnecessary referral of patients to private clinics, unofficial/informal payment for services and theft of drugs and medical supplies.

Table 4: Malpractices experienced by patients

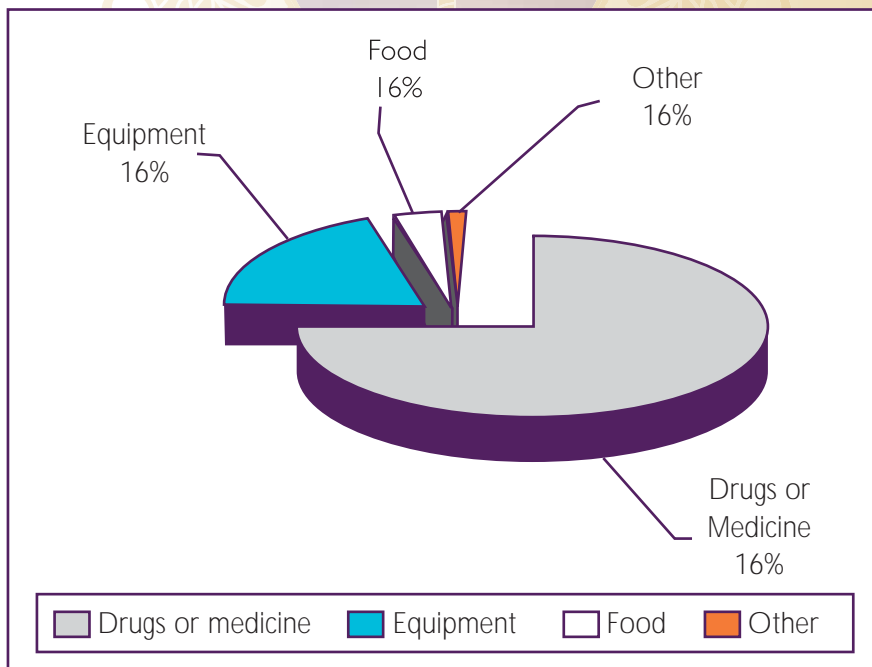
Malpractice	% of patients who experienced
Informal payments required from patients	13.6
Unofficial payments for services that are supposed to be free	11.4
Theft of drugs and medical supplies	9.0
Use of public facilities and equipment for private practice	1.9
Unnecessary referral of patients to private clinics	14.4
Absenteeism of staff	41.1
Billing patients for services that were unavailable	4.1
Prescribing or performing unnecessary procedures	1.5
Scheduling surgery dates	2.4
Theft of user fee revenue, other diversion	0.5

3.3.1 Official user fees, informal payments and other problems

Introduction of user fees in health facilities has been promoted as a strategy to generate revenues that can be channeled back into operational activities or used to meet personnel costs such as salaries for health workers. The survey thus sought to determine whether the respondents were familiar with the user fees. The survey revealed that most patients were not informed of the processes and procedures, including information on the user fee. A total of 56 percent of the patients indicated that they do not know the official gazetted fees to be paid while seeking medical services. Another 45 percent indicated that they do not know the kind of medical services that are to be offered free-of-charge by the government. This finding is confirmed by key informants, who observed that official communication on user fees is limited thereby making it difficult for patients to ascertain whether the rates have been inflated or not, or whether the services are supposed to be offered for free or not. Making information public also tend to have an effect on providers directly by holding them up to scrutiny by peers, making it more difficult to conceal dishonorable activities.

The survey sought to establish if patients were asked to buy any items in order to get treatment. At least 38.6 percent of the patients were asked to buy certain items. Figure 1 below shows the items bought by the patients. Top among the items bought are drugs/medicine, followed by equipments, indicating a clear shortage of the same in the facilities.

Figure 1: Items bought by Patients



During the survey, patients were asked whether they paid a bribe to receive service. A total of 3.3 percent of the patients were directly asked to pay a bribe in order to access services. Table 5 below provides the reason why patients make informal payments. The informal payments increase the cost of accessing health care services, thus undermining the government's objective of equitable and affordable healthcare to the citizenry.

Table 5: Reasons for making informal payments in public health facilities (%)

Why did you pay?	Percentage of patients who paid
To gain access to health services	30.9
To reduce waiting time/speed the process	24.7
To obtain drugs/medicine/meals	28.9
To ensure better attention/improved quality services	15.5

Of those who paid a bribe, 30.9 percent of the patients indicated paying in order to gain access to health services; 28.9 percent to obtain drugs/medicine/meals; 24.7 percent to reduce waiting time/speed up the process and another 15.5 percent paid out a bribe to ensure better attention/improved quality services. Table 6 below provides the average amount of bribe and attending medical personnel whom the bribe was paid to.

Table 6: To whom the bribe was paid to and amount of bribe paid

Health Personnel	Amount (Kshs)
Clerk	62.70
Nurse	120.00
Doctor	347.20
Laboratory technologist	241.70
Pharmacist	176.00

3.3.2 Private practices, self-referral & absenteeism

The survey confirmed that doctors working in public health facilities have been increasingly allowed to open private practices. While the private practice policy was well-intentioned, it has produced mixed results. According to key informants, doctors spend official time in private practices, use public facilities and equipment to treat private patients, or merely utilize the public system to channel patients to their private practice. This observation concurs with the responses of health professionals on the most prevalent irregular practices as a result of weak or inadequate supervision and control (Table 7). Absence from duty without permission among medical staff was the most prevalent malpractice followed by theft of drugs from the facility.

Table 7: Most common forms of irregularity in public health facilities (%)

Irregularity	Staff Reporting Irregularity
Unjustified absence among medical staff	38
Mismanagement of procurement	16
Theft of drugs or equipment	39
Unauthorized use of equipment, facilities, or supplies	5
Unauthorized billing of patients	2

Further analysis focused on two forms of irregular conduct - theft of drugs and unjustified failure of medical staff to fulfill their contracted working hours - that were considered to seriously affect the ability of public health facilities to provide timely and good quality services. Most medical staff respondents blamed high absenteeism and theft of drugs on weak supervision and control mechanisms (Table 8). When further questioned the primary causes for doctors' absenteeism, 46 percent identified *"ineffective supervisory and control measures"*; 33 percent blamed *"tolerance of these situations in the public health sector"*; only 12 percent indicated *"low pay"*. This last result is important since pay is a principal argument for explaining why doctors hold several jobs in the private and public sector.

Table 8: Reasons given by medical staff for absenteeism and theft of drugs (%)

Causes for irregular the practices	Percentage of staff	
	Doctors' Absenteeism	Theft of drugs
Low pay	12	8
Work shifts that are too long	6	-
Tolerance of such behavior by the public sector	33	20
Inefficient supervisory and control mechanisms	46	60
Other reasons	3	12

Patients were asked whether they always find medical staff to attend to them whenever they sought medical attention at public health facilities. Table 9 below gives an assessment of the patients' views on the availability of medical professionals, in particular, doctors and nurses, at the facilities. The findings indicate that doctors were mostly absent from duty than nurses. Health facility administrators identified understaffing as the major problem, perhaps this would explain the problem of absenteeism as perceived by the patients. According to patient respondents, absenteeism of doctors from duty is largely attributed to attending to personal issues (30.6%), multiple job holdings (18.3%), responsibility to many facilities (14.4%), illness (10.9%), manage own private facilities (19.2%), poor attitude towards work (19%), long shifts (11.4%) and lack of controls/supervision (11.1%).

Table 9: Availability of medical personnel (%)

In general do you always find the following personnel whenever you seek medical attention at the health facility?	Doctor	Nurse
Always	40.0	62.0
Sometimes	38.8	31.3
Hardly	7.0	2.2
Never	6.8	1.5
Do not know	7.3	3.1

Moreover, the health administrators identified understaffing as the major problem, perhaps this would explain the problem of absenteeism as perceived by the patients. Other problems mentioned included inadequate supply of drugs and non pharmaceutical commodities; inadequate bio-equipment and facilities, and inadequate allocation of funds.

Patients were further asked why they were referred to private facilities and most of them, 37.5 percent indicated that it was done to benefit the doctor. Table 10 below illustrates the various reasons for the referral as captured from the patients.

Table 10: Reasons for referral to private health facility (%)

Reason for referral	% of patients
Patient's request	1.7
To reduce waiting time	4.8
Better quality treatment	27.6
For the doctor's benefit	37.5
No specialised equipment at facility	17.6
Others	10.8

The survey also sought to know from the patients whether doctors who are accredited to government hospital should be allowed to run private practices. A majority 80.2 percent object to this proposal with only 19.3 percent consenting. At least 36 percent of those who objected explain that if allowed to operate private clinics, then doctors will neglect public duty and result to further absenteeism; use government supplies to run own facilities (24.7%), unnecessary referral to private facilities (7.9%), while 7 percent state that they are employees of the government.

3.3.3 Training and selling of accreditation or positions and licensing

Responses from medical personnel indicate that political influence, nepotism and favoritism occur during the selection of candidates for training, appointment, hiring, and promotion and licensing of health personnel. Training is a particularly vulnerable area with trainees paying bribes to gain a place in a medical school or passing exams, jeopardizing the competence of trained health workers.

Promotion is another area where corruption occurs. During the survey, 45.9 percent of the health facility managers indicated that no officer from their facility had been promoted in the last three years prior to the survey. Lack of promotions would be attributed to non-implementation of the policy on promotions after the three years, unclear systems and procedures on promotion in the Ministry and ineffective communication channels of human resources management issues to the officers. Other reasons included delays in effecting promotions and corruption in personnel management at the Ministry's headquarters.

3.3.4 Health care fraud

Key informants indicated that a large range of fraudulent practices occur when paying medical bills by insurance companies. These include billing for services that were not rendered, billing for more expensive services than were rendered, billing for over-prescribed services or billing for unnecessary interventions performed. At least 23 percent of medical practitioners cited this malpractice of which 67 percent indicated that prices are inflated. Due to complicated procedures, such practices are often difficult to monitor, detect and sanction.

3.3.5 Conflict of interest

Pecuniary gains can influence a physician's decision and induce unnecessary interventions or over-prescriptions because of the remunerative aspect of the treatment rather than a patient's medical needs. The questionable relationships between doctors, firms and pharmacies have led to manipulation of tender documents (34.2%), misappropriation of supplies (31.7%), procurement of sub-standard or poor quality drugs (24.8%), hoarding of supplies (11.8%) and payment for non delivered goods (6.8%).

3.4 Causes of Corruption in the health care delivery system

3.4.1 Lack of accountability and transparency in management

Monitoring performance of staff has great potential to reduce corruption. The survey sought to know from the health facility managers whether certain management tools/conditions that are supposed to enhance efficiency, transparency and accountability are present in their facilities. Table 11 indicates low awareness/presence of these management tools. Consequently, over 34 percent of the health providers indicated that supervision of the facility is ad hoc and unreliable.

Table 11: Availability of tools at the health facilities (%)

Tool/ conditions	% of responses from facility managers
Up to date duty roster for all staff	18.7
Weekly/monthly meetings	13.2
Organizational charter for each unit	6.6
Written job description for all staff	6.3
Strategic plan	8.4
Adequate staff	1.2
Adequate facilities and equipment	2.0
Income and expenditure budget	8.4
Expenditure agreements	5.7
Operational targets	10.3
Service charters	10.8
Mechanism for personnel evaluation	8.4

Clearly, the table above indicates low awareness/presence of the tools or conditions. Other studies including PETS (2007) established that the LATF and CDF are significant revenue contributors both for capital and operations and management particularly at the health centre and dispensary level. The report reckons that capture of the same within the DMOH records is limited. The report states that there is no evidence of standard procedure for financial records or reporting at facility level making it almost impossible to track the flow of funds as well as monitor efficiency of resource distribution or even compare expenditures from year to year. It reckons that the facilities lacked sound financial management systems or record keeping systems for easy retrieval of data.

Similarly, when the facility managers were asked whether to confirm usage of tools by management or methods to enhance efficiency and transparency: 28.8 percent confirmed a system of handing over reports to the in-coming officer; a clocking system/report to the duty register (13.4%); staff

leave roster (16.4%); training committee (6%); monitoring of staff (15.6%) and (19.8% confirmed a records management system.

Majority of the health facility managers (52.1%) indicated that there are no procurement committees in their facilities, 46.6 percent confirmed existence while 1.3 percent do not know whether one exists or not. Of those who had the procurement committee in place, 63.8 percent had quarterly procurement plans; 15.6 percent monthly plans; 3.7 percent annual plans and 3.2 percent had weekly plans. 13.8 percent of the managers cited other plans.

3.4.2 Management and control of health facilities

Management of public health systems, hospitals and dispensaries typically fall on trained physicians, with little or no training as managers to run health facilities as autonomous entities. The survey found a low level of knowledge among facility managers regarding standard procedures and regulations, and even current budget allocations. The vague and poorly understood policies, uneven record-keeping and minimal use of such information contribute to poor management⁸. This is greatly compounded by unfair hiring practices, nepotism and preferential treatment to well-connected individuals. Clearly such policies do leave systems wide open to abuse.

Public health care systems require oversight and accountability for all providers with swift punishment for transgressors. Fundamental to this are use of acceptable accounting standards, procurement rules, and ex-post auditing of facility accounts combined with tools to ensure that health facility managers comply with set policies, regulations and procedures. Such basic information and management tools include development plans, annual budgets with regular budget review, and investment plans, along with performance targets. According to health facility managers, public health facilities have minimum tools to implement supervision and control, but are ineffectively applied (Table 12). However, analysis focusing on responses from doctors and nurses found that most public health facilities lacked these basic information and management tools, but the rate varied strongly across the facilities.

Table 12: Availability of management instruments

Management tool	Management Team	Doctors			Nurses		
		Yes (%)	No (%)	Don't Know (%)	Yes (%)	No (%)	Don't Know (%)
Institutional development plan	YES	17	23	60	26	34	40
Income and expenditure budget	YES	5	27	70	6	32	62
Expenditure agreements	YES	13	34	53	12	36	52
Operational targets	YES	13	48	39	22	34	44
Written statement of institutional mission	YES	20	29	59	18	20	62
Mechanism for personnel evaluation	YES	23	25	52	30	30	40

⁸ This poses a major problem as they move to reform the health system, and is at the heart of ineffective service delivery in the sector.

Public health facilities have the minimum tools to implement supervision and control, but are ineffectively applied. Lack of strict supervision (11.3%) has led to at least one form of irregular conduct in their facility. Of the staff interviewed, 65 percent indicated that irregular conduct existed in their facility.

3.4.3 Inadequate access to information

The survey further found that poor recordkeeping capacity and failures to submit timely reports undermine health care delivery and regular availability of inputs. Key informant interviews established that existing management information systems are ineffective due to complicated and obscure reporting requirements, incomplete record keeping and low capacity. According to public health facility management teams, drug management by KEMSA, exhibits particular weaknesses in logistics and distribution attributed to flawed information systems and inadequate monitoring. Each of these represent deficient aspects of recordkeeping that compromise good governance and propagate corruption. A major problem is the absence of readily available data even on items that the health facilities receive in kind (PETS, 2007). The report further states that such flows should be incorporated into annual district or hospital plans, and should capture all sources of funding and should include donor funding of drugs and supplies, all supplies from KEPI, DRH and other programmes, together with a summary of allocations through KEMSA and any other suppliers as this would then provide a baseline against which actual receipts could be checked to allay any suspicions of misappropriation and other malpractices.

3.4.4 Commodity management

The procurement process is marred with lengthy processes and very long delays resulting in expiry and the short life span for some of the drugs supplied. Table 13 shows the quality of service by KEMSA in regard to procurement of pharmaceutical supplies as rated by facility managers. Delays in delivery, inadequate supplies of required drugs and the supply of drugs not specific to the disease patterns of the region are some of the problems mentioned by the facility managers as experienced when procuring drugs from KEMSA. Moreover, the distribution system is weak with no clear distribution policy therefore drugs remain in the stores. It was established that procurement and delivery delays result to short life and eventual expiry of the supplies. Lack of resource allocation is also responsible for challenges experienced in the distribution and transport of the supplies.

Table 13: Assessment of procurement process by KEMSA (%)

In procurement of pharmaceutical supplies, how would you rate the services of KEMSA?	Good	Poor	Do not know
Accessibility and availability of drugs	63.7	34.5	1.8
Efficiency, speed and timeliness	46.4	50.9	2.7
Quality of Drugs	81.6	15.8	2.6
Professionalism in Procurement	73.2	18.8	8.0
Supply and delivery of medical supplies	67.9	30.4	1.8
Clarity of information of medical supplies	75.9	22.3	1.8

Due to the “push system” of pharmaceutical supplies, the facilities end up with supplies they do not need immediately or are about to expire. On being asked how they handle this, 54.8 percent indicated that they return the particular supplies to KEMSA/ District Hospital; 35.6 percent distribute to other facilities directly and 9.6 percent use the drugs on priority basis with the aim of depleting them before expiry.

Delays in delivery, inadequate supplies of required drugs and the supply of drugs not specific to the disease patterns of the region are some of the problems mentioned by the facility managers as experienced when procuring drugs from KEMSA. On stocks management, a majority of the facility managers indicated that they verify the level of inventories by use of stock cards (96.8%), while another 2.7 percent use audits.

3.4.5 Organizational factors

Key informants indicated that corruption in the Kenyan health care sector mainly arises from the roles and relationships among the different players. In their view, corruption in the public health sector is uniquely influenced by several organizational factors. Roles and responsibilities within the Kenyan health sector are split between regulators (Ministry of Health Services, Ministry of Public Health, Parliament, and KEMSA); payers (National Hospital Insurance Fund, private insurers); health care providers (health facility managers, doctors, nurses, pharmacists); suppliers (medical equipment and pharmaceutical companies) and consumers (patients), in ways that make good decision-making difficult. The patient-provider relationship is also marked by risks stemming from imbalances in information and inelastic demand for services. In addition, colossal amounts involved in procurement within the sector, combined with a powerful market of vendors and companies, present risks of bribery and conflict of interest in the health sector.

3.4.6 Greed and low pay

Higher salaries are traditionally assumed to inhibit corruption within public bureaucracies because they diminish officials' urge to increase their income through illegal means. However, the feeling that medical professionals receive low wages (28.0%) coupled with greed (21.6%) has led medical professionals to seek additional employment outside government establishments. Key informant interviews established that health workers missed work or cut short their hours to devote time to other economic activities to supplement their income. On the other hand, health facility managers feel that delays in payment of salary force the workers to engage in sale of drugs or seek other employment in the private sector. For instance by the time the survey was carried, nurses employed under National Aids Control Programme (NAS COP) had not been paid their salaries for more than 6 months in the past year, thus converting them into virtual volunteers. Moreover, the need to have additional sources of income effectively compromises providers' ability to carry out their public duties on the scale intended.

3.5 Impact of Corruption on Health Care Delivery System

The findings of the survey confirmed that among others, as resources are drained from health budgets, less funding is available to fund operations and maintenance, leading to de-motivated staff, poor quality of care, and reduced service availability and use, especially for the poor, and causes delays in care-seeking behavior. Further, the informal user payments increase the cost of

accessing health care services rendering them inaccessible. As indicated earlier, informal charging has serious equity implications thus undermining the government's objective of equitable and affordable healthcare to the citizenry.

Users and providers explained the rampant stealing of public drugs and their resale in the parallel or black market, in particular, private pharmacies and clinics. Half of the patient-exit survey respondents had not received a prescribed drug due to non-availability. In this case, pilfering and unnecessary prescriptions simply divert public money into private hands without any gain for patients. Other types of corruption which clearly affect health outcomes are bribes to avoid government regulation of drugs and medicines, which have contributed to the rising problem of counterfeit drugs. In addition to fake and sub-therapeutic drugs in the market, corruption leads to shortages of drugs available in government facilities, due to theft and diversion to private pharmacies. The lack of drugs leads to reduced utilization of public health facilities.

Asked what the consequences of these unjustified in availability were, 27 percent of nurses listed *"delaying or hindering activities at the times and in the form required,"* which obviously generates more inefficiency in the use of public resources. Another 26 percent thought that these absences were responsible for *"generating a bad image for the institution,"* and 26 percent thought it *"lowered the quality of care."* The high rate of absenteeism curtails accessibility of public health facilities, thus compromising the equity and health objectives of publicly financed health care.

The weakness of public health care services has led to a search for alternative care. Development of genuine private health services requires a framework to regulate and monitor the quality, reliability, and cost-effectiveness of care, determine issues relating to access, and provide transparent criteria for licensing and monitoring private health insurance funds. Unfortunately, much of the "private care" is currently either financed partly by government or uses public infrastructure and equipment to treat private patients⁹. This includes the use of equipment, supplies and, perhaps most importantly, sometimes known as creeping privatization or privatizations from within. Services offered to patients may include simple additions to the treatment already provided as part of the official state package of care. Alternatively, a doctor may provide treatment entirely on a private basis during the time he should be spending on public duties and/or using public supplies and equipment. Another possibility is for a public doctor who also has a private practice to spend less time than contracted for in public facilities to extend the amount of time in private practice. The presence of a substantial quasi-private health care system operating within the public health care sector is arguably detrimental to the development of a strong private health care sector.

A key policy question is whether doctors should be permitted to work both in the public and private sectors. Prohibiting fully private out-of-hours practice may help to ensure that public physicians do not attend private clinics when they should be doing their public practice. It also reduces the possibility that physicians will refer patients to their own private practice or increase public waiting times to encourage greater use of the private sector. At the same time, it is likely to increase the chance that they will carry out unofficial private activities during public working hours.

⁹ It may often be more profitable to provide private health care services using the convenience of public healthcare facilities, supplies and public time and also a ready supply of patients, rather than go to the expense of establishing a private clinic and mechanism for recruiting patients.

As in other sectors, corruption in the health sector has spill-over effects on the macro-economy. Other than the lost man hours, productivity could also suffer as a result of treatment taking longer than necessary because of the need to pay a bribe before treatment commences. Individual productivity is affected due to sub standard and poor quality services that in some cases might be altogether inaccessible to the masses.

Corruption might also lead to misplaced priorities within the health sector, as mentioned by the key informants and some health personnel, renovations and procurement of furniture and non medical equipment might take precedence over investment in primary health care programmes such as immunization and family planning.

Table 14 below gives a summary analysis of the facility managers', medical staff and patient opinions on the types of corrupt practices, causes of corruption and the impact of corruption in the health sector.

Table 14: Areas, types and causes of corruption in the public health sub-sector

Area or Process	Types of Corruption and Problems	Causes	Impact/ Results
Procurement	<ul style="list-style-type: none"> • Bribes, kickbacks, & political interference • Tailor specifications • Manipulation of tendering system • Collusion or bid rigging during procurement • Procurement of sub standard supplies • Inflated quantities • Inflation of costs • Unnecessary procurements • Unethical drug promotion • Suppliers fail to deliver and are not held accountable 	<ul style="list-style-type: none"> • Lack of an accountability & transparency system • Poor record keeping • Poor enforcement of the anti-corruption legislation • Political interference • Bureaucracy • Overstaying at a given work station • Lack of incentives to boost morale • Culture- both at the national and organizational level • Favoritism/nepotism • Unqualified personnel in inequities 	<ul style="list-style-type: none"> • High cost of goods and services • Location of facilities that does not correspond to need, resulting in access • Biased distribution of infrastructure favoring urban- and elite-focused services, high technology • Sub-therapeutic or fake drugs allowed on market; • Marginal suppliers are allowed to continue participating in bids, getting government work • Spread of infectious and communicable diseases • High cost, inappropriate or duplicative drugs and equipment • Inappropriate equipment purchased without consideration of true need • Sub-standard equipment and drug

Area or Process	Types of Corruption and Problems	Causes	Impact/ Results
Finance/ cash /revenue offices	<ul style="list-style-type: none"> • Bribery • Embezzlement/Fraud • Diversion of budget allocation • Mishandling and mismanagement of records 	<ul style="list-style-type: none"> • Lack of strict supervision • Lack of an accountability& transparency system • Poor enforcement of the anti-corruption legislation • Poor management system • Political interference • Bureaucracy • Overstaying at a given work station • Inadequate facilities & resources • Lack of incentives to boost morale • Unqualified personnel 	<ul style="list-style-type: none"> • Inequities due to inadequate funds left to provide for all needs
Pharmacy	<ul style="list-style-type: none"> • Theft (for personal use) or diversion (for private sector resale) of drugs/supplies at storage and distribution points • Sale of drugs or supplies that were supposed to be free • Bribery 	<ul style="list-style-type: none"> • Lack of strict supervision • Lack of an accountability& transparency system • Poor enforcement of the anti-corruption legislation • Understaffing • Overstaying at a given work station • Inadequate facilities & resources • Lack of incentives to boost morale • Unqualified personnel • Impatience among patients • Long queues & delays 	<ul style="list-style-type: none"> • Lower utilization • Patients do not get proper treatment • Patients must make informal payments to obtain drugs • Interruption of treatment or incomplete treatment, leading to development of anti-microbial resistance
Personnel Management & Administration	<ul style="list-style-type: none"> • Biased application of accreditation, certification or licensing procedures and standards • Employment of unqualified personnel • Political influence • Favoritism/tribalism/nepotism/ discrimination • Mismanagement of time i.e. lateness, absenteeism • Extortion • Mishandling and mismanagement of records • Lack of promotion • Bribery • Engaging in unauthorized private practice 	<ul style="list-style-type: none"> • Lack of strict supervision • Lack of an accountability& transparency system • Pronounced variations in pay among the personnel • Poor enforcement of the anti-corruption legislation • Poor management system • Understaffing • Political interference • Bureaucracy • Overstaying at a given work station • Lack of incentives to boost morale • Unqualified personnel 	<ul style="list-style-type: none"> • Incompetent professionals continue to practice • Loss of faith and freedom due to unfair system

Area or Process	Types of Corruption and Problems	Causes	Impact/ Results
Out-patient Department/ Consultations	<ul style="list-style-type: none"> • Informal payments required from patients to get access to treatment • Use of public facilities and equipment to see private patients • Unnecessary referrals to private practice or privately owned • Absenteeism • Theft of user fee revenue, other diversion of budget allocations • Bribery • Extortion • Harassment of patients • Mishandling and mismanagement of records 	<ul style="list-style-type: none"> • Ignorance/ lack of information • Poor enforcement of the anti-corruption legislation • Understaffing • Overstaying at a given work station • Inadequate facilities & resources • Lack of incentives to boost morale • Impatience among patients • Long queues and delays 	<ul style="list-style-type: none"> • Deaths • Low utilization of services • High cost health care services • Inequity and limited access to health provision
Laboratory	<ul style="list-style-type: none"> • Informal payments required from patients for services 	<ul style="list-style-type: none"> • Lack of an accountability & transparency system • Poor enforcement of the anti-corruption legislation • Understaffing • Overstaying at a given work station • Inadequate facilities & resources • Lack of incentives to boost morale • Impatience among patients • Long queues & delays 	<ul style="list-style-type: none"> • High cost of treatment • Inequity and limited access to health provision
Wards	<ul style="list-style-type: none"> • Use of public facilities and equipment to see private patients • Bribery • Unnecessary referrals to private practice or privately owned ancillary services • Absenteeism • Informal payments required from patients for services • Theft of user fee revenue, other diversion of budget allocations 	<ul style="list-style-type: none"> • Understaffing • Overstaying at a given work station • Inadequate facilities & resources • Lack of incentives to boost morale • Impatience among patients • Long queues & delays 	<ul style="list-style-type: none"> • Government loses value of investments without adequate compensation • Employees are not available to serve patients • Reduced utilization of services by patients who cannot pay • Impoverishment as citizens use income and sell assets to pay for health care • Reduced quality of care from loss of revenue • Loss of citizen faith in government
Stores	<ul style="list-style-type: none"> • Hoarding of supplies • Misappropriation of drugs/supplies • Understaffing 	<ul style="list-style-type: none"> • Poor enforcement of the anti-corruption legislation • Overstaying at a given work station • Inadequate facilities & resources • Lack of incentives to boost morale • Unqualified personnel 	<ul style="list-style-type: none"> • Shortages of medical supplies

4. CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

Based on the objectives of this study and the relevant findings the following conclusion can be drawn:

Areas and processes vulnerable to corruption: In this Survey, procurement was identified as the most corrupt operational area in the entire health sector. Health personnel were blamed for manipulating the tendering systems, misappropriating supplies, procurement of substandard/poor quality commodities and equipments, hoarding of supplies and inflating purchase price for all supplies. The pharmacy was also identified as the other corrupt operational area within the health care institutions.

Types of corrupt practices: This study established that corruption within the health sector manifests itself in a number of ways and mainly involves staff absenteeism, unnecessary referral to private health care providers, and unofficial/informal payment for services by the health care seekers and theft of drugs and other medical supplies by the health personnel.

Causes of corruption in the sector: The study establishes a number of factors contributing to corruption within the sector including lack of accountability and transparency mechanisms that is characterized by poor staff performance monitoring, management and control of health facilities by staff with little managerial training a situation that is characterized by low levels of awareness of key government policies affecting the sector and poor knowledge of standards procedures and regulations. Other factors include inadequate/poor access to information by the health care seekers, greed and low pay among the health care personnel.

Impact of corruption: The study established that corruption drains the much needed resources (financial, medical and non medical supplies) targeted at the sector leaving very little to fund operations and maintenance hence affecting the overall the overall quality of services delivered. In most cases, corruption leads to non availability of drugs and other essential medical supplies hence affecting the quality of health care.

4.2 Recommendations

Based on the study findings, the following major recommendations are made. The recommendations have been classified along key thematic area.

4.2.1 Policy, Legal and Regulatory Framework

- Policy development should encompass capacity development needs to ensure strong implementation and monitoring and evaluation framework.
- Various Acts of Parliament, Regulations, and Codes of conducts governing various practices and conduct of healthcare professionals should be examined, reviewed, harmonized and enforced to improve sector governance and to stem corrupt and unethical conduct;
- All institutions and statutory bodies connected with health care provision should be examined to identify loopholes for corruption and to initiate measures to strengthen the policies, systems and procedures of governance so as to prevent corruption, improve corporate governance and improve equity, access, affordability and quality of health care services;

- Introduced and enforce stringent human resources, financial and facilities management policies and regulations at all levels (national, provincial, districts, health centers and dispensaries) to enhance staff performance, increase efficiency of resource utilization and eliminate wastage and mis-management of health facilities;
- Put in place policies and systems for User Fees collection, appropriation and accounting to facilitate efficiency of administration of the fees and enhance transparency and accountability.
- Create a framework for greater community oversight and involvement in service management, procurement and distribution, and health care reform initiatives. This requires effective implementation of the programmes proposed under the MTP for Vision 2030. The challenges posed by the events and effects of the 2007 post election violence call for a redefinition and re-prioritisation of the scope and coverage of policy interventions.
- Enhance coordination of implementation of all healthcare programmes from government and donors to eliminate duplication, overlaps and wastage and to minimize over-commitment of the scarce human resource capacity on administrative and none aspects of service delivery.
- De-link the central government from health care provision and let it play the policy and regulatory role.
- Review and harmonize the legal framework to address the latest developments in the sector and set up a body to manage healthcare provision.

4.2.2 Human Resource Issues

- Define clear, transparent and enforced rules and behaviour standards as well as implementing merit based promotion policies.
- Define and set clear performance standards and targets for all healthcare institutions and personnel including specifications of jobs for each cadre of staff;
- Enforce performance management policies and systems for all cadre of staff in headquarters and field offices;
- Ensure equity, fairness and merit in deployment, training and promotions of healthcare staff;
- Modernize and decentralize human resource records management systems to all levels of service provision to facilitate effective monitoring of staff complement and planning for recruitment, training, deployment, promotions etc
- Deal decisively with persistent and prevalent staff absenteeism through strict enforcement of service regulations and codes of conduct and ethics;
- De-concentrate financial, procurement, administration and operational decision making and empower field managers with the right tools and instruments for operational decision making
- Develop and enforce policies and regulations on private practice to facilitate informed decision and choice between public service and private practice for health care professionals.
- Deliberate measures to decentralize the operations and structures at the Ministry should be undertaken, especially targeting Human resources, finance and procurement.
- Establish effective disciplinary mechanisms at the provincial and district levels.
- Review the remuneration arrangement.

4.2.3 Planning and Cost control Measures

- Institutionalize regular monitoring and evaluation of healthcare policies and programmes to measure outcomes and impact of healthcare reform initiatives

- Complement and enhance internal supervision with regular external audits, unannounced visits to health facilities and evaluation of services by clients and beneficiaries. External monitoring can be improved by providing channels for whistle blowing and legal support to citizens who feel they have been treated unfairly.
- The relevant ministry within the sector should coordinate and streamline the government and donor funded activities to ensure harmony of programmes.
- Raise awareness of patients of the cross referral policy so that they know of their rights through the service charter and other instruments.
- Liberalize the sector by accrediting more facilities to the ministry and also allow doctors to advertise and market their services.
- Innovative technology and management procedures at the facility level can also enhance efficiency and quality of service provision; reduce lead-times and opportunities of bribery to gain or speed up access to medical care.

4.2.4 Procurement

- Enhance the human resources capacity to ensure quality and monitoring of the market in view of diversity and dynamism of the market and technology since generation of the various specifications is a major challenge.
- Develop and operationalise a clear policy on capitalization of KEMSA so that it can discharge it is intended responsibilities.
- Enforce the policy on rehabilitation and disposal of premises, furniture and fittings within the ministry and the government at large.
- Establish a clear logistic and distribution information management system for distribution of essential drugs and supplies.
- Enforce the provisions of the Public Procurement and Disposal Act, 2005 on the proper disposals of stores to ensure that set procedure and criteria for declaring stores unsuitable by the designated authority is adhered to.
- Enforce procurement regulations on specialized procurement for medical and non-medical supplies so that the set specifications and quality standards are maintained
- Review the role of the MOH and others institutions involved in procurement of medical and non-medical supplies with a view to providing KEMSA the mandate and authority to execute medical supplies procurements. This will minimize conflict of interest among various stakeholders.
- A clear procurement policy needs to be adopted on whether a push system or a pull system is appropriate. In view of the complicated nature of the commodities mainly used, the current processes of procurement should be reviewed to reduce wastage and enhance transparency and accountability among the stakeholders.
- Liberalize the commodity supply sector by accrediting more commodity suppliers such as the Catholic Medical Board (MEDs)¹⁰ and allow them to compete with KEMSA. However, the accredited players should be adequately regulated. Therefore, this call for a clear and comprehensive framework.

10 An agency by the Catholic Mission which distributes both pharmaceutical and non pharmaceutical commodities

4.2.5 Financial Management

- The MoH should ensure that all financial resources are allocated on the basis of an approved budget. During budgeting, priority should be given to areas/items considered critical for the effective and efficient delivery of services to the public. No re-allocation of funds should be allowed except with the prior authorization of the Treasury. Budget variances (both positive and negative) in excess of 15 percent between the actual and budgeted expenditure should be investigated and appropriate action taken.
- The MoH should establish amount of funds necessary for effective supervision in the Districts/ Provinces and ensure that no more than the amount is allocated for the item. The practice of giving blanket allocation in percentages should be discontinued. All allocated funds should be fully and properly accounted for. Subsequent disbursements in this account should be withheld until all the previous allocations have been fully and properly accounted for.
- The MoH headquarters should conduct frequent audits and financial needs assessments for the individual health facilities, to ensure that requests made by the facility managers are justified. Defined standards of quality care within strict cost limits should also be set. The continuous internal audit systems should advise on internal control systems and risk management systems in all management processes
- The MoH should conduct periodic reconciliations in order to match requests by individual facilities, projected requests and the services/items bought.
- The ministry should employ the services of a cost and management accountant to ascertain costs of various services in order to obtain realistic information for planning purposes.
- The MoH should review and harmonize the accounting process for various projects which use similar facilities and with similar project outputs to avoid duplication of resource inputs.
- There is need to strengthen the Treasury and the Ministry links so that activities and programmes are streamlined to enhance planning efficiency and funds utilization. Since the itemized budgetary allocation has proved inefficient, there is need to review the allocation procedure.
- Implement fiscal and administrative decentralization as envisaged in the decentralization policy to avert governance and corruption challenges, that previously, and could still prove an obstacle to the effective execution of this policy at the Ministry level.

4.2.6 Corruption Prevention Measures

- Examine policies, systems and procedures of all institutions connected with healthcare provision to identify and seal corruption loopholes
- Conduct public service integrity and assurance training for all health service providers
- Sensitize the public on the dangers of corruption in the healthcare delivery systems and the rights to quality, affordable and accessible healthcare
- Initiate sector-wide investigations into alleged corruption in procurement, distribution and use of medical and non-medical supplies

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