



USAID
FROM THE AMERICAN PEOPLE

CORRUPTION ASSESSMENT OF RWANDAN HEALTH SECTOR

DECEMBER 23, 2008

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

CORRUPTION ASSESSMENT OF RWANDAN HEALTH SECTOR



A subsidiary of Coffey International, Ltd.

Management Systems International

Corporate Offices

600 Water Street, SW
Washington, DC 20024



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

CORRUPTION ASSESSMENT OF RWANDAN HEALTH SECTOR
December 23, 2008

Prepared for USAID/Rwanda by
Dr. Sheldon Gellar (MSI, Team Leader)
Dr. Abdou Salam Fall (MSI)
Dr. Jean-Paul Kimonyo (MSI),
Barbara Friday (RTI International)

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

CONTENTS

ACRONYMS ii

EXECUTIVE SUMMARY iv

HEALTH SECTOR GOVERNANCE ISSUES AND CORRUPTION

VULNERABILITIES 1

 Evolution of the Post-Genocide Health System in Rwanda: The WHO Model Phase
 (1994-2003) 1

 A New Orientation and Strategy Based on Decentralization, Rigorous Management,
 and Demand-Driven Service Provision (2004-2008)..... 2

 Health Sector Vulnerabilities to Corruption and Recommendations for Action..... 3

 Procurement 3

 Recruitment, Personnel Relationships, and Dealing with the Public 6

 Financial, Material, and Human Resource Management 8

 Functioning of the Community-Based Health Insurance (CBHI) system (Mutuelles) 10

 Community Health Workers and Citizen Participation and Oversight in
 Decentralized Health Institutions..... 12

STRATEGIC RECOMMENDATIONS 15

LIST OF PERSONS CONTACTED 18

REFERENCES..... 20

ACRONYMS

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

PPP	Public Private Partnership
PRSP	Poverty Reduction Strategic Paper
RALGA	Rwandan Association of Local Government Authorities
RRA	Rwanda Revenue Authority
RPPA	Rwanda Public Procurement Agency
RPSF	Rwandan Private Sector Federation
RSDF	Rwandan Strategic Decentralization Framework
RURA	Rwanda Utility and Regulatory Agency.
RWF	Rwanda Franc
SCMS	Supply Chain Management System
SD	Service Delivery
SIDA	Swedish International Development Agency.
SNI	Système National d'Intégrité.
SWAP	Sector Wide Approach
TA	Technical Assistance
TBA	Traditional Birth Attendant
TI	Transparency International.
TOT	Training of Trainers
TR	Transparency Rwanda.
UNDP	United Nations Development Program
USG	United States Government
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

Unlike most country corruption assessments that address broader political and economic forces and provide a review of corruption vulnerabilities in several sectors, this report and its recommendations focus primarily on the Rwandan health sector.

Analysis of Corruption in the Health Sector

The evolution of post-genocide health sector institutions has parallels with broader institutional changes at the national level designed to control corruption, decentralize political institutions and technical services, and make government service delivery more efficient. As an institution, the MOH is highly committed to fighting corruption and to modernizing and improving health services. Since 2004, the MOH has adopted a demand-driven health policy that has succeeded in dramatically increasing access to and use of Rwandan health facilities.

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

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

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

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

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

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

The CBHI (Mutuelle) program has seen phenomenal growth in a short period of time. More than 80% of the population are members of Mutuelles. Use of local health facilities has also jumped sharply in the past three or four years to over 75%. Mutuelle managers have been overwhelmed with work and lack the means to supervise and monitor the village mobilization committees who collect the premiums. Thus funds and premiums do not always go to Mutuelle coffers. The practice of identifying and placing indigents who do not have the means to pay for health insurance on the rolls without paying provides an opportunity for corruption when the genuinely needy do not get on the rolls while some of those who can afford it do.

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

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

Recommendations for Anticorruption Action

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

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

- **Increase citizen participation and oversight** at all levels of the health system, especially at the local and community levels.

The strategic recommendations reflect the team’s consensus that national level anti-corruption institutions and rules are relatively strong. The future success of the GOR’s ambitious health sector policies and programs will depend heavily upon the effective implementation of its decentralization reforms and greater citizen participation, oversight, and ownership of health sector policies and reforms, hence the saliency of our recommendations in this area.

Unlike most country corruption assessments which give the bulk of attention to broader political and economic forces affecting corruption and provide a brief review of corruption vulnerabilities in several key sectors, this report and its recommendations focuses primarily on the health sector.¹ Concentration on the health sector reflects the fact that the Health Sector Corruption Assessment was commissioned by USAID/Rwanda and the Rwanda MOH as a tool for designing and implementing more effective public health programs and for providing guidelines to USAID/Rwanda for integrating good governance techniques and anti-corruption safeguards in the next round of health sector programs beginning in 2009 and 2010.

The team was in Rwanda from September 7-September 23. The short period of time in-country necessitated an intensive interview schedule. The team met with representatives of USAID/Rwanda, implementers of USAID programs, officials from the MOH, CAMERWA, and representatives of key national anti-corruption institutions, Parliament, the media, civil society, and private sector health providers.² The team also met with representatives of the donor community working in the health sector. Given the importance of decentralization, the team made an all day field trip to Ruhango to look at decentralized District level health institutions and services and the role of local government officials in planning and implementing health services. The team also visited the CHK and discussed governance issues with the director and other hospital officials. Based on initial interviews and concerns expressed in these interviews, the existing literature, and documentation provided by USAID/Rwanda, the MOH, MINALOC, national anti-corruption institutions, and donors, the team decided to focus on corruption vulnerabilities in the following areas:

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

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

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

¹ The team reviewed the growing literature on health governance and corruption in the health sector. Key articles from the literature are cited in the references section of the report. Three of the four members of the team also had experience working on health governance issues in Cameroon, Senegal, Benin, and Rwanda.

² See the List of Persons Contacted for names and affiliations of those interviewed by the team.

HEALTH SECTOR GOVERNANCE ISSUES AND CORRUPTION VULNERABILITIES

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

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

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

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

The absence of effective national anti-corruption institutions to oversee governmental institutions during the early-post-genocide period left these institutions vulnerable to corruption as did the absence of internal control mechanisms and procedures within Ministries. MOH officials interviewed by the team stated that corruption was rampant in the past within the health sector. For example, budget officers had easy access to the resources they controlled and diverted funds to amass wealth and buy big houses. At the health district level, nurses often pocketed funds they collected when dispensing drugs, overcharged, or diverted drugs to the black market because of lack of internal controls. Over the past decade, the GOR has created and strengthened national anticorruption institutions like the National Tender Board, the Office of the General Auditor, the Office of the Ombudsman, and the Rwanda Revenue Service as well as anti-corruption laws that have been effective in reducing corruption.

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

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

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

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

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

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

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

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

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

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

Health Sector Vulnerabilities to Corruption and Recommendations for Action

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

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

Procurement

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

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

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

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

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

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

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

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

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

- Simplify, stabilize, and disseminate procurement rules to health sector personnel and procurement committee members, especially at district and sector levels. Current manuals are voluminous and complex. A simple brochure or a two page summary and/or check list of basic procurement principles and processes would enhance the ability of personnel to understand and better follow proper procedures. Such documents, publicized in the media and available for pick up at a government offices or health centers would also provide the public with information that would enable them to better understand how decisions are made and as well as monitoring and procurement processes.
- Provide training in procurement procedures and standards to members of health sector procurement committee members at district level.
- Work on annual and longer-term procurement plans to avoid running out of stock and having to resort to emergency measures. This is practice is currently being done by CAMERWA and could also be carried out by district level hospitals.
- Create an autonomous national agency to regulate and ensure drug quality akin to the American Federal Drug Agency.
- Establish MOH mechanisms to monitor procurement of medicines and medical equipment at district and health center levels in collaboration with MINALOC.
- Offer and improve appeal mechanisms for firms contesting the fairness of the procurement process and make results public.
- Get more input from private sector pharmacists and drug producers concerning improving drug procurement procedures.
- Place firms consistently violating contractual obligations on a black list.
- Enforce sanctions to penalize those knowingly violating the rules and standard procedures.

Warehousing, Stocking, and Distribution of Drugs

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

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

The warehousing system has also been improved in the major hospitals in Kigali and even at the district hospital levels. While hospitals do not have the resources to replicate the methods used by CAMERWA, they are moving to improve control mechanisms. Lax monitoring mechanisms and poor bookkeeping on the part of hospital administrators had enabled those dispensing drugs to avoid accountability by not

turning in their receipt books. As a result, hospital officials didn't know how much was actually collected for the sale of drugs, thus giving those dispensing drugs the possibility of keeping the money they collected for themselves or overcharging customers and keeping the difference for themselves. This practice had been even more rampant at the district level where the personnel distributing the medicine to the patients also collected payment for medicines and kept the records. The absence of checks and monitoring mechanisms provided temptations for corruptive practices. The situation has improved at all levels thanks to the practice of separating dispensation functions from collecting money. The health personnel still gives out the prescribed drugs, but the money is collected by someone else who is accountable to hospital management. In one district hospital visited by the team, hospital officials asserted that this reform seems to have practically eliminated corruption in this area. Although still present, petty corruption in the form of asking patients to pay extra for obtaining drugs seems to be dwindling.

Another area offering possibilities for petty corruption concerns the shelf life of drugs. Expired drugs need to be taken off the shelf. If there are no mechanisms in place to ensure that they are disposed of, then unscrupulous health personnel can keep the drugs, remove the expiry dates and sell these drugs to unsuspecting clients at different levels of the distribution chain.³

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

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

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

Recruitment, Personnel Relationships, and Dealing with the Public

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

³ This practice seems to be less widespread in Rwanda than in other neighboring African countries.

While improved standards are essential, the recent upgrading of requirement criteria may encourage some candidates to falsify their records and recommendations. The need to fill a post or to maintain services may push officials to hire candidates not meeting the official requirements. Subjective criteria often affect hiring—friendship, nepotism, gender and social discrimination. Old practices persist, though on a smaller scale. Applicants may seek to influence members of recruiting committees. In some cases, successful candidates may give a month’s salary even when not solicited. The power to assign scholarships and participation in national and international seminars also opens up opportunities for favoritism and other forms of corruption.

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

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

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

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

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

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

⁴ USAID Capacity Project, *Etude sur la Violence en milieu de Travail dans le Secteur de la Santé au Rwanda, Rapport Final* (Kigali, July 2008).

- Offer higher salaries and long-term benefits to encourage high performance health sector personnel to stay with MOH. This may not be feasible without a broader civil service reform and significant increases in GOR revenues coming from domestic sources rather than international funding.
- Develop mechanisms for better communications and relationships between health providers and patients such as suggestion boxes, question and answer sessions, procedures for processing patient complaints, etc. Build upon and adapt the PAQ mechanism that has been developed by the Twubakane project.
- Provide training to improve transparency, open discussion and trust among health personnel in the workplace taking into consideration gender, social, and cultural differences.
- Integrate measures to stop violence and discrimination in general and gender violence and discrimination in particular in the workplace and in treatment of patients as a key component of the MOH's Human Resources Strategy. These measures could include a MOH conduct code concerning patient rights and health personnel obligations stressing the need to fight against gender discrimination and violence, workshops to bring these issues out in the open and to find solutions, and the enforcement of sanctions on those blatantly engaging in gender and other forms of discrimination.

Financial, Material, and Human Resource Management

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

While impressive efforts have taken place at the national level to put into place modern managerial systems and anticorruption controls—e.g. computerization systems to track personnel and expenditures,⁵ rationalization of recruitment and procurement procedures, higher skill levels for health sector personnel, and improved data collection systems—these efforts have been less successful at the district and grassroots level of the health system because of major deficits in capacity due to shortages of skilled personnel, the complexity of national level management systems, regulations and data collection techniques, lack of experience and difficulty of integrating local government and health sector institutions and functions, and the limited effectiveness of monitoring and other control mechanisms.

The General Audit report indicates that officials still use health sector vehicles, gasoline, and supplies for personal use. Thus, one finds examples of District level MOH vehicles being registered by private individuals. Bookkeeping procedures, particularly by those responsible for collecting money for services, have been lax. In the past, health professional technicians, such as doctors and nurses with little managerial experience had the responsibility for financial management of district and sector level health facilities. Before the implementation of decentralization reforms, local government and district level health officials had little involvement in formulating plans at the local level since planning was top down,

⁵ For example, the MOH now has the capacity to produce a computerized list of its 9,727 employees and provide a breakdown by category and geographical distribution. Computerization has drastically reduced the possibility of inflated numbers of personnel on the payroll who collect salaries without actually working. The National Health Account (NHA) system also provides the MOH with a useful tool for tracking actual health sector expenditures rather than budgetary projections.

reflected national priorities, and was implemented in vertical national programs. The elaboration of District Development Plans (DDPs) gave more initiative and autonomy to district level officials both elected and technical and required that they learn planning skills.

A 2008 District Capacity Building Assessment highlighted the major challenges in the system---lack of knowledge and understanding of the legal framework, especially at the lower levels; ministries not honoring pledges to transfer resources in time, service delivery and monitoring of staff at the sector, cell, and community hampered by lack of adequate transport for staff to travel; weak public financial management in budget execution, accounting, procurement, internal auditing, and financial management; weaknesses in procurement systems, no monitoring systems to monitor implementation of DDPs; and little consultation by national level institutions in elaborating policies ⁶

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

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

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

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

- Provide more training in fiscal management and health administration at all levels of the system
- Increase transparency in sharing information concerning national and district health accounts to better assess leakages of financial resources by the MOH's disseminating this information to District Hospitals, Health Centers, local government units, civil society organizations concerned with health issues, and private sector health providers.
- Simplify data collection systems and reduce the number of core indicators to measure results in the health sector. Each donor agency has its own set of core indicators, thus placing a heavy burden on MOH officials to provide many sets of data. Fortunately, donors and the MOH are aware of this issue and have formed a group to explore ways of reducing the number of core indicators and harmonize data collection. These efforts should be strongly supported.
- Simplify reporting systems and reduce frequency of reports.

⁶ See MINALOC/MIFOTRA, *District Capacity Building Needs Assessment, Findings and Recommendations* (Kigali, 17 March 2008).

- Strengthen efficiency and credibility of district level tender boards by providing training to members, simplifying rules and procedures, and getting the private sector and civil society more involved in overseeing these institutions
- Provide mechanisms for documenting, archiving, and sharing information concerning lessons learned and best practices concerning financial and human resource management, anti-corruption institutions, planning, customer relationships, and IEC.
- Provide sufficient offices, equipment, and transport facilities to enable health personnel to meet its reporting and monitoring requirements and to supervise field personnel. The absence of sufficient funds for gasoline and vehicle maintenance and replacement hinders the capacity of local level health units to monitor and supervise grassroots operations and health personnel.
- Hire more personnel and provide training to fill gaps in key areas where there are shortages. For example, there is a chronic shortage of gynecologists, midwives, and adequately trained TBAs which are needed to reduce maternal and infant mortality rates.
- Reorient donor programs to support MOH efforts to recruit, retain, and expand health and managerial staff in critical areas which need more and better trained personnel
- Provide opportunities for existing health staff to upgrade skills to prevent losing experienced personnel. For example, new rules call for hiring A0 and A1 nurses to replace A2 nurses who currently constitute the core foundation of the health system at the grassroots level. Many A2 nurses are leaving for lack of incentives to stay. Since it takes 3 years to train an AO level nurse, it might be more efficient and less disruptive to offer A2 nurses training programs to upgrade their skills to A1 or A0 levels.

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

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

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

The CBHI system is exposed to corruption vulnerabilities due to a number of factors including: the rapid growth and newness of the system; the insufficient numbers, lack of experience, and low salaries of Mutuelle officials and managers; inadequate office space and equipment, the lack of understanding of and conformity with Mutuelle rules on the part of community mobilization committees and sectional management committees; limited transport resources available to Mutuelle managers to make field visits to supervise and monitor community volunteers; discretionary powers in naming needy individuals to

obtain insurance free of cost; and lack of transparency concerning billing. These challenges are compounded by weak fiscal management skills, the lack of computers and well defined procedures to track the flow of money and to conduct effective audits. There also seems to be a shortage of national level Mutuelle officials and limited mechanisms to supervise district and lower level Mutuelle staff.

Records indicate that premiums collected at the community level do not always arrive at the Mutuelle offices. It is difficult to allocate blame because of poor bookkeeping records. For example, corruption could take place at the community level in several ways. First, the person charged with collecting premiums might give an individual a receipt for payment without actually collecting any money as a favor or in exchange for a bribe or a gift. Second, the collector could collect the money, give a receipt to the individual, and keep the money. In this instance, the person who paid the premium would not be adversely affected because he would have the receipt entitling him to access to health services. It would also be possible for Mutuelle managers to manipulate accounts to show that his office received less money than actually received.

The designation of those capable of paying premiums as indigent constitutes a corruptive practice as does the non-designation of the needy as indigent.⁷ The first deprives the system of funds and gives the beneficiary a free ride. The second deprives access to health care facilities for needy persons not on the list. Two other corruptive practices fostered by weak control mechanisms consists of health service facilities and providers overcharging for services paid for by the insurance program and prescribing more drugs to patients than actually needed since the cost will be paid by the insurance program. Low salaries, an avalanche of paperwork, and weak control mechanisms also provide temptations for Mutuelle managers to cut corners in reporting, falsifying records, and misappropriating funds.

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

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

- Reduce paperwork of Mutuelle section managers and explore the feasibility of raising their salaries when revenues generated by CBHI programs increases.
- Provide training to Mutuelle personnel and section managers in using new Mutuelle fiscal management manuals to learn proper procedures for registering members, collecting premiums, giving receipts controlling rights to services of members, billing of health providers, etc.
- Train community auditors to monitor payment of premiums, bills, and transfer of funds and ensure that external District level Mutuelle auditors check sectional and community level Mutuelle accounts at least once a year to reduce misallocation and embezzlement of funds
- Provide training to community mobilization committees and section management committees concerning Mutuelle rules and regulations and their responsibilities as members of these committees.
- Provide sufficient logistical support- vehicles, motorbikes, gasoline, -- to enable sector personnel to make field visits to communities and supervise community level volunteers and committees.

⁷ The Global Fund is providing \$34 million dollars over a four year period to cover the costs of the 800,000 Rwandans listed as indigents who are covered but not paying dues.

Traditionally, donors are reluctant to fund these expenditures after their projects are completed or in areas where they are not working. Donors may need to rethink their traditional opposition to financing “recurrent costs” and create a joint resource pool in collaboration with the MOH and MINALOC to help fund these essential expenditures needed to insure proper monitoring and supervision of grassroots operations. Over time, as Rwanda experiences economic growth and its capacity to increase government revenues, support for recurrent costs could gradually be phased out. For its part, GOR will also need to make a greater effort to provide more funding for grassroots operational costs.

- Use “Ubudehe” cells at the community level to compile lists of indigents based on the “Ubudehe” method of identifying indigents in the health Mutuelles⁸
- Limit premium subsidies only to indigents and eliminate those capable of paying from indigent list
- Place a Mutuelle agent at the DH level to verify and monitor billing at DHs to reduce overbilling and over prescription of medicines to CBHI patients
- Integrate Mutuelle management and community mobilization committees and Mutuelle employees to benefit from PBF and c-PBF incentive systems.

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

The MOH defines Community Health “as a holistic and integrated approach that takes into account the full involvement of communities in planning, implementation and evaluation processes.”⁹ It sees communities as an essential determinant of health and an indispensable ingredient for effective public health practice. In elaborating Community Health policies, the MOH notes the need to take into account local culture, norms, belief systems, institutions, and politics.

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

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

Incentives will go to CHW cooperatives rather than to individuals. Thus, CHWs will be encouraged to organize cooperatives to generate incomes and as a pre-condition for receiving c-PBF incentives. Sound cooperative principles affirm that voluntary organizations organized at the initiative of its members who

⁸ The Ubudehe method trains community members to work together to define and analyze local problems, come up with solutions, and take collective action to resolve the problem. The methodology was introduced in Rwanda by Action-Aid and can be applied to deal with all kinds of problems, not just those involving health services. For more on the methodology, see Ubudehe Policy Group, *Ubudehe in Rwanda: Community Collective Action* (Kigali, nd).

⁹ Ministry of Health, *National Community Health Policy* (Kigali, March 2007), 2.

pool their resources to engage in common economic activities are usually the most successful. The MOH sees cooperatives as a an instrument for providing financial support to CHWs and a substitute for paying CHWs. Top-down approaches to organizing cooperatives usually do not succeed when members have little ownership of these institutions and join because of government pressures and/or benefits provided by the government rather than as a spontaneous response to market incentives. Members of economic cooperatives usually engage in full-time economic activities. CHWs working long hours under the current CHW program may not have much spare time or energy to engage in income-generating activity. Nor do CHW members necessarily share similar or adequate skills to earn a profit from their economic activities. Though CHWs are trained to be health service providers, they are asked to earn money through other activities. It remains to be seen whether c-PBF incentives will be sufficient to keep CHWs motivated.

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

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

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

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

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

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

- Simplify data collection procedures and develop performance indicators which are more relevant to health conditions and needs in specific Districts by reducing the number of data indicators elaborating indicators which address the major health issues and MOH and citizen rather than donor priorities in specific districts.
- Explore the possibility of building upon and adapting cultural traditions and institutions based on community solidarity and reciprocity norms traditionally used by the community to manage community affairs to monitor and sanction corruptive practices in the community today.
- Replicate the Twubakane Project's PAQ (*Partenariat pour l'Amélioration de Qualité*) model for community involvement in health sector activities which fosters collaboration between local government representatives and civil society groups to set up commissions to deal with health issues decided by the group. This kind of collaboration increases transparency, builds trust, and provides the community with opportunities to monitor health service delivery and influence community health sector priorities.
- Provide more training in human resource and fiscal management skills to directors of HCs charged with supervising CHWs
- Rethink the policy of mandating CHWs to organize cooperatives as a precondition for receiving c-PBF incentive payments. If cooperatives are formed, provide training to cooperative members in financial management, elaboration of business plans and feasibility studies, and the skills needed to engage in specific income generating activities.
- Provide training to community members involved with district administration in basic skills in health governance and financial and administrative management as citizen responsibilities and oversight functions increase with the next phase in the implementation of decentralization reforms.

STRATEGIC RECOMMENDATIONS

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

SUMMARY OF STRATEGIC ANTICORRUPTION PROGRAM OPTIONS FOR RWANDA PUBLIC HEALTH SECTOR

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

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

Many of the problems and issues raised in the health sector as in other sectors are due to the low capacity of the GOR in human, financial and material resources rather than to rampant corruption. Good governance calls for a high degree of transparency and accountability. These two governance practices provide two important safeguards against corruption. Efficiency depends upon professional technical and managerial skills to get the most out of existing resources. The GOR and MOH deserve much credit for

working hard to implement decentralization reforms and improve the living standards and health of their people by insuring greater access to public services and preventing the squandering of limited resources through corruptive practices. It remains to be seen whether the rapid pace of change can be sustained and serious mistakes avoided in the future. This assessment concludes that the GOR would benefit from soliciting more feedback from the people and giving the people more leeway to develop their own solutions and modes of organizing to solve their problems at the local level.

LIST OF PERSONS CONTACTED

Rwanda Ministry of Health

Dr. Jean Damascène Ntawukiliryayo, Minister of Health
Dr. Claude Sekabaraga, Director of Planning
Dr. Nizeyimana Bonaventura, Director of Health Service Quality
Fidèle Karanwa, Deputy Budget and Finance Director
Hertilan Inyubuga, Coordinator of Cellule Technique d'Appui aux Mutuelles de Santé
Theobald Hategekimana, Director-General, University Teaching Hospital of Kigali (CHUK)

CAMERWA

Ambassador Zephyr Mutanguha, Director General
Fidele Ndiayisenga,
Geoffrey Ngwive, Consultant, coordination of procurement and Drug Distribution System

GOR National and Local Institutions

Peter Ruyumbu, Commissioner for Quality Assurance Department, Rwanda Revenue Authority
Pascal Bizimana, President, National Independent Review Panel for Public Procurement
Bernard Kayiranga, Head of Legal Affairs Unit, RPPA
Elysée Nsenyaremye, Administrator Gitwe Hospital
Vedasate Rudasingwa, Human Resources Manager, Gitwe Hospital
Frodvald Nyilishema, Health Director, Ruhango District

Political and Civil Society Organizations

Mike Rugema, Deputy, V.P. of Economic Commission, and head of APNAC Rwanda
Anicet Kayigema, Executive Secretary, Consultative Forum of Political Organizations in Rwanda
Charles Carbonaro, Journalist
Ignace Baraho, CEO of STRATEGIKA consulting firm and former Executive Director of NTB
Léon Fundira, pharmacist and President of Association of Rwandan Pharmacists

Donors

Dr. Jean Marie Tromme, Coordinator of Belgian Technical Assistance at MOH
Dick DeClercq, First Secretary, Health Specialist, Belgian Embassy
Celestin Karamira, Technical Assistant, Health Sector, GTZ
Alexis Kamurase, Health Specialist and Operations Officer, World Bank
Diane Muhongerwa, Health Finance Specialist, World Health Organization
Joseph Mwangi, CPA, Audit Team Global Fund,
Tristan Burton, Advisor, Public Finance Management, Audit Team,

USAID/Rwanda

Dennis Weller, Director
Tye Ferrell, Democracy and Governance Officer
Guillaume Bucyana, Governance Specialist
Jessica Forrest, TDY and CTO for Rwandan Health Sector Corruption Assessment
Mahita Mishra, PEPFAR Program Manager
Wayne Stinson, PMI Advisor
Patrick Condo, Malaria Specialist
Christianna Pangalos, Health Commodity and Logistics Technical Advisor
Soukeynatou Traoré, Senior Health Advisor

Erick Kagame, Maternal and Child Health Specialist

USAID Implementers

Pascal Bijeveld, Country Director, Clinton Foundation HIV/AIDs Initiative

Caroline Healy, SCMS Lead Resident Advisor

Dr. Ousemane Faye, Chief of Party, IntraHealth Capacity Project

Constance Newman, Senior Technical Advisor, Intra-Health, Capacity Project

Laura Hoemecke, Chief of Party, Intra-Health International, Twubakane Project

Dean Swerdlin, Decentralization and Policy Team Leader, Twukabane Project

Antoinette Uwimana, Decentralization Activities Coordinator, Twubakane Project

Francoise Ukulikiyabandi, sociologist, Health Financing Associate, Twubakane Project

Anatole S. Kaboyi, DIF Grants Manager, Twibakane Project

Jean Paul Kagarama, DIF Grants Assistant, Twubakane Project

Mame Abdoulaye Guèye, Resources Mobilization, Health Finance and Facilities Advisor, Twubakane Project

Dr. Defa Wane, Quality and Community Health, Twubakane Project

Dr. Pascale Musoni, Mutuelles and Child Survival specialist, Twubakane Project

US Embassy

Cheryl Jane Sim, Deputy Chief of Mission

REFERENCES

- Azfar, Omar, "Corruption and the Delivery of Health and Education Services," in Bertram I. Spector (Ed.) *Fighting Corruption in Developing Countries; Strategies and Analysis* (Bloomfield, CT: Kumarian Press, Inc., 2005), 181-212).
- Bizimana, Jean Damascène and Paul Kananura, *Etude et Proposition d'un Projet de Prévention, Lutte et Repression de la Corruption dans la Magistrature Rwandaise* (Kigali, transparence Rwanda, December, 2006).
- Bossert, Thomas J., "Decentralization and Governance in Health," www.HealthSystems2020.org, (June, 2008), 1-16.
- Brinkerhoff, Derick, "Health Governance: Concepts, Experience, and Programming Options," www.HealthSystems2020.org, (February 2008), 1-30.
- Burnett, Jennie E., "Rwanda," in Freedom House, *Countries at the Crossroads 2007*(Washington, DC: 2008), 1-26.
- Casals & Associates, *Anti-Corruption Workshop and Technical Assistance, USAID/Rwanda.Health Sector, February25-29, 2007, Final Report*. Alexandria, VA, n.d.
- Checchi and Company Consulting, Inc., *Africa Bureau Anti-Corruption Initiative (ACI) Mid-Term Evaluation, Final Report* (Washington, DC, USAID, July 2006).
- Chr. Michelsen Institute, "Corruption in the Health Sector," www.U4.no, U4 issue 1:2006.
- Chr. Michelsen Institute, "Overview of Corruption in Rwanda," www.U4.no, April 16, 2008.
- Cross, Peter, *Strengthening CAMERWA's Financing and Financial Management Systems* (Kigali, SCMS, May 28, 2008).
- European Union Election Observation Mission, "2008 elections prove a sound basis for further reform" (Kigali, September 17, 2008).
- Friday, Barbara, *Corruption: What is corruption, why does it matter, what can we do? Local Governments Workshops, Kigali, Rwanda, March 9 and 10, 2007* (Kigali. 2007).
- Gellar, Sheldon, Anicet Kayigema, and Sharon Moris, *Civil Society in Rwanda: Assessment and Options* (Burlington, VT, ARD, 2001).
- Inyarubuga, Hertilan, *Les Mutuelles de Santé au Rwanda*, (Powerpoint Presentation). Kigali, n.d.
- Kayira, Fidèle, *Using Ubudehe (Local Collective action) to identify poor households to enter Mutuelles* (Powerpoint Presentation, Kigali, 2008).
- Kimonyo, Jean-Paul, Rwanda, *Un génocide populaire* (Paris: Karthala, 2008).
- Kolstad, Ivar and Odd-Helge Fjeldstad, "Fiscal decentralization and corruption: A brief overview of the issues," *U4issue, e3:2006*

- Manning, Judy, Kamden Hoffmann, and Jessica Forest, *Rwanda Community Health Needs Assessment* (Kigali: USAID/Washington, September 10, 2008)
- MCC Scorecard, *Rwanda FY2008*.
- MINALOC/MIFOTRA, *District Capacity Building Needs Assessment, Findings and Recommendations* (Kigali, March 17, 2008).
- Republic of Rwanda, Ministry of Local Government, Good Governance, Community Development and Social Affairs, *Rwanda Decentralization Strategic Framework: Towards a sector-wide approach for Decentralization implementation* (Kigali, August, 2007)
- Republic of Rwanda, Ministry of Local Government and Social Affairs, *National Decentralization Policy* (Kigali, May, 2000).
- Republic of Rwanda, The Office of the Ombudsman, *Summary Report of the Activities of the Office of the Ombudsman in 2007*. Kigali, January 2008.
- Republic of Rwanda, Rwanda Revenue Authority, *Annual Report 2006*, Kigali, May, 2007
- Republic of Rwanda, Ministry of Health, *National Community Health Policy* (Kigali, March, 2007)
- Republic of Rwanda, *Rwanda Health Strategic Plan, HSSP I, 2005-2009, Evaluation Report* (Kigali, July 24, 2008).
- République du Rwanda, Ministère de la Santé *Plan Stratégique de Santé Communautaire* (Kigali, February-March, 2006).
- République Rwandaise, Ministère de la Santé, *Document de Politique de la Décentralisation du Ministère de la Santé* (Kigali, April 2003).
- République du Rwanda, Ministère de la Santé *Politique de Développement des Mutuelles de Santé au Rwanda* (Kigali, 2004).
- République du Rwanda, Ministère de la Santé, *Procédures de Gestion Financière d'une Mutuelle de Santé* (Kigali, May, 2008).
- Smith, Zeric, Timothy Longman, Jean Paul Kimonyo, and Théoneste Rutagengwa, *Rwanda Democracy and Governance Assessment* (Washington, MSI, November 2002)
- Spector, Bertram I., Michael Johnston, and Svetlana Winbourne, *Corruption Assessment Handbook, Final Report* (Washington DC: USAID, May 16, 2008).
- Spector, Bertram I. (Ed), *Fighting Corruption in Developing Countries: Strategies and Analysis* (Bloomfield, CT: Kumarian Press, Inc., 2005).
- The Steadman Group, *Report on the assessment Study on Corruption at the Northern Road Corridor Transit Points* (Kigali, July 2007).
- Transparency Rwanda, *Rwanda, Etude du Système National d'Intégrité* (Kigali, January, 2008)
- Transparency Rwanda, *Séminaire atelier sur "la lutte contre la corruption dans les marchés publics," Kigali, Serena Hotel, July 25, 2008. (Kigali, 2008/*
- Ubudehe Policy Group, *Ubudehe in Rwanda, Community Collective Action* (Kigali, n.d.)

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

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

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

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

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