Fighting health sector corruption in uganda: the deliverables must change

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Uganda is often ranked as high in corruption in Transparency International (TI)'s Corruption Perceptions Index (CPI). TI rates countries basing on a scale of CPI scores ranging from 0 to 10, where 10.0 is the score of the cleanest and 0.0 is that of the most corrupt country. Although Uganda's position improved from 130th out of 180 countries surveyed in 2009 to 127th out of 178 in 2010, it retained the same CPI score of just 2.5 (Transparency International, 2010). Apart from Rwanda (score 4.0), other regional countries obtained comparable scores (Ethiopia 2.7, Tanzania 2.7, Kenya 2.1, DRC 2.0, Burundi 1.8, and Sudan 1.6). There are always accusations of lack of political will to fight corruption in government because it is perceived to be perpetrated by government officials and their family members, and supporters of the ruling National Resistance Movement (NRM) party. Corruption has become a "*Kit"* (Luo, a Ugandan language: Culture). In response to "*Kit Corruption"*, the government has created a number of institutions to fight corruption at different levels, such as the Inspector General of Government (IGG), and departmental units such as the Police Standards Unit (PSU) and the Educations Standards Agency (ESA). Reportedly, the health sector is one of the most corrupt sectors in Uganda, an image enhanced by a recent history of widely-publicised corruption scandals like those which affected funds from the Global Fund and Global Alliance for Vaccines and Immunisation (GAVI). Yet, the sector did not move to establish a sector inspectorate similar to those in some other reportedly corrupt departments. Brian Tracey, the famous Management specialist and teacher, often says that if you do not plan for yourself, you soon become a part of other people's plans. The 2009 creation of the Medicines and Health Service Delivery Monitoring Unit (MHSDMU) by the president, to investigate allegations of all forms of mismanagement of health care resources in Uganda, was meant to fill this gap.

The unit was, however, received with mixed feelings in the country. According to the views expressed on the issue in the local media and health policy corridors, to some it was a final admission of the guilt that had always been denied by the ruling NRM party, of the existence of corruption in its government. To others, it was *"too little, too late"*, the creation of *"yet another state bloodhound"*, *"another toothless bulldog"*, *"an extra burden on the taxpayers"*, *"a reward to NRM cadres"*, *"a political gimmick to hoodwink the population in thinking that the government is interested in dealing with corruption, in preparation for the 2011 general elections"* etc. However, to others, it was a case of *"at least* (and at last) *something will be done to restore service delivery"*, *"our government is working"*, *"better late than never"* etc.

Several factors served to stir the emotions. The first was the surprise, *"unilateral"* and *"irregular"* creation of the unit without going through the usual channels and stages of cabinet and parliament debate, where even the opposition could also discuss its composition and functions. The second was the personal involvement of the president in the creation of the unit. The third was the location of the unit under State House (officially, the residence of the president), and not under the line ministry, under other corruption-fighting agencies or under the Office of the President which handles other office matters pertaining to the presidency. The fourth was the appointment of somebody variously reported to be *"too junior"*, *"inexperienced and unqualified in such matters"*, *"a loyalist"*, *"an NRM cadre"*, *"a family member"* etc, to head the unit. The second, third and fourth concerns above portrayed the unit as serving the president's personal interests, not those of the wider public. The fifth factor was the initial absolute lack of information to the media, parliament and public about its size, composition, scope of work and work methods. This portrayed it as being a security or political outfit out to hound those politically opposed to the government. The sixth factor was the timing of its creation, coming at a time when there was no heated debate about abundant corruption in the health sector (the "bad times" of health sector scandal had come and gone with little action) and, most importantly, coming less than two years before an election. This was reminiscent of the abolition of user fees on the eve of elections in 2001, which significantly contributed to favourable outcome for the ruling NRM. The seventh factor has been its work methods, which are similar to those of security intelligence bodies. There could have been other perspectives and this list does not claim to be exhaustive. However, all these factors led to shrouding the unit in mystery and speculation about its purpose.

In the face of such largely negative perception from the outset, however, the unit had to be seen to deliver on its

said mandate, with the public anxiously waiting to see its outputs in order to confirm or drop their suspicions. The unit enthusiastically embraced its work, and set up three toll-free telephone hotlines [(+256) 0800100447, 0414288445 and 0414288442] to receive complaints regarding the mismanagement of medicines in health services. At the time of its creation, it was actually called a Drugs Monitoring Unit (DMU), because of rampant complaints about the near-permanent lack of medicines in health facilities. Although health workers reported that medicines were not arriving from the central National Medical Stores (NMS), the public believed the medicines to have been pilfered by health workers. Uganda operates a system whereby the NMS receives all funds for medicines from the government, purchases the medicines from foreign manufacturers, stores them and distributes them to the peripheral health facilities. This is, ostensibly, to guarantee quality up to the district and occasionally to the service delivery point, especially for those medicines dependent on a cold chain, and to guarantee that the medicines actually reach the districts. However, there are reports that, often, NMS staff too does not deliver their luggage to the districts (OAG Uganda, 2010).

The initial task of the MHSDMU was, therefore, to track medicines supplied from the NMS to their intended destinations, and to receive reports about which health workers stole medicines. However, the unit quickly realized that the problems of health service delivery in Uganda go far beyond the diversion of medicines. Although medicines are both a visible physical indicator of the existence of a health service and a proxy indicator of the perceived quality of care, most of the complaints received were about other aspects of health service delivery. High levels of staff absenteeism, corruption in allocation of tenders for construction of health facilities, supply of "air", poor quality construction of facilities, existence of ghost health workers and even "ghost" health units (complete with ghost buildings, ghost cars, ghost compounds and ghost staff) were reported. Some of these were reported even within the outskirts of the capital, Kampala. It became clear that the mandate of the DMU had to be widened beyond just medicines, hence the renaming of the unit to MHSDMU. Officially, therefore, a health sector inspectorate was born, not just a DMU.

Deliverables

From the outset, the "deliverables" of the unit have always been publicly stated to be people – "the corrupt officials". In this respect, the unit has delivered (to use Ugandan speak) a number of "small fry" and "big fish" ranging from unqualified health workers in remote health centres all over the country, through district health officers, senior planners at the Ministry of Health headquarters, to the director of a national referral hospital. However, some of those "delivered" accuse the unit of weak investigative capacity and impulse action, without sufficient evidence in some cases. Apparently, some people have reported their colleagues to the unit to solve local vendettas. One very senior official also said "*if the president has the money to pay those young doctors such a high salary to investigate us, why can't he pay the consultants the same amount and he sees if they do not report for duty?*" In its methods of work, the MHSDMU has continued to work like an intelligence body. Usually, nobody knows when it will visit his/her district or office.

Failed efforts

This paper argues that the emergence of this unit is a consequence of failed previous efforts to improve service delivery. Some of this failure can be linked to corruption or simply due to a lack of clear implementation strategies and plans. We highlight just a few examples.

In the early 1990s, the Ministry of Health set up a Department of Quality Assurance (QA). It was a promising unit and did a lot to raise awareness about and interest in health care quality in Uganda. At a time when health sector reform was the buzzword, quality assurance efforts took centre-stage in the ministry. No wonder, therefore, that the former head of the QA department soon became the overall Director General of Health Services in Uganda. He brought a QA perspective into the reform process and the concept of Area Teams (AT) was readily incorporated into Uganda's first ever Health Sector Strategic Plan (HSSP I). Area Teams were teams of experts constituted at the Ministry of Health level, at times incorporating experts from the private sector and regional hospitals, which would make scheduled support supervision visits to districts, hospitals and lower level health units. The experts would work with the staff on the ground, identify and discuss the problems, train staff on how to avoid similar weaknesses in future and even make a call-back to check on the progress since the last visit. It was a strategy well appreciated by the health workers, who did their best to improve their performance despite the shortage of supplies. However, it was a pioneer action, which did not reach its fifth birthday. Within five years, Area Teams and support supervision were effectively no more.

In an attempt to replicate, entrench, expand and regionalize the previous Ugandan success in quality assurance, new projects to train in quality of health care were started in the country, some with a regional or continental focus. Within five years, though, they are probably known more outside Uganda than within. Their legacy on the local health system will be a subject of intense soul-searching in the future. In the meantime, the quality of care has continued to decline.

Another effort that failed was the "pull" strategy for purchase of medicines by the health facilities. Under the strategy, NMS was to stop automatically sending pre-packaged medicine kits to the health units every three months (the "push" system). Instead, funds for purchase of medicines for each health facility would be put at the

NMS, as a "Credit Line". Each health facility would make its requisition directly to the NMS and order for only those products which it needs, progressively reducing its credit at NMS. The NMS was a privileged supplier to government health facilities. Only those products not available at the NMS would be bought in private pharmacies after the NMS issued a Certificate of Non-Availability (OAG Uganda, 2010). This "pull" system was meant to avoid the heavy losses that had been observed under the "push" system where unwanted medicines accumulated and expired in some facilities where they were not needed, while facilities which needed them elsewhere in the country experienced shortages (Nazerali et al, 2006). However, the NMS is addicted to the "push" system. Until now, even when medicines are not available and are not about to arrive, the NMS resists issuing the Certificate of Non-Availability (OAG Uganda, 2010). In addition, NMS still insists on physically delivering all medicines to the consumer health units and districts. However, their delivery schedule, although clearly written and displayed, is not adhered to, slow and unpredictable. Often, they have to wait until they have sufficient orders from a given region before they send their truck. By that time, health units are over two months out of stock in essential medicines and supplies. Much to chagrin of the health workers, NMS still includes products which were not ordered for, some with a short shelf-life (OAG Uganda, 2010). This supplier-induced demand is often to exhaust the available funds within the bounds of the financial year. This addiction to the "push" persists despite evidence that availability of medicines is much better with the "pull" system not tampered with (Tumwine et al., 2010). NMS officials continue to argue that it has reserve managerial capacity to do all the procurement, quality assurance, storage, sales and delivery of Uganda's pharmaceutical needs, but that it only lacks funding, since most of the medicines they store are purchased by "third party" donors for vertical programmes. TheNMS only acts as a store and is paid demurrage charges (Sewanyana et al., 2010).

The Health Sub-District, which was meant to bring supervision and service delivery closer to the population, has failed to stabilize due to lack of infrastructure and human resources, despite its heavy financial cost. Unfinished, poorly constructed health centre buildings without medical equipment, and incomplete doctors' houses dot the whole country, abandoned by the districts which have no resources to complete them. No systematic value-for-money audit has been conducted on the health facilities. The entire strategy is at stake.

Misuse of medicines

Without supervision and sure that nobody will check on them, health workers sought to bridge the gaps created by poor pay and loss of income through abolition of user fees by doing private work during office hours and pilfering government medicines for use in their private clinics or for re-export. In response to multiple complaints about pilferage of medicines, the government directed the NMS to label all government medicines in order to prevent them from being pilfered. Capsules, syringes and gloves were to be labeled and tablets were to be embossed. Anyone caught with them in private hands would be penalized. Despite the high additional cost of these measures, the medicines continued to disappear. New rackets, only brought to light recently, emerged, which would exchange Uganda government medicines with counterpart rackets from the neighbouring countries. Uganda government medicines would be sold in Kenya or DRC, while Kenyan and DRC medicines would be sold in Ugandan private clinics. It was reported recently that since the MHSDMU started its work, it has recovered stolen medicines worth UGX 5bn (about $2.5m) (Radio Sapientia, 2011).

Conclusions and solutions for debate

The situation described above shows that Uganda's health system has some well-known and manageable weaknesses but that the correct actions have not been taken by the responsible people. This gap, therefore, called for several actions, an inspectorate being just one of them. This paper argues that the MHSDMU is not *the* lasting solution to the question of weak health service delivery in Uganda, but rather, stronger systems. Our proposals to address the problems which currently form the docket of the MHSDMU are as follows:

a) There is need to rejuvenate, facilitate and strengthen the Department of Quality Assurance in the Ministry of Health, to enable it to do its duty of ensuring adequate support supervision of the health services. It is an integral department of the Ministry of Health and stands better chances of being sustainable than the MHSDMU project. The MHSDMU can then ensure that the Department of QA does its work.

b) There is need to uncouple and segregate NMS functions and duties in order to improve efficiency and transparency in the management of medicines. As an expert bulk pharmaceutical procurement, storage and sales body, the NMS does not have to be involved in the delivery of medicines to rural health facilities. At a time when the unemployment rate is over 50%, private sector specialist medicine transporters with accredited facilities, appropriately monitored by relevant government agencies, could serve this transport function better than NMS, as well as create new employment. This would shorten the lead-time and reduce on the current stock-out. Uganda has successful local examples of these proposed changes to learn from. As they say in some Ugandan languages: *"Amagezi murro, ogaiha nju eri"* (Rutooro) or *"Ubwenge burarahurwa"* (Kinyarwanda/ Rufumbira): Knowledge is like fire, you can obtain it from your neighbour. First, the private-not-for-profit (PNFP) health sub-sector in Uganda uses a private pharmacy, the Joint Medical Store (JMS) for bulk external procurement, storage and sales, just like the

NMS. PNFP health facilities purchase from them individually, never lose their medicines, and never have stock-outs due to late delivery because they pick their own medicines. Second, Uganda has the experience of improvement in service delivery after segregation of duties in a large parastatal. When the then inefficient Uganda Electricity Board (UEB) was segregated into the Generation, Transmission and Distribution components, service delivery improved in some aspects and it was also easy to see that inefficiencies mainly lay in the distribution. This segregation has also allowed local expertise in each of the three areas to develop, and it has generated new employment. The National Water and Sewerage Corporation (NWSC) has had the most successful segregation of duties, having separated water collection, distribution, billing and sewerage services. Although the NWSC uses the outsourcing model, the principle is the same – segregation of duties. For the NMS, the Procurement and Import function, the Storage and Sales function, and the Distribution function need to be segregated. After all, the quality assurance function for medicines has already been devolved to the National Drug Authority and the National Bureau of Standards. There is need to consider the operationalization options to apply after the segregation of the functions. The possibilities are outsourcing the different components, separation into three different government organs, or outright privatization of each one of those functions to enable the new bodies to compete with other expert providers of the same services in the country. This would ensure that the most competent providers do the service. Government would concentrate its efforts on quality assurance, and quality and availability of medicines would improve.

c) Most importantly, there is need to address the fundamental cause of why the health workers steal medicines. Their salary remains very low and with very valuable unchecked resources at their disposal, it will be impossible for the government to stop them from all forms of pilferage. They will beat any inspectorate in order to survive.

d) Whereas the president, perhaps in keeping with his ancestors' wisdom that: *"Ahu embuzi mbi eri, tosibikaho eyaawe"* (Runyankore: Do not tether your goat next to an ill-mannered one, lest it picks the same habits), wanted to keep the MHSDMU outside the health sector, and to demonstrate that the fight against corruption in the sector is something personal to him, its location in State House has bred a different connotation, as highlighted earlier. This paper recommends the transfer of the unit to an independent housing e.g. IGG's Office or directly Office of the President, for it to be seen to do a national, not personal duty. After all, justice must not only be done, it must be *seen* to be done.

In conclusion, an inspectorate for the health sector is a welcome and long overdue innovation. Its role should be wide, covering all the functions and services of the sector at all levels. However, it can only succeed in the long-term if it is credible rather than feared. To be credible, it has to be properly staffed, facilitated, and technical in its work. It has to use transparent and replicable methods of work and remain above reproach. The systems it is supposed to work upon (its substrates, so to say) must also be established, rendered functional through appropriate facilitation before they are checked. Its work is well cut out. For instance, it can investigate why Area Teams are no longer effective, alternative options on how best to eliminate the current delays in the delivery of medicines, how best to ensure quality of care, how best to build health facilities to good quality. In short, its primary deliverables must stop being people, but suggestions for new, improved systems. Thereafter, to finally defeat *"Kit Corruption"*, those caught in the wrong need to face the appropriate consequences, to stem deliberate wrongdoing which has become a norm.

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