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USAID GLOBAL HEALTH ANTI-CORRUPTION INTEGRATION HANDBOOK

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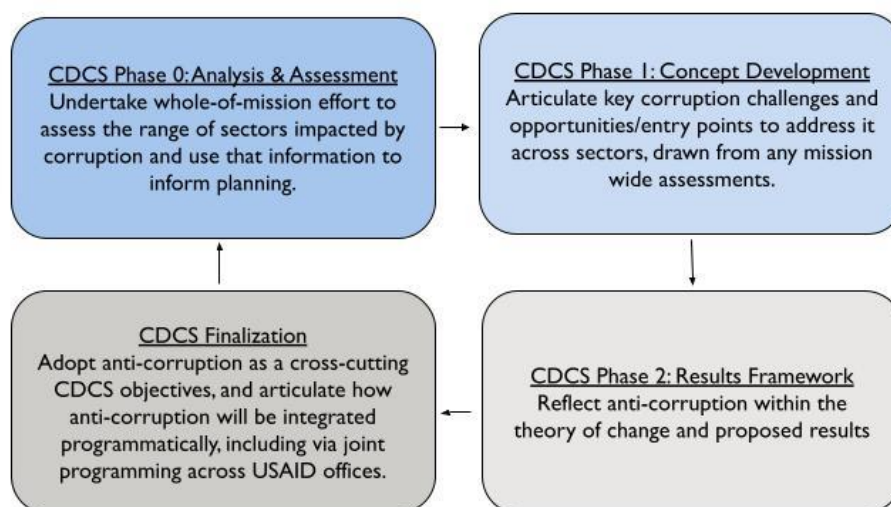
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Executive Summary

In line with the U.S. Strategy on Countering Corruption, USAID now defines corruption as “the abuse of entrusted power and influence for personal or political gain”. At the heart of this definition is the exploitation of power - both formal and informal - to divert, misappropriate or capture public resources, goods and access for personal and political purposes. Corruption in the health sector wastes scarce public health resources, undermines citizen trust in government, and ultimately leads to unnecessary deaths and illness. The World Health Organization (WHO) estimates that globally more than US\$400 billion in health resources are lost annually to corruption.¹ In low income countries, over 80 percent of people have experienced health sector corruption.² Moreover, corruption tends to impact the poor and vulnerable most acutely.

Health systems are complex with a multi-layered landscape of actors, each with potential drivers and forms of corruption. Within central governments and their devolved entities, Ministries of Health (MOH) or regulatory bodies may be subject to state capture and corruption in the development and application of pharmaceutical registration policies and procedures, health equipment standards, and quality control and inspections. MOH are vulnerable to nepotism or falsification of public health data. Public health procurement, contract management, and asset management are rife with corruption risks. Within subnational governments and at the service delivery level, patients might experience numerous forms of corruption including requests for informal payments or bribes, medical personnel absenteeism, ghost workers, dual practice (i.e., moonlighting), and referrals made on the base of personal profit - for example making a referral from a physician working in the public sector to his or her private practice for a service that could be provided in the public health system (i.e., self-referral). Citizens’ experiences with corruption – at all of these levels and points of service – fundamentally erode their trust in government and confidence in the health sector.

Figure. Integrating Anti-Corruption in the Program Cycle at the CDCS Level



USAID health teams engaging in activity design should explore these issues, and consider conducting assessments to understand how corruption impacts health outcomes. USAID has several tools to conduct health sector corruption assessment, including modules within the [Health Sector Assessment Approach](#), an adapted version of the World Health Organization [Health Systems Assessment](#), the USAID Global Health Supply Chain Risk Management Playbook, and USAID’s [Anti-Corruption Assessment Handbook](#). USAID also has numerous tools to






¹ Jones, B., & Jing, A. (2011). Prevention not cure in tackling health-care fraud. *Bulletin of the World Health Organization*, 89(12), 858–859. <https://doi.org/10.2471/BLT.11.021211>

² Holmberg S, Rothstein B. Dying of corruption. *Health Econ Policy Law*. 2011 Oct;6(4):529-47.

assess and mitigate corruption risks within the use of our health foreign assistance resources. Health teams are encouraged to use approaches like political economy analysis or systems mapping to better understand the underlying drivers of corruption. Based on the assessment of health sector corruption risks, USAID health teams are encouraged to integrate corruption considerations throughout the program cycle, and in particular into their Country Development Cooperation Strategy (CDCS) (see figure above) and activity design.

The health sector has a range of different approaches it might consider in order to integrate anti-corruption measures - regardless of the programming approach taken (e.g., working on anti-corruption from a cross-sectoral perspective or addressing corruption within a health program). Health teams may consider these approaches in the design of new programs or when engaging with partners on work planning. In all cases, health teams should seek opportunities to coordinate with, leverage, or co-fund anti-corruption activities with other pieces of the USAID portfolio, including - but not exclusive to - programs in the DRG space. The major categories of approaches are summarized in the table below.

Table. Categories of Global Health Anti-Corruption Approaches

Category	Description
 Transparency and awareness raising	Government and external actors rely on transparency to provide oversight and ensure accountability for the planning, use and delivery of public resources. GH programs may support: data transparency, access to information, and/or public awareness campaigns.
 Social and institutional accountability	Social and institutional accountability complement efforts to improve transparency and strengthen prevention and response. GH programs may support: parliamentary oversight, ombudsman or independence oversight, civil society oversight, private sector engagement, social accountability or engagement with interagency partners to better coordinate programming and diplomatic messaging.
 Prevention	Prevention approaches in the health sector reduce the ability of actors within the system to undertake corrupt acts. GH programs may support: improved administrative rules and procedures, leadership and change management, financial and supply chain management, training in ethics and the legal framework, innovative technology, theft and fraud deterrence, civil service reform and/or enhanced donor safeguards.
 Detection	To complement systems and processes that prevent corruption, it is important that health systems are able to detect corruption when it does take place. GH programs may support: audit capabilities and processes, management oversight, complaints and community feedback, development of whistleblower protections and reporting structures, and/or third party market surveillance.
 Response	When corrupt behaviors are detected in the health sector, it is important to have a clear and effective system to respond to those cases. GH programs may support strengthening of partner country systems to improve health sector corruption reporting and referrals, investigations, sanctions, and corrective actions.

During implementation of programming, monitoring, evaluation and learning is critical given the complex and dynamic nature of corruption. Moreover, it is important to build learning and adaptation into our programming, and share new approaches and lessons learned across Missions and sectors.

As part of USAID's broader effort to elevate anti-corruption efforts across the Agency, we are adapting our programming to transform the fight against corruption. To achieve this, health teams are being asked to become more agile to respond to windows of opportunity to address corruption in the sector, improve coordination across the agency and interagency, experiment with new approaches to tackle long-standing and deeply embedded forms of corruption in the health sector as well as new and evolving issues of transnational corruption and crime, such as illicit trade in counterfeit medicines. USAID's Global Health Anti-Corruption Integration Handbook provides a practical set of tools and approaches to advance this agenda.

USAID Global Health Anti-Corruption Integration Guide

SECTION 1: BACKGROUND

In line with the U.S. Strategy on Countering Corruption, USAID defines corruption as “the abuse of entrusted power and influence for personal or political gain”. Whether corruption is perpetuated by public officials or external actors, in all cases its defining characteristic is that the perpetrators seek to subvert the public good in service of narrow personal, economic, and political interests. At the heart of this definition is the exploitation of power - both formal and informal - to divert, misappropriate or capture public resources, goods and access for personal and political purposes. Corruption in the health sector wastes scarce public health resources, undermines citizen trust in government, and ultimately leads to unnecessary deaths and illness. According to the WHO, the world spends about US\$8.5 trillion on health services annually, of which more than \$400 billion is lost to corruption. This exceeds the estimated cost to fill the gap to finance global universal health coverage by 2030.³ The real world effects of corruption are staggering. Studies estimate that more than 140,000 annual child deaths may be indirectly attributed to corruption.⁴ Moreover, corruption tends to impact the poor and vulnerable most acutely. [Transparency International](#) notes that women and girls, youth, LGBTQIA+ individuals, and ethnic and religious minorities are particularly vulnerable to corruption because discrimination can result in greater exposure to or disparate impact of corruption, while these groups’ weaker social and political power creates barriers to challenging corruption and accessing justice. The impact of corruption in the health sector is widespread. In low income countries, over 80% of people have experienced health sector corruption.⁵ Citizens’ experiences with corruption – at all of these levels and points of service – fundamentally erode their trust in government and confidence in the health sector.

Corruption contributes to and is a symptom of weak health governance. Corruption in a health system demonstrates a lack of accountability and transparency, and may result from limited citizen voice.⁶ Efforts to combat these issues and strengthen health systems can therefore reduce or prevent corruption. The Agency’s [Vision for Health System Strengthening 2030](#) outlines a systems-based approach to achieve quality, equity, and health resource optimization, critical elements of a high-performing health system. For instance, strengthening community participation in the management of the health system, and increasing opportunities for social accountability, both reduces the opportunity for corruption and helps to address some of the inequity that may result from such corruption. In order for this increased accountability to occur, institutions must provide transparent and reliable information, and deliberately create opportunities to provide feedback into the system. While this handbook touches on a number of critical resources and approaches it is critical that the broader systems thinking be applied as approaches are implemented.

This handbook aims to provide USAID staff working in the health sector with information on the particular corruption risks, challenges and considerations in the health sector, as well as programmatic options for addressing them. This handbook forms part of a suite of Anti-Corruption Integration Guidance, and serves as an

³ Garcia, Patricia J, 2019. [Corruption in global health: the open secret](#). Lancet 2019; 394: 2119–24, Published Online November 27, 2019

⁴ Hanf, Matthieu, Astrid Van-Melle, Florence Fraisse, Amaury Roger, Bernard Carme, and Matthieu Nacher. "Corruption kills: estimating the global impact of corruption on children deaths." PLoS One 6, no. 11 (2011): e26990.

⁵ Holmberg S, Rothstein B. Dying of corruption. Health Econ Policy Law. 2011 Oct;6(4):529-47.

⁶ Ciccone DK, Vian T, Maurer L, Bradley EH. Linking governance mechanisms to health outcomes: a review of the literature in low-and middle-income countries. Social science & medicine. 2014 Sep 1;117:86-95.

annex to the Agency-wide, cross-sectoral [USAID Anti-Corruption Integration Guide](#). Deliberately designed as a modular, living suite of documents, this guidance will continue to evolve and expand as the Agency’s elevation of anti-corruption progresses.

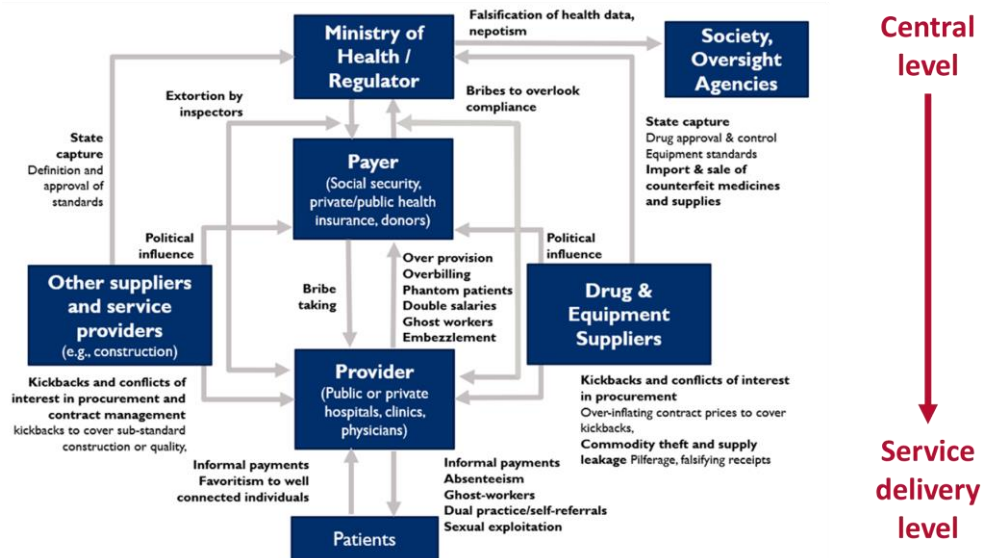
A. Corruption considerations and issues in the sector

Health systems involve a complex, multi-layered landscape of actors, each with potential drivers and forms of corruption. Figure 1 below provides a graphical representation of major categories of health sector corruption that span from the central level, including the Ministry of Health (MOH) central office and regulatory bodies, to administrative functions, such as health sector procurement, logistics and hiring, and extending all the way down to the service delivery level in the relationship between patients and providers.

Within national governments, as well as devolved national entities, MOHs or other regulatory bodies may be subject to state capture and corruption in the development and application of pharmaceutical registration policies and procedures, health equipment standards, and quality control and inspections. MOHs may be vulnerable to nepotism or falsification of public health data. Public health procurement, contract management, and asset management are rife with corruption risks - such as bid rigging, conflicts of interest, kickbacks and theft.

Within subnational governments and at the service delivery level, patients might experience numerous forms of corruption including requests for informal payments, bribes, or even sexual favors to receive treatment. Service delivery is also undermined by medical personnel absenteeism, ghost workers, dual practice (i.e., moonlighting), and referrals made based on personal profit.

Figure 1. Illustrative framework of corruption in the health sector



Source: Adapted from Savedoff and Hausmann (2006) updated with inputs from USAID Global Health staff

Note: See Annex 1 for a list of related and alternative frameworks

The following sections provide additional detail on the forms of corruption most applicable to USAID’s programming.

Corruption in medical registration

Before medical supplies can enter a market they must first be registered by a country's regulatory agencies. These agencies sometimes have weak accountability structures in place, along with limited capacity and resources.⁷ Furthermore these regulators may face pressure from pharmaceutical companies to bring products to market faster and without proper process. In these instances regulators could be offered bribes and kickbacks, or the regulators themselves may seek payment for preference in approval. Strong accountability mechanisms, and sufficient capacity help to address some of these issues. Efforts such as the East African Community Medicines Regulatory Harmonization Program and the African Medicines Agency (AMA) may create an opportunity to address these issues through harmonization of regulatory requirements and coordination of regulatory processes.⁸

Key Resources:

- [WHO's Global Benchmarking Tool for evaluation of national regulatory systems](#)
- [World Bank: Pharmaceuticals and corruption: a risk assessment \(2005\)](#)
- [Transparency International: Corruption in the Pharmaceutical Sector \(2016\)](#)

Substandard and falsified (SF) medical products

Sale of substandard and falsified pharmaceuticals and medical products is a dangerous and pervasive form of corruption. A 2018 systematic review found that 13.6% of essential medicines tested in low- and middle-income countries (LMIC) failed quality analysis, with failure rates of 18.7% in Africa, and 13.7% in Asia.⁹ This has disastrous results. As many as 450,000 annual preventable deaths from malaria are due to counterfeit medicines and about 1 million patients die annually from toxic counterfeit pharmaceuticals.¹⁰ This problem may have become more widespread during COVID-19 as measures to expedite procurement and distribution reduced oversight to identify counterfeit products.¹¹ The WHO has found the use of fake COVID-19 vaccines and saline solutions to inoculate patients in some countries in Southeast Asia and Africa.¹² The presence of fake vaccines further exacerbates vaccine hesitancy and undermines the pandemic response.

Several factors increase the prevalence of substandard and falsified medical products, including weak regulatory capacity, high out-of-pocket costs for medical products through official sources (leading to use of unlicensed distributors), product shortages, opaque procurement processes, lack of surveillance and specialized equipment to detect poor quality products, and weak reporting systems and enforcement actions. Many counterfeit products are traded across borders due to weak quality controls. While some countries require proof of Good Manufacturing Practices (GMP), completion of a WHO prequalification process, or other regulatory requirements

⁷ Note that in this context, capacity relates to the skills, knowledge and systems in place within the regulatory agency. Resources refers to the material or financial assets the regulatory agency has access to.

⁸ For more see: [AMRH Partnership Platform – a game changer in the medicines regulatory space | AUDA-NEPAD](#)

⁹ Ozawa S, Evans D, Bessias S, et al. (2018) Prevalence and estimated economic burden of substandard and falsified medicines in low- and middle-income countries: a systematic review and meta-analysis. *JAMA Network Open*. 2018;1:e181662.

¹⁰ Behner, Peter, Marie-Lyn Hechy and Fabian Wahl (2017). [New defenses for an underestimated — and growing — menace: Fighting counterfeit pharmaceuticals](#). Strategy&, PriceWaterhouseCoopers, 2017.

¹¹ Steingrüber, Sarah, Muktar Gadanya (2021). [Weak links: How corruption affects the quality and integrity of medical products and impacts on the COVID-19 response](#). U4 Issue 2021:15.

¹² <https://www.u4.no/blog/COVID-19-corruption-in-2021-augustseptember>

to establish product quality, efficacy and safety, there is concern that the regulators of these processes may be vulnerable to bribery in return for false certifications.¹³ For example, in one 2018 case a Chinese pharmaceutical company falsified GMP documentation for the import of an antipsychotic drug (aripiprazole) and a chemotherapy treatment (pemetrexed disodium).¹⁴

Key Resources:

- [OECD: Trade in Counterfeit Pharmaceutical Products \(2020\)](#)
- [WHO: Member State mechanism on substandard/spurious/falsely-labeled/falsified/ counterfeit medical products \(2017\)](#)
- [U4: Weak links: How corruption affects the quality and integrity of medical products and impacts on the COVID-19 response \(2021\)](#)

Theft, fraud and misuse in public health supply chains

Corruption in public health supply chains involves misuse of power and resources in the systems to source, procure, store and deliver health commodities. Public pharmaceutical procurement, in particular, is vulnerable to corrupt practices like back channeling of funds, nepotism, and overpricing commodity unit values. The highly specialized nature of the goods being procured may undermine the ability of agencies such as Supreme Audit Institutions to effectively provide oversight. Additionally, novel pharmaceutical products cannot be put out for tender due to their nature, and contracts are often confidential, meaning oversight is limited.¹⁵ For example, civil society led investigations in Honduras found that the Health Minister had misused emergency procurement rules to purchase 57 percent of Honduras’s essential medicines using non-competitive procedures from a single supplier at costs that were as much as 41 percent higher than international averages.¹⁶ COVID-19 has exacerbated these risks, with use of expedited purchases of personal protective equipment (PPE), medicines and vaccines. In countries like Guatemala, Bangladesh, and Brazil, irregular procurement of COVID-19 vaccines led to major scandals.¹⁷

Box 1. Theft from Medical Stores in Zambia

Over \$1 million in HIV test kits, antiretrovirals (ARVs) and malaria rapid diagnostic test kits (MRDTs) were stolen from the Zambian central medical stores between 2014 and 2016.

Source: Lusaka Times (2018)

Warehousing and distribution of pharmaceuticals and health supplies create additional opportunities for diversion. For example, valuable pharmaceuticals and supplies may be stolen for sale on the black market or for personal use at any point in the distribution chain where there is a lack of clear processes and strong oversight. Thefts can be covered up by false invoices or records, particularly where IT systems are weak. The losses to the health sector can be significant, as shown in the text box on Zambia above.¹⁸ Weaknesses in procurement,

¹³ Steingrüber and Gadanya (2021)

¹⁴ Liu, A (2018). [Fosun Pharma ‘massively’ fakes API production data and bribes regulators, whistleblower says](#). Fierce Pharma. 31 August 2018.

¹⁵ For more, see [For Whose Benefit? Transparency in the development and procurement of COVID-19 vaccines](#) for analysis of vaccine contracts for transparency

¹⁶ Amin, Lucas (2017). [Making the Case for Open Contracting in Healthcare Procurement](#), London (UK): Transparency International; 2017. update 2019 May21.

¹⁷ U4 (2021). [COVID-19 corruption in 2021: Late-May–July developments](#), U4 Anti-Corruption Research Center, July 2021.

¹⁸ Lusaka Times (2018). [Zambia : Medical Stores Plunder: US\\$1 million worth of drugs stolen at Medical Stores](#), Lusaka Times: Main News, June 9, 2018. Accessed: May 9, 2022.

warehousing and distribution of health commodities lead to significant losses to the health sector and exacerbate limited access to key medicines, equipment and medical devices. [Annex 2](#) describes a number of the corruption issues in public procurement and mitigation measures.

Key Resources:

- [USAID SCRM Practical Application Guide: Preventing, Detecting and Addressing Corruption](#)
- [Transparency International: Corruption in the Pharmaceutical Sector \(2016\)](#)

Informal payments

Patients in many countries are asked to make informal payments outside of formal payment channels, in kind or in cash, at the point of service delivery for routine services, better quality care, or expedited access to medical services. There are many potential drivers of informal payments, including low or infrequent payment of health workers, scarcity of certain medical treatments, or cultural norms on providing gifts. Patients who are compelled to make informal payments may forgo or delay care because they cannot afford to pay, exacerbating inequity in health services and systems. In some extreme cases expecting mothers who cannot afford to pay have had “labor on credit,” where women have gone into debt to health facilities for services that should legally have been free.¹⁹ Even when clients are able access systems with informal payments, there may be a reduction in the quality of care. For example, a survey of hospital patients in Kazakhstan, who should expect to receive the same care under universal health coverage, found that the patients who made informal payments had decreased waiting time, longer hospital stays and higher subjective ratings of quality.²⁰ [Annex 3](#) describes potential interventions to address informal payments.

Key Resource:

- [Institutional Determinants of Informal Payments for Health Services: An Exploratory Analysis across 117 Countries](#)

¹⁹ Kabia, Evelyn, et al (2021). "The hidden financial burden of healthcare: a systematic literature review of informal payments in Sub-Saharan Africa." Wellcome Open Research 6.297 (2021): 297.

²⁰ Xavier, Ana & Thompson, Robin. (2003). [Unofficial payments for acute state hospital care in Kazakhstan. A model of physician behaviour with price discrimination and vertical service differentiation](#). LICOS Discussion Papers, Discussion Paper.

Ghost Workers and Absenteeism

Ghost workers and absenteeism lead to human and financial resources being siphoned out of the health system, and access to quality services being reduced. Absenteeism occurs for a number of reasons, including insufficient salaries or untimely payment. This may lead to dual practice (also known as moonlighting) wherein public health workers are absent from public health facilities during work hours to attend to their private practice. Even when health workers exercise dual practice during non-work hours, this can cause problems when it leads them to underperform on duties at public facilities (e.g., to sleep through shifts). Ghost workers refers to individuals who are fraudulently added or remain on health workforce payroll systems after they have left a facility. The presence of ghost workers on a payroll results in underestimates of the number of needed health workers and makes it difficult for health systems to hire the staff needed and pay the salaries of existing workers.²¹ These human resource management challenges often arise when it is difficult to observe attendance at health centers (e.g., in rural areas) and where payroll, financial management, and human resource systems are not integrated, making data validation and audits difficult. The global shortage of healthcare personnel, which is exacerbated by absenteeism, is prevalent in USAID partner countries and can have a devastating impact on health outcomes. World Bank Service Delivery Indicator Survey data from Africa in 2012–2016 show absentee rates ranging from 14.3 percent of health facility staff in Tanzania, to 33.1 percent in Niger.²² A study in Western Kenya, an area of high HIV prevalence, found that women who were not tested during their first antenatal visit due to nurse absenteeism were 50 percent less likely to learn their HIV status during pregnancy.²³ [Annex 4](#) provides additional information on corruption risks and mitigation measures related to human resource management in the health sector.

Box 2. Payroll reforms in the Dominican Republic (DR)

USAID's CapacityPlus activity supported the Ministry of Health in the DR to implement a new payroll reform, revealing nearly 10,000 ghost workers. The salaries of these workers represented approximately 30% of the Ministry's budget. Through a phased result, the Ministry cleaned its payroll and reclaimed over \$6 million annually which funds that are being used to hire new health workers, increase salaries to improve equity and improve motivation, eliminate user fees, and invest in improved procurement process for HIV testing kits and antiretroviral drugs. In turn, this reinvestment is helping improve service delivery and health outcomes.

Source: CapacityPlus/IntraHealth (2014)

Key Resource:

- [USAID: Holding Health Workers Accountable: Governance Approaches to Reducing Absenteeism \(2012\)](#)
- [U4: Corruption and anti-corruption practices in human resource management in the public sector \(2015\)](#)
- [WHO: Findings from a rapid review of literature on ghost workers in the health sector: towards improving detection and prevention](#)

²¹ Jean-Robert Likofata Esanga, Claire Viadro, Leah McManus, Jennifer Wesson, Nicaise Matoko, Epiphane Ngumbu, Kate E Gilroy, Daren Trudeau, How the introduction of a human resources information system helped the Democratic Republic of Congo to mobilize domestic resources for an improved health workforce, *Health Policy and Planning*, Volume 32, Issue suppl_3, November 2017, Pages iii25–iii31, <https://doi.org/10.1093/heapol/czx113>

²² Service Delivery Indicator Survey, World Bank in partnership with the African Economic Research Consortium and the African Development Bank, www.sdindicators.org, Accessed 28 January 2018.

²³ Goldstein M, Zivin JG, Habyarimana J, et al. The effect of absenteeism and clinic protocol on health outcomes: the case of mother-to-child transmission of HIV in Kenya. *Am Econ J Appl Econ.* 2013;5:58–85

Corruption in medical referral and billing

Frontline healthcare providers may face corrupting incentives to supplement with respect to the care they recommend, the referrals they make, and how they bill. These incentives encourage them to make medical decisions on the basis of personal profit rather than patient well-being. This can lead to practices such as providing referrals on the basis of kickbacks from certain providers or to their own private medical practices. In other cases it can lead to the recommendation for unnecessary procedures, misrepresentation of the service provided to charge a higher fee, or submission of fake medical reimbursement claims in return for incentive payments. A 2019 *Lancet* article noted a case in Peru where a paperclip had been used to damage the x-ray machine in the public clinic so that physicians could refer patients to a private clinic where the physicians could collect fees.²⁴ As shown in box 3, identifying cases of corruption in medical referral and billing, however, is not always clear and may be difficult to detect.²⁵

Box 3. Difficulties in detecting corruption in medical referrals and billing

A study of facilities in Tanzania found that 81% of patients received some form of unnecessary care, 67% received care harmful to public health (e.g., prescription of unnecessary antibiotics) and 6% received clinically harmful care. It is difficult to define how much of this is due to patient preference, weak medical provision protocols, physician behavior, concerns about adverse outcomes from normal deliveries, or incentives in the provider payment system. Given the implications of this issue for public health, there is a need to better understand how to detect and control corruption within medical referral and billing.

Source: King et al (2021).

Key Resources:

- [Transparency International: How Corruption in Healthcare Service Delivery Threatens Universal Health Coverage \(2019\)](#) (page 12)
- [OECD: Tackling Wasteful Spending on Health \(2017\)](#)

Corruption in public sector hiring

The quality of health services depends on health system functionality (e.g., effective leadership, financing, information, etc.), an important aspect of which is the skills and qualifications of the health workforce. When individuals are hired and promoted on the basis of “who they know,” (political and personal ties), rather than “what they know” (expertise and performance), healthcare provision may suffer. Individuals may also be obliged to “pay” for positions through bribes or sexual favors. A 2019 assessment in Nigeria’s Cross River and Bauchi states found that payment for positions was routine; one respondent noted that, “...they turn to the highest bidder, sometimes they don’t even consider competence, provided you can afford what they want....”²⁶ In some cases, hiring decisions may not be under the purview of the MOH or local health officials. In these cases, there is a heightened risk of politicization of hiring decisions. Corruption may begin even earlier, with prospective students

²⁴ García PJ. Corruption in global health: the open secret. *Lancet*. 2019 Dec 7;394(10214):2119-2124. doi: 10.1016/S0140-6736(19)32527-9. Epub 2019 Nov 27. PMID: 31785827.

²⁵ King, Jessica et al (2021). How much healthcare is wasted? A cross-sectional study of outpatient overprovision in private-for-profit and faith-based health facilities in Tanzania. *Health policy and planning*.

²⁶ Dirisu Osasuyi, Akinola Akinwumi, Okereke Ekechi, Unumeri Godwin, Suleiman Ibrahim, Jibril Aisha and Eluwa George 2019. [“An assessment of human resources for health hiring, deployment and retention, procedures and practices in Cross river and Bauchi states, Nigeria”](#). Population Council

paying bribes to gain admissions to medical or nursing school and potentially to obtain their professional qualifications.²⁷

This practice may lead to the hiring or promotion of unqualified or compromised workers, resulting in negative outcomes. For administrative positions, such as roles in procuring and distributing health commodities, hiring based on patronage can create pressure to disregard rules and commit theft, fraud or bid-rigging to benefit their patron. Similarly, a “tone from the top” that corruption is permissible can enable other corruption to flourish such as theft or absenteeism. In combination, this leads to low motivation for qualified health personnel to perform and worsened health outcomes for patients. A meta-analysis on cancer care across Africa found that corruption in hiring practices led to the recruitment of personnel not able to appropriately administer complex treatment protocols.²⁸

Key Resources:

- [Promoting anti-corruption, transparency and accountability in the recruitment and promotion of health workers to safeguard health outcomes](#)
- [OECD: Public Integrity Handbook - Merit \(2020\)](#)

Corruption in the use of health sector foreign assistance

In addition to the loss of health sector resources to corruption in partner country health systems in general, there is a specific need to consider how to mitigate against loss of U.S. foreign assistance resources supporting global health. Theft, waste, fraud, and abuse in the use of health sector foreign assistance is destructive for several reasons. First, valuable taxpayer resources are lost and taxpayers may lose trust in foreign assistance agencies and create pressure to cut funding. A 2013 Kaiser Family Foundation study found that while more than 60 percent of Americans think U.S. health aid is “too little” or “just right”, almost half also think “corruption and misuse of funds” is the main reason health aid might not be effective.²⁹ Second, the effectiveness of the overall health sector assistance is diluted due to the loss of resources. Third, diversion of resources may strengthen corrupt networks with partner countries. Corruption in the use of foreign assistance may take many of the forms already outlined above, and may take place through the conduct of agency staff, implementing partner staff, partner government officials, or other vendors.

Key Resources:

- [USAID Anti-Fraud Plan](#)
- [CGD: Global Health, Aid and Corruption: Can We Escape the Scandal Cycle?](#)

²⁷ For examples see: [My office exposed corruption in MBBS admissions: Bedi | Puducherry News - Times of India](#), and [Reducing corruption in a Mexican medical school: impact assessment across two cross-sectional surveys | BMC Health Services Research](#)

²⁸ Saskia Mostert, Festus Njuguna, Gilbert Olbara, Solomon Sindano, Mei Neni Sitaresmi, Eddy Supriyadi, Gertjan Kaspers, [Corruption in health-care systems and its effect on cancer care in Africa](#), The Lancet Oncology, Volume 16, Issue 8, 2015, Pages e394-e404, ISSN 1470-2045,

²⁹ Kaiser Family Foundation (2013). [2013 Survey of Americans on the U.S. Role in Global Health](#). KFF Polling, November 7, 2013.

B. Factors enabling health sector corruption

As outlined above, the health sector experiences a wide range of forms of corruption. The prevalence and variety of corruption challenges in a given country can be affected by a number of contextual factors. This includes the factors that create opportunities for individuals to engage in corrupt behaviors (proximate causes; e.g., weak financial controls), as well as factors that lessen the risk of engaging in corruption (enabling factors; e.g., weak citizen voice).³⁰ These factors may be found at every level of the health system, from the central office of the health ministry to the service delivery level. Health sector corruption may also be enabled by government-wide corruption challenges and broader social and cultural factors. In addition, donors can influence the incentives to engage in corruption in the health sector.

Within the health sector, at the central level, there are a number of elements that increase the vulnerability of the sector to corruption. First, health service provision is highly technical. Because staff in health ministries and their counterparts in industry have specialized knowledge that is not broadly available in accountability agencies, it can be difficult to provide adequate oversight.³¹ Additionally, the internal incentives to address corruption within the health ministry may be limited by individuals' loyalty to the politically powerful individuals who helped them obtain a post or appointment. These factors may be compounded by a tendency to limit transparency around health sector operations, which may derive from a general lack of transparency across the government or from specific limitations within the health sector that limit external oversight and control.

Within the health sector at the local and service delivery levels, there are several additional elements that come into play. Health workers may justify corruption, particularly requests for informal payments, on the basis of low salaries or because they are volunteers. Informal payments may also be a coping mechanism to deal with routine delays in salary payments. When important medical products are in short supply, bribe taking may be used as a way to ration limited quantities. Finally, some categories of corruption may be costly or difficult to observe or control (e.g., absenteeism), particularly in the context of weak, disconnected management systems.

More broadly, several factors in a country's governance environment can strongly influence the extent of corruption in the health sector. For example, when the rule of law and institutional checks and balances are weak, especially in fragile contexts, corrupt actors perceive a low risk of detection or sanction for their actions. Further, when individuals are hired on the basis of nepotism or political connections they may be more prone to influence by politically connected patrons within government, which in some cases play into factional politics. Further, corrupt actors may use nationalism as a smokescreen to favor certain vendors.

Social and cultural factors can also have a major impact on corruption risks. For example, countries with a disempowered civil society may suffer from weak or dispersed public pressure to address corruption issues. In the health sector specifically, low literacy rates and low awareness of rights may also create obstacles to citizens observing corrupt behavior when it takes place. In some cases, social and cultural norms may even feed into corruption - such as acceptance that those in government should help their family and connections gain employment even if they are not well qualified for the position. Moreover, addressing corruption may not be

³⁰ Vian (2008); for more see [Annex 1](#).

³¹ This may also be referred to as asymmetric information

seen as a priority when it disproportionately affects vulnerable populations (e.g., women, youth, people with disabilities, LGBTQIA+).

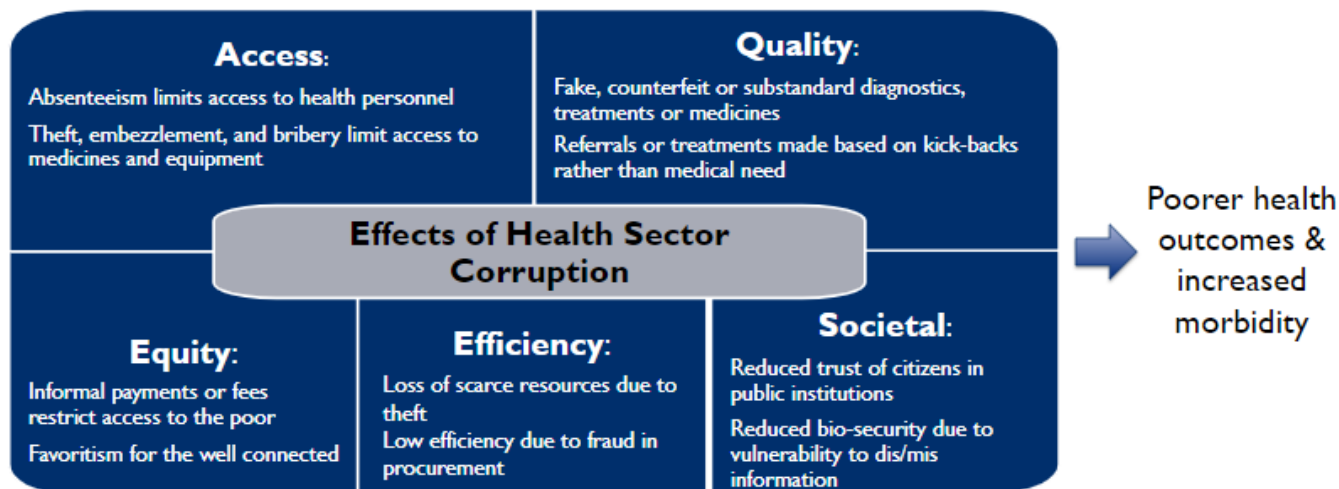
Development partners may also play an important role. For example, pressure to deliver during a health crisis creates real and perceived tradeoffs between safeguards and responsiveness. There may also be limited time to identify corruption issues within the life of an individual activity. Individuals may not feel comfortable to report corruption or not be aware of the correct protocols for doing so.

SECTION 2: ANALYSIS

A. Diagnosing and measuring corruption’s impact in the health sector

The first step of understanding whether and how to engage corruption challenges in the health sector is to identify the broader effect of corruption on the health services we seek to deliver. Figure 2 below summarizes a number of the damaging effects of corruption on health care access, quality, equity and efficiency, as well as broader societal effects of this corruption - all of which translate into poorer health outcomes and increased morbidity. These effects are treated in more detail in [Annex 7](#), along with proposed indicators and data sources to analyze the importance of these impacts.

Figure 2. Effects of Health Sector Corruption



Source: USAID³²

Teams engaging in new activity design should explore these issues and consider establishing baseline measures of these effects to understand how corruption dynamics impact health outcomes. This analysis can inform the level and type of programming that might be appropriate to mitigate against corruption challenges, and can be used to help build consensus for the need to consider corruption issues within the health program. [Annex 5](#) outlines a number of metrics that design teams might consider to track changes in the effects of health sector corruption.

³² Note that “bio-security” refers to measures aimed to protect humans or animals from infectious diseases or harmful biological agents. Corruption induced mis- or dis-information can limit the ability of public health officials to introduce biosecurity measures.

B. Assessing corruption risks within the health sector

During the strategic planning or activity design process, staff should not only consider the potential impacts of corruption on their programming, but should also consider the specific corruption risks that might undermine the achievement of their targeted goals. USAID has several tools available to conduct this form of risk assessment, as outlined below. A summary table of all of the assessment tools is provided in [Annex 6](#).

Health sector assessments

The Health Sector Assessment Approach or [HSAA v3](#) is the primary health system assessment tool deployed by USAID. It is designed to analyze the performance of policies and regulations in the context of core health system functions: service delivery; human resources for health; medical products, vaccines and technologies; health information systems; health financing; and governance. Anti-corruption elements are integrated throughout the guidance. For example, the issue of informal payments is raised in the context of health sector financing and absenteeism is touched on in the health labor market module. Health offices are encouraged to draw on this tool to link corruption issues with broader health system strengthening considerations.

In 2018, the WHO - in collaboration with the U.K. government - created a separate guide, which is also framed around the health system functions, but is focused on [Integrating a focus on anti-corruption, transparency and accountability in health systems assessments](#). The WHO guide provides a critical addition to other health assessments, including key indicators to determine whether corruption may be present within a health system. Where health system assessments are planned by USAID and others, USAID health offices may want to advocate to employ the integration tool and include a focus on anti-corruption, transparency, and accountability.

Mission teams exploring health sector corruption issues are encouraged to explore both tools and bring forward the questions and modules most applicable to their individual programming and country context. Ideally, partner governments and other local health sector stakeholders should be engaged as a part of the assessment process in order for health sector assessments to reflect local actors' experiences regarding priority health sector corruption challenges and proposed solutions.

GH Supply Chain Risk Management approach

The USAID Global Health Supply Chain Risk Management (SCRM) Working Group has developed the USAID Global Health Supply Chain Risk Management Playbook, a reference tool designed to assist Missions with Global Health (GH) funding and NextGen partners in anticipating and managing Supply Chain (SC) risk in a proactive manner. The USAID GH SCRM Playbook represents a standardized and collaborative process toolkit for identifying, prioritizing and subsequently managing SC risk.

The SCRM Playbook is a living document and toolset devised to evolve over time. It contains a portfolio of SCRM "assets" that include process templates, procedure libraries, risk-related forms and management tools, standard operating procedures (SOPs), and SCRM assessment tools and checklists. The Playbook helps ensure the necessary implementation techniques and processes are readily available to program managers to institutionalize best practices for risk mitigation, including identifying and countering the elements of corruption in GH SC.

USAID Anti-Corruption Assessment

USAID's [Anti-Corruption Assessment Handbook](#) (2009) provides step-by-step guidance on diagnosing underlying causes of corruption through the analysis of both the regulatory environment and the political-economic dynamics of a country. The handbook also provides complementary tools for sector-specific corruption analyses, including a Health Sector analysis framework, shown in [Annex 7](#).

Though this Handbook needs to be updated, it may still be useful for Missions engaging in strategic planning or activity design. Particularly in countries facing challenges of endemic corruption, Missions may choose to conduct an Anti-Corruption Assessment as a whole-of-Mission effort to inform opportunities to weave anti-corruption across the portfolio and address corruption in a more coordinated manner. In the absence of a whole-of-Mission assessment, a health office may conduct an analysis of corruption dynamics affecting the health sector and on that basis identify priority actions or areas of intervention. Some actions identified in this process may require cross-Mission collaboration.

C. Safeguards risk assessments

Health teams should carefully consider appropriate safeguards in our programming given the corruption risks associated with many GH programs and the risk that corruption in the use of health foreign assistance might lead to worse health outcomes, reinforcement of corrupt networks in the countries where we work, reputation risks to the agency, and future cuts in health funding. Fortunately, USAID has several tools that Missions and other Operating Units are required to use under the Automated Directive System (e.g., ADS 220, 303, 308) to analyze and introduce safeguards against risks of waste, fraud and abuse in our programming. Several of these tools are described below.

Assessing Risks in Multilateral Arrangements

USAID regularly engages in large, multi-country arrangements with Public International Organizations (PIOs) such as the Global Fund to improve the coordination of our assistance with other development partners and benefit from scale. These agreements are also frequently used for humanitarian assistance in fragile and conflict-affected contexts where international organizations under the UN umbrella have a unique infrastructure which enables them to operate. While this form of engagement has distinct benefits, it also introduces risks and side effects, as USAID generally has less day-to-day oversight of PIOs and their implementing partners.

Agreements with PIOs are governed under [ADS Chapter 308](#), which requires USAID to conduct an organizational capacity review (OCR) for each PIO at least every five years to ensure that a PIO is organizationally capable of adequately safeguarding USAID resources and assess any other significant risks of working with the PIO. The OCR should evaluate the efficiency and effectiveness of past performance, data on financial management (internal and external audits, assessments, financial statements), established policies and procedures on financial management and controls, and efforts to address previous adverse findings, among others (see ADS 308.3.2.1 for more). At the activity level, USAID also requires an analysis within the Agreement File Documentation as to whether, in the context of the activity proposed, there are credible reasons why the PIO may not be organizationally capable of adequately safeguarding USAID resources. The Agreement File Documentation must delineate any special provisions required in the agreement to mitigate identified risks. Special agreement conditions to address risks at

the activity level could include such things as more frequent or detailed financial reporting or third-party monitoring.

When considering the appropriate conditions to include in agreements with PIOs, it is important to explicitly outline expectations for regularly updating and/or consulting with USAID/W or in-country Missions. While maintaining a collaborative approach with the partner PIO, proactively engaging the PIO in open and transparent dialogue about the project's successes and challenges will provide an opportunity for USAID to reinforce safeguarding standards and identify potential risks and seek out solutions. It is not uncommon for PIOs to channel funds through partner government financial systems, which can increase risk. It is important to identify and understand what (if any) safeguards have been put in place by the PIO in these instances and to track the funds getting to the operational level to ensure timely and accountable implementation of activities. The technical and management staff at PIOs may differ in expertise, number and location. Often PIO staff is centrally located and this may present challenges to implementing safeguards and mitigating risk.

Assessing risks for local partners

The [Non-U.S. Organization Pre-award Survey \(NUPAS\)](#) is USAID's main tool for assessing whether a not-for-profit or for-profit non-U.S. organization being considered for USAID assistance has adequate organizational governance, financial management, procurement, human resources, and internal control systems to manage, control, account for, and report on the uses of USAID funds, thus safeguarding U.S. taxpayer funds. The assessment tool also looks at issues of performance management and organizational capacity, such as an assessment of the capacity of the partner to meet USAID's budgeting, control, financial accounting, and reporting requirements. Where capacity gaps are identified, members of the Mission's Office of Acquisition and Assistance (OAA) and Financial Management Office (FMO) may be brought in to provide coaching and support. USAID can face challenges in conducting the NUPAS because it requires significant staff time to conduct the NUPAS assessment, develop corrective action plans with the local partner, and provide follow-up mentoring as needed with the local partner. To address these challenges, USAID can use a Regional Inspector General (RIG)-eligible local accounting or audit firm to conduct the initial pre-award survey. Note that NUPAS scopes of work must include conflict of interest restrictions prohibiting the firm from providing capacity building services to local partners it surveys.

As areas for improvement are identified in the NUPAS, special conditions can be included in the award to focus on strengthening these areas and also measuring improvement moving forward. Technical assistance both focused on organizational development and also technical capacity can be provided through various capacity building models and options. This could also include strengthening systems that support anti-corruption, such as Whistle Blower programs, standard operating procedures for Human Resources, enhanced financial management systems, etc. There are also various capacity building and technical assessment tools that can be utilized to identify areas of strength and gaps (e.g., OCA, OPI, NUPAS). Through dedicated technical assistance, organizations can use these assessment findings to develop action plans with tangible performance goals and strengthen specific organizational and technical areas of focus. It is also critical to include capacity building as an objective in the local award to allow for resource and level of effort to support this development for sustainability.

Government to Government (G2G) Risk Management approach

USAID is increasingly using G2G programming tools in the health sector as a means to promote local ownership and sustainability of our programming. G2G programming, however, carries with it a unique set of risks which require special analysis. USAID's [G2G Risk Management and Implementation Guide](#) provides an approach for Missions to identify, assess, evaluate, mitigate, and monitor the threats that USAID may face when implementing direct U.S. Government (USG) assistance with a partner government. This risk management approach draws on the parameters set forth in ADS 220 as well as in the Agency's [Enterprise Risk Management program](#). Overall, USAID's G2G Risk Management Approach provides a framework to assess several categories of risk through a seven step process, risks include (1) programmatic risk, (2) fiduciary risk, and (3) reputational risks. Corruption risks in global health may manifest as programmatic, fiduciary risks and/or as reputational risks, depending on the nature of the corruption. Some risks that might appear in a health G2G risk assessment include (but are not limited to):

- Lack of a proper fixed asset register and verification processes may contribute to theft of medical equipment
- Lack of accurate and timely medical resource inventory tracking may contribute to theft of pharmaceuticals
- Excessive use of exceptional procurement procedures limits competition and creates risks for collusion in pharmaceutical procurement
- Weak internal controls create risk that payments may be issued prior to appropriate verification and quality assurance processes for health facility construction contracts

While the G2G Risk Management and Implementation Guide is designed specifically to address risks that might affect the implementation of a G2G activity, Missions may also consider options to address some of the risks, including corruption risks, through technical assistance wrap-around support to strengthen the broader financial management systems that the Health Sector relies on.

D. Complementary assessment and planning tools

Political Economy Analysis (PEA)

PEA provides a structured approach to analyze power dynamics and economic and social forces that influence development, including in the health sector. USAID has been promoting [PEA and "thinking and working politically" \(TWP\) approaches](#) as a means to improve the effectiveness and sustainability of our programming. Ideally, PEA is not a one-off exercise, but is paired with Collaboration, Learning, and Adaptation (CLA) to understand and adapt to foundational influences (such as history or geography); the impact of immediate events and actors (such as leadership changes or natural disasters); and the institutional framework (encompassing formal laws and informal practices) and how it shapes the behaviors and outcomes in the health sector. This type of analysis is particularly important in [understanding and being able to address corruption issues](#) in the sector, which are often driven by historical and existing norms, values and incentives. For example, PEA may guide an exploration of the kinds of changes that may be possible when there is a new Minister of Health who expresses a commitment to combating corruption in a context where patronage has historically guided decision making. For more information on cases

where PEA has been used in the context of health systems work, please refer to this [informational brief](#), and this [WHO-sponsored analysis](#).

System Dynamics Causal Loop Mapping

A systems map is a useful tool to capture the various interrelated factors that drive outcomes in a health sector (or other) system. A system dynamics causal loop diagram, first developed at MIT³³, is one form of systems mapping that examines:

- Factors: drivers, enablers of system outcomes, including corruption.
- Mental models/social norms: deeply ingrained, often subconscious, ways of thinking about issues that frame behavior.
- Causal links, shown as arrows: indicating the relationship and direction of influence between variables.³⁴

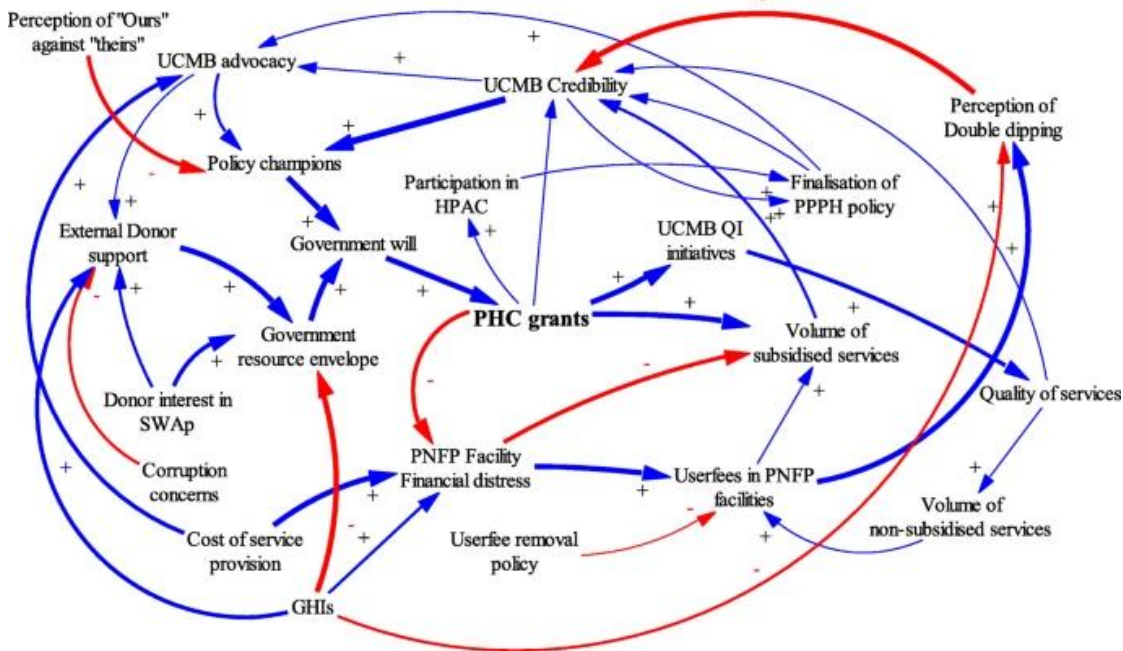
In the health sector, causal loop maps have been used to understand a range of issues, including [general health system effectiveness](#), [demand for neonatal health service](#), and [the HIV care continuum](#). Corruption may be a factor within a causal loop map that looks at a sectoral issue, or a causal loop map may be used to unpack and better understand complex forms of health sector corruption (e.g., absenteeism).

Figure 3 below demonstrates how this was used to analyze challenges related to the implementation of primary health care (PHC) grants in Uganda. This causal loop map shows a positive arrow (+) in blue where a change in one factor caused another factor to change in the same direction. A negative arrow (–) in red shows when a change in one factor caused an opposite change in the connected factor. These interactions may result in positive or negative feedback loops. The thickness of the arrow shows the researchers’ assessment of the significance of the relationship. In the diagram, corruption concerns decreased donor support for the PHC grants, which in turn lessened the resources available for the program. Similarly, perceptions of “double dipping” reduced the credibility of the provider network. As these factors reduced funding for the program, this increased the pressure on health units to charge user fees, even though such fees had been abolished in the public sector.

³³ For a more complete discussion of the tool first piloted at MIT, see Morecroft, J. (2020). System Dynamics. In: Reynolds, M., Holwell (Retired), S. (eds) [Systems Approaches to Making Change: A Practical Guide](#). Springer, London.

³⁴ [How to Read a Causal Loop Map – Henry J. Leir Institute](#)

Figure 3. Uganda Primary Health Care Grant Causal Map



Source: [Ssenyonjo et al. \(2018\)](#)

For more information on use of systems maps, please consult this [short course on causal loops in the health sector](#) and [this blog from the Corruption, Justice and Legitimacy project](#) at Tufts on systems mapping of corruption.

Development and Humanitarian Partner Program Mapping and Coordination

It is also critical to understand how USAID’s development and humanitarian partners are engaging around global health programming, particularly as relates to anti-corruption and system-strengthening. This engagement will not only allow USAID to better align its programming and avoid duplication with other partners, but it will also allow USAID to learn from our partners’ programming. Some practical approaches to improve coordination in anti-corruption health integration include:

- Request Mission leadership to define clear topics of focus to avoid the effort becoming too diffuse.
- Conduct Mission geocoded mapping of Humanitarian Assistance (HA) and Development Assistance (DA) implementation areas including primary investment focus such as food and disaster aid.
- Assign two specific HA and DA partners (and representatives of the Disaster Assistance Response Team (DART) and/or Response Management Team (RMT) where applicable), to convene regular (monthly or quarterly) information sharing and joining planning meetings with relevant USAID implementing partners (IP) and key USAID staff.
- Extend joint coordination sessions with IP coordinators to include coordination meetings with relevant DRG programs and local government and civil society leadership on a bi-annual or annual basis.
- Request designated IPs to provide geographic summaries of joint planning, opportunities, challenges, security/vulnerability trends to the Offices funding programming in that location.
- Update analysis regularly as the security and vulnerability landscape changes.

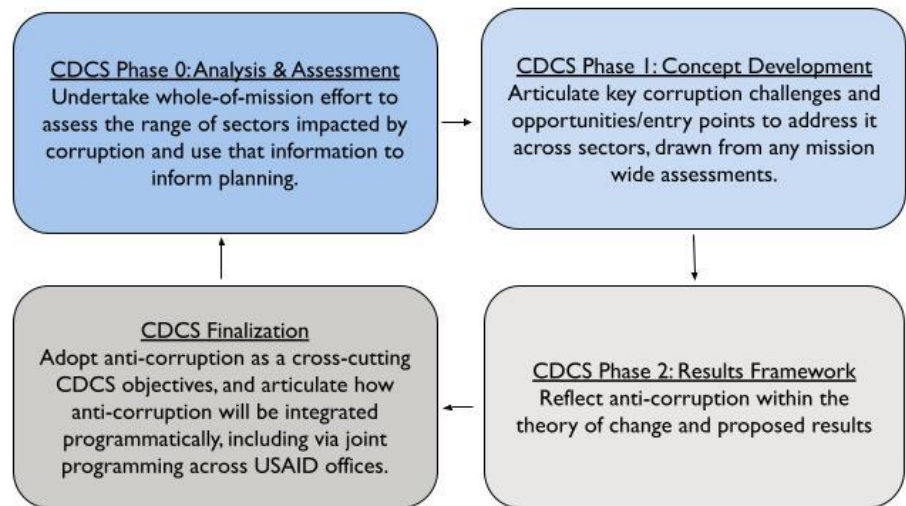
Given the level of responsibility required, IPs leading in this effort should be rewarded/recognized for their leadership; the leadership can be rotated but usually best to have the duties assigned for at least one year or more.

SECTION 3: STRATEGY, DESIGN AND TECHNICAL GUIDANCE

A. Strategy Integration

In line with the [US Strategy on Countering Corruption](#), and recognizing corruption’s corrosive effects on development and democracy, Missions and Bureaus/Offices (B/IOs), as relevant, are expected to prioritize anti-corruption efforts by identifying corruption challenges and issue-sets, seeking opportunities to affirmatively address corruption across USAID’s work, and mitigating corruption risks.

Figure 4. Integrating Anti-Corruption at the CDCS Level



Missions are increasingly analyzing anti-corruption issues on a whole-of-Mission and sector-by-sector basis, starting with the development of a CDCS for a bilateral Mission or a Regional Development Country Strategy for regional Missions. This integration is anticipated to extend into activity design, implementation, monitoring, evaluation and learning.

CDCS Phases

There are multiple opportunities to integrate anti-corruption considerations throughout the country's strategy planning process.

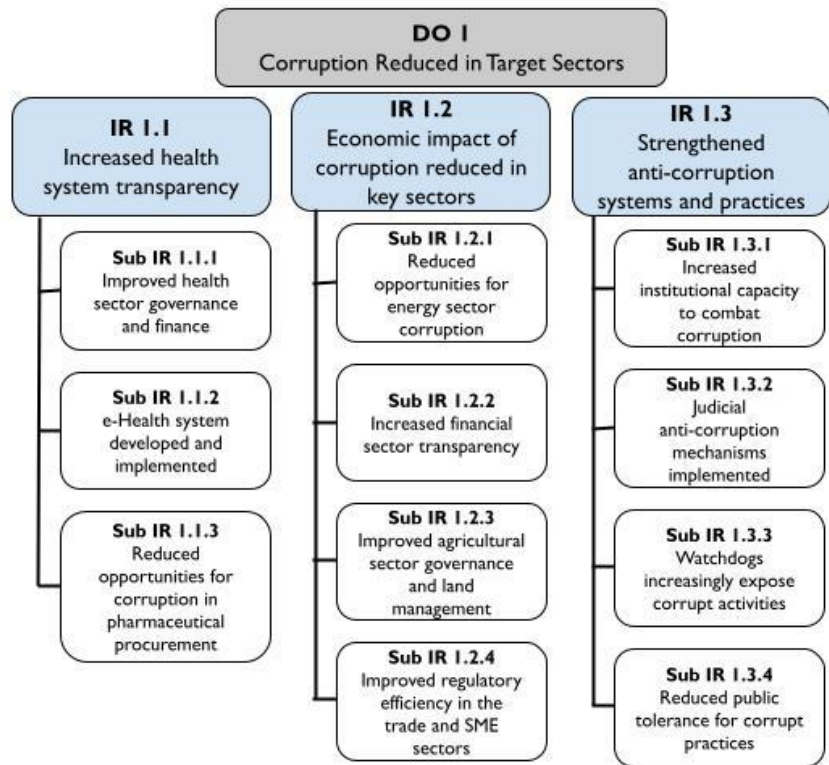
Before the CDCS process officially launches (unofficial CDCS Phase 0), Missions consider and plan for analysis and assessments to inform the CDCS development. A Mission, especially in a country recognized to have a high level of systemic corruption, should at this stage consider a whole-of-Mission effort to understand the range of sectors affected by corruption and use that information to inform planning.

In the CDCS Phase 1 (Concept Development), a Mission should identify any relevant corruption challenges by drawing from any Mission-wide anti-corruption assessments. If the health sector was identified as a critical sector regarding corruption, the health office may draw on the analytic tools mentioned earlier in this guide.

In Phase 2 (Results Framework), a Mission conceptualizes a Results Framework, a diagram of the cause and effect logic for achieving each Development Objective (DO) over a defined time period. The health office, with others,

will reflect on the Mission and sector assessment findings, and other analyses, to develop the Theory of Change for a GH objective. As appropriate, anti-corruption may be reflected at the intermediate result (IR) level or potentially within the narratives for those sections. Health offices should work closely with other offices to identify opportunities for cross-sector engagement to address the corruption challenges faced in the health sector. For example, the health office could identify cross-sectoral indicators with the Democracy, Human Rights, and Governance (DRG) office and other interested sector offices. An example of an integrated anti-corruption DO from USAID/Ukraine is provided in Figure 5.

Figure 5. USAID/Ukraine DO 1: Corruption Reduced in Target Sectors



Source: [USAID/Ukraine 2021-2024 CDCS](#)

In Phase 3, the final step, the Mission completes its fully developed CDCS document. The health office should state its plans for GH sector (and potentially integrated) programming in the GH DO narrative. The narrative should clearly explain the reason for and how the programmatic integration will appear and the potential for joint programming with other offices. The Sensitive But Unclassified (SBU) version of the CDCS should provide nuanced or sensitive relevant context and information on how programming is anticipated to combat specific corruption concerns. (The subsequent public version of the CDCS will have redacted any language considered too sensitive for the partner government).

In addition, the draft CDCS includes sections on Monitoring, Evaluation, and Learning (MEL) and Management. Given USAID’s limited measurement and evaluation of anti-corruption efforts in non-DRG programming to date, the health office (and others at the mission) should state the plan for more intentional measurement and evaluation of anti-corruption efforts for its programming in the Performance Monitoring Plan (PMP). After CDCS approval, the mission will develop the PMP as a tool to measure its performance against the Results Framework. Please refer to this Handbook’s MEL section (final section) for suggestions, and to consider drawing from for the two CDCS sections. The health office should confer with the mission Program Office, Global Health/W, GH country teams, regional Bureau’s GH and DRG technical officers, or other contacts for assistance if/as needed.

Applying Relevant Strategies and Priorities

Per ADS 201, missions should consider the relevance of each USG and USAID policy for their context (based on partner country needs and priorities, available resources, findings in analyses, and investments by other members of the development community, among other factors) to determine whether and how they should integrate the

policy into their CDCS and other planning processes under the Program Cycle. Please see the registry of [USAID policies](#).

Box 4. Relevant Strategy and Policy References

<p>The United States Strategy to Combat Corruption, which challenges implementing agencies like USAID to put greater emphasis on grand corruption, the transnational nature of corruption, the role of intermediaries and global financial system, strategic corruption of external actors, and improved collaboration with USG and other partners. The health office should consider what resonates from the strategy and may be advanced through Global Health sector programming in the partner country.</p>
<p>USAID’s Vision for Health System Strengthening 2030 underlines that “high-performing health care is accountable, affordable, accessible, and reliable.” These four characteristics are, in turn, reinforced by the health system strengthening goals of improving equity, quality, and resource optimization. As noted in the “Analysis” section above, corruption in the health system can fundamentally undermine the extent to which the health sector can achieve these goals. Health sector anti-corruption and health system strengthening are mutually reinforcing approaches to improve the ability of the health sector to sustainably advance and maintain overall health outcomes.</p>
<p>The U.S. Department of State and USAID Joint Strategic Plan (JSP) (2022-2026) notes that corruption, “wastes public resources, undermines development efforts, exacerbates inequalities in access to services and exercise of rights, fuels transnational crime, and is increasingly weaponized by authoritarian states to undermine democracy and governance.” Further, Objective 3.3 (Prevent, expose, and reduce corruption) notes that USAID has a comparative advantage in its programming, “to build anti-corruption safeguards across the climate, health, education, economic growth, biodiversity, humanitarian response, and post-conflict sectors to ensure public resources are used for human development outcomes.”</p>

B. Opportunities for Integration and Programming Options at the Activity Level

Identifying Opportunities and Entry Points

A Mission or Operating Unit (OU) has a number of programming options it may consider when identifying the best ways to address the corruption risks identified during assessments and the CDCS process. Each approach has its benefits and pitfalls, and the best approach for a mission to take will largely depend on the prevailing country context, commitment to address corruption among key stakeholders, priorities established within the country strategy, identified entry points, and categories of funding available. Table 1, below, outlines the main categories of programming and opportunities to integrate anti-corruption efforts, which has been adapted from USAID’s crosscutting [Anti-Corruption Integration Guide](#) to demonstrate potential applicability to the health sector.

Table 1. Cross-USAID Activity Types and Opportunities to Integrate Anti-Corruption

Approach	Description	Examples: Opportunities for Health Integration
Direct anti-corruption programming	Has a project purpose with an explicit focus on improving partner	A project aiming to strengthen open government, transparency, or corruption

Approach	Description	Examples: Opportunities for Health Integration
	country systems and capacity to prevent, detect, investigate and disrupt corruption.	prevention tools - <i>may include the health sector (and institutions) as an area of focus/application (e.g., Bosnia ACCOUNT)</i>
Anti-corruption-adjacent or integrated programming	May include multiple development objectives, including at least one that focuses on preventing or mitigating corruption, or enhancing transparency and accountability.	A cross-sectoral or integrated program that supports enhanced expenditure controls and oversight across the health, education, and agriculture sectors, but also works on other sectoral finance issues (e.g., Uganda GAPP).
Sectoral programming with anti-corruption elements	Has a project purpose that focuses on improving a set of health outcomes, but which includes activities that address related corruption risks.	A project focused on improving maternal and child health outcomes that works to reduce absenteeism and theft of resources in health clinics (e.g., Pakistan Maternal and Child Health Program). May also include programs involving the community in social accountability efforts with health management committees.
Anti-corruption safeguards	Elements of USAID’s regulations, policies and procedures that enable more effective detection, prevention, and response to corruption risks.	Enhanced oversight of health work conducted under PIOs through third-party monitoring.

Note: Table includes forms of programming that could potentially be funded with health funding, per ADS Use of Funds Guidance as well as those that might be funded from other sources of funding but link to health corruption issues.

Any Mission or Office may employ one or multiple of these programming types, and should consult their program office and Democracy and Governance team for support in making decisions on the best route to pursue. Individual activity design teams may also consider including language in their Requests for Proposals (RFPs) and Request for Quotations (RFQs) requiring offerors to explore and address the ways in which corruption may impact the underlying health outcomes of the activity as a cross-cutting theme. See sample language used in the Honduras Mission’s solicitations for this purpose in the box below.

Integrated Design Teams

Several of the above programming approaches require strong collaboration and alignment of work between a mission’s technical offices. *Importantly, opportunities for integration can go both ways, and include both integration of anti-corruption considerations and activities within health programming, and the application of health sector needs within anti-corruption programming.* For example, a mission may consider integrating specific anti-corruption prevention activities within a core maternal health program. On the other hand, a mission may consider integrating health sector specific considerations into an activity working on core anti-corruption systems managed by the Democracy, Human Rights and Governance Office (e.g., a justice sector strengthening activity) by including corruption in the health sector as a particular area of focus. This might be facilitated through a formal mission-wide anti-corruption working group involving interested technical offices.

Alternatively, cross-sectoral integrated programming might identify corruption risks (such as weak disclosure rules) that cross several technical sectors, and seek to find ways to strengthen systems to reduce corruption in these sectors concurrently (e.g., a government-wide red flag system in procurement that touches on the health sector, among others). Missions and other OUs may also benefit from sharing successful approaches to improve the corruption safeguards within our own programming in the interest of reducing the risks across USAID’s full portfolio of programming.

Integrating Anti-Corruption programming at a mission requires management and coordination across teams, not only of technical but functional staff as well (e.g. Program Officer, Contracting Officer, etc.). Missions may explore cross-sector, cross-office, and/or interagency agreements to establish the participants’ roles and responsibilities. This reduces the risks of technical stovepiping and brings together the joint perspectives and knowledge on corruption issues from GH, DRG, EG and other technical offices to help conceptualize and design programming.

Besides the design of the programming, a cross-sectoral team should be established to continue collaborating across the program cycle. For example, during program implementation, the integrated team should regularly review progress, including during mission portfolio reviews. They should focus on impact, and decide together if any needed course corrections. It is important for all staff engaged in integrated programming -- from activity managers or CORs/AORs handling day-to-day management of programming to budget analysts conducting pipeline analyses, to build the capacity to understand the implications of integration across the program cycle. This ensures that they can all support programming progress, whether through budget planning, implementation, reporting, or monitoring.

SECTION 4: TECHNICAL GUIDANCE

A. Affirmative Anti-Corruption Approaches in the Health Sector

The health sector has a range of different approaches it might consider - regardless of the programming approach taken (e.g., working on anti-corruption from a cross-sectoral perspective or addressing corruption within a health program). Health teams may consider these approaches in the design of new programs or when engaging with partners on work planning. In all cases, health teams should seek opportunities to coordinate with, leverage, or co-fund anti-corruption activities with other pieces of the USAID portfolio, including -but not exclusive to - programs in the DRG space.

Figure 6. Applying Affirmative Anti-Corruption Approaches

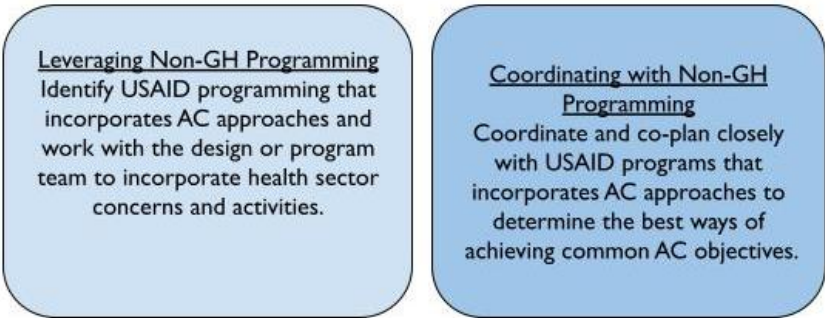


Figure 7 - Main Anti-Corruption Approaches to Leverage within Global Health



Source: Authors

The five main categories of approaches, shown in Figure 7, are discussed in more detail below.

Transparency and awareness raising

Government transparency is at the heart of efforts to prevent, detect, and mitigate corruption. Both government and external actors alike rely on transparency to provide oversight and ensure accountability for the planning, use and delivery of public resources. This is especially important within complex sectors. Public health systems generate and rely upon complex and multifaceted data systems that support actors within the sector to identify and respond to changes in the public health environment, distribute health commodities to where they are needed, track resources within the health sector, and, at a patient level, to guide diagnosis and treatment plans. The approaches listed below aim to increase availability of this data to various stakeholders in order to enable greater accountability and raise public awareness of both corruption risks and mitigation measures. GH programs may support:

- **Data transparency.** Voluntary disclosure and dissemination of important data by public health agencies which might help to mitigate against corruption (e.g., procurement data on vaccine purchases).
- **Access to information.** Access to information, including by strengthening the ability of the public to request and receive data not voluntarily disclosed by the health sector, but which serves an important accountability function (e.g., data on budget allocations for a new health clinic in a given area).
- **Public awareness.** Efforts to make citizens more aware of health sector governance issues and their rights within the public health system (e.g., free services), and to build a broad stakeholder base for demanding accountability. These efforts could include broader public awareness building, such as the one in the box to the right, around corruption risks within the health sector (articles, radio broadcasts, posters within health facilities etc), as well as resources available for reporting misconduct (hotlines etc), and media reporting on investigations of misconduct.³⁵

Box 5. Reducing informal payments in Ukraine

In Ukraine, USAID’s Health Reform Support (HRS) worked to make medical charges and fees more transparent (including free services) and leveraged civil society networks to institute a public awareness campaign on appropriate fees and charges. This was complemented with awareness raising among medical workers and the establishment of a reporting mechanism for citizens to lodge complaints regarding informal payments.

Source: Deloitte (2021)

³⁵ Deloitte (2021). [USAID/Ukraine Health Reform Support \(HRS\)](#), Anti-Corruption in Health, Deloitte, December 2021)



Social and institutional accountability

Health systems are a critical part of the social infrastructure, and as such a number of important stakeholders have an interest to demand accountability. Social and institutional accountability efforts are necessary and complementary counterpoints to efforts to improve transparency and strengthen the prevention and response mechanisms as they create the needed pressure to effectively implement reforms. Leveraging anti-corruption accountability approaches, a sample of which are outlined below, may range from strengthening formal oversight roles, such as those related to Parliamentary committees, or may encompass efforts to strengthen external accountability measures, such as via media and press coverage or civil society activism. GH programs may support:

- **Parliamentary oversight.** Strengthening the capacity of legislatures or parliaments to conduct oversight of the health sector, including holding specialized hearings, reporting or investigations related to potential for waste, fraud and abuse in the public health system.
- **Ombudsman or independent oversight institutions.** Supporting enhanced sectorally-specific understanding to allow anti-corruption and other oversight institutions to effectively review and audit public health finances and services (including any such institutions set up during a response situation, such as with COVID-19).
- **Civil society and media watchdogs.** Strengthen the technical understanding and capacity of civil society and investigative journalists to engage in analysis and engagement around issues that relate to corruption in the health sector. These activities may be closely linked with or supported under existing or planned USAID civil society programs.
- **Private sector engagement.** Actively seek partnership with the private sector on preventing, mitigating and detecting corruption within the health sector, including by exploring supply chain integrity opportunities and private sector integrity coalitions. Leverage private sector innovation to better address corruption risks and to find ways to overcome collective action problems by bringing together integrity minded private sector actors in the health sector.³⁶
- **Social accountability.** Engage communities to provide oversight and accountability at the service delivery level. (e.g., community scorecards, see box)
- **Diplomatic pressure and interagency coordination.** Align messaging and diplomatic pressure across the USG interagency in a country to create pressure to address corruption.

Box 6. Community scorecards in Malawi

Community scorecards, which enable community feedback on specific aspects of service provision and sector governance, were introduced in 2002 in Malawi to bring communities into health sector accountability efforts. They have enabled community members to identify and elevate governance, service delivery and accountability issues they observe in their communities using a collaborative approach. A systematic evaluation of the approach conducted 20 years later found that the scorecards are now a mainstay of local governance - continuing with little or no donor support.

Source: Care (2021)

³⁶ For more details see: <https://www.transparency.org/en/private-sector-support>



Prevention

Health systems manage an enormous array and volume of resources - human, material, and financial. There are a number of prevention approaches the health sector might take to reduce the ability of actors within the system to undertake corrupt acts, prevent those actors from entering the system in the first place, or encourage actors to be better stewards of health sector resources. GH programs may support:

- **Administrative rules and procedures.** Reinforce rules, requirements, and procedures within health sector institutions to reduce discretion, minimize opportunities for corruption, and formalize ethical behavior. These might include implementing conflict of interest or asset disclosure policies, strengthened internal controls (including on procurement), developing new requirements around open contracting and beneficial ownership, and enhancing suspension and debarment processes.
- **Leadership and change management.** Where procedures are changed, it is important to have leadership to ensure their effective implementation. This might also include change management or social and behavior change interventions to strengthen the institutional norms needed for the change.
- **Financial and supply chain management.** Bolster systems and processes around budgeting, financial management, procurement, contract management, and inventory and asset management to reduce opportunities for fraud and theft. (e.g., introduce a track and trace system - see box below).
- **Training in ethics and legal framework.** Training for public officials and health workers on their ethical and legal responsibilities to mitigate against health system waste, fraud, and abuse .
- **Use of technology.** Enable more automation of processes and greater transparency through the use of technology (e.g., [shifting from cash to mobile money payments](#)).
- **Theft and fraud deterrence.** Use technologies such as video surveillance or biometrics or other techniques to deter potential theft or fraud (e.g., use of CCTV at warehouses).
- **Civil service reform.** Facilitate improvements in how public health workers are hired, rewarded, promoted, sanctioned and fired to reduce opportunities for patronage and political favoritism (e.g., introduction of merit based hiring).
- **Enhanced donor safeguards.** Use management techniques such as assessment of beneficial ownership and pre-solicitation back lists.

Box 7. Track and Trace: A key tool to reduce risks in pharmaceutical supply chains

A centralized national track and trace system checks pharmaceutical products at specific points in the supply chain by relevant supply chain parties reporting into a central data repository. This type of system enables real-time tracking throughout the supply chain, stock management for timely detection and prevention of stock-outs, targeted product recalls, and reduction of reimbursement fraud, theft, and medication errors. The system can help to address corruption in supply chains by identifying and removing counterfeit or substandard medical supplies from the supply chain and deterring and detecting theft along the chain. USAID has been supporting regulatory reforms and IT system upgrades to introduce a [track and trace system in Ethiopia](#). Experience has shown that effective implementation of these systems takes several years and may require a broader supportive infrastructure. For more information on this approach, please consult [USAID's Guidelines with Key Considerations for Centralized National Pharmaceutical Traceability Approaches](#).



Detection

To complement systems and processes that prevent corruption, it is important that health systems are able to detect corruption when it does take place. Some examples of detection techniques that are applicable in the healthcare sector are outlined below. Most of these approaches may be used either as safeguards or as a means to strengthen country systems. GH programs may support:

- **Audit.** Improve capacity of public sector auditors (internal and external audit) to detect cases of mismanagement, waste, fraud, or abuse in the health sector. Forensic audit is a specific audit technique designed to unearth cases that may be criminal in nature.
- **Management oversight.** Support techniques to improve monitoring and accountability, such as conduct of site visits. May also include third party monitoring, as described in the box below.
- **Complaints and community feedback mechanisms.** Engage communities to raise potential cases of corrupt behavior they observe at the service delivery level.
- **Whistleblower protections and reporting.** Empower public officials to flag potential corruption for further investigation and response, and protect whistleblowers from retaliation. In some cases, introduction of a whistleblower mechanism may need to be paired with social and behavior change interventions if the social and cultural norms might not support active reporting.
- **Third party surveillance.** Develop mechanisms to identify stolen pharmaceuticals or other health supplies in marketplaces where they appear for secondary sale.

Box 8. Using Third Party Monitoring in Fragile Environments: The Example of Yemen

Due to a protracted and pervasive civil war in Yemen, USAID is managing all programming remotely. This creates unique challenges for USAID and its implementers supporting service delivery along a range of essential services including education, health and livelihoods, conflict reduction, entrepreneur support, and financial reform. The Yemen Continuous Learning and Evaluation (YCLE) program supports USAID to monitor activities, evaluate program performance and program impacts and provide up-to-date information through monitoring visits, surveys and polls, implementation of monitoring databases, delivering remote learning and training events, situation assessments, and specialized studies.

Box 9. Lessons Learned from Monitoring in Uganda

Transparency International's Global Corruption Barometer (GCB) estimated that almost half of people who engaged with the health sector in Uganda in 2010 paid a bribe. In response to the high rates of bribery, the Government created a Health Monitoring Unit (HMU) with power to monitor and evaluate health facility performance and investigate instances of corruption. This unit achieved significant results -- more than 30 billion Ugandan Shillings (US\$84 million) in stolen medicines were recovered and over 600 healthcare workers and healthcare worker 'imposters' were arrested, leading to over 100 convictions. By 2015 the bribery rate in the health sector fell to just 25%.

One method HMU used was unannounced investigations at healthcare facilities, followed by publicly 'naming and shaming' those found to have engaged in corrupt behavior. This seems to have resulted in a dramatic shift away from bribery. However, it appears to have also resulted in important unintended consequences. Because the anti-corruption bribery interventions did not address bribery's underlying functions – low and irregularly paid health worker salaries – the results are not likely to be sustainable. A month-long nationwide strike of medical personnel in November 2017, for example, was blamed in part on HMU's activities. There are also concerns that more qualified health workers may leave the public health system. This points to a need, when addressing issues like bribery, to consider the root causes of such behavior rather than only detection and prevention.

Source: [Marquette et al \(2019\)](#)



Response

When corrupt behaviors are detected in the health sector, it is important to have a clear and effective system to respond to those cases. The health sector's response to such cases can vary based on the severity and nature of the corruption. GH programs may support:

- **Reporting and referrals.** Establish processes within health sector entities to report potential corruption cases not already captured through whistleblower programs through management and in some cases refer them to the justice system.
- **Investigations.** Improve linkages with administrative bodies (e.g., ethics commissions) or criminal bodies (e.g., public prosecutors) that conduct investigations to ensure the use of actionable data in the investigation and ultimate prosecution of corruption cases.
- **Sanctions.** Support administration of appropriate sanctions, such as loss of a professional certification or demotion, administrative or civil fines and penalties, or, where appropriate the referral of criminal sanctions.
- **Corrective actions.** Introduce appropriate corrective actions and remedies (e.g., new controls or oversight) where weaknesses in the system have been identified.

[Annex 8](#) provides a cross-walk of these five main anti-corruption approaches and the main categories of health sector corruption outlined in the typology provided in Section 1.

B. Cross-cutting approaches

To overcome the various forms of corruption in the health sector, and the different economic, social and political dynamics that drive it, it is important to use an appropriate mix of technical approaches, including the ones articulated above. Yet none of these approaches alone can fully address the issues of corruption within the sector, especially when it is entrenched, expected and perpetuated. In addition to the more technical and programmatic interventions listed above, USAID programs should seek to adopt cross-cutting approaches that aim to uncover the real roots or drivers of corrupt behavior in order to inform and adapt our approaches. GH programs should support:

- **Thinking and Working Politically (TWP).** Analyze the processes, actors, incentives and informal rules or norms that might facilitate or obstruct efforts to address health sector corruption, and adapt programming accordingly.³⁷ Rather than being merely a one-time assessment, TWP is instead a way of using data and learning to constantly adapt and pivot programming for maximum impact.
- **Coalition Building and Networking.** Map stakeholders interested in a particular health sector corruption issue and build linkages between them to overcome collective action problems.
- **Social and Behavior Change.** Analyze and design programming to address social and behavioral norms that influence individuals' willingness to accept or participate in corrupt behaviors, or which might heighten social norms of integrity (see USAID's [Social and Behavior Change and Health Systems Strengthening](#))

³⁷ For more see USAID's Guide on Thinking and Working Politically: <https://www.usaid.gov/sites/default/files/documents/1866/PEA2018.pdf>

- **Whole of Government.** Analyze and identify opportunities to support activities that strengthen whole-of-government approaches to combating corruption in the health sector. These may include efforts to link partner country institutions working at various levels and across branches of government. This may also include efforts to tie USAID programming into broader U.S. government efforts to combat corruption in the sector.
- **Do No Harm.** Anti-corruption activities inherently involve powerful interests. It is critical, when working on anti-corruption in the health sector, to analyze and seek to mitigate against any potential harms that might arise to USAID staff, implementing partners, and our counterparts in the implementation of this work.

C. Safeguards approaches

USAID has numerous tools to address corruption risks in our programs, through the procurement, financial management, and contract/grant management procedures established in the [Federal Acquisition Regulation \(FAR\)](#) (for acquisition), [2 C.F.R. part 200](#) (for assistance), and USAID’s ADS (notably the [300 series](#) and [590-595](#)). These regulations and USAID’s ADS establish the foundation for controls to prevent corruption throughout procurement, contract/grant administration, audit and closeout, and create responsibilities for oversight. They also create obligations for USAID implementing partners to establish their own internal mechanisms to protect against individual or institutional conflicts of interest, waste, fraud or abuse in their organizations.

These regulations also create responsibilities for the lead implementing partner to provide oversight of their subcontractors. Within USAID’s Government-to-Government (G2G) programming, USAID has established a [practical set of tools](#) and guidance to help identify, measure and mitigate corruption risks within G2G programming. The Bureau for Global Health is also establishing specialized guidelines and tools to address the specific challenges within the sector.

SECTION 4: MONITORING, EVALUATION, AND LEARNING GUIDANCE

It is notoriously difficult to measure and evaluate efforts to address corruption, regardless of sector, given the complexity and illicit nature of the issue. Moreover, corruption is dynamic; actors change the nature of their behavior in response to changes in the environment. Despite these challenges, USAID missions and DC-based staff overseeing health programs with an anti corruption component need to be able to use data to inform program design, implementation, and learning.

A. Measuring Change in Health Sector Corruption

Monitoring and evaluation of anti-corruption must go beyond specific outputs and outcomes and should include indicators pertaining to attitudes or perceptions, as these can provide further context on how and why corruption seems to be an endless dilemma in governance. A set of context indicators may be useful to understand the broader environment for countering corruption in the country, and how it is evolving over time. However, for the purposes of integrated health sector anti-corruption programming - Missions and OUs should focus on the specific forms of corruption being targeted. Some examples of common approaches to measuring change in corruption are included in the table below.

Table 2 - Cross-Sectoral Indicators and Tools for Anti-Corruption measuring change

Category	Description
Experience-based user surveys or citizen score cards	These surveys aim to measure changes in reported prevalence of certain patterns of corrupt behavior. For example, this type of survey could be used to assess whether patients are requested to access basic health services, or if importers of medical supplies and equipment passing through customs are requested to pay a bribe. This may also include citizen service delivery scorecards that include compliance with anti-corruption measures.
Perception-based stakeholder surveys	These surveys gather the views of citizens, public service users, private sector and/or government officials on corruption and can be specified to a specific service or sector -- such as maternal and child health. In interpreting results, it is important to note that perceptions are slow to change, may be biased by increased media reporting on corruption (perhaps with USAID support) and may be systematically more positive in countries with more repressive governments.
Corruption risk monitoring	This is a systematic approach to identify critical corruption risks within a sector or program and estimate key performance indicators that can track changes in the severity or probability of a risk. For example, if tracking corruption risks related to conflicts of interest of government officials, you might track the % compliance of personnel in completing annual asset and income disclosure requirements, or a change in audit findings. USAID's SCRM system is another example of this type of approach.
Measurements of process improvements	Particularly in cases of administrative corruption, it can be useful to track the number and scale of process improvements that streamline and/or reduce discretion. These indicators may consider reductions in the time and steps required for a specific process due to automation, or may track the number of processes improved to address corruption risks.
Direct outcome measurement	In some cases, corruption issues may be directly observable either through conduct of specialized diagnostics or direct tracking. An example of a diagnostic might be the use of a public expenditure tracking survey (PETS) to measure the leakage of funds in health transfers between the national and local levels. An example of direct tracking might be using biometrics to track absenteeism rates in health facilities. Another example might be to use medicine quality monitoring techniques to assess changes in the presence of counterfeit and substandard medications.
Social norms surveys and tracking	Careful analysis of the social and institutional norms that reinforce or counteract corruption, followed up stakeholder surveys to assess how these norms evolve over time. An example of how to conduct this type of monitoring is available here .
Individual capacity building	This type of measurement should aim to capture not only the number of people trained and their satisfaction with the training, but also the acquisition and application of anti-corruption knowledge, skills and attitudes, and ideally translation of the capacity into targeted results. An example of applying this type of approach to anti-corruption training is provided here .
Organizational capacity building	Measurement of the resources allocated by organizations toward anti-corruption goals. This might include budgeted and actual expenditures, personnel, equipment, or facilities. It may also consider the quality of those resources.

The quality of monitoring and evaluation data is of critical importance across all of USAID’s work. Because this data can have an impact on future awards - it can also represent an area where USAID should consider safeguards to ensure the integrity of that data.

B. Capturing and Sharing Anti-Corruption Learning

Corruption, by its nature, is dynamic - responding to changes in the environment and adapting based on new measures that aim to mitigate corruption risks. Moreover, USAID is in the process of re-thinking and expanding its approaches to address corruption in the technical sectors where we work, including the health sector. As a result, it is critically important to intentionally build learning and adaptation into our programming, and share new approaches and lessons learned across missions and sectors.

One important way of sharing learning across missions working on corruption in the health sector is to align learning efforts with existing global learning plans and agendas such as [the HSS Learning Agenda](#). The learning questions for this learning agenda are in the table below, along with linkages to anti-corruption integration.

Table 3. Learning questions from the Health System Strengthening Learning Agenda

<i>Learning Questions</i>	<i>Illustrative Linkage with Anti-Corruption</i>
Question 1: What are the contributions of systems thinking approaches and tools to changes in health system outcomes ? How do systems thinking approaches affect health system outcomes?	Examining the systems and root causes that enable corruption is critical to understanding how to counter it. For example in countries with endemic corruption, social norms that reinforce corruption are often part of the “roles” people play and the “rules” they play by (as provided for in USAID’s 5 Rs framework).
Question 2: What conditions or factors successfully facilitate the institutionalization and/or implementation at scale of good practices that improve health system outcomes, and why? What are lessons learned regarding planning for sustainability and achieving results at scale?	How can we best address corruption across the many institutions that make up the health sector in our partner countries? How can we modify standard approaches to work best and be sustained in a given social, cultural and institutional context?
Question 3: What measurement tools, approaches, and data sources, from HSS or other fields, are most helpful in understanding interrelationships and interactions, and estimating impact of HSS interventions on health system outcomes and priority health outcomes?	How can we better identify, measure and assess changes in health sector corruption? How can we better understand the impact of corruption and of implementation approaches addressing these challenges on health sector outcomes?
Question 4: What are effective and sustainable mechanisms or processes to integrate local, community, sub-national, national, and regional voices, priorities, and contributions into USAID’s health system strengthening efforts?	How do local partners see corruption challenges in the health sector? What are their priorities and why? How might USAID and local efforts better align? How can USAID programs ensure local priorities are incorporated in their approaches and goals?
Question 5: What are effective and sustainable mechanisms or processes that enable the participation of private sector, civil society, and public organizations in developing locally-led solutions to improve high-performing health care , especially for poor and vulnerable populations? What enables the effective participation or leadership of	Who might be effective local voices to address corruption in the health sector in our partner countries? How might these actors connect within a country and across countries? Do they represent the interest of poor and vulnerable populations? How might they be better connected to other anti-corruption actors? What

<i>Learning Questions</i>	<i>Illustrative Linkage with Anti-Corruption</i>
marginalized populations themselves in the development and implementation of these solutions? Under what conditions is this participation different?	processes and mechanisms are in place to enable effective participation of local actors addressing corruption? How can the global community best support their work?
Question 6: What are key behavioral outcomes that indicate a functioning, integrated health system? In what ways can integrated health system strengthening approaches explicitly include social and behavior change?	What social and behavioral norms might advance or impede our efforts to address corruption in the health sector? What key behavior changes or norm changes would be useful to track to monitor or understand progress? How can we effectively elevate and reinforce narratives that will counter health sector corruption?

SECTION 5: CONCLUSIONS

Corruption undermines national security and the rule of law, stunts development and equitable economic growth, exacerbates the impacts of climate change and other shocks, and saps governments of legitimacy, eroding faith in democracy itself. In the global health sector, it diverts commodities and resources which are needed to provide care and universal health coverage, reduces the effectiveness of the health workforce, undermines trust in the health system and erodes health outcomes. It is an issue that crosses borders, sectors and bureaucratic silos. That is why USAID has placed countering corruption - at the local, national, and international levels - at the top of our development agenda.

As part of USAID’s broader effort to elevate corruption across the Agency, we are adapting our programming to **transform the fight against corruption**. To respond to this urgent challenge, health teams are being asked to plan, design, program, implement, and evaluate our programming in a new way. To do this we need to:

- Increase our **agility** to take advantage of - what can be fleeting - windows of opportunity and respond to moments of backsliding on corruption - whether at the country or sectoral level;
- Enhance **collaboration** on anti-corruption issues across USAID and with other U.S. departments and agencies, other donors and partner governments, local anti-corruption reformers, and the private sector; and
- **Experiment** with new programmatic approaches, tools, and technologies to tackle both the long-standing and deeply embedded forms of corruption in the health sector as well as new and evolving issues of transnational corruption and crime, such as illicit trade in counterfeit medicines.

There are many ways to respond to this call to action. Health teams should actively consider what corruption challenges are degrading health system performance and thereby health outcomes in their country and explore opportunities to take on those challenges. Across each mission, and across the agency, staff should work to better coordinate efforts to address corruption - such as by convening cross-office mission anti-corruption working groups - to share successes and lessons learned and find ways our programming can be mutually reinforcing to amplify the impact of our efforts. And design teams should take calculated risks to try new approaches and engage in learning to help to understand how and when we are making meaningful progress.

In this effort, USAID health sector staff are encouraged to leverage the tools and approaches provided in this guide to better understand the many corruption challenges present in the sector and identify and support programming to advance health sector anti-corruption integration.

ANNEX 1 FRAMEWORKS AND TYPOLOGIES OF CORRUPTION, TRANSPARENCY AND ACCOUNTABILITY IN THE HEALTH SECTOR

A typology of forms of corruption is presented in Section 1 of this guide, which builds off a framework included in Savedoff and Hausmann (2006) updated with inputs from USAID Global Health staff based on USAID’s experience. While not explicitly presented in the guide, the following frameworks, typologies and definitions provide additional perspectives on how to understand the forms of corruption commonly present in the health sector.

Framework	Purpose	Constructs/definitions
<p>EHFCN Waste Typology © European Healthcare Fraud and Corruption Network, 2014</p>	<p>To clarify anti-fraud definitions; avoid semantic confusion when exchanging information on counter fraud activity; and allow benchmarking</p>	<p>Errors: unjustly obtaining a benefit of any nature by unintentionally breaking a rule or a guideline</p> <p>Abuses: unjustly obtaining a benefit of any nature by knowingly stretching a rule or guideline or by taking advantage of an absence of rule or guideline</p> <p>Fraud: illegally obtaining a benefit of any nature by intentionally breaking a rule</p> <p>Corruption: illegally obtaining a benefit of any nature by abuse of power with third party involvement</p>
<p>European Union Corruption in the Healthcare Sector Typology, 2013 (updated 2017)</p>	<p>To come to an analytically, practically and policy-wise meaningful grouping of corruption in health.</p> <p>To clarify various forms of corruption for a deeper analysis of the drivers and prevalence of corruption in health</p>	<p>Bribery in medical service delivery: Informal payments offered by patients or demanded by service providers. The 2017 update renamed this category “privileged access to medical services” also including use of privileged information</p> <p>Procurement corruption: Occurring throughout bidding cycle, involves bribes to individuals or institutions, collusion, favoritism, false invoicing, etc.</p> <p>Improper marketing relations: Problematic interactions between industry and providers or regulators (gifts, money, sponsorship, fees) which may bias decisions. Involves prescription influencing, undue promotion, and influence on market authorization and reimbursement of medicines/medical devices.</p> <p>Misuse of high-level positions: Regulatory state capture, trading in influence, conflicts of interest, favoritism and nepotism. Involves regulators, political parties, industry and providers.</p> <p>Undue reimbursement claims: Upcoding, reimbursement of unnecessary or non-delivered treatments. Involves payers and providers.</p> <p>Fraud and embezzlement of medicines and medical devices:</p>

		<p>Sale of public or prepaid medicines for private gain; sale of counterfeit medicines; use of publicly owned or financed devices or facilities for private gain. Involves providers.</p> <p>Double practice: The 2017 update considered risks associated with dual practice.</p>
<p>Typology of Individual and Institutional Corruption</p> <p>Sommersguter-Reichmann, et al., 2018, citing Thompson (2013) and Oliveira (2014)</p>	<p>To help determine what is to count as corrupt and to help prevent conduct already known to be corrupt</p>	<p>Individual corruption: When an institution or a public official receives a personal gain or benefit in exchange for promoting private interests (usually undeserved). The conduct does not serve the institution and involves a quid pro quo motive.</p> <p>Institutional corruption: When an institution or a public official receives a benefit while providing a service to the benefactor under conditions that undermine procedures that support the primary purposes of the institution.</p>
<p>Five Key Actors in the Health System, William D. Savedoff and Karen Hussmann, 2006</p>	<p>To identify possible types of corruption based on opportunities and interests that encourage corrupt behavior among the different categories of actors involved and the complexity of their multiple forms of interaction</p>	<p>Government regulator. Defines and approves norms for construction, equipment, medicines approval and control which can be affected by state capture; may accept bribes to overlook compliance issues; inspectors may extort suppliers or providers.</p> <p>Payer e.g. social security, private or public health insurance. Affected by supplier influence on decision-makers (bribes, kickbacks related to procurement). May set negative incentives to save costs.</p> <p>Drug & Equipment and Other suppliers. May attempt to influence prescription and treatment practices, could engage in corruption in medicine and equipment procurement, procurement of facilities and ambulances.</p> <p>Provider. May engage in over-provision, overbilling, phantom patients, absenteeism, unnecessary treatment and prescriptions, demand informal payments</p> <p>Patients. May engage in fraud in beneficiary ID use, or understatement of income to obtain benefits</p>
<p>OECD framework of integrity violations in health care systems, Couffinal and Frankowski, 2017</p>	<p>To link health care system actors to the main types of integrity violations they are involved in; to help organize categories of policy options to tackle integrity violations</p>	<p>Actors</p> <ul style="list-style-type: none"> • Regulators (ministry or dedicated agencies) • Payers (entities that pool funds and finance care) • Suppliers and manufacturers of medical goods and services • Providers of medical goods and services • Individuals (patients, tax-payers, or the insured) <p>Categories of integrity violation</p>

		<ul style="list-style-type: none"> • Integrity violations in health service delivery, payment and coverage (denial of coverage, payroll tax evasion, informal payments, absenteeism, and over-billing). • Integrity violations in procurement and distribution (bid-rigging, kickbacks, SF medicines). • Inappropriate business practices (gifts and advantages to influence prescribing; corruption to influence regulation of private insurance market; bribes to obtain license or accreditation, systemic corruption).
<p>Framework of Corruption in the Health Sector, Vian, 2008</p>	<p>To model the proximate causes and enabling factors that promote or impede corruption in the health sector</p>	<p>Proximate causes for individual corruption include opportunities to abuse power (gaps in control systems, excess discretion, etc.); pressures or incentives (which provide motivation to abuse), and rationalizations (how agents justify abuse of power).</p> <p>Enabling factors which allow individual or institutional corruption include monopoly (limiting choice or ability to exit a corrupt system); too much discretion (autonomous power to make decisions); lack of accountability; lack of transparency; weak citizen voice (participation of citizens in planning and monitoring government); and inadequate detection and enforcement.</p>
<p>WHO definitions of substandard and falsified medical products</p>	<p>To clarify in what cases a medical product might be considered substandard or falsified, and when it might only be unregistered or unlicensed.</p>	<p>Substandard medical products: Also called “out of specification”, these are authorized medical products that fail to meet either their quality standards or their specifications, or both.</p> <p>Falsified medical products: Medical products that deliberately/fraudulently misrepresent their identity, composition or source. Any consideration related to intellectual property rights does not fall within this definition. Such deliberate/fraudulent misrepresentation refers to any substitution, adulteration, reproduction of an authorized medical product or the manufacture of a medical product that is not an authorized product.</p> <p>Unregistered/unlicensed medical products: Medical products that have not undergone evaluation and/or approval by the National or Regional Regulatory Authority (NRRRA) for the market in which they are marketed/distributed or used, subject to permitted conditions under national or regional regulation and legislation. These medical products may or may not have obtained the relevant authorization from the national/regional regulatory authority of its geographical origin.</p>

EHFCN = European Healthcare Fraud and Corruption Network; SF = Substandard or Falsified; ID = Identification card Sources: EHFCN. EHFCN Waste Typology ©.

Adapted from: Vian (2020) (<https://www.tandfonline.com/doi/full/10.1080/16549716.2019.1694744#>)

ANNEX 2: CORRUPTION RISKS AND POTENTIAL INTERVENTIONS IN PHARMACEUTICAL PROCUREMENT

Procurement stage	Risks and Manifestations	Potential interventions
Pre-bidding	<ul style="list-style-type: none"> ● Falsified type or amount of product ● Fabricated bidders ● Bids drafted to favor a particular company ● Forged documentation ● Bidding vendors provide bribes and kickbacks to government officials ● Information regarding contracts distributed in an unequal manner 	<ul style="list-style-type: none"> ● Giving all eligible bidders the opportunity to participate ● Enhancing transparency in bidding process ● Publicizing tender criteria ● Putting in place integrity pacts ● Ensuring the procurement agency issues clear and transparent policies and procedures that are publicly available ● Training of procurement officers on policies and procedures as well as how to detect potential corruption within the procurement process ● Providing procurement officers a process to escalate “red flags” in procurement processes to relevant oversight bodies (e.g., pressure to inappropriately use sole source methods) ● Providing clear policies and procedures for the national procurement regulatory agency ● Eliminating unnecessary approvals ● Regular checks on procurement processes and outcomes by outside watchdog agency
Bidding	<ul style="list-style-type: none"> ● Tender influenced by bribery and extortion ● Conflicts of interest that may influence tenders overlooked ● Exclusion of bids not justified 	<ul style="list-style-type: none"> ● Ensuring transparent and open bidding process through mechanisms such as electronic bidding ● Creating conflict of interest policies with appropriate measures to manage them ● Ensuring the national public procurement agency monitors the implementation of procurement rules by procuring entities (such as the Ministry of Health) ● Introducing a formal appeals process
Post-Bidding	<ul style="list-style-type: none"> ● Falsified invoices ● Inflated contracts ● Rewritten contract terms ● Goods not delivered 	<ul style="list-style-type: none"> ● Publicizing information about bid chosen and rationale ● Disclosing bids that did not win ● Citizen monitoring of contract execution ● Evaluating company performance ● Conducting formal audits

Based on [15,26,27]. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170361/#CIT0020>

ANNEX 3: POTENTIAL INTERVENTIONS TO REDUCE INFORMAL PAYMENTS IN HEALTH SYSTEMS

Theme	Risks and Manifestations	Potential interventions
Structural factors	<ul style="list-style-type: none"> ● Health facilities may be starved for resources leading to use of informal payments as a coping mechanism ● Health providers may be paid late or inadequately to meet basic needs ● Patients may not have good knowledge on what fees are and are not permitted ● Lack of oversight capacity creates challenges to enforce 	<ul style="list-style-type: none"> ● Provide adequate, predictable, and timely financial public resources for the health sector, especially at the service delivery point ● Promote a means of communication about amount and frequency of healthcare fees, outside of prepaid insurance premiums, to insured patients ● Reform the patient-physician relationship to focus on patient care and remove opportunities for financial transactions ● Provide effective oversight and regular capacity building for public sector providers (e.g. external audits, supportive supervision, coaching and mentoring, cross-facility learning and knowledge exchanges).
Legal factors	<ul style="list-style-type: none"> ● Legal framework may not enable health providers to recover costs with resort to informal payments 	<ul style="list-style-type: none"> ● Develop, adopt, implement, and/or measure the effectiveness of health laws and regulations (including as relates to insurance) that govern fees and charges in the health sector ● Reform cost sharing to enable health providers to adequately recover costs
Quality factors	<ul style="list-style-type: none"> ● Lack of resources may lead to rationing of important medicines and treatments 	<ul style="list-style-type: none"> ● Improve access to high quality essential health services, including quality-assured medical products, vaccines and technologies in the public sector (to limit use of informal payments as rationing mechanism) ● Reinforce norms for the provision of safe, effective, timely and equitable patient centered care and treatment
Cultural factors	<ul style="list-style-type: none"> ● Patients are not well informed and intimidated by health care providers and unlikely to raise concerns ● Informal payments socially acceptable 	<ul style="list-style-type: none"> ● Inform and empower patients about the services, health information, and medicines provided free as basic services and payments related to insurance and cost-sharing

		<ul style="list-style-type: none"> ● Inform patients about how complaints and grievances can be addressed and encourage feedback ● Alter the beliefs of patients about the necessity of informal payments, informing patients that quality services should be delivered without informal payments
Motivational factors	<ul style="list-style-type: none"> ● Low probability of being caught ● Low professional costs of being caught ● Feeling that you “earned” an informal fee due to late payment 	<ul style="list-style-type: none"> ● Establish or reinforce rewards and punishment system ● Pay staff at health facilities and throughout the health system on time

Source: Zandian H, Esfandiari A, Sakha MA, Takian A. Strategies to reduce informal payments in health systems: a systematic review. East Mediterr Health J. 2019 Dec 29;25(12):914-922. doi: 10.26719/emhj.19.057. PMID: 32003450.

ANNEX 4: CORRUPTION RISKS AND POTENTIAL INTERVENTIONS IN HUMAN RESOURCE FOR HEALTH

Category	Risks and Manifestations	Potential interventions
Nepotism or Corruption in Hiring and Promotions	<ul style="list-style-type: none"> Hiring managers hire individuals based on connections or bribe paying rather than merit Manager promote individuals based on connections or bribe paying rather than performance 	<ul style="list-style-type: none"> Establish a competency framework for key positions within the health workforce to inform hiring and promotion decisions Ensure all vacancies are published in widely available sources with adequate time for all interested parties to apply Introduce greater transparency in job requirements and promotion requirements Introduce standardized exams for entry into key positions Use panels to make hiring and promotion decisions Identify and mitigate conflicts of interest in hiring and promotion decisions
Absenteeism or Moonlighting	<ul style="list-style-type: none"> Unexcused absence of health workers in facilities during designated hours Health workers engage in private practice during hours assigned in public health facility 	<ul style="list-style-type: none"> Conduct awareness efforts regarding standards for attendance, schedules and leave policies Enforce sanctions of not meeting standards Define conditions under which dual practice is allowed Improve working conditions in health facilities Improve supervision practices Introduce biometric monitoring of attendance Improve payment and benefits, including linking attendance to pay-for performance Introduce community monitoring and reporting of absenteeism Improve HR Information Systems (HRIS) ability to track attendance, leave and absence
Ghost workers	<ul style="list-style-type: none"> Staff remain on the payroll after retirement or moving to a new position Fictitious health workers enter payroll Family members added as ghost employees No show employees Fraud in hiring of temporary employees 	<ul style="list-style-type: none"> Computerization of payroll and integration with IFMIS and HRIS Payroll census or audit Separation of payroll duties from those entering time, approving timesheets and issuing payments Use of biometrics to validate individual employees Link

Sources: [USAID \(2012\)](#), [U4\(2015\)](#) and [WHO \(2021\)](#)

ANNEX 5: ILLUSTRATIVE INDICATORS AND DATA SOURCES TO MEASURE EFFECTS OF HEALTH SECTOR CORRUPTION

Effect of health sector corruption	Illustrative indicator	Potential source
Access		
Absenteeism limits access to health personnel	% absenteeism at sampled health centers or hospitals	Third party monitoring
Informal payments restrict access to the poor	% patients reporting being asked to pay informal fees	Anonymous surveys
Theft, embezzlement, and bribery limit access to medicines and equipment	% health facilities with material weaknesses in financial audits	Audit reports
Quality		
Fake, counterfeit or substandard medical products	% sampled medicines found to be fake, counterfeit or substandard	Third party monitoring
Equity		
Informal payments or fees restrict access to the poor	% patients reporting being asked to pay informal fees (by income quintile, gender and other social groups)	Anonymous surveys
Favoritism for the well connected	% patients reporting access to essential health services (by income quintile, gender and other social groups)	Anonymous surveys
Efficiency		
Loss of scarce resources due to theft	Unexplained stock variance in key medicines	Supply chain audit
Low efficiency due to fraud in procurement	% of targeted health facilities with audit findings related to procurement (compared to baseline)	Audit reports
Societal		

Reduced trust of citizens in public institutions	% respondents expressing low levels of trust in health sector institutions	Anonymous surveys
Reduced bio-security due to vulnerability to dis/mis information	% respondents expressing agreement with statements of dis/mis information related to public health	Anonymous surveys

ANNEX 6: HEALTH SECTOR CORRUPTION ASSESSMENT TOOLS

Assessment tool	Description	Primary Use
<i>Identification of Corruption Challenges</i>		
USAID Health Systems Assessment (HSA)	Analyzes the performance of policies and regulations in the context of core health system functions: service delivery; human resources for health; medical products, vaccines and technologies; health information systems; health financing; and governance.	The primary health system assessment tool deployed by USAID. Includes modules that touch on the several of the forms of corruption highlighted in this guide, including informal payments, absenteeism and supply chain issues.
WHO Health Systems Assessment with anti-corruption focus	Examines six core health system “building blocks”: service delivery; human resources for health; medical products, vaccines and technologies; health information systems; health financing; and governance.	To identify areas of joint engagement with other donors on health systems issues, including anti-corruption.
Global Health Supply Chain Risk Management (SCRM) Playbook (internal USAID only)	Describes a standardized and collaborative process and associated toolkit for identifying, prioritizing and subsequently managing SC risk.	To address supply chain risks within USAID GH programming.
USAID Anti-Corruption Assessment	Provides step-by-step guidance on diagnosing underlying causes of corruption through the analysis of both the regulatory environment and the political-economic dynamics of a country.	To connect corruption issues in the Global Health sector to broader corruption dynamics in a country. Particularly useful in the context of cross-sectoral efforts on anti-corruption.
<i>Safeguards risk assessments</i>		
Organizational Capacity Reviews (OCRs) (ADS 308)	Analysis conducted at least every five years to ensure that a Public International Organization (PIO) is organizationally capable of adequately safeguarding USAID resources, along with any other significant risks of working with the PIO	Examination of risks for agreements with PIOs
Non-U.S. Organization	USAID’s main tool for assessing whether a	Examination of risks for

Pre-award Survey (NUPAS)	<p>not-for-profit or for-profit non-U.S. organization has adequate organizational governance, financial management, procurement, human resources, and internal control systems to manage, control, account for, and report on the uses of USAID assistance, thus safeguarding U.S. taxpayer funds.</p>	<p>agreements with non-U.S. organizations</p>
G2G Risk Management and Implementation Guide	<p>Describes USAID’s seven-step risk management process used to plan, assess, evaluate, implement, and adapt activities throughout the G2G project/activity life cycle. Through this framework, missions identify opportunities and risks of providing assistance to partner countries, including corruption related risks.</p>	<p>G2G Agreements</p>
<p><i>Complementary assessment and planning tools</i></p>		
Political Economy Analysis (PEA) and “thinking and working politically” (TWP) approaches	<p>A structured approach to analyze power dynamics and economic and social forces that influence development, including corruption challenges in the health sector.</p>	<p>Recommended for all programs addressing corruption issues, though level of effort applied may vary.</p>
System Dynamics Causal Loop Mapping	<p>Captures the various interrelated factors that drive outcomes in a health sector (or other) system in a graphic and dynamic manner.</p>	<p>Recommended for programs that include numerous interrelated actors and ingrained social and behavioral norms.</p>
Development and Humanitarian Partner Program Mapping and Coordination	<p>Practical approaches to improve coordination in anti-corruption health integration across humanitarian assistance and development assistance programming.</p>	<p>Recommended for work in countries managing complex crises or humanitarian disasters.</p>

ANNEX 7: HEALTH CORRUPTION DIAGNOSTIC QUESTIONS

This set of questions is drawn from USAID’s Anti-Corruption Assessment, which provides step-by-step guidance on diagnosing underlying causes of corruption through the analysis of both the regulatory environment and the political-economic dynamics of a country. This assessment tool includes specific health sector diagnostic questions as well as more general questions assessing the country context for corruption. Questions address both underlying risk factors as well as the prevalence of corrupt behaviors.

The full Diagnostic Tool is available here: https://pdf.usaid.gov/pdf_docs/pa00jp37.pdf. An updated and adapted set of questions is below. When conducting consultations with counterparts on health sector corruption issues, health officers may consider reviewing and selecting from this list of questions to assist in better understanding corruption challenges in the health sector in their country.

DIAGNOSTIC AREA	CORRUPTION DIAGNOSTIC QUESTIONS
Provision of Services by Front-Line Health Workers	<ul style="list-style-type: none"> ● Is exceptional performance of healthcare staff rewarded? Is poor performance penalized? ● Are wages in the healthcare sector comparable with wages in other sectors? ● Are there clear rules that govern tenure? Are tenure rules followed? ● Are civil service wages linked to performance? ● To what extent has the civil service/public sector organized its work based on/committed themselves in any extraordinary way to an agenda of integrity, transparency and good governance? What is the evidence for this? ● Are employees satisfied with their jobs? Are they involved in making decisions? Are communication lines open? ● Are rules and regulations disseminated promptly and discussed with employees? Are rules made as specific and as clear as possible? If discretion is allowed, is there a clear delineation of responsibilities and a corresponding system of punishments, which prevents employees from “going too far”? ● Is there legislation that regulates separation of public and private practices for healthcare providers? Is it effectively enforced? ● Do financial ties to pharmaceutical companies influence doctors to serve the commercial objectives of these companies, thereby compromising the ethical obligations of doctors to their patients? ● Do patients have an ability to choose their healthcare provider? ● Do doctors provide patients with options for treatment/services to choose from? ● Is complete and uninterrupted treatment common? (treatment that requires multiple steps can lead to more instances of corruption). ● Are health clinics and hospitals properly staffed (no shortage of doctors and other medical staff)? ● Are health clinics and hospitals well equipped with medical supplies,

DIAGNOSTIC AREA	CORRUPTION DIAGNOSTIC QUESTIONS
	<p>equipment, medicine, etc?</p> <ul style="list-style-type: none"> ● Is the theft/diversion of drugs/supplies common at storage and distribution points? ● Do healthcare workers often sell public stock of drugs for private gain? ● Are there clear, standardized procedures for signing up for doctor appointments at clinics? Do patients often pay the nurse/administrator to get an appointment? ● Is there a clear and transparent distinction between services provided for free and services provided for a fee? ● Are the fees for services clearly established and made available for patients? ● Are patients charged for drugs or medical supplies that should be free under government provided health care systems or health insurance policy? ● Do doctors or clinics perform services that are not necessary in order to make a profit? ● Are patients often forced to pay the doctor to get prescriptions or referrals? ● Are there instances when doctors and other medical personnel insist on informal payments before providing treatments/drugs/surgery to deal with life threatening medical emergencies? ● Are public health care facilities often used to see private patients? ● Do patients often receive unnecessary referrals to private practice or privately owned ancillary services? ● Are there frequent instances when healthcare workers do not show up to work?
Complaints/ enforcement mechanisms	<ul style="list-style-type: none"> ● What are the provisions for whistleblowing on misconduct in the civil service/public sector? Have these been exercised? ● Who investigates allegations of corruption committed in the civil service? ● What kind of oversight mechanisms are in place for such organizations? ● What options exist for sanction against civil servants? Are they invoked with any regularity? ● How successfully has corruption been targeted by this institution, as an internal problem? An external problem? ● Have civil servants been investigated or prosecuted in the last five years? ● What capacity is there for citizen complaints/redress? Is there a particular right of redress regarding employment?
Inspections and Oversight	<ul style="list-style-type: none"> ● Do inspectors typically overlook violations in health facilities for a fee/favor?

DIAGNOSTIC AREA	CORRUPTION DIAGNOSTIC QUESTIONS
	<ul style="list-style-type: none"> ● Are inspectors required to participate in asset or income disclosure programs? Is there training or certification for avoidance of conflicts of interest? ● Are effective complaint mechanisms in place for patients? Is information about these complaints mechanisms widely known and accessible?
Healthcare billing fraud	<ul style="list-style-type: none"> ● Are patients billed only for services rendered? ● Are patients billed for more expensive services than were rendered? (A doctor performs one service on the patient, but bills for a similar more expensive treatment). ● Are patients billed for the supplies or drugs that were actually provided? (For example, a doctor may collude with a pharmacist, by prescribing a brand name drug, but having the pharmacist supply the patient with a generic. The insurance is then billed for the brand name drug). ● Do drug companies often pay doctors to prescribe their medicines?
Theft, fraud and misuse in public health supply chains	<ul style="list-style-type: none"> ● Does the government often buy high-cost, inappropriate drugs and equipment? How do unit costs compare to national or regional benchmarks? ● Does the government have adequate capacity for managing procurement processes for health commodities? ● Do bribes, kickbacks, and political considerations often influence the contracting process? ● Does the country have an essential drug list (EDL) and is this list justified? (having an EDL reduces discretion in drug prescriptions) ● Is true need considered in equipment procurement and distribution? ● Is the quality of drugs and equipment standard? ● Are there adequate funds allocated to provide for all needs? ● Do bribes, kickbacks, and political considerations often influence specifications and winners of bids? ● Is the procurement process transparent? Is collusion or bid rigging typical? ● Are there incentives to choose low cost and high quality suppliers? ● Are suppliers typically held accountable if they fail to deliver? ● Are there mechanisms in place to ensure drugs and supplies are delivered? <p>(for additional questions see Chapter on PUBLIC PROCUREMENT)</p>
Corruption in medical regulation, policy and drug approvals	<ul style="list-style-type: none"> ● Are fake drugs often sold on the market? ● Is the process for drug approval or registration transparent? ● Does the country have sufficient technical, human, institutional, and financial capacity to fully regulate their pharmaceutical markets? ● Are post-marketing surveillance systems in place to routinely monitor for substandard and falsified medical products and enable appropriate

DIAGNOSTIC AREA	CORRUPTION DIAGNOSTIC QUESTIONS
	<p>and effective regulatory action against these products?</p> <ul style="list-style-type: none"> ● Do laws and regulations set out legal sanctions that allow for transparent and appropriate enforcement actions? ● Are there sanitary regulations and are they enforced for restaurants or food production?
Substandard and counterfeit goods	<ul style="list-style-type: none"> ● Is there an unethical drug promotion by suppliers or the government? ● Are counterfeit drugs readily available? ● Is the regulatory process for approval and licensing of drugs transparent? ● Are drug inspectors well paid? Are inspections clearly regulated? Are findings made public?
Education of Health Professionals	<ul style="list-style-type: none"> ● Is the application process to medical schools and other public health training programs transparent and standardized? ● Is the admission and selection process at the medical schools and other public health training programs transparent and subject to systematic (internal/external) control? Are the decision makers accountable to the public or other reviewers? ● Do medical students and other students in public health training programs often bribe doctors/professors to get qualified? ● Are healthcare professionals competent?
Hiring and Promotion	<ul style="list-style-type: none"> ● Is there formal independence of the public sector? Is the public sector independent in practice? ● What safeguards exist to prevent political interference in the public sector? Are they effective? ● Is there a law and detailed implementing regulations governing public employment? ● Are political appointees clearly distinguished from career civil servants and public service employees (i.e. non civil servant status) as a matter of law and policy? ● Is there a legislative framework for the civil service regulating recruitment, job security and independence? Is it followed? ● Are there specific rules for transparent hiring and promotion to help avoid abuses of patronage, nepotism and favoritism and to foster the creation of an independent civil service? Are these rules enforced? ● Is there a system of competitive exams for prospective civil servants? ● Are vacancies advertised publicly to ensure fair and open competition? ● Does the civil service lay out clear job descriptions and qualification standards for all positions for hiring and promotion? ● Are civil servants hired and promoted according to professional criteria, which are known to all employees? ● Are periodic reviews of staff performance carried out and documented?

DIAGNOSTIC AREA	CORRUPTION DIAGNOSTIC QUESTIONS
	<ul style="list-style-type: none"> ● Are rewards and promotions (including compensation packages and pension funds) based upon these reviews, including any infractions? Is it documented? ● Are the outcomes of personnel selection and promotion regularly reviewed? ● Is it documented? ● Is special attention given to officials in positions particularly susceptible to corruption (e.g. public procurement, inspections, etc.)? ● Is competition among officials promoted via overlapping responsibilities and jurisdictions (e.g., passport agencies in various areas)? ● Are task assignments of supervisors and employees periodically changed to reduce insularity (for example, every 1-2 years)? ● Is training conducted regularly for civil servants, on rules and procedures governing recruitment, hiring, and promotion? ● Are civil servants who are dismissed from employment on grounds of corruption or professional malfeasance barred from public service? ● Is there an oversight body that reviews hiring and promotion decisions and ensures fairness and professionalism in recruitment?
Integrity mechanisms	<ul style="list-style-type: none"> ● Are there codes of conduct for public servants or any other legislation regulating core values and ethics of public service? What is their legal status? Is there any evidence of their effectiveness? ● Are core public service values communicated when someone joins the public service? Are they included in the employment contract/document? ● Are these codes nation-wide, local, or sector-specific? ● Are there rules (including registries) concerning acceptance of gifts and hospitality? ● If so, are these registers kept up to date? By whom? Are they made public? ● Are there rules on conflict of interest? Are they effective and implemented in practice? Are they applied nation-wide, locally, and across sectors? ● Do restrictions on post-public service employment exist? Are they enforced? ● Is bribery of civil servants/public sector officials an offense? If so, is such bribery governed by criminal or administrative law, or both? Is it enforced? ● Is it enforced fairly throughout all levels of officials and civil servants?
Internal audit and controls	<ul style="list-style-type: none"> ● How does internal control support corruption prevention efforts (e.g., does it enable management to detect irregularities and identify procedural problems)? ● Do health sector institutions have internal audit units? Are they






DIAGNOSTIC AREA	CORRUPTION DIAGNOSTIC QUESTIONS
	<p>sufficiently well funded and staffed with qualified personnel to complete their mandates?</p> <ul style="list-style-type: none"> ● Do health sector institutions have internal audit committees? Are these committees active? Are at least half of the membership of the audit committee functionally independent from the operations and management of the institution? ● Do health sector institutions analyze systemic failures and trends in criminal and disciplinary cases? Does the review of problems lead to specific recommendations to strengthen prevention strategies? Are the recommendations implemented? Are the recommendations made available to supervisory bodies or legislators? ● Does the government identify corruption risks and develop appropriate safeguards and controls? ● Are employees trained on how to manage corruption risks and rewarded for identifying responses to them?
Transparency	<ul style="list-style-type: none"> ● What kinds of disclosure rules govern the civil service? ● Do some civil servants have to disclose assets? Does this take place in practice? Is there an independent agency that monitors disclosure? ● Is such disclosure required to be publicly accessible? Is it, in practice? ● Must procedures, criteria and fees for administrative decisions be published (e.g. for granting permits, licenses, bank loans, building plots, tax assessments, etc)? Are they? ● To what extent are there electronic provisions for public services (i.e. ePayment or mobile payment for health fees, use of eProcurement)? ● Have these demonstrably had an impact on opportunities for corruption?
Independent Audit	<ul style="list-style-type: none"> ● Is the supreme audit institution (SAI), auditor-general, or comparable body guaranteed constitutionally or through primary legislation? ● Is there formal independence for the SAI? Is it independent in practice? In practice, has the SAI been protected from political interference? ● Does the SAI have reasonable access to all information, facilities and persons within the health sector without hindrance for the conduct of audits? ● Are the total resources of the SAI – funding and staffing level – adequate in comparison with the budgets of all the entities subject to audit by the SAI? ● Has the SAI established any auditing standards? If such standards have been established, are they compatible with other international standards, such as the INTOSAI standards? If the SAI has not established its own internal standards, has it adopted other international standards and does it use such standards in its operations? Do the internal policies and procedures (e.g. Audit






DIAGNOSTIC AREA	CORRUPTION DIAGNOSTIC QUESTIONS
	<p>Manuals) provide sufficient guidance for applying auditing standards and managing the audit process? If no policies or procedures have been established, how does the SAI manage itself?</p> <ul style="list-style-type: none"> • Is the policy established for types of audit and their frequency? Is this policy clear, free of political influence and strictly followed? If the SAI does not undertake performance audits, what are the reasons for not doing so, e.g., mandate restrictions or lack of adequate trained staff? Does the SAI evaluate the effectiveness of internal audits and internal control systems in its audits?
Demonstrated Political Will	<p>Did the government initiate any policies or reforms to address corruption, increase transparency and accountability? If so, what policies and reforms were implemented? Did the government establish milestones and measurements for effectiveness of the reforms? To what extent were these reforms effective? Is there a consensus among branches of the government and governmental institutions about reforms? Who is a champion?</p>






Source: Adapted from https://pdf.usaid.gov/pdf_docs/pa00jp37.pdf

ANNEX 8: CROSSWALK OF CORRUPTION CONSIDERATIONS AND APPROACHES

The table below provides illustrative examples for the main anti-corruption approaches for each of the key health sector corruption risk areas highlighted in section 1 of the guide. These approaches are only illustrative and are not a comprehensive list of potential approaches.

	 Transparency and Awareness Raising	 Social and Institutional Accountability	 Prevention	 Detection	 Response
Theft, fraud and misuse in public health supply chains	Disclose procurement data related to pharmaceutical procurements.	Citizen checks of health facility medical stores.	Implementation of segregation of duties in pharmaceutical procurements and payments.	Training of Supreme Audit institutions on supply chain audit techniques.	Sensitize justice sector actors on how to investigate and adjudicate health supply chain fraud.
Corruption in medical regulation, policy and drug approvals	Publication of medical legal framework and procedures for rule-making.	Conduct of stakeholder engagement and comment periods in development of new medical statutes and regulations.	Introduction of conflict of interest disclosure requirements for staff involved in drug approval processes.	Conduct of independent systematic reviews of drug approval decisions.	Introduce and enforce administrative and criminal sanctions for failing to disclose conflicts of interest.
Substandard and counterfeit goods	Disclose lists of pharmacies or distributors known to have sold substandard or counterfeit medicines and the specific medicines affected.	Support for public campaigns by civil society to create pressure for the government to address the problem of counterfeit and substandard medications.	Introduce use of modern testing methods by officials conducting inspections at the border to detect shipments of substandard or counterfeit medicines.	Train dispensing staff in pharmacies to detect and report substandard and counterfeit medicines.	Train law enforcement to investigate cases of illicit trade in substandard and counterfeit medical products.

	 Transparency and Awareness Raising	 Social and Institutional Accountability	 Prevention	 Detection	 Response
Informal payments	Publicly disclose authorized fees for health services and public awareness campaigns on patients rights to not pay informal fees and charges.	Introduce a reporting mechanism for patients to report requests for informal payments.	Review cost recovery requirements for the package of essential health services and ensure health facilities receive adequate funds to meet resource requirements.	Conduct of stakeholder surveys to assess the prevalence of informal fees in the area serving a targeted health facility.	Introduce a system of repercussions for health facilities or health practitioners found to routinely charge informal fees and charges.
Ghost Workers and absenteeism	Publicly post of health facility hours and minimum staffing requirements.	Launch or expand citizen reporting mechanism regarding staff absenteeism.	Integration of HR MIS and payroll systems to eliminate opportunities for ghost workers to enter the system.	Conduct of payroll audits and/or civil service census.	Introduce or enforce administrative sanctions for absenteeism.
Corruption in public sector hiring	Publicize all new positions being hired in widely accessible platforms along with hiring requirements and criteria.	Engage health civil society groups during public comment period for minimum requirements included in competency frameworks for key positions.	Establish clear procedures and documentation requirements for hiring panels.	Support period systematic reviews of hiring decisions.	Introduce or enforce administrative sanctions for cases of nepotism in hiring.
Corruption in medical referral and billing	Establish requirements for medical providers to disclose any visits and gifts from industry representatives.	Introduce a reporting mechanism for patients to report potential cases of self-referrals for investigation.	Educate providers regarding rules prohibiting self-referrals or the acceptance of kick-backs to provide referrals.	Train internal audit staff to better detect falsified billing.	Introduce or enforce administrative or criminal sanctions for providers accepting kick-backs to provide referrals.
Corruption in the	Expand awareness	Use of third party	Enhance local partner	Provide wraparound	Educate USAID staff on

	 Transparency and Awareness Raising	 Social and Institutional Accountability	 Prevention	 Detection	 Response
use of health sector foreign assistance	raising with implementing partners on corruption risks and appropriate mitigation measures.	monitoring of PIO agreements.	capacity on financial management, internal controls, and reporting.	technical assistance to Supreme Audit Institutions supporting the audit of health sector G2G activities.	appropriate methods to report and escalate suspected corruption issues.