TRANSPARENCY INTERNATIONAL Rwanda

CORRUPTION RISK ASSESSMENT OF THE HEALTH SECTOR IN RWANDA

In partnership with Canada

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Transparency International is a global movement with one vision: a world in which government, business, civil society and the daily lives of people are free of corruption. With more than 100 chapters worldwide and an international secretariat in Berlin, we are leading the fight against corruption to turn this vision into reality.

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Author: Transparency International Rwanda

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ALAC: Advocacy and Legal Advice Centres

CBHI: Community Based Health Insurance

ECD: Early Childhood Development

FGD: Focus Group Discussions

GAC: Global Affairs Canada

GMO: Gender Monitoring Office

KII: Key Informant Interview

MIGEPROF: Ministry of Gender and Family Promotion

MINALOC: Ministry of Local Government

MoH: Ministry of Health

NCDA: National Child Development Agency

RSSB: Rwanda Social Security Board

SIDA: Swedish International Development Cooperation Agency

TI: Transparency International

UNDP: United Nations Development Programme

RAB: Rwanda Agriculture Board

MIFOTRA: Ministry of Public Service and Labour

EXECUTIVE SUMMARY

This corruption risk assessment aims to assess the corruption risk in the delivery of healthcare in Rwanda, as well as to look at how corruption may prevent women, girls, and other vulnerable groups from their right to access healthcare services. Using literature and primary data from focus group discussions, eleven areas with various decision points that are usually susceptible to corruption were selected in order to assess whether there is a risk of corruption.

Those areas of focus are:

1. UBUDEHE Categorisation
2. Access to CBHI (Mituelle de Santé)
3. Patient transfer services
4. Medical Appointments
5. Healthcare human resource services
6. Internship practices for medical students
7. Hospitalisation/Admission services
8. Medical examinations and prescription of medicine
9. Supply of medicines and non-medical materials
10. Registration and authorization of health facilities
11. Practices of nutritious foods for vulnerable citizens (stunted children and pregnant women)

This assessment employed a participatory methodology that comprised key informant interviews, focus groups, and observational techniques. Interviews and focus group discussions with healthcare providers and users were conducted to gather information regarding the risk of corruption in the above-mentioned services. Respondents also shared their perceptions on the likelihood of corruption in the selected services and its related impact on the victims.

The overall perception of corruption risks among healthcare service providers and users was low to average, although there is variation across the districts studied with respondents from Rubavu and Rusizi on average giving higher risk scores. The highest risk areas in terms of corruption were found to be the Categorisation of UDEBEHE, followed by access to CBHI (Mituelle de Santé).

Nevertheless, despite the low scores obtained from the questionnaires, focus group participants were open and revealed a range of corruption-related incidents they encountered while seeking medical care. For example, testimonies gathered in the research indicate sextortion is perpetrated across different service areas in the healthcare sector, and there are indications that vulnerable women, including widows and those with chronic diseases, are targeted. Focus group discussions often yield more information than questionnaires, particularly when discussing a sensitive topic like corruption.

TEN KEY POLICY RECOMMENDATIONS

1. **Transparent Criteria:** Corruption risk in CBHI practices. MoH, RSSB and MINALOC should establish clear, publicly available criteria for selecting CBHI beneficiaries. This can include eligibility requirements based on income, age, or other objective factors

2. **Digitalization:** Direct interaction between services providers and services seekers may lead to corruption. MoH, RSSB and MINALOC should promote the use of digital tools and platforms for the application and selection process of Community- Based health Insurance beneficiaries

3. **Independent oversight:** Corrupt practices may be tolerated in the absence of active participation from independent oversight organizations in service delivery. MoH should put in place practical ways that enable CSOs, CBOs, and other independent bodies to monitor healthcare delivery in all medical facilities

4. **Electronic systems that reduce discretion by human actors:** Direct interaction between recruiters and applicants may lead to corruption. MoH AND MIFOTRA should promote the use of electronic appointment systems, publication of job and internship opportunities, and applications.

5. **Standard operating procedures:** Inconsistency in Standard operating procedures might create room for corruption. MoH AND MIFOTRA should ensure that hiring practices have to go through the same standard evaluation templates, job postings have to be online for a predetermined period of time.

6. **Integrity trainings:** A lack of integrity in the community at large and among service providers could make corruption more likely. MoH, MINALOC, OoO, MINIJUST need to mobilize significant efforts into training healthcare providers and community members on integrity, and often sustained over a long period of time and backed with effective sanctioning

7. **Digital procurement of pharmaceutical products:** Accuracy and precision in inventory control might be hampered by outdated tracking technology and a lack of automated processes. Government needs to Promote the use of electronic systems to track, and manage stock levels as well as any information related to pharmaceuticals in all healthcare facilities

8. **A functional steering committee**: Lack of guidance and direction may create corruption loopholes. MINALOC and MoH need to establish a committee responsible for guiding selection and distribution of nutritious foods to stunted children and pregnant women I all healthcare facilities

9. **Governmental audits**: A lack of oversights may result in abuse of power. Moh need to Establish an effective oversight for all processes related to registration and authorization of health facilities

10. **Corruption reporting mechanism where anonymity is assured:** Inadequate safe and confidential reporting platforms may limit victims from reporting corruption. Government needs to provide an anonymous reporting system for victims to report corruption in all healthcare facilities.

INTRODUCTION

TI Rwanda is implementing the "Inclusive Service Delivery Africa (ISDA)" project to improve access to education and healthcare services for women, girls, and other groups at risk of discrimination in Rwanda by addressing corruption-related barriers.

1. THE ISDA PROJECT

Transparency International is a global movement working in over 100 countries to end the injustice of corruption. Transparency International is implementing a four-year regional project in five countries in Africa (Democratic Republic of Congo, Ghana, Madagascar, Rwanda, and Zimbabwe), aimed at improving access to education and healthcare services for women, girls and other groups at risk of discrimination. TI-S is managing the project in partnership with national chapters in the five countries, with technical expertise and stakeholder engagement support from TI's Global Health Programme and TI's national chapter in Canada. This work is supported by Global Affairs Canada (GAC).

The project responds to a core development challenge linked to the impact of corruption and impunity on access to education and healthcare services for groups at risk of discrimination, particularly women and girls in Africa. Corruption undermines the quality and quantity of public services, fuels inequalities in access to basic services and reduces the resources available for women and groups at risk of discrimination who are more reliant on public services, resulting in heightened poverty for those most marginalised.

To address corruption-related barriers to gender equality in education and healthcare, the project is focusing on three dimensions of change:

- A performance change of public institutions that have the capacities to ensure that education and healthcare services are provided free of corruption (supply side of services);
- A behavioural change among citizens, particularly women, girls and those at risk of discrimination, to speak out and report corruption and demand accountable and transparent services; and
- A practice change among influential intermediaries and stakeholders who engage in coalitions and partnerships to mainstream anti-corruption issues within the education and healthcare agenda and create a supportive environment to reduce corruption-related barriers to gender equality in the education and health sector.

Ultimately, the desired impact is that more women, girls and individuals and groups at risk of discrimination are no longer being left behind because the attention and spotlight of the interwoven nature of corruption and discrimination and how they act as barriers to gender equality in education and health will become mainstreamed and top of mind among public institutions and influential stakeholders in the education and healthcare sector. Not only will they

feel like they are no longer left behind, but they will exercise their rights and demand results and accountability from those entrusted to provide these services corruption free.

At an institutional level and policy level, governments that embed policies, procedures and mechanisms of accountability and transparency, will be able to more effectively detect and sanction those that abuse their power and hold to account those that prey on marginalized communities that already deal with other forms of discrimination. This will ultimately help to close loopholes and reduce vulnerabilities that women, girls and groups at risk of discrimination face, giving them an equal opportunity to access vital basic services to protect and promote their human dignity and collectively, this will contribute to increased citizen trust and confidence in the institutions that deliver inclusive services as well as reinforce norms, behaviours and practices that strengthen a gender sensitive social fabric within communities and contribute towards countries' national development progress to reduce poverty and promote justice in line with the SDGs.

Transparency International Rwanda is the national chapter leading the implementation of the ISDA project in Rwanda. TI Rwanda, with its experience in citizen engagement, is eager to collaborate with key stakeholders to address issues that may have a negative impact on the lives of women, girls, and other groups at risk of discrimination. TI-RW has various mechanisms in place to engage citizens, inform local leaders for advocacy purposes, hold local leaders accountable, and ensure transparency while serving citizens.

TI-RW has established Advocacy and Legal Advice Centres (ALACs) in 5 districts and one at Headquarters. These ALACs have permanent employees (With legal expertise) who provide legal advice and technical support to citizens who seek redress for their corruption complaints through various channels including gender-sensitive reporting platforms and IT-based ones like "IFATE". Under the ISDA project, ALACs support gender-sensitive corruption reporting and case management with a specific focus on the education and health sectors. Through ALACs, TI-Rwanda has also begun to provide legal aid and advocacy support to women, girls, and other groups at risk of discrimination, as well as victims and witnesses of corruption in the education and health sectors.

2. CORRUPTION RISK ASSESSMENT

A corruption risk assessment is a diagnostic tool which seeks to identify weaknesses within a system which may present opportunities for corruption to occur (TI 2011). Several different corruption risk assessment methodologies have been developed. Most corruption risk assessments take an institutional approach. They aim to identify the institutional processes and practices that are vulnerable to corruption, as well as to identify weaknesses in rules and regulations in the institution, sector and/or process under analysis (TI 2011). They can be applied at all levels from government institutions to donor support programmes and down to sectoral programmes (TI 2011).

The corruption risk assessment methodology implemented by the ISDA project is informed by a conceptual framework document titled "Managing Risks to Corruption in the Health Sector", which is in the ownership of the United Nations Development Programme (UNDP). As of September 2023, this document is still under development and is not yet published. UNDP has given permission to the ISDA project team to use the document.

3. AREAS OF FOCUS

3.1. BACKGROUND

As it has been reported in various studies, corruption poses a significant barrier to countries' development, particularly for its most vulnerable residents. According to a report released by WHO in 2020, corruption in health systems not only squanders scarce public resources and development funds allocated to the health sector, but also restricts citizens access to services, erodes citizens' trust in governments, and worsens health services. In its analysis, WHO found that the consequences of corruption in health systems often affect poor and vulnerable groups the most (WHO, 2020).

In the same vein, Transparency International identifies corruption as one of the causes of inadequate healthcare in low-income countries. The report reveals that one of the major factors contributing to the poor performance of health systems, which has disastrous effects on the health and life of millions of people, is corruption. Transparency International claims that corruption impedes the provision of public goods like healthcare by draining resources from already limited healthcare budgets, causing an inefficient allocation of resources (TI, 2021). According to a survey by Swedish International Development Cooperation Agency (SIDA, 2017), corruption tends to make gender disparities worse. The analysis demonstrates that people who are poor, illiterate, and unaware of their rights and entitlements are disproportionately affected by corruption. The findings of their study also show that corruption can affect both men and women in a variety of ways, but that because of the gender gap in society, women are frequently more susceptible to corruption and its consequences.

In Rwanda, various reports show that a lot has been done in terms of improving healthcare for all. According to the Ministry of Health, Rwanda has built a network of healthcare facilities with good geographic coverage with the aid of a reliable fleet of ambulances for pre-hospital and emergency care. From the community level up to the referral level, the healthcare packages have been specified for each level (MoH, 2020g). In order to speed up the development of nutrition and food security initiatives, Rwanda has identified multisectoral approaches and coordination efforts as essential components. In order to complement the National Food and Nutrition Coordination Secretariat, which was established to help coordinate the country's efforts to reduce undernutrition, the government established a national early childhood development (ECD) program with a family-focused strategy to address child stunting in the country (UNDP, 2018). Although many efforts have been made in the health sector, various studies show the gap of corruption that still prevents the most vulnerable people from accessing healthcare.

An example is the report of Transparency International Rwanda (TI-Rwanda, 2020a) which revealed unequal access to healthcare and medicine in various health facilities operating in Rwanda. It found that even a low level of corruption prevents some members of the community from getting access to quality medical care (TI-Rwanda, 2020a). The report found that some citizens opt to pay a small bribe in exchange for receiving high-quality and fast services. In its Situational Analysis on Compliance and Effectiveness of Health Sector Service Delivery during the Covid-19 Pandemic, TI-Rwanda found that corruption is still observable in health service delivery chain, albeit at relatively low levels (TI-Rwanda, 2020b).

In Rwanda as well as other parts of the world, inequality in opportunity makes women, girls, and other vulnerable groups into easy targets for corruption. (SIDA, 2017). A UNDP study found that women still face gender-based violence, notably sexual harassment, and assault by males in positions of authority in Rwanda (UNDP, 2018). As per the Rwandan Gender Monitoring Office's report, women are still more likely to contract HIV than males in the same age range (15-49 Years) due to biological and social variables, including economic dependence of women upon men (GMO, 2018).

3.2. UNDERLYING RATIONALE FOR SELECTED AREAS OF FOCUS

The services that were chosen for focus under this study were those that are regularly associated with corrupt practices and healthcare services, such as the community-based health insurance program, that are frequently needed by vulnerable people. These areas are highlighted in the literature having a focus on Rwanda and but also more globally. Participants in focus groups also assisted in choosing services that are frequently susceptible to corruption threats. Some of the loopholes that lead to corruption include a lack of transparent job offers.

According to TI, high levels of corruption within the healthcare system work against merit-based hiring and promotion, negatively affecting the overall skill set, morale, and performance of the workforce which may lead to stagnation in terms of improving maternal health and particularly reducing maternal mortality (TI, 2021). In a UN Women (2020) report, gender inequality at work was linked with increased odds of sexual abuse at workplace. In the same report, UN WOMEN adds that sexual harassment is more likely to result in a female health worker leaving a job (UN WOMEN, 2020. There is therefore a need to assess the extent of corruption risks in services of human resources for health and in internship practices for medical students.

A study conducted by the U4 Anticorruption Resource Center and CMI also shows that corruption in the health sector limits access to quality, equity, efficiency, and effectiveness of health services (U4/CMI, 2020). In some countries, patients are required to pay bribes in exchange for admission and a hospital bed (Naher et al., 2020). Therefore, there is a need to examine whether some of the essential services in healthcare, including patient transfers, admissions, medical appointments, medical examinations and medication administration, face corruption risks in Rwanda. Corruption can impact each step of the delivery process for health services, including the management of organizational resources and procurement of medical supplies (TI, 2017).

Therefore, there is a need to investigate potential corruption risks in the supply of medical and non-medical materials as well as in the registration and authorization of health facilities in this assessment. Even though there are many different kinds of assistance available for addressing of poverty and food insecurity in Rwanda, the Ministry of Gender and Family Promotion ded in the Rwanda Country Strategic Review of Food and Nutrition Security (MIGEPROF, that possible corruption in the social service delivery system needs greater attention.

3.2.1.UBUDEHE CATEGORISATION

UBUDEHE categorization entails classifying all households into different categories based on their level of wealth or poverty; the system is used to organise forms of assistance provided in various government programs aimed at lifting people out of poverty (MINALOC, 2018). Usually, UBUDEHE has four categories: category 1 corresponds to the poorest households whose members enjoy unlimited access to public health services provided free of charge. UBUDEHE categories 2, 3, and 4, consisting of more affluent residents are required to pay a co-payment commensurate with their income level in order to obtain public health care (Basel Institute on Governance, 2017). Currently, those who fall into categories 1 and 2 are frequently eligible for different packages of assistance from the government or other partners.

Healthcare services, are among the assistance provided to members of households in the lower categories of UBUDEHE. For instance, the Ministry of Health published directive No. 20/0002 on February 26, 2018, regulating the free distribution of Long-Lasting Impregnated (Bed) Nets to residents in UBUDEHE 1 and 2, and the sale of other nets to those in UBUDEHE 3 and 4 (MoH, 2020g). In the same vein, UBUDEHE categories determine how contributions under Community Based Health Insurance (CBHI) coverage is determined. Contributions of CBHI is paid based on the UBUDEHE category that a person belongs to. The government and other donors fund Category I, which pays 3,000 Frw each person per year. Persons under Categories II and III also pay 3,000 Frw, whereas persons under Category IV pays 7,000 Frw.

Nevertheless, there is evidence that the UBUDEHE categorization still has gaps. Community councils are often in charge of carrying out the UBUDEHE categorization procedure and making sure that residents obtain government-issued health insurance cards, which are necessary in order to obtain medical treatments. However, research shows that corruption can hinder the smooth running of this process (Basel Institute on Governance, 2017). In a working paper produced by Dr. James Ngamije in 2021, the UBUDEHE categorization process was found to be unfair in terms of identifying the poor/non-poor. There is still weakness in the process of ranking the population using community participation techniques. Dr. Ngamije found there have been cases where people are unfairly categorized (Ngamije, 2021). According to his analysis, only 6% of respondents were happy with their UBUDEHE categorization, while the majority, 62%, thought their placement in UBUDEHE categories was unfair. Moreover, given that some individuals desire or need to be placed in the lower categories in order to receive various benefits, there may be corruption risks.

3.2.2. ACCESS TO CBHI (MITUELLE DE SANTÉ)

Community-based health insurance often known as mutuelle de santé, is a form of solidarity health insurance in which people (mostly families) band together and financially contribute towards the protection and receipt of medical care for the wider community. It aims to help families/individuals who do not have enough financial means to access affordable healthcare services Any person who enrols in the Community-Based Health Insurance program and makes an annual contribution, whether directly or indirectly, is considered a member. According to RSSB, the government and other contributors pay premiums to those who fall under UBUDEHE category I while citizens who belong to other categories are required to pay their own premiums. According to some studies, some people who must cover their own premiums nevertheless struggle because of their limited means. The findings of an IMF working paper demonstrate that the premium and benefit structures of the programs are somehow unfavourable to the poor because some households choose not to enrol their families in CBHI due to a lack of resources (IMF, 2019).

Although families in UBUDEHEDE category 1 are not required to pay CBHI contributions (the government and partners cover family contributions in this category), it is likely that those in other categories, especially category 2, are still unable to afford community-based health insurance. A study by Nyandekwe et al., (2020) revealed that there is an imbalance between unit cost and unit income per CBHI beneficiary. For those who are not eligible for free access to CBHI coverage but lack the resources to pay for it themselves, numerous partners provide financial assistance towards paying premiums. For instance, in May 2022, the Rwanda Social Security Board (RSSB) received support from the AIDS Healthcare Foundation Rwanda (AHF Rwanda) for a grant of 133,866,000 Frw that was used to fund CBHI premiums for 10,822 families (totalling 44,622 beneficiaries). The process of selecting and enrolling the vulnerable people to receive financial assistance to pay CBHI premiums may be vulnerable to corruption risk. Due to the high demand from numerous people who need to be added to the list of aid recipients because they are unable to pay for CBHI coverage, there may be room for various forms of corruption. Additionally, a Transparency International Rwanda study demonstrated that corruption can impact the health insurance card registration process (TI-Rwanda, 2018). A study conducted on petty corruption in the health sector of Rwanda, revealed some of the forms of corruption in the services related to the issuance of health insurance cards (Basel Institute on Governance, 2017). Some instances of revealed corruption include the following:

1) Bribing during the health insurance card registration process
2) Favouritism in the service delivery
3) Gift-giving

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3.2.3. PATIENT TRANSFER SERVICES

Patients may need to be transferred from one facility to another for a variety of medical reasons. Corruption risks are possible during the process especially on deciding whether the patient is suitable for transfer, arranging patient beds, preparing transport facilities, and throughout other required processes that link patients and healthcare providers. There is also a risk that medical staff transfer a patient to another facility for unnecessary procedures, for which more fees are extracted from the patient and the staff obtains a commission for every referral made. (TI-Rwanda, 2022b). A Situational Analysis of compliance and effectiveness of healthcare delivery during the Covid-19 pandemic conducted by Transparency International Rwanda (TI-Rwanda, 2020b) found that 27% of respondents experienced corruption when requesting transfers.

3.2.4. MEDICAL APPOINTMENTS

In Rwanda's health sector, there are still a limited number of medical professionals to meet the demand for services. As highlighted in the Health Sector Policy of Rwanda, the Ministry of Health is still mobilising resources to face the challenges posed by the low ratio of health care workers to the general population (MoH, 2015). In certain healthcare facilities therefore, securing an appointment with a medical professional can take very long. This can lead to the risk that patients and medical officials engage in corruption to skip waiting times.

3.2.5. HEALTHCARE HUMAN RESOURCE SERVICES

In general, human resource services can be corrupted in numerous ways. For instance, a Transparency International Rwanda report (TI-Rwanda, 2022a) found a lack of transparency in hiring, promoting, and granting other benefits to employees. It was also shown that gender-based corruption typically affects people differently depending on a variety of factors, including gender. According to TI-Rwanda's study on gender-based corruption in the workplace, women are especially vulnerable to several forms of gender-based corruption in the workplace. Women are frequently targeted for a variety of reasons, including the fact that they often have fewer career options and are therefore more likely to be pressurised into sexual encounters in exchange for job benefits (TI-Rwanda, 2022a). Corruption in human resource management can lead to adverse health outcomes. USAID's research found that corruption in hiring procedures can result unqualified employees being employed carry out intricate treatment protocols (USAID, 2022).

3.2.6. INTERNSHIP PRACTICES FOR MEDICAL STUDENTS

There are various studies demonstrating that corruption can affect the administration of internships. According to research published in 2019 by the U4 Anti-Corruption Resource Center, fraud and corruption in higher education are global issue that prevents the development of human capital, particularly in developing nations with internships being one of the areas listed in the study as being vulnerable to corruption (U4/CMI, 2019). In a study conducted by Transparency International Rwanda on governance in TVET schools in Rwanda, several corruption cases were found in the internship application and certification processes (TI-Rwanda, 2021a). The present research aimed to assess the risks within internship programmes for medical students.

3.2.7. HOSPITALISATION/ADMISSION SERVICES

As per a number of studies, corruption affects hospitalization and admission services. (UNODOC, 2019,Naher et al. (2020) conducted research in low and middle-income countries of south and south-east Asia. Their findings revealed many cases of informal payments to facility staff to speed up the admissions procedure in public health facilities. In district hospitals and sub-district hospitals, some patients paid an extra fee for admission; 8% of them did so at least three times; this was more common among the poor since they lacked connections with or recommendations from influential people (Naher et al., 2020. According to a Transparency International study on healthcare corruption, patients were frequently charged for services that should have been free of charge (such as obtaining a hospital bed in a public hospitals) (TI, 2021).

3.2.8. MEDICAL EXAMINATIONS AND PRESCRIPTION OF MEDICINE

Medical tests and prescription are among the key healthcare services that are susceptible to corruption. The corruption risks associated with medical examinations and prescription of medicine can include overcharging of patients for medicine, demanding extra payments to carry out a tests/prescribe medicines, etc. As reported by CMI–U4 in 2021, Healthcare professionals can

be bribed by suppliers to prescribe poor-quality or harmful products. The patient-provider relationship is also marked by risks stemming from imbalances in information and inelastic demand for services. Resulting corruption problems include, among others, inappropriate ordering of tests and procedures to increase financial gain (Transparency International Global Health, 2016).

3.2.9. SUPPLY OF MEDICINES AND NON-MEDICAL MATERIALS SUPPLY

Another entry point of corruption is services related to medical and non-medical material supply. The U4 Anti-Corruption Resource Centre report highlights the risks of corruption in the drug supply chain and procurement of materials (U4, 2020b). WHO identified three major types of corruption in the health sector, including procurement, pharmaceuticals purchasing and provider payments (WHO, 2020). Additionally, Transparency International noted that the purchase of medical supplies and equipment is particularly vulnerable to corruption (TI, 2021).

In 2010, USAID used an evaluation methodology designed by the World Health Organization (WHO) to analyse the susceptibility of Rwanda's pharmaceutical supply and management system to corruption. The assessment finds that stock-outs and the consequent urgent need for medicines often lead to the relaxation of procurement rules and procedures in the interest of expediency. This increases the threat of corruption and abuse within the system. During the COVID-19 pandemic, newspapers reported on the arrest of pharmacists and senior staff members from the vaccination unit on charges of "misusing property of public interest" (COVID-19 vaccines) (USAID,2010).

3.2.10. REGISTRATION AND AUTHORIZATION OF HEALTH FACILITIES

Corruption risks in the registration and authorization of medical facilities, equipment, or pharmaceutical items has previously been highlighted in various studies. For example, Transparency Internaational's (TI, 2021) research indicated the possibility of corruption during the registration, licensing and inspection of pharmaceutical facilities as well as during clinical trials, drug registration and authorization. According to their findings, there is a likelihood that medication manufacturers may pay government officials to register their products or delay the registration of products from their rivals (TI, 2021. Potential corruption in the licensing, inspection, and registration of pharmaceutical facilities was also highlighted by the U4 Anti-Corruption Centre (U4 2020b).

3.2.11. PRACTICES OF NUTRITIOUS FOODS FOR VULNERABLE CITIZENS (STUNTED CHILDREN AND PREGNANT WOMEN)

In Rwanda, stunted children and pregnant women receive support with nutritious foods. Out of the many people who need aid, local authorities must choose the most vulnerable individuals for this support. However, this may constitute a gap as the Rwanda Governance Board (RGB, 2018) has found that some local leaders act corruptly when choosing the beneficiaries of other programs aimed at helping the poor. RGB found evidence of fraudulent practices being used to the GIRINKA Program's beneficiaries, including bribery (RGB, 2018).

The GIRINKA (One Cow per Poor Family) program was launched in 2006 to fight rural poverty. The main goals of the GIRINKA Program are to boost agricultural production by using manure as fertilizer, improve livelihoods through increasing milk consumption and income creation, reduce poverty through dairy cattle husbandry, and improve soil quality. The village leaders call a meeting to select the beneficiaries through making a list of poor households that should benefit from program cow. As per the guidelines, the distribution of cows is contingent upon the quantity of cows available, and it is done in the order listed with the first person on the list.

To be selected for receiving a cow, an individual must fulfil specific criteria, such as being perceived as economically disadvantaged in their community and possessing less or no alternative source of income (RAB, 2019). Thus, due to the high demand, there may be a possibility of corruption while selecting the recipients of nutritious foods.

3.3. OVERVIEW OF HEALTHCARE SECTOR IN RWANDA

This section briefly discusses the background of Rwanda's health sector, explains the selection criteria, and explains why certain areas may be vulnerable to corruption. This section also discusses how previous international and local studies assess the status of corruption in the health sector. The literature in this section explains why it is common for women, girls, and other groups at risk of discrimination to fall victim to corruption when requesting medical care.

3.4. ORGANIZATION OF HEALTHCARE DELIVERY SYSTEM IN RWANDA

The Government of Rwanda has made great efforts to expand the quantity and quality of health facilities and services in order to enable easy access to healthcare for the people. Rwanda's healthcare system extends from community to national referral hospitals to continuously enhance quality, cost-effective, preventive, curative, and rehabilitative healthcare services (MoH, 2020g). The Rwandan health system is organized in a pyramidal shape with central, intermediary, and peripheral levels. Below is the organizational framework of the health sector of Rwanda.

Table 1: Organization of Rwanda's Health Care Delivery

LEVEL	SERVICES/RESPONSIBILITIES
Central level	The central level consists of the Ministry of Health, Rwanda Biomedical Center (RBC), and the national referral hospitals. The central level develops policies and strategies, ensures monitoring and evaluation, builds capacities, and mobilizes resources. It is also responsible for organizing and coordinating the intermediary and peripheral levels of the health system and provides them with administrative, technical, and logistical support (MoH, 2015). Five national referral and teaching hospitals have the mission of providing specialized health care, teaching in medical and health sciences schools, and conducting health-related research (WHO, 2022).
Intermediary level	At the province level, provincial hospitals act as intermediary-level referral hospitals. Three referral hospitals and four provincial hospitals are being gradually upgraded to relieve the burden of high numbers of individuals seeking care in national reference hospitals (MoH, 2015)
Peripheral level	This level is made up of a district hospital, an administrative office (district health unit), and a network of clinics, health posts, and community health workers. A district health unit is a type of administrative body in responsible for planning, directing, and overseeing implementing agencies. This unit reports to the vice-mayor for social affairs. These healthcare implementing agencies include; 36 district hospitals, 499 health centers at the sector level, and around 45,516 community health workers serving the population at the village level. Rwanda also has national referral laboratories, national blood transfusion services, national services for purchasing and storing medical supplies, and councils for health professionals to oversee and manage professional practices (MoH, 2018).

Table 2: Administrative structures and related health facilities (Data of 2018)

ADMINISTRATIVE LEVEL	NUMBER	HEALTH FACILITIES	NUMBER
Villages	14,837	Community Health Workers	45,516
Cells	2,148	Health Posts	476
Sectors	416	Health Centers	499
Districts	30	District Hospitals	36
40-45	10	District Pharmacies	30
Provinces (including Kigali city)	5	Provincial Hospitals	4
National level	N/A	National Referral and Teaching Hospitals	8
Registered Private healthcare facilities	250		

Source: (MoH, 2018)

3.5. RWANDA'S LEGAL FRAMEWORK GOVERNING SERVICES UNDER THIS ASSESSMENT

The legal framework that governs all activities related to healthcare in Rwanda consist of Laws, Ministerial instructions, Ministerial orders and regulations. A summary of the legal framework for the areas of focus in this assessment, can be seen in the table below.

Table 3: Legal framework for the services under this assessment

LEGISLATION	DESCRIPTION
Law n° 48/2015 of 23/11/2015	This is the law governing the organization, functioning, and management of health insurance schemes in Rwanda
Ministerial instructions n° 20/7017 of 31/08/2021	Determines the methodology to define the community-based health insurance benefit package
Law N°46/2012 of 14/01/2013	The law establishing the Rwanda Allied Health Professions Council and determining its organization, functioning, and competence
Law No 47/2012 of 14/01/2013	The law relating to the regulation and inspection of food and pharmaceutical products.
Ministerial order nº 002/17/10/tc of 27/10/2017	Determines the fees for registration of pharmaceutical products, medical devices, and other related services
Ministerial instructions nº 7016 of 30/11/2020	Governs dual clinical practice
Ministerial instructions n° 7015 of 30/11/2020	Determines the responsibilities, powers, and functioning of committees in charge of the management of public or subsidised health facilities
Ministerial order nº 002/17/10/tc of 27/10/2017	Determines the fees for registration of pharmaceutical products, medical devices, and other related services
Ministerial order n° 20/20 of 03/06/2010	Establishes the internship program for medical doctors

Source: https://www.moh.gov.rw › moh › Publications

3.6. REFERRAL OF PATIENTS IN THE HEALTHCARE SYSTEM OF RWANDA

A thorough approach to providing health services necessitates proper instruction on service standards at various systemic levels, including effective referral management. Referral is a two-way mechanism that guarantees patients' or clients' access to a continuum of care. Referrals may be made vertically from the community to the more senior levels of the health system, and vice versa, in accordance with the structure of the healthcare system.

Due to factors like cost, location, and other considerations, it may also be horizontal across facilities of comparable quality for the benefit of the patients. Additionally, it can be carried out among several services at the same medical facility (MoH, 2020a). According to the Integrated National Health Sector Referral Guidelines established by the Ministry of Health, a referral flow in the public health sector of Rwanda is as follows.

Table 4: Patient referral flow

LEVEL OF FACILITY	REFERRAL FACILITY
Community level	Community health workers refer patients to health posts or health centers
Health Post	Health posts refer to health centers where a case is not urgent. Health posts will refer patients straight to a district hospital for emergencies involving obstetrics, children, injuries, and NCDs. A health post will also direct clients seeking follow-up at the community level. Second-generation health roles will promptly refer patients to the district hospital.
Health center	Health centers make referrals to district hospitals. Clients will be referred from the health center to the tertiary level in the case of a special emergency (after speaking with the district hospital), bypassing the district hospital to prevent case management delays. Health centers may also refer obstetric emergencies to the nearby upgraded medical facility. For client follow-up or treatment continuation, the health center will also refer patients to the community level.
District Hospitals	Patients at district hospitals are referred to provincial hospitals, reference hospitals, or teaching hospitals directly. For continuity of care or follow-up, district hospitals might counter-refer patients to health centers or community level.
Provincial and referral hospitals	Provincial and referral hospitals transfer patients directly to teaching hospitals. They may also counter-refer patients to district hospitals, health centers, or community levels for continuity of care or follow-up.
Teaching and national referral hospitals	Teaching hospitals and national referral hospitals may counter-refer patients to lower levels for continuity of care or follow-up. These hospitals also have the option of sending patients abroad or to more specialist facilities for further investigations via the Medical Review Board (MRB).
Private institutions	All private facilities can refer to either the private or public health system at any level, depending on the condition and needs of the patient or client as determined by the treating healthcare professional.

Source: (MoH, 2020a)

3.7. PROCUREMENT PROCEDURES FOR PHARMACEUTICAL PRODUCTS IN RWANDA

Pharmaceutical products are in high demand in various healthcare facilities. Therefore, it is essential to establish a fair supply process to prevent any room for wrongdoing or corruption. To maximize the benefits of pharmaceutical purchases and reduce corruption and partiality in procurement, competitive tenders are advised for the majority of pharmaceutical supplies. The Rwanda Medical Supply Ltd (RMS Ltd) and Bureau des Formations Médicales Agréées du Rwanda (BUFMAR) are the two central medical stores importing medicines and consumables for the public sector in Rwanda.

Central medical stores (RMS Ltd and BUFMAR) supply medications and medical supplies to RMS Ltd branches, referral hospitals, national blood transfusion centers, and national reference laboratories. These healthcare facilities can also get supplies from private wholesale pharmacies once medicines and medical supplies are not available at central medical stores. District hospitals, health centers, and provincial hospitals purchase medications and medical supplies from RMS Ltd Branches (MoH, 2021a). Procurement is processed using the electronic logistics management information system (eLMIS). This system was established by the Ministry of Health to improve supply chain processes and best standard practices, and to ensure the availability of accurate logistic data promptly for informed decision-making.

3.8. RWANDA'S HEALTH SECTOR POLICY

The Health Sector Policy provides broad guidelines for the sector, which are expanded upon in the numerous sub-sector policies guiding key health programs. The Health Sector Policy is the basis for all updates to the subsector's policy. The Health Sector Policy is the cornerstone of national health planning and the main information source for all stakeholders in the health sector. The main objective of the policy is to give every resident, regardless of location or financial means, equal and affordable access to high-quality preventative, curative, rehabilitative, and promotional health care. It establishes the goals of the health sector, lists the most important health interventions to achieve these goals, describes the functions of all levels of the health system, and offers recommendations for better organizing and assessing sector operations.

3.9. MINISTRY OF HEALTH'S POLICY STATEMENTS ON HEALTHCARE DELIVERY IN RWANDA

In various documents, the Ministry of Health in Rwanda has been presenting short statements that determine the provision of medical services in various healthcare facilities. The table below highlights some of those statements that are relevant to the present assessment's focus areas.

Table 5: Policy statements on assessment's focus areas

MEDICAL SERVICES	POLICY STATEMENT	POLICY NUMBER	SOURCE
Internship for medical students	The hospital must make sure that the clerkship, training, and internship are completed in compliance with hospital internal policies and procedures as well as the trainee's educational setting and training program while adhering to the standards of training and upholding ethical integrity	HR2-05	(MoH, 2020c)
Admission services	Patient admission and registration must be managed promptly and effectively. Every patient is hospitalized in accordance with the admission standards. Every person who is involved in patient registration and admission must have the authorization required to perform their job obligations, according to hospital policy. In case of emergency, a physician will immediately admit a patient in an emergency through the Emergency/Neonatology/Maternity and Outpatient Departments	LM1-16	(MoH, 2020d)
Medical examinations	The hospital makes sure that every patient who is consulted or admitted has a thorough and prompt medical evaluation that is documented. In an emergency, the physician conducts an immediate (no later than 5 min) examination, in accordance with existing clinical treatment guidelines	CS4-03	(MoH, 2020f)
Medication administration	To reduce medical errors and dangers associated with improper medication usage, healthcare facilities must make sure the standardized approach for managing and administering medication is in place. Healthcare facilities should also conduct monitoring and evaluation practices across the clinic	CS4-16	(MoH, 2020f)
Patient Transfer and Referral	The hospital shall ensure that patient transfers and referrals are done by hospital clinical staff and all relevant patient information is documented in the Referral / Transfer Form and communicated to the receiving facility.	CS4-19	(MoH, 2020e)
Visitors/ Appointment	The hospital shall ensure that visitors are received, oriented and safe while on hospital premise. The hospital shall ensure that Customer Care Officer or Public Relations Officer are easily accessible by visitors and able to receive them appropriately. The hospital ensures the Security Officer is oriented and trained on visitors' orientation. Visitors shall abide by all hospital rules and regulations while on the hospital premise.	LM1-01	(MoH, 2020b)

Source: Compiled by researcher, 2023

RESEARCH DESIGN

RESEARCH DESIGN

A "corruption risk assessment" is a helpful tool for locating the most serious corruption threats in any given sector. Risk assessments do not aim to quantify the perception, existence, or level of corruption. Instead, the objective is to find systemic gaps that could create opportunities for corruption. In its handbook for E-learning, Transparency International has noted that, it is simpler to measure the likelihood that corruption will occur than assessing how frequently it really occurs because corrupt behaviours are hidden and untraceable (TI, 2018).

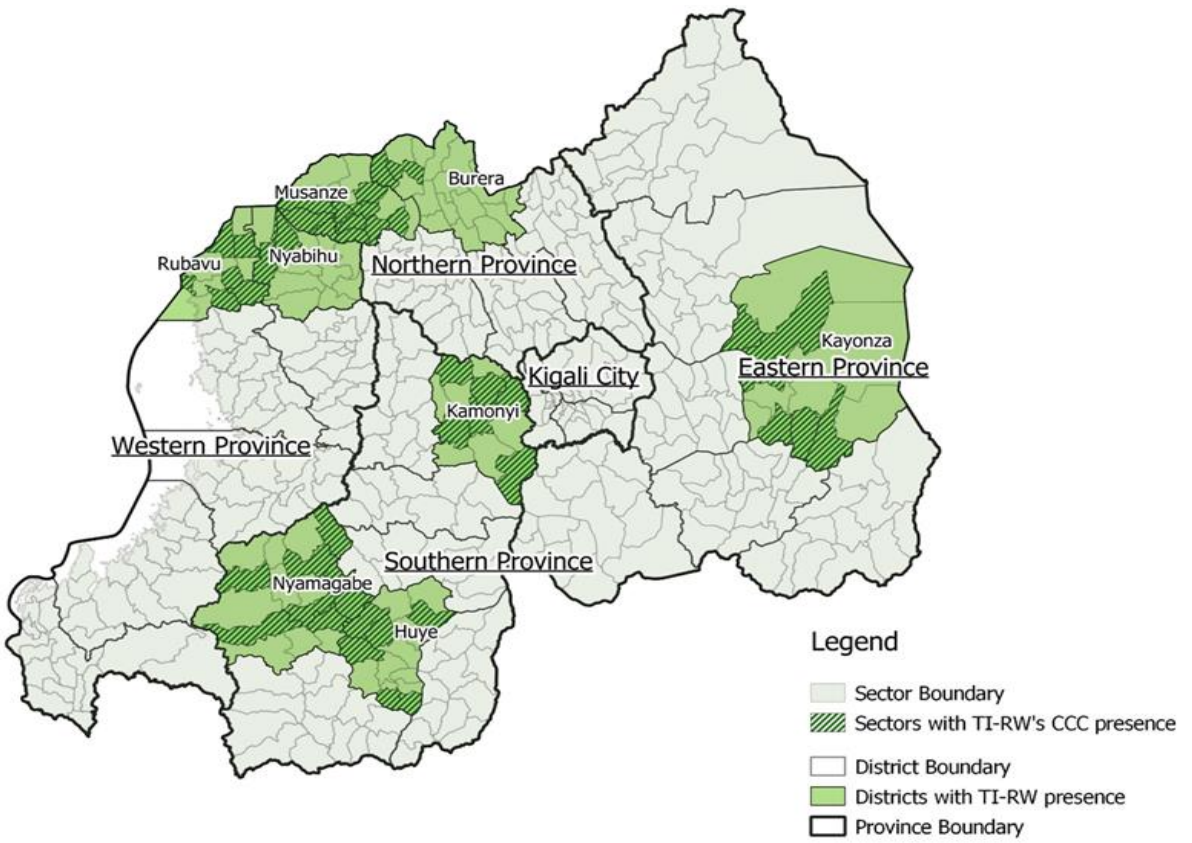
This assessment examines corruption risk in the delivery chain of healthcare in Rwanda. The assessment employed a cross-sectional research design using data collected from both primary and secondary sources. This study design was chosen because it allows researchers to collect data from a variety of participants and compare differences between groups. According to Transparency International it is highly helpful to involve a small group of professionals knowledgeable about the field under study to carry out a corruption risk assessment (TI, 2018). This assessment used a participatory methodology that comprised key informant interviews, focus groups, and observational techniques in order to achieve the stated objectives. Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) were employed to acquire qualitative data, enabling researchers to learn different viewpoints from the administrators of health facilities and hospitals, medical staff as well as the general public who utilizes their services.

The guiding tools for KIIs and FGDs were developed and validated both internally and externally. Respondents of this assessment were selected from five districts in Rwanda (Huye, Kayonza, Musanze, Rubavu, Rusizi). The selection of these districts was made purposively where TI-Rwanda has offices and Advocacy and Legal Advice Centers (ALACS), with a view to establishing successful advocacy campaigns based on the research.

Table 6: Description of the districts sampled

DISTRICT	POPULATION	GENDER		GEOGRAPHICAL LOCATION		DISABILITY (%)	USERS OF CBHI
		Female	**Male**	**Urban**	**Rural**		
Huye	381,900	193,041 ***(50.5%)***	188,859 ***(49.5%)***	79,744 ***(20.9%)***	302,156 ***(79.1%)***	4.5%	93%
Musanze	476,522	249,182 ***(52.3%)***	267,299 ***(48.7%)***	234,258 ***(49.2%)***	242,264 ***(50.8%)***	3.1%	90.5%
Kayonza	457,156	235,708 ***(51.6%)***	221,448 ***(48.4%)***	65,071 ***(14.2%)***	392,085 ***(85.8%)***	2.3%	95.5%
Rubavu	546,683	279,384 ***(51.1%)***	267,299 ***(48.9%)***	294,448 ***(53.9%)***	252,235 ***(46.1%)***	2.5%	93.3%
Rusizi	485,529	249,103 ***(51.3%)***	236,426 ***(48.7%)***	162,165 ***(33.4%)***	323,364 ***(66.6%)***	4.2%	95.6%

Figure 1: Districts map



2. METHODOLOGY

2.1. DESK RESEARCH

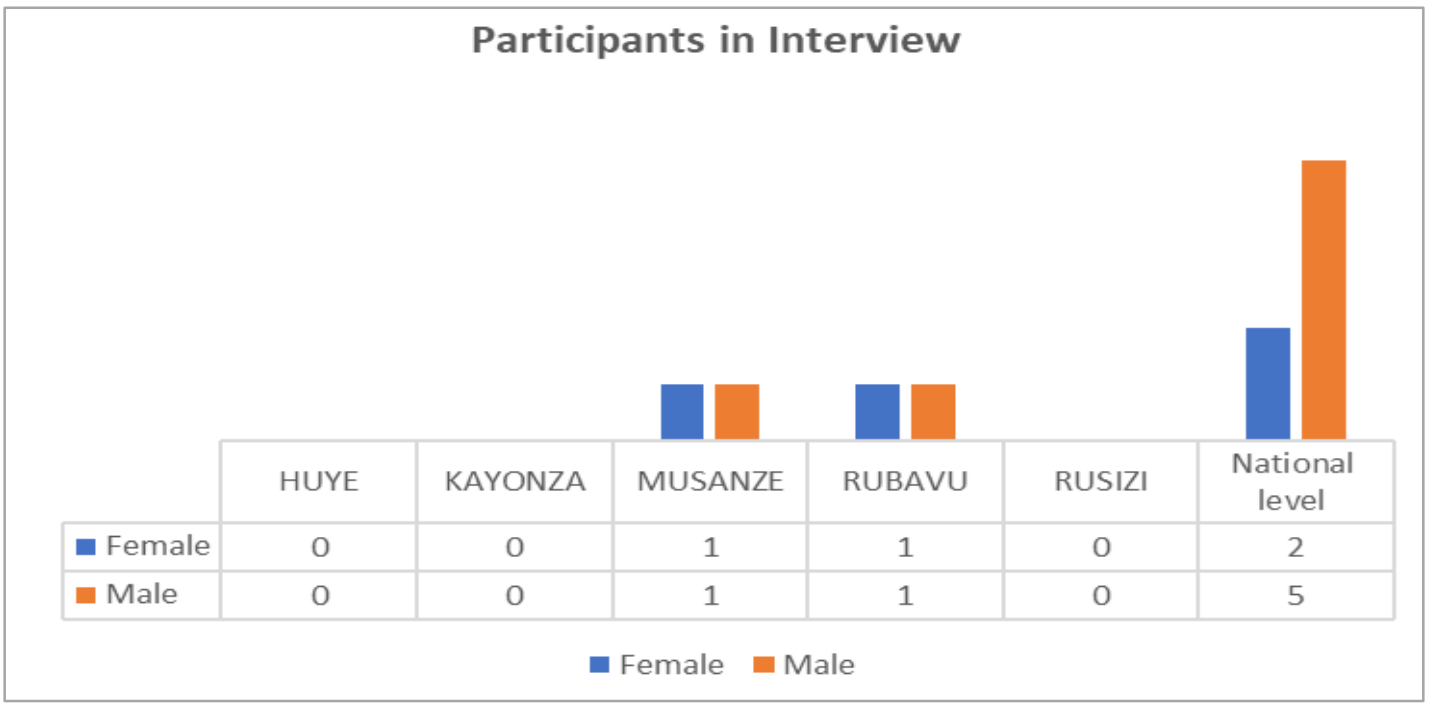
Desk research includes analyses of the sociopolitical context of the country, the overall structure of the health sector, corruption-prone areas, prevalent corruption forms, their causes and effects, and ongoing anti-corruption initiatives. Documents reviewed include; government reports, laws, provisions, national strategies/guidelines and other relevant documents. This provided the background information needed to contextualise the Centered on conducting one-on-one interviews with key stakeholders relevant to the assessment's subject area such as service providers and regulators.

The interview's main focus was on corruption risks specific to the respondents' line of work, and it gave participants the chance to share their in-depth observations and discuss how they perceive and evaluate corruption risks in the context of their job. Participants in the interview were stakeholders from central level healthcare institutions, medical staff and healthcare facility administrators.

Table 7: Participants in Interviews

PARTICIPANTS IN KIIS	DESCRIPTION
Medical staff	Medical staff in various healthcare facilities participated in the interview. Their knowledge and insight as stakeholders in the healthcare delivery system were valuable in reaching assessment's objectives. 5 medical staff participated in the interview.
Administrators of healthcare facilities	Administrators of healthcare facilities implement government policies, procedures, rules, regulations, and other programs. Their ideas, strategies, and experiences made a strong contribution to this assessment. The interview involved 5 members of the management team for the healthcare facilities.
Officials from central healthcare institutions	Policymakers, particularly in the health sector. They design and evaluate health-related policies and initiatives, making it essential to consider their insights in the corruption risk assessment. 4 senior staff participated in interviews

Figure 2: Distribution of respondents (KIIs) per district and gender



As per the above figure, the participants in the interview are 11 in total including 4 women and 7 men. It is evident that national healthcare institutions had a higher participation rate than districts. Due to intended respondents' limited availability, the research team was unable to interview respondents from the districts of Kayonza, Rusizi, and Huye.

2.2. FOCUS GROUP DISCUSSIONS (FGDS)

Purposive sampling, also known as judgemental sampling, was used to gather in-depth information from people with knowledge in the field. Based on the fact that corruption is normally committed out of sight which makes detection difficult, this technique was adopted to identify individuals who have sufficient knowledge in healthcare delivery to help the researchers achieve

the objectives of the assessment. Enumerators visited various healthcare facilities to collect data, selecting respondents who met the criteria and were available. To ensure inclusive participation in this assessment, the research team selected a set of respondents considering people with disabilities, people with chronic illnesses, widows, teen moms, and other vulnerable people. The targeted respondents for focus group discussions were 250, including 240 respondents from all districts considered in this assessment, and 10 respondents from national-level institutions in the health sector. However, due to availability constraints, the sample size in this assessment was 198 (79.2% of the target sample). As the project targets the most vulnerable groups, vulnerable people were also selected to learn more about the difficulties they often face while seeking healthcare. The testimonies from the participants highlight the forms of corruption that vulnerable people often encounter across various healthcare facilities. The following respondent categories were selected using a sampling process. Key stakeholders and subject matter experts participated in a group exercise to better assess the effectiveness of institutional restraints and drivers of corruption in the selected priority area of emphasis. Participants in group discussions include stakeholders in the healthcare delivery chain; there was a total of 191 respondents throughout five districts and 7 respondents at national level participated in FGDs.

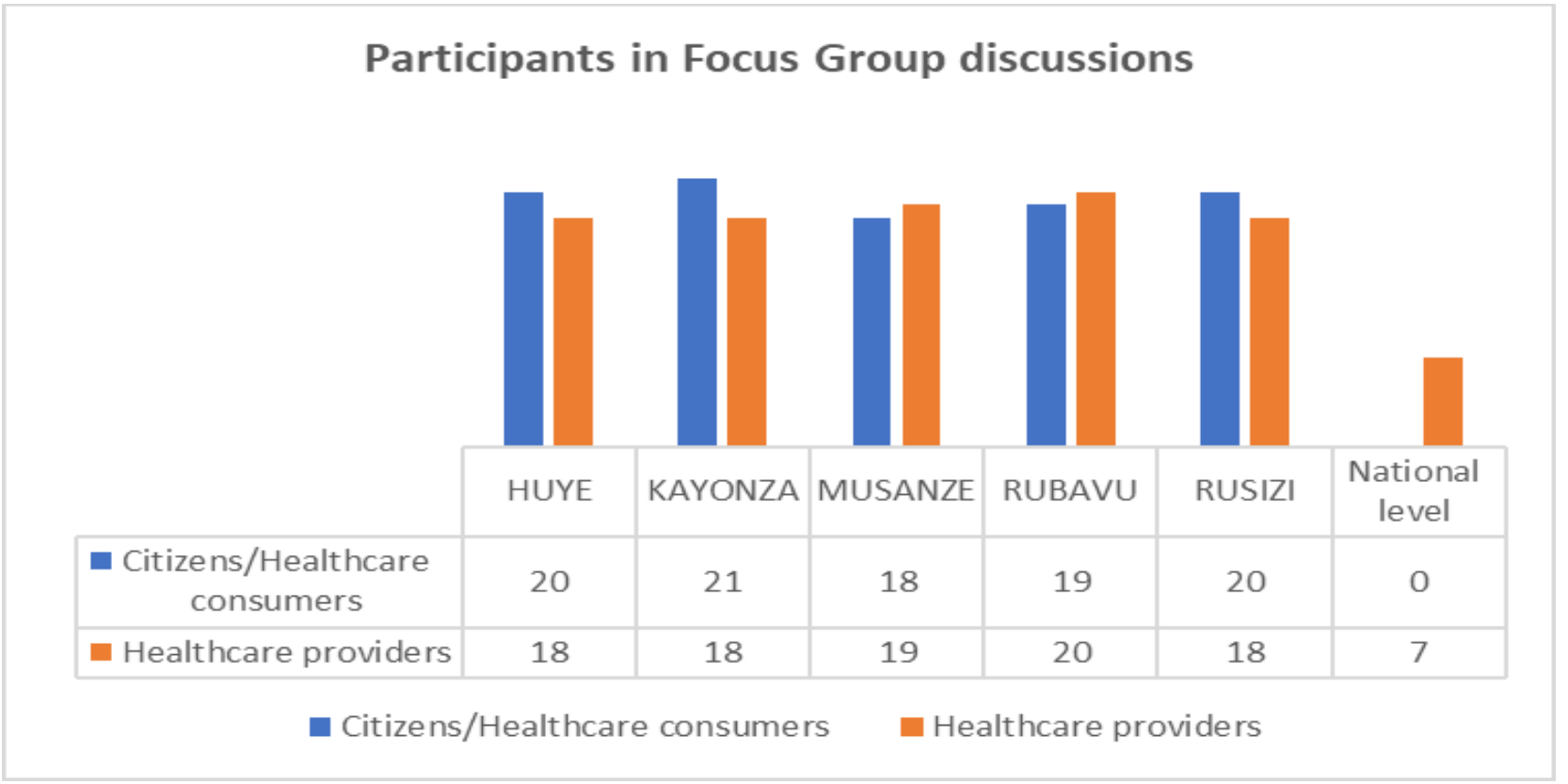
Table 8: Participants in group discussions

PARTICIPANTS IN FGDS	DESCRIPTION
Community members/Healthcare Clients	Users/beneficiaries of health services and hence relevant to assess corruption risk in the health sector. In each of the districts that were selected, three sessions of focus group discussions were held, with 6 to 8 participants in each group.
Vulnerable people	People with disabilities, those with chronic illnesses, single mothers and teen mothers were selected to show possible corruption cases that affect them while seeking healthcare. These participants were selected from three districts and placed in 14 groups.
Healthcare providers	Healthcare providers in charge of delivering health services to community members (medical personnel, healthcare facility administrators). Three sessions of FGDs were conducted in each of the selected five district.
National level stakeholders	Personnel from the Ministry of Health, Rwanda Medical Supply, Rwanda Social Security Board, Rwanda Biomedical Center, and Rwanda medical and dental council. One FGD session was conducted at the national level.

The respondents of this assessment were selected from 5 districts of Rwanda. Only three sectors (local administrative entities) per district were chosen to serve as sampling units, with one healthcare facility selected from each sector. In each sector, two groups were selected, one of which consisted of healthcare providers, while the other group made up of residents who visited various healthcare facilities seeking services. An FGD was also held at the national level with a single group of 7 participants.

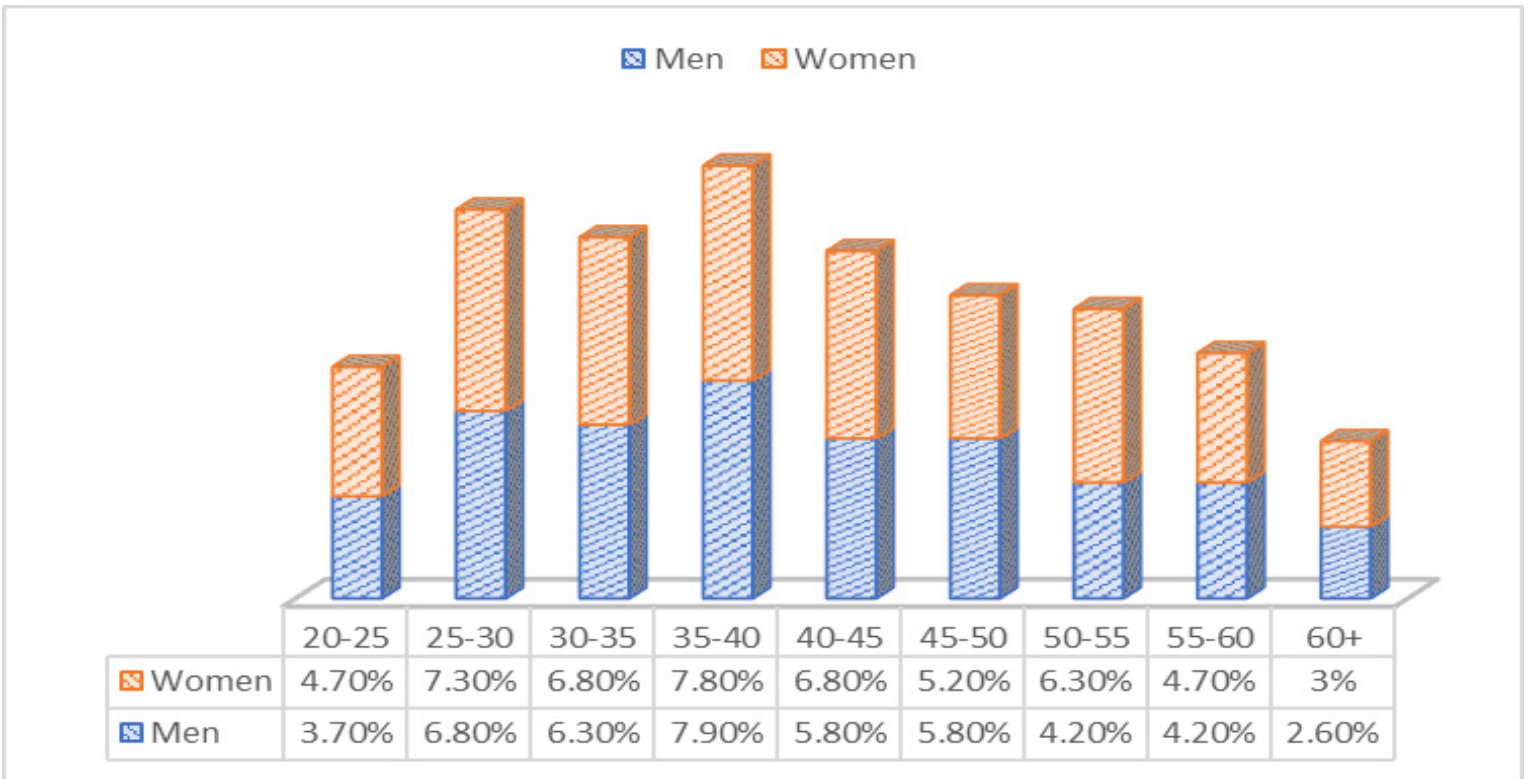
In order to minimize common method bias (response tendencies that raters can apply uniformly across measures), assessment data were collected in 4 phases. After matching the time lag of data collection, all raw data was entered in Excel sheets. Data was cleaned to fix issues such as duplicate, or incomplete data within a dataset. Data cleansing was followed by data analysis. In this assessment, the data was segregated and analysed at the district level. There was a total of 191 respondents throughout five districts and 7 respondents at national level participated in FGDs.

Figure 3: Distribution of respondents (FGDs) per districts



The results show that 38 of the 48 intended respondents took part in this survey from Huye district. Four members of citizen groups and six members of healthcare provider groups were unable to participate. These figures are also seen in Rusizi district. In Kayonza district, 39 out of 48 targeted respondents were able to participate in this assessment. 37 of the 48 targeted respondents in the Musanze district were able to take part in this assessment. In Rubavu district, 38 out of 48 also participated in group discussions while 7 participants were from national level healthcare institutions.

Figure 4: Gender and Ages of Respondents



The statistics show that men and women participated in the focus group discussions almost equally, with women's participation slightly higher than men by 5.4% (47.3% of men and 52.7% of women). Statistics also show that the participants between the ages of 35 and 40 were the age group which took part the most, followed by those between 25 and 30, those between 30 and 35,those between 40 and 45 and between 45 and 50. Overall, the assessment then captured the inputs of respondents of different age groups.

Furthermore, to ensure the participation of vulnerable people in this assessment, the research team selected vulnerable groups of people consisting of people with disabilities, people with chronic diseases, single mothers and teen mothers. These groups consisted of 83 participants including 69 females and 14 males.

Table 9: Participation of Vulnerable Groups in FGDs

VULNERABILITY STATUS	NUMBER OF PARTICIPANTS	FEMALE	MALE
Chronicle diseases	26	20	6
Disability	21	13	8
Both Chronicle Diseases and Disability	1	1	0
Single mothers	32	32	0
Teen mothers	2	2	0
Both disability and orphans	1	1	0

2.3. DATA COLLECTION AND ANALYSIS

In order to minimize common method bias (response tendencies that raters can apply uniformly across measures), assessment data were collected in 4 phases. After matching the time lag of data collection, all raw data was entered in Excel sheets. Data was cleaned to fix issues such as duplicate, or incomplete data within a dataset. Data cleansing was followed by data analysis. In this assessment, the data was segregated and analysed at the district level.

The data analysis undertaken in this study took the form of the corruption risk assessment. The implemented methodology involved the following steps;

1. Key operational processes and decision points were identified for each area of focus. A decision point is the point at which relevant actors need to make the necessary decision to drive a process forward.
2. Based on research findings and available data, corruption risks occurring at the decision points were mapped out. These corruption risks involve an abuse of public power for private gain that leads to a deviation of the decision. This deviation means that the service delivery process is not upheld as it should be.
3. To determine the likelihood and impact scores, the scoring process was carried out through the FGDs. Participants, including service users and providers, were asked to give their provide scores as individuals based on their own personal perception or experience of corruption at the decision point. After this, average scores for each FGD were computed; the risk score was determined by the average scores across all FGDs.
4. The decision points were then placed on a risk heat map which illustrates where risks within processes are higher and lower, and therefore where prioritized action is needed.
5. Mitigation strategies were designed to eliminate or reduce the corruption risks identified for the decision points. The mitigation strategies were identified and agreed upon in FGDs
6. A plan for implementing as well as monitoring the implementation of the mitigation strategies was developed.

Table 10: Determination of the Scores

SCORES	PROCESS
Likelihood (scale from 1-5)	Likelihood of corruption risk in each decision point was scored by respondents directly
Impact (scale from 1-5)	Impact of corruption risk in each decision point was scored by respondents directly
Risk score (scale from 1-5)	Risk score (Likelihood +Impact/2) of each decision point (Average)

After this, average scores for each FGD were computed; the risk score was determined by the average scores across all FGDs.

Table 11: Aggregation of scores

DATA COLLECTION POINTS	**PROCESS**
Group level	The responses within a group were determined by taking the average of all the respondents' scores.
Sector Level (Administrative entity)	Responses were identified using the average of responses from all groups (Administrative entities) within a sector
District level	Responses were identified using the average of responses from all sectors (Administrative entities) within a district

2.4. LIMITATIONS OF RESEARCH DESIGN

Respondents who took part in focus groups were medical professionals and residents who visited various healthcare institutions for treatment during the data collection period, while interviewees included senior executives from healthcare institutions at national level. It was found that some participants were unable to participate because of the nature of their profession and the fact that those who are looking for healthcare services are often extremely busy. In an attempt to boost the response rate, the TI-Rwanda research team made several trips to the field to meet with respondents at their convenience. Despite the efforts, the sample size remained smaller than anticipated, with 198 individuals as opposed to the 250 planned. The findings, however, are not significantly affected by these constraints, particularly given that the response rate was above 79%. Additionally, it was difficult for the research team to find vulnerable people to take part in the assessment. It was found that on the day of data collection, the team in some cases did not get a chance to meet vulnerable people in healthcare facilities. The team had to wait a long time to locate some vulnerable individuals who came for treatment, and sometimes they had to return to the field more than once, to ensure the participation of vulnerable people in the assessment.

Corruption is a sensitive subject that people can be afraid to talk about it freely. It is extremely challenging to detect corruption because it is a serious crime that is frequently committed in strict secrecy. Giving testimony about corruption is often difficult due to various reasons including the fear of the repercussions of testifying about corruption, especially where those making the reports rely on the services of the corruption perpetrators. In an attempt to obtain relevant information on the potential for corruption risk in healthcare delivery, data was gathered by people with experience, especially in collecting sensitive information. Participants were placed in a safe environment and given the assurance that their answers would remain confidential.

The data for the corruption assessment was provided by responses to perception-based questions. While perceptions of corruption risks on an aggregate level can be a useful indicator, they are not without error and should not be treated as corresponding entirely to the situation on the ground. Respondents might, for instance, not give truthful and precise responses. Sometimes, respondents might not feel comfortable giving responses that cast them in an unflattering light. To mitigate such issue, Data for this assessment was collected from respondents such as healthcare providers and users who have enough information about the questions posed.

FINDINGS

3. RESULTS

This section reproduces some of the qualitative experiences and insights regarding various forms of corruption in the health sector shared. This is followed by an analysis of the respondents' scores on the likelihood and impact of corruption risks in various healthcare services. The experiences and perceptions shared by many participants in the FGDs indicated that corruption risks exist across all the areas of focus of the assessment. Participants in focus group discussions (FGDs) also shared their perceptions on the forms of corruption risks disaggregated by decision points. Nepotism, favoritism, sextortion and bribery were highlighted as the four most prevalent types of corruption across all areas of focus. Participant perceptions across five districts indicate that at least every area of focus selected for this assessment has a form of corruption risk (see annex 1).

3.1. EXPERIENCES OF FGDS AND KIIS PARTICIPANTS ON CORRUPTION RISKS IN HEALTHCARE DELIVERY

Some participants in the focus group discussions highlighted perceptions or direct experiences of corruption seeking healthcare. Indeed, this was the case for most of the areas of focus selected in this assessment.

Priority area 1: Categorization of UBUDEHE

"Citizens are not classified or categorized objectively; instead, it is based on favouritism, friendship, and illegal benefits given to cell leaders who lead the categorization process. As per the guidelines issued by the local government ministry, the process of classifying citizens into UBUDEHE categories is expected to take place during community gatherings. However, due to the influence of certain leaders, this exercise is not carried out in accordance with guidelines; instead, some people corrupt (bribe) some leaders in order to fall within the categories that qualify them for government assistance programs. ***A participant in FGDs of healthcare clients.***

Corruption practices are still observable in the categorization of UBUDEHE, where some people bribe officials in order to be placed in categories that enable them receive government assistance such as community-based health insurance, nutritious food, exemption from court fees and various other assistance packages provided to the poor families in the lower categories. ***A participant in FGDs of healthcare clients***

The process of UBUDEHE categorization is highly corrupt. It is commonly known that some people pay bribes to be placed into the categories that grant them advantages in order to benefit from some of the assistance programs offered by the government. ***A participant in FGDs of healthcare client.***

The UBUDEHE program was established as a Home-Grown Initiative (HGI) program twenty years ago, and it has shown to be a successful complement to Rwanda's Social Protection programs in

addressing the socio-developmental issues facing the country. Rwandan families are classified into UBUDEHE categories according to their income.

The UBUDEHE database is used by the government to identify the categories that qualify for various packages of aid. As per UBUDEHE manual, a household's economic status determines which group it belongs to; community involvement typically plays a vital role in this process. Although the government recommends the use of a citizen participatory approach in UBUDEHE categorization, participants in this assessment indicate that corruption poses threats to this activity.

Priority area 2: Access to CBHI (Mituelle de Santé)

Children from families that cohabit illegally, those born to single mothers, or those born to underage females are denied access to health-based health insurance due to the fact that most of them are not registered in national birth records. Registering those kids many of whose parents' identity is often not well known (male parents are often unknown), requires a long process and an investigation by local leaders. Their parents sometimes have to bribe local authorities to get them quickly registered in national birth records and granted access to CBHI. **An FGD participant from one of the districts selected for this assessment.**

In the context of Rwanda, teen mothers, single moms, and illegal cohabiting people (In the Rwandan context, people who are cohabiting illegally are considered unserious and fear family responsibilities because of their frequent breakups, cohabitation with others, and further breakups; mostly those without formal education) are frequently at risk. Due to their poverty, lack of proper education, and ignorance of their rights, the majority of these people most likely lack a thorough understanding of the procedures used in registering their newborns in the national birth records.

However, as obtaining community-based health insurance (CBHI) for their children requires lengthy procedures, perpetrators of corruption may target them. Respondents also highlighted the lack of specific and clear guidelines outlining the criteria and procedures used to select CBHI beneficiaries.

Priority area 3: Transfer of a patient to another hospital for those who use CBHI

It is very difficult to get a transfer to go to a specialized hospital unless you have someone with the power to help you. Sometimes, when I have a mental health crisis issue, they deny me a transfer to go to Neuropsychiatric Hospital. One of my neighbours was also denied a transfer to a specialized facility even though he needed it. We are not at all satisfied with the service at our hospital, because a neuropsychiatrist can come once a week. **A person with the neuropsychiatric problem who participated in this study.**

Medical transfers for CBHI users require a lengthy process approved by several administrative bodies. This therefore gives the perpetrators room for corruption mostly in the form of favoritism. In some

healthcare centers, obtaining the transfer can be completed quickly and effectively when the patient has a personal relationship with some medical staff. In order to receive a medical transfer at the appropriate time, some patients search for other people who have close relationship with some medical staff in the health center because the referral procedure takes longer if you do not have a personal relationship with medical staff. **A participant in FGDs of healthcare clients.**

In the procedures of transfers, I would say that there isn't much possibility of corruption; however, if a patient has connections or family ties with a member of the medical staff team, the services are provided more quickly. Actually, there would be a delay in services, but in my opinion, the patient cannot return home without treatment. **A participant in FGDs of healthcare clients.**

In Rwanda, people using other types of medical insurances (not CBHI) are able to receive treatment in different private or public hospitals and clinics without a required medical transfer (it is optional since it reduces the cost of services). This is the opposite case with CBHI users who are only allowed to seek treatment at health centers and health posts. When they are diagnosed with an illness that requires advanced treatment in public hospitals, they are required to have the medical transfer.

Community-Based Health Insurance has extremely low premiums since the government pays a substantial portion of the costs. CBHI users are requested to receive treatment at health centers and health posts first since the cost of services there is less expensive than at other healthcare facilities. This prevents persons with this kind of medical insurance (mostly used by people with limited financial means) from going straight to hospitals for treatment without a medical transfer. As per the respondents in this assessment, obtaining medical transfer for CBHI users requires a lengthy process. The lack of readily available medical transfers for CBHI users can lead to them to resort to forms of corruption such as favouritism in order to manipulate the process in their favour.

Priority area 4: Medical Appointments

Although processes are in place for scheduling a visit to a specialist doctor, these processes are sometimes broken. Some medical staff members at our hospital abuse their power for favouritism rather than following the order or numbers that indicate the sequence in which applicants follow. **An FGD participant from one of the districts selected for this assessment.**

Certain medical staff do not follow protocols for scheduling appointments, such as allocating numbers based on patient arrival or queuing. In some hospitals, medical staff show favouritism in giving medical appointments to patients who need specialist doctors. ***A participant in FGDs of healthcare clients.***

Favouritism is clearly observed in the procedures of following up the hospitalized patients. In fact, a patient who does not have a relationship with some medical staff is not treated appropriately. Some patients provide illegal benefits to healthcare providers in order to receive adequate treatment. ***A participant in FGDs of healthcare clients.***

Participants in the FGDs indicated that favoritism can affect the operation of medical appointments. However, these participants attest that procedures for making medical appointments have been established; the issue lies in their non-adherence. Nepotism was another

type of corruption mentioned in the discussions, with some participants claiming that it is evident in hospitals.

Priority area 5: Medical worker's recruitment, remuneration, training and evaluation, promotion, and transfer

In my opinion, guidelines governing the training of medical personnel and eligibility for further education are not clear. Thus, it gives room for favouritism in selecting the nurses to go for further training and education. some of our colleagues are granted this chance without adhering to the guidelines. Because of their connections to the senior officials in charge of these services. **A registered nurse who participated in FGDs.**

Pieces of evidence of corruption in the hiring, assigning, and promoting of medical staff in healthcare facilities are still observable. In certain instances, medical personnel bribe officials in order to be placed in preferred facilities. There are also some medical staff who are placed in the facilities of their choice with the influence of favouritism. **One of the medical staff participating in the FGDs.**

Promotional regulations exist but are not effectively reinforced. Some people in our organization receive unfair promotions even though they don't meet the requirements. However, those that satisfy every requirement are not taken into account. **One of the medical staff who participated in FGDs in this assessment.**

"In our institution, there are instances where staff members arrange with their supervisor to work at a private clinic during hours when they are actually supposed to be working at the clinic where they are permanently employed (Public). Oftentimes, a supervisor falsely gives an employee a break pretending that he/she is exhausted. We notice that, and it stems from corruption". **One of the medical staff who participated in FGDs in this assessment.**

The medical staff's testimonies demonstrate that policies on human resources for health are either unclear or disregarded when it comes to hiring, staff development, promotions, and other human resources-related operations. These participants, who work in the health sector and possess sufficient knowledge about human resources in the sector, brought attention to the existence of corrupt practices between senior officials and medical staff who either need to continue their education or be placed in facilities of their preference. They stated in their testimonies during focus group discussions that bribery and favoritism are still prevalent forms of corruption in these services.

in terms of human resource management, some interviewed administrators of healthcare facilities indicated that there can be shortages of medical staff, which may lead to a wide patient-to-provider ratio and create a room of opportunity for people with bad moral principles to commit corruption.

However, a common challenge is that there aren't enough medical staff to handle the volume of patients seeking care in our health center. For example, when a medical staff resigns, it takes a long time to find

a replacement. Consequently, the number of patients keeps rising very quickly, causing inappropriate control of the mentioned measures. **A director of health center who participated in interview.**

Priority area 6: Internship practices for medical students

Some female interns are victims of sexual harassment in health facilities and most of them are those doing supporting services. I know a young woman who was doing an internship in a hospital, after just two weeks, the director began to harass her and pressurize her into having sex with him. I met her mother trying to help her get an internship in another health facility. **A woman participant in the Women's' FGD from selected districts.**

Respondents pointed out some drivers of corruption risks including lack of guidelines outlining placement, supervision, and grading of medical students during the internship process, as well as an appropriate follow-up method (from schools and hosting institutions) for the students during the internship.

Priority area 7: Hospitalization/Admission

Once patients are hospitalized, they need follow-up and effective care. However, there are cases where some patients give illegal benefits to some medical staff in exchange for quality of care. In various healthcare facilities, there is also favouritism in the process of follow-up patients. **An FGD participant from one of the districts selected for this assessment.**

It hurts when you see a patient being treated specially or being served first due to family ties or just because he/she is a friend of a health service provider. Next time, you need to create a friendship with doctors, nurses, or other health service providers in a bid to secure attention in the future when you come back to the health facility. **Said a woman participant in the PWD's FGDs from selected districts.**

Due to their ill health, hospitalized patients require greater medical attention. Nevertheless, some participants in focus group discussions mentioned that patients' need for care can be compromised by corruption. As the participants pointed out in discussions, some patients choose to form friendships with certain medical staff members not out of personal affection but rather to ensure they receive appropriate care every time they go for treatment. Some patients give unlawful benefits to certain medical staff members to strengthen their friendship. This, therefore, leads to favoritism that is observable in healthcare delivery.

Priority area 8: Medical examinations and medication administration

There are significant delays in the provision of these services, especially for medical exams, which take a very long time. Although there isn't much corruption in these services, if the patients have relationships with the providers through friendship or family, the process will often go more quickly. In rare instances, some give bribes to speed up the services. **An FGD participant from one of the districts selected for this assessment.**

There is fraud in the use of health insurance cards. Investigated cases include people who used others' cards. Moreover, some doctors have also been caught prescribing medicines on someone's insurance but sell them to others or sell medical prescriptions to pharmacies. **One senior staff from national level health institutions.**

The participants indicated that there is very little possibility of corruption in services related to drug administration and medical examinations. However, nepotism may make it more difficult to ensure fairness in these services because these are among the services that are often delayed, especially medical exams, whereby some patients might get care more quickly due to their relationship with service providers.

Priority area 9: Supply of medicines and non-medical materials

Participants indicated that in the area of medical and non-medical material supplies, there is little risk of corruption due to an effective procurement system in place, including the electronic logistics management information system (eLMIS).

Due to the fact that procurement is done in the system, corruption cases are not often seen in these services, instead, we often face the problem of insufficient medicines in the pharmacies of the healthcare facilities where he receives treatment. Sometimes, a doctor may prescribe medication that is not available in the facility pharmacy. In these cases, patients are recommended to get the medication from outside pharmacies that do not accept Community-based health insurance, and they are responsible for paying for it. Some people choose not to get the medicines even though they are ill because they cannot afford it. **A medical staff who participated in KII.**

However, in an interview, some administrators of healthcare facilities indicated that some medication may not be available in internal pharmacies. In line with The U4 Anti-Corruption Resource Centre's analysis, medicine scarcity can create corruption risks.

It is possible that a patient would be prescribed medication but find that the medication is not available at the health center pharmacy. Due to the high demand for frequently needed medications, which leads them to run out rapidly, some patients may feel as though they aren't receiving their prescribed medication even though those medications are available at the pharmacy. To be honest, I doubt any pharmacist would turn down a patient's request for a prescription medication that is in stock**. A medical staff at the health center who participated in the interview.**

The organization in charge of supplying medications to Rwanda's public healthcare facilities, Rwanda Medical Supply, admitted that some medical facilities continue to struggle with a shortage of medications. The Rwanda Medical Supply official clarified that some healthcare facilities are reluctant to order medications needed due to the large debts these institutions have not paid. He did point out, though they usually have these drugs in stock.

Strategic advisor at Rwanda Medical Supply*: We acknowledge that certain healthcare facilities run out of certain medications. However, it is usually caused by medical facilities delaying requests. We have at least 94% of vital products, about 97% of essential products, and 87% of non-essential medicines in*

our stocks. However, there have been instances where certain hospitals have less than 37% of all necessary medicines in their stores. This is due to health facilities' delays in submitting requests. Frequently, it's because they have so many unpaid bills. To resolve this matter, we committed to keep delivering medicines on loan in the event that healthcare facilities experience such financial troubles.

Priority area 10: Registration and authorization of health facilities

Although there are regulations governing the registration and authorization of health facilities, oftentimes, the investor pays a bribe to get the go-ahead to open and run a health facility in a desirable or advantageous location. These services are also often characterized by favouritism. **A senior staff in a healthcare facility who participated in KIIs.**

Some of the entrepreneurs offer bribes to get an operational license for medical facilities like a pharmacy or to start a small clinic in a short period of time. When one resists paying for such corruption, the process is delayed, and getting feedback on the process becomes difficult. **One of the medical facility executives participated in the FGDs.**

While certain individuals are authorized to establish medical facilities, others are rejected for inexplicable reasons. In some cases, some applicants receive their operation license without delay, while others have to wait for a very long period. I think it stems from personal ties-based corruption or bribery. **One of the medical staff participated in the FGDs.**

Participants in focus groups raised the issue that although guidelines and procedures are in place to regulate the registration and authorization of healthcare facilities, they can be violated by means of corruption. Investors' need for quick services and permission to run their facilities in preferred locations are major forces that drive corruption and participants highlighted bribery as a commonly prevalent form of corruption in this area of focus.

Priority area 11: Access to nutritious foods for stunted children and pregnant women

The nutritious foods are supports given to the most vulnerable people including poor pregnant women and stunted children. In the process of selecting beneficiaries of this support, local leaders and community health workers use the categories of UBUDEHE. Eligible beneficiaries are those from low-income families in categories 1 or 2 who have been diagnosed by community health providers as malnourished. However, these activities are sometimes characterized by corruption in the form of bribery and illegal benefits given to local leaders, especially at the cell level to be registered among the beneficiaries of such government programs aimed at supporting vulnerable citizens. There are also some cases where beneficiaries are selected based on favouritism. **An FGD participant from one of the districts selected for this assessment**

In fact, the guidelines say that nutritious foods are given to pregnant women and children who show signs of malnutrition who are in UBUDEHE category 1. However, in some instances, selection criteria are not being followed, and nutritious foods are sometimes given to families who are not eligible. Members of the community health worker program together with local leaders select the most vulnerable citizens

to receive nutritious foods. Although you generally see that they are trying to perform these duties well, there is some favouritism in the process. ***A participant in FGDs of healthcare clients***

In fact, there are families who receive nutritious foods yet are not eligible while on the other hand some poor families are denied this assistance. This makes one suspect that it is due to family ties or friendships between some recipients of such aid and community health members who are in charge of selecting beneficiaries. ***A participant in FGDs of healthcare clients***

The National Child Development Agency (NCDA) has few staff but it's held accountable on issues that should be sorted out and followed-up by the Ministry of Local Government (MINALOC) and districts. For instance, for some cases, health facilities decry shortage of the stock while the stock is full at district level. Over and above, due to lack of coordination and monitoring, some nutritious foods are misused swindled or be provided on the basis of corruption. *One senior staff from national level health institutions*

As the participant's testimonies during focus group discussions indicate, corruption can limit access to nutritious foods meant to benefit pregnant mothers and stunted children. Although there are predetermined criteria for selecting participants in this type of government assistance program, the testimonies suggest that these criteria are not fully followed. As revealed during focus group discussions, corruption in the form of favoritism, nepotism and bribery are common in the delivery of these services. Some of the drivers of corruption risks identified include the lack of the detailed guidelines that specify the selection and distribution of nutritious foods to stunted children and pregnant women as well as the proper method of monitoring and controlling the program's process aimed at improving the lives of the most vulnerable citizens.

3.2. SEXTORTION TARGETING WOMEN AND GIRLS IN VARIOUS HEALTHCARE FACILITIES

Gender inequalities in the health workforce are one reason why women and girls are frequently impacted by various forms of corruption. Due to gender disparities in access to resources like money, influence, and information that can easily be manipulated for corrupt reasons, women, particularly the poorest, are positioned in unequal hierarchical positions. Gender bias often exists in poor families when allocating resources within the household, with resources disproportionately going to the male family members in terms of health, food, and education (TI, 2017a).

A variety of intersecting dimensions, including gender, contribute to persistent inequities in access to services. Taking the health workforce as an example, a report by UN Women reveals that it is highly gendered in terms of its composition, professional hierarchies, seniority, compensation, and working conditions, with women often occupying lower positions in the organizational hierarchy of the workforce (UN WOMEN, 2020). In a similar vein, the SIDA research on gender equality and the knowledge society demonstrates that women in Rwanda are notably underrepresented in leadership roles in general, in the labor market, and particularly in fields involving science, technology, and innovation (SIDA, 2016). Within this context, women and girls increasingly find themselves in the position of seeking services rather than offering them and thus they are targeted by corruption perpetrators.

A study conducted by TI-Rwanda revealed evidence that corruption has different consequences on men and women and that women are more likely to experience its negative effects because of the power gap between men and women (TI-Rwanda, 2021b). In this assessment, FGD members shared experiences indicating that how women and girls are often targeted by perpetrators of sextortion across various healthcare facilities.

When I gave birth to my firstborn, a doctor who operated on me asked me to visit him in his home after recovering but I refused. After some months, he was appointed as the head of the vaccination site. When I went for a vaccination, he took me out and did not receive me. I went to another site. **A woman participant in the PWD's FGDs from selected districts.**

A friend of mine went to a hospital seeking prenatal care services. Dismayingly, while making a checkup, a doctor stripped her and requested her to have sexual relations. Fortunately, at that very moment, another nurse entered the room which put an end to the planned harassment. **A participant in the Women's' FGD from one of the selected districts.**

A nurse in charge of NCDs at a Health Center in one of the districts*: In our health center, we once had a nurse reported by citizens accusing him of sexually assaulting them. While we were making an investigation, he actually sexually abused another young lady and she reported him to the health center administration. Unfortunately, he escaped before the arrest and he is no longer here.*

I'm a victim of doctors' sexual assault and they intimidated me when I tried to report them. When I went for a pregnancy checkup, a doctor started touching me everywhere, especially my sexual parts. He explained that he was performing a routine checkup when I questioned why he was touching me. Later on, his colleague came and requested me to accept such a medical checkup. I woke up and said I was going to report them but they intimidated me that they would do their best and that no other doctor could take care of me. However, both of them continued to laugh with joy. The fact that they thought I didn't know foreign languages, and they started talking in English and making comments about my sexual parts. Because I was hospitalized, I ultimately went back to my room. In the following days, all the nurses and doctors started whispering that I was rude and that I did not want to have a checkup. One day, another doctor came and said he would take me out of the hospital, saying I was denying a checkup. I told him the truth that his colleagues had assaulted me and I immediately took his photo with my smartphone. I told him: "I will report all of you!" He was very afraid and he called his colleagues who had assaulted me and they apologized for what they had done. I kept quiet and did not report them because they begged forgiveness. **A woman participant in FGDs from one of the selected districts.**

There are advantages given to women to go to missions or get employed in health projects with good remuneration especially if these women have sexual relationships with people with power. **One senior staff from national level health institutions.**

These testimonies indicate that sextortion is a serious obstacle limiting women and girls from accessing healthcare. During Focus Group Discussions, Participants also revealed the high levels of impact that women often face after declining to have sexual affairs with healthcare providers.

Alarmingly, perpetrators of sextortion appear to target women who seek pre and antenatal services, which attests to the gendered dimensions of corruption.

As per the victims' claims, there are some doctors who abuse their duties, and make unnecessary tests with the intention of satisfying their lust. They may also exploit positions of authority such as being a supervisor of internships. There is also encouraging evidence however that sextortion perpetrators can be deterred when victims report them.

3.3. CORRUPTION AFFECTING OTHER VULNERABLE PEOPLE IN HEALTHCARE DELIVERY

Corruption in the health sector has a negative impact on effective service delivery (TI, 2020). Therefore, the majority of developing countries continue to experience persistent disparities in access to health services (U4, 2020a) and vulnerable groups often suffer the most. A Transparency International report demonstrates that marginalized groups, such as women, LGBTQI people, those who engage in sex work, youth, and the poor, are exposed to specific corruption risks as a result of stigmatization, relatively weaker bargaining power, fewer financial resources, and limited access to redress (TI, 2021). USAID also stressed that the poor and disadvantaged are typically the most severely affected by corruption (USAID, 2022). In this assessment, it was revealed that widows, single parents, people with disabilities, and patients with chronic diseases often experience corruption across various healthcare facilities in Rwanda and face serious consequences. In other cases, they faced discrimination which limited their access. Testimonies of corruption were revealed by respondents who participated in focus group discussions (FGDs).

A single mother with chronic disease in one of the districts selected under this study; A friend of mine suffering from a chronic disease gave birth and, the fact that she is a very poor single mother, she was allowed to receive government support known as "Shisha Kibondo", the flour used to make a highly nutritious complementary porridge for malnourished children. In my own eyes, she was refused assistance at the health center. She was required to pay a bribe to an official in charge of serving the support before she could get it. As the one who had accompanied her, I beseeched them to give her the support but they said her baby had no vaccination record tracker notebook. It is a handbook that is usually provided for free, and it is required at the time of vaccination only, so it was not clear why the lady was required to show it yet she did not come for vaccination services. In actuality, it was perceived as delaying the service in order to persuade the woman to accept payment of the bribe. He kept us waiting a long time, and since we were traveling a long distance and the woman was too weak to come back another time, especially since she is disabled, she made the decision to pay a bribe of 1000 frw to receive the help.

At health facilities, single mothers, widows, and teen/young mothers are most likely to experience sexual corruption. Most of the time when a doctor asks you if you have a husband and you respond that you do not, the doctor's behavior changes right away. Sometimes, they ask for a phone number. A single mother participant in the FGD from one of the selected districts.

Widows are very vulnerable to sexual harassment and assault in health facilities. This is because when you turn up, they ask you if you have a husband. When you don't, they start telling you nonsense words.

I have a friend of mine who was about to give birth but she was hesitant to go to the hospital because his husband was not available to accompany her. Finally, she delayed going to hospital which could undoubtedly have a negative impact. A woman participant in FGDs from one of the selected districts.

I once went to a hospital but I was sexually assaulted by the doctor. When he recognized that I had no husband, he told me that I had to have sex with him so that he could prescribe me the drugs that I needed. I made every effort to reject it, but he persisted in sexually coercing me until I agreed to do things that looked like having sexual pleasure in the consultation room and finally, he prescribed me drugs. I accepted because I had no other money to go to another hospital or I could even give him something (a bribe) instead of sex. A single woman with chronic disease in one of the districts selected under this study..

A single mother with a chronic disease in one of the districts selected under this study; When I suffered Urinary Tract Infection, I went to a hospital but a doctor sexually assaulted me. When he was taking a test, because he was alone and no other person had accompanied me like a husband or any other relative, he stripped me and started touching me in my private parts. Right away, I stopped him, he then refused to treat me because I prevented him from reaching his goal of coercing me into a sexual act. I then went home without receiving any treatment. I suffered for two weeks without medicines. I continued to experience pain at home, and when I ran out of options, I made the decision to visit the doctor once more. When I arrived, I learned that the doctor had also harassed other patients sexually. I joined them in complaining about him. Due to pressure from different people, they decided to give me another doctor to treat him. Later, I learned that the doctor who was abusing women sexually had been transferred to another hospital. It is very sad to see someone who commits such crimes being awarded a transfer instead of arresting him.

Among other things, this case illustrates the impact that corruption and discrimination (or in this case sextortion) can have on victims by preventing them from accessing treatment and causing their illnesses to worsen. Furthermore, it indicates that impunity may exist for sextortion perpetrators, meaning that there may be no effective deterrent in place to prevent them from committing the crime again.

3.4. ANTI-CORRUPTION CONTROLS

In this assessment, representatives of the Ministry of Health and Rwanda Medical Supply explained some of the measures being taken to address the identified corruption issues.

Actually, we use all possible means to improve the quality of our services. We specifically use suggestion box where patients can report malpractices of healthcare providers; patient numbers are assigned based on arrival time (first come, first served). All of this is done to prevent any medical staff members from acting inappropriately. A director of health center who participated in interview

Health Facility Specialist at the Ministry of Health: *We are aware that doctors and healthcare workers are still few in our country. Therefore, the ministry has set a plan dubbed "Four by Four" in which we want to quadruple the number of doctors and healthcare workers. In doing so, we have seen an increase in medical schools in universities and higher learning institutions. Most of those schools are*

teaching doctors and nurses. Hitherto, in Rwanda, it is estimated that a doctor takes care of over 18,000 patients while he/she should care only about 10,000 per year.

Health Facility Specialist at the Ministry of Health: *As part of achieving universal health coverage depicted also in increasing health facilities including health posts at every local level, the Ministry of Health always endeavors to make sure that the quality of healthcare service is superb. At this juncture, the ministry and health institutions have toll-free numbers to receive complaints and we urge all health facilities to provide a phone number to be used by clients who are not satisfied with service. In addition, all hospitals and health centers have customer care officers and M&E Officers. More importantly, at every hospital, there is a special health committee comprised of different people who make up a kind of board. Those include ordinary citizens, the private sector, community health workers, focal persons from the ministry, and many others. Over and above, these days, we are kicking off a new project called "IJWI RY'UMURWAYI (Patients voice)" and, through this project, we want to increase the level of patients' feedback on how they receive service and fight injustices in service delivery.*

In the Integrated National Health Sector Referral Guidelines published in 2020, the Ministry of Health offers advice to healthcare professionals regarding how to address the special needs of people with disabilities. Although it appears that there are still vulnerable people affected by corruption across various healthcare facilities, the government through the Ministry of Health is taking various measures. During the interview, a representative of the Ministry outlined the measures being taken.

Health Facility Specialist at the Ministry of Health: *The government has made remarkable progress in ensuring inclusiveness in healthcare service provision especially when it comes to people with disability. In this vein, the government of Rwanda through the Ministry of Health is planning to increase the number of specialized hospitals for people with disabilities. So far, we have three best hospitals namely GATAGARA, RILIMA, and INKURU NZIZA all of which the government is supporting. In the coming days, the government is pondering over how it will cover some costs including salaries of all their employees.* Furthermore, senior healthcare professionals, proposed some measures to address corruption. Some of the suggested actions are awareness campaigns (to put the rules and regulations into effect), utilizing large billboards to display flyers, banners, and other items to raise awareness of corruption in its various forms.

As we really need our community to abide by the law, there is still a need to increase campaigns geared towards raising awareness of laws and policies. The level of awareness is obviously still low. **One senior staff from national level health institutions**

The fact that our community does not really understand what corruption is and its forms, there are some who blindly indulge in corrupt practices. For instance, we've had cases of documents forgery, illegal abortion attempts made by health service providers, and other cases related to corruption. **One senior staff from national level health institutions**

Some of the other mitigation measures that have been proposed include; introducing new checkpoints for policy implementation and service delivery (waiting time of the patients; Feedback

mechanisms to the patients); Service Charter; Sanctions measures. These senior leaders in the health sector claim that using internal control authorities alone will not be sufficient to address identified issues. Working with independent bodies on a regular basis is vital to maintain efficient management and inspection of healthcare services. include the need for clearly defined guidelines that outline in detail the criteria and procedures used in the hiring and placement of personnel in healthcare institution was also highlighted, as well as appropriate means to monitor and control the implementation of those guidelines. Respondents noted that organizations in charge of supplying nutritious food to pregnant women from poor families and stunted children, such as MINALOC and NCDA, do not have adequate staff to monitor the service delivery. Thus, they recommended improved coordination among these institutions. In order to eradicate corruption risk in these activities, respondents suggested more follow-up. Additionally, they advised districts to keep an extra stock on hand for use in local health centres.

CORRUPTION RISK ASSESSMENT

UBUDEHE CATEGORISATION

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
1.1	Categorizing citizens into UBUDEHE	Placing people in inappropriate categories. Some people might be asked to pay bribes in order to be classified in the appropriate categories. In a study by the former Minister of Health in Rwanda revealed a gap in UBUDEHE categorization, where the findings show a lack of fairness during the process, causing some people to be placed in inappropriate categories. During FGDs, some respondents revealed that this process is often characterized by corruption in the forms of bribery, family ties and networks.	The decision point was identified using literature (Ngamije, 2021). Participants in FGDs also described how corruption causes deviations of the decision point.
1.2	Filing complaints about the classification in UBUDEHE categories	Complaints about the classification in UBUDEHE categories may not be channelled properly and thus creates a corruption gap. Some respondents pointed out that in order for the complaint to be accepted and to receive an appropriate solution, the complainant needs to offer a bribe, subject themselves to sextortion, or have a close friendship with one of the service providers.	The decision point and its potential deviations were identified during focus group discussions
1.3	Justice for people who were misclassified into UBUDEHE	Claims relating to UBUDEHE classification might not be handled appropriately, thus lead to corruption risk. Bribery, sextortion, favouritism, friendship, and family relationships were cited during FGDs as elements that some service providers consider in responding to complaints concerning UBUDEHE classification and offering the appropriate solutions.	The decision point and possible deviations were identified during focus group discussions.

Table 12: Risk score UBUDEHE Categorisation

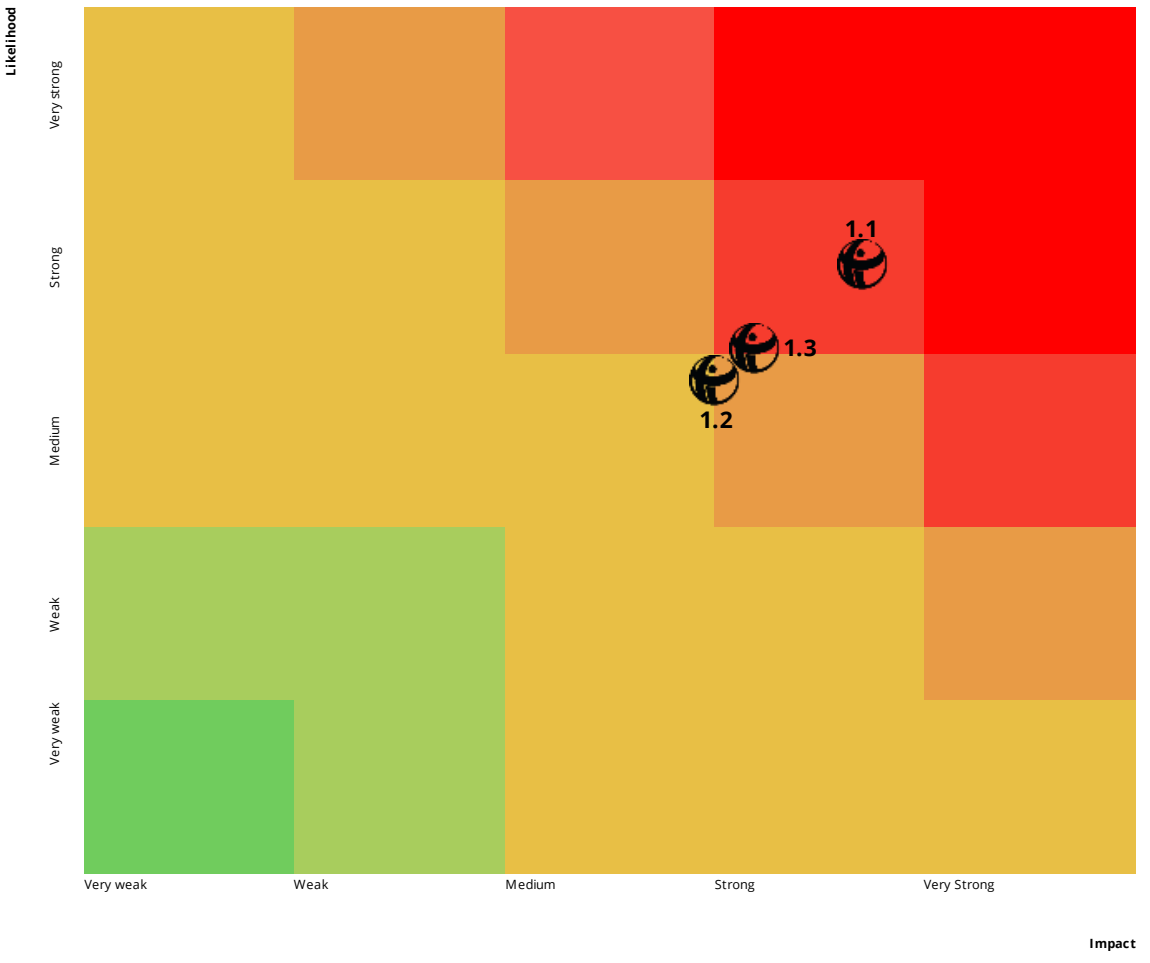
CODE	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
1.1	Categorizing citizens into UBUDEHE	3.4	3.8	3.6
1.2	Filing complaints about the classification in UBUDEHE categories	2.9	3	3
1.3	Justice for people who were misclassified into UBUDEHE	3	3.2	3.1

Disaggregating the average scores further by districts and type of respondents, according to healthcare users, services falling under the UBUDEHE classification are very susceptible to corruption. With the exception of Musanze District, which received a slightly lower probability of corruption score, the other 4 districts received higher scores on the possibility of corruption in those services. On the impact of corruption in the services of UBUDEHE categorization, the score is very high especially in Rubavu district where the average score is close to 5 out of 5. In Rubavu, Rusizi and Kayonza districts, there is a higher likelihood score of corruption regarding filing complaints about the classification in UBUDEHE categories compared to other districts. In the same context, the risk of corruption in the justice process for people who were misclassified into UBUDEHE is also high, with scores above half of the maxima in each of the five districts selected for this assessment.

In consistent with findings from service-users, healthcare providers also indicated that the level of corruption risks during Categorizing citizens into UBUDEHE is high. As shown in the ratings, both the likelihood of corruption risk in this activity and its impact on victims were given high scores. According to respondents from Kayonza, Musanze, and Rubavu, the influence of corruption is clearly present when citizens make complaints about dissatisfaction with the categories they have been given.

Except in Rubavu district, where the likelihood of corruption gets a slightly high score, the risk of corruption is minimal when it comes to resolving claims for individuals who were incorrectly classified into UBUDEHE. These results are also consistent with a study carried out in 2021, which drew attention to the unfairness of classifying citizens into UBUDEHE (Ngamije, 2021).

Figure 5: Risk heat map for UBUDEHE Categorisation



2. Access to Community-Based Health Insurance (CBHI) services

Code	Decision point	Potential deviated decisions	How the decision point and deviated decision points were identified
2.1	Selection of CBHI Beneficiaries	Possible unfair selection of CBHI Beneficiaries. During the process of paying health insurance premiums and registering for cards, there are still instances of corruption (TI-Rwanda, 2018). Participants in focus group discussions pointed out that sometimes people are asked to pay a bribe in order to be selected among CBHI beneficiaries and receive treatment cards (CBHI cards are only given to people who have not reached the age of National ID). Respondents also added that people who have family ties or friendship with some of the service providers are prioritised for services.	The decision point and its deviation were identified via literature and FGDs.
2.2	Charge and recover CBHI contributions in the community.	Recovery of contributions might not be carried out fairly. The team in charge of recovering CBHI contributions may engages in favouritism, friendship, and family relationships. Some participants in FGDs revealed that there are corruption vulnerabilities in the process of charging and recovering CBHI contributions in the community. Respondents noted that some of the people in charge of the aforementioned services are corrupt, frequently showing care for those with whom they are close friends or have ties to the family.	This decision point was identified in the literature. Participants in FGDs also described how corruption causes deviations at this decision point.
2.3	Distributing CBHI cards.	CBHI cards might be issued in an inappropriate manner. In isolated cases, people who prepare and distribute these cards sometimes request little bribes or are influenced by friendship and family ties. The majority of respondents attest that this service is not vulnerable to corruption, particularly in light of the fact that there are few people who use CBHI cards because they are only issued to those who have not reached the eligibility age for National ID. Despite this, there are participants from one of the sectors selected for this assessment (administrative entity) that stated that sometimes persons in charge of issuing CBHI cards demand corruption to deliver a fast service.	The literature was used to identify this decision point. Deviation of this decision point was suggested by respondents during FGDs.
2.4.	Dealing with citizen complaints about CBHI	If a person has a complaint with CBHI and files an appeal, it might not be taken into consideration. Thus, there may be a possibility of corruption, in order for the complainant to get the right kind of response. Some participants in focus group discussions pointed out that there are no effective mechanisms to file complaints about CBHI. During discussions, they noticed that certain leaders take advantage of this gap in order to demand bribes in exchange for such services or to settle disputes of people from their familial networks only.	This decision point and its deviation was identified through discussions in focus groups and literature.

Table 13: Risk score Access to Community-Based Health Insurance (CBHI) services

	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
2.1	Selection of CBHI Beneficiaries	1.9	2.7	2.3
2.2	Charge and recover CBHI contributions in the community.	2.1	2.3	2.2
2.3	Distributing CBHI cards.	1.7	2	1.9
2.4.	Dealing with citizen complaints about CBHI	1.8	1.8	1.8

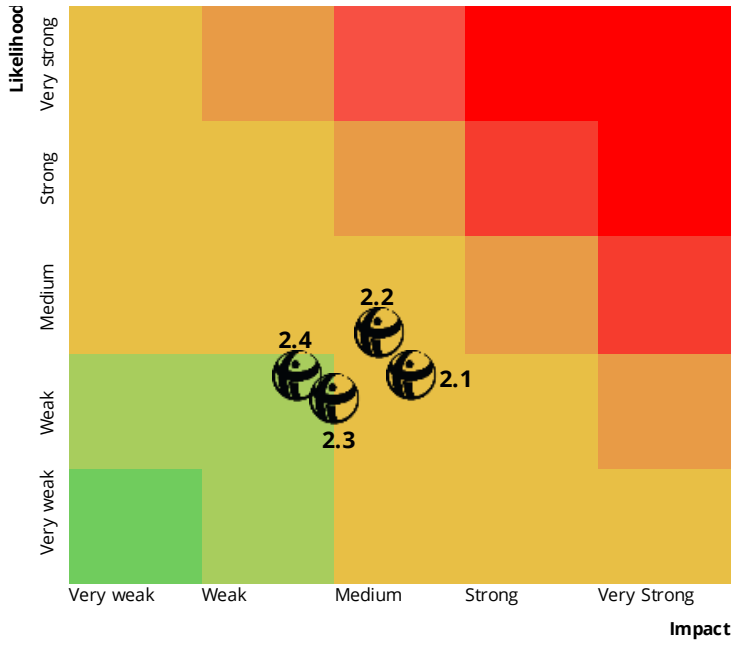
Disaggregating the average scores further by districts and type of respondents, some districts have a high risk of corruption whereas other districts have a lower risk regarding the process of CBHI-related services. Compared to other districts, healthcare users in the Rubavu and Rusizi districts gave a high rating to the possibility of corruption during the CBHI beneficiary selection process. The impact of such risk is similarly highly rated, with respondents from Rubavu and Rusizi districts. The risk of corruption in distributing CBHI cards was shown to be low except in Rusizi district where the likelihood of corruption during distribution of CBHI cards was given high score. Many participants in FGDs stated that the majority of CBHI beneficiaries no longer utilize cards and instead use their own identification cards (which have been integrated into the national identification system). They also pointed out that the only children who still receive CBHI cards are youngsters who are not yet of legal age to possess national identification cards. Thus, this may be one of the factors contributing to the low corruption risk in this service.

The likelihood score on the corruption risk in the process of charging and recovering CBHI payments in the community was rated highly in the districts of Kayonza and Rubavu; scores are low in other districts. In the same findings, perceptions of the respondents from Rusizi district indicate serious concern about the possibility of corruption in the handling of citizen complaints about CBHI as well as the potential consequences for victims. The likelihood of corruption during the selection of CBHI Beneficiaries is not very high according to the healthcare providers. On the other hand, respondents from the districts of Huye and Rubavu demonstrate that the impact of such risk might pose serious threats to the lives of the victims. In the opinions of healthcare providers, the provision of CBHI cards, as well as charging and collection of CBHI contributions in the community are services that are not vulnerable to corruption risk.

Unlike other districts, in Rusizi district healthcare providers indicated a higher chance of corruption in dealing with citizen complaints about CBHI. Healthcare providers from Kayonza district have indicated that this risk can have a severe impact on the health of victims even though it is not often

seen in their healthcare facilities. Various reports have also found a variety of problems with CBHI-related services. For instance, IMF research demonstrates that many poor households frequently find it challenging to pay CBHI premiums, therefore some decide not to visit the clinic (IMF, 2019). Thus, these may create room for corruption.

Figure 6: Risk heat map for Community-based Health Insurance (CBHI) services



3. Patient transfer services

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
3.1	Referral procedures for CBHI users	The referral processes for CBHI users may not be followed properly. CBHI users sometimes offer bribes to speed up the transfer. Some respondents admitted that they offered bribes in exchange for medical transfer during the COVID-19 outbreak (TI, 2017b). During focus group discussions, some participants brought up the issue of CBHI users who experience corruption while seeking medical transfer at various healthcare facilities. This corruption includes bribery, favouritism, friendship ties, and sextortion.	This decision point was selected through the literature. During FGDs, participants in also described how its corruption causes deviations.
3.2.	Filing complaints about medical transfer	Suggestion boxes are often used for patients who are not satisfied with the services to file complaints and thus lead to improvement. However, it is possible that there are still some injustices and few cases where a patient must be a family member or otherwise connected to the service provider in order to receive appropriate feedback. Although the majority of respondents believed there was little risk of corruption in this procedure, a small number of respondents mentioned the possibility that some service providers who have familial connections to people who complain about medical transfers may speed up the process.	FGDs were used to determine this decision point and its deviance.
3.3.	Dual clinical practices	There are clear guidelines governing dual clinical practices and carried out effectively. However, some medical personnel might bribe their superiors to be given permission to work in other clinics under the pretense that they are exhausted and need to rest. In the literature, some studies also suggest that there are some medical professionals who engage in illegal dual practices in order to supplement unsustainable public sector salaries (Glynn, 2022). Some of the medical staff who participated in FGDs revealed that some of their colleagues do not adhere to the guidelines for dual clinical practices. During the discussions, they asserted that	The decision point and its deviation were identified using Focus Group Discussions.

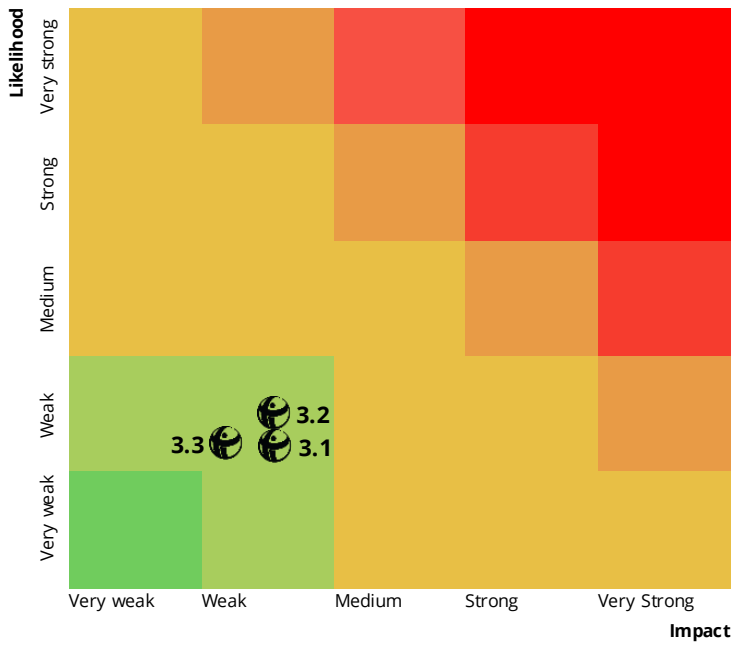
CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
		there are instances in which certain medical personnel bribe their line supervisors to let them work in private clinics during hours that they are supposed to be working in public healthcare institutions. They contend that the bosses give those staff a leave on false pretenses of being overworked.	

Table 14: Risk score Patient transfer services

	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
3.1	Referral procedures for CBHI users	1.2	1.6	1.4
3.2.	Filing complaints about medical transfer	1.5	1.6	1.6
3.3.	Dual clinical practices	1.2	1.2	1.2

Disaggregating the average scores further by districts and type of respondents, for the majority of healthcare users, the risk of corruption is extremely minimal for services related to the transfer of a patient to another hospital for those who use CBHI. Respondents from the districts of Rusizi and Rubavu, however, stated that there is a chance of corruption throughout the transfer process and that it may negatively affect the victims. On the side of healthcare providers, only respondents from Rubavu district reported corruption risk in the services associated filing complaints about medical transfer. Although the corruption risk in this process is at a low level, it is against the guidelines of the Ministry of Health on effective referral management (MoH, 2020a). Healthcare users stated that there is no chance of corruption with dual clinical practices, while healthcare providers said there is little risk of corruption in these practices. This low risk may be associated with the fact that there are clear procedures for dual clinical practice (Dual Clinical Practice Policy, 2020).

Figure 7: Risk heat map for patient transfer services



4. Medical Appointments

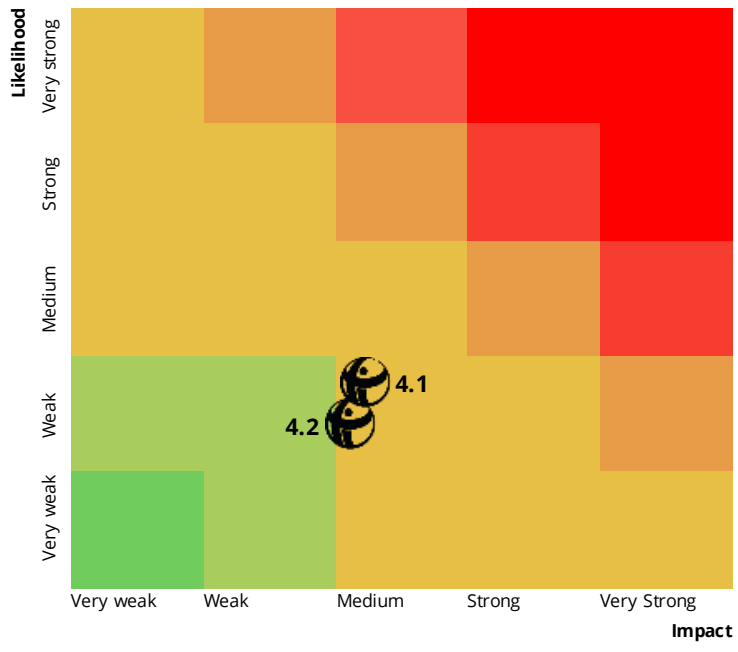
CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
4.1.	Scheduling medical appointments	Scheduling medical appointments might not be done fairly. Some people unfairly receive recent dates while others are made to wait a long period for appointments. Participants in FGDs revealed corruption in the forms of bribery, family ties and friendship in the procedures of medical appointments.	The literature was used to identify this decision point. Participants in FGDs also described how corruption causes deviations.
4.2.	Adherence to medical appointments	Medical appointments might be violated. Some people may be prioritized for medical visits without taking booked appointments into account. This might be as a result of networks and family ties that link some patients and healthcare providers. Literature that suggests corruption vulnerabilities in the healthcare delivery system (see U4/CMI, 2020b). FGDs were also used to identify this critical decision point. A couple of the FGD participants brought up the issue of unfair medical appointments. During discussions, they singled out bribery and family ties as the main sources of corruption that threaten this process.	This decision point was identified using literature. Participants in FGDs also described how corruption at this decision point causes deviations.

Table 15: Risk score Medical Appointments

CODE	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
4.1.	Scheduling medical appointments	1.8	2.2	2
4.2.	Adherence to medical appointments	1.4	2.1	1.8

Disaggregating the average scores further by districts and type of respondents, with regard to services related to medical appointments, healthcare users from 2 district out of five selected for this assessment expressed concern about the potential risk of corruption in the delivery of such essential healthcare services. Respondents from the districts of Rusizi and Rubavu gave the likelihood and impact of corruption risk high ratings for both the fairness and the processes for scheduling medical appointments. Respondents from the remaining three districts, however, attested that there is little chance of corruption in the aforementioned process. As per healthcare providers, medical appointments are not likely to be corrupted. Despite the low likelihood of such a risk, respondents from Huye and Rubavu districts show that the impact of corruption risk in fairness and procedures for medical appointments are severe.

Figure 8: Risk heat map for medical appointments



5. Healthcare human resource services

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
5.1.	Recruitment and placement of medical workers	The process may not be done fairly as a result of certain forms of corruption, including gender-based corruption. Literature reveals the risk of corruption on these processes. USAID's report shows that corruption in hiring procedures results in employing unqualified medical staff (USAID, 2022). During data collection in focus group discussions, some medical professionals who participated revealed corruption in the recruitment process. In their testimonies, some candidates claim to have been given the answers to the exams they must take before sitting for them formally. In this process, corruption manifests in the forms of friendship, family ties, bribery, and sextortion.	Through the use of literature, this decision point was proposed. Participants in FGDs also described how corruption at this decision point causes deviations.
5.2.	Promotion of medical personnel	Sometimes the promotion of medical personnel can be influenced by corruption rather than merit. As the participants in FGDs pointed out, fairness in the promotion of medical staff is hindered by corruption in the forms of bribery, friendship, family ties, and sextortion.	The literature was used to determine this decision point Participants in FGDs also described how corruption at this decision point causes deviations.
5.3.	Employee remuneration and salary increases	Some employees engage in corruption in exchange for certain job benefits. Salary increases depending on posts or duties. Participants in FGDs indicated that there are guidelines and procedures followed. However, there are a few cases where some medical staff may be given recommendations for posts with better salaries and allowances due to their family ties with those in charge or having sexual relations with them.	This decision point and its deviation was identified through the literature and FGDs.
5.4.	Selection of medical personnel for Training and further education.	Possibility of unfair selection of medical personnel for training or further study. According to the participants in FGDs, medical staff are recommended by their leaders to go to training or further education. These participants, who are made up of medical staff, showed that corruption in this process is not common in this process. They point out, though, that under some circumstances, medical staff members might choose to pay bribes in exchange for such recommendations.	This decision point and its deviation was identified through review of the literature and FGDs.
5.5.	Evaluations and appraisals	Possible limited fairness in evaluations and appraisals of medical staff, which might increase the possibility of corruption. Some FGD participants believe that the process's execution does not adhere to fairness principles. Some people assert that biased staff performance assessments and sextortion are frequent occurrences. Some assert that during the procedure, sextortion	This decision point was selected through the literature. Participants in FGDs also described how corruption at this decision point causes deviations.

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
		and unfair staff performance appraisals are frequent occurrences.	
5.6.	Transfer of medical personnel to other medical facilities for a variety of reasons.	Application of transfer of medical staff who need to work in another healthcare facility due to various reasons is generally effective in the system. However, in some circumstances, applicants might be asked to pay bribes in exchange for a fair response. Some participants in the focus group discussions (FGDs) stated that the job transfer processes are quite intricate, leading some medical staff members to choose to pay bribes in exchange for being relocated to the healthcare facilities of their choice.	The decision point and its possible deviation was identified using literature and Focus Group Discussions.

Table 16: Risk score Healthcare human resource services

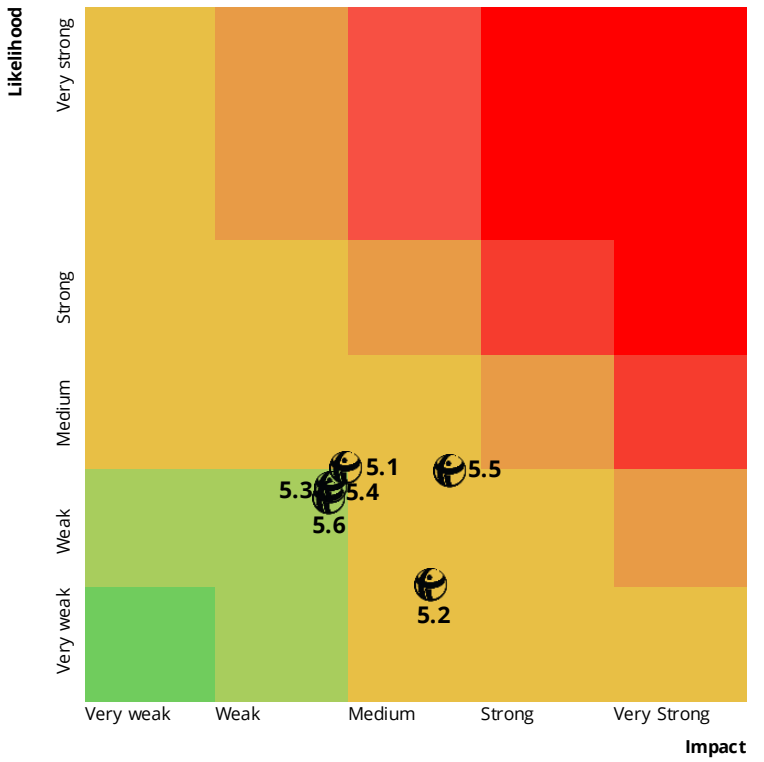
	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
5.1.	Recruitment and placement of medical workers	2	2	2
5.2.	Promotion of medical personnel	1	2.7	1.9
5.3.	Employee remuneration and salary increases	1.9	1.9	1.9
5.4.	Selection of medical personnel for Training and further education.	1.9	1.9	1.9
5.5.	Evaluations and appraisals	2	2.8	2.4
5.6.	Transfer of medical personnel to other medical facilities for a variety of reasons.	1.8	1.8	1.8

As this priority area concerns internal processes, the risks scores were given only by service providers and not users. Findings show a low corruption risk in services related to medical workers' recruitment, remuneration, training and evaluation, promotion, and transfer. Disaggregating the average scores further by districts there was significant risk score for corruption in the aforementioned services in Rusizi district. In four other districts, scores on the risk of corruption in the hiring and placement of medical personnel are quite low. Although results show that the risk of corruption in the promotion of medical professionals is relatively low,

perceptions of healthcare users from the districts of Kayonza and Rusizi indicate that it can have a serious impact on the victims.

With the exception of respondents from the Rusizi district, who show a high corruption risk in employee remuneration and salary increases, respondents from other districts show that this risk is quite low. As per the respondents' perceptions, selecting medical staff for training and further education in the Rusizi district also carries a considerable risk of corruption. Respondents from Rusizi district also indicated a high corruption risk in services related to the transfer of medical personnel to other medical facilities.

Figure 9: Risk heat map for healthcare human resource services



7. Internship practices for medical students

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
6.1.	Internship placement	Possible lack of fairness in placement of medical students doing internship. These practices might be characterized by certain forms of corruption including gender-based corruption. In a study conducted in TVET schools, the findings revealed corruption in internship practices (TI-Rwanda, 2021a). Transparency International found in another study that corruption poses a significant threat to education in developing countries (U4/CMI, 2019). Participants in focus groups asserted that friendship, familial ties, sextortion, and favouritism are some of the	Literature reviews and focus group discussions were used to determine the decision point and any potential deviations from it.

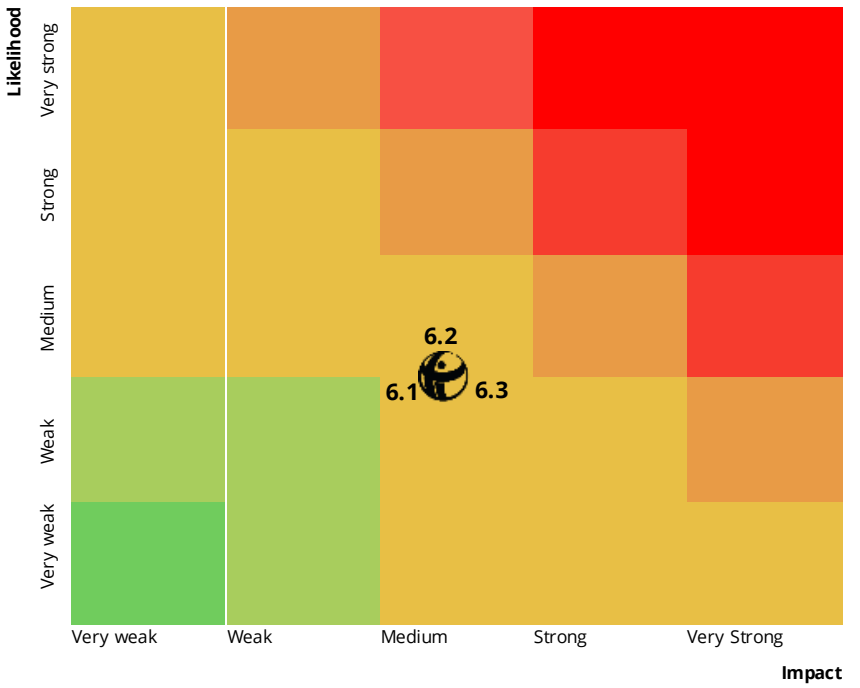
CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
		forms of corruption seen in the practice of placing medical students in healthcare facilities for internship.	
6.2.	Internship supervision	Possible lack of fairness in supervision of medical students doing internships. The participants in the focus group discussions (FGDs) disclosed that the supervision of medical interns is marked by corruption of various kinds, including sextortion or corruption based on friendships and networks.	The decision point was identified via literature (TI-Rwanda, 2021a). Participants in FGDs also described how corruption at this decision point causes deviations.
6.3.	Internship grading	Possible lack of fairness in grading of medical students doing internship. As revealed during focus group discussions, grading practices are often characterized by certain forms of corruption including gender-based corruption or friendship and network.	The decision point was identified via literature and discussions in focus groups. Participants in FGDs also described how corruption at this decision point causes deviations.

Table 17: Risk score Internship practices for medical students

CODE	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
6.1.	Internship placement	2	2.4	2.2
6.2.	Internship supervision	2	2.4	2.2
6.3.	Internship grading	2	2.4	2.2

As this priority area concerns internal processes, the risks scores were given only by service providers and not users. Disaggregating the average scores further by districts there was, unlike other districts, the healthcare providers from Rusizi district indicated there was a high risk of corruption in the services of internship practices for medical students. Although they believed it was not high, the respondents from the Rubavu district admitted the possibility of corruption in this service. Respondents from the Rusizi district show that victims of this kind of corruption may suffer serious consequences that harm their health status; this issue was also raised, albeit less gravely, in the Rubavu district

Figure 10: Risk heat map for internship practices for medical students



7. Hospitalisation/Admission services

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
7.1.	Procedures for hospitalization/ admission in various health facilities	Possibility of corruption in the process of hospitalization/admission in various health facilities. As revealed during focus group discussions, there are still cases of corruption in the forms of family ties and networks, as well as bribery in the procedures for hospitalization/admission.	This decision point was selected based on the literature that suggests corruption in the process of hospitalization/admission in various health facilities (TI, 2021) and during FGDs, participants revealed its deviation.
7.2.	Follow-up and care procedures for hospitalized patients	As participants in FGDs indicated, friendship and family ties might influence care for hospitalized people. As a result, those who don't have family or friends working in hospitals or clinics may get poor care.	The decision point and its deviation were identified via literature and discussions in focus groups.

Table 18: Risk score Hospitalisation/Admission services

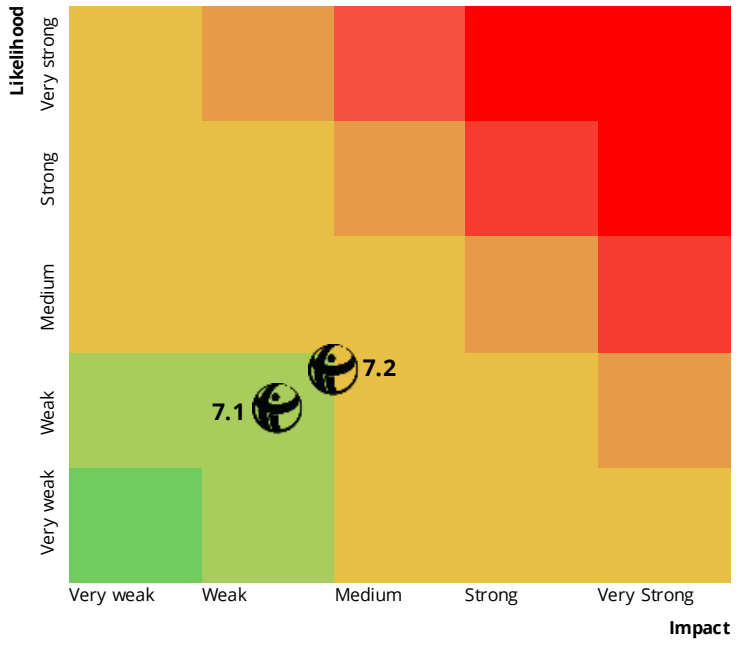
CODE	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
7.1.	Procedures for hospitalization/admission in various health facilities	1.5	1.7	1.6

CODE	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
7.2.	Follow-up and care procedures for hospitalized patients	1.9	2	2

Disaggregating the average scores further by districts and type of respondents, hospitalization and admission services from the districts of Rusizi and Rubavu exhibit a high risk of corruption and it has a very negative impact on victims according to healthcare users. Respondents in other districts, however, suggest that there is little chance of corruption in the aforementioned services. In terms of patients' medical examinations and the dispensing of medication, findings from healthcare users indicates that there is little risk of corruption in the delivery of such basic healthcare. Despite the low likelihood of corruption in these services generally, respondents from Rusizi district voiced concerns regarding the duration of medical exams, noting out that there is no time limit in place and that this can lead to corruption, particularly for individuals who need quick treatment. The likelihood of corruption in the administration of medicines to patients was also rated high in the same district.

As per the scores from healthcare providers, there is a low risk of corruption in the admission or hospitalization processes. However, follow-up and care procedures for hospitalized patients still have corruption gaps in Rusizi district.

Figure 11: Risk heat map for Hospitalisation/Admission services



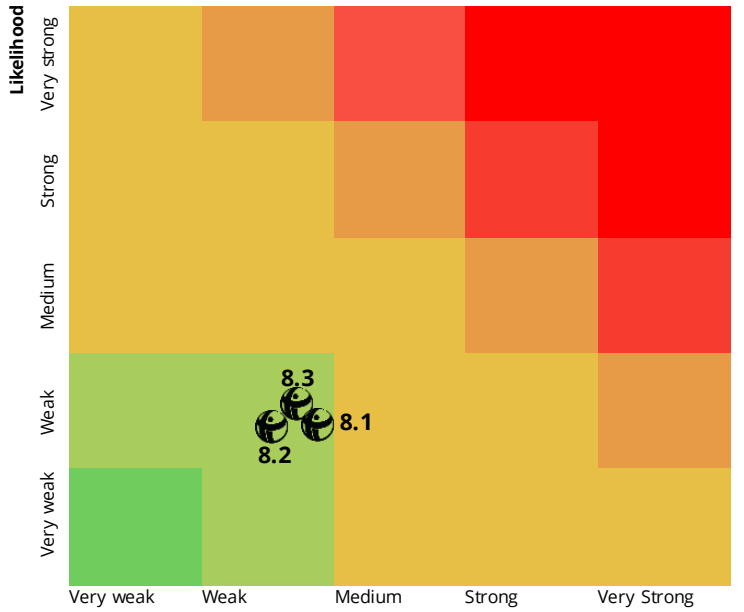
8. Medical examinations and prescription of medicine

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
8.1.	Procedures for medical exams	Corruption may limit fairness in medical examinations, which could make access to healthcare difficult for everyone, but notably for the poorest. The FGD participants demonstrate that the few instances of corruption in this process typically take the shape of friendships, networks, and familial relationships.	The decision point and its deviation were identified via literature (TI-Rwanda, 2020a) and discussions in focus groups.
8.2.	Duration of Medical examinations	As reported during Focus group discussions, the length of the medical exam might be significantly cut down, and the services being accelerated, if the people seeking the services are family members or friends of the healthcare professionals. However, this may lead to corruption risk that often affects women and girls due to the gender power imbalance that makes them more vulnerable.	This decision point and its deviation were identified through the literature and FGDs.
8.3.	Medication administration	Corruption may limit fairness in administration of medication to patients. Participants in focus groups asserted that patients who have ties to some medical staff members through friendship or family are more likely to receive fast medication and care.	This decision point was selected through the literature. Participants in FGDs also described how corruption at this decision point causes deviations.

Table 19: Risk score medical examinations and prescription of medicine

CODE	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
8.1.	Procedures for medical exams	1.4	1.9	1.7
8.2.	Duration of Medical examinations	1.4	1.6	1.5
8.3.	Medication administration	1.6	1.8	1.7

Figure 12: Risk heat map for medical examinations and prescription of medicine



Disaggregating the average scores further by districts and type of respondents, these statistics from respondents indicate that there is little risk of corruption in the patient medical examination and medication administration services.

It turns out that significant efforts are being made to combat any injustices or corruption in this procedure. However, as noted by the respondents, there are still observable corruption risks varying from high to low in different districts. It is imperative therefore, that healthcare providers comply with policy statement on medical examinations, requiring this service to be performed in accordance with existing clinical treatment guidelines (MoH, 2020f).

9. Supply of medicines and non-medical materials

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
9.1.	Procurement of medical and non-medical materials	Corruption poses a severe threat to the supply of both medical and non-medical supplies across the world. In response to this, Rwandan regulations governing the medical supply chain place restrictions on the power of administrators of healthcare facilities to buy medications anywhere. However, the process might still have a very low risk of corruption. According to a TI-Rwanda report, purchasing medical supplies and equipment still susceptible to corruption (TI, 2021).	The decision point was identified using literature. Participants in focus groups noted that there is little chance of corruption in this procedure.
9.2.	Handling complaints	Complaints might be rarely received due to the fact that the supply of medical materials	The decision point was identified using literature.

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
	about the supply of medical and non-medical materials in various health facilities.	in public healthcare facilities is done by an agency established by the government and no medical supplies are passed through the procurement information system established by the government.	Participants in focus groups noted that there is little chance of corruption in this procedure.

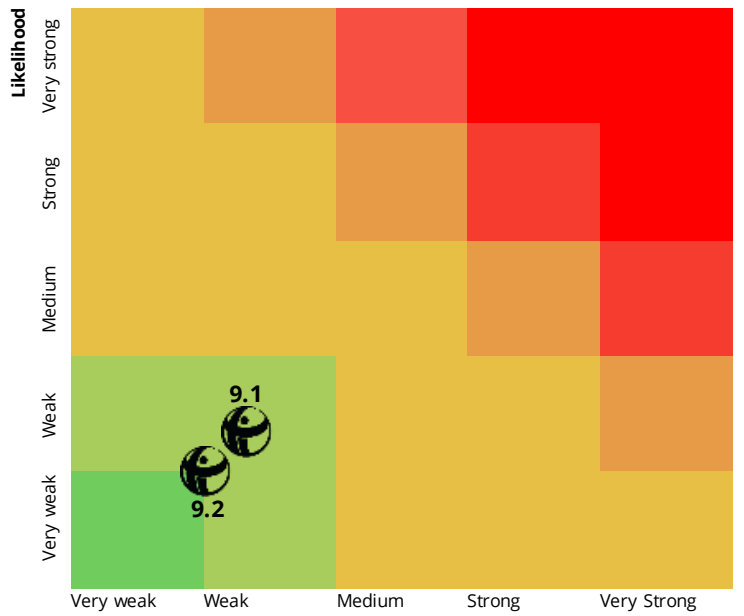
Table 20: Risk score Supply of medicines and non-medical materials

DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
Procurement of medical and non-medical materials	1.3	1.3	1.2
Handling complaints about the supply of medical and non-medical materials in various health facilities.	1	1	1

Disaggregating the average scores further by districts and type of respondents, with regard to medical and non-medical material supply, healthcare users from all selected districts indicated that there is very little perceived corruption risk. The scores for both likelihood and impact of corruption risk suggest that there is extremely minimal perceived corruption risk in these services. In the opinions of healthcare providers, supply of both medical and non-medical materials is one of the services with low risk of corruption as shown by respondents from all selected districts.

These results are consistent with the literature demonstrating that only Rwanda Medical Supply or another organization approved by the government is authorized to supply medical supplies through authorized procedures and protocols to public healthcare facilities (MoH, 2021a) .

Figure 13: Risk heat map for supply of medicines and non-medical materials



10. Registration and authorization of health facilities

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
10.1.	Registration of health facilities	As revealed during the FGDs, with influence of corruption, certain applications for registration of health facilities may be accepted while others are rejected. Participants in the discussions pointed out that corruption in this process is in the form of bribery. Literature also reveals potential corruption in the licensing, inspection, and registration of pharmaceutical facilities (U4/CMI, 2020b). However, this might pose serious threats to universal healthcare access, with vulnerable people suffering the most.	The decision point and its deviation were identified using literature and Focus Group Discussions.
10.2.	Authorization of health facilities	Participants in focus groups raised the concern that corruption through networks with officials, bribery, or familial relationships could affect healthcare facilities' authorization.	Discussions in focus groups revealed that there is room for deviation from this decision point.
10.3.	Provision of operational licenses	As per focus group discussions, corruption in the provision of operational licenses may influence the decision. The prevalent form of corruption that comes up in discussions is bribery. This might prevent the most vulnerable people from accessing healthcare.	Focus group discussions and literature were used to determine the decision point and its deviation.

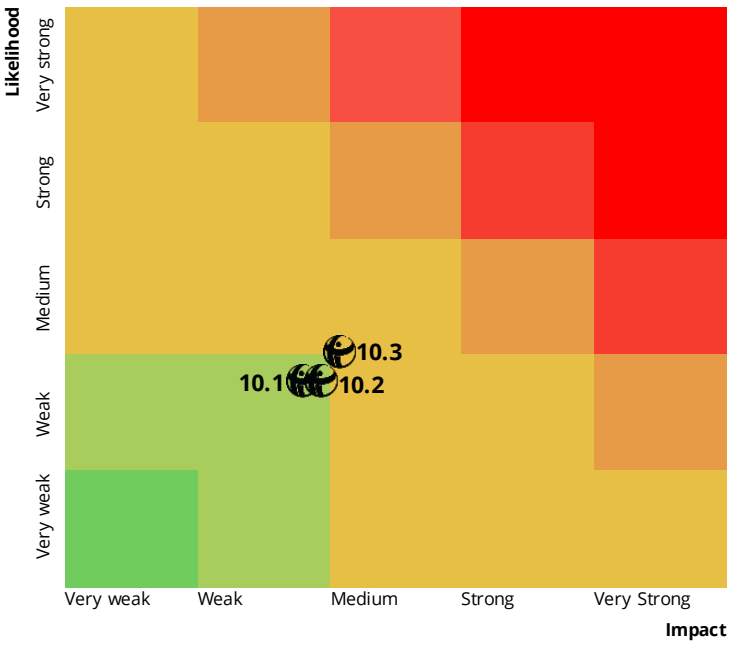
Table 21: Risk score Registration and authorization of health facilities

DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
Registration of health facilities	1.8	1.8	1.8
Authorization of health facilities	1.8	1.9	1.9
Provision of operational licenses	2	2.1	2.1

Disaggregating the average scores further by districts and type of respondents, healthcare users from Kayonza and Musanze districts indicated that there is a possible corruption risk in the Authorization of health facilities and the issuance of operational licenses. In the same vein, respondents from Musanze district indicated that such risk might have a severe impact on the lives of the victims.

As indicated by the healthcare providers, there is a low corruption risk during registration of health facilities in Rubavu and Rusizi districts. In the same vein, perceptions of healthcare providers from Rusizi district show high likelihood of corruption risk in the process of authorization of health facilities and provision of operational licenses. Respondents in this assessment and the literature both point to corruption vulnerabilities in these practices. Meanwhile, the Ministry of Health recently issued regulations, procedures, and all other requirements for the registration and licensing of private healthcare institutions (MoH, 2021b). However, as a practical measure to end the problem, efforts are needed to control these practices.

Figure 14: Risk heat map for Registration and authorization of health facilities



11. Practices of nutritious foods for vulnerable citizens (stunted children and pregnant women)

CODE	DECISION POINT	POTENTIAL DEVIATED DECISIONS	HOW THE DECISION POINT AND DEVIATED DECISION POINTS WERE IDENTIFIED
11.1.	Selection and distribution of nutritious foods to malnourished children and pregnant women.	Participants in focus group discussions indicated that corruption in the form of bribery, personal connections, networks, or favouritism influence this process. The literature demonstrates that some local leaders engage in wrongdoing, particularly corruption when selecting beneficiaries of different government assistance programs (RGB, 2018).	The decision point and its potential deviation were identified via literature and discussions in focus groups.
11.2.	Filing a complaint when denied nutritious foods despite being eligible	Vulnerable persons may continue to have poor health conditions if their complaints are not treated properly as a result of some corrupt behaviors of local authorities. Focus group discussion (FGD) participants said that sometimes, in order to obtain the right answers, there is a risk that those who submit complaints bribe or have sexual relations with some of the local leaders.	A review of the literature and discussions in focus groups were utilized to identify the decision point and its possible deviance.

Table 22: Risk score Practices of nutritious foods for vulnerable citizens (stunted children and pregnant women)

	DECISION POINT	AVERAGE LIKELIHOOD SCORE	AVERAGE IMPACT SCORE	AVERAGE RISK SCORE
11.1.	Selection and distribution of nutritious foods to malnourished children and pregnant women.	2.2	2.6	2.4
11.2.	Filing a complaint when denied nutritious foods despite being eligible	2	2.2	2.1

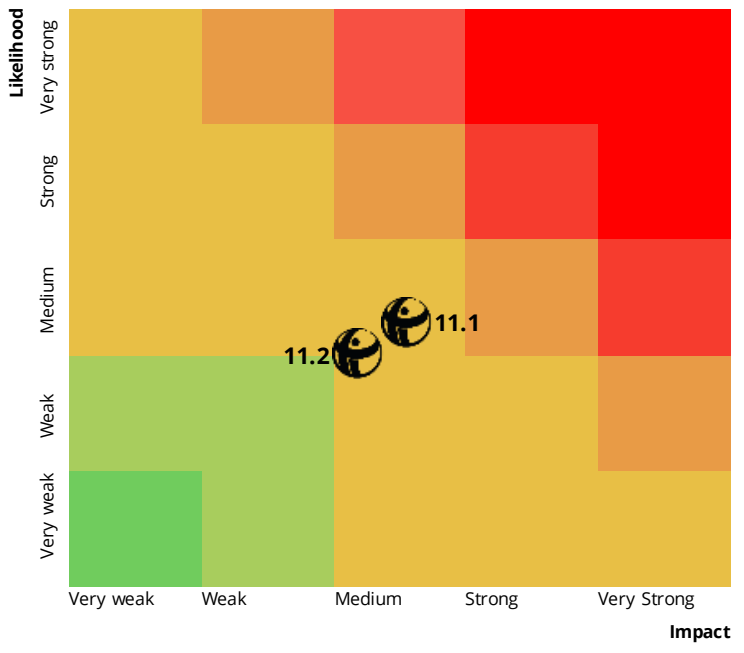
Disaggregating the average scores further by districts and type of respondents, Healthcare users from Rubavu and Rusizi districts expressed concern about the possible risk of corruption in the services related to nutritious foods for stunted children and pregnant women. For instance, in the Rubavu and Rusizi districts, respondents' perceptions show high likelihood of corruption risks

during the selection and delivery of nourishing foods to stunted children and pregnant women. Additionally, respondents mentioned that victims may suffer badly as a result of this risk. Respondents from these districts also mentioned possible corruption risks in filing a complaint when denied nutritious foods despite being eligible.

On the side of healthcare providers, respondents from other districts show low corruption risk in services of nutritious foods for stunted children and pregnant women, with exception of Rubavu and Rusizi districts, where it seems that these services are prone to corruption as per the respondents' perceptions, both healthcare users and providers. As statistics show, these services are vulnerable to corruption. However, the government's policy is extremely clear in this regard. The policy states that nourishing diets are provided to pregnant and lactating women in UBUDEHE 1 and 2 as well as nutritionally vulnerable children under the age of five only (MOH, 2014).

Despite such a policy that specifies eligible recipients precisely, certain focus group participants' testimonies indicated that corruption behaviors still exist, especially when it comes to the selection procedure for this nutritional support program's beneficiaries. Therefore, it appears that the policy's implementation is still ineffective, which leaves space for corruption.

Figure 15: Risk heat map for Risk heat map for Registration and authorization of health facilities



Overall observations

The qualitative data does suggest that there might be a chance of corruption, even though the results demonstrate that overall risk scores are quite low. The participants in the focus group discussions (FGDs) with vulnerable groups perceived that widows, single women, and divorced women were more likely to be the target of sextortion. Findings suggests that some services are more vulnerable to corruption risk than others. Findings also show that corruption in healthcare delivery is not at the same level in the five districts selected for this assessment. The UBUDEHE categorization process is the service with the highest risk of corruption in all sampled districts (the average corruption risk score for this process is 3.2 out of 5).

The delivery of nutritious foods to pregnant women and stunted children, as well as the process of selecting recipients, appear highly susceptible to corruption in the districts of Rubavu and Rusizi. (In both districts, the average corruption risk score varies from 3.5 to 4 out of 5). Furthermore, there is a high likelihood of corruption in the services related to Community-Based Health Insurance program in the same districts. (Both districts have average corruption risk scores ranging from 2.4 to 3 out of 5). Recruitment, selection, training, and transfer services for medical personnel and internship for medical students are also prone to the possibility of corruption, particularly in the Rusizi district (corruption risk score is 4 out of 5). As per the healthcare providers, corruption risk also often threatens the registration and authorization of health facilities, especially in Rubavu and Rusizi districts (average risk score is 2.6 and 3.3 out of 5 respectively).

Respondents from the Rusizi and Rubavu districts generally rate the decision points highlighted in the assessment as having high risks of corruption compared with scores given by respondents from the other three districts. The reasons for this discrepancy were not clear from the research. These districts are both known to have large commercial cities and are located on the border although it may not be linked to the findings in question. However, there is a need for other in-depth studies that might provide more insights on corruption drivers in these two districts to support the findings of this assessment.

The government of Rwanda established the UBUDEHE categorizing process to demonstrate the ability of the citizens in order to develop plans and strategies that assist the poor and lift them from below the poverty line. Depending on which UBUDEHE categories they fall under, residents get different packages of government aid while some groups are not eligible. In this process, some local leaders tend to act in ways that lead to corruption since there are so many poor people who need to benefit from various assistance packages/schemes from the government. Hence, this has an impact on the vulnerable people who cannot afford corruption in exchange for services. For instance, vulnerable citizens frequently assert that they are placed in UBUDEHE categories that do not match their abilities, which prevents them from accessing healthcare.

People need or use health insurance services in different ways. However, services related to community-based health insurance are especially needed by vulnerable people. The reasons include the fact that this insurance scheme was usually established by the government to help the poor access healthcare, so it is understood that it is an insurance scheme that includes a large number of vulnerable people. This program also includes many citizens from low-income households who receive government support for CBHI premiums (Premiums are paid by the government). Services related to nourishing foods are also needed by the most vulnerable people, especially poor pregnant women and stunned children. In fact, it is extremely worrying that services that are frequently needed by vulnerable persons have significant corruption risks. This shows that vulnerable people who cannot afford to pay corruption often face limited access to healthcare. Therefore, many efforts are needed to eliminate all barriers that prevent vulnerable people from accessing such vital services.

Corruption risk in healthcare delivery has been shown at various levels in selected districts, However, Rusizi and Rubavu districts have the highest levels of corruption risk compared to other districts. Although the Ministry of Health recently established a clear policy on dual clinical practices, medical staff from Rubavu and Rusizi districts show that these practices are still vulnerable to high level of corruption risks. Although the delivery of said services is prone to the risks of corruption, the literature in this assessment demonstrates that exist laws, regulations, processes, policies, and numerous other measures have been established by the government in the framework of fostering fairness in healthcare delivery in the country. Within this regard, it is likely that there is still a gap in the implementation, demonstrating the need for more efforts in implementation and controls.

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The above tables show a summary of ratings of two categories namely healthcare providers and healthcare clients. These ratings for likelihood and impact scores were obtained by averaging the ratings from all districts. As it turns out, the rating of healthcare providers and healthcare clients are largely the same. Both categories of respondents provided almost the same scores on some of the decision points where corruption risks are high. Some of the services that have high corruption risk as indicated by both categories of respondents include the categorization of citizens into UBUDEHE.

Access to CBHI (Mituelle de Santé) especially the Selection of CBHI Beneficiaries and Charge and recover CBHI contributions in the community are some of the decision points that both sides show as having a risk of corruption. Other services identified by both sides as having a corruption risk include registration and authorization of health facilities. Both categories of respondents also showed similar ratings on possible corruption in the services related to nutritious foods for stunted children and pregnant women. Despite evidence from healthcare providers that the services associated with filing complaints regarding medical transfers are done in a way that can lead to corruption risk, healthcare clients have a different perspective because they show that the corruption risk in this service is relatively low. Healthcare providers also showed corruption risk in the procurement of medical and non-medical materials, while healthcare clients showed a low rating of corruption risk in such services. This can be explained by the possibility that patients may not have adequate information about procurement practices in healthcare facilities.

RECOMMENDATIONS

4. RISK MITIGATION STRATEGIES

Mitigation strategies for each decision point were suggested during focus group discussions. In adopting a strategy to mitigate corruption risk, consensus was used within each group. Opinions from all the groups were compiled by researchers in each district. To formulate mitigation strategies, the views of healthcare recipients and medical professionals were merged (the final risk score was calculated as the average of the risk scores from both categories of respondents). The risk score was used to rank the mitigation strategies that were suggested for each decision point.

Table 23: Risk mitigation strategies

	Decision point	Average Risk Score	Mitigation Strategy
1.1	Categorizing citizens into UBUDEHE	3.6	Engaging citizens in the categorization of UBUDEHE (as they are familiar with one another, citizens may propose and debate the categories pertaining to their peers' economies). Local leaders should only facilitate the process. Establishing consistent controls in the process of categorization. UBUDEHE categories, or classes of residents depending on their income level, should not be taken into account when evaluating the performance of local leaders (having a large population in the poor categories isn't necessarily a sign of poor performance).
1.2	Filing complaints about the classification in UBUDEHE categories	3.1	Valuing, following up on, and responding appropriately to citizen complaints.
1.3	Justice for people who were misclassified into UBUDEHE	3	Reducing the lengthy procedures used to provide justice to citizens who have filed complaints
2.3	Distributing CBHI cards.	2.4	Providing guidance on policies, rules, and procedures to leaders in charge of these services. Establishing continuous monitoring.
11.1	Selection and distribution of nutritious foods to malnourished children and pregnant women	2.3	Greater adherence to guidelines for providing nutritious foods to malnourished children and pregnant women. The list of beneficiaries should be made public. Food should be distributed during community meetings. An oversight committee should monitor the process.
5.5	Staff evaluation and appraisals	2.2	Reinforcing internal control procedures and severely punishing those who engage in corruption.
5.4	Selection of medical personnel for Training and further education.	2.2	Increase efforts in the reinforcement of policies, guidelines, and procedures of the training/further education process for medical professionals.

	Decision point	Average Risk Score	Mitigation Strategy
5.6	Transfer of medical personnel to other medical facilities	2.2	Establish a team to keep an eye on how medical transfer services are being delivered across various facilities
2.4	Dealing with citizen complaints about CBHI	2.2	Establish a functioning mechanism for follow-up and providing feedback on citizens' complaints. Establishing a committee to control and monitor how community complaints are handled.
2.3	Referral procedures for CBHI users	2.1	Establish a team to keep an eye on how healthcare services are being delivered across various facilities. Putting in place a simple process for gathering complaints from clients who are not satisfied with the service they received.
2.2	Charge and recover CBHI contributions in the community.	2	Organize regular training for local leaders who are responsible for these activities. Establish an active committee responsible for controlling activities related to CBHI.
5.1	Recruitment and placement of medical workers	2	Increase efforts in the reinforcement of policies, guidelines, and procedures of the recruitment process for medical professionals.
4.1	Procedures for medical appointments	2	Establish a committee to keep an eye on how healthcare services are being delivered across various facilities. Putting in place a simple process for gathering complaints from clients who are not satisfied with the service they received.
2.1	Selection of CBHI Beneficiaries	1.9	Organize regular training for local leaders who are responsible for these activities. Establish an active team responsible for controlling activities related to CBHI.
4.2	Fairness of medical appointments	1.9	Providing guidance on policies, rules, and procedures to leaders in charge of these services. Establishing continuous monitoring.
10.2	Authorization of health facilities	1.9	Training of people who deliver this service on adhering to rules and regulations. forming an oversight committee with responsibility for battling corruption in these services. Using electronic system in the process would reduce the corruption risk.
7.2	Follow-up and care procedures for hospitalized patients	1.9	Establish a team to keep an eye on how healthcare services are being delivered across various facilities. Putting in place a simple process for gathering complaints from clients who aren't happy with the service they received. Establishing a gender-sensitive reporting mechanism in healthcare facilities.
6.1	Internship placement	1.8	Establishing oversight committees in both medical schools and hosting organizations (Healthcare facilities). Conduct intensive campaigns for medical students to be aware of and take care of their rights.
10.3	Provision of operational licenses	1.8	Training of people who deliver this service on adhering to rules and regulations. forming an oversight committee with responsibility for battling corruption in these services. Using electronic system in the process would reduce the corruption risk
8.2	Duration of medical examinations	1.8	The duration of medical exams in the laboratory should be communicated to the patient in writing. Appointing individuals in

	Decision point	Average Risk Score	Mitigation Strategy
			charge of overseeing the provision of healthcare in various facilities.
9.2	Procurement of medical and non-medical materials	1.8	Reinforcement of procedures for procurement of medical and non-medical materials. Strengthen internal control over procurement in various healthcare facilities.
5.3	Employee remuneration and salary increases	1.8	Increase efforts in the reinforcement of policies, guidelines, and procedures on Employee remuneration and salary increases.
5.2	Promotion of medical personnel	1.7	Increase efforts in the reinforcement of policies, guidelines, and procedures of promotion for medical professionals.
3.2	Dual clinical practices	1.7	Reinforcement of the implementation of the new policy on dual clinical practices. Serious sanctions for medical staff found to be in violation of dual clinical practices.
6.2	Internship grading	1.6	Establishing oversight committees in both medical schools and hosting organizations (Healthcare facilities). Conduct intensive campaigns for medical students to be aware of and take care of their rights.
10.1	Registration of health facilities	1.6	All processes related to the registration of health facilities should be digitized to reduce corruption risk that can arise from in-person interactions.
6.2	Internship supervision	1.5	Establishing oversight committees in both medical schools and hosting organizations (Healthcare facilities). Conduct intensive campaigns for medical students to be aware of and take care of their rights.
8.3	Administration of medications to patients	1.5	Establish an active committee to monitor healthcare delivery. Establish severe sanctions for anyone who found guilty of misconduct.
8.1	Procedures for medical exams	1.3	Establishing a committee in charge of overseeing the delivery of medical exam results. The committee shall be responsible for closely monitoring the medical examination process and notifying patients of any delays.
11.2	Filing a complaint when denied nutritious foods despite being eligible	1.2	Establish a functioning mechanism for follow-up and providing feedback on citizens' complaints. Establishing a committee to control and monitor how community complaints are handled.
7.1	Procedures for hospitalization/admission in various health facilities	1	Establish a team to monitor delivery of healthcare across various facilities. Establish a simple process for gathering complaints from clients who are not satisfied with healthcare.

4. MONITORING AND EVALUATION

Monitoring and analysing the identified corruption risks are essential for this assessment. In order to ensure that healthcare programs and services are efficient and meet community health needs, there is a need for consistent monitoring and evaluation of identified risks, advocacies and working closely with the relevant authorities to address the corruption risks revealed in this assessment. The ISDA project in general and this assessment in particular have made it a top priority to collaborate closely with government institutions that have the power to fix any gaps in healthcare delivery. In this assessment, some of the leaders in decision-making positions were invited and actively participated.

This close interaction with the decision-makers would therefore continue to be strengthened during monitoring and evaluation of corruption risks revealed in the assessment. This will allow the TI-Rwanda team to determine whether or to what extent the recommendations are being implemented. Monitoring and Evaluation can be organized through technical meetings with stakeholders, outreach in various healthcare facilities, and ALACs operating in the 5 districts selected for this assessment.

Local communities should also be engaged in monitoring and evaluation of healthcare delivery in clinics near them using suggestion boxes and Citizens Concerned Committees (CCCs) facilitate the activities. Associations/councils or other bodies representing women and girls such as Women councils at district and sector levels, teen mothers, Association of Deaf Women, and others should be involved in monitoring and evaluation of healthcare delivery.

In order for the monitoring and evaluation to be done properly and to reach the goal, the following institutions will be engaged as they had an active role in the assessment;

- Ministry of Health in Rwanda, with its mission to provide and continuously improve affordable promotive, preventive, curative and rehabilitative health care services of the highest quality and enhancing the general well-being of the population, will make a practical contribution in this assessment.

- Rwanda Biomedical Center as Rwanda's national health implementation agency, its role in addressing identified corruption risks is irreplaceable.

- The Rwanda Medical and Dental Council, whose mission is to create a society in Rwanda where everyone has access to high-quality medical treatment and where the medical profession thrives and upholds its dignity through constant improvement.

- Rwanda Medical Supply Limited, a large-scale corporation created and owned by the Government of Rwanda. RMS Limited's mandate is to make sure that consumables, medical supplies, and medications are available in public healthcare facilities in the appropriate quantities and of acceptable quality. Rwanda Social Security Board, a government agency in charge of Community Based Health Insurance, also has practical powers in addressing identified corruption risks in the health sector.

5. LESSONS LEARNED

In this assessment, there are lessons learned during the entire research process. The assessment's findings, which point out corruption risks in healthcare delivery, will be used in advocacy campaigns. This proves the need for another study in the future to capture any change that might have been brought about by this assessment.

Despite the fact that the study's findings show that the levels of corruption risk vary by district, with some districts showing higher levels of corruption risk than others, the study's scope (conducted in 5 of Rwanda's 30 districts) cannot accurately depict the overall level of corruption risk in the country's health sector. In order to capture a more accurate status of corruption risks in healthcare delivery in Rwanda, another assessment is needed to be conducted on a wider scale with ample time and funding. Institutions, especially those at the national level, were eager to participate in the assessment process in a meaningful way.

Leaders from the ministry and other national-level institutions in the health sector were invited, and they actively participated in both focus group discussions and interviews. The lesson learned from these decision-making bodies' readiness to cooperate was the necessity of strengthening that relationship, particularly during advocacy efforts and monitoring and evaluation.

CONCLUSIONS

This assessment used data from focus groups, interviews, literature, and ratings on a number of specified decision points. Results indicate that certain services are more susceptible to the risk of corruption than others. The findings also reveal different levels of corruption risk in healthcare delivery among the five districts that were part of this assessment. The provision of nutritious foods to pregnant women and stunted children, the UBUDEHE categorization process, and services related to the Community-Based Health Insurance program are among the services that the respondents believe are most vulnerable to the risk of corruption. Other decision points that may be vulnerable to the risk of corruption include; Recruitment, selection, training, and transfer services for medical personnel and internship for medical students particularly in the Rusizi district. The findings show that Rusizi and Rubavu districts had higher corruption risk scores in the delivery of various health services as compared to other districts selected for this study.

Participants in focus groups reported that certain vulnerable groups are frequently the target of sextortion when they seek medical care in various clinics and hospitals. Participants in the discussions identified widows and single women as the most vulnerable to being targeted by sextortion perpetrators. The government of Rwanda has given primary healthcare top priority in an effort make progress towards universal health coverage. Rwanda has made significant efforts to improve the nation's healthcare system, both nationally and locally, making it attainable. Despite all this, the findings of this assessment show corruption risk in in certain services provided by various healthcare facilities, which may impede women, girls, and other vulnerable people from fully accessing healthcare.

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ANNEX

Respondents' perceptions on possible forms of corruption risk in healthcare delivery

Categorization of UBUDEHE		
Districts		**Forms of corruption**
1	RUBAVU	Nepotism, Favoritism, Bribery
2	HUYE	Nepotism, Favoritism, Bribery
3	RUSIZI	Nepotism, Favoritism, Bribery
4	MUSANZE	Favoritism, Nepotism
5	KAYONZA	Favoritism, Nepotism
Access to CBHI (Mituelle de Santé)		
Districts		**Forms of corruption**
1	RUBAVU	Nepotism, Favoritism, Bribery
2	HUYE	Nepotism
3	RUSIZI	Nepotism, Favoritism, Bribery
4	MUSANZE	Nepotism, Favoritism, Bribery
5	KAYONZA	Nepotism, Bribery, Favoritism
Transfer of a patient to another hospital for those who use CBHI		
Districts		**Forms of corruption**
1	RUBAVU	Nepotism, Favoritism, Bribery
2	HUYE	Nepotism
3	RUSIZI	Nepotism, Favoritism, Bribery
4	MUSANZE	Nepotism
5	KAYONZA	Bribery, Favoritism, Nepotism
Medical Appointments		
Districts		**Forms of corruption**
1	RUBAVU	Sextortion, Nepotism, Favoritism, Bribery
2	HUYE	Favoritism
3	RUSIZI	Nepotism, Favoritism, Bribery, Sextortion
4	MUSANZE	Nepotism, Favoritism, Bribery
5	KAYONZA	Nepotism, Bribery, Friendship, Favoritism
Medical worker's recruitment, remuneration, training and evaluation, promotion, and transfer		
Districts		**Forms of corruption**
1	RUBAVU	Nepotism, Favoritism, Bribery, Sextortion
2	HUYE	Nepotism, Bribery
3	RUSIZI	Nepotism, Favoritism, Bribery, Sextortion
4	MUSANZE	Nepotism, Favoritism, Bribery
5	KAYONZA	Bribery, Nepotism
Internship practices for medical students		
Districts		**Forms of corruption**
1	RUBAVU	Nepotism, Favoritism, Bribery, Sextortion
2	HUYE	Nepotism, Sextortion
3	RUSIZI	Nepotism, Favoritism, Bribery, Sextortion
4	MUSANZE	Bribery
5	KAYONZA	Sextortion

Hospitalisation/Admission		
Districts		**Forms of corruption**
1	RUBAVU	Nepotism, Favoritism, Bribery, Sextortion
2	HUYE	Nepotism
3	RUSIZI	Nepotism, Favoritism, Bribery
4	MUSANZE	Nepotism
5	KAYONZA	Nepotism

Patients' medical examinations and medication administration		
Districts		**Forms of corruption**
1	RUBAVU	Nepotism, Favoritism, Bribery
2	HUYE	Nepotism
3	RUSIZI	Bribery, Favoritism
4	MUSANZE	Bribery, Favoritism
5	KAYONZA	Nepotism, Favoritism, Bribery

Medical and Non-medical material supply		
Districts		**Forms of corruption**
1	RUBAVU	Nepotism, Favoritism, Bribery
2	HUYE	Bribery
3	RUSIZI	Favoritism
4	MUSANZE	Bribery, Favoritism
5	KAYONZA	Bribery, Nepotism

Registration and authorization of health facilities		
Districts		**Forms of corruption**
1	RUBAVU	Bribery, Favoritism
2	HUYE	Nepotism, Favoritism, Bribery
3	RUSIZI	Nepotism
4	MUSANZE	Nepotism, Favoritism, Bribery
5	KAYONZA	Bribery

Access to nutritious foods for stunted children and pregnant women		
Districts		**Forms of corruption**
1	RUBAVU	Nepotism, Favoritism, Bribery, Sextortion
2	HUYE	Nepotism, Favoritism, Bribery
3	RUSIZI	Bribery, Favoritism
4	MUSANZE	Nepotism, Favoritism, Bribery, Sextortion
5	KAYONZA	Nepotism

Source: Compiled by researcher,2023

Annex 2: Districts scores

Area of Focus 1: Categorisation of UBUDEHE

Risk scores based on healthcare users

Decision points Code	**Likelihood score (A number between 1-5)**						**Impact score (A number between 1-5)**					
	Selected Districts						Selected Districts					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.1	3	3.2	2.5	4	3.3	**3.2**	3	3.7	3.5	4.6	3.7	**3.7**
	2.3	3	2	4.3	3.3	**3**	2.3	2.5	2	4.6	4	**3**

	4	3.2	3	4	4.7	**3.8**	2.3	2.7	3	4.6	5	**3.5**

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts						Selected Districts					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.1	3	3.5	3.5	4.6	3	**3.5**	3.7	4.3	3.7	4.6	3	**3.8**
	2.3	3	3	3	2.5	**2.8**	2.3	2.7	3	4.6	2.5	**3**
	2.3	1.7	1.7	3.3	2	**2.2**	2.3	4	2	3.3	2.5	**2.8**

Access to CBHI (Mituelle de Santé)

Risk scores based on healthcare users

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts						Selected Districts					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.2	2.3	1.3	1	3.3	3	**2**	2.5	1.3	1	4	3.7	**2.5**
	1.3	3	1	3.3	2.7	**2.3**	1.7	2	1	3.6	3.3	**2.3**
	1	1	1	2.3	3	**1.6**	1	1	2	3	3.5	**2**
	2.5	1	1	2	4	**2**	1	1	1	2.3	4	**1.8**

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts						Selected Districts					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.2	2.5	2.2	1	2.3	2	**1.8**	3	2.3	2	4.3	2.5	**2.8**
	1	1.5	1.5	2.6	2.5	**1.8**	1	2.3	2	3.3	2.5	**2.2**
	1.7	1.3	2.2	1.6	2	**1.7**	1.7	2	2.7	2	2	**2**
	1	1	1	2	3	**1.6**	1	3	1	1.3	2	**1.7**

Transfer of a patient to another hospital for those who use CBHI

Risk scores based on healthcare users

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts						Selected Districts					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.3	1	1	1	2	2	**1.4**	1.7	1	1	3.3	3	**2**
	1	1	1	1	1	**1**	1	1	1	1	1	**1**
	1	1.5	1	1.3	1	**1**	1	1.5	1	1	1	**1**

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts						Selected Districts					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.3	1.7	1	1	1	1	**1**	1	2	1	1	1	**1.2**
	1	1	1	3	4	**2**	1	1	1	3.6	5	**2.3**
	1	2	2	1	1	**1.4**	1	1	1.5	1.3	2	**1.4**

Medical Appointments

Risk scores based on healthcare users

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.4	1.7	1	1	3.3	2.7	**1.9**	2.3	2	1	3.6	3.3	**2.4**
	1.7	1	1	3.3	2.7	**1.4**	1	3	1	3.3	3.3	**2.3**

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.4	2.3	1	1	2	2	**1.6**	3	1.7	1	2.3	2	**2**
	1	1	1	2.3	2	**1.4**	1	1.7	1	3.3	2.5	**1.9**

Hospitalisation/Admission

Risk scores based on healthcare users

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.5	1	1.3	1	2	2.5	**1.5**	1	1	1	3	3.1	**1.8**
	1	2.3	1	3.3	2.7	**2**	1	1.6	1	3.3	3.3	**2**

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.5	1	1	1	2	2	**1.4**	1	1	1	2.3	2	**1.5**
	1	1	1	2.6	3	**1.7**	1	1.7	1	2.6	4	**2**

Patients' medical examinations and medication administration

Risk scores based on healthcare users

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.6	1.3	1	1	1.3	2	**1.3**	1.6	1	1	2	3	**1.7**
	1	1	1	1.6	3	**1.5**	1	1	1	2.3	4	**1.9**
	1	1	1	2	4	**1.8**	1	1.2	1	2	4.5	**1.9**

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.6	2	1	1	1.6	2	**1.5**	2	1.7	1	2.3	3	**2**
	1	1	1	2	1	**1.2**	1.7	1	1	1.6	1	**1.3**
	1	1.5	1.5	1.3	1	**1.3**	1	1	2	2	2	**1.6**

Medical and non-medical material supply

Risk scores based on healthcare users

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.7	1	1	1	1	1	**1**	1	1	1	1	1	**1**
	1	1	1	1	1	**1**	1	1	1	1	1	**1**

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.7	2.3	1	1	1.3	2	**1.5**	2.3	1	1	1.3	2	**1.5**
	1	1	1	1	1	**1**	1	1	1	1	1	**1**

Registration and authorization of health facilities
Risk scores based on healthcare users

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.8	1.7	2.7	2.5	1	1	**1.8**	1.3	1.8	3.5	1	1	**1.7**
	1.3	3	3	2	1	**2**	1	2	4	1.6	1	**1.9**
	1	3.3	3	1.6	1	**2**	1.3	2	4.5	2.3	1	**2.2**

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.8	1	1	1	3	3	**1.8**	1	1.3	1	2.6	3	**1.8**
	1	1	1	2.3	3	**1.6**	1	1.3	1	2.6	3	**1.8**
	1.3	1	1	2.6	4	**2**	1.3	1	1	3	4	**2**

Access to nutritious foods for stunted children and pregnant women

Risk scores based on healthcare users

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.9	1	1.3	1.5	4.3	4	**2.4**	1	1	1.5	4.3	5	**2.6**
	1	1	1	3	4	**2**	1	1	1	4	5	**2.4**

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.9	1	1	1	3.3	3.5	**2**	1	3	1	3.6	4	**2.5**
	1.3	1	1	2.6	4	**2**	1.3	1	1	3	4	**2**

Medical worker's recruitment, remuneration, training and evaluation, promotion, and transfer

Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.10	1	1	1	2.6	4.5	**2**	1	1	1	3.3	4.5	**2**
	1	1	1	1.6	1	**1**	1	4	1	2.3	5	**2.7**
	2.3	1	1	2.3	3	**1.9**	2.3	1	1	2.3	3	**1.9**
	1.5	1	1	2	4	**1.9**	1.5	1	1	2	4	**1.9**
	3	1	1	2.3	2.5	**2**	3	4	1	3	3	**2.8**
	1	1	1	2	4	**1.8**	1	1	1	2	4	**1.8**

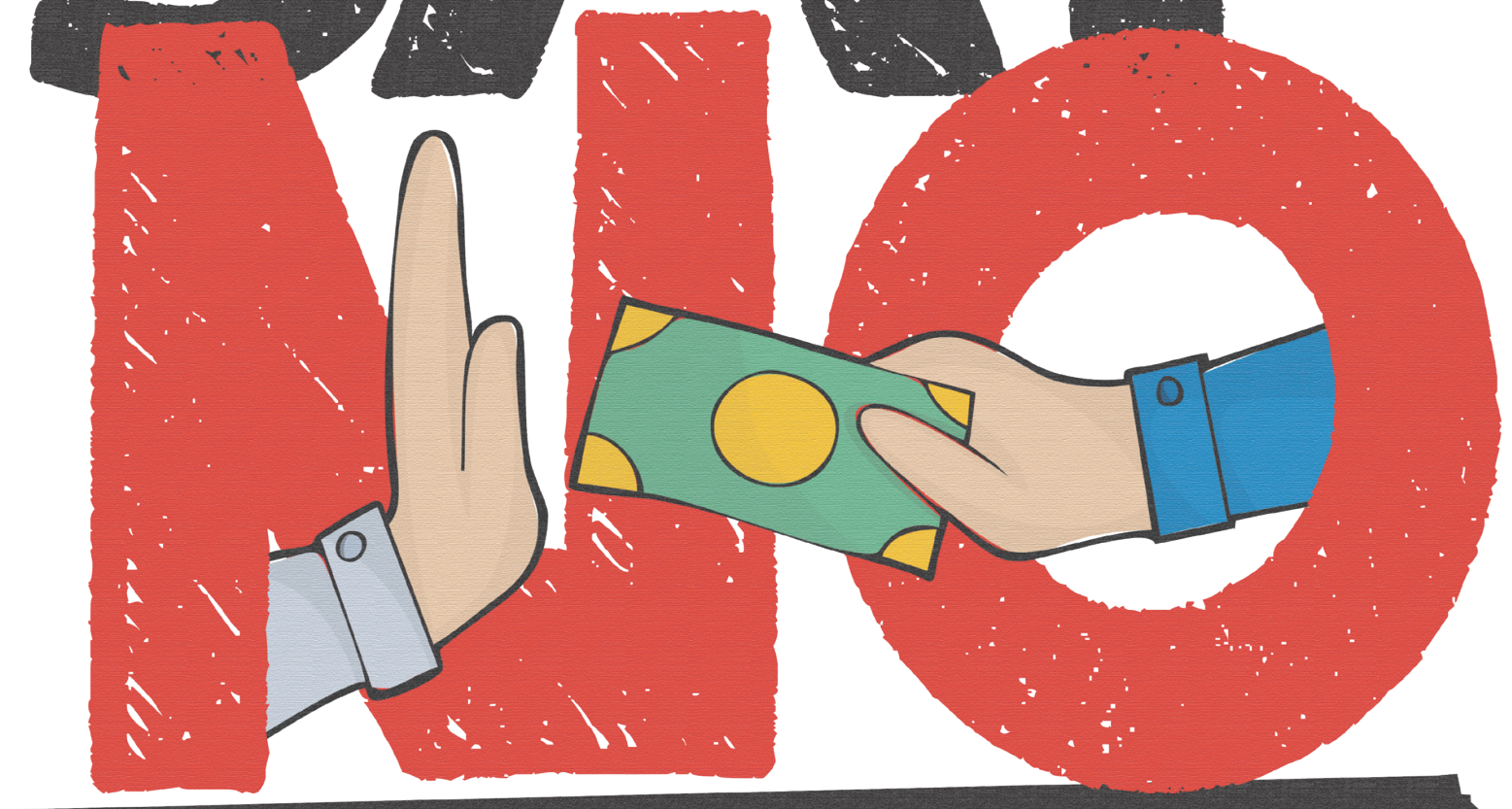
Internship practices for medical students
Risk scores based on healthcare providers

Decision points Code	Likelihood score (A number between 1-5)						Impact score (A number between 1-5)					
	Selected Districts (Codes)						Selected Districts (Codes)					
	1	2	3	4	5	**Ave**	1	2	3	4	5	**Ave**
1.11	2	1	1	2.3	4	**2**	2.5	1.7	1	2.6	4	**2.4**
	2	1	1	2.3	4	**2**	2.5	1.7	1	2.3	4	**2.4**
	2	1	1	2.3	4	**2**	2.5	1.7	1	2.3	4	**2.4**

Codes of districts

District name	Code
HUYE	1
KAYONZA	2
MUSANZE	3
RUBAVU	4
RUSIZI	5

SAY



NO

TO CORRUPTION

CORRUPTION RISK ASSESSMENT OF THE HEALTH SECTOR IN RWANDA

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