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Economic Affairs



Integrity in the Public Health Sector Service Delivery in Busia County

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March 2013

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Published by

Institute of Economic Affairs

With the support of Diakonia Sweden



Institute of
Economic Affairs

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Acronyms and Abbreviation

| | |
|-------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| DFID | Department for International Development |
| GOK | Government of Kenya |
| HIV | Human Immunodeficiency Virus |
| IEBC | Independent Electoral and Boundaries Commission |
| IEA | Institute of Economic Affairs Kenya |
| IMF | International Monetary Fund |
| IPAR | Institute of Policy Analysis and Research |
| MDG | Millennium Development Goal |
| MOPHS | Ministry of Public Health and Sanitation |
| MOMS | Ministry of Medical Services |
| NGO | Non-Governmental Organization |
| TI | Transparency International-Kenya |
| WB | World Bank |
| WHO | World Health Organization |

Acknowledgements

The Institute of Economic Affairs (IEA Kenya) would like to extend sincere gratitude to several people and institutions that have made the completion of this survey possible. Second, we extend a vote of thanks to all households in Busia County who participated in the survey. Their willingness to sacrifice their precious time made it possible to complete this survey. The IEA does not take this for granted. Third, the IEA would like to extend appreciation to Ms. Veronica Nguti and Mr. Chrispine Oduor for having travelled to nearly all corners of Busia County to carry out the interviews and Mr. Mungai Karori for offering logistical support during the survey. IEA also extends appreciation to Mr. Abraham Rugo for editing the report and quality assurance.

The IEA extends our appreciation to Diakonia-Sweden who was the financier of the survey.



Kwame Owino,
Chief Executive Officer

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1.0 Executive Summary

The importance of the health sector's contribution to economic growth and poverty reduction is recognized globally. Three of the eight Millennium Development Goals (MDGs) - reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and other diseases - refer directly to health. The Abuja Declaration of the year 2001 requires countries to earmark 15 per cent of their national budgets for the health sector, a target that is yet to be met by the Government of Kenya (GOK). The amount of money earmarked by the government for the health sector in the 2011/2012 financial year accounted for 5.8 per cent of the national budget. 2.8 per cent of this allocation was to the Ministry of Public Health and Sanitation (MOPHS) while 3 per cent was to the Ministry of Medical Services (MOMS).

A 2006 report by the World Health Organization (WHO) indicates that insufficient health budgets in low income countries combined with health problems such as HIV/AIDS, have led to an acute shortage of health workers. Many low income countries experience shortage of drugs and medical supplies, poorly remunerated health personnel or non-payment of health workers, poor quality of care, and inequitable healthcare services (WHO, 2008). With corruption as both a cause and effect, the result has been the deterioration of general health among individuals as well as degradation of health systems in developing countries (World Bank; 2004).

Transparency International (TI) defines corruption as the 'misuse of entrusted power for private gain'. Corruption in public service delivery occurs when officials in the public sector who have been given the authority to carry out goals which further the public good, instead use their position and power to benefit themselves and others close to them.

Corruption is a key obstacle to good governance and development. Opportunities for corruption in public service delivery are greater in situations where the government agent has monopoly powers; where officials have discretion without adequate control of this decision-making authority; where there is not enough accountability for decisions or results; where transparency is lacking and active participation by the citizen does not allow for external control; and where abuse or corruption is not detected or punished.

The 2008 Transparency International (TI) Kenya Bribery Index ranks the health sector eighth. Corruption in the health sector drastically reduces the resources available for health, and lowers the quality, equity and effectiveness of healthcare services. It also increases the cost of provision of health services (World Bank, 2001). Corruption in the health sector also has a direct negative effect on access and quality of healthcare. It may discourage people from the use and payment for health services thereby having a negative impact on people's health. It may also contribute to an increase in poverty as people might also be forced to dispose their assets to meet some of the costs arising from the vice.

Corruption in service delivery in the health sector includes but is not limited to health care provider absenteeism resulting in lower volume of health care and poor quality care, theft of drugs and medical supplies and informal payments mainly done for better health services.

¹http://archive.transparency.org/news_room/faq/corruption_faq.

2.0 Purpose of the Study

The Constitution of Kenya, 2010 (COK, 2010) shifts service delivery in the key sectors of health, water and agriculture to the newly established county governments. The National government on the other hand has the mandate of formulating national policies for these sectors and the management of referral health facilities in the counties. The study is part of efforts by the IEA-Kenya in Busia county aimed contributing towards reducing corruption prevalence in service delivery in the public health sector in Busia County. The action will include the development of a service charter for the sector in collaboration with the stakeholders. The study will be replicated after two years so as to gauge the effectiveness of the action in contributing towards a reduction in corruption in the county's health sector.

The survey's principal aim was to attempt to ascertain the extent of corruption in service delivery in the public health sector in Busia County and to determine how citizens understand and perceive it and how the citizens have actually experienced it in practice.

The survey results:

- Provide knowledge on the extent of corruption in service delivery in the public health sector in Busia county;
- Give data on some of the empirically describable dimensions of corruption upon which governance and anti-corruption policies, strategies and measures should be formulated;
- Measure perceptions relating to corruption and delivery of public health services in Busia county.

The findings in this report are part of efforts aimed at improving good governance in the Busia county public health sector. The survey was carried out by the Institute of Economic Affairs (IEA Kenya) with funding from Diakonia Sweden in implementing the project 'Enhancing Community Engagement and Accountable Governance.' The survey aims at capturing the experiences and perceptions of the consumers of public health service in the county.

The findings of the study, highlighted in this report may serve as a basis for an action plan to improve service delivery in the county's public health sector. The study will provide a foundation for empowering the citizens to increasingly demand for better service delivery in the public health sector. The survey findings may also inform policy and advocacy campaigns towards the promotion of better health services in the county.

3.0 Methodology

The study used data collection techniques including individual/household interviews, Focus Group Discussions (FGD), facility exit interviews, and other existing literature, reports and studies. The field survey was conducted for five days between the 7th and 12th of October 2012 in the five constituencies that make up Busia County namely: Amagoro, Budalangi, Butula, Funyula and Nambale constituencies . A total of 183 individuals/households were interviewed during the survey.

²The number of constituencies in Busia County has since increased to seven following the review of boundaries by the IEBC. These include: Teso North, Teso South, Nambale, Matayos, Butula, Funyula and Budalangi constituencies

The survey covered both rural and urban areas of the county. Some of the questions and responses relate to the actual experiences, not perceptions, of those interviewed.

4.0 Sample respondents

Table 1: Distribution of respondents by selected characteristics

| | | | |
|---------------------------|------------------------|-----|-------------|
| Sex | Male | 86 | 47 per cent |
| | Female | 97 | 53 per cent |
| Age | | | |
| Age | Under 25 years | 23 | 13 per cent |
| | 26-35 years | 85 | 46 per cent |
| | 36-45 years | 35 | 19 per cent |
| | 46-55 years | 22 | 12 per cent |
| | 56 years and over | 18 | 10 per cent |
| Marital Status | | | |
| Marital Status | Single | 63 | 34 per cent |
| | Married | 108 | 59 per cent |
| | Widowed | 12 | 7 per cent |
| Level of Education | | | |
| Level of Education | None | 9 | 5 per cent |
| | Primary (Incomplete) | 29 | 16 per cent |
| | Primary (Complete) | 77 | 42 per cent |
| | Secondary (Incomplete) | 21 | 11 per cent |
| | Secondary (Complete) | 38 | 21 per cent |
| | College/University | 9 | 5 per cent |

5.0 Limitations of the Study

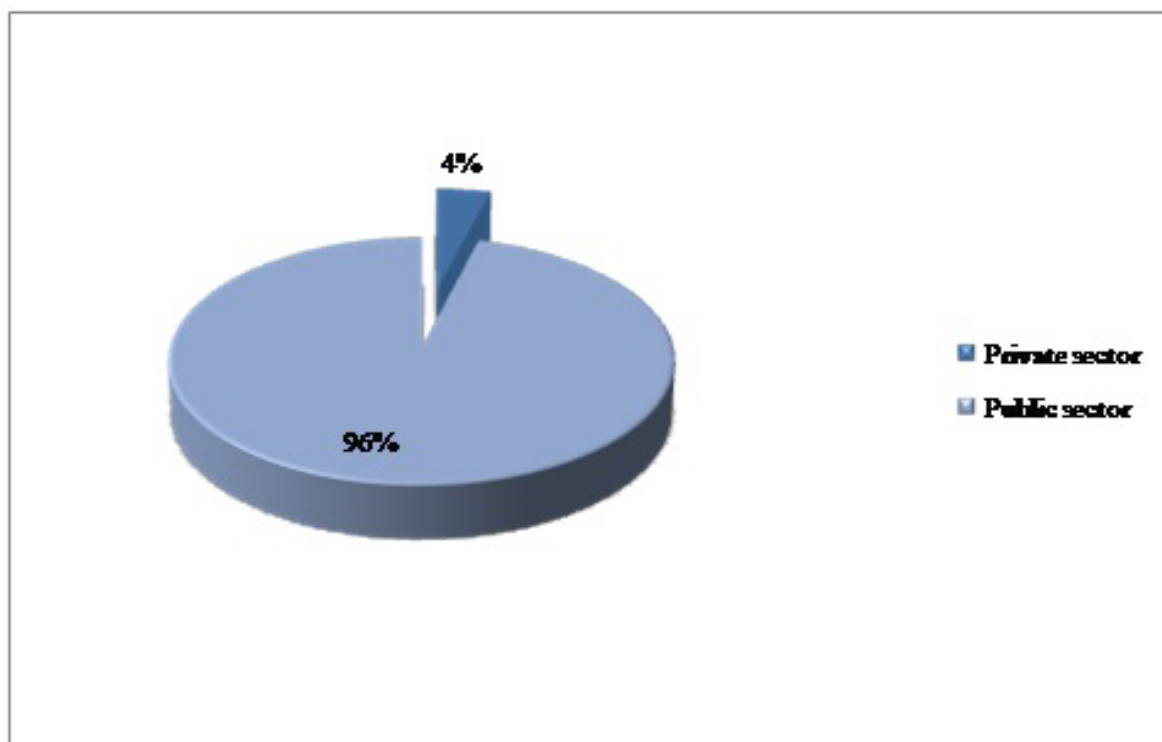
The survey provides a reliable representation of the views and quantitative estimates of the respondents. However, the Institute of Economic Affairs acknowledges that these views cannot possibly assess the level of knowledge or honesty of each respondent.

6.0 Key Findings

6.1 Source of health service: Public versus private sector

Majority, 96 per cent of the sample population reported that they obtained health services from the public sector health facilities. Only 4 per cent of those interviewed reported that they obtained health services from private health facilities. Those seeking services from private health facilities reported that they opted for these facilities due to “poor” services provided in the public health facilities. However, this did not mean that they no longer visit public health facilities as a number reported that they still visited government health facilities.

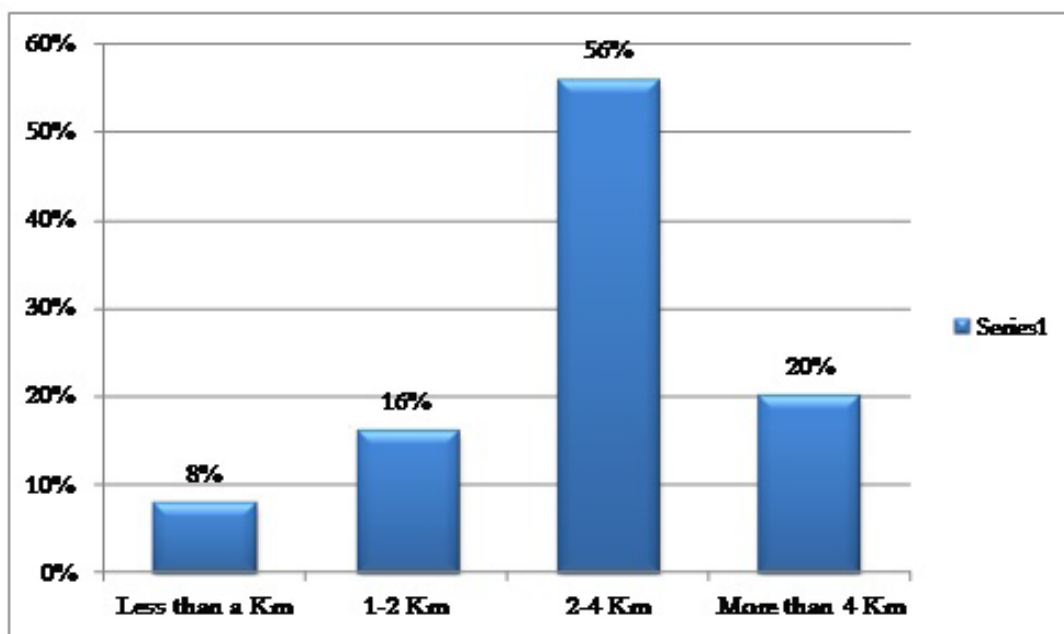
Figure 1: Health service provider: Public versus private sector



6.2 Distance covered in order to access public health facilities

The survey sought to gather information on the distance covered by individuals/households in order to access the nearest public health facility. This is important as some patients get discouraged from seeking health care even when the services are being offered for free by the government due to the long distance that they have to cover to get to the facilities. This may be attributed to their inability to afford fare/transport to these facilities due to poverty among other reasons. Sixteen (16) per cent of the respondents reported that they covered a distance of between 1 and 2 kilometers to get to the nearest public health facility. Fifty six (56) per cent of the respondents reported that they covered a distance of between 2 and 4 kilometers, while 20 per cent reported that they covered a distance of over 4km.

Figure 2: Distance covered in order to access public health facility



6.3 Handling by service provider and staff at the public health facilities

Forty two (42) per cent of the respondents reported that they were talked to in a friendly and cordial manner. Seventy five (75) per cent reported that they were able to ask questions and 95 per cent of these reported that they were able to understand answers to the questions asked. However, sixty eight (68) per cent of the respondents reported harassment at the facilities.

Respondents were of the opinion that harassment and poor services by some of the service providers may be a deliberate move aimed at pushing the patients to seek service from private health facilities most of which they claimed are owned by the same service providers, their colleagues or partnerships between the service providers. This was of concern given that private health facilities charged higher fees in comparison to public/government health facilities.

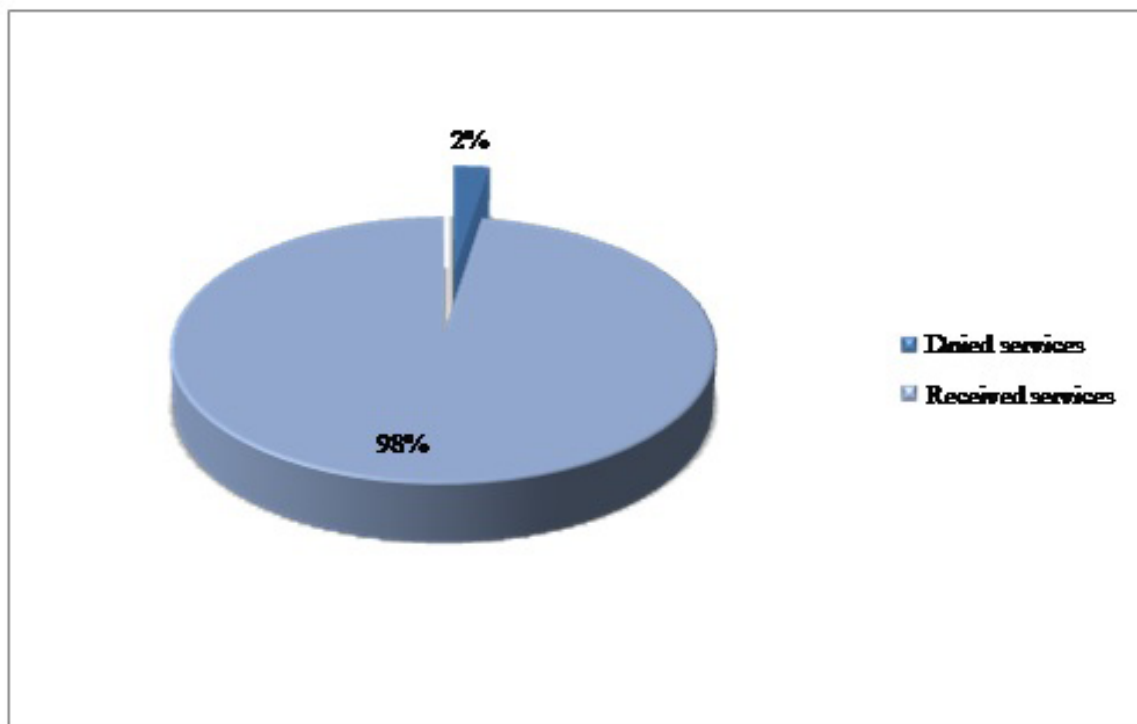
Table 2: Service provider attitude

| Attribute | Percentage |
|--|------------|
| Was talked to in a friendly and cordial manner | 42 |
| Asked staff questions | 75 |
| Understood answers to questions asked the service provider | 95 |
| Was harassed | 68 |

6.4 Ever denied service

Those who reported having ever been denied services were 2 per cent of those surveyed. They reported that this mainly happened at night as some of the service providers were either unavailable or unwilling to offer the services. A respondent reported of a case where patients were denied X-Ray services in one of the main government hospitals in the county and that he only managed to get the service after making an informal payment of Ksh 3,000 on demand. A majority, ninety eight (98) per cent of those interviewed reported having received services at the public health facilities.

Figure 3: Ever denied service



6.5 Client affirmation of quality of services

Ninety seven (97) per cent of those interviewed strongly agreed that they were well advised by the doctors on how to use medication. Only 57 per cent of the respondents were of the opinion that the service providers were kind or caring. This is of concern as it may discourage patients from seeking services from the affected facilities thereby impacting on the people's health. Only 28 per cent of the respondents reported having received adequate medicine on visiting the public health facilities.

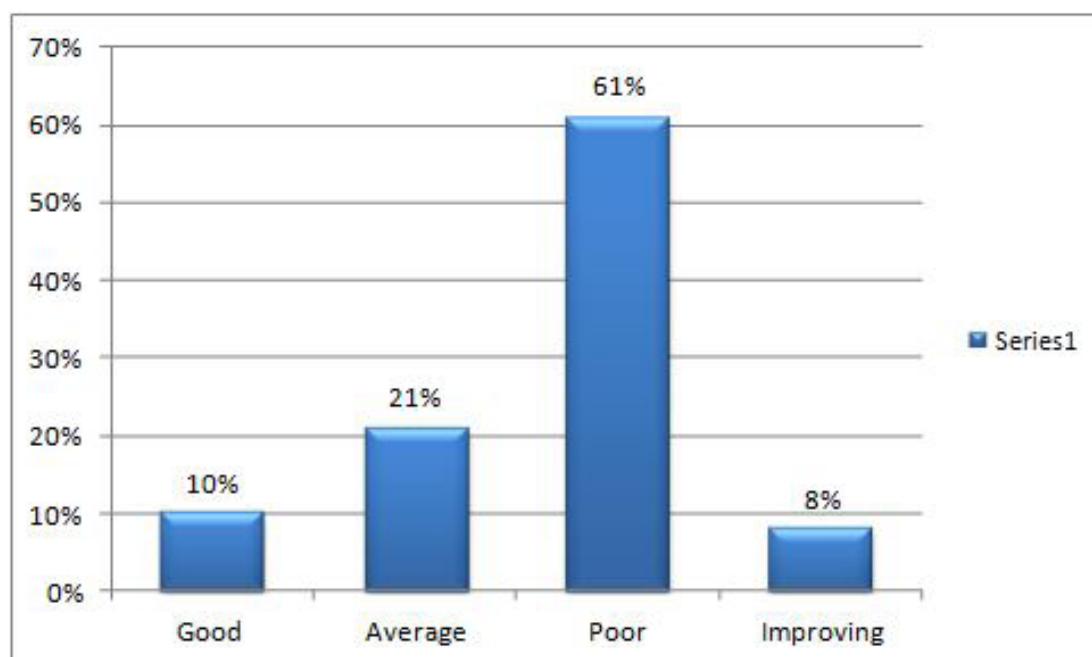
Table 3: Client affirmation of quality of service

| Attribute | Strongly agree | Agree |
|---|----------------|-------------|
| I was well attended to | 46 per cent | 52 per cent |
| I was provided with sufficient hospital materials | 14 per cent | 21 per cent |
| I was given adequate medicine | 12 per cent | 28 per cent |
| I was advised on how to use the medicine | 97 per cent | 3 per cent |

6.6 Gauging the provision of service by the provider

A majority of the respondents, at 61 per cent were of the opinion that the quality of service provided in public health facilities was poor. 21 per cent were of the opinion that it was average, 10 per cent were of the opinion that it was good while 8 per cent were of the opinion that it was improving. They attributed this to: lack of medicine as they had to buy the same from the chemists, poor attitude by some of the service providers, poor standards of hygiene, neglect of patients, and laxity on the part of some service providers among other reasons.

Figure 4: Gauging provision of service by provider

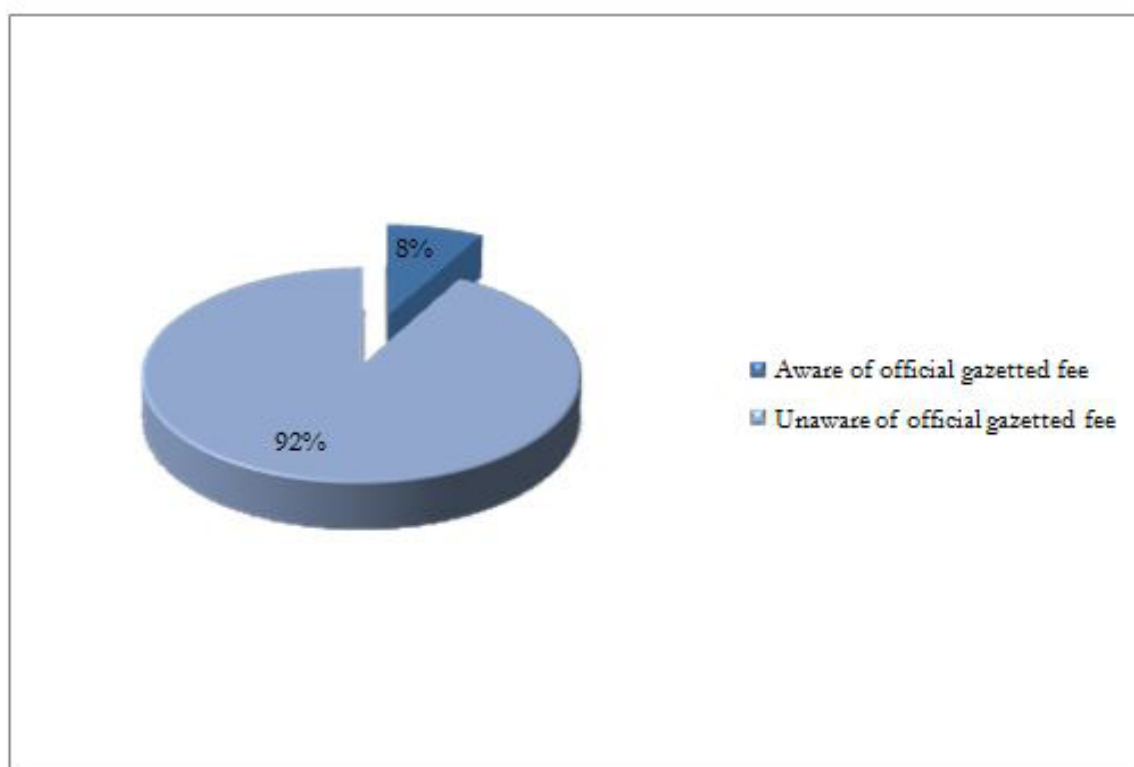


Forty eight (48) per cent of the respondents in the survey expressed dissatisfaction with the attitude of some of the service providers in the public health facilities. There were also complaints that some of the health service providers took their time before attending to the patients. Respondents with patients admitted in the public health facilities reported on inadequate number of care givers in the facilities with the family members being required to stay in the hospital to take care of their sick relatives.

6.7 Knowledge of official gazetted fee for health services in public health facilities

Majority of the respondents at 92 per cent were not aware of the official gazetted fee for various health services provided in public health facilities. Respondents who attended the same facility reported different fee for the same service. The service fee for getting an injection ranged between Ksh 30.00 and Ksh 80.00. There were reports of extreme cases of extortion with some patients reporting having paid as much as Ksh 200.00 and Ksh 300.00 on demand by the service provider in order to get an injection even after buying the syringe and the medicine. Lack of information among the consumers of service on the gazetted fee for services is risky as some service providers may take advantage of the patient's ignorance to charge more than it is required. Some of the respondents reported that even though the costs for some services were on display at the facilities, the actual charge for these services was not the same and in most instances exaggerated.

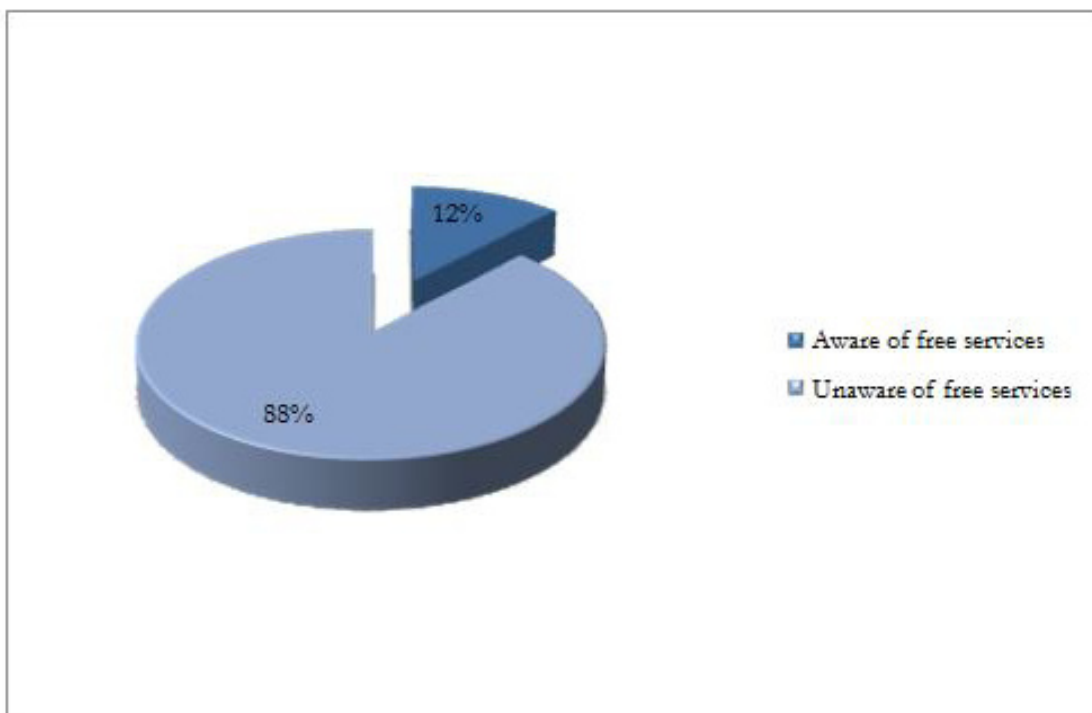
Figure 5: Knowledge of official gazetted fee for services



6.8 Knowledge of services offered for free in public health facilities

Eighty eight (88) per cent of the respondents were not aware of services that were being provided for free in public health facilities. This is of concern among the respondents majority of who were of the opinion that consumers of service might end up paying for services that are free with the money paid for the same not being remitted to the health facility. Majority of those who were aware of these services mentioned: the treatment of tuberculosis (TB), child immunization, provision of Anti-Retroviral (ARV) for the management of HIV/AIDS and medication for the treatment of malaria.

Figure 6: Knowledge of services provided for free



6.9 Items patient was required to purchase in order to get treatment

Respondents raised concern over unavailability of drugs in public health facilities. Eighty nine (89) per cent of the respondents reported that they had to purchase all medication as it was not available at the facility. They reported that the only medicine that was readily available and that was being provided for free in most of the facilities was paracetamol/painkillers. Other items purchased included syringes. Seventy seven (77) per cent of the respondents attributed the lack of medical supplies in public health facilities to diversion of the same to private health facilities and chemists some of which they claimed are owned by the service providers.

6.10 Awareness level about the service charter

Ninety three (93) per cent of the respondents reported that they had never seen the service charter in the public facility visited. Only 7 per cent of the respondents reported having seen the charter though less than one (1) per cent of these reported having had actually read it. Respondents who had read the charter raised concern that it is never adhered to by the service providers.

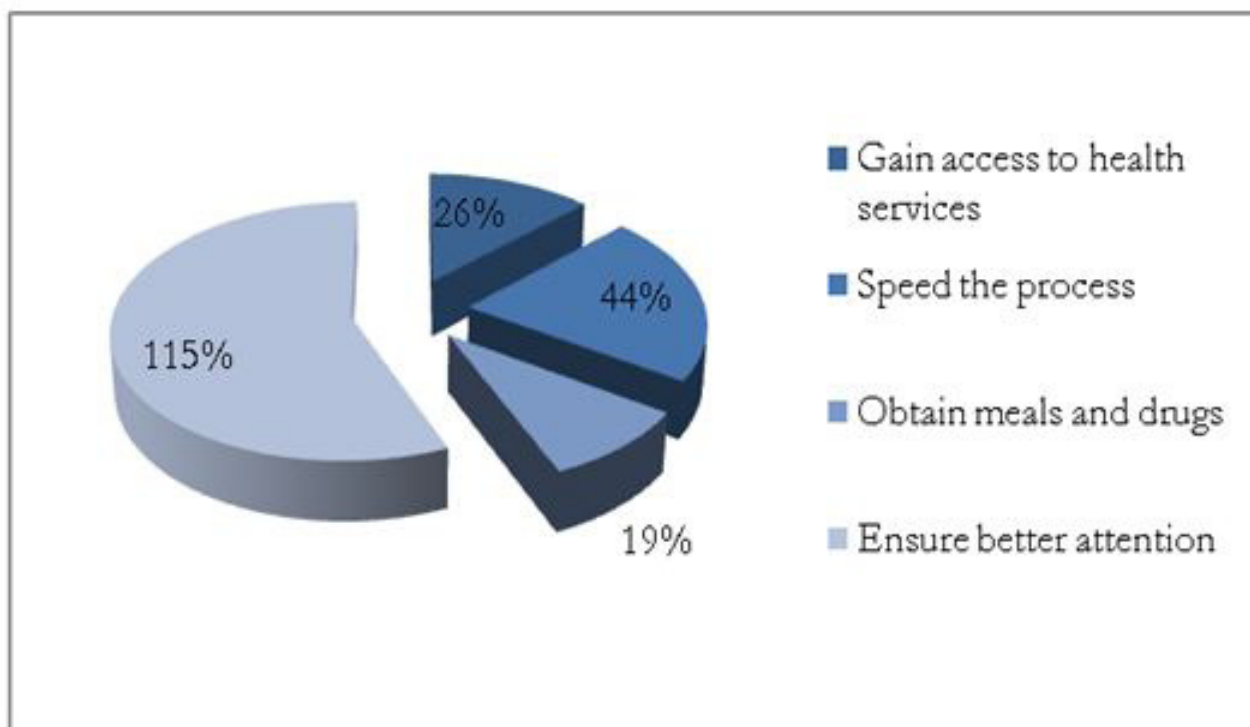
Table 4: Service charter

| Observation | Response by percentage |
|----------------------------|------------------------|
| I have seen it | 93 |
| I have never seen it | 7 |
| I have seen it and read it | 3 |

6.11 Reasons for making informal payments

Twenty six (26) per cent of those who paid bribe reported paying in order to gain access to the health facility; 44 per cent to reduce wasting time or speed up the process; 19 per cent paid to obtain drugs, medicines or meals while 11 per cent paid in order to ensure better attention and improved quality of service.

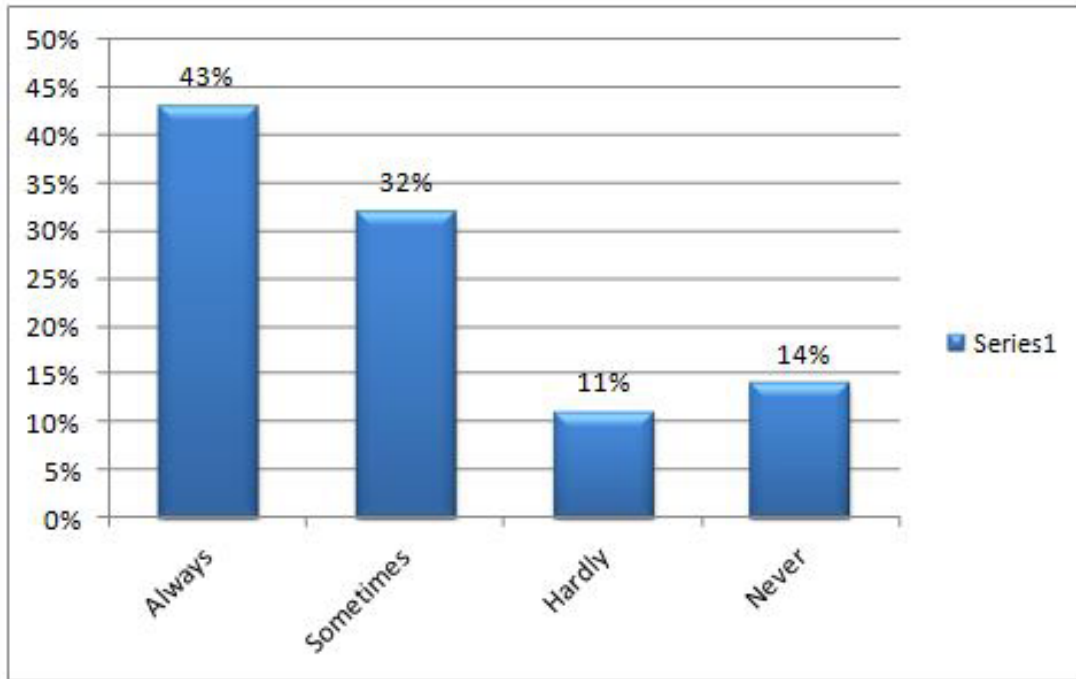
Figure 7: Reasons for making informal payments



6.12 Availability of medical personnel

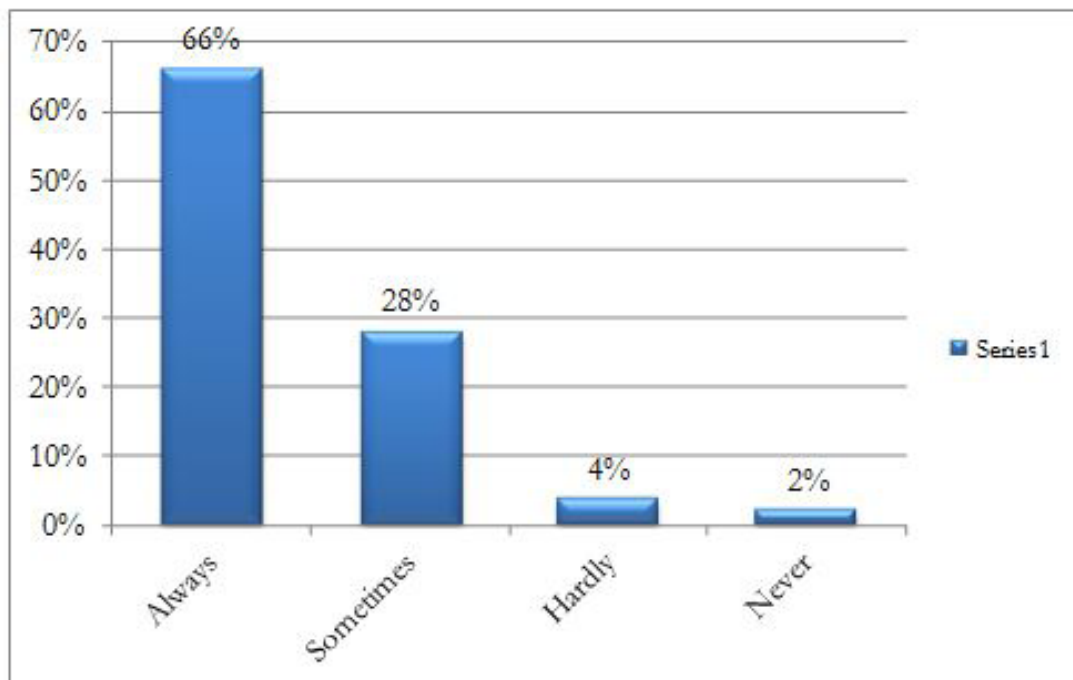
Personnel absenteeism is one of the forms that corruption may take. Respondents were of the opinion that some service providers in the public health facilities take time off work in order to attend to private practice which is more lucrative. This denies service to the public affecting access and quality of services. 43 per cent of the respondents reported that the doctor was always available in the facility. 32 per cent reported that he/she was sometimes available. 11 per cent reported that the doctor was hardly available. Respondents attributed doctor absenteeism to: attending to personal issues, multiple jobs, taking time off to manage private facilities, poor attitude towards work and lack of supervision among other reasons.

Figure 8: Availability of the doctor



Sixty six (66) per cent of the respondents reported that the nurse was always available in the facility. 28 per cent reported that he/she was sometimes available. 4 per cent reported that the nurse was hardly available. 2 per cent reported that the nurse was never available.

Figure 9: Availability of the nurse



6.13 Opinion as to whether doctors accredited to public hospitals should be allowed to operate private practice

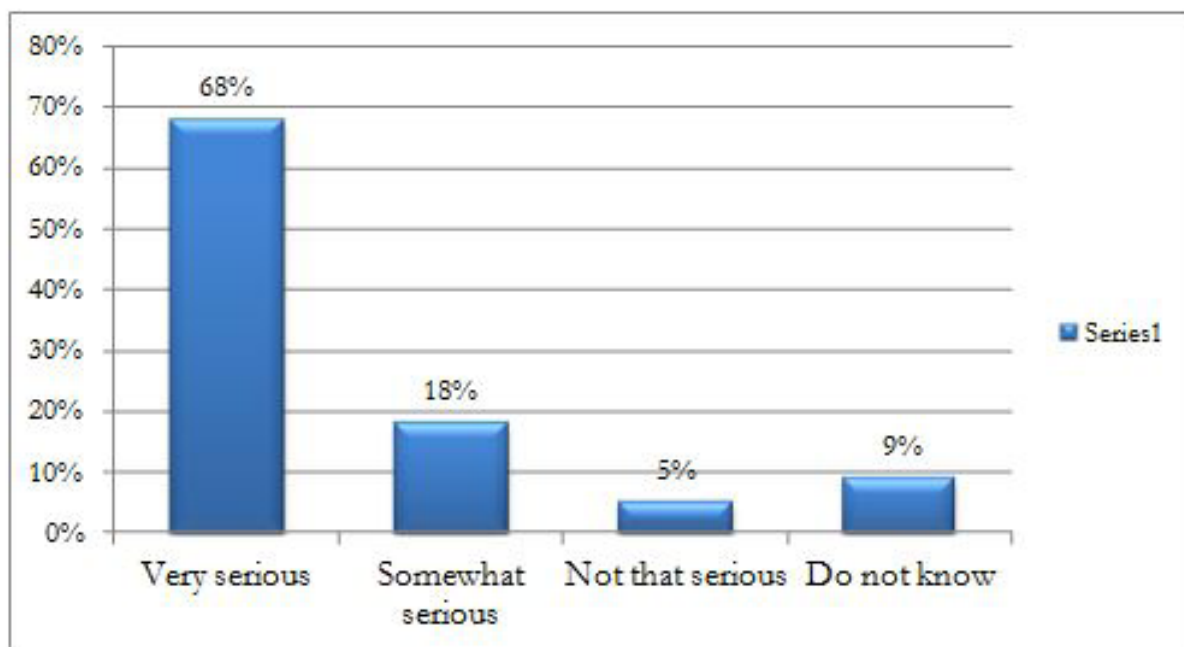
An overwhelming majority (97 per cent) the respondents objected to the idea of having doctors accredited to government hospitals being allowed to run private practice. They argued that this would increase absenteeism as they will be unavailable in the public facilities attending more to private practice where they are assured of making more money. They were of the opinion that this would also lead to an increase in loss of drugs in the public facilities as some unscrupulous medical personnel may divert the same to private facilities. They were also of the opinion that this would result in poor services and an increase in cases of referral to private facilities as some service providers might want to cash in on the patients. Respondents were of the opinion that doctors in public facilities are paid through the tax payer and they owe it to the government to be available at all times.

Respondents were also of the opinion that such doctors should not also be allowed to run chemists as this would lead to loss of medicine from the public health facilities as some may divert the medicine to their clinics.

6.14 Seriousness of corruption in the health sector in the County

Sixty eight (68) per cent of the respondents were of the opinion that corruption in the public health sector was a very serious problem in the county. Eighteen (18) per cent were of the opinion that it was somewhat serious while 5 per cent said that it was not that serious. Nine (9) per cent of the respondents could not tell whether it was serious or not.

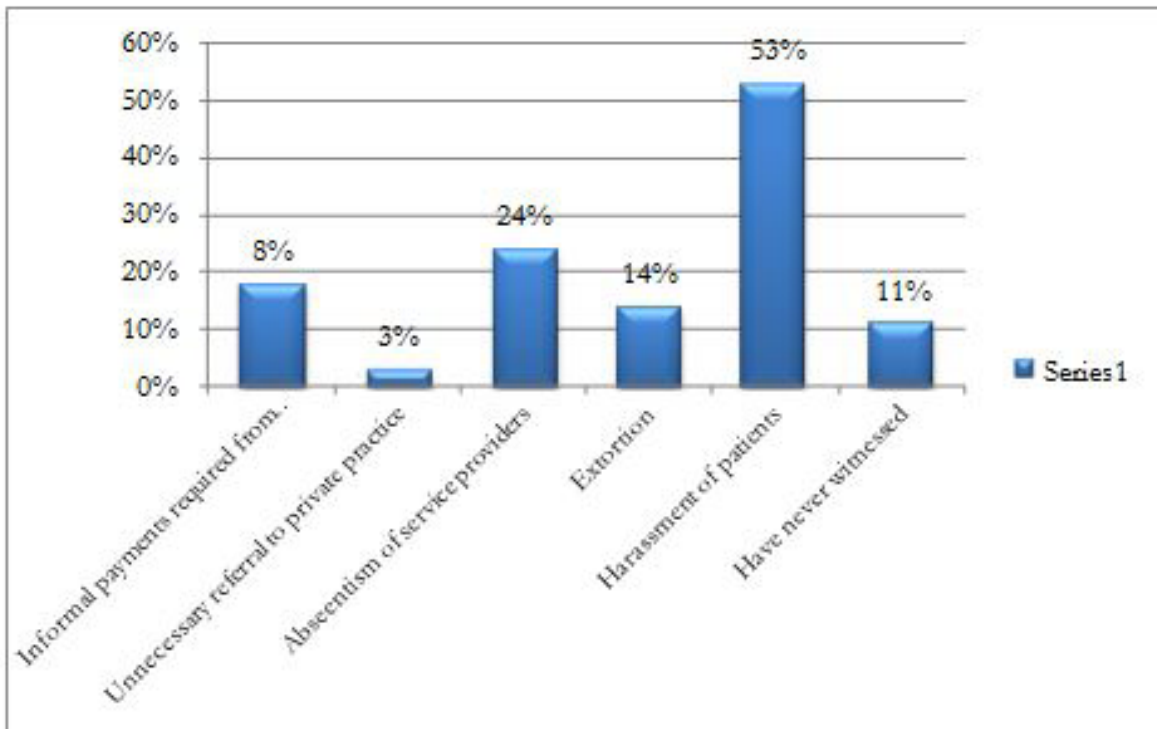
Figure 10: Seriousness of corruption in the health sector



6.15 Types of corruption encountered in out-patient department

Respondents who used out-patient services in the government/public health facilities reported having encountered different forms of corruption. Twenty four (24) per cent of these reported absenteeism of the service provider, 53 per cent reported harassment, 14 per cent reported extortion, 8 per cent reported informal payments required for one to get access to treatment; and 3 per cent reported unnecessary referral to a private health provider.

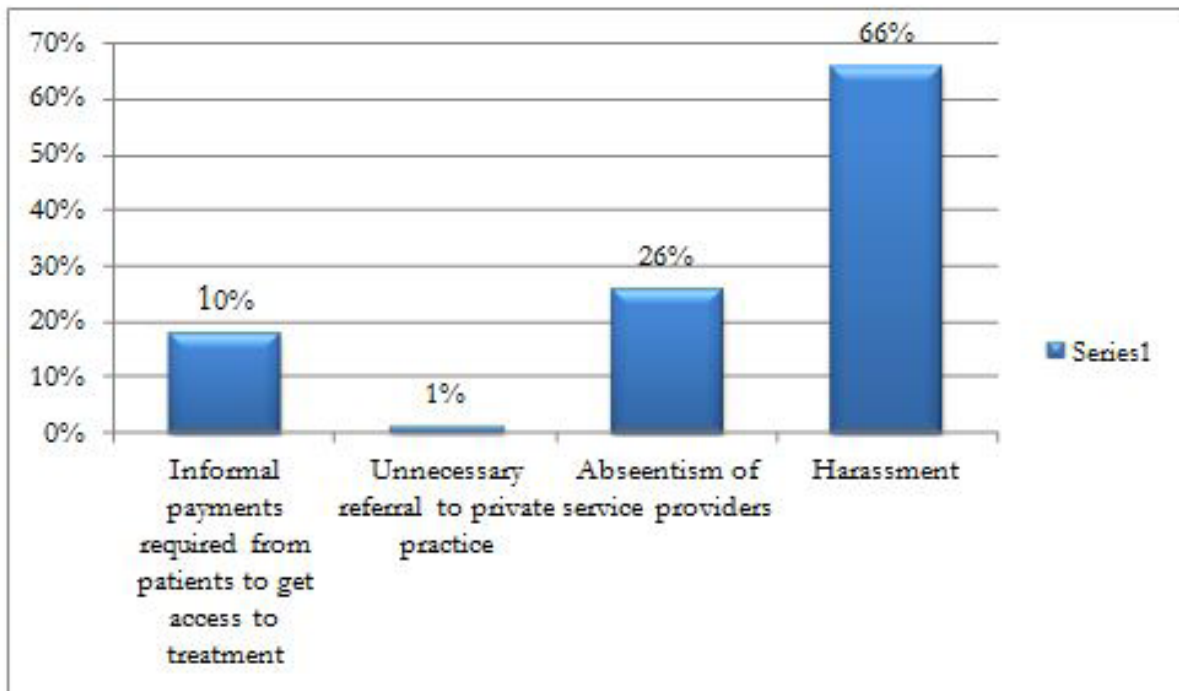
Figure 11: Types of corruption encountered in out-patient departments



6.16 Types of corruption/problems encountered in in-patient department

Respondents who used in-patient services in the public health facilities reported having encountered different forms of corruption. Twenty six (26) per cent of these reported absenteeism of the service provider, 66 per cent reported harassment by the service provider, 11 per cent reported extortion and 10 per cent reported informal payments required for one to access treatment.

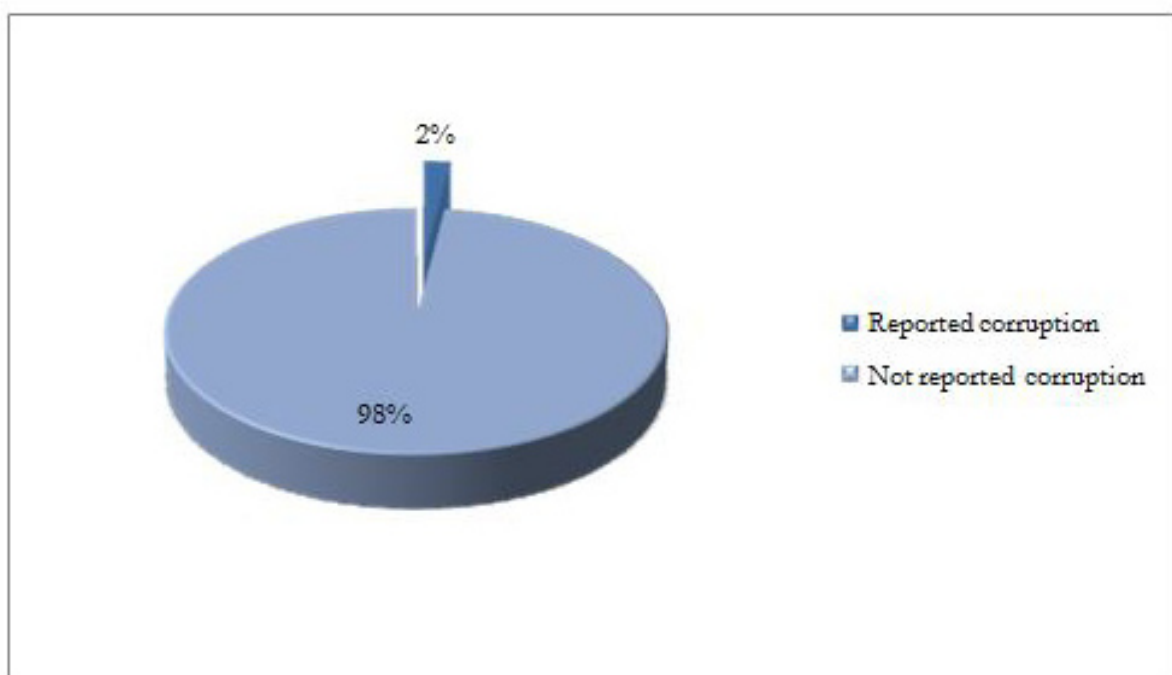
Figure 12: Types of corruption encountered in the in-patient department



6.17 Reporting corruption to authorities

Ninety eight (98) per cent of the respondents reported that that they had not reported corruption practices experienced in public health facilities as they did not know where to report. Only 2 per cent of the respondents reported corruption to the hospital management. Most of these were persons who seemed to be aware of the provisions of the service charter and the gazetted fee for services being offered in the public facilities.

Figure 13: Reporting corruption to authorities



7.0 Key Constraint of the study

The study was carried out at a time when health workers in public health facilities were on a nationwide strike and this made it difficult to obtain required information from staff in the facilities. This may also have affected the response obtained from respondents in the study.

8.0 Conclusion

Tackling corruption in the health sector is essential for achieving better health outcomes. Mitigating strategies put in place should focus on corruption prevention by strengthening transparency, enforcing accountability by the service providers and ensuring stakeholder participation in the sector. These must be linked to measures to detect abuse and apply sanctions (Hassman et al, 2010). High level of corruption in a country's health sector is likely to have negative impact on the health of its population. Corruption in the sector is also likely to have adverse consequences for the country's child, infant and maternal mortality rates. Studies on corruption in the health sector indicate that child mortality rates in countries with high corruption prevalence in the sector are about one third higher than in countries with low corruption prevalence.

Reducing the level of corruption in the provision of public health services would help improve the quality of services. This may be done through the empowerment of the poor as a way of limiting the monopoly power exercised by the government officials responsible for the provision of public health service.

Citizen participation in the sector can be attained through sensitization on the fee for various services provided in public health facilities, services that are provided for free in public health facilities and the service delivery charter among other issues. Providing information to the communities on their rights to health care services can have a significant impact on actual utilization of services, with a corresponding improvement of health care outcomes. This may need to be combined with an effective complaints handling mechanism to ensure that providers who fail to deliver the expected results are held accountable.

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