PETTY-CORRUPTION IN PUBLIC HEALTHCARE DELIVERY

IN NORTHERN, UPPER EAST AND UPPER WEST REGIONS OF GHANA

DECEMBER 2018

COMMUNITY DEVELOPMENT ALLIANCE (CDA-GHANA)

RISE-GHANA
Human Rights & Sustainable Development For All
UKaid from the British people
STAAC

Petty-Corruption in Public Healthcare Delivery in Northern, Upper East and Upper West Regions of Ghana

December 2018

Dr. Samuel K. K. Dery,
Department of Biostatistics
School of Public Health, University of Ghana

Mr. Salifu Issifu,
Executive Director,
Community Development Alliance (CDA)
P O Box 490, Wa

Community Development Alliance (CDA-Ghana) and its Coalition Partners:

Petty-Corruption in Public Healthcare Delivery in Northern, Upper East and Upper West Regions of Ghana

December 2018

Dr. Samuel K. K. Dery,
Department of Biostatistics
School of Public Health, University of Ghana

Mr. Salifu Issifu,
Executive Director,
Community Development Alliance (CDA)
P O Box 490, Wa

Community Development Alliance (CDA-Ghana) and its Coalition Partners:

ACKNOWLEDGEMENT

The Community Development Alliance (CDA-Ghana) and its Coalition Partners are grateful to the United Kingdom Department for International Development (DFID) and the Strengthening Action Against Corruption (STAAC) for providing funding and technical assistance to enable us implement the "Strengthening Citizens Actions Against Corruption in Healthcare Delivery project in the Northern, Upper West and Upper East Regions of Ghana. We are also grateful to the research team members especially Dr. Samuel Dery of the School of Public Health; University of Ghana-Legon for his dedication that led to this final report.

Designed & Printed by BlueVyne Limited

+233 303932712, 504662121

DISCLAIMER

The views expressed in this publication are entirely the views of the researcher's and the People's Action Against Corruption (PAAC) Coalition Partners who are directly responsible for the conduct of the research work. The findings, conclusions and views expressed in this report do not in any way mirror the views of the United Kingdom Department for International Development (DFID) or the Strengthening Action Against Corruption (STAAC) who provided funding for the research.

Executive Summary

Introduction

The health sector in Ghana is choked with allegations of both petty and grand corruption (The World Bank, 2010). Grand corruption consists of acts committed at a high level of government that distort policies or the central functioning of the state, enabling leaders to benefit at the expense of the public good. Petty corruption on the other hand, refers to everyday abuse of entrusted power by low- and mid-level public officials in their interactions with ordinary citizens, who often are trying to access basic goods or services in places like healthcare. Petty corruption is practiced in different forms. These include health worker soliciting a bribe/informal payment, a patient/care giver prompting a health worker to receive a bribe meant to induce him or her to provide better quality care to the patient, use of public facilities and equipment to see private patients, unnecessary referrals to private practice or privately owned allied services. Petty corruption has a direct impact on the poor by denying them access to services and thereby jeopardizing their health.

The core of the problem is that, on daily basis, individuals and groups involved in healthcare service delivery are placing their private self-interests over wider public health goals across the health sector in Ghana. This situation has adversely compromised the access and quality delivery of basic healthcare services to poor people mostly pregnant women, children and the aged who suffer and in some cases lose their lives needlessly due to corruption related issues in the healthcare sector. In order for Ghana to meet the Sustainable Development Goal 3 that aims to ensure healthy lives and promote the wellbeing of all people of all ages, there is the urgent need to redouble efforts to tackle corruption and eliminate its negative impact in the health delivery system. However, there is limited studies on petty corruption in the health sector in general and the Northern Ghana in particular.

This baseline study therefore sought to examine the awareness and practices of corrupt activities at public health facilities by health service providers and users and the effect of such practices on utilization of health services and patient's satisfaction in the three Northern Regions of Ghana. Specifically, the study sought to:

1. Examine the knowledge of individuals as health care consumers or practitioners on what constitute corruption.
2. Explore the perception of patients and healthcare providers about the various types of petty corruption that occur in health facilities.

3. Assess the magnitude or rate of occurrence of the various petty corrupt practices that occur in health facilities.
4. Ascertain the effects of petty corruption on the delivery of basic quality healthcare services

Method

The study employed a cross-sectional design, using both qualitative and quantitative approaches for data collection. It targeted both healthcare providers and users (both out- and in-patients) in various health facilities in the three northern regions to help get the perspectives of both the providers and the users of the health services provided. The study included 201 healthcare workers and 834 healthcare users selected from 24 health facilities. Both patients and healthcare providers were interviewed using structured questionnaires and data was analyzed using Stata version 14.

Results

1. Knowledge of corruption:

a. More than 75% of all patients and 79% of healthcare workers generally know that: informal payment, extortion, embezzlement and favoritism by public officials constitute acts of corruption.

b. More than 76% of patients and healthcare workers know that: receiving informal payments, stealing medical supplies, charging fee higher than the official rate, absenteeism and using public health facilities to see private patients are acts of corruption.

2. Perception of Corruption:

a. 97% of patients and 96% of healthcare workers indicated that bribery and corruption is widespread within the healthcare delivery system.

b. 67% of patients and 62% of healthcare workers agree that corruption is accepted as normal in the delivery of health care.

c. About 66% of patients have often/very often heard/seen or experience informal payments in a health facility within the last one year

d. About 34% of health workers indicated that "unofficial/informal payments from patients to healthcare providers in return for receiving healthcare services" happens often/very often in the last one year.

e. 50% of health workers indicated that their co-health workers sometimes/often engage in corrupt practices.

f. More than 57% of patients and 70% of the workers believe that each of the various categories of health workers are corrupt.

3. Experiences with corruption

a. Payment without being issued receipts (unofficial/informal payments) is the most prevalent experience of patients across all the three regions with 58.6% of patients experiencing it.

b. The main motivations for patients being involved in bribery and corruption are the quest to get good quality health services (24%) and avoid long queues (17%)

c. 40% of healthcare workers said they have been involved with corruption or taken a bribe.

d. About 51% of health workers indicated that they often/very often give prefer-

ential services or better treatment to friends and family members.

e. 31% health workers indicated they often/very often receive payments from patient without giving receipt and 25% admitted often charging a service fee higher than the official rate.

f. 54% of health workers have never reported a corrupt colleague to management of the facility.

4. *Consequences of Petty Corruption*

a. 32% of patients said they have sought care outside a public health facility as a result of corruption and bribery with most of them seeking care in private clinic and chemical shops.

b. According to patients, the effects of corruption include: long waiting hours/ delayed services (94.5%), limits the poor and vulnerable to afford necessary medical treatments (93.9%) and Loss of confidence and mistrust in health system (87.4%)

c. According to patients, the main causes of corruption include: lack of/limited supervision (59.7%), greed (54.1%), lack of/limited punishment for corrupt practices

d. According to health workers, the main causes of corruption include: "lack of/ limited punishment for corrupt practices", greed (59.7%), "lack of/limited supervision" (59.7%) and poor wages (57%)

5. *Ways to Minimize Bribery and Corruption*

a. 65% of patients and 76% health workers believe that punishing corrupt officials is the number way to minimize corruption.

b. 48% of patients and 69% of health workers believe that educating patients and the general public on the social norms and consequence of corruption would help minimize its occurrences.

6. *Patients Satisfaction and Quality of Care*

a. 32% of patients described the length of time they spent in the facility before receiving service was too long.

b. Overall, 69% of patients were satisfied with the quality of care received.

c. Majority (83%) of the patients indicated that corruption affect the quality of care they received

Conclusion

The baseline evidence concludes that there is widespread perception and experience of corruption in health facilities in the three northern regions of Ghana. This situation does adversely compromise the access and quality delivery of basic healthcare services to people, especially the poor, pregnant women and children who in some cases may lose their lives needlessly due to corruption related issues in the healthcare sector. For patients who got involved in corrupt practices with health workers such as making informal payments, their main motivations were to help get good quality health services and also avoid long queues. This quest to get better treatment and services couple with the long queue in most facilities provides incentives for health workers to take advantage and extort money from patients, as the findings reveal. Reducing these incentives in the healthcare delivery system could potentially support a reduction in corrupt behavior.

The evidence also reveals that both health

care providers and citizens score equally in the majority of perceptions of corruption, consequences of corruption and ways to minimize corruption. Both sides agree that there is a need for urgent action to tackle health corruption in northern Ghana.

Recommendations

There is therefore the need to develop and implement interventions and advocacy actions to combat corruption in the healthcare delivery sector in Ghana. There is also the need to strengthen citizens' oversight in the prevention of corrupt practices and demand for accountability in the healthcare delivery systems. Public health sector reforms that ensures that robust systems are put in place to reduce the opportunities for corruption and eliminate any potential incentive to engage in acts of petty corruption is most appropriate. Therefore, the Ministry of Health (MoH) and the Ghana Health Service (GHS) together with its decentralized Regional and District Health Administrations should take urgent steps to:

1. Stop all forms of informal payments across all the public health facilities in the three Northern Regions of Ghana.
2. Establish and operationalize a patient's complaints unit that allows for speedy investigation and sanctioning of public healthcare workers who are found culpable of engaging in petty acts of corruption in public health facilities.
3. Educate both patients and healthcare providers on the negative effects of corruption and the need for all to co-operate to reduce it.

GLOSSARY

1. Corruption:	The abuse of entrusted power for private gain
2. Petty Corruption:	Petty corruption refers to everyday abuse of entrusted power by low- and mid-level public officials in their interactions with ordinary citizens, who often are trying to access basic goods or services in places like hospitals, schools, police departments and other agencies
3. Informal / Unofficial payment:	Payments that occurs when patients are tasked to make payments for health care services that they ought not to pay under Ghana Health Care financing policy. These are payments that patients are forced to pay, which in most cases are not receipted and even when receipts are issued those receipts are often found to be private in nature and funds received not accounted for in the health facilities official accounting systems.
4. Extortion:	Intimidation of a private citizen or business to obtain money
5. Embezzlement:	Stealing funds or equipment from the government
6. Favoritism:	Offering preferential service or better treatment to friends, family members or specific groups at the expense of the wider population.
7. Absenteeism:	Providers purposefully do not attend work and do not fulfill their responsibilities despite claiming a salary
8. Theft of medical supplies:	stealing/pilfering of medicines, medical devices and supplies during the distribution and storage process for private use of sale.

Contents

List of Abbreviations

ANC	Antenatal care
CDA	Community Development Alliance
CWC	Child welfare clinic
ED	Emergency Department
IEA	Institute of Economics Affairs
IMF	International Monetary Fund
OPD	Out-patients Department
PAAC	Peoples Action Against Corruption
PNC	Post-natal care

List of Tables

List of Figures

1.0 Introduction

1.1 Background

Corruption is often defined as the misuse of entrusted authority for private gain (Transparency International, n.d.-a). Corruption is both a governance and economic problem, and it is manifested in all development and service delivery sectors (Spector, Johnston, & Winbourne, 2006). Corruption has become part and parcel of daily life in many countries (Institute of Economics Affairs (IEA), 2016). While corruption is a major problem in most sectors, it is of particularly critical concern in the health sector. Corruption is quite pervasive within the healthcare delivery system in Ghana to the extent that some types of corruption have become normalized in most local health facilities.

The health sector in Ghana is choked with allegations of both petty and grand corruption (The World Bank, 2010). Grand corruption consists of acts committed at a high level of government that distort policies or the central functioning of the state, enabling leaders to benefit at the expense of the public good. Petty corruption on the other hand, refers to everyday abuse of entrusted power by low- and mid-level public officials in their interactions with ordinary citizens, who often are trying to access basic goods or services in places like hospitals, schools, police departments and other agencies (Lanyi & Azfar, 2005; Spector et al., 2006; Transparency International, n.d.-b; United Nations Development Programme, 2011). Petty corruption is practiced in different forms. For instance, it might be in the form of a health worker soliciting a bribe/informal payment or a patient/career prompting a health worker to receive a bribe meant to induce him or her to provide better quality care to the patient. In some countries such as Tanzania and in other poor countries, bribes are socially acceptable and are justified as a way of compensating poorly paid health professionals working for government health facilities (Sikika, 2010, 2015).

In the healthcare sector, corruption negatively impacts health outcomes at the individual, community and national levels. Corruption can mean life or death for an individual patient. Its consequences include: reducing of resources aimed at improving health; denied or delayed access to health care services and treatment; loss of lives, loss of trust in public health facilities, personnel and to a wider extent national governance as a whole; weakening of quality, equity and effectiveness of health care services, and an increased cost for healthcare service (Agbenorku, 2012; Sikika, 2015; United Nations Development Programme, 2011).

The crux of the problem is that, on daily basis, individuals, companies and groups involved in healthcare service delivery are placing their private self-interests over wider public health goals across the northern sector of Ghana. This situation has adversely compromised the access and quality delivery of basic healthcare services to poor people mostly pregnant women, children, youth and the aged who suffer and in some cases lose their lives needlessly due to corruption related issues in the healthcare sector. In order for Ghana to meet the Sustainable Development Goal 3 that aims to ensure healthy lives and promote the wellbeing of all people of all ages, there is the urgent need to redouble efforts to tackle corruption and eliminate its negative impact in the health delivery system.

1.2 The People's Action Against Corruption (PAAC)

The Peoples Action Against Corruption (PAAC), which is a grass-root Civil Society Anti-Corruption Campaign Coalition led by Community Development Alliance (CDA-Ghana) together with RISE-GHANA and NORSAAC as Collaborating Partners has received funding from UKAID through its Strengthening Action Against Corruption Program in Ghana (STAAC-Ghana). The Coalition exists to contribute towards the goal of a Corruption Free Society underpinned by accountable, efficient and equitable public service delivery that meets the needs of the poor and most vulnerable segments of the society. Part of the funding is to undertake a comprehensive baseline research, which will serve as a key entry point to strengthening evidenced based anti-corruption advocacy actions in Ghana.

As part of strategies to combat corruption in public healthcare delivery system, this research generated evidence that can be used to develop advocacy strategies and action points to fight corruption in the healthcare delivery system. The findings of the research will help to deepen understanding on the various corrupt practices that are prevalent in the healthcare sector and their effects on access to basic quality healthcare for vulnerable groups.

1.3 Objectives

The general objective of the study was two-fold, examine i) the awareness and practices of corrupt activities at public health facilities by health service providers and users and ii) the effect of such practices on utilization of health services and patients satisfaction in the Upper West, Upper East and Northern Regions of Ghana.

Specifically, the study sought to:

1. Examine the knowledge of individuals as health care consumers

or practitioners on what constitute corruption.

2. Explore the perception of patients and healthcare providers about petty corruptions that occur in health facilities.
3. Assess the magnitude or rate of occurrence of the various petty corrupt practices that occur in health facilities.
4. Ascertain the effects of petty corruption on the delivery of basic quality healthcare services

1.4 Literature Review

A study by the Ghana Integrity Initiative (GII) has shown that corruption persists in both the health and education sectors of Ghana. According to the study, generally, the perception of corruption exceeds actual experience of the phenomenon at both sub-national and national levels in health and education sectors (BusinessGhana, 2018). In 2017, a Deputy Minister of Health in Ghana lamented the high rate of fraud in the health sector and described the sector as one with the weakest level of accountability in the country (Tijani, 2017). Corruption in the health sector is a reflection of the structural challenges in the health care system. Among the key reasons for corruption in the health sector are weak or non-existent rules and regulations, lack of accountability, low salaries and limited offer of services among others (Deliversky, 2016).

Several quantitative and qualitative studies illustrate how the burden of corruption impacts the poor most heavily given their limited ability to meet demands imposed by corruption. For example, poor and marginalized individuals can be denied access to necessary care if payments are required for health care services (Agbenorku, 2012; Ecorys & European Healthcare Fraud & Corruption Network, 2013; Sikika, 2015; United Nations Development Programme, 2011)nature and impact of corrupt practices in the healthcare sector across the EU; and to assess the capacity of the MSs to prevent and control corruption within the healthcare system and the effectiveness of these measures in practice. This study focused on three areas of healthcare: medical service delivery; procurement and certification of medical devices; and procurement and authorisation of pharmaceuticals. On the basis of desk research, interviews (with EC officials and representatives of health professional's organisations, medical device industry, pharmaceutical industry and health insurers. A study by Amnesty International on maternal health in Burkina Faso found that one of the primary causes of the deaths of thousands of pregnant women annually (including during childbirth) is due to corruption by health professionals. Poor women may not get critical health care services simply because they are unable to pay informal fees (United Nations Development Programme, 2011). Further evidence comes from an International Monetary Fund (IMF) report showing that corruption has a significant, negative effect on health indicators such as infant and child mortality, even after adjusting for income, female education, health spending, and level of urbanization (Gupta, Davoodi, & Tiongron, 2000). Corruption lowers the immunization rate of children; can prevent the provision of necessary treatment, particularly for the poor; and discourages the use of public health clinics (Azfar & Tugrul, 2005). The two clear and related conclusions are that corruption hurts health outcomes

and it is the poor who are affected the most (United Nations Development Programme, 2011).

Petty corruption has a direct impact on the poor by denying them access to services and thereby jeopardizing their health. Petty corruption associated with health providers includes (Ecorys & European Healthcare Fraud & Corruption Network, 2013; Spector et al., 2006; United Nations Development Programme, 2011):

a. Unofficial/Informal payments required from patients for services

b. Absenteeism (not showing up for work yet claiming a salary);

c. Theft for personal use or diversion of public drugs to private clinics by health workers;

d. Embezzlement or fraud related to health-care funds;

e. Sale of drugs or supplies to patients that are supposed to be free;

f. Diversion of public medical equipment to private clinics;

g. Use of public facilities and equipment to see private patients;

h. Unnecessary referrals to private practice or privately owned ancillary services;

i. Poor handling of patients, especially the vulnerable groups such as the elderly and expectant mothers.

It is well known that informal payments for medical services are more common in low-income countries than high-income countries, which suggests barriers to services for patients with limited resources. According to Lewis (2007), informal, under-the-table payments to public health care providers are increasingly viewed as a critically important source of health care financing in developing and transition countries. With minimal funding levels and limited accountability, publicly financed and delivered care falls prey to illegal payments. A study of informal payments in the United Republic of Tanzania found that patients commonly make informal payments for better health care services (in other words, patients do not always perceive them as bribes). Health workers in Tanzania took advantage of the population's 'willingness' to pay for services by deliberately creating shortages in order to gain surplus payments from patients (Sikika, 2010, 2015). A study in Sierra Leone revealed widespread informal payments: patients were most commonly charged for medicines such as infant paracetamol or cough syrups. Reported service charges ranged from a small fee to have a baby weighed, or for ante-natal check-ups, to payments for consultations and even vaccinations. Many women reported paying for the free card that recorded their ante-natal visits or their baby's vaccination records (Pieterse & Lodge, 2015).

Whether informal payments are viewed as an accepted part of health care services or as a form of corruption, the imposition of a 'tax' on public health care services that should be free of charge has a negative impact on health care provision. The end result is that poor people will be denied access to health services. In Ghana, there exist limited studies on petty corruption in the health sector and how it affects service delivery and patient satisfaction.

2.0 Methods and Materials

2.1 Study Design

A cross-sectional design was employed, using both qualitative and quantitative approaches for data collection. A cross-sectional approach was the most appropriate since it helps to obtain responses from participants within a definite time period to ascertain prevalence of corruption.

2.2 Study population

The study targeted both the healthcare providers and the users (patients) in various health facilities of the three northern regions. This was to help get the perspectives of both the providers and the users of the health services provided. All patients (both out- and in-patients) who were at the selected health facilities on the day of the visits to the facilities were eligible for inclusion in the study. For patients who could not answer the questions due to the severity of the sickness or being under age, the caretaker or relative taking care of the patient responded to the questionnaire. All healthcare providers in the selected health facilities who provide direct care to patients were eligible for inclusion in the study.

2.3 Sample size estimations

A. *For service users (patients)*

The sample size for patients was determined using the following formula;

$$n = z^2 * \frac{p * q}{d^2}$$

Where:

n = the desired sample size,

z = the standard normal deviate, set at 1.96,

p = proportion of service users involved in corruption practices

(this will be put at 21.6% (Sikika, 2015),

q = 1 – p, and

d = degree of accuracy desired, set at 0.05.

Assuming 95% confidence level, a margin of error of 5% and 21% proportion of service users involved in corrupt practices - the sample size was calculated as follows:

n = $(1.96)^2$*[0.216*0.784] /0.0025 = 261

This is approximately 261 for each region (783 for all 3 regions). However, a non-response rate was adjusted for at 7%. This resulted in a sample size of 850 respondents approximately.

B. *For service providers*

The sample size for health workers was determined using the same formula above with 18% of health workers reported to be involved in corrupt practices (Sikika, 2010). This gives a sample size of 199 and after adjusting for 5% non-response, the final sample size was 210 respondents.

2.4 Sampling Techniques

The study employed a simple random technique to select three (3) district hospitals each in the Upper East and Upper West Regions and four (4) districts hospitals in the Northern Region. One health centre in each of the selected districts was randomly selected. However, the teaching hospital and regional hospitals in each region was purposively selected since they act as referral facilities to the district hospitals (as shown in Table 1).

TABLE 1: STUDY SITES

Region	Selected Facilities/Districts
Upper West	1) Wa Regional Hospital 2) Jirapa Municipality 3) Sissala East Municipality 4) Nadowli/Kaleo
Upper East	1) Bolgatanga Regional Hospital 2) Bongo 3) Talensi 4) Bawku Municipality
Northern Region	1) Tamale Teaching Hospital 2) Tamale Regional Hospital 3) Karaga 4) West Gonja 5) West Mamprusi 6) Nanumba North

Tables 2 and 3 show the distribution of health workers and patients across the various regions and facilities.

Both in-patients and out-patients were included in the study, however, the study mainly focused on maternal and child health related units. At the out-patient level, five key units was involved, namely: general out-patient's department (OPD), antenatal care (ANC), post-natal care/ child welfare clinic (PNC/CWC), Emergency department, and family planning for all levels of health facility. For the in-patient; labour & delivery, surgical, children wards, emergency department, Obstetrics & Gynecology, and other units were selected.

TABLE 2: DISTRIBUTION OF HEALTH WORKERS

Region	Teaching Hospital	Regional Hospitals	District Hospitals	Health Centre's	Total
Upper West		13	24	6	43
Upper East		13	24	6	43
Northern	71	13	32	8	124
Total Respondents	71	39	80	20	210

TABLE 3: DISTRIBUTION OF PATIENTS (BOTH IN AND OUT PATIENTS)

Region	Type	Teaching Hospital		Regional Hospitals		District Hospitals		Health Centres	Total
		Out	In	Out	In	Out Patient	In	Out Patient	
Upper West	No of facilities			1		3		3	7
	Respondents			40	20	90	45	30	225
Upper East	No of facilities			1		3		3	7
	Respondents			40	20	90	45	30	225
Northern	No of facilities	1		1		4		4	10
	Respondents	80	40	40	20	120	60	40	400
	Total Respondents	80	40	120	60	300	150	100	850

However, at the health centre level, only out-patients were involved. For each selected health facility unit, a systematic random sampling technique was used to recruit out patients in exit interviews. The average number of patients visiting each unit was obtained as the sampling frame to determine the number of respondents to be interviewed for each day. The average number was established through the support of officials in charge of the respective units. A simple random sampling approach was then used to select in patients in each ward/unit using the list of patients in the ward. For health workers, they were selected using simple random sampling using the list of staff for the health facility

2.5 Data Collection

The questionnaires (shown in the appendices) were made up of both close- and open-ended questions that are highly structured and elicited choices based on pre-formulated alternative answers to a set of questions. The close-ended questions were used in order to obtain information that was relevant to the research objectives and also to facilitate codification and analysis of data. In addition, in-depth interviews were done for some patients to share more of their experiences with corruption at the health facilities. The structured questionnaire was transformed using a mobile application (REDCap) for the data collection from the selected

facilities. The use of the mobile application is to help reduce the time in data collection and processing and facilitate real-time monitoring of the data collection. For the healthcare providers, they completed the questionnaire themselves and submitted it to the research assistants for entry into the mobile app. Data quality issues in data collection was identified in real-time and data cleaning occurred simultaneously with the collection. Data analysis started immediately the data collection ended. All research assistants were adequately trained to use the data collection tools and as well as how to use the mobile application. Field supervisors were also recruited to monitor the exercise to check data quality issues and provide technical backstopping in the data collection throughout. The questionnaires captured information on socio-demographic characteristics of respondents, knowledge, perception and experiences of corruption as well as effects of corruption.

2.6 Data Management and Analysis

We transformed the structured questionnaire using a mobile application (REDCap) for the data collection from the selected facilities. The use of the mobile application was to help reduce the time in data collection and processing and facilitate real-time monitoring of the data collection. Data quality issues in data collection was identified in real-time and data cleaning occurred simultaneously with the collection. Data analysis started immediately the data collection ended. All research assistants were adequately trained to use the data collection tools and as well as how to use the mobile application. We recruited field supervisors who monitored the exercise to check data quality issues and provide technical backstopping in the data collection throughout.

Quantitative data collection records were checked for completeness on a daily basis through the REDCap system. Data was analyzed using STATA version 14. Tables and descriptive statistics were used to summarize the data. Qualitative data was transcribed verbatim and handled using a thematic analysis approach using Nvivo software. For this, data was analyzed by examination and categorization of respondents' opinions. Major categories and themes were identified accordingly. Finally, the information under major and sub-categories were presented through summaries and narrative text (quotations).

2.7 Ethics

Ethical approval for the survey was obtained from the Ghana Health Services Ethics Review Committee. Additionally, permissions were sought from the Director General of the Ghana Health Service, Regional Directors of Health Services and the managements of the various health facilities before collecting data in the facilities. Written informed consent, specifying the intent of the study including the possible risks and benefits of participation, were also sought from all participants. The consent form were written in English language and explained in the local language if the participant's did not understand English. The interviews were conducted at the premises of the health facilities or at a location were participants were comfortable and that

ensured privacy, confidentiality and devoid of likely influence of the health providers on the respondents.

2.8 Limitations

Cases of corruption as reported in the study are self-reported and may not necessarily be real cases of corruption. So the results should be interpreted taking into consideration this limitation since it is possible for people to under report their involvement in corruption. Additionally, in situation were the patients could not participate in the study either due to the severity of the sickness of or being a child, the caretaker responded to the questions. The views expressed may then be the view of the caretaker and not that of the patients.

3.0 Results

3.1 Socio-demographic Characteristics

In all, 834 patients/caretakers of patients and 201 healthcare workers were interviewed for the study. About 70.5% (588) of the patients were out patients while 29.5% (246) were in patients. The socio-demographic characteristics of the patients are presented in Table 4 while that of the healthcare workers are presented in Table 5. Majority of the patients (42.2%) were between the ages of 30-39 with about 76% being females. Most of the patients had some form of formal education with 46.9% having secondary school education and above. However, a significant number (23.7%) of them had no formal education at all. Although majority of the patients were employed (70.6%), about 29% were unemployed. Also, majority (52.4%) of the participants who responded to the questionnaires were patients themselves. About 53% of the respondents in the patients' survey were Muslims while about 2% were Traditionalists.

Health workers in the study included: doctors, nurses, physician assistants, and allied health personnels. About 45% of the healthcare workers were from the Northern Region while 19% were from the Upper East and 36% from the Upper West Regions. Majority of the workers (57.2%) were males with approximately 48% being between the ages of 30-39. Most of them had some form of formal education with a significant proportion (75.2%) having tertiary education and above. Also, majority (56.2%) of the healthcare workers who responded to the questionnaires were nurses. About 59.1% of them were Christians while about 40% were Muslims.

TABLE 4: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

	Out-Patients		In-Patients			
Characteristics	**No.**	**Percent***	**No.**	**Percent***	**Total**	**Percent****
Region						
Northern Region	249	70.0	109	30.0	358	42.9
Upper East	160	71.4	64	28.6	224	26.9
Upper West	179	71.0	73	29.0	252	30.2
Sex						
Male	131	64.9	71	35.1	202	24.2
Female	457	72.3	175	27.7	632	75.8
Age of Respondents						
Below 20	50	78.1	14	21.9	64	7.7
20-29	235	77.8	67	22.2	302	36.4
30-39	228	65.1	122	34.9	350	42.2
40-49	55	61.8	34	38.2	89	10.7
50+	16	64	9	36	25	3.0
Respondent Type						
Relative/Care taker	213	54.6	177	45.4	390	47.6
Patient	362	84.4	67	15.6	429	52.4
Education						
No education	125	63.5	72	36.5	197	23.7
Primary	66	77.6	19	22.4	85	10.2
Middle/JHS/JSS	105	66.0	54	34.0	159	19.1
Secondary/SHS/SSS	151	74.0	53	26.0	204	24.5
Post-secondary	39	75.0	13	25.0	52	6.3
Tertiary	100	74.6	34	25.4	134	16.1
Main occupation						
Unemployed	161	73.2	59	26.8	220	29.4
Peasant Farmer	109	68.1	51	31.9	160	21.4
Businessman/women	164	64.6	90	35.4	254	34.0
Public servant	87	76.3	27	23.7	114	15.2
Religion						
Christian	269	71.5	107	28.5	376	45.1
Muslim	307	69.5	135	30.5	442	53.1
Traditionalist	11	73.3	4	26.7	15	1.8
Total	588	70.5	246	29.5	834	

* *Represent the row percentage* ** *Represent the column percentage*

TABLE 5: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF HEALTH WORKERS

Characteristics	No. of Respondents	Percentage
Region		
Northern Region	90	44.8
Upper East	38	18.9
Upper West	73	36.3
Sex		
Male	115	57.2
Female	86	42.8
Staff category		
Doctor	7	3.5
Nurse/midwife	113	56.2
Pharmacist	21	10.5
Allied Health	21	10.5
Administration	16	8.0
Physician Assistant	11	5.5
Other	12	6.0
Age of Respondents		
Below 20	0	0.0
20-29	68	33.8
30-39	97	48.3
40-49	28	13.9
50+	8	4.0
Education		
No education	1	0.5
Primary	2	1.0
Secondary/SHS/SSS	4	2.0
Post-secondary	43	21.4
Tertiary	151	75.1
Religion		
Christian	117	59.1
Muslim	79	39.9
Traditionalist	2	1.0
Total	201	100.0

3.2 Knowledge of Corruption

Over 75% of all patients and 79% of healthcare workers generally know that: informal payment, extortion, embezzlement and favoritism by public officials constitute acts of corruption

Over 76% of patients and healthcare workers know that: receiving informal payments, stealing medical supplies, charging fee higher than the official rate, absenteeism and using public health facilities to see private patients are acts of corruption

The study examined the knowledge of individuals as health care consumers or providers on what constitute corruption. Table 6 shows the results of the knowledge of corruption among patients while Table 7 shows knowledge of corruption among healthcare workers. Majority of respondents have good knowledge of corruption by all indicators used to measure knowledge. Over 75% of all patients agree that informal payments (76%), extortion (84%), embezzlement (90%) and favoritism (80%) by a public official constitute acts of corruption. Additionally, majority of health workers agree that informal payments (81%), extortion (84%), embezzlement (88%) and favoritism (79%) constitute acts of corruption.

Respondents were unanimous when it comes to what constitute corruption in the health sectors. Majority of patients agree that the following actions undertaken by a healthcare official constitute acts of corruption: stealing medical supplies (97%), receiving informal payments (91%), charging a service fee higher than the official rate (91%), absenteeism (91%), using public facilities and equipment to see private patients (77%) among others. Also, most of the health workers agree that the following actions undertaken by a healthcare official constitute acts of corruption: stealing medical supplies (91%), receiving informal payments (89%), charging a service fee higher than the official rate (91%), absenteeism (90%), reserving beds to allocate to patients as they wish (77%), among others.

About 64% of patients and 63% healthcare workers agree that raising the prices of essential items like electricity when people can't pay for it could be considered an act of corruption. Additionally, about 38% of patients and 50% of providers believe that 'Buying goods from foreign firms when domestic firms are operating below capacity' is corruption. However, these two indicators are not usually considered as acts of corruption. In the Upper East region, all patients (100%) indicated that a healthcare official absenting himself/herself from work despite claiming a salary was corruption.

The results show that both patients and healthcare workers have good

understanding of what constitutes corrupt practices whether undertaken by a public official in general or undertaken by a healthcare profession. However, sizeable number of both patients and healthcare workers do not see a public official taking gifts from a citizen for services provided as corruption though they see taking informal payments from a citizen for services provided as corruption. This could stem from the fact that people generally may consider gifts to be willingly given by the recipient of the services whereas informal payments may be demanded by the provider of the service. The high knowledge of both patients and healthcare workers is however, encouraging. This is so because knowledge of what constitutes corrupt practices or not is the first step in fighting corruption.

TABLE 6: KNOWLEDGE OF CORRUPTION AMONG PATIENTS

Percentage of patients/care takers who agree (including strongly agree) that the following actions undertaken by a public official constitute instances of corruption, by region

Description actions undertaken by a public official		Upper East	Upper West	All Regions
General (any public official)				
Informal payment for services provided	64.9	87.4	79.8	75.5
Take a gift from a citizen for a service provided	48.0	57.2	55.6	52.8
Intimidation of a private citizen or business to obtain money (extortion)	77.6	87.0	90.4	84.0
Stealing funds or equipment from the government (embezzlement)	92.1	97.6	80.3	90.1
Favoritism, that is, showing preference to relatives and other close persons	75.5	86.1	81.75	80.3
Raising the prices of essential items like electricity when people can't pay for it	58.9	77.6	58.8	63.9
Buying goods from foreign firms when domestic firms are operating below capacity	34.8	39.0	41.4	38.0
Actions undertaken by a healthcare official				
Stealing medical supplies	95.5	98.7	96.82	96.8
Receiving payments without giving a receipt	92.7	96.0	83.7	90.8
Charging a service fee higher than the official rate	91.0	92.8	89.3	90.9
Diverting public medical equipment to private clinics.	84.9	88.34	86.0	86.2
Using public facilities and equipment to see private patients	75.8	73.1	80.5	76.5
Making unnecessary referrals to privately owned allied services.	75.6	79.7	75.4	76.6
Reserving beds for themselves, to allocate to patients as they wish	86.4	92.3	86.5	88.02
Absenteeism	89.9	100.0	84.1	90.7

TABLE 7: HEALTH WORKERS KNOWLEDGE OF CORRUPTION

Percentage of health workers that agree or disagree that the following actions undertaken by a public official constitute instances of corruption

Description actions undertaken by a public official	Strongly agree	Agree	Neutral	Disagree	Strongly	No. of workers
Informal payment for services provided	49.8	30.9	5.5	8.0	6.0	201
Take a gift from a citizen for a service provided	24.9	36.3	14.9	16.9	7.0	201
To take an informal payment from a company in return for buying its products	34.3	38.3	12.4	10.0	5.0	201
Intimidation of a private citizen or business to obtain money (extortion)	48.0	35.5	6.5	5.5	4.5	200
Stealing funds or equipment from the government (embezzlement)	61.2	26.9	5.0	2.5	4.5	201
Favoritism, that is, showing preference to relatives and other close persons	53.5	25.0	8.5	9.5	3.5	200
Being systematically absent from work for no reason	53.3	30.2	7.0	5.0	4.5	199
Raising the prices of essential items like electricity when people can't pay for it	31.3	31.3	19.4	13.4	4.5	201
Buying goods from foreign firms when domestic firms are operating below capacity	21.4	28.9	20.4	22.9	6.5	201
Actions undertaken by a healthcare official						
Stealing medical supplies	76.5	14.5	0.5	5.5	3.0	200
Demanding or accepting gifts and favours from a supplier in return for prescribing product or inclusion on a product list.	53.2	30.9	8.0	5.5	2.5	201
Receiving payments from a patient without giving a receipt	58.0	31.0	3.5	4.0	3.5	200
Charging a service fee higher than the official rate	56.3	32.7	4.0	4.0	3.0	199
Diverting public medical equipment to private clinics.	49.8	29.9	7.5	5.5	7.5	201
Using public facilities and equipment to see private patients	37.5	35.5	9.5	10.5	7.0	201
Making unnecessary referrals to privately owned allied services.	37.5	35.5	9.5	10.5	7.0	200
Reserving beds to allocate to patients as they wish	46.3	30.4	6.0	11.9	5.5	201
Absenteeism	54.2	35.8	3.0	3.5	3.5	201
Doctors prescribing medicines that they know are not available in Government facilities and advise patients to procure them in their privately owned facilities	40.3	29.4	10.0	8.0	12.4	201

3.3 Perception of Corruption

97% of patients and 96% of healthcare workers indicated that bribery and corruption is widespread within the healthcare delivery system

67% of patients and 62% of healthcare workers agree that corruption is accepted as normal in the delivery of health care.

About 66% of patients have often/very often heard/seen or experience informal payments in a health facility within the last one year

About 34% of health workers indicated that "unofficial payments from patients to healthcare providers in return for receiving healthcare services" happens often/ very often in the last one year.

50% of health workers indicated that their co-health workers sometimes/often engage in corrupt practices

Respondents were asked how often within the last one year they had heard or seen or experienced any of the following cases (Tables 8 and 10) in a health facility. Most of the patients (65.7%) indicated that they have often heard/seen or experience 'patient or relatives making payment without getting a receipt' whilst fewer people (19.9%) have seen or experienced 'patients or relative making payment to healthcare worker to secure an appointment'. Comparing the three regions, more respondents in the Northern Region have heard or seen or experienced all the cases compared to the other regions. This could suggest that these cases could be more prevalent or patients in the Northern Region take more notices of these cases compared to the other regions.

The top cases that patients have heard or experience include informal payments (65.7%), Patients or relatives making payments to get preferential treatment (52.7%) and health workers insisting on payments before providing services to deal with life-threatening medical emergencies (52.3%). Informal payments' are generally defined as payments made by patients or their relatives for those services that are to be provided free of charge or at a lower price. Given that they pose extra and non-foreseen costs, they may constitute a barrier to access healthcare, especially for the poorer socio-economic class of the population (Ecorys & European Healthcare Fraud & Corruption Network, 2013). Table 9 shows detailed rating of the patients' perception of corruption in the health sector within the past one year.

Majority of healthcare workers (52.7%) indicated that they think officials or providers steal medical supplies during the distribution and storage process whilst about 49% think employment

opportunities or promotion are given to healthcare providers based on personal connections and inducements rather than merit. Additionally, 32% reported that they think 'healthcare providers overcharge healthcare funders (e.g NHIA) for services provided to patients or charge for services that were actually unnecessary or undelivered'. Table 10 shows detailed rating of the health workers perception of corruption in the health sector within the past one year.

Patients were also asked the extent to which they thought that the practice of giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector. About 97% of patients indicated that bribery and corruption were widespread (Great extent: 52.7%, some extent: 33.6% and small extent: 10.8%) as shown in Table 11. Additionally, patients were asked the extent to which they agree that corruption is accepted as normal in the delivery of health care. In all, 65.7% in the Northern Region, 68.1% in the Upper West Region and 67.7% in the Upper East Region agree or strongly agree that corruption is accepted as normal in the delivery of health care.

Staffs of health facilities were asked the extent to which they thought that the practice of giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector. About 96% of them indicated that bribery and corruption were widespread (Great extent: 50%, some extent: 34.7% and small extent: 11.3%) as shown in Figure 1. Additionally, they were asked how often their co-health workers engage in corrupt practices. About 39% and 9% indicated that their fellow health workers sometimes and often respectively, engaged in corrupt practices at the health facilities. However, only 2.0% admitted that their colleagues engage in corrupt practices all the time.

The findings show that the perception of corruption is very high in the health sector. Almost all patients and health workers agree that bribery and corruption is widespread within the healthcare delivery system. Additionally, majority of patients and health workers agree that bribery and corruption is accepted as normal in the delivery of healthcare. Indeed, if this is not checked, in the near future, both the bribe givers and those who solicit bribes will come to recognize corruption as normal behavior and institutionalized as part of care delivery. This high perception of corruption has the tendency to lead to mistrust and eroded confidence in the health delivery system. For the health workers who work on a daily basis within the health system to have such high perception gives indication the corrupt practices could be real. There is need for the healthcare system to do lot of work to purged itself of this high corruption tag and the acceptance of corruption as normal. Another worrying findings is the fact that healthcare workers themselves admit that providers often overcharge healthcare funders like the national health insurance authority (NHIA) for services provided to patients or charge for services that either were actually unnecessary or services not delivered at all.

TABLE 8: PATIENTS PERCEPTION OF CORRUPTION BY REGION

Percentage of patients that have often (including very often) heard/seen or experience any of the following cases in a health facility (in the last one year)

Description		Upper East	Upper West	Total
Patient or relatives making payment without getting a receipt	69.6	62.9	62.6	65.7
Patients or relatives making payments to get preferential treatment	63.03	53.6	37.5	52.7
Health workers charging a service fee higher than the approved fee	54.8	27.0	35.1	41.3
Doctors using public facility and equipment to see private patients	37.4	10.9	26.5	26.9
Doctors asking patients to come to their private facility	36.7	20.5	26.4	29.2
Patients or relatives making payment to secure a hospital bed	31.6	7.76	15.6	20.3
Patients or relative making payment to healthcare worker to secure an appointment	31.8	5.45	16.1	19.92
Health workers insisting on payments before providing services to deal with life-threatening medical emergencies.	64.0	42.3	44.7	52.3
Healthcare professionals unnecessary referring patients to private practice or privately owned allied services.	37.6	36.3	28.1	34.4

TABLE 9: PATIENTS PERCEPTION OF CORRUPTION

Percentage of patients who have heard/seen or experience any of the following cases in a health facility (in the last one year)

Description	Very Often	Often	Less often	Not at all	Don't Know	No of respondents
Patient or relatives making payment without getting a receipt	36.9	28.8	23.6	8.3	2.4	821
Patients or relatives making payments to get preferential treatment	31.3	21.4	20.1	21.7	5.6	822
Health workers charging a service fee higher than the approved fee	17.1	24.1	27.4	14.9	16.4	817
Doctors using public facility and equipment to see private patients	8.9	18	26.3	20.8	26.0	817
Doctors asking patients to come to their private facility	9.1	20.1	26.4	25.3	19.1	815

Patients or relatives making payment to secure a hospital bed	8.8	11.5	19.2	38.9	21.5	817
Patients or relative making payment to healthcare worker to secure an appointment	7.7	12.2	17.1	38.6	24.3	818
Health workers insisting on payments before providing services to deal with life-threatening medical emergencies.	30.2	22.2	26	18.5	3.1	816
Healthcare professionals unnecessary referring patients to private practice or privately owned allied services.	13.6	20.8	26.7	25.7	13.2	782

TABLE 10: HEALTH WORKERS PERCEPTION OF CORRUPTION

Percentage of health workers that think the following cases occur in health facilities (in the last one year)

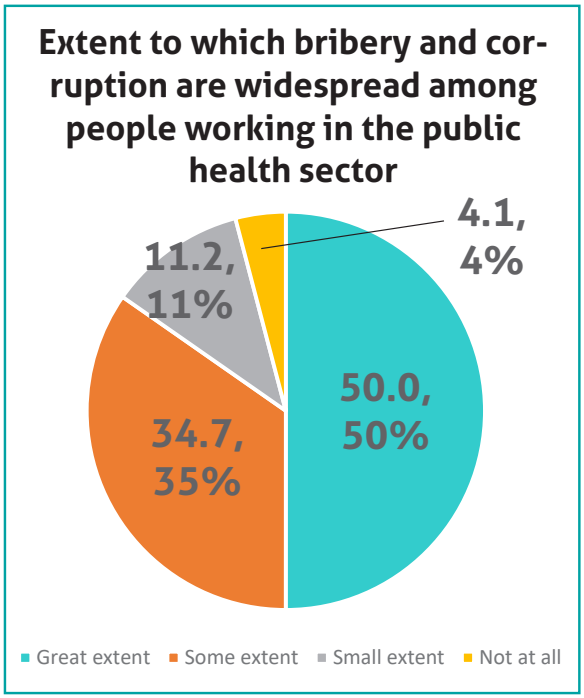
Cases	Very Often	Often	Less often	Not at all	Don't Know	No. of workers
Unofficial payments from patients to healthcare providers in return for receiving healthcare services.	14.6	19.6	39.7	17.1	9.1	199
Healthcare officials demanding or accepting gifts and favours from a supplier in return for prescribing or inclusion on a product list.	12.4	26.4	30.9	21.9	8.5	201
Officials determining the winner of a tender due to inducements from a supplier.	13.6	27.6	23.6	15.6	19.6	199
Officials or providers stealing medical supplies during the distribution and storage process.	20.9	31.8	26.9	14.9	5.5	201
Healthcare worker charging a service fee higher than the official rate	17.4	26.4	25.9	23.9	6.5	201
Diversion of public medical equipment and supplies to private clinics	12.0	27.5	28.0	23.0	9.5	200
Use of public facilities and equipment to see private patients by clinicians	10.7	32.0	25.9	22.3	9.1	197
Clinicians making unnecessary referrals to privately owned allied services.	15.4	28.9	22.4	18.4	14.9	201
Healthcare providers diverting patients to private care.	16.5	26.5	22.0	23.5	11.5	200
Doctors prescribing medicines that they know are not available in public facilities and advise patients to procure them in their privately owned facilities	13.9	24.4	25.9	20.4	15.4	201

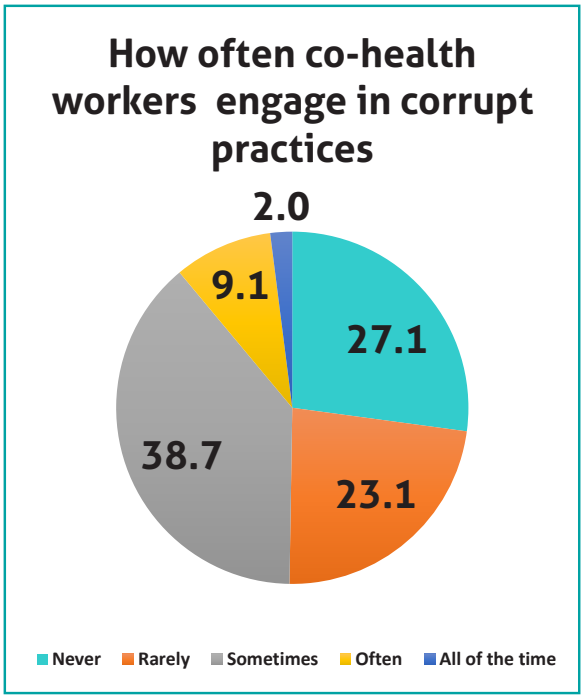
Healthcare workers encourage patients to have services or treatments they do not require	12.1	23.6	22.6	28.6	13.1	199
Employment opportunities or promotion are given to healthcare providers based on personal connections rather than merit.	28.9	20.4	27.9	15.4	7.5	201
Healthcare providers purposefully do not attend work despite claiming a salary.	15.4	27.4	31.3	22.9	3.0	201
Healthcare providers overcharge healthcare funders (e.g NHIA) for services provided to patients or charge for services that were actually unnecessary or undelivered.	11.9	20.4	22.9	27.4	17.4	201
Cases	**Very Often**	**Often**	**Less often**	**Not at all**	**Don't Know**	**No. of workers**
Healthcare professionals offer preferential service or better treatment to friends, family members or specific groups at the expense of the wider population.	24.6	26.1	21.1	26.6	1.5	199
Healthcare professionals reserving beds for themselves, to allocate to patients as they wish	16.6	18.1	25.6	28.6	11.1	199
Patients are overcharged by a healthcare provider or health facility for the services they receive, or patients do not receive the level or quality of service they should receive.	10.6	26.1	25.6	27.6	10.1	199

TABLE 11: EXTENT OF BRIBERY AND CORRUPTION

Region	Percentage of patients that indicated the extent to which they thought bribery and corruption is widespread in the public health sector.				Percentage of patients who agree or disagree that corruption is accepted as normal in the delivery of health care.					No of respon-dents
	Great extent	Some extent	Small extent	Not at all	Strongly agree	Agree	Neutral	Disagree	Strongly	
Northern	58.9	27.4	9.4	4.3	33.4	32.3	14.6	11.7	8	350
Upper East	50.4	34.2	14	1.4	22.5	45.1	9	15.3	8.1	222
Upper West	46	41.6	10	2.4	18	50	14.4	12	5.6	250
All Regions	52.7	33.6	10.8	2.9	25.8	41.1	13	12.8	7.3	822

Figure 1: Health workers view of the extent of bribery and corruption





3.4 Experiences with corruption

- *Payment without being issued receipts (unofficial/ informal payments) is the most prevalent experience of patients across all the three regions (58.6%).*
- *The main motivations for patients being involved in bribery and corruption are the quest to get good quality health services (24%) and avoid long queues (17%)*

Patients were also asked about their experiences with bribery and corruption in health facilities. Figure 2 shows the results of the patients' experiences with corruption in health facilities. More than half (58.6%) of them admitted that they have ever made payments without being issued receipts. This was the most prevalent experience of patients across all the three regions. This was followed by payments for services or drugs covered by the health insurance (23.9%). However, only 5% of patients have been asked to pay or paid money or gave a gift to help secure a hospital bed. Overall, the main motivation for patients being involved in bribery and corruption were the quest to get good quality health services (24%) and wanting to avoid long queue (17%) as shown in Table 12.

Beyond, issues of perception of corruption, some patients have experienced instances of bribery and corruption. The number one experience of patients was the issue of unofficial/informal payment. Unofficial, under-the-table payments from patients to healthcare providers in return for healthcare services in public health facilities is said to be wide spread in most public health

facilities in Northern Ghana. These occur when patients are tasked to make payments for health care services that they ought not to pay under Ghana Health Care financing policy. Patients are forced to pay, which in most cases are not receipted and even when receipts are issued they are often found to be private in nature and funds received not accounted for in the health facilities official accounting systems. Most pregnant women especially, complain of several unofficial payments being demanded from them ranging from payments for detergents, payment for delivery bed, and several other petty payments to health staff. Patients felt helpless with regards to these informal as in most instances they either pay before services are provided or they forget about getting the services. Some patients complained that the health Insurance is virtually not servicing its purpose, as they have to pay for Laboratory test, drugs, etc. Another patients also said "after delivery, 'we pay to go through to check whether we are in good condition and is compulsory'"

The following statements are attributed to patients in some hospitals:

> *"I am sick and have come to the hospital for treatment, whatever I have been asked to pay, I just have to find the money and pay for it to save my life. If I die what use will the money be to me? But what the health workers are doing is not good".*

> *"I made payments in this hospital without receipts. It is like the norm here but I can't even complain to anybody because they are all the same".*

"It is only God saved my baby when I came to this hospital to deliver. I was in labour and could feel the baby coming out. I was in pain and calling the nurses but they were all fast sleep, I kept calling and I heard one of them remarked that I should not worry them; they are tired for the night because they delivered four women. I suffered alone and delivered my baby without any help. God is my savior and He kept my baby alive not this people".

Patients complain that they were denied certain healthcare/treatment services in public health facilities and instead, they were referred to private healthcare facilities owned and operated by individuals who are also employed fulltime in public facilities. In some facilities, pregnant women are being directed to go to specific labs for their scanning with excuse that the one in the hospital is not clear and apart from the one you are directed to no other scan is accepted. Because of this situation the place is always crowded and one can only imagine what these women are go through after following the long queue to do a scan and will have to follow the same long queue to see a doctor. At the end of the day their entire day is spent at the hospital.

For patients who got involved in corrupt practices with health workers such as making informal payments, their main motivations were to help get good quality health services and also avoid long queue. About 57 (6.8%) of the participants indicated the amount of money paid with patients paying an average amount of GH¢60, median amount of GH¢20 and minimum and maximum amount of Gh¢2.00 and Gh¢500.00 respectively. A similar study in Tanzania showed how health service users in Tanzania were ready to make unofficial payments so as to access quality services including shorter

waiting times (Maestad, 2007). A study on corruption in the Ghanaian healthcare system shows similar findings, with health facility staff demanding unofficial payments from patients before they can access quality care, particularly appointments with a doctor, drugs and other investigations (Agbenorku, 2012). This finding implies that corruption is condoned by both service providers and users. This quest to get better treatment and services couple with the long queue in most facilities could constitute a fertile ground for health workers to take advantage and extort money from patients. On the other hand if the healthcare delivery system aims at providing prompt quality services to every patient, the motivation to pay bribe could be eliminated.

Figure 2: Experience of Bribery and Corruption

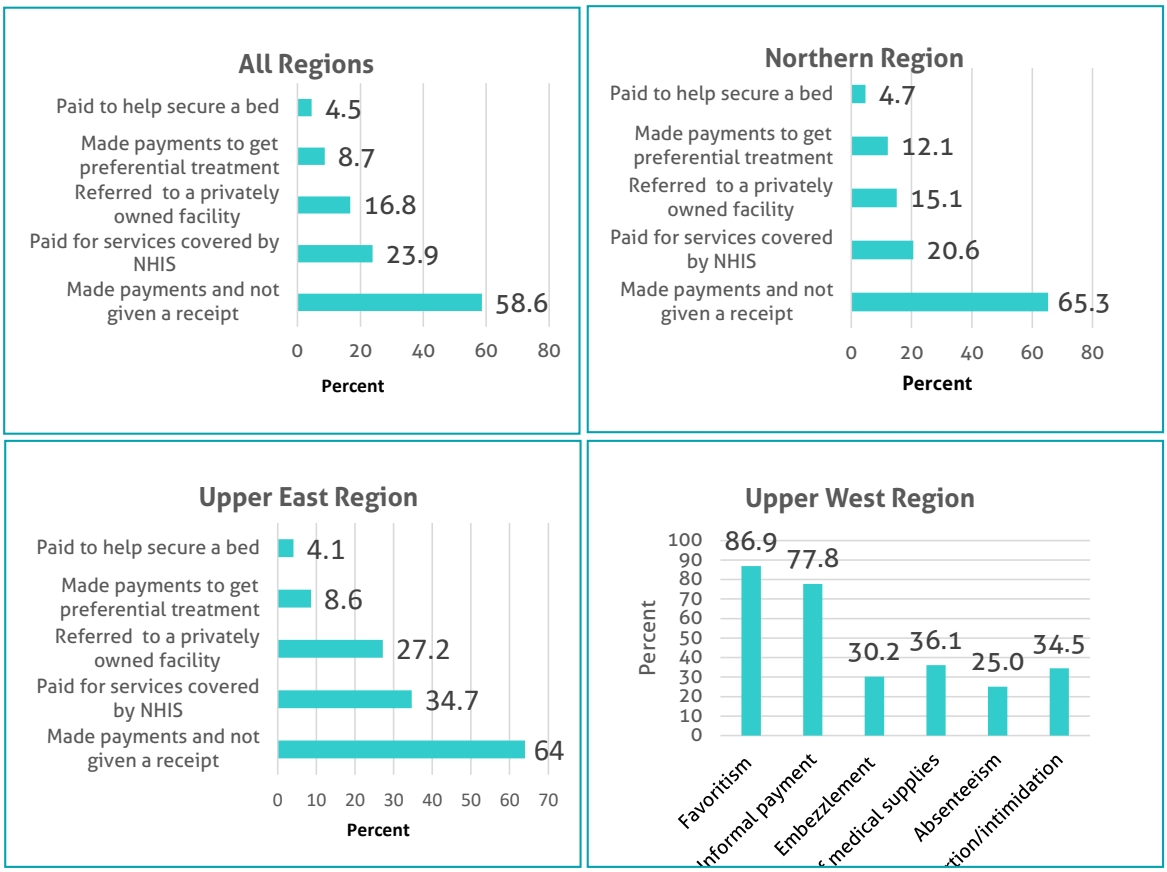


TABLE 12: MOTIVATION FOR BEING INVOLVED IN BRIBERY AND CORRUPTION

Motivation for being involved in any form of corruption with healthcare workers

Motivation	Northern n(%)	Upper East n(%)	Upper West n(%)	All Regions n(%)
Wanted to avoid long queue	44 (19.5)	18 (12.7)	21 (18.9)	83 (17.3)
It was a pressure from health workers	15 (6.6)	2 (1.4)	19 (17.2)	36 (7.5)
Quest to get good quality health services	65 (28.8)	35 (24.7)	15 (13.5)	115 (24.0)
Poor responsibility among health workers	9 (4.0)	1 (0.7)	3 (2.7)	13 (2.7)
Wanted to avoid long bureaucratic procedures	13 (5.8)	7 (4.9)	15 (13.5)	35(7.3)
Poor living standards among health workers	7 (3.1)	0	0	7 (1.5)
Poor access to information about my health service rights	8 (3.5)	10 (7.0)	7 (6.3)	25 (5.2)

3.5 Health Workers Involvement with Corruption

54% of health workers have never reported a corrupt colleague to management of the facility.

40% of healthcare workers said they have ever been involved with corruption or taken a bribe.

About 51% of health workers indicated that they often/very often give preferential services or better treatment to friends and family members.

31% health workers indicated they often/very often receive payments from patient without giving receipt and 25% admitted often charging a service fee higher than the official rate.

Health workers were asked about their involvement with corruption. Approximately two out of five (40%) of them indicated they have ever been involved with corruption or taken a bribe. This, however, varies across the regions with 55% of health workers in the Northern, 27% in Upper East and 26% in Upper West Regions indicating ever been involved with corruption or taken a bribe. Additionally, health worker were asked about the involvement in specific types of corruption. About 51% of health workers indicated that they often/very often give preferential services or better treatment to friends and family members or specific groups at the expense of the wider population (favouritism). There is high perception of patients about various acts of favouritism being openly displayed by public healthcare providers towards their friends, family member and social networks to the neglect or disadvantage of

poor and vulnerable groups. This practice has the tendency to cause public distrust and confidence in many health facilities and thus deny access to basic quality health care service to vulnerable groups who are simply dissatisfied with the long waiting time spent in seeking healthcare services in public health facilities largely due to the widespread acts of favouritism that has been normalized. Furthermore, 31% of healthcare workers indicated they often/very often receive payments from patient without giving receipt (informal payments), 30% "do not attend work regularly despite claiming a salary" while 25% admitted often/very often charging service fees higher than the official rate (Table 13). However, only 20% indicated reserving beds for themselves and allocating them to patients as they wish. Apart from receiving informal payment and giving preferential treatment, over 50% of the workers indicated that they have never engaged in the specific types of corruption.

The fact that a sizeable number of health workers have admitted ever been involved in corruption or taken bribe gives an indication of the size of the problem. Given that corruption is a criminal activity, there is the high tendency of people understating their involvement in corruption. There is therefore high possibility that the proportion of health workers involved in corruption could be higher. A statement by a nurse attest to this: *"I must be honest and confess that I have ever engaged in corrupt practice but for the purpose of this interview, please put no*". Additionally, there is a disconnect between the number that stated they have ever been involved in corruption and the number that admitted they often/very often give preferential services or better treatment to friends and family members. This is an indication that some health workers do not consider giving preferential services or better treatment to friends and family members (favoritism) as corruption. The study also shows that the higher level of knowledge of corruption by health workers is not being translated to low involvement in corruption. A significant number have received money without issuing receipts and have charged fees higher than the approved rates among other forms of corruption. Reasons for receiving the informal payments and charging higher fees are not known: whether these form part of the institutional arrangements or individual health workers taking advantage of vulnerable patients to extort monies from them. One would have thought that the issue of staff reserving beds to allocate to their patients occurs only in the big cities. However, some staff actually indicated allocating beds to their patients. The following statement by both patient and nurse illustrate this point.

"As a nurse, I reserve beds for my relative, friend and other people I know and for me I know this is not corruption because this happen in all public institutions".

"I lay on the floor with my child for three days because the nurses said there was no bed but other people who came later were given beds" (patient).

The study also revealed that some healthcare professionals divert patients to private facilities and other places or use public products, equipment, facilities and time for private gain. Some health staff admitted, they often/very often make unnecessary referrals to private practice or privately owned allied services, use public facilities and equipment to see private patients, do not attend work regularly despite claiming a salary, diverting patients to private care, and reserving beds for themselves and allocate to patients as they wish. These practices could adversely

compromise the quality of care in public health facilities and also collapse many public healthcare systems to the benefit of private individuals.

Although health workers attest to the existence of corruption in most facilities, most people do not report incidents of corruption for fear of jeopardizing relationships with their co-workers or management failing to take actions on previously reported cases. This is resulting in corruption being seen to be tolerated by both staff and management.

TABLE 13: SELF-RATED INVOLVEMENT IN CORRUPTION

Percentage of health workers that rated their personal involvement in the following cases

Cases	Very Often	Often	Less often	Not at all	Don't Know	No. of Workers
Receiving payments from patient or relative without giving receipt.	23.6	7.0	16.6	49.3	3.5	199
Giving preferential service or better treatment to friends, family members	24.6	26.1	21.1	26.6	1.5	199
Charging a service fee higher than the official rate	10.7	14.2	10.7	62.9	1.5	197
Making unnecessary referrals to private practice or privately owned allied services.	8.5	13.6	10.1	64.3	3.5	199
Use public facilities and equipment to see private patients	8.5	14.1	16.6	56.3	4.5	199
Do not attend work regularly despite claiming a salary.	13.6	16.2	14.1	54.0	2.0	198
Diverting patients to private care	7.4	10.5	12.1	65.8	4.2	190
Reserving beds for yourself and allocate to patients as you wish	8.7	11.7	10.7	60.7	8.2	196

3.6 Rating of health workers with respect to corruption

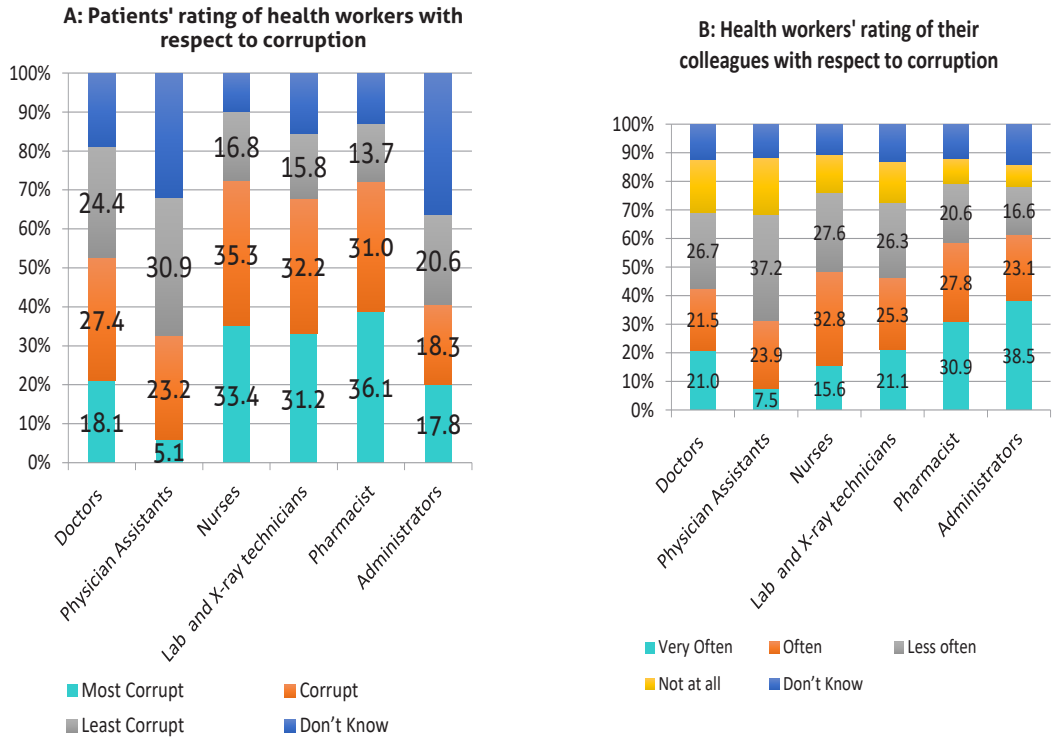
More than 57% of patients and 70% of the workers believe that each of the various categories of workers is corrupt.

Patients were asked to rate each of the various categories of health workers from most corrupt to not corrupt at all. Figure 3 shows that pharmacists (36.1%) followed by nurses (33.4) and laboratory and X-ray technicians (31.2%) were ranked highest with respect to been most corrupt. Physician assistants were seen to be least corrupt by most patients. Apart from the physician assistants and the administrators, more than 70% of all patients see the other categories of health workers as being corrupt with about 69% describing nurses, pharmacists (67%) and laboratory and X-ray technician (64%) as most corrupt or corrupt as shown in Figure 3 (A).

Additionally, health workers were asked to rate the various categories of health workers. According to the health workers, about 38.5% think that the Administrators are those who very often engage in corrupt practices whereas Physician Assistants are seen as the category of health workers who are less likely to be corrupt (Figure 3, B). What is noteworthy is that not less than 30% of the workers believe that each of the various categories of workers often or very often engage in corrupt practices. The difference is actually in the levels of corruption. About 61% of the workers think the administrators are often/very often corrupt, this was followed by the pharmacist (59%) and the nurses (48%) while doctors and physician assistants had the lowest of 43% and 31% respectively.

This high perception of corruption among the various healthcare professionals presents a worrying situation. Both patients and workers themselves perceive all categories of health workers to be corrupt. What is further troubling is the fact that the workers have even a worse self-rating compared to the patients.

Figure 3: Rating of Health Workers



3.7 Common Types of Petty Corruption

According to both patients and health workers, favoritism is the most common type of petty corruption, followed by informal payments.

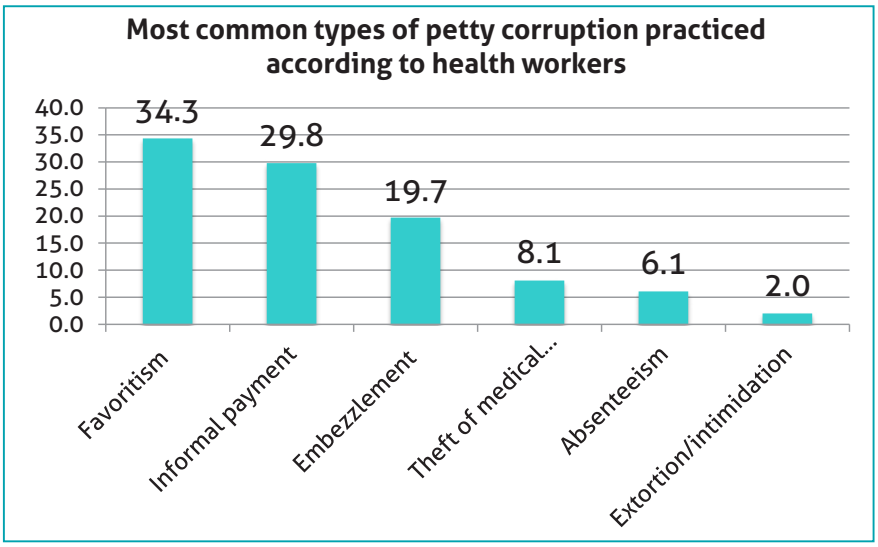
The study reveals that among the various types of corruption according the patients, favoritism emerges the most corrupt with 75% overall (Figure 4). This is followed by informal payments with about 62.8%. About

17.5 % of patients indicated extortion/ intimidating as one of the most common corrupt practices in the three regions. Favoritism was scored highest in the Upper East Region (92%) followed by Upper West (87%). Once again, according to the health workers, 'favoritism' was the most common type of corruption practiced with 34.3% of the health workers indicating it. This was followed by 'informal payments' (30%) while 'extortion/intimidation' was the least common (2%) as shown in Figure 5. The overall top 3 common types of corruption indicated by the respondents were the same for both patients and healthcare providers.

Even though both health workers and patients indicated favouritism as the most common type of corruption, the context is different. Patients' view of favouritism refers to care officials giving preferential service or better treatment to friends, family members and other individuals at the expense of the general population while healthcare workers view favouritism from the angle of management making appointment, promotion and other decisions to favour specific individuals or group not based on merit. From the experience of patients, informal payment is the most common type of corruption. However, when patients were asked to indicate the most common type of corruption, favouritism came top. This is because, those who paid these unofficial payments were mostly going to be favoured compared to others. There is therefore the link between informal payment and favouristism since the main motivation for patients' involvement in corruption were to get better treatment and avoid long queues.

Figure 4: Patients view of most common types of petty corruption practiced

Figure 5: Most common types of petty corruption practiced



3.8 Consequences of Petty Corruption

- *32% of patients have ever sought care outside a public health facility as a result of corruption and bribery.*
- *According to patients the effects of corruption include: long waiting hours/delayed services (94.5%), limits the poor and vulnerable to afford necessary medical treatments (93.9%) and Loss of confidence and mistrust in health system (87.4%)*
- *According to patients, the main causes of corruption include: lack of/limited supervision (59.7%), greed (54.1%), lack of/limited punishment for corrupt practices*
- *According to health workers, the main causes of corruption include: "lack of/limited punishment for corrupt practices", greed (59.7%), "lack of/limited supervision" (59.7%) and poor wages (57%)*

Petty corruption has many negative consequences on the poor by denying them access to services and thereby endangering their health. Patients were asked about the negative consequences of petty corruption. Most patients (74%) mentioned that, to a great extent, the effect of corruption is "long waiting hours or delayed service". The consequences with the highest score (Great extent + some extent) were: long waiting hours/ delayed services (94.5%), limits the ability of the poor and vulnerable to afford necessary medical treatments (93.9%), loss of confidence and mistrust in health system (87.4%) as shown in Figure 6. The health workers were asked about the negative consequences of petty corruption. Most (71%) agreed that corruption makes 'Poor people sometimes experience healthcare from unfriendly health personnel'. The consequences with the highest score (strongly agree + agree) were: poor people resort to seeking alternative source of care

(68%), Poor people sometimes do not get medication at all (59.8%), loss of confidence and mistrust in health system (87.4%) as shown in Table 15.

About 32% of patients indicated that they have ever sought care outside a public health facility as a result of corruption and bribery as shown in Table 9. This ranged from 28.5% in Upper West to 36.7% in Northern Region. A greater percentage of these persons however, went to private hospitals (40%) and pharmacy/ chemical shops (39%). Patients in the Upper East and Upper West Regions had more people moving to private hospitals and pharmacy/ chemical shops compared to the Northern Region who sought care from other public health facilities or traditional medicine.

On the question of what respondents thought were the main causes of or contributors to corruption in delivery of health services, most patients indicated lack of/limited supervision (59.7%), greed (54.1%), lack of/limited punishment for corrupt practices (51.4%) while low probability of detection and prosecution was the lowest (8.0%) as shown in Figure 7. With regards to health workers, 61% of them blamed "lack of/limited punishment for corrupt practices", greed (59.7%), "lack of/limited supervision" (59.7%) poor wages (57%) as key contributors. Approximately 21% of health workers identify 'ignorance of entitlements by service users' as a contributor to corruption as shown in Figure 8.

These findings agrees with the observations made by (Lewis, 2007) that inadequate attention to good governance in health service delivery is to be blamed for the high corruption in health institutions in most developing countries. The weaknesses in governing health facilities (lack/inadequate supervision, lack of/limited punishment for corrupt practices, poor wages etc) encourage health staff to engage in corrupt practices. A review by Rowe AK, de Savigny, Lanata, & CG Victora, (2005), noted that lack of or inadequate supervision of health workers leaves them unchecked and consequently free to do whatever they choose.

It is worth noting, that one third of the patients sought care outside a public health facility because of the existence of corruption. These findings, therefore, underscore the need to fight corruption within the public health sector, as it is the primary source of care for the overwhelming majority. Additionally, fighting corruption in the public health sector will reduce the number of patients who are forced to seek alternative care in private health facilities. Additionally, fighting corruption will help reduce the long waiting time and improve the quality of services provided to care users.

Figure 6: Effects of Corruption

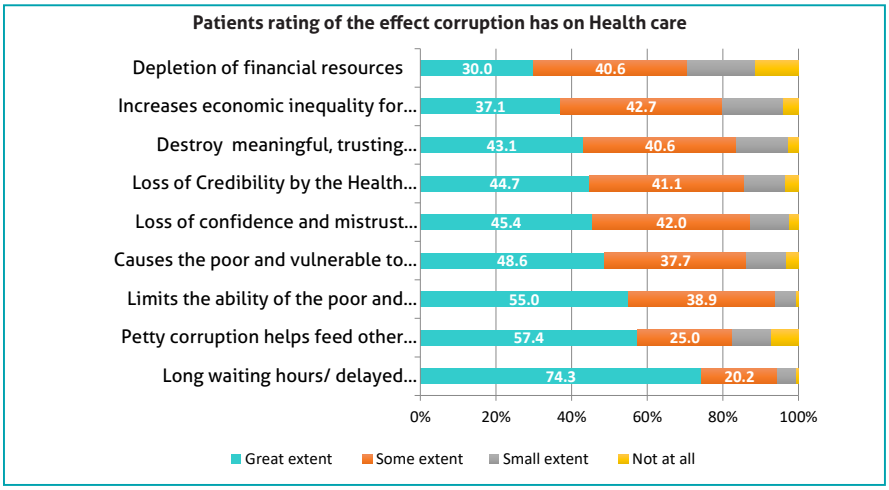


TABLE 14: SEEKING CARE OUTSIDE PUBLIC HEALTH FACILITY BECAUSE OF CORRUPTION

Region	Percent of patient ever sought care outside of a public health facility because of corruption	Places where care was sought			
		Another public health facility	Private hospital	Traditional medical practice	Pharmacy/ Chemical shops
Northern	36.7	28.0	27.2	25.6	21.6
Upper East	29.4	18.8	48.4	9.4.7	67.2
Upper West	28.5	15.7	54.3	12.9	44.3
All Regions	32.2	22.4	39.8	18.2	39.0

TABLE 15: HEALTH WORKERS VIEW OF THE EFFECTS OF BRIBERY AND CORRUPTION

To what extent do you agree with the following statements, due to the existence of corruption in health facilities

Statements	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
Poor people sometimes experience healthcare from unfriendly health personnel	25.5	45.5	6.5	14.5	8.0
Poor people sometimes do not get medication at all	28.1	31.7	12.6	17.1	10.6
Poor people may resort to seeking alternative source of care	29.5	38.5	15.5	12.0	4.5
Pregnant women do not get maximum attention during delivery	17.5	30.0	13.5	26.5	12.5
Pregnant women avoid skilled birth delivery	18.4	30.1	14.8	25.5	11.2
Children do not get appropriate attention from health workers	13.1	32.3	13.6	27.3	13.6

Figure 7: Patients view of the contributors to corruption

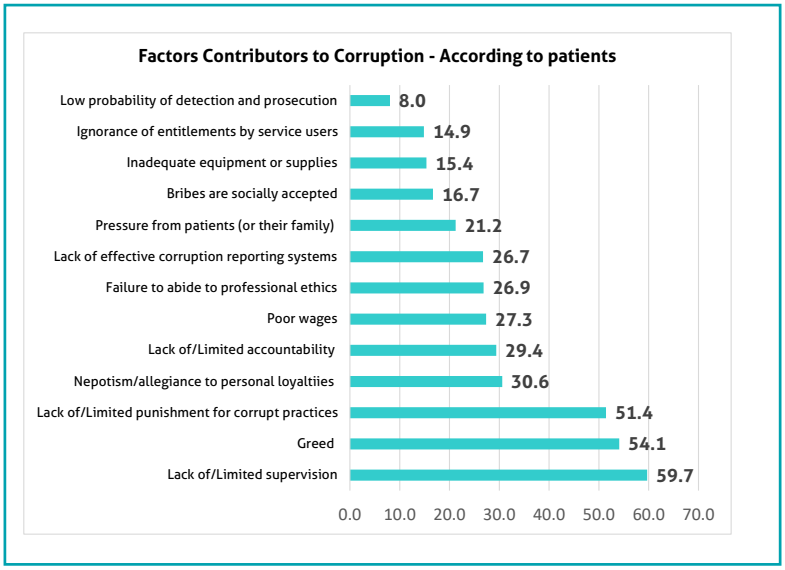
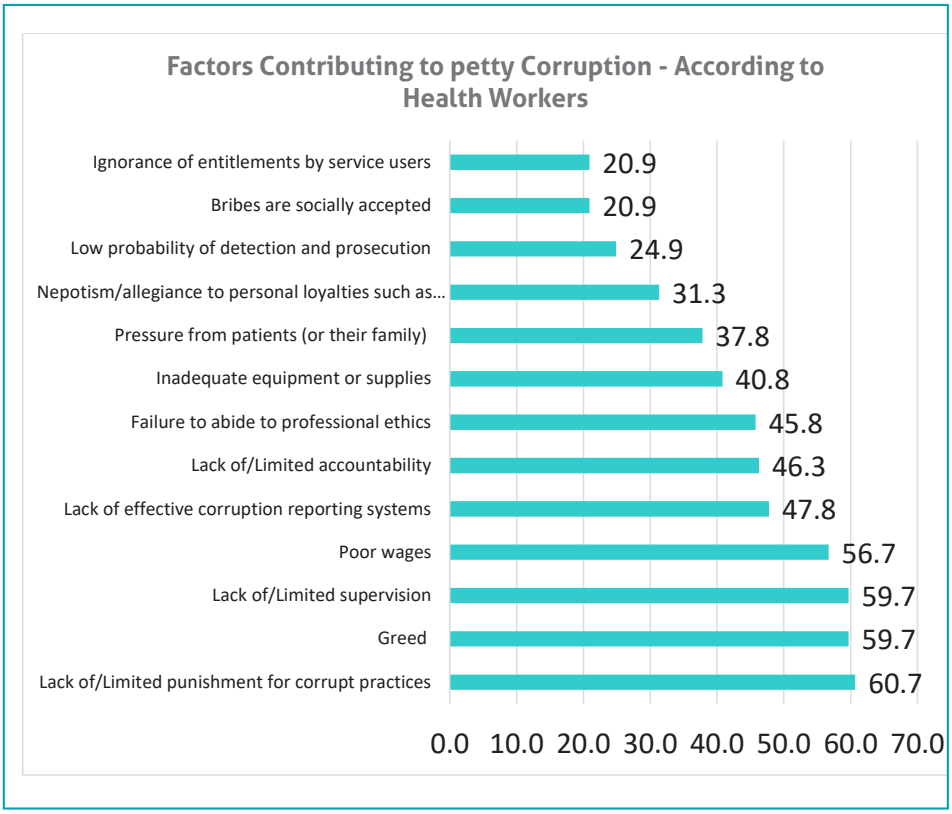


Figure 8: Health workers view of factors contributing to corruption



3.9 Ways to Minimize Bribery and Corruption

65% of patients and 76% health workers believe that punishing corrupt officials is the number way to minimize corruption. This is followed by educating patients and the general community.

Respondents were asked ways that bribery and corruption in the health sector can be minimized. Both patients (65%) and health workers (76%) indicated that punishing corrupt officials was the number way to minimize corruption as shown in Figure 9 and 10. This was followed by educating patients and the general community with 48% of patients and health 69% of workers indicating this option. About 45% of patients and 68% of health workers indicated that improving working conditions would help minimized instances of corruption. However, some health workers (5%) believe that corruption cannot be minimized.

Some staff and patients believe that the situation cannot be minimized as shown in the following statements:

"We cannot stop corruption. The people you are to report the cases to are even more corrupt, so when they come to look at things they keep saying all is normal and everything is going on well" (a patient)

"Corruption cannot be stop because there's no law that protect people who report corruption cases and even when reported nothing is being done about it" (a staff)

"I have reported corruption many times but, nothing was done and we still see more of those things happen" (a staff).

"Avenues for seeking redress are not available and making health staffs treat patients the way they wish (negative); not taking their time to explain issues to their understanding and so on" (patient).

For corruption to be minimized there is the need to make it a disincentive to anyone involved. If avenues to address corruption case do not exist, health workers will treat patients as they wish. People involved must be punished to serve as a deterrent to others. The weak governance of the systems at the various health facilities must be improved. Health facility management must improve supervision of staff, put in place mechanism to help users and workers to report instances of corruption and reduce the long waiting times.

Figure 9: Ways to Minimize Bribery and Corruption

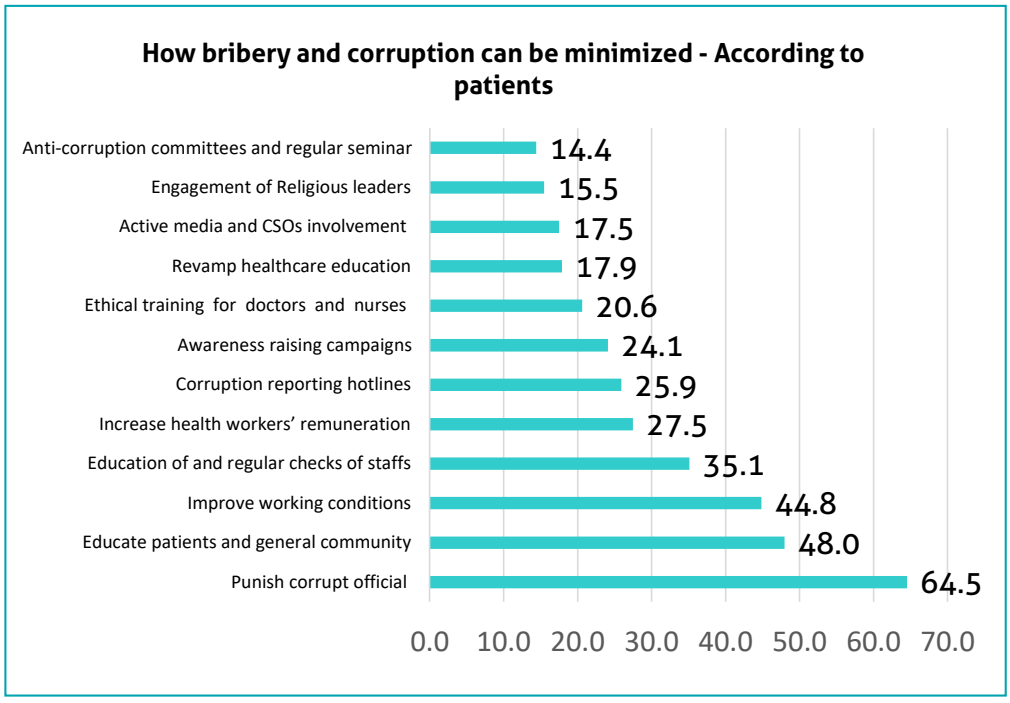
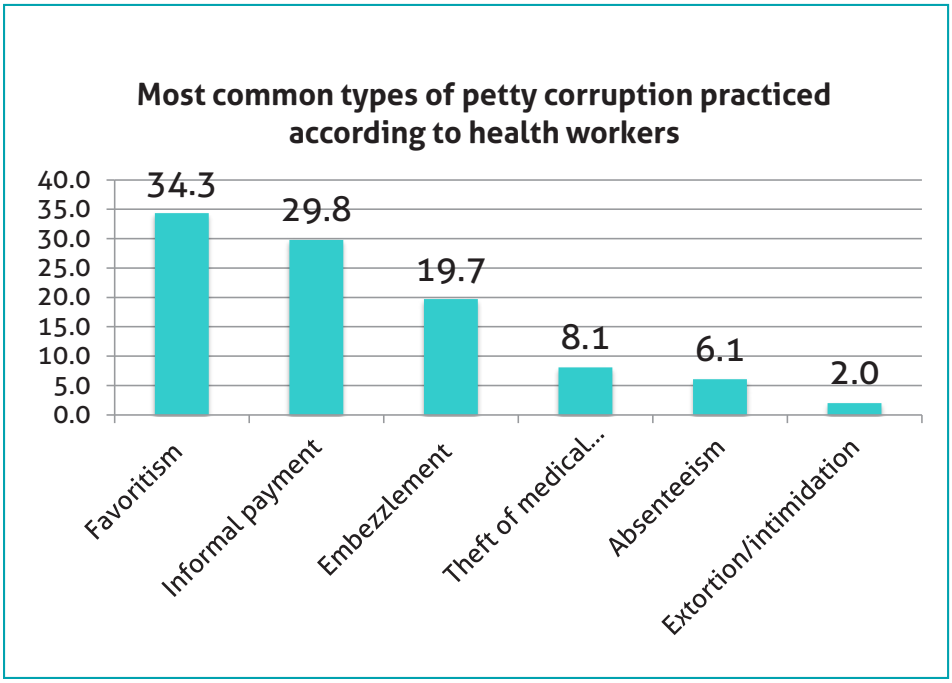


Figure 10: Health workers view of ways to minimize bribery and corruption



3.10 Patients Satisfaction and Quality of Care

- *32% of patients described the length of time they spent in the facility before receiving service was too long.*
- *Overall, 69% of patients were satisfied with the quality of care received.*
- *Majority (83%) of the patients indicated that corruption affect the quality of care they received*

Patients were asked about their satisfaction with the quality of care received using their most recent visit as a point reference. In all, 58% of the patients indicated that the length of time they spent in the facility before receiving service was too long (Figure 11). The highest proportion was from the Upper East (69%) compared to the others. This finding is important as it may provide the evidence for the existence of quiet corruption – a form of corruption that does not involve monetary transactions, but results in services not being provided according to set quality standards ((Sikika, 2015). Despite the long waiting times, overall, 69% of patients indicated that they were satisfied (19% very satisfied and 50% satisfied) with the quality of care they received. Patients in the Northern Region were more satisfied with the quality of care (80%) while patients in the Upper East Region were least satisfied (61%) as shown in Figure 12. This could be an indication that patients place more

importance on the quality of care received than the amount of time spent receiving the care even though they wish for the waiting time to be improved. In the opinion of the respondents, corruption does affect the quality of health services. Majority (83%) of the respondents indicated that corruption affect the quality of care they received with 50% indicating "to a great extent" and 33% indicated "to some extent". More respondents in the Upper West Region (92.3%) indicated that corruption affect the quality of care compared to the other regions (Figure 13).

Figure 11: Patients satisfaction with waiting time

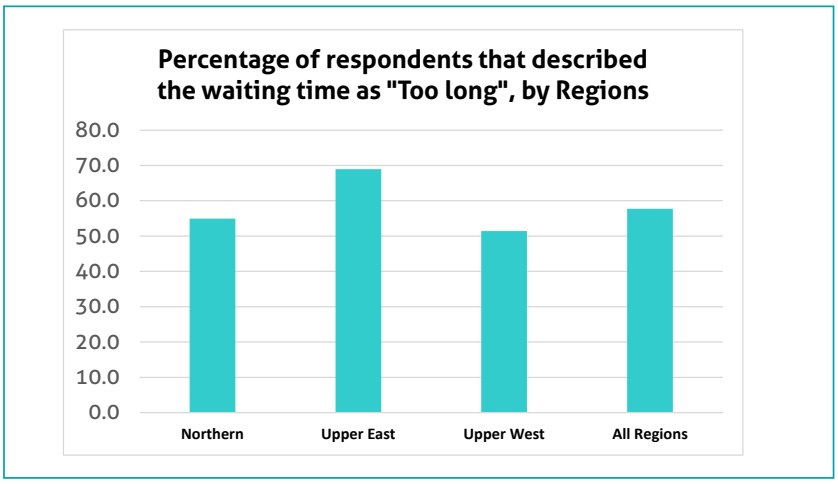


Figure 12: Patient satisfaction with quality of care received

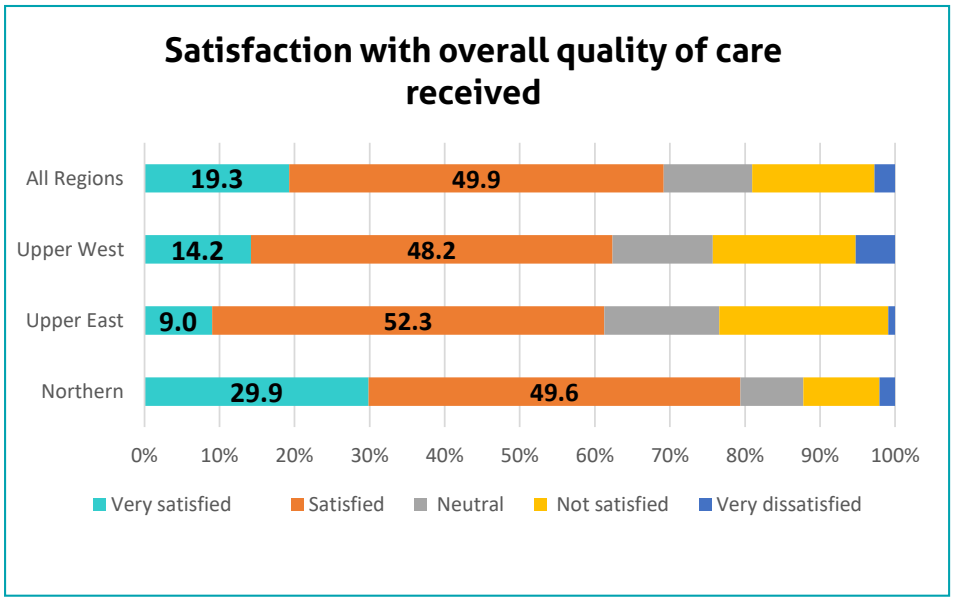
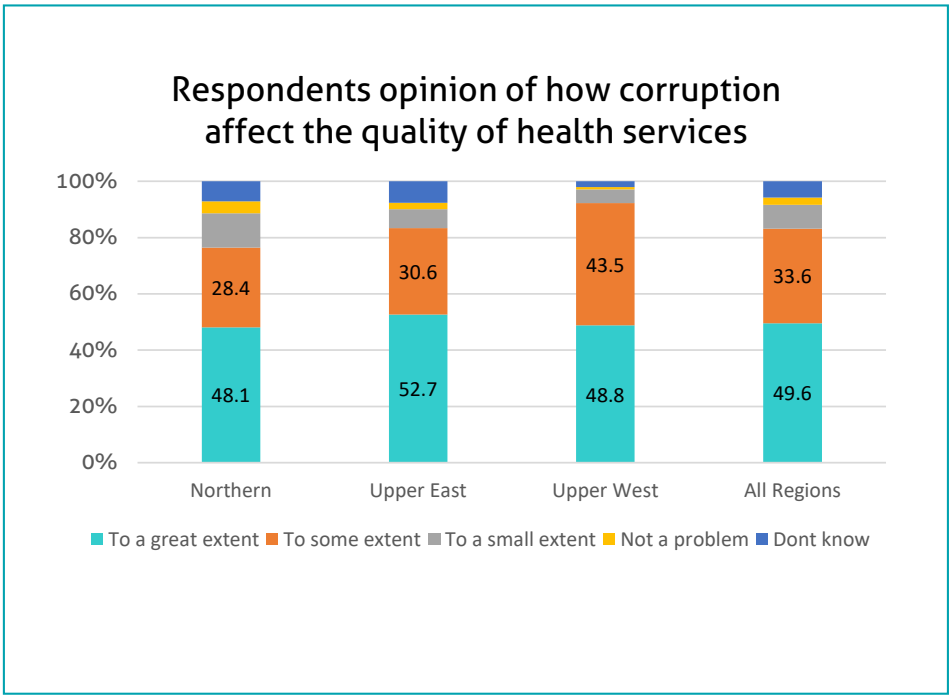


Figure 13: How corruption affects quality of care



4.0 Conclusion and Recommendations

This study sought to examine i) the awareness and practices of corrupt activities at public health facilities by health service providers and users and ii) the effect of such practices on utilization of health services and patients satisfaction in the Upper West, Upper East and Northern Regions of Ghana. It was guided by four specific objectives that sought to:

1. Examine the knowledge of individuals as health care consumers or practitioners on what constitute corruption.
2. Explore the perception of patients and healthcare providers about petty corruptions that occur in health facilities.
3. Assess the magnitude or rate of occurrence of the various petty corrupt practices that occur in health facilities.
4. Ascertain the effects of petty corruption on the delivery of basic quality healthcare services

The study has revealed that knowledge of corruption is high among both patients and healthcare workers. For example, 91% of patients and 89% of health workers agree that informal payment (Receiving payments from a patient without giving a receipt) constitutes corruption. The high knowledge of both patients and healthcare workers is encouraging as good knowledge of what constitutes corrupt practices is the first step in fighting corruption.

However, the high knowledge does not seem to translate to lower corruption cases. There is widespread perception of corruption in the healthcare delivery system. Almost all patients and health workers agree that bribery and corruption is widespread within the healthcare delivery system. Additionally, majority of patients and health workers agree that bribery and corruption is accepted as normal in the delivery of healthcare. Indeed, if this is not checked, in the near future, both the patients and care providers will come

to recognize corruption as normal behavior and institutionalized as part of healthcare delivery. This high perception of corruption has the tendency to lead to mistrust and erode confidence in the health delivery system. For the health workers who work on a daily basis within the health system to have such high perception gives indication that the corrupt practices could be real. There is need for the healthcare system to do lot of work to purge itself of this high corruption perception tag and the acceptance of corruption as normal. Another worrying finding is the fact that healthcare workers themselves admit that providers often overcharge healthcare funders like the national health insurance authority (NHIA) for services provided to patients or charge for services that either were actually unnecessary or not provided at all.

Beyond, issues of perception, some patients have experienced instances of corrupt practices with unofficial/informal payments being top of the list. Unofficial, under-the-table payments from patients to healthcare providers in return for healthcare services in public health facilities is said to be wide spread in most public health facilities. Patients felt helpless with regards to these informal payments as in most instances they either pay before services are provided or they forget about getting the services.

A sizeable number of health workers also admitted ever been involved in corruption or taken bribe thus giving an indication of the size of the problem. Given that corruption is a criminal activity, there is the high tendency for people understating their involvement in corruption and as such the number of health workers involved in corrupt practices could be higher than reported. The widespread perception and experience of corruption could adversely compromise the access and quality delivery of basic healthcare services to poor people mostly pregnant women and children who suffer and in some cases lose their lives needlessly due to corruption related issues in the healthcare sector.

As noted by Deliversky, (2016), corruption in the health sector is a reflection of the structural challenges in the health care system. "Among the key reasons for corruption in the health sector are weak or non-existent rules and regulations, lack of accountability, low salaries and limited offer of services among others" (Deliversky, 2016). This study shows that weaknesses in the governance of health facilities as illustrated by lack/limited supervision, lack/inadequate punishment for corrupt practices, lack/non-functional mechanism to ensure proper reporting and investigation of alleged corruption cases remain the key drivers of corrupt practices. They provide the fertile ground for corruption to thrive. This implies that, if health workers are not supervised and the system for making them answer for their actions or inactions is weak, health workers are less likely to adhere to professional ethics. Finally, the existence of poor governance system as a driver of corruption in public health facilities is further compounded by the lack of citizens' voice in the management of service delivery and fighting corruption. The weak governance of the systems at the various health facilities must be improved. Health facility management must improve supervision of staff, put in place mechanism to help users and workers to report instances of corruption and reduce the long waiting times.

4.1 Recommendations

There is the need to develop and implement interventions and advocacy actions to combat corruption in the healthcare delivery sector in Ghana. There is also the need to strengthen citizens' oversight in the prevention of corrupt practices and demand for accountability in the healthcare delivery systems. Public health sector reforms that ensures that robust systems are put in place to reduce the opportunities for corruption to take and eliminate any potential incentive to engage in acts of petty corruption is most appropriate. Therefore, the Ministry of Health and the Ghana Health Service together with its decentralized Regional and District Health Administrations should take urgent steps

1. Stop all forms of Informal Payments in Public Health Facilities: The GHS should put measures to stop all forms of informal payments across various units/levels of public healthcare delivery in the Northern, Upper West and Upper East Regions of Ghana. All eligible payments due health facilities should be formalized by designating official payment points were all payments are received, official receipts issued to patients for services. Ghana Health Service should develop and enforce clear guidelines to regulate payments in healthcare facilities and criminalize all forms of payments in public healthcare facilities that takes place outside the designated payment points to foster a transparent and accountable payment system.

2. Establish and operationalize a patient's complaint unit with disciplinary codes that allows for speedy investigation and sanctioning of public healthcare workers who are found culpable of engaging in petty acts of corruption in public health facilities. Weak accountability mechanisms and disciplinary action against healthcare workers who engages in petty corrupt practices creates a culture of impunity that allows petty corruption to thrive in public health facilities. All directors and managers of public health facilities should be required to sign performance contracts that entails specific anti-corruption actions and targets that they are require to implement and report on. Holding managers of public health facilities directly responsible and answerable for acts of petty corruption in their facilities could serve as a strategic game-changer in the fight against corruption in public health facilities.

3. Stop health professionals who own and operate health facilities/clinics from full-time employment roles in public health facilities located within the same township/city. The Ministry of Health and the Ghana Health Service should develop and implement bold policy initiatives that stops and prevents owners of private health facilities/clinics from full-time employment roles in public healthcare facilities that are within the same township or city where both facilities are located. The existing policy on Public Private

Partnership (PPP) on healthcare delivery should be vigorously implemented without allowing the conflict of Interest roles where private healthcare professionals undermine public health delivery by virtue of their dual roles as public officers as well as private operators.

4. Stop private sale of medical supplies including essential medicines directly to patients and receiving payments thereof from patients by individual public healthcare officials or acting in concert with private businesses in public health facilities during official hours. Where there is a shortage of essential drugs or medical supplies in a public health facility, the management of the said facility should be directly responsible for arranging and making available the said essential medications within a reasonable time limit to the patients in need.

5. Provide anti-corruption social norms education focused on improving knowledge, attitudes and practices among health workers, patients and care givers: There should be behavior change campaign through the mobilization of citizens and civil society movements for collective action against corruption in public healthcare delivery focusing on addressing the systemic normalization of acts of petty corruption in healthcare facilities. Information, Education and Communication materials should be developed and used to educate patients and health workers alike on how corruption undermines public health delivery outcomes.

4.2 Further Research

1. There is the need for further research to understand how inadequate resources and particularly delay payments from the National Health Insurance Authority influences/contributes to informal payments within the healthcare delivery system

2. There is need for in-depth study to understand why petty corruption still exist despite all the management measures that have been put in place health facilities.

3. There is need also for a comparative study that examines petty corruption in private health facilities as against public healthcare facilities. This will also examine the management systems and best practices that can be learned and shared from the two systems to improve on the anti-corruption reform agenda.

5.0 References

Agbenorku, P. (2012). Corruption in Ghanaian healthcare system: the consequences. *Journal of Medicine and Medical Sciences*, *3*(10), 622–630.

Azfar, O., & Tugrul, G. (2005). Does corruption affect health and education outcomes in the Philippines? *Available at Social Science Research Network*. Retrieved from http://ssrn.com/abstract=723702

BusinessGhana. (2018). Corruption persists in health and education sectors – GII Consortium report. Retrieved December 29, 2018, from https://www.businessghana.com/site/news/general/177060/Corruption-persists-in-health-and-education-sectors-GII-Consortium-report

Deliversky, J. (2016). How Does Corruption Affects Healthcare Sector in Bulgaria. *Journal of IMAB*, *22*(1), 1088–1090. https://doi.org/10.5272/jimab.2016221.1088

Ecorys, & European Healthcare Fraud & Corruption Network. (2013). *Study on Corruption in the Healthcare Sector*. https://doi.org/10.2837/58154

Gupta, S., Davoodi, H., & Tiongron, E. (2000). *Corruption and the provision of health care and education services*.

Institute of Economics Affairs (IEA). (2016). The Roots of Corruption in Ghana.

Lanyi, A., & Azfar, O. (2005). Tools for Assessing Corruption & Integrity in Institutions. *IRIS Center*, (August).

Lewis, M. (2007). Informal Payments and the Financing of Health Care in Developing and Transition Countries. *Health Affairs*, *26*(4). https://doi.org/https://doi.org/10.1377/hlthaff.26.4.984

Maestad, O. (2007). *Informal pay and the quality of health care: lessons from Tanzania* (No. 5/2007) (Vol. 5). Norway.

Pieterse, P., & Lodge, T. (2015). When free healthcare is not free. Corruption and mistrust in Sierra Leone's primary healthcare system immediately prior to the Ebola outbreak. *International Health*, *7*(6), 400–404. https://doi.org/https://doi.org/10.1093/inthealth/ihv024

Rowe AK, de Savigny, D., Lanata, C., & CG Victora. (2005). How can we achieve and maintain high-quality performance of health workers in low-resource settings? *Lancet*, *17–23*(366(9490)), 1026–35.

Sikika. (2010). *Petty Corruption in Health Services in Dar es Salaam and Coast Regions*. Dar es Salaam, Tanzania.

Sikika. (2015). *Institutional Factors Influencing Petty Corruption in Public Health Services in Tanzania*.

Spector, B. I., Johnston, M., & Winbourne, S. (2006). *Corruption Assessment Handbook*. https://doi.org/10.1088/0004-637X/792/2/129

The World Bank. (2010). Africa Development Indicators 2010 - Silent and lethal: How quiet corruption undermines Africa's development efforts. *The World Bank*, 45. Retrieved from http://siteresources.worldbank.org/AFRICAEXT/Resources/english_essay_adi2010.pd

Tijani, H. (2017). Too much fraud in health sector – Minister complains. Retrieved December 29, 2018, from http://citifmonline.com/2017/10/02/too-much-fraud-in-health-sector-minister-complains/

Transparency International. (n.d.-a). What is Corruption. Retrieved December 27, 2018, from https://www.transparency.org/what-is-corruption

Transparency International. (n.d.-b). What is Corruption.

United Nations Development Programme. (2011). *Fighting Corruption in the Health Sector*. New York, USA.

6.0 Appendices

6.1 Patients Questionnaire

Patients Satisfaction and Petty Corruption Survey in Health Facilities in Upper East, Northern and Upper West Regions of Ghana.

Patients Exit Interview

Interviewee ID ..... Interviewer Code..... Date:.....

Region: Northern [1] Upper East [2] Upper West [3]

Facility Type: Health Center [1] Hospital [2] Regional Hospital [3] Teaching Hospital [4]

Take Consent:

Good day! My name is _____. I am here on behalf of CDA-Ghana, NORSAAC & RISE-GHANA, a grass-root Civil Society Anti-Corruption Campaign Coalition to better understand health services delivery in this area.

While nothing you tell us will be shared with anyone other than the researchers, some questions may make you uncomfortable or you may not want to answer a particular question. You are free to skip any question that you are not comfortable answering.

The information gathered will help policy makers design and implement policies to ensure ac-

countable, efficient and equitable public service delivery that meets the needs of the poor and most vulnerable segments of the society.

The information you provide will be treated with the greatest confidentiality and will be protected to the best of our ability. Your name and personal identifiers will NOT be recorded on the questionnaire and in any report. The health facility staff will NOT be made aware of any of your responses. Your honest responses will therefore help to understand the nature and types of petty corruption within the health sector.

Your participation in this research is completely voluntary. Also, you can choose to end your participation at any time during the interview.

At this point, do you have any questions? Do I have your agreement to begin the interview?

___ **YES, consent is given—Proceed to 1**

___ **NO, consent is not given—stop interview**

A. *Socio-demographic Characteristics*

1. Patient type:

a. OPD (ANC [1] PNC [2] Family Planning [3] Emergency Dept [4] General OPD [5] Child Welfare Clinic [6] other [7] (Specify .....)

b. In-patient (Labour & Delivery [1] Surgical [2] Children ward [3] Emergency Dept [4] Other [5] Specify (.....)

2. Age of respondent: Below 20 [1] 20-29 [2] 30-39 [3] 40-49 [4] 50+ [5]

3. Sex of respondent: Male [1] Female [2]

4. Respondent type: Relative/Care taker [1] Guardian (where patient is child) [2] Patient [3] Other [4] specify .....

5. Highest educational level: No education [1] primary [2] Middle/JHS/JSS [3] Secondary/SHS/SSS [4] Post-secondary [5] Tertiary [6]

6. Religion: Christian [1] Muslim [2] Traditionalist [3] other [4]

7. Marital Status: Never married [1] Married [2] Living together [3] Divorced/ separated [4] Widowed [5]

8. Main occupation: Unemployed [0] Peasant Farmer [1] Businessman/women [2] Public servant [3] Other specify [4] .....

B. *Knowledge of corruption*

9. Which of the following actions undertaken by a public official do you consider to be an instance of corruption?"

Actions	Strongly agree [5]	Agree [4]	Neutral [3]	Disagree [2]	Strongly Disagree [1]
General					
To take an informal payment from a citizen for a service provided					
To take a gift from a citizen for a service provided					
To take an informal payment from a company in return for buying its products					
Intimidation of a private citizen or business to obtain money (extortion)					
Stealing funds or equipment from the government (embezzlement)					
Favoritism, that is, showing preference to relatives and other close persons					
Being systematically absent from work for no reason					
Raising the prices of essential items like electricity when people can't pay for it					
Buying goods from foreign firms when domestic firms are operating below capacity					
Health Sector					
Healthcare officials stealing medicines, medical devices and supplies during the distribution and storage process.					
Healthcare officials demanding or accepting gifts and favours from a supplier in return for prescribing or advocating for the inclusion of a product on a product list.					
Healthcare worker receiving payments from a patient without giving a receipt					
Healthcare worker charging a service fee higher than the official rate					
a. Healthcare worker diverting public medical equipment to private clinics.					

b. Healthcare professional using public facilities and equipment to see private patients					
c. Healthcare professionals making unnecessary referrals to private practice or privately owned allied services.					
d. Healthcare professionals reserving beds for themselves, to allocate to patients as they wish					
e. Healthcare providers purposefully do not attend work and do not fulfil their responsibilities despite claiming a salary					
f. Doctors prescribing medicines that they know are not available in Government facilities and advise patients to procure them in their privately owned facilities					

C. *Perception of corruption*

10. How often have you heard/seen or experience any of the following cases in a health facility (in the last one year)?

Cases	Very Often [5]	Often [4]	Less often [3]	Not at all [2]	Don't Know [1]
a. Patient or relatives making payment without getting a receipt					
b. Patients or relatives making payments to get preferential treatment (e.g jump the queue, get better services etc)					
c. Health workers charging a service fee higher than the approved fee					
d. Doctors using public facility and equipment to see private patients					
e. Doctors asking patients to come to their private facility					
f. Patients or relatives making payment to secure a hospital bed					
g. Patients or relative making payment to healthcare worker to secure an appointment					
h. Doctors and other medical personnel insisting on payments before providing treatments/drugs/ surgery to deal with life-threatening medical emergencies.					

a. Healthcare professionals unnecessary referring patients to private practice or privately owned allied services.					

11. To what extent do you think that the practice of giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?

Great extent [4] Some extent [3] Small extent [2] Not at all [1]

12. To what extent do you agree that corruption is accepted as normal in the delivery of health care?

Strongly agree [5] Agree [5] Neutral [3] Disagree [2] Strongly disagree [1]

D. *Experiences with corruption*

13. Have you ever made payments and you were not given a receipt at a public health facility before? Yes [ ] No [ ] No Response [ ]

14. Have you ever made payments or asked to make payment to get preferential treatment (e.g jump the queue, get better services etc) at a public health facility before?

Yes [ ] No [ ] No Response [ ]

15. If 'yes' to question 14, how much were you asked to pay (from your most recent experience)? GH¢.....

16. Have you ever been referred by a doctor to a private practice or privately owned allied health facility before? Yes [1] No [2] Don't know [9]

17. If yes to 16, what services were you referred for? .....

.....

.....

18. Have you ever paid for or asked to pay for services or drugs covered by the health insurance (NHIS) before? Yes [1] No [2] Don't know [9]

19. Have you ever been asked to pay or paid money or gave a gift to help you secure a hospital bed? Yes [1] No [2] No response [8]

20. What other types of corruption have you experienced in a public health facility?

.....

.....

.....

21. If you have been involved in any form of corruption with healthcare workers, what was the motive behind? (check all that apply)

a. Wanted to avoid a long queue [ ]

b. It was a pressure from health workers [ ]

c. Quest to get good quality health services [ ]

d. Poor responsibility among health workers [ ]

e. Wanted to avoid long bureaucratic procedures [ ]

f. Poor living standards among health workers [ ]

g. Poor access to information about my health service rights [ ]

h. I've never been involved [ ]

i. Other [ ] (specify .....)

22. Which of the following health worker do you consider to be most or least corrupt?

Professional	Most Corrupt [5]	Corrupt [4]	Least Corrupt [3]	Not Corrupt [2]	Don't Know [1]
a. Doctors					
b. Physician Assistants					
c. Nurses					
d. Lab Technicians (including X-ray and ultrasound)					
e. Pharmacist					
f. Administrators					

23. Would you want to report corruption if you encountered it? Yes [1] No [2]

23a. If "yes" to question 23, who will you prefer to report to and why?

.....

.....

23b. if "no" to question 22 why not? .....

.....

24. How often have you reported a corrupt health worker to officials of the facility (in the last one year)

Never [0] Once [1] Twice [2] More than twice [3]

If 'Never' to question 24, why? ……

……

25. What do you think are the most common types of petty corruption practiced? (Check all the patient mentions)

- **a.** Informal payment/payment without receipt [ ]
- **b.** Favoritism (Giving preferential service or better treatment to others [ ]
- **c.** Extortion/intimidation to obtain money [ ]
- **d.** Absenteeism of health worker [ ]
- **e.** Embezzlement (stealing funds or equipment from the government) [ ]
- **f.** Theft of medical supplies/equipment [ ]

E. *Effects of corruption*

26. To what extent do you think these are negative consequences of corruption?

Consequences	Great extent [4]	Some extent [3]	Small extent [2]	Not at all [1]
a. Long waiting hours/ delayed service				
b. Limits the ability of the poor and vulnerable to afford necessary medical treatments				
c. Causes the poor and vulnerable to postpone when they first seek medical help resulting in deteriorating health				
d. Depletion of financial resources				
e. Increases economic inequality by siphoning resources away from poorer families				
f. Destroy the opportunity for a meaningful, trusting doctor-patient relationship				
g. Loss of confidence and mistrust in health system				
h. Loss of Credibility by the Health Professions				
i. Petty corruption helps feed other forms of corruption				

27. ……Have you ever sought care outside of a public health facility because of corruption and bribery? Yes [1] No [2] No response [8]

28. If yes to question 26, where did you seek the care?

- **a.** Another public health facility [ ]
- **b.** Private hospital [ ]
- **c.** Traditional medical practice [ ]
- **d.** Pharmacy/Chemical shops [ ]

29. What do you think are the main causes of or contributors to corruption in health service delivery? (Check all the patient mentions)

- **a.** Poor wages [ ]
- **b.** Greed [ ]
- **c.** Pressure from patients (or their family) [ ]
- **d.** Inadequate equipment or supplies [ ]
- **e.** Bribes are socially accepted [ ]
- **f.** Lack of/Limited supervision [ ]
- **g.** Lack of/Limited accountability [ ]
- **h.** Failure to abide to professional ethics [ ]
- **i.** Ignorance of entitlements by service users [ ]
- **j.** Lack of/Limited punishment for corrupt practices [ ]
- **k.** Low probability of detection and prosecution [ ]
- **l.** Nepotism/allegiance to personal loyalties such as family, ethni etc identities [ ]
- **m.** Lack of effective corruption reporting systems [ ]
- **n.** Other [ ]
  (specify .....)

F. *How corruption can be minimized*

30. In your opinion, how can bribery and corruption be minimized in the health sector? (Check all that apply).

- **a.** Increase health workers' remuneration [ ]
- **b.** Improve working conditions [ ]
- **c.** Revamp healthcare education [ ]
- **d.** Educate patients and general community [ ]
- **e.** Engagement of Religious leaders [ ]
- **f.** Punish corrupt official [ ]
- **g.** Education of and regular checks of staffs [ ]
- **h.** Total withdrawal of service [ ]

i. Awareness raising campaigns [ ]
j. Corruption reporting hotlines [ ]
k. Active media and CSOs involvement as watchdogs [ ]
l. ethical training for doctors and nurses during their training [ ]
m. Constitute anti-corruption committees and organise regular seminar [ ]
n. It cannot be minimized [ ]

G. *Perception of the quality of care*

31. How would you describe the length of time you spend in the facility before receiving service (from your most recent experience)? Too long [1] a little long [2] satisfactory [3]

32. How would you describe the overall quality of care received (from your most recent experience)?
Very satisfied [5] Satisfied [4] Neutral [3] Not satisfied [2] Very dissatisfied [1]

33. In your opinion, how does corruption affect the quality of health services?
To a greater extent [4] To some extent [3] To a small extent [2] Not a problem at all [1] Don't know/ not sure [0]

6.2 Health Workers Questionnaire

Patients' Satisfaction and Petty Corruption in Health Facilities in Upper East, Northern and Upper West Regions of Ghana.

Healthcare Staff Questionnaire

Interviewee ID ..... Interviewer Code..... Date:.....

Region: Northern [1] Upper East [2] Upper West [3]

Facility Type: Health Center [1] Hospital [2] Regional Hospital [3] Teaching Hospital [4]

Take Consent:

Good day! My name is _____. I am here on behalf of CDA, RISE-GHANA AND NORSAAC, a grass-root Civil Society Anti-Corruption Campaign Coalition to better understand health services delivery in this area.

While nothing you tell us will be shared with anyone other than the researchers, some questions may make you uncomfortable or you may not want to answer a particular question. You are free to skip any question that you are not comfortable answering.

The information gathered will help policy makers design and implement policies to ensure accountable, efficient and equitable public service delivery that meets the needs of the poor and most vulnerable segments of the society.

The information you provide will be treated with the greatest confidentiality and will be protected to the best of our ability. Your name and personal identifiers will NOT be recorded on the questionnaire and in any report. Your superiors will NOT be made aware of any of your responses. Your honest responses will therefore help to understand the nature and types of petty corruption within the health sector.

Your participation in this research is completely voluntary. Also, you can choose to end your participation at any time during the interview.

At this point, do you have any questions? Do I have your agreement to begin the interview?

___ **YES, consent is given—Proceed to 1**

___ **NO, consent is not given—stop interview**

H. *Socio-demographic Characteristics*

34. Staff category: Doctor [1] Nurse/midwife [2] Pharmacist [3] Allied [4] Administration [5] Physician Assistant [6] Other[ ]

35. Age: Below 20 [1] 20-29 [2] 30-39 [3] 40-49 [4] 50+ [5]

36. Sex: Male [1] Female [2]

37. Highest educational qualification: Certificate [1] Diploma [2] First Degree [3] Post Graduate [4]

38. Religion: Christian [1] Muslim [2] Traditionalist [3] Other [4]

39. Marital Status: Never married [1] Married [2] Living together [3] Divorced/ separated [4] Widowed [5]

40. Duration of service (within the health sector): ..... years

I. *Knowledge of corruption*

41. To what extent do you agree that the following actions undertaken by a public official are instance of corruptions?"

Actions	Strongly agree [5]	Agree [4]	Neutral [3]		Strongly Disagree [1]
General					
a. To take an informal payment from a citizen for a service provided					
b. To take gift from a citizen for a service provided					
c. To take an informal payment from a company in return for buying its products					
d. Intimidation of a private citizen or business to obtain money (extortion)					
e. Stealing funds or equipment from the government (embezzlement)					
f. Favoritism, that is, showing preference to relatives and other close persons					
g. Being systematically absent from work for no reason					
h. Raising the prices of essential items like electricity when people can't pay for it					
i. Buying goods from foreign firms when domestic firms are operating below capacity					
Health Sector					
a. Stealing medicines, medical devices and supplies during the distribution and storage process.					
b. Demanding or accepting gifts and favours from a supplier in return for prescribing or advocating for the inclusion of a product on a product list.					
c. Receiving payments from a patient without giving a receipt					
d. Charging a service fee higher than the official rate					
e. Diverting public medical equipment to private clinics.					
f. Using public facilities and equipment to see private patients					
g. Unnecessary referrals by Clinician to private practice or privately owned allied services.					

h. Healthcare professionals reserving beds for themselves, to allocate to patients as they wish					
i. Healthcare providers purposefully do not attend work and do not fulfil their responsibilities despite claiming a salary					
j. Doctors prescribing medicines that they know are not available in Government facilities and advise patients to procure them in their privately owned facilities					

J. *Magnitude or rate of occurrence*

42. How often do you think these cases occur in health facilities (within the last ONE year)?

Cases	Very Often [5]	Often [4]	Less often [3]	Not at all [2]	Don't Know [1]
a. Unofficial, under-the-table payments from patients to healthcare providers in return for receiving healthcare services.					
b. Healthcare officials demanding or accepting gifts and favours from a supplier in return for prescribing or advocating for the inclusion of a product on a product list.					
c. Officials determining the winner of a tender due to inducements from a supplier or personal considerations between the two actors.					
d. Officials, healthcare providers or other individuals and groups stealing medicines, medical devices and supplies during the distribution and storage process.					
e. Healthcare worker charging a service fee higher than the official rate					
f. Diversion of public medical equipment and supplies to private clinics					
g. Use of public facilities and equipment to see private patients by clinicians					
h. Clinicians making unnecessary referrals to private practice or privately owned allied services.					

i. Healthcare providers diverting patients to private care and use publicly paid for supplies, facilities and time.					
j. Doctors prescribing medicines that they know are not available in Government facilities and advise patients to procure them in their privately owned facilities					
k. Healthcare workers encourage patients to have services or treatments they do not require, in return for receiving a benefit from the party performing the service.					
l. Employment opportunities or promotion are given to healthcare providers based on personal connections and inducements rather than merit.					
m. Healthcare providers purposefully do not attend work and do not fulfill their responsibilities despite claiming a salary.					
n. Healthcare providers overcharge healthcare funders (e.g NHIA) for services provided to patients or charge for services that were actually unnecessary or undelivered.					
o. Healthcare professionals offer preferential service or better treatment to friends, family members or specific groups at the expense of the wider population.					
p. Healthcare professionals reserving beds for themselves, to allocate to patients as they wish					
q. Patients are overcharged by a healthcare provider or health facility for the services they receive, or patients do not receive the level or quality of service they should receive.					

43. To what extent do you think that the practice of giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?

Great extent [4] Some extent [3] Small extent [2] Not at all [1]

44. Which group of health professionals do you think often engage in corrupt practices?

Professional	Very Often [5]	Often [4]	Less often [3]	Not at all [2]	Don't Know [1]
a. Doctors					
b. Physician Assistants					
c. Nurses					
d. Lab Technicians (including X-ray and ultrasound)					
e. Pharmacist					
f. Administrators					

45. How often do your co-health workers that you have worked with engage in corrupt practices?

Never [0] Rarely [1] Sometimes [2] Often [4] All of the time [5]

46. How often have you reported a corrupt health worker to officials of the facility?

Never [0] Once [1] twice [2] More than twice [3]

46a. If answer to question 46 above is 'Never' why?

.....

.....

.....

47. To what extent have you ever been involved with any of the following?

Involved in	Very Often [5]	Often [4]	Less often [3]	Not at all [2]	Don't Know [1]
a. Receiving payments from patient or relative without giving receipt.					
b. Giving preferential service or better treatment to friends, family members					
c. Charging a service fee higher than the official rate					
d. Making unnecessary referrals to private practice or privately owned allied services.					
e. Use public facilities and equipment to see private patients					
f. Do not attend work regularly despite claiming a salary.					
g. Diverting patients to private care					
h. Reserving beds for yourself and allocate to patients as you wish					

48. What percentage (out of 100%) of your co health workers do you think engage in corrupt practices or take bribe? .... %

49. What do you think are the main reasons some healthcare workers take bribes or engage in corrupt practices? (check all that apply)

- **a.** Poor wages [ ]
- **b.** Greed [ ]
- **c.** Pressure from patients (or their family) [ ]
- **d.** Inadequate equipment or supplies [ ]
- **e.** Bribes are socially accepted [ ]
- **f.** Lack of/Limited supervision [ ]
- **g.** Lack of/Limited accountability [ ]
- **h.** Failure to abide to professional ethics [ ]
- **i.** Ignorance of entitlements by service users [ ]
- **j.** Lack of/Limited punishment for corrupt practices [ ]
- **k.** Low probability of detection and prosecution [ ]
- **l.** Nepotism/allegiance to personal loyalties such as family, ethnic etc identities [ ]
- **m.** Lack of effective corruption reporting systems [ ]
- **n.** Other [ ]
  (specify .....)

50. To what extent do you agree that corruption is accepted as normal in the delivery of health care?

Strongly agree [5] Agree [5] Neutral [3] Disagree [2] Strongly disagree [1]

51. What do you think are the most common types of petty corruption practiced? (Check all the patient mentions)

- **a.** Informal payment/payment without receipt [ ]
- **b.** Favoritism (Giving preferential service or better treatment to others) [ ]
- **c.** Extortion/intimidation to obtain money [ ]
- **d.** Absenteeism of health worker [ ]
- **e.** Embezzlement (stealing funds or equipment from the government) [ ]
- **f.** Theft of medical supplies/equipment [ ]

K. *Negative Impact of Corruption*

52. Do you think corruption has any serious negative consequences?

Yes [1] No [2] Don't know [9]

53. To what extent do you think these are negative consequences of corruption?

Consequences	Great extent [4]	Some extent [3]	Small extent [2]	Not at all [1]
a. Long waiting hours/ delayed service				
b. Limits the ability of the poor and vulnerable to afford necessary medical treatments				
c. Causes the poor and vulnerable to postpone when they first seek medical help resulting in deteriorating health				
d. Depletion of financial resources				
e. Increases economic inequality by siphoning resources away from poorer families				
f. Destroy the opportunity for a meaningful, trusting doctor-patient relationship				
g. Loss of confidence and mistrust in health system				
h. Loss of Credibility by the Health Professions				
i. Petty corruption helps feed other forms of corruption				

54. To what extent do you agree with the following statements, due to the existence of corruption in health facilities?

Statements	Strongly agree [5]	Agree [4]	Neutral [3]	Disagree [2]	Strongly Disagree [1]
a. Poor people sometimes experience healthcare from unfriendly health personnels					
b. Poor people sometimes do not get medication at all					
c. Poor people may resort to seeking alternative source of care					
d. Pregnant women do not get maximum attention during delivery					
e. Pregnant women avoid skilled birth delivery					
f. Children do not get appropriate attention from health workers					

55. To what extent do you think the following contribute to corruption?

Issues	Great extent [4]	Some extent [3]	Small extent [2]	Not at all [1]
a. Lack of/Limited supervision				
b. Lack of/Limited accountability				
c. Failure to abide to professional ethics				
d. Ignorance of entitlements by service users				
e. Limited knowledge of patients on bribery and corruption				

56. To what extent do you think the management of the health facility has succeeded in preventing and combating corruption?

a. Don't know/Not sure [1]

b. No efforts made [2]

c. To a small extent [3]

d. To a great extent [4]

57. Who do you think should be responsible for stopping corruption in the health facility? (check all that apply)

a. Management [1]

b. GHS/MOH [2]

c. Government [3]

d. Civil Society [4]

e. Everybody [5]

57a Why .....?

58. What are some of the anti-corruption measures management has taken in your health facility? (check all that apply)

a. Seminars [ ]

b. Meetings [ ]

c. Notice on boards/walls [ ]

d. Suggestion boxes [ ]

e. Special complaints office [ ]

f. Issuing receipts on payments made [ ]

g. No measure [ ]

h. Not aware [ ]

59. Has any group/organization helped to effectively reduce corruption in the health service?

Yes [1] No [2] Don't Know [9]

If yes to question 26, which organization(s). ……..

……

60. In your opinion, which measures can effectively combat corruption in the health sector? (check all that apply)

a. Increase health workers' remuneration [ ]

b. Improve working conditions [ ]

c. Revamp healthcare education [ ]

d. Educate patients and general community [ ]

e. Engagement of Religious leaders [ ]

f. Punish corrupt official [ ]

g. Education of and regular checks of staffs [ ]

h. Total withdrawal of service [ ]

i. Awareness raising campaigns [ ]

j. Corruption reporting hotlines [ ]

k. Active media and CSOs involvement as watchdogs [ ]

l. ethical training for doctors and nurses during their training [ ]

m. Constitute anti-corruption committees and organise regular seminar [ ]

n. It cannot be minimized [ ]

61. In your opinion, how does corruption affect the quality of health services?

To a greater extent [4] To some extent [3] To a small extent [2]

Not a problem at all [1] Don't know/ not sure [0]

COMMUNITY DEVELOPMENT ALLIANCE (CDA-GHANA)

Post Office Box 490 – WA, Upper West Region
Email: info@cdaghana.org Tel: 0208446939

Designed & Printed by **BLUEVYNE LTD.** (Accra)
» 0303 932 712 / 0504 662 121