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Making Anti-Corruption Real

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Irregularities, informal practices, and the motivation of frontline healthcare providers in Bangladesh: current scenario and future perspectives towards achieving universal health coverage by 2030

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Executive Summary

Background

Globally, the health sector faces relatively high risks of corruption for various reasons, including the uncertainty of illness, a multiplicity of actors, the broad range of services that it encompasses and asymmetry of information. Corruption in the health sector often ends up costing lives, or results in impoverishment which impacts disproportionately on poor and marginalised populations. It also leads to erosion of trust in the health system, which is a prerequisite for its effective and efficient functioning.

A rising trend in corruption is noticeable in the low- and middle-income countries of south and south-east Asia, including Bangladesh. Irregular practices include absenteeism, informal payments and bribes, embezzlement, and poor service delivery and regulatory practices. The pluralistic, largely informal nature of the health system serves to make the scenario worse. For the most part, conventional, top-down 'carrot-and-stick' methods have been found to be largely ineffective in curbing such corruption in these countries.

There is thus a need to re-think and re-visit the discourse around corruption in the health sector, with calls for a bottom-up approach. However, in order to design an effective strategy, detailed information is first needed regarding the different forms of health-sector corruption, alongside evidence on what has worked previously to combat irregular practices and how. This systematic review attempts to fill this knowledge gap with respect to Bangladesh, by describing the literature on the nature, extent and effect of corruption in health service provision, as well as relevant national policies and remedial efforts.

Key findings

- There has been a **rising trend in irregularities and informal practices in the health sector in** Bangladesh, both in the public and private sectors, which is evident from the Corruption Perception Index (CPI).
- **Common types of corruption** include: taking 'donations' during admission to private medical colleges; the forced payment of informal fees by health workers to secure public-sector jobs; non-merit-based hiring practices; stock-out of drugs; the use of public-sector medical equipment in private practices; preferential contracts with pharmaceutical companies and laboratories; trading of human organs; absenteeism and private practice during office hours; and payment of bribes for licensing, registration and certification.
- **Divisions within the sector that are susceptible to corruption** include**:** construction of health infrastructure, especially hospitals and clinics; procurement of medicines, medical products and instruments; licensing of pharmacies (medicine shops) and approval of private healthcare facilities. People also experience corruption while seeking and receiving healthcare services due to lack of information, and poor responsiveness of the system.

- The **process of corruption starts** from the recruitment of prospective students in educational institutions, and continues throughout professional postings, transfers, training and promotion.
- The **impact of corruption** is large, particularly on access to healthcare for poor and vulnerable groups. It negatively affects resource use; the costs of treatment, medicines and equipment; quality of care and treatment outcomes; and trust in the health system and service providers.
- **Certain conditions incentivise** corruption**,** including the high cost of medical education, poor salaries and career prospects, lack of transparency and accountability in health-sector expenditure, absence of performance incentives, poor work environments with gender inequalities and political clientelism.
- The **influence of the ruling government and political power** makes law enforcement and anti-corruption agencies weak in the region with anti-corruption agencies unable to act in most of these countries due to political pressure, including in Bangladesh.
- **Micro-level, novel initiatives are** contributing **to efforts to combat health-sector irregularities in Bangladesh,** particularly at facility level. These include community-based monitoring; public dialogue, campaigns and theatre; community mobilisation around complaints and the reporting of complaints in the media; patient welfare committees; school programmes; and community scorecards and health committees. Some examples include the mobilisation and active involvement of community volunteers; advice and information (AI) desks to provide information and advice on key public services; demand-side financing ('voucher schemes'); and improved service delivery through the mobilisation of local communities and resources, and public hearings for complaints.

Recommendations

Based upon the above findings, this paper puts forward recommendations for the short term (around one to two years) for awareness-building and health literacy of patients and care-givers, and holding service providers and facilities accountable to local communities through citizen engagement. In the long term, recommendations are made for institutionalising the process of citizen engagement in the supervision and monitoring of service delivery at various levels, facilitating the exchange of management information between local and central authorities to improve service delivery, and including the subject of irregular practices and relevant ethical codes in the medical curriculum so that healthcare professionals are aware of – and able to avoid and report – corruption within the sector. Regulatory apparatus also need to be strengthened, both in terms of human resources and logistics, to effectively improve the implementation of existing legislation.

Acronyms

ACE	Anti-Corruption Evidence
AI	Advice and information
BDT	Bangladeshi Taka
BMDC	Bangladesh Medical and Dental Council
BRAC JPGSPH	BRAC James P. Grant School of Public Health
BMA	Bangladesh Medical Association
CCC	Committee of Concerned Citizens
CoE-UHC	Center of Excellence for Universal Health Coverage
CPI	Corruption Perceptions Index
CSO	Civil Society Organisation
HMC	Hospital Management Committee
LMIC	Low- and middle-income country
LSHTM	London School of Hygiene and Tropical Medicine
MoHFW	Ministry of Health and Family Welfare
NGO	Non-governmental organisation
NIS	National Integrity Strategy
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis
SHO	Self-help organisation
SOAS	School of Oriental and African Studies
TI	Transparency International
TIB	Transparency International Bangladesh
UNCAC	United Nations Convention Against Corruption
WHO	World Health Organization
WHRAP	Women's Health and Rights Advocacy Partnership

1. Introduction

1.1. Background

Corruption within the health sector can have severe consequences for access to, and the quality, effectiveness and equity of, healthcare services (Muhondwa et al., 2010). It also hampers the successful implementation of interventions to improve health services. Health-sector spending often represents a large share of government expenditure, however the health sector is susceptible to corruption because of asymmetries of information, uncertainty as to when and how resources need to be used, and complexities around accountability mechanisms (Azfar and Gurgur, 2008). This can be particularly evident at the micro- or facility and patient levels where providers often have the freedom to shape what care is available to the population. The behaviour of service providers is central to this debate, as they operate at the frontline of service delivery. Understanding the decision-making process and motivations to engage in corrupt activities is essential to combat corruption, but a significant knowledge gap exists that limits progress.

In 2012, Transparency International (TI) ranked Bangladesh as the 13th most corrupt country globally using the Corruption Perceptions Index (CPI) (TI, 2012). In 2015, the National Household Survey on Corruption in Service Sectors of Bangladesh estimated the annual cost of bribery (unauthorised/informal payments) to be Bangladeshi Taka (BDT) 8,822 crore[1] (US$1.1+ billion), equal to 0.6% of gross domestic product (GDP) and 3.7% of the national budget (TIB, 2016). Of this, health-sector bribes accounted for BDT 57 crore (US$7+ million). Of the households seeking healthcare services, 37.5% faced irregularities and corruption in one form or another, with the average cost of informal payments amounting to BDT 196 (ibid.). The top three services for which informal payments were made include trolley/wheelchair services (54%), wound-dressing services (26%), and surgery (16.5%). The reasons given for making informal payments include: wouldn't receive service without extra payment (44%), didn't know the fee amount (40%), to receive services on time (24%), to receive proper services (23%), and to avoid 'hassle' (11%). The same survey also revealed that around 14% of the households faced irregularities in obtaining medicines (ibid.).

For the recruitment, transfer and promotion of the health workforce under Bangladesh's Ministry of Health and Family Welfare, the following annual costs to the country were reported in a survey by Transparency International Bangladesh (TIB, 2014a): appointment of a doctor on an ad hoc basis, BDT 3-5 lakh;[2] transfer of health administrative officials to Dhaka or areas nearby, BDT 5-10 lakh; transfer of doctors, BDT 1-2 lakh; promotion of doctors, BDT 5-10 lakh.

[1] 1 crore = 10 million BDT.

[2] 1 lakh = 100,000 BDT.

The reasons providers engage in corruption and poor practices are multifaceted. One motivation is to maximise private gain in settings characterised by poor salaries, scarce resources and limited career choices (Savedoff and Hussmann, 2006). Other reasons relate to ineffective management, poor governance, and mistrust between providers and managers. In such situations, provider behaviour is a (often rational) response to regulatory failures and a general lack of law and order in the broader health system (ECORYS and EHFCN, 2013). In addition, social norms, traditions and culturally determined behaviour shape the role of the providers who are very often in reciprocal relationships with other members of the community (Savedoff and Hussmann, 2006).

The focus of this systematic review is on the types and forms, and the institutional, organisational and political causes of corruption in order to identify knowledge gaps that are hampering anti-corruption efforts in the health sector in Bangladesh.

1.2. Relevance and scope of the review

Irregularities and informal practices ('corruption') in the health sector undermine the equitable delivery of quality healthcare services. Therefore, it is important to identify and close potential loopholes within health systems to improve performance. This review identifies common concerns in Bangladesh's health sector, and critically analyses evidence for the categories of frontline healthcare providers and facilities where most detrimental irregularities occur.

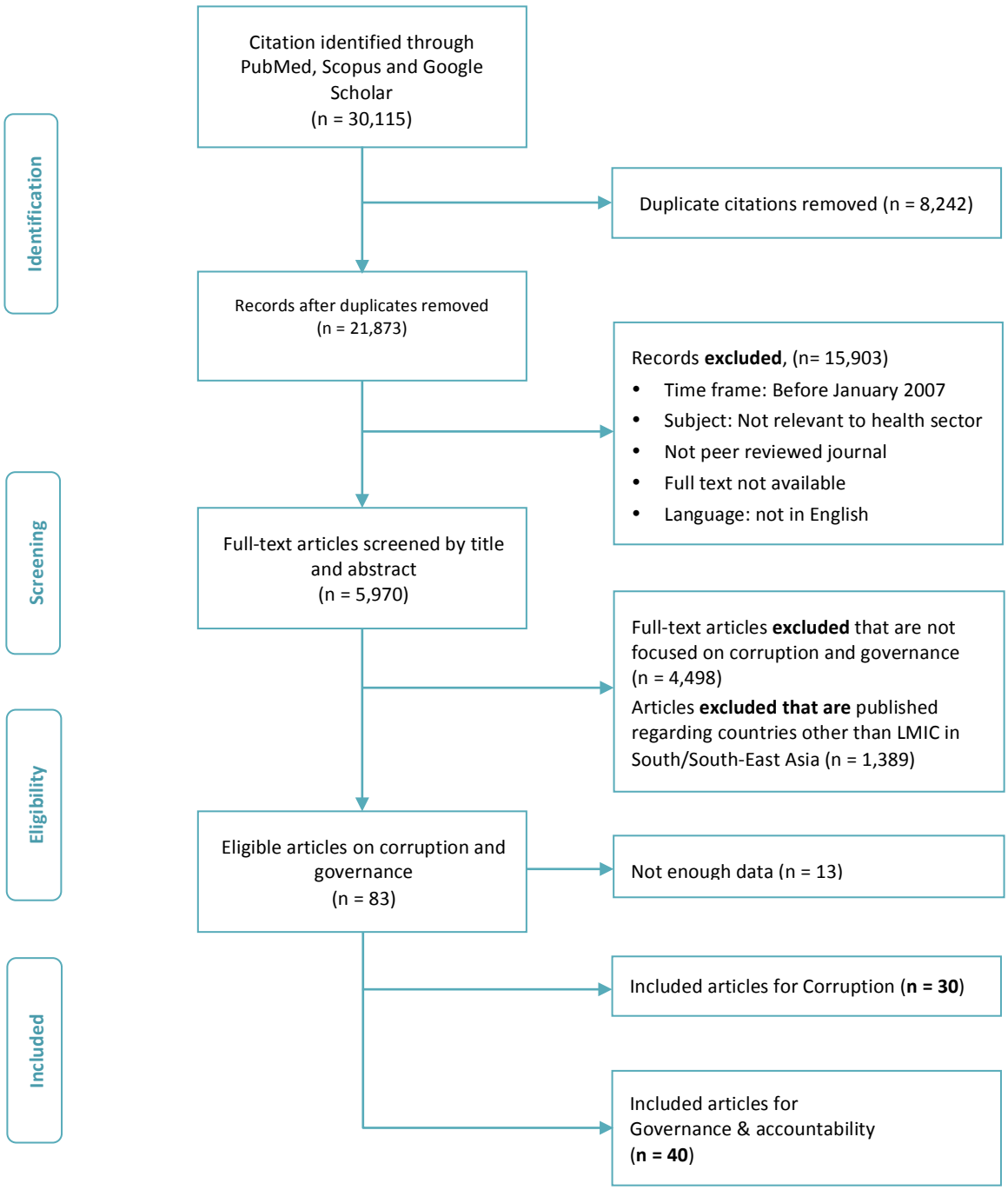
1.3. Methodology

We used a systematic approach to review the literature on health-sector corruption and relevant national policies. A detailed protocol outlining the objectives, key questions, data sources, key search terms, and inclusion criteria was developed.

In brief, all articles published in English from January 2007 to August 2017 on health-sector corruption in the low- and middle-income countries (LMICs) of south and south-east Asia were included for initial scrutiny using *PubMed, SCOPUS* and *Google Scholar*, in addition to relevant grey materials on policies, transparency and accountability from government websites and hand searches of some relevant journals. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) method for screening articles (see Figure 1). Search terms were developed collaboratively between the study partners, and included the following key words: corruption, informal payment, rent-seeking behaviours, bribery, anti-corruption strategy and/or behaviour, governance/good governance and/or accountability in frontline health workers/managers, service providers of health facilities/system, hospitals. The literature search was conducted between 14 September and 15 October 2017, and citations for the journal articles were managed using EndNote X7.7.1 software. Two reviewers identified articles independently from electronic databases and grey literature.

After removing duplicate articles and reviewing the search results for certain exclusion criteria, we screened 5,970 articles by title and abstract. Four reviewers (including the principal investigator) discussed and checked articles for eligibility. In total, 30 papers on corruption and 40 papers on governance/accountability closely related to the study objectives were selected for data extraction and synthesis.

Figure 1: PRISMA flow diagram for selection of articles



2. Context

2.1. A definition of corruption

Corruption is defined as the use of public property and power in a given position for personal gain and benefit (Vian, 2008), and the misuse or abuse of public office or property for private gain (Factor and Kang, 2015; Huss et al., 2011). TI explains that private gain may be either actual or potential (to be realised in the future), and financial or even political (TI, 2015). In the health sector, corrupt behaviour includes misinformation to patients, unlawful activities, excessive medical tests and costs, etc. Corruption can also be defined as abuse of trust and intentional violation of duty (Mostert et al., 2012). Corruption within the health sector can threaten people's lives (TI, 2015), and predominantly affects marginalised people.

2.2. Forms and practices of corruption within the health sector

There are many forms of corruption in the health sector, from informal payments for consultations, 'jumping the queue' for treatment and bribes to obtain medicine. While negligence happens when a medical practitioner fails to provide an expected level of care which results in injury or death of a patient (Mahajan, 2010), nepotism is the unfair use of power to favour someone financially or in the provision of treatment or other services. Descriptions of negligence and nepotism are common in the literature on the health sector in Bangladesh (Chattopdhyay, 2013; Knox, 2009).

Corruption can occur across different tiers of the health system, throughout procurement, the pharmaceuticals and medical supply chain, and health system delivery. Worldwide, 17% of people pay a bribe when seeking medical care in hospitals (Mackey et al., 2016). Petty bribes, absenteeism, the embezzlement of funds and 'kickbacks' (informal commission) are the most common forms of corruption globally. Other examples include the forced payment of fees from health workers to secure themselves public-sector jobs, use of ghost workers to obtain wages and other benefits, frequent 'stock-outs' of drugs and supplies, and patients paying 'under the table' directly to individual service providers (Factor and Kang, 2015). Theft and diversion of resources are also common (Demming, 2017). Nepotism, non-merit-based hiring practices and non-compliance with regulations result in poor governance, which often leads to corruption.

The pharmaceutical industry compounds the problem by bribing doctors to prescribe their brands, while some physicians have set up their own foundations with donations from pharmaceutical companies and have accepted gifts for themselves and their families (Sachan, 2013). Some practices are straightforwardly corrupt, such as selling official positions, kickbacks and theft. However, other practices operate on the margins between private gain and mismanagement and inefficiency (Lewis, 2006). While some of these informal payments are considered 'fair' where public-sector wages are low, socially this is 'corrupt' behaviour. In such cases it is difficult to delineate between the use of regulatory power for the public good and rent-seeking behaviour (Bloom et al., 2011).

Table 1: Common corrupt practices in the health sector

Area	Practices
Administration, including payment, procurement and drugs	• Nepotism and patronage • Taking 'donations' during medical college admission • Health workers forced to pay to secure public-sector jobs and non-merit-based hiring practices • Kickbacks in the construction of medical infrastructure and the procurement of medical apparatus • 'Stock-outs' of drugs • Use of public equipment for private service delivery
Pharmaceuticals and diagnostics	• Preferential contracts with pharmaceutical companies and laboratories
Service delivery	• Poor interaction between patients and providers • 'Under the table' payments • Trading of human organs • Absenteeism and private practice
Regulation	• Bribes for licensing, registration and certification

2.3. Why the health sector is prone to corruption

Many underlying factors make the health system prone to corruption (see Table 2).

Table 2: Factors contributing to health-sector corruption

Factors	Examples
Uncertainty of illness	Who will fall ill and when, treatment options and the allocation of resources
Multiplicity of actors	Providers, patients, suppliers, regulators
Multiplicity of services	Curative, preventive, immunisation, family planning
Information asymmetry	Among different stakeholders of the system
Monopoly and authority	Autonomous authority to make decisions versus monopolies within services and supplies

2.4. Conditions that incentivise corruption

Box 1: Common conditions that incentivise corruption

- High costs of medical education
- Poor salaries, facilities and career prospects
- Lack of accountability
- Absence of performance incentives in the workplace
- Political patronage and high payments (bribes) for recruitment, promotion and transfers
- Lack of community ownership

Lack of effective pluralism and political will are the leading factors in health-system corruption (Holvoet et al., 2013). In developing countries like Bangladesh, health providers' behaviours are not like those of 'Weberian bureaucrats' with good salaries and career prospects. Mostly, their performance is influenced by financial incentives and political patronage, which leads to government system failure (Bloom et al., 2011). Lack of accountability is one of the major causes of corruption, which is aggravated by inadequate management, lack of oversight, poor training and absence of performance incentives (Mackey et al., 2016). Types of corruption can be predicted by indicators such as total household income per month, where a patient lives, gender, and whether payments have been made for prescriptions or referrals to private clinics (Knox, 2009). Communities often perceive oversight of health services as being the responsibility of health managers or the government, rather than their own responsibility (Lodenstein et al., 2016). Communities don't feel the ownership to question or challenge irregularities within the system and they accept irregularities as natural phenomena, and perceive oversight of health services as being the responsibility of health managers or the government.

Corruption is incentivised at the beginning of a medical career. When students are admitted to private medical colleges, they often have to pay large 'donations' to their undergraduate and postgraduate courses. Many families have to sell land, mortgage their property or seek credit to afford these payments. Moreover, it is expensive to study in government-run medical colleges, therefore health professionals have little choice but to earn extra money through informal means. Indeed, healthcare providers in public hospitals in LMICs receive low salaries compared with other public-sector workers (Berger, 2014) – sometimes an average of 10% less – which is a major incentive for people to start private practices and accept informal payments (Mahajan, 2010).

Many young health professionals are posted to rural health centres, but post-graduate or higher degrees pull them back to cities. Staff shortages in rural centres negatively affect the motivation of remaining staff, generate stress and increase the risk of more staff leaving (Hope, 2015). Added to this, many government-run hospitals lack facilities for health workers (especially transportation, accommodation and proper education facilities for their children) as well as adequate security, particularly for female professionals on night duty, which act to increase absenteeism in rural health centres also.

Directors of district hospitals are given great autonomy with regards to the recruitment and promotion of healthcare staff, which can incentivise them to accept bribes for the transfer and promotion of staff. Weak or non-existent regulations, lack of accountability, low salaries, limited opportunities for promotion and inadequate training also incentivise corrupt behaviour (ibid.).

2.5. The impact of corruption

Box 2: Impacts of corruption

- Poor use of available resources
- Inequitable access to and utilisation of healthcare services
- Increased costs of treatment and medicines
- Loss of trust between providers, patients and other stakeholders
- Inefficiency amongst the labour force

Corruption can cause negative outcomes with regards to developmental assistance and the achievement of global health objectives (Demming, 2017). Corruption results in poor resource use and labour-force inefficiencies, loss of trust in public services and organisational legitimacy, reduced competition, and lack of motivation amongst health workers (see Table 4) (Hechanova et al., 2014; Huss et al., 2011). Informal payments, unnecessary treatment, price hikes and poor availability of medicines ultimately affect both poor and wealthier citizens and create barriers to health services (Demming, 2017).

Corruption can increase the cost of treatment if bribes are paid in addition to official fees, which acts to reduce demand for services and may therefore worsen health outcomes (Azfar and Gurgur, 2008). Indeed, countries that have a high incidence of corruption have been found to have higher infant mortality rates (Hope, 2015). According to TI's Global Corruption Barometer 2013, in countries where the percentage of the population who paid a bribe in the past year was 60% or more, the average maternal mortality rate per 100,000 live births was 482 – nine times higher than in countries where less than 30% of the population paid a bribe.

Poor people are disproportionately harmed by corruption, because they cannot afford bribes or private alternatives. Furthermore, inadequate information services can bolster corrupt practices such as unofficial payments for health services (Paredes-Solís et al., 2011) as well as the exploitation of patients who are made to undergo unnecessary tests only to make money for the private health sector.

Widespread corruption and nepotism are persistent challenges to good governance also. Doctor-patient relationships are eroded so that patients no longer trust their physicians (Thappa and Gupta, 2014), and instead rely on pharmacists, some of whom also demonstrate a lack of ethics through the sale of inappropriate drugs and excessive pricing (Berger, 2014). Similarly, corruption can create distrust between government and health service users (Demming, 2017). For example, the people of Liberia perceived their government as corrupt, and as a result they disbelieved health-related information and early warnings of Ebola (ibid.).

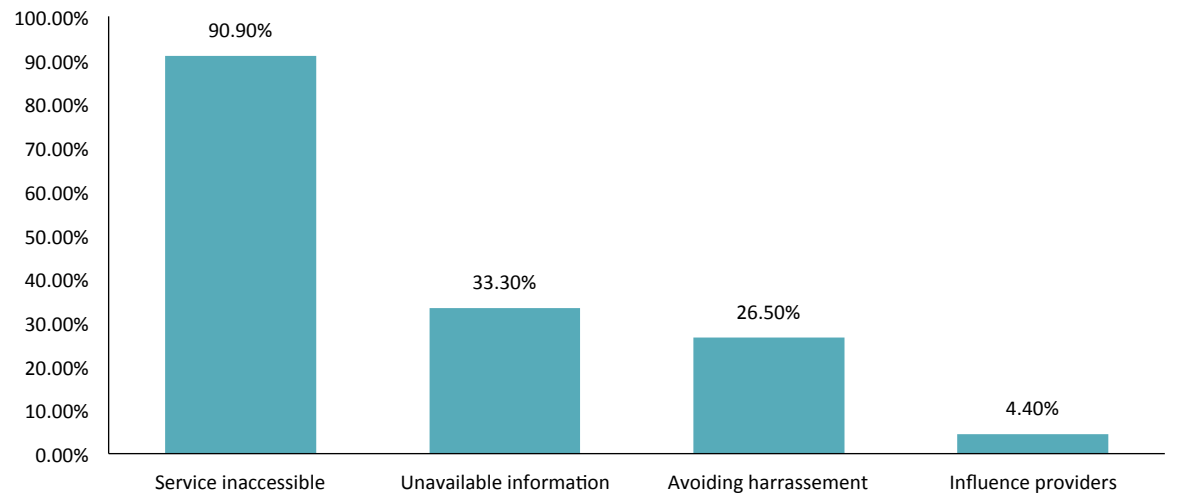
3. Health-sector corruption in Bangladesh

Box 3: Causes of corruption in Bangladesh

- Poor work and living conditions
- Local political pressure and threats to personal safety
- Limits to higher study, promotion and transfers due to political patronage
- Lack of supervision and monitoring in different tiers of the health system
- Poor patient documentation
- Lack of awareness amongst communities about services available

The rate of corruption in Bangladesh's health sector was 40.2% in 2012 and 37.5% in 2015 (TIB, 2016).[3] Reasons for the payment of bribes include that services are inaccessible without bribes (90.9%), lack of information (33.3%), the avoidance of harassment (26.5%) and attempts to influence service providers (4.4%) (see Figure 2).

Figure 2: Reasons for paying bribes in Bangladesh's health sector



Source: TIB (2016)

Among all health service users who responded to the 2015 national household survey, 37.5% faced corruptive behaviour (including bribery (16.7%), irregularities regarding medicine (13.8%), and absenteeism of doctors and nurses (4.8%) amongst other practices (TIB, 2016)). According to TIB (2014a) and Andaleeb et al. (2007), absenteeism, poor quality services,

[3] Measured by % respondents to national household survey reporting that they were victims of corruption.

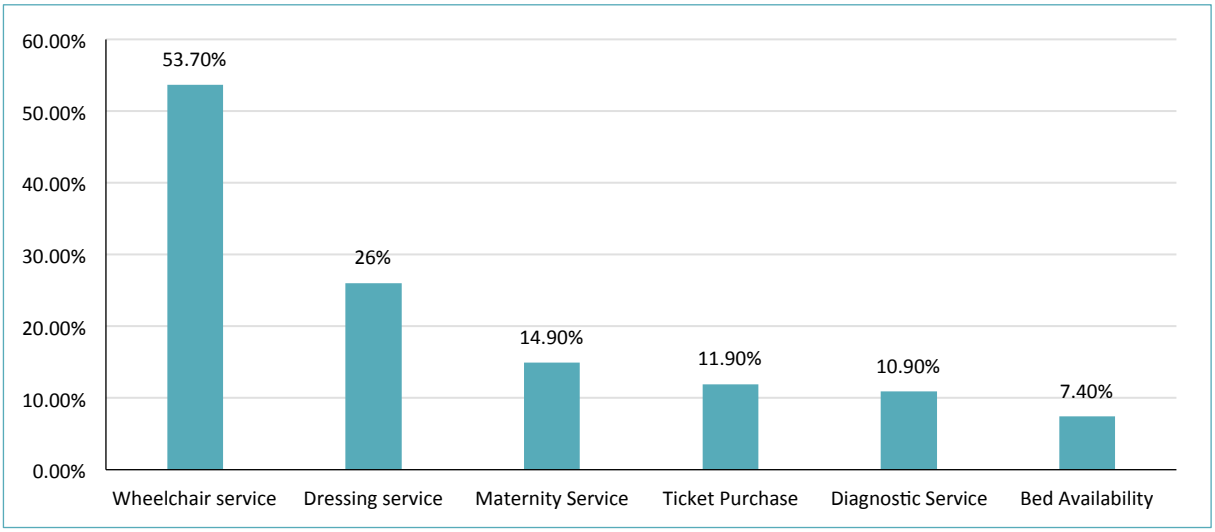
irregularities in getting beds and medicines, the presence of middlemen luring patients to private health facilities, and financial corruption amongst patients and health professionals are pervasive in Bangladesh's health system.

Health service provision in Bangladesh is influenced by party politics, corruption within the Ministry of Health and Family Welfare (MoHFW) and the Directorate of Health, conditions imposed by the Ministry of Establishment and Ministry of Finance, and purported interference by development partners (Andaleeb et al., 2007) – all of which has an impact on recruitment and promotions, budgetary planning and procurement.

It has been reported that the salaries of 379 newly recruited staff nurses were delayed due to failures to pay bribes of BDT 700 each to the Hospital Diploma Nurse Association (*The Kaler Kantho*, 2017). Even then, the nurses had to pay bribes to administrative staff for their release and transfer letters. Such scenarios affect hospital structure and systems of service provision. Feni Sadar Hospital has 250 beds, and positions for 46 doctors and nine consultants (*The Daily Ittefaq*, 2016). At present, 24 positions are vacant and of 21 doctors only five or six of them are working. There are 40 positions for medical technologists with 33 of them vacant, 57 positions for cleaners with 41 vacant, and 15 positions for security guards with nine vacant. Under such circumstances, the hospital is about to close. Appointed doctors do not come to the hospital on time, and most record their attendance only and then return to their private clinics (ibid.).

According to Bangladesh's national household survey for 2015 (TIB, 2016), across all sectors, 58.1% of households have faced corruption in the form of bribery. On average, people paid BDT 196 for healthcare services, with the highest share of households (38%) facing corruption in Upazila Health Complex, followed by medical colleges (35.1%) and district sadar hospitals (33.6%).

Figure 3: Services for which bribes were paid



Source: TIB (2016)

A source from Chittagong Medical College Hospital reported that pregnant women will not be discharged if they are unable to pay a 'Baksheesh' (gratuity) (*The Daily Jugantor*, 2017). This practice is compounded by the absence of patient records and inappropriate systems of discharge (Andaleeb et al., 2007), and results in 41% of patients paying an average of US$2.11 as an extra (illegal) consultation fee for consulting a doctor in a public clinic.

Sometimes 'brokers' force caregivers and patients to admit themselves to private clinics from government-run hospitals. For this, brokers used to receive a commission of BDT 2,000 per patient admitted, and BDT 200 for investigations/diagnostics (*The Daily Kaler Kantho and Daily Jugantor*, 2017). This 'commission business' is another significant form of corruption in Bangladesh's health sector, whereby diagnostic centres also receive huge amounts of money from patients, of which 30-60% is given to doctors (*The Bangladesh Pratidin*, 2017). It has even been reported that doctors have prescribed medicine without any clinical reason, have admitted patients to intensive care units for life support and have prescribed surgery in order to earn money through unnecessary out-of-pocket expenditures by patients (ibid.). Such practices undermine the ethics and morality of the medical profession and result in mistrust by patients and service users. Due to the high costs and poor services in Bangladesh, wealthier patients prefer to go to hospitals overseas for treatment, and consider the travel and visa processing costs as investments in return for higher quality yet less expensive treatment (Andaleeb et al., 2007).

As another form of corruption, discrimination has been observed in the promotion and opportunities for continued studies by doctors within public and private medical college hospitals. Doctors are not promoted or permitted to study unless they are committed to any political party (*The Daily Ittefaq*, 2017). Indeed, the safety of doctors is sometimes threatened by local political influence and pressure, and they may be forced to issue false certificates following harassment by local people (ibid.).

Poor supervision and monitoring across different tiers of the health system, including lack of accountability to local authorities, can promote corruption in Bangladesh. In Rajnagar Upazila Health Complex, healthcare providers are not supervised appropriately by district supervisors, and are disconnected from district-level managers in terms of decision-making and information-sharing (Faguet and Ali, 2009). They are also disconnected from elected Union Parishad representatives. As a result, there is a lack of awareness about health services, high prevalence of disease, facilities that are in poor repair, personnel who lack training, and absenteeism rates of 10%.

3.1. Anti-corruption policy and legislation in Bangladesh

Box 4: Existing legislation and policies that address health-system corruption in Bangladesh

- The Medical and Dental Council Act 1980
- The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance 1982
- Bangladesh Medical and Dental Council, Code of Medical Ethics
- The Public Procurement Act 2006
- Whistle Blower Protection Act 2007
- The Right to Information Act 2009
- The Consumer Rights Protection Act, 2009

For full details of these policies, see appendix 1.

The United Nations Convention Against Corruption (UNCAC) is a global instrument and landmark anti-corruption treaty that was adopted by 181 countries in 2003 to combat corruption and set guidelines for action (Hechler, 2010). Bangladesh's caretaker government adopted the treaty in February 2007, and committed to develop guidelines to deal with corruption at different levels within the country (TI, 2015). Following this, Bangladesh reported gaps in different sectors and the new parliament issued guidance in 2008 on compliance with the treaty (Mostafa, 2009).

The Government of Bangladesh has also ratified the Anti-Corruption Act 2004, the National Human Rights Commission Act 2009, the Chartered Secretaries Act 2010, the Whistle Blowers' Protection Act 2011, the Prevention of Money Laundering Act 2012, and the Competition Act 2012 to promote good governance and combat corruption (TIB, 2014b). We also reviewed other related legislations in Bangladesh, including the Mutual Legal Assistance Act 2012, the Consumer Protection Act 2009, the Public Procurement Act 2006, and the National Health Protection Act 2014 (see Table 6). Despite these initiatives, implementation of the UNCAC has proven challenging in Bangladesh and progress across different sectors is uneven. Generally speaking, we found the legislations to be weak in nature and poorly implemented.

3.2. Anti-corruption initiatives by the Government of Bangladesh

In addition to the legislation detailed above, the Government of Bangladesh has taken strategic steps since 2007 to combat corruption, some of which address irregularities in the health sector (TIB, 2014b).

Information Commission

The Information Commission was established in 2009 to ensure implementation of the Right to Information Act. This Commission oversees the activities of the 'Information Provision Unit' of service-provision organisations, and investigates complaints related to rights to information (ibid.).

Performance Audit System

The Government of Bangladesh introduced a Performance Audit System to evaluate the role and performance of public-sector employees based on mutually agreed indicators (ibid.).

Strengthening Public Expenditure Management program (SEMP)

The SEMP seeks to improve budget-management processes in the public sector and strengthen financial accountability throughout the expenditure management cycle (ibid.).

Citizen Charter

A Citizen Charter was introduced in 2000 following recommendation by the Public Administration Reform Commission (ibid.). Since then, the government has started a second-generation Charter to create a platform for civil servants and citizens to interact democratically and solve their problems related to service provision (ibid.).

National Integrity Strategy (NIS) 2012

As a part of the ratification of UNCAC in 2007, the Government of Bangladesh developed its NIS to combat corruption and ensure transparency, accountability, efficiency and effectiveness of state and non-state organisations. The intention was to give these actors freedom over decision-making and to prevent influence from the ruling party. The vision of NIS is 'a Bangladesh free from corruption', and its mission is 'People and institutions embrace values and principles of integrity, and increasingly practice them as part of their individual and institutional activities'. In 2013 the Cabinet Division – the chief executive body of the government – conducted an independent review of NIS and set guidance for future action (GoB Cabinet Division, 2013). These guidelines cover coordination, monitoring and reporting, and include an action which will be updated on an ongoing basis according to demand.

Comprehensive Social and Behavioural Change Communication Strategy 2016

Bangladesh's MoHFW introduced a strategy in 2016 to support the required social change to improve health outcomes (MoHFW, 2016). This strategy particularly focuses on communicating behaviour change to patients across different tiers of society and the health system (ibid).

Innovations to curb corruption within non-state sectors

Committee of Concerned Citizens (CCC)

TIB set up an intervention in selected areas of Bangladesh to involve communities in anti-corruption efforts and create a participatory social movement to encourage accountability. CCCs were established with volunteers from youth groups and local community people. TIB prepared operational manuals and factsheets, set up advice and information desks (AIs), and organised street theatre to raise awareness about corruption and how it can be addressed. Training was provided to CCC members on social mobilisation, tackling corruption, good governance, networking, marketing, gender, financial sustainability and advocacy. Following this intervention, access, quality levels and demand for health services increased in all catchment areas (TIB, 2018a).

Active engagement of communities and local government

In Saturia Upazila Health Complex in Bangladesh, the rate of staff absenteeism is 1% and the facility is clean, organised and responsive to patients (Mahmud, 2004). The reason behind this success is proper top-down monitoring of staff from the district level, regular interaction between the community and health workers, and active involvement of the Union Parishad Chairman and officials involved in health service delivery. As a result, the population of Saturia suffers less from disease, is aware about existing healthcare provision and actively seeks services from the facility.

In 1998, the GoB decided to establish community clinics to improve utilisation of health services. Both the community and local government contributed financially to the construction and operation of the clinics. Community groups consisting of local government representatives, local service providers and local residents were established to ensure an affordable, accessible, reliable and responsive health service capable of meeting the needs of the community. Subsequently, service utilisation increased to 60%, and women were able to access services without facing barriers. Still, the success of the programme was hindered by issues of poverty, inequalities in power and party politics (ibid.).

Community volunteers

A project has been completed between icddr,b and self-help organisations (SHO) of Chakaria to encourage individual and collective efforts by the community to seek healthcare services and contribute towards participatory planning, monitoring and service delivery. Community members have been trained as health volunteers to produce and disseminate communication materials to raise awareness about available health services. These SHOs have also raised funds for poor people within the community to ensure their proper treatment when needed – schemes which have since been converted into micro-health insurance (Bhuyian and Ribaux, 1997).

Advice and information desks (AI desks)

AI desks provide basic information (e.g. the cost of drugs; surgery hours; examination fees) and advice on key public health services. They also receive reports of corruption, educate the public at the local level on their rights and duties in challenging corruption, provide effective channels for dialogue and feedback on corruption cases, and establish working partnerships with relevant government institutions involved in curbing irregular practices. AI desks are located at CCC offices, with 'satellite' desks placed at schools, hospitals and local government offices (TIB, 2018b).

NariDal (women's group) initiatives

Naripokkho, a women's organisation in Bangladesh, worked with 16 local non-governmental organisations (NGOs) that are members of the Women's Health and Rights Advocacy Partnership (WHRAP) in 14 *upazila* (district sub-unit, equivalent to a county) to improve service delivery systems in healthcare facilities (Centre for Health and Social Justice, 2015). They formed 'NariDals' (women's groups) with 640 active members amongst the poorest and most marginalised women who had good communication skills. Training was provided to enable the women to advocate for their rights and raise awareness through community meetings about available services and payment structures at existing facilities. As a result, women started to seek services at health facilities instead of paying informal fees. At the same, WHRAP committee members visited health centres fortnightly to monitor cleanliness, and the presence and behavior of providers. The committee members then shared their findings in *zila* (districts) and *upazila* coordination meetings. Although the NariDal initiative saw positive results, they faced challenges in obtaining permission to observe within health centres, and an unwillingness by higher government officials to discuss bottlenecks in their facilities (ibid.).

Hospital Management Committees (HMCs)

Every health facility in Bangladesh has a HMC, which consists of health department officials, NGO representatives, local members of parliament, hospital employees, media representatives and well-known citizens. Naripokkho worked with these committees to improve the service delivery system for women specifically (ibid.). HMCs have been found to reduce absenteeism and the practice of informal payments, and to improve patient-doctor interaction. However, the main challenges of HMCs are that members lack knowledge regarding their membership and responsibilities, poor attendance at meetings, funding shortages and a lack of formal authority (ibid.).

Demand-side financing and voucher schemes

Pilots of demand-side financing programmes implemented in 33 disadvantaged districts in Bangladesh have shown promising results for poor households, with maternal health vouchers creating significant purchasing power for patients. While adequate administrative and financial resources have been mobilised for the timely processing and disbursement of vouchers and incentive payments, the initiative has been limited by lack of capacity to deliver local health services (Ahmed and Khan, 2010).

The Chowgacha model

Dr Emdadul Haque, senior consultant of Chowgacha Health Complex of Jessore in Bangladesh, focused his efforts on minimising inequality through local participation. During his leadership of the complex from 1996 to 2012 he helped to develop standard health services in the district and mobilised 46 additional workers from the community to improve the service delivery system. By providing health cards to pregnant women, monitoring services and encouraging uptake, the health complex managed to deliver 52% of babies born in the district within a health facility as opposed to at home, compared to a national average of only 15%. As a result, it was awarded for best performance in emergency obstetric care in the administrative division every year from 2005 to 2014 (Global Health Insights, 2016). The Chowgacha model has shown how improved service delivery can be achieved through financial collaboration between political actors and the community (ibid.)

Dr Haque also initiated community participation in Sadar Hospital of Jhenaidah in Bangladesh to improve service provision there (. In response to his efforts, members of parliament, doctors and townspeople are providing substantial manpower to support the initiative. The Mayor of Jhenaidah is also playing an important role in ensuring hospital cleanliness, security and waste management. This support from different segments of society has proven successful and has contributed to Jhenaidah Sadar Hospital becoming the highest revenue-generating hospital in Khulna Division in 2014 (ibid.).

Public hearings and dialogue

Public hearings are formal multi-stakeholder meetings, where end users raise their concerns regarding public service provision (TIB, 2017). In Bangladesh these have proven an effective tool for improving service provision and combating corruption. The Anti-Corruption Commission conducted 35 public hearings across the country – 30 in *upazilas* within 29 districts and five in Dhaka Metropolitan City – engaging local government representatives, service providers and community people (ibid).

The European Union-supported SHARE (Strengthening Health, Applying Research Evidence) programme and icddr,b assisted local communities to improve its health by connecting people to resources through public health dialogues. Team members engaged with local health managers and healthcare seekers throughout Bangladesh, hoping to encourage deeper public engagement in the health sector (Global Health Insights, 2016)

In line with the principles and strategies of Bangladesh's National Health Policy, public engagement dialogue on health issues can create a platform for collaboration between the public, health managers, policy-makers, researchers and other relevant stakeholders (ibid.). It can give underserved people a real voice in how health services can be improved through local participation, and allow communities to initiate constructive conversations with health managers, government representatives and other stakeholders (ibid.).

3.3. Organisations that facilitate anti-corruption activities in Bangladesh

Table 3: Organisations tasked with facilitating anti-corruption activities in Bangladesh

Government organisations	Bangladesh Medical and Dental Council (BMDC)
	Bangladesh State Medical Faculty
Development partners	World Health Organization (WHO)
	National Association for Medical Education (NAME)
	Center for Medical Education (CME)
	Transparency International Bangladesh (TIB)
	Anti-corruption Commission (ACC)
Professional associations	Bangladesh Medical Association (BMA)
	Bangladesh Nursing Association (BNA)

The Bangladesh Medical Council was established in 1972 to regulate practice and etiquette of medical doctors in the country, and was later expanded to become the Bangladesh Medical and Dental Council (BMDC).

The BMDC is an autonomous body, with executive members selected by the government from amongst parliament and other high-ranked people (Kasturiaratchi et al., 1999). Its function is to oversee ongoing medical practices, standards of practice and education, and to protect the health and wellbeing of the people in the country. The Council is authorised to register all qualified doctors and dentists in the country, assess their medical practices, and take disciplinary action in the case of irregularities. But, inadequate administrative and technical manpower, lack of resources and weak accountability and monitoring mechanisms restrict the BMDC from enforcing their mandate, which can lead to corruption within medical practice. Likewise, the Bangladesh Nursing Council, Pharmacy Council and Bangladesh State Medical Faculty are unable to fulfil their duties to monitor practices in a proper way (ibid.).

The Anti-Corruption Commission is the only agency responsible for monitoring corruptive practices and taking further steps. However, the Commission's structure is weak due to political influence over its chairman and the selection of commissioners, its low coverage of the population (only 40%), and lack of awareness amongst the public about its activities (TI, n.d.).

The Bangladesh Medical Association (BMA) is the elected body and forum to protect doctors' interests and to give advice about medical education and healthcare practices (Kasturiaratchi et al., 1999). The BMA has no authority to take action regarding malpractice and negligence, however.

The National Association for Medical Education represents medical teachers and students, and organises awareness-raising activities on patients' rights and medical ethics. The Center for Medical Education is a WHO-collaborating learning organisation for health professionals to improve, promote and sustain the quality of health professional education in Bangladesh. This organisation aims to deliver continuous professional development through better education, training and research (ibid.).

4. Conclusion and recommendations

Globally, corruption in the health sector has deleterious effects on the development of a pro-poor, people-centered, and equitable and inclusive health system for achieving universal health coverage for all by 2030. Bangladesh also have high level political commitment to achieve universal health coverage by 2030 and ensure health care for all. Evidently, 'business-as-usual' conventional approaches will not combat the problem. The development community needs to devise innovative ways of addressing the various forms of corruption in Bangladesh, by implementing learning from other countries and scaling up some of the anti-corruption initiatives and strategies implemented on a small scale in different parts of Bangladesh.

Based upon our review of corruption and anti-corruption efforts in the health sector in Bangladesh, we put forward a series of short- and longer-term recommendations for action by Bangladesh governments and its relevant ministries, private- and public-sector organisations, development practitioners, and communities and citizen groups of Bangladesh.

Recommendations for the short term (one-two years):

- Every patient and citizen should have access to appropriate information about hospital services and facilities. Citizen charters, web-based health information and resources at the point of service delivery could support access to information.
- Awareness-building activities among patients through public theatre, anti-corruption campaigns, and dialogue and media initiatives would improve knowledge amongst end-users.
- Patient education centres and patient rights groups should be established in every district-level hospital.
- Different stakeholders from NGOs, youth groups and other citizen groups should be engaged regularly to review hospital services and ensure effective hospital management and good governance.
- Existing laws and policies should be implemented fully, with improved supervision and monitoring systems. Central government should increase the number and quality of audits in the health sector.

Recommendations for the long term (beyond two years):

- The active involvement of local government and communities in issues of hospital and patient management could improve service delivery systems.
- Training around different forms of corruption and ethical codes within medical curriculum (at both undergraduate and graduate level) could make healthcare professionals more aware of – and able to avoid and report – corruption within the sector.
- Mechanisms should be developed between central- and local-level authorities to facilitate the exchange of supervisory and monitoring reports, with necessary steps taken to improve service delivery based on the shared information.
- District-level hospitals should be given autonomy around financial resources and the recruitment of doctors, nurses and allied health professionals.
- Key institutions and anti-corruption apparatus should be strengthened and supported by central government to act on cases of corruption in the health sector.

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