

Approaches to teaching and learning about corruption in the health sector

Training and education programmes which deal with the topic of corruption and health can help change the way people approach their jobs as public administrators or development agency workers, and increase transparency and accountability. This U4 Brief summarises experiences and approaches to educating new and experienced public health professionals and donor agency practitioners about how to analyse problems of corruption in the health sector and design strategies to address them.

Importance of training programmes in anti-corruption and health

Better governance in the health sector could have a major impact on health and development. Most people care deeply about their health, and studies have shown citizens in many countries are aware of corruption in the health sector and see it as a problem. Governments and development agents are increasingly trying to understand what works to prevent corruption and improve governance, and books and articles have been written to share lessons learned (Shah 2007; Vian, Savedoff, and Mathisen *in press*).

Sectoral approaches require engaged and well-trained professionals to take action. Yet, often people are uncertain where to start, or how to integrate anti-corruption approaches into ongoing health sector strengthening activities. Most health professionals have had little chance to develop skills in anti-corruption programme design or analysis, and opportunities to talk frankly with experts are few.

This U4 Brief highlights how this can be done. Lessons learned are drawn from educational programmes which have already been developed, including a graduate-level course for Masters in Public Health students, and professional workshops aimed at development agency staff and government officials in several countries.¹ Together, more than 80 graduate students and 110 development agency officials, NGO representatives, and government officials have attended these training activities in five countries.

In describing the programmes, the brief focuses on programme goals and objectives, content, teaching and learning activities, feedback and assessment methods.

In addition, lessons learned are discussed from the perspective of instructors and participants.

Goals and objectives: What do people need to know about corruption?

The overall goals for training in anti-corruption in health are to help people develop the knowledge, skills, and attitudes they will need to identify and understand problems of corruption in health, design anti-corruption strategies, strengthen health systems for good governance, transparency, and accountability, and advocate for integrity in governance. An additional goal is to prepare people to respond to individual experiences they may have with corruption, such as how to react when they suspect someone has engaged in corruption, when they are asked to pay or accept a bribe, or other situations.

Specific objectives for an introductory training programme described below were derived by examining the activities required to achieve these goals, and discerning the information and skills needed for each task. The resulting set of skills and content was distilled into a list of the core competencies required for anti-corruption work, from which learning objectives were developed. Instructors then tailored teaching and learning activities to help people strengthen and develop these competencies through problem-solving exercises, case studies, reading and discussion.

These objectives are similar for less experienced professionals and graduate students, with a few differences. First, participants who lack prior field experience may not understand the context in which corruption occurs in developing countries. For this reason, more focus and time might need to be spent on discussing causes and consequences of corruption, and social or cultural differences in how corruption is perceived. Young professionals may also be more motivated to learn personal skills to cope with individual experiences of corruption, and less interested to learn about systems-level interventions which they may perceive are beyond their control. Evaluating the benefits and drawbacks of whistle-blowing and deciding whether to blow the whistle are objectives one might add to the curriculum for this audience.



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This curriculum would ideally be taught by an instructor who has worked in the health sector and has a strong background in health care management and governance. A health economist or political scientist perspective is helpful for some topics.

Table 1 provides examples of objectives developed for an introductory training programme including about 15 hours of instruction for experienced professionals.

Table 1: Objectives for introductory training programme in anti-corruption and health
Define corruption.
Identify the types of corrupt activities that occur in the health sector, and their scope and seriousness.
Explain why corruption occurs, applying principles of economics, governance, and crime prevention to understand the issues involved.
Assess risks and vulnerabilities which make corruption more likely in certain settings.
Identify the consequences which can result from corruption.
Discuss cultural differences in defining morality and corruption, including the blurred line between corruption and trading favours, giving gifts, using contacts, etc.
Describe the core elements of corruption prevention and control programmes.
Given a particular country situation or programme, explain how corruption can be reduced in drug supply, financial systems, and delivery of health services.
Become an effective advocate for anti-corruption strategies and reforms to promote accountability and transparency in health programmes.

Content

The curriculum content includes three parts: basic background and definitions, corruption theory, and application of anti-corruption strategies, including problem analysis and intervention design.

Basic background and definitions

As an introduction to the topic of corruption in the health sector, people need to understand some basic vocabulary and concepts. People should be able to define the meaning of common terminology such as “grand” versus “petty” corruption, “state capture” and “fraud”. They should be able to describe the background and purpose of key organisations working in this field (for example, the U4 Anti-Corruption Resource Centre, Transparency International, etc.). They also should gain a sense of the “epidemiology” of corruption in the health sector, including the causes and consequences of corruption, the winners and losers – who gains and who is harmed by corruption – and major patterns or types of corruption.

Corruption theory

A theory is a “set of interrelated concepts, definitions, and propositions that present a systematic view of events or situations.” (Kerlinger and Lee 2000) Theories about corruption and anti-corruption specify relationships among factors such as knowledge, attitudes, discretion of government agents, and transparency of institutions, to help predict corruption and identify ways to reduce the likelihood that it will occur. Theory of rational choice, principal-agent theory, and the fraud examiners’ “fraud triangle” theory are examples of models which provide a framework for understanding and addressing the problem of corruption.

Application of anti-corruption strategies

In an introduction to anti-corruption, two specific types of application are most important: problem identification and analysis, and intervention design. First, health care professionals need to understand how they can measure corruption or vulnerabilities to corruption. They need to be trained to identify risks, assess the scope and seriousness of different problems, estimate potential harm, and set priorities for intervention. A good problem definition and needs assessment are essential to inform anti-corruption planning.

The second application skill introduced is intervention design. People are eager to learn what they can actually do to curb corruption and reduce risks in health programmes and across the health sector. To effectively design interventions, they need to know operational and contextual details about what has worked in other countries and what might work in their own country of interest. They also need to understand how an anti-corruption strategy is useful in guiding interventions, how to plan and get support for anticorruption programmes or activities, and how to assess feasibility and adapt programmes for greater probability of success.

Teaching and learning activities

People learn best when they are motivated and active. They are intrinsically more motivated when they are studying topics they have chosen and learning things they feel they need to know. With more senior audiences, therefore, it is critical to focus on analysis of specific problems of systems-level corruption encountered by their own agency or recently in the news. Areas addressed in training programmes should be tailored to interests and felt needs where possible, and may expand on, or differ from, the three problems listed in Table 1. Other topics of interest include absenteeism of health workers, supplies theft, contracting and general procurement corruption, vehicle misuse, or the risks of corruption in situations where user fees are being abolished.

Active learning activities are also critical for an effective anti-corruption training programme. Adult learners bring rich and varied experiences into the classroom, enabling instructors to organise learning around real-life problems, organisations, and events (Knowles, Holton, and Swanson 1998). While lectures can be helpful, participants also need opportunities to apply concepts and integrate what they are learning with what they already know or have experienced. To promote significant learning, it is helpful to provide opportunities to work alone, in pairs, or in small groups on exercises that allow reflection, synthesis, and the human dimension of learning through team work.

People have different learning style preferences, so trainers should try to vary the teaching style approaches used in the course. Some people benefit from written or spoken explanations, while others learn more from visuals such as charts, rubrics, or diagrams. It is therefore helpful to have a mix of lecture, discussion, and individual or team problem solving.

The examples presented below show how particular teaching techniques may be paired with an objective to enrich learning.

Objective: define corruption

Teaching activity 1: “Is this Corruption?”

The “*Is this corruption?*” exercise helps participants to see some of the nuances in defining corruption. For example, is a corrupt act necessarily illegal? Does corruption happen only in the public sector, or can it happen in the private sector as well? Does corruption always “take two” – the person who offers a bribe and one who accepts? What is the difference between a gift and a bribe? This exercise helps promote the discussion and debate which can help to clarify understanding, as the term corruption must be understood within a particular national or regional set of laws and social norms. See Textbox 1. This exercise works for experienced professionals, as well as graduate students.

Objective: Assess risks and vulnerabilities to corruption. Identify the consequences which can result from corruption.

Teaching activity 2: Case study of polio eradication

Case studies are useful in teaching because they provide a chance to analyse a real-life situation and apply theory, without requiring the student to actually collect the data first hand. In the *Polio eradication case study* (Textbox 2), participants learn about a supervisor responsible for engaging and paying vaccination volunteers who is instead siphoning off the funds for herself. After working alone and then with a neighbor to analyse the case, students discuss the case in a large group, exploring questions such as: what is the scope and seriousness of this type of corruption? Who are the “winners” and “losers”? What prevention strategies might be used to make it less likely that the supervisor would do what she did? What could be unintended “side effects” of the anti-corruption strategies you have proposed?

This case study can also be divided into two parts, so that participants first explore vulnerabilities in the initial design of the programme, before learning about

Textbox 1 – Is it corruption?

1. A health officer works in the WHO country office. She is also on the social action committee in her church. She sometimes will use the WHO photocopier to make a few copies of flyers for church events.
2. Country A has a problem with fake drugs in pharmacies. The drugs are produced by unlicensed drug manufacturers and disguised in packaging to pass as approved products.
3. A private pharmacy is located very close to the Provincial General Hospital. The pharmacy is owned by the Medical Superintendent in charge of the public hospital.
4. A nurse accepts a bag of mangos from a patient.
5. The Director of Pharmaceutical Services in the Ministry of Health is offered money in exchange for a list of the names of the people on the Essential Drugs List selection committee.

(Source: U4 [mimeo])

the corruption which has occurred. While the two-part case takes a little more time, it builds skills in exploring vulnerabilities before corruption happens.

Objective: Explain how corruption can be reduced in service delivery

Teaching activity 3: Preventing absenteeism

Following a brief lecture on the different types of incentives and strategies which theory predicts may be effective for preventing absenteeism (for example, hierarchical control, beneficiary control, or demand-side interventions), participants are given a set of mini-case studies and asked to analyse them following principles introduced in a lecture. Textbox 3 (next page) presents one of the mini-case studies. Participants are also given a graphic organiser framework in which they can jot down notes about the characteristics of the intervention, its potential impact, and possible problems which could influence effectiveness. The benefit of this exercise is that students have heard the principles, but it is harder to see them illustrated in an actual case study. Yet, this is what people need to do in the field. Another benefit of the mini-case studies is that they are drawn from empirical research, so we know what really happened and can tell participants after they have analysed the cases themselves.

Feedback from participants

“Before the workshop I thought we were corrupt because we are poor; now I understand that it is actually the reverse” (Participant in Anti-corruption and health training in Armenia).

The anti-corruption training programme using active and cooperative learning methods has been well received by both audiences. Professional audiences appreciated being introduced to a theoretical framework for thinking about corruption, which they felt would help them to plan more effective anti-corruption activities and programme components. They appreciated learning about international experiences and practices, and liked the case studies and exercises where they could practice identifying vulnerabilities and possible solutions.

Textbox 2 – Polio eradication case study

A government polio eradication campaign is being launched in Country B, with support from WHO. The campaign depends on volunteers as local guides and vaccinators. Supervisors are hired and paid \$25/day to recruit the volunteers, explain their tasks and train them, make sure the volunteers have adequate supplies and know where to go, and keep records of work done.

The volunteers are supposed to receive small stipends to defray costs and compensate them for their time. The supervisor is responsible for giving the stipends out. After carrying out a needs assessment and looking at population catchment areas, the campaign has divided districts into communities. In each community area, 10 volunteers will need to be engaged, and each will need to work for 10 days at \$10/day to complete the immunisation campaign.

Maya Santos was hired as a supervisor for Area A. She underwent a one-day supervisor training and learned the requirements of the campaign. Maya would like to make more money than \$25/day, and she sees a way to do it. First, she reduces the number of volunteers hired to 8 instead of 10. She then pays each of the 8 volunteers \$8/day instead of \$10/day. She also has them work only 8 days instead of 10. She turns in her forms stating that 10 volunteers worked 10 days. She receives \$1,000. But she pays the 8 volunteers only \$8 for each of the 8 days worked.

(Source: U4 [mimeo])

Textbox 3 – Rajasthan health clinics

A randomised evaluation was implemented in government health clinics in Rajasthan, India. A member of the community was paid to check once a week, on unannounced days, whether the auxiliary nurse-midwife assigned to the health center was present in the clinic or in the village. A parallel system (a monthly visit by a member of the survey team, on the same day) confirmed that this system of local monitoring was properly implemented: external monitors and community members found similar absence rates. Villagers were allowed to choose how they would use the monitoring information they were generating. It was thought that villagers might choose to put explicit pressure on the nurse-midwife or try to shame her by exposing her absences. They might even promise an explicit reward. The weekly local monitoring system was put in place in 143 randomly selected clinics for eight months. Then, for the next four months, attendance was measured by external monitors carrying out monthly checks in a randomly chosen sample of 80 comparison health centers in addition to the treatment centers. Local monitoring continued in treatment centers during the four additional months.

What kind of strategy is being used to reduce absenteeism? What might be the unintended consequences of this strategy? What do you think happened?

(Mini-case study based on Banerjee and Duflo [mimeo, 6-10])

Some suggestions for improvement which arose from review of course evaluations included:

- 1. Introduce theory.** Especially among experienced professionals, people like to have models that help them to organise their approach to issues. As one development professional said, “I found the workshop valuable because I learned a new framework for thinking about corruption.” Another said, “[d]on’t shy away from theory – it helps us apply general information to specific programmes we may be involved in.”
- 2. Include country-relevant examples.** People attending professional workshops always want more examples from their own context or country. Context-specific examples increase the relevance of course concepts and instill greater motivation and eagerness to learn (Millis and Cottell 1998). Trainers should therefore try to customise materials as much as possible. For example, a training held in Armenia included an exercise to analyse vulnerabilities to corruption in a new maternal health care voucher programme, while a workshop in Malawi considered transparency problems arising from the implementation of service-level contracts between the Ministry of Health and church-affiliated health care providers. It is also good to have handouts in local language, and to make single language small groups in the case where there is a mix of different languages spoken by participants.
- 3. Provide additional resources and mentoring.** Promote learning beyond the workshop by providing a CD, reader, or website of professional reports, articles, web links and other resources. It is helpful if people know where they can

get assistance with programme implementation or to answer technical questions, such as by contacting the U4 Helpdesk available to U4 member agency personnel, or someone from the national Anti-corruption Agency. As one person said after attending a programme “I was going to submit an application for a new programme and I feel now, after the workshop, that I will make some changes to my application, particularly with reference to monitoring and evaluation and indicators proposed.” Having access to problem-solving assistance or mentoring after the training programme can help assure that people use the knowledge and skills they have gained. ■

Conclusion

Well designed education programmes for new and experienced health professionals are an important component of an anti-corruption strategy. Training programmes can help to change attitudes, develop skills and expand vision for good governance in health. They are an important tool in promoting actions to achieve greater transparency and accountability in health programmes, and better health care access and outcomes for citizens in all countries.

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Endnotes

- ¹ The graduate course in Preventing Corruption in Health Programs has been taught at the Boston University School of Public Health for the last 5 years, while the professional education programmes were developed by the Boston University School of Public Health with support from the U4 Anti-Corruption Resource Centre, Belgian Technical Cooperation (BTC), and USAID.