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LEFT BEHIND

Corruption in education and health services in Africa

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Left Behind

Corruption in Education and Health Services in Africa

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LIST OF ACRONYMS

ALAC	Advocacy and Legal Advice Centre
CSO	Civil society organisation
CRA	Corruption risk assessment
DRC	The Democratic Republic of Congo
FGD	Focus group discussion
GII	Ghana Integrity Initiative
GDP	Gross Domestic Product
IFFs	Illicit financial flows
ISDA	Inclusive Service Delivery in Africa
KII	Key informant interview
LGBTI+	Lesbian, gay, bisexual, transgender, queer and intersex
LICOCO	*Ligue Congolaise de Lutte Contre la Corruption* (the Congolese League to fight against Corruption)
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
PHC	Primary Health care Centre
PPP	Purchasing power parity
SAI	Supreme Audit Institution
SDG	Sustainable Development Goal
TII-MG	Transparency International Initiative Madagascar
TI Rwanda	Transparency International Rwanda
TI Zimbabwe	Transparency International Zimbabwe
TVET	Technical and vocational education and training
UHC	Universal health care coverage
UNCAC	United Nations Convention against Corruption
UNGASS	Special Session of the General Assembly against Corruption
UNODC	United Nations Office on Drugs and Crime

EXECUTIVE SUMMARY

- People with disabilities having to pay carers to carry them within health facilities.
- Local leaders selecting undeserving service users for social protection support, at the expense of poor families who need it.
- Officials colluding to put non-existent "ghost teachers" on the books of rural schools, to siphon off already scarce resources.
- Women students being coerced into giving sexual favours to pass the next class, with no repercussions for the perpetrator.

What do all these examples have in common?

The answer is an abuse of power for private gain, that is exclusionary of marginalised groups and deprives them of education and health care they are entitled to.

Corruption undermines the equal access to quality education and health services. The result is the failure of states to uphold fundamental rights and meet basic needs – with women, girls and groups at risk of discrimination shouldering the impacts most severely. Corrupt practices and associated abuses of power deprive millions of people of the opportunities that well-functioning education and health institutions can provide. While this is clearly a human rights issue at the individual level, the aggregate impact on socio-economic development can be ruinous for societies straining to escape the traps of poverty. At the same time, corruption widens the equality gap faced by marginalised groups, and aggravates social exclusion.

To better understand how in practice corruption obstructs access to health care and education for marginalised communities, Transparency International's national chapters in the Democratic Republic of Congo (DRC), Ghana, Madagascar, Rwanda and Zimbabwe conducted corruption risk assessments in these sectors as part of the Inclusive Service Delivery for Africa project. Each chapter selected and studied different functions within the two sectors, largely with an eye to services and operational areas that most impact women, girls and groups at risk of discrimination.

These national-level findings revealed stark common trends, pointing to a multitude of corruption risks occurring across the entire service delivery cycle.

- The most visible manifestations of corruption occur at the point of service delivery, where service providers and users interact, and demands for bribes or illicit extra fees are made. This type of corruption impedes access to basic education and health care, such as where school principals invent and demand registration payments for school enrolment from a family that cannot afford it, or when health care providers demand illicit fees from pregnant women, forcing them to forgo safe maternal delivery.
- However, corruption permeates these sectors far beyond this point. Less visible forms of corruption risks manifest in the use of organisational resources in education and health, such as nepotism sabotaging the fair recruitment of teachers; conflicts of interest and favouritism distorting fair public

procurement processes; "ghost workers" receiving a salary from the state payroll, despite being absent; and staff diverting medical and school supplies from storage facilities. These all negatively affect the quality of services provided and contribute to shortages of essential materials. The financial pressures such shortages cause can, in turn, trickle down and limit people's access to services – for example, where a school restricts enrolment levels due to the lack of desks for students.

+ At the policymaking level, corruption can manifest as large-scale misappropriation of budget funds, and undue influence resulting in the misallocation of education and health expenditures. This has a trickle-down effect on education and health outcomes by causing extreme resource shortages. Such scarcity can undercut reliable payment of providers' salaries, or the ability of education and health services to cater to all users' needs. These scenarios foster competition over resources, which engenders corruption. This, in turn, further disadvantages those whose access to resources is typically limited, such as women, girls and groups at risk of discrimination.

+ Leading drivers behind corruption in these sectors include wide information asymmetries, such as low transparency around prices and regulations, and the lack of consistent enforcement of policies and sanctioning of offenders. The existence of power imbalances between service providers and users can be exploited by providers, meaning users often face pronounced corruption risks at critical junctures where livelihoods are at stake, such as people seeking secure school enrolment for their children, or essential medical treatment.

+ In all five countries, women, girls and groups at risk of discrimination are severely impacted by this state of affairs. While the research did not explore all potential grounds of discrimination, evidence emerges that rurality, poverty, disability status and gender are key vulnerability factors which – both in isolation and when intersecting – heighten service users' exposure to the occurrence and impact of corruption.

+ This occurs directly, but also indirectly – for example, due to the greater reliance of women, girls and groups vulnerable to discrimination on public services, or their relative weaker access to financial resources in many countries. Among other scenarios, researchers documented incidents of parents of children with disabilities being asked for extra fees for enrolment, and users – primarily women and girls – being targeted for sexual corruption (or sextortion). Conversely, it is largely male teachers, doctors and other service providers who abuse their position of power to extract sexual acts from victims – usually with impunity, due to the absence of clear legal frameworks penalising their conduct.

This report demonstrates how service providers and public officials exploit corruption loopholes in education and health systems, resulting in serious human costs to victims. These extend beyond the monetary costs of corruption, to encompasses wide-ranging and long-term social, economic and psychological consequences resulting from poor-quality education and health services or denied access to such services. But there are also examples of resilience, demonstrated by individuals and communities in these five countries who support themselves and each other in circumventing the effects of corruption and seeking accountability for the wrongs they encounter. This should serve as an inspiration for much-needed change.

KEY RECOMMENDATIONS

Inclusive participation

+ Civil society organisations (CSOs) should capitalise on local community and individual resilience to facilitate participatory mechanisms that enable service users to demand transparency, accountability and integrity from education and health actors. They should ensure these communities are given a platform to inform the design of policies that affect them and to monitor their implementation.
+ Competent authorities should partner with local CSOs to address information asymmetries and ensure existing public information campaigns on education and health are adapted to reach marginalised groups; provide accessible information on prices of services and user rights, and encourage service users to recognise and report corruption by service providers.
+ Anti-corruption authorities and CSOs should enable the meaningful participation of equality partners, such as women's organisations and organisations representing other marginalised groups, in the design and implementation of anti-corruption interventions, and ensure that interventions address the needs of women, girls and groups at risk of discrimination.
+ Anti-corruption CSOs should build coalitions with equality partners, such as women's organisations and organisations representing other marginalised groups. Together, these actors can engage with and support these groups in their access to services, as well as advocate for policy responses to corruption in health care and education grounded on the inclusion and empowerment of these groups.

At the point of service delivery

+ Ministries, regulatory bodies and other oversight institutions within the education and health sectors should introduce or strengthen codes of conduct and other policies and procedures with robust anti-corruption provisions and clearly defined sanctions to deter wrongdoing and hold service providers accountable. They should also ensure that anti-corruption indicators are mainstreamed in their assessment of facilities such as schools and hospitals.
+ Service providers such as hospitals and schools should develop corruption risk assessments as part of their internal risk management processes, and implement control and mitigation measures on an ongoing basis.
+ Ethics committees should ensure service providers are thoroughly trained on expected standards of behaviour and their duty of care towards users. They should enforce codes of conduct through regular inspection and by rewarding integrity and sanctioning illicit behaviour.
+ Competent authorities and CSOs within the education and health sectors should create locally accessible, gender-sensitive and inclusive reporting mechanisms. These should enable citizens, especially women and girls, to safely report sexual corruption and other forms of corruption, and ensure every report receives meaningful follow-up. There should be safe, accessible channels that encourage whistleblowers and third parties with knowledge of sexual corruption to report it.

Management of organisational resources

+ National, regional and local governments should maintain high levels of transparency in the disbursement of resources, including through the clear and timely publishing of information on the volume and nature of organisational resources received by service providers. In turn, service providers should publish data on how these resources are distributed, including disaggregation by socio-economic, gender and geographical

indicators, to mitigate against shortages and waste.

+ Competent authorities within the education and health sectors should strengthen oversight systems for storing and transporting material resources. They should facilitate community-based monitoring and auditing of stocks, to improve accountability for public goods and counter risks of embezzlement or diversion.
+ Competent authorities should procure supplies for educational and health facilities in accordance with open contracting and transparent public procurement standards, ensuring that information from pre-tendering, tendering, allocation and implementation stages is published in a timely and comprehensive way. For highly risky procurement processes, such as construction of school and hospital facilities, they should use integrity pacts.[1]
+ Competent authorities within the education and health sectors should ensure merit-based and transparent recruitment and other human-resource (HR) processes, to counter risks of bribery, favouritism and sexual corruption. These processes should include independent assessments and mechanisms to ensure candidates are aware of channels for reporting corruption.
+ National governments should digitalise registration, recruitment and procurement processes in the education and health sectors, to enhance transparency and minimise opportunities for corruption. They should adopt a risk-management approach, to proactively ensure digitalisation does not create new loopholes or further exclude marginalised groups.

National policymaking

+ National governments should ensure that resource allocation for free universal education and health care is sufficient to prevent opportunities for corruption risks. They should consider using alternative funding mechanisms, such as direct transfers, formula funding and grants per capita, to ensure accountability for resources allocated to the education and health sectors.
+ National governments should enable or strengthen robust public participation and civic monitoring in the education and health budget cycles, using participatory budgeting, public expenditure tracking, gender budgeting, social audits and other social accountability mechanisms to ensure oversight of the allocation and use of public funds.
+ Ministries and regulatory authorities should mainstream anti-corruption safeguards and inclusive, equality-based policies into all key processes in the education and health sectors that impact women, girls and groups at risk of discrimination.
+ Competent authorities should create and participate in multi-stakeholder and multi-disciplinary task forces that bring together anti-corruption actors with interest groups representing women, girls and those at risk of discrimination, to ensure continual and inclusive monitoring of and follow-up on corruption risks, and to track the enforcement of policies and legislation.
+ Governments should strengthen the mandate and resources of oversight entities, such as supreme audit institutions (SAIs), to safeguard their independence in auditing the performance of public entities spending education and health care resources. Oversight bodies should ensure that anti-corruption indicators are a key part of their assessment methodology. Such entities should foster collaboration between CSOs in the education and health sectors, to raise relevant, locally identified issues, as well as to disseminate audit reports and ensure monitoring of the required follow-up actions.
+ Governments should invest in the resources and capacities required by competent authorities to ensure anti-corruption policies and laws are not only promulgated, but

actively enforced, including through regular reviews.

+ National governments and parliaments should introduce or amend legislation to prohibit sexual corruption, so that offenders can be prosecuted on the basis of clear legal provisions.

Regional and global policymaking

+ Within regional and global spaces, intergovernmental bodies and international CSOs should advocate for recognition of the discriminatory nature of corruption – including gendered manifestations, such as sexual corruption – as a fundamental threat to effective service delivery and wider progress in development and equality.
+ Regional bodies such as the African Union should establish and operate learning fora within the Global South, and cooperate to collect and disseminate existing best practices in countering corruption in the education and health sectors.
+ Activists and organisations working in anti-discrimination and anti-corruption should foster dialogue and partnerships, in order to lead coordinated efforts against discriminatory corruption.
+ The international community should enhance technical assistance and sustainable development funding to address gaps in the education and health sectors in African countries, conditional on their committing to robust anti-corruption policies and implementing these effectively.
+ Donors should also place strong emphasis on robust, transparent and accountable public financial management frameworks that enable civil society to monitor budget allocation and expenditure, as well as on participatory planning and budgeting approaches involving beneficiaries.

BACKGROUND

Transparency International chapters in Democratic Republic of Congo, Ghana, Madagascar, Rwanda and Zimbabwe carried out corruption risk assessments of education and health care services highlighting the impacts on women, girls and other groups at risk of discrimination.

WHAT IS AT STAKE?

Access to public services is a prerequisite for the fulfilment of many fundamental human rights, and stands at the heart of key development goals and equality aspirations. This holds especially true for the education and health sectors, which offer universally needed public services. These are especially critical for ensuring the wellbeing and progressive inclusion of those living at the margins, such as women, girls and groups at risk of discrimination.

Article 21(2) of the Universal Declaration of Human Rights states that "Everyone has the right of equal access to public service in his country". The rights to education and health are recognised under the International Covenant on Economic, Social and Cultural Rights, among other instruments. Education and health are increasingly recognised as important drivers of economic development and prosperity in Africa.[2] Research indicates that better education leads to better health and vice versa, meaning both positively reinforce each other.[3]

Agenda 2063 of the African Union recognises both as underpinning the aspiration for "prosperous Africa, based on inclusive growth and sustainable development". Similarly, the 2030 Agenda for Sustainable Development builds its third and fourth goals around health and education respectively, and through the principle of "leave no one behind", embraces the idea that sustainable development must focus on addressing discrimination and inequalities.[4]

However, the reality on the ground is very different. Recent data indicates that the international community is lagging behind in achieving the Sustainable Development Goals (SDGs).[5] While notable progress has been achieved in terms of expanding access to quality education and health in Africa, the data also shows there are not only gaps in access to education, but also significant disparities in terms of gender, socioeconomic status, urban or rural location, and other factors.[6,7] Despite the integration of Universal Health care(UHC) as a goal into national health strategies, only 43 per cent of the population in Africa reportedly had access to essential health services in 2021.[8] One study of 36 African countries found that rural women of reproductive age with a low level of education or little wealth were more likely to fall within the 57 per cent without access.[9] In short, many people, especially women, girls and groups at risk of discrimination, are vulnerable to being left behind.

Myriad social, economic and political factors explain this state of affairs, but this report seeks to ascertain whether corruption plays a role, and if so, how and to what extent.

The report is produced as part of "Inclusive Service Delivery in Africa", a four-year regional project implemented by Transparency International in five countries in Africa: Democratic Republic of Congo (DRC), Ghana, Madagascar, Rwanda and Zimbabwe. The project aims to improve access to education

and health care services for women, girls and other groups at risk of discrimination.

CORRUPTION IN SERVICE DELIVERY

"Public service delivery" refers to services provided by governments to their citizens. The state typically delegates the role of service provider to public institutions or outsources to private actors. Local bodies such as hospitals and schools then cater to citizens or service users.
However, in many countries across the Global North and South, corruption obstructs this relationship between service provider and user, rendering the provision of education or health inadequate or even preventing it entirely.

Virtually all major forms of corruption occur in the education and health sectors. In the education sector, typical risks include demands for bribes to access education; nepotism and favouritism in the appointment of teachers; the diversion of funds, and forms of clientelism, patronage and bid-rigging in the awarding of contracts for school supplies.[10]

Similarly, corruption can manifest in various forms in health services. These include bribery to access treatment; inflated pricing; collusion in the procurement of medical equipment; diversion of drugs, and conflict of interest in referring patients to other health providers, among many other forms.[11]

Such corruption comes at a great cost, especially to the potential of education and health to promote development and equality. Various studies have demonstrated that corruption in the education sector tends to increase school dropout and poverty levels, as well as reducing public trust and even promoting civil unrest.[12]It has also been hypothesised that children exposed to corrupt behaviour in schools will be more likely to mimic such behaviour in their adult lives.[13]

In the health sector, the threats are extensive. Corruption and the absent or substandard medicines and treatment it entails, tend to increase child mortality, lower life expectancy and promote antibiotic resistance.[14] Additionally, evidence from 29 African countries indicates that corruption leads to health care deprivation, not only through the loss of income incurred, but because the loss of trust in health services leads those affected to forgo them.[15]

These factors add to income inequality and poverty, which some argue can create traps that cause even more corruption.[16] They can further create cleavages between those who can meet demands for illicit payments or afford access to alternatives, and those who cannot due to their circumstances, which undermines the human right of equal access to public services.[17]

In this sense, corruption risks often impact marginalised and underrepresented segments of the population the most.[18] Women, girls and groups at risk of discrimination are often more dependent on public services, due to biological, social, cultural and economic factors, which heightens their exposure to corruption relative to the general population.

CORRUPTION AND DISCRIMINATION

Access to services is a fundamentally multi-disciplinary issue, making it necessary to explore the intersection of corruption with different topic areas, such as discrimination.

Discrimination

Discrimination is normally found to occur when an individual's enjoyment of their human rights is obstructed on prohibited grounds. The right to non-discrimination guarantees to all persons the right to enjoy all other human rights without discrimination. It protects people from unfavourable treatment or disproportionate impacts on the basis of their identity, status or beliefs (known as "grounds"). Almost every state in the world has accepted non-discrimination obligations through instruments such as the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). These explicitly prohibit discrimination on the grounds of "race, colour, sex, language, religion [or belief], political or other opinion, national or social origin, property, birth, or other status". Non-discrimination obligations are also reflected in various regional instruments. For example, Article 2 of the African Charter on Human and Peoples' Rights (the Banjul Charter) states that "Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or any status".[19] The references to "other status" are significant, as they mean that these instruments encompass other grounds not explicitly listed – for example, gender identity or expression and sexual orientation.

Previous research carried out by Transparency International and the Equal Rights Trust found evidence of a vicious cycle in which corruption and discrimination combine to deny human rights and perpetuate experiences of disadvantage.[20] These phenomena manifest in at least five overlapping and mutually reinforcing ways (see Table 1).

Table 1: The Mutually Reinforcing Dynamics of Discriminatory Corruption

Dynamic	Explanation
Discrimination results in greater exposure to corruption.	Discrimination facilitates corruption, as it incentivises corrupt behaviour on the part of perpetrators to exploit the less powerful, while eroding the ordinary standards that work to constrain such behaviour. This is particularly true where aspects of a person's identity are stigmatised, stereotyped or criminalised. For example, young women may be profiled by health workers for engaging in what is perceived as early sexual activity, and charged for contraceptives that should be provided free of charge. LGBTQI+ people may face extortion by health care professionals in order to prevent the disclosure of their sexual orientation or gender identity.
Certain acts of corruption are directly discriminatory.	In some cases, there is a direct causal link between a corrupt act or practice and the differential or unfavourable treatment of a protected group. In this context, corruption can serve as a vehicle for discrimination, and is often the means by which individuals are conferred or denied access to their rights. An example might include the building of a school in a district populated by a politically dominant ethnic group, or the denial of critical health resources in a region known to support an opposition political party.
The impacts of corruption are felt disproportionately by groups exposed to discrimination.	Corruption is bad for society in general, but its impacts are often felt differently by different groups, for reasons linked to their legally protected status, identity or beliefs. In some cases, there is a direct causal link between a corrupt act or practice and the disadvantage experienced by a community. For example, the embezzlement of antiretroviral medicines by heath workers can lead to drug shortages and higher market prices, with a disproportionate impact on people living with or affected by HIV, who depend on these medicines.
Both discrimination and corruption result in the denial of justice.	The marginalisation faced by groups at risk of discrimination can impede their ability to challenge corrupt practices and respond to violations of their rights. Corruption and discrimination in justice mechanisms can prevent a person who experiences harm from achieving redress.
Corruption impedes the effectiveness of measures designed to advance equality	To address discriminatory corruption, measures to overcome structural inequalities are essential. However, these measures may themselves be vulnerable to corruption. For example, where a school principal misappropriates funds earmarked to make school infrastructure more accessible, children with disabilities are likely to be disadvantaged. In this way, corruption prevents governments from addressing the conditions that embolden corrupt actors and allow them to operate with impunity. These dynamics are constantly at play, exerting pressure at different stages of the corruption lifecycle. Discriminatory corruption is a dynamic process that perpetuates inequality.

Transparency International Chapters in DRC, Ghana, Madagascar, Rwanda and Zimbabwe are currently undertaking research documenting the links between discrimination and corruption in the context of service delivery. We expect to publish the findings of this research in 2024.

INTERNATIONAL RECOGNITION

Although closely intertwined and mutually reinforcing, corruption and discrimination are still largely treated in isolation, meaning the efforts to better understand the links between them and access to services are at an initial stage. However, there is growing international recognition that corruption can both lead to a denial of basic services and cause specific disadvantages to women, girls and groups at risk of discrimination. While the United Nations Convention against Corruption (UNCAC) and the African Union Convention on Preventing and Combating Corruption do not directly refer to provision of basic services, UNCAC signatories stated the following in a political declaration made during the 2021 Special Session of the General Assembly against Corruption (UNGASS):

"We are concerned about the negative impact that all forms of corruption, including the solicitation of undue advantages, can have on access to basic services and the enjoyment of all human rights, and recognise that it can exacerbate poverty and inequality and may disproportionately affect the most disadvantaged individuals in society."[21]

In a 2023 resolution from the 10th Conference of the States Parties to UNCAC, member states recognised that:

"...women and girls have specific and diverse health needs and that corruption can have a negative impact on their rights to access quality and affordable health services, especially for those in vulnerable situations."[22]

In 2024, a report prepared by the Office of the United Nations High Commissioner for Human Rights, ahead of the 56th session of the Human Rights Council, took note of the disproportionate impacts corruption in service delivery can have on women, girls and other groups at risk of discrimination, and issued conclusions and recommendations, stating that:

"Corruption is one of the key challenges to efficient public service delivery. Reducing the risk of corruption in public service delivery requires the increased engagement of rights holders, effective oversight mechanisms and strong institutions, coupled with efforts to increase transparency and accountability that contribute to promoting and building trust in public institutions."[23]

SCOPE AND METHODOLOGY

This report seeks to build on this momentum and break new ground in looking for empirical evidence at the national level on corruption in the education and health sectors that individuals and groups at the margins particularly depend on. It provides insights from national-level research that show how these topics are deeply linked and need to be tackled in conjunction, through targeted interventions.

The report summarises and synthesises the findings of the 10 national-level corruption risk assessments undertaken by five Transparency International national chapters: *Ligue Congolaise de Lutte Contre la Corruption* (LICOCO) based in the Democratic Republic of Congo; Ghana Integrity Initiative (GII); Transparency International Initiative Madagascar (TII-MG); Transparency International Rwanda and Transparency International Zimbabwe.

A corruption risk assessment (CRA) is a diagnostic tool that seeks to identify weaknesses within a system which may present opportunities for corruption to occur. For the purposes of the ISDA project, an advantage of the CRA approach was its ability to trace and document the decision points at which corruption could arise that would reduce people's access to services.

By considering risks, CRAs focus on the potential for corruption, rather than its perception, existence or extent.[24] By assessing a wide range of risks, the CRA is a well-placed tool for research into new sectors or studying the impacts on new target groups.

A CRA also helps identify the risks that need prioritisation and informs the design of mitigation strategies to address them, making its findings fundamentally actionable.[25]

Over the years, many different CRA methodologies have been developed and applied by various researchers. For the purposes of this research project, we took an institution-focused approach, meaning the CRAs aimed to identify weaknesses within processes operated by relevant institutions, such as educational or health facilities.[26] The methodology also uniquely considered the impact of such institutional weaknesses on women, girls and groups at risk of discrimination.

The methodology was informed by a conceptual framework document entitled "Managing Risks to Corruption in the Health Sector", developed by the United Nations Development Programme (UNDP).[27]

Under this methodology, key processes are broken down into different decision points, against which corruption risks are mapped. The term "decision point" denotes that an actor in a position of authority has the responsibility to make a decision intended to serve a specific education or health outcome – for example, a medic's responsibility to make decisions which serve the interests of their patients. However, if the actor behaves corruptly at this decision point – that is, they abuse their entrusted power for private gain – this will typically lead to a decision which does not result in the outcome originally intended for beneficiaries, and can have discriminatory effects.

A high level of precision and detail is required to identify decision points, carry out the analysis and develop targeted mitigation strategies. Education and health facilities operate a vast number of processes that are essential to delivering services, meaning assessing risks across all of them is not feasible. In addition, the most egregious expressions of corruption in these sectors will likely vary across countries and contexts.

Each national chapter therefore chose processes within the education and health sectors to prioritise for the assessment. Some selected processes that they had reason to belief were susceptible to corruption, based on various sources, including literature reviews, expert interviews and previous research they had undertaken. Other chapters prioritised processes on which women, girls and other groups at risk of discrimination rely heavily.

The main steps of the CRA methodology used by the national chapters to identify and assess the corruption risks within each process were as follows:

1. Analyse existing literature and solicit inputs from stakeholders from the health and education sectors to identify processes to prioritise in field research.
2. Conduct field research and collect the data to inform the assessment.
3. Trace the decision points and identify the main actors associated with them, including not only actors who may initiate acts of corruption, but also those liable to be affected.
4. Map out the corruption risks occurring at the decision points, namely the forms of corruption that may arise.
5. For each corruption risk identified for a given decision point, determine the level of risk by assessing two factors: the likelihood of the corruption risk occurring, and the impact it would have if it did. Using the available evidence, the likelihood is estimated based on how frequently corruption risks appear to materialise at the decision point, while the impact is estimated according to the severity of the anticipated effect of corruption at this decision point on beneficiaries – in particular, women, girls and other groups at risk of discrimination.
6. Propose mitigation strategies to eliminate or reduce the corruption risks identified for the decision points.

Each national chapter implemented these six steps and documented them in their national reports.

SCOPE AND METHODOLOGY

The data used as inputs to the CRA was collected through various research methods. Most chapters carried out a literature review of national policies and legislation in order to map sectoral processes and decision points. They also implemented field research, primarily qualitative, targeting actors involved in or familiar with these processes. This included key informant interviews (KIIs) with service providers and public officials, and focus group discussions (FGDs) with service users. Some chapters also carried out large-scale surveys. These methods were used to solicit testimonies from respondents on their experiences and perceptions of corruption within the studied processes, as well as to document impacts on affected groups. In many cases, testimonies alluded to personal or second-hand experiences of corruption, indicating that many corruption risks are not hypothetical but do materialise in practice.[28]

Chapter researchers also drew on data collected by Transparency International's Advocacy and Legal Advice Centres (ALACs). The ALACs empower people and communities to safely report corruption they experience or witness, and provide advice and support for those seeking redress. Complaints received or processed by ALACs relating to the health or education sectors were a valuable source of anecdotal information on the prevalence and forms of corruption in these areas. The researchers used ALAC data in anonymised, aggregated form in the corruption risk assessments. Some chapters also used it to select priority research areas.[29]

RESEARCH LIMITATIONS

The researchers heard and documented a range of testimonies and views on corruption in the education and health sectors, which form most of the evidence presented in this report. They were unable or did not attempt to confirm the veracity of each testimony or view expressed by participants. However many, if not most, of the testimonies presented in this report reflect views expressed by multiple respondents.

In order to allow chapters to take a tailored approach to studying their specific priority areas in line with local needs, we decided not to use a harmonised methodology for data collection. This implies that a direct comparison of the data and risk levels between countries is not possible. However, common trends did emerge from the different studies.

While each chapter's research yielded sufficient data to carry out a risk assessment, some faced challenges in gaining access to key respondents. Among service providers, many individuals approached to participate in the research declined to do so, often because corruption and discrimination were perceived as sensitive topics and they feared reprisals for discussing them.

Some chapters were refused authorisation to carry out research within public facilities such as hospitals and schools. While the reasons for refusal were not explained, corruption in the education and health sectors appeared to be an acutely sensitive political issue in some countries, and one with which public officials were very reluctant to engage. Other chapters experienced a lack of responsiveness from public officials due to the research coinciding with electoral cycles and turnover of ministry personnel, as well as complex bureaucratic processes involved in obtaining necessary clearances to conduct fieldwork.

In terms of accessing service users, most of the chapters faced challenges identifying or interviewing members of certain groups at risk of discrimination. This included, notably, members of the LGBTQI+ community, who are persecuted in many of the target countries, and may therefore be understandably reluctant to engage in research of a sensitive nature. Some chapters intended to document the experiences of migrants and refugees, but were unable to gain authorisation to access displaced persons' camps. However, the relative lack of coverage of such groups in this report should not be interpreted as meaning they are less vulnerable to corruption. For example, evidence suggests that the need for the LGBTQI+ community to go "underground" in response to persecution can expose them more severely to corruption.[30] There is therefore a pressing need for further research in more amenable settings to document these groups' experiences.

STATE OF AFFAIRS

This section provides an overview of how the five target countries perform on indicators measuring corruption, as well as education and health standards.

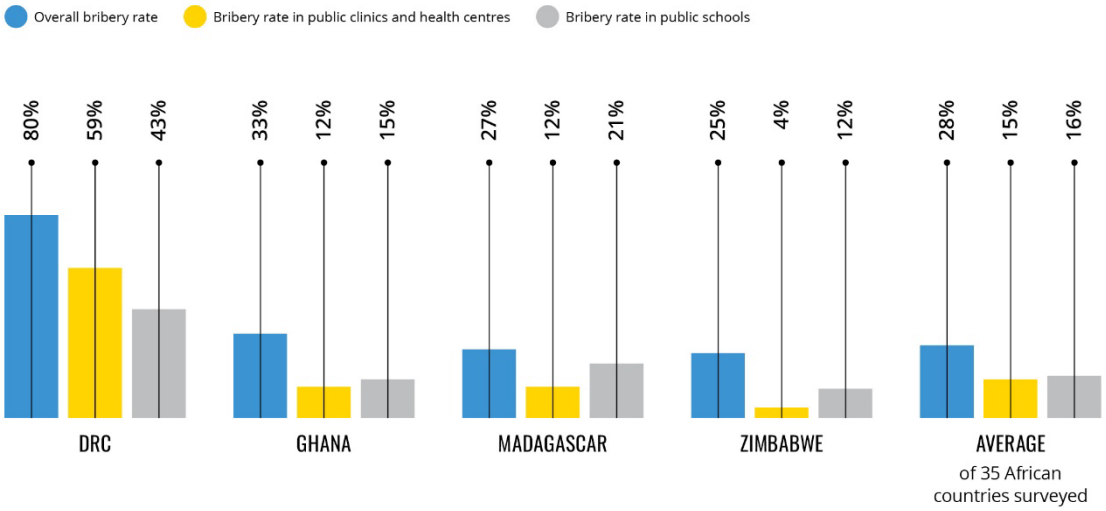
The extent to which corruption deprives marginalised people of access to health care and education in each of the target countries is influenced by contextual dynamics. This can be gleaned by considering the level of public expenditure provided for these services, key performance indicators for health care and education outcomes, and the incidence of corruption affecting the general population.

The five countries generally perform below the global average, in terms both of the level of estimated corruption and of education and health standards. However, a comparison of relevant indicators reveals considerable differences between them.

CORRUPTION INDICATORS

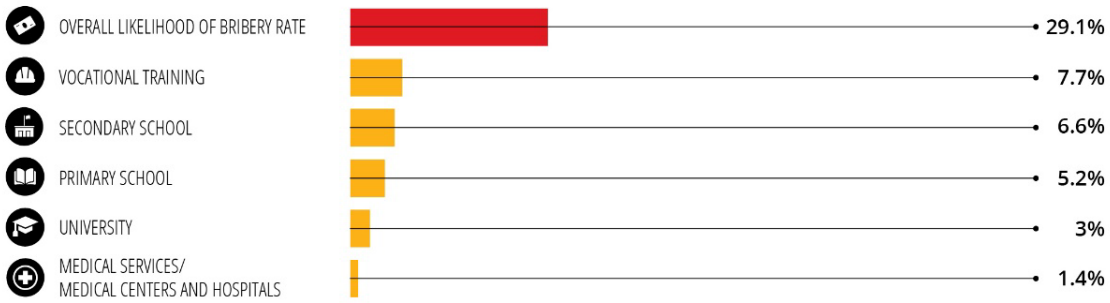
Existing evidence suggests that the five ISDA target countries demonstrate widely different levels of corruption in the education and health sectors. Transparency International's 2019 *Global Corruption Barometer* asked people who had used certain public services within the previous 12 months whether they had paid a bribe, given a gift or done a favour in order to access that service. As shown in Figure 1[31], the overall bribery rates recorded for the education and health sectors in four of the five ISDA countries were fairly close to the African average. The exception was the DRC, which recorded a much higher bribery rate. The picture becomes more nuanced when considering sector-specific bribery rates. With the exception of DRC for both sectors, as well as Madagascar for the education sector, the bribery rates tend to be below the African averages.

FIGURE 1: GLOBAL CORRUPTION BAROMETER 2019



Asking similar questions to respondents who used public services in 2022, TI Rwanda found that the bribery rate was generally low in the health sector and somewhat higher in the education sector (see Figure 2[32]).

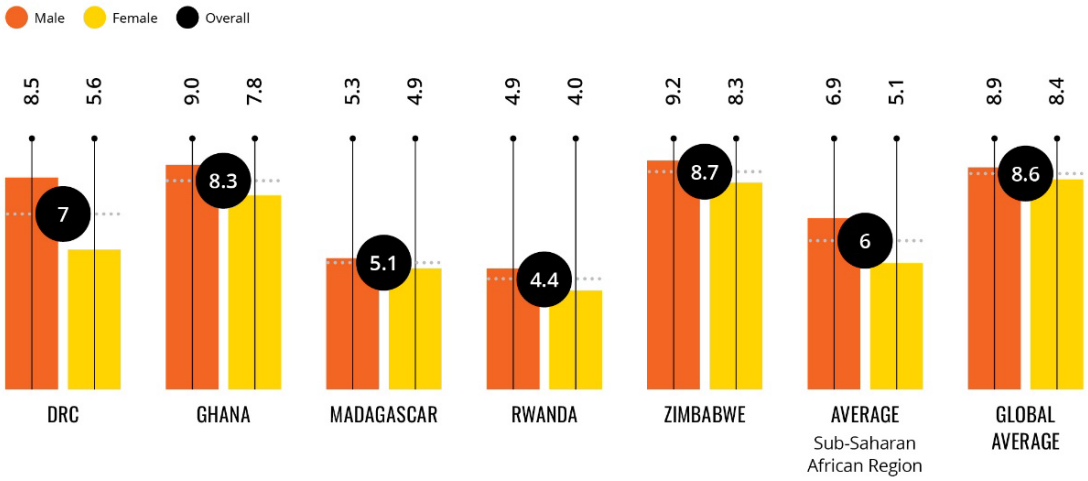
FIGURE 2: RWANDAN BRIBERY INDEX 2022



EDUCATION INDICATORS

There are also recorded disparities in the levels of access to education across the five countries. Statistics sourced for the 2021 UNDP Human Development Report indicate that residents of DRC, Ghana and Zimbabwe generally attend school for longer than the regional average, while this is generally shorter for residents from Madagascar and Rwanda. In all five countries, women and girls have fewer years of schooling on average than men and boys (see Figure 3[33]). This indicates that their access to education may suffer more than that of their male counterparts in the event of disruption.

FIGURE 3: UNDP HUMAN DEVELOPMENT REPORT: MEAN YEARS OF SCHOOLING BASED ON COMPARABLE ESTIMATES



In some African countries, access to education is conditional on payment of school fees, which are meant to cover operational costs. In many other countries, while enrolment itself has been declared free, other financial barriers exist, such as payments for school materials. Data collected by Global Findex indicates that 54 per cent of adults in Sub-Saharan Africa were very worried about paying for the education of their children.[34]

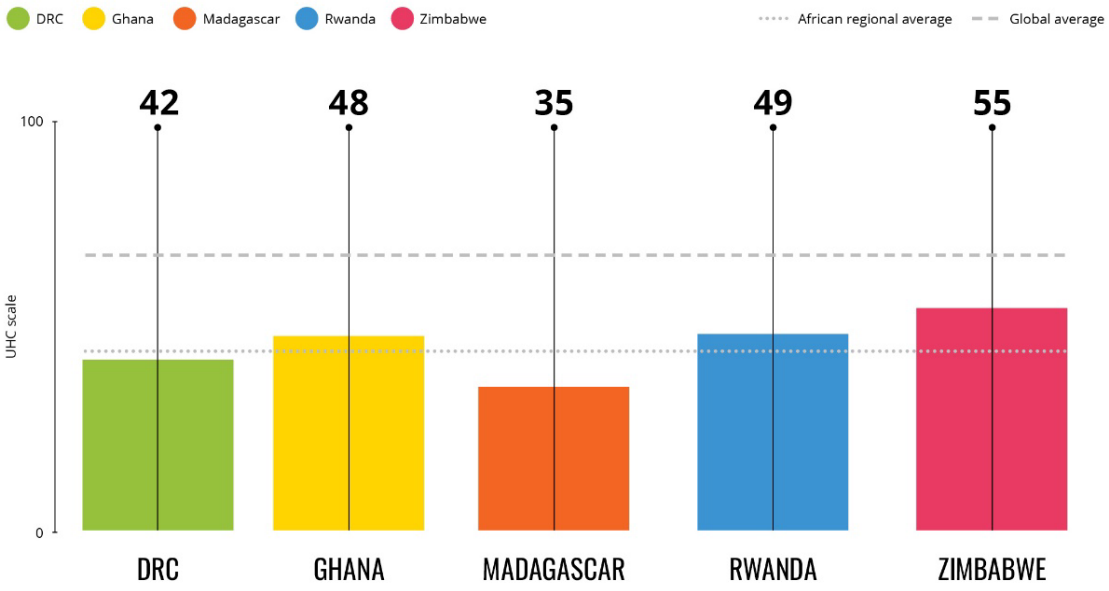
HEALTH INDICATORS

In terms of access to health, the World Health Organisation (WHO) has estimated varying levels of coverage of essential health services in the five target countries. The WHO's UHC Service Coverage Index assesses "average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population". The index accounts for differences between the general population and the most disadvantaged population, meaning it serves as a measure for equitable access to essential services.

DRC and Madagascar were below the African regional average, while the other three countries were above, although all were below the global average (see Figure 4[35]).

The gaps in UHC mean that the private sector often plays a prominent role in health care in the African region. For example, it has been estimated that private for-profit providers and informal private providers deliver up to 35 per cent and 17 per cent of outpatient care respectively.[36]

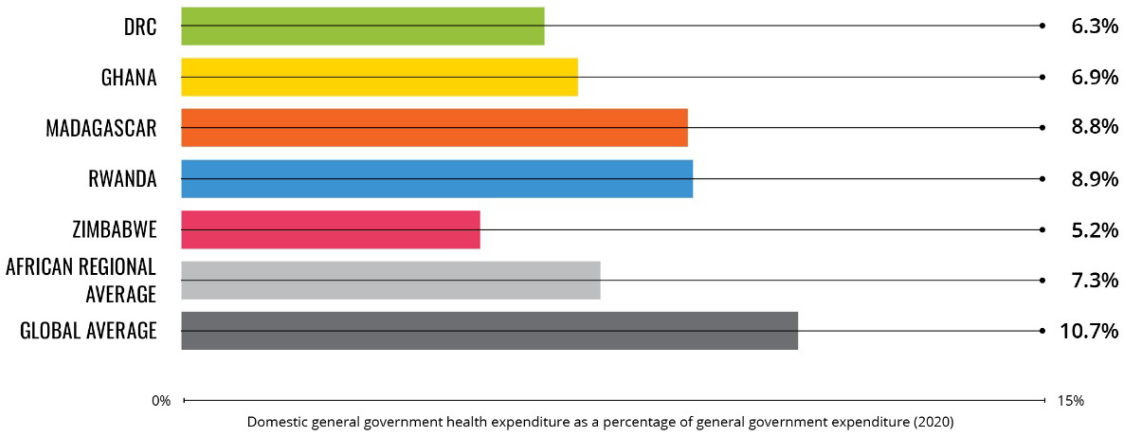
FIGURE 4: WORLD HEALTH ORGANISATION: SERVICE COVERAGE INDEX BASED ON COMPARABLE ESTIMATES FROM 2021



RESOURCE ALLOCATION INDICATORS

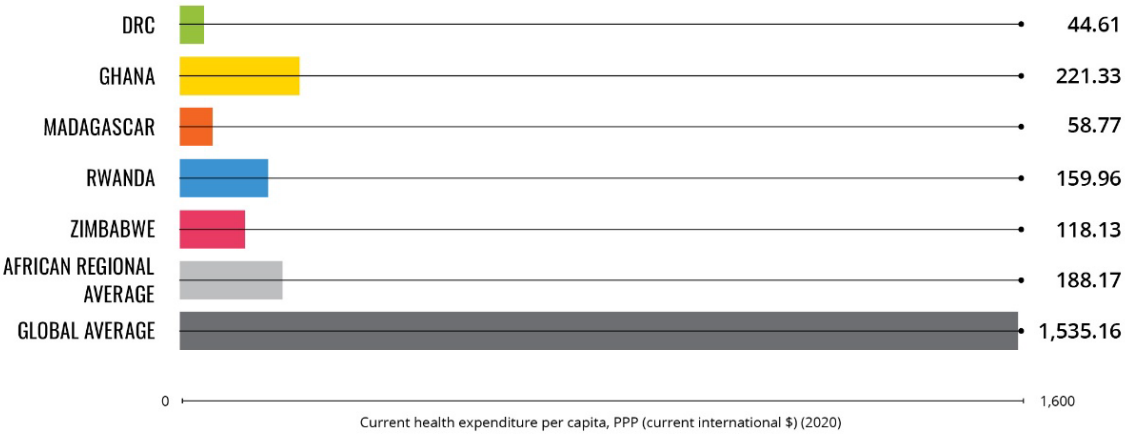
Data indicates that the education and health sectors receive different levels of government funding relative to overall government expenditure across the five countries. In terms of health expenditure, all five countries are below the global average, but two are above the African regional average. All countries fall short of the 15% spending target set by the African Union (AU) in the 2001 Abuja Declaration.[37] It should be noted that even in countries with higher levels of allocation to one sector, this may be insufficient to meet population needs, due to low overall rates of government income and expenditure. For example, although Madagascar allocates 8.8 per cent of government expenditure to health care (see Figure 5[38]), dollar spending per capita on health care is substantially lower than in Ghana, which spends 6.9 per cent of the government budget on health.

FIGURE 5: RESOURCE ALLOCATION TO HEALTH (PERCENTAGE OF GENERAL GOVERNMENT EXPENDITURE)



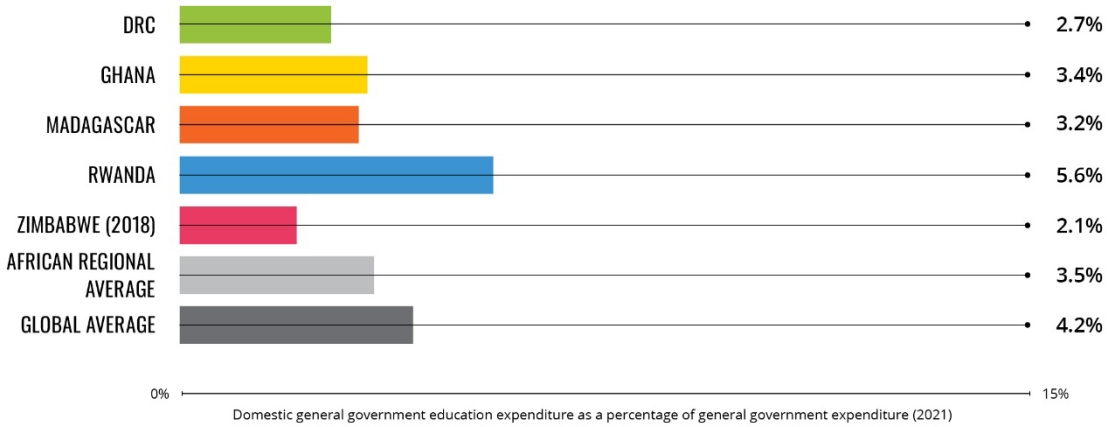
When health care spending per resident is adjusted for local living standards and prices across the five counties using purchasing power parity (PPP), it is clear there is a wide gulf between them (see Figure 6[39]).

FIGURE 6: RESOURCE ALLOCATION TO HEALTH (PPP PER CAPITA)



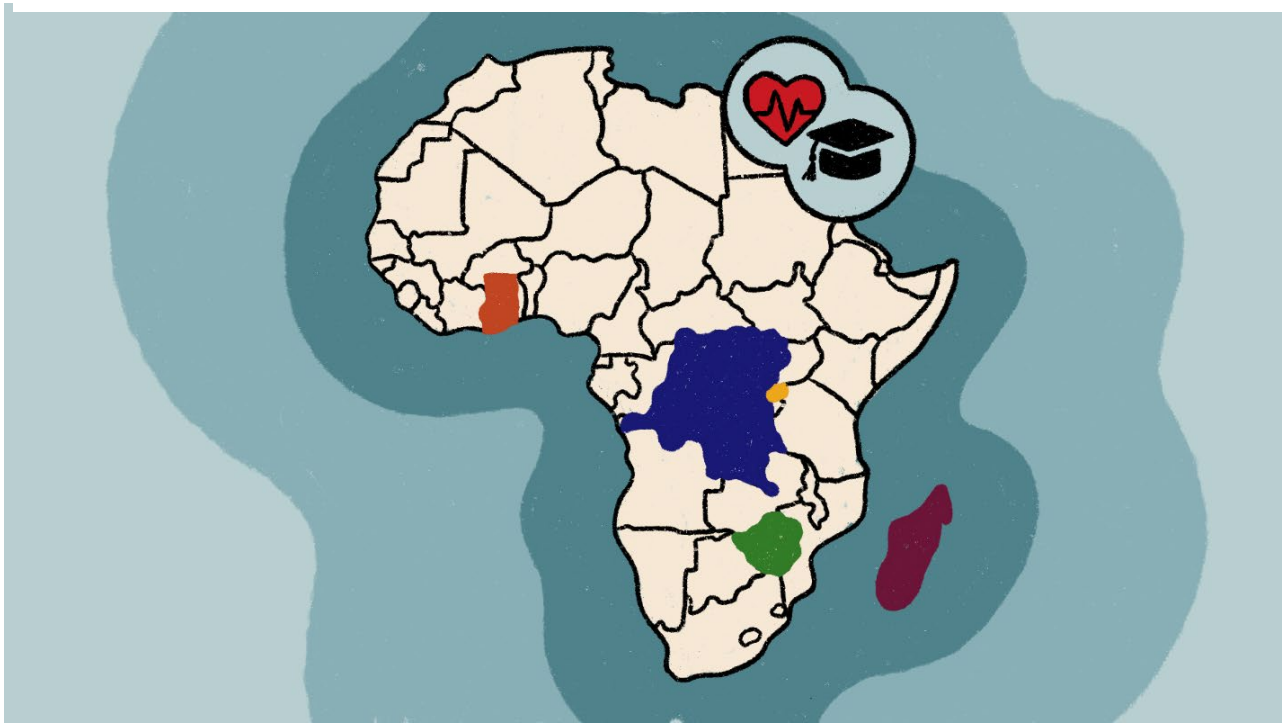
There are also disparities in resource allocation in terms of education across the five countries. While Rwanda is above both the global and African regional averages, the other four countries are below them (see Figure 7[40]); all countries fall short of the 15-20% target agreed in the Education 2030 Incheon Declaration[41]. These figures should again be interpreted with respect to overall government expenditure and population size. However, unlike health expenditure, current education expenditure per capita based on PPP is not a featured indicator on the World Bank DataBank or other similar databases, making it difficult to disaggregate the level of spending on education per resident in a country.

FIGURE 7: RESOURCE ALLOCATION TO EDUCATION (PERCENTAGE OF GENERAL GOVERNMENT EXPENDITURE)



However, it can be concluded that between these five countries, there are disparities in the level of public expenditure for these two sectors, and for some countries, the levels of spending may be insufficient to meet population needs when measuring by both global and African regional standards. As the findings below demonstrate, low levels of resource allocation to these sectors may act as a driver for corruption risks.

A map highlighting the five countries participating in this study: the Democratic Republic of Congo, Ghana, Madagascar, Rwanda and Zimbabwe



NATIONAL-LEVEL FINDINGS

This section summarises highlights from the 10 national-level corruption risk assessments carried out in the five target countries.

Each national chapter carried out two corruption risk assessments, one covering select education processes and one covering select health processes. Each assessment is rich in analysis and detail, and it is not possible to reproduce all their main findings here. The corruption risk assessment reports published during 2024 by the national chapters provide a greater overview.[42]

DEMOCRATIC REPUBLIC OF CONGO

The Democratic Republic of Congo is the second-largest country in Africa by land area. It has a population of around 105 million people, and is frequently listed as one of the poorest countries in the world, a situation exacerbated by political instability and protracted internal insecurity. However, the country has recently experienced a consistently high GDP growth rate, except during the COVID-19 pandemic.[43]
Ligue Congolaise de Lutte Contre la Corruption (LICOCO) – or the Congolese League to fight against Corruption – is Transparency International's national chapter in DRC and was created in 2002. The chapter carried out the research for its corruption risk assessments exclusively in the Kinshasa metropolitan area.

Corruption Risk Assessment of the Education Sector

LICOCO prioritised four processes in its CRA, selected on the basis of its assessment of which processes would have the most significant impact on vulnerable groups' access to education:

1. Student enrolment
2. Recruitment of teachers
3. Student examinations
4. Supplementary tutoring.

Using a survey tool, the research team interviewed 250 stakeholders in public primary and secondary educational institutions in Kinshasa, including teachers, administrative staff, parents and students.

Free public primary education has been enshrined in the DRC Constitution since 2006, but primary education was only declared free by the government in 2019. Before that, fees were charged for enrolling children in schools, to fund teacher salaries and operating costs. Since 2019, enrolment rates have increased dramatically, especially for girls, but at the cost of classroom overcrowding. In addition, an imbalanced rollout has led to reported regional disparities. The abolition of fees has also allegedly resulted in widespread delays in teachers receiving their salaries, triggering many strikes as well as an increase in donations to teachers from parent committees.[44]

Against this background, the level of corruption risks was classified as high to very high for three of the four processes studied, the exception being student examinations, where the risk was rated as less serious.

The research found evidence of bribery and favouritism in enrolment – for example, education officials helping family and friends skip the waiting list. When asked how women were affected by corruption in enrolment, 49 out of 102 respondents said that mothers were at risk of sexual corruption.

> **Women can be subjected to sexual threats**
>
> A respondent on the risks facing women when enrolling their children in educational institutions

Sexual corruption (or sextortion) is the abuse of entrusted power to demand or obtain sex or acts of a sexual nature – for example, a school principal abusing their power to demand or obtain sexual acts from a mother seeking school placement for her child. Several respondents in DRC pointed out how poverty can accentuate this risk.

> **The lack of money to bribe can push [women] into sexual compensation**
>
> An education-sector stakeholder from the DRC

Unreliable teacher salaries have reportedly led to the rise of widespread supplementary tutoring, whereby teachers give extra lessons to children of parents willing to pay. Many respondents agreed this has the effect of unfairly disadvantaging children unable to have private lessons.

A high number of respondents attested to corruption also affecting recruitment processes for teachers, primarily in the form of favouritism. This leads not only to unqualified teachers in the classroom, but to the fear that such candidates, having already demonstrated a lack of integrity, were likely to engage in further corruption after taking the job.

Based on these findings, LICOCO's recommendations included, among others, that the government meet the declaration of free basic education with adequate public funding, in order to ensure teacher salaries are paid in full and on time. This would reduce the risk of bribe-taking and the diversion of teachers' energies to private tutoring for families that can pay. The chapter also recommended that the Ministry of Education ensure mandatory competitive examinations and a transparent recruitment process, to reduce the risk of favouritism in recruitment of education sector staff.

Corruption Risk Assessment of the Health Sector

LICOCO considered four processes in its CRA of the health sector which, again, were selected on the basis of what researchers assessed had the most significant impact on access to health care by marginalised groups:

1. Access to health services
2. Recruitment of medical staff
3. Supply of medicines
4. Inspection of hospitals.

The researchers visited eight public hospitals in Kinshasa and used a survey tool to interview 221 respondents, including doctors, nurses, heads of administration and patients.

The research found that when accessing treatment, patients often face demands for informal payment. This ranges from basic treatment to serious operations, as well as emergency treatment, which is supposed to provided immediately without the requirement of a prepayment.

> **You have to bribe to have your case taken care of. You have to bribe even if it is an emergency**
>
> An interviewed patient from DRC

Other risks include doctors prescribing unnecessary, often costly, tests, and referral of patients to private health services associated with them or their acquaintances.

One of the most frequently mentioned forms of corruption was the diversion of medicine intended for patients by medical staff, which is then resold for their own private gain. Respondents also alluded to frequent misappropriation of hospital equipment.

Pharma Sac

The use of "pharma sacs" was highlighted as particularly vulnerable to corruption. These are pouches storing medical products that pharmacy and medical storage workers provide to nurses and social workers, so they can give them to specified patients. However, due to poor traceability, diversion often occurs.

Many respondents argued that these risks are driven to some extent by low levels of supervision, as well as inadequate funding of public hospitals, forcing them to become self-financing in informal and often illicit ways.

One of LICOCO's key recommendations based on its CRA findings was the replacement of the "pharma sac" arrangement with a more accountable and monitorable system, based on accurate written prescriptions and logging of receipts, to make diversion more difficult.

GHANA

Situated in West Africa, with an estimated population of 34 million, Ghana is widely considered to have among the highest standards for democracy and freedom of speech on the continent. While economic growth levels have been comparatively strong, high debt levels precipitated a macroeconomic crisis in 2022.[45]
Established in 1999, Ghana Integrity Initiative (GII) is Transparency International's national chapter in the country.

Corruption Risk Assessment of the Education Sector

GII chose two processes to focus on in its education CRA, based on existing research suggesting that both were vulnerable to particularly high corruption risks:

1. Payroll management
2. Inventory management.

While access to education in Ghana is relatively high, as is its quality, the sector experiences regular budget deficits. A 2021 report by the national Office of the Auditor General determined that an estimated 35 per cent of financial irregularities within the education system took place in the areas of payroll and store management. While these areas focus on operational arrangements prior to service delivery, GII's research demonstrated that these losses have a significant trickle-down effect which can considerably impact the quality and reach of education.

GII conducted KIIs and FGDs with a total of 50 respondents, focusing on actors involved in these processes, such as district directors of education, district stores officers and school headmasters in six urban, peri-urban and rural districts from the northern and southern parts of Ghana.

In terms of payroll management, respondents indicated a high risk of district officials or teachers offering bribes to get their salary, in order to overcome delays in payroll processing. A lack of checks and balances at the school level also created a medium-level risk of collusion between teachers and headteachers to have so-called "ghost teachers" listed on the payroll register. Ghost teachers are absentee teachers who do not actually teach, but still get paid a full salary, or entirely invented workers whose salary is then embezzled by other school employees.

The CRA also studied vulnerabilities in inventory management for state-provided education materials, such as computers, textbooks or desks, which are distributed to schools and stored for the benefit of pupils. While there were good tracking systems and checks and balances at the district level, this was not the case at the school level, creating a risk that materials are misappropriated by headteachers and teachers, to be resold. GII heard reports of textbooks being diverted from public schools and sold to private-school managers, who make a profit by selling the textbooks for higher prices to fee-paying parents.

Desks

School materials such as desks are critical for children to fulfil their right to education. However, in Ghana, up to 40 per cent of children nationally and up to 80 per cent of children in the poorer Northern regions have no regular access to a school desk. A 2021 study by Africa Education Watch found that the lack of desks is often used as a ground for refusing enrolment and can even lead parents to take their children out of school.[46]

These corruption risks effectively undermine equality of access to education in Ghana. The risk of corruption in payroll management can translate to an inflated teaching budget. This, in turn, may lead to cuts in educational needs such as special education, as well as to lower teacher-pupil ratios in classrooms, to the detriment of children living in poorer rural areas, where there can already be overcrowding. In the event of misappropriated educational materials, parents are normally solicited to purchase replacements for their children, which disadvantages those from poorer backgrounds.

To mitigate the risks of "ghost teachers", GII recommended more regular validation of teachers listed on the payroll, including by giving parental committees an oversight role. In order to ensure inventory management is more secured against diversion, recommendations included quarterly internal audits of stores at the district and school levels.

Corruption Risk Assessment of the Health Sector

For its CRA of the health sector, GII looked at corruption risks within the National Health Insurance Scheme (NHIS), specifically at two processes:

1. Insurance claims processing
2. Management and supervision.

The focus on NHIS was selected because women, girls, people with disabilities and the elderly are among the main users relying on the scheme.

The NHIS is a key component of Ghana's strategy to achieve universal health coverage. Under the scheme, the National Health Insurance Authority (NHIA) is responsible for reimbursing health service providers, such as hospitals, which submit claims for expenses incurred by patients that subscribe to the scheme. Patients must pay a premium, but there are exemptions for some groups, such as pregnant women, people living under the poverty line and the elderly. In 2021, approximately 54 per cent of Ghana's population was covered by the scheme; women constituted 58.6 per cent of the active membership.

Data was collected through 188 KIIs and six FGDs carried out in six districts, representative of various regions in Ghana: Ayawaso Central and Ada East in the Greater Accra Region, Cape Coast Metropolis and Upper Denkyira East in the Central Region, and Kassena Nankana West and Kassena Nankana Municipal in the Upper East Region.

Most respondents agreed that NHIA's recent introduction of a digital system to process insurance claims had largely positive effects, but also attested to persistent delays in processing, attributed mostly to insufficient staff and resources. As per agreements between NHIA and service providers, claims should be processed within four weeks, but respondents said it was quite common to take at least 12 weeks. This means service providers must offset expenses in the short term, which generates incentives for corrupt practices. Respondents reported risks of bribes to accelerate filing of claims or the NHIA prioritising favoured service providers during waiting times, as well as collusion between NHIA and service providers to inflate the value of submitted claims, meaning a portion of the public funds allocated to NHIA are squandered.

> **"Some facilities are likely to receive payments faster than others, because someone knows someone**
>
> A service provider from Ghana

GII also looked at how well NHIA managed and supervised its staff to prevent and address corruption. It found evidence of inadequate supervision at local levels, as well as a medium level of risk that NHIA officials could receive bribes from service providers in order not to inspect facilities.

In terms of impact, GII found that any losses incurred by the NHIS led to further delays or inability to process claims, which in turn made service providers less willing to provide treatment to NHIS card users. This imposes a financial burden on some users, while many others have no alternative and resort to self-medication or forms of herbal medicine. This is especially to the detriment of the women, girls and groups at risk of discrimination, such as people with disabilities, who are among the main and most reliant beneficiaries of the scheme.

GII identified mitigation strategies to make the NHIS more resilient to bribes and collusion, such as increasing the number of claims processing centres to prevent backlogs, undertaking capacity building of NHIA officials around the code of conduct for

Ghanaian public officials and ensuring consistent sanctioning of those who breach it.

MADAGASCAR

Madagascar is a large island state with a population of around 30 million people. It has experienced increasing GDP growth in recent decades, but continues to have one of the world's highest poverty rates, with approximately 75 per cent of the population living below the poverty line.[47][48] Transparency International Initiative Madagascar (TII-MG) was founded in 2000 and is the Transparency International national chapter.

Corruption Risk Assessment of the Education Sector

TII-MG focused its education CRA on two processes which key stakeholders had flagged as areas susceptible to high corruption risks:

1. Admission and retention in basic education
2. Human resources (HR) processes.

To understand the extent of corruption in the sector, TII-MG carried out a large survey answered by 4,854 pupils, parents and teachers across six regions of the country. Of these respondents, 62 per cent lived in urban areas and 38 per cent in rural areas. Results showed that 39 per cent of respondents had personally been victims or witnesses of corruption in the education sector, including 53 per cent of teachers and administrative staff.

The results also found that rural inhabitants were more likely to have personally experienced or witnessed corruption in education than urban dwellers. Neither gender nor disability was found to be a significant determinant of experiences with corruption.

However, TII-MG found that social norms foster unequal gender conditions which instances of corruption would be likely to aggravate. For example, while 76 per cent of respondents felt the duration of schooling should be the same for male and female students, 19 per cent believed schooling should last longer for boys. Several respondents hypothesised that if corruption leads to a reduction of available resources in education, girls are more likely to lose out. For instance, where paying illicit fees is necessary to enrol children at schools, some parents may decide to prioritise schooling for their sons instead of their daughters. This marks a case of corruption interacting with social norms to perpetuate a cycle of gender inequality.

TII-MG also carried out 106 KIIs with school staff. When asked which processes in the education sector were most affected by corruption, 67 out of 90 respondents mentioned HR processes, such as the recruitment, relocation and promotion of civil servants and teachers. Respondents flagged sexual corruption and favouritism as specific risks – for example, recruitment based on membership of a political party. This, in turn, can create a pathway into the sector for political influence and patronage.

> **"There is too much political interference in the education sector, and it leads to corruption cases. It takes time to become a permanent official, so when they become one, they take advantage of it**
>
> A college director from Madagascar

School registration

In 2020, the national government decreed that enrolment in Madagascar's public schools should take place free of fees, but people report widespread implementation gaps, especially in remote, rural areas. For example, the research uncovered evidence that new fees are demanded by school officials for services that should be free, such as obtaining registration forms, pupils' report cards or photocopies.

The research found that of the 39 per cent of survey respondents who had been victims or witnesses of corruption in the education sector, only 19 per cent had attempted to seek redress. When they did, this normally took the form of raising the matter with the school principal. Very few respondents used a formal, anonymous reporting mechanism. TII-MG's recommendations therefore include the establishment and strengthening of safe and secure reporting mechanisms within educational facilities, to enable service users to report corruption.

Corruption Risk Assessment of the Health Sector

For its health CRA, TII-MG selected six processes for corruption risks which it determined especially relevant for groups at risk of discrimination, especially women and girls:

1. Basic access to treatment
2. Antenatal care
3. Vaccination
4. Surgery
5. Storage of medical supplies
6. Family planning.

To achieve this, TII-MG carried out another large-scale survey, with more than 4,500 respondents and 89 KIIs, and also analysed ALAC data. Survey findings included that individuals from lower income brackets were more likely to report having experienced corruption in the health sector than those from higher income brackets.

TII-MG also compared corruption risks in district hospitals and primary health centres (PHCs). These centres are not equipped to provide complex forms of treatment, but they are more numerous than hospitals and are relied on by a large majority of the population, especially those living in rural areas. The CRA found that reports of corruption were more frequently made at PHCs compared to hospitals. This could be driven in part by the fact that many PHCs face resourcing challenges in terms of financing and personnel, and depend on voluntary community members, who may demand extra fees from users to financially sustain themselves.

Antenatal care, especially maternal delivery, was found to involve a very high risk of corruption in the forms of extra fees or referrals for unnecessary caesarean procedures. There was also a reasonably high risk that women were overcharged for contraceptive pills and implants when consulting family planning services.

Maternal delivery

Maternal delivery care should be provided to prospective mothers free of charge in PHCs, but the research found cases of midwives charging illicit fees. These varied between 30,000 to 100,000 Ariary (approximately US$7 to US$23), but respondents reported that higher fees are often charged when a newborn baby is male, with lower fees for females. This is an example of discriminatory corruption, in which a service appears to be targeted based on the gender of its main users.

High corruption risks were also associated with surgery, especially the unnecessary referral of patients from PHCs to expensive private hospitals, due to collusion between different health-sector actors. Respondents also reported that medical supplies were vulnerable to diversion and embezzlement.

> **"A leak was discovered in the drug distribution system, resulting in a financial discrepancy of 12 million Ariary[49]**
>
> A health stakeholder from Madagascar

Among TII-MG's recommendations based on the CRA results were for local CSOs to sensitise health care staff and patients on entitlements to free services and the consequences of corruption, including addressing illicit antenatal health care fees. The recommendations also highlighted the importance of using multilingual and culturally appropriate communication to reach remote populations, and recommended establishing clear and transparent guidelines for patient referrals from PHCs to public hospitals, to mitigate collusion risks.

RWANDA

Rwanda is a small, landlocked country located in the Great Lakes Region, with a population of 14 million. The country has generally enjoyed steady GDP growth in recent decades and aspires to middle-income country status by 2035. However, its general

decline in poverty levels has reportedly stagnated over the past 10 years.[50]
Transparency International Rwanda was founded in 2004. The chapter carried out both health and education CRAs in five districts reflecting different average income levels: Huye, Kayonza, Musanze, Rubavu and Rusizi.

Corruption Risk Assessment of the Education Sector

For its CRA of the education sector, TI Rwanda prioritised five processes which emerged as areas of key risk in initial focus group discussions:

1. Supply of food in schools
2. Internships for technical and vocational education and training (TVET) and tertiary-level students
3. Grading in schools and tertiary institutions
4. Recruitment of teachers
5. Student enrolment in secondary schools

TI Rwanda held KIIs with 14 government officials working in education, and convened separate FGDs with both service providers and users, comprising a total of 193 respondents. Notably, researchers found broad consensus between public officials, service providers and users on the main corruption risks in the sector, especially the forms of favouritism, conflict of interest and sexual corruption.

For example, respondents described high risks of nepotism, conflicts of interest and collusion in the procurement of school food supplies, leading to poorer quality food being delivered to pupils.

> **"I won a tender to supply foods to a school, I was told to increase the price on my invoice and give the balance to the manager of the school**
>
> A businesswoman from Rwanda

One of the highest risks was that internship supervisors extract bribes and facilitation payments and attempt or commit sexual corruption against tertiary-level and technical and TVET students. This occurs at specific points in the process – for example, when students seek approval for an internship placement or when they are given grades.

The research also found a high risk that school officials attempt or commit sexual corruption against teachers during recruitment processes or when they apply to be transferred to other schools. Teachers or lecturers commonly target female students of secondary or tertiary institutions, in exchange for good grades or prior access to examination material.

> **"[M]y supervisor…made inappropriate advances towards me. I declined…he began mistreating me…made it difficult to complete my internship**
>
> A tertiary-level student doing a teaching internship in Rwanda

As in other countries, there is a risk that staff extract extra fees or bribes from parents seeking to enrol their children in schools. Some participants in the FGDs highlighted the risk that a school official demand that parents of a child with a disability pay "care fees" on enrolment, amounting to a violation of the child's right to access education equally.

Among TI Rwanda's policy recommendations was the establishment of multi-stakeholder internship committees, to increase transparency and oversight of student internship processes. To tackle the risks of sexual corruption across the education sector, TI Rwanda recommended that educational institutions establish and promote gender-sensitive reporting mechanisms.

Corruption Risk Assessment of the Health Sector

TI Rwanda carried out an extensive scoping of the health sector in its CRA and selected 11 processes that emerged as areas of key corruption risks in initial focus group discussions:

1. Eligibility for *Ubudehe* community-based support
2. Access to community-based health insurance (CBHI)
3. Patient transfer services
4. Medical appointments
5. Health care HR services
6. Internship practices for medical students
7. Hospitalisation and admission
8. Medical examinations and prescriptions
9. Supply of medicines and non-medical materials
10. Registration and authorisation of health facilities
11. Food provision to stunted children and pregnant women.

TI Rwanda convened FGDs with 198 participants, comprising both service users and providers, as well as 11 KIIs with health-sector experts. While the overall impression was that the level of risk was lower in comparison to the education sector, the research revealed many qualitative insights into corruption.

Key findings included that corruption can impede marginalised groups' access to health support programmes designed with them in mind. For example, the government established a scheme to provide nutritious food to groups such as pregnant women and children at risk of stunted growth due to malnutrition ("stunting"). However, the CRA uncovered evidence that due to corruption, this support may be provided to certain recipients who would otherwise not be qualified to receive it.

> **"People bribe and give illegal benefits to local leaders to be registered among the beneficiaries of government programmes aimed at supporting vulnerable citizens**
>
> An FGD participant from Rwanda

Ubudehe[51]

Accord ing to Rwanda's Local Administrative Entities Development Agency (LODA), "Ubudehe is a Rwandan practice and cultural value of mutual assistance among people living in the same area in order to overcome or solve their socio-economic problems". Based around this principle, LODA managed a programme that aims to support access to health care for people in the lower income tiers, for example, by giving them free or favourable prices for medicines.[52] It was grounded on a community-based approach that gives local leaders the role of categorising who should be eligible to receive the various forms of assistance. However, evidence suggests there is a risk that local leaders can be susceptible to nepotism, taking bribes or colluding with community members to list them as eligible for support, often at the expense of others who are in greater need. Corruption at this point and failure to correctly categorise *Udebehe* status can prevent intended beneficiaries from receiving other benefits, such as access to the Community-Based Health Insurance (CBHI) scheme.

TI Rwanda made several policy recommendations aiming to increase the resilience of these social protection schemes. These included making the categorisation process more participatory and ensuring that local leaders facilitate, rather than lead, the process. This would reduce favouritism in selection, as well as creating more consistent independent controls and checks, to ensure vulnerable groups receive the benefits they are entitled to.

ZIMBABWE

Zimbabwe is a landlocked country in Southern Africa with a population of around 17 million. Following independence in 1980, Zimbabwe invested heavily in the education and health sectors, but since the late 1990s, the economy has experienced high inflation and debt, which have limited its growth potential.[53] TI Zimbabwe was founded in 1996 and is the national chapter implementing the ISDA project.

Corruption Risk Assessment of the Education Sector

TI Zimbabwe assessed six education processes for its CRA, identified as potential high-risk areas

through an initial literature review and stakeholder consultations:

1. Enrolment in primary and secondary education
2. Examinations
3. Staff recruitment
4. Procurement of school supplies
5. Use of school property or assets
6. Supplementary tutoring.

To collect data, TI Zimbabwe distributed a survey questionnaire to 378 respondents nationwide, carried out 13 FGDs – each with an average of eight participants, focusing on teachers and parents – and conducted 22 KIIs with public officials.

One of the areas to emerge with the highest risk of corruption was examinations. Many respondents mentioned the risk that students or their parents pay teachers and lecturers to obtain exam material in advance. Some respondents had heard allegations of teachers taking exams on behalf of students, in exchange for bribes. They also flagged the risk of deliberate leakage of exam papers by officials working at the institution responsible for setting exams, suggesting possible collusion between these officials and teachers.

> **"We used to hear about leaking of examination papers at certain places but now…it has affected a lot of schools**
>
> A teacher from Zimbabwe

Respondents pointed out that this unfairly disadvantages students unwilling or unable to engage in corruption, making it likely they will receive poorer grades. More broadly, this contributes to the emergence of an underqualified workforce and undermines the wider credibility of Zimbabwean education standards, due to widespread high marks.

Supplementary tutoring

TI Zimbabwe heard evidence of teachers offering supplementary tutoring for students in exchange for benefits. This practice is prohibited under Zimbabwean law, but a lack of supervision and enforcement measures has reportedly made it prevalent. Supplementary tutoring creates a risk of corruption and can lead to learning disparities when teachers prioritise preparing for and delivering extra lessons, to the exclusion of those pupils unable or unwilling to pay for them.

Respondents identified low and unstable salaries as the main driver for these risks. In recent years, teachers in Zimbabwe have regularly gone on strike or left the profession. To avoid creating further financial pressure on teachers, TI Zimbabwe proposes that supplementary tutoring should not be banned, but should rather be better regulated – for example, to ensure that teachers do not provide tutoring to their own students. The chapter also called for greater oversight and monitoring of education staff access to examination materials, to counter the risk of leakages and collusion.

Corruption Risk Assessment of the Health Sector

The two selected priority areas for TI Zimbabwe's corruption risk assessment of the health sector were:

1. Procurement of medicine
2. Inventory management of medicines at service delivery level.

These priorities were selected amid reports of growing shortages, leaving many users without the medicines they needed. TI Zimbabwe carried out 27 KIIs to collect data for the assessment. The responsible national authorities denied the researchers permission to conduct interviews at public health facilities and at the ministry level, meaning the interviews were carried out largely with public health experts in their individual capacity, consumers and street vendors of medical supplies, based in the regions of Bulawayo, Mashonaland East, Harare and Midlands.

The assessment found that the procurement of publicly funded medical supplies is centralised through a single national-level authority, although researchers could not obtain official clearance to contact the authority for inputs into the study.

Despite this challenge, stakeholders interviewed in their private capacity flagged that the lack of transparent processes created a high risk of medicines being procured at artificially inflated prices This risk contributes not only to higher prices at the user level, but also to stock shortages.

Street vendors testified that a large amount of the medical supplies they sold on the black market originated from public health facilities. They flagged that both senior and junior staff were diverting medicines from warehouses and other storage facilities. Some consumers highlighted cases where pharmacies and other official dispensary units were completely out of contraceptives, but street vendors maintained full stocks, with significant portions sourced from staff diverting public medical supplies.

> **"Some senior staff divert small amounts of medicines for use by themselves, family and friends, and justify this diversion as necessary to compensate for their perceived low remuneration**
>
> A key informant from Zimbabwe

The negative impacts on vulnerable groups flowing from this corruption risk were primarily twofold. First, it meant that those who needed specific medicines could not obtain them. One consumer reported that nurses at a psychiatric unit were allegedly selling medicines that patients were supposed to obtain free of charge. Others noted they are forced to purchase their prescribed medicines on the black market, where they have often expired.

This situation also means that users can purchase drugs for which they have not obtained a medical prescription. A KII respondent said this has led to psychotropic medicines such as diazepam being leaked and sold on the black market to people with substance abuse issues, especially young and vulnerable individuals.

Most of the interviewed street vendors admitted they had no medical background and little knowledge of the possible adverse side effects of the products they sold. They also said that if they are arrested for selling illicit medicines, they are normally released after paying a small bribe to the police.

Among TI Zimbabwe's key policy recommendations was that national oversight authorities conduct independent assessments of hospitals and storage facilities, to strengthen security systems. The government must also adequately resource the medicine regulatory authority to carry out random audits, to counter the risk of diversion of medicines. The chapter also recommended that community engagement initiatives be launched that aim to educate street vendors and consumers on medicine safety, to help prevent the negative impacts of unauthorised prescription of diverted medicine.

COMMON TRENDS

This section presents insights gleaned from the 10 studies, indicating where and why corruption occurs in the education and health sectors, who carries it out, and how these factors combine to impact women, girls and groups at risk of discrimination.

The differences in focus areas across the chapters' CRAs mean that not all findings are readily comparable. However, certain trends common across at least two or more of the countries are observable. While these may have some relevance for other African countries, they should not be considered as representative of the region, given the sheer diversity of education and health systems.

WHERE DOES CORRUPTION OCCUR?

The CRAs suggest that virtually all the processes discussed above in the health and education sectors appear to face corruption risks. Persistent loopholes or vulnerabilities within these processes give rise to corruption risks which, if they materialise, distort service delivery in these sectors, often with discriminatory outcomes.
These loopholes often occur at specific decision points within these processes. For example, in terms of the provision of vaccination services in Madagascar, testimonies indicated that patients face little risk of being asked to pay a bribe at the health facility reception, but are usually asked to pay extra fees for syringes in the treatment room, just before vaccination takes place.

In Ghana, the research found that while there were low risks associated with use of an electronic verification system for management of the teachers' payroll, the reliance on headteachers to approve other steps in the process created a loophole for collusion.

Breaking down each process into its constituent steps helped chapters to identify the specific decision points requiring the most urgent measures to mitigate types of corruption that deprive marginalised people of access to basic services.

It is also useful to analyse the appearance of corruption risks more wholly, by considering the so-called service delivery chain, which can be broken down into three essential stages:

1. The point of service delivery
2. The organisation of resources
3. Policymaking.[54]

The different institutional processes assessed in the national CRAs exist and operate across these stages. Researchers found that regardless of where corruption occurs, its impacts cascade down to the user level and are often more keenly felt by those most vulnerable.

Service delivery

As evident from the research overview, some of the most visible forms of corruption take place at the point of service delivery, where there is a direct interface between the service provider and the user. This often requires a physical interaction between them, which can expose the user to types of corruption that are among the most coercive in the education and health sectors. In addition, certain local contexts offer a paucity of public services, giving providers a monopoly which they may exploit, leaving users vulnerable, especially those without the means to turn to private structures.[55]
Typical examples of this coercive corruption include "petty" bribery, where low- and mid-level public officials extort illegal fees for services.[56]

ALAC complaint

In DRC, a parent issued a corruption report after a teacher demanded an extra payment of 5,000 Congolese Francs (US$2) in exchange for issuing his daughter's test results – a necessary step for her to graduate to the next class. Due to the ALAC's intervention, the teacher eventually withdrew his demand.

In such a scenario the user may be compelled to pay bribes to receive a service they are entitled to – for example, access to medicine or their child's access to schooling.

> **Security personnel sometimes make access to the hospital conditional on the payment of a sum of money**
>
> An hospital clerk from DRC

However, in other cases, users may themselves offer bribes in exchange for a better service or access to a service to which they are not entitled, as in the example of social protection schemes in Rwanda.[57]

Corruption risks at this stage also include providers overcharging the user for the service provided, often exploiting information asymmetries and a lack of price transparency. For example, in DRC, many hospital patients said they were charged prices different from those others had been charged for the same treatment or medicine, and they were not given proper receipts.

The breadth of corruption risks at this stage is not to be underestimated. As the unnecessary referrals of patients to private structures in Madagascar demonstrate, users can also be exposed to forms of collusion or favouritism at the point of service delivery.

The direct, physical interaction between user and providers may also give rise to sexual corruption risks. For example, in DRC, many respondents flagged the risks mothers can face when attempting to register their children for schooling. This is discussed in further detail below, including its severe and long-lasting impacts on victims, especially women and girls.

The organisation of resources

Corruption can affect the management of organisational resources, such as personnel, goods, supplies and funding – resources which all play a critical part in delivering public services.[58] The effects of corruption at this stage trickle down and impede access to education and health care, or reduce their quality and quantity.
When coupled with weak oversight, the complex and bureaucratic organisational structures of education and health authorities can make it difficult to monitor budget inflows and large volumes of material resources.[59]

Ghana's health CRA indicates the risks facing management of public funds, where corruption contributes to delays or complete failure of the national health insurance authority to process claims. This reportedly leads to a loss of trust in the system among some hospitals and medical facilities, which turn away patients who rely on public insurance to pay, instead treating only private patients. While the mismanagement of resources incurs substantial financial losses at a national level, respondents were well aware that this can trickle down and impact them personally.

> **If the money that the government will use in improving health care is stolen through corruption…drugs at the hospitals will be in short supply and patients will be asked to buy the rest themselves**
>
> A patient from Ghana

In terms of materials goods, corruption risks often appear during public procurement, where the need for a level of standardisation in the education and health sectors – for example, in textbooks or medical testing equipment – can lead to lucrative

contracts.[60] Typical risks include bribery and collusion between the authorities and bidders in the specification of public contracts.[61] This can translate not only into a waste of taxpayers' funds, but also widespread shortages and higher market prices for users.[62]

Such procurement risks exist in centralised and decentralised systems alike. For example, the lack of transparency around Zimbabwe's centralised procurement authority can create risks of collusion over sizable medicine contracts. Similar collusion and favouritism risks were found in Rwanda between education officials and local providers for school food contracts, albeit it at a smaller scale.

A common risk identified across the CRAs was that of diversion and leakages of material resources, often implicating service providers.[63] This includes diversion of medical supplies in DRC, Madagascar and Zimbabwe by senior and administrative-level staff from storage facilities, typically to be resold for personal profit. It also includes the diversion of textbooks, desks and other school equipment, as witnessed in Ghana and Zimbabwe.

This again leads to shortages and higher costs, which marginalised users can find difficult or impossible to shoulder. In Zimbabwe, key informants pointed out that individual cases of corruption tend to concern low-value transactions, but their cumulative effect results in huge quantities of medicine being lost and not accessible to those in need. Research in the country showed how the unauthorised reselling of diverted psychotropic medicines causes further risk of substance abuse and social harm.

Corruption risks also exist in terms of personnel management. While these can be difficult to accurately measure, recruitment processes that are compromised by forms of favouritism – for example, nepotism or political connections – are associated with lower service quality. Where unqualified people are teaching or administering medical care, this results in poorer education and health outcomes for users.[64]

In Rwanda, researchers found that while there were generally clear policies on fair recruitment in the health sector, some hospital administrators agreed that these are sometimes overlooked when there are urgent shortages of medical staff. In contrast, in Madagascar, the number of applicants typically greatly exceeds the number of teaching positions available in public schools. This can lead teachers to engage in corruption to be recruited or maintained in their role.

While corruption in recruitment and HR processes indirectly generates negative impacts on users, it is important to emphasise the negative impacts it has on the service providers or aspiring service providers engaging in corruption. For example, in DRC and Zimbabwe, many candidates are subjected to salary deductions in order to obtain their positions.

Even more strikingly, in all countries with the exception of Ghana (which did not explore this area), sexual corruption was flagged as a significant risk in recruitment processes. In such scenarios, authority figures in charge of recruitment for a post typically abuse their power to extract sexual acts from candidates.

Policymaking

At top of the delivery chain sits the policymaking stage, where key decisions regarding the mobilisation and allocation of public resources to basic services are made.
While none of the chapters examined processes occurring at this stage, the inadequacy of financial resources for the education and health sectors was cited as an issue in virtually every CRA. Numerous political and economic factors contribute to insufficient resource allocation, but it is possible that at least part of this funding gap can be explained by corruption – in particular, undue influence and the role of illicit capital flows from Africa that derive from corruption.

The actors responsible for policymaking and budget allocation can be susceptible to undue influence from other private actors and other members of the political elite.[65] This can lead to distortion of budget allocation and execution for the education and health sectors.[66] For example, decision makers may approve the construction of schools or hospitals in areas where there is no pressing need, in order to benefit politically connected companies. Or political elites may be tempted to "buy" votes by prioritising resource allocation to their local communities.[67]

There is evidence that these dynamics are pronounced in the Sub-Saharan African region. Bazie et al. find that "preferential treatment linked to corruption and rent-seeking can introduce bias into the composition of public spending and the allocation of resources".[68] Their study found that corruption generally leads to a higher share of public funds allocated to sectors such as health, but a lower share of resources allocated to education, arguing that the large-scale projects typical in the

health sector may often better cover for corruption schemes.

Other scholars have found that corruption in African countries is associated with higher levels of current expenditure at the expense of capital expenditure, as corrupt officials seek to abuse the more discretionary nature of the former.[69]

Undue influence can also lead to sub-national regional disparities in education and health spending. Some Sub-Saharan African countries experience significant regional disparities in education and health standards, which often correlate with the distribution of ethnic groups, although there are also other identifying factors. For example, a study of 18 countries found that sharing the same ethnicity as the country's leader resulted in an average reduction of 0.4 per cent in infant mortality, along with gains in school attendance and literacy.[70] Similarly, another study found evidence that neonate and infant mortality is lower when the current health minister originates from their region.[71] Other studies have identified that the construction of schools or disbursement of other education-related resources are disproportionately split across regions.[72]

Many factors unrelated to corruption can account for such regional disparities, but some regions and groups may benefit from preferential treatment linked to resource allocation, which occurs ultimately to the detriment of other regions and potentially to minority groups.[73]

Underrepresentation of women and members of groups at risk of discrimination in policymaking may be significant. For example, at the beginning of 2024, the share of women members of parliament across Sub-Saharan Africa was estimated to be 27.3 per cent. Although this is higher than the global average of 26.9 per cent, it still falls short of full gender parity.[74] Other groups which are generally underrepresented in African national-level politics include youth, people with disabilities, refugees and migrants, ethnic and religious minorities and the LGBTQI+ community.[75]

This can make it more likely that policymakers make decisions which are not inclusive of such groups, leading to adverse outcomes for them. In settings where political corruption is pervasive, patronage networks are also more likely to prioritise the interests of their own cohorts than those of women, girls and groups at risk of discrimination, leaving the latter comparatively more vulnerable to corruption and its impacts.

Resource scarcity and misallocation may also attribute to some extent to illicit financial flows (IFFs), which Transparency International defines as the "movement of money that is illegally acquired, transferred or spent across borders". In a 2024 report *Risks of Illicit Financial Flows in Africa,* Transparency International found that IFFs from corruption cause a major drain on capital and revenues in African countries, leading to a significant reduction in the resources available to governments to provide public services such as education and health care.[76]

A 2020 report from the United Nations Conference on Trade and Development (UNCTAD) found significant correlations in this regard. In African countries with high levels of IFFs, governments spend 25 per cent less on health than countries with low IFFs, and 58 per cent less on education. The report infers that such negative effects deriving from high IFF levels disproportionally impact women and girls, as they often have less access to education and health in the first place.[77]

Due to the secretive nature of both undue influence and IFFs, it is difficult to accurately measure the volume of losses they cause, but estimates indicate these can be substantial. They also necessarily trickle down to other stages across the service delivery chain, by limiting the resources available in education and health, and creating pressures and competition over these limited resources, which drives both service providers and users to engage in corruption.

While it is possible these dynamics contribute to the findings identified across the five countries, this remains unsubstantiated based on the scope of the national CRAs.

WHO IS INVOLVED IN CORRUPTION?

A wide array of actors within the education and health sectors is implicated in forms of corruption which restrict access to these essential services. This has a disproportionate impact on marginalised people.

The CRAs provide ample examples of how actors including school principals, teachers, doctors, nurses and administrative staff abuse their ability to withhold services. Often, this is a self-interested act to line their pockets, but their actions have wider ramifications in determining which and how many people have access to health care and education. Other actors exploit their control over public resources for non-monetary private benefits.

> **Some headmasters use school materials to build their own houses. Some schools' grounds are used for political rallies**
>
> A respondent from Zimbabwe

While a distinction between service users and providers can be useful, it cannot explain the whole spectrum of corruption in service delivery. Evidence from HR practices shows how employees within the system are also vulnerable to certain forms of corruption, such as solicitations of bribery, forced salary deductions or sexual corruption.

While many of the documented risks of corruption occur on a one-to-one basis, there is also a wealth of evidence pointing to the existence of corrupt networks, including across hierarchies where both senior and junior staff are complicit.

For example, several FGD participants in Zimbabwe alleged that school heads collude with bursars and other administrative staff during the student enrolment process. In other countries, the research highlighted a risk that members of parent councils try to unduly influence procurement processes.

ALAC complaint In Ghana, it was reported that multiple teachers in one school continued to collect pay checks despite no longer actively teaching, because the headmaster was misleading the relevant authorities.

There is also evidence that people external to institutions, but with political clout, can drive corruption – for example, local leaders.

> **We are seeing the enrolment of students into the medical faculty who did not qualify…[but] get in after the intervention of politically connected individuals at state and party levels**
>
> A KII respondent on corruption at universities in Zimbabwe

WHAT DRIVES CORRUPTION?

Another layer of understanding comes from identifying what drives those involved in corruption to engage in such unethical behaviour. The CRAs give a nuanced picture, documenting how a combination of drivers can contribute to the forms and nature of corruption in health care and education.

Information asymmetry

Processes within education and health systems typically involve a complex array of actors and multiple procedural steps.
This can be pronounced in countries where there have been recent policy shifts, such as the announcement of free education, but a failure to adequately inform all populations of this shift.

In Ghana, users reportedly found it difficult to discern which forms of treatment were covered under the NHIS scheme – for example, which hospital services are covered for new-borns. In such cases, it can be easier for service providers to mislead users, especially those from vulnerable groups, who may be unaware that they are victims of corruption.

ALAC complaint In Ghana, a medical doctor was suspected of abusing his position in a public hospital to refer patients to his own private clinic. He also reportedly used a company registered in his wife's name to rent equipment, such as an X-ray machine, to the hospital, to try and hide the conflict of interest.

Information asymmetry is especially evident in pricing of education or health goods. If adequate price transparency measures are not in place, parents may end up being overcharged for school materials such as textbooks, or patients may pay more than necessary for medicine or treatment. For example, in DRC, regulations on the pricing of medical treatment are outdated. Prices are reportedly still listed in the country's former Zairian currency, and have not been updated into current Congolese francs. This means many public hospitals independently set their own prices. All these factors can serve to disadvantage vulnerable users, such as those in remote settings or people with disabilities, who are less able to choose the facilities where they receive treatment.

There is also evidence that service providers themselves may be ignorant over the content of laws and policies affecting their work. Health officials in the Zimbabwean study said that while there is a clear policy on anti-corruption in the sector, health workers are often unaware of it and may unknowingly be engaging in corrupt practices.

> **There is still a need to increase campaigns geared towards raising awareness of laws and policies…the level is obviously still low**
>
> A senior staff member from a Rwandan national health institution

Lack of enforcement

This speaks to another cross-cutting issue identified in the CRAs – that anti-corruption policies often exist, but there is a lack of enforcement. Many respondents attributed this to low investment in resources and capacities dedicated to investigating and sanctioning reported wrongdoing. Madagascar's large survey on the education sector found that only 20 per cent of respondents felt that sufficient efforts were being made to crack down on perpetrators of corruption.

In Rwanda, medical staff said that while there were clear guidelines on staff promotion, these were not effectively enforced, leading to unfair decisions. Similarly, while there were detailed guidelines setting out who in Rwanda is entitled to receive support from the nutritious food scheme, the research found that the absence of an effective oversight mechanism made these redundant.

Another reason for low enforcement is corruption among the people responsible for enforcement. For example, in DRC, many respondents indicated their belief that hospital inspectors may be corrupted by hospital administrators, and turn a blind eye to any misconduct they identify.

In Ghana, the research found that while many corruption risks within the NHIS tend to occur during contact between staff from the scheme and service providers such as hospitals, abuses of power by those in management and supervision positions can play an enabling role. Respondents indicated that there was a code of conduct, and that following monitoring missions, inspectors can recommend sanctions for violations of this code. However, these recommendations are often ignored and not implemented in practice.

Scarcity of resources

Across the countries studied, the driver of corruption most frequently mentioned for both the education and health sectors was the scarcity of resources. Many corrupt officials appear to be motivated by remuneration levels they perceive to be low.

As previously mentioned, this can largely be explained by lack of adequate funding, attributable to the five countries' status as low- and middle-income countries, as well as other short-term economic challenges. For example, in Rwanda, some people cited unpredictable inflation as a reason why individuals resort to corrupt practices.

In the face of already low allocations, corruption further deprives health care and educational institutions of much-needed resources. In DRC, health workers reportedly even embezzle medical supplies donated to public hospitals to address shortages. However, amid low salaries and low resource allocation, many study participants justified corruption as a survival tactic. In Zimbabwe, many of the interviewed street vendors said they were aware that selling illicit medicines had negative impacts on women, children, and vulnerable and marginalised people, but they saw no other option, as it was their sole source of livelihood.

ALAC complaint In Madagascar, health sector officials were accused of inflating the prices of medicines and overcharging patients. Some claimed they do this to compensate hospital or health centre staff when their salaries are delayed or unpaid.

Nevertheless, this justification may not always be made in good faith. In Madagascar, 42 people interviewed about corruption in the education sector expressed the view that greed was the main reason staff engaged in corruption, compared to 29 who pointed to the low remuneration rate. Service providers taking the redistribution of public resources into their own hands is clearly not a viable answer, because it leads to uncoordinated and unfair outcomes.

In countries where resources are allocated to address inequitable access to services, corruption still poses a significant threat. For example, in Rwanda, the potential of the *Ubudehe* programme to alleviate the disadvantages faced by people living in poverty was not fully realised, due to favouritism in the process of categorising eligible recipients.

ALAC complaint In Rwanda, a complaint was made against a director of an early childhood development centre that hosted 38 children suffering from malnutrition. The director allegedly misled authorities and requested nutritious food packages for 65 children, so she could sell the extra ones for profit.

Across the five countries, researchers found that services provided free of charge are among the most vulnerable to corruption. While essential to uphold citizens' rights to education, the recent establishment of free education in DRC and Madagascar appears to have created its own corruption risks, with officials finding new ways to demand enrolment fees. If the drivers of corruption remain unaddressed, corruption risks will manifest in new ways during policy shifts, even towards policies designed to promote equality.

Power imbalance

It is not a coincidence that some of the starkest corruption risks arise in processes where the education or health outcomes at stake are most critical. Accessing school, delivering a baby safely or getting a job can all have life-altering effects. Even less ostensibly critical forms of educational and health services entail strong inherent dependencies, because they contribute to these outcomes. This is especially true for people living in rural areas where there are fewer facilities to choose from, and for people from a background of poverty unable to turn to private-sector provision. In what has been termed "need corruption", users may engage in corruption not out of greed, but in order to obtain fair treatment towards the satisfaction of their basic needs.[78]

Service providers are invariably aware that these dependencies and what is essentially a power imbalance are at play, and that they can extract an illicit gain by threatening to withhold a critical service. Users may also be dissuaded from reporting corruption out of fear that the provider will retaliate with service withdrawal – particularly the case for people with caring responsibilities trying to access services for those they care for. This partly explains why underreporting of corruption and the scale of corruption in both sectors can seem to be underestimated by media coverage.

ALAC complaint In Madagascar, parents in several regions complained that they are asked to pay a sum of money to education officials at the beginning of the school year. They said while they knew that education should be free according to the government decree, they normally paid out of fear their children would lose their places in schools.

In DRC, some patients interviewed said that while they knew their rights, they were afraid to challenge medical staff, because they depended on them to access treatment. Other respondents indicated that not only is the lack of medical supplies in pharmacies caused by corruption and diversion, but that these shortages can themselves encourage the illicit sale of medicines by doctors and nurses, because patients have no other ways to purchase medicine. This suggests the existence of vicious corruption cycles, where corruption in the management of organisational resources begets further corruption at the interface with service users.

In certain circumstances, the reality is that users and providers face little option but to act in ways that facilitate corruption, unless they wish to make significant personal sacrifices. Indeed, this is analogous to the so-called "collective action problem" of systemic forms of corruption, whereby individuals do not resist corruption because they cannot trust others would do the same. Without a collective condemnation, the individual cost of not complying with corrupt practices may be perceived as too high.[79]

HOW DOES CORRUPTION AFFECT WOMEN, GIRLS AND GROUPS AT RISK OF DISCRIMINATION?

The ISDA project aims to develop an understanding of how corruption impedes access to services for all citizens, but with a particular focus on the experiences of women, girls and groups at risk of discrimination. Against the backdrop of risks affecting the general population's access to education and health, as uncovered by the research, there is also evidence that corruption and its drivers, forms and impacts can all affect marginalised groups in unique ways.

> **Corruption…will run it down to the point that…there is a wide gap between the vulnerable and well-established people**
>
> A health worker from Zimbabwe

It should be noted that while generally a minority view, some respondents in the five countries felt that the corruption risks and impacts faced by vulnerable groups were no different from those faced by others, or that they did not have the necessary information to assess this.

Vulnerability factors

Specific vulnerabilities compound the effects of corruption on certain groups at risk of discrimination. There is evidence that corruption overlaps with both direct and indirect forms of discrimination against certain groups.

Direct and indirect discrimination

Among other types, discrimination can be differentiated between direct and indirect forms. Direct discrimination refers to a person being treated unfavourably or otherwise subjected to disadvantage because of a characteristic protected under human rights law. Conversely, indirect discrimination occurs where the application of a uniform standard results in a particular disadvantage for persons sharing a particular characteristic.[80]

Evidence from Madagascar that people with disabilities may be directly targeted for bribery demands because of their disability status provides an example of direct discrimination. In Rwanda, the policy of allowing local leaders to categorise social protection beneficiaries can have the effect of indirectly discriminating against those groups not seen favourably by such leaders.

Rural or urban settings

Another key vulnerability factor identified in the national CRAs was the status of living in a rural area. There is a pronounced urban-rural divide in all ISDA target countries. Despite the emergence of growing urban centres, many people live in rural areas where availability of services tends to be comparatively lower.

This vulnerability is in part attributable to the challenges in oversight of facilities in remote locations. For example, in Ghana it was found that rural schools were more vulnerable to having "ghost teachers" listed on the payroll, because the authorities were less likely to inspect schools and verify whether they were teaching.

GII also found that corruption in the Ghanaian education sector could have more extreme impacts on children living in rural areas. Due to prevailing social norms, girls are less likely to be enrolled or retained in school in rural Ghana than boys. In rural areas in Northern Ghana, there are greater rates of child labour – for example, in illegal mining or on farms. Parents could therefore consider the financial pressure exerted by corruption in the education sector as a reason for removing their children from formal schooling and putting them to work.

Similarly, in Madagascar, researchers found that due to higher poverty rates, parents in rural areas were more likely to arrange early marriages for children or engage them in labour. Certain forms of corruption within schools can reinforce these tendencies and mean that parents are more likely to remove their children from the classroom. For example, it was found that dropouts are most likely to occur when the pupil fails to pass an official exam, making it crucial that all exams are administered and results issued in a fair and transparent manner.

TII-MG explored this vulnerability factor further in its research. The large-scale survey conducted on corruption in the education sector found that residents of rural areas were proportionally more likely to have encountered corruption compared to urban residents. It also found that people from rural regions may be more reluctant to report corruption because they were unfamiliar with the formal justice system, and even afraid of it.

In its health CRA, TII-MG found the shortage of health care staff was more likely in the primary health care units that rural populations rely on, leading to an excessive workload for existing staff, an overreliance on voluntary workers and a deterioration in the quality of treatment. Stakeholders reported that medicines often do not arrive in rural areas as scheduled. As a result,

doctors prioritise patients who can pay. TII-MG also found that around 52 per cent of individuals living in rural areas had not been exposed to anti-corruption information campaigns, compared to 33 per cent of those living in urban areas.

Of the six districts covered in Ghana's research, respondents from two of the more rural districts – with the lowest access to services – perceived corruption risks in the NHIS as higher than other respondents. This could indicate sub-national regional disparities in exposure to corruption, as well as correlations with levels of access to services.

Similarly, in DRC, several health-sector stakeholders said that while the number of inspections of facilities in Kinshasa was very low, inspections were virtually non-existent in rural areas. This suggests that the positive effects of anti-corruption efforts may not be distributed equitably, which can in turn widen the existing urban-rural gulf.

Ethnicity

In Africa, the demarcation of urban and rural areas, as well as national subregions in general, can correspond to various demographic patterns – for example, ethnic or religious lines. Ethnicity and religion as potential grounds for discrimination were not extensively discussed in the research. For example, all of the 108 school principals and teachers interviewed as key informants in Madagascar asserted that there was no discrimination in the admission of pupils based on ethnic origin. However, this could be due to political and sensitivities around these issues. In DRC, several respondents said that forms of favouritism such as tribalism can affect recruitment processes or even drive decision makers to unfairly terminate current staff contracts.

Other forms of discrimination faced by certain groups can make the impact of corruption more severe. For example, FGD respondents in Ghana agreed that corruption in the NHIS led fewer health facilities to treat members of the scheme. While this affects all subscribers, respondents noted that members of the Fulani – a minority ethnic group in Ghana, many of whom are nomadic or semi-nomadic – would be worse off. This is because Fulani people are often rejected from work opportunities that could give them sufficient financial means to access alternative health facilities.

Disability status

The findings also indicated that people with disabilities face aggravated corruption risks because of their status. For example, in Rwanda, reports indicated that as few schools are adequately equipped to teach children with disabilities, there is competition over places. One FGD respondent related that her neighbour was unable to pay the requested illicit fee to secure her child's place in such a school, meaning the child now remains at home. In a large-scale survey, TII-MG received responses from 4,040 parents, including 253 parents of children with disabilities. Among parents of children without disabilities, 27 per cent said they had at least one child of school age who was not in school, whereas the result was 61 per cent for parents with at least one child with a disability. Twelve parents of children with disabilities stated that their children had been refused enrolment in schools due to what they said was discrimination.

While factors unrelated to corruption may explain this variation, such as the unavailability of infrastructure like wheelchair ramps, inequitable access can be exacerbated by any form of corruption which restricts access to education.

Similarly, 128 people with disabilities responded to TII-MG's health-sector survey, almost 20 per cent of whom reported having to pay for care that should, in Madagascar, be free. Research findings included a report of people with disabilities having to pay carers to carry them within a health facility, due to the lack of wheelchairs, ramps and other forms of accessible infrastructure.

Poverty

The research found that poverty was one of the most severe factors affecting vulnerability to corruption in service delivery – a corollary of the scarcity of resources being one of the most significant drivers of such corruption.
Poverty or socio-economic disadvantage has not been universally recognised as a ground for discrimination to the same extent as other grounds.[81] However, regardless of this disagreement, poverty bears special relevance because of the concept of intersectionality, whereby individuals become exposed to discrimination when poverty is combined with another ground of discrimination.[82]

> **Women with disabilities face double discrimination. This discrimination is more pronounced among disabled women than among men**
>
> An NGO leader from Madagascar

For example, in several countries, respondents highlighted that rural women from backgrounds of poverty were especially vulnerable to corruption. When asked if they thought corruption had increased in the health sector over the past five years, rural Malagasy women with lower incomes held more pessimistic perceptions on average than men residing in urban areas.

Groups at risk of discrimination, such as people with disabilities, are often disproportionally exposed to poverty.[83] This also goes for women. In Africa, there are an estimated 127 women aged 25-34 living in extreme poverty for every 100 men.[84]

Corruption has particularly severe consequences for individuals and communities from a background of poverty. Some of the starkest impacts were documented in the DRC. While medical treatment is supposed to be immediately provided to patients in emergency situations, hospital staff often illicitly demand an illicit deposit is paid before they begin treatment. Many participants in the study said they knew cases where patients who were unable to pay this deposit were left untreated, leading to long-term health consequences or even death. Previous research has shown that low-income users are more likely to be discouraged when encountering corruption in basic services and to forgo such services completely, to the detriment of meeting their education and health needs.[85]

ALAC complaint In Zimbabwe, staff at a general hospital demanded payments from a man with a heart condition when he sought treatment. He was unable to afford them, and as a result his condition remains untreated at the time of writing.

Education and health care are both key to exiting poverty.[86] Corrupt practices that limit access to both can therefore reinforce the poverty trap and reduce social mobility.[87] This often takes on intergenerational dimensions.

ALAC complaint In Zimbabwe, a woman faced challenges enrolling her children in school because they did not have birth certificates. This was because she herself did not have a certificate, as her mother had died when she was young and there was a lack of necessary records to prove their familial relation. When the woman tried again to get a birth certificate, the authorities demanded she pay a US$100 bribe.

Similarly, forms of favouritism such as cronyism or nepotism can reinforce social cleavages. For example, in Rwanda, there is a backlog of patients awaiting transfers to hospitals. Several health workers admitted that knowing someone working in the facility is the best way to overcome this and be transferred. It is possible, then, that those who end up benefitting from these ties will often have similar backgrounds and characteristics to the education and health staff.

The research identified an extra layer of complexity in DRC, where there was widespread acknowledgement that medical staff may divert patients from a public hospital to receive treatment at private clinics that their relatives operate, from whom they can receive a commission.

In many cases, where quality is impacted, the alternative is to move to private-sector providers. But research has shown this is less viable for people from a background of poverty.[88] This creates disparities between those who can afford to address the gaps in public services that corruption creates. and those who cannot.

> **The children of poor parents who don't pay are excluded**
>
> A teacher on supplementary tutoring in DRC

Gendered manifestations

The gendered manifestations and impacts of corruption in public services are deeply rooted. One reason for this is that women and girls may be more reliant on such services, meaning the impacts of corruption limiting access are all the more critical to their survival and wellbeing. For example, women have differentiated health needs during their reproductive years, meaning they generally require more health care.[89] Some health concerns – for example, neglected tropical diseases – disproportionately affect women and girls in Africa, due to a combination of biological and sociocultural factors.[90]

This holds equally true for education. Some studies indicate that prevailing social norms mean that completing secondary education tends to be comparatively more important for girls in Africa than boys, in terms of obtaining employment and avoiding child marriage, among other factors.[91]

There are some services within both sectors that cater primarily to women or girls – for example, certain education sponsorship programmes or antenatal care. If corruption risks manifest in these processes, the impact primarily affects women and girls.

ALAC complaint In Rwanda, 15 single mothers complained that they had unfairly been removed from a social protection programme for health care. They suspected this was because others had bribed local leaders to be listed in their place. Rwanda's ALAC coordinated follow-up to the complaints and with the support of various agencies, all the women were relisted.

When asked about the likelihood of encountering corruption when accessing health services in DRC, 45 out of 107 women respondents (42 per cent) said it was "very high", while 41 out of the 114 men respondents (36 per cent) gave this response. In Madagascar, the ALAC based in the Atsimo-Andrefana region recorded 576 complaints by women aged between 15 and 60 relating to corruption in the health sector, compared to only 54 complaints by men within the same age bracket. While a wide range of other factors could contribute to these discrepancies, including how raising awareness about the ALAC is carried out, it is possible that they are indicative of women being more targeted by corruption in accessing health care, or at least having a higher level of perception of corruption in the sector.

Sexual corruption (or sextortion) occurs when those entrusted with power use it to sexually exploit those dependent on that power.[92,93] It is a gendered form of corruption, as women and girls are disproportionally targeted. People who have experienced sexual corruption may identify as "victims", but many identify as "survivors" or use other appellations. This report adopts the term "victim", but acknowledges that it may not be viewed as applicable in all cases.

The results of the ISDA research confirm the gendered nature of sexual corruption, identifying many personal and second-hand experiences of such corruption experienced by women and girls. However, there was at least one case in which a male victim of sexual corruption was mentioned.

Sexual corruption[94] is a form of gender-based violence that can cause physical harm and lasting psychological trauma.[95] Several longstanding impacts were documented in the ISDA project, including that sexual corruption can lead to students dropping out, contracting sexually transmitted diseases, or becoming pregnant and undergoing unsafe abortions. In Madagascar, it was noted that victims of sexual corruption in schools often go without any psychological treatment or support from trained social workers and psychologists.

> **If it [sexual corruption] is something that you wouldn't do…you will end up having to drop out**
>
> An FGD participant from Zimbabwe on the long-term impacts of sexual corruption in the education sector

Sexual corruption occurs across many education and health services. It often takes place at pressure points where the victim or their family's livelihood is at stake. For example, in DRC, many people said that supervisors solicit sex from female candidates for positions in the health sector, and that once recruited, they are still vulnerable to sexual corruption by supervisors.

ALAC complaint In DRC, a professor attempted to commit sexual corruption against a medical student. When she refused his advances, he failed her in the examinations, blocking her progression to the next class. The ALAC from DRC relayed her complaint to the university, which agreed to independently re-examine the student. She performed very well and passed.

Such abuses are facilitated by the widespread impunity which perpetrators of sexual corruption typically enjoy. This is often due to the failure of legislation or codes of conduct to explicitly account for the crime.

Sexual corruption commonly goes underreported because of higher barriers to reporting, including shame, fear of facing retaliation, experiencing re-traumatisation and the unavailability of a gender-sensitive reporting mechanism which recognises the unique aspects of the crime. The Madagascar large-scale education survey found that while 80 per cent of respondents believed citizens were free to report corruption, only 25 per cent believed women and girls had a safe space in schools to report sexual corruption. Victims may also fear facing further discrimination on reporting. Sexual corruption can be fundamentally misunderstood, due to prevailing

social norms towards gender. For example, some respondents from the DRC indicated victims of sexual corruption were themselves at fault.

In some countries, means of redress for sexual corruption exist – for example, rotation of staff to another facility. However, these mechanisms are usually inadequate and do not reflect the gravity of the offence.

> **Later, I learned that the doctor who was abusing women sexually had been transferred to another hospital**
>
> A Rwandan victim of sexual corruption

In Rwanda, FGD participants from marginalised groups expressed the view that widows, single women and divorced women were more likely to be targets of sexual corruption.

> **I was sexually assaulted by the doctor. When he recognised that I had no husband, he told me that I had to have sex with him so that I could have access to medicines**
>
> A Rwandan woman suffering from a chronic disease

Others noted that intersectional characteristics can deepen vulnerabilities. In Zimbabwe, researchers found that people with disabilities may be specifically targeted for sexual corruption. Poverty can also play a significant role, as the evidence suggests monetary forms of corruption and sexual corruption do not exist in isolation from each other, but rather that perpetrators may demand one when the other is not available. As in many societies, women possess fewer financial assets, or have less control over them. This can lead to corrupt individuals abusing their positions of authority to coerce and exploit women into sexual activities, because they cannot pay cash bribes. However, in other cases, women have been coerced into giving both a bribe and a sexual act (sometimes referred to as a "double-bribe").

Resilience

In uncovering corruption risks, the research findings paint a negative, even bleak, picture of access to education and health care in the five countries. However, the CRAs also documented many accounts of resilience, at the individual, community and institutional levels.

At the institutional level, respondents in Ghana largely agreed that digitalising the NHIS process made it easier to monitor for suspected corruption risks, although some noted that this digitalisation had not been rolled out evenly across the entire country.

At the individual level, the research uncovered cases of service providers who act with integrity and often go the extra mile in supporting their clients.

In Madagascar, community health workers, most of whom receive no formal payment, play an instrumental role in helping rural PHCs to overcome staff shortages and support local populations with nutrition and general health services. In Zimbabwe, researchers found that even where corruption leads to classroom overcrowding, many teachers do their best to cater to all students' needs, even if it is not sustainable.

> **Sometimes nurses or doctors spend their own money to buy syringes or gloves or even medicines**
>
> A respondent from the DRC

Reporting corruption is, in itself, one of the most profound expressions of individual and community resilience. In 2022, LICOCO set up two new ALAC mobile centres outside Kinshasa, to offer assistance to vulnerable people wanting to access services, and to distribute information about tools for combatting discriminatory corruption.

Madagascar's regional ALACs received complaints about corruption in the education and health sectors from 626 women and 83 men during 2023.

In 289 of these cases, the ALAC informed the competent authorities, but for many, follow-up action is still lacking.

At the community level, there is evidence of local actors supporting users in informal ways to circumvent the barriers to access caused by corrupt practices. In an FGD convened in Rwanda, a teenaged mother related a powerful story of overcoming adversity. After giving birth to her child, she attempted to enrol in a school again, but the headmaster rejected her, saying the school did not accept mothers. When she applied to another school, she became a victim of sexual corruption when a headmaster coerced her into having sexual intercourse to be admitted. A local NGO began to support her with financial means and other needs, and despite all these setbacks, she eventually graduated from secondary school.

Existing research suggests that community monitoring can be effective in decreasing corruption and improving the quality of service delivery in lower- and middle-income countries.[96] Despite this, the country research uncovered very few examples of deliberate measures to promote community participation in anti-corruption monitoring across education and health services.

Mainstreaming bottom-up approaches in this regard could be pivotal to improve access to these services. For instance, education stakeholders from DRC widely agreed that corruption in the sector could not be addressed by the ministry alone. Instead, it required a broader, multi-stakeholder approach based on community participation that empowers parent committees and civil society organisations to become more involved in oversight.

Inspiring examples are already emerging. In Ghana, GII helped form 11 Social Auditing Clubs across the Greater Accra, Central and Upper East regions. The clubs facilitate grassroots participation in decision making, monitoring local project implementation and service delivery in education and health, promoting transparency and accountability to ensure efficient use of public resources. Each club comprises 13 volunteers from recognised local groups, with at least 40 per cent female representation and at least one member living with a disability.

Such bottom-up interventions complement the need for state action by leading to more resilient communities. They serve as an inspiration which can – and should – be replicated and scaled up.

POLICY RECOMMENDATIONS

This section sets out key high-level and grassroots policy measures to address corruption in service delivery for the benefit of citizens, especially for those living on the margins.

The sheer level and impacts of the corruption risks described in the findings make the status quo in the five countries untenable. Policy shifts and new approaches are needed to ensure that the education and health systems perform their functions, and that service users – especially women, girls and groups at risk of discrimination – can enjoy their right to access quality public services. For these reasons, Transparency International has set out recommendations to address the drivers and manifestations of corruption risks found at the three main stages of the service delivery chain. These focus on some of the overlapping, common recommendations from the national CRAs, as well as broader recommendations deriving from a review of related literature.[97]

The recommendations largely require action from state actors, as the primary provider of services, but also emphasise a strong role for civil society, community initiatives, and actors engaged in regional and global policymaking.

A multi-stakeholder approach is especially critical to address corruption in public services. Anti-corruption solutions in the education and health sectors may not always sufficiently address the needs of women, girls and groups at risk of discrimination. This can mean that such solutions may not equally benefit all citizens, and could therefore widen existing inequalities.

On this basis, the United Nations Office on Drugs and Crime (UNODC) argues that "a gender perspective is a key component when developing effective programmes and projects to combat and prevent corruption and achieve sustainable development".[98]

All policy reforms and interventions should therefore be designed and implemented through a gender- and equality-sensitive lens, that translates into inclusive, active and authentic dialogue with women, girls and marginalised groups, to ensure their specific needs, vulnerabilities and interests are accounted for. This is best achieved by enabling their meaningful and inclusive participation on the path towards solutions.

INCLUSIVE PARTICIPATION

+ Civil society should capitalise on local community and individual resilience to facilitate participatory mechanisms that enable service users to demand transparency, accountability and integrity from education and health actors. CSOs must ensure these communities are given a platform to inform the design of policies that affect them, and to monitor their implementation.
+ Competent authorities should partner with locally based CSOs to address information asymmetries and ensure existing public information campaigns on education and health are adapted to reach marginalised groups. Communication campaigns must provide accessible information on prices of services and user rights, and encourage service users to recognise and report corruption by service providers.

+ Anti-corruption authorities and CSOs should enable the meaningful participation of equality partners such as women's organisations and organisations representing other marginalised groups, and ensure that the design and implementation of anti-corruption interventions address the needs of women, girls and groups at risk of discrimination.
+ Anti-corruption CSOs should build coalitions with equality partners such as women's organisations and organisations representing other marginalised groups. Together, anti-corruption actors can engage with and support these groups in accessing services. They can also advocate for policy responses to corruption in health care and education, based on the inclusion and empowerment of these groups.

AT THE POINT OF SERVICE DELIVERY

+ Ministries, regulatory bodies and other oversight institutions within the education and health sectors should introduce or strengthen codes of conduct and other policies and procedures with robust anti-corruption provisions and clearly defined sanctions to deter wrongdoing and hold service providers accountable. They should also ensure that anti-corruption indicators are mainstreamed in their assessment of facilities such as schools and hospitals.
+ Service providers such as hospitals and schools should develop corruption risk assessments as part of their internal risk management processes, and implement control and mitigation measures on an ongoing basis.
+ Ethics committees should ensure service providers are thoroughly trained on expected standards of behaviour and their duty of care towards users. They should enforce codes of conduct through regular inspection and by rewarding integrity and sanctioning illicit behaviour.
+ Competent authorities and CSOs within the education and health sectors should create locally accessible, gender-sensitive and inclusive reporting mechanisms. These should enable citizens, especially women and girls, to safely report sexual corruption and other forms of corruption, and ensure every report receives meaningful follow-up. There should be safe, accessible channels that encourage whistleblowers and third parties with knowledge of sexual corruption to report it.

MANAGEMENT OF ORGANISATIONAL RESOURCES

+ National, regional and local governments should maintain high levels of transparency in the disbursement of resources, including through the clear and timely publishing of information on the volume and kinds of organisational resources received by service providers. In turn, service providers should publish data on how these resources are distributed, disaggregated by socio-economic, gender and geographical indicators, to mitigate against shortages and waste.
+ Competent authorities within the education and health sectors should strengthen oversight systems for storing and transporting material resources. They should facilitate community-based monitoring and auditing of stocks, to improve accountability for public goods and counter embezzlement and diversion risks.
+ Competent authorities should carry out the procurement of supplies for educational and health facilities in accordance with open contracting and transparent public procurement standards, ensuring that information from pre-tendering, tendering, allocation and implementation stages is published in a timely and comprehensive way. For highly risky procurement processes such as construction of school and hospital facilities, the authorities should use integrity pacts.
+ Competent authorities within the education and health sectors should ensure merit-

based and transparent recruitment and other HR processes, to counter risks of bribery, favouritism and sexual corruption. This should include integrating independent assessments and ensuring candidates are aware of reporting mechanisms.

+ National governments should digitalise registration, recruitment and procurement processes in the education and health sectors, to enhance transparency and minimise opportunities for corruption. They should also adopt a risk-management approach, to proactively ensure digitalisation does not create new loopholes or further exclude marginalised groups.

NATIONAL POLICYMAKING

+ National governments should ensure that resource allocation for free universal education and health care is sufficient to prevent opportunities for corruption risks. They should consider using alternative funding mechanisms, such as direct transfers, formula funding and grants per capita, to ensure accountability for resources allocated to the education and health sectors.
+ National governments should enable or strengthen robust public participation and enable civic monitoring in the education and health budget cycles, using participatory budgeting, public expenditure tracking, gender budgeting, social audits and other social accountability mechanisms to ensure oversight over the allocation and use of public funds.
+ Ministries and regulatory authorities should mainstream anti-corruption safeguards and inclusive, equality-based policies into all key processes in the education and health sectors that impact women, girls and groups at risk of discrimination.
+ Competent authorities should create and participate in multi-stakeholder and multi-disciplinary task forces that bring together anti-corruption actors with interest groups representing women, girls and those at risk of discrimination, to ensure continual and inclusive monitoring of and follow-up on corruption risks, and to track the enforcement of policies and legislation.
+ Governments should strengthen the mandate and resources of independent oversight entities, such as supreme audit institutions (SAIs), to safeguard their independence in auditing the performance of public entities spending education and health care resources. Oversight bodies should ensure that anti-corruption indicators are a key part of their assessment methodology. Such entities should foster collaboration between CSOs in the education and health sectors, to raise relevant, locally identified issues, as well as to disseminate audit reports and ensure monitoring of the required follow-up actions.
+ Governments should invest in the resources and capacities required by competent authorities to ensure anti-corruption policies and laws are not only promulgated, but actively enforced, including through regular reviews.
+ National governments and parliaments should introduce or amend legislation to prohibit sexual corruption, so that offenders can be prosecuted on the basis of clear legal provisions.

REGIONAL AND GLOBAL POLICYMAKING

+ Within regional and global spaces, intergovernmental bodies and international CSOs should advocate for the recognition of the discriminatory nature of corruption – including gendered manifestations, such as sexual corruption – as a fundamental threat to effective service delivery, and to wider progress in development and equality.
+ Regional bodies such as the African Union should establish and operate learning fora within the Global South, and cooperate to collect and disseminate existing best practices in countering corruption in the education and health sectors.

+ Activists and organisations working in anti-discrimination and anti-corruption should foster dialogue and partnerships, in order to lead coordinated efforts against discriminatory corruption.
+ The international community should enhance technical assistance and sustainable development funding to address gaps in the education and health sectors in African countries, conditional on their committing to robust anti-corruption policies and implementing these effectively.
+ Donors should also place strong emphasis on robust, transparent and accountable public financial management frameworks that enable civil society to monitor budget allocation and expenditure, as well as on participatory planning and budgeting approaches involving beneficiaries.

ADOPTING A CONTEXT-SENSITIVE APPROACH

Reformers should account for local contexts and dynamics, to avoid unintended consequences. Policies designed to address corruption risks should themselves be subject to ongoing risk-sensitive analysis and monitoring, to ensure they do no harm. For example, while enabling local community participation can be the basis of many successful anti-corruption measures, cases such as Rwanda's discontinued *Ubudehe* system demonstrate that involving community-level actors and intermediaries can create new opportunities for corruption, and reproduce power hierarchies and discrimination. Likewise, digitalisation initiatives may entail their own risks of perpetuating discrimination and exclusion. While sanctions are an important deterrent and means of redress, authorities must take care that they do not unfairly punish those who have been driven to initiate corrupt acts due to lack of alternatives – for example, people forced to make an informal payment to access emergency medical treatment.

CONCLUSIONS

This research on corruption risks in education and health systems paves the way for further research and advocacy to improve access to essential services for all citizens – especially women, girls and groups at risk of discrimination.

CORRUPTION IN SERVICE DELIVERY

The CRAs conducted by the five Transparency International chapters deepen our collective understanding of corruption in service delivery. The research largely found that while there are idiosyncrasies to the education and health sectors in each country, they exhibit similar vulnerabilities to corrupt practices with discriminatory impacts.

The risks are highest where the stakes are highest. This includes corrupt behaviour at the interface between provider and user, but there also is a need to better document how corruption in resource organisation and policymaking processes creates incentives for corruption throughout the sectoral value chain, with knock-on exclusionary effects. Regardless of where it materialises, corruption reduces the quantity and quality of public services, and hits people who are most reliant on them the hardest. This means that while corruption has severe negative impacts for the general population, it can have especially tragic implications for women, girls and other people at risk of discrimination.

The nature of corruption across the five ISDA countries is not uniform, but the research painted an alarming picture of corruption patterns that are at times systemic and normalised. When this occurs, corruption paradoxically becomes almost invisible, as do the victims who bear the brunt of its impacts. The CRAs are a positive step in highlighting this reality in the five target countries and beyond.

AFRICAN SUSTAINABLE DEVELOPMENT

The findings are also relevant for wider African sustainable development projections and goals. Corruption is a cross-cutting issue which undermines the achievement of virtually every target related to education and health in the African Union's 2063 Agenda and the UN 2030 Agenda for Sustainable Development.
All the corruption risks identified from this research – be they bribery, sexual corruption or diversion – occur globally across higher-, middle- and lower-income countries. Although they are not unique to Africa, the research indicates that such risks have particularly extreme impacts on the continent, due to prevailing socio-economic challenges.

Robust education and health spending is a key bedrock for Africa's growth, including to maximise the promise of its youthful population. Not only does corruption undermine the right of each citizen to education and health care, but it also amounts to the waste of resources already scarce. This squanders the promise that quality education and health care hold for Africans.

The inadequacy of current funding for these sectors is both a driver and a consequence of corruption, as the illicit diversion of resources intensifies competition for them among service users and providers.

Addressing corruption in these sectors is essential to improving social and economic outcomes for millions of people across the continent. In light of the evidence presented in this report, tackling corruption in service delivery would entail

considerable net benefits for equality and development outcomes. Anti-corruption measures that improve access to quality health care and education can make an important contribution to the fight against entrenched poverty, especially where strategies to curb corruption account for the needs of those currently being left furthest behind.

AREAS FOR FUTURE RESEARCH

The CRAs have documented the most severe corruption risks in the health care and education sectors, and shed the clearest light to date on the discriminatory impact that unchecked corruption has on marginalised people's access to these essential services.

The next step will involve studying broader patterns of discriminatory corruption in these sectors affecting women, girls and other marginalised groups. This second phase of research will move away from the institutional focus of the CRAs to adopt a bottom-up approach, focused on participatory and exploratory research with disadvantaged communities.

Due to gaps, more work will be undertaken to analyse corruption risks at the policymaking stage – for example, to better understand to what extent corruption identified at the point of service delivery and the organisation of resources can be traced back to risks of corruption existing in public resource allocation. There is also a need to conduct deeper research on the role that social norms play in shaping corruption in service delivery, especially behaviours towards women, girls and groups at risk of discrimination.

Ultimately, Transparency International and its partners will use this aggregated body of evidence to inform more targeted efforts to improve access and overcome identified barriers to education and health care services for women, girls and other groups at risk of discrimination in the DRC, Ghana, Madagascar, Rwanda and Zimbabwe.

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