

Using power and influence analysis to address corruption risks

The case of the Ugandan drug supply chain



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Power and influence analysis can be used to assess corruption vulnerabilities in the public sector. This approach helps identify powerful stakeholders that should be engaged to achieve maximum impact for anti-corruption strategies. It also helps reveal informal political networks and relationships that can hamper anti-corruption efforts. Power and influence analysis was applied to the Ugandan public sector drug supply chain and suggested that interventions aimed at reducing corruption risks would need to take into account the influence of informal political power in addition to the formal institutional mandates, and the prevalence of a vast network of patronage networks across the country.



combining institutional and stakeholder mapping with rational choice assumptions to develop tailored interview questionnaires.¹

This brief illustrates this approach drawing on evidence from a recent study of the Ugandan public sector drug supply chain (Baez-Camargo and Kamujuni 2011).² In this case, interviews and focus group discussions were conducted with a broad range of stakeholders, including health care practitioners, patients, donors, and civil society organisations working in the health sector.

Power and influence analysis is intended to uncover discrepancies between formal and informal rules, actors, and the distribution of decision-making power. It helps reveal how informal elements can generate incentives that have an impact on basic state functions such as the delivery of public services. The methodology involves

Background to the Ugandan case

In November 2009, in a context of public outrage over widespread stock-outs of essential drugs at public health facilities (Njoroge and Lister 2009), the Ugandan government

centralised the budget for drugs and medical supplies. The National Medical Stores (NMS), a parastatal corporation mandated with the procurement, storage, and distribution of drugs for the public sector, was given direct decision-making authority over these funds, which had been previously allocated to local governments and mostly under the control of District Health Officers (DHOs). Concern over the outcome of this reform in terms of corruption risks generated the motivation for donors to commission the study on power and influence analysis.

A first output generated from the study is illustrated in Figure 1. Firstly, it shows that the formal governance structure of the Ugandan public sector drug supply chain is complicated by the number of actors involved and by a complex division of tasks.

The Ministry of Health (MoH) has the formal and ultimate responsibility for ensuring continuous distribution of drugs across the public health sector, and has the ability to call NMS to account through the regular monitoring of its activities.

However, the reform has placed the NMS in a key position to ensure drug supply outcomes given its centrality in the processes of financing, procurement, and distribution of drugs for the public sector.³ More importantly, a point on which there was consensus in the interviews conducted for this study was the fact that the MoH has lost much influence in the health sector, generally, and in matters relating to the drug supply chain, specifically. Frequently mentioned was the fact that relations between the NMS and the MoH are quite strained, permeated by mistrust and lack of communication. An expression of this situation is that the NMS began producing its own data and statistics on drug tracking and monitoring, and stopped altogether using the data produced by the MoH. Furthermore, stakeholder consultations also suggested that the MoH has

been sidestepped because the policy change has directed the actual accountability incentives of the NMS towards the Ministry of Finance, Planning and Economic Development, which retains control over the budget for drugs.

At the same time, local stakeholders also consistently expressed the view that even though the new system has improved overall availability of essential drugs, stock-outs at health facilities persist, and drugs intended to be dispensed free of charge continue to be found for sale in private pharmacies at inflated prices. Furthermore, other problems with the drug supply have become increasingly common. For example, health facilities often receive items they did not order and that poorly match the disease burden in their constituencies, which may be due to inefficiencies but could also be linked to corrupt practices in the procurement process.

The study identified two major corruption risks along the drug supply chain:

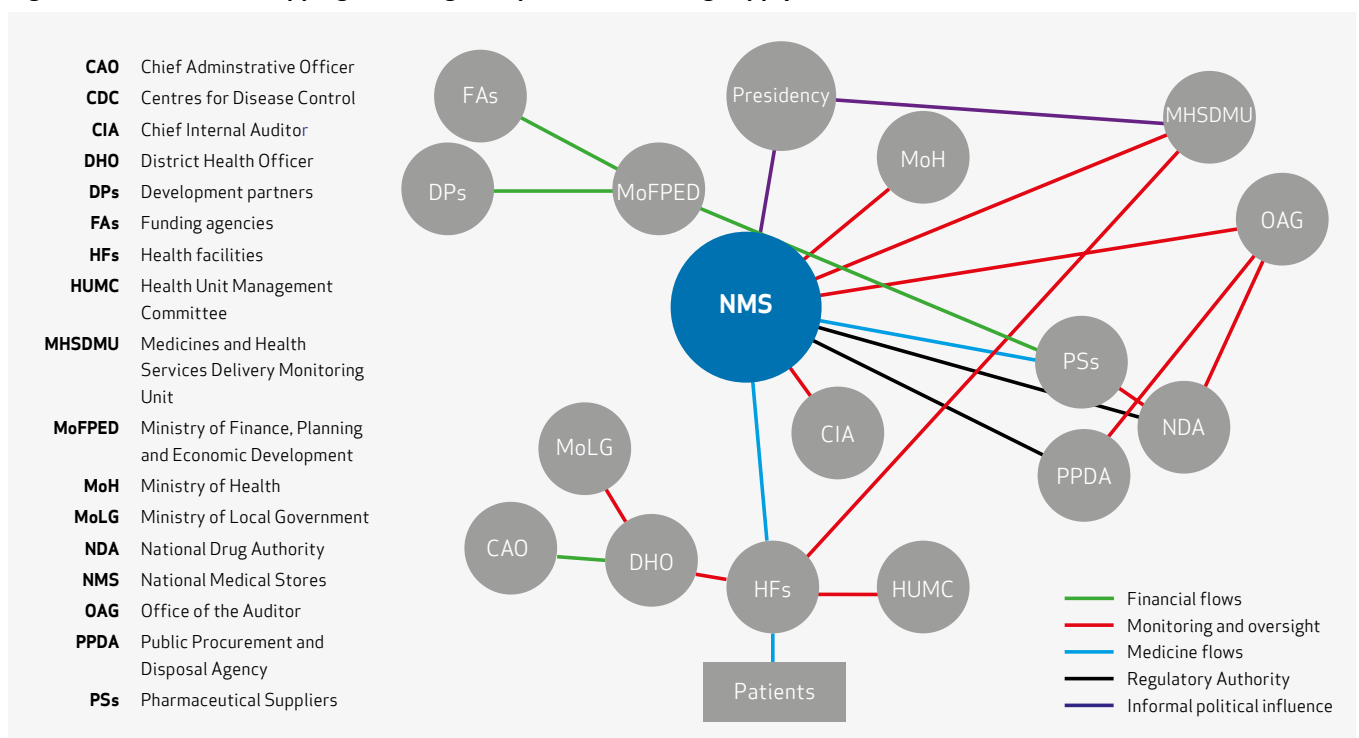
1. Lack of NMS accountability and transparency regarding the manner in which the budget is being executed,⁴ and
2. Drug pilferage.

The next sections describe how, by incorporating the political context explicitly, the application of a power and influence lens can shed light on key factors underlying these corruption risks.

Political context I: Centralisation of informal power and lack of accountability and transparency at the NMS

Despite formal democratic provisions, the Ugandan political landscape can be described as an authoritarian

Figure 1: Institutional mapping of the Uganda public sector drug supply chain



Source: Baez-Camargo and Kamujuni

regime, characterised by the personalisation of power, especially in the figure of President Yoweri Museveni. In the absence of meaningful checks and balances, the president has almost unlimited power to make decisions regarding appointments, demotions, and policy changes. Political decisions tend to be highly discretionary mainly because actual power relations are a function of individuals and not of institutions (Tangri and Mwenda 2010).

The government of President Museveni, in power since 1986, has been facing increasing opposition and criticism. This was especially visible following the 2011 presidential elections when, after the announcement of Museveni's "undisputed" victory, opposition groups took to the streets in Kampala in massive demonstrations and riots. The political situation is sensitive, raising the perceived costs of criticising the regime.

This system, where the possibility of discretionary decision-making is based on personal loyalties and relationships, generates incentives for government officials to act in ways that protect and advance their political positions rather than adhere to their legal mandate. Personalised and informal power generates important incentives that work against transparency and accountability of public officials and agencies.

As mentioned before, the most powerful agent along the Ugandan public drug supply chain is the NMS. A personal connection of its general manager to the president and the fact that this agency was given large space for discretionary action skewed power and influence in the health sector in the direction of NMS. Nevertheless, the main counterpart of donor agencies supporting health sector reform in Uganda has continued to be the MoH.

However, what the discussion in the previous section suggests is that just as the decision to centralise the budget for drugs was taken abruptly, unilaterally, and against the will of important stakeholders, it could potentially be reversed in the same manner. In fact, during the period when the study was conducted the NMS general manager demonstrated concern about a possible reversal of the reform.

The analysis suggests that the NMS general manager operates under substantial political pressure, especially because poor perceptions about the performance of highly visible officials were seen to intensify public discontent in a context of already growing opposition to the regime. Because the decision to pre-finance the NMS was a "presidential" response to outrage over persistent stock-outs, the highest levels of government were concerned about the strong criticism of the NMS's performance by the Office of the Auditor General (2010) and the media.

Bringing all these elements together, it can be concluded that the NMS is trapped in a vicious cycle: to avoid potentially harmful criticism, it does not open its operations and accounts to outside scrutiny. This behaviour in turn generates further suspicions among stakeholders. On the other side, the more external voices criticise the NMS in a spirit of confrontation, the greater the incentives are for the NMS to remain closed to public scrutiny.

Political context II: Fragmentation of formal decision-making power and drug leakages at the local level

A significant mechanism to maintain support for the Ugandan regime is through widespread patronage networks (Mwenda 2007). Though informal authority is highly concentrated and personalised, formally the Ugandan state is substantially decentralised.⁵ This decentralised structure facilitates the distribution of benefits to political supporters by generating a multiplicity of local budget allocations and public sector positions that can be exchanged for political support from powerful ethnic and regional groups. For example, at the district level, the human resources decisions for health centres represent an integral part of the spoils available to District Health Officers to feed local patronage systems.

In order to understand the motivations behind the persistence of drug pilferage down the distribution line, one must look at the incentives faced by health facility workers at the local level. A survey conducted among health workers revealed that at the top of the list of concerns for this group were, quite unequivocally, money and career progression (Medicines and Health Service Delivery Monitoring Unit 2010). On these two aspects, however, the prospects of an average health worker in Uganda are quite grim. Although government increased the salary of lower medical staff recently, their pay remains among the lowest in East Africa. According to the same study some staff in the health centres had for months and, in some cases, years not received salaries (Medicines and Health Service Delivery Monitoring Unit 2010). Also, among the impacts of Uganda's decentralisation is the fact that health workers cannot be promoted beyond their district, which results in limited career opportunities.

Local health workers' incentives are also impacted by the manner in which monitoring of their activities is carried out. Monitoring is extremely challenging in a context of scarce economic resources and a decentralised health system.⁶ To address these challenges Uganda created a new and powerful agency: the Medicines and Health Service Delivery Monitoring Unit (MHSDMU). Though more is needed to know about the MHSDMU'S performance, anecdotal evidence from civil society organisations and donors suggest that the MHSDMU operates in a harsh, authoritarian manner, which makes people afraid. For example, in order not to be punished for stock-outs, health facility staff are said to keep a safety stock on hand even when patients need the drugs. On the other hand, the profit margins resulting from selling drugs at inflated prices in the private sector constitute an incentive for persistent drug leakages from the public to the private sector.

Addressing corruption at this level thus requires a comprehensive approach in order to make a career in the health sector a viable, attractive avenue to personal advancement involving not only better remuneration and promotion possibilities, but also adequate monitoring and enforcement mechanisms. The institution of a civil service-type scheme for health workers could address all such issues by generating the correct incentives for workers to adequately store, manage, and dispense drugs.



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However, perhaps the most problematic obstacle to developing a merit-based career path has to do with the politics of decentralisation as discussed above. At the district level the human resources decisions for health centres represent an integral part of the spoils available to feed local patronage systems. Therefore local politicians, who benefit from the patronage system, are unlikely to support reforms that might create better career opportunities (for example, centralising some human resources decisions). In fact one official working with a multilateral organisation in Uganda who was interviewed for the study confirmed that opposition to this type of reform had already been voiced by a number of local health authorities.

Lessons learned

The power and influence analysis of the Ugandan drug supply chain revealed a mismatch between formal and informal powers, especially between the MoH and the NMS, with the latter being de facto more powerful than its purely formal mandate would suggest. This situation underpins the lack of accountability and transparency of the NMS and is one that would be overlooked by relying solely on a formal assessment of the regulatory framework. A power and influence analysis is therefore useful to identify the most powerful decision

makers regardless of their formal mandate. For donors it is thus important to directly engage the actors who have greatest power over the issue, in addition to work with those with the formally assigned authority, in order to improve the effectiveness of any anticorruption effort.

Power and influence analysis may also help donors to avoid devising technically sound but politically unfeasible solutions, especially avoiding interventions that generate political zero-sum situations for stakeholders. In the Ugandan case any intervention aimed at improving the incentives faced by those who handle drugs should take into account the vested interests in the existing system shared by local authorities, who rely on patronage networks for legitimacy and support among their constituencies.

Power and influence analysis can be used by donors as a tool alongside other analytical frameworks that focus on formal rules and regulations as the basis to devise sound anticorruption strategies. Rather than pointing to a technical solution, the power and influence analysis can serve as a reference to guide donors to select good practice strategies in their anticorruption toolkits that could best be adapted to the local context putting special emphasis on political feasibility given the political constraints of each case.

The author wishes to acknowledge the financial support of the Swiss National Science Foundation, Grant Number K-13K1-122277/1 for development of the ideas applied in this study and the financial and logistical support of the Swedish International Development Cooperation Agency (SIDA), Embassy of Sweden, Kampala, Uganda for field research.

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Notes

1. For a full description of this approach as well as the analytical tools and sample questionnaires please see Baez-Camargo and Jacobs (2011). The approach was originally developed for the assessment of health systems' governance but can be used across other sectors.
2. This study was commissioned to the Basel Institute on Governance by SIDA/Swedish Embassy Kampala to assess corruption risks in the Ugandan drug supply chain during May 2011. The findings were shared in a workshop with the Development Partners Health Working Group in June 2011.
3. A complete description of the different agencies involved in the drug supply chain is beyond the scope of this brief and can be found elsewhere (World Bank Institute 2010, Economic Policy Research Centre 2010).
4. An expression of this can be verified by visiting NMS's webpage, which has fields designed to provide information on budget, suppliers, and national price survey among others, but are all empty displaying a note reading "No information has yet been uploaded" <http://www.natmedstores.org/>, last accessed 25 February 2012.
5. This is illustrated by the fact that the country went from having 33 districts in 1990 to 112 in 2010.
6. For example, the National Drug Authority (NDA) is in charge of monitoring the registration of pharmacies across all 112 districts with a total of 1,000 sub-counties in the country, but NDA has only seven regional centres with an average of two staff members per regional office.