STRENGTHENING INTEGRITY IN AFRICA'S HEALTH SYSTEMS

Combating Corruption and Inequality

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Transparency International Global Health is dedicated to advancing universal health care coverage by reducing corruption in the health sector.

ACRONYMS AND ABBREVIATIONS

Acronym	Full Form
AFEM	Association des Femmes des Médias
AMA	African Medicines Agency
AUDA-NEPAD	African Union Development Agency – New Partnership for Africa's Development
CSO	Civil Society Organisation
DRC	Democratic Republic of the Congo
eLMIS	Electronic Logistics Management Information System
ECOWAS	Economic Community of West African States
EAC	East African Community
GHS	Ghanaian Cedi
HMIS	Health Management Information System
IRP	International Reference Pricing
ISDA	Inclusive Service Delivery Africa
MOH	Ministry of Health
NGO	Non-Governmental Organisation
SALAMA	Centrale d'Achat de Médicaments Essentiels (Central Medical Store of Madagascar)
SDG	Sustainable Development Goal
SIDA	Swedish International Development Cooperation Agency
TI	Transparency International
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Corruption in health systems reduces access to essential services, devalues public spending, undermines public trust, and widens gender and social inequalities. This policy brief outlines evidence from Corruption Risk Assessments (CRAs) conducted in the Democratic Republic of Congo (DRC), Ghana, Madagascar, Rwanda, and Zimbabwe under the Inclusive Service Delivery in Africa (ISDA) project. Data reveals deep integrity[1] gaps across procurement, supply chains, workforce governance, and service delivery. These gaps hinder the right to health for millions of people, with women, girls, and marginalised populations bearing the greatest burden. These forms of corruption weaken progress towards Sustainable Development Goal (SDG) 3 on health and wellbeing, and SDG 16 on peace, justice, and strong institutions.

As women and girls are the primary users of public health services for reproductive, maternal, and child health, when corruption diverts medicines or imposes illegal fees, they are the first to be excluded. The United Nations in 2023 noted that nearly US $9.5 billion is lost annually to corruption in the health sector in Africa [1]. In Ghana, national procurement audits have shown that approximately US $5 million was paid in bribes to public officials in the health sector [2]. In the DRC, audits of donor-financed and government health commodities have repeatedly found large volumes of medicines that have gone missing [3,4]. In Zimbabwe, audits and Civil Society Organisations (CSO) investigations between 2020 and 2023 found irregular and non-competitive contracts worth tens of millions of US dollars at NatPharm, including contracts to suppliers with no track record and payments without delivery [5,6,7]. In Rwanda, recent national monitoring reports show public facilities stocked around 60% of traced medicines, well below the 80% WHO target, and that shortages were more frequent in rural facilities [8,9]. In Madagascar, supply chain assessments in 2022 and 2023 found systematic gaps in delivery confirmation from the Central Medical Store (SALAMA) to health centres, particularly in rural districts, resulting in a significant proportion of consignments that could not be verified at the point of use [26,27,39].

Evidence from countries beyond the ISDA project further illustrates the scale and scope of the challenge. In Nigeria, the health sector ranks among the top four where bribes are solicited, with approximately 45% of service users reported paying a bribe, according to recent UNODC findings [2]. These figures quantify how corruption adversely affects availability, affordability, and quality of health services, particularly among women and girls. The World Health Organization (WHO) recognises that corruption and inefficiency are among the main systemic causes of avoidable maternal and child deaths in low- and middle-income countries [12]. In sub-Saharan Africa, the maternal mortality ratio is 448 deaths per 100,000 live births as of 2023, which is almost three times higher than the global average [13]. Corruption contributes an unseen role in these outcomes, through bribery, procurement fraud, absenteeism, diversion of supplies, weak accountability mechanisms, and sexual coercion in health facilities [13,17,18]. Disabled persons and those living in remote areas face even higher exclusion when shortages or bribery force travel to distance private providers or prevent services from being delivered altogether.

Strengthening integrity in health systems requires a comprehensive strategy built on transparency, accountability, and community engagement. Key recommendations include improving access to procurement data, adopting digital systems to track medicines and payroll, reinforcing anti-corruption oversight, and engaging women's groups in monitoring roles. Alongside strong protection mechanisms for whistle-blowers, these measures will help reduce corruption, enhance service delivery, and ensure resources reach vulnerable populations, ultimately improving trust and health outcomes.

Building public trust requires both technical efficiency and visible integrity. Individuals are less likely to seek care in facilities perceived as corrupt or where medicines are routinely unavailable. Tackling corruption through open contracting, civic monitoring, digital traceability, and protection against informal payments is therefore essential to restoring confidence and ensuring that public resources reach those most in need. Strengthening integrity in health systems requires coordinated reforms that improve transparency, accountability, and skills, from budgeting and procurement to medicine distribution and frontline service delivery. Without such reforms, inequities in access to healthcare will persist, and progress towards universal health coverage will remain constrained.

GOVERNANCE, FINANCIAL, AND PROCUREMENT INTEGRITY IN HEALTH SYSTEMS

Public trust is both an outcome and determinant of effective health systems. Corruption destroys the legitimacy of health systems and creates a moral hazard for those unable to pay. In this policy brief, corruption encompasses bribery, procurement fraud, diversion of medicines, absenteeism, payroll manipulation, insurance abuse, and failures of oversight and accountability across the health system. In the health sector, integrity failures have particularly severe consequences, as they directly affect life-saving services and the realisation of the right to health for all.

Across countries in the ISDA project, the evidence is consistent. In Ghana, nearly 40% of individuals identify the health sector as corrupt [14]. The Ghana Statistical Service (GSS) and United Nations Office of Drugs and Crime (UNODC) found that 27% of adults reported paying a bribe to a public official in 2021, representing approximately US $5 million in illicit payments [2]. Women were more likely than men to encounter those demands, particularly during childbirth and child immunisation visits [2,14]. The GSS report highlighted that informal fees raise the effective cost of institutional delivery by 25% above official rates, deterring low-income households from seeking care [2]. Beyond direct bribery, evidence also points to systemic abuses within service delivery and insurance arrangements, including overcharging, double billing, and referral practices that financially benefit providers at the expense of patients, disproportionately affecting women and low-income groups.

In the DRC, the 2019 Transparency International Global Corruption Barometer found that 43% of citizens reported paying bribes to access medical care, which is one of the highest rates in sub-Saharan Africa [14]. Research shows that more than 50% of women who delivered in public hospitals were asked to make unofficial payments for essential items such as gloves and medicines, despite national policies providing free maternal care [15,16]. Evidence from the WHO Independent Commission and national civil society groups also documented cases of sexual exploitation and coercion by health staff, eroding confidence in public maternity services and contributing to the country's high maternal mortality ratio of 547 deaths per 100,000 live births [13,17,18]. These practices reflect broader workforce governance failures, including weak supervision, limited accountability, and insufficient protection for whistle-blowers.

Transparency International Zimbabwe documented that irregularities affected 30–35% of public procurement contracts in the health sector, including cases where deliveries were not verified and funds were misused [19]. An audit by the Office of the Auditor General found stock discrepancies in 28% of medical stores, indicating weak oversight and diversion of supplies [20]. Such procurement failures have resulted in recurring shortages of essential medicines in public hospitals, forcing patients to seek care in the private sector or forego treatment altogether. This illustrates how procurement fraud and supply chain manipulation, can generate medicine shortages and undermine service delivery. Household surveys in rural provinces revealed that over half of women (around 52%) reported being asked to provide informal "appreciation" payments to access maternity or child health services [19,22]. These unofficial charges typically ranged from US $2 to 5 per visit, which constitutes a serious financial strain given that over 70% of

Zimbabweans live below the poverty line [21]. Such practices drive women to seek care from unregulated traditional birth attendants or informal medicine sellers, increasing risks of maternal and neonatal complications [14,22].

In Rwanda, national pharmaceutical data show that public-sector availability of essential medicines averaged 60% in 2022, well below the 80% target recommended by the WHO [23]. A performance audit by the Office of the Auditor General found that 17% of insured patients were charged additional or unofficial fees for maternity services already covered by community-based health insurance schemes [24]. Field surveys indicate that women living in rural areas spend significantly longer, typically up to two additional hours per visit, negotiating or contesting these informal fees, which delays care and discourages facility-based delivery [25]. These informal costs undermine confidence in the Mutuelle de Santé insurance programme and deter poorer households, particularly female-headed ones, from accessing needed care [24,25]. These findings highlight that insurance coverage alone does not guarantee access when integrity and enforcement mechanisms are weak.

In Madagascar, corruption and logistical failures continue to undermine equitable access to medicines. A 2022 national assessment found that nearly 40% of essential medicines failed to reach rural health centres, largely due to weak stock-tracking systems and irregular procurement oversight [26]. The World Bank's Service Delivery Indicators survey showed that around one-third of rural households (33%) postponed or avoided medical consultations because of informal payments or medicine shortages [27]. Qualitative interviews further revealed that approximately 30% of women reported being mistreated, ignored, or verbally abused by staff when unable to pay these fees [28]. The interactions between procurement failures, supply chain weaknesses, and frontline service delivery compounds exclusion for women, people with disabilities, and those in remote areas.

Corruption also contributes to the gradual erosion of public systems and the expansion of private provision. When procurement failures, workforce absenteeism, and medicine shortages persist, public services become unreliable, creating space for private providers to fill gaps that should be publicly financed. This dynamic can benefit politically exposed individuals and exacerbate inequality, as services that were previously free or subsidised become accessible only to those who can pay. Similar governance patterns have been observed across other public sectors, including education, where procurement and ownership conflicts undermine public provision, suggesting that integrity challenges are systemic rather than sector specific.

A further challenge is the normalisation of corruption within public services. In several contexts, inefficiencies are tolerated or deliberately sustained, and informal payments become socially accepted as a means of accessing basic services. This normalisation weakens accountability, discourages reporting, and entrenches inequity, particularly for women and vulnerable groups who rely most heavily on public health systems.

Corruption amplifies existing gender, geographic, and disability inequalities. When bribes are required for care, wealth and connections become the gatekeeper of survival. For women and marginalised populations, integrity in the health system directly impacts their lived experiences, whether childbirth is safe, a sick child receives adequate treatment, or persons with disabilities can access essential rehabilitation services.

Public trust in health systems depends on transparency, accountability, and fair access to care. When corruption goes unaddressed, individuals lose confidence in public institutions and turn to unsafe or unaffordable alternatives. Governments must ensure that funds are managed openly, procurement processes are verified, and health workers are held accountable for ethical conduct. Strengthening integrity across these interconnected systems is therefore essential not only for improving efficiency, but for protecting human rights and ensuring equitable health outcomes. Clear oversight and public reporting build credibility and ensure that women, girls, and marginalised groups receive the services they are entitled to.

THREE KEY PILLARS

Recommendations arising from this policy brief are structured around three interconnected pillars of integrity in health systems. Together, these pillars reflect the full lifecycle of public health resources, from allocation and procurement to distribution and service delivery, and finally to frontline governance and accountability. Weaknesses at any stage creates opportunities for corruption, inefficiency, and abuse, with compounding effects across the system.

This approach reflects evidence that corruption in health systems is rarely isolated to a single function and instead emerges from systemic governance failures.

Pillar 1: Procurement Integrity

Procurement integrity is essential for an efficient health system. In countries where the ISDA project was implemented, weak oversight of tendering and contract management diverts scarce funds from frontline services, undermines medicine availability, and inflates treatment costs for health service users. Procurement integrity refers to the objective, transparent, and rules-based allocation of public contracts, ensuring that suppliers are selected based on value, quality, and compliance. The gendered consequences are critical; fewer obstetrics equipment, contraceptives, and essential drugs reach facilities that serve women and children.

In Ghana, the Office of the Auditor-General reported in 2023 that 26% of Ministry of Health contracts were awarded through restricted or sole-source procedures, contravening the Public Procurement Act [29]. The audit estimated potential losses of approximately US $30 million from inflated pricing and unverified deliveries [29]. Independent analyses found that maternal health commodities procured through non-competitive tenders cost up to 34% more than those obtained through open bidding processes [30]. This inefficiency has tangible consequences for service delivery, as 12% of hospitals reported stockouts of oxytocin in 2022, leaving maternity wards without an essential obstetric drug [31]. These outcomes illustrate how procurement malpractice can undermine maternal health services.

In Zimbabwe, the Office of the Auditor-General identified irregular contracts amounting to nearly US $100 million between 2020 and 2023, including tenders awarded to companies without delivery verification or adequate performance histories [20,32]. This practice of prepayment without delivery has been a recurrent feature of procurement failure, directly contributing to shortages of essential medicines in public hospitals. Field assessments and civil society reports revealed that shortages of antibiotics and obstetric supplies have been associated with increased maternal infection risks in public hospitals [22]. These failures demonstrate how systemic mismanagement of resources translates into heightened maternal risk and preventable deaths.

In DRC, a 2021 public expenditure review estimated that approximately 35% of the national health budget is lost annually to procurement fraud, inflated contracts, and mismanagement, equating to around US $225 million per year [33]. Civil society organisations report that such leakages cause chronic shortages of reproductive health commodities, forcing expectant mothers to purchase "maternity kits" privately for US $15–25, which represents more than a week's household income for most families [17]. These corruption-driven practices severely constrain women's access to safe and affordable care and entrench health inequalities between rich and poor.

In Rwanda, the introduction of the electronic procurement platform, Umucyo, in 2016 helped reduce tender processing time by 35% and increase supplier participation by 22% [34]. However, evidence from the COVID-19 period demonstrated that emergency procurement procedures increased exposure to corruption risks, including limited competition, opaque supplier selection, and weakened delivery verification mechanisms [4]. National audits found gaps in documentation and compliance during emergency health procurements, highlighting the importance of maintaining integrity safeguards even during crises. Research across African countries demonstrates that greater gender diversity among suppliers enhances market transparency, reduces collusion, and promotes equitable access to public resources [36]. Expanding women's participation in procurement is therefore both an integrity and equity imperative.

In Madagascar, the Central Medical Store (SALAMA) reported in 2023 that 44% of consignments were delayed beyond contract deadlines, largely due to payment disputes, opaque supplier selection, and weak performance monitoring [26,39]. These delays disrupted the timely distribution of contraceptives and maternal health commodities, leaving 37% of rural health facilities without reproductive health supplies for at least one

month each year [27,39]. Persistent bottlenecks in procurement and delivery systems undermine service continuity, erode public confidence, and reinforce gender and geographic disparities in health access

Actions for Transparent Procurement

1. **Transparent Procurement Disclosure**
   Countries should commit to publishing procurement plans, tender announcements, evaluation outcomes, contract values, and delivery confirmations through open-data platforms. Real-time transparency strengthens public oversight and helps prevent collusion.

2. **Benchmark Pricing and Pre-Award Review**
   Procurement systems should apply benchmark pricing based on database sources from the WHO and UNICEF. Any bid exceeding the benchmark by more than 20 percent should automatically trigger a technical review before approval, as it signifies potential corruption and overpricing above market value. International Reference Pricing (IRP) should be mandatory for medicine procurement to detect abnormal price inflation. In highly corrupt or weakly regulated settings, medicine prices can reach up to 100% above international reference prices, particularly where competition is limited or emergency procurement is misused [63]. Bids exceeding reference prices must trigger automatic review, public justification, and independent verification to prevent inflated or fraudulent contracts.

3. **Civic Oversight and Integrity Pacts**
   Civil society, specifically women's networks and patient advocacy groups, should be actively involved in monitoring tenders and tracking deliveries. Their role is to strengthen oversight and accountability. In Madagascar, a World Bank-supported citizen-monitoring pilot improved delivery verification and reduced stock diversion by increasing oversight of medicine distribution [45]. This approach boosted accountability and helped ensure essential supplies reached facilities more reliably.

4. **Gender Inclusive Procurement Policies**
   Health ministries should implement measures that support women-owned businesses, such as procurement quotas or scoring incentives, supplier training programs, and public reporting of sex-disaggregated contract data. Procurement integrity is strengthened by ensuring that women's organisations, patient groups, and frontline service users are represented in oversight, complaints, and monitoring mechanisms. Strengthening women's participation enhances transparency and broadens accountability.

5. **Independent Verification of Deliveries**
   Supplier payments should be contingent on third-party confirmation that goods have arrived at their intended facilities. Verification teams including community health workers, community health committees, and women's groups can play a key role in preventing false delivery claims. A set of criteria for quality checks should be used for verification.

Transparent procurement brings two key benefits. It protects public funds and strengthens trust in institutions. When women see maternal health supplies arrive on time and have clear access to information about how resources are used, confidence in the health system grows. Procurement integrity is a cornerstone of equitable health systems and helps deliver essential care to women, girls, and marginalised populations.

Pillar 2: Strengthening Supply Chain Integrity

A transparent and well-regulated medical supply chain is essential for reliable access to medicines. In many African countries, weak inventory systems, unverified deliveries, and inadequate monitoring create opportunities for diversion and theft. However, evidence indicates that corruption and governance issues that begin upstream in financing and procurement systems are often the root cause of these failures. Upstream financing and procurement systems are strongly related to supply chain integrity since deficiencies in these domains affect inventory control, delivery confirmation, and monitoring results. These failures disproportionately harm women and girls who depend on public clinics for reproductive, maternal, and child health services.

In DRC, the Ministry of Health estimated in 2022 that approximately 30% of medicines procured through public supply channels never reached health facilities, primarily due to theft, falsified delivery records, and mismanagement in central storage [40]. Audits of donor-financed supply chains revealed significant leakage of essential commodities, with discrepancies in stock reporting exceeding US $25 million in losses across two funding cycles [41,42]. These losses highlight persistent gaps in delivery verification, inventory controls, and accountability mechanisms within public supply chains. Such inefficiencies result in frequent shortages of reproductive and maternal health supplies, forcing patients to purchase drugs privately at unaffordable prices or forgo treatment.

In Zimbabwe, the Office of the Auditor General reported in 2023 that 27% of consignments inspected contained mismatches between invoiced and delivered quantities, equating to losses of approximately US $14 million [20,43]. Prepayment practices combined with limited post-delivery verification increase exposure to diversion, non-delivery, and stock manipulation. Verification data from the National Pharmaceutical Company (NatPharm) further showed that missing or diverted stock primarily involved antibiotics, vaccines, and obstetric medicines [43]. These recurrent shortages disrupt the continuity of care and

increase dependency on informal medicine vendors, which heightens safety risks for women and children.

In Rwanda, facility-level studies found that 19% of public health centres experienced more than two shortages of essential maternal or child-health medicines per quarter, mainly due to inaccurate inventory forecasting and delayed reporting [8,44]. These inefficiencies are associated with gaps in accountability, data accuracy, and enforcement across the supply chain. Such shortages undermine the credibility of health insurance coverage and delay life-saving treatment, especially for pregnant women in rural areas who rely heavily on public facilities.

The implications of these supply failures are severe. Each missing shipment translates into shortages of oxytocin, contraceptives, or antimalarial medicines that are vital for women and children. UNICEF estimates that medicine shortages contribute to up to 15% of preventable maternal deaths in sub-Saharan Africa [45]. Supply chain disruptions contribute to increased reliance on private providers and informal markets for essential medicines.

In Madagascar, assessments by the Ministry of Public Health and WHO found that 38% of health facility managers could not account for deliveries received from the central medical store, while 41% of households reported paying out-of-pocket for medicines meant to be free [26,27,46]. These costs disproportionately affect women and low-income households who rely more heavily on public health services and pooled financing mechanisms.

Weak regulation and limited enforcement also enable the circulation of falsified and substandard medical products. The WHO Global Surveillance and Monitoring System estimates that around 11% of medicines sampled in African markets are substandard or falsified, with a higher prevalence in fragile settings such as the DRC and Madagascar [47]. Substandard and falsified medicines constitute a significant integrity risk linked to procurement practices, quality assurance gaps, and regulatory oversight limitations. Women, children, and older persons are particularly at risk because they are more dependent on low-cost or public suppliers. Strengthening oversight mechanisms and digital tracking of medical consignments is therefore critical to ensuring the safety, transparency, and reliability of health supply chains.

Actions for Supply Chain Integrity

1. **Digital Tracking and Verification**
   Governments should implement end-to-end digital systems to track medicines from procurement to delivery. Barcoding, electronic proof-of-delivery, and automated stock reconciliation can detect discrepancies and prevent diversion. In Ghana, the electronic logistics management information system improved delivery accuracy by 40% in 2022 [49]. These systems support accountability by clarifying responsibility for losses, delays, and discrepancies.

2. **Independent Audit and Real-Time Monitoring**
   Audit offices and anti-corruption agencies should conduct unannounced inspections of warehouses and transport routes. In Ghana, random checks in 2022 recovered about US $3.7 million worth of missing medicines [50]. Similar audits in Zimbabwe and Madagascar revealed repeated gaps between invoiced and delivered supplies, underscoring the need for consistent oversight [20,26]. Audit activities should include verification of supplier compliance, delivery timelines, and documentation.

3. **Citizen Reporting Platforms**
   SMS and WhatsApp-based tools allow citizens to report shortages, falsified medicines, or delivery issues in real time. In Rwanda, facilities using citizen feedback platforms cut average stockout durations by 12% between 2021 and 2023 [8,51]. Expanding such systems across countries can strengthen accountability and responsiveness. Citizen reporting increases visibility of shortages and irregularities and supports accountability at facility level.

4. **Regional Regulatory Coordination**
   The African Medicines Agency and regional blocs (ECOWAS, SADC, EAC) should harmonise medicine registration and quality-control standards to enable regional data-sharing and rapid counterfeit alerts. AUDA-NEPAD estimates such coordination could reduce falsified medicines in sub-Saharan Africa by up to 30% within five years [52]. Regional coordination supports consistent enforcement across cross-border supply chains.

5. **Gender-Sensitive Oversight**
   Women's and patient organisations should participate in monitoring committees to ensure timely identification of shortages in reproductive and maternal health supplies. In Madagascar and the DRC, women-led community monitoring reduced unaccounted medicine losses by about 18% within one reporting cycle [53]. This role strengthens accountability and responsiveness within supply chain oversight mechanisms.

Effective supply chain integrity prevents financial waste and ensures the continuous availability of quality medicines. It strengthens public trust by showing that government systems deliver tangible results for communities that rely on them the most. Sustained enforcement and transparency are necessary to ensure that supply chain reforms produce measurable improvements in medicine availability and public confidence.

Pillar 3: Ethical and Accountable Health Workforce

The health workforce is the most visible link between public institutions and the communities they serve. When staff engage in absenteeism, bribery, nepotism or sexual

exploitation, public trust declines and access to care becomes unequal. These behaviours often stem from deeper systemic issues such as weak oversight, low pay, and limited protection for whistle-blowers. Health workforce integrity is closely connected to procurement, supply chain, and financing systems, as weaknesses in these areas shape incentives, accountability, and enforcement across service delivery. Addressing these challenges is essential to building a health system that is fair, accountable, and responsive to all.

In Ghana, the Office of the Auditor General's 2022 performance audit revealed that 13% of payroll entries under the Ministry of Health had no verified employees, reflecting widespread "ghost workers" and causing an estimated annual loss of about US $9 million [51]. The Ghana Audit Service further noted that the absence of biometric payroll validation and weak internal controls had enabled persistent salary leakages within regional health directorates [52]. These payroll failures reduce resources available for frontline staffing and essential services, compounding shortages created elsewhere in the health system.

In Zimbabwe, the Public Service Commission and the Office of the Auditor General found that approximately 22% of nurses and clinical officers were routinely absent from duty, largely due to engagement in informal private practice or parallel employment [20,53]. Dual practice and absenteeism are associated with weak enforcement of attendance rules and limited monitoring capacity. This absenteeism strained public hospital capacity, increased patient waiting times, and contributed to poorer outcomes in maternity and emergency care.

In DRC, the WHO Independent Commission on the 2018–2020 Ebola response documented that around 5% of verified sexual exploitation and abuse complaints involved coercive exchanges of medical services, medication, or employment for sex [18]. Civil society investigations led by the Association des Femmes des Médias (AFEM) in 2023 confirmed continued incidents of sextortion within public hospitals, especially targeting poor and young women seeking reproductive or emergency care [17]. These cases highlight the consequences of weak safeguarding systems, limited reporting mechanisms, and inadequate disciplinary follow-up.

Integrity failures in the health workforce have distinct gendered impacts. Women represent more than 70% of frontline health workers across countries on the ISDA project yet remain under-represented in senior management and more exposed to workplace harassment and gender-based violence [54]. Limited representation in decision-making roles constrains women's ability to influence institutional culture and accountability mechanisms. On the patient side, women living in poverty are particularly vulnerable to exploitation, often facing informal payment demands or sexual coercion in exchange for health services [63].

In Rwanda, national health facility surveys showed that 9% of women seeking maternal care were charged unofficial fees, while 3% reported unwanted sexual advances from health workers [25,55]. These figures illustrate how corruption, gender inequality, and weak enforcement of ethical standards intersect to compromise patient safety and erode confidence in public health institutions. Workforce misconduct contributes directly to underutilisation of public services, particularly among women who may delay or avoid seeking care following negative experiences. Systematic measures to strengthen oversight, enforce ethics training and protect whistle-blowers are therefore essential to ensure both integrity and equity in health service delivery.

Actions for Workforce Integrity

1. **Transparent Recruitment and Payroll Management**
   Governments should publish recruitment criteria and use biometric systems to verify attendance. Ghana's payroll audit in 2021 removed over 6,000 ghost workers, saving US $25 million [59]. Digital payroll systems improve accountability and identify staffing gaps [60]. Capacity building should accompany payroll reforms to ensure staff responsible for human resources, payroll management, and verification are adequately trained in relevant systems and procedures. Clear role definitions should align responsibilities with qualifications and competencies to reduce errors and opportunities for manipulation.

2. **Ethics and Safeguarding Training**
   Mandatory ethics and anti-harassment training should be implemented for all health workers. Following the DRC Ebola inquiry, WHO recommended gender-based violence prevention modules for national staff [18]. Embedding ethics in professional training helps prevent exploitation. Training programmes should be tailored to staff roles and functions, ensuring that personnel responsible for financial oversight, procurement liaison, or supervision understand applicable procedures, controls, and reporting obligations.

3. **Performance Monitoring and Sanctions**
   Regular reviews tied to attendance and patient satisfaction deter absenteeism. In Zimbabwe, quarterly performance scoring improved nurse attendance by 15% within one year [53]. Performance monitoring frameworks should distinguish between clinical, administrative, and financial roles, with responsibilities assigned based on capacity and expertise. Misalignment between skills and duties increases the risk of errors and weakens accountability.

4. **Protection for Whistle-Blowers**
   Whistle-blower laws must ensure anonymity and independent follow-up. Ghana and Rwanda saw a 20%

rise in fraud reporting after new protection frameworks were introduced [59,60]. Effective whistle-blower systems should be supported by staff awareness training, so workers understand reporting procedures, protections, and their responsibilities within accountability structures.

5. **Community Accountability Mechanisms**
   Citizen scorecards and health committees strengthen oversight. In Ghana, community scorecards improved maternal-care satisfaction by 28%, while similar pilots in Rwanda and Madagascar enhanced responsiveness to complaints [61,62]. Community oversight mechanisms are most effective when facility staff have clearly defined roles and adequate capacity to respond to feedback, investigate issues, and implement corrective actions.

An ethical and well-supervised health workforce plays a vital role in building public trust and protecting vulnerable populations. When misconduct is consistently addressed and professionalism is visibly recognised, individuals gain confidence in the system and feel safe accessing care. This shift encourages greater use of public health services, particularly among marginalised groups who may otherwise avoid treatment due to fear or past mistreatment. Over time, improved trust and accountability contribute to more equitable service delivery and better health outcomes.

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[1] "integrity" primarily refers to financial, procurement, supply chain, and governance within health systems, including the management of public funds, contracts, medicines, and workforce accountability mechanisms.