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Corruption in the Health Sector kills!

It is really as simple as that.

Today Transparency International launches its Global Corruption Report (GCR) 2006 worldwide, and this year the thematic focus is graft in the provision of health services around the world. The findings from various studies conducted by T.I. chapters make compelling reading – if there was ever any doubt, corruption, simply and bluntly put, is a matter of life and death. Three of the UN's eight Millennium Development Goals are related directly to health – reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases – and the pervasiveness of corruption in national health care systems severely hampers the fulfilment of the targets for the dates set.

However, why does the health sector seem so prone to abuse and misuse?

This year's GCR offers us the following hypotheses as to why health sectors across the globe are riddled with corruption?

1. There is an *imbalance of information* – health professionals know more about illnesses and cures than their patients, pharmaceutical companies know more their products than public officials charged with purchasing them on behalf of their citizens etc. This imbalance can easily be taken advantage of.
2. *Uncertainty rules* – the management of resources by policy-makers is made difficult when nobody can predict where and of what, which people will fall ill. This uncertainty is heightened in times humanitarian crises and often allows for oversight mechanisms to be by-passed.
3. *Complexity of health systems* – there is a huge number of parties involved in the supply and demand of health services, between which relationships are often opaque and result in distortions of policy and service provision.

Given these characteristics, what then are the 'hot-spots' for corruption in the health sector – what are the main danger zones?

1. *Embezzlement and theft* from the health budget or user-fee revenue at central, local government level or at particular health authorities or centres. Supplies and equipment are stolen for personal use, use in private practice or resale.
2. *Corruption in procurement*, including collusion, bribery and kickbacks result in the overpayment for goods and contracted service and more often than not insufficient standards of quality.
3. *Corruption in payment systems*: these are as numerous as they are varied and include waiving fees, falsifying of documents, creation of 'ghost' patients as well as performing unnecessary medical interventions in order to maximise fee revenue and many other crimes.
4. *Corruption in the pharmaceutical supply chain* – a few examples might include: products may be diverted or stolen, require 'fees' by officials to be authorised; demands for favours may be placed on suppliers in order for a tender to be won and counterfeit and sub-standard supplies may be allowed to circulate.
5. *Corruption at the point of service delivery* – this may take many forms, the most usual are extorting and accepting illicit payments for services which should be provided by right, clandestine payments in exchange for special privileges and improper decisions in areas of hiring, accreditation and certification of individuals and facilities.

This special edition of 'Adili', taking its cue from the GCR, thus further investigates corruption in Kenya's health sector, following last year's revelations of huge scale corruption scandals in the sphere of public health provisions. We ask: how do things look a year on? Are we any closer to eradicating this scourge from our health care system?

For more information on corruption in the health-sector, both in Kenya and internationally and a copy of T.I.'s GCR 2006, do not hesitate to contact us at transparency@tikenya.org.

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FOR PRESS: to request a review copy of the *Global Corruption Report 2006* or to view the report electronically, contact gcr@transparency.org or visit www.globalcorruptionreport.org. For interview requests please contact press@transparency.org

**Regional Highlights from the Transparency International Global Corruption Report 2006
Africa and Middle East**

The recent experiences of several countries in Sub-Saharan Africa indicate that expending effort creating anti-corruption laws and institutions can be rendered meaningless if these bodies are not granted the powers and resources needed to do their job properly.

The High Commission for the Coordination of Anti-Corruption Activities (HACLC) in **Burkina Faso** serves as a “bad practice” example of an anti-corruption agency created to mollify critics rather than with genuine political will to clean up corrupt practices in a country. The government has failed to respond to its 2003 recommendations, while its 2004 report remained confidential, contrary to commitments that it would be made public. Widespread graft in the judiciary, as revealed by a judicial council commission of inquiry in June 2004, diminishes the likelihood that corruption uncovered by the HACLC would be effectively prosecuted.

In **Kenya**, John Githongo, President Mwai Kibaki’s special adviser on governance and ethics, resigned in February 2005, and his office was scaled down, two indicators that corruption may no longer be on the president’s list of priorities. The US and German governments suspended grants in support of anti-corruption programmes in the wake of Githongo’s resignation.

The situation in **Uganda** give cause for more optimism when the country’s new Inspector General of Government (IGG), Justice Faith Mwendha, appointed in January 2005, promised to shake up the agency, whose power had been trimmed by senior government officials who were unhappy to find their wealth and possessions published in the media in 2002 and subsequently investigated by the IGG. The government issued a White Paper in October 2004 recommending the restoration of the IGG’s powers to arrest and prosecute persons involved in corruption or abuse of public office.

There were positive developments in **Cameroon**, as well. In a month that saw 500 civil

servants referred to a disciplinary council on charges of fraud or misappropriation and news that 3,000 fictitious officials had been stripped from the payroll, the government of Cameroon gave further evidence it was taking corruption seriously by signing up to the Extractive Industries Transparency Initiative (EITI) in March 2005. It promised to publish online quarterly data on oil production, sales prices and revenue since 2000 by the end of June 2005, and to update it regularly.

Political corruption continues to be a source of grave concern in many parts of the region. In **South Africa** the first five MPs were convicted in March 2005 in connection with a scandal involving misuse of travel expenses that enveloped more than 100 MPs and seven travel agencies. The sentences ranged from R40,000 (US \$5,800) or one year's imprisonment, to R80,000 (US \$12,000) or three years in prison. Many of the convicted continue to sit as MPs as an MP can only lose a seat if sentenced to more than 12 months' imprisonment without the option of a fine.

In the three countries reviewed from the North Africa and the Middle East region, access to information and press freedoms were topics of concern. In **Kuwait** and **Morocco** corruption is beginning to be discussed more openly. The Kuwaiti government, in consultation with the World Bank, asked the Citizens Services and Governmental Bodies Assessment Agency (C2G) to assess administrative corruption in the public sector – which employs 94 per cent of the labour force. The report pointed to public contracting agencies as being the most frequent site of corruption. In Morocco, the most notable development in 2004–05 was the media's new freedom to discuss the issue of corruption. Journalists unravelled complex accounts of reported corruption in parastatal agencies and banks and examined the business activities of senior officers in the Royal Armed Forces (FAR).

In **Algeria**, by contrast, restrictions on the public's access to information, plus the threat of libel action, continues to constrain the media's ability to investigate corruption. The managing editor of the daily *Le Matin* was sentenced in June 2004 to two years in prison for writing a book critical of the president, and the newspaper was forced out of publication a month later when the state-owned printing company suddenly demanded payment of debts. The lack of fiscal and budget transparency and excessive use of private agreements for public procurement deals has cast doubts over a planned investment projects worth US \$55 billion in infrastructure and other public works over the next five years.

Please refer to the country reports section of the Global Corruption Report 2006 for detailed country-specific information on the following:

Algeria, Bangladesh, Bolivia, Brazil, Burkina Faso, Cameroon, China, Costa Rica, Croatia, Ecuador, Finland, France, Georgia, Greece, Guatemala, Ireland, Israel, Japan, Kazakhstan, Kenya, Kuwait, Kyrgyzstan, Malaysia, Morocco, Nepal, New Zealand, Nicaragua, Panama, Papua New Guinea, Peru, Poland, Romania, Serbia, Slovakia, South Africa, South Korea, Spain, Sri Lanka, Switzerland, Uganda, Ukraine, United Kingdom, United States of America, Vanuatu, Venezuela,

The *Global Corruption Report 2006* is published in London by Pluto Press (ISBN 0 7453 25092). The book can be ordered (£19.99 / \$29.95 plus postage and packing) through online booksellers, local bookshops or the publisher (www.plutobooks.com).

The NACC – a year later...

Nixon Ng'ang' describes developments at the NACC after speaking to its director, Dr. Patrick Orege...

NEARLY a year after revelations of rampant graft in Government co-ordinated efforts to tackle HIV/Aids, the top agency leading the fight claims to have implemented successful remedial reforms.

The National Aids Control Council (NACC) that was at the centre of a damning corruption report that revealed a large chunk of the Sh23.4 billion (\$30 million) entrusted to it for Hiv/ Aids mitigation projects had been misappropriated claims to have since activated stringent supervision measures making such squander difficult if not impossible.

But with deaths from the disease that was declared a national disaster seven years ago peaking at around 150,000 annually—around 300 deaths daily—the reforms impact is apparently yet to be felt on the ground. In fact, NACC critics see a link between the high figures and its documented squander.

NACC director Dr Patrick Orege however attributes the high death rate to the maturation of the disease. Those falling now were probably infected before the Council's existence and would have likely died earlier without NACC or its affiliates intervention, he says.

The donors are however apparently yet to be impressed with the reforms. Sh1.1 billion (\$15 millions) remains withheld by the Global Fund to Fight Hiv/Aids, Tuberculosis and Malaria to protest wastage in NACC.

The World Bank has separately frozen around Sh19 billion (\$24 million) part of which would have gone to boosting the kitty for fighting Hiv/Aids. Although the Bank cites big-time corruption in the government for the freeze, it has been known to make exceptions in say, health and education. In the case of NACC that operates an independent budget outside the parent ministry (Office of the President), and can therefore be funded directly by the Bank, the blanket punishment amounts to a dim indictment of loss of trust.

Dr Orege says that partly from recommendations of the Efficiency Monitoring Unit that compiled the report and the Council's own efforts to ensure accountability and efficient use of received funds, a major restructuring of its management system and operations followed.

He credits the fall of infection rates from 14 percent of the population in 2000 to the current 6.1 percent to NACC and other agencies campaigns against the disease arguing that HIV/Aids awareness levels in the country was now 100 percent.

Fresh infections however remain high. Joint surveys by NACC, the Central Bureau of Statistics and the National Aids and STD Control Programme under the Ministry of Health estimates around 250 people are contracting the disease daily. There are around 2.5 m Hiv/Aids-related orphans so far and the figures will rise with fatalities from the 1.3 million currently infected. NASCOP has its own accountability problems that are however yet to benefit from the extent of publicity the EMU report gave NACC. The agency domiciled in the Ministry of Health has been the prime recipient of around \$135 million staggered over five years to combat Hiv/ Aids and improve in reproductive health.

At risk from waning donor confidence in the two main organisations fronting the fight against the disease is sufficient funding for the Anti-Retroviral Therapy project.

Health Minister Charity Ngilu is on record as saying the Government hoped for Sh25 billion (\$32 million) this year to extend the ART to the infected.

It has since heavily subsidised ART drugs to around Sh100 (\$0.78) but the sustainability of the arrangement is likely to depend heavily on donors' goodwill.

The Minister has herself courted controversy over improper use of Hiv/Aids funds. In 2004, she organised a sensitisation workshop for rural women at Nairobi estimated to have cost Sh30 million (\$39,000) but whose effect was highly questionable.

Her kin and political friends were contracted to facilitate the meeting that ended up spending more time paying out allowances to participants than in any serious

The World Bank has separately frozen around Sh19 billion (\$24 million) part of which would have gone to boosting the kitty for fighting Hiv/Aids

discussions.

A company associated with her known political confidant was contracted irregularly to coordinate NASCOP publicity efforts at a handsome fee of Sh800,000 (\$10,300) a month.

According to the Dr Orege, the changes at NACC essentially targeted the overhauling of procurement and the finance sections that have served as fertile grounds for much of the graft unearthed by EMU.

The changes, like NACC documented rot, began at the top with the firing of four senior managers. The EMU report was critical of the competence and probity of NACC top management including former Director Dr Margaret Gachara who was charged and convicted of fraudulently receiving Sh27 million in exaggerated salary and allowances.

The Kenya Anti Corruption Commission is pursuing Gachara for a surcharge of the money she received by forging a letter from her former employer that placed her salary seven times above her real entitlements. It also wants former senior managers compelled to return around Sh20 million (\$25,600) they irregularly paid out to themselves.

Six more cases cantering on embezzlement of funds earmarked for community-based organisations are currently pending in court. But besides Gachara, there has been no conviction so far.

Dr Orege talks of more prosecutions likely to follow from “investigations” by KACC. But in the absence of another extensive probe into NACC finances like that by EMU, evidence of whether that has sufficed to instil management prudence and accountability is hard to ascertain.

Eight new appointees were recruited to take the place of fired officers. Dr Orege admits the extra employees created a “top-heavy management” that he however defends as essential for NACC greater efficiency.

He insists the new staff was “competitively recruited.” A reputed international agency, Price Waterhouse-Coopers was contracted to do the hiring and NACC undertook to remunerate successful applicants particularly to insure them from possible corruption.

Besides better remuneration, the council has also upped sensitisation against corruption. Its entire staff is routinely taken through a “risk management policy” designed to inculcate work ethics that include intolerance to corruption. Its offices in Nairobi are dotted with posters that advice “Corruption is bleeding Kenya.”

Special attention, according to the Director, has been paid to strengthening its internal audit section. Ten auditors have been hired to do the job that apparently looks thin considering the bulk of accounting has been contracted to a financial management agency.

It must however be noted that the agency was still doing the job when shell companies that seemed to have been designed only to pocket NACC disbursements flourished. In fact, EMU considered the contracting of the agency to have been opaquely done that it concluded it to have been part of the corruption.

The Council that was set up to specifically co-ordinate efforts to roll back the disease has also opted to decentralise its operations by vesting more supervisory powers in district and constituency-based management councils.

These are now mandated to decide on priority projects that deserve NACC funds to CBOs involved in HIV/Aids mitigation. According to Dr Orege, there word is “as good as final.”

The arrangement is meant to cure collusion that the

EMU found to have been rampant between NACC secretariat and some CBOs. Against the Council laid out policies, the watchdog body unearthed evidence that project proposals were, in some cases, hurriedly written and approved suggesting suspect motive between the presenters and approvers.

Now, NACC claims all CBOs must have a notice board that lists all proposed projects and allocated funds that must be prominently displayed and accessible to the public. The transparency is meant to be insurance against phoney projects and accounting of the magnitude uncovered by EMU.

On paper, that should take care of “briefcase” organisations that EMU reports misappropriated most a larger chunk of the Sh1.4 billion (\$18 million) of the four-year NACC kitty.


NACC has set up the guidelines it says the constituency-based entities must follow. They must have a membership of between 18-21 people drawn from “all shades of community leaders.” A CBO must also have documented existence of more than four to five years to lock out expedient creations that fold up as soon as they receive NACC funds.

Part of the problem with CBOs lies with the country’s dogged political past according to the Director. The KANU government, he says was extremely wary of such organisations and discouraged their existence. Thus at the time of NACC creation, few existed and even fewer had been around long enough to evolve a reasonable structure.

The Director also blames political considerations for the rot in CBOs. He says that in some instances and against the better judgement of NACC, some organisations were funded merely to strike ethnic and geographical balance to insure the Council from possible hostilities from MPs,

NACC has further provided a manual of how the funds must be utilised and accounted for. But in the Director’s own words, compliance is hardly foul proof.

Besides, the laissez faire attitude to education qualifications dilutes rigid implementation of the policy. No minimum certification is insisted on for organisations that receive as much as Sh7 million (\$90,000) to manage. The Director says the sham organisations are still under KACC investigations. But the directors of some the EMU well-documented fraud organisations are still free. Against the inherent possibility that though apparently well-intentioned, decentralisation could amount to spreading out inefficiency, NACC claims to have strengthened its “monitoring and evaluation department.”

Thus it now has its officers routinely visiting the CBOs just to make sure they are still operating within its guidelines. But it will probably take another in depth scrutiny of NACC accounts to confirm whether, indeed, the decay has been completely eradicated. 

Corruption in the Kenyan Health Sector

By Osendo Con Omere, Research Officer, Transparency International - Kenya

Health is one of the most important factors that contribute to the productivity of an economy. When the Ministry of Health declared that its objective was *to achieve health for all by the year 2000*, its strategy was hinged to individuals and communities taking greater responsibility for their health hence achieving cost-effectiveness and the promotion of health awareness. The policy shift targeted here is one of changing the mentality that the Ministry of Health is solely responsible for the health of the individual. The focus was also to shift from curative programs to preventive ones. Unfortunately this has not been the case. Kenya's health sector strategy continues to concentrate on curative health hence making it reactive in nature.

The Government of Kenya, in its Public Expenditure Review 2005 highlights some of the Health sector improvements through formulation of action plans to address recommendations as observed in the Ministerial Public Expenditure Review. The main recommendations focused on three areas namely:

1. The need for increasing allocation for spending on lower level service delivery facilities and staff;
2. Improvement on drug provision
3. Spending at the tertiary institutions.

In addressing these recommendations, the Ministry of Health developed broad based action plans for implementation of these issues. These include development of a better system for management of human resource, allocation of more resources to pro-poor and rural health facilities and improvement of financial flow and cash release system.¹

Various stakeholders have expressed concern at the running of the Health Sector in Kenya. There is concern that the sector is still under-funded. The Government has committed itself to providing at least 15% of the budget to health in accordance with the Abuja Declaration which contrasts with the 12% committed in the IP-ERS. Minimal increases in absolute terms (Kshs.23 Billion to Kshs.27 Billion) do not take into account an increased population, an increased disease burden and reduced income for service providers. The Minister of Health, though, has indicated that the health sector will receive additional funding during the Medium Term Expenditure Framework period.

Increased corruption in the Health sector has denied Kenyans their basic right to health care. A researcher with a public policy analysis organization cites

that *"There have been widespread complaints about the acute shortage of medicine in hospitals and the diversion of drugs and medical supplies en route to the public health facilities. Irregularities in tendering, procurement and distribution of drugs have also led to severe shortages."* (Were, Maureen, Kenya's Health Care: A Perpetual Decline: Kenya at The Cross Roads, Institute of Economic Affairs and Society for International Development, 1998).

The Kenya Bribery Index Findings.

Transparency International – Kenya's flagship study, the Kenya Bribery Index, has captured corruption in the health sector. The Kenya Bribery Index 2005 ranks 34 public and private sector organizations according to reported bribery experiences of ordinary citizens in their daily interactions with them. It should be clarified that this instrument measures (so-called) petty bribery– it does not adequately capture grand corruption at the higher levels—for instance, bribery involved in big public procurement projects. The Index has a value range from 0 to 100, where the higher the value the worse the performance.

In the four studies carried out since the inception of the study, four key health sector organizations have been captured. The Ministry of Health (the major employer and provider of health services in Kenya – 70% of the sector's workforce); The Kenyatta National Hospital (The largest referral Hospital and teaching facility in the region); The National Hospital Insurance Fund and Public Hospitals spread out across the country.

Some of the bribery incidences reported includes paying \$3 for access to a hospital bed. This would occur after the patient had been informed that there are no vacant beds. Respondents also reported that hospital attendants demanded that they purchase their own syringes, bandages and other important items. In the majority of instances, these items would only be available from the attendants themselves, or a chemist owned by one of their accomplices.

Overall indices for Health Sector in the Bribery Index

	2002	2003	2004	2005
Public Hospitals	27.7	33.0	21.9	15.3
Ministry of Health	20.8	34.6	12.7	10.8
Kenyatta National Hospital	18.7	23.4	-	-
National Hospital Insurance Fund (NHIF)	11.8	17.0	-	4.1

Source: Kenya Bribery Index 2005: Transparency International – Kenya www.tikeny.org

The Daily Nation in their week day edition of March 12th 2003 reported that parastatal chiefs who deposited millions into the scandal-ridden Euro Bank ignored four clear warnings from successive Permanent Secretaries at the Treasury not to invest in weak financial institutions. The parastatal chiefs included a former director of the Kenyatta National Hospital, who deposited Kshs.51 Million (in addition to Kshs.441 Million deposited by another director) and the former director of the National Hospital Insurance Fund, who deposited Kshs.493 Million. The same former NHIF director was also charged with corruption for having corruptly received Sh20 million from his fellow suspects as an inducement to award a contractor, the contract to build a medical care centre. (Daily Nation, April 27th 2005)

Corruption in the fight against HIV/AIDS and devolved funds.

One of the biggest challenges facing the health sector is the HIV/AIDS. Despite the sobering statistics of the scourge, corruption has plagued the Council charged with coordinating the multi-sectoral fight against the pandemic. The political will and attention given to HIV/AIDS is worth mentioning, with the former President first declaring the disease a national disaster in 1998. The current administration has a cabinet sub-committee on HIV/AIDS chaired by none other than the President. The government development plan for 2003 – 2007 outlines its objectives for a society that reportedly has almost 90% awareness of the disease and its effects. These include training communities on home based care and implementing HIV/AIDS curriculum in schools.

Kenyans woke up to a rude shock when newspaper headlines screamed into reality their worst fears. The East African Standard ,on Thursday April 28th 2005,exclusively reported the chilling account of corruption in the National Aids Control Council (NACC) with headline banners that read like this: *“Robbing the Dying”*, *“Looting frenzy as millions of patients continue suffering”*, *“NACC officials paid themselves over Sh37million”*, and *“How dubious NGOs were set up to steal millions”*. According to the above press reports, a report released by the Efficiency Monitoring Unit (EMU) based in the Office of the President revealed how for years several top public servants assigned the task of fighting HIV/AIDS turned their programmes into cash cows.

According to the article,the report, titled Financial Management Audit of the National Aids Control Council (NACC) in the Office of the President, and whose compilation began in 2003 ,was completed in April 2005. The EMU wants all the fraud and abuse of office cases listed in the report investigated and prosecuted by the Kenya Anti-Corruption Commission. The report further made a startling revelation, that Kenya cannot account for Ksh3.64 billion donated by Britain for five years, beginning 2001, to help fight the spread of HIV/Aids. In August 2004, the immediate former director of the NACC was found guilty of defrauding the government of \$340,000. She spent time in jail, but the president pardoned her in December 2004, along with 7,000 “petty offenders” who had stolen

from various government offices.

The government of Kenya has always adopted a decentralized strategy of development where funds are allocated to devolved units. Various strategies have been adopted, including at the district level, the local authorities level and recently at the Constituency level. Funds for Roads maintenance, Local Authority development, Education bursary schemes and general constituency development have since been devolved. There have been allegations of misappropriation of funds and opaque procedures of appointments and allocations in the administration of devolved funds. Funds for HIV/AIDS have also been devolved and are administered under the Constituency AIDS Control Committees. Members of Parliament are patrons to the respective Constituency Committees charged with approving project proposals and disbursing funds. As a result, their role has come under great scrutiny with civil society organizations and the press documenting allegations of favouritism in appointments to the committee and project approvals.

Procurement: Findings from TI-Kenya’s pilot study

Procurement continues to be a challenge yet to be overcome by the government. The Public Procurement and Disposal Act 2005 was recently enacted. This law was introduced based on the assumption that there is a critical need to harmonize the procurement procedures and to ensure that all public entities follow the same rules and procedures. Public perception of the procurement process has been that it is an obscure area of state activity, agreed upon in “customized” tenders and in dark rooms through a series of undisclosed agreements. In a public opinion poll carried out by Transparency International – Kenya in September 2003 called *the Integrity Check*, 60% of the respondents said that public procurement procedures are a key avenue for corruption in the government.


The EMU barely a week after releasing the aforementioned report, published another report on allegations of entrenched graft in the largest referral hospital in East Africa, the Kenyatta National Hospital. According to the East African Standard ,in their report to the Head of the Civil Service, EMU’s director pointed out several irregularities in the procurement of medical equipment and accessories, lung ventilators, anesthetic delivery systems as well as the rehabilitation of the hospital’s casualty department.

Results from an unpublished pilot research project on procurement procedures and quality control issues in the health sector commissioned by Transparency International – Kenya, confirmed that flaws in the health sector procurement system as the main reason for this poor state of affairs. The study identified some loopholes in the procurement procedures in the health sector. Findings indicated that suppliers were frustrated mainly by delayed payments of goods already delivered, forcing them to bribe Ministry officials to hasten the process. Furthermore during the tendering process, some suppliers are often privy to other suppliers quoted prices.

Given the nature of information sought, a qualitative approach to data collection was followed. One focus group discussion was conducted with members of the Kenya Coalition for Access to Essential Medicines and 15 in-depth interviews with representatives of manufacturers, distributors, Kenya Medical Supplies Agency (the state institution mandated to procure, store and distribute drugs to the health facilities in the Ministry of Health.), Crown Agents and GTZ, the last two being procurement agents. The discussions and interviews were audio recorded to facilitate data analysis and reporting

The recommendations arising from the study focused on strengthening KEMSA to be more effective in achieving its goals and objectives. All stakeholders and interested parties should come together and help strengthen it in the following areas:

- KEMSA should establish a Logistics Management Information System for essential drugs.
- The Government of Kenya should secure a clear policy on the capitalization of KEMSA.
- The Government of Kenya should relinquish responsibility for the procurement of drugs and commodities to KEMSA or its appointed agents.
- Capacity Building of staff especially in the area of procurement. International procurement agents (GTZ and Crown Agents) have shown an interest in assisting. This could go a long way in ensuring that KEMSA eventually has the capacity to carry out all procurement for the Ministry.

1 Public Expenditure Review 2005: Achieving the Economic Strategy for Wealth and Empowerment Creation. 

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