U4 Helpdesk Answer

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Corruption and the right to sexual and reproductive health in sub-Saharan Africa

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Corruption negatively affects access to sexual and reproductive health (SRH) in sub-Saharan Africa in several ways.

Political corruption, patronage and illicit financial flows divert resources away from healthcare more broadly and SRH service delivery in particular. At the service delivery level, access to care is restricted by bribery, absenteeism of healthcare staff, theft and embezzlement of essential medicines and supplies, as well as corruption in procurement processes. Marginalised populations, including women, LGBTQI populations, people engaging in sex work, youth and the poor are exposed to particular corruption risks.

Mitigating corruption risks in SRH requires both reforms of the healthcare system, such as increasing accountability and improving management processes, as well as tackling the specific marginalisation of SRH's main target users.

RELATED U4 MATERIAL

↗   Health Sector Corruption (2020)

Query

Please provide an overview of how corruption affects sexual and reproductive health rights (SRHR) in sub-Saharan Africa (SSA), as well as potential mitigation strategies.

Contents

Introduction

It is now widely recognised that SRHR, and especially reproductive and maternal health, are crucial to achieve a variety of development goals (Ortega, Sanjuán & Casquero 2020). But while progress has been made on SRHR in recent years, SSA as a region still lags significantly behind, with some of the worst health outcomes on maternal and child health globally (Chiao-Wen Lan & Tavrow 2017 and Makuta & O'Hare 2015).

Corruption is one of the main reasons for health systems' underperformance, with devastating consequences for the health and lives of millions of people. The healthcare sector has been identified as particularly corrupt in lower- and middle-income countries, in part due to high information asymmetries, the large amounts of money involved, the multitude of involved stakeholders with sometimes diverging interests, the complexity of its processes and the vulnerability of its target

MAIN POINTS

— Sexual and reproductive health rights challenges in SSA include limited access to maternal health, high maternal and infant mortality, high rates of HIV infections and unsafe abortions.

— Challenges are compounded by weak healthcare systems, healthcare funds lost to corruption and restricted access for patients due to petty corruption.

— Women, youth, the rural poor, sex workers and LGBTQI individuals face some of the biggest challenges in realising their SRHR due to stigmatisation, economic weakness and a lack of political power.

— Limited accountability and transparency in the healthcare system and vulnerabilities of patients facilitate corruption in SRH service delivery.

— As yet, insufficient and inadequate data hampers evidence-based decision and policy making.

recipients (Hutchinson, McKee & Balabanova 2019; Transparency International 2019a; UNDP 2011).

Corruption in healthcare is said to be responsible for the death of 140,000 children every year, it hinders success in the fight against HIV/AIDS, it hampers the achievement of universal health coverage and

leads to losses of around US$500 billion every year (Transparency International 2019a).

Corruption occurs in the form of grand and political corruption, which diverts resources away from health budgets and leads to larger issues of resource constraints and scarcity. It also occurs at the service delivery level, where patients are required to pay bribes to receive services, and where corruption fuels absenteeism, embezzlement and other forms of service delivery corruption by healthcare workers.

While corruption in healthcare has been receiving increasing attention, much less studied are specific corruption risks in the delivery of sexual and reproductive health (SRH) services and how corruption contributes to adverse health outcomes for women, youth, LGBTQI and other marginalised communities.

But from the limited data is available, it appears that health services related to SRHR are particularly vulnerable as they are doubly affected by corruption. First, background corruption in the healthcare system can entail informal payments, procurement fraud, absenteeism and reduced quality of care, among others. Secondly, the marginalisation and stigmatisation of the primary users of SRH services across many parts of sub-Saharan Africa (SSA) leaves them at higher risk of extortion, abuse and sextortion, and less able to report instances of corruption or to access justice.

This Helpdesk Answer aims to take stock of particular corruption risks that affect SRHR in SSA, as well as identified mitigating measures to help reduce corruption risk in healthcare and address the vulnerability of SRH services' primary users.

Caveat

There is a scarcity of data and studies on the levels and incidents of corruption in the delivery and exercise of SRHR. Recent years have seen an increase in studies on corruption risk in healthcare as well as studies looking more closely at the specific exposure to corruption experienced by marginalised populations, including women, LGBTQI and people living in poverty.

However, neither strand of research typically includes disaggregated data that would allow the identification of specific corruption risk in services related to sexual and reproductive health (SRH) or specific risks of the different target recipients of SRH services.

This Helpdesk Answer thus considers studies on corruption risk in healthcare more broadly in as far as they are expected to be relevant to SRH provision. It also includes studies on particular corruption vulnerabilities of the primary targets of SRH services (women, youth, LGBTQI, etc.) in as much as they are expected to be relevant in accessing healthcare.

Background

Definition and scope of SRHR

According to the UN Population Fund, "good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so" (UNFPA undated).

The WHO defines sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity" (WHO Europe undated). As such, in addition to including health services related to the prevention and treatment of sexually transmitted diseases, including HIV, and services related to gender-based violence, it also includes health services that contribute to the safe experience of sexuality free of coercion, discrimination and violence, including information services (Ghebreyesus & Kanem 2018 and UN 2020).

Reproductive health refers to health services surrounding fertility and family planning as well as pregnancy and maternal care. As such, reproductive care includes services related to access to modern contraceptives and other modern family planning methods as well as infertility care that allow women and men to determine their family planning needs. It also includes antenatal care for expectant mothers, to ensure safe pregnancies and childbirths for mothers, improving the health of both mothers and children as well as abortion-related care (Ghebreyesus & Kanem 2018).

According to Ghebreyesus & Kanem (2018), more than 200 million women in developing countries who want to avoid pregnancy do not have access to modern contraceptive methods, an estimated 35 million unsafe abortions are performed every year, and over 350 million people require treatment for sexually transmitted diseases. Yet despite the obvious centrality of SRHR, almost all of the world's 4.3 billion people of reproductive age will have access to only inadequate reproductive health services at some or all points of their reproductive years (Ghebreyesus & Kanem 2018).

Health and SRHR in sub-Saharan Africa

Access to healthcare generally continues to be a challenge in SSA, with SRH services often particularly under-resourced.

According to a 2014/2015 Afrobarometer survey, nearly half of respondents in Africa went without medical care, and 4 out of 10 of those who managed to access some form of medical care had found doing so difficult. Reasons for difficulties in accessing healthcare included (fear of) discrimination, lack of education, lack of transportation and financial barriers due to the need to make out of pocket payments as well as pay illegal fees and bribes (Hsiao, Vogt & Quentin 2020).

Similarly, the Africa Health Agenda International Conference Commission (AHAIC Commission 2021) calculated that 48% of people in Africa did not receive the healthcare they need. In addition, the quality of healthcare that is received is often poor and healthcare service access inequitable.

Access challenges result from overarching issues related to the region's healthcare systems, such as lack of funds, small healthcare workforce, outdated infrastructure, poor leadership, a healthcare system stretched by other infectious diseases, mismanagement and widespread corruption (AHAIC 2021; Eghtessadi et al. 2020; Ogunkola et al. 2021).

Cost is another factor inhibiting access. According to the AHAIC Commission (2021) approximately 97 million people across the continent incur "catastrophic healthcare costs" every year, and about 15 million people annually are pushed into poverty due to healthcare costs.

Access to and quality of sexual and reproductive health (SRH) services continues to be a particular challenge across SSA.

This is especially true for marginalised populations (such as women, youth and LGBTQI individuals) as well as populations living in poverty or in rural areas who are likelier to not have their needs met by African healthcare systems due to discrimination and stigma as well as the inadequate design of services (AHAIC Commission 2021).

According to Onwujekwe et al. (2018), poorer and less educated patients, especially those from rural areas, are also at higher risk of being exposed to corruption risk because the information gap to the service provider can be higher and they may see healthcare professionals as infallible. According to several studies on West Africa, poor patients from rural areas were more willing to pay bribes, both to access services at all as well as to speed up processes (Onwujekwe et al. 2018).

According to a review of studies by Melesse et al. (2020), adolescent SRH presents challenges in SSA due to high rates of child marriages, adolescent child bearing, HIV transmission and limited access to contraceptives. Some improvement has been noted over the last two decades in pregnancy and marriage rates among minors, as well as in access to contraceptives. But progress has been slow and uneven with girls at significantly greater risk than boys, and adolescents with less education and from rural areas at greater risks than those in urban centres and with higher levels of education.

In studying coverage with reproductive, maternal, newborn and child health across SSA, Faye et al. (2020) further found persistent inequalities at sub-national levels, chiefly due to poor governance and conflict. Inequalities within countries were generally found lowest in countries with an overall relatively high healthcare coverage. In countries with low overall coverage, capital regions are usually better covered and poorer, while remote areas are the most neglected.

Prenatal care and maternal mortality

Another continuing concern across the region is the consistently high rates of maternal mortality. While maternal care has been improving and maternal mortality rates have been dropping over the past two decades – both across the globe and in sub-Saharan Africa – rates in SSA remain worryingly high, and the region is still struggling to provide adequate prenatal health services to expectant mothers (Ogunkola et al. 2021). Today 99% of maternal mortality cases occur in developing countries, with half of these in SSA, which also accounts for 40% of global infant mortality (Chiao-Wen Lan & Tavrow 2017 and Makuta & O'Hare 2015).

According to Ogunkola et al. (2021) one of the main reasons for the high rates of maternal mortality in SSA is insufficient access to quality antenatal care for pregnant women. While 90% of women in SSA now have at least one antenatal care visit during pregnancy, only slightly over half receive the recommended four or more.

Ackers, Ioannou & Ackers-Johnson (2016) likewise point towards inadequate access to prenatal services and, in particular, long delays as one of the main reasons for maternal and infant mortality in Uganda and other countries in SSA as women are either unable to access needed care or they access it too late.

Studies on maternal mortality evaluated by Chiao-Wen Lan & Tavrow (2017) have concluded that, globally, certain indicators of female empowerment correlate with better maternal healthcare

outcomes. In many studies, higher levels of education among women have led to better access to contraceptives and family planning methods, lower fertility rates, lower child mortality and lower maternal mortality. Similarly, greater representation of women in positions of political influence corresponds to greater spending on health, including SRH. However, for SSA, Chiao-Wen Lan & Tavrow (2017) arrived at somewhat mixed results, with female empowerment not significantly linked to lower rates of maternal mortality. The authors did, however, identify a strong link between corruption and maternal mortality: the more corrupt a country was (perceived to be), the higher its maternal mortality rate.

Family planning services and abortion-related care

Family planning services are another area of concern in SSA.

While fertility rates and population growth have been on the decline in Africa and SSA as elsewhere, the region currently has the highest fertility and population growth rates in the world and is expected to continue to have until at least 2100 (Aassve et al. 2019; UN 2019). At the same time SSA has one of largest unmet needs for family planning services, defined as the number of women wishing to prevent or delay pregnancy but not using any modern form of contraceptive (Aassve et al. 2019; Ortega, Sanjuán & Casquero 2020).

According to the AHAIC Commission (2021), less than half of women and girls (49%) had their family planning needs met, with the richest quintile having their service needs met four times as much as the poorest quintile. Gahungu et al. (2021) determine the number to be as high as 88% in some SSA countries for postpartum women.

The provision of abortion-related care is a particularly complicated question as abortion law varies quite significantly across the region, ranging from being relatively liberal in countries like Zambia, Mozambique or South Africa to decidedly restrictive in countries like Tanzania and variations in between in countries like Ethiopia, Chad, Niger and others (Council on Foreign Relations 2019 and Moland et al. 2017). It is important to note that restrictive abortion laws do not necessarily reduce abortion rates. Rather, they increase the risk of unsafe and illegal abortions (Moland et al. 2017), including exposing the women seeking them out to risks of extortion and abuse. As of 2011, SSA accounted for 60% of global abortion-related mortality (Haaland et al. 2020).

Abortion access can also be hindered in practice, even were abortion is legal, due to stigmatisation or a lack of awareness. In the case of Zambia, for example, the law is comparatively liberal, allowing abortions on socio-economic grounds, but access is nonetheless restricted in practice. With abortion still stigmatised and with only one practicing medical doctor per 10,000 inhabitants, and some regions without a single clinic offering legal abortions, women may still be pushed to seek out risky abortions outside the law (Council on Foreign Relations 2019 and Haaland et al. 2020).

SRHR of people engaging in sex work

People engaging in sex work are among the highest risk populations in terms of SRHR and face some particular barriers in accessing care. In their study of female sex workers in Mozambique, Lafort et al. (2016) found them at a significant risk of contracting sexually transmitted infections (STI) including HIV, experiencing unwanted pregnancies, being victims of gender-based violence and getting cervical cancer. At the same

time, they faced specific barriers in accessing SRH care, particularly in treating unwanted pregnancies. And while the majority did utilise the local public health clinic to seek care for STIs, get tested for HIV, receive HIV related care and get help regarding an unwanted pregnancy, they also reported difficulty in accessing such care. Care surrounding pregnancy termination was reported as particularly difficult. The most common reason for dissatisfaction with the service was being regularly asked to pay bribes or otherwise being pushed to the back of the queue or not receiving any service at all. This included bribe requests for services that should have been free of charge and are life-saving, such as HIV treatment. Younger sex workers also reported difficulty accessing contraceptives or being denied STI tests if not bringing a partner. Foreign sex workers also reported greater stigmatisation due to language barriers and being easily identifiable as sex workers, often resulting in larger bribe requests.

Effects of COVID-19

Pre-existing inadequacies in the healthcare systems in SSA, specifically with regards to SRH, have been exacerbated during the COVID-19 pandemic, which has increased poverty among women and reduced access to much needed SRH services. With already limited resources as well as attention redirected to curbing the pandemic, and with freedom of movement restricted and health services unavailable, several SRH services have suffered, including prenatal care and HIV treatments, increasing the risk of sexual and gender-based violence and unintended pregnancies (Eghtessadi et al. 2020 and Ogunkola et al. 2021).

While it is too early to evaluate the full effects of the COVID-19 pandemic, early studies point to a substantial worsening of already existent access

problems. A recent survey among Save the Children programme participants found that 90% of families struggled to access healthcare services and medicines, with those reporting income losses during the pandemic facing particular challenges (Transparency International 2020b).

Transparency International (2020b) has also recorded cases from almost all world regions where patients were requested to pay bribes to receive protective equipment or COVID-19 tests, and there is an expectation that the general patient overflow in healthcare facilities during the pandemic will increase the likelihood of rent-seeking behaviour and other forms of corruption.

Corruption in sub-Saharan Africa and its effect on SRHR

As a region, SSA commonly fares worst globally on global corruption indices, including Transparency International's Corruption Perceptions Index. The public sector in many African countries is viewed as highly corrupt, while many citizens believe corruption levels are worsening and are dissatisfied with their governments' anti-corruption efforts. Political corruption, state capture, patronage and unresolved conflicts of interest are identified as some of the common corruption concerns in the region (Duri 2020).

High levels of corruption negatively affect healthcare services, and particularly SRHR, in two main ways:

1. grand corruption, state capture and patronage diverting resources away from healthcare budgets
2. petty corruption at the service delivery level negatively affecting access, quality and

speed of service, with marginalised groups disproportionately affected

Diversion of funds

Corruption distorts the provision of public goods, including healthcare, by draining resources from already limited healthcare budgets and promoting an inefficient allocation of resources. This affects the availability and cost of essential health products and services and leaves less funding available to pay for salaries and regular infrastructure maintenance, resulting in lower quality services undertaken by demotivated staff (Aassve et al. 2019; Hsiao, Vogt & Quentin 2020; Onwujekwe et al. 2018).

In particular illicit financial flows (IFFs), i.e. "cross-border transfers of funds that are illegally earned, transferred, or utilised", pose a significant strain on domestic budgets and public spending in low- and middle-income countries (Ortega, Sanjuán & Casquero 2020: 2). Ortega, Sanjuán & Casquero (2020) note that Togo, for example, lost on average 34% of its annual GDP to illicit financial flows in the years between 2008 and 2013. Africa as a continent is estimated to have "lost between US$1.2–1.3 trillion dollars over the period 1980–2009 through IFFs" (Ortega, Sanjuán & Casquero 2020: 4), which far outstrips the amount of development assistance the continent received from donors.

In countries with a high incidence of corruption, total investment in healthcare is generally lower (Aassve et al. 2019). In these settings, what public resources that are made available for the health sector are typically allocated to large-scale prestigious projects, such as new hospitals and expensive equipment, that are conducive to siphoning of bribes, while smaller-scale and geographically dispersed services, such as local

health centres and clinics crucial for SRH services, fall by the wayside (Aassve et al. 2019). This assessment is seconded by Onwujekwe et al. (2018: 13) who have found that in West Africa corruption "favours the construction of hospitals and the purchase of expensive, high technology equipment over primary healthcare programmes, such as immunisation and family planning".

State capture and patronage

In settings characterised by state capture and extensive patronage networks, political and economic decisions are made to benefit particular interests over the public good, and in-group entities or individuals get preferential access to public services, government contracts, jobs and other benefits (Duri 2020).

Political patronage can also have decidedly negative impacts on universal healthcare service delivery, access to essential medicines and SRHR investments because resources, medication and investments are channelled and distributed according to political allegiance or within ethnic or social groups rather than according to need (Friedman 2015 and Onwujekwe et al. 2018). This was observed for example in Nigeria by Onwujekwe et al. (2018), where healthcare services were prioritised for communities that supported the incumbent government.

Petty corruption in public service access

Petty corruption, such as low-level bribery to access public services, is widespread across SSA. According to the 2019 Global Corruption Barometer, more than one in four people (28%) that had contact with a public service in the past year (police, healthcare, schools, ID or utilities) had to pay a bribe or give some kind of favour to receive the desired service. The worst rates were recorded in the DRC (80%),

Liberia (53%) and Sierra Leone (52%). The poor appear to be particularly affected, with two out of five of the poorest people reporting having to have paid a bribe to access public services (Duri 2020 and Transparency International 2019c).

While the bribery rates for healthcare services were lowest among the services inquired about (14%), rates were still high in several countries, including Sierra Leone (50%), DRC and Liberia (43% each) (Transparency International 2019c).

Corruption and SRH services

Although comprehensive numbers on corruption's effect on SRH are scarce, sexual and reproductive health rights (SRHR) are likely disproportionately affected by both political and petty corruption. This is in part due to a lack of political prioritisation of SRHR, and SRH's reliance on decentralised, low-barrier service, which receive even less investment in corrupt systems than healthcare overall (Aassve et al. 2019).

At the service delivery level, patients seeking out SRH services are often at a greater risk of corruption (especially extortion and sextortion) than patients attempting to access other forms of healthcare (Melesse et al. 2020). This is partly because SRH's primary users (women, youth, LGBTQI individuals, HIV positive individuals, people engaging in sex work, etc.) often face particular marginalisation and discrimination (Transparency International 2020a).

Corruption risk factors across the healthcare value chain

The healthcare sector has been identified as one of the most corrupt sectors in high-, middle- and low-income countries alike due to the competing interests and incentives between private and public stakeholders, knowledge and information asymmetries between providers and patients, considerable public expenditure, and the vulnerabilities of those seeking care (Hutchinson, McKee & Balabanova 2019).

According to UNDP (2011: 6) common corrupt practices in the health sector include "absenteeism, theft of medical supplies, informal payments, fraud, weak regulatory procedures, opaque and improperly designed procurement procedures, diversion of supplies in the distribution system for private gains and embezzlement of healthcare funds". Corrupt behaviour is facilitated by poor regulation, a lack of accountability and oversight, low salaries and a scarcity of services as demand far outstrips supply.

Hutchinson, McKee and Balabanova (2019) have identified informal payments, absenteeism, medicine theft, fraud and bribes for professional advancement as some of the most common forms of corruption in the healthcare sector. Similarly, when looking at the healthcare sector in West Africa, Onwujekwe et al. (2018) found five primary forms of corruption: absenteeism, diverting patients from the public sector to private practice, inappropriate prescriptions, informal payments and bribery, and theft of drugs and other supplies.

The following section considers specific corruption risks that arise in the healthcare sector more broadly, but are also relevant to SRHR. Corruption risks are grouped under the conceptual model provided by the World Health Organisation's Building Blocks of Health Systems (2010). The six "building blocks" covered below are:

- health service delivery
- health workforce
- health information systems

- access to essential medicines
- health systems financing
- leadership and governance

This Helpdesk Answer will then look at some of the particular corruption risks that can be attributed to the marginalisation and stigmatisation of those seeking SRH services, before considering potential mitigation strategies.

Corruption in health service delivery

Health service delivery relates to the provision of any healthcare service. According to the WHO (2010) its effectiveness should be measured against eight core characteristics: i) the comprehensiveness of the range of services delivered; ii) the accessibility of services; iii) the coverage of all target patients; iv) services that ensure a continuity of care; v) the quality of services delivered; vi) person-centeredness of services; (vii) coordination between levels and types of service providers; and viii) accountability and efficiency of services provided.

Corruption risks often arise in the process of delivering these services. Such risks include kickback-driven procedures, unnecessary or inferior procedures, overcharging and others.

Cases of superfluous procedures are particularly difficult to identify as they are not always illegal and not always classified as corruption. Examples could be where doctors refer patients to the provider paying them higher commissions rather than the best ones or doctors prescribing additional (potentially unnecessary) procedures or medicines (Transparency International 2019a). For example, in Kenya, Nairobi's Women Hospital was found to defraud patients by administering unnecessary tests and admissions to raise revenue, with participating doctors and nurses apparently

pressured by their supervisors to do so (Transparency International 2020b).

In some cases, it may also be difficult to ascertain when a procedure is necessary or not, as can be the case with doctors pushing for usually more expensive caesarean sections over natural births. This is compounded by the information imbalance between doctor and patient, which can be particularly high in low-income and rural settings. Due to differences in practices and pricing levels and because there may be legitimate reasons for differing treatment suggestions, depending on a doctor's assessment and patient's indication, numbers on this phenomenon are hard to come by. However, the WHO estimated that 6.2 million unnecessary caesarean sections are performed globally every year (Transparency International 2019a).

Access problems and associated corruption risks can be particularly high for services that are stigmatised or criminalised. According to Moland et al. (2017) unsafe abortions are estimated to account about 14% of maternal deaths in sub-Saharan Africa.

Informal payments

According to Transparency International (2020b: 3):

> "Informal payments from patients is a common practice in many countries. They are defined as a contribution made by patients (or others acting on their behalf) to healthcare providers for services patients are entitled to. These payments are not always illegal, corrupt or harmful, and might be encouraged by cultural norms, habits and low salaries, among other reasons. However, informal payments can

constitute corruption when they happen before treatment, if they are solicited – or extorted – by the provider, and if they involve cash or expensive items."

Informal payments are more widespread where healthcare systems are underfunded and where salaries and quality of care is low (Transparency International 2019a), as is the case in many countries in sub-Saharan Africa.

Marginalised groups, such as women, youth and LGTBQI individuals appear to be at particular risk of having to pay irregular payments or risk not having their healthcare service needs met. According to a 2018 survey conducted by the African Union, 63% of young people who responded reported being directly affected by corruption, including by having to pay bribe to access healthcare (Bullock & Jenkins 2020).

According to Transparency International (2019a), poor people unable to afford the extra fees are at risk of either not accessing healthcare at all, or seeking out less specialised or less qualified, and thus cheaper, providers.

As women are likelier to be affected by poverty, they are at a higher risk of not receiving the care they need or opt to access care only when there is no other option, which may mean a health situation that would have been easily treatable earlier can become deadly (Ackers, Ioannou & Ackers-Jones 2016 and Hsiao, Vogt & Quentin 2020)

A study in Tanzania had found that patients were regularly making informal payments to receive better care and often did not perceive these payments as bribes. This in turn incentivised healthcare providers to deliberately create shortages to then extract additional payments for service delivery (UNDP 2011).

Similar cases were observed in Anglophone West Africa by Onwujekwe et al. (2018). Their review of several studies on corruption in healthcare found repeated instances where patients were charged for services that should have been free (such as hospital beds in public hospitals or the monitoring of babies).

In a survey conducted by TI Zimbabwe (2019), out of 98 respondents who had sought medical services from a public hospital or health centre, 58% said they had been asked to pay a bribe to access services, and 60% said they paid a bribe to be served faster.

In Sierra Leone, following the Ebola outbreak in 2014, there were repeated reports that women were asked to pay irregular payments to receive a health card on which their antenatal visits and later child healthcare checks were recorded, although this card was meant to be free (UNODC 2020). According to the UNODC (2020) the social standing of healthcare workers and their position of power relative to those seeking care had increased during the Ebola crisis to a degree that it encouraged rent-seeking and made it unlikely that patients felt able to challenge the bribery demands.

Studies from Uganda, Tanzania, Angola and others have shown that informal payment requests when accessing pregnancy and childbirth related care deter poor women from giving birth in health facilities, with negative outcomes for maternal care and maternal and child health and mortality (Chiao-Wen Lan & Tavrow 2017).

In Zimbabwe, there have been reports of pregnant women required to pay bribes to be let into delivery rooms in Harare hospitals or receive assistance during childbirth, while other women reportedly gave birth waiting in line outside maternity clinics. One of the drivers of this corruption was allegedly

the closure of several maternity clinics. With few clinics left, nurses engaged in rent-seeking behaviour and giving priority to patients able to bribe them in US dollars. According to the lawyers of two women that took city officials to court over the clinic closures, babies have died during or before birth due to delayed or non-attendance by health staff and women have resorted to giving birth at home, outside health facilities, increasing the risks of complications and maternal and child mortality (Chingono 2020).

Restricted access to marginalised populations

Access to SRH services is also particularly challenging for youth, especially if they are unmarried or part of the LGBTQI population. According to Morris & Rushwan (2015) youth access to SRHR is made difficult by societal and cultural stigmas surrounding youth sexual activity, restrictive laws, judgmental and unsupportive healthcare personnel, information asymmetries, low political priority, and corrupt and inadequate service provision. In addition to exposing youth to health and socio-economic risks, it also makes them more vulnerable to extortion and overcharging.

LGBTQI individuals are also at particular risk of being extorted for bribes when accessing public services, including health. In addition to sharing many of the challenges faced by women and youth, such as reduced bargaining power and higher risks of poverty, they are further marginalised by the fact that same-sex behaviour is criminalised or highly stigmatised in several countries of the region. This exposes LGBTQI individuals to even higher risks of being extorted by public officials and law enforcement, and makes them even less able to seek redress following experiences with extortive corruption (Amnesty International 2013 and Bullock & Jenkins 2020).

According to Amnesty International (2013: 57), "the criminalisation of sexual orientation and gender identity has a devastating impact on access to healthcare generally and on HIV prevention work in particular". Men living with HIV are likelier to experience discrimination in accessing treatment due to HIV's association with same-sex conduct and the stigmatisation or criminalisation of that across much of SSA.

Marginalised and vulnerable groups are also at a higher risk of sextortion. Sextortion refers to people in positions of power, including medical staff with access to crucial products or services in a scarce market, using their power to sexually exploit clients requiring the product/service. This is likelier to affect patients who are unable to pay requested monetary bribes (Transparency International 2020a).

In a survey undertaken by Transparency International Zimbabwe (2019), around 24% of women indicated they had experienced non-monetary forms of corruption, of which 57.5% said that the bribery took the form of sexual acts. TI Zimbabwe (2019: 11) concludes that women who are unable to pay a requested bribe are then "forced to use sex as a form of payment".

Corruption in the healthcare workforce

According to the WHO (2010: 24), the health workforce includes "all people engaged in actions whose primary intent is to enhance health", which includes doctors, nurses, pharmacists as well as management and support staff in health facilities. To contribute to an effective healthcare system, this workforce needs to be large enough in numbers and have the skills, knowledge and motivation to carry out their functions as required.

High levels of grand corruption, especially at the political level, divert resources away from the healthcare system, which results in an inability to hire enough personnel or invest in the infrastructure needed for them to effectively do their jobs. High levels of corruption within the healthcare system work against merit-based hiring and promotion, negatively affecting the overall skill set, morale and performance of the workforce (Onwujekwe et al. 2018; Transparency International 2019a; UNDP 2011).

Absenteeism

Absenteeism – healthcare workers not showing up for work, or showing up late and leaving early – is one of the most common forms of corruption cited in several studies on the region (Onwujekwe et al. 2018). It should be noted, however, that not all absenteeism is due to corruption. It can also occur due to understaffing and mismanagement when healthcare workers do not come to work because they were sick, overworked or worried, due to inadequate protective measures at work – a fact often observed during the COVID-19 pandemic.

Absenteeism constitutes corruption where healthcare professionals are employed by and receive salaries in public healthcare institutions but abandon their posts for private practice, outside engagements or unauthorised leisure time, during contracted working hours. Absenteeism rates vary across countries but on average can reach about 35% to 40% in low- and middle-income countries, leaving a massive gap in healthcare coverage (Transparency International 2019a).

The practice was repeatedly observed in Nigeria, for example, where doctors were found absent from their posts to "moonlight" elsewhere to make an additional income, sometimes performing services

beyond their qualifications or expertise (Onwujekwe et al. 2018).

In Uganda, Ackers, Ioannou & Ackers-Johnson (2016) found that doctors being absent during contracted working hours was the single biggest reason for women being unable to access prenatal care in a timely manner, with estimates for absenteeism ranging between 35% and 65% on a given day. This in turn contributes to Uganda's stagnation on improving maternal health and particularly reducing maternal mortality.

According to Ackers, Ioannou & Ackers-Johnson (2016) reasons for the high rates of absenteeism include low pay and delayed salary payments, high levels of moonlighting in private practice, ineffective or non-existent human resource (HR) management systems, and a lack of incentive schemes or enforcement of contractual obligations. But it should be noted that while low salaries are often cited as justification by healthcare staff, pay increases on their own are unlikely to solve the problem. Absenteeism tends to be higher among doctors than among midwives and nurses, for example, suggesting that pay on its own is not the reason for the absenteeism (Ackers, Ioannou & Ackers-Johnson 2016).

Transparency International (2019a) similarly notes that while low or irregular pay is often cited as a driver of high levels of absenteeism, better paid healthcare workers sometimes have higher rates of absenteeism than lower paid ones, and regions with similar pay levels differ in their rates of absenteeism. A lack of accountability and supervision as well as no or limited consequences for employees not showing up for work, lack of staff motivation and poor incentive structures appear to be more relevant variables in explaining absenteeism.

Dual practice

Absenteeism can also be fuelled by dual practice, where healthcare professionals, especially doctors, work for both public and private practice. While this does not qualify as corruption per se, several studies have found that where doctors engage in dual practice, they often use time they are meant to be working at a public facility to make extra money in private practice (Hutchinson, McKee & Balabanova 2019).

Dual practice can also increase the risk of diverting patients from public to private practice. Where this is done without a medical need or while misleading the patient by claiming a medical need, when the true motivation is the higher fee for the doctor, this crosses the threshold into corrupt behaviour (Onwujekwe et al. 2018).

Corruption in health information systems

Health information systems, according to the WHO (2010), refer to the data and information collected on a healthcare system and its operations to inform decision and policymaking.

One reason the healthcare sector is particularly prone to corruption, according to UNDP (2011), is that it is characterised by high levels of uncertainty, complexity and information asymmetry. The sector also involves a vast variety of stakeholders with very different levels of information, this is especially true between providers and patients, which makes accessing comprehensive information and data collection challenging.

Information asymmetry between doctors and patients, and patients' lack of independent access to information about fees, costs and necessary procedures have repeatedly been identified as

creating loopholes for corruption. This information asymmetry is particularly severe where oversight systems are complex, inadequate or lack the sanctioning mechanisms to be effective (UNDP 2011; Hilber et al. 2016; Hutchinson, McKee & Balabanova 2019).

Routine health information systems (RHIS) are commonly used to collect needed information and data within the health system to inform decision-making. However, especially in low- and middle-income countries there are often concerns regarding the "quality, accuracy, timeliness, completeness and representativeness" of collected data (Hoxha et al. 2020). In a review of 60 studies on RHIS in low and middle-income countries, Hoxha et al. (2020) discovered that 55 of those studies identified technical, behavioural and/or organisational challenges surrounding data collection.

For certain SRH services that can be sensitive or stigmatised, a lack of information regarding process, legality and rights can be found on the side of the patient as well as the provider. In studying access to abortion-related care in Zambia, Haaland et al. (2020), for example, documented a lack of awareness on the part of medical professionals regarding the legality of terminating a pregnancy, with many assuming it was illegal in situations where it was not.

Several sources have noted that the non-existence or inadequacy of available data on SRHR and corruption, especially in terms of gender-disaggregated quantitative data, which has made it difficult to assess the true extent of the problem and design adequate responses (Transparency International 2020a; TI Zimbabwe 2019; UNODC 2020).

Accessing essential medicines and equipment

According to the WHO (2010: 60) "a well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use" – all of which may be hampered due to corruption risks in the supply of and access to medicines and needed medical equipment.

Patients looking to access essential medicines and products related to SRH services are not only exposed to extortion by medical professionals. According to Aassve et al. (2019), high levels of corruption are also likely to divert resources away from health centres and public information campaigns as well as increase the price of contraceptives, making them less accessible to especially vulnerable populations. Their study on SSA has found that both a low level of women's education as well as high bribery rates correlate with unmet needs in contraceptives access.

High levels of corruption also correlate with the unequal distribution of anti-retroviral drugs (ARV) for HIV positive patients. A study conducted by Friedman (2015) found that higher levels of corruption were associated with a reduction in efficacy of imported ARV. Countries with high levels of corruption saw fewer positive health effects and more HIV related deaths than countries with lower levels of corruption that had the same amounts of ARV to distribute. For Kenya, the study revealed that ARV medication was distributed among clinics not based on need but rather to geographic regions with majority populations of the same ethnicity as the new president. And, in Zimbabwe, there were reports of HIV positive patients being required to pay for ARV drugs that were meant to be distributed free of charge.

Theft and embezzlement of medicines and supplies

A common corruption risk in healthcare is the theft of medicines and medical supplies by healthcare personnel who then re-sell it at a higher price for their personal benefit, sometimes replacing the stolen products with inferior ones. This contributes significantly to medicine shortages and stock-outs in which case patients may be unable to access needed medicines or are forced to pay higher prices or buy expired, inferior or inappropriate medicines from private sources (Onwujekwe et al. 2018; Transparency International 2019a; UNDP 2011).

A study in Uganda had found, for example, that the theft and resale of medicine provided the single greatest source of income for healthcare personnel (UNDP 2011). In Zimbabwe, the entire management team of Masvingo Provincial Hospital had to resign in 2019 after it came to light that they had diverted drugs to private pharmacies to be resold in foreign currency (TI Zimbabwe 2019). A government audit in Togo found that anti-malarial drugs provided by the Global Fund and worth over US$1 million had been stolen, and a study in Uganda had found a median leakage rate of drugs in healthcare facilities of 76% (Transparency International 2019a).

In Ghana, a BBC report found healthcare workers illegally selling PPE equipment during the COVID-19 pandemic for personal profit, while at the same time PPE equipment was scarce in healthcare facilities, with many healthcare workers working without protective equipment, risking infecting themselves and their families (Transparency International 2020b).

For several countries in the region, including Tanzania, Sierra Leone, Mozambique, Cape Verde and Nigeria, studies have found that scarcity, both in human resources and medicines, was incentivising rent-seeking behaviour by healthcare staff (Hutchinson, McKee & Balabanova 2019).

Reasons identified for the widespread theft and embezzlement of medicines and medical supplies are somewhat similar to those identified for bribery risks in accessing services and include low salaries, demotivated staff, limited oversight, weak record keeping and inventory management, weak professional norms and a lack of clear policies (Transparency International 2019a).

Corruption in drug registration and prescription

Another common corruption risk surrounding pharmaceuticals, which was also observed in West Africa by Onwujekwe et al. (2018), is healthcare workers receiving kick-backs or bribes from pharmaceutical companies to prescribe their medication, even if cheaper drugs that are equally as effective would have been available.

Drug registration and authorisation is another area where corruption can be prevalent (Onwujekwe et al. 2018 and UNDP 2011). Especially where national drug agencies are understaffed and underfunded, and where the regulatory environment is weak and accountability low, there is an increased risk that drug manufacturers may bribe government officials to register their drugs or delay the registration of drugs from their competitors or to bypass inspections, leading to sub-standard or overpriced drugs entering the market.

Corruption in medical procurement

Medical procurement, both for drugs and equipment, is particularly prone to corruption,

leading to shortages, diversion, a siphoning off of funds and the purchasing of sub-par products. The process carries a high corruption risk as drug volumes are typically large and medical equipment expensive, making the contracts very lucrative. Additionally, the process can be rather complex and involve several stages and stakeholders, opening up opportunities for collusion, bid-rigging and the manipulation of specifications (Onwujekwe et al. 2018 and UNDP 2011).

While corruption risks in medicine procurement are generally high, health supplies and medicines specifically required for women's health are at a particular risk of being overcharged or "lost" due to corruption, presumably because women are expected to not have the position of political or economic power or collective bargaining ability to object to, or take action against, such corrupt practices (Bullock & Jenkins 2020 and UN Development Fund for Women 2010).

Corruption risks are also likely to have increased during the COVID-19 pandemic, with procurement processes expedited due to urgency, often at the expense of accountability and transparency measures (Transparency International 2020b).

In Zambia, a medical supply scandal worth US$21 million occurred throughout 2020 and 2021. Allegedly, the Ministry of Health authorised the company Medical Stores Limited to distribute condoms and latex gloves, supplied by the company HoneyBee, in a process that bypassed the official procurement and bidding process. Both the condoms and gloves proved defective, failing safety tests, but were distributed anyway. While the Zambia Medicines Regulatory Authority later recalled the products and the Minister of Health was forced to resign, it was unclear how many products had already been used, putting people's

lives at risk (Africa Science Focus 2021 & Nganga Ziba 2021).

Meanwhile in Zimbabwe, health minister Obediah Moyo was fired in July 2020 after being accused of having awarded a multi-million-dollar contract that inflated the cost of medical equipment and, in Kenya, the Ethics and Anti-Corruption Commission initiated investigations into allegations of graft over the procurement and supply of COVID-19 equipment (Uche et al. 2021). According to Uche et al (2021), procurement corruption was particularly rife in the wake of the COVID-19 pandemic, with public officials hoping to cash in on the emergency funds, often through schemes involving the supply of masks and other protective equipment, and in the process diverting money away from health services.

Corruption in health systems financing

Health system financing is the "function of a health system concerned with the mobilisation, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system" (WHO 2010: 72). For most low- and middle-income countries this usually means a mix of domestic and foreign funding.

While increased investments in healthcare are needed to achieve universal health coverage in the region, these need to be accompanied by greater efforts to curb corruption in the sector to ensure investments lead to the desired outcomes and money is not wasted or lost (Hsiao, Vogt & Quentin 2020).

Domestic funding constraints due to corruption

A main concern regarding healthcare systems across SSA, and one of the main drivers of corruption discussed in the literature, is scarcity.

This refers to scarcity in terms of medicine shortages, lack of qualified personnel, too few or ill-equipped clinics, and a lack of specialised healthcare services. In part this is due to a general lack of funds due to many sub-Saharan countries' overall budget shortages. But grand corruption plays a significant factor as to why insufficient funds are available to spend on the region's healthcare systems. All too often, budgets are lost or diverted through embezzlement or fraud, lining the pockets of corrupt politicians instead of financing crucial public services (Duri 2020 and Ortega, Sanjuán & Casquero 2020).

When testing the link between illicit financial flows and healthcare spending in low- and middle-income countries, Ortega, Sanjuán & Casquero (2020) found that greater estimated volumes of illicit financial flows correlated with relatively lower family planning coverage, fewer women receiving antenatal care and a lower rate of child vaccination.

A case in point is Mozambique. The country has been estimated to having lost around US$4.9 billion to corruption annually between 2004 and 2014 – the equivalent of 60% of the country's 2015 budget. Newly discovered resource wealth in the early 2010s could have funded different development efforts, including healthcare. Instead, it resulted in a corruption scandal involving international banks and national state-owned enterprises, in which off-budget loans worth US$2.2 billion were issued, large chunks of which ended up in the pockets of a group of high-ranking government officials (Transparency International 2019b). Another US$200 million were estimated to have been lost to bribes and kick-backs as part of the scheme, where one effect of the scandal was to significantly elevate Mozambique's debt levels. Donors withdrawing support triggered a collapse in

Mozambique's currency, which lost more than a third of its value in 2016, and led the country to default on its sovereign debt in early 2017 (Transparency International 2019b: 4).

Corruption risks in donor funding

A second area of corruption risk occurs where international donors step in to fill funding gaps left by a lack of domestic financing. Donors spend an estimated US$20 billion annually on health globally, and in low-income countries they often significantly outspend national governments (Transparency International 2019a).

Aid effectiveness has long been a contentious debate. Donor countries had often opted to finance aid programmes, including health, through their own independent channels and structures because channelling funds through national governments was considered ineffective and risky due to their high levels of corruption. However, this approach resulted in its own set of criticisms, arguing that the creation of parallel structures was unsustainable and would weaken national systems and capacity (Transparency International 2019a and WHO & World Bank 2017).

Studies aiming to quantify the amount of money lost to corruption in donor funded health efforts are scarce, or where existent tend to underestimate amounts of money lost. Some snapshot studies are available for individual projects, such as a World Bank project financing hospitals in India. An evaluation identified "construction problems" in 54 out of 55 hospitals built, in many cases due to corruption; detected signs of fraud in 9 out of 12 related procurement processes; and estimated that poor material and quality of work used would reduce the "useful life" of the buildings by as much as 50-75% (Transparency International 2019a).

In Zambia, a corruption case was uncovered at the Ministry of Health by the country's Anti-Corruption Commission around 2009. High-level officials in the Ministry of Health and Social Welfare had embezzled US$1.4 million, among other sources from donor funds from the Swedish government. Once the case became public, and following the assessment that Zambian authorities were not implementing effective enough control mechanisms to respond to the loss of funds, donor support to the Ministry of Health, which represented half of the national health budget, was frozen by the Global Fund to Fight AIDS, Tuberculosis and Malaria as well as several European donors (UNDP 2011 and Usher 2010).

According to Usher (2015), the following years saw a marked decline in previously positive health trends, including a deterioration in performance in antenatal care and maternal and newborn care, among others. This demonstrated the difficult balance for donors to navigate, in instituting a zero tolerance for corruption while also ensuring continued healthcare (Usher 2015).

Corruption in health systems leadership and governance

According to WHO (2010: 86), "leadership and governance in building a health system involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability".

As such, governance in healthcare relates to both national level governance in terms of the establishment of adequate policies and regulations, as well as how these frameworks are translated into practice at the local level and within the management systems of healthcare facilities.

According to Gilson, Lehman & Schneider (2017), such an understanding of governance needs to consider the importance of bottom-up processes, and transition from a state-centred to a society-centred approach that recognises the diversity of stakeholders involved.

In identifying reasons for the continent's healthcare systems underperformance and inability to ensure universal health coverage, the AHAIC Commission (2021) identified inadequate legal and policy frameworks, weak management of reform processes, poor leadership and management of the healthcare sector, weak coordination and an insufficient prioritisation of primary healthcare.

In looking at the effect of good governance on aid effectiveness in relation to HIV incidence, Hwa-Young Lee et al. (2016) found that, in countries with higher levels of government accountability, overseas development aid to counter HIV/AIDS was more effective. However, in countries with below average government accountability, more aid actually had a detrimental effect on HIV/AIDS prevalence, suggesting that in these countries aid money was either diverted, mismanaged or otherwise lost to corruption.

Conversely, Makuta & O'Hare (2015) had found that improved governance, and specifically government effectiveness, rule of law, control of corruption and accountability positively correlated with health outcomes in SSA (as measured in child mortality and life expectancy at birth) by boosting the positive effects of public health spending.

Several studies have found that corruption among the healthcare workforce is facilitated and incentivised by a lack of accountability and oversight as well as an absence of consequences for violating laws, regulations, or protocol at the healthcare facility level. This includes a lack of inspections, internal controls, ineffective or non-existent systems for reporting corruption, and insufficient penalties or lack of enforcement thereof (Hilber et al. 2016; Hutchinson, McKee & Balabanova 2019; Pieterse & Lodge 2015; UNDP 2011).

In Sierra Leone, for example, patients were routinely charged for services that should have been free under the country's Free Healthcare Initiative of 2010 (Pieterse & Lodge 2015). Several tested accountability measures, which were applied to improve health worker performance and reduce bribery requests failed, except those involving substantial financial rewards. According to Pieterse & Lodge (2015), a reason for the high levels of corruption and ineffectiveness of accountability measures was that healthcare workers generally faced no consequences for corrupt behaviour, with disciplinary procedures largely unheard of.

Corruption risk factors affecting SRHR's target recipients

"Women and girls have unique health needs, but they are less likely to have access to quality health services, essential medicines and vaccines, maternal and reproductive healthcare, or insurance coverage for routine and catastrophic health costs, especially in rural and marginalised communities. Restrictive social norms and gender stereotypes can also limit women's ability to access health services" (UN 2020: 10).

Healthcare access restrictions for women

While it has often been postulated that women suffer from the effects of corruption than men, the

overall evidence of this claim is somewhat inconclusive given the range of other variables at play, including income, education, social structures, rural vs. urban (Boehm & Sierra 2015). This demonstrates the need for more disaggregated data and calling "for careful and independent academic research beyond anecdotic evidence", especially data that considers non-monetary forms of corruption (Boehm & Sierra 2015: 4).

Despite this, there is some evidence that corruption affects women and men differently, "due to social and cultural norms that influence how people interact and how they access public services such as education and health care" (UNODC 2020: 128).

Boehm & Sierra (2015) detail how a higher exposure to corruption risk largely depends on which group predominantly engages in specific corruption-prone activities more. And women tend to more commonly engage with the healthcare system, especially SRH, due to their own healthcare needs related to reproductive care and pregnancy, as well as those of their children.

While the available data is somewhat unclear as to whether gender affects overall exposure levels to corruption, there is mounting evidence that women are more at risk to extortive and coercive forms of corruption, including sextortion, due to the relative weakness of their socio-economic position in many countries and thus often inability to pay large bribes (Transparency International 2020a; Transparency International 2014; UNDP 2008).

Other vulnerable populations, such as LGBTQI individuals are also likely to be at an increased risk of sextortion, but the scarcity of reliable data on sextortion makes a credible assessment difficult.

Sextortion results in especially low instances of reporting, as victims often fear the stigma and potential victim-blaming that may come with such a report, as well as the potential for persecution of the victim and the difficulty to provide evidence. This challenge is exacerbated by the lack of gender-sensitive reporting channels (Transparency International 2020a).

Healthcare access restrictions for LGBTQI and other marginalised communities

Marginalised communities, which often include women, LGBTQI individuals, youth and others, are often doubly impacted by corruption. Firstly, because their relative lack of political and economic power and exclusion from decision-making processes often means that resources and investments get allocated to more powerful groups, leaving services catering primarily to these populations, including SRH services, underfunded or absent. Secondly, where such relevant services exist, marginalised groups trying to access them are often at higher risk of being extorted due to their limited bargaining power and higher rates of poverty. And where they experience instances of corruption, including extortion and sextortion, marginalised populations often lack the ability to seek redress or justice because they lack the needed resources, awareness of their (legal) rights, and/or access to gender-sensitive reporting mechanisms (Boehm & Sierra 2015; Bullock & Jenkins 2020; Transparency International 2020a; UNDP 2011).

People engaged in sex work are often at particular risk, even where sex work is decriminalised and regulated. According to the WHO (2015), in jurisdictions where police are charged with monitoring sex workers' compliance with relevant regulations, such as carrying health cards, police officers have forced sex workers to undergo health checks, extorted bribes, blackmailed or sexually

abused sex workers and/or arbitrarily arrested them to extract additional fines or bribes. Sex workers, irrespective of gender or gender identity, often face additional barriers, including abuse and corruption when trying to access SRH services.

Effects of COVID-19 on gender-based violence

The COVID-19 pandemic has increased women's economic vulnerability while they, especially in developing countries, are often performing precarious jobs in the informal economy, are typically primary care givers for the sick and elderly, and are overrepresented among healthcare workers, which exposes them to additional health risks (Transparency International 2020b and UN 2020).

As elsewhere, rates of domestic violence and overall sexual and gender-based violence have been on the rise in SSA during the COVID-19 pandemic due to economic and social factors, restrictions on movement and a breakdown of social protection mechanisms. At the same time, access to needed response services, which was already a challenge, has been reduced as health services, NGOs, domestic violence shelters, law enforcement and other public sector entities have shifted their focus or had to reduce their in-person services due to lockdown measures (Eghtessadi et al. 2020 and UN 2020).

That being said, several countries in SSA have taken measures in the wake of COVID-19 to respond to the increasing risk of gender-based and domestic violence by strengthening services for women survivors through helplines, continued psychological support and dedicated police responses. Malawi established a community complaint mechanism, for example, while Angola created a helpline for psychological support. South

Sudan and Mozambique have likewise established or expanded their helplines to be available 24/7; Niger and Ethiopia have launched awareness campaigns; and in Uganda the Ministry of Health, together with UNFPA, developed standard operating procedures to ensure continuity of gender-based violence, sexual and reproductive health and HIV services during the pandemic (UN Women & UNDP 2020).

Mitigating corruption risks in SRH service delivery

Mitigating corruption risks in healthcare is crucial both at the national level and among international donors. International aid into the healthcare sector has grown from US$5 billion in 1990 to US$23 billion in 2014. In low-income countries, donors account for around 30% of healthcare expenditure and spend more than twice as much to fight HIV/AIDS, malaria and TB than national governments (Transparency International 2019a:16).

Yet, according to Transparency International (2019:4), current efforts to curb corruption in healthcare service delivery have largely been unsuccessful because of the "weak and disparate evidence base on corruption, failure to take into account local political realities, flawed programme designs, and a misguided focus on paper trails rather than on the impact that corruption and anti-corruption interventions have on health outcomes".

Measures to mitigate corruption risk in SRHR include those that tackle specific corruption risks within the healthcare system as well as tackling the factors that make SRHR recipients particularly vulnerable to corruption.

Measures to improve and strengthen the healthcare system more broadly include better monitoring of regulatory compliance, greater transparency and accountability in procurement and service delivery, better reporting channels, education and awareness raising for healthcare staff and patients, improved incentive structures for healthcare professionals, consistent sanctioning of violations, and improved data collection and disclosure (Onwujekwe et al. 2018 and UNDP 2011).

Addressing the particular vulnerabilities of the intended beneficiaries of services related to SRHR requires a greater focus on community engagement, effective reporting lines, greater protection for minorities, better gender sensitivity in designing policy responses, and training and awareness raising for patients and service providers (Transparency International 2020a and TI Zimbabwe 2019).

Mitigation measures need to be designed with a greater understanding of how the healthcare sector, and particularly SRH service delivery functions in a given country and context, what the particular corruption risks are and who is most affected by them. All of these require additional investments in research and data collection on the topic to design evidence-based policy and decision making (Transparency International 2019a; Transparency International 2020a; TI Zimbabwe 2019).

Strengthening accountability of the healthcare system

A lack of accountability and enforcement of existing regulations has been repeatedly noted as a reason why so many loopholes for corruption exist in healthcare service delivery. To close these gaps both top-down oversight as well as bottom-up accountability need to be improved (Transparency International 2019a).

According to Transparency International (2019a), top-down supervision needs to include internal supervision within health facilities, such as by implementing internal and financial controls, improving record keeping, audits and improved supervision by line managers. It also needs to encompass a greater involvement of supervisory bodies and regulators to conduct effective inspections based on clear indicators. Similarly, the UNDP (2011) found that the healthcare system's internal oversight should be strengthened by improved management processes, such as oversight mechanisms, internal control mechanisms, codes of conduct and formal fee structures.

Improved oversight needs to be accompanied by sanctions for breaches of regulations that are effectively and fairly enforced (Transparency International 2019a and UNDP 2011).

In evaluating different accountability mechanisms implemented across SSA to improve maternal and newborn health, Hilber et al. (2016) concluded that, to be effective, accountability measures need to involve a wide range of stakeholders including CSOs, government, the healthcare sector itself, media, the private sector and the donor community. Additionally, "accountability mechanisms should be context-specific and address health system as well as socioeconomic, political, and cultural barriers to MNH [maternal and newborn health] across the continuum of care" (Hilber et al. 2016: 346).

However, the study also found that, while accountability mechanisms have been increasingly introduced throughout SSA to improve maternal and newborn health – ranging from financial accountability systems, political and democratic accountability measures to performance

accountability mechanisms – results regarding their impact were mixed. Overall, accountability systems appeared to be more effective where they were accompanied by recourse or sanctioning mechanisms that facilitated an enforcement of rules. Furthermore, multi-stakeholder approaches that went beyond tackling a particular problem to address "underlying norms around inequality in access to care" had the most impact (Hilber et al. 2016: 351).

Strengthening service providers and their workforce

A lack of motivation, awareness, capacity and insufficient remuneration on the part of the healthcare workforce has repeatedly been mentioned as a reason for high levels of corruption at service delivery level. Strengthening healthcare systems by improving management processes, HR functions, planning capacity, oversight and employee training may thus reduce opportunities for corruption.

While raising salaries alone has been repeatedly identified as insufficient to reduce corruption in healthcare, a combination of raised salaries, an effective incentive structure, career progression opportunities including training and promotion, and merit-based hiring can all help reduce opportunities and incentives for corrupt behaviour of healthcare workers (Onwujekwe et al. 2018 and Transparency International 2019a).

In evaluating a USAID funded project to strengthen Mozambique's healthcare system in the delivery of HIV health services, Jacobson et al. (2015: 2) found that a newly introduced district approach was "positively associated with improved HIV service quality". The district approach was meant to strengthen service delivery by introducing an

assessment tool to monitor management capacity at the district level, increase supervision of clinics through standardised checklists, training courses for healthcare staff, quality assurance initiatives, and improving patient flow and facility-based information systems, among others. The reforms also included an element of community outreach to lower barriers of access between citizens and healthcare facilities.

The study found that the introduced management reforms had decreased the number of "phantom" staff on the clinics' payrolls, which is a common form of corruption in the public sector. The study also found other system improvements that, while not explicitly (or necessarily) linked to corruption, are expected to close loopholes and incentives for corrupt behaviour. These include improvements in staff motivation, job performance, planning skills, frequency of supervisions and reporting, quality of data analysis and needs-based staffing. They further eliminated stock-outs, improved supply and quality of medicines, improved distribution and quality control, reduced waiting times, reduced loss and destruction of products, and improved the quality of care and services.

To improve maternal health and reduce maternal mortality, Acker et al. (2015) also point towards the importance of paying attention to HR management, workforce motivation and enforcement to reduce absenteeism of healthcare personnel and improve health outcomes for expectant mothers.

Strengthening CSO service providers

CSOs have been filling a crucial role in SSA, especially during the COVID-19 pandemic, by filling gaps left behind by inadequacies in national healthcare systems. According to Eghtessadi et al. (2020) it thus essential to support and strengthen

CSOs in delivering critical services, providing much needed social protection, ensuring the localisation of services, and instituting accountability networks. The latter is especially crucial in the wake of the COVID-19 pandemic, with several countries, including Zimbabwe, South Africa, DRC, Uganda and Kenya, having witnessed allegations of large-scale fraud and mismanagement involving COVID relief funds.

Increasing transparency in healthcare service provision

Greater transparency is crucial to ensure bottom-up accountability and reduce the information asymmetry between providers and patients. Often, corruption in healthcare service delivery is facilitated by patients not knowing what the price for a medication should be or the difference between the regular service fees and irregular payments. To that end, publicising prices for medicines and fee structures for services could help in closing corruption loopholes (Transparency International 2019a).

Hsiao, Vogt & Quentin (2020) likewise mention the importance of transparency measures in noting that transparent fee structures between providers and patients as well as an effective complaints mechanism for patients, and a move away from direct payments could help reduce instances of corruption in healthcare access.

Procurement and pricing transparency are also noted as useful tools to reduce corruption risks and allow for greater monitoring by Onwujekwe et al. 2018 and UNDP 2011. An example includes the Medicines Transparency Alliance (MeTA) in Ghana, which through multi-stakeholder councils disclose information on the price, quality and

availability of medicines and thus removes information asymmetries (Onwujekwe et al. 2018).

Supplier prequalification and e-procurement systems as well as general ICT measures to monitor healthcare operations are also mentioned as effective tools to lower the risk of kick-backs, procurement fraud, and overcharging on essential medicines and equipment (Onwujekwe et al. 2018 and UNDP 2011).

Citizen monitoring of service delivery

Community engagement and bottom-up monitoring can be particularly useful to address corruption at the service delivery level were patients are involved in monitoring health worker absences or shortages in medicines and medical supplies (Transparency International 2019a).

According to UNDP (2011), citizen monitoring, including the introduction of citizen scorecards, participatory budgeting and effective reporting lines, can help prevent (or at least identify) cases of large-scale fraud and embezzlement and improve payer performance.

Community monitoring has also proved successful, according to Onwujekwe et al. (2018: 18), by "reducing medicine stock-outs, unjustified absenteeism, informal payments, and other forms of abuse of power". However, when implementing such measures it is paramount to take local context into consideration, "pay attention to local knowledge and build on local values".

In addition to facilitating digital civic participation and social accountability monitoring mechanisms, according to Eghtessadi et al. (2020: 288) "[community service organisations] must institute health systems monitoring and assessment, and make recommendations for health systems

strengthening, in co-operation with judicial systems, human rights institutions, and parliamentary structures, for the attainment of SRH rights throughout the pandemic".

However, although community monitoring programmes have grown in popularity and are increasingly favoured by donor agencies, according to a comparison of studies by Transparency International (2019a), the evidence of their effectiveness in improving service delivery and reducing absenteeism and informal payments is somewhat mixed, with past studies identifying both successful and unsuccessful examples. In a successful example from Uganda, where community monitoring significantly improved service delivery and health outcomes of a local healthcare facility, the authors of the study found that a key indicator of the initiative's success was providing citizens with baseline performance data of the facility (Transparency International 2019a).

A need for gender-sensitive reporting lines

While ways to report cases of corruption exist in most countries, levels of reporting are commonly low, especially for stigmatised forms of corruption such as sextortion.

People do not report corruption for a variety of reasons. In a survey conducted by TI Zimbabwe (2019) reasons cited for not reporting an experience of corruption included perceiving the police as corrupt, suspecting the perpetrators may simply bribe their way out, fear of reprisals and not knowing where to report. In the particular case of sextortion, the male domination of the justice system was another reason given for choosing not to report. According to UNODC (2020) women may be particularly hesitant to report corruption

for fear of reprisal, concerns about confidentiality and a lack of protection.

It is thus paramount to improve avenues and mechanisms to report cases of corruption and make them more accessible to vulnerable groups.

For reporting lines to be useful, especially for marginalised groups, they need to be transparent both in their design and who operates the channel, as well in how reports are dealt with. They also need to be accountable, e.g. by including review and appeal options, accessible, responsive, confidential, culturally appropriate and independent (Transparency International 2016). To be gender sensitive and accessible to victims of sextortion, reporting channels should put a particular focus on confidentiality and anti-retaliation measures, and provide access to needed legal and health services (both physical and psychological) (Transparency International 2020a and Zuñiga 2020).

A need for better data

According to the UNODC (2020: 129), "evidence-based policymaking in the field of gender and corruption remains far from the norm. More reliable data about the prevalence of different varieties of corruption and their associated gendered processes would greatly enable national policy creation".

While corruption in the healthcare system is relatively widely studied and recent years have seen an increase in studies on the gender dimension of corruption and how marginalised groups are disproportionately affected, there is a notable lack of studies looking specifically at corruption risks in SRH service delivery. There is also a lack of gender-disaggregated data available for specific corruption experiences and instances in healthcare. Such data

is greatly needed to design effective policy interventions (TI Zimbabwe 2019).

Data on sextortion is particularly scarce as the phenomenon has only relatively recently been considered in the anti-corruption debate and so often goes unreported. Additional research in the field is thus crucial, including disaggregated data collection (Transparency International 2020a).

The need for more gender-disaggregated data, and data on specific non-monetary forms of corruption, is widely noted to improve policy design and decision-making (Boehm and Sierra 2015; Transparency International 2014; UNODC 2020). However, data collection needs to pay attention to the sensitivity of the subject matter and the vulnerability of its victims.

Addressing sextortion

Sextortion as a phenomenon has only relatively recently entered the focus of debate. As such, most legal frameworks and anti-corruption frameworks are ill-equipped to take on the challenge. While sextortion could technically be covered by anti-corruption legal frameworks or laws against sexual violence and gender-based discrimination, according to Transparency International (2020a) anti-corruption laws often do not apply. They may not cover benefits that are neither financial nor include property gains, or they may classify a victim of sextortion as a bribe payer, opening them up to prosecution. This, together with the social and cultural taboo surrounding sextortion means that in practice it rarely leads to a report, investigation or prosecution. It is thus necessary to update legal frameworks and anti-corruption frameworks to explicitly include and define sextortion, to raise awareness and provide training among the public, the judiciary and law

enforcement, and to improve reporting lines by making them more gender sensitive.

To counter sextortion, training and awareness raising among law enforcement and the judiciary is likewise paramount to not only facilitate reporting but also ensure adequate responses to reports made (TI Zimbabwe 2019).

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KEYWORDS

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