

U4 Helpdesk Answer

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Corruption risks in maternal and perinatal health.

**Informal payments and unnecessary
procedures drive mothers away from
safe labour.**

Corruption in maternal and perinatal health negatively affects the health of mother and child in different ways. Corruption can divert much needed funds from obstetric healthcare specifically, driving down the quality of the services provided. Informal payments can deter low-income pregnant mothers from giving birth in institutional facilities, imperilling their lives and their unborn children. Such practices can also damage the trust relationship between patient and doctor.

Unnecessary procedures, particularly caesarean sections, can be driven by profit or to facilitate and speed up births in an understaffed environment.

More research should be done on the drivers of the different corruption risks to understand how to mitigate them.

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Query

Please provide a summary of the key corruption risks and potential mitigation measures in maternal and perinatal health.

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MAIN POINTS

- Informal payments are the most common type of corruption risk in the sector. These may be health workers seeking personal financial gain, but it can also be a way to finance medicine and supplies in underfunded systems.
- Corruption in maternal and perinatal health can deter women from going to institutional facilities to give birth, with great risk to their lives and their unborn child.
- Unnecessary procedures, particularly caesarean sections, have increased greatly in the past decades, but the exact drivers behind this increase have to be better researched.

Introduction

Corruption is defined as “the abuse of entrusted power for private gain” ([Transparency International](#) no date). Evidence shows that marginalised groups, including women, tend to be more affected by corruption (Bullock and Jenkins 2020: 1).

Women constitute a larger part of those living in poverty worldwide and tend to be their families' caregivers (Bauhr & Charron 2020; UNODC 2020). Because of their place in society, both in terms of their socio-economic status and their caregiver position, they tend to rely more on public services, which also means they are more affected by having to pay bribes for them (UNODC 2020). As women

often must deal with public officials at the service delivery point, they appear to be in a more vulnerable position than men when confronted with corrupt officials (Bullock 2019). It is illustrative that women tend to perceive corruption in healthcare and education as more prevalent, which could be explained in part because they spend more time dealing with those services (Bauhr and Charron 2020). Corruption at the point

of delivery of maternal and perinatal healthcare services¹ will also affect them disproportionately.

Healthcare systems are susceptible to corruption as they often have numerous stakeholders dispersed throughout a territory, with large financial flows and limited oversight, making accountability more difficult (Devrim 2021; Schoeberlein 2021; Abisu Ardigó & Chêne 2017). Furthermore, the asymmetry of information between health providers and patients is large, making proper assessments about the necessity of certain procedures or treatments and estimating costs difficult, which may further encourage corruption at the point of delivery (Amnesty International 2009).

Corruption is associated with poor health outcomes. For example, worse corruption scores, collected through public, private and NGO sector experts' and a regular citizens' surveys are associated with less HIV prevention of mother-to-child transmission coverage (Man et al. 2014). A study by Hanf et al. (2011) found that 1.6% of annual deaths of children under 5 years of age are linked in part to corruption as measured by the Corruption Perceptions Index (CPI). Similarly, a study by Mostert et al. (2015) discussed the negative effects that corruption in African countries had on the quality and accessibility of care to cancer patients, contributing ultimately to lower cancer survival rates. Of course, other factors, like poor infrastructure and a dearth of resources also have an effect, but if corruption leads to the misallocation of available resources, it compounds an already difficult situation.

Different regressions have found a correlation between corruption and infant mortality rate (IMR) and maternal mortality rate (MMR) (Muldoon et al. 2011; Pinzón-Flórez et al. 2015; Ruiz-Cantero 2019). In one particular study, governance as a whole was found to be highly associated with a lower MMR, proving equally important as a country's wealth (Ruiz-Cantero 2015). A regression in African countries found that for sub-Saharan Africa, perceived corruption per the CPI was the only significant predictor of MMR according to their modelling (Lan & Tavrow 2017). Interestingly, even though the basic correlation suggested a relationship between corruption perception and MMR in sub-Saharan Africa and the rest of the countries studied, it was only in sub-Saharan Africa that the relationship remained significant after running several regression analyses and adjusting for other variables (Lan & Tavrow 2017).

Considering these concerning trends and the fact that women have differentiated needs in their reproductive years, they are put at particular risk if corruption is prevalent in the healthcare system (Devrim 2021). This Helpdesk Answer presents some of the corruption risks specific to maternal and perinatal health. Existing literature has focused mainly on the prevalence of informal payments and unnecessary procedures, but other risks also appear. Particularly in low and middle-income countries (LMIC), some of the corruption risks and practices identified might be related to systemic and structural deficiencies and not necessarily to an abuse of power for private gain. Future research should pay more attention to disentangling this.

¹ According to the WHO, "maternal health refers to the health of women during pregnancy, childbirth and the post-partum period,

whereas perinatal health refers to health from 22 completed weeks of gestation until 7 completed days after birth" (WHO).

Corruption in resource allocation

The risks of grand corruption affecting maternal and perinatal health can be twofold. First, grand corruption might divert or misuse funds that could have been used to improve health service delivery for pregnant women and newborns. Funds mishandled due to corruption could have been invested in maternal and childcare programmes (Mpambije 2017). If funds are illegally diverted specifically from obstetric care this can lead directly to higher rates of maternal mortality (Barkhouse et al. 2018). For example, a study found an association between an increase in illicit financial flows (IFFs) and a decrease in the percentage of women receiving antenatal care, which could be attributed to the loss of resources through IFFs and a following lack in funding stability (Ortega et al. 2020).

Secondly, as with any large operation, maternity hospitals and similar facilities can be sites of grand corruption. In Uzbekistan, for example, the prosecutor general's office conducted an audit of the Republican Specialized Centre for Obstetrics and Gynaecology and found that 15.3 billion soums (approx. €1.18 million) had been misappropriated over two years (KUN 2020). In the US, a hospital chain was charged with paying kickbacks and bribes to a prenatal clinic so it would unlawfully refer over 20,000 Medicaid patients to their hospitals (US Department of Justice 2016) while an ob-gyn in Virginia colluded with a licensed pharmacist to prescribe expensive compounded pain and scar creams which resulted in US\$1.8 million in losses to private health care benefit programmes (US Attorney's Office 2021). In India, a health mix and iron supplement from a private firm used by the government was costlier than

those from a state-run agency, incurring larger costs for the state (NDTV 2022).

Grand corruption can thus directly affect the maternal healthcare sector through the mishandling or embezzlement of funds to the detriment of the quality and operation of its services. Similarly, it can lead to less valuable available funding for better quality services.

Corruption at the point of service delivery

Corruption in the maternal and perinatal health sector tends to take place at the point of service delivery, where pregnant women and their families interact with healthcare providers. It can take several different forms, listed in this section.

Informal payments

Informal payments in the healthcare system can be 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” (Transparency International 2020).

Informal payments can be attributed to the social acceptance of such practices and to the underfunding and demanding work conditions in the sector (TI Magyarország & Női Érdek 2019).

Frontline health workers might demand payments to deliver their services in healthcare systems with inadequate infrastructure and, in those contexts, fees can be used to fund goods and services that go to the patients and other supportive inputs (Schaaf & Topp 2019). They can also be driven by a lack of funds that leads to facilities being underfunded and not reimbursed on time (when reimbursed), which in turn reduces their credit-worth and elevates their operating costs (Derkyi-Kwarteng et al. 2021).

In countries where staff are underpaid, informal payments may also be for private gain, driven by a necessity to subsidise low wages. However, the relationship between salaries and informal payments is not consistent, with cases of doctors (who have higher wages) commanding higher informal payments than nurses (who have lower wages) (Schaaf & Topp 2019). Ultimately, regardless of the reason, informal payments give frontline workers a lot of discretion as they determine who pays for a service and who gets it for free (Derkyi-Kwarteng et al. 2021). They also determine who gets better treatment, linking the quality of the healthcare to the ability to pay. Thus, they hinder universal healthcare, either by preventing access or diminishing the quality, and out-of-pocket payments, whether informal or formal, decrease access to health services and increase catastrophic health expenditure for households, which is particularly detrimental for lower-income families (Derkyi-Kwarteng et al. 2021).

Informal payments are prevalent in the healthcare systems in many LMICs (Abdallah et al. 2015; Lindkvist 2012; Piroozi et al. 2017; Kabia et al. 2019; Derkyi-Kwarteng et al. 2021; Schaaf & Topp 2019; Myint et al. 2018) as well as in transition

economies (Ensor 2004) and appear to be particularly prevalent in the maternal and perinatal sector. A synthesis of studies shows that informal payments appear often in the obstetric care setting, which could be partly explained by the dynamics of obstetric care delivery, where women are in urgent need and have less time to negotiate, leaving them more vulnerable to these payments (Schaaf & Topp 2019). This has been found in maternal care in Bangladesh (Akter et al. 2020), Nigeria (Aluko 2018), Uganda (Matayo 2019; Fazekas et al. 2021; Roed et al. 2021), India (Khan & Jahid 2023), Zimbabwe (Choguya 2018), Kenya (Tumlinson et al. 2021; AlJazeera 2019), Afghanistan (Rahmani & Brekke 2013), Sierra Leone (Pieterse & Lodge 2015), Vietnam (Malqvist 2012), Hungary (Baji et al. 2017), Bosnia (Augustinovic 2021), Ukraine (Pryrodni Prava Ukraina 2019) and Greece (Kaitelidou et al. 2013).²

Informal payments in state-run healthcare systems, where treatment should be free, are made to ensure better treatment during and before childbirth, for example, to make sure the chosen doctor, or sometimes any doctor, is present at birth. Sometimes it might be that patients are not aware that their insurance, whether private or public, covers certain payments, and workers can take advantage of this and charge them for services for which they are covered (Derkyi-Kwarteng et al. 2021).

In Bosnia, the problem seems rampant, as a survey by an organisation seeking to reduce “corruption in childbirth” found that 50% of mothers had given money or a gift to medical staff in maternity wards (Baby Steps 2021). In Zimbabwe, pregnant women need to pay bribes to receive assistance during

² This is by no means an exhaustive list.

childbirth, and some claim that priority is given to those who can pay in US dollars (The Guardian 2020). Birth registration officers have also been known to demand bribes (Khan & Jahid 2023).

Patients might make informal payments hoping to get better care, including more personalised care, shorter wait times (skipping the queue), getting subsidised medicines and ensuring a continuous relationship with the provider, among others (Schaaf & Topp 2019; Kabia et al. 2019). In Kenya, for example, a mother told how her two first pregnancies led to stillborn children as other women were cared for before her. She eventually learned most women paid bribes to avoid long queues and decided to pay a gynaecologist to ensure he would be there to deliver her child (AlJazeera 2019). In Burkina Faso, Amnesty International found that women needed to pay for access to medical facility treatment and for medical supplies which should have been free of charge but had been misappropriated and sold by staff for personal gain (2009). In Nepal and rural Tanzania, women reported paying to give birth in an institutional facility, despite the existence of free maternity services (Kruk et al. 2008; Acharya 2016).

Particularly relevant appears to be paying to ensure that a chosen particular doctor accompanies women through pregnancy and labour, as is common in Hungary, where an online survey found that 79% of women with a chosen doctor made informal payments, at an average of €191, to secure the chosen doctor's presence at birth, while only 17% of women without a chosen doctor made an informal payment, at an average of €86 (Baji et al. 2017; Kremmer 2020). Similarly, in Bosnia, a mother recounted paying bribes as her first childbirth, when she had not paid a bribe, had been traumatic as the doctor was not present during labour and she was sutured without anaesthesia

(Augustinovic 2021). In Albania, people also pay out of fear of being denied treatment or the necessary follow-up (Devrim 2021). In Bangladesh, women received abusive and poor-quality treatment if they refused (or could not) meet informal payments (Akter et al. 2020).

In one study conducted in rural Tanzania (McMahon et al. 2014), only men, usually the partners, were described as making the informal payments on behalf of the pregnant women, reenforcing gendered views on who is in charge of the money. These payments were seen as necessary to be "seen" by health providers (McMahon et al. 2014). Something similar was mentioned in interviews in Albania, where the husband would make the payments and each nurse in turn would expect to get a payment or the women risked not receiving any attention from them (Devrim 2021).

While sometimes the payments are expected implicitly, they can also be demanded. In many places, the informal payment demand can be accompanied by coercion, telling patients that they risk negligence if they do not pay, refusing them pain relief during suturing, denying them seeing their newborn until they pay, and other similar threats (Schaaf & Topp 2019). In other circumstances, the demand might be more subtle. In Kenya, for example, some informal payment demands were framed as a sign of appreciation as one patient recounts: "The provider also said that he can take a little cash as it pleases me as a sign of appreciation of his service" (Tumlinson et al. 2021:344).

In Greece, a study found that 74.4% of women who used public maternity services made informal payments and that 56.3% of the respondents had provided them at the request of their obstetrician (Kaitelidou et al. 2013). These payments might be

requested for all types of services; for example, in India, they range from providing medicine that are free for pregnant women to stitching up women and cremating stillborn bodies (The Guardian 2015). Informal payments can also be found in family planning visits in Kenya, where they constitute a financial barrier that can contribute to unintended pregnancies (Tumlinson et al. 2021).

A study in Tanzania showed that informal payments in the healthcare system, in general, did not seem to lead to a higher effort made by the providers who received them but rather a larger variability in the effort they exerted with regard to different patients, meaning they are possibly lowering their base effort to maximise patients' payments for better services (Lindkvist 2012).

For policy purposes, it is important to differentiate between informal payments that are demanded for the private gain of the healthcare provider or worker from informal payments that might genuinely be needed for the delivery of the service, such as asking the patient to purchase drugs that should be available for them at the hospital but which, for various reasons, are not (Schaaf & Topp 2019). This might be a fine line and sometimes difficult to determine. For example, in Ukraine, some medical tests related to pregnancy cannot be done for free because public prenatal clinics do not have the capability to do so, which results in paying for private tests (Pryrodni Prava Ukraina 2019). Although, legally, the patients are entitled to this free service, the capacity in the public healthcare system does not allow it. It would be different if the hospital had colluded with the private laboratories.

In sub-Saharan Africa, in-kind informal payments at the local level are largely made by pregnant women and comprised of items to be used during labour (Derkyi-Kwarteng et al. 2021). Women are

sometimes asked to buy the medicines and medical supplies needed for their treatment, but when the medication is later re-sold by the health workers this constitutes corruption (Thomson Reuters Foundation 2010). For example, in Afghanistan, they resell medicines on the black market while telling patients they are out of stock (Rahmani & Brekke 2013). While there might be a genuine need to ask for additional payments or for women or their families to bring medicines and medical supplies to ensure those are available for them, the reasons for the scarcity should be assessed to determine if it is a case of corruption.

Another point of complexity is that of practical norms. Practical norms arise in the gap between official rules and the actual practice of state agents at the "street level" (street-level bureaucrats), giving a certain sense of meaning and structure to what otherwise might appear as random corruption (Sardan in Derkyi-Kwarteng et al. 2021). This can make it difficult to differentiate between practical norms and isolated forms of corrupt behaviour (Derkyi-Kwarteng et al. 2021).

Finally, informal payments are also seen as forms of gratitude (Devrim 2021) or subscribe to a cultural norm of gift-giving (Derkyi-Kwarteng et al. 2021) which might make their regulation difficult. When informal payments are considered a form of tip for a service, criminal codes might not classify them as corruption, allowing for the condonation of such practices by hospital directors, as is the case in Hungary (TI Magyarország & Nöi Érdek 2019). In Uganda, although mothers and health workers considered bribes to be detrimental, they were in a way normalised and thought of as a way to show gratitude to a health worker for helping during childbirth (Matayo 2019).

Thus, the drivers for informal payments are diverse and range from actual necessity to the seeking of personal financial gain. Context matters – and in many contexts, drivers and causes often overlap and reinforce each other, to the detriment of patients and society at large.

Impact of informal payments

The effects of informal payments are complex and manifold. First, when the refusal, or impossibility, to meet informal payments leads to a refusal to provide the service, it can lead to women dying from complications during pregnancy and childbirth (Thomson Reuters Foundation 2010). Informal payments also have an effect on the system as they can erode trust and satisfaction in the healthcare system, leading to women avoiding facility-based delivery (Schaaf & Topp 2019; Jeffery & Jeffery 2010). Concomitantly, to avoid informal payments women may prefer homebirths; for example, in a study in Kenya, respondents admitted to preferring homebirths because they were more affordable as they avoided several payments, including bribes to facilitate services (Izugbara and Ngilangwa 2010). When informal payments deter pregnant women from seeking health services in institutional facilities, maternal and child death is a possible outcome if they decide to give birth at home or at a non-institutional facility where complications are more likely to be lethal.

Informal payments have negative effects on households' budgets and can force families to borrow money, sell assets or ask friends and family for contributions (Schaaf & Topp 2019; Joe 2015). Additionally, there is no evidence that informal payments in the healthcare system have a "Robin Hood" role, where better-off patients pay them and healthcare providers use this to subsidise services to worse-off patients; the opposite appears to be

true, and, in Africa, the informal payment system is regressive (Kankeu & Ventelou 2016).

Finally, these payments can also worsen healthcare service delivery as providers might compete for more lucrative patients and healthcare workers might purposely provide lower quality service until payment is received, pushing for unnecessary procedures or services to elicit higher payments (Schaaf & Topp 2019).

Unnecessary procedures

Unnecessary procedures refer to procedures that were not necessary from a medical point of view, that is, they were not relevant to improve the life and health of the mother or child. An unnecessary surgery is concretely defined as "any surgical intervention that is either not needed, not indicated, or not in the patient's best interest when weighed against other available options, including conservative measures" (Stahel et al. 2017). In maternal healthcare, the literature highlights the overuse of three procedures: caesarean sections, episiotomies and the induction of labour.

Caesarean sections have been increasing around the world. Between 2000 and 2015, the global average for this type of intervention increased by 9% (Opiyo et al. 2020). The rise was particularly steep in Latin America and the Caribbean, with 44.3% of births, and in the central Africa region, with 41% of births using this method (Boerma et al. 2018) but it also appears elsewhere; in Greece more than 50% of deliveries were through C-sections (Kaitelidou et al. 2013).

The evidence suggests that most caesareans are not medically necessary, and some argue that their overuse is associated with increased risk for women

and infants (Opiyo et al. 2020)³. After controlling for risk factors and potential confounders, some research found that the postpartum death risk of a caesarean is 3.6 times higher than that of vaginal delivery (Deneux-Tharaux et al. 2006). Therefore, the increase in caesarean section rates may be worrisome and currently outnumber vaginal deliveries in five countries: Dominican Republic, Brazil, Cyprus, Egypt and Turkey (WHO 2021).

Caesarean use in richer subgroups inside LMICs tends to be higher than for other groups, suggesting overuse for wealthy patients; in 19 countries (26% of those studied) the difference in caesarean rates between the richest and the poorest fifth of the population was 20 percentage points or higher, and in four countries this exceeded 40 percentage points (Boatin et al. 2018). The findings are not restricted to LMICs, and a study in Australia showed that the overuse of caesarean was more prevalent among wealthier mothers with no medical need for it (Fox et al. 2019). This suggests that financial incentives might be among the potential factors behind their surge. In Bangladesh, for example, caesareans are more prevalent in private facilities and some hospitals prefer them for profit-making (Nahar et al. 2022).

Although the drivers remain diverse, and so far causation has not been proven, some possible organisational drivers mentioned in the literature include financial incentives as well as a more predictable work agenda for doctors (Boatin et al. 2018; Vieira et al. 2015), which would also constitute a misuse of power for private gain. In India, caesareans are much more prevalent in the private sector, where nearly 38% of births were

through C-sections compared to 14% in the public sector, which could corroborate the profit incentive of private providers (Singh et al. 2018). Similar findings appear in Brazil, in a study that also investigated mothers' preferences regarding birth type. The study found that preferences were identical between women with public and private healthcare providers, but the private sector had a much higher caesarean delivery rate (70% of deliveries) and thus cannot be attributed to middle to high-income women having a preference for C-sections as had been stated (Potter et al. 2001). More recent studies corroborate the prevalence of caesareans in the private sector in Brazil, where a 2015 study found an 86.2% prevalence of caesarean delivery in the private sector (Vieira et al. 2015). Similar results can be found in Peru, where a study showed that giving birth in a private hospital added 19% to the probability of a C-section (Arrieta 2011).

Informal payments can drive the recommendation of unnecessary procedures to increase their income, which could explain why a country like Hungary, where informal payments are common, has higher rates of caesarean, at 35.7%, than the WHO recommended level of 15% (Baji et al. 2017). Although proving this relation is difficult, a study of 317 women in Hungary found that informal payments to remain with an obstetrician significantly predicted caesareans (Rubashkin et al. 2021). Therefore, mothers pay to ensure the presence of their selected ob-gyn but are not aware that this leads to higher rates of interventions (Iványi n.d.).

However, the reasons for ordering unnecessary procedures go beyond private gain. For example,

³ However, it should be noted that the evidence is divided on whether caesareans carry higher risk for mothers or not (see Steinmark 2022).

doctors in Mexico appear to use caesareans as a way to control risk and pre-empt possible demands (Smith-Oka 2022). Exhaustion and a lack of motivation in midwives and doctors can lead to an increase in caesareans, as the procedure is faster and can be easier for the midwives and obstetricians than helping through a vaginal birth that can last for several hours (Schantz et al. 2020). This, however, would be more prevalent in facilities that are understaffed and with health workers that are underpaid.

Unfortunately, the available evidence on financial and regulatory strategies trying to curb unnecessary C-sections remains inconclusive (Opiyo et al. 2020) as is the evidence on the dangers of C-sections as opposed to vaginal births (Steinmark 2022).

Inducing labour might also be considered an unnecessary procedure if done for the convenience of the doctor and not for the health of the mother and child or for financial gain. In Ukraine, anonymous reports by ob-gyns showed that labour was sometimes induced without having informed women about it (Pryrodni Prava Ukraina 2019).

In the United States, an ob-gyn physician was found guilty of fraudulent claims and charging Medicaid and TRICARE for the elective induction of labour in cases that did not comply with the standard of care. To comply with standards, the physician altered the due dates of his patients (Shwayder 2021). He also falsified dates to satisfy the 30-day waiting period necessary between patient consent and sterilisation procedures (US Attorney's Office 2020; Shwayder 2021).

Episiotomies are still common despite evidence of some of the problems they cause and medical advice to reduce their practice (Borruto & Comparetto 2016; NPR 2016). Their use could be

explained in part because doctors want to speed up births (NPR 2016).

While it can be difficult to assess whether a procedure is really unnecessary, informed consent is an essential part of healthcare and the circumstances under which this is given need to be taken into account. In Hungary, for example, procedures are not explained to women during prenatal care, and consent must be signed when in active labour (Iványi n.d.). Similarly, in Ukraine, women are often not informed about their medical interventions, such as amniotomy, episiotomy, medication use or even sterilisation (Pryrodni Prava Ukraina 2019). This makes it difficult for them to understand the risks or benefits of any procedure, let alone consider its necessity. This potentially allows for abuse on the behalf of health workers, since women will not be able to seek further opinions and assess them to reach a decision. Under such circumstances, a health worker seeking to do a procedure that would entail more financial gain can gain consent under dubious circumstances. Although the information asymmetry between a doctor and a patient will always remain high, this may be improved by careful protocols for consent. For example, in contexts where both illiteracy and a lack of understanding of anatomy is widespread, a trusted medical interpreter may be necessary.

Lastly, long hospitalisations, beyond necessity, could also be considered an unnecessary procedure and a possible corruption risk if they happen so health facilities can charge more. In Romania, for example, a study found that 56.2% of hospitalisations of pregnant women were not necessary and half of the women hospitalised for institutional delivery remained in the hospital unnecessarily long (Jullien et al. 2023).

Beyond the risks the procedures entail for mothers and infants and the fraudulent financial gains they might represent for health providers, the abuse of such procedures could deter women from going to healthcare facilities, worsening maternal health outcomes. In Bangladesh, for example, Indigenous women perceived hospital staff to have a preference for caesarean and episiotomies, which they saw as unnecessary and harmful (Akter et al. 2020).

Patronage and fees for jobs

Patronage refers to a “form of favouritism in which a person is selected, regardless of qualifications or entitlement, for a job or government benefit because of affiliations or connections” (Transparency International Corruptionary A-Z). The maternal and perinatal healthcare sector is not immune to this type of abuse, and we can expect that in countries where this is a common practice in the staffing of the public sector, such considerations will also play a role when hiring in this area. If this leads to the recruitment of workers that do not have the necessary qualifications this can have an impact on maternal and perinatal health.

Patronage can also reflect who gets better care. In Afghanistan, having personal contacts inside the hospital was considered necessary for accessing quality care (Rahmani & Brekke 2013). A study in Nigeria found the allocation of the different opportunities created by an internationally funded family planning programme was based on social ties and kinship, in accordance with local usual practices (Smith 2003).

Another problem is the demand for informal payments to get or keep one’s position in the healthcare system. For example, in Albania, some nurses needed to pay a fee to a political party to keep their jobs while doctors would pay to get

positions in hospitals of their choosing (Devrim 2021). Similarly, career advancement is thought to be dependent on bribery in certain countries of sub-Saharan Africa (Moosa et al. 2014).

If bribes are elicited to get a position, this also feeds into the informal payments problem, since health providers might pay to remain where they are or to have a more desirable posting and can also be indebted to superiors (either for obtaining the post or for overlooking their misbehaviour) (Schaaf & Dasgupta 2019).

Absenteeism

Beyond the corruption risks of demanding bribes or performing unnecessary procedures for financial gain, bribery can also occur in misbehaviours that amount to corruption understood as the abuse of power for personal gain. One particular risk is that of absenteeism: not showing up for work without a legitimate reason.

Examples of absenteeism abound, as in Nepal, where health facilities were found closed when they should have been open and health workers were supposed to conduct outreach services as part of a programme to improve maternal healthcare but did not actually conduct that outreach and only reported it on paper (Paudel et al. 2018). Or in Uganda, where health workers often found themselves alone on duty (Roed et al. 2021). In Niger, although the official working hours for health workers were 7:30 to 16:30, with a one-hour lunch break, many midwives tended to arrive around 9.00 and leave at 13:00 (Olivier de Sardan et al. 2017).

Absenteeism can be affected by dual practice, where healthcare workers have second jobs at private practices, which can amount to corruption if they work for the private facility when they should be working for the public one (Schoeberlein

2021). This would be abusing their position as they would not show up for their official duties for which they would still get paid. However, it is important to consider that this might be driven by poor wages and difficult working conditions. Research suggests healthcare workers can be absent due to needing additional income from other sources to compensate for their low or delayed wages (Fazekas et al. 2021). In Kenya, for example, staff in the maternal sector are underpaid and overworked (AlJazeera 2019). Moreover, nurses and midwives tend to have long work hours and be underpaid, making less than the average salary of high-skilled workers in 34 out of 49 countries researched in one study (Limani 2023) and they work in difficult, unsafe and poorly equipped settings in LMICs (Homer et al. 2018).

Additionally, irrespective of the country, overwork and burnout appear to be prevalent among ob-gyns, ranging from 40% to 75% (Smith & Rayburn 2021). Absenteeism thus can also be driven by a more legitimate necessity of seeking rest.

Absenteeism has severe consequences for mothers and children. In Kenya, for example, a study found that pregnant women who were not tested due to nurse absenteeism were 50% less likely to know their HIV status during pregnancy (Vian 2020). Although not only related to workers in the maternal healthcare sector, a study in Uganda estimated that absenteeism of health workers, in general, meant an approximate loss of UGX495 billion to the state budget in terms of wasted salaries (Fazekas et al. 2021).

Absenteeism thus worsens an already difficult situation as many prenatal care facilities in LMICs suffer from a shortage of human resources (Mohseni et al. 2023). In Sierra Leone, understaffing has led to charging for otherwise free care to pay for clinic-

based “volunteers” (Pieterse & Lodge 2015), which could also happen to cover the shifts of absentees.

Understaffed facilities, whether due to absenteeism or otherwise, also carry an additional problem: healthcare workers who violate policies – who, for example, demand informal payments – cannot be sanctioned if this will leave the hospital unable to provide services (Schaaf & Dasgupta 2019).

Other corruption risks

There are a number of other corruption risks, which have not been as fully researched or are not as prevalent as those previously described. For example, the theft and pilferage of medicines and equipment by healthcare workers to resell them on the black market is a known risk in the healthcare system (Abisu Ardigó & Chêne 2017). For example, in Ghana, midwives misappropriated drug consumables from pharmacies for personal gain (Derkyi-Kwarteng et al. 2021). A programme in India, meant to supplement mothers and children with food and nutrition supplements, sometimes failed to reach its beneficiaries as officials sold the rations for cash (The Guardian 2015).

Another corruption risk can be the misappropriation of funds. In India, the “Janani Suraksha Yojana”, a conditional cash transfer to promote mothers to give birth in health facilities and sometimes payments to village health workers that accompany women to the facilities, did not improve health outcomes despite increasing facility based births. A study found that this was in part due to health service providers focusing on capturing economic rents while continuing to provide poor-quality care (Coffey 2014). Misuse of incentives meant for mothers was also found in a similar programme in Nepal (Paudel et al. 2018).

In a free maternal and child health programme in Nigeria, some of the officers over-registered the number of participants to increase the money they got from the national health insurance scheme (Onwujekwe et al. 2019). In Illinois, USA, an ob-gyn billed Medicaid close to US\$60,000 for ultrasounds and other procedures that were not provided (Chicago Tribune 2020).

The unlawful use of equipment is also a known risk in the healthcare sector (Abisu Ardigó & Chêne 2017). In Malawi, members of the local community in Chikhwawa told how healthcare workers misused medical equipment and resources that could have otherwise been used for maternal and perinatal healthcare. They conveyed stories of an ambulance transporting beers from Mozambique or health workers selling mosquito nets and drugs in the neighbouring country (Kambala et al. 2011).

Another corruption risk is covering up negligence or malpractice (Habek 2017). This will likely entail bribing different health workers who were present and possibly engaging superiors. This could be particularly difficult to spot in the context of high-risk pregnancies or of understaffed and poor-quality facilities where many cases might go otherwise uninvestigated.

More serious risks entail the possibility of healthcare staff being embroiled in human trafficking. In Kenya, the Pumwani Maternity Hospital is under investigation for medical negligence and child trafficking (AlJazeera 2019). In India, the police in West Bengal police found staff had told mothers their babies were stillborn only so they could be stolen, while in other districts staff tried to persuade mothers to sell their newborns (VOA News 2017).

Other forms of corruption might affect the health of women during pregnancy and in postnatal stages in

a more indirect manner, as when it affects the basic services they need, like water and sanitation. For example, pregnant women need to urinate more often, and if they want to avoid inadequate sanitation services to prevent diseases, they can become dehydrated (Schreiner 2019). Similarly, safe water is important for the health of the mother, and if corruption makes access to water difficult, it will have an indirect impact on maternity healthcare outcomes.

Finally, the links between bans on abortion and corruption remain to be explored, but it is conceivable that, where abortion is illegal, women will have to resort to bribes to terminate their unwanted pregnancies, as has been reported in Turkmenistan (RFE/RL 2022). Although making such payments might not always entail corruption, since obstetricians might not be abusing their power for private gain, it can lead to situations where the disparity in power between doctors and the women seeking this service allows for different forms of corruption, from continuing to exert payments to remain silent or sextortion. Ultimately, illegal abortions expose women to risks of extortion and abuse (Schoeberlein 2021).

Intersectionality

Although not always related to corruption, the literature agrees that the abuses that exist in the maternal and perinatal health sector are more prevalent when the patient is a woman from a lower socio-economic status and/or from an Indigenous minority. For example, some studies found that people living in poverty were sometimes mistreated due to their status (Jeffery & Jeffery 2010).

Obstetric violence, or the mistreatment of women during childbirth, was found to be more prevalent against women of lower social standing (Shrivastava

& Sivakami 2019; Ishola et al. 2017). In Ukraine, Roma women suffered greater mistreatment and disrespect (Pryrodni Prava Ukraina 2019), similar to Vietnam, where women from ethnic minorities suffered from more discrimination and negative attitudes (Malqvist 2012).

Derkyi-Kwarteng et al. (2021) found that some pregnant women in Ghana would pay more than others because they were uneducated, nulliparous or belonged to a different religion. The study found that this was because health workers saw them as high-risk clients who made more demands or because they considered they would comply more easily with the demanded payments (Derkyi-Kwarteng et al. 2021).

Similarly, these women will experience the corruption risks mentioned differently, as they will compound their disadvantageous situation. For example, informal payments deepen existing inequalities as women of lower socio-economic strata cannot afford them and, as a result, can be neglected, humiliated and verbally abused, as seen in the case of Roma women in Hungary (Iványi n.d.).

For Indigenous women in Bangladesh, paying for transportation and accommodation near the health facilities as well as medicines was already a great burden, when informal payments were also required, it created distrust in the system (Akter et al. 2020) and can ultimately deter them from going, affecting the health of minorities disproportionately.

Single mothers are also likely to suffer more as they will not have a partner with whom to share the informal payment expense. Finally, if women are more likely to earn less than men, it will have a relatively bigger impact on their income when they make informal payments (Devrim 2021).

This is in line with the finding that corruption can have a disproportionate impact on already discriminated groups (McDonald et al. 2021).

Due to the vulnerable and unequal position women of lower income occupy in society, they will likely have fewer possibilities to voice their complaints and demands (Bullock & Jenkins 2020; Chêne 2008), making it easier for the services that cater to them than those catering to groups with louder voices. It is possible then to envision that public hospitals that attend to an already vulnerable section of the population in lower-income areas of the country would be the first to suffer under budget cuts caused by corruption and dwindling state funds.

Policy priorities and recommendations

Systemic reforms

As we have explored, some of the corruption risks do not always arise from someone seeking personal gain but rather from larger structural problems that healthcare workers try to mitigate at the point of delivery. Although informal payments might go into their pockets, we have seen they also go to cover health supplies, and some staff might be absent from their posts because they need to have additional sources of income to supplement poor salaries. While there is no excuse for unnecessary procedures, monitoring alone might not solve the problem if hospitals are not better staffed and equipped.

The organisations working on the ground consider that real change and improvement can only be achieved through reforming the healthcare system, including the increase of salaries of all healthcare workers, particularly midwives, the improvement

of hospital infrastructure and the enforcement of laws against bribery (TI Magyarország & Női Érdek 2019).

Political will to curb corruption is always crucial (Amnesty International 2009) but so is understanding the structural drivers behind it. Structural factors at the level of the health system as well as policies, facility cultures and power dynamics can disempower women (Bohren et al. 2015). Isolated policies are unlikely to yield structural change.

For example, a quasi-experimental study in a Kurdistan province of Iran showed that the health transformation plan launched in Iran to reduce out-of-pocket payments and eradicate informal ones appeared to yield positive results (Piroozi et al. 2017). This was a broad reform, implemented in three stages and with a vast amount of interventions. The interventions included providing free basic health insurance for all non-covered Iranians, keeping physicians in underserved areas through incentive payments, improving healthcare services in villages with less than 20,000 inhabitants and introducing a dedicated hotline to report violations, among others (Piroozi et al. 2017). This illustrates the importance of implementing reforms that address the healthcare system as a whole and not one-offs that only target one specific problem.

Finally, the literature agrees that systemic reforms need to be accompanied by proper accountability at all levels (Amnesty International 2009; Derkyi-Kwarteng et al. 2021) as well as by health system governance, which is a crucial determinant for curbing informal payments as it challenges the

underlying system-wide failures (Schaaf & Topp 2019).

Monitoring and accountability

Enhancing monitoring and accountability tools in the healthcare system, in general, but also specifically in maternal and perinatal health (Cabero and Chervenak 2015) can increase transparency and reduce corruption risks. In one study, maternal mortality risk was found to be 12 times higher in countries that had low regulatory quality. Particularly interesting was the finding that low-income countries that had higher regulatory quality had similar MMR values as middle-income countries with lower regulatory quality (Ruiz-Cantero 2015).

Accountability is key for putting limits on the abuse of discretionary power of actors in the health system and for breeding transparency in the policy process (Derkyi-Kwarteng et al. 2021). Collected information should then be used to address the problems of the system (Human Rights Watch 2011), whether related to corruption or not.

At the point of delivery, hospitals can establish anti-corruption teams or a designated staff member and provide anti-corruption material, including how and to whom to report corruption (Augustinovic 2021)⁴. Policies to make drugs and medical supplies free need to come with stock control mechanisms and sanctions for people who misappropriate them for personal gain (Amnesty International 2009). Copayment systems need to be uncomplicated and consistent since, if the patient does not understand

⁴ However, anti-corruption policies and teams should be carefully implemented. Some research shows that, for example, the Health Monitoring Unit that targeted bribery in the health sector in Uganda

in part led to a nationwide strike and lowered staff morale (Marquette et al. 2019).

why they have to pay for certain things, corrupt practices might arise (Derkyi-Kwarteng et al. 2021).

It is also important to consider the particularities of maternal and perinatal health services. For example, monitoring might be increasingly difficult during the night when health facilities cannot provide proper financial monitoring (or more general supervision) (Derkyi-Kwarteng 2021).

Finally, any monitoring system will need to provide the proper incentives in order to function. It has to come with appropriate sanctions and allocation of resources for its implementation (Derkyi-Kwarteng et al. 2021). However, it also needs to consider the how to break a situation that might have been prevalent for years. In an intervention in Sierra Leone, it was only the placement of rewards along evaluation and participatory monitoring that led to improved care practices (Pieterse & Lodge 2015).

Healthcare staff

One way to improve the healthcare process leading up to birth is strengthening the role of midwives (TI Magyarország & Női Érdek 2019). In Guatemala, care navigators help to develop more trusting relations between patients, traditional midwives and biomedical providers (Austad et al. 2017). While the approach targets reducing disrespectful and abusive care, it entails accompanying women through their hospital level obstetric care, which can also decrease corruption risks by having a trusted person present in the process.

Finally, establishing medical expert committees women could turn to might curb unnecessary procedures. In Ukraine, for example, women can file complaints, for free, to a medical expert committee of regional health departments (Pryrodni Prava Ukraina 2019). This provides a clear mechanism in which a medical committee is

asked to evaluate whether a procedure had a medical need.

Reporting mechanisms

Reporting mechanisms for women and families to issue complaints are crucial to enhance accountability. Facilities should have complaint mechanisms that are clear and easily accessible to patients and can provide them with remedies (Human Rights Watch 2011). They should also establish whistleblowing mechanisms that cater to the specific context in which they will be set (UNODC 2021). However, beyond setting up a functioning mechanism, these entail a number of considerations.

Individuals and communities also need to be aware of their rights and to whom they can express their concerns (Schaaf & Topp 2019). For this to work, people need to feel safe when claiming their rights, particularly those in more vulnerable positions, like women and poverty-stricken people, who might be less willing to alienate the workers in the only health facility they have available (Schaaf & Topp 2019).

Anonymity should not only be guaranteed but it should also be communicated in a way that patients trust to be the case. In Albania, interviewees were afraid of making complaints as they believed the doctor would be informed (Devrim 2021).

Finally, complaints should ensure investigations examine not only the conduct of the individuals but also failings in oversight and management (Human Rights Watch 2011).

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The U4 anti-corruption helpdesk is a free research service exclusively for staff from U4 partner agencies. This service is a collaboration between U4 and Transparency International (TI) in Berlin, Germany. Researchers at TI run the helpdesk.

The U4 Anti-Corruption Resource Centre shares research and evidence to help international development actors get sustainable results. The centre is part of Chr. Michelsen Institute (CMI) in Bergen, Norway – a research institute on global development and human rights.

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