

Gendered Impact of Corruption in Healthcare Service Delivery in Nigeria

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DOI: 10.36108/NJSA/3102/11(0140)

Abstract

This paper supports the hypothesis that corruption and non-delivery of services in key sectors such as health have gender-specific poverty consequences. The study utilized qualitative micro-level information about the structures of corruption and its impact on poor women. Respondents expressed their perceptions on the occurrence of corrupt practices in public health care system and its wider impact on society. The findings revealed that the impact of corruption is felt disproportionately by women and the poor, who are most dependent on public services, and have no alternative even when facing corrupt practices in a life threatening situation, such as complicated birth delivery. Pregnant women denied access to doctors tended to deliver at home, which increased the likelihood of complications and maternal and child mortality. Medical supplies meant for public hospitals are sold to private clinics who charge more for drugs and supplies. There is need to strengthen sectoral oversight mechanisms and transparency as well as increase women's voices in service delivery.

Keywords: gender, corruption, health sector, service delivery

Introduction

The history of corruption is as old as the world, because ancient civilizations have traces of widespread “illegality and corruption” (Dike, 2005 cited in Aluko, 2009; Abbas, 2008). Various writers agree that corruption, as a malaise, is not exclusive to any nation, race or section of the world but transcends national boundaries and frontiers (Okunola, 1991; Oyeboode, 1999). However, some countries experience more corrupt practices among its citizens than others. It is argued here that corruption is widespread in Nigeria and accounts for the culture of impunity that pervades the country in virtually all sectors of human endeavour. This is despite a catalogue of commissions of enquiry and anti-corruption agencies set up by successive governments to rid the society of the malaise.

Corruption is defined by Transparency International (TI) (TI, 2007: XXI) as ‘misuse of entrusted power for private gain.’ Corruption occurs when public officials who have been given the authority to carry out goals which further the public good, instead use their position and power to benefit themselves and those close to them. It is increasingly acknowledged that there are weak links in the chain from public spending to actual outcomes in making basic services available to poor people (Gupta, Gauri & Khemani, 2004). Simply increasing

budget allocations to essential services such as health and education is not enough to ensure that quality services are indeed delivered. Even when resources are appropriately allocated they may not reach their intended destinations because of organizational and incentive problems in public agencies. When they do, the service providers may have weak incentives or capacities to deliver effectively (Gupta *et al.*, 2004).

Corruption is, therefore, a pervasive problem affecting the Nigerian health sector. At the level of individuals and households, there is mounting evidence of the negative effects of corruption on the sector in general and maternal health care in particular (Hadi, 2008). Hadi (2008) also observed, over 50,000 Nigerian women die from child birth every year. Nigeria accounts for 10% of the world's maternal deaths in child birth whereas the country represents 2% of the world's population. One in five Nigerian children dies before the 5th birthday. About a million Nigerian children die of preventable causes every year. Only 18% of Nigerian children are fully immunized by their first birthday. Malaria kills more Nigerians than any other disease, and yet less than 5% of its population has access to insecticide treated nets proven to be effective in preventing malaria (www.gamji.com/article6000/NEWS7913.htm).

Governments in Nigeria, at all levels, spend less than 5% of public expenditure on health, despite being signatory to the 2000 Abuja Declaration to increase this to 15% and notwithstanding that over 75% of the Millennium Development Goals are health-related (Hadi, 2008). The WHO (2010) report shows that major health indices in Nigeria have remained poor even when compared with those of poorer African countries. Improving the quality of health services is vital to improving health of the people, and the role of institutions and incentives in the public sector in translating budgeted resources into actual outcomes is therefore critical.

As Savedoff & Hussmann (2006) noted, corrupt practices are widespread in health organizations largely because no other sector has the specific mix of uncertainty, asymmetric information and large numbers of dispersed actors. Consequently, susceptibility to corruption is a systemic feature of health systems and controlling it requires policies that address the entire sector. Just as the governments in Eastern European countries met resistance at many fronts in tackling corruption in the health care system, attitudes of the public and politicians were as difficult to change as those of health care professionals (Hayhurst, 2001). Indeed, issues of corruption in the Nigerian health sector are as delicate. Policy makers, health managers and professionals rarely mention it, particularly the effect on quality of care even when it is quite clear that the country is notable for intractable poor health indices.

At the moment, health care provision in Nigeria is a concurrent responsibility of the three tiers of government in the country and is structured such that the Federal government's role is mostly limited to coordinating the affairs of the University Teaching Hospitals and Federal Medical Centers (tertiary health care), state governments manage various general hospitals (secondary health care), and local governments focus on dispensaries and

health centres (primary health care), (which are regulated by the federal government through National Primary Health Care Development Agency - NPHCDA). Although the recurrent expenditure on health has risen from 12.48 million naira in 1970 to 98.200 million in 2008 (Bakare & Olubokun, 2011), healthcare system remains inefficient and plays a major role in impoverishing the country. Various studies (Baba & Omotara, 2012; Hadi, 2008) have established that a key aspect contributing towards low impact of public investments in the social sectors particularly health is endemic corruption and an inefficient monitoring mechanism.

This study, therefore, considers how inefficient public health care system contributes to women's vulnerability. The outcome will enrich the body of knowledge on the impact of corruption in health-care delivery on poor women.

Brief Review of Literature

The State of Nigeria's Public Health Care System

Nigeria's health care system reflects the federal character of the country which comprised 36 States (and a Federal Capital Territory) further sub-divided into 774 local government areas. This means that the federal, states and local governments have roles to play in the provision of health care services. Private health care institutions exist to complement the role of the government. Health facilities in the private sector are not generally accessible to the poor, and private hospitals mainly cater for higher income households. Poor health outcomes in public health care institutions are attributed to lack of appropriate targeting strategies for reaching the poor, low levels of public funding, and poor implementation of the government's public spending (Osafa-Kwako & Apampa, 2009).

The poor performance of Nigeria's health sector has been attributed mainly to government's attitude towards health care service delivery. It has been revealed that budgetary allocations to the health sector have been persistently below 5% except for years 1998–1999 and 2002–2003 when they were about the above percentage. Although infant mortality rates have decreased from 99 per 1000 live births in 2003 to 75 in 2008 (NDHS 2008), there is much to be done in the health sector.

Corruption in Health Care Delivery: An Overview

Corruption in the health sector is a concern in several countries, but is more of a critical problem in developing and transitional economies where public resources are already scarce (Vian, 2002; 2007). Corruption in the health sector is a reflection of structural challenges in the health care system. Among the key reasons for corruption in the health sector are weak or non-existent rules and regulations, over-regulation, lack of accountability, low salaries and limited offer of services [i.e., more demand than supply](UNDP, 2011).

Corruption reduces the resources available for health, lowers the quality and effectiveness of health care services, and increases the cost of provided services. It discourages people to use and pay for health services and ultimately

has a corrosive impact on the population's level of health (U4 Issue, 2008). A study by the International Monetary Fund (IMF) on 71 countries shows that those with high indices of corruption have higher rates of infant mortality (Gupta, Davoodi & Tiongron, 2000). Preventing abuse and reducing corruption is therefore important in improving the health status of the population.

Basically, health care provision depends on effective combination of financial and human resources, supplies, and timely delivery of services throughout a country. This requires a "system" that mobilizes and distributes resources, processes information and motivates health care workers and administrators (Lewis, 2006). Good governance is a critical factor in making such a system function, which often is lacking in most developing countries, including Nigeria. Capturing the effectiveness of public health care services, the extent of corruption and the degree of accountability usually pose serious challenges, which contribute to negligible effort at addressing governance issues in the sector.

Consequences of Corruption on the Health sector

Studies have shown that corruption has a significant negative effect on health indicators such as infant and child mortality, even after adjusting for income, female education, health spending, and level of urbanization (Gupta *et al.*, 2002). In Azerbaijan, it has been shown that about 35% of births in rural areas take place at home, in part because of high charges for care in facilities where care was supposed to be free (World Bank, 2005).

In Nigeria, Dora Akunyili, former Director General of the National Agency for Food and Drug Administration and Control (NAFDAC), introduced measures to rid Nigeria of counterfeit drugs (Akunyili, 2006). Unregulated medicines which are of sub-therapeutic value can contribute to the development of drug resistant organisms, increase the threat of pandemic disease spread, and severely damage patients' health (WHO IMPACT, 2006). In addition to fake and sub-standard drugs, corruption can lead to shortage of drugs available in government facilities, due to theft and diversion to private pharmacies. Unethical drug promotion and conflict of interest among physicians can have negative effects on health outcomes as well.

Theoretical Framework

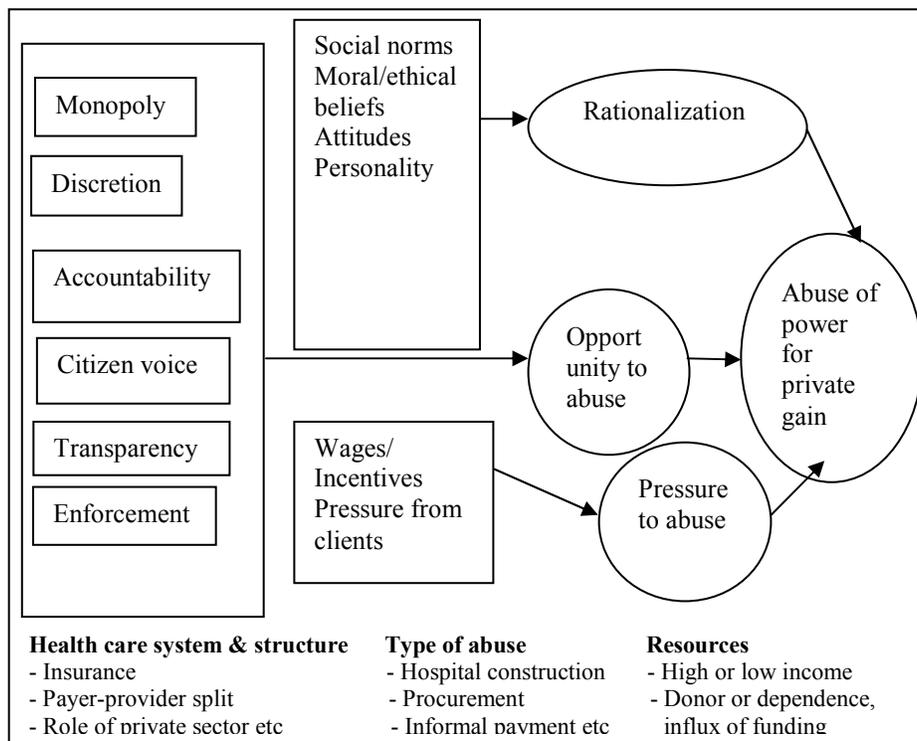
Figure 1 presents a theoretical framework on corruption in the health sector which consolidates some of the concepts and models that have been developed previously (Di Tella & Savedoff, 2001; Lewis, 2006). Looking at it from the viewpoint of the government agent, the framework suggests that corruption is driven by three main forces: government agents who abuse public power and position for private gain do so because they feel pressured to abuse (financially or by clients), because they are able to rationalize their behaviour or feel justified (attitudes and social norms support their decision), and because they have the opportunity to abuse power. The factors involved, and the application

of this model to the health sector, are discussed below, looking in most detail at the opportunities to abuse.

According to economic theory, officials weigh the costs and benefits of acting corruptly against the costs and benefits of acting with integrity, and choose to act in the way that maximizes their self-interest (Jaen & Paravisini, 2001). Opportunities for corruption are greater in situations where the government agent has monopoly of power over clients; officials have a great deal of discretion, or autonomous authority to make decisions, without adequate control on that discretion; and there is not enough accountability for decisions or results (Klitgaard, 1988).

Monopoly creates opportunities for corruption by limiting the ability of citizens to choose other providers of services. If the government is the only provider offering medical services, for example, patients could be compelled to pay bribes to access those services. General strategies to reduce monopoly include health reforms to separate payer and provider, privatization or contracting of services with many providers, and increasing the number of government agents providing particular services (Klitgaard *et al.*, 2000).

Figure 1: Framework of Corruption in the Health Sector



Source: Vian, T. (2008) Review of corruption in the health sector; theory, methods and interventions. <http://heapol.oxfordjournals.org/>

Discretion refers to the autonomous power of a government official to make decisions, such as hiring staff or deciding what medicines are needed and in what quantities to procure them. Clinical care providers also exercise discretion by making decisions about the amount and types of health care services a patient should have. High amounts of discretion without adequate controls can create opportunities for corruption.

Accountability is government's obligation to demonstrate effectiveness in carrying out goals and producing the types of services that the public wants and needs (Segal & Summers, 2002). Lack of accountability creates opportunities for corruption. Brinkerhoff (2004) identifies three key components of accountability, including the measurement of goals and results, the justification or explanation of those results to internal or external monitors, and punishment or sanctions for non-performance or corrupt behaviour. Citizen voice refers to the channels and means for active participation by stakeholders in planning and provision of services (Thompson, 2005; Lewis, 2006; Milewa, 2006). One purpose of citizen voice is to increase external accountability of government.

Transparency is another concept which is closely related to accountability. The idea behind transparency is that by actively disclosing information on how decisions are made, as well as measures of performance, we can improve public deliberation, reinforce accountability and inform citizen choice. In addition, transparency helps to document and disseminate information on the scope and consequences of corruption, information which can help build support for anti-corruption programmes and target enforcement efforts.

Detection and enforcement include steps taken to collect evidence that corruption has occurred, and to punish those who engage in corruption. The goal of detection and enforcement is both to get rid of bad agents, i.e. those government officials abusing their power, and to deter others from engaging in corruption in the future.

Rationalization: in addition to the institutional or organizational factors described above, which collectively affect the opportunities for corruption, behavioural scientists have studied the ways in which individual beliefs, attitudes and social norms influence corruption. Although a sense of moral obligation and concern for others is an important influence on behaviour, especially in the medical professions and among public servants (Randall & Gibson, 1991; Kurland, 1995; Raats *et al.*, 1995), researchers point to eroding public service values which create a vacuum in which corruption appears justified (Miller *et al.*, 2001). In a similar way, Olivier de Sardan explores social norms which permit African societies to justify corruption, arguing that these "logics" of negotiation, gift-giving, solidarity, predatory authority, and redistributive accumulation' allow corruption to become 'socially embedded', and must be considered in developing anti-corruption policies and interventions (Olivier de Sardan, 1999). Personality character traits and demographic characteristics may also be important in explaining corruption.

Pressures to abuse: a government agent may feel pressure to embezzle to pay-off personal financial debt, or may accept informal payments because

government salaries are too low to make a living. Government agents may also feel pressured by clients to accept bribes. This is especially true in situations where people are sick and suffering, and feel that bribes are the only way to ensure they receive the best possible treatment (Vian *et al.*, 2006). Pressure may also be exerted by suppliers, or by other agents involved in corruption.

Methods

The study was carried out in Ibadan, the capital city of Oyo State, Nigeria. The city is made up of 3 distinct zones, namely, the inner core, made up of transitional area; traditional zone; and the sub-urban periphery (Brieger & Adeniyi, 1982). The inner core is characterized by indigenous people whose occupations are mainly petty trading and subsistence farming. The transitional zone consists of both indigenous and non-indigenous people who are mostly Yoruba in ethnic origin. They are civil servants or are engaged in trading. They represent the middle socio-economic class. The periphery consists of people from diverse ethnic origins but mostly Yoruba. People in this area are professionals, businessmen and highly qualified academics and top civil servants. They represent the higher socioeconomic class. The study focused on the inner core because of its obvious characteristic- low- income level.

Respondents were purposively selected in the available health facilities in Ibadan South/East Local Government area of Ibadan, with headquarter in Mapo. In-depth interviews were carried out among twenty-five women age 15-45. The respondents were required to self-identify as belonging to the category of people who were thought to be knowledgeable about public health care delivery because they were either pregnant or nursing mothers who needed to or received immunization and maternal/child care services at the time of the study. Interviews were conducted in Yoruba language and later translated into English language. Content analysis was done after the interviews. Three key questions were asked: What is corruption and how do they perceive corruption in the healthcare sector? How does corruption affect the quality of patient care? How does corruption in health care service delivery affect women and girls?

Results and Discussions

Corruption defined

Respondents defined corruption in many ways, with the majority describing it as dishonest or immoral practices in cash or kind; behaving contrary to rules, ethics or the law; public and private officers unlawfully using organizational resources for private use; and quickest way of survival for the guys. In the words of some of the respondents:

“To be corrupt is to selfishly direct funds, materials and other resources meant for public use into private use. This is found among top government officials and cuts across.” It is also: *“The act of dishonesty, immoral behavior exhibited by somebody at any place and anywhere.”* Yet another said: *“Not doing what you are supposed to do at the right time and at the right place. It*

is also asking or requesting kickbacks before any rightful duty is done, both the giver and the receiver in this respect.”

Perception of Corruption in Health care organizations

Perceptions about corruption reflect how these women view health systems and their effectiveness in producing acceptable health outcomes. Perceptions provide the basis for assessing governance at any level. Expectations on paying for public care correspond to the perceptions of corruption, which in turn are closely related to the need for informal payments. In this study, nearly all the respondents confessed to have offered bribes at one time or the other in order to access medical services. However, most perceived corruption in healthcare contexts as overpayment for supplies, selling of fake drugs, taking bribes or informal payments to individual and institutional providers outside official payment channels. This encompasses *under-the-table* payments to doctors, nurses and other public medical staff for jumping the queue, receiving better or more care, obtaining drugs, or just simply for any care at all. A respondent described the situation in the health care system as follows:

Everyone in the health care organisation is corrupt, from the nurses, doctors who receive kicks for services, to doctors who divert patients from government establishments to their private hospitals, to members of regulatory bodies who fail to undertake monitoring.

Yet another said:

Get rich quick syndrome/value system that encourages corrupt enrichment. In the bid to get rich there are those that believe that the end justifies the means. In some cases people collude with some foreigners to import substandard product.

The public health care system is perceived to be corrupt for a number of reasons. Health system corruption is less likely in societies where there is broad adherence to the rule of law, transparency and trust, and where the public sector is ruled by effective civil service codes and strong accountability mechanisms. Corruption is widespread in Nigeria largely due to poor governance structures, weak accountability systems and tolerance for sharp practices. Despite the poor health indices, methodical approaches for tackling corruption in the health system and addressing the quality of health care do not exist at any level. Most of the respondents strongly feel that lack of accountability is the major cause of corruption, while others said that lack of transparency, shortages of medical supplies and staff, low salaries of doctors and nursing staff, and lengthy and difficult procedures encourage corruption. In the words of one of the respondents: *“Medical personnel may prescribe inappropriate drugs to unsuspecting patients just to satisfy some pharmaceutical company that would have given some form of incentive to the officer.”*

Another respondent has this to say:

I lost my immediate senior sister through the inefficiency of the medical personnel. The husband, who is a commercial motorcycle rider, rushed his wife to hospital when she suddenly went into labour. When it became apparent on arrival that she needed a cesarean section, the man expected the treatment to be free, as it was government policy. But a nurse, acting on the doctor's directive, demanded that he pay for blood transfusion in the course of surgery. When the husband mentioned the government policy to the nurse she replied sarcastically, "Ok, go and meet the governor to donate his blood for your wife" and then insisted she would not prepare his wife for surgery until he paid. He had no choice but to rush to a friend's place to borrow the money, but unfortunately the wife was already dead by the time he returned with the money.

This experience is not an isolated case, but in fact emblematic of an endemically corrupt healthcare system in Nigeria. There are countless tales of extortion and unnecessary deaths at the hands of corrupt health care workers in a system which claims to provide free healthcare to mothers, young children, and several other in need. The evidence abounds of doctors and pharmacists running a parallel system of private health care using some of the resources intended for the public system. Respondents noted that through a permanently open 'revolving door', they tell persons attending the public clinics, and eligible for free treatment and medicines, that they are unavailable due to fictional 'stock outs'. They then refer them to their private clinics where the drugs are available, but now need to be paid for. It was revealed that these drugs are often directly or indirectly stolen from the very public hospitals where they hold positions. In sum therefore, the foregoing explains why corruption is so evident in the health sector. Indicating the lack of accountability and transparency in health care operations, and in some the "power of monopoly" where other public or private alternatives simply do not exist.

Effects of Corruption on Quality of Care

To most of the respondents, corruption has led to lack of drugs, equipment and other materials needed for patient care. It has also led to poor quality of patient care; deaths and physical handicap of some patients due to poor quality care. It is as if only the rich receive adequate care, because charges are made too high for patients of low socioeconomic status to cope with. For instance, one of the respondents said: "*It affects patient care by making the poor and less privileged unable to enjoy health services since they may be asked to pay monies before certain services such as surgery could be offered.*"

Others said:

Sometimes it warrants that patients give tips to health care providers before he or she is given attention; this affects patient care adversely as this may prevent them from presenting themselves at hospital if they do not have extra money for the provider or in the alternative seek recourse from traditional care providers.

Patients do not get maximum care when resources are mismanaged; some even lose their lives or acquire permanent deformity when diagnoses are made in order to enrich those concerned.

This shows that, due to corruption some basic facilities necessary for patient care are lacking and so patients do not get adequate care. Patients who have nothing to offer are often in danger of being given poor attention. This system of extortion works alongside or as an alternative to the direct demand for payment in the public hospitals. It preys on people who are either ignorant of the fact that the service should be free, or know that the health workers will let their relative go without treatment, and sometimes die, if they do not pay up. Those unwilling or unable to pay often fail to access services, leaving a chasm between the formal entitlement to free care, and a very different reality.

Effects of Corruption on Women and girls

Everyone suffers when there is corruption in the delivery of basic services and the effects can continue across generations. Although women and girls tend to bear the burden more, high-income urbanized patients were more likely to make informal payments and thus receive care they needed in contrast to low-income patients. In this study, respondents were of the opinion that because of women's biological make up they tend to have greater need for health services than men. As a result, bribes requested for the delivery of basic services in the sector affect women in a significant way since their income level tends to be lower and have fewer alternatives to acquire these services. Coupled with the fact that women are perceived to be less able to pay bribes. However, this does not always mean that women access the required services without paying bribes. But, in many cases they simply cannot access the services since they are unable to find the adequate entry-point to the network where bribes can be paid. A respondent said:

I was brought in here two years ago, at the last stage of labour, but the medical personnel on duty refused to attend to me on the ground that first, I must pay a certain amount of money which I couldn't afford then. Second, my husband must be present before they can do anything. Unfortunately I couldn't meet any of the conditions because my husband has absconded due to my prolonged labour. I eventually lost the baby, but I thank God I am alive today to carry another pregnancy.

Yet another stated:

I had to deliver my last child at home because I couldn't afford the money demanded at the primary health care centre. Though there were little complications, but I thank God I survived it.

The majority of respondents attested to the fact that most women have lost their lives to childbirth due to “delays in getting skilled help”. Instances also abound where women have lost their lives due to the inability to travel miles to reach medical facilities for delivery or even to purchase drugs to sustain live. There was also a particular case where the lack of electricity and oxygen caused the death of a woman whose labour was prolonged. Incidentally, for most the cases, no one is blamed for these death but destiny. This and many others confirm the fact that poor women may not get critical health care services simply because they are unable to pay the real fees talk less of the informal fees. This has resulted in many of them using the Traditional Birth Attendants (TBAs) for both ante-natal and delivery services, which cost less though records higher rates of maternal mortality, instead of using hospital services. In the words of one of the respondents:

I believe most women prefer to go for the TBAs or mission houses because of the cost. Although the prices varies, but it is especially high if the woman delivers through Caesarian operation. There was a case of a woman whose husband ran away, it was his relations who helped to pay to secure the release of the woman. In other cases, the family may be employed to work off the hospital debt by providing menial services like cleaning and washing the hospital surrounding for a specified period.

This attest to the fact that oftentimes poor women tend to have reduced control over household resources, making such payments on their own becomes difficult or impossible, hence they are subjected to such sorrowful experiences. Instead, compensation may take the form of sexual favours from the ‘returned run-away husband’ after all the debts have been settled.

Women’s greater interaction with public services means that they are disproportionately exposed to corruption at the point of service delivery with its resultant effects on cost, volume and quality of the care provided. With less control over household income, women are doubly disadvantaged as they are then less able to seek alternative sources of services that may be provided by private health care providers and therefore remain dependent on what may often be a corrupt public system, whose original objective was to make health services accessible and available to everyone wherever they live or work. Like the pathetic story of one of the respondents:

When I wanted to have my first child, I went into labour and was taken to the hospital, where I was a registered patient. On this fateful day, there was not a single doctor on duty. The maternity

ward was very hot and only illuminated by a lit candle. When I complained, the nurses told me that I was not the only one on admission. They told me that if I needed light, I should provide money for fuel to power the generator. Because I was feeling very uncomfortable, I had to give them the money. Several minutes later, a nurse brought me a lantern, although the generator was never put on. I even had to pay for my own file as part of the 'stationery needed'. I was then left alone in spite of my cries for assistance as the pains were becoming unbearable. When the nurses eventually came to check on me, they discovered that my baby's heart beat was already failing, at which point the senior nurse advised my relative to take me to another hospital as there was no doctor to carry out the caesarean section I needed.

From the above, it can be inferred that much of this neglect is directly linked to the problem of corruption in one way or another with serious impact on women in particular.

Policy Implications

Due to gender roles, expectations and cultural attitudes in the society, women tend to have less involvement and participation in civil service and administrative positions related to the delivery of key services such as water, health, sanitation and schooling. When public service positions are overwhelmingly held by males, the result may be that men deliberately misrepresent and complicate government processes for women (TI, 2010). In the process, women become disempowered or feel obliged to provide compensation for assistance which they have the legal right to receive as citizens rather than through corruption, concession or magnanimity.

Also, because rights, responsibilities and opportunities are skewed towards men, women become marginalized from decisions. They have fewer occasions and resources to inform policy makers of their needs, influence decision-making processes and demand accountability from public officials. Women may not have the knowledge or time to hold their elected officials and government agencies accountable, having to make hard trade-offs between getting politically involved and providing for their families. Decisions regarding government budgets, spending and policies on basic services tend to be managed by men given the gender imbalances in government leadership positions and national parliaments.

Suggested way forward

The state of research on gender and corruption clearly indicates that the gendered dimensions of corruption are complex issues. Understanding and assessing the impact of corruption on women needs to be examined with close attention to the socio-economic and cultural norms that shape how women live

their lives. Policy interventions need to take into account the particular circumstances of women in Nigeria and the barriers to real decision-making power, both in its gender and broader institutional-political contexts.

Mainstreaming gender in anti-corruption work would ensure that women are adequately represented at all stages of service delivery, with the introduction of effective mechanisms to promote women's participation and strengthen their voice in the planning, management and oversight of public services. Some steps towards a deeper understanding of gender dynamics and impacts of corruption are provided below:

1. Collecting reliable gender disaggregated data: Due to weak systematic collection of disaggregated data, there is a significant gap in knowledge of the engendered effects of corruption in service delivery.
2. Ensuring women's participation in decision-making processes: Participation, by both men and women, should be facilitated by a process that ensures those in positions of power do not monopolize influence or control, but that women are integrated.
3. Promoting gender responsive budgeting: Gender responsive budgeting is a technique used to map budgets according to gender-specific issues and is designed to ensure that government spending on public services is responding to women's needs.

Summary and Conclusions

The foregoing indicates that corruption in the health sector is not exclusive to a particular health system but prevalent in public and private settings. The extent of corruption is however partly a reflection of the society in which it operates. Health system corruption is less likely in societies where there is broad adherence to the rule of law, transparency and trust, and where the public sector is characterized by effective civil service codes and strong accountability mechanisms.

Corruption is wide spread in Nigeria largely due to weak governance structures, poor accountability systems and permissiveness to corrupt practices. Despite the poor health indices, genuine methodical approaches for tackling corruption in the health system and addressing the quality of health care do not exist at any level. There is therefore need to strengthen the sector by improving health facilities especially in rural communities. Once corruption is eradicated, health services in Nigeria will improve. The problem existing now is not that of lack of ideas, but that of capacity and sincerity to implement them.

Lastly, there is currently a dire need for more gender disaggregated corruption data, both to better understand how corruption affects women and the role they can play in combating it. Only with the help of such comprehensive and in-depth research can we hope to eliminate the barriers that corruption poses to achieving gender equity and, ultimately, development.

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