When sex is demanded as payment for health-care services

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Sexual corruption or sextortion has gained recent attention in the anti-corruption space. It occurs when a sexual favour is used as the currency for a bribe. Sexual corruption is a manifestation of gender-based violence, is inherently a human rights violation, and is a grave public health concern because of its effects on the physical, emotional, and mental wellbeing of the person who has experienced sexual corruption. It impacts health systems' abilities to achieve universal health coverage and deliver services in the most effective, high-quality manner. Despite the health consequences, limited evidence exists on sexual corruption occurring in the health sector. This Viewpoint briefly reviews the literature on sexual corruption occurring within health systems focusing mainly on low-income to middle-income countries, with a concentration on its prevalence, the driving forces associated with it, and recommendations to address it.

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Sexual corruption, also called sexual extortion and bribery, or sextortion is a form of corruption that disproportionately affects women and a form of sexual violence that occurs when those entrusted with power use it to transact a sexual favour as currency with those who depend on them to access vital services.[1] This exploitation of power and trust typically takes the form of an unwanted demand for sexual activity, subtly or overtly, using the authoritative role as a means to enforce compliance with said demand for personal gain.[1,2] Sexual corruption sets itself apart from other types of sexual violence and exploitation by incorporating a transactional element. This element can portray the person who has experienced sexual corruption as actively involved in the sexual act, thereby legitimising the obtained sexual favours and serving as a risk-reduction strategy for the perpetrator. As such, it is paramount to maintain focus on the abuse of entrusted power as the violation.[3]

Sexual corruption has steadily gained attention in the anti-corruption and health systems space, with its definition and conceptual understanding still being developed (eg, sextortion *vs* sexual corruption).[3] There is an increasing consensus and acceptance that sexual corruption is a public health concern and a human rights violation affecting the physical, emotional, and mental wellbeing of those affected.[4,5] It undermines the realisation of universal health coverage as it acts as a deterrent for individuals to access quality health care when and where they need it.[6] Furthermore, the issue is increasingly seen as similar to other corrupt acts at the service delivery level such as financial bribes.[7]

Despite the health consequences, limited evidence exists on sexual corruption occurring in the health sector. Sexual corruption tends to be studied sporadically in public surveys and is generally not sector specific. Yet the potential scale of sexual corruption prevalence and the gendered differences in women accessing health services more than men indicate the unique risk it has within the sector. This Viewpoint briefly reviews the available literature on sexual corruption in health systems. While we note that sexual corruption theoretically could be as or more prevalent in high-income countries, we focus mainly on low-income to middle-income countries, with a concentration on the prevalence of sexual corruption, drivers associated with it, and preventive tactics to stem this form of corruption. The act is gendered and disproportionately affects women although it can also affect men, boys, girls, and other gender and sexual identities. We recognise that sexual corruption can happen to any gender including the LGBTQ+, transgender, and the gender non-conforming community; however, most of the available literature focuses on sexual corruption's effect on women, and this is reflected in our analysis.

We know very little about the scale of sexual corruption due to it largely being hidden from mainstream discourse in health systems and corruption research and it involving sensitivities such as stigma, which potentially lead to underreporting. As the health sector is consistently plagued by different forms of corruption,[8] sexual corruption is likely to also occur in health system settings. It is also a relatively new area to violence against women research and is mostly addressed as sexual exploitation, potentially causing misclassifications, although there are attempts to merge the fields.[9] As such, estimating the prevalence of sexual corruption, what type of sexual violence is occurring, or where it is occurring within the health system is difficult. A 2021 working paper that considered different sexually related forms of corruption confirms that research on sexual corruption in the health sector is limited.[10] However, some nascent data within and outside of the health sector illustrate that sexual corruption is occurring at the service delivery level and highlights an urgent need to study what, how, and why it manifests in health systems.

Estimates from Transparency International's Global Corruption Barometer 2019 data show that in Latin America and the Middle East and north Africa, one in five people have experienced or know someone who has experienced sexual corruption while accessing health or education services.[11] A 2020 survey conducted by the UN Office on Drugs and Crime in Nigeria found that nearly 69% of respondents believed that public officials ask for sexual favours in exchange for preferential treatment very or fairly frequently (the type of preferential treatment in terms of a service or sector were not specified in the study).[12] In a survey in the water, sanitation, and hygiene (WASH) sector conducted in two sub-districts of Nairobi

County, Kenya, 67% of participants had heard of or knew of sexual corruption, with the most common forms being the offering or demanding of sex as payment for water. Overall, 22% of these respondents knew a person affected by sexual corruption.[13]

A 2019 study conducted by Transparency International Zimbabwe found that 57% of the women surveyed reported having to offer sexual favours to access medical care, have their children enrolled in school, or to be given a job.[14] Similarly, a 2021 study conducted in Rwanda speculated that because women were employed less than men, there were more occurrences of sexual corruption as men could demand sex more frequently and freely in exchange for goods and services.[5] In Malawi, researchers reported that women in need of transport paid for bicycle public transit with sex, with the perpetrators knowing and not caring about the potential for HIV transmission.[15] A literature review focusing on corrupt practices in the recruitment and promotion of health workers found evidence of sexual harassment of workers that was implicitly linked to employment and promotion practices, in particular for female nurses.[16] Together these studies suggest, sexual corruption is occurring throughout the world, in various sectors and settings, but little is known about its occurrence within health systems specifically.

When trying to understand, more broadly, how sexual corruption manifests at the service delivery level, researchers have begun to study how it is conceptualised. Case studies conducted in Colombia and Tanzania revealed incidents of sexual corruption spanning various sectors, including police, immigration services, and education. In Tanzania, researchers found an awareness and recognition of sexual corruption, but in Colombia, this practice was normalised in many contexts, and not widely acknowledged as unacceptable.[9] Preliminary research in Malawi found that while acts of sexual corruption are predominantly initiated by those in positions of power, there are instances in which the user of the service would initiate it because of an assumed expectation to pay this way or a lack of means to pay in another way. Normalisation of the practice in Malawi has left some users, mainly women, with no choice but to initiate this practice as it is used and accepted in the system.[15,17]

Not only do we lack data on the prevalence, forms, and severity of sexual corruption, there is also little information on the drivers of sexual corruption in the health sector. We speculate that power and gender differentials cause and widen inequalities and inequities also apply here. Specifically, sociocultural norms that shape the roles of men and women can result in men often occupying positions of power outside of the household, which in turn, can restrict women to domestic and childbearing roles and limit their financial independence. Consequently, these power differentials can increase the likelihood of women and marginalised groups relying on public services, and resorting to alternative means to pay for them.[4,5,17–20] Since sexual corruption typically involves the exchange of goods or services, this, coupled with the elevated prevalence of women and marginalised groups accessing public services, exacerbates the impact of corruption on these individuals.[18]

Gender power dynamics are also compounded by other social stratifiers such as poverty, rural and urban living, education levels, disability, and sexual orientation, requiring an intersectional lens to also be applied when designing interventions.[2,17,18] For example, another study conducted in the WASH sector in Bangladesh studied factors that make women more vulnerable to sexual corruption and found women who live in poverty, water insecure households, or are illiterate face higher risks of sexual corruption when accessing WASH services than those without other intersecting factors.[19]

Further, a deeper understanding is needed of the social norms that deter people who have experienced sexual corruption from reporting it, which contribute to the stigma surrounding it. These norms are similar to those that make reporting sexual assault or violence difficult, such as shame and fear of disclosure or being ostracised by the family and community.[5,21] The 2020 UN Office on Drugs and Crime survey in Nigeria found men and women were reluctant to speak about sexual corruption. More than 30% of respondents said they did not feel comfortable telling anyone if they were asked to exchange a sexual favour for preferential treatment by a public official.[12]

Reporting mechanisms might not exist and when they do, people who have experienced sexual corruption might hesitate to report, fearing inadequate handling of their cases, minimal options for legal follow-up and support, and possible reprisals. Commonly recommended anti-corruption measures such as building capacity of human resource management could apply here as they would encourage the development of personnel management systems that include safe reporting channels (eg, whistleblowing), codes of conduct development, and compensation management to deter corruption, and by extension, sexual corruption at the service delivery level.[22] This reluctance to speak about and report sexual corruption[1,17] could in part be due to fear that even as a person who has experienced sexual corruption they could be subject to prosecution if their reporting of an event could lead to a perception that they were a consenting participant in corruption, further building the stigma and fear around power differentials that they might not be believed.[4,7,19,23] The aforementioned WASH study from Bangladesh revealed that about 40% of respondents who experienced sexual corruption stated it adversely affects family honour or brings shame to the family. Furthermore, of the general survey respondents, 40% placed responsibility for the sexual corruption event on the person who has experienced

sexual corruption rather than the perpetrator.[19] Both statistics underscore the stigma associated with sexual corruption and cast blame on who has experienced it, which is likely to contribute to lower rates of disclosure and reporting.

Within the legal communities there also remains little consensus on how to define and subsequently prosecute sexual corruption.[23] This has led to a dearth of reporting mechanisms, further contributing to an avoidance of reporting.[4,19] The reporting systems in place focus on financial bribes as the currency of exchange, disregarding sexual favours from being a recognised currency.[4] The International Bar Association analysed eight jurisdictions across the globe with regard to their existing legal frameworks around sexual corruption and found that anti-corruption laws do not focus on sexual favours and that sexual offence laws do not include the possibility of corruption, which means it might not be able to be prosecuted at all, depending on the sexual offence committed.[23]

International conventions or frameworks also do not always explicitly designate or reprimand sexual extortion,[23] and this is likely due to anti-corruption efforts taking a gender-blind approach, in which gender is not specifically considered in anti-corruption strategies, and is an obstacle to understanding this complex issue fully.[1,2] Furthermore, engaging in the corrupt act can incriminate both parties (including the person who has experienced sexual corruption). For instance, Article 4 of the African Union Convention on Preventing and Combating Corruption allows the prosecution of the person affected by sexual corruption as well as the corrupt actor.[24] Without legal frameworks, protections, recognition, and prosecution of sexual corruption, it will continue to remain hidden. An opportunity exists to capitalise on new momentum from the 10th Conference of the States Parties to the UN Convention against Corruption resolution passed in December, 2023, on the societal impact of corruption. This resolution specifically calls out demanding sex or acts of a sexual nature as a particular form of corruption within the UN Convention Against Corruption. It also encourages states to raise awareness and close legislative gaps to prevent and prosecute sexual corruption, a monumental step in raising awareness of the issue.[25]

In writing this Viewpoint, our aim is to elevate the significance of engaging in discourse and establishing redress mechanisms on sexual corruption. Without addressing it, we cannot hope to meet universal health coverage. We seek to prioritise its inclusion in development, justice, health, human rights, and legal agendas, offering the following recommendations to advance this aim.

Establishing a unified understanding of sexual corruption that is widely accepted across sectors, public and private spheres, and among different stakeholders including governments, health-care workers, human rights bodies, the judiciary and legal professions, citizens, and the media is imperative.

In-depth information must be gained about where, how, what types, and why sexual corruption occurs and to whom; thus, further research across various settings is needed on the prevalence, nuances, and complexity of such a human rights violation. A first step is to develop a strategy to capture and analyse sex disaggregated data to illuminate the relationship between gender and corruption. This should be complemented by context-specific qualitative data on social and gender norms, roles, and dynamics, enabling a more nuanced understanding of how these contribute to and are affected by sexual corruption. Sexual corruption should also be captured more systematically in routine surveys as a distinct form of sexual violence and exploitation (ie, demographic and health surveys, the Global Corruption Barometer, and service use surveys) to understand the scale of the problem and to inform context-specific mitigating actions.

Further research is needed to examine and address factors that might make individuals vulnerable to sexual corruption in health service delivery, both in the public and private sector. Mitigation measures including analytics, regulation, and policy tools that recognise and prevent sexual corruption are key elements to improve access to care and reduce this form of gendered corruption. Frameworks and research approaches applied to sexual corruption in education and other sectors could be useful here.

Awareness raising and engaging the public and media on sexual corruption and working with powerful champions, including those active on social media and able to reach young people, can widen recognition of its unacceptability and challenge underlying harmful gender norms, which underpin sexual corruption.

Recognising and addressing sexual corruption requires collaborative action between a wide range of stakeholders as it sits at the nexus of the anti-corruption, women's empowerment, and gender-based violence spheres. Not only does it impede progress towards achieving universal health coverage, Sustainable Development Goal 3, it is a major barrier to obtaining Sustainable Development Goal 5 (achieving gender equality), and in particular target 5.2.1, which seeks to eliminate violence against women and girls. It hampers the goals of Sustainable Development Goal 16, especially target 16.5, which seeks to reduce corruption in all its forms.[26] Collaborative cross-sectoral dialogues and developing strategies involving professionals from the legal, health, justice, and research sectors, advocates, and those affected on the ground can co-design strategies, policies, and actions to counter sexual corruption in the health system.

Sexual corruption cannot be understood outside the institutional and societal structures that reinforce inequalities and powerlessness among certain groups, which make them vulnerable to such acts. We

recommend organisations, especially those within the health sector, develop policies and practices to become more gender responsive and inclusive, and we advocate for the development of sexual corruption-specific policy tools and implementation frameworks, such as the integration of an anti-sextortion policy within organisations.

Interventions are required to improve accessibility to recourse mechanisms for people who have experienced sexual corruption. This includes legal reform that enables courts to convict those that perpetrate sexual forms of corruption. Furthermore, reporting mechanisms are desperately needed to enable those affected by this crime to receive justice and have confidence that the health system can counter this sexual corruption and other forms of corruption that undermine the delivery of quality services.

Increasing the accountability of health-care personnel by training health professionals and managerial cadre and leaders in professional integrity and incentivising them to better respond to, and respect the needs of the end users, families, and communities is important. This should be coupled with improving health sector governance—especially when a recurrent issue is found—through periodic internal assessments of facility or departmental policies and practices related to patient safety, and specific to sexual harassment, exploitation, and sexual corruption, to uncover illicit behaviour. If an occurrence is identified, there should be mandatory sanctions for the perpetrator, and a follow-up review to identify if there was an enabling environment for such actions. Moreover, ensuring that the training of health workers, managers, and leaders has a social justice lens, including recognising the existing vulnerabilities in the local communities, awareness that health care is a public good that should be accessible for all, and that it is a part of critical public provisioning that cannot be denied in any circumstances, can change mindsets and social norms that affect how health systems operate and ensure that sexual corruption is seen as unacceptable.

Effectively addressing sexual corruption within the health sector requires a combination of gender-responsive strategies that deal with the consequences of gender inequality and gender-transformative approaches that target the underlying causes driving such inequality. Initiatives involving reforms and engagement methods should challenge detrimental gender norms and power dynamics. Moreover, changes to laws and policies promoting anti-corruption and ensuring equitable distribution of resources and services, along with the removal of structural barriers hindering access to health care (including addressing information asymmetries), can play a crucial role in countering sexual corruption while promoting gender equity and equality.

Advancing these recommendations is paramount, as they provide the foundation for global collective action against sexual corruption, and in turn, safeguard universal health coverage and uphold human rights. Therefore, we argue that solutions should incorporate a human rights and gender-transformative approach, address wider social determinants, raise awareness to sway public opinion, counter damaging social and gender norms, and improve health systems transparency and accountability.

Contributors
MLC, MCo, and DB conceptualised the Viewpoint. MLC conducted the formal analysis and wrote the original Viewpoint. SB, TW, MCh, MCo, DB, and MLC all reviewed and edited the Viewpoint.

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We declare no competing interests.

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