

# Workshop Paper



## Gender and Corruption in Development Cooperation

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12th EADI General Conference  
**Global Governance for  
Sustainable Development**

The Need for Policy Coherence  
and New Partnerships



**Gender and Corruption in Public Health Services in  
Nicaragua: Empirical and Theoretical Conclusions for  
Governance**

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## **ABSTRACT**

### **Gender and Corruption in Public Health Services in Nicaragua: Empirical and Theoretical Conclusions for Governance**

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The paper takes as its starting point the question about the supposedly beneficial role of women in governmental, political and administrative posts in relation to good governance (World Bank, Dollar). Are women less involved in corruption because they are women or because they have fewer opportunities to corruption because of their gender role (Goetz)?

The paper is based on fieldwork carried out in November 2006. To start with, it presents the different potential gateways (windows) to corruption found in interviews with authorities, donor and civil society observers and end users. All the different forms of corruption listed by the Utstein Group (U4) and Transparency International were found, of which theft of supplies and working time (absenteeism) are the most widely spread. In the minds of end users, (il)legal payments and bribes get confused. This is in part due to the environment of scarcity created by political decision-making and the limitations to public spending imposed in the name of budgetary discipline; a scarcity at the macro level creating incentives for corruption at the level of individual health service facilities.

While having an important poverty impact both on state budget and individual poor households, corruption constitutes a regressive redistribution of resources from the poor to the non-poor. It can be claimed that corruption supports, stabilises and deepens social and economic inequality. The fieldwork also highlighted the importance of social capital in corrupt practices. Especially Coleman's notion of "open" social capital proved to be useful. In corrupt networks of open social capital, strong solidarity and internal cohesion develop: there is a "pact of silence" between corrupt colleagues who form a "circle of trust" (Hellstén). This aspect has been mostly neglected in anti-corruption strategies. A bribe paid becomes, as it were, the "price" to pay for not belonging to one of the open networks of social capital.

In analysing corruption from a gender point of view, it was found that women are more affected by corruption in healthcare because of their biological sex (reproductive cycle); they are the large majority of service users. Corruption is also gendered on the demand side. E.g. referral to private practice of doctors at the public payroll is an almost exclusively male domain; their female colleagues combine professional activity with their role of housewives. Thus, the female gender role can "protect" women from engaging in corrupt exchanges. The fieldwork findings tend to suggest that corruption should also be seen as a field where gender roles are performed and gender role expectations fulfilled. But as the model of accountability in Nicaragua is informal and nepotist, an increase in the number of women in public office alone is not likely to be conducive to a reduction of corruption.

The paper ends with a discussion about practical measures to fight corruption in order to ensure gender equality. These range from measures taken at the level of individual service facilities to the creation of "closed" national-level social capital. Finally, important policy incoherence in the global aid architecture will be pointed out.

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between poverty, corruption and gender in health, education and local government. The opinions expressed in the paper do not necessarily represent the official view of Finland.

## INTRODUCTION

Since 2001, the thesis that increasing the number of women in political office provides an efficient means for fighting corruption has been widely circulated in international media. It was supported by a cross-country regression analysis published in a World Bank Development Research Group report, which indicated that at the country level, higher rates of female participation in government are associated with lower levels of corruption. Since a review of selected social science literature suggested that women may have higher standards of ethical behaviour and be more concerned with the common good, the report concluded that bringing more women into government might have significant benefits for society in general, and for the reduction of corruption in particular (Dollar et al. 1999).

In response to the World Bank thesis, various scholars have, however, observed that accountability mechanisms within the political system are likely to be more important in fighting corruption than the number of women decision-makers. As expanded opportunities for women tend to go along with a social and political structure that is generally more open and accountable towards all social groups, including women, the observed statistical correlation between gender and corruption at cross-national level could be misleading (Goetz 2007; Sung 2006). Are women, then, less involved in corruption because they are women or because they have fewer opportunities to use corrupt practices to their own advantage because of their gender role?

The fieldwork for this study was carried out in Managua and two provinces in the central part of Nicaragua during the three first weeks of November 2006, around and after the November 2006 general elections. The elections prevented the study team from meeting some potentially important informants who were occupied with the elections and their aftermath, and obviously the change of government in January 2007 imposes limitations on some of the conclusions made in this paper. The paper is an abbreviated version on the Nicaragua case study published in Seppänen and Virtanen (2008). The fieldwork in Nicaragua was assisted by Angel Saldomando

The field work methods included semi-structured interviews with authorities and donors' representatives, project staff, civil society activists, the research community and journalists. In addition to interviews, the study did a review of the available literature, including academic research and other publications, press coverage and consultancy reports of different donors. 37 experts and observers were interviewed (14 male, 23 female). In addition to their own interviews, the study team had access to transliterations of 44 interviews with the Nicaraguan political elite which were carried out in early 2003 by Anna Perttula for her M.A. thesis on political culture and political corruption in Nicaragua (Perttula 2005).

The different potential or hypothetical gateways to corruption in the health system were studied in detail. The suspected gateways implied or explicitly stated in expert and observer interviews listed above were submitted to a 'reality check'. This was done through informal interviews at the premises of a health oriented NGO that offers low-cost reproductive and sexual health services to women in a poor neighbourhood of old central Managua. The women (12 patients in waiting rooms) were asked about their experiences of public sector

health services. The comments made by the women were very much uniform and can be seen to corroborate what was found in the other interviews.

## **CORRUPTION AND SOCIAL CAPITAL**

There are various theoretical approaches towards corruption; however, this paper focuses on a neglected dimension of corruption, namely the formation of social capital. Both democratic governance and corruption are based on networks of social capital in the form of trust and reciprocity. While the concept has been criticised, especially James Coleman's (1988) differentiation between open and closed networks of social capital is useful for the study of corrupt practices in their social context. With open networks of social capital, Coleman refers to structures where person A deals bilaterally and separately with persons B and C, but as B and C do not have relations with one another (but instead with D and E), they cannot combine forces to sanction person A in order to constrain his/her actions. When the network is closed, persons B and C communicate and can join forces to provide a collective sanction, or can reward the other for sanctioning person A.

The social theory of liberal democracy is based on the idea of a relatively homogeneous community of rational individuals (the nation-state and its citizens) constituting a closed social network characterised by transparency, accountability and effectiveness. The related norms of public service, and the legal definitions of corruption, which are currently promoted as global, are based on the European historical experience. They are essentially egalitarian and individualistic, and rely on a distinction between public and private affairs (Olivier de Sardan 1999). In Europe the institutional basis therefore corresponds, or at least attempts to harmonise, with the predominant socio-cultural basis characterised by Coleman's closed network model. In contrast to the above model, in many developing countries there is a glaring discrepancy between the institutional basis, and the predominant socio-cultural basis (Falk Moore 1973). Often the formal state institutions are only weakly embedded locally, and the failure of trust in national level institutions has left space for communitarian solidarity networks (Hellstén and Larbi 2006). These communitarian solidarity networks are typically closed and operate at the expense of the national political community, which has consequently failed to achieve closed network status. These solidarity networks are manifested in such social institutions as gift exchange, payment of tribute, and an imperative of reciprocity. One cannot refuse a service to a kinsman or neighbour or someone who is sent by them (Perttula 2005).

This phenomenon has an important equity implication for the delivery of public services in a socio-political context where the national level political community does not constitute a closed network, which is the case in Nicaragua. Instead, the national level consists of separate networks of solidarity aiming at the common good of particular collectives rather than towards the national public good (Hellstén and Larbi 2006). The poor are often excluded from the particular networks of solidarity because they have little to offer reciprocally to form a network of social capital (Ruud 2000). Recent findings from Cambodia (Nissen 2005) and Ghana (Alolo 2007) seem to support this view. A bribe paid becomes, as it were, the price to pay for not belonging to one of the networks of social capital.

## **CORRUPTION IN PUBLIC HEALTHCARE**

The following gateways to corruption in public healthcare in Nicaragua should be taken as potential windows to corruption, not that all these gateways always materialise, or that they are found in all places; yet all of them were reported in the interviews during fieldwork. The categories of corruption are taken from the Utstein Group (U4).

Bribery is the first and most visible form of corruption; and in many contexts corruption is wrongly equated with paying bribes. Bribes always imply some form of material benefits for the person in the position of power, but these need not be monetary; instead, it can be a question of a sexual favour, reciprocal exchange of favours, or rewards in kind.

In the Nicaraguan public health services, the very common practice of asking for payment for supposedly free medicine can be understood as a bribe. A nurse can, for instance, tell a hospital patient that a medicine is out of stock, but 'she can buy it' if she is given the money. No cases where a pregnant woman would have been asked for a bribe in order to get a bed or to be attended in a maternity hospital were reported; but the *post partum* treatment given after (and possibly during) delivery may be different if the relatives bring the nurse or doctor a reward, monetary or in kind. Hospital guards ask for a 'tip' (a bribe) for letting relatives in out of official visiting hours. The case of a patient's relatives bringing a gift for the nurse is active bribery and often happens before or without the nurse having asked for such a reward; therefore technically speaking it is active bribery, albeit well-intentioned.

For a medical doctor, the prerequisite to be able to demand a bribe is a certain monopoly position of power. A bribe for a service or a medicine is possible only because the patient has no other option, usually for economic reasons, and because of the asymmetry of information between a doctor and a patient prevailing in health services. This is the reason why a bribe is sometimes difficult to distinguish from extortion and illegal payment. Especially in health, where the question, in the ultimate instance, is about life and death, asking for a bribe can often be interpreted as extortion: pay or perish. Here the threat is posed *a priori* not by the attitude of the medical doctor, but by the urgency of the situation. According to the interviews, it seems to be a common practice of Nicaraguan medical doctors to demand a bribe especially in urgent situations, such as a need for an immediate operation.

No cases of embezzlement or fraud in the health sector were reported during the fieldwork, although in the case of supplies it is difficult to distinguish fraud from theft. In the public health services, indeed, theft seems to be a widespread, common and methodical practice, with significant economic and health consequences for patients, especially women who are the majority of patients in the public healthcare system. Medical doctors 'borrow' equipment (ultrasound, x-ray, for instance) from public hospitals for their private clinics, and supply their private medical practice with medicine and other supplies from public hospital dispensaries. Sometimes nurses are used by doctors to carry out the theft; in these cases there may be extortion implied under the threat of dismissal. Nurses may also steal medicines on their own initiative and sell them to pharmacies (normally) or individual patients (more commonly under the form of a bribe). Car drivers steal and sell fuel from official vehicles for personal profit, especially at the central level at MINSA.

A conservative enlightened guess about the losses due to theft from the yearly health budget allocation designated for procurement of supplies and medicine is 20% (at least 5% but probably not more than 50%). The total annual amount for procurement is roughly USD 20 million (interview, MINSA). If a hypothetical 20% is lost due to theft of medicine, equipment and other supplies, this represents fewer supplies to deliver to patients to a value of USD 4 million. Furthermore, the important point is that the amount of resources lost due to

corruption is transferred from the poor users of public healthcare services to the pockets of the medical doctors, nurses and other staff in the service of the Ministry of Health, even without taking into account that medical staff may sell the stolen supplies at a price higher than the original tendered purchase price paid by MINSA. Zambrana (2006) concludes that the average coverage of supplies in healthcare centres in Nicaragua is 50%.

Uncoordinated donations may contribute to theft. A first-hand personal experience was reported by a donor representative, a medical doctor by training, where two ultrasound machines were donated simultaneously to a departmental hospital by two different donors, after which a medical doctor took one of them to his private practice (interview, Managua).

The extent and frequency of theft suggests that the appropriation of supplies and equipment is well-organised and enjoys, if not directly at least silently, the approval and complicity of higher managerial levels who turn a blind eye and thus could be considered negligent in their attempts to control the situation. According to a survey (Government of Nicaragua 2006), the situation is worst in Managua, where the specialised hospitals dealing with the most difficult diseases, and the main private clinics are situated, and where there are ample opportunities (and a market) for medical doctors working in public hospitals to carry out private practice in their spare time, in contrast to the countryside where no private clinics exist due to lack of purchasing power.

Another common practice of medical doctors in Nicaragua could be called indirect theft: public hospitals are used for attending and operating on private patients without paying compensation (rent) to the hospital administration. The reported cases are difficult to distinguish from illegal payments and extortion, because the doctor asks for a fee to carry out the operation right there at the public hospital, often only in emergency cases. Here also, the complicity and tolerance of colleagues and the hospital administration are needed to be able to use public establishments for private care.

Theft of paid working time is called absenteeism. In the public health services, absenteeism of medical doctors takes the form of early departure for private practice, or the dedication of working time to the semi-private medical provision centres operating within the premises of public hospitals instead of attending patients in the public section. In these cases, absenteeism may have fatal consequences for patients; a death of a woman in labour was reported during the interviews due to medical absenteeism (and a strict sanction – loss of licence for life – for the absent doctor).

In regard to the frequency of illegal payments, according to the above mentioned survey, based on a geographically representative sample of 6,043 persons and commissioned by the Government of Nicaragua and carried out in April 2006 (Government of Nicaragua 2006), 'undue payments' were paid by 11% of those who used the public health services in Nicaragua, down from 28% in 1998 and 17% in 2003 (regional variation from 5 to 15%; the highest rate 15% was found in the capital city). One fourth (24%) was given a receipt for the payment, which means that 76% of patients who made undue payments did not get a receipt.

According to the fieldwork, not one anecdote suggested that favouritism (cronyism, nepotism) is practised in appointments at the public health in Nicaragua, which of course does not mean that it does not exist. What this lack of reported cases or anecdotal evidence of favouritism among healthcare staff may mean, instead, is that favouritism may be mitigated by the technical and professional requirements that must be met for appointments in healthcare. Those who are preferred through favouritism must at least have the professional qualifications

for the post. However, favouritism was recorded in the access to care. For instance, the health oriented NGO visited by the research team, can call upon sympathetic (female) medical doctors working in the public health sector to give preferential treatment to patients sent by them. Here the role of networks of social capital is important; and this favouritism obviously discriminates against those who do not have access to these networks of social capital.

State capture, that is, the bending of state laws, policies and regulations by private interests or individuals to their benefit, is not always external, and does not always take the form of bribes or other transactions falling under the definitions of corrupt practices. State capture is so destructive and intractable precisely because it can take place legally. Two suspected forms of state capture were found. In Nicaragua there is no earmarked tax on alcohol, contrary to the practice for tobacco products, while traffic accidents and machete fights, closely linked with alcohol, are the main contact points of adult males with the public healthcare system. This is interpreted by interviewees as a result of the political influence of the quasi-monopoly of production of beer and rum by a very influential person in the country as a favour in exchange for elections campaign funding. Another probable form of state capture, denounced by health worker's trade unions and pointed out by the Pan-American Health Organisation (PAHO 2006), concerns the reference prices of medicines and pharmaceuticals registered by the Ministry of Industry and Commerce. The Ministry registers reference prices, below which drugs may not be sold, for imported drugs by their unit price without taking into account economies of scale (the real price paid to the manufacturers by the companies). The pharmaceutical companies are then allowed to charge a maximum 33% margin on top of the reference price, which makes imported medicines very expensive and negatively affects household economies and puts people's health in jeopardy.

State capture and other forms of political corruption are not necessarily connected with bureaucratic corruption. One can imagine a situation in which there is political corruption among elites in a country without significant bureaucratic corruption (as in some European countries), and *vice versa*. But in the case of Nicaraguan healthcare, political and bureaucratic corruption are closely connected in that the more there is leakage from the health budget due to political corruption (state capture), or an environment of scarcity due to low budget allocation, the more there are incentives for bureaucratic ('petty') corruption at the lower end of the supply chain of health services: the shortage of supplies and personnel creates incentives and windows for corruption. Furthermore, corrupt practices as such operate through networks of social capital, and even a petty bribe, by definition a deal between two persons, can form part of a larger corrupt system of 'commissions' that reach higher administrative levels. For this reason, political and bureaucratic corruption should not be viewed as independent from each other: corruption at the lower ranks is the result and consequence of corruption at the higher levels (Karstedt 2001). The less medicine that can be purchased with the state budget for health, the greater is the temptation to demand bribes in exchange for access to medicines. It was found that a greater proportion of funds disappear at the higher end of supply chains, and at the local level of health centre, there is very little left to extract.

The health sector is especially prone to corruption, primarily because of the imbalance of information that prevails between doctor and patient, and between pharmaceutical and medical companies and the persons in charge of procurement of medical supplies. Other reasons for the corruption-proneness of the health sector are the uncertainty in health markets and the complexity of healthcare systems in which the large number of parties involved and the opaque relationship between suppliers, care providers and policy-makers enable all manner of chicanery. Due to its specific nature, healthcare presents, in addition to the

'normal' categories, also special types of corruption not found in other sectors of public services. (TI 2006).

All the major types of corruption in hospital administration specific to the sector as listed by Transparency International (TI 2006, 50) were found in Nicaraguan public healthcare: insurance fraud, illegal referral arrangements and inducement of unnecessary medical procedures. In addition to the cases mentioned here, high officials of the Health Ministry in Nicaragua suspect the national pharmaceutical companies of cartel formation in the tendering process of procurement of supplies. While cartel formation may not be formally illegal in Nicaragua, it means that less supplies and medicines can be purchased by the public health budget, thus creating incentives for corruption at the level of health centres and hospitals. At the same time, this is an indication of the difficulty of applying procurement laws in non-perfect market conditions; there can be no real competition in tendering when there are only two or three pharmaceutical companies in the country.

Concerning insurance fraud, the situation seems more complicated than suggested by Transparency International. Fieldwork interviews depicted something that might be called 'reverse' insurance fraud, rather than the more common type of insurance fraud known in the industrialised countries consisting of over-billing. In Nicaragua there are negative incentives against over-billing built into the social security healthcare coverage: the way healthcare provision centres receive funds from the national social security (INSS) is constructed so that the less they bill the INSS for care given to the covered patient, the more resources per insured person they receive. The consequence is that the expenditure incurred for patients covered by social security is not billed but instead, is informally 'charged' upon public healthcare by the way of theft of supplies, time and other resources from public hospitals.

Another specific category found is illegal referral arrangements. When a doctor prescribes a medicine which is either not in stock or not included in the official list of medicines provided by the public health service, he can refer the patient to a certain pharmacy to purchase it. According to end-user interviews in Managua, this happens in about 50% of the cases whereby it can be suspected that there are some 'arrangements' between the doctor and the specific pharmacy. A very common practice is to refer patients from public healthcare to private clinics. A special corrupt practice difficult to classify (theft? fraud? malpractice? or all of them?) was reported in an interview with a medical doctor: practitioners steal medicines from public hospitals, sell them to private patients who can afford to pay and hand out, free of charge, falsified or diluted medicines to poor patients.

The last and most dramatic corrupt practice found during fieldwork is the inducement of unnecessary medical procedures of which one reported and confirmed case was found (false hysterectomy). Another case was recorded during user interviews: a woman reported that she had discovered that her ovary had been removed during what was supposed to be a simple appendicitis operation many years earlier. The cases in this category are sometimes difficult to distinguish from plain medical negligence or malpractice. This is the most dramatic expression of corruption, because it potentially damages a person's physical integrity, her/his most important capability *sine qua non*. Due to the anatomic specificities of women, this corruption also affects the female more than the male population.

## **CORRUPTION AND GENDER**

When analysing the possible gendered dimension of corruption, the object of study will have to be divided into two: on the one hand, women and men as ‘corruptors’ on the demand side; and on the other hand, women and men as victims of corruption on the supply side. To start with the latter, in the case of the Nicaraguan public health system, there is hard evidence to claim that statistically women are overall directly more affected by corruption than men<sup>1</sup>: about two-thirds of all patients in the public healthcare system are female (female attendance is double that of male). Women are more frequent users of healthcare services than men, and the female reproductive cycle predisposes women to more frequent and potentially more dangerous interventions than the male reproductive system, increasing the odds for women of the negative impact of corruption and medical negligence. Women are also the ones to take sick children (and elderly relatives) to healthcare centres; women thus are a potential target for extracting bribes and illegal payments in both their gender roles, as caretakers of children and the elderly, and due to their biological sex, as birth givers.

The opportunity structure of corruption is also gendered on the demand side. In public healthcare, especially in hospitals, male doctors are the authors of corrupt practices in five out of six cases sanctioned<sup>2</sup> in 2006 (interview, MINSAs), and private practice of doctors on the public payroll is an almost exclusively male domain (interviews, NGO). Their female colleagues combine professional activity with their role as housewives and cannot carry on a private practice in which they could use supplies and equipment ‘borrowed’ or stolen from the public health system (interview, NGO). This is a clear example of a gendered opportunity structure, and how in some situations the female gender role ‘protects’ women from engaging in corrupt exchanges.

It has to be underlined here that the end result of the corruption affecting public expenditure for provision of services has a similar effect on women and the poor as do cuts in budget allocations due to political decision-making. Therefore, many of the negative impacts of budget cuts in health, as listed by the EU Toolkit for Gender Mainstreaming (EC 2005, 61), as putting an increased burden on women’s time, namely: queuing in clinics; decline in health status in families and communities; reduction of women’s time for paid and productive work or work for communities; reduction in agricultural production; and reduction in tax revenue for the government, all these are the *same* negative impacts which result from the impact of corruption on health service delivery through theft of supplies and absenteeism.

Corruption, together with the low priority given to public healthcare, can therefore be seen as one of the mechanisms which support and contribute to the maintenance of the dominant inequality in Nicaragua. This is valid not only in the economic sphere but also in the symbolic spheres of social and gender hierarchy. In the interviews, end users emphatically denounced ‘humiliating’ and ‘disrespectful’ treatment from medical staff towards patients (although one end user also had observed improvements in recent years). The explanation most commonly given for such treatment was ‘because we [the patients] are women and poor’<sup>3</sup>.

There is also anecdotal evidence to support the view that corruption, too, is a field where gender roles are performed and gender expectations fulfilled. The general experience of the Nicaraguan women reported in the interviews claimed that women drivers have a lower

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<sup>1</sup> There is some evidence that in local government and the justice system the reverse is true; men are the victims of larger and more repeated bribes than women, because men are the majority among property owners.

<sup>2</sup> These figures may conceal the fact that men in supervisory positions are punished for not imposing sufficient controls in cases where their female inferiors (nurses) carry out the thefts.

<sup>3</sup> An anecdote narrated by an end user illustrates this. When she had protested against the demanded bribe and claimed her rights, the doctor had retorted: ‘Who do you think you are; have you gone to the university or what?’

probability of being asked a bribe by male police officers in cases of traffic infraction, thereby allowing the male officer the opportunity to show his gender superiority through generous gallantry. Further anecdotal evidence, widely shared among all persons met, was that female police officers in Nicaragua are less prone to demanding bribes than their male colleagues; instead, they sign the fine ticket. This may be because of their Catholic gender role of 'Immaculate Virgin Mary'<sup>4</sup>. For a woman in Nicaragua, demanding a bribe implies a much higher transgression of supposed good behaviour than for a man, and in general girls' transgressions are suppressed in the gendered socialisation process. Hard evidence from Nicaragua shows that women are a large majority in social audit committees at the municipal and provincial level (interviews and field visits); here the ethic of care is extended from the level of the household to the community level.

The integration of women in the social audit or municipal transparency committees should also be seen from the point of view of networks of social capital. Contrary to what is the case with political parties, the access to these committees is not bound by clientelistic networks but is open to all citizens. In the networks of corrupt exchanges, women as the hierarchically inferior sex in Nicaragua have less social capital, less negotiation power, because the networks are male dominated and require 'upwards' accountability. Women have access to these networks mainly by clientelistic relations, such as in the Justice system, and with them, to opportunities in engaging in corruption (and most probably, to obligation to join in corrupt practices in order to retain their job). Another possibility for women is to form all-woman networks such as those created by the health oriented NGO mentioned above which can take advantage of female doctors' favourable treatment to their patients in the public health sector.

## CONCLUSIONS

When arguing against essentialist conceptions about the supposedly non-corrupted nature of women, Sung (2006) concludes that it is actually the presence of liberal democratic institutions which promote both gender equality and good governance that is the factor at play in reduced corruption here. When analysed in isolation from each other, both the number of women in government and the strength of democratic institutions were strongly and negatively correlated with corruption in her sample. But when both the gender and the institutional variables were inserted in the same model, the effects of gender on corruption became statistically non-significant, whereas most of the liberal democracy indicators remained powerful predictors. In another study Susanne Karstedt (2001) found a negative correlation between levels of corruption and female attainment of secondary education and a high proportion of women in government positions. However, she used women's school attainment and share in government posts as indicators of social mobility and elite exchange, and no direct conclusions about supposed gender differences concerning corruption should be drawn from her study. It may well be that the number of women in public positions is an *indicator* of social mobility and elite exchange, factors that correlate with less corruption, not the cause of high societal moral.

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<sup>4</sup> The idea that female police officers could not be bribed was intentionally launched by the institution in the context of opening the career to women (after the Sandinista defeat in 1990, during the conservative-Catholic presidency of Violeta Chamorro), originally in order to protect women officers from abuse when exercising their functions (interviews, Managua); a similar tactic as that described by Goetz (2007) concerning Peruvian and Mexican traffic police forces. In hospitals, a nurse having stolen a drug may offer to 'buy' the medicine for a patient if handed the money, naturally without giving receipt of the purchase; this conceals the transgression against her gender role.

On the basis of our fieldwork findings it seems evident that increasing the number of women in public office alone does not resolve the problem of corruption. The relatively high percentage of women in the Parliament and the very high proportion of women in the Justice system in Nicaragua do not prevent these state institutions from being considered the most corrupt state powers of the country. In clientelistic/nepotist political systems where downwards accountability is low, increasing the proportion of women in public office without increasing transparency and downwards accountability might even strengthen the exclusionary nature of the political system by involving another social group, women, in the corrupted open networks of social capital.

The fact that gender differences in moral behaviour and political attitudes do exist in most societies does not necessarily mean that they are biologically based or that one sex is ethically superior to the other (Noddings 1990; Sung 2006). As gender is always a social construction, the differences between men and women in their attitudes and behaviour towards corruption are more likely to reflect their social roles, powers and positions. The notion of women behaving honestly is actually widely used in the management of aid resources. For example in humanitarian food aid, assistance is usually targeted to the female adult members of the household. Women are considered less likely to misuse aid resources provided to them, hence increasing programme efficiency and minimizing leakages. Targeting women with resources seems to be a more efficient use of aid, as assets and funds under women's control are more likely to be spent on children's and whole families' welfare, whereas men always reserve some money for their own consumption. Different studies have also confirmed that expenditure patterns of female headed households are more biased towards nutrition and education than of those of male households (Bendera 1999; Chant 1995). Even when they are poorer, female headed households enjoy more equal internal resource distribution patterns (Bradshaw 2002). These practices are based on the social construction of gender roles, such as women internalising the values and behaviour considered typical for a good mother, not on essential notions of women being more altruistic than men by nature.

A similar view is supported by the findings of Alatas et al. (2006) concerning gender differences in regard to corruption. They found that in Australia, women tend to be less tolerant of and engage less in corruption than men, whereas in the three Asian countries covered by their study, no difference was found between women and men. They also suggest that there is a larger variation among women in attitudes towards corruption than among men, because there is "*larger variation in the social roles of women than the social roles of men across countries*" (Alatas et al. 2006, 5). Furthermore, in her study in Ghana, Namawu Alolo (2007) found that the probability differences between male and female government officials in approving corrupt practices were not significant, but there were interesting gender differences in the way corruption is rationalised and explained.

There are only a few studies where the prevalence of corrupt practices in local level service provision (including micro-credit) has been studied from a gender perspective. The findings of recent studies by Alolo (2007) based on fieldwork in Ghana, and by Vijayalakshmi from India (cited in Sung 2006), support the view that socially determined networks and opportunities for corruption are greater determinants to attitudes towards corruption than a person's sex. This view is compatible with the above notion that corruption should be understood as a field where gender roles are performed and gender role expectations fulfilled. The female gender role can thus also prevent a woman from engaging in corruption in contexts where moral integrity forms part of culturally defined female traits.

In the end-user interviews, it was striking (and moving!) how openly all patients spoke about the bribes they had had to pay. The explanation for this is that the environment of scarcity of public healthcare is not conceptualised in terms of corruption; there is resignation in the face of the under-resourced public health services, and the end-users (poor to working class) accept as a lamentable fact the necessity to pay fees without thinking that at least parts of them constitute corruption. Therefore, it could be claimed that the environment of scarcity created by political decision-making and the limitations to public spending in social expenditure imposed in the name of budgetary discipline by the international financial institutions have increased the odds of accountability failure through contributing to the creation of opportunities of and incentives to corruption. Additionally, illegal fees confused with bribes limit the extent to which developing countries can promote citizenship building, resulting in reduced legitimacy of the state.

## RECOMMENDATIONS

The recommendations will necessarily be limited to basic, underlying causes of corruption because after the new Nicaraguan government took office on January 10, 2007, new laws are being passed and the institutional scenery is unsettled. Some important changes can be envisaged. The new government (Ministry of Education), for instance, immediately (Jan 11, 2007) cancelled the financial decentralisation called ‘school autonomy’ which had given schools the right (or obligation) to find self-funding (another term for ‘cost sharing’). ‘School autonomy’ had been imposed as part of structural adjustments by the international financial institutions, and was felt by the population to promote corruption in the form of undue fees. The same initiative included the training of 1,500 school ‘ombudsmen’ to control the effective gratuity of primary school enrolment<sup>5</sup>. According to reports in the Nicaraguan press, this measure locally increased enrolment by up to 20% compared to the previous year. This detail, by the way, gives an idea about the extent of the impact of cost sharing (various due or undue fees) on school enrolment (20%), and the potential for poverty reduction in the long run.

The pernicious impact of various ‘cost sharing’ mechanisms underlines important policy incoherence in the global aid architecture. Donors under the hat of bilateral aid agencies often encourage and contribute to larger public spending in social areas while at the same time they impose limitations to the very same public spending under the hat of share holders of international financial institutions. (And in the last instance, this second role most often overrules the first.) This issue of the internal ‘power geometry’ of donor governments should be addressed in one way or another in the near future.

From a purely theoretical viewpoint, the main set of recommendations that can be given on the basis of this study concerns the ‘closure’ of social capital at the different levels of service provision, from the individual service facility to national level transparency and downwards accountability.

In the health sector, the internal control unit of the Ministry of Health should be provided with sufficient resources to carry out its functions. Similar ‘ombudsmen’ to those introduced by the Ministry of Education or user complaint centres could be used to provide for control at the grassroots level and to receive and process complaints at the level of health centres and hospitals. Civil society organisations should be actively involved in controlling theft of

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<sup>5</sup> According to El Nuevo Diario of February 8, 2007, teachers’ trade unions protest against the school ombudsmen. In the present political situation in Nicaragua, the post may also be used for purposes other than controlling corruption.

medicine and supplies. Consciousness raising campaigns should be promoted to inform users of their rights (and legal fees), and health personnel about professional ethics; this could be carried out at the national level by NGOs and the health authorities. All user fees should be visibly posted outside service facilities. Clear separation between public healthcare and private clinics should be made. A law on political parties should be passed in order to oblige political parties to democratise internally, instead of the present system in which representatives are hand-picked by the party leader, in order to promote downwards accountability. (For more points still pending in anticorruption, see *Etica & Transparencia* 2006).

Concerning what donors can do, it is probably more efficient to direct efforts to the demand side of accountability in the hope that citizen's demand for accountability and transparency will 'trickle up' to the political establishment. A special Nicaraguan feature, perhaps now strengthened by the Sandinista victory in the elections of November 2006, is the 'mentality' of cold war and the consequent absolute obedience paid to party leaders, as if one was still on either side of the guerrilla war of the 1980's. From this perspective, any effort to strengthen people's individual capacity to decide – and to disobey – will lead to increased openness and transparency and, in the long run, to a reduction of corruption.

Last but not least, supporting (free or very low cost) quality public service delivery to everybody reduces the economic and social weight of corrupt networks of social capital controlling access to those services. Reducing corruption in public healthcare services is one means of defending women's rights in Nicaragua.

**Table 1. Gateways to corruption in the public health sector in Nicaragua**

<b>Gateway to corruption</b>	<b>The beneficiary</b>	<b>Majority of beneficiaries (male/female)</b>	<b>Benefit for the benefiting part?</b>
Cartel of pharmaceutical industries in public tendering	Pharmaceutical industries	n/a	Larger margins
MIFIC registers reference prices for imported medicine and supplies by unitary price, not by economies of scale	Pharmaceutical industries and import companies	n/a	Larger margins
State capture: Private economic interests have impact on public policy formulation: no earmarked tax for health on alcohol	The (quasi)monopoly brewing company and distillery	Almost exclusively men	Larger margins
Traffic insurance companies not fully charged for care given to traffic accident victims	Insurance companies	n/a	Larger margins
Unclear and opaque payment structure between public sector/private provider and INSS	Social security fund	n/a	Public health budget used indirectly to support pensions and 'medicare' fund
Departments for private attention in public	No conclusive information; may	n/a	Possibly (as is officially expected) the public sector

hospitals suspended but not prohibited (after March 2006); under the category of embezzlement of user-fees	benefit the public sector as well as private medical providers		may benefit (depending on the hospital manager's personal ethics); public resources may be diverted to the benefit of private physicians
Theft of supplies and equipment (moved to private practices)	Medical doctors	Majority probably male but female doctors may be involved	Larger margins for private clinics
Theft (indirect): use of public sector supplies and equipment for private medical care in public hospitals -subcategory: extortion in emergency or severe cases ('pay or perish')	Medical doctors	No major difference between the sexes.	Private gain for medical doctors
Theft of medical supplies and  -fuel sold out of official vehicles	Nurses  -Car drivers	Female  -Male	-private clinics: Larger margins -nurses: job security when theft is done on the orders of doctors -sold personally for "salary complement"
Absenteeism	Medical staff leave the public sector early in the day	Majority male (female doctors have family obligations)	-Better attention in private health clinics; economic gain to physicians -Male doctors economically benefited; lesser income for a female of the same educational level
Informal payments	Extorting payments for medical supplies that are supposed to be free of charge	Equally men and women	"Salary complement"
Illegal referral to private clinics	Private medical practitioners	Majority male	Increased income
Referral to specific pharmacies for purchasing supplies that are supposed to be free of charge at hospitals and health care centres	Relatives and/or friends of the practitioners	n/a	Increased income of pharmacies related to the practitioners
Inducement of unnecessary medical procedures	Medical practitioners	Perception: more male practitioners involved	Increased income
Extortion: asking for "entrance fees" (bribes) to see relatives/family members in hospitals outside of normal visiting hours	Guardians of hospital	Male	"Salary complement"
Informal payments (bribes) to medical staff (mostly nurses)	Patients	n/a, though mostly women (because women are the majority of hospitalised patients)	Better care ; salary complement

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