

night blindness by history is high (eg, >10%) and the risk of maternal mortality is very high (eg, >500 deaths per 100 000 livebirths).

We declare that we have no conflicts of interest.

*Keith P West Jr, Parul Christian, Joanne Katz, Alain Labrique, Rolf Klemm, Alfred Sommer
kwest@jhsph.edu

Center for Human Nutrition, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD 21205, USA

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Authors' reply

We agree with Keith West and colleagues that one possible explanation for the difference in findings between the Nepal, Bangladesh, and Ghana trials of the effect of weekly vitamin-A supplementation on pregnancy-related mortality could be differences between the trial sites in levels of maternal mortality and vitamin-A deficiency. In support of this argument, they highlight that, in the subgroup of 10 422 women with information on night blindness in the Nepal study, virtually all the survival benefit was among night-blind women.¹ However, only 17.6% of the deaths in women with night blindness in the subgroup analysis were injury-related or assigned to miscellaneous causes compared with 35.3% of deaths among non-night-blind women. This finding is inconsistent with the main trial findings based on 22 189 women where the highest reductions were seen

in deaths related to injury or of unknown or uncertain causes.² Thus we do not believe the case for this explanation of the differences in effect is proven.

Furthermore, even if this is the explanation, the body of evidence is insufficient to meet current standards for formulating guidelines³ or to determine the settings in which women would benefit from vitamin-A supplementation; the cutoffs suggested are somewhat arbitrary. We therefore believe that our conclusion holds: current evidence does not support inclusion of low-dose vitamin-A supplementation for women in either safe motherhood or child survival strategies.

We declare that we have no conflicts of interest.

Betty Kirkwood, on behalf of the ObaapaVitA trial team
betty.kirkwood@lshtm.ac.uk

Department of Nutrition and Public Health Intervention Research, London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK

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Corruption in health systems

The courageous description of prevailing institutional politicisation and corruption in Nepal (June 12, p 2063)¹ should lend impetus to the unravelling of pervasive collusive behaviours in developing countries, which are undermining health systems performance.

Corruption is a systemic issue in health and broader systems of governance in many countries. It compromises the impact of public investments in constrained environments and

negatively affects health outcomes.^{2,3} Corrupt behaviours in the health sector can be financial, procedural, or ethical in nature and broadly fall in two categories. One includes corruption in the administrative and regulatory domains, with the former characterised by procurement graft and patronage in deployment, and the latter embodying deliberate inattention to oversight. Collusive behaviours in health service delivery are the result of interplay between inadequate funding for the public system, a burgeoning unregulated role of the private sector, and lack of overall transparency in governance.⁴ Some of these behaviours, being individual coping strategies, can be amenable to reform which balances incentives with accountability.⁵

The other category involves a level of state capture rooted in weak capacity of state institutions along with lack of accountability and vested economic interests of the powerful elite; these are not amenable to isolated reform within the health sector.

Corruption in the health sector leads to leakages and pilfering of public resources and mistargeting of services and subsidies; it undermines the equity objective of publicly financed health care, compromises quality in the private sector, and skews spending priorities. By virtue of its scale and pervasiveness, corruption merits to be a priority in health systems and governance empirics.

I declare that I have no conflicts of interest.

Sania Nishtar
sania@heartfile.org

Heartfile, 1 Park Road, Chak Shahzad. Islamabad, Pakistan

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