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Anti-Corruption Evidence

Making Anti-Corruption Real

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Networks, incentives and informal payments in the Tanzanian health system: a qualitative study

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Executive summary

Informal payments constitute one of the most persistent problems of corruption within the Tanzanian health system. However, recent research suggests that following the Tanzanian government's top-down action on corruption, informal payments are no longer as prevalent as they used to be. Research has yet to identify the spaces within the health system where informal payments remain common, or the factors driving them. Drawing on the SOAS-ACE framework, which aims to find feasible and high-impact strategies, we use qualitative methods to identify the healthcare settings and actors who continue to extract informal payments from patients and their carers.

Our research shows that informal payments continue to be commonplace in hospitals and larger urban health centres in the following departments: maternity and labour wards, outpatient departments, surgery, and in the mortuary. In maternity departments, such payments appear to be made to an individual nurse by the patient or the patient's family, especially when managers are not on duty (overnight or early in the morning). Informal payments are made in these instances to ensure good, attentive care for the inpatient. Similarly, in the mortuary, payments seem to be made to individual mortuary staff by the family of the deceased. In contrast, payments made in surgical departments and the outpatients department were described as being organised within networks of actors. In surgical departments, informal payments are made to speed up procedures (especially to move patients up the waiting list), organised by large networks of junior and senior staff working together. The large number of staff involved in these networks means that payments are often high, as they have to be distributed among all involved. They appear least amenable to a transparency and accountability strategy as so many staff benefit from these networks, and it is rarely within their interests to be a whistle-blower. Networks of staff members also manage informal payments in the outpatients department but here, the networks appear smaller, sometimes just two people – often the medical attendant who was in charge of triaging patients and organising patient records and notes, and the doctor or medical officers on duty.

In the surgical department and outpatients department, anti-corruption strategies have to understand corruption as a collective action problem, and seek ways of disrupting the networks that extract payments from patients. This could include changes to the shift pattern, so that staff no longer have the opportunity to develop these networks. In the maternity and labour wards, interviewees suggested that any strategy would have to include more supervision and managerial oversight.

1. Introduction

Corruption is a complex problem across all sectors of society. It threatens the impact of public investments and access to services (Hanf et al., 2011). It has long been recognised that the health sector is particularly vulnerable to corruption: it has large asymmetries of information between patient and health worker and between the health worker and the payer; many interactions take place in private between health professionals and patients; and providers have considerable discretionary space (Lewis, 2007; Savedoff, 2007). Coupled with this recognition of the health sector's vulnerability to corruption is a long-term concern about the consequences for people's health. Corruption creates additional expenditure for governments with no tangible outcomes, makes it difficult to transform services, and undermines the possibility of achieving universal health coverage (World Health Organization (WHO), 2013). Corruption compels health workers to behave in ways that are contrary to their technical skills and, in some cases, their underlying values; its costs for society are substantial, because of the direct and indirect consequences that range from lost productivity through to job losses, to catastrophic expenditure (Hussmann, 2011). Its consequences are, however, most serious for patients in need of care. In 2011, it was estimated that corruption results in the deaths of 140,000 children each year (Hanf et al., 2011).

As of now, there is no consensus on a definition of corruption. The first widely used definition – 'the abuse of public or private resources/ power for private gain' (Gaitonde et al., 2016) – has been criticised for failing to recognise that corruption can also take place in the private sector. The second broader definition used by Transparency International, 'the abuse of power for private gain', provides a welcome focus on power and broadens the scope to both the public and private sectors, but for health systems researchers in particular, this has a problematic focus on the individual. As Gaitonde and colleagues argue, groups, organisations and networks close to the person who is abusing power very often benefit from corruption, but their role is obscured in these definitions (Gaitonde et al., 2016; Hutchinson et al., 2020). There is more agreement on which practices constitute corruption within the health sector: theft (of money, medicines, or consumables); absenteeism among staff; inappropriate referral and diversion of patients from public to private facilities; inappropriate prescribing (often under pressure from pharmaceutical firms) and provision of misinformation; and informal payments and bribery (Gaitonde et al., 2016; Hutchinson et al., 2020).

Traditional top-down approaches to anti-corruption in the health sector have mainly focused on improving transparency and accountability mechanisms, but have mostly yielded disappointing results (Gaitonde et al., 2016). In response to their failures, new approaches to tackle corruption have been developed (Camargo, 2020; Hutchinson et al., 2020; Marquette and Peiffer, 2018). These new approaches recognise the social or group nature of corrupt practice, the role of politics and economics in shaping the forms of corruption that emerge, the role of social norms in rendering corruption acceptable, and the problem-solving (as well as problem-creating) nature of *some* forms of corruption. The forms of anti-corruption that emerge from these insights are context-specific; interventions no longer rely on blueprints for action but must take into account the local conditions in which corruption occurs.

The SOAS-ACE approach argues that successful anti-corruption interventions need to take into account socio-political networks, the interaction between formal and informal rules, and the economic incentives that they create (Khan et al., 2019). Within health systems, the SOAS-ACE approach focuses on how informal networks and rules intersect with health policy and exacerbate health system shortcomings (Hutchinson et al., 2020). Work in Bangladesh, inspired by SOAS-ACE, has revealed how junior doctors rely on informal socio-political networks and bribes to secure urban placements and to help them leave their rural positions – a process that drives absenteeism (Angell et al., 2021; Hutchinson et al., 2020). SOAS-ACE suggests four anti-corruption strategies, to which we have added a fifth (see Box 1).

Box 1: New anti-corruption strategies for health systems developed at global level

1. Changing individual and group incentives.
2. Creating policy that recognises and acts on differences between actors usually seen as homogenous.
3. Creating forms of collective action among groups who are powerful enough to effect anti-corruption.
4. Rendering the rights of different actors transparent.
5. Targeted anti-corruption investments.

Source: Adapted from Khan et al., 2019, in Hutchinson et al., 2020.

In common with other health systems, the Tanzanian health system faces a particular problem of widespread informal payments, according to research undertaken between 2010 and 2019 (Olan’g and Msami, 2018; Mamdani et al., 2018; Sikika, 2014; Stringhini et al., 2009). Health workers were shown to have a number of strategies to extract bribes from patients, including: imposing unnecessary delays in service delivery; taking advantage of shortages of material and human resources; taking advantage of cost-sharing measures; taking advantage of patients’ ignorance of service delivery procedures; and provision of inappropriate services (Olan’g and Msami, 2018; Mamdani et al., 2018; Sikika, 2014; Stringhini et al., 2009). Although there is some evidence that some Tanzanian health workers dislike taking informal payments, and that they lead to low job satisfaction and motivation (Stringhini et al., 2009), other evidence suggests that some health workers created artificial shortages and deliberately lower quality of care in order to extract extra payments from patients or to bargain for a higher share of the payments received by their colleagues (Mæstad and Mwisongo, 2011).

Evidence from the past three years, however, suggests that there has been a shift and likely a reduction in the informal payments taking place in the Tanzanian health system. Camargo (2020) argues that payments for improved services are no longer ubiquitous. While that study argues that there has been a generalised reduction in informal payments in the country, it does not describe where these informal payments continue to take place or, beyond attending to social norms, what it is that drives informal payments in different parts of the health system.

This paper adds to the body of evidence on informal payments in the Tanzanian health system by attending to their heterogenous, dynamic nature, and examining the spaces in which they are prevalent and the different networks of actors involved.

2. Study objectives, setting and methods

The study is part of a larger body of research that sought to identify feasible and high-impact anti-corruption solutions for the Tanzanian health sector. The overall purpose of this qualitative study was to understand the underlying determinants of informal payments and to identify novel approaches to address these practices.

The specific research objectives were:

- to identify the different forms of informal payments among front-line health providers;
- to understand the practices and mechanisms through which informal payments occur;
- to identify the departments and cadres of health workers that engage in informal payments.

2.1. Study setting

Tanzania is a lower middle-income country with a population of around 58 million (as at 2019). Its healthcare system is decentralised, with local managers and providers having autonomy to plan and manage resources as their funds are received through a direct health financing approach (Frumence et al., 2013; Kapologwe et al., 2019). Health services in Tanzania are delivered largely through the public sector but there are also private services, both for-profit and not-for-profit, provided by faith-based organisations and non-governmental organisations (NGOs). As of 2020, there were 8,458 health facilities in the country, of which dispensaries constituted the majority (about 7,200), with 369 hospitals and 926 health centres (Faria, 2021). Tanzania's health sector faces many challenges, including shortage of trained health staff, inadequate funding, lack of effective staff supervision, poor communication and transport infrastructure, and shortages of drugs and medical equipment (Kwesigabo et al., 2012; Swere, 2016). The study was conducted in three adjacent regions in the eastern part of Tanzania: Dar es Salaam, Morogoro and Pwani.

2.2. Study design and participants

A qualitative research design was employed, using two phases of qualitative data collection. Study participants included front-line health workers (doctors, nurses, medical attendants) and their district and regional health managers. A total of 47 participants were purposively selected to be included in the study, of which 40 were front-line health workers and 7 were health managers. The 40 health workers were from 16 health facilities (4 dispensaries, 6 health centres and 6 hospitals).

2.3. Data collection

A total of 47 in-depth interviews (IDIs) were conducted with the selected health managers and front-line health workers. Data was collected by three experienced qualitative researchers, and interviews were conducted in two phases. During the first phase of data collection in January 2019, participants were purposively selected based on their fit with the study objectives and willingness to participate. During the second phase, in November and December 2020, snowball sampling was used to select participants from within a network of health workers who then referred us to their colleagues whom they believed had information about informal payments.

Some of the study participants in the selected facilities were recruited by visiting their workplace. Others were contacted and introduced to the aims of the study via their mobile phone. Following their consent, arrangements were made to interview health managers in their offices and front-line health workers in their respective facilities, or another convenient venue in case they were not free or comfortable to participate in their place of work.

Data was collected using a semi-structured in-depth interview guide developed by the research team. The guide was pre-tested with 4 front-line health workers and 2 managers. After pre-testing, it was revised further.

All interviews were conducted in Swahili and were recorded. The recordings were transcribed verbatim to ensure that all the information communicated during the interviews was captured. Transcripts were labelled using a unique code so as not to identify participants by their full names. Transcripts were double checked to ensure everything had been captured before being translated into English by experienced translators (fluent in both English and Swahili). The translated transcripts were double checked against the Swahili transcripts and audio records to ensure that no content had been altered.

2.4. Data analysis

Analysis was done using NVIVO 12 software using a thematic analysis method. The data analysis process involved reading through the transcripts to become familiarised with the data and identify the emerging topics or themes. The researchers developed a code book that was shared and discussed with the wider study team, and subsequently revised after receiving inputs from the team. Coding was conducted by the research team. Participants' opinions were examined and categorised, and findings are presented throughout the narrative text.

2.5. Ethical considerations

Ethical clearance was obtained from the Institutional Review Board of Ifakara Health Institute (IHI/IRB/No: 009-2018) and from the National Institute for Medical Research (NIMR/HQ/R.8a/Vol.IX/2812). The local government authorities granted clearance for the study in Dar es Salaam, Morogoro and Pwani regions. Study participants were informed

about their voluntary participation in the study. They had the opportunity to ask questions and all questions were addressed by the researcher before the participant agreed to take part in the study. Participants were assured about data confidentiality.

3. Results

3.1. The nature of informal payments

According to the interviewees, informal payments are made between patients and health workers, between families/ carers and health workers, and between health workers and their supervisors or managers. Interviewees described a range of practices between actors, including: patients paying health providers to bypass the queue; patients paying to ensure good care (especially for overnight stays in hospital); managers enabling health workers to attend training (and so receive per diems) based on personal preference rather than professional skills; health workers demanding fees for services that should be free; payments being made to receive goods or services in the future; and payments being made for medicines and commodities that were supposed to be provided for free.

Despite Carmargo (2020) finding that informal payments in Tanzania's health system have been substantially reduced, interviewees argued that they still occurred daily within the public health system, as an assistant medical officer in Mkuranga said: 'I don't think a whole day might pass without having people who engage in informal payments.' There was potential for informal payments to be made across the public health system but those interviewees with a more nuanced description of practices argued that the number and type of incidence would 'differ depending on the level of care' (medical doctor, Ilala). For many, informal payments were described as a problem that occurred in larger urban hospitals, with fewer incidences at dispensary level:

> *Informal payments are more prevalent in hospitals and health centres because in hospitals and health centres there are many specialised services which are not available at the lower level of health facilities (i.e. dispensary). You find that there is a special day to meet a specialised health provider, maybe every Tuesday there is a specialist and you are supposed to make an appointment two weeks before or one week before, so asking for an appointment while you want to receive services fast is a challenge that leads to informal payments… You pay money so that you can be put in the list to see the specialist early. Also, there is a large number of staff in hospitals and health centres so it becomes a challenge to manage a large number of staff.*
>
> (Health manager, Dar es Salaam region)

As the health manager quoted above explained, the opportunity to take informal payments was created due to the increasing complexity of how services are organised and the increasing number of providers, which made oversight and management of personnel more difficult. Reflecting findings in the literature, our interviewees also thought that in these settings, informal payments were linked to the scarcity of services and particularly the long waiting times that many patients experience; patients' desire to see a specialist quickly thus creates the opportunity to extract a charge. While scarcity of services and the numbers of staff involved are certainly important factors in driving informal payments, they only go

some way to explaining the patterning of behaviour in the Tanzanian health system. Participants agreed that all departments in the health facility had the potential to elicit informal payments, but that providers working in certain departments were unlikely to do so, we explore this below.

3.2. Informal payments in different specialisms

The following services were described as less common places for informal payments to be made: eye clinics, child health, HIV and diabetes. According to one interviewee, these services are different from other services because they are exempted from any payments.

> *For instance [for] Reproductive and Child Health services it is known that these services are exempted, and they should be provided for free. Family planning services are free, TB [tuberculosis] services are free, care and treatment centres for HIV services, services in the diabetic clinic, eye clinics and paediatric wards are free, so it is very difficult to find informal payments in these units. So, you find that it is difficult to ask for informal payments in all the units where the services are exempted.*
>
> (Assistant medical officer, Mkuranga district, Pwani region)

In contrast, informal payments were thought to be much more common in labour and delivery wards, surgical departments, outpatient departments, emergency departments and at the mortuary. In all of these settings, formal as well as informal payments are taken for the services provided. A range of factors make it more likely that these services are susceptible to informal practices; it is not only exemption from fees that makes informal payments for a service less common. We now look at each of these services in more detail.

3.2.1. Maternity services

Study participants argued that informal payments in labour and delivery wards were driven by the nature of the medical condition and the idea that pregnant women (and their families) will be willing to pay anything to ensure the safe delivery of the child.

> *Because the nature of their problem, in some cases, requires immediate action, some actions should be done immediately as it is not allowed to be delayed, so health providers take that advantage to exploit for their benefit.*
>
> (Health administrator, Dar es Salaam region)

The fact that maternity services usually involve inpatient treatment, however, was also identified as a driving factor. Relatives – who would, for the most part, be away from the wards at night – were often eager to ensure that overnight stays were safe and comfortable. They were reported to seek out staff who would accept informal payment in order to provide additional care. Although all patients should receive attentive care (as the health manager quoted below explains), the expectation is that only those who pay will have a comfortable place and be well cared for. These resembled cases reported by Mæstad and Mwisongo (2011), whereby those who do not pay would receive only limited care.

You find that the mother wants to stay in a place that is comfortable so she asks the nurse if she can have a place that is comfortable, so she or the husband will already engage in informal payment… You will ask the nurse to oversee your patient closely so you will also engage in informal payments.

(Health manager, Bagamoyo, Pwani region)

For the most part, there are no managers on duty during the night and so overnight stays on the maternity wards in particular offered health workers the opportunity to engage in eliciting informal payments without their supervisors finding out.

Informal payments in the labour ward mainly occur during the night because at night there are no leaders to make follow-up or to supervise the health provider.

(Health officer, Bagamoyo, Pwani region)

3.2.2. Surgical departments

The negotiations around informal payments for surgery services were described as beginning at the point at which initial appointments are scheduled. Long waiting times for surgery, driven by a lack of specialists and facilities, provides a context of scarcity and impetus for patients to make payments that will prioritise their treatment. As an assistant medical officer in Kinondoni said, 'Staff are not sufficient, the surgeons are not sufficient and the operating area is also not sufficient.' As we explore in more detail below, networks of actors were involved in organising these payments, as the doctor conducting the procedure would rely heavily on having a large team with him, all of whom required a payment.

It is a complete team, there is the doctor, medical attendant and nurse. Because of the nature of care, the doctor must be present, the nurse to take care of the patient and there must be someone who you can send to sterilise the equipment and run other errands, and this person is the medical attendant. These three must be present. Also, the laboratory technician to make sure that blood is available.

(Health manager, Dar es Salaam region)

Given the team of people involved, informal payments for surgery were reported as being very high in comparison to payments for other services in the hospital, as a health manager in Dar es Salaam noted: 'I think in terms of money, surgery department leads. I have never seen an informal payment which is below 150,000 shillings [TZS]. It ranges from 150,000 shillings and more. In other departments, a person might pay 10,000 shillings.'

As with the description of informal payments for maternity services, the nature of the illness would dictate whether or not payment was made. Some interviewees reported that it was often impossible to seek an informal payment from a patient who was very sick. This suggests that it takes some time to negotiate an informal payment, but it should be noted that there was considerable variation in this regard. This suggests that the nature of the illness is not the main factor that drives informal payments.

> *There are other operations which are emergencies – for example, if a person has an ectopic pregnancy, it is an emergency, and you have to provide services to the patient immediately and you can't ask for an informal payment. There is also obstructed hernia, which is also an emergency it is very difficult to ask for an informal payment, but there are cases where a person just feels pain and the operation can be postponed for a month. In this situation, you can create an environment to ask for an informal payment from the patient, but for the emergency cases you can't ask for payment because the patient requires immediate care.*
>
> (Medical doctor, Kisarawe, Pwani region)

3.2.3. Outpatients' departments

As with the surgical departments, long queues in outpatients' departments caused by a shortage of health workers was an important factor driving informal payments. Interviewees described patient-driven informal payments for those in a hurry or those who needed to be attended to quickly. Individuals will look for health providers whom they can pay and sometimes a lower cadre staff member may attempt to help the patient by presenting the patient to the doctor as a relative, with the informal payment made afterwards.

> *…What the medical attendant does is that she goes to the doctor and tells him that the patient is her relative and asks the doctor to help her, so sometimes the doctor provides services for free while she [the medical attendant] has lied.*
>
> (Nurse, Kibaha District Council, Pwani region)

Interviewees also reported that there are certain diagnostic services that are not provided at all times of the day, thus creating overcrowding at particular times (daytime), which provides an opportunity for payment:

> *Also, there is a peak of patients from 8 a.m. to 2 p.m. due to the fact that some services such as ultrasound and x-ray are not provided in the evening or at night. This creates a loophole for corruption because some patients will wish to give money to health providers so as to jump the queue.*
>
> (Health manager, Dar es Salaam region)

As with informal payments made at night in maternity services, informal payments in the outpatients department were described as more common at certain times: early in the morning, at night, and during weekends and public holidays, when people in management positions were not present.

> *From the experience I had in the past, most of the time it was in the evening – for example, those who are in the night shift say that they can't wake up without having money to take back home. The environment at night facilitates informal payments as there are no leaders [present].*
>
> (Nursing officer, Ilala, Dar es Salaam region)

From the description given by one interviewee (below), however, it seems that informal payments are driven by different factors throughout the course of the day. While the absence of staff in an oversight role at night drives informal payments during the night-time hours, peak hours also drive informal payments because there are many patients requiring attention, creating long queues and thus a loophole for health workers to take informal payments, as a health manager in Dar es Salaam explained:

> *Informal payments occur all the time, but they differ with time. There are those which take place very early in the morning when people in management are not present – for example, those in the surgery mainly take place during that time from 4 a.m. or 5 a.m. There are other scenarios which occur during peak hours, around 9 a.m. to 10 a.m. where there are many patients. Also during weekends there are few doctors who are on duty, meaning that they will have a big workload, creating congestion, and that creates a loophole for someone to engage in informal payments.*
>
> (Health manager, Dar es Salaam region)

3.2.4. Mortuary services

Study participants also cited mortuary services as having various loopholes that allow for informal payments, and they reported that there are many such payments. Whereas drivers of informal payments for other services relate to the nature of the condition being treated, the scarcity of services and the particular forms that treatment takes, informal payments for mortuary services highlight the importance of socio-cultural practices, as the following quotes illustrate:

> *There are informal payments at the mortuary in washing dead bodies as people are afraid to wash the dead body, identifying or tracing the dead body. If you are travelling with the dead body, you will be told to pay more money to buy the medicine for keeping the body fresh throughout the journey.*
>
> (Assistant medical officer, Kinondoni, Dar es Salaam region)

> *Informal payments occur at the mortuary because people want their deceased relative to be treated well. Human beings are also afraid to take care of a dead body so what they do is that they talk to the mortuary attendant to bathe and dress the body, so you negotiate and pay the informal payment. When you come back, you find that the body has been washed, dressed and has been put in the coffin.*
>
> (Health manager, Dar es Salaam region)

Participants also reported that mortuary attendants sometimes create an environment that facilitates relatives of the deceased person making an informal payment at the time when they arrive to identify the body or to take it from the mortuary for burial:

When identifying the dead body, the relative will have to say the name of the deceased so that he/she can be shown the corpse. So, what normally happens is that if you have paid the mortuary attendant some money, when you go to identify the body, he will take you directly to the refrigerator where your relative's body was kept. But if you haven't paid any money, he will open many refrigerators even though he knows exactly where the body is. Also sometimes, when you go to take the corpse, you find that there is a queue. If you pay something, then you won't stay waiting in the queue.

(Health manager, Dar es Salaam region)

3.3. Individuals and networks of health workers involved in informal payments

Informal payments in health facilities are often presented in the literature as taking place between individuals (health workers and their patients/carers and/or managers). Similarly, when we asked study participants to give a general description of informal payments, they were often presented as occurring between two people with little reference to networks of professionals or family groups within which they were embedded. For example, as one doctor explained:

The experience I have heard is that pregnant women and children are not supposed to pay for services, but a health provider might come and tell you that there are some things which are needed so you should ask clients to pay. For example, surgery for pregnant [women] is supposed to be conducted for free but sometimes health providers take advantage and ask patients to pay money for buying medical supplies needed for the operation.

(Medical doctor, Morogoro region)

Study participants often identified nurses as the cadre of staff most likely to be collecting these payments from patients and their carers. Some argued that this was primarily because there are so many nurses in these settings:

The nurses are the ones who mostly engage in informal payments maybe because they are many in number compared to other cadres, the doctors follow and other cadres such as those working at the x-ray department and laboratory.

(Health manager, Dar es Salaam region)

Others, however, highlighted the fact that nurses have a significant amount of contact with patients and provide numerous caring roles, and thus have more opportunities to ask for or receive informal payments. As the head of one facility in Morogoro said: '...the nurses also provide more services such as giving injections, wound dressings and assisting with delivery than doctors, lab technicians or pharmacists' (head of health facility, Morogoro). When we probed further, however, it appeared that nurses would often elicit informal payments as part of a network of actors:

The other reason might be because they [nurses] are the caretakers for the patients and are first contact persons when seeking care. So, I think that the nurses have a big role in doing the negotiation as they are very close to patients.

(Health manager, Dar es Salaam region)

In terms of organisation and in contrast with work on corruption and social networks in Bangladesh, there was no suggestion from study participants that these networks were created outside the health system. Instead, they were groups of doctors, nurses and medical attendants who would work together and provide care in exchange for payment. The organisation of these networks followed traditional medical hierarchies, with more junior members of staff who triage patients and manage patient files providing a critical link between patients and the doctors/medical officers whom they wish to see. However, as senior members of staff, doctors and medical officers were described as holding the power to decide who to work with to facilitate the exchange of payments, with nurses playing a more subordinate role. As one health manager explained:

Most of the time the doctors are the ones who decide whom to work with. Of course, it has to be a nurse, but the doctor is the one who determines which nurse. If the medical attendant is required, the doctor is still the one to determine which one.

(Assistant medical officer, Mkuranga, Pwani region)

Teams of providers were described as getting to know one another by working long term in the same departments or area, and medical attendants and nurses were described by one interviewee as seeking out doctors who were known to take bribes.

Medical attendants will come to look at which doctor is on duty, so she knows that maybe this doctor likes to engage in informal payments or not. She just doesn't go to anyone.

(Assistant medical officer, Kinondoni, Dar es Salaam region)

Informal payments for referrals, however, were organised differently as they took place after the medical officer or doctor was with the patient and had made an initial diagnosis or recognised that the patient needed additional services. These payments bypassed nurses and junior staff and were established between medical officers, doctors and dentists. Just as with the teams of staff described above, these appear to be networks of actors who know each other professionally from their work in the hospital. An assistant medical officer explained how such a network operates:

I will communicate with the dentist and tell him the amount the patient is willing to pay for the service, maybe TZS 50,000, so I will take the money from the patient and give to the dentist who in return might give me TZS 10,000 or 15,000 and is left with the remaining amount… You can't link a patient without having your share. For example, I am not a surgeon and a patient comes and tells me that she is supposed to undergo surgery, so it means that I will talk to the surgeon and tell him that this person doesn't want to be on the waiting list, this

> *person wants to be operated on as soon as possible. So if the patient is willing to pay TZS 250,000, it means that I will also have my share.*
>
> (Assistant medical officer, Mkuranga, Pwani region)

While networks of medical attendants, nurses, medical officers and doctors were clearly necessary to facilitate the process of informal payments, working in networks was also important as a form of protection against disciplinary measures. The description below, of a doctor who failed to share the payments he charged with the network of other actors involved, illustrates how it is rarely in the interests of staff to report informal payments to managers:

> *There are few cases of those acting alone because it is easy to get caught when acting alone compared to when acting in groups. There is a scenario which I faced where the doctor was performing post-abortion care service to a client, he was alone, he didn't want to divide the money with others. The incident was reported by people working in the operating theatre. If they work in a team, it is difficult to know about it, nobody is going to report you unless there is some misunderstanding.*
>
> (Health manager, Dar es Salaam, region)

Even when health workers were excluded from these groups, there were indications that other health workers would be reluctant to report colleagues who took informal payments from patients. Below is an account from a nurse, who describes how social norms and the fear of punishment of those taking informal payments stopped nurses from reporting corrupt colleagues. As the nursing officer explained, this even includes those who regarded informal payments as very detrimental:

> *There is no one who protects this person because you find that no one is happy about the things done by this person, everybody hates these acts, but you can't dare to speak in public. So there is no one who likes these acts but there is no evidence, so how can this person get caught? The other thing is that colleagues are afraid to report incidences of informal payments from others as they will be seen as the source for ruining this person's life, so you find that people are afraid. So it is possible that they are being protected indirectly.*
>
> (Nursing officer, Ilala, Dar es Salaam region)

Unsurprisingly, therefore, some participants argued that those who engage in informal payments are also rarely caught, and that there was often a lack of evidence to show that a health provider has taken an informal payment.

> *There are leaders and some elder health providers who warn those engaging in informal payments. Those who have authority try to take measures when a person has been reported to engage in informal payment, but most of the time it is a bit difficult to get the evidence.*
>
> (Clinician, Morogoro region)

3.4. Informal payments solve some problems for health workers

The traditional corruption frameworks assume that corruption is driven by opportunity coupled with an ability to justify corrupt actions (Vian, 2008). As we described above, more recent, pragmatic approaches to anti-corruption have highlighted how informal payments may solve problems for the individuals and groups involved. Understanding the problem-solving element of corruption is important – as is understanding the social and economic context in which corruption occurs – to ensure that interventions do not have unintended consequences that entail social costs. In this subsection, we discuss how informal payments are seen to solve certain structural issues within the Tanzanian health system.

Health workers often linked informal payments to structural problems within the health system, including: low salaries; shortages of health workers; lack of timely payment of employees' entitlements (leave allowance and extra duty allowance); and lack of medical equipment and supplies:

> *We know that salaries differ depending on the hierarchy and a person's position [role]. Let's take an example of registered nurse – their salary is very little; therefore this might lead them into corruption so that they can fulfil their needs.*
>
> (Health worker, Ilala, Dar es Salaam region)

Lack of medicines and medical supplies create space for sales of medicine and for conflict of interests, which can lead to corruption. Patients are unaware whether there are medicines in the facility or not. Sometimes health facilities do not receive their medical supplies on time or they receive insufficient quantities to serve their catchment areas, as an assistant medical officer explained:

> *The supply is very little and is not on time. Most of the time these medical supplies and drugs are not on time. You can go to any public facility as an elder, pregnant woman or a child under five years old, you might be prescribed with a lot of medicine but when you go to the pharmacy you will be told the medicine is not available. This person might talk to the nurse or doctor and say that he has been prescribed medicine which he is required to be given for free and the nurse or doctor will tell him to pay something so as to get the medicine.*
>
> (Assistant medical officer, Kinondoni, Dar es Salaam region)

Lack of timely payment of employees' entitlements such as overtime allowances, leave allowances and lack of promotion can motivate health workers to engage in informal payments so as to solve their financial problems:

> *There are some employees who haven't received their leave allowances for six years and others have stayed for about nine years without receiving promotion, such things might contribute to corruption.*
>
> (Health worker, Ilala, Dar es Salaam region)

Study participants also acknowledged that the exemption policy is not working and is a burden to health facilities. For example, although pregnant women and children are eligible to receive free services in public health facilities, this is rarely the case in practice. Health facilities do not receive any reimbursement from the government or sometimes they receive relatively little compared to the exempted population.

3.5. Informal payments solve problems for patients

Study participants indicated that patients are willing to make informal payments to health workers so as to solve problems for themselves. The health workers interviewed often reported that patients were concerned that they would not receive quality services unless they made a payment. Patients also believe that making informal payments ensures that they will be attended to quickly or prioritised for treatment, as these quotations illustrate:

> *I think that other people are used to corruption and they think that if they do not give bribes, they won't receive the right service or they won't be attended quickly. I think the community has this belief that you can't get good services unless you give something.*
>
> (Registered nurse, Ilala, Dar es Salaam region)

> *They just feel like their patient is not getting enough attention as needed. One might see that the patient's drip is almost over and no one is concerned to put a new drip. Such things are what makes the relative start looking for a nurse so that his patient can be given enough attention from the time of admission until being discharged to go back home.*
>
> (Health officer, Pwani region)

> *Other people have the mentality that health workers do not provide quality care so a person wants his patient to receive quality care or to be favoured or maybe a nurse should pass to see him every time. In such circumstance, a person talks to the nurse asking her to take good care of a patient and gives her some money.*
>
> (Health worker, Bagamoyo, Pwani region)

Patients also pay health workers money as a guarantee to receive good services in the future and as a means of establishing a relationship between the patient and the provider. For example:

> *You depend [on the hospital] to get healed. That's why someone might think that if I annoy the service provider another day when I come back, it will be chaos. So it's better I offer him at least 10,000 shillings so that when I come back another day, things will go smoothly.*
>
> (Health officer, Pwani region)

Normally, patients will not complain if the service is delivered as agreed, but they will complain if they are not satisfied with the quality of care. This shifts the balance of power away from the health worker and towards the patient, which makes some health workers uncomfortable. This has previously been reported in the literature (Mæstad and Mwisongo, 2011). Some health providers are reluctant to engage in informal payments because once the patient has given a bribe, they are in a stronger bargaining position, regardless of the amount they paid:

> *If you receive an informal payment from a client, you become his slave. Sometimes I think that if you receive money from a patient, it is like being his slave because he knows that he has already paid you, so he thinks that he has the right to hold you accountable. I think that taking an informal payment makes you become obliged to the patient because every time when he sees you, he knows he can control you because he has already given you an informal payment. But if he hasn't given you an informal payment, you are the one who will be in a position to control him and exercise your duties as a health worker.*
>
> (Assistant medical officer, Mkuranga, Pwani region)

4. Conclusions

This study sought to understand the determinants of and spaces in which informal payments take place in the Tanzanian health system and the role of individuals and networks of actors in this form of corruption. Informal payments are often presented as a singular practice, driven by particular social norms and system inefficiencies. In contrast, our research shows the range of ways in which informal payments are organised in the Tanzanian health system. Our study participants identified informal payments as more prevalent in hospitals, with few incidences in dispensaries. Within these hospitals, our findings suggest that informal payments are much more common in surgical settings, maternity and labour wards, the outpatients' department and the mortuary; and that payments are taken from doctors who refer patients between different departments and specialisms in hospitals. On maternity and labour wards, patients (or their relatives) appear to make informal payments to individual health workers to ensure that the woman giving birth is comfortable and attended to quickly, especially during the night. In the outpatients' department and on surgical wards, informal payments are made to groups of actors working together. At the outpatients' department, the networks appear to be smaller, possibly between medical attendants and medical officers or doctors. Within surgical departments, the size of the networks of actors involved seems to drive higher informal payments, but more research is needed to understand whether this is the case.

Informal payments that take place within groups of actors appear to be especially difficult for health managers to identify and so act on. This is because so many health workers are involved, and it is against the interest of all actors involved to inform managers of poor practice. While patients could be involved in reporting these informal payments, our research also suggests that if they receive a good service or good care after they have made an informal payment, then they are unlikely to make a complaint or report. These individual and group incentives make it challenging for transparency-based anti-corruption interventions to be effective in these departments.

Study participants reported many incidences of informal payments in mortuary services, initiated by mortuary attendants when relatives go to identify the deceased's body or to pick the body up from the mortuary before burial. Also, relatives tend to pay informal payments to mortuary attendants as they believe that if they did not make such payments, their relative's deceased body would not be treated well.

Several problem-solving factors that motivate health providers to engage in informal payments were identified during our research. We grouped these factors as health system drivers of informal payments: low salaries; shortage of health workers; lack of timely payment of employees' entitlements; lack of medical equipment and supplies; and lack of supervision. Participants cited low salaries as the main driver for health providers engaging in informal payments. Any strategy that seeks to tackle informal payments in different settings in the Tanzanian health system therefore needs to take account of these problem-solving functions that such practices entail.

5. Recommendations

Our findings suggest that there need to be a variety of strategies to counter informal payments in the Tanzanian health system. In surgical and outpatients departments, informal payments appear to be driven through hierarchical networks that are created within the health system among groups of actors that have worked together, possibly for a number of years. Interventions should focus on disrupting these group incentives by changing shift systems, by rotating clinicians, medical officers and other senior members of staff, and more junior members of staff who appear to control networks in surgical departments. Targeted health systems interventions would increase the supervision and management of care staff in maternity and labour wards at night to ensure good-quality, equitable care and make it more difficult to trade attentive care for an informal payment.

Our findings suggest that at least some of these informal payments solve problems for health workers and patients, and that these problems fall under the health system drivers, which include low salaries, lack of timely payment of health worker entitlements, lack of medicine and medical supplies, and shortages of staff. There are also drivers that relate to clients' (patients) and health workers' attitudes and behaviours, as well as poor supervision. These can be addressed by strategies within the health facilities, which are likely to have a greater impact.

Anti-corruption strategies should address both the individual and the health system drivers of informal payments. Some suggested strategies include the following:

- Allocate sufficient funding to the health sector to resolve issues such as low salaries, payment of health worker entitlements, and shortage of medical equipment and supplies.
- Strengthen effective supervision to address the fact that informal payments are mostly taken at night or during weekends and public holidays when there are no supervisors present. Supervision can be strengthened by ensuring that supervisors are scheduled to be present at every shift.
- Raise public awareness about whether fees are to paid for a particular service by displaying the client service charter in health facilities and broadcasting recorded messages about service delivery instructions. Also, health facilities should display a phone number people can call should they wish to make a complaint about the service or care they received.
- Disrupt networks of actors involved in receiving informal payments by changing shift systems, especially in hospital outpatients and surgical departments.
- Informal payments that take place at night between individuals in the maternity and labour wards might be better managed through increased supervision and management, to improve transparency and accountability.
- More research is needed on mortuary services as they are rarely mentioned in the literature on corruption in health systems.

6. Limitations of the study

The study was conducted only with front-line health workers in the three regions of Tanzania, so is missing service users' perspectives. Future research should include service users so as to capture their perspectives on what really drives them to make informal payments and to inform effective solutions that would make such payments unnecessary.

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