

# Understanding informal payments in healthcare: motivation of health workers in Tanzania

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# **Abstract**

## **Background**

There is growing evidence that informal payments for healthcare are fairly common in many low- and middle-income countries. Informal payments are reported to have a negative consequence on equity and quality of care; however it has been suggested that they may contribute to health worker motivation and retention. Given the significance of motivation and retention issues in human resources for health, a better understanding of the relationships between the two phenomena is needed. This study attempts to evaluate to what extent informal payments occur in Kibaha, Tanzania. Moreover, it aims to assess if, and to what extent, informal earnings help boost health worker motivation and retention.

## **Methods**

Nine focus groups were conducted in three health facilities of different levels in the health system. To the extent possible, focus groups were divided by cadres. In total, 57 health workers participated in the focus group discussions (78% female, 22% male). All data was processed and analysed using NVIVO.

## **Results**

The use of informal payments in the study area was confirmed by this study. Furthermore, a negative relationship between informal payments and job satisfaction and better motivation is suggested. Participants mentioned that they felt enslaved by patients as a result of being bribed and this resulted in loss of self esteem. Furthermore fear of detection was a main de-motivating factor. These factors seem to

counterbalance the positive effect of financial incentives. Moreover, informal payments have not been related to retention of health workers in the public health system. Other factors such as job security seemed to be more relevant for retention.

## **Conclusions**

This study suggests that the practice of informal payments contributes to the general de-motivation of health workers and negatively affects access to health care services and quality of the health system. Policy action which not only provides better financial incentives for individuals but also tackles an environment in which corruption is endemic is needed.

## **Background**

The debate surrounding the financing of healthcare with user fees has dominated the research agenda during the last two decades [1]. Until the late 1990s, the charging of fees in low-income countries was seen as inevitable due to budget constraints, and even desirable given the positive impact user fees had on the quality of care and the discouragement of frivolous use of health services [1]. In recent years policy agenda has been directed towards the elimination of user fees due to concerns about equity [2,3] and access to health services [4], as well as the growing recognition of the inapplicability of the positive arguments in many contexts. However, it is clear that due to a general lack of resources for healthcare, the simple abolition of formal fees does not guarantee users with free services. In fact, there is growing evidence that informal payments are, in many low- and middle-income countries, the main source of healthcare financing [5].

In this paper, informal payments will be considered as unreported or unregistered illegal payments that have been received, in cash or in-kind, in exchange for the provision of a service (or of a faster or better service) that was officially free [6-8].

In Poland, informal payments have been estimated to contribute to “as much as double of the physician’s salary” (p.22)[9]. In Bangladesh earnings from unofficial charges exceeded the official salary by a factor of ten [10], and by a factor of five in Cambodia [11]. Recent studies have estimated that unofficial fees constitute 10-45% of total out-of-pocket expenditures for healthcare in the countries considered [6,11-13]. Evidence of the existence of informal payments has been found in at least twenty-two studies [7], almost all referring to low income countries.

Even if informal payments take the same form as official fees, as pointed out by Gaal [7] (p.256) they could be “the worst possible form of private financing” exacerbating the vicious effect of user fees often without producing positive consequences. First, they create a barrier to the accessibility of health services [13-19], which could affect the poor even more than official fees due to the unavailability of exemption policies [7], and the arbitrariness of the payment [20]. Second, informal payments compromise the efficiency of healthcare provision by directing resources to services that are more profitable rather than to the most effective ones [21], and to patients that are more profitable rather than to the patients most in need [22]. Third, they create perverse incentives that potentially represent an obstacle to health policy [14,20,21]. Finally, the informal nature of unofficial payments undermines governments’ ability to raise finances for health [5,6] and to regulate the financing of health care. On the other hand, some authors have suggested that part of “these payments can be regarded as cost-contributing since they may ensure that staff receive their reservation wage and

stay in employment” (p.7) [5,23]. In addition, sometimes patients may pay for improved services [5].

Health worker motivation and retention is increasingly being considered as a crucial response to the human resources for health crisis, especially in low- and middle-income countries [24,25]. In fact, the decision of health workers to migrate to other countries or take employment in the private sector is not solely due to de-motivation caused by insufficient salaries and extreme working conditions, but is also influenced by the difficult environment remaining workers face having to manage staff shortages due to the migration of health workers [26,27]. A number of studies have confirmed the predominance of financial incentives in determining health worker motivation and performance [28] . In fact, the relationship between inadequate salaries and the seeking of opportunities to raise earnings through the charge of informal fees has been strongly suggested [5,17,29,30].

The relationship between motivation, retention and seeking additional income in the public sector in the form of informal charges may not be straightforward. The use of such a practice can cause rivalries among health workers due to the competition for receiving payments, as well as the feeling of guilt and general discomfort [15]. This practice can de-motivate health workers more than retain them, especially in rural areas where patients are poor and for lower cadres of workers who do not receive a high share of the payments [15]. The extent to which each of these two possible relationships, positive or negative, apply has not yet been sufficiently investigated.

A clear understanding of the impact of informal payments on the health system has not yet been reached. It is clear that they represent a failure of the system, but Gaal’s (2006) argument that an available service still guarantees better access to healthcare

than no service at all needs reviewing. For this reason and given the context of a global health workers crisis [24] the specific relationship between informal payments, motivation and retention of health workers needs to be urgently investigated. Consequently, the authors explore the linkages between motivation, retention and informal payments using a case study from Tanzania

### **Background on Tanzania**

The human resource crisis has been particularly stringent in Tanzania, as a consequence of restrictive government policies in the last few decades which resulted in a freeze in health workers recruitment [31] . As a result, the country suffers from a critical staff shortage, particularly in rural areas. In 2002, there were 4 nurses/midwives per 10.000 population, and there were only 822 physicians for the whole country [32]. Health worker motivation seems to be a central factor in retaining existing health workers and increasing the attractiveness of the profession [33]. In addition, the practice of charging informal payments in the health care system seems to be fairly common in the country [15], but its relationship with motivation and retention has not been fully explored. The study had three objectives. Firstly to evaluate to what extent informal fees occur in the case study area of Tanzania and to what extent they represent a critical issue for the health system in the opinion of health workers. Second, assess if, and to what extent, informal earnings help boost the health worker motivation. Third, to understand if, and to what extent, informal payments contribute to health worker retention in public health facilities.

## Methods

The phenomenon of informal payments is extremely complex and sensitive. The approach taken in the study has been qualitative to allow for this. As pointed out by Miles and Huberman [34] (p.6), with qualitative research “the researcher attempts to capture data on the perceptions of local actors from the inside [...] and suspending preconceptions about the topics under discussion”. In addition, qualitative research enables the researcher to “explicate the ways people in particular settings come to understand, account for, take action, and otherwise manage their day-to-day situations”[34].

Since the practice investigated is illegal, the use of focus groups was preferred, for its aptitude in exploring a difficult and sensitive topic. In fact, focus group discussions allow the participant to withhold self-incriminating information, something that might not have been possible with the use of in-depth interviews.

This research has been carried out in the district of Kibaha, Pwani region. This district is relatively close to the commercial capital of Dar es Salaam, but still mainly rural. Per capita income of the region is along the average of the country [35]. Given that the issue analysed is in some ways connected with the income of the patients, the selection of an average region can help the generalisability of results.

Health facilities of different levels in the health system were selected. The district hosts only one regional hospital (Tumbi) and one district health centre (Kibaha Health Centre); both of which have been included in this study. The study was originally expected to include at least two health dispensaries; however, due to the small number

of health workers in the dispensaries it was only possible to hold the FGD by stopping all other activities. This is unethical and so the study only includes one dispensary.

All focus groups discussions were recorded with the permission of participants according to best practice [34] and field notes were taken. Discussions were transcribed in Kiswahili and then translated into English. All data was processed and analysed using NVIVO. Discussions were coded following the technique described by Strauss and Corbin (1990), adapted to the use of NVIVO. A list of the codes used is provided in additional file 1. Data were reviewed line by line and categories (Tree Nodes) were attributed to key concepts. During the process, sub-categories were identified and sub-codes (Child Nodes) were added. All the codes were created while keeping in mind the research questions. Two out of nine documents were checked to ensure that code-recode consistency was above 90% [34]. After coding all documents, each Tree Node was reviewed separately to check the appropriateness of the content.

## **Results**

In total, nine focus groups were conducted and where possible groups were divided by cadres. Due to this requirement, six out of nine focus groups were held in Tumbi regional hospital, which had a large number of employees available for each category, allowing the research team to conduct the focus groups without stopping routine activities. Furthermore, when more than one group was to be held within the same category, at least one was composed of females only.

A total of 65 health workers were approached by the clinic managers, who acted as gatekeepers, of which 57 (88%) participated in the focus group discussions (78% female, 22 % male).

Focus group discussions lasted between 1 and 2 hours depending on the size of the group and of the cadre. In general, it was observed that the lower the cadre, the longer the duration of discussion. Groups composed only by females tended to develop better group dynamics than mixed ones, confirming the literature on the topic [36]. All focus groups apart from one were carried out in Swahili with the help of a local researcher. In the focus group held in English, it was observed that participants were much less likely to participate and become involved in group discussions. For this reason, the remaining discussions were conducted in Swahili.

### ***Job satisfaction***

In general, health workers do not seem to be satisfied with their jobs. Even though almost all participants recognised that they appreciate and like their job, they expressed dissatisfaction because of the low salary and difficult working conditions.

*It's not necessary that I'm not feeling happy; I can be feeling happy despite being paid little. But I'm not satisfied (Nurse, Tumbi Hospital).*

Clinical officers and medical attendants tended to be completely dissatisfied, which could be due to the fact that these two particular categories, in addition to low salary and heavy workload, suffer from an absence of job specification. They complained that they did not know what their duties were and were asked to do anything.

*This job is very hard and salary is low, and makes me very unhappy (Medical Attendant, Kibaha Health centre).*

### ***Salary***

Almost 30% of all text was coded as “salary”, showing how important this issue is for health workers. Even though a strike of health workers in 2005 resulted in pay being improved by more than 70% for doctors, and by around 30% for nurses, clinical officers and medical attendants, salaries are still very low when compared to the cost of living and the inflation rate, especially for low cadres. Indeed, salary was frequently reported as insufficient when compared to needs and workload.

*We are seriously living in a hard condition: salary itself can never sustain even food for the whole month, not to talk about school fees for our school children (Health Worker, Dispensary of Mwendapole).*

*On my side the work is good but payment is very low comparing to the work we do (Midwife, Tumbi Hospital)*

Often health workers experienced consistent delays in payment or missing refunds of travel expenses. Moreover, salary is not adjusted for risks and for responsibilities.

### ***Coping strategies***

When asked to discuss the strategies adopted in order to cope with the difficult situation, health workers mentioned the possibility of borrowing money, reducing expenses, relying on Labour Unions, running small private business, growing vegetables to sell at the market, doing extra-jobs not in the health sector, working in the private sector as health professionals, and charging informally for services.

Moving to the private sector and especially to jobs with NGOs was described as an opportunity, but only for doctors and nurses. This could help to explain the lower job satisfaction noticed among other cadres. However, the private sector, even if it offers

higher salaries and better working conditions given the availability of drugs and equipment, lacks *job security* and is profit oriented.

*For those who are running to the private sector, it is because of salary but some hate to be in private sector simply because there is no job security, people are offended, no job satisfaction, tyrannies, and you can even loose the job anytime. Bad enough, in private sector you can learn some behaviours that we never expect from the public sector simply because they're profit minded. (Doctor Specialist, Tumbi Hospital).*

The issue of job security was found to be particularly important for health workers; some even stated that they would not have accepted even double salaries offered in the private sector because job security was not guaranteed. All groups raised and discussed this issue, even if it was not included in the focus group guideline. The value given to job security can be due to the high unemployment rate and to the low recruitment rate in the public sector. In case of job loss, the possibility of being unemployed was seen as extremely high.

### ***Informal payments***

Evidence of the existence and use of informal payments in the selected health facilities was confirmed, even if not every participant agreed. Sometimes participants recognised that the phenomenon may exist in other health facilities, but not in theirs (Tumbi Hospital). Different typologies of informal payments were described.

Interestingly, participants frequently commented that unofficial payments were more commonly patient initiated than provider led:

*There are two different languages about this issue, one is when the health workers force the patients to give payments to them before service and this situation is not so*

*common to happen since the health workers will not be sure of the identity of the patients who could be a policemen or related. Second is when patients themselves force the health workers to receive gifts and money from them and this is very common. Most of the patients are having the idea that to get a quality service then they should give the health workers something so that they will be much considered (Clinical Officer, Tumbi Hospital)*

The interpretation of this is quite tricky, as staff may wish to defend their integrity in the focus groups together with the practice of charging. The fact that it is the patient offering the payment to the health worker may not exclude the compulsory nature of the fee. An “unwritten” rule known by both actors could be in operation.

Nevertheless, the patient seems to be empowered by paying fees. Patients pay in order to obtain better or faster services, for example, by jumping the queue.

Many participants also described the circumstance where having paid a little bribe the patient felt entitled to control the health worker through the entire episode of illness. This was the main de-motivating factor for health workers in accepting informal payments.

*Also the patients themselves after giving something they do control the health workers, you find that they don't respect the hospital regulations simply because of the favour that he/she gave to the health workers (Doctor, Dispensary of Mwendapole).*

*Bribery is a torture to health attendants, because even when you succeed to receive bribery from a person or patient then you will be locked to him for he won't allow you to serve anyone else than him (Midwife, Tumbi Hospital).*

The consequent “slavery” to the patient is perceived as humiliating and degrading. Staff also was found to be recommending patients to services or treatments in their own private practice:

*They just tell them: this is the address of my clinic, come this afternoon, come tomorrow. This is the normal thing (Nurse, Tumbi Hospital).*

The amount taken as an informal payment seems to vary with the category of health worker. It is generally between 500 and 2,000 Tsh (1,000 Tsh = 0.53 Euro) for medical assistants or nurses, but could be much higher for doctors and specialists, where amounts from 10,000 to 200,000 Tsh were mentioned.

Participants from all the groups recognized that the main reason for informal payments from the provider perspective was the inadequacy of salaries when compared to the needs of staff. All groups reported having difficulties in facing all the expenses until the end of the month, and even if they admitted not to be happy with the situation, they generally perceived the practice of asking for bribes as necessary and justified by the situation.

*Just imagine if a nurse or a doctor leaves nothing at home for that day. It's easy thing and normal for a person to ask for bribes in any places, so it is in the hospital. If one could be paid well and could provide for his family, he could leave in peace and attend patients well (Midwife, Tumbi Hospital).*

Inadequate working conditions, disproportionate workload, absence of risk allowances or transport allowances, shortages of health workers have also been mentioned as reasons to explain the practice from the providers' perspective.

As suggested by health workers, instead, patients are sometimes motivated by the belief of getting higher quality services or by the need or the willingness to be treated faster.

Widespread corruption in the government, in all the public sectors and of top managers and clinics managers in the health sector has also been mentioned as a factor which could justify and encourage the same practice to be adopted throughout the system.

When asked to describe how the phenomenon could affect the health system, all participants agreed that access to healthcare was seriously compromised by this practice. It appears that poor people are unable to afford even primary care, while the majority of the population cannot access specialized services at all in urban public hospitals.

Very frequently health workers reported that not only access but also quality of the health system was seriously compromised by this phenomenon. Informal payments create competition among health workers; induce dangerous income seeking behaviours and direct staff attention to profitable patients/ services instead of necessary ones. Participants also mentioned that informal payments could damage the reputation of the category of health workers and of the hospitals involved.

### ***Informal payments, motivation and retention***

The analysis of the perceived relationship between informal payments, and motivation and retention in the public health sector has yielded controversial and discordant results. For the majority of groups, informal payments were one of the strategies by which health workers cope with salaries that are sometimes below a reasonable level, but were not the reason for staying in the public sector, see later.

*I just want to say that for those who are engaged in informal payments they are not happy of that. They are forced with hard environment and their little income (Health Worker, Dispensary of Mwendapole).*

The fear of being caught or accused is one of the main sources of discomfort and demotivation.

*When you receive bribery you become uncomfortable, even if you receive corruption from patient you become afraid, you become insecure in such a way that sometimes when you hear a knock in your office you become afraid or if one talks about bribery you become confused. We don't like this situation, really it's not good (Midwife, Tumbi Hospital).*

The discomfort of being involved in a situation they know has serious consequences on poor peoples' access to health services, has also been reported very frequently.

*On my side bribery is a trouble and a disturbance, and pity to those who are unable to give anything to be treated (Midwife, Tumbi Hospital).*

Another issue described is the competition that informal payments create among and within categories. Since it is unlikely that a patient or his relatives can afford to bribe

all the health workers involved in their treatment during an illness episode, they would have to select who to corrupt and this is a source of rivalry and discontent.

However, in general other factors were more important in the decision to stay in the public sector. First of all, job *security* was mentioned as the most important factor. In addition, opportunities of further education and training were considered important by certain categories such as nurses and midwives. Clinical officers, instead, reported that the peculiarity of their category would not allow them to switch to the private sector or to migrate so easily. All categories, apart from specialists, conveyed that migration to other countries would have been difficult because they were not fluent in English, as Swahili was more commonly spoken and written.

As expected, given the reasons reported for the existence of this phenomenon, health workers proposals on how to reduce the problem were all focused on incentives.

The need to obtain salary increases was reported by all groups. After that, they mentioned the need to increase working conditions through better equipment, training opportunities and better management. The possibility of being compensated for risks, transport fees, night work and uniforms was often described as important in increasing job satisfaction and loyalty to the government, therefore decreasing illicit behaviour.

In addition, they mentioned the importance of implementing policies discouraging corruption in the entire public system by increasing accountability and transparency. Increasing patients' awareness of the issue and educating people to respect rules was also seen as crucial.

Sometimes, priorities on government expenses were strongly questioned, as prior attention by the government was given to the army, police, and the education sector *“because teachers were doing more strikes”*.

## **Discussion**

Informal payments have been reported to be very common in Tanzania in all levels of care and among all health worker categories. The amount paid varied depending on the services required and seemed to rise with the increase of specialisation. They have been described as a coping strategy employed to respond to the circumstance of earning a salary that is insufficient to cover basic needs and incompatible with workload, responsibilities and risks taken. On the opinion of the health workers involved in this study, their impact on both access and quality of the health system is undoubtedly negative, contradicting the hypothesis of a possible positive impact over quality.

A synthesis of the framework of informal payments as emerges from this study is presented in Figure 1. A generally widespread discontent of health workers has been observed. They appear to be de-motivated, dissatisfied and unhappy with their profession and their working environment. Interestingly, the same reasons behind job dissatisfaction were found to be behind the providers' justification of informal payments.

Based on the results of this study, it appears that most health workers are de-motivated by accepting informal payments rather than motivated. It seems that informal payments are asked for and accepted, but only because it is the easiest way of coping with a salary that is not in line with their need and workload. It seems that

informal fees while increasing financial incentives may at the same time lower motivation. In fact, informal payments are a particular form of financial incentive which is associated with other factors such as fear of being detected, loss of self-esteem, a sense of guilt and humiliation. Informal payments contribute to an environment of corruption and dishonesty which in turn create dissatisfaction, discomfort and de-motivation among health workers. This may be true for all cadres apart from doctors. This study suggest that doctors, and particularly specialists, practice dual jobs in the majority of cases, and they often use their public job to maintain their reputation and recruit their patients for their private clinics is much more likely. However, the practice of shifting patients from public to private sector is slightly different from the charge of informal fees for the provision of services offered in the public facilities, even if it can have the same effects for patients.

Results from this study also suggest that informal payments probably do not much contribute to retention in public health facilities. It has been stated that the fact that health workers would accept a salary below the subsistence level indicates that there are factors that affect motivation other than the official wage (p.7) [5]. In a context of high unemployment, temporary jobs and absence of labour rights, the emphasis that participants give to job security suggests that other factors can be more relevant.

Moreover, if it is true that “a health worker will accept a job if the benefit of doing so outweighs the opportunity cost” (p.1310) [37], it is also true that the opportunity cost associated with working in the public sector can be very low, and benefits can go beyond salary and gratification. In Tanzania, as noted, the lack of English fluency represents a great obstacle to migration. Furthermore, certain health categories as clinical officers, medical assistants, nurse aids, have been created with the special purpose of not being “exportable”. Therefore, if other more attractive jobs are not

available, benefits of staying in the public sector, however low, are at least higher than the alternatives, which may be unemployment or subsistence farming.

This study had several limitations. The study was informative and exploratory, and the findings cannot be generalized outside of similar contexts. Moreover, possible biases could have occurred in the selection of participants. Participants have been chosen randomly whenever possible but the gatekeepers carried out the selection. It is therefore possible that the gatekeepers purposely chose more loyal health workers to preserve the reputation of the clinic. This may have led to an underestimation of the phenomenon. Furthermore, the need to divide by cadres and ensure the continuance of the activity in the clinics has limited the number of health workers involved in the study, and this could have hampered the richness of the discussions.

## **Conclusions**

This study suggests that, at least in this context, informal payments may de-motivate health workers more than motivate them. This can be explained by negative factors involved with this practice, such as fear of detection, loss of self-esteem and sense of guilt, which counterbalance the positive financial incentives. With the possible exception of specialists, this study suggests that informal payments probably do not contribute much to the retention of health workers. On the contrary, other factors such as job security and lack of alternative employment may play a more important role in retaining staff. As suggested by health workers in this study, the practice of informal payments contributes to the general de-motivation of health workers and negatively affects access to health care services and quality of the health system. The generalisability of this study is limited by the size and methodology adopted. Results

are therefore applicable only in similar contexts. However, even though further research is needed on this topic, the picture emerging requires urgent policy action which not only provides better financial incentives for individuals but also tackles an environment in which corruption is endemic. The reduction of informal payments will have a positive effect on access to and quality of health care.

## Competing interests

None

## Authors' contributions

Please see sample text in the instructions for authors.

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## Figures

Figure 1 – A new framework for Informal Payments

## Additional files

Additional file 1 – Code List

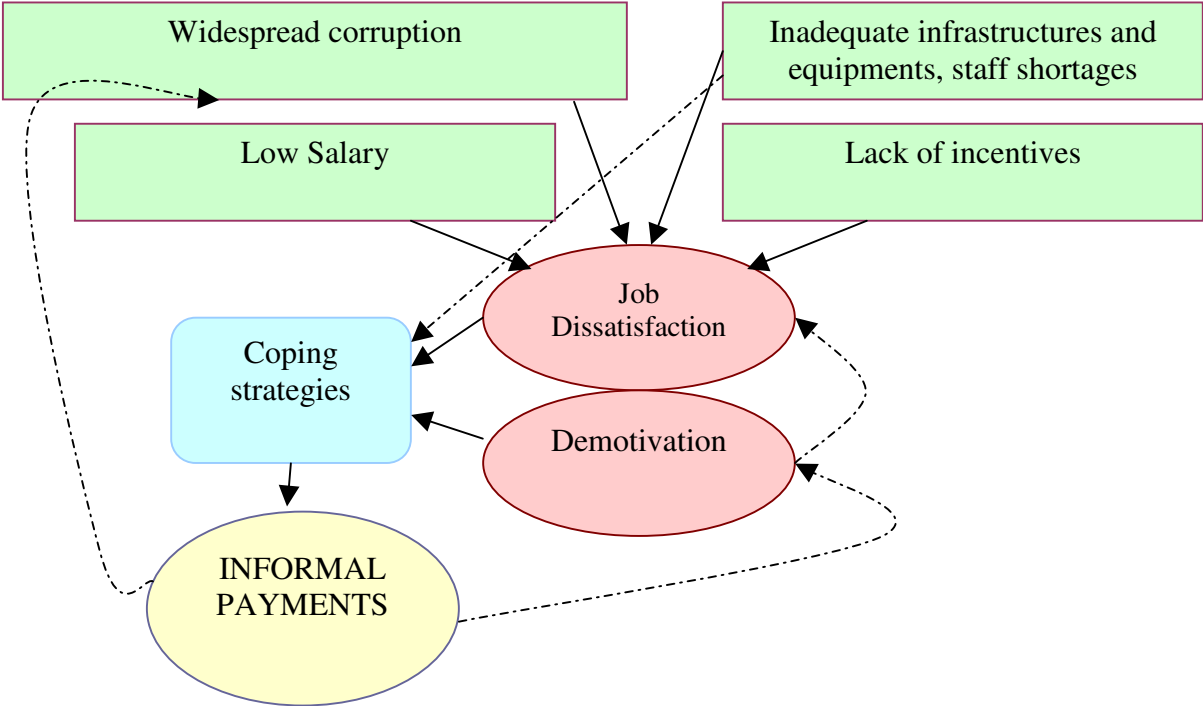


Figure 1

**Additional files provided with this submission:**

Additional file 1: code name.doc, 67K

<http://www.human-resources-health.com/imedia/5598508262497991/supp1.doc>