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Research

Keywords: Malawi, Informal Payment, Public Health System, Access to Healthcare

Posted Date: January 11th, 2021

DOI: <https://doi.org/10.21203/rs.3.rs-141193/v1>

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Informal Payments in Public Hospitals of Malawi – A Case of Kamuzu Central Hospital

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Abstract

Background: Informal payments in public health facilities act as a barrier to accessing quality healthcare services especially for the poor people. There is growing evidence that in most low-income countries, most poor people are unable to access quality health care services due to demands for payments for services that should be accessed for free. This research was aimed at investigating informal payments for health care services at Kamuzu Central Hospital, one of the referral public hospitals in Malawi. Results of this study provide evidence on the magnitude and factors influencing informal payments in Malawi so that relevant policies and strategies may be made to address this problem.

Methods: The study employed a mixed methods research design. The quantitative study component had a sample size of 295 patients and guardians at Kamuzu Central Hospital (KCH). The qualitative study included 7 in-depth interviews with key informants (health workers) and 3 focus group discussions with guardians. Each FGD had 10 people. Thus, in total the whole qualitative sample constituted 52 participants. Quantitative data was analyzed using Excel and STATA. Qualitative data was analyzed using thematic content analysis approach.

Results: 80% of patients and guardians at KCH had knowledge of informal payments. About 47% of the respondents admitted paying informally to access health care services at KCH and 87% of the informal payments were made at the request of a health worker. The study identifies lack of knowledge, fear and desperation by patients and guardians, low salary for health workers and lack of effective disciplinary measures as some of the key factors influencing informal payments in the public health sector in Malawi.

Conclusion: Informal payments exacerbate inequality in the access of health care services that should be provided for free. Specifically, poor people have limited access to quality health care services when informal payments are demanded. This practice is unethical and it infringes on people's rights to universal access to health care. There is need to strengthen the public health care system in Malawi by formulating deliberate policies that will deter informal payments.

Keywords: Malawi, Informal Payment, Public Health System, Access to Healthcare

Introduction

Equitable access to health service is a fundamental requirement in provision of health care. Public health services in Malawi are provided for free to all Malawians through the Essential Health Package (EHP) to promote universal access to healthcare [1]. However, since the majority of the population in Malawi; above 60% is living below US\$1.25 per day [2], informal payments act as a barrier and violate right to healthcare access by poverty stricken Malawians and limit people from accessing health care services. Informal payments are described as unreported or unregistered payments that have been received in exchange or to fast-track provision of a public service that is officially free [3]. It is argued that informal payments are inevitably linked to corruption, and also defined as “the use of public office for private gains” [4]. Health sector-related research often uses the concept “informal payments” to label the exchange of money, gifts or services between patients or their families and healthcare personnel [5].

There is growing evidence that many low-income countries have limited access to quality health care services due to demands for payments required for services that should not be paid for [3,6]. The challenge about informal payments is that they are shrouded in secrecy and therefore difficult to document [2]. This “under the table” payment motivates the health worker and can also influence the physician on what health care services to provide to which patient [7]. In general, informal payments in public hospitals are seen by most as being morally undesirable and unethical [4] and can result in low quality service, in terms of time and services. It is also suggested that poor working conditions and social-cultural environment force the health workers to indulge in informal payment [9].

According to the literature, informal payments are an important barrier to healthcare utilization for low-income patients [10]. A multi-country study in Africa found that 50% of the poorest households were more likely to make informal payments at public facilities and socio-economic disadvantage by itself directly exposed patients to informal payments [11]. The study further found that the poorest households often delay seeking help or do not seek help at all when they are ill because they cannot afford to make informal payments.

Despite health workers being the perpetrators of the malpractice, some patients give informal payments as ‘a gift’ while in the real sense they seek to obtain quality service and to receive care fast [4]. Others do not participate in the informal payments as they believe it is not proper and others cannot afford the informal payment due to poverty/lack of money. Patients paying informally usually *jump the queue, receive better service or more care*. Such payments have the potential to limit access to healthcare services on patients who do not have the ability to pay and are in greatest need [12].

Informal payments for health services are common in many countries globally especially in low and middle income countries [13]. For instance, a Bulgarian study found that about 13% of users reported informal payments for out-patients visits and 33% of users reported to have paid informally for hospitalizations [14]. The average amount paid by inpatient services was nearly twice higher than that for outpatient services. More than 50% of the sample had a negative attitude towards informal payments but about 27% of respondents had a positive attitude towards the practice. It also reported that Albania, one of the poorest countries in Europe, provides most health care services free of charge, but still more informal payments to medical personnel are common [15]. Its studies suggested that 60-70% of Albanian citizens made informal payments to hospital doctors in order to receive services. Factors that influence informal payments in Albania included

low salaries of health workers, desire to get better quality care, the tradition of giving gifts to show gratitude and lack of deterrents [16].

In Niger's health sector, informal payments practice is given a socio-cultural explanation such as 'voluntary' behavior, and is said to be related to an endemic culture of gifts in Asia, Central, Southern and Eastern European countries [17]. Gifts are not thought to generate inequalities among patients or to affect the distribution of health services.

In Tanzania, a similar study found that the health workers at all levels receive payments in a number of different contexts [13] and that the workers sometimes shared the payments across the cadres. Other findings indicated that health workers were involved in 'rent seeking' activities such as creating artificial shortages and deliberately lowering the quality of services in order to get extra payments from the patients and it was also concluded that this behavior impacts negatively on the quality of healthcare.

There have been a few reports of informal payments in healthcare in Malawi [18], however, a review on the subject shows that literature is limited, hence the need to do a study on informal payments in the public hospitals. Very few studies offer a glimpse into the existence of informal payments in healthcare in Malawi, but have not documented the magnitude of the problem. One of the studies found that due to low salaries health workers are tempted to get gifts or demand payment from patients for a service [18]. Patients are sometimes pressured to pay for services provided at the public health facility, which are officially provided for free so that they are attended to faster or get a better service [2]. This is affecting the achievement of Universal Health Coverage (UHC) whereby all people are supposed receive quality and affordable essential health services [2]. Therefore this study was aimed at investigating the magnitude and factors influencing informal payments in healthcare in Malawi in order to determine its existence; the factors that influence the

existence of informal payment; services that are associated with informal payment and challenges that guardians and patients as well as the health system faces as a result of informal payments. The findings may help to influence policy formulation on curbing the malpractice.

Methods

Study Design and setting

A cross sectional study, using mixed methods approach, was conducted at Kamuzu Central Hospital located in the central region of Malawi between July 2017 and June 2019. KCH was chosen because it is the largest referral hospital in the central region and Lilongwe District, the capital city Malawi. KCH provides tertiary health services to a catchment population of over four million. This study was conducted in gynecology, surgery department, out-patient department and eye department. These departments were chosen because they were the ones highly patronized and the researcher felt they would provide rich data.

Study population: The study targeted patients, guardians and staff at KCH. It also included national level key informants at the Ministry of Health, Directorate of Quality Management. The staff (hospital managers and heads of departments at KCH) were interviewed as key informants. Three focus group discussions and seven key informant interviews were conducted.

Sampling and sample size determination

To calculate sample size for the quantitative component the study adopted a statistical formula proposed by Cochran and expanded by Yamane to calculate the sample size for this study [19]. KCH receives about 800 patients every day. At 95% level of significance, the study had a sample

size of 266. Adjusting with 10% non-response, the study had a final sample size of 292, which was randomly recruited. For the qualitative component, the study had 7 key informants, which were purposefully selected, and 3 focus group discussions. Key informants included staff personnel from KCH (hospital managers and heads of departments) and one member from the Quality Management Unit.

Data Collection and Analysis

A structured questionnaire was administered to collect quantitative data, whilst in-depth and FGD guides were used to collect qualitative data. Data collection instruments were translated and piloted prior to data collection.

Quantitative data were analyzed using STATA and the data were further presented in tables and graphs. To determine the relationship between frequency distribution of respondent based on demographic factors and informal payments, we used Fisher's exact test and to determine the relationship between frequency distribution of respondent, based on other variables and informal payments, using chi-square test.

Thematic analysis was used to analyze qualitative data. All FGDs and KIIs were tape-recorded and transcribed verbatim, with the FGDs being translated into English for analysis. Careful and repeated reading of transcribed texts helped the researcher to identify patterns and trends of participant responses. The data was coded manually, themes were induced and deduced and categorized based on similarities and differences.

Study limitations: Locating participants was a challenge as some potential participants were unwilling to provide sensitive and accurate information due to the sensitivity of the study. Time

and resource constraints were also limiting factors and forced the study to be conducted only at KCH instead of all the central/ referral hospitals in Malawi.

Results

Demographic Characteristics of the Study Respondents

In total, there were 298 respondent who participated in this study. Among these 134 (45%) were men, whilst 164 (55%) were women. Table 1 below presents in detail the demographic characteristics for the respondents according to gender.

Table 1: Demographic characteristics of study participants according to gender

Characteristic		Male (n=134, 45%)	Female (n=164, 55%)
Age range	18-25 years	32 (23.9%)	33 (20.1%)
	25-35 years	44 (32.8%)	47 (28.7%)
	35-45 years	39 (29.1%)	39 (23.8%)
	45-55 years	15 (11.2%)	28 (17.1%)
	Above 55 years	4 (3.0%)	17 (10.4%)
Marital status	Married	99 (73.9%)	123 (75.0%)
	Divorced/separated	12 (9.0%)	5 (3.0%)
	Widowed	3 (2.2%)	3 (1.8%)
	Never married	20 (14.9%)	33 (20.1%)

	Formal		
Occupation	employment	38 (28.4%)	68 (41.5%)
	Self-employed	50 (37.3%)	44 (26.8%)
	Not employed	45 (33.6%)	52 (31.7%)
			0 (0.0%)
	Others (specify)	1 (0.7%)	

Informal Payment according to selected demographic characteristics

Table 2, presents the median of informal payments made in cash with consideration to demographic features of the participants. There was no significant relationship between median of informal payments made with respect to age (P=0.022), gender (P=0.4520) and marital status (P= 0.075) patient demographics but were significant on characteristics, age group and occupation (P=0.034).

Table 2: Informal payments according to the demographic characteristics of respondents

	Variable	median(payment)	Test
Age	18-25	4055	Kruskal
	25-35	7264	Wallis
			P = 0.022
	35-45	4360	Significant
	45-55	12809	

	>55	18846	
Gender	Males	12394	Kruskal Wallis P = 0.4520
	Females	5027.27	Not Significant
Marital status	Married	4000	Kruskal Wallis P = 0.075
	Divorced/separated	600	Not Significant
	Widowed	25000	
	Never married	2750	
Occupation	Formal employment	5000	Kruskal Wallis P = 0.034 Significant
	Self-employed	3000	
	Not employed	3500	

Table 2.1 below shows that occupation and age of patients highly influenced the probability of payment for health care respectively (correlation coefficient = 0.1168; p-value = 0.04) and

(correlation coefficient = -0.2802; p-value<0.001). However, informal payments paid for patient care were not statistically correlated to the marital status and gender for patient care respectively (correlation coefficient = 0.1011; p-value = 0.0816), (correlation coefficient = -0.0346; p-value = 0.5522).

Table 2.1: Correlation coefficient of covariance on informal payments		
Characteristic	Coefficients	
Payment	1	P=0.0439
Occupation	0.1168	1
Payment	1	P=0.0816
Marital status	0.1011	1
Payment	1	P=0.5522
Gender	-0.0346	1
Payment	1	P<0.001
Age range	-0.2802	1

Existence and magnitude of informal payments

The study found that 97% (240/248) of the participants knew about the existence of informal payments in public hospitals and 47% of them had experienced paying for health services informally in form of cash (Table 3). The median amount paid by patients irrespective of age and gender was MK 600 (USD 0.83). It was also established that 87% of the informal payments were requested by health care worker and 13% percent were initiated by the patients themselves. **Table 3** below presents results on knowledge of informal payment for health care among clients and patients attending curative services.

Table 3: Payments for health services reported by patients exiting the health facility

	Male		Female	
<i>N</i>	134		164	
	Yes	No	Yes	No
	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
Knowledge of Paying services	110(74 -87)	24(13–25)	131(72-85)	33(14–27)
Of those that paid for services received, median amount paid (MK):				
	Median (IQR)		Median (IQR)	
<i>N</i>	62		66	
Paid for services	1000(2250.00 -5000.00)		600(2000.00-6000.00)	
<i>N</i>	52		67	

Table 3: Payments for health services reported by patients exiting the health facility

	Male		Female	
<i>N</i>	134		164	
	Yes	No	Yes	No
	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
	HCW	Patient	HCW	Patient
	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
Who initiated the informal payment	87(74 -94)	13(07–25)	87(75-92)	13(07–25)

From qualitative side, some guardians indicated that they were aware that informal payments were practiced at KCH for patients to access some health care services. Others indicated that they had never heard about it nor experienced it. For the guardians who acknowledged existence of the informal payments, they asserted as follows:

"...what surprised me is that after an operation, I was asked to pay to get the results, I paid K9000. So, I asked them why they didn't tell me in the first place that I will have to pay. [Because]I didn't want to argue with them, I was angry and I just paid K9000 and left for home." [FGD_3]

The guardians who have never experienced nor heard about informal payments at KCH indicated

that if asked to pay some money to get treatment for their relations, they would pay so as to save the life of their relations:

"I can pay, if I have the money. This is a difficult situation because you can't just sit and see your child in pain, you can even sell a cloth so that you find money and pay to the doctor so that your child is saved." (FGD_2).

The majority of key informants indicated that they were aware of informal payments practice at KCH. Most of them stated that they have evidence about informal payments, while a few indicated they just hear about it but had no evidence. One of the participants said:

"... because there was a long queue [and] a lot of people were waiting, the man who sorts the healthy passports tipped my father - that 'if you want to be assisted quickly you should give me something' - then because my father was desperate[and] when I was getting there my father said he was happy [because]... 'you know I have been assisted very quickly because this guy asked me to give him money so that he should give the one who operates the x-ray to do it faster.'" (Key informant-4_ Nurse)

Factors that influence patients' decision to make informal payments

Different patients had different purposes for participating in informal payments. The study found that 54% of patients paid because they were seeking to receive a holistic care while 25% paid just to express gratitude and only 11% paid because they wanted quick services. Of these payments, *2% were made before the service, 5 % during the services and 13% after receiving the services.

Fear and lack of knowledge

Guardians and patients are compelled to pay money for services that are formally offered for free out of fear of not being treated by the doctors, which may result in death of their loved ones. This

is also aggravated by lack of knowledge by the patients and guardians on what to do when the health care providers demand payment for services that are formally offered for free:

“Fear makes us pay. We are afraid that if we don’t do what we are being asked to do we will lose our beloved because they will not be treated and because of that we are forced to pay. Sometimes one can pay because maybe she or he does not know how things work. But the bottom line is that they fear they might lose their beloved if they don’t pay (because their patient will not be treated).” (FGD_3)

Desperation

The guardians stated that illness brings desperation to people as such when the patients and guardians get to the hospital they are willing to do anything possible including making informal payments to see that their loved one receives treatment:

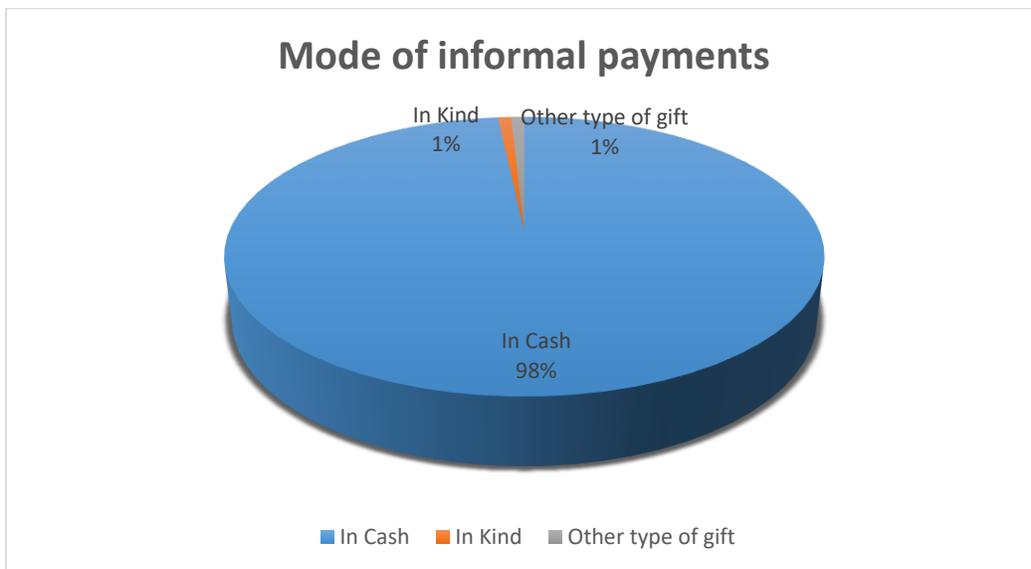
“This is a difficult situation because you can’t just sit and watch your child who is in pain. You can even sell a cloth to raise money and pay the doctor so that your child is saved.” (FGD_2)

This statement collaborates with what the key informants said, that serious illnesses force patients to informally pay health care workers so that they get treated quickly to prevent the condition of the patient from deteriorating:

“A good example was, I met one man who was so desperate [because] his mother had a tumor in the brain and they (doctors) were saying the earlier it was removed, the better before it degenerated into cancer. So he (the guardian) went and looked for the money and paid”. (Key informant-3)

Types or Modes of Informal Payments

This section presents the types/ mode of informal Payments and frequency of the informal payments that were being made by patients. It was found that most (98%) of the informal payments were made in cash and were made to the hospitals' staff to ensure more and better services. **Figure 1** below shows the valid percentage of participants who reported experiencing informally paying in cash or in-kind.



Factors influencing health workers to demand or receive informal payments

Self-indulgence: Participants in all categories suggested that it is greed that drives health care providers to demand informal payments from patients and guardians:

“Some health care providers are merely greedy because even those who are financially stable still demand or accept the money from patients.” (Key informant:-Doctor1)

Shortage of resources - drugs, staff-work overload (More demand against short Supply)

Participants collaborated that shortage of resources such as drugs, equipment and human resource are contributing to the informal payments practice. This imbalance leads to more waiting time as a result, the patients or guardians resort to bribing health care workers to fast track access to health care services. In addition, due to shortage of staff, the health care workers feel they are overworked for less pay and resort to demanding or accepting money or materials from patients as compensation:

“KCH serves a big population of people but is under-staffed. There are always a lot of patients, and most want to be assisted quickly and go to attend to other matters. Because these people are desperate to get a quick service, they give money to the health worker. [On the other hand], health workers feel they are not compensated fairly and they start demanding money from patients.” (Key informant 5: Human Resource Staff)

"And these other problems come because of shortage of medicine in hospitals, and since the medicine is not enough, the health workers start to help their relations or friends only. If you are not related to him (health worker), you don't get treatment and if you also don't have money to bribe the Doctor you don't get treatment." (FGD 2)

Low salaries: Some health care providers demand or accept money from patients because of low salaries, for instance patients' attendants and cleaners:

"I know for example in orthopaedic department, there are patient attendants, they work hard but you will hear that they get K50000 or K40 000 (US\$55-69) a month. These people have to pay rent and send their children to school. When they see that their seniors are receiving money from the patients, you know they also do the same. And I

understand they are doing this because they don't get paid enough money." (Key informant-1: Doctor)

Lack of effective disciplinary measures: There is lack of effective punishments for offenders, which encourages the health care providers to demand payment for services which are formally offered for free. The health care providers know that nothing will happen to them even if they are caught receiving money from patients:

"Loopholes in disciplinary actions make health workers comfortable to continue indulging in this bad behavior. There are no repercussions for the offender" (Key informant 5: Human Resource manager)

Discussion

This study revealed that people have knowledge about the existence of informal payments in public hospitals and perceive them as evil because they are a form of corruption that hinder the poor from accessing health services. The participants were unhappy that informal payments were demanded for health care services which should be accessed for free. Even though some participants stated that they would refuse to pay for a service they knew to be provided for free to discourage corruption, it is our view that this could not be easy because it was illustrated that informal payments were mostly done out of desperation to get a service. Similar sentiments have been expressed in other countries' studies. For example, a multi-country study in Albania, Bulgaria, Poland and Lithuania in which 64% of the participants indicated they would rather go to a private hospital than make informal payments in public hospitals for services which should be offered for free [16].

There are a number of factors that have been identified from both quantitative and qualitative

results of the study which include low salaries, shortage of staff, and lack of strict disciplinary actions to members of staff who engage in informal payments. Perhaps one may argue that the patients can be excused when they engage in informal payments because they want quick access to services or they want to express gratitude and or to get quality health care. However, some key informants were of the view that both patients and healthcare providers initiate informal payments at different times when they create unnecessary pressure of a situation, one policy maker at the MoH commented. He also commented that the fact that Malawian health workers are the least paid in Southern Africa, puts them at risk of being tempted to engage in informal payments.

However in Romania, providers were reluctant to discuss any kind of informal payments except gifts and described them as presents (chocolate, flowers) or small amounts of cash given after discharge [8]. Most key informants thought that gift giving has a strong cultural value and does not cause harm. However, when asked about the underlying causes of out of pocket payments (OOP), they concur with what our study found, that low salaries was the driving factor for informal payment [20].

A Bulgarian study found similar results and reported that informal payments continue to take place because of poor adherence to law by both citizens and government officials and the lack of governmental effort to increase salaries and generally increase funding for healthcare [21].

Hence the need for government to improve the salaries of the workers to address the informal payment issues.

In both qualitative and quantitative results, the views of participants collaborated that lack of effective punishments for the offender encourages the health care providers to demand for payment for services that should be offered for free. The Malawian health system has a good

public services regulation which is never applied when a situation arises. As a result, people involved in malpractice are not punished due to lack of evidence or favoritism for those who have relations and friends at the ministry headquarters. Miller et al. recommends enforcing rules and punishing offenders, which Malawi could borrow from [22]. Emphasis should be put on formulating deliberate policies and rules prohibiting informal payments to deter abuses [22].

If patients had reasonable waiting time to access health care, guardians or patients would not be forced to pay. These sentiments were collaborated by both qualitative and quantitative data which indicated that when guardians spend days or weeks in hospital, they feel they are being delayed as such they resort to informally paying for the services so that they return home quickly. Onwujekwe et al. and a Romanian study concurs with these findings that in some cases patients pay informally to jump the queue and receive better quality services or more care. Such payments have the potential of limiting access to healthcare services to patients who have more ability to pay rather than those most in need [20].

Illness brings desperation to people, as such, when the patients and guardians get to the hospital they are willing to do anything possible including informal payment to see their loved ones get the needed health services. This outcome confirms Moldovan's study which established that patients felt they had to pay as demanded, 'because you have to give it. Otherwise, you won't receive the service you need [23].

The study reported there was lack of knowledge on the part of the patients and guardians on what to do when the health care providers demand payment for a service that should be free. Most patients in the public hospitals do not know their rights and responsibilities when accessing care and this coupled with not being assertive by nature accelerates the malpractice and they fail to demand the free services and question anything contrary to free services. The good news is that

hospital ombudsman office has been recently set up by the MoH in all health centres to address complaints and grievances of those accessing health services.

The blame of informal payments should not entirely rest on health workers but patients/guardians as well because most studies including this one established that both patients and health workers initiate informal payments at some point [14]. This result shows that it will take both the community and health workers to control or end informal payments practice.

Informal payments can bring about inequalities in accessing care. It therefore, may result in no treatment or delayed treatment for patients who do not have money. It also results in poor quality care, loss of possessions and poor health seeking behavior among patients and guardians.

Furthermore, when some of the guardians pay the money they are left with no means to fend for their food and even money for their transport to return home when they are discharged. These results are similar to a Bulgarian study that found that among those who paid, about 6% borrowed money to pay for services and more than 10% of users borrowed money to pay for hospitalization [12]. In addition, 32% of the sample forewent physician visits due to the patients' inability to pay informally. It can be concluded, therefore, that the practice of informal payments sometimes negatively affects the health seeking behaviour of the public despite government's efforts to promote universal access to health.

There was a feeling of regret from key informants (senior hospital staff) who suggested that the informal payments have created a negative reputation for the hospital and health workers

generally as people think that every health care worker at KCH is involved in the malpractice.

Malawi depends on the donor community's support in order to sustain its health sector therefore informal payments will likely destroy its credibility and trust from development partners who are essential in supporting government social service delivery [24].

The study findings collaborates with Lewis that informal payment practice has created inequalities in accessing care between those who have money and those who do not have money to pay for services in a situation where health care services should be provided for free [25]. The health care workers who are involved in informal payments prioritize those who have paid money leaving out those who cannot afford to pay, therefore creating inequalities in accessing health care services.

It is quite challenging to end IP because health care providers involved in this practice walk free because sometimes management ignores to discipline the perpetrators because they are also benefiting from it. Furthermore it was also found that the Malawian culture of silence make patients afraid to speak out against informal payments or raising an alarm when something is wrong and this contributes to the increase of this malpractice. Both FGDs and key informants indicated that since this practice is shrouded in secrecy it is hard to end it because the patients and guardians are afraid to talk about it openly due to fear of unknown consequences from the perpetrators.

Conclusion and Recommendations

Informal payments in public hospitals in an issue of concern in Malawi. This study found that a majority of patients/guardians had paid for services which were supposed to be free. It has also been established that both the health workers and care seekers are perpetrators of this behavior. This practice has caused poor people to fail to access services in public hospitals and other social-economic problems.

There is need to develop policies and regulations and clearly spelt out strict disciplinary actions to be taken against the perpetrators. In addition, government should seriously consider improving

the working conditions for the health care workers in the wake of repeated statements that Malawian health workers are among the lowest paid in Africa. Lastly, patients and guardians should be sensitized on their rights and responsibilities about accessing health care services so that they are able to demand accountability from the health care service.

Abbreviations

KCH: Kamuzu Central Hospital

SDGs: Sustainable Development Goals

OOP: Out of Pocket

IP: Informal Payment

KII: Key Informant Interview

FGD: Focus Group Discussion;

HIV: Human Immunodeficiency Virus

UHC: Universal Health Coverage

HSSP: Health Sector Strategic Plan

EHP: Essential Health Package

WHO: World Health Organization

Declarations

Ethics Approval and consent to participate

Ethical approval was obtained from the College of Medicine Research and Ethics committee in Malawi and the committee's reference number is P.O8/17/2244. Informed written consents were obtained from study participants. Willingness to participate in the study was confirmed by signing or thumb printing on the informed consent sheet. Anonymity and confidentiality were ensured by using codes other than names on the data collection tools. Privacy was ensured by conducting interviews in a private place.

Consent for publication

Not applicable

Animal or human data or tissue

Not applicable. This manuscript does not contain any individual person's data in any form.

Availability of data and materials

Data and materials supporting the conclusions used in the manuscript are available from the corresponding author on request.

Competing interests

The authors declare that they have no competing interests

Funding

The research was self-funded, therefore funding declaration is 'Not applicable'.

Authors' contributions

AN planned the study, developed the study methods, and conducted the in-depth interviews, KII and the FGDs. She also analyzed the data and drafted the manuscript.

IK supervised and directed the planning, development of the methods, analysis plan and data analysis. She also contributed and supervised the writing of the manuscript. Both authors read and approved the final manuscript.

Acknowledgements

The authors would like to thank all the participants for their contribution to this study. We would also like to acknowledge the KCH staff and other key informants from the Ministry of Health for their contribution

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Figures



Figure 1

Factors influencing health workers to demand or receive informal payments