Working paper 564

Informal payments in the public health sector in Guinea-Bissau

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Key messages

- Informal payments are widespread in the health sector in Guinea-Bissau. They impact negatively on equity and introduce distortions that are sub-optimal from the point of view of efficiency and quality. In the worst cases, treatment may be withheld or deliberately delayed with a view to soliciting informal payments, sometimes with catastrophic results for the patient.
- Informal payments in the health sector in Guinea-Bissau fall into four categories: solicited unofficial salary supplements; cost-contribution payments; genuine and faux nepotism; and unsolicited donations.
- Factors influencing the prevalence of informal payments include low remuneration and demotivated health workers; asymmetries of information and power; a culture of demanding informal payments; and a lack of accountability.
- In view of the political environment in Guinea-Bissau, this paper advocates for experimental and incremental approaches to tackle informal payments. These approaches should be monitored and evaluated by a coordinating body of reform champions, in particular by a scaled-up Health Worker Forum, accompanied by measures to increase knowledge and awareness of those using the health service. There is also a need to start a dialogue on issues via an in-country health financing conference.

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The views presented in this paper are those of the author, and do not necessarily represent the views of ODI or the Government of Guinea-Bissau.

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Acronyms

ECOWAS	Economic Community of West African States
EMI	International Medical Assistance (*Entraide Médicale Internationale*)
EU	European Union
EUR	Euro
FGD	focus group discussion
GDP	gross domestic product
INASA	National Institute of Public Health (*Instituto Nacional Saúde Pública*)
LMICs	low- and middle-income countries
MCH	maternal and child health
MINSAP	Ministry of Public Health (*Ministerio da Saúde Pública*)
NGO	non-governmental organisation
ODI	Overseas Development Institute
PIMI	Integrated Mother and Child Health Programme (*Programa para a Redução da Mortalidade Materno Infantil*)
SAB	Autonomous Sector of Bissau (*Sector Autonomo de Bissau*)
UHC	universal health coverage
UNDP	United Nations Development Programme
XOF	West African XOF Franc

1 Introduction

1.1 Informal payments in Guinea-Bissau

This paper addresses the problem of informal payments in the health sector in Guinea-Bissau, which we define broadly as 'payments to individual and institutional providers, in kind or in cash, that are made outside official payment channels or are purchases meant to be covered by the health care system' (Lewis, 2006).

Informal payments are often discussed in studies of corruption (Gupta and Tiongson, 2000; Tatar et al., 2007; Onwujekwe et al., 2018). But corruption is a contested and morally loaded term that can hinder understanding of the true nature of particular behaviours in different contexts (Ensor, 2004; Bhargava, 2005; Blundo and de Sardan, 2006; Vian, 2008; World Bank, 2017). For this reason, we use the language of corruption sparingly, preferring 'informal payments', which is a more descriptive and value-neutral term.

There is a growing literature on informal payments in the health sector, which are widespread in low- and middle-income countries (LMICs). It is estimated that between 10–45% of the total out-of-pocket payments across low-income countries are informal (Jahangiri and Aryankhesal, 2017). Informal payments have been found to compromise the efficiency of healthcare provision, create perverse incentives that represent an obstacle to health reform policy and undermine the government's ability to raise funds for health (Stringhini et al., 2009). The cost of informal payments and the barrier this creates to accessing healthcare also places a heavy burden on the poorest members of society (Belli et al., 2004; Lewis, 2006). The practice of informal payments therefore undermines increasing international efforts towards achieving universal health coverage (UHC) (Vian et al., 2015). At the same time, informal payments have been described as part of a wider remuneration strategy whereby such payments are one of the many coping mechanisms for health workers, often due to poor working conditions, low and irregular salaries, and a sense of abandonment by the state (Lewis, 2006; Russo et al., 2013, Bertone and Witter, 2015, Bertone et al., 2016).

This paper adds to the growing literature on informal payments in the health sector by studying them in the context of Guinea-Bissau. It aims to contribute to our overall knowledge of informal payments in LMICs, as well as to provide data and discussion to inform current policy processes in the country. The paper is based on the premise that it is important to be aware of the reasons for, and nature of, unofficial charges when designing policy responses to them (Ensor, 2004).

The research was undertaken as part of a post-ODI Fellowship Scheme research grant. The initial research question arose from discussions between the author (an ODI Fellow) and the Director of Heath Systems Administration within Guinea-Bissau's Ministry of Public Health (MINSAP – *Ministério da Saúde Pública*) in order to orient policy-makers in the country.

The paper is divided into five sections. Section 2 offers some background on Guinea-Bissau and its health sector. Section 3 explains the methodology used. Section 4 explores the findings from the qualitative research: the types of informal practices; the processes in which they occur; and the causes and impacts of the informal payments in relation to the efficiency, equity and quality of care in the health sector. Section 5 makes some tentative recommendations framed within an understanding of the political and economic context of Guinea-Bissau.

2 Country context

Guinea-Bissau, situated on the west coast of Africa, has a population of 1.8 million people, around half of whom live in urban areas, mostly the capital Bissau (World Bank, 2019). The economy is dominated by agriculture, which contributes over 40% of gross domestic product (GDP) and employs about 80% of the workforce. Guinea-Bissau ranked 178 out of 188 countries in the 2016 Human Development Index (UNDP, 2016: 200). Life expectancy at birth of males and females is 58 and 61 years respectively (WHO, 2016). The under-five mortality rate was 95 per 1,000 live births in 2015 and the maternal mortality rate was 549 per 100,000 live births (UNICEF, 2016). In the same year, 26% of the population were categorised as undernourished.

Guinea-Bissau is politically fragile (Fund For Peace, 2019). Since independence from Portugal in 1974 there have been four successful coups, and another 16 attempted, plotted or alleged (World Bank, 2019). Despite the aspirations of Amilcar Cabral – the country's most celebrated nationalist leader – to build a strong social democratic state, this has never been achieved. In a pattern that stretches back to colonial times at least, a highly fractious set of political and military elites has been incorporated into the country's political settlement by being granted access to spoils or rents from various sources, including external financial assistance, income from trade (peanuts and cashews), and from the sale of illicit fishing licences, illegal logging and narcotics.[1] There is also the potential for future spoils from unexplored natural resources. The civil service is highly politicised, and the bureaucratic culture is personal and characterised by patronage and nepotism. In general, elites are unable to act collectively or coordinate for common needs.

In 2016, tensions among two key leaders, José Mário Vaz and Domingos Simões Pereira, led to a full-blown political crisis, partially resolved by the Conakry Agreement mediated by the Economic Community of West African States (ECOWAS). The agreement aimed to resolve the disagreements over appointment of the prime minister and cabinet and advance national conversations over constitutional and political reform.[2] However, it proved difficult to implement in practice and it was not until April 2018 that a prime minister was successfully appointed in line with the Conakry Agreement. Prime Minister Aristides Gomes has since formed an inclusive transitional cabinet, the National Assembly has re-opened, and the government programme and budget have been approved. Parliamentary and presidential elections are due to take place in 2019.

Despite this recent progress, Guinea-Bissau is probably still best classed as a 'narrow-dispersed' political settlement, in which an organisationally weak society provides few incentives for elites to develop broad-based, inclusive development programmes, and in which elite disunity compromises the success of any such programmes (Kelsall, 2018). As we shall see later, it is important to keep this configuration in mind when exploring options for health policy.

1 Guinea-Bissau is ranked 171 out of 180 countries surveyed in Transparency International's 2017 Corruption Perceptions Index (CPI) (TI, 2017).

2 Signed by: 1) elites and their political parties; 2) military and liberation struggle heroes; 3) civil society organisations, traditional and religious leaders, youth, and women; 4) regional actors (ECOWAS, the African Union (AU), Senegal, Guinea, Angola); and 5) international partners (the United Nations Integrated Peacebuilding Office in Guinea-Bissau (UN-UNIOGBIS), the Community of Portuguese Language Countries (CPLP), the European Union (EU) and others).

2.1 The health sector

The public health sector in Guinea-Bissau is structured around 11 health regions and is delivered at three levels. At the local level, primary healthcare is provided through 132 health centres, classified as types A, B and C, distinguished by their capacity to deliver more or less complex health interventions. At the regional level, there are 11 administrative regional health directorates and five secondary-level regional hospitals offering more specialised care. The central level, in the capital Bissau, comprises the National Hospital *Simão Mendes*, and policy institutions such as MINSAP and the National Institute of Public Health (INASA – *Instituto Nacional Saúde Pública*). Health facilities by region are displayed in Table 1.

Guinea-Bissau's health system faces persistent challenges related to low public spending, poor infrastructure, inadequate supply of health workers, inadequate clinical and managerial training systems, a malfunctioning referral system, non-operational health-information systems, weak governance, and inadequate management capacity and systems (such as budgeting, public financial management and human resources management) (World Bank, 2019).

Government spending accounts for about 20% of total health expenditure and is mostly to pay staff salaries. Development partners finance nearly 90% of recurrent costs (ibid). There has been almost no public investment in the health sector for the past three years. The government, via the Ministry of Health, sets the prices for consultations, laboratory examinations and medicines in the public health sector. According to the government's '2003 cost-contribution policy', the revenue collected by health facilities from official user fees and the sale of medicines is managed by the health facility and used to fund the purchase of medicines; recurrent costs; salaries of locally contracted staff; facility and vehicle maintenance; staff incentive payments (bonuses); and a monthly contribution to the regional health directorate (MINSAP, 2003). User fees and the sale of medicines make up on average almost 80% of funds received by facilities (World Bank, 2019).

Table 1 Health facilities by region

Regions	Population (2017)	Regional hospital	MCH centre	Health centres		
				Type A	Type B	Type C
Bafata	217,045	1	1	–	1	12
Bijagos	24,007	–	–	1	–	10
Biombo	54,507	–	–	–	1	6
Bolama	11,510	–	–	1	–	4
Cacheu	229,204	1	2	1	1	17
Farim	58,060	–	–	1	1	4
Gabu	259,570	1	1	–	1	17
Oio	180,428	1	–	–	1	8
Quinara	77,465	–	–	1	3	10
SAB	513,846	–	1	–	3	6
Tombali	116,994	1	–	–	2	19
Total	**1,742,636**	**5**	**5**	**5**	**14**	**113**

Source: MINSAP (2017)

Box 1 PIMI, EMI and the World Bank

Given the high rate of maternal and infant mortality, international partners have prioritised maternal and child health (MCH) programmes. Of particular relevance to this paper is the Integrated Mother and Child Health Programme (PIMI – *Programa Integrado de Reducao da Mortalidade Materna e Infantil*), an initiative financed by the EU. Various services for pregnant women and children under five are offered to the public free of charge. The non-governmental organisation (NGO) *Entraide Medicale Internatinoale* (EMI) is one of the implementers of this programme, which includes reimbursing the health facilities for services offered free of charge into health facility bank accounts based on certain indicators. Such efforts to reduce financial barriers to accessing MCH services have lacked appropriate verification systems.

The new World Bank 'Strengthening maternal and child health service delivery' project will pay performance-based bonuses for delivery of a package of MCH services at hospital and health centre levels, implemented by EMI, and will provide grants to health facilities. This project will design and use a more robust verification system (World Bank, 2018). However, caution should be given regarding the long-term sustainability of financing performance-based bonuses.

3 Methodology

This paper is based on primary data collected between May and August 2018 in five health regions: Quinara, Bafata, Oio, Cacheu, and the Autonomous Sector of Bissau (SAB – *Sector Autónomo de Bissau*) with ethics approval from the National Institute of Public Health. The regions were chosen to reflect the country's cultural and geographical heterogeneity. Based on the sensitive and complex nature of the study, and since informal payments go largely undocumented, a qualitative approach was chosen that allows for the process of corruption to be described and explored. The data was collected and triangulated by source and method to minimise point-of-view bias and to gain a rich understanding of the data.[3] The data-collection method is outlined in Table 2.

The research team spent on average three to four days in each region and selected informants with the help of the regional health authorities. All respondents were reassured on the issues of confidentiality and the importance of collecting data on informal payments was explained. Consent was obtained for all interviews and, despite the sensitive nature of the subject, participants were eager to share their experiences. The interviews, except the *Djumbai* sessions with community members (see Section 3.1) and individual interviews with patients, were recorded using a handheld device. The interviews were in Portuguese, Bissau-Guinean Creole, or regional languages, with all recorded interviews later transcribed into Portuguese.[4]

Table 2 Data collection

Category	Location	Quantity
Focus group discussions (FGDs)		
Health workers	Regional hospitals	4
Adapted FGDs *Djumbais*		
Female community members	Rural communities, urban neighbourhoods	10
Male community members	Rural communities, urban neighbourhoods	10
Lifeworld interviews		
Health workers	Health centres, regional hospitals, National Hospital *Simão Mendes*	12
Semi-structured interviews		
Government officials	Regional directorates, regional hospitals, Ministry of Health, Ministry of Finance	18
Non-government officials	Stakeholder offices	13
Patients and carers	Rural communities, urban neighbourhoods, regional hospital, National Hospital *Simão Mendes*	9

3 Triangulation refers to the use of multiple methods and/or data sources in qualitative research to develop a comprehensive understanding of a particular phenomenon.

4 Three interviewees did not give their permission to be recorded, therefore thorough notes were taken during the interview process which were then transcribed. One interview with a health partner was in English. Two *Djumbai* sessions were held in regional languages with the help of a community health worker to translate.

3.1 Focus group discussions and *Djumbais*

In each regional hospital a focus group discussion (FGD) with health workers was held to collect a range of opinions and views, guided by the ODI handbook *Tools for policy impact* (Start and Hovland, 2004).

For discussions with community members we decided, in consultation with the National Research and Studies Institute (*Instituto Nacional de Estudos e Pesquisa*), to adopt the *Djumbai Focalizad*[05] method, which they have been using for the past two decades in socioeconomic and ethnographic studies. This method is similar to FGDs, but there are no recordings or notes and there is no limit to the number of participants, who come and go freely during the session. *Djumbai* sessions with community members took place in markets, village meeting points or in the home of a community member. These *Djumbais* were split into groups of women and of men, to ensure that women felt free to speak.

3.2 Lifeworld interviews

The FGDs with health workers were complemented by 12 individual interviews with doctors and nurses in the health facilities to explore individual experiences and perceptions in richer detail. Each interview began by getting to know the health worker, thus giving a platform for an often-unheard voice, and covered their motives for working in health, what they like and dislike about the job, etc. The core of the interview focused on the practice of informal payments.

3.3 Semi-structured interviews

Semi-structured interviews with 18 government officials and 13 non-government stakeholders were conducted to provide insights from a different point of view, particularly relating to the policy environment. Interviewees in this category included hospital directors and administrators, regional directors and administrators, staff at the Ministry of Public Health and the Ministry of Finance, politicians, international partners, NGO workers, and representatives from health workers' unions. The semi-structured interviews involved preparing pre-determined but open-ended interview questions, which allowed for flexibility as questions evolved during the interview.

The *Djumbai* sessions were complemented by nine individual interviews with patients or patients' carers inside regional hospitals and at the National Hospital to understand personal experiences in more depth.

3.4 Data analysis and dissemination

The data was processed and analysed by means of the Dedoose application and coded and categorised using Content Analysis.[6] Content Analysis aims to systematically organise a large amount of text into a concise summary of key results. Transcripts were reviewed line by line several times to identify key phrases or meaning units, which were then derived into codes and organised into categories and sub-categories. This is a non-linear process that involves continually returning to the meaning units (Erlingsson and Brysiewicz, 2017). All codes and categories were created in line with the key research question.

The communication strategy for policy involved constant interaction with MINSAP and members of the Health Partner Coordination Committee. The initial research findings were presented in Guinea-Bissau at a National Seminar on Informal Payments in the Health Sector, organised by the principal researcher and funded by the World Bank, and attended by 50 stakeholders including government officials and international partners.

5 *Djumbai* is creole for a group of people sitting around, often under a mango tree, discussing anything from football to politics. Any gathering can be called a *Djumbai*. It is also the name of the national beer.

6 Dedoose is a web-based qualitative and mixed-methods research application, developed by academics at the University of California, Los Angeles (UCLA) that allows you to organise and analyse research data (available at: https://app.dedoose.com/App/?Version=9.0.42).

4 Findings

This section explores the findings from the qualitative research: categorising the types of informal practices; describing the contextual details involved in the process; and discussing the causes and impacts of the informal payments in relation to the efficiency, equity and quality of care in the health sector.[7]

4.1 Types of informal practice

Many types of informal practice, often highly interdependent, were discussed during the interviews. This paper focuses on informal practices at health facilities, with a narrower focus on informal payments. These have been organised into four categories: 1) solicited unofficial salary supplements; 2) cost-contribution payments; 3) genuine and faux nepotism; and 4) unsolicited donations. Categorising the forms of informal payments is useful for policy-makers. For example, mistaking cost-contribution payments for the unofficial salary supplements could lead to misplaced sanctions and incentivise staff to switch purely to the private sector.

4.1.1 Solicited unofficial salary supplements

First, we look at the incidence of paying for a free service or product or *paying higher than the official price (being overcharged)*. This occurs with both smaller amounts for consultations and medicines as well as with larger sums for more specialised care.

> *It happens to many people, they [the health worker] go tic, tic, tic, on the calculator, and then they ask for 20,000 XOF [~30 EUR], but of course that isn't the actual price* (Key informant, SAB)

Patients can be refused the service if they do not pay upfront, most frequently for childbirth and surgery. Few facilities in Guinea-Bissau display their prices clearly. In addition, there is the challenge of a high rate of illiteracy, especially among women who are the most frequent users of the public health system. Services that are currently provided free of charge, such as antenatal consultations, and services when the patient is vulnerable, such as when about to give birth, are susceptible to this form of corruption.

> *You know how you shouldn't pay for consultations when pregnant right? But the health worker tells the user to pay 'X', and so then they pay 'X', but nobody says anything. This has been verified, not just here, but all over the country* (Administrator, regional hospital)

The second form of solicited unofficial salary supplement that fits under this category includes the user *paying the official price, but the payment is not entered in the ledger*. Often this takes place outside official facility opening hours, when there are less staff available and the health worker takes on an additional administrative

7 Given the existence of user fees for most services, a formal payment involves the transfer of money from the patient to the health worker to provider, and the transfer of receipt from the health worker to the patient. This transaction is noted in an accounting ledger. In most facilities this involves a financial intermediary, as health workers should not be handling cash. In smaller facilities and during non-official opening hours in larger facilities (4pm – 8am), health workers often take on a dual role and are responsible for taking payments and giving receipts.

role. Attending a facility outside official hours puts patients in a more vulnerable position, which increases the power asymmetries between provider and the patient.

> *For example, one night you could receive 20 patients, but only write down 10 names in the book. The names in the book are the amount to be accounted for, the other 10 names you put the money in your pocket* (Doctor, regional hospital)

This often goes unnoticed by the patient and was justified by health workers as a means of increasing their own salaries, stating it was less damaging and more amicable, as they were taking funds directly from the state and not the patient. However, with less money entering the facility, a lower quality of care is likely, thus ultimately affecting patients' care.

The third form of solicited unofficial salary supplement involves *pressurised gift offering*. Throughout the interviews and discussion sessions it became apparent that across the country the provision of healthcare is viewed more as a favour than as a right. Taking advantage of this, this form of corruption involves the health provider demanding a gift, particularly when the patient is in a vulnerable state. In this case the patient is usually aware that this is not a legitimate payment.

> *In the maternity ward the midwives mention 'sumo' [juice money], usually between 5000-7000XOF [~ 8 EUR], after you've delivered your baby. They do not wait for it to be given, they demand for it to be offered* (Woman, urban market)

The fourth form is the *falsification and sale of patient appointment logs, certificates or cards* that should normally be provided for free to patients. Such items are used to log childhood vaccinations or antenatal appointments. Again, the health worker is taking advantage of the patient's or carer's lack of knowledge, since they are often unaware they are making an illicit payment.

> *You will hear about people selling appointment logs and cards to pregnant women. And you don't know where that money is going. These items should not be sold. But somebody takes the card, makes a photocopy of it, and then sells it* (Deputy Director, regional health directorate)

Fifth, is the *sale of private supplies and medicines within the public facility*, which are usually sold at higher prices than they would otherwise cost. This internal privatisation occurs inside the consulting room or at the patient's bedside, even though there may be stocks at the facility's pharmacy. Patients may be in a vulnerable position or are unaware that they can choose where to make their purchases. Again, there is confusion for the patients about whether they are making a necessary and legal, or an illicit, purchase. Respondents referred to after-hours at the National Hospital as a 'night market', alluding to the high frequency of illicit sales of medicines and materials.

> *With the nurses, it is more the illicit sales than the illicit payments… they say, 'I have this medicine and I will sell it to you'. But they don't sell it at the normal price. They will sell it at a much higher price.* (Nurse, National Hospital *Simão Mendes)*

Patients at the National Hospital in the capital city said that if they did not purchase the medicines sold by the nurses at their bedside then they would be ignored. This favouritism has a severe impact on both the real and perceived quality of healthcare.

The sixth form of informal payment is the *'referral', or diversion of patients and materials from the public to the private health system*: to clinics for consultations, laboratories for examinations and specific pharmacies to purchase medicines.

> *All patients that go to National Hospital Simão Mendes, they are then directed to the private clinics. All patients. They are told to go and do their analysis in the doctors' private clinics* (Health worker, FGD, regional hospital)

Health workers either own these facilities themselves or will receive a kickback from the proprietor. This also includes the deviation to private clinics of materials and medicines donated to the health facility or purchased using facility revenues. Theft of materials or medicines by health workers diminishes the revenue-earning potential for the public facility and can distort central-level planning. This can include pretending that medicines provided for free via development partner funding are not available in the health facility and sending patients to private clinics to where the donated medicines have been diverted for sale.

> *Health workers steal materials for private consultations at home. For example, they steal the material given by the NGO. If you were to undertake research at the national level, you would find that nowadays most health professionals also work at home. And that we are missing a lot of material* (Hospital Director, regional hospital)

Related to the sixth form, but of a slightly different nature, is the practice of *overprescribing medicines or treatments for private monetary gain*. Not only does this increase the cost for the patient, but recommending unnecessary treatment can have severe effects on the quality of healthcare and may be contributing to antimicrobial resistance (Llor and Bjerrum, 2014).

4.1.2 Cost-contribution payments

Cost-contribution payments include a *payment paid by service users when drugs or supplies are under-provided*.

Unlike the practices described above, cost-contribution payments, in their purest form, would not be considered corruption but would still be considered an informality. Working practically in an under-funded health sector means working in facilities lacking the full supplies and basic equipment to function. In Guinea-Bissau, working without electricity or clean running water at a health facility is not uncommon. On top of official user fees, patients may wittingly or unwittingly pay more to contribute to health facility running costs, thus minimising the state budget deficit or the gap in external funding. This cost contribution is not used to enrich the individual, as the services, materials or medicines are sold at the market value (or the price that the health facility had to pay). This is exemplified by a laboratory technician during an FGD with health workers at a regional hospital:

> *Another thing, an example from our laboratory, usually you should not pay for the thick blood test [gota espessa]. But there is an exemption. Here you have to pay for the thick blood test, why? Because the malaria programme does not supply the necessary material. We do not have the sheet/blade [lamina], we have to buy it with money from the hospital, and so then we have to charge for the test.* (Laboratory Technician, regional hospital)

However, the health worker may use the underfunded health service and challenges such as a medicine being out of stock as the underlying reason to demand a payment and to use their position of power to charge a higher than market-value price. This informal practice would now be considered a solicited unofficial salary supplement. The boundaries between this and the first category become blurred and it is difficult for a patient to distinguish between them. It is important for policy-makers to understand that there are differences in informal practices, such as those between these two categories, as these will have different impacts and require different approaches. There are fewer forms of informal payments in this category than in the first, as it is more common for health workers to use their market position to supplement their income.

4.1.3 Genuine nepotism and faux nepotism

Genuine nepotism and faux nepotism refer to the use of informal networks to receive a service such as jumping a queue, and may or may not involve an actual payment.

In order to obtain an extra service, a patient may make a payment to the provider. A payment to reduce waiting time is common in Guinea-Bissau across all sectors, occurring in the education sector to receive a scholarship to study abroad, or at the bank to get to the cashier faster. This is referred to as *suco di bas*.[8] This type of additional service can be categorised under genuine nepotism. Often the user makes use of their informal social networks and the health worker displays favouritism at the expense of the general population. This does not necessary include an actual payment.

The use of informal social networks is so widely accepted socially that it is also at times faked, creating 'faux nepotism'. Support staff or a cleaner may assist a patient in bypassing the queue by falsely presenting the patient to the health worker as one of their relatives and receiving a payment in exchange for doing so. It is important to distinguish between genuine nepotism and faux nepotism, however, as the latter acts as a solicited unofficial salary supplement. This preferential treatment raises concerns for equity in the provision of health services. All respondents were aware of the term *suco di bas* and community members from outside the capital city made many references to Bissau and the National Hospital as places where this type of payment occurs most frequently.

> *I have witnessed "suco di bas" many times, someone arrives with money and cuts the line* (Man, Djumbai, regional capital)

Despite health workers often mentioning that they should not accept this payment, most stated that they do – paradoxically both denouncing and justifying the act.

> *If someone offers this payment, this 'suco di bas', you have to sacrifice a patient waiting and take that money from the patient offering, because you have nothing...* (Nurse, FGD, regional hospital)

4.1.4 Unsolicited donation

A donation is *a payment made freely by the service user*, without pressure from the provider, when the user is satisfied with the service received and would like to show their appreciation via cash or a gift.

A donation is still considered an informal practice. However, from the perspective of the health worker, it is considered something transparent and legal:

> *… there are other people that just give, for example, I bring my patient, I see that the person who attended my patient attended them well, I'm happy with the work he did, I take money and give it to them, I am happy with the service. This is normal all over the world, it is given after the treatment, it's transparent, and it's a clear thing* (Doctor, regional hospital)

Although considered donations, there may still be potential issues relating to this practice in terms of service delivery. For example, if the donation is made with the expectation of receiving preferential treatment in the future; if providing gifts influences whom doctors treat, e.g. after receiving a few gifts they only treat those from whom they expect to receive a 'voluntary' donation; and if the payment is not actually voluntary, but rather the patient feels somewhat pressured to provide it (see above under the first category).

During a *Djumbai*, one pregnant woman who was aware of which services are offered free of charge, expressed her desire to pay:

8 Translated as 'a low blow', referencing boxing for when a low punch is given without the opponent's knowledge (i.e. it is hidden). But this low blow will guarantee that the opponent will be knocked out (i.e. the problem is resolved).

> *Yes, I know that the [antenatal] consultation is free, but I have to think about my baby, and the nurse is helping me, I want to pay* (Woman, Djumbai, rural village)

In this sense the service user believes that by paying they are placing a value on their health. The willingness to pay is fundamental in understanding the user-fee mechanism. In this case, the service user is also sympathising with the working conditions of the health provider.

4.2 Impact on equity, efficiency and quality of care

To analyse whether the practice of informal payments is a problem for the health system we consider the likely impacts on equity, efficiency and quality of care. The provision of public healthcare aims to achieve efficiency – the allocation of limited financial resources to meet the health needs of a society – while not compromising equity – the fair distribution of resources across the population. It is important to note the difference between equity and equality, the latter referring to the equal distribution of benefits across the population, which does not always result in equal gains. Quality of care is defined by the World Health Organization as 'the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred' (WHO, 2006 in Tunçalp et al., 2015: 1046).

Box 2 Case study: corruption of the Medical Board

The Medical Board (*Junta Medica* in Portuguese) in Guinea-Bissau has an agreement with the Portuguese government that permits the evacuation of patients who cannot be treated in Guinea-Bissau. In 2016, 1,569 Guineans sought evacuation to Portugal through MINSAP; of these, 1,025 applications were forwarded to the Portuguese Embassy in Bissau; of which 425 obtained the visa for treatment. However, this evacuation route is also widely known to be an illegal migration route:

> *A lot of people seek junta medica… some seek junta when they're sick, and others seek junta as a form of immigration* (Government Official, MINSAP)

The official fee for a patient evacuation is 15,000XOF [~23 EUR] yet demands of more than 100 times this have been quoted. In 2017, MINSAP responded to media pressure and created a commission in which more than 450 false applications were identified and passed to the Public Ministry, where the process remains at the time of writing. Difficulty in administrating punishment effectively due to weak enforcement of laws was cited as a major constraint in resolving this problem:

> *… One doctor escaped, even though they took away his passport…. They took his document, they communicated with immigration and the border security that this person could not leave the country, but he got another passport and took that very same route… where is the State? Something is failing.* (Government Official, MINSAP)

During interviews and discussions with health workers in regional hospitals outside SAB, the falsification of papers for *Junta Medica* and the high associated price-tag were often used to justify accepting or demanding small-scale illicit payments, with the view that Bissau is the centre of corruption where the 'big money' changes hands. The existence of this larger-scale corruption influences the acceptance level of smaller-scale corruption.

4.2.1 Impact on equity

The greatest concern is the effect of informal payments on equity. The additional financial burden for patients and their carers creates a barrier to healthcare that is not distributed evenly across society. The findings show that the most vulnerable, especially those living in rural areas or with urgent health needs, are likely to be worst off.

> *For example, with antenatal consultations, women stay in the village for a long time, and when I ask them why they have not come to the hospital, they say it is because of money. But it's free for them, but some health workers are taking advantage, asking for 1000XOF [~2 EUR], or 2000XOF [~3 EUR]…* (Doctor, regional hospital)

Those who are unable to pay may delay treatment, seek alternative care that may be unregulated or of lower quality, or avoid seeking care altogether. The high dependence on informal social networks in receiving care also results in the inequitable allocation of healthcare. The higher cost of healthcare due to informal payments increases the burden on individuals and households. With a global shift towards UHC, primarily for equitable reasons, the reality of informal payments must be considered, since ignoring such payments undermines efforts to achieve UHC.

4.2.2 Impact on efficiency

The practice of informal payments can lead to resource allocation that is different to the social optimum. Services are used by those who are able to pay rather than those with the greatest need, thus affecting social efficiency.

Our findings show that informal payments are used to increase income in the context of an under-funded health sector with limited resources to pay adequate salaries and provide minimum working conditions. This means that such payments, acting as a form of income for health professionals, could positively contribute to health-worker retention in the public sector, ensuring that providers are being paid for delivering some services and that some services do indeed reach end users.

Despite the possibility of influencing staff retention in the physical space of public facilities, however, private practice inside these public facilities is common (Russo et al., 2017). Further research is necessary to understand if informal payments motivate the retention of health workers or whether they are linked with a greater sense of demotivation.

4.2.3 Impact on quality

The effect of informal payments on the quality of care is hard to measure and was not the objective of the study: it is nevertheless useful to consider in evaluating the practice of informal payments. The ability to extract rent can incentivise health workers to create delays in providing treatment to justify demanding payment from a patient. The quality of care may also be reduced by health workers to signal that the forthcoming service will be of inferior quality unless an informal payment is made.

An informal payment as a pre-condition for treatment can result in an outright refusal to treat patients, and was often cited as resulting in avoidable death, especially among patients who could not find the money to pay for surgery, or for pregnant women who arrive to give birth and are turned away. Respondents mentioned that health workers, mainly at the National Hospital in Bissau, refuse to assist pregnant women if they do not pay an additional up-front payment, which has led to maternal deaths and stillbirths. Attending childbirth and associated medical procedures such as caesarean sections are currently free of charge under the EU-funded PIMI programme (see Box 1).

It is also possible that informal payments have a positive impact on quality, although this is likely only for those patients who are able to pay. The financial incentive may motivate service providers to provide better care and may be an influencing factor in their decision to remain providing services in the public health sector. In terms of deviation of patients to the private sector, this could have a negative or positive effect on the quality of service provision in the overall health system depending on the quality of private care.

4.3 Causes

This section aims to understand the underlying causes of the informal practices discussed in the previous section.

4.3.1 Low remuneration and demotivation of health workers

The reasons given for the occurrence of informal payments among health workers focus on low or lack of remuneration, demotivation, a contagion effect among employees, poor working conditions, and personal attitudes to their work. An insufficient level of income, which would normally be the sum of the base salary, subsidies and incentives (i.e. bonuses), was cited as the most common reason for informal payments in the public health sector. The language health workers used often implied that they considered the act of demanding an informal payment as a coping mechanism or survival strategy:

> *When you are hungry, you lose your dignity* (Health worker, FGD, regional hospital)

The basic salary was considered unjust and health workers made comparisons between the public sector salary for health workers in Guinea-Bissau and other public sector workers, e.g. lawyers and diplomats; health workers in other parts of the world and neighbouring countries, such as Senegal; and health workers in externally funded programmes such as Doctors Without Borders.

> *The organisations pay doctors and nurses a good salary. The state doesn't. But then they want you all to work together, we are doing the same job. Doctors Without Borders came here, to our hospital, to the paediatric ward, but we do the same job as them. We work a lot. I work a lot. I make sacrifices. We do not have time to rest, but that doctor is receiving 400,000 XOF [~ 600 EUR], and I get 130,000 XOF [~ 200 EUR], what is that money even worth* (Health worker, FGD, regional hospital)

Government officials, health partners and community members all commented on the low salaries as a reason for the continued existence of informal payments.

> *I think it's because of the bad salary that the health workers earn. It must be the main factor. They are escaping the ethics of the profession because they lack resources. The salary is not enough for them to live, to survive. If they receive 75,000XOF per month, [~114 EUR] will they be able to pay rent, school fees etc.? They'll charge illicitly. There is a lack, and lack of what? Salary.* (Administrator, SAB, health centre)

Reference was made to the low, irregular and sometimes lacking subsidies for isolation (distance to facilities), overtime, and risks.

> *We are exhausted..., we are doing a 24-hour service. For an after-hours night shift we are paid 750XOF [~1.14 EUR], that's not enough to buy a plate of food, not enough to buy a drink, it would make more sense to sit at home instead of coming to work a night shift for 750XOF [~1.14 EUR]. It is a joke, people are receiving incentive payments of millions, they don't do anything, social inequality is huge, I cannot even begin to explain.* (Health worker, FGD, regional hospital)

The current incentives are considered dis-incentivising by health workers.

4.3.2 A culture of informal payment-taking

Contrasting opinions were also given, more so from non-government officials, who argued that the low salary is an excuse given by health workers to justify their acts.

The sense that the practice of informal payments is 'normalised' was highlighted by one doctor, who implied that the problem runs deeper than low or insufficient remuneration and that it can be interpreted as stemming from a 'tradition of corruption', which is not just corruption in

itself, or tradition alone. It is a social norm that is engrained in society to conduct activities in an illicit way, to one's personal benefit.

Responding to this question on the causes of informal payments, more senior doctors focused on personal attitudes and the mindset of health workers, while more junior staff focused on the poor working conditions and low salaries.

> *…because in Guinea-Bissau, it is something that people have created as a habit, but a bad habit. Now people understand that it is normal, but it is still a bad habit. If you do not work with the mindset of people, well ... you can pay people millions, even if you pay them millions, they can continue to do bad things, because there is a problem. It is not that the money is not enough, the problem is that the habit has already been created…* (Doctor, regional hospital)

During interviews with health workers there was a general sense of having been abandoned by the state, which created persistent demotivation and justification for the occurrence of informal payments. This is likely to stem from the lack of government investment in infrastructure and health professionals.

> *The act is wrong, but if they could create working conditions, and improve the control then… but if they don't create working conditions, well..., if I am hungry I will find a way to eat.* (Nurse, rural health centre)

The lack of supervision and lack of state funding reaching the facilities implies that health workers can make whatever decisions they want to. Poor working and living conditions, combined with a high workload, were cited as driving forces behind a demotivated workforce.

> *I already said why there are illicit charges, there is no light, there is no water, and there are no gloves, there is nothing, nothing, nothing, so now, how are you going to end these illicit practices?* (Doctor, FGD, regional hospital)

Additionally, interns and trainees enter the system without any form of remuneration, which was described as an 'invitation' to corruption. A 'peer effect' can occur here with current health workers involved in teaching and encouraging new recruits to demand informal practices.

> *If you say, 'this has a fee', and then you take the money and put it in your pocket, and I saw you do that, do you think I will not have the courage to do the same thing? I'll have the courage, I'm going to do it too, and no one is taking responsibility* (Nurse, rural health centre)

This situation persists partly because of information and power asymmetries.

4.3.3 Information and power asymmetries

Discussions in rural communities indicated that people were not aware that certain payment practices are illicit or constitute an informality. When asked if pregnant women paid for health services, respondents either said they themselves paid, or they knew of somebody who had paid for antenatal consultations, childbirth or consultation logs.

Villagers travelling to receive care at regional hospitals are at the greatest risk of paying informal charges. These patients are less able to rely on an informal social network, as they are mostly unknown to the health workers. They are penalised for arriving without the financial resources to make *suco di bas* payments and are in general less informed on fees/prices and their rights.

Respondents highlighted a lack of knowledge on prices, gratuity schemes and how to use a health facility in general, including where to pay, whom to pay, whether it is necessary to ask for receipts and where to buy medicines:

> *Very often the people that are going to be treated in hospitals, in the health centre, are unaware of all the information and the health workers*

> *take advantage of the fact that the people don't know…* (Coordinator, NGO)

Given the information asymmetry among health workers and patients, the former can take advantage of the latter's knowledge gap, for example, not knowing that a particular service should be offered free of charge.

Urban community members were more aware of the informalities, specifically the sale of medicines in private pharmacies, *suco di bas*, and the impression that they were being tricked into paying more by being charged for multiple services or medicines, and/or were being prescribed more medicine for the health workers' personal profit.

The urban health facilities have a higher through-put of patients and perform more complex services in which the health workers are able to use their power to charge more. There is a longer waiting time in such facilities and therefore greater recourse to *suco di bas* payments. In the National Hospital the occurrence of informalities is normalised and rife. Respondents implied that all services were subject to informal payments and that it is common knowledge that if you do not have the money to pay for surgery you will not be attended to, and that you will most likely have to incur a cost relating to childbirth even though this service is currently provided free of charge.

Service users are often afraid of confrontation because of concerns that they will be penalised when seeking future treatment, and because health is viewed more as a favour than a right:

> *People think that the health workers that are treating them are doing them a favour, it is not a right that the person deserves, but the person thinks it is a favour, so when the health worker asks for some money, they give some money, thinking that if they don't they won't be treated* (Health worker, National Hospital, SAB)

This creates an environment in which it is rare to make complaints or denounce anybody. Patients are aware that they may have to return to this very same health worker.

> *Guineans are afraid to say, 'he charged …' they are worried because they may have to go back and be treated by the same health worker, so they don't want to talk*. (Director, health centre, SAB)

With very few health specialists working in Guinea-Bissau and little competition in the health sector, health workers find themselves in an asymmetrical power relationship and are able to take advantage of this for personal monetary gain. Their position is strengthened due to the lack of enforcement and weak controls across the sector.

4.3.4 Lack of accountability

Interviewees referred to a severe lack of organisation, a dismantled system and bad management practices throughout the sector from facility to central level. Some examples are given below.

> *But the problem is who can control us? If our boss who is there at the Regional Office was here and did this, and has a straw tail (rabhol de palha)*[9]*, you have a straw tail, I have a straw tail, who will control whom? I know what you are doing, you know what I am doing, how are you going to control me? We are all just going to pretend.* (Nurse, FGD, regional hospital)

This highlights the sense of impunity, as any actor who has power is involved in a game with no incentive to break this structure, which has become the norm.

> *There is no penalty. For example, if a health worker decides to work only on Tuesdays, there is no penalty, no sanction. If he makes illicit charges,*

9 The 'straw tail' refers to the feeling that if one was to be set alight then they would all catch on fire.

> *there is no penalty, no sanction, there is a lack of authority and a lack of respect for authority* (Coordinator, NGO)
>
> *You are dealing with public money and you have your own needs, so you will look to this public money ... the safe in my office, it is a safe for public money, but you have your children who should be in school… Often this is what motivates someone to be corrupt. Being so close to public money creates motivation to touch it* (Director, regional hospital)
>
> *As hospital managers we have no power, we are completely limited* – Director, regional hospital

There is general acceptance of widespread corruption not only throughout the health sector but the country as a whole. It is described as a routine and a habit with a sense that everybody, especially the decision-makers, are connected and immune.

> *Here [in Guinea-Bissau] someone is always "my nephew" or some family member, so they are protected, but we know that there are people who practise these acts and that they should be punished* (Government official, SAB)
>
> *In health, people make mistakes and are not penalised, and if they were to be penalised then these people run to MINSAP because they know somebody there... it's a problem throughout the whole country* (Doctor, National Hospital, SAB)

The vast number of actors involved highlights that transparency in itself would not eliminate these practices. Currently, there are incentives to remain in line with practical norms such as participating in demanding informal payments as per others in the network.

As alluded to in an earlier section, the national-level political system exerts few pressures to follow rules or to improve performance. Political instability compromises civil servants' work; staff recruitment, appointment and transfer are largely determined by political affinity and personal connections, and frequent changes in power result in a high turnover of leadership positions.

Studying the human resources in the health sector in Guinea-Bissau, Russo et al. (2017) find that health workers have come to 'own' the public health system, providing erratic, low-quality and payment-only services to make a living. The scarcity of funds and the 'stable political instability' have led to the commercialisation of public health services (ibid). A study exploring physicians' engagement in dual practice found that in Bissau formal private practice *outside* public facilities was very limited while informal private practice *inside* public facilities was unregulated and 'integrated' across the public sector (Russo et al., 2013). In assessing the implementation of the Bamako Initiative[10] in Guinea-Bissau in 2011, Einardóttur (2011) found nurses used informal payments to keep health facilities open during turbulent times, such as the during the 1998 and 1999 military conflict, charging high costs for curative and preventive health services.

Given that decisions regarding recruitment, deployment and promotion are mostly made on the basis of patronage, and that there is widespread impunity, malpractice and absenteeism among health workers, then remaining in a position is often dependent on the individual's ability to strengthen their informal network. Revenue-generation at health facilities (both through formal user fees and informal payments) thus helps in maintaining localised political settlements for elites at the facility level, at a cost to the wider society.

10 The Bamako Initiative was a formal statement adopted by African health ministers in 1987 in Bamako, Mali, to implement strategies designed to increase the availability of essential drugs and other health services in sub-Saharan Africa. It proposed decentralising health-related decision-making to local levels and establishing realistic national drug policies to enhance the provision of essential drugs.

5 Discussion

Informal payments in the health sector are a problem because they have a negative impact on equity and also introduce distortions that undermine efficiency and quality. In the worst cases, treatment may be withheld or deliberately delayed with a view to soliciting informal payments, sometimes with catastrophic results. There are a range of actions in place at the time of writing that address informal payments, either directly or indirectly (see Table 3).

Our research has revealed that informal payments take a number of forms and are caused by a variety of factors, of which low salaries and a culture of accepting informal payments are probably the most serious. Thus, any solution to the problem of informal payments in Guinea-Bissau will need to address both factors simultaneously. For analytical purposes we discuss each in turn.

Firstly, low salaries. It is unrealistic to think that informal payments can be eradicated or even significantly reduced without doing something to raise health workers' salaries. But what is to be done? Salaries are low because Guinea-Bissau has a small GDP per capita and government revenue is low, with only a comparatively small proportion of revenue allocated to health. One underlying reason for the latter is that the political settlement in Guinea-Bissau is of a narrow, elitist type. The urban and rural poor are not well organised and, insofar as they are incorporated into the political system, it is mostly by means of patronage networks. There is no strong pressure to increase social spending; there

Table 3 Current actions that target informal payments either directly or indirectly in Guinea-Bissau

Implementer	Action
Patient's Office and AIDA	The Patient's Office (Gabinete de Utente) and Ayuda, Intercambio y Desarrollo (AIDA) (both NGOs funded by the EU) seek to provide information to patients and protect their rights. Actions include posting price lists in health facilities; supporting a group of neighbourhood youth representatives from SAB to write monthly bulletins outing malpractice; assisting centres in SAB to write a rules of procedure document; assisting with denouncements; working with social workers, etc.
PIMI	The PIMI programme offers many MCH services free of charge to help reduce financial barriers (see Box 1). Information pamphlets are distributed by EMI.
MINSAP	Social assistants are working in health facilities, in particular in the National Hospital, providing support and information to patients. A Health Workers' Forum has been organised by staff from the National Hospital (see Box 3).
National Hospital *Simão Mendes*	A Health Workers' Forum has been organised by staff from the National Hospital (see Box 3).
MINSAP	A committee has been formed by MINSAP to identify false evacuation papers (see Box 2).
Health facilities	Some individual hospitals or regional directors are acting independently to prevent practices using conversations, warnings and letters.
UNDP and NMP	The National Malaria Programme (NMP) and the United Nations Development Programme (UNDP) have created a hotline for members of the public to denounce issues relating to the Malaria programme, including illicit charges for malaria tests and medicines.
MINSAP	Policy documents exist that cover schemes from partners and government.

Box 3 Forum for health workers

One potential starting point is to expand upon the initiative of the 'First conference of technicians and collaborators of the National Hospital *Simão Mendes*' that was independently organised by health workers at the National Hospital. This Forum took place on 14–15 September 2018 in Bissau and was attended by 120 participants, most of whom were health workers. The agenda included discussions on professional ethics; the relationship between different professionals and users; the main problems facing health professionals and the hospital, such as patients without medical records, staff absenteeism, illicit charges, illicit sales of medicines and private consultations; the importance of teamwork; identification of organisational constraints and a proposal for improvements; and the importance of protocols for the functioning of the hospital.

Resolutions and recommendations were agreed in a signed document. Examples of resolutions relating to this research include: not to perform or allow an illicit charge in the hospital, namely charges for medical consultations, surgeries, filling a medical report, requesting medical advice, etc.; not to sell medicines to patients; not to use the hospital facilities for private consultations; and a commitment to establish a report card procedure. At the time of writing regular meetings within the hospital directorate are being held to monitor the progress of such agreements. The uniqueness of this approach is that it has come from within, initiated by health workers to address issues facing health workers. This Forum, which focused on the National Hospital, could be supported and duplicated across the regions in an attempt to start a much-needed internal discussion. The monitoring of actions decided in the Forums will be critical and should be supported by non-state actors.

is no social contract in which political elites earn legitimacy by using the state to deliver services, effectively, at scale. International partners and health advocates in Bissau and beyond can lobby the state to increase healthcare spending and the 2019 elections may provide an opportunity to raise the profile of health spending; but it is unrealistic to expect a dramatic change. Even if spending were increased, there is no guarantee that it would reach health workers. The dispersed nature of power in the political settlement means that revenue delays and leakages are commonplace.

A radical proposal is to permit some formalisation of informal payments. This would involve allowing health workers to transparently charge fees and retain revenues locally, providing effective incentives for them to deliver services and stay in post. It would be a step down the road of formally privatising a health service that is already to a considerable extent informally privatised. The increased transparency regarding payments might well mitigate some of the more damaging aspects of the current system – such as exploiting the most vulnerable patients and subjecting them to unnecessary delays – leading, perhaps, to greater efficiency and quality.

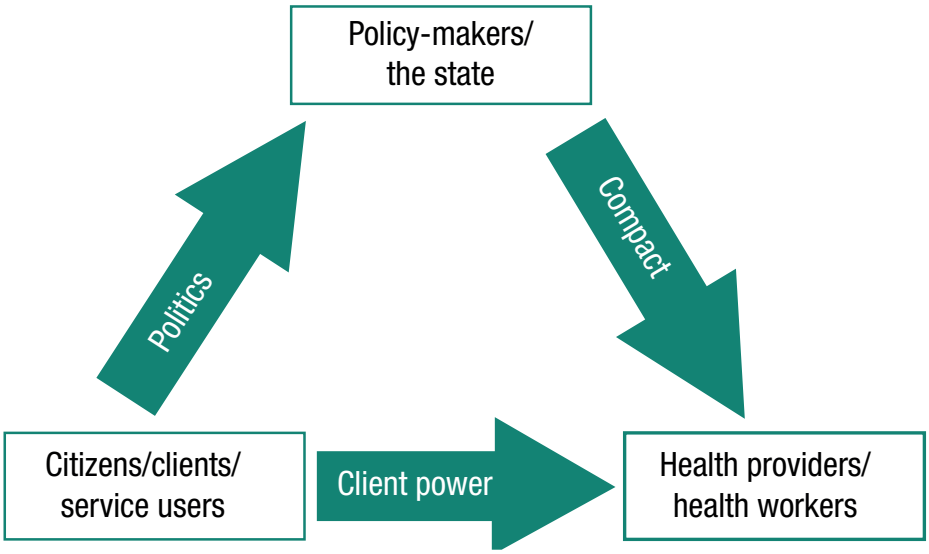
Such a proposal would do little to address the equity issue, however, and may even exacerbate it, in the sense that patients who are genuinely unable to pay would be denied treatment. International partners and NGOs would probably oppose such moves, since they offend the idea that a modern state should have a well-functioning health service that provides quality services to all. Conceivably, the government, development partners and NGOs could institutionalise measures to help the poorest, for example through health-equity schemes, such as those operating in countries such as Cambodia, or exemptions for certain types of treatment (Kelsall and Heng, 2016). Yet the fact that the latter already exist for MCH services but are not honoured, brings us to the second dimension of the problem.

In Guinea-Bissau there is a culture of demanding or accepting informal payment, and the reasons this persists, as we have seen,

are various. Patients sometimes lack proper information about fees and charges. Even when they have the information, there is a power imbalance between them and the health workers who treat them, sometimes making them afraid to speak out. Even where malpractice is exposed, health workers are often protected by patrons elsewhere in the service. Doubtless, if health workers were better paid, the incentives underpinning this culture would be reduced. But the culture is unlikely to be eliminated until there is better information, monitoring and accountability throughout the system. As we have seen, the nature of the political settlement in Guinea-Bissau means that this is unlikely to come via what the World Bank calls the 'long route' of accountability, with citizens putting pressure on their political representatives that is then transmitted downwards, through the bureaucracy, to frontline service providers (see Figure 1) (World Bank, 2004). Nor is the 'short route' of client power likely to work without considerable investment, since the poverty and illiteracy of most of Guinea-Bissau's rural population makes it difficult for them to hold health workers to account.

Levy and Walton (2013: 11) highlight the opportunity for achieving gains in the large space in between the short and long route. The authors point out how citizens can influence organisational behaviour by 'engaging with a variety of stakeholders that influence organizational behaviour at intermediate levels'. Change is most likely to come when groups of concerned actors join together to experiment with solutions. These are likely to be found in the health development partner and NGO community and among some sections of the health sector itself. For example, the National Hospital recently held a forum covering topics on ethics and corruption and agreeing upon a set of ambitious objectives (see Box 3). Given what we know about the financial drivers of the problem, such an initiative seems highly optimistic. However, its champions could aim to learn from what does and doesn't work in the experiment and join forces with other partners to pilot these in an iterative way elsewhere. The ingredients of the solution are likely to involve increased information, monitoring and sanctions (positive or negative), and could draw on a range of approaches, including media campaigns with investigative journalism, community theatre, NGO monitoring, community scorecards, health-sector performance league tables, disciplinary commissions, awards for outstanding service, and so on; but the precise 'recipe' for success

Figure 1 ***World development report*** **accountability triangle**



Source: Adapted from World Bank (2004: Overview)

will have to be worked out by local actors in the national context.[11]

All of these initiatives have the potential to reduce the prevalence of informal payments. A coordinating body of reform champions could monitor these individual experiments and assess their efficacy. But reformers need to be realistic. Given the constraints on the system, initial successes are likely to be modest. But that does not mean that, over time, if energy is sustained, they cannot grow into something more substantial.

The occurrence of informal payments indicates the need to re-think the current financing policy of the health sector in Guinea-Bissau and open up a dialogue on alternative health financing mechanisms to design a health system that works for the longer term. The health sector is highly dependent on out-of-pocket payments and external funds, which raises equity and sustainability issues. In practical terms, opening a dialogue on alternative health financing mechanisms should start by hosting a conference on the topic, in collaboration between MINSAP and the Health Sector Partner Coordination Committee. The conference should promote open debate and ensure that minority groups are given space to be heard, and it should be attended by government officials, health partners, the association of health workers, civil society groups and health workers themselves. The conference should begin by illustrating the current financing policy, followed by the presentation of alternative financing mechanisms to be discussed and ranked according to how technical, feasible, cost-effective, equitable and sustainable they are. The reality of informal payments must be addressed in this discussion; ignoring corruption undermines any future efforts towards achieving UHC.

The following examples are suggestions of mechanisms that could be discussed at such a conference: the introduction of 'sin taxes' on tobacco, earmarked for the health sector; a national health insurance scheme rolled out at community level; and community-based financing mechanisms. Key speakers should be invited to describe experiences from other contexts, and a dynamic workshop session should assess the different financing options. An action plan with clear short-, medium- and long-term goals should be drawn up and closely monitored and evaluated by both internal and external actors.

5.1 Conclusion

This paper contributes to understanding the complexity of the informal privatisation of the public health system in Guinea-Bissau, which is weakly regulated and under-financed domestically. By qualitatively understanding the four core types of informal payments and related processes from users of and providers in the system, we can begin to explore a realistic starting point for who may be convinced to tackle the situation and how it might be technically and feasibly possible to go about this to improve the equity, efficiency and quality of service provision.

High costs associated with informal payments and increased uncertainty for patients can lead to inequitable distribution of healthcare, a loss of confidence in the public health system and an inefficient social outcome. Addressing the incentives and motivations of health workers should be the government's first priority, but in the current climate it is unrealistic to expect a substantial increase in public salaries. Supervision and control measures need to be put in place, but, given the distribution of power and the network of players involved, incentives are lacking for individuals to break from this structure and to take the lead on accountability and transparency processes.

This paper advocates for experimental and incremental approaches that must be monitored and evaluated, in particular, the scaling up of the

11 Starting points could be: television adverts and social media campaigns showing a scenario on 'how to use a public health facility', including paying only at the cashier, asking for a receipt, only buying medicines at the pharmacy. This could be communicated at the regional level via interactive theatre groups or with the aid of a projector; radio campaigns in local languages; informative mobile messaging nudging the population to 'ask for a receipt' or 'pay at the till'; and involvement of community health workers and citizens groups in distributing price lists and facility 'how to' pamphlets.

Health Worker Forum and measures to increase information access among service users. There is also a need to start a dialogue on the current financing policy of the health sector via an in-country health financing conference taking a longer-term macro view.

By providing a taxonomy of informal payments and an analysis of drivers, we hope this paper is a valuable input for all those searching for a solution to the problem of informal payments in Guinea-Bissau.

Annex 1: Terms and perceptions

Table A1 illustrates the variety of terms respondents used when discussing informal payments in Portuguese/Creole and translated into English.

Two proverbs came up in the interviews when discussing the prevalence of informal payments. The first, '*kabra nunde kume na ki ta kume*' in Creole means 'where the goat is tied is where it eats', meaning that people are by nature greedy and will always look to their own advantage, whether dealing with vulnerable sick people or otherwise. The second, '*lala keima, kau di segunda ka tem*' in Creole means 'the place is on fire, there is no second place', implying that in a bad situation people take care of themselves first. This proverb suggests a sense of necessity and urgency, implying that such practices are a last resort.

Overwhelmingly, informal payments were perceived as negative. Table A2 states the various perceptions, opinions or related comments given by respondents in Portuguese/Creole and translated into English. The attitudes to and perceptions of informal payments are negative regardless of the type of respondent. Nevertheless, the sense that the act is 'normal' was repeated, implying it is a pervasive and frequent practice, and at times giving a sense of hopelessness to the situation.

Table A1 Vernacular terms

Portuguese/Creole	English
Pagamentos ilícitos	Illicit payments
Atos anormais	Abnormal acts
Pagamento anormal	Abnormal payments
Pagamentos informais	Informal payments
Cobranças ilícitas	Illicit charges
Suco di bas	Low-blow (payment to reduce waiting time)
Cola/Prenda	Gift/present
Sumo	Juice (requested after childbirth)
Pagamento fora de Sistema	Payment outside the system
Jogos ilícitos	Illicit games
Roubo	Robbery
Malandrasse	Mischief

Table A2 Perceptions of respondents

Portuguese/Creole	English	Respondent
Uma intenção lucrativa, um crime	A profitable action, a crime	Non-government stakeholder, SAB
Já é rotina, faz parte do sistema	It is already routine, it is part of the system	Non-government stakeholder, SAB
A kila i ka sta diritu	It is not right	Man, Djumbai, regional capital
O ato é errado	The act is wrong	Nurse, rural health centre
Uma vergonha pa Sistema di saude	Shame for the health system	Doctor, regional hospital
É uma coisa normal no hospital	It is a normal thing in the hospital	Doctor, National Hospital Simao Mendes
Comportamento é de malvadeza	The behaviour is perverse	Woman, Djumbai, regional capital
É um ato que não dignifica o profissional	It is an act that does not dignify the profession	Government official, SAB
Um comportamento negative	Negative behaviour	Man, Djumbai, rural
I ka sta bom, populacon i na sufri	It is not good; the population is suffering	Nurse, FGD, regional hospital
Desumano	Inhumane	Deputy Director, regional directorate
Sabemos que não é ético	We know it is not ethical	Doctor, regional hospital

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