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Research Report

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POLICY INNOVATION CENTRE

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# Understanding the Multiple Social Norms Behind Informal Payments

## in the Health Sector of Nigeria

# Understanding the Multiple Social Norms Behind Informal Payments in the Health Sector of Nigeria


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## Abbreviations

| | |
|---|---|
| CHEW | Community health extension worker |
| CSO | Civil Society Organisation |
| DPH | Director of Public Health |
| EFCC | Economic and Financial Crimes Commission |
| FGD | Focus group discussion |
| HWs | Health workers |
| ICPC | Independent Corrupt Practices Commission |
| IDI | In-depth interview |
| KII | Key informant interview |
| LGA | Local Government Area |
| LIO | Local immunisation officer |
| LMICs | Low- and middle-income countries |
| NBS | National Bureau of Statistics |
| NPHCDA | National Primary Health Care Development Agency |
| OIC | Officer in charge |
| PHC | Primary health care |
| RIO | Regional immunisation officer |
| SDGs | Sustainable Development Goals |
| SUs | Service users |
| UNODC | United Nations Office on Drugs and Crimes |
| VCAT | Value Clarification and Attitude Transformation Training |
| WDC | Ward Development Committee |

# Executive Summary

## Introduction

Nigeria's healthcare system is one of the most underperforming and inequitable in the world, with one in 16 children dying within the first year of life, and one in nine before age 5. The discrepancy in access between the highest and lowest income populations is vast. Nearly 95% of high-income women receive pre-natal care, in contrast to 37% in the lowest wealth quintile. Similarly only 5% of children in the highest wealth quintile are unvaccinated, but this increases to 50% in the lowest quintile (Federal Ministry of Health and Social Welfare of Nigeria (FMoHSW) et al. 2024).

Under-the-counter payments, along with medical staff absenteeism, are two of the critical barriers to equitable access to essential, life-saving vaccines and basic healthcare services in Nigeria (Onwujekwe et al. 2020). People who pay such informal charges are 4 times more likely to report difficulties obtaining medical care than those who do not (Hsiao et al. 2019). Faced with the prospect of informal payments, patients often delay or do not seek care or rely on traditional healers or unofficial sellers of medicine, who may further harm their health. The payments deplete their resources, deepening existing poverty, and often undermine their trust in the health system altogether (Hsiao et al. 2019). At the same time, institutional corruption reduces health system funding, diverting resources needed to purchase medicines and equipment, hiring qualified staff, and maintaining facilities.

Nigeria, like many countries, has put in place robust legal frameworks and institutions to combat corruption, such as the Independent Corrupt Practices and Other Related Offences Commission (ICPC). Yet these have not been sufficient to curb informal payments in primary healthcare. According to the 2024 National Corruption Survey conducted by the United Nations Office of Drugs and Crime (UNODC) and the National Bureau of Statistics, 12-15% of people who interact with healthcare workers paid bribes in 2023, an increase from 2019 (United Nations Office on Drugs and Crime 2024). And informal payments are generally not a "one-off" event; the average rate of repeat bribe-paying to healthcare providers by people is high, approaching that of police and transportation officials (United Nations Office on Drugs and Crime, 2024, pp. 68, 71).

Conventional anti-corruption approaches, with their focus on reducing discretion and increasing transparency and accountability through monitoring and punishment, tend to ignore significant factors that motivate **health workers** and **service users** to engage in informal payments. Emerging global evidence on the effectiveness of anti-corruption interventions points to social norms as a significant reason for this persistent gap between policy and practice. **These shared expectations within a group about what is typical and appropriate can drive people to engage in corrupt behaviours (or circumvent anti-corruption measures), *despite* the formal rules and *despite* their own personal attitudes.** The social norms interact with institutional failures and personal incentives, sustaining these harmful practices even when they are widely perceived as wrong.

In this report, we present findings of a study designed to identify and unpack the social norms driving informal payments in Nigeria's health sector. The research applies an intersectional lens to understand **how gender and faith-based norms influence health workers' and service users' decisions around informal payments** and how those lead to differences in corrupt behaviours. Understanding the intersecting influences of different norms is critical to designing effective, context-sensitive anti-corruption interventions.

The study employed a participatory, qualitative research approach. 156 interviews which includes 30 focus groups, 90 IDIs, and 36 KIIs were conducted with 366 participants across three diverse states: Kano, Nasarawa, and Ebonyi. These states were selected for their varied geographical, cultural, religious, and corruption indices. The study used Cislaghi and Heise's (2016) Flower Framework, together with intersectional analysis, to unpack how social norms, particularly those related to gender and faith, interact with individual beliefs, moral justifications, material conditions and institutional dynamics to shape people's actions around informal payments. Data was coded using qualitative software, and the analysis was supplemented

by three sense-making workshops – one in each of the states in which the fieldwork was conducted. This holistic approach helped to distinguish between social norms and non-normative drivers of informal payments (e.g. low salaries, inadequate oversight, and poor facility resourcing) revealing how they are both a structural and social phenomenon with multifaceted causes.

## Key Findings

### 1. Informal Payments Are Widespread and Typical

Informal payments (commonly referred to as under-the-counter payments) have become a typical part of accessing healthcare, particularly maternal, newborn, and child health services. **Health workers** frequently ask for payments, particularly from those perceived to be unlikely to challenge the request. Similarly, **service users** often proactively offer payments to secure faster or better treatment. This occurs despite widespread agreement among both **service users** and **health workers** that it is wrong to charge for services that are supposed to be free. Over time, this behaviour has become normalised, eroding public confidence in the health system.

> **"If you don't give something to nurses, they will delay you or treat you badly. Most times I don't like it, but I just have to pay."**
> (Service user)

**Service users** rationalise the payments as necessary to receive adequate care, while **health workers** often justify the practice by pointing to low salaries, shortages of supplies, and the lack of resources within facilities. They argue that the funds gained through informal charges cover institutional gaps and allow primary healthcare facilities to operate.

### 2. Health workers: Pressured by a combination of social, gender and faith norms

Over time, what began as an exception has become expected, driving **health workers** to solicit or accept informal payments and influencing **service users** to refrain from challenging them when they are requested.

For these **health workers**, informal payments are not just about personal choices or institutional failure. They are deeply entangled in the social expectations that surround them within and outside the health facility. Within the facilities, especially in under-resourced areas, a quiet but powerful institutional culture exists where collecting something extra from **service users** is not just tolerated but expected. There is often an unspoken understanding among **health workers** reinforced by peers, supervisors, and even **service users** that collecting something 'on the side' is simply how things are done. Peers do not say it outright, but the message is clear: this is how things are

> **"[T]he demand at home is too much on a health worker, so they will just succumb to asking for payments at the facility, especially that's what everyone is doing."**
> (Female Community Health Extension Worker, Kano)

Refusing to request informal payments leads to subtle social sanctions for **health workers**: being mocked for being naive, sidelined, and labelled as "difficult" by colleagues who depend on the extra income stream. They are seen as naive or uncooperative and often lose support and are ostracised, especially by supervisors who themselves turn a blind eye and often participate in corrupt practices. As a male **service user** in Ebonyi said: "If a health worker wants to be different and not take the charges, the colleagues will see her as a bad person and try to avoid her."

These social pressures do not stop at the facility. In the community, **health workers** are often perceived to be financially secure and socially elevated. A community **health worker** explained this expectation: "people generally believe that once you are a health worker, you are the richest person, and when ceremonies like weddings come, you should be able to contribute to your family." As a result, families and friends expect them to contribute generously at home, as well as to events and ceremonies.

When a **health worker** cannot meet these expectations, social sanctions are imposed by the community. They are quiet but swift: whispers about stinginess, questions about whether the job is as "good" as it seems, or even withdrawal of respect. For many, informal payments have become a way to meet these unspoken obligations and maintain status.

**Gender shapes how this pressure is felt and acted upon.** Male health workers often feel a direct pressure to be good "providers", not just for their immediate families, but also for broader kinship networks. Their ability to provide is closely tied to gendered expectations about masculine identity, and the extra income from informal payments helps sustain this role. This heightens the existing pressures on them as health workers to collect informal payments to meet family and community expectations.

> **"Men are the ones who are breadwinners of their family, and your wife cannot ask you for money and you don't have; it reduces your worth as a man."**
> (Male health worker, Kano)

For female health workers, the experience is more complex. **Gender norms create expectations on female health workers that they should be compassionate, caring and honest**. To ask directly for informal payments could invite harsh social judgment; being seen as greedy, unkind, or "unwomanly". **This does not, however, lead them to solicit informal payments less frequently than men.** The expectations from peers and superiors within health facilities to collect informal payments are not gender dependent. And in some places, like Ebonyi, where women are entering the workforce in greater numbers, female health workers have come to be viewed not just as homemakers and caregivers, as gender norms traditionally prescribe, but also as breadwinners, like men, with all the pressures to support family and community that come with that role.

**Women experience a gender double bind:** feeling pressure to collect informal payments to fulfill their "provider" role but also expected to be caring and not corrupt. To resolve this dilemma, most collect informal payments in less visible ways, dropping hints, waiting for service users to offer, or framing the payment as support for the facility rather than a fee to ensure better care for the service users, reinforcing their role as nurturers.

**Faith norms create similar tensions for health workers, especially women, in communities where faith values strongly shape social life**, as in Kano. Religious norms proscribe corrupt behaviours. Most health workers know that overtly demanding money can damage their reputation, not just professionally, but spiritually as well. If it becomes known that someone has accepted an informal payment, community members may see it as sinful, and religious leaders may speak against such practices.

Yet pressures to collect informal payments due to social norms amongst health workers and within the community do not disappear. Faced with demands from competing norms and serious social and reputational consequences for violating them, health workers learn to adapt. They continue the practice but try to reduce the risk of sanction for violating the faith norm by rebranding payments as "tokens," collecting them discreetly, and often deferring them until after treatment. The language shifts, but the underlying behaviour remains; only now it is more covert and cloaked in socially and morally acceptable terms.

> **"Even though they don't really ask for payments here, but the truth is that it is those who pay them that get the best and also information when supplies and free drugs comes."**
> (Female service user, Nasarawa)

In Nasarawa, it is not faith norms, but stronger institutional oversight and accountability processes that have made open solicitation of informal payments less acceptable. There, being a "good health worker" means delivering services without expecting extra rewards. Also, more active oversight and enforcement of formal regulations by Ward Development Councils and the National Primary Health Care Development Agency, along with a more informed public, has created an environment where health workers feel more accountable to their communities. The presence of these structures has nudged behaviour in a different direction: collecting informal payments is no longer openly accepted.

But informal payments persist. They are merely asked and accepted differently: more quietly, sometimes in private or at odd hours, or shifted to post-service, purportedly voluntary and permitted "appreciation". And so, even in a place where accountability was stronger like Nasarawa, health workers continued to navigate the same gendered and moral pressures, only now with more caution and greater subtlety. This shows how persistent these social norms are. Which means even when systems im-

prove, the expectations tied to one's role, as a health provider do not simply fall away. Instead, they can become more difficult to manage, leading to quiet resistance, or deeper secrecy. Ultimately, what emerges is a story not just of broken systems, but of social weight of how norms, gender roles, and faith shape decisions in ways that often go unseen. Hence, **health workers** continue to solicit informal payments, not because people are unaware, they are wrong, but because the pressures to comply often outweigh the means and incentives to refuse.

### 3. Service Users: Social norms reinforce expediency and practical need to offer informal payments

For **service users**, the motivation to offer or accept to pay informal payments is primarily practical. **Health workers**, as gatekeepers to life-saving services, occupy a powerful role vis-à-vis the user. **Service users** perceive that health care workers deny care, manufacture delays, claim that there are no drugs available or avoid users all together if they do not receive informal payments. This makes **service users** feel obligated to offer or comply with demands for payment to access treatment.

> **"I noticed that the next time I came to the facility, the nurse I appreciated the last time just called me up and attended to me with all joy and that made my day, so every time I visit the facility, I just give her money for drinks".**
> (Female Service User, Kano)

> **"My wife noticed that a nurse attends to me faster whenever I take our daughter to the hospital because she is a Sickle cell patient, and it's only because I give them lunch money whenever I'm leaving".**
> (Male Service User, Nasarawa)

But social and gender norms also shape **service user** responses. Making informal payments helps **service users** bypass delays so they can return quickly to the personal, work, or household responsibilities—often gendered—that their families and communities expect them to fulfil. When they refuse to pay, they suffer not only negative consequences in their treatment by **health workers**; they also are subjected to social criticism from families and peers.

As the traditional primary caregivers in their families and often the main users of healthcare, **women experience greater vulnerability to informal payments, not only because of pressure to fulfill their gender role of caring for their family, but also due to gender norms of submissiveness and trust**. Gender norms dictate that women should be agreeable, nurturing, and avoid confrontation. Thus, even when a woman knows she is being exploited, she is more likely to pay quietly than to speak out. Challenging a **health worker** can seem not just futile but also unwise, as refusing or questioning a request can lead to delayed or denied care. Men, on the other hand, are expected to be assertive, confident, and connected. This social positioning gives them a bit more room to push back when they choose to do so.

> **"We women, if they confuse us small, we will just give."**
> (Female community member, Nasarawa)

### 4. The grey zone of "appreciation": Informal payment or gratitude?

**Service users**, especially those of higher social and economic status, typically offer "tokens of appreciation" as an expression of gratitude for the care they have received. These are given after (as opposed to before or during) the procedure, with no explicit request from the **health worker**. Especially in culturally tight-knit communities like those in Kano, it is customary to show gratitude to those who are "of service", such as teachers, religious leaders, and most especially "life savers" (e.g. **health workers**). **Culturally, these gifts reflect a norm of appreciation and reciprocity, grounded in values of respect and communal relationships**. In some places, failure to give might be interpreted as being ungrateful, or even religiously disrespectful, not only by **health workers**, but in the community, damaging a person's reputation and social standing. Both **health workers** and **service users** thus distinguished "appreciation" from informal payments, viewing them as appreciation and therefore acceptable because it is a gift and are voluntary.

However, in the context of material scarcity, low salaries and social pressures to support family and community, this framing has been shifting. What began as a heartfelt "thank you" after receiving care has increasingly come to be expected after services. **Service users report that**

**they feel they are expected to offer a gift or small amount of cash to secure better attention next time**, or simply to avoid being ignored.

> **"It could be after you have tried and done all you can do with all your effort to help a couple during delivery. When they feel appreciated, they will ask you to take this gift from the bottom of their hearts, so those appreciations are normal."**
> (Community Health Worker, Nasarawa)

> **"It is a gift, there is no problem because anyone can be given a gift; I do this most times when I know the health worker has really tried for me, it is normal."**
> (Service User, Kano)

Health workers do not request "appreciation" explicitly, but communicate the expectation in subtle, but clear, ways. As one female service user from Nasarawa explained, "[t]here is something called reading the room. Of course they won't ask you to give them gifts, but actions speak louder these days. Especially when you see the OIC always hurrying the nurse, you just know you haven't been doing the right thing." What was once seen as a voluntary gesture has become a strategic necessity.

This reframing of informal payments as "appreciation" is more than just a coping mechanism. It is a way for service users to rationalise the transaction, to protect the health worker's dignity, and to avoid confrontation. But it also reinforces and legitimises the practice, making it harder to call out and dismantle because it is "just appreciation", not corruption. As a result, "appreciation" has evolved from a positive expression of respect and gratitude for exceptional care to a harmful practice that limits access to healthcare, reinforces inequality and favouritism, and further marginalises the most vulnerable, all the while shielding health workers who benefit from the practice from accountability for their behaviour.

## 5. Programmatic Implications

Informal payments are a complex problem. They are not just about greed or ignorance or even material need. **Informal payments are the result of deeply entangled dynamics of structural and institutional deficits, scarcity, fear, and unspoken social rules, and expectations**.

Any effort to combat informal payments must take this complexity into account. Many people (service users and health workers) already believe that these payments are wrong. What is needed is a more holistic approach that addresses the gaps in transparency, accountability, and oversight that enable these practices *and* the structural weaknesses and social norms that motivate people to engage in them. Practitioners and policy makers convened by the research team to identify practical implications of the findings regarding social norms identified several key elements of such a holistic approach.

1. **Address social norms together with non-normative causes.** Social norms cannot be addressed in isolation from material conditions. Attempting to transform social norms driving health workers and service users to engage in informal payments will be unsustainable if the hospital has no commodities, consumables, no oversight, and a long line of service users. The reverse is also true – tackling oversight, accounting and resourcing without addressing norms will also not generate sustainable behavior change. These problems do not exist in silos, but rather reinforce each other – so our response cannot be siloed either.

   Social norms change therefore needs to be integrated into existing efforts to address non-normative drivers and enablers of health workers' and service users' behaviours, from inadequate funding and shortage of supplies to low salaries and lack of transparency around pricing of services. For example, increasing transparency of pricing and billing for services and medications could enable service users to hold health workers accountable, while a social norms intervention could address expectations that hinder people, especially female service users, from speaking up. Similarly, creating processes for aggregating charges could institutionalise a facility-wide process that ensures needed supplies are obtained while diminishing individual health workers' incentive ability to charge more, while a social norms component could address motivations stemming from community expectations to solicit payments. In other words, conventional anti-corruption tools to strengthen transparency, monitoring, oversight, and reporting procedures can and should be pursued alongside social norms change efforts.

2. **Move beyond citizen-focused strategies alone:** Engage health workers to address the social norms and other incentives that motivate their behaviour.

Citizen-focused tools, such as community scorecards, budget tracking, and citizen charters are important, but they are not enough. Real change requires engaging **health workers** themselves as the power holder in informal transactions. **Health workers** need to be engaged not only as professionals, but also as people influenced by their environments, families, and religious communities.

One major pitfall to be avoided is over-reliance on sensitisation, or awareness-raising, campaigns. Awareness without structural change can do more harm than good. It can normalise the practice and even increase it by heightening its salience without changing the conditions or expectations that fuel it. It can create perceptions that informal payments are more prevalent than they are, discouraging those who may want to behave differently (Peiffer and Cheeseman 2023). Worse still, it can place blame on **service users**, especially women, who already carry the weight of societal expectations, without providing them the tools or protection to say "no." Where social norms play a role, awareness-raising raising must also seek to change perceptions that "everyone does it" and use multiple channels, from preaching to dialogue, professional groups as well as media to diffuse messaging and influence perceptions. It must go hand-in-hand with creating safer, more equitable systems.

3.. **Work to change the components of social norms that are most feasible to influence.** Norms are made up of several components, each requiring different strategies for change. It may be possible to influence the social rewards and sanctions within health facilities for complying or defying norms to collect informal payments. This would weaken the norm by shifting perceptions that defying the norm will bring personal and professional harm. And while it may be difficult to change family and community expectations that **health workers** (like all government employees) should contribute generously, it may be possible to "right size" expectations of how much **health workers** realistically can contribute and thereby reduce pressure on them to collect informal payments.

4. **Gender and faith norms must be part of the conversation as a central pillar.** The nuanced influence of these intersecting norms needs to be considered in segmenting the target population (both **health workers** and **service users**) for programming. Goals and activities need to be tailored to the different pressures different people experience because of gender or faith norms. For example, programmes may need to intentionally engage men separately in conversations about masculinity and provider roles to address the particular pressures they face to collect informal payments. They may also need to challenge the idea that resisting informal payments is a mark of masculine weakness and instead promote male role models who demonstrate values of integrity, fairness, and care for the community.

   By contrast, women, who are often at the frontlines of these interactions, may need to be engaged differently, with approaches that help them navigate the competing social pressures they face, while also avoiding putting them at further risk. This could mean building solidarity among women, training female health advocates, promoting female role models, or creating discreet reporting mechanisms.

   Faith leaders, too, may be vital partners. In many communities, interpretations of religious teachings can either reinforce or challenge corruption. Working closely with religious leaders to support integrity can help shift these narratives and create space for ethical, justice-oriented interpretations that support accountability rather than excuse exploitation. Yet this will require going beyond preaching and influencing attitudes: engaging religious leaders as social influencers to enhance social rewards in the community for those who challenge informal payments and to temper expectations and rewards related to contributions to religious communities.

5. **Approach reforms with humility and care.** The social norms that motivate **health workers** and **service users** to engage in informal payments are not always harmful. Many, such as expectations of support to family hospitality, respect, and reciprocity, are worth protecting. It is important to ensure that these positive values are not misused to justify exploitation. That means designing interventions with community input, anticipating and minimising unintended negative consequences, and committing to a "do no harm" approach that avoids increasing stress or expectations on women to engage in informal payments or punishing them more when they choose to resist.

## Conclusion

Informal payments in Nigeria's health sector are not merely a result of weak policies or poor enforcement; they are entrenched social practices shaped by expectations, relationships, and daily realities. **Health workers** and **service providers** are not simply on opposite ends of a corrupt transaction; they are navigating a system that is broken and often hostile to both of them. The social norms identified in this study create pressures that make it difficult for them to change their behaviour.

Tackling this issue requires moving beyond the behaviour itself to understand the broader normative and structural forces at play. Through integrating an intersectional lens, prioritising social norms, and investing in multi-level accountability mechanisms, it is possible to design inclusive and context-sensitive programs that not only reduce corruption but also restore trust, promote dignity, and ensure equitable access to healthcare for all.

# I. Introduction

## A. Background

Effective healthcare delivery constitutes a crucial pillar of national development, with far reaching impacts not only on health outcomes but also on broader socioeconomic indicators such as economic productivity, educational attainment, and poverty reduction. Several interrelated factors hinder governments from achieving Universal Health Coverage, particularly in Low- and Middle-Income Countries (LMICs). These include weak health systems, underfunded primary healthcare, systemic issues such as poor governance and corruption, and harmful social norms that limit access to care, among others.

Corruption is the quicksand undermining Nigerians' access to healthcare. It not only impairs access but is additionally associated with adverse health outcomes, including higher infant and child mortality rates, low life expectancy, and reduced immunisation (Glynn 2022; Bukari, Seth, and Yalonetkzy 2024). One in 16 children die within the first year of life, and one in nine before age 5. At the same time, the discrepancy in access between the highest and lowest income populations is vast. Nearly 95% of high-income women receive pre-natal care, in contrast to 37% in the lowest wealth quintile. Similarly, only 5% of children in the highest wealth quintile are unvaccinated, but this increases to 50% in the lowest quintile (Federal Ministry of Health and Social Welfare of Nigeria (FMoHSW) et al. 2024).

Women, especially those with low incomes or other vulnerabilities, disproportionately bear the burden of these consequences deepening the existing gender, socio-economic, and health inequalities (Aluko and Aluko 2017). For example, in many primary healthcare facilities in Nigeria, informal payments are frequently demanded for services that are officially free or subsidised services, such as maternal healthcare or vaccines. Lacking the financial means to afford these additional charges, many women delay or never access essential care. This increases risks of complications, maternal mortality, and poor child health outcomes significantly.

Corruption in healthcare takes on many forms, from absenteeism to procurement-related corruption and informal, under-the-table payments for services (Onwujekwe et al. 2020). Recent studies, including with senior and frontline healthcare managers and policy makers, found informal payments to rank second in significance and harm, after absenteeism (Buowari 2017; Onwujekwe et al. 2020).

Corruption in healthcare is not distinct from the corrupt systems that are deeply entrenched in Nigeria's political, economic, and social systems and has serious impacts on access to and quality of public services, governance, and human rights (Izuchukwu, Awakessien, and Awakessien 2024). Nigerians perceive corruption to be among the country's most important problems, after the cost of living, insecurity and unemployment (United Nations Office on Drugs and Crime 2024).

Political instability, lack of transparency, and judicial inefficiencies contribute to corruption incidence, making reform efforts complex. Despite successive governments introducing anti-corruption initiatives, including the creation of Economic and Financial Crimes Commission (EFCC) and the Independent Corrupt Practices Commission (ICPC), inconsistent enforcement undermines progress. Corruption continues to erode public trust, hinder economic growth, and exacerbate social inequalities. Nigerians' confidence in the government's anti-corruption efforts has been declining as well; in 2023, less than one-third of citizens believed the government was effective in combating corruption, down from over half in 2019 (United Nations Office on Drugs and Crime 2024).

Given the deeply embedded nature of corruption, there is an ongoing debate about whether institutional reforms alone can effectively tackle the problem (Awhefeada 2023). Many countries, including Nigeria, have implemented robust legal frameworks and institutions reflecting international best practices, only to see them undermined by institutional weaknesses and resistance, leading to what has been termed the 'implementation gap' (Johnsøn, Taxell, and Zaum 2012). A growing body of evidence suggests that a key driver of this gap is the role of informal networks and social norms, with gender, faith, and other social identities shaping both engagement in and resistance to corrupt practices (Kubbe, Baez-Camargo, and

Scharbatke-Church 2024; Jackson and Köbis 2018). This research suggests that informal normative frameworks grounded in reciprocity and solidarity operate alongside formal legal frameworks for regulating service delivery to influence people's decisions about whether to engage in corrupt behaviours (Baez-Camargo et al. 2017). These informal norms not only reinforce the social acceptability of corrupt practices in certain contexts but also provide motivation to engage in corrupt behaviours and may even be more influential than formal laws and institutions in shaping them.

In Nigeria, researchers have increasingly identified social norms underlying various corrupt practices, from judicial bribery, vote-selling and procurement fraud to bribery in traffic violations, absenteeism in hospitals and bribery in schools (Hoffmann 2024; Hoffmann and Patel 2017; 2021b; 2022). In the Nigerian health sector specifically, recent studies have found that normative factors play a role in driving informal payments, alongside non-normative ones. In Enugu, for example, pressure on facility leads by health managers was identified as a significant driver of informal payments, along with institutional drivers such as underfunding, lack of consistent and transparent regulation around fees and lack of oversight (Ogbozor et al. 2023).

While it is increasingly clear that social norms influence and need to be integrated into anti-corruption strategies, research remains limited on how overlapping group norms interact with social norms to reinforce corrupt behaviours in complex socio-political environments. Some studies acknowledge that individuals of different genders and social identities experience distinct expectations regarding corruption (Hoffmann and Patel 2017; Baez-Camargo et al. 2017; Scharbatke-Church and Chigas 2016). However, none of these studies have systematically explored the intersecting influence of these norms. This leaves an important gap.

This gap raises critical questions for those developing anti-corruption strategies. For instance, will promoting women as integrity role models be effective at influencing their male colleagues? Will invoking religious norms against corruption influence behaviour? Understanding the interaction of gender and other social identities with social norms influencing corruption is crucial to designing effective and sustainable interventions.

## B. Research Goals and Questions

Our study examines how gender, faith, and social norms intersect to normalise informal payments for free health commodities and vaccines in public healthcare (PHC) across three Nigerian states. Informal payments are charges for services officially designated as free or payments made to gain or expedite access to care. These payments are common at primary and secondary levels of healthcare and create significant barriers to access, affecting the ability of vulnerable service users to access essential healthcare.

The study explores the behaviours and perspectives of healthcare providers and service users in relation to informal payments for free vaccines and commodities. This includes health workers soliciting informal payments and accepting payments offered by service users seeking access or expedited service, as well as service users offering informal payments on their own initiative and paying them when requested by health personnel.

An intersectional analysis provides a critical lens for developing a more nuanced understanding of the motivations driving healthcare providers' and service users' corrupt behaviours (Ivanov 2024). With this in hand, the study aims to generate insights that can improve policy and intervention strategies to combat corruption in Nigeria's health sector, especially the PHCs.

## C. Conceptualising the Issues: Social Norms, Gender Norms, Faith Norms and Corruption

### 1. What are Social Norms?

Social norms are unwritten (informal) rules about the right or appropriate way to behave within a group (Scharbatke-Church and Chigas 2019; Jackson and Köbis 2018). They consist of mutual expectations about a) what is typical and appropriate behaviour within the group (i.e. beliefs about how most people do or will behave) (descriptive norm); and b) what behaviour is expected or approved within the group (injunctive norm) (Ivanov 2024). Social norms should be distinguished from attitudes, values, and morals, which are personally held normative beliefs. Some social norms are direct; they mandate the specific behaviour; others are indirect in that they manifest in many behaviours (Bicchieri 2017). Attitudes

or beliefs may align with social norms, and social norms also can be internalised to become personal beliefs (Gross and Vostroknutov 2022). However, people often comply with social norms even when they disagree or think the prescribed behaviour is wrong.

Social norms are maintained and 'enforced' through positive rewards for compliance and negative rewards for violations. These sanctions are social; they relate usually to relationships and reputation and can include approval/disapproval, recognition and inclusion/criticism and ostracism, trust and confidence/distrust (Bicchieri 2006; 2017; Paternotte 2018; Scharbatke-Church and Chigas 2019). In institutional contexts, officials often use their formal authority to impose professional consequences (such as denial of promotions, transfers, etc.) in enforcing informal rules.

An important dimension of social norms is the 'reference group', a network within which any norm operates. This is the group to which a person looks for guidance on behaviour: "a group people who identify with each other or are important to each other in some way, among whom mutual expectations about what is an appropriate behaviour (i.e. social norm) are generated, maintained, and applied" and which also enforce social sanctions" (Scharbatke-Church and Chigas 2019, p. 39).

## 2. Gender Norms and Faith Norms

In this report, we define gender norms and faith norms as different types of social norms representing socially (or divinely) enforced rules of behaviour within a given group. Gender norms (sometimes referred to as gendered expectations) are social norms "defining acceptable and appropriate actions for women and men in each group or society. They are embedded in formal and informal institutions, nested in the mind, and produced and reproduced through social interaction. They play a role in shaping women and men's (often unequal) access to resources and freedoms, thus affecting their voice, power and sense of self" (Cislaghi and Heise 2020, pp. 415-416). For example, in many Nigerian communities, women may be expected to prioritise caregiving and domestic responsibilities over formal employment, while men may be socially expected to assume the role of the primary breadwinners. In healthcare settings, this can manifest as expectations from women to seek care for children but to deprioritise access care for themselves due to financial dependence or decision-making hierarchies within households.

We define faith norms as social norms governing the behaviour and interactions within a religious community. They include socially enforced rules regarding morally right and wrong behaviour as well as rules about dress, language and interactions with other members of the community. These norms are socially enforced. In the same vein, it is important to define religiosity so as to clearly differentiate it from faith norms. Religiosity refers to the extent an individual is dedicated to and personally follows the teachings of their religion (Bjornsen et al. 2019). For instance, religious adherents may promote honesty and discourage bribery among healthcare providers as a moral obligation.

## 3. Interactions of Gender, Faith, and Social Norms Driving Corrupt Behaviour

While the role of social norms in corruption has gained increasing attention, the cross-cutting influence of gender and faith norms (and norms associated with other social identities) has remained underexplored. Existing literature suggests a strong link between gender and corruption, particularly in relation to petty corruption. Studies indicate women are less tolerant of corruption, corruption is lower in societies with higher gender equality (Alexander 2021). In Nigeria, women have been found to engage in bribery less than men, both as bribe-payers and bribe-takers, with men being more aggressive in soliciting bribes (United Nations Office on Drugs and Crime 2024). The 2024 UNODC-NBS survey on corruption found that male public officials are twice as likely to solicit or accept a bribe than their female counterparts, with the difference falling to one and a half times for health workers specifically.

When it comes to gender norms, research suggests that they influence women's and men's corrupt behaviours in two ways:

- **Expectations about what is appropriate male and female behaviour influence decision-making about whether or not to engage in corrupt behaviours.** For example, women have been found to experience harsher societal judgment when they are caught in corrupt acts (Hoffmann and Patel 2017; Barnard-Webster 2017). This may influence decision-making and discourage women from engaging in corrupt practices.

- **Expectations about what responsibilities men and women should assume in the family may create pressure to engage in corrupt acts.** For example, gender role expectations of men as providers and women as caregivers put pressures on both to fulfil their respective roles and make them more likely to engage in corrupt practices in order to do so (Bukuluki 2013; Asiedu 2020).

With respect to faith, the evidence on the relationship between faith, religiosity, and corruption is mixed. Some studies suggest no significant correlation (Shadabi 2013). Others underscore the degree of religiosity (i.e. the extent to which an individual is dedicated to and personally follows the teachings of their religion as the key determinant in attitudes toward corruption, regardless of religious affiliation (Villani et al. 2019), although some suggest this is only true at high levels of religiosity and in low-corruption environments (Gouda and Park 2015; Chantziaras et al. 2020). Still others indicate that religious societies may in fact be more tolerant of corruption. This is because religious identity fosters strong in-group loyalty, trust and obligations of support. These in turn reduce incentives for monitoring and oversight and induce greater reluctance to challenge corrupt practices within one's own religious community and greater acceptability of corruption perpetrated for the benefits of the religious community (Dos Santos and Lemes 2022). Thus, while there is widespread belief that religious institutions can play a pivotal role in anti-corruption efforts (Shadabi 2013), in deeply religious societies like Nigeria, anti-corruption efforts must navigate existing religious norms and hierarchies that create counter-pressures to engage in or tolerate corrupt behaviours (Hoffmann and Patel 2021a).

In summary, when social norms promote corruption-related behaviours, intersecting gender and faith norms may reduce or reinforce their influence. For example, religious and social norms promoting mutual support and respect for hierarchy may discourage individuals from speaking out against corrupt figures within their communities. Gender norms that associate integrity with women could lead men to dismiss female-led anti-corruption initiatives as irrelevant to them. Collective loyalty norms in some ethnic and religious groups may create pressure to protect members engaged in corrupt activities rather than report them. The role of the interaction of multiple social identities in influencing corruption in health facilities is still unclear. This study builds on the interest in social norms in the anti-corruption field while adding a more nuanced perspective to the existing body of knowledge by exploring how multiple social identities interact to shape corruption-related behaviours.

## 4. Situating Social Norms in Context: The Flower for Sustained Health Model

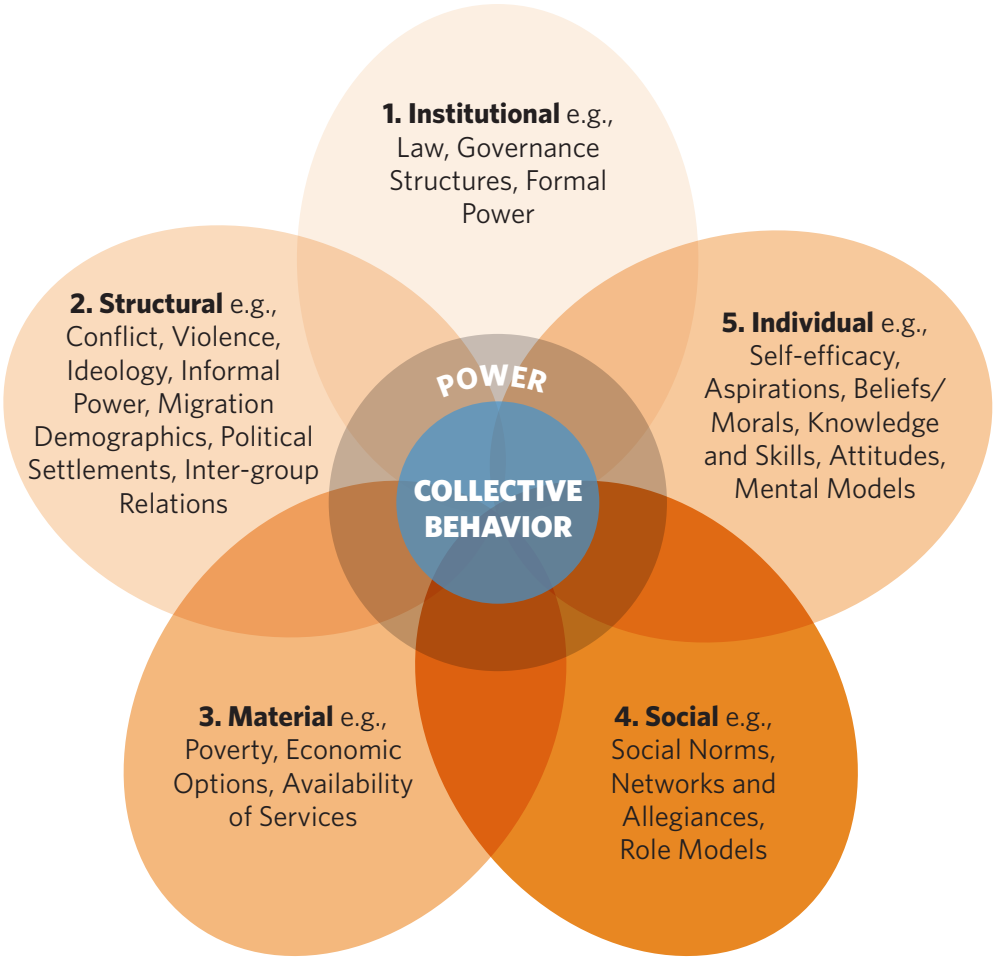
Analysis of social norms should not be done in isolation. While social norms can drive corrupt behaviours, they are rarely the sole drivers. Corrupt behaviours are shaped by a complex web of factors that interact within a system to sustain and normalise corrupt practices (Scharbatke-Church and Chigas 2019). Social norms thus must be understood and addressed alongside, and in relation to, the other drivers and enablers of corrupt behaviours, which include individual attitudes, economic realities, political dynamics and institutional failures, and structural conditions.

The Flower Framework (see Figure 1) offers an integrated model for understanding the interplay of factors that influence corrupt behaviours, including social norms. Based on the Flower for Sustained Health model for addressing harmful health behaviours (Institute for Reproductive Health 2017), it posits that their position is that social norms intersect with a number of non-normative factors to drive behaviour: individual (e.g. knowledge, skills, attitudes), resources (e.g. infrastructure, services, funding), and structures (e.g. laws, policies, institutions). Social norms are shaped and sustained by these individual, institutional and structural factors. For instance, in primary healthcare settings, weak accountability mechanisms and poor oversight enable informal payments with impunity, while underfunding creates practical needs to collect them. Poor working conditions and irregular salaries further incentivise such practices. Social expectations on people to support their extended families create further incentives to amass money; they interact with the systemic weaknesses to foster and normalise the practice of informal payments.

At the centre of the model is the role of power in reinforcing and enabling enforcement of norms as well as in shaping opportunities for challenging them. Power asymmetries often drive adherence to norms, as individuals may comply with these norms due to enforcement by those who matter to them, or due to perceived social sanctions for non-compliance. The Flower Framework model does not explicitly account for the intersection of overlapping

norms and identities and how they interact with other factors. Understanding these intersections is critical, as they may dilute or amplify anti-corruption messages depending on context, for example, when gendered expectations shape perceptions of acceptable behaviour or when religious loyalty suppresses dissent against corrupt practices within faith communities (Institute for Reproductive Health 2017).

**Figure 1: Flower Framework – Different categories of factors in a system**




Source: The Learning Collaborative to Advance Normative Change. 2017. The Flower for Sustained Health: An integrated socio-ecological framework for normative influence and change. A working paper." Washington, D.C.: Georgetown University.

# II. Methodology

This section outlines the procedures we followed to gather and analyse data on how gender, faith, and social norms intersect to drive informal payments for free health commodities and vaccines in primary health centres (PHCs) across three Nigerian states.

The research employed an exploratory qualitative design using a Participatory Action Research (PAR) approach (Cornish et al. 2023), which prioritises the value of experiential knowledge for tackling problems caused by unequal and harmful social systems. This method emphasised collaborative inquiry, active participation and iterative learning, ensuring that stakeholders were directly involved in both the research process and findings interpretation. In order to generate actionable findings, which was a major purpose of the study, participation of those who would utilise them was important.

As part of the PAR approach, an intersectional lens was applied to facilitate exploration of how gender and faith norms intersect with social norms to sustain or inhibit unauthorised charges. The intersectional lens was also applied to facilitate exploring how normative expectations, sanctions and reference groups vary across social identities such as gender and faith (religion) across states (study sites). This approach enabled exploring how these intersecting norms (social norms, gender norms and faith norms) influence the behaviours of different populations of interest for the study.

The methodology is organised into four phases. Phase One focuses on behaviour and sector selection. Phase Two details the study approach, including the study design, study areas, sampling techniques, sample size, study population, and data collection methods. Phase Three and Four focus on a sense-making workshop – conducted to validate initial findings and ensure contextual relevance and a practical implications workshop, aimed at gathering actionable programming recommendations from practitioners in Nigeria.

## Phase 1: Behaviour and Sector Selection Process

The team adopted a multi-stage approach to selecting the sector and behaviours to focus on in the study, while ensuring participant engagement throughout implementation. The initial step involved a consultative workshop with key government and non-governmental stakeholders from the agriculture, humanitarian, health, and education sectors. The workshop provided participants with an opportunity to critically examine corrupt practices within their respective sectors and analyse their drivers, enablers and key actors. Discussions delved into the possible social norms and prevailing attitudes that may perpetuate such behaviours. Additionally, participants explored the influence of gender and faith-based expectations on these practices, considering how these norms might collectively contribute to the normalisation of corruption.

The study team presented the findings from the consultation to the study's advisory group, a multidisciplinary team of technical and field experts and practitioners1 who provided strategic input throughout the research process. These diverse practitioners supported research utilisation for both the study process and research findings, ensuring that insights are effectively contextualised, validated, and translated into actionable interventions.

Following the advice of the advisory group, the team selected the health sector due to the robustness of data available. Additional consultations were then held with healthcare stakeholders to prioritise specific behaviours and geographic locations of interest. After multiple iterations between the team and the advisory group, two behaviours were selected. A third behaviour emerged during data collection, which was added to the analysis. The behaviours explored in the study are summarised in Table 1.

1 The Advisory Group members included: Oluwaferanmi Iyanda - Director of Programmes, Step up Nigeria; Dr. Sakina Bello - Senior Technical Advisor, Pathfinder International Waziri Adio - Founder, Agora Policy; Mark Faison - Head Advocacy and External Relations, Anti-corruption Academy of Nigeria; Catherine Angai - Doctoral Researcher, Institute of Development Studies, Sussex; Princess Chifiero - Programme Manager (Anticorruption), UNODC

**Table 1: Behaviours of Interest**

| Corruption Type | Behaviours of Interest | |
|---|---|---|
| | Health workers | Service users |
| Informal payment | Ask for informal payments from service users prior to delivery of the service | Accept to pay when health workers ask for informal payments prior to delivery of the service |
| | Accept informal payments offered by service users prior to delivery of the service | Offer informal payments before service to get expedited or better services |
| | Accept appreciation after service is rendered | Offer appreciation after they receive a service |

## Phase 2: Study Approach

### 1. Study Sites

The research was conducted in three states, one predominantly Christian, one Muslim, and one mixed, with the selection of a rural and an urban Local Government Area (LGA) in each state.[2] The selection of study sites followed a staged process. Initially, participants at the consultative workshop in Phase 1 identified several potential sites in a co-creation process that included mapping where agencies had existing programming. The technical team analysed secondary data from national surveys to determine which had the highest prevalence of bribery among public healthcare professionals, specifically doctors and nurses and established a shortlist of the sites (National Bureau of Statistics 2016).[3]

Following the shortlisting of potential sites, additional criteria were employed to select the three states in which the research was conducted: Kano, Nasarawa, and Ebonyi:

- *Religious demographic composition:* Specifically, the Muslim-Christian population ratio was essential for capturing the influence of diverse sociocultural and religious contexts on community attitudes, social norms, and perceptions of corruption.
- *Geographic accessibility:* Locations were chosen based on the availability of reliable transportation networks and infrastructure to support efficient and timely field operations. This consideration helped minimise logistical challenges and ensured that field teams could reach study communities safely.
- *Local institutional presence and stakeholder cooperation:* States with existing relationships with research institutions, local NGOs, or government actors were prioritised to facilitate smooth community entry, build trust, enhance respondents' comfort in speaking honestly, and uphold ethical research standards.
- *Potential use of the research results:* Based on the mapping of types of corruption and programming conducted in the consultative workshop in Phase 1 and the input of the advisory group. Table 2 below summarises key information about each of the states chosen.

2 Nigeria has 774 Local Government Areas (LGAs), each administered by a local government council. LGAs are further divided into wards with 10-20 wards in each LGA. The Association of Local Governments of Nigeria (ALGON) has published maps of local government areas in each Nigerian state as of July 2024 at https://algon.ng/index.php/lga

3 This data was analysed because the prevalence rate of bribery among doctors and nurses in Nigeria was the most closely aligned in the National Bureau of Statistics' and UNODC's surveys of corruption in Nigeria (United Nations Office on Drugs and Crime (UNODC) 2024; 2019; 2017) with the concept of informal payments, which is our behaviour of interest with the last available data on corruption in the health sector disaggregated by state is from 2016. This metric was therefore used as one criterion for selecting sites: states with the highest rates among those for each religious demographic covered in the study. Subsequent surveys of corruption by UNODC and the Nigerian National Bureau of Statistics (2019; 2024) provide data on rates of prevalence of corruption by state but are not further broken down by sector. These subsequent reports reveal significant shifts in general corruption rates in Ebonyi, Kano, and Nasarawa; while they do not provide data by sector, it is likely the health sector experienced trends over the years.

**Table 2: Prevalence of Bribery Indices for Study Area**

| State | Geopolitical zone | Population[4] | Predominant Religion[5] | Sub-national Human Development Index[6] | Prevalence of bribery among public healthcare professionals[7] |
|---|---|---|---|---|---|
| Kano | Northwest | 16,253,549 | Muslim 97% | .482 | 7.0% |
| Nasarawa | Northcentral | 3,632,239 | Muslim 60%<br>Christian 40% | .549 | 8.3% |
| Ebonyi | Southeast | 2,176,947 | Christian 75% | .706 | 2.6% |
| National prevalence: 8.3% | | | | | |

## 2. Sampling Technique and Sample Size

Purposive sampling technique was employed to ensure the inclusion of a wide range of participants, including health workers, service users, and members of the reference groups, allowing for maximum variation across demographic categories and perspectives. In total, the sample included 30 Focus Group Discussions (FGDs), 54 In-depth Interviews (IDIs) with health facility workers, and 36 Key Informant Interviews (KIIs) with members of the reference groups. In addition, social network mapping (Institute for Reproductive Health, CARE International, and Plan International 2020) was conducted to identify key actors and relationships within the community to explore how norms are reinforced and maintained.[8] An additional 36 IDIs were conducted with these 'reference group' members who ranked high in the social network analysis. In total, we conducted 156 interviews with 366 participants. A table summarising the categories of people in the study population and the distribution of FGDs, IDIs and KIIs as well as the research instruments used can be found in Annex 1.

## 3. Study Population and Data Collection

Data was collected qualitatively using vignettes - short stories about a person (the protagonist) and/or situation in which respondents can project their experiences and feelings without directly answering questions about themselves or their own experiences. The vignettes were developed based on the analysis developed in the consultation workshop, the team's own research experience in the primary healthcare sector, and subsequent individual stakeholder conversations in Phase 1 and tested and refined in a pilot focus group and follow-up interviews. They were further refined and adapted to the context of each state by the data collectors, who were recruited locally in each state. Vignettes were incorporated in all of the data collection instruments (Bukuluki et al. 2024):

- Focus Group Discussions were conducted with users in health facilities catchment areas, disaggregated by age (18-24, 25-34, 35+), sex (male/female), and Local Government Area (urban/rural).
- In-Depth Interviews were conducted with health administrators (director of health), supervisors (those in charge of health facilities, ward development committee) and frontline health providers (nurses, midwives, community health workers). Healthcare providers were identified in health facilities that do have and those that do not have cold chain stores, vaccines, family planning and reproductive health services.[9]

4 The last official census data in Nigeria is from 2006. Population data here is drawn from the Nigerian National Bureau of Statistics' Open Data Portal and reflects 2016 figures.
5 Figures are taken from Nwanko (2019).
6 The figures represent 2022 values drawn from the Sub-national HDI developed by the Global Data Lab at the Nijmegen School of Management of Radboud University in the Netherlands, applying UNDP's methodology. The Sub-national HDI is an average of subnational values of education, health and standard of living. Global Data Lab, https://globaldatalab.org/shdi/. See Smits and Permanyer (2019) for a full description of the methodology.
7 Based on 2016 figures, the last available data on a subnational basis (National Bureau of Statistics, 2016).
8 Social network mapping is a method used to visualize and analyse relationships and interactions among individuals, groups, or organizations within a defined social system. It helps to identify the structure of social connections, the influential actors, and the flow of information, resources, or influence within the network.
9 We chose to conduct IDIs with health workers because our experience has been that while FGDs work well with citizens, they do not within institutions. See Scharbatke-Church's (2017) blog on the research in CAR: https://www.corruptionjusticeandlegitimacy.org/post/research-methodology-for-identifying-social-norms-that-catalyze-corruption.

- Key informant interviews were held with social and cultural reference group members identified through the FGDs and IDIs, as well as individuals who wield powerful influence in health and development actions in their communities (Batt, Tavares, and Williams 2019).

Additionally, the team adhered to the principle of data saturation where data collection continued until no new themes or insights emerged from subsequent interviews. Once it became evident that additional interviews were yielding no novel findings, the team concluded data collection upon completing the initial sample size.

The tools were designed to operationalise an intersectional approach by exploring how gender and faith norms intersect with social norms to sustain the practice of unauthorised charges. All guides captured key identity markers, such as gender and religion, and used targeted probes and vignettes to explore differentiated normative expectations related to gender and faith norms. For example, participants were asked whether male and female health workers experience different social pressures from their families/communities and religious/faith communities to contribute financially to typical social events, potentially increasing likelihood of health workers charging informal payments. These vignettes and related questions enabled the study to unpack how intersecting identities shape social expectations that normalise unauthorised charges in the health sector, particularly at primary health care facilities.

## 4. Data Analysis

All interviews were audio-recorded, labelled and transcribed. The analysis was organised in two phases. First, the team used a Participatory Rapid Analysis in a workshop setting to distil factors from the transcripts and the field notes that influenced the behaviour of interest and the accompanying rewards and sanctions. This enhanced the development of the code book.

For the second phase, the study team transferred all the transcripts into Dedoose software to increase the thoroughness of the coding and analysis process. To ensure that all concepts in the data were fully captured, the analytical strategy utilised a hybrid of a deductive and inductive approach to coding. Using this approach, a priori codes and emergent codes (concepts or experiences that emerged from the data during analysis but were different from a priori codes) are presented in the social norms exploration.

The following analytic framework, following the components of a social norm, was used to identify norms[10]:

1. *Prevalence* (descriptive norm): The behaviour is considered a norm if it is commonly practiced within the group and individuals engage in it because they observe others doing the same, reinforcing a cycle of conformity.
2. *Social Expectations* (injunctive norms): The behaviour is perceived as appropriate or inappropriate if individuals engage in it not only because others do but also because they believe it is socially expected or required, even if it conflicts with their personal beliefs or values.
3. *Sanctions* (Rewards or Punishments) and *Sensitivity to Sanction:* The behaviour is reinforced if there are social rewards for compliance (such as acceptance, respect, or financial benefits) and punishments for non-compliance (such as exclusion, criticism, or missed opportunities), shaping individuals' willingness to conform.
4. *Reference group(s):* The specific reference group(s) who hold expectations, whose approval or disapproval matters or influences a person when they decide whether to engage in soliciting/accepting or paying/offering unauthorised charges, and/or who provide social rewards or punishments.

The presence and influence of faith and gender norms based on gendered roles and stereotypes were also explored as causal factors.

Data analysis followed a structured, multi-phase process guided by a collaboratively developed analysis plan. The plan ensured systematic exploration of how gender and faith norms intersect with broader social norms to influence unauthorised charges for free vaccines and commodities. The team began by identifying preliminary themes based on the study objectives and refined these through collaborative discussions and transcript reviews.

10 See Bicchieri (2017) and Scharbatke-Church and Chigas (2019) for a full description of each of the social norm elements in the framework.

A comprehensive codebook was developed to define key themes and sub-themes, with clear application criteria and illustrative examples. This coding framework operationalised the study's intersectional lens, enabling a systematic analysis of how gender, faith, and social norms interact to shape unauthorised charging practices. It distinguished between descriptive and injunctive norms across individual, family, community, and institutional levels. For instance, it captured how male health workers were often expected to charge unauthorised fees to fulfil breadwinner/provider roles, while female health workers faced normative expectations that constrained their behaviour (unauthorised charges/informal payments), leading them to charge more discreetly or sometimes abstain altogether. Additionally, the framework examined how faith-based expectations, such as contributing to religious projects or embodying compassion, could either legitimise or deter informal charging. Codes related to sanctions (e.g. gossip, exclusion, reputational harm) and exceptions (e.g. emergencies, social status, gender or faith identity of service users) provided deeper insight into when and why norms are enforced or relaxed and whether sanctions were more severe for women or men under specific circumstances.

Coding was conducted using open and axial coding in Dedoose, with memo-writing to document emerging insights. After coding, the team used Dedoose analytical tools to review and synthesise data within each theme and conduct cross-tabulations to examine how normative patterns varied by gender, religion, actor type (health worker vs service user), across the geographic location. This allowed for comparative analysis across the three study sites, highlighting regional variations in the manifestation of norms and social expectations.

Patterns were examined across intersecting codes, such as those capturing gender roles, sanctions, and institutional influence, to identify how overlapping norms reinforced or mitigated unauthorised charging practices. The coded data were then synthesised into a cohesive analytical narrative that integrates participants' voices and directly addresses the study's research questions, while reflecting cross-site and identity-based differences in experiences and normative pressures.

## Phases 3 and 4: Sense-Making Workshop and Practical Implication Workshop

After the analysis was complete, state-level sense-making workshops were held across the three study sites to validate findings within their respective sociocultural and policy contexts. These workshops engaged community leaders, health workers, and service users in a structured dialogue aimed at critically assessing findings, refining interpretations, and ensuring contextual relevance. The feedback from each state was systematically integrated into the findings, strengthening analytical rigor and reinforcing the applicability of findings to real-world governance and policy settings.

Across the three states – Kano, Ebonyi, and Nasarawa, the sense-making workshops had a total of 79 participants, with diverse and gender-balanced representation. Each workshop included diverse stakeholders such as Officers-in-Charge (OICs), Local and Regional Immunisation Officers (LIOs and RIOs), frontline health workers, and both male and female service users, along with representatives from Civil Society Organisations (CSOs). A summary table detailing the categories of participants at the sense-making workshops across the three states is provided in Annex 3.

Building on this, a national-level practical implications workshop was convened with 37 high-level stakeholders, including policymakers, programme designers, CSOs, NGOs, academia, and development partners to translate research conclusions into actionable programming strategies. This workshop focused on bridging the gap between research and practice, ensuring that study findings informed evidence-based policy formulation and programmatic interventions. Discussions explored why intersectionality matters and the implications for programme design and policy interventions. A summary table detailing the categories of participants at the practical implications workshop across is provided in Annex 4.

## Ethical Considerations

Due to the sensitive nature of the study, strict measures were implemented to ensure the confidentiality of all participants. Participation was entirely voluntary, and both verbal and written informed consent were obtained

from each participant. The research team received comprehensive training on research ethics to uphold ethical standards throughout the study. No personal identifiable information was collected from any participant. Prior to implementation, the study protocol was developed and submitted for ethical review by the National Health Research Ethics Committee as well as the respective state-level ethics committees.

## Limitations to Methodology

While the study provides valuable insights into norms-driven corruption behaviours in the healthcare sector, a few methodological limitations constrain the breadth and depth of its findings. First, the research focused primarily on informal payments for vaccines and medical commodities. This limited the study's ability to explore informal payments for other primary healthcare services, including consultations, diagnostic procedures, maternity services, and referrals. While the social norms identified in this study are likely relevant to these other services, their nature and extent of their relevance in other services would need to be tested further.

Second, the study's focus on primary healthcare (PHC) facilities limits the generalisability of the findings to secondary and tertiary facilities. While PHCs are often the first point of contact for service users seeking care, secondary and tertiary healthcare institutions typically manage more complex and expensive service contexts in which corruption and informal payments may be more frequent and severe. Respondents in the study itself noted that informal payments, such as extortion for surgeries and informal payments for hospital admissions are more pronounced in secondary-level facilities. Moreover, the gender balance and professional backgrounds of staff at these levels is different, potentially affecting both the nature and extent of social norms influence, especially at the intersection with gender norms.

Third, geographically, the study was conducted in only three states out of Nigeria's 36 states and the Federal Capital Territory (FCT). This limited geographic scope weakens the representativeness of the findings and makes it inappropriate to draw national-level conclusions about the prevalence or patterns of these corrupt behaviours within the healthcare system. Nigeria is characterised by significant sociocultural, economic, and governance-related diversity across its regions, which influence both the form and drivers of corruption. The exclusion of a wide cross-section of states means the study may not reflect the full spectrum of experiences and institutional behaviours across the country.

Fourth, due to budgetary and time constraints, the study design was not able to include kick-off or inception meetings with stakeholders in each study sites, only a national consultative workshop was done. The absence of these early engagements limited opportunities for context-specific insights, reduced local stakeholder buy-in, and may have hindered the identification of unique state-level issues or nuances in how informal payments manifest. Early engagement might have helped align the study more fully with ongoing local health reforms or initiatives, improving both relevance and uptake of findings.

Fifth, the use of a purely qualitative methodology, while offering deep, contextualised understanding, limits the ability to generalise findings to the broader Nigerian population. Qualitative methods are inherently interpretive and rely heavily on the perspectives of selected participants, which may not be representative of all healthcare users or providers. In addition, while the study took steps to reduce social desirability bias through the use of the vignette methodology, the potential for social desirability bias and interviewer influence may still have affected the authenticity of the responses. Given the sensitivity of discussing corruption, some participants may have been reluctant to fully disclose their experiences or may have underreported the extent of illicit practices due to fear of reprisal, mistrust in confidentiality assurances, or cultural taboos surrounding the criticism of authority figures.

Finally, it is important to note that informal payments are only one of many corrupt practices affecting primary healthcare delivery in Nigeria. The findings related to social norms may be relevant to other forms of corruption as well, such as ghost workers, absenteeism, and embezzlement of facility funds. However, as social norms influence behaviours, identifying the specific behaviour of focus for the study was critical; the findings thus cannot be generalised to other corrupt behaviours without further investigation.

In summary, while the study contributes important insights into healthcare corruption at the primary level, its limited thematic scope, narrow geographic coverage, exclusion of secondary healthcare institutions, lack of early stakeholder engagement, and the constraints of

qualitative methodology collectively restrict the comprehensiveness, representativeness, and generalisability of its findings. Future studies could benefit from a broader, mixed-methods approach, greater geographic inclusivity, and multi-tiered health system analysis to capture a more holistic picture of social norms related corruption in the healthcare sector.

# III. Findings

## A. Experiences on the Commonness of Informal Payments

Findings from the study reveal that informal payments to access healthcare are widespread in primary healthcare centres (PHCs). Despite government programmes offering cost-free access to essential services such as family planning and basic medications, service users reported making out-of-pocket payments regularly. The informal payments include fees for registration cards, medical gloves, drugs, vaccines, transportation and other free commodities. They are not the only form of corruption that occurs in primary healthcare centres. Favouritism, nepotism, diversion of material and other forms also occurs, especially prior to service delivery, and are forms of corruption, but they are perceived to be a common practice.

> *One thing we should know is that if those payments are informal, and you go to the health facility to tell the worker there that those things are unauthorised, you may lose a patient. So, sometimes we know that it is unauthorised, but we have to pay them because if you don't, you won't access the medical facility. You will then pay them knowing fully well that it is unauthorised, to avoid stories that touch.*[11] **IDI, Male Reference Group, Ebonyi**

> *I experienced this once. A friend went to a federal medical centre, and they did not ask him for informal payment, but he willingly offered payment so he can be attended to on time.* **IDI, Male Reference Group, Nasarawa**

> *That is what we are saying. Assuming I am the one that went to the hospital for treatment, and I give them money, the reason for giving the money is so that they can commence treatment immediately, you understand. This payment will make them attend to me immediately, but if I don't give them money, they will abandon me and attend to others that have paid them.* **FGD, Female, Ebonyi**

As Table 3 illustrates, informal payments occur at all stages of the service delivery process: before, during, and after delivery of health services.

**Table 3: Service Touchpoints Indicating Circumstances Under Which Informal Payments Occur**

| Pre-Service | Post-Service | During Service |
|---|---|---|
| Service users voluntarily offer, and health workers accept, informal payments to receive quicker attention or shorten wait-time, even when health workers do not explicitly request them. | Service users sometimes offer gifts to health workers after receiving services as a way of showing appreciation. This behaviour is often seen among affluent individuals or those with religious affiliations. It may seem to come from a genuine desire to thank the health worker. In some cases, it is done with the hope that the health worker will reciprocate the gesture in the future, creating expectations for preferential treatment and favouritism in subsequent service delivery. | Health workers request informal payments from service users throughout the entire service delivery process, at any point during their interaction with service users. Requests are ostensibly to fill institutional gaps (e.g. for medical supplies that are out of stock or in short supply at the PHCs or transport costs). |
| Service users often feel compelled to comply with informal payments asked by health workers due to fear of losing access to care or worsening condition, even when fully aware that these payments are unjustified. | | |

11 'Stories that touch' means they could result in an avoidable sad event.

Overall, our findings underline the persistence and commonness of informal payments and favouritism in Nigeria's healthcare system, despite widespread knowledge of service users' rights and entitlements. These findings are consistent with other research on corruption in primary healthcare in Nigeria (Aluko 2013; Agu et al. 2025; Buowari 2017) which emphasised that corruption in Nigeria's primary healthcare system is widespread and systemic, manifesting through informal payments, diversion of resources, and abuse of power. This disproportionately affects poor and vulnerable populations, especially women, and is sustained by weak accountability mechanisms and limited oversight across both service delivery and administration.

## Perceptions, Attitudes, and Justifications Surrounding Informal Payments

Attitudes about informal payments varied across participant groups but were predominantly negative. Service users commonly expressed discontent, noting that the government allocates funding to ensure free healthcare at primary healthcare facilities. Participants shared examples of out-of-pocket payments for vaccines, registration cards, basic medications, and delivery-related supplies, items that should have been provided at no cost under government-funded healthcare schemes. While informal payments were occasionally rationalised by service users as a mechanism for dealing with institutional constraints, they were generally perceived to be problematic, particularly when they contradicted government policies on free basic healthcare services.

Service users consistently emphasised that these informal payments disproportionately affect vulnerable populations, including low-income individuals, women, and children. Several participants expressed concern that informal payments limit access to essential care for those unable to pay, exacerbating disparities in health outcomes. The financial burden was seen to deter healthcare-seeking behaviour, especially for preventive services like immunisation and maternal care.

In addition to concerns about informal payments themselves, participants described stark inequities in how service users are treated, especially based on perceived wealth or social status and the resulting expectations that informal payments should be made by these service users. Service users reported experiences where individuals arriving in private cars or with obvious signs of affluence were prioritised over others who had waited longer or had equally severe health needs:

> *I have been to a hospital far from home and I spent time in a queue, and somebody came who drove in a car with their own case not more dangerous than the one I brought here. But because they came with executive cars, and they came in numbers, the attention of the health workers was moved from us to them because there are things they are going to benefit after the services.* **IDI, Male Reference Group, Ebonyi**

This perception of preferential treatment caused by the commercialisation of basic healthcare services fosters a deep sense of injustice in the health system, especially among those from low-income backgrounds. Participants noted that these practices erode public confidence in both the healthcare system and government accountability and foster scepticism about the integrity of public health institutions. They noted experiences of social stratification in healthcare delivery, where the poor are overlooked or delayed in receiving treatment simply due to their socioeconomic status. Such experiences reinforce powerlessness and exclusion among the most vulnerable among seekers of primary healthcare.

A strong and consistent understanding was present among healthcare providers that demanding payment for services or items that are supposed to be free is inappropriate and unacceptable. This awareness appears to stem from both professional ethics and community-level knowledge of health entitlements. Some express commitment to reporting such practices when observed.

> *Any payment demanded for free government-provided services, like ANC drugs or vaccines, is not acceptable.* **IDI, Female Health Worker, Kano**

> *You are not supposed to pay for anything that comes for free, any person that collects money from service users for services that are free, we have to report. So, it is not advisable for you as a health worker to collect any amount from a client.* **IDI, Female Reference Group, Nasarawa**

These statements reflect an internalised sense of ethical responsibility and some emerging sense of accountability on the part of some health workers. Yet although they largely viewed informal payments as inappropriate, health workers pointed to institutional gaps that affect the sustainability of service delivery, including persistent shortages and complete stockouts of critical medical sup-

plies, irregular funding, insufficient remuneration of health workers, the obligation to remunerate temporary personnel, and high operational costs. These institutional gaps, in their view, justified the adoption of informal coping mechanisms, including informal payments. In the words of two health workers:

> *Honestly, I will attribute it to economic factors, because we do not necessarily get everything for free at the health facility. So, the service users will have to pay for some medication.* **IDI, Female Health Workers, Kano**

> *Not all charges are wrong. We all know immunisation is free, but family planning comes with some charges. Some are free when donated by NGOs, but if donated items are not available, they have to charge for the things they bought at the facility which is appropriate for me.* **IDI, Female Reference Group of a Health Worker, Nasarawa**

> *Nowadays we pay more than 2500 [Naira] for both drugs and card, and they will explain in detail the expiry and manufacturing date which is the reason you were asked to pay.* **FGD, Male, Ebonyi**

Table 4 below presents a structured overview of the patterns in attitudes about informal healthcare fees, categorised by different participant groups. It highlights our finding that informal payments are widely viewed as inappropriate by health workers and service users alike because they create financial barriers to essential care, worsen health inequities, and undermine public trust. These concerns were echoed across all study sites. However, particularly among healthcare providers, and among some, especially male service users, informal payments are perceived as legitimate in light of the challenges stemming from supply shortages and financial constraints within facilities. Female service users, in contrast, frequently spoke of denial of service as a 'punishment' for not paying.

**Table 4: Overview of the Patterns in Attitudes on Informal Healthcare Fees Across Different Groups**

| Categories | Kano | Ebonyi | Nasarawa |
|---|---|---|---|
| Male Health Workers | Most considered informal payments inappropriate as most services/ commodities in PHCs should be free. | Some considered informal payments as inappropriate. Some insisted that it does not occur in their facilities. | Most considered informal payments inappropriate because they believe these commodities and vaccines should be free if provided at the facility. Many referred to the influence of strict institutional measures put in place, which cautions health workers and reduces the rate of informal payments in the state. |
| Female Health Workers | Most believed that charging for services and commodities supplied by the government is inappropriate. | Most considered informal payments inappropriate as commodities should be free. Some also believed that informal payments might discourage users from accessing health services. | Most perceived informal payments to be inappropriate. |

| Categories | Kano | Ebonyi | Nasarawa |
|---|---|---|---|
| Male Service Users | Most perceived informal payments to be inappropriate.<br><br>However, some justified them as potentially appropriate because 'People do not value what is free'. | Most male service users believed that informal payments are inappropriate and should be curbed by the government.<br><br>Some service users believe that the reason for the charges is for transportation. | While most service users viewed informal payments as inappropriate, some believed that charging for certain services and drugs was justifiable. For example, charging for ice blocks to preserve vaccines was considered acceptable, as the government did not provide for this in the case where there was no electricity, and facilities lacked the funds to cover such expenses. |
| Female Service Users | Informal payments were considered inappropriate by participants. Some noted that when health workers realised that they could not charge service users (such as in the case of National Health Insurance Scheme service users, who receive completely free services), health workers deliberately withheld the provision of quality services | Most service users considered informal payments as inappropriate. Some cited instances where services have been delayed or denied due to the non-payment of such charges.<br><br>Due to poor institutional oversight there is high presence of informal payments with sanctions for service users who do not comply. | Most believe the government provides essential commodities and vaccines, but informal payment persists in some areas, despite the state's strict enforcement efforts against service users not having a choice but to comply in most cases, in order to receive adequate care. |

## B. Non-Normative Drivers and Enablers of Informal Payments

Consistent with the Flower Framework, participants raised a number of non-normative drivers and enablers of informal payments, including individual, material, structural, and environmental factors. Drivers are factors that motivate people to engage in a behaviour; enablers are conditions or factors that open opportunities for informal payments, such as inadequate oversight (Scharbatke-Church and Chigas 2019).

Discussions on the drivers of informal payments revealed a complex interplay of attitudes, economic pressures, and cognitive biases. Among service users, two primary perspectives emerged. A wide range of service users viewed the practice as stemming from personal greed, framing it as a deliberate moral failing by health workers. Another perspective offered a more empathetic explanation, grounded in economic rationality. They argued that health workers are underpaid relative to public expectations, and this perceived compensation gap creates both social and financial pressures. In this context, when peo-

ple feel like there is not enough to go around, or they are afraid of losing what they already have, it can affect the way they behave, even if it is unfair or against the rules. This was viewed as influencing health workers to seek informal payments as a necessary viable means for gaining financial stability.

On the other hand, health workers, especially in Ebonyi and Nasarawa States, attributed this behaviour to systemic and institutional deficiencies. They stated chronic shortages of essential supplies, inefficient logistics, and understaffing and reliance on unpaid volunteers as operational constraints that hinder effective service delivery. Within this context, health workers explained informal payments as the only means to sustain service provision where formal systems fall short.

Findings indicate the crucial role that weak accountability structures play in enabling health workers to request and accept informal payments. Across varying healthcare settings, participants, especially service users, pointed to a lack of effective checks and balances, poor oversight, inadequate transparency of pricing and billing as key institutional gaps that allow such behaviours to flourish. These structural deficiencies create an environment where informal payments are not only possible but can become normalised.

From a behavioural perspective, this absence of strict monitoring and clear consequences for unethical practices actually encourages opportunistic actions and a sense of moral detachment among health workers. In settings where leadership is either absent or ineffective, unethical behaviours such as soliciting or accepting payments for free services are often rationalised as necessary coping strategies in a broken system. Health workers view these actions not as individual moral failings, but as widespread, systemic responses to the challenges of underfunding, poor remuneration, and resource scarcity. This mindset is reinforced by the diffusion of responsibility when no one is actively enforcing rules or setting clear ethical standards, individuals feel less personally accountable for their actions.

As this pattern continues, informal payments are no longer seen as corrupt practices but rather as routine aspects of engaging with the healthcare system. This shift in attitude reflects a broader cultural adaptation to persistent institutional shortcomings, where both health workers and service users begin to accept the informal exchange of money as part of the healthcare experience.

> *The reason we have all these challenges of informal payment is because we don't have any regulatory body that monitors the activities at the facility, so that the workers can be called to order if things are not going in the right way.* **FGD, Female, Ebonyi**

> *Most times, we (service users) don't know services that (are) free from those that are not free and that's why it is easy to make these payments since most people are not aware of their pricing.* **FGD, Female, Ebonyi**

> *The fact that where they get these vaccines are far away, they use that opportunity to charge service users and hide it under transportation cost due to greed and love for money.* **KII, Male LIO, Nasarawa**

> *The truth of the matter is that anything that is free, in most cases, people tend to abuse it. But if health workers ask you to buy something with your money, some service users appreciate doing that rather than collecting something for free.* **KII, Female Reference Group, Nasarawa**

> *Even the monitoring system we have is very weak and corrupt, because we have seen cases where officials even liaise with health workers to share funds charged from service users.* **KII, Male WDC, Kano**

In summary, non-normative drivers and enablers of informal payments in healthcare emerge along all the dimensions of the Flower Framework. One significant pattern is the interplay between individual incentives (greed or financial need) and system lapses (low salaries, shortages, and failing accountability systems). Our findings suggest that informal payments are not solely the result of individual bad actions but often the result of poor management, poor monitoring systems, inadequate community control, and complex pricing policies. The combination of economic crisis, institutional breakdown, and regulatory fault lines offers a permissive environment in which informal payments become routinised as a survival strategy or operational shortcut rather than as an ethical issue.

Table 5 summarises the range of non-normative drivers and enablers of informal payments identified by health workers and service users.

**Table 5: Non-Normative Drivers and Enablers of Informal Payment across the Flower Framework**

| Flower Framework | Non-Normative Drivers of Informal Payment | Non-Normative Enablers of Informal Payment |
|---|---|---|
| **Individual** | • Personal greed – framed as deliberate moral failings by health workers<br>• Economic rationalisation – underpaid workers seek informal payments as coping strategy for financial stress | • Absence of strict monitoring and moral guidance – allows moral detachment and opportunistic action<br>• Weak leadership and ineffective supervision – no one reinforcing ethical norms or discipline |
| **Material** | • Shortages of essential supplies and staff – health workers feel unsupported<br>• Economic pressures – under-compensation | • Material deficiencies (such as supply shortages) – reinforce the perceived need for informal charges to fill operational gaps<br>• Inadequate funding – resource scarcity makes informal payment a practical solution |
| **Institutional** | • Delayed and poor remuneration<br>• Institutional lapses like insufficient staff strength and PHCs having to depend on volunteers who are paid through informal payments | • Inadequate supervisory and monitoring system<br>• Absence of internal checks and balances encourages unethical conduct |
| **Community** | | • Lack of awareness and feedback systems in the community<br>• Inadequate accountability from community structures (e.g. Ward Development Committees) |
| **Structural** | • Systemic failure, broken logistics create an environment that fosters informal payment practices<br>• Economic inequality and lack of opportunities – people act to survive within unequal systems | • Regulatory bodies compromised or colluding with health workers<br>• Ambiguity in healthcare pricing, unclear information about free vs paid services leaves room for exploitation |

## C. Norms Driving Informal Payments in Selected Primary Healthcare Facilities and Their Intersections with Gender and Faith Norms

Understanding the drivers of informal payments within primary healthcare facilities requires a nuanced exploration of both normative and non-normative influences. While structural and systemic deficiencies play a central role in creating opportunities for such behaviour, social norms shape how individuals perceive and engage with informal payment practices by creating deeply-rooted collective beliefs and shared expectations within communities and institutions. During discussions on the drivers of informal payment practices in PHCs, interviewees noted that, beyond non-normative factors, family and community pressures significantly contribute to perpetuating these behaviours.

This section explores the normative landscape that underpins informal payments in selected primary healthcare facilities in Ebonyi, Nasarawa, and Kano States. The findings reveal how informal payments are not merely the result of economic hardship or institutional failure but are also sustained by widely accepted beliefs, familial and community-level expectations, as well as social pressures inside and outside health facilities. As mentioned previously (see Section II.A above), in order to explore the norms, we split the practices of informal payments into specific behaviours by health workers and service users:

- Health workers soliciting informal payments for free vaccines, services, and commodities
- Health workers accepting offers of payments from service users seeking access or expedited services
- Service users making the offers of payments to obtain access or faster services
- Service users accepting to pay when health workers ask for informal payments.

The data revealed that similar social norms influenced both behaviours of health workers; both behaviours of service users similarly exhibited similar social norms dynamics. As a result, in this section, we combine them in our presentation of the findings into two behaviours:

- Section III.C.1. Behaviour 1: Health workers solicit and accept informal payments from service users
- Section III.C.2. Behaviour 2: Service users offer informal payments to obtain or expedite access to health services or accept to pay them when requested

Findings regarding the practice of post-service offers and acceptance of 'appreciation' are addressed in Section III.D. Table 6 on the next page provides a brief roadmap on how the findings are presented. We begin each section with a brief summary of the findings for the behaviour, then present findings on each of the social norm components and the intersection with gender and faith norms.

### Behaviour 1: Health Workers Ask and Accept Informal Payments from Service Users

In this section, we describe facility-based norms and community and family-level norms that shape health worker behaviour within PHCs. We then explore the intersection of social and faith norms, such as beliefs in reciprocity, and social and gender norms, which shape obligations and power dynamics differently for male and female health workers.

**Table 6: Social Norms Analysis Framework**

| | Component | Description |
|---|---|---|
| 1 | **Behaviour of interest** | Specific behaviour(s) under exploration |
| 2 | **Associated social norms** | |
| | • Descriptive norms | Perceptions of common and typical behaviours |
| | • Injunctive norms | What people believe others will approve/disapprove of them doing |
| | • Direct norm | The norms prescribe the specific behaviour in question |
| | • Indirect norm | The norm manifests in many behaviours |
| 3 | **Social Sanctions** | |
| | • Rewards | A positive reaction by the reference group members to a person's behaviour that is intended to enforce compliance with norms |
| | • Punishments | A negative reaction by the reference group members to a person's behaviour that is intended to enforce compliance with norms |
| | • Sensitivity to sanctions | The degree to which the person engaging in the behaviour is responsive to or disregards a sanction |
| 4 | **Reference groups** | People whose opinions matter for a particular behaviour or context; people who reward or punish the person for complying with or violating the norm through their behaviour |
| 5 | **Intersecting identities (faith and gender norms)** | The intersectionality of gender, faith, and social norms: how interconnections between social, gender and faith norms collectively influence the behaviour in question, to perpetuate, weaken or intensify it |
| 6 | **Exceptions to norms** | Conditions under which the norm does not operate |

**Table 7: Overview of Findings: Health Workers Ask and Accept Informal Payment from Service Users**

**Descriptive Norm:** Health workers typically ask for informal payments from service users to provide or speed up services and this is supported by senior staff like the OIC; however, health workers usually refrain when service users appear knowledgeable, of high status, or likely to challenge them, etc).

**Direct Injunctive Norm:** There is a shared expectation among health workers backed by superiors and colleagues at the facility to ask for informal payments from service users prior to receiving the service.

**Social Sanction:** Health workers who comply with the norm are in the good books of colleagues and superiors who act as the reference group in the facility. Health workers who do not comply are often ostracised and ridiculed by colleagues and superiors who conform to the norm and see it as a means to make extra cash.

**Indirect Injunctive Norm:** Health workers are expected by their families (spouses, parents, extended relations) and community members (friends, neighbours, faith community members), who serve as their reference group to provide financial support. They are also expected by family and community members to contribute to community projects and gatherings like parties and ceremonies. It is believed that, given their status as civil servants, they should be able to adequately fulfil family and community obligations.

**Social Sanction:** Health workers who comply experience elevated status in the family and society for meeting expectations placed on them. If they are unable to meet these expectations, they risk being labelled as an insufficient man or woman by family and community members.

**Gender and Faith Intersection with Social Norm:**

- Male health workers experience more pressure to comply to the social norm, because of the gender norm that they should be the 'breadwinner' and head of household, with the expectation that they provide adequate financial support for their family. Male health workers are seen to be bolder in asking for informal payments with minimal sanctions. This behaviour is partly driven by societal expectations tied to their masculine trait as being assertive.
- Female hzalth workers are equally expected to ask for and accept informal payments, because they hold a government job (as health worker) and earn money. They experience social pressure by friends to support lifestyle commensurate with their status as 'civil servants.' However, gender norms create conflicting expectations that change how they respond to the social norm.
    1) Female health workers experience lighter negative sanctions for non-compliance when they do not ask for informal payments because they are socially expected to be kind and considerate, as well as honest.
    2) Female health workers engage just as much in the practice as men. However, they provide justification that it is for the greater good and engage in the practice more discreetly. Moreover, when comparing the severity of sanction from the facility and community for violating this norm, the sanction for violating the gender norm is less severe; community members mostly understand and accept circumstances as a means to an end.
- Faith norms create mutual expectations for health workers not to ask or accept informal payments, especially in Kano, as this is against religious teachings and precepts. Health workers engage in the practice nonetheless, due to family and community (including religious community) expectations of financial support; however, they do so in a more quiet and covert way.

**State Specific Dynamics:**

Social norms are similar across the three states, but there are differences in how they manifest.

- In Ebonyi, female health workers take advantage of the expectation to be an 'ideal woman' to solicit informal payments boldly; their confidence that people believe that women do not engage in the practice allows them to follow the social norms driving health worker behaviours without fear of being apprehended.
- Nasarawa has a strong checks and balances through formal regulations actively overseen by the WDCs and National Primary Health Care Development Agency (NPHCDA). In addition, the area's proximity to the Federal Capital Territory (FCT) creates a more metropolitan environment where residents are generally more informed about standard payment procedures and aware of the distinction between formal and informal payments. This limits the practice of asking for or accepting informal payments compared to other states, and the informal payments are undertaken more covertly.

**Attitude and Justification:**

- Health workers feel justified in asking because of low salaries, inadequate of supplies and equipment in facilities.
- Health workers believe it is for the greater good, i.e., charging for commodities helps them to render effective services and facilitates transportation of consumables and commodities, electricity, and cleaning of the health facility.

**Exception to Norm:** There was an exception during emergency cases to first render services before following through with the norm.

## Descriptive Norm - Health Workers Typically Ask for Informal Payments from Service Users

Health workers typically request informal payments to deliver or expedite services. However, they typically refrain when service users appear knowledgeable, hold high status, or seem likely to challenge them. Health workers often rationalise the behaviour by referring to institutional deficiencies, which they claim justify and legitimise the practice under certain circumstances. The findings suggest that institutional punishments that would have prevented the practice at the facility are weak, inconsistent, or absent, further enabling the persistence of the descriptive norm at the facility that everyone does it, especially when endorsed by superiors like the OICs.

> *So what I have observed here is that the health centres most especially the seniors do not even care. What they are interested in is the money. They are even the ones that charge you because they do not trust the junior staff especially in government facility.* **FGD, Male, Ebonyi**

> *Even though we hear that there are monitoring groups patrolling the facility, most of them don't come regularly and even when they come, they don't do much in changing anything.* **FGD, Female, Kano**

The absence of clear penalties associated with the weak checks and balances contribute to this moral disengagement, allowing health workers to rationalise their actions as necessary or even justifiable under certain circumstances. Moreover, structural challenges such as non-payment of stipends to volunteers act as indirect enablers. In Nasarawa, data shows that volunteers who receive little to no compensation were reportedly encouraged by permanent staff to collect money informally mostly during less supervised hours, with portions of the proceeds shared among staff members. This practice represents an informal reward system that replaces official remuneration.

> *And so, the volunteers, the government is not even paying them. Some of them (volunteers), the little thing that they are given cannot even afford the transport for a month, so the real staff can persuade them to take advantage of*

*the nighttime, but they will still remit some percentages to other health workers.* **KII, Female WDC, Nasarawa**

### Direct Injunctive Norm - Health Workers Expect other Health Workers to Ask for Informal Payments from Service Users before Providing Care

The findings indicate that informal payments are sustained by direct social norms embedded in the day-to-day interactions within primary healthcare facilities. Participants across all three states described a common understanding that solicitation of informal payments is expected under specific conditions depending on the service user's perceived status, knowledge, or ability to pay. In Nasarawa, for instance, the social expectation among health workers that service users of higher social standing should pay more was explicitly noted. This practice was not seen as deviant but as part of the accepted service routine, suggesting the existence of a stratification based on appearance, influence, and social identity.

> *Because sometimes if you go to the hospital, they will look at you first and examine where you are coming from. You know some people are very knowledgeable. So, they will charge you according to your status and level of influence.* **IDI, Female Reference Group, Nasarawa**

In Kano and Ebonyi States, service users' perceived lack of knowledge regarding which services are free informal payments influence health workers' behaviour. The findings suggest that when service users are unaware of their entitlements, health workers are more likely to exploit this gap to request payment.

> *I would say the lack of knowledge is contributing a lot to informal payments because, you see, most people affected are not knowledgeable on what is free. If they know, the health worker will not even be confident to charge them.* **IDI, Male Nurse, Kano**

> *It depends on the service user's knowledge about the service the health worker is rendering if it's free or not. Only if it's really not free will he freely give him without questioning him.* **IDI, Male CHEW, Ebonyi**

The findings indicate variation across states in how reference groups within the health facilities influence compliance with the norm. In Nasarawa and Kano, senior staff like the OICs and senior nurses enforce the norm at the facility.

> *There is a confidence a junior staff has if the order to ask for these informal payments is from the senior staff.* **KII, Male WDC Member, Nasarawa**

As will be discussed later (Section II.C.2.), family members like the spouses and parents of health workers, who were frequently identified as reference groups outside the facility, further legitimise and indirectly pressure health workers to engage in informal payments. As one health worker notes:

> *I have seen cases where the demand at home is too much on a health worker, so they will just succumb to asking for payments at the facility, especially since that's what everyone is doing.* **IDI, Female CHEW, Kano**

In Ebonyi, peer dynamics among colleagues and pressure from senior staff appear to be key factors. Participants reported that senior health workers like the OIC often initiate the collection of informal payment, creating a permissive environment where health workers who comply are informally rewarded with income and protection. This positive reinforcement sustains the norm by signalling approval from authority figures within the facility. Health workers thus comply with the norm, not necessarily because they believe it is right, but because it is what is expected within their work environment. They believe it is the only way to meet institutional obligations; they further fear being ostracised or gossiped about at the facility or being looked down upon as not matching up in the family and society if they do not solicit or accept informal payments.

> *If a health worker wants to be different and not take the charges, the colleagues will see her as a bad person and try to avoid her.* **FGD, Male, Ebonyi**

### Intersection of Social and Gender Norms

Data indicate that gender roles and social expectations shape how male and female health workers participate in soliciting or accepting informal payments. Although both male and female health workers are involved in the collection of these payments, gendered social expectations result in different levels of scrutiny and sanction for each gender. Participants reported that male health workers are perceived by service users to be more assertive and willing to take risks, thus more likely to boldly demand informal payments. They face minimal negative sanctions from their colleagues or institutional punishment for doing so, and service users often interpreted the behaviour

as assertiveness, not deviant behaviour. This perception is underpinned by broader social norms that support male boldness and risk-taking in economic matters within and outside the health facility.

> *I feel men are more involved in collecting informal payments because they are fearless and bold. A woman might be sceptical to take bribes not because she isn't corrupt but because she is not very strong at heart. But a man can be confident to demand for bribe.* **FGD, Male, Nasarawa**

> *The men among us still collect these charges because they have the heart to take the consequences, how much is even our salary.* **IDI, Female Nurse, Nasarawa**

Female health workers, by contrast, even while equally engaged in collecting informal payments, are socially expected generally in the community to act with compassion, honesty, and restraint. As one service user from Nasarawa commented:

> *If as a woman, if you are the one charging these payments, people will look at you badly because a woman is expected to be understandable.* **FGD, Female, Nasarawa**

This expectation often leads them to provide moral justifications for such acts. Findings suggest that when women engage in these practices, they tend to present them as necessary, especially in situations where commodities must be procured to ensure patient care. The social framing of women as caretakers allows their actions to be perceived in the community as acts of necessity or self-sacrifice rather than profit-seeking, leading to lower negative sanctions; which comes with initial subtle objections from the community that gives way to eventual understanding of the need at the facility by community members, which include service users who receive care. This finding contrasts with research on gender and corruption finding that gender norms, particularly expectations to embody integrity, high moral standards, and care would lead women to refrain from informal payments and would lead service users to judge them more harshly than men when they did, regardless of the circumstances or motivations behind their actions.

> *If those things are not available and there is none remaining at the moment to be used and the government doesn't provide those things for them too, so instead of it hindering the person's treatment, she can collect money to purchase those items to treat her.* **IDI, Female CHEW, Ebonyi**

> *If the commodities are not available during emergency cases for instance, it can cause more harm to the patient, because the nurse will not use her bare hands to treat you, so they have to look for every means to gather money to make the commodities available.* **IDI, Female Nurse, Ebonyi**

> *Most service users understand these reasons - which come from shortages at the facility - so they just give the payments without querying the nurse when asked, particularly because she is a woman.* **IDI, Female Reference Group, Kano**

> *At first, service users may raise eyebrows due to the extra charges, but they eventually realised the need for the payment and just comply.* **KII, Male WDC Member, Nasarawa**

These findings highlight that while both genders navigate the same systemic deficiencies, such as underfunded facilities and unpaid/delayed salaries, and the same direct social pressure from colleagues to solicit and accept informal payment, their decisions are filtered through gendered expectations. Female health workers, facing conflicting social and gender norms about the appropriateness of informal payments, try to reconcile the two by framing their compliance with the norm mandating informal payments in ways that still preserve their social acceptability.

### Intersection of Social, Gender and Faith Norms

Generally, most health workers believe that asking for and accepting informal payments is contrary to religious teachings, particularly in Kano State where faith exerts a strong influence on how informal payments are perceived and justified. The findings suggest that religious teachings in Kano strongly discourage the solicitation or acceptance of informal payments, with a deeper emphasis on moral conduct and public accountability compared to other states. This religious framing, deeply embedded in the state's social fabric, acts as a deterrent for overt engagement in informal payments.

> *It is against the teaching of the Quran, you don't cheat anyone, it is a big sin, and truthfully, any form of informal payments is a form of cheating.* **IDI, Female Health Worker, Kano**

> *If as my Muslim sister, you are the one now asking me for payment that I shouldn't make, I will note you, and start to view you as a bad Muslim, one of those spoiling our religion.* **FGD, Female, Kano**

However, this deterrent is not absolute. The data show that exceptions are made when informal payments are seen as serving a greater good, particularly when used to purchase essential medical commodities that are unavailable due to supply gaps. In such cases, health workers recharacterise the informal payments not as self-enrichment, but as a morally justified solution to meet urgent needs at the facility. This moral reinterpretation helps mitigate potential faith-based sanctions and enables the continuation of the norm within a socially acceptable frame.

> *So that service delivery gap will make them transport the commodity from the warehouse on their own cost or even buy directly from the market. If unavailable at the warehouse (the commodity), because service users will always need the commodity and so they will increase the price for the patient because they also have to gain.* **IDI, Female CHEW, Kano**

This dynamic reveals a tension between faith norms that prohibit unethical financial practices and the socio-economic realities of service delivery in resource-constrained environments. While the moral guideline is clear, contextual exceptions are justified, particularly when they align with the value of saving lives, a principle that is deeply enshrined in religious teaching. A line is drawn, however, when health workers take advantage of these lapses to secretly get enriched, which some health workers do. This they do by overtly asking or accepting informal payment from service users, even when there are no institutional lapses at the facility.

> *Even though, collecting payment is because of the inadequate supplies by the government. We see cases of health workers using this as a means to ask for informal payment, even in cases when there are no urgent needs or lapses at the facility, in order to enrich their pocket, and still hide under the justification that, the payments are for the inadequate supplies.* **IDI, Male Health Worker - Storekeeper, Kano**

The intersection of gender and faith norms further complicates how informal payments are navigated and socially evaluated. In Kano, where faith norms are strongest, female health workers are mandated by both faith and gendered expectations to behave in morally upright and altruistic ways. This in turn brings greater rebuke when they request or accept informal payments—both at the facility, from service users who expect them to do better as females, and outside the facility, from religious leaders, who preach against corruption. As a result, female health workers tend to downplay the act of taking informal payment and instead frontline the necessity and benevolence of the act even more. This convergence of gender and faith norms creates a powerful framework where female health workers must carefully balance moral expectations with the pragmatic demands of healthcare delivery.

> *I once saw a health worker taking part of the money collected to give her child to go to school, and I confronted her that, isn't the money supposed to be used to buy the materials needed at the facility? Then she said, someone has gone to buy the materials and these were the remainders which was meant for them.* **FGD, Female, Kano**

This dynamic also exists in Nasarawa and Ebonyi:

> *A female nurse who is my church member already knows that I will always scold her. She's a Christian and she's joining her unbeliever colleagues to ask for informal payments, I always see the remorse in her afterwards.* **IDI, Female Reference Group, Ebonyi**

However, it is less prominent in these states, as faith norms are not as dominant in shaping workplace behaviour. In these contexts, female health workers rely more heavily on social expectations and community understanding, rather than faith-based moral justifications, to legitimise their actions. The community, recognising the hardships health workers face, particularly women, often interprets their participation in informal payments through a lens of empathy and survival.

> *Even though, we know that what they are doing is wrong and against what a good Christian should do, but seeing the work they have done since morning, I just always let it go, especially the females, the work they do at the facility is always a lot, with nothing much to show for it.* **KII, Male WDC, Ebonyi**

> *Although the government monitors them, they still ask for these payments, and imagine if the period is when salaries was delayed, even we the 'monitors' would just pity them.* **KII, Male WDC, Nasarawa**

### Indirect Injunctive Norm - Health Workers Are Expected by Their Families and Communities to Provide Financial Support

Health workers are expected by their families and communities to provide financial support. This expectation manifests in different dimensions. Health workers are

regarded as professionals with elevated social status. As a result, they are expected to fulfil familial financial obligations, providing for their families in a manner commensurate with their perceived status. They are also expected by community members to contribute to social networks or communities and social events, such as weddings, funerals, and community projects in mosques and churches irrespective of their actual income, especially in Ebonyi State. It is believed that, given their status as civil servants, they should be able to adequately fulfil family and community obligations. This societal expectation places additional pressure on health workers to meet family needs, which for most health workers comes with stronger pressure, especially in Kano and Nasarawa States. These expectations often function as a justification for accepting or asking for informal payment.

> *The community members think health workers earn well, so they expect them to always drop something whenever the need arises. I was the one that was even telling them at a meeting in the village square the other day that the assumption that health workers earn well is wrong.* **KII, Male WDC, Kano**

> *Your wife can't ask you for money at home and you will say you don't have it, especially since you are a health worker.* **IDI, Male Nurse, Kano**

> *As a health worker here, whenever there is a family event, I must drop something because they will be gossiping that I'm stingy despite getting paid.* **IDI, Female OIC, Ebonyi**

> *It is mostly the pressure to contribute at home with paying children school fees, taking care of other bills like light, security and others that push the health workers to ask for payments informally.* **FGD, Female, Nasarawa**

In Nasarawa, the expectation to 'give back' is socially embedded and often invoked in family and community settings, reinforcing the perception that health workers are inherently wealthy.

> *People believe once you are a health worker, you are the richest person, if it comes to the aspect of wedding, you should be able to contribute to your family.* **IDI, Female CHEW, Nasarawa**

Findings indicate that failing to meet family and community expectations may lead to reputational damage, social exclusion, or strained familial relationships. Health workers reported that when they explain their inability to meet financial expectations, relatives and peers often express disbelief or disappointment. In most cases, this pressure from the prospect of social sanction leads them to engage in informal payments as a means to maintain social standing.

> *Sometimes, it truly takes the grace of God to explain things to people. So, most times, the health workers try to fit into the expectations from the community and go out of their way to do extra things like accepting informal payments.* **IDI, Female Reference Group, Nasarawa**

The findings indicate that meeting these community expectations enhances social status and reinforces the perception of the health worker as successful and generous. In this way, informal payments are not just tolerated but seen as facilitating a health worker's ability to fulfil culturally valued roles. Participants identified several different reference groups responsible for shaping and enforcing these norms: family members, church communities, professional peers, and in Kano, faith-based networks. In Ebonyi, the church plays a visible role in framing expectations around generosity, with contributions to faith-based projects viewed as an implicit moral obligation.

> *Since the health worker are salary earners, it is expected that they contribute towards church projects.* **IDI, Female Reference Group, Ebonyi**

In Nasarawa, community members and family function are strong enforcers. The community uses public roles, such as assigning prestigious titles at events, to indirectly pressure health workers into financial displays of success.

> *When anybody is having a wedding... they will give you a big post and be expecting you to bring money.* **IDI, Female Reference Group, Nasarawa**

### Intersection of Social and Gender Norms

Findings reveal that traditional gender roles deeply intersect with the indirect injunctive norm to shape informal payment practices among health workers. These informal exchanges are not merely economic transactions but are entangled within the social fabric that defines how men and women should behave, earn, and provide. In Kano and Nasarawa States, male health workers are under societal pressure to meet expectations attached to their role as primary providers; male health workers described an ongoing internal conflict between their moral obligations as professionals and the societal expectations placed upon them as men. The dominant narrative of masculinity in

these settings equates a man's worth with his ability to provide financially for his household. When faced with irregular or inadequate salaries which are non-normative justification for engaging in the behaviour, male health workers often experience an internalised compulsion to ask for informal payments from service users, sometimes not out of greed or necessity, but as a means of preserving social status and fulfilling entrenched gendered responsibilities. Community perception plays a critical role here; failure to provide can lead to ridicule, diminished respect, or even familial conflict, further entrenching the normalisation of informal payments among men as these comments by these male participants highlight:

> *As a man, you have many responsibilities on you to provide, so you just have to look for ways to get more to meet up.* **IDI, Male Health Worker, Kano**

> *Your wife cannot ask you for money now and you will say (No). That's why men always look for a way to get more money to be a responsible man.* **FGD, Male, Kano**

> *Men are the ones who are breadwinners of their family, and your wife cannot ask you for money and you don't have; it reduces your worth as a man.* **IDI, Male Health Worker, Kano**

For women, the situation in Ebonyi State reveals a shifting paradigm. Here, female health workers are increasingly taking on the role of financial providers. This transition reflects broader societal changes, including economic necessity and increased female labour force participation. This development challenges previously held norms about women's economic roles. Participants in Ebonyi noted that both male and female health workers are viewed as financially secure and are expected to contribute to family and community projects. The data show that women increasingly bear the dual responsibility of income generation and caregiving, which increases the financial pressures they face.

> *Since male and female health workers are salary earners, people believe that the government pay them (health workers) well so they should contribute generously to parties and ceremonies.* **IDI, Female Reference Group, Ebonyi**

Interestingly, there are also social penalties attached to not meeting gendered expectations of their role at their families, particularly for women who are now seen as providers.

> *I am a woman and mother, and I am the one taking responsibility for my home, so many things are expected of me in my home too.* **IDI, Female Health Worker, Ebonyi**

> *Normally, it's supposed to be more male. It's just that women are catering to their families now more than men.* **IDI, Female Nurse, Ebonyi**

While women are increasingly expected to be providers and experience similar pressures as men to support family and community generously, they are still expected to be kind, caring and honest, as mentioned earlier (see section III.C.1.b.i.). As women assume greater economic responsibility, they become more visible and exposed to communal scrutiny for engaging in informal payments. The societal lens through which their actions are viewed is often harsher and more moralistic than for men, especially at the community level. Women who accept informal payments may be labelled as opportunistic or morally compromised, while those who refuse them might be judged as failing their families. In either case, the double bind of gender expectations creates a space where female health workers are more vulnerable to community gossip, judgment, and pressure. While men are driven by the pressure to maintain their image as providers and are scrutinised less when they solicit or accept informal payments due to gender norms depicting them as aggressive, self-focused and risk-taking, women are navigating a delicate balance between new economic roles and lingering societal expectations. These nuanced dynamics underscore the importance of addressing gendered dimensions in any effort to reform healthcare financing and eliminate informal payments.

### Intersection of Social and Faith Norms

In Kano State especially, faith and social norms converge to shape behaviours around public accountability, particularly within the health sector. These two expectations, faith doctrines and community expectation, do not operate in isolation; instead, they reinforce each other, forming a strong moral framework that discourages charging informal payments. Islam, the dominant religion in Kano, plays a central role in everyday life and public conduct. Religious teachings emphasise integrity, justice, and service to humanity, values that are deeply woven into the social fabric of the community. Findings reveal that the expectation that health workers should act honestly is not merely a professional requirement, but a faith obliga-

tion. The moral weight of religious duty lends a profound seriousness to issues of corruption, making unethical behaviour a transgression not just against institutional policy, but against God.

Moreover, in tightly knit communities like Kano, where social reputation is paramount, being perceived as corrupt carries a heavy stigma. Findings indicate that health workers found to be engaging in unethical practices risk more than formal sanctions; they face public shame, loss of respect, and exclusion from religious and community spaces. The fear of these social repercussions serves as a powerful deterrent, often more immediate and persuasive than bureaucratic enforcement mechanisms. Health workers internalise these expectations, leading to a form of self-regulation that reinforces public accountability. Most health workers highlighted that the decision to refrain from collecting informal payments is not only a matter of personal integrity, but a reflection of religious devotion.

> *It has truly prevented most of us from engaging in it, because we fear Allah's wrath, even when there are expectations from families, we would rather manage and trust God for the best.* **IDI, Female CHEW, Kano**

> *I want to blow (a desire to make money), but that doesn't mean my family will put pressure on me. But of course, the community especially will be expecting that as a health worker, I should have my own car in the next two years.* **IDI, Female PHARM, Kano**

The indirect normative influences on health workers, stemming from expectations imposed by family members, peers, community, and faith networks intersect with direct normative pressures encountered within primary healthcare facilities to ask or accept informal payments. Health workers, especially in Kano State, face a dilemma similar to that faced by female health workers: they are subject to the expectations of contradictory norms, both of which carry serious social and reputational consequences if they are violated. As mentioned earlier (section III.C.1.b.), health workers resolve this conflict not by refraining from informal payments, but by engaging in them more covertly and framing them as a necessary means to meet service users' needs in order to legitimise them.

This dynamic also exists in Nasarawa State, even though less influenced by faith norms as in Kano State, but the moral foundation here is further strengthened by social norms that enforce public accountability through communal pressure and social surveillance.

> *If a health worker and a service user attend the same church, the health worker will not be able to ask him for informal payments because it is against the teachings of the Bible and asking him means being seen as a sinner.* **FGD, Male, Nasarawa**

### Behaviour 2: Service Users Offer and Accept to Pay Informal Payments for Services

Similar to Behaviour 1, we initially investigated the behaviour separately (offer and accept to pay informal payment), but data suggest that practical motivations and norms drive service users to offer and accept to pay informal payment. Given that healthcare workers are often perceived to ask and accept such payments, the findings reveal how service users process, navigate, and respond to these practices. Most reasons for engaging in the behaviour appear to be practical, such as reducing wait times, avoiding denial for service and simplifying the complex nature of the healthcare system. However, findings show that gender and faith norms also influence service users to offer and accept to pay informal payments in PHCs. The results are organised to explore the practical motivations and sanctions (positive and negative) of service users to engage in the behaviour. It then describes the ways gender and faith norms shape their behaviour in relation to informal payments and elaborates on the how these dynamics manifest differently in each state.

**Table 8: Overview of Findings: Service Users Offer and Accept to Pay Informal Payments for Service**

**Descriptive Norm:** It is typical for service users to offer informal payments to access or expedite services or pay them when requested.

**Injunctive Norms:** Service users are not primarily driven by direct social expectations to make these payments. They pay primarily for practical reasons to access healthcare services; refusal to pay often results in denied, delayed or lesser quality service from health workers. However, they experience indirect social expectations driven by gender norms to make these payments; when they do not pay, they are judged poorly by colleagues in the workplace (men) and at home by family and community members (women) who serve as the reference group for this norm.

**Gender Norms:** Gender norms reinforce practical motivations, creating indirect pressures on service users to offer or accept informal payments.

- Gender norms related to women's role as caretakers of household and family add pressure to accept to pay informal payments requested by health workers.
- Female service users are more at risk when trying to challenge the norm because of the gendered expectation that they should be modest and honest. This hesitation can lead to more severe consequences for them, including delays in accessing timely services.
- Male service users are seen by participants as more impatient and thus more likely to engage in informal payments, due to gender norms related to their role as primary provider (with no time to wait); as well, participants reported that they are typically more assertive in confronting health workers who attempt to pressure them into offering informal payments, due to gender norms making it more acceptable for them to confront the norm.

**Social Sanction:** Female service users risk being judged by family and community members as bad mothers, wives or caregivers if they refuse to give payments. Men will be considered smart and savvy by peers and community members if they succeed in avoiding delays by paying, while they may be criticised especially in the workplace if they are delayed because they did not pay.

**Faith Norms:** A positive faith norm mandates faith adherents not to offer or accept to pay informal payments under any circumstance or condition; the faith mandate, however, is not generally enforced by the religious or broader community when complying means possible delay and refusal when accessing healthcare as this may ultimately delay even fulfilments of faith obligations like prayer and fellowship time.

**State Dynamics:**

In Kano, social expectations outside the health facility often pressure service users to offer and accept to pay informal payments. Due to expectations from family and husbands, women feel the need to return quickly to their caregiving roles at home, while men are expected to lead, protect, and provide for their families; delays at health facilities are a threat to fulfilling these responsibilities.

In Nasarawa, strong checks and balances discourage health workers from directly requesting informal payments. However, service users often voluntarily offer such payments to receive faster services.

In Ebonyi, service users often discreetly initiate informal payments, frequently perceived as bribes, because it is common for health workers to ask for and accept such payments. In most cases, service users readily comply when asked.

**Attitudes and Justification:** Service users justify informal payments as a pragmatic choice to access quicker care and meet other obligations, viewing it as a necessary compromise.

**Exception to Norm:** When male companions (husbands, fathers, or brothers) accompany female service users, they are able to challenge health workers' requests for informal payments on their behalf. This shields female service users from paying and conforming to the norm.

### Descriptive Norm: Service Users Typically Offer or Accept to Pay Informal Payments

In all states, it is common for service users to offer informal payments or pay them when requested by health workers. This behaviour is primarily driven by practical reasons: to access services or commodities or expedite them. In Nasarawa and Kano, participants noted that while health workers might not explicitly request payments, there is a widespread belief that offering a 'tip' can expedite services and minimise waiting times.

> *To meet a need is better than going round circles... If I am told to give something in the hospital, if I have it, I will give; the remaining is between them and the federal government.* **FGD, Male, Nasarawa**

Healthcare workers themselves subtly encourage payments or punish non-conformity through neglect. In Nasarawa, the officer in charge reportedly instructs subordinates to avoid resistant service users.

> *The OICs would begin to avoid them...tell her that we don't have the drugs.* **KII, Male DH, Ebonyi**

Refusal to engage in informal payments is met with institutional neglect. The data suggest that service users who refuse to pay are deliberately ignored by health workers or subjected to passive forms of denial, such as being told drugs are unavailable.

> *They will start avoiding you...tell her that we don't have the drugs, let her go to another place...meaning they won't treat them, and this can worsen their case.* **KII, Male DH, Ebonyi**

> *The person will just leave him there...they will just silence him and just leave him. By the time they will leave you without any attention, you will do what they want.* **IDI, Female RG, Nasarawa**

### Injunctive Norms Driven by Gender Norms

Social expectations reinforce the practical pressures on service users to give informal payments. This norm is not always articulated but is embedded in the logic of navigating a weak and overburdened healthcare system. The findings suggest that making informal payments help service users bypass delays so they can return quickly to the personal, work, or household responsibilities their families and communities expect them to fulfil. When they refuse to pay, they suffer not only practical consequences, denial and delay of services or neglect by health workers; in addition, they are subjected to social criticism from families and peers.

Gender norms play a pivotal role in shaping how social expectations are internalised and practiced. For women it is ensuring she fulfils the caregiving responsibilities assigned to women by gender norms. Women are expected to be caregivers and tend to the household. In Kano and Nasarawa, these caregiving responsibilities create pressure to make informal payments despite competing expectations, often internalised, of modesty and honesty.

> *She might be rushing for market to pick one or two things or maybe to cook for her husband who might be enraged... everyone knows.* **FGD, Female, Kano**

In Kano, women specifically described the internal conflict they face when navigating this indirect norm. Although gender norms expect patience and modesty of them, the social pressure to maintain domestic roles sometimes pushes them to comply with the norm.

> *Even though a woman is expected to be calm and patient, she also has other obligations to meet in her home...so she is left to choose which option matters most, her home or the stranger in the facility?* **FGD, Female, Kano**

For men, their gendered role as head of household and primary breadwinner creates pressure to return to work or other related responsibilities. In Nasarawa and Kano, male service users often view navigating health facilities as time-consuming and often opt to make informal payments to reduce treatment duration, enabling them to fulfil their daily responsibilities.

> *You know men, if he knows he cannot wait on the queue, he will pay, even though he shouldn't have.* **FGD, Female, Kano**

> *Most men do not want time wasting... some men will offer the bribe in order to receive immediate attention.* **FGD, Female, Nasarawa**

> *Conforming to the norm enables service users to attend to other personal obligations.* **KII, Male WDC, Kano**

Social backlash from family, community and faith institutions follows those who do not comply. In Ebonyi and Kano, family members, particularly husbands, mothers-in-law, and peers act as powerful reference points, often reinforcing expectations to conform.

> *His wife will even query him that how much is the money that he cannot just accept to pay.* **FGD, Male, Ebonyi**

> *Parents, well-wishers, church, community, and friends... will react.* **IDI, Female, Ebonyi**

In Ebonyi, participants noted that families and community members criticise a woman, for example, for returning home without having secured services, especially for her children.

> *People will blame her, the husband, sister, mothers-in-law, and siblings because they feel the money is not much and should have been paid instead of coming home without vaccinating the children.* **IDI, Female, Ebonyi**

Moreover, female service users face greater risk when challenging norms due to gendered expectations of submissiveness and trust. This increases their vulnerability to negative sanctions if they resist. As one community member commented:

> *We women, if they confuse us small, we will just give.* **IDI, Female Reference Group, Nasarawa**

Men, on the other hand, are sometimes more likely to challenge unethical behaviour, reflecting their societal role as protectors and decision-makers.

> *I remember a day we went to collect a drug...my husband challenged the pharmacist.* **IDI, Female Health Worker, Kano**

### Intersection of Faith Norms

Faith norms bring a positive dimension which generally discourages corruption, including offering or accepting to pay informal payments. However, this intersection brings an exception to the faith norm against corruption on health workers. In this case, service users guided by spiritual and moral principles are faced with internal conflict to choose between ethical values and practical outcomes like timely care. Faith adherents are not expected to offer or accept to pay informal payment under any circumstance or condition. However, in situations where adhering to faith norms delays care, especially for vulnerable family members, service users may face internal and external conflicts. This adherence means possible delay and refusal in accessing healthcare which can ultimately delay even fulfilments of faith obligation like prayer and fellowship time.

> *Even though that's what they teach us in church, but when it becomes life-threatening or having to wait for the whole day, I have to reconsider on what to do then.* **FGD, Female, Nasarawa**

> *Yes, it's against the teaching of the Quran, but even the Quran preaches about wisdom, so you know the right things to do at the right time to get what you need and want.* **FGD, Male, Kano**

The findings indicate that service users often experience a conflict between their faith-based norms, which advocate for honesty and discourage corrupt practices, and the prevailing practical norms within healthcare facilities. Due to systemic shortcomings in the health system, service users are frequently compelled to engage in informal payments to access necessary care. When faced with this dilemma, service users tend to prioritise practical realities and gender norms that influence both men and women to offer or accept to pay informal payments. Consequently, faith-based norms are often perceived as less influential compared to the immediate pressures of the healthcare environment.

### Intersection of Gender and Faith Norms

The interplay between gendered expectations and faith-based morality creates a complex terrain, especially for

women. While faith norms call for integrity, women are also expected to ensure the well-being of their children resulting in the household pressuring them to comply with unethical practices for the sake of expedience.

> *If a child is sick, women easily get confused, they just make the payment, so they won't lose the sick person.* **IDI, Female RG Health worker, Kano**

For men, faith norms may strengthen their resistance to corruption, but gendered pressure to provide and protect often overrides these ideals.

> *Some men will just agree to protect his child even when he can confront the system, but time is essential is saving lives.* **FGD, Female, Nasarawa**

> *A man is expected to go to the farm to feed his family, so he can't be wasting time at the facility because he doesn't want to accept to make payments.* **KII, Female Reference Group, Ebonyi**

The findings suggest a deeply embedded normative system around informal payments in PHC facilities across the three states. While norms are sustained by institutional practices, and reference group members, their enforcement and resistance are heavily influenced by the intersection of gender roles, social obligations, and faith values.

### State Dynamics in How the Behaviour Plays Out

While reflecting a common dynamic, these gender norms and the pressure and social sanctions that service users experience because of them play out slightly differently across the three states. In Kano State, the decision-making process around healthcare service use is deeply intertwined with community expectations and gendered social roles. Informal payments are not simply transactional; they are embedded in a web of survival strategies. Findings reveal that, for many women, especially those with young children or dependants at home, the pressure to expedite healthcare services is immense. The burden of domestic responsibility means that any delay at a health facility is more than just an inconvenience, it disrupts caregiving responsibility that is central to women's role in the household. Refusing to pay an informal fee may result in longer wait times, which are socially interpreted as negligence or even irresponsibility. Consequently, findings indicate that some women often feel compelled to offer informal payments to avoid being judged as inattentive or uncaring mothers or wives.

> *As a woman, you can't spend too much time outside, because you have children to take care of, and also family members, so you have to do whatever it takes to be attended to on time, to avoid being called an inattentive mother or wife.* **IDI, Female Reference Group, Kano**

> *You can't keep your family at home and say you were delayed because you did not want to pay at the facility, that does not make sense, especially when you could have avoided it.* **FGD, Female, Kano**

For men, the pressure takes on a different form. In Kano's patriarchal structure, men are expected to lead decisively and protect the wellbeing of their families. Prolonged wait times at health facilities, particularly when the solution (usually an informal payment) is known and accessible, create a dilemma. In such situations, refusing to make the payment is sometimes seen as a failure to fulfil one's role as provider and protector. Data show that a man who refuses to conform risks being perceived as either weak or miserly, both socially undesirable traits.

> *He will pay to save time. A man will pay to avoid the queue and being called slow, especially when he must meet up to go to his workplace to feed his family.* **FGD, Female, Kano**

There are subtle but strong punitive consequences for non-compliance. The findings indicate that a service user who refuses to offer informal payments may be scolded by family members or ridiculed by peers for being the architect of their own delays. Remarks such as 'Why didn't you just do what others are doing?' or 'You wasted time for nothing' reflect a collective attitude that prioritises efficiency over ethical considerations.

> *Your colleagues at your workplace will abuse you that why didn't you just pay to avoid being delayed and you can even be queried for coming late to work, nobody will understand what happened at the health facility.* **IDI, Male Reference Group, Kano**

> *Your husband will even abuse you for wasting time for what could have been avoided.* **FGD, Female, Kano**

Conversely, there are rewards for those who conform. By offering informal payments and speeding up service, individuals demonstrate their competence, resourcefulness, and understanding of 'how things work.' They can fulfil family and social obligations more swiftly, which enhances their reputation within the community.

*You will be seen as smart and someone who knows how to get what he wants.* **IDI, Male Storekeepers, Kano**

In Nasarawa State, informal payments are more shaped by practical necessity rather than deeply ingrained gender roles. Here, the dynamic is more influenced by economic hardship. Findings show that service users are aware that healthcare workers often expect tokens in exchange for prompt service. However, in Nasarawa, this expectation is less about status and more about health workers imposing expectations of reciprocity. Findings show that service users who refuse may face ostracism or passive-aggressive remarks when seeking services. For example, one participant recounted that her refusal to 'offer informal payment' to a nurse led to her being overlooked for future health outreach benefits in her ward.

I just noticed that the nurse always ignores me whenever I come to the facility and it started from the first day of refusing to pay when others were paying. FDG, Female, Nasarawa

Meanwhile, those who pay are often rewarded with favourability and better treatment during subsequent visits, insider information about outreach programmes, and a generally warm reception. Informal payments, in this case, create a form of social capital that can be drawn upon when needed.

*Most men would offer money so that they would be attended to quickly, so they could go back to their workplace on time to avoid getting queried by their boss or even getting sacked.* **IDI, Male RG, Nasarawa**

*Even though they don't really ask for payments here, but the truth is that it is those who pay them that get the best and also information when supplies and free drugs come.* **FGD, Female, Nasarawa**

In Ebonyi State, data indicate that informal payments are perceived as both a coping strategy and a social norm within the community. The state's healthcare infrastructure often faces shortages of staff and essential resources. As a result, service users come to view informal payments as a necessary evil to ensure they receive timely and quality care. When they do not pay, they suffer immediate consequences, including delay in care, unfair treatment by healthcare workers, and, in some cases, denial of certain services. Reputationally, families may be seen by health workers as difficult or uncooperative, making future health-seeking efforts more challenging.

What stands out in Ebonyi is the communal enforcement of the norm. Individuals are frequently advised by family members, neighbours, or even religious leaders to 'do the needful' when accessing healthcare services. There is a strong undercurrent of peer surveillance; people know who paid and who didn't, and those who resist are often labelled as stubborn or 'too principled for their own good'.

For example, a male respondent who refused to offer an informal payment during his wife's delivery was criticised by extended family members for putting pride over his wife's health. This shows how quickly the moral framing shifts from systemic corruption to personal responsibility when informal payments are resisted.

*You can't be proving to be a man when it comes to healthcare and not make payments if that's what it takes to save your wife, so even when you know the service is supposed to be free, you just accept to pay to be attended to on time.* **KII, Male WDC, Ebonyi**

In contrast, compliance with informal payment expectations is often celebrated. Someone who is able to 'get things done quickly' is admired, and the service user, male or female, is commended for being proactive and smart.

*If you were able to meet up with other things because you complied at the facility, you will be commended for ensuring to avoid delay.* **FGD, Male, Ebonyi**

## The Practice of Post-Service 'Appreciation': Intertwined Practical and Normative Drivers

This practice emerged as a recurrent theme across study sites. Participants often distinguished 'appreciation', gifts typically offered after health services and often (though not always) monetary from what they categorised as informal payments. A thin line exists between a voluntary gift and an informal payment. It is often unclear whether health workers expect a gift and will sanction service users who do not offer them because the expectations are rarely made explicit. Similarly, it is unclear whether service users offer 'appreciation' out of gratitude or in an effort to create a relationship with the health worker in which norms of reciprocity apply in order to secure better services in the future. Regardless of the ambiguity, our findings suggest that different social norm dynamics manifest in these behaviours, different from the services users and health workers perspective.

## Behaviour 3: Service Users Offer Appreciation after Service Is Rendered

Findings reveal that service users themselves often feel a social obligation to offer such appreciation, driven by the perception that those who conform to this norm receive more favourable treatment or attention. This insight prompted a deeper exploration into the service users' role in sustaining this behaviour. Specifically, this section examines the characteristics of service users who participate in this behaviour and the situational context surrounding the act of appreciation. The analysis considers how this dynamic reinforces social hierarchies within the health facility setting and contributes to differential experiences of healthcare.

**Table 9: Overview of Findings: Service Users Offer Appreciation Before and After Service is Rendered**

| |
|---|
| **Descriptive Norm:** It is typical for service users with higher social and economic status to offer appreciation, often monetary, to health workers after they have received a service. |
| **Direct Injunctive Norms:**<br>• Although health workers do not explicitly request gifts, service users believe that health workers expect that they should offer appreciation for the services received as an expression of gratitude.<br>• It is commonly expected by the family of the service users that he or she should offer appreciation for the services received as an expression of gratitude.<br>**Social Sanction:** Service users who comply with the norm by offering tokens of appreciation often experience increased reputations within both the health facility and in the community. This practice not only increases goodwill, but leads to benefits, such as expedited services and preferential treatment during subsequent visits. Service users who do not give appreciation risk their reputation being tainted in the health facility and in the community. They risk being delayed in the facility and not receiving preferential treatment during future visits. |
| **Gender and Faith Intersection with Social Norm:**<br>• Male service users are expected more by health workers and by family and community to offer appreciation, in order to be seen as being honourable and to achieve elevated status within the health facility and in the community.<br>• In certain religious contexts, such as in Kano State, gift giving is viewed as a divine obligation toward those who do good for others, particularly health workers whom some service users recognise as being underpaid despite the demanding nature of their work. |
| **State Specific Dynamics:**<br>• In Kano, the social and faith influence on gift giving and acceptance creates pressure to offer appreciation and the service users who conform typically gain preferential treatment from health workers.<br>• In Ebonyi, service users who do not offer appreciations are typically sidelined, especially in future engagement.<br>• In Nasarawa, there are concerns about maintaining ethical standards due to the strong checks and balances in the state. Gifts are typically offered as a form of appreciation by service users to facilitate services and for future preferential treatment, since most health workers in Nasarawa would typically not ask or accept informal payments. |

**Attitudes and justifications:** This is generally considered to be acceptable because it is a gift and voluntary; for some (e.g. Kano), the gift is believed to also facilitate healing.

**Exception to Norms:** When the gift comes with an obvious (i.e. explicit) condition.

### Descriptive Norm: It is Typical for Service Users with Higher Social and Economic Status to Offer Appreciation to Health Workers after Receiving Service

Findings indicate that it is common practice for service users, especially those perceived to have a high social and economic status, to offer tokens of appreciation to health workers within PHCs. These tokens, typically monetary or material, are given after services are rendered and are generally viewed as expressions of gratitude rather than informal payments. In all three study states, participants described gift-giving as a normative behaviour embedded within routine interactions at health facilities. In Kano, the practice appears deeply entrenched and is often associated with faith and moral obligations and reinforced by religious leaders who preach their importance and by health workers who give preferential treatment to service users who offer gifts. While the frequency and perceived necessity of offering gifts vary in Ebonyi and Nasarawa, the practice is still widely accepted as an expression of gratitude reinforced by health workers who treat these service users who conform to the norm specially.

> *It could be after you have tried and done all you can do with all your effort to help a couple during delivery. When they feel appreciated, they will ask you to take this gift from the bottom of their hearts, so those appreciations are normal.* **IDI, Female CHEW, Nasarawa**

> *It is a gift, there is no problem because anyone can be given a gift; I do this most times when I know the health worker has really tried for me, it is normal.* **FGD, Female, Nasarawa**

> *This is not wrong but a gift, I enjoyed what you did for me and decided to bless you. For example, a woman comes for child delivery... she brings meat, biscuits, or candy, that's a gift and it's not a problem.* **IDI, Female Health Worker, Kano**

### Direct Injunctive Norm within Primary Health Facilities: Service Users Are Expected by Health Workers and by Family and Community to Offer 'Appreciation'

The findings suggest a widely held belief, both among service users and health workers, that offering appreciation is expected, especially when the health worker is perceived to have provided exceptional care. Health workers often do not verbally request these tokens. However, there is an implicit social expectation from health workers that such gestures should follow satisfactory service, as well as an implicit expectation by service users to receive favourable treatment (e.g. expedited service, access to care and to medicines, greater attention) in the future when they give them. In Kano and Ebonyi, this expectation is particularly pronounced; in Nasarawa, health workers emphasised professional boundaries due to the strong checks and balances in the state but still accepted gifts within the frame of 'gratitude'.

> *Truthfully, some service users give gifts after service is rendered to get preferential treatment when next they come to the facility. So, in order not to be delayed, they just water the ground even when you didn't ask them, and that money they give will make you remember them faster when next they come.* **IDI, Female Health Worker, Ebonyi**

> *If as a health worker, I go the extra mile for you, it is just natural for most to want to offer appreciation to me even without asking.* **IDI, Female Health Worker, Ebonyi**

> *It's just your own intuition that will tell you to give the health workers something, because they most times don't ask directly. But you know you will still come back, so you must do the needful.* **IDI, Female Reference Group, Kano**

Service users' belief that gifts are expected by health workers is reinforced by subtle signals from health workers as well as observed patterns of behaviour where those who give gifts tend to receive more attention or preferential treatment for future attention as shown by the findings.

> *You just know that you have to offer an appreciation with the body language you will get if you intend to leave without anything.* **FGD, Female, Nasarawa**

> *There is something called reading the room. Of course they won't ask you to give them gifts, but actions speak louder these days. Especially when you see the OIC always hurrying the nurse, you just know you haven't been doing the right thing.* **FGD, Female, Nasarawa**

> *There are sometimes when the OIC will give you signal to drop something for them, especially when they have done a lot for you and you will just see the need to offer gifts too.* **IDI, Female OIC, Nasarawa**

The norm is enforced both internally within PHCs and externally by community and religious institutions. In Kano, religious leaders play a role in framing appreciation as a moral and spiritual obligation, as one health worker emphasised;

> *Some give as an obligation from God, especially the case of health workers who some service users know to be earning lesser and giving is preached in our alms here, so it's only natural to see many services offering gifts even without asking.* **IDI, Female CHEW, Kano**

Participants reported that those who comply with this norm by offering appreciation are often perceived more highly, both health workers within the facility (especially senior staff and facility managers like OICs) and in their broader communities. These service users may receive faster services, more attention, and are remembered favourably by health workers, creating a cycle of preferential treatment during subsequent visits, as indicated by health workers:

> *Some service users give gifts after service is rendered to get preferential treatment... they know that they might still come again and need our help.* **IDI, Female Health Worker, Ebonyi**

> *The husband willingly gave the nurse 50,000 naira as appreciation because of the extra efforts the health worker puts in and the next time his wife came with the baby for immunisation, she helped her, so she won't be delayed, one good turn deserves another.* **KII, Male Director of Health, Nasarawa**

> *When she comes back for immunisation, she says, 'this madam you tried for me... please take this for recharge card, I was so impressed with her, because there were many women there who did not see the need to show gratitude'* **IDI, Female OIC, Nasarawa**

Service users corroborated these findings, sharing lived experiences where the gifts offered ensured timely services, especially in future visits to the health facilities.

> *I noticed that the next time I came to the facility, the nurse I appreciated the last time just called me up and attended to me with all joy and that made my day, so every time I visit the facility, I just give her money for drinks.* **FGD, Female, Kano**

> *My wife noticed that a nurse attends to me faster whenever I take our daughter to the hospital because she is a SS patient, and it's only because I give them lunch money whenever I'm leaving.* **FGD, Male, Nasarawa**

> *It's good to build rapport with these nurses through appreciation, that will make them remember your face because we only have one PHC in this area and you will just be delayed unnecessarily if they don't know you.* **FGD, Female, Ebonyi**

Findings suggest that service users who fail to offer appreciation may face subtle or overt forms of punishment. These include longer wait times, less personalised care, or being overlooked during subsequent visits from health workers. In some cases, especially in Ebonyi and Kano, failing to conform to the norm could damage a person's reputation within the community or diminish their perceived moral and social standing within the facility by health workers who expect these appreciations and outside the facility by families and friends who expect them to do whatever they have to do for better and faster healthcare.

> *It once happened to me that I didn't give the nurse anything as I always do before, and she didn't ask as always, but the next time I came to the facility, she was giving me harsh attitude, and I knew it was because I didn't appreciate her the last time and my family and friends even queried on why I didn't just do the needful.* **FGD, Female, Ebonyi**

*If I helped you bypass protocols, I will expect you to give me something. If you give me, I will surely collect but if you don't, I will just see you as a stingy person who can't repay the good done to him.* **IDI, Male Storekeeper, Kano**

*The other day we had two emergency patients here and we only have one bed, we had to choose who to admit and who to refer, eventually we pick the woman everyone knows in the facility, she frequents here and give our nurses something every time, so it was only natural to put her first.* **IDI, Female OIC, Ebonyi**

### Intersection of Social and Gender Norms

The data reveal a distinct gendered dimension to the norm of offering appreciation. Male service users are expected to demonstrate honour and status through generosity, reinforcing their social positioning both within the health facility and in their family and community. Female service users face a different reality. Social norms that frame women as dependent, modest, and less financially autonomous limit their ability to navigate the system in similar ways. Most women, even when they do have money, are discouraged from using it to negotiate better care. Their interactions with the health system are often marked by deference, vulnerability, and reliance on male figures (fathers or husbands) to advocate on their behalf or provide the appreciation. Consequently, findings show that they are more likely to face delays, dismissiveness, or subpar care, especially when they present alone or without male accompaniment.

*The men give appreciation more because they always have where to go and they don't like to wait with women. Women can still wait since their fellow women are on ground.* **IDI, Female Nurse, Ebonyi**

*If a man and woman give appreciation to a health worker, the man will still be attended to faster than the women, because it's not every time you see a man at the facility.* **FGD, Female, Kano**

An interesting dynamic from the findings highlighted by the programme to increase male involvement in maternal healthcare in PHCs by creating an environment that encouraged men to visit health facilities and receive prompt-mattention[12]. Although the programme has officially ended, it had unintended consequences on gender equity in access to healthcare and on the levels of appreciation given, particularly in places like Ebonyi: health facilities now tend to prioritise men when they seek care, which in turn creates an expectation for them to show appreciation for the timely service.

*The male involvement in MNCH was one thing that led to men offering more appreciation, because anytime a man comes to facility, he is always usually attended to faster than women and then when leaving, he offers gifts.* **IDI, Female Health worker, Ebonyi**

### Intersection of Social and Faith Norms

In Kano, the convergence of religious beliefs and social expectations grounded in social and faith norms plays a role in reinforcing the practice of appreciation. The act of giving is often interpreted as a spiritual duty, especially toward individuals such as health workers who are perceived to provide essential but underappreciated services.

*Some give to get better quicker; it's like a religion here to offer alms in form of appreciation to those you believe deserve it.* **IDI, Female OIC, Kano**

*Giving of gifts is seen as an obligation from God to those who do good to people.* **IDI, Male Nurse, Kano**

*Even you will pity them and be compassionate unto them to offer money to the health workers.* **FGD, Male, Nasarawa**

### Intersection of Gender and Faith Norms

Religious beliefs around giving are gendered in their application. Male service users are positioned as moral agents whose public acts of appreciation are framed as demonstrations of leadership, devotion, and social capital. These expectations place additional pressure on men to conform, especially in faith-driven settings like Kano.

*The gift is believed to also facilitate healing, which makes it a religious expectation.* **KII, Male WDC, Kano**

*As a man, when I follow my wife to the facility and we were attended to well and quickly, I will want to offer appreciation to the nurses to show that I take initiative and that I understand protocols.* **FGD, Male, Kano**

12 This was corroborated at the sense-making workshop in Ebonyi State.

These findings illustrate how what is a voluntary gesture of appreciation is deeply embedded within a complex web of descriptive and injunctive norms, enforced by formal and informal actors and reinforced through multiple intersectional lenses: social, gender, and faith. These dynamics have implications for health equity, as they risk creating differential access to quality care based on one's conformity to implicit cultural expectations.

## Behaviour 4: Health Workers Accept Gifts or Appreciation from Service Users after Service Is Provided

Social norms not only influence service users' offers of appreciation but also underpin the acceptance of gifts by health workers after the provision of service. The findings suggest that a culture of appreciation is deeply embedded and often reinforced within health facilities through peer behaviours and tacit acceptance by facility leadership, as well as expected by external reference groups, most notably religious and community leaders. This section unpacks these multilayered norms, highlighting how they structure health worker-service user interactions and contribute to the normalisation of gift acceptance within the healthcare delivery context.

**Table 10: Overview of Findings: Health Workers Accept Gifts or Appreciation from Service Users after Service Is Provided**

| |
|---|
| **Descriptive Norm:** It is common for health workers to accept offers of appreciation from service users after service provision. |
| **Direct Injunctive Norm:** Health workers are expected by service users as well as by fellow health workers to accept gift after services have been rendered. Acceptance is believed to create an obligation for health workers to provide preferential treatment or extra attention to 'appreciation' (gift) givers in future interactions.<br>**Sanction:** Health workers who refuse gifts risk being criticised by service users as well as by fellow health workers as rude and too self-righteous. |
| **Gender and Faith Intersection with Social Norm:**<br>• Female health workers accept appreciation more not only because they constitute a large proportion of PHC staff, but because they are expected by their peers and senior colleagues to be cooperative in accepting appreciation from service users.<br>• In some contexts, like Kano State, religious leaders and community members intervene to pressure the health worker to conform to the norm. Accepting gifts is generally considered acceptable as it is a form of sunnah in Islam. Health workers who refuse a gift suffer reputational harm; they are seen as outliers and as not acknowledging the precepts of the holy Quran. |

**State Specific Dynamics:**

- In Kano, faith norms play an important role in reinforcing the acceptability of appreciation and creating pressure on health workers from peers and community to accept gifts of appreciation after health services are rendered.
- In Ebonyi, health workers do not receive gifts as frequently as in Kano and Nasarawa because the rate of informal payments appears to be higher. Health workers demand appreciation from service users more frequently, especially when they believe they have gone above and beyond for the service user to get better.
- In Nasarawa, since there are strong checks in the state against informal payments, accepting gifts in the form of appreciation is considered appropriate, as this is usually done after a good service is rendered.

**Attitudes and Justifications:** This is generally considered to be acceptable because it is a gift and voluntary; for some like in Kano, they go as far as believing the gift helps to facilitate healing.

**Exception to Norms:** It is acceptable to refuse a gift of appreciation when:

- the gift is accepted before service was rendered.
- the gifts have an obvious hidden intention, which puts the health workers under pressure to reciprocate.
- the gift is explicitly demanded by the health worker.

### Descriptive Norm: It is common for health workers to accept offers of appreciation from service users after service provision

In all three states, health workers typically accept gifts after the provision of services, especially when the service is considered satisfactory or extraordinary. This practice is not perceived as informal payment or corruption by service users or health workers; rather, it is seen as a gesture of appreciation rooted in long-standing cultural and religious traditions among family and communities to appreciate any good and noble work, such as providing healthcare. These expectations are often internalised by health workers as part of the professional culture within their facilities.

In Kano and Nasarawa, findings show that the timing of the gift, after the service has been rendered, is particularly important. Gifts offered before care are considered suspicious or inappropriate by health workers, who perceive it as a form of bribery. Those given afterward, however, are deemed expressions of gratitude and are often encouraged by the broader community. In Ebonyi, health workers recall specific situations, such as prolonged deliveries or work during power outages, where they were rewarded with gifts as a form of recognition for going above and beyond their duties.

> *There was a time we delivered a baby for 12 hours late in the night without light, the husband just had to give us something for our labour. The energy in the room was enough for him to drop something.* **IDI, Female OIC, Ebonyi**

> *It is even very wrong to refuse gifts in Islam and that's the culture most of us practice here. Since the appreciation is after the service is provided, that can't pass for a bribe again; it's for a job well done.* **IDI, Female OIC, Kano**

These examples highlight that the moral lens through which gift-giving is viewed varies across contexts but ultimately reinforces a permissive environment where informal appreciation is not only tolerated but normalised.

### Direct Injunctive Norms: Health Workers Are Expected to Accept Gifts

The acceptance or refusal of gifts is not solely a matter of personal ethics. Health workers are expected by service users as well as by fellow health workers to accept gifts offered to them after services are rendered. Findings indicate that health workers who accept gifts are often positively reinforced by through public praise, continued community trust, and improved relationships with service users. Service users see such health workers as approachable,

respectful, and deserving of more patronage. The act of giving a gift becomes a form of social currency, where the giver and receiver reinforce mutual respect, recognition, and gratitude.

> *Women are naturally caring, so they will always attend to us when we come for immunisation and this melts my heart always. If I offer to give the nurse gifts, she must collect it, because we are just like friends now.* **FGD, Female, Ebonyi**

Health workers who reject gifts may face subtle or overt forms of social punishment. They may be labelled as unfriendly, arrogant, or disrespectful by their colleagues and community members who are aware of such acts. This dynamic is especially apparent in contexts like Kano, where refusing a gift can be interpreted as rejecting communal values and religious teachings. Over time, such refusals can affect the provider's reputation and reduce community trust in their care.

> *There was a time an Igbo nurse worked here, and she was always refusing gifts saying it makes the service users ask her for anything when next they come to the facility, but because that's the norm here to accept gifts, the community members started seeing her as a rude nurse and tried to avoid her treating them.* **IDI, Female OIC, Kano**

In addition to service users, health workers' peers and superiors influence their beliefs that it is appropriate and expected to accept gifts of appreciation, as one service user commented when their gift was refused:

> *There was a time that a new health worker at the facility refused the lunch money I gave, the way her colleagues looked at her, she had to comport herself and collect it because it's the usual thing I do whenever I come to the facility.* **FGD, Male, Kano**

In Nasarawa, because the formal rules against informal payments are stricter, the norm manifests as non-enforcement of the rules. Institutional actors, such as Local Immunisation Officers (LIOs), who supervise healthcare staff and intervene when ethical boundaries appear to be crossed, show flexibility when the gift is clearly framed as post-service appreciation:

> *I once went for inspection and saw a mother offering money to a nurse and I first thought it was a bribe and confronted them, but the mother explained how nice the nurse has been... which is understandable.* **KII, Male LIO, Nasarawa**

These sanctions show how powerful social and cultural expectations can be in regulating behaviour in healthcare settings, even overriding formal policies on ethical conduct.

### Intersection of Social and Gender Norms

Gift-giving practices are not gender-neutral. The findings suggest that female health workers are mostly the recipients of gifts, especially in maternal and child health contexts. This is not only because PHCs have a large share of female staff. Communities associate caregiving with women, and this aligns with broader gender norms that position women as nurturers deserving of appreciation.

In Ebonyi, for example, it was noted that female health workers, especially those involved in labour and immunisation, are the ones performing the 'hard work' and thus are more likely to receive gifts. Even when male staff are present, the community tends to direct their appreciation towards female staff who are expected to accept the appreciation as a 'thank you' for a job well done.

> *Even if a male health worker is in the facility, naturally, it is the female health worker that would be given the gift, because they are the ones that do most of the work here.* **IDI, Female CHEW, Ebonyi**

> *There are situations where as a health worker you just have to accept the appreciation because you have worked a lot for the service users and it's only expected for you to receive appreciation, which can serve as your bonus, and you can't be rejecting.* **IDI, Female Nurse, Ebonyi**

These patterns reinforce traditional gender roles within the healthcare system and validate gendered assumptions about who performs emotional and physical labour and who deserves to be appreciated.

### Intersection of Social and Faith Norms

Religion, particularly Islam in northern Nigeria, provides a strong foundation for the acceptance of gifts. In Kano, religious values are deeply embedded in daily practices, including within health facilities. The refusal to accept a gift is not only seen as ungrateful but also as contrary to Islamic teachings, which encourage the acceptance of kindness and appreciation from others. Religious leaders such as imams who could be service users themselves play a role in setting moral expectations. Their sermons reinforce community norms about gratitude and appreciation, including through the giving of gifts to health workers. These leaders act as informal enforcers of community be-

haviour, ensuring that even health workers internalise religious interpretations of gratitude.

> *You would be surprised that the chief imam has influence in the facility, too. It's a small community here, so whatever you do as a health worker can be used as a sermon in the mosque.* **IDI, Female CHEW, Kano**

> *Service users will even blame you for depriving them of the blessings from Allah by rejecting their gift and even in Islam, accepting such gifts is expected of me as a faithful.* **IDI, Female CHEW, Kano**

Such faith framing of gifts not only justifies the practice but also makes it difficult for health workers to refuse without facing theological or social scrutiny.

### Intersection of Gender and Faith Norms

The interplay between gender and religion creates a compounded expectation for female health workers, particularly in Kano. As women, they are expected to be nurturing and accommodating; as Muslims, they are expected to accept acts of kindness and gratitude. This intersection makes gift refusal particularly complex for them, as it can be interpreted as both a violation of cultural gender roles and spiritual misconduct.

> *Health workers always keep that in your mind and not do things that are against the teachings of Islam like refusal of sunnah of your fellow Muslim.* **IDI, Female CHEW, Kano**

This double pressure limits the autonomy of female health workers and places them at the centre of conflicting expectations between institutional ethics and socio-religious obligations.

# IV. Implications for Practice

This study has identified several direct and indirect social norms driving informal payments at primary healthcare facilities for free vaccines and health commodities in Nigeria. The analysis of intersections of gender and faith norms provides a more nuanced understanding of these motivations, as a basis for enhancing the effectiveness of social norms change efforts. We convened a workshop of organisations and government agencies working on healthcare and on anti-corruption approaches grounded in behavioural insights to identify programmatic implications of the research findings. These include ways to design and implement social norms programming to account for the gender and faith norm intersections that were discovered. Annex 5 lists the social norms change programming ideas generated by practitioners during the Practical Implications Workshop to shift the social norms influencing health workers' behaviours - both direct and indirect norms. Developing a full social norm change strategy that accounts for intersections of gender and faith norms will require each organisation to identify the elements that are most relevant for their mission, their ongoing programmatic work and the populations they serve. Following are key headlines of an approach developed by the practitioners in the workshop for addressing the social norms identified in the research, particularly in relation to health workers' behaviour:

## 1. Address social norms together with non-normative causes in multi-faceted programming.

Social norms change should be integrated into existing efforts to promote integrity in healthcare. Social norms are rarely the only driver of corrupt behaviour and therefore need to be part of a larger, multi-pronged initiative that addresses key non-normative drivers and enablers of health workers' and service users' behaviours, such as inadequate funding, shortage of supplies and medicines, low salaries, and reliance on volunteers, which are among the factors motivating and legitimising health workers' behaviours. In addition, lack of transparency of pricing and billing, weak monitoring and oversight, and limited knowledge and agency among service users open opportunities for health workers to divert charges for personal gain. If these non-normative factors are not addressed alongside social norms, the impacts of any anti-corruption efforts will be limited.

A number of efforts to deal with these non-normative factors were proposed concurrently with social norms change. For example, while resolving national to LGA supply chain management issues is not possible from the PHC level, other efforts could alleviate the problem. Transparency of pricing and billing for services and medications, for example, could clarify what additional charges are needed to make the provision of services possible and enable service users to hold health workers accountable. A process for aggregating such charges could regularise and institutionalise a facility-wide process that ensures needed supplies are obtained while diminishing individual health workers' decision-making autonomy and ability to charge more. Additional conventional anti-corruption tools can and should be pursued alongside social norms change efforts, including:

- Strengthening formal monitoring and oversight processes as well as easy procedures for service users to report irregularities without fear of social sanctions;
- Developing a code of conduct for health workers that directs their dealings at the facility.

## 2. Move beyond citizen-focused strategies alone.

It is important to engage health workers as well as service users and citizens to address the social norms and other incentives that motivate their behaviour. Citizen-focused tools, such as community scorecards, budget tracking, and citizen charters are important, but they are not enough. Real change requires engaging health workers themselves as the power holder in informal transactions. Health workers need to be engaged not only as professionals, but also as people influenced by their environments, families, and religious communities.

One major pitfall to be avoided is over-reliance on sensitisation, or awareness-raising, campaigns. Awareness without structural change can do more harm than good. It can normalise the practice and even increase it by heightening its salience without changing the conditions

or expectations that fuel it. It can create perceptions that informal payments are more prevalent than they actually are, discouraging those who may want to behave differently (Peiffer and Cheeseman 2023). Worse still, it can place blame on service users, especially women, who already carry the weight of societal expectations, without providing them the tools or protection to say 'no.' Where social norms play a role, awareness-raising raising must also seek to change perceptions that 'everyone does it' and use multiple channels, from preaching to dialogue, professional groups as well as media to diffuse messaging and influence perceptions. It must go hand-in-hand with creating safer, more equitable systems.

### 3. Develop a social norm change strategy.

Developing and using champions, key influencers, or 'trendsetters'13 is a key feature of a strategy for changing the social norms driving health worker behaviour (Bicchieri 2017; Bentley and Mullard 2019). To do this effectively, participants highlighted several steps:

**a. Target the component of the social norm that is most feasible to change and would have the greatest impact.**

Efforts to change social norms can target any one component of a social norm and, ideally, several simultaneously. For the direct norm among health workers (that they should demand and accept informal payments), the focus considered to be most feasible and useful is influencing the social rewards and sanctions for complying/defying the norm. In other words, diminishing the perception (and the reality) that one will be punished socially and professionally for not engaging in the practice can help weaken the norm.

For the indirect community norm expecting high-level contributions to family and community institutions, it was noted that people believe that health workers, due to their high status, earn more than they actually do; in other words, health workers are expected to contribute more than they are able to (based on their compensation) due to (mis)perception of their earnings based on their status. In this case, managing, or 'right sizing', expectations of how much health workers are able to contribute (not the expectation of support itself) could reduce pressure on health workers to ask or accept informal payments.

**b. Build on and reinforce positive social norms and attitudes where possible.**

Several positive social norms were identified in the study: a professional norm that health workers should care for service users, which discourages informal payments and unequal treatment, and a positive faith norm against corruption. Moreover, attitudes about informal payments among health workers and service users alike were uniformly negative, even though the structural and resource deficiencies affecting PHCs legitimised them to some degree in those circumstances. These attitudes and norms are weak compared to the norms pushing health workers to solicit and accept informal payments. But they do exist. Alongside efforts to weaken the influence of the negative social norms, programmes can work to reinforce these positive norms through promotion of positive social rewards for integrity and social costs for engaging in informal payments.

**c. Include the community in changing norms related to informal payments.**

Given how gender and faith norms shape health workers' beliefs, especially among men, about how much support to provide families and communities, it is important to engage both health workers and the wider community. What is happening in the facility has bearing on what is happening in the family and community; the reverse is also true.

**d. Support and build capacity of diverse key influencers or champions, for social norms change.**

Key influencers or champions in the community and in the facility are important for social norms change; they can spearhead change by engaging in the desired behaviour and showing that it can be done without severe consequences. In programme design, it is necessary to assess who those influencers may be and look beyond generic ones to identify people who may not be public figures or leaders but who have status or are influential within the particular 'reference group' of the health workers for the particular behaviour. These may be people able to inflict social sanctions (rewards or punishments) related to compliance with the norm. Often, they are people within health workers' reference groups to whom they can relate, such as peers, supervisors, key family members, and friends, in addition to religious leaders, high status com-

13 Trendsetters are people who demonstrate that people in a group can behave differently and not suffer terrible social consequences. They can catalyse abandonment of a negative norm or spearhead the formation of a new positive norm.

munity members, and others whose behaviour can signal the possibility of defying the norm without serious negative consequences.

A key aspect highlighted by participants for supporting champions to promote change in dealing with both the direct and indirect norms influencing health workers' behaviours is to make social norms 'discussable.' Value clarification and attitude transformation training (VCAT) was proposed as the starting point, where health workers reflect individually and together on who they are in relation to their workplace, family and community values and expectations, and how their socialisation in these places influences their decisions about informal payments. Understanding and reflecting the roots and influence of social norms and their relation to values and attitudes through VCAT should be followed by collective commitment and public action by champions and role models who defy existing social norms and behave with integrity.

**e. Use multiple channels to diffuse messaging and influence expectations.**

Participants in the practical implications workshop recommended using multiple channels to influence social norms, such as preaching, dialogue, professional groups, and media. They emphasised integrating this into existing education and training systems, like medical school, continuing education, workplace orientation, and community pipelines like religious education. In addition, practitioners noted that dealing with direct norms within health facilities without addressing the reinforcing community norms that pressure health workers to engage in informal payments would reduce effectiveness; a multipronged approach, with different target audiences or reference groups, would be necessary.

**f. Do no harm: Do not undermine positive aspects of social norms that influence corruption.**

Social norms of gift giving 'appreciation' to someone who has done something good for you are deeply engrained in the culture in all three states; they are seen to be pro-social, a sign of gratitude and reciprocal goodwill that reinforces social cohesion. While there are ethical concerns about offers and acceptance of 'appreciation' between service users and health workers related to underlying and inappropriate motives for and expectations of such 'gifts', participants warned about not damaging the broader culture around gift-giving when trying to limit and regulate it in the context of healthcare service delivery.

## 4. Address intersections of gender and faith norms as part of the contextualisation of the programme.

Practitioners' reflections on the findings underlined that intersecting norms are part of the context and need to be considered as part of the contextualisation of a programme. These nuanced impacts of intersecting norms need to be taken into account in framing programme goals, segmenting the target population and designing and implementing programme activities with health workers. Expectations related to these different roles of men and women or of faith communities and beliefs need to be taken into account when deciding messaging in media - who are 'key influencers', who should be a role model and how they should be presented, or how to work with different groups. Programmes may, for example, require more intensive work with men related to norms of masculinity and role expectations as providers. For female health workers, focusing on women's groups and organisations could be a key entry point, given the influence of women's opinions and judgments on other women. Likewise, a strategy to promote role models or champions, for example, would need to reflect on whether and how women could be effective 'role models' for men or vice versa, or whether parallel programming for men and women might be warranted. Religious leaders may be engaged in a different way in Kano than in Nasarawa and Ebonyi, given the differing ways faith norms and obligations influence health workers.

## 5. Consider gender norms intersections when promoting gender equity to reduce corruption.

Promoting women (who are seen to be more honest) to leadership positions in healthcare administration and oversight was widely believed to be a useful step, as the current leadership is heavily imbalanced in favour of men, who have additional pressure from gender norms to accumulate wealth. The findings of this study on the interaction of gender norms within workplace and community expectations of health workers, however, suggest that this should be undertaken with care.

For example, gender-focused strategies to promote women into leadership positions may have limited impact if they do not correspondingly work on the social norms influencing all health workers to solicit and accept informal payments; gender norms that women are and can be more

honest may not be strong enough to counteract these norms, even if women gain greater power. Similarly, our findings suggest greater gender-equal sharing of roles could increase, rather than decrease, pressures to be corrupt if women begin to be subject to similar expectations as men. These questions would need to be monitored and addressed adaptively in any programming and could provide an opportunity for collaboration between practitioners and researchers.

# V. Conclusion

This study underscores the urgent need to reimagine anti-corruption strategies within Nigeria's primary health sector by going beyond institutional fixes and instead foregrounding the complex interplay of social norms, gender dynamics, and faith-based expectations. The normalisation of informal payments for free healthcare services is not merely a by-product of systemic failure, it is deeply embedded in the social fabric of communities, sustained through relational expectations, identity-driven pressures, and weak enforcement mechanisms. Our intersectional approach reveals that both health workers and service users operate within ecosystems of competing norms: moral codes, professional ethics, familial obligations, gendered expectations, and religious imperatives that collectively shape behaviour, justify deviance, and neutralise sanctions.

Importantly, this research challenges the dominant view that corruption is a rational, individual decision-making problem, and instead demonstrates how social expectations, both direct and indirect, act as powerful drivers that often supersede formal policy and training. Whether it is the pressure on male health workers as providers to fulfil their breadwinner roles or the moral buffering accorded to female health workers due to societal perceptions of their selflessness, corruption-related behaviour is entangled within the ways in which society scripts gendered and faith-based responsibilities. These behaviours are not uniformly experienced or enforced across geography or identity, they are deeply contextual and often adaptive responses to structural dysfunctions.

Thus, any meaningful attempt to address informal payments must move beyond compliance-based interventions or punitive audits. Efforts must be rooted in shifting social norms at the household, facility, and community levels. This entails reconfiguring the invisible networks of accountability and rewarding those that shape not just what is done, but what is seen as normal, permissible, and even moral. It also means building trust-based coalitions with faith leaders, community key influencers, and peer networks who can credibly challenge the status quo. In doing so, anti-corruption programmes will need to grapple not only with the systems that allow corruption to persist, but with the very meanings people ascribe to those systems.

Ultimately, tackling informal payments in Nigeria's health sector requires a paradigmatic shift: from seeing corruption as an individual vice to understanding it as a social practice. Only through such a shift, anchored in deep contextual understanding and intersectional approaches can interventions become truly transformative. Hence, this report offers a foundational roadmap for that shift.

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# VII. Annexes

## Annex 1: Categories of Study Population

| S/N | Activity | Urban | Rural | State Total | Total (x3 States) |
|---|---|---|---|---|---|
| 1 | **FGD + SNE (Service Users)** | | | | |
| | i. Women (18 – 24 years) | 1 | 1 | | |
| | ii. Women (25 – 34 years) | 1 | 1 | | |
| | iii. Women (Above 35 years) | 1 | 1 | 10 | 30 |
| | iv. Men (25 – 34 years) | 1 | 1 | | |
| | v. Men (Above 35 years) | 1 | 1 | | |
| 2 | **Key Informant Interviews** | | | | |
| | i. Director of Health (LGA level) | 1 | 1 | | |
| | ii. Local Immunisation Officer (LIO) | 1 | 2 | 12 | 36 |
| | iii. WDC Members | 4 | 3 | | |
| 3 | **IDI + SNE (Health Workers)** | | | | |
| | i. OICs | 2 | 2 | | |
| | ii. Nurses | 3 | 3 | 18 | 54 |
| | iii. CHEWS | 3 | 3 | | |
| | iv. Other Health Workers | 1 | 1 | | |
| 4 | **IDI (Reference Groups from Rapid Analysis of the SNE)** | | | | |
| | i. Service Members- Reference Group | 3 | 3 | 12 | 36 |
| | ii. Health Workers- Reference Group | 3 | 3 | | |
| | **Total** | **156** | | | |

## Annex 2: Glossary

- **Attitude:** Personal belief about what is good or bad about a behaviour.
- **Behaviour:** What people do or do not do.
- **Knowledge:** What people believe is true.
- **Incentives:** Benefits, such as monetary rewards or goods, provided to encourage a particular behaviour like bringing children for vaccinations.
- **Drivers:** Underlying factors or root causes that shape and sustain a behaviour.
- **Enablers:** Factors or conditions that make it possible to engage in a behaviour.
- **Social Norms:** Mutual expectations about what is typical and appropriate, or approved, behaviour within a group, that influence how individuals act.
- **Descriptive/Empirical Norm:** What people believe others in their group typically do or will do in a particular situation.
- **Injunctive Norm:** What people believe others in their group expect them to do or approve/disapprove of them doing in a particular situation.
- **Direct Norm:** Social norm that mandates the specific behaviour at issue.
- **Indirect Norm:** Social norm whose expectations can be met by many different behaviours.
- **Faith Norms:** Standards of shared belief and behavioural expectations that govern the actions and interactions of people who share a faith.
- **Gender Norms:** Social norms that define acceptable and appropriate actions for women and men in a group or society.
- **Sanction:** The consequences—usually social rewards or punishments—for engaging in a particular behaviour, intended to enforce norms.
- **Sensitivity to Sanction:** The degree to which a person's behaviour is influenced by the potential consequences (sanctions) for violating social norms.
- **Reference Group:** People whose opinions matter for a particular behaviour or context. People who reward or punish a person for their behaviour.
- **Informal payments:** Unauthorised charges for free services solicited by service providers or offered by service users.
- **Intersectionality:** The interconnections of norms related to individuals' different social identities that collectively influence their behaviour and experiences.
- **Outcome Expectations:** Expected results for complying or not complying to a norm.

## Annex 3: Sense-Making Workshop List of Attendee and Categories

| Kano | Ebonyi | Nasarawa |
|---|---|---|
| 5 Female OICs | 4 Female OICs | 4 Female OICs |
| 3 Male Health workers | 4 Female Health workers | 5 Female Health Worker |
| 4 LIOs and RIOs | 2 Male Health workers | 1 Male Health worker |
| 4 Female Service users | 6 LIOs and RIOs | 4 LIOs |
| 5 Female Health Workers | 4 Female Service users | 6 Female Service users |
| 2 Male Service users | 2 Male Service users | 1 Male Service users |
| 4 CSOs Representatives | 4 CSOs Representatives | 5 CSOs Representatives |
| **Total: 27** | **26** | **26** |

## Annex 4: Practical Implications Workshop List of Attendee and Categories

| |
|---|
| 15 Male high cadre CSOs/NGOs representatives |
| 16 Female high cadre CSOs/NGOs representatives |
| 1 Male tertiary university representatives |
| 3 Male chairpersons from coalitions |
| 1 Male government bodies representatives |
| 1 Female tertiary university professor |
| **Total: 37** |

## Annex 5: Social Norms Change Programming Ideas Generated by Practitioners in the Practical Implications Workshop to Shift Social Norms Influencing Health Workers' Behaviours

**General approach for direct norm – expectations within facilities that health workers solicit and accept informal payments:**

- Focus on shifting reward structure for behaviour: greater rewards for integrity, social sanction for engaging in informal payments.
- Use value clarification and attitude transformation training (VCAT) as a starting point. Facilitate health workers to reflect on who they are in relation to their workplace, family and community values and expectations, and how their socialisation in these places influences their decisions about informal payments. Work at the community level to address community and gender and faith norms that influence healthcare providers.
- Support and develop VCAT champions to provide role models for different behaviours, both within the facility to influence workplace culture, and in the community, to ensure consistent and sustained impact.
- Integrate and embed in existing interventions and processes – such as medical education, continuing education, workplace orientation.
- Address non-normative factors: put in place an ethics code and enhance monitoring and oversight.
- Contextualise activities to the realities of the community and the facility.

**General approach for indirect norm: health workers are expected by communities and family to provide financial support in accordance with their high-status level:**

- Focus on managing (lowering) expectations of what health workers can support financially as a goal.
- Make health worker salaries more transparent to avoid the pressure of 'earning more'.
- Identify and build capacity of key influencers and champions on how to sensitise people and management expectations; use integrity role models and influencers within the health system as well as in community.
- Use pipelines that produce key influencers (such as faith and traditional leaders) as key entry points for messaging.
- Address non-normative causes: monitoring and oversight, emphasise consequences for those who err in workplace orientation and onboarding, etc.; strengthen regulatory measures that have worked.
- Adapt for influence of gender and faith norms: Use women's groups and organisations as entry points to address influence of social pressure on women to conform to norms; involve women more in leadership positions and regulatory oversight.

# VIII. About the Team

**Mayokun Adediran** is a Sociologist and Anthropologist with expertise in social norms research and interventions that advance gender equality, economic, financial, and digital inclusion. He is the Policy Lead at the Policy Innovation Centre (Nigeria) and serves as the lead researcher for this research project.

**Eseoghene Adams** is the Gender and Inclusion Advisor at the Policy Innovation Centre. She supports gender research and integration, with expertise in gender analysis, social norms, and mainstreaming. Her work supports equity, capacity building, and social inclusion, through evidence-based, gender-responsive approaches. She serves as the gender norms expert for this research.

**Oluwabusola Oni** is a Research Assistant at the Policy Innovation Centre (Nigeria). Passionate about social Impact and inclusive policies, she currently contributes to digital Inclusion, DPI, and norms projects. She is also pursuing a master's in public health and holds several certifications in social change and public health short courses. She is a field researcher and methodological and analysis team member for this project.

**Isaac Oritogun** is a Senior Research Advisor at the Policy Innovation Centre, Nigeria, specializing in social and gender norms and development. He has over a decade of experience in research, monitoring and evaluation. He holds a Master's in Sustainable Development Practice and Public Health. He coordinates and conducts field research, methods development and analysis for this research.

**Paul Bukuluki** is Professor at Makerere University, Department of Social Work and Social Administration, School of Social Sciences (Uganda) and an Honorary Professor at the University of Edinburgh, School of Social and Political Science, United Kingdom. He is Besa Global's methodology lead for this project.

**Diana Chigas** is Co-Director of the Corruption, Justice and Legitimacy Program at Besa Global (Canada) and Professor of the Practice of International Negotiation and Conflict Resolution at the Fletcher School at Tufts University (USA). She is the team lead for this research project.

**Aloysious Nnyombi** lectures in the Department of Social Work at Makerere University (Uganda). He is a technical advisor on social norms at the Impact and Innovation Development Centre in Uganda and coordinator of the Eastern Africa Agency, Social and Gender Norms Learning Collaborative. He is Besa Global's Methods Development Assistant for this project.

**Osasuyi Dirisu** is the Executive Director of the Policy Innovation Centre and Senior Fellow, Nigerian Economic Summit Group where she oversees behavioural and policy interventions in health, governance, gender and social inclusion in Nigeria. She is PIC's lead for this research project.

**Cheyanne Scharbatke-Church** is a practitioner-scholar applying systems thinking and behavioural science to anti-corruption, governance, and peacebuilding. She is the Executive Director of Besa Global and co-directs its flagship program on Corruption, Justice and Legitimacy. She conceived of the project and supports the conceptual direction.