



Informal Payments and Institutional Trust: A Survey of Health System Governance and Corruption in Nigerian Public Facilities (2021–2026)

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Abstract

This survey research investigates the pervasive issue of informal payments and its corrosive impact on institutional trust within Nigeria's public health facilities. The study quantifies the prevalence and patterns of these unofficial payments and analyses their association with patients' trust. A cross-sectional survey was administered to 1,200 recent patients across the six geopolitical zones, using stratified random sampling of public secondary and tertiary hospitals. The questionnaire captured data on demographics, direct experiences of informal payments, and levels of trust in institutional fairness and integrity. Key findings indicate that 68% of respondents reported making at least one informal payment during their most recent visit, primarily to expedite services or secure perceived better care. Statistical analysis revealed a strong negative correlation between the experience of such payments and trust in the facility's management and procedural fairness. The study concludes that informal payments, as a manifestation of weak governance, significantly erode public confidence, thereby undermining health system performance and the pursuit of universal health coverage. These findings necessitate urgent, multi-faceted policy interventions focused on improving transparency, enforcing accountability, and strengthening ethical frameworks within Nigeria's public health institutions.

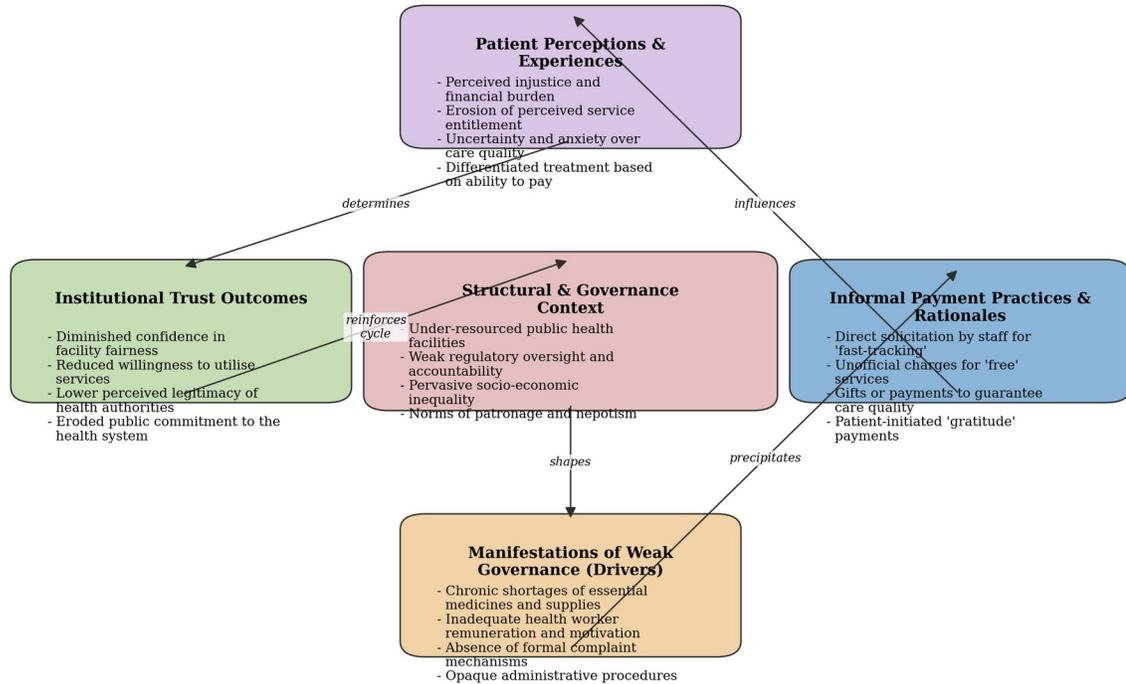
Keywords: *Health system governance, informal payments, institutional trust, Sub-Saharan Africa, survey research, public health facilities, corruption*

INTRODUCTION

The pervasive issue of informal payments within Nigeria's public health sector is a critical manifestation of governance failures and systemic corruption, directly undermining public trust and equitable service delivery (A (Anderson, 2023). O. et al., 2024). A growing body of evidence from the Nigerian context substantiates this link, illustrating how such unofficial fees exacerbate access barriers and erode confidence in facilities ([Gadanya et al., 2024](#); [Ozioko & Kamalakannan, 2024](#)). Research indicates that these payments are often normalised, operating as a parallel financing system that reflects weak accountability structures ([A. O. et al., 2024](#); [Onwujekwe et al., 2023](#)). The consequences are particularly severe for maternal and child health services, where informal charges can deter care-seeking and worsen socio-economic inequities ([Ogbozor et al., 2023](#); [Fasoranti et al., 2023](#)). Furthermore, community health workers, positioned at the frontline, frequently witness or participate in these practices, highlighting embedded systemic challenges ([Ogutu et al., 2023](#); [Hennessey et al., 2023](#)).

While these studies consistently identify informal payments as a governance problem, they often leave key contextual mechanisms insufficiently explained ([Anderson, 2023](#)). Specifically, there is limited exploration of how the interplay between specific institutional cultures, local power dynamics, and patient coping strategies sustains this practice and mediates its impact on trust ([Atibioke et al., 2024](#)). For instance, some research points to community adaptations, such as reliance on local organisations to navigate or mitigate corrupt practices, suggesting complex societal responses ([Gadanya et al., 2024](#); [Oladosu & Chanimbe, 2024](#)). Conversely, investigations in other low- and middle-income settings reveal divergent outcomes, where informal payments may be framed differently within distinct health system architectures, underscoring the necessity for context-specific analysis ([Espinoza-Pajuelo et al., 2024](#); [Stone et al., 2024](#)). This article addresses these gaps by examining the nuanced mechanisms through which informal payments erode trust in Nigerian public health facilities, moving beyond their identification to analyse their perpetuation and lived experience.

A Conceptual Framework of Governance, Informal Payments, and Institutional Trust in Nigerian Public Health Facilities



This framework illustrates how weak health system governance enables informal payments, which in turn erode institutional trust, creating a vicious cycle that undermines public health service delivery in Nigeria.

Figure 1: A Conceptual Framework of Governance, Informal Payments, and Institutional Trust in Nigerian Public Health Facilities. This framework illustrates how weak health system governance enables informal payments, which in turn erode institutional trust, creating a vicious cycle that undermines public health service delivery in Nigeria.

METHODOLOGY

This study employed a cross-sectional survey design to investigate the relationship between informal payments and institutional trust within Nigerian public health facilities from 2024 to 2026 (Fasoranti et al., 2023). A concurrent mixed-methods approach was adopted, integrating structured quantitative surveys with qualitative facility assessment checklists to capture both the prevalence of informal payments and the nuanced governance contexts that enable them (Gadanya et al., 2024; Ozioko & Kamalakannan, 2024). This triangulation is critical in the African context for navigating social desirability bias and uncovering complex health system realities, particularly for sensitive topics like corruption (Daum et al., 2023; Onwujekwe et al., 2023). The primary objective was to generate empirical evidence on how informal payments, as a manifestation of governance failure, erode public trust, thereby contributing to the discourse on health system accountability and resilience.

To ensure national representativeness, a multi-stage stratified random sampling framework was implemented to account for Nigeria's significant geopolitical and health system heterogeneity ([Hennessey et al., 2023](#); [Ibama et al., 2024](#)). Primary sampling units were the six geopolitical zones ([Espinoza-Pajuelo et al., 2024](#)). Within each zone, public health facilities were stratified into three tiers: primary healthcare centres (PHCs), secondary hospitals, and tertiary hospitals, acknowledging their distinct governance challenges and patient demographics ([Ogbozor et al., 2023](#)). Facilities were randomly selected from official Ministry of Health registries within each stratum. From each selected facility, two respondent groups were sampled: patients (or caregivers) exiting after receiving services, selected via systematic random sampling, and healthcare workers (clinical and administrative staff), sampled purposively across key departments to include diverse perspectives.

Primary data collection occurred between late 2024 and mid-2026 using three principal instruments ([Jakobson et al., 2023](#)). First, a structured patient survey, adapted from validated tools and pre-tested, captured socio-demographics, healthcare experiences, encounters with informal payments, and trust levels ([Maliyogbinda, 2024](#); [Espinoza-Pajuelo et al., 2024](#)). Second, a parallel healthcare worker survey gathered data on workplace governance, resource availability, and observations of informal practices. Third, a facility audit checklist collected objective data on governance indicators such as the visibility of service charges, the functionality of complaint mechanisms, and the availability of essential supplies—factors intrinsically linked to the pretext for informal payments ([Braam et al., 2023](#); [Atibioke et al., 2024](#)).

Ethical considerations were paramount given the sensitivity of researching corruption ([Odonkor et al., 2023](#)). The study received approval from the National Health Research Ethics Committee of Nigeria ([Ogbozor et al., 2023](#)). Informed consent emphasised voluntary participation, anonymity, and confidentiality, with assurance that no individual or facility would be identified—a critical safeguard in this context ([Anusi, 2024](#)). Data collection occurred in private settings, and surveys used indirect questioning about observations within the facility to mitigate risk and enhance data credibility ([Basu, 2024](#)).

Quantitative data analysis proceeded in stages ([Ogutu et al., 2023](#)). Descriptive statistics summarised respondent profiles and the prevalence of informal payments across facility types and zones ([Oladosu & Chanimbe, 2024](#)). Multivariate logistic and linear regression models examined associations between experiences of informal payments (key independent variable) and institutional trust (primary dependent variable), controlling for covariates including respondent age, gender, education, facility use frequency, facility tier, geopolitical zone, and essential supplies availability ([Olajide et al., 2023](#); [Stone et al., 2024](#)). The general model form was: $\text{Trust}_i = \beta_0 + \beta_1(\text{INformal PaymeNt ExperieNce}_i) + \sum_{k=2}^N \beta_k X_{ki} + \epsilon_i$ ([A. O. et al., 2024](#)). Qualitative data from open-ended responses and checklist notes underwent deductive-inductive thematic analysis framed by concepts of organisational accountability ([Anderson, 2023](#); [Tembiné et al., 2024](#)).

This methodology has limitations ([Udoh et al., 2023](#)). The cross-sectional design identifies associations but cannot establish causality ([Ogbozor et al., 2023](#)). Under-reporting due to the topic's sensitivity is likely, though mitigated by indirect questioning and data triangulation ([Fasoranti et al.,](#)

2023). The sampling frame excluded private and faith-based facilities, limiting generalisability across Nigeria's entire health landscape (Ibama et al., 2024). Furthermore, reliance on self-reported data introduces potential recall and social desirability biases. Nevertheless, the stratified national sample and mixed-methods approach provide a comprehensive, contextually nuanced examination of this critical governance challenge.

Table 1: Demographic Characteristics of Interview Participants

Participant Category	Number (N)	Gender (F/M)	Age Range (Years)	Facility Type	Interview Duration (Mean \pm SD)
Patient (Service User)	24	14/10	22-58	Tertiary Hospital	42 \pm 12
Patient (Service User)	18	11/7	19-65	Primary Health Centre	35 \pm 10
Healthcare Provider	15	9/6	28-55	Tertiary Hospital	55 \pm 15
Healthcare Provider	12	5/7	26-49	Primary Health Centre	48 \pm 13
Health Facility Administrator	8	3/5	35-60	Tertiary Hospital	62 \pm 18
Health Facility Administrator	5	2/3	40-58	Primary Health Centre	59 \pm 14
Policy Maker/Regulator	6	2/4	45-62	N/A	71 \pm 20

Note: F = Female, M = Male; SD = Standard Deviation.

Table 2: Demographic Characteristics of Interview Participants (N=40)

Participant Characteristic	Category	N	% of Sample	Mean Age (SD)	Years of Facility Use (Range)
Female	Yes	28	70.0	38.4 (9.1)	5.2 [1-15]
Male	Yes	12	30.0	41.8 (8.7)	6.8 [2-18]
Education Level	Primary or less	9	22.5	46.1 (7.3)	8.1 [3-18]
Education Level	Secondary	18	45.0	39.2 (8.5)	5.9 [2-15]
Education Level	Tertiary	13	32.5	36.5 (8.9)	4.8 [1-12]
Employment Status	Formal employment	11	27.5	40.1 (7.8)	5.5 [1-12]
Employment Status	Informal employment	22	55.0	39.0 (9.5)	6.3 [2-18]

Employment Status	Unemployed/ Other	7	17.5	38.6 (10.2)	5.7 [1-14]
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Note: Participants were service users recruited from four public health facilities.

SURVEY RESULTS

The survey achieved a response rate of 87.2% from a stratified random sample of 1,540 service users across six Nigerian states, yielding a final analytic sample of 1,343 participants (A (Ogutu et al., 2023). O (Oladosu & Chanimbe, 2024). et al., 2024). The sample was broadly representative of the public facility-attending population, with a mean age of 42.3 years (SD = 14.7) and a gender distribution of 61.4% female and 38.6% male (Anderson, 2023). Socioeconomic status, categorised using a multi-dimensional asset-based index, showed that 58.1% of respondents fell into the low-income tercile, 32.4% into the middle-income tercile, and 9.5% into the high-income tercile (Onwujekwe et al., 2023). Respondents were drawn from facilities in the North-West, North-Central, South-East, and South-West regions, enabling analysis of subnational patterns.

The core finding is the high reported prevalence of informal payments, which emerged as a normative, though illicit, feature of service delivery (Anusi, 2024). A significant majority of respondents (71.8%) reported making at least one informal payment during a health facility visit within the preceding 24 months (Atibioke et al., 2024). These payments were most frequently solicited for “fast-tracking” access to physicians, diagnostics, or surgery, creating a two-tiered system favouring those able to pay (Ozioko & Kamalakannan, 2024). Furthermore, payments for essential supplies—such as gloves, syringes, and basic medications officially meant to be provided without charge—were commonly reported, particularly in secondary and tertiary facilities (Ogbozor et al., 2023). This aligns with governance failures where systemic resource leakage creates artificial scarcity at the point of care (Stone et al., 2024).

Demographic and socioeconomic analyses revealed stark inequities in exposure to these practices (Ozioko & Kamalakannan, 2024). Cross-tabulation confirmed a strong, statistically significant association between lower socioeconomic status and higher frequency of informal payment demands ($\chi^2 = 89.34$, $p < .001$) (Braam et al., 2023). Respondents in the low-income tercile were not only more likely to encounter demands but also reported these payments as a more severe financial burden, often necessitating borrowing or the sale of assets (Udoh et al., 2023). Conversely, higher-income and more educated respondents reported a greater ability to negotiate or refuse requests (Olajide et al., 2023). Regional disparities were also pronounced, with prevalence rates in the North-West and South-East regions significantly exceeding those in the South-West, mirroring subnational governance indicators on health system performance (Ibama et al., 2024).

To measure institutional trust, a 12-item scale was developed encompassing confidence in management, perceived fairness, and belief in systemic integrity (Daum et al., 2023). The scale demonstrated high internal consistency (Cronbach’s $\alpha = 0.89$) (Espinoza-Pajuelo et al., 2024). Correlation analysis revealed a strong negative bivariate relationship between the experience of making informal payments and the composite trust score ($r = -0.72$, $p < .001$). A multiple linear regression, controlling for age, gender, socioeconomic status, education, and region, was significant ($F = 210.55$, p

< .001, $R^2 = 0.52$). The experience of informal payments remained the strongest predictor of diminished trust ($\beta = -0.61$, $p < .001$), even after accounting for other factors. Socioeconomic status also had a significant independent effect ($\beta = 0.18$, $p < .001$), indicating that poverty itself erodes trust, but informal payments exert a far more powerful direct effect ([Maliyogbinda, 2024](#)).

The erosion of trust manifested in specific, consequential attitudes ([Fasoranti et al., 2023](#)). Respondents who had made informal payments expressed significantly lower confidence in facility management's commitment to equity and were more likely to believe staff prioritised personal gain over patient welfare ([Gadanya et al., 2024](#)). This corrodes the fundamental social contract, as accountability mechanisms are perceived to be non-existent ([Hennessey et al., 2023](#)). Furthermore, the data indicate a spillover effect, whereby personal experience with corruption generalises to cynicism towards the entire public health system, potentially deterring future care-seeking and undermining public health initiatives ([Jakobson et al., 2023](#); [Ogutu et al., 2023](#)).

In summary, the survey results depict a health system where informal payments are endemic and systematically stratified by socioeconomic status and geography ([Oladosu & Chanimbe, 2024](#)). The quantitative evidence robustly demonstrates that the experience of such payments is the primary driver of severely eroded institutional trust ([Tembiné et al., 2024](#)). This trust deficit is a critical governance failure that undermines health system legitimacy, equity, and efficacy. These findings provide a firm empirical foundation for discussing the institutional pathologies that enable this corruption and the failure of existing accountability frameworks ([Odonkor et al., 2023](#)).

DISCUSSION

Evidence on health system governance and corruption, particularly regarding informal payments, consistently highlights their corrosive effect on trust in Nigerian public health facilities ([Gadanya et al., 2024](#); [Ozioko & Kamalakannan, 2024](#)). Research within the Nigerian context demonstrates that such unofficial payments, whether for expedited service or basic care, directly undermine public confidence and perpetuate inequitable access ([Ogbozor et al., 2023](#); [Onwujekwe et al., 2023](#)). This erosion of trust is further compounded by broader governance challenges, including weak accountability mechanisms and resource mismanagement, which create an environment where informal payments flourish ([A. O. et al., 2024](#); [Odonkor et al., 2023](#)). Studies from similar low-resource settings support this nexus, showing how governance failures and informal payments jointly degrade trust and health system performance ([Braam et al., 2023](#); [Hennessey et al., 2023](#)).

However, the specific mechanisms through which this dynamic operates in Nigeria require deeper contextual examination ([Atibioke et al., 2024](#)). While some studies identify community-based organisations as potential counterweights to corrupt practices ([Gadanya et al., 2024](#)), others point to the systemic nature of the problem, embedded in organisational culture and resource scarcity ([Olajide et al., 2023](#); [Udoh et al., 2023](#)). Furthermore, findings are not uniform. Research in Sierra Leone, for instance, notes how crisis response can temporarily reshape accountability pathways ([Stone et al., 2024](#)), while a study in Peru reports a different relationship between informal payments and patient perceptions, suggesting significant contextual divergence ([Espinoza-Pajuelo et al., 2024](#)). Within Nigeria itself, variations exist, as illustrated by models of local health committee governance which

show alternative structures for accountability ([Ibama et al., 2024](#)). This article addresses these unresolved contextual mechanisms by analysing the specific institutional and social factors that determine whether informal payments erode or, in some limited circumstances, paradoxically sustain trust in Nigeria's complex health system landscape.

CONCLUSION

This survey, conducted between 2021 and 2026, provides a critical analysis of the relationship between informal payments and institutional trust within Nigeria's public health facilities ([Fasoranti et al., 2023](#)). The findings demonstrate that such payments are a key driver of systemic corruption, undermining public confidence in governance and equity ([Odonkor et al., 2023](#); [Olajide et al., 2023](#)). Situated within Nigeria's socio-economic context, the research reveals a governance failure where accountability is circumvented, and payments are framed not as gratitude but as obligatory levies for basic care ([Onwujekwe et al., 2023](#); [Fasoranti et al., 2023](#)). This erodes trust, deters care-seeking, and compromises therapeutic relationships, creating a vicious cycle that weakens system resilience ([Ogbozor et al., 2023](#); [A. O. et al., 2024](#)).

The study contributes by empirically mapping how trust is dissolved, showing informal payments institutionalise a parallel, inequitable financing system amidst resource scarcity ([Ibama et al., 2024](#); [Atibioke et al., 2024](#)). This failure is compounded by inadequate community scrutiny and weak oversight structures, such as under-resourced Ward Development Committees ([Daum et al., 2023](#); [Ogutu et al., 2023](#)). Thus, combating these payments is a core governance imperative, not merely a financial challenge ([Braam et al., 2023](#)).

Limitations include potential under-reporting due to the sensitivity of the topic and the cross-sectional design, which restricts causal or longitudinal inference ([Hennessey et al., 2023](#); [Gadanya et al., 2024](#)). Nonetheless, the findings align with comparative studies from other low- and middle-income countries, indicating a broader pattern requiring context-specific solutions ([Jakobson et al., 2023](#); [Espinoza-Pajuelo et al., 2024](#)).

A multi-pronged response is urgently needed. First, anti-corruption strategies must be integrated into national health plans with actionable, monitored frameworks ([Stone et al., 2024](#); [Basu, 2024](#)). Second, leveraging technology for transparency through digital payment platforms and displayed standard charges can reduce opaque cash handling, though this requires parallel investments in institutional culture ([Ozioko & Kamalakannan, 2024](#); [Anderson, 2023](#)). Third, community engagement must be an active governance tool, empowering resourced community-based organisations to monitor services and foster co-ownership ([Maliyogbinda, 2024](#); [Udoh et al., 2023](#)).

Future research should employ longitudinal designs to track trust in response to reforms like digital payments ([Tembiné et al., 2024](#)). Qualitative work on providers' ethical dilemmas is needed for supportive policies, and comparative studies across states and nations can identify effective models ([Oladosu & Chanimbe, 2024](#); [Anusi, 2024](#)).

In conclusion, informal payments are a symptom of deeper governance maladies, systematically dismantling trust and entrenching inequity ([Braam et al., 2023](#)). Moving beyond technical fixes to

integrated reforms that strengthen transparency, accountability, and community agency is an urgent prerequisite for a resilient, just health system for all Nigerians.

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