Tracking of Out-of-Pocket Expenditures for Sexual and Reproductive Health

Expert Meeting
UNFPA/NIDI Resource Flows (RF) Project
NIDI, The Hague

12-13 December 2011

Contents

Agenda 1

Background Discussion Paper 3
1. Introduction 5
2. Out-of-pocket expenditurse for SRH: conceptual issue 6
2.1 Defining out-of-pocket health care expenditures 6
2.2 Catastrophic expenditures 8
2.3 Defining sexual and reproductive health services 9
3. Level of OOPE and effects on households 12
3.1 General health 12
3.2 Sexual and reproductive health 14
4. Measurement of OOPE 16
4.1 Surveys 16
a. Household surveys 16
b. Demographic and Health Surveys 17
c. Unicef's Multiple Indicator Cluster (MIC) Survey 18
d. OOPE surveys 19
4.2 Demographic and Health Surveillance Systems 20
4.3 Financial Diaries 20
4.4 Costing Studies 21
4.5 Recommendations 21
5. Conclusion and discussion 23
Annex I: Health expenditure ratios, by country (WHO) 31

Draft questionnaires 33
Introduction 34
Household Questionnaire 37
Men’s Questionnaire 44
Women’s Questionnaire 47

Agenda

Monday, 12 December 2011

9:30 – 9:50 Welcome by prof. Leo van Wissen, Director of NIDI
Welcome by drs. Erik Beekink, Leader RF Project
Introduction of participants

9:50 – 10:30 Brief presentation of discussion paper
Frans Willekens, NIDI

10:30 – 11:00 Coffee

11:00 – 12:30 Out-of-pocket expenditures for SRH: conceptual issues

12:30 – 13:30 Lunch

13:30 – 14:15 Levels of OOPE and effects on households: general health

14:15 - 15:00 Levels of OOPE and effects on households: sexual and reproductive health

15:00 – 15:30 tea

15:30 – 16:00 Measurement of OOPE: overview of issues and methods

16:00 – 16:30 OOPE survey in Nepal (part of RF Project) (Mahesh Puri, Centre for Research on Environment Health and Population Activities (CREPHA), Kathmandu)

16:30 – 17:00 OOPE survey in Ethiopia (part of RF Project) (Damen Hailemariam, University of Addis Ababa)

19:00 Dinner at spiZe

Tuesday, 13 December 2011

9:00 – 9:45 Household surveys as source of OOPE for SRH

9:45 – 10:30 Demographic and Health Surveys as source of OOPE for SRH

10:30 – 11:00 Coffee

11:00 – 11:45 DSS as source of OOPE for SRH

11:45 – 12:30 Special OOPE surveys as source of OOPE for SRH

12:30 – 13:30 Lunch

13:30 – 15:00 Prospects (includes general discussion)

15:00 Closure

Background Discussion Paper

Out-of-pocket expenditures (OOPE) for sexual and reproductive health

As an input for the workshop

Tracking Out-of-Pocket Expenditures for Sexual and Reproductive Health

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Outline

1. Introduction 5

2. Out-of-pocket expenditures for SRH: conceptual issue 6
2.1 Defining out-of-pocket health care expenditures 6
2.2 Catastrophic expenditures 8
2.3 Defining sexual and reproductive health services 9

3. Level of OOPE and effects on households 12
3.1 General health 12
3.2 Sexual and reproductive health 14

4. Measurement of OOPE 16
4.1 Surveys 16
a. Household surveys 16
b. Demographic and Health Surveys 17
c. Unicef's Multiple Indicator Cluster (MIC) Survey 18
d. OOPE surveys 19
4.2 Demographic and Health Surveillance Systems 20
4.3 Financial Diaries 20
4.4 Costing studies 21
4.5 Recommendations 21

5. Conclusion and discussion 23

Annex I: Health expenditures ratios, by country (WHO) 31

1. Introduction

There is increasing evidence that out-of-pocket expenses (OOPE) act as a financial barrier to essential health care, are a source impoverishment, ill health and can exacerbate inequity (van Doorslaer et al., 2006; Anderson et al., 2011). They may force households to reduce expenditure on other essential items such as food and rely on risky coping strategies. This applies particularly to catastrophic expenditures, i.e. expenditures that represent a significant proportion of the household budget. The expenditures may result from an illness or other health condition requiring an expensive intervention or repeated interventions. Relatively small repeated payments can result in financial catastrophe forcing people into poverty or pushing them deeper. Although few households may actually incur catastrophic health expenditures in a given year, all households are at risk of major health problem (*health shock*) and the need for costly care. Some households have better coping strategies than others. The level of vulnerability depends on the availability of accumulated resources including savings, and risk pooling or risk sharing mechanisms.

Addressing the financial barriers to access to essential health care is critical to improving progress towards MDGs 4 (Reduce Child Mortality) and MDG 5 (Reduce Maternal Mortality & Achieve Universal Access to Reproductive Health). Health problems may impose a financial burden on households and families for two reasons. The first is the cost of the health care (incl. transportation, waiting time). The second is the income foregone because of reduced activity levels[1]. Income loss may affect not only the person with a health problem but also other household members having to care and therefore reduce paid activity levels. Households with limited means are likely to sink further into poverty because of the adverse effects of poor health or illness on their earnings and general welfare. Van Doorslaer at al. (2006) estimate that the overall prevalence of absolute poverty in the 14 Asian countries they studied was 14% higher than conventional estimates that do not take account of out-of-pocket payments for health care. WHO (2005) estimates that globally approximately 44 million households, or more than 150 million individuals face catastrophic expenditure, and about 25 million households or more than 100 million individuals are pushed into poverty by the need to pay for services. These figures are also cited in the World Health Report 2010 (WHO, 2010a).

The amounts households spend on health care annually and the burden of catastrophic expenditures depend on (1) the utilization of health services and (2) how health care is financed, i.e. on who pays for service delivery. Health care paid from the government budget, by donors (development aid) or employers, or by innovative financing does not require households to pay. The World Health Report 2010 proposes a higher priority to health in government budgets and innovative financing as two ways to raise money for health (WHO, 2010a). Rising health care costs may burden the government budget or the employer's competitiveness, however. Insurance schemes, social or private, are burden-sharing mechanisms. In order to reduce the financial burden to governments and at the same time prevent that health problems lead to poverty, financial protection schemes based on risk pooling and prepayment should accompany health reforms. As the World Health Report 2010 illustrates, few countries have effective protection schemes. It is however the most efficient and equitable base for increasing universal health coverage.

[1] The earning loss may exceed the direct costs of health care. Gertler and Gruber (2002) find that in Indonesia earnings losses are more important than medical spending in disrupting household living standards following a major health problem.

The aim of this paper is twofold. The first is to document the magnitude of the problem: what is OOPE, what does it encompass, what is the level and what financial burden is implied? The second is to review experiences with the collection of data on out-of-pocket spending. The focus is on sexual health and reproductive health. The structure of the paper is as follows. In Section 2 the economic rationale for OOPE for health care is presented, OOPE is defined and the main spending categories in sexual and reproductive (SRH) are listed. Section 3 reviews what is known about OOPE for SRH: spending levels and their effects on households. The measurement of OOPE is the subject of Section 4. It covers data sources and direct and indirect measurement methods. Section 5 concludes the paper.

2. Out-of-pocket expenditures for SRH: conceptual issues

2.1 Defining out-of-pocket health care expenditures

OOPE are part of private health care expenditures. Private expenditure consists of expenditure made by private funding sources: households, firms, non-profit organizations and medical insurance schemes. Murray (2000) defines household expenditure for health as all direct and indirect financial contributions to the health system attributable to the household through taxes, social security contributions, private insurance and out-of-pocket payments. Direct payments are distinct from indirect payments. Indirect payments such as payments of health insurance premium or tax are paid in advance whether health care is received or not. Out-of-pocket spending includes all categories of health-related expenses paid directly by the household at the time the household receives the health service (Xu, Klavius, Kawabata et al., 2003). This broad definition is also endorsed by Guthrie (2005). It includes all direct and indirect costs incurred by the individual and/or household in securing or maintaining their health (Guthrie, 2005):

- Health service user fees
- Contributions to health insurances
- Purchase price of consultation, treatment, drugs (including traditional healers and medicines)
- Additional costs in treating ill health, securing & maintaining health, including nutritional supplements, transport costs, opportunity costs, loss of production costs, care and support costs to individuals who are ill or sick, time, time costs.

WHO has a narrow definition of OOPE: “The direct outlays of households, including gratuities and payments in-kind, made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or to the enhancement of the health status of individuals or population groups. This includes household payments to public services, non-profit institutions or nongovernmental organizations. It excludes payments made by enterprises which deliver medical and paramedical benefits, mandated by law or not, to their employees” (WHO 2003). Following from the WHO conceptualization of OOPE, out-of-pocket expenditures include direct household expenditures used for the purchasing of health services such as co-payments, fee-for-service payments, self-medication, informal payments and all other expenses paid directly (in cash or in-kind) by the households for the health services and goods (Belli, Gotsadze, & Shahriari, 2004). They exclude outlays for insurance premiums and other pre-payment schemes, and re-imbursements by third party payers (Table 1).

Table 1: OOPE as subcategory of household expenditures on health

Household Expenditures	**OOP expenditures**
Direct spending by households, *including* premiums and third-party payments, such as insurance	Direct purchase of services, medicines, appliances, including cost sharing and self-medication *but excluding* • Premiums for insurance • Reimbursements by third party payers (govt. or insurance agencies)
Measured at financing source (FS) level	*Measured at financing agent (FA) level*

Part of the out-of-pocket expenditures are user fees, i.e. direct charges to users of health services. Proponents of user fees suggest that fees help recover the costs of health care, enhance quality, and could make the health service delivery more efficient by guiding demand to cost-effective health care at the appropriate levels (for a discussion, see e.g. Bijlmakers et al., 2006; Nanda, 2002). 'Cost recovery' suggests that the client pays for the entire cost of the service or product obtained, which is usually not the case. User fees could improve equity if revenues generated from fees are allocated to addressing the health needs of the poor. In many countries the poor are exempt from user fees. Nanda (2002) examines the implementation of exemption policies in Africa and found that exemptions are vulnerable to subjectivity and distortion. Others also show that reallocation of user fees is not guaranteed and actually price the poor out of the market for health care. They point to an urgent need to examine the budgetary implications of user fees on households. User fees are an important subject of debate in international health. In the World Health Report 2010 on health systems financing, The WHO Director General, Dr. Margaret Chan, states that user fees and other forms of direct payments, are "by far the greatest obstacle to progress" to universal health coverage. Many studies assessed the effects of abolision of user fees. A number of these studies have recently been published in a special issue of *Health Policy and Planning* (Meessen et al., 2011). In that special issue, Ridde et al. (2011) report on a scoping review of 20 studies on the effects in Africa of the abolition of user fees, which are part of OOPE. The review revealed that user fees act as barriers and the abolition had generally positive effects on the utilization of services, but that the implementation process (top-down vs bottom-up) has a significant impact on how households respond the abolition of fees (Ridde et al., 2011).

Out-of-pocket expenditures include informal payments. Informal payments for health services are unofficial payments (under-the-table payments) that are added to the official service fees that are recorded in the administration of health service providers. Informal payments are payments in kind or in cash that are outside official payment channels or for purchases meant to be covered by the health system (Lewis, 2002).

This could encompass cash payments, exchanging goods and services (barter) or in-kind contributions (e.g. supplies needed for hospital treatment like sheets, drugs, blood) or gifts (usually more symbolic). Such informal payments (sometimes even in kind) are ubiquitous in developing countries and countries-in-transition (Lewis 2002; Vian et al. 2004). By its very nature, data on the latter category of expenditure are lacking in financial accounts statistics of health providers and are known to be under-reported. In particular the tracking of household (out-of-pocket) payments to private providers for outpatient services is challenging (Rannan-Eliya 2005). Informal fees should be taken into account however when estimating total household spending for health.

In summary, we define Out-of-Pocket expenditures as consisting of:

- Co-payments: consist of a health insurance provision or another third-party arrangement by which the individual who is assisted is required to share part of the cost of provision at the point of service. In turn, reimbursements from social or private health insurance schemes are to be deducted from 'gross' OOP payments (Xu, Klavius, Kawabata et al., 2003).
- Fee-for-service payments: cover all costs of service provision, plus a profit margin, according to a fee schedule set by each medical provider (Belli et al, 2004).
- Informal payments: all payments that clients report to pay directly to the health care individual or institutional provider above the legally set free services and goods package, and above (or below) the regulated fee-for-service, plus all in-kind contributions and gifts (Belli et al, 2004)
- Transportation and accommodation costs.

2.2 Catastrophic expenditures

OOPE are paid from the household budget at the time health care is received. One large payment for health care may be a substantial part of the household resources (income and wealth) at that time. Small but recurrent payments may also cause a financial burden. When payments are high in relation to income a "financial catastrophe" may be the result. High expenditure, single or cumulative, can mean that people have to cut down on necessities such as food and clothing, or their children's education.

Catastrophic expenditures are not uniformly defined. Health expenditure in a given period is viewed as catastrophic when it exceeds a given proportion of (part of) the household budget or household income **during that period**. The period is usually one year. A common definition of catastrophic expenditure is payment for health services exceeding 40 percent of annual disposable household income after subsistence needs (e.g. spending for food, shelter and other basic needs) have been met (Xu et al., 2003). The latter has been referred to as "nondiscretionary expenditure" (Wagstaff and van Doorslaer 2003) or "capacity to pay" (Xu et al. 2003). WHO (2005) and the OECD (2009, p. 146) adopt that "capacity to pay" approach to the definition of catastrophic expenditures. Some authors use non-food expenditures as an approximation of income after subsistence needs are met. Other authors define catastrophic expenditures as 10 percent of household budget (van Doorslaer et al., 2006; Russell, 2004). The rationale is that this represents an approximate threshold at which the household is forced to sacrifice other basic needs, sell productive assets, incur debt, or become impoverished. For a discussion, see O'Donnell et al. (2008), who provide an excellent introduction to the concept in the context of household surveys. The first definition better captures the ability to pay and better distinguishes between the rich and the poor. Bonu et al. (2009) use both measures of catastrophic expenditure and conclude that 40 percent of the capacity to pay may be the better measure of financial distress and the financial barrier to maternal care.

Whatever the precise definition, magnitude and threshold used, catastrophic expenditures mean hardship, disruption of family life and a risk of impoverishment (pushed into poverty or deeper poverty). In the case of major health problems, households may finance health care by cutting back on current consumption or through savings, the sale of assets, or credit. Households, in particular poor households, may also cope by foregoing prevention, treatment or health services more generally. Poor households have limited or no savings while at the same time they lack access to credit or other sources of finance. It should be noted that information on OOPE is necessarily incomplete because measures of catastrophic payments ignore households that delay or avoid prevention, treatment or health care generally because of the cost. High costs are often mentioned as the reason for not using health services. In the area of sexual and reproductive health, low utilization of services may be considerable because of high costs. For instance, Bonu et al. (2009) noted an increase in home delivery when maternal health care services are perceived as a high cost and thus an unaffordable service. Garg and Karan (2005) found that in India households belonging to lower castes such as SCs/STs are less likely to incur catastrophic payments mainly because of poor ability to pay. Most of these households do not have enough income to purchase medicines and/or health care services. Kruk et al. (2007) list several studies that show that out-of-pocket payments at the point of care reduce utilization of maternal health services.

The fact that catastrophic expenditures exclude (a) households that forego treatment and (b) earnings lost weakens the concept. Any study of OOPE for health care should at least consider two aspects: the level of OOPE and the non-use of services because they are not affordable. Pradhan and Prescott (2002) take a different perspective. They focus on the risk of incurring catastrophic expenditures. They estimate exposure to, rather than incurrence of catastrophic payments. Exposure points to the risk of a catastrophic event whereas incurrence points to the event itself. Exposure and risk point to prevention and insurance against the financial consequences of major losses. That perspective situates health spending in the context of *life-course risk management*. Everyone runs the risk of a catastrophic expenditure due to a major health event whether it be illness, disability, income loss or even having a baby. Asset accumulation and risk sharing are common ways to prepare for the financial consequences of major losses. Households vary greatly in their ability to accumulate assets or share risks. Households are vulnerable if they cannot put resources aside to cope with major losses or to share the risks with others. A discussion of catastrophic expenditures should be situated within the context of life-course risk management and include a discussion of risk sharing mechanisms, and in particular their reliability and affordability.

2.3 Defining sexual and reproductive health services

To estimate the amount households spend on SRH, the goods and services included in sexual and reproductive health care should be determined. According to the ICPD Plan of Action, reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Sexual health is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases. Reproductive rights refers to the right to (1) decide freely and responsibly the number, spacing and timing of children, and to have the information and means to do so (2) attain the highest standard of sexual and reproductive health and (3) make decisions concerning reproduction free from discrimination, coercion and violence.

The definitions of reproductive rights and sexual and reproductive health serve as a basis for the reproductive rights and sexual and reproductive health (SRH) framework
developed by UNFPA to provide overall guidance for implementing the Reproductive Health and Rights elements of the UNFPA Strategic plan 2008-2011 (UNFPA, 2008).

A number of functional classifications of goods and services included in SRH exist. One has been developed for reproductive health subaccounts of national health accounts (WHO, 2009), another as part of the development of Sexual and Reproductive Health Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health (WHO, 2010b).

Functions are goods and services produced by health care providers and by public and private institutions and actors engaged in activities related to health care. They include curative, rehabilitative, preventive, and long-term nursing care, as well as medicines and other commodities, such as condoms (WHO, 2009, p. 22; WHO, 2003, para. 3.15). Out-of-pocket expenditures may significantly differ by health care provider. Examples of health care providers include hospitals, clinics, pharmacies, independent physicians, and NGOs. The first step is to decide on the functional boundary by assessing: (1) the primary purpose of the expenditure; (2) the local (national) policy perspective; and (3) the extent to which the expenditure complies with international norms and recommendations. An expenditure should be included if its primary purpose is to maintain a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. The boundaries of different programme- or disease-specific subaccounts may overlap. RH subaccounts may overlap with the HIV/AIDS, and newborn and child health care subaccounts. The inclusion of these areas in one subaccount or another, or in multiple subaccounts, will largely be determined by the local policy context.

The WHO guidelines for reproductive health subaccounts include the following activities. The activities are grouped according to five core aspects of sexual and reproductive health care, as defined in the reproductive health strategy adopted by WHO in 2004 (WHO, 2009, pp. 19-20).

1. Improving antenatal, perinatal, and postnatal care
   - Antenatal care, including the provision of micronutrients (such as iron sulfate, folic acid, vitamin A) and food supplements to mothers before, during, and after pregnancy.
   - Postnatal care, including services for the mother up to 6 weeks after delivery and for routine care for the infant up to 28 days.
   - Deliveries, including emergency obstetric care to deal with complications, and transportation for emergency obstetric care.
2. Providing high-quality services for family planning, including infertility services
   Includes all programmes, goods, and services, as well as counselling, health education, and information, intended to assist people to control their fertility:
   - outpatient counselling and provision of contraceptive commodities, such as insertion of intrauterine devices (IUDs);
   - retail sale of family planning commodities, such as oral contraceptives, condoms, and spermicides;
   - female and male surgical sterilization;
   - abortion (where legal);

- infertility counselling, fertility drugs, and procedures; and programmes that support or promote family planning, such as IEC, public awareness, health education campaigns, training, and research.

3. Eliminating unsafe abortion
4. Combating STIs, including HIV, RTIs, cancers of the reproductive system, and other reproductive morbidities

   Includes general reproductive care:
   - routine examinations (e.g. Papanicolaou (Pap) smears);
   - diagnosis, management, and treatment of STIs (may be included in either the RH subaccount or the HIV/AIDS subaccount depending on country context);
   - health education;
   - treatment of RTIs;
   - screening and treatment of uterine, cervical, ovarian, breast, prostate cancers, etc.; and
   - treatment of fistula.
   - STI prevention and awareness programmes
5. Promoting sexual health
   - Programmes addressing gender-based violence, elimination of harmful sexual practices, sexual trafficking, and exploitation of minors,
   - Programmes addressing adolescent sexual and reproductive health.
   - Programmes addressing the issue of sexual trafficking (social protection, family and children).
   - Programmes addressing the issue of exploitation of minors.

An illustration of the impact of the local context on the functional classification is the report by Rannan-Eliya et al. (2000). The authors study reproductive health expenditures in Sri Lanka and adopt a functional classification that fits the policy concerns and data availability of Sri Lanka. They define a package of RH services consisting of:

- Family planning services: All programs, goods and services intended to assist women control their fertility, and all counseling, health education and information in support of the same.
- Maternal health services: All special programs designed to provide antenatal and postnatal care to mothers, including provision of dietary supplements for malnourished pregnant and lactating mothers, such as iron and vitamins.
- Childbirth services: Services to provide medical care for women delivering and giving birth.
- Infant care: All services intended to promote and improve the health and development of infants (defined as children aged less than 1 year), including well-baby health care, growth monitoring and growth promotion, and provision of dietary supplements such as micronutrients.
- Other personal reproductive health services for women: All other clinical services for women, which intend to enable women to safely exercise their reproductive health functions, to be operationalized as the equivalent of all obstetric and gynecological services.

In the above definition Rannan-Eliya et al. exclude services intended to treat sexually transmitted diseases and HIV/AIDS.

OOPE for the prevention and treatment of HIV/AIDS was the subject of one of UNAIDS notebooks. The notebook was prepared by the UNFPA/NIDI Resource Flows Project (2008). The spending categories distinguished in OOPE studies are the categories that are distinguished in the UNAIDS' National Aids Spending Assessments (NASA) (UNAIDS, 2007 [Classification tables]). The classification adopted by UNAIDS follows international agreed concepts and nomenclatures. It includes ISIC (the International Standard Industrial Classification 3rd Revision), COFOG (the Classification of the Functions of Government), COICOP (the Classification of Individual Consumption by Purpose), COPNI (the Classification of Non-Profit Institutions), CPC (the Central Product Classification), but also ICD (the International Classification of Diseases), ATC (the Anatomic Therapeutic Classification), ICHA (the International Classification of Health Accounts).

The classification for the three dimensions and six categories constitutes the skeleton of the NASA system. UNAIDS distinguishes eight spending classes or chapters of AIDS Spending Categories:

1. Prevention
2. Care and treatment
3. Orphans and vulnerable children
4. Program management and administration strengthening
5. Incentives for human resources
6. Social protections and social services
7. Enablement of environment and community programs
8. Research

In the present report expenditures are included if they cover goods and services to restore, improve and maintain sexual and reproductive health. There is a growing awareness that the health and well-being of women and that of newborns and children are closely linked and should therefore be managed in a unified way[2] (see e.g. Sines et al., 2006 and *Global Strategy for Women's and Children's Health*). Sexual, reproductive, newborn and child health implies a continuum of care of mothers, newborns and children. That continuum points to the need for a life-course perspective on health and to the importance of intergenerational transmission of health. That continuum, although important, is beyond the scope if this project.

3. Level of OOPE and effects on households

In this section we consider OOPE for health care in general and sexual reproductive health in particular.

3.1 General health

In low-income countries, private expenditures, which include out-of-pocket expenditures, form the bulk total health expenditure WHO (2011). In 2009 globally private expenditures on health was 17.6 percent of the total health expenditures (WHO, 2011). The data by country is obtained from the WHO website and given in Annex I. Out-of-pocket expenditures as a percentage of total health expenditures is particularly high in Asian countries (Anderson et al., 2011).

[2] The Cairo International Conference on Population and Development in 1994 already proposed a holistic perspective on the concept of reproductive health by linking the reproductive health of women and the health of children (for a discussion, see Padmadas, 2000).

Van Doorslaer and members of the *Equitap* project (2006) that was carried out in 11 countries of Asia estimated that the overall prevalence of absolute poverty in the countries studied was 14% higher than the poverty prevalence estimated by conventional methods that do not take account of out-of-pocket payments for health care. They calculated that an additional 2.7% of the population under study (78 million people) ended up with less than $1 per day after they had paid for health care. In Bangladesh, China, India, Nepal, and Vietnam, where more than 60% of health-care costs are paid out-of-pocket by households, their estimates of poverty were much higher than conventional figures, ranging from an additional 1.2% of the population in Vietnam to 3.8% in Bangladesh. In many developing countries OOPE form the primary or secondary source of health financing (Rannan-Eliya 2005, p. 4). In the absence of government-subsidized health care or universal health insurance, out-of-pocket payments for health care are usually substantial.

The level of OOPE depends on a number of factors including:

- Health profile of the population and extant demand for health services
- Costing of health services
- Access and utilization of health services, in turn dependent on their: i) availability (in time and space), ii) affordability, iii) acceptability.

The amounts households spend on health care in a year and the burden of catastrophic expenditures depend on how health care is financed, i.e. on who pays for service delivery. Rising health care costs may burden the government budget or the employer's competitiveness. Insurance schemes, social or private, are essentially burden-sharing mechanisms. Sustainable health financing schemes address both efficiency and equity in health care and protect households with health problems from falling into a poverty trap. WHO advocates the design of health systems that reduce catastrophic health expenditures: "National health financing systems must be designed not only to allow people to access services when they are needed, but also to protect households from financial catastrophe, by reducing out-of-pocket spending. In the long term, the aim should be to develop prepayment mechanisms, such as through social health insurance, tax-based financing of health care, or some mix of prepayment mechanisms." (WHO, 2005). In the World Health Report 2010 on Health System Financing WHO reiterates that message: "the report identifies continued reliance on direct payments, including user fees, as by far the greatest obstacle to progress. Abundant evidence shows that raising funds through required prepayment is the most efficient and equitable base for increasing population coverage." (Executive summary).

Others expressed similar views. For example Bijlmakers et al. (2006) conclude their assessment of user fees and health insurance in health financing by calling for an overall health financing strategy, the user fees and OOPE are part of: "Ministries of health should demonstrate a comprehensive vision on the ongoing commercialisation of health care in their respective countries and on the impact it may have on current and future health inequalities; they should use this vision in the formulation of appropriate national strategies for health sector development." The Kampala Declaration on Fair and Sustainable Health Financing (2005) states that out-of-pocket spending on health should be minimized while governmental spending on health increased and the scope of prepayments expanded, with a view to avoiding impoverishment of individuals.

3.2 Sexual and reproductive health

The amount households in low-income countries pay directly for sexual and reproductive health care (SRH) is largely unknown. Household surveys (e.g. Living Standards Measurement Study; Household Budget Surveys) and the World Health Survey are the main sources of information on health expenditures in low and middle income countries. However, they provide little data on SRH. The Demographic and Health Surveys (DHS), UNICEF's Multiple Indicator Cluster Survey (MICS) and the Demographic and Health Surveillance Systems (DSS) include information on service utilization but little or no data on financing. Few population-based surveys on OOPE spending for SRH exists (e.g. Perkins et al., 2009). In the period 2005-2007, the UNFPA/NIDI Resource Flows (RF) project carried out OOPE surveys in India, Nepal and Ethiopia, in cooperation with local research institutions (UNFPA/NIDI Resource Flows Project, 2008). The studies revealed that catastrophic expenditures for sexual and reproductive health can be significant, e.g. as a result of complications during delivery or treating opportunistic infections in PLWAs. The studies were not representative for the national population because (1) sampling from the national population was beyond the financial means of the investigation, (2) persons living with AIDS could be identified only in close cooperation with NGOs, and (3) the number of observations was too small for nationally representative figures on catastrophic expenditures. In the years following these studies, the RF project adopted a different strategy and aimed at financial modules attached to ongoing and sustained data acquisition efforts such as the DHS (ICF Macro http://www.measuredhs.com/), MICS (http://www.unicef.org/statistics/index_24302.html) and DSS (http://www.indepth-network.org/). The rationale was that spending for SRH is related to service utilization. Insight in the need for health care and service utilization is considered an important step towards insight in out-of-pocket spending. A module was developed for MICS, but could not be implemented due to financing issues.

Few studies measure OOPE for SRH. Bonu et al. (2009) use data from the 60th round of the National Sample Survey of India (2004) to study catastrophic expenditures for maternal health. In the survey data were collected on prenatal care, delivery care and postnatal care expenditures for all ever-married women aged 15 to 49 who were pregnant during the year prior to the survey. No information was elicited for expenditure for abortion care. Bonu et al. limited their study to women who gave birth during the reference period. 'to capture full maternal health care expenditure'. Note that in general the sample for such estimation includes only those households
where at least one member sought hospitalization or other formal health care. By including all women who gave birth, households are included that forego health care to avoid catastrophic expenditure[3]. The authors found that the average maternal expenditure for women who gave birth in the preceding year was the equivalent of US$ 50.5. Two-thirds is spent on delivery care, twenty percent for prenatal care and the remaining 12 percent for postnatal care. Major differences exist between populations, between states and between providers. The payment in a private institution is about four times that in a public institution (US$ 149 vs US$37). The authors also found that households from the poorest two deciles have maternal health care expenditure higher than their annual 'capacity to pay', which indicates the scale of financial distress that the poorest households may suffer due to expenditure relating to maternal health care.

[3] The National Family Health Survey III revealed that most women who did need delivery care but did not seek institutional delivery care mentioned the high cost as the reason.

Afsana (2004) reports on an ethnographic study of childbirth practices in 2000-01 in Apurbabari village and the adjacent district in Bagladesh. Families had to spend what for them added up to a fortune for a caesarean section and other surgery, medicines, laboratory investigations, blood transfusion, food, travel and other expenses. The study revealed corruption practices. The study is particularly interesting for designing coping strategies for individuals and households.

Kaufman and Jing (2002) examined the impact of privatization on financing, provision and use of reproductive health services by women in two rural counties in Yunnan Province, China. The study revealed that hospital-based delivery and use of antenatal care is very low and adversely affected by costs and perceived low quality. The authors also list several studies showing that the cost of medical services have a negative influence on hospital utilization by the poor and contribute to households falling into poverty. They also point to the vulnerability of women living in households where women' s health needs are a low priority in the allocation of household resources.

Rannan-Eliya (2008) studies access to maternal and child health care in the Asia-Pacific region. The access to maternal and child health (MCH) services varies greatly between countries and within countries, with access being close to adequate and universal in advanced economies, and often, but not always, inadequate and unequal in poor countries. Significant disparities exist between the rich and the poor. Some poorer regional countries, notably Sri Lanka, Malaysia and Thailand, do quite well in ensuring effective risk protection despite significant levels of out-of-pocket financing. At the same time, a few countries, such as Viet Nam, which have relatively good performances in terms of overall access to services, do poorly in terms of risk protection. The study revealed that accessing maternal and child health care can clearly be one source of financial risk for households, and this is most likely to be the case for maternal care, in particular childbirth and its complications. Although richer households are more likely to use private services and spend more than 10% of their income on accessing care, the incidence of catastrophic expenditures where households spend more than 40% of their income on accessing care is concentrated in the poorest households. The author concludes that reducing maternal deaths requires ensuing access to emergency obstetric care, which ultimately means widespread use of institutional and medically-supervised childbirth. Cost is not the only consideration. Health-seeking behaviour is also important. Whether mothers and children have access to services and actually make use of them when they are available depends on a number of factors related to both the supply of services, the knowledge of the mothers and their families, and other physical and economic barriers to use.

Skordis-Worral et al. (2011) studied expenditure data for maternal and neonatal care, collected during post-partum interviews. Interviews were conducted in 2005-2006, with a sample of 1200 slum residents in Mumbai (India). They found that a high proportion of respondents spent catastrophically on care. Lower SES was associated with a higher proportion of informal payments. Overall, the incidence of catastrophic maternity expenditure was 41%, or 15% when controlling for coping strategies. The authors found no significant difference in the incidence of catastrophic spending across wealth quintiles. They conclude that health reforms aimed at increasing institutional deliveries may force households deeper into poverty unless the reforms are accompanied by measures that address OOPE and informal payments, and protect the poor.

A study of reproductive and child health care (RHC) financing in the state of Rajasthan, India, Sharma et al. (2000) found that direct payments to private providers constituted nearly half the services financed (49 percent) and OOP payments to public providers 30 percent of total RCH spending.

The studies listed above and other studies (e.g. Richard et al., 2008) indicate that access of sexual and reproductive health services is a multi-dimensional issue, with cost being an important aspect. They also indicate the need to distinguish between types of services and service providers (private vs public). Some services are required regularly while the need for other services is relatively rare. Obstetric care can be particularly costly. Reducing the financial barriers to obstetric care in low-income countries is therefore a priority (see also Richard et al., 2008).

4. Measurement of OOPE

A number of data sources may contain information on OOPE for health services. They include surveys, health surveillance systems, financial diaries and costing studies. In some instances, they may be alternatives to specialized out-of-pocket expenditure surveys. In addition to primary data collection, indirect methods for estimating OOPE have been tried (see e.g. Horstman, 2007; Kruk et al., 2007). In this section data sources are discussed. The discussion is followed by recommendations for studies on the direct measurement of OOPE for SRH.

4.1 Surveys

a. Household surveys (including Household Budget Surveys)

A household survey collects information on a range of topics from people living in private households. Use of health facilities and expenditures are usually included, but only broad categories of health functions are distinguished.

A useful reference to the use of household surveys for measureming health spending is O'Donnell et al. (2007). The *Equitap* project, mentioned above relied on household surveys (van Doorslaer et al., 2006). Recently, Rannan-Eliya (2010) reviewed and assessed different approaches to estimation of household expenditure on health in the context of national health accounts, in order to identify best practices.

A type of household survey is the Living Standard Measurement Study (LSMS). These studies are household surveys aimed at the measurement and understanding of poverty in developing countries. The World Bank maintains a website of LSMS: (http://www.worldbank.org/LSMS/).

Waters (2007) uses the LSMSs from Latin America to measure the share of total household spending that is taken up by spending on healthcare. Falkingham (2004) uses the Tajikistan Living Standard Survey to investigate the level and distribution of out-of-pocket payments for health care in Tajikistan and to examine the extent to which such payments act as barriers to health-care access.

More recently the Asia Development Bank (ADB) initiated a study to determine the level of OOPE for Mother, Newborn and Child Health (MNCH) from household surveys. The project "Impact of Maternal and Child Health Private Expenditure on Poverty and Inequity " is carried out by Anderson, consists of two phases. The first phase is to scope and validate the availability and reliability of household survey data as a basis for measuring the effect of OOPE on MNCH.

It consists of a concise literature review of the latest main findings related to OOPE and MNCH in the region, and summary of international developments. The second phase analyzes the relationship between OOPE and MNCH for the countries that are found to have reliable data. This second phase answers questions such what is the level of OOPE on MNCH in absolute and relative terms; How much of such expenditure is catastrophic and how much is impoverishing; What is the distribution of such expenditure by wealth quintiles How much would it cost at a national level for a government to defray catastrophic expenditures in its society per year. Where data sets are reliable and robust, the analysis extends to a multivariate analysis of those factors that predispose a household to catastrophic expenditures (e.g. income levels, age, geographical location, ethnicity). The study is expected to inform the development partners in the region about "how much or how little reliance they can put on their existing household surveys when trying to understand the impact of OOPE on MNCH". For a description of the project, see the ADB website (Project Information Documents) and Anderson et al. (2008).

b. Demographic and Health Surveys

The DHS program collects, analyses and disseminates data on population, health (including HIV/AIDS) and nutrition through more than 200 surveys in 75 countries. Data can be downloaded from the website (http://www.measuredhs.com/). DHS surveys include data on health needs and
service utilisation, but few include information on expenditures (e.g. Morocco 1995 DHS). DHS surveys may be useful sources for costing studies, however. Household surveys and Demographic and Health Surveys address different issues. An alignment of the two surveys, as suggested by Falkingham and Namazie (2001), offers cost-effective ways of spending for sexual and reproductive health. They suggest that the DHS remains the starting source for measuring health status and that LSMS includes questions on self-reported health status, utilisation of health services and, for women of reproductive age, birth history. LSMS should also include questions on out-of-pocket payments related to health care.

Some authors combine DHS data and data from National Health Accounts (NHA) to determine the impact of health financing schemes on the utilization of health services. For instance, in a cross-country analysis, Kruk et al. (2007) estimated the impact of government financing of health (government health expenditure as a percentage of total health expenditure) on the utilization of maternal health services. They found that government financing is associated with better access to some essential maternal health services. In particular they found that government participation in health care financing is associated with utilization of skilled birth attendants and Caesarian section, two key interventions for reducing maternal mortality (MDG 5). Other studies showed that pooled payment schemes (e.g. insurance) help increase access (Ensor and Ronoh, 2005). A combination of individual data (DHS) with country-level data (NHA) has severe limitations but it is an ingenious way to obtain estimates of the impact of health financing schemes on utilization of key SRH services. In order to remove the limitations, individuals, households and providers should be interviewed to determine the impact of health financing on the utilization of SRH services. In out-of-pocket surveys, individuals and households are approached to determine the expenditures on SRH and to what extent access to health services is restricted by the direct out-of-pocket payment at the point of care.

c. Unicef's Multiple Indicator Cluster (MIC) Survey

The MIC survey includes information on service utilization that may be used to estimate health care spending. The UNFPA/NIDI Resource Flows Project team prepared a module to collect information on out-of-pocket expenditures in connection with service utilization. It was proposed to include a module in both the household questionnaire and the individual woman questionnaire. In cooperation with Unicef and UNFPA, the following questions were proposed for the household questionnaire:

1. How much did you spend in the last 30 days on:
   - health (fees, medicines, etc.)
   - in total
2. Is the household covered by a health insurance?
   - yes:
     - by the employer
     - private insurance agency: specify the name
     - other: specify the name
   - no

The following questions were proposed for the individual woman questionnaire:

1. Have you experienced reproductive health problems in the last 12 months?

- yes: mark the problems (1 = most important; 2 = second most important; etc.)
  - sexually transmitted disease
  - pelvic inflammatory disease
  - abortion
  - miscarriage
  - pregnancy-related problems (e.g. preeclampsia, hemorrhage)
  - delivery-related complications (e.g. prolonged labor, abnormal presentation of the baby, amniotic fluid embolism)
  - post-delivery complications (e.g. fistula involving female genital tract)
  - other reproductive health problems: specify
- no

For the most important reproductive health problem specified in question 1, ask:

2. Did you seek health care for this reproductive health problem?

- yes
  - public sector (government hospital, government clinic, government health care post, other public)
  - private medical sector (private hospital, private clinic, other private medical)

        - other (e.g. traditional birth attendant, community health worker): specify
- no

If the answer to question 2 is “yes”, then ask:

3a. How did you pay for the health care?

- cash: specify the amount
- in kind: what did you give?
- provided for free: specify who paid for it (government, NGO, or someone else)
- paid by the insurance

4. Were there other expenses incurred for that heath care?

- yes
    - drugs, dietary supplements, kit: specify the amount
    - transportation: specify the amount
    - accommodation & food: specify the amount
    - other: specify the amount
- no

If the answer to question 2 is “no”, then ask:

3b. Why did not you seek health care?

- did not know where to seek health care
- did not think health care was needed
- did not get permission to seek health care
- too costly
- too far
- concerned that the health provider could be a male

The module is not implemented yet due to financial restrictions.

d. OOPE surveys

OOPE surveys collect data on OOPE in detail by distinguishing between the various health services utilized and by health service providers. The number of surveys of OOPE for SRH is still small. Rannan-Eliya (2005) provides a good
introduction to OOPE surveys. Khan (2005) studies the out-of-pocket expenditures for maternity services and related costs such as transportation by persons visiting a large hospital in Dhaka, Bangladesh. All interviewees incurred
substantial out-of-pocket expenditures for travel, hospital admission fees, medicine, tests, food, and tips. As part of the Resource Flows Project (UNFPA/UNAIDS/NIDI study) in the period 2005 - 2007, surveys for OOPE for SRH were organized in the State of Karnataka, India, and in Nepal and Ethiopia.

In this section we briefly present the major methodological findings of these studies.

The general aims of these surveys were to:

- Assess levels of individual and household spending on SRH.
- Assess the equity of SRH expenditures across gender and life-course stages.
- Relate household spending on SRH to the wealth status of households, to the costs of health service provision by the public and private sector, and to general household spending on health.
- Strengthen health resource tracking capacity of counterpart organizations and stimulate south-south co-operation.

For a description of these surveys in some detail, see UNFPA/NIDI Resource Flows Project (2008).

Several lessons were learned as a result of these surveys. They are listed in Section 4.5.

4.2 Demographic and Health Surveillance Systems (DSS)

Demographic surveillance tracks births, deaths, and migrations in a population over time (Baiden et al., 2006). Surveillance systems are often set up around specific intervention studies and later converted into standing DSS sites that can form a
platform for further studies. There are over 30 DSS sites in Africa, Asia, and the Americas. They are a major source of longitudinal data. At most sites, core demographic data are supplemented with social and economic correlates of population and health dynamics. DSS sites have come together under the banner of the INDEPTH network: (http://www.indepth-network.org/). Mugisha et al. (2002a, 2002b) used the Nouma DSS in Burkina Faso as a sample frame to study
the impact of OOPE on health care. The Butajira DSS site in Ethiopia is used by the Resource Flows Project to collect information on OOPE for SRH .

4.3 Financial diaries

Financial Diaries were originally proposed by a team from the Institute for Development Policy and Management at the University of Manchester
led by David Hulme. Financial diaries use detailed balance sheets of all income and expenditure and monthly cash flow statements maintained by family and researcher. The objective of financial diaries is to shed more light on how poor households manage their finances over a full year, and in particular, how and why they make use of financial services and devices. The diaries present a picture of the financial lives of the poor by interviewing households over the course of a year and compiling a record of daily income, expenditure and financial exchange. For details, see Rutherford (2001), the website maintained by the Finance and Development Research
Programme at the University of Manchester: (http://www.devinit. org/findev/) and the website maintained by the Southern Africa Labour and Development Research Unit (SALDRU) of the University of Cape Town, South Africa: (http://www. Financialdiaries.com/). Financial diaries have become an important tool in microfinance. Diary data have been collected in India, Bangladesh and South Africa (Cape Town). The Cape Town data are disseminated by SALDRU and can be accessed through the internet:at: (http://blogs.uct.ac.za/blog/saldru/2006/04/26/release_of_the_financial_diaries _dataset). Guthrie (2005) lists strengths and limitations of financial diaries.

Collins and Liebbrandt (2007) use financial diaries to study the financial impact of death at the household level in three urban and rural areas in South Africa. Their diaries track household-level cash flows over one year. The data can be accessed at: (http://www.datafirst.uct.ac.za/data_fdiaries. html). For details on the dataset, including survey instruments, see: (www.financialdiaries.com) and in Collins (2005).

4.4 Costing studies

Costing studies collect data on expenditures from the provider's perspective.

4.5 Recommendations

In general OOPE for SHR are difficult to measure because of conceptual and measurement problems. As a result the evidence base is still meager. The following steps should receive particular attention when executing a study on SRH-related OOPE. These recommendations follow from the special OOPE survey for SRH organized in Karnataka (India), Nepal and Ethiopia by the UNFPA/NIDI Resource Flows Project. Additional recommendations are derived from household surveys (see Ranna-Eliya, 2010). The steps are:

a. First step: mapping the health system

Since OOPE expenditures for health depend on the idiosyncrasies of the health system in the country or region, a detailed mapping of the system is required, including e.g. financing sources, public and private providers, range and type of health services available and health insurance schemes. In addition to mapping the relevant actors in the health system, the mapping exercise can also be used to identify useful data sources and databases. In the context of OOPE for HIV/AIDS prevention and treatment, one needs to map which providers are providing what HIV/AIDS related services to whom. For each data source a thorough evaluation of the availability, scope, quality, detail (expenditure by service category, commodity), compatibility, representativeness and reliability should be made. On the basis of this, and in light of available resources, a detailed data collection plan needs to be drawn up. Gaining a thorough understanding of the local health system, its actors, functions and types of available data is a necessary prerequisite for any OOPE study. For an illustration of mapping the reproductive health system, see Mishra et al. (2006).

b. Functional boundaries

After a detailed mapping has been accomplished one needs to determine what is considered SRH related treatment and care within the given country context. This does not only pertain to official guidelines from Ministries of Health or international classifications, but could also include services/treatment outside mainstream health care services, e.g. use of traditional healers or ayurvedic medicines. For example, the use of condoms could be classified under FP/RH, but could also be seen as a preventive measure against HIV. For clarity in analysis and to make international comparisons possible (if required), these categories should be clearly distinguished and measured separately. One should be aware that users and providers could have differing views as to what comprises SRH prevention/treatment. Therefore, during a survey boundaries should be clearly defined and cross-checking with respondents as to what they consider spending on services such as family planning, c-sections, delivery, HIV HAART, that are part of SRH services.

c. Sample frame

Some studies use as a sample frame existing surveillance schemes. In the Karnataka and Nepal studies, in preparation of the survey all households in the enumeration areas were visited to determine eligibility of household members. In Ethiopia, the DSS households were screened for SRH problems in the past 12 months to determine eligibility. In addition hospital data were used to identify persons that meet the eligibility criteria. Since the interview was conducted some months after the initial screening, some households or members of households had migrated. That is not a problem if these migrants do not differ from the general population.

d. Time frame

The reference period is generally 12 months. Hence, service utilization and expenditures are recorded for the past year. Lack of memory, recall bias and telescoping are main problems. For instance, persons may report catastrophic expenditures that occurred more than 12 months ago. One should also be aware that the same time frame is used to measure consumption and payment of health services. However, longitudinal data with measurement at several time intervals can relate trends in expenditure and disease burden to the various stages of the disease (Bachmann and Booysen 2003; 2004) The use of the financial diary method could be a way to enhance accuracy, but the method also has its limitations. In order to arrive at useful OOPE data, care should be taken to circumscribe the time boundary clearly and relate this to respondents. In case of memory loss concerning small outlays for health services, it could be considered to record payments over a shorter period and extrapolate this for the whole period, based on average number of visits or purchasing of health services or commodities and taking into account the common problems such as seasonality.

e. Questionnaire design

The instruments should be tailored to elicit information specific to the local situation, actors and funding. It is recommended that categories and classifications (providers, functions etc) are compatible with international classification guidelines (e.g. Producers Guide WHO, Aids Accounts guidelines). It serves international comparability, which is often required, e.g. in health accounts and comparative analyses. It is helps transparency because concept and measures are generally well-defined and broadly supported. In order to maximize response the design of the instruments needs to takes into consideration issues of sensitivity, culture, confidentiality and ethics.

For chronic diseases the questionnaire(s) should take account of the clinical stage of the disease. The questionnaire should also include demographic characteristics and socio-economic status of households. The questionnaire should include information on service providers, services provided by type (prevention, treatment) and other costs (e.g. transportation and accommodation). It should distinguish between payments that are eligible for reimbursement from health insurance schemes or employers and that are not. In case such reimbursements do not exist the questions in the questionnaire may be skipped.

f. Analysis

It is good practice to formulate an analysis plan before and during the questionnaire design. The analysis plan includes (a) a set of questions that need to be answered bur cannot using available data, and (b) a plan of data analysis that includes tabulations and methods of analysis.

A dimension that is not adequately covered in surveys and analyses is duration. The health status and the social participation of persons with SRH problems may vary with the duration of the disease. For AIDS patients, ARV treatment extends over a lifetime.

Unless the treatment is free, the financial consequences are likely to worsen with duration of the disease. Duration analysis calls for longitudinal data. Longitudinal research capacity is still limited, particularly in developing countries (See Durrant and Menken, 2002; Willekens, 2006).

Care should be taken that reported data refer to the same time frame; if possible data could be transformed into annualized data. In addition, given country/regional variations in what constitutes a household. It should be verified whether data refer to individual level expenditure or household's level expenditure.

After arriving at OOPE estimates it is important to triangulate and validate the data using other cost and utilization studies, provider surveys, national health accounts or expert opinion.

It should be clear from the analysis and reporting whether OOPE estimates refer to health events and direct health care expenditure related to a single episode (e.g. illness episode) or multiple episodes, or to a specific defined period. In order to be a meaningful concept, OOPE for SRH should be in terms of specific health care categories e.g. spending for counseling, treatment, medicines, hospital admission fees, medical tests, bed charge, travel, tips, informal payments etc. The categories that are considered should be culture-sensitive since culture has a large influence on health care and health-seeking behaviour.

In estimating annualized OOPE or reporting trends in spending (in US$), account should be taken about currency exchange fluctuations, which can be erratic.

5. Conclusion and discussion

In several parts of the world, OOPE for health represent more than 50 percent of health care spending. The financial burden of SRH problems to individuals and households remains largely unknown. The level of catastrophic health expenditures associated with a major health event (severe illness or impairment, a pregnancy or a childbirth) is an indicator of the vulnerability of households to health care spending and the risk of falling into poverty because of high costs. Households may not vary much in their risk to major health events that require costly intervention, but they vary greatly in their ability to cope. They differ in their ability to accumulate assets and/or pool risks to prevent a financial catastrophe upon occurrence of major health event. In discussion on catastrophic out-of-pocket expenditures, *exposure* to the risk of catastrophic payments and the *incidence* of these payments should be considered in addition to the *prevalence* of these payments. Incidence points to the risk of an event whereas prevalence points to the occurrence. That shift from prevalence to incidence is essential for developing innovative strategies to hedge against the risk of catastrophic health expenditures. A discussion of catastrophic expenditures should be situated within the context of risk management and more particularly *life-course risk management*. Major health events have often lifetime consequences, not only for health but also for household finance. Minor health events may lead to catastrophic spending if they are recurrent and repeat at a considerable pace. The life course provides a proper framework to address sexual and reproductive health issues in general and financial aspects in particular. Households vary greatly in their ability to manage health risks and the financial consequences. A risk management perspective on major health events and the associated catastrophic payments points to the need to manage the risk of the event as well as the risk of excessive payments upon occurrence of the event. Safe motherhood, i.e. ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth, is an effective way to reduce the risk of catastrophic costs associated with complications during pregnancy or childbirth. It does not reduce the cost per se but it reduces the risk of the unwanted event.

Risk pooling does not reduce the risk of a catastrophic event but reduces the risk of excessive spending following the event. Life-course risk management involves the management of both the *event risk* and the *financial risk*.

What households in low-income countries pay directly for sexual and reproductive health care (SRH) is not known. Household surveys (e.g. Living Standards Measurement Study and Household Budget Surveys) and the World Health Survey are the main sources of information on household expenditures in low and middle-income countries. They provide information on spending for overall health but little data on SRH. The Demographic and Health Surveys (DHS) and UNICEF's Multiple Indicator Cluster Survey (MICS) include information on service utilization but little or no data on financing. Demographic and Health Surveillance Systems (DSS) may collect information on health financing, but the results are seldom published. Insight in the need for health care and service utilization is an important step towards insight in out-of-pocket spending. Two aspects of OOPE should be considered in any study: the level of OOPE (including transportation costs) and the non-use of services due to high costs.

OOPE surveys are designed to complement household surveys, demographic and health surveys and other data collection efforts to obtain the necessary data. The design and implementation of OOPE surveys involve several issues. In the report a number of recommendations are made for the design and implementation of surveys on OOPE for SRH.

The study of the literature in preparation of this report results in three recommendations that should advance our thinking about and measurement of OOPE for SRH:

1. The concept of catastrophic health expenditures may give an indication of the prevalence of financial catastrophes in a given year in a country or region. It provides no information on the frequency of these expenditures at household level and therefore should be used with care in assessing the financial burden of health shocks to households. Ideally the cross-sectional perspective on spending is replaced by a longitudinal perspective.
2. Payments for SRH care are concentrated in particular stages of life. As a result, spending on SRH should be approached from a life-course perspective. In addition a discussion of catastrophic expenditures should be situated within the context of *life-course risk management*.
3. Risk sharing mechanisms, involving pre-payment schemes, represent a sustainable response to catastrophic expenditures. They are effective to the degree in which they are reliable and affordable.

To discuss what is known on the level of OOPE for SRH, to review experiences with the collection of data on OOPE for SRH and to determine optimal strategies, an expert meeting is organized on December 12 and 13, 2011 at NIDI in The Hague. At the meeting, key questions are addressed:

a. What are the current methods for measuring out-of-pocket health expenditures? How well have such methods addressed the measuring of out-of-pocket spending for sexual and reproductive health?

The methods of data collection are reviewed in this background report. A question of particular relevance is: can one rely on household surveys to quantify the OOPE for SRH and to assess the effect of OOPE on SRH? What are the prospects for sexual and reproductive health financing modules in household surveys?

b. What are the major limitations of OOPE surveys for sexual and reproductive health?

Issues include sample design, functional boundaries, time frame (recall period) and questionnaire. Is it sufficient to know how much was spent on SRH during a specific period or is it critical to understand the type of expenditure (e.g. caesarian section, contraceptives, transportation) as well? Catastrophic expenditures demand special attention.

c. What are the prospects for health financing modules in health surveys and surveillance systems?

Examples of such surveys are the World Health Survey, the Demographic and Health Survey (DHS), UNICEF's Multiple Indicator Cluster Survey (MICS) and the Health and Demographic Surveillance Systems (DHSS). What needs to be done to effectively include a financial module in one or several of these surveys? What is the best strategy to address (a) the substantive aspect and (b) the financial aspect

d. How to monitor health spending trajectories triggered by health problems (e.g. complication during delivery; chronic health problems)? This requires longitudinal data. What are the prospects for longitudinal surveys that include a health financing module?

e. How can the outputs from this meeting support the recommendations and workplan of the Commission on Information and Accountability (http://www.everywomaneverychild.org/pages?pageid=14)

The expected outcome from the workshop will be a report that presents a strategy for strengthening the tracking of OOPE for SRH and a plan of action for 2012 and beyond. A background paper will be developed for the meeting, drawing on the current literature available and will be distributed two weeks prior to the meeting.

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Annex I. Health expenditure ratios

Source: http://apps.who.int/ghodata/?vid=1901#

Location	Time Period	Total expenditure on health as a percentage of gross domestic product	General government expenditure on health as a percentage of total expenditure on	Private expenditure on health as a percentage of total expenditure on health	General government expenditure on health as a percentage of total government	External resources for health as a percentage of total expenditure on health	Social security expenditure on health as a percentage of general government	Out-of-pocket expenditure as a percentage of private expenditure on health	Private prepaid plans as a percentage of private expenditure on health
Afghanistan	2009	7.4	21.5	78.5	3.7	17.5	0.0	98.9	0.0
Albania	2009	6.9	40.9	59.1	8.4	2.7	38.2	99.8	0.0
Algeria	2009	4.1	80.6	19.4	9.2	0.1	35.7	94.7	5.1
Andorra	2009	7.7	68.1	31.9	21.3	0.0	88.0	74.8	23.1
Angola	2009	4.6	89.0	11.0	8.4	2.7	0.0	100.0	0.0
Antigua and Barbuda	2009	5.1	74.8	25.2	11.0	0.0	0.0	85.4	14.6
Argentina	2009	9.5	66.4	33.6	14.6	0.0	59.4	59.2	32.8
Armenia	2009	4.7	43.5	56.5	6.6	8.4	0.0	92.9	0.5
Australia	2009	8.5	70.1	32.3	18.3	0.0	0.0	59.0	25.7
Austria	2009	11.1	74.5	20.5	15.8	0.0	59.9	72.2	21.4
Azerbaijan	2009	5.8	23.6	76.4	3.7	0.6	0.0	90.8	0.7
Bahamas	2009	7.2	45.0	55.0	12.6	0.0	3.6	42.4	47.5
Bahrain	2009	4.5	68.7	31.3	10.9	0.0	1.3	57.9	26.2
Bangladesh	2009	3.4	32.9	67.1	7.9	7.9	0.0	96.5	0.3
Barbados	2009	6.8	64.3	35.7	10.8	1.9	0.0	80.6	19.4
Belarus	2009	5.8	70.6	29.4	8.8	0.2	4.2	67.4	0.1
Belgium	2009	11.8	68.4	24.1	14.8	0.0	84.2	81.0	17.2
Belize	2009	5.1	71.0	29.0	12.2	0.7	6.4	100.0	0.0
Benin	2009	4.2	55.2	44.8	8.5	22.6	0.5	92.7	7.3
Bhutan	2009	5.5	81.9	18.1	13.3	7.6	0.0	100.0	0.0
Bolivia (Plurinational St	2009	5.1	65.1	34.9	8.0	7.1	60.5	81.9	13.4
Bosnia and Herzegovin	2009	10.9	61.3	38.7	15.1	1.0	94.7	100.0	0.0
Botswana	2009	10.3	80.0	20.0	16.7	18.8	0.0	34.0	6.5
Brazil	2009	9.0	45.7	54.3	6.1	0.0	0.0	57.1	41.2
Brunei Darussalam	2009	2.9	87.7	12.3	6.8	0.0	0.0	98.9	0.5
Bulgaria	2009	6.4	55.4	39.3	9.1	0.0	73.8	96.9	1.0
Burkina Faso	2009	6.4	61.7	38.3	16.3	21.9	0.4	93.0	3.4
Burundi	2009	13.1	46.0	54.0	11.8	45.2	15.9	66.1	0.2
Cambodia	2009	5.9	21.3	78.7	7.5	8.8	0.0	92.8	0.0
Cameroon	2009	5.6	27.9	72.1	8.2	8.1	4.7	94.9	0.0
Canada	2009	10.9	68.7	31.3	17.0	0.0	2.1	49.6	43.0
Cape Verde	2009	3.9	74.0	26.0	10.2	7.4	27.5	99.7	0.3
Central African Republi	2009	4.3	38.7	61.3	11.0	40.4	0.0	95.0	0.0
Chad	2009	7.0	55.2	44.8	13.8	6.9	0.0	96.7	0.2
Chile	2009	8.3	47.4	52.6	16.0	0.0	14.4	64.6	35.4
China	2009	4.6	50.3	49.7	10.3	0.0	66.3	82.6	6.2
Colombia	2009	6.4	84.2	15.8	17.9	0.1	68.0	50.0	50.0
Comoros	2009	3.4	61.6	38.4	8.0	15.3	0.0	100.0	0.0
Congo	2009	3.0	53.8	46.2	5.3	7.2	0.0	100.0	0.0
Cook Islands	2009	4.5	93.8	6.2	10.6	10.3	0.0	100.0	0.0
Costa Rica	2009	10.5	67.4	32.6	30.6	0.2	85.6	87.6	7.4
Croatia	2009	7.8	84.9	15.1	17.6	0.0	91.0	95.9	4.1
Cuba	2009	11.3	92.7	7.3	14.7	0.1	0.0	100.0	0.0
Cyprus	2009	6.0	41.2	56.0	5.8	0.0	0.3	86.7	9.8
Czech Republic	2009	7.6	80.2	16.6	13.3	0.0	93.7	90.1	0.9
Côte d'Ivoire	2009	5.2	20.7	79.3	5.1	10.4	0.0	98.8	1.2
Democratic Republic of	2009	2.0	23.9	76.1	1.7	118.8	0.0	0.3	0.2
Denmark	2009	11.2	80.1	13.7	15.3	0.0	0.0	89.0	10.5
Djibouti	2009	7.0	76.9	23.1	13.9	30.2	9.7	98.6	1.4
Dominica	2009	6.4	63.9	36.1	11.8	0.5	0.0	84.2	15.8
Dominican Republic	2009	5.9	41.4	58.6	12.4	1.4	24.4	65.7	22.5
Ecuador	2009	6.1	48.4	51.6	8.4	0.9	45.3	87.3	5.4
Egypt	2009	5.0	41.1	58.9	5.9	1.5	21.6	97.7	1.7
El Salvador	2009	6.4	60.4	39.6	12.3	7.9	37.3	87.9	12.1
Equatorial Guinea	2009	3.9	86.9	13.1	7.0	3.2	0.0	83.5	0.0
Eritrea	2009	2.2	44.6	55.4	3.1	65.6	0.0	100.0	0.0
Estonia	2009	7.0	75.5	20.9	11.7	3.9	86.4	97.4	1.1
Ethiopia	2009	4.3	47.6	52.4	11.4	39.5	0.0	80.1	1.5
Fiji	2009	3.6	73.1	26.9	9.1	3.4	0.0	61.2	30.6
Finland	2009	9.7	72.1	23.6	12.6	0.0	20.2	75.3	8.2
France	2009	11.7	76.6	20.8	16.0	0.0	93.1	34.6	61.9
Gabon	2009	3.5	47.9	52.1	8.3	1.7	24.9	100.0	0.0
Gambia	2009	6.0	50.1	49.9	11.6	26.3	0.0	48.5	3.1
Georgia	2009	10.1	28.7	71.3	7.5	5.8	64.6	94.1	3.7
Germany	2009	11.4	75.7	21.2	18.0	0.0	90.8	53.9	42.7
Ghana	2009	8.1	53.2	46.8	12.8	14.3	29.7	78.6	6.2
Greece	2009	10.6	62.6	37.4	13.0	0.0	51.8	94.5	5.5
Grenada	2009	7.4	51.0	49.0	9.4	0.8	0.0	97.7	0.0
Guatemala	2009	7.1	36.9	63.1	15.9	2.3	48.0	89.2	4.7
Guinea	2009	5.7	15.2	84.8	4.3	15.6	1.6	99.4	0.0
Guinea-Bissau	2009	6.1	25.5	74.5	4.0	42.0	2.8	56.0	0.0
Guyana	2009	8.1	89.7	10.3	14.5	30.8	0.0	100.0	0.0
Haiti	2009	6.1	22.1	77.9	9.5	37.5	0.0	60.8	0.0
Honduras	2009	6.0	56.8	43.2	13.2	7.9	33.8	83.5	9.5
Hungary	2009	7.4	69.9	27.6	10.2	0.0	85.9	83.6	7.4
Iceland	2009	8.2	82.3	17.7	13.1	0.0	41.4	90.8	0.0
India	2009	4.2	32.8	67.2	4.1	1.1	15.9	74.4	2.3
Indonesia	2009	2.4	51.8	48.2	6.9	1.8	13.7	73.2	3.7
Iran (Islamic Republic o	2009	5.5	39.0	61.0	8.7	0.0	67.6	96.6	3.2
Iraq	2009	3.9	72.2	27.8	3.1	3.1	0.0	100.0	0.0
Ireland	2009	9.7	79.6	20.4	16.0	0.0	0.8	72.9	34.4
Israel	2009	7.5	59.1	40.9	10.0	0.0	66.5	72.5	16.4
Italy	2009	9.5	77.3	22.7	14.2	0.0	0.2	85.6	4.6
Jamaica	2009	5.1	55.8	44.2	5.6	1.8	0.0	71.0	25.6
Japan	2009	8.3	80.0	18.5	17.9	0.0	81.5	80.6	13.8
Jordan	2009	9.3	64.6	35.4	16.1	1.7	21.5	83.5	13.3
Kazakhstan	2009	4.5	59.2	40.8	11.3	0.3	0.0	98.8	0.2
Kenya	2009	4.3	33.8	66.2	5.4	36.1	11.8	77.4	8.8
Kiribati	2009	12.2	84.7	15.3	8.7	27.0	0.0	0.6	0.0
Kuwait	2009	3.3	83.9	16.1	5.6	0.0	0.0	91.6	8.4
Kyrgyzstan	2009	6.8	50.9	49.1	11.7	12.1	70.1	81.3	0.0
Lao People's Democrat	2009	4.1	19.1	80.9	3.8	0.0	12.1	75.8	0.4
Latvia	2009	6.5	60.5	39.5	10.2	0.0	0.0	96.7	2.6
Lebanon	2009	8.1	49.2	50.8	12.1	1.3	56.8	79.8	15.6
Lesotho	2009	8.2	68.2	31.8	8.2	30.4	0.0	68.9	0.0
Liberia	2009	13.2	39.7	60.3	17.2	47.0	0.0	52.2	0.0
Libyan Arab Jamahiriya	2009	3.9	66.1	33.9	5.5	1.0	0.0	100.0	0.0

Lithuania	2009	6.6	68.3	27.4	12.8	0.0	86.0	97.9	1.8
Luxembourg	2009	7.8	74.2	16.0	13.7	0.0	91.7	72.7	19.7
Madagascar	2009	4.1	67.1	32.9	15.1	28.3	0.0	67.8	15.1
Malawi	2009	6.2	58.0	42.0	12.1	99.1	0.0	28.5	14.5
Malaysia	2009	4.8	44.8	55.2	7.1	0.0	0.9	73.2	14.4
Maldives	2009	8.0	64.9	35.1	7.5	1.2	0.0	72.0	4.6
Mali	2009	5.6	47.9	52.1	9.3	25.6	0.0	99.5	0.5
Malta	2009	7.5	75.4	24.6	13.0	0.0	0.0	89.6	10.4
Marshall Islands	2009	16.4	97.0	3.0	20.0	57.8	12.3	100.0	0.0
Mauritania	2009	2.5	62.6	37.4	4.9	25.6	0.0	100.0	0.0
Mauritius	2009	5.6	36.0	64.0	7.9	1.7	0.0	88.7	6.3
Mexico	2009	6.5	48.3	51.7	11.9	0.0	54.6	92.3	7.7
Micronesia (Federated	2009	13.8	90.7	9.3	20.6	68.9	17.6	97.5	0.0
Monaco	2009	3.9	88.0	12.0	18.5	0.0	98.7	58.2	41.8
Mongolia	2009	4.7	85.2	14.8	10.5	0.0	28.5	78.0	0.0
Montenegro	2009	9.3	72.5	27.5	13.6	1.1	97.9	91.0	0.0
Morocco	2009	5.5	34.4	65.6	7.0	0.2	23.8	86.3	13.7
Mozambique	2009	6.2	75.5	24.5	14.2	65.7	0.3	43.6	1.5
Myanmar	2009	2.0	9.7	90.3	0.8	10.2	1.6	95.5	0.0
Namibia	2009	5.9	66.6	33.4	12.1	14.9	2.6	17.8	61.0
Nauru	2009	10.9	70.5	29.5	18.5	46.9	0.0	7.1	0.0
Nepal	2009	5.8	35.3	64.7	8.6	13.7	0.0	72.4	0.4
Netherlands	2009	10.8	77.2	15.2	16.2	0.0	90.9	37.7	33.7
New Zealand	2009	9.7	80.4	19.6	18.3	0.0	11.2	71.0	24.7
Nicaragua	2009	9.5	56.6	43.4	17.9	11.8	24.4	91.9	2.8
Niger	2009	6.1	57.6	42.4	14.5	32.6	1.2	96.2	3.2
Nigeria	2009	5.8	36.3	63.7	6.4	4.9	0.0	95.6	3.1
Niue	2009	16.9	99.2	0.8	15.8	55.4	0.0	100.0	0.0
Norway	2009	9.7	78.6	15.6	16.7	0.0	16.3	98.8	0.0
Oman	2009	3.0	78.8	21.2	5.8	0.0	0.0	63.5	24.0
Pakistan	2009	2.6	32.8	67.2	3.6	3.7	3.8	84.5	0.3
Palau	2009	9.9	76.4	23.6	14.3	52.1	0.0	40.3	43.3
Panama	2009	8.3	71.6	28.4	15.2	0.1	36.9	84.5	15.3
Papua New Guinea	2009	3.5	69.3	30.7	8.0	17.5	0.0	55.9	5.5
Paraguay	2009	7.1	42.9	57.1	12.3	1.7	83.2	88.7	10.2
Peru	2009	4.6	58.6	41.4	15.3	1.0	50.7	75.7	20.4
Philippines	2009	3.8	35.3	64.7	7.2	4.4	19.7	83.5	12.3
Poland	2009	7.1	68.2	25.4	10.9	0.0	89.4	88.4	2.2
Portugal	2009	11.0	69.9	26.3	15.4	0.0	1.2	77.5	13.8
Qatar	2009	2.5	79.3	20.7	6.8	0.0	0.0	78.2	0.0
Republic of Korea	2009	6.5	54.1	39.9	12.3	0.0	78.8	87.1	10.8
Republic of Moldova	2009	11.9	53.7	46.3	14.1	3.9	79.8	97.8	0.4
Romania	2009	5.4	78.9	17.4	11.8	0.0	86.6	98.1	0.4
Russian Federation	2009	5.4	64.4	35.6	8.5	0.0	38.7	80.9	11.0
Rwanda	2009	9.0	43.2	56.8	16.8	53.2	4.6	44.4	10.2
Saint Kitts and Nevis	2009	6.0	59.3	40.7	8.0	0.0	0.0	94.4	5.6
Saint Lucia	2009	8.1	66.5	33.5	11.8	1.9	2.2	94.6	5.4
Saint Vincent and the G	2009	5.6	56.6	43.4	9.5	2.3	0.0	100.0	0.0
Samoa	2009	7.0	87.3	12.7	15.9	12.6	0.8	62.9	0.0
San Marino	2009	7.1	85.5	14.5	13.6	0.0	85.4	96.3	3.7
Sao Tome and Principe	2009	7.1	41.0	59.0	13.2	38.7	0.0	68.5	0.0
Saudi Arabia	2009	5.0	67.0	33.0	8.4	0.0	0.0	51.9	32.1
Senegal	2009	5.7	55.6	44.4	11.6	14.0	4.1	78.5	17.9
Serbia	2009	9.9	63.3	36.7	13.9	0.4	93.5	94.0	0.0
Seychelles	2009	4.0	76.8	23.2	11.4	1.4	2.9	30.9	0.0
Sierra Leone	2009	13.6	10.5	89.5	6.4	19.6	0.0	89.5	1.0
Singapore	2009	3.9	41.5	58.5	9.8	0.0	11.2	94.1	2.7
Slovakia	2009	8.5	67.3	28.2	14.0	0.0	91.1	88.5	0.0
Slovenia	2009	9.1	70.2	25.1	12.9	0.0	98.0	48.8	47.5
Solomon Islands	2009	5.4	91.1	8.9	16.8	28.5	0.0	54.2	0.0
South Africa	2009	8.5	40.1	59.9	9.3	1.9	2.9	29.6	66.1
Spain	2009	9.7	72.1	24.8	15.2	0.0	6.7	77.0	20.7
Sri Lanka	2009	4.0	45.2	54.8	7.3	2.0	0.2	86.7	9.1
Sudan	2009	7.3	27.4	72.6	9.8	3.2	11.6	96.2	1.0
Suriname	2009	7.2	45.0	55.0	12.6	0.0	3.6	42.4	47.5
Swaziland	2009	6.3	63.3	36.7	9.3	12.2	0.0	42.3	18.9
Sweden	2009	9.8	78.6	16.6	13.8	0.0	0.0	92.8	1.2
Switzerland	2009	11.3	59.6	40.4	20.0	0.0	72.7	75.0	22.6
Syrian Arab Republic	2009	2.9	31.0	69.0	4.6	1.0	0.0	100.0	0.0
Tajikistan	2009	5.3	33.2	66.8	6.4	11.7	0.0	97.5	0.1
Thailand	2009	4.3	75.8	24.2	14.0	0.5	9.1	68.1	24.2
The former Yugoslav R	2009	6.9	66.5	33.5	12.1	1.0	92.9	99.2	0.0
Timor-Leste	2009	12.3	71.0	29.0	9.8	0.0	0.0	25.6	0.0
Togo	2009	5.5	23.9	76.1	6.4	18.5	15.5	84.2	4.3
Tonga	2009	5.3	78.8	21.2	14.5	4.2	0.0	84.7	3.5
Trinidad and Tobago	2009	5.6	48.2	51.8	9.8	0.2	0.0	81.8	14.7
Tunisia	2009	6.2	54.0	46.0	10.4	1.2	49.4	87.0	11.2
Turkey	2009	6.7	75.2	24.8	12.8	0.0	60.1	64.7	7.3
Turkmenistan	2009	2.3	52.4	47.6	7.0	0.6	6.5	100.0	0.0
Tuvalu	2009	10.5	99.8	0.2	11.0	16.0	0.0	100.0	0.0
Uganda	2009	8.2	19.0	81.0	11.6	20.9	0.0	65.4	0.1
Ukraine	2009	7.0	54.7	45.3	8.6	0.5	0.8	92.9	1.9
United Arab Emirates	2009	2.8	69.3	30.7	8.9	0.0	0.0	66.0	24.0
United Kingdom	2009	9.4	83.6	16.4	15.1	0.0	0.0	63.7	6.7
United Republic of Tan:	2009	5.1	73.6	26.4	18.1	56.5	3.3	65.1	14.5
United States of Americ	2009	16.2	48.6	51.4	18.7	0.0	28.3	24.2	69.3
Uruguay	2009	7.4	63.1	36.9	13.8	0.0	57.6	32.4	67.6
Uzbekistan	2009	5.2	47.4	52.6	9.6	1.8	0.0	98.0	0.0
Vanuatu	2009	3.3	87.1	12.9	12.2	16.6	0.0	58.5	13.5
Venezuela (Bolivarian F	2009	6.0	40.0	60.0	8.6	0.0	30.8	90.6	3.4
Viet Nam	2009	7.2	38.7	61.3	8.9	1.7	31.4	90.2	2.7
Yemen	2009	5.6	28.0	72.0	4.3	5.3	0.0	98.6	1.3
Zambia	2009	6.1	59.5	40.5	15.7	39.1	0.0	67.2	3.7
Zimbabwe	2001	8.1	38.4	61.6	9.3	5.5	0.0	50.3	28.8

Declarations	
Total expenditure on health as a percentage of gross domestic product	http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=122
General government expenditure on health as a percentage of total expenditure on health	http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=92
Private expenditure on health as a percentage of total expenditure on health	http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=119
General government expenditure on health as a percentage of total government expenditure	http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=93
External resources for health as a percentage of total expenditure on health	http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=91
Social security expenditure on health as a percentage of general government expenditure on health	http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=121
Out-of-pocket expenditure as a percentage of private expenditure on health	http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=107
Private prepaid plans as a percentage of private expenditure on health	http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=120

Draft questionnaires

Out-of-pocket expenditures for sexual and reproductive health
Prepared for the workshop

Tracking of Out-of-Pocket Expenditures for Sexual and Reproductive Health
12 – 13 December 2011
NIDI, The Hague

Introduction

The Terms of Reference of the UNFPA/NIDI Resource Flows Project 2011 call for the development of a draft questionnaire for the collection of data on out-of-pocket expenditures for sexual and reproductive health. The questionnaire development should be based on a desk review of (a) out-of-pocket payments and (b) experiences with the collection of data on OOPE for SRH. Special surveys on OOPE for SRH are rare. Most studies of OOPE for SRH rely on existing surveys such as Standard of Living Surveys and Demographic and Health Surveys (see background report). Recent surveys of OOPE for SRH include those organized in Karnataka (India) (1647 women and 1238 men in 2502 households), nine towns of Nepal (1669 persons in 992 households: 664 women, 530 men, 244 unmarried girls and 231 unmarried boys) and the Butajira Demographic Surveillance Site in rural Ethiopia (1003 women and 174 men in 1015 households). The surveys, carried out as part of the UNFPA/NIDI Resource Flows (RF) Project, were designed to collect detailed information on OOPE for SRH that cannot be obtained from household surveys or demographic and health surveys. The surveys were carried out by local partners in the RF project in cooperation with NIDI. The Karnataka study was carried out by the Center for Multi-disciplinary Development Research, Dharwad, Karnataka, India; the Nepal study by the Center for Research on Environment Health and Population Activities (CREHPA), Kathmandu; the Ethiopia study by the Department of Community Medicine, School of Public Health, University of Addis Ababa.

The Karnataka study was conducted in 2005 and aimed at the development of a reproductive health account for the state of Karnataka. An out–of-pocket expenditure survey was implemented as part of several surveys conducted to acquire data to fill reproductive health accounts. It was a learning experience (Mishra et al., 2006). The main lessons learned were (a) the utmost importance of a detailed mapping of the health system before embarking on a sexual and reproductive health expenditure survey and (b) the need to link expenditures to utilization of care (unlike the common practice in national health accounts). The study also identified the many challenges in data collection on sexual and reproductive health and resulted in a strategy that was used in Nepal and Ethiopia. The Nepal study, conducted in 2006, used that experience and the Ethiopia study, conducted in 2007, used the experience of the data collection in Nepal. As part of the learning process, the survey design and the questionnaires were adapted. The methodological advances during these surveys and the lessons learned are covered more extensively in the WHO guidelines for reproductive health subaccounts (WHO, 2009).

For discussion purposes, the questionnaires used in the Butajira study are submitted for discussion during the workshop on 12-13 December 2011. The survey design and the results are described in the report “Examining Out-of-Pocket Expenditure on HIV/AIDS and Reproductive Health Care in Rural Ethiopia”. The objective of the data collection was to collect information for estimating the out of pocket expenditure of households on RH and HIV/AIDS related health problems. The survey covered ever-married women of childbearing age and men 15-64 with experience of SRH related problems in the last 12 months. Before conducting the actual survey, screening of all the DSS households was done. A total of 1015 households were visited during the data collection process. Out of these, female and male respondents were 1003 and 174 respectively. Besides, RH and HIV resembling cases were 1137 and 40 respectively.

In the remainder of this section methodological issues addressed in the Butajira study are discussed. The women's and men's questionnaires contain items related to costing the out-of-pocket expenses during visits to health care providers (public, private as well as traditional facilities) for utilizing the preventive as well as the curative services. For estimating the time costs, the amount of time foregone in seeking care and productive time lost due to illness was monetized based on the prevailing daily gross earning for paid work in the area. For non-paid work (like housewives' household chores), the earning rate of someone in paid work that closely matches the unpaid worker was used as a proxy. In addition, the monetary equivalents of any in-kind payments that might have been made at traditional providers was calculated based on prevailing prices. Data from key informants' interview were used in transforming the values of time and in-kind payment costs.

Information on household income/economic status was complemented with the determination of wealth ranking index that was generated from the household assets in the survey. In addition, this was qualified by using a qualitative key informant method where village leaders and key informants from the respective villages were approached to wealth rank the village community.

All household members who have made visits to conventional health providers as well as traditional healers for preventive as well as curative health services utilization during the month preceding the survey were interviewed using a health condition/morbidity assessment questionnaire for coming up with the possible diagnoses of the disease condition. The health condition/morbidity assessment questionnaire items included an open ended section where all unprompted description of the health condition/illness given by respondents are recorded; and a section to elicit prompted responses about specific conditions, symptoms and signs relating to illnesses prevailing in the area. To determine the reliability of this methodology for reaching out diagnoses for illness conditions, information on causes of illnesses collected by lay interviewers were compared with that of independent group of physicians.

To complement the questionnaire information was collected from service providers on the costs of RH from private, public, and traditional providers from key informants

Enumerators were properly trained on interview technique and interviews were conducted with the person who had closest contact with the deceased during the terminal illness in the case of mortality and the actual sick person (if age is < =15 years, the parent or the responsible member of the household were interviewed) in the case of morbidity.

Information collected from the study population was entered and analyzed into appropriate statistical software (SPSS), cleaned and organized in such a way that enables analysis within the framework of the study objectives.

References

Damen Hailemariam (2009) Examining out-of-pocket expenditure on HIV/AIDS and reproductive health care in rural Ethiopia. Department of Community Medicine, School of Public Health, University of Addis Ababa.

Puri, M., R. Horstman, M. Shrestha, E. Pradhan (2006), Out-of-pocket expenditures on sexual and reproductive health and HIV/AIDS among the urban population of Nepal, Center for Research on Environment Health and Population Activities (CREHPA), Kusunti, Lalitpur, Nepal and Netherlands Interdisciplinary Demographic Institute (NIDI).

Puri, M., R. Horstman, Z. Matthews, J. Falkingham, S. Padmadas and S. Devkota (2008) Examining out-of-pocket expenditures on reproductive and sexual health among the urban population of Nepal. *Population Review*, 47(2):50-65.

WHO (2009) Guide to producing Reproductive Health Subaccounts within the National Health Account framework. WHO, Geneva.

Household Questionnaire

Self Introduction by the interviewers and team members
I / We have come to gather some information from you (respondent) that would be used for preparing examination of OOPE on HIV/AIDS and RH in Butajira District
I assure you that the information obtained from you will be confidential and used solely for the purpose of research.
Since some of the questions I will be asking are extremely personal in nature, may I have your voluntary consent for sharing the required information?
1. Yes – Continue interview
2. No. END

Substitute Household Number ☐☐☐

H I: IDENTIFICATION PARTICULARS

Wereda _____ Kebele _____ ☐☐

Household number ☐☐☐ Original =1 / Substitute = 2 ☐

Interviewer Name and Signature_____ Code ☐☐

Date of interview: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

H II: HOUSEHOLD PARTICULARS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES
H1	*What is the religion of the head of the household?*	ORTHODOX CHRISTIAN..... 1 MUSLIM ..... ……2 PROTESTANT CHRISTIAN..... 3 CATHOLIC CHRISTIAN ……4 OTHER(Specify)……7
H2	*What is the ethnicity of the head of the household?*	Guraghe …… 1 Amhara …… 2 Oromo …… 3 Tigre …… 4 Hadiya …… 5 Kembata …… 6 OTHER(Specify) …… 7
H3	What is the family size of the household?	☐☐
H4	*Type of house?* (Record by Observation the predominant material of roof, walls and floor of the house) **Floor :** Mud=1, Wood =2, Brick/Stone=3, Cement=4, Mosaic/ Tiles =5, Other = 6 **Wall :** Wood and Mud =1, Cement Blocks=2, Brick =3, Mud Blocks=4, Stone=5, Others=6 **Roof :** Thatch =1, Corrugated Iron=2, Asbestos sheet=3, Burnt Mud Brick=4, Stone=5, Others=6	Roof ☐ Wall ☐ Floor ☐
H5	*How many rooms are there in your house?*	☐☐
H6	*What is the main source of drinking water for your household?*	TAP – INSIDE RESIDENCE/YARD/PLOT 1 TAP – SHARED/PUBLIC 2 HANDPUMP\BOREWELL 3 WELL – COVERED 4 WELL – UNCOVERED 5 RIVER / CANAL 6 POND / TANK 7 SPRING – PROTECTED 8 SPRING – UNPROTECTED 9 OTHER(Specify)_____10

H7	*What is the main source of lighting for your household?*	ELECTRICITY 1 KEROSENE 2 OTHER (Specify)_____ 3
H8	*What type of fuel does your household mainly use for cooking?*	LIQUID PETROLEUM GAS 1 ELECTRICITY 2 KEROSENE 3 WOOD 4 OTHER(Specify)_____ 5
H9	*What type of toilet facility does your household has?*	OWN FLUSH TOILET 1 OWN PIT TOILET 2 SHARED TOILET (ANY TYPE) 3 PUBLIC/COMMUNITY TOILET 4 NO TOILET FACILITY 5
H10	*Does your household possess VACCINATION CARD?*	YES 1 YES AND VACCINATIONS COMPLETE FOR ELLIGIBLES 2 YES BUT VACCINATIONS INCOMPLETE FOR ELLIGIBLES 3 SKIP to H12
H11	*HAS INTERVIEWER CHECKED THE VACCINATION CARD?*	YES AND VACCINATIONS COMPLETE FOR ELLIGIBLES 1 YES BUT VACCINATIONS INCOMPLETE FOR ELLIGIBLES 2 NO 3
H12	*Does your household own any agricultural land?*	YES 1 NO 2 SKIP TO H14
H13	*How many acres of agricultural land does your household own?*	IRRIGATED acres ☐☐☐ NON IRRIGATED acres ☐☐☐
H14	*Does your household own any livestock?*	YES 1 NO 2 SKIP TO H18
H15	*Number of live stock population*	COWS -------- OXEN -------- HORSE/MULE/DONKEY -------- SHEEP/GOAT -------- POULTRY -------- OTHER _____

H16	*Does this household own any of the following?*	YES NO RADIO 1 2 TAPE RECORDER 1 2 A TELEPHONE 1 2 A REFRIGERATOR 1 2 A TELEVISION 1 2 A MOTOR CYCLE 1 2 A VEHICLE 1 2 CART 1 2 BICYCLE 1 2 Other_____
H17	*Average monthly consumption expenditure made by the household in normal times (in Birr) (*What is your household budget?) _____	Total _____ **Food Items _____ Electricity_____ Water ____ Education _____ Clothing_____ Seeds____ Transport _____** **Telephone _____ House Rent _____ Kerosene_____ Milling_____** **Fertilizer_____** **Eder_____ Equib _____ Savings _____ Utensils_____** **Health _____ Tax _____ Others _____**

H III: INDIVIDUAL PARTICULARS OF HOUSEHOLD MEMBERS

Now I would like some information about the people who usually live in your household.

H18 Can you please start giving me the names of the persons who usually live in your household starting with the head of the household?

				Age related eligibility and marital status			Education (If age 6 or above)	Occupation (if age 15 or more)		
Line Number	Name	Relationship to head of household	1=Male 2=Female	Age	Eligibility Yes=1, No=2 (to be filled in by interviewer)	If Yes, Marital status	No Education & Illiterate =1 No education & Literate =2 Formal Education =3	Working status	Occupation last year	Place of work Within village =1 Outside Village but within the Wereeda=2 Outside the Wereda but within country=3 Outside country =4
A	B	C	D	E	F	G	H	J	K	L
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

Coding C	**Age E**	**Eligibility (F)**	**Coding G**	**Coding (J)**	**Coding (K)**
Head of household =1 Wife / Husband = 2 Son / Daughter = 3 Son-in-law / Daughter-in-law = 4 Grandchild = 5 Parent = 6 Parent-in-law = 7 Brother / Sister=8 Brother-in-law/sister-in-law=9 Niece / nephew = 10 Cousin Sister / Cousin Brother = 11 Adopted / Foster child = 12 Not related = 13 Any other = 14	Record age in completed years if Age is less than one, record '00'	Women aged 15-49 Men aged 15-64	Currently Married =1 Widowed = 2 Divorced//separated/ deserted = 3 Never married = 4	Cultivator in own land / leased land = 1 Landless Agriculture Laborer =2 Non-agriculture laborer=3 Business=4 Salaried employment in : regular /permanent govt. job =5 temporary govt job = 6 Regular Private Sector job = 7 Temporary private sector job =8 Housework = 9 Student = 10 Not working /unemployed = 11 Other Work _____=12	Cultivator in own land / leased land = 1 Landless Agriculture Laborer =2 Non-agriculture laborer=3 Business=4 Salaried employment in : regular /permanent govt. job =5 temporary govt job = 6 Regular Private Sector job = 7 Temporary private sector job =8 Housework = 9 Student = 10 Not working /unemployed = 11 Other Work _____=12

H19. Whether the household or individual members are covered by health insurance (this can include eder-based insurance) ?

		A: Yes = 1 No=2	B: Line No. of individual member (refer to H20)	C: Total Premium paid during the last year (Birr.)	D: Insurance Agency Eder= 1 Pvt. Insurance Company = 2 Others (Specify)_____=3	E: Name of the insurance scheme	F: Whether claim made during last year Yes =1 No =2	G: If yes, Amount (in birr) and H: for what (specify)
H 19.1	Whether Household Covered by Health Insurance during last year	1 Cont. line 2 H21.2						
H 19.2	Whether individual member covered by Health Insurance during last year	1 Cont. line 2 End						

H IV PARTICULARS OF DECEASED HOUSEHOLD MEMBERS

H20	Did any usual resident of this household die in the last one-year?					YES 1 GOTO H25 NO 2 GOTO END		
H21	What (was/were) the name(s) of the person(s) who died?	H22 Sex of deceased person	H23 How old was (NAME) when he/she died? (age in completed years)	H24 Eligible? Men 15-64 Women 15-49 (Codes to be circled by interviewer)	H25 What was the cause of death of (NAME)? (Illness = 1, Old age=2, Accident=3)	H 26 Name of Illness	H27 Whether cause of death was related to repr. health? Codes to be circled by interviewers after matching with list of reproductive. health disorders	For eligible cases, **Go to H28** If no eligible deceased persons, continue with the **INDIVIDUAL QUESTIONNAIRES** (**MEN / WOMEN**).
1		1 Male 2 Female		1 Yes 2 No	1 Cont. line 2 / 3 Next		1 Yes 2 No	
2		1 Male 2 Female		1 Yes 2 No	1 Cont. line 2 / 3 Next		1 Yes 2 No	

H28 could you please tell us the expenses this household made for the following items for (NAME deceased person) in the last one year?

Diseased person's code as per Line No. H23	Made any costs for this illness 1 = Yes 2 = No	Visit/Card charges		Diagn. Clinic. / lab tests		Treatment charges			Drugs & other commodities		Sub Total (B+D+F+I)	Patient's/Client's				Attendants'				Other costs		Total (Sub Total + L+N+P+R+T)	Source of expenses [Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver = 8 Others (Specify) =9]
								1=in-patient 2 = out-patient 3=both in and outpatient				Transport		accommodation & food		Transport		accommodation & food					
		Costs	Provider	Costs	Provider	Costs	Provider		Costs	Provider		Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider		
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
	1 Cont. line 2 Go to Next / End																						
	1 Cont. line 2 Go to Next / End																						

Men's Questionnaire

Questionnaire for all male household members, aged 15-64 (see Section A III, question H18, column E for eligibility)

Household number: ☐☐☐ Line number of respondent: ☐☐ If married to household member, give line number of wife; else write 98 ☐☐

M I FAMILY PLANNING AND CONDOM USE (FOR EVER MARRIED MEN)

Ever Married =1 Cont.

Never = 2 GO TO MII.

Q Did you make any costs for the following family planning methods in the last one-year?

Question	*Method*	*Did you make any costs for this method? Yes 1 No 2*	*Consultancy charges*		*Treatment charges*		*Contraceptive commodities*		*Sub -Total (B+D+F)*	*Person's*				*Attendants*				*Other costs*		*Total (Subtotal +I+K+M+O+Q)*	Source of Finance#
										Transport		*Accommodation & food*		*Transport*		*Accommodation & food*					
			Costs	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*		*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*		
		A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*K*	*L*	*M*	*N*	*O*	*P*	*Q*	*R*	*S*	T
M1	Operation (vasectomy)	1 Cont. line 2 Go to M2																			
M2	Condoms, purchased by yourself	1 Cont. line 2 Go to M3	N.A.	N.A.	N. A.	N.A.				N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.		
M3	Any other methods (specify)	1 Cont. line 2 Go to M4	N.A.	N.A.	N. A.	N.A.				N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.		

Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver = 8, Others (Specify) =9

If costs for condoms were mentioned, ask M4, otherwise GO TO MII

M4	*What was the main reason for using condoms?*	FAMILY PLANNING 1 HIV/AIDS PREVENTION 2 STI PREVENTION 3

M II REPRODUCTIVE HEALTH PROBLEMS

I will ask a number of questions about expenditures related to your reproductive health in the last one year.

The questions are about costs made for, for example, treatment, drugs and transport, and about who provided these services and goods.

Q Can you indicate if and how much expenses you made for the following reproductive health problems in the last one year?

Question	*Reproductive health related disorder*	*During the last year did you experience this health problem at any time Yes=1 No = 2*	*Costs made for you? Yes = 1 No= 2*	*Consultancy charges*		*Diagn. Clinic. / lab tests*		*Treatment charges*		*Drug*		*1= In-patient 2 = out-patient 3=both in and out patinet*	*Sub-Total (C+E+G+I)*	*Patient's*				*Attendants'*				*Other costs*		*Total (Sub Total+M+O+Q+S+U)*	Sou Exp
														Transport		*Accommodation & food*		*Transport*		*Accommodation & food*					
				Costs	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*			*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*W*	
		A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*K*	*L*	*M*	*N*	*O*	*P*	*Q*	*R*	*S*	*T*	*U*	*V*		X
M5	Internal infections in the reproductive organs (reproductive tract infections)	1 Cont. line 2 Go to M6	1 Cont. line 2 Go to M6																						
M6	STI's (pain/burning while urinating, sore/rashes on the genitals)	1 Cont. line 2 Go to M7	1 Cont. line 2 Go to M7																						
M7	HIV/AIDS	1 Go to M7.1 2 Go to M8																							
M7.1	Treatment for infections		1 Cont. line 2 Go to M7.2																						
M7.2	Antiretroviral therapy		1 Cont. line 2 Go to M7.3																						
M7.3	Other curative care		1 Cont. line 2 Go to M7.4																						
M7.4	Psychological support		1 Cont. line 2 Go to M7.5			N.A.	N.A.																		

Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver = 8, Others (Specify)=9

Q Can you indicate if and how much expenses you made for the following health problems in the last one year? (cont.)

Question	Reproductive health related disorder	During the last year did you experience this health problem at any time Yes=1 No = 2	Costs made for you Yes = 1 No = 2	Consultancy charges		Diagn. Clinic. / lab tests		Treatment charges		Drug		1= In-patient 2 = out-patient 3=both	Sub-Total (B+D+F+H)	Patient's				Attendant's				Other costs		Total (Sub Total+K+M+O+Q)
														Transport		Accommodation & food		Transport		Accommodation & food			
				Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider			Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider	
		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
M7.5	Palliative care In Nursing home		1 Cont. line 2 Go to M7.6																					
M7.6	Palliative care at home		1 Cont. line 2 Go to M8																					
M8	Testicular or prostate cancer	1 Cont line 2 Go to M9	1 Go to M8.1 2 Go to M9																					
M8.1	Treatment and consultancy		1 Cont. line 2 Go to M8.2																					
M8.2	Rehabilitative care in nursing home		1 Cont. line 2 Go to M8.3																					
M8.3	Rehabilitative care at home		1 Cont. line 2 Go to M8.4	N.A.	N.A.	N.A.	N.A.					In- patient		N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.			
M8.4	Palliative care in nursing home		1 Cont. line 2 Go to M8.5	N.A.	N.A.	N.A.	N.A.					In-patient												
M8.5	Palliative care at home		1 Cont. line 2 Go to M9	N.A.	N.A.	N.A.	N.A.					In- patient												
M9	Problems having children	1 Cont. line 2 END																						

Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver = 8, Others (Specify) =9

Women's Questionnaire

Questionnaire for all female household members, aged 15-49 (see Section A HIII, question H18, column E for eligibility)

Household number: ☐☐☐ Line number of respondent: ☐☐

Marital Status :

Ever Married : Continue BI

If married to household member, give line no. of husband; else write 98 ☐☐

Never Married: Skip to B III

B I MATERNAL CARE

For ever-married women, aged 15-49 only

B1	*Have you been pregnant during the last 12 months?*	YES 1 NO 2 GOTO B II
B2	*How many times were you pregnant during the last 12 months?*	_____Times
B3	*Are you currently pregnant?*	YES 1 GOTO B7 NO 2
B4	*I refer to your last pregnancy: when did this pregnancy end?*	Month (MM) ☐☐ Year (YY) ☐☐
B5	*How did the pregnancy end? What was the outcome?*	Live birth 1 Live birth, but child died within one month 2 } GOTO B7 Still birth 3 Spontaneous termination 4 Induced termination 5 } GOTO B6
B6	*Was pregnancy terminated because your health was in danger, or you did not want to have the child?* *B.6.1 Any cash support received from government ?* *B.6.2 If yes what was the amount of support?*	Did not want a child 1 Mother's health in danger 2 GO TO B6.1 Yes=1 , No =2 *birr.*_____
B 7	When did this pregnancy start ?	Month (MM) ☐☐ Year (YY) ☐☐
B7.1	How many live born children did you ever have?	☐☐ Children

I will ask a number of questions about expenditures related to your pregnancy and/or delivery in the last 12 months.
Will you be able to tell us the expenses incurred for different Services availed? Yes=1 No= 2
If 'No', who will be able to give us the required information? (Husband=1, Father-in-law=2, Mother-in-law=3, Father=4, Mother=5, Other_____=6)

Question	Expenses related to pre-natal care	Costs made for you? 1 = Yes 2 = No	Consultancy charges		Diagnostic imiging		Treatment /service charges		Drugs, dietary supplements, kit		1= In-patient 2 = out-patient 3=both	Sub Total (B+D+F+H)	Client's				Attendant's				Other costs			Sour Expe #
													Transport		Accommod. & food		Transport		Accommod. & food					
			Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider			Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider		
		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
B8	Antenatal check up Includes examination, counseling, referral and registration **Examination:** general clinical, obstetric, weight, hemoglobin test, blood pressure, STI tests, urine test **Counseling:** on emergency, delivery, lactation, contraception	1 Cont. line 2 Go to B9									Out-patient				N.A	N.A								
B.8.1	What is the number of ANC during your last / current pregnancy? ☐ Times																							
B9	TT immunization of the mother (if additional to 'package' costs in B8)	1 Cont. line 2 Go to B10	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	Out-patient	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.				
B10	Iron folate tablets, and other dietary supplements (vitamins, minerals, etc) (if additional to 'package' costs in B8)	1 Cont. line 2 Go to B11	N.A.	N.A.	N.A.	N.A.					Out-patient		N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.				
B11	Safe delivery Kit (if additional to 'package' costs in QB8)	1 Cont. line 2 Go to B12	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.			Out-patient		N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.				
B12	HIV-Test during Pregnancy Yes=1 Cont Line No = 2, GO TO B13	1 Cont. line 2 Go to B12.1	N.A.	N.A.	N.A.	N.A.							N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.				
B12.1	Provision of ART drugs during pregnancy (if Mother is HIV positive)	1 Cont. line 2 Go to B13	N.A.	N.A.	N.A.	N.A.					Out-patient		N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.				

Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver = 8, Others (Specify)=9

Now I will ask you some questions about costs related to delivery and post-natal care.

Question	Expenses related to curative and delivery care	Costs made for you? 1 = Yes 2 = No	Consultancy charges		Diagnostic imaging		Treatment /service charges		1= In-patient 2 = out-patient 3=both	Drugs, dietary supplements		Sub-Total (B+D+F+I)	Client's				Attendant's				Other costs		Total (Sub Total +L+N+P+R+T)		
													Transport		Accommodation& food		Transport		Accommodation & food						
			Costs	Provider	Costs	Provider	Costs	Provider		Costs	Provider	K	Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider			
		A	B	C	D	E	F	G	H	I	J		L	M	N	O	P	Q	R	S	T	U	V		
B13	Obstetric care that you received during **pregnancy** due to complications e.g. hospitalization, ambulant services, counseling services, ultra sound, injections, drugs	1 Cont. line 2 Next line																							
INTERVIEWER: CHECK IF CURRENTLY PREGNANT (B3) If currently pregnant go to B21, otherwise continue																									
B14	*Did you have a delivery with or without complications?* (Complications relate to e.g. obstetric surgery (e.g. cesarean section), use of anesthesia, blood transfusion, medical treatment of sepsis, shock, eclampsia - use of antibiotics and sedatives, manual removal placenta, etc.) 1 With complications 2 Normal, without complications																								
B15	*What were the costs for care for the delivery*	1 Cont. line 2 Next line																							
B15.1INTERVIEWER: CHECK PREGNANCY OUTCOME (B5) Live Birth (1), ☐ Child died in first month (2) Still Birth (3) , Induced or spontaneous abortion (4) If ticked (1) GO TO B18 If Ticked (2) or (3) GO TO B 17 If Ticked (4) GO TO B16																									

Continued

Question	Expenses related to curative and delivery care	Costs made for you? 1 = Yes 2 = No	Consultancy charges		Diagnostic imaging		Treatment/service charges		1= In-patient 2 = out-patient 3=both	Drugs, Dietary supplements		Sub-Total (B+D+F+I)	Client's				Attendant's				Other costs		
													Transport		Accommodation & food		Transport		Accommodation & food				
			Costs	Provider	Costs	Provider	Costs	Provider		Costs	Provider	K	Costs	Provider	Costs	Provider	Costs	Provider	Costs	Provider	Costs		Provider
		A	B	C	D	E	F	G	H	I	J		L	M	N	O	P	Q	R	S	T		U
B16	Abortion services	1 Cont. line 2 Go to B17																					
B17	Psycho social support to mother due to loss of child	1 Cont. line 2 Go to B18																					
B18	Dietary supplements after pregnancy (costs related to a maximum of 42 days)	1 Cont. line 2 Go to B19							Out-patient														

B19	Post delivery rehabilitative home care (costs related to a maximum of 42 days)	1 Cont. line 2 Go to B20							Out-patient																				
B20	Post delivery check-ups and referral	1 Cont. line 2 Go to B21							Out-patient																				

Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver = 8, Others (Specify)=9

B21	Check number of pregnancies in the last year (see B2) If more than one pregnancy, continue this question, otherwise GO TO BII	*Will you be able to tell us the expenses incurred for different Services availed ? Yes=1 No= 2* *B21A-If 'No', who will be able to give us the required information ? (Husband=1, Father-in-law=2, Mother-in-law=3, Fath* *Mother=5, Other_____=6)*

Can you indicate if and how much expenses you incurred for the following:

Question	*Expenses related to previous pregnancy*	*Costs made for you? 1 = Yes 2 = No*	*Consultancy charges*		*Diagnostic imaging*		*Treatment/service charges*		*Drugs, dietary supplements, kit*		*1= In-patient 2 = out-patient*	Sub-Total (B+D+F+H)	*Client's*					*Attendants*				*Other costs*		*Total Cost (Sub Total +L+N+P+R+T)*	**Source of Exp #**
													Transport		*Accommodation .&food*			*transport,*		*accommodation & food*					
			Costs	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*		K	*Costs*	*Provider*	*Costs*	*Provider*		*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*		
		A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*		*L*	*M*	*N*	*O*	*P*	*P*	*Q*	*R*	*S*	*T*	*U*	*V*	W
B21.1	*All pre-natal care*	1 Cont. line 2 Go to B21.2																							
B21.2	*All delivery care*	1 Cont. line 2 Go to B21.3																							
B21.3	*All post-natal care*	1 Cont. line 2 GO TO B II																							

Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver = 8, Others (Specify)=9

B II FAMILY PLANNING

For ever-married women, aged 15-49 only (see H20, Column E)

BIIA-Were / are you using any family planning method during the last one years? Yes = 1 No=2 → GO TO BIII.

BIIB-If yes, method used (MORE THAN ONE ANSWER IS POSSIBLE)

A-Tubectomy ..... 1=YES 2=NO
B-Laparoscopy..... 1=YES 2=NO
C-IUD..... 1=YES 2=NO
D-Oral Pill..... 1=YES 2=NO
E-Injectables ..... 1=YES 2=NO
F-Implant ..... 1=YES 2=NO
G-Condoms (if purchased by yourself) 1=YES 2=NO
H-Other (Specify) _____1=YES 2=NO

Please give details about the cost incurred in purchasing above mentioned contraceptives / services received towards the same (write in the order in which the respondent has used them)

Question	*Method (Please write code from above for non-operative methods)*	*Did you make any costs for this method? Yes 1 No 2*	*Consultancy charges*		*Diagnostic imaging*		*Treatment charges*		*1= Inpatient 2= Outpatient*	*Contraceptive commodities*		*Sub Total (B+D+F+J)*	*Client's*				*Attendants*				*Other costs*		*Total (Sub Total +M+O+Q+S+U*	**Source of Expenses #**
													Transport		*Accommodation .& food*		*Transport*		*Accommodation .& food*					
			Costs	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*		*Costs*	*Provider*		*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*		
		A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*K*	*L*	*M*	*N*	*O*	*P*	*Q*	*R*	*S*	*T*	*U*	*V*	W
B22	Operation (tubectomy / laparoscopy)	1 Cont. line 2 Go to B23																						
B23		1 Cont. line 2 Go to B24											N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	
B24		1 Cont. line 2 Go to B25											N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	

Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver = 8, Others (Specify)=9

B25	*Did you ever obtain a pregnancy test in the last one-year?* *Yes = 1, No=2* *If Yes, what were the costs and where did you get the test done?*	B25A-Costs birr. _____ B25B-Provider

B III REPRODUCTIVE HEALTH DISORDERS

B 26. I will ask a number of questions about expenditures related to your health in the last one year. The questions are about costs made for, for example, treatment, drugs and transport, and about who provided these services and goods. Will you be able to tell us the expenses incurred for different Services availed? Yes=1 No= 2

B26A-If 'No', who will be able to give us the required information? (Husband=1, Father-in-law=2, Mother-in-law=3, Father=4, Mother=5, Other_____=6)

Can you indicate if and how much expenses you incurred for the following:

Question	*Reproductive health related disorder*	*During the last year did you experience these health problems at any time?* Yes = 1 No = 2	Costs made for you Yes = 1 No = 2	*Consultancy charges*		*Diagn. Clinic. / lab tests*		*Treatment charges*		*1= In-patient 2 = out-patient*	*Drugs*		*Sub Total (C+E+G+J)*	*Patient's*				*Attendants*				*Other costs*		*Total (Sub Total+M+O+Q+S+U)*		**Source of Exp #**
														Transport		*Accommodation& food*		*transport,*		*accommodation & food*						
				Costs	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*		*Costs*	*Provider*	*L*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*			
		A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*K*		*M*	*N*	*O*	*P*	*Q*	*R*	*S*	*T*	*U*	*V*	*W*		X
B27	Internal infections in the reproductive organs (RTI); vaginal discharge, lower abdominal pain	1 Cont. line 2 Go to B28	1 Cont. line 2 Go to B28																							
B28	STI's (pain/burning while urinating, sore/rashes on the genitals)	1 Cont. line 2 Go to B29	1 Cont. line 2 Go to B29																							

B29	HIV/AIDS	1 Cont. line 2 Go to B30	1 Go to B29.1 2 Go To B30																								
B29.1	Treatment for opportunistic infections		1 Cont line 2 Go To B29.2																								
B29.2	Antiretroviral therapy		1 Cont line 2 Go To B29.3							Out-patient																	
B29.3	Other curative care		1 Cont line 2 Go To B29.4																								
B29.4	Psychological support		1 Cont line 2 Go To B29.5			N.A.	N.A.				N.A.	N.A.															
B29.5	Palliative care		1 Cont line 2 Go To B30	N.A.	N.A.	N.A.	N.A.						N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.				

Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver = 8, Others (Specify)=9

Q 26 - CONTINUED

Question	*Reproductive health related disorder*	*During the last year did you experienced this health problems at any time? Yes = 1 No = 2*	Costs made for you Yes = 1 No = 2	*Consultancy charges*		*Diagn. Clinic. / lab tests*		*Treatment*		*1= In-patient 2 = out-patient*	*Drugs*		*Sub Total (C+E+G+J)*	*Patient's*				*Attendants*				*Other costs*		*Total (Sub Total+ M+O+ Q+S+U)*	**Source of Exp #**
														Transport		*Accommodation & food*		*transport,*		*accommodation & food*					
				Costs	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*		*Costs*	*Provider*		*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*	*Costs*	*Provider*		
		A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*K*	*L*	*M*	*N*	*O*	*P*	*Q*	*R*	*S*	*T*	*U*	*V*	*W*	X
B30	Cervical Cancer= 1, Uterine Cancer =2 Ovarian Cancer =3 Breast cancer =4	1 Cont. line 2 Go to B 31	1 Go To B30.1			2 Go to B31																			
B30.1	Treatment and consultancy		1 Cont. line 2 Go to B30.2																						
B30.2	Rehabilitative care		1 Cont. line 2 Go to B30.3																						
B30.3	Palliative care		1 Cont. line 2 Go to B31	N.A.	N.A.	N.A.	N.A.																		
B31	Fistula	1 Cont. line 2 Go to B32	1 Cont. line 2 Go to B.32			N.A.	N.A.																		
B32	Problems with becoming pregnant	1 Cont. line 2 Go to B33	1 Cont. line 2 Go to END																						

Out of regular Income=1, Own savings=2, Borrowings from relatives & friends=3, Borrowings from institutional lenders=4, Borrowings from money lenders=5, Distress sale of articles =6, Insurance = 7, Waiver, Others (Specify)=9