



The Programme of Action adopted at the 1994 International Conference on Population and Development (ICPD) in Cairo outlines specific funding targets to be met to achieve the ICPD population and development objectives. The Declaration of Commitment on HIV/AIDS adopted at the 2001 United Nations General Assembly Special Sessions (UNGASS) on HIV/AIDS urges the international community to supplement the efforts of developing countries through increased international development assistance, particularly for those countries most affected by HIV/AIDS. The project on 'Financial Resource Flows for Population and AIDS Activities' aims at monitoring expenditures and future commitments for population and AIDS programmes in response to the ICPD and the UNGASS on HIV/AIDS.

The 'Resource Flows' Project is a collaboration between the United Nations Population Fund (UNFPA) and the Netherlands Interdisciplinary Demographic Institute (NIDI).

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## UNFPA/NIDI Resource Flows Newsletter. March 2010

*The purpose of the UNFPA/NIDI Resource Flows Newsletter is to inform donor and developing country governments, public and private organisations, research institutes, universities and civil society about resource tracking for population and AIDS activities in general and the role of the Resource Flows (RF) project in particular.*

### Examining Out-of-Pocket Expenditures on Sexual and Reproductive Health in Rural Ethiopia

#### 1. Introduction

The main goal of the UNFPA/NIDI Resource Flows (RF) Project is tracking of financial transactions for sexual and reproductive health (SRH) by a variety of donor and domestic financial sources. Households are an important domestic financing source and a growing need exists for data on how much households spend on health. Household expenditures for health include direct payments at the time health care is received and indirect payments to the health system through taxes, social security contributions, and premiums for private health care insurance. The direct payments at the time when health care is received are usually referred to as out-of-pocket expenditures (OOPE). These include co-payments, fee-for-service payments, self-medication, informal payments and all other expenses paid directly (in cash or in-kind) by households for health services and goods (WHO, 2003).

Examining OOPE is important for several reasons. First, OOPE are found to be an important financial burden for low-income families and an important cause of impoverishment (Xu et al., 2003; Van Doorslaer et al., 2006). Costly health care can also deter people from using health services, generating thereby prolonged and worsened health problems. Second, as a result of increased demand for health care, the absence or inadequacy of collective schemes of health finances, and the introduction and maintenance of user fees (i.e. direct charges to users

for health services), OOPE are on the rise in most parts of the world. The interest in OOPE is also expected to grow further because in most cases health system reforms transfer the financial burden of health problems from the collective to the individual. Finally, examining OOPE is important from policy perspective. Sound health financing policies address not only issues of efficiency but also of health equity and try to protect households with health problems from falling into poverty. High OOPE can be also seen as an impediment to achieving the Millennium Development Goals (MDGs).

Despite the importance of knowing the financial burden to households due to OOPE, including expenditures on SRH, specialized OOPE surveys are scarce. To fill in this gap, the RF project organized surveys on OOPE on SRH in the State of Karnataka, India, and in Nepal and Ethiopia during the period 2005-2007. 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.



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In this newsletter we briefly present the major findings of the survey about OOPE on SRH conducted in Ethiopia.<sup>1</sup> As is the case in many developing countries, Ethiopia faces great challenges with respect to SRH. This is mainly due to the poor socioeconomic environment, high proportion of young population, and harmful traditional practices such as early marriage and female circumcision. The 2005 Demographic Health Survey revealed that the median age at first marriage for women is only 16 years. Childbearing also begins at an early age. This has resulted in a high total fertility rate of 5.4 children per women. These problems are aggravated by low levels of health service provision and utilization. Antenatal care coverage is merely 28% of live births. Only 5% of all women give birth at health facility, and only 6% are attended by a skilled professional at birth. For these and other reasons, many Ethiopian women continue to suffer from pregnancy- and delivery-related complications. Other SRH problems are also issues of concern: e.g., HIV/AIDS is emerging as one of the major public health problems.

In Ethiopia there is heavy reliance on out-of-pocket financing of health care. According to the National Health Accounts estimates, the OOPE share of total expenditure on health was about a third in 2007. Evidence on OOPE for SRH is largely missing. Taking into account the significant SRH problems described above and the consequences of heavy reliance on OOPE for household living standards, it is important to estimate the magnitude and distribution on OOPE for this type of medical care.

The structure of the newsletter is as follows. Section 2 briefly introduces the study area, data collection process, and characteristics of the dataset. In section 3 we examine the extent of household OOPE by specific SRH services such as maternal health, family planning, and reproductive health disorders. Section

4 concludes by summarizing the results of our analysis, describing the challenges and limitations confronted during the study, and by drawing policy recommendations.

### 2. Study area and dataset

The OOPE survey was conducted in the Butajira Demographic Surveillance Site (DSS) in the Southern Nations Nationalities and People's (SNNP) region of Ethiopia. The Butajira DSS has been a community-based DSS since 1987. The district is predominantly rural with estimated 87% of the population being engaged in subsistence agriculture. There are 12 health hosts, 3 health stations, 2 malaria control centers, 2 health centers, and 1 hospital. The health service coverage in the district is estimated significantly below the national level.

Prior to conducting the actual survey, the DSS households were screened for identifying individuals with SRH problems in the past 12 months to determine eligibility. In addition hospital data were used to identify persons that meet the eligibility criteria. Data were collected at the household level through interviewing members of households using a structured questionnaire. The survey included 1,015 households in which 1,003 female and 175 male members aged 15 and above were interviewed using separate gender-based questionnaires.<sup>2</sup> To complement the study, information was collected from the available public, private and traditional health care providers on the cost of the services they offer.

<sup>1</sup> For a detailed account of the findings from the OOPE survey in Nepal, see Puri et al. (2008).

<sup>2</sup> The reasons for the discrepancy in the number of women and men interviewed are the following: (i) women are more vulnerable to SRH problems due to pregnancy, delivery-related problems, and harmful traditional practices; (ii) men were often working outside of home at the time of the interview; (iii) men who were present during the interview usually showed tendency to perceive SRH problems as a "woman's problem" and were not interested in responding to the questionnaire.



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The dataset includes basic socio-economic characteristics of the households, the pattern of utilization of health services (preventive and curative; public, private and traditional), as well as financial costs incurred by households for dealing with SRH problems. An advantage of our dataset is that we have information on both direct (medical) and indirect (non-medical) OOPE. Direct expenditures are made for consultation, laboratory and diagnostic tests, treatment, and medicines. Indirect expenditures are incurred for transport, accommodation, food for both the patient and accompanying person(s), and other expenses such as tips, self-medication and nutritional supplements. As recognized in the literature (Nahar and Costello, 1998; Borghi et al., 2003; Afsana, 2004), accounting for indirect OOPE is important since they could be quite significant and thus contribute to low utilization of SRH services.<sup>3</sup> In addition, we have calculated the monetary equivalents of in-kind payments that might have been made at traditional providers based on prevailing prices.

Another advantage of our dataset is that it includes detailed information on OOPE across the whole spectrum of SRH services. We have detailed data on costs incurred for maternal health services. Data were collected on expenses for various antenatal care services and on obstetric care received during pregnancy due to complications. We can also differentiate between OOPE on delivery with and without complications. The dataset includes data on expenses for postnatal care and family planning methods. In addition, data were collected on reproductive health disorders such as reproductive tract infections, sexually transmitted infections and HIV/AIDS.

<sup>3</sup> The non-medical OOPE are often referred to as the “hidden” costs of healthcare.

### 3. Results

#### *Characteristics of the sample population*

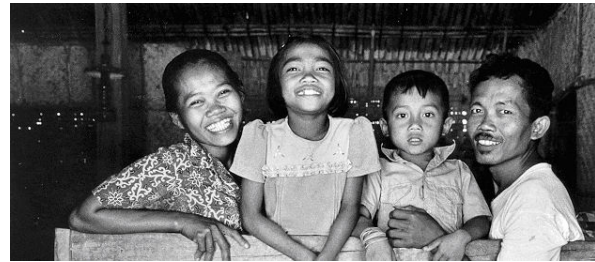
The average family size of the sampled households is five. The age profile of the respondents shows that the households are dominated by younger members: 68% of the household members are less than 20 years old. A large portion of the interviewed (38%) is illiterate. Cultivation on either own or leased land is the main economic activity of the households.

Based on the household expenditure per capita as a proxy for household income, the sample was divided into terciles: households having less than Birr 46 per capita expenditure were defined as “poor”, per capita expenditure between Birr 46 and Birr 69 as “medium”, and per capita expenditure higher than Birr 69 as “rich”.<sup>4</sup> The average expenditure of the rich is more than double the average expenditure of the poor.<sup>5</sup> The wall and floor of houses are mainly made up of wood and mud, while the main material for the roof is thatch. Most of the interview households (67%) occupy a single room house. The number of rooms in the house is strongly correlated with the household expenditure.

As in most of the country, formal health insurance is nonexistent in the study area. Only 44 households reported having health insurance in an informal manner through so-called *eders*. *Eders* are a major form of indigenous community-based arrangements in Ethiopia utilized mainly for assisting victims in bereavement and executing funeral-related activities, but sometimes they provide health insurance to members in an informal manner (Haile Mariam,

<sup>4</sup> The exchange rate at the time of the survey was: 1 US\$ = 8.7 Ethiopian Birr.

<sup>5</sup> This comparison refers only to our sample. Comparison of our data with the socio-economic classification as defined by the Central Statistical Agency based on the nationally representative Ethiopian Welfare Monitoring Survey shows that a large majority of the sampled households can be classified as poor.



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2003). Unfortunately, the percentage of households having this type of insurance is too small (only 4%) for meaningful analysis of the effect of eders on SRH utilization and related costs.

### *Maternal health services*

Of the total 1,003 women of reproductive age included in the survey, 767 (76%) reported being pregnant in the 12 months prior to the survey. Out of these 767 women, 625 (81%) completed their pregnancies prior to the survey. In Ethiopia, maternal health (MH) services delivered at public facilities are free, at least in principle. Nevertheless, about half of the women reported making OOPE to get needed healthcare services. *Table 1* displays data on OOPE for different MH services across the household income distribution.

Only 132 (17% of the women who reported being pregnant in the 12 months prior to the survey) reported expenditures on antenatal care (ANC), including tetanus toxoid (TT) injection and iron folic acid (IFA) tablets. Data show that women from poor households are less likely to pay for ANC services than better-off women. The average amount spent by better-off women for ANC is also higher than the amount spent by poorer women. For the other MH services – obstetric care during pregnancy due to complications, delivery with and without complications – there are no significant differences in the proportion of women who made OOPE across the income categories.<sup>6</sup> A plausible explanation is that these expenses are more non-discretionary than the ANC expenditures and the poor have to incur them more-or-less equally often as the rich. As expected, the average cost for obstetric care services for MH-related complications was much higher than for regular ANC and normal delivery. Particularly worrisome is that the poor spent the highest average amount on obstetric care during pregnancy and on delivery with complications.

<sup>6</sup> We do not include postnatal care in the analysis since only 5 women reported paying for postnatal services.

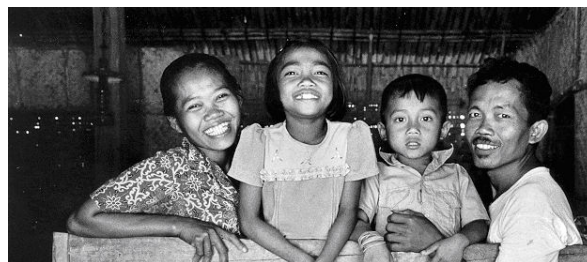
*Table 2* shows disaggregated data on OOPE for different components of MH services by type of provider.<sup>7</sup> Most women who paid for MH care sought this care from public facilities. This confirms the important role of the public sector in provision of MH services. The dependence on the public sector is particularly noteworthy for ANC treatment and delivery with no complications, although the costs seem to be higher than in the private sector. Very few women sought care from traditional providers.

The highest amounts are spent on MH drugs and medical supplies. This finding is consistent with other studies: for example, drugs are found to be the major cost component of delivery in Bangladesh (Nahar and Costello, 1998), Ghana (Borghi et al., 2003), and Pakistan (Khan and Zaman, 2010). In our sample, in case of delivery with complications the costs of drugs seem to be even higher for public patients compared to private patients. This highlights the need for special attention to pricing and charging policies, but also utilization practices, for MH drugs. Indirect OOPE – transport, accommodation, food, other expenses – also account for a large fraction of OOPE on deliveries with or without complications.

This underlines the difficulty of access to MH services in rural Ethiopia.<sup>8</sup> Overall, the combined direct and indirect cost of the apparently “free” maternity care is significant and may deter utilization especially by poor mothers.

<sup>7</sup> The breakdown by provider for indirect OOPE (transport, accommodation and food, other expenses) is not shown in the table since these services were provided by private facilities.

<sup>8</sup> Contrary to this, Puri et al. (2008) find that the cost of travel and lodging constitutes a very small part of delivery expenses in urban Nepal.



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*Table 1. Expenditure on maternal health services across the income distribution*

Type of care	Poor		Medium		Delivery		Total	
	# women	Mean exp.	# women	Mean exp.	# women	Mean exp.	# women	Mean exp.
Antenatal care	31 (12)	96	36 (16)	103	59 (24)	110	132 (17)	102
Obstetric care during pregnancy	28 (11)	185	25 (11)	140	36 (15)	159	93 (12)	155
Delivery without complications	37 (17)	121	60 (31)	119	42 (22)	140	143 (23)	126
Delivery with complications	41 (19)	225	19 (10)	130	36 (19)	175	104 (16)	195
Total maternal health	115 (45)	190	115 (50)	146	140 (57)	174	385 (50)	172
# of pregnant women	257		230		247		767	
# of completed pregnancies	218		193		188		625	

*Notes:* The figures on expenditure are given in Ethiopian Birr. Antenatal care includes expenditures on tetanus toxoid injection and iron folic acid tablets. Obstetric care during pregnancy included only women who faced complications during pregnancy. The total number of women differs slightly from the sum of the number of women across the income groups since for a few women information on household income is missing and they could not be assigned to the income groups.

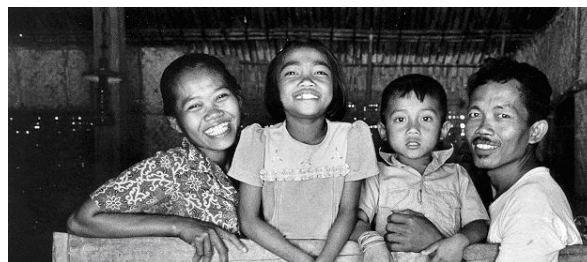
Figures in parentheses denote percentages. For antenatal care, obstetric care during pregnancy, and total maternal health the percentages were calculated by dividing the number of women who paid for health services by the number of pregnant women. For delivery with and without complications the percentages were calculated by dividing the number of women who paid for health services by the number of completed pregnancies.

### *Reproductive health disorders*

The survey included a question on a variety of reproductive health (RH) disorders: reproductive tract infections (RTI), sexually transmitted infections (STI), HIV/AIDS, RH cancers, obstetric fistula, and infertility. Only RTI and STI proved to be significant problems in the study area. Getting data on HIV/AIDS turned out to be a major challenge. Out of the total sample, only 18 men and 22 women reported

living with HIV/AIDS. Most of the interviewed individuals did not test for HIV and did not know their HIV status. Many were unwilling to discuss this issue and provide information.

*Table 3* displays data on OOPE for RTI and STI of women and men across the household income distribution. Before explaining the figures it should be noted that, unlike in the case of MH services, there



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*Table 2. Expenditure on maternal health services by type of provider*

Type of provider	Antenatal care		Obstetric care during pregnancy		Delivery without complications		Delivery with complications	
	# women	Mean exp.	# women	Mean exp.	# women	Mean exp.	# women	Mean exp.
<i>Consultation</i>								
Private	16	7	15	10	4	48	3	7
Public	30	5	36	5	13	5	28	6
Traditional	-	-	-	-	1	35	-	-
<i>Laboratory tests</i>								
Private	29	17	21	41	7	49	10	25
Public	56	16	48	18	7	10	22	15
Traditional	-	-	-	-	1	45	2	25
<i>Treatment</i>								
Private	27	37	18	79	14	33	8	92
Public	40	43	44	36	20	34	41	77
Traditional	-	-	4	33	3	40	2	8
<i>Drugs</i>								
Private	40	47	24	74	22	176	16	97
Public	47	46	52	60	17	62	38	134
Traditional	-	-	1	30	4	22	1	30
Transport	96	20	74	19	25	48	53	61
Accommodation and food	51	31	53	39	39	67	41	69
Other expenditure	19	54	17	50	81	89	63	44
<b>Total expenditure</b>	<b>132</b>	<b>102</b>	<b>93</b>	<b>155</b>	<b>143</b>	<b>126</b>	<b>104</b>	<b>195</b>

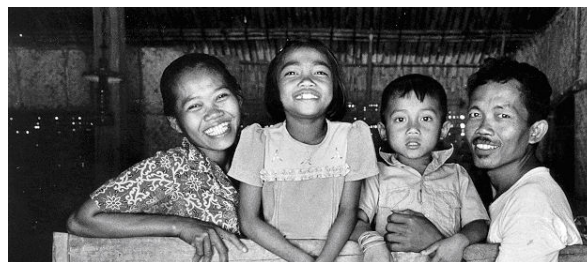
*Notes:* The figures on expenditure are given in Ethiopian Birr. Antenatal care includes expenditures on tetanus toxoid injection and iron folic acid tablets. Obstetric care during pregnancy included only women who faced complications during pregnancy. The providers of transport, accommodation, food, and other services were overwhelmingly private and thus only the aggregate numbers are shown in the table.

are user charges for treating these RH disorders at public facilities. Of the total 1,003 women of reproductive age included in the survey, 417 (42%) reported having RTI problems and 388 (39%) reported having STI in the 12 months prior to the survey.<sup>9</sup> The prevalence of both RTI and STI is higher among poorer women. About a third of the women having RTI and 26% of the women having

STI reported making expenditures for the needed health care. Data show that women from poor households are more likely to pay for RTI and less likely to pay for STI than better-off women.<sup>10</sup> The average cost for RTI seems to be higher than for STI across all income groups. However, the average

<sup>9</sup> 221 women reported having both RTI and STI.

<sup>10</sup> Puri et al. (2008) also find the utilization of STI services to be comparatively lower in respondents from poorer households.



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*Table 3. Expenditure on reproductive health disorders across the income distribution*

Type of care	Income group							
	Poor		Medium		Rich		Total	
	# persons	Mean exp.	# persons	Mean exp.	# persons	Mean exp.	# persons	Mean exp.
RTI of women	60 (41)	123	37 (30)	199	33 (26)	151	136 (33)	149
STI of women	37 (26)	121	27 (22)	134	33 (32)	103	102 (26)	116
RTI of men	14 (52)	153	11 (50)	137	4 (33)	310	30 (47)	165
STI of men	17 (30)	130	17 (39)	107	16 (41)	316	50 (35)	182
Total RTI	74 (43)	129	48 (33)	185	37 (27)	168	166 (35)	152
Total STI	54 (27)	124	44 (26)	123	49 (35)	172	152 (29)	137
# of women with RTI	145		123		126		417	
# of women with STI	142		125		102		388	
# of men with RTI	27		22		12		64	
# of men with STI	56		44		39		143	

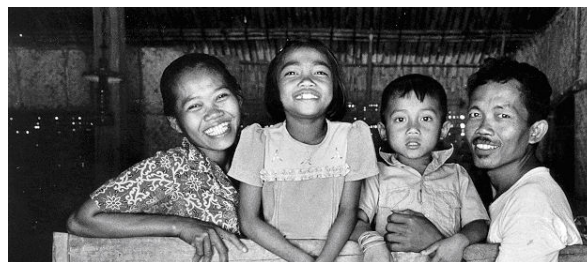
*Notes:* The figures on expenditure are given in Ethiopian Birr. RTI denotes reproductive tract infections. STI denotes sexually transmitted infections.

Figures in parentheses denote percentages. The percentages were calculated by dividing the number of women/men who paid for health services by the total number of women/men who were affected by the health problem.

amount spent by poorer women for STI is higher than the amount spent by better-off women.

The figures on OOPe for RTI and STI of men displayed in *Table 3* should be interpreted with particular caution due to the small samples. Summarizing briefly we can say that, as in the case of women, the prevalence of both RTI and STI is higher among poorer men. Men seem to be comparatively more affected by STI than women. Importantly, men are more likely to make expenditures for treating their RH disorders and to pay higher average amounts than women. This could be taken as indicative of gender discrimination within households when it comes to RH expenditures.

*Table 4* shows disaggregated data on OOPe for different components of RTI and STI services by type of provider. As in the case of MH care, most women who paid for RH care sought this care from public facilities. This is particularly striking in the case of RTI treatment, although the costs in the public sector seem to be higher than in the private sector. In contrast to women, most of the men with RTI went to private providers, although the costs reported by men were higher in the private sector than in the public sector. Further research is needed to establish if there is a real gender-based discrepancy in the pricing and utilization of RTI services between the public and the private sector perhaps related to demand or supply of these services



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*Table 4. Expenditure on reproductive health disorders by type of provider*

Type of provider	RTI of women		STI of women		RTI of men		STI of men	
	# persons	Mean exp.	# persons	Mean exp.	# persons	Mean exp.	# persons	Mean exp.
<i>Consultation</i>								
Private	21	7	18	8	13	7	11	25
Public	41	4	32	6	6	4	14	10
Traditional	2	15	-	-	-	-	-	-
<i>Laboratory tests</i>								
Private	41	22	36	42	17	24	20	34
Public	64	17	41	13	10	2	23	26
Traditional	1	30	1	5	-	-	-	-
<i>Treatment</i>								
Private	34	54	31	36	14	57	15	95
Public	54	58	33	32	9	47	18	26
Traditional	2	28	-	-	-	-	1	150
<i>Drugs</i>								
Private	49	67	49	49	20	81	22	101
Public	64	60	41	59	8	46	22	43
Traditional	4	85	1	100	-	-	-	-
Transport	105	23	75	18	25	16	38	17
Accommodation and food	76	28	55	15	21	20	33	29
Other expenditure	15	47	6	29	4	32	11	47
<b>Total expenditure</b>	<b>136</b>	<b>149</b>	<b>102</b>	<b>116</b>	<b>30</b>	<b>165</b>	<b>50</b>	<b>182</b>

*Notes:* The figures on expenditure are given in Ethiopian Birr. RTI denotes reproductive tract infections. STI denotes sexually transmitted infections. The providers of transport, accommodation, food, and other services were overwhelmingly private and thus only the aggregate numbers are shown in the table.

or, since the number of observations for men is quite small, the averages may be vulnerable to outliers.

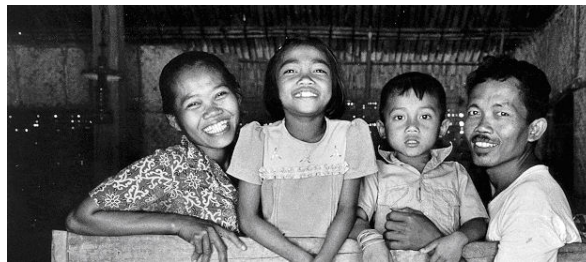
As in the case of MH services, spending on drugs for RTI and STI accounts for a very large fraction of OOPE. According to Van Doorslaer et al. (2007), the share of total OOPE that goes to medicines is generally larger in poorer, more rural countries. This is certainly valid for rural Ethiopia. The indirect OOPE on RTI and STI are not as high as in the case

of MH services, but they can nevertheless amount to a significant share of OOPE.

### *Family planning services*

Of the total of 1,003 women and 175 males of reproductive age included in the survey, 193 women (19%) and only 3 men (2%) had used modern contraceptives (*Table 5*). Among women who reported using contraception, the majority reported using injectables, followed by oral pills. The costs of





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these methods are exempted at public health care providers and all women sought such services from public facilities. Only one woman reported being sterilized and for this service she used a private provider. Although almost all of the respondents incurred no direct OOPE on FP services, the indirect OOPE (such as transportation and the opportunity cost of time) are significant for women who seek or

would like to seek FP services. This applies particularly to women living far away from health centers.

Male contraceptive users were exclusively using condoms. The condoms were bought from private providers and the cost ranged from Birr 3-50. Only a small percentage of men used contraception.

Table 5. Use of family planning services

	Women		Men	
	Number	Percentage	Number	Percentage
Condom	-	-	3	1.7
Oral pill	63	6.3	-	-
Injectable	159	15.9	-	-
Female sterilization	1	0.1	-	-
Total	193	19.2	3	1.7

Notes: The percentages were calculated by dividing the number of users by the number of all women of reproductive age (1,003 women) and all men of reproductive age (175 men) included in the survey.

### 4. Conclusions

As in many other developing countries, in the absence of formal or informal health insurance, rural Ethiopians need to pay significant amounts out-of-pocket for SRH services. We find that spending on drugs accounts for a large fraction of OOPE. There are also significant indirect costs associated with MH services. The poor seem to pay as much as the better-off for SRH services, and in some instances even more so. This reflects the absence of collective payment schemes in the study area and the consequent inability of the poor to avoid paying out-of-pocket for health services that are largely non-discretionary, such as obstetric care during pregnancy or delivery due to complications. Relying on out-of-pocket financing could leave many of the households exposed to the risk of impoverishment.

We faced certain challenges and limitations during the study. First, a major challenge was reaching people living with HIV/AIDS. Second, opportunity cost of travel time and time spent at healthcare facilities is not included in our analysis. Nor is the lost income due to possible long-term morbidity suffered by mothers as a result of pregnancy- or delivery-related complications.<sup>11</sup> Thus the study provides only a lower-bound estimate of the total financial burden to households. Third, the study was conducted in a rural district in Ethiopia and the results may not be readily generalized to the wider

<sup>11</sup> Gertler and Gruber (2002) find that in Indonesia earnings losses are more important than medical spending in disrupting household living standards following a health shock.



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Ethiopian population. Finally, lack of memory and recall bias regarding the incurred costs for SRH also emerged as problems.

Despite these limitations, the study makes a contribution to filling the gap in our knowledge about OOPE on SRH. Based on the above analysis, we can draw the following policy recommendations. Improvement in drug supplies at public healthcare providers could alleviate some of the costs borne by households. Supply shortages in public providers force women or their families to make purchases from private pharmacies. This is more expensive and may act as a deterrent to seeking healthcare. If public providers could guarantee a regular availability of essential drugs and medical supplies for SRH, this could insure more prompt and possibly life-saving healthcare for women. The same argument applies to the need to improve the overall quality of service provision at public health providers, including reduction of waiting time for patients.

Inaccessibility (both physical and financial) of healthcare providers is a major problem in rural Ethiopia. Especially when there are complications during pregnancy or emergencies due to labor, easy and affordable access to healthcare facilities is of crucial importance. The study finds that even for SRH services that are provided for free at public facilities, such as MH services, indirect costs can be significant. In this regard, community-supported local

transport could be promoted to facilitate transfer to healthcare facilities in emergency situations.

The mechanism for collecting fees is an important factor in determining access to healthcare, with direct payment systems often inappropriate for rural populations that face the problem of temporary or permanent inability to pay. Numerous studies show that it is easier for households to finance the cost of illness when part of the cost is prepaid (e.g. Diop et al., 1995; Schneider et al., 2001). An alternative approach to financing would be for public providers to include flexible rather than fixed payment schemes, enabling the spread of payment over time. Another, probably more viable, method of financing would be promoting community-based schemes such as eders. Haile Mariam (2003) argues that eders have the potential to serve as a workable mechanism for financing health care in rural Ethiopia.

More effort is needed in the area of health education in order to increase awareness about the advantages of early care seeking, preventive care, and institutional delivery. Collaborative endeavors among the public, NGO, and private sectors could be considered for enhanced campaigns for HIV testing, early HIV treatment, provision of HIV/AIDS counseling services, reducing AIDS-related stigma, and promoting tolerance of people living with HIV/AIDS.



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### References

- Afsana, K. (2004), The tremendous cost of seeking hospital obstetric care in Bangladesh. *Reproductive Health Matters* 12(24): 171-180.
- Borgh, J., et al. (2003), Costs of near-miss obstetric complications for women and their families in Benin and Ghana. *Health Policy and Planning* 18(4): 383-390.
- Diop, F., A. Yazbeck, and R. Bitran (1995), The impact of alternative cost recovery schemes on access and equity in Niger. *Health Policy and Planning* 10(3): 233-240.
- Gertler, P., and J. Gruber (2002), Insuring consumption against illness. *American Economic Review* 92(1): 51-70.
- Haile Mariam, D. (2003), Indigenous social insurance as an alternative financing mechanism for health care in Ethiopia (the case of *eders*). *Social Science & Medicine* 56(8): 1719-1726.
- Khan, A., and S. Zaman (2010), Costs of vaginal delivery and Caesarian section at a tertiary level public hospital in Islamabad, Pakistan. *BMC Pregnancy and Childbirth* 10:2.
- Nahar, S., and A. Costello (1998), The hidden cost of 'free' maternity care in Dhaka, Bangladesh. *Health Policy and Planning* 13(4): 417-422.
- Puri, M., et al. (2008), Examining out-of-pocket expenditures on reproductive and sexual health among the urban population of Nepal. *Population Review* 47(2): 50-66.
- Schneider, P., et al. (2001), *Utilization, cost and financing of district health services in Rwanda*. Bethesda, MD: Abt Associates Inc.
- Van Doorslaer, E., et al. (2006), Effects of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data. *The Lancet* 368(9544): 1357-1364.
- Van Doorslaer et al. (2007), Catastrophic payments for health care in Asia. *Health Economics* 16(11): 1159-1184.
- WHO (2003), *Guide to producing national health accounts: with special applications for low-income and middle-income countries*. Geneva: World Health Organization.
- Xu, K., et al. (2003), Household catastrophic health expenditure: a multicountry analysis. *The Lancet* 362(9378): 111-117.