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**FORMAL AND INFORMAL
FEES FOR MATERNAL
HEALTH CARE SERVICES IN
FIVE COUNTRIES:**

Policies, Practices, and Perspectives

By

Suneeta Sharma
Sarah Smith
Emily Sonneveldt
Marissa Pine
Varuni Dayaratna
Rachel Sanders

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Executive Summary

User fees are gaining widespread use in government health programs as a means of alleviating pressure on constrained budgets as demand for services increases. Concerns that fees reduce access to services among the poor have led to the promotion of fee exemption mechanisms in order to protect those unable to pay for services. The exemptions, however, may not effectively ensure access among the poor because (1) informal fees and other costs associated with seeking and receiving services are not alleviated by most exemption mechanisms and (2) exemption mechanisms are poorly implemented. The low proportion of formal fees to total costs to the consumer and the unpredictable nature of informal fees and other costs of access may actually work against formal fee exemption mechanisms. Even though little is known about how well fee and waiver mechanisms function for maternal health services, it is important to understand whether exemption mechanisms alone hold promise for protecting access for the poor or whether the mechanisms need to be supplemented with other strategies.

This study was conducted simultaneously in five countries: Egypt, India (Uttaranchal), Kenya, Peru, and Vietnam. The objectives were to survey actual costs to consumers for antenatal and delivery care; survey current fee and waiver mechanisms; assess the degree to which these mechanisms function; assess the degree to which informal costs to consumers constitute a barrier to service; and review current policies and practices regarding the setting of fees and the collection, retention, and use of revenue.

Methodology

For purposes of the study, formal fees are defined as those charges to patients for health care goods and services as published in a health care facility's policy or elsewhere in an official policy document. Informal fees are any other payments made by clients not formally sanctioned by the health care facility or other expenses clients must incur in order to receive care, including "under-the-table" payments made to any staff affiliated with the health care facility when such payments are a condition of receiving care. Informal fees and other costs to access services also include costs incurred by clients or their families for supplies or drugs that must be purchased outside and brought to the facility, costs for transportation and food, informal board charges, and costs of travel for an accompanying family member. The report presents data synthesized from several sources, including government policies, facility records, household surveys, facility surveys, focus group discussions, and key informant interviews.

Results

Despite government efforts and favorable policies aimed at improving service provision, utilization rates for maternal health services were low among the poor in the five countries of interest. In Peru, 31 percent of poor women had no antenatal care (ANC) during their last pregnancy, and 83 percent of poor women delivered at home. Similarly, 29 percent of poor women in Kenya had no antenatal care during their last pregnancy, and 85 percent of poor women delivered at home. Irrespective of poverty status, a large proportion of women rely on public sector services. In India (Uttaranchal), 29 percent of ANC clients and 18 percent of delivery clients who receive free services at public facilities fall into the nonpoor category, raising the question of whether subsidized government services are properly targeted to women most in need. The study also found that poor women incurred substantial maternal health expenses in both the public and private sectors. In India (Uttaranchal), poor women who paid for maternal health services in the public and/or private sector spent about US\$1.90 on ANC, US\$4.50 on home delivery, and up to US\$66.90 on institutional delivery.

Provider perspectives. Provider knowledge of the official fees for ANC and delivery services differed by country. For example, in Kenya, less than half of providers were aware that ANC services were exempt from user fees for all clients while all providers in Peru knew that ANC services were mandated to be provided to all clients at no charge. Providers in all countries reported that clients had to pay additional fees for ANC services, such as for enrollment, laboratory tests, or supplies. Responses also varied among countries regarding provider knowledge of waivers/exemptions for ANC and delivery services. Most providers in Kenya reported that the nation had implemented a waiver system for deliveries while most providers in Egypt reported that, contrary to government policy, a client could not receive free delivery care.

In Egypt, India (Uttaranchal), and Vietnam, the study asked questions about under-the-table payments made directly to providers or other facility staff for ANC or delivery services. Most providers reported that staff did not ask for payment when providing ANC services and did not request payment for delivery services. In India (Uttaranchal), some providers stated that midwives or nurses may ask for money or gifts, especially following the birth of a boy. Again, in India (Uttaranchal), providers reported that lower-level staff, including ward *aayas* and sweepers, generally asked for additional payment for services, such as laundering sheets or clothes and cleaning rooms.

Client perspectives. Generally, women in all five countries were not aware of the waiver/exemption mechanisms for maternal health services. In Kenyan focus group discussions, all participants were aware that ANC services were free for all but the first visit; however, none of the respondents knew that the fee for the first visit could be waived. Lack of awareness among the majority of potential beneficiaries mainly resulted from a lack of publicity, which was largely attributable to the unwillingness of some health staff to inform their clients. In the Egyptian focus group discussions, few individuals had heard of the waiver mechanism or knew of anyone who had taken advantage of it.

Women in focus groups in all five countries indicated that informal user fees constitute a barrier to services. In Peru, some women mentioned that they had to postpone the receipt of ANC because they did not have the money needed to pay for laboratory tests. Respondents in India (Uttaranchal) reported that, in view of limited financial resources, they sometimes cut down on or did not take prescribed medicines. They also stated that they were too embarrassed to share their financial difficulties with doctors and thus hesitated to ask providers for less expensive medicines.

Discussion

How do current formal and informal fees pose barriers to accessing maternal health services?

Cost of services leads to a low level of utilization of maternal health services among poor women. Despite governments' efforts and favorable policies aimed at improving service provision, utilization rates for most of the maternal health services analyzed in this study were very low among the poor.

Poor and nonpoor women benefit equally from highly subsidized government services. A large proportion of women, irrespective of poverty status, rely on public sector services, raising the question of whether government services are properly targeted to women most in need of them.

Poor women incurred substantial expenses for maternal health in both the public and private sectors. High costs, in part, explain the low level of utilization of services among poor women.

Women demonstrated poor knowledge of waivers and exemptions. Generally, women in all five countries were not aware of the waiver and/or exemption mechanisms for maternal health services.

Informal payments constitute a significant proportion of out-of-pocket expenses. Per the study's definition of formal and informal fees and given that poor women are eligible to receive all services without charge, all direct and indirect expenses incurred by poor women constitute informal payments. The large share of these costs fall into two categories: payments for supplies, medicines, and laboratory services that are included in national waiver and/or exemption mechanisms and payments made directly to health facility staff for higher quality care, shorter wait times, or as a general condition of service.

Policy Recommendations

- Generate awareness among low-income clients about the availability of free services and develop community-based surveillance systems.
- Enforce payment of user fees by those who can afford to pay in order to generate sufficient revenue for quality improvements and cross-subsidization for the poor.
- Encourage governments to rationalize spending on health services.
- Design and implement monitoring and evaluation mechanisms that focus on the needs of the poor.
- Permit health facility administrations to retain and use revenues collected at the facility level.
- Minimize informal payments in order to make services affordable to a large number of clients.
- Improve insurance schemes so that they include all aspects of antenatal and delivery care.

Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ANM	Auxiliary nurse midwife
DHMB	District Health Management Board (Egypt)
DHMT	District Health Management Team (Egypt)
DHS	Demographic and Health Survey
EDHS	Egypt Demographic and Health Survey
ENDES	Peru Demographic and Health Survey
FGD	Focus group discussion
FP	Family planning
GDP	Gross domestic product
HIO	Health Insurance Organization (Egypt)
HIV	Human immunodeficiency virus
IUD	Intrauterine device
KDHS	Kenya Demographic and Health Survey
LGA	Local Government Area (Nigeria)
MCH	Maternal and child health
MMR	Maternal mortality ratio
MOH	Ministry of Health
MOHP	Ministry of Health and Population (Egypt)
NGO	Nongovernmental organization
Ob-Gyn	Obstetrician/gynecologist
PDS	Public Distribution System (India)
PHC	Primary health care
RHC	Reproductive health care
SIS	Seguro Integral de Salud (Peru)
SMI	Seguro Maternal Infantil (Peru)
TB	Tuberculosis
TBA	Traditional birth attendant
VND	Vietnamese Dong
VNDHS	Vietnamese Demographic and Health Survey
WHO	World Health Organization

1. Introduction

As demand for health services increases, government health programs are turning to user fees to help alleviate pressure on constrained budgets. Concerns that fees reduce access to services among the poor have led to the promotion of fee exemption mechanisms as a means of protecting those least able to pay for services. The exemptions, however, may not effectively protect access to health services among the poor. As a matter of practice, most exemption mechanisms have not meant an end to the imposition of informal fees and other costs associated with seeking and receiving health services. The low proportion of formal fees to total costs to the consumer and the unpredictable nature of informal fees and other access costs may actually work against formal fee exemption mechanisms. Even though little is known about how well fee and waiver mechanisms function for maternal health services, it is important to understand whether exemption mechanisms alone hold promise for protecting access for the poor or whether the mechanisms need to be supplemented with other strategies. The objectives of this study are to (1) survey actual costs to consumers for antenatal and delivery care; (2) survey fee and waiver mechanisms currently in place; (3) assess the degree to which these mechanisms function as intended; (4) assess the degree to which residual costs to consumers (after accounting for fee waivers) may constitute a barrier to services; and (5) review current policies and practices regarding the setting of charges and the collection, retention, and use of fee revenue.¹

This study was conducted in five countries: Egypt, India (Uttaranchal), Kenya, Peru, and Vietnam. For purposes of the study, formal fees are defined as those charges to patients for health care goods and services as published in a health care facility's policy or elsewhere in an official policy document. Informal fees and other costs to access are defined as any other payments made by clients that are not formally sanctioned by the health care facility or other expenses clients must incur in order to receive health care services, including under-the-table payments made to any staff affiliated with a health care facility when such payments are a condition of receiving care. Under-the-table payments may be made to health care professionals or other support staff at the facility, such as maintenance and housekeeping staff, guards, and so forth. Informal fees and other costs to access services also include costs incurred by clients or their families for supplies or drugs that must be purchased outside and brought to the facility. Costs for transportation and food, informal board charges, and travel costs for an accompanying family member are included as other costs to accessing services and would not be covered by the government.

This report addresses why the topic of user fees for maternal health services is an issue in need of study in developing countries. The following section provides a brief overview of the literature on user fees and household expenditures. Section 3 discusses the approaches and methodologies used to investigate formal and informal user fees for maternal health services. Section 4 provides background on the five countries included in the study. Section 5 assesses national, subnational, and facility policies regarding financing mechanisms, targeting/equity, and access to maternal health care services and also describes user fee collection, retention, and use practices as well as exemption mechanisms at the facility level. Section 6 looks at the perspectives and knowledge among providers about policies for user fees, waivers, and exemptions. Section 7 presents the findings of focus group discussions and household surveys regarding various reproductive health care services and analyzes expenditures for medical supplies, tips, transport to and from the hospital, food and lodging, and hospital fees. Section 8 presents a case study of client perspectives in India (Uttaranchal). Section 9 brings together policies, practices, and clients' perspectives in order to develop an understanding of overall demand and supply for maternal health services.

¹ Additional data were collected on family planning in Egypt and Kenya. See the Appendix for an analysis of the information.

2. Why Is the Topic of User Fees for Maternal Health Services Important to Study in Developing Countries?

Growing populations and poor economies continue to overwhelm government health care programs. As a result, user fees have attracted considerable attention during the last decade as a potential source of supplementary financing to meet nonsalary recurrent expenses. The introduction of user fees in public hospitals has generated mixed experiences in developing countries. Although the results in some instances are encouraging in terms of cost recovery, effective exemption of the poor remains an issue of major concern.

In the late 1980s, many developing countries introduced user fees to help defray the cost of maternal health services. Many of the studies addressing user fees have focused on a broad definition of fees for curative care while few have specifically examined maternal health user fees. These studies do, however, distinguish between formal and informal user fees. Nonrandom rapid surveys in Bangladesh (Killingsworth et al., 1999) found that the average level of informal fees per patient was 12 times the amount expected to be incurred in official payments. The largest payments went for commodities such as medicines, supplies, and surgical equipment (85 percent of the total), with fees for service and improved access to beds or transportation accounting for the remaining 15 percent. Results also suggest that those least able to pay are charged a proportionately higher amount of their disposable income than higher-income groups.

A survey conducted in Ghana, Malawi, and Uganda found that, owing to higher user fees for some services and increased travel costs, routine services cost more in hospitals than at health centers (Levin et al., 2000). The survey also found that, in Uganda, costs to the user other than fees for routine services represented more than 50 percent of total costs. In cases where fees were relatively high, such as in mission facilities in Malawi and all facilities in Uganda, costs other than fees accounted for less than 50 percent of total costs. The study also found that service fees charged by private midwives were higher than those charged at public health centers and sometimes as high as those charged for hospital services.

Demand Surveys

Most studies focus on the impact of user fees on the demand for curative or preventive care in general, although a few recent studies conducted under the PHRPlus Project have generated information about user fees and maternal health in Ghana, Malawi, and Uganda (Levin et al., 2000; Tien and Chee, 2002). Nahar and Costell (1998) studied unofficial fees for maternal health services in Dhaka, Bangladesh.

Reproductive Health Expenditures at the Household Level in India

Most studies that investigated health care utilization and expenditure patterns among households focused generally on curative care rather than specifically on reproductive and maternal health care.

A recent study conducted by Bhatia and Cleland (2001) in Karnataka, India, found that clients visiting government doctors spent more on drugs purchased from outside pharmacies than on consultation fees. The study also found that most users of public services said that they voluntarily offered or were urged to make unofficial payments to the provider and had to purchase pharmaceuticals and pay travel expenses to secure the consultation.

Another study conducted in Udaipur, Rajasthan, found that most women who used public facilities (74 percent of ANC clients, 100 percent of delivery clients, 66 percent of postnatal care clients, and 81 percent of child health clients) paid out of pocket for consultations, medicines, tests, transportation, or lodging. Payments for services in public facilities ranged from a low of 42 percent to a high of 56 percent of what women would have paid for similar services in private facilities. The study also found that payments for drugs by public facility clients were comparable to those of private clients (Hotchkiss et al., 2000).

Impact of Fees on Maternal Health Services in Africa

In Africa, fees have had a negative effect on utilization of maternal health services (Nanda, 2002). In Zimbabwe, use of ANC services declined with the introduction of user fees in the early 1990s. In Tanzania, the introduction of user charges led to a 5.3 percent decline in ANC utilization in three public health facilities. However, suspension of user fees led to an increase in attendance at ANC clinics in South Africa. A study conducted in Ghana by Overbosh and others (2003) found that household income, distance to a health facility, and charges for services significantly influenced demand for ANC services. The study demonstrated that distance and charges negatively affected the utilization of antenatal care services. A survey carried out in Nigeria showed that the introduction of fees led to a 46 percent decline in the number of deliveries at the main hospital in the Zaria region (Nanda, 2002).

Quick and Musau (1994) found that, with the introduction of user fees (registration fees) in Kenya, ANC attendance declined by 19 percent in three provincial hospitals and by 19 and 28 percent, respectively, in two district hospitals—despite the fact that ANC clients were exempt from the fees. The study also established that the reduction in ANC utilization was followed by a modest financial recovery in provincial and district hospitals. Nevertheless, the sample facilities experienced a gradual long-term decline in ANC utilization from 1990 to 1993. The authors inferred that the decline was attributable to either mothers' lack of awareness that the fee program did not apply to ANC or the "one-stop-care" effect, whereby a patient tries to achieve several objectives in one visit. For instance, a mother would travel to a facility for a combined ANC and general clinic visit, with the latter requiring user fees. The authors did not analyze the impact of fees on maternity care services, although they did not find any significant effect of fees on admissions and average length of stay.

Another Kenyan study (Nganda, 2003) used monthly attendance data from selected public facilities and found a decline in average utilization of delivery care services following an upward fee adjustment. The ANC services, however, remained unaffected by the adjustment as average attendance continued to increase.

User Fees in Government Health Units in Uganda

A study based on semistructured questionnaires with national and district policymakers, health workers, and patients, among others, interviewed 348 patients in three districts: Mukono, Mpigi, and Jinjas (Mwesigye, 1999). Fifty-six percent of patients said that they incurred expenses apart from the initial fee. The "other costs" were primarily under the table or payments for supplies. Focus group participants complained about the corruption associated with the extra costs. Interviews with health workers established that many extra costs, particularly those associated with maternity services, are required for supplies that the health center may not provide. The health workers procured the supplies and sold them at a profit.

Cost of Maternal Health Care in Anglophone Africa

Interviews with 120 clients in Ghana, Malawi, and Uganda who received ANC services, had a vaginal or cesarean delivery, or received treatment for obstetrical complications revealed that clients incurred a range of fees and expenses. The costs per visit for antenatal care ranged from US\$0.63 to US\$3.15 in Ghana, from US\$0.15 to US\$8.70 in Malawi, and from US\$0.97 to US\$2.79 in Uganda. Vaginal delivery incurred costs of US\$12.52 to US\$20.64 in Ghana, US\$0.35 to US\$7.86 in Malawi, and US\$2.20 to US\$22.75 in Uganda.

Unofficial Fees in Dhaka, Bangladesh

A questionnaire survey accompanied by in-depth interviews targeted 220 postpartum mothers and their husbands who had used four government maternity facilities in Dhaka (three referral hospitals and one mother and child health hospital) (Nahar and Costella, 1998). Although maternity care is nominally free in Dhaka, the survey revealed a number of hidden costs for medicine, blood tests, travel, food, hospital fees, services provided by *ayas*, and tips. The survey also found that expenditures for normal deliveries were significantly lower than those for caesarean sections. Expenditure for maternity care as a portion of family income was high; the study shows that (1) 21 percent of families spent 50 to 100 percent of monthly income on these services and that (2) 27 percent of families were spending one to eight times their monthly income for maternity care.

Supply Surveys

A Nigerian study showed that revenues generated by the Bamako Initiative in the Ogoja local government area (LGA) accounted for 24 percent of total drug revenues (Ogunbekun, Adeyi, Wouters, and Morrow, 1996). User fees were perceived as generally affordable in all the study's LGAs. However, one district in the Ogoja LGA noted an increasing number of problems with clients' ability to pay the fees and thus had to grant some exemptions. Barkin-Ladi LGA already had established an exemption policy for widows and orphans and some indigents, but the indigents had to render community service in exchange for benefits. Most other LGAs granted no exemptions. The facilities transferred all fee revenues directly to the LGA, with no retention by the facility.

Another study in Ghana, Malawi, and Uganda collected data on the direct costs of providing maternal health services, including personnel and material costs, as well as data on indirect costs such as administrative overhead, utilities, transportation maintenance, and supervision (Levin et al., 2000). ANC costs recovered by user fees in the 12 facilities of interest were relatively low. In Malawi and Uganda, the recovery rates were less than 35 percent, except in the paying ward of the hospital. In Ghana, recovery rates ranged from 15 percent in the public health center to 81 percent in the mission hospital. Cost recovery rates for vaginal delivery ranged from 12.2 percent in health centers in Uganda to 152 percent in the Ghana mission hospital. Cost recovery for treatment of obstetrical complications was lowest in Malawi mission hospitals, at 6.5 percent, and highest in Ghana mission hospitals, at 211 percent.

Inadequate Linkage of Supply and Demand

The household surveys in the published reports cited above provide useful information on household reproductive and maternal health-seeking behavior and expenditure patterns. However, none of the studies has linked the supply and demand sides of the market in an effort to analyze policies, provider perspectives, and consumer expenditure patterns and thus complete the picture of formal and informal fees and other costs of access. In particular, the studies do not describe and explain the household characteristics that determine selection of a particular provider or level of service.

The present study adds to the existing literature by analyzing both consumer and provider perspectives on user charges, evaluating user fees and exemption policies and practices at different levels, assessing household expenditures on reproductive and maternal health care services, and estimating actual costs to consumers, including formal and informal payments. It provides a comprehensive overview of policies, practices, and women's perspectives, including the impact of user fees and additional payments on service utility. The information will help assess the effectiveness of user fees and exemption mechanisms with regard to ensuring poor women's access to maternal health care.

3. Approach and Methodology

The present study was conducted in five countries: Egypt, India (Uttaranchal), Kenya, Peru, and Vietnam. In each country, with the exception of Peru, we sought the services of a national firm to implement data collection and the necessary field work to provide the POLICY Project (POLICY) with documentation and materials as described herein. In Peru, local POLICY staff conducted data collection as part of an ongoing study of operational barriers to maternal health services.

The data presented in the study synthesize data from several sources, including government policies and facility records, household surveys, focus group discussions, facility surveys, and key informant interviews. This section provides information on sample size, data collection tools, and data analysis methods.

Household Survey

The study undertook a desk-top analysis of data sets from household surveys to assess utilization patterns for ANC and delivery care and to establish geographic differences in patterns. Secondary analysis of Demographic and Health Survey (DHS) data and data from the Household Expenditure Survey provided the basis for identifying key variables related to health-seeking behavior, socioeconomic status, and household power relations correlated to the low use of prenatal care and/or high levels of unassisted deliveries. POLICY analyzed DHS data for Egypt, Kenya, Peru, and Vietnam to assess the utilization and expenditure patterns for maternal health services (see Table 1).

As a part of the study, POLICY conducted a household health expenditure survey of 2,830 household in Uttaranchal State in India. We drew the sample from urban and rural areas in four districts (Almora, Haradwar, Nainital, and Tehri Gharwal) and surveyed households to learn about household health expenditure on maternal health services, including expenditures incurred for private/public sector services and for formal/informal fees and other costs of access. The study used two instruments: a household questionnaire and a women’s questionnaire, both of which were precoded with fixed-response categories in English and Hindi. The women’s questionnaire gathered data from married women age 15 to 49 years who were household residents. For women who reported a living child younger than two years of age, the questionnaire collected information on the utilization of antenatal care, childbirth assistance, postnatal care, and child health care services. If a woman reported utilizing health services, the questionnaire also asked about whether she received care in the home or at a health care facility, type of practitioner, and expenditures incurred for consultations, medicine, tests, travel, and lodging.

	Peru	Kenya	India	Egypt	Vietnam
Number of women	27,843	8,195	2,830	9,159	5,665
Data source	ENDES 2000	KDHS 2003	Household Expenditure Survey	EDHS 2003	VNDHS 2002

National Policy Review

The study called for an extensive document review to collect information on national/subnational policies and operational guidelines regarding financing mechanisms, waiver and exemption mechanisms, access to maternal health services, and targeting. We reviewed government orders and operational guidelines to obtain information about policies governing the monetary amount of formal and informal fees.

Researchers analyzed and determined how national policies are communicated and monitored at the subnational and health care facility levels. We conducted key informant interviews with national policymakers, as needed, to fill gaps in information not obtainable from the desk-top review of documents.

Health Facility Information

For the facility survey, we selected one urban region simply for convenience of data collection, but preferably not in the national capital area. We also selected one or two rural regions depending on the extent of regional diversity with respect to provider choices and utilization patterns for ANC and delivery care. In the participating urban and rural regions, we collected data on one hospital and two health centers within the hospital's catchment area. Each selected facility offered both ANC and delivery care services.

Researchers collected two types of information from the selected facilities: (1) documents and data and (2) information from key informant interviews.

Documents and Data

Researchers located the following documents from all facilities included in the study:

- Official policies regarding formal fee collection, including fee levels, person(s) who collects formal fees, location in the facility where fees are collected, and relevant information needed to analyze differences in the fee collection processes for ANC and delivery care services as compared with other health services;
- Official policies, if any, regarding informal fee collection;
- Official policies regarding waivers from fees, including any special dispensation for maternal health services, criteria for eligibility, and process for determining eligibility;
- Information about official posting of fees or other mechanism to inform clients and the community about fee levels and waiver policies;
- ANC and delivery care service statistics for the most recent 12-month period; and
- Official revenue information for the most recent year, including revenue collected for maternal health services, number of waivers granted and value of those waivers, and client characteristics of those receiving waivers for maternal health services.

Key Informant Interviews

We conducted individual interviews with the following staff members at each selected facility, assuring as much privacy as possible (see Table 2):

- Head administrative manager;
- Head/senior Ob-Gyn at hospitals and head physician at health centers;
- Head/senior midwife or nurse/midwife responsible for maternal health services;
- Head pharmacist; and
- Head registration clerk.

We relied on interview instruments, appropriately tailored to local needs and conditions, to conduct interviews and collect the following information:

- Knowledge about monetary amount of formal user fees and official fee collection practices;
- Knowledge about official fee waiver criteria and the eligibility determination process;

- Patterns and practices of formal and informal fee collection, including who collects fees, from which types of clients, at what points in the delivery of services, for what types of products and services, and monetary amount of fees; and
- Opinions about the appropriateness of formal and informal fee collection practices and the impact of informal fees and other costs on access to and utilization of services and health outcomes.

	Peru	Kenya	India	Egypt	Vietnam
Number of providers	72	100	35	67	
Number of facilities	9	19	6	10	9
Number of districts	3	7	3	3	3

Client Information

The study uses both qualitative and quantitative tools to understand clients' perspectives and expenditure patterns. In Egypt and Kenya, we conducted exit interviews at selected facilities; in all five countries, we conducted focus group discussions to obtain client information.

Exit Interviews

For the exit interviews, we administered questionnaires to women who had received ANC or family planning (FP) services in the selected facilities in order to investigate the real costs, whether formal or informal, of obtaining ANC and FP services. We interviewed 215 women from 10 facilities in Egypt and 453 women from 19 facilities in Kenya (see Table 3).

	Kenya	Egypt
Number of clients	453	215
Number of facilities	19	10

In Peru, we collected qualitative data by conducting interviews with 49 women who had received antenatal or delivery care, their partners, and their family members. They were the same clients who participated in the focus group discussions and in-depth interviews.

Women's Focus Group Discussions

Each country team conducted at least two focus group discussions (FGDs) with women in each selected facility's catchment area, one to investigate the costs of obtaining ANC care at the public health care facility (or from public health staff working in the community) and one to investigate the costs of obtaining delivery care at the facility (or from public health staff working in the community). Approximately eight to 10 women residing in each selected facility's catchment area participated in each of the two FGDs (see Table 4). Women were selected for FGDs in accordance with the following criteria:

- Gave birth in the past year and were not pregnant at the time of FGD participation;
- Sought care for pregnancy or delivery from the public health care facility (or its staff) in the catchment area;
- Were judged to be poor (in one of the two lowest socioeconomic quintiles); and
- Were not immediate relatives of current employees of the health care facility.

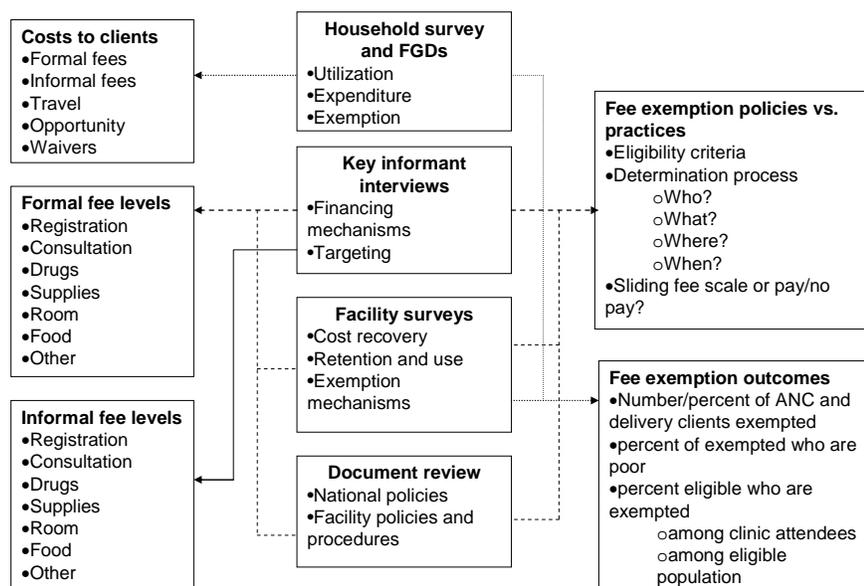
	Peru	Kenya	India	Egypt	Vietnam
Number of FGDs	9	4	16	51	24
Number of women and husbands	108	36	128	413	206
Number of districts	3	3	2	5	3

Each country team worked with local nongovernmental organizations (NGOs) or other community groups, such as primary school staff, to identify and recruit prospective FGD participants. A professional facilitator and a recorder organized the FGDs in accordance with focus group guidelines and around the following discussion topics:

- Choice of health facility/provider and reasons for choice;
- Costs associated with seeking maternal health services, including costs of accessing services (e.g., transportation, time costs, child care);
- Understanding of formal price lists and waiver policies;
- Actual costs incurred at facilities (e.g., registration fees, consultation fees, fees for drugs and supplies, room charges for inpatients, charges for meals and other incidentals);
- Place and timing of fee collection and staff requesting payment;
- Means of financing costs and financial planning for pregnancy-related services;
- Experience with requests for fee waivers; and
- Assessment of costs as a barrier to care.

Figure 1 depicts the various sources of information included in the study but does not reflect the methodology used in Peru, where a study was already underway to identify operational barriers to gaining access to the nation’s maternal health services.

Figure 1. Data/Information Sources–Maternal Health User Fee Study



4. Country Information

We selected the five study countries from a list of USAID countries with a public health and nutrition objective, basing our choices on geographic location, maternal mortality ratio (above 500, 200 to 500, less than 200), proportion of births with skilled attendants (above 60 percent, 30 to 60 percent, less than 30 percent), presence/absence of formal fee systems, and high and low private sector market share of provision of delivery care. We purposefully selected countries for reasons of diversity.

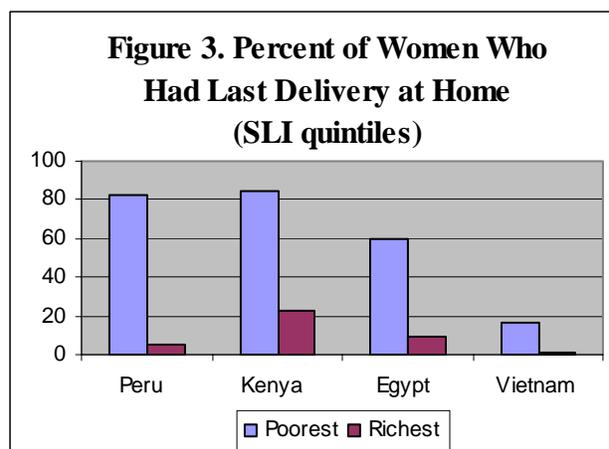
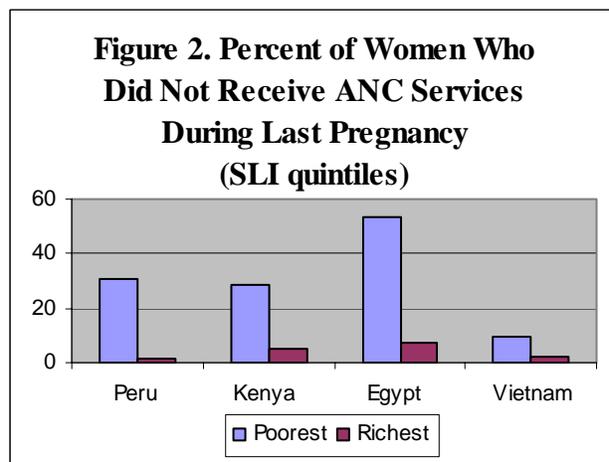
Peru

The maternal mortality ratio (MMR) in Peru is one of the highest among Latin American nations. Although it has declined in the past decade, Peru's MMR remains high at 185 per 100,000 live births (DHS, 2000). Moreover, the MMR varies significantly by urban and rural areas and by geographic region, with some low-income regions reporting an MMR above 200 (Ministry of Health statistics). The MMR in rural areas is three times as high as that in urban areas. Underlying the high mortality ratio is the fact that Peruvian women often decide to deliver at home, in many instances with unskilled birth attendants and no possibility of professional care in the case of complications. According to DHS 2000 data, 42 percent of births in Peru occur without a skilled professional. In rural low-income settings, almost 75 percent of births occur in noninstitutional settings. In Puno, Huancavelica, Amazonas, and other regions with an extremely high incidence of maternal mortality, medical professionals assist less than 30 percent of births. It is important to note that these delivery practices have persisted since the late 1990s despite the government of Peru's efforts to provide free prenatal and delivery care services through various social insurance systems, particularly in low-income areas.

An analysis of Peru DHS 2000 data shows that the percentage of women using ANC and institutional delivery services increases as economic status increases. On average, 16 percent of women made no ANC visits during their last pregnancy, varying from 31 percent in the bottom quintile to only 1 percent in the top quintile (see Figure 2). Approximately 42 percent of women delivered their most recent infant at home, varying from 83 percent in the bottom quintile to only 5 percent in the top quintile (see Figure 3).

Kenya

In Kenya, as in most developing countries, the burden of pregnancy-related risks is high. However, the picture for Kenya compares more favorably than with that for Africa's average. While the estimated lifetime risk of maternal death is 1 in 16 for Africa, it is 1 in 36 for Kenya. In terms of maternal mortality,



the ratio for Africa is about 1,000 deaths per 100,000 live births compared with 590 deaths per 100,000 live births for Kenya (Republic of Kenya, 1999). Secondary analysis of DHS data found that utilization of ANC services is high among women in the richest quintile with only 4.8 percent of women in this group not receiving antenatal care. Nearly 29 percent of women in the poorest quintile did not receive ANC services (see Figure 2). A Republic of Kenya study (2000) found cost of services to be the main reason that the poor do not seek medical care, though the analysis was not sufficiently specific to explain the reasons for not using ANC. Secondary analysis of DHS data also found that a greater percent of women in the poorest quintile (84.9 percent) had their last delivery at home compared with women in the richest quintile (22.5 percent) (see Figure 3).

India

The Indian government has long been committed to improving maternal and child health. Policies adopted as early as 1951 have addressed maternal health services. The National Population Policy endorsed by the government of India in 2000 stresses the government's commitment to safe motherhood programs as well as reproductive health programs in general. However, WHO estimates show that the MMR for India is 540 deaths per 100,000 live births. Almost two-thirds of women, mostly living in villages, deliver at home. More than half of Indian women are anemic and only 20 percent of pregnant women receive antenatal care.

Egypt

The past 15 years have witnessed an improvement in maternal health in Egypt. However, with a MMR of 85 per 100,000 live births, Egypt's MMR still falls in the middle of other countries in the Middle East and North Africa region, showing a continued need for improvement. The 2003 DHS reports that trained medical providers participated in 69 percent of deliveries and that 56 percent of women had the recommended four ANC visits during pregnancy. Secondary analysis found that 53.6 percent of women in the poorest quintile received no ANC services during their last pregnancy compared to 7.3 percent of women in the richest quintile (see Figure 2). For delivery, only 9.1 percent of women in the richest quintile had their last delivery at home compared with 59.7 percent of women in the poorest quintile (see Figure 3).

Vietnam

The MMR, as reported by the WHO in 2000, in Vietnam is 130 deaths per 100,000 live births. On average, seven women die from pregnancy and childbirth related causes every day and 82 newborns die daily. Death rates vary considerably across the country (UNICEF, 2005), with the highest rates occurring in the mountainous regions and among ethnic minorities. The MMR is almost 10 times higher in Cao Bang province than in Binh Duong province (411 per 100,000 versus 45 per 100,000). The secondary analysis of DHS data shows that only 1.9 percent of women in the richest quintile did not use ANC services during their last pregnancy compared with 9.7 percent of women in the poorest quintile (see Figure 2). Very few women delivered at home, though many more women in the poorest quintile (16.8 percent) compared with the richest quintile (1.2 percent) had their last delivery at home (see Figure 3).

5. Policy Overview

This section summarizes results from the policy document review and key informant interviews with policymakers and service providers. It provides an assessment of the national, subnational, and facility policies regarding access to health services, financing mechanisms, equity and targeting of resources, and maternal health care services.

Peru: National and Subnational Policies and Practices

Policies and Practices Related to Improving Access to Health Services

In Peru, many of the high-level policies and laws pertaining to health specify that low-income groups must receive priority status as part of the government's efforts to ensure universal health care. The General Health Law mandates that state financing must be directed to public health activities and provide totally or partially subsidized medical care for low-income populations without alternative public or private sector coverage. The National Accord, a multisectoral coordination mechanism that establishes state policies to be implemented over the next 20 years in areas of national interest, states that the government is obligated to ensure universal and free access to health services, with a priority in zones with high concentrations of the poor and most vulnerable populations. Within this context, the government's health insurance scheme, *Seguro Integral de Salud* (SIS), has set forth the written objective of ensuring increased access for the poorest citizens, specifically for maternal health services.

Financing Mechanisms for Health Services

The main sources of financing health care services in Peru are public taxes, households' out-of-pocket expenditures, social security, and donors. Per the *World Health Report 2004: Changing History* (World Health Organization, 2004), the government was the major source of health finance in 2001, accounting for 55 percent of total expenditure on health. Peru's social security system is both a health care provider and a third-party funding mechanism for health care. Social security services are funded through a 9 percent payroll tax levied on employers.

Policies and Practices Related to Targeting Resources and Ensuring Equity

In 2004, the Peruvian government issued a decree mandating the targeting of health services provided under the umbrella of the SIS, including maternal health services and FP for postpartum women. The targeting effort is currently undergoing a pilot test.

Specific Policies and Practices Related to Maternal Health

Over the years, the central government has shown commitment to addressing maternal mortality. The practical application of Peru's approach to reducing maternal mortality has taken the form of its *Seguros* (insurance schemes). In 1998, through the establishment of the *Seguro Materno Infantil* (Maternal Infant Insurance) (SMI), the Fujimori government mandated the free provision of delivery care to pregnant women and infants in the low-income segments of the population through a mechanism of (indirect) geographic targeting. In 2001, the Toledo government instituted its own insurance system—the *Seguro*

Integral de Salud (SIS)²—whose benefits plan covers services related to pregnancy, delivery, and the postpartum period. At its inception, the SIS targeted low-income women, and norms required would-be beneficiaries to complete a questionnaire on their socioeconomic status for use in determining eligibility. However, a few months after the plan’s inception, the government changed its strategy (possibly because it was not reaching preset coverage rates) and sent new directives to the Regional Health Directorates, making SIS universal such that all who sought maternal health services at government facilities were eligible.

The absence of appropriate operational guidelines and mechanisms to direct implementation of Peru’s national policies may cause operational barriers at the subnational and facility levels. For example, in keeping with the government’s expectations and wishes, the SIS has increased demand for maternal health services. Institutional births rose by 10 percent between 2000 and 2004. However, in terms of financial resources, the SIS has been unable to keep up with demand, and complaints of inadequate and delayed reimbursements abound at health facilities. The financial problems have placed the burden of payment back on the shoulders of clients. Recognizing this dilemma and understanding its negative impacts on poor women, the current Minister of Health has, once again, set in place a pilot strategy to target the SIS to the poorest segments of the population. In the meantime, directors of health facilities and SIS in some regions have responded to the situation by unofficially attempting to reinstate the aforementioned targeting mechanism based on socioeconomic evaluations (findings from in-depth interviews/POLICY core package) such that only the poor are eligible for SIS coverage. The result has been the arbitrary and inconsistent application of the SIS, leading to confusion and uncertainty for clients who expect but do not receive free services.

Kenya: National and Subnational Policies and Practices

Policies and Practices Related to Improving Access to Health Services

Kenya’s National Health Sector Strategic Plan 1999–2004 aims to provide affordable and accessible health care to all Kenyans. In translating the vision into practice, the plan defines national priority health packages to be provided by the public health sector. Per the Poverty Reduction Strategy Paper, the government is committed to shifting financial, human, and other resources from curative to primary health care in order to improve equity and increase cost-effectiveness in the health sector. The government expects that poverty reduction will result from improvements in the health status of the poor through increased coverage and access to primary health care.

The government’s policies on increasing access to health services are tied to the expanded availability of services—all underlain by the issue of health care financing. The key strategy is to decentralize the implementation of the priority health packages to the districts and thus minimize loss of resources due to inefficiency. The improvement in efficiency is perceived as helping to increase access through the availability of “additional” resources for service provision. Another strategy is to create an enabling environment that will encourage other providers to participate in the delivery of health care services. The national strategic plan proposes to rationalize human resources in order to reduce the concentration of key health personnel in urban areas. Given that the majority of the population resides in rural areas, redistribution and deployment of health staff to rural areas would increase the availability of services and improve the rural population’s access to services. To enhance the use of public health facilities and hence access, the strategic plan calls for strengthening planning activities and managing drugs and other medical

² At the outset, the SIS focused on the same population groups as the SMI—pregnant women and children. However, over time, its mandate expanded to include children and adolescents age five to 17 years as well as specific adult groups.

supplies to ensure constant availability of safe, efficacious, high-quality, and cost-effective pharmaceutical products (Republic of Kenya, 1999).

Financing Mechanisms for Health Services

The main sources of health care financing in Kenya are public taxes, households' out-of-pocket expenditures, employer contributions to health insurance, and donors. As documented by the Republic of Kenya (1999a), the government was the major source of health financing, accounting for 47 percent of health care funding. In addition, the cost-sharing program (tied to user fees) is one of its major health financing reform initiatives. The guiding principles of the user fee program call for 100 percent retention of revenue in districts, of which the collecting facilities retain 75 percent, with the remaining 25 percent allocated to preventive and promotion activities at the district level; local planning for use of the revenues; the application of collected revenues to supplement and not substitute for allocations from the central government; user fees to increase with the level of health facilities to promote use of dispensaries and health centers; and the vigorous pursuit of reimbursement from the National Health Insurance Fund to enhance program equity (Republic of Kenya, 2002).

Responsibility for the organization and management of the user fee program rests with headquarters and the provinces, districts, and facilities. The provinces are responsible for the overall management and supervision of user fee activities in the respective provinces. At the district level, two groups are charged with management of the program—the District Health Management Board (DHMB) and the District Health Management Team (DHMT). The DHMBs were established to enhance community participation and ownership of the program. As such, a DHMB represents key stakeholders in its district and is primarily responsible for overseeing the provision of health care services in the district and ensuring client representation and prudent use of user fee revenue. In addition, the DHMBs recommend areas for the imposition of user charges and review/amend/approve plans and budgets for spending user fee revenues. The Ministry of Health (MOH) has allowed the DHMBs to set fees, which must be approved by the Provincial Medical Officer, who then informs the Health Care Financing Division of the charges (Republic of Kenya, 2002). The DHMTs, on the other hand, plan and coordinate district health activities. With respect to user fees, the DHMTs supervise the collection of user fees, monitor facility expenditure from user fee revenues, monitor service improvement and the impact of fees, and plan and implement primary health care (PHC) in their districts. The facilities collect user fees and prepare and implement expenditure plans for the 75 percent of retained user fee revenues (Republic of Kenya, 2002).

Policies and Practices Related to Targeting Resources and Ensuring Equity

When Kenya introduced its public sector cost-sharing program for health care, it instituted waivers and exemptions to enhance access to health care services among the poor and other vulnerable groups (Quick and Musau, 1994; Republic of Kenya, 1996; Owino, 1998). Waivers are a direct protection mechanism for the poor. The Republic of Kenya (2002) defines a waiver as a release from payment based on financial hardship at a particular time. A waiver is not automatic, however; a patient must request a waiver and await a ruling based on predefined procedures and criteria involving a two-step process. In the first step, a person, usually a service provider, recommends a waiver by completing a waiver application form and forwarding it for approval. The second step consists of authorization of the waiver, usually by facility administrative staff. Patients likely to be granted waivers include students away from home, patients with chronic illnesses that are not automatically exempt, and patients who have spent money to travel long distances to a health facility. A hospital's Health Administrative Officer is required to ensure that the waiver application forms are always available, inform all facility staff about the operation of the program, inform all patients about the program, and make sure that staff members are always available to grant waivers. For purposes of recordkeeping, the waiver application forms should be serialized and printed in duplicate in book form (Republic of Kenya, 2002).

In contrast to a waiver, an exemption is an automatic excuse from payment based on a patient's meeting certain criteria. The four types of exemptions are patient exemptions (children under five years, certain students, prisoners, and destitute individuals); exempt outpatient services (maternal and child health services); exempt illnesses (HIV/AIDS, tuberculosis, and leprosy); and exempt inpatient services (downward and upward referral). In Kenya, the criteria for exemptions are based on history taking and close observation of the patient's socioeconomic status and that of relatives. Exemptions must be registered in the relevant department's service register, stating clearly the specific reason for the exemption (Republic of Kenya, 2002).

Specific Policies and Practices Related to Maternal Health

The National Reproductive Health Strategy 1999–2003 undertook the following activities to reduce maternal and child morbidity and mortality: providing comprehensive ANC services at the facility level, conducting outreach maternal and child health (MCH) services, strengthening laboratory services to support MCH, establishing and maintaining appropriate referral mechanisms at all levels of care, procuring and distributing basic obstetric equipment and essential equipment for ANC, and training and updating skills of service providers (Republic of Kenya, 1998). To reduce the burden of disease attributed to perinatal and maternal causes, the MOH defined national priority health packages in the National Health Sector Strategic Plan 1999–2004, including reproductive health care. The main components of the reproductive health care package are family planning, safe motherhood, child survival, management of sexually transmitted diseases and HIV/AIDS, management of infertility, and gender issues and reproductive rights (Republic of Kenya, 1996).

With the implementation of its user fee programs, Kenya continues to provide preventive and promotion services—such as FP, ANC, postnatal care, and child welfare—at no charge (Quick and Musau, 1994; Republic of Kenya, 1996). Therefore, the exemption list still includes ANC services, according to the Republic of Kenya (2002). Based on the exemption rules issued by the MOH in 1994, antenatal clients are exempt from ANC treatment, laboratory, and x-ray fees. Delivery care services, like most other inpatient services, generate user fees. The main categories of charges for delivery services are delivery fees and boarding fees; however, in cases of financial hardship, a mother may be considered for a waiver.

India: National and Subnational Policies and Practices

Policies and Practices Related to Improving Access to Health Services

The Health and Population Policy of Uttaranchal clearly states that “all efforts will be made to reach people in the remotest inaccessible areas.” The state policy recognizes that more than 75 percent of the population lives in rural areas and villages in noncontiguous hilly areas and that more than 50 percent of the population does not have road access. The policy also recognizes disparities in household expenditures on health care. Often, households allocate a higher proportion of financial resources to men's versus women's health care. Similarly, disparities in dietary intake place women at a disadvantage relative to men. A recent study indicates that families are often unwilling to allocate more than minimal resources to the preventive care and treatment of women (Schuler, 2002).

In an effort to improve underserved populations' access to health care, the state government has issued various orders that address decentralization to the grassroots level, spell out poverty alleviation schemes, encourage and support providers of Indian systems of medicine to serve in rural areas, and mandate government doctors and nurses to work in rural areas for a specified number of years. The various orders are aimed at enhancing access to funds and increasing hospital efficiency, thereby improving both access

to and quality of care. Hospitals will be able to offer better facilities and equipment, appropriate levels of drugs and supplies, and higher quantities of free care through cross-subsidization.

Financing Mechanisms for Health Services

The Health and Population Policy of Uttaranchal emphasizes the need for directing government resources to public health programs, particularly primary health care. It recognizes that the costs associated with secondary and tertiary health care are high and that the government alone is not able to shoulder the burden. Cost recovery measures have been introduced in hospitals with more than 30 beds. Poor and disadvantaged groups are entitled to free services. The Health and Population Policy outlines the following interventions to be conducted by the state government:

- Reviewing cost recovery measures, rationalizing user fees for various services, and simplifying procedures to generate and expand financial resources;
- Eventually allowing health institutions to retain the full amount of revenue they generate (as opposed to the current arrangement that requires half the revenue generated by health institutions to be retained by the institution and the remaining half to be deposited in the treasury), thus allowing for greater flexibility in providing financial resources to health institutions and motivating the greater involvement of service providers in health care delivery; and
- Making health insurance available in the private sector to increase the number of households opting for health insurance and exploring the feasibility of providing health insurance coverage for poor and disadvantaged groups unable to afford insurance premiums.

The government of Uttaranchal issued an order in March 2003 establishing a Medicine Management Committee under the chairmanship of a District Officer. The main objective of the committee is to procure funds of various sources “autonomously and independently” and to use the funds to extend services and improve quality. The committee is allowed to procure funds from sources such as user fees, donations, and funds received in lieu of other services. The committee is also responsible for upgrading, modernizing, and maintaining government hospitals to ensure the delivery of sustainable, high-quality services. The state government issued several orders specifying guidelines that health care facilities are to follow when setting, collecting, retaining, and using user fees; identifying and applying exemption mechanisms; and managing resources. One government order stipulates that 50 percent of funds received from user charges are to be deposited in the state treasury, with the remaining 50 percent to be used by the Medicine Management Committee for improving hospital services.

Policies and Practices Related to Targeting Resources and Ensuring Equity

At present, Uttaranchal is witnessing considerable disparity in the health status of the population living in different regions of the state and among various groups. The Health and Population Policy recognizes an urgent need to address equity issues by establishing a health system that focuses on regional and geographic disparities, gender issues, and class/caste inequalities.

Per the government order of March 2003, patients who are destitute, under trial, or receiving emergency treatment are exempt from registration fees or other types of service/facility fees. The state’s Public Distribution System (PDS) issues White Ration Cards to identify individuals below the poverty line. Family members identified/certified under the PDS scheme receive free treatment and clinical services as out-patient department patients and may be admitted to general wards of hospitals. If any poor person does not have the ration card, the hospital administrator can decide whether to provide free medical services per the government’s intent. Honorable Legislators, former Legislators, Freedom Fighters, and their dependents continue to receive free medical services as provided earlier. Retired government

workers continue to receive the same medical services after retirement as permitted on the date of retirement.

Specific Policies and Practices Related to Maternal Health

The Uttaranchal policy seeks to reduce the MMR from 400 per 100,000 live births to 250 per 100,000 live births by 2006 and further to 100 per 100,000 live births by 2010. To promote safe motherhood and primary health care, the state government trains selected village women in midwifery and primary health care and provides these women with the necessary logistical support to offer high-quality services.

Substate and facility guidelines place strong emphasis on effective implementation of national programs and compliance with state government policies and directives. Within this context, a government order states that the Medicine Management Committee is responsible for supervising and inspecting nationally mandated but state-operated programs such as maternal and child health, AIDS control, family welfare, and other programs.

Egypt: National and Subnational Policies and Practices

Policies and Practices Related to Improving Access to Health Services

A presidential decree (1975) states that the Ministry of Health and Population (MOHP) is responsible for the preservation of the health of the Egyptian people through the provision of preventive and curative services. All Egyptians may access health care through the MOHP regardless of economic status. Provisions of the Egyptian constitution contain statements such as, “The State shall guarantee equality of opportunity for all citizens; The State shall guarantee the protection of motherhood and childhood.” In effect, the constitution says that resources should be distributed according to need and based on equality of opportunity. In recent years, the government of Egypt and the MOHP have focused on improving access and quality of health services in Upper Egypt and rural areas.

Financing Mechanisms for Health Services

The government of Egypt and the MOHP have interpreted their mission in terms of a classic public investment approach whereby the government is the prime financier of primary health care, including MCH services. The MOHP offers highly subsidized health services. Public facilities receive budget support from general revenues. MOHP facilities are numerous, with approximately 4,000 to 5,000 units for a population of 70 million. To improve access to services in Upper Egypt and rural areas, the MOHP has purchased several hundred mobile vans that deliver services at no charge. In addition, the Health Insurance Organization (HIO), operating under the auspices of the MOHP, provides health care to employed people and is financed through a combination of earmarked contributions from beneficiaries and employers, user fees, a cigarette tax, and the government.

The MOHP issued several decrees or financial regulations to facilitate the implementation of national policies at the governorate and facility levels. The basic decree calls for the formation of nine-member hospital boards, with members consisting of public representatives, an NGO representative, the governor, and a hospital director. The board can suggest any amendments to treatment fees according to the socioeconomic condition of the governorate. Accordingly, ANC follow-up fees and delivery fees may differ from place to place depending on the rules suggested by the hospital’s board and accepted by the governor.

In public facilities in Egypt, morning and afternoon sessions operate differently with respect to fees. All patients except those receiving immunizations and family planning services pay an “entrance” fee of one Egyptian pound (or US\$.17) from 8:00 a.m. to 11:00 a.m. Clients pay no other service fees but must pay for commodities. In the afternoon, an “economic services” system is in place such that clients pay for both services and commodities. The poor may be granted a waiver. The quality of services provided in the morning versus afternoon does not differ.

ANC services, including physician consultations, laboratory tests, and a follow-up health card, are provided free in MOHP facilities. Clients must, however, pay one Egyptian pound for iron tablets and vitamins. After official working hours, the facilities may charge a total US\$1.63 for routine laboratory tests. In addition, the official fee for an ultrasound is US\$0.82. Normal delivery costs range between US\$3.26 and US\$4.90. Women who cannot afford to pay the fees are eligible for free delivery services. According to financial regulations, the revenue collected in the afternoon under the economic services system is distributed as follows: 8 percent to the district health department and governorate, 52 percent to health center employees, and 40 percent to health center expenses.

Policies and Practices Related to Targeting Resources and Ensuring Equity

The recent emphasis on health reform supports the notion that public subsidies should target the disadvantaged. In Egypt, one of the primary aims of health reform is to ensure that the poor are protected by a social safety net and enjoy access to high-quality services. However, the nation needs a consistent definition of poverty.

The MOHP focuses on two segments of the population. The first group is the general population, particularly the rural and the poor served through a network of government out-patient clinics, mobile vans, and publicly financed hospitals. Services for this group are provided at highly subsidized prices. The second group is families for whom the government has pursued a strategy of partially financing services for employed persons and their families. This group is served by the HIO, which manages a social insurance program with services provided through its own clinics and hospitals. The government expects the HIO to operate on a cost recovery basis with minimal public support.

In Egypt, a woman may receive waivers from all or part of the delivery fee after submitting a request stating her financial status. Facilities also conduct social surveys to study users’ financial status and determine their eligibility for free services. Women receive all supplies free of charge as well as a maternal card for free immunization services. As indicated, all services offered in MOHP mobile vans are free.

Specific Policies and Practices Related to Maternal Health

The government of Egypt has endorsed a comprehensive approach to women’s health with a focus on reducing maternal mortality, a major goal of the MOHP’s National Five Year Plan (1998–2002). The Directorate of MCH under the Division/Sector of Primary Health Care of the MOHP oversees and implements efforts to reduce maternal mortality. The national plan directed particular attention to improving the quality of delivery care and encouraging appropriate care-seeking behavior. At the national level, the MCH Directorate has defined a package of MCH services that includes basic and comprehensive essential obstetric care for normal delivery and management of obstetric complications. The MOHP developed and officially approved clinical protocols and service standards for essential obstetric care. A series of administrative decrees has addressed quality of care with respect to the presence of a senior obstetrician during deliveries, midwife training and licensing, improvement in blood services, and use of facility-generated revenues for local service improvement.

Under the national plan, Egypt saw more than 170 maternity centers upgraded in underserved urban and rural areas to provide safe and clean delivery services and to be able to refer pregnant women with complications. Seventy-five rural postnatal care units have also been upgraded to offer normal delivery care and to improve linkages with referral centers.

Vietnam: National and Subnational Policies and Practices

Policies Related to Improving Access to Health Services

Vietnam's Strategy for People's Health Care and Protection 2001–2010 emphasizes "secured access to primary health care services as well as access to and utilization of good quality health services for every inhabitant." The strategy recognizes the need for both fee exemptions and the gradual replacement of direct charges by health insurance. At present, the government does not target social assistance and fee exemptions to those most in need and has yet to articulate a clear exemption policy for the cost of commune health services, an important source of care for the poor.

Financing Mechanisms for Health Services

Vietnam spends an estimated 5 percent of its gross domestic product (GDP) on health. While the government is the main source of funds for reproductive health care, other sources include health insurance, hospital and service fees, funds from bilateral and multilateral cooperation, NGOs, and community contributions.

In 1989, Vietnam introduced an orthodox stabilization program that called for opening up the pharmaceutical industry, legalizing private health care services, promoting health insurance, and introducing a cost recovery system for user fees at the country's three levels of health facilities. The user fee system allowed facilities to charge between US\$0.07 and US\$0.27 for a basic consultation and additional fees in accordance with the type of service and medications provided. The user fee system underwent a series of modifications in 1993, 1994, and 1995, granting hospital directors responsibility for collecting fees and authorizing exemptions, reducing health care workers' bonus from 35 percent to between 25 and 28 percent, and increasing nonwage expenses from 60 to 70 percent. Some anecdotal evidence suggests that facilities do not adhere to the modifications (Sepehri et al., 2005).

In 1993, the government introduced a social insurance scheme that includes both compulsory and voluntary components. Included in the compulsory component are the costs of inpatient and outpatient treatment at state facilities. The compulsory component applies to current and retired civil servants and employees of state organizations and private organizations of greater than 10 people. The voluntary component covers the remainder of the population, with school children constituting the vast majority of enrollees (about 90 percent). Fees for clients enrolled in the insurance scheme are cost-based and tend to be higher than fees charged to the uninsured (Sepehri et al., 2005).

In 1998, the Vietnamese Ministry of Health introduced user fees for the public system's provision of services and drugs. Fee collections increased dramatically such that they have become an important source of health financing, and, in 1998, accounted for nearly a third of all hospital revenue. Informal payments from patients compensate for the low salary of health staff. A recent study on informal payments made to health care providers in Vietnam found that under-the-table payments accounted for up to 36 percent of hospital fees and 19.6 percent of total hospital bills for patients receiving higher-quality inpatient care. For patients receiving standard inpatient care, the fee ratios were 10.1 and 7 percent, respectively (Sepehri et al., 2005). The government encourages public hospitals to collect more

user fees to increase staff salary. In 2002, only 15 percent of the population was covered by health insurance, and another 5 percent was covered by other prepayment schemes.

A recent benefit incidence analysis revealed a tremendous difference between the nominal and real public subsidy in Vietnam. The official accounts indicate total user fee revenue of 436 billion VND (US\$32,864,313.35) in 1998; however, this figure is only one-eighth of the total amount that individuals reported paying for care in public hospitals, excluding payments for drugs. The analysis also indicates that the poorest receive the smallest share of public subsidy (World Bank, 2002).

Policies Related to Targeting Resources and Ensuring Equity

Vietnam's policies place special emphasis on improving the quality of health services in mountainous and remote areas. In particular, the government has formulated several policies to reduce the burden of medical expenses on the poor:

- Decision 139/2002/QĐ-TTg: Establishment of Health Care Fund for the Poor created a fund to increase government spending on health, channeling additional resources to subsidize those unable to pay for health care.
- Interministerial Circular 77/2003/TTLT-BTC-BYT on Implementation of Voluntary Health Insurance is a policy aimed at assisting farmers and other members of the informal sector in joining health insurance schemes and increasing fund pooling and risk sharing within a community.
- The government has piloted community health insurance schemes to find the most appropriate and feasible financing approach to support the poor.

Specific Policies Related to Maternal Health

Vietnam's National Strategy on Reproductive Health Care 2001–2010 outlines guiding principles and objectives as well as actions to be taken in reproductive health care (RHC) over the next decade. In particular, the strategy guides relevant ministries and committees, government agencies, NGOs, and the private sector in conducting activities—appropriate to the various institutions' respective functions—designed to improve the quality and sustainability of RHC in general and maternal health care in particular. The strategy aims to improve the health status of women and mothers through a more even reduction in maternal mortality and morbidity, prenatal deaths, and infant mortality in different regions and among various target groups, with special attention to disadvantaged areas and beneficiaries of government policies. The strategy also clearly identifies policies that should be promulgated to support the national RHC strategy, including those aimed at achieving equality and narrowing the gap in RHC provision in general and maternal care in particular in urban and rural areas, among all regions, and among all target groups. Such policies may take the form of a full or partial exemption of RHC service charges.

Consistency among National, Subnational, and Facility Policies

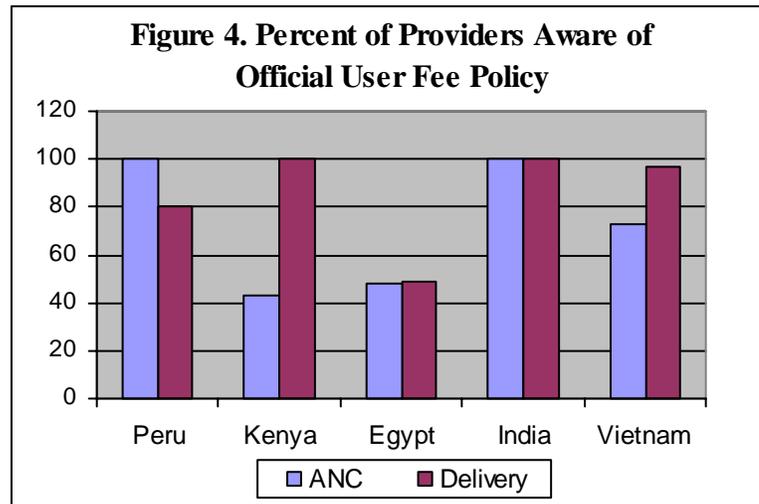
In most of the selected countries, national policies support the implementation of user fees, exemptions for the poor, and improvement in access to health care for women and segments of the population living in geographically inaccessible and underserved areas. To implement their national policies, governments have issued several operational guidelines and orders/regulations addressing authorities at the subnational and facility levels.

6. Practices and Perspectives at Facilities

Providers' Knowledge of Policies Governing User Fees, Waivers, and Exemptions

Formal and Informal Antenatal Care Fees

Across the countries included in this study, providers varied in their knowledge of the official ANC user fee policy. For example, most providers in Peru were aware that all women are entitled to antenatal, delivery, and postpartum services at no charge. Conversely, in Kenya, less than half (43 percent) of providers were aware that ANC services are exempt from user fees for all clients. In Egypt, 48 percent of respondents reported the absence of official fees, in accordance with the Government of Egypt's mandate that MOHP facilities must provide ANC services at no charge (see Figure 4).



Providers in all five countries reported that clients pay additional fees for ANC services. In Peru, fees range from US\$1.49 to US\$1.79 for the first ANC visit even though the client is required to pay only US\$0.30 for enrollment. Twenty-four percent of Peruvian providers reported additional fees of US\$5.97 to US\$14.92 for laboratory tests. Providers in Kenya reported that ANC user fees range from US\$0.13 to US\$4.57. In India (Uttaranchal), providers reported an official ANC fee of US\$0.04 to US\$0.11, with 70 percent of providers charging US\$0.11. However, providers also reported that, on average, women pay an additional US\$2.21 and up to US\$4.98 for nutritional supplements and, for women preferring to bring their own supplies, US\$0.11 for syringes. In Egypt, where ANC services are supposed to be free, 87 percent of providers reported that the fee ranges between US\$0.16 and US\$0.18. During the economic clinic hours, 77 percent of providers reported that fees increased from US\$0.49 to US\$0.57.

Among the providers asked about a woman's ability to secure a waiver or exemption for ANC services, the responses varied, although the waiver issue did not pertain to Peru, which is supposed to render services to all clients without charge. In Kenya, respondents reported that waivers were an option for women unable to pay for services, though only 38 percent of respondents reported that the population in their facility's catchment area was aware of the waiver option. The vast majority (95 percent) of Egyptian respondents stated that it was not possible for a woman to receive services for free; of the remaining 5 percent of respondents, 3 percent reported that services were already provided free.

The majority of respondents in India (Uttaranchal), Egypt, and Vietnam reported that ANC staff generally did not ask clients for additional payment, though clients may pay for speedy work. In India (Uttaranchal), all respondents specified that neither admissions clerks nor doctors ask for additional payment, and most (94 percent) reported that nurses and midwives do not request additional payment. In Egypt, the vast majority of respondents stated that clerks and workers (82 percent) and doctors, nurses, and midwives (84 percent) do not ask for additional payment. Similarly, most reported that clerks and

workers (89 percent) and doctors, nurses, and midwives (92 percent) do not ask for in-kind gifts. In Vietnam, 17 of 18 respondents reported that registration clerks do not ask for additional payments; 18 of 19 respondents reported that nurses and midwives do not ask for additional payments; and all respondents reported that neither doctors nor other staff members ask for additional payment for ANC services.

Respondents in India (Uttaranchal) reported that, in addition to the official fee, women may incur out-of-pocket expenses for food, lodging, child care, wage loss, and so forth when they seek ANC. When a hospital does not perform certain laboratory tests or stock certain medicines, women spend approximately US\$0.33 to US\$0.89 on tests and US\$0.44 to US\$2.77 on medicine. Approximately 20 percent of respondents pointed out that women spend on average US\$0.66 on food while 30 percent of respondents stated that women may pay on average between US\$1.11 and US\$1.66 for transportation to the facility.

Formal and Informal Delivery Fees

Provider knowledge of a nation’s delivery fee policy differed from country to country (see Table 5). In Peru, 80 percent of respondents recognized that the SIS fully covers charges for delivery services; however, 18 percent of respondents did not know whether women are charged for delivery services or medications. While all Kenyan providers were aware of the official delivery fee, the amounts charged varied widely. Health center fees ranged from US\$1.04 to US\$13.05 and district hospital fees from US\$6.52 to US\$24.14. Indian providers were well aware of the delivery fee structure and the varying amounts charged for different services. Fifty percent of respondents reported that delivery fees range from US\$4.43 to US\$5.53; the remaining 50 percent stated that delivery fees vary with type of ward, complications, and so forth. In Egypt, providers were split in their knowledge of delivery fees, with 52 percent reporting no fee for delivery and 49 percent reporting the cost of delivery between US\$0.16 to US\$4.96. Vietnamese respondents reported that the official delivery fee ranges from US\$3.28 to US\$19.65.

Kenya	1.04–24.14
India (Uttaranchal)	4.43–5.53
Egypt	0.16–4.69
Vietnam	3.28–19.65

Of the countries included in this study, only India (Uttaranchal) and Egypt reported that skilled attendants are available to assist in home deliveries. Furthermore, in India, only field workers trained in midwifery respond to emergency calls and assist during home deliveries; doctors and nurses from health facilities do not assist in home deliveries. In Egypt, 63 percent of providers reported that their facility makes personnel available to assist in home delivery. All providers who responded that their facilities employ personnel skilled in home delivery stated that there is no standard fee for the service; however, 21 percent did state that charges vary with the type of service provider (nurse, midwife, doctor, or other) attending the delivery.

Nearly all Kenyan providers (97 percent) reported that waiver systems were set up for delivery services. Conversely, in Egypt, 82 percent of respondents stated that women could not receive free delivery care.

In India (Uttaranchal), Egypt, and Vietnam, providers reported that most staff members do not ask delivery clients for payment beyond the official fee. In India (Uttaranchal), only 20 percent of respondents mentioned that nurses or midwives may ask clients to make additional payments for delivery services, especially for delivering at night or providing high-quality care. According to 50 percent of interviewees, lower-level staff, including ward *aayas* and sweepers, generally ask for additional payment for providing services such as changing bed sheets, laundering clothes, and cleaning rooms. In Egypt, slightly more respondents (58 percent) stated that staff members do not ask delivery clients for additional payment. In Vietnam, the vast majority of respondents reported that nurses or midwives (five of 12

respondents), doctors (17 of 17 respondents), and other staff members (15 of 15 respondents) do not ask delivery clients for payment in addition to the official delivery fee.

In addition to unofficial monetary payment for delivery services, staff may ask for or receive unsolicited gifts from delivery clients. In India (Uttaranchal), 25 percent of respondents indicated that nurses or midwives receive sweets, especially following the birth of a boy. In Egypt, most respondents reported that staff (82 percent) and clerks (79 percent) did not ask clients for in-kind gifts.

Consistency Between Policies and Practices as Reported by Key Informants

Generally, the countries were divided with respect to the consistency with which they follow their respective government's policies on user fees. Government policies mandate the free provision of all maternal health services in Peru and all ANC services in Kenya; however, providers reported that clients still pay for these services. In India (Uttaranchal) and Egypt and for delivery services in Kenya, government policy allows facilities to recover costs for services—and facilities do so.

We observed minimal consistency between official policies governing maternal health user fees and practices as reported by providers. In Peru, while providers were aware that national policy mandates the free provision of services, the poor functioning of the SIS makes it necessary for facilities to use discretion and creativity when implementing national policy. Health facilities lack adequate funds to meet the local demand for antenatal and delivery care services primarily because (1) reimbursement from the SIS is not sufficient to cover the cost of services and (2) as long as three months might elapse before reimbursement. As a result, some facilities suspend the provision of services under the SIS for weeks at a time and charge clients for services. Other facilities require clients to pay for or provide drugs or supplies even though the SIS covers these items. When some facility directors face fiscal problems and have no choice but to charge clients for maternal health services, they institute a system whereby only poor women are eligible for care under the SIS; these directors effectively put in place a system of direct targeting based on socioeconomic evaluations.

In India (Uttaranchal), existing policies and guidelines call for instituting a nominal fee for services while granting exemptions for the poor. In view of the low levels of cost recovery and retention and use of revenues, facilities are unable to cover the cost of the complete package of services, including drugs, laboratory tests, transportation, and so forth, thus prompting providers to institute other cost recovery mechanisms such as charges for both direct and indirect expenses.

Kenya's failure to honor the centralized fee-setting structure, whereby the Provincial Medical Officer supervises the setting of fees by the DHMBs, provided an opportunity for facilities to levy charges on services that are free per national policy. The Provincial Medical Officers' lax supervision of the user fee program, coupled with the national and provincial governments' inability to enforce program requirements, has meant that the DHMBs set and implement fee structures that are generally contrary to national guidelines. An example is the charges levied by some facilities on ANC services that, according to national policy, are exempt from fees.

Conversely, Egypt demonstrates consistency between official policy and its implementation with respect to ANC services but not with respect to delivery care. Providers reported that clients pay US\$0.16 to US\$0.18 for ANC services in accordance with official policy, which permits MOHP facilities to generate income by charging for services such as consultation and laboratory tests. Clients incur additional costs ranging from US\$0.16 to US\$1.63 for iron supplements, vitamin tablets, and laboratory tests conducted after working hours. For delivery services, policy states that the fee is US\$3.26 to US\$4.90, with waivers available for women unable to pay. However, just over half of the providers included in the study had no

knowledge of the user fee for delivery care while the remaining respondents reported the fee at between US\$0.16 and US\$4.96. Interestingly, most respondents were not aware that clients could receive free delivery care services if needed. Providers are acutely aware of and implement the correct ANC user fee policy, though they lack sufficient knowledge of the delivery care user fee policy and thus do not execute it properly.

The Vietnamese policy does not specifically dictate the cost for maternal health services; however, it does establish a fund that subsidizes health care for those unable to afford it. Unfortunately, providers were not asked about their knowledge of waivers or exemptions that would make services more accessible to the poor.

7. Client Perspectives

In all five countries, the study conducted focus group discussions (FGDs) with women (and their husbands) who had received antenatal or delivery care at a health facility during their most recent pregnancy. We collected information on reasons for choosing a particular health facility, formal and informal costs of antenatal and delivery services, knowledge of exemption practices, and attitudes toward costs for ANC and normal delivery services. In addition, we conducted exit interviews with women in Kenya and Egypt and carried out a household survey in India (Uttaranchal).

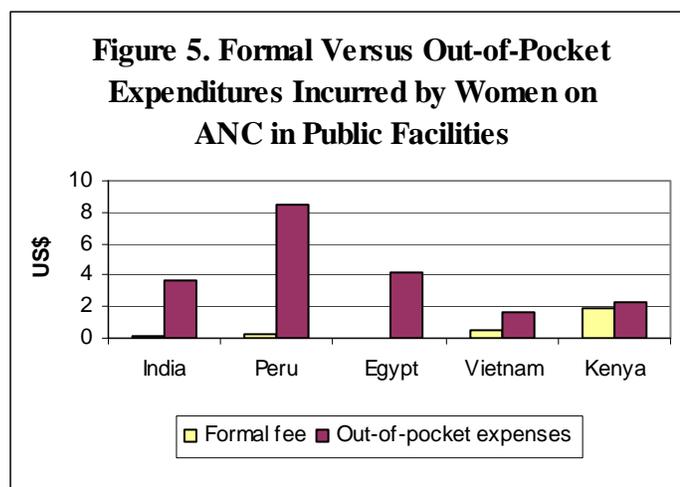
Reasons for Choosing Health Facility

Discussion of the reasons for choosing a particular health facility was limited to the FGDs in Kenya, Egypt, and Vietnam. In Kenya, the majority of ANC clients cited distance to the facility as a decisive factor in seeking ANC services, followed by quality of services and cost of services. Among women in Egypt and Vietnam, quality of services was the most important factor in their decision to seek care at a particular facility. Quality of care was also a priority for Egyptian women delivering at home and attended by a provider from a facility. For Egyptian women seeking either facility- or home-based care, the second most important factor was cost. In Vietnam, distance to the health facility was the second most important factor, followed by cost of services. Vietnamese husbands also identified quality and distance as the most important factors in determining where to seek services.

Payments by Women and Their Families

Formal and Informal Antenatal Care Fees

In all countries with the exception of Kenya, formal fees composed a relatively small part of actual out-of-pocket expenditures for ANC services. As shown in Figure 5, women in Uttaranchal paid US\$3.65 for ANC services when the formal fee was only US\$0.11. In Peru, women paid a total of US\$8.52 for ANC and only US\$0.30 of this covered the formal fee. In Kenya, the formal fee for ANC is higher than the other countries at US\$1.37; however, women still reported paying an additional US\$0.90 to receive services.



According to FGD participants in all countries, laboratory tests accounted for the highest ANC fees. In Peru, the SIS should have covered the laboratory costs, but ANC clients reported that the fees ranged from US\$1.87 to US\$4.48, amounting to between 32 and 54 percent of total out-of-pocket expenses for ANC services. Some women in Peru mentioned that they had to postpone ANC because they did not have the funds to pay for the laboratory tests. In Kenya, 54.8 percent of exit interview respondents reported that they paid for ANC services despite the fact that policy exempts ANC services from user fees; in fact, the majority paid between US\$0.13 and US\$1.30. Of the 185 women who reported paying for ANC services, 76 said that payment went to registration fees, 48 said that fees covered laboratory tests, and 46 said that payment went to provider services; other women reported that they paid for immunizations, iron

supplements, supplies, or antimalarials. It should be pointed out that even in cases where ANC clients stated that they paid registration fees, the amounts largely covered laboratory services.

In the Indian household survey, women reported that they paid an average US\$3.65 for ANC services. At least 50 percent of that amount covered for laboratory tests while the remaining amount covered medicine, transportation to the health facility, and food/lodging. The FGDs conducted with Indian women yielded varying responses about ANC laboratory fees. Participants in rural Dehradun reported that they did not need laboratory tests. Respondents in urban Dehradun did undertake blood and urine tests when advised by doctors at the hospital; urine tests cost US\$0.89 and blood tests ranged from US\$0.13 to US\$0.44. Women in both rural and urban Nainital indicated that, although the hospital performs blood and urine tests for a fee of US\$0.55 to US\$1.11, doctors may still ask patients to have the tests at private facilities, which charge US\$2.21. According to the Indian women in the FGDs, women who were advised by a doctor to undergo an ultrasound examination had to visit a private facility and pay between US\$3.32 and US\$9.96. Focus groups conducted in Egypt showed that respondents were most concerned about the cost of ultrasound tests, which are not available at most facilities. Women in need of an ultrasound test who sought services in the private sector paid US\$3.26 per test; the cost of the service in public facilities offering ultrasound was US\$0.82 to US\$0.90. In Vietnam, most women interviewed agreed that ultrasound tests, urine tests, injections, syringes, and medical registration books are not included in the standard cost of ANC services and therefore represent additional costs.

Many participants also mentioned medicines as an additional cost of ANC services. Peruvian women reported that they pay between US\$0.13 and US\$1.79 for medications. In India (Uttaranchal), respondents in all four focus groups complained that the facilities they patronize for antenatal care at all levels of the health system lack needed medicines. Government facilities make only iron and calcium supplements available at no charge to clients seeking services. Respondents believed that two supplements are available at the hospital at no charge simply because of their relatively low cost. All other medicines, if and when prescribed by doctors, must be purchased at variable prices in the private sector. Respondents reported that their limited financial resources sometimes require them to cut down on or not take their prescribed medicines. They also stated that they are embarrassed to disclose their financial difficulties to doctors and hesitate to ask providers for less expensive medicines. None of the Indian husbands from rural Dehradun who participated in focus group discussions reported the private purchase of medicines or supplies. In contrast, husbands from rural Nainital reported that while immunizations for pregnant women were available at no charge at the hospital, expensive injections, such as for hepatitis B, had to be purchased privately at a cost of US\$3.32. Male respondents from Nainital shared doubts about the quality of medicines available at no charge at government hospitals. Iron and calcium supplements are available free, but those who can afford to purchase them do not take what is offered at the hospital because the supplements are dispensed in open packages that in many cases are past their expiration date. Husbands reported the approximate cost of medicines for ANC at US\$4.43 to US\$11.07 per month or US\$33.20 to US\$99.60 per pregnancy. According to Indian husbands who participated in the FGDs, for complicated pregnancies, the cost can rise from US\$221.34 to US\$332.01 for medicine alone.

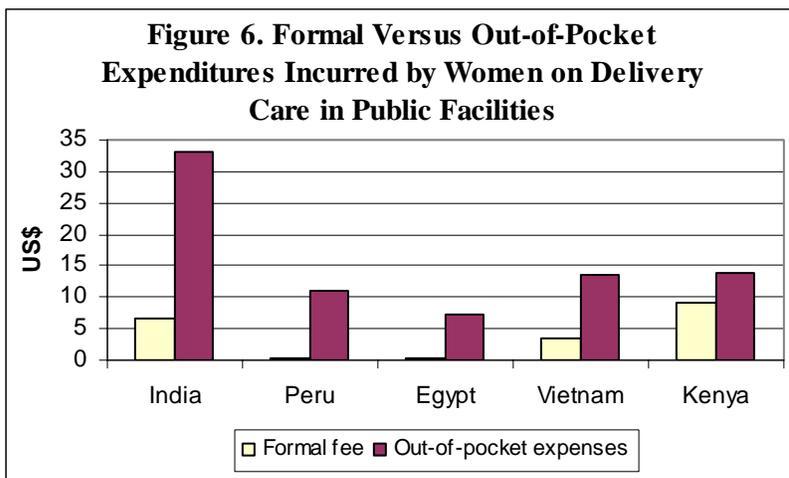
In Egypt, the need for additional medication occasioned a major cost for women. Most women received vitamins as well as calcium and iron supplements from the ANC facility either free or for US\$0.16, but only if the items were in stock. If supplies were depleted, women had to purchase the necessary items from a private pharmacy. Similarly, women with complications during pregnancy who required additional medications had to purchase the items at pharmacies, which are not subject to price controls. Twenty-four percent of respondents to the Egyptian exit survey reported that they purchased medicines for ANC service at a cost ranging from US\$0.20 to US\$6.53. The FGD participants in Vietnam were divided as to whether the official ANC fee included iron supplements and tetanus vaccines. The focus groups conducted in Peru and Kenya did not address the cost of medicines.

Several respondents in Egypt and in Kenya mentioned that they incurred transportation costs in seeking ANC services. In Kenya, the majority (76.8 percent) of exit interview clients incurred transportation costs to reach an ANC facility. Most of these respondents (80.7 percent) reported that they paid between US\$0.07 and US\$0.46. In the Kenyan focus groups, most participants reported walking to ANC facilities for services; however, most clients seeking care at district hospitals incurred transportation costs ranging from US\$0.26 to US\$0.52. Participants in the Indian household survey reported that one-third of expenses for the first ANC visit incurred by the average user of government services went to travel and lodging costs. In the exit interviews in Egypt, 77.8 percent of respondents reported that they walked to the ANC facility; the remaining 22.2 percent reported that they relied on a car/taxi or microbus. Respondents who had to pay for transportation reported fees ranging from US\$0.02 to US\$0.82. Focus group participants in Peru, India (Uttaranchal), and Vietnam did not discuss transportation costs.

Informal fees also include under-the-table payments to service providers. In all the focus groups conducted in India (Uttaranchal), respondents concurred that they were not aware of other payments made to any but the staff member they see at the health facility they visit for ANC. Of course, ANC clients interact only with their doctor, auxiliary nurse midwife (ANM), or health post worker. Interaction with the laboratory technician is limited to the time of the laboratory test, with fees limited to official fees for the test performed. Administration of injections at the hospital is the responsibility of compounders (male nurses) who do not levy a separate service charge. Respondents in all focus groups in India (Uttaranchal) stated that they made no other payments in cash or in kind for ANC. In Kenya, information from clients about informal payments was difficult to obtain given that such payments are illegal. Health care providers, the potential recipients of such payments, were adamant that they neither request nor accept informal payments; most ANC clients were similarly insistent that they do not make informal payments. However, a few FGD participants in Kenya did allude to the fact that long waiting times provide a fertile breeding ground for informal payments. None of the participants in the Peru or Vietnam FGDs reported making payments of money or gifts to ANC providers.

Formal and Informal Delivery Care Fees

In all countries there was a marked difference between the stated formal fee for delivery services and the amount women reported actually paying (see Figure 6). For example, in India (Uttaranchal) the formal fee for delivery care is US\$6.64, but women included in this study reported paying almost five times that amount to receive services. In Vietnam, women reported paying US\$13.43 for delivery care, approximately 3.5 times more than the formal fee for this service. Kenya’s formal fee for delivery is higher compared to that of other countries, though there is still a difference of US\$4.70 between the formal and the actual payments made by clients.



In Peru, India (Uttaranchal), and Kenya, respondents noted that medicines and other supplies often account for additional costs of delivery care. In Peru, out-of-pocket spending on medicines for delivery is relatively high in the three regions included in the study, ranging from 10.2 to 49 percent of total health

care costs. In the San Marco region, delivery-related supplies constituted the highest out-of-pocket cost component, at 39 percent of the total delivery cost.

Analysis of the household survey conducted in India (Uttaranchal) showed that, for institutional deliveries, consultations and medicines constituted the largest share (77 percent) of delivery expenditures. For home deliveries, respondents to the household survey reported that nearly 50 percent of expenditures went to medicines, 40 percent to consultations, and 11 percent to other costs related to complications. In the focus groups conducted in India (Uttaranchal), participants reported that they paid for delivery supplies for home-based deliveries, including injections, syringes, gloves, antiseptic, castor oil, cotton, gauze, clean bed sheets, and towels. In the focus groups conducted with Indian husbands, all respondents noted that most of the medicines and supplies required for delivery care at government hospitals had to be purchased privately. Few respondents could recollect any case in which they received medicines or supplies from the hospital itself. According to the husbands who participated in the FGDs in Nainital, the cost of medicines during a three-day stay at the hospital for delivery-related care amounted to US\$44.27, increasing to approximately US\$110.67 for complicated deliveries.

Exit interviews conducted in Kenya found that 50.2 percent of responding mothers incurred extra costs for supplies required at delivery. The average cost for supplies was highest at health centers (US\$2.39), followed by district hospitals (US\$2.28) and provincial hospitals (US\$1.28). The information gathered during the FGDs in Kenya supported the experiences reported in the exit interviews that women who seek delivery care services in health facilities are required to provide their own supplies. However, the focus groups' estimates of costs associated with such supplies diverged greatly from those given by delivery exit interview clients. The estimated costs for supplies reported by focus group participants ranged from US\$1.30 to US\$19.57, with no clear distinction between costs incurred at health centers versus district hospitals. Women in all focus groups agreed that it was less expensive to provide their own supplies for delivery services than to purchase the necessary supplies at the hospital.

In Vietnam, FGD participants responded with varying estimates of the cost of delivery services, ranging from US\$3.28 to US\$56.99. The wide range can be attributed to participants' inability to separate service fees from additional costs. Participants instead reported the total fee paid to the health facility for delivery services. However, participants did agree that any intervention resulting from a delivery complication, such as blood transfusions, injections, or medications, is not included in the service fee. In addition, the service fee did not cover bathing the newborn.

In all countries except Peru, the most commonly cited informal payment for delivery service was payment to service providers and other paramedical staff. In India (Uttaranchal), focus group participants reported that doctors assisting in facility-based deliveries did not ask for any money; however, in the case of a complicated delivery requiring surgery, participants reported that they were asked to make a payment to the hospital in the range of US\$8.85 to US\$24.35; the hospital then provided the proper receipt. Participants in the focus group in rural Dehradun reported that nurses or midwives who assisted doctors in deliveries asked for money or accepted money when offered. The amount ranged from US\$11.07 to US\$28.77. Common to all FGDs in India (Uttaranchal), other health facility staff, specifically sweepers, ward boys, maids (*ayahs*), midwives (*dais*), and garbage collectors (*jamadars*), demanded unofficial payments for services. Participants reported that demands for money started in the delivery room immediately following the baby's birth, with midwives requesting an average of US\$2.21. The total number of staff demanding payment from a woman could be as high as eight; in a rare instance, one or two staff members would ask a woman for money. Payments ranged from US\$1.11 to US\$2.21 per staff member, with the total payment amounting to an average US\$11.07. Staff members usually demand payment upon patient discharge, though respondents reported sometimes paying in advance of services to receive better treatment. All women who participated in the focus groups resented the informal costs; however, they are compelled to pay and make peace to avoid unpleasantness.

Egyptian focus group participants, both clients and their husbands, reported similar experiences, noting that staff demanded additional payments. According to discussions in Egypt, nurses and other health facility workers were much more forthright and aggressive in asking for money. Despite a cultural tradition that calls for celebrating a birth, participants acknowledged strong pressure to make informal payments to facility-based workers.

Conversely, results from focus groups in Kenya showed large regional disparities in participants' experiences with informal payments to health staff for delivery services. Focus groups attended by women and those attended by husbands indicated that none of the facilities in the Thika district demanded informal payments. As for the Kisumu district, participants reported no payments to staff at health centers, but occasional cash payments ranging from US\$0.65 to US\$6.52 at district hospitals. At the other end of the scale, all focus groups reported that informal payments to health staff are a normal occurrence in all three facilities in the Bungoma district.

Focus group participants in India (Uttaranchal) and Egypt commented on fees paid to health care workers attending births at home. In India (Uttaranchal), respondents reported that ANMs received no fixed fee for home delivery; however, the same respondents reported that they paid ANMs amounts ranging from US\$8.85 to US\$11.07 as an "honorarium" for their services. Respondents commented that, unlike health care workers based in facilities, ANMs did not ask for or demand payment. After the delivery, the ANM usually visits regularly and provides five days of post-delivery care for mother and child, including check-ups, injections for the mother, and eye drops for the child. The rural respondents of Dehradun reported that the only cost incurred after delivery is that associated with registration of the newborn at the health facility (US\$0.11). In Egypt, many focus group participants said that midwives and nurses who attended home deliveries did not charge a standard fee but that women or their husbands would tender money as payment for services rendered. The sum was larger than normal if a difficult birth necessitated more time or supplies provided by the birth attendant. Payments to providers based at health facilities were unofficial, with no portion returned to the health facility.

Knowledge About Facilities' Policies on Waivers and Exemptions

ANC

Generally, women in all five countries were not aware of the waiver and/or exemption mechanisms for maternal health services. In Peru, although clients were aware of the SIS and knew that they were entitled to free maternal health services, they were confused as to the types of free services available to them. Given that many women consistently had to pay for laboratory tests, they incorrectly believed that the SIS did not cover the tests. In the Kenya focus groups, all participants were aware that ANC services were free for all but the first visit; however, none of the respondents was aware that the fee for the first ANC visit could be waived. Respondents in one group knew women who had received fee waivers, but they believed that the waiver was a reflection of favoritism rather than a provision of public policy. In the Indian household survey, only 10 percent of women in the poor and near-poor categories were aware of exemptions for services in government facilities. In the Indian focus group discussions, none of the participants was aware of exemptions for ANC services. Among Egyptian ANC clients who took part in the exit interviews, 96 percent had never received free ANC services. In the Egyptian FGDs, few individuals had heard of the waiver mechanism or knew of anyone who had taken advantage of the system. Those who were aware of the waiver mechanism for either ANC or delivery care said that the government had to research the family to establish its social and financial condition. Participants also commented that the effort and paperwork necessary to receive free services was not worth the difference

in cost. As with the other countries, none of the focus group participants in Vietnam was aware of the possibility of receiving free services.

Delivery Care

In Peru, women commented that they attended delivery services with the expectation that the SIS would cover all charges; they then learned that they needed to provide their own medicines and supplies. Despite the fact that 103 (50.7 percent) of the 203 Kenyan mothers who took part in the exit interview reported difficulty in raising the money to pay for delivery services, only seven (3.4 percent) qualified for and received waivers for delivery. In the Kenyan focus groups, participants demonstrated a lack of awareness of the existence of policies on waivers and exemptions for delivery services; no participants knew of any woman who had benefited from the waiver system by receiving free delivery care. Indian focus group participants were unaware of the possibility of waivers for either home- or facility-based delivery. Respondents in both urban and rural Dehradun felt that decisions on home-based delivery waivers were likely to lie with the ANM, who is permitted to attend certain home deliveries for free. One focus group in Vietnam reported that fee exemptions were available for the poor. Participants noted that it was possible to get a reduction in health care costs, though most said such reduction was not available for delivery services.

Attitudes Toward Costs for ANC and Normal Delivery Care

ANC

Peruvian women reported that the costs incurred for maternal health services constituted a financial hardship and often posed a barrier to the receipt of professional antenatal and delivery care. Nearly 23 percent of Kenyan women interviewed at health facilities reported that current ANC charges were not affordable to the majority of women. Findings from focus groups in Kenya also indicated that most participants were not able to pay for their first ANC visit. For both ANC and delivery services, the majority of women (72 percent of poor, 60 percent of near poor, and 63 percent of nonpoor) who participated in the Indian household survey believed that services rendered in government facilities should be available at no charge. Approximately 15 to 20 percent of women across all socioeconomic classes approved of all user fees charged at government facilities. In the Indian FGDs, most participants considered their expenditure on ANC to be reasonable and affordable. Respondents in urban Nainital, acknowledging that it is not possible for the government to provide every service at no charge, were prepared to spend money on health care. Most women in Egypt indicated that the fees they paid for typical services were low. Most Vietnamese focus group participants reported the ANC fee as “normal” or “comfortable.” Despite these various findings, quantitative data show that most respondents believed that the services should be provided at no charge.

Delivery Care

In the Indian FGDs, respondents in rural and urban Dehradun were of the opinion that the cost of home delivery was reasonable and affordable primarily because it costs less than facility-based delivery. By contrast, rural respondents were wary of “unexpected” costs that might be incurred in hospital deliveries. Most respondents agreed, however, that they had to bear some of the expense for facility-based delivery care, though women with financial difficulties found medication costs inordinately high. Participants felt that medicines should be available at the hospital. Respondents from urban Dehradun commented that government hospitals could be considered expensive when all the “extra” costs (implying informal payments demanded by hospital staff) were taken into account. They agreed that clients needed to be bold and call attention to the practice of informal payments. Forty percent of Kenyan women who participated

in exit interviews felt that delivery charges were not affordable; similarly, the Kenya focus groups expressed major concern over individuals' inability to pay for delivery charges in health facilities. Vietnamese participants were divided in their opinions of user fees; women seeking delivery services at community health centers felt the cost of service to be reasonable while one focus group reported the cost as reasonable at the district health center level; one group was divided in its opinions, and the last group reported that the cost was high.

8. Case Study on Clients’ Perspectives: Payments by Women and Their Families in India

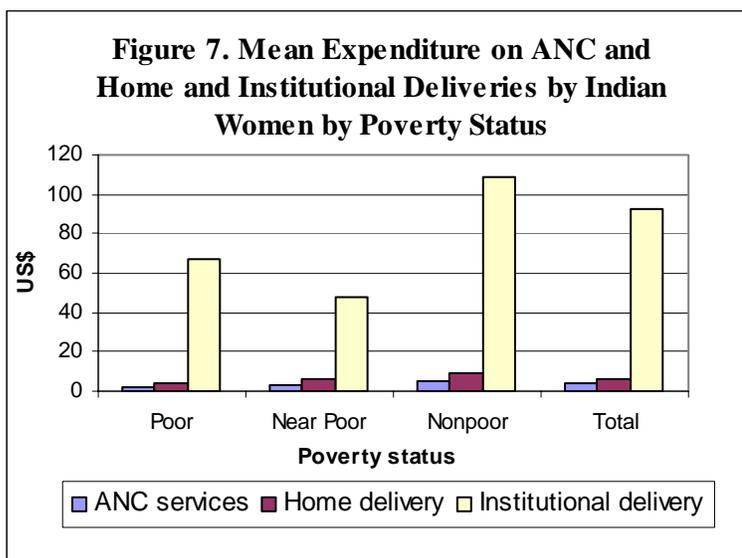
This section presents a case study of the findings of the household survey regarding ANC and birth delivery in India (Uttaranchal). It provides information on utilization, sources of care, out-of-pocket expenditures, and composition of expenditures. It analyzes the expenditures for medical supplies, tips, transport to and from the hospital, food and lodging, and hospital fees.

ANC

Utilization. Among the 575 women who were mothers of a young child, only 61 percent had used ANC services from any source. Poorer women were considerably less likely than better-off women to use ANC services.

Source of care. Out of 575 women, 122 (21 percent) reported that they received at least one ANC visit at home, 308 (54 percent) reported at least one visit to a government facility, and 137 (24 percent) reported a visit to a private facility. Government staff provided approximately 70 percent of home-based ANC services. Dependence on home-based services is relatively higher among poor and near-poor women. In addition, low-income women were far more likely to use home-based government services than their high-income counterparts (85 percent compared with 53 percent), reconfirming that the public sector can have an important role in providing outreach services.

Out-of-pocket expenditures. Over 14 percent of women who received ANC services at home from government providers reported that they paid for services (see Figure 7). Over half the women who used government services (58 percent) incurred some out-of-pocket costs—an average US\$3.65. The average cost for poor women was US\$1.88, US\$2.63 for near-poor women, and US\$5.09 for nonpoor women. For the first ANC visit, women who reported using only government services spent an average US\$0.93 while the corresponding figure for women who used only private services was US\$6.84.



Composition of expenditures. The expenditure composition is based on data for women who reported paying some amount for ANC services. For these women, the average expenditure totaled US\$3.65 in the government sector. Laboratory tests accounted for at least 50 percent of the total, followed by medicine, transportation, and food/lodging. It is important to note that one-third of the first ANC expenses incurred by an average government sector user went to travel and lodging costs, highlighting the inadequacy of outreach services.

The average consultation fee among women using only the public sector (US\$0.11 to US\$0.18) constituted 2 to 3 percent of total out-of-pocket expenditures. High out-of-pocket expenditures for

medicine and laboratory tests indicate that the government system is, to a large extent, inadvertently supporting, *de facto*, private sources for pharmaceuticals and laboratory services. Due to a shortage of essential drugs at public facilities and nonfunctional equipment, consumers are compelled to purchase medicine from private pharmacies and rely on private facilities for laboratory tests.

Delivery

Utilization. Among the 575 women who had given birth in the past two years and who had at least one living child under two years of age, about three-fourths (440 women) had delivered in their own homes or their parents' home.

Source of care. The proportion of women who had an institutional delivery increases as wealth increases. Only 7 percent of poor women had institutional deliveries as compared with 16 percent of near-poor and 44 percent of nonpoor women. Almost 85 percent of rural women delivered at home as compared with 60 percent of their urban counterparts. Furthermore, either traditional birth attendants (TBAs) or relatives assisted at about 80 percent of all home deliveries. Given that only a small percentage of TBAs are properly trained in safe delivery practices, women attended by TBAs put themselves at substantial risk. Overall, nearly 29 percent of institutional deliveries took place in public clinics or hospitals. The public sector is a particularly important source of care among poor women who delivered in health care facilities. Most of the nonpoor women (73 percent) chose to deliver at private facilities.

Out-of-pocket expenditures. A particularly high percentage of women (93 percent) reported that they incurred some costs for institutional delivery. On average, women incurred US\$92.47 for institutional delivery. The average cost was about US\$66.89 for poor women, US\$48.25 for near-poor women, and US\$108.52 for nonpoor women (see Figure 7). The average cost of using government services was US\$30.07, less than one-fourth the average cost of a private institution (US\$132.96).

Public sector providers, including government doctors, ANMs, nurses, and dais, assisted at approximately 82 percent of deliveries. About 80 percent of women reported that they incurred some costs for home delivery. On average, women paid US\$6.57 for home delivery, with the average cost about US\$4.54 for poor women, US\$5.84 for near-poor women, and US\$9.38 for nonpoor women (see Figure 7). Women who were assisted by public providers at home spent more than three times as much as women assisted by private providers, friends, or relatives.

Composition of expenditures. For institutional deliveries, consultations and medicine constituted the largest share (77 percent) of delivery expenditures, followed by food and lodging (8 percent), transportation (5.5 percent), and other costs (9 percent). For home deliveries, nearly 50 percent of expenditures went for drugs, 40 percent for consultations, and 11 percent for other costs related to complications.

9. Bringing It All Together: Policies, Practices, and Women’s Perspectives

Mounting evidence indicates that informal fees for health services account for a large share of spending when such fees are necessary for additional supplies or drugs (Schuler, 2002; Barber, 2004). Introduction of a formal user fee is intended to protect clients from the unpredictability of informal fees and other costs of access, in addition to reducing out-of-pocket expenditures. For those who can afford to pay, formal fees can potentially improve access to and availability of free services for the poor through cross-subsidization.

What Are the Formal and Informal Costs of ANC and Normal Delivery Care?

This section compares the formal and informal fees and other costs of access for ANC and delivery services for the five countries of interest. Information regarding formal fees is derived from government orders, facility records, and provider interviews. Total out-of-pocket expenses represent the actual expenditures incurred by government sector users for consultations, medicines, laboratory tests, transportation, supplies, and food/lodging for ANC or delivery services. The information on out-of-pocket expenditures is derived from the household survey and focus group discussions. Informal fees and other costs of access are calculated by subtracting formal fees from out-of-pocket expenditures incurred by public sector users:

Informal fees and other costs to access = (Total out-of-pocket expenditures by public sector users) – (Formal fees in public sector).

Table 6 shows that formal fees constitute a small portion of total out-of-pocket expenditures incurred by clients using ANC and delivery services. For example, in Peru, apart from the US\$0.30 that clients are required to pay for inscription in the SIS, all other payments indicated in the table are discretionary and therefore informal. Fees are charged when facilities run out of drugs and supplies and do not have the funds to replenish their stock. In India (Uttaranchal), insufficient stores of medicines and supplies, limited transportation options, and a shortage of laboratory equipment mean that women incur considerable informal expenses. For example, with drugs often not available at government facilities, public sector clients must rely on private medical stores to fill prescriptions. Apart from these expenses, Indian women reported that they paid for transportation, child care, and loss of wages. In Kenya, a significant proportion of costs, between 6 percent at provincial hospitals and 26 percent at health centers, was attributable to other payments, mainly supplies; formal fees did not cover the cost of these supplies.

	ANC		Delivery	
	Home	Facility	Home	Facility
Egypt				
Formal fee	0	0.00	0	0.16
Out-of-pocket expenses	0	4.18	6.53	7.20
Informal fee	0	4.18	6.53	7.03
India (Uttaranchal)				
Formal fee	0	0.11	0	6.64
Out-of-pocket expenses	0.74	3.65	5.98	33.08
Informal fee	0.74	3.54	5.98	26.44

Kenya				
Formal fee	0	1.87	0	9.17
Out-of-pocket expenses	0	2.27	0	13.87
Informal fee	0	0.40	0	8.22
Peru				
Formal fee	0	0.30	0	0.30
Out-of-pocket expenses	0	8.52	0	11.03
Informal fee	0	8.22	0	10.73
Vietnam				
Formal fee	0	0.17	0	3.60
Out-of-pocket expenses	0	1.70	0	13.43
Informal fee	0	1.53	0	9.83

Proportion of Fees That Are Formal and Informal

In India (Uttaranchal), which does not impose official charges for home-based ANC and delivery services, 100 percent of out-of-pocket expenses incurred for home-based ANC and delivery services are informal (see Table 7). Informal fees and other costs of access account for 97 percent of facility-based ANC and 80 percent of institutional delivery services. In Peru, the proportion of expenditures classified as informal is 97 percent for ANC and delivery care services at public facilities. In Egypt, ANC services are supposed to be free such that 100 percent of out-of-pocket expenditures incurred by women for ANC are informal. Overall, informal fees and other costs of access constitute more than 90 percent of expenses incurred by public sector users of ANC and delivery services in Egypt, India (Uttaranchal), and Peru.

In Vietnam, the proportion of expenditures classified as informal is 90 percent for ANC and 73 percent for delivery care at public facilities. In Kenya, the proportion of informal fees is lower as compared with the other four countries. Informal fees and other costs of access account for 18 percent of facility-based ANC and 59 percent of institutional delivery services. The high percentages of formal user fees underscore the importance of formal charges in influencing the level of utilization of delivery care services.

	ANC		Delivery	
	Home	Facility	Home	Facility
Egypt				
Informal fee	0	4.18	6.53	7.03
Out-of-pocket expenses	0	4.18	6.53	7.20
Informal fee/Out-of-pocket expenses		100%	100%	97.7%
India (Uttaranchal)				
Informal fee	0.74	3.54	5.98	26.44
Out-of-pocket expenses	0.74	3.65	5.98	33.08
Informal fee/Out-of-pocket expenses	100%	97%	100%	80%
Kenya				
Informal fee	0	0.40	0	8.22
Out-of-pocket expenses	0	2.27	0	13.87
Informal fee/Out-of-pocket expenses		17.8%		59.2%
Peru				
Informal fee	0	8.22	0	10.73
Out-of-pocket expenses	0	8.52	0	11.03

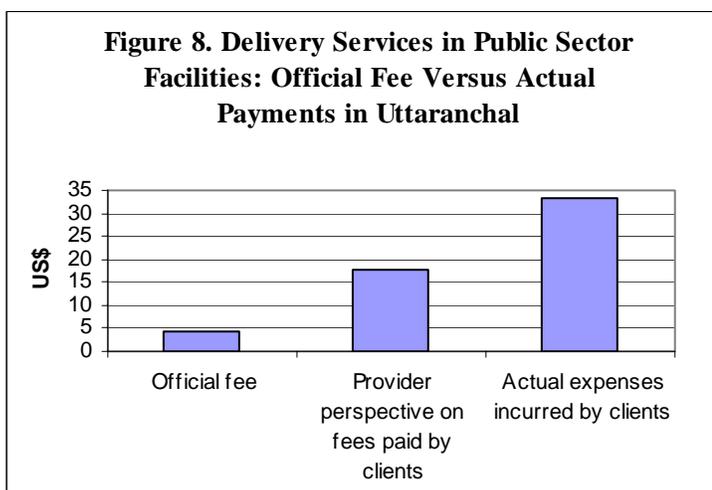
Informal fee/Out-of-pocket expenses		96.5%		97.2%
Vietnam				
Informal fee	0	1.53	0	9.83
Out-of-pocket expenses	0	1.70	0	13.43
Informal fee/Out-of-pocket expenses	0	90%	0	73.2%
<i>Note: Proportion of fees that are informal = (Informal/Total)</i>				

In India (Uttaranchal), an analysis of informal fees and other costs of access by poverty status shows that 100 percent of out-of-pocket expenses incurred by poor women for ANC and delivery services are informal. Given that poor women are supposed to receive free services at public facilities, payments for registration, medicines, laboratory tests, transportation, and food are considered informal payments. Informal fees and other costs of access account for 87 percent of facility-based ANC and 84 percent of institutional delivery services for the near poor. For the nonpoor, the proportion of expenditures considered informal is 93 percent for ANC and 67 percent for delivery care services at public facilities.

Differences Between Client and Facility/Provider Perspectives on Fees Paid by Clients

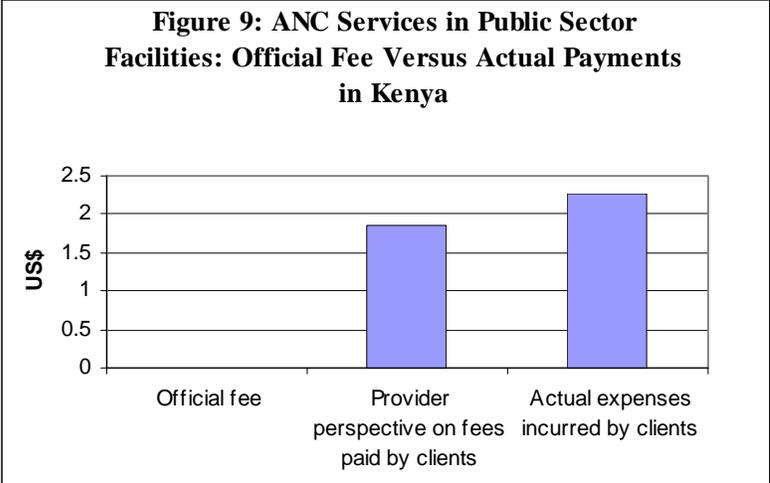
In Peru, clients and providers alike claimed that charges for services ought to be free under the SIS while providers were reluctant to disclose that they were violating SIS directives. However, almost all providers interviewed for the study complained of inadequate and delayed reimbursements owing to financial hardship for facilities. Clients indicated that they almost always had to pay something, usually for medicines or laboratory tests, and professed that the payments posed a financial burden.

The study revealed significant disparities in official fees, providers' perspective on the fees paid by clients, and what clients pay for services. In India (Uttaranchal), the official fee is about US\$4.40 for delivery in a general ward (see Figure 8). According to providers, clients incur considerable direct and indirect expenses in addition to the official fee. Often medicines, laboratory supplies, and nutritional supplements are not available at the hospital. As a result, clients pay extra for these items. Indirect expenses include transportation, food/lodging, and child care. Most providers suggested that lower-level staff such as sweepers and ward *aayas* ask for additional payments. The sum of these payments ranges from US\$17 to US\$22 for delivery services, four to five times higher than the stated fee. According to FGDs, women paid informal fees and other costs of access in the range of US\$33 to US\$44.



The Indian household survey revealed that women pay about US\$33 for delivery services in public sector facilities—an amount seven times higher than the official fee and twice the amount suggested by providers. FGDs noted that women spent between US\$86 and US\$177 on normal delivery in public institutions, a figure that corresponds with the average amount of US\$86 disclosed in the household survey and includes both public and private sector expenses.

The data for Kenya reveal a significant difference in the official fee, providers' perspective on fees paid by clients, and what clients pay for services. For example, in the absence of an official user fee for ANC services, providers stated that clients pay about US\$1.80 for ANC services while clients reported that they paid about US\$2.20 for ANC services (see Figure 9).



10. Discussion and Conclusions

This section presents the study's main finding, specifically, the financial barriers to maternal health services and policy changes to improve access to such services among poor women.

How Do Current Formal and Informal Fees Pose Barriers to Maternal Health Services?

Cost of services leads to low level of utilization of maternal health services among poor women. Despite the five subject governments' efforts and favorable policies aimed at improving service provision, utilization rates for most of the maternal health services analyzed in this study were markedly low among the poor. In India (Uttaranchal), only 7 percent of poor women had institutional deliveries. The Indian household survey demonstrates that the high cost of transportation and medicines is the main impediment for 70 percent of poor and 60 percent near-poor women. In Peru, 31 percent of poor women made no ANC visits during their last pregnancy, and as many as 83 percent of poor women delivered at home. DHS 2000 and POLICY's study on operational barriers to maternal health services in Peru cite "cost to user" as the main reason for the low level of utilization of public facilities for delivery care. Similarly, in Kenya, 29 percent of poor women made no ANC visits during their last pregnancy, and 85 percent of poor women delivered at home. Focus group discussions in Kenya revealed that the majority of women cannot afford to pay the prevailing user charges for delivery care. In addition, women's decision to deliver at home without skilled care is indicative of low levels of awareness of the procedures and waiver/exemption mechanisms, high out-of-pocket expenses, poor access to facility-based services, and cultural issues.

Poor and nonpoor women benefit equally from highly subsidized government service. Irrespective of poverty status, a large proportion of women rely on public sector services, raising the question of whether government services are properly targeted to women most in need. Table 8 shows the percentage of poor, near-poor, and nonpoor clients in India (Uttaranchal) who reported that they received free government services. Twenty-nine percent of ANC clients and 18 percent of delivery clients in the nonpoor category received free services in public facilities. Government health care facilities are not able to generate sufficient revenues to improve the quality of services and thus cross-subsidize services for poor clients.

	Poor	Near Poor	Nonpoor	Total
ANC home	84	81	80	82
ANC facility	55	46	29	41
Home delivery	17	8	4	10
Institutional delivery	25	11	18	17

Poor women incurred substantial expenses for maternal health care in both the public and private sectors. In India (Uttaranchal), poor women who paid for maternal health services in the public and/or private sector spent an average US\$1.90 on ANC, US\$4.50 on home delivery, and as much as US\$66.90 on institutional delivery. Vietnamese focus group participants reported that they spent between US\$3.28 and US\$56.99 for delivery services. In part, these costs reflect poor women's low level of service utilization. A recent study in Vietnam found that poor households with illness spend as much as 22 percent of their income on health as compared with 8 percent among nonpoor households. Poor people stretch their resources to obtain health care by reducing food consumption, selling assets, and assuming debt (Segall et al., 2000). In Kenya, although providers were well aware of the exemption policies and

mechanisms, few poor women availed themselves of free services at the facility level. Per the exit interviews, only seven (3.3 percent) of 214 mothers received waivers.

Women demonstrated poor knowledge of waivers and exemptions. Generally, women in all five countries were not aware of the waiver and/or exemption mechanisms for maternal health services. In Peru, even though clients were aware of the SIS and knew that they were entitled to free maternal health services, they were confused about the types of services provided at no charge. Given that many women consistently had to pay for laboratory tests, several incorrectly believed that the SIS did not cover the tests and thus incurred fees. In the Kenyan focus groups, all participants were aware that ANC services were free for all except the first visit; however, none of the respondents was aware that the fee for the first ANC visit could be waived. In Kenya, lack of awareness among the majority of potential beneficiaries was mainly a function of lack of publicity, which resulted from the unwillingness of some health staff to inform clients of the availability of free services. Indian household data reveal that knowledge about exemption schemes and availability of free services is alarmingly low across all socioeconomic groups. Only 10 percent of women in the poor and near-poor categories were aware of exemptions. In the Egyptian FGDs, few individuals had heard of the waiver mechanism or knew of anyone who had taken advantage of it. As with the other countries, none of the focus group participants in Vietnam was aware of the availability of free ANC services, and few participants knew of the exemption system for delivery services.

Informal payments constitute a significant proportion of out-of-pocket expenses. Per the definition of formal and informal fees presented in this study and given that poor women are eligible to receive all services at no charge, all direct and indirect expenses incurred by poor women are informal payments. Most of the costs fall into two categories: payments for services that are included in a national waiver and/or exemption mechanism such as for supplies, medicines, and laboratory services, and payments made directly to health facility staff for higher-quality care, shorter wait times, or as a general condition of service. The study reveals that informal payments constitute a significant proportion of out-of-pocket expenses. For example, informal fees account for more than 80 percent of out-of-pocket expenses in most of the selected countries. Poor knowledge and awareness of the availability of free services at the community level compounds the problem of poor women not receiving exemptions.

What Policy Changes Are Recommended to Improve Financial Access to Maternal Health Services Among Poor Women?

Despite progress, an unacceptably high level of disparity persists between the poor and the rich in maternal health outcomes and access. Growing evidence suggests that, with political support, pro-poor health policies can result in substantial reductions in health inequalities through improved access for the poor. Policy efforts that cast maternal health in the context of poverty alleviation and the reduction of inequalities require a recognition that inequalities exist. To develop and implement effective pro-poor policies and plans, countries need to take a fresh look at modes of financing basic health and maternal health care by undertaking a review of basic user fees, informal payments, indirect payments (economic costs), and the access costs imposed on poor groups (long distance, transportation to clinics, lost wages, and child care). There is an urgent need to enhance the implementation of pro-poor health policies by conducting operational analyses of barriers, thereby identifying which barriers can be addressed and prioritizing the most effective interventions. Operational analyses might include review and revision of exemption policies, simplification of means-testing mechanisms, level of financial autonomy, and reduction of informal fees to improve access to free services for the poor.

Generate Awareness among Low-Income Clients about the Availability of Free Services and Develop Community-Based Surveillance System

Both clients' and providers' poor knowledge and awareness of the availability of free services further limit opportunities for poor women to receive the exemptions to which they are entitled; thus, poor women continue to incur out-of-pocket expenses. Governments should diversify their information dissemination methods and not rely solely on providers. In some cases, providers themselves are not aware of the specifics of exemption categories and mechanisms. In other cases, given that facilities need to supplement their revenues owing to insufficient or delayed government reimbursements, providers simply ignore the mechanisms. Anecdotal evidence also suggests that providers may disregard exemption mechanisms for personal gain (Nahar and Costello, 1998; Sepehri et al., 2005).

Facilities need to ensure that information on official fees and exemptions for maternal health services is accessible to clients and that the process of qualifying for waivers is simple and transparent. Information should be displayed on bulletin boards in reception and patient sitting areas. Better counseling and effective information, education, and communication (IEC) campaigns can help generate awareness of the availability of free services for the poor. However, awareness alone is not sufficient to ensure that poor clients will receive free services. Surveillance mechanisms, particularly at the community level, must be developed to make certain that facilities are following fee and exemption policies and that information is disseminated to both clients and providers by, for example, mobilizing the community and training community members to monitor local facilities and advocate for clients' rights.

Enforce User Fees for Those Who Can Afford to Pay in Order to Generate Sufficient Revenues for Quality Improvements and to Cross-Subsidize the Poor

The magnitude of formal household out-of-pocket expenditures indicates that households may be an important source of funds for further improving the availability and quality of public sector maternal health services. The study revealed that clients currently pay for maternal health services and are willing to pay for high-quality services. However, given the nature of the user fee system in many countries, individual facilities do not have access to a considerable share of the revenues generated by formal fees that might otherwise be allocated to improving the facilities or their services. Instead, facilities must send fee revenues to the central government or not officially record the fees as health facility revenue. A system that allows facilities to retain control over their finances would permit facilities to improve services and subsidize services offered to the poor.

Based on the assumption that government services and essential drugs will be available at no cost to the poor, it is essential to improve access to and the availability of high-quality services in government facilities in order to ensure that services are affordable for poor women. Sharply focused strategies and implementation plans that target free maternal health services to clearly defined vulnerable populations, such as low-income women, rural women with poor access to services, and youth, coupled with user fees for those who can afford to pay, can improve access among these groups by minimizing financial barriers. It will be incumbent on ministries of health to supervise, monitor, and evaluate the user fee systems to ensure that the systems are properly implemented.

Rationalize Spending on Health Services

Governments need to identify available information and collect missing data in order to formulate reasonable estimates of the costs incurred by individual facilities in delivering essential maternal health services, thereby reducing the need for providers to shift the financial burden to clients, particularly the poor. Providers practicing in facilities in Kenya, India (Uttaranchal), and Peru reported that inadequate government funding prompted the imposition of user fees to cover the cost of services.

Given its limited resources, the public sector should concentrate on serving the poor either through cross-subsidizing services for those unable to pay or encouraging utilization of private sector services. Governments should consider the adoption of various mechanisms and strategies in order to create protected budget line items for the issuance of vouchers for the poor and to establish a fee structure whereby fees at higher-level facilities are greater than those at lower-level facilities. Such an approach requires effective facility supervision by ministries of health to ensure proper implementation of policies.

Another aspect of rational spending is the reduction of resource wastage and inefficiencies through, for example, the introduction of policies that increase the scope of activities that may be performed by less expensive nonphysician providers, such as nurses and midwives. Policies then need to be amended to allow facilities to be reimbursed for the full range of services provided by nurses and midwives. For example, in Peru, given that only physicians can officially provide delivery services, deliveries attended by midwives are not reimbursable.

Design and Implement Pro-Poor Monitoring and Evaluation Mechanisms

Most ministries of health set forth equity as a policy objective in their mission statements but rarely translate it into plans and programs. Ministries are not held accountable for meeting equity objectives largely because of the absence of actionable information to support advocacy efforts and improve the policy environment. Without monitoring indicators, ministries are unable to demonstrate that the poor benefit from exemption and waiver mechanisms. Development of maternal health indicators by wealth quintiles and rural-urban differences would help determine progress in achieving equity goals. Indicators could include facility-based data such as utilization of services by the poor and application of exemption and waiver mechanisms to the poor or population-based data such as contraception prevalence rates or unmet need among the poor.

Allow the Health Facility Administration to Retain and Use Collected Revenues at the Facility Level

Governments can demonstrate a high level of commitment to revenue generation, privatization, and managerial flexibility by granting essential autonomy to hospital administrators. In several countries, the willingness of the state to support, both philosophically and financially, greater autonomy for public sector facilities has been a central factor in the successful implementation of cost recovery programs. Local retention of revenue is essential to improving service quality at the facility level. At the same time, administrators need to be trained in management in order to make efficient use of the collected revenues and improve the accessibility of high-quality services. The added funds allow managers to improve services while continuing the delivery of and/or increasing free care for those who need it.

Minimize Informal Payments in Order to Make Services Affordable to a Large Number of Clients

This study shows that informal fees and other costs of access create a further barrier to services. In many cases, formal fees and other costs of access, such as the cost of health care supplies and medicines not provided by the health care facility, the cost of transportation, under-the-table payments, and the cost of food and board, leave women with little choice but to forgo antenatal and facility-based delivery care. Yet, as the study demonstrates, simply creating waiver or exemption mechanisms is not sufficient to prevent the imposition of informal fees. Both the government and the community need to take an active role in structuring fees and widely disseminating associated policies. Community members can discourage the payment of informal fees by becoming involved in management committees and boards or participating in advocacy groups that articulate the rights of the client. Citizen surveillance mechanisms are an effective instrument for ensuring the protection of client rights and the proper implementation of policies.

Improve Insurance Schemes to Include All Aspects of Antenatal and Delivery Care

Countries with insurance schemes should strengthen their systems by ensuring that reimbursements cover the cost of providing antenatal and delivery care services, that providers are not restricted from delivering services that fall within their skill set just because they are not reimbursed for providing these services, and that the application of insurance schemes is consistent across all facilities and does not impose undue financial burden on poor clients. Insurance packages should cover transportation and additional medications and supplies, especially with respect to women seeking delivery services. Other community-based financing mechanisms can be explored to help poor women access maternal health services. Although most formal waiver and exemption mechanisms do not include transportation, many countries, such as India, Rwanda, and Uganda have experimented with the inclusion of emergency transportation services in their community-based insurance mechanisms. For example, some Ugandan villages operate maternal health support cooperative insurance arrangements that fund the transport of women with difficult pregnancies to health facilities.

Conclusion

Constrained budgets and an increase in demand for maternal health services have led many countries to impose user fees. In response to concerns that the fees reduce access to such services among the poor, governments have implemented waiver and exemption mechanisms. However, the mechanisms do not address informal fees and other costs incurred by clients, and little information is available on the effectiveness of the mechanisms in increasing access to maternal health services. This study explored the impact of these formal and informal fees on the poor in five countries.

Based on the objectives set forth for the study, the major findings are as follows:

1. Clients, even in the presence of waiver and exemption systems, continue to pay for maternal health services, a large proportion of which are informal payments.
2. Waiver and exemption mechanisms do not alleviate the burden of out-of-pocket costs; more than 80 percent of out-of-pocket costs for maternal health services are informal costs.
3. Many poor clients are not able to access subsidized services because of their own and providers' general lack of awareness of fee structures and exemption mechanisms.
4. Policies that dictate facilities' use of revenues limit the facilities' ability to improve the quality of services and/or subsidize services for the poor.

Appendix: Provider Perspective—Formal and Informal Family Planning Fees

Only Kenya and Egypt were included in the portion of the study dealing with provider perspectives. In Egypt, 40 percent of respondents stated that there was no official fee for FP services. Of the 34 percent who provided a figure for FP services, most reported that the fee ranged between US\$0.16 and US\$0.18 with additional costs for the method and related supplies (e.g., IUD, pills, Norplant). Within the economic system, respondents reported FP fees of US\$0.49 to US\$0.57. In Kenya, respondents stated that government policy included free FP-related commodities, supplies, and related services (92, 88, and 52 percent, respectively). Most Kenyan providers also reported that their facility's policy included free FP-related commodities and supplies (80 and 60 percent, respectively). However, the majority of Kenyan respondents reported that FP-related services, such as laboratory tests, were not free. The most common reasons offered by respondents for differences between policies include the need to bridge the gap for related services (42 percent) and to replenish stock (12 percent). These reasons are consistent with the perception among 76 percent of facility administrators in Kenya that government funds for FP services were not sufficient to cover the costs of such services. Respondents in both Kenya and Egypt reported that clients unable to pay for FP services could receive waivers (100 and 71 percent, respectively).

Exclusive to Kenya were questions to a facility administrator regarding funding for FP services. Among the 76 percent of respondents reporting government funding as insufficient, 74 percent stated that user fees help cover some costs, 47 percent said their facility received additional funding from donors, and 90 percent reported receiving additional funding from harambees, or cooperative societies. The majority of Kenyan facility administrators reported that user fees had not affected client attendance (71 percent) and that charges were affordable (76 percent). A minority of facility administrators stated that clients were asked to provide FP-related supplies (24 percent), most of whom reported the request as a rare occurrence (83 percent). While 100 percent of Kenyan facility administrators reported that clients were able to access free service through a waiver system, 54 percent cited abuse and dishonesty as problems with the system. However, when asked to make a recommendation on how to respond to clients unable to pay for FP services, 92 percent suggested a waiver or exemption system.

Only providers in Egypt were asked about unofficial FP fees. Most respondents (70 percent) stated that staff did not ask FP clients for additional payment. Of the five respondents who said that staff requested additional payment, four reported that clients were asked to pay US\$0.08. Seventy-eight percent of all respondents reported that registration clerks did not ask FP clients for gifts in kind, and 100 percent reported that service providers did not ask for gifts in kind.

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