



APPROPRIATENESS OF USER FEES FOR REPRODUCTIVE HEALTH IN MALAWI

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ABSTRACT

The introduction of cost-sharing strategies, such as user-fees, for health care in developing countries has received increasing attention due to declining Government expenditure on health and reduced donor funding. Many developing country Governments face the dilemma of introducing fees for health care while maintaining contraceptive prevalence rates. This study conducted 16 focus group discussions with poor communities in urban and rural areas of Malawi, to identify their views on the affordability of contraception and the perceived impact of user fees on family planning use. The results show that amongst poor communities the long term health benefits of contraception are considered to be greater than a marginal increase in the cost of methods; therefore the introduction of modest fees is likely to have little impact on contraceptive prevalence. Those most likely to be affected by user fees are rural residents, for whom targeted assistance may be required to maintain contraceptive use.

**Southampton Statistical Sciences Research Institute
Applications & Policy Working Paper A04/17**

Appropriateness of User Fees for Reproductive Health in Malawi

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September 2004

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Introduction

Many countries in sub-Saharan Africa are now experiencing the long-awaited demographic transition so that the demand for family planning methods is increasing. However, high fertility in the past has led to the current large proportion of women in their childbearing years, which has put heavy demand on reproductive health services. In many countries expenditure on health has declined in real terms, mostly because of poor economic performance and also as a result of external economic factors and natural disasters. In some regions donor funding has decreased so that the issue of financial sustainability is now of high priority. One solution for health providers is to introduce some form of cost-recovery scheme so that revenue generated from such can be used to improve or expand facilities. The most common of these schemes is the introduction of user fees (Collins *et al.* 1996; Russell 1996; Gilson 1997; Thomas *et al.* 1998; Killingsworth *et al.* 1999).

The persistent high level of fertility in sub-Saharan Africa has prompted many governments to formulate population policies with clearly defined demographic targets. For example, Lesotho aims to achieve replacement level by 2011 and to raise contraceptive prevalence from the current 23 per cent to over 70 per cent by 2011 (Tuoane, 1999). The 1984 Kenyan population policy did not specify total fertility targets nor those for contraceptive prevalence but the tone of the policy suggested that fertility was very high and contraceptive use low (Ajayi and Kekovole 1998). Malawi hoped to lower its total fertility of 6.7 children per woman to 5 and to increase the contraceptive prevalence from 7 to 28 per cent by 1992 (Malawi Population Policy, undated). These demographic targets assume that contraceptive use will increase substantially over coming years. Clearly, many factors are necessary for contraceptive use to increase, primarily increasing demand and acceptability for methods and improving access should be the priorities. Thus the challenge for many governments is how to achieve cost-recovery from family planning methods and an *increase* in the contraceptive prevalence.

Impact of User Fees on Utilisation

Contraceptives are regarded by many to be *social goods* since they are perceived to benefit not only the individual couples but the general population. Thus, the impact of user fees on utilisation of such services is a major concern for policy planners. One of the concerns of introducing user fees is that contraceptive utilisation will fall, particularly among poor and vulnerable communities. Studies from developing countries have shown that after the introduction or increase of user fees on reproductive health services there is an initial reduction in use followed by a rise to previous levels (Lewis, 1986; Molyneaux and Dimani, 1991). This pattern is most common where prices increase only modestly. Huge price increases often have a larger and long-lasting dampening impact on utilisation. For example, in Bangladesh, a social marketing project increased condom prices by 60% which led to a drop in condom sales of 29% , when prices were subsequently lowered, use rates increased again (Ciszewski and Harvey, 1995).

A review of 13 studies by Lewis (1986) found that prices were generally inelastic where increases were modest. In some countries, even huge price increases did not affect the demand; for example, in Thailand when the cost of injectable contraceptives doubled there was no effect on user numbers, but this was attributed to extra efforts by the providers to retain client numbers (Lewis, 1986). In addition, the family planning program of Thailand is more mature so that price inelasticity is much more likely compared to the relatively recent programs of many African countries. Lewis also found that there was no difference in demand between low or moderately priced contraceptives and free contraceptives; suggesting that clients value commodities where they pay (even a small fee), which explains why modest fees tend not to lower utilisation (Lewis 1986; Foreit and Levine 1993). Lewis did, however, find that income was a factor in determining the elasticity of demand implying that the poor were more likely to be affected by user fees than those with modest wealth or the rich.

Many studies on the impact of user fees on health service utilisation in sub-Saharan Africa have tended to focus on curative services rather than preventive services. This causes difficulty in generalising the findings of price inelasticity of demand to preventive services, such as family planning, since these may

not be a priority for poor people (Harvey 1991). However, some lessons can be learnt; modest increases in user fees designated for specific items are more readily accepted than introducing a consultation fees (Collins *et al.* 1996; Gilson 1997). Karanja Mbugua *et al.* (1995) report that when user fees were introduced in Kenya in 1989, attendance at government health facilities in some rural areas dropped and only went back up after the *registration fee* was removed.

One of the recommendations of the UNICEF's Bamako Initiative was to use the revenue from user fees to improve the quality of health care in local communities. Indeed, this has been an argument of the proponents of user fees for reproductive health care. There is some evidence that where this works, there can be an increase in utilisation. A study in Cameroon found that when fees were introduced and the quality of health services improved, the poor increased their use (Litvack and Bodart, 1993). Of the studies reviewed by Russell (1996), those that reported an improvement in the use of health services after the introduction of fees also reported an improvement in the quality of care provided.

Ability and Willingness to Pay

Identifying a clients' ability to pay for reproductive health care is difficult. Firstly, it would involve determining the services and /or commodities foregone as a result of paying for health care. This may require lengthy determination of household income, expenditure and allocation of resources among household members. Second, most researchers and policymakers have confused the concepts of willingness to pay with ability to pay (Russell 1996; Gilson 1997). Some households may be willing to pay for health care at the expense of other vital commodities (ie: food, safe water, school fees) or may sell assets (ie: livestock, land) to finance short-term health care. However, this makes them vulnerable to lower economic productivity in the long term (Sauerborn *et al.* 1996).

To ensure that the most vulnerable people are not denied health care, most providers have exemptions or subsidy systems which offer free or heavily subsidised care to people below a certain income. However, evidence from previous research suggests that these have not been successful (Thomas *et al.* 1998;

Russell 1996). Firstly, these schemes involve high administrative costs in determining eligibility and they may be inaccurate in determining an individual's ability to pay as some household members (ie: women, young people) may be allocated a lower priority to household resources for health care. Secondly, subsidies may not be widely publicised to prevent abuse, so the poorest individuals may be unaware of the subsidies and not avail the schemes.

Self-selection is one method of providing a product at a range of prices to cater for individuals' ability to pay. This method can work successfully as clients can select a health-care option within their means (Thomas *et al* 1998). For example, variations in condom packaging may be used to obtain higher fees from those who prefer luxuriously packaged condoms and provide more affordable basic packaged condoms for poorer people. This enables the higher revenue from more expensive products/services to subsidise the health care for the poor.

One of the problems with interpreting studies of the impact of user fees on contraceptive use is that of methodology. Janowitz and Bratt (1996) identified two main methodological approaches: econometric theoretical modelling and the experimental or quasi-experimental approach. They argue that a basic problem with the econometric modelling approach is whether the model outputs can actually be used to predict real impact of price changes. Also the use of cross-sectional data may be problematic in that it fails to take into account of consumer behaviour, whereby consumers adapt their consumption patterns to the new prices (Griffin 1988). The experimental or quasi-experimental approach attempts to measure the changes in demand to actual price changes. One of the short-comings of this approach is the neglect of the issues of method or source substitution (Janowitz and Bratt, 1996). If a single provider increases prices, clients may go elsewhere to obtain supplies or they may switch to a cheaper method so that the overall impact on contraceptive prevalence may be minimal. Clearly, the impact of user fees on contraceptive use is not fully understood and more detailed research is required to fully identify the complexities of price change on contraceptive behaviour.

Context of Malawi

Malawi is ranked 157th on the UNDP's World Development Index and it has a per capita income of about \$200. Real average earnings have been falling since the 1980s, and more than half the population live below the poverty line (<\$40 per capita p.a.). Approximately 60 per cent of the rural population live in poverty and 65 per cent of urban residents are poor (Malawi Government, 1993).

Malawi's health services face huge strain due to the rapid increase in population and the very high morbidity and mortality rates. At the 1998 census, Malawi's population stood at 9.8 million, with 1.9 per cent annual growth (National Statistical Office, 1998). Fertility is 6.3 births per woman and the under-five mortality rate is among the highest in the world, with 234 deaths per every 1000 live births (National Statistical Office and ORC Macro 2001). Maternal health is also poor, more than 1000 women out of every 1000,000 giving birth die every year. Only 55% of pregnant women are attended by skilled personnel. About 17% of women have birth intervals of less than 24 months with the resultant risk of higher mortality (National Statistical Office and Macro International, 2001). The use of modern contraception in Malawi is still very low. Although the contraceptive prevalence rate has tripled since 1992, only 26% of all married women were using contraception in 2000. However, there are huge differentials in use according to socio-economic and demographic factors, and the place of residence. For example; 42% of married women with secondary or higher levels of education were using modern methods compared to 22% of women with no education, and 38% of urban women use modern methods but less than a quarter of rural women do so (National Statistical Office, ORC Macro 2001). Malawi also faces huge strains on health services because of long-term illness from AIDS. Approximately 14% of adults are infected with HIV and nearly 87,000 had died in 2003 as a result of AIDS (National AIDS Commission, 2003).

Family planning provision in Malawi has been through both the public and private sector, but only since 1987 have private-for-profit providers emerged (Ngalande Banda and Simukonda, 1994). Government health centres and hospitals offer family planning services free of charge, moderate fees are charged at

family planning clinics, such as *Banja la Mtsogolo* (BLM) and mission hospitals, while the highest fees are charges at private clinics. Prices at private outlets are unregulated and vary considerably, for example the cost treatment for a sexually transmitted infection may range from US\$0.50 and up to \$12. *Banja la Mtsologo*, a non-government organisation, is an important provider of family planning services in Malawi and accounts for 61 per cent of the market share. It operates on a market basis to recover some costs, which enables the provision of subsidised treatment for those unable to pay. Private clinics and hospitals also offer family planning services but these are small scale compared to BLM. Other organisations such as Population Services International provide condoms through social marketing.

Aims

Much previous research on user-fees has focussed on the impact on consumers' use of curative services rather than preventative health services, such as contraception. In addition, previous research has adopted a quantitative measurement approach to assessing impact, rather than seeking the views of those most affected. Although the Malawi Government has commissioned several studies to assess cost recovery from health services (Ngalande Banda and Simukonda, 1994), no previous research has been undertaken to assess the appropriateness of user fees for reproductive health services in Malawi. The central aim of this study is to identify the views of poor communities in Malawi on their current affordability of family planning services and the likely impact of introducing user-fees for reproductive health services.

Methods

The target population for this study were residents of poor urban and rural communities in Malawi, as these are likely to be most vulnerable to price fluctuations. The data were collected during 2001. Focus group discussions were used to collect information for this study as the purpose was to explore the range of influences on payment for health services amongst poor communities. Sixteen focus group discussions were conducted, eight each with men and women, each group comprised between 8-10 participants. The groups were stratified by gender and included only those within the reproductive ages of 15-45 years.

The groups were further stratified by geographic region (north, central and south) and residence (urban, rural). The three districts selected for the study were Zomba (southern region), Lilongwe (central region), and Mzimba (northern region). These districts were selected due to the large concentrations of urban poor communities and the provision of both public and private reproductive health services in the regions. Zomba district comprises a large rural population, while the urban population comprises of a small affluent community and large poor communities in unplanned settlements. Chinamwali, an unplanned urban settlement, and Makawa village were selected as the study sites in Zomba district. Lilongwe district includes the capital city, which has large unplanned urban settlement areas; Kawale Township was selected as the urban poor area, and Nzuluwanda village as the rural study site. Mzuzu city is the main urban location in the northern district, Zorozoro area was selected within the city and Nkhorongo village was selected as the rural site.

Within the six study sites participants were purposively selected with the assistance of the village chief (rural areas) or community leader (urban areas); once permission was sought these ‘gatekeepers’ were able to assist with recruiting the required participants, identifying suitable discussion times and locations. The discussions were conducted in local houses or in open areas. The fieldwork was conducted during the statutory public holidays when most residents were at home. The topics of discussion included; local employment activities, family planning service use; defining poverty; affordability of family planning; and strategies for payment of health services.

Discussions were conducted in Chichewa or Tumbuka by moderators whose characteristics were matched as far as possible to those of the respondents in terms of age and gender, so to reflect the group homogeneity. Discussions were tape-recorded, transcribed and translated into English. Data analysis involved coding the textual data by themes raised by participants and entering the coded data into the ETHNOGRAPH software package. The textual data were then analysed using *thematic analysis*, which involves identifying issues, opinions and processes from group discussions; and analysing these across the whole data set to build a comprehensive picture of collective experience. Themes are also compared

between subgroups of the target population (i.e. gender, location) to identify variations in opinions or behaviour by these strata. Verbatim quotations from respondents are used to illustrate key issues or patterns of behaviour.

Results

Participants were asked about the income generating activities within their community. In the Lilongwe urban area participants reported that the majority of men and approximately one quarter of the women in the study areas were formally employed as drivers, mechanics or office workers. In all other study sites, the majority of the community was not formally employed. In the urban areas many were vendors of clothing, firewood, vegetables, roadside snacks or brewed beer; while in rural areas the majority were involved in brick-making or farming crops such as maize, groundnuts, beans, and tobacco. Both men and women in rural areas stated that many relied on *ganyu* (casual labour) for an income.

Affordability of Reproductive Health Services

Focus group participants were asked their views on the current cost of family planning methods and whether these are affordable. In general, women considered the cost of contraception not in monetary terms but in relation to their health and to the costs of raising a child; an unwanted pregnancy was seen as a high cost compared to the cost of family planning methods. Women felt that the long term benefits of contraception were greater than the initial costs and thus thought that family planning methods were affordable. In contrast, men tended to assess the cost of contraceptive methods against the duration of protection, indicating that the condom was relatively expensive for a single sexual episode. Men also highlighted that the protective health benefits of condom use were far greater than the cost. These issues are illustrated below;

The price for the injection is appropriate because with K20 (US\$0.20) you cannot buy a baby's napkin, but you will use contraception for three months. Even the K450 (US\$4.50) for sterilisation, it's OK because it's expensive to be pregnant, this will help you for the rest of your life (urban women)

You'd rather part with K250 in order to undergo the hysterectomy than to lose your life through excess childbirth (urban women)

R1 The cost of condoms is K3.50 for pack of three. It is cheap and reasonable because the majority of people can afford to buy. Those who use them care for their dear lives as compared to the charge they pay. R4 The price generally is expensive because it is for 3 in a pack and these can only last a day. So, how much can you spend on condoms in a year? The charge is expensive. (rural men)

In addition, women contrasted the more affordable costs of temporary methods (pills, injections) against the relatively expensive costs of sterilisation. Women felt that the cost for sterilisation was harder to bear; but noted that free services were available if these costs were not affordable.

It is difficult to part with K250 (for sterilisation) whereas parting with K30 (for injectables) is bearable. The cost of the short term contraceptive is quite bearable whereas the money for the permanent contraceptive is difficult to part with since it is on the higher side. (urban women)

After visiting BLM I was scared of the charges (for sterilisation), I went back later and decided to buy condoms (rural women)

The cost of contraceptives are not so expensive to warrant consideration in the budget. After all the income is already not adequate. Anyhow family planning services are free, those who obtain them from private centres in just out of personal wish. All the same at a private hospital they don't cost that much (urban women)

Although family planning services are provided free of charge through Government health centres and hospitals, participants highlighted a range of hidden costs which mean that users still incur costs in using the free family planning services. Many urban participants walked to health facilities, however in rural areas distances to services are greater and using cost free Government services often entailed travelling

to urban areas. Rural participants highlighted the high costs of transport to access the Government services, which was a deterrent to service use. In addition, rural residents stated that they had no choice of family planning provider, so if they required family planning methods they were often compelled to pay for these at private clinics or pharmacies available locally. The following extracts highlight these issues in rural areas;

If we want to visit a government health centre then we have to pay an average of K60 per person (for transport) to and from the health centre....to hire a taxis is K350 per trip to the health centre. (rural men)

Sometimes you plan to go on a certain date, then you don't have money on that date for transport... sometimes you wait at the bus stop but by the time you arrive the clinic is closed (rural women)

Those who live close to the health centre get them (contraceptives) free of charge, while those who live far from the health centre have no choice but to buy them. (rural men)

Participants reported that the Government facilities sometimes had stock-outs of contraceptive methods, in these situations users were asked to return at a later date or were referred to family planning clinics (ie: *Banja La Mtsologo*) or private providers for methods to ensure continuous contraceptive coverage. Even though such a referral meant that free family planning would be received from the alternative services, this was often not the case and women were still required to pay for additional fees such as registration fees or pregnancy tests. For example, it is a requirement of the *Banja La Mtsologo* clinics that women undergo a pregnancy test before receiving family planning methods; the cost of this test can be prohibitive to those seeking free services and a high additional cost for those using BLM services without a referral. For example;

In some instances, at these free service centres you may be greeted by non-availability of the products and consequently you are advised to go back some time later. By that time contraception becomes a non-starter (urban women)

It sometimes happens that at free health service centre there are no medicines, so you are constantly advised to go to Banja La Mtsologo clinic, but you don't have any money. (urban women)

Some don't use methods because the Government clinics have run out of supplies and they can't afford to buy pills at the pharmacy (urban women)

When you go to BLM and say that you want to start using family planning methods they tell you that you must provide proof that you are not pregnant. So they do tests on you but you must pay for these. I think that the charges for the tests are too high. These tests should be free. So all together, you may end up paying K360. That is a lot of money especially if you are not working. (urban women)

Almost all participants highlighted that the quality of care at the Government facilities was a disincentive to availing the free services. In particular the long waiting times, poor treatment by staff and frequent stock-out of contraceptives discouraged the use of these facilities in place of cost incurring services. Many participants stated that if they have the money they prefer to utilise the BLM or private services for family planning. The following extracts show typical comments made.

As soon as you arrive at Banja La Mtsologo clinic, present your problem and declare your favourite method you are instantly attended to, so that before long you return home. In contrast, when we go to a public health facility you are made to wait intolerably long hours unattended. That's why we reluctantly take recourse to the private centre. (urban women)

If you have cash you would certainly proceed to BLM clinic because you know you would be given immediate attention and return home quickly... You would leave behind those people who were in your company and opted for the Government hospital... (urban women)

Although participants identified that the direct and indirect costs of contraceptive methods could discourage use of family planning, they also noted that cost barriers were just one of a range of barriers to the use of family planning. Participants also identified non-financial barriers to family planning use, such as fear of method side effects, desire for more children, religious opposition, husband's disapproval of contraception and method dissatisfaction. Therefore the cost barriers need to be considered within a context of other non-monetary barriers to contraceptive uptake.

Impact of Price Increases

Participants were asked whether they would be willing to pay a contribution towards the costs of reproductive health care. Participants stated that they would only be willing to pay for curative health care and would be willing to forgo essential items (ie: food) to cover the costs, as the treatment would be essential for survival; but payment towards preventative health, such as family planning, was given low priority. However, when asked if contraceptive use would continue if modest fees were introduced in Government outlets and fees were increases at BLM and other private providers, many felt that use would continue and that the costs would be covered, albeit with some difficulty, as shown below.

What if the contraceptive pill is raised from K30 to K45, would people be discouraged? We can manage to buy. We can still buy, but with difficulties. (urban women)

If prices are adjusted upwards, people automatically adjust and would go on using, not so many would be discouraged. They could go on to the extent of borrowing money so that they are able to purchase the contraceptives. (rural men)

In my view, if Banja La Mtsogolo clinic raised the cost of its family planning service the number of attendees or customers wouldn't change that much. However, potential customers from the village would be tremendously discouraged. People would want to have their desire satisfied, despite the price increases. (rural men)

Some felt that the introduction or increase in fees for family planning methods would lead to an abandonment of contraceptive use and an increase in unplanned pregnancies and transmission of sexually transmitted infections. For example;

Some will go on. If you are serious about family planning you will continue, however, if you are having difficulty making ends meet you might stop using the pills (rural women).

If the cost of the condom goes up...it would be a problem and therefore the spread of venereal diseases becomes wide. If one doesn't have K5 (for the condom), one would go ahead with unprotected sex to release frustrations because of protracted abstinence. (urban men)

It was clear that those who would be most disadvantaged by an introduction of costs or cost increases would be rural residents and the urban unemployed. Many rural participants highlighted that they currently experience difficulty to purchase essential items for survival, so would face extreme difficulty to pay for continuous contraceptive coverage if fees were introduced, as shown below;

Think of an unemployed person, where would he get money for condoms? (urban men)

If people don't have enough money to go to the hospital when they are ill, it is difficult to pay for contraceptives. You cannot buy contraceptives when your family is hungry (rural women)

There is no way of one has toiled for a whole day to do a job to earn money for food, then later on he uses it for family planning methods. If you are failing to buy food how can you put condoms on a budget? It's impossible. If I find money I will buy food for my family. I can't spend money on useless things! (rural men)

Participants stressed that they would not be willing to pay for family planning services from Government facilities, which they perceived to provide the poorest quality of care, particularly with respect to waiting times, treatment by staff and availability of supplies. Others feared that an introduction of fees would soon escalate and services would no longer be economically accessible. However, participants were more

willing to accept payment for services from family planning clinic providers (ie: BLM) or private providers as they recognised the better quality of service provided.

Cost-Sharing Strategies

Focus group participants were asked about the feasibility of a range of cost-sharing strategies, including, health care subsidies, health insurance and credit schemes. The range of issues discussed is highlighted below.

a) Subsidised Treatment

One strategy for cost-sharing of reproductive health services is to introduce a user fee with the availability of subsidised treatment for those unable to meet the charges. Subsidised treatment funds were seen as a viable cost-sharing strategy by many participants as they felt it would enable users to continue contraceptive use whereby they would only contribute a manageable amount for service use. Most participants felt that this was a fair strategy as those who are able will be charged for treatment, while the most disadvantaged would receive reduced fee treatment. However, some felt that in poor communities even a small contribution was not feasible.

Let's consider the costs at Banja La Mtsogolo which were K300...then the government introduces a subsidy to the effect that the service consumers have to pay only K100 to access the family planning service. People would discuss in their families and decide to seek the K100. Now to pay K300 to Banja La Mtsogolo clinic is so disturbingly hard because it leaves you helpless...
(rural men)

Yes, the government should help us a little. Even those of us who have a little money would appreciate government subsidies. We would be willing to pay a little. (urban women)

Are you saying that the government want us, poor people, to pay something toward our treatment? We have no money. We shall die! (urban men)

The key issue in implementing subsidised treatment schemes is the criteria used to determine eligibility for subsidies. While monetary indicators may seem a viable means to assess eligibility, participants highlighted that amongst poor communities income-based measures may be unreliable due to the high level of unemployment and that monthly income from casual or seasonal employment may be misleading. This is particularly true of rural income, for example;

If I produce some timber I'd make K300 per month. It's not possible to state [average earnings] because work can be seasonal. There are times when crops become quite affordable, such seasonal changes affect timber sales. There are other occasions when timber is plentiful at the market. What that implies is that a piece of timber that would normally fetch K20 can be sold for as low as K9. Thus it becomes difficult to estimate the average income. (rural men).

Therefore, participants stated that monetary indicators alone were not the only defining indicator of poverty but consideration also needed to be given to a range of social indicators of poverty to more clearly identify those who may be disadvantaged and require subsidised access to health services. Figure 1 shows a range of economic, social and physical indicators identified by participants which may more fully determine poverty status. Participants highlighted that any one of these indicators alone was not sufficient and may be a misleading indicator if used alone, and that a combination of social and economic indicators would be required to assess the eligibility of individuals for the subsidised treatment funds.

< FIGURE 1 ABOUT HERE>

b) Health Insurance Schemes

Participants discussed the feasibility of community-based health insurance schemes to assist with the payment of health care, including reproductive health. This may involve community members contributing to a common fund and accessing the fund when healthcare is required. Although community members saw the benefits of community insurance schemes, particularly for emergencies and when money is short, they felt that this strategy would be less feasible amongst poor communities primarily due to the lack of surplus money to contribute to the fund, particularly in rural communities where many are struggling with poverty. Participants also felt it would be difficult to decide which illness warranted

assistance from the fund and reproductive health may not be seen as a priority. In addition, high unemployment and a transient population in urban slum areas would mean that many would not contribute. There was also a fear of mismanagement of the fund and that its use may be dominated by richer or influential community members and the poorer members would lose access. These issues are shown in the extracts below:

Sometimes, an emergency difficulty occurs when you don't have money. Therefore the notion of a fund establishment would prove beneficial in that people would resort to the fund to meet health service costs. That sounds possible (urban men)

R1 I accept to have the fund set up to assist the government, but not by the poor people in villages... R5 The set back to such kind of a fund is that there will be a lot of pretences of illness in order to take the money to solve other personal problems. It will be difficult sometimes to decide on which illness could be allowed to benefit from the fund.(rural men)

We don't have money, where would we find the money for such a fund, it's very difficult... here there are only unemployed people. People in this area are rough, they might attack the chief, wanting the money to use for alcohol. (urban men)

c) Credit Schemes

The use of credit systems or borrowing money for health care costs was not seen as a viable option due to poverty and repayment difficulties amongst the poor and unemployed. The benefits of credit schemes for health care emergencies were acknowledged, but only seen as an option for richer communities and those in regular employment. Participants in urban areas noted a range of payment options with some private health care providers, including, deferred payment arrangements and payment in instalments.

Make an arrangement for deferred payments...then the use of the family planning service would be promoted that way (urban men)

In private hospital you are allowed pay in parts for an agreed period of time... (urban women)

What about if you got treatment on credit so that you could pay at the end of the month? Yes. This is okay for those who are employed. However this would not work for the unemployed. What would you pay with? (urban women).

Discussion and Conclusion

This study found that poor communities assessed the affordability of contraception not only in simple monetary terms of the cost of a method, but in relation to the health benefits of avoiding a further pregnancy and the cost of raising another child. Therefore, many residents of poor communities felt that that contraception was affordable. Many felt that the actual cost of temporary methods (pills, injections) was acceptable, and still affordable even with moderate price increases, but financing permanent methods of contraception was much more difficult. This may imply that with user-fees for family planning poor women may opt for more affordable temporary methods of contraception even though they would prefer sterilisation.

Even though family planning services are currently free of charge at Government facilities, a range of situations (ie: stock-outs) and hidden costs (transport, registration fees or pregnancy testing fees) meant that users still incurred a cost to use the free services or had to use private facilities. These costs placed a greater burden on rural residents wishing to access family planning services, either due to high transport costs to access services, or the lack of provider choice in rural areas which compelled them to use private facilities.

Would the introduction of user fees alienate the poor from access to family planning services? The findings of this research show that although poor residents may experience difficulties in finding the fee for contraceptive methods, most would continue to use contraception, as long as the cost (or cost increase) was modest. However, the introduction of user fees may have a differential impact on poor communities, with the greatest hardships placed on rural poor residents, whose incomes are meagre and dependent on unreliable crop yields. Rural communities currently face high levels of poverty and

increased costs in using family planning services, therefore the additional burden of payment for family planning would not be sustainable. In addition, the unregulated price structure of contraceptives in private outlets could also impose additional burdens on rural communities, as it is possible for prices to be higher in rural than urban areas. Although there was a willingness to pay a modest fee for reproductive health care, this would need to be accompanied by a noticeable increase in the quality of service provided. Many participants in this study were not willing to pay for current Government services, which they felt offered the poorest quality of care. This suggests that the introduction of user fees may lead to a change in consumer behaviour, with clients forgoing Government services for higher quality of care provided at other outlets.

Although the provision of subsidised treatment for those most vulnerable was seen as a positive strategy, the difficulties in determining eligibility for subsidies was seen as the critical issue. This study showed that measuring poverty solely via economic indicators is inadequate, poor communities themselves consider a range of social and physical indicators together with economic determinants in assessing poverty. Therefore, eligibility for determining access to subsidised family planning services needs to apply broader criteria and include non-monetary indicators of poverty, and reproductive health need. Other cost-sharing strategies such as health insurance or credit schemes, were not seen as viable in poor communities due to the lack of surplus cash and the high unemployment.

In conclusion, there are three key findings from this study with regard to the dilemma of introducing user fees for reproductive health while maintaining contraceptive prevalence rates. First, users of family planning in poor communities consider the non-monetary benefits of contraception to be greater than an increase in cost of methods, and therefore an introduction of modest fees is likely to have little impact on contraceptive prevalence. However, user-fees at Government facilities would need to be accompanied by an increase in quality of care in service provision, to be acceptable. Second, those most likely to be affected by price increases are rural residents and the urban unemployed, for whom targeted assistance may be required to maintain or increase contraceptive use. Third, the introduction of user fees with subsidised treatment funds appears to be a feasible strategy; however, the application of eligibility

criteria appropriate for poor communities would need to be developed. This study has provided an understanding of how poor communities themselves regard the affordability of family planning services and the likely impact of user-fees on their contraceptive use. Further research is needed to identify how households finance user fees and whether this has longer term detrimental effects, through sacrificing vital commodities to pay for family planning and thereby creating greater vulnerability amongst poor communities.

Acknowledgement

This study was funded by the UK's Department for International Development Knowledge Programme, *Opportunities and Choices*, based at the University of Southampton, UK.

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Figure 1 Type of Indicators to Assess Eligibility for Subsidised Treatment

Monetary Indicators:

- Employment status
- Type of job
- Frequency of income (regular, irregular, casual, seasonal)
- Level of savings
- Household assets, ownership of property, business or livestock

Physical Indicators:

- Physical appearance (clothing, footwear, skin, body appearance)
- Type of health services used (public/private)
- Regularity of contraceptive use (regular, irregular)

Social Indicators:

- Number of children and birth intervals
- Widowhood
- Disability
- Marital status (ie: unmarried with children)