



Appropriateness of user fees for Family Planning in Malawi: findings from focus group discussions

Introduction

Demand for health services is increasing in many African countries, particularly those affected by HIV/AIDS. Sub-Saharan Africa is experiencing the long-awaited demographic transition leading to an increase in demand for contraceptive services and STI treatment facilities. Health services are strained due to increasing population and declining public spending on health services. Introducing cost sharing measures is one solution for health providers to recover cost and generate revenue to expand provision.

The impact of cost sharing schemes on poor communities is not fully understood, but may exclude or deny access to reproductive services due to an inability or unwillingness to pay for such services.

Research Aims

The central focus of the research is to assess the appropriateness of user fees for reproductive health (RH) services amongst poor communities in Malawi. The specific aims are:

- to assess the *ability* of clients to pay for RH by identifying household income, assets, expenditure and social support;
- to assess the *willingness* of clients to pay for RH by type and quality of services;
- to explore the feasibility range of payment options for poor communities.

Research Methods

Target Population: Poor communities in rural and urban areas of Malawi. These groups are the most vulnerable to price fluctuations.

Sixteen focus group discussions (FGD) held separately with men and women in the three regions of Malawi. Each area has a large urban poor population and is served by several private family planning providers. The study areas were:

- Zomba (southern region)
- Lilongwe (central region)
- Mzimba (northern region)



Findings

Willingness to Pay for Family Planning Services

Respondents were willing to pay for services if the quality of care improved. In particular, removing delays in treatment,

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poor staff attitudes and availability of methods.

“We can contrast. For example, as soon as you arrive at Banja La Mtsogolo clinic and 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 private centre”.

Payment Strategies

Payment options for family planning services when money is short include: requesting deferred payment or credit, using private hospitals where payment in instalment is accepted, using cost-free government clinics, and selling assets.

“In private hospital you are allowed to pay in parts for an agreed period of time and they give you the medication also in part” (urban women)

Affordability of Family Planning Services

People are willing to forgo essential items (i.e. food) for curative health care but not for preventive health (i.e. contraception)

“There is no way if one has toiled for a whole day to do a job to earn money for food, then later on he uses it on family planning methods” (rural men)

Public hospital are free but often do not have the required medical supplies and respondents are referred to private services for which they cannot pay.

Some improvised condoms or abstained from sex if they could not afford a condom.

“For some who are clever, they improvise condoms using plastic bag” (urban men).

Women weighed the costs for contraceptive methods against the cost and burden of child bearing.

Temporal methods were felt to be acceptably priced as they provided protection for sometime. Condom was seen as comparatively expensive for one sexual episode. For some sterilisation was seen as expensive (K450).

Some services require proof of non-pregnancy to receive contraception. The charge for pregnancy test was a deterrent.

Appropriateness of User Fees

User Fees

- urban respondents agreed with a modest client contribution to services, but rural respondents felt income was too meagre to contribute
- fees were generally acceptable if quality improved
- there was objection to fees in government services
- there were fears that prices will escalate quickly.

Client Subsidies

- Subsidised treatment was generally
- accepted but it is difficult to determine eligibility of clients for the subsidies.

Health Insurance Schemes

- community-based funds are generally seen as beneficial.
- barriers to this scheme included; a lack of cash in rural communities, lack of trust and fear of mismanagement, domination by well-off and influential members.

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