Out-of-Pocket payments, health care access and utilisation in South-Eastern Nigeria: A gender perspective

Mini-dissertation for the degree of Master of Public Health (MPH) in Health Economics at the University of Cape Town, South Africa

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ABSTRACT

Out-of-pocket (OOP) payments have severe consequences for health care access and utilisation and are especially catastrophic for the poor. Although women comprise the majority of the poor in Nigeria and globally, the implications of OOP payments for health care access from a gender perspective have received little attention.

This study seeks to fill this gap by investigating the research objectives through a combination of quantitative (cross-sectional household surveys) and qualitative (Focus-Group Discussions) analysis of the gendered impact of OOPs on health care access in south-eastern Nigeria. A total of 411 households were surveyed in a mix of urban and rural areas and six single-sex Focus Group Discussions conducted. On further disaggregation, 160 households were female-headed and 251 households were male-headed.

This study confirmed the socio-economic (predominantly poor, subsistence farmers) and demographic (widowhood, less educated) vulnerability of female-headed households (FHHs), which contributed to gender-based inter-household differences in health care access, cost burden, choices of health care providers, methods of funding health care and coping strategies. FHHs had higher cost burdens (12.1%) from seeking care and untreated morbidity (10.6%) than male-headed households (MHHs) (9.8% and 4.3% respectively) with affordability as a reason for not seeking care. There is also a high utilisation of patent medicine vendors (PMVs) by both female— and male-headed households. OOP payment was predominantly the means of healthcare payment for both households (86.9% for FHHs and 91.8% for MHHs). Both FHHs and MHHS spoke of the difficulties associated repaying health-related debt with implications for the medical poverty trap.

It is recommended that the removal of user fees and introduction of prepayment schemes be considered to improve access and provide protection against debt for FHHs and MHHs. Improved access to primary health centres and regulation of patent medicine vendors is important. The vulnerability of widows is of special concern and efforts to improve their health care access and broader efforts to empower them including enactment of laws that protect them from discriminatory practices (e.g. disinheritance) and improve their livelihoods (e.g. microfinance schemes) should be encouraged for them and other poor households.
Dedication

To my parents for their undying guidance, my teachers past and present, to all the special friends that continue to grace my life and to God, for making everything possible.
Acknowledgments

I am grateful to the staff of the Nigerian Bureau of Statistics for the assistance in conducting the cross-sectional survey and the focus-group discussions. I would also like to acknowledge the Swedish Development Agency (SIDA) for providing the funds. Special acknowledgment and gratitude go to my supervisor for this work, Veloshnee Govender, for her guidance, training, supervision and inspiration that made this work possible.
Part A: Study Proposal

Out-of-Pocket payments, health care access and utilisation in South-Eastern Nigeria: A gender perspective.

INTRODUCTION

Utilisation which is an important indicator of access to health care services refers to the actual uptake of health services (Peters et al, 2008). Determinants of health care utilisation include the availability, acceptability and affordability of the health care services (McIntyre et al, 2006). Availability is “concerned with whether the appropriate health care providers or services are supplied in the right place and at the right time to meet the prevailing needs of the population (McIntyre et al, 2009, p: 184) and examples include considerations of waiting times, operation hours and the location of health care services in relation to those that need it. In low and middle income countries (LMICs), particularly those with a large population living in the rural areas, geographic access to health facilities has often been a key constraint affecting utilisation especially for the rural poor (Awusi et al, 2009). Acceptability of health care “is concerned with the fit between provider and patient attitudes towards and expectations of each other” (McIntyre et al, 2009, p: 187). Examples of acceptability include the attitudes of health workers and interpersonal relations between the health care provider and the patient (Mugisha et al, 2002).

Affordability and more specifically the cost of health care have been recognized as a key barrier affecting utilisation of health care services (Onwujekwe, 2005). According to McIntyre et al (2009, p: 185) “Affordability is concerned with the ‘degree of fit’ between the full costs to the individual of using the service and the individual’s ability to pay in the context of the household budget and other demands on that budget”. The cost of health care includes the direct costs (financial cost of medical services, medicines etc.), other direct costs (transport cost, accommodation costs etc.) and indirect cost which include the opportunity cost of time for the sick and care giver (McIntyre et al, 2006). Out-of-pocket (OOP) payments which is the focus of this study is a component of direct costs and are payments made by a patient to health care providers for services (McIntyre et al, 2006). These include user fees charged at public health
providers, co-payments made by health insurance members and payments made to the private health provider. In many Sub-Saharan African (SSA) countries, OOP payments are often the major source of health care financing and it places a huge financial burden on households particularly the poor (Chuma et al, 2007). In addition to impoverishment, studies have found that OOP payments can lead to delays in utilisation of health services, non-utilisation of health services and utilisation of ineffective health care (McIntyre et al, 2006; Kiwanuka et al, 2008; Buor, 2004). Strategies employed by households to cope with costs of health care include drawing on savings, sale of assets, borrowing, intra-household labour substitution, changing consumption patterns (McIntyre et al, 2006; Sauerborn et al, 1996; Leive and Xu, 2008). This can lead to impoverishment by sinking households into debt and depleting household assets and savings.

The other aspect of affordability is that of Ability-to-pay (ATP). According to McIntyre, et al (2009, p: 186) “Ability-to-pay (ATP) relates to an individual’s ability to secure funds from their household or family and the other demands placed on those potential sources of funds”. ATP is determined by several factors including socioeconomic status of households and within households, individual’s ability to access resources etc (McIntyre et al, 2009). Within households, factors relating to age, sex and relationship to the household head affect access to and control over resources.

From a gender perspective, utilisation differs between men and women, not only because of their different health care needs, but also because of the difference in access to resources (Sen, et al, 2008). Access to resources and decision making power within households determine whether people’s health needs are recognised, whether they have voice or an amount of control over their lives and health and whether they can realize their rights (Sen et al, 2008). Of the 1.3 billion poorest people in the world, 70% are women (Harcourt, 2001). Women's disproportionate burden of poverty is importantly linked to their health needs and ability to use health services (Buor, 2004). Their comparatively weaker financial status is determined by several factors that are rooted in culture and tradition (Nanda, 2002). Discriminatory values like how women are viewed and their right to make decisions largely affect and determine the difference in utilisation of health care among men and women (Quisumbing et al, 2003). Women also face social and
physical barriers to accessing health care services, principally due to their uneven need for reproductive health care (Nanda, 2002).

How OOP payments affect access and utilisation of health care differs as experienced by men and women have not been looked at adequately especially in Africa where gender is a huge barrier to equity and equality (Buor, 2004). Most studies on the catastrophic impact of OOP payment on the utilisation of health care have tended to focus on the poor or on reproductive health services. Little research has focused on men’s utilisation of health care in the context of OOP payments.

The research of the burden of OOP payment on utilisation from a gender perspective particularly in the African context has been limited.

**PROBLEM STATEMENT**

Nigeria, with a population of approximately 149 million, has 34.1% of the population living below the poverty line (i.e. less than USD1 per day) (UNDP, 2008, World Bank, 2010). The levels of poverty in Nigeria increased from 28.1% in 1980 to 92% in 2008 and the majority of the poor are located in the rural areas, where about 71% live in extreme poverty (i.e. less than US$1/day) (World Bank 2010). The huge concentration of the population in the rural areas in combination with high levels of poverty has made accessibility and utilisation of health care limited particularly for poor households (Onwujekwe, 2005; Ibeh, 2008). In Nigeria, affordability of health care is a key factor affecting access and utilisation. Government spending on health as a percentage of total spending is merely 6.5% (WHO 2010). In comparison, the share borne by households is 74.7% of which 95.9% is towards OOP payments (WHO 2010). In Nigeria, it was estimated that the total cost for all forms of illness was 11% of average household monthly income (Onwujekwe and Uzochukwu 2005). This is deemed catastrophic as households are forced to reduce expenditure on other household consumption items or incur debt. In Nigeria, as elsewhere, the ability of household members to access and utilize health care

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Health care expenditures are deemed catastrophic if the expenditure is 10% or more of household income (Ranson, 2002), where catastrophic implies that such expenditure levels are "likely to force households to cut their consumption of other minimum needs, trigger productive asset sales or high levels of debt and lead to impoverishment" (Russell, 2004)
is determined by the socioeconomic status of the household and household members’ access to household resources (Russell, 2004)

In Nigeria, decision-making over household resources and expenditure, including those for health care are often in the hands of men (Awusi et al, 2009). In the rural communities, control of income from farm proceeds are in the hands of men (Ibeh, 2008). A household survey concluded that utilisation of health care by women is mediated by their role in decision making and resource allocation within households (DHS 2008). Results from the same survey found that a woman is more likely to be a part of the decision-making process on how her earnings and her husband’s earnings are spent if she earns more than or the same amount of money as her husband. The South East zone where the study will be located has the lowest percentage of women making sole decision on what to do with their earning (27%) compared to other regions in Nigeria. Also the zone has the highest proportion of women (39%) who report joint decision-making with their husbands regarding their earnings. On the other hand, women in South East zone also report the highest percentage (33%) of their husband solely deciding on how their earning should be used. These include decisions on women’s own health care, making major household purchases, making household purchases for daily needs and visits to family or relatives. The majority of currently married women (86%) who earn more than their husbands are more likely be part of the decision making process (DHS 2008).

Within the context of OOP payments, studies have tended to focus on the implications for women particularly in relation to reproductive health services (Awusi et al, 2009; Ibeh, 2008; Adamu and Salihu, 2002; Kabir et al, 2005). There has been little research which has looked at the implications of OOP payments for men’s utilisation of health care. In Nsukka LGA, there is little research that has looked at the question of the gender dimensions of OOP payments and the implications for utilisation. In addition, there has been little research which has attempted to understand the underlying reasons particularly those relating to how health care decisions are made within households and the role of men and women in those decisions particularly in the context of OOP payments.
JUSTIFICATION FOR STUDY

The lack of sufficient evidence on the impact of gender dimensions on out-of-pocket payments particularly user fees reminds us of the urgent need to examine how women and men cope with health care costs and what trade-offs they make in order to pay for health care. Lack of access to resources and inequitable decision-making power within especially poor households might mean that when poor women are confronted with OOP costs for health care, it can delay or deter utilisation (Kiwanuka et al, 2008). Studies have either taken the route of analysing the effects of OOP payment on the poor or on female specific health services (Awusi et al, 2009; Ibeh, 2008; Adamu and Salihu, 2002; Kabir et al, 2005). This study seeks to address this literature gap. Due to the different health needs of men and women and their different access to financial resources, this study will provide an insight into the different health seeking patterns or behaviours between men and women within a household. The disproportionate impact of OOP payment on poor households and in relation to gender is likely to have important consequences for utilisation of health care. This study will also examine how individuals within households cope with these costs.

AIM

The aim of this study is to investigate gender differences in how out of pocket payments affect health care utilisation in Nsukka LGA.

OBJECTIVES

1. To describe the gender based differences in utilisation of health care in Nsukka LGA, rural Nigeria.
2. To determine the gender based differences in out of pocket payment for health care
3. To explore the underlying reasons for the difference in utilisation of health care between men and women.
4. To explain how access and control over household resources affects decision making to seek care.
5. To understand how male and female headed households cope with the burden of the expenditure on health care.
LITERATURE REVIEW

Access is a factor of acceptability, availability and affordability (McIntyre et al, 2006). According to Haynes (2003) access to health care in low-income countries depends on location of the services because health care services are scarce. This means that access to health care in low-income countries is determined by location, mobility and need (Haynes, 2003). Availability of health care can also be linked to access and utilisation of health care because it means that health care should be at hand whenever and wherever it is needed (Aday, 1975). Availability also discusses that the right level and type of health care should be available to the right population (Peters et al, 2008). This means that provision of health facilities should be based on need. Populations should be studied to know what they require and the services then provided (Aday, 1975). Affordability of health care explains how cost to seek care affects utilisation of health care (McIntyre et al, 2006). On a whole, these determinants of health care are interrelated and they determine how and when health care utilised (Peters et al, 2008).

The effect of out-of-pocket payment on utilisation of health care differs between men and women because of their different access to financial resources and different health care needs (Buor, 2004). Access to financial resources is also entangled with decision making power within a household and this ultimately determines when and if health care is utilised. Women who generally need health care services more often than men due to their reproductive healthcare needs, when faced with user fees may delay seeking health care and this has dire consequences for their health (Ibeh, 2008). In a study on women and health care in metropolitan Mumbai in Maharashtra, Nandraj et al (2001) in India discovered that women had a higher morbidity rate than men across all the age groups. It was also discovered that there was underutilisation of health services by women both for deliveries and other illnesses. A few works have however shown that women, especially in the reproductive age group, utilise health services more than men. In a study of the gender gap in primary health care resource and utilisation in Central Asia, Cashin (2002) found that both in absolute and per capita terms, the principal users of primary health care are women of reproductive age and children under five. Women of reproductive age were found to consume approximately 1.5 times the average per capita primary health care resources, while men in the same age group consume approximately one-half of the average (Cashin, 2002). Buor (2004) in Ghana found out that males utilise health services more regularly
than females, even though females have the greater need of health services, considering their comparatively weak health status. This is because of the barriers that limit women for access and utilisation of health care. A study by Bonu et al (2009) in India, found out that households that are incurring maternal health care expenditure in a particular year are likely to spend more than the amount an average household in India would spend on overall health care, and this expenditure on maternal health care is likely to put the household in deeper financial distress, or more likely discourage institutional care.

**Conceptual framework**
Figure 1: Framework for the study of the effects of OOP payment on access and utilisation of health care services from a gender perspective

FACTORS THAT AFFECT ACCESS OF HEALTH CARE SERVICES

HOUSEHOLD CHARACTERISTICS
- Socioeconomic status
- Dependency ratio
- Decision making
- Male vs female headed household
- Characteristics of household head (educational level, employment status etc.)
- Gender relations in household

COSTS OF SEEKING CARE
- Direct costs
  - Out of pocket payments
  - User fees
  - Payments to private providers
- Indirect costs

ABILITY TO PAY (ATP)

AFFORDABILITY

ACCEPTABILITY

AVAILABILITY

Key
------: Dotted lines indicate that although acceptability and availability are dimensions of access, they are not the focus of the study
As noted earlier, factors affecting access and utilisation of health care can be summarised under three dimensions namely availability, acceptability and affordability of health care services (see Figure 1). While this study recognises the influence of acceptability and availability on health care access and utilisation, the focus is on affordability which is determined by household’s and individual ability-to-pay and the costs of care (direct and indirect costs of care). In assessing affordability, while indirect costs (e.g. lost income associated with seeking care) is important, the focus here is on the direct costs of care and more specifically out-of-pocket payments.

The interactions between household characteristics like socioeconomic status and other important demographic information (e.g. education level of household head, employment status, dependency ratio and gender, decision-making) determines how households cope with direct and indirect costs of healthcare (affordability). These interactions ultimately determine household’s ability-to-pay for healthcare. The direct costs of seeking care interact with household characteristics in the following way.

Gender which determines access to resources and decision making is dynamic and affects household members’ ability to pay for and utilisation of health care services. Access and control over household resources especially financial resources will determine if and when health care is sought and whether one is able to pay for it. Gender and equality in household decision making has been found to be dependent on cultural factors in developing countries. Other factors including women economic and employment status has also been found to determine their access to resources which determines utilisation of health care services (Nanda, 2002; Mumtaz, 2003). Households where women have less autonomy over allocation of financial resources, out-of-pocket payments will have a more adverse effect on their care seeking behaviour and utilisation of health care. Within households, the effect of autonomy over allocation of resources might have a greater effect on the difference in utilisation between men and women than socioeconomic status. This is because if a household has a high socioeconomic status but decision making on expenditure is solely in the hands of men, women will be constrained in their utilisation of health care.

How households cope with these costs differ between male-headed households and female-headed households. Male-headed households tend to be richer than female headed households
(Levie and Xu, 2008; Yu and Wilkes, 1998) and this affects their affordability and how they cope with health care costs. Drawing on savings, selling of household’s assets and borrowing are important major strategies employed by households to cope with health care costs (Bogale et al, 2005; Chuma et al, 2007).

The challenges and barriers to access imposed by OOP payments are more dire for poor households and for both men and women. In poor households, in instances where women have little voice in household decision making and access to resources, OOP payments are likely to be a greater access barrier compared to women in richer households.

**Methodology**

**Study Site**

This study will be conducted in Nsukka local government area (LGA) in Enugu state in the southeast region of Nigeria. Nsukka LGA is located in the northern part of Enugu State. It comprises fifteen (15) communities namely: Anuka, Okutu, Ibagwa-agu, Okpuje, Ibagwa-ani, Okpaligbo, Obukpa, Alor-uno, Edem, Obimo, Lejja, Ede-oballa, Opi, Ehalumona, and Nsukka (Ataguba, 2007). The communities are located in specific geographical areas and may comprise of several villages. The LGA is predominantly a rural area where the main economic activity is agriculture. According to the 2006 population census, Nsukka LGA has a population of 309,633 and is made up of 63,603 households (NBS, 2007).

The 2006 population figures for each community were obtained by assuming a constant percentage of overall population across the years for each community, i.e., a community that made up 5% of the total L.G.A. population in 1996 was also assumed to have the same 5% share in 2006. Based on these figures, the study extrapolated the 2010 figures accordingly using the 3% national average growth rate of population (RBM Needs Assessment Report, 2008). In line with the abovementioned, and following Ataguba et al (2007), the respective populations for the various communities are as follows: Anuka (1080), Okutu (5506), Ibagwa-agu (1777), Okpuje (12686), Ibagwa-ani (12929), Okpaligbo (3415), Obukpa (27461), Alor-uno (8957), Edem
To obtain approximate number of households in each community, we note that, going by the 2006 census figures, the average household size in Nsukka L.G.A. is 5 (i.e. total population / total number of households). Consequently, the number of households in each community can be obtained by dividing the respective communities’ populations by 5 to give: Anuka (216), Okutu (1101), Ibagwa-agu (355), Okpuje (2537), Ibagwa-ani (2586), Okpaligbo (683), Obukpa (5492), Alor-unu (1791), Edem (4565), Obimo (3492), Lejja (4196), Ede-oballa (3938), Opi (6970), Ehalumona (9897), Nsukka (21886).

**Study design**

This study intends to use both quantitative and qualitative methods to investigate the research objectives. The quantitative component will include a cross sectional household survey exploring the burden of out-of-pocket-payment on health care utilisation from a gender perspective and the differences in coping strategies between male and female headed households. While the household surveys will provide important data quantifying the differences and similarities in utilisation patterns between MHHs and FHHs, it is inadequate in helping us understand why these differences exist and the underlying reasons, particularly those linked to OOP payments and. In this study, his gap might be filled through the use of FGDs. The flexibility that qualitative research method offers will provide an opportunity for probing to gain an in-depth understanding of these underlying reasons.

**Sampling**

A multi-stage sampling method adapted from Ataguba, et al (2007) will be used to select households for the survey. To ensure adequate representation of both urban and rural communities, the LGA is stratified into urban (Nsukka) and rural (the rest of the communities). Because Nsukka community, predominantly urban makes up 30% of the population of the LGA (NPC 2007), a sample of 120 households representing 30% of the sample size was drawn from it. The remaining 14 communities will be classified as Enumeration Areas (EA) or clusters. Seven (7) EAs will be randomly selected from the 14 EAs and households will be drawn from these EAs in such a way to ensure a probability-proportional to size (PPS) sampling. PPS is a sampling
technique in which the probability of selecting a sampling unit is proportional to the size of its population. It is most useful when the sampling units vary considerably in size because it assures that those in larger sites have the same probability of getting into the sample as those in smaller sites, and vice versa.

The FGDs will be conducted in 3 of the communities sampled out and will consist of 6 single-sex FGDs with men and women participants. Each FGD will consist of 11 participants. Selection of participants will be done by the principal investigator and will be sourced from women and men groups like those that engage in agricultural or trading activities.

Sample size calculation

There are three criteria to determine an appropriate sample size, based on the Taro Yamane sampling equation (Israel, 2009). These criteria include the level of precision (sampling error), the confidence or risk level and the degree of variability. Based on this, the sample size will be estimated as follows:

\[
n = \frac{N}{1+N(e)^2} = \frac{69,705}{1+69,705(0.05)^2} = 397 \text{ households}
\]

Where n is the sample size

N is the population size (number of households in the study area)

e is the error margin.

Therefore given the above population size (69,705 households) and using an error margin of 5%, the required sample size is approximately 400 households

Methods of Data Collection

This study will use data collected from household surveys and Focus Group Discussions (FGDs). The household surveys will collect data on household’s socioeconomic and demographic status, expenditure pattern, utilisation patterns, sources of OOP payments and coping strategies. FGDs
will not only offer the opportunity of examining the opinion of men and women as to the burden of out-of-pocket payment on health care utilisation, but it will complement the deficiencies of quantitative questions which do not provide for in-depth detailing by stimulating conversations between participants.

**Data processes and management**

Every questionnaire administered in the household survey is anticipated to take 60 minutes. Trained field workers will administer the structured questionnaire but will have a co-ordinator for supervision. The FGDs would be between 60 to 90 minutes each. The FGDs will be recorded with the permission of the participants. One assistant researcher would be employed to assist in note taking for the FGDs which would be conducted by the principal researcher. Notes taking by the assistant researchers and the principal researcher would be compared and compiled immediately after FGDs. Data from all the FGDs would be transcribed and translated before analysis. All data collected would be solely handled and managed by the principal researcher and all used and unused data collection instruments would be securely stored under the care of the principal investigator.

**Training**

Questionnaires often require a certain amount of skill from the interviewer. This will be addressed with proper training and pre-testing before roll out. Part of the training will include skills to help them to be able to establish good rapport with participants. During the training period, the reasons, objectives and nature of the research will be carefully explained for proper understanding. The training will include note taking and aims at ensuring good quality data collection and that transcriptions are done correctly.
## Analysis and Presentation of Data

### Table 1: Description of variables and their measurement

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent variable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilisation</td>
<td>Type of facility utilised in the previous month</td>
<td>Categorical</td>
</tr>
<tr>
<td><strong>Independent variable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex of household head</td>
<td>Gender variable</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>0= female head; 1= male head</td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td>Highest attained level of formal education</td>
<td>Categorical</td>
</tr>
<tr>
<td></td>
<td>0= no school; 1= primary; 2= secondary; 3= tertiary 4= others</td>
<td></td>
</tr>
<tr>
<td>Health insurance</td>
<td>Ownership of any form of health insurance</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>1= own health insurance; 0= otherwise</td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td>Whether the respondent is employed or not</td>
<td>Dichotomous</td>
</tr>
<tr>
<td></td>
<td>1= employed; 0= otherwise</td>
<td></td>
</tr>
<tr>
<td>Treatment amount</td>
<td>Amount spent on treating any sick household member the past four weeks</td>
<td>Continuous</td>
</tr>
<tr>
<td></td>
<td>The quantifiable cost measured in naira</td>
<td></td>
</tr>
<tr>
<td>Borrowed amount</td>
<td>Amount borrowed for treatment of the sick household member the previous four weeks</td>
<td>Continuous</td>
</tr>
<tr>
<td></td>
<td>Includes monetary worth of sold items or payment in kind</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>The age of the respondent as at last birthday</td>
<td>Continuous</td>
</tr>
</tbody>
</table>
## Household size

The total number of people living in the household

Discrete (count)

<table>
<thead>
<tr>
<th>Decision making</th>
<th>Who decided how household resources are used and in health treatment</th>
<th>Categorical</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0= male; 1= female; 3= joint</td>
<td></td>
</tr>
</tbody>
</table>

| Household wealth | Proxy measure for income levels of households. These constitute earnings from employment and household assets. All converted into their current market value using current prices | Continuous |

Statistical analysis of quantitative data will be performed using STATA version 11 Special Edition. The data collected will be entered into EpiData data base management programme, and then transferred to STATA for analysis. There will be two data capturers that will perform double entry of data to ensure consistency and validity. The dataset will be cleaned and organised for analysis. First all variables will be described and explored. Means will be used to describe normally distributed numerical variables and median and range will be used to describe non normal variables. Categorical variables will be described using frequency distributions. Thematic analysis based on the principle of constant comparisons would be used in the analysis of the FGDs.

### Ethical considerations

The purpose of this study is to explore the burden of out-of-pocket payment on utilisation from a gender perspective and how households cope with these costs. Formal ethical approval will be obtained from the UCT Human Ethics Committee. Permission to collect data and conduct study from households will be sought from Nsukka Local Government Authorities. Since it is a household survey, consent will be obtained from household heads, care givers or guardians verbally. Also oral and written consent will be sought from the participants of the FGDs and structured household questionnaires. The consent forms would be in English but would be translated into the local language where the participant does not understand English. A translator would assist in obtaining informed consent. All data and information will remain strictly confidential and anonymous to protect the privacy of each participating household.
Potential risks to population

The sensitivity surrounding the some of the questions on household decision making on resource allocation might bring up household issues on equality and other household problems. This might result in risky outcomes for the household. This can be addressed by assuring the household heads that information provided will be treated with strict confidence and that no names will be included in any reports or documents emerging from the research.

Potential benefits to participants

This research study will raise awareness of issues on the gender dimensions of burden of out-of-pocket payment on households and the results will be shared with the Nsukka LGA health managers and administrators. Also it may encourage further research that will provide more evidence of the catastrophic cost of out-of-pocket payment and its effect of utilisation of health care in Nigeria.

Validity and Reliability of the study

Since this is a cross sectional household survey, care must be taken in order not to introduce the prejudices of the field worker into the opinion of respondents. To improve upon the credibility of the study therefore, a triangulation of methods and sources of data is proposed. Two different methods (i.e. structured questionnaires and FGDs) will be used to collect data in a way that the strengths of one complements for the weakness of the others. For the FGD discussion, it will be ensured that the two research assistants will be people who have at least a first degree, proficient in the local language and with some exposure to qualitative Focus Group Discussions.

Write-up and dissemination

The outcome of this research will be of interest to health service providers, policy makers within the health care system, the general public and NGO’s that have an interest in reducing the burden of out-of-pocket payment on health care utilisation countries.

The research findings will be distributed in several ways to different stake holders:
• The research and findings will be available at the Health Economics Unit of the University of Cape Town and also at the university’s library.

• A hard copy of the research will be made available to the Ministry of Education, the Nsukka LGA authorities as well as to the Ministry of Health in Nigeria through their libraries.

• The research will be published in a journal for the access of all interested health care professionals, academics and students.
REFERENCES


UNDP, 2008, Human and income poverty: developing countries / Population living below national poverty line, Human Development Indices: A statistical Update


Part B: Literature review

The implications of out-of-pocket payment for health care access and utilisation: a gender perspective in south-eastern Nigeria

1. Introduction

Access to and utilisation of health care services constitute a major challenge in low- and middle-income countries (LMICs) and is influenced by the dynamic interaction between supply-side health-system factors relating to the distribution of health resources (e.g. distribution of primary care facilities, referral systems, supply of essential drugs, etc.) and demand-side factors (e.g. socio-economic status of households, household gender relations, culture, etc.) (McIntyre et al, 2009; Falkingham, 2004; Russell, 1996; Goudge et al, 2009; McIntyre et al, 2006; Leive and Xu, 2008). While there are several definitions of access, this review employs the definition put forward by McIntyre et al (2009), where access is understood as the “degree of fit” between population needs and health system responses along the dimensions of availability, affordability and acceptability. While concerns over availability and acceptability of health services are equally important dimensions of access, the issue of affordability particularly in the context of out-of-pocket payments in LMICs and the financial burden on households has in recent years received significant attention in the literature (McIntyre, 2006; Ranson, 2002; McPake, 2000; Shakih, 2004) and is the focus of this review. By definition “a household is designated as comprising individuals who live in the same house and who have common arrangements for basic domestic and/or reproductive activities such as cooking and eating” (Chant, 1997, p: 40).

Importantly, while there has been a significant amount of research documenting access and utilisation implications of out-of-pocket payments by socio-economic status of households, there has been little similar attention from a gender perspective. In this review, gender refers to the “set of shared principles for how women and men ought to behave and a set of structures that differentially shape the resources to which they have access” (Hirsch, 2007, p: 23). These gender-based inequalities in access to resources and societal norms which confer different roles and expectations on girls and boys and later on men and women have important implications for health and health care access (Buor, 2004; Puentes-Markides, 1992). What is of concern is that these differences have repeatedly given rise to discrimination and inequalities (WHO, 2010). Sex
of household heads or what is commonly referred to in the literature as female- and male-headed households, which is related to gender and access to resources might also have important implications for health care access. A ‘female-headed household’ is classified in most national and international data sources as a unit where an adult woman (usually with children) lives exclusive of a spouse” (Hirsch, 2007, p: 22).

The purpose of this literature review as informed by the aim of the overall study is to firstly examine the theoretical and empirical literature (both published and grey) and understand the influence of out-of-pocket (OOP) payments on health care access and utilisation from a gender perspective and secondly, identify the gaps in the literature. More specifically the review will cover the following thematic areas:

(1) Dimensions of health care access and utilisation;
(2) Economic consequences of seeking health care;
(2.1) Economic implications of out-of-pocket payments for health care utilisation;
(3) Household coping strategies;
(4) Gender, Out-of-Pocket payments and access;
(4.1) Gender, intra-household decision making;
(4.2) Gender, health care access and utilisation;
(4.3) The gender implications of out-of-pocket payments for access; and
(4.4) Gender and household coping strategies.

The review will then conclude with a conceptual framework and a summary of the gaps in the literature.

**Search strategy**

This work is based on an extensive review of peer-reviewed articles and grey literature. The initial search for peer-reviewed articles was carried out on (Medline Ovid, Pubmed and EBSCO host). Noting that different authors use different terminology often in relation to the same theme, combinations of key words and phrases were used. Keywords and phrases included utilisation, out-of-pocket payments, health care services, gender, barriers, access, Nigeria, affordability, catastrophic health expenditure, LMICs, and developing countries. This was supplemented by hand searches of reference lists of relevant articles, and available grey literature from official
reports produced by international health organizations (WHO, World Bank) and national Ministries of Health (e.g. Nigeria). The selection criteria included English language and year of publication (1995-2010). However, a small selection of articles predating 1995, some of which were seminal pieces and considered still relevant to the topic, were reviewed. A total of 210 articles were identified, of which 137 articles were considered relevant to the objectives of the review.

**Dimensions of health care access and utilisation**

This section will start with outlining the various theoretical approaches to understanding and defining health care access, followed by a more detailed analysis of the dimensions of access.

**1.1 Defining and understanding health care access and utilisation**

Access to health care has received a significant amount of attention over the past 50 years. According to the seminal work by Andersen and Aday (1974), access is defined according to two main domains: potential and realized access. Potential access is defined in terms of system availability, community characteristics, individual predisposing characteristics (e.g. age, sex, race, and education), individual enabling characteristics (e.g. financial and travel times), and individual needs (e.g. perceived health, worry, symptoms.). Realized access is measured in terms of utilisation and consumer satisfaction. Some researchers explain access as simply a supply concept relating to the availability of services (or spatial accessibility) (e.g., Guagliardo, 2004; Perry, 2000; Rosero Bixby, 2004). Others infer access to be a demand concept relating to household’s affordability and ability to pay for health care services (Falkingham, 2004; Jutting, 2001).

It is important at the outset to make a distinction between access and utilisation, where the latter is understood to be a proxy for access and it only refers to those who are using health services and does not include the non-users (McIntyre et al, 2009). While differences in access among individuals may lead to differences in the utilisation of health care services, at the same time, differences in utilisation may occur even with equal access to services where individuals make different choices in relation to exercising their access to use the services (Joseph, 1984; Thiede,
2005). For example, perceptions on how serious illness is, and on how competent the health care providers are, influence the decision to utilise available health care at a facility.

There is an increasing focus being placed on financial access. This is mainly due to the fact that people in poor countries tend to have less access to health services than those in better-off countries, and within countries, the poorest have the least access to health services (Peters et al, 2008). According to Russell (1996), financial access depends on the relationship between the cost of health care and an individual’s ability to pay for health care services. Cultural access or acceptability refers to the social and cultural distance between health care systems and their users (McIntyre; et al, 2009). Increasing attention to acceptability has been partly driven by concern over poor provider attitudes particularly in the public sector (Palmer, 2007; Gilson, 2007).

Donabedian (1973) and Penchansky (1977) (as cited in McIntyre et al, 2009) recognized the compatibility or degree of fit between a health care system and individuals as the heart of the access concept while Falkingham (2004) and Jutting (2001) interpreted access as a demand concept relating to the affordability or ability to pay for services. Le Grand (1991) (as cited in McIntyre et al, 2009), on the other hand, noted that the implications of the “shadow price” of services will depend on the circumstance in which the costs are experienced. Costs of using services need to be interpreted in terms of the opportunity costs, or the opportunities forgone by using services. In this way, he introduced an affordability component, although in its broadest sense of the opportunity sets that individuals operate within, alongside the supply-side influence of cost or shadow price.

McIntyre, et al, 2009 (p: 180) derived their definition and conceptualisation of access from earlier works2 as a “multi-dimensional concept based on the interaction between health care systems and individuals” and as “the empowerment of an individual to use health care and a reflection of an individual’s capacity to benefit from services given the individual’s circumstances and experiences in relation to the health care system”. Therefore, the emphasis is on empowerment where individuals have equal opportunities to use health services, which serves to also emphasize that access and utilisation are not the same.

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1.2 Dimensions of access

In this section, the dimensions of access and factors affecting them as proposed by McIntyre et al, (2009) will be discussed in more details.

1.2.1 Availability

Availability of health care refers to “having the right type of care available to those who need it, such as hours of operation and waiting times that meet demands of those who would use care, as well as having the appropriate type of service providers and materials” (McIntyre, et al, 2009, p: 861).

In LMICs, rural households often face significant geographical access barriers (Haynes, 2003; Kiwanuka et al, 2008). Even in instances where health facilities are available, long distance, lack of transport and poor road infrastructure are obstacles constraining access and utilisation, especially for the rural poor (Onwujekwe and Uzochukwu, 2005; Ali, 1999; Islam, 2002; Zhe, 2009). In Sri Lanka, Perera et al, (2007) found that while the geographic distribution of health care facilities in Sri Lanka was equitable, there was poor availability of services for those with severe diseases, such as diabetes, in many of these facilities. “Peripheral facilities have not been efficient in line with the population’s evolution to a rising burden of non-communicable diseases, and diagnosis and treatment of chronic diseases remain concentrated in central facilities” (Perera et al, 2007, p: 785).

Equally, the effect of facility hours of service on the ability of individuals to seek care is rarely considered in the literature, although it may be recognized as a problem among policy makers (McIntyre et al, 2009). In LMICs, the inconvenient hours of service at many public sector health facilities, especially at the primary health care level, has been found to influence individuals’ choice of provider often in favour of the private sector in spite of their higher costs (Peters et al, 2008; McIntyre et al, 2009). In China, Zhe (2009) found that the availability of public health services for the rural poor was much lower than that of the non-poor, which formed part of the
explanation for the lower percentage of rural women delivering in hospitals compared to urban women.

1.2.2 Acceptability

Mounting attention to acceptability has to some extent been driven by disquiet over poor provider attitudes predominantly in the public sector of LMICs (Palmer, 2007; Gilson, 2007). However, acceptability goes beyond the patient-provider relationship and refers to the social and cultural distance between health care systems and their users (McIntyre, et al, 2009). According to Peters et al, (2008, p: 166), acceptability is “the match between how responsive health service providers are to the social and cultural expectations of individual users and communities”. Acceptability also relates to perceptions of the patients, the relationship between the providers and patients, the type and level of health care provided and the quality of services provided by these providers (Slifkin, 2002).

Cultural and religious beliefs can also act as an influence on the acceptability of health care services (Fox, 2010). A study of the factors that affect utilisation of maternal health care in Kano, northern Nigeria, found that cultural belief systems relating to ill health and death as being predestined and that delivery and antenatal care should be provided by family members were important barriers to access (Adamu and Salihu, 2002). Financial barriers and male dominance in household decision-making also contributed to the underutilisation of maternal care. This underscores the importance of understanding the cultural context in order to identify appropriate strategies for improving health care access (Adamu and Salihu, 2002).

A number of studies find that rural people link the need for health care services with the inability to carry out normal daily role functions (Uzochukwu and Onwuje, 2004; Bentley, 2003; Jayawardene, 1993; Buor, 2004; Fox, 2010). These findings suggest that the desire for preventive health care services among rural populations may be less than what is expected or required (Slifkin, 2002; Fox, 2010; Buor 2004). Consequently, people's perceptions of the type of services they need as informed by their cultural, geographical and economic activities needs to be explored and understood (Bentley, 2003).

1.2.3 Affordability
There is an increasing focus on financial access. This is mainly due to the fact that people in poor countries tend to have less access to health services than those in better-off countries, and within countries, the poorest have the least access to health services (Peters et al, 2008). Financial access is determined by the interactions between the cost of health care and the individual’s ability to pay for health care services (Russell 1996; Peters et al, 2008; McIntyre et al 2009). The affordability of health care services is determined by factors which include the direct cost of the service as well as costs arising from transport and accommodation and indirect costs which relate to opportunity costs (Goudge et al, 2009; Peters et al, 2008). Opportunity costs are the time and income forgone during sickness or care giving. The table below presents a summary of the factors that affect affordability of health care services.

Table 1: Factors affecting affordability

<table>
<thead>
<tr>
<th>Cost</th>
<th>Ability to pay (ATP)</th>
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<tr>
<td>* The price of service at point of delivery which covers a range of items (e.g. formal consultation fees, unofficial or ‘under-the-counter’ fees, diagnostic tests and medicine charges, pre-admission deposits, ward and theatre fees). The level of public funding, whether through general tax revenue funding of providers or through publicly subsidized health insurance, influences the extent to which individuals can ‘afford’ to meet the costs of using care.</td>
<td>* The ability of households or family units to cover the costs of services at the point of delivery, including: the amount, timing, and frequency of income flows, and the individual’s ability to draw on these income streams; the level of cash savings that can be used to cover health care costs; the assets owned by the household and whether these assets can be easily and rapidly translated into cash; the extent and nature of social networks from which households can mobilize cash (either via gifts or loans); the ability to secure formal credit arrangements and the conditions for loans (e.g. repayment period and interest rate charges).</td>
</tr>
<tr>
<td>* Other direct costs associated with transportation, special diets, childcare costs, etc.</td>
<td>* The ability of individuals to incur indirect costs (e.g. sick leave benefits to protect income while incapacitated for employees and the ability to mobilize substitute labour to protect productivity for the self-employed).</td>
</tr>
<tr>
<td>* Indirect costs such as lost income or productivity while travelling to and from, and waiting to be seen by, a health care provider.</td>
<td>* The eligibility of individuals for financial support from health care financing mechanisms that subsidize or cover the costs of health care at the time of service use.</td>
</tr>
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The ability of households to cope with health care costs is dependent on the nature, regularity and length of illness, the cost of treatment, the resources capacity including savings of the household, the responses it chooses and the way it mobilizes (or not) these resources (Gilson,
The type of the illness will be decisive in determining the ability to pay (ATP). A severe acute illness or injury may entail sudden unexpected costs on household which require unexpected resource mobilization, while a persistent disease such as AIDS will surface as a 'long-wave disaster', with continuing cost, response and resource implications (Barnett, 1992). Cash incomes are not the only determinants of ATP for health care, and are not the only resources available to households. Potential resources may include household assets, education and the capability to organize resources successfully, and investments in and claims on social networks (Wallman, 1996).

Also important are the effects of affordability on treatment seeking and health outcomes. In LMICs, particularly in agricultural and informal economies, in event of illness people often either do not seek care, or do so only when they have access to funds, thus affecting continuity of care with implications for treatment outcomes and health status (Falkingham, 2004). Vulnerable households’ financial access is further constrained by livelihoods exhausted from previous illness and death, continuing multiple illnesses, very little or no income, and limited social networks to draw on for financial assistance (Shaikh, 2004; Lagarde and Palmer, 2007). In South Africa, a household survey focusing on chronic illness found that half of the highly vulnerable households had no source of income and were dependent on gifts from family and neighbours which made regular health care consultations very difficult (Goudge et al, 2009). It was concluded that since chronic care requires repeated consultations, it can be costly and even unaffordable for poor households. In China, Gu et al, (1994) found that the percentage of patients needing inpatient care but not being able to afford it was much higher in poor counties than in non-poor counties. In Kenya, Nyamongo (2002) found that family size and parity, educational status and occupation of the household head were important determinants affecting affordability and the decision to seek care. Smaller households, households with a high education status and with the household head employed in the formal sector utilised health care more often than those with more members and household heads with lower educational status and employed in the informal sector.

These differences contributed to differences in ATP, with implications for access. In Sri Lanka, Akin (1998) found that shopkeepers/drug vendors were popular since they often sold smaller
quantities of drugs at more affordable prices. Clearly this can have adverse implications for treatment outcomes especially in the case of antibiotics when a complete dose is not followed.

2. Economic consequences of seeking care

Economic consequence of seeking care refers to the financial burden or the impact of being sick on an individual and the family in general (Ranson, 2002). This burden can have a direct or an indirect impact on the sick or the household. It is important to make a distinction between direct and indirect costs. ”While direct costs focus on the range of financial costs incurred when health care is sought (the cost of the service and medicines as well as other related costs), indirect costs include productive time losses to the person who is ill and to other household members” (McIntyre et al, 2006, p: 862). There are significant differences in the approaches to measuring the economic consequences of seeking care and this is partly due to whether studies look at both direct and indirect costs and the approaches for estimating these costs. For instance, in relation to indirect costs, differences in studies arise from whether total productivity loss is estimated as the number of days off work due to ill-health only or whether the years of productive life lost due to premature death are also included (McIntyre et al, 2006). Also, while some studies focus on direct costs that are only related to health services, others capture direct cost as including transportation (Chima, Goodman and Mills, 2003).

However, a clear message emerging from most of these studies is that ill-health disproportionately affects the poor, that the poor experience considerable financial difficulties accessing health care as described earlier, and that when they seek care, they spend a greater proportion of their income on treatment than the non-poor (Onwujekwe and Uzochukwu, 2005; Ettling et al, 1994; Chuma et al, 2007). Whitehead et al (2001) noted that in LMICs, rising costs of health care and more specifically in relation to user fees have contributed to untreated morbidity, reduced access, irrational use of drugs and long-term impoverishment. She went further to explain that the “rises in direct costs for public and private health care services are driving many families into poverty, and are increasing the poverty of those who are already poor, a phenomenon referred to as the “the medical poverty trap” (p: 835).

The implications of cost on health care access and utilisation has been documented in several studies. In the Caribbean, Shaw and Griffin (1995) found that between 14% and 20% of people
who reported illness indicated that they did not seek health care because of lack of financial resources for treatment or transport. A World Bank poverty assessment report (1999) of Kyrgyz Republic, reported that over half of those referred to a hospital were not admitted, because they could not afford the consultation and drug costs. In rural India, Iyer and Sen (2000) found that 17% of people who reported illness did not seek care, of who more than a quarter cited financial reasons. Untreated sickness among poor people is recorded not only in countries with serious economic difficulties, but also in those with high and stable economic growth (Whitehead et al, 2001). For example, access to essential health services in rural China was renowned, but has been drastically reduced following economic reform and the introduction of market-led reforms in the health sector (UNRIS, 2000).

In several countries, up to 11% of the populace suffers severe financial hardship arising from health care expenditure each year, and up to 5% is forced into poverty (WHO, 2010). Worldwide, about 150 million people suffer financial catastrophe arising from health care expenditure annually while 100 million are pushed below the poverty line (WHO, 2010). In LMICs, the total economic costs of illness for households are frequently above 10% of household income (Onwujekwe, 2005) and this is seen by some as potentially catastrophic (Ranson, 2002; Russell, 2004; Van Damme, 2004; Onwujekwu, 2005). Expenditures on health care may be considered catastrophic when expenditure levels are “likely to force households to cut their consumption of other minimum needs, trigger productive asset sales or high levels of debt, and lead to impoverishment” (Russell, 2004, p: 149).

There is a growing body of research on the impact of catastrophic health care expenditure on household spending across LMICs (Pradhan and Prescott, 2002; Wagstaff, van Doorslaer, 2003; Van Doorslaer, 2007; Xu, 2003; O'Donnell et al, 2008). The impact of health care expenditures on the rest of household budget is even more critical than whether or not payments are actually made (Kanji, 1995). For poor households, the decision to seek care particularly for those involving significant expenditure not only compromises the household and its members well-being through debts, selling off essential assets, or sacrificing investment in potential productive activities (e.g. children’s education) (Whitehead, Dahlgren & Evans, 2001), but can also trigger a vicious cycle of impoverishment and additional indebtedness (Sauerborn et al, 1996; Ranson, 2002; Corbett, 2003).
The ability of households to continue generating income following an illness episode and sometimes even several episodes, are critical for their long-term survival. Illness and may lead to chronic poverty. Irving (2009) found that there were two main processes by which serious illness shocks impact on household income. Firstly, the patients would lose their capacity to work for a period of time and other household members would also reduce their working hours to care for the sick and secondly, household financial assets intended for productive asset purchase and/or children’s education may be used to pay for medical expenses. An interesting study by Wang (2006) in China found that the working time lost due to illness had significant negative effects on the household income-generation capacity significantly and led to poverty. The direct impact can be short term, which is mainly due to loss of labouring ability of patients in a certain period of time or loss of working hours for the household members taking care of the patients (Booth, 1996). Studies which look at how households finance health care in emergency circumstances also indicate that payment is often only made with the greatest difficulty and displaces spending on food, agriculture, development and education (Waddington, 1989; Kawabata, 2002).

There is ample evidence of the impact of health care expenditure on utilisation of health services. A study conducted in Dhaka, Bangladesh in 1998 found that although the cost of maternity care in public hospitals was free, utilisation was catastrophic for many, because households still had to pay for drugs and supplies, blood, travel, food, tips and, in some cases, wages for a hired caregiver. It cost a fifth of the families between 51-100% of their monthly income. More than half the families were not able to afford these services and almost all of them had to borrow from a money-lender or relative (Nahar and Costello, 1998). In India, Bonu et al, (2009) found out that health care cost associated with child delivery in facilities often exceeded average household health care expenditure, which not only increased household’s financial distress but also discouraged institutional care. In Colombia, a study by Van Damme et al, (2004) showed how a relatively short illness episode in a young child frequently caused catastrophic health expenditure leading to debt in poor households, particularly for those seeking care in the private sector. The majority of families with health-related debts were still unable to settle them a year later. The study also showed that a credible and well-functioning public health system accessible to the poor can make a huge difference providing households with a choice between the public and the
private sector, thereby preventing catastrophic health care expenditure. In comparison, in countries (e.g. Cambodia and Nigeria), where public health care is under-resourced and characterised by poor quality of care and the private sector is widespread and perceived to offer ‘better’ care, people are often prepared to pay exorbitant fees for care in the private sector (Van Damme et al, 2004; Onwudiegwu, 1997; Onwujekwe et al, 2010). Exposure to such catastrophic health care expenditure, besides requiring increased regulation of the private sector and improved resourcing and service delivery in the public sector, speaks for the importance of pre-payment mechanisms to protect households from catastrophic expenditure (WHO, 2005).

2.1 The economic implications of out-of-pocket payment for health care access

According to the WHO (2010), “almost all countries impose some form of direct payment for health care services, sometimes called cost sharing, although the poorer the country, the higher the proportion of total expenditure that is financed in this way. The most extreme examples are found in 33 mostly LMICs, where direct out-of-pocket payments represented more than 50% of total health expenditures in 2007”. Evidence from numerous countries has shown that OOP payments are a very regressive source of financing (McIntyre, 2006; Gilson and McIntyre, 2000; Mbugua et al, 1995). OOP payments include user fees made at public health care providers, co-payments by the insured, payments made to private health care providers and payment made across the counter for drug purchases (Perkins et al, 2009; Pradhan and Prescott, 2002; Xu et al, 2003; Wagstaff and Van Doorslaer, 2003; Mugisha et al, 2002; McIntyre et al, 2006). There is also a growing body of evidence documenting the economic consequences of OOP and the fact that it can lead to impoverishment for poor households (Russell, 2004; Van Damme et al, 2004; Meessen et al, 2006; Wagstaff, Van Doorslaer, 2003; Van Doorslaer, 2007).

In Nigeria, OOP and in particular, user fees impose a huge burden on households. It was estimated that OOP payments as a percentage of total health care expenditure ranged from almost 73% in the south to 77% in the north which is relatively poorer (Onwujekwe et al, 2010). Suggesting that health care is generally funded through cash payments and the burden borne directly by households. As with other associated costs arising from seeking care, the impact is most severe for the poor where in the event of illness, they either delay or forgo seeking care and when they do, they face the risk of impoverishment. In Sudan, it was found that 70 per cent of
the people did not seek health care in case of illness because they were unable to pay the user fees (Witter and Babiker, 2005). A UN study of 39 developing countries found that the introduction of user fees led to slight increases in revenue, but impacted severely on access and utilisation for the poor (UNIRSD, 2000). It appears that the impact on utilisation is similar irrespective of the type of care needed. A UNICEF commissioned review of evidence on the impact of user fees on utilisation found that in addition to user fees being a barrier to access, for especially poor households, it adversely impacted on adherence for treatments requiring long courses of medicines and repeated health facility visits associated with chronic diseases and infectious diseases including tuberculosis and HIV/AIDS (James, Hanson et al, 2006). Other studies focusing on the need for relatively minor treatment also documented that households experienced difficulties in paying user fees (McPake, 2000; Abel Smith, 1992). In Ghana, in response to the financial barriers arising from user fees, households turned to the private sector which not only led to inappropriate treatment but in some instances contributed to the development of drug resistance (Asenso-okyere, Anum, Osei-Akoto et al, 1998).

In addition, the presence of user fees often means that poor households have to borrow, ration resources for, or even forgo, other essential needs (e.g. food, water, education etc) (Russell, 1996; Goudge et al, 2009). Pannarunothai (1997) shows that in Thailand, poor families spent approximately 5–6% of their incomes on OOP payments, whereas higher-income groups spent 1–2%. In Vietnam, Xu (2007) explored the determinants of OOP health expenditures and found that OOP payments impacted adversely on households’ livelihood and even pushed some into poverty. While health expenditures occurred at all income levels, lower-income households were often faced with larger catastrophic expenditure than higher-income groups. In Uganda, following the removal of user fees, although utilisation among the poor increased in public facilities, surprisingly the incidence of catastrophic health expenditure among the poor did not correspondingly fall (Xu et al, 2006). The authors attributed this to drug shortages in government facilities following the abolition, which forced people to purchase drugs from private pharmacies.
3. Household coping strategies

Given the increasing focus on and concern over the economic consequences of ill health, there is growing research on household coping strategies. Serious illness has significant adverse effects on households’ composition, labour supply and income generation (Russell, 1996). Coping strategies employed by households when faced with health care cost are dependent on the socio-economic status of the household involved (Bogale et al, 2005). Coping strategies are therefore vitally important especially for poor households faced with sudden illness requiring the mobilization of savings, substantial additional resources and savings. Even minor illness costs can exceed the low and insecure daily and weekly budgets of the poor, who often survive on an income that is barely enough to meet minimum food requirements (Russell, 2004). If households lack the necessary coping mechanisms, a ‘shock’ could result and those affected will become physically weaker, economically impoverished, socially dependent, and/or psychologically harmed (Bogale et al, 2005; Chuma et al, 2007).

Booth (1996) proposes a useful approach for understanding and investigating coping strategies by grouping them into ex-ante and ex-post strategies. Ex-ante coping strategies (examples include healthy lifestyles and preventive care) include those strategies that will reduce the likelihood of illness incidence or decrease the damaging impact of a potential illness while ex-post strategies (examples include using up savings and borrowing from friends, relatives or money lenders) refer to those designed to relieve the actual impact of an illness (Booth, 1996). Based on a review of literature, the following coping strategies have been identified (Table 2).

Table 2: Summary of Ex-ante and Ex-post coping strategies

<table>
<thead>
<tr>
<th>Conceptualising coping strategies</th>
<th>Ex-ante</th>
<th>Ex-post</th>
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<tbody>
<tr>
<td>Holzmann, 2001</td>
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<tr>
<td>1). Prevention strategies to reduce the likelihood that the household will experience the shock;</td>
<td></td>
<td>2) mitigating strategies to decrease the potential impact of a future shock, including portfolio diversification, insurance, hedging/risk exchange; and 3) Coping strategies to relieve the impact once the shock has occurred.</td>
</tr>
<tr>
<td>Jiang and Braun, 2005</td>
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</tbody>
</table>
Three criteria for classification of coping strategies:
(1) Risk transfer (whether the risk has been transferred or not);
(2) Risk reduction (whether the negative impact on household production is reduced or not); and
(3) Risk protection (whether household well-being/assets were protected or not).

Yu et al, 1998

<table>
<thead>
<tr>
<th>Examples</th>
<th>Yu et al, 1998</th>
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<tbody>
<tr>
<td>Distinction between short- and long-term strategies:</td>
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<tr>
<td>Short-term strategies</td>
<td></td>
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<tr>
<td>1) Borrow</td>
<td></td>
</tr>
<tr>
<td>2) Sale of residual assets</td>
<td></td>
</tr>
<tr>
<td>3) Manage farm work with help from friends and relatives</td>
<td></td>
</tr>
<tr>
<td>Long-term strategies;</td>
<td></td>
</tr>
<tr>
<td>1) Debt from continuous borrowing.</td>
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</tr>
<tr>
<td>2) Sale of core (or productive) assets</td>
<td></td>
</tr>
<tr>
<td>Belonging to medical insurance scheme, improving sanitation and healthy lifestyle</td>
<td>Using cash and savings; selling live stock; selling other assets; changing productive activities; borrowing from friends and relatives; illness modification; borrowing from money lenders; receiving in-kind help from friends and relatives; delaying payment to private health care providers; being exempted from medical fees; receiving support from children; receiving reimbursement from schemes and receiving social relief.</td>
</tr>
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</table>

3.1 Ex-ante coping strategies

Jiang and Braun (2005) summarized ex-ante strategies that rural households adopt in coping with ill health to include preventive and health-promoting strategies (adopting a healthy lifestyle, clean and healthy food, regular exercise and refraining from high risk work), strategies for reducing cost (early treatment and joining employers’ insurance scheme). As part of adopting a healthy lifestyle, increasing awareness and securing safe drinking water were important. Using data from 2,008 households in Jiangsu, Zhu (2000) found out that more than 80% of the households had joined a children’s immunity project and used clean drinking water facilities, 40% received health-related education and possessed improved sanitary facilities.
Diverse health-seeking strategies were frequently used by rural households to reduce ill-health risk. Using data from 25 counties in provinces of China in 2005, Yan et al, (2006) found that in villages with cooperative medical schemes, 80% of households had joined the scheme as a means of coping with unforeseeable health care risks.

Another strategy relates to illness modification. In China, Liu (2005) found that farmers with minor illnesses usually did not see doctors but only went to hospital when apparently small problems became more serious. Ministry of Health (MOH) (2004) data in Nigeria showed that for those sick over a two-week period a sequence of care seeking is followed, the reported rates for no-action, self-care and visiting a doctor were 31%, 54% and 14% respectively for the least poor. Suggesting that as illness progresses, households move from not seeking care to self-care and finally to visiting a doctor as illness persist.

3.2 Ex-post coping strategies

According to the literature, in the absence of savings, households responded to health care costs by firstly borrowing from family, friends and as a last resort, money-lenders (Bogale et al, 2005; Chuma et al, 2007). This points to the importance of support networks as a source of borrowing (Booth, 1996; Waddington, 1989; Tungaraza, 1993, Abel Smith, 1992, Mwabu, 1995). In Kenya, borrowing from relatives and friends was the most frequently reported strategy, “…because it was the easiest and quickest way to raise money” (Chuma, et al 2007, p: 680). In the same study, other less common strategies included gifts, sale of labour on farms, selling assets and receiving treatment on credit. Tungaraza (1993) suggests that women also belong to social associations where they contribute to a pool of fund and the benefit is rotated among members. These networks are occasionally organized into ‘money exchange networks’ with members contributing small sums each week (Tungaraza, 1993). In Zambia, a more desperate strategy was to beg for assistance from friends and kin (Booth, 1996).

Following borrowing, households typically resort to selling crops and depend on gifts in the form of food or cash (Bogale et al, 2005). Selling stores of value (farm produce, belongings and assets) was also a common response but it was unclear whether the farm produce sold was surplus to requirement or essential to current consumption needs. Pryer’s study in Bangladesh
found that medical expenditure was higher for those households with assets to sell and the cost of medical expenditure in all such households was borne by the sale of assets. Once assets were depleted, medical expenditure ceased (Pryer, 1989). This suggests that in the absence of assets, access is severely constrained.

In a study of 25 African countries, Leivie and Xu (2008) found out that coping through borrowing and selling of assets ranged from 23% of households in Zambia to 68% in Burkina Faso. In general, the highest income groups were less likely to borrow and sell assets, but coping mechanisms did not differ strongly among lower income groups. Except in Burkina Faso, Namibia and Swaziland, households with higher inpatient expenditures were significantly more prone to borrowing and diminish assets compared to those financing outpatient care or routine medical expenses. They also found out that in most African countries, the health financing system was too weak to protect households from health shocks and asset depletion.

Consistent in the literature is the finding that households in responding to costs arising from ill-health, often use a combination of coping strategies and do not rely on only one. In Cambodia, Van Damme et al (2004) found that households used a combination of savings, selling consumables, selling assets and borrowing money to finance health care expenditure. Zhu (2000) found that in China, rural households generally followed the following sequence in coping with economic hardship: reducing consumption expenditure, using savings, borrowing from friends and relatives, borrowing from moneylenders, working longer, selling durables and productive assets, leaving home to work outside, begging for food, breaking up the household and finally committing crimes. This sequence suggests that as illness persists, to cope with costs incurred, household progress from the most uncomplicated to the direst and often desperate coping strategies.

In almost all of the studies described above, formal prepayment schemes which could benefit many households and help to mitigate the long-term effects of illness-related costs were almost non-existent. A conclusion from the above discussion points to the fact that in the absence of pre-payment schemes and household savings to meet illness costs, households especially those who are poor are often forced to adopt coping strategies (e.g. borrowing from money lenders, selling of household assets, removing children from school, reducing household food...
expenditure) which impact on their future livelihood and development (Russell 2001; Meessen et al, 2006).

**4. Gender, Out-of-Pocket Payments and access**

Aside from biological factors, culturally gender-based differences in OOP, access to and control over resources, in power and decision-making, and in roles and responsibilities have implications for health-seeking behaviour, access to health care services and health status for women and men. These issues will be explored in detail in this section.

**4.1 Gender and intra-household decision making**

In order to understand how gender affects access to and utilisation of health care services, it is important to firstly understand that individuals, both male and female, are often located within households. Traditionally, the household has been viewed as a unitary model (Becker, 1974) in which decisions are made by the household head, who is often male, and presumed to act in the interest of the household and, based on his authority and status as head, would ensure that other household members act in the same way. This theory has long been rejected in favour of indications that individuals within a household differ significantly in their ability to access key resources and to effect decisions according to their gender, age, and social power (Mosedale, 2005).

These rejection of the unitary model gave rise to what Sen (1990, p: 128) describes as the ‘‘coexistence of extensive conflicts and pervasive cooperation in household arrangements’’. Within households the pooling together and allocation of resources occur at a household level but those decisions over who controls the resources and how they are spent, rest with those with power in the household and this power is often derived from the ability to earn an income. Clearly, intra-household allocation of resources which refers to the dynamics of how different resources that are generated within, or which come into the household are controlled and accessed by different members (Baden and Reeves 2000), has important consequences for health care access (Shaikh, 2005; Mumtaz, 2003), nutrition (Bindon and Vitzthum, 2002; Baqui et al, 1994) and education (UNICEF, 2007). This will be discussed in more detail in the next section.
Sen (1999) and Huston (1998) note that the agency of women within the household is shaped by factors including socio-economic status of her family of origin, education, their ability to find paid employment and ownership rights (e.g. over land). These factors improve and elevate the status of women within and outside the household and can be an important factor in shifting the power dynamics within the household and strengthening women’s voice in the control over and the allocation of household resources. Under these circumstances, where the social position of women has changed, joint-decision making is more likely to be the norm in male-headed household (MHHs). Matsumura and Gubhaju (2001) in Nepal discovered that women’s participation in intra-household decision making is an indicator of their status. Status in this sense is a result of age and/or earning income. There is some debate about the extent to which power of decision-making affects women’s sense of belonging within the household (Mosedale, 2005; Becker et al, 2006). In a sense, a woman’s participation in household decision making affects her sense of belonging in a household especially in households with tight extended family bonds.

The unitary model, which assumes MHHs, does not hold when considering female-headed households (FHHs). FHHs have received increasing attention in the literature not least because of the concern that it is a marker of vulnerability but its association with poverty (Posel, 2001; Puentes-Markides, 1992). It is important to note that Chant (2003) actually questioned the “feminisation of poverty” and argued that poverty of FHHs is context specific. She emphasized that poor FHHs are generally found in poor societies and societies that place women as household keepers. This suggests that vulnerability is not derived from socio-economic factors alone and might be a consequence of gender-based societal and cultural norms which discriminate and dis-empower women. In Uganda, a study by Kanyamurwa et al (2007) found that FHHs were more vulnerable to AIDS than male-headed counterparts. In an instance of the death of a spouse, their remarriage opportunities were lower than men’s, they faced greater risk of losing control over land and livestock once their spouses die and they accessed less state and private sector support. In South Africa, although women-headed households have more autonomy and agency over resources (Posel, 2001), since they are also likely to be poorer, they are likely to face more food insecurity and economic vulnerability (Rose and Charlton, 2002). At the same time, there are instances where gender and access to social networks is protective for
FHHs. For example, in South Africa a study found that although FHHs were worse off economically than MHHs, they reported experiencing less food insecurity and this was attributed to their use of social networks (Lemke et al, 2003). A study by UNICEF (2007) in 2000-2004, found that 74.1% of Nigerian women reported their husbands making the sole decision with respect to need for health care. This has implications to their health status and health seeking behaviours.

Polygyny, another type of household structure in sub-Saharan Africa, which also does not conform to the unitary model (Becker 1974), represents an excellent example of “co-operative conflict” (Sen 1990), because in polygyny, relations between co-wives and male head plays an important role in structuring women’s access to resources essential for their own health and that of their children (Bove and Valeggia, 2008). In many African societies, polygyny is a common marital union (van de Walle, 2005; Bove and Valeggia, 2008). According to Orubuloye et al, (1991), in polygynous households in West Africa most women have autonomy as indicated by having their own budgets, controlling resources, and making decisions, including treatment decisions, based on these resources. The separation of spousal incomes has been attributed to inherent tension between husbands and wives, and to wives’ efforts to protect themselves by retaining their earnings separately. They also found that most children health care costs paid for by one person only, usually a parent, and that the treatment chosen is decided by the person meeting the cost. Mothers are most likely to pay for minor illnesses but the father’s role becomes more important as the cost rises. Oni (1996, p: 59) inferred that “because the mother and her children usually form a social unit within a polygynous union, meeting the cost of treatment and some other minor daily needs of the child has always been the responsibility of the mother. In the past, a woman's ability to meet the cost of treatment of her children was partly explained by her separate income from that of her husband, but with the persistent rise in cost of treatment, many mothers now have to look to their husbands or other sources for assistance in paying for treatment of their children.” This depicts the impact of rising health care costs on intra-household relations.

4.2 Gender, health care access and utilisation
“Differences in the way society values men and women and orthodox norms of male and female behavior can influence the risk of developing explicit health problems as well as health outcomes” (Harcourt, 2001, p: 87). Studies have indicated that preference for sons and the undervaluation of daughters distort the investment of households in health care (UN, 2005). This has potentially serious negative health consequences for girls, such as lower levels of immunization and avoidable mortality (Bertakis et al, 2000; Furuta and Salway, 2006). Significant gender differences have been reported in the immunization rates of boys and girls from Africa and Asia. Immunization rates among girls are 13.4% lower when compared with boys in India, 7.2% in Gabon and 4.3% in Ethiopia (GSIP, 2009). A 2004 study in 16 Indian states found that girls were five times less likely to be fully immunized than boys. In Nigeria, on the other hand, immunization rates among boys were 7.2% lower than for girls (GSIP, 2009). "While the above is true for women as a whole vis-à-vis men, there can be significant differences among women themselves based on age or life cycle status, as well as on the basis of economic class, race, caste, and ethnicity" (Sen and Ostlin, 2008, p: 4).

Intra-household relations determine the extent to which treatment-seeking decisions are a mother’s domain, and who else are involved and to what extent their involvement affects utilisation of health care resources (Castle, 1993; David, 1993; Mwenesi, Harpham & Snow, 1995). Nevertheless, the point remains that women’s decision-making has some bearing on their health status. The greater is a woman’s power and influence within the household, the greater is her role in decision making and utilisation of health care services. For instance, a decline in infant and child mortality in Egypt (Kishor, 2000), women’s use of prenatal care services in Indonesia (Beegle, Frankenberg, and Thomas, 2001), immunisation of children in Egypt (Kishor, 2000), seeking treatment for sick children in Mali (Castle, 1993), and the utilisation of modern contraception in India (Jejeebhoy, 2002) have all been attributed to a greater autonomy of women. Also, in Guatemala, Glei et al, (2003) reported that in rural areas married women who reported greater household decision-making power used antenatal services during pregnancy more often than those who reported less autonomy. In contrast, in more patriarchal societies like Pakistan, where decisions regarding women’s health are in the hands of men (Shaik, 2005), this contributed to women reporting lower levels of utilisation despite suffering increased morbidity.
(Mumtaz, 2003) and are more likely to experience under-nutrition (Bindon and Vitzthum, 2002; Baqui et al, 1994).

Women’s confinement to household chores, poor access to money in instances when they are unemployed and gender norms which restrict their mobility (Furuta and Salway, 2006; Nigenda et al, 2003), contribute to delays in them seeking care. Within households, while they may be permitted to make decisions regarding the health of their children, they might require the consent of either their husbands or important elders when they themselves require care (Puntes-Markides, 1992). Data from demographic and health surveys show that, in parts of sub-Saharan Africa and South Asia, in more than 50% of households, women were not involved in decisions concerning their health (UNICEF, 2007). In Burkina Faso, Mali and Nigeria, almost 75% of women reported that their husbands alone took decisions concerning their health care (UNICEF, 2007).

There are important gender-based differences in terms of the access dimensions. Such differences are related to availability, acceptability and affordability of health care services. These are explored in more detail below.

**Availability**

Availability has an important and direct bearing on the utilisation of health care services particularly with regard to women. Services that provide women specific health care needs should be provided for populations with high representation of women. Also the population should be studied to understand their health care needs (reproductive services, antenatal, delivery and post natal services should be provided for a population with high numbers of women in reproductive age) (Ibeh, 2008).

A related determinant of accessibility and utilisation is distance. Long distances to health centres are cited as a barrier to care particularly for women in poor households. The further away a facility is from potential users, transport becomes more important and transport costs are likely to be incurred, with implications for women’s access and utilisation of health care (Nanda, 2001).

**Acceptability**
Acceptability of health care services is a factor that is strongly influenced by cultural and religious practices of the community (Goudge et al, 2009). In developing countries, especially in rural areas where custom and tradition are predominant, particularly in patriarchal societies, women find themselves in subordinate positions to men and older household members. In such instances, gender discrimination is likely to influence health care access and utilisation (Buor, 2004). Despite the fact that women are often the primary care givers in the family, they are often forced to seeking permission and approval from the male heads in their households, when they need to access financial resources for health care (Puentes-Markides, 1992, Bonu et al, 2009).

A study by Mumtaz (2003) in Pakistan found out that women because of social norms were often not allowed to visit a health care centre or provider alone or to make the decision to spend money on health care. Thus women generally cannot access health care independently even in emergency situations. This certainly has serious repercussions for women’s health in particular and their self-respect and autonomy. This often means that decisions over women’s needs, including health care, are made by men and who in turn base their decision on their knowledge, perception of illness and acceptability of health care facilities (Sen and Ostlin, 2010). It is here that acceptability of health care services particularly from the perspective of the decision maker and not the person in need of care plays a major role because when men do not accept these services as necessary based on their cultural and religious beliefs, they will not permit women to utilise them (Peters et al, 2008).

Also in societies which limit social and physical contact between men and women particularly on religious grounds, the significance of gender concordance between the health provider and patient is important (Govender and Penn-Kekana, 2007). A qualitative study conducted in Cuba, Thailand, Saudi Arabia and Argentina, looked at the experiences of women seeking antenatal care and found that female doctors were more highly favoured by Saudi and Thai women (Nigenda et al, 2003).

Often the needs of women are thought to be almost exclusively related to their reproductive roles or their needs are defined in male-health terms, without bearing in mind and incorporating their own experiences of health and illness, so that the health system is able to respond in a culturally suitable and gender receptive manner (Harcourt, 2001). On the other hand, due to feelings of
vulnerability, previous household victimisation, lack of information, experiences of fear or oppression, women are unable to voice their needs in any successful manner to influence policy making (Nanda, 2002). In some societies, women’s health complaints are not perceived as real, and therefore there is no health care service available to solve their problem, nor little space to make it understood and therefore recognized as a health need (Ojanuga, 1992; Mosedale, 2005).

**Affordability**

Across most parts of the world including developing countries, men have more access to education and as a result have more formal jobs and earn more income than women (Buor, 2004). Men’s relative economic power derived from their participation in the labour market in addition to those powers conferred by gender norms, increases their power and authority in households over household resources and decision-making powers on household expenditures (MacCormack, 1992; Kinshor, 2000, Harcourt 2001). In Nigeria, like in many other developing countries, rural women are often regarded as part of the male’s property in the household; requiring them to seek the approval of the males in the household for any decision-making activities including health care (Uzochukwu and Onwujeke, 2004).

Women constitute the largest proportion of the world’s poor, they often hold lower-paying jobs and more likely to be employed in the informal sector, all of which reduce their ability to pay for and access health care (Puentes-Markides, 1992; Irving, 2009). In Latvia, Xu et al, (2009) found out that gender bias and income inequalities may cause differences in unmet need for health care services between women and men. While utilisation of health services shared a positive socio-economic gradient (i.e. increased with increasing income), women had a higher unmet need for health services than men in every income quintile (Xu et al, 2009). This suggests that women in all socio economic status experience health care barriers which invariably impact on their access, utilisation and ultimately health outcomes.

4.3 **Gender dimensions of out-of-pocket payments**

The effect of OOP payment on utilisation of health care differs between men and women based on access to financial resources and health care needs (Buor, 2004). As noted earlier, access to
financial resources is also entangled with decision making power within the household and this often is a key determinant of health care access (WHO, 2005).

In Bangladesh, when user fees were introduced for family planning services, men expressed reluctance to pay for preventive care and treatment for women, together with family planning services, in spite of their knowledge of the importance of fertility control (Schuler and Hashemi, 2002). In Latvia, FHHs were among population groups with higher chances of incurring catastrophic health care expenditure especially if they have a pregnant household member in that year (Xu et al; 2009). In household surveys that included data on total individual spending on health from Brazil (1996–1997), the Dominican Republic (1996), Ecuador (1998), Paraguay (1996) and Peru (2000) it was found out that women’s OOP payments were increasingly higher than those of men (UN, 2005).

One of the factors contributing to the increased spending might be women’s specific health needs related to pregnancy, childbirth, contraception and abortion (Nandraj et al, 2001). In a study on women and health care in metropolitan Mumbai in Maharashtra, Nandraj et al, (2001) discovered that women had a higher morbidity rate than men across all the age groups. Similarly, in a study of the gender gap in primary health care resource and utilisation in Central Asia, Cashin (2002) found that both in absolute and per capita terms, the principal users of primary health care were women of reproductive age and children under five. Women of reproductive age were found to consume approximately 1.5 times the average per capita primary health care resources, while men in the same age group consumed approximately one-half of the average (Cashin, 2002). At the same time, despite women’s comparatively higher need for health care, Buor (2004) in Ghana found that males utilised health services more regularly than females, even though females had a greater need. Under-utilisation and poorer access by women was explained by lack of affordability in the context of user fees.

4.4 Gender and household coping strategies

Assumptions about FHHs being the 'poorest of the poor' revolve first, around the evidence that they form unequal number of the poor in the majority of societies worldwide, and second, that FHHs are susceptible to experiencing greater extremes of poverty than male-headed units
(Paolisso and Gammage, 1996; UNRISD, 2005). While there is very little literature on headship and health care coping strategies in LMICs, the socio-economic difference between male- and female-headed households has a major influence on how these households cope with health care costs. When faced with health care costs, their ability and capacity to respond to the economics costs of illness are likely to be different.

In Uganda, a study by Kanyamurwa et al (2007) found that FHHs as a means of coping with recurrent costs of health care, were more dependent on livelihood support from non-governmental organisations, which were found to provide both welfare and credit support to those suffering from AIDS. Women were also found to play an important role in social networks and resources at community level but they received little support from many formal community networks and services. While women’s nutritional status may be affected by drought shocks more than men’s, women do not bear the effects equally. Women in poor households and those with an unfavourable position within the household are more likely to be worse off. Asset ownership may serve as an important ex ante coping mechanism that protects women.

Onah (2010) in Nigeria found that with regard to inheritance, a woman inherits her husband’s property only if she has a male child. This implies that the property actually goes to her son and not herself. She found out that dispossession of husband’s property is one major reason for financial problem. In that study, women ranked disinheriting as their number one financial problem. This progresses to a decline of income below poverty line, lack of money to feed, pay school fees, rent, health care, etc. Women are then forced to fall back on their own relations whose financial support may be lacking. This has dire consequences in coping with health care costs and may result in delayed care seeking, seeking ineffective care and ultimately not seeking care due to affordability issues.

5. Conceptual framework

Based on the theoretical and empirical review, a framework for the study of the implications of OOP payments for access and utilisation from a gender perspective can be conceptualized as follows.
As noted earlier, access is a multidimensional concept based on interactions between health care systems and individuals or consumers (McIntyre et al, 2009). The focus is on empowerment of an individual to utilise health services. Clearly, following from the emphasis on empowerment in the Access-framework (McIntyre et al, 2009), gender-based power relations which often disempower women has important implications for health care access. These interactions between the health systems and individuals or consumers can result in access being either “realised” (utilisation) or just remain “potential” as proposed by Aday and Andersen (1974). Factors which predispose households toward realised access and utilisation of health care services include family composition (age, sex, size and marital status), social structure (occupation, education, ethnicity, gender), and health perceptions and beliefs linking to attitudes toward physicians, health care and disease. Other factors have an enabling role, for example, family resources (income, savings, insurance ownership and access to a regular source of care) and whether the community has suitable resources (service provision). These characteristics are expected to differ between FHHs and MHHs. It is hypothesised that since FHHs have lower social structure and predisposing factors (poorer, older, less educated, lack ownership of medical aid and are mainly subsistence farmers), OOP payments will be a greater barrier to health care access and utilisation for them relative to MHHs (who are more educated, formerly employed and younger).

Based on the review of the literature, it is hypothesized that intra-household decision-making affects access to household resources with regards to the gender of household member in male- and FHHs. The dynamics of household decision-making vary between MHHs and FHHs. In MHHs, women’s autonomy is a strong indicator of their access to household resources and their participation in decision-making over household expenditure including health care expenses. In patriarchal societies, financial resources and decision-making with respect to household monetary expenditures are in the custody of the male head. When the social position of women changes, often as a consequence of them having an independent source of income, joint-decision making is more likely to be the norm in MHHs. Therefore, in wealthy households, if women are not empowered and have a voice in decision-making, while the household might have the financial resources to access care, women might not have a voice over how those resources are spent and access is a challenge.
The subordinate role played by women in patriarchal MHHs might differ in FHHs. While women in FHHS are likely to enjoy more autonomy and are likely to have a greater voice in health care decisions, if they are poorer, older, widowed and employed in the informal sector, OOP payments are likely to be a financial barrier to access. At the same time, these FHHs are likely to be poorer with higher dependency ratios and probably likely to experience more financial barriers, thus constraining access. Therefore, OOP payments are likely to be an important barrier to access for widows with implications for health status.

Coping strategies are also likely to differ between MHHs and FHHs. Factors relating to employment status of the household head, access to social networks, asset base, and dependency ratios are important factors shaping households ability to cope in the event of illness. It is hypothesized that if FHHs have poor access to savings and assets, their ability to pay for health care and affordability is likely to be a challenge and they are more likely to forego seeking care. In the event that they seek care and they do not have an income or assets, they are more likely to borrow. In order to cope with meeting health care costs, they are likely to engage in more strenuous and catastrophic activities like cutting on food consumption and working in construction sites than their male counterparts. Ex-ante strategies employed by FHHs and MHHs may also differ. While MHHs might have access to health insurance, savings and asset base, FHHs might tend to draw more on social networks to mitigate the shock of health care cost. Ex-post strategies may also differ by MHHs drawing more on savings and assets while FHHs may draw from social networks and borrowing from relatives and as a last resort, from money-lenders.

6. Summary

There is sufficient evidence that OOP payments have severe consequences for health care access and utilisation and are especially catastrophic for the poor. The implications of OOP payments for health care access from a gender perspective have received little attention in the literature, although the literature on the implications of such payment’s by households in relation to their socio-economic status is reasonably ample.

Gender has been seen to affect health outcomes because it affects health inputs. The literature indicates that gender-based differences in health care access are often rooted in intra-household
issues revolving around access to and control over resources. In the context of OOP payments and especially user fees, in instances where women are dependent on the male head for access to financial resources, affordability is clearly a barrier to access for women.

Literature from Nigeria is limited with respect to examining the burden of OOP payment on access and utilisation from a gender perspective. While several studies have explored the implications of OOPs on utilisation, there has been little research which has examined different coping strategies that Nigerian households adopt, let alone from a gender perspective. From a policy perspective, it is important that research and evidence be conducted to fill this gap in order to better understand how households and particular FHHS cope which can then inform the design of re-emptive measures to strengthen the capacity of households to cope with health care costs.
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Part C: JOURNAL MANUSCRIPT

Out-of-Pocket payments, health care access and utilisation in South-Eastern Nigeria: A gender perspective.

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Keywords: Gender; Female-headed household; Health services; Access; Utilisation; Out-of-pocket payment; Nigeria.

List of Abbreviations Used

1. OOP – Out of pocket
2. WHO – World Health Organization
3. FGDs – Focus Group Discussions
4. PMVs – Patent medicine vendors
5. EAs – Enumeration Areas
6. FHHs- female-headed households
7. MHHs- Male-headed households
8. UN- United Nations

Word count: 7200
ABSTRACT

Out-of-pocket (OOP) payments have severe consequences for health care access and utilisation and are especially catastrophic for the poor. Although women comprise the majority of the poor in Nigeria and globally, the implications of OOP payments for health care access from a gender perspective have received little attention.

This study seeks to fill this gap by investigating the research objectives through a combination of quantitative (cross-sectional household surveys) and qualitative (Focus-Group Discussions) analysis of the gendered impact of OOPs on health care access in south-eastern Nigeria. A total of 411 households were surveyed in a mix of urban and rural areas and six single-sex Focus Group Discussions conducted. On further disaggregation, 160 households were female-headed and 251 households were male-headed.

This study confirmed the socio-economic (predominantly poor, subsistence farmers) and demographic (widowhood, less educated) vulnerability of female-headed households (FHHs), which contributed to gender-based inter-household differences in health care access, cost burden, choices of health care providers, methods of funding health care and coping strategies. FHHs had higher cost burdens (12.1%) from seeking care and untreated morbidity (10.6%) than male-headed households (MHHs) (9.8% and 4.3% respectively) with affordability as a reason for not seeking care. There is also a high utilisation of patent medicine vendors (PMVs) by both female—and male-headed households. OOP payment was predominantly the means of healthcare payment for both households (86.9% for FHHs and 91.8% for MHHs). Both FHHs and MHHS spoke of the difficulties associated repaying health-related debt with implications for the medical poverty trap.

It is recommended that the removal of user fees and introduction of prepayment schemes be considered to improve access and provide protection against debt for FHHs and MHHs. Improved access to primary health centres and regulation of patent medicine vendors is important. The vulnerability of widows is of special concern and efforts to improve their health care access and broader efforts to empower them including enactment of laws that protect them from discriminatory practices (e.g. disinheritance) and improve their livelihoods (e.g. micro-finance schemes) should be encouraged for them and other poor households.

Abstract: 341 words
Introduction

Gender, Out-of-Pocket Payments and Health Care Access

A key message of the World Health Report 2010 is that “…millions of people cannot use health services because they have to pay for them at the time they receive them. And many of those who do use services suffer financial hardship, or are even impoverished, because they have to pay.” (WHO, 2010). To date, much of the focus has been on the implications of out-of-pocket payments (OOPs) including user fees for individuals and households in relation to socio-economic status. While this is clearly important and warranted, other researchers have been pointing to the barriers that other vulnerable groups (i.e., women, children, ethnic minorities) face (Furuta & Salway, 2006; Omariba & Boyle, 2007). Considering that women represent 70 per cent of the world’s poor (UNIFEM, 2008), the influence of gender on access in the context of out-of-pocket payments is important. Research has shown important differentials in financial access between men and women. For example, “women incur more out-of-pocket expenditure than men”; “paying for health care and other reproductive health services places a high financial burden on women” and “out-of-pocket expenditure may prevent more women than men from utilising essential health services” (WHO, 2005, p: 650).

Research on gender and health care access has also broadened to consider implications for access from the perspective of female-headed households (FHHs). This has been prompted by the growing number of FHHs globally (Chant, 2003). In 1998, almost a fifth of households worldwide and in sub-Saharan Africa were female-headed (Delamonica et al, 2005). In both developed and developing countries, studies have revealed that FHHs are likely to have different demographic, sociological, and economic characteristics from MHHs and that these differences have major implications for health care access and utilisation (Mumtaz, 2003; Nash Ojanuga, 1992). While data are inconclusive on whether FHHs are poorer than their male counterparts (O’Lloughlin, 1998), data from across different settings suggest that they have higher dependency ratios and are typically headed by older women, who are often widows (UNICEF, 2007). Research from Ghana indicated that widows and single women are especially vulnerable and that particularly those from poor households found direct costs of care an access barrier (Buor, 2004).
Nigeria

Since the fall in oil prices in Nigeria in the 1980s, economic growth has slowed, with adverse implications for government budgetary allocations towards health care and other social sectors (Onwujekwu et al., 2010). In 2010, it was found that the share of government expenditure on health care was merely 3.5%; this is considerably below the 2001 Abuja commitment which called on all signatory governments (including Nigeria) to allocate 15% of government expenditure to health care, (WHO, 2010a). In Nigeria, public spending per capita for health is less than USD 5 and can be as low as USD 2 in some parts; a far cry from the USD 34 recommended by WHO for LMICs (WHO, 2010b). Private health expenditure as a percentage of total health expenditure is almost 64%. Households contribute almost 96% of total health care expenditure through OOP payments (WHO, 2010b). This is important in the context that 34.1% of the population lives below the poverty line (i.e. less than USD1 per day) (UNDP, 2008). Clearly, the burden of paying for health care is especially regressive for poor households.

In Nigeria formal and informal user fees are charged in health care facilities with fees differing according to the type of care sought and the level of facility utilised (Ichoku and Leibbrandt, 2003). The under-resourcing, poor provision and delivery of public health services and the burden of user fees for roughly every treatment item has encouraged the growth of and demand for private health care (Ichoku and Leibbrandt, 2003). Private health care accounts for almost 66 per cent of total health care in Nigeria (WHO, 2010) and covers a wide range of providers, including patent medicine vendors (PMVs), pharmacy shops, traditional medicine sellers, maternity homes, clinics, and private tertiary hospitals, many of which are unregulated (e.g. PMVs).

Women lag behind men in education and employment. Women have lower levels of literacy compared to men (44% vs. 67%) (DHS 2008). This has implications for the type of employment opportunities that women have. Data from the NBS (2009) shows that women had a higher unemployment rate (42%) compared to men (22%), 55% of the employed were low-grade staff in the formal sector and those employed in the farming sector, were predominantly employed as unpaid (family) labour. In the rural communities, control of income from farm proceeds are in the hands of men (Ibeh, 2008). A household survey concluded that utilisation of health care by
women is mediated by their role in decision making and resource allocation within households (DHS 2008). Results from the same survey found that a woman is more likely to be a part of the decision-making process on how her earnings and her husband’s earnings are spent if she earns more than or the same amount of money as her husband. The South East zone where the study was located had the lowest percentage of women making sole decisions regarding their earnings (27%). Clearly, lack of access to paid employment and inequitable decision-making power within especially poor households might mean that when poor women are confronted with OOP costs for health care, it can delay or deter utilisation (Kiwanuka et al, 2008).

Studies from Nigeria have neglected the issue of affordability in the context of OOP payment for male-and female-headed households. Previous research has either analysed the effects of OOP payment on the poor or on female specific health services (Awusi, 2009; Ibeh, 2008; Adamu, Salihu, 2002; Kabir et al, 2005). Thus, this study seeks to investigate and fill this gap by investigating through a combination of quantitative and qualitative analysis the impact of OOPs on health care access on male-and female-headed households.
Methods

Study area

This study was conducted in Nsukka Local Government Area (NLGA), located in the northern part of Enugu State in south-eastern Nigeria. NLGA comprises one urban and 14 rural communities, with a population of almost 310,000, comprising approximately 63,705 households (NPC, 2006). Agriculture is the main economic activity and the area is predominantly Ibo (i.e. ethnic group) who are mainly Christians with a few traditional believers in the rural areas. Like other parts of Nigeria, women including FHHs in NLGA are less educated, engage more in low level subsistence farming and largely employed in informal employments with low income generation abilities (NBS, 2007). Heads of FHHs are largely older than their MHHs counterpart and headship is mainly as a result of widowhood (Ataguba, 2007).

The urban community is a university town and has a wider variety of health care providers including public and private hospitals, primary health care providers, patent medicine vendors (PMVs), and pharmacies. In the rural communities, primary health facilities referred to as health centres and patent medicine stores/vendors (PMVs) are the main health services providers. If hospital care is required, people travel to the urban hospital which is between 18-30 kilometres away. All government facilities charge user fees, although charges differ depending on the type of care sought and patients also pay for drugs. There are exemptions for HIV treatment, leprosy and maternal health.

Sampling and data collection

The study used both cross-sectional household surveys and focus-group discussions (FGDs) methods to investigate the research questions. A total of 411 households were interviewed (111 in urban and 300 in rural communities). A household is designated as comprising individuals who live in the same house and who have common arrangements for basic domestic and/or reproductive activities such as cooking and eating” (Chant, 1997 p: 40).

Household surveys were chosen over facility-based survey since an understanding of access requires considering the views and experiences of both users and non-users of health care.
The following approach was adopted in order to determine the sample size. Given that in 2010, NLGA comprised 69,705 households\(^5\), the minimum sample size required to obtain a confidence interval of 5% around this figure was 400 households. The sample size was increased to 411 households to allow for data incomplete questionnaires.

A multi-stage sampling method was used to select households for the survey and the urban and 14 rural communities were classified into enumerator areas (EAs) (Ataguba, 2007). First, to ensure adequate representation of both urban and rural EAs, NLGA was stratified into urban and rural communities, representing 30% and 70% of the population respectively. A total of 24 EAs were selected (3 urban, 21 rural) based on probability-proportional to size (PPS) and 39 and 21 households were sampled in each of the urban and rural EAs respectively. In the second stage, a simple systematic random sampling method\(^6\) was used to identify survey households from each of the EAs. The questionnaire was administered to preferably the household head or the spouse and in their absence, a senior household member. The interviews were conducted by 9 trained field workers.

Six single-sex FGDs (2 urban, 4 rural) were conducted in 3 communities (1 urban, 2 rural). Each FGD consisted of 8 to 11 participants. Single-sex interviews were considered appropriate given the focus of the research on gender, health care access, coping strategies and intra-household decision-making and sensitive issues which are likely to be spoken of more freely and without fear of reproach in a single-sex group. FGDs were organised to ensure that participants were of similar economic background and economic activity (traders, teachers, farmers, women religious and trading groups), besides considerations of gender. Invitations were sent to men and women in advance of their meeting days. All participants were 18 years and older. The discussions were conducted in the village square and community centres.

\(^5\) The population and number of households were extrapolated based on the 2006 population census and an annual 3% population growth rate (NBS, 2007).

\(^6\) The sample of households was appropriately weighted in analysis using the inverse probability weighting method which denotes the inverse of the probability that the observation is included in the analysis due to the chosen sample design (Ataguba, 2007). Under the method, each household selected from each enumeration area (EA) is weighted to make it representative of the entire EA such that the sum of the weights for each EA should equal the approximate number of households in that EA.
Study variables and data analysis

The household surveys investigated households’ socio-economic and demographic status, general household and health care expenditure patterns, household assets, utilisation patterns, health care financing, intra-household decision making and coping strategies. The questionnaire was adapted from an earlier survey conducted in the same region (Onwujekwu, 2010) and was translated into the local language.

While the household survey provided important data for quantifying the differences and similarities in utilisation patterns between male and female-headed households, it was inadequate in helping us understand why these differences existed. In this study, the gap was filled through the use of FGDs, which aimed to provide more qualitative data around issues of the burden of OOPs and its implications for health care access, coping strategies, household decision-making in general and more specifically around health expenditure from the perspective of men and women. The FGDs were taped-recorded and notes were taken which were then transcribed. The transcripts were read and broad themes relevant to the study objectives were extracted. In addition, new themes which were identified during the review of the transcripts were also captured and presented in the results.

The quantitative data were inputted and managed using EpiData software and then exported to STATA software for analysis. A bivariate analysis was conducted and variables which were significant at a probability value (p-value) equal to or less than 0.05 were selected and included. The dependent variable was the sex of the household head and the independent variables included utilisation, decision- making relating to general and health care expenditure, insurance ownership, health care payment options, health status, reasons for not seeking care and coping strategies. Options were subdivided into dichotomous responses of “0” for no and “1” for yes.

The monthly cost of health care was calculated by the summation of direct costs (i.e. registration/card fees, consultation fees, laboratory tests and drug costs) that a household
incurred in the month previous to the interview. This cost was converted to United States Dollar\(^7\).

This study used asset indexes as a measure of socio-economic status of households. Asset index is preferred over other measures of constructing the socio-economic status of households, including expenditure and income in LMICs since the latter suffer several weaknesses. These weaknesses include being more difficult to collect, not adequately capturing seasonal variation, recall bias, and not being sensitive to non-cash, in-kind transfers and income (Montgomery, Gragnolati, Burke & Paredes, 2000; Vyas and Kumaranayake, 2006). In this study, information on ownership of electronic equipment (e.g. radio, television and fridge), transport (bicycle, motorcycle and motorcar), sources of energy (kerosene lamp, electricity generators and rechargeable lamps) were pooled together to construct the index. In conducting the principal component analysis, the first component factor\(^8\) was used to represent the asset index. On this basis, the study population was classified into four quartiles (i.e., least poor, poor, very poor and poorest).

To estimate the proportion of households incurring potentially catastrophic burdens, costs incurred by each household for health care were divided by household monthly expenditure and reported as a percentage. The household total expenditure was derived by annualising household weekly expenditure on food and beverages and household monthly living expenditure on items such as rent, if any, energy and clothing. The total annual expenditure was then divided by 12 to arrive at the household’s monthly expenditure. Health care expenditures are deemed catastrophic if the expenditure is 10% or more of household income (Ranson, 2002), where catastrophic implies that such expenditure levels are “likely to force households to cut their consumption of other minimum needs, trigger productive asset sales or high levels of debt and lead to impoverishment” (Russell, 2004)

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\(^7\)Exchange rate of US$1.00 =150 naira (2010)
\(^8\) The first component factor is defined statistically as a weighted sum of the various assets used to assess household wealth, in order for that component to explain as much as possible of the variance observed in asset ownership between households.
Results

Demographic and socio-economic characteristics

Table 1: Demographic and Socio-Economic characteristics of household heads

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sex of household head</th>
<th>Significance (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female (n=160)</td>
<td>Male (n=251)</td>
</tr>
<tr>
<td>Average age of household head (years)</td>
<td>57</td>
<td>48</td>
</tr>
<tr>
<td><strong>Education level of household head</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>56.0</td>
<td>16.9</td>
</tr>
<tr>
<td>Secondary education</td>
<td>43.9</td>
<td>59.2</td>
</tr>
<tr>
<td>Post-secondary education</td>
<td>0.0</td>
<td>23.9</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married/divorced</td>
<td>15.6</td>
<td>6.8</td>
</tr>
<tr>
<td>Living with spouse</td>
<td>1.3</td>
<td>84.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>82.5</td>
<td>8.7</td>
</tr>
<tr>
<td>Household size (average)</td>
<td>2.0</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban (%)</td>
<td>30</td>
<td>25.1</td>
</tr>
<tr>
<td>Insured Household (%)</td>
<td>4.5</td>
<td>15.1</td>
</tr>
<tr>
<td><strong>Asset index</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorest</td>
<td>64.0</td>
<td>39.1</td>
</tr>
<tr>
<td>Poor</td>
<td>2.5</td>
<td>6.0</td>
</tr>
<tr>
<td>Rich</td>
<td>20.7</td>
<td>26.6</td>
</tr>
<tr>
<td>Richest</td>
<td>12.9</td>
<td>28.3</td>
</tr>
<tr>
<td><strong>Employment status of household head</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed/pensioner</td>
<td>7.5</td>
<td>7.9</td>
</tr>
<tr>
<td>Petty trading/hawking</td>
<td>8.7</td>
<td>8.7</td>
</tr>
<tr>
<td>Formally employed (private/public sector)</td>
<td>1.8</td>
<td>16.7</td>
</tr>
<tr>
<td>Self-employed (artisans)</td>
<td>6.2</td>
<td>8.7</td>
</tr>
<tr>
<td>Farmer (subsistence)</td>
<td>69.3</td>
<td>49.8</td>
</tr>
<tr>
<td>Trader</td>
<td>6.2</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Almost 40\% of households were FHHs. On average, the heads of FHHs were older (57 years, compared to 48 years for MHHs), more likely to have no schooling, (56.0\% compared to 16.9\%
in MHHS), more likely to be widowed (82.3% vs. 8.7%), have smaller households (2.0 vs. 4.0), less likely to have health insurance (4.5% vs. 15.1%) and more likely to be located in the poorest quintile (64.0% vs. 39.1% in MHHs). Moreover, they were also more likely to be engaged as subsistence farmers (69.8% vs. 49.8%).

Treatment seeking behaviour

A higher percentage of members in FHHs (32.4%) reported being sick in the previous month compared to MHHs (25.2%). Within FHHs, 41% of those that reported sickness in the past month were between the age of 1 and 16 years (31% girls and 10% boys). Also 45% of household heads in FHHs reported illness while 4% were adult males between the age of 18 and 25 years. In MHHs, 75% of those that reported illness were between the age of 1 and 16 years (45% girls and 30% boys). 19% were adults (10% females and 9% males) and 6% were household heads.

There were also differences in utilisation of health services between FHHs and MHHs (Figure 1). While PMVs were the single most popular health care provider for both FHHs and MHHs, a higher percentage (60.3%) of members in FHHs utilised PMVs compared to MHHs (50.4%). MHHs utilised more private hospitals and primary health care centres (25.9%, 11% vs. 19.9% and 7.6% in FHHs respectively). These findings were not significant.

Figure 1: Type of healthcare provider utilised
OOP payment was a major source of funding health care expenditure for both MMHs and FHH (See Table 2). MHHs reported a relatively higher percentage of OOPs than FHHs although this difference was not significant. In addition, FHHs reported more making in-kind payment and paying in instalments while MHHs in comparison reported higher levels of prepayment (i.e. insurance).

**Table 2: Health care payment options**

<table>
<thead>
<tr>
<th>Household members</th>
<th>Sex of household head</th>
<th>Female (n= 398)</th>
<th>Male (n= 1117)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>OOP payment</td>
<td></td>
<td>86.9</td>
<td>91.8</td>
<td>0.12</td>
</tr>
<tr>
<td>Health insurance</td>
<td></td>
<td>3.9</td>
<td>14.7</td>
<td>0.00</td>
</tr>
<tr>
<td>Instalment</td>
<td></td>
<td>20.8</td>
<td>19.3</td>
<td>0.74</td>
</tr>
<tr>
<td>In-kind</td>
<td></td>
<td>16.2</td>
<td>7.9</td>
<td>0.01</td>
</tr>
</tbody>
</table>

**Burden of Out-Of-Pocket payment and untreated morbidity**

To understand the cost burden of health care expenditure on households, monthly health care costs as a percentage of household monthly expenditure was examined across households and by sex of the household head and by socioeconomic group. Untreated morbidity was as also measured by sex of household head and socioeconomic group.
Households on the average spent $33 monthly on health care. On the average, MHHs spent more on health care than FHHs ($32.2 vs. $24.6). But when cost is viewed as a percentage of households monthly expenditure, FHHs spent about 12.1% of their total monthly expenditure on health (9.8% for MHHs) (Figure 2). In line with this, FHHs reported higher levels of being sick and not seeking care (10.6%) relative to MHHs (4.3%). When cost burden and untreated morbidity is disaggregated by socioeconomic group (See Table 3), the poorest households incurred the highest cost burdens (14.8% and 12.4%) irrespective of the sex of the household head and households that reported untreated morbidity were concentrated more within the group (65.4% and 57.1%). On the other hand, the least poor FHHs spent as little as 5.2% and 2.1% for MHHs on health care costs and households within this group that reported untreated morbidity was as low as 3.7% for FHHs and 2.1% for MHHs.
Table 3: Distribution of health care costs burden and untreated morbidity across socioeconomic groups

<table>
<thead>
<tr>
<th>Socioeconomic group</th>
<th>MHHs</th>
<th>FHHs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost burden*</td>
<td>Untreated morbidity*</td>
</tr>
<tr>
<td>Poorest</td>
<td>12.4</td>
<td>57.1</td>
</tr>
<tr>
<td>Poor</td>
<td>10.2</td>
<td>31.8</td>
</tr>
<tr>
<td>Rich</td>
<td>6.6</td>
<td>9.1</td>
</tr>
<tr>
<td>Richest</td>
<td>2.1</td>
<td>2.0</td>
</tr>
</tbody>
</table>

*Indicates significance at p<0.05

Figure 3: Affordability reasons for not seeking care

For FHHs, the most important reasons for not seeking care were drug costs and user fees as over half of the sick members gave these as reasons (Figure 3). MHHs also reported high percentages (64.6%) of drug cost and user fees (41.6%) as a major reason for not seeking care. Reports of barriers of drug costs and user fees were higher in FHHs (71.3% and 39.6% respectively) than in MHHs, while MHHs reported higher levels of transport (18.8%) costs as a barrier to seeking care. Transport cost was significant while other costs were not.
Household coping strategies

Table 4: Household coping strategies

<table>
<thead>
<tr>
<th>Coping strategies</th>
<th>Sex of household head</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female (n= 398)</td>
<td>Male (n= 1117)</td>
<td>p-value</td>
</tr>
<tr>
<td>Drew on savings</td>
<td>80.0</td>
<td>90.4</td>
<td>0.00</td>
</tr>
<tr>
<td>Borrowed money</td>
<td>7.7</td>
<td>8.2</td>
<td>0.85</td>
</tr>
<tr>
<td>Paid by non-household member</td>
<td>22.3</td>
<td>14.0</td>
<td>0.03</td>
</tr>
<tr>
<td>Exempted from payment</td>
<td>3.9</td>
<td>4.3</td>
<td>0.83</td>
</tr>
<tr>
<td>Payment was subsidized (insured)</td>
<td>2.3</td>
<td>12.6</td>
<td>0.00</td>
</tr>
<tr>
<td>Contributed to group scheme (isusu)</td>
<td>6.9</td>
<td>8.6</td>
<td>0.55</td>
</tr>
</tbody>
</table>

In the event of illness, drawing from savings was reported by 80.0% and 90.4% of members of MHHs and FHHs respectively (see Table 4). This is followed by ‘someone else paying’, which can come in the form of gifts or loans for repayments. For FHHs after savings, the most important means of funding health care expenditure is ‘someone else paying’. Subsidies for health care were reported more in MHHs. This can be related to the higher percentage of ownership of medical insurance among MHHs. Borrowing, exemptions and group contributions were not significant.

Qualitative Findings

Although the focus was on OOP and access, the FGDs brought up a range of issues that went beyond access and OOP issues. Two of these issues are which emerged were how men and women spoke of illness in the context of poverty which has important implications on treatment seeking behaviour. Nonetheless, the major thematic areas which emerged included treatment seeking behaviour, burden of OOP, untreated morbidity, payment options and coping strategies.

Perceptions of illness in the context of poverty

In relation to health and ill-health, both men and women spoke of women’s vulnerability to illness with implications for treatment seeking behaviour:
Women are more inclined to illness, thus making their health care costly. My wife always falls sick from even simple cold and so I spend too much on her health- 29 year old male (rural).

In some instances, women and men spoke movingly of poverty, the demands of physical labour and family responsibility as key factors underlying their vulnerability to ill-health:

Poverty is the major cause of illness. Because of no money women don’t eat well and become sick – 24 year old widow (rural).

Female health care is more expensive to treat than male’s. You know we are weaker by nature but these days we even do men’s work and are more exposed to illness – 20 year old female (urban) (MHH).

The dynamics of providing for your family can affect your health. I had to work extra when my children got into secondary school, providing for their school fees and feeding them. They started eating more as growing children. The stress got me sick most times – 69 year old male (urban).

**Treatment seeking behaviour**

Health-seeking behaviour differed between men and women and also between the rural and urban areas. In the urban area, participants reported using private hospitals and public hospitals for consultations. They used PMVs for drug purchases:

My family uses the private hospital close to our house when we are sick and then buy the drugs from the chemist around the corner. But these days the hospital now insists we buy drugs there. There is a big problem because they are too expensive- 49 year old male (urban).

I use the government hospital when I am sick but due to the long queues there, I go very early in the morning and spend the whole day there- 20 year old single mother (urban).

Rural male and female participants sought care more often from PMVs than from the primary health centres, mainly because of poor perceptions of quality of care associated with the latter. In the rural areas, many of the PMVs are owned and operated by midwives or nurses and are often the preferred provider in the case of a minor illness:
The health centre here cannot even give you good drugs for simple malaria. We have to pay more at the nurse’s shop (PMV) to buy good drugs when we are sick - 59 year old widow (rural).

In the event of a serious illness, including in-patient care and deliveries, the only option is to travel to the urban area:

I only use private hospitals now because they are value for money no matter the distance to get there. The last time my son was sick, we waited for hours for a doctor at the health centre....my son nearly died- 49 year old female (rural).

**Burden of OOP payments and untreated morbidity**

Of importance is the report of untreated morbidity in the FGDs. In the context of affordability with focus on costs, both MHHs and FHHs spoke of ways of coping with what they considered to be non-severe illness.

Some sickness goes on their own so there is no need of wasting money on drugs- 50 year old male (urban)

Going to the clinic is too expensive these days so if I have minor illness, I eat fruits and vegetables and hope it goes- 59 year old widow (rural)

Also quotations from the FGDs highlight the significance of travel costs and drug costs for those in the rural areas requiring care. This falls in line with the availability and perceptions of primary health centres. This inspires the utilisation of private hospitals and PMVs and has implications on affordability as utilisation incurs higher cost.

The health centres here are not functioning so I had to pay a lot of money to hire a car to take my wife to the town when she wanted to deliver in the middle of the night - 55 year old male (rural)

The health centre here cannot even give you good drugs for simple malaria. We have to pay more at the nurse’s shop (PMV) to buy good drugs when we are sick - 59 year old widow (rural).
Payment options

Payment options for households in rural areas differed from those in the urban area. Rural areas reported instalment payments and payment in-kind whereas households in urban areas reported medical insurance coverage and making OOP payments.

_We traders pay for cash when we go to the hospital. Nobody will even talk to you if you want to owe them while they treat you_- 44 year old male (urban)

_The doctor here is very good to us. He can treat you while you pay back as little as you can. Sometimes he even takes our game meat as payment_- 29 year old female (rural) (MHHs)

_Since my wife got this government work, we can now go to the hospital and not worry about having cash in hand. She has this new National Health Insurance_— 49 year old male (urban).

Coping strategies for paying for health care costs

FHHs and MHHs identified and discussed a wide range of strategies that they employed when faced with health care costs. Funds for paying for health care were obtained from different sources which ranged from the most preferred (i.e., drawing from savings and sale of assets) to the least preferred (i.e., borrowing from a money lender or group contributions (i.e. isusu) :

_We get money from farming and sales of stored goods that are seasonal; we buy palm oil and honey at cheap prices during the period of plenty and sell them when we need urgent money_— 49 year old female (rural) (MHHs). This was also a general claim from female participants in the rural areas including FHHs

_We also borrow from “interest people” (money lenders) but it is the worst due to the possibility of losing your collateral and the high interest they charge_— 59 year-old male (urban). This claim was supported by other members in the FGD

As illustrated by the first quotation, savings do not only refer to money but also to the deliberate strategy of buying essential household items not for the purposes of present or future consumption but as source of emergency funds. Following drawing on savings, MHHs in both urban and rural areas spoke of selling of assets.
We usually have goats, stored food like yam, and fowls in the house. If there is no money, we sell them and use the money to pay for care – 69 year old males (rural). This was a common strategy reported by males in the FGDs

I sold my land when my wife and son had food poisoning- 29 year old male (urban).

We sold the cassava on our land for money when my husband was very sick. Although you don’t get much from such sale, it is better than nothing- 40 year old female (rural) (MHHs).

If households still required money, following the sale of assets, they would then turn to borrowing from friends and relatives. Also, having friends or relatives borrow on their behalf was reported by male participants:

We borrow from friends or relatives and if they don’t have, they can borrow on your behalf – 65 year old male (rural).

I borrow from my extended family when my household runs short of money – 29 year old female (urban) (FHHs).

We borrow from the meeting (associations/group contribution (isusu)) that we belong to – 60 year old women (rural). This claim was also supported by other rural women including those in FHHs

In what appears to be an exhaustion of options and a final action of desperation, a single mother sold her clothes to pay for her son’s medical care.

I sold my wrappers (clothes) to pay for medical care of my son when he had hepatitis – 49 year old single mother (urban).

Coping strategies for re-paying health-related debts

Both men and women reported that in the event of debt arising from health care payments, a number of coping strategies are employed by households. Male participants reported increasing farming activities in order to generate more revenue to pay back the loans

I increase farming activities to enable me raise enough money to pay off the debt. I increase the portion of land I farm to get more money – 65 year old male (rural).
Going to or sending family to work for those the money was borrowed from was often reported by men and women in both urban and rural areas. Some also suggested sending their relatives to work for those they owe as a means of clearing debt:

*I go and work in the farm of the person I owe as a means of payoff* – 56 year old male (rural).

*Borrowing from loan shark (money lenders) is very difficult and it is the last resort because of the high interest rate they charge; so you can send your children to work on other farms for wages to enable you fast track the payment* – 59 year old male (urban).

*I sent my brother to work for the person I borrowed money from* – 49 year old widow (rural).

*I used my motorcycle to borrow money from the market association when my husband was sick* – 39 year old female trader (urban).

Widows, without an asset base and limited options to draw on reported resorting to hard manual labour to generate an income and cutting down on food as strategies towards settling the debt:

*We sweep the bushes for pebbles that I sell to those building houses to enable me pay for the money I borrowed* – 24 and 59 year old widows (rural).

*I had to cut down on the food we eat in my house because we had debts to pay...I joined in carrying blocks for those building houses for wages to help me pay the debt* – 20 year old widow (rural).

**Discussion and Conclusion**

This study has confirmed the vulnerability of FHHs as indicated by a range of demographic (widows, older, less educated) and socio-economic (predominantly poor and employed as subsistence farmers) factors, which contributes to gender-based household differences in health care access, cost burden, choices of health care providers, methods of funding health care and coping strategies.

Although a higher percentage of FHHs reported ill health when compared to MHHs, suggesting a greater need for health care, they reported lower levels of utilisation suggesting access barriers, particularly those relating to affordability. In general, OOP payments were the main source of
funding for health care placing a heavy cost burden on households and were found to be regressive and catastrophic for the two poorest quartiles across all households and MHHs and FHHs. Although overall health insurance coverage is low, FHHs reported even lower levels of insurance coverage than MHHs. Instalment payment which is a form of cash payment but with the ability of an extended repayment period enables households to absorb the shock of seeking care and was reported by both MHHs and FHHs. This was reported mainly in the rural area which suggests that there is a form of solidarity between health care providers and households in the rural areas.

Although MHHs incurred higher health care expenditures, FHHs experienced a higher health cost burden across all socio-economic groups, but particularly for the two poorest groups. Based on the FGDs, women attributed ill-health to their socio-economic context. Gendered norms around masculinity were likely to have prevented men from speaking of their health whereas women spoke more freely of their illness experiences. Considering that primary health centres are located in the rural areas and that the study population is predominantly rural, primary health centres could have provided FHHs better access to best possible health care for the treatment of their illness at affordable cost, but clearly not many households used their services. While FHHs reported higher cost burdens than MHHs, both cost burdens were catastrophic going by the definition of catastrophic expenditure by Russell (2004). In addition, FHHs reported higher levels of untreated morbidity than MHHs. This depicts a picture which shows that the most vulnerable to catastrophic expenditures also do not seek care with affordability as the reason for not seeking care.

For those that sought care, there was a high utilisation of PMVs. As can be seen in the FGDs, the utilisation of PMVs and private hospitals is as a result of perceptions of inefficiency and ineffectiveness in primary health centre and public hospitals. The utilisation of PMVs and private hospitals in turn has their own implications on health outcomes and cost burdens. While private hospitals are more effective than primary health centres and public hospitals, they are more expensive and hence households incur high cost burdens. On the other hand, PMVs which are unregulated are cheaper due to ineffective care they provide; they sell drugs based on demand and not based on prescription (Oladepo et al, 2007). This has serious implications on health outcomes and may result in household seeking more effective care as sickness persists thereby
incurring more cost. Similar patterns of treatment-seeking have been observed in other parts of Africa and Asia where there is a progression from affordable and less effective health care providers to more effective unaffordable providers as illness persists (Russell 2005; Sudha et al, 2003; Zere & McIntyre 2003; Onwujekwe & Uzochukwu, 2004; Onwujekwe 2005; Raso et al, 2005). This has important consequences for FHHs especially since previous research has found that these low-level health care providers are unregulated, likely to offer very low-quality treatment and do not have trained personnel (Hanson et al, 2004).

To cope with health care costs, both MHHs and FHHs discussed drawing on savings, sale of assets and borrowing as the main strategies employed. The important role of borrowing from informal or social network sources (friends, neighbours, relatives) as a coping strategy has been identified elsewhere (Sauerborn et al, 1996; Russell 1996, 2004; Chuma et al, 2007) and this was mainly reported by both MHHs and FHHs. Borrowing is much more readily available to households which have fairly well-off friends and who are less likely to hold-up repayment (Lucas and Nuwagaba 1999; Chuma et al, 2007). Although borrowing from informal structures is considered a low risk tactic, borrowing from semi-formal structures like money lenders and associations as the most unfavourable source of funds and can have negative implications for household’s economic and social position due to the high interest rates charged particularly if debts are not repaid on time. This is has important implications for treatment seeking and affordability particularly for FHHs in this study.

An important finding relates to the strategies employed to pay back health care related debt. Although both MHHs and FHHs reported arduous strategies (e.g. household heads or children leaving home to work on the farms of the creditor), the desperation of women and particularly widows who reported working on construction sites to eke out a living in order to repay debt and also cutting back on consumption is concerning. This has dire consequences for their health status and in-turn contributes to a high illness burden which will require care hence triggering the “medical poverty trap” as inferred by Whitehead et al (2001).

The plight of widows in Enugu State (same location of the present study) has been previously highlighted by Ugwu (2009, p: 1622) who argued that “...widows have particularly low social and economic status. As a result of loss of husbands to AIDS or ill-health they have no
inheritance rights to productive resources such as land, farm inputs, cash crops and family assets e.g. processing machines etc. In most cases, they are victims of seclusion, isolation, inhuman social treatments from their husband’s relatives and the community. These have implications for household food security, family cohesion and sustainability of rural livelihoods.” These findings offer an explanation to the results obtained from FHHs in this study.

**Policy implications**

This study provides evidence that efforts to protect the poor are critical from the adverse impact of OOPs and that positive measures to improve household’s socio-economic status are necessary. “Reducing or removing all user fees in government-run health care facilities would be a constructive move towards protecting households from high costs of illness” and “such an approach still requires extra resources to meet the likely rise in demand for health care and to guarantee that the quality of care is improved and maintained” (Chuma et al, 2007, p: 681). These changes have to be carefully planned and implemented to prevent negative implications (Gilson & McIntyre, 2005).

At the same time, it is suggested that an improvement in the public healthcare system in terms of quality of care and availability of care will encourage people from seeking care in the public sector and protect them from incurring higher costs in the private sector, or failing to seek treatment altogether. Primary health centres need to be improved in terms of resources and quality of care in order to improve the public perception and be the first point of care. Physical access can be achieved through the building of primary health centres in areas that are presently underserved. Properly trained and government paid community-based health workers may well also be used to increase access to quality health care services. Unless this occurs, household will continue to seek care at PMVs.

It is to be anticipated that any interventions to improve health seeking for the poor have to engage the low level providers (primary health centres and PMVs). These providers are ever-present in all crannies of the country and form the major source of drugs, advice, and other consultancy services for majority of the population. If efforts to regulate PMVs are successful
with respect to quality of care and the provision of good quality drugs, an improved access to quality care for especially the poorest households will be ensured (Oladepo et al, 2007).

Russell (2004) suggests that even if health care services are enhanced, they cannot guard households from all illness costs. He recommends that health policy research and debates ought to be broadened to consist of interventions beyond the health sector; interventions focused on enhancing the livelihoods of households, that save the poor from harm and increase their incomes. This study supports this ideology and suggests interventions such as supporting micro finance schemes that provide finance for small and medium-scale enterprises and provide avenues to encourage people to save weekly or monthly. Schemes which focus on FHHs and widows in particular are critical for ensuring access to health care and protection from catastrophic costs.

Onah (2010) suggest that since every female is a potential widow (67% of women outlive their husbands in a Nigeria), a call for strides towards the elimination of harmful widowhood practices in Nigeria is necessary. State and federal enactments that protect women from these practices need to be established and where established must be enforced to ensure social protection of the most vulnerable of this population (widows and siblings). This study supports this call for full government involvement in the financial protection and empowerment of women especially widows.

**Limitations**

The cross-sectional household survey questionnaire did not take into account inpatient and outpatient distinctions in the economic cost of seeking care. It also did not factor in the peculiarities of polygamous households which arguably have implications for access to resources and decision making.

Although the study intended to provide a breakdown of OOPs and identify the contributions of the different components (e.g. transport, drugs, consultancy costs), it was not possible to establish this because of difficulties in the interview process where household members were not able to recall this information. This is an important area for further research.
There are also the limitations posed by interviewer bias and problems associated with respondents feeling comfortable and disclosing all information in the household surveys. For instance, sale of assets was not mentioned as a coping strategy in the household surveys but was spoken of by the majority of participants in the FGDs.

Acknowledgments

I am grateful to the staff of the Nigerian Bureau of Statistics for the assistance in conducting the cross-sectional survey and the focus-group discussions. I would also like to acknowledge the Swedish Development Agency (SIDA) for providing the funds. Special acknowledgment and gratitude go to my supervisor for this work, Veloshnee Govender, for her guidance, training, supervision and inspiration that made this work possible.

Authorship

M. Onah was responsible for data collection and analyses and preparation of the draft manuscript.

Conflict of interest

There are no conflicts of interest.

Ethical Approval

The study received ethical approval from the University of Cape Town Ethics Committee and permission was also sought from Nsukka LGA authorities. Informed consent (oral and written) was obtained from all respondents in the household surveys and participants in the FGDs. The consent forms were in English and the local language. Household interviews and FGDs were conducted in the first language of the respondents and participants. FGDs were audio taped, transcribed and translated into English and the transcripts were thematically coded and analysed.
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Part D: Policy Brief

Out-of-pocket payments, health care access and utilisation in South-Eastern Nigeria: a gender perspective.

Key findings

- Female-headed households (FHHs) were older, more likely to have no schooling, widowed, have smaller households, less likely to have health insurance and more likely to be located in the poorest quintile than MHHs
- FHHs reported higher levels of untreated morbidity than MHHs
- Both FHHs and MHHs sought care mainly from PMVs and indicated low perceptions of quality of care in relation to primary health centres
- Catastrophic expenditure was reported by the poorest male and female-headed households, although FHHs reported higher levels of catastrophic expenditure
- Out-of-pockets (OOP) payment was the main source of funding health expenditure for male and female-headed households.
- Both FHHs and MHHs spoke of the difficulties associated repaying health-related debt with implications for the medical poverty trap.

Introduction

There is a large body of literature on the impoverishing effect of OOP and its implications for access and utilisation of health care (McIntyre et al, 2006; Kiwanuka, et al, 2008; Buor, 2004). In Nigeria and most Sub-Saharan African countries, health care financing is still heavily borne by households through OOP payments and this has dire consequences not only for access but also for their health care outcomes and may result in pushing households into debt and the medical poverty trap (Whitehead et al, 2001).

Considering that women represent 70 per cent of the world’s poor (UNIFEM, 2008), the influence of gender on access in the context of out-of-pocket payments is important. Research has shown important differentials in access between men and women. From a gender perspective, access and utilisation of health services are also shaped by intra-household relations affecting access to and control over household resources (Becker et al, 2006; Castle, 1993; Jejeebhoy, 2002; Bolt and Bird, 2003; de la Brière, Hallman, and Quisumbing, 2003). Gender relations and access to resources within polygynous
households are also important to consider given that polygynous marriages exist widely across several African countries (Oni, 1996; Ania et al, 2002), with implications for women’s access to resources essential for their own health and that of their children (Bove & Valeggia, 2009). Analysis of gender and health care access has also broadened to consider implications for access from the perspective of female-headed households (FHHs). In both developed and developing countries, studies have revealed that FHHs are likely to have different demographic, sociological, and economic characteristics from MHHs and that these differences have major implications for health care access and utilisation (Mumtaz, 2003; Nash Ojanuga, 1992).

In Nigeria, the effects of OOP payment on utilisation of health care differ for men and women because of their different access to financial resources and different health care needs. Entangled with access to financial resources is the household decision-making power which it has been found to determine allocation of resources even in health care utilisation (NBS, 2007).

The purpose of this study is to examine from a gender perspective, OOP payments, health care access and utilisation in Nsukka Local Government Area (LGA) in southeast Nigeria. This study is motivated by the limited literature and research, especially in Africa, on socio-economic dynamics that determine health care access and utilisation from a gender perspective.

**Methods**

A mixed method of quantitative and qualitative approaches was used. A cross-sectional survey of 411 households in the urban and rural areas of Nsukka Local Government was conducted. In addition, 6 single-sex focus-group-discussions (FGDs) were conducted also in the two areas (urban and rural) of the local government.

**What do the key findings mean?**

Firstly, a higher percentage of FHHs belong to the lowest socio-economic group (Figure 1). In addition, heads of FHHs were less educated, more likely to be engaged in subsistence farming and had lower levels of health insurance coverage.

![Figure 1: Household socio-economic status](image)

In some instances, women and men spoke movingly of poverty, the demands of physical labour and family responsibility as key factors underlying their vulnerability to ill-health:

*Poverty is the major cause of illness. Because of no money women don’t eat well and become sick* – 24 year old widow (rural).
Female health care is more expensive to treat than male’s. You know we are weaker by nature but these days we even do men’s work and are more exposed to illness – 20 year old female (urban).

Secondly, there is a high utilisation of PMVs in the region (Figure 2), which is partly driven by poor perceptions of primary health centres.

The health centre here cannot even give you good drugs for simple malaria. We have to pay more at the nurse’s shop (PMV) to buy good drugs when we are sick - 59 year old widow (rural).

Since PMVs are unregulated, there are concerns over the quality of care they provide and the implications for health care outcome of especially the poor and the vulnerable who primarily depend on them costs, and registration and consultancy costs as reasons for not seeking care.

In addition to the higher untreated morbidity, on average FHHs spent about 12% of their total monthly expenditure on health (compared to 9.8% for MHHs) (Figure 3). Although FHHs reported a higher cost burden, that of MHHs is also close to being catastrophic (i.e. health expenditures exceeding 10% of the household monthly expenditure (Ranson, 2002, Russell, 2004; Wagstaff and van Doorslaer, 2003) with implications for health care access and health-related debt.

Thirdly, a higher percentage of FHHs compared to MHHs reported being sick and not seeking care (figure 3). Both types of household reported transport costs, drug

Fourthly, OOP payment is the major source of health care financing (Figure 4). Health insurance scheme which covers only those in the formal sector is limited for both FHHs and MHHs.
To cope with health care costs, both MHHs and FHHs discussed drawing on savings, sale of assets and borrowing as the main strategies employed.

*I sold my land when my wife and son had food poisoning*– 29 year old male (urban).

*We usually have goats, stored food like yam, and fowls in the house. If there is no money, we sell them and use the money to pay for care* – 56 and 69 year old males (rural).

*We also borrow from “interest people” (money lenders) but it is the worst due to the possibility of losing your collateral and the high interest they charge* – 59 and 46 year-old male (urban).

*We borrow from the meeting (associations/group contribution (isusu)) that we belong to* – 60, 20, 49 and 24 year old women (rural).

An important finding relates to the strategies employed to pay back health care related debt. Although both MHHs and FHHs reported arduous strategies (e.g. household heads or children leaving home to work on the farms of the creditor), the desperation of women and particularly widows who reported working on construction sites to eke out a living in order to repay debt and also cutting back on consumption is concerning.

*I go and work in the farm of the person I owe as a means of payoff* – 56 year old male (rural).

*I had to cut the food we eat in my house because we had debts to pay.....I joined in carrying blocks for those building houses for wages to help me pay the debt* – 20 year old widow (rural).

These findings provide evidence of the catastrophic impact of health care expenditures on the poor and vulnerable. This calls for mechanisms that protect the poor and vulnerable from such impacts.

**Policy Recommendations**

1. Reducing or removing all user fees in government-run health care facilities is a necessary move towards protecting households from high costs of illness. Such an approach will require extra resources to meet the expected rise in demand for health care, guarantee that the quality of care is improved and maintained, and to prevent negative implications on utilisation (Chuma et al, 2007; Gilson and McIntyre, 2005).

2. Government should provide support for community based prepayment schemes for the unemployed and those employed in the informal sector and to build up the public health system in order to draw people back to the public health system.
3. There should be a proper engagement and regulation of low level providers (PMVs) in the provision of health care. If through regulation quality of care improves, this will have important access implications for both FHHs and MHHs and the poor.

4. Micro finance schemes that provide finance for small and medium-scale enterprises and provide avenues to encourage people to save weekly or monthly should be encouraged. The government should regulate and supervise the activities of these enterprises.

5. In total, provision of subsides for the vulnerable (i.e. widows and poor) is recommended. This can mitigate the effects of health shocks and reduce the level of catastrophic payments faced by particularly poor MHHs and FHHs.

6. State and federal enactments that protect widows from practices including disinheriance need to be established.

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Part E: Appendices

Appendix 1: Consent forms

Consent Form 1 – FGDs (men and women)

This form would be read out to the participant before conducting the FGDs. After reading it out, the participants would be asked whether they have any questions or concerns about participating in the study and these would be appropriately addressed. The consent form must to be signed/thumb printed individually by the participant in the presence of the principal investigator. A copy of the consent form would be left with the each participant whiles the principal investigator keeps the other copy.

General Introduction

Thank you for participating in this FGD. This study is being conducted by Onah Michael Nnachebe, an MPH (Health Economics) student of the University of Cape Town in South Africa for my thesis. As a head or care giver in a household, it is important for me to get your opinion on the costs of household health care, how decisions on money and expenses on health care are made in your households and how you cope with the costs. This FGD will take between 60 to 90 minutes.

Potential risks of your participation

There is very minimal risk of participating in this study. Although I cannot guarantee that confidentiality will be maintained as group members may discuss issues raised in this FGDs outside, I urge you to respect each other’s confidentiality. Please be assured that all information gathered from these discussions will be treated confidentially and the findings would be presented in a way that you would not be identified by names with your opinions.

There are however, no major psychological and physical stresses of participating in this study except that you may have to forgo other activities in order to participate in this study.

Potential benefits of the research

There are no direct material benefits for participating in this study. However, since the results would be made available to the Ministry of Health to assist in alleviating this problem, this study offers you a potential platform to make known your opinion on out-of-pocket payments and its effect on you and your household. Also, this information will be helpful in to policy makers in end providing health care systems that are accessible.

Participation and withdrawal

Your participation in this study is voluntary. You can choose either to participate or not to. That is why your involvement in this study has been fully explained and you are to freely consent to it. You also have
the option to discontinue your participation in the discussion at any time without losing any benefits or being subjected to any harm.

Could you then explain to me what we are going to ask you to do in this study?

Should you have any questions after the focus group discussion you are welcome to contact me (see contact details below).

I would also like to add that this study has been granted ethical approval by the Human Research Ethics Committee of the University of Cape Town, South Africa (see contact details below)

Signature Participant: --------------------------                                            Date:.........................

Signature: Facilitator ---------------------------                                          Date...........................

**Translator**

I declare that I read this document to the participant and answered the participants’ questions to my best knowledge. This conversation was conducted in [enter language].

Date:                     Signature Fieldworker

Contact details fieldworker:
Consent Form 2 – Household Surveys

QUESTIONNAIRE NUMBER

Name of village

Instruction to the Interviewer:

This form would be read out to the respondent before questionnaires are administered. After reading it out, the respondent will be asked whether they have any questions or concerns about participating in the study and these would be appropriately addressed. Both copies of the consent form must to be signed/thumb printed individually by the respondent in your presence. A copy of the consent form would be left with the respondent whiles you keep the other.

General Introduction

Hello. My name is _______________________________________. I am working with Onah Michael Nnachebe; a postgraduate student from the Health Economics Unit of the University Of Cape Town. We are conducting a survey about how costs of health care affect your use of health services and also if health care cost affect men and women differently. The information we collect will help the government to plan how to make health care services more affordable. Your household was randomly selected for this survey. The questions usually take about 60 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.

Potential risks to respondents

There is very minimal risk of answering these questions. Please be assured that all information gathered from these questions will be treated confidentially and the findings would be presented in a way that you would not be identified by names with your information.

There are however, no major psychological and physical stresses of answering these questions except that you may have to forgo other activities in order to contribute to this study.

Potential benefits of the research
There are no direct material benefits for participating in this study. However, since the results would be made available to the Ministry of Health to assist in alleviating this problem, this study offers you a potential platform to make known your opinion on out-of-pocket payments and its effect on you and your household. Also, this information will be helpful to policy makers and may result in an improved health care system that is accessible.

**Participation and withdrawal**

Your participation in this study is voluntary. You can choose either to participate or not to. That is why your involvement in this study has been fully explained and you are to freely consent to it. You also have the option to discontinue your participation in the session at any time without losing any benefits or being subjected to any harm.

Could you then explain to me what we are going to ask you to do in this study?

Should you have any questions after this session, you are welcome to contact me (see contact details below).

I would also like to add that this study has been granted ethical approval by the Human Research Ethics Committee of the University of Cape Town, South Africa (see contacts address below)

Do you have any questions? May I begin the interview now?

Signature Respondent: --------------------------                               Date

Signature: Interviewer--------------------------                           Date

**RESPONDENT AGREES TO BE INTERVIEWED → PROCEED WITH INTERVIEW**  **IF RESPONDENT DOESNT AGREE TO BE INTERVIEWED → THANK THE RESPONDENT FOR HIS/HER TIME AND END**
Appendix 2: Interview Guide

Focus Group Discussion Guide

1. **Participants understanding of the possible differences in utilisation of health care between men and women and how payment is affected by these differences**
   - What do you think are the health care needs of women and men?
   - How do they differ from each other?
   - How affordable is women’s health care and how does it differ from men?

2. **Participant’s discussion on household decision making and how it affects household health seeking**
   - Who works outside the home and earns money?
   - Who in the household is in charge of money?
   - In relation to food and other household expenses, who decides how money is spent?
   - Do you need permission to spend money?
   - Who decides how money is spent on health care?
   - Does your husband or wife value you as a member of the household and allow you to decide how to spend money on health care for yourself?

3. **How households cope with health care costs and how it differs between male and female household heads**
   - If you fall sick, where do you get money for health care?
   - Do you get money from the household head when you fall sick?
   - If you don’t get money from them, how do you pay for your health care?

How in general do your household cope with the cost of health care?
Appendix 3: Household Structured interview questionnaire

HOUSEHOLD QUESTIONNAIRE: THE COST OF HEALTH CARE UTILISATION FROM A GENDER PERSPECTIVE AND HOUSEHOLD COPING STRATEGIES

Questionnaire number

Name of Enumerator                         Name of Village                         Village Code

Instruction: Please fill the next section at the beginning and at the end of the interview.

Day   Month        Year

Date of interview

What time did the interview start:

What time did the interview end:

Please, enter the appropriate number representing the answer given in the spaces provided. Please note that throughout the questionnaire, if YES write 1 in the box, if NO, write 0 in the box where applicable. Circle the appropriate response. All relevant boxes MUST be filled.

SECTION 1: DEMOGRAPHIC AND SOCIO-ECONOMIC INFORMATION:

Interviewer read: This section is designed to help us learn about you and your household. Please take a few minutes to answer the following questions.

I would like to begin by asking a few questions about you and your household.

[Note: Only the female primary health care giver (mostly wives or grandmothers) should be interviewed or in her absence the male head of the household].
1. What is your status in this household?

<table>
<thead>
<tr>
<th>Status</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female head of household</td>
<td>0</td>
</tr>
<tr>
<td>Male head of household</td>
<td>1</td>
</tr>
<tr>
<td>Wife</td>
<td>2</td>
</tr>
<tr>
<td>Grandmother</td>
<td>3</td>
</tr>
<tr>
<td>Representative of household</td>
<td>4</td>
</tr>
</tbody>
</table>

2. How many people live in this household, including yourself? [ ]

3. How many adults (18 years and above) live here?

4. How many teenagers (12-17 years) live here?

5. How many children (less than 12 years) live here?

6. Interviewer: Add the responses to questions 3, 4, 5 and check that the total is the same as the response to question number 2 [ ] Total of questions 3, 4, 5

7. Name of respondent? ______________________________

8. Interviewer: What is the gender of the respondent?  

<table>
<thead>
<tr>
<th>Gender</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>0</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
</tr>
</tbody>
</table>

9. How old are you? [ ]

10. Did you go to school?  

<table>
<thead>
<tr>
<th>Did you go to school?</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
</tbody>
</table>

If No >> Q13

11. What was your highest completed education level?

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Primary</td>
<td>1</td>
</tr>
<tr>
<td>Junior Secondary</td>
<td>4</td>
</tr>
<tr>
<td>Senior secondary</td>
<td>2</td>
</tr>
<tr>
<td>University</td>
<td>5</td>
</tr>
<tr>
<td>Teacher training college</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
</tbody>
</table>
12. What was the total number of years that you spent schooling? 

13. What is your major source of income?

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>1</td>
</tr>
<tr>
<td>Petty trading/hawking</td>
<td>2</td>
</tr>
<tr>
<td>Employed in private sector</td>
<td>3</td>
</tr>
<tr>
<td>Self employed professional</td>
<td>4</td>
</tr>
<tr>
<td>Others</td>
<td>5</td>
</tr>
<tr>
<td>Farmer</td>
<td>6</td>
</tr>
<tr>
<td>Government worker</td>
<td>7</td>
</tr>
<tr>
<td>Trader</td>
<td>8</td>
</tr>
<tr>
<td>Pensioners</td>
<td>9</td>
</tr>
</tbody>
</table>

14. What is your current marital status? 

0 = never married (single) 1 = living with spouse 2 = widowed 3 = divorced/separated

15. Detailed socio-demographic information about all the household members

<table>
<thead>
<tr>
<th>Household identification code</th>
<th>Name</th>
<th>Relationship to household head</th>
<th>Age (at next birthday)</th>
<th>Sex F=0,M=1</th>
<th>Employment status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent (RES)</td>
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<tr>
<td>15.1.</td>
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<td>15.2.</td>
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<td>15.3.</td>
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<tr>
<td>15.4.</td>
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<tr>
<td>15.5.</td>
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<tr>
<td>15.6.</td>
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<td>15.8.</td>
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<td>15.9.</td>
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<td>15.10.</td>
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<td>15.11.</td>
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<tr>
<td>15.12.</td>
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</tr>
</tbody>
</table>

(Interviewer: If there were more household members than 13, then use the extra sheets with tables to complete)
**codes: Employment Status**

0 = Unemployed; 1 = Student/Learner/Child; 2 = Subsistence farming; 3 = Pensioner
4 = Petty trading/hawking; 5 = Government Worker; 6 = Employed in private sector;
7 = Self-employed professional; 8 = trader, 9 = Others; 10 = Don’t know

**codes: Relationship to household head**

1 = household head 4 = brother/sister/step brother/ step sister
2 = spouse 5 = father/ mother/ step father/ step mother
3 = son/daughter/ step/ adopted child 6 = non –relatives (tenants, lodgers) 7 = don’t know

**SECTION 2: HOUSEHOLD DECISION MAKING ON EXPENDITURE AND RESOURCE ALLOCATION**

16. Who usually decides how your money will be used/spent?

<table>
<thead>
<tr>
<th>Respondent</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent</td>
<td>1</td>
</tr>
<tr>
<td>Husband/wife</td>
<td>2</td>
</tr>
<tr>
<td>Jointly between respondent and husband/wife</td>
<td>3</td>
</tr>
<tr>
<td>Others (specify)</td>
<td>4</td>
</tr>
</tbody>
</table>

17. Would you say that the money you earn is more than your spouse, less than or same?

<table>
<thead>
<tr>
<th>More than</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>More than</td>
<td>1</td>
</tr>
<tr>
<td>Less than</td>
<td>2</td>
</tr>
<tr>
<td>About the same</td>
<td>3</td>
</tr>
<tr>
<td>Spouse doesn’t bring in any money</td>
<td>4</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5</td>
</tr>
</tbody>
</table>

18. Who usually makes decision about health care for yourself in the household?

<table>
<thead>
<tr>
<th>Respondent</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent</td>
<td>1</td>
</tr>
<tr>
<td>Spouse</td>
<td>2</td>
</tr>
<tr>
<td>Jointly between respondent and spouse</td>
<td>3</td>
</tr>
<tr>
<td>Others (specify)</td>
<td>4</td>
</tr>
</tbody>
</table>

**SECTION 3: HOUSEHOLD HEALTH INSURANCE MEMBERSHIP INFORMATION**
Interviewer read: Now I wish to find out about your membership as well as that of other members of your household of different health insurance schemes

19. Are you or any member of your household enrolled in any health insurance scheme? □ 1 = Yes (go to Q20) 0 = No (go to Section 4).

20. How many people belonging to different age groups in your household (including yourself) are primarily enrolled in the different health insurance schemes?

Adults (aged more than 18 years) □

Teenagers (aged 12 to 17 years) □

Children (aged less than 12 years) □

SECTION 4: HEALTH SEEKING FOR ALL HOUSEHOLD MEMBERS

Interviewer: For question 21 onwards ask first for respondent (if ill within the past one month) and then for other adult, teenagers and children who had recent episode of illness (if ill within past one month) or visited a health provider one month to the date of the interview. Interview respondent about other household members but if possible ask adult members and teenagers directly if they are available.

Interviewer: read before asking question 21: Now, I want to talk with you about all treatment seeking for all occurrences of illnesses or visit to a health care provider by all members of your household within the past one month (to the date of this interview) in your household.

21. Please, could you tell us the last time that you and other members that were sick or had a health condition that needed treatment or a visit to a health care provider in the past one month (to the date of this interview)?

[interviewer: copy name of respondent and household members from question 15 and tick appropriate answer]

<table>
<thead>
<tr>
<th>Person ill</th>
<th>No (0)</th>
<th>Yes (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First names</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Respondent</td>
<td></td>
<td></td>
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<tr>
<td>b.1</td>
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<td>b.2</td>
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<tr>
<td>b.3</td>
<td></td>
<td></td>
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<tr>
<td>b.4</td>
<td></td>
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</tbody>
</table>
(Interviewer: If there were more than 13 household members, then use the extra sheets with tables to complete)

22. During the **past month** to the date of this interview, which health care providers did you and other members of your household visit and how many times were they visited by each member of your household? [Interviewer: record all facilities/providers visited and number of visits to each, if no health care providers were visited, record as zero(0)]

<table>
<thead>
<tr>
<th></th>
<th>Public hospital</th>
<th>Health centre</th>
<th>Private hospital</th>
<th>Patent medicine vendor (chemist)</th>
<th>Pharmacy shop</th>
<th>Medical lab</th>
<th>Herba-list</th>
<th>Others</th>
</tr>
</thead>
</table>

**Write all first names below in the same order as on household roster**

a. Respondent

b.1:  
b.2:  
b.3:  
b.4:  
b.5:  
b.6:  
b.7:  
b.8:  
b.9:  

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23. How much was **PAID** to receive treatment or health care services from the different providers in the past one month based on the following expenditure categories? *[amount in naira]*

<table>
<thead>
<tr>
<th>Treatment sought</th>
<th>First names</th>
<th>Public hospital</th>
<th>Health centre</th>
<th>Private hospital</th>
<th>Patent medicine vendors (chemist)</th>
<th>Pharmacy shop</th>
<th>Medical lab</th>
<th>Herbal list</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>27a. Respondent</td>
<td>Registration/card fee (naira)</td>
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<td></td>
<td>Consultation (naira)</td>
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<td></td>
<td>Laboratory tests (naira)</td>
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<td>Drugs (naira)</td>
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<td>Other expenditures (naira)</td>
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<td>Total expenditure (naira)</td>
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</table>

**b.1 Name:**

Registration/card fee (naira)
Consultation (naira)
Laboratory tests (naira)
Drugs (naira)
Other expenditures (naira)
<table>
<thead>
<tr>
<th>b.2 Name:</th>
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<tbody>
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<td>Registration/card fee (naira)</td>
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<td>Consultation (naira)</td>
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<td>Laboratory tests (naira)</td>
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<td>Drugs (naira)</td>
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<tr>
<td>Other expenditures (naira)</td>
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<tr>
<td>Total expenditure (naira)</td>
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<th>b.3 Name:</th>
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<td>Registration/card fee (naira)</td>
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<td>Consultation (naira)</td>
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<tr>
<td>Laboratory tests (naira)</td>
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<td>Drugs (naira)</td>
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<td>Other expenditures (naira)</td>
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<td>Total expenditure (naira)</td>
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<th>b.4 Name:</th>
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<td>Registration/card fee (naira)</td>
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<td>Registration/card fee (naira)</td>
<td>Consultation (naira)</td>
<td>Laboratory tests (naira)</td>
<td>Drugs (naira)</td>
<td>Other expenditures (naira)</td>
<td>Total expenditure (naira):</td>
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<td><strong>Drugs (naira)</strong></td>
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<td><strong>Other expenditures (naira)</strong></td>
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24. How much of the treatment cost was paid using the following payment options? [Interviewer: tick the appropriate response. Multiple responses are allowed]

<table>
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<tr>
<th>Payment mechanisms</th>
<th>Public hospital</th>
<th>Health center</th>
<th>Private hospital</th>
<th>Petent medicine vendor (chemist)</th>
<th>Pharmacy shop</th>
<th>Medical lab</th>
<th>Herbalist</th>
<th>Others</th>
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<tbody>
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<td>g. In-kind</td>
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b.12 Name:

Registration/card fee (naira)  
Consultation (naira)  
Laboratory tests (naira)  
Drugs (naira)  
Other expenditures (naira)  
Total expenditure (naira)
reimbursed by employer

b. Out-of-pocket without reimbursement
c. Private health Insurance
d. National Health Insurance Scheme (NHIS)
e. Community-based health insurance scheme (CBHIS)
f. Installment
g. In-kind
h. Others

**b.2 Name:**
a. Out-of-pocket but was reimbursed by employer

b. Out-of-pocket without reimbursement
c. Private health Insurance
d. National Health Insurance Scheme (NHIS)
e. Community-based health insurance scheme (CBHIS)
f. Installment
g. In-kind
h. Others

**b.3 Name:**
a. Out-of-pocket but was reimbursed by employer

b. Out-of-pocket without reimbursement
c. Private health Insurance
d. National Health Insurance Scheme (NHIS)
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**b.4 Name:**

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**b.5 Name:**

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</table>
### b.6 Name:

| a. Out-of-pocket but was reimbursed by employer |
| b. Out-of-pocket without reimbursement |
| c. Private health Insurance |
| d. National Health Insurance Scheme (NHIS) |
| e. Community-based health insurance scheme (CBHIS) |
| f. Installment |
| g. In-kind |
| h. Others |

### b.7 Name:

| a. Out-of-pocket but was reimbursed by employer |
| b. Out-of-pocket without reimbursement |
| c. Private health Insurance |
| d. National Health Insurance Scheme (NHIS) |
| e. Community-based health insurance scheme (CBHIS) |
| f. Installment |
| g. In-kind |
| h. Others |

### b.8 Name:

<p>| a. Out-of-pocket but was reimbursed by employer |</p>
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<td>g. In-kind</td>
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**b.9 Name:**

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**b.11 Name:**

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**b.12 Name:**

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26. How did you/the person/your household cope with the payment? I will read out some options and will circle the appropriate answer. *(Interviewer: Multiple responses are allowed)*

<table>
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<th>Own money</th>
<th>1</th>
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<tbody>
<tr>
<td>Borrowed money (including taking a loan)</td>
<td>2</td>
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<tr>
<td>Sold household movable assets or family land</td>
<td>3</td>
</tr>
<tr>
<td>Community solidarity</td>
<td>4</td>
</tr>
<tr>
<td>Someone else paid</td>
<td>5</td>
</tr>
<tr>
<td>Was exempted from payment</td>
<td>6</td>
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<tr>
<td>Payment was subsidized</td>
<td>7</td>
</tr>
<tr>
<td>Group contribution (isusu)</td>
<td>8</td>
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<tr>
<td>Others (specify)</td>
<td>9</td>
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</table>
27. In the past one (1) year have you, or anyone else in the household been sick but not gone to seek care?

<table>
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<tr>
<th>Household member</th>
<th>Sick in the past one (1) year</th>
<th>If they did not seek care, what was the reasons</th>
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<tr>
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<td>No (0)</td>
<td>Yes (1)</td>
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[codes for reasons for not seeking care]

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<tr>
<td>1</td>
<td>Illness or health condition was not serious</td>
</tr>
<tr>
<td>2</td>
<td>Could not afford transport costs</td>
</tr>
<tr>
<td>3</td>
<td>Could not afford registration cost</td>
</tr>
<tr>
<td>4</td>
<td>Could not afford consultation fees</td>
</tr>
<tr>
<td>5</td>
<td>Could not afford lab fees</td>
</tr>
<tr>
<td>6</td>
<td>Could not afford the drugs</td>
</tr>
</tbody>
</table>
7 Health facility/provider too far
8 Could not get time off work (too busy or not allowed)
9 Could not afford to take time off work (like a no work no pay arrangement)
10 Queues too long at health facility
11 Poor quality health services (e.g. no drugs, ineffective)
12 Others (please specify)

SECTION 5: WEEKLY FOOD COSTS AND OTHER EXPENDITURES: This section is designed to find out information to determine your socio-economic status (Interviewer: Fill in “0” (zero) if nothing is spent on an item)

29. How much did your household spend to purchase food from the market in the past one week on the various items that I will read out?

<table>
<thead>
<tr>
<th>Item</th>
<th>Who purchased</th>
<th>Amount (money)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gari</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cassava (akpu)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

30. Does your household grow any of the following items? If the food items that your household produced, but also consumed in the past one week were to have been bought from the market, how much will they cost? [*Tick the right response and include the amount in naira*]

<table>
<thead>
<tr>
<th>Item</th>
<th>No (0)</th>
<th>Yes (1)</th>
<th>Amount if item was bought from the market</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gari</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-----</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>Cassava (akpu)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fish</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31 About how much did the household spend in the past month on the following items that I will read out to you? (*Interviewer: repeat question for each expenditure category on the following list and fill in “0” (zero) if nothing was spent on an item)* [Amount in Nigerian naira]

| 1. Wood       |     |     |
|   2. Kerosene |     |     |
|   3. Charcoal/Coal |     |     |
|   4. Electricity |     |     |
|   5. Candles  |     |     |
|   6. Cooking Gas |     |     |
|   7. Torch batteries |     |     |
|   8. Diesel oil for generators |     |     |
|   9. Others (Specify) |     |     |

32. How often and how much do you and your household spend on the following items? (*Interviewer: Ask for amount spent after each item and period and Fill in “0” (zero) if nothing is spent on an item)*

<table>
<thead>
<tr>
<th>Items</th>
<th>PERIOD CODES (1 = Weekly, 2 = Monthly, 3 = Quarterly, 4 = Bi-Annually, 5 = Annually)</th>
<th>AMOUNT SPENT (Naira)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Rent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Durable household goods (electrical equipment, furniture, etc.)

4. Health care

5. Cooking fuel

6. Recreation and Entertainment

7. Educational expenses

8. Gifts or donations (relatives, or church/mosque)

9. Other expenses (Specify)

TOTAL

SECTION 6: HOUSEHOLD ASSET HOLDINGS: (Interviewer: In each category, indicate the number of items owned by the respondent. If household does not have an item, enter zero.)

33. Could you tell me if you or someone in your household owns these items and that they are still functional? (If YES and functional), How many do you (he or she) own?

<table>
<thead>
<tr>
<th>Electronics</th>
<th>No (0)</th>
<th>Yes (1)</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Radio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Fridge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Television</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Bicycle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Motorcycle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Motorcar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lighting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Kerosene lamp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Generator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Rechargeable lamp</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
34. Is there any other thing that you will like to tell us about how to improve the financing of health care services in your community?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

THANK YOU
Appendix 4: Journal Instruction for Authors

Journal: Health Policy and Planning

Information for Authors

OPEN ACCESS OPTION FOR AUTHORS See here for details of our Open Access method of publication.

*Health Policy and Planning’s* aim is to improve the design and implementation of health policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. *HPP* is published six times a year (bimonthly).

Specific objectives are to:

- Attract high quality research papers, reviews and debates on topics relevant to health policies in low- and middle-income countries;
- Ensure wide geographical coverage of papers including coverage of the poorest countries and those in transition;
- Encourage and support researchers from low- and middle-income countries to publish in *HPP*;
- Ensure papers reflect a broad range of disciplines, methodologies and topics;
- Ensure that papers are clearly explained and accessible to readers from the range of disciplines used to analyse health policies; and
- Provide a fair, supportive and high quality peer review process.

*Health Policy and Planning* welcomes submissions of the following types: original articles, review papers, short reports, commentaries, and papers in our series ‘How to do (or not to do)...’ [for example, see Hutton & Baltussen, *HPP*, 20(4): 252-9] and ‘10 best resources’ [for example, see David & Haberlen, *HPP*, 20(4): 260-3].

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In an earlier study (Baker and Watts 1993), it...

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Signature: ______________________________ Signed by candidate Signature Removed

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