

**The RESPOND Project Study Series:
Contributions to Global Knowledge**

Report No. I

**Payments in the Public Sector
for Reproductive Health Services
in Eastern Europe and the Caucasus**

**Lisa Patel, PhD, FHI
Barbara Janowitz, PhD, FHI**

November 2010

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The RESPOND Project
c/o EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@respondproject.org
www.respondproject.org

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Acronyms and Abbreviations

BBP	Basic Benefits Package
CDC	U.S. Centers for Disease Control and Prevention
DC	doctors' ambulatory clinic
DHS	Demographic and Health Surveys
EE&C	Eastern Europe and the Caucasus
FAP	feldsher accoucher post
IUD	intrauterine device
MH	maternity home
MOH	Ministry of Health
PH	peripheral hospital
RHS	Reproductive Health Surveys
USAID	U.S. Agency for International Development
WC	women's consultation

Executive Summary

Informal payments for health care services that patients are entitled to receive for free are highly prevalent in many countries of the Eastern Europe and the Caucasus (EE&C) region. Research has also highlighted the widespread reliance on abortion in this region. In several countries of EE&C, abortion rates are among the highest in the world. Historically, in most of the region, low-cost and safe abortions have been easy to access, whereas effective methods of contraception have not been.

Little information exists in the literature on the financial costs to clients in the EE&C region who access abortion, family planning, and other reproductive health services. This report reviews relevant literature and describes the results of a secondary analysis of data from Demographic and Health Surveys and Reproductive Health Surveys conducted in three countries in the EE&C region (Armenia, Azerbaijan, and Georgia), to examine how financial and nonfinancial factors may affect the provision of abortion, family planning, and obstetric services.

Barriers to quality family planning services in the countries of the EE&C region are considerable. Contraceptive supplies are limited, method choice is inadequate, providers and consumers lack knowledge about modern contraceptive methods, and governments have shown limited commitment to family planning. In addition, informal payments made to health care providers may act as an incentive encouraging providers to promote and provide abortion over contraception.

Informal payments are defined as “a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services the patients are entitled to.” The literature review reveals that health care providers often supplement their incomes by charging patients informal fees, a practice seemingly driven primarily by a need to survive underfunding within the health care system. Such payments may also be necessitated by chronic shortages and inadequate supplies of medications, equipment, and other provisions in public facilities.

Health care seekers are willing to make informal payments for several reasons: to receive improved quality of care, to expedite treatment, to ensure continued or ongoing care, to acquire contraceptive supplies, and to express gratitude to providers. In some cases, informal payments may be made to a number of different types of providers—not only to the treating physicians, but also to nurses, other health care providers, and facility staff such as cleaning personnel and guards. More specialized providers or those with a better reputation often command higher payments.

More than half of all respondents in most EE&C countries reported making informal payments in exchange for public-sector services, with percentages ranging from around 20% in Russia and Ukraine to as many as 90% in Albania and Armenia. In recent years, the proportion of women who have received reproductive health services at no cost in the public sector has never exceeded 8%.

While nearly all women appear to have to pay for all reproductive health services, they often pay more for family planning than for abortion. In most countries of the region, an abortion performed at a public facility should be free or relatively low-cost, but informal payments can increase the cost to clients so much that poorer women are unable to afford it. Yet modern family planning methods can be relatively expensive, because many countries in the region must import their supplies from elsewhere. Thus, the average amount paid for an abortion may be greatly exceeded by the cost of a one-year supply of imported condoms or a one-year supply of oral contraceptives.

Other factors that appear to reduce the availability and use of modern contraceptives include health care providers' low levels of knowledge about and even bias against modern methods, especially hormonal methods. Providers' lack of training and accurate information can hinder their ability to appropriately counsel clients about modern methods. Government policies can also hamper access to both abortion and contraceptive services by allowing obstetrician-gynecologists to provide them—which can create financial and time barriers for rural women in particular, as these specialists are usually located in urban areas. Women in the region also often have misconceptions about modern contraceptive methods or may not know where to obtain methods, how to use them, or how effective they are.

In contrast, access to abortion is fairly unrestricted in most EE&C countries, and the procedure does not carry the stigma that it does in other parts of the world. The centralized medical systems common to most of the EE&C region have historically focused more on curative rather than on preventive care, leading to a greater focus on abortion than on contraception.

Results of the secondary analysis of data from Armenia, Azerbaijan, and Georgia were in line with the main finding from the literature review—that most clients pay for care in the public sector. Among those who did pay and knew what they paid, the cost of an institutional delivery was higher than the cost of an abortion or of getting an IUD. The amounts that women paid for an abortion and for an IUD were about the same in Armenia, and IUD costs were higher than abortion costs in Azerbaijan. A number of factors affected what women paid for a given service, including their wealth, whether they were located in an urban or a rural area, the type of facility they attended, and what specific procedures they received on a visit. While specific findings varied across countries, the amount that women paid tended to be higher in urban areas and to be positively associated with wealth, especially in urban areas. There is also some evidence that the type of procedure that women received, at least for abortion, affected what women paid.

The lessons learned from these results will inform future research about the role of financial and nonfinancial factors in the provision and acceptance of reproductive health services in the EE&C region. In particular, future research needs to take into account the fact that both the provision and the use of these services are influenced not only by monetary factors, but also by contextual factors such as women's knowledge, attitudes, beliefs, demographic background, sociocultural environment, and economic status, as well as health care providers' knowledge, attitudes, and training and the context within which they practice.

Introduction and Rationale

Research conducted over the past two decades has highlighted the widespread reliance on abortion rather than the use of modern methods of contraception for fertility control in several countries of Eastern Europe and the Caucasus (EE&C) (Bradley, et al., 2007; David, 1992; Dolian et al., 1998; Kovacs, 1999; Kulakov, 1995). Abortion rates in a number of countries in this region are among the highest in the world; levels of induced abortion are especially high in the Caucasus, which includes Armenia, Azerbaijan, and Georgia (Sedgh et al., 2007a; Sedgh et al., 2007b). Only 14–27% of married women in these three countries report using a modern method of contraception (Serbanescu et al., 2005; NSS, MOH, & ORC Macro, 2006; and SSC & Macro International, 2008). Given the relatively low use of modern contraceptive methods and small desired family size, more than half of pregnancies in this region are unintended (Serbanescu, Goldberg, & Morris, 2005). A significant majority of these unintended pregnancies end in elective abortion (Serbanescu, Goldberg, & Morris, 2005).

Historically, in most of EE&C, low-cost and safe abortions have been easy to access, whereas effective methods of contraception have not been (Serbanescu, Goldberg, & Morris, 2005). Barriers to accessing quality family planning services persist even today. The continued extensive reliance on abortion, the low use of modern methods of contraception, and the high use of traditional methods such as withdrawal among couples in the region are influenced by a variety of monetary and nonmonetary factors. These factors include limited family planning supplies, inadequate method choice, provider bias, and out-of-pocket costs (Bradley, et al., 2007; Kovacs, 1999; Serbanescu, Goldberg, & Morris, 2005; NSS, MOH, & ORC Macro, 2006). Additionally, women and providers in this region lack knowledge and/or have negative attitudes about modern methods of contraception, particularly hormonal methods (Kovacs, 1999; Serbanescu, Goldberg, & Morris, 2005; Horga, 2006). While past research has highlighted a number of nonmonetary factors that may contribute to the low use of modern methods of contraception and high rates of abortion in the EE&C region, few researchers have explored the influence of payments for services.

Informal payments for health care services that patients are entitled to receive for free are highly prevalent in many countries of the EE&C region. The proliferation of informal payments made to health care providers in these countries could act as an incentive encouraging providers to promote certain health care services over others. Some stakeholders are concerned that informal payments made to health care providers for abortion services may deter providers from encouraging family planning services (Emerging Markets Groups, Ltd./USAID, 2005). However, financial incentives through informal payments could also influence providers to promote unnecessary and costly clinical and laboratory procedures in order for women to adopt and continue the use of a modern contraceptive method (Horga, 2006). The frequency of use of different services by clients can also determine the income that providers can generate from them. For example, if a woman obtains multiple abortions, her payments to the physician may be higher than if she obtains an intrauterine device (IUD), which lasts for several years.

An effort at understanding whether monetary incentives may discourage the promotion of contraception and encourage the use of abortion for fertility control must consider the larger context of charges for health care, including other reproductive health care services.

While the prevalence of informal payments for health services have been investigated and documented in the region, little information exists in the literature on the financial costs (including informal payments made to providers) to clients accessing abortion, family planning, and other reproductive health services. The Demographic and Health Surveys (DHS) have collected data on payments for antenatal care, delivery, abortion, and family planning methods from women in a few countries in this region; however, the final reports do not present any results on payments made by women for abortion and other reproductive health services, and they offer very limited information on the cost of family planning in these countries. Nor is any published literature available presenting information on the effect that informal payments may have on health care provider behavior in relation to providing abortion, family planning, and other reproductive health-related services in this region.

The Europe and Eurasia Bureau of the U.S. Agency for International Development (USAID) asked the RESPOND Project to investigate how financial and nonfinancial factors may affect the provision of abortion and family planning services in the EE&C region. FHI, the lead RESPOND partner on this activity, prepared this background paper as a first step in the process. The countries of interest are Albania, Armenia, Azerbaijan, Georgia, Moldova, Russia, and the Ukraine.

Objectives

This background paper includes a literature review and a secondary data analysis. The objectives of each of these components are as follows:

1. The literature review was conducted on the provision of health services, including family planning, abortion, and other reproductive health services, in the EE&C region to:
 - a. Define informal payments for health services and describe the informal payments situation and the factors that influence who makes payments, who receives payments, how payments are made, and the types and amounts of payments
 - b. Describe the reproductive health profile, especially in relation to family planning and abortion
 - c. Describe the financial and nonfinancial factors that may influence the use of family planning and abortion services
 - d. Describe how other studies have elicited data on informal payments and the lessons learned that can help inform data collection instruments for studies on informal payments and reproductive health services in the EE&C region
2. In addition, data from the DHS and from the Reproductive Health Surveys (RHS), which were conducted by ORC Macro the U.S. Centers for Disease Control and Prevention (CDC), respectively, for several countries in the region, were analyzed to describe the payments made for abortion, family planning, and other reproductive health services. This analysis included whether women paid for these services, what they paid, and the factors that may affect what they pay, as well as where these services were obtained and the ability of the women to pay for services.

Methods

The methodology used to prepare this background paper consisted of a literature review of both published and “gray literature” and an analysis of DHS and RHS data. The two aspects of the methodology were undertaken concurrently, with the literature review giving background information on informal payments and reproductive health trends in the region and the data analysis providing findings specifically on payments made for different reproductive health services in select countries in the region.

We began the literature review by looking for papers on “informal payments for health care” and used Medline, Google Scholar, and Google Web Search to conduct the search. The reference lists of papers retrieved were further used to gather other sources of information. The above-mentioned three online resources and reference lists of papers were also used to search for literature on reproductive health with an emphasis on abortion and family planning in the EE&C region.

In preparation for analysis of the DHS and RHS data, we first listed all countries in the region of interest to USAID that had either of the surveys conducted there in the past 10 years. For each country, we picked the most recent survey. To describe the reproductive health picture in the seven countries of interest in the EE&C region, we abstracted the data of interest from DHS and RHS reports (Serbanescu et al., 2005; NSS, MOH, & ORC Macro, 2006; SSC & Macro International, 2008; CDC et al., 2005; NCPM & ORC Macro, 2006; UCSR et al, 2008). Before analyzing the DHS and RHS data to describe the financial and nonfinancial factors that may influence the use of family planning and abortion services, we went through several steps. First, we examined the questionnaires and datasets from the most recent DHS or RHS survey for the seven countries, to see which countries had questions on payments made for abortion services and at least one of the following reproductive health services: IUD, antenatal care, and delivery services. Azerbaijan, Armenia, Albania, and Georgia met these criteria. Though Albania met these criteria, it was not included in the analysis because the RHS researchers questioned the reliability and generalizability of the abortion data (CDC et al., 2005). While the Moldova and Ukraine surveys asked about payments made for family planning services, they did not collect information on payments for abortion. The Russian data were more than 10 years old, so we did not attempt to analyze these data.

The questions used to ascertain information on payments and the time period covered varied among the countries. In some cases, the analysis population was limited by the time period covered by the data collection questionnaires. Originally, to minimize recall bias, we had chosen to restrict the analysis of payment data to the past three years. However, the time period was expanded in some instances to increase the number of cases for analysis. Details about the time period covered and questions asked related to payment for reproductive health services are shown in Table 1 (page 6).

Table 1. Questions asked and time period covered by DHS and RHS surveys about payment for reproductive health services in selected countries in the EE&C Region

Country	Source of data	Most recent survey	Abortion	IUD	Antenatal care	Delivery care
Armenia	DHS	2005	The (last) time you had an abortion, how much did you officially pay in total, including any consultation, procedures, and follow-up? How much did you pay in additional expenses the (last) time you had an abortion? (ANY ABORTION IN LAST 12 MONTHS) Period covered by analysis data: 2004–2005	The last time you obtained (CURRENT METHOD IN 311), how much did you officially pay in total, including the cost of the method and any consultation you may have had? How much did you pay in additional expenses the last time you obtained (CURRENT METHOD IN 311)? Period covered by analysis data: 2001–2005	Not asked	Did you or any family member pay anything for the delivery (NAME)? Altogether, how much was officially paid for the delivery, including examination, laboratory tests, medicines, and staff fees? How much was paid in additional expenses? (EACH BIRTH IN 2000 OR LATER) Period covered by analysis data: 2000–2005
Azerbaijan	DHS	2006	How much did you pay for this abortion, including gifts or money given to the doctor (person who performed the abortion)? (most recent abortion since Jan. 2001 or later) Period covered by analysis data: 2004–2006	The last time you obtained (HIGHEST METHOD ON LIST IN 311), how much did you pay in total? Please include the cost of the method, any consultation you may have had, and the cost of any gifts you may have given the provider. (method currently using) Period covered by analysis data: 2002–2006	How much did you pay in total for the last antenatal visit, including any consultation you may have had and the cost of any gifts that were given to the provider? (last birth since 2001) Period covered by analysis data: 2001–2006	How much did you pay in total for delivery of (NAME), including any consultation you may have had and the cost of any gifts that were given to the provider? (last birth since 2001) Period covered by analysis data: 2001–2006
Georgia	RHS	2005	How much did you pay for that abortion, including gifts or money given to the doctor? (IF GIFTS, CONVERT IN LARI) (for last abortion since Jan. 2000) Period covered by analysis data: 2000–2005	Question asked, but not comparable to DHS question.	Not asked	How much did you pay for that delivery, including gifts or money given to the doctor? Period covered by analysis data: 2000–2005

We restricted the analysis to currently married women (or those living with a partner) who accessed public-sector services. We report the percentage of women who paid for services and the median¹ payments made for the various services that women obtained. Payments were converted into U.S. dollars to facilitate comparisons across countries using the exchange rate from the survey year for each country. The analysis of factors affecting what women pay for services varies by country, depending on the questions included in the survey in the particular country and the number of cases, which in turn depends on the time period covered. Thus, while the basic tabulations are similar across countries, more in-depth information is obtained for some countries than for others. Where data permit, the information on what women paid is stratified by urban and rural location (of the woman's residence). Other factors considered include type of public health facility, use of anesthesia, method of abortion, and wealth. We divided the urban and rural populations into wealth quintiles using information on household assets, following the methodology used by the DHS. Separate analyses are conducted for urban and rural populations, since the items in the wealth index (assets, services, and amenities) are more likely to be found in the households of urban women than of rural women.

¹ The abortion payment data were highly skewed; hence, median payments are reported. The median is less sensitive to extreme scores and thus a better measure of central tendency than is the mean in such situations.

Informal Payments— Review of the Literature

Definition of Informal Payments

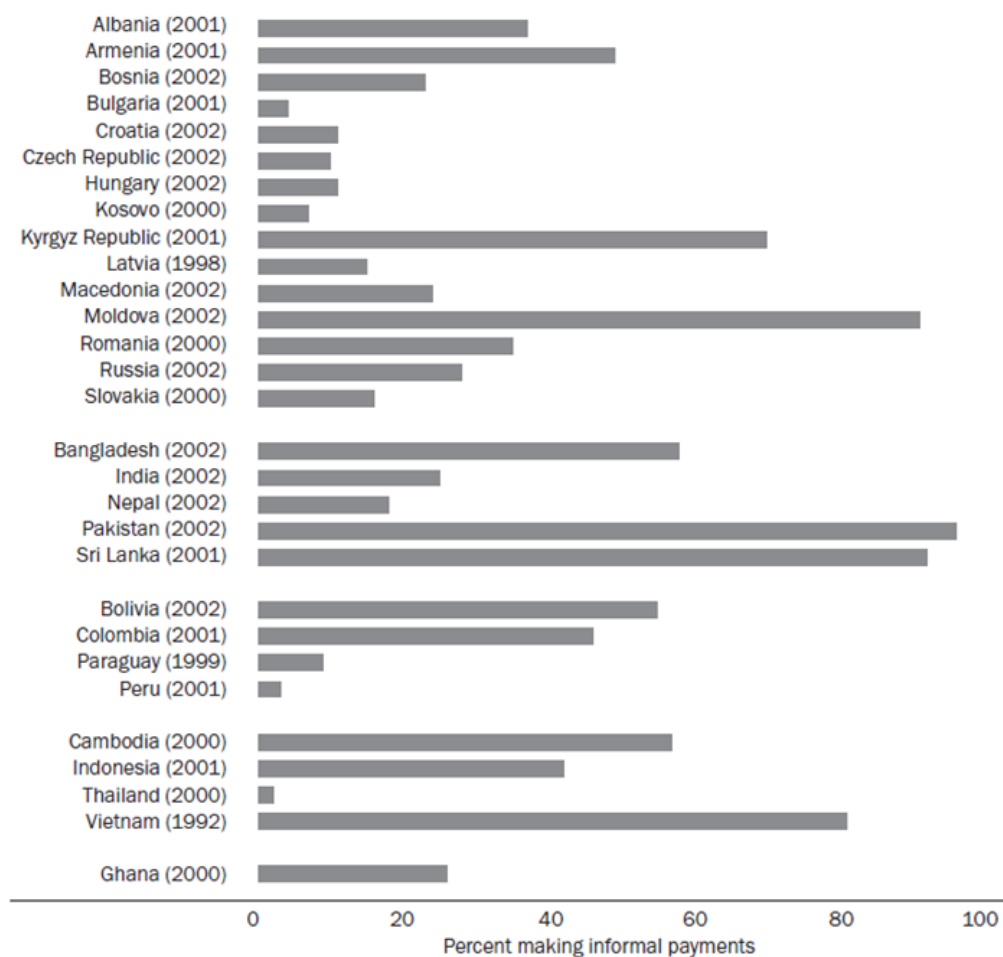
The topic of informal payments made for health care is of great interest among researchers, especially for the health sectors of EE&C countries. A paper by Gaal et al. (2006) emphasizes how a lack of consensus among researchers on the definition of informal payments can hamper research. In that paper, the authors review various ways in which past researchers have defined informal payments, propose a new definition, and describe the importance of studying informal payments. For example, one widely used definition of informal payments (which has been criticized by Gaal and colleagues) is: “payments made to individuals or institutions, in cash or in kind, made outside the official payment channels for services that are meant to be covered by the public health care system... In effect informal payments are a form of corruption” (Lewis, 2000). Gaal and coauthors argue that this definition has several shortcomings: The definition asserting that informal payments are a form of corruption brings in the author’s own interpretation of the practice in a biased manner, and it cannot include all types of informal payments. Gaal et al. put forward a new definition of informal payments (intended to describe particular episodes of care) that encompasses all varieties of the practice and does not try to explain whether informal payments are good or bad: “a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services the patients are entitled to.” This definition provides a relatively neutral, nonjudgmental starting point for further discussion on the topic.

Informal payments for health care are common in various parts of the world, particularly in developing and transitional countries. The most common form of informal payments for health care is when a patient usually pays a physician for services that he or she is entitled to receive free of charge in the public sector. Gathering empirical evidence on and accurately estimating the prevalence of informal payments for health care is difficult, as such transactions are often made covertly and are not formally recorded. Nevertheless, as the body of research on informal payments for health care has grown in the past decade, the estimated percentage of users of health care services who make informal payments can be approximated. Findings presented in a World Bank paper that compiled data from a variety of sources on informal payments in countries around the world between 1992 and 2004 (Lewis, 2007) are presented in Figure 1 (page 10). While the definition of what constitutes an informal payment and the time period covered vary depending on the data source, the data in Figure 1 show that a considerable proportion of health care users, especially those in the EE&C region, as well as in selected other countries, make informal payments for health care.

Informal Payments in Eastern Europe and the Caucasus and the Reasons for Such Payments

The countries of EE&C highlighted in this report share not only geographical proximity and a shared history of being a part of the former Soviet Union or under its influence, but also recent social, economic, and political changes as they transition from socialist governments to

Figure 1. Proportion of users of health care services who made informal payments in various countries, by regions, selected years, 1992–2002



Source: Lewis, 2007.

democratic nations with market economies. These changes have impacted and are affecting the way health care is delivered, the way health care is accessed, and the health status of the populations of these nations. Health care systems in the region are modeled on the Soviet Semashko system, which historically ensured universal access to health care through a centrally organized system; as governments could not deliver what they promised, informal payments became a common feature of such health systems. Some highlights of the health care systems in these countries are summarized in Table 2 (page 11).

A significant proportion of health care seekers in EE&C countries make informal payments for health care services in the public sector, as is revealed by the few studies in the region that have collected data on informal payments using both qualitative and quantitative methods (Table 3, page 11) (Lewis, 2000; Bonilla-Chacin, 2003; Albania MOH, 2000; Shishkin et al., 2003; Vian & Burak, 2006; Balabanova et al., 2004). More than half of all respondents in most EE&C countries report making informal payments. The frequency of such payments made by individuals seeking health care services shows that the practice of informal payments is an

important factor to consider when examining patterns of health care use by patients and the provision of health care by providers in this part of the world.

Table 2. Health care systems in selected countries of Eastern Europe and the Caucasus

Country (year of report)	Highlights
Albania (2002)	Abortion was legalized in 1992; virtually no family planning services were available before 1991; the right to universal free health care was abolished in 1993. Today, the Ministry of Health is the major funder and provider of health care.
Armenia (2006)	The Basic Benefits Package (BBP), which was introduced in 1997, comprises a publicly funded package of services specifying a list of services that are free of charge for the entire population and stipulating the population groups that are entitled to receive any type of health care service for free. All other residents in Armenia must pay out-of-pocket, in full, at the point of use, for all care not listed in the BBP.
Azerbaijan (2004)	The 1995 constitution of Azerbaijan maintained the formal guarantees of access to health care as a citizen's right, stating that, "[E]veryone has the right for protection of his/her health and for medical care." Services free to all citizens include maternal health services, family planning, child health care, and the treatment of certain diseases.
Georgia (2002)	Under the BBP concept, all services included on the BBP list are either free or partially subsidized. For any services not included in the BBP, patients must pay the hospital or doctor directly (or through private insurance, if they possess it). People paying into the insurance program receive an insurance card that must be shown to access services to which they are entitled. For example, free antenatal care covers only four antenatal visits after the third month of pregnancy and delivery, with two possible additional visits requiring some copayment.
Moldova (2008)	The Moldovan health care system aims to provide the entire population with universal access to a basic package of health care services, including family planning services. Some reproductive health services, however, including abortion, have become fee-based and are not covered by social health insurance.
Russia (2003)	The Russian constitution guarantees a full range of free health care services.
Ukraine (2004)	Ukraine has universal and theoretically free coverage. Officially, the provision of free services in state-owned health facilities is guaranteed by the Constitution of 1996, which states in Article 49 that "in state and community health facilities, care is provided free of charge; the existing network of these facilities may not be reduced."

Sources: Country reports issued by the European Observatory on Health Care Systems. Available from: www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits.

Table 3. Percentage of health care service users who made informal payments in outpatient and/or inpatient settings in selected countries of Eastern Europe and the Caucasus

Country (year data collected by studies)	Percentage
Albania (2000, 2002, 2004)	45–87%
Armenia (1999 and 2001)	56–91%
Azerbaijan (1995)	78%
Georgia (2001)	65%
Moldova (1999)	70%
Russia (2001)	19–56%
Ukraine (2001)	20–30%

Sources: Bonilla-Chacin, 2003; Albania MOH, 2000; Shishkin et al., 2003; Vian et al., 2006; Balabanova et al., 2004; Lewis, 2000.

While little research evidence exists explaining why informal payments occur in the EE&C region, researchers have posited historical and sociocultural reasons to explain the existence and continued prevalence of informal payments in the region (Lewis, 2000; Allin, Davaki, & Mossialos, 2006; Ensor, 2004). A variety of factors related to government, health care providers, and health care users interact and continue to drive the practice of informal payments and provide little incentive for stakeholders to demand a change to the system. These factors are considered below.

Government

The break-up of the former Soviet Union and the subsequent reduction in public resources in post-Communist Europe and the former Soviet countries exacerbated the use of informal payments for accessing health care services (Lewis, 2000). As countries in the region transitioned from a socialist system to a market economy, these countries experienced an economic slowdown, and the substantial reduction in public resources led to the proliferation of more formal and informal out-of-pocket payments as service providers had to rely more on private spending to finance the provision of health care services.

Governments in this region have little incentive to prevent informal payments, as this allows them to sustain the illusion of free health care and save on labor costs in the public sector, as doctors can supplement their low salaries with informal payments (Fotaki, 2009; Belli, 2003). However, informal payments also have the potential to contribute to corruption, which can undermine the ability of governments to manage the public sector. A study carried out in Ukraine reported that respondents found health care to be the most corrupt public service except for automobile inspection (Lewis, 2000). Accountability is low, as governments in the region do not have the resources to monitor their health systems in general, let alone identify and address how informal payments affect the health care system and access to care (Lewis, 2000). A lack of accountability on the part of governments allows the practice of giving and taking informal payments to continue.

Health Care Providers

The motivations for health care providers to supplement their incomes by charging patients informal fees are strong in EE&C countries and seem to be driven primarily by a need to survive underfunding within the health care system. In-depth interviews of health care providers conducted in Albania, Georgia, and Russia have found that the main reason providers say they accept informal payments is their low official salaries (Table 4) (Vian et al., 2006; Belli, Gotsadze, & Shahriari, 2004; Shishkin et al., 2003). A unit head of an urban hospital in Russia said: *“Everything boils down to the salary. Judge for yourself: a bus driver gets three to four thousand rubles a month, and an experienced physician’s monthly salary is four or five thousand. But the services they provide are so different. That’s it. This is what causes informal payments”* (Shishkin et al., 2003). Another doctor in Russia stated: *“I personally justify informal patients’ payments. It is impossible to survive with my official salary. Nonmedical professionals do not believe when I tell them how much money I make officially. A worker at a mechanical plant will never work for that kind of money”* (Shishkin et al., 2003).

On the same point, physicians in Russia and Georgia further explain that officially they do not receive an adequate share of the revenue they help the health facility generate, so they accept informal payments for services without officially making any reports about the

consultations with the cashier (Shishkin et al., 2003; Belli, Gotsadze, & Shahriari, 2004). For example, a doctor in Georgia stated: *“Doctors are not pleased that they generate eight Gel for the facility and get less than one Gel for their income. They prefer to receive three Gel informally, which is cheaper for patients. The situation forces them to act this way. At the same time, everybody knows about it, but nobody reacts, because it serves everybody’s interests: the administration’s as well as the doctors”* (Belli, Gotsadze, & Shahriari, 2004).

Related to the need to raise incomes, there is evidence from Albania that providers may recommend unnecessary tests and interventions to increase compensation through informal payments (Vian et al., 2004). A health program administrator in Albania reported: *“Doctors tend to dramatize the situation and decide to have an operation instead of a normal, natural delivery because for difficult interventions they take more [informal payments]”* (Vian et al., 2004).

There are also other reasons why providers ask for payments. Research in Azerbaijan and Russia reveals that a chronic shortage and lack of adequate supplies of medication, equipment, and other provisions in public facilities necessitates that health care providers charge patients informally to provide care, even though services and medications are supposed to be provided for free at public health facilities (Shishkin et al., 2003; Sule et al., 2008).

Finally, some health care providers report that they accept informal payments to not insult patients, because patients want to give gifts and make payments to express their gratitude. A doctor in Albania stated: *“If the patient is satisfied with my work at the end of the examination and gives me something, why should I not take it? Baksbish (tips) are accepted by everyone”* (Vian et al., 2006). A doctor in Russia said: *“Of course, extortion and corruption must be eradicated. But ‘saying thanks’ to your doctor is a long-standing tradition. It dates back to Stalin times”* (Shishkin et al., 2003).

While informal payments are prevalent, not all providers are in favor of them. Shishkin et al.’s study (2003) on informal payments in Russia, for example, has shown that health care providers do not all agree on the practice of informal payments. The study found both strong supporters and ardent opponents of physicians’ accepting informal payments from their patients. A physician opposing taking informal payments stated: *“This is incompatible with the medical profession. To take money from patients is filthy. My upbringing will never let me do that.”*

Health Care Users

Health care users make informal payments to health care providers for diverse reasons, but certain common themes emerge from studies (Table 4, page 14), including the need to access health care, to receive improved quality of care (including making health care personnel more responsive to needs), to expedite treatment, to compensate low salaried health care providers so that they continue to provide services, and to show gratitude (Lewis, 2000; Shishkin et al., 2003; Vian & Burak, 2006; Belli, Gotsadze, & Shahriari, 2004). While individuals make informal payments, not all users of services are in agreement with this practice. For example, a survey of 222 Albanian citizens found that more than three-quarters had made informal payments for health care in the past and that 67% intended to do so in the future, even though more than 70% agreed that it is wrong and illegal to give informal payments at government health facilities (Vian & Burak, 2006).

Table 4. Reasons for informal payments

Reasons why providers ask for or accept informal payments	
Albania (2003 study of health care providers and general public)	
<ul style="list-style-type: none"> • Financial problems, low salaries • To have a higher standard of living • Market orientation (health care is a market, people should pay) • Socialization during medical training (learning how to solicit payments) • Lack of social connection or personal relationship • Not to insult patients, because patients want to give gifts or make payments 	
Georgia (2001 study of health care providers and health care users)	
<ul style="list-style-type: none"> • Low official salaries • Official salary too low in relation to income generated for facility 	
Russia (2002 study of health care providers)	
<ul style="list-style-type: none"> • Low salaries • Can negotiate price of services to make win-win situation for self and patient (provider is paid more than what hospital/clinic would give and patient is charged less than what hospital/clinic would charge) • A source of funds to purchase necessary instruments, equipment, and disposable materials • A source of funds for professional education and participation in conferences, workshops, etc. 	
Reasons why health care users offer or give informal payments	
Albania (2003 study of health care providers and general public)	
<ul style="list-style-type: none"> • Recognition that providers are not paid adequately • For a feeling of security (did all that it was in your power to achieve good outcome) • To motivate the provider to provide more attention, better service • For fear that sub-standard care will be provided if you don't pay • Because you must pay or you will not be seen or receive any care • To "warm up" or create a closer provider–patient relationship • To expedite or speed up care • Because of gratitude, appreciation; to reward the provider, (may be called a gift) 	
Georgia (2001 study of health care providers and health care users)	
<ul style="list-style-type: none"> • Cultural reasons: a norm to pay providers since socialist times and before • Gratitude: express thankfulness • Desire to support physicians: high respect for physicians and believe they are suffering the same economic hardships as others • Lack of trust in the government: people believe they will receive proper services through direct market transactions as they distrust the government 	
Russia (2002 study of health care providers)	
<ul style="list-style-type: none"> • To get services of a higher quality, or more services than are guaranteed by the government as the free health benefit package • To get treatment at health care facilities and from physicians they trust more than those they are assigned to • A patient may require a service that is not available neither for free, nor under legally established fee-for-service arrangements • To reduce the time from referral to procedure/hospitalization • Sometimes, the amount the patient pays to the doctor is less than what the patient would have to pay through the institution's cashier's office • To thank doctors and nurses for successful treatment 	

Sources: Belli, Gotsadze, & Shahriari, 2004; Shishkin et al., 2003; Vian et al., 2006

Clearly, considerations of access and quality affect the need to make payments. Health care users report feeling forced to make payments to access health care services and to obtain quality services (Vian et al., 2004). For example, in a study in Albania, both health care providers and public informants described cases in which no treatment would be given if a payment was not made: *“The generality here is that the doctors do not even touch you if you don’t give any money, and when you see that the doctor does not take care of you, but leaves you waiting while you are sick, of course you have to pay them”* (Vian et al., 2004). Patients also fear that they may receive a lower standard of care if they do not pay (Vian et al., 2006). More than half of the respondents surveyed in Albania agreed that making informal payments improves quality of care, is required to get any attention, and results in being seen more quickly (Vian & Burak, 2006). The researchers concluded that “the practice of informal payments in Albania is driven by two kinds of factors: informal payments which are given to obtain a benefit or privilege...and informal payments given because the patient perceives that informal payments are obligatory in order to receive care.” Discussions with health care providers in Russia indicated that if patients cannot or do not pay after being asked to do so, they take the risk of not being hospitalized at all, being put in overpopulated rooms, having the cheapest available drugs used, having surgery done by the least experienced physician, and/or being left without due attention from physicians and nurses (Shishkin et al., 2003; Belli, Gotsadze, & Shahriari, 2004). Health care users also report giving informal payments as a way of building a relationship with a provider to ensure future access to and improved quality of health care, especially in cases where there is a need for continued care (Vian et al., 2004).

Patients may also perceive that they are expected to supplement the low salaries received by health care providers and that asking for or expecting informal payments is a way that providers can earn enough to continue to provide services. Respondents in Georgia believed that physicians face the same economic hardships as others and said they are willing to help support them by paying directly for services. One focus group respondent in Georgia stated: *“Doctors suffer and they do have families that need support. This is the reason they are forced to charge [informal payments]. If they could have higher incomes, I am sure they would never do this”* (Belli, Gotsadze, & Shahriari, 2004).

Finally, patients may regard payments as a way of expressing their gratitude, or they may simply consider payments to be the “norm” and just what is done. A respondent in Georgia stated: *“We are paying to express our thankfulness and respect for the doctor’s work”* (Belli, Gotsadze, & Shahriari, 2004).

Factors That Influence the Informal Payment Process

The process of giving and receiving informal payments is a complex social interaction where health care providers and health care users must go through an elaborate process of interpreting the expectations of the giver and the receiver. A variety of factors influence who makes informal payments, who receives the payments, the types and amounts of payments, and how payments are made.

Research conducted with both health care providers and health care users explain how attributes related to the patient, the provider, the health facility, the service, and other contextual factors (such as the economy and social norms) influence who pays and how much

is paid. Table 5 summarizes the factors that help explain variations in informal payments, using findings from a study conducted in Albania (Vian et al., 2006). Analysis of household survey data from Albania found that socioeconomic status does not affect the likelihood of making informal payments—implying that the poor and nonpoor are equally likely to make such payments (Hotchkiss et al., 2005). However, findings do suggest that informal payments are less common in rural and small urban communities, where community ties and relationships deter a provider from asking for informal payments (Vian et al., 2006). In contrast, rural patients who go to the city for treatment are reported to be charged more than their urban counterparts. Russian doctors report that informal payments should never be accepted from older retired people or colleagues and their relatives (Shishkin et al., 2003). Informal payments may also vary by the services that a patient receives. For example, payments are more frequent and are higher in inpatient settings and those linked to surgery and childbirth (Shishkin et al., 2003; Vian et al., 2006).

According to studies in Albania, Georgia, and Russia, informal payments may be made to a number of different types of providers. Thus, health care users make informal payments not only to the physicians treating them, but also to nurses and other health care providers and health facility staff including cleaning personnel and guards. Providers who are surgeons, are obstetrician-gynecologists, are highly specialized, or have a better reputation command higher payments (Shishkin et al., 2003; Vian et al., 2006). General practitioners receive relatively smaller amounts.

Table 5. Explanations given by providers and public informants in Albania for variation in amounts of informal payments requested or given

<p>Patient attributes</p> <p>Economic status of patient (poorer people may pay less)</p> <p>Relationship with provider (if patient and provider have relationship, patient may pay less)</p> <p>Ethnicity (immigrants may pay more, will be less likely to complain)</p> <p>Whether the patient resides in locality of clinic (may pay less where one lives)</p> <p>Political position of patient (patients who have political connections or know rights are less pressured to pay)</p> <p>Provider attributes</p> <p>Qualification of provider (more training, experience, good reputation or a higher level appointment command higher payments)</p> <p>Specialist versus generalist (specialists command higher payments)</p> <p>Scarcity (if there is only one provider, the payment may be higher)</p> <p>Service attributes</p> <p>Facility location (generally pay more at urban locations)</p> <p>Facility type (more at hospitals)</p> <p>Inpatient versus outpatient (more for hospitalizations)</p> <p>Specialty (more for surgery and obstetrics)</p> <p>Procedure complexity (more for complex procedures)</p> <p>Level of technology (more for higher technology)</p> <p>Other contextual factors</p> <p><i>Economy:</i> transition from planned to market economy has increased informal payments over time. Government revenues can't support salaries of workers. Also, there is a general trend toward valuing monetary transactions more than before.</p> <p><i>Social norms:</i> over time, the status or prestige associated with saying you made an informal payment may be increasing, driving informal payments up.</p>
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Source: Vian et al., 2006.

Even if just one provider collects the payments, the payments may be shared. Some physicians report, for example, that they share the revenue they make through informal payments with other health care personnel. An informant in Russia explained how revenue distribution works on a surgical team: *“...a surgeon gives part of the money to his anesthesiologist, nurse, nurse’s aide, and the unit head—that is, to all people who have made their contribution. But he does it in a fair manner, as opposed to the way they do it at the hospital’s accountant’s office, where they pay only 30% of the sum to him. He is a surgeon and deserves 70%, because he has found the patient and he has done the operation”* (Shishkin et al., 2003).

Health care providers communicate the need to make an informal payment in both direct and indirect ways, including asking the patient directly for payment, explicitly complaining about their economic hardships, or even withholding care (Vian et al., 2006; Belli, Gotsadze, & Shahriari, 2004). The main ways in which providers conveyed the need for patients to pay, as reported by general public informants in Albania, are summarized in Table 6 (page 17). Informants in Georgia further said that when payment is asked for directly by the provider, it is usually requested before or during treatment. Researchers in Georgia and Albania found that the payments for services rendered are often negotiated and the amount health care users pay may depend on the provider’s assessment of a patient’s ability to pay (Belli, Gotsadze, & Shahriari, 2004; Vian et al., 2004). Provider and public informants in Albania also mentioned that people ask friends and relatives who had similar health needs how much they paid for their services to estimate how much to pay physicians for services, as there seem to be some standard “informal prices” (Vian et al., 2004). Studies have also shown that health care users report not understanding what part of their payment is an official fee and what is an informal payment (Belli, Gotsadze, & Shahriari, 2004; Vian et al., 2004).

Table 6. How providers convey that patients need to pay, according to informants in Albania

<p>Staff talk about their difficult financial conditions The nurse said: “1,000 or 2,000 lek are not a big deal. Our salary is not enough...” “When the doctor finishes the examination, he says ‘Do you know that we live under market economy conditions?’ So you have no other choice but just to give him the money, because if you don’t give him the money, he would say, ‘Are you here to be examined or to talk?’”</p> <p>Leave money on the table, showing that others have paid “The doctor leaves some money in his working desk, so that when the patient goes there to be checked, he is obliged to give money... With this gesture he tells you that you have to pay.”</p> <p>Ask directly “Ryshfet (bribes) are flatly asked for by the doctor.” “They ask to be paid before the service provided. In the case of my aunt, they had asked her before the operation.”</p> <p>Act in an indifferent or unfriendly manner “The doctors speak in an angry voice to you.” “We understand from their reaction, when they are not satisfied you need to increase the amount.”</p> <p>Ask “who is with the patient”? “When the doctor saw us, he asked, ‘Who accompanies the patient?’ When he asked who accompanied the patient, he intended to ask who would be the persons to give the money.”</p> <p>Withhold or delay care, pretend to be busy “The doctor wants 2,000 lek for the prescription, otherwise he will not give it to you...” “[The nurses] don’t ask directly, but if you don’t put the money in their pockets, they don’t come...or they come too late.”</p> <p>Staff tell you patients must buy their own medicines “They tell you to buy a large amount of medicines at the drug store because the doctor owns that drug store.”</p>
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Source: Vian et al., 2006.

Informal payments are most often made by direct cash paid to the provider (Shishkin et al., 2003; Belli, Gotsadze, & Shahriari, 2004; Vian et al., 2004). This is also the method of payment providers prefer. Informal payments also may be made by offering in-kind contributions or gifts. In-kind contributions include providing supplies needed for the patient's treatment, such as medicines, food, bedding, syringes, and bandages. Providers report that they receive gifts such as chocolate, cheese, cognac, and flowers. Patients in rural areas may also give products they produce or make, such as eggs, milk, sour cream, or meat.

Reproductive Health in Eastern Europe and the Caucasus—Review of Literature and Results of Data Analysis

The majority of the countries highlighted in this report have fertility rates well below replacement level (Table 7); five of the seven countries have total fertility rates under 2.0 lifetime births per woman. Women tend to marry early and have only one or two children by age 30, leaving many of them with as many as 20 years of being at risk for unintended pregnancy (CDC & ORC Macro, 2003). Many women rely on induced abortion rather than on contraception to avoid unintended births. The percentage of currently married women who reported having ever used contraception in the EE&C countries varies greatly, from about 35% in Azerbaijan to 81% in Moldova (Table 8). Withdrawal is the most widely used method of contraception in Albania, Azerbaijan, and Armenia, where 67%, 33%, and 28% of women, respectively, report current use (not shown). The IUD is the most-used modern method in the region. In Moldova, Russia, and Ukraine, current use of a modern method is over 40% (Table 8).

Table 7. Reproductive health indicators for selected countries in the EE&C region

Country	Total fertility rate	Total abortion rate	Percentage ever had an abortion
Albania RHS 2002	2.6	NA	NA
Armenia DHS 2005	1.7	1.8	55
Azerbaijan DHS 2006	2.0	2.3	56
Georgia RHS 2005	1.6	3.1	43
Moldova DHS 2005	1.7	1.1	49
Russia RHS 1999	1.3	2.3	NA
Ukraine DHS 2007	1.2	0.4	NA

Note: DHS data are for currently married women aged 15–49; RHS data are for all women aged 15–44. NA=not available

Table 8. Contraceptive use and modern method use among women in the EE&C region

Country	% who have ever used contraception		% who currently use contraception		% who currently use the IUD
	Total	Modern	Total	Modern	
Albania RHS 2002	NA	NA	75	8	0.5
Armenia DHS 2005	76	39	53	20	9.4
Azerbaijan DHS 2006	70	35	51	14	9.2
Georgia RHS 2005	66	46	47	27	11.6
Moldova DHS 2005	91	81	68	44	25.2
Russia RHS 1999	NA	NA	73	53	25.0
Ukraine DHS 2007	89	78	67	48	17.7

Note: DHS data are for currently married women aged 15–49; RHS data are for all women aged 15–44. NA=not available

Given the desire for a small family size and the relatively low use of modern contraceptive methods, more than half of pregnancies in this region are unintended (Serbanescu, Goldberg, & Morris, 2005). A significant majority of these unintended pregnancies end in elective abortion (Bradley, et al., 2007; David, 1992; Dolian et al., 1998; Kovacs, 1999; Kulakov, 1995; Serbanescu, Goldberg, & Morris, 2005). Thus, it is not surprising that several EE&C countries have abortion rates that are among the highest in the world. The total abortion rate² ranges from 0.4 lifetime abortions per woman in Ukraine to 3.1 per woman in Georgia. Induced abortion levels are especially high in the Caucasus—Armenia, Azerbaijan, and Georgia (Sedgh et al., 2007a; Sedgh et al., 2007b). More than half of currently married women in Armenia and Azerbaijan have experienced an abortion (Table 7). It is also interesting to note that two of these countries (Moldova and Ukraine) have the lowest abortion rates and the highest use of modern contraceptive methods in the region (Table 7).

To gain a more complete picture of the use of reproductive health services and to better understand the context of payments made for such services, women's use of maternal health services must be described. In all countries where data are available, with the exception of Azerbaijan, antenatal care is almost universal, as is hospital delivery. All women surveyed in Ukraine, for example, reported that they had at least one antenatal care visit and that they delivered at a facility (Table 9).

Table 9. Percentage of women with a live birth who used antenatal care and who had an institutional delivery in the five years preceding the survey, in selected countries of the EE&C region

Country	Antenatal care	Delivery in a health facility
Albania RHS 2002	NA	95
Armenia DHS 2005	94	97
Azerbaijan DHS 2006	78	80
Georgia RHS 2005	NA	93
Moldova DHS 2005	98	99
Russia RHS 1999	NA	NA
Ukraine DHS 2007	100	100

Note: DHS data are for currently married women aged 15–49; RHS data are for all women aged 15–44.
NA=not available

Reasons for the Low Use of Modern Methods and High Reliance on Abortion

A number of sociocultural and historical factors interacted to affect the use of modern methods of family planning and reliance on abortion in the EE&C region. During Communist times, most of this region was isolated from contraceptive developments in the West, leaving both health care providers and couples with low levels of knowledge about modern methods (CDC & ORC Macro, 2003). While the use of modern methods was legal in the former Soviet Union, access to and availability of methods was difficult. The methods available were locally made, and the quality was generally poor. Historically, providers in the Soviet health system did not encourage the use of modern contraceptives, as they were thought to lead to negative

² The total abortion rate is the expected average number of abortions per woman in her lifetime if during the course of her childbearing years, she were to experience the age-specific abortion rates existing in a given year or period, for a given region.

health outcomes and serious side effects (CDC & ORC Macro, 2003). Barriers to accessing quality family planning services and recourse to abortion persist in the region due to a variety of factors that interact to influence the use of family planning and abortion (CDC & ORC Macro, 2003; Muscato & Kidd, 2003; David et al., 2007; Senlet & Kantner, 2004; Mogilevkina & Odland, 2003; JSI/USAID, 2007).

The degree of government commitment to improving access to family planning varies in the EE&C region, and some policies actually discourage the use of some modern methods. For example, sterilization use is low in the EE&C countries, as policies range from a complete ban on sterilization to restricted access based on age or the number of children born—a legacy of the Communist system. Many countries lack government procurement and distribution of family planning commodities, and health facilities often have insufficient contraceptive supplies (CDC & ORC Macro, 2003; Muscato & Kidd, 2003). Without a reliable supply of high-quality and affordable methods of contraception, providers face barriers in promoting and providing family planning services (David et al., 2007).

The relative out-of-pocket costs of an abortion and of modern methods of contraception may also affect their use. In most countries of the region, while the cost of an abortion at a public facility should be free or relatively low, some research indicates that informal payments increase the cost to clients so that poorer women may not be able to afford them (Bradley, et al., 2007; Kovacs, 1999). Furthermore, modern methods of family planning are relatively expensive, because many of the countries in the region do not produce the methods themselves and have to import their supplies from other countries (Kovacs, 1999; Muscato & Kidd, 2003). The immediate cost of modern contraceptive methods can be more costly than an abortion and may be unaffordable for a significant proportion of the population in some countries in the region (Senlet & Kantner, 2004). For example, the average amount paid for an abortion in one city in Russia was found to be \$16; in comparison, a one-year supply of imported condoms cost \$33 and a one-year supply of oral contraceptives cost \$25 (CDC & ORC Macro, 2003; Muscato & Kidd, 2003). IUD costs may be high for users also; providers in Russia report preferring imported, and hence more costly, IUDs over Russian-made devices, which are significantly cheaper (Mogilevkina & Odland, 2003; JSI/USAID, 2007).

Other factors also reduce the use of modern contraceptives. Health care providers in the region have low levels of knowledge and are biased against modern methods of contraception, especially hormonal methods (David et al., 2007). Providers sometimes lack training and accurate information regarding family planning methods, and hence they cannot appropriately counsel their clients about modern methods (David et al., 2007). Moreover, anecdotal evidence suggests that health care providers require unnecessary tests and examinations that drive up costs, and they may impose inappropriate eligibility restrictions that limit the provision of modern family planning methods (Armand et al. 2007).

As to potential users of modern methods, research shows that women in the region have misconceptions about modern methods; they also do not know where to obtain methods, how to use them, or how effective they are for pregnancy prevention (Chong et al., 2009). Data from household surveys show high levels of misinformation about the pill and the IUD in Moldova, Russia, Ukraine, Azerbaijan, and Georgia (Bradley et al., 2007; David et al., 2007).

While some factors in the EE&C region discourage the use of modern methods, other factors encourage the use of abortion. Abortion is fairly unrestricted, is relatively easy to access in most EE&C countries, and does not carry the stigma that it does in other parts of the world. In most of EE&C region, the centralized medical systems have historically focused more on curative rather than on preventive care, so safe abortions have been easy to access, whereas effective methods of contraception have not been (CDC & ORC Macro, 2003; Westoff & Serbanescu, 2008).

Access to both services can be hampered by the fact that government policies in many of these countries allow abortion and contraception to be provided only by obstetrician-gynecologists (CDC & ORC Macro, 2003). Often obstetrician-gynecologists are located in urban areas, which can create financial and time barriers for rural women trying to access family planning, abortion, and other reproductive health services.

Payments for Reproductive Health Services

This section presents the results of an analysis of the latest DHS and RHS data on payments made by women for abortion, family planning, and other reproductive health services and the factors that may affect what they pay in three countries in the EE&C region: Azerbaijan, Armenia, and Georgia. Our rationale for including payments made only for IUDs and not for other family planning services is that IUDs are provided in a clinical setting, usually by the same providers who are authorized to provide abortions. Methods like condoms and oral contraceptives can often be purchased directly from pharmacies.

Analysis of the DHS and RHS data for these countries shows that the percentage of women who received any of the reproductive health services of interest at no cost in the public sector never exceeded 8% (Table 10). These results are similar to those from past studies that indicated that women generally pay something to receive health care.

Table 10. Selected information on payments for reproductive health services in public-sector facilities in three countries in the EE&C region

Country	Abortion			IUD			Antenatal care			Delivery		
	% free	% don't know	Median costs* (US\$)	% free	% don't know	Median costs* (US\$)	% free	% don't know	Median costs* (US\$)	% free	% don't know	Median costs* (US\$)
Azerbaijan 2006	1.8	3.5	11.80	2.9	4.8	15.93	8.1	18.3	19.25	2.0	10.0	96.15
Armenia 2005	1.7	5.7	19.55	4.8	10.3	20.27	NA	NA	NA	0.5	19.2	120.09
Georgia 2005	1.8	0.4	15.45	NA	NA	NA	NA	NA	NA	7.3	7.1	110.34

*Among those who paid. For information on currency conversions, see tables 11-17. NA=not available

Among those who did pay and knew what they paid, the cost of an institutional delivery was higher than the cost of an abortion or of getting an IUD. Moreover, delivery costs are at minimum six times higher than the cost of an abortion. The amount that women paid for abortion and for an IUD were about the same in Armenia, and IUD costs were higher than abortion costs in Azerbaijan. In Azerbaijan (the one country in which women were asked about the cost of antenatal services), antenatal care costs were actually greater than the cost of

obtaining an abortion. Thus, the data in Table 10 indicate that payments for abortion must be viewed within the constellation of payments for other reproductive health services, and these data show that women pay for all of these services and that at times they pay more for family planning and delivery-related services than for an abortion.

A number of factors may influence what women pay for services, including the type of facility where they receive services, whether women are located in an urban or rural location, their ability to pay, and the particular procedures that they receive on any visit. These factors are examined in Tables 11–17. The four factors that we considered in terms of their impact on the price women paid for abortion are as follows: residence (urban/rural); ability to pay (using information on wealth); type of facility providing the service; the method of abortion (dilation and curettage [D&C] vs. vacuum aspiration); and receipt of anesthesia during the abortion. Only in Azerbaijan were data available on all variables. For Armenia, information was not available on the latter two variables, and the small number of cases did not allow for an analysis controlling for residence. In all three countries (Tables 11–13), women residing in urban areas paid more for an abortion than did women in rural areas, with the difference largest in Georgia. However, no other variables listed above affected what women paid for abortion services in Georgia, so we do not discuss additional findings for Georgia below.

Table 11. Azerbaijan: Cost of most recent abortion at public-sector facilities among currently married women aged 15–49 between 2004 and 2006, by selected indicators

	Urban				Rural				Total			
	% Free	% don't know	Median cost* (US\$***)	N	% free	% don't know	Median cost* (US\$**)	N	% free	% don't know	Median cost* (US\$**)	N
Adjusted Wealth Index												
Poorest	0.0	5.9	11.69	165	0.0	3.7	9.98	116	Calculations not applicable for total group. Wealth Index was computed for urban and rural areas only.			
Poorer	1.7	0.4	11.49	123	2.3	1.8	9.62	119				
Middle	2.3	5.6	12.12	87	0.0	1.9	10.55	75				
Richer	3.2	1.8	13.82	83	3.1	4.5	10.91	84				
Richest	2.2	2.8	16.32	67	4.4	7.2	9.82	105				
Type of Public Facility												
Hospital/MH	2.2	3.7	11.93	291	2.2	2.7	11.22	333	2.2	3.2	11.71	624
Polyclinic/WC	0.9	3.2	12.29	176	0.3	8.2	10.43	79	0.8	4.5	12.03	255
FAP/DC/PH	***	***	***	10	3.8	2.3	9.72	45	3.3	2.8	9.83	55
Use of Anesthesia												
Yes	1.3	3.8	13.73	324	2.1	3.7	10.60	265	1.6	3.8	11.73	589
No	2.8	2.4	11.72	156	1.9	2.7	9.16	199	2.3	2.6	11.23	355
Don't know	***	***	***	15	***	***	***	15	0.0	9.9	10.92	30
Method of Abortion												
D&C	0.9	3.9	11.47	190	1.1	3.8	9.88	247	1.0	3.9	10.58	437
Vacuum aspiration	1.6	2.6	12.36	285	3.0	3.3	11.34	208	2.1	2.9	12.00	493
Other	***	***	***	18	***	***	***	23	6.7	10.8	7.36	41
Total	1.7	3.4	12.22	525	1.9	3.7	11.22	499	1.8	3.5	11.8	1,024

Notes: Frequencies are unweighted; percentages and medians are weighted.

MH=maternity home; WC=women's consultation; FAP=feldsher accoucher post; DC=doctors' ambulatory clinic; PH=peripheral hospital.

*Among those who paid. **Cost calculated on 2006 US\$ (US\$1=4015.50 Azerbaijan Old Manat). ***Variable categories are not shown if row total is <25 unweighted cases.

Table 12. Armenia: Cost of most recent abortion at public-sector facilities, by residence, among currently married women aged 15–49 who had an abortion between 2004 and 2005

Residence	% free	% don't know	Median cost* (US\$**)	N
Urban	2.5	7.1	19.84	117
Rural	1.0	4.5	17.84	98
Total	1.7	5.7	19.55	215

Notes: Frequencies are unweighted; percentages and medians are weighted. Variable categories are not shown if row total is <25 unweighted cases. There were too few cases to analyze the impact of wealth on client costs.

*Among those who paid. **Cost calculated on 2006 US\$ (US\$1=383.90 Armenian Dram).

Table 13. Georgia: Cost of most recent abortion at public-sector facilities and of last delivery between 2000 and 2005, by residence, among currently married women aged 15–44

	Urban				Rural				Total			
	% free	% don't know	Median cost* (US\$**)	N	% free	% don't know	Median cost* (US\$**)	N	% free	% don't know	Median cost* (US\$**)	N
Abortion	1.4	0.4	16.55	697	2.0	0.4	13.79	797	1.8	0.4	15.45	1,494
Delivery	9.0	2.0	137.93	718	5.8	12.2	110.34	839	7.3	7.1	110.34	1,557

Notes: Frequencies are unweighted; percentages and medians are weighted. Variable categories are not shown if row total is <25 unweighted cases.

*Among those who paid. **Cost calculated on 2005 US\$ (US\$1=1.8125 Georgian Lari).

In Azerbaijan, a woman's ability to pay, as assessed by her wealth quintile, affected what she paid for abortion services if she lived in an urban area but not if she lived in a rural area (Table 11). Unfortunately, because there were too few cases in each residence group, it was not possible to determine whether a woman's wealth had any impact on whether she paid for services, and if she did pay, what the median payment was.

Other factors, including the type of facility in which the abortion took place, whether anesthesia was used, and the method of abortion, also had an impact on what women paid for services in Azerbaijan. For example, the median price that urban women paid for an abortion with anesthesia was 17% higher than the median price paid without anesthesia (Table 11). Similarly, the median payment that rural women paid for an abortion with anesthesia was 16% more than that for an abortion procedure without anesthesia. The median payment made by women obtaining an abortion using vacuum aspiration was 8% greater among urban women and 15% higher among rural women when compared to their counterparts that had an abortion using D&C. The median payment of urban women who obtained abortions at a polyclinic or a women's consultation was slightly higher than that of women going to a hospital or a maternity home for an abortion. In contrast, the median payment made by rural women for an abortion in a hospital or maternity home was slightly greater than the amount they paid for an abortion at a polyclinic or a women's consultation.

In Azerbaijan and Armenia (Tables 14 and 15), women paid more for IUDs in urban areas than in rural areas. Wealth had a positive impact on what women paid in urban areas but not in rural areas in Azerbaijan, a finding that is similar to those reported above for abortion services in that country. The type of facility that provided the IUD also affected what women paid, with the differences greater in urban areas than in rural areas of Azerbaijan.

Table 14. Azerbaijan: Cost of an IUD at public-sector health facilities, by type of facility and residence, among current users who are currently married women aged 15–49

	Urban				Rural				Total			
	% free	% don't know	Median cost* (US\$**)	N	% free	% don't know	Median cost* (US\$**)	N	% free	% don't know	Median cost* (US\$**)	N
Adjusted Wealth Index												
Poorest	2.8	2.9	11.64	64	4.3	0.0	11.41	35	Calculations not applicable for total group. Wealth Index computed for urban and rural areas only			
Poorer	3.0	4.6	14.06	67	1.3	0.0	11.54	39				
Middle	6.7	6.5	21.96	56	3.9	10.4	11.25	40				
Richer	0.1	7.5	24.37	52	0.0	2.9	13.46	32				
Richest	4.2	5.5	30.40	61	0.0	3.7	11.26	44				
Type of Public Facility												
Hospital/MH	4.4	3.0	15.30	138	0.0	1.1	11.02	105	2.7	5.1	12.30	243
Polyclinic/WC	2.6	3.7	24.30	144	0.0	5.7	13.68	52	2.1	4.1	23.18	196
Total	3.5	5.5	22.52	300	1.9	3.4	11.55	190	2.9	4.8	15.93	490

Notes: Frequencies are unweighted; percentages and medians are weighted. Variable categories are not shown if row total is <25 unweighted cases.

MH=maternity home; WC=women's consultation; FAP=feldsher accoucher post; DC=doctors' ambulatory clinic;

PH=peripheral hospital.

*Among those who paid. **Cost calculated on 2006 US\$ (US\$1=4,015.50 Azerbaijani Old Manat).

Table 15. Armenia: Cost of an IUD at public-sector health facilities, by type of facility and residence, among current users who are currently married women aged 15–49

	% free	% don't know	Median cost* (US\$**)	N
Type of Public Facility				
Hospital/maternity home	5.1	12.2	19.50	257
Polyclinic/woman's consultation	1.9	7.4	23.55	105
Location				
Urban	6.6	9.4	20.68	256
Rural	1.8	11.8	17.84	121
Total	4.8	10.3	20.27	377

Notes: Frequencies are unweighted; percentages and medians are weighted. Variable categories are not shown if row total is <25 unweighted cases. Too few cases to analyze wealth on client costs.

*Among those who paid. **Cost calculated on 2006 US\$ (US\$1=383.90 Armenian Dram).

The clearest picture emerges for deliveries (Table 13 and Tables 16 and 17, page 26). In all three countries, in both urban and rural areas, what women paid for a delivery increases with their wealth quintile. Moreover, in all three countries, the biggest difference in what women paid occurred in urban areas. For example, in Azerbaijan, women in urban areas in the highest wealth quintile paid more than twice as much as did women in the lowest quintile. In contrast, women in the highest quintile in rural areas paid just 25% more than did women in the lowest quintile. Moreover, what women paid in urban areas was higher overall than what women paid

in rural areas. Finally, the type of facility in which women delivered their baby also affected what they paid.

Table 16. Azerbaijan: Cost of last delivery at public-sector health facilities, by wealth index and type of facility, among currently married women aged 15–49 whose most recent birth occurred between 2001 and 2006

	Urban				Rural				Total			
	% free	% don't know	Median cost* (US\$**)	N	% free	% don't know	Median cost* (US\$**)	N	% free	% don't know	Median cost* (US\$**)	N
Adjusted Wealth Index												
Poorest	3.4	18.4	72.80	207	0.3	3.8	57.86	115	Calculations not applicable for total group. Wealth Index was computed for urban and rural areas only.			
Poorer	3.8	6.7	124.55	159	3.6	3.5	66.74	115				
Middle	0.8	23.1	138.93	133	0.4	4.4	67.78	118				
Richer	1.8	12.7	181.85	107	1.5	4.7	72.48	115				
Richest	1.3	7.6	191.49	104	1.8	4.4	72.41	140				
Type of Public Facility												
Hospital/MH	2.2	13.6	134.85	658	0.7	3.2	71.85	458	1.7	10.0	99.53	1116
FAP/DC/PH	2.4	22.5	70.7 4	36	3.9	6.2	45.80	124	3.6	8.7	46.8 4	160
Total	2.3	13.9	132.44	710	1.5	4.2	70.17	603	2.0	10.0	96.15	1313

Notes: Frequencies are unweighted; percentages and medians are weighted. Variable categories are not shown if row total is <25 unweighted cases. Percentages and medians are shown in gray if row total is <25 unweighted cases within urban and rural.

MH=maternity home; WC=women's consultation; FAP=feldsher accoucher post; DC=doctors' ambulatory clinic; H=peripheral hospital.

* Among those who paid. **Cost calculated on 2006 US\$ (US\$1=4,015.50 Azerbaijani Old Manat).

Table 17. Armenia: Cost of last delivery at public-sector health facilities, by wealth index and type of facility, among currently married women aged 15–49 whose most recent birth occurred between 2000 and 2005

	Urban				Rural				Total			
	% free	% don't know	Median cost* (US\$**)	N	% free	% don't know	Median cost* (US\$**)	N	% free	% don't know	Median cost* (US\$**)	N
Adjusted Wealth Index												
Poorest	0.5	19.1	116.74	174	0.0	22.8	77.45	54	Calculations not applicable for total group. Wealth Index was computed for urban and rural areas only.			
Poorer	0.2	23.1	112.51	153	0.0	11.1	89.62	63				
Middle	0.6	22.7	151.46	123	0.0	20.5	90.22	48				
Richer	0.0	14.2	154.72	110	0.0	15.0	97.16	62				
Richest	1.2	25.6	219.05	96	2.0	12.5	101.91	73				
Type of Public Facility												
Hospital/ mat. home	0.3	20.8	151.44	646	0.5	15.0	96.11	291	0.3	18.7	122.29	937
Total	0.5	21.1	151.36	656	0.5	15.9	95.93	300	0.5	19.2	120.09	956

Notes: Frequencies are unweighted; percentages and medians are weighted. Variable categories are not shown if row total is <25 unweighted cases.

*Among those who paid. **Cost calculated on 2006 US\$ (US\$1=383.90 Armenian Dram).

These results are in line with findings from the literature on payments for health care. Analyses of the DHS and RHS data support the findings from other studies that most clients do pay for care in the public sector. Moreover, a number of factors affect what women paid for a given service, including their wealth, whether they were located in an urban or a rural area, the type of facility they attended, and what specific procedures they received on a visit. However, findings vary across countries, although there is some tendency for the amount that women paid to be higher in urban areas and to be positively associated with wealth, especially in urban areas. There is also some evidence that the type of procedure that women received, at least for abortion, affected what women paid, but that evidence is limited.

Lessons Learned

The purpose of this section is to show how findings from the literature review and data analysis can be used to inform studies attempting to understand the roles of financial and nonfinancial factors that affect the provision and acceptance of reproductive health services in public-sector clinics in the EE&C region.

The sources of data for past studies on informal payments are from the individuals who participate in the transaction itself: patients and health care providers. Data used to understand informal payments in the past have come from sources that range from focus group discussions and in-depth interviews to large household surveys, health facility exit surveys, and corruption studies (Serbanescu, Goldberg, & Morris, 2005). The World Bank's Living Standards Measurement Surveys have gathered data on informal payments in several EE&C countries, including Albania, Armenia, Azerbaijan, Georgia, Moldova, and the Russian Federation. Qualitative methods used by a few studies have elicited data from providers and patients in Albania, Armenia, Azerbaijan, Georgia, and Russia and have offered insight into why providers feel they have to accept payments for services their clients are entitled to for free and into why patients feel they should make such payments (Bradley, et al., 2007; USAID, 2008). These past studies offer some insight into conducting studies on informal payments in the future.

Collecting accurate information on the prevalence and amount of informal payments for health care is difficult, as these payments are often made in a secret manner and the transaction is not formally recorded. Also, cross-national comparisons are difficult to make, as past research has shown that clients' and providers' interpretations of what comprises an informal payment differ across countries. Nevertheless, as it is a topic of great interest and importance, the body of research on informal payments for health care has been growing in the past decade.

As one thinks about designing a study on informal payments and women's reproductive health, one challenge that may be faced is that women and providers might be reluctant to say that they make or receive informal payments. However, the literature and data that we have analyzed indicate that paying for health services is common and that the vast majority of women are willing to tell you that they paid and also know what they paid. With regard to providers, most studies ask providers if and why they charge. Eliciting information from providers may be more difficult, as women may pay different amounts for the same service or they may receive different tests and procedures for a particular type of visit.

- The proposed solution is to ask clients about payments that they make for different services (see below), but to only ask providers about recommended tests and procedures that they perform for a particular health service, given the difficulty of obtaining detailed information from providers on payments.

A second challenge is to separate formal and informal payments. While clients may know what they pay for services, they may not know what part of the payment is formal or informal or they may be reluctant to provide that information.

- The proposed solution when eliciting information from clients is to concentrate instead on the components of payments as they relate to drugs, tests, and procedures that women receive for the service visit type that they make and whether each of these tests, etc., are required or optional. Thus, less attention will be paid to whether a payment is formal or informal, especially given the fact that women almost universally pay for “free” services.

The third challenge is to recognize that a wide variety of factors affect the use of different reproductive health services. Therefore, the role of both financial and nonfinancial factors in explaining the use of these services may be quite complex.

- The solution is to obtain information not only on payments, as described above, but also on what women know and think about strategies to prevent pregnancies and the role that abortion plays in those strategies, as well as what providers tell women about abortion and contraception.

The fourth challenge is to determine what factors affect payments for various reproductive health services. Preliminary data indicate that some factors are important for some services but not for others. But variables included in the DHS will need to be expanded to take into consideration a wider range of factors that might affect payments.

- The solution is to collect more detailed information on a variety of factors that may influence the use of reproductive health services.

Researchers attempting to understand the monetary factors that may influence health care providers’ provision and women’s use of family planning and abortion services need to recognize that payments for abortion, contraception, and other reproductive health services are widespread. Furthermore, the provision of these services by providers and the use of the services by women are influenced not only by monetary factors, but by nonmonetary factors as well. Women’s fertility-related decisions are influenced by characteristics such as their knowledge, attitudes, beliefs, demographic background, and sociocultural environment, as well as their economic status. Health care providers’ decisions to provide services may be influenced not only by the payments they may receive, but also by the characteristics of the health care facility where they practice, their knowledge and attitudes, their past training, and the larger environment within which they practice. When designing studies that focus on the role of financial factors, researchers need to keep in mind this broad context within which decisions are made and services provided.³

³ Conducting such studies is a complex task involving consideration of a number of critical issues, including what populations to target and how to phrase questions about payment of and receipt of informal payments, as well as some of the concerns raised by early studies. Appendix A summarizes how past studies have elicited information about informal payments for health care in Albania, Georgia, and Russia.

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Approaches Used in Past Studies to Gather Information about Informal Payments for Health Care

Albania

2003 study of health care providers and general public (Vian et al., 2006)

Target population and research methods used: Focus group discussions (FGDs) and in-depth semi-structured interviews were used to document beliefs and perceptions that underlie the practice of informal payments in the Albanian public health sector. The study gathered views about informal payments from the general public, clinical care providers, and health program administrators.

Questions asked: Questions asked during the FGDs and individual interviews covered five main areas: Other than official fees, what do people give to providers, and how do they categorize these “unofficial payments”? Why do people make such payments? What are the advantages and disadvantages of making informal payments? What are the ways that people make these payments (details about the process, how people know what to pay, etc.)? What is being done now about informal payments, and what should be done in the future? In the in-depth interviews, the latter question was probed by asking what the respondent thought about specific reforms under consideration, such as increasing insurance coverage, instituting official user charges, and establishing community health boards.

Issues to consider: During the pilot test, the study found that some providers were reluctant to answer questions when interviewed alone but that they were more communicative when interviewed in a focus group. The researchers thought that perhaps people felt more protected in the group and were therefore more inclined to share their opinions. Nurse focus groups were held separately from doctor focus groups, again to facilitate more open discussion.

Analysis of the practice of informal payments is complicated by some confusion of terms. First, for the general public in Albania, there seemed to be some problems distinguishing official from unofficial payments. At times, people reported being told they had to pay an “official” charge but that they could choose whether to pay the provider directly or make a special trip to the office. Often, people preferred to pay the provider directly, either for convenience or because they felt a direct payment would motivate the provider to give better care. Finally, some informants reported seeing “unofficial price lists,” which might actually be official price lists for user charges for noninsured patients or copayments for insured patients. The researchers observed that policies regarding copayments or exemptions for insured patients were not really understood and may not be uniformly applied. These observations suggest that some “informal payments” may actually be authorized charges that are not being collected in transparent ways or that are being siphoned off at the point of collection. This problem needs to be studied further to identify appropriate interventions.

Georgia

2001 study of health care providers and health care users (Belli, Gotsadze, & Shahriari, 2004)

Target population and research methods used: This was a qualitative study complemented with the quantitative data presented elsewhere. The qualitative study considered two target groups: patients and service providers. Patients were engaged in in-depth interviews and focus group discussions, while for providers only in-depth interviews were conducted. Two geographical localities were selected for the study. The principal aim of in-depth interviews with patients was to understand the level and pervasiveness of out-of-pocket payments (OPPs), both formal and informal; whether and to what extent OPPs create a barrier to access health services; and the dynamics of payment.

Questions asked: The interviewers asked specific questions on when, how, to whom, and why payments generally occur. Guides for in-depth interviews included questions concerning illness- and non-illness-related episodes (such as pregnancies or preventive services), services included and not part of the basic benefits package (BBP), cases when services were fully utilized, as well as cases when treatment was forgone or delayed or interrupted because of financial or other reasons. FGDs reiterated some of the same questions from the in-depth interviews but concentrated on more general policy-related issues concerning service provision and payments. Questions about the perceived causes of payment and about households' perceptions concerning the viability of different policy interventions to contain informal payments were discussed. In-depth interviews with providers aimed at exploring the dynamics in the flow of funds within health facilities, including the mechanisms of payment collection, distribution, and utilization of revenues from OPPs (formal or informal), and health workers' perceptions of the causes and consequences of informal payments.

Issues to consider: Pretesting of the questionnaire showed that providers in Georgia were willing to speak openly about their experiences with informal payments. Responses based on the participants' and their household members' experiences with utilization of health services were compared with the information given during the in-depth interviews.

The objective of this part of the focus groups was to ascertain whether confidentiality (obviously absent in a focus group discussion) made any difference and to further probe the results of the in-depth interviews. The researchers found that responses during focus group discussion perfectly matched those during in-depth interviews, suggesting that, contrary to what the authors found in Poland, in Georgia people were willing to speak openly about their experiences with paying for health services.

Russia

2002 study of health care providers (Shishkin et al., 2003)

Target population and research methods used: Face-to-face interviews were conducted with health administrators, financiers (leaders of executive and representative branches of power, mandatory health insurance officers, leaders of health insurance companies, administrators [chief doctors] of health institutions), and health professionals (rank-and-file physicians/doctors and nurses). The study was conducted in two Russian regions. Since informal payments violate applicable Russian laws, respondents agreed to provide information on condition of confidentiality.

Issues to consider: The researchers stated that since the respondents were direct recipients of under-the-table payments, one might ask: To what extent they were honest with us, and how reliable can those sorts of data be? That is why their questions had been formulated in a way that would allow respondents to “save face” and minimize temptation to distort or conceal the facts because of fear or embarrassment. They used a “flexible interviewing technique” that allowed moderators to adjust to each respondent’s personality. The interview structure was intended as a tool that would make respondents openly reflect on their past experiences. It was designed not so much for getting unambiguous comparable answers for further quantification, but to make respondents talk as much as possible and trigger their own “mini-study” of the discussed problems. Although such methodology makes data processing difficult, it is a very useful tool when there is a need to collect as many perceptions and facts as possible. Discussion of possible ways to expand chargeable services or legalize patients’ OPPs was used as a motivation for the respondents. The survey was carried out in two Russian regions that differed in the following characteristics: One region received federal subsidies, had a fairly low per capita income, and had a rural/urban population ratio close to the average national value; the other region was a donor of funds to the federal budget with a reasonably high level of per capita income and a high proportion of urban population.

A total of 136 interviews with health professionals in the two regions were carried out. The sample included deputy chief doctors, health institutions’ unit heads, rank-and-file physicians/doctors, and nurses. The interviews were conducted at the following locations: regional state-owned teaching hospitals; municipal teaching hospitals; municipal urban outpatient clinics; central district municipal hospitals; district municipal hospitals located in rural settlements; and private health care facilities.

1999–2000 study of factory employees, students, and pensioners who were clients at polyclinics (Fotaki et al., 2009)

Target population and research methods used: The survey was undertaken during autumn 1999 and spring 2000 and was carried out in four (out of 89) regions of the Russian Federation. These regions were chosen to represent different models of health insurance. Convenience samples of the population in all four regions were selected, as it was neither possible nor intended to randomize sample selections. Two hundred face-to-face interviews with groups of factory employees (from two enterprises with varying histories of paying contributions to the insurance scheme) and with students and pensioners (whose contributions were likely to be left unpaid by the local governments) were carried out in polyclinics using structured questionnaires and metric scales. A total of 796 responses were received. Trained interviewers approached potential respondents as they came to polyclinics located in enterprises or in community and university centers until a total of 100 employees, 50 pensioners, and 50 students were reached in each region.

Issues to consider: Different responses were also given when a question was phrased in terms of “under-the-table payments” as opposed to legal charges for services that should otherwise be provided free of charge or covered by the insurance but that were nonetheless levied by hospitals or polyclinics at their discretion.

2006 study of adult population (Aarva et al., 2009)

Target population and research methods used: The purpose of this study was to reveal the differences in health care payment practices between cities of different socioeconomic status. The particular interest was in informal (unofficial/under-the-table) payments. Although there are several studies on informal payments in Russia, no comparative studies on differences between specific Russian regions were available.

This cross-sectional study was conducted as a part of a survey on the population's health behavior, health attitudes, and satisfaction with health care services in two Russian regional capitals. The data consisted of a representative random sample of the adult population of the regional capitals Lipetsk and Tyumen. Personal face-to-face interviews were conducted in December 2006 for the randomly selected sample of inhabitants aged 18 and older, using a multistaged sampling of households with stratification by four city districts in Lipetsk and three in Tyumen. A total of 2,001 properly filled questionnaires were included in the analysis (998 in Lipetsk and 1,003 in Tyumen).

Questions asked: Prevalence of health care payments, whether formal or informal, was measured by the question "Have you used chargeable medical services in the past three years?" Multiple-choice questions on the facilities where the chargeable services occurred included 13 options that were merged into two major groups: governmental and private facilities. Governmental health facilities included outpatient units, dispensaries, general physicians' offices, health facilities at governmental workplaces, obstetric clinics, hospitals (district, city or regional), medical doctors' assistants' (feldshers) offices, and trauma departments. Private health facilities included medical centers, private clinics, dental care units, private hospitals, and healers. Multiple-choice questions were used to examine the reasons for using chargeable services. For the analysis, the replies were grouped into four categories. The prevalence of informal payments was measured by the question "Have you in the past three years paid or given gifts for medical services that should be provided free of charge—that is, did you make unofficial payments?"

The survey instrument was developed based on a review of similar surveys conducted in Russia and in other transitional countries. The questionnaire, consisting mainly of structured multiple-choice questions and a few open-ended questions, was pretested in Moscow in September 2006. It included 70 questions on: (1) socioeconomic factors; (2) use of health care services (visits to medical facilities during the past three years, visits to doctors during the past 12 months, use of preventive check-ups, types of chargeable and free-of-charge services used, and willingness to pay for health care services); (3) perceptions of the quality of health services and satisfaction with different aspects of health care services (personnel, location, and comfort of facilities); and (4) health behavior and opinions on health-related issues (smoking, alcohol consumption, body mass index, self-rated health, chronic diseases, disability, self-reported anthropometric data, psychoemotional status, self-help activities, and opinions on factors positively/negatively affecting health).