



ECONOMIC FACTORS AS DETERMINANTS OF WOMEN ACCESS TO REPRODUCTIVE HEALTH SERVICES

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Abstract

This study examines how economic factors determine women access to reproductive health services. Poverty creates barriers through direct costs like service fees and medicine purchases as well as indirect costs including transportation and foregone daily wages. Out of pocket payment systems discriminate against poor households who lack savings for unexpected health expenses. Economic exclusion accumulates across women life cycles from adolescence to adulthood and transmits poverty across generations through maternal deaths and disabilities. Employment status, geographic residence, and health insurance coverage moderate the influence of economic factors on service access. Fee removal policies alone insufficiently reach the poorest groups because they still face indirect cost barriers. Conditional cash transfer programs compensating for transportation costs and lost wages prove more effective but require substantial administrative capacity and budgets. Corruption through informal payments in public health facilities worsens economic exclusion and requires strong political commitment with participatory oversight mechanisms. Policy makers must design reproductive health financing systems that explicitly consider poor groups ability to pay.

Keyword: reproductive health, economic exclusion, poverty, health financing, access barrier

Introduction

Women's reproductive health is one of the fundamental indicators of societal well-being in various countries. Access to reproductive health services encompasses a wide range of services, from contraceptive counseling, pregnancy check-ups, and safe delivery, to the treatment of sexually transmitted infections. Every woman has the right to obtain these services without discrimination of any kind. However, the reality on the ground shows that rights which have been legally recognized often cannot be realized by a large portion of women due to various structural barriers. These barriers are multidimensional and interconnected, forming a complex network that is difficult for those in low socioeconomic positions to penetrate. Economic factors are one of the most dominant obstacles that appear in various studies in both developing and developed countries. An individual's financial ability determines whether they can access quality reproductive health services or are forced to ignore their needs. The gap between rich and poor groups in the utilization of reproductive health services continues to widen along with the commercialization of health systems in many countries. Women from poor households often ignore early symptoms of reproductive diseases due to the high costs of doctor consultations and diagnostic tests (Barcelona & Edouard, 2024). From a broader perspective, these accessibility challenges are also influenced by the dynamics of national health development as well as regulations regarding infectious disease management in Indonesia (Harianto et al., 2024).

Reproductive health service providers, both private and public, generally apply fees that must be paid by service users. This payment system includes registration fees, consultation fees, laboratory examination fees, medication costs, and other medical procedure costs. For households with limited income, the accumulation of these costs becomes a very heavy burden. When a woman requires a pap smear or a pregnancy test, she must sacrifice money that should have been used to buy food for her family. This condition forces women to choose between meeting basic daily needs or taking care of their own reproductive health. The choices faced by poor women are very bitter because both options are equally important for the survival of their lives and their families. Public health insurance systems in some countries have actually been designed to protect the poor from the

burden of health costs. However, the coverage of this insurance is often limited to certain types of services, while specific reproductive health services may not be included in the benefit package (Taqi & Singh, 2023). This is closely related to the evaluation of service quality in public health facilities, which directly influences the level of patient satisfaction (Darmawan et al., 2022; Mardikaningsih, 2022).

Structural poverty creates a vicious cycle that is difficult to break between low economic status and poor reproductive health conditions. Women who are unable to access modern contraceptives will continuously experience unplanned pregnancies. Pregnancies that occur too frequently and with short birth intervals increase the risk of maternal and infant mortality. Families with many children but limited income will fall further into more severe poverty. Children from large, poor families tend to drop out of school because their parents cannot afford their education. Dropping out of school makes it difficult for them to get decent jobs in the future, so poverty continues to the next generation. Women in poverty are also more vulnerable to sexually transmitted infections due to their inability to negotiate condom use with partners. Low bargaining power in sexual relationships leaves poor women powerless to protect themselves. When they eventually contract a sexually transmitted disease, the high cost of treatment makes them reluctant to seek medical help, causing the disease to worsen and spread to others. This vicious cycle shows that economic factors are not just momentary obstacles, but long-term determinants of women's reproductive health status (Stoner, 2024). This phenomenon also encompasses the complexity of stress factors in vulnerable groups (Issalillah & Aisyah, 2022) as well as the importance of women's roles as drivers of social transformation in society (Aisyah, 2023).

The inability to pay for reproductive health services often occurs even though these services are legally available for free at public facilities. The phenomenon of unofficial costs or informal payments has become a common practice in many healthcare systems in developing countries. Healthcare workers may request additional money outside of official rates in exchange for faster or better service. Poor women who cannot afford these unofficial fees must queue for hours or even days to get their turn for service. Time lost due to queuing means a loss of daily income for informal sector workers who are paid by the day. Transportation costs

to healthcare facilities also become a separate burden, especially for women living in remote areas without access to affordable public transportation. The long distance between homes and healthcare facilities requires fuel costs or vehicle fares that may exceed the cost of the service itself. When a woman is seriously ill and requires a referral to a hospital in the city, the cost of transportation and accommodation during treatment can exhaust her family's savings at once. This condition explains why maternal mortality rates remain high in poor areas, even though healthcare facilities capable of handling pregnancy complications are already available in the district capital. Economic barriers are cumulative and become greater when the disease is already severe and requires more complex treatment (Nasir, 2022). This reality demands a strong legal review to guarantee the protection of the rights of poor patients (Noor et al., 2023) as well as the prevention of ethical and legal violations in healthcare services (Hartika et al., 2023).

The economic exclusion from reproductive health services has a more severe impact on groups of women who are at the intersection of various forms of discrimination, such as poor women in rural areas, women with disabilities, or women from minority ethnic groups. They face multiple obstacles that exacerbate their inability to access services. Poor rural women must deal with poor road infrastructure, making transportation costs more expensive and travel times longer. A lack of information about available reproductive health services makes them unaware of the rights they should be obtaining. Healthcare workers who are less sensitive to the socioeconomic conditions of patients may provide treatment that demeans the dignity of poor women, making them reluctant to return to healthcare facilities in the future. Feelings of shame and inferiority when dealing with more educated and affluent healthcare workers make poor women choose to stay at home rather than seek help. Stigma surrounding certain reproductive diseases, such as cervical cancer or HIV/AIDS, further strengthens women's reluctance to get checked. They fear being found out by neighbors or relatives that they are visiting a reproductive health clinic due to negative societal assumptions about the morality of women who go to such clinics. These socio-cultural factors interact with economic factors, creating a total barrier that is almost impossible to penetrate for poor

women without strong policy intervention (Jayachandran, 2019). In addition to economic barriers, the failure of service support systems can also trigger information disruption that impacts the legal responsibility of healthcare providers (Yatno et al., 2023).

The first problem in accessing reproductive health services is the gap between public policies that guarantee the availability of services and the reality of the community's financial capacity to utilize those services. Governments in many countries have issued regulations requiring public healthcare facilities to provide reproductive health services for all citizens without discrimination. However, these regulations are not accompanied by adequate financing mechanisms to guarantee that poor women can truly access services without sacrificing other basic needs. Direct costs, such as service tariffs, medication costs, and contraceptive costs, must still be borne by the patient, even if the amounts are small for middle and upper-income groups. For women living on an income of less than one dollar per day, any amount, no matter how small, remains an unavoidable burden. Indirect costs, such as the loss of daily wages due to absence from work to go to a healthcare facility, are also a very heavy sacrifice. The decision to access reproductive health services means choosing between paying for those services or buying food for their children (Paul, 2017). This gap between law and reality creates the illusion that reproductive health rights have been fulfilled, when in reality, the poor remain unable to access them. Policies that do not consider the purchasing power of the target community will always fail to reach those who need them most.

The second problem is the presence of systematic economic exclusion in the design of reproductive health service payment systems, which tends to benefit financially capable groups. Payment systems that require users to pay upfront before receiving services automatically exclude those who do not have cash at the time of need. Poor women often have to borrow money from neighbors or loan sharks at high interest rates to pay for emergency delivery costs. This debt then becomes a long-term burden that further worsens their family's economic condition. Health insurance systems that require monthly premium payments are also unfriendly to informal sector workers with irregular incomes. In months where income is low, insurance premiums may be the last priority after food and children's education costs. As a result,

their insurance membership status is inactive when they truly need health services. Complicated cost reimbursement or insurance claim mechanisms with numerous document requirements also make it difficult for poor women who may be illiterate or lack access to photocopiers. Long claim processes cause them to lose much-needed money for a long time. This complex system design unintentionally functions as a filter that excludes the poor from accessing services. Economic exclusion is latent because it is not visibly apparent, yet its impact is very real in reproductive health statistics, which show striking differences between rich and poor groups (Barcelona & Edouard, 2024). In addition to the financing aspect, adequate promotive approaches and social support also play an important role in improving physical and mental well-being (Issalillah, 2021; Issalillah & Khayru, 2022).

The Sustainable Development Goals target a reduction in maternal mortality rates and universal access to reproductive health services by 2030. With less than a decade remaining, evaluation of economic barriers becomes critical to formulate targeted interventions. The COVID-19 pandemic has worsened the economic conditions of poor households worldwide and has the potential to accelerate the decline in reproductive health achievements that have been fought for over decades (Abigail, 2022). Resources diverted for pandemic response reduced budgets for reproductive health services in many countries. Poor women became the group most affected because they lost access to contraceptive services and pregnancy care while health systems were overwhelmed. A systematic literature review is needed to identify empirical evidence regarding the relationship between economic factors and access to reproductive health services. This evidence will become the basis for policy advocacy that is more supportive of poor women. Without a clear understanding of the mechanisms of how economic exclusion works, designed interventions will be speculative and at risk of failing to reach the intended targets. In the long term, comprehensive attention to health is highly necessary to prevent complications from other diseases that can affect the quality of life of the community (Issalillah, 2022).

The purpose of this review is to explain the causal relationship between various dimensions of economic factors and the level of women's access to reproductive health services. This explanation includes the

identification of specific mechanisms of how poverty limits women's choices in utilizing available services. This review also aims to map the differences in economic barriers among various subgroups of women based on employment status, place of residence, and age. The theoretical contribution of this review is the enrichment of the understanding of socioeconomic determinants of reproductive health, which have received less attention in mainstream literature. Its practical contribution is evidence-based policy recommendations for designing inclusive reproductive health financing systems.

Method

This study utilizes a qualitative literature review approach to trace the relationship between economic factors and access to reproductive health services. Kalof and Dan (2008) explain that library-based research aims to synthesize existing knowledge from various written sources without conducting primary data collection. This method is appropriate for the purpose of the study because the topic of poverty and access to reproductive health services has been widely discussed in various disciplines, including public health, economics, sociology, and gender studies. Bailey (2008) suggests that literature reviews in social research allow researchers to identify consistent patterns across different geographical settings and population groups. This approach helps researchers draw generalizations about the universal principles that govern the relationship between economic status and healthcare-seeking behavior. The data sources for this study consist of public health textbooks, reports from international organizations such as the World Health Organization, articles from reproductive health and health economics journals, and qualitative studies on the experiences of poor women in accessing healthcare services. Henn, Weinstein, and Foard (2005) emphasize that the success of a literature review depends heavily on the researcher's analytical depth in comparing findings from various sources that may have different perspectives. The analysis procedure in this study is carried out in three stages: document collection based on relevant keywords, data reduction based on source methodological quality criteria, and the presentation of synthesis results in the form of a coherent argumentative narrative. All sources used were selected based on the reputation of the

publisher and direct relevance to the topic of economic determinants of reproductive health service access.

The analysis technique used in this study is thematic content analysis, which focuses on grouping statements from various sources into specific thematic categories. Thematic analysis in literature reviews allows researchers to identify both consensus and debates among authors regarding a particular issue (Ibrahim, 2019). The thematic categories established in this study include direct costs of reproductive health services, indirect costs such as transportation and lost wages, payment mechanisms and health insurance, as well as the coping strategies of poor households in facing healthcare costs. The validity of conclusions in a literature review depends on the researcher's transparency in selecting sources and the clarity of document inclusion and exclusion criteria (Bryce & Forrester, 2024). Researchers must be aware of publication bias, where studies with statistically significant results are more likely to be published compared to studies with null results. This awareness encourages researchers to actively seek sources that report no relationship between economic factors and service access. The sources used in this study were selected based on criteria of recency of publication within the last fifteen years to ensure relevance to contemporary health systems, the reputation of internationally indexed publishers or journals, and rigorous research designs. All collected documents were then analyzed repeatedly to ensure an accurate interpretation of the original authors' statements. The bibliography listed at the end of this document contains all the references cited during the analysis process.

Result and Discussion

Poverty as the primary determinant of access to reproductive health services works through the mechanism of limiting the options available to women (Vizheh et al., 2023). When household income is only sufficient to meet basic food needs, expenditure on reproductive health will always be the last priority. Women in poor households must allocate every rupiah of income for the most urgent needs, such as rice, cooking oil, and children's school fees. The cost of a consultation with a midwife or obstetrician, which may only be equivalent to the price of one kilogram of rice, remains an unjustifiable expense when the rice supply

at home is only enough for the next three days. The short-term thinking mechanism that poor households are forced to adopt makes investment in reproductive disease prevention unattractive because the benefits are only felt years later. Meanwhile, the sacrifices that must be made now are very real and painful. Poor women prefer to wait until the symptoms of a reproductive disease become severe and unbearable before finally deciding to go to a healthcare facility. At an advanced stage of disease, the cost of treatment becomes much more expensive than if it had been treated from the beginning. Poor households are then trapped in a situation where they cannot afford the cheap cost of prevention and also cannot afford the expensive cost of treatment. This vicious cycle repeats continuously throughout the life cycle of poor women, with no way out unless there is external intervention that changes the structure of the economic incentives they face.

The inability to pay for the direct costs of reproductive health services is exacerbated by the presence of indirect costs that are often not realized by policymakers (Paul, 2017). Transportation costs to healthcare facilities are a significant component, especially for women living in areas with limited transportation access. Remote villages are often served by only one public transport in the morning that is crowded and uncomfortable for pregnant women. If there is no public transport, women must walk several kilometers through difficult terrain. This long journey risks causing complications for pregnant women with high blood pressure or a history of bleeding. Opportunity costs or the loss of daily wages are also a heavy burden for women working in the informal sector, such as food vendors or farm laborers. They are paid based on daily attendance, so every day not working means losing much-needed income. Visiting a healthcare facility for routine pregnancy check-ups means sacrificing one full day's wage. Consequently, many women skip routine pregnancy check-ups that are actually crucial for detecting early complications. They only come to the healthcare facility when they are in an emergency condition, such as bleeding or seizures. In emergency conditions, the costs incurred are much higher because they require intensive care and the possibility of blood transfusions. These indirect costs are latent and difficult to measure, but their impact on access to reproductive health services is very real.

Reproductive health service payment systems that require upfront payment or out-of-pocket payment create barriers that are impenetrable for poor households without savings (Menotti & Farrell, 2016). The characteristic of poverty is the inability to save because all income is exhausted on daily consumption. When reproductive health needs arise suddenly, poor households have no cash reserves to pay for the necessary costs. They are forced to seek loans from various sources with very high interest rates. Moneylenders in villages often exploit these emergency situations by charging strangling daily interest. Debt for delivery costs can take years to pay off, and during that time, the family lives under severe psychological stress. Upfront payment systems also penalize women who require recurring services, such as monthly pregnancy check-ups or the retrieval of long-term contraceptives. Each visit means spending more cash, which may be small in amount but accumulates into a large sum throughout the pregnancy period. Comparisons with post-service payment systems or bills that can be paid in installments show that the payment method significantly influences the decision to utilize services. Countries that implement capitation payment systems or national health insurance with little or no additional cost at the point of service have higher rates of reproductive health service utilization among the poor. This international experience shows that the structure of service payment is not neutral but has significant distributive consequences. In consumer protection, transparent medical advertising regulations and the protection of patient rights are highly necessary to guarantee fair access (Sahidu et al., 2023).

Economic exclusion from reproductive health services impacts women's health cumulatively throughout their life cycle (Wasser et al., 2024). Women unable to access modern contraceptives during adolescence are at high risk of experiencing unplanned pregnancies. Early-age pregnancy increases the risk of obstetric complications such as eclampsia and obstetric fistula, which can cause permanent disability. Women with obstetric fistula are often excluded by their communities due to the unpleasant odor resulting from urinary incontinence. They lose the opportunity to work and socialize, causing poverty to worsen. In adulthood, the inability to access cervical cancer screening means that a disease that is actually curable if detected early develops into a fatal advanced stage. Maternal death due to cervical cancer or pregnancy

complications leaves behind children who then grow up without a mother's love. Orphans from poor families have a high probability of dropping out of school and experiencing malnutrition. Poverty is transmitted from generation to generation through failing reproductive health mechanisms. Women who survive pregnancy complications but must bear enormous treatment costs often sell their productive assets, such as land or livestock. Selling these assets eliminates the family's ability to generate income in the future, causing structural poverty to become more deeply entrenched. This cumulative impact shows that reproductive health intervention is not just a humanitarian issue but also a long-term economic investment to break the intergenerational chain of poverty. Efforts toward social transformation and the deconstruction of patriarchal culture through legal reform are crucial in protecting women from sexual violence and injustice that exacerbate their health conditions (Rochman et al., 2024).

Geographic differences between urban and rural areas strengthen the influence of economic factors on access to reproductive health services (França et al., 2022). In urban areas, the density of healthcare facilities is higher, so the distance that must be traveled is shorter and transportation costs are lower. Competition among private healthcare providers in urban areas also suppresses tariffs, making them more affordable for the urban poor. However, the higher cost of living in urban areas means the minimum wage received by informal workers may still leave little after deducting rent and food costs. Urban poor women face the challenge of a high cost of living that leaves little room for health expenditures. In rural areas, the long distance to healthcare facilities becomes the main obstacle, worsened by poor road conditions, especially in the rainy season. Transportation costs to district hospitals can consume half of a poor farmer family's monthly income. A lack of information about reproductive health service schedules at village community health centers often causes women to arrive when services are unavailable. This access disparity between urban and rural areas creates a sharp reproductive health inequality between the two regions. The maternal mortality rate in remote rural areas can be two to three times higher than in urban areas. Policies that only focus on providing physical facilities without considering transportation and opportunity

costs will not be able to bridge this gap. Interventions that bring services closer to women's residences, such as mobile reproductive health services or integrated health posts, have proven to be more effective in reaching poor rural women. In this case, the competitive advantage of service providers and the marketing mix of health services are key to improving more equitable service coverage (Darmawan & Grenier, 2021).

Women's employment status significantly affects their ability to pay for reproductive health services (Finlay, 2021). Women with formal employment in the public sector or large private companies usually have access to corporate health insurance that covers delivery costs and pregnancy care. They also have the right to paid maternity leave, so they do not lose income while attending pregnancy check-ups. Conversely, women working in the informal sector, such as street vendors, farm laborers, or domestic workers, have no social safety net whatsoever. Their income is irregular and highly dependent on macroeconomic conditions. During lean seasons or economic recessions, their income can drop drastically, while reproductive health needs cannot be postponed. Women working in the informal sector also lack the bargaining power to negotiate flexible working hours for health check-up purposes. Their employers or customers may not allow them to leave the workplace to go to a clinic. As a result, they postpone check-ups until symptoms become very severe or until a holiday when health services might be closed. This difference in access based on employment status shows that labor protection and sick leave rights are important determinants of reproductive health that are often overlooked in public health discourse. Effective reproductive health policies must be integrated with employment and social protection policies. This condition is exacerbated by gender structures and the double burden experienced by working women, both in their careers and in the domestic sphere (Khairi, 2021), which also influences women's involvement and decisions in broader aspects of household consumption (Halizah & Nuraini, 2021).

The inability to pay for reproductive health service costs does not only impact adult women but also adolescent girls who require access to adolescent-friendly reproductive health information and services (Mahmood & Bitzer, 2024). Adolescents from poor families often do not have enough pocket money to pay for consultation fees at reproductive

health clinics. Feelings of shame and the fear of being found out by parents make them reluctant to ask for money for needs related to reproductive health. As a result, poor adolescent girls seek information from irresponsible sources, such as peers who are also uninformed, or the internet, which is full of misleading information. They are at high risk of experiencing unplanned pregnancies because they do not access modern contraception. Teenage pregnancy forces them to drop out of school and lose the opportunity to improve their family's economic status in the future. Children born to teenage mothers have a higher risk of being born with low birth weight and experiencing developmental disorders. Investment in free and adolescent-friendly reproductive health services is actually a highly cost-effective intervention because it prevents much larger long-term social costs. However, because the benefits are only visible after one or two decades, governments often prefer to allocate budgets for programs with faster visible results. This short-term approach in reproductive health policy disadvantages poor young generations who are most in need of protection.

National health insurance systems designed to protect the poor often fail to reach them due to complicated administrative requirements (Yazbeck et al., 2023). Registration as a contribution assistance recipient requires documents such as a family card, birth certificate, and a certificate of poverty from the village. Many poor women do not have complete civil registration documents because their births were not registered or because their documents were lost during natural disasters or conflicts. The process of arranging documents requires significant transportation costs and time. Village officials might request unofficial money to issue a certificate of poverty. Once registered, the utilization of insurance is also often hampered by tiered referral mechanisms. Patients must start from a village community health center before being referred to a district hospital, even if an emergency condition requires immediate handling at the hospital. Healthcare workers at the village community health center may refuse to provide a referral letter if they feel the patient does not meet certain medical criteria. Pregnant women with complications requiring a cesarean section can be stranded for days waiting for a referral letter. Bad experiences with this insurance system make many poor women choose not to manage insurance membership at all, even though in theory, they

are entitled to it. They prefer to rely on traditional birth attendants, whose costs are cheaper and processes simpler, even though the risks are much higher. The failure of the insurance system to reach the poor is not due to a lack of good intentions but due to a design that does not consider the socioeconomic reality of potential beneficiaries. Furthermore, it is important to ensure equal access to healthcare services for people with disabilities (Subiakso et al., 2023) and to provide comprehensive legal protection for patients at community health centers (Tampil et al., 2023).

The cost of medication and contraceptives is a component of reproductive health expenditure that is often not covered by public insurance systems (Weinberger et al., 2021). Insurance benefit packages usually cover consultations and medical procedures but do not cover prescribed medication. Women diagnosed with sexually transmitted infections must purchase antibiotics from pharmacies at a significant cost. Treatment for sexually transmitted infections often requires several types of antibiotics that must be taken by both partners to prevent reinfection. The cost of treatment for two people doubles, which may be unaffordable for poor households. As a result, patients only buy half of the prescribed dose or treat only themselves without their partner. Incomplete treatment leads to antibiotic resistance and persistent infection. For contraception, intrauterine devices (IUDs), which are the most effective at preventing pregnancy, have high upfront costs even though their annual cost is low. Poor women cannot afford the large upfront cost, so they choose oral contraceptive pills, which have a small monthly cost but lower effectiveness because they are easily forgotten. The high failure rate of oral contraceptives leads to many unplanned pregnancies among poor users. Government subsidies for long-acting contraceptives have proven effective in increasing the use of more effective contraceptive methods among the poor. However, subsidy programs are often hampered by budget limitations and competing political priorities.

Delivery costs represent the largest reproductive health expenditure that poor households must face (Goli et al., 2021). Normal delivery at a healthcare facility involves examination fees, delivery assistance fees, medication costs, and newborn care costs. If complications occur that require a cesarean section, costs can soar dozens of times over. Many poor families are unprepared to face this surge in costs, leading them to fall

into debt after delivery. Some families are forced to sell inherited land or livestock, which are their main sources of livelihood. Post-delivery economic pressure leads to postpartum depression and domestic violence. A husband who is stressed due to debt may take out his anger on his wife who has just given birth. The baby who is born then grows up in a family environment full of pressure and conflict. The alternative of home delivery with a traditional birth attendant is indeed cheaper, but the risk of maternal and infant mortality is much higher. Traditional birth attendants are not trained to handle complications such as postpartum hemorrhage or breech births. Delayed referral to healthcare facilities is often fatal because the bleeding is already too severe. This dilemma between safety and the ability to pay is faced by millions of poor women every year. Free delivery guarantees that cover all costs without any charges at the point of service are the most effective policies to overcome these economic barriers. Countries that implement universal free delivery policies have succeeded in drastically reducing maternal mortality rates in a short time. On the other hand, the accountability of healthcare facilities in providing palliative care for terminal patients is also a legal aspect that must be considered to guarantee the quality of humanistic healthcare services (Wahyusetiawan et al., 2024).

Economic exclusion from reproductive health services is exacerbated by systemic corruption in the provision of public health services (Barcelona & Edouard, 2024). The practice of illegal levies or informal payments to obtain faster service occurs in almost all healthcare systems in developing countries. Healthcare workers exploit their stronger bargaining position over desperate poor patients. A woman with postpartum hemorrhage may be asked to pay extra money before being treated because staff know that she has no other choice. The patient's family is forced to collect money from relatives quickly to meet the staff's demands. Money that should have been used to purchase medication or for follow-up care is exhausted by these illegal levies. Corruption is not always in the form of cash but also in the form of nepotism, where patients with relatives working in healthcare facilities receive priority. Poor patients without connections must queue longer and receive worse service. This culture of corruption is difficult to eradicate because it is deeply rooted and involves many parties. Efforts to eradicate corruption in the health sector require strong political

commitment from the highest national leadership as well as active public participation in oversight. Complaint mechanisms that are easily accessible to poor patients and protections for whistleblowers are highly necessary. As long as illegal levies remain a common practice, the guarantee of free health services will never be realized in practice because patients must still pay to obtain decent service.

The inability to pay for reproductive health service costs has specific gender dimensions because the burden of reproductive health expenditure is largely borne by women (Mahmood & Bitzer, 2024). In poor households, spending decisions are often made by men as the heads of the family. A husband may not consider expenditure for pregnancy check-ups or contraception important because it is not a need whose benefits are directly felt by himself. Women must ask for permission and money from their husbands every time they want to go to a healthcare facility. An authoritarian husband may refuse to give money, deeming his wife excessive or because he prioritizes expenditure for cigarettes or alcohol. Women's economic dependence on their husbands leaves them powerless to meet their own reproductive health needs. Women who work and have their own income have a stronger bargaining position in household spending decisions. However, many poor women do not work outside the home because they have to take care of children and the household. Women's economic empowerment through access to jobs and microcredit has a close relationship with improvements in reproductive health. Women with their own income are more likely to use contraception and undergo regular pregnancy check-ups. Investment in women's economic empowerment is an investment in women's reproductive health.

Policies to waive fees or eliminate service tariffs for reproductive health at public facilities have been proven to increase service utilization by the poor but do not eliminate all economic barriers (Menotti & Farrell, 2016). Transportation costs, opportunity costs, and administrative costs must still be borne by the patient, even if service tariffs are abolished. Studies in various countries show that eliminating tariffs increases antenatal visits and deliveries at healthcare facilities, but the increase is greater in non-poor groups compared to poor groups. The poor remain left behind because they still face other obstacles besides tariffs. More comprehensive policies combine tariff elimination with

conditional cash transfer programs that provide financial incentives to poor women to utilize reproductive health services. Cash transfers can compensate for transportation costs and lost opportunity costs. Conditional cash transfer programs in Latin America have succeeded in increasing coverage of institutional deliveries and child immunizations. This mechanism shows that positive economic incentives are more effective in changing behavior than simply removing negative disincentives. However, cash transfer programs require strong administrative capacity to target beneficiaries accurately and prevent leakage. The administrative costs of these programs are also not cheap, requiring sustained budget commitments. Poor countries may not have the resources to implement large-scale cash transfer programs.

Conclusion

Economic factors are the primary determinant limiting women's access to reproductive health services, even when those services are legally available. Poverty restricts women's choices through mechanisms such as direct costs including service tariffs, medication expenses, and contraceptive costs as well as indirect costs, such as transportation and lost daily wages. Upfront payment systems or out-of-pocket payments discriminate against poor households that lack savings to face unexpected health expenditures. Economic exclusion has a cumulative impact throughout a woman's life cycle, from adolescence to adulthood, and transmits poverty across generations through maternal mortality and disability. Employment status, place of residence, and access to health insurance moderate the influence of economic factors on service access. Policies to eliminate tariffs alone are insufficient to reach the poorest groups because they still face indirect cost barriers. Conditional cash transfer programs that provide compensation for transportation costs and lost wages have proven more effective but require significant administrative capacity and budget. Corruption in the form of illegal levies at public health facilities exacerbates economic exclusion and must be eradicated through strong political commitment and participatory oversight mechanisms.

The implications of this study for policymakers include the need to design reproductive health financing systems that explicitly consider the ability to pay of poor groups. Tiered referral systems that force poor

patients to start from the lowest-level facilities must be evaluated because they actually increase transportation costs and lost time. Suggestions for the government include integrating reproductive health services with social protection programs, such as direct cash assistance and women's economic empowerment programs. Public health facilities should implement post-service payment systems that allow poor patients to pay in interest-free installments or waive costs entirely for the lowest-income groups. For international donor agencies, it is recommended to shift funding focus from physical facility construction to strengthening financial protection systems for service users. Further research is needed to measure the magnitude of indirect costs faced by poor women in accessing reproductive health services across various geographical settings. Collaboration between the Ministry of Health, the Ministry of Finance, and the Ministry of Social Affairs is necessary to design cross-sectoral financing mechanisms. Periodic evaluation of the impact of financing policies on the poor must be conducted using data disaggregated by economic status.

References

- Abigail, M. 2022. Addressing Access To Sexual And Reproductive Healthcare For Women During The COVID-19 Pandemic In Low-Resourced Settings. *Medical Journal Of Zambia*, 48(4), 358-359.
- Aisyah, N. 2023. Social Movements and Social Change: Women's Role as Agents of Transformation. *Studi Ilmu Sosial Indonesia*, 3(1), 321-342.
- Bailey, K. 2008. *Methods of social research*. Simon and Schuster.
- Barcelona, D., & Edouard, L. 2024. Sexual And Reproductive Health: Right Not Privilege. *African Journal Of Reproductive Health*, 28(11), 11-17.
- Bryce, J., & Forrester, M. 2024. *Doing A Literature Review*. 52(8), 964-973.
- Darmawan, D. & E. Grenier. 2021. Competitive Advantage and Service Marketing Mix, *Journal of Social Science Studies*, 1(2), 75-80.
- Darmawan, D., Issalillah, F., Khayru, R. K., Herdiyana, A. R. A., Putra, A. R., Mardikaningsih, R., & Sinambela, E. A. 2022. BPJS patients satisfaction analysis towards service quality of public health center in Surabaya. *Media Kesehatan Masyarakat Indonesia*, 18(4), 124-131.
- Finlay, J. E. 2021. Women's Reproductive Health And Economic Activity: A Narrative Review. *World Development*, 139, 105313.
- França, U. L., Adler, A., & Ramirez, L. B. 2022. Association Between Fertility Service Utilization And County-Level Median Household Income. *Fertility And Sterility*, 118(4), E86-E86

- Goli, S., Goli, S., Moradkhvaj, Pradhan, J., & Reja, T. 2021. The Unending Burden Of High Out-Of-Pocket Expenditure On Institutional Deliveries In India. *Public Health*, 193, 43-47
- Halizah, S. N. & R. Nuraini. 2021. Women's Household Involvement and Decisions on Green Consumption, *Studi Ilmu Sosial Indonesia*, 1(1), 177-192.
- Harianto, A. V., Vitrianingsih, Y., Issalillah, F., & Mardikaningsih, R. 2024. Challenges and Changes Concerning National Health Development in Indonesia: Legal Perspectives, Service Access, and Infectious Disease Management. *International Journal of Service Science, Management, Engineering, and Technology*, 5(2), 22-26.
- Hartika, Y., Saputra, R., Pakpahan, N. H., Darmawan, D., & Putra, A. R. 2023. A Study on the Falsification of Health Certificates: Perspective of Criminal Law and Professional Ethics. *Journal of Social Science Studies*, 3(2), 175-180.
- Henn, M., Weinstein, M., & Foard, N. 2005. *A Short Introduction To Social Research*. Sage.
- Ibrahim, K. 2019. *Thematic Analysis*. <https://doi.org/10.13140/Rg.2.2.36275.68649>
- Issalillah, F. 2021. Potential of Curcumin in Turmeric as a Preventive Modality from Covid-19 in Pregnant Women. *Journal of Social Science Studies*, 1(2), 55-64.
- Issalillah, F. 2022. Exploring the Interconnection Between Periodontal Health and Systemic Disease Progression in Chronic Conditions. *Journal of Social Science Studies*, 2(1), 173-178.
- Issalillah, F., & Aisyah, N. 2022. The Elderly and the Determinants of Stress. *Journal of Social Science Studies*, 2(1), 9-12.
- Issalillah, F., & Khayru, R. K. 2022. The Role of Social Support in Reducing Anxiety Among Pregnant Women Before Childbirth. *Studi Ilmu Sosial Indonesia*, 2(2), 19-28.
- Jayachandran, S. 2019. Social Norms As A Barrier To Women's Employment In Developing Countries. *IMF Economic Review*, 69(3), 576-595.
- Kalof, L., & Dan, A. 2008. *Essentials Of Social Research*. Mcgraw-Hill Education (UK).
- Khairi, M. 2021. Career Women, Double Burden, and Gendered Structures in Feminist Sociological Perspective. *Studi Ilmu Sosial Indonesia*, 1(2), 173-186.
- Mahmood, T. A., & Bitzer, J. (2024). 5 Public Health Aspects. *Textbook Of Contraception, Sexual And Reproductive Health*, 28.
- Mardikaningsih, R. 2022. Patient Satisfaction Based on Quality of Service and Location. *Journal of Islamic Economics Perspectives*, 4(1), 31-37.
- Menotti, E. P., & Farrell, M. 2016. Vouchers: A Hot Ticket For Reaching The Poor And Other Special Groups With Voluntary Family Planning Services. *Global Health, Science And Practice*, 4(3), 384-393.
- Nasir, M. 2022. *Financial Barriers To Medical Care*. <https://doi.org/10.13140/Rg.2.2.29455.25761>

- Noor, A., Herisasono, A., Hardyansah, R., Darmawan, D., & Saktiawan, P. 2023. Juridical Review of the Rights of Indigent Patients in Health Services in Indonesia. *Journal of Social Science Studies*, 3(2), 253-258.
- Paul, H. (2017). *Financial Barriers To Accessing Reproductive, Maternal And Neonatal Health Services In Four Provinces*. <https://doi.org/10.13140/Rg.2.2.31328.07688>
- Rochman, H. N., Hardyansah, R., & Gautama, E. C. 2024. Transforming the Protection of Women from Sexual Violence through Legal Reform, Patriarchal Cultural Deconstruction, and Social Change. *Studi Ilmu Sosial Indonesia*, 4(2), 79-96.
- Sahidu, S., Putra, A. R., & Darmawan, D. 2023. Medical Advertising Regulations and Patient Protection as Consumers of Healthcare Services. *Journal of Social Science Studies*, 3(1), 331-342.
- Stoner, B. P. 2024. Reproductive Health: Sexually Transmitted Infections (Stis): Overview. *International Encyclopedia of Public Health (Third Edition)*. 4, 630-639.
- Subiakso, A., Juliarto, T. S., Darmawan, D., Sisminarnohadi, S., & Romli, R. I. A. 2023. Legal Rights in Access to Health Services for Persons with Disabilities. *Bulletin of Science, Technology and Society*, 2(3), 15-20.
- Tampil, V. C., Mubasyiroh, A. A., Khayru, R. K., Darmawan, D., & Prasetyo, B. A. 2023. Legal Protection for Patients in Health Services at Community Health Centers. *Studi Ilmu Sosial Indonesia*, 3(2), 85-100.
- Taqi, I., & Singh, S. 2023. How Universal Health Coverage Can Increase Access To Sexual And Reproductive Health Services In Sub-Saharan Africa. *International Planned Parenthood Federation*.
- Vizheh, M., Zurynski, Y., Braithwaite, J., & Rapport, F. 2024. Determinants Of Women's Agency In Accessing And Utilising Reproductive Healthcare Services; A Systematic Review. *Culture, Health & Sexuality*, 26(2), 248-264.
- Wahyusetiawan, R., Herisasono, A., Khayru, R. K., Vitrianingsih, Y., & Issalillah, F. 2024. Health Facility Accountability for Terminal Patient Palliative Care Services Under Health Law. *International Journal of Service Science, Management, Engineering, and Technology*, 6(2), 45-57.
- Wasser, O., Ralph, L. J., Kaller, S., & Biggs, M. A. 2024. Catastrophic health expenditures for in-state and out-of-state abortion care. *JAMA network Open*, 7(11), e2444146.
- Weinberger, M., Bellows, N. M., & Stover, J. 2021. Estimating Private Sector Out-Of-Pocket Expenditures On Family Planning Commodities In Low-And-Middle-Income Countries. *BMJ Global Health*, 6(4).
- Yatno, Y., Darmawan, D., & Khayru, R. K. 2023. Hospitals' Legal Responsibility for Service Disruptions due to Information System Failures. *Journal of Social Science Studies*, 3(1), 319-330.
- Yazbeck, A. S., Soucat, A. L., Tandon, A., Cashin, C., Kutzin, J., Watson, J., ... & Evetovits, T. 2023. Addiction to a bad idea, especially in low-and middle-income countries: contributory health insurance. *Social Science & Medicine*, 320, 115168.