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Partnering to Save Lives

Learning Update – October 2016
Theme 4: Financial Barriers

What is PSL?

Partnering to Save Lives (PSL) is a partnership between CARE, Marie Stopes International Cambodia, Save the Children, the Australian Government and the Cambodian Ministry of Health (MoH). PSL aims 'to save the lives of women and neonates in Cambodia through improved quality, access and utilisation of reproductive, maternal and neonatal health (RMNH) services through a partnership approach' in line with the objectives of the MoH's Fast Track Initiative Roadmap for Reducing Maternal and Neonatal Mortality (FTIRM).

PSL Learning agenda

One outcome of PSL is focused on documenting learning and evidence that can contribute to improved policy and practices. The PSL four Learning Agenda themes are technical harmonisation, community referrals, garment factories and financial barriers.

What are the issues?

Tackling financial barriers to accessing RMNH services is one of two cross-cutting components of the FTIRM. At the national level, Health Equity Funds (HEFs) are the primary mechanism for addressing financial barriers to access, covering user fees and some indirect costs for a range of RMNH services at public health facilities for the poorest, identified through the Ministry of Planning's asset-based ID Poor card system or through a health specific post-identification interview process. In order to reduce financial barriers for other vulnerable groups or for services/costs not covered by HEFs, PSL has been implementing a range of complementary health financing approaches such as Village Savings and Loans Association (VSLA), conditional cash transfer and supply side financing.

What learning approaches have we used?

PSL has used a mix of quantitative and qualitative methods to learn more about these issues, including:

- Consultations with PSL's Technical Reference Group and other key stakeholders since the program began in August 2013
- Learning and testimony from PSL field managers and implementing staff during the Annual Review Workshop in March 2016
- Research from Tulane University on financial barriers to accessing RMNH services in the Northeast provinces involving literature review and interviews with 1,391 women of reproductive age (15-49 years), 23 focus group discussions (FGDs) and 60 in-depth interviews conducted between October and December 2015
- DFAT-commissioned external midterm review between September to November 2015
- Midterm evaluation of PSL conducted between December 2015 and January 2016
- Learning on HEFs and health system financing reforms.

What have we learned?

Financial barriers to access RMNH services:

The research undertaken on financial barriers to accessing RMNH services found that the cost to access RMNH services varies substantially across wealth quintiles and the type of service being sought. **The cost of services ranges from $4.10 for antenatal care (ANC) and $5.89 for family planning to $46.84 for delivery care and $49.89 for postnatal care.** The cost of delivery care included not just the delivery, but also medicines and supplies including a sarong and sanitary pads, as well as the cost of food and lodging at a health facility, which placed a financial burden on women and their families. The high cost of postnatal care also included the cost of a traditional practice called Yu Fai (roasting), which requires the purchasing of charcoal, traditional medicines and mats practiced by nearly half of the women interviewed. Women also reported receiving injections as part of their postpartum care practices. Interestingly, while some households incurred substantial expenditures for RMNH services, **financial considerations appeared to play a relatively minor role in determining the use of RMNH services**. One fifth of non users of antenatal care cited that services were "too expensive", as did 19.4% of women who chose to deliver at home rather than in a health facility. Most reasons for not accessing services were distance, transport, or believe that the service is not necessary.

The PSL midterm evaluation showed that the amount spent on all RMNH services in the past 12 months varied greatly, from no expenditure at all to US$ 1,555 per woman, with a median of US$ 8.80. At the 2014 baseline, the amount spent on all RMNH services in the past 12 months varied from no expenditure to over US$ 3,000 per woman, with a median of US$ 8. Comparison between both surveys (using the non-parametric test) shows a significant difference ($p<0.05$). A similar pattern is also observed for out of pocket payment on delivery. At both surveys, **the highest median expenditure was on delivery and abortion services.**

From financial barriers research we learnt that distance matters to RMNH service use. Poor households tend to live farther away, and while transportation costs tend to be a small proportion of the total cost, there is a significant time cost in using RMNH services. For example, 78% of the total average time spent on family planning services was time spent travelling, while for antenatal care this represented 73% of the total time. As a result, for every five kilometres from a health facility that a woman lived, the likelihood of delivering in a health facility decreased by 5-6 percentage points. Similar patterns were evident for ANC4 and receipt of modern family planning from a formal sector provider.

Distance and absence of wealth pose a double burden for accessing RMNH services for poor women, who have both fewer resources for care and must travel greater distances to reach those services. Nearly half of women in the poorest quintile (47.7%) live more than 10 kilometres from the closest facility, compared with only 27.9% of women in the wealthiest quintile. While the likelihood of delivering in a health facility decreases the farther a woman lives from the closest health facility, distance is not the sole determinant. Only half of women in the poorest quintile reportedly delivered in a health facility even if they lived less than a kilometre from the closest facility. In comparison, all women in the highest quintile living within a kilometre of the closest facility chose to deliver in a health facility.

The financial barriers research also found that having an **ID Poor Card** correlated positively with poverty status as measured by the asset index, with 36.4% of households in the poorest asset index quintile having an ID Poor Card versus only 5.4% in the wealthiest asset index quintile. However, this still indicates **absence of coverage and some leakage.** The majority of the poorest households in PSL's four target Northeast provinces – 63.6% - do not have an ID Poor Card. Meanwhile, nearly 40% of ID Poor households are in the wealthiest three asset index quintiles, and 19% of these in the wealthiest two asset index quintiles. Generally, households with ID Poor Cards spend less on RMNH services than non-ID Poor Card households, although family planning and abortion care services were an exception to this.

The majority of women interviewed knew the eligibility requirements for an ID Poor Card and how to obtain one, but half were not aware that ID Poor Card/ HEF could pay transportation costs for certain services. Overall, the **HEF was only a minor source of payment for services. Across all RMNH services,** women with an ID Poor Card overwhelmingly paid for the services with out of pocket money with a range from a high of 76.0% for family planning to a low 41.0% for postnatal care.

About PSL interventions to address financial barriers: The DFAT-commissioned external mid-term review found that the activities being undertaken or proposed by the NGOs to address financial barriers (Village Savings and Loans Associations, supply-side financing of long acting family planning methods and Conditional Cash Transfers) were costly, complicated, and may not be an improvement over simple reimbursement of travel costs. The review recommended that these activities be phased out and alternative strategies and advocacy are used which are better integrated with government service delivery and promotion, with a view to better scalability and sustainability.

What are we doing about it?

Given the learning outlined above, PSL has revised the ways in which it will work to address financial barriers to RMNH services. The program will continue to work at multiple levels, but with a greater focus on advocacy and integration with government service delivery and promotion.

Community	Health System	Provincial/National Advocacy
• Identify and engage with motivated Commune Council/Commune Council for Women and Children to use funding to support access to RMNH services for women and/or address transportation barriers. • Promote HEF in the community through existing Behaviour Change Communication activities. • Continue piloting of the Traditional Birth Attendance/Midwife alliance and assess effectiveness as a strategy to link poor pregnant women from remote communities to care.	• Promote effective implementation of HEFs to improve access for vulnerable groups to Health Centres. • Work with Provincial Health Departments/ Operational Districts to maximise use of new health financing resources to sustain PSL impact.	• Contribute to policy dialogue on HEFs, particularly around expansion of benefits in revision of HEF benefit package for vulnerable groups/remote communities. Work with local authorities and HEF promoters to improve utilization of ID Poor Card. • Disseminate findings from financial barriers research to promote understanding of ministries and other stakeholders of the challenges in the northeast provinces.
• Ensure PSL staff understand HEFs and are updated on changes so that this can be incorporated into key activities above.		