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 Newborn Mortality (FTIRMN).

What are the issues?

Tackling financial barriers to accessing RMNH services is one of two cross-cutting components of the FTIRMN. 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 post-identification interview process. In order to reduce financial barriers for other vulnerable groups or for services/costs not covered by HEFs, PSL is implementing a range of complementary health financing approaches, including:

- Village savings and loans associations (VSLAs): VSLAs provide community members with access to cash, through savings, loans or grants, which they can use to cover transportation and other indirect costs of accessing healthcare, in order to promote health-seeking behaviour. The underlying aim of the VSLAs is to foster community investment for maternal and child health.
- Supply-side financing for long-acting family planning methods: Implants and intra-uterine devices (IUDs) are available free-of-charge at all health facilities in selected provinces to women of reproductive age (WRA) who are not eligible for HEF support. Health facilities are reimbursed for the services, which are promoted through community-based distributors (CBDs) and behaviour change communication (BCC) activities. This replaced a previous voucher-based approach.
- Conditional cash transfers (CCTs): Due to be implemented by the end of Year 2, CCTs involve the payment of cash to WRA when they fulfil certain conditions, most commonly the uptake of recommended RMNH services. As such they can cover indirect costs not covered through other health financing mechanisms.

What learning approaches have we used?

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

- a review of the pilot VSLA project in Koh Kong, conducted in October 2013, involving observation of six VSLA groups and discussion with project staff and village agents.
- a literature review and field-based research conducted in mid-2014 in preparation for development of PSL’s BCC Framework.
- an assessment of the family planning voucher approach, completed in July 2014, which involved a literature review, health facility observations and key informant interviews
- a qualitative exploration of cultural barriers to uptake of RMNH services conducted over four months in late 2014 among ethnic minority communities in Kratie province
- background research conducted in late 2014 and early 2015 to inform the design of PSL’s CCT approach, involving a literature review, key informant interviews and a consultative workshop
- a ‘snapshot’ survey in February 2015 which involved exit interviews with 138 WRA after they had received an RMNH service from a health centre in one of the four north-eastern provinces
- fieldwork in Koh Kong, Ratanakiri, Sihanoukville and Stung Treng provinces as part of PSL’s Annual Review process in March 2015, which involved key informant interviews and focus group discussions with local health and planning officials, HEF operating agencies, health centre staff, local government representatives, community health volunteers and WRA in the community.

What have we learned?

Rural and ethnic minority respondents highlight lack of money as a significant barrier to accessing public sector RMNH services, where they judge service fees to be too high. Choice of provider is strongly influenced by the Costs incurred. The combination of user fees, high transport, accommodation and other costs incurred travelling to health facilities from remote areas across challenging terrain increases the likelihood that WRA from these communities will opt for a home delivery with a TBA, who may also offer flexible payment options. Overall, more than 90% of snapshot survey respondents covered the costs of accessing an RMNH service at a health centre (user fees, transport and other costs) using their own funds. Women may have to borrow money to access RMNH services, paying back relatives or neighbours in cash or in kind. Therefore, financial support mechanisms can act as strong incentives to use RMNH services. However, Commune Councils, which have the mandate to support health in the community and often receive related funding, lack the capacity to apply the complex administrative processes required to use funds to offer financial support to RMNH users.

The annual review found that the ID Poor Process is clear at local government level but lacks transparency within communities. As a result, ID Poor card holders may not all be the poorest and most vulnerable in their communities. Internal migrants and people with disabilities are particularly at risk of exclusion from the ID Poor
process. The proportion of health centres enabled to offer **Health Equity Fund** support has thus far been low in the north-east, but is being phased in, with the aim of 100% coverage by the end of 2015. Although almost 30% of snapshot survey respondents held an ID Poor card, only 8% of card-holders accessed HEFs for their RMNH service. Awareness of HEF benefits (including transport reimbursement) and post-identification processes is correspondingly poor in the north-east, but should also improve with the expansion planned in the region throughout 2015. Effective implementation of HEFs requires flexibility from HEF Operators, for example, by enabling the post-identification process to be completed in a single visit for those living a long way from the facility. Where health centres are applying HEFs, delayed reimbursement from the national level for HEF expenditures continues to be a challenge. Even when the ID Poor and HEF systems function effectively, other barriers may constrain access to RMNH services, including transport and other opportunity costs, culture and RMNH knowledge.

The annual review found that all three **PSL Financial Barriers Approaches** are complementary to HEFs by addressing financial barriers for the ‘near-poor’ or vulnerable groups, such as people with disabilities, who face additional costs. Some also cover transport and other costs not covered by HEFs at health centres. The review of the **Village Savings and Loans Associations** pilot in Koh Kong reported that the groups were functioning very well and recommended expansion of the approach to PSL catchment areas in Mondulkiri and Ratanakiri. VSLA funds are not ring-fenced for health, but intensive promotion of healthy RMNH behaviours by trained VHSGs has increased the proportion of participating members using funds for health expenditure more than four-fold within 12 months. Whereas group members in Koh Kong are predominantly women, around two-thirds of current members in Ratanakiri are men, reflecting their role in decision-making and control of household resources. The annual review confirmed the strong ownership of VSLAs by the community and the potential they offer for sharing health and other information (e.g. on HEFs), but also observed that approval processes result in an inevitable delay in releasing funds in emergency situations.

While vouchers address financial barriers and are a results-based approach to increase supply and encourage demand for family planning services, they do not promote competition and choice of providers. There are also significant transactional costs involved in administering a voucher scheme. The switch from vouchers to **Supply-side Financing for Long-acting Family Planning Methods** should offer WRA greater choice of method and provider, and direct more resources towards service delivery, rather than administration. The impact of demand creation using CBDs and innovative BCC, rather than vouchers, will be monitored closely. Using CBDs should provide the opportunity to offer women a range of short- and long-acting methods. The proposed **Conditional Cash Transfer** approach would cover all WRA within catchment areas selected on the basis of vulnerability and current uptake of RMNH services. Cash would be given directly to women in three tranches, based on uptake of ANC, safe delivery, and PNC services. The design also proposes a cash incentive for VHSGs and others who accompany the woman to the health facility for safe delivery. Transport reimbursements based on distance travelled should be considered.

### What are we doing about it?

PSL is working to address financial barriers to RMNH services at multiple levels:

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<thead>
<tr>
<th>Community</th>
<th>Health Facility</th>
<th>Provincial/National</th>
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<tbody>
<tr>
<td>• Continue to implement VSLAs.</td>
<td>• Continue to implement supply-side FP financing and roll out CCT approach.</td>
<td>• Conduct comparative analysis of PSL financial barriers approaches linked to RMNH indicators and sustainability.</td>
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<td>• Monitor development and implementation of Commune Council initiatives relating to RMNH.</td>
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<td>• Engage actively with URC and HEFOs to support expansion of HEFs in the north-east.</td>
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<td>• Encourage VSLA participation in Commune Investment Program planning processes.</td>
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<td>• Raise awareness about HEFs through BCC, Commune Councils/CCWCs, health centres and VHSGs.</td>
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<td>• Develop and implement BCC approaches to increase male engagement in RMNH.</td>
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<td>• Facilitate information flow between URC/HEFOs/PHDs/ODs, health centres, local authorities and communities in relation to ID Poor and HEF systems.</td>
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*Australian Aid*  
*Care*  
*Maria Stopes International*  
*Save the Children*