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?

Most attention on referrals within the Cambodian health system focuses on emergency situations, particularly obstetric emergencies. However, there are also considerable challenges relating to referrals for essential routine and other non-emergency RMNH services, such as family planning, normal deliveries, antenatal and postnatal care, and safe abortion services. PSL learning has focused on non-emergency referrals from the community to the health centre using a broad definition of ‘referral’ as being any process or person that supports, escorts or encourages a woman to attend a health centre for a non-emergency RMNH service.

What learning approaches have we used?

PSL has used qualitative methods to learn more about these issues, including:

- a literature review and field-based research conducted in mid-2014 in preparation for development of PSL’s Behaviour Change Communication Framework
- qualitative exploration of cultural barriers to uptake of RMNH services conducted over four months in late 2014 among ethnic minority communities in Kratie province
- a ‘snapshot’ survey in February 2015 which involved exit interviews with 138 women of reproductive age (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 officials, health centre staff, local government representatives, community health volunteers and WRA in the community.

What have we learned?

Traditional beliefs and practices, such as a reliance on traditional healers for conditions believed to have a spiritual cause, and a cultural need for privacy, as well as restrictions around travel and social interactions for pregnant and postnatal women, act as barriers to the uptake of RMNH services, particularly among Ethnic Minorities. In these communities, traditional birth attendants (TBAs) play a central role in childbirth and the post-partum period, including providing emotional support. They may also be consulted during pregnancy if a woman is experiencing pain or discomfort. TBAs are highly respected within the community. They can block access to skilled birth attendance if they perform home deliveries. These may be preferred by women for labour that is particularly quick or happens during the night, and TBAs offer flexible payment options not available at health centres. Alternatively, through links with the formal healthcare system, TBAs can facilitate uptake of RMNH services by escorting WRA from the community and providing support during safe delivery at the health facility. However, their potential loss of income in this situation must be addressed. Men, who hold considerable decision-making power in these rural communities, can also block or facilitate uptake of services. Clan leaders are particularly influential in ethnic minority communities.

Uptake of RMNH services also depends on the community’s familiarity with, and trust in, the formal health system. Public confidence in health services is often weak, especially for newborn care. ‘Softer’ elements of Quality of Care, either real or perceived, can act as barriers or facilitators to access. Certain vulnerable groups, including ethnic minorities and people with disabilities, experience stigma and discrimination from some health service providers, and rumours of poor quality care spread easily. Lack of effective communication between providers and clients, including language barriers, presents a great challenge. Allowing ethnic minority families to integrate spiritual rituals into health care practices would facilitate uptake.

Compared with a year ago, RMNH Outreach from
health centres is now very successful at providing RMNH information and services to remote communities, and acts as an effective referral mechanism. The snapshot survey showed that health workers were the biggest source of referral for WRA using RMNH services.

Among the various Community Referral Processes supported by PSL, the snapshot survey showed that those involving VHSGs and other community volunteers, such as community-based distributors (CBDs), are most likely to facilitate uptake of RMNH services (one third of respondents). WRA perceive that going with a VHSG to the health facility may result in quicker service and the VHSG can help them with necessary paperwork. However, VHSGs and CBDs may suffer from a lack of credibility depending on their status in the community, and their capacity is sometimes weak. There is the potential for greater cooperation between health centres and commune councils/commune councils for women and children (CCWCs) to improve and support community referral systems.

Learning activities showed that Practical Issues are as likely to form barriers to access as cultural practices or quality of care. Transport from remote areas is particularly important. Almost all respondents in the snapshot survey travelled to the health facility by motorbike (their own or others’). However, field investigations revealed that even when communities have set up contracts with vehicle owners for fixed-rate transport to health facilities, these agreements often do not function. Financial Barriers more broadly can significantly inhibit uptake of services¹. Another practical constraint is lack of accommodation for family members to enable them to accompany WRA to health facilities. Maternity waiting homes/rooms can be helpful, but only if they offer sufficient light and cooking facilities.

**What are we doing about it?**

PSL’s technical harmonisation activities will focus particularly on health facility and PHD/OD staff:

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<thead>
<tr>
<th>Community</th>
<th>Health Facility</th>
<th>Provincial/National</th>
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<td>• Strengthen community referral systems involving VHSGs and CBDs under the leadership and support of Commune Councils/CCWCs.</td>
<td>• Continue to support the delivery in selected remote communities of the full package of services mandated in the 2013 Outreach Management Guidelines.</td>
<td>• Develop a training package for health centre staff for supportive supervision of VHSGs / CBDs.</td>
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<td>• Develop further the capacity of VHSGs, CBDs, Commune Councils/CCWCs through existing mechanisms.</td>
<td>• Strengthen further the function and capacity of Health Centre Management Committees to oversee and monitor referral systems.</td>
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<td>• Continue to encourage Commune Councils to focus on RMNH and VHSGs/HCMCs to participate in Commune Investment Program planning.</td>
<td>• Strengthen the capacity of health centre staff to supervise and support VHSGs and CBDs.</td>
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<td>• Develop midwife-TBA alliances in order to create an enabling environment for TBAs to refer and support women for safe delivery at a health facility.</td>
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<td>• Explore the use of financial incentives for referrals and birth support by VHSGs, TBAs and others as part of the conditional cash transfer approach.</td>
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¹PSL’s learning on financial barriers is covered in Learning Update 4.