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.

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

What are the issues?
PSL aims to be a partnership that demonstrates high impact, cost-effective methods for achieving RMNH outcomes. As a joint program between the Cambodian and Australian Governments and three NGOs, PSL has a unique opportunity to identify technical approaches that are effective in improving RMNH, particularly among vulnerable groups with significant unmet needs in terms of information and services.

PSL’s Quality Team, comprising technical representatives from the three NGOs, advises on technical issues, including the selection or development of guidelines, standards and protocols for health service quality improvement and for capacity development among health centre staff and community health actors.

What learning approaches have we used?
PSL has used a mix of quantitative and qualitative methods to learn more about these issues:
- Consultations with PSL’s Technical Reference Group and other key stakeholders since the program began in August 2013
- Monthly meetings of PSL’s Quality Team
- Learning and testimony from PSL field managers and implementing staff and members of the Quality Team, during the Annual Review Workshop in March 2016
- Review of 23 PSL-supported Health Centres (HC) in Northeast provinces from June to September 2015
- Fieldwork in Kratie and Kampong Cham as part of PSL’s Annual Review process in February 2016, which involved key informant interviews, focus group discussions, observations and simulation exercises
- PSL midterm evaluation conducted in December 2015- January 2016.

What have we learned?
About successful approaches to neonatal health:
The review of 23 PSL-supported HCs conducted over June to September 2015 identified a total of 4,121 live births in these HCs in 2014. Of these, four babies were reported to have not breathed for longer than one minute after birth. All made a recovery, but only two were given inflation breaths with a bag and mask. Midwives caring for the other two either had faulty equipment or did not feel confident in providing this intervention.

Despite resuscitation training being provided in all 23 HCs, midwives at five health centres reported that they would like refresher training as it is not a skill they get to practice often.

Related to this, fieldwork as part of PSL’s annual review process had a focus on learning about emergency referrals. It found that at the HC level there was poor case documentation, that partographs were not being completed resulting in misjudgement of whether/when to refer and that there was a lack of life-saving skills available for use prior to transfer to a referral hospital.

There were also issues identified with logistical capability to facilitate an emergency referral, including the availability of skilled staff, equipped vehicles and a driver 24 hours a day. With newborn emergencies, it was noted that because there are few cases, midwives do not often get the chance to practice skills and they are more likely to refer when newborn emergency cases do present.

During the midterm survey, appropriate immediate newborn care was assessed by three proxy indicators: (1) the newborn was placed on the bare chest of mother for a few minutes immediately after birth; (2) the newborn was dried or wiped immediately after birth; and (3) the first bath was delayed at least six hours after birth. Any newborn given all three types of care was considered as having received appropriate immediate newborn care. The percentage of
all newborns receiving appropriate immediate care was significantly higher at the midterm (56.9%) than at the 2014 baseline survey (36%). The percentage of women of reproductive age (WRA) who can identify three danger signs for neonatal distress increased significantly from 11.3% at the baseline to 28.1% at the midterm survey. The same pattern of increase was observed among the three identified vulnerable women groups (ethnic minority women, ID Poor card holders and women with disability).

About coaching/mentoring and on the job training and remaining challenges to transfer knowledge and skills into practice:

The annual review fieldwork sought to understand the barriers that prevent health workers from fully implementing the knowledge and skills acquired through PSL capacity building and how these could be addressed. This found that individual commitment and awareness of the added value of applying skills were key factors influencing implementation of knowledge and skills learned. It was found that familiarity with old practices, which are ‘good enough’ most of the time in non-emergency situations, was the key barrier on an individual level. It is important that there is an ongoing focus on opportunities for midwives to reinforce skills, including through learning from more senior/experienced midwives, exposure to caseload, continuous reinforcement of skills and supervision. Overall though, the fieldwork found that skills had increased in PSL facilities relative to others and that clients are satisfied with midwife skills, confidence and attitudes.

Supervision was found to be an important activity in influencing midwives’ implementation of their skills and knowledge. Effective supervision, however, was dependent on the ‘supportiveness’ and skills of the supervision team and whether the midwife was able to practice his or her skills during supervision. It was also noted that there is a lack of standardised tools for supervision and that the ‘scores’ collected using the current supervision checklist often did not reflect real practice as health staffs pay additional attention to follow protocols and guidelines during supervision.

A number of system level factors were also identified during the fieldwork as key influencers of midwife application of knowledge and skills. These included the level of support and motivation from management (HC Chief, Operational Districts (OD), Provincial Health Departments (PHD)), availability of staff on duty and availability of necessary equipment. It was also found that the availability of financial incentives can play a key role in influencing midwife performance.

The fieldwork also looked specifically at factors influencing comprehensive abortion care (CAC)-trained providers. It found that religious beliefs; age; support received from HC management, community and family; and financial incentives all played a role in whether a provider would deliver the CAC services in which they had been trained. The review of PSL HCs also found that only 12 of the 23 HCs offered services for first trimester vacuum abortion, with four HCs that had received CAC training offering no or very limited services due to staff turnover and personal beliefs. In one HC the CAC-trained midwife refuses to offer CAC due to religious beliefs. In another, midwives have withdrawn the service apart from in exceptional circumstances (e.g. sexual assault) because they felt that women were becoming reliant on abortion. Field work found that experience and confidence in providing CAC services was also a factor influencing service delivery. This included skills in clinical assessment (age of pregnancy); previous experience with, and skills in dealing with, adverse events; and the availability of technical support from other providers.

The review of PSL-supported HCs also highlighted how the personal beliefs of service providers can affect the provision of contraceptives. Only seven HCs offered all contraceptives to all women. A number of HCs would not provide unmarried adolescents with the contraceptive pill (5), contraceptive injection (7), IUD (8), implant (4) and condoms (3). As to why some health centre staff would not offer contraceptive methods to unmarried adolescents, some reported that they would only provide condoms due to concerns about STD transmission. There were also a number of HCs which would not offer some contraceptives to post-partum women, including condoms (2) and the contraceptive pill (1), although there was no rationale provided as to why contraceptives were sometimes not being provided to post-partum women.

About access to RMNH for vulnerable groups:

The midterm survey showed an increase in access to RMNH services for the targeted vulnerable groups. For example, the use of modern contraception methods increased to 41.4% compared to 33.4% at baseline for ethnic minority WRA. Also, WRA with some functional impairment delivering in a health facility with Skilled Birth Attendance increased to 78.2% (56.6% at baseline). However poor WRA accessing RMNH services benefited from a lower increase in access to financial support compared to general WRA and other vulnerable groups.

The PSL Behaviour Change Communication framework review highlighted that women with disability may be less likely to access modern contraception and reproductive health services thinking that these are not for them as they are unlikely to marry. The review also noted that, in addition to husbands or partners, parents play a key influencing role for access to RMNH services for disabled women.
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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<tr>
<th>Health Facility</th>
<th>Provincial/District/National</th>
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<td>• Work more closely with HC Chiefs given the critical management support role they play. Support development of a ‘no blame’ culture if poor outcomes occur as long as proper protocols were followed.</td>
<td>• Support PHDs/ODs to move away from ‘checklist’ supervision and towards more supportive supervision that encourages skills transfer, observation, simulations/practical exercises and continual feedback.</td>
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<td>• Check emergency equipment during supervision visits.</td>
<td>• Reinforce skills through better integration and feedback between Midwifery Coordination Alliance Teams (MCATs), supportive supervision and quality assessments; ensuring each informs the other where possible.</td>
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<td>• Conduct values clarification for provider and HC chief during recruitment for CAC training.</td>
<td>• Advocate for revision of national supervision protocols.</td>
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<td>• Conduct attitudes training to sensitise midwives to the needs of vulnerable groups ethnic minorities, young and unmarried women and people living with a disability.</td>
<td>• Support the understanding and use of new supervision/coaching tools by OD and PHD teams and ensure the PSL learning and good practices are integrated into new systems.</td>
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