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.

What are the issues?
Most attention on referrals within the Cambodian health system has focused 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. This includes both formal and informal processes, which form a complex network of ‘referrals’: between communities and health service providers, between different levels of the public health system, between different services within a health facility, and between the public and private (informal and formal) health sectors (see Figure 1). In Year 1 of the PSL program, the partners aimed to get a clearer picture of the structure and function of this network, particularly in the four north-eastern provinces, in order to determine where we can best intervene to improve these processes.

What learning approaches have we used?
PSL has used a mix of quantitative and qualitative methods to learn more about these issues, including:

- consultation with PSL’s Technical Reference Group, which includes key RMNH stakeholders1 (November 2013)
- consultation with a broader range of health NGOs at the MEDiCAM RMNCH Task Force meeting (January 2014)
- a household survey conducted in eight provinces as part of PSL’s baseline study (December 2013 – February 2014)
- fieldwork in Ratanakiri and Stung Treng as part of PSL’s Annual Review process in March 2014, which involved key informant interviews and focus group discussions with local health officials, health centre staff, local government representatives, NGOs/CBOs and community health volunteers.

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1 CDPO, FHI360, GIZ, KOICA, MEDiCAM, RACHA, RHAC, UNFPA, UNICEF, URC, WHO
What have we learned so far?

Our learning activities identified several key blocks to the referral pathways shown in Figure 1, particularly in the four north-eastern provinces:

**Transport** continues to be a major limitation, especially for remote villages with challenging terrain, which may be cut off from services completely during the rainy season. Issues include the quality of roads, access to vehicles and the cost of transport. As a result, outreach conducted by health centre staff, as mandated in the 2013 MoH Outreach Management Guidelines, is critical for enabling remote communities to access RMNH services, but in practice implementation is inconsistent, both in terms of frequency of visits and the range of services delivered.

There are significant **Financial Barriers** along many of these referral pathways, including direct, indirect and opportunity costs. Awareness is poor, particularly in remote north-eastern communities, of existing financial support mechanisms, such as health equity funds, as well as the range of services available at local health facilities. Delays in transfer of budgeted funds (from national level to PHDs/communes and from provincial level to health facilities) can prevent the delivery of services, including through outreach.

There are some good examples of community initiatives to provide transport and support the costs of RMNH referrals, and Commune Councils can play a key role through allocation of funds they expect to receive to support RMNH in their community. Broader **Community Engagement** is also critical. Village health support groups (VHSGs), community-based distributors (CBDs) and other community volunteers, when properly mobilised and supported under the leadership of Commune Councils, have key roles to play in facilitating access to RMNH services for rural women. Male family members can help women to overcome some of the barriers identified, for example by providing funds or transport to access services, but male involvement in RMNH is often lacking.

**Quality of Care** is another key factor. It is difficult to motivate people in remote communities to overcome transport, financial and social barriers if the RMNH services they need are unavailable or of poor quality. Inadequate infrastructure, equipment and supplies in health facilities, as well as a lack of staff with the required skills and experience, mean that high quality services may not be available when they are needed. There is also a lack of data and systems to enable follow-up of referrals between health facilities and between the health system and communities. PSL’s review found limited awareness of the particular challenges facing vulnerable groups such as ethnic minorities and people with disabilities, which means their needs are inadequately addressed.

**What are we doing about it?**

PSL is working to improve non-emergency RMNH referral systems at multiple levels:

<table>
<thead>
<tr>
<th>Community</th>
<th>Health facility</th>
<th>Provincial/National</th>
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<tbody>
<tr>
<td>• Implementing and strengthening community referral systems (VHSGs, CBDs) under the leadership of Commune Councils.</td>
<td>• Supporting the delivery in selected remote communities of the full package of services mandated in the 2013 Outreach Management Guidelines.</td>
<td>• Advocating for timely and efficient budget transfers to avoid delays in service delivery.</td>
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<td>• Supporting Village Savings and Loans Associations and encouraging similar community-led financial schemes that support RMNH referrals, including within Commune Investment Programs.</td>
<td>• Strengthening the function and capacity of Health Centre Management Committees to oversee referral systems.</td>
<td>• Researching the impact of PSL’s financial barriers interventions on the most vulnerable groups.</td>
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<td>• Raising awareness of available health services and financial support mechanisms and the importance of accessing them.</td>
<td>• Developing and implementing an integrated capacity building approach to build the skills of midwives.</td>
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<td></td>
<td>• Supporting infrastructure quality improvement activities, through minor refurbishments and procurement of equipment and supplies.</td>
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