Learning Update – October 2016
Theme 2: Non-Emergency Referral Systems between Communities and Public Facilities

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.

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?

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 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
- A baseline for the traditional birth attendant (TBA)/Midwife Alliance in Mondulkiri and Ratanakiri provinces
- A community referral system 'snapshot' survey in August 2015 (rainy season) as a follow up to the 'snapshot' survey that was conducted in February 2015 (dry season), involving exit interviews with 137 women of reproductive age (WRA) after they had received an RMNH service from health centres (HC) in the four Northeast Provinces
- Fieldwork in Kratie and Mondulkiri provinces as part of PSL's Annual Review process in February 2016, 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
- Midterm evaluation of PSL conducted between December 2015 and January 2016
- A qualitative evaluation of PSL Behaviour Change Communication (BCC) work in the four Northeast provinces involving 24 semi structured interviews conducted between February and March 2016
- A review of PSL BCC framework for Ethnic and Indigenous Women based on reviewed literature pertinent to RMNH behaviour in Cambodia and interviews with key informants undertaken in April-May 2016
- A research conducted by Tulane University on financial barriers to accessing RMNH services in the Northeast provinces.

What have we learned?

About barriers that prevent women to access RMNH:
Transport is generally reported as the main barrier to access RMNH services. According to **community referral system 'snapshot' survey** in August 2015, motorbike was by far the most common means (84%) to access RMNH services. The average distances travelled and journey durations are similar in dry and rainy seasons, but **the longest/maximum journeys (in distance and duration) are considerably greater in the rainy season,** for example 75km compared to 52km and 420 minutes compared to 180 minutes. Some roads are impassable in rainy season. The financial barriers research observed that distance and absence of wealth pose a double burden for accessing RMNH services for poor women. Women in the poorest quintile were found to be more than four kilometres farther on average from the

closest facility than women in the wealthiest quintile.

The 2014 baseline for PSL's TBA/Midwife Alliance showed that **55% of women in parts of Ratanakiri and Mondolkiri are still delivering at home.** The most common reason noted was lack of transport (39%) followed by personal or familial preference (29%) and shortage of funds (24%). Priority villages were selected to pilot the TBA/Midwife Alliance based on these data, including villages with over 50% unskilled delivery and more than five currently pregnant women, for a total of 63 villages in five health centre catchment areas in the two provinces.

The **majority of respondents in the 2015 snapshot surveys paid for costs related to accessing RMNH services out of their own pocket,** although this did fall from 91% to 82% between the two surveys. The rainy season survey witnessed an increase in parents/relatives providing financial support, use of Health Equity Funds (HEFs) and travel reimbursement from Marie Stopes. The financial barriers research also confirmed the large proportion of out-of pocket expenditures for RMNH services. Women with an ID Poor card overwhelmingly paid for services out of pocket money, ranging from a high 76% for family planning to a low 41% for postnatal care.

Fieldwork as part of PSL's annual review process took a holistic approach to referrals and considered barriers preventing women from accessing health services. The fieldwork found, that in general, respondents were knowledgeable about RMNH issues, particularly if they had been exposed to PSL BCC activities, but that the **barriers in putting this knowledge into practice included financial constraints, transportation/distance, lack of child care and attitudes of health workers.** It was thought that the engagement of Commune Councils (CC) and CC Women's Committees (CCWCs) with community referral mechanisms (e.g. Village Health Support Groups (VHSGs) and community-based distributors (CBDs)) through monthly meetings was important to understand and address some of these issues, with further suggestions made that CC/CCWC promote community referrals through the Commune Investment Plans (CIPs).

The **Review of PSL BCC framework for Ethnic and Indigenous Women,** identified key barriers limiting adoption of good RMNH practices and recommended relevant communication strategies. Main barriers included the lack of knowledge of "what to expect" from various RMNH services and where to access these, low self-efficacy, especially for young women/adolescents, associated with strong taboos around sex for unmarried women, concerns about confidentiality in public health facilities, cultural beliefs and traditional practices and costs and arrangement for delivery at the HC such as transport and child care.

About effectiveness of community referral systems:

In the rainy season survey, respondents were almost equally likely to have been referred to the service by health staff (36.5%) and VHSG volunteers (37.2%). There were similar patterns of referral across different groups (i.e., all respondents, ID Poor and ethnic minorities), although ethnic minorities were more likely to have been referred through a listening and dialogue or men's group than others and ID Poor card holders were less likely than other groups to have been referred by a VHSG. This appears to indicate the **importance of community referral mechanisms for the vulnerable populations with whom PSL works.**

The rainy season survey also showed that 48% of referrals were through PSL-supported community referral mechanisms including Pregnancy clubs, Mens' clubs, Listening and Dialogue groups, Village Savings and Loan Associations, VHSGs, CBDs, CC/CCWCs and community health promotion. This compared to 34% of referrals in dry season. The difference is particularly stark for ethnic minorities and women with some functional impairment with an increase from 33% to 46% and 32% to 55%, respectively, of referrals through community referral systems. Although this may relate to changes in delivery of outreach services due to access or financial challenges, it also suggests that **interventions by PSL are starting to show some success, particularly for the vulnerable groups that are the focus of PSL activities.**

The **PSL midterm evaluation** also showed that the percentage of all WRA using RMNH services who were referred through a community referral mechanism increased significantly from 8.5% at the baseline to 24.9% at the midterm survey ($p<0.001$), with the same pattern found for ethnic minorities, women with some functional impairment and ID Poor card holders. The most commonly used referral mechanisms were VHSGs, CBDs and community health promotion. The midterm evaluation also shows that the percentage of all **WRA accessing RMNH service receiving financial support in the past 12 months significantly increased** from 10.3% at the baseline to 14.7% at the midterm survey. This pattern is also observed among the vulnerable groups, except for poor WRA for which the difference between both surveys is not significant.

The **Evaluation of PSL BCC activities in the Northeast provinces** demonstrated that Listening and Dialogue Groups (LDG's) were an excellent way to communicate RMNH messages. Radio broadcasts worked well with indigenous populations but not in Kratie and Stung Treng where radio access was minimal. Phone-based interventions are unlikely to reach women who are less likely to have a phone and should be targeted for men. Key stakeholders such as midwives and elder generations should be better integrated in BCC activities. The most significant changes in knowledge, attitude and practice as a result of the interventions were women attending health centres for antenatal care (ANC) and delivery. Regarding the least significant change, postnatal care (PNC) and an unhealthy diet were the main two that require additional attention.

What are we doing about it?

Community	CC/CCWC	Provincial/National
• Continue health education programs (radio, TV, health fairs). • Continue with listening and dialogue groups, including pregnancy and men's clubs. • Strengthen capacity and supervision of VHSGs, and introduce PSL's new VHSG materials which target ethnic minorities. • Continue implementation of the TBA-Midwife Alliance to link pregnant women to care through TBAs.	• Continue to conduct regular meetings and support to VHSGs and CBDs. • Encourage the sustainability of RMNH promotion and referral mechanisms through mobilising commune resources/ funds (e.g., CIPs).	• Deliver an attitudes training 'package' to health providers. • Encourage facilities' teams to have an effective use of their service delivery grant to promote quality of service • Engage leadership and partners at national and provincial levels to strengthen the equity and effectiveness of the HEF system.