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Partnering to Save Lives

FACTSHEET

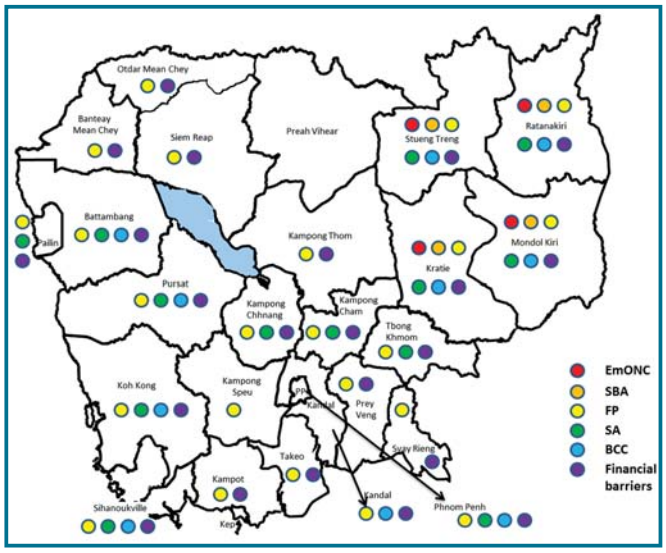
Background

The Partnering to Save Lives (PSL) program demonstrates the high priority placed by the Royal Government of Cambodia (RGC) and the Australian Government's Department of Foreign Affairs and Trade (DFAT) on reproductive, maternal and neonatal health (RMNH), and their recognition of the added value of partnerships in achieving RMNH outcomes. Building on the considerable progress made on RMNH within Cambodia in recent years, PSL combines the complementary strengths of government and non-governmental partners to achieve the goals of the Fast-Track Initiative Road Map for Reducing Maternal and Newborn Mortality (FTIRMN) and beyond.

Goal

To save the lives of women and neonates in Cambodia through improved quality, access and utilisation of RMNH services through a partnership approach.

Where does PSL work?



Coverage of PSL activities by FTIRMN component and province

PSL focuses on holistic RMNH service provision in the underserved north-eastern provinces of Kratie, Mondulkiri, Ratanakiri and Stung Treng. PSL supports family planning services and training on safe abortion in an additional 17 provinces across the country. PSL also works to improve access to RMNH information and services for vulnerable young women working in garment factories in Phnom Penh and Kandal.

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Partners

CARE, Marie Stopes International Cambodia, Save the Children, RGC Ministry of Health, Australian Government (DFAT).

Timeframe

Aug 2013 – Jul 2016 (with a possible two-year extension).

What will PSL achieve?

PSL will contribute to FTIRMN targets through:

- improved quality of RMNH services
- greater equity of access to RMNH services
- more responsive RMNH services
- improved RMNH behaviours
- evidence-based innovation and learning leading to improved policy and practices
- partnership for greater impact and value-for-money.

What does PSL do ?

PSL focuses on 6 of the 7 components of FTIRMN:

- emergency obstetric and newborn care (EmONC)
- skilled birth attendance (SBA)
- family planning (FP)
- safe abortion (SA; training and quality improvement)
- behaviour change communication (BCC)
- removing financial barriers.

The program has 3 core functions:

- improving health service delivery
- community strengthening and engagement
- translating learning and knowledge into policy.

How does PSL measure success?

PSL's monitoring, evaluation, reporting and information (MERI) framework involves:

- FTIRMN indicators
- joint M&E between the partners
- participation of stakeholders and community
- an annual review and planning process that bases future program direction on the latest results and learning.

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Partnering to Save Lives

PSL Update – August 2014
Theme 3: Garment Factories

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.

What are the issues?

Up to half a million people are employed in Cambodia's growing garment sector and many of these workers are young women who have migrated from rural areas to work in factories in Phnom Penh and other large towns. PSL's baseline survey showed that around one third are married and a similar proportion has children. Garment factory workers (GFWs) are particularly vulnerable with regard to RMNH for a variety of reasons, including isolation from their family and community support networks. There is also substantial movement back and forth between urban and rural areas (e.g. GFWs returning to their village to give birth), highlighting the importance of an integrated approach to RMNH awareness-raising and service delivery that is consistent with MoH protocols.

The PSL program aims to increase access to RMNH information and services for GFWs by:

- improving the capacity of garment factory infirmaries to deliver a wider range of high quality RMNH services
- promoting positive RMNH behaviours through innovative means as part of the PSL's Behaviour Change Communication (BCC) Framework
- strengthening systems for referral of GFWs to affordable quality services from public and private providers in the factory catchment areas.

Successful implementation requires an in-depth understanding of GFWs' RMNH knowledge, attitudes and practices, and their opportunities for accessing and using health services. Advocacy for greater engagement by garment factory management in RMNH issues depends on the ability to link workers' improved RMNH status with the industry's 'bottom line'.

What learning approaches have we used?

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

- a baseline survey conducted among 909 workers at four of PSL's target garment factories in Phnom Penh and Kandal (December 2013 – January 2014)
- fieldwork in Phnom Penh as part of PSL's Annual Review process in March 2014, which involved key informant interviews and focus group discussions with factory management, local health officials, staff in factory infirmaries and external public and private clinics, and peer health educators in the factories
- experiences and testimony from PSL field managers and implementing staff during the Annual Review Workshop in March 2014
- consultations and feedback meetings with key stakeholders between February and April 2014.

What have we learned so far?

Infirmaries in PSL Garment Factories have medical staff, but the quality of their clinical skills is variable and they rarely engage in health promotion activities. Some infirmaries offer short-term family planning methods but other RMNH services are limited and there are no national standards in place for provision of RMNH services within GFs.

RMNH services are available from **Public and Private Facilities** in the communities where GFWs live and work, but workers' access to services is limited by affordability, convenience, and the quality of services and customer care.

Referral Systems between infirmaries and other health service providers are weak and there is minimal follow-up. Although some financial support mechanisms are available for RMNH services, few GFWs are utilising them and so health expenditures are high. Mean total costs of services, including transport, represent about 34%, 51% and 58% of their average monthly income for abortion, safe delivery and post-natal care, respectively.

Peer educators are active in PSL factories. They have knowledge and promotional materials on reproductive health and GFWs engage actively in their educational sessions. However, GFWs' **Knowledge on Some RMNH Issues** is low and does not always translate into positive behaviour change.

What are we doing about it?

PSL is leveraging the strengths of all five partners and consulting with other key stakeholders to develop a range of tools that can be used by stakeholders wishing to implement RMNH activities with GFWs. These include:

- standards and assessment tools for GF infirmaries based on national guidelines and protocols
- referral systems for GFWs to access more easily affordable public, private and NGO RMNH services
- proven, effective and innovative BCC approaches, based on PSL's BCC Framework.

PSL will also work with relevant stakeholders to advocate for endorsement of key tools and standards at the national level.

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PSL Update – August 2014
Theme 2: Non-Emergency Referral Systems

What is PSL?

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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.

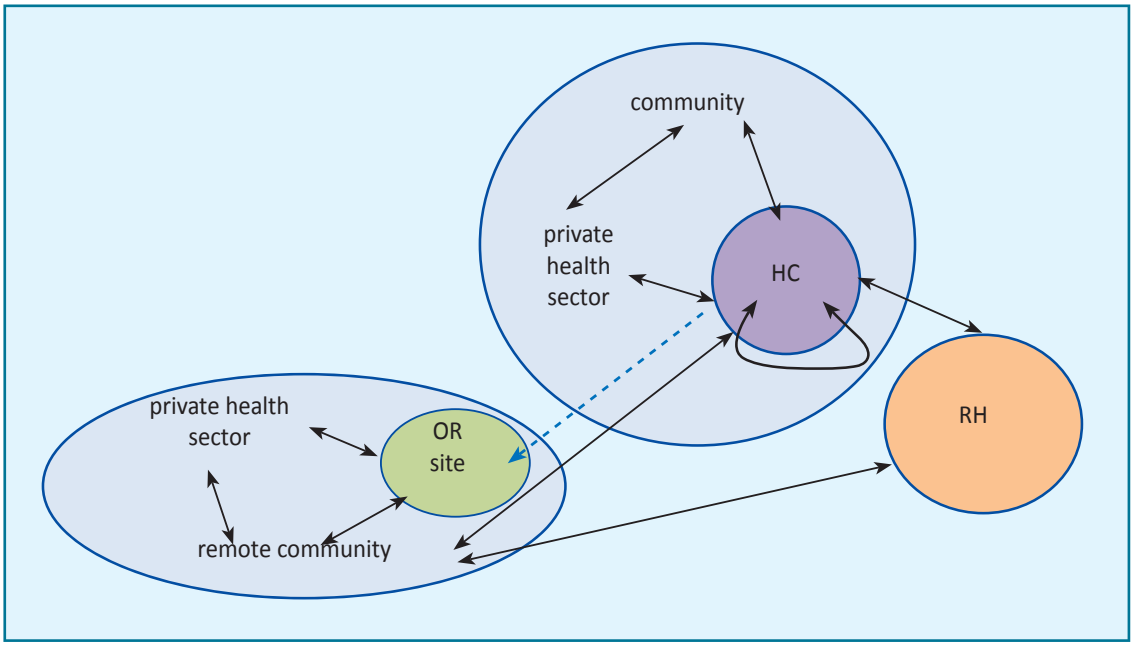

Figure 1 Model of non-emergency referral systems (HC = health centre; RH = referral hospital; OR = outreach)

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 stakeholders[1] (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.

[1] CDPO, FHI360, GIZ, KOICA, MEDiCAM, RACHA, RHAC, UNFPA, UNICEF, URC, WHO

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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:

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

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PSL Update – August 2014

Theme 1: Technical Harmonisation

What is PSL?

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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, especially among particularly vulnerable groups with unmet need for information and services.

PSL has established a Quality Team, comprising technical representatives from the three NGOs, to advise on technical approaches, including the selection or development of guidelines, standards and protocols for health service quality improvement, and the development of capacity among health centre staff and community health actors. Nationally-approved tools are used where available; where gaps exist, new tools are developed or adapted, in collaboration with MoH. Learning to date has focused on identifying opportunities for further integration and harmonisation and examining the potential benefits and challenges that these may bring.

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
- a household survey conducted in eight provinces as part of PSL's baseline study (December 2013 – February 2014)
- fieldwork in Mondulkiri and Kratie 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
- learning and testimony from PSL field managers and implementing staff and members of the Quality Team, during the Annual Review Workshop in March 2014.

What have we learned so far?

Learning in Year 1 has centred on three key areas of technical harmonisation:

1. The current MoH-approved Level 1 **Health Facility Assessment** tool focuses on infrastructure and systems rather than service delivery skills. There is limited capacity to implement it routinely and to develop and implement action plans based on the results.

2. There is an ongoing need for **Capacity Development of Midwives** at Health Centres as some midwives lack comprehensive clinical skills and experience. Staff recruitment and retention are problems for more remote health facilities. Supportive supervision and Midwife Coordination Alliance Team (MCAT) meetings offer opportunities for additional skills-building, with appropriate and consistent per diems and related incentives to motivate participation.

3. **Capacity Development in Communities** is another priority for improving RMNH. While some skilled and experienced village health support groups (VHSGs) and community-based distributors (CBDs) exist, motivation varies widely, particularly if they lack support or sufficient (mostly financial) incentives. Links between health centres and communities are often weak which means that the community referral system does not function properly.

What are we doing about it?

PSL's technical harmonisation activities will work at multiple levels:

Community	Health facility	Provincial/National
• Develop a non-financial motivation package for VHSGs and other community health volunteers (e.g. t-shirts, IEC materials). • Build the capacity of health centre staff and Commune Councils to support and supervise VHSGs. • Implement Community Scorecards to improve the accountability of health services to the community.	• Use Level 1 assessment tools until improved tools are fully approved by MoH and funded under HSSP2. • Support PHD/OD staff to build the technical skills of midwives through cross-visits, MCATs and supportive supervision. • Incorporate long-term family planning into a comprehensive package of MCAT modules, linked to follow-up quality assurance visits.	• Engage actively in national dialogue regarding roll-out of improved facility assessment tools that incorporate both infrastructure and provider quality. • Work with other RMNH stakeholders to develop a national package of MCAT resources.

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