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Partnering to Save Lives

Learning Update – July 2017
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 reaching vulnerable groups.

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.

In Year 4 our learning questions for this theme were the following:

1. What are the remaining barriers to effective referrals?
2. What roles the volunteers are playing in referral and how these roles can be sustained beyond the programme timeframe?
3. What links can be made with Commune Councils (CC) and Commune Councils for Women and Children (CCWCs) to promote community referrals?
4. What is the situation of vulnerable groups[1] in relation to access to Health Equity Fund (HEF) in the northeast provinces?

What learning approaches have we used?

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

- Fieldwork in Kratie and Mondul Kiri provinces as part of PSL's Annual Review process in February 2017, which involved key informant interviews and focus group discussions with local authorities, village health support groups (VHSGs), traditional birth attendants (TBAs), community based distributors (CBDs), CCs and men and women of reproductive age in the community;
- Learning and testimony from PSL field managers and implementing staff during the Annual Review Workshop in March 2017;
- A community referral system 'snapshot' survey in March 2017, as a follow up to the 'snapshot' surveys that were conducted in February (dry season) and August 2015 (rainy season) involving exit interviews with 162 women of reproductive age after they had received a RMNH service from health centres in the four 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 the **community referral system 'snapshot' survey** in March 2017, motorbikes continue to be the most common means (88%) to access RMNH services, while 4% of respondents reported walking to the health centre. The average distance travelled and journey duration were 10 km and 34 minutes, both higher than in previous surveys in February and August 2015. **The longest/maximum journey was 55 km and 210 minutes.**

1 For more information on gender equity and disability inclusion, refer to the learning update "Theme 4: reaching vulnerable groups"

Among women who came to receive services in facilities in MondulKiri and Ratanak Kiri, payment for transport varied from 0 to 60,000 riels, with an average of 6,090 riels.

91% of respondents in the 2017 snapshot survey paid for costs related to accessing RMNH services out of their own pocket, and 6% received HEF support compared to 10% in the August 2015 survey. This reduction in proportion of clients receiving HEF support may be linked to the transition period in HEF management since July 2016 and the interruption of payment of the non-medical benefits. Parents and relatives support reduced to 4% compared to 7% and 14% in previous surveys.

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 transportation remains the main challenge in accessing RMNH services. Motorbike is the preferred choice for community referral. Ambulance is available in some health centres, but poor road condition does not allow ambulance to reach villages. **Cost is a challenge as well:** the transportation reimbursement from HEF or incentive to TBAs when they accompany women to the health centre for delivery are not sufficient compared to real costs. Traditional norms remain strong, even more so in remote villages and ethnic minority groups. **Decision making is influenced by husband and parents.** For example, the husband drives the motorbike to bring his wife to the health centre to get antenatal care (ANC) but if the husband is busy, she may not be able to make the trip.

It was suggested by provincial health authorities to consider contracting vehicle owners in communities to support transportation cost. However, previous experiences of vehicle contracting at community level were not effective as drivers have their own priorities and are not always available when needed. It can be explored for particular difficult contexts where vehicles are not available or when boat is needed.

About the role of community volunteers

The Snapshot survey 2017 continues to **confirm the key role of VHSGs and health staff in referrals with respectively 30% and 35% of respondents mentioning being referred by them.** The percentage of respondents reporting referral from the PSL introduced listening and dialogue groups, pregnancy clubs and men's clubs increased to 9% compared to 2% and 7% in previous surveys. The referrals from TBA's also increased to 11% compared to 7% and 4% during previous surveys. **Importance of community groups/clubs and TBAs is more significant for ethnic minorities with 22% respondents from this group being referred by community groups and 20% by TBAs.** This demonstrates that community groups, clubs and the innovative TBA-Midwife Alliance in remote ethnic communities are facilitating access. ID Poor respondents were more likely to be referred by health staff (41%).

The snapshot survey also showed that 69% 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 is compared to 34% and 48% in February and August 2015. The difference is particularly stark for ID poor. The increase in community referrals is particularly important in Mondul Kiri and Ratanak Kiri with increases in community referrals from 29% to 90% and 50% to 87% between the second and third survey, respectively.

The PSL annual field review in February 2017 looked at the role and added value of volunteers such as VHSGs, TBAs and CBDs. **All interviewees from local authorities, volunteers and community members emphasized the central role that volunteers play in the referral system.** It was highlighted that they have close relationships with health centre staff and village chiefs. VHSGs have multiple tasks and support community level implementation of a number of programmes (vaccination, malaria, RMNH, and others). TBAs we met were all convinced of the need for women to deliver at the health facility with a skilled birth attendant and they are scared to perform deliveries. They provide information to pregnant women in the community about safe delivery, ANC and PNC and can also provide mental support to women after the delivery. However, they still face difficulties to convince some of the women who had previous experience with delivery at home. They also felt the current transport incentive provided by the programme is not sufficient. After the introduction of the TBA-Midwife Alliance in April 2016, PSL is currently working with 109 TBAs in Ratanak Kiri and Mondul Kiri provinces.

All volunteers interviewed have a good understanding of their role and responsibilities. They expressed that **their motivation is driven by a sense of being valued and trusted by the community, health centres and NGOs staff.** All also wish to receive further capacity building to better facilitate group discussions and to improve their knowledge on RMNH topics. CBDs are lacking sufficient information on long term, permanent contraception services, and information, education and communication (IEC) materials to distribute to communities. It is also difficult for volunteers to move around villages to call people for meetings, often using their own motorbikes. Some TBAs are also encountering a lack of value from younger generations. They can be more recognized by this group if they play a more active role in community level education sessions and referrals. **VHSG and TBAs do not**

necessarily know each other and more collaboration could be promoted between them. All face difficulties to maintain attendance in meetings especially for men's groups. Men should be more involved in discussions and meetings on contraception either by the organization of men specific clubs (as in Mondul Kiri and Ratanak Kiri) or by a more proactive attitude of volunteers and village authorities to encourage men to join existing groups.

In relation to volunteer sustainability after the project ends, volunteers interviewed appreciated the behaviour change communication (BCC) package recently introduced by PSL that provides good guidance on group facilitation. The dramas shared through both radio and prerecorded audio allowed them to recollect initial training messages, apply them to that situation and thus further impress knowledge. Provincial health authorities recognize the work of volunteers and **believe they have the capacities to continue providing information at a community level. The challenge is to mobilize budgets to support their work.**

About the link with Commune Councils

Commune Council for Women and Children (CCWC) plays an important role in communities and could support the efforts of other volunteers to refer women to the health centre at the time of delivery or for ANC and PNC. They have close relationships with health centres' staff and they know most of the VHSGs, TBAs and CBDs in their community. They already conduct education sessions about RMNH topics and can support the inclusion of gender awareness and gender based violence topics in PSL existing community groups (Listening and dialogue groups, men's clubs and pregnancy clubs). Collaboration between CCWC, VHSGs, TBAs and health centres' teams can be further strengthened. At provincial level, some collaboration also exists and could be leveraged between the Provincial Committee for Women and Children and the Provincial Health Department.

A **"social service package"[2] is available at commune level and could be mobilized to support referral mechanisms.** There are lot of challenges in using this budget. CCWC themselves need to use their own money first and then get reimbursement from the commune clerk. When experiencing challenges to get reimbursed, CCWCs do not want to use the budget again and, in consequence, the budget is not spent.

About access to HEF

During the PSL annual field review, the team conducted semi structured focus group discussions with community members with and without ID Poor cards with a total of 113 interviewees. We found that **90% of ID poor card holders use their card when visiting health facilities.** 80% of ID Poor card holders knew well how to use their card and the benefits it covers. All interviewees who had no ID Poor card did not know about the benefit package and how the card can be used. 70% of ID Poor card holders in Mondul Kiri and 90% in Kratie knew about the process to get the card, while people with no ID poor card could not describe the process. Participants with ID poor card in Mondul Kiri said they did not receive transportation support when they went to deliver at the health centre, but received it when they are sick and go to the referral hospital. In Kratie they received transportation support for both delivery and when they get sick. **ID Poor card holders reported that health staff attitudes improved in the last two years and that they never pay additional fees.** Volunteers found the identification process for getting ID poor cards was not transparent, but CCs also complained about community responsibility. The community members pre-selected for interviews are sometimes away from the village at the time of the appointment, despite being informed in advance.

2 A specific community based fund available at Commune Council to support social work

What are we doing about it?

Community	CC/CCWC	Provincial/National
• Continue supporting listening and dialogue groups, including pregnancy and men's clubs and better engage men in all community based activities. • Involve TBA in community group meetings and encourage more links between TBA and VHSG. • Strengthen capacity of VHSG through regular monitoring visits. • Continue implementation of the TBA-Midwife Alliance to link pregnant women to care through TBAs. • Build knowledge of volunteers on long term and permanent contraception methods. • Share the information of HEF system to the vulnerable groups.	•Encourage the sustainability of RMNH promotion and referral mechanisms through mobilising commune resources/ funds (e.g., Commune Investment Plans). •Engage CCWC in community based activities and participate in monthly CC meetings. •Mobilise the "Social support package" at commune level to support referral mechanisms. •Strengthen relationships between CC/CCWC and volunteers.	• Deliver an attitudes training 'package' to health providers. • Encourage health facility teams to effectively use their service delivery grants to promote quality services. • Engage leadership and partners at national and provincial levels to strengthen the equity and effectiveness of the HEF system. • Consider supporting community based transportation solutions.