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Partnering to Save Lives

Learning Update – October 2016
Theme 1: Technical Harmonisation

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 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 23HCs, 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 RNMH 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:

Health Facility	Provincial/District/National
• 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. • Check emergency equipment during supervision visits. • Conduct values clarification for provider and HC chief during recruitment for CAC training. • Conduct attitudes training to sensitise midwives to the needs of vulnerable groups ethnic minorities, young and unmarried women and people living with a disability.	• 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. • 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. • Advocate for revision of national supervision protocols. • 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.

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

What is PSL?

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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.

Learning Update – October 2016
Theme 3: Garment Factories

What is PSL?

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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?

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. PSL's 2016 midterm survey showed that the average female garment factory worker (GFW) was 27 years old, and had completed primary education. Half (48.7%) were currently married and 43.2% were single and not in a committed relationship. GFWs are particularly vulnerable with regard to RMNH for a variety of reasons, including isolation from their family and community support networks. 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 and strengthening referral systems.

What learning approaches have we used?

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

- Family planning perceptions research from CARE in 2014
- Monthly meetings of PSL's Quality Team and Garment Factory Coordination Group
- Learning and testimony from PSL field managers and implementing staff during the Annual Review Workshop in March 2016
- Fieldwork in Garment Factories in Phnom Penh and Kandal as part of PSL's Annual Review process in February 2016
- Garment Factory Referral System review report conducted in November-December 2015
- Garment Factory midterm survey and evaluation conducted in the last quarter of 2015
- Review of our Behaviour Change Communication (BCC) framework for GFW in May-June 2016.

What have we learned?

About garment factory workers' Sexual and Reproductive Health (SRH) knowledge and practices:
The midterm survey found that **four in five female GFW respondents (80.8%) had exposure to some or all of the PSL BCC campaign activities** in the previous three months before interview, which included contraceptive advertising, posters/leaflets/hotline cards, lunchtime meetings on SRH, training/video sessions, the mobile game, and counselling with peer educators.
The mid-term survey found that **nearly all female GFW respondents (98.8%) were aware of contraception**. The daily pill and contraceptive injection were the two most recognised methods (both 98%), followed by intra-uterine (IUD) device and implant (both 97%), male condoms (94%) and tubal litigation (89%). Traditional methods are also widely known, with withdrawal the most common, known by about 80% of women. This **knowledge of contraceptive methods has increased substantially since the baseline** when the most commonly known methods – the daily pill, injection and IUD – were known by just over half of respondents. **BCC activity participation correlated with an increase in contraceptive knowledge of 18%.**
Overall, half of the female GFW respondents had been sexually active in the last year. Of these, just over three-quarters (77.3%) used contraception (traditional and modern methods) during that time, compared to 40.9% during 2014 baseline. The most popular methods of contraception (both modern and traditional) used in the last year were the daily pill and withdrawal, each used by around half of women (53% and 50%, respectively). In terms of modern contraception methods (MCM), at **midline this was being used by one-fifth (20.3%) of all female GFW in the study, and 40.4% of sexually active GFW in the last 12 months. This is a considerable increase from the baseline** of 10.6% for all female GFW and 24.2% of sexually active GFW. Interestingly, there is no relationship between BCC participation and higher use of modern contraception or Long Acting and Permanent Methods (LAPMs).

Only 16.5% of female GFW respondents knew that abortion up to 12 weeks (and later in certain situations) is legal in Cambodia, a doubling compared to the baseline (8%). Overall, 44.1% of female GFW correctly identified at least one safe abortion provider, compared to 27% at baseline. Slightly more than one in ten female GFW (11%) reported ever having an abortion. Two-thirds (63.6%) received induced abortions at a health facility. Over half of women who received abortion services (56%) began using a form of modern contraception within 14 days of their last abortion. **This is more than double of the baseline value (22.5%).**

The survey also examined changes in female GFW **attitudes and confidence levels around various issues related to sexual and reproductive health.** One-quarter of women (24.8%) felt empowered to discuss and use modern family planning methods in all scenarios presented, even when their partner objected, compared to 5.0% during the baseline. In regards to scenarios on **sexual rights,** 60.6% of female GFW were completely confident they could refuse sex if they were tired, compared to only 22.6% of respondents at baseline. In each of the other four scenarios, nearly half of women (45.0-47.4%) were completely confident they could refuse sex with their partner when they did not want to and he did, including if he became angry, threatened to hurt them or threatened to have sex with another woman, compared to baseline values between 10.0-16.8%. **Despite significant progress, important challenges remain in improving confidence and awareness of GFW of their reproductive rights.**

The **review of PSL BCC framework for GFW** highlighted key barriers for GFWs to adopt certain healthy behaviours, including the lack of knowledge of "what to expect" of services such as modern contraception, safe abortion, postnatal care (PNC); a lack of knowledge of where to get the services and what services infirmaries provide; misconceptions about MCM and feeling that traditional methods are easier; beliefs that RMNH services at public facilities are not confidential; limited knowledge of danger signs for both the mother and the newborn; low self-efficacy especially for unmarried GFW and strong social norms around sexual matters for unmarried GFW.

About the use of infirmaries and referrals:

Nearly all female GFW respondents to the midterm survey (99.4%) knew their factory had an infirmary for worker use, which the large majority (80.1%) had used in the previous 12 months. The primary use of the infirmary was for minor health problems, with only about **one in ten (10.6%) infirmary users accessing RMNH services.** The most common RMNH service received was short-term family planning (4.0%); the least common was safe abortion counselling and referrals (0.5%). This represents an **increase on baseline of the number of infirmary users accessing RMNH services** from 3.6% to 10.6%. **Fieldwork as part of PSL's Annual Review** process confirmed that garment factory infirmaries were most commonly being used for minor health problems, but that overall female **GFW seemed comfortable accessing reproductive health services as available as well.** There were, however, issues highlighted related to infirmary staff attitude and capacity of infirmary staff to provide services identified in some factories, although at the same time infirmary staff were open to further training/ capacity building to provide better services. Issues of lack of privacy and the prescription of a variety of medicines without assessment and counselling were also mentioned by GFWs and observed in infirmaries.

A review of the **PSL Garment Factory Referral System** pilot was also undertaken to understand the effectiveness of this system in enabling GFW to access RMNH services. The 'referral system' consists of a referral directory, which provides basic information for 86 health facilities in Phnom Penh and Kandal; a summary sheet, which lists selected health facilities close to a factory with basic information; and a referral slip, which the infirmary/peer educators use to record basic GFW information and the health service providers use to record services accessed by workers.

The review found that in general, the garment factory referral system was viewed positively and that it had provided informed choice to GFW about health facilities, their location, services available, price and working hours. However, the review did note that the referral slip was often not being used and that the purpose of it was unclear since it did not entitle the user to any discounts or other support. It was also highlighted that GFW often prefer to seek services close to their home/accommodation rather than close to the factory, underlining the need for updating the complete referral directory rather than relying only on the summary sheet.

What are we doing about it?

Given the learning outlined above, PSL will focus on the following key activities in Year 4 of the program to ensure continued success of results in ensuring that GFW have access to sexual and reproductive health services and improved knowledge and behaviours in this area.

Garment Factory Workers	Infirmaries	Referral System
• Continued scale-up of Chat! Contraception BCC package, focusing on areas where GFW knowledge remains low (e.g., use of MCM and safe abortion). • Evaluate BCC Chat! package in terms of knowledge, behaviours, and self-efficacy. • Incorporate men into BCC efforts through male engagement modules in order to shift widespread norms that RMNH is a woman's sphere.	• Provide capacity building to infirmaries, especially related to sexual and reproductive health, including contraception and referrals for safe abortion and focus on improving negative staff attitude. • Ensure basic health services such as short term family planning and condoms available at infirmaries, as well as counselling and referral for longer-term methods. • Contribute to infirmary guidelines (National working group, factory, advocacy with ministries) and particularly to address issues around the privacy of infirmaries.	• Update and strengthen use of Referral Directory and Sheet. • Ensure referral systems account for workers often wanting to seek services close to home, not the factory. • Incorporate new National Social Security Fund (NSSF) benefits into infirmary guidelines, referral system and services.

Learning Update – October 2016
Theme 4: Financial Barriers

What is PSL?

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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?

Tackling financial barriers to accessing RMNH services is one of two cross-cutting components of the FTIRM. At the national level, Health Equity Funds (HEFs) are the primary mechanism for addressing financial barriers to access, covering user fees and some indirect costs for a range of RMNH services at public health facilities for the poorest, identified through the Ministry of Planning's asset-based ID Poor card system or through a health specific post-identification interview process. In order to reduce financial barriers for other vulnerable groups or for services/costs not covered by HEFs, PSL has been implementing a range of complementary health financing approaches such as Village Savings and Loans Association (VSLA), conditional cash transfer and supply side financing.

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
- Research from Tulane University on financial barriers to accessing RMNH services in the Northeast provinces involving literature review and interviews with 1,391 women of reproductive age (15-49 years), 23 focus group discussions (FGDs) and 60 in-depth interviews conducted between October and December 2015
- DFAT-commissioned external midterm review between September to November 2015
- Midterm evaluation of PSL conducted between December 2015 and January 2016
- Learning on HEFs and health system financing reforms.

What have we learned?

Financial barriers to access RMNH services:

The research undertaken on financial barriers to accessing RMNH services found that the cost to access RMNH services varies substantially across wealth quintiles and the type of service being sought. **The cost of services ranges from $4.10 for antenatal care (ANC) and $5.89 for family planning to $46.84 for delivery care and $49.89 for postnatal care.** The cost of delivery care included not just the delivery, but also medicines and supplies including a sarong and sanitary pads, as well as the cost of food and lodging at a health facility, which placed a financial burden on women and their families. The high cost of postnatal care also included the cost of a traditional practice called Yu Fai (roasting), which requires the purchasing of charcoal, traditional medicines and mats practiced by nearly half of the women interviewed. Women also reported receiving injections as part of their postpartum care practices. Interestingly, while some households incurred substantial expenditures for RMNH services, **financial considerations appeared to play a relatively minor role in determining the use of RMNH services**. One fifth of non users of antenatal care cited that services were "too expensive", as did 19.4% of women who chose to deliver at home rather than in a health facility. Most reasons for not accessing services were distance, transport, or believe that the service is not necessary.

The PSL midterm evaluation showed that the amount spent on all RMNH services in the past 12 months varied greatly, from no expenditure at all to US$ 1,555 per woman, with a median of US$ 8.80. At the 2014 baseline, the amount spent on all RMNH services in the past 12 months varied from no expenditure to over US$ 3,000 per woman, with a median of US$ 8. Comparison between both surveys (using the non-parametric test) shows a significant difference ($p<0.05$). A similar pattern is also observed for out of pocket payment on delivery. At both surveys, **the highest median expenditure was on delivery and abortion services.**

From financial barriers research we learnt that distance matters to RMNH service use. Poor households tend to live farther away, and while transportation costs tend to be a small proportion of the total cost, there is a significant time cost in using RMNH services. For example, 78% of the total average time spent on family planning services was time spent travelling, while for antenatal care this represented 73% of the total time. As a result, for every five kilometres from a health facility that a woman lived, the likelihood of delivering in a health facility decreased by 5-6 percentage points. Similar patterns were evident for ANC4 and receipt of modern family planning from a formal sector provider.

Distance and absence of wealth pose a double burden for accessing RMNH services for poor women, who have both fewer resources for care and must travel greater distances to reach those services. Nearly half of women in the poorest quintile (47.7%) live more than 10 kilometres from the closest facility, compared with only 27.9% of women in the wealthiest quintile. While the likelihood of delivering in a health facility decreases the farther a woman lives from the closest health facility, distance is not the sole determinant. Only half of women in the poorest quintile reportedly delivered in a health facility even if they lived less than a kilometre from the closest facility. In comparison, all women in the highest quintile living within a kilometre of the closest facility chose to deliver in a health facility.

The financial barriers research also found that having an **ID Poor Card** correlated positively with poverty status as measured by the asset index, with 36.4% of households in the poorest asset index quintile having an ID Poor Card versus only 5.4% in the wealthiest asset index quintile. However, this still indicates **absence of coverage and some leakage.** The majority of the poorest households in PSL's four target Northeast provinces – 63.6% - do not have an ID Poor Card. Meanwhile, nearly 40% of ID Poor households are in the wealthiest three asset index quintiles, and 19% of these in the wealthiest two asset index quintiles. Generally, households with ID Poor Cards spend less on RMNH services than non-ID Poor Card households, although family planning and abortion care services were an exception to this.

The majority of women interviewed knew the eligibility requirements for an ID Poor Card and how to obtain one, but half were not aware that ID Poor Card/ HEF could pay transportation costs for certain services. Overall, the **HEF was only a minor source of payment for services. Across all RMNH services,** women with an ID Poor Card overwhelmingly paid for the services with out of pocket money with a range from a high of 76.0% for family planning to a low 41.0% for postnatal care.

About PSL interventions to address financial barriers: The DFAT-commissioned external mid-term review found that the activities being undertaken or proposed by the NGOs to address financial barriers (Village Savings and Loans Associations, supply-side financing of long acting family planning methods and Conditional Cash Transfers) were costly, complicated, and may not be an improvement over simple reimbursement of travel costs. The review recommended that these activities be phased out and alternative strategies and advocacy are used which are better integrated with government service delivery and promotion, with a view to better scalability and sustainability.

What are we doing about it?

Given the learning outlined above, PSL has revised the ways in which it will work to address financial barriers to RMNH services. The program will continue to work at multiple levels, but with a greater focus on advocacy and integration with government service delivery and promotion.

Community	Health System	Provincial/National Advocacy
• Identify and engage with motivated Commune Council/Commune Council for Women and Children to use funding to support access to RMNH services for women and/or address transportation barriers. • Promote HEF in the community through existing Behaviour Change Communication activities. • Continue piloting of the Traditional Birth Attendance/Midwife alliance and assess effectiveness as a strategy to link poor pregnant women from remote communities to care.	• Promote effective implementation of HEFs to improve access for vulnerable groups to Health Centres. • Work with Provincial Health Departments/ Operational Districts to maximise use of new health financing resources to sustain PSL impact.	• Contribute to policy dialogue on HEFs, particularly around expansion of benefits in revision of HEF benefit package for vulnerable groups/remote communities. Work with local authorities and HEF promoters to improve utilization of ID Poor Card. • Disseminate findings from financial barriers research to promote understanding of ministries and other stakeholders of the challenges in the northeast provinces.
• Ensure PSL staff understand HEFs and are updated on changes so that this can be incorporated into key activities above.		