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Partnering to Save Lives

PSL Learning Update – June 2015
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 Newborn Mortality (FTIRMN).

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'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. Learning in Year 2 has focused in particular on:

- newborn care at health centres
- supportive supervision at health centres by Provincial Health Department (PHD) and Operational District (OD) teams
- midwifery coordination alliance teams (MCATs)
- monitoring of correct implementation of active management of third stage labour (AMTSL) and immediate newborn care (INC) by midwives at health centres using short checklists stamped onto the partograph.

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
- quality assessment observations of seven live births at four health centres in Mondulkiri and Ratanakiri provinces between November 2014 and January 2015
- fieldwork in Mondulkiri and Kratie as part of PSL's Annual Review process in March 2015, which involved key informant interviews and focus group discussions with local health officials and health centre staff, and observations and simulation exercises with health centre midwives
- a six-month pilot using the AMTSL/INC stamps in six designated basic emergency obstetric and neonatal care (BEmONC) health centres in Kratie, Mondulkiri and Stung Treng, which was reviewed during the Annual Review in March 2015
- learning and testimony from PSL field managers and implementing staff and members of the Quality Team, during the Annual Review Workshop in March 2015.

What have we learned?

Learning activities identified a number of challenges relating to **Newborn Care**, which are linked to a lack of opportunity for health centre midwives to gain practical experience with newborns. Areas of particular concern include:

- infection prevention
- caring for babies during delivery, including preparedness for resuscitation
- routine care for newborn babies
- kangaroo mother care for premature and low birthweight babies
- diagnosis, treatment and referral of sepsis cases
- APGAR scoring.

MCAT meetings are useful for reinforcing the capacity and confidence of midwives through sharing their experiences, practising skills together and building relationships with each other. The meetings provide an opportunity to update the skills and knowledge of health centre midwives by practising specific clinical skills. Health centre midwives report that, due to MCATs, they feel better able to refer complicated cases to Provincial and Referral Hospitals because improved relationships allow for better communication with their colleagues at the hospitals. MCATs have also improved the completion of registers, records and reports. PHD/OD officials appreciate the MCAT curriculum and would like to see more attention to improving teaching methods so that they can better support the midwives. There are also some challenges around scheduling to ensure that remote health

centres are not left without midwife coverage. Effectiveness of MCAT meetings would also be improved through the provision of resources such as equipment for simulation exercises and by linking the content of MCATs more closely to the focus of supportive supervision visits and other quality improvement activities.

Gaps in the skills and knowledge of midwives can be improved through **Supportive Supervision** when supervisors work with midwives to build their confidence and skills. However, time available is limited as often only one supervisor will travel to each health centre for a morning every one to three months. As a result, supervision can end up seeming like an inspection, rather than supporting skills development. PHD/OD supervisory staff are keen to receive training; targeting of these staff can maximise the effectiveness of the limited supervision time available to help to improve and streamline clinical skills and knowledge. On-the-job coaching, including the use of simulation exercises, is a useful tool to assess midwives' and supervisors' skills, confidence and understanding. Adding referral hospital staff to the supervision team would support additional learning for the midwives and strengthen referral processes.

The **AMTSL/INC** stamps are useful for tracking implementation only if they are filled in correctly. However, they have additional benefits as they not only remind midwives how to complete both procedures but also to fill in the partograph.

Learning activities also identified problems with health centres' capacity to manage eclampsia through the use of **Magnesium Sulphate** (MgSO4). The supply chain is not functioning fully so MgSO4 is not always available at every health centre. In addition, a misconception that midwives are not allowed to administer MgSO4 reinforces a lack of confidence in its use.

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
• Continue to focus intensively on quality improvement with an increasingly systematic approach.	• Strengthen supportive supervision as the core of an integrated approach to quality improvement.
• Strengthen an integrated system of midwife capacity development and incorporate more skills practice.	• Build on supportive supervision coaching by rolling out training to PSL, PHD, OD and referral hospital staff.
• Integrate additional early essential newborn care (EENC) components into ongoing INC training and capacity development activities, with plenty of skills practice.	• Add referral hospital staff to supportive supervision teams.
• Expand AMTSL and INC stamps into all PSL-supported health facilities in the north-east.	• Incorporate supervision skills, QI, technical areas (including EENC) and simulation exercises into supervision training.
• Integrate AMTSL/INC stamps into ongoing capacity development and supportive supervision to ensure correct use.	• Review and procure training materials for supervisory teams.
• Enhance coaching, supervision and quality improvement activities to build midwives' skills and confidence to use MgSO4.	• Continue to help to communicate MgSO4 stock-outs through appropriate channels.
	• Contribute to national consultations to develop revised MCAT guidelines and reviews of the FTIRMN and the National EmONC Improvement Plan.

PSL Learning Update – June 2015
Theme 2: Non-Emergency Referral Systems between Communities and Public Facilities

What is PSL?

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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 qualitative methods to learn more about these issues, including:

- a literature review and field-based research conducted in mid-2014 in preparation for development of PSL's Behaviour Change Communication Framework
- qualitative exploration of cultural barriers to uptake of RMNH services conducted over four months in late 2014 among ethnic minority communities in Kratie province
- a 'snapshot' survey in February 2015 which involved exit interviews with 138 women of reproductive age (WRA) after they had received an RMNH service from a health centre in one of the four north-eastern provinces
- fieldwork in Koh Kong, Ratanakiri, Sihanoukville and Stung Treng provinces as part of PSL's Annual Review process in March 2015, 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.

What have we learned?

Traditional beliefs and practices, such as a reliance on traditional healers for conditions believed to have a spiritual cause, and a cultural need for privacy, as well as restrictions around travel and social interactions for pregnant and post-natal women, act as barriers to the uptake of RMNH services, particularly among **Ethnic Minorities**. In these communities, traditional birth attendants (TBAs) play a central role in childbirth and the post-partum period, including providing emotional support. They may also be consulted during pregnancy if a woman is experiencing pain or discomfort. TBAs are highly respected within the community. They can block access to skilled birth attendance if they perform home deliveries. These may be preferred by women for labour that is particularly quick or happens during the night, and TBAs offer flexible payment options not available at health centres. Alternatively, through links with the formal healthcare system, TBAs can facilitate uptake of RMNH services by escorting WRA from the community and providing support during safe delivery at the health facility. However, their potential loss of income in this situation must be addressed. Men, who hold considerable decision-making power in these rural communities, can also block or facilitate uptake of services. Clan leaders are particularly influential in ethnic minority communities.

Uptake of RMNH services also depends on the community's familiarity with, and trust in, the formal health system. Public confidence in health services is often weak, especially for newborn care. 'Softer' elements of **Quality of Care**, either real or perceived, can act as barriers or facilitators to access. Certain vulnerable groups, including ethnic minorities and people with disabilities, experience stigma and discrimination from some health service providers, and rumours of poor quality care spread easily. Lack of effective communication between providers and clients, including language barriers, presents a great challenge. Allowing ethnic minority families to integrate spiritual rituals into health care practices would facilitate uptake.

Compared with a year ago, **RMNH Outreach** from

health centres is now very successful at providing RMNH information and services to remote communities, and acts as an effective referral mechanism. The snapshot survey showed that health workers were the biggest source of referral for WRA using RMNH services.

Among the various **Community Referral Processes** supported by PSL, the snapshot survey showed that those involving VHSGs and other community volunteers, such as community-based distributors (CBDs), are most likely to facilitate uptake of RMNH services (one third of respondents). WRA perceive that going with a VHSG to the health facility may result in quicker service and the VHSG can help them with necessary paperwork. However, VHSGs and CBDs may suffer from a lack of credibility depending on their status in the community, and their capacity is sometimes weak. There is the potential for greater cooperation between health centres and commune councils/commune councils for women and children (CCWCs) to improve and support community referral systems.

Learning activities showed that **Practical Issues** are as likely to form barriers to access as cultural practices or quality of care. Transport from remote areas is particularly important. Almost all respondents in the snapshot survey travelled to the health facility by motorbike (their own or others'). However, field investigations revealed that even when communities have set up contracts with vehicle owners for fixed-rate transport to health facilities, these agreements often do not function. **Financial Barriers** more broadly can significantly inhibit uptake of services[1]. Another practical constraint is lack of accommodation for family members to enable them to accompany WRA to health facilities. Maternity waiting homes/rooms can be helpful, but only if they offer sufficient light and cooking facilities.

What are we doing about it?

PSL's technical harmonisation activities will focus particularly on health facility and PHD/OD staff:

Community	Health Facility	Provincial/National
• Strengthen community referral systems involving VHSGs and CBDs under the leadership and support of Commune Councils/CCWCs. • Develop further the capacity of VHSGs, CBDs, Commune Councils/CCWCs through existing mechanisms. • Continue to encourage Commune Councils to focus on RMNH and VHSGs/HCMCs to participate in Commune Investment Program planning. • Develop midwife-TBA alliances in order to create an enabling environment for TBAs to refer and support women for safe delivery at a health facility. • Explore the use of financial incentives for referrals and birth support by VHSGs, TBAs and others as part of the conditional cash transfer approach.	• Continue to support the delivery in selected remote communities of the full package of services mandated in the 2013 Outreach Management Guidelines. • Strengthen further the function and capacity of Health Centre Management Comm-ittees to oversee and monitor referral systems. • Strengthen the capacity of health centre staff to supervise and support VHSGs and CBDs.	• Develop a training package for health centre staff for supportive supervision of VHSGs / CBDs.

[1]PSL's learning on financial barriers is covered in Learning Update 4.

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Partnering to Save Lives

PSL Learning Update – June 2015
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 (FTIRMN).

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 and institutionalising a set of national guidelines on RMNH service delivery by infirmaries
- 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.

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 garment factory infirmary service providers.

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 qualitative methods to learn more about these issues, including:

- research conducted in mid-2014 in preparation for development of PSL's BCC Framework, which comprised a literature review, in-depth interviews (IDIs) with 25 key informants at national level, IDIs and focus group discussions with a total of 84 respondents in five garment factories in Phnom Penh and Kandal provinces, and direct observation of factory floors, infirmaries and other factory facilities
- investigation into GFWs' perceptions relating to RMNH, involving a desk review and five focus group discussions with married and unmarried women and men.
- meetings with officials at the Ministry of Labour and Vocational Training (MoLVT) and MoH to investigate the legal and policy framework for garment factory infirmaries.

What have we learned?

Married GFWs expect to have children, which honour the family, but they may delay having children due to the economic status of the family. Married couples discuss different contraceptive methods, but women are responsible for their use.

Most **Unmarried Female GFWs** have boyfriends but pre-marital sex and pregnancy are taboo and shameful. They value contraception for preventing pregnancy, but service providers, peers and unmarried women themselves perceive that they are not entitled to access contraception. Unmarried women report that they primarily have unprotected sex due to lack of planning and sometimes being coerced into having sex. Unmarried men view sex before marriage as just for fun, and have low perception of pregnancy risk. There is also poor communication between unmarried couples about contraceptive use. These factors combine to increase the likelihood of unplanned pregnancies among unmarried GFWs, at which point their sexual partners are likely to abandon them. If an unmarried woman becomes pregnant it is expected that she will terminate the pregnancy, rather than get married while pregnant.

GFWs have good **Awareness of Modern Contraceptive Methods** but not the details of their use. Both married and unmarried women report knowing about pills, IUDs, implants, injections, condoms and natural methods such as withdrawal and rhythm. Men are less familiar with contraceptives. Women learn about contraceptives from NGOs, health facilities, TV, and friends, including peer educators. Fears centre on their effectiveness and impact on health and fertility. GFWs are concerned about side effects with hormonal methods: particularly nausea and weight gain or loss. Women tend to prefer the least invasive method.

Results from the two pieces of learning regarding **Abortion** suggest differences in women's perceptions between their right to have an abortion and its legal status in the country. The BCC study confirmed the PSL baseline finding that the vast majority of

women believe abortion is illegal, whereas the perceptions study reported that all women believe they have a right to an abortion. The BCC study found that stigma related to abortion among unmarried women leads to great secrecy. The perceptions study, which used different methods and focused solely on abortion and family planning, was able to explore this issue further and found that stigma attached to abortion may be reduced if it is done for economic reasons or for optimal birth spacing, particularly among married women. The BCC study reported good awareness of the risks of unsafe abortion, whereas some participants in the perceptions research believe that abortion is safer and cheaper than using contraception. The perceptions research reported that women tend to follow a sequence of methods until one is successful, starting with traditional (and unsafe) methods, then trying medical abortion pills from a pharmacy, finally going on to medical or surgical abortion at a health facility. Cost of facility-based services, which is seen as prohibitive, may be a factor in these choices, as may the perception of abortion as being illegal.

All factories have a pregnancy policy, largely managed by the HR department, which covers issues such as maternity leave and time off for antenatal care (ANC). These **Policies** are governed by the Labour Law and related sub-decrees and 'prakas', issued and overseen by MoLVT. Infirmaries are mandatory for enterprises over a certain size. The Labour Law and related documents outline requirements for infirmary staffing and service hours (based on the size of the workforce), as well as basic infrastructure and equipment. However, there are no regulations relating to the quality of care provided and RMNH services (other than for HIV) are not mandated. The MoLVT has limited capacity for technical oversight of garment factory infirmaries and welcomes support from non-governmental partners, while infirmaries are outside the mandate of the MoH. However, the MoH sees the need to address the needs and vulnerabilities of the GFW population and has included technical support to development of RMNH guidelines for factory infirmaries in the NMCHC workplan for 2015.

Pregnancy-Related Services are not available from garment factory infirmaries (with the exception of pregnancy testing), which instead provide referrals to external providers. GFWs have good awareness of the benefits of ANC, skilled birth attendance (SBA) and post-natal care (PNC), but very limited knowledge of danger signs for mothers and babies during pregnancy and after delivery. Some women return to their home village for delivery, which disrupts the continuum of care and increases the likelihood of their having a home delivery with a traditional birth attendant. Perceptions of skilled staff, good equipment and sufficient supplies at health facilities, along with support from family and community, are likely to encourage SBA. GFWs observe many traditional practices during post-natal period. As PNC usually occurs during maternity leave, factories do not get involved in educating GFWs about PNC.

While public health facilities are trusted as **Sources of Healthcare** because they have older, more skilled, midwives, and sufficient material and medicines, many women, particularly those who are unmarried, prefer to access private clinics, due to factors such as confidentiality and convenience. NGO clinics are trusted but seen as niche providers of specialised services. Unmarried women's choice of RMNH service provider may be influenced by the likelihood of being seen by someone they know. Garment factory infirmaries represent untapped potential to reach GFWs with information and services but vary in their levels of confidentiality and privacy, number and capacity of staff, and services provided, which can all influence uptake.

Health is not a high priority for GFWs, so **Behaviour Change Communication** must be integrated into other activities. Edutainment, including songs, games and comedy shows, is popular; written messages are not. There is a lack of materials featuring young, urban, and particularly unmarried women. Information materials on abortion should be discreet (e.g. wallet-sized). More than 80% of GFWs own mobile phones and SMS provides a confidential mechanism for providing reproductive health information, particularly for youth, but evidence of impact of mHealth activities in Cambodia is limited. Key change agents within factories are factory owners, HR managers, supervisors and team leaders; all can have positive or negative impact. However, GFWs trust information from sources they can identify with, particularly aspirational characters. So peers are the main source of contraception and abortion information for GFWs, particularly unmarried women, although there is limited evidence of the effectiveness of formal peer education approaches.

What are we doing about it?

PSL is working to improve access to RMNH information and services through an integrated approach:

- Working with key stakeholders under the leadership of MoLVT, with technical guidance from MoH, to develop national guidelines on the delivery of RMNH services by garment factory infirmaries.
- Implementing a pilot referral system which facilitates access for GFWs to RMNH service providers close to their factory or home. The providers were selected based on previous trainings by NGOs such as MSIC and PSK, however no ongoing quality follow-up is provided at these facilities under PSL. The pilot will be reviewed and, if successful, expanded to cover a greater number of factories.
- Implementing an innovative multi-platform BCC approach, based on PSL's BCC Framework, which particularly promotes informed choice of contraceptive methods and provides information on safe abortion services to sexually active unmarried GFWs. The package includes a mobile phone quiz application, video dramas, and a curriculum for training peer networks of GFWs.
- Building the capacity of garment factory infirmary staff to deliver high quality, convenient and non-judgemental RMNH services and referrals to all GFWs.
- Continuing to gather and share learning about RMNH among this large, diverse and rapidly evolving population of vulnerable women, through implementation of PSL's Learning Agenda and Advocacy Action Plan. In particular, learning is shared through inputs into national Technical Working Groups, presentations to relevant stakeholders, including the PSL Technical Reference Group and the SAFE Working Group, and awareness-raising through site visits, publications and the media.

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Partnering to Save Lives

PSL Learning Update – June 2015
Theme 4: Financial Barriers

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 (FTIRMN).

What are the issues?

Tackling financial barriers to accessing RMNH services is one of two cross-cutting components of the FTIRMN. 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 post-identification interview process. In order to reduce financial barriers for other vulnerable groups or for services/costs not covered by HEFs, PSL is implementing a range of complementary health financing approaches, including:

- Village savings and loans associations (VSLAs): VSLAs provide community members with access to cash, through savings, loans or grants, which they can use to cover transportation and other indirect costs of accessing healthcare, in order to promote health-seeking behaviour. The underlying aim of the VSLAs is to foster community investment for maternal and child health.
- Supply-side financing for long-acting family planning methods: Implants and intra-uterine devices (IUDs) are available free-of-charge at all health facilities in selected provinces to women of reproductive age (WRA) who are not eligible for HEF support. Health facilities are reimbursed for the services, which are promoted through community-based distributors (CBDs) and behaviour change communication (BCC) activities. This replaced a previous voucher-based approach.
- Conditional cash transfers (CCTs): Due to be implemented by the end of Year 2, CCTs involve the payment of cash to WRA when they fulfil certain conditions, most commonly the uptake of recommended RMNH services. As such they can cover indirect costs not covered through other health financing mechanisms.

What learning approaches have we used?

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

- a review of the pilot VSLA project in Koh Kong, conducted in October 2013, involving observation of six VSLA groups and discussion with project staff and village agents.
- a literature review and field-based research conducted in mid-2014 in preparation for development of PSL's BCC Framework.
- an assessment of the family planning voucher approach, completed in July 2014, which involved a literature review, health facility observations and key informant interviews
- a qualitative exploration of cultural barriers to uptake of RMNH services conducted over four months in late 2014 among ethnic minority communities in Kratie province
- background research conducted in late 2014 and early 2015 to inform the design of PSL's CCT approach, involving a literature review, key informant interviews and a consultative workshop
- a 'snapshot' survey in February 2015 which involved exit interviews with 138 WRA after they had received an RMNH service from a health centre in one of the four north-eastern provinces
- fieldwork in Koh Kong, Ratanakiri, Sihanoukville and Stung Treng provinces as part of PSL's Annual Review process in March 2015, which involved key informant interviews and focus group discussions with local health and planning officials, HEF operating agencies, health centre staff, local government representatives, community health volunteers and WRA in the community.

What have we learned?

Rural and ethnic minority respondents highlight lack of money as a significant barrier to accessing public sector RMNH services, where they judge service fees to be too high. Choice of provider is strongly influenced by the **Costs** incurred. The combination of user fees, high transport, accommodation and other costs incurred travelling to health facilities from remote areas across challenging terrain increases the likelihood that WRA from these communities will opt for a home delivery with a TBA, who may also offer flexible payment options. Overall, more than 90% of snapshot survey respondents covered the costs of accessing an RMNH service at a health centre (user fees, transport and other costs) using their own funds. Women may have to borrow money to access RMNH services, paying back relatives or neighbours in cash or in kind. Therefore, financial support mechanisms can act as strong incentives to use RMNH services. However, **Commune Councils**, which have the mandate to support health in the community and often receive related funding, lack the capacity to apply the complex administrative processes required to use funds to offer financial support to RMNH users.

The annual review found that the **ID Poor Process** is clear at local government level but lacks transparency within communities. As a result, ID Poor card holders may not all be the poorest and most vulnerable in their communities. Internal migrants and people with disabilities are particularly at risk of exclusion from the ID Poor

process. The proportion of health centres enabled to offer **Health Equity Fund** support has thus far been low in the north-east, but is being phased in, with the aim of 100% coverage by the end of 2015. Although almost 30% of snapshot survey respondents held an ID Poor card, only 8% of card-holders accessed HEFs for their RMNH service. Awareness of HEF benefits (including transport reimbursement) and post-identification processes is correspondingly poor in the north-east, but should also improve with the expansion planned in the region throughout 2015. Effective implementation of HEFs requires flexibility from HEF Operators, for example, by enabling the post-identification process to be completed in a single visit for those living a long way from the facility. Where health centres are applying HEFs, delayed reimbursement from the national level for HEF expenditures continues to be a challenge. Even when the ID Poor and HEF systems function effectively, other barriers may constrain access to RMNH services, including transport and other opportunity costs, culture and RMNH knowledge.

The annual review found that all three **PSL Financial Barriers Approaches** are complementary to HEFs by addressing financial barriers for the 'near-poor' or vulnerable groups, such as people with disabilities, who face additional costs. Some also cover transport and other costs not covered by HEFs at health centres.

The review of the **Village Savings and Loans Associations** pilot in Koh Kong reported that the groups were functioning very well and recommended expansion of the approach to PSL catchment areas in Mondulkiri and Ratanakiri. VSLA funds are not ring-fenced for health, but intensive promotion of healthy RMNH behaviours by trained VHSGs has increased the proportion of participating members using funds for health expenditure more than four-fold within 12 months. Whereas group members in Koh Kong are predominantly women, around two-thirds of current members in Ratanakiri are men, reflecting their role in decision-making and control of household resources. The annual review confirmed the strong ownership of VSLAs by the community and the potential they offer for sharing health and other information (e.g. on HEFs), but also observed that approval processes result in an inevitable delay in releasing funds in emergency situations.

While vouchers address financial barriers and are a results-based approach to increase supply and encourage demand for family planning services, they do not promote competition and choice of providers. There are also significant transactional costs involved in administering a voucher scheme. The switch from vouchers to **Supply-side Financing for Long-acting Family Planning Methods** should offer WRA greater choice of method and provider, and direct more resources towards service delivery, rather than administration. The impact of demand creation using CBDs and innovative BCC, rather than vouchers, will be monitored closely. Using CBDs should provide the opportunity to offer women a range of short- and long-acting methods.

The proposed **Conditional Cash Transfer** approach would cover all WRA within catchment areas selected on the basis of vulnerability and current uptake of RMNH services. Cash would be given directly to women in three tranches, based on uptake of ANC, safe delivery, and PNC services. The design also proposes a cash incentive for VHSGs and others who accompany the woman to the health facility for safe delivery. Transport reimbursements based on distance travelled should be considered.

What are we doing about it?

PSL is working to address financial barriers to RMNH services at multiple levels:

Community	Health Facility	Provincial/National
• Continue to implement VSLAs. • Monitor development and implementation of Commune Council initiatives relating to RMNH. • Encourage VSLA participation in Commune Investment Program planning processes. • Raise awareness about HEFs through BCC, Commune Councils/CCWCs, health centres and VHSGs. • Develop and implement BCC approaches to increase male engagement in RMNH.	• Continue to implement supply-side FP financing and roll out CCT approach.	• Conduct comparative analysis of PSL financial barriers approaches linked to RMNH indicators and sustainability. • Engage actively with URC and HEFOs to support expansion of HEFs in the north-east.
• Facilitate information flow between URC/HEFOs/PHDs/ODs, health centres, local authorities and communities in relation to ID Poor and HEF systems.		