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Partnering to Save Lives

Learning Update – July 2017
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 reaching vulnerable groups.

What are the issues?

PSL partnership aims at identifying technical approaches that are effective in improving RMNH, particularly among vulnerable groups[1] with significant unmet needs in terms of information and services.

Coaching and Midwifery Coordination Alliance Teams (MCATs) are promoted as key interventions to build capacities of midwives to provide quality RMNH services. In 2016, the MoH finalised and disseminated a National MCAT Protocol and is introducing a new quality enhancement monitoring system including two coaching sessions per facility per quarter. The recently updated Safe Motherhood Clinical Management Protocol is also a key reference document for improving midwives' clinical skills and practices.

In the meantime, progress across components of RMNH is uneven and some key services continue to face challenges.

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

We observed that attendance to postnatal care (PNC) remains low and the quality of this service scored poorly during the Level II Quality of Care Assessment. Provision of comprehensive abortion care (CAC) remains very limited in public health facilities despite training of providers.
With this in mind, the PSL annual review aimed to inform a better understanding of key quality improvement mechanisms (MCATs and coaching) and provider confidence with clinical skills specific to postnatal care with attention to newborns and mothers, and abortion.

Learning questions in year 4 were as follows:

1. Do health workers and health department/district representatives find MCATs and coaching an effective means to transfer skills and increase confidence and motivation to deliver appropriate life-saving services to women and newborns?
2. Do health workers, particularly midwives, demonstrate the appropriate skill sets to deliver appropriate newborn services including PNC for newborns and mothers, and CAC?

What learning approaches have we used?

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

- Consultation with PSL's Technical Reference Group to share experience and lessons learnt on coaching, in October 2016;
- Monthly meetings of PSL's Quality Team comprising technical representatives from the three NGOs;
- Learning and testimony from PSL field managers and implementing staff and members of the Quality Team, during the Annual Review Workshop in March 2017;
- Fieldwork in Kratie, Mondul Kiri and Kampong Cham as part of PSL's Annual Review process in February 2017, which involved key informant interviews, focus group discussions, observations and simulation exercises.

What have we learned?

Are MCATs and coaching an effective means to transfer skills and increase confidence and motivation?

MCATs

During **PSL year 4 annual field review,** 30 midwives and five provincial health department (PHD) staff were interviewed and shared their views on successes and challenges with MCAT meetings. **Midwives found that MCATs function well to improve their knowledge on clinical skills especially when participatory approaches and simulation are used.** MCATs also help improve relationships between midwives and between health centers, hospitals, and Operational District (OD)/PHD teams. It has helped solve problems and promote team work. PHD/OD teams demonstrate good ownership and found that the new National MCAT Protocol provides good guidance to MCAT facilitators. They found that the large number of participants during meetings is not an efficient means to promote active participation. Challenges remain in the absence of midwives and sometimes facilitators due to per diem issues. **Providers from referral hospitals do not participate regularly** due to conflicting agenda or lack of interest, which limits the possibility to discuss and solve issues around referrals. Time is also too limited to practice skills as the capacity building session is limited to the afternoon only. Some midwives do not have the chance to practice new skills after MCATs, due to limited cases. MCAT meetings are mostly supported by development partners budget and **should be included in annual operation plan (AOP) budgets.** The continuous education requirements for health professional licensing may be an incentive for PHDs and ODs to invest budget in MCATs.

Coaching

Midwives interviewed during the **annual field review** were also asked if they found coaching effective to build their clinical skills. **Midwives found coaching to be very useful. It provides hands on experience and helps to gain self-confidence.** Midwives appreciated to be praised by their supervisors when they do well and to receive advice to further improve their practices. The coaches expressed the **need to receive more training and guidance on how to do coaching.** They remain confused about what coaching is and some have difficulties to adopt a supportive attitude. They are also lacking materials such as mannequins to practice skills when patients are not present. Limitations observed were the insufficient involvement of referral hospital staff in coaching teams to share their clinical knowledge and practices and the limited real case opportunity at the time of coaching in some health centres. Also, midwives are sometime absent or not available due to other duties, even though the appointment for coaching was agreed in advance.

Common lessons learnt identified during the technical reference group meeting in October 2016 included the following:

- Coaching does not only improve skills but also **self-confidence** to practice and perform life-saving skills, **supportive relationship** between the staff and PHDs/ODs, and it **empowers** staff to make the right decision.
- **Having the right coaches** is of primary importance for successful coaching. Results of coaching are very dependent on coaching skills and supportiveness of the supervisors.
- Coaching skills cannot be acquired through theoretical training only. There is a need to **"Coach the coaches"**.
- Coaching must happen **on-site,** ideally with actual patients.
- Coaching should be **structured and competency based.**
- Follow up needs to be **supportive,** not "controlling/checking".
- Checklist use should be kept to a **minimum.**
- **Provision of feedback** can happen through the coaching session directly to the midwife/staff being coached and then during a feedback session involving facility chief to develop joint action plan.

Do health workers demonstrate the appropriate skill sets to deliver appropriate newborn services and comprehensive abortion care?

Postnatal care service:

During PSL Year 4 field review, simulations of PNC 1 visits including immediate newborn care were organized to measure the quality of service provided. Gaps were observed in the application of the national standards and steps such as in recording information, checking mother's breasts and newborn vital signs. **It was noted that very little attention was paid to the newborn.** PNC outreach visits remain limited especially during rainy season. It was also observed that some vaccines were out of stock.

The Level II Quality of Care Assessment completed by the MoH in 2015 among public health facilities in 15 provinces and Phnom Penh municipality identified that PNC was among the poorest quality services with scores of 36.4% for PNC2 and 47.6% for PNC1. This poor quality is reflected by the relatively low coverage of such services. Discussion with women at the community level during the PSL field review also confirmed the fact that women are not visiting health centers after delivery except in cases of emergency or for vaccinations. Despite awareness messages and community education on PNC, **women are not convinced of the usefulness of this essential check-up for them and their baby.** The practices of roasting and other traditional methods continue to be very high, especially among ethnic communities.

During the first six months of PSL Year 4, 18 newborns died across the four northeast provinces (four still birth and 14 neonatal deaths) both in community and in facility. Causes of death included mother's severe anemia, prematurity, low birth weight and congenital defects among others. Most could have been avoided with appropriate referral.

CAC

The fieldwork also looked specifically at factors influencing CAC with trained providers. It was found that some health centres do not receive CAC clients. As a result of their limited use of these skills, **providers do not feel confident in their skills to perform CAC.** Strong moral barriers are also reasons for midwives not to perform CAC, suggesting that values clarification needs to be strengthened. Additionally, sharing financial incentives for CAC with other staff is not well perceived by providers.

Simulation of CAC services during field work showed that providers did not follow CAC protocol. Issues were found with checking vital signs, hygiene and infection control (hand washing, wearing aprons, material preparation and waste management), history taking and recording information. There is a need to reinforce CAC supervision and to build the clinical skills of supervisors on CAC.

Women in the community also expressed that they prefer going to private clinics to receive this service due to privacy issues.

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 provide MCAT with systematic use of participatory approach and simulation. • Encourage participants to MCAT to share their good experience with their absent colleagues to motivate them to join next round. • Continue to provide coaching support to midwives at health centre level. • Address clinical weaknesses in PNC and in CAC through quality assurance visit, coaching and MCATs. • Integrate attitude issues and CAC value clarification in MCATs and coaching. • Conduct values clarification for provider and health centre chief during recruitment for CAC training. • Conduct attitudes training to sensitise midwives to the needs of vulnerable groups such as ethnic minorities, young and unmarried women and people living with a disability.	• Support and build the capacities of coaches in both clinical and soft skills. • Identify and mobilize coaching teams that combine representatives from PHD/OD and from referral hospitals. • Include RMNH activities, especially MCATs and coaching in Annual Operation Plans and Commune Investment Plans. • 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. • 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. • Coach MCAT facilitators in participatory methods.

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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.

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Partnering to Save Lives

Learning Update – July 2017
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 Neonatal Mortality (FTIRM).

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?

More than 700,000 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 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. Garment factory workers are particularly vulnerable with regard to RMNH for a variety of reasons, including isolation from their family and community support networks.

In the garment sector, PSL has worked in cooperation with factories to improve female workers' access to sexual and reproductive health care and services through factory infirmaries and referrals to external health providers, and implemented numerous behaviour change communication (BCC) activities to promote sexual and reproductive health and rights (SRHR), including knowledge on contraceptives, maternal and neonatal health, and safe abortion.

Recent changes in the policy landscape around garment factories include the introduction of the National Social Security Fund (NSSF) scheme for garment factories, which began in September 2016 and the finalisation of the National Guidelines for Developing Enterprise Establishment Infirmary's by the Ministry of Labour and Vocational Training (MoLVT).

Our learning questions are the following:

1. How can we ensure that garment factory workers can access quality RMNH information and services?
2. How can we best engage with factory management, the MoLVT and the MoH to improve and sustain access to quality RMNH for garment factory workers?

What learning approaches have we used?

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

- CARE's evaluation on the implementation of Chat! in 16 PSL factories;
- Marie Stopes' infirmary assessments and quality improvement monitoring visits in seven garment factories;
- Garment Factory Coordination Group meetings;
- Fieldwork in Garment Factories in Phnom Penh and Kandal as part of PSL's Annual Review process in February 2017 including interviews and focus group discussions with six infirmary staff, six human resources managers and 67 garment factory workers (34 women);
- Learning and testimony from PSL field managers and implementing staff during the Annual Review Workshop in March 2017;
- Participation in the consultative process for the development of the National Guidelines for Developing Enterprise Establishment Infirmary.

What have we learned?

About garment factory workers' Sexual and Reproductive Health (SRH) knowledge and practices:

Since April 2016, PSL introduced the innovative BCC package "Chat! Contraception" in 16 PSL targeted factories and another eight factories supported by other projects. Chat! is a suite of flexible tools and activities which are easy to tailor to meet a factory's individual needs. Chat! includes eight short training sessions, three video drama episodes and an interactive mobile game as well as a five-topic male engagement module.

The implementation of Chat! Contraception including the male engagement module reached 11,979 females and 262 male workers between August 2016 and January 2017. A mini-evaluation of Chat! conducted

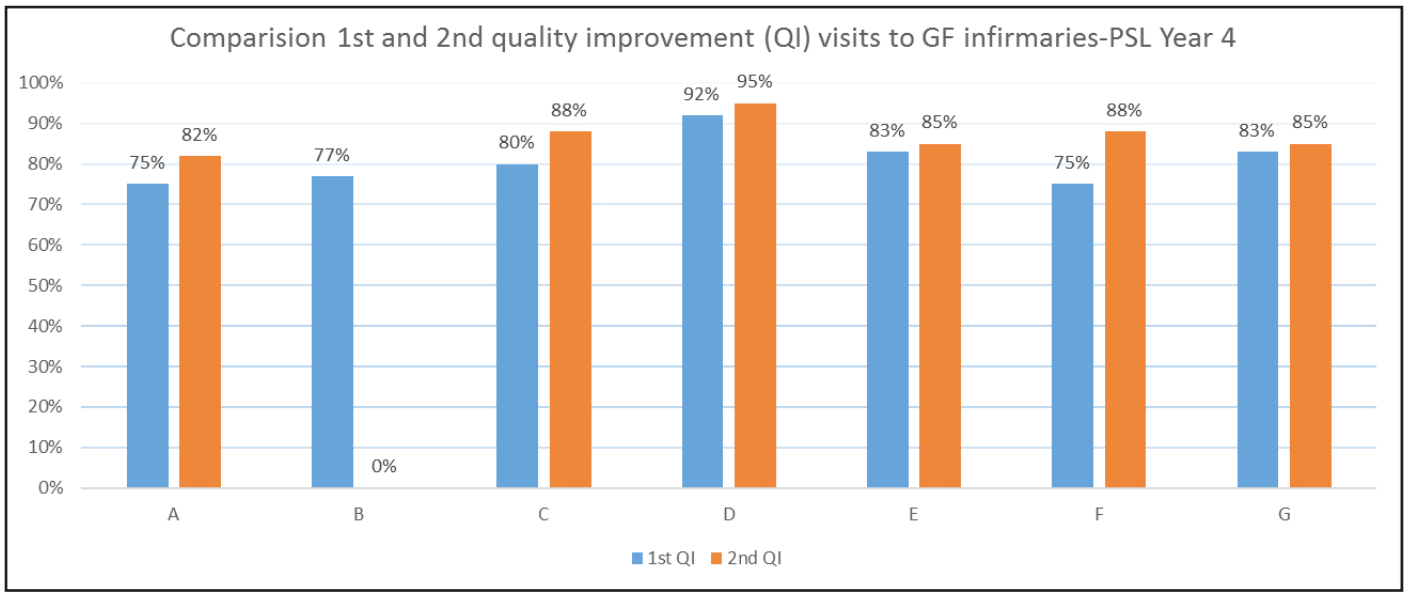
in December 2016 found that it doubled the rate of contraception use (from 24.2% in baseline to 48%), more than doubled RMNH service utilization (8.6% to 20%), doubled the confidence of women to discuss contraception (23.7% to 50%), and tripled the confidence to refuse sex with their partners (from 16.8% to 50%) compared to the PSL baseline.

During the PSL annual field review in February 2017, all garment factory workers interviewed who attended Chat! Sessions reported improved knowledge and behavior change following Chat! interventions, particularly with family planning methods and safe abortion. **Workers knew where to access services and information (factory infirmary, public health facilities and private providers) and shared information with partners, colleagues, friends and relatives.** They felt more confident in their knowledge and in choosing the right contraception for them. The role play used during education sessions and the video drama episodes were particularly appreciated. **Men reported having gained a better understanding of different modern contraceptive methods and the risks posed by natural methods.**

Human resources managers also reported benefits from the BCC interventions such as **increased staff retention rate from 8% to 12%, reduced staff absenteeism due to health reasons and productivity gains.** They also observed that workers are healthier and more productive as a result of an increased knowledge and awareness. Buyers and unions appreciated that they have a cooperation with NGOs, buyers were also happy to see improvements in performance. The time necessary to invest in the education sessions remains the main challenge expressed by both the workers and the managers. Some managers mentioned potential negative impacts on the production line.

About the use of infirmaries and referrals:
Recent qualitative study undertaken by Population Council and the National Institute of Public Health in Phnom Penh and Kandal provinces on health needs and health seeking pathways of female garment factory workers found that workers' main health concerns are sexual and reproductive health care and family planning services. The mapping of the health seeking behaviour of workers illustrates that workers seek infirmary services for mild general illnesses (flu, headache...) during working hours. It also identified the limited capacity and quality of factory's infirmary as a barrier to access and use of health care services. (Health needs, health seeking pathways and drivers of health seeking behaviours of female garment factory workers in Cambodia. Policy brief, WorkerHealth, March 2017.)

When quality improvement support is available, the use of garment factory infirmaries for RNMH is increasing: **the use of the infirmary for RMNH services in PSL factories increased from 3.6% to 10.6% between PSL 2014 baseline and 2016 midline.** The quality improvement monitoring visits in infirmaries supported by the programme showed important improvements in the quality of services provided. The graph below shows improvement in services provided by infirmaries supported by PSL between the first and second quarter of PSL year 4:



Improvements were observed in hygiene (hand washing), patients' records, use of referral sheets and information on emergency contraceptive pill. Remaining areas for improvements include history taking, asking clients about previous contraception methods used, providing clear explanations on emergency contraceptive pills as well as information on all contraception methods.

About impact of NSSF:
During the PSL annual field review, all workers interviewed knew about NSSF healthcare and how to access facilities contracted under NSSF near their factory. They knew how deductions for NSSF linked to their salary. There was some confusion among workers and human resource managers about health facility and service coverage and **all workers wanted additional information on NSSF coverage and benefit packages.** There were mixed experiences with NSSF at facility level with some workers reporting good experience and others reporting feeling discriminated against when showing their NSSF ID at facilities. This included anecdotal experience of the feeling that when waiting for services they had been kept to wait longer, had been told certain services were not available under NSSF and being sent away.

About engaging with factory management:
When interviewing human resource managers and infirmary staff during PSL's annual field review, we learnt that **all of them are willing to continue Chat! and provide quality health services.** Some suggested they could invest money in the provision of BCC materials. They expressed the need to be more directly involved in activities and a **strong need to receive training of trainers** and training curriculum, to be able to train future infirmary staff and potential teams involved in education sessions.

They also mentioned cooperation with ministries (MOLVT and MoH) to provide training, guidelines, inspection and infirmary standards for supervision visits. The introduction of the newly approved national infirmary guidelines that are pending roll-out should also assist in this.

What are we doing about it?

Garment Factory Workers	Infirmaries	Referral System
• Continue scale-up of Chat! Contraception BCC package and build the capacities of factory teams to implement it. • Evaluate BCC Chat! package in terms of knowledge, behaviours, and self-efficacy. • Work with human resource managers, production teams and factory managers to demonstrate the effectiveness of CHAT! • Offer opportunity to join CHAT! to infirmary and human resource staff. • Adapt time and duration of the BCC sessions to available time of workers.	• Provide capacity building to infirmary staff in relation to hygiene, counselling and referrals as well as staff attitude. • Provide training of trainers to infirmary staff so they can train new staff. • Work closely with MoLVT, MoH and factory management to explore exit options.	• Reinforce awareness raising on available services and facilities offering NSSF especially in the areas where workers live. • Expand the number of health facilities offering NSSF and geographic coverage. • Need to strengthen relationships with external health facilities and infirmaries for referrals.

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Partnering to Save Lives

Learning Update – July 2017
Theme 4: Reaching most vulnerable groups

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 reaching most vulnerable groups.

What are the issues?

PSL has a focus on equity and responsive delivery, through both working in geographical areas and target populations with the poorest and most marginalised groups. PSL has particular consideration for people facing multiple challenges such as ethnic minorities, people with disabilities, young men and women.

For our Year 4 annual review, we included a new learning theme to measure how successful PSL approaches are in increasing access to RMNH for vulnerable groups. We asked ourselves the following research questions:

1. What achievements have been made in ensuring that vulnerable groups (especially ethnic minorities, people with disabilities, young men and women, female-headed households) are accessing RMNH services and information?
2. What are the remaining barriers particular groups are still facing?
3. How can gender equity and disability inclusiveness in access to RMNH be further improved?

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 Stung Treng and Ratanak Kiri provinces as part of PSL's Annual Review process in February 2017, which involved key informant interviews and focus group discussions with provincial health, social welfare and women affairs departments, Commune councils for Women and Children (CCWC), village health support groups (VHSGs), persons with disability, teenagers, 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;
- Discussion and exchange of lessons and good practices with disability stakeholders;
- 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 an RMNH service from health centres in the four Northeast Provinces;
- A qualitative research on RMNH knowledge and practices of adolescent mothers in Ratanak Kiri by a student of Deakin University.

What have we learned?

Ethnic minorities

PSL works in provinces populated by ethnic minorities and has introduced approaches and tools designed to meet their specific needs. Radio programmes (drama and call-in programmes), village events, listening and dialogue groups, SMS and voice messages have been implemented in the four Northeast provinces. A new behaviour change communication (BCC) package including flip charts, activity cards, community games and audio material in four local languages has been introduced in Year 4 for VHSGs. A traditional birth attendant (TBA)-Midwife Alliance helps engaging TBA's in referrals to health centres in remote communities with high rates of home delivery.

Progress has been observed at the time of **PSL midterm evaluation** (July 2016) in access to RMNH services for ethnic minorities. For example, the percentage of women of reproductive age from ethnic minorities using modern contraception methods increased from 33.4% to 41.4% between baseline (2014) and midline (2016) surveys. **The percentage of women from ethnic minorities delivering in health facilities with support from skilled birth attendant increased from 37.1% to 53.8%** and

from 30.5% to 46.9% for access to antenatal care (ANC). Percentage of RMNH service users from ethnic minorities referred through a community referral mechanism increased from 6.5% to 35.4%. Similarly, **the snapshot survey on community referral from March 2017 shows that 63% of ethnic minority members interviewed were referred by PSL supported community referral systems** (clubs and listening and dialogue groups, village saving and loans associations (VSLA), VHSG, community based distributers (CBDs), CCWC and community health promotion). They were also more likely to be referred by TBA, pregnancy clubs, listening and dialogue groups, men's clubs, and CBDs compared to other groups.

Whilst important progress is observed in relation to access to ANC and safe delivery, some traditional practices such as roasting remain strong and women do not see the need to go to the health centre after delivery (refer to Learning Update Theme 2). Language barriers, discrimination and lack of support from community and family are mentioned as barriers for some ethnic minorities. Persons working in the farm far from the village remain unreached by any community based interventions.

Staff from health centres met during the annual review reported that the **attitude training module on ethnicity helped them better understand the different culture of ethnic groups** and to better behave with them. Some health providers are from ethnic groups and/or can speak local language.

Persons with disability

PSL wishes to promote access to RMNH services for persons with disability. The BCC material promotes inclusive communities and services. In Year 3 and 4, 66 healthcare providers received attitude training including a one day module on disability. In Year 4, the Cambodian Disabled People's Organisation (CDPO) took part in some PSL activities and in the annual review to take stock on inclusion of persons with disability in the programme. A partnership is being established to implement some recommendations from the review.

In Ratanak Kiri and Stung Treng, most persons with disability we met during the annual field review mentioned having access to medical services free of charge. Most health centre staff also confirmed the practice of fee exemption for this group. The main barrier expressed to access RMNH services is transport, especially as one person needs to accompany the person with disability or to drive the motorbike for them. Generally, persons with disability did not report negative attitudes or discrimination from health centre staff. **However, none of the persons with disability we met had access to information on sexual and reproductive health and none were participating in community education groups.** Decisions about accessing health services mostly depend on family members/parents. Some women with disability we met were unmarried and had no children and it was reported that it is very unlikely for women with disability to get married. The discrimination seemed stronger in remote communities.

The attitudes training (or other clients' rights/ providers' duty training) led to an improved knowledge and behavior of health care providers towards persons with disability. Still, most health centres are not equipped with ramps or accessible toilets. Community volunteers seemed to be willing to have persons with disability participate in community education sessions, but **did not realize at first that this topic can be of interest for them.**

Provincial authorities and CCWC have some understanding of disability inclusion and make efforts to include persons with disability but they are lacking technical guidance and budget. Social support to disabled people is included in annual commune investment plans and five-year commune development plans. Disabled people organizations have set up some self-help groups for persons with disability in PSL target provinces that we can link with.

Unmarried young men and women and teenagers

We learnt from our **annual field visit** that teenagers and young unmarried men and women continue to be hard to reach. Some unmarried men and women start to access services in health centres and it seems there is no barrier for unmarried men to participate in men's clubs. Men are very interested in learning about reproductive health and family planning prior to getting married. On the contrary, **unmarried women rarely receive information on sexual and reproductive health except if they attend secondary school.** Stigma around unmarried women attending reproductive health services remains very strong. Teenagers in general do not feel comfortable to access health services due to shyness and privacy issues. **Misconceptions such as taking contraception before pregnancy can make you infertile are largely spread and even perpetuated by health centres' staff.**

The qualitative research on sexual and reproductive health of adolescent mothers in Ratanak Kiri gathered information from 22 interviews of women aged 15 to 19 with at least one child. They were all married. The findings showed that the knowledge of modern contraception prior to pregnancy was very poor. Most women thought abortion was illegal but all interviewees believed they could access safe abortion services at health centres. Most accessed ANC and delivered at health centres but they did not go to the health centre after delivery except for the child vaccination. Adolescent mothers received information from either health centre staff or other women from the community, family members or husband.

Gender equity

PSL recognises the importance to involve both men and women in RMNH activities and has introduced activities tailored to the specific needs of men and women of reproductive age. This includes in Ratanak Kiri and Mondul Kiri the facilitation of men's clubs and pregnancy clubs while both men and women participate to listening and dialogue groups in Stung Treng and Kratie. In garment factories, a male engagement module is targeting the male garment factory workers. The attitude training provided to health care providers includes a one day module on gender. PSL BCC material promote men's supportive attitude.

During the **PSL annual review,** we met with the Provincial Office for Women's Affairs (POWA) of Stung

Treng and Ratana Kiri as well as with 12 CCWC. We met members of men's clubs, pregnancy clubs and listening and dialogue groups. We learnt that in overall, men have a better understanding of gender roles, and are supportive of their wife, particularly when she is pregnant. Husbands and wives discuss family planning and make decisions together. **Specific listening and dialogue groups for men and women worked well.** Men are showing interest to learn about family planning and reproductive health, but their participation is limited by their poor time availability, especially during harvest time.

Despite these positive achievements, traditions and strong gender norms (women role, unmarried women, early marriage (13-15), acceptance of violence against women) still persist in remote communities especially among ethnic groups.

Provincial authorities and CCWC have a good understanding of gender. **Gender related activities such as gender awareness or support to victims of gender based violence are included in annual commune investment plans and five-year commune development plans.** There is also good collaboration between village gender focal points and local authorities in reporting and solving gender based violence issues in the community. The provincial committee for women and children promotes collaboration across sectors under the lead of PoWA and **CCWCs have good relations with health centres and VHSGs.** However, CCWC have no specific budget and the collaboration with them can be strengthened. In Stung Treng Province, it was found that having women chiefs of commune helped to mobilise resources to implement gender related activities in the community.

What are we doing about it?

For all vulnerable groups: Roll out attitude training or advocate to Provincial Health Departments (PHDs) and Operational Districts (OD) to implement it through their annual operation plans (AOP). Split modules and provide brief summary sheets. Invite trainers from national level for this training.

Persons with disability	Gender equity
• Conduct disability awareness sessions in communities (listening and dialogue groups, clubs). • Involve authorities and VHSG to encourage persons with disability to participate. • Build capacities of Disabled People Organisations to provide information on sexual and reproductive health to persons with disability. • Advocate with PHD and health centres to ensure all health centres provide free of charge service to persons with disability. • Advocate for collection of disaggregated data on disability and ethnicity at health centre level.	• Conduct gender awareness sessions in communities (listening and dialogue groups, clubs). • Specifically target men in activities. Strengthen men's clubs and consider expanding where there are not. • Address social norms and communicate with parents/elders to address traditional practices. • Involve authorities to encourage men to participate. • Link more with CCWC. Invite them to join PSL activities and continue to advocate CC to put budget for inclusion of gender and disability in their planning.
Ethnic minorities	**Unmarried young men and women, teenagers**
• Continue supporting community based referral mechanisms. • Monitor the use of the BCC package by VHSG. • Continue implementation of listening and dialogue groups and clubs.	• Encourage unmarried women and men to join community groups meeting (listening and dialogue groups, clubs).