ROLE OF VILLAGE HEALTH COMMITTEE
in community-based emergency referral mechanism
for Maternal Newborn and Child Health problems
in Middle Island, Nga Pu Daw Township, Myanmar

Department of Medical Research (Lower Myanmar)
Maternal and Child Health Section, Department of Health
Save the Children & University of Public Health

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Nga Pu Daw Township, Myanmar

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Abbreviations

AMW  Auxiliary Midwife
AN   Antenatal
ANC  Antenatal Care
BHAP Burma Humanitarian Assisted Program
BHS  Basic Health Staff
CBO  Community Based Organization
CCMP Community Case Management Provider
CDK  Clean Delivery Kit
CHW  Community Health Worker
CS   Cesarean Section
CTHP Coordinated Township Health Plan
DHF  Dengue Haemorrhagic Fever
DOH  Department of Health
ECC  Emergency Child Care
EmOC Emergency Obstetric Care
EPI  Expanded Programme of Immunization
FGD  Focus Group Discussion
FOC  Free of Charge
HA   Health Assistant
HBMR Home Based Maternal Record
H2R  Hard to Reach
IDI  In Depth Interview
IP   Implementing Partner
INGO International Non Governmental Organization
JI-MNCH Joint Initiative on Maternal Newborn and Child Health
JTHP Joint Township Health Plan
KII  Key Informant Interview
LHV  Lady Health Visitor
LSCS Lower Segment Cesarean Section
MDGs Millennium Development Goals
MMK  Myanmar Kyat
MNCH Maternal Newborn and Child Health
MO Medical Officer
MOH  Ministry of Health
MW  Midwife
NGO  Non Governmental Organization
OPD Out Patient Department
PE  Pre Eclampsia
PONREPP Post Nargis Recovery and Preparedness Plan
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<tr>
<td>RHC</td>
<td>Rural Health Center</td>
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<tr>
<td>SC</td>
<td>Save the Children</td>
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<td>SHG</td>
<td>Self Help Group</td>
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<tr>
<td>SMO</td>
<td>Station Medical Officer</td>
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<tr>
<td>TA</td>
<td>Travel Allowance</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendance</td>
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<tr>
<td>TMO</td>
<td>Township Medical Officer</td>
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<tr>
<td>TV</td>
<td>Television</td>
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<tr>
<td>USD</td>
<td>United States Dollar</td>
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<tr>
<td>USG</td>
<td>Ultrasonogram</td>
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<tr>
<td>VHC</td>
<td>Village Health Committee</td>
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<td>VHT</td>
<td>Village Health Team</td>
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<td>VHW</td>
<td>Village Health Worker</td>
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<td>VTHC</td>
<td>Village Tract Health Committee</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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Executive Summary

This study was conducted in collaboration with Department of Medical Research (Lower Myanmar), Maternal and Child Health Section, Department of Health and Save the Children. This study illustrates how the community-based emergency referral mechanism for Maternal, Newborn and Child Health (MNCH) was piloted by different funding mechanisms in Middle Island. It aimed to describe roles of Village Health Committees (VHCs) in community-based emergency referral mechanism for maternal and child health care services in Middle Island, Nga Pu Daw Township in Myanmar. The study explored existing community-based emergency referral mechanism for MNCH problems, barriers for the referral mechanism and analyze community-based financing interventions for MNCH. It also describes opinions and suggestions for the community-based emergency referral mechanism for MNCH. This is a cross-sectional study using both quantitative and qualitative methods. The study was conducted in six villages of Middle Island, Nga Pu Daw Township, Ayeyawaddy Region. Data collection was done in March 2013. Study villages were selected according to having functioning or non-functioning VHCs and three different funding mechanisms. Informal group discussion and social mapping in each village was done. Total of six Focus Group Discussions (FGDs) with women of reproductive age group, three FGDs with VHC members of functioning VHCs, twelve in-depth interviews (IDIs) with mother who had experienced of emergency referral for Emergency Obstetric Care (EmOC) or Emergency Child Care (ECC) within six months were conducted. For Key informant interviews (KII), 18 KII with Public Health Staff, key persons from VHCs, volunteers and Save the Children staff form Yangon office and field office were included. Record review of register and record books from 125 villages for 3 years (2010-2012) was also carried out.

Village Health Committees were formed in villages after the Cyclone Nargis. It was revitalized the original guideline or structure of Village Tract Health Committee (VTHC) by creating two new posts—casher and accountant—when Save the Children provided funding for VHCs. Although there were three different funding mechanisms to facilitate and support VHCs in previous years, existing funding was from Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH) project. Selection of VHC members was
carried out at mass meeting and usually by voting. Almost all community were aware about VHCs and its’ main function for supporting emergency referral for MNCH. Most respondents highlighted that health knowledge and access to health services were much better after formation of VHCs in their villages. Strong linkage and coordination among VHCs, Basic Health Staff (BHS) and Save the Children was observed as one of the main strengths of JI-MNCH project. Public Health Sector/Government took the leading role and Save the Children took facilitating or supporting role in implementing health activities for MNCH. Criteria for getting emergency referral supports were linked with utilization of health services such as taking 4 Ante Natal (AN) cares, having referral letter from MW, having AN card and Home Based Maternal Record (HBMR) or Maternal and Child Health (MCH) handbook. JI-MNCH also supports for health system strengthening such as support for special AN visits, support to conduct quarterly meeting at sub-centre and township levels, support for trainings of volunteers (Auxiliary Mid Wife (AMW) or Community Health Worker (CHW)), providing clean delivery kits and new born kits for delivering with skilled birth attendants. These support also enhanced utilization of health services by community.

With JI-MNCH project all cases of EmOC and ECCs i.e. either rich or poor could get travel cost from VHC, meal cost for patient and medical cost free at hospital. There were two different views for providing support for those who can afford in case of emergency. Identifying emergency was based on knowledge and skill of referred person and initial treatment obtained before the referral. Although decision maker to identify emergency was Mid Wife (MW), for villages which were not easily accessible to sub-centre, AMW or CHW could decide.

Most common barriers for emergency referral mechanism were variations for defining emergency; over-demand or unnecessary demand of community to refer to get meal cost at hospital; attitude of BHS. As there were three main players in community-based emergency referral mechanism—VHCs, BHS and Save the Children—it was crucial that three parties were harmonized and well coordinated. Well functioning health systems plays pivotal role to gear up this community-based emergency referral pathway. Monitoring and stewardship of VHC activities by BHS was also essential to make VHC involve more in health activities apart from providing travel cost.
Community-based financing intervention for MNCH was successful in villages with functioning VHCs. Although there were three funding mechanisms, basically seed fund was given by Save the Children to VHCs, it was divided into two parts—revolving fund and emergency health fund. The original concept of revolving fund to provide some portion to emergency health fund became unclear when JIMNCH made replenishment for emergency health fund. Most VHCs intended to practice this concept if Save the Children or JI-MNCH project phase out in their areas. Very few respondents mentioned about development fund. For the sustainability and obtaining ownership of community, contribution of community for VHC fund was suggested by most key informants. Some discussed to link revolving fund with livelihood activities for the sustainability. For the sustainability of VHCs, four main factors were identified by respondents--

- Unity of members
- Gaining trust of villagers
- Having mutual respect between leaders and members
- Having transparency and accountability

In conclusion, VHC eventually engaged in emergency referral mechanism for MNCH. However challenges of capacity building, monitoring, logistics, accountability and strengthening health systems needed to be addressed by the implementing partner (Save the Children) and the public health sector. The main lessons learned were empowering community, combined with strong linkage with public health sector which demonstrates the benefit of community involvement in emergency referral mechanism. The success and advantage of VHC for community-based emergency referral comes from its ability to mobilize communities to take the responsibility; and strong coordination among public health sector, VHCs and implementing partner at all levels.

In the light of above findings the following recommendations were drawn:

1. **Maintaining strong linkage with government or public health sector and Village Health Committee (VHCs)**
2. **Building Capacity of VHCs for leadership, team building and management; and capacity of Basic Health Staff for community mobilization and development**
3. **Strengthening health systems with facility and human resources**
   a. To equip station hospital with full facility and skillful staff to manage emergency cases at station level
   b. To build up clinical and management skills and attitude of BHS and volunteers at sub-centre or village level.

4. **Conducting VHC meetings at village level and encouraging to share information among VHC members**

5. **Maintaining emergency health fund**
   a. Raising awareness of community for importance of emergency health fund
   b. Encouraging VHCs to contribute some portion of interest from revolving fund to emergency health fund
   c. Promoting contribution of community for funding of VHC
   d. Advocating local donors for contribution of emergency health fund at station hospital
   e. Developing strategy for poor migrant population to access health services in case of emergency
INTRODUCTION
Introduction

In Myanmar, 23.35% of population is women of reproductive age and 11.7% are under 5 children\(^1\). Implementation of maternal, newborn, child health and reproductive health care are priority areas in National Health Plan (2006-2011)\(^{(2)}\). General objective of Maternal, Newborn and Child Health (MNCH) is to provide quality health care services for women and children to reduce under 5 mortality and maternal mortality ratio in Myanmar. Therefore, focus activities of maternal health are improving emergency obstetric care, strengthening referral system, community education and involvement and integration with other services and partnership\(^{(3)}\). Under strengthening referral system, community health volunteers working as a bridge between service providers and community; and emergency transportation in collaboration with community-based organizations were included. Improve maternal health and reduce child mortality are two health related goals in Millennium Development Goals.

Previous studies conducted on emergency obstetric care (EmOC) mostly focused on access to and utilization of EmOC\(^{(4,5)}\) barriers to Ante Natal care (ANC) and safe deliveries\(^{(6,7)}\). According to available literature, there is little study on role of community based organization in emergency referral mechanism.

The Save the Children (SC) is implementing the JIMNCH (Joint Initiative on Maternal, Newborn and Child Health) Project in Nga Pu Daw Township, Ayeyarwaddy Region. The JIMNCH programme includes a community –based referral that will seek to improve access to maternal and child health care services. In 2008, after Cyclone Nargis, Save the Children implemented packages of health care to support the recovery of previously existing healthcare services in Nga Pu Daw Township which includes setting up village health committee (VHC) and providing village health funds for emergency referral of maternal and child health\(^{(8)}\). In addition, Save the Children facilitated fund management trainings for all village leaders, cashiers and accountants who were handling these village health funds. Village health committees were provided a cash distribution of 240,000 Kyats each as seed fund. Cash was disbursed and managed into two portions: 40,000 Kyats for health emergencies and 200,000 Kyats for community contributions for revolving funds. (See Annex 1 for criteria and supports for emergency referral).
Future perspectives of referral for maternal and child health care is strengthening of referral system through existing community empowerment (3). Thus, it is necessary to explore existing community-based referral mechanism and role of village health committee in order to provide necessary information for future planning of MDGs.

General Objective
To describe roles of village health committee in community-based emergency referral mechanism for maternal and child health care services in middle island, Nga Pu Daw Township

Specific Objectives
1. to explore existing community-based emergency referral mechanism for maternal, newborn and child health problems
2. to find out barriers for emergency referral mechanism for maternal, newborn and child health problems
3. to analyze community-based financing interventions for maternal, newborn and child health problems
4. to elicit opinions and suggestions of community and health care providers on village health committee and community-based referral mechanism for maternal, newborn and child health problems
Methodology

Study design: It was a cross-sectional study by using both qualitative and quantitative methods.

Study population
Women of ages 30-45 years from low socio economic condition, Public health staff from Station Hospital, Rural Health centers and Sub-centers in the study areas were included. Station Medical Officer (SMO), Lady Health Visitor (LHV) Health Assistant (HA) and Midwife (MW).

Key person from Save the Children
Key person from Village Health Committee

Study area
Six villages in Middle Island, Nga Pu Daw Township were included namely TakhonDaing, Tha Yet Kone, Thapayay Ngu-2, Sar Kone, Thayet Taw and Mae Zali Kone villages.

Middle island map showing 6 study villages
Sampling and sample size

Selection criteria for villages:

Selection of villages was based on functioning or non-functioning status of Village Health Committees. There are 3 different fund mechanisms (US Appeal-2, USAID and JI-MNCH). Deviant sampling of villages was applied i.e. most well functioning and most problematic (non-functioning) villages were included in the study. Two villages (one functioning and one non-functioning village) under same fund mechanism were selected. Thus, three villages which have functioning VHC and 3 villages which have non-functioning VHC were selected.

Functioning and non-functioning VHC were defined based on the following criteria:

- Presence of referred cases
- Maintenance of VHC funding
- Conducting regular meetings
Sample size

Record review: Referral records and register book at VHC were reviewed for 3 years from all 125 villages of Middle Island.

Focus Group Discussion (FGD) One FGD was conducted with women of reproductive age in each village. One FGD with VHC members from functioning villages was carried out. Thus total 6 FGDs with women and three FGDs with VHC members were conducted.

Key informant interviews (KII): There were 18 key informants including five Public Health staff (SMO, HA, MW), four key persons from VHC (leader and cashier/accountant), five Voluntary Health Workers (AMW/CHW) and four focal person from Save the Children National Office and SC field staff.

In depth interviews (IDIs): Women, either mother of under 5 children or women who had experience of emergency referral for emergency obstetric care (EmOC) or Emergency Child Care (ECC) within six months from each village are involved for IDIs. Total of 12 IDIs were conducted.

Data collection methods

Record review: Referral records and register book at VHC were reviewed for 3 years (2010, 2011, 2012) from all 125 villages of Middle Island to estimate number of referral, type of referred cases and functioning status of VHCs. (See Annex 2 for example of referral letter and format of referral register)

Informal group discussion and Social mapping was conducted with community key informants to identify social group differences and women who obtained support for emergency referral in each village. (See Annex 3 for Social maps)
Key-informant interviews (KIIls): Eighteen KIIls with key persons from Station Hospital, Rural Health Centre, Village Health Committee and Save the Children were conducted.

In depth interviews (IDIs)

Total of 12 IDIs were conducted with mother of under 5 children or mother who had experience of emergency referral for obstetric care.
Focus Group Discussions (FGDs): One FGD with community members (women of 30-45 years age) was conducted in each village to explore their opinion and suggestion on access to emergency maternal and child health care services.

Data processing and analysis
Descriptive analysis was carried out for quantitative data from record review. Indicators for referral mechanism were measured as number of referred cases for maternal and child emergencies. Qualitative data from KII s, IDIs and FGDs were transcribed and analyzed according to main themes and sub-themes by using ATLAS ti version 6.0 software. There are five code families, 45 codes, 278 quotations.
Triangulation

Methodological triangulation
Findings from different data collection methods (KII, IDIs and FGDs) were triangulated to ensure validity.

Researcher triangulation
Qualitative data were analyzed by using ATLAS ti software. Thus coding and interpretations of data could be carried out by principal investigator and co-investigators and validated. Research team composed of researchers, service providers from DOH and SC. Interpretation and drawing conclusion of data was conducted by discussion with all team members to reduce possible bias.

Limitation of the study
Two KIIIs cannot be conducted (one MW and one VHC leader refused to participate). Study population did not include public health staff from Regional level. However, the main aim of this study is to describe emergency referral mechanism and this referral mechanism focused on Station Hospital as referred centre. Study population included all dimensions of referral mechanism i.e. BHS and public health staff from Station Hospitals; SC staff, community members (women) and VHC members to obtain reliable and valid data. Public health staff (both currently working staff as well as the staff who had worked there during the project and now transferred to other place) from two Station Hospitals were included in the study. Moreover SC staffs not only from national Office but also from SC Field Office were included in KIIIs. Thus it will enhance to capture the holistic views and valid information.
FINDINGS
Findings

Village Health Committee

Formation of Village Health Committee

Almost all respondents stated that VHCs were formed after the Cyclone Nargis. However there are only few who mentioned that there was existence of VHCs before the Cyclone Nargis and Save the Children (SC) provided necessary support to revitalize VHCs. They also said that there was no funding support for VHC before SC initiated their projects in the areas. Some respondents could recall their memory of when VHC was formed as 2008. According to the key informant interviews with Save the Children staff, SC revitalized VHC by providing necessary support and facilitating. Save the Children add two new posts—accountant and cashier—in original structure of VHC when they provided funding support. In villages where USAID projects provided funding, formation of VHC was not linked with public health sector. At that time, Voluntary Health Workers (VHW) such as Auxiliary Midwife and/or Community Health Workers (CHWs) was included in VHC or Village Health team (VHT).

Village Health Committee—that is revitalized. Actually VHC was already in government structure for every village. Chair is local authority, secretary is BHS. That was there. What we (SC) do is revitalize VHCs by holding meetings and facilitate to discuss issues monthly. Main thing is to attend most people to such meetings. Meeting could not be held for each and every village. So it was done for village tract.

(KII with SC staff-1)
One Health Assistant (HA) from village that was funded by USAID described revitalization of VHC as follows:

VHC...When USAID phased out, Save the Children started PONREPP project and at that time there was revolving fund and emergency fund. At the time of USAID, we have only heard about emergency referral fund. But government health staff was not informed about it and they (SC staff) never consult us. So we know nothing. When PONREPP started, SC tried to continue its’ unfinished painting. Then they hand over all their revolving fund and VHCs to us to take responsibility. Before they join us, our VHC had no fund.

(KII with BHS-3)
Structure of VHC and Selection of members and leaders

Structure of VHC

Generally, all VHCs had leader, secretary, 2 members, interested person or local or informal leader (See Annex 5 for structure of VHC from DOH Manual). When SC revitalized existing structure of VHC, they create 2 posts—casher and accountant—because they provide funding to VHC. One key informant from SC described how they facilitate the existing structure of VHC with their trained Voluntary Health Workers (VHWs) as follows:

There were usually 5 people in VHC: Leader/Chair, Secretary, 2 members and the last one is person who is interested in health activities. That is Number 5. For Number 3 and 4, local NGOs like Red Cross or MMCWA. That was original structure. We did not make any change. That structure was appointed according to posts. Leader must be chair of local authority, secretary is BHS. So what we can do is number 5 position...informal leaders (Yat mi yat Pha). Then we discussed with MW to select one who is helping her. He or she may be male or female; old or young; even not getting along well with local authority but support MW.

မှားရွယ်ချက်များ၌ မိဖုန်းများ၊ ဝါးကျင့်ရာ၊ မော်ရှင်း၊ အစိုးရသူများနှင့် မစေျးစွာရှိနေပါသည်။ MMCWA ကို အခန်းကို စတုတ်နိုင်မည်။ အစိုးရသူများနှင့် ပတ်သက်ရန် အစိုးရသူများ စီစဉ်ပါသည်။ သီချင်ချင်သူဆိုလျော်သော ကြိုးစားသူများကို အစိုးရသူများ အစိုးရသူများနှင့် ပတ်သက်ရန် အစိုးရသူများ စီစဉ်ပါသည်။ သီချင်ချင်သူဆိုလျော်သော ကြိုးစားသူများကို အစိုးရသူများ အစိုးရသူများနှင့် ပတ်သက်ရန် အစိုးရသူများ စီစဉ်ပါသည်။ သီချင်ချင်သူဆိုလျော်သော ကြိုးစားသူများကို အစိုးရသူများ အစိုးရသူများနှင့် ပတ်သက်ရန် အစိုးရသူများ စီစဉ်ပါသည်။ Informatively

communication မှားရွယ်ချက်များ၌ မိဖုန်းများ၊ ဝါးကျင့်ရာ၊ မော်ရှင်း၊ အစိုးရသူများနှင့် မစေျးစွာရှိနေပါသည်။ MMCWA ကို အခန်းကို စတုတ်နိုင်မည်။ အစိုးရသူများနှင့် ပတ်သက်ရန် အစိုးရသူများ စီစဉ်ပါသည်။ သီချင်ချင်သူဆိုလျော်သော ကြိုးစားသူများကို အစိုးရသူများ အစိုးရသူများနှင့် ပတ်သက်ရန် အစိုးရသူများ စီစဉ်ပါသည်။ သီချင်ချင်သူဆိုလျော်သော ကြိုးစားသူများကို အစိုးရသူများ အစိုးရသူများနှင့် ပတ်သက်ရန် အစိုးရသူများ စီစဉ်ပါသည်။
According to findings of record review from 125 villages, number of VHC members was 4 to 22 (median=10)

**Selection of members and leaders**
Selection of members and leaders for VHC was done by conducting and facilitating mass meetings in each village. Focus Group Discussions with community also revealed that they involved in the process of VHC formation. Some mentioned the selection of leader, secretary, accountant and cashier was mainly based on voting system.

For Mass meeting, all were invited. In one village, for selection of volunteer, MW and local authority had different views. Then at the mass meeting, we told the criteria to select the person. One from each house hold attended the meeting. So we asked questions to all, who should be that post/volunteer. There was discussion among villagers. The respective person was also asked whether he/she can do. I cold not attend the meeting. But I’ve heard that community selected the one whom was not proposed by MW nor local authority. But both parties agreed. That community is quite strong.

(KII with SC staff -1)
The following is the extract of how cashier and accountant were selected:

There was no post for cashier and accountant in previous structure of VHC. When we provide fund, those posts are essential. So we need to create 2 posts when we give see fund. We select them at mass meeting. We describe nature of job and job description such as to manage fund. We also proposed some criteria such as honest, resident in village, have certain level of education and help Mid Wife.

(KII with SC staff-1)

One of the members of VHC also described selection criteria especially for accountant and cashier. She also convinced that selection was done by community.
Accountant must be skillful to handle account and cashier also needs to be able to manage money; they should also have interest and could spare sometimes to do these tasks. So for the selection, there was discussion with villagers. It was not done by one's decision. He/she must be acceptable by the community.

Awareness of community on VHC
Almost all respondents mentioned that all villagers know about VHC. However, when exploring in-depth, few respondents were confused VHC with other Community-based organizations (CBOs) for health and organizations for micro financing. In some villages (especially villages which received funding support from USAID) there are small CBOs which also implement health related activities like mother group, water and sanitation group, nutrition group and child group. The following are the excerpts of FGD with mothers described VHC activities and IDI with mother who confused activities of VHC and activities of Nutrition group.

Participant 1, 5, 8:., Providing loans for children’s health
Participant 9: Give emergency transportation cost, (cost for hiring boat) for poor. Also give oral and injection contraception.
Participant 1 & 9: We know that. Also building latrines to prevent diarrhea. (FGD with mothers- Village 1)

Question: Have you heard about Village Health Committee?
Answer: Yes
Question: What do they do?
Answer: For under 5 years children, they provide nutrition.
Question: How?
Answer: They give 3 food groups; they also demonstrate cooking and feed children.
Question: How many children were fed at that time?
Answer: About 50. (IDI with Mother-1)

(IDI with Mother-1)

One SC-staff also pointed out many CBOs made community confused and some may not know VHC specifically:

One confusing issue is that for some villages, there is only one group so they know well. For some, there is for example a microfinance group organized by PACT, other groups like Nutrition group and the likes. Most community knows that the group was organized by Save the Children but some don't. What they know is AMW and CHW in most villages. (KII with SC Field staff-1)
Delay due to lack of knowledge, Delay in reaching health care and then even reaching health centre, not getting service. For all those, we focus on reaching the health centre. So we support referral mechanism/pathway to cut off delay in reaching health centre. First, we defined emergency. (KII with SC staff-1)

KIIIs with BHS also revealed that they preferred this coordinative approach and cutting off first delay is very beneficial and supportive.

Before SC started the project, VHC had no fund. When they came, there was fund. They hand over both fund and trained persons to us. I like that. Because if we can cut off first delay, it is very good. That’s why I like this and trying hard to support this (VHC activities.) (KII with BHS-3)
Some community members also knew objectives of VHC as to provide necessary support for emergency referral for pregnant mothers and under 5 children.

Q: What are the objectives of forming VHC?
A: Mainly is for under 5 children and pregnant women; not included for elderly. To improve health knowledge and self-care.
(KII with Voluntary Health Worker-2)

Participant 6: This group is for referring under 5 children and mothers in case of emergency
Participant 4 & 5: To help them when necessary
Participant 2: To arrange transportation
Participant 3: It was said that for pregnant women and under 5 children. They give loans if necessary and also conduct health meetings.
(FGD-2 with mothers)

**Capacity building and Training for VHC**
When asking about capacity building or training for VHC, majority of respondents mentioned about book keeping training. Different trainings spelled out by the participants were as follows:
- Book keeping training
- Leadership training
- Volunteer training (especially AMW training)
- Livelihood training
- Training on health related topic such as reproductive health, Contraception methods, nutrition, water and sanitation

Among all trainings, bookkeeping training was mentioned by most VHC members. SC staff described how they provide the trainings as follows:

We give bookkeeping training for cashier and accountant for 2 days at the monastery. We asked VHC members from villages to gather there and there were about 25-30 people. We teach. We have training curriculum. Main principle is doing exercises and we teach in Myanmar. For bookkeeping training, here were 3 people (cashier, accountant and local authority) from one VHC attended.

One of the respondents who attended the bookkeeping training recalled her memory as follows:

They told us how to withdraw money, how to open account by showing records. Mainly is for accountant if there was errors, he/she has to reimburse. So it is more important to make it clear and systematically.

According to the key informant interviews with Save the Children staff, SC initiated community-based health programme with funding supports from US Appeal-2. At that time, village health teams were
formed in project villages and there were training for volunteers called Community Case Management Promoter (CCMP). Such trainings were not linked with public health sector. However, the majority of CCMP became AMWs and CHWs later. Village Health Teams (VHT) also became VHC in later stage with funding support from JI-MNCH. With JI-MNCH, SC provides financial support such as per-diem and logistics for AMW training and Public Health Sector provides technical guidance. Although previous projects were not coordinated with government/public health sector, concept of JI-MNCH is to support Health Systems and link with public health sector.

What is emergency? and then “how we’d support?” Who will take the lead for this mechanism?, what is our (SC) role? What about role of Township Health Department and Station Health Unit or Station Hospital? All such issues were mentioned in PONREPP proposal. In PONREEP project, leadership is government and Township Health Department. We (SC) will support and facilitate. That was the first concept. How we implement such concept? That is Joint Township Health Plan (JTHP); in other words, Coordinated Township Health Plan (CTHP). (KII with SC Staff-1)

Emergency နေထိုင်ပြီးနောက် အစိုးရသို့ support ရွေးချယ်ရာ ကျင်းပသော များ ဗားများ ဆောင်ရွက်သူများ Business ကြီးမားသော အချက်အလက်များ ပြောင်းလဲသော အချက်အလက်များ Township Health Department နှင့် Station Health Unit က ဗားများ ဆောင်ရွက်သော အချက်အလက်များ PONREPP ကျင်းပသော များ ရွေးချယ်ရာ ဗားများ leadership နှင့် အစိုးရ ဆောင်ရွက်သော အချက်အလက်များ Township Health Department နှင့် Station Health Unit က ဗားများ ဆောင်ရွက်သော အချက်အလက်များ Facilitate တိုးတက်စေရာ ဗားများ လိုက်လာသော ကျက်စိုး ကျင်းပသော များ concept ချောင်း တိုးတက်စေရာ တိုးတက်စေရာ Joint Township Health Plan ကျင်းပသော များ အပေါ် ကျင်းပသော များ Coordinated Township Health Plan ကျင်းပသော များ (KII with SC Staff-1)
The following excerpt shows role of SC for supporting volunteers training:

For AMW training, we requested TMO to do need assessment with MWs i.e. how many AMW or CHW is necessary to trained for which villages. Both refresher training and initial training included. For refresher training, it is for functioning AMW. They we told that we have so and so amount of budget to support refresher training and how many people MWs wish to train or nominate. We facilitate MWs by raising questions such as why she wishes to select this AMW, what would be the expected outcome or benefit after giving training for her, how she will support MW. Then if it is all Okay, she can be said as functioning AMW. For training, DOH is taking leading role for technical support. (KII SC Staff-2)

Providing initial financial support for VHC
Majority of respondents expressed about getting funding support from SC when they described about formation of VHC. Most knew about revolving fund and emergency health fund. The amount and
mechanism for providing initial fund varies according to different funding sources or project such as US appeal-2, USAID, JI-MNCH.

**Responsibilities and activities of VHC**

When exploring about responsibilities of VHC leaders and core members, most respondents could tell about functions of accountant and cashier. Some said that there was job description spelled out in the documents that they received during the training. However, most VHC members could not mentioned specifically about that. Few show the written document in their note book when asking about this. For non-functioning villages, some members were newly appointed and few even did not know about their job description or responsibility clearly.

One secretary states as follows:

Q: What are the responsibilities of secretary?
A: Nothing special; just discussion and there was not much problems or issues.

Q: What about cashier and accountant?
A: To reimburse money once a month with interest money. Then giving loans again and making records. Three are 100 households and so it is complicated. (KII with secretary of VHC-2).

One SC staff also stated that there was no specific job description for each member. Only brief description of committee’s role and responsibility was there. The main two functions or roles are to manage village fund and to support referral.

Almost all community participants knew about giving loan money and providing referral support and support during hospitalization in
general as activities of VHC. There are some variations in amount and type of support for emergency referral and for hospitalization. Majority said transportation cost was provided free but a few said some amount of money was given as a loan without interest.

**Involvement or linking with public sector and local authority**
Although there was no linkage or coordination with public sector in US Appeal-2 and USAID projects, JI-MNCH directly coordinate well with public health sector. Both BHS and SC staff mentioned that at the beginning of JI-MNCH project, coordination between them has been done in all levels—regional level, township level and RHC and Sub-centre levels. Most key informants mentioned about Township Coordination meeting and Township Health Plan as an important activities.

One HA described the difference between USAID projects and PONREPP project for coordination with BHS.

*For USAID project, they did health related activities. So we wished them to let us know because we are health staff. But we know nothing. When I enquired, they did not like me. For example, latrines, it is very easy to provide latrines. But one household which already had it also took it. There was a household which had 3 latrines. Such thing is useless. When I did inspection, they thought that I intervened for their activities. But... For PONREPP project, they are just supporting us. I quite like it.*
PONREPP plan တည်ဆောက်ရွေးချယ်မှုသည် အသိပေးနေပါသည်။ အနိုင်ရင်းများသည် အသိပေးနေပါသည်။

One key informant from SC described how SC coordinate for emergency referral mechanism with public health sectors in all levels as follows:

We get along well at all levels—regional level and township level—and MWs for emergency referral process. Because before referral mechanism started, we have a meeting with BHS. If we would decentralize referral pathway, we wish patient to go to accessible referral centre to make them easy. For Middle Island, Township Hospital is in Lapputa. If we refer to Lapputa Township Hospital, there are a lot of difficulties...no one can go there by boat...that river is like a sea! Because of those difficulties, no one goes to Lapputa if BHS referred there. So...according to the needs and opinion of community and BHS, station hospital would be the best place to refer. According to existing facility at station hospital, Medical Supreident also agreed to do so i.e. Station Hospitals as referral centre for Middle Island.

Level ကျင်းပါသည် emergency referral ရှေ့ဆောင်ရွက်မှုများ process တွင် BHS meeting တွင် referral mechanism ဖော်ပြထားသည်။ BHS အတွက် referral path way ကို decentralize ဖော်ပြထားသည်။ community အပေါ် access သုံးပြုသော referral center သည် အမှန်တကယ်အရ referral path way ကို ယူဆောင်မှုလေးများမှာ middle island ကို refer တွင် Township Hospital emergency refer အပေါ်ကြောင်း အပေါ်ကြောင်း ရင်းသားသည် အနေဖြင့် အပေါ်ကြောင်း BHS အား refer တွင် အပေါ်ကြောင်း community အပေါ်ကြောင်း refer တွင် Station Hospital အပေါ်ကြောင်း facility အပေါ်ကြောင်း Township မှ MS အတွက် agree တွင် Middle Island သည် refer သို့ Sation Hospital အပေါ်ကြောင်း အပေါ်ကြောင်း
Community-based financing intervention for MNCH Funding Mechanism of VHC
There were three funding sources-USAID fund, US Appeal 2 Fund and JIMNCH Fund. Although USAID and AU Appeal 2 fund initiated in different areas of Middle Island in different periods, JI-MNCH provided all areas in Middle Island in 2009. (See Annex 4 for Fund Matrix)

Figure 1: Map of Middle Island showing 3 funding mechanism
There were three types of fund—revolving fund, emergency health fund and development fund. Seed fund was provided by Save the Children which was divided into revolving fund and emergency health fund. Among 125 villages in Middle Island Area, Nga Pu Daw Township, 10 villages (8%) had no activities for revolving fund. (See Annex 4 for Fund Matrix)

Seed Fund

Majority of community respondents knew that SC gave fund to VHC in the initial stage. However, most did not know the amount of fund given. According to the respondents, total amount of fund given as seed fund varied from 100,000 kyats to 300,000 kyats. Findings from record review of 125 villages in Middle Island showed that Save the Children gave seed fund ranging from 145,000 kyats to 2,888,847 kyats with the median of 300000 kyats.

Respondents also knew that there were two types of fund—revolving fund and emergency health fund. None of the community respondents and public health staff key informants mentioned about development fund although key informants interview with some SC staff mentioned that there was some amount of fund for development.

For US Appeal-2 and USAID project, there was contribution of community for VHC fund. For US Appeal-2 project, community were mobilized to donate fund from households and SC provided about 100,000 kyats which was equivalent to 100 or 125 US$.

Figure 2: Presence of Community contribution for funding of VHC (n=125 villages)
As shown in Figure 2, contribution of community for VHC fund was found in 49 villages (39%) out of 125 villages. Total contributed fund from village was ranged from 3,300 kyats to 320,000 kyats (mean=37,000 kyats, median 22,900 kyats). Types of contribution were voluntary 58.5%, membership 40% and fixed amount per household 1.5%.

Save the Children staff described how they mobilized community contribution as follows:

*There is a group in village. So we provide training first and then funding. We facilitated like “Don’t you think it is better if you have fund for this group (VHC), how much you can get (from villagers); how much the village will contribute; that must not be compulsory but voluntary donation. We do not fix the amount. Then there was a commitment to get certain amount. We will also give training and support. Let’s try...how long it will take? Then we could confirm the date. Well...we will provide something we said. Then we brought money and when we saw collected money from village, we mixed it with ours.*
USAID project initiated funding for VHC by collecting small amount from mothers/women. One household or one mother had to contribute about 200 kyats to become a member and then member have to save 200 kyats 2 weekly. Benefit of getting support for referral i.e. travel cost were given as loan to those who contributed fees regularly. In 2009, JI-MNCH project started and provided about 100,000 kyats as seed fund for VHCs. According to interviews with all respondents, there was no community contribution for the fund. Seed fund was divided into two portions—revolving fund and emergency health fund.

Mass meeting for village was held on 14th January 2009 (looking at note book) at 1 pm. After formation of the committee (VHC), 100,000 kyats was given to Health Committee in April 2009. We spared 20,000 kyats for emergency health fund and remaining 80,000 kyats for revolving and we started work. (KII with cashier of VHC-2)
**Emergency Health Fund**

When providing seed fund, some portion of it was given as emergency health fund mainly to support for emergency referral. According to key informant interviews with SC staff, with USAID project, some percentage of interest from revolving fund had to be put into emergency health fund. For USAID project, travel cost was given as a loan without interest. However, when JI-MNCH project started, travel cost was provided free and emergency health fund of VHC was reimbursed by SC. Thus there was no contribution from revolving fund to emergency health fund in all study villages. Findings from FGDs with community and VHC members also showed that none of them put any percentage of interest from revolving fund to emergency health fund because it was not necessary.

KII with SC staff pointed out pros and cons of replenishment for emergency fund:

*That can be said as good thing as well as bad thing of JI-MNCH. It always reimburse emergency health fund. We have fund to support some number of patients for emergency for a year. So when VHC referred one, we reimburse that cost to VHC. With JI-MNCH, no need to return travel cost. It was given to patient. But for USAID, travel cost was given as a loan and it had to return back. For JI-MNCH or PONREPP, there were two portions—one is revolving and another one is emergency fund. For emergency fund if it was used, there was replenishment.* (KII with SC staff-1)
Findings from record review of 125 villages showed that all VHCs put interest from revolving into revolving fund. About 58 (46.4%) VHCs returned 100% of interest, 48 (38.4%) VHCs returned 50% of interest and the rest of VHCs returned (60% - 80%) of interest to revolving fund.

For emergency health fund, 76 (60.8%) VHCs did not save it from revolving. Among 49 VHCs which saved emergency health fund, 23 VHC saved 30% of interest, 25 VHCs saved 50% and one VHC saved 40% of interest for emergency health fund. (See Figure:4)
Revolving Fund

The most discussed issue of VHC was about revolving fund. Almost all respondents knew there was a fund given to VHC to revolve. Key informants from SC stated that original aim of providing revolving fund was to contribute emergency health fund and sustainability of VHC. However, majority of respondents including VHC leaders could not tell exactly about the main aim of revolving fund. Although majority mentioned that it aimed to raise fund of VHC they did not talked about contribution of interest from revolving fund to emergency health fund. Few respondents stated that they knew some portion or percentage of revolving fund interest had to be given for emergency health fund. However they did not know how many percentage and they did not practice that because SC reimbursed the emergency health fund.

Question: How are you replenishing emergency health fund?
Answer: Meanwhile, SC reimburses. But if they (SC) leave, we will reimburse from revolving fund.

Question: How many percentage of revolving fund has to be given for emergency health fund?
Answer: Some portion was defined but I can’t remember.

One key informant stated that “The aim of revolving fund was targeting the poor. But when people could not return loan and main objective was to contribute referral fund from revolving, there was change of criteria for giving loans—second criteria is to give loans for those who could return money.”
The system for giving loans varied according to villages. Most VHCs gave loans to number of villagers/households and amount of money given to individual depended on the amount of total revolving fund available. If the fund was not enough to give all households, most usually applied lottery method. Some VHC also applied Group-based Credit Program (waing-gyee-choke)".  (လက်နှစ်လုံးပါ)  i.e. 5 people as a group had to guarantee to return loans; if someone absent to return, the rest 4 had to pay for him/her. For functioning VHC in which there was enough revolving fund, all household took loans and some took it just to contribute interest for their VHC. One AMW (secretary of VHC) stated—

Previously, few households took loan. Later, all households took it. Some people actually did not need to borrow. But they took loan for few months because they wished to contribute for health committee (VHC). It is like donation. Interest would become more if more people took loans. Although they do not need money, they take loans. That means they are donating. They took loan although they do not need because interest is for health and for our village development.

Duration for taking loans also varied from one month to three months. Usually the interest money had to give monthly and both interest and loan money had to return after three months.
The day on which VHC collected loan and interest was known as “Ngwe-Pone” day (Ngwe=money; Pone=dump) which literally means dumping money. FGD with mothers described this event as follows:

Participant 3, 4, 5, 7: We have everyone there. Few were late; meeting at about 1 pm, 2 pm.
Participant 4: No misuse of fund. This village is working for development.
Participant 2: Interest was given monthly and 3 monthly, both interest and loan money was returned.
Participant 4, 10: At the end of month, we will dump money (Ngwe Pone)
Participant 2: It will be 1st March.
Participant 8: We did it at local authority’s house.
Participant 1, 7, 8&9: There was hosting with snacks on that day.
Participant 10: Rules and regulation for returning loans were told.
Participant 8: Collect both interest and loan and then give loan again. It is not given to one who did not follow rules.
Participant 1: The amount of remaining fund was also informed to all.

စကြာသူ ရှိသော်လည်း အခြေခံသော်လည်း ကျန်စွဲစွဲထားသောအချက်တွေကို အခမဲလေ့လာခဲ့ပါသည်။
စကြာသူ ၅− အသောက်ရှေးရှေးချောင်း သို့မဟုတ်အသောက်ရှေးရှေးချောင်းထားသည်။
စကြာသူ ၇− သို့မဟုတ်လိုအပ်ချက်တွေကို စွဲကြေညစ်သူများကို ကိုးကွယ်ပါသည်။
စကြာသူ ၁၀− အသောက်ရှေးရှေးချောင်းထားသည်။
Development Fund

Key informant interviews with SC staff mentioned that there were three types of fund (Revolving fund, emergency health fund and development fund). However, none of the respondents from VHCs, BHSs and community knew about development fund. According to key informant interviews, for USAID projects, there was a concept of development fund and linkage with livelihood. Although most community did not tell about development fund, one HA mentioned about it.

There is Interest for education. Thirty percent of revolving fund is interest for education. The remaining (i.e. 70%) is given to revolve. The percentage for each is decided by them (VHCs) since USAID project started. There were rules and regulations. If we wish to know, we have to read (their record). Like that.

During FGD with VHC members, they also mentioned that some amount of fund has been used for development.
We used this fund for maintenance of lanes. You can see electric cables. Health Committee called business man. In our village, 3,000 kyats was given for lighting one bulb; 12,000 kyats for using Television. So we gave 718,000 kyats to man form the fund without interest for 5 months. Then we only need to give 2000 kyats for lightening and 6,000 kyats for Television per month. Previously village has to give more than 200,000 kyats per month. Now it is cheaper. (FGD with VHC-2)

Record review of 125 villages showed 99 VHCs did not save for development fund. About 25 VHCs saved 20% of interest from revolving for development fund and one VHC saved 40%.

**Problems for Fund management**
The most common problem of VHC was related to revolving fund. Non functioning VHCs could not collect revolving fund after giving loans. There was conflicts between VHC and villagers especially in non-functioning VHCs. Weakness in accountability and transparency for fund management was also observed such as accountant was not informed about the fund balance and how it was used or issued by a cashier. It was also found that there was no hard and fast rule for not returning loans. When there was a problem, SC took facilitating role and few BHS took the lead to solve the problem. Strong VHC also tackled the problem by itself.

The most common problem is not returning loans. About 30% of cases mostly are postponing the date to return money. Previously there was no rule for such cases. Then VHC decided to wait such cases till 6 months. If it is not retuned after 6 months, they would take
some action. In one village, that was emergency case for child but the child died. Such case could not return loan money. So VHC asked that person to work for school i.e. to reimburse loan money by providing labors. That decision was made by VHC and it is okay.  
(KII with SC staff 1)

Funding status of VHCs
Among 125 villages, the amount of fund for each category of fund (i.e. revolving fund, emergency health fund and development fund) varied. However the highest amount was for revolving fund. Total amount of current revolving fund in 125 villages was 42,000 kyats to 3,054,000 kyats (mean=768,578). Emergency health fund was 2250 kyats to 419870 kyats (mean=98605, median=82400, mode=90000). For 25 villages which had development fund, it ranged from 15245 kyats to 279190 kyats (median=121270).

Opinion on Fund Management

No reimbursement

Some respondents pointed out that it would be better if there is no reimbursement for emergency health fund from SC. They also discussed some advantages of “no reimbursement” as
- referred person would screen the emergency cases properly before referral
- having more ownership and responsibility by the community

For the sustainability, it is better if there is no reimbursement. Replenishment is not sustained. If there is no reimbursement, community or referred person will screen the emergency case properly. The way of thinking technically would be different. Even if there is no Mid Wife; even AMW or CHW knows how much fund remains in village. So he or she will think carefully whether it needs to refer or not. If we (Save the Children) reimburse, he or she may not think so carefully but refer whenever doubtful.

Sustainability အခြေအဝါမှာ သတ်မှတ်ပေးသော လုပ်ငန်းများအားလုံးကို စိုးရိုးသင် သုံးစွဲသော community မှ အကြီးအမှတ်အရာများကို အထူးအချက်အချက် မှန်ကန်သော screen ထုတ်ကျင်မှု မရှိသေးဘဲ technical လုပ်ငန်းများအားလုံးကို စိုးရိုးသင် သုံးစွဲသော MW မရှိသေးဘဲ အကြီးအမှတ်မှာ မှန်ကန်သော (မှန်ကန်သောအချက်အချက်ကို) သတ်မှတ်သောကောင်းမှု အရှိုက် အကြီးအမှတ်ကို မသိရှိသေးဘဲ ပြုလုပ်သင်ရာတွင် မှန်ကန်သော Sustainability အစွမ်းအရေးများကို ပြုလုပ်သင်ရာတွင် မှန်ကန်သော သတ်မှတ်ပေးသော လုပ်ငန်းများကို ဖော်ပြသင်ရာတွင် ၊ ပြုလုပ်လျော်စွာ အကြီးအမှတ်ကို အနေဖြင့် သတ်မှတ်သော Sustainability အစွမ်းအရေးများကို ဖော်ပြသင်ရာတွင် မှန်ကန်သော Community contribution

For obtaining better ownership of VHC fund, some respondent especially key informants suggested to get contribution from the community.

At present, there is donor, it would be better if village contribute. Other people are helping. So, local people should provide some inputs for their village. Then they would value more. If they get it (fund) from outside, they may not appreciate much.
Livelihoods

A few key informants pointed out that livelihood were important for sustainability of VHC fund. One key informant discussed the phases of the project as follows:

*We do not need to reimburse when they (VHCs) can stand with their livelihood. This plan is a continuation of post Nargis which is immediate after disaster when everything was collapsed. At that time, we support. After that period, we should go development phase. Now PONREEP concept is still in relief phase.*

Livelihood ယောင်းလိုက်သည် ပါဝင်သည်ပေါ်ထွေးသည်သူငယ်ကြောင့်
လိုက်သည် ပါဝင်သည်ပေါ်ထွေးသည်သူငယ်ကြောင့် အထူး plan သင်္ဘောဒီယို post
လိုက်သည်ပေါ်ထွေးသည် ပါဝင်သည်ပေါ်ထွေးသည်သူငယ်ကြောင့် အထူး immediate after disaster ဗား
လိုက်သည်ပေါ်ထွေး collapse စိတ်ချစ်သောသူငယ်ကြောင့် လိုက်သည်ပေါ်ထွေး support ဗား
လိုက်သည်ပေါ်ထွေး immediate after disaster ဗား collapse စိတ်ချစ်သောသူငယ်ကြောင့်
လိုက်သည်ပေါ်ထွေး support ဗား period စိတ်ချစ်သော development phase စိတ်ချစ်သော အထူး PONREEP
လိုက်သည်ပေါ်ထွေး Relief phase စိတ်ချစ်သော

Loan without interest

When asking about how VHC should run if there is no support from donors, majority of respondents said that they would give loan without interest for 2 or 3 months in case of emergency health problems instead of giving travel cost.
Emergency Referral for EmOC and ECC

Figure 5: Number of EmOC and ECCs in 125 villages for three years (2010-2012)

As shown in Figure 5, number of EmOC and ECC increased over three years. Findings from social mapping showed that referral supports was benefited to the poor who are in need. (See Annex 3 for Social maps)

How community tackle Emergency referral before the formation of VHC/ before the Cyclone Nargis

Before having VHC with funding support from SC, most community collected donations from village household in case of emergency referral to support especially for the poor. There was no pool fund for any kind of health emergency. All respondents stated that having emergency health fund in-hand is better rather than collecting donations when emergency referral is necessary.

Question: What are the differences of health status for under 5 children and pregnant mothers now and previously?
Answer: Much difference. Rural people now know well. Previously they deliver with traditional birth attendant and now they don’t. They have health knowledge. If child was ill, they know where to go; for pregnancy, what are the danger signs, what will happen if vitamin B 1 deficient. Health talk was given once when people gathered for immunization. Previously we have to call or ask. Now no need to call them. (KII with AMW)
Participant 2: We are thankful to SC. We’re depressed after the Cyclone Nargis. Now we’re encouraged and our knowledge as well as living standard was developed.
Participant 3: Health status was changed. Previously there was dump of faces; now there was none.
Participant 7: 6: Previously there was no latrine so people went into bushes (to defecate).
Participant 3: Some people did in the field. We found trouble when we raised our cows in the field.
Participant 7: Now my children wash their hands with soap.
Participant 8: Children also gained knowledge.
(FGD with VHC-3)
Awareness of Emergency Referral Support

Almost all respondents from FGDs knew about there was a fund to support emergency referral for pregnant women and under 5 children. Few even knew what the emergency health conditions are. Most of them said they’ve been informed about this at mass meeting during which at least one person from each household attended.

All: Everyone in the village knows there was health fund.
Participant 4: Health fund must not be given as loans but keep to give loans for pregnant mother and under 5 children if necessary.
Participant 2, 4: Another fund is for giving loan with 3% interest rate.
Participant 6.7: That day, interests were given and gave loan of 20,000 kyats for villagers who won lottery.
(FGD-3 with mothers)

(ချင်း) - မိဖုရားများနှင့်သီးခြားဖြစ်သောအချက်ကို ကြေညာ
(က) - မိဖုရားများနှင့်သီးခြားဖြစ်သောအချက်ကို ကြေညာ
          အချက်ကို ကြေညာ
          သင့်သူများကို ကြေညာ
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          မိဖုရားများနှင့်သီးခြားဖြစ်သောအချက်ကို ကြေညာ
          သင့်သူများကို ကြေညာ

One key informant from SC pointed out that few poor people may not be aware of such support because they were struggling for their daily living.

To be honest, when I was there, there was no fund. For example, people lives in the periphery of village may not aware about that (support for emergency referral) because they are busy with their livings. I suppose about one third would know.
(KII with SC Field staff-1)
**Definition of Emergency**

Majority of community participants could tell major symptoms for emergency referral. The most common symptoms spelled out by the respondents are as follows:

**For pregnant women**
- Life threatening conditions
- Difficult labor
- Excessive bleeding during delivery or after delivery
- Sticky placenta (retained placenta)

**For under 5 children**
- Fits
- High fever
- Severe diarrhea

The following is the discussion with mothers from village-2.

*It (support) is entitled only for under 5 children. Even one day older than 5 years cannot get it. Even for under 5 children, travel cost is given in case of emergency. Not for minor illness but for real emergency. Emergency means pregnant mother who could not deliver easily; Dengue Hemorrhagic Fever in children especially in rainy season; severe loose motion, fever with fits…* (FGD-4 with mothers)
There were some variations in criteria and types of support for emergency referral according to three different funding mechanisms. For USAID project areas, most respondents said that support for emergency referral is like lone money but it was not necessary to give interest. It gave priority for the poor. For JI-MNCH, transportation cost for emergency referral was given free to any emergency cases either rich or poor. Almost all key informants (both SC staff and BHS) mentioned that emergency conditions for pregnant mothers and under 5 children were defined by public health staff.

Decision makers for emergency referral
When exploring about who made the decision to refer, most key informants stated that BHS (MW or LHV). However some convinced that Voluntary Health Workers (AMW or CHW) should be able to decide in case there is no MW. Few pointed out that there were many variations in defining emergency according to knowledge and experience of referred person. One key informant from SC and BHS indicated that it was more important not to miss emergency case rather than over diagnosis or over referral of emergency cases.

We cannot set specific criteria (for emergency) because we’re afraid of missing real emergency. For example, Mid Wife saw chest in drawing of child but she’s doubtful for respiratory rate and then missed to diagnose severe pneumonia. I am so worried such thing would happen. So I taught danger signs to AMWs and CHWs. I also requested Save the Children ... in rainy season, there are about 4 hard-to-reach villages in my area. They have to walk at least 4 hours to reach me. In that case, during raining season, if they (AMW or CHW) diagnose emergency, it should be regarded as emergency. And I request to provide travel allowance for such cases. The only thing is to get to hospital. (KII with HA)

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Two schools of thoughts
Providing referral supports for all socio-economic strata has two schools of thoughts. Majority of community respondents and few providers (SC staff and BHS) stated that it was good to provide both rich and poor. However, some key informants expressed that priority should be targeted to the poor. For both views there were reasons or explanations behind.

The followings are the expressions of participants who agreed to give support for both socio-economic strata:

Village health fund was for pregnant women and under 5 children in case of emergency. If it is emergency, either rich or poor can get it. In our village, there is no rich, most are hand-to-mouth workers, mostly odd jobs; manual labors, vendors…no other livelihood such as fishing nor working in salt fields. (IDI with mother-5)

When we first given fund management training, it was told that this fund can be used for either rich or poor. But it must be life threatening and emergency. Some are poor but not emergency case. So Mid Wife did not want to refer. But they wished to go to hospital. Such
problems occur. So…it is entitled for both rich and poor but it must be life threatening emergency condition. Emergency must be diagnosed by Mid Wife. That’s it. (KII with SC Field staff-1)

The contradictory views of key informant expressed as follows by giving the reasons that if there is not enough funding from outside, there should be certain criteria for support:

It is good for the time being when supports are available. But when it stops, we need to set certain criteria. That’s my opinion. If it is given free, everyone wants to get whether rich or poor. I named it as “Dependency Syndrome” after the Cyclone Nargis. Even for 100 kyats, rich people also wish to get it. So..while NGO is here, they support and not a problem. But when they (NGO) leave, we need to set up criteria. For example, in villages, there are 4 strata. Stratum (1) is manual workers, (3) is “well-to-do” who possesses lands; (4) is very rich people..like that. I suppose to give stratum (1) and (2). But we need to consider carefully. Decision must be made by a group of people but not by oneself.
Another key informant argued how to define poor and rich. Therefore, he prefers to follow strictly to the law or specific guidelines to provide any emergency EmOC and ECC cases: 

*It is hard to measure rich or poor. Another thing is laws do not usually consider feeling. Law is systematic and straightforward. Whether rich or poor, one can get support if it is emergency, If it is not emergency, there is no support. Law will not consider rich and poor. That is personal issue. That needs to be explained to people. We are also responsible to explain public but actually, that is the responsibility of political sector. (KII with BHS-4)*
Referral Process
The first contact for emergency conditions was BHS or AMW or CHW. All community respondents knew that they have to take referral letter from BHS to get referral support and support during hospitalization. Few respondents stated that they informed local authority first and then BHS or VHW. Almost all respondents convinced that there was an improvement for emergency referral mechanism after formation of VHC. Most BHS also mentioned that utilization of public health service was also increased.

Figure 6: Referral Letter, Referral register and MCH Handbook

Figure 7: Referral Process for EmOC and ECC
First level Referral centre
All respondents stated that referral centers were two Station Hospitals. The decision for referred centre was made during coordination meeting with SC and Public Health Staff in the initial stage of JI-MNCH project. The main reasons for selecting Station Hospital were more accessible from villages and capacity and skill of public health staff to manage emergency cases.

For referral, it must be able to do operative procedure for emergency cases there. Medical Officer (MO), SMO (Station Medical Officer) must be there. Two centers (two Station Hospitals in Middle Island) have well-trained staff, two SMOs can operate. That’s why 1st level referral centre becomes station hospital. At that meeting (Township coordination meeting), SMOs were also present. (KII with SC Staff-1)

Supports
There are three types of supports—support for referral, support during hospitalization and other supports for MNCH. One key informant described supports aimed to demolish two delays:

We have identified the centre. How will we support? Then sayagyi (Township Medical Officer) said to discuss with two SMOs. We aimed to demolish two delays in referral pathway—transportation delay and delay for getting medicine at the centre. To reach the health centre, we need to demolish transportation delay. That’s not a problem. We used strengths of community-based. (KII with SC staff-1)
Some requirements or criteria for getting referral support are mainly related to taking care from public health sector. The followings are the criteria mentioned by the respondents:

Having at least 4 AN visits with MW
Referral must be from BHS or VHW countersigned by BHS
Having Referral letter from MW
Figure 8: Pamphlet informing about emergency referral

One BHS described criteria for getting support at hospital as follows:

*It (Support at hospital) is given to either rich or poor, it must be emergency. In record, at least took 4 AN visits. I gave this pamphlet (showing the pamphlet) to patient when hospitalized. I gave it when they discharged to show others so that people would also know.*

*အပင်း ဗိုင်းအတွက်လိုဟာ အချင်းချင်းတောင်းခွဲ ရက် AN care ရှိသေးသည်။ ကျွန်တော်ကြား အချင်းချင်းတောင်းခွဲရက် AN care ရှိသေးသည်။ ကျွန်တော်ကြား အချင်းချင်းတောင်းခွဲရက် AN care ရှိသေးသည်။ ကျွန်တော်ကြား အချင်းချင်းတောင်းခွဲရက် AN care ရှိသေးသည်။

One key informant pointed out essential role of BHS for referral process and especially for getting support:

*I encountered one case who came to me directly; not through Mid Wife. We did not give support. VHC also came along but I could not*
give and asked them to make own arrangement. We took care but there was no referral support, no meal cost. Then they said they would put up this case to higher level. I told them to do as they wished. We are dealing with many people so Law is Law. We cannot consider individually.

Another public staff also expressed similar case:

Some are not get along well with Mid Wife so they did not wish to go there. Then they came to me. I know it is emergency case. But it did not come through routine channel. I cannot give (support) even I am sympathetic.

Referral Support
Providing transportation cost is the main support for emergency referral by VHC. It was paid from emergency health fund of VHC. According to IDIs with mothers, Majority stated that they took referral letter signed by MW to VHC leader/cashier and then got the transportation cost. The cost was defined according to types of vehicle, mode of travel and distance from station hospital to referred village. The transportation cost ranged from 2,000 to 10,000 kyats. Modes of travel were by trishaw, by motor cycle, and by boat. SC donated a fiber boat for some health centre to be used in case of emergency referral.
For cycle carry, it costs 2,000 kyats; by boat it is 5,000 kyats. Transportation cost is given only when referral letter with my signature was shown. I cannot inform all members in case of emergency but inform leader and get his signature. I also come along with patient. Referral letter was given by SC; one part has to be taken and one part is kept for record.

(KII with AMW-2)

One HA said that there is another referral form/letter developed by her to monitor VHC activities.

Apart from SC Referral letter, I have my own form (showing her refer form) with my stamp. Patient cannot take transportation cost without this form. I made it to be uniform for all villages. When we visited to their villages to check fund, those forms must be there. For example, when I visit one village, in my record there were 2 referred cases and there should be 2 referred forms. Then 4000 kyats was used. I also record in my stock book when I refer. So...I know whether this village needs money (emergency health fund) even though I did not go there.
The following is the scenario highlighting essentials of referral support to cut off first delay:

*When we ask patient to go to hospital, travel cost was not in hand for most people. Then there would be first delay; we cannot overcome the first delay. With emergency fund, we can provide it and make patient to reach hospital.* (KII with HA-2)
The was a child case... very severe pneumonia. His history showed that his mother delivered with severe PE with fits. So he had high risk of getting pneumonia. They arrived to my house at 10:20 am. I examined thoroughly and decided to refer. I am not so sure whether they will get support at hospital. I can give travel cost. So I asked them to find some money. Then... patient came back at 3:30 pm! I was searching for them in village round and round. They gave their address as 8 ward but actually it was not correct. They lived in 18 ward. I was looking for them by motorcycle in village but not found. I was worried. Initial dosages were already given. When I asked VHC whether they came to get money, no one can tell exactly. Finally they came and said they could not go because they have to find some money. Fortunately we did not loose the child. Otherwise, there would be a case of child dead. For emergency, MO will take necessary action if the patient reach the hospital, he will not ignore. So I wish to give TA (Travel Allowance) for patient. If we can give TA, we can order patient firmly to go to hospital. "Well I arranged this (TA) for you and so go to hospital straight away by boat without any delay" like that...
Support at Hospital
Mainly patients got all medical costs for free of charge and meal cost for patient (2000 kyats per day) during hospitalization. Previously, meal cost was provided for both patient and for one attendant. However, later, it was cut off and only meal cost for patient was provided. For the accountability, patient or attendant had to sign the form to certify that they got such support.

I know after 2 days that for meal cost and for one attendant, we got 3500 kyats per day. Then for operation and other cost, we do not need to pay. Besides, we got meal cost. I had to stay in hospital for 14 days. Others stayed for a week. I stayed 14-15 days because of high blood pressure. Meal cost was not for 14 days but for 7 days. The rest was spent by us.

(IDI with women who underwent emergency LSCS)
There were some forms to be used for referral and for receiving support at hospital. Some documents such as AN card and Home Based Maternal Record (HBMR) were necessary as an evidence of taking AN care to get supports. In early phase of the project, recommendation from local authority for residence was also necessary. Some documents were used for accountability of financial management.

There was a form to be signed by SMO as witness. Another form called “Without voucher” for consumable items. We also tell the patient how much cost for medicine and that is the meal cost... There were two budget lines—one is medicine cost was given to Saya Gyi; all medicine are FOC (free of charge) for you and another line is meal cost for patient, 2000 kyats. (KII with SC Field staff -1)

(KII with SC Field staff -1)

Receipt for Cash Payment  
(IF official receipt is not available)

<table>
<thead>
<tr>
<th>Sr.</th>
<th>Detailed Description of Service &amp; work, etc</th>
<th>Accounts Code</th>
<th>SOF</th>
<th>Project</th>
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Total

Paid By: Name: Signature & Date

Received by: Name: Signature & Date

Figure 9: without voucher form from Save the Children
For support at hospital, all community respondents from FGDs and IDIs stated that medical cost are free of charge and some said there was support for meal cost for both patient and one attendant. Some said that in later period, there was no meal cost for attendant. Most community thought that reduction of meal cost for attendant was due to reduced funding support. However, one key informant from SC explained the scenario as follows:

Later there was no meal cost for attendant. It was not because we have reduced funding but because...we change our idea. Few people especially who have no earning wants to be hospitalized because they want meal cost. Such amount of money i.e. 4000 kyats per day is more than their daily wages. So such people asked BHS to refer them as emergency case to stay at the hospital and get 4000 kyats per day. So...we decided to pay only for the patient i.e. 2000 kyats for meal cost. Before we control meal costs for attendant, there were many cases in hospital especially more ECC (Emergency Child Case) than EmOC (Emergency Obstetric Cases). (KII with SC field staff-1)

One mother stated that she did not get support for attendant when she was hospitalized because of less funding from donor.

When I was hospitalized, we did not receive any support for attendant. I think it was the time when there was less funding from donors. The one from our area who underwent CS for twins, she got supports. At that time, there was support and funding from organization. Medicine cost for children...all were free including 2000 kyats per day for attendant too. (IDI with mother)

Cost incurred by patients
Although most costs were provided, few costs were incurred by patients during hospitalization such as travel cost and meal cost for family members and loss of income for family members who attend the patients. However most respondents said those costs were trivial and not much burden for them.
We did not cost for anything during hospitalization. It was enough for food if we contented. We spent about 15000 kyats for travel cost of family members to and fro between hospital and home to take clothing. It costs 700 kyats by motor cycle including return. Then for buying cheroots, washing soaps, thanakha...like that. (IDI with mother-2)

During hospitalization, family members are sitting and spending money. They cannot work for earning. There was no income. My husband attended me and we have children at home so spent some for their food etc. Then it cost about 40000 to 50000 kyats. (IDI with mother-7)

Other supports for MNCH
Other supports for MNCH are support for special AN visits; support for home delivery with skilled birth attendants; support for training of AMWs and CHWs, supports for RHC and sub-centre meetings, VHC meetings and township coordination meetings.

Support for special AN visit
Save the Children provides supports for special AAN visit in hard-to-reach areas. Supports mainly include transportation and per-dieum
for MWs to conduct special AN visits. Majority of BHS appreciated such support and mentioned that it was effective to carry out their activities especially in hard-to-reach areas.

They (SC) are supporting us such as providing TA and perdiem for BHS. Previously, we did without any support. But when they provide supports, we can do twice instead of once. We’re encouraged. For special AN, we can reach” hard-to-reach” areas. If we have to go there with our own expense, we can go only once, you know. When they support us, we can go there twice as necessary. (KII with HA-1)

Support for home delivery with skilled birth attendants
For home delivery, SC provides Clean Delivery Kit (CDK) and newborn kit. Majority of respondents from IDIs said they got newborn kit. However, few said they did not receive.

Participant 2: For pregnant women, when they deliver, they get “a packet”
Participant 6: It is given only to those who deliver with Sayama (MW)
Participant 2: One blanket, one tower, 5 “Ah- hnee” (piece of cloth to wrap baby), 2 tops and 2 hats; 2 sets of gloves and stockings, a soap...
Participant 5: Now I do not have all at home. Most were used. Only few piece of cloths and tower is used.
(FGD-6 with mothers)
Clean Delivery Kit (CDK) was given by SC. It includes gloves, blade, soaps etc. CDKs were given to MWs and sometimes to AMW. MW gave it to pregnant mothers only one month prior to due date. She also told the pregnant women to use CDK even if she would not be delivered by MW. MW also asked patient not to open this package but keep it at home.

Most key informants viewed that support for VHC meetings, sub-centre and RHC meetings and township coordination meetings enhanced better coordination and strengthen the health systems. Save the Children provides Travel Allowance (TA) and per-diem for such meetings. SC staff also attended the meetings and took supporting or facilitating roles.
One SC staff elicited how SC supports the meetings.

For MNCH, according to activities, there are township level activity, RHC level and Sub-centre level. For township level, township coordination meetings and monthly BHS meetings are supported by SC. (KII with SC staff-1)

Barriers/Problems for Emergency Referral mechanism
Most common problems were spelled out more from providers (BHS, SC staff) sides than beneficiaries. Majority described definition of emergency varied according to experience and knowledge of the person who made decision to refer. Sometimes initial treatment given masked the emergency condition when patient reached to station hospital. Some key informants pointed out supports created unnecessary or over demand from community and may lead to dependency. Thus there were few scenario of referring non-emergency cases by BHS. Another important point made by few key informants was attitude of BHS who referred the emergency case was crucial. According to them, MW or AMW or CHW had to have good attitude to serve the community. There was a problem if MW was not getting along well with her community or if MW had poor attitude. Most key informants—both public health staff and SC staff—pointed out that there must be functioning public health system to make this referral pathway effective.

The followings are the excerpts of KIIIs regarding initial treatment masked emergency conditions:

Sometimes, for pneumonia, we diagnosed it as severe pneumonia and gave initial dosages. Sometimes it took 3-4 hours on the way.
Then...when the child reached the hospital, there was no chest-indrawing. Such case was diagnosed as emergency at my place and no emergency when reaching the hospital. I always noted the time when I see patient. Maybe patient reached to hospital after 6 hours. We would like to provide TA if we diagnosed as emergency case whether MOs diagnosed it as emergency or not. (KII with BHS-2)

One SMO also agreed that defining emergency was complicated for some cases.
When I looked at the child, he was okay. For e.g. Beri beri. When BHS referred Beri Beri case to hospital after injecting Vitamin B 1. So patient was fine when I saw him. If I defined it as emergency, it may not good for organization. If I did not give support at hospital, patient would not satisfy. Patient was told that he will be hospitalized and get support for meals etc. Then when he reaches the hospital, I cannot give support. For such case, I enroll in OPD and put under observation and return home. I had to spend treatment cost from my pocket but patient did not get meal cost. Then they were unhappy.
Some key informants pointed out that well functioning public health system was crucial for smoothness of referral pathway. The followings are the worst scenarios of defect in public health sector as narrated by some key informants:

"No refer" and "More refer"
Some junior staff is not getting along well with community. Then they did not refer a case because he/she did not like the patient. Such patient came to me with complaint saying that MW did not refer. When I examine and did USG at hospital it was a post date case. So it needs to be referred. But I cannot order MW to refer. Because decision has to be made by MW. So I told patient to ask MW whether she will take responsibility if there was something wrong because she did not refer. If she says yes, to get her signature to take responsibility. Some referral cases reached hospital after that.
The following is the scenario of “More refer”

Later, there was problem with referral. HA or MW referring many cases without having any risk to me. There was one area which sends many referrals. So I have to take action. If I let such cases hospitalized, organization will misunderstand me. So...I cannot give and asked them to return home because they were not emergency.

How to reach un-reached?
Almost all respondents convinced that supports from VHC and JI-MNCH project are beneficial for the poor and reached the target population—poorest of the poor. However, few key informants indicated that it was necessary to do something for the poor migrant population. They are the ones who might not aware of the supports or services and who were not accessible for routine health services such as regular AN care. According to the requirement to get support, one has to take at least 4 AN visits. Thus for migrant population, if they did not receive 4 AN visits, they could not get benefits for emergency referral. One key informant described such problems as follows:

Such people do not have time to seek ANC even for 4 times. Because Salt mall owners do not allow them to come or they are busy with works, etc. We should do something for such migrants. They are struggling for their day-to-day living and so they could not come for AN care. If there is no AN care for 4 times, in case of emergency, they cannot get any support. (KII with SC Field staff-1)
Success, challenges and sustainability

Success indicators

Basically there are indicators related to fund management and indicators related to VHC activities. According to respondents, followings are identified as indicator for success of VHC:

Indicators for success of VHC

Fund management
Maintaining seed fund
Having more fund for VHC
Returning loan money regularly by VHC members
Following rules and regulation for taking loan money

VHC activities
Stability of VHC leaders and members
Maintaining Unity of VHC members
Attending regular meetings
Actively participating of most members for VHC activities
Coordinating well with public health staff

There was no loss of fund yet. I haven’t heard. So at present, I think it (VHC) is successful. Anyone can take loans but there should be trustful person. If borrower cannot return, he/she has to reimburse the loan. I did not hear that loans were lost. If I hear like that I would regard that VHC is not successful. (KII with BHS-2)
For health activities, there is no village that does not help us. We have very limited man power. For some cases, we have to rely on them (VHC). Only one ward is weak...weak leader who cannot take the lead; not so interested in others except his business. For such ward, I go there to organize. Then it is okay. But if other staff goes, it does not smooth. The rest areas, all are actively take part in any health activities. All want to attend the (VHC) meeting so we have to reduce number of invitees to half.

Health service

One BHS described some points to consider as indicators of success for VHCs.

In my opinion, number 1 is physically and quantitatively, there was a fund given to them; how they utilized it and make more fund, how systematic etc. Another point is that what are the activities of VHC, how about the structure and members; whether structure is stable/persistent or changing frequently...If there was frequent change, it may have some issues or problems. Another thing is how they view towards DOH and INGO. That is qualitative part. Their perceptions, feeling, how coordinate or collaborate with us...
One key informant expressed that success of VHC did not depend on economic conditions of village. He described factors for success of VHC was good attitude and strong leadership of BHS; and commitment of community/villagers.

Some BHS are only interested in technical or clinical issues; no interest in management and mobilization. Some are very interested in mobilization and development concept. Success of VHC is not because of the village is wealthy; not because BHS can mobilize…it depends on strong commitment of villagers; they follow rules and regulation; and BHS has good attitude. These two point are the key. If BHS is good, it is better and village fund are more supportive for health activities. (KII with SC staff-1)
Figure 12: Map of Middle Island showing functioning status of VHCs in 125 villages
Figure 13: Functioning Status of VHC (n=125 VHCs)

Functioning status of VHCs were categorized according to the following criteria and scoring. As shown in Figure 13, 48 villages (38.4%) were in Status “A” and 77 villages (61.6%) were in Status “B” among 125 VHCs.

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Increase in amount of Revolving Fund</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Certain amount of Interest contribution to Emergency Health Fund</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Support Referral Cases in 2010, 2011, 2012</td>
<td>2</td>
</tr>
</tbody>
</table>

Functioning status A = score 6

Functioning status B < score 6

**Significant changes (before and after formation of VHC)**

Almost all respondents mentioned that there were significant changes after formation of VHC in their villages. The most common evidence for change was improved referral mechanism and increased health service utilization. More institutional deliveries, more deliveries with skilled birth attendants, improved health knowledge and behavior, and better collaboration of community with health service providers were
also observed.

There were more institutional deliveries and hospital deliveries because of supports. Those who were not referred for emergency previously get emergency referral service now. Government health service utilization is improved. And another thing is communities rely on MWs more. If MW or AMW refer a case, it can get support at hospital. So... MW can work for health service more confidently. Previously even MW referred patient, patient had to go there with her own expense and had to rent accommodation etc. So even MW referred, patients did not go because they could not afford, they had no money. Now community trust MW and MW can also guarantee patient to get all FOC there (hospital). So patient follows MW’s advice. (KII with SC staff2)

Support does not mean institution delivery because the community health service utilization is improved. Government health service utilization is improved. MW refer even emergency refer another hospitals in the community. MW refer AMW and refer. Every patient support even MW. MW can work for health service with confidence. All the communities refer MW. MW refer another hospitals in the community. All the communities refer MW. MW refer another hospitals in the community. All the communities refer MW. FOC community. (KII with SC staff2)

According to IDIs with mothers and FGDs with community, all convinced that there was an improvement after formation of VHCs.

Before Cyclone Nargis, it was hard. After Nargis, health committee has fund and supports. So it is very supportive for the poor and also for rich. In our village, most are poor. In the past, there were cases who died in labour because she could not afford to go to hospital.
Monitoring and evaluation of VHCs
Monitoring of VHCs was mainly carried out by SC filed staff and few public health staff. It was conducted during VHC meetings quarterly. Previously with US Appeal-2 Fund Project, Out Reach Workers or Project Assistants of SC visited to the villages and compiled data. However, with JI-MNCH, monitoring of VHC activities and fund management was done at VHC meetings. BHS were also present at VHC meetings and thus they were also informed about VHCs under their coverage villages. Among 125 villages, 96 (76.8%) VHCs conducted quarterly meetings.

There were two main records (Records of referral cases and record for revolving fund) with each VHCs. According to document review of 125 villages, about 113 (90.4%) VHCs had meeting records. Although SC field staff did not made monthly visits to VHCs as a routine, they visited to selected villages which had some problems. They could identify problematic villages at VHC meetings. When they visited to such village, they talked to villagers and listened to their voices about respective VHCs.

One key informant said that she visited to some villages and listen to the community about VHCs:

Some villages, VHC members attended the meeting but not sharing information to villagers. In that case, when I arrived to such village, I talked to the villagers whether they know such information or not. If they could not tell exactly, it is sure that VHC did not share information. So I told about that case at next VHC meetings. Then VHC shared information and later, most villagers got information.

(KII with SC field staff-2)
We cannot go to every village. What we do monitoring is at VHC meeting where cashier and accountant attend. We check the records that they bring to the meetings especially for cash withdrawal and reimbursement. If the data is not so reliable, then I noted such village and visit. For one village, the problem is that wife and daughter of local authority misused the revolving fund. (KII with SC Field staff-1)

One BHC elicited how she monitored funding of VHCs by forming a steering committee over 20 VHCs. The patron of that committee is influential person who is interested in health and social welfare of community and leaders of 20 VHCs become members.

There is a Steering committee over VHCs to monitor funding and not to misuse the fund. Patron is the elderly man who is influential to all. He is not local authority but he is interested in “pa-ya-hi-ta” and social welfare activities and influential to all. The leaders of 20 VHCs become members of Steering committee. (KII with BHS-2)
VHC meeting
There were two levels of meetings for VHC. One was VHC meetings for all villages under one sub-centre. Another was VHC meeting in each village.

**VHC meeting at Sub-centre level**
VHC meetings were conducted quarterly according to sub-centers wise. Previously 5 from each VHC were invited. However, after 2012, only 3 were invited due to budget constraints. SC provided travel cost and meal cost for each participant. If there were more interested VHC members, they were allowed to attend with their own expense. The most common topics discussed at VHC meetings were criteria for getting referral support, revolving fund and sometimes complaints on BHS. SC staff facilitated the discussions. BHS and VHWs also took this opportunity to get some data and local authority to deliver some information to the community. The duration of meeting was about one to three hours depends on number of VHCs, number of participants and issues discussed.

At VHC meeting, MW also conveys some message to community for example head counts and population census. AMW, CHW and local authority also attend. So local authority also discuss sometimes. The most common topics are related to revolving fund and referral.

(KII with SC Field staff-2)
VHC meeting at each village level

According to key informants and interviews with VHC members, VHC meeting among all members in each village was not conducted regularly. When asking about such meeting, in functioning villages, monthly or two monthly or three monthly meetings were carried out mainly for management of revolving fund and loans. Frequency of village level VHC meetings were depended on duration or time frame to return loan money. Thus issues discussed at village level VHC meeting were related to revolving fund only. At the meeting, loan money were returned, interest were collected and giving loan to members again.

“Ngwe-pone” day (dumping money day)....25th of December at AMW’s hosue. VHCs and yat-mi-yat-pha (local leaders) attended. There was discussion about fund. We dump money in December and give loans to villagers on 10th January. It is necessary to dump/show loan money as well as interest. Loan is 40000 kyats for one person. I also took loan. (KII with VHC leader-3)

Participant 3: at 3 month, both interest and loans were collected
Participant 4: Then there is a meeting and give loans. If there is new one who wishes to borrow, he can get it.
Participant 3: at the meeting, new comers need to stand up.
Participant 5: At that time, all come.
Participant 3: at 3 month, the house was full. Money was put in a pot.
Participant 5: We can see lump sum.
(FGD with VHC-4)
**Recording of VHC meetings**

Key informants from SC stated that there was meeting minutes or notes for some VHC meetings. Recording was mainly done by SC field staff (Project Assistant). For only few VHC meetings which held at RHCs, some BHS noted down the discussion points. One key informant pointed out that recording of VHC meetings was weak and they were not asked to do recording.

*The weakness of us is there is no specific instruction to record or note the discussion of VHC meetings.* (KII with SC Field staff-1)

**Challenges/ VHC problems**

The main challenge of VHC was related to fund management, coordination among VHC members and problems for referral.

**Challenges for Fund management** includes concept and objective of revolving fund is not clear. There was no Job opportunity and no income generation. The concept of saving for health emergency was unclear and no specific guidelines for health fund.

The most problematic issue was revolving fund in some villages; most villagers did not return loan money. Majority could only give interest but not loan money. Thus there was less amount of revolving fund. Some respondents mentioned that migrant people did not return loan and left the village without notice. Therefore, fund was lost. Some VHC members shared their concerns and difficulties as most were unhappy with them when they ask villagers to return loan money. The following is the excerpt of FGD with VHC:

Participant 2: They (villagers) thought that is not our money. That is their or village fund. So we cannot force them to return. That’s why we
found it difficult to ask them.
Participant 1: We were misunderstood by majority.
Participant 3: They said we are asking them to return money though it is not ours.

One key informant stated how she tried to solve above problems by attending VHC meeting and facilitate.
Some people especially VHC members and local authority or informal leaders; they said SC has gone and no need to return loan money. When we heard such news, we go to that village on “money collection day” and tell that SC is still present. (KII with SC Field staff-1)

One BHS narrated the story of loss of VHC fund and how she found out the case.

In one village, cashier misused the money and told that was stolen. When we open the iron box (box with 3 keys to keep money inside), there was no money in it. I have to trace the case, who took the key and returned it etc. After collecting all facts, I can see that she must be the one. So I met her and asked her to admit before we had a village meeting. Then she admitted at the meeting and returned the money (45000 kyats). We dismissed her from VHC too.

Figure 14: Photo of Iron Box with 3 keys to keep money inside
Problems related to Emergency Health Fund

According to guidelines, some percentage of interest from revolving fund should be given to emergency health fund. However, some VHCs did not follow that guideline. Majority thought if they give it to emergency health fund, that money will not get any interest. And that’s why they did not wish to give it. One key informant described the problem of complex issue between revolving fund and emergency health fund as follows:

At that time, VHC members were not so happy with other side (casher of Emergency Health Fund). They did not want to give 50% of revolving interest money for emergency health fund. Thus they did not return the loan money. When I looked at them, it was obvious they can afford; wearing gold chains! VHC members said here and there. So… I told them that we will give one month to return money. If they could not return by then, we will take all seed fund. I also told that “image of your village will not so good. Other villages also follow the rules. Emergency health fund is essential to save lives. So if they do not have it, how they can go in case of emergency, are you going to die like that… After one month when I return there, they collected loan money but did not give 50% for emergency health fund. They wished to keep 100000 kyats as emergency fund and reimburse the amount used for emergency referral.
The following is the scenario of one VHC which did not return VHC fund after facilitation of SC staff. They misunderstood what SC staff talked about ownership.

I would say our people really do not wish to return money. Actually SC staff told that “those are your village fund. So it is only concern of VHC. SC is glad if fund is increased. And if there is fewer fund, we (SC) are sorry”. Then villagers perceived that is their own money and not belong to SC. they do not need to return instead of thinking how to improve or increase funding for the village.

Problems of coordination among VHC members
There was problem of coordination among VHC members especially in non-functioning VHCs. The most common problem is not sharing information among each other and no transparency for use of fund. One BHS also mentioned about loss of VHC fund and how she tackled it.

Participant 2: We as VHC members did not know anything about health issue.
Participant 4: Frankly speaking, we did not know about the training.
Participant 3: He (local authority/chair of VHC) is doing and deciding all by himself.
Participant 1: He asked me to give 15,000 kyats to attend training and I gave it.
Participant 2: When the organization (SC) came, they said it is not necessary to give money. SC provided the cost. But we know nothing about that.

Referral Problem and how it was solved
There was a problem for referring. Few BHS asked money about 20,000 kyats to write referral letter. At the hospital, meal cost was 4000 kyats per day which was not so bad. Therefore some patients wanted to attend hospital unnecessarily. Some MWs consult with VHC and did not refer if it is not emergency case. Sometimes there were conflicts between MW and community. One key informant stated that such issue of referral was discussed and solved at VHC meeting when SC staff facilitated.

At that time, there were some problems of referral letter and TA (Travel allowance). During DHF seasons, most parents are worried and wished to go to hospital. MW says “I will examine first and it is not necessary to go to hospital for having fever only, I will wait and see for 3 days by giving medicine. Some parents are not so happy and they complained. We discussed such issues at VHC meeting and solved. (KII with SC Field staff-2)

Concerns for retention of volunteers
Some key informants were concerned about recruitment of volunteers such as AMWs and CHWs. They pointed out that there was attrition of volunteers. They concerned whether volunteers would remain if SC do not support them.

Some of them are really brilliant. But as they are volunteers, they may not stay permanently in their villages for the seek of their living (i.e. they may also go somewhere to do paid work). So there is very few people remained. If they are not functioning in their village, then if VHC is actively functioning, it will not be a problem. But...if SC was not there, and if VHC members were not united and misuse fund, if no support for AMW or CHW....it is very concerned whether they can run
like previously. According to current situation, there is attrition of AMWs and CHWs. So I am quite concerned and worried. (KII with SC Field staff)

Sustainability
When describing about sustainability of VHC, all respondents wished to sustain VHC. They convinced that having VHC was very beneficial for their community especially for the poor. Both community and VHC members; and key informants concerned sustainability of VHC especially if there is no funding support from outside. However, functioning VHCs had confident that their VHCs will be sustained even though there is no funding support from outside. The most common factors mentioned by the respondents for sustainability are as follows:

Factors for sustainability
- Unity of members
- Gaining trust of villagers
- Having mutual respect between leaders and members
- Having transparency and accountability

For sustainability of VHC and success of VHC---we have to unite. For unity, members have to do correctly. Then they can gain trust by community. Leader is role model for following rules and regulation, showing transparency for fund management, sacrifice and having no bias etc. So he can influence others. (FGD with VHC-1)
Sustainability depends on VHC. If VHC can do with democratization and consensus, then it would be successful. There should be power balance; decision maker should not be only one person. Community and authority should be harmonized. Then there is counter checking mechanism. At few VHC meetings, we can see such dynamics—Administrative authority and community pointed out what are the MW needs and weaknesses. (KII with SC Staff-1)

The following is an evidence of empowering community to raise their voices:
Empowering Community: Voices of Community

In a village, pregnant woman wishes to deliver by normal delivery with Traditional birth Attendant. Then the community is very strong and urged her to deliver with Mid Wife. If so happen, service charges and medical cost would need to consider. So... village health team and community said “we will support this patient to go to Mid Wife from village health fund. That is to get service by MW. From other side (i.e. from MW), when providing services, it is necessary to mention how much it will cost for service fees. Such discussions took place at VHC meeting. At that time, community was asking and making their voices heard. Then MW also had to answer something. Community said that they understand there are some costs to buy medicine and etc. They will take patient to reach MW, and they asked MW to use such medicines and services for patient. They only need to know the minimum cost. It is necessary to define minimum cost for normal delivery with MW. For very poor cases, community and MW will share the cost. Community said that people are talking about variation of amount that MW charged in the village. So it is necessary to let them know the average amount of charges by MW for normal delivery. So that VHC can also advocate villagers and also for people moving in from other areas to save how much money for birth plan etc. So....such strong community asked how much MW will charge at the VHC meeting. In that way, community raised their voices.
Empowering Community: Voices of Community

The project aims to empower the community in rural areas to address health care issues. Community health teams, supported by a village health fund, provide medical services and support for health care. VHC meetings are held regularly to discuss and plan for the community's health needs. The minimum monthly wage for poor families is considered in planning health care services. Normal labour and maternity care are also considered. An advocate is appointed to ensure the community's rights are protected. Birth plan is an important part of community health care.
The Way Forward
All respondents agreed that VHC is necessary and beneficial. Suggestions of respondents can be categorized as follows:

- Mobilizing existing social group (e.g. For funeral services)
- Giving loan for Emergency Referral without interest for 2 months and Providing support for poor (criteria for poor needs to be defined)
- Providing Capacity building for VHCs (leadership, team building trainings)
- Making more emphasis on concept of Emergency Health Fund
- Having Steering committee for VHCs
- Developing specific strategy for migrant workers

*It is better and stable if we can apply insurance system at hospital. Donor money is not stable. There should be facilities provided by the government at hospital. If there is full facility at hospital and a system that link community and hospital directly, I think this referral mechanism would sustain.* (KII with BHS-7)

Another key informant pointed out the importance of policy and mechanism.

*Main thing to implement the insurance mechanism is having a policy to do so. Such policy should be developed by government/MOH and NGO to apply in region. If we cannot apply it for the whole country; we can start in one region. After developing policy, NGO could provide training, mobilization of community and other supports. Station hospital would be the smallest unit. All villages under the station hospital should give health insurance.*

(KII with SC staff-2)

Some respondents, especially key informants suggested encouraging community to contribute some amount of money for funding of VHC.

*It is necessary to change their (community’s) attitude. They should also initiate a little bit. If they do not involve anything but just depend...I don’t like that. I think the weakness of JI-MNCH is that. When there is more dependency, people do not wish to make any afford. If possible I prefer to save small amount of money monthly*
from each one as membership. (KII with SMO)

Capacity building and training of VHCs for leadership and team building and fund management are also important as mentioned by key informants. Few also suggested giving incentives for VHC which are very active. Incentives are not necessarily in terms of money but in kinds. One HA elicited how she motivated her VHWs as follows:

There should be some incentives or recognition of VHCs especially for very active ones. For example, I reward my AMW and CHW every year based on 16 criteria or scores developed by me. I noted such 16 points monthly and calculated the total scores and give award 2 AMWs and 2 CHWs who get highest marks annually. So they are motivated. I give medals which costs 3000 kyats. For “Best AMW” and “Best CHW” like that.

She also continued how she recognized VHCs...

In 2011, there was no DHF. Actually that area is high risk for DHF in 2009 and 2010. During 2011, we did lava control and there was no DHF. Then I announced at VHC meeting that there was no DHF in this area because of their activities. I recorded in meeting minutes
too. If we can give something to recognize them it is better. For example like certificate.

According to KII's with SC staff, SC provides some gifts as an incentive for volunteers such as bags, caps, rain coats, umbrellas.

**One logical concept proposed by key informant**

I have one equation which is very risky. We will define range. You can use this elsewhere if you wish. We have cost for medical care...including operation cost, medicine cost, for LSCS, transportation cost, everything. This range of cost for medical care is comfortable both for community and for doctor. And that range is fixed. We can also predict number of referred cases for one year. That is percentage of emergency case such as how many percentage of total under 5 children could be emergency. So two variables are now fixed. We only need to get one variable from revolving fund. At one point, if interest of revolving fund over seed to certain amount that can provide support for those two variables, support from outside would be stopped. That is logical concept. All programme would be stopped when interest can cover this cost (Excluding the investment money). But community +Township Health Department, we cannot delete this link or variable. If we can identify ceiling cost for community (for normal delivery with Mid Wife), we can do it. But...when we discussed this ceiling cost at regional meeting, one higher level staff censored that slide (from PowerPoint presentation).
He said Mid Wife must not take service charg, all Services must be provided free. (KII with SC staff)
If there is no support...

Majority of community and VHC members said that they would try to run VHC activities for emergency referral if there is no support from outside.

Participant 6: Running on our own feet
Question: What does that mean?
Participant 9: to reimburse by ourselves
Participant 8: That is not possible if the amount is large. In case of emergency, it is hard.
Participant 7: If there is no money, just waiting to die?
Participant 6: If there is no support (from outside) we should try to raise existing fund and help.
Participant 8: If there is no support from outside, in case of emergency, we would have to run with raised fund in future.

One key informant concerned whether community would go to health centre if there is no travel allowance from outside. She expressed her views as follows:

*I am concerned that if there is no travel allowance from us, whether they (community) would go. If there is no emergency health fund, no travel allowance, no one would go. Then there may be deaths due to un-affordability of travel cost in case of emergency. So we facilitate them to save 50% of revolving fund to emergency health fund. Now*
they do not practice that. But if we leave, they said they will spare 100000 kyats. Now they know the advantages and benefits (of emergency health fund). So they guarantee that they would reimburse it. I am glad to know that they will reimburse. It is better than no emergency fund. (KII with SC Field Staff-2)

Concerns and worries for migrant population in case of emergency...

Most key informants from public health sector and Save the Children expressed their concerns for poor migrant population in case of emergency. They are at risk of having emergency condition while they are not accessible to health services. Then they are not entitled to get referral support according to existing criteria as discussed under previous section. One BHS elicited her opinion of possible solution for the migrants:
Before NGO phases out, it’s better if they can invest some portion for migrant and let village know about it. For the village, it needs to consider some issues to monitor and control the fund. It may be something like before save the Children leave this area, to inform villagers that this revolving fund is given by SC and benefits can be shared for all i.e. not only for members but also for others (including migrants) in case of emergency.

Opinion for Pre payment system

Non functioning VHCs had positive views towards pre-payment system whereas functioning VHCs thought it was not necessary because they already had fund.

One key informant elicited his opinion for possibility of health insurance scheme in this area:

For insurance, NGO alone cannot do it. It is possible only when government lay down the policy. Before that policy comes, at least community should be acquainted with community-based financing. There must be contribution of community for the fund. They can also mange the fund and get used to the mechanism. If there is insurance scheme, people in this area know the concept and they also convince benefits of it for 2-3 years. For community, it (emergency health fund) benefits for emergency cases. So…when policy comes with insurance scheme, it is not necessary to mobilize such community much. If
community has some technical knowledge, it is more successful and faster to implement. (KII with SC staff-2)

Insurance အောက် INGO အစီသင်. ရွေးချယ်မှု. စိတ်ချောင်း. မောင်းပိုး အောက် policy ဥပဒေပါ. မောင်းပိုး. community-based financing ဥပဒေပါ. အခြေခံ ဆောင်ရွက်. contribution ပြုပြင်ရန်. fund မှ ချိန်မှာ manage ပြုပြင်ရန်. အဆောက်အဦတစ်ခု mechnism မှ. အောက်ပါ မောင်းပိုး insurance scheme ဥပဒေပါ. ကမ္ဘာ့ရောင်းချက်မှ သတိပေးချက်မှာ. အောက်ပါ အောက်ပါ. မောင်းပိုး. မောင်းပိုး စီစဉ်ပြုခြင်း. Fund သတိပေးချက်မှ အောက်ပါ စီစဉ်ပြုခြင်း. advantages အောက်ပါ. ရွေးချယ်မှု policy ပြုပြင်ခြင်း. insurance scheme ဥပဒေပါ. မောင်းပိုး mobilize အောက်ပါ စီစဉ်ပြုခြင်း. မောင်းပိုး စီစဉ်ပြုခြင်း. technical အောက်ပါ. မောင်းပိုး mobilize အောက်ပါ စီစဉ်ပြုခြင်း. technical အောက်ပါ.
DISCUSSION and CONCLUSION
Discussion

1. Existing community-based emergency referral mechanism for MNCH

Formation of VHC: Revitalization or newly initiatives?
Community-based emergency referral for MNCH was mainly based on Village Health Committee. In Township Health Committee handbook developed by Ministry of Health in 2010, organization structure and functions of Village Tract Health Committee (VTHC) was mentioned. However, it was not exactly the same as VHC which was formed in each village whereas for VTHC, one VTHC was formed for all villages under respective village tract. Although VTHC existed, it had no funding support and not functioning. After the Cyclone Nargis, when VHC was formed in each village, there was funding supports from SC with different funding sources (US Appeal-2, USAID and PONREPP/JI-MNCH). Then it became active and revitalized. There was addition of two posts—casher and accountant—into original structure of VTHC. The main aim of VHC was to support emergency referral mechanism for MNCH. Although job description of members for Village Health Team were spelled out in US Appeal-2 and USAID projects, majority of respondents did not know specific job description or roles and responsibilities of VHC members.

Working with the community and/or collaborating with public health sector?
In early phase of community-based projects funded by US Appeal-2 and USAID, there was weak coordination between Save the Children and public health sector. However, at that time, SC built capacities of volunteers and established community empowerment. With JI-MNCH project, SC took supporting and facilitating roles and leading role was given to government or public health sector. Much coordination at all levels was observed as one of the main strengths of JI-MNCH project.

2. Barriers for emergency referral mechanism for MNCH
There was no major barrier for emergency referral identified while Save the Children provides both transportation cost and medical and meal cost at hospital. However some of the criteria and definition of emergency may become barrier for getting support. Strong link with public health system for getting emergency referral supports was strength of the project. For example, one of the criteria for getting emergency referral support includes patient has to take four AN care with MW. On the other hand, for hard-to-reach population, such criteria might become a barrier; for example poor migrant population
could not take four AN visits and thus they were not entitled to get supports in case of emergency. For making emergency referral pathway alive, each and every part of the links in referral chain must be in place. If one of the components is defunct, the referral mechanism will be disintegrated. The study also highlights having strong public health system was a backbone of effective emergency referral mechanism even there were many supports from outside. The findings of CARE learning tour to Bangladesh pointed out that healthcare facilities—private or public—must be equipped with the appropriate level of human resources and technical capacity to provide adequate healthcare with access to a skilled health professional and a reliable referral system in place for emergency obstetric care services in the event of a complication\(^9\). Thus strengthening capacity of public health staff at referral centre as well as front line workers at the community level in referral pathway needed to be addressed by public health sector. Although there were some incentives for public health staff at referral centers (Station Hospitals), MWs and volunteers (AMW and CHWs) who referred emergency cases had no incentive for identifying and referring emergency cases. To embrace active participation of few BHS who made some problems in referring, motivation of BHS in kind of rewards and acknowledgement for those who made right decision and did right things for referring EmOC and ECC should be considered.

3. Does Money make everything?: Strengths and challenges of community-based financing interventions for MNCH

Although there was variation in amount of seed fund given to VHC according to 3 funding mechanisms, seed fund was divided into revolving fund and emergency health fund. It was found that main objective of providing emergency health fund was fulfilled. Even in non-functioning VHCs, travel support/cost for emergency referral of MNCH was given. Thus it can demolish the first delay. In all study villages, emergency health fund was retained although revolving funds in non-functioning villages were lost. This may be due to replenishment of Save the Children for emergency health fund with JIMNCH project. The most common problem discussed by respondents was financial management of revolving fund. Although there were posts for accountant and cashier, most VHCs appointed only one person for both posts. All key informants from Save the Children stated that VHC had full authority to manage VHC fund. That concept is ideal for VHCs which is strong and functioning. However,
systematic monitoring and stewardship from outside would be beneficial to ensure accountability of VHC funds.

**How we could overcome “Dependency syndrome”?**

Most community respondents expressed that existing emergency referral mechanism is beneficial for them. However, majority of key informants from provider side were concerned about dependency of community on supports. Whether community would go and utilize public health service in emergency if there is no support for travel cost and support at hospital is questionable. More engagement of the community and contribution of them could be the solution to tackle dependency. It will also pave the way for sustainability of community-based emergency referral mechanism.

**Replenishment or Revolving for emergency health fund?**

Most VHCs more focused on revolving fund than emergency health fund while Save the Children reimburse emergency health fund. Then the original concept of revolving fund to provide emergency health fund became unclear. According to the qualitative findings, there was no contribution of emergency health fund from interest of revolving fund while Save the Children reimbursed it. Document review of 125 VHCs also showed that only 40% of VHC reported that they saved some portion of interest from revolving fund to emergency health fund. Most respondents said they would contribute for emergency health fund if there is no reimbursement from outside. Thus no reimbursement of emergency health fund from outside would be better to obtain ownership and sustainability of VHC. However, such VHC must be strong enough to manage revolving fund and it should be linked with providing livelihood opportunities of villagers or income generation activities. Operational research on TB patient Self Help Groups (SHGs) in Myanmar (11) and study in Africa on community-based MNCH and Nutrition intervention (12) also found similar finding—sustainability of Community-Based Organizations (CBOs) was strongly linked with livelihood factor and fund raising activities.

**4. If there is no support.**

Strong and functioning VHCs convinced that they can stand on their own if there is no support from outside funding sources. Both functioning VHCs and non-functioning VHCs acknowledged that VHC was necessary and beneficial for their community. Sustainability of VHCs and community-based emergency referral mechanism depends on several factors. Lessons learned from other countries showed that Community ownership is important in enhancing sustainability (12). As in other studies (10,11), our study illustrated important role of public health staff and preparedness of health systems for referred cases
were crucial for success and survival of Community-based Organization/VHCs as well as community-based emergency referral. The community was aware the benefits and advantages of having VHCs and emergency health fund. Thus it may be possible to initiate community health financing or prepayment systems for emergency health problems if group-based micro-credit schemes could be initiated through management of local CBOs. Later when success of the micro-credit schemes observed and trust built between the leadership of CBOs and the community, community financing schemes basing on pre-payment systems for emergency health problems may become possible to be initiated. Although this study did not explore in-depth for community health financing or community-based health insurance, community could be mobilized for contribution and saving for emergency health. The study illustrated many opportunities and strengths of VHCs for sustainability. However, it is necessary to address capacity building of VHCs for team building and leadership; and BHS for community development and mobilization.

**Conclusion**

This study illustrates how the community-based emergency referral mechanism for MNCH was piloted by different funding mechanisms in Middle Island. Although VHC eventually engaged in emergency referral mechanism for MNCH, challenges of capacity building, monitoring, logistics, accountability and strengthening health systems needed to be addressed by the implementing partner (Save the Children) and the public health sector. Understanding the local context, empowering community, combined with strong linkage with public health sector which demonstrates the benefit of community involvement are the main lessons that emerged. The success and advantage of VHC for emergency referral comes from its ability to mobilize communities to take on the responsibility and strong coordination and partnership between public health sector and implementing partner at all levels.
RECOMMENDATIONS
Recommendations

1. Maintaining strong linkage with government or public health sector and Village Health Committee (VHCs)
2. Building Capacity of VHCs for leadership, team building and management; and capacity of Basic Health Staff for community mobilization and development
3. Strengthening health systems with facility and human resources
   a. To equip station hospital with full facility and skillful staff to manage emergency cases at station level
   b. To build up clinical and management skills and attitude of BHS and volunteers at sub-centre or village level.
4. Conducting VHC meetings at village level and encouraging to share information among VHC members
5. Maintaining emergency health fund
   a. Raising awareness of community for importance of emergency health fund
   b. Encouraging VHCs to contribute some portion of interest from revolving fund to emergency health fund
   c. Promoting contribution of community for funding of VHC
   d. Advocating local donors for contributing emergency health fund at station hospital
   e. Developing strategy for poor migrant population to access health services in case of emergency
Recommendations

1. Maintaining strong linkage with government or public health sector and Village Health Committee (VHCs)
   The study identified three main players for community-based emergency referral mechanism for MNCH—VHC, Public Health Sector and NGO (Save the Children). Harmonization and strong coordination among them was highlights of this study and it was the main strength for success of referral mechanism. Therefore, it is crucial to maintaining this linkage even if three were transfer of public staff and new appointment of BHS.

2. Building Capacity of VHCs for leadership, team building and management; and capacity of Basic Health Staff for community mobilization and development
   The study found out that some of the VHCs are not functioning and weak coordination among members and lack of strong leadership. Therefore, it is suggested to strengthen capacity of VHCs. Involvement of BHS is essential for emergency referral mechanism. The study point out there was few problems of non-coordinating and poor attitude BHS. Thus capacity building and training of BHS for community mobilization and development concept were necessary.

3. Strengthening health systems with facility and human resources
   a. At Station Hospital
      As discussed earlier, the chain of referral pathway depends on functioning health systems. Thus it is crucial to strengthen health system at station hospital to equip with full facilities and also appoint skillful staff to manage emergency cases.
   b. At Sub-centre land village level
      Ability and attitude of volunteers (AMWs and CHWs) and MWs were crucial for effective and timely referral for emergency cases. Therefore, clinical skills as well as management skill and attitude of them should be built up. Motivation and acknowledgement of volunteers and BHS is also essential.
4. Conducting VHC meetings at village level and encouraging to share information among VHC members
Quarterly there was VHCs meeting at sub-centre level for all VHCs under one sub-centre. However, VHC meeting at each village was not held to discuss health activities of VHC except gathering to collect loan money and discuss about revolving fund. Thus it is suggested to conduct VHC meetings focusing on health activities at the village level.

5. Maintaining emergency health fund
a. Raising awareness of community for importance of emergency health fund
The study found that community was more orientated to revolving fund rather than concept of having emergency health fund while Save the Children replenished emergency health fund.

b. Encouraging VHCs to contribute some portion of interest from revolving fund to emergency health fund
For the sustainability, the original concept of revolving fund i.e. giving some portion of interest from revolving fund to emergency health fund should be recapitulated.

c. Promoting contribution of community for funding of VHC
The study highlighted that for the sustainability of VHCs and obtaining ownership of community, contribution of community for VHC fund should be developed. For community contribution, prepayment system or membership approach is suggested.

d. Advocating local donors for contribution of emergency health fund at station hospital
Emergency health fund at Station Hospital also needs to be sustained even though INGO phased out its activities. Thus mobilizing local resources and advocating local donors for emergency health fund at station hospital is also important for successful and sustainable emergency referral mechanism for MNCH.

e. Developing strategy for poor migrant population to access health services in case of emergency
Some poor migrant population in study areas could not gain benefits of this community-based emergency referral mechanism because they were not able to take 4 AN visits. Most VHC members decided not to provide support or loan money for those who were unstable and migrating. Thus specific strategy for poor migrant population in case of emergency should be considered.

**For future research**
Exploring possibility of community-based health insurance for MNCH
Existing situation of poor migrant population in accessing health services and emergency referral for MNCH
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4. Annotated Bibliography of research findings on Reproductive Health (2006), Department of Medical Research (Upper Myanmar)
5. Assessment of Emergency Obstetric Care in Myanmar (2010), Ministry of Health, Department of Health, Women and Child Health Development Section
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### Annexes

#### Annex 1: Criteria and supports for emergency referral

**Referral to Upper level**

<table>
<thead>
<tr>
<th>Village</th>
<th>Sub-centre</th>
<th>RHC</th>
<th>Station Hospital</th>
<th>Emergency referral confirmed by;</th>
<th>Cases</th>
<th>Medical charges (Maximum)</th>
<th>Remark</th>
<th>Meal Cost (Maximum * 7 days)</th>
<th>Save the Children Reimbursement Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMW or CHW</td>
<td>To MW &amp; MW directly to SMO or To HA &amp; HA directly to SMO</td>
<td>Magyipin Pyinkayaing</td>
<td>SMO</td>
<td>ECC</td>
<td>40000</td>
<td>28000</td>
<td>For Magyipin Station Hospital, weekly</td>
<td>For Pyinkayaing Station Hospital, weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EM OC</td>
<td>90000</td>
<td>28000</td>
<td>LSCS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50000</td>
<td></td>
<td>NVD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 2: Referral Letter and Referral register
Annex 3: Social maps
## Annex 4: Fund Matrix

Original Standards for Community-Based Financing initiatives under US Appeal, USAID (BHAP) & JI-MNCH

<table>
<thead>
<tr>
<th>Key Project Details</th>
<th>US Appeal 2</th>
<th>USAID (BHAP)</th>
<th>JI-MNCH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emergency Health Programme in Cyclone Nargis-Affected Communities in Yangon and Ayeyawady Regions</td>
<td>Burma Humanitarian Assistance Program (BHAP)</td>
<td>Joint Initiative on Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>1 August 2008 to 31 Dec 2010</td>
<td>7 May 2010 to 8 August 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Goal:</td>
<td><strong>Project Goal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To prevent mortality and morbidity of vulnerable groups (children under 5 and women of reproductive age) during the early recovery stage of cyclone-affected communities in the Divisions of Yangon (Kungyangon and Kyauktan) and Ayeyawady (Nagpawdaw and Mawlamyinggyun) in Myanmar</td>
<td>The goal of the project is to improve livelihoods security and maternal health/child survival outcomes among the most vulnerable and marginalized population in the Delta.</td>
<td>The core objective of the proposed 3 year “Health PONREPP” programme is to increase access to essential maternal and child health services amongst hard-to-reach populations in areas most affected by Cyclone Nargis. The programme will result in enhanced provision of, and access to, quality basic maternal and child health care services (including nutrition and immunization). Psychosocial needs of affected populations will be met whilst mitigation of future risks will be achieved through a focus upon emergency preparedness.</td>
<td></td>
</tr>
<tr>
<td>Project Strategic Objectives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To help achieve the above goal, the project will have two Strategic Objectives (SOs):</td>
<td>(1) increased coverage of transformational and sustainable livelihood services (SO1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Increased use of quality health services; and</td>
<td>(2) increased practice of transformational and sustainable livelihood behaviors (SO2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Increased adaptation of healthier behaviors</td>
<td>(3) increased use of quality health/nutrition and WASH services (SO3) and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>These strategic objectives will result in an increase in the demand for health services thus attributing to the reduction of morbidity and mortality risks among the vulnerable groups in the target population. This proposal takes into consideration and incorporates the key contents of the draft SC Emergency Health Programme Strategy paper for the cyclone Nargis response.</td>
<td>(4) increased practice of health/nutrition and WASH behaviors (SO4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Myanmar Nurses and Mid Wife Association (MNMA)</td>
<td>Township Health Department</td>
<td></td>
</tr>
<tr>
<td>78 villages</td>
<td>DAWN Microfinance (OMF), Thigah</td>
<td>118 villages</td>
<td></td>
</tr>
<tr>
<td>Children under five years and women of reproductive age (15 to 48 years old)</td>
<td>54 villages</td>
<td>Maternal, Newborn and Children under five years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of target Villages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Beneficiaries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revolving Fund (RF)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does RF component exist?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Amount of original capital given to VHC</td>
<td>140,000 MMK</td>
<td>100,000 MMK</td>
<td>100,000 MMK</td>
</tr>
<tr>
<td>Criteria for getting the funds from VHC?</td>
<td><strong>Mother of children &lt; five yrs</strong></td>
<td><strong>DAWN Microfinance</strong></td>
<td><strong>Mother of children &lt; five yrs</strong></td>
</tr>
<tr>
<td>Who decided the criteria?</td>
<td>Community decided, SC facilitated Yes</td>
<td>Yes</td>
<td>Community decided, SC facilitated Yes</td>
</tr>
<tr>
<td>Is there interest?</td>
<td>3% to 5%</td>
<td>2.5%</td>
<td>3% to 5%</td>
</tr>
<tr>
<td>What is the rate?</td>
<td>Community decided, SC facilitated 4 months</td>
<td>DAWN Microfinance</td>
<td>Community decided, SC facilitated 2 months</td>
</tr>
<tr>
<td>Who decided the rate?</td>
<td>25% installment + interest (3% - 5% on total loan amount) per month</td>
<td>2 months</td>
<td>Community decided, SC facilitated 2 months</td>
</tr>
<tr>
<td>How much time is given for reimbursement?</td>
<td>Allowed community contribution, no fix amount</td>
<td>Lump sum after 2 months + 2.5% interest</td>
<td>Lump sum after 2 months</td>
</tr>
<tr>
<td>What is the reimbursement mechanism (installments or lump sum)?</td>
<td>No “freezing”</td>
<td>200 MMK per 2 weeks per member</td>
<td>Allowed community contribution, no fix amount</td>
</tr>
<tr>
<td>Were other contributions to this fund made by community, other organizations or donors?</td>
<td></td>
<td>No “freezing”</td>
<td>No “freezing”</td>
</tr>
<tr>
<td>If a process of “freezing”?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Referral Fund (ERF)</strong></td>
<td><strong>US Aid (BHAP)</strong></td>
<td><strong>JI-MNCH</strong></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>- Does ERF component exist?</td>
<td>- Yes</td>
<td>- Yes</td>
<td></td>
</tr>
<tr>
<td>- Focus of ERF (e.g. EmOC or ECC or any emergency cases), is it intended to be used for transport, medical charges or other?</td>
<td>- Emergency relating with maternal, newborn and child health, only for transportation charges</td>
<td>- Emergency Obstetric Care and Emergency Child Care, transportation charges only</td>
<td></td>
</tr>
<tr>
<td>- Amount of original capital allocated to ERF? Who decided the amount? Who keeps the funds?</td>
<td>- 40,000 MMK, SC decided the amount, Village Health Team keep the funds</td>
<td>- 40,000 MMK, community decided, SC facilitated, Village Health Team keep the funds</td>
<td></td>
</tr>
<tr>
<td>- Criteria for getting the funds from ERF?</td>
<td>- Trained volunteers or AMW or CHW or BHS identified as emergency, follow the Ministry of Health criteria</td>
<td>- Trained volunteers or AMW or CHW or BHS identified as emergency, follow the Ministry of Health criteria</td>
<td></td>
</tr>
<tr>
<td>- Who decided?</td>
<td>- Actual transportation charges maximum up to 20,000 MMK, community decided</td>
<td>- Actual transportation charges maximum up to 20,000 MMK, community decided</td>
<td></td>
</tr>
<tr>
<td>- Is there maximum amount?</td>
<td>- Yes</td>
<td>- Yes</td>
<td></td>
</tr>
<tr>
<td>- Is reimbursement required? In all cases or in specific cases?</td>
<td>- No interest for first 2 months, starting on 3rd month 2% interest rate, Community decided, SC facilitated</td>
<td>- No interest</td>
<td></td>
</tr>
<tr>
<td>- Is there interest? What is the rate? Who decided the rate?</td>
<td>- 2 months no interest, 2 months with interest, total 4 months</td>
<td>- 2 months no interest, 2 months with interest, total 4 months</td>
<td></td>
</tr>
<tr>
<td>- How much time is given for reimbursement?</td>
<td>- Lump sum</td>
<td>- Lump sum</td>
<td></td>
</tr>
<tr>
<td>- What is the reimbursement mechanism (installments or lump sum)?</td>
<td>- 30% of total amount get from interest will contribute to emergency referral fund &quot;freezing&quot; in 2011 3rd quarter for balancing the emergency referral fund up to 100,000 MMK from PONREPP fund and restarted immediately after balancing. After that no need to reimburse by community, SC will reimburse according to referral cases</td>
<td>- 30% of total amount get from interest will contribute to emergency referral fund &quot;freezing&quot; in 2011 3rd quarter for balancing the emergency referral fund up to 100,000 MMK from PONREPP fund and restarted immediately after balancing. After that no need to reimburse by community, SC will reimburse according to referral cases</td>
<td></td>
</tr>
<tr>
<td>- Were other contributions to this fund made by community, other organizations or donors?</td>
<td>- Yes</td>
<td>- Yes</td>
<td></td>
</tr>
<tr>
<td>- If a process of &quot;freezing&quot; was used, please mention in detail</td>
<td>- Yes</td>
<td>- No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Development Fund (DF)</strong></th>
<th><strong>US Aid (BHAP)</strong></th>
<th><strong>JI-MNCH</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Does DF component exist?</td>
<td>- Yes</td>
<td>- Yes</td>
</tr>
<tr>
<td>- Focus of DF (what is it to be used for)?</td>
<td>- Renovate the village foot path, bridges, etc.</td>
<td>- Renovate the village foot path, bridges, etc.</td>
</tr>
<tr>
<td>- Amount of original capital allocated to DF?</td>
<td>- Originally 0 MMK, 20% of the total amount of interest from revolving fund will pool in development fund</td>
<td>- Originally 0 MMK, 20% of the total amount of interest from revolving fund will pool in development fund</td>
</tr>
<tr>
<td>- Who decided the amount?</td>
<td>- Decision come from Village Health Team meeting, it must be related with development of village</td>
<td>- Decision come from Village Health Team meeting, it must be related with development of village</td>
</tr>
<tr>
<td>- Who decided?</td>
<td>- Depend on the amount needed in renovation</td>
<td>- Depend on the amount needed in renovation</td>
</tr>
<tr>
<td>- Is reimbursement required?</td>
<td>- No need to reimburse</td>
<td>- No need to reimburse</td>
</tr>
</tbody>
</table>
Annex 5: Structure of Village Health Committe in Manual developed by Ministry of Health

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Annex 5: Structure of Village Health Committee in Manual developed by Ministry of Health

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