



Evaluation of Emergency Referral Mechanism in Pyapon Township

Médecins du Monde

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List of Abbreviation

3MDG -Three Millennium Development Goal	JI-MNCH - Joint Initiative on Maternal, Newborn, and Child Health
AMW - Auxiliary Midwife	MdM - Médecins du Monde
ANC - Ante-Natal Care	MMK - Myanmar Kyat
BEmOC - Basic Emergency Obstetric Care	MNCH - Maternal, Newborn and Child Health
BHS - Basic Health Staff	MW - Midwives
CEmOC - Comprehensive Emergency Obstetric Care	RHC - Rural Health Center
CHW - Community Health Worker	TBA - Traditional Birth Attendance
ECC - Emergency Child Care	THA - Township Health Assistant
EmoC - Emergency Obstetric Care	THD - Township Health Department
ERF - Emergency Referral Fund	THN - Township Health Nurse
FGD - Focused Group Discussion	ToR - Term of Reference
H2R - Hard to Reach	VHC - Village Health Committee
HA - Health Assistant	VHF - Village Health Fund
HAP - Humanitarian Accountability Principle	VHW- Village Health Workers
	VTHC- Village Tract Health Committee

EXECUTIVE SUMMARY

A participatory evaluation of the Médecins du Monde (MdM) 3MDG Funded Village Health Fund (VHF) program was facilitated by an external consultant team (Ziwaka Health) in May and June, 2016. The evaluation was conducted following completion of the fiscal year (FY) 2015 with an eye toward the program's anticipated conclusion at the end of 3MDG grant in 2017. The evaluation was conducted to determine the impact of emergency referral funds rural villages access to MNCH services in Pyapon Township, assess accountability and financial management systems of Village Health Committees and make recommendations regarding possible strategy for strengthening program sustainability beyond 2016. This report documents the process, findings and recommendations of the evaluation team.

Background

In the aftermath of Cyclone Nargis that hit the delta region of Myanmar in May 2008, Médecins du Monde (MdM) operated an emergency medical intervention and further programs to improve access to essential health services during the post-emergency phase. In January 2011, the project in Pyapon Township integrated a specific MNCH component. Starting from January 2013, under 3MDG funding, the project's focus shifted towards technical support to local health authorities in implementing a comprehensive MNCH program. Key activities included capacity building of public health staff; support to public health facilities in planning and budgeting; and management of health services delivery including community based volunteer interventions as well as monitoring of health information systems. In 2016, MdM, in collaboration with the Township Health Department (THD), is currently supporting 252 villages with access to comprehensive MNCH program in Pyapon Township.

MdM's Emergency Referral Fund (ERF) program focuses on improving access to MNCH care for mothers and children and was implemented in 193 villages in Pyapon Township. Access to ERF means that MNCH emergencies in community face reduced barriers to access emergency services (i.e. EmOC/Emergency Child Care (ECC) services). Specific attention was also put on providing access to all communities, including those communities in remote areas (i.e. Hard to Reach - H2R- villages) that were previously not able to access public services. The program includes two components: 1) village health fund established at village level, and 2) emergency referral reimbursement system established at township level.

The identified objectives of the ERF program, as stated in the program documents, were to:

- To ensure that MNCH emergencies will have no barriers to access emergency services (i.e. BEmOC/CEmOC services)
- To reduce delays in reaching and receiving care by increasing the availability of emergency services through health facilities capacity reinforcement

Main Evaluation Findings

Village Health Fund Component:

Relevance (reaching the poor and rural families): The VHF encouraged poor mothers and

families to seek healthcare at the hospital. Although ERF could reasonably overcome the financial barriers, organizational cultures within the health system and social barriers still exist. Existing relationship, trust and convenience are key attributes of choosing home deliveries over institutional delivery. There is also lack of common understanding among community and Village Health Committees (VHC) regarding the definition and eligible criteria for use of emergency referral fund. Thus, VHF is more commonly used for non-emergency referrals. Nevertheless, the majority of communities, VHC, expressed that VHF is very useful for poor women and families in their village.

Management and accountability of VHC: the current VHF utilization pattern in villages was found to be insufficient as it not enough focused on improving access to healthcare for mothers and children under five-years old. The knowledge of financial management and eligibility for use of emergency referral is weak in many VHCs. Bookkeeping and basic financial management trainings from MdM helped VHCs. However, most of the VHCs were not clear on VHF financial management tools and more supportive supervisions are required.

Accountability: Information sharing about VHF is neither transparent nor good enough to reach the wider community. In addition, proper cash management system and practice were lacking at VHCs level and this could bring a lot of challenges for sustainability of VHF beyond MdM support. Thus, financial accountability is a significant problem among VHCs.

Equity and Inclusiveness: The village funds are generally found to be equitably distributed to women and children within the community, even to aged population with chronic diseases. The majority of respondents agreed that ERF was a life-saver for poor in rural villages and can prevent unnecessary delay for patient transportation to the hospital; particular for poor families. Regarding the VHC formation, appropriate number of women were selected in the committees.

Sustainability of VHF: There was significant growth of VHF in 3 MDG supported villages in last two years which was largely contributed by the regular returns of the loans disbursed from revolving fund pool and leadership of VHC members who had previous fund management experiences. However, there is no formal mechanism determining how revolving fund growth will replenish the emergency referral fund pool if and when the ERF amount is reduced for some reasons. Even if it is encouraging to see the growth of revolving fund pool under VHF, VHC' lack of intent and plan to maintain or grow emergency referral fund pool did not look promising for sustainability.

Emergency Referral Reimbursement Component

Improving access to MNCH: MdM support for EmOC and ECC referral cases from rural villages gradually increased over the last 3 years. More referrals from H2R villages were supported in 2014 compared to 2013, however, the number of EmOC and ECC referral support to H2R seemed to have reduced in 2015. It can be correlated with the lack of Village Health Workers (VHWs) as well as lack of access to VHF.

Impact of ERF in Pyapon Township is quite hard to determine based on available data and information.

Moreover, VHF also lead to regular meetings among VHC members and community and enhanced social cohesiveness among them; strengthened welfare, charity and volunteer spirit within community.

Main Conclusions

From the above findings and the conclusions derived at each section it is possible to formulate the following general conclusions about the program:

Village Health Fund Component: The village health fund component of the program did encourage poor mothers and families to seek health care at the hospital, and it is still necessary to improve access to MNCH services for poor communities. As it is appreciated by the recipient mothers and children, VHC and the basic health staff of THD, it cannot be only justified on the basis of its expected impacts on improving access to essential maternal and child health services. Utilization of the VHF for emergency referral support at the village level is not only women and under five children. The access to VHF was more limited and uptake of maternal and child health referrals remained low for poor communities in hard to reach villages. The proper utilization of VHF for maternal and child health referrals and VHF sustainability cannot be guaranteed at current level of functioning of VHCs, unless the THD and BHS would provide continuous support to VHCs beyond MdM project closure.

Emergency Referral Reimbursement Component: In contrast, the emergency referral reimbursement component of the program has had a substantial impact on increasing EmOC and ECC referrals in the past three years. It has been successful in helping poor families to reduce their catastrophic, out-of-pocket expenditures for health services they seek at township hospital. It is highly appreciated and it is still needed, although it is very unlikely that the THD could mobilize resources to take over this component from MdM beyond June 2017.

Key Recommendations

Based on the key findings, the following recommendations are developed.

Village Health Fund Component

- The primary objectives of establishing VHF should be explained again among wider community and the messaging should focus on definitions of “emergency and life threatening” and eligibility criteria for use of emergency referral fund. MdM should discuss with the THD how BHS staff particularly Mid-Wives (MW) could support the VHCs for long-term sustainability of the VHF.
- MdM should take necessary actions immediately to reinforce the accountability, management and governance mechanisms of VHCs at intervention villages. The refresher trainings on financial management, bookkeeping and accountability principles should be organized for VHCs before the project closure. The management tools and materials should be simple and developed in a participatory way to ensure user-friendliness and meet the requirements for the VHC.
- MdM should facilitate to switch the focus of VHCs more on establishing appropriate mechanism to grow or maintain emergency referral pool under VHF; and to divert

thinking pattern of VHCs towards how to benefit mothers and under 5 children with the VHF rather than growing revolving fund pool.

- Data and information management system of VHF should be strengthened at VHC level by introducing participatory monitoring and evaluation tools since the impact of effectiveness of VHF is hard to measure in current state.

Emergency Referral Reimbursement Component

- In consultation with the THD, eligibility criteria for emergency referral reimbursement should be clarified at all levels of fund management.
- Basic Health Staff (MW or HA), and more qualified healthcare personnel should be involved at village level in providing technical endorsement for any referral cases.
- Information management system of emergency referral reimbursement – should be strengthened at MDM field office level by focusing more on data analysis, interpretation and response processes.

Sustainability of VHF / Emergency Referral Fund beyond MDM

- VHF should be integrated within existing social safety net programs in the villages such as community charity fund and Mya Sein Yaung community development fund.
- To ensure continued support to VHCs for effective management of VHF, all VHCs managing VHFs should be integrated into Village Tract Health Committee (VTHC) that will hold accountable to Township Health Committee (THC) managed by Township Health Department.
- The existing coordination mechanisms at both RHC and Township levels should be strengthened where BHS and VHCs can come to discuss about emergency referral improvement as an agenda item to those meetings.

MDM should organize a brainstorming meeting among IPs, who have been implementing VHF component with 3MDG support, and jointly develop a memo to 3MDG highlighting the need of 3MDG advocacy support at central level. By highlighting benefits and achievements of emergency referral program, the key advocacy message should call the Ministry of Health to consider increasing budget allocation for 3MDG supported townships so that the THDs can continue supportive supervision and RHC level coordination meeting.

ACKNOWLEDGMENT

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Many thanks to MdM field team: Adam Tousley, Dr. Chit Ye Zaw, Ma Phyo Thida Aung, and logistic teams for their continuous support throughout the evaluation process; Health Facilitators for their tenacity, efforts, and valuable inputs in the data collection exercise. Our sincere appreciation also goes to the Township Health Department staff; Township Medical Officer/Medical Superintendent of Pyapon Township Hospital, Township Health Nurse (THN), Township Health Assistant (THA), Health Assistants (HA) and Basic Health Staff (BHS) from each Rural Health Center (RHC), and Village Health Committee members for sharing their insights and suggestions during the field visit and consultation workshop.

We are also thankful to all wonderful staff at MdM in Yangon office and Dr. Panna Erasmus and Dr. Khin Sabei Maung from 3 MDG office. Thank you for your time, sharing all relevant project information, providing all requested support, organizing overall aspect of evaluation design and implementation, and facilitation support for data collection exercises such as stakeholder's consultation workshop, interviews and Focus Groups Discussions (FGD) in both rural and hard to reach villages.

Special thanks to all evaluation participants, for their willingness, time and trust.

1. INTRODUCTION

1.1 PURPOSE OF THIS REPORT

The purpose of this report is to document the outcomes of an evaluation of Médecins du Monde (MdM)'s Village Health Fund (VHF) program activities for 2013-2015, funded by 3 Millennium Development Goals (3MDG). The evaluation was conducted in Pyapon Township, Myanmar over the period of May 14 to June 2, 2016. After brief overviews of the objectives and approach of the evaluation (Section 1), and some background information on the design and evolution of the Emergency Referral Support program (Section 2), the design of the evaluation is presented in (Section 3). Evaluation findings are presented in (Section 4) and this leads to a summary of the main conclusions in (Section 5) and the formulation of recommendations in (Section 6).

1.2 OBJECTIVES OF THE ASSIGNMENT

This assignment had the dual purpose of conducting a participatory evaluation of the VHF program to date and of simultaneously developing staff capacity in the evaluation process. Although this evaluation is technically an end-of program evaluation for emergency referral support program, which was implemented from January 2013 to 2017, it was mainly intended to review the impact of village health fund (VHF) on MNCH and inform the continued implementation of the emergency referral support program in absence of MdM. Defining an appropriate exit strategy for the program was a main concern of this evaluation. Finally, the evaluation was to be designed to maximize learning opportunities for MdM staff to reflect on the program, derive conclusions and generally own the results of the evaluation.

The detailed Statement of Work for the evaluation is attached in Annex (1).

1.3 OVERVIEW OF THE ASSIGNMENT

The evaluation was led and facilitated over a three-week period by an external evaluation team, working closely with MdM management and staff. The evaluation coordination team consisted of 1) Dr. Khin Thawdar Shein (Ziwaka Health External Consultant – Lead Evaluator with expertise in MNCH programs, monitoring and evaluation systems and staff training and development), 2) Adam Tousley (MdM Field Coordinator), 3) Dr. Chit Ye Zaw (MdM Program Manager), & 4) Dr. Khin Yupar Kyaw (Ziwaka Health External Consultant with expertise in evaluation and training). The evaluation team also included six program staff members.

The evaluation process included an initial preparatory workshop with the full evaluation team to introduce concepts and design and plan of the evaluation, nine days of field work by consultant team in different areas of the township, data entry and analysis by Ziwaka Health team members and a final participatory evaluation workshop with the full team to interpret results, derive conclusions and formulate recommendations and action plans.

Evaluation activities also included analysis of existing project documents and monitoring data; semi-structured interviews with project manager and staff, local government officials and village health committee members, community members and BHS at rural health centers; focus group interviews with village health committees, beneficiaries and healthcare providers; interviews with emergency referral support program staff and management and observation by the evaluation team.

2. BACKGROUND ON PROGRAM DESIGN AND EVOLUTION

In the aftermath of Cyclone Nargis that hit the delta region of Myanmar in May 2008, Médecins du Monde (Mdm) operated an emergency medical intervention and further programs to improve access to essential health services during the post-emergency phase. In January 2011, the project in Pyapon Township integrated a specific Maternal, Newborn and Child Health (MNCH) component. Starting from January 2013 under 3MDG funding, the project's focus shifted towards technical support to local health authorities in implementing comprehensive MNCH program. Key activities included capacity building of public health staff; support to public health facilities in planning and budgeting; and management of health services delivery including community based volunteer interventions as well as monitoring of health information systems. In 2016, Mdm, in collaboration with the Township Health Department (THD), is currently supporting 252 villages with comprehensive MNCH program in Pyapon Township.

Access to quality primary health care is very limited for the population particularly for pregnant women and children in the rural areas of Pyapon Township. Scarcity of trained health staff, lack of equipped facilities and daunting geographic constraints – and high treatment costs result in limited access to primary health care services. Thus, the intervention supports a network of community health workers (CHW), auxiliary midwives (AMW) and village health committees (VHC) aiming to reduce maternal and child morbidity and mortality in the rural population, through strengthening of the VHCs, establishment of a referral system and implementation of a supervision system from township level to village level.

2.1 EMERGENCY REFERRAL SUPPORT PROGRAM DESIGN

Mdm's emergency referral support program focuses on improving access to MNCH care for mothers and children, which was implemented in 193 villages in Pyapon Township. Access to ERF means that MNCH emergencies in community face no barriers to accessing emergency services (i.e. EmOC/ECC services). Specific attention was also put on providing access to all communities, including those communities in remote areas (i.e. Hard to Reach - H2R- villages) that were previously not able to access public services. The program includes two components: 1) **village health fund** established at village level, and 2) **emergency referral reimbursement** system established at township level.

The **village health fund component** was designed to reach rural communities in Pyapon Township, within 193 villages. Although Mdm has assisted the THD in establishing VHC in 241

villages in Pyapon Township, MdM could mobilize 193 villages (including 4 H2R villages) for establishment of VHF. VHCs are mainly responsible for supporting MCH and Health Education (HE) activities, administering the VHF and other public health activities within communities. Particularly in 74 villages under 3MDG fund, the VHFs are co-funded between MdM and the community, whereas the rest are self-funded by the community alone. Within each community, the VHF are usually managed and utilized in two ways:

- Revolving Fund: Disbursed as small loans to community for livelihoods and income generation activities, which is designed to increase the VHF capital over time.
- Referral Fund: used for medical referrals of all types, and is usually required to be repaid by the individual/family or reimbursed through the Township referral reimbursement system.

The **emergency referral reimbursement component** supported MMK 351,742,000 covering 4,927 referral cases in Pyapon Township through 2013-2015. Referral cases can be distinguished into three categories; 1) EmOC, 2) ECC, and 3) Other. In addition to VHF managed by the VHC at village level, MdM field office in collaboration with the THD also designed and implemented a third and separate referral support system, which is intended to support medicine and food costs of the referral to ensure wider community reach.

Over the three years of the program, the design of the program approach has evolved considerably. At time of evaluation, MdM is in a phase of transitioning out of Pyapon in 2017 while ensuring the THD has the resources and technical capabilities necessary to continue MNCH services.

2.2 OBJECTIVES OF THE PROGRAM

The identified objectives of the Emergency Referral Support program, as stated in the program documents, were:

- 1) To ensure that MNCH emergencies will have no barriers to accessing emergency services (i.e. BEmOC/CEmOC services)
- 2) To reduce delays in reaching and receiving care by increasing the availability of emergency services through health facilities capacity reinforcement

2.3 PROGRAM APPROACH

The design of emergency referral program also evolved over time. The initial design came from the **Joint Initiative on MNCH (JI-MNCH) Emergency Referral Program** (2010-2012) implemented to increase access to essential maternal and child health services amongst hard-to-reach populations in six townships in the Ayeyarwaddy Region. All women and children under age of five who meet at least one medical emergency criteria outlined in the emergency referral guidelines were eligible to receive financial and logistical assistance for emergency referrals. Patients were reimbursed based on actual expenditure up to a set ceiling amount. According to JI-MNCH program evaluation, patients on average paid \$56 for maternal and

child health referrals, and \$204 for caesarian section¹. The average reimbursement cost was \$19 for child and maternal health referrals, and \$123 for caesarean section. The referral mechanisms varied from organization to organization and region to region.

Under **3MDG supported Emergency Referral program** (2013-current), the key difference in program design is the standardization of the Emergency Referral Guidelines, which were developed by a Ministry of Health-lead working group. Eligibility criteria are based on medical needs and assessed by a trained health care professional, and reimbursement based on actual costs for the following: transportation, meal/food, treatment costs (if not free at the point of care), and ancillary costs such as laboratory and radiology services.

MdM piloted the VHF model that includes ERF component in 25 villages in 2014, and that model was extended to 24 additional villages in 2015 and another 25 villages in 2016 in Pyapon Township. All those ERFs are managed by VHC in 74 villages. The design of this ERF is that MdM provided 300,000 kyats while the community had to match the other half of the fund. The majority of VHCs in Pyapon had set up their own fund either donating from each households in villages² or share among the members³.

As encouraged by 3MDG fund, MdM was able to set up in 74 villages only local emergency referral funds managed by VHCs to provide patients receiving cash advance to pay for the costs, and submit the receipts upon return to the village. However, the MdM project team manages implementation of emergency referral support system set up at Pyapon field office, and are responsible of overseeing proper distribution of funds to the beneficiaries.

2.4 PROGRAM LOG-FRAME

The program log-frame in **Table 1** was reconstructed for the purpose of this evaluation from the information contained in program documents, as no log-frame existed within the original project documents.

Table 1: Original Emergency Referral Support Program Logical Framework

Goal	To improve access to essential maternal and child health services		
Objectives	Outputs	Activities	Indicators
Improved capacity of VHC	VHC trained how to manage VHF	- Design training curriculum - Train VHC on management of VHF	- Outcome level Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)

¹ Reducing financial barriers to health services: a program summary report of emergency referral programs supported by the JI-MNCH and the 3 MDG Fund by 3 MDG and MOH-Myanmar

² The household donation varies from whatever a household can afford to compulsory monthly payment, for example 200 MMK per month (equivalent with 2 cents)

³ Pyapon Project Report by Health Advisor, Richard James, August 2013-2014

		- Provide supportive supervision to VHC - Collect Data	Number and percentage of institutional deliveries - Output level Number of VHC trained on VHF management
Increased utilization of maternal and child health services	More emergency referrals for mothers and children under 5 years of age	- Establish village health funds to support emergency referral - Establish emergency referral system at township level - Train VHCs and THD on emergency referral guideline	- Output level Number of appropriate EMoC referrals supported - Total Number of appropriate EMoC referrals supported - hard to reach areas Number of ECC referrals supported - Total Number of ECC referrals supported - hard to reach areas

It became clear at the end of the evaluation that some components of this program, in particular the entire community mobilization aspect, were only partially implemented and so this logical framework is more an indication of intent than actual program implementation.

3. EVALUATION DESIGN

As mentioned in the introduction, the evaluation was designed through a participatory process involving an extended evaluation team made up of two external resource people working closely with the local management and program staff. As mentioned in the introduction, this was not only an evaluation, but a staff training on the process of evaluation. The evaluation design and process were therefore developed as part of an evaluation workshop that preceded the evaluation at which participants were exposed to design, monitoring and evaluation concepts and then engaged in the actual design of the evaluation.

3.1 EVALUATION ISSUES

The VHF/RF part of the program lacked a dedicated log-frame and work-plan. While some indicators were included in the donor reporting, they did not provide clear measures for assessing program success. Therefore, the evaluation design was based instead on staff learning and follow-on program needs. The process focused on gathering and analyzing data necessary for understanding the success of previous program activities and for charting a responsible exit strategy from the emergency referral support program.

Key Questions

Key questions for the evaluation were designed by the evaluation team, and the key questions addressed through the evaluation process. Those aligned with the ones included in the original scope of work for this evaluation (Annex 1).

Relevance:

1. To what extent the village funds are improving access to healthcare for mothers and children under five years old?
2. Is this support encouraging institutional deliveries as opposed to utilization of traditional birth attendants?
3. Are the VHF used for extending MNCH to poor and rural families? Are they perceived as useful for the women?

Accountability:

1. Are the tools in place and being utilized to ensure funds are used for their intended purpose?
2. How effective is budgetary management training given to the village health committees by MdM Health Facilitators?

Equitability and Inclusion:

1. Are village funds equally accessible to women and children within the community?
2. Are the village health committees composed of the appropriate number of women to represent the demographics of the community?
3. To what extent is the VHF able to support the expected EMOC and ECC referrals? (cost of expected referrals versus size and capacity of VHF).

Sustainability:

1. To what extent can the village fund continue to serve as a source of MNCH referral support after MdM involvement has ended?
2. What progress has been made by MdM in handing over responsibility to the Township Health Department?
3. How can the Township Health Department mobilize resources and capacity to manage Village Health Funds after MdM involvement has ended?

3.2 EVALUATION METHODOLOGY

The evaluation methodology consisted of the following main streams of activity: Analysis of existing project documents and monitoring data; semi-structured interviews with project manager and project staff, local government officials and village health committee members, community members and basic health staff (BHS) at rural health centers; focus group interviews with village health committees, beneficiaries and healthcare providers; interviews with emergency referral support program staff and management and, observation.

Evaluation Schedule

Day 1: Planning and preparation; expectations established with management team.

Day 2-4: Planning and training workshop with evaluation team. Content included: purpose of evaluation, clarification of key evaluation questions and information sources, development

of data collection instruments, site selection and development of evaluation work plan.

Day 5-12: Data collection in 7 villages

Day 13: Facilitation of evaluation workshop with THD, VHC

Day 14-17: Data entry and analysis

Day 18-25: Report writing

Sites Selection

Field sites were selected to ensure proportional coverage in each cluster, a mix of less-difficult to reach and hard to reach (H2R) villages, and representation of each funding type (i.e. Villages with 3MDG funded VHF and non-3MDG funded VHF). Logistical considerations and team capacity were also necessary considerations in choosing evaluation sites. A total of eight villages were visited by evaluation team for data collection and daily analysis. Seven less difficult to reach and one H2R village were represented. Of these, five villages received 3MDG fund support to establish VHF, and three villages had self-funded VHF. The list of sites is included in **Table 2** below.

Table 2: Selected Evaluation Sites

Date of field visit	Village name	VHF type
14.5.2016	Ah Lan Pha Lut	Self-funded
15.5.2016	Kyone Ka Wa	MdM fund ,2015
16.5.2016	Phoe Thu Chaung	MdM fund, 2015
17.5.2016	Kone Tan	Self-funded
18.5.2016	Thein Kone	MdM fund, 2014
19.5.2016	Ah Mar Su	Self-funded
19.5.2016	Taw Kyo	MdM fund, 2014
2.6.2016	Sa Lu Chaung (H2R)	MdM fund, 2015

Approach

The data collection instruments developed by the evaluation team and used during this evaluation can be found in Annex (2-5). Each team member conducted both interviews and focus groups with most, if not all types of informants. Data collection was followed each day by sub-team debriefing and comparison of information gathered. Additionally, team members discussed the process itself and identified suggestions for improving data collection for the following days. All findings and recommendations presented here were a result of team workshops to analyze data, compile observations and formulate recommendations for the exit strategy for MdM's emergency referral program. Following the team workshop, results were shared with the Project Manager who expressed support for the adoption of many of the included evaluation recommendations.

Below in **Table 3** is a summary of the types and numbers of people interviewed during the evaluation process.

Table 3: Summary of Participants in Individual and Focus Group Interviews

Respondents	Village Health Committee			Caregiver Mother
Village	M	F	T	F
Ah Lan Pha Lut	2	3	5	10
Kyone Ka Wa	1	3	4	8
Phoe Thu Chaung	1	1	2	10
Kone Tan	1	8	9	9
Thein Kone	1	5	6	10
Ah Mar Su	0	0	0	10
Taw Kyo	1	5	6	0
Sa Lu Chaung (H2R)	2	2	4	7
Total	9	27	36	64

3.3 LIMITATION

While the evaluation team benefitted from the diligent support of MdM Pyapon office, the breadth of the term of reference (ToR) meant that in 12 days the evaluator could not have an in-depth analysis of ERF funding status at villages, and a full picture of the functionality of VHC and effectiveness of ERF program activities. Due to access, weather and time constraints, the evaluator could not reach as many H2R villages as planned (Only 1 H2R village was visited although 2 were planned in study design.) The data and information regarding the fund situation and referral cases at village level was based on the description of respondents; and the evaluation team could not check the validity of those information because of limited documentation at VHC level.

4. KEY FINDINGS

The findings presented here are derived from several sources, including an analysis of available program data from the evaluation field work, observations by the evaluation team, review of project documents, and interviews and workshops with program staff.

The findings are presented separately for the village health fund and the emergency referral reimbursement components of the program.

4.1 VILLAGE HEALTH FUND COMPONENT

IN 2011, MdM piloted a village fund to assist referrals and emergencies in 25 villages with EU fund. The villages were selected from the H2R areas and the funds they received were calculated according to the size of the population. Roughly 10% of the fund total was made up from EU donation to cover referrals. Of the remaining total, half of the money was ‘matched’ by MdM to the funds that the village itself raised. With 3MDG support, MdM extended a similar model of VHF in 74 villages in Pyapon Township.

The main issues that were examined in the evaluation of this component are relevance; management and accountability; equitability and inclusion; and future sustainability of the VHF scheme. The findings for each of these major issues areas are summarized briefly in this section.

4.1.1 Relevance – Reaching the Poor and Rural Families

Literature indicates that many pregnant women in poor setting are usually facing three major delays regarding their deliveries in a health facility: 1) delay in decision making, 2) delay in reaching to the health facilities and 3) delay in receiving adequate health care. Thus, various strategies focus on removing these delays to care and aim to improve MNCH care and outcomes in the community. ERF is one of the mechanisms to improve timely access for pregnant mother or neonate to health services by reducing huge transportation and “out-of-pocket” service costs for poor households and reduce the maternal and neonatal deaths. Literature review also indicated that community health fund type schemes can provide protection to community members by significantly reducing the level of out of pocket payments for health care. In Pyapon Township, MdM designed the VHF at the village level with the aim of reducing financial barriers in timely utilization of health services particularly for pregnant mothers and children from poor communities, and improving their access to essential health services.

The village health funds encouraged poor mothers and families to seek healthcare at the hospital. During discussions with beneficiaries, most respondents perceived that financial barrier for medical treatment and/or transportation was most common constraints for seeking care at health facility. Easier access to the fund within the village through the VHC encouraged

poor mothers and families to seek care at the hospital. Despite the argument that VHF scheme usually fails to cover sufficiently the “poorest of the poor” groups in the community, the healthcare providers also agreed that community members were more likely to seek health care from qualified healthcare providers compared to traditional healers or traditional birth attendance.

Access to Village Health Fund did encourage deliveries attended by skilled health providers, as well as institutional deliveries. As mentioned in **Table 4** below, there was significant improvement in institutional deliveries from 9% to 49% in 2014, and percentage of skilled birth attendant deliveries also notably increased in 2014. MdM supported a package of AMW/CHW recruitment and training in order to support MNCH continuum of care through front line service providers, called Auxiliary Midwives (AMW). AMWs usually provide basic preventive, curative and referral services at grass-root level and directly report to midwives at sub-rural health center (sub-RHC) or Rural Health Center (RHC). However, based on the available data provided by MdM field office, the percentage of births attended by trained AMWs seemed stagnant over the last three years at 7%.

Table 4: Key Program Achievements in Pyapon Township (2013-2015)

Key Indicators	2013 (figures)	2014 (figures)	2015 (figures)
Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)	71% (4150)	85% (4666)	76% (4,218)
Number and percentage of births attended by trained AMW	7% (390)	7% (370)	6% (306)
Number and percentage of institutional deliveries	9% (508)	49% (2, 718)	47% (2,608)

Although ERF could reasonably overcome the financial barriers, organizational cultures within the health system and social barriers still exist. Existing relationship, trust and convenience are key attributes of choosing home deliveries. Many mother groups expressed that existing relationship, trust with Traditional Birth Attendance (TBA) and convenience are key factors when they considered to choose home deliveries over institutional deliveries, which indicated that the community still have preference on TBA and home deliveries regardless of community promotion effort for institutional delivery with skilled health providers.

There were a few cases where the referral fund was found to be used for the transportation cost of Midwife to provide delivery services at mother's home. In such cases, the pregnant mothers had improved access to MNCH care provided by skilled health personnel but that did not help to increase institutional deliveries.

"Though I had received ANC regularly with Midwife during my pregnancy, at term, I suffered labor pain and tried to deliver with TBA. But it took a few days and could not go to health center. My relatives urgently took Midwife to see me at home and the VHC provided transport fees from Village Health Fund for the Midwife to come and see me at village."

-In depth Interview with mother

The basic health staff (BHS) are not confident of service readiness for institutional deliveries.

From the perspective of service providers, in-depth interview revealed that MWs could not confidently promote institutional delivery because their RHC and sub-RHC had insufficient medical equipment to perform delivery. According to MdM transitional plan report⁴, this service readiness issues at primary health institutions seemed to be originated from limited capacity of THD in stock management and monitoring the use of commodities and medicines supplies; including guideline compliance, which were main challenges for effective supervision of MW and AMW for MNCH care.

Thus, it can be concluded that successful delivery of MNCH interventions is dependent on addressing various elements of health system such as improving infrastructure of health facility, medicine and equipment supplies, service quality provided by BHS and VHWS, as well as understanding community perception and designing services that meet community preference.

There is lack of common understanding among community and VHC regarding the definition and eligible criteria for use of emergency referral fund, and thus VHF is more commonly used for non-MNCH emergency referral. The main objective of establishing emergency referral fund at village level is to reduce the delay in referral during the time of emergency particularly for MNCH cases and aim to reduce avoidable maternal mortality and mobility within Pyapon Township. Interviews with multiple stakeholders consistently showed that VHF availability and eligibility criteria to use fund are poorly understood by many VHC members, wider community and basic health staff. Particularly, level of understanding of "emergency referral" varied widely from one community/VHC to another at the village level. Therefore VHC in some villages frequently used emergency referral support for non-maternal and non-child health cases i.e. chronic disease cases and other emergencies, although this VHF was mainly support pregnant women, mother and children under five-years old in emergency.

⁴ MdM – MNCH transitional Plan Report

However, the majority of community and VHC interviewed felt that VHF is very useful for poor women and families in their village. In the past the village had to collect community donations and contributions when a community member from poor family needed to go to the secondary facilities. With VHF availability, it became much easier and faster for the poor families to make the decision to go to the hospital thus preventing unnecessary delay to seek care.

4.1.2 Management and Accountability

Role of VHC in VHF Management

The VHC is responsible for administering VHF at community level. That involves not only introducing VHF to community stakeholders including opinion leaders in the community, village development committee, households; but supervision of financial management records of the fund management. The VHC component of the project was introduced in February 2012 in Pyapon Township. The VHCs are formed at the village level only and the different members take on different roles within the committee such as chairperson, secretary, treasurer and accountant. MdM established or revitalized these VHCs by inviting community members and the CHW and/or AMW of the village, if present. VHCs had predominant role in linking health facilities and communities.

The village health funds (VHF) were established by two sources of revenue: community contribution and the 3MDG matching grant (the MdM tops up the amount collected through community contribution by 100% or even more). MdM supported villages to set up VHF to support referral and medical emergencies, where MdM supported technical assistance and series of training including book keeping, leadership and community mobilization.

Management and Use of VHF

The VHF is usually managed in two different fund pools:

- **Revolving fund**, two third of the collected fund is used for small loans with interest to individuals who want to set up income generation/small businesses. The purpose of this fund pool is to increase the village fund capital over time.
- **Referral fund**, one third of the collected fund (estimated about 150,000 MMK) is used for medical referrals of all types and is usually required to be repaid by the individual/family or reimbursed through the Township referral reimbursement system.

The current VHF utilization pattern in villages was found to be insufficient as it does not focuses enough on improving access to healthcare for mothers and children under five-years old. Functioning mean a fund should be growing and effectively use as intend. The original purpose of VHF is designed to finance a basic package of maternal and child health services at health facilities and reduce out-of-pocket payment for services amongst poor population in hard-to-reach areas. This is also intended to prevent from catastrophic health expenditure if the rural populations go seek secondary medical services in secondary health facilities in urban

areas. The evaluation team consistently found that the emergency referral fund pool of VHF is not as frequently and actively utilized as the revolving fund pool and, hence, remained idle at the village level. In depth interviews with VHC showed that two-third of visited communities put more emphasis on managing the loan and growing the revolving fund rather than providing a helping hand to vulnerable communities with emergency referral fund to access MNCH services in health facilities, which is the main objective of establishing emergency referral fund in their community. Though it is encouraging to observe that the funds are revolving in most of the villages, the funds were not sufficiently utilized as its intended. Thus, it is a great concern in fund sustainability and utilize effectively beyond MdM.

Effectiveness of Financial Management

Training

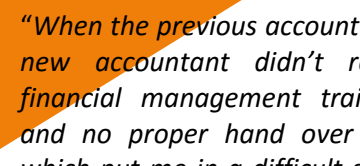
The knowledge of financial management and eligibility for use of emergency referral is weak in many VHCs. Although VHC received trainings and technical support from MdM, it was quite apparent that most VHCs were not clear on VHF financial management tools, rules and procedures. Both categories of VHCs, whether they are managing 3MDG funded or self-funded VHFs, could provide data on the fund status during the evaluation visits. The VHC generally agreed that they received support from MdM for financial management tools and regular audit of VHF.

Book keeping trainings helped VHCs but more supportive supervisions are needed to strengthen their competencies. MdM provided series of capacity building for chairman, accountant and treasurers of VHCs on book keeping; and for AMW/CHW on leadership and community mobilization. Generally, the VHC members were satisfied with the training they received from MdM. Despite MdM strengthened the data management capacity of VHC and provided the forms to keep financial record, those forms/templates seemed not much useful and appropriate for VHC members most of which have low level of formal education. When the evaluation team conducted desk review of book keeping training documents, the training curriculum had not been reviewed and adapted to meet the new requirements for the VHC.

The turnover of the VHC members was also identified as a major challenge for effective fund management. Some VHCs complained about the turnover of accountant was the main hurdle

“The record keeping and filling forms are quite a big headache”

- Focus group discussion with VHC



“When the previous accountant left, the new accountant didn’t receive any financial management training again and no proper hand over was done, which put me in a difficult situation for financial data recording”

Key Informant Interview with VHC,
TawKyo Village, Seik Ma RHC

for them to efficiently manage VHF. Thus, some VHCs requested refresher training in book keeping and financial management.

Accountability

Information sharing about VHF is neither transparent nor good enough to reach wider community. Transparency and capacity building of individuals within the organization are key elements of Humanitarian Accountability Partnership (HAP) benchmarks. Literature review highlighted that transparent information sharing and community participation were crucial parts to ensure functioning and sustainability of the VHC. Regular meetings and information sharing about relevant health activities at village level are supposed to be main activities for VHCs. The VHCs from the selected villages usually conducted the meeting at least once a month. It was a good sign for functionality of the committee; yet the meeting usually took place among the VHC members only, (sometimes included loan borrowers,) and not extending invitation to wider community.

MdM in its transition plan identified that there was a big gap in information sharing, participatory approach, feedback mechanisms and systematic procedures because of poor understanding about accountability among staff, and beneficiaries. Besides, MdM had dedicated AEI officer and introduced suggestion box at village level, yet, AEI components need to be strengthened for both staff and VHC members.

Proper cash management system and practice is lacking at VHCs. MdM provided the VHC a safe box to keep the village health fund with financial record (balance sheet), which is one of the basic cash management procedures. However, when attempting to do cash counting during the evaluation visit, the VHF balance was found only in balance sheet in the hands of VHC, not in the safe box. The VHC explained one of the committee members kept the cash. This issue should be taken seriously as this would bring a lot challenges for sustainability of VHF beyond MdM.

Financial accountability is a significant problem and many VHCs did not do internal audit or receive regular audit from external organizations. The evaluation team found that not all VHCs conducted regular audits; or received external audits from MdM or THD; or reported to community members.

4.1.3 Fund Utilization Issues (Equity and Inclusiveness)

The village funds are found to be equitably distributed to women and children within the community, even to aged population with chronic diseases. Out of eight villages visited, only six were able to use VHF for emergency referrals (find details in **Table 5.**)

Table 5: Equitable Distribution of VHF in Study Sites

Village	3MDG support	Year	# 3MDG support	Com Match	Referral cases		
					Under 5	Preg Mother	Other
Kyone Kan Wa	Yes	2015	300000	150000	0	0	2
Phoe Thu Chaung	Yes	2015	300000	150000	0	1	0
Kone Tan	No	2013		600000	2	2	5
Taw Kyo	Yes	2014	300000	150000	5	1	0
Theing Kone	Yes	2014	300000	150000	10	12	21
Sa Lu Chaung	Yes	2014	300000	150000	0	1	1

Appropriate number of women were selected in village health committees. VHCs are usually made up of 8-20 members. However the size and number of active members of VHCs vary. For example, in one village although the VHC was formed with 11 members, only five members were found to be active at time of evaluation. Conversely, it was great to see active and enthusiastic women VHC members in five out of eight villages visited.

The emergency referral support from VHF usually covers transportation cost to secondary health facility, and it will be able to support from four to seven EmOC and ECC referrals in each community. The amount of support varies depending on the cost of transportation or distance to the secondary health facility. For example, the patient referred to a clinic would receive MMK 3,000; Seik Ma MMK 5,000; Nauk Mee MMK 10,000; whereas those referred to Daw Nyein station hospital would receive MMK 20,000; and Pyapon Township Hospital MMK 40,000. The average size of VHF established in 2014 is MMK 431,808 and MMK 494,000 in 2015. As previously mentioned under VHF fund management mechanism, each VHC allocated one third of the collected fund (about 150,000 MMK) as emergency referral fund for medical referrals of all types. Therefore, it can generally be concluded that with current VHF size each VHC could cover up to seven emergency referrals to Station Hospital or four referrals to Township hospital.

The poor families in H2R villages get lesser chance to receive emergency referral fund support. A health provider (HA) during an in-depth interview mentioned that some referral cases from H2R villages (e.g. Ah Mar village) may be referred to Bogale Township hospital because it was a closer point of service facility. For such cases most H2R villages do not have an access to village level VHF and neither the patients were entitled to get referral reimbursement from MdM.

No more delay for referral because they know they can access the money for medical emergency if it is required”
– Key Informant Interview with Daw Tin Mar Win, Midwife, Kan Seik (Zin Baung) Sub RHC

The majority suggested ERF was a life-saver for the poor in rural villages. Midwives in project area generally agree that VHF (ERF) can prevent unnecessary delay for patient transportation to the hospital; especially for the poor families.

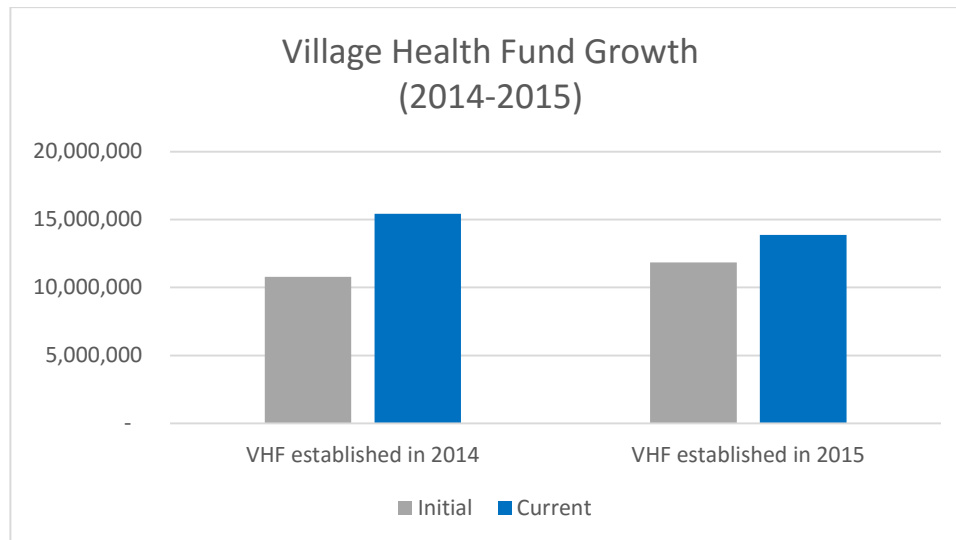
4.1.4 Sustainability of VHF

To ensure sustainability of VHF beyond MdM project, it is imperative to leave each VHC at highest level of functionality with ability to manage the growing fund with transparency and financial accountability. Supportive supervision and ongoing support from THD will also be necessary to hold VHC accountable for effective management of VHF for the benefits of the community. The evaluation team reviewed those key areas to understand readiness of VHCs and THD to take over responsibility from MdM at the end of the project.

Growth of Village Health Funds

In last two years, there was significant growth of village health funds in 3MDG supported villages. (Figure 1)The VHF established in 2014 grew by 43% from MMK 10,795,200 to MMK 15,424,900 whereas those established in 2015 grew by 17% from MMK 11,856,000 to MMK 13,861,750. The average size of each VHF established in 2014 is MMK 431,808; and that established in 2015 is MMK 494,000. MdM contributed MMK 300,000 for each VHF and thus each community contributed an average of 31 to 39 percent of total VHF amount.

Figure 1: Growth of Village Health Fund in Pyapon Township



The fund growth was largely contributed by the regular returns of the loans disbursed from the revolving fund pool, not from contributions from community members. To ensure sustainability, it is expected that the largest source of revenue to VHF should come from community contribution.

The fund growth success was mainly due to leadership of VHC members who had previous fund management experiences. The VHCs properly screened and selected the borrowers who would paid back the loans. To get a loan from revolving fund pool, the borrowers were also to be guaranteed by five persons living in the same community. They also set the specific timeframe for loan pay back and paid close attention for interest collection and loan repayment timeline.

When the revolving fund keep growing and we have more money, we will buy a boat because transportation is the most challenging barrier for our village"

- Focus group discussion with VHC Theing Kone Village

Nonetheless there were some cases where the fund recipient could not pay the loan back due to financial hardship. Hence, this type of issue could be a big threat for long-term sustainability of the VHF in the future.

There was no formal mechanism determined how revolving fund growth will replenish the emergency referral fund pool if and when the ERF amount is reduced for some reasons. Unfortunately the evaluation team learned that most VHCs were more interested in revolving fund growth rather than growing referral fund component. However in one village the VHC

mentioned that they intended to procure an emergency referral boat when the revolving fund grew in the future.

Functioning VHC for VHF Sustainability

- **Only if the VHC has improved level of functioning and put more emphasis on emergency referral fund pool, the VHF can continue to serve as a source of MNCH referral support in the future.** The proxy indicator of functioning VHC is the growth of village health fund and whether it is used for intended purposes efficiently and effectively. In most villages, the funds did grow noticeably; yet, a few emergency cases were referred using the VHF and the referral fund portion of VHF was found to be quite limited.
- **Although it seemed encouraging to see the growth of revolving fund pool under VHF, VHC's lack of intent and plan to maintain or grow emergency referral fund pool did not look promising for sustainability.** Qualitative interviews highlighted the fact that the growth of revolving fund pool of VHF did not necessarily translate into improving access for MNCH services for poor communities. Some VHCs lost sight of original objective of setting up the VHF – to provide more emergency referral support for most needed and poor individuals in the community, while figuring out ways to increase the revolving fund pool.

On the other hand, the functionality assessment for VHC (in **Table 6**) showed that the level of functioning status is quite different among the visited villages.

Table 6: Functionality Assessment for VHC

Indicators	Alan Pha Lut	Theing Kone	Taw Kyo	Phoe Thu Chaug	Kyone Kan Wa	Kone Tan
4.1 Committee Management Training: attendance by all members?	yes	yes	yes	Yes	Yes	yes
4.1.1 Constitution / ToR formulated?	2	2	2	1	1	2
4.2 Finance/ Book keeping Training: attendance by all members?	no	yes	yes	yes	yes	yes
4.2.1 Proper book keeping and in time done	3	2	3	2	2	3
4.2.2. Cash book and bank account in place	1	3	3	3	4	3
4.2.3 the leaders are regularly updated and informed about financial matters/ decisions	1	2	1	2	1	2
4.2.4 any financial procedure in place when withdrawing cash for referral ?	1	3	3	3	3	1
4.3 Leadership training: attendance by all members?	yes	yes	yes	yes	yes	yes
4.3.1 Active involvement/ participation of all members in discussion and decisions?	2	3	2	1	1	1
4.3.2 Decision are made in a democratic way	2	3	2	3	2	2

One consistent finding was that financial management procedures, ToR for VHC members and participatory decision making process among the members were found to be generally weak among all visited VHCs. In addition, there was no proper recording for information and data at the village level regarding emergency referral cases. The VHCs could not provide detailed information of referral cases when asked. Regarding MdM HMIS mechanism, it was very difficult to track down the records and data information related to ERF beneficiaries at the village level. The MdM staff also kept all those village data in hard copy and there was no computerized data for VHF status in intervention villages.

Readiness for handing over to THD

To ensure necessary support to VHCs, MdM has been facilitating the coordination mechanism in Pyapon Township and there are two types of coordination meeting;

1. RHC coordination meetings at RHC level where Basic Health Staff (BHS) (Midwives; MW and Health Assistance; HA) and volunteer health workers (Auxiliary midwives ; AMW and Community Health Workers) and MdM staff attend
2. Township Coordination meeting in Pyapon General Hospital where only BHS and MS (Medical Superintendent) where MdM has to participate in Day 1 of 2 days meeting and MS takes the leading role.

With discontinuation of per diem support for attendance to BHS and VHWs, it could disrupt continued engagement of BHS and VHWs, including VHCs at RHC level coordination meetings. MdM initiated the coordination platform in collaboration with Township Health Department (THD), which is the access point for both BHS to collect the salaries; AMW and CHW to collect medications and material distribution at RHC level. MdM reinforced this coordination platform by providing the per diem for the attendants. Hence, the attendance rate of BHS increased up to 95%. It would be a serious concern if THD does not have enough budget to cover per diem for meeting participants after MdM departure.

So far the 3MDG nor the THD is ready to take over responsibility of managing VHF and emergency referral fund components beyond 2016. The evaluation team understood that MdM has approached to 3MDG and THD to discuss and build consensus on implementation of action items during project close out phase, and agree on clear roles and responsibilities of each organization in the transitioning phase. At this point, it can be concluded that **it is very unlikely that the THD will be able to mobilize resources to manage VHF after MdM involvement has ended.**

4.2 EMERGENCY REFERRAL REIMBURSEMENT COMPONENT

In early 2013, the referral reimbursement system was established with the support of 3 MDG fund that covered the treatment cost for EmOC and ECC cases as endorsed by the Pyapon THD. In 2014, the reimbursement scheme was changed according to 3MDG and covered all referrals to institutional health facilities for life threatening emergencies affecting whole population (not just EmOC and Under 5 pediatric emergencies.)

The main areas that were examined in the evaluation of this component are outcomes and impact of emergency referral reimbursement system. The findings of these areas are summarized briefly in this section.

4.2.2 Improving Access to MNCH

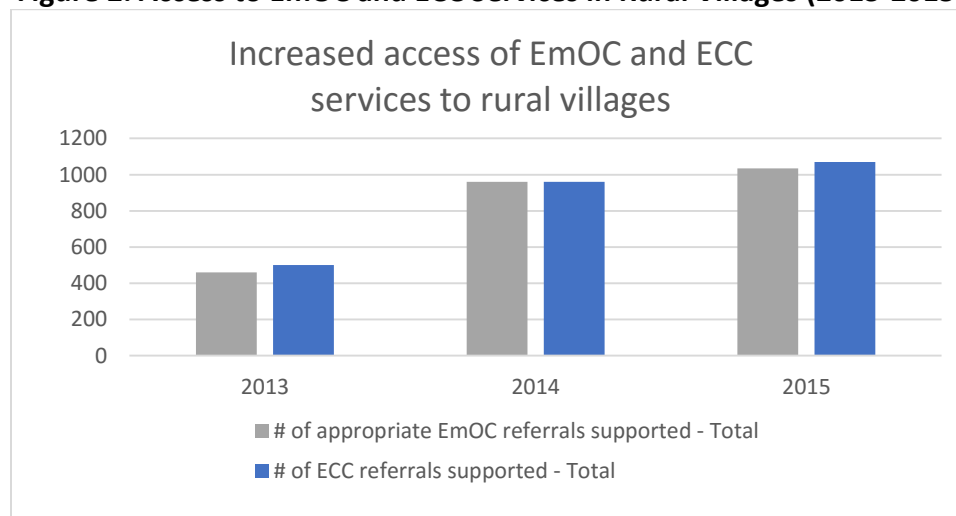
MdM initiated ERF in Pyapon Township has extended MNCH access to rural villages, but not really for H2R villages. In Pyapon Township, the project area covers 252 villages. Out of 252, the VHC are established in 241 villages. Out of 241 villages, 193 villages has established village health fund or ERF where 74 villages received co-funding support from 3MDG. However, ERF benefits were extended to 4 villages only – Saluchaung, LayKine, Laik Chaung, and Phaung Gyi Tan (in **Table 7**).

Table 7: ERF Coverage in Pyapon Township

	Project Area	VHC established	ERF Established	ERF established with 3MDG support	ERF established with self-funding	ERF established in H2R areas
Number of Villages	252	241	193	74	119	4

The graph (**Figure 2**) below depicts that **MdM support for Emergency Maternal and Obstetric Care (EmOC) and Emergency Child Care (ECC) referral cases from rural villages gradually increased over last 3 years (2013-2015).**

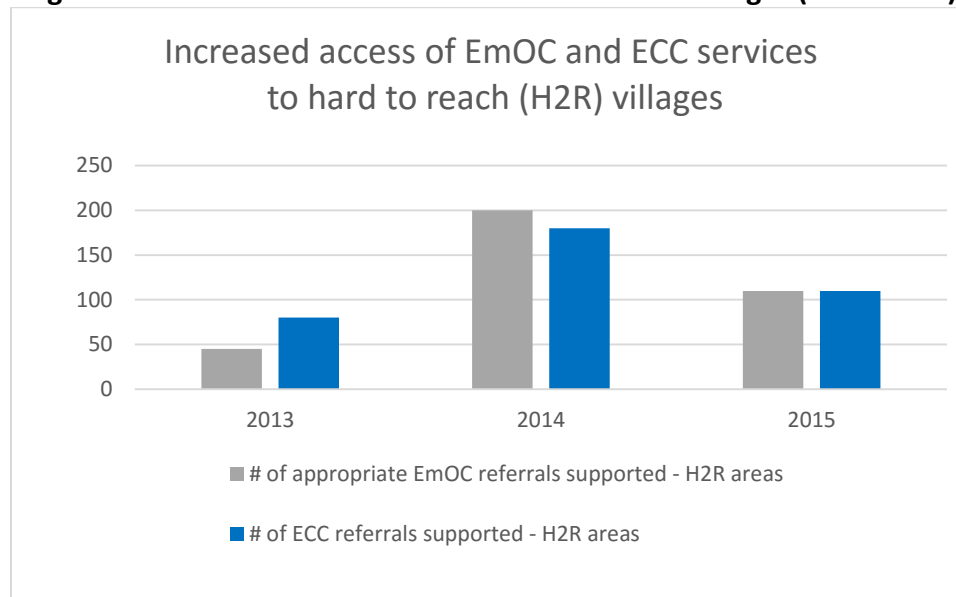
Figure 2: Access to EmOC and ECC Services in Rural Villages (2013-2015)



The graph (**Figure 3**) below depicts that for H2R villages, **although more referrals from H2R villages were supported in 2014 compared to 2013, the number of EmOC and ECC referral support to H2R villages seemed to be reduced in 2015.** It is however important to note the

definition of H2R was adjusted in second half of 2015, thus reducing the number of H2R villages from 29 to 13.

Figure 3: Access to EmOC and ECC Services in H2R Villages (2013-2015)



The low number of EmOC and ECC referrals from H2R villages can be connected with the lack of VHWs as well as lack of access to VHF. Out of 13 H2R villages in Pyapon Township, only 8 have CHWs and 6 have AMWs, and 12 have established VHC. The assumption that villages in

"We were able to transfer the case of 79 years old man with urethral rupture and excessive bleeding on time. We are glad that we could save one life".

- Stakeholder consultation workshop presentation by VHC

H2R areas might be seeking care at Bogale Hospital could not be tested due to limited data and information.

Qualitative interviews revealed that definition on "Emergency" had variations among the stakeholders, which was dependent on experiences and knowledge of the

referred person. Group discussion with VHC mentioned that although they referred the patient as an emergency, the patient was found to be not entitled to receive the benefit from referral reimbursement scheme at MdM office. In depth interview with Pyapon Hospital Medical Superintendent pointed out that many AMW made wrong diagnosis and incorrectly referred as a medical emergency and the hospital received many referral cases. Hence, the THD could not solely rely on the decision from AMWs since they were not well trained. This feedback was supported by report of Richard James, from MdM, said that MOH trained AMW as front line staff for MNCH; nevertheless, MOH did not fully recognize AMW as a part of THD structure and level of trust on skill of AMW is still at odd. Thus, emergency referral

reimbursement system started including life threatening non-MNCH cases and chronic cases referred by MWs/AMWs as eligible cases.

Those findings indicated that the level of understanding and interpretation about “medical emergency and life threatening” seemed to be quite different between skilled health personnel depending on experience and perception of each individual. Obviously, the term “emergency and / or life threatening “is generally hard to define for non-medical population.

4.2.3 Impact of Emergency Referral Fund

The impact of emergency referral fund in Pyapon Township is quite hard to determine based on the available data resources. Highlights of MdM’s major achievements over the last three years included:

- In 2013, 71% (4150) births attended by a skilled birth attendant; and 496 EmOC referrals supported.
- In 2014, improved institutional deliveries from 9% to 49%; improved skilled birth attendant deliveries from 71% to 85%
- In 2015, women representation on village health committees increased over 50%.

The following table (**Table 8**) of key MNCH indicators over the past three years summarizes and highlights the key program achievements in Pyapon Township.

Table 8: Summary of Key Program Achievements in Pyapon Township

MNCH indicators	2013	2014	2015
Number of appropriate EmOC referrals supported - Total	108% (496)	81% (782)	103% (1,067)
Number of appropriate EmOC referrals supported - hard to reach areas	113% (51)	4% (8)	40% (44)
Number of ECC referrals supported - Total	51% (257)	34% (328)	83% (888)
Number of ECC referrals supported - hard to reach areas	24% (19)	1% (2)	17% (19)

There is no doubt that VHF fund also catalyzed regular meetings among the VHC members and community; strengthened welfare, charity and volunteer spirit within communities. In other words, it also enhanced social cohesiveness within VHC members and communities.

4.2.4 Case Studies



Sandar win, 2 years old baby girl of Daw Tin Tin Aye, lives in Theing Kone Village, suffered from recurrent ARI since one month of age. On 12.5.2016 she got another attack of high fever, cough and tightness of chest. With the help of community health volunteer, her mother borrowed 10'000 kyats from village health fund to go to Seik Ma RHC and get treatment there. Daw Tin Tin Aye felt that village health committee is supportive and they offered for her to get help of health fund whenever she need.

Daw San San Aye, 42 years old, Muiti Gravida, living in Sa Lu Chaung Village, hard to reach area of Pyapon, was referred by the Midwife for elderly high risk pregnancy. On 23th May 2016, she suffered from labor pain and taken to Ah Mar Hospital by using 15'000 kyats from emergency referral fund as transport charges. At Ah Mar hospital, a male baby of 7 lb was delivered by EmLSCS. Her case was also entitled to emergency referral support and she was provided 130'000 kyats for transport, meal and medicine costs. When she returned to her village, she could pay back to village health fund. Now she feels relieved as emergency referral support from MdM and the emergency fund saved lives of both baby and mother, and also eased the financial burden.



Referral Fund increases social bonding and social cohesiveness among Village Health Committee and community

The Village Health Committee in Theing Kone Village under Hnit Char Sub-Center was formed with the support of Mdm in 2009. There are 5 female and 2 male members. So as to help poor people in case of emergency health conditions, they initiated on their own to establish a village health fund by contribution of 1'500 kyats among members. It grew by selling draw tickets at social events and existing amount of fund was matched with 300'000 kyats, support of MDM from 3MDG project for the objective of referral of EmoC and ECC. 300'000 kyats were revolved according to Mdm guidelines and 150'000 was supposed to use for transport fees in emergency referral. Once the fund was set up, the committee put a lot of efforts and struggled not to lose the revolving fund. At first, members were blamed and criticized by community, as they didn't realize the purpose and outcome of emergency referral fund. However, VHC members never gave up and their volunteerism was not ended. They are always very active to help people who are in need and in emergency conditions. At the moment, VHC could support 10 cases of under 5 children, 12 cases of pregnant mothers and 21 of other health problems including emergency and non-emergency. As a result, they gained their community trust and interest on their activities. In addition, as community participation and sense of ownership for emergency health fund is increasing, members feel proud to stand as VHC in the village.

“When the community realized the fund is used for them and the village health committee is the only management body which have no intention to abuse it, they don't have any negative thoughts on VHC anymore and we feel very motivated to be part of the VHC.”



5. OVERALL CONCLUSIONS

The identified objective of the emergency referral fund program, as stated in the program documents, were to improve access to essential maternal and child health services for poor families in rural communities in Pyapon Township.

From the above findings and the conclusions derived at each section it is possible to formulate the following general conclusions about the program:

- ***Village Health Fund Component:*** *The village health fund component of the program did encourage poor mothers and families to seek health care at the hospital, and it is still necessary to improve access to MNCH services for poor communities. As it is appreciated by the recipient mothers and children, village health committees and the basic health staff of THD, it cannot be justified on the basis of its expected impacts on improving access to essential maternal and child health services. Utilization of the VHF for emergency referral support at the village level is not necessarily or only benefiting women and under five children. The access to VHF was more limited and uptake of maternal and child health referrals remained low for poor communities in hard to reach villages. The proper utilization of VHF for maternal and child health referrals and VHF sustainability cannot be guaranteed at current level of functioning of VHCs, unless the THD and BHS could provide continuous support to VHCs beyond MdM project closure.*
- ***Emergency Referral Reimbursement Component:*** *In contrast, the emergency referral reimbursement component of the program has had a substantial impact on increasing EmOC and ECC referrals in the past three years. It has been successful in helping poor families reduce their high out-of-pocket expenditures for health services they seek at township hospital. It is highly appreciated and it is still needed, although it is very unlikely that the THD could mobilize resources to take over this component from MdM beyond MdM program.*

6. RECOMMENDATIONS

Based on the key findings, the following recommendations are developed.

Village Health Fund Component

- The primary objectives of establishing VHF should be re-educated among wider community and the messaging should focus on definitions of “emergency and life threatening” and eligibility criteria for use of emergency referral fund. MdM should discuss with the THD how BHS staff particularly MWs could support the VHCs for long-term sustainability VHF.
- MdM should take necessary actions immediately to reinforce the accountability, management and governance mechanisms of VHCs at intervention villages. The refresher trainings on financial management, bookkeeping and accountability principles should be organized for VHCs before the project closure. The management tools and materials should be simple and developed in a participatory way to ensure user-friendliness and meet the requirements for the VHC.
- MdM should facilitate to switch the focus of VHCs more on establishing appropriate mechanism to grow or maintain emergency referral pool under VHF; and to divert thinking pattern of VHCs towards how to benefit mothers and under 5 children with the VHF rather than growing revolving fund pool.
- Data and information management system of VHF should be strengthened at VHC level by introducing participatory monitoring and evaluation tools since the impact of effectiveness of VHF is hard to measure in current state.

Emergency Referral Reimbursement Component

- In consultation with the THD, eligibility criteria for emergency referral reimbursement should be clarified at all levels of fund management.
- Basic Health Staff (MW or HA), and more qualified healthcare personnel should be involved at village level in providing technical endorsement for any referral cases.
- Information management system of emergency referral reimbursement – should be strengthened at MdM field office level by focusing more on data analysis, interpretation and response processes.

Sustainability of VHF / Emergency Referral Fund beyond MdM

- VHF should be integrated with existing social safety net programs in the villages such as community charity fund and Mya Sein Yaung community development fund.
- To ensure continued support to VHCs for effective management of VHF, all VHCs managing VHFs should be integrated into Village Tract Health Committee (VTHC) that will hold accountable to Township Health Committee (THC) managed by Township Health Department.
- The existing coordination mechanisms at both RHC and Township levels should be strengthened where BHS and VHCs can come discuss about emergency referral improvement as an agenda item at those meetings.

- MdM should organize a brainstorming meeting among IPs, who have been implementing VHF component with 3MDG support, and jointly develop a memo to 3MDG highlighting the need of 3MDG advocacy support at central level. By highlighting benefits and achievements of emergency referral program, the key advocacy message should call the Ministry of Health to consider increasing budget allocation for 3MDG supported townships so that the THDs can continue supportive supervision and RHC level coordination meetings.

ANNEXES

ANNEX 1: SCOPE OF WORK

SELECTION OF METHODS		
Objectives	Methodology	Target groups
<ul style="list-style-type: none"> To appraise the Emergency Referral Fund as a tool to extend MNCH access to rural villages in Pyapon with particularly emphasis on H2R villages. To measure the impact of Emergency Referral Fund has had on overcoming barriers to life saving EMOC/ ECC referrals for relevant beneficiaries To explore how the village health funds could be used to maximize MNCH access to services in the context of the end of 3MDG direct support to referral services. 	Qualitative method through the rapid appraisal approach <ul style="list-style-type: none"> - Key informant interviews - Focus Group Discussions - Secondary Data 	Village Health Committee, Intended Beneficiaries
To access the current financial and accountability systems used by the VHC in management of the Emergency Referral Fund	Functionality Assessment tool	Village Health Committee members
To make recommendations which will support the development of a strategy to ensure the sustainability of the village fund beyond December 2016	Participatory Evaluation Workshop	MdM project team, Township Health Department, Health care providers, Village Health committee

Data analysis

Qualitative data will be collected in a form of recording, transcripts and field notes, and analyzed using the framework approach manually. The analysis will start from the day of the data collection.

Results from Qualitative interviews will be cross-referenced to the identified areas of consistency and divergence of viewpoints from Quantitative data analysis process for better triangulation.

QUALITY ASSURANCE

Through deploying different quality control measures, the consultancy team will make sure that the whole process of this evaluation will be of high technical quality. These strategies include but not limit to Protocol and tools presented to MDM experts for review and feedback, provision of enumerator's training, before actual fieldwork, maintaining high ethical standards, etc. In addition, to ensure the data quality, the consultancy team will apply different measures such as: data recording such as taping all interviews and FGDs, field level spot check and back check by the consultants, data triangulation using both research strands, data cleaning before data analysis, etc.

ETHICAL CONSIDERATION

Confidentiality and privacy will be assured in all the interviews. Efforts will be exerted to identify places for the interviews which ensured privacy, participant choice and no interruption. Interview or the FGD will start only after obtaining consent from the participants. Additionally, individual responses to evaluation questions will be held confidentially (ensure anonymity while using the quotes) in the process of analysis and presentation of results.

ANNEX 2: FOCUS GROUP DISCUSSION GUIDE (BENEFICIARIES, PREGNANT WOMEN, LACTATING MOTHERS, CARE GIVERS OF UNDER 5 CHILDREN)

1. What is the referral process to hospital if you/your child is in emergency condition? Who and How?
2. Is there any difficulty when you know it is essential to go hospital to get treatment for you/your under 5 kid?
3. Please explain about how difficult did you get decision to go hospital?
4. What do you consider going to hospital? Please tell/list the required things before going to hospital?
5. Do you consider the travelling time from home to hospital to get treatment?
6. Do you consider the waiting time at hospital to get treatment from hospital staff?
7. How long did you consider going to hospital when you got the referral advice from VHW or BHS?
8. Do you get any support for going to hospital? Which organization? Whom? How?
9. What are the objectives of MDM supports for emergency referral? Please describe? Who give you this information?
10. Is there any experience of un-receipt cost from MDM? Please describe how much different occurred between actual payments and amount received from MDM?
11. Is there any barrier to use the MDM emergency referral service? What were the barriers that you encountered during ER process?
12. Can you please share your experience on receiving care from hospital?

13. Can you please share your experience on receiving referral cost from MDM office /support from village health fund? And tell me your impression on the service provided?

Village Health Fund

14. How much do you know about village referral fund? Do community have to contribute to this fund?
15. Can you please tell how villagers can access to this referral fund? How do you know this information?
16. Is there any barriers/challenges to use this fund? What are these?
17. Is there any change (positive/negative) you can tell after setting VHF in your village? Please describe.

ANNEX 3: FOCUS GROUP DISCUSSION: VILLAGE HEALTH COMMITTEE

1. Please tell me what you know about how this village fund was established?

Fund Management

2. What is the mechanism for managing the fund? TOR/guideline?
3. What are the prioritized areas in utilization of Fund?
4. What trainings have VHC received for managing VHF?
5. Any further trainings and support provided
6. What monitoring and supervision measures are in place, how implemented

Status of the fund

7. Please share with me your impression about current situation of the fund, like is it growing or else
8. Why do you think so, what are the factors contributing — what further improvement will be needed
9. How can the fund be made growing, apart from earning interest from loans
10. What measures are in place to ensure loans are returned
11. What other measures need to be introduced to ensure loans are returned
12. Before setting up the fund are there any local arrangements for helping those facing financial hardships relating to illness and deaths
13. Are there any social group upon which to rely on when in financial needs
14. Please tell me your view on the advantages and weaknesses comparing the fund mechanism and traditional practices mentioned/How do they affect each other
15. How can service providers be benefited from the fund arrangement
16. How can they be involved? What improvement can they make for the fund to work better
17. Any success/significant change after setting up village fund? Please describe.
18. Any challenges regarding with village health fund? (Management/ Fund raising/Procedure, etc.) How to overcome this challenges?

19. What will be your suggestions/long term plan to sustain this referral fund without any support from MDM? Any support needed or not?

ANNEX 4: KEY INFORMANT INTERVIEW QUESTIONS FOR HEALTH SERVICE PROVIDERS (MW/HA/LHV/SMO)

- Type of facility
 - Name of facility
 - Covered Villages
 - No of emergency referral (ECC/EMOC)
1. What is your current role in emergency referral fund management?
 2. What are the challenges you encountered during emergency referral process?
 3. How did you manage the challenges for the ER process?
 4. What are the current factors that make ER services difficult?
 5. What would you recommend to improve the existing service and procedures to reduce the under5 mortality?
 6. What are the factors influencing to promote the institutional deliveries in your coverage area?
 7. What is your role to improve establishing referral fund/supporting VHC for community?
 8. Have you seen any success/best practices/significant change after setting up village fund in your coverage area? Please describe.
 9. Any challenges regarding with village health fund? (Management/ Fund raising/Procedure, etc)How did you support to overcome these challenges and how did the community overcome by themselves?
 10. Please describe your experience and suggestions how to grow Emergency referral fund.
 11. What will be your suggestions for long-term sustainability of this fund and for support needed?

ANNEX 5: KEY QUESTIONS FOR STAFF AT TOWNSHIP HEALTH DEPARTMENT

1. What are your roles in emergency referral services?
2. What are the current factors that make ER services difficult? What will be the solutions at township level?
3. What would you recommend to improve the existing service and procedures to reduce the under5 mortality?
4. What are the factors influencing to promote the institutional deliveries in your coverage area?
5. Do you aware there are village health fund established by MDM and community existing fund? Do you have any comments on it? Please share.

6. Have you seen any success/best practices/significant changes/ effectiveness after setting up village fund in your coverage area? Please describe.
7. Any challenges regarding with village health fund? (Management/ Fund raising/Procedure, etc.)
8. Do you consider village health fund should be maintained? Then what will be your suggestions for long-term sustainability of this fund and for support needed? Any action plan initiated with MdM?

ANNEX 6: RAPID APPRAISAL FOR VHC

Village

Village Tract

Township

- 1) Received MdM support referral fund Yes/ No
- 2) If Yes, Amount of fund received Kyats
- 3) Any community matching fund yes/ No
- 4) Amount of total fundKyat
- 5) Is there any fund management committee in the village? Yes/ No
- 6) No of Committee members
- 7) How the fund is made to grow?
- 8) Number of referral cases in last consecutive 3 years?
Under 5
Pregnant mothers
- 9) Any further information / Comment

ANNEX 7: FUNCTIONALITY ASSESSMENT TOOL FOR VILLAGE HEALTH COMMITTEE

	Aspect of assessment	Indicators	1 Poor	2 Average	3 Good	4 Distinctive
1	Formation of the VHC	1.1 Members of VHC could attend social mobilization meeting				
		1.2 Member of VHC were appointed or elected by the community				
		1.3 Composition of VHC represent the community				
2	Efficiency of management of VHC	2.1 VHC members carry out their tasks				
		2.2 Involvement, participation and information of other stakeholders (authorities, village leaders) in meeting and by reporting				
3	Efficiency of regular meetings of the VHC	3.1 Regular meetings (at least once per month)				
		3.2 Participation in meeting; have issue being discussed by all?				
		3.3 Have discussion lead to decision?				
		3.4 Minutes of meeting are written				
4	Capacity of VHC	4.1 Committee Management Training: attendance by all members?				
		4.1.1 Constitution / ToR formulated?				
		4.2 Finance/ Book keeping Training: attendance by all members?				
		4.2.1 Proper book keeping and in time done				
		4.2.2. Cash book and bank account in place				
		4.2.3 the leaders are regularly updated and informed about financial matters/ decisions				
		4.2.4 any financial procedure in place when withdrawing cash for referral ?				
		4.3 Leadership training: attendance by all members?				
		4.3.1 Active involvement/ participation of all members in discussion and decisions?				
		4.3.2 Decision are made in a democratic way				
5	Administrative matters in place	5.1 Bank account/ safe in placed?				
6	Phasing out of the organization	6.1 Taking up own initiatives to main or extend referral fund				
		6.2 Coordination with township health department				