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Save the Children

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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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



RHC	Rural Health Center
SC	Save the Children
SHG	Self Help Group
SMO	Station Medical Officer
TA	Travel Allowance
TBA	Traditional Birth Attendance
TMO	Township Medical Officer
TV	Television
USD	United States Dollar
USG	Ultrasonogram
VHC	Village Health Committee
VHT	Village Health Team
VHW	Village Health Worker
VTHC	Village Tract Health Committee
USAID	United States Agency for International Development



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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, Ayeyarwaddy 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 (KIIs), 18 KIIs with Public Health Staff, key persons from VHCs, volunteers and Save the Children staff from 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—cashier 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

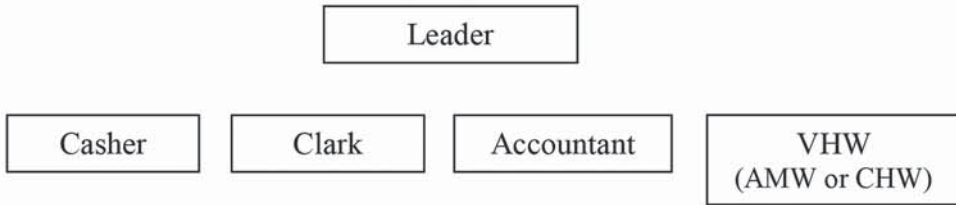
In Myanmar, 23.35% of population is women of reproductive age and 11.7% are under 5 children ⁽¹⁾. Implementation of maternal, newborn, child health and reproductive health care are priority areas in National Health Plan (2006-2011)⁽²⁾. General objective of Maternal, Newborn and Child Health (MNCH) is 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).



Village Health Committee



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

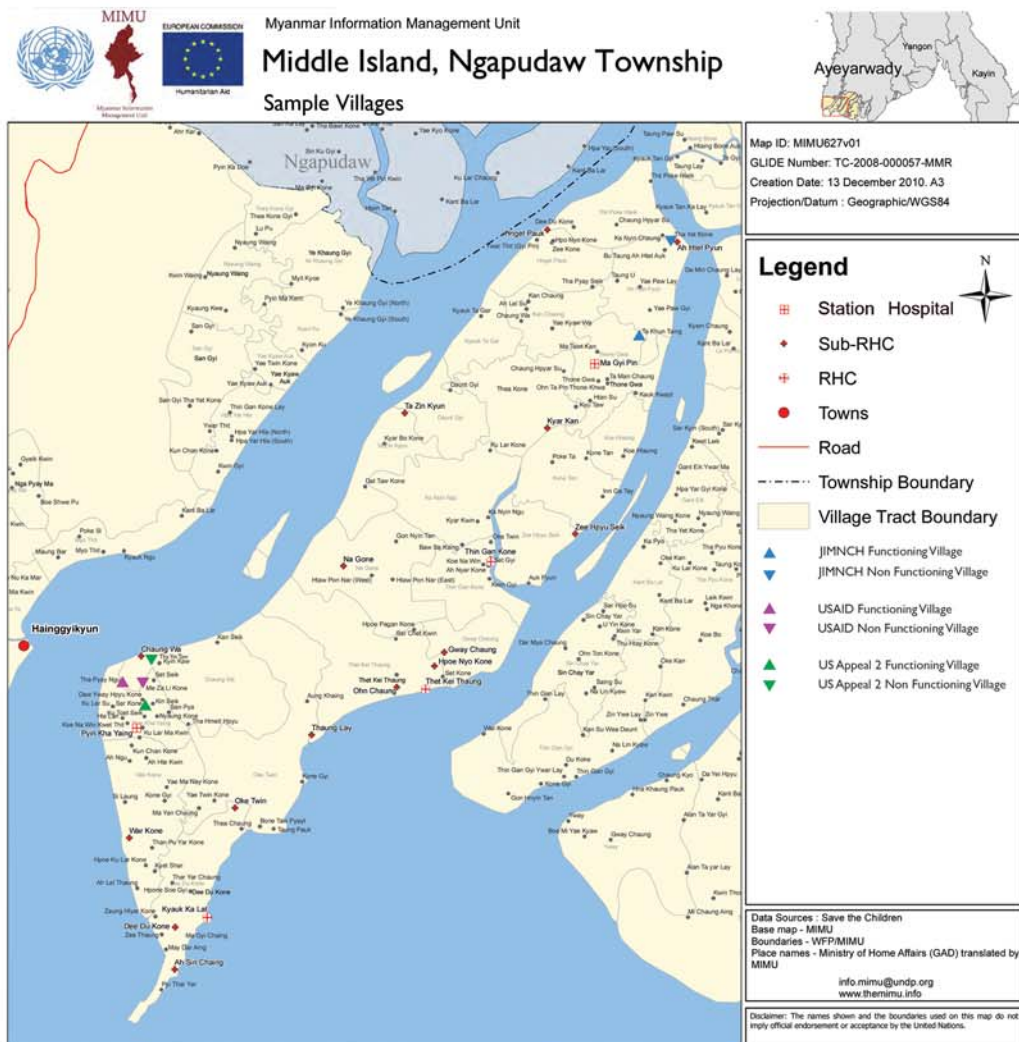
Women of ages 30-45 years from low socio economic condition, Public health staff from Station Hospital, Rural Health centers and Sub-centers in the study areas were included. Station Medical Officer (SMO), Lady Health Visitor (LHV) Health Assistant (HA) and Midwife (MW).

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, Thapyay Ngu-2, Sar Kone, Thayet Taw and Mae Zali Kone villages.



Middle island map showing 6 study villages

Sampling and sample size

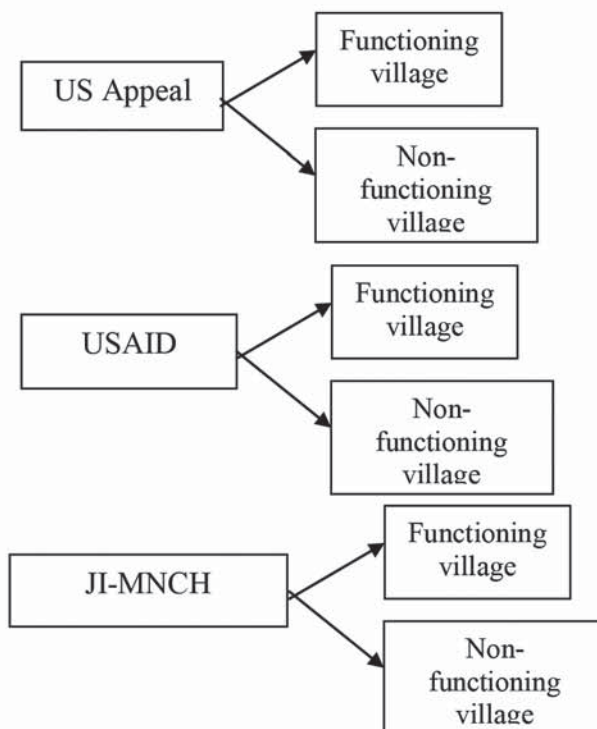
Selection criteria for villages:

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.

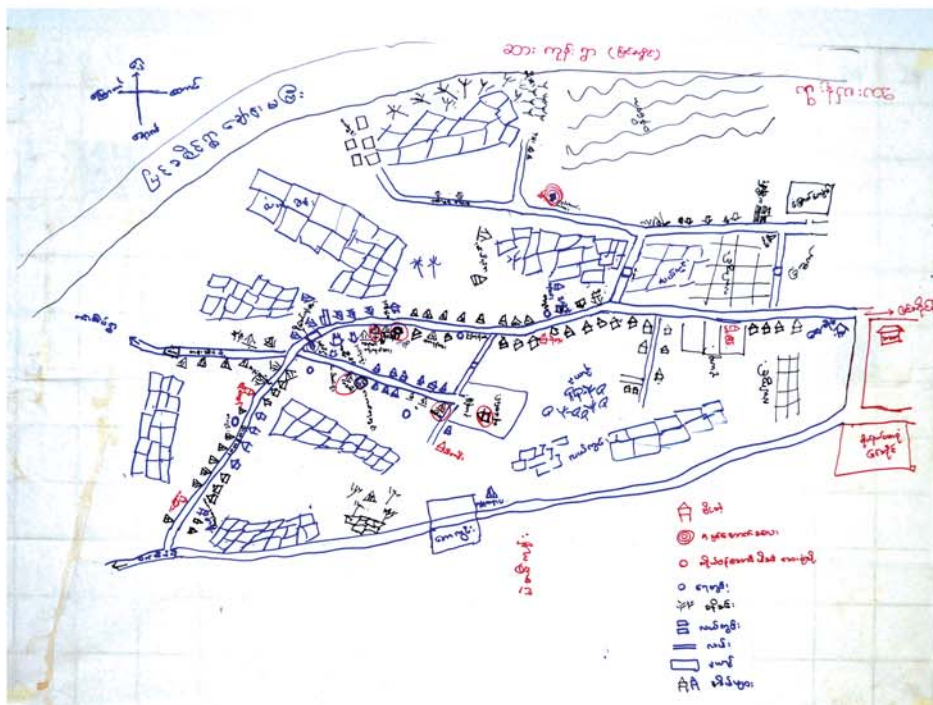
In depth interviews (IDIs): Women, either mother of under 5 children or women who had experience of emergency referral for emergency obstetric care (EmOC) or Emergency Child Care (ECC) within six months from each village are involved for IDIs. Total of 12 IDIs were conducted.

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 (KIIs): Eighteen KIIs 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 KIIs, 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 (KIs, 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 KIs 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 KIs. 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)

ကျေးရွာကျန်းမာရေးကော်မတီ VHC အဲတာကပြန်ပြီးတော့ အသက်သွင်းတာ၊ VHC ဆိုတာက government မှာ on structure ကရှိပြီးသား၊ ရွာတိုင်းရှိတယ်။ ဥက္ကဋ္ဌသည် ကျေးရွာအုပ်ချုပ်ရေးမှူး၊ အတွင်းရေးမှူးသည် BHS၊ နဂိုကတည်းက ရှိတယ် ၊ အဲဒီမှာကျေးရွာကျန်းမာရေးကော်မတီလိုရေးထားတယ်။

အဲဒီကော်မတီကို ပြန်အသက်ဝင်အောင်လုပ်ရတာပေါ့။ meeting ပြန်ခေါ်တာပဲ။ အစည်းအဝေးတွေ ပြန်ပြီးလုပ်ဖြစ်အောင် တကယ့် issue တွေဆွေးနွေးလို့ရအောင် ကျွန်တော်တို့ ဘက်က facilitate လုပ်ပေးတယ်။ monthly ပေါ့၊ အဓိကလူတွေစုံဖို့ လိုတယ်။ ရွာတိုင်းကိုတစ်ရွာချင်းစီ မလုပ်နိုင်ဘူး။ village tract လောက်အထိကို ပေါင်းတယ်။ (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)

Village Health Committee ကဒီလိုရှိတယ်။ USAID ကထွက်တော့ Save the Children ကပဲ PONREPP project ကဝင်လာတယ်။ PONREPP ကဝင်လာတဲ့အချိန်မှာ သူတို့မှာ revolving fund တွေရှိတယ်။ emergency fund တွေရှိတယ်။ ဒါပေမယ့် USAID လုပ်တဲ့အချိန်မှာ emergency referral fund ဆိုတာ ရှိတယ်ဆိုတာပဲကြားဘူးတယ်။ ကျန်းမာရေးဝန်ထမ်းတွေလုံးဝ အသိလည်း မပေးဘူး။ တိုင်လည်းမတိုင်ပင်ဘူး။ ကျန်းမာရေးဝန်ထမ်းကလုံးဝမသိဘူး။ သူတို့က ထွက်လည်းထွက်ရော PONREPP project က ဆက်ဝင်လာတဲ့အခါကျတော့ ဒီ Save the Children ပဲဖြစ်တဲ့အတွက်ကြောင့်မို့လို့ သူတို့ရဲ့မဆုံးသေးသော ပန်းချီကားကိုဆက်ဆွဲရတာပေါ့။ သူတို့ရဲ့ revolving fund ကော်မတီ အကုန်လုံးကို ကျွန်မတို့ကိုပစ်ထည့်ခဲ့တာ။ ကျွန်မတို့ကို သူတို့ရဲ့ ဒီအဖွဲ့တွေကို ဆက်လက်ပြီး တာဝန်ယူပေးပါဆိုပြီး ထားခဲ့တာ။ သူတို့က သူတို့ member တွေရော ပိုက်ဆံတွေရော၊ ကျမတို့ village health committee အောက်ထဲ ကိုထည့်လိုက်တာ။ အကုန်လုံးကို တာဝန်ယူလိုက်ရတာ။ သူတို့အဲလိုမဝင်လာခင် ကတုန်းက Village Health Committee က fund မရှိဘူး။ ဘာ fund မှမရှိဘူး။ သူတို့ဝင်လာတဲ့ အခါကျမှ fund ရှိလာတာ။ ဟုတ်တယ်။ fund ရော လူရော ကျမတို့ကို လွှဲပေး လိုက်တယ်ပေါ့။

(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—cashier 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.

ကျေးရွာကျန်းမာရေးကော်မတီမှာ ပုံမှန်အရဆို ၅ယောက်၊ ဥက္ကဋ္ဌ၊ အတွင်းရေးမှူး၊ အဖွဲ့ဝင် ၂ယောက်၊ နောက်ဆုံးတစ်ခုကကျန်းမာရေးလုပ်ငန်း စိတ်ပါဝင်စားသူ ရပ်မိရပ်ဖ တစ်ဦး။ နံပါတ် ၅ပေါ့။ ၃နဲ့ ၄က local NGCကနေကြက်ခြေနီတို့ MMCWA တို့။ အဲတာက နဂိုရှိတဲ့ structure ကျနော်တို့ဘာမှမပြင်ဘူး။ ကျွန်တော်တို့ဘာမှလုပ်လို့မရဘူး။ government ရဲ့ structure ဖြစ်တယ်။

ဒီ structure ကြီးသည် သူက post နဲ့ခန့်ထားတာ ဥက္ကဋ္ဌသည် administrator အတွင်းရေးမှူးသည်လည်း BHS ဖြစ်ရမယ်။ အဲဒီ ၂ခုကလည်း သူ့ဟာသူ ရှိတယ်။ ကျွန်တော်တို့လုပ်လို့ရတာ နံပါတ် (၅)တစ်ခုပဲရှိတယ်။ ကျန်းမာရေး လုပ်ငန်း စိတ်ပါဝင်စားသူ ရပ်မိရပ်ဖတစ်ဦး။ အဲဒီတစ်ဦးနေရာမှာပဲ functioning လုပ်မဲ့သူ ထည့်လို့ရတယ်။ နောက်ဆုံး စိတ်ပါဝင်စားသူ တစ်ယောက်ကိုပဲ ဆရာမနဲ့ သေချာဆွေးနွေးပြီး ဘယ်လိုလုပ်မလဲ။ Informally communication ရှိတဲ့လူ ဘယ်သူတွေရှိလဲ။ ဥပမာအားဖြင့် ဆရာမ ရွာသွားလို့ ကလေးမလာလို့ လိုက်ခေါ်ပေးတဲ့လူမျိုးပေါ့။ သူသည် အသက် ကြီးချင်ကြီးမယ် ငယ်ချင် ငယ်မယ်၊ ကျား-မဖြစ်ချင်ဖြစ်မယ်။



အုပ်ချုပ်ရေးဘက်က ဟုတ်ချင်လည်း ဟုတ်မယ်၊ အုပ်ချုပ်ရေးနဲ့ မတည့်တဲ့လူလည်း ဖြစ်ချင်ဖြစ်မယ်။ ဒါပေမယ့် ဆရာမ အတွက် support လုပ်နိုင်တယ်။

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 could 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)

Mass meeting ဆိုတစ်ရွာလုံးဖိတ်တယ်။ တရွာမှာ လူရွေးဖို့ အုပ်ချုပ်ရေးဘက်နဲ့ ဆရာမဘက်ကသူလူ၊ ကိုယ့်လူတွေဖြစ်နေတော့ အဲဒီအခါ mass meeting ခေါ်လိုက်တယ်။ mass meeting ခေါ်ပြီး ရွာမှာစေတနာ့ဝန်ထမ်းလုပ်ဖို့အတွက် ဒီလို၊ ဒီလိုမျိုး အရည်အချင်းရှိတဲ့ လူတွေလိုချင်တယ်။ အဲလိုလူမျိုးတွေကို ဘယ်သူတွေဖြစ်နိုင်မလဲ။ အဲဒီအစည်းအဝေးမှာ လူတိုင်းတက်ရတယ်။ တစ်အိမ် တစ်ယောက်၊ အများစုကတော့ လာကြပါတယ်။ အားလုံးကိုမေးလိုက်တာ၊ ဒီလူဆိုရင်ရောအဆင်ပြေနိုင်မလား။ အဲဒီမှာတင်ပဲအပြန်အလှန်ပြောပြ အရင်ဆုံး criteria အရင်ချရတယ်။ အဲလိုလူတွေရော ဘယ်သူတွေရှိလဲ ၊ သူဆိုရင်ရော လုပ်နိုင်မလား ၊ ကာယကံရှင်ရော ဘယ်လိုသဘောရလဲ။ အဲဒီအစည်း အဝေးတုန်း ကလည်း ကျွန်တော်မပါသွားဘူး၊ နောက်ပိုင်း ပြန်ကြားတာကသူတို့ယောက်လုံးထဲ ကမဟုတ်ဘူး၊ တခြားတစ်ယောက်ရသွားတယ်တဲ့။



အဲတာကိုလည်း နှစ်ဖက်စလုံးကသဘောတူတယ်။ Community ကတော်တော် strong ဖြစ်တယ်။
(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)

ကျွန်တော်တို့က ရံပုံငွေဆိုတဲ့ဟာကိုလုပ်ဖို့အတွက် ရံပုံငွေကိုကိုင်မယ့် ငွေကိုင် စာရင်းကိုင်က essential ပဲ။ နဂို structure အရမရှိဘူး။ မရှိဘူးဆိုတော့ ပိုက်ဆံ ချမယ်ဆိုလို့ရှိရင်တော့ ယောက်ကတော့ထပ်ထည့်ရတော့မယ်။ ငွေကိုင်၊ စာရင်းကိုင်၊ အဲဒီ ၂ ယောက်ကိုတော့ ကျေးရွာကျန်းမာရေး ကော်မတီအဖွဲ့ဝင် အဖြစ် သတ်မှတ်မယ်။ သူ့ကို အပေါင်းအနုတ် သင်မှာဖြစ်တဲ့အတွက်ကြောင့် mass meeting နဲ့ဘဲ ရွေးတယ်။ ရွာကိုမသွားခင် ဦးနောက်ထဲမှာ အကြမ်းဖျင်း ၅ ချက်၊ ၆ ချက်လောက်တော့ စဉ်းစားသွားတယ်။ ဆရာမဒီလူကတော့ဖြင့် ဒီလို အလုပ်မျိုးကို လုပ်မယ်။ ဘယ်လိုမျိုး manage လုပ်ဖို့ရ၊ ပိုက်ဆံတွေပေးမယ်၊ သင်တန်းတွေပေးမယ်၊ အဲဒီလူက ပထမဆုံး ရွာမှာနေတဲ့လူ ဖြစ်ရမယ်၊ ရိုးသား ရမယ်၊ အတော်အသင့် ပညာအရည်အချင်း ရှိတဲ့လူဖြစ်ရမယ်၊ နောက် စိတ်ပါဝင်စားသူပေါ့၊ ဆရာမနဲ့ တကယ်ရော အတူတူလုပ်မှာလား၊ အဲလို လူမျိုးတွေ ရွေးတယ်။
(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.

စာရင်းကိုင်ဆိုတာ စာရင်းနိုင်ဖို့လိုတယ်။ ငွေကိုင်က ငွေလဲထိန်းသိမ်းနိုင်ရမယ် စိတ်ဝင်စားရမယ်။ လုပ်နိုင်တဲ့သူလဲဖြစ်ရတယ် ဒီအတွက်လဲ အချိန်ပေးနိုင်ရမယ်။ အဲလိုမျိုးပေါ့၊ ကျေးရွာထဲမှာရှိတဲ့လူတွေနဲ့ တိုင်ပင်ပြီးဆွေးနွေးတယ်။ တယောက်ထဲ ဆုံးဖြတ်တာတော့ မဟုတ်ပါဘူး၊ အများလက်ခံတဲ့သူဖြစ်ရမယ်။

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)

ဖြေဆိုသူ ၁၊ ၅၊ ၈ - ကလေးကျန်းမာရေးအတွက် ပိုက်ဆံထုတ်ချေးပေးတယ်။

ဖြေဆိုသူ ၉- အရေးပေါ်လမ်းစရိတ် ဒိန်ဒေါင်းခဘယ်လောက် နှိမ်ပါးတဲ့လူ တကယ်ထောက်ပံ့ပေးတယ် ထိုးဆေး၊ စားဆေး၊ သားဆက်ခြားဆေး တွေလုပ်ပေးတယ်။

ဖြေဆိုသူ ၁၊ ၉- အဲဒါတွေလုပ်တာတော့ သိတာဘဲ ဝမ်းပျက်၊ ဝမ်းလျှော အိမ်သာတွေ ဆောက်ပေးတယ်။

(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)

မေး- ကျေးရွာကျန်မာရေး ကော်မတီအကြောင်းကြားဘူးလား။

ကြားဘူးတယ်။

မေး- ဘာလုပ်ပေးတာလဲ။

ကလေးတွေအတွက် အာဟာရကျွေးတယ်(၅နှစ်အောက်ကလေးတွေ)

မေး- ဘယ်လိုကျွေးတာလဲ။

အစာအုပ်စု(၃)မျိုးညီအောင်ကျွေးတယ်။

လက်တွေ့ချက်ပြုတ်ကျွေးမွေးတယ်။ သရုပ်ပြချက်ပြုတ်ပြီး ဒီအိမ်မှာဘဲကျွေးတယ်

မေး- ကျွေးတဲ့အချိန်မှာ ကလေးဘယ်နှစ်ယောက်လောက်ရှိလဲ။

အယောက်(၅၀)လောက်ရှိတယ်။

(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)

တခု မျက်စိနောက်စရာ တချို့နေရာမျိုးဆိုရင် တရွာလုံးမှာ ၁ ဖွဲ့ဘဲရှိတယ် ဆိုတော့ သိတယ်။ ဒီဘက်မှာကျတော့ ဘယ်လိုလည်းဆိုတော့ ပက်က ဖွဲ့ထားတာရှိတယ်။ ပက်ဆိုတာ ငွေစုငွေချေးအဖွဲ့ပေါ့။ တခြား Nutrition တို့နည်းနည်း မျက်စိနောက်စရာလေးတွေပေါ့နော်။ တခြားဟာလေးတွေလည်း ရှိချင်သေးတယ်။ နောက်တခါကျတော့ Community အနေနဲ့ Save the Children ကဖွဲ့ထားတာကို တချို့တော်တော်များများသိတယ်။



ဒါပေမယ့် တချို့တွေကမသိဘူး၊ သူတို့တွေက ဘယ်သူတွေသိလည်းဆိုတော့ AMW, CHW ရှိတယ်ဆိုတာသိတယ်၊ ရွာတွေတော်တော် များများပေါ့။ (KII with SC Field staff-1)

KIIs with SC staff and BHS mentioned objective of VHC is to cut off the first delay.

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)

မသိခြင်း delay၊ မရောက်ခြင်း delay၊ ရောက်တော့လည်းမရခြင်းပေါ့၊ service မရခြင်းပေါ့။ အဲဒီမှာမှ ကျွန်တော်တို့က မရောက်တဲ့ delay ပေါ့။ Health centre ကို မသွားနိုင်တဲ့ delay ကိုဖြတ်ဖို့အတွက် ကျွန်တော်တို့က referral ကို support လုပ်တယ်၊ အရင်ဆုံး emergency case ကို define လုပ်တယ်။ (KII with SC staff-1)

KIIs 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)

SC မဝင်လာခင်ကတုန်းက Village Health Committee က ဘာ fund မှမရှိဘူး၊ သူတို့ဝင်လာတဲ့ အခါကျမှ fund ရှိလာတာ၊ fund ရော trained လုပ်ထားတဲ့ လူတွေရော ကျမတို့ကိုလွှဲပေးလိုက်တယ်ပေါ့၊ ကျွန်မက ကြိုက်ပါတယ်။ ဘာလို့လဲ ဆိုတော့ အခုနပြောတဲ့ first delay ကိုဖြတ်နိုင်ရင်တော့ ကျွန်မတို့ အရမ်းပဲ အဆင်ပြေတယ်လေ၊ အဲဒီအတွက်ကြောင့်မို့လို့ ကျွန်မ ကြိုက်တယ်၊ ဘာပဲဖြစ်ဖြစ် ဒီဟာလေးကို အားကြိုးမာန်တက်နဲ့ ဝိုင်းလုပ်ပေးတာပေါ့။ (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)

မေး- ကျန်းမာရေးကော်မတီဖွဲ့တာက ဘယ်လိုရည်ရွယ်ချက်တွေနဲ့ ဖွဲ့တာလဲ။
အဓိက ၅နှစ်အောက်နဲ့ ကိုယ်ဝန်ဆောင်ပေါ့။ သက်ကြီးရွယ်အိုတွေမပါဘူး
ကျန်းမာရေး အသိပညာ ဖွံ့ဖြိုးတိုးတက်စေဖို့၊
ကိုယ်တိုင်စောင့်ရှောက်မှုလုပ်နိုင်စေဖို့ ရည်ရွယ်ပြီးဖွဲ့ထားတာ။

(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)

၆-အဲဒီအဖွဲ့ကညွှန်ပေးဖို့၊ ၅နှစ်အောက်ကလေးနဲ့ အမေတွေ အရေးပေါ်ဖြစ်ရင်
လွှဲလို့ ရအောင် ဆိုပြီးတော့-----

၄၊၅- လိုအပ်ရင်ကူညီပေးဖို့-----

၂- သွားဖို့လာဖို့စီစဉ်ပေးရလုပ်ပေးရတာပေါ့။

၃-ကိုယ်ဝန်ဆောင်နဲ့၅နှစ်အောက်ကလေး ကျန်းမာရေးအတွက်လို့ပြောတယ်။

ပိုက်ဆံတွေဘာတွေလိုရင်ချေးတယ်၊ ကျန်းမာရေးအတွက် အစည်းအဝေးခေါ်တယ်။

(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, book keeping training was mentioned by most VHC members.

SC staff described how they provide the trainings as follows:

We give book keeping 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 book keeping training, here were 3 people (cashier, accountant and local authority) from one VHC attended.

စာရင်းကိုင်ကတစ်ယောက်၊ ငွေကိုင်ကတစ်ယောက်၊ Book keeping training ပေးတယ်။ စာရင်းအင်းပညာသင်ပေးတယ်။ ၂ရက်သင်တယ်။ ဘုန်းကြီးကျောင်းတွေမှာ သင်တယ်။ ဘုန်းကြီးကျောင်း တစ်ခုမှာစုပြီး ခေါ်လိုက်တယ်။ ရွာတွေအကုန်လုံး ခေါ်တယ်။ အယောက်၂၅၊ ၃၀လောက်၊ ကျွန်တော်တို့သင်တယ်။ သင်တာက သင်ရိုးစာအုပ်တွေဘာတွေ ရှိတယ်။ အဓိက principal ပြောပြီးရင် exercise လုပ်တယ်။ မြန်မာလိုပဲ အဲတာ၂ရက်သင်တယ် - - - book keeping သင်တန်းပေးတုန်းက ကျွန်တော် တို့က ငွေကိုင်တစ်ယောက်၊ စာရင်းကိုင် တစ်ယောက်ခေါ်တယ်။ အုပ်ချုပ်ရေးမှူး ခေါ်တယ်။ ဥယျာဉ်ခေါ်တယ်။

One of the respondents who attended the book keeping 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 PONREPP 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 ဆိုတာ ဘာကိုပြောချင်တာလဲ။ အဲတာကိုဘယ်လို support လုပ်မှာလဲ။ အဲဒီ support လုပ်မယ့် mechanism ကြီးတစ်ခုလုံးကို ဘယ်သူကဦးဆောင်မှာလဲ။ ကျွန်တော်တို့ကဘယ်နေရာမှာနေမှာလဲ။ Township Health Department ပေါ့။ Station Health Unit က ဘယ်နေရာမှာနေမှာလဲ။ အဲတာတွေအကုန်လုံးက ပထမဦးဆုံး PONREPP ဆိုတဲ့ proposal ကြီးစကတည်းက PONREPP သည် leadership က government ဝဲ။ Township Health Department ဝဲ။ ကျွန်တော်တို့ဘက်က support လုပ်ပေးမယ်။ Facilitate လုပ်ပေးမယ်။ ပထမဆုံး concept ပေါ့။ ပထမဆုံးစပြီး အဲဒီပုံစံမျိုးနဲ့ develop လုပ်တယ်။ အနှစ်သာရကတော့ အဲတာ။ အသွင်သဏ္ဌန်ပြောင်းတဲ့အခါမှာ ဘယ်လို plan ဆွဲမလဲဆိုတာ Joint Township Health Plan လို့ခေါ်တယ်။ Joint Township Health Plan (JTHP) ကိုနောက်တစ်မျိုးခေါ်တာ Coordinated Township Health Plan လို့ခေါ်တယ်။ CTHP ပေါ့။ (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)

ဆရာကြီး (TMO)က need assessment လုပ်ပါ။ ဒီ midwife တွေနဲ့။ အဲဒီမှာပဲ ဘယ်ရွာကဘယ်နှစ်ယောက် AMW or CHW လိုမယ်ဆိုတာ ထွက်လာတယ်။ refresher training ရော initial training ရောပါတယ်။ Refresher မှာ functioning AMW ပေါ့။ ဆရာမတွေဘယ်လို criteria မျိုးနဲ့ functioning သတ်မှတ်ချင်လဲ။ ကျွန်တော်တို့မှာ refresher ပေးဖို့အတွက် ဘယ်နှစ်ရက်စာ။ ဘယ်လိုပေးနိုင်တဲ့ပမာဏ budget ဒီလောက်ရှိတယ်။ ဆရာမတွေက AMW ဘယ်နှစ်ယောက်ကို ပေးချင်လဲ။ အဲဒီအခါ ကျွန်တော်တို့ဘက်က facilitate လုပ်ရတာက တကယ့် well functioning AMW ပေါ့။ ဆရာမတွေကို မေးခွန်းတွေပြန် မေးပေးရတာပေါ့။ ဘာဖြစ်လို့ functioning လို့ပြောတာလဲ။ ဘာဖြစ်လို့ ပေးချင်ရတာလဲ။ ပေးပြီးရင်ဘာအကျိုးအမြတ်ရမှာလဲ။ ကိုယ့်အတွက် ဘယ်လိုမျိုး အထောက်အကူ ဖြစ်မလဲ။ ဖြစ်ပြီလား၊ ရပြီလား၊ အိုကေ ပြီလားဆိုတော့မှ ဒါသည် functioning ပေါ့။ Technical support ကတော့ leading role ကတော့ DOH ပါပဲ။ (KII with 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. There are 100 households and so it is complicated. (KII with secretary of VHC-2).

မေး- အတွင်းရေးမှူးက ဘာတာဝန်ယူရလဲ

ဖြေ- ထွေထွေထူးထူးတော့မရှိဘူး ဆွေးနွေးတိုင်ပင်တာပဲရှိတယ်။ ပြဿနာကြီးကြီးလဲမရှိဘူး

မေး- ငွေကိုင်စာရင်းကိုင်တွေကကော ဘာလုပ်ရလဲ။

ဖြေ- တလတကြိမ်ငွေဖြည့်တယ် အတိုးပေးတော့ငွေပြန်ဖြည့် ပြန်ထုတ်ချေးတယ်။ စာရင်းထဲသွင်းတယ် အိမ်ခြေ ၁၀၀ကျော် စာရင်းသွင်းရတော့ အလုပ်ရှုပ်တာပေါ့။ (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.

USAID လုပ်ခဲ့တုန်းက ကျန်းမာရေးနဲ့ပတ်သက်တဲ့ဟာပေါ့။ ကျွန်မတို့က ကျန်းမာရေးဝန်ထမ်းတွေ၊ ကျွန်မတို့မရောက်ခင်ကတည်းက သူတို့လုပ်နေတာပေါ့။ ကျွန်မတို့ကတိုင်ပင်စေချင်တယ်။ နည်းနည်းပါးပါး၊ လုံးဝမသိခဲ့ရဘူး။ ကျွန်မကသာစပ်စပ်စုစုလိုက်လုပ်တာ။ သူတို့ကမကျေနပ်ဘူး၊ ဥပမာ အိမ်သာပေါ့။ ကျွန်မပြောတာ အိမ်သာပေးတယ်ဆိုတာ အရမ်းလွယ်တယ်။ အိမ်တစ်အိမ်က သူ့မှာ အိမ်သာရှိရဲ့သားနဲ့ သူလိုချင်လို့ယူထားတယ်။ အိမ်တစ်အိမ်တည်းနဲ့ အိမ်သာ ၃လုံး ဖြစ်နေတာရှိတယ်။ အဲတာတွေက နည်းနည်း useless ပေါ့။ အဲတာတွေ ကျွန်မလိုက်စစ်တယ်။ လိုက်စစ်တော့ သူတို့အလုပ်တွေ ဝင်ရှုပ်တယ်ဆိုပြီး ကျွန်မတို့နဲ့ သူတို့နဲ့သိပ်ပြီး သဟဇာတမဖြစ်ဘူး။

USAID လုပ်တုန်းက တော်တော်များများကို ကျွန်မတို့မသိရဘူး။



PONREPP plan စဝင်လာတဲ့အချိန်ကစပြီး သူတို့ကတကယ့်ကို ကူညီပံ့ပိုးသူသပ်သပ်ပဲ။ အဲလို လုပ်တယ်၊ ကျွန်မကတော့ ကြိုက်တယ်။

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 Superintendent also agreed to do so i.e. Station Hospitals as referral centre for Middle Island.

Level တိုင်းမှာတိုင်းမြို့နယ်တွေမှာ MW တို့နဲ့ emergency referral နဲ့ပတ်သက်ပြီးတော့ process တွေမှာအဆင်ပြေတယ်ဆိုတာက ဘာကြောင့်လည်းဆိုတော့တကယ့် referral mechanism ကိုမစခင်မှာ ဘာလုပ်လည်းဆိုတော့ BHS တွေနဲ့ meeting လေး လုပ်လိုက်တယ်၊ referral path way ကို ကျွန်တော်တို့ decentralize လုပ်မယ်ဆိုရင် တကယ် community အတွက် လက်လှမ်းမှီ access ဖြစ်တဲ့ လက်လှမ်းမှီတဲ့ referral center စီကို သွားစေချင်တယ်။ သူတို့အတွက်လည်း လွယ်လွယ်ကူကူဖြစ်ရမယ်။ middle island က လပွတ္တာကို township hospital emergency refer လုပ်မယ်ဆိုရင် အခက်ခဲတွေ အများကြီးဘဲ ရိုးရိုးလေ၊ သဗ္ဗာန်တိုနဲ့ သွားလို့မရဘူး။ သူတို့ရဲ့မြစ်က ပင်လယ်လောက် ဖြစ်နေတယ်။ - - - - - အဲဒီအခက်ခဲတွေကြောင့် BHS တွေက refer ကိုလပွတ္တာ ဆေးရုံကိုလွှဲရင် ဘယ်သူမှမသွားဖူး။ အဲတော့ BHS တွေနဲ့ community ရဲ့needတွေက ဒီသဘောရှိတယ်။ refer လုပ်ရင် Station Hospital ကိုသွားစေချင်တယ်။ နောက်ပြီးတော့ရှိတဲ့ facility အရော township က MS ကလည်း agree ဖြစ်တယ်။ Middle Island က refer ကို Sation Hospital ကိုလွှဲပါဆိုပြီး သဘောတူလိုက်ကြတယ်။



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)

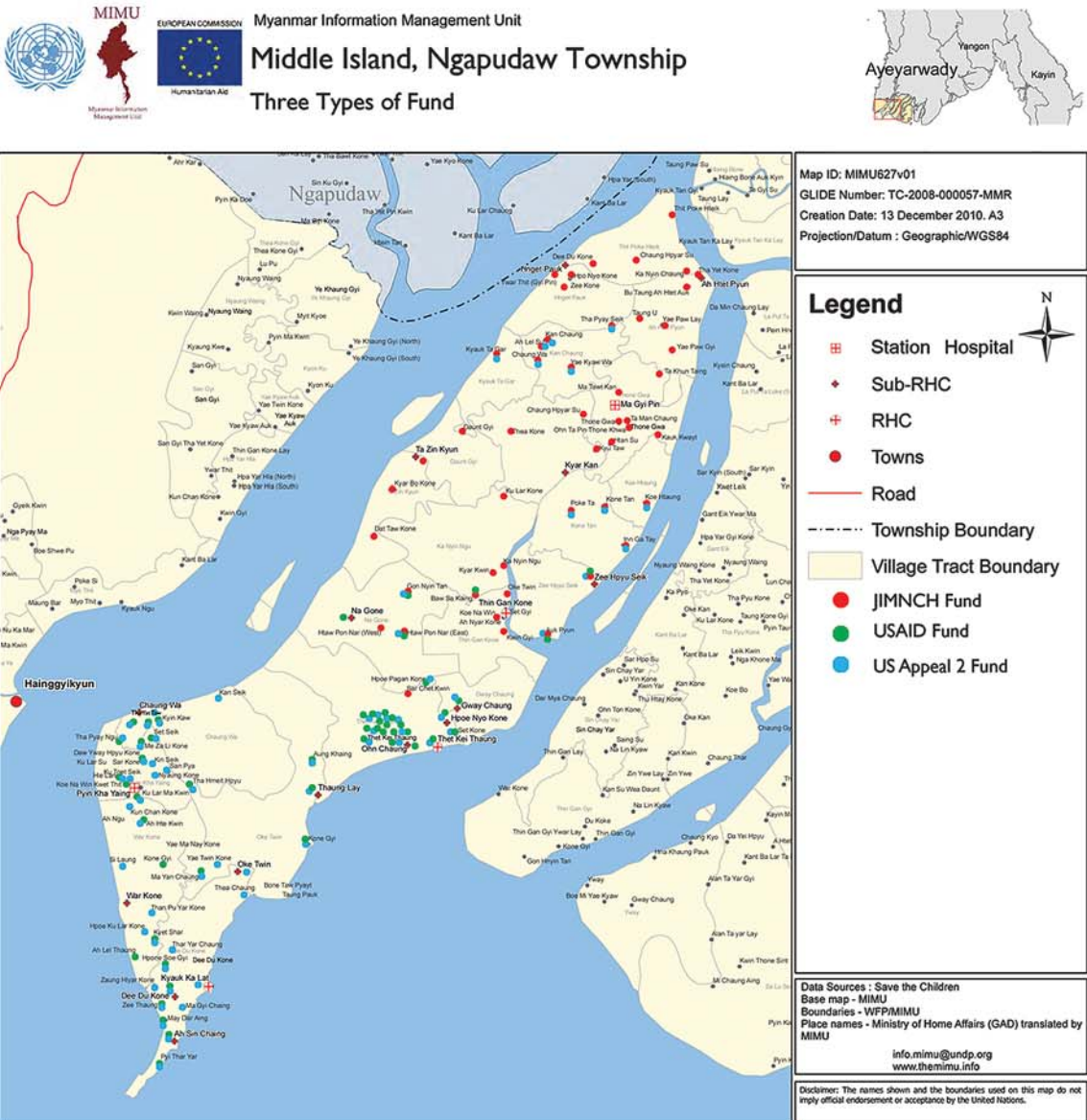


Figure 1: Map of Middle Island showing 3 funding mechanism



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\$.

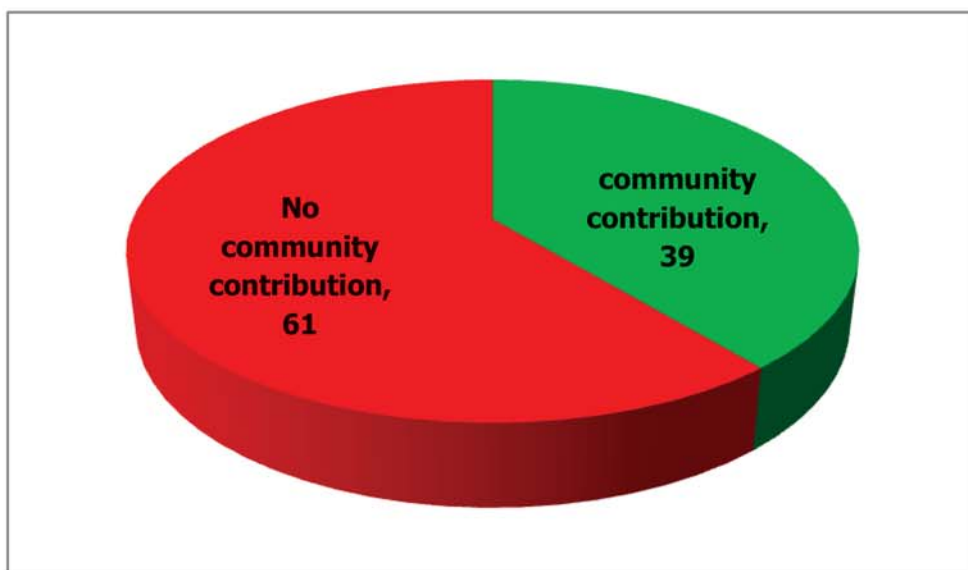


Figure 2: Presence of Community contribution for funding of VHC (n=125 villages)



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.

ရွာမှာလည်းအဖွဲ့လည်းရှိနေပြီဆိုတော့ သင်တန်းပေးပြီး မှပိုက်ဆံချတယ်။ အဲဒီအဖွဲ့မှာပဲ ရန်ပုံငွေတစ်ရပ်အနေနဲ့ထားရင်မကောင်းဘူးလား။ အဲလိုမျိုးစုမယ်ဆိုရင် ဘယ်လောက်လောက်ရနိုင်မလဲ။ ရွာကဘယ်လောက်ထည့်မလဲ။ အဲလိုထည့်တဲ့အခါမှာ ကောက်တာမဖြစ်ရဘူး။ လှူတာဖြစ်ရမယ်။ ဘယ်လောက်ရယ်လို့ကျွန်တော်တို့ မသတ်မှတ်ပါဘူး။ အဲဒီamount တစ်ခု commitment ရသွားတယ်။ ကျွန်တော်တို့ ဘက်ကလည်းနိုင်သလောက် သင်တန်းတွေပေးမယ်။ ကြိုးစားကြည့်မယ်။ သေချာပြီလား။ ကြိုးစားမယ်ဆိုတာ။ ဘယ်လောက်လောက် ကြာရင်ဖြစ်နိုင်မလဲ။ သူတို့ဆီက date တောင်းလိုက်တယ်။ ဟုတ်ပြီ။ ကျွန်တော်တို့ဘက်ကလည်း တစ်ခုခုထည့်နိုင်အောင်ကြိုးစားမယ်။ ဘယ်နှစ်ရက်ကြာရင် စုထားပါ။ အဲဒီနေ့ လာခဲ့မယ်။ ကျွန်တော်တို့ ဘက်ကလည်း အတိုင်းအတာတစ်ခုအထိ ကူညီလို့ရတယ်။ ကျွန်တော်တို့ဘက်ကပိုက်ဆံယူသွားတယ်။ ရွာကစုထားတဲ့ ပိုက်ဆံမြင်ပြီဆိုရင် အဲဒီပိုက်ဆံ ၂ခုကို ရောလိုက်တယ်။



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 casher of VHC-2)

ရွာလုံးကျွတ်အစည်းဝေးပွဲကို ၁၄-၁-၂၀၀၉ခုနှစ်မှာ စခေါ်တယ် နေ့လည် ၁နာရီမှာစခေါ်တယ် စပြီးတော့ အဲဒီအသင်းဖွဲ့တွေဖွဲ့ပြီးတော့ ကျန်းမာရေးအဖွဲ့ကို ငွေ ၁သိန်း၂၀၀၉၄လပိုင်းမှာ၁သိန်းပေးတယ်။ ကျွန်တော်တို့ အရေးပေါ်ရန်ပုံငွေ ၂သောင်းထားပြီးတော့ ကျန်တဲ့ငွေ ၈၀၀၀၀ကို လည်ပတ်ရန်ပုံငွေဆိုပြီးတော့ စလုပ်တယ်။ (KII with casher of VHC-2)

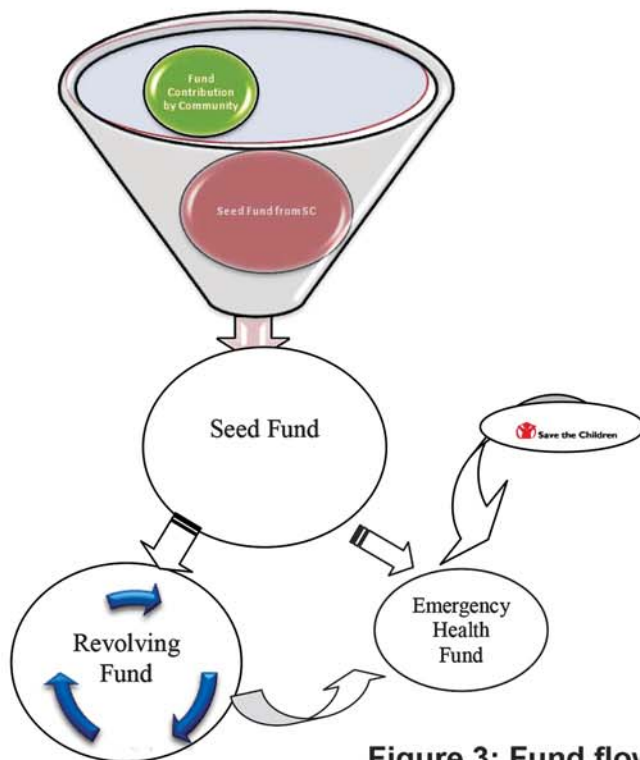


Figure 3: Fund flow in JI-MNCH



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)

အခု JI-MNCH မှာ ကောင်းတဲ့အချက်လည်းပြောလို့ရတယ်။ မကောင်းတဲ့အချက်လို့လည်း ပြောလို့ရတယ်။ သူက emergency ကို လုံးဝအပွန်းမခံဘူး။ ပြန်ဖြည့်တယ်။ ကျွန်တော်တို့ဆီမှာ ဒီနှစ်ကို emergency ဘယ်နှစ်ယောက်ကို support လုပ်မယ်ဆိုတဲ့ ပိုက်ဆံကရှိတယ်။ ရှိတဲ့အတွက်ကြောင့်မို့လို့ တစ်ယောက်လုပ်လိုက်တာနဲ့ ပြန်မဆပ်နဲ့ နောက်ကပြန်ဖြည့်တယ်။ JI-MNCH က ပြန်ဆပ်စရာမလိုဘူး။ အပြီးပေးလိုက်တာ။ ဟိုဟာက (USAID project) ပြန်ဆပ်ရမယ်။ ဒီဘက် PONREPP/JI-MNCH မှာကျတော့ နှစ်ပုံပုံတာ၊ နှစ်ပုံကို သပ်သပ်ပုံတာ။ တစ်ပုံက လုံးဝ revolving။ revolving fund ဆိုပြီးတော့ ပိုက်ဆံချတယ်။ အဲလိုပဲ emergency fund ဆိုပြီး ပိုက်ဆံထပ်ချတယ်။ emergency fund က လျော့သွားရင် ပြန်ဖြည့်ပေးတယ်။ (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)

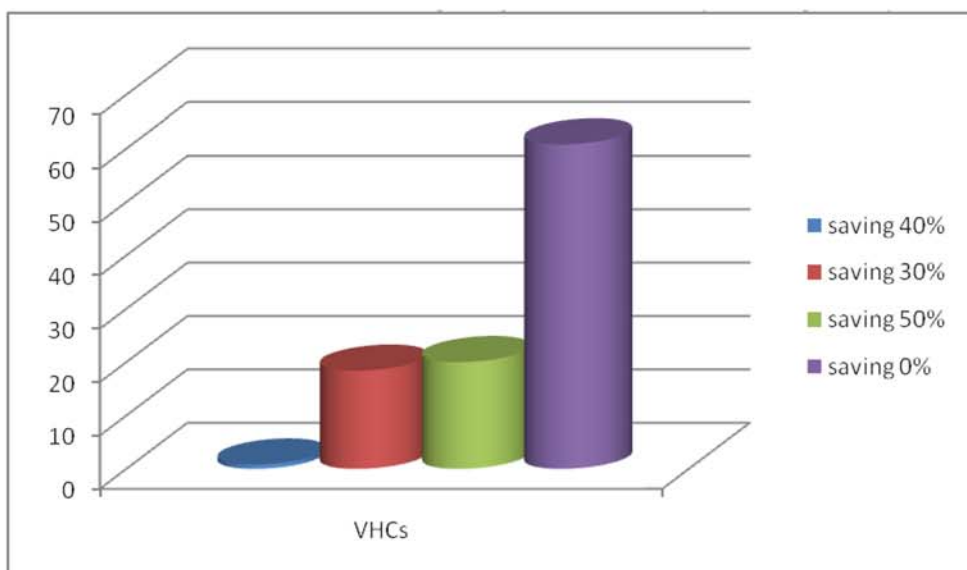


Figure4: Distribution of VHCs and percentage of saving from revolving to emergency health fund (n=125)



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 talk 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.*

မေး- အဲဒီအရေးပေါ်ကုန်သွားတဲ့ ပိုက်ဆံကိုဘယ်လိုဖြည့်လဲ။

ဖြေ- လောလောဆယ် SC က ပြန်ဖြည့်ပေးမယ်လို့ပြောတယ်။တကယ်လို့ သူတို့ မရှိ တော့ရင် လည်ပတ်ရန်ပုံငွေထဲက ဖြည့်ပေးမယ်။

မေး- လည်ပတ်ရန်ပုံငွေကနေ ဘယ်လောက်ရာခိုင်နှုန်းကိုတော့ ဘယ်ထဲကို ထဲ ရမယ်လို့ သတ်မှတ်ထားတာရှိလား။

ဖြေ- သတ်မှတ်ထားတာတော့ရှိတယ် မမှတ်မိတော့ဘူး။

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*”.

အဓိက revolving fund က poor ကိုရည်ရွယ်တာ၊ ဒါပေမဲ့ မဆပ်နိုင်ကြတော့ revolving fund ရဲ့ အဓိက ရည်ရွယ်ချက်က referral fund ကို မပျောက်ပျက်အောင် support ပေးတဲ့ အဓိက objective နဲ့ထားတာဆိုတော့ တဖြည်း ဖြည်းနဲ့ ပြန်ပြီးတော့ပြောင်းရတာပေါ့။ မဆပ်နိုင်ကြတဲ့အတွက်



ဒုတိယက criteria ဘာလည်းဆိုတော့ ဆပ်နိုင်တဲ့လူကို ဘဲချေးမှာ
တဖြည်း ဖြည်းနဲ့ပြန်ပြောင်းရတာ။

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)". (ဝိုင်းကြီးချုပ်စနစ်) 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.

ကျယ်ကျယ်ပြန့်ပြန့် မဖြစ်ခင်က အိမ်နံနံလောက်ပဲ ချေးတာ၊ နောက်ပိုင်းမှ အိမ်စေ့ပဲ တအားကြီး ပြေလည်တဲ့သူကတော့ ချေးဖို့မလိုဘူးပေါ့၊ ဒါပေမဲ့ ချေးထားလိုက်၊ လ အနည်းငယ်လောက်ပါပဲ၊ သူတို့ကလဲ ကျန်းမာရေးအဖွဲ့ကို ပြန်ကူညီချင်တယ်၊ အလှူငွေပါဝင်တဲ့သဘော၊ တိုးပွားလာဖို့ ကိုယ့်ရပ်ကွက်ထဲက ချေးတဲ့လူတွေတိုးမှ ရံပုံငွေတိုးပွားမှာ၊ သူတို့ဘက်က အလှူငွေထဲတဲ့ သဘောပုံစံမျိုး သက်ရောက်သွားတာပေါ့။ (အသုံးမလိုပေမဲ့ ချေးလိုက်တော့) အသုံးမလိုပေမဲ့ သူတို့က ချေးပေးတယ်။ ဘာလို့လဲဆိုတော့ အတိုးကကျန်းမာရေးအတွက် တိုးတက်မှု ကိုယ့်ရပ်ရွာ တိုးတက်မှုအတွက် ဆိုတော့ ချေးပေးကြတယ်။

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:



Photo of “Ngwe Pone” Day

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.

ဖြေဆိုသူ ၃၊၄၊၅၊၇-အမြဲစုံတယ် နည်းနည်းနောက်ကျတာတော့ရှိတယ်
၁ချက်တီး၊၂ချက်တီး

ဖြေဆိုသူ ၄- အလွဲသုံးစားမလုပ်ဖူး၊ တကယ်တိုးတက်အောင်လုပ်တဲ့ရွာ

ဖြေဆိုသူ ၂- တလတခါအတိုးပေး ၃လတခါအရင်း ပြန်ပေါ်တယ်။

ဖြေဆိုသူ ၄၊၁၀- လကုန်ရက်ငွေပုံရမှာ



ဖြေဆိုသူ ၁- ဘယ်လောက်ရှိသေးတယ်ဆိုတာရှင်းပြတယ်။

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)

ဒီရန်ပုံငွေနဲ့လမ်းပြင်တယ်။ မီးလိုင်းတွေ တွေ့တယ်မဟုတ်လား ကျန်းမာရေးအဖွဲ့၊ ဦးဆောင်ပြီး လုပ်ငန်းရှင်ခေါ်တယ်။ ရွာမှာ အိမ်မီးတဖွင့်ဆို ၃၀၀၀ပေးရတယ်။ TV ဆို ၁၂၀၀၀ ပေးရတယ်။ အဲဒါကြောင့် မီးစက်သမားကို ရန်ပုံငွေထဲက ဂုဏ်ထူး ၁သောင်း ထောင် အတိုးမဲ့ချေးပေးတယ်။ ၅လ အတိုးမဲ့ ချေးပေးတယ်။ အဖွဲ့၊ မီးစက်လာမောင်းတော့ အိမ်မီးက တလ ၂၀၀၀။ TV က ၆၀၀၀ ဖြစ်သွားတယ်။ အရင်က တလကို ၂သိန်းကျော် ရပ်ရွာမှာပေးရတယ်။ အခု သက်သာ သွားတယ်။ (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 returned 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)

ငွေမဆပ်နိုင်တာကတော့များတယ်။ လကျော်တဲ့ဟာတွေပေါ့၊ ၃၀ %
လောက်ရှိတယ်။ မဆပ်နိုင်တာထက် ၃၀% က problem ဖြစ်တဲ့ဟာတွေပေါ့။
ရက်ရွှေတာတွေပေါ့။ ၃လမှာပုံရမှာ ၃လမှာမပုံနိုင်ဘူး။ မပုံနိုင်ရင်
ဘယ်လိုလုပ်ပြာမလဲ။ အစတုန်းက rule ထဲမှာမဆွဲထားဘူး။ အဲဒီ
လူကမလာတော့ဘူး။ မပေးတော့ဘူးဆိုတော့။ အဲလိုဆို village health
committee ကဆုံးဖြတ်လိုက်တယ်။ ဖိလစောင့်မယ်။ ရရင်ရ။ မရရင်တစ်ခုခုပေါ့။
ဘယ်လိုလုပ်မလဲ။ ဘာညာ၊ တချို့ဆိုလုံးဝ မပေးနိုင်ဘူး။
ရွာတစ်ရွာကတော်တော်ကောင်းတယ်။ emergency case ပဲ။ ချေးလိုက်တာ
ကလေးက ဆုံးသွားတာလား။ ဘာလားမသိဘူး။ ပိုက်ဆံပြန်လဲမပေး
နိုင်တော့ဘူးဆိုတော့ သူ့ကိုအလုပ်ခိုင်းတာပေါ့။ ကျောင်းမှာလား၊
ဘာလားမသိဘူး။ လုပ်အားပေးနဲ့ဆပ်ပေါ့။ အဲတာက village health committee
က ဆုံးဖြတ်တာ။ VHC ကအိုကေတယ်။ agree ဖြစ်တယ်ဆိုပြီးပြီ။
(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 အတွက်က မဖြည့်တာပိုကောင်းတယ်။ ဖြည့်တာ က sustain မှ မဖြစ်တာ။ community က သူ့ပိုက်ဆံမဖြည့်ဘူးဆိုတဲ့ အတွက်ကြောင့်မို့လို သူကလွှတ်တဲ့လူကိုယ်တိုင်က သူကသေချာ screen လုပ်တယ်။
 ဟိုမှာက technical စဉ်းစားမှကကွာသွားမှာပဲ။ ဒီရွာက ဥပမာ- MW မဟုတ်ဘူး။ အရံ သားဖွား လကလ (လူထုကျန်းမာရေးလုပ်သား) ဖြစ်အုံးတော့။ သူ့ရွာမှာ ပိုက်ဆံ ဘယ်လောက်ရှိလဲသူသိတယ်။ ဒီတစ်ယောက်ကိုလွှတ်ရမလား။ မလွှတ်ရဘူးလား။ သူသေချာ စဉ်းစားမယ်။ ဟိုဟာကျတော့ လွှဲပေးလိုက်တာနဲ့ ကျွန်တော်တို့ နောက်က ပြန်ဖြည့်မှာပဲ။ သူသည် နည်းပညာပိုင်းကို အဲလောက် ကြီးထိ စဉ်းစားမှာမဟုတ်ဘူး။ နဲ့နဲလေးမသေချာရင်လွှဲမှာပဲ။

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.



အခုလောလောဆယ်လုပ်နေတယ် အလှူရှင်လုပ်နေတယ် ရွာက ထပ်ထည့်ရင် ပိုကောင်းမယ်။ အခု တခြားလူကူညီတာဘဲ နယ်ခံအနေနဲ့ ရွာတိုးတက်ဖို့ ကောင်းစားဖို့ ဒါလေးစိုက်စေချင်တယ်။ ပိုပြီးဂရုစိုက်မယ်။ သူများဟာနဲ့ဆိုရင်သိပ် တန်ဖိုးမထားတာရှိတယ်။

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 PONREPP concept is still in relief phase.

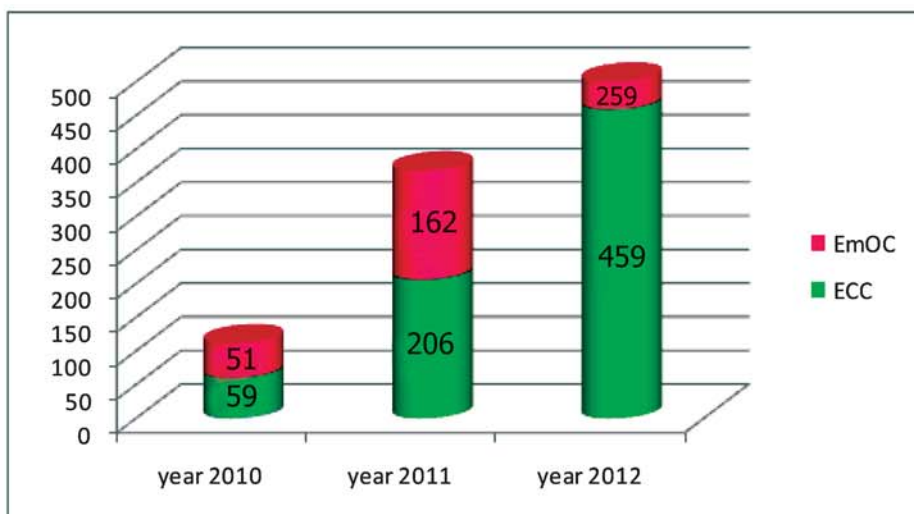
Livelihood က သူတို့ဟာသူတို့ ရပ်တည်တဲ့အချိန်ကျရင် ကျွန်တော်တို့ပြန်ဖြည့်ဖို့ မလိုဘူး၊ အခု plan ကြီးတစ်ခုလုံးက post နာဂစ်ကနေဆက်ထားတာ။ post နာဂစ်ဆိုတော့ immediate after disaster မှာ အကုန်လုံးက collapse ဖြစ်နေတဲ့အချိန်။ ကျွန်တော်တို့ support လုပ်တာလေ။ အဲဒီ period ပြီးတာနဲ့ development phase ကိုသွားရမှာပဲ။ အခု PONREPP ရဲ့သဘောက Relief phase ပဲ ဖြစ်နေတာ။

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



(n=125)

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. (Kil with AMW)



မေး- ကိုယ်ဝန်ဆောင်မိခင်တွေနဲ့ ၅ နှစ်အောက်ကလေးတွေရဲ့
 ကျန်းမာရေးအရင်နဲ့ အခု ဘာတွေ ကွာသွားလဲ။
 ဖြေ- ကွာသွားတာပေါ့။ တောကသိကုန်ပြီ၊ အရင်က အရပ်လက်သည်နဲ့
 မွေးတယ်၊ အခုမမွေးတော့ဘူး ကျန်းမာရေး ဗဟုသုတရှိသွားပြီ။ ကလေးဆိုလဲ
 ဖြစ်ရင် ဘယ်ကိုသွားဘယ်ကိုလာရှိတယ်တာ ဆိုတာသိကြတယ်။
 ဘယ်လိုကိုယ်ဆောင်ဆို အန္တရာယ်ရှိတယ် B1 ချို့တဲ့ရင်ဘယ်လိုဆိုတာသိနေပြီ။
 ကျန်းမာရေးဟောပြောဘို့က ကာကွယ်ဆေးထိုးရင် ဝကြိမ်လုပ်ဖြစ်တယ်။
 လူစုမိရင်ပြောဖြစ်တယ်။ အဆင်ပြေတယ်။
 အရင်ကကာကွယ်ဆေးထိုးဖို့ကိုယ်ခေါ် ရတယ် အခုမခေါ်ရဘူး အဆင်ပြေတယ်။

(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)

ဖြေဆိုသူ ၂- SC ကို ကျေးဇူးတင်ပါတယ်။ နာဂစ်ဖြစ်ပြီး
 စိတ်ဓါတ်ကျဆင်းနေတယ် စိတ်ဓါတ် ပံ့ပိုးမှုတွေလာလုပ်ပေးတယ်
 အတွေးအခေါ်လဲ မြင့်လာတယ် လူနေမှုလဲ မြင့်လာတယ်။

ဖြေဆိုသူ ၃- ကျန်းမာရေးက ပြောင်းလဲသွားတယ် အရင်ကဆို မစင်ပုံတွေ
 တွေ့ရတယ်။ အခု လုံးဝ မတွေ့တော့ဘူး။

ဖြေဆိုသူ ၇-၆ အရင်က အိမ်သာမရှိလို့ ချုံတိုးတယ်။

ဖြေဆိုသူ ၃- လူလစ်ရင် ကွင်းထဲပါတယ် ကျွန်တော်တို့ နွားလှန်းတော့ ဒုက္ခ
 ရောက်တယ်။

ဖြေဆိုသူ ၇- ကျမ ကလေးတွေတော့ အခုဆပ်ပြာနဲ့လက်ဆေးတယ်။



ဖြေဆိုသူ ၆ - ကလေးတွေ အသိဉာဏ်ဖွံ့ဖြိုးလာတယ်။
(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)

(အားလုံး) - ကျန်းမာရေးရုံပုံငွေပေးထားတာတစ်ခုလုံးသိကြတယ်။

ဖြေဆိုသူ (၄) - ကျန်းမာရေးရုံပုံငွေတစ်ခုက အပြင်ကို
ချေးငွားစားတာမလုပ်ရဘူး။ တစ်ခုက၅နှစ်အောက်ကလေး
နဲ့ ကိုယ်ဝန်ဆောင်မိခင်တွေအတွက် အဲဒီငွေကို အဲဒီအတိုင်းထားရမယ်။
လိုအပ်လို့ရှိရင် ထုတ်ပေးရမယ်ပေါ့။

ဖြေဆိုသူ (၂၊၄)- နောက်တစ်ခုကအပြင်မှာ ချေးထားတာ ၃ကျပ်တိုးနဲ့ပေါ့။

ဖြေဆိုသူ (၆၊၇)- ဟိုနေ့ကလာပြီးအတိုးတွေ ခွဲသွားသေးတယ်။

ရွာသားတွေကိုမဲနှိုက်ပြီး တစ်ယောက်ကို ၂သောင်းကျ

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)



အဲဒီတစ်ခုက အမှန်တိုင်းဝန်ခံရရင် ညီမတို့အဲဒီထဲကိုဝင်ပြီးတော့ အစကစ
Fund လုပ်ခဲ့တာ မရှိဘူး။ ဥပမာပြောရရင် ရွာတစ်ရွာရဲ့ အစွန်အဖျားနေရာ ရွာ
 တစ်ရွာရဲ့ ၃ပုံ ၁ပုံ ကိုဘဲသိတယ်လို့ဘဲထင်တယ်။ အစွန်အဖျားနေရာ
 တွေကသိဖို့က သူ့ကိစ္စနဲ့သူ ရုန်းကန်လှုပ်ရှားနေကြရတာ။ သိဖို့သိပ်မလွယ်ဘူး။

(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)

၅နှစ်အောက်သာပေးတာ ၅နှစ်ပြည့်ပြီးသွားရင် တရက်စွန်းသွားရင် မပေးဖူး၊
 ရက်နဲ့လနဲ့ဘလှိုင်းမပေးဖူး။ ၅နှစ်အောက်ဖြစ်တာပေးတာတောင် အရေးပေါ်မှ
 ခရီးစရိတ်ဘဲ ပေးတာ တော်ရုံတန်ရုံဖြစ်တာဆိုမပေးဖူး။ အတိအကျ
 အရေးပေါ်ဖြစ်မှ ပေးတာ။ အရေးပေါ်မှိုက်ကြီးသည်တွေ ဒီမှာမမွေးနိုင်တဲ့လူ
 မိုးတွင်းဘက်ဆို အဖြစ်များတယ် ကလေးတွေဆိုသွေးလွန်တုပ်ကွေးတို့၊
 ကလေးတွေဖြစ်တယ် ဝမ်းရောဂါတို့၊ နေထိုင်မကောင်း အပူတအားတက်နေတာ
 တက်တာချက်တာပေါ့။

(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 LHVs). 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)

ကျွန်မတို့က criteria တွေကိုသတ်မှတ်မပေးနိုင်ဘူး။ တကယ့် emergency လွတ်သွားမှာ ကိုအရမ်းစိုးရိမ်တယ်။ ဆရာမကတော့ ဥပမာပေါ့နော်။ ကလေးက chest in-drawing ရနေတာပေါ့၊ တစ်ခုခုပေါ့။ သူတို့စိတ်ထဲမှာ respiratory rate မမြန်လို့ဆိုတာမျိုး၊ severe pneumonia ကို လွတ်သွားတာမျိုး၊ ဒါမျိုးတွေ တစ်ခုခုပေါ့။ ဖြစ်သွားမှာကို တအားစိုးရိမ်တာ၊ တကယ့် emergency လွတ်သွားမှာကို စိုးရိမ်တဲ့အတွက်ကြောင့် danger sign ကိုအဓိက သူတို့



(AMW/CHW) ကို ရိုက်ထည့်ပေးထားတယ်။ Save the children ကိုလည်း ကျွန်မတို့ တောင်းဆိုထားတယ်။ မိုးတွင်းဘက်မှာ လမ်းပန်းဆက်သွယ်ရေးခက်တဲ့ နေရာ ကျွန်မဆီမှာ ငှရွာလောက်ရှိတယ်။ ကျွန်မဆီကို လာဖို့အတွက် ငှနာရီ ကျော်လမ်းလျှောက်မှ ရောက်တယ်။ အဲဒီအခါ မိုးတွင်းဘက်မှာ တကယ့် emergency လွတ်သွားနိုင်တဲ့အတွက် သူတို့ emergency လို့သတ်မှတ်ရင်လည်း ကျွန်မတို့ကို သတ်မှတ်ပေးပါလို့ တောင်းဆိုထားတယ်။ ဘယ်သူပဲ emergency လို့သတ်မှတ်သတ်မှတ် ခရီးစရိတ်လေး ပေးပါလို့တောင်းဆိုထားတယ်။ ဆေးရုံ ရောက်သွားဖို့ပဲ လိုတယ်။

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)

ကျေးရွာရန်ပုံငွေက ၅နှစ်အောက်ကလေးနဲ့ ကိုယ်ဝန်ဆောင်မိခင်တွေအတွက် အရေးပေါ်ပေးတာပဲရှိတယ်။ အရေးပေါ်ဖြစ်တဲ့သူက ပိုက်ဆံရှိရှိ၊မရှိရှိ အရေးပေါ်ဆို ဦးစားပေးတယ်။ ရွာကပိုက်ဆံတအားရှိတဲ့သူမရှိဘူး၊ လုပ်လုပ်စားစားပဲ။ များသောအားဖြင့် ကျဘမ်းပေါ့ လယ်အငှားလုပ်တယ်။ ဈေးရောင်းတယ် ရေလုပ်ငန်းလဲ မရှိဘူး။ ဆားလုပ်ငန်းလဲမရှိဘူး။ (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)

ညီမတို့အဲဒီမှာစပြီး fund management training ပေးကတည်းက ဒီပိုက်ဆံကို ဆင်းရဲ ချမ်းသာမရွေး သုံးပိုင်ခွင့်ရှိတယ်ပေါ့။ ဒါပေမယ့် တကယ့်အသက် အန္တရာယ် စိုးရိမ်ရမှ သွားရမယ်၊ တချို့ကျတော့ဘယ်လိုဖြစ်လဲဆိုတော့ လုံးဝပိုက်ဆံမရှိဘူး။ ဆရာမကတော့ မလွှဲချင်ဘူး၊ အသက် အန္တရာယ်က အလောက်ကြီး မဟုတ်ဘူး။ တကယ်ပိုက်ဆံမရှိဘူး၊ သွားချင်တယ်၊ သူတို့ ကိုယ်တိုင်ကိုက အသက်အန္တရာယ် မစိုးရိမ်ရဘူးလို့ ဆရာမကပြောပါလျက်နဲ့ အဲလိုမျိုး သွားချင်တဲ့ ပြဿနာတွေလည်း ရှိတယ်၊ ဆင်းရဲချမ်းသာမရွေး အရေးပေါ် ကျန်းမာရေး ရံပုံငွေကို သုံးပိုင်ခွင့်ရှိ တယ်။ ဒါပေမယ့် တကယ်အသက်အန္တရာယ်စိုးရိမ်ရတဲ့လူပဲဆို ဘယ်သူဖြစ်ဖြစ် မသတ်မှတ်ထား ဘူးပေါ့။ ဆရာမကိုယ်တိုင်က emergencyဆိုပြီးရော၊ အဲဒါကအဆင်ပြေပါတယ်။

(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.

ကျွန်မကတော့ လောလောဆယ်ပေးနေနိုင်တဲ့အချိန်မှာ အရမ်းကောင်းတာပေါ့။ မပေးနိုင်တဲ့အချိန် ကျရင် criteria လေးတစ်ခုသတ်မှတ်မှ ရလိမ့်မယ်လို့ထင်တယ်။ ကျွန်မထင်တာပြောတာပါ။ လူတိုင်းလူတိုင်းက အလကားပေးတယ်ဆိုရင် ဆင်းရဲချမ်းသာ ယူချင်ကြတာပဲ။ ကျွန်မတို့ကနာမည်



ပေးထားတယ်။ “Dependency syndrome” လို့ နာဂစ်ကြောင့်ဖြစ်လာတဲ့ဟာပေါ့။ ၁၀၀စီးပဲရရ သူဌေးကလည်းလိုချင်တာပဲ။ အဲလိုလည်းရှိတဲ့အခါကျတော့ NGO ရှိနေတဲ့အချိန်မှာတော့ သူတို့က လက်ရှိပေးနေတာပေါ့။ ဒီ emergency ကလောလောဆယ်မှာ ပြဿနာ မတက်နိုင်ဘူး၊ မရှိတော့တဲ့ အချိန်ကျရင် criteria လေးတစ်ခုသတ်မှတ်ထားပြီး အားလုံးဝိုင်းဝန်းဆုံးဖြတ်ထားမှရမယ်။ ဥပမာ ရွာတွေမှာ အဆင့်ခွဲထားတာ တွေရှိတယ်။ အဆင့်(၁၊၂၊၃၊၄)၊ အဆင့်(၁)လက်လုပ်လက်စား၊ အဆင့်(၂) လက်လုပ်လက်စား၊ ဒါပေမယ့်လေ့ပိုင်၊ လှည်းပိုင် အဲလိုရှိတယ်။ သူ့မှာလုပ်စားတဲ့ ပစ္စည်းတစ်ခုခု အပိုင်ရှိတယ်။ (၁)သည် လုံးဝလုပ်စားဖို့ အပိုင်မရှိတဲ့သူ။ (၂)ဆိုလို့ရှိရင် ပြေလည်တယ်။ သူ့မှာတစ်ခုရှိတယ်။ လယ်တို့ဘာတို့ပေါ့။ သူ့မှာလုပ်စားနိုင်တဲ့ ဟာတစ်ခုရှိတယ်ပေါ့။ (၄)ဆိုလို့ရှိရင်သူက တကယ့်ဂရိတ်။ သူဌေးပေါ့အစ်မရယ်။ ကျွန်မ (၁)(၂)လောက်အထိပေးမယ်လို့ စဉ်းစားထားတယ်။ နည်းနည်း လေးတော့ စဉ်းစားဆုံးဖြတ် ပြီးတော့ လုပ်ရမှာပေါ့။ တစ်ယောက်တည်း ကနေ ဆုံးဖြတ်တာမဟုတ်ဘူး၊ အများကြီးဝိုင်းဝန်းပြီးဆုံးဖြတ်မှရမယ်။

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 straight forward. 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)

ဆင်းရဲသည် ချမ်းသာသည်ဆိုတာကို ဘယ်လိုမျိုးနဲ့ တိုင်းတာမယ်ဆိုတာကို ပြဿနာရှိပါတယ်။ နောက်တခုက အဲဒါကလည်း public ကနားမလည်လို့ပါ။ ကျတော်တို့ law ရဲ့ ထုံးစံ အရ ဒီခံစားချက်ကို သိပ်ပြီး ခံစားရမှာမဟုတ်ဘူး law ဆိုတာက တိကျတယ် ပြတ်သားတယ်။ ရှင်းရှင်းလေးဘဲ။ သူ့ဟာသူ ဆင်းရဲရဲ ချမ်းသာသာ emergency ဆိုရမယ်။ emergency မဟုတ်ရင် မရဘူး။ law မှာထည့်ပြီး စဉ်းစားမှာတော့ မဟုတ်ဘူး၊ ဘာလို့လဲဆိုတော့ အဲဒါတွေက personal ပိုင်းဖြစ်သွားပါပြီ။ ဒီဥစ္စာကိုတော့ public တွေ နားလည်အောင် ရှင်းပြဖို့ အတွက် ကတော့ ကျွန်တော်တို့ဘက်က တာဝန်ရှိသလို အမှန်အတိုင်း ပြောရရင် ပိုပြီး တာဝန်ရှိတာက ခုနပြောတဲ့ political sector အပိုင်းကပိုပြီးတာဝန်ရှိပါတယ်။ (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.

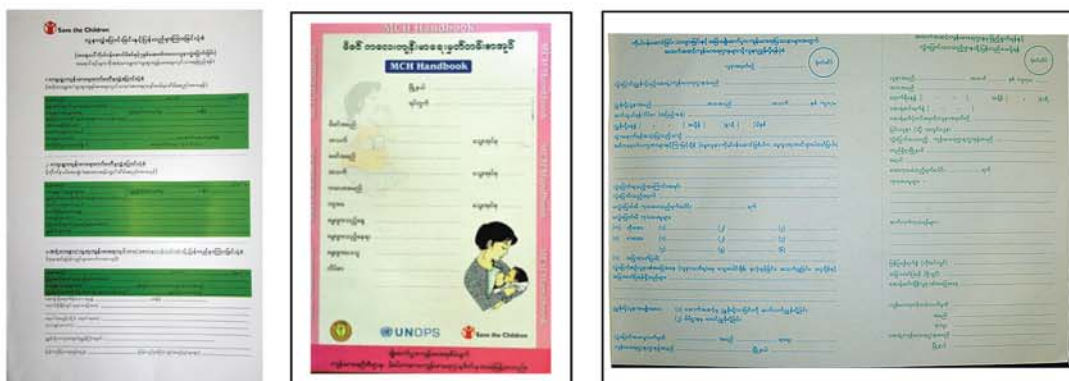


Figure 6: Referral Letter, Referral register and MCH Handbook

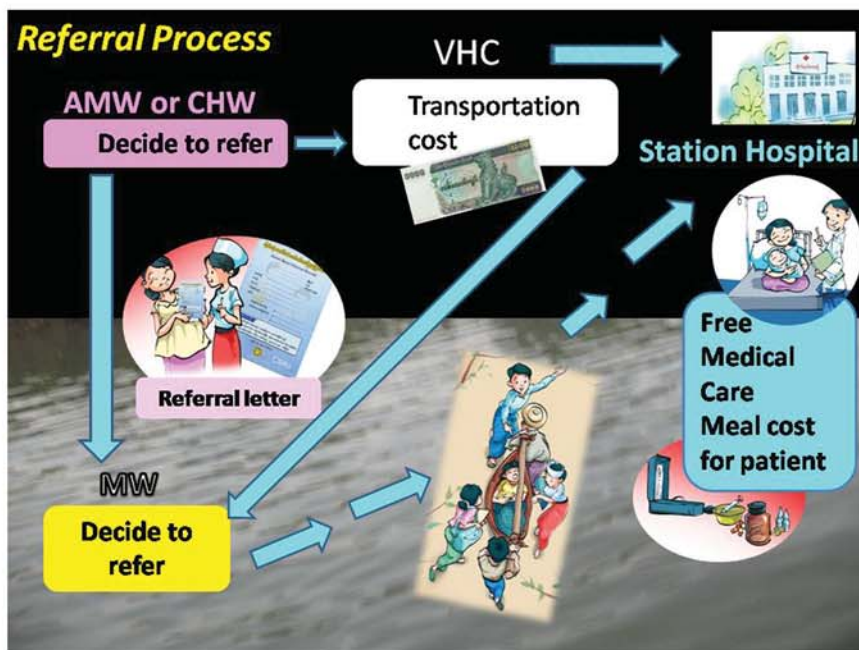


Figure 7: Referral Process for EmOC and ECC



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)

လွှဲမယ်ဆိုရင်အဲဒီနေရာမှာ emergency ဖြစ်တဲ့အတွက်ကြောင့် operative procedure လုပ်နိုင်ရမယ်။ အဲဒီမှာ Medical Officer (MO) ပေါ့။ SMO (Station Medical Officer) ထိုင်တဲ့နေရာဖြစ်ရမယ်။ ၂နေရာလုံးကတကယ့် well-trained staff ရှိနေတယ်။ vacancy မရှိဘူး။ SMO နှစ်ယောက်လုံးကလည်းခွဲနိုင်တယ်။ လုပ်နိုင်တယ်ဆိုတဲ့အတွက်ကြောင့်မို့လို့။ first level referral centre က Station Hospital ဖြစ်သွားတယ်။ အဲဒီ meeting မှာ။ အဲဒီမှာ SMO ၂ယောက်လုံး လဲပါတယ်။ (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 we will 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)



နေရာကတော့ identify လုပ်လိုက်ပြီး။ ဘယ်လို support လုပ်မှာလဲ။ အဲဒီမှာ ဆရာကြီးကပြောတယ်။ Local context အရပဲ။ ဒီ SMO ယောက်နဲ့ လွှဲပေးလိုက်ပါတဲ့။ ကျွန်တော်တို့က အဲဒီ referral mechanism က delay ယူလောက်ကိုဖြတ်မှာ။ transportation delay ရော health centre မှာရှိတဲ့ medicine ပြဿနာရော delay ရောဖြတ်မှာ။ health centre ရောက်ဖို့အတွက် transportation ဖြတ်ရမယ်။ transportation barrier အတွက်ကပြဿနာမရှိဘူး။ community-based ရဲ့ အားသာချက်တွေကို ဆွဲသုံးလိုက်တယ်။ (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

ပေါ်မြေရပ် အကျွေးပိုင်မှု



- လွှဲပြောင်းမှုပုံစံစာရွက်
- ကိုယ်ဝန်ဆောင်မိခင်အတွက် (သားမွေးဆရာမတံတွင်ပုံမှန်ကိုယ်ဝန်ဆောင်ခရောက်မှု မယူထားသော မှတ်တမ်းစာအုပ်) (ကိုယ်ဝန်ဆောင်မိခင်လက်ဝယ်ထားရှိရမည့်မှတ်တမ်း)

အထက်ပါအချက်အလက်များမပြည့်စုံပါကတိုက်နယ် စောင့်ရှောက်ရေးနှင့်ကုသစရိတ်အခမဲ့မရနိုင်ပါ။



ပိုက်ဆံပေးဆောင်မှုရရှိရန် အခြေခံအချက်အလက်များ



- စောင့်ရှောက်မှု
- ကုသစရိတ်အခမဲ့



ကျွန်တော်တို့အဖွဲ့သည် အရေးပေါ်ကျန်းမာရေး အခြေအနေတွင် လူနာအား စောင့်ရှောက်ပေးရန် ကိုယ်ပိုင်ဆိုင်သော တိုက်နယ် စောင့်ရှောက်မှု တာဝန်ရှိသော ဆရာဝန်ထံသို့ ရောက်ရှိစေရန်အတွက်ပေးကြိုက်ပေးသော ဖြစ်ပါသည်။

လူနာ၏ကျန်းမာရေးနှင့်ပတ်သက်သော အကောင်းအဆိုးများသည် Save the Children နှင့် ယှဉ်သိမှု မသက်ဆိုင် ပါကြောင်းအသိပေးအပ်ပါသည်။



Joint Initiative on MNCH အစီအစဉ်ဖြင့် လေ့လာမှုများ ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် Save the Childrenအဖွဲ့တို့ ပူးပေါင်းဆောင်ရွက်သော အရေးပေါ်ကျန်းမာရေးလွှဲပြောင်းမှုအစီအစဉ်



UNICEF Save the Children



ဘယ်လိုအမိအမိန့်လဲ



မိခင် (ကိုယ်ဝန်ဆောင်စဉ်မီးဖွားစဉ်နှင့်မီးတွင်းကာလ) သို့မဟုတ် မွေးကင်းစကလေးငယ် (၂၈ ရက်အောက်) သို့မဟုတ် ၅ နှစ်အောက်ကလေးငယ် နှင့် ပတ်သက်သော အရေးပေါ်ကျန်းမာရေး အခြေအနေတွင်ဖြစ်ရမည်။ ကျန်းမာရေးဝန်ထမ်းရှိသောကျေးရွာများတွင် ကျန်းမာရေး ဝန်ထမ်း၏ လွှဲပြောင်းမှုပုံစံစာရွက်၊ ကျန်းမာရေးဝန်ထမ်းမရှိသောကျေးရွာများတွင် အရံသားဖွား / လူထုကျန်းမာရေး လုပ်သား၏လွှဲပြောင်းမှု ပုံစံစာရွက်တောင်းယူရမည်။ ကျန်းမာရေးဝန်ထမ်းမှ လွှဲပြောင်းမှုပုံစံစာရွက်ဖြင့် ကျေးရွာ ကျန်းမာရေးကောင်စီထံတွင် စရိပ်ခရိုက် (သတ်မှတ်ထားသော နှုန်းထား / ပမာဏအတိုင်း) ကိုအကူအညီယူနိုင်သည်။ မြန်လည်ပေးဆပ်ရန်မလိုပါ။ လွှဲပြောင်းမှုပုံစံစာရွက်နှင့် ကျန်းမာရေးစောင့်ရှောက်မှုခံယူထားသော မှတ်တမ်းစာအုပ် (ကိုယ်ဝန်ဆောင်များအတွက်) မြင့်တင်ပါသည်။ တိုက်နယ်ဆေးရုံသို့ရောက်ရှိသောအခါ ဆေးဝါးနှင့်ကုသစရိတ် (အခမဲ့) ကုန်ကျရန်မလိုဘဲ ကျွမ်းကျင်သောဆရာဝန်ဖြင့် ကျန်းမာရေးစောင့်ရှောက်မှု ခံယူနိုင်သည်။



ဘယ်သူတွေ့အတွက်လဲ



- ကိုယ်ဝန်ဆောင် နှင့် ပတ်သက်သော အရေးပေါ် ကျန်းမာရေးအခြေအနေ နှင့် ကြံ့ခံတွဲရသော အမျိုးသမီး (ကိုယ်ဝန်ဆောင်စဉ်ကာလ၊ မွေးဖွားစဉ် ကာလ နှင့် မီးတွင်းကာလ ၄၅ ရက်)
- မွေးကင်းစ (၂၈ ရက်) ကလေးငယ်၏ အရေးပေါ် ကျန်းမာရေးအခြေအနေ
- အသက် ၅ နှစ်အောက်ကလေးငယ်၏ အရေးပေါ်ကျန်းမာရေးအခြေအနေ

အရေးပေါ်အခြေအနေကြိုရွှေ့ပါက ဘယ်သူနဲ့ဘယ်သူပျံ့နှံ့ရမည်။



- ကျေးလက်ကျန်းမာရေးဌာန / ခွဲ (သို့) ကျန်းမာရေးဝန်ထမ်းများ
- ကျေးလက်ကျန်းမာရေးဌာန / ခွဲ (သို့) ကျန်းမာရေးဝန်ထမ်းများ မရှိပါက အရံသားဖွား / လူထု ကျန်းမာရေးလုပ်သား



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.

ဆင်းရဲ ချမ်းသာမရွေးပေးတယ် အရေးပေါ်ဖြစ်ရမယ် record မှာ AN care ၄ ကြိမ် ပြရမယ်။ ပန်းဖလက်လေးကို လူနာတယောက်တက်ရင်ပေးတယ်။ တခြားလူဖတ်လို့ရအောင် ယူသွားပါဆို ထဲပေးတယ် ဆေးရုံဆင်းလဲထဲပေးတယ်။ ဘေးလူတွေလဲသိရအောင်။

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.

ကျွန်တော်တယောက်ကြီးဖူးတယ်။ emergency ဖြစ်တယ် ၊ သူ့ဘာသာလာတယ်။ MW ကို Pass မလုပ်လာဘူး ကျွန်တော်တို့ မပေးဘူး VHC ပါလာတယ်။ မပေးဘူး။ ကိုယ်ဖာသာဘဲစီစဉ်ပါ။ ကျွန်တော်တို့ကလုပ်ပေးမယ် ဒါပေမဲ့ ဒီ refer support ကို ရမှာမဟုတ်ဘူး meal cost ရမှာ မဟုတ်ဘူး တိုင်မယ် တောမယ်နဲ့ စကားများတယ်။ တိုင်ချင်လဲတိုင်လို့။ ကျွန်တော်တို့အများနဲ့ လုပ်တဲ့နေရာမှာ law is by law ဘဲ ကျွန်တော်တို့က တစ်ယောက်နဲ့ မကြည့်နိုင်ဘူး။

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.

တချို့လဲ MW နဲ့အကြောင်းအမျိုးမျိုးကြောင့် အဆင်မပြေဘူး၊ သွားကို ပြချင် စိတ်မရှိဘူး။ အဲလူက ကျွန်တော်ဆီလာပြီ၊ ဒီလူနာ emergency မှန်း ကျွန်တော်လဲ သိတယ် သနားတယ်၊ ဒါပေမဲ့ routine channel လာတာ မဟုတ်တဲ့အတွက် သနားလဲ ပေးလို့မရဘူး။

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/casher 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)

ဆိုင်ကယ်ကယ်ရီနဲ့ သွားမယ်ဆို ၂၀၀၀ ပေးတယ်။ စက်လှေနဲ့ဆို ၅၀၀၀။
ကိုယ်ဆီကလွှဲစာပါမှရတာလေ။ လက်မှတ်ထိုးပြီး လွှဲစာမပါရင် မရဘူး။ အဓိက
တော့ ကော်မတီအကုန်လုံးတော့ မပြောနိုင်ဘူး။ လူကြီးလောက်သွားပြောပြီး
လက်မှတ်ထိုးပြီး ကိုယ်တိုင်လိုက်သွားတယ်။ လွှဲစာကျတော့ SC က
ပေးထားတဲ့ ပုံစံ။ အဲဒါကျတော့ကော ယူသွားရတာပေါ့။ ကိုယ့်ဆီမှာတစ်ခုသိမ်း
ရတယ်။

(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 referral 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.

သူတို့. SC referral စာရွက်အပြင် အဲတာလေးထုတ်ထားတယ်။ (showing referral letter) ကျွန်မတံဆိပ်တုံးနဲ့။ စည်းတံဆိပ်တုံးနှိပ်တယ်။
ကျွန်မတံဆိပ်တုံးနှိပ်တယ်။ သက်ဆိုင်ရာရပ်ကွက်မှာ အဲဒီစာရွက်မပါရင်
ပိုက်ဆံလုံးဝ ထုတ်လို့မရဘူး။ ယူနီဖောင်းဖြစ်အောင်ပေါ့။ သူတို့ဆီမှာ
ပိုက်ဆံသွားစစ်တဲ့အခါကျရင် ကျွန်မ စာရွက်ကလေးတွေရှိရမယ်။ ရွာတစ်ရွာကို
ကျွန်မဝင်လိုက်တယ်ပေါ့။ ကျွန်မကတော့ဒီလမှာ နှစ်ယောက်လွှဲထားတယ်။
စာရွက်နှစ်ရွက်ပြု။ ဟုတ်တယ်။ အဲဒီကနေ ၄၀၀၀၊ ကျွန်မရဲ့ stock
မှာလည်းပြန်နုတ်တယ်။ အဲတာဆိုရင် ဒီရွာမှာ ပိုက်ဆံလိုနေပြီလား။



မလိုလားဆိုတာ ကျွန်မဆင်းမစစ်ပဲနဲ့သိနိုင်တယ်၊ လူနာလွှဲပြီ ဆိုတာနဲ့ တခါတည်း stock ထဲကို ထည့်လိုက်တယ်။



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)



နင်ဆေးရုံသွားလို့ ပြောလိုက်ပြီးဆိုတာနဲ့၊ ခရီးစရိတ်ဆိုတာ လူတိုင်းလူတိုင်းမှာ လက်ထဲမှာ ပိုက်ဆံအလွယ်တကူမရှိဘူး။ first delay ဖြစ်သွားမယ်။ first delay ကို ကျွန်မတို့ ဖြတ်နိုင်မှာမဟုတ်ဘူး၊ emergency fund လေးရှိနေတဲ့အတွက်ကြောင့် ဒါလေးထုတ်ပေးပြီး ဆေးရုံ အလွယ်တကူရောက်သွားတယ်။ (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...

လူနာက ကလေးလူနာ၊ very ဆားဗီးယားနမိုးနီးယား၊ အဲဒီကလေးရဲ့ History က သူ့အမေက PE နဲ့မွေးထားတာ fits ရပြီးမွေးထားတာ၊ အဲဒီကလေးက အမြဲတမ်း ဂလုဂလုဖြစ်နေတယ်။ သူကနမိုးနီးယားရဖို့ chance အရမ်းများတယ်။ မနက်၁၀နာရီ၊ မိနစ်၂၀မှာ ကျွန်မဆီကိုရောက်လာတယ်။ ကျွန်မသေချာပြာညှိ ပေးပြီးတော့ ဒီ case ကို refer လုပ်ရမယ်ပေါ့။ အဲဒီအခါကျတော့ ပိုက်ဆံကဟိုရောက်လို့ရှိရင် ပေးမယ် မပေးဘူးဆိုတာမသိဘူး။ ဒီကနေသွားဖို့ အတွက် ခရီးစရိတ်ကိုကျွန်မပေးနိုင်တာပေါ့။ သူ့ကို ပိုက်ဆံသွားရှာလို့ပြော လိုက်တဲ့အခါမှာ ၃နာရီခွဲမှပြန်ရောက်လာတယ်၊ ကျွန်မလူနာကိုပတ်ရှာနေတာ။ လူနာကစာရင်းပေးခဲ့တာ စရပ်ကွက် ဘောလုံးကွင်းလို့ပေးခဲ့တာ။ အမှန်တကယ် သူတို့နေတာ ၁စရပ်ကွက်မှာနေတာ။ ကြားထဲမှာရပ်ကွက်ကြီးတစ်ခုခြားနေတယ်။ ဆိုင်ကယ်နဲ့ပတ်ရှာတာ အဲဒီလူနာကို။ ကျွန်မစိတ်မချဘူးဖြစ်နေတယ်။ initial



dosages တော့အကုန်ထိုးပေးပြီးသားပေါ့။ လိုက်ရှာတာမတွေ့ဘူး။ ရပ်ကွက်မှာ ပိုက်ဆံလာထုတ်လားဆိုတော့လည်း ဇေဝေဝါနဲ့။ အဲတာနဲ့ လိုက်ရှာတာ။ ပိုက်ဆံရှာနေရလို့ သူတို့မသွားနိုင်သေးတာပါတဲ့။ တော်သေးတာပေါ့။ ဒီကလေး လေးကဘာမှမဖြစ်သွားလို့။ ဖြစ်သွားရင် child dead တစ်ယောက်ဖြစ်အုံးမယ်။ emergency ဖြစ်လာရင် ဆေးရုံရောက်ရင် ဆရာတို့ကတော့ လက်ပိုက် ကြည့်မနေပါဘူး။ လုပ်ပေးမှာပါ။ ဘယ်လိုပဲဖြစ်ဖြစ် အဲဒီ TA လေးတော့ ရချင်ပါတယ်။ အဲတာလေးပေးလိုက်ရင် ကျွန်မတို့က လူနာကို အမိန့်ပေးလို့ လည်းရတယ်။ ကိုယ့် role ပေါ့နော်။ ညီမကိုဆရာမက ဒါစီစဉ်ပေးလိုက်မယ်။ ညီမရော ဒါတခါတည်းသွား။ အခုချက်ချင်းပဲ့ထောင်နဲ့ဆင်း။ အချိန်တွေဆွဲမနေရ ဘူးပေါ့။ တစ်ခွန်းတည်းပေါ့။

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)

နောက်၂ရက်ကြာမှသိရတော့ စားစရိတ်ရယ်၊ လူနာစောင့်တယောက်ရယ်၊ တနေ့ ၃၅၀၀ရတယ်တဲ့။ နောက်သူခွဲတာရော ဆရာဝန်ကြီးကိုပေးရမယ့် စရိတ်တွေက မပေးရဖူးပြောတယ် အဲတော့ ကျွန်မဝမ်းသာသွားတယ် အဲဒါတွေ ဘာမှမပေး ရတော့ဖူးပေါ့။ မပေးရတဲ့အပြင် ထမင်းစရိတ်ရယ် ကျွန်မ ၁၄ရက်နေရတယ်။ သူများတကာတွေကတပတ်နေရတယ်။ ကျွန်မက ၁၄၊ ၁၅ရက်နေရတယ်။ သွေးပေါင်မကျလို့၊ ၁၄ရက်လုံးထမင်းစရိတ်မရဘူး၊ ၇ ရက်ဘဲရတယ်။ ကျန်တဲ့ဟာ ကိုယ့်တာဝန်။


(IDI with women who underwent emergency LSCS)



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. (KIL with SC Field staff -1)

SMO ငွေလက်ခံစာရင်းသီးသန့် လက်မှတ်ထိုးရတာရှိတယ်။ SMO ကိုအသိသက်သေအနေနဲ့ ထိုးခိုင်းတာရှိတယ်။ နောက်က ၂သောင်းနဲ့ အထက်မို့လို့ ထိုးရတဲ့ဟာမှာတော့ ရှေ့စာမျက်နှာမှာတော့ လူနာထိုးရတယ်။ Without ဘောက်ချာလို့ခေါ်တယ်။ ပြန်မရနိုင်တဲ့ အသုံးစရိတ်တွေဆိုရင် သုံးတဲ့ ဘောက်ချာဆိုရင် အမကြီးရဲ့ဆေးဖိုးက ဘယ်လောက်ကျတယ်။ ထမင်းစရိတ် ဘယ်လောက်ကျတယ်။ ၂ ကြောင်းရေးတယ်။ ၁ ကြောင်းမှာတော့ ဒီဆေးဖိုးကတော့ ဒီပမာဏကတော့ ဆရာကြီးတို့ဆီမှာ အပ်ပြီးပါပြီ။ အစ်မကြီးတို့လည်း FOC ထုတ်ပေးတာပေါ့။ အောက်ကဟာကျတော့ ထမင်းစရိတ်ပေါ့။ လူနာအတွက် ၂ထောင်။
(Kill with SC Field staff -1)

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

 Save the Children

Date: _____

Sr.	Detailed Description of Service & work, etc	Accounts Code	SOF	Project
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). (KI 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)

ဆေးရုံတက်တာ ဘာဖိုးမှမကုန်ဘူး၊ စားတာသောက်တာလောက်တယ်။ ခြံ၊ ခြံ၊ ချန်ချန်စားမယ်ဆိုလောက်တယ်၊ လိုလိုမယ်မယ်ဆိုပြီး အိမ်ကယူယူသွားတဲ့တစ်သောင်းခွဲ ကုန်တယ်ဆိုတာက အိမ်သားတွေ ဒီကသွားရင်၊ ရွာကိုပြန်ပြီး အဝတ်တွေ ဘာတွေယူလာမယ်။ ဆိုင်ကယ်နဲ့ပဲ အသွားအပြန်ဆို ၇၀၀ ပေးရတယ်။ ထမင်းချိုင့်တွေဘာတွေယူလာရင်လဲ ဆိုင်ကယ်နဲ့လာတယ်။ ကွမ်းဖိုး၊ ဆေးလိပ်ဖိုး၊ ယောက်ျားတွေဆိုလည်း အဲလိုမျိုးကုန်တာပေါ့။ လျှော်ဖွတ်ဖို့ဆပ်ပြာဝယ်တယ်။ သနပ်ခါးဗူးဝယ်တယ်။ (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)

ဆေးရုံတက်နေတော့အိမ်သားတွေလည်း ထိုင်စားနေတယ်။ အဲဒီအချိန်မှာ အလုပ် မလုပ်ရတော့ဝင်ငွေမရှိဘူးပေါ့။ ယောက်ျားက ကိုယ်ကိုစောင့်ကြည့် နေရတယ်။ အိမ်မှာလည်းကလေးတွေရှိသေးတော့ အိမ်မှာချက်ဖို့စားဖို့ ရှိသေးတယ်။ ကိုယ့်ပိုက်ဆံ (၄၊ ၅)သောင်းကုန်တာပေါ့။ (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)

သူတို့ကနောက်ကနေပြီးတော့ ကျွန်မတို့ သွားနိုင်တဲ့နေရာတွေကို TA တွေ Perdiem တွေပေးတယ်။ BHS တွေကို အရင်တုန်းကတော့ မရှိလည်းမပေးလည်းလုပ်နေရတာပေါ့နော်။ ဒါပေမယ့် သူတို့ပေးတဲ့အခါကျတော့ ကျွန်မတို့ တစ်ခေါက်လုပ်မယ့်နေရာမှာ နှစ်ခေါက်လုပ်နိုင်တာပေါ့။ ပိုပြီးတော့အားရှိတာပေါ့။ နောက် special AN care တွေ ကျွန်မတို့သွားကြတယ်။ အဲဒီအခါကျတော့ hard to reach area ကိုပိုရောက်လာနိုင်တယ်။ သူတို့ပေးတဲ့အခါကျတော့ ကိုယ့်ပိုက်ဆံနဲ့ ကိုယ်သွားရင် တစ်ခေါက်ပဲရောက်နိုင်တာပေါ့မမရယ်။ သူတို့က နောက်ကနေ ထောက်ပံ့ပေးတဲ့အခါကျတော့ လိုအပ်သလို နှစ်ခေါက်လည်း သွားနိုင်တယ်။ (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 towel, 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 towel is used.

(FGD-6 with mothers)



- (၂)- ကိုယ်ဝန်ဆောင်သည်တွေဆို မွေးရင် အနီးထုပ်ပေးတယ်။
- (၆)- ဆရာမနဲ့ မွေးတဲ့သူတွေဘဲရတာ။
- (၂)- ဆပ်ပြာတုံးပါတယ်။
- (၇)- စောင်ထည်၊ သဘက်၂ထည်၊ အနီးက၅ထည်၊ အကျီ၂စုံ၊ ဦးထုပ်၁လုံး။
လက်အိတ်ခြေအိတ်၂စုံ ဆပ်ပြာတုံးပါတယ်။
- (၅)- အခုအိမ်မှာအကုန်အစုံတော့မရှိဘူး၊ သုံးလိုက်ပြီ၊ အနီးတွေလောက်ပဲရှိတယ်။
တဘက်လည်းအခုသူတို့ရေသုတ်နေတယ်။ (FGD-6 with mothers)



Figure 10: New Born Kit

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.



Figure 11: Clean Delivery Kit



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)

MNCH နဲ့ပတ်သက်ပြီး activity တွေအပိုင်းပိုင်း ဖြတ်လိုက်လို့ရှိရင် township level activity ရှိတယ်။ RHC ရှိတယ်။ sub-centre ရှိတယ်။ township level activity မှာဆိုရင်သူက coordination meeting တွေ၊ township coordination meeting ရယ် Township ရဲ့ monthly BHS meeting ရယ်။ အဲတာကို support လုပ်ရတယ်။
(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 KIIs 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)

တခါတရံကျရင်ပေါ့၊ ကျွန်မတို့ဆီက နမိုးနီးယားပေါ့၊ ကျွန်မတို့က ဆားမီးယား နမိုးနီးယားလို့သတ်မှတ်တယ်၊ initial dosages တော့ရအောင်ထိုးပေးလိုက်တယ်၊ ညွှန်ကြားထားတဲ့ဆေးတွေပေါ့။ တခါတလေ ကျရင် လမ်းမှာ ၃နာရီ၄နာရီကြာသွားတဲ့အခါကျတော့ ကလေးက အဲဒီအချိန်ကျရင် chest in-drawing က ပျောက်သွားတာမျိုးရှိတယ်၊ ကျွန်မဆီမှာ emergency ဆရာဆီရောက်သွားတော့ emergency မဟုတ်တော့ဘူး၊ ကျွန်မတို့က တွေ့တဲ့အချိန်၊ တွေ့တဲ့မိနစ်ကို တခါတည်း မှတ်ထားတယ်။ ဆေးရုံကို ဖုန်းရိုလောက်ကျမှ ရောက်ချင်ရောက်သွား မယ်လေ၊ ဆရာဟာဆရာဆေးရုံရောက်မှ emergency သတ်မှတ်ချင် သတ်မှတ်။ မသတ်မှတ်ချင် မသတ်မှတ်။ ကျွန်မတို့က emergency သတ်မှတ်ရင် TA တော့ ပေး ပေး ပါလို့ပြောထားတယ်။ (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.

ကျွန်တော့်ကြည့်လိုက်တော့ ကလေးက အကောင်းကြီးဘဲ ဥပမာ Beri Beri လိုဟာမျိုးပေါ့၊ Beri Beri ဖြစ်တယ်ဆိုပြီး emergency ပို့လိုက်တယ် B1 ၁လုံးထိုးပြီး ပို့လိုက်တော့ ကျွန်တော်ဆီရောက်တော့ ကောင်းနေတယ်၊ အဲဒါကို Emergency ဆိုပြီး ပေးပြန်ရင်လဲ တဖက်က အဖွဲ့အစည်းနဲ့ အလှူရှင်အတွက် မကောင်းဘူး၊ မပေးပြန်ရင်လဲ ဟိုက ဘယ်လိုပြော လွဲ



လိုက်လံ ဆိုတော့ စိတ်ချ refer ပေးမယ် ဟိုရောက်ရင် ထမင်းလဲစားရမယ် ဆေးရုံလဲ တက်ရမယ် ဒီရောက်တော့ ပေးလို့မဖြစ်ဘူး၊ အဲဒီတော့ OPD ထဲမယ် စောင့်ကြည့် ပြန်လွှဲတယ်၊ ကျွန်တော်ဘက်က treatment cost လိုတာတွေ အလကား စိုက်ရတယ်၊ ဒါပေမဲ့ Meal cost တော့မရဘူး။ patient က မကြည်ဘူး၊ အဲဒါမျိုး ရှိတယ်။

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.

တချို့တချို့သော အငယ်ဝန်ထမ်းတွေ public နဲ့ သဟဇာတ မဖြစ်ဘူး။ ငါနဲ့ အဆင်မပြေဖြစ်လို့ refer မပေးဘူး။ အဲလူနာ ကျွန်တော်ဆီရောက်လာတယ်။ ဆရာ ကျမကို refer မပေးဘူး။ တကယ် ကြည့်လိုက်တော့လဲ သူက post date case ကျွန်တော်ဆေးရုံက နည်းနည်းလဲ အဆင်ပြေလာတော့ အာထရာဆောင်းရှိတယ်။ ကျွန်တော်ဘာသာ ဆွဲကြည့်တယ်။ refer ပေးသင့်တယ်၊ ဒါပေမဲ့ ပေးပါလို့ ကျွန်တော်မပြောဘူး။ refer ပေးခြင်း မပေးခြင်းက MW က ဆုံးဖြတ်ရမယ်။ patient တွေက အဲဒီ complaint လာတယ်။ MW က မပေးဘူး၊ တစ်ထားတယ်။ နောက်ဆုံး ကျွန်တော်က ပြောပါတယ်။ မပေးဘူးဆိုရင် ဆရာမ တာဝန်ခံ မလား မေးကြည့်ပါ။ ဆရာမ တာဝန်ခံမယ်ဆို ဆရာမနဲ့မွေးမယ် ၊ လက်မှတ်ထိုးပေးထား၊ တခုခုဖြစ်ရင် ဆရာမတာဝန်ယူရမယ်။ အဲဒါမှ Refer ထွက်လာတဲ့ အခါမျိုး လဲရှိတယ်။



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.

နောက်ပိုင်းကျတော့ အဆင်ပြေရင်ပြေသလို မပြေရင်မပြေသလို refer ပြဿနာ ဖြစ်လာတယ် ၊ risk factor မရှိဘဲနဲ့ HA or MW ကျွန်တော်ဆီ လွှဲလိုက်တယ်။ နယ်တနယ်ဆို ကျွန်တော်ဆီ အများကြီး လွှဲ လိုက်တယ်။ ကျွန်တော်လည်း နောက်ပိုင်းဖြတ်ချရတယ်။ indication မရှိဘဲနဲ့ ကျွန်တော် လုပ်ပေးရရင် ၊ အဖွဲ့အစည်းက တမျိုးမြင်ပြီး နာမည်ပျက်မယ် ၊ အရေးပေါ် မဟုတ်လို့ မပေးနိုင်ဘူး။ ပြန်လွှတ်လိုက်တယ်။

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)

အဲဒီလူတွေက AN ကိုတောင်မှ ၄ခါပြီဖို့အချိန်မရဘူး။ ဆားဖိုကမအားတာနဲ့ ဆားဖိုသူကြီးက မလွှတ်တာနဲ့ အထူးသဖြင့် ရွှေ့ပြောင်းနေတဲ့ လူတွေအတွက်ကို တနည်းနည်းလုပ်ပေးသင့်တယ်ပေါ့။ သူတို့က စားဝတ်နေရေးအတွက် လုပ်နေရ



တာဆိုတော့ AN အကြိမ် ပြည့်အောင်လာပြချင်မှလာပြနိုင်မယ်။ AN ငှကြိမ်
မပြထားရင် Emergency Support တွေမရတော့ဘူး။
(KII 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)

ပေးတဲ့ပိုက်ဆံ ပျောက်သွားတာမရှိဘူး။ မကြားသေးဘူး အခုအနေနဲ့ အောင်မြင်တယ်လို့ယူဆတယ်။ ချေးတာကတော့ လွတ်လပ်စွာချေးလိုရတယ် ယုံကြည်စိတ်ချတဲ့လူပေါ့ မရခဲ့ရင် သူတို့ဘဲစိုက်ရမယ်လို့ပြောထားတယ် ဆုံးတယ်လို့ မကြားမိသေးဘူး အဲလိုကြားခဲ့ရင်မအောင်မြင်ဘူးလို့ယူဆမယ်။ (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 နဲ့ပတ်သက်ပြီး ကျွန်မတို့လုပ်တဲ့အခါကျရင် တခါမှမကူညီတဲ့ ရပ်ကွက်မရှိဘူး။ ကျွန်မတို့နေရာမှာ men power အရမ်း အားနည်းတဲ့ အခါကျတော့ တချို့ကိစ္စတွေဆိုရင် သူတို့ကိုပဲ အားကိုးရတယ်။ ရပ်ကွက်တစ်ခုက နည်းနည်း အားနည်းချက်တော့ရှိတယ်။ သူက leader ကိုယ်တိုင်က အားနည်းတာ။ lead မလုပ်နိုင်တာ။ သူ့စီးပွားရေးပဲ သူစိတ်ဝင်စားတယ်။ ကျန်တဲ့ဟာတွေကို စိတ်မဝင်စားဘူး။ အဲဒီရပ်ကွက်ဆင်းတဲ့ အခါကျရင် MW မရှိတဲ့အခါကျရင် ကိုယ်တိုင်ဆင်းရတယ်။ ကိုယ်တိုင်ဆင်းပြီးလုပ်ရင်တော့ အဆင်ပြေသွားတာပေါ့။ တခြားလူနဲ့လုပ် ခိုင်းရင် အဆင်မပြေဘူး။ အဲတာမျိုးလည်းရှိတယ်။ ကျန်တဲ့နေရာတွေကတော့ အကုန်လုံး ဘာလုပ်မယ်ဟေ့ဆိုရင် ညီညီညွတ်ညွတ် အကုန်လုပ်ကိုင်ကြတယ်။ meeting ဖိတ်ရင်တောင် တဝက်လျော့ဖိတ်ရတယ်။ အကုန်လုံးကတက်ချင်ကြတယ်။

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...



ကျွန်တော်တို့၊ မြင်တာက active ဖြစ်တာ နံပတ် ၁ physical ပေါ့၊ quantitative ပြန်ကြည့်တော့ သူတို့ကို ထောက်လှို.ရတယ် fund ပေါ့၊ ပေးထားတယ် ဘယ်လောက်ရှိတယ် ဒီဟာကို အသုံးချပြီး ထိန်းသိမ်းပြီး တိုးပွားလာအောင် လုပ်နိုင်သလား၊ မလုပ်နိုင်ဘူးလား။ ဘယ်လောက်ထိ သူတို့ ကျစ်ကျစ်လစ်လစ် တောင့်တောင့်တင်းတင်း systematic ဖြစ်သလဲ ပြန်ထောက်လှို.ရတယ်၊ နောက်တခုက activity တွေ ဘယ်လောက်ရှိသလဲပေါ့၊ structure မှာ ခဏ ခဏ မူပြောင်းနေသလား persistence ဖြစ်သလား၊ မူပြောင်းနေတယ်ဆို မဟုတ်ဘူးပေါ့၊ ကြားထဲက တခုခု ရှိလို့ဖြစ်မယ်။ ကျွန်တော်တို့၊ အပေါ် DOH အပေါ် ဘယ်လိုမြင်လဲ ၊ INGO အပေါ် ဘယ်လိုမြင်လဲ ၊ သူတို့အမြင်ပေါ့။ ဒါက quality အပိုင်းပေါ့။ သူတို့ရဲ့ feeling ပေါ့၊ ကျွန်တော်တို့၊ cooperate လုပ်တဲ့နေရာ အဆင်ပြေလား၊ လုပ်ချင် စိတ်ရှိသလား၊ မရှိဘူးလား။

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)

တချို့က BHS တွေက သူတို့ရဲ့ technical or clinical ကိုဘဲစိတ်ဝင်စားတယ်၊ management တွေ mobilization တွေ စိတ်မပါဘူး၊ တချို့ BHS ကျတော့ mobilization လုပ်ရတာတို့၊ development concept တွေ သူတို့ အရမ်း စိတ်ဝင်စားတယ်၊ VHC အောင်မြင်နေတာ ရွာကချမ်းသာ နေလို့ကြောင့် မဟုတ်ဖူး။ BHS တဖက်ထဲကအရမ်း mobilize လုပ်တတ်လို့လည်း မဟုတ်ဖူး။ အများကြီး



အကြောင်းအရာအများကြီးပေါ့၊ အဓိကနံပါတ်(၁)က အောင်မြင်တဲ့ရွာ
 တော်တော်များများက ရွာသားတွေ committee ကောင်းတာရယ်၊
 ရွာသားတွေအပေးဆပ်မှန်၊ စည်းကမ်းလိုက်နာတယ်၊ BHS ကလဲ attitude
 မှန်တယ်။ အဲဒါကတော့ ကျိန်းသေပါတယ်၊ BHS ကောင်းရင်
 ပိုအဆင်ပြေတယ်။ ရွာရဲ့ fund က health activity တွေမှာ supportive
 ဖြစ်တယ်။

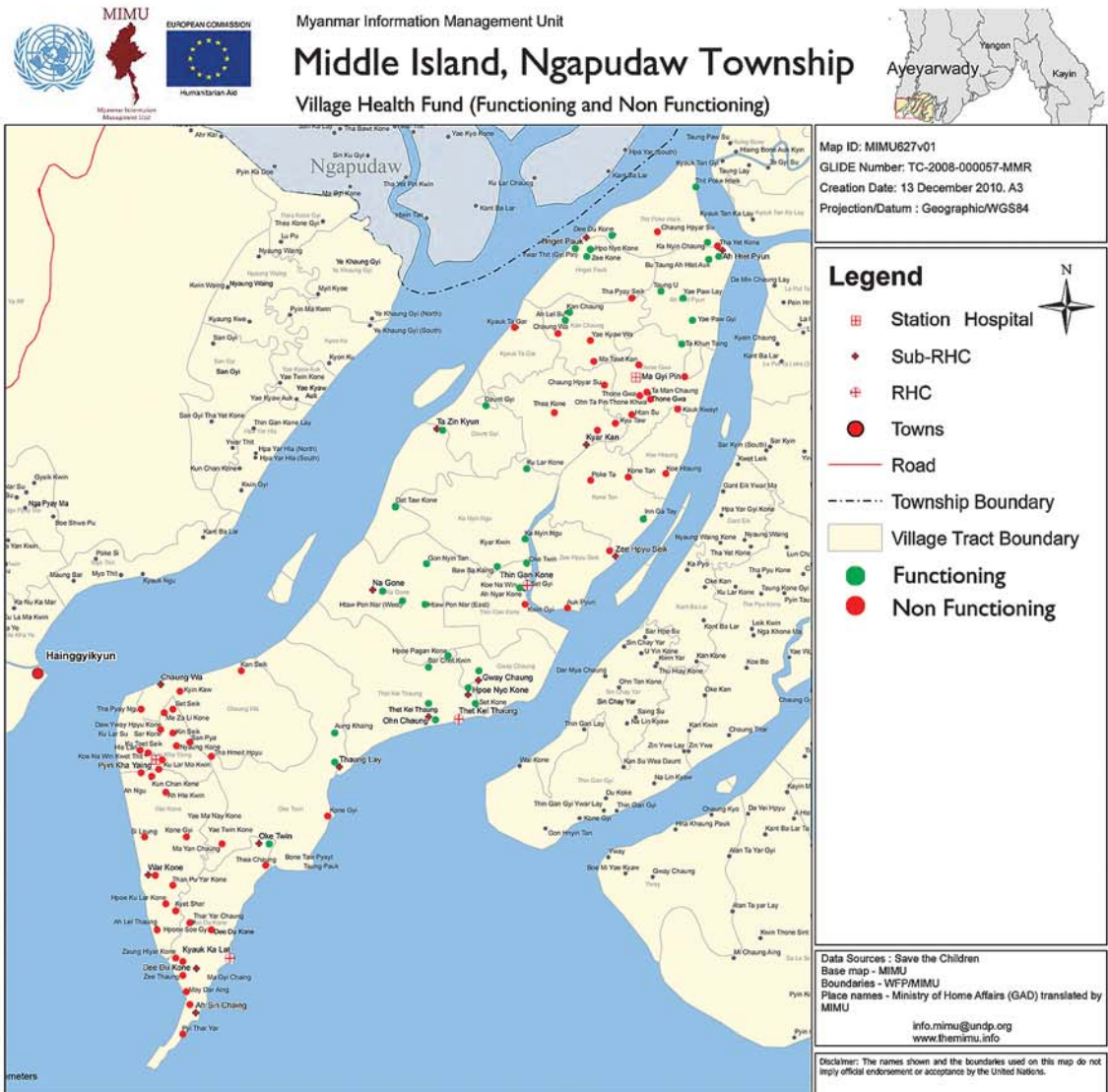


Figure 12: Map of Middle Island showing functioning status of VHCs in 125 villages



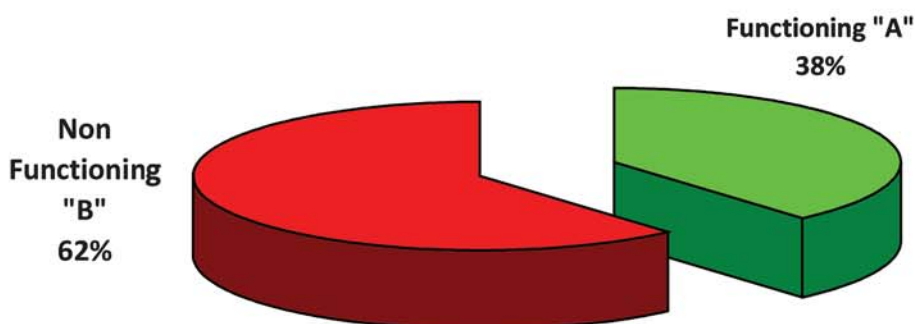


Figure 13: Functioning Status of VHC (n=125 VHCs)

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.

Sr. No.	Criteria	Score
1	Increase in amount of Revolving Fund	2
2	Certain amount of Interest contribution to Emergency Health Fund	2
3	Support Referral Cases in 2010, 2011, 2012	2

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 ရှိတဲ့အတွက် institution delivery လည်း သိသိသာသာ တက်လာတယ်။ hospital delivery တက်လာတယ် အရင်က emergency ဖြစ်ပြီးတော့ refer မရတဲ့ သူတွေ emergency refer တွေတက်လာတယ်။ government ရဲ့ health service ကို utilization တက်လာတယ်။ နောက်တစ်ခုက MW ကို အားကိုးလာတယ် MW က refer လုပ်တယ် AMW ဆီ က refer လုပ်တယ်ဆို ဆေးရုံရောက်ရင် support ရတယ်။ MW က သူတို့ရဲ့ health service ကို confidence ရှိရှိလုပ်လို့ရသွားတာ အရင်ကဆို MW က refer လွှဲတယ်ဆိုရင် ကိုယ့်ပိုက်ဆံနဲ့ ကိုယ်သွားရမယ် ကိုယ့်ဟာ ကိုယ်အိမ်ငှား ရမယ် MW refer လွှဲပေမဲ့မသွားရဲကြဖူး၊ ပိုက်ဆံကုန်တာ ပိုက်ဆံမရှိတာနဲ့၊ အခုဆို MW ကို ယုံကြည်လာတယ် M.W က ရဲရဲတင်းတင်း ပြောရဲသွားတယ် သွား---ဟိုရောက်ရင် FOC အကုန်ရတယ် ဆိုတော့ MW စကားပေါက် တာပေါ့။ (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.



နာဂစ်မဖြစ်ခင်က ပိုက်ဆံမရှိလို့ အခက်ခဲရှိတယ်။ နာဂစ်ဖြစ်ပြီး ကျန်းမာရေးအဖွဲ့ ရံပုံငွေ ထောက်ပံ့မှုတွေ ရှိလာတော့ မရှိတဲ့သူတွေအတွက် အတော်အဆင်ပြေ တယ်။ ရှိတဲ့သူတွေလဲ အဆင်ပြေတယ်။ ရွာမှာကမရှိတဲ့သူကတော့ အများဆုံးပေါ့။ အရင်တုန်းကဆို မရှိတဲ့သူဆို မမွေးနိုင်လို့ သေတာတို ပိုက်ဆံမရှိလို့ ဆေးရုံသွားဘိုလဲ အခက်ခဲရှိတယ်လေ။ အဲဒါကြောင့် အရင်ကဆိုသေတာများတယ်။

Monitoring and evaluation of VHCs

Monitoring of VHCs was mainly carried out by SC field 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)

တချို့ရွာဆိုရင် အစည်းအဝေးလာ တက်တယ်။ ကိုယ့်ရဲ့ VHC ကိုယ့်ရဲ့ရွာသူ ရွာသား တွေကို ပြန်ပြီးတော့မဝေမျှဘူး။ မပြောပြပေးဘူး။ အစည်းအဝေး လုပ် ပြီးတိုင်း ညီမတို့ကရွာရောက်လို့ရှိရင် ညီမတို့ ပြောခဲ့တဲ့ ဟာတွေ သူတို့သိ



လားဆို ပြီးပြန်မေးတယ်။ ဒီတိုင်းမေးတာမဟုတ်ပဲ စကားပြောရင်းနဲ့ ပြန်
မေးကြည့်တယ်။ သူတို့ နည်းနည်း ဇေဝဇဝါဖြစ်နေတယ်။ သူတို့သိပ်သိတဲ့
ပုံမပေါ်ဘူးဆိုရင် ဒါဆိုသေချာတယ်။ ဒီ VHC ပြန်မပြောဘူး၊ အဲဒီ VHC
meeting ကျရင် ညီမတို့ကပြန်ပြောတယ်။ အဲတာဆိုသူတို့
ပြန်ပြောတော့တယ်။ နောက်ပိုင်း ရွာရောက်ရင် သိတာတွေများလာတယ်။
(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)

အဲလိုမျိုးရွာတိုင်းတော့မသွားနိုင်ဘူး၊ ညီမတို့အဓိကစစ်တာတော့ VHC meeting မှာစစ်တယ်၊
ငွေကိုင်စာရင်းကိုင်ပါတဲ့အတွက် သူတို့ကို fund management training ပေးတုန်းကလည်ရုာ
စာအုပ်တွေပေးလိုက်ပြီးသား၊ ဘယ်လိုမျိုး အသွင်း အထုတ်တွေလုပ်၊ သူတို့က အဲတာကို
ယူလာပြီးသား၊ ကြည့်လိုက်တယ်၊ သူတို့ စာရင်း လုပ်ထားတာသိပ်မဟုတ်ဘူးပေါ့၊ အဲဒီရွာကို
မှတ်ထားတယ်၊ မှတ်ထားပြီးလို့ရှိရင် အဲဒီရွာကိုသပ်သပ်၊ သွားကြည့်တယ်၊ အဲဒီရွာမှာတော့ ပြဿနာ
ကအုပ်ချုပ်ရေးမှူးရဲ့မိန်းမနဲ့သမီးက revolving fund သုံးလိုက်တာ။

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)

အဲဒီပိုက်ဆံတွေကို အလွဲသုံးစားလုပ်လို့ တစ်ခုခုဖြစ်လာခဲ့ရင် ထိန်းချုပ်ဖို့အတွက်



ကော်မတီအချုပ်အဖွဲ့တစ်ခုဖွဲ့ခိုင်းထားတယ်။ ဩစာအာဏာရှိ တဲ့လူပေါ့။ Local authority မဟုတ်ဘူး။ အဲဒီအတိုင်းကြီးကအရမ်းကို လူမှုရေး ပရဟိတလုပ်ငန်းတွေစိတ်ဝင်စား ပြီးတော့ လူတိုင်းလူတိုင်းကို influence လုပ်နိုင်တဲ့ အဖိုးကြီးတစ်ယောက်ရှိတယ်။ သူ့ကိုကျွန်မ နာယကထားတယ်။ ဒီရွာ၂၀၀လုံးမှာရှိတဲ့ leader တွေအကုန်လုံးက အဲဒီကော်မတီအချုပ်ကြီးရဲ့ members တွေဖြစ်လာတယ်။

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)

အဲဒီမှာမှဆရာမက သူ့မှာစရာရှိတာလေးတွေပေါ့။ ဥပမာ လူဦးရေကောက်တာမျိုး။ အဲဒီအချိန်မှာ အကုန်လုံးစုံတဲ့အတွက်ကြောင့် အုပ်ချုပ်ရေးမှူး၊ AMW, CHW လာတယ်။ အုပ်ချုပ်ရေးမှူးကလည်းဆုံ တဲ့အတွက်ကြောင့် မှာချင်တာမှာ လိုရတယ်ပေါ့။ သူလည်းပြောတယ်။ အများဆုံးပြောတာက referral ရယ်။ revolving ရယ်။



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)

ငွေပုံတဲ့ရက်၊ ၁၂လပိုင်း၂၅ရက်နေ့က၊ ကျန်းမာရေး အရံသားဖွားဆရာမ အိမ်မှာ လုပ်တယ်။ ကျန်းမာရေးကော်မတီနဲ့ ရပ်မိရပ်ဖတွေတက်ကြာတယ်။ ငွေရေး ကြေးရေး ကိစ္စတွေတိုင်ပင်တာပေါ့။ ၁၂လပိုင်းမှာငွေပုံပြပြီး ၁လပိုင်း၁၀ရက် နေ့မှာပြန် ချေးတာပေါ့။ အရင်းပါပုံပြပြီးပြန်ချေးတာပေါ့။ တစ်ယောက်ကိုငှသောင်း ပြပြီးပြန် ချေးတာပေါ့။ ကျွန်တော်လည်း ငှသောင်းပြန်ချေးတယ်။
(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)

ဖြေဆိုသူ(၃)- ၃လဆို အတိုးအရင်းပုံတယ်
ဖြေဆိုသူ(၄)- လာပုံပြီး အစည်းအဝေးလုပ်ပြီးပြန်ချေးတယ်။ အသစ်ချေးချင်တဲ့သူ ရှိ လဲပေးတယ်။ ၃လ အစည်းအဝေးမှာ လူအသစ်ရှိရင် ထပြရတယ်။
ဖြေဆိုသူ(၅)- အဲဒီအချိန်ဆို အားလုံးလာတယ်။
ဖြေဆိုသူ(၃)- ၃လအချိန်ဆို အိမ်ပြည့်တယ် ပိုက်ဆံတပုံကြီးဘဲ အိုးနဲ့ ထည့်ထားတယ်။
ဖြေဆိုသူ(၅)- အလုံးအရင်းမြင်ရတယ်။
(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)

ညီမတို့ဘက်ကတခုအားနည်းတာက VHC meeting မှာ တရားဝင်အကုန်လုံး မဖြစ်မနေပေါ့။ အဲတာကိုရေးပြီးထည့်ရမယ်လို့ ပြောတာအားနည်းတယ်ပေါ့။
(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, casher 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 (cashier 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)

သူတို့ကတကယ်လည်း တော်ကြတဲ့လူတွေရှိတယ်။ သူတို့က စေတနာ့ဝန်ထမ်းဖြစ်တဲ့ အတွက်
ကြောင့် ရွာမှာလည်းအမြဲမရှိဘူး။ သူတို့ရဲ့စားဝတ်နေရေးအတွက်ပေါ့၊ တကယ်ကို ဝါသနာပါပြီး
လုပ်နေတဲ့ နည်းနည်းပဲ ရှိတော့တာပေါ့။ သူတို့တွေက functioning မဖြစ်တော့ပဲ
ရွာမှာမရှိဘူးဆိုရင် အဲဒီအချိန်မှာ VHC ကသူတို့ဟာသူတို့စည်းစည်း လုံးလုံးရှိနေတော့ လုပ်ပေး
ရင်တော့ကိစ္စမရှိဘူးပေါ့၊ save the children လည်းမရှိတော့ရော သူတို့ ဟာသူတို့လည်း
အပိုင်တွေစည်း၊ သူတို့ဟာသူတို့လည်းစိတ်ဝမ်းတွေကွဲ။ AMW, CHW လည်း ဘာမှ support
မရှိတော့ဘူး၊ support မရှိတော့ရင် အရင်ကလိုမျိုးဆက်ပြီးတော့လုပ်နိုင်ပါ့မလား၊
အခုအခြေအနေအရဆိုရင် AMW, CHW နည်းလာတဲ့အတွက်ကြောင့် သူတို့တွေအတွက်
နည်းနည်းတော့စိုးရိမ်တယ်။ (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)



ကျေးရွာကျန်းမာရေးအဖွဲ့ ရေရှည်တည်တံ့ဖို့၊ အောင်မြင်ဖို့ဆိုတာ---
အချင်းချင်းစည်းလုံးရမယ်၊ စည်းလုံးဖို့ဆိုရင်လဲ ပါဝင်တဲ့သူတွေက
မှန်မှန်ကန်ကန် လုပ်ပြမှ၊ အများရဲ့ ယုံကြည်မှုရမယ်၊ ဦးဆောင်တဲ့သူကလဲ
ရှေ့က စံနမူနာပြ စနစ် စည်းကမ်းနဲ့ ငွေစာရင်းရှင်းတမ်း သေချာပြနိုင်တာ၊
ကိုယ်ကျိုးမဖက် ဘက်မလိုက်တာတွေပေါ့၊ အဲဒါမှလဲ ပြောတဲ့အခါ အားလုံးကို
ဩဇာညောင်းမယ်၊
(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

ရွာတစ်ရွာမှာ ဗိုက်ကြီးသည် သူ့ဟာသူမွေးမယ်။ အရပ် လက်သည်နဲ့မွေးမယ်။ အဲတာကိုဒီဘက်က community က အရမ်းကို strong ဖြစ်နေတော့ ဆရာမနဲ့မွေးဖို့အတင်းကိုသွားခိုင်းတာ၊ သွားတဲ့ အခါမှာ service charge ပါလာပြီး၊ medical cost တွေပါလာတော့ ဟိုဘက် က team ကပြောတာ၊ village health team နဲ့ community ဘက် ကဘာပြောလဲဆိုတော့ ကျွန်တော် တို့ဘက်က ဒီလူနာကိုသွားဖို့။ ဆရာမ ဆီရောက်အောင်လာဖို့။ အတိုင်းအတာတစ်ခုအထိ support လုပ်ပေးမယ်။ village health fund နဲ့ ဆရာမ service ရအောင် ဒီဘက်က လုပ်ပေးမယ်။ ဟိုဘက်ကလည်း service ပေးတဲ့အခါမှာ လိုက်လျော ညီထွေမှုရှိတဲ့ service နဲ့ ဝန်ဆောင်ခ ဘယ်လောက် လဲဆိုတာပြောပေးပါ။ အဲတာကို VHC meeting မှာပြောတယ်။ အဲဒီ ဟာမှာ အကုန်လုံးက ဒီဘက်ကလည်း ပြောလာပြီ။ ဆရာမ လည်းအဖြေတစ်ခုပေး ရတော့မယ်။ ဟိုဘက်ကပြော တာက ဆရာမ ဆေးတွေဝယ် ရတာရှိတယ်။ ဘာညာက စိုက်ဝယ် ရတာရှိတယ်။ ဆရာမဆီ ခေါ်လာပေးမယ်။ ဆရာမအဲဒီ ဆေးတွေ သုံးပေး၊ ပိုက်ဆံ ဘယ်လောက် သုံးဖို့ လိုမလဲ။ minimum ကိုပြောပြ ပေးပါ။ အဲဒီမှာ ရိုးရိုးမွေးဆိုရင်၊ လုံးဝ poor ဖြစ်တယ်ဆိုရင် minimum ၅၀၀၀၊ ဆရာမဘက် ကလည်းစိုက်မယ်။ ရွာဘက်က လည်းပေး၊ တတ်နိုင်ရင် normal labour ရိုးရိုးမွေးမယ်။ ပိုက်ဆံ ကတော့မရှိဘူး။ ဒါပေမယ့် ရိုးရိုးမွေးတာကို ဆရာမနဲ့မွေးချင်တယ်။ ရွာက ပြောတယ်။ ဆရာမယူတဲ့ပမာဏ amount က ရွာ မှာ အမျိုးမျိုးပြောနေကြတယ်။ သောင်းဂဏန်း ဘယ်လောက်ဘယ်လောက် ပြောနေ ကြတယ်။ အဲဒီအတွက် ကြောင့်မို့လို့ကျွန်တော်တို့ ရွာကို advocate လုပ်ဖို့တွက်ဆိုရင် ဆရာမ ပျမ်းမျှ ဘယ်လောက်ယူမလဲဆိုတာသိရမယ်တဲ့ အဲဒီလို ဆရာမ ဘယ်လောက်ယူမှာလဲ သိမှ ကျွန်တော်တို့ဘက်က ပြော လို့ရမယ်။ အထူးသဖြင့် အပြင်က ဝင်လာတဲ့လူမျိုးတွေ၊ ဒီမှာ ကလေး လာမွေး တဲ့လူမျိုးတွေဆို ကျွန်မတို့ပြောမှ သူတို့ ပိုက်ဆံဘယ်လောက်။ birth plan ဆွဲဖို့ သူတို့ ပိုက်ဆံဘယ်လောက် save လုပ်ရမယ် ဆိုတာ သိသွားမယ်။ အဲတော့ ဆရာမ ပျမ်းမျှဘယ်လောက် ယူမယ် ဆိုတာမျိုး။ Community က သူ့ရဲ့ voice ကိုပြောပြီး meeting မှာ မေးလာတယ်။



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.

ကျွန်မတို့နေရာမှာ ဥပမာ ပြောပြတာပါ။ ကျွန်မနေရာမှာ CHW၊ AMW တွေ criteria ခဏချက်သတ်မှတ်ထားတယ်။ လစဉ်တိုင်း tick လုပ်ထားတယ်။ ခဏချက်ရှိတယ်။ ဥပမာ သူတို့ကအစည်းအဝေးပုံမှန်တက်တယ်။ ကျန်းမာရေး ဝန်ထမ်းနဲ့ ပူးပေါင်းပါဝင်တာ၊ အမိန့်နာခံတတ်တာ၊ ပြည်သူလူထုကို သူတို့ ပူးပေါင်းပါဝင်ဆောင်ရွက်နိုင်တာ။ ပြည်သူလူထုကို ကျန်းမာရေး ပညာပေး တာပဲဖြစ်ဖြစ်၊ ပြည်သူလူထုရဲ့ဟိုဟာ ကိုသူတို့လုပ်ပေးနိုင်တာပေါ့။ ကိုယ့်ရွာထဲမှာ ကူးစက်ရောဂါနဲ့ပတ်သက်ပြီး သူတို့ဘယ်လိုမျိုးတွေ ထောက်လှမ်းနိုင်တယ်။ ဆရာမတွေနဲ့ ဘယ်လိုချိတ်ဆက်နိုင်တယ်။ ဆရာမတွေကိုရော သူတို့ဘယ်လိုမျိုး ကူညီနိုင်လဲ။ ခဏချက်ရှိတယ်။ နှစ်တစ်နှစ်ကုန်သွားလို့ရှိရင် ကျွန်မ အဲဒီအမှတ် တွေ ပေါင်းတယ်။ AMW နှစ်ယောက်၊ CHW နှစ်ယောက် ဆုပေးတယ်။ အဲလိုမျိုးလုပ်တယ်။ အဲတာကြောင့် ကလေးတွေကတက်ကြွတယ်။ ကျောင်းတွေမှာ ပေးသလိုမျိုး ဒိုင်းဆုပေးတယ်။ ၃၀၀၀ လားမသိဘူးကျတယ်။ ထူးချွန် ကျန်းမာရေး လုပ်သား၊ ထူးချွန်အရံသားဖွား၊ အဲလိုမျိုး။..

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.

ကျွန်မရဲ့အသိအမှတ်ပြုမှုက ၂၀၁၁တုန်းက DHF လုံးဝ မဖြစ်ဘူး။ ဒီနေရာက DHF တကယ့်ဧရိယာကြီး၊ ၂၀၀၉တအားဖြစ်တာ၊ ၂၀၁၀ဖြစ်တာပဲ၊ ၂၀၁၁ကျရော larva control တွေလုပ်တဲ့အခါကျတော့ သိပ်မဖြစ်တော့ဘူး၊ မှတ်တမ်းတင်ထားတာပေါ့၊ မှတ်တမ်းတင်ထားတယ်ဆိုတာ သူတို့ကိုပြောပြတာပေါ့၊ အစည်းအဝေး မှတ်တမ်းမှာလည်းရေးထားတာပေါ့၊ DHF ဒီနှစ် တစ်ယောက်မှမဖြစ်ပါဘူး၊ ဒါ VHC တို့ရဲ့ပူးပေါင်း လုပ်ဆောင်မှုကြောင့်ပါပေါ့၊ သူတို့ကို ပါးစပ်နဲ့ ချီးကျူးတာပေါ့၊ ကျွန်မက အဲလောက်ပဲတတ်နိုင်တာ၊ တစ်ခုခုများပေးနိုင်ရင်တော့ သူတို့အတွက်ပိုပြီးတော့ ဟိုဟာဖြစ်တာပေါ့၊ အလှူခံဖြတ်ပိုင်းလိုမျိုး၊ ကတ်ပြားလေး တွေရှိတယ်၊ ဂုဏ်ပြုမှတ်တမ်းလိုမျိုးပေါ့၊ တစ်ရပ်ကွက် တစ်ရပ် ကွက်ချင်း အလိုက် ပေါ့၊ အဲတာမျိုးလေးတွေပေးရင် မကောင်းဘူးလား။

According to KIIs 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 charge, all Services must be provided free. (Kil with SC staff)

ကျွန်တော်လည်း equation တစ်ခုထုတ်ထားတယ်။ အဲတာကအရမ်း အန္တရာယ်များတယ်။ ကျွန်တော်တို့ range သတ်မှတ်တယ်။ အစ်မတခြား နေရာတွေမှာသုံးရင် လည်းရတယ်။ ကျွန်တော်တို့က medical care ရဲ့ဘယ်လိုပြောမလဲ cost of medical care , cost of medical care မှာ အကုန်ပါသွားပြီး၊ ခွဲတာရော၊ ဆေးဖိုးရော၊ CS တွေဘာတွေအကုန်ပါတယ်။ transportation ရောပါတယ်။ cost of medical care က ကျွန်တော်တို့အခု project ဝင်တဲ့ နေရာမှာ အားသာချက်တစ်ခုက ဒီ range လောက်သည် community ဘက်ကရော၊ ဆရာဝန် အတွက်ရော အဆင်ပြေနိုင်တဲ့ range တစ်ခုဖြစ်နေ၊ ပြီးတော့ range က fix ဖြစ်သွားပြီး၊ တစ်နှစ်မှာဘယ်လောက် လွှဲနိုင် မလဲဆိုတာ data၊ အဲတာ လည်းမှန်းလိုရနေပြီး၊ percentage of emergency case ပေါ့၊ Total under ၅ ရဲ့ဘယ်လောက်၊ range ကလည်း ဒီဟာလည်း fix, fix, ၂ခုဖြစ်တဲ့အတွက်ကြောင့် ကျွန်တော်တို့က နောက်ထပ် variable တစ်ခုက revolving fund က ဟာကိုပဲ variable လုပ်လို့ရတယ်။ တချိန်ချိန်မှာ revolving fund ရဲ့ interest သည် ဒီနှစ်ခုကို ဖာထေးနိုင်တဲ့ support လုပ်နိုင်တဲ့ amount ဖြစ်ရင်ရပ်ရမယ်။ အဲတာ logical concept ဝဲ၊အရင်းမပါ၊ အတိုးကဒီဟာကို cover ဖြစ်နိုင်တဲ့ အချိန်ကျရင် program အကုန်ရပ်ရမယ်။ support လုပ်တာရပ်၊ community run နိုင်တယ်။ but community Township Health Department 'D variable ကိုဖြတ် လို့မရဘူး။ ကျွန်တော်တို့မှာ equation ထုတ်ထားတယ်။ community ရဲ့ ceiling cost ကို သတ်မှတ်လိုက်လို့ရှိရင် ရသွားနိုင်တယ်ဆိုတာ ceiling cost ကို regional meeting တစ်ခုမှာပြောတာ ဆရာကြီး တစ်ယောက်က မပြောပါနဲ့ဆိုပြီးအဲဒီ slide ကို ဖြတ်တဲ့ midwife တွေကပိုက်ဆံမယူရဘူးတဲ့၊ service charge ကိုလုံးဝမယူရဘူးတဲ့၊ free ပေး ရမယ်တဲ့။



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.

၆- ကိုယ်ခူး၊ ကိုယ်ချွန်ပေါ့။

မေး- ကိုယ်ခူး၊ ကိုယ်ချွန်ဆိုတာ ဘယ်လိုလည်း

၉- ကိုယ့်ငွေ ကိုယ်ပြန်ဖြည့်

၈- ကိုယ်ခူး၊ ကိုယ်ချွန်ကလည်း ပိုက်ဆံများများဆိုမရဖူးပေါ့။
အရေးပေါ်ဆိုအခက်ခဲတော့ရှိတာပေါ့။

၇- ပိုက်ဆံမရှိရင်အသေခံရမှာပေါ့။

၂။၈- ကူညီမှုမရှိရင် ထောက်ပံ့ထားတဲ့ပိုက်ဆံတွေနဲ့ တိုးပွားအောင်လုပ်ရမယ်
ကူညီရမှာပေါ့။

၈- ဒီတိုင်းတော့ ဘယ်နေမလဲ စုထားတဲ့ပိုက်ဆံနဲ့ ကူညီရမှာပေါ့။

၈- အရေးပေါ်လာရင် ဒါတွေနဲ့ အလှူရှင်မရှိလည်း တိုးထားတဲ့ ပိုက်ဆံနဲ့
လုပ်ရမှာပေါ့။ ရှေ့ဆက်ပြီးတော့

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)

အဲတာတော့နည်းနည်းတော့ စိုးရိမ်စရာပေါ့။ ညီမတို့က TA ပေးနေတဲ့အချိန်မှာ တော့ရတယ်။ TA မပေးတော့ဘူးဆိုရင် သူတို့ ဒီလိုမျိုး သွားပါတော့မလားပေါ့။ တကယ်လို့ အရေးပေါ်ကျန်းမာရေး ရုံပုံငွေသာမရှိတော့ဘူးဆိုရင် ခရီးစရိတ် သာမရှိတော့ရင် ဘယ်သူမှသွားမှာမဟုတ်ဘူး။ ကိုယ့်ရွာမှာပဲ ခရီးစရိတ် မတတ်နိုင်လို့ ဆေးရုံ ဆေးခန်းကိုမရောက်လို့ သေတဲ့အဖြစ်မျိုး ပြန်ဖြစ်လိမ့် မယ်ပေါ့။ အဲတာကြောင့်ဒီဟာကို၅၀ရာခိုင်နှုန်း ထည့်ပေးကြပါဆိုပြီး တဖက်က ပြန်ဆွယ်ရတယ်။ အဲလိုမျိုးသာ သူတို့မထည့်တာမထည့်တာ၊ တကယ်လို့ ညီမတို့ ထွက်သွားတယ်ဆိုရင် လျော့သွားရင် တစ်သိန်းအထိပြန်ထားမယ်။ အခုက သူတို့ သိနေပြီး၊ ဒီကောင်းကျိုးတွေ သူတို့ သိနေတဲ့ အတွက်ကြောင့် လျော့သလောက် ကိုတော့ ပြန်ဖြည့်ပေးမယ်။ စိတ်ချ၊ အဲတာကတော့ ကျွန်တော်တို့ရဲ့ ရွာကောင်းကျိုး အတွက်ပဲ ပြန်ဖြည့်ပေးမယ်။ အကုန်လုံးနီးပါး အဲလိုမျိုးပြောကြတယ်။ ၅၀ရာခိုင်နှုန်းသာ မထည့်ချင် မထည့်မယ်။ အကုန်လုံးက လျော့သလောက်ကိုတော့ ပြန်ထည့်ပေးမယ်။ လုံးဝ မရှိတော့တာထက်စာလို့ရှိရင်တော့ လျော့သလောက် ပြန်ဖြည့်ပေးမယ် ဆိုဝမ်းသာတာပေါ့။
(KII w 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.

ဒီလိုမျိုး NGO တွေကမထွက်ခင်မှာ hard to reach area တွေ migrant တွေအတွက် စဉ်းစားပြီး ထူထောင်ပေးခဲ့မယ်ဆိုရင် ပိုပြီးတော့ ကောင်းမယ်ထင်တယ်။ migrant အတွက်ပေါ့။ ရွာအတွက်က အဲတာလည်း စဉ်းစားရမယ်။ ရွာအတွက်က member ဝင်တွေမဟုတ်ပဲနဲ့ သူတို့ကို ထိန်းချုပ်နိုင်အောင် တစ်ခုခုတော့လုပ်ရမယ်။ ဆုံးဖြတ်ချက်တစ်ခုခုချပေးရမှာပေါ့။ ဥပမာ- save the children မထွက်ခင်မှာ ဒီ revolving fund တွေက ကျွန်တော်တို့ပေးထားတာ။ အကုန်လုံး ခံစားခွင့်ရှိတယ်ဆိုတာမျိုး။ တစ်ခုခု လုပ်ပေးစေချင်တယ်။ အဲတာမှ ကျွန်မတို့ထိန်းချုပ်ရတာပိုလွယ်မယ်။ member ဝင်မှ emergency ဖြစ်မှာ မဟုတ်ဘူး။ တခြားလူတွေလည်း emergency ဖြစ်နိုင်တယ်။ အဲလိုမျိုး---

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 manage 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 ကျတော့ INGO တခုထဲနဲ့ လုပ်လို့မရဖူး government policy ချထားပေးမှ လုပ်လို့ရမှာ အဲဒီ policy မထွက်မချင်းက အဲဒီ insurance screen နဲ့ အကျွမ်းတဝင်ရှိအောင် အနီးစပ်ဆုံး community-based financing သူတို့ကလည်း အခုပုံစံက သူတို့ contribution ရှိရမယ်။ ဒီ fund က ရပ်ရွာက manage လုပ်ရဲ့လား၊ နောက်အားလုံးနဲ့ သက်ဆိုင်တဲ့ ဒီ mechanism နဲ့ အကျွမ်းတဝင်ရှိရမယ် insurance scheme ထွက်လာ တယ်ဆိုရင် ဒီဧရိယာကလူတွေက ဒီဟာကို အကျွမ်းတဝင်ရှိတယ်၊ တကယ် အကျိုးကိုလည်း ၂-၃-၄ နှစ် အတွင်းမှာ သူတို့ သိနေပြီလေ၊ ဒီဟာက သူတို့အတွက် အကျိုးရှိတယ်၊ ရွာထဲမှာ ဘယ်လိုဘဲဖြစ်ဖြစ် ဒီ Fund ရှိတဲ့အတွက် အဆင်သင့်ဖြစ်တယ်။ advantages တွေလည်း သူတို့သိနေပြီဆိုတော့ policy ချိန်ပြီးတော့ insurance scheme ထွက်လာမယ်ဆိုရင် သူတို့တွေက mobilize သိပ်မလုပ်ရဖူးပေါ့။ ဒီဟာရဲ့ အကျိုးကျေးဇူးကိုသိနေတဲ့အတွက် လွယ်လွယ်ကူကူ insurance ဝင်မှာဘဲ အဲဒါဆို mobilize သိပ်မလုပ်ရဖူး၊ technical ဘက်ကလည်း နည်းနည်း နားလည်မှရှိတယ်ဆိုရင် လုပ်ရတာအောင်မြင်တယ်၊ မြန်တယ်။



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—cashier 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 JI-MNCH 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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Annexes

Annex 1: Criteria and supports for emergency referral

Referral to Upper level

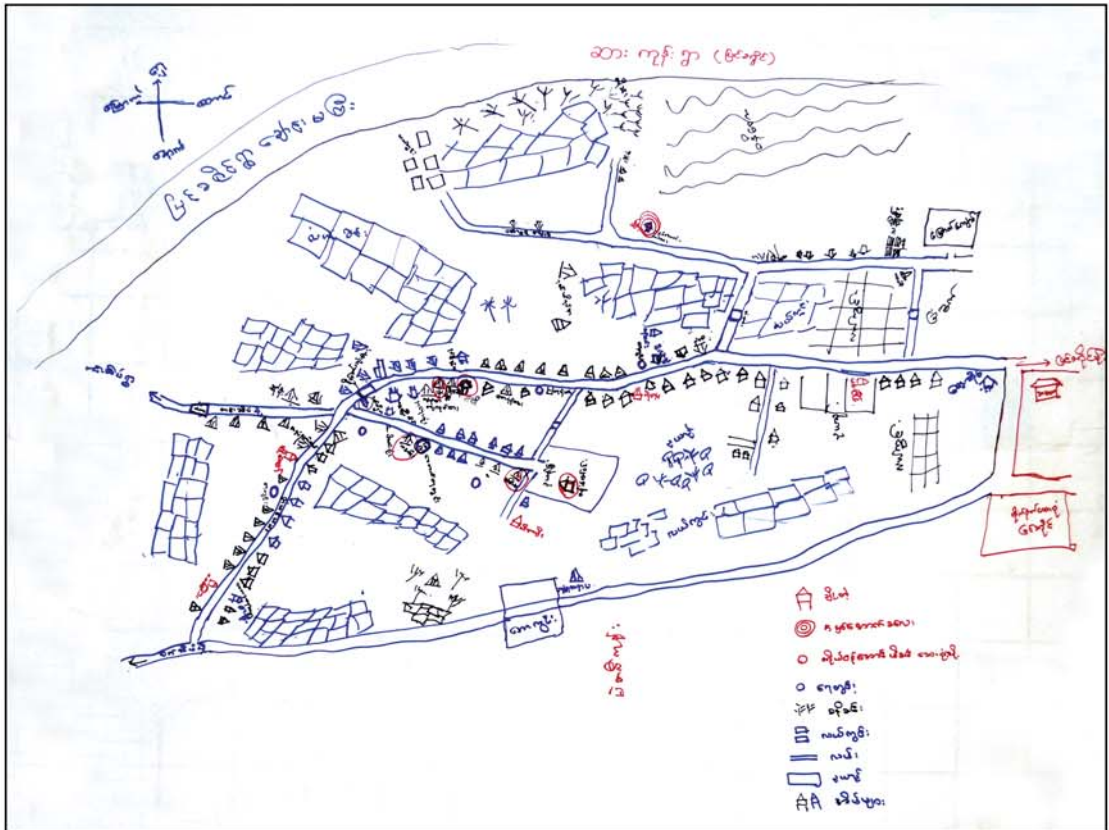
Village	Sub-centre	RHC	Station Hospital	Emergency referral confirmed by;	Cases	Medical charges (Maximum)	Remark	Meal Cost (Maximum * 7 days)	Save the Children Reimbursement Frequency
AMW or CHW	To MW & MW directly to SMO or To HA & HA directly to SMO		Magyipin Pyinkayaing	SMO	ECC	40000		28000	For Magyipin Station Hospital, weekly
					EMOC	90000	LSCS	28000	For Pyinkayaing Station Hospital, weekly
						50000	NVD		

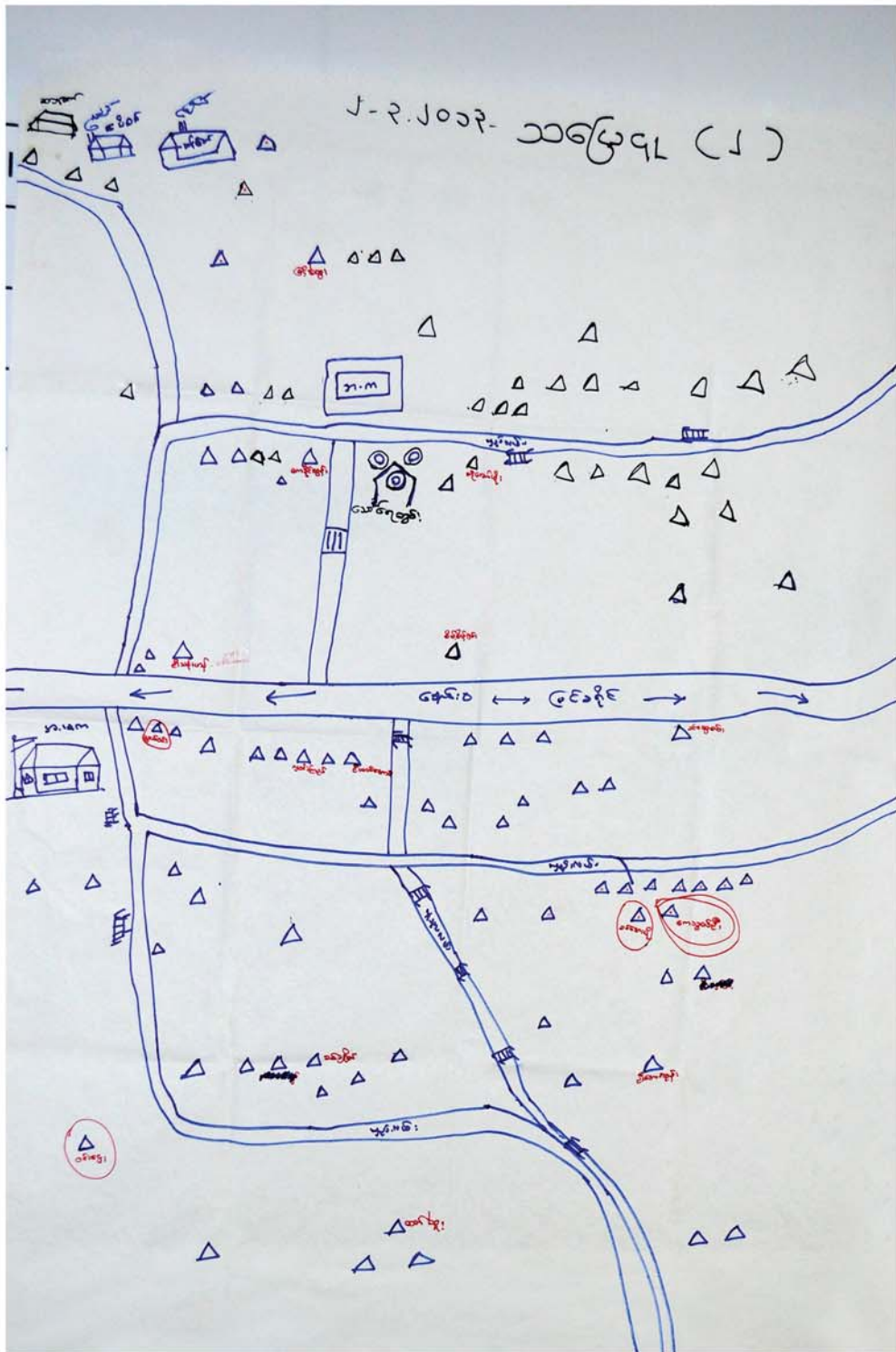


Annex 2: Referral Letter and Referral register

[illegible][illegible]

Annex 3: Social maps





Annex 4: Fund Matrix

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

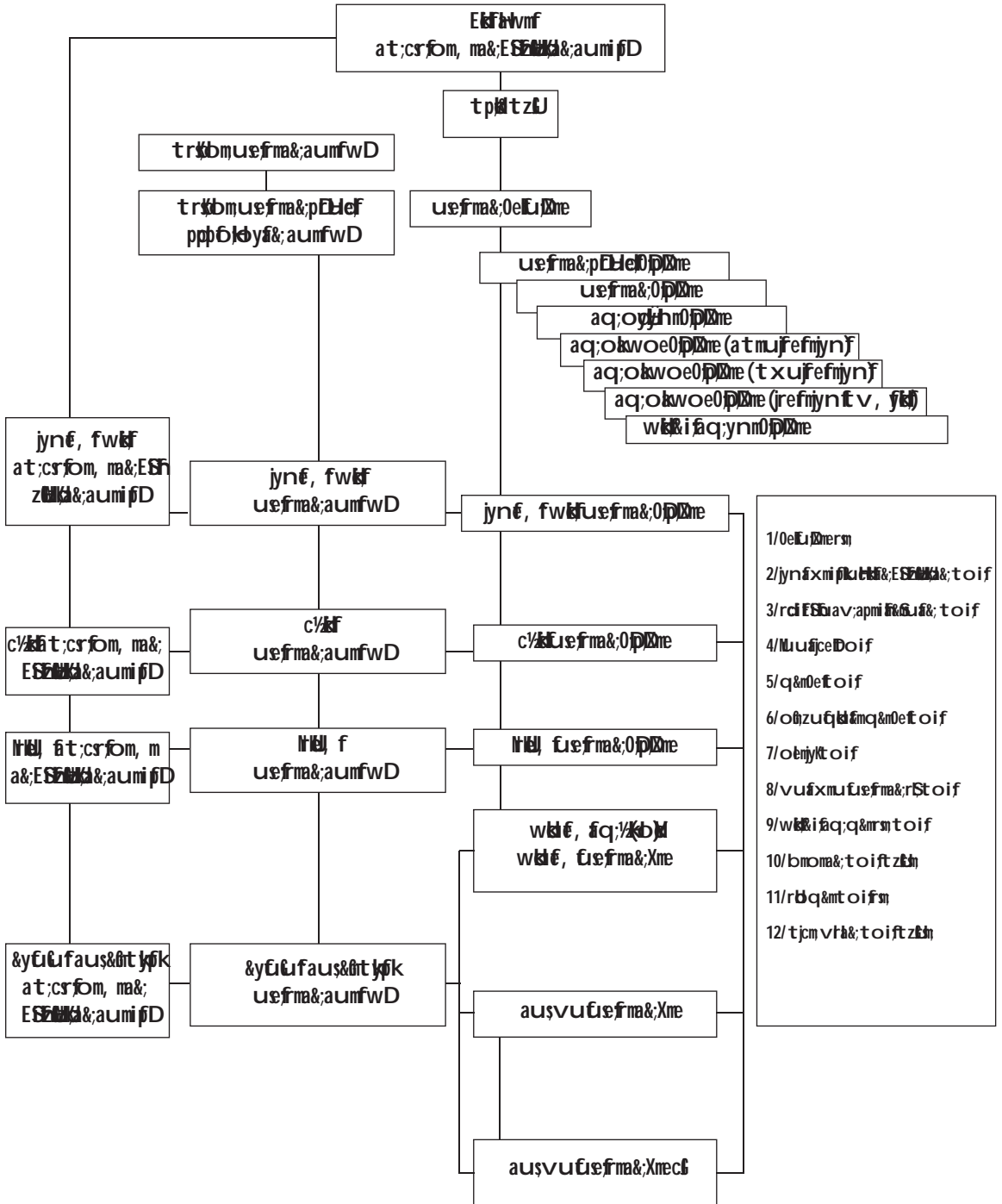
	US Appeal 2 Emergency Health Programme in Cyclone Nargis-Affected Communities in Yangon and Ayeyarwaddy Regions	USAID (BHAP) Burma Humanitarian Assistance Program (BHAP)	JI-MNCH Joint Initiative on Maternal, Newborn and Child Health
Key Project Details <ul style="list-style-type: none"> Timeframe (Month, Year-Month, Year) Objective of the Fund (e.g. to cover emergency health care, improve income etc.) 	<p>1 August 2008 to 31 Dec 2010</p> <p>Project Goal 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 Kyautan) and Ayeyarwady (Ngapudaw and Mawlamyinegyun) in Myanmar</p> <p>Project Strategic Objectives To help achieve the above goal, the project will have two Strategic Objectives (SOs):</p> <p>(1) Increased use of quality health services; and (2) Increased adaptation of healthier behaviors.</p> <p>These strategic objectives will result to 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</p> <p>and incorporates the key contents of the draft SC Emergency Health Programme Strategy paper for the cyclone Nargis response.</p> <p>Nil</p> <p>78 villages Children under five years and women of reproductive age (15 to 49 years old)</p>	<p>7 May 2010 to 6 August 2011</p> <p>Project Goal 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.</p> <p>Project Strategic Objectives The goal is dependent upon the attainment of four strategic objectives (SOs):</p> <p>(1) increased coverage of transformational and sustainable livelihood services (SO1) (2) increased practice of transformational and sustainable livelihood behaviors (SO2) (3) increased use of quality health/nutrition and WASH services (SO3) and (4) increased practice of health/nutrition and WASH behaviors (SO4)</p> <p>Myanmar Nurses and Mid Wife Association (MNMA) DAWN Microfinance (DMF), Thigaha 54 villages Maternal, Newborn and Children under five years</p>	<p>15 Nov 2010 to 31 Dec 2013</p> <p>Objective 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.</p> <p>Township Health Department</p> <p>118 villages Maternal, Newborn and Children under five years</p>
Revolving Fund (RF) <ul style="list-style-type: none"> Does RF component exist? Amount of original capital given to VHC Criteria for getting the funds from VHC? Who decided the criteria? Is there interest? What is the rate? Who decided the rate? How much time is given for reimbursement? What is the reimbursement mechanism (installments or lump sum)? Were other contributions to this fund made by community, other organizations or donors? If a process of "freezing"? 	<p>Yes</p> <p>140,000 MMK</p> <p>Mother of children < five yrs</p> <p>Community decided, SC facilitated</p> <p>Yes</p> <p>3% to 5%</p> <p>Community decided, SC facilitated</p> <p>4 months</p> <p>25% installment + interest (3% - 5% on total loan amount) per month</p> <p>Allowed community contribution, no fix amount</p> <p>No "freezing"</p>	<p>Yes</p> <p>100,000 MMK</p> <p>Member</p> <p>DAWN Microfinance</p> <p>Yes</p> <p>2.5%</p> <p>DAWN Microfinance</p> <p>2 months</p> <p>Lump sum after 2 months + 2.5 % interest</p> <p>200 MMK per 2 weeks per member</p> <p>No "freezing"</p>	<p>Yes</p> <p>100,000 MMK</p> <p>Mother of children < five yrs</p> <p>Community decided, SC facilitated</p> <p>Yes</p> <p>3% to 5%</p> <p>Community decided, SC facilitated</p> <p>2 months</p> <p>Lump sum after 2 months</p> <p>Allowed community contribution, no fix amount</p> <p>No "freezing"</p>

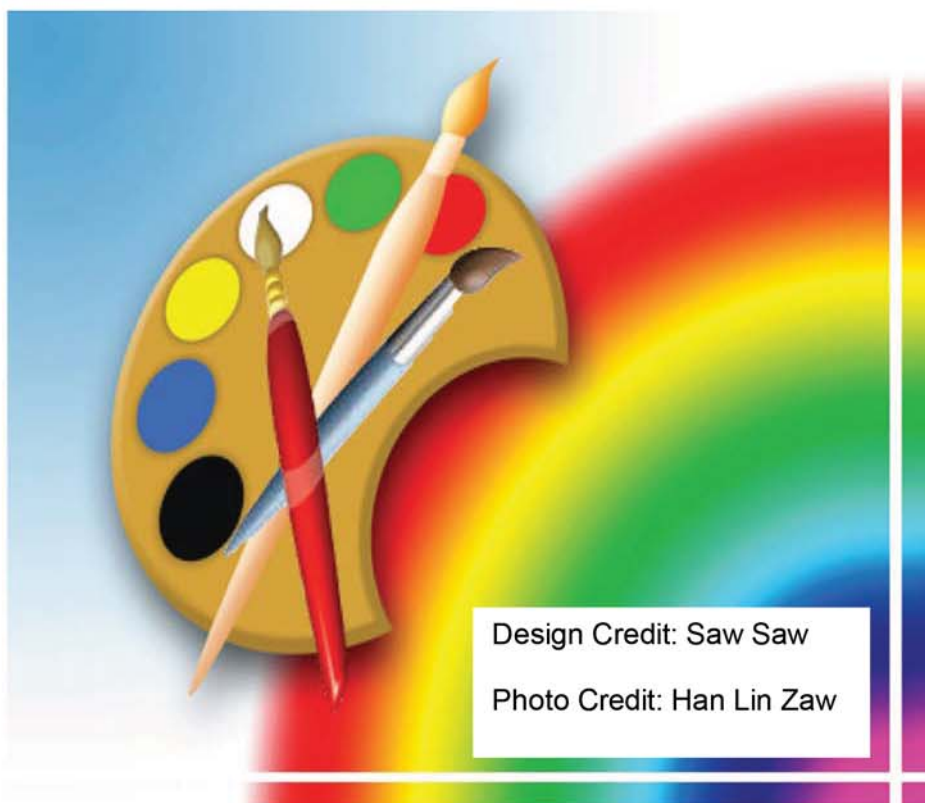


	US Appeal 2 Emergency Health Programme in Cyclone Nargis-Affected Communities in Yangon and Ayeyarwaddy Regions	USAID (BHAP) Burma Humanitarian Assistance Program (BHAP)	JI-MNCH Joint Initiative on Maternal, Newborn and Child Health
Emergency Referral Fund (ERF) <ul style="list-style-type: none"> Does ERF component exist? Focus of ERF (e.g. EmOC or ECC or any emergency cases); is it intended to be used for transport, medical charges or other? Amount of original capital allocated to ERF? Who decided the amount? Who keeps the funds? Criteria for getting the funds from ERF? Who decided the criteria? How is the amount to be taken from ERF decided? Who decides? Is there maximum amount? Is reimbursement required? In all cases or in specific cases? Is there interest? What is the rate? Who decided the rate? How much time is given for reimbursement? What is the reimbursement mechanism (installments or lump sum)? Were other contributions to this fund made by community, other organizations or donors? If a process of "freezing" was used, please mention in detail 	<p>Yes Emergency relating with maternal, newborn and child health, only for transportation charges</p> <p>40,000 MMK, SC decided the amount, Village Health Team keep the funds</p> <p>Trained volunteers or AMW or CHW or BHS identified as emergency, follow the ministry of health criteria Actual transportation charges maximum up to 20,000 MMK, community decided</p> <p>Yes</p> <p>No interest for first 2 months, starting on 3rd month 2% interest rate, Community decided, SC facilitated 2 months no interest, 2 months with interest, total 4 months</p> <p>Lump sum</p> <p>30% of total amount get from interest will contribute to emergency referral fund "freezing" in 2011 3rd quarter for balancing the emergency referral fund up to 100,000 MMK from PONREPP fund and restarted immediate after balancing. After that no need to reimburse by community, SC will reimburse according to referral cases</p>	<p>Yes Emergency relating with maternal, newborn and child health, only for transportation charges</p> <p>40,000 MMK, community decided, SC facilitated, Village Health Team keep the funds Trained volunteers or AMW or CHW or BHS identified as emergency, follow the ministry of health criteria</p> <p>Actual transportation charges maximum up to 20,000 MMK, community decided</p> <p>Yes</p> <p>No interest for first 2 months, starting on 3rd month 2% interest rate, Community decided, SC facilitated 2 months no interest, 2 months with interest, total 4 months</p> <p>Lump sum</p> <p>30% of total amount get from interest will contribute to emergency referral fund "freezing" in 2011 3rd quarter for balancing the emergency referral fund up to 100,000 MMK from PONREPP fund and restarted immediate after balancing. After that no need to reimburse by community, SC will reimburse according to referral cases</p>	<p>Yes Emergency Obstetric Care and Emergency Child Care, transportation charges only 40,000 MMK Emergency Obstetric Cases and Emergency Child Cases, Community decided, SC facilitated</p> <p>Actual transportation charges, community decided</p> <p>No need to reimburse, SC will reimburse according to emergency referral cases</p> <p>No interest</p> <p>No need to reimburse</p> <p>Nil</p>
Development Fund (DF) <ul style="list-style-type: none"> Does DF component exist? Focus of DF (what is it to be used for)? Amount of original capital allocated to DF? Who decided the amount? Who keeps the funds? Criteria for getting the funds from DF? Who decided the criteria? How is the amount to be taken from DF? Who decided? Is there a maximum amount? Is reimbursement required? 	<p>-Yes -Renovate the village foot path, bridges, etc. -Originally 0 MMK, 20% of the total amount of interest from revolving fund will pool in development fund</p> <p>-Decision come from Village Health Team meeting, it must be related with development of village -Depend on the amount needed in renovation -No need to reimburse</p>	<p>-Yes -Renovate the village foot path, bridges, etc. -Originally 0 MMK, 20% of the total amount of interest from revolving fund will pool in development fund</p> <p>-Decision come from Village Health Team meeting, it must be related with development of village -Depend on the amount needed in renovation -No need to reimburse</p>	-No



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