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198/05

UNICEF MYANMAR MID-TERM REVIEW
Studies and Evaluations

In-depth review of Community Health Management and Financing Project

UNICEF/DOH

JUNE 1998

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In-Depth Analysis of the

Community Health Management and Financing Project

(Draft)

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In-Depth Analysis of the Community Health Management and Financing Project

Back ground information

Community Cost Sharing Project was developed in 1994. Nippon Foundation from Japan made bilateral agreement with the government of Myanmar and provided essential drugs for the project. UNICEF was requested to monitor and assist the project implementation in cooperation with the Department of Health, Ministry of Health. The project cycle was 4 years and has ended in 1997. The project is now implementing in 72 townships. 42 Townships are in the first phase, 25 in are in the second phase and 6 in the third phase. At the same time, there are different community cost sharing schemes implemented by different agencies. Myanmar Essential Drug Project (MED) of WHO in 54 townships and Human Development Initiative Project (HDI-E) of UNDP (HDIEP) in 11 townships. Other two CCS schemes are the Staff Welfare System (SWS) and the Central Medical Store Depot (CMSD) system. It is the time for Myanmar to conduct the in-depth interview of the CHMF project and compare with other CCS schemes implemented by different agencies and departments and to recommend for a future CCS model for the country.

Objectives of the in-depth analysis

1. Review over all project activities.
2. Compare the CHMF project performance with other existing projects implementing community cost sharing schemes.
3. Provide comments and recommendations for future CCS model for Myanmar.

Methodology

A cross sectional survey was conducted to assess the performance of cost sharing activities by the health staff using quantitative and qualitative methods. Authorized persons from the central, state and divisional, township, station hospital, rural health centre, sub rural health centre and community members were interviewed. Study questionnaires were developed and in-depth personal interview was conducted. Review of existing documents and records were also done.

Sampling methodology and sample size

Sampling was done to reveal the differences in performance according to

1. Geographic distribution (Hilly, plain and delta regions).
2. First and second phase CHMF townships.
3. MEDP and non project townships.

From the above criteria, random sampling of one State and two Divisions were selected. At each level, 4 townships were randomly selected from the sampling frame of 72 CHMF project townships, 54 MEDP project and non-project townships. Total of 12 townships were included in the study.

At each level the following four townships were selected and health staff at different levels were interviewed.

1.	CHMF project first phase	= 1 township
2.	CHMF project second phase	= 1 township
3.	MEDP project township	= 1 township
4.	Non-project township	= 1 township
	Total	= 4 townships

Townships selected for in-depth review

No	State and Divisional lev	Townships	Projects
1.	Magwe Division	Pwintphyu	CHMF (Phase one)
		Sinbaungwe	CHMF (Phase two)
		Salin	MEDP
		Satoketayar	Non project
2.	Ayeyarwady Divison	Yekyi	CHMF (Phase one)
		Hinzada	CHMF (Phase two)
		Kyaungkone	MEDP
		Pathein	Non project
3.	Shan State	Naungcho	CHMF (Phase one)
		Theinni	CHMF (Phase two)
		Pinlaung	MEDP
		Kyaukme	Non project

Health staff invoved in the study

Township Medical Officer (TMO)	=	12
Assistant Surgeon (AS) and Station Medical Officer (SMO)	=	8
Blue Staff (BS)	=	1
Health Assistant (HA)	=	8
Lady Health Visitor (LHV)	=	2
Midwive (MW)	=	25
Total		56

CHMF project MTR in-depth study committee members

1.	Prof. Hla Myint Advisor, MEDP Project, MOH	Advisor
2.	Dr. Hla Pe Director, Public Health, DOH	Advisor
3.	Dr. Christiane Dricot d' Ans Chief, health and Nutirtino Section, UNICEF	Advisor
4.	Dr. Htay Lwin Project Manager, CHMF project, DOH	Chairman
5.	Dr. Myint Thaung Deputy Director, CMSD, DOH	Member
6.	Dr. Maung Maung Myint Assistant Director, BHS, DOH	Member
7.	Dr. Tin Min Assistant Director, Medical Care, DOH	Member
8.	Dr. Min Swe Project Manager, MEDP, DOH	Member
9.	Dr. Nilar Tin Assistant Project Manager, BHS, DOH	Member
10.	Maung Maung Thoe programme Assistant, CHMF project	Member
11.	Dr. Kyaw Win Project Officer, UNICEF Yangon	Member
12.	Dr. Nyunt Win Myint, Project Officer, CHMF project	Member

Findings of the in-depth interview of the Community Health Management and Financing Project

The findings of the study is presented in a question and answer type of format for easy reference.

How is the project managed at different levels ?

At the central level

Deputy Director of the Public Health Division of the Department of Health (DOH) is the Project manager of the CHMF project. He is supported by a project officer and a project assistant funded by UNICEF and Nippon Foundation. The project do not have separate office in the DOH. It is a drawback because the project officials can not placed things belonging to the project. Charts and boards to monitor the project activities and revolving drug funds can not be mounted.

Office equipments, copier machines and computers are used by staff of DOH. The maintainence cost became very high and life spend of the equipments became low. The foure wheeel drive vehicle supplied for the project from the donors for field monitoring was not available. It was utilize by the DOH for other purposes. It limits project staff to make frequent travels to visit out reach areas to monitor the project activities.

Project Manager was changed three times during the four years project cycle. Project Manager due to his other duties, can not give time to followup on the day to day project activities. The project was implmented mainly by the Project Officer and Project Assistant supported by the Nippon Foundation. It is important for the DOH to consider assigning one specific Project Manager to supervise and implement the project because when external support is stoped, the local person could pick up the project with out any problem.

MED and HDI-E projects have offices with project staff to assist the project managers. The project which has its own project office are better mange than those which do not have such facility.

At State/Divisional and District Levels

CHMF project do not have focal person in State/Divisional and district levels. It directly implements at township level. It uses State/Divisional level for annual evaluation only. Therefore, the officials from State/Divisional levels do not take responsibility and are also not aware of the project activities. Supervision from State/Divisional and District levels became weak. The project structural plan should be inlined with the administrative structure of the DOH for better monitoring and implementation. Officials at different levels should take the responsibility, ownership and support the project at all times. The same structural arrangement is seen at MED and HDI-E projects. At the end, the central team can not monitor all project townships.

At the township level

TMOs are responsible for the implementation of the project activities. CHMF townships are scatted all around the countries and was quite difficult to monitor by the central team. It is too far away for some of the townships to reach the central level and have problems in obtaining liquidations in time. The same problem is seen in MEDP townships. HDI-E projects have assigned field level project staff who lives in the project townships and had better monitoring on project activities.

How many different types of Community Cost Sharing (CCS) schemes are operating at the township level ?

All townships have Staff Welfare (SW) and CMSD CCS schemes. The Staff Welfare scheme is organized independently by the health staff at the township hospital and supervised by the TMO. Most of the funds are collected from the staff and profit is shared at the end of each month. For the CMSD CCS scheme, it is organized by the DOH and the profit is devided into four parts. One forth has to be sent back to the DOH accopunt, one forth is kept for the development of staff, one forth for renovation of health facility and one forth for replenishing drugs, equipments etc. In project townships, the project CCS as well as both the SW and the CMSD CCS schemes exist. SW - CCS scheme replenished drugs from the local market based on the daily demand and is the most popular and sustainable RDF mechanism at the township level.

Is there any CCS sign boards ercted at township hospitals and health centres ?

All townships have Community Cost Sharing (CCS) signboard placed infront of the entrances. This is a directive made by the MOH. The sign board is written in Myanamr language and it reads : " *This hospital practice CCS for those who can afford and for those who can not afford, will be free of charge".* Sub-centre of Naungcho and RHC of Pwintphyu township under CHMF phase one township also hvae the same sign board.
It increases community awareness on CCS. It also gives the message that those who can not afford can have examption. It should be posted at all health facilities.

Do health staff open their health fcilities at thier houses. ?

19% at the RHC and 51% at the SRHC levels, health facilitiesstaff houses and health facilities are the same. Health staff living in this situation can provide 24 hour health services. It is also more convenient for them.

How many villages does one MW has to cover ?

Villages covered by the MW	Percentage
2-10 villages	50%
11-20 villages	35%
21-30 villages	15%

50% of MWs have to cover 11-30 villages. Depending on the area, the workload for the MW is quite heavy. One MW should not have more that 10 villages. More MWs are needed in the service.

How many villages can be reached within one hour walking ?

59% of people live in villages which are within one hour walking distance from the RHCs and SRHCs. It indicates that half of the community can easily reach the health facilities and visiversal for the health staff to reach them. Special strategy is needed to provide health services for those who are not reachable.

What is the main reason for a health staff to visit villages ?

Main reason	%
UCI/Delivery/AN care	68%
Nutrition/CCS/CDD/ARI	32%

The main reason for a health staff to visit villages is for UCI, AN care and delivery. Other projects should integrate its activities. UCI is the only foundation for other projects to reach the communities regularly.

How is the drugs distributed to the health facilities ?

Drugs are store at CMSD and distributed to the townships according to the breakdown provided by the CHMF project. Drugs are pre-pack at CMSD and sent to the project townships. The distribution charges are given from the CHMF project. During the pay day at the end of every month, staff from SH, RHC and SRHCs will collect their supply. It is a pull system. There is no demand indent system practice. Depending on the amount of drugs received, the TMO provide drugs to RHC and SRHC by quota system.
Transportation charges are born by health workders. It varies from 200 to 500 Kyats depending on the distance and mode of travel.

Does a health worker check the amount of drugs supplied ?

81% of the health workers check the drugs. Out of those who have checked the drugs, 87% checked all drugs, 3% randomly and 10% count only the packings. 38% of the health workers found regular shortage of drugs at township level. When tested, the packaging used for essential drugs very easy to open it without damaging the original packing. Future packaging should be made with plastic coated covers.

What have you done when you found out that there is a shortage in the drug supply?

Action	%
Report back to authority concerned	14%
Replenish from their own pocket money	50%
Put into the patient register as exemption cases	36%

Drugs which are most commonly in shortage are items like Amoxicillin , Cotrimoxazole, Paracetamol and Pencillin V. There is no clear guidlines on how to report back in the case of shortage of drugs found at the township level. There is no register and standard form to record shortage.

All health workers should check the drugs before receiving and if there is any shortage, they should report immediately to the authorities concerned at the township level. The authority should take immediate action and report it back to the CMSD. Astandard format should be utilized. It is not good to put the amount of shortage drugs into the patient register. This will increase the disease morbidity without having any cases.

What are the storage facilities and conditions ?

All township hospitals and Station hospitals visited have separate stores except one station hospital at Pathein township in Ayeyarwaddy Division. All RHCs have store rooms except one RHC from Pathein township. All SRHCs do not have stores to keep drugs. Drugs are kept in a safe cupboard at SRHCs.

The store rooms at the TH, SH and RHC have an average of two windows for ventilation. The stores at township and station hospital levels, 36% are opened and 64% are never opened due to the security reason. The average opening time of windows at RHC level is as follows.

Clinic hours	%
Opened daily	25%
3 times/week	13%
Opened once a week	62%

42% at township and 27% of store rooms at RHC/SRSC levels do not have cabinets to store the drugs. Average number of cabinets in the township is two and for RHC/SRHs levels are one. 25% at township and 68% of store rooms at RHC/SRHC levels do not have racks to keep the drug properly. Average number of racks present in the store rooms is 3 for township and 1 for RHC/SRHC levels.

Storage of drugs with bin cards according to items, expiry date and security conditions of drugs are as follows:-

Level of health facility	items, Expiry date and Bin cards		Security
	Good	Not good	
Township	82%	18%	100%
RHC/SC	4%	96%	68%

Store room conditions are worst in the non project townships. Standard Store Managment training should be conducted and condition of the drug stores should be upgraded.

What will health workers do when drugs supplied by the project have been utilized?

70% of health workers buy drugs from the private drug shops. To replenish the drugs, most of the health workers used their own money.

Self	Donation	Other
70%	5%	25%

20% of health workers procured drugs once a week, 68% once a month and 12% very frequently (every 1 or 2 days). Decision on which drugs and when to procure is made by the health workers alone is 92%, by the health supervisory committee is 4% and by the group of health workers is 4%.

The drugs are available in the local markets and replenishing them is not a major problem. But for the health facilities, due to strict rules and regulations, drugs procured from the local market can not be officially recorded in the registers. In the case of health worker's own private clinic, it is quite convenient. Many items of drugs from the open market are low quality un-registered drugs. A new user friendly drug procurement and supply system shold be field tested.

What are the stationeries needed for health workers to do their daily work ?

At the begining of the project, stationaries are provided to helath workers for their daily use. There is no regular supply of stationaries and helath workers have to buy from the open market. The folowing table shows the different types of stationaries needed at different health facilities for a year supply.

Items	Unit	Township/Station		RHC/SC	
		Number	Estimated amount (Ks.)	Number	Estimated amount (Ks.)
Foolscap paper	Reams	10	3000	2	600
File cover	Each	24	240	6	60
Exercise book (120 pgs)	Each	24	2400	6	600
Exercise book (80 pgs)	Each	24	2000	6	500
Pencil	Each	12	360	6	180
Ball pen	Each	24	1200	12	600
Carbon paper, punch, stapler, cello tape,	Set	1	1000	1	1000
Total			10,200		3,540

To procure the stationaries, health workers uses money from thei r own pocket. The % of cash utilization from different sources is as follows :

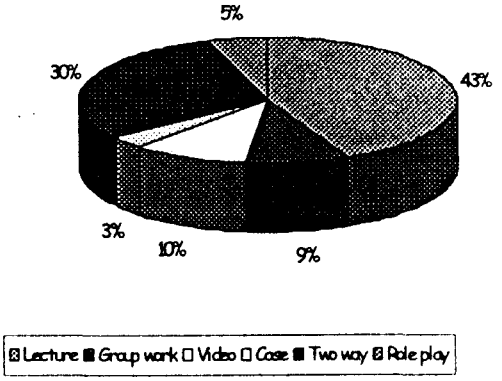
Self	81%
10% profit from the CCS scheme	11%
Donation	8%

Consideration should be made to have a system to provide regular supply of stationaries. For township levels, there are more funds to compansate but for RHC and SRHC levels, health workers have to rely mostly on their own. It is extra burden for the health staff to spend their own money to buy stationaries which are mainly used for recording informatins and data for different projects.

How are training conducted ?

Different projects give different types of training to health staffs but there is lack of coordination between each project. The methodology of teaching is not up to a standard. Mostly training are conducted in lecture style. They are not participatory in nature. Types of training provided are as follows :

Type	%
Lecture	43%
Group work	9%
Video	10%
Case presentation	3%
Two way discussion	30%
Role play	5%



New participatory and problem oriented skill based learning methodologies should be introduced to up-grade the skill and knowledge of health workers.

Is the perdiem provided for the training ?

96% of health workers received perdieums when they attended training courses. Different donor agencies use different perdiem rates trainees. WHO provides 250 Kyats per day for all levels and UNICEF provides 300 Kyats for township and 500 Kyats for State/Divisional levels. Usually, each training has other expenses like buying stationaries, hiring of vocal system, video deck and TV, refreshments and preparing heading for the opening ceremony and so on. Many of the expenses can not be shown in the usual training expenditures due to strict rules and regulations of the donor agencies especially for UNICEF. In such cases, the training organizers have to deduct some cash from the perdiem to compansate the expenses. The total amount of perdiem is reduced. The average amount of perdiem received by the helath staffs for a training of five days varies. For the last training attended by the helath workers 32% received 200 to300 Kyats, 52% received 300 to 1000 Kyats and 12% received 1000 to 1500 Kyats. Only 12% received full perdiem for attending five days training course.

Health workers have to spend travelling and lodging expenses when ever they have to attend training courses at township or higher levels. These extra expenses have to be borned by the health workers from their own pocket. Average expenditure for one health worker to spend for a training is as follows :

50-500 Kyats	= 46%
500-1000 Kyats	= 25%
1000-2000 Kyats	= 18%
2000-5500 Kyats	= 11%

Although the health workers wanted to attend new training conducted by different projects, it is quite impossible for them to spend extra money from their pocket every time they attend the courses. This became the main reason for the health workers not willing to come fot training. They should be provided with sufficient amount of perdiem to cover lodging, food and travelling expenses.

Do health workers keep training material at the health centres for quick reference ?

Only 49% of health workers keep their training material in hand for quick reference. This is noted more in the project townships. It also depends on the TMO whether he or she organizes regular continuing medical education for the helath workers. The training materials provided are very simple in design and are not attractive enough for the health worker to keep it near her or him. Each project provides its own training material and became too much for the health workers. It is time to integrate training programmes and to develope user friendly training material to help health workers at the grassroot level. Many of the training materials are kept aside in a corner and had never use it after the training.

<u>What is the knowlede of health workers on ARI case management ?</u>

There are three important factors to be remembered to diagnose the severity of the pneumonia in the case of ARI in children under the age of five. The health worker needs campare the respiration rate according to the age of the child. It is also very important to find danger signs for early referral. The knowledge of health workers on ARI, is shown in the following table. Only 30% knows the age difference. 78% can not remember the different respiration rates to diagnose pneumonia. 70% of them cna identify at least three danger signs for early referal. It is important to learn that the level of knowledge is split in nature and because the health staff can not campare age and respiration rate, he or she could miss to diagnose early pheumonia.

Age in ARI case		Respiratory Rate in ARI case		Referral stage in ARI case	
Correct	Wrong	Correct	Wrong	Correct	Wrong
30%	70%	22%	78%	70%	30%

Refresher training courses are needed for the health workers to refresh their memories.

What is the knowledge of health workers on rational use of essential drugs ?

The helth workers were asked to answer the standard treatment guidline for drug use in ARI - Paracetamol, Cotrimaxazole and Salbutamole. The following is the out come of the findings.

Paracetamol		Cotrimoxazole		Sulbutamol	
Correct	Wrong	Correct	Wrong	Correct	Wrong
46%	54%	19%	81%	16%	84%

From the findings of the above two tables, it is obvious that the health staffs are not able to diagnose and do not know the standard treatment guidlines to treat pneumonia in ARI. This is the time to give kill based learning to all health workers in the country in an integrated approach.

How many under five children with ARI cases are seen in a month by the MW ?

ARI new cases (1997) = Average 35 cases per month at the health centre
Follow up ARI cases (1997) = Average 14 cases per month at the health centre
ARI new cases (1997) = Average 31 cases at health workers own private clinic

There is an equal number of under five children with ARI going to the public and private clinic run by the same health worker. Follow up cases are on;y one third of the new cases. More health education is needed for mothers to look after their children who are not well.

How is supervision & monitoring taking place in the existing health system ?

73% of the health workers go for supervision and monitoring to villages in CHMF and MEDP townships. Only 7% use checklist. 97% of the health workers are supervised by the higher level. Only 14% of the supervisors used checklist.

Poper satandardised checklist, visitors book and follow-up on the monitoring visits and findings should be recorded and developed.

How is the CCS Supervisory Committees formed at different levels ?

Usually there are average of 7 committee members in each supervisory committee.

The average number of meeting organized during 1997 is 3 times. Members of Supervisory Committee consists of :

Chairman - Chairman of Peace and Development Council (P&DC)
Secretary - Health workers
Members - Member of P&DC
- One representative from Peoples' Police
- Township or village elder
- School teacher (Headmaster/Headmistress)
- Ex-government employee

How is the revolving drug fund managed at different levels ?

Monthly, 68% of the health workers sent the revolving drugs funds (RDF) to the TMO at township level. Only 3% of the health workers keep the 10% profit locally. 11% of the health workers put their own mark-ups on CCS drugs. There is no fix financial control and management at the grass-root levels. A modifies version of the WHO-UNICEF financial module should be introduced.

How does the exemption mechanism works ?

35% of the BHS said 10-50% of the community could pay for the full course and 38% said 51-80% could pay for the full course. 59% of BHS said 20% of the community could pay half the drug course. 49% of the health workers are practicing partial exemption mechanism of their own. 62% of the BHS said 30% of the community memebrs will not be able to pay any amount for the treatment. The people who are usually exempted are as follows:

Type	%
Poor persons	55%
Religious persons	40%
Prisoners & Other	5%

Decision for exemption is made mostly by the health staff (68%), and some times with advice from other health workers (32%). There is a need to have a proper exemption guidelines developed by the central level.

How does the community participate in the project activities ?

Community participation is mostly in contribution of cash and kind to the health centres.

Donation of
- Land = 19%
- Building = 18%
- Maintenance = 12%
- Furniture = 19%
- Money = 9%
- Manpower = 20%
- Other = 3%

How many advocacy meetings were conducted ?

41% of the health workers have organized advocacy meeting at lest one time per year, and 6% have organized 3 times per year which shows proper and frequent advocacy meeting and health education is needed for the community.

What is the personnel back ground data of the health workers ?

The youngest age of BHS is 26 years, the oldest 59 years and mean age is 43 years. The minimum years in the service is 6 months, maximum 36 years and mean 18 years. 81% of the health workers stated that they have job satisfaction.

Indepth Analysis COMMUNITY MEMBERS	Percentage				
	CHMF I	CHMF II	MEDP	Non	Total
Townships	22.5	31.8	24.8	20.9	100.0
1. When one of the family member ill-					
Self	10.9	13.0	14.3	6.8	45.1
Retail drug shop	7.5	8.2	3.8	9.2	28.7
Go to RHC/SC	1.4	7.8	3.8	2.4	15.4
Go to BHS's own clinic	1.0	4.4	1.0	1.4	7.8
GP's clinic	0.3	0.0	0.0	0.0	0.3
Traditional	0.0	0.3	0.0	0.0	0.3
Hospital	0.0	1.4	0.0	0.3	1.7
Other	0.7	0.0	0.0	0.0	0.7
2. If self-					
Western medicine	19.5	19.9	16.9	14.4	70.8
Traditional medicine	2.1	5.5	3.8	1.3	12.7
Folk medicine	0.0	2.5	1.7	4.2	8.5
Other	1.3	0.4	0.0	0.0	1.7
No response	1.3	3.8	0.0	1.3	6.4
3. If self, know what drugs to be taken					
Yes	10.8	8.2	15.5	6.0	40.5
Somebody's advice	11.2	19.8	7.3	13.8	52.2
No response	1.7	3.9	0.0	1.7	7.3
4. If self, and if the problem is not reliev, where do you go?					
To RHC/SC	14.2	17.0	15.1	10.8	57.1
BHS's own clinic	4.2	6.1	5.7	2.8	18.9
GP's clinic	4.2	4.2	2.4	2.8	13.7
Traditional	0.0	0.5	0.0	0.5	0.9
Quack	0.0	0.0	0.0	0.5	0.5
Hospital	0.9	2.4	0.5	4.2	8.0
Other	0.0	0.0	0.5	0.5	0.9
5. Been treated at RHC/Hospital before					
Yes	15.7	24.6	16.0	14.6	70.9
No	6.0	6.0	11.6	5.6	29.1
6. If yes, when					
One week ago	0.5	2.6	2.6	4.7	10.4
One month ago	5.7	5.7	5.2	2.1	18.7
Six months ago	8.8	5.2	8.3	3.6	25.9
One year ago	1.6	4.1	4.1	2.6	12.4
Over one year ago	5.2	9.3	2.6	6.2	23.3
Cannot remember	0.0	7.8	0.5	1.0	9.3

Indepth Analysis	Percentage				
	CHMF I	CHMF II	MEDP	Non	Total
7.. When was your last visit to the clinic?					
No visit	0.4	0.8	1.2	1.9	4.2
One week ago	0.4	2.7	1.9	4.2	9.2
One month ago	5.4	5.0	6.5	2.7	19.6
Six months ago	7.7	4.2	8.1	3.8	23.8
One year ago	3.5	4.6	3.5	2.7	14.2
Over one year ago	5.0	7.7	2.7	4.6	20.0
Cannot remember	0.8	6.5	0.8	0.8	8.8
8. For what problem					
No visit	0.0	0.0	1.3	2.1	3.4
Don't know	0.4	0.9	3.0	0.0	4.3
Fever/not feeling well/cold/flu	12.8	12.0	14.1	9.0	47.9
Catch cold in bathing/cough & cold/ Sore throat	2.1	3.4	3.4	0.9	9.8
Diarrhoea	1.3	2.6	1.3	1.3	6.4
Malaria	1.7	1.3	0.0	2.1	5.1
Asthma	2.1	1.7	1.7	0.0	5.6
Headache	2.1	1.3	0.9	0.4	4.7
Gastritis	1.3	0.9	0.4	0.4	3.0
Back ache/ache	1.3	2.1	0.0	0.0	3.4
Giddiness	1.7	1.3	0.0	0.4	3.4
Normal delivery	0.9	1.3	0.4	0.4	3.0
9. What was the diagnosis?					
No visit	0.0	0.8	1.2	2.0	4.1
BHS didn't tell	13.0	15.9	15.4	7.3	51.6
Don't know	1.2	1.6	3.3	1.6	7.7
Fever/common cold/flu	0.8	2.8	7.7	2.8	14.2
Pneumonia	1.2	1.6	0.4	0.0	3.3
Diarrhoea	0.0	0.4	0.8	0.0	1.2
Malaria	1.2	2.8	0.4	3.3	7.7
Asthma	0.8	0.4	0.8	0.0	2.0
Hypertension	1.2	0.4	0.0	0.0	1.6
General weakness	0.8	1.2	0.4	0.4	2.8
Dysentry	0.4	0.0	0.4	0.4	1.2
DHF	0.4	0.8	0.0	0.0	1.2
Food poisoning	0.4	0.4	0.4	0.0	1.2

Indepth Analysis	Percentage				
	CHMF I	CHMF II	MEDP	Non	Total
10. What drugs did you get?					
Oral	24.2	30.8	25.1	19.9	100.0
IM	32.6	29.6	19.3	18.5	100.0
IV	25.9	48.1	11.1	14.8	100.0
Drip	10.0	50.0	10.0	30.0	100.0
Don't know	28.6	71.4	0.0	0.0	100.0
Other	12.5	56.3	18.8	12.5	100.0
Eye drop	6.3	0.0	6.3	6.3	18.8
Anti tussic	0.0	56.3	6.3	0.0	62.5
X'ray	6.3	0.0	6.3	6.3	18.8
11. How much you have to pay for the drugs?					
Free	1.9	3.5	3.5	5.0	14.0
1-25 Kyats	5.0	6.6	6.2	5.0	22.9
26 - 50 Kyats	4.7	3.1	5.0	3.5	16.3
51 - 100 Kyats	5.8	5.4	5.4	0.4	17.1
101 - 200 Kyats	2.7	5.0	1.9	3.1	12.8
201 - 1000 Kyats	1.6	5.8	2.7	2.3	12.4
1001 - 5000 Kyats	0.4	1.6	0.0	1.2	3.1
More than 5000 Kyats	0.4	0.8	0.0	0.4	1.6
12. When your child sick last time, can you find BHS easily?					
Didn't go to BHS	6.2	5.8	7.4	5.8	25.2
Yes	10.9	19.0	9.7	7.4	46.9
No	1.2	2.7	0.8	0.8	5.4
No response	4.3	4.3	7.0	7.0	22.5
13. Find BHS within					
Within a minute	17.2	26.0	17.7	15.6	76.6
Within 15 minutes	5.2	4.7	4.2	0.5	14.6
Within 30 minutes	0.5	2.1	1.0	1.0	4.7
Within an hour	0.0	1.0	0.0	0.0	1.0
Within 6 hours	0.5	0.0	0.0	0.5	1.0
More than 6 hours	1.0	1.0	0.0	0.0	2.1
14. Find BHS at the					
Health centre	17.8	22.0	20.9	9.4	70.2
BHS's own clinic	5.8	13.6	2.1	8.4	29.8
15. Is there any PHS in your place?					
No response	0.0	0.4	0.0	0.8	1.2
Yes	7.0	5.0	3.5	3.9	19.4
No	12.4	20.5	10.1	8.9	51.9
Don't know	3.1	5.0	11.2	7.4	26.7
Yes, but not functioning	0.0	0.8	0.0	0.0	0.8

Indepth Analysis	Percentage				
	CHMF I	CHMF II	MEDP	Non	Total
16. Find PHS within					
Didn't go to PHS	15.5	26.7	21.3	17.1	80.6
Within a minute	1.6	2.3	2.3	2.3	8.5
Within 15 minutes	3.9	1.9	0.8	0.8	7.4
Within 30 minutes	0.8	0.4	0.4	0.8	2.3
Within an hour	0.8	0.4	0.0	0.0	1.2
17. Where will you go if you cannot find BHS/PHS					
Didn't go to BHS/PHS	27.6	32.0	0.0	28.7	88.4
Quack	1.1	1.7	0.0	1.1	3.9
Ex army health assistant	2.2	0.0	0.0	0.0	2.2
Outside doctor	2.2	2.2	0.0	0.0	4.4
To other township hospital	0.6	0.0	0.6	0.0	1.1
18. Exemination at the place					
Don't know	11.8	20.6	0.0	8.8	41.2
Use stethoscope	14.7	5.9	2.9	0.0	23.5
Abdomen & back examine	0.0	8.8	0.0	0.0	8.8
Count child's resp. rate	20.6	0.0	0.0	0.0	20.6
No physical examination	0.0	0.0	0.0	5.9	5.9
19. How many courses of drugs (from that place)					
Don't know	0.0	11.1	0.0	0.0	11.1
One week	0.0	30.6	0.0	5.6	36.1
Three days	11.1	11.1	0.0	0.0	22.2
Two days	0.0	2.8	0.0	5.6	8.3
One day	8.3	11.1	0.0	2.8	22.2
20. Any injections?					
IM	8.3	41.7	0.0	13.9	63.9
Drip	0.0	5.6	0.0	0.0	5.6
No injection	11.1	19.4	0.0	0.0	30.6
21. No. of injection					
No injection	11.1	30.6	0.0	0.0	41.7
1	5.6	27.8	0.0	5.6	38.9
2	2.8	5.6	0.0	2.8	11.1
3	0.0	2.8	0.0	2.8	5.6
5	0.0	0.0	0.0	2.8	2.8
22. Cost (at that place)					
1-100 Kyats	18.8	37.5	0.0	6.3	62.5
101 - 500 Kyats	3.1	21.9	0.0	6.3	31.3
1500 Kyats	0.0	0.0	0.0	3.1	3.1
5000 Kyats	0.0	3.1	0.0	0.0	3.1

Indepth Analysis	Percentage				
	CHMF I	CHMF II	MEDP	Non	Total
23. Do you go to BHS for your child's ARI case					
No response	0.0	0.4	0.0	0.0	0.4
Yes, for my child	15.5	20.2	17.1	9.7	62.4
Yes, for other's child	0.8	0.4	0.0	0.4	1.6
No	6.2	10.9	7.8	10.9	35.7
24. Have you ever seen that BHS count the Resp. rate for ARI case					
No response	6.2	8.9	7.8	10.1	32.9
Yes	8.1	9.7	6.6	5.8	30.2
No	8.1	13.2	10.5	5.0	36.8
25. Got drugs for ----- days					
No drugs	6.9	10.7	7.7	11.5	36.8
For one week	1.1	0.8	1.5	0.0	3.4
For 3 days	4.2	6.5	5.0	4.2	19.9
For 2 days	1.5	4.2	7.7	1.9	15.3
For one day	8.4	9.2	2.7	4.2	24.5
26. What drugs					
Don't know	5.5	5.1	7.4	9.9	27.9
Oral	14.7	18.4	15.8	8.1	57.0
IM	2.2	6.6	2.9	2.9	14.7
IV	0.0	0.0	0.4	0.0	0.4
27. Cost (For ARI)					
Free	7.4	11.2	8.5	11.6	38.8
1 - 25 Kyats	9.3	8.5	8.5	4.7	31.0
26 - 50 Kyats	3.1	5.0	4.3	2.7	15.1
51 - 100 Kyats	1.6	5.0	3.1	0.4	10.1
101 - 800 Kyats	1.2	1.9	0.4	1.6	5.0
28. Asked to come again					
Cannot remember (No response)	7.0	11.2	7.8	11.2	37.2
Yes	12.4	15.5	8.5	6.6	43.0
No	3.1	5.0	8.5	3.1	19.8
29. If yes, did you go there again?					
Cannot remember (No response)	10.1	16.3	16.3	14.3	57.0
Yes	8.9	10.9	6.6	6.6	32.9
No, because of getting well	0.0	0.8	0.4	0.0	1.2
No, because feeling better	1.9	2.3	0.8	0.0	5.0
No, because disease is cured	1.6	1.2	1.2	0.0	3.9
30. Ever visited to the BHS's own clinic for the same problem					
Cannot remember (No response)	6.2	10.5	16.7	11.2	44.6
Yes	13.6	15.9	8.1	5.8	43.4
No	2.7	5.4	0.0	3.9	12.0

Indepth Analysis	Percentage				
	CHMF I	CHMF II	MEDP	Non	Total
31. If yes, have you pay for the drugs					
Yes	28.6	33.0	18.8	9.8	90.2
No	2.7	3.6	0.0	3.6	9.8
32. If yes, how much?					
1-100 Kyats	27.0	31.5	17.1	9.9	85.6
101 - 500 Kyats	3.6	5.4	1.8	1.8	12.6
501 - 1500 Kyats	0.0	0.0	0.0	1.8	1.8
33. Were the drugs items the same as the drugs from health centre?					
Yes	29.7	27.0	14.4	11.7	82.9
No	1.8	9.0	4.5	1.8	17.1
34. Were the drugs price the same as the drugs from health centre?					
Don't know	8.9	15.9	16.7	15.1	56.6
Yes	11.2	9.7	5.0	3.9	29.8
No	2.3	5.8	3.1	2.3	13.6
35. If yes (different), What is the difference (Item, Price of the drugs)					
More money in BHS's private clinic	1.9	3.5	1.6	1.6	8.5
China drugs in BHS's private clinic	0.0	0.4	1.2	1.2	2.7
Better quality of drugs in BHS's private clinic	0.4	1.9	0.0	0.4	2.7
No response	20.2	26.0	22.1	17.8	86.0
36. Know there is CCS					
Yes	15.1	7.4	9.7	8.9	41.1
No	7.4	24.4	15.1	12.0	58.9
37. If yes, any difference before and after CCS?					
Yes	21.3	13.1	12.3	10.7	57.4
No	6.6	3.3	1.6	4.9	16.4
Don't know the difference	6.6	9.0	6.6	4.1	26.2
38. Got more drugs					
Yes	18.0	9.0	11.0	8.0	46.0
Same	12.0	13.0	6.0	11.0	42.0
No response	12.0	0.0	0.0	0.0	12.0
39. Clinic is more clean					
Yes	20.6	15.7	11.8	11.8	59.8
Same	8.8	7.8	4.9	6.9	28.4
No response	11.8	0.0	0.0	0.0	11.8
40. BHS are sweeter					
Yes	18.6	4.9	10.8	6.9	41.2
Same	9.8	18.6	4.9	11.8	45.1
Worse	1.0	0.0	1.0	0.0	2.0
No response	11.8	0.0	0.0	0.0	11.8

Indepth Analysis	Percentage				
	CHMF I	CHMF II	MEDP	Non	Total
41. Quicker relief					
Yes	23.8	14.9	13.9	6.9	59.4
Same	5.0	7.9	3.0	11.9	27.7
Worse	1.0	0.0	0.0	0.0	1.0
No response	11.9	0.0	0.0	0.0	11.9
42. Know exemption					
Yes	14.0	14.0	12.0	3.5	43.4
No	8.5	17.8	12.8	17.4	56.6
43. If yes, to whom					
Poor	27.4	23.4	24.2	7.3	82.3
Religious	1.6	4.0	4.8	0.0	10.5
Prisoners	0.0	1.6	0.0	0.0	1.6
Emergency cases	1.6	0.8	1.6	0.0	4.0
Other	0.0	0.8	0.8	0.0	1.6
44. Williness to pay					
Willing to pay	15.9	23.6	14.7	18.2	72.5
Not willing	3.1	8.1	7.8	2.3	21.3
Good for rich, bad for poor	1.9	0.0	2.3	0.4	4.7
Ok if cheaper in RHCs	1.6	0.0	0.0	0.0	1.6
45. Can the community pay for the drugs					
Don't know					
Yes					
No					
46. Some people didn't go to health centre because they cannot pay					
Yes	10.9	12.8	5.0	8.5	37.2
No	11.2	10.5	12.8	6.6	41.1
Don't know	0.4	8.5	7.0	5.8	21.7
47. If yes, guess how many household					
Cannot guess	12.4	19.8	19.8	12.8	64.7
1 - 10	3.1	1.6	3.5	3.9	12.0
11 - 50	5.0	5.8	1.6	3.1	15.5
51 - 100	1.2	3.5	0.0	0.8	5.4
101 - 350	0.8	1.2	0.0	0.4	2.3

Indepth Analysis	Percentage				
	CHMF I	CHMF II	MEDP	Non	Total
48. Where did they go if they cannot afford					
Folk medicine	2.7	5.0	0.8	4.3	12.8
Asked BHS for credit	1.9	2.3	0.4	0.0	4.7
Self	0.8	2.7	0.4	1.2	5.0
Traditional medicine	3.9	2.7	0.8	1.6	8.9
Quack	0.8	2.3	0.0	0.4	3.5
Super natural craft	0.0	0.0	0.0	0.4	0.4
Nowhere	0.8	0.4	1.2	0.0	2.3
Traditional healer	0.8	0.4	0.4	1.2	2.7
No response	10.9	15.9	20.9	12.0	59.7
49. Any difference between health centre and above places?					
No	4.2	4.2	3.0	1.7	13.1
Don't know	11.0	15.2	18.1	13.5	57.8
Health centres are more expensive	6.3	11.8	2.5	4.2	24.9
Other places are more expensive	0.4	1.3	0.4	1.3	3.4
Self (bought drugs from drug shops)is cheaper	0.4	0.4	0.0	0.0	0.8
50. Difference between health centres and other places (TIME)					
Health centre spent less time	4.7	6.6	1.9	1.6	14.7
Private clinics spent less time	9.3	7.4	9.3	4.7	30.6
Don't know	8.5	17.8	13.6	14.7	54.7
51. Donation for CCS					
Yes, there is donation, but don't know how much	22.5	31.8	24.8	20.9	100.0
52. Other donations					
Land	0.0	0.4	0.0	0.0	0.4
Building	5.4	4.7	3.9	3.1	17.1
Furniture	3.9	2.7	1.2	2.3	10.1
Drugs	0.0	0.0	0.4	0.0	0.4
Manpower	1.2	0.0	0.8	0.0	1.9
Other	2.3	1.2	0.8	0.8	5.0
Don't know	9.7	22.9	17.8	14.7	65.1
53. Drug replenishment done by community					
Yes	0.0	0.0	0.0	0.4	0.4
No	22.5	31.8	24.8	20.5	99.6
54. What will be the openion of community if there were no drugs at HC?					
Buy from outside drug shops	12.8	11.2	2.3	7.8	34.1
Unhappy	6.2	5.4	10.1	1.6	23.3
Angry	1.2	2.3	1.9	1.2	6.6
Drugs should not be exhausted	0.8	1.2	0.4	1.2	3.5
Donate money for drugs	0.4	0.0	0.8	1.6	2.7
Don't know	1.2	11.6	9.3	7.8	29.8

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Myanmar **MYN/1998/0005**

Review of Community Health Management and Financing Initiative and Community Cost Sharing

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