

Evaluating Village Health Funding Mechanisms in Mawlamyinegyun Township



International Organization for Migration (IOM)
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Acknowledgement

We would like to thank the Township Health Department and local authorities of Mawlamyinegyun Township and the community members and respondents of the villages who helped throughout the key informant interviews and focus group discussions, and actively participated to reach the outcomes reflected in this assessment.

IOM would like to express our gratitude to all who reviewed the report, including those who participated in the electronic consultation process. We appreciate the help of Dr. San San Aye (Director, Department of Health Planning, MOH) and team members involved in that process and co-facilitated in the training of methodology of this assessment. IOM would also like to thank the JI-MNCH/3MDG staff and IOM regional office team members for their valuable comments and suggestions on the draft report.

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Produced by IOM with support from the 3MDG fund

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List of acronyms

FGD	Focus Group Discussion
JI-MNCH	Joint Initiative on Maternal, Newborn and Child Health
KII	Key Informant Interview
MoH	Ministry of Health
PONREPP	Post Nargis Recovery and Emergency Preparedness Plan
TB	Tuberculosis
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

Introduction

Cyclone Nargis hit 11 townships in the Ayerwaddy and Yangon Regions in May 2008, severely disrupting the health system and its capacity to deliver essential services while simultaneously elevating health-care needs and decreasing the ability of families to pay for treatment. Mothers and children, the most vulnerable population groups, were accorded priority for health interventions. The Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH) is an existing collaborative programme that was initiated in May 2010 to increase access to maternal and child health services among the poor and hard to reach in areas affected by the cyclone. The initiative takes on a demand-side approach, and is working on efforts such as strengthening Village Health Committees and establishing emergency referral systems.

In May 2010, a development partner established a village fund scheme in each of the 60 villages in the township by providing grants as seed money. The main component of the scheme is a Revolving Fund, whereby village households provide financial contributions to the fund and members can take out loans at low interest rates for emergency health needs or for investment. The development partner also provided a seed grant for an Emergency Health Fund to be used for emergency referrals of maternal and child health conditions. 30 per cent of the interest earned from the Revolving Fund is put into the Emergency Health Fund, and a further 30 per cent finances the Development Fund to address needs of the village such as road maintenance and schools. A Fund Management Committee was set up in each village to manage the fund activities. The development partner has now withdrawn from the activities and handed over responsibility to local stakeholders.

Objectives and methods

The overall objective of this research is to analyse the existing community-based health financing mechanisms in villages given access to the grants, to provide a basis for further expansion and for improved community case management. To this end an evaluation study was undertaken starting from June 2012 using both quantitative and qualitative methods. Quantitative data was based on a desk review of the relevant and available documents, and a rapid assessment to describe and analyse the balance, interests, community contributions and the usage of funds. The qualitative assessment, based on six selected villages, was based on Key Informant Interviews and Focus Group Discussions.

The study does not intend to evaluate the work of a development partner or to make comparisons between interventions by different partners. As the study is confined only to assessing village health funding mechanisms, no attempt was made to look into the performance of other funding arrangements supported by other development partners.

The study had to depend on available documents and statistics, and completeness and reliability of these will to some extent determine the quality of the findings.

Findings

Fund status and activities carried out

It was reported that 30 out of 60 villages were still running the activities with the fund. Some 8 villages could no longer run the activities although still had access to remaining funds. In 22 villages there were no funds remaining at all. The Emergency Health Fund was found to be growing in almost all of the villages in 2010 and 2012. The Development Fund was also found to be growing in almost all villages. Overall nearly half of the funded villages could manage to make the funds grow in the period from 2010 to 2012.

Among villages that had carried out any activities, the most frequent activities were related to fund management and holding meetings. Out of 60 villages in total, only 26 villages were found to be involved in emergency referral. Activities related to nutrition were the least frequently carried out.

Villages where the Fund Management Committee was active, competent and had positive relationships with the village authorities and community, were more successful in maintaining activities. The findings reinforce the concept that the ability to mobilize and involve the community is an important ingredient for success. If the fund management was found to be incompetent, inactive and unable to mobilize the community, the fund mechanisms failed. The lower socioeconomic status of some villages was also found to hamper the growth of the fund.

In four villages where funds were found to be growing, good collaboration was reported, with community members expressing high regard for and trust in service providers. They also expressed an expectation for health service providers to take more active roles and collaborate with fund management. They provided evidence that basic health staff, particularly the midwife, and local health volunteers were mutually supportive and collaborative, leading to successful management of some cases in the village.

Sustainability

Among the six villages selected for the in-depth study, the fund was reported to be growing in four villages. Fund growth was reported to be mainly attributable to the regular return of loans. Villagers felt that it was their responsibility to make regular repayment so as to enable fund growth. In two villages where there were no more activities, the inability to repay loans was the main reason for failure. Villagers were said to be unable to follow the rules because of economic hardships.

The Fund Management Committee took utmost care that loans were paid back. Potential borrowers and their guarantors were properly screened, while decisions and rules were made only after consultation with, and consent from, the community. The committee took on monitoring and supervisory works to ensure loans were paid back regularly. Help from village elders and unity among committee members made regular repayment and disbursement possible. Fund Management Committee members from these villages expressed their satisfaction with the trainings they had received, and further indicated their willingness to get additional training, particularly on leadership, effective use and management of funds, and public communication.

In two villages where funds were reported to be no longer functioning, fund management was reported to have poor coordination with villagers and village administration.

Community perception and contribution

All those interviewed perceived financial constraints as the most important barrier to accessing health-care. They identified transport as an additional barrier. Good relations between the Fund Management Committee and the community were perceived as essential to building trust and sustaining the fund. Good communication, understanding, adherence to commitments, and taking into account the benefit of the whole village were reported to be necessary for sustaining fund growth. The community also wished for transparency in terms of how interests earned were effectively used in development activities. The community was reported to be willing to use the fund for referring other non-emergency but high-risk maternal cases requiring specialist consultation, as well as for replenishing medicines dispensed by the health volunteers.

The Initial contribution to the fund was mostly in the form of counterpart funding. All community members other than mothers of under-five children were invited to contribute. Some well-wishers were reported to be making contributions commemorating their birth days or some auspicious occasions.

Fund utilization

Fund utilization was mostly in the form of granting loans. The Emergency Health Fund was not frequently used, as cases could be managed locally and the need did not arise. Most unused was Development Fund, because, among other reasons, the amount was not sufficient to meet activity requirements, such as the building of an early childhood development centre.

Roles of partners

As discussed above, good coordination and communication between partners, namely village authorities, fund managers, and community members, was essential for effective fund utilization. In villages with the most active funds, village administrators, particularly hundred household leaders, took up bridging roles between the community and the Fund Management Committee.

Most community members in villages where the fund was successful had high regard for and relied on basic health workers and volunteer health workers, and thus expected basic health staff to take more active roles in managing the funds. Accordingly, volunteers carried out timely referrals to basic health outposts and health institutions. In villages where the fund was less successful, the mothers tended to start self-treating with home remedies before seeking the service of health workers.

These referral schemes can be regarded as a step forward in removing barriers and improving access to health service. Although the overall coverage may still be limited, it is expected that the strategy will be effective in supporting the development of potentially longer-term governance arrangements to support improved health access. The strategy with more community involvement can be a good way to encourage the spirit of self-determination and solidarity. It is important for development partners to see that their efforts are leading to positive and sustainable developments rather than making communities more dependent.

Recommendations

Capacity strengthening

Fund Management Committee members should be able to access more training, particularly in leadership, effective utilization of fund money, and public communications. Since most of the fund is in circulation and only a small amount is maintained as reserve, the task of book keeping and accounting is challenging. This is exacerbated by the introduction of additional development programmes,

making accounting increasingly prone to errors. The fund management also required a basic and conceptual understanding of risk pooling and sharing, and the need for solidarity if a more comprehensive community based health-financing strategy is to be introduced.

Scope of coverage and target

The Emergency Health Funds are limited to emergency referral of the target group of mothers and children under five. With the growth of the fund it may be appropriate to reconsider the scope of benefits and target groups covered. Additional financial requirements can be met by small and frequent contributions as agreed by the community.

Improving service provision

In places where volunteers are active, reliable, and trusted, the additional support of essential medicine along with refresher trainings as required will improve service provision. This arrangement can also be an incentive for volunteers to work more effectively and with more confidence and enthusiasm. Equally, it is important to see that this will not create rivalry and tension between local basic health staff and volunteers.

Community empowerment

Involvement of development partners can be highly effective in rehabilitating and helping the community. They should assume a catalytic role, with support oriented towards building an enabling environment to enhance sustainable and self-reliant community capacity. Close collaboration with governmental departments and authorities is also essential.

Generating more evidence relevant to local situation

The government and development partners need to have a more complete and locally relevant evidence base to identify the conditions under which demand side approaches improve access to quality maternal and child health services without financial burden. Different community health financing approaches by different agencies are in place in the Delta Region. Documenting and sharing of experiences will be of much help in improving and expanding interventions.

Conclusion

The village health funding mechanisms introduced in 60 villages in Mawlamyinegyun Township are progressing in more than half of the villages. Competency, interest and ability of the fund management to mobilize and form positive relationships with the community were found to be key ingredients for fund growth. The economic status of villages and predictability of the working environment also determine success. Fund growth does not however guarantee that health and development needs will be met. Additional technical support and flexibility in managing and utilizing the health and development funds in particular will be essential to ensure fund growth is accompanied by effective utilization as intended.

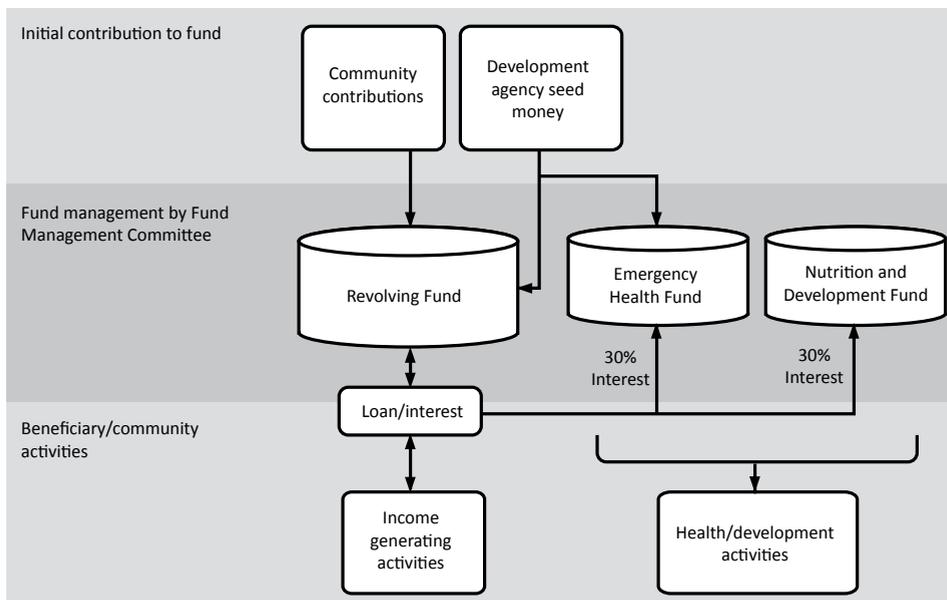
I. Introduction

Cyclone Nargis hit 11 townships in the Ayeyarwady and Yangon Regions in May 2008, affecting 2.4 million people with an estimated loss of 140,000 lives. The cyclone had a severe impact on the health system and its capacity to deliver essential services, and simultaneously increased health-care needs and decreased the ability of families to pay for treatment. Three weeks after Nargis, a Health Cluster was formally convened by the World Health Organization, which later evolved into a group responsible for ensuring the efficient implementation of long-term recovery plans. Mothers and children, the most vulnerable population groups, were accorded priority for health interventions (PONREPP, 2009). The Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH) is an existing collaborative programme that aims to increase access to maternal and child health services among the poor and hard to reach in areas affected by the cyclone, and is built on the successful post-Nargis coordination within the former Health Cluster. Initiated in May 2010, the programme takes on a demand-side approach, and is working on efforts such as strengthening Village Health Committees and establishing emergency referral systems (JI-MNCH, 2011).

Mawlamyinegyun is among the 11 townships hit by the cyclone and ranked fifth in terms of severity of cyclone impact. It is an island township situated 50 miles from the seacoast, and borders Bogale and Kyaitlatt townships to the east, Laputta and Wakema townships to the west, Wakema and Kyaitlatt townships to the north, and Laputta and Bogale townships to the south. Mawlamyinegyun's total population is estimated to be 339,083, with 304,855 (90%) residing in rural areas. There are 108 village tracts and 627 villages. Road transport is now made possible by the construction of bridges and roads where transport by water previously presided. Agriculture is the main occupation, with fishing and commodity trading in some population groups. There is one 100 bed hospital, one station hospital, 12 rural health centres, one maternal and child health centre, and 3 diseases control teams for TB, malaria and leprosy providing (IOM, 2011).

In May 2010, Save the Children, a development partner developed a village fund in each of 60 villages in the township by providing grants as seed money along with a system of financial contributions by the community (Figure 1). The main component of the fund is revolving, whereby village households provide financial contributions to the fund and members can take out loans at low interest rates for emergency health needs or for investment. The development partner also provided a seed grant for the Emergency Health Fund to be used for transporting emergency referral of maternal and child health conditions. Thirty per cent of the interest earned from the revolving fund is put into the Emergency Health Fund, and a further 30 per cent is used to set up the Nutrition and Development Fund (abbreviated to Development Fund) to address needs of the village such as road maintenance and schools. A Fund Management Committee was set up per village to manage the fund activities. The development partner has now withdrawn from the activities and handed over responsibility to local stakeholders.

Figure 1: Conceptual Diagram of flow of fund money in the village fund scheme



2. Objectives

The overall objective of this research is to analyse the existing community-based health financing mechanisms in villages given access to grants, to provide a basis for further expansion and for improved community case management. Specifically the study assesses:

- (a) The functioning status of village health grants;
- (b) The views and perceptions of the community and beneficiaries regarding the use and functionality of these health grants; and
- (c) The perceptions of health-care providers and partners on the functionality of these grants.



3. Methodology

3.1 Study design

A cross sectional design was used to collect both quantitative and qualitative data.

3.2 Study population

The study population was those in the 60 Mawlamyinegyun villages who had accessed health grants through the fund system introduced in 2010, as well as health-care providers in these villages.

3.3 Study period

The total study period was from 17 September to 23 November 2012, inclusive of both preparatory and reporting phases. A field study took place from 1 October to 14 October 2012.

3.4 Sampling

60 villages with access to the grant were categorized into three groups based on the status of the fund, as shown in the table below. For the qualitative study, two villages were selected from each category of villages, with a total of six villages studied (Annex-A).

Table 1: Village category by fund status and sample size

Village Category	Criteria (Fund Status)	No. sampled for qualitative study
A	Fund still exist and functioning	2
B	Fund still exist but not functioning	2
C	Fund no longer exist	2
Total		6

To select the villages, purposive sampling was carried in consultation with field IOM staff, based on the prevailing climatic conditions, the feasibility of reaching the villages, and the possibility of finding required informants.

3.5 Data collection

3.5.1 Methods and instruments for data collection

Both quantitative and qualitative data were collected. The quantitative assessment was based on a desk review of the relevant and available documents and on data collected from a rapid assessment of balance, interest, community contributions and the usage of funds.

Qualitative data was used to assess the views and perceptions of the community and beneficiaries on the functioning status of the funds and factors underlying it (Table 2). Health-care providers and partners including local authorities were interviewed in Key Informant Interviews (KIIs) to gain insight into their perceived roles in sustaining and using funds, and the contributing factors. Focus Group Discussions (FGDs) were applied to determine the views and perceptions of the beneficiaries regarding the utilization of funding, fund progress, and perceptions of the Fund Management Committee (Annex-B).

Table 2: Data collection methods and respondents

Methods	Respondents
Key Informant Interviews	4 per village, consisting of: Health-care providers, local authorities, Fund Management Committee members
Focus Group Discussions	1 session in each village with 7-9 participants, consisting of: Mothers of children under 5 (Including those who had and had not been benefited from emergency referral services) Those who had taken loan

3.5.2 Basis for developing data collection tools: Key informant interviews and focus group discussions

The development of the training material and themes for the qualitative research tools was based on the need to assess the fund status and its contributing factors. The funds are set up to provide financial assistance to mothers and children seeking health-care. In particular, funds are directed towards the emergency referral of obstetric cases and common childhood emergencies and illnesses, particularly for children under the age of five years old. The size and sustainability of funds are vital and depend on the managing capacity of the Fund Management Committee and their willingness to volunteer. Contributions by the community are also important. Also to be assessed are practices of mutual aid when times of need exist, and the reciprocal effects that occur with these funding arrangements. The roles taken by other partners and service providers as well as local authorities and the opinions they provide are also important, particularly for understanding demand side financing. (See Annex-C for instrument for data collection and guides for interview and group discussion).

3.6 Data management and analysis

Quantitative data was analysed using Excel. Qualitative data collection was conducted in the Myanmar language and recorded using both note-taking and a voice recorder. The interviews and discussions were then transcribed. Transcripts were subsequently analysed manually to observe key themes.



4. Ethical considerations

Informed consent was obtained from all respondents. They were provided with information on the purpose of the study and the potential risks and benefits of participation. Participation was voluntary and potential respondents were assured that refusal to participate would in no way affect any health or other social services they may seek in the community, and that all information collected would be confidential and used for research purpose only (Annex-D).



5. Scope and limitations

5.1 Scope

The study does not intend to evaluate the work of the development partner or make comparison across interventions of different partners. As the study is confined only to the assessment of the village health funding mechanisms, no attempt was made to look into the performance of other funding arrangements supported by other development partners.

5.2 Limitations

The study had to use available documents and statistics, and the completeness and reliability of these materials will to some extent determine the quality of the findings. Data and information on the funding situation was based on the description of respondents, and as the objective of the study was to assess the funding situation and mechanisms only, no attempt was made to review or check the documents. Finally, within the categorization of villages into three types based on the functioning status, the growth of and sustenance of funds was easy to define, however the delineation between category A and B was not clear-cut.



6. Findings

Out of the 60 villages that were supported, data on the status of fund activity was available for a range of 51 to 59 villages, depending on fund type, between May and August 2010 (Table 3). In the later part of the year, October and December, the overall information on fund status was available for less than half of the villages: only 14 villages had data on the revolving fund in October for example (Table 3). However a rapid assessment in June 2012 found that over half of the villages were still able to provide information on their fund situation.

Table 3: Villages reporting fund status in 2010 and June 2012

Fund	Number of Villages reporting fund status							
	May 2010	June 2010	July 2010	Aug 2010	Sept 2010	Oct 2010	Dec 2010	June 2012 (Rapid assessment)
Revolving Fund	52	53	53	58	41	14	15	37
Emergency Health Fund	52	53	53	59	43	27	14	39
Development Fund	52	51	53	59	41	29	15	30
All fund	52	51	53	58	41	14	14	30

6.1 Fund status

At the time of the rapid assessment of fund status in June 2012, 30 villages could provide data on all three types of funds (Table 3), seven villages provided data on revolving funds and Emergency Health Funds, and two villages provided data on Emergency Health Funds. The remaining 21 villages could not provide any data on their fund status. Upon further questioning it was reported that 31 villages were still running activities with the funds, while 8 villages could no longer run activities although still had access to remaining funds. In 21 villages there were no funds remaining at all. Most of the respondents were accountants (24),

followed by leaders (16) and treasurers (13). The remaining respondents (7) were volunteer health workers, hundred-household leaders and members.

6.2 Fund growth

The availability and growth of the funds are highly essential for sustaining activities. Among the villages with functioning funds and available data, it was observed that between May 2010 and the end of 2010, the revolving funds grew by 12 per cent on average. One village (*Kuntheechaung2*) gained as much as 366,760 kyats¹ (97%) while another village (*Kuntheechaunglay*) depleted 221,968 kyats (-29%). During the period between the end of 2010 and June 2012, the revolving funds grew by 145 per cent on average. *Kuntheechaung3* village earned almost nine times the original seed, while the funds in *Mabay village* were depleted by 56 per cent. During the entire study period from May 2010 to June 2012, the revolving funds grew by 174 per cent on average. Again the highest growth was seen in *Kuntheechaung3*, where funds increased by almost 10 times, and the lowest seen in *Mabay* which lost 50 per cent (Table 4; for details see Annex-E).

Table 4: Revolving fund total and growth on average and among villages with highest (in green) and lowest (in red) per centage changes per time interval

Village	Fund total			Fund growth/decline (%)		
	May 2010 (seed)	Dec 2010	June 2012	May to Dec. 2010	Dec. 2010 to June 2012	May 2010 to June 2012
Average	493,141	550,559	1,351,806	574,18 (12%)	801,246 (145%)	858,665 (174%)
Kuntheechaung2	379,000	745,760	882,000	366,760 (97%)	136,240 (18%)	503,000 (133%)
Kuntheechaunglay	765,000	543,032	1,200,000	-221,968 (-29%)	656,968 (121%)	435,000 (57%)
Kuntheechaung3	384,000	419,760	4,100,000	35,760 (9%)	3,680,240 (877%)	3,716,000 (968%)
Mabay	348,000	398,400	175,000	50,400 (14.4%)	-223,400 (-56%)	-173,000 (-50%)

Emergency Health Funds were also found to be growing in almost all the villages in 2010 and 2012 (Table 5). Between May and December 2010, the Emergency Health Funds grew by 83 per cent on average. The largest growth, almost quadrupled, was found in *Kuntheechaung2*, and the largest loss in *Kuntheechaunglay* (32%). Between the end of 2010 and June 2012, average growth was by 102 per cent. *Seinpan* village gained over four times the starting

1 1 USD = 985 Kyat; 100,000 Kyat = 101 USD (February 2014).

quantity and *Mabay* depleted 64 per cent of the fund during these periods. Over the entire study period, average growth was 270 per cent, with the highest growth of 1,255 per cent in *Kuntheechaung2* (Table 5; See Annex-F for details).

Table 5: Emergency fund total and growth on average and among villages with highest (in green) and lowest (in red) per centage changes per time interval

Village	Fund total			Fund growth/decline (%)		
	May 2010 (seed)	Dec 2010	June 2012	May to Dec. 2010	Dec. 2010 to June 2012	May 2010 to June 2012
Average	80,000	146,316	295,998	66,316 (83%)	149,682 (102%)	215,998 (270%)
Kuntheechaung2	40,000	198,921	542,000	158,921 (397%)	343,079 (172%)	502,000 (1255%)
Kuntheechaunglay	110,000	75,184	400,000	-34,816 (-32%)	324,816 (432%)	290,000 (264%)
Seinpan	110,000	119,950	639,130	9,950 (9%)	519,180 (433%)	529,130 (481%)
Ywalechaung	110,000	167,493	100,000	57,493 (52%)	-67,493 (-40%)	-10,000 (-9%)
Mabay	40,000	157,050	56,000	117,050 (292%)	-101050 (-64%)	16,000 (40%)

The Development Funds were also found to be growing in almost all of 22 villages in both periods. Between May and December 2010, the development funds grew by an average 113 per cent. *Hmyarchaung* village recorded the highest growth of 165 per cent and *Thankanaut* depleted 8.5 per cent. Between December 2010 and June 2012 average growth in the Development Funds was 457 per cent. *Thankanaut* village recorded the highest growth of 2,692 per cent and the lowest was recorded in *Hmyarchaung* village which depleted by 70 per cent. Overall from May 2010 to June 2012, development funds grew more than tenfold. Consistent with the second period, the largest growth (2,454%) was in *Thankanauk* village, and the highest loss was in *Hmyarchaung* village (-21%) (Table 6; see Annex-G for details).

Table 6: Development Fund total and growth on average and among villages with highest (in green) and lowest (in red) per centage changes per time interval

Village	Fund total			Fund growth/decline (%)		
	May 2010 (seed)	Dec 2010	June 2012	May to Dec. 2010	Dec. 2010 to June 2012	May 2010 to June 2012
Average	16,724	35,660	198,605	18,936 (113%)	162,945 (457%)	181,991 (1,087%)
Hmyarchaung	26,500	70,257	21,000	43,757 (165%)	-49,257 (-70%)	-5,500 (-21%)
Thankanauk	11,745	10,745	300,000	-1,000 (-8.5%)	289,255 2692%	288,255 2454%
Gawtu	13,080	44,685	133,785	31,560 (242%)	89,100 (899%)	184,295 (1173%)

Overall nearly half of the funded villages managed to make the funds grow in the period from 2010 to 2012. Of further interest and importance is how these funds were utilized and made to grow.

6.3 Activities undertaken

Along with assessing the funding situation, this study also looked at activities undertaken by the Fund Management Committee, namely fund management activities to promote fund growth, monthly meetings, emergency referrals and educational talks on healthy foods and balanced diets. Accordingly, a rapid assessment was conducted in June.

Table 7: Activities undertaken by each category of villages in 2012

Activities	Implement	No. of Villages Category (A)	No. of Villages Category (B) and (C)	Total	Chi	p
Fund management	Yes	29 (48.3%)	1 (1.7%)	30 (50%)	48.654	<.0001
	No	2 (3.3%)	28 (46.7%)	30 (50%)		
	Total	31 (51.6%)	29 (48.4%)	60 (100%)		
Meeting	Yes	30 (50%)	1 (1.7%)	31 (51.7%)	52.258	<.0001
	No	1 (1.7%)	28 (46.6%)	29 (48.3%)		
	Total	31 (51.7%)	29 (48.3%)	60 (100%)		

Activities	Implement	No. of Villages Category (A)	No. of Villages Category (B) and (C)	Total	Chi	p
Emergency referral	Yes	24 (40%)	2 (3.3%)	26 (43.3%)	30.347	<.0001
	No	7 (11.7%)	27 (45%)	34 (56.7%)		
	Total	31 (51.7%)	29 (48.3%)	60 (100%)		
Nutrition	Yes	7 (11.7%)	0 (0%)	7 (11.7%)	Not valid	
	No	24 (40%)	29 (48.3%)	53 (88.3%)		
	Total	31 (51.7%)	29 (48.3%)	60 (100%)		

Among villages that carried out activities in 2012, the most frequently undertaken activities were related to fund management and meetings. Out of 60 villages, only 26 villages were found to be involved in emergency referral. Activities related to nutrition were the least frequently carried out. Villages with functioning funds were found to be carrying out the activities relating to fund management, meeting and emergency referral compared to villages that were no longer functioning. The difference is statistically significant (Table 7; see Annex-H for details).

Among villages where funds and functions still exist (category A) it was found that referral activities increased during the 2010 to 2012 period, from 64.5 per cent of villages in 2010 to 77.4 per cent in 2012. More childhood illnesses than maternal cases were referred. In the remaining villages where funds or functions no longer exist, (category B and C) referral became less frequent between the same intervals of periods. There were no obvious difference between number of childhood illnesses and maternal cases referred (Table 8; see Annex-I for detail).

Table 8: Referral activities undertaken by villages, presented by village category

Category	Village No.	2010			2011			2012
		No. Village referring	No. Child referred	No. Mother referred	No. Village referring	No. Child referred	No. Mother referred	No. Village referring
A	31	20 (64.5%)	64	34	22 (70.9%)	57	30	24 (77.4%)
B	8	5 (62.5%)	8	8	4 (50%)	7	2	1 (12.5%)
C	21	16 (76.2%)	28	17	5 (23.8%)	17	20	1 (4.8%)

Table 9: Referral activities undertaken by sampled villages

Category	Village Name	2010			2011			2012
		Referred Y/N	No. Child referred	No. Mother referred	Referred Y/N	No. Child referred	No. Mother referred	Referred Y/N
A	Hmyarchaung	Y	4	1	Y	0	2	Y
	Kyonlamugyi	Y	4	0	Y	1	3	Y
B	Thuhtaygone	N	0	0	N	0	0	N
	Kwinchaung-gyi	Y	0	2	Y	0	2	Y
C	Kyonlatta	Y	1	1	Y	1	1	N
	Swesone	Y	4	1	N	0	0	N

6.4 Size and sustainability of funds

Among six villages selected for the qualitative study, the funds were reported to be growing in four villages. Fund growth was mainly attributed to the regular return of loans, in which both the Fund Management Committee and the villagers played important roles. Members of the Fund Management Committee set good examples by returning the loans in time, and advised other members to amass small daily savings to be able to pay back in time. In addition, corrective and punitive actions were taken for those who failed to return in time. In one village, it was reported that those failed to pay back in time had to make an additional daily payment of 500 kyats until the payment due was made.

Villagers felt a sense of responsibility and consideration for others who wished to take a loan, applying pressure and encouragement to ensure no failure in repayment, although there were some delayed payments.

“As I am willing to spend the loan, she will also have the same desire. As she is willing to spend I will also be willing to do so. If I pay back she will have the chance to spend. The fund will also grow and stable in the long run. It’s good if we have such way of thinking.”

(Mother of under-five child, casual worker, village where fund growing and functioning)

On the other hand, two villages that had stopped fund activities reported lack of loan repayment as the main reason for failure. Villagers were said to be unable to follow the rules because of economic hardships. After taking out the loan they also claimed to have found that investments were unsuccessful. In some instances non-repayment became the norm due to bad examples set, and some villagers were reported to be more interested in benefiting from the loan than in repaying. In some cases people were taking out additional loans to enable repayment, finding themselves in a debt cycle.

“People in our village are poor and do not find life easy. Being fishermen, they don’t have much time and have to spend most of their time getting food. It isn’t that they don’t want to pay; they don’t have money to pay – they don’t even earn enough for one day’s need and don’t have any means to pay back.”

(Leader of fishery group and committee member, female, village where fund failed)

“In my opinion some people were not paying back because they could go on without paying back. They took advantage of the situation.”

“What’s worse was that those who had to pay back loans had to go to pawn shop, so were unable to escape from the debt cycle.”

(Health volunteer, male, village where fund failed)

6.5 Fund management

In two villages (Kyonlamu and Hmyarchaung), funds were growing and functioning, and the Fund Management Committee took utmost care that loans were paid back. Potential borrowers and guarantors were properly screened, and loans were given only to those who could clearly indicate their intentions with the loan. Those who were later found to not be making effective use of the loan were denied or delayed subsequent loans. Decisions and rules were made only after consultation with and consent from the community. The committee took on monitoring and supervisory works to ensure loans were paid back regularly. Although there were no special arrangements for meetings, regular monthly meetings took place at the time of returning and disbursing loans. Help from village elders and unity among committee members also made regular repayment and disbursement possible. When there were delays in paying back loans, the Fund Management Committee took on more persuasive methods and inquired reasons for delay, explaining the need to pay back without fail and to be considerate to others. Those who made a delayed payment were fined according to rules that had previously been agreed upon.

“There are three factors necessary for the fund to be long lasting. Regular repayment and disbursement, help from village elders, and unity among fund management committee members.”

“This fund is the concern of all villagers. It won’t be good if we don’t pay back. We need understanding. Good organizational work is needed to instill such thinking. We need to explain this with patience all the time.”

(Health volunteer, female, village where fund was growing and functioning)

However in one village it was reported that not all villagers were involved in decision making. One fund member was found to be borrowing money under

false pretenses. The number of Fund Management Committee members was reduced from 8 to 3 due to lack of interest, and they faced difficulties recruiting replacements. There was one instance where miscommunication escalated to expressions of hostility by the villagers, due to villager dissatisfaction with the loan process and difficulties among the committee members in explaining the process. In another village where a livelihood grant was also provided, the Fund Management Committee was found to be active and the fund was growing. Regular repayment was a rule except for one case where a member failed to return the loan and the management had to resort to taking legal action when that person repeatedly failed to keep their promise. In this particular village, the fund activities were found to be oriented more towards improving livelihood.

“Most villagers wanted to take out a loan. Some fund management committee members were young and inexperienced, and needed training on conceptual knowledge to explain the situation. There were instances when villagers were using abusive and threatening words because of dissatisfaction with the situation.”

(Leader of 100 households, male, village where fund was growing but not functioning)

“She herself was not considerate. Every means to persuade her failed. Ultimately we could not afford to ruin our cause because of her, and had to take legal action.”

(2 males and 3 females during FGD among those who had taken loans, village where fund was growing and with livelihood grant)

Fund Management Committee members from these villages expressed their satisfaction with the trainings they had received. At the same time they indicated their willingness to get further training, particularly on leadership, effective use and management of funds, and public communication.

In two villages where funds were reported to be no longer functioning, the Fund Management Committee was described as having poor coordination with villagers and village administration. They were reported to be behaving inappropriately and following one another in breaching rules. The committee did not make an effort to claim back loans. On the other hand even the leaders of the committee, themselves encountering economic hardships, could not pay back the loans. Although a lender requires a guarantor who agrees to pay back the loan on the lender’s behalf if he/she fails to pay back, in practice, guarantors only assisted with requesting for repayment, as opposed to providing actual financial assistance. Local management also appeared to gain less respect, as villagers were more likely to return loans to other development partners when they visited the villages to claim repayments.

“One committee member was found to be taking out not only a loan for himself but an additional loan under another person’s name.”

“Eventually the norm was to breach rules, including among some leaders, and the guarantee system no longer worked.”

(Health volunteer, male, village where fund failed, livelihood fund granted)

“The villagers did not care much about locals. If they happened to take a loan from more than one source they took more effort to pay back UNDP’s loan.”

(Committee member, leader of fishery group, female, village where fund failed, livelihood fund granted)

6.6 Community perception and contribution

All those interviewed perceived financial constraints as the most important barrier to accessing health-care. They identified difficulties accessing transport as an additional barrier. The community readily accepted the idea of forming a village network to share experiences. Good relations between the Fund Management Committee and the community were perceived as essential to building trust and sustaining funds. Good communication, understanding, adherence to commitments, and taking into account the benefit of the whole village were reported to be necessary for sustaining fund growth. The community also wished for transparency in terms of how interests earned were effectively used in development activities. They expressed dissatisfaction with the fact that the Emergency Health and Development funds, though growing in amount, were not distributed as loans. This was particularly the case when the Revolving Fund was not sufficient to give out as loans to all those who wished to borrow. In one village where the funds were growing and functioning well, the community followed the advice of the Fund Management Committee and there were even instances where some members paid back in advance because they were not free on the due date. However, in this village the fund management still sensed that the villagers were more willing to follow the advice from external bodies and individuals.

“There were meetings among a network of villages where experiences were shared. It would be good to arrange this type of meeting in the future. There is a difference between using only one brain and stimulating discussion among people.”

(Volunteer health worker, female, fund growing and functioning)

“Members should be encouraged to sustain the fund. But they usually do not follow such advice if given by locals. They tend to accept advice if given by people from outside. There is an old saying: cows do not eat grass growing in their village.”

(Accountant, male, village where fund growing and not functioning, livelihood fund granted)

In some cases, although the funds for emergency referrals were in place, these were not used frequently as most cases could be managed by basic health staff and the health volunteers. The community was reported to be willing to use the funds for referring other non-emergency but high risk maternal cases requiring specialist consultation, and also for replenishing medicines dispensed by the health volunteers. Some respondents expressed their desire to have support for education, such as provision of books, stationary and school uniforms. In villages where the fund was no longer functioning, the main reason for failing to return the loans was economic hardship, and the community expressed their desire to restart the fund with stronger regulations.

The Initial contribution to the fund was mostly in the form of counterpart funding. Community members other than mothers of under-five children were invited to contribute. Some well-wishers were reported to be making contributions commemorating their birth days or some auspicious occasions. In villages where livelihood funds were in place, members were required to make fortnightly contributions of 200 kyats.

6.7 Fund utilization

Fund utilization was mostly in the form of granting loans. The emergency health funds were not frequently used as cases could be managed locally and the need did not arise. Most unused was the Development Funds, although there were cases in which the finances were used for social welfare activities, including the roofing of a boat, clearing of ditches, and a *kahtein* robe offering ceremony. One reason given for not using the Development Funds was that the amount was not sufficient to meet their requirements, such as the building of an early childhood development centre which would have required three million kyat. However the funds were also used for less costly development activities, such as in one village where the money was used to provide refreshments for youth who contributed their labour to village road maintenance.

“A reason for not using the Development Fund was, for instance, that it would cost three million kyats to build a child nursery. Taking into consideration the existing Development Fund and the amount that the

community could contribute, it was found that the total amount would be insufficient. Regarding the health fund, we did not need to use much for emergency referrals, as the Sayama (Midwife) has been in the village.”

(Former hundred household leader, male, village where fund was growing and functioning)

Furthermore, a per centage of the Development Fund was used for giving out loans when the revolving fund was not sufficient. In one village where the livelihood fund was in place and where the village health funds were growing but not functioning, just 40,000 kyats of the Emergency Health Funds was kept aside and the surplus amount was merged with the Development Funds and used for giving out loans. The idea was to make the money more productive and prevent the currency notes from gathering mold.

“Initially the development and Emergency Health Funds were kept separate, but they later merged. It would have been useless to keep these funds as originally intended. As the health fund was limited to health uses only, the currency notes would have just ended up gathering mold. Emergency health needs were unusual in our village. We just kept 30,000 to 40,000 kyats for emergency use and the rest was used for loan.”

(Accountant, male, village where fund growing and not functioning, livelihood fund granted)

6.8 Mutual aid and reciprocity with fund

There were no formal arrangements for supporting those in need in time of ill health or death of family members. As setting up the health funds was meant only for emergency referral and was limited to expecting mothers and children under five, they still had to rely on existing coping mechanisms. These included reliance on money-lenders, relatives, or employers; taking out loans with high interest rates; or taking advanced payment at less than the standard rate for works. There is however a custom of community members providing each other financial support for funerals.

6.9 Roles of partners

The relationship between village authorities, village elders and the Fund Management Committee was reported to be good in villages where the fund was thriving and functioning. Village administrators, particularly hundred household leaders, were found to be taking active roles bridging between the community and fund management. In some cases where loan business and local relations were going smoothly, the local authorities even had no notice of what was going on. In villages where the fund was failing however, there were poor coordination and communication between village authorities and the Fund Management Committee.

“The day before was when repayment and disbursement of loan was made. The fund was not sufficient for all those willing to take loan. The 100 household leader with concern over others might have delay in getting loan offered not to take his loan.”

(A male who had taken loan before, village where fund growing but not functioning, livelihood fund granted)

Most community members in villages with successful funds had high regard for and reliance on basic health workers and volunteer health workers. They thus expected basic health staff to take more active roles in managing health fund. Accordingly, volunteers carried out timely referrals to basic health staff for institutional delivery. In villages where the fund was less successful, the mothers tended to start self-treating with home remedies before seeking the service of health workers.

“Although the health centre is in place, some patients who want to visit clinics in town try to get a loan. In this case we need the help of the health staff as we want those cases that can be treated locally to be treated here.”

(Accountant, male, village where fund was growing and functioning)

“Generally health staff posted in the village are respected by the villagers. Because of their status they can organize the community and can advise them to make regular payment for the loan.”

(Former hundred household leader, male, village where fund was growing and functioning)

“Compared to before, our health is improving. With health education training in place, it’s good even if you follow the guidelines occasionally, and even better if you follow the advice all the time.”

(Mother of under-five child, house-wife, village where fund growing and functioning)



7. Discussion

The funds were found to be growing in four of the villages chosen for the qualitative study. However fund growth, though desirable, does not necessarily equate to fund functionality. The utilization of funds as intended is also required for a fund to be called functioning. In all four villages the funds were mainly used for provision of loans.

7.1 Functioning status

The rapid assessment indicated the fund was growing in almost half of the 60 villages. In some villages it was found that the funds were growing enormously, by a magnitude of ten to twenty times. Since the data for the rapid assessment was based on verbal responses rather than on records and reports, interpretation of these findings needs to be made with caution. Activities undertaken by the fund management were focused more on meetings and loan disbursement. It can thus be concluded that the loans taken for health and development activities were the drivers of emergency and Development Fund growth.

In depth assessment in six selected villages indicated loan business was thriving *at the expense of health and development activities*. As use of the health fund is limited only to emergency referral of a target population, and as the need for referral did not arise as frequently as expected, fund management had to face the issue of keeping and safeguarding the growing health funds. As for the Development Funds, the amount, although growing, was not sufficient to meet their development needs. The communities on the other hand were unhappy with the knowledge that these specific funds were growing but not for use unless indicated. They were more interested in getting loans. The introduction of a livelihood grant in one village, where the fund management committee was also inclining more towards loan business, led to using Emergency Health and Development Funds in the loan business.

7.2 Functionality of funds

To be called functional, a fund must be growing and used effectively as intended. In four of six villages chosen for the qualitative study, it was obvious the funds were growing. In two of these villages there were some emergency referrals reported and use of the Development Fund was limited. The remaining two villages focused more on loan business because the need to use the Emergency Health Fund did not arise and the Development Fund was not sufficient to meet their felt need.

Overall it is encouraging to observe that the funds have been growing in more than half of the villages. In villages where the fund management committee was active, competent and got along well with the village authorities and community, success was the rule rather than the exception. The findings further reinforce the fact that the ability to mobilize and involve the community is an important ingredient for success. If the fund management was found to be incompetent, inactive and unable to mobilize the community, these fund mechanisms failed. Good will and proactivity on the part of all those involved is however not the sole determinant of growth. Socioeconomic difficulties also hampered the growth of the fund in some villages.

A demand side approach can thus improve access to quality maternal health services without financial burden in the right conditions. A more complete evidence base is needed by governments and development partners to identify these conditions (Ahmed and Morgan, 2011). Any approach that is to be developed for future interventions needs to take these facts into account.

7.3 Roles of partners

In addition to the village authorities and the community, health service providers, both government and volunteers, play an important part in making the health funds functional. In four villages where funds were found to be growing it was reported that service providers and community got along well. The community trusted and relied on them and had high regards for them too. They also expect health service providers, being respectable, to take more active roles and collaborate with fund management. They provided evidence that basic health staff (especially the midwife) and local health volunteers were supporting each other and collaborating, and that some cases could be managed successfully in the village. An effective demand side strategy will need to strengthen local service capacity (Ahmed and Khan, 2011). The community identified financial constraints as the most important barrier for accessing health services, followed

by barriers to transport. Strengthening the local primary health-care network and bringing essential and basic services closer to the community may to some extent remove other non-financial barriers and improve service utilization (WHO, 2010).

These referral schemes can be regarded as a positive step forward in removing barriers and improving access to health service. Although the overall coverage may yet be limited it is expected that the strategy will be effective in supporting the development of potentially longer-term governance arrangements to support improved health access (MoH, WHO, 2012). A strategy with more community involvement can be a good starting point to infusing the spirit of self-determination and sense of solidarity. It is more important for development partners to see that their efforts are leading to positive developments than making community more dependent (UNICEF, 2012).



8. Recommendations

8.1 Capacity strengthening

The fund management indicated their satisfaction with the trainings that had been provided. At the same time they expressed their desire to have more training, particularly on the effective utilization of the funds and public communication. Since most of the funds are in circulation and only some amount is maintained as reserve, the task of book keeping and accounting is challenging. This is exacerbated by the introduction of additional development programmes, making accounting increasingly prone to errors. The fund management also required a basic and conceptual understanding of risk pooling and sharing, and there is need for solidarity if a more comprehensive community based health-financing strategy is to be introduced.



8.2 Scope of coverage and target

The Emergency Health Funds are limited to the emergency referral of mothers and children under five. This is understandable in the context of resource limitation and the elevated vulnerabilities and health needs of this target group. With the growth of the funds and because most of the health funds were unused as cases were found to be treatable within the village, fund managers can easily be tempted to have alternative uses for the funds. It may thus be appropriate to reconsider the scope of benefit and target covered. Additional financial requirements can be met by small and frequent contributions as agreed by the community.

8.3 Improving service provision

Setting up the Emergency Health Funds for referral may be a good approach to reduce barriers to accessing services. As difficulties in transport were reported as a barrier, strengthening local service provision will also bring services closer to the community. In places where volunteers are active, reliable, and trusted, the additional support of essential medicines along with refresher trainings as required will improve local service provision. This arrangement can also be an incentive for volunteers to work more effectively and with more confidence and enthusiasm. At the same time it is also important to see that this will not create rivalry and tension between local basic health staff and the volunteer.

8.4 Community empowerment

The involvement of development partners is highly effective in rehabilitating and helping the community. Taking into account the tendency of the community to become financially dependent and expect more help rather than trying to stand on their own, it is essential that development partners assume a catalytic role, with support oriented towards building an enabling environment to enhance sustainable community capacity. Close collaboration with governmental departments and authorities is also essential.

8.5 Generating more evidence relevant to local situation

The government and development partners need to have a more complete and locally relevant evidence base to identify the conditions under which demand side approaches improve access to quality maternal health services without financial burden. Different community health financing approaches by different agencies are in place in the Delta Region. Documenting and sharing of experiences will also be of much help in improving and expanding more effective interventions.

9. Conclusion

It is encouraging to observe that the village health funding mechanisms introduced in some 60 villages in Mawlamyinegyun Township is progressing in more than half of the villages. Competency, interest and ability of the Fund Management Committee to mobilize and form positive relationships with the community were found to be key ingredients for fund growth. The economic status of villages and predictability of the working environment also determine success. Fund growth does not however guarantee that health and development needs will be met. Additional technical support and flexibility in managing and utilizing the Emergency Health and Development Funds in particular will be essential to ensure fund growth is accompanied by effective utilization as intended.



Bibliography

Ahmed, S. and M. Chris

- 2011 Demand-side financing for maternal health-care: the current state of knowledge on design and impact. *Health Policy & Health Finance Knowledge Hub (The Nossal Institute for Global Health)*, Issue 1.

Ahmed, S. and M. Khan

- 2011 A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh? *Health Policy and Planning*, 26(1), pp.25–32.

Australian Government Department of Foreign Trade and Affairs

- 2011 Joint Initiative on Maternal, Newborn and Child Health (Myanmar)—Semi-annual Report (January–June 2011). Available at: <http://aid.dfat.gov.au/Publications/Pages/ji-mnch-semi-annual-rep-2011.aspx>.

International Organization for Migration (IOM)

- 2011 *Community Health-care Programme - Evaluation Report*, IOM Mawlamyinegyun.

SEARO Secretariat

- 2009 Description of the Action: Implementation and Management Arrangements. In *Post Nargis Recovery and Emergency Preparedness Plan*.

UNICEF & Ministry of National Planning and Economic Development

- 2012 *Situation Analysis of Children in Myanmar*, Available at: http://www.unicef.org/eapro/Myanmar_Situation_Analysis.pdf.

World Health Organization

- n.d. *The world health report - Health systems financing: the path to universal coverage*, Available at: <http://www.who.int/whr/2010/en/>.

World Health Organization & Ministry of Health

- 2012 *Health Financing Review - Myanmar*.

Annexes

Annex-A - Sampled Villages for qualitative research, by category

Sr.	Village	Category	Livelihood Programme
1.	Hmyarchaung	A - Fund exists and functioning	Exists
2.	Kyonlamu	A - Fund exists and functioning	Nil
3.	Thuhtaygone	B - Fund exists not functioning	Exists
4.	Kwinchaunggyi	B - Fund exists not functioning	Nil
5.	Kyonlatta	C - Fund no longer exists	Exists
6.	Swesone	C - Fund no longer exists	Nil

Annex-B - Respondents of KII and FGD, by village

Sr.	Village	Respondents	
		Key Informant Interview (KII)	Focus Group Discussion (FGD)
1.	Hmyarchaung	Health volunteer, female Health volunteer, female Former 100 Household leader, male Village elder, male	Loan borrower, female, 24 years Mother of U 5, 35 years-no health loan Mother of U 5, 23 years-no health loan Mother of U 5, 29 years-no health loan Mother of U 5, 25 years-no health loan Mother of U 5, 42 years-no health loan Loan borrower, female, 49 years Mother of U 5, 37 years-no health loan
2.	Kyonlamu	Accountant, male First leader, male Health volunteer, female 100 household leader, male	Loan borrower, male, 41 years Loan borrower, female, 22 years Loan borrower, female, 31 years Health loan beneficiary, female, 43 years Loan borrower, female, 31 years Loan borrower, female, 30 years Health and other loan, female, 44 years Loan borrower, female, 45 years Loan borrower, female, 38 years
3.	Thuhtaygone	100 household leader, male First leader, male Health volunteer, female Accountant, male	Loan borrower, male, 52 years Loan borrower, male, 36 years, Villager, female, 45 years Villager, female, 23 years Loan borrower, female, 34 years Loan borrower, female, 37 years Loan borrower, female, 31 years

Annex-B (Continued) - Respondents of KII and FGD, by village

Sr.	Village	Respondents	
		Key Informant Interview (KII)	Focus Group Discussion (FGD)
4.	Kwinchaunggyi	100 household leader, male Treasurer, female Accountant/health volunteer, female Leader, male	Loan borrower, male, 47 years Loan borrower, female, 33 years Health loan beneficiary, female, 27 years Mother of U5, female, 23 years Loan borrower, female, 27 years Loan borrower, female, 50 years Health loan beneficiary, female, 44 years Loan borrower, female, 44 years Villager, female 54 years
5.	Kyonlatta	Health volunteer, male Leader, Fishing group, female Health volunteer, female 100 household leader, male	Health loan beneficiary, female, 49 years Health loan beneficiary, female, 32 years Villager, female, 30 years Villager, female, 34 years Health loan beneficiary, female, 37 years Health and fund loan, female, 42 years Villager, female, 30 years Villager, female, 31 years Loan borrower, male, 51 years Health loan beneficiary, female, 29 years
6.	Swesone	100 household leader, male Accountant, female Leader, female	Loan borrower, female, 30 years Loan borrower, female, 32 years Health loan beneficiary, female, 24 years Health loan beneficiary, female, 23 years Loan borrower, female, 24 years Health loan beneficiary, female, 35 years Loan borrower, female, 24 years

Annex-C – Rapid Assessment Tool

Instrument for Data collection Assessing Village Health Grant Mawlamyainggyun Rapid Assessment Form

To interview Committee leader, Accountant or Treasurer

Date _____
 Village _____
 Village Tract _____
 Interviewer _____
 Interviewee _____
 Responsibility _____

1. Amount of fund received _____ kyats

2. Community contribution Yes/No

a. (proceed to 3 if answer is No)

b. Total contribution _____

c. Amount fixed/unfixed _____

3. How the fund is divided

a. Revolving _____

b. Emergency Health Fund _____

c. Development Fund _____

4. Is Fund Management committee present in village Yes/No

5. Number of committee members _____

6. Is the committee performing the following activities

a. Making revolving fund growing Yes/No

b. Monthly regular meeting Yes/No

c. Emergency referral Yes/No

d. Nutrition promotion Yes/No

7. How the revolving fund is made to grow

Annex-C (Continued) – Rapid Assessment Tool

Key Informant Interviews Guide

- Number of interviews
- One each for head of township health department and for health staff identified by the head of township health department
- At each of six villages-one each for one local authority, two members of fund management body one to three volunteers trained and deployed by development agency
- For the whole township there will be 32 interviews.

Interview Guide

- Note down-Time, date, place (village), name of respondent and interviewer
- Part 1-Introduction
- Introduce yourself
- Explain purpose of the interview
- Read out informed consent form
- Part 2-Questions

Theme 1 Experiences with the village health funds

- Please tell me what you know about how this village fund came into existence
- How were you involved, what roles are you playing?
- What is the mechanism for managing the fund
- What trainings did you and other members received
- Any further trainings and support provided
- What monitoring and supervision measures are in place, how implemented

Theme 2 Functioning status of the fund

- Please share with me your impression about current situation of the fund, like is it growing or else
- Why do you think so, what are the factors contributing
- What further improvement will be needed
- How can the fund be made growing, apart from earning interest from loans
- What measures are in place to ensure loans are returned
- What other measures need to be introduced to ensure loans are returned

Annex-C (Continued) – Rapid Assessment Tool

Theme 3 Use of the funds

- What else can the funds be used apart from providing loans
- How people in the village are benefited apart from getting loans
- What is your opinion on the fund being used as intended, for example-for emergency referral, for constructing schools, roads, etc

Theme 4 Mutual aids, social networks and reciprocal effects with fund arrangement

- Before setting up the fund are there any local arrangements for helping those facing financial hardships relating to illness and deaths
- Are there any social group upon which to rely on when in financial needs
- Please tell me your view on the advantages and weaknesses comparing the fund mechanism and traditional practices mentioned
- How do they affect each other

Theme 5 Relationship with health service providers

- How can service providers be benefited from the fund arrangement
- How can they be involved
- What improvement can they make for the fund to work better

Focus Group Discussions Guide

- Number of discussions-one in each village six in total
- Total number 7-9
- Group composed of mothers of under-5 year old child including those who had been benefited and those who had not. Make sure mothers are selected from different parts of village. Also include loan takers whether male or female

Discussion Guide

- Note down-Time, date, place (village), name of respondent and interviewer
- Seating arrangement-U shape with moderator facing all mothers
- Part 1-introduction
- Introduce yourself
- Explain purpose of the interview
- Read out informed consent form
- Part 2-Questions

Theme 1 Service utilizing patterns

- During last episode of illness of your child where did you go and from whom did you seek health-care
- What are the reasons
- Where did you deliver your youngest child and with whom
- What are the reasons
- What are usual health seeking practices of mothers

Theme 2 Barriers to health-care and fund assistance

- What are the factors (list) preventing you from seeking health-care from government facilities
- What do you think which is the most important one
- What support did you get from village health funds and how
- Before the existence of village health fund from where did you seek support
- What more do you think the village fund should provide

Theme 3 Responsibilities of those taking loans

- Please tell me what do you think an important responsibility of a loan taker?
- Why do you think so?
- How does this responsibility affect the status of the fund (saving)?
- What measures can be taken to ensure loan taker knows that responsibility and follow?

Theme 4 Mutual aids, social networks and reciprocal effects with fund arrangement

- Before setting up the fund are there any local arrangements for helping those facing financial hardships relating to illness and deaths
- Are there any social group upon which to rely on when in financial needs
- Please tell me your view on the advantages and weaknesses comparing the fund mechanism and traditional practices mentioned
- How do they affect each other

Theme 5 Relationship with health service providers

- How can service providers be benefited from the fund arrangement
- How can they be involved
- What improvement can they make for the fund work better

Annex-D – Consent form

Informed Consent for participating in evaluating village health fund mechanisms

Mawlamyinegyun Township

Introduction

The followings are the information provided to you as a participant of the evaluation. You can freely seek any clarifications at any time.

Objective

The objective of this study is to assess the status, strength and weakness encountered in implementing village health fund.

Confidentiality

The information provided will be kept secret and will be utilized for the study only. Your name will not be disclosed and you can provide the information freely.

Benefits

Participating in the study may not bring immediate benefits to you. However based on the findings of the study, measures for improving village fund mechanisms and can be identified and this will be beneficial to you as a person residing in the village, in the long run.

Denial or discontinuation

Your participation is voluntary. You may not participate if not willing to do so. You can stop participating at any time. Denial or discontinuation will in no way affect your privileges to accessing health services

Date _____

Place _____

Signature of interviewer _____

Name of interviewer _____

Annex-E - Growth of Revolving Fund, by village (highest and lowest per centage changes per time interval are marked in green and red respectively)

Sr.	Village	Fund total			Growth (Seed - Dec 2010)		Growth Dec 2010 - June 2012)		Growth (Seed – June 2012)	
		Initial (Seed)	Dec-10	Jun-12	Numeric	%	Numeric	%	Numeric	%
1	Thankanauk	627,850	643,510	1,700,000	15,660	2.5	1,056,490	164.2	1,072,150	170.8
2	Thaungphone	706,000	728,040	918,080	22,040	3.1	190,040	26.1	212,080	30.0
3	Kyunchaung	610,000	639,460	962,500	29,460	4.8	323,040	50.5	352,500	57.8
4	Kyonlamugyi@	421,500	288,280	600,000	-133,220	-31.6	311,720	108.1	178,500	42.4
5	Thuhtaygone#	586,000	606,180	900,000	20,180	3.4	293,820	48.5	314,000	53.6
6	Aunghlaing	277,500	322,680	480,000	45,180	16.3	157,320	48.8	202,500	73.0
7	Kanasogyi	327,000	389,400	600,000	62,400	19.1	210,600	54.1	273,000	83.5
8	Tasaychaung	553,000	574,900	400,000	21,900	4.0	-174,900	-30.4	-153,000	-27.7
9	Gawtu	316,000	389,280	403,080	73,280	23.2	13,800	3.6	87,080	27.6
10	Merlein	330,000	387,600	499,120	57,600	17.5	111,520	28.8	169,120	51.3
11	Aunghthukha	520,000	538,480	1,700,000	18,480	3.6	1,161,520	215.7	1,180,000	226.9
12	Seinpan	658,000	684,600	3,800,000	26,600	4.0	3,115,400	455.1	3,142,000	477.5
13	Awachaung	676,000	699,040	2,105,160	23,040	3.4	1,406,120	201.2	1,429,160	211.4
14	Thuyechaung	891,600	936,720	2,184,400	45,120	5.1	1,247,680	133.2	1,292,800	145.0
15	Thonekhwa-chunkyawnu	493,000	587,476	1,124,400	94,476	19.2	536,924	91.4	631,400	128.1
16	Mezaliasesu	480,500	593,480	1,328,020	112,980	23.5	734,540	123.8	847,520	176.4
17	Mezalikyawnu	316,000	375,592	718,800	59,592	18.9	343,208	91.4	402,800	127.5
18	Mabay	348,000	398,400	175,000	50,400	14.5	-223,400	-56.1	-173,000	-49.7
19	Hmyarchaung@	413,000	574,670	570,000	161,670	39.2	-4,670	-0.8	157,000	38.0
20	Ywalechaung	376,000	449,660	600,000	73,660	19.6	150,340	33.4	224,000	59.6
21	Gonminchaung	282,000	341,500	500,000	59,500	21.1	158,500	46.4	218,000	77.3
22	Kwinchaung#	330,500	391,940	700,000	61,440	18.6	308,060	78.6	369,500	111.8
23	Kuntheechaung 1	363,000	723,666	3,000,000	360,666	99.4	2,276,334	314.6	2,637,000	726.5
24	Kuntheechaung 2	379,000	745,760	882,000	366,760	96.8	136,240	18.3	503,000	132.7
25	Kuntheechaung 3	384,000	419,760	4,100,000	35,760	9.3	3,680,240	876.8	3,716,000	967.7
26	Kuntheechaung-glax	765,000	543,032	1,200,000	-221,968	-29.0	656,968	121.0	435,000	56.9
27	Ngadantaya	680,000	710,960	3,000,000	30,960	4.6	2,289,040	322.0	2,320,000	341.2
28	Phonesoe	697,500	731,600	2,700,000	34,100	4.9	1,968,400	269.1	2,002,500	287.1
Total		13,807,950	15,415,666	37,850,560	1,607,716	11.6	22,434,894	145.5	24,042,610	174.1
Average		493,141	550,559	1,351,806	57,418	11.6	801,247	145.5	858,665	174.1

@=sampled village for qualitative survey, category A

= sampled village for qualitative survey, category B

\$ = sampled village for qualitative survey, category C

Annex-F - Growth of Emergency Health Fund, by village (highest and lowest per centage changes per time interval are marked in green and red respectively)

Sr.	Village	Fund total			Growth (Seed - Dec 2010)		Growth Dec 2010 - June 2012)		Growth (Seed - June 2012)	
		Initial (Seed)	Dec-10	Jun-12	Numeric	%	Numeric	%	Numeric	%
1	Thankanauk	110,000	122,145	300,000	12,145	11.0	177,855	145.6	190,000	172.7
2	Thaungphone	110,000	132,530	215,510	22,530	20.5	82,980	62.6	105,510	95.9
3	Kyunchaung	110,000	132,095	116,845	22,095	20.1	-15,250	-11.5	6,845	6.2
4	Kyonlamugyi@	110,000	124,010	250,000	14,010	12.7	125,990	101.6	140,000	127.3
5	Thuhtaygone#	110,000	125,135	364,355	15,135	13.8	239,220	191.2	254,355	231.2
6	Aunghlaing	40,000	143,885	400,000	103,885	259.7	256,115	178.0	360,000	900.0
7	Kanasogyi	40,000	150,130	120,000	110,130	275.3	-30,130	-20.1	80,000	200.0
8	Tasaychaung	110,000	130,025	320,000	20,025	18.2	189,975	146.1	210,000	190.9
9	Gawtu	40,000	130,025	243,785	90,025	225.1	113,760	87.5	203,785	509.5
10	Merlein	40,000	130,025	205,920	90,025	225.1	75,895	58.4	165,920	414.8
11	Aungthukha	110,000	128,940	300,000	18,940	17.2	171,060	132.7	190,000	172.7
12	Seinpan	110,000	119,950	639,130	9,950	9.0	519,180	432.8	529,130	481.0
13	Awachaung	110,000	128,880	630,320	18,880	17.2	501,440	389.1	520,320	473.0
14	Thuyechaung	110,000	144,240	534,230	34,240	31.1	389,990	270.4	424,230	385.7
15	Thonekhwachunk-yawnu	40,000	180,857	157,069	140,857	352.1	-23,788	-13.2	117,069	292.7
16	Mezaliashesu	40,000	172,010	243,476	132,010	330.0	71,466	41.5	203,476	508.7
17	Mezalikyawnu	40,000	154,694	285,800	114,694	286.7	131,106	84.8	245,800	614.5
18	Mabay	40,000	157,050	56,000	117,050	292.6	-101,050	-64.3	16,000	40.0
19	Hmyarchaung@	110,000	180,257	310,000	70,257	63.9	129,743	72.0	200,000	181.8
20	Ywalechaung	110,000	167,493	100,000	57,493	52.3	-67,493	-40.3	-10,000	-9.1
21	Gonminchaung	40,000	147,125	190,000	107,125	267.8	42,875	29.1	150,000	375.0
22	Kwinchaung#	110,000	156,680	300,000	46,680	42.4	143,320	91.5	190,000	172.7
23	Kuntheechaung 1	40,000	198,109	230,000	158,109	395.3	31,891	16.1	190,000	475.0
24	Kuntheechaung 2	40,000	198,921	542,000	158,921	397.3	343,079	172.5	502,000	1,255.0
25	Kuntheechaung 3	40,000	198,920	363,510	158,920	397.3	164,590	82.7	323,510	808.8
26	Kuntheechaunglay	110,000	75,184	400,000	-34,816	-31.7	324,816	432.0	290,000	263.6
27	Ngadantaya	110,000	133,220	270,000	23,220	21.1	136,780	102.7	160,000	145.5
28	Phonesoe	110,000	134,300	200,000	24,300	22.1	65,700	48.9	90,000	81.8
Total		2,240,000	4,096,835	8,287,950	1,856,835	82.9	4,191,115	102.3	6,047,950	270.0
Average		80,000	146,315	295,998	66,315	82.9	149,683	102.3	215,998	270.0

@=sampled village for qualitative survey, category A

= sampled village for qualitative survey, category B

§ = sampled village for qualitative survey, category C

Annex-G - Growth of Development Fund, by village (highest and lowest per centage changes per time interval are marked in green and red respectively)

Sr.	Village	Fund total			Growth (Seed - Dec 2010)		Growth Dec 2010 - June 2012)		Growth (Seed - June 2012)	
		Initial (Seed)	Dec-10	Jun-12	Numeric	%	Numeric	%	Numeric	%
1	Thankanauk	11,745	10,745	300,000	-1,000	-8.5	289,255	2,692.0	288,255	2,454.3
2	Thaungphone	17,980	22,530	154,310	4,550	25.3	131,780	584.9	136,330	758.2
3	Kyunchaung	22,025	22,095	116,845	70	0.3	94,750	428.8	94,820	430.5
4	Kyonlamugyi@	0	13,710	100,000	13,710	-	86,290	629.4	100,000	-
5	Thuhtaygone#	15,135	15,135	254,355	0	0.0	239,220	1,580.6	239,220	1,580.6
6	Aunghlaing	13,860	33,885	100,000	20,025	144.5	66,115	195.1	86,140	621.5
7	Kanasogyi	14,760	47,600	100,000	32,840	222.5	52,400	110.1	85,240	577.5
8	Tasaychaung	15,705	20,025	200,000	4,320	27.5	179,975	898.8	184,295	1,173.5
9	Gawtu	13,080	44,685	133,785	31,605	241.6	89,100	199.4	120,705	922.8
10	Merlein	13,320	44,880	105,860	31,560	236.9	60,980	135.9	92,540	694.7
11	Aungthukha	8,100	18,540	150,000	10,440	128.9	131,460	709.1	141,900	1,751.9
12	Seinpan	17,340	19,950	376,290	2,610	15.1	356,340	1,786.2	358,950	2,070.1
13	Thuyechaung	28,080	33,840	422,630	5,760	20.5	388,790	1,148.9	394,550	1,405.1
14	Thonekhwachunk-yawnu	32,310	70,857	196,578	38,547	119.3	125,721	177.4	164,268	508.4
15	Mezaliashesu	22,050	60,210	243,476	38,160	173.1	183,266	304.4	221,426	1,004.2
16	Mezaliyawnu	18,474	44,694	24,500	26,220	141.9	-20,194	-45.2	6,026	32.6
17	Hmyarchaung@	26,500	70,257	21,000	43,757	165.1	-49,257	-70.1	-5,500	-20.8
18	Kwinchaung#	16,785	46,680	300,000	29,895	178.1	253,320	542.7	283,215	1,687.3
19	Kuntheechaung 1	18,770	47,459	200,000	28,689	152.8	152,541	321.4	181,230	965.5
20	Kuntheechaung 2	19,071	38,820	24,000	19,749	103.6	-14,820	-38.2	4,929	25.8
21	Kuntheechaung 3	19,710	35,184	444,290	15,474	78.5	409,106	1,162.8	424,580	2,154.1
22	Kuntheechaunglay	0	35,184	400,000	35,184	-	364,816	1,036.9	400,000	-
23	Ngadantaya	19,845	23,220	200,000	3,375	17.0	176,780	761.3	180,155	907.8
Total		384,645	820,185	4,567,919	435,540	113.2	3,747,734	456.9	4,183,274	1,087.6
Average		16,724	35,660	198,605	18,936	113.2	162,945	456.9	181,881	1,087.5

@=sampled village for qualitative survey, category A

= sampled village for qualitative survey, category B

\$ = sampled village for qualitative survey, category C

Annex-H – Table of activities undertaken by villages

Sr.	Village	Category	Activities			
			Fund management	Meeting	Emergency referral	Nutrition
1.	ThanKanaut	A	Yes	Yes	Yes	No
2.	Thaungphone	A	Yes	Yes	Yes	No
3.	Myesangu	B	No	No	Yes	No
4.	Ngwethazin1	C	No	No	Yes	No
5.	Kyunchaung	A	No	Yes	No	No
6.	Kyungyar	A	Yes	Yes	No	No
7.	Yuzana1	C	No	No	No	No
8.	Yuzana2	B	No	No	No	No
9.	Kyonlamugyi@	A	Yes	Yes	Yes	No
10.	Thuhtaygone #	A	Yes	Yes	No	No
11.	Aunghlaing	A	Yes	Yes	Yes	No
12.	Kanasogyi	A	Yes	Yes	Yes	No
13.	Tasaychaung	A	Yes	Yes	No	No
14.	Gawtu	A	Yes	Yes	Yes	No
15.	Marlein	A	Yes	Yes	Yes	No
16.	Paungtachaung1	B	No	No	No	No
17.	Paungtachaung	C	No	No	No	No
18.	Kyetsnar	B	No	No	No	No
19.	Danichaung	B	No	No	No	No
20.	Aungthukha	B	No	No	No	No
21.	Tankauk	C	No	No	No	No
22.	Seinpan	A	Yes	Yes	Yes	No
23.	Shaukchaung	C	No	No	No	No
24.	Sarphyusu	C	No	No	No	No
25.	Awachaung	A	Yes	Yes	Yes	No
26.	Kyonlata\$	C	No	No	No	No
27.	Bandoola	C	No	No	No	No
28.	Swesone \$	C	No	No	No	No
29.	Laykhwa	A	Yes	Yes	Yes	No
30.	Thuyechaung	A	Yes	Yes	Yes	No
31.	Htannynaung	C	No	No	No	No
32.	Mezalisitawthar	C	No	No	No	No
33.	Kunchangone	C	No	No	No	No
34.	Sakhanchaung	C	No	No	No	No
35.	Thonekhwachun	C	No	No	No	No
36.	ThonekhwachunKyawnu	A	Yes	Yes	Yes	No
37.	MeZaLi-Ashesu	A	Yes	Yes	Yes	No
38.	MeZaLi-Ywama	C	No	No	No	No
39.	MeZaLi-Kyawnu	A	Yes	Yes	Yes	No
40.	Kangone	C	No	No	No	No
41.	Ywathanyunt1	C	No	No	No	No
42.	Ywathanyunt2	C	No	No	No	No
43.	Mabay	A	Yes	Yes	Yes	Yes
44.	Shaukchaung	C	No	No	No	No
45.	Saikpyochin	A	Yes	Yes	Yes	Yes
46.	Lamutapin	C	No	No	No	No
47.	Hmyarchaung@	A	Yes	Yes	Yes	Yes
48.	Ywalechaung	A	Yes	Yes	Yes	Yes
49.	Gonminchaung	A	Yes	Yes	Yes	No
50.	Kwinchaung #	A	Yes	Yes	Yes	Yes
51.	Kuntheechaung1	A	Yes	Yes	No	No
52.	Kuntheechaung2	A	No	No	No	Yes
53.	Kuntheechaung3	A	Yes	Yes	Yes	No
54.	Kuntheechaunglay	A	Yes	Yes	No	No
55.	Aungthukha	A	Yes	Yes	Yes	No
56.	Ngadantaya	A	Yes	Yes	Yes	Yes

@=sampled village for qualitative survey, category A (Fund exists and functioning)

= sampled village for qualitative survey, category B (Fund exists but not functioning)

\$ = sampled village for qualitative survey, category C (Fund no longer exists)

Annex-I - Referral activities undertaken, by village

Sr.	Village	Category	Referral						
			2010	2011	2012	2010		2011	
						Child	Mother	Child	Mother
1.	ThanKanaut	A	Y	Y	N	0	0	1	0
2.	Thaungphone	A	Y	Y	Y	4	0	5	0
3.	Myesangu	B	Y	Y	N	0	0	0	1
4.	Ngwethazin1	C	Y	Y	N	0	0	10	0
5.	Kyunchaung	A	N	Y	Y	0	2	0	1
6.	Kyungyar	A	N	N	N	0	0	0	0
7.	Yuzana1	C	N	Y	Y	2	0	4	0
8.	Yuzana2	B	N	Y	Y	6	0	5	0
9.	Kyonlamugyi	A	Y	Y	Y	4	0	1	3
10.	Thuhtaygone	A	N	N	N	0	0	0	0
11.	Aunghlaing	A	Y	N	N	0	0	0	0
12.	Kanasogyi	A	Y	Y	Y	2	0	1	0
13.	Tasaychaung	A	N	N	N	0	0	0	0
14.	Gawtu	A	Y	N	N	0	0	0	0
15.	Marlein	A	Y	N	N	0	0	0	0
16.	Paungtachaung	B	N	N	N	0	0	0	0
17.	Paungtachaung	C	N	N	N	0	0	0	0
18.	Kyetshar	B	Y	N	Y	1	2	0	0
19.	Danichaung	B	N	Y	Y	0	4	1	1
20.	Aungthukha	B	N	N	N	0	0	0	0
21.	Tankauk	C	N	N	Y	1	0	0	0
22.	Seinpan	A	Y	Y	Y	7	1	17	0
23.	Shaukchaung	C	N	N	Y	2	1	0	0
24.	Sarphyusu	C	N	N	Y	3	1	0	0
25.	Awachaung	A	Y	Y	Y	3	0	1	1
26.	Kyonlata	C	N	Y	Y	1	1	1	1
27.	Bandoola	C	N	Y	Y	3	0	3	0
28.	Swesone	C	N	N	Y	4	1	0	0
29.	Laykhwa	A	Y	Y	Y	7	4	5	1
30.	Thuyechaung	A	Y	Y	Y	1	0	1	1
31.	Htannynaung	C	N	Y	N	3	0	0	0
32.	Mezalisitawthar	C	N	Y	N	4	0	0	0
33.	Kunchangone	C	N	Y	N	0	2	0	0
34.	Sakhanchaung	C	N	Y	N	0	2	0	0
35.	Thonekhwachun	C	N	Y	N	0	1	0	0
36.	ThonekhwachunKyawnu	A	Y	Y	Y	2	2	2	2
37.	MeZaLi-Ashesu	A	Y	N	Y	0	0	0	1
38.	MeZaLi-Ywama	C	N	Y	N	0	1	0	0
39.	MeZaLi-Kyawnu	A	Y	Y	Y	2	3	4	3
40.	Kangone	C	N	Y	N	1	1	0	0
41.	Ywathanyunt1	C	N	Y	N	0	3	0	0
42.	Ywathanyunt2	C	N	N	N	0	0	0	0
43.	Mabay	A	Y	Y	Y	2	1	0	2
44.	Shaukchaung	C	N	Y	Y	4	3	2	1
45.	Saikpyochin	A	Y	Y	Y				
46.	Lamutapin	C	N	N	N	0	0	0	0
47.	Hmyarchaung	A	Y	Y	Y	4	1	0	2
48.	Ywalechaung	A	Y	Y	Y	10	10	5	0
49.	Gonminchaung	A	Y	N	Y	0	0	0	1
50.	Kwinchaung	A	Y	Y	Y	0	2	0	2
51.	Kuntheechaung1	A	N	N	N	0	0	0	0
52.	Kuntheechaung2	A	N	N	N	0	0	0	0
53.	Kuntheechaung3	A	Y	Y	Y	3	0	2	0
54.	Kuntheechaunglay	A	N	Y	N	0	1	0	0
55.	Aungthukha	A	Y	Y	Y	7	3	2	1
56.	Ngadantaya	A	Y	Y	Y	5	4	6	8

Annex-I (Continued) - Referral Activities undertaken, by village

Sr.	Village	Category	Referral						
			2010	2011	2012	2010		2011	
						Child	Mother	Child	Mother
57.	Phonesoe	A	Y	Y	Y	1	0	4	1
58.	Paganpon	B	N	Y	N	0	2	0	0
59.	Sinmawechaung	C	N	N	N	0	0	0	0
60.	Myitto	B	N	Y	Y	1	0	1	0

Category A = Fund exists and functioning

Category B = Fund exists but not functioning

Category C = Fund no longer exists



International Organization for Migration (IOM)