Mid-term review of Maternal and Child Health Voucher Scheme

Yedarshey Township , Nay Pyi Taw

Republic of Union of Myanmar

Ministry of Health, Myanmar
World Health Organization (WHO)
Health Intervention and Technology Assessment Program (HITAP)

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LIST OF CONTRIBUTORS

Team of Contributors
Ministry of Health, Myanmar
Dr. Nwe Ni Ohn
Dr. Wai Mar Mar Htun
Dr. Tin Thun Aung
Dr. Mya Lay Nwe

World Health Organization country office in Myanmar
Ms. Sangay Wangmo
Dr. Kyaw Htin
Dr. Yee Yee Cho
Dr. San Shway Wynn

Team of Evaluators
Health Intervention and Technology Assessment Program
Dr. Yot Teerawattananon
Dr. Sripen Tantivess
Miss Pitsaphun Werayingyong
Dr. Inthira Yamabhai
Miss Nattha Tritasavit
Miss Wantanee Kulpeng
Dr. Thant Htoo Aung
Mr. Songyot Pilasant

ABBREVIATION

ANC	=	Antenatal care
AMW	=	Auxiliary midwife
BHS	=	Basic health staff
DoH	=	Department of Health
EPI	=	Expanded programme on immunisation
FGD	=	Focus group discussion
GAVI	=	Global Alliance for Vaccines and Immunization
HEF	=	Hospital equity fund
HITAP	=	Health Intervention and Technology Assessment Program
HSS	=	Health System Strengthening programme
LHV	=	Lady health visitor
MCH	=	Maternal and child health
MCHVS	=	Maternal and Child Health Voucher Scheme
M&E	=	Monitoring and evaluation
MoH	=	Ministry of Health
MMK	=	Myanmar Kyats
MMR	=	Measles, Mumps, Rubella
MW	=	Midwife
NGO	=	Non-governmental organization
PNC	=	Postnatal care
RHC	=	Rural health centre
SBA	=	Skilled-birth attendant
TBA	=	Traditional birth attendant
UHC	=	Universal health coverage
VD	=	Voucher distributor
WHO	=	World Health Organization

Introduction

Chapter 1

CHAPTER 1 INTRODUCTION

1.1 Background of the health care system in Myanmar

The Republic of the Union of Myanmar is a developing country in Southeast Asia that has a mix of public and private health care systems. The Ministry of Health (MoH) is responsible for the provision of health care services and engages in collaboration with many development partners such as United Nations agencies, international and local non-governmental organizations (NGOs), and other government sectors. As one of the pioneering countries for primary health care (PHC), Myanmar established a system of rural health centres (RHC) in every administrative district beginning in 1964 [1]. With 70% of the total population residing in rural areas, it is crucial that adequate health services are provided to these regions. At the township level, primary health care has been provided at multiple levels: maternal and child care can be obtained from Maternal and Child centres (MCCs), urban areas are home to Urban Health Centres, and rural areas have RHCs and sub-centres.

The World Health Organization (WHO) has recommended antenatal care (ANC) as a basic health service that should be provided to pregnant women. However, providing ANC with skilled-birth attendants (SBAs) remains challenging due to numerous factors such as the availability of health providers; quality of service provided; distance to health facility; affordability of health service utilisation; and cultural and social factors. In recent years, the MoH has increased investment in the implementation of maternal and child health (MCH) as one of the government's top priorities in the National Health Plan. Many strategies and programmes for MCH delivery are planned and implemented under the guidance of a 5-year strategic Reproductive Health Plan. They include safe motherhood; family planning; adolescent reproductive health; essential new-born care; an expanded programme on immunisation (EPI); referral; and capacity development of basic health staff (BHS) including Health Assistants, Lady Health Visitors (LHVs), and Midwives (MWs) [2].Currently, it is estimated that the country meets only 36% of its target for the infant mortality rate (36 per 1,000 live births) and 62% for the maternal mortality rate (130 per 100,000 live births)[3]. In order to reduce maternal and neonatal mortality, MCH services must be improved in many ways. In particular, reducing maternal and child mortality still remains a major challenge in order to meet the health-related Millennium Development Goals (MDGs) 4 and 5.

In 2008, Myanmar proposed the development of a Health System Strengthening (HSS) programme to the Global Alliance for Vaccines and Immunization (GAVI) and thus received funding and support for its initiative. The HSS framework aimed to shore up three main gaps which were identified: service delivery, programme coordination, and human resources. Service delivery gaps were to be improved upon via the distribution of MCH, EPI, and Nutrition and Environmental Services to communities, particularly for hard-to-reach areas. Programme coordination would be strengthened by capacity building focusing on management and organization at the township level. This would include the development of the Coordinated Township Health Plan guidelines, conducting health financing research, and developing the community health initiative scheme. As for human resources management and development, the framework aimed at improving the distribution, skill, number, and mix of health workers, once again placing an emphasis on rural, hard-to-reach areas [4]. These service packages are to be provided by BHS in order to improve the accessibility of service to the people. In turn, these staffs are compensated with per-diems and transportation expenses for the whole year. As a result, this promoted the supply-side by improving financial incentives for BHS to increase accessibility of service.

According to the HSS proposal, a community health initiative scheme was recommended for implementation in a pilot township in order to enhance accessibility to hospital-based services for poor mothers and their children. The specified scheme – also known as the Maternal Child and Health Voucher Scheme (MCHVS) – aimed to synergise with the Hospital Equity Fund (HEF) by covering medical allowances for emergency transport and life-saving procedures at the township level. However, in terms of scaling up, there is a requirement in financing under the GAVI HSS especially on the demand side. Thus, the Health Intervention and Technology Assessment Program (HITAP), the research arm of Thailand's Ministry of Public Health, was requested to provide technical support for the financing component as well as to conduct a feasibility study to design a program which would introduce attractive demand-side financing initiatives to be implemented by the MoH, Myanmar. A team of HITAP researchers travelled to Myanmar three times between 2010 and 2011 to conduct the feasibility study of the community health initiative for MCH.

1.2 Feasibility study of the community health initiative for maternal and child health in Myanmar

During May 2010 to March 2011, a feasibility study of the community health initiative for MCH care was conducted in the Lewe, Yedarshey and Tatkone Townships by HITAP, the WHO and the MoH, Myanmar. The first study mission in May 2010 developed a protocol for the community health initiative which was technically and financially feasible, acceptable among stakeholders, and also relevant to the country context. The second mission was conducted in August 2010 to assess the budgetary requirements for the newly designed community health initiative. The last mission, conducted during March 2011, estimated the potential cost and health outcomes from the future implementation of the community health initiative and devised a system and mechanism for its monitoring and evaluation through the use of a decision analytics model.

The results from this study showed that the MCHVS was feasible and had a good chance of being implemented in Myanmar with the aim of increasing the service utilisation of ANC and delivery by SBAs, especially for poor households. Demand-side financing under the programme was also expected to eliminate any provider fees and other household expenses related to the use of MCH services. If pregnant women had the choice of using MCH vouchers at any health facility and there were enough incentives for providers to offer to voucher holders, it should promote the quality of MCH services and reduce both neonatal and maternal mortality [5].

After the study, the guidelines for the MCHVS were developed in collaboration by the MoH and HITAP and the responsibilities for further implementation of the scheme were transferred solely to the MoH. The guidelines consisted of four sections including: voucher distribution guidelines; financial management guidelines; communication guidelines; and monitoring and evaluation guidelines. Once the guidelines were approved, the MCHVS pilot programme was initiated in Yedarshey Township on 11 May 2013 after much preparation and advocacy.

1.3 Objectives of this study

Since the launch of the MCHVS programme in Yedarshey Township, the Health Planning Unit of the Department of Health (DoH) has been responsible for taking care of the implementation procedures directly from the central level and a National Finance Officer from the WHO has been working in the field to help facilitate and closely monitor the process. Six months after the programme's

commencement, the WHO and MoH have requested to see the current process being used according to the guidelines and the present utilisation status of the MCHVS. Thus, HITAP was once again invited to conduct a mid-term review by the WHO and the Health Planning Unit of the DoH from 21 – 23 January 2014 with the following objectives:

Objective 1: To assess the current process of the scheme implementation and whether it is in line with the guidelines. If not, what are the underlying reasons?
Objective 2: To assess the utility of the existing forms and reporting system and suggest practical changes if needed.
Objective 3: To assess the benefits and challenges faced by both beneficiaries and service providers in implementing the scheme.
Objective 4: To assess the supply-side capacity; provided the administrative procedures, reporting system, essential supplies (benefit package) and human resources involved in managing the scheme.
Objective 5: To assess the coverage and utility of the scheme.

Methodology

Chapter 2

CHAPTER 2 METHODOLOGY

A mix of quantitative and qualitative approaches was employed in this programme evaluation. Prior to a visit by HITAP to the MCHVS management unit in the MoH and pilot site in Yedarshey Township in Nay Pyi Taw from 21-23 January 2014, a set of materials was requested from the MoH and the WHO Country Office for preliminary analysis. The materials included comprised a self-administered questionnaire, self-evaluation form, and utilisation information questionnaire. Based on the responses of the materials, a set of focus group discussions (FSDs) and interview questions were created for use during fieldwork.

2.1 Conceptual Framework

In this evaluation, a framework dubbed the theory of change was built to obtain a better standing of the logical consequences of the MCHVS on MCH in Myanmar [6-8]. This theory of change (Figure 1) illustrates that if the MCHVS was promoted and implemented appropriately according to the guidelines (Objectives 1 and 2), its communications campaigns would raise the awareness and willingness of pregnant mothers and their relatives to receive MCH services offered by SBAs. At the same time, the subsidisation of service costs to the providers would reduce the financial burden of households in undertaking MCH services. In the same vein, the MCHVS offers additional resources to MWs based on their performance. This incentive offered to MWs will help improve service quality which would eventually enhance the use of services by pregnant women (Objective 5). Ultimately, the improvement of MCH service quality and the increased access to MCH provided by SBAs will simultaneously reduce maternal and infant morbidity and mortality (Objective 5). However, one of the significant assumptions that the theory of change is based on is that there is no problem for providers in terms of availability of safe delivery kits, essential medicines, vaccines, and maintenance of facilities. This assumption was taken because at the moment UNICEF procures free of charge the safe delivery kits, medicines, and vaccines for the MoH.

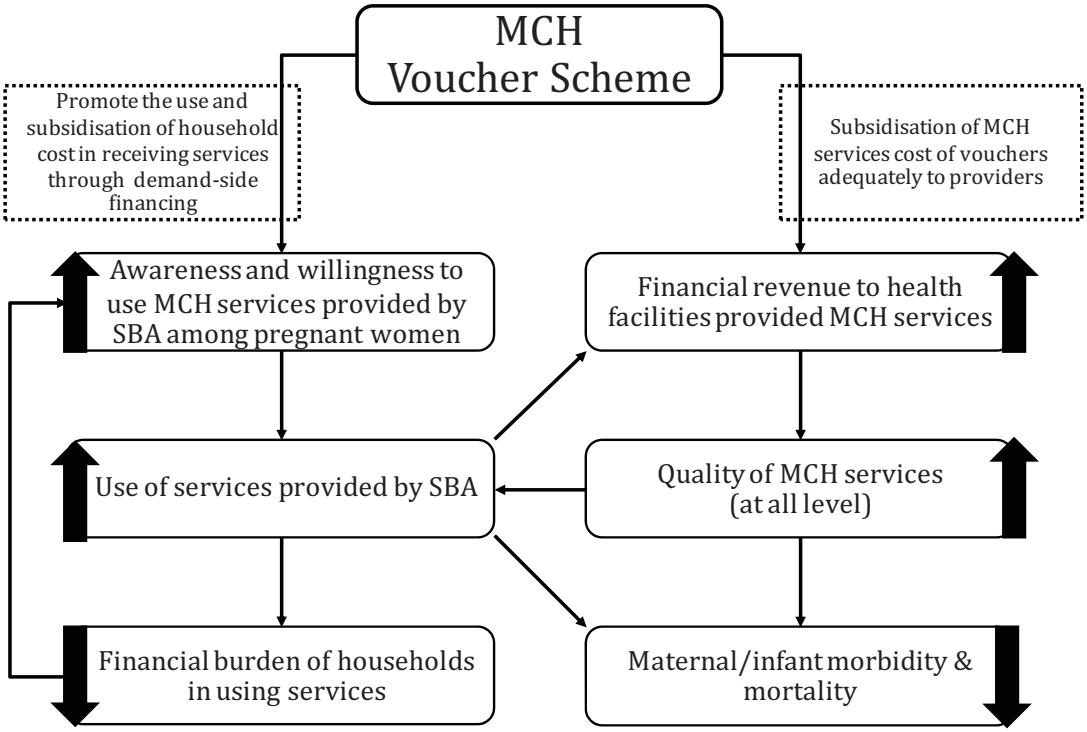


Figure 1 - Theory of Change for the MCHVS in Myanmar

Using this theory of change, the evaluation addresses the effectiveness of communications strategies including voucher distribution and awareness of the MCHVS among communities as well as the power of financial incentives provided to households and providers. However, although this evaluation does not focus on the quality of MCH services, maternal and infant morbidity and mortality will be used as a proxy.

2.2 Data Collection

2.2.1 Self-Administered Questionnaire

A self-administered questionnaire (Annex 1) was used to generate qualitative data on the first-hand experiences of the MoH staff regarding the performance of the MCHVS since 11 May 2013. This questionnaire was used to help determine whether the current implementation of the scheme is in line with the established guidelines as well as related impediments. The questionnaire was sent to two MoH officers and only one completed questionnaire was returned.

2.2.2 Self-Evaluation Form

A self-evaluation form (Annex 2) was designed to qualitatively assess the benefits, challenges, progress, and obstacles of the implementation of the scheme according to the perceptions of the MoH staff. The self-evaluation form was sent to three DoH staff within the MoH, and only one completed form was returned.

2.2.3 Utilisation Information Questionnaire

A dummy table (Annex 3) was created to collect secondary data on the administrative management of the scheme's implementation and this data was used to measure the coverage and utility of the scheme. The dummy table was sent to the manager located in Yedarshey responsible for monitoring and evaluating data recording as well as the management system. The targeted areas where information was collected included the MCH unit, station health unit, and RHCs and sub-centres.

2.2.4 Focus Group Discussions and Interviews

The FGDs, face-to-face interviews, and direct observations were conducted to collect qualitative data on the experiences of the voucher distributors (VDs), beneficiaries, and managers. The groups of key informants were determined by HITAP based on the objectives of the proposal and identified by the MoH based on the availability of participants.

The data collected was used to give an overall indication of the usefulness and challenges of the implementation of the scheme as well as give insight to specific objectives (see Table 1).

HITAP divided its team into two to carry out the FGDs and interviews at the site visits on 22 January 2014 with translators accompanying each team (see Table 2). The first team, which included four HITAP staff, one WHO staff, and 2 MoH staff, visited the township hospital between 9:30AM and 12PM and interviewed participants consisting of service providers from the Yedarshey Township hospital, the Aung Chan Thar RHC, and the MCH unit. Between 1PM and 3:30PM, the first team proceeded to visit the Amagyikhone RHC and conducted FGDs with three different groups of villagers: pregnant women and new mothers, village community leaders, and the general public.

The second team comprising three HITAP staff and two WHO staff visited the Swar Station Health Unit between 9AM and 10:50AM to interview a group of beneficiaries - pregnant women and new mothers - and a group of LHVs and MWs. In the afternoon, the second team visited the Tha Ga Ra sub-centre to interview the beneficiaries - seven new mothers, three pregnant women, and two relatives of the beneficiaries - between 1PM and 1:50PM; VDs - one traditional birth attendant (TBA), the president of the Myanmar Maternal and Child Welfare Association (MMCWA), and three auxiliary midwives (AMWs) - between 1:45PM and 2:35PM; and a MW between 3:15PM and 4:30PM.

On 23 January 2014, HITAP conducted face-to-face interviews with the management officer overseeing the scheme, three WHO staff, and four MoH staff. For the interviews, HITAP divided into three groups to conduct interviews with the respective interviewees between 10:30AM and 12PM. From 1:30PM until 3:15PM, the HITAP, WHO, and MoH staff began discussions on the findings of the mid-term review as well as future implications for the programme.

The ethical approval of this mid-term review was given by the MoH, Myanmar based on the mid-term review proposal that was submitted to the WHO and MoH.

2.3 Data Analysis

A content analysis was employed to describe the situation of the MCHVS and its context by using the data collected from the self-administered questionnaire, self-evaluation form, FGDs, and face-to-face interviews.

In order to tally the number of ANC registrations and vouchers distributed to each RHC and to pregnant women, descriptive statistics were used to illustrate the voucher distribution and its coverage by each RHC in Yedarshey Township from June to December 2013. The voucher coverage was calculated as a percentage by dividing the number of vouchers distributed to pregnant women over the total number of registered women in each RHC.

The T-test was used to assess the statistical significance in the changes between pre- and post-implementation of the MCHVS to determine whether there was an increase in access to MCH care owing to the MCHVS. The utilisation of each activity under the MCHVS - the 1st ANC, Delivery, PNC and 1st immunisation - were recorded five months before the programme's implementation and six months after.

For the outcomes assessment, this study chose to assess a number of outcomes with the variables listed as follows: the increase in the number of staff; maternal mortality rate; neonatal mortality rate; infant mortality rate; proportion of deliveries performed by SBAs; average ANC visits; and average immunisation uptakes. The odds ratio (OR), mean difference, and their 95% confidence interval (CI) were calculated to observe the significant change of the outcomes before and after programme implementation.

All data collected via the various methods were intentionally designed to overlap for quality assurance purposes. In particular, the FGDs, in-depth interviews, and field visits can be used to validate the findings from the documents, questionnaires, and forms.

Table 1 - Details of data collection approaches by objectives

Audience	Objective 1	Objective 2	Objective 3	Objective 4	Objective 5
MoH • Officers • Management agency officer	Self-administered questionnaire Interview	Review of MoH documents Interview	Self-evaluation form	Self-evaluation form Interview Utilisation information questionnaire	Utilisation information questionnaire
Township: • Medical officer • Doctors • Nurses	Interview	Interview	Focus group discussion	Focus group discussion	Utilisation information questionnaire
RHCs/Sub-centres • LHVs • MWs • Health assistants • Pregnant women	Focus group discussion Interview Direct observation	Focus group discussion Interview Review of MoH documents	Focus group discussion Interview	Focus group discussion Interview	Utilisation information questionnaire
Villages • Community leaders • Voucher distributors • Beneficiaries (Pregnant women, family members) • Villagers	Focus group discussion Direct observation	Review of MoH documents	Focus group discussion Interview	Focus group discussion Interview	Utilisation information questionnaire

Table 2 - Details of field visit data collection methods

Date	*Venue*	*Data collection method*	*Informants*	*Venue*	*Data collection method*	*Informants*
22/01/14	**Team 1**			**Team 2**		
	09:30-12:00			**09:00-10:50**		
	Township hospital	Focus group discussion	Township hospital: nurses, trained nurses, township health nurses, doctors Aung Chan Thar Rural Health Centre (RHC): health assistant, lady health visitor (LHV) MCH unit: MWs	Swar Station Health Unit	Focus group discussion	Group 1: pregnant women and new mothers Group 2: LHV, MWs
	13:00-15:30			**13:00-16:30**		
	Amagyikhone RHC	Focus group discussion	Group 1: pregnant women and new mothers Group 2: village community leaders Group 3: the general public	Tha Ga Ra Sub-centre	Focus group discussion, Interview	Group 1: pregnant women and new mothers Group 2: voucher distributors Group 3: MW

Results

Chapter 3

CHAPTER 3 RESULTS

3.1 Assessment of the current process of the scheme implementation; whether it is in line with the guidelines. If not, what are the underlying reasons?

The guidelines for the MCHVS in Myanmar comprised four major components which need to be carefully implemented. These criteria included: voucher distribution; financial management; voucher communications; and monitoring and evaluation.

3.1.1 Voucher Distribution

According to the guidelines, various groups of people in the community should be recruited as VDs to ensure that the vouchers reach pregnant women who are poor, live in hard-to-reach areas, and have never used services from SBAs before. The guidelines also suggested that the distributors should be well-trained so that they have a thorough understanding regarding the coding system; approaches to identifying eligible pregnant women; benefits package; reimbursement procedure; reporting system; incentive rates; and VD responsibilities.

The evaluation for the voucher distribution indicated that during the first six months, the MCHVS faced difficulties in recruiting and training non-MWs as VDs. In particular, it took a longer time to find and train those who were non-MWs than MWs and therefore resulted in training not being undertaken in time. As such, there may be reason to believe that the inadequacy of non-MWs as VDs might be a key impediment in distributing the vouchers to pregnant women in hard-to-reach area (see results in 3.5). However, six months after the scheme's implementation, voucher distribution was significantly improved as all of the distributors were fully-trained.

The guidelines also suggested that the eligible beneficiaries – poor pregnant women – should be identified by using the questionnaire developed by the hospital equity fund (HEF) programme. The HEF's exclusion criteria were relatively objective; these included, for example, possession of motorcycles or mobile phones, or having a family monthly income of over 30,000 MMK. The inclusion criteria comprised numerous criteria such as a maximum daily income of 1,000 MMK per household or those facing severe financial issues who would need to loan funds from other sources for travel and other basic necessities. Although these criteria were clearly defined, the significant differences in weighting made the identification process quite difficult on a practical level. For instance, the daily income of pregnant women household was assigned a score of 80 and borrowing money for food and travelling was assigned a score of 50 whereas other criteria were much less than these. The FGDs with the VDs found that despite the proper inclusion and exclusion of respective recipients so far – where the poorest pregnant women received vouchers while those in the richest group were screened out from the programme - the difficulty of identifying poor pregnant women still remained, signifying a grey zone where those eligible for the scheme were still somehow neglected.

The interviews with VDs and management agency officers also suggested that there might be a number of pregnant women who had difficulties covering the costs of ANC and delivery even though they did not fall within the inclusion criteria. Furthermore, the income threshold of 1,000 MMK was not as helpful as expected owing to seasonal fluctuations in household incomes for those in the agricultural sector. In such cases, the recruitment of beneficiaries solely relies on the personal judgment of the VDs. Some argued that the inclusion criteria where the daily income of

pregnant women households should be raised to as much as 1,500 MMK per day or should be amended by using other factors that accurately reflect the economic status of pregnant women and their families. However, the scores currently used in the criteria are considered as inappropriate scores and need to be adjusted.

In urban areas, the demand for the scheme increased continually and identifying the poor and non-poor was more difficult than their rural counterparts. One factor which contributed to the exacerbation of this problem was the stigma which people felt if they received vouchers as it unintentionally indicated the family's low economic status. The stigmatisation was prevalent even though the health personnel responsible for the communications campaigns put in tremendous effort to avoid this undesirable consequence. Therefore, this is another potential area for further study to ensure that the scheme targets the most impoverished and does not create conflict among people in communities due to the subjective judgment of the VDs.

As far as evaluations go, it seems that the voucher distribution followed the processes detailed in the guidelines especially for two major components: recruiting non-MWs to be VDs and training VDs. In addition, the interviews with representatives of the community support groups and village community leaders, and local authorities in the township revealed that these stakeholders were very supportive of the scheme and would be willing to help advocate the use and distribution of the vouchers; this could serve as an alternative way to help VDs obtain eligible beneficiaries. However, in the early stages of the scheme, these interviewees perceived that it would only run for a short period of time so they were reluctant to participate.

3.1.2 Financial Management

One aspect of an excellent programme is good financial management which is run systematically and comprehensively. In the guidelines, a number of reporting forms (see details about the forms in 3.2) was introduced as tools for financial management which aimed to improve efficiency in the implementation of the MCHVS. All of the forms served different purposes and the MWs, LHV, and management agency were responsible for completing and filing them. In addition to the forms, the guidelines also provided clear instructions on the submission process and were enhanced through the use of illustrations for ease of understanding.

Overall, the activities in the reimbursement and payment processes were undertaken in accordance with the guidelines as asserted by key informants in the MoH. However, it was found that the reporting forms were modified to make them suitable for non-computerised use. In an interview with the MWs, LHV, health assistant, and management agency officers, they argued that the modifications were necessary because the original format was designed for a computerised system which proved inadequate in real-world settings due to the lack of equipment and infrastructure. However, it should be noted that the MoH and WHO developed the system for future management purposes and once the system has been implemented, this should provide better ease of use and data retrievability.

While the difficulty of filing forms was not mentioned by the persons responsible for completing and filing them – the MWs, LHV, and health assistant - they pointed out that the work burden had significantly increased due to the reporting mechanisms for this scheme especially from completing the forms manually. Moreover, these administrative processes did not provide any additional benefits for them as the only benefit the staff obtained was the moral incentive of providing health care services to pregnant women. As such, the health assistants suggested that incentives should

also be offered to them in the same manner in order to boost morale. This was considered by health assistants as a benefit gained from the scheme and they should be incentivised in the same manner.

Therefore, one factor which may help manage the financial aspects of the scheme run more smoothly is the recruitment of a full-time management officer. In the future, the programme may be expanded onto a larger scale so it is crucial to have full-time staff for each township for proper management as indicated in the guidelines.

3.1.3 Voucher Communications

Communications is a good strategy for raising awareness of the scheme. An effective communications programme should be aimed at both providers and beneficiaries with the intention of creating a positive attitude and thorough understanding of the MCHVS for providers and raising understanding and demand for beneficiaries. In particular, the main message and media channels through which it is distributed are very important to its success. In the guidelines, the message about saving the lives of the mother and child and receiving financial incentives was recommended for use in the media and a variety of media were also suggested with a certain type used in different situations.

The evaluation found the various communication channels as suggested in the guidelines were created. These included posters, community loudspeakers, events, and accessories for VDs, such as umbrellas, t-shirts, waistcoats and bags. Such accessories were used as media, as they illustrated the scheme's title in the Myanmar language in order to maximize exposure to the target groups and other villagers. Additionally, FGDs revealed that print media, especially posters, were widely recognised by people in communities. The posters were normally seen at the RHCs but they were also hung in many places in villages such as markets, schools, and shops. However, community leaders and women in the village suggested that road junctions, village markets, and small snack shops would be more suitable venues for effective voucher communications to the target audience. In terms of effectiveness, the most used form of media was through personal communications between the VDs and pregnant women although using a loudspeaker was also another effective dissemination channel.

By employing the above-mentioned approaches, a significant number of people in the village could obtain information about the MCHVS. Officers in local authorities and senior villagers in many villages argued that 25% to 80% of women in the reproductive age group were aware of the scheme's introduction. Following the evaluators' observations, however, it was not clear whether the detailed messages about the scheme were disseminated to the pregnant women. More crucially though, the messages about the expected health outcomes of mothers and infants did not reach the communities and focused solely on the financial benefits provided. Observations also showed that most of the pregnant women in the villages joined the programme simply because the VDs recommended them to do so, and thus they sought out care from SBAs at the RHCs without any awareness of the health outcomes. In addition, most pregnant women perceived that once they had the vouchers, there would be no need to pay for anything as the scheme completely subsidised the costs of health services and travelling expenses of the beneficiaries to the health facilities. However, in reality, they still had to pay for the extra expenses not currently covered such as referral costs or extra medicines not included in the essential package.

Although some components indicated in the guidelines such as communication channels (songs or events) or main messages ("we can have a safe delivery for free" and "voucher saves lives of mother and child for free") was not mentioned or seen in this evaluation, most of the activities which

focussed on communicating the scheme to the people guidelines suggestions. Moreover, it found from the FGDs that men played an important role in the dissemination of information in the communities. Communicating and advocating the use of vouchers through men is another effective strategy because men are more likely to gather together than women.

3.1.4 Monitoring and Evaluation

Monitoring and evaluation (M&E) are crucial to following up on the activities and results of the programme. To develop an M&E system, the guidelines suggested that M&E should be linked to the objectives of the programme. The M&E should also be accountable to the funders or the persons responsible for making decisions about resource allocation. Generally, the three types of outcomes that can be measured are immediate outcomes, intermediate outcomes, and final outcomes. Immediate outcomes can measure changes in the awareness, attitude, and trust of an individual. Intermediate outcomes can provide information about the quality of services and the utilisation of the scheme as well as satisfaction. The final outcome is arguably the ultimate output determinant and can be split into two types: health - saving lives - and economic - saving costs; these represent the ultimate goal of the MCHVS. In the guidelines, high priority measures for monitoring and evaluating the outcomes of the scheme were outlined such as required data, source of information, and frequency of evaluation.

So far, the programme has provided good infrastructure and primary data collection to ensure meaningful M&E. Now, the MTR will offer a clear guideline not only for the MTR, but also afterward. In addition, the MoH and WHO have established a comprehensive system which includes a computer-based data collection system in order to provide ease of access to the accumulated data. However, it is not clear which type of data the computer-based system will be developed for.

3.2 Assessment of the utility of the existing forms and reporting system and suggest practical changes if needed.

The system report required persons involved in the MCHVS such as the VDs, health care providers, and administrative staff to complete a set of forms after providing any of the services under the scheme as these forms were designed to assist in the facilitation of financial management and M&E. According to the guidelines, seven forms were required to be completed by officers responsible for the task in the health facilities and management agency (administrative body). Three of the forms dealt with voucher distribution guidelines - voucher distribution 1 form (VD1), VD2 form, and VD3 form - while the other four pertained to financial management guidelines - reimbursement form for individual healthcare providers (P1 form), reimbursement form for health centres (P2 form), reimbursement approval form (M1 form), and disbursement summary form (M2 form).

Four out of the seven forms - VD2, P2, M1 and M2 - were modified to assist persons responsible for filling them out by increasing the ease of use. To comply with WHO financial regulation, two other forms - the acquittance roll for per diem/honorarium/salary/other fees (U1) and acquittance roll for travel allowance (U2) - were later developed to be used as evidence for payment. The nine forms were used not only to assess the performance of the financial management but also aimed to collect data necessary for the scheme's prospective health and economic impact M&E. In addition, the MoH used information from the forms reported by health facilities as a basis for future modifications and improvements to the scheme as well as to enhance its performance.

Every month, MWs had to fill a total of eight forms regarding health services and reimbursement which were subsequently sent to the management agency. In the interviews and FGDs, the MWs and LHVs pointed out that the forms were easy to understand and complete. However, owing to the notable volume of information required, it took approximately one hour per day to complete the forms. Moreover, they mentioned that most of the information such as in forms VD1 and VD3 were redundant. As a result, the MWs and LHVs thereby proposed the minimization and/or combination of these forms if it will not result in a decrease of the quality of services and the scheme's performance.

The utilisation information questionnaire which consisted of the utilisation of MCH services and budget in each type of health facility under the MCHVS was able to be completed within two weeks by the management agency even though they had to consolidate the hardcopies from all of the health facilities at the township level. It should be noted that although the combined form should reduce the workload of LHVs and MWs, it might actually increase the workload amount for the management agency since they would have to enter the data through a computerised system. While it was observed that the system might be limited in sub-centres and RHCs in terms of both budget and human resources, it should still be considered for client registration and reporting because it would prove more efficient in the long-run when the scheme begins to expand into other townships and eventually country-wide. Thus, it is important to build up the computer skills of health care workers not only for the MCHVS but also for the Universal Health Coverage (UHC) and other essential health services in the future.

3.3 To assess the benefits and challenges faced by both beneficiaries and service providers in implementing the scheme.

Based on the FGDs, the benefits and challenges faced by the scheme's beneficiaries and healthcare providers can be described as follows:

3.3.1 Benefits

Beneficiaries

For those who utilised the vouchers, they were very satisfied with the MCHVS since access to the services was free of charge as even food and transportation costs associated with their visits were also reimbursed. In terms of health benefits, some FGD participants knew that they could access essential laboratory tests at the health facilities such as HIV tests, venereal disease research laboratory (VDRL) tests, and urine tests. In the event that the tests revealed undesirable results including pregnancy complications, they may have subsequently been referred to the township hospital. Family members who joined the discussion thought that the scheme was very helpful in terms of financial burden. Before the scheme was launched, they were worried about MCH service accessibility as well as potential avenues of income in order to pay for the delivery. One case discussed by the FGD members revolved around a pregnant woman who had to loan money and could not repay the full amount of 20,000 MMK for the delivery cost. Instead, she repaid in instalments of between 1,500-2,000 MMK each time (or however much she had available) until the loan was settled Finally, while reimbursements take about a month after having received the service, the beneficiaries were fine with a one-month lag time.

Providers

The interviews with MWs indicated a significant jump in the utilisation of ANC and delivery services provided by SBAs, especially for MWs at the health facilities but the additional incurred workload was not significant at the township hospital. The increase in the provision of health services resulted in a rising surge of income at the health facilities and resulted in a much different situation prior to the scheme's introduction. Before the MCHVS was introduced, health facilities experienced cash shortages which resulted in health workers having to give their own money to ultra-poor clients.

Pregnant women, VDs, and MWs believed that ANC and delivery by AMWs and TBAs significantly decreased as only those who were not eligible for the vouchers continued to seek care from them. Key informants also argued, however, that this change in practice would not have a significant negative effect on their income because AMWs and TBAs did not earn much money by providing services to clients in the poorest group prior the MCHVS's launch. In fact, poor pregnant women sometimes paid AMWs and TBAs with agricultural products instead of cash. At the same time, AMWs and TBAs generally had more than one job or had an alternative major source of income compared to delivery service which earns very little money. It is expected that some eligible pregnant women who live in hard-to-reach areas where MCH services are unavailable will still use the services of AMWs and TBAs.

3.3.2 Challenges

Beneficiaries

There were some challenges regarding the inclusion criteria of the poor. With a system in place that identified key criteria which would determine eligible poor women, issues arose when said criteria proved to be too rigid. For instance, pregnant women whose families earned even slightly higher than the cut-off point of 30,000 MMK were excluded from the scheme. The pregnant women in the families of government officers such as policemen and soldiers who earned around 50,000 MMK per month were also not eligible even though they are considered poor. The participants of the FGDs suggested that the criteria should be more flexible in order to incorporate families that earn just above the cut-off point, thereby promoting a more inclusive scheme.

Another issue raised by the participants in the FGDs was about equitable access to the scheme. Given the difference in context or living standards of each area, the residents' purchasing power are also guaranteed be different. The key challenge here would be to include the differences in socio-economic characteristics into the selection criteria, with one such example involving the identification of townships that would need a different income threshold in order to promote eligibility for the scheme. At present, it is estimated that 30% of pregnant women are poor when comparing the number of vouchers distributed to the total number of pregnant women in the Yedarshey Township. However, this may not always be the case because some areas where the pilot study was not conducted may have a higher concentration of poor women. Therefore, the management team of the MCHVS should identify areas that should proportionately receive more vouchers to consider threshold differentiation.

The non-MW VDs who volunteered were allowed to hold on to only one voucher packet. Once the VDs passed the voucher to an eligible woman, they had to come back and pick up another one at their designated health facility. The interviewees disclosed that the VDs who lived a distance away from the health facilities and had to commute via a bicycle for 5 miles distributed the lowest

number of vouchers (five) since the programme's implementation. Thus, the challenge remains in developing a mechanism to help facilitate transportation and ease of voucher access for VDs, particularly for hard-to-reach areas.

Providers

Given the significant increase in the number of pregnant women receiving ANC and delivery by SBAs as well as the number of visits, the increased burden to MWs should not compromise the quality of the services provided. Otherwise, the ultimate goal of the scheme could not be achieved. As a result, quality standard measures should be implemented as a key indicator for the M&E of the program.

The increased burden for MWs is not only from the provision of services but also through providing information about the vouchers to their clients and completing the forms as suggested in the guidelines. The MWs needed support from the MCHVS for management tasks since there were several forms to complete in order to meet the protocol for reimbursement. Additionally, the coordination between the RHC and township hospital for referral cases were not concise and clear. The pregnant women were reluctant to go to the township hospital by themselves when referred because they were unsure whether the services were free. Some health workers at the township hospital were also unaware or did not understand the scheme. Therefore, the MWs had to eventually accompany the beneficiaries to the hospital.

Despite the increase in service utilisation, the MW informants maintained that they could cope with the incurred workload since their clients rarely visited at the same time. Although the present capacity of health facilities were able to cope with the current demand for MCH services, it would be worth considering to prepare for additional capacity at both the infrastructure and human resources levels when the MCHVS is implemented either on a larger scale or via extension to other townships.

Financial management on the supply-side proved to be one of the areas with very minor areas for improvement. One health facility suggested that the money should be kept at the RHCs with the MWs in advance, but others suggested that this would not be a feasible option. However, the rest of the health facilities visited were fine with the reimbursement lag time.

3.4 Assessment of the supply-side capacity; provided the administrative procedures, reporting system, essential supplies (benefits package) and human resources involved in managing the scheme.

This evaluation indicated that only a few additional SBAs were allocated to Yedarshey after the initiation of the scheme despite significant increased service burden to the RHC, station health units, and sub-centres. Based on our interviews with the MWs, the current capacity of the MWs had not yet reached the maximum limit. While the current workload of the MWs varied largely between 0-12 deliveries per month depending on areas, it was found that one MW could provide up to 20 deliveries per month with most of them currently providing an average of 3.5 deliveries per month. Therefore, the MWs would still be able to accommodate more demand provided that they are released from their other responsibilities such as attending meetings at the township and special vertical training programmes. If demand jumped, the programme manager would need to find alternative ways for MWs to coordinate closely with AMWs. For instance, the MWs should continue

to provide services for the first ANC, fourth ANC, and delivery but hand over the responsibilities for the second and third ANC, and postnatal care (PNC) to the AMWs.

Through the interviews with MWs and community leaders, it was found that there were problems in implementing the MCHVS in hard-to-reach areas primarily because there were not enough incentives for pregnant women to make the journey to RHCs or sub-centres. The only way to address this situation would be to build a sub-centre or RHC and provide additional MWs in those areas.

Since it would be plausible to anticipate an increase in demand for ANC and delivery by SBAs in the long-term and at the national scale given the significant economic growth in Myanmar, it is necessary to develop a long-term human resources plan for MWs and related health professionals in order to avoid workforce shortages. This should include a proper recruitment strategy from people who live in areas where there are inadequate MWs or high turnover rates.

At the same time, the WHO staff working on the strategic management and administration of the MCHVS have put in a significant amount of effort to ensure that the programme would run smoothly. The WHO recruited one full-time staff, Dr. Kyaw Htin, to work at the township level so that they could work on monitoring the progression of the scheme, coordinate all relevant staff/organisations at both central and local levels, and provide input for strategic programme management to the WHO and MoH. However, it will be interesting to observe whether the MoH can handle this administrative burden especially when the scheme is transferred from the WHO to the MoH in the long-run.

Although the government increased its health investment in recent years including increased support for essential drugs and safe delivery kits to health facilities, the RHCs in some communities in Yedarshey were running out of essential drugs for MCH services (e.g., misoprostol) and safe delivery kits. Given the increased demand for MCH services as a result of the demand-side financing, it is necessary the MoH ensures an adequate supply of these drugs and equipment with an increased rate of supply of at least 3-5% per month until the maximum coverage of all pregnant women is reached.

3.5 Assessment of the coverage and utilisation of the scheme

A total of 1,346 vouchers were distributed to poor pregnant women in nine settings during June to October 2013 (Table 2). The voucher coverage in the catchment area of particular RHCs varied from 40% to 96%. The highest coverage was found in Mayokhone, the lowest-income area in Yedarshey Township. It was notable to see that Swar, which had the highest ranking among the nine settings in terms of economic status, recorded the highest number of vouchers distributed as well as a high amount of coverage. On the other hand, Hlae Pyawe Lay, the second poorest setting, was found to have the lowest number of vouchers distributed.

Table 2 - Voucher coverage from June to October 2013 by setting

Economic ranked (Richest to poorest)	Setting	No. of registrations	No. of vouchers distributed to the setting	No. of vouchers distributed to target pregnant women	% coverage
		(A)	(B)	(C)	(C/A)
1	Swar	340	310	248	73%
2	Yae Ne	411	230	163	40%
3	Myo Hla	297	210	181	61%
4	MCH	84	134	68	81%
5	Amagyikhone	258	243	217	84%
6	Aung Chan Thar	250	183	112	45%
7	Kyar Inn Kone	276	200	170	62%
8	Hlae Pyawe Lay	69	120	42	61%
9	Mayokhone	152	170	145	96%
Total		**2,135**	**1,800**	**1,346**	**63%**

Source: Management agency, 2014

After implementing the scheme for seven months (June to December 2013), almost 20 million MMK were reimbursed to households and providers equally as shown in Figure 2. Among the provider segment, it can be seen that services were slightly higher for home services (52%) compared with health facility services (48%).

Figure 2 - Total amount of money reimbursed to household and providers during June to December 2013 (MMK)
Source: Analysis from the utilisation information questionnaire developed by HITAP

Figure 3 shows that the number of pregnant women using MCH services increased over time with the exception of the first ANC. The first ANC increased during the first half of the year but declined during the second half despite the voucher scheme's implementation and its significant usage. Although the number of deliveries by SBAs increased over the year, it significantly increased after the implementation of the MCHVS (P<0.01). Similarly to delivery, PNC visits and immunisations also increased over time but the increase was not statistically significant. For immunisation, the data showed irregular increases in numbers during alternating months due to the immunisation schedule of some facilities.

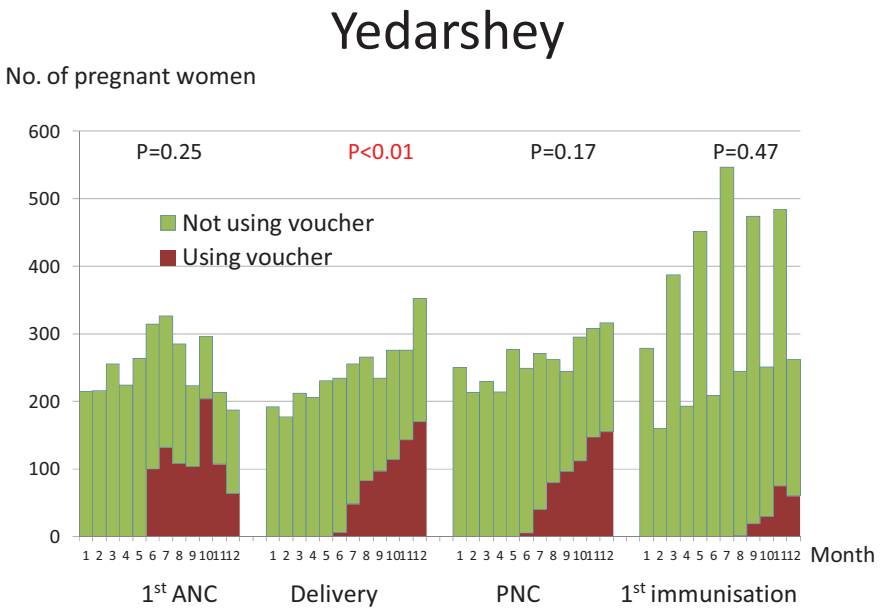
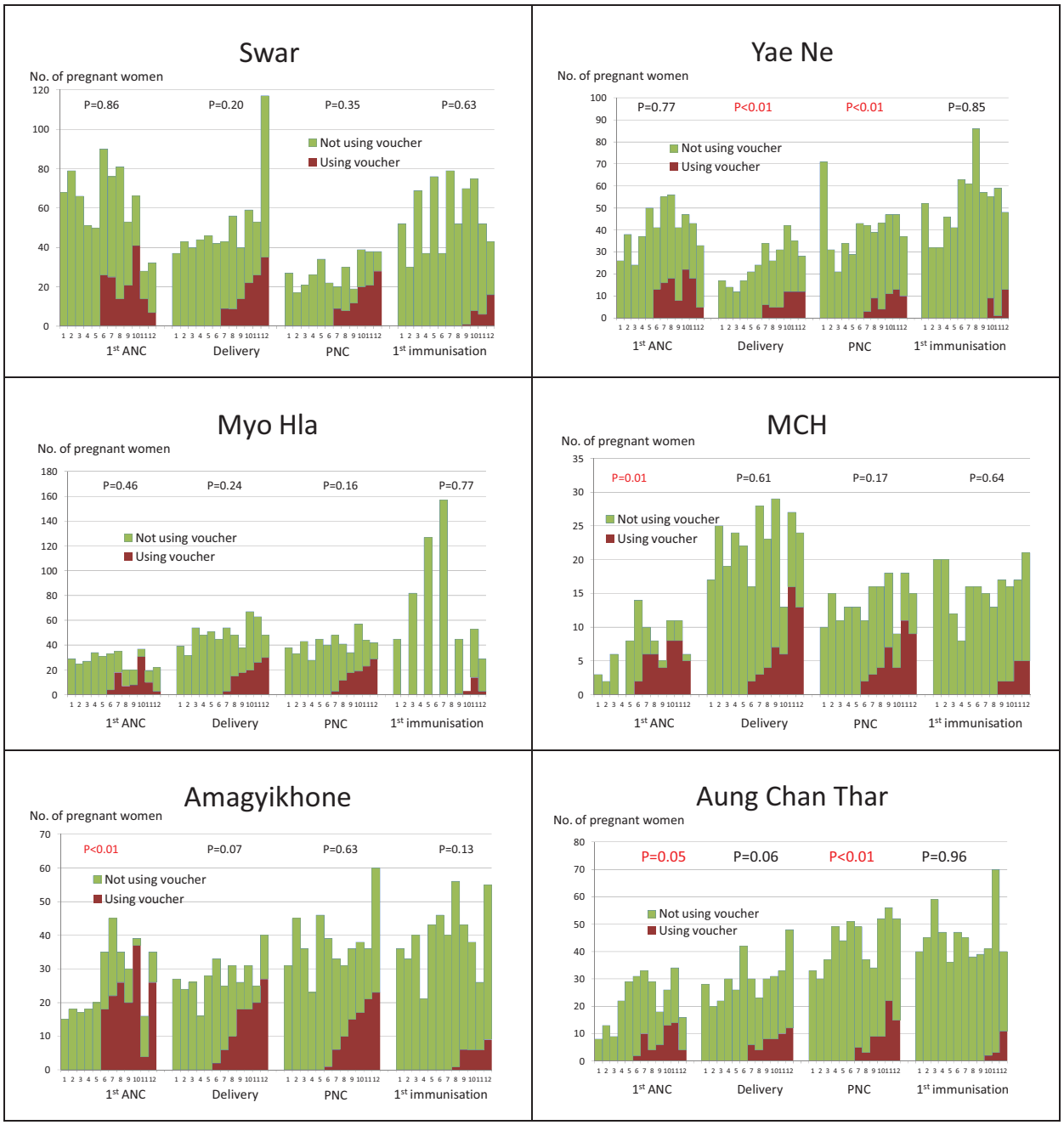


Figure 3 - Number of monthly clients by services in Yedarshey Township, pre- and post-implementation of the voucher scheme in January to May and June to December of 2013**.**
Source: Analysis from the utilisation information questionnaire developed by HITAP

Figure 4 was modified from Figure 3 to represent a sub-group analysis (the nine areas in Yedarshey). It can be seen that the MCHVS significantly increased the number of first ANC visits, deliveries by SBAs, and PNC visits in some areas. There were two areas, namely Swar and Myo Hla, where there were no significant increases in service after the implementation of the MCHVS. Based on the FGDs, this could be due to two reasons. The first is that the samples may not have been large enough to detect a significant increase in the use of MCH services provided by SBAs among pregnant women in this area because they already had a relatively high service utilisation. The second is that the VDs could not distribute the vouchers to those who did not receive services provided by SBAs without the voucher's incentives. On the other hand, the VDs could only provide vouchers to those who would have used MCH services provided by SBAs even without the voucher.

Aung Chan Thar and Yaene observed significant increases in ANC and PNC, and deliveries by SBAs and PNC, respectively. However, Aung Chan Thar also almost observed a significant increase in deliveries by SBAs. Although these two areas had low coverage of the MCHVS compared to other areas, it could be the case that the VDs were able to provide the vouchers to those who would not have come without the voucher's incentives. In the remaining five areas, there was at least one type of MCH service utilisation that increased significantly after the implementation of the scheme during the second half of the year.



Ministry of Health, World Health Organisation, Country Officer for Myanmar, Health Interventions and Technology Assessment Program, Thailand. Mid-term review of Maternal and Child Health Voucher Scheme. Yangon, 2014

Figure 4 – A comparison of the number of clients across nine health facilities, pre- and post-implementing of the voucher scheme.
Source: Analysis from the utilisation information questionnaire developed by HITAP

The figure above shows that there were variations in terms of access to and utilisation of MCH services among poor pregnant women across the nine areas. Some areas had a low number of voucher utilisations and it was determined from the FGDs that the differences may have arose from at least three reasons: 1) VDs (especially those who are SBAs) were unable to give vouchers to eligible pregnant women especially those who had never visited health facilities (those currently using ANC and delivery services provided by non-SBAs); 2) beneficiaries were not better off when using vouchers because they had to absorb higher costs by paying for commutes to the health facility or loss from a higher opportunity cost such as absence from work; and 3) providers preferred to provide services at health facilities because of the increased workload after the introduction of the voucher, thereby reducing the amount of time available to travel to patients' homes in order to provide services in the community. In addition, the FGDs revealed that providers selected to use the fourth ANC voucher instead of the first for some pregnant women who came for the first ANC late in their pregnancy because the fourth voucher provided the most incentives among all of the ANC vouchers. Therefore, there may be problems counting the first and fourth ANC visits in the database.

Table 3 illustrates the MCH service utilisation and related health outcomes before and after the implementation of the scheme in January to May and June to December of 2013, respectively. During this period, only one additional SBA was allocated to the pilot site while the original number of MCH staff remained the same. Deliveries performed by SBAs increased 1.6 times compared with the scheme's pre-implementation period. The MCHVS also contributed to an increase in average ANC as well as immunisation visits. Moreover, the increased utilisation of MCH services resulted in the reduction of neonatal and infant mortality by 52% and 8%, respectively. However, this reduction was not yet statistically significant because the rates were not different between the pre- and post-implementation of the scheme. Given that the maternal mortality rate was very low, the current sample size may have been too small to detect such a difference and it is possible that the difference can become significant in the later stages.

Table 3 - Comparison outcomes between pre-and post-implementation of the voucher scheme

Items	Pre-implementation	Post-implementation	Comparison of the difference (Post vs Pre)
Average ANC visits	1.81	2.37	Mean diff=0.56
			95%CI=0.13 to 0.99*
Average immunisation obtained per infant	2.45	2.99	Mean diff=0.54
			95%CI=-1.11 to 2.20
Maternal death rate	0.03%	0.04%	OR=1.29,
			95%CI=0 to inf.
Neonatal death rate	0.92%	0.44%	OR=0.48,
			95%CI=0.20 to 1.15
Infant death rate	1.18%	1.09%	OR=0.92,
			95%CI=0.49 to 1.79
Proportion of deliveries performed by SBAs	67%	77%	OR=1.62,
			95%CI=1.40 to 1.80*

OR: Odds ratio, CI: confidence interval, *P<0.05
Source: Analysis from the utilisation information questionnaire developed by HITAP

Discussion and conclusion

Chapter 4

CHAPTER 4 DISCUSSION AND CONCLUSION

4.1 Discussion

The mid-term review offers a good opportunity for the MoH and WHO to review the progress of the MCHVS's implementation in Yedarshey through the lens of external experts from HITAP. This proved to be important as HITAP had been involved since the very beginning in the design and feasibility study of the scheme but not directly in its implementation. Although the mid-term review was conducted only eight months after implementation, significant progress is clearly notable. The review has shown that the scheme offers suitable incentives for poor pregnant women to undertake ANC and delivery by SBAs. However, in some particularly hard-to-reach areas without health facilities, the MCHVS has limited effect in attracting pregnant women from those regions to visit a health facility that is far away from their home as the financial benefits are insufficient. Therefore, extra effort may be needed to organise mobile units for ANC and home delivery for the hard-to-reach population in the short-run and build health facilities with adequate SBAs in those areas in the long-run. Since GAVI's HSS programme in Myanmar covers two activities to include infrastructure and human resources development, it would be optimal to attain better coordination between the MCHVS and GAVI's other HSS projects in Yedarshey.

In terms of voucher distribution, marketing the vouchers in communities by emphasizing the financial benefits of the scheme to eligible households is a very good strategy. This will help most of the pregnant women - as well as other community members - realise that the vouchers provide obvious benefits in monetary terms such as financial subsidisation for travel and accommodations for pregnant women and their relatives in seeking MCH care. However, advertising the vouchers solely on its monetary benefits would also mask the true benefit and ultimate goal of the MCHVS: the safety and health of both mother and child. As a result, the MCHVS should be introduced as a temporary programme to promote good delivery practices through ANC and deliveries by SBAs. Once people in the community start believing that ANC and SBA deliveries are beneficial practices with desirable health impacts and the government becomes fully supportive in fostering such practices, the norms, culture, and attitudes and beliefs of the community will eventually start to form. For the future sustainability of MCH services, it is necessary that the health benefits of having ANC and delivery by SBAs are highlighted in order to encourage pregnant women to use the services from SBAs regardless of the MCHVS.

Regarding the target population, the poorest among the poor were eligible for the benefits in this scheme. We found in the fieldwork that the recruitment process was a very difficult task for VDs. In this case, depending on the available budget, the criteria for selecting the target population should be relaxed in order to obtain more poor beneficiaries under the scheme. This will allow pregnant women who are not the poorest but face difficulties in paying for ANC and delivery by SBAs to participate in the voucher scheme. If the budget does not allow for an increase in coverage, the management team should identify and target the poorest areas where people are poorer than others and allocate more vouchers there. Additionally, the field visits found that selecting only the poorest also created unnecessary negative consequences such as stigmatisation in some areas for those receiving the vouchers since local authorities were in charge of deeming the beneficiaries as poor. In this case, increasing the amount of beneficiaries would be helpful in desensitising this issue.

At present, most of the VDs are composed of MWs, AMWs in some areas, and non-health professionals in only a few areas. It was necessary to include many groups in the community as VDs

to ensure that hard-to-reach groups are listed. Doing this would create many potential groups that could be trained to become capable distributors such as the local authorities; community health volunteers; shopkeepers; school teachers; and etc. However, it should be noted that distributors who are not MWs will not receive any incentives. While the fieldwork results found that non-MW VDs asked for incentive, this may cause unnecessary negative consequences such as distributors dispensing voucher packs in order to get money even if the recipients did not meet the eligibility criteria.

Although a significant increase in workload for MWs, especially on delivery, occurred due to the introduction of the scheme, most MWs were willing to accept the increased burden. This might be because of the financial incentives gained by the MWs in addition to the increased efficiency of the service delivery because most of the MCH services are now provided at the facility as opposed to being offered at home. However, one factor that might aggravate the issue of increased burden is the additional activities outside of the scheme such as a specialized vertical program training which would require time and effort. Therefore, the MoH needs to carefully consider the impacts of introducing new programmes in this township or it could consider recruiting additional MWs in the township in order to maintain the quality of MCH services.

The MoH and WHO performed well in the M&E of the scheme and thus resulted in the ability to track key indicators (see tables 2 and 3) in order to assess performance and achievement of the scheme at the sub-township level as shown in the previous chapter. It is recommended that the MOH and WHO consider using the process and outcome indicators developed from this mid-term review coupled with other relevant benchmarks for the M&E of the scheme's progression at the sub-township level on an explicit and regular basis. Nevertheless, a computerised system should first and foremost be established as most of the management and M&E are still being run manually prior to scaling up the programme on a nationwide level. As a result, all of the forms necessary for reporting will need to be modified into individualised forms instead of aggregate ones. Furthermore, in the M&E, the non-health benefits of the voucher scheme such as financial protection and poverty reduction should be taken into account as outcomes of the scheme since they are also widely recognized as one of the primary objectives of universal health coverage (UHC).

Considering that there is likely to be increased demand for MCH services provided by SBAs in the future, the MoH should start considering a concrete plan for increasing the production capacity of MWs and related health professionals in order to address upcoming demand. Based on international experiences, human resources development should go hand-in-hand with its health infrastructure plans to ensure sustainability.

4.2 Study limitations

There are some limitations in this mid-term review. First, although the theory of change was developed by HITAP and subsequently validated by the MoH and WHO staff who were managing the scheme, the mid-term evaluation did not address all of the aspects in the theory of change due to time and resource constraints. For example, the service quality enhanced by the scheme was not included in this evaluation. Meanwhile, supply-side capacity (Objective 4) was not included in the theory of change but was instead later found to be affected by the scheme, and thus should be included in the theory of change for future evaluation.

Second, this is a practical evaluation which means that there was no township used as a control in order to capture the potential confounding factors. Therefore, the significant outcome of the

program, for example the increased average of ANC visits or the increased delivery by SBAs, may not have arisen only from the MCHVS, but may also have arisen from other program factors so the results should be interpreted with caution. It is recommended that in a further review, a control township should be used in the evaluation.

Second, even though maternal and infant mortality was included in the evaluation, the results are still uncertain because a longer time horizon is needed to observe such an effect. Essentially, eight months is too short of a time period to gauge whether the scheme has made a significant contribution in reducing maternal and infant mortality and morbidity.

Third, HITAP conducted field visits and interviews with relevant stakeholders according to the arrangement made by the MoH. The timing and distance did not allow us to visit and interview remote and hard-to-reach areas which may have had different experiences to the places that were visited. Therefore, the next evaluation should focus on addressing other areas, particularly the hard-to-reach places.

Fourth, it would be ideal to have a comprehensive evaluation that includes community surveys in order to interview every pregnant woman in Yedarshey township during the past eight months. This would be beneficial to learn from those who use and do not use the MCHVS and understand the reasons and limitations of the scheme. However, this would most likely be a very costly survey to carry out so the limitations of the scheme's coverage presented in table 2 of Chapter 3 should be kept in mind.

Finally, this mid-term evaluation did not include a value-for-money assessment of the MCHVS even though it is crucial and relevant for determining the future resource allocation of both the local government and international donors. Therefore, it is expected that an assessment of value-for-money will be included in a future evaluation of the scheme.

4.3 Policy recommendations to the MoH and WHO

Based on our findings, HITAP would like to propose the following recommendations to the MoH and WHO:

1. The scheme should include more non-MW VDs because it was found from the evaluation that MWs were less likely to identify poor pregnant women not currently using services provided by SBAs. This issue is crucial because the VDs determine the success of the scheme: the programme will be successful if they can identify the right target group - poor pregnant women who are unable to use MCH services provided by SBAs due to economic reasons - and will be less effective if the wrong group is identified regardless of the consequences of other activities under the MCHVS. However, the current design provides no incentives for non-MW VDs and this may not be sustainable in the intermediate and long-term. In trying to identify a balance between the risks and benefits of providing financial incentives to non-MW VDs, we recommend that non-financial incentives such as certificates, some kind of social recognition or health care benefits, should be provided to non-MW VDs as opposed to providing financial benefits.

2. The programme manager should disseminate clear messages to the public and pregnant women about the ultimate goal of the scheme - to improve MCH - as this is crucial for the sustainability of maternal child services in Myanmar. We believe that the financial incentives given in the voucher is just a means to an end and this can be eliminated in the future once the general

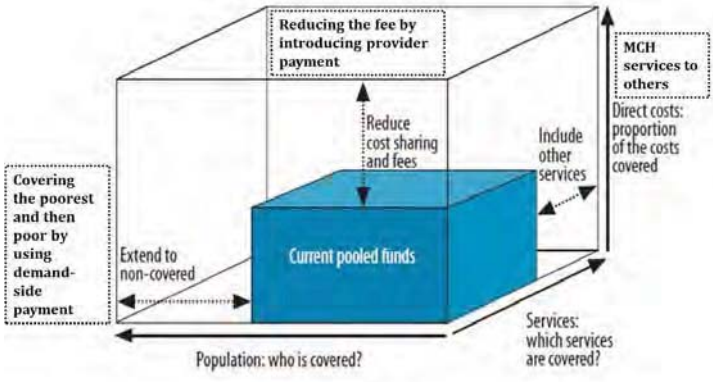
public has a clear understanding about the benefits of MCH services provided by SBAs. By then, the perceived benefits such as travel allowance would outweigh the actual costs and opportunity costs of pregnant women coming to the health facilities.

3. We should remind the beneficiaries that essential MCH services go beyond ANC, delivery, and PNC and also include proper immunisation and care for infants. Right now, the communications message remains purely financial but we should also provide facts about the benefits of the child in terms of immunisation and care. Currently, the vouchers include vaccinations for DPT (diphtheria, pertussis, and tetanus) and OPV (oral polio vaccine) vaccines but not the MMR (measles, mumps, and rubella) vaccine. It is possible that a future version of the voucher will cover MMR at 9 and 18 months old and send a strong message to the public that the two doses of MMR vaccine can save the lives and health of the younger generations. This will also increase the impact of the programme.

4. We need to start thinking about the long-term sustainability of the programme because it is important for convincing people to participate in the scheme. For example, local authorities and senior leaders hesitated to participate because they believed the programme would eventually be terminated. The MoH should make this scheme sustainable before thinking about scaling it up. This can be aided by proper evaluation of the programme and disseminating the results in order to convince local governments as well as overseas development aids to provide support. One potential organisation for aid is GAVI because the scheme has linked vaccine coverage and delivery. This is to ensure that long-term plans are made for the township and communicated to the villagers. Additionally, long-term human resources capacity, infrastructure, and a computerised system should be considered. For long-term planning, it is worthwhile to include a comprehensive evaluation.

5. Although the design of the MCHVS has been made with caution about the need for coordination across activities under GAVI HSS and other programs, MCHVS could be better coordinated with other HSS interventions especially at the local level. For example, the HEF can complement the referral to township hospitals through the voucher scheme and the link with the GAVI project on infrastructure creation should be strengthened, thereby insuring a synergistic effect. M&E should then be emphasized to assess the overall impact of the programme.

Figure 5 - Three dimensions to consider when moving towards universal health coverage



4.4 Final remarks

Overall, very good progress was found despite the shortage of time and limited resources and expertise. It seems that the programme is heading towards the right direction and will only need minor adjustments in order to take off. This is a very crucial step toward UHC because MCH services are recognized as a cost-effective intervention and all countries that have UHC cover MCH. Figure 5 illustrates the relationship between the strategies for UHC and the MCHVS. A universal approach for UHC consists of three elements: 1) extending coverage to non-covered; 2) reducing cost sharing and fees; and 3) including other services. The MCHVS is a good case study for those involved with UHC strategies in Myanmar because it is moving towards covering the non-covered. In other words, it initially beings with coverage of the poorest among the poor and subsequently expands towards covering the other poor as suggested in this report. Furthermore, the MCHVS aims to reduce cost sharing and fees by bestowing demand-side financing for providers and households. Although the MCHVS started with a focus on ANC, delivery, and PNC, it is expanding to cover more vaccinations. As the evaluator of the programme, HITAP strongly supports additional investment for the scheme in Yedarshey and advocate for its continuation as well as scaling up if opportunities are presented.

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Annex 1

Self-administered questionnaire for Ministry of Health (MoH) officers

Introduction/Background: (on the Voucher Scheme and this survey)
A pilot study of the MCH Voucher Scheme and Health Equity Fund (HEF) has been implemented in a selected pilot township (Yedashay) with the aim of getting rid of the financial barriers. These barriers prevent pregnant women from accessing the MCH services of basic healthcare at the primary level through the MCH Voucher Scheme. Stakeholders including the MoH officers who are involved in the pilot study of the MCH Voucher Scheme and the HEF in Yedashay Township should have employed the Guidelines for the Maternal and Child Health (MCH)
Voucher Scheme in Myanmar for the implementation of the MCH Voucher Scheme.

The MCH Voucher Scheme has been piloted in Yedashay since June 2013. The mid-term audit will be conducted in order to review the current process and progress of MCH Voucher Scheme implementation and suggest appropriate recommendations and a way forward in January 2014. This self-administered questionnaire will be distributed to gather some important information regarding the performance of the MCH Voucher Scheme.

Objective
To assess the current processes of the scheme implementation against the established guidelines and related impediments.

Instruction
Please complete the form by ticking the appropriate box or filling in the blanks and table. You may consult your colleagues, if needed.

Respondent's information:
Affiliation:
Department ……..
Position: ……..
Major responsibility concerning the MCH Voucher Scheme: ……..

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1. Which of the following statements regarding the Guidelines for the Voucher Scheme are correct?

1.1 Respective staff have been informed about the Guidelines	1.2 Copies including electronic version of the Guidelines are available in your department	1.3 The Guidelines have been consulted by staff in your department
☐ Well informed ☐ Yes, but inadequate ☐ Never ☐ Don't know	☐ Yes, how many copies? …….. ☐ None ☐ Don't know	☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never ☐ Don't know

Do you have any comments/suggestions regarding the information on, and availability and usefulness of the Guidelines? ……..
……
……
……
……
……
……
……

2. Please describe the processes introduced by your department and provide the reasons if any of why these processes are not followed or modified

Tasks	**Processes as stated in the Guidelines**	**Processes introduced by your department**	**Why the Guidelines are not followed or modified?**
a. Voucher distribution	a1. The MoH established a management agency to be responsible for the introduction of the scheme.	☐ Yes ☐ No ☐ Don't know	…… …… …… …… …… …… …… ……
	a2. The MoH organizes training for staff in the management agency and voucher distributors.	☐ Yes ☐ No ☐ Don't know	…… …… …… …… …… …… …… ……
	a3. Under this scheme, pregnant women whose family have motorcycle and/or mobile phone are not eligible for the benefits.	☐ Yes ☐ No ☐ Don't know	…… …… …… …… …… …… …… ……
b. Voucher communication	b1. The MoH distributed only poster and pamphlet as media to communicate with communities.	☐ Yes ☐ No ☐ Don't know	…… …… …… …… …… ……

Tasks	Processes as stated in the Guidelines	Processes introduced by your department	Why the Guidelines are not followed or modified?
			…… ……
	b2. The main messages "Voucher saves lives of mother and child for free" and "We can have safe delivery for free" were distributed to potential beneficiaries and people in communities.	☐ Yes ☐ No ☐ Don't know	…… …… …… …… …… …… ……
	b3. Auxiliary midwives and traditional birth attendants were included as targets of communication	☐ Yes ☐ No ☐ Don't know	…… …… …… …… …… …… ……
c. Monitoring and evaluation	c1. The MoH established the monitoring and evaluation system for this scheme.	☐ Yes ☐ No ☐ Don't know	…… …… …… …… …… …… ……
	c2. The MoH collected the data on health and economics outcomes.	☐ Yes ☐ No ☐ Don't know	…… …… …… …… …… …… ……
	c3. The MoH conducted an evaluation by using the data collected in c2.	☐ Yes ☐ No ☐ Don't know	…… …… …… …… …… …… ……

3. Does the MoH have a financial/reimbursement guideline for the Scheme? If yes, please give us some description.

……
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……
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……

4. Please fill in the reimbursement rate for the beneficiaries in the table below:

Type of health service	Reimbursement Rate (MMK)	
	Home service	Health facilities
1st ANC		
2nd ANC		
3rd ANC		
4th ANC		
Delivery		
PNC		
1st Vaccination for baby		
2nd Vaccination for baby		
3rd Vaccination for baby		

5. Who are responsible for providing (incentive) money to the pregnant women?

……
……

6. When will the pregnant women get the (incentive) money? How?

……
……

7. Do you have any comments/suggestions for improvement of the Scheme?

……
……
……
……
……
……
……
……
……

Thank you for your cooperation!

Annex 2

Mid-Term Review: MCH Voucher Scheme

This self-evaluation is an important part of the Mid-Term Review of the pilot of the MCH Voucher Scheme. It is an opportunity for you to tell us in writing how the MCH program works and what it is achieving. We are keen to read about the program's accomplishments and highlights. This questionnaire will be sent to MoH Officers responsible for implementing the Voucher Scheme and/or main users of the final mid-term review report.

Please answer all the questions or explain why you are not answering a particular question. Answer in whichever style you prefer – for example some points could be illustrated by vignettes. If possible, please be specific in your answers by informing us who does what by how and when. If answers overlap, feel free to reference previous answers.

Your responses will be seen only by members of the Mid-Term Review team. Some direct quotations may be used in the final report except in particular instances where you specify otherwise. Please return your self-evaluation by January 13th at the very latest. Delays may result in delays to writing the report. If you have any questions, please contact Inthira Yamabhai at inthira.y@hitap.net.

1. What do you want to see if this pilot program is fully implemented across the country?

2. What do you consider to be the major success(es) of pilot implementation and are these successes worthwhile for scaling up the scheme?

3. Do you feel responsible for the pilot program and/or nationwide implementation of the program as a whole?

4. Which parts of the pilot program have worked well and which have not? What lessons can you draw from this?

5. Have you observed any progress of the pilot program? Please give examples.

6. What accounts for any significant delays, if any, in producing outputs related to this program?

7. If you have more resources, what would you like to invest to improve the output?

   If you could start piloting this program again, what would you change? How would the milestones in the program differ?

Thank-you.

Annex 3

Instructions

This tool is originated for measuring utilisations and outcome of the Voucher Scheme in Myanmar. The tool comprises of 7 worksheets;

	Name	Description
1	Instructions	Provides overview and general instructions
2	MoH	Contains required information on reimbursement and human resource, is requested to be completed by the focal point of MoH.
3	Township	This form asks for information on human resource and maternal care service in Township Hospital as well as MCH clinic, is required to be filed by the focal point of Township Hospital.
4	RHC1	Consist of part I- human resource and part II- maternal care service, are required to have the focal point of 4 rural healthcare centres complete (a worksheet per each rural healthcare centre). Information from sub-health centres are needed to be obtained and reported along with rural healthcare centre.
5	RHC2	
6	RHC3	
7	RHC4	

Helpful Hint: Yellowed cells are needed to be completed. Make an entry (including "0" when appropriate) on cells requiring an amount to be reported. Use "NA" for not applicable.

If you need help or have questions for completing this form, please contact Ms.Wantanee Kulpeng (wantanee.k@hitap.net)

Thank you for your time and effort

MoH

No. of administrative staff of MoH who are serving the maternal care

Reimbursment

Facility ID	Facility name	Facility level i.e. 1) hospital, and 2) rural healthcare centre	Total amount of money reimbursed for providers as a result of the Voucher Scheme		Total budget reimbursement to households (transportation cost and per diem)
			At home	At the health facility	
1	Township Hospital	1			
2	Station Health Unit				
3					
4					
5					
6					

Township

Facility ID:	1
Facility name:	Township Hospital
Date of voucher scheme implementation:	
No. of voucher distributors:	
The mean gestational age at first antenatal care:	

Section I : Human resource

No. of staff who are involved with the maternal care: ANC, delivery and PNC						No. of administrative staff who are serving the maternal care
One month before the voucher implementation			Current			
Physicians	Nurses	Skilled birth attendants (midwives and lady health visitors)	Physicians	Nurses	Skilled birth attendants (midwives and lady health visitors)	

Section II : Maternal care

Part I: Antenatal care

Month	Monthly incidence of pregnancy (cases)	No. of vouchers distributed	No. of pregnant women coming to receive antenatal care by skilled birth attendant							
			Using voucher				Non-using voucher			
			ANC1	ANC2	ANC3	ANC4	ANC1	ANC2	ANC3	ANC4
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

Part II: Delivery

No. of deliveries performed by unskilled birth attendants	No. of deliveries performed by skilled birth attendants		No. of pregnant women referred to township hospital	
	Using voucher	Non-using voucher	Using voucher	Non-using voucher

Part III: Postnatal care

No. of mothers coming to receive PNC by skilled birth attendants		No.of infants who have been vaccinated					
Using voucher	Non-using voucher	Using voucher			Non-using voucher		
		Immunization 1 (1.5 mo)	Immunization 2 (2.5 mo)	Immunization 3 (3.5 mo)	Immunization 1 (1.5 mo)	Immunization 2 (2.5 mo)	Immunization 3 (3.5 mo)

Part IV: Outcomes of the program

No. of women who died while giving birth or due to complications during pregnancy	No. of premature deaths			
	Abortions (0 – 22 weeks)	Perinatal deaths/still births (above 22 weeks)	Neonatal death (0 – 1 month)	Infant death (0-1 year)

Station Health Unit

Facility ID:	1
Facility name:	
Date of voucher scheme implementation:	
No. of voucher distributors:	
The mean gestational age at first antenatal care:	

Section I : Human resource

No. of staff who are involved with the maternal care: ANC, delivery and PNC						No. of administrative staff who are serving the maternal care
One month before the voucher implementation			Current			
Physicians	Nurses	Skilled birth attendants (midwives and lady health visitors)	Physicians	Nurses	Skilled birth attendants (midwives and lady health visitors)	

Section II : Maternal care

Part I: Antenatal care

Month	Monthly incidence of pregnancy (cases)	No. of vouchers distributed	No. of pregnant women coming to receive antenatal care by skilled birth attendant							
			Using voucher				Non-using voucher			
			ANC1	ANC2	ANC3	ANC4	ANC1	ANC2	ANC3	ANC4
1										
2										
3										
4										
5										
6										
7										
8										
9										

10										
11										
12										

Part II: Delivery

No. of deliveries performed by unskilled birth attendants	No. of deliveries performed by skilled birth attendants		No. of pregnant women referred to township hospital	
	Using voucher	Non-using voucher	Using voucher	Non-using voucher

Part III: Postnatal care

No. of mothers coming to receive PNC by skilled birth attendants		No.of infants who have been vaccinated					
Using voucher	Non-using voucher	Using voucher			Non-using voucher		
		Immunization 1 (1.5 mo)	Immunization 2 (2.5 mo)	Immunization 3 (3.5 mo)	Immunization 1 (1.5 mo)	Immunization 2 (2.5 mo)	Immunization 3 (3.5 mo)

Part IV: Outcomes of the program

No. of women who died while giving birth or due to complications during pregnancy	No. of premature deaths			
	Abortions (0 – 22 weeks)	Perinatal deaths/still births (above 22 weeks)	Neonatal death (0 – 1 month)	Infant death (0-1 year)

RHC1 – RHC7

Facility ID:	2
Facility name:	
No. of sub-health centres under the facility	
Date of voucher scheme implementation:	
No. of voucher distributors:	
The mean gestational age at first antenatal (second half-year 2013):	

Section I : Human resource

No. of staff who are involved with the maternal care: ANC, delivery and PNC						No. of administrative staff who are serving the maternal care
One month before the voucher implementation			Current			
Physicians	Nurses	Skilled birth attendants (midwives and lady health visitors)	Physicians	Nurses	Skilled birth attendants (midwives and lady health visitors)	

Section II : Maternal care

Part I: Antenatal care

Month	New pregnancy women in each month (cases)	No. of vouchers distributed	No. of pregnant women coming to receive antenatal care by skilled birth attendant							
			Using voucher				Non-using voucher			
			ANC1	ANC2	ANC3	ANC4	ANC1	ANC2	ANC3	ANC4
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

Part II: Delivery

No. of deliveries performed by unskilled birth attendants	No. of deliveries performed by skilled birth attendants		No. of pregnant women referred to township hospital	
	Using voucher	Non-using voucher	Using voucher	Non-using voucher

Part III: Postnatal care

No. of mothers coming to receive PNC by skilled birth attendants		No.of infants who have been vaccinated					
Using voucher	Non-using voucher	Using voucher			Non-using voucher		
		Immunization 1 (1.5 mo)	Immunization 2 (2.5 mo)	Immunization 3 (3.5 mo)	Immunization 1 (1.5 mo)	Immunization 2 (2.5 mo)	Immunization 3 (3.5 mo)

Part IV: Outcomes of the program

No. of women who died while giving birth or due to complications during pregnancy	No. of premature deaths			
	Abortions (0 – 22 weeks)	Perinatal deaths/still births (above 22 weeks)	Neonatal death (0 – 1 month)	Infant death (0-1 year)