GAVI HEALTH SYSTEMS STRENGTHENING SUPPORT (HSS) STUDY

REPORT ON THE QUESTIONNAIRE DEVELOPMENT WORKSHOP, 17-19 NOVEMBER, 2016

THE HEALTH INTERVENTION AND TECHNOLOGY ASSESSMENT PROGRAM
MINISTRY OF PUBLIC HEALTH, THAILAND

Abbreviations and Acronyms

AAR	After Action Review
GAVI	The Global Alliance for Vaccines and Immunizations
HEF	Hospital Equity Fund
HH	Household
HITAP	Health Intervention and Technology Assessment Program
HMIS	Health Management Information System
HSS	Health Systems Strengthening Support
iDSI	International Decision Support Initiative
MCH	Maternal and Child Health
MCHVS	Maternal and Child Health Voucher Scheme
MoHS	Ministry of Health and Sports
RHC	Rural Health Center
SAVE	Save the Children
SRHC	Sub-Rural Health Centers
TSH	Township hospital

Table of Contents

PART I: INTRODUCTION 5

BACKGROUND OF THE VISIT 5

PART II: QUESTIONNAIRE REVIEW WORKSHOP 6

QUESTIONNAIRE REVIEWS 6
ELIGIBILITY CRITERIA 6
CONTENT OF THE QUESTIONNAIRE 8

PART III: SAMPLING 9

SAMPLING STRATEGY FOR SURVEYS 9
INCLUSION AND EXCLUSION CRITERIA 9
INCLUSION CRITERIA 9
EXCLUSION CRITERIA 9
TARGET RESPONDENTS 9
SAMPLE SIZE 10
DISCUSSION WITH PARTICIPANTS 10
MEETING WITH DEPUTY DIRECTOR, DEPARTMENT OF MEDICAL RESEARCH 10
REVISING SAMPLING STRATEGY AND PLAN FOR NEXT STEPS 11

PART IV: FIELD SUPERVISOR TRAINING 11

PART V: FEEDBACK FROM THE FIELD 12

PART VI: DATA MANAGEMENT 13

STEP 1 CHECK VALIDITY OF THE DATA 13
STEP 2 SEND THE QUESTIONNAIRE TO HITAP 14
STEP 3 DATA CLEANING 14
STEP 4 RECORD DATA 14

PART VII: AFTER ACTION REVIEW AND NEXT STEP 14

PART VIII: FEEDBACK FORM PARTICIPANTS 15

ANNEX I: AGENDA 17

ANNEX II: NAME OF PARTICIPANTS.....19

ANNEX III: SUPPORTING DOCUMENTS.....19

Part I: Introduction

Background of the visit

In 2008, the Government of the Republic of the Union of Myanmar submitted a proposal for Health Systems Strengthening Support (HSS) to the Global Alliance for Vaccines and Immunizations (GAVI), a global agency that supports children's access to vaccines, to ensure a holistic approach to providing maternal and child healthcare (MCH). Approved in the same year, funding was received in 2011 with planned activities starting in 2012. Over three years, the government received USD 30 million and the program was expanded to 120 townships in a phased manner, covering a range of activities such as having township health plans and construction of sub-centers. One component of this program was introducing two health financing schemes, the Hospital Equity Fund (HEF) and the Maternal and Child Health Care Voucher Scheme (MCHVS), to mitigate demand-side constraints faced by households in accessing healthcare through different modalities: while the HEF provided township hospitals with funds to subsidize the target population, the MCHVS gave redeemable vouchers to the target population.

The Health Intervention and Technology Assessment Program (HITAP) was requested by the World Health Organization (WHO), on behalf of the Ministry of Health & Sports (MoHS), to provide technical assistance for completing its closure reports. This study will focus on conducting an evaluation of the two health financing schemes i.e. the HEF and MCHVS. The work is supported by the WHO and the International Decision Support Initiative (iDSI). This is the second visit by HITAP staff to Myanmar and follows the consultation meeting held on 25-27 October in Yangon when the proposed plan for the study was presented and discussed with senior advisors, colleagues from WHO and the MoHS as well as colleagues from Save the Children (SAVE), who are conducting a qualitative survey on out-of-pocket health expenditure, and a draft questionnaire was tested.

One component of the study is conducting a survey of the population targeted by the two health financing schemes. During the previous visit, it was agreed that three surveys would be conducted at the Rural Health Centre (RHC)/Sub-Rural Health Center (SRHC) level, the Township Hospital level, and the Household level to assess target population characteristics, utilization, health expenditure and awareness of schemes. The focus of this visit was on questionnaire development of the three survey instruments. The workshop covered activities and discussions related to questionnaire development including a field test, sampling for the survey, training and data management. Specifically, the objectives of the visit were: to discuss and revise draft questionnaire and accompanying handbooks for surveys to be conducted at (1) RHC/SRHC, (2) Township Hospitals, and (3) Household level; and to test three questionnaires in field locations. The report has been divided into the following parts: summaries of the proceedings of the workshop (Parts II – VI), after action review (Part VII), feedback from participants (Part VIII) and supporting information in the Annexes.

Part II: Questionnaire Review Workshop

Questionnaire reviews

Three questionnaires, i.e. questionnaire for household survey (HH questionnaire), questionnaire for RHC/SRHC survey (RHC questionnaire), and questionnaire for township hospital survey (TSH questionnaire), that will be used to collect data in this study. They were developed in English by the HITAP research team. Each questionnaire is divided into seven parts, namely demographics, household expenditure, household income, living conditions, service utilization, awareness of HEF and MCHVS. There are some differences in details of the questions in each questionnaire. Each questionnaire aimed to gather data from different samples. Each questionnaire aimed to collect data from the respondents in the different settings.

Eligibility criteria

Each questionnaire aimed to collect data from different respondents. Target population, eligibility criteria for selecting household of target population, and comments on target population and the criteria from the participants are shown below:

<u>The HH questionnaire</u>

Target population:
1. Head of the household and
2. Woman who is/was pregnant or delivered a baby within the last 12 months or members who experienced an emergency life threatening condition in the past 4 years

Eligible household:
1. Households with at least one woman who is/was pregnant or delivered a baby in the past 12 months, or
2. Households which have had children aged less than 5 years in the past 4 years, or
3. Households with at least one member who experienced an emergency life threatening condition (e.g. accidents, injuries, snake bites) in the past 4 years
4. Households with at least one child who experienced acute illnesses in the past 4 years

This HH questionnaire was developed to collect data from respondents at their homes on the same day of receiving home-based care from midwives. The research team raised the issue about the inconvenience that this approach may cause respondents as there may be a lot of people visiting their homes on that day and some of respondents may not be able to spend a long time for the interview as they already spend some times to receive care. On suggestion made by participants was to conduct home-based interviews within 7 days after respondents' receiving services. However, they added that visiting on the same day as the visit of midwives seemed to be a proper choice because the interviewers need to be accompanied by midwives every time of visiting. Also, going to the respondents' houses on the same day may be less of a distraction to the midwife than going on another separate day. However, one limitation of this approach is that visiting respondents' houses will depend on the schedule of midwives and location of respondent's house.

Both, respondents who had and had not received care under HEF and MCHVS services, will be identified as eligible respondents, but they need to fulfil the criteria that were used to select the

poor to be eligible for availing the services. The participants gave more information on the current practice of the HEF program, which expanded its coverage to all poor people, instead of poor pregnant women and children aged under 5. Hence, the eligibility criteria of the target population household were revised.

Moreover, recall issue seemed to be one major issues that participants raised. Given that the eligibility criteria focused on the household experiences, life threatening or acute illnesses of family members, in the past 4 years. These criteria would most probably make recruitment of respondents difficult because it may not be easy to recall events from a long time. Thus, the research team revised all criteria to cover the past 12 months.

The RHC questionnaire

Target population:

At health facility-based setting:

1. Women who have just received ANC, delivery or PNC, or
2. Women who visited health facility regarding pregnancy/delivery related conditions, or
3. Pregnant women who visited health facility regarding emergency life-threatening health conditions,
4. Parents of children aged less than 5 years who visited the health facility for emergency life-threatening health conditions, or
5. Parents of children who took their child for receiving immunization, or

At home-based setting:

6. Women who have just received ANC, delivery or PNC, or
7. Women who have home-based delivery should be interviewed at least 7 days after their deliveries
8. Parents of children who have just received immunization

The TSH questionnaire

Target population:

At selected township hospital:

1. Hospitalised pregnant women or mother – who have just delivered babies – who admitted to hospital with pregnancy or delivery related conditions or emergency life-threatening conditions
2. Parents of children aged less than 5 years who admitted to hospital for emergency life-threatening health conditions or acute illness

This RHC and TSH questionnaires were aimed at collecting data from respondents at health facilities, after receiving care and before going back home on the same day that eligible respondents visit health facilities. The eligible respondents will be identified by the services that they use at health facilities.

Content of the questionnaire

The content of the questionnaires was presented to the participants by HITAP researchers. Several comments and suggestions were given by the participants. A major change was in a HH questionnaire in which Section 1: Demographics, the difference between “member with disability”, “members who cannot take care of themselves (for regular activities)” and “members who cannot travel (out of the house)” were discussed at length. The participants explained that unlike in Thailand, not all of disabled people have been registered, so it was difficult to classify the disabled in Myanmar. It was then agreed to use the word “dependent” in order to avoid double counting and misunderstanding. Also, it was agreed that “dependents” includes only children and elderly who have no income but consume the resources in the household.

There was also a change in the question on education: it was suggested that ‘informal education’ be added as a choice in this question. Informal education is a common form of education that is widely prevalent in rural areas of Myanmar, where there are no schools. Manual worker were also added into an occupation question because it is a common occupation in Myanmar. All agreed on the definition of the main occupation that is any job that makes the most of income to respondents, regardless of time spent on that job.

In Section 2 on Household expenditure, there were several changes made, as follows: First, the respondent to this section was changed from the head of household to any member who knows about household expenditure. This was applied to household income too. Second, expenditure on food was recategorized into seven main groups: 1) rice, 2) vegetable, 3) meat, 4) oils and fats, 5) non-alcohol beverages and drinking water, 6) alcohol beverages, and 7) tobacco products. Third, *thanaka war* was added as a choice under expenditure on goods and services because it is a common cosmetics item used in Myanmar. Fourth, the type of payment for expenditure on health care “payment in cash” was replaced by “payment in cash or in kind”. However, payment in kind will be used only when an informal fee is made to pay for the services, while payment in cash will be used to describe both formal and informal fees. Moreover, a question to obtain a total number of health facility visits was added into this part. The data collected in this section will be calculated as monthly expenditure, although respondents will be asked to provide information over the past 12 months.

In Section 6-7: awareness of HEF and MCHVS, a 5-point Likert scale that had been used to assess the intention to use the services under HEF and MCHVS of respondents, was changed into a ‘yes/no/not sure’ answer, as suggested by the participants.

In general, the word “poor” might be too sensitive to use in this study because it probably make a stigma to the respondents. Thus, other words in Myanmar language that are associated with the word “poor” will be used instead. For any question about age, the approach of asking and recording data were changed from asking date of birth of respondents to asking their current age. This is done because a recall problem and complex year conversion, from Myanmar Era into Common Era.

The research team will develop a questionnaire handbook to assist in conducting interviews. The handbook would contain useful information regarding the questionnaire such as the definition of words in the questionnaires in order to avoid ambiguous meanings, the example of choice in order to give a clear understanding to the respondents and control quality and standard of the interviews in case interviewers need to explain questions and choices to the respondents.

Part III: Sampling

Sampling strategy for surveys

This study will employ stratified two-stage sampling. Stratification will be achieved by classifying each state/region into two groups. In total, 28 sampling strata will be created. In each stratum, one township will be randomly selected. In each township, a number of villages (mix rural and urban areas) will be randomly selected based on number of sample size.

1st stage sampling

1. The sampling frame will be divided into 15 states/regions.
2. All townships implementing HEF in each state/region will be classified into 2 groups.
   Group 1: Townships classified as hard to reach areas
   Group 2: Townships not classified as hard to reach areas
   Townships identified as having security issues will be excluded.
3. Two townships per state/region (one township per group) will be randomly selected, except Bago where 2 townships implementing MCHVS will be purposively selected.

2nd stage sampling

4. In each township, a number of villages/ward/ villages tract (clusters) residing in rural and urban areas will be randomly selected using probability proportional to size. The number of villages being selected depends on the sample size.
5. All eligible households in each ward/village will be interviewed.

Inclusion and exclusion criteria

Households will be screened with the following inclusion and exclusion criteria;

Inclusion criteria

- Household with women who is/was pregnant or just delivered within the past 12 months, or
- Household which have had children aged less than 6 years, or
- Household which have had any members who experienced emergency life threatening conditions (e.g. accidents, injuries, snake bites)

Exclusion criteria

- Participants who have intellectual or cognitive impairments

Target respondents

1. Head of the household and
2. Women who are/were pregnant or just delivered within the last 12 months or members who experienced emergency life threatening conditions, will be invited for interview in the community.

Sample size

The HITAP team presented a method of sample size calculation. A proposed sample size based on the assumption that the proportion of the outcome of interest was equal to 0.5, which will result in the maximum sample size of 96 per stratum, was presented. The precision level was 10% and design effect was 1.5. After accounting for 10% non-response rate, the final sample size was 158 per stratum. Total sample size was 2,376. The MoHS staff did not have comments on the sample size and the proposed sample size was considered to be feasible.

Discussion with Participants

The MoHS staff participating in the meeting agreed that all states/regions should be selected so that the information could be used in the state/region level. However, one MoHS staff commented that the selection of two townships per state/region using hard to reach area as a criterion was not appropriate. She asked about how the hard to reach areas were classified. Moreover, hard to reach areas could be present in each township. Due to this limitation of using "hard to reach" townships as a criterion, it was suggested that other criteria to select the townships such as number of eligible target population be used. Further, proportional to size method may be applied. However, it was difficult for MoHS staff to provide a list of villages and households at that point and would provide the village level details once the townships are finalized. The MoHS has had experience conducting surveys and said that they could do a random selection of villages and households.

The number of eligible participants for the survey varies across villages. Some villages are big and it may be possible to have 30 eligible participants. However, for smaller villages, finding 10 eligible participants would be difficult. The latest survey on maternal and child health selected 8 pregnant women per village.

Meeting with Deputy Director, Department of Medical Research

After discussing with the MoHS staff, HITAP team was referred to Dr.Ko Ko Zaw, Deputy Director of the Department of Medical Research, MoHS, who has experience in conducting surveys in Myanmar. For the sampling strategy and sample size, he suggested that states/regions, as they pertain to to health administration, should be divided into 17 regions where Shan should be divided into 3 areas. If we plan to select 2 townships per state/region, 34 townships will be needed. An MoHS officer was concerned that it might be not possible for the data collection given the short time frame (3 months) and limited budget. Dr. Ko Ko, suggested that one township might be acceptable. So, in total 18 (16 +2 in Bago where MCHVS is implemented) townships are needed. He added that the HITAP team did not need to calculate sample size for each area of Shan but it should make sure that all areas of Shan are included. Regarding the sample size calculation, he said that the precision of 10% was quite high comparing with frequent use of 5% but he understood the limitation. So, the proposed sample size of 2,376 was accepted. It was suggested to have ten eligible participants per ward/village tract. He also suggested that by having only one township per state/region, the selection of townships using random sampling was not appropriate. HITAP team should use a judgmental sampling or purposive sampling based on a valid criterion such as the performance of townships. The MoHS officer proposed number of skill birth attendants as a criterion. As HITAP team did not know much about Myanmar context, so they proposed that the MoHS may help to select townships based on the suggested criterion or other criteria that were agreed among MoHS staff and HITAP team.

Revising sampling strategy and plan for next steps

On 19th November, HITAP team presented the revised sampling strategy of a household survey to MoHS staff. Sixteen village tracts/wards will be selected in each township, excluding Bago, 8 village tracts/wards and Shan 5-6 village tracts/wards will be selected. The MoHS will select 16 townships using an agreed criterion and will inform HITAP team about the selection. Once the townships are selected, the MoHS should prepare a list of villages and households for further selection. The HITAP team and MoHS team agreed to discuss this in detail via e-mail or teleconferences.

Regarding an exit survey at township hospitals, MoHS staff did not understand why this survey needed to be conducted given that the majority of questions is similar to the household survey. In addition, they were concerned that they will not have enough data collectors for this survey. The proposed number of samples for township hospital survey was 2,366 which exceed their capacity to manage. The MoHS staff and Dr. Yee Yee Cho suggested combining the surveys and if HITAP team is interested in patients who have recently finished their admission, the selection method would need to be adapted. The HITAP team therefore proposed that it will consult our technical team in Thailand about the issue and inform the MoHS and WHO about its decision.

Regarding the rural health center survey, the main focus will be on the MCHVS. Thus, 2 townships comparable to Yedarshe and Paukkhaung will be selected as a control group. The sample size calculation will be determined later.

The HITAP team will work on finalizing sampling strategy for the three surveys and will consider combining the household survey with the township hospital survey. The maximum sample size for this 3 month data collection period, as advised by MoHS staff, should not exceed 4,000 participants.

Part IV: Field Supervisor Training

The research team arranged to have a training for all participants. The objectives of the training session were to test the flow of questions, understanding content of the questionnaires, and suitability of questionnaire for the Myanmar context.

Participants were divided into two groups, one was a HH questionnaire survey and another one was RHC and TSH questionnaires surveys. Genders were mixed in both groups in order to perform a role play as interviewer and respondent (i.e. a pregnant woman or parent of child who has an acute illness). All participants needed to perform as both interviewer and respondent. Researchers from HITAP were separated into 2 teams for observing each group.

The interviews took approximately 45-60 for the HH questionnaire and 30-45 minutes for RHC and THS questionnaires. However, some participants, who already knew and understood the questions tended to answer before interviewer finished asking questions, especially when those questions were long. Also, in the training, the questions were asked in English, as it was in the questionnaires, but most of participants cautioned that in the real situation, questions will be asked in Myanmar language and it might be replaced by other words that suite the Myanmar context, which were probably longer than the words that were written in English. Thus, the time for real interview was assumed to be longer than during the training.

Several participants asked asked about the use of the term “you” in cases where interviews are conducted with parents or guardians of the children. Then, the term ‘you or your child’ will be used instead. All participants required to have a full list of examples for some questions, such as, questions personal supplies and services, in order to give those examples to the participants. HITAP agreed to add this request in the handbooks.

Part V: Feedback from the field

In this visit, all participants were asked to conduct interviews with the people in communities, in order to test the questionnaire that the research team revised after getting feedback and comments from the first and second day of meeting. The participants separated into 3 groups. One group went to the township hospital, another group went to the rural health centers, and the last group went to the community to conduct their interview at home.

One major concern from this field visit was about the number of questions in each questionnaire, totaling more than 150 questions and making one interview longer than one hour, estimated. This might affect the validity of information. The research team agreed in this case and will work to reduce the number of questions. The word ‘poor’ in the questionnaire was sensitive to the respondents as expected. All participants needed to find some words to replace this word or gave some examples or described situations to describe the state of being poor instead.

For the facility-based questionnaires, RHC and TSH questionnaires, the participants found that it might be difficult to get a certain number of respondents in one day due to many factors. First, even if the interviewer asks health facility staff to arrange the appointment for interviewing, showing up at health facility still depends on the respondents. Second, given that the respondents come to the health facility very early and finish receiving the service in the afternoon, more than six hours are already used in that day, which makes the respondents want to go home and they may not coorperate with the interviewers.

There were a several minor suggestions from the participants, related to the difficulty in understanding the questions and choices, as it may not be appropriate or applicable in the Myanmar context. The flow of questions, definitions and examples of each question were also of concern. The research team will revise the questionnaire as suggested by the participants.

Interviewer report form

During the field test, there is the interviewer report form and each observer complete this form just after finishing each interview session. After the field test, it was found that only the Township group send the interviewer report form. The observer reporting based on direct observation on each issue is as follows:

1. The questions that interrupted the flow of the questions include, question 30 to 32 (Q= losing any regular income because of accompanying the person seeking care admission, food and drink cost for admission, cost for other items in this admission. The interviewer was not sure about whether it was the total time or only 1 day) and 38 (Q=the main condition of your visit to the health facility)
2. The questionnaire was not understandable by audience or was sensitive. The sections for which this point was raised includes, section 7 on HEF awareness, knowledge, about

services and questions 75 to 84. The participants suggested that there is no need to know about HEF in detail.

3. The part difficult to communicate in Myanmar language include, questions 89 to 90 (Q.89 is “I will not see SBAs if I get in an accident during my pregnancy and there is nothing wrong about it” and Q.90 is “If I have an extreme case of stomachache during my pregnancy, it means that I am in labor. In that case, I will not consult SBAs and I will directly ask TBAs to assist me deliver”) and giving a score about HEF awareness in questions 87 to 91 as, they could not understand that 5 point scale. The participants suggested to change the choices to “yes, no” or “true, false”. In Section 3, household expenditure (Q.19.1 Household food consumption expenditure), it was difficult to measure the amount and unit of vegetables, fruit & non-alcoholic beverage. The participants suggested that they should count amount in Myanmar kyats only, and not both amount and unit.

Part VI: Data management

After interviewing, there will be 4 steps for the data management including, (see Figure1)

1. Check validity of the data
2. Send the questionnaire to HITAP
3. Data cleaning
4. Record data

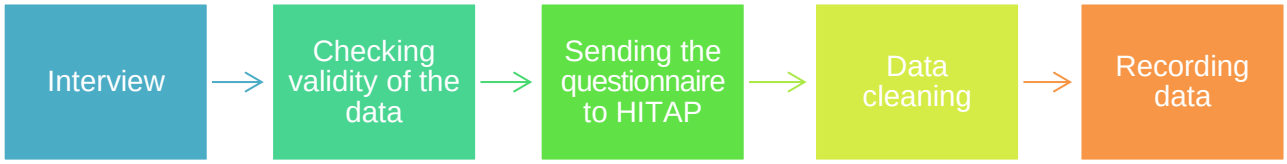

Figure 1 the key steps of data management

Step 1 Check validity of the data

The validity of data needs to be checked for three times.

The First time the interviewers check data of the questionnaires before leaving the field or the area. If the information is incomplete, the interviewers need to check those incomplete or missing data with the respondent for more information.

The Second time the field supervisors who head the interviewer team, will do a double check for validating data. The points of double checking are the completion and the consistency of the questionnaire. The supervisors also need to screen and exclude the questionnaires that are collected from those who are not eligible.

The Third time the supervisor records the code in the questionnaire. Specific codes will be assigned to the questionnaires, once all questions are completions. The methods of recording code will be added into the questionnaire handbooks.

Step 2 Send the questionnaire to HITAP

After checking validity of the data and recording all code into the questionnaire, the supervisor of each township will send the questionnaires and field work report to WHO Myanmar and Then WHO Myanmar will send the questionnaires and the field work report to HITAP. In the first period of time it will be good if the completed questionnaire can be shared every 2 weeks and feedback can be provided in a timely manner as well as address any other issues.

Step 3 Data cleaning

Once HITAP receives the questionnaires, data will be checked again, in terms of validity, before recording it in the specific platform.

Step 4 Record data

The data will be recorded using ina statistical program called “Epidata”.

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Part VII: After Action Review and Next Step

After the first day of the workshop, the HITAP team conducted an after action review (AAR) at the workshop venue. Each question from each of the three questionnaires was reviewed by all participants. It was clearly seen that some participants did not focus on the discussion until the end, and some participants were absent in the afternoon. Only a few people could make suggestions and comments from the beginning to the end and they seemed to have experience with this kind of research. For next time, these parts (questionnaire review) can be short and only important parts that we would like to verify can be highlighted rather than going over each question. Further, the training can be arranged on the same day as the questionnaire review so that all members can participate in the activity. Three questionnaires can be reviewed and trained separately. Moreover, preparation of questionnaires and interviewer’s handbook should be well prepared, and these tasks require more time; however, there was limited time and a major constraint while preparing for this mission.

For the training day, due to major changes from the first day (e.g. adding and removing some parts), the instruction for questionnaire was only completed for the household expenditure part. However, the HITAP team which took responsibility for each group closely observed and responded to any queries from participants during interview training. A major problem during the training session was the language barrier as most of participant conducted the interview in Myanmar language, so the HITAP team could not evaluate their understanding and accuracy of interview process. Even though some participants were required to interview in English, it took a long time and there was no time left to switch roles (interviewer and interviewee). Next time, the time for questionnaire training can be increased and all participants will be required to interview only in English. For discussion about sampling strategy, the HITAP team had a chance of meeting with a local expert who has experience in sampling in Myanmar. It was a useful discussion and the team learned about the local context.

On the last day of the workshop, the team discussed the overall preparation before and during workshop. Before the workshop, the contact among HITAP, WHO team, and MoHS team seemed to be delayed sometimes, and this specially limited time for preparation all material needed as well as higher logistic cost. For the 2nd visit, HITAP team did not have the first mission report to review the overall discussion, so we sometimes asked Myanmar language team the same issues

as discussed during the last visit. Thus, the previous mission reports are very important in terms of providing information that should be completed before the next visit. In addition, the HITAP staff who take responsibility for the whole project from the start should be involved in all visits to help the others who were not involved in all visits, so he/she can keep the project on the track and focused on mission's objectives. Moreover, the 6-month period might not be suitable for survey design research that might be able to conduct high quality research, so for the next research that will use survey design should have at least 1-year. Thus, the method used should be matched with the given timeline.

Part VIII: Feedback form participants

At the end of workshop, the participants were asked to complete feedback forms to help improve the quality of the workshop. There were 10 participants who completed the feedback form. The results suggest that 80% participants agreed with the statement that the objectives of the workshop were achieved while half of them agreed with the statement that facilitators were well prepared for the sessions and 3 participants stated that they were "neutral". Six participants agreed with the statement that the materials distributed were helpful, 50% agreed with the statement that participation and interaction were encouraged during the workshop; however, 2 participants disagreed with this statement. In the end, 7 out of 10 participants (70%) agreed with the statement, "I will be able to apply the knowledge and/or skills gained from this workshop" even as 1 participant disagreed with it. *(see Table 1)*

Table 1 Summary of Participant Feedback on Level of Agreement with Statement

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	NA/Don't know
The objectives of the workshop were achieved.	0	0	1	8	1	0
The facilitators were well prepared for the sessions.	0	0	3	5	2	0
The materials distributed were helpful.	0	0	2	6	1	1
Participation and interaction were encouraged during the workshop.	0	2	0	5	3	0
I will be able to apply the knowledge and/or skills gained from this workshop.	0	1	0	7	2	0

In addition, the participants responded to overall questions about the workshop as follows:

The questions on the content of this workshop and additional resources or support. *(5 participants)*

- Send the agenda to attendees before the start of the workshop.
- Guidebook for interviewer.
- Development of the questionnaires should be same format with previous times.
- The questions in some sections not need to ask detail and some questions are difficult to be asked.
- Additional references

The most like about this workshop. *(6 participants)*

- Session health equity and expenditure in developing countries by Prof. Supasit.
- Take the feedback of the participants and adjust based on discussion.
- Discussion about HEF questionnaires.
- Role play section for testing questionnaires.
- Group work session.
- Appreciate that all are actively participate.

The suggestions for improving the workshop. *(8 participants)*

- The facilitators need to digest more about GAVI HSS functions.
- The indicators to be used & collected should be the same as those in HMIS (Health Information Management System) of MoHS so that we could easily collect the data.
- The HITAP need to understand the organization set up and nature of program. It mean that before starting workshop, they should learn ahead.
- Need more time for field visit and discussion.
- It is better to learn more for Myanmar context for developing questionnaire because some questionnaires are not convenient for our respondent.
- The Myanmar supervisor need to clear the project first before the workshop it can be more beneficial.

The other comments. (3 participants)

- The first time questionnaire and second time are a little different. The second time questionnaire must be finalized of first time questionnaire.
- It would be better the research team have well-understanding and orientation about the program.
- Most facilitators are not familiar with Myanmar context.

Annex I: Agenda

GAVI HSS Study: Questionnaire Development Workshop

Dates: 17-19 November, 2016

Location: Yangon, Myanmar

Objectives:

- To discuss and revise draft questionnaires and accompanying handbooks for surveys to be conducted at (1) Rural Health Centres (RHC)/Sub-Rural Health Centres (SRHC), (2) Township Hospitals, and (3) Household level
- To test three questionnaires in field locations

Participants:

- GAVI Health Systems Strengthening Officers (HSSOs).
- Experience with questionnaire development: Involved in previous testing of draft RHC/SRHC questionnaire.
- Expected number: 18-20

Scope of Activities:

- Participants will engage in discussions and work in groups to revise questionnaire and handbook.
- Participants will conduct a field test for each questionnaire.
- Participants will be asked to provide feedback on workshop through forms provided.

Outputs:

- Tested versions of draft questionnaires.
- Revised handbook for conducting survey.
- List of activities and next steps.
- Workshop report.

Schedule:

Day 1: Review of Questionnaires			
Time	**Session**	**Description**	**Person (s) Responsible**
9:00 – 9:30	Introductions and Opening Remarks	• Participants introduce themselves • Overall objective of workshop	Dr. Alaka Singh
9.30 – 10.15	Sharing experience on health equity in health care use and expenditure in developing countries	• Presentation	Professor dr. Supasit Pannarunothai
10.15-10.30	Break		
10:30 – 11:30	Rural Health Centre (RHC)/Sub-RHC (SRHC) Questionnaire	• Discuss questions and handbook for questionnaire	Pattara
11:30 – 12:30	Township Hospital Questionnaire	• Discuss questions and handbook for questionnaire	Songyot
12.30 – 13. 30	Lunch		

13:30 – 17:00	Household Questionnaire	• Discuss questions and handbook for questionnaire	Roongnapa
Day 2: Questionnaire training and sampling strategy			
Time	**Parallel Session 1**	**Parallel Session 2**	**Person (s) Responsible**
9:00 – 10:30	*Group 1*:Training of the questionnaire and handbook (RHC/SRHC and township hospitals)	*Group 2*:Training of the questionnaire and handbook (Household)	Parallel 1. Pattara +Songyot + Wittawat Parallel 2. Suradech+ Roongnapa + Akanittha
10:30-12:00	*Group 2*:Training of the questionnaire and handbook (RHC/SRHC and township hospitals)	*Group 1:*Training of the questionnaire and handbook (Household)	Parallel 1. Pattara +Songyot + Wittawat Parallel 2. Suradech+ Roongnapa + Akanittha
Lunch			
Time	**Session**	**Description**	**Person (s) Responsible**
13:00 – 15:00	Review of Questionnaire & Handbook	• Discuss questions and handbook for questionnaires	HITAP
15:00-17:00	Sampling strategy	• Discussion on sampling strategy	HITAP
Day 3: Field Work & Next Steps			
Time	**Parallel Session 1**	**Parallel Session 2**	**Person (s) Responsible**
08.00 – 16:00	Testing of questionnaires: Teams to test questionnaires at: - 1 RHC/SRHC, - 2 Township Hospitals - 2 Communities (1 urban/1 rural) Participants: HSSOs	**10:00-16:00** Discussion on data management, timeline, and activities Participants: MoH/WHO/HITAP	(N/A)
Time	**Session**	**Description**	**Person (s) Responsible**
16:00 – 17:30	Debriefing questionnaire testing	• Discuss questionnaire testing in three groups working in parallel	HITAP
17:30 – 18:00	Feedback forms	• Participants to complete feedback forms	HITAP
End of Workshop			

Annex II: Name of participants

Sr. No.	Name	Designation	Organization
1.	Dr. Thiri Win	(AD) National Program Officer	GAVI HSS
3.	Cho Cho Mor	NFO	GAVI HSS
2.	Dr. Aye Mya Mya Kyaw	Monitoring and Evaluation officer	GAVI HSS
4.	A Thi Win Shue	Pharmacist	Mahidol University
5.	Dr. May Phyo	HSSO	WHO
6.	Dr. Thant Mon Cho	HSSO	WHO
7.	Dr. Chit Zaw Min	HSSO	WHO
8.	Dr. Sithu Nairg	HSSO	WHO
9.	Kaung Mon Winn	HSSO	WHO
10.	Dr. Aung Kyan Hein	HSSO	WHO
11.	Dr. Thet Zaw Hiet	HSSO	WHO
12.	Suphasit Panarunothai	Professor	Centre for Health Equity Monitoring Foundation (CHEMF)
13.	Pattara Leelahavarong	Researcher	HITAP
14.	Roongnapa Khampang	Researcher	HITAP
15.	Songyot Pilassant	Researcher	HITAP
16.	Suradech Doungthipsirikol	Researcher	HITAP
17.	Witthawat Pantumongkol	Researcher	HITAP
18.	Akanittha Poonchai	Researcher	HITAP

Annex III: Supporting Documents

The following materials may be accessed at the link provided below:

1. Household survey questionnaire
2. Township questionnaire
3. Rural Health Center (RHC)/Sub-Rural Health Center (SRHC) questionnaire
4. Evaluation Form

Link: https://drive.google.com/open?id=0B9B2iYyLIGcCZ1NqQXptRDFWSDA