GAVI HEALTH SYSTEMS STRENGTHENING SUPPORT (HSS) STUDY

REPORT ON CONSULTATION MEETINGS, 14-16 DECEMBER, 2016

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

Acronyms and Abbreviations

3MDG Fund	The Three Millennium Development Goal Fund
AAR	After Action Review
CHE	Catastrophic Health Expenditure
DHS	Demographic Health Survey
DiD	Difference in Difference
DPT3	Diphtheria, Pertussis and Tetanus vaccine
GAVI	Global Alliance for Vaccines and Immunizations
HEF	Hospital Equity Fund
HITAP	The Health Intervention and Technology Assessment Program
HMIS	Health Management Information System
HSS	Health Systems Strengthening Support
HSSO	Health Systems Strengthening Officer
HTR	Hard to Reach
iDSI	International Decision Support Initiative
IHLCS	Integrated Household Living Conditions Survey Myanmar
INGO	International Non-Governmental Organization
KII	Key Informant Interviews
M&E	Monitoring and Evaluation
MCH	Maternal and Child Healthcare
MCHVS	Maternal and Child Healthcare Voucher Scheme
MICS	Multi-Indicator Cluster Survey
MIMU	Myanmar Information Management Unit
MoHS	Ministry of Health and Sports, Myanmar
MPLCS	Myanmar Poverty and Living Conditions Survey
OOPE	Out of Pocket Expenditure
PDA	Personal Digital Assistant
RHC	Rural Health Center
SBA	Skilled Birth Attendants
SRHC	Sub-Rural Health Center
TMO	Township Medical Officer
TRAPD	Translation, Review, Adjudication, Pre-testing and Documentation
WHO	World Health Organization

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Executive Summary

The Government of the Republic of the Union of Myanmar received the GAVI Health Systems Strengthening Support (HSS) grant and initiated activities in 2012 through a no-cost extension in 2016. One of these activities related to health financing through the modality of a Hospital Equity Fund (HEF) and the Maternal Child Healthcare Voucher Scheme (MCHVS). This study is part of the closure reports and will focus on the impact of the program on out-of-pocket expenditure (OOPE) on health. In addition to providing insights on the impact of the GAVI HSS program, this study is expected to contribute to the understanding of OOPE in Myanmar and inform the next generation of health financing schemes in the country.

The Health Intervention and Technology Assessment Program (HITAP) was requested by the World Health Organization, on behalf of the Ministry of Health and Sports (MoHS), Myanmar, to provide technical support for the study. This consultation meeting was the third since the beginning of the study and covered the following: working with partners in the study as well as externally; discussing the sampling strategy, role of supervisors, translation and other items for the survey component; and meetings with relevant staff in the MoHS or other agencies to learn about as well as obtain relevant secondary data for analysis.

The visit achieved its objectives in sharing experiences with Save the Children, which is conducting a qualitative study on OOPE, finalizing the sampling strategy, planning the data collection process for the survey component of the study as well as presenting the plan for analysis of secondary data. The timeline and activities to follow this visit were also agreed on.

Introduction

The second largest country in Southeast Asia, Myanmar is a lower middle income country. Health spending in the country is low compared to its peers and out-of-pocket expenditure (OOPE) has been high. In 2008, the Government of the Republic of the Union of Myanmar submitted a proposal for Health Systems Strengthening Support (HSS) to 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 activities starting in 2012 with a no-cost extension until 2016. One component of this program comprised health financing schemes in the form of the Hospital Equity Fund (HEF) and the Maternal and Child Healthcare Voucher Scheme (MCHVS). These were introduced 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 scheme gave vouchers to the target population which were redeemable for use of MCH services.

The Health Intervention and Technology Assessment Program (HITAP) was requested to provide technical assistance for completing the GAVI HSS closure reports with support from the World Health Organization (WHO) and the International Decision Support Initiative (iDSI). This study will focus on conducting an evaluation of the two health financing schemes i.e. the HEF and MCHVS. The methodologies to be applied for this study are: document review, self-assessment form for collecting data on HEF, analysis of existing data, and a household survey of the eligible population of the schemes. A consultation meeting was held on 25-27 October in Yangon where HITAP staff presented and discussed the framework for the study with various stakeholders of the study. Further, during this visit, a draft questionnaire was tested. A second visit was made on 17-19 November to focus on questionnaire development. During this visit, the questionnaire was revised and tested.

This is the third visit to Yangon as part of this project. There were three parts to this visit: a consultation meeting to be held with WHO, Ministry of Health and Sports (MoHS), Senior Consultants, and Save the Children (which is conducting a qualitative study on out of pocket expenditure in Myanmar) to share experiences and preliminary findings; a workshop on the survey component of the study to discuss the sampling strategy, role of supervisors, translation and other items; and meetings with relevant staff in the MoHS or other agencies to learn about as well as obtain relevant secondary data for analysis. The report provides a summary of the visit and is structured as follows: summary of the proceedings during visit, results, lessons learned and next steps with supporting documents in the Annexes.

Section Summaries

Overview of GAVI HSS Study

Dr. Alaka Singh opened the meeting and gave an overview of the GAVI HSS Program, the study and the three-day meeting. She noted that this was one of the largest awards given to Myanmar and the largest component of that funding was directed to the two health financing schemes viz HEF and MCHVS. She highlighted the importance of the study and how it relates to the broader trends in the health sector in Myanmar. There are two parts to this study: a report on the 120 townships where the program was implemented using the Monitoring and Evaluation (M&E) data collected routinely as well as a sample study, which was the focus of this meeting, to examine the impact of the HEF and MCHVS. It was also noted that this was not an external but an internal assessment with a focus on lessons learned, working together and building capacity.

Qualitative Study on Out-Of-Pocket Expenditure

Save the Children and the World Bank are conducting a qualitative study on OOPE in Myanmar. In an effort to learn from the experiences and findings from both the studies, it was agreed during the visit in October, 2016, to meet at regular points and share information and keep the dialogue open.

Alyssa, from Save the Children, provided a background to the study and said that she and her colleagues will be presenting on their experiences with pre-testing and initial data collection process. She explained the overall objective and the sub-objectives which were related to assessing the user (demand) and provider (supply) experiences with OOPE. Alyssa then explained the process for sampling, which was done purposively taking into account large schemes such as the GAVI HSS and 3MDG Fund. She also elaborated on the selection of providers and users within each township, which involved consultations with various stakeholders such as Township Medical Officers (TMOs) and INGOs and use of health information which was triangulated to find the hard to reach (HTR) population. At the rural health center (RHC) level, they asked the networks of health assistants and midwives to confirm the location of the HTR population. In the two peri-urban areas, a social mapping process was used to identify the target households and providers. This involved conducting key informant interviews (KIIs) and focus group discussions with users, public health providers as well as informal service providers. Through this process, the HTR population was mapped and targeted by focusing on one street, for example, and identifying each household in that street. Four categories of socio-economic strata were developed using information on assets as proxies. Further, all health facilities in these communities were mapped. This data collection process was adapted from the one developed by QSAM which also incorporates verification of community information.

The initial experiences have shown that public health staff are welcoming and collaborative, help in organization of groups and are engaged with their communities. In terms of administering the questionnaire, it was essential to explain the purpose of the survey with the informed consent form stating that there would be no benefit accruing from participation in the study. The definition of HTR population was more than simply geographical and also included migrants. There were some challenges faced while interviewing private providers. Use of the midwife service users' registry was found to be useful in identifying household; not only do midwives provide MCH services but also serve as primary healthcare. There were some issues identified in terms of perception of terminology such as names for formal or informal providers. It was stressed that since this was a qualitative study, it was not just about definitions, but also people's perceptions which can vary. Finally, the team provided quotes from the study as they related to the sub-objectives of the study.

The team shared some feedback received and also responded to questions. During the ethical review process, it was advised that they should be careful about dividing health providers into broad categories such as public, private and informal. Responding to a question on whether they gave hints to interviewees in order to classify households into the socio-economic groups, the Save the Children team said that usually participants decide themselves but when it becomes difficult for them to respond, they are guided. A question was asked about how they managed with the variation in local language, and the responded that this would be addressed by notes made by interviewers and debriefing sessions. A point was made about the "non-specific expenditure" which would normally be considered "under the table" dealings, but in Myanmar, it was given as gratitude. With reference to a point on how providers rationalize resources, a disconnect between what providers and users perceive as big budget items was noted; on the user side, transportation cost was seen as the largest proportion of the cost while from the perspective of providers, it was medical supplies, which were scarce, but not reported by users. This, it was suggested during the discussion, may have to do with expectations for payment.

The team outlined their next steps which included data collection from another township, followed by detailed coding and analysis of the response. A short report on the data collection process in Yangon would be prepared before moving to Bago. The data collection process would continue through the first quarter of 2017 with the report being submitted in May 2017.

Analysis of Existing Data

HITAP presented the proposed plan of analyzing existing data and explained the importance of getting access to the datasets in order to address the following key questions: (#2) Is the process to identify the target population adequate in targeting the most poor and vulnerable?; (#4) Whether utilization of health services increased as a result of the schemes?; (#5) What is the impact of the HEF/MCHVS on OOPE/CHE of households?

The proposed analysis aims to compare the pre-GAVI period (before 2012) with the GAVI period data (2012-2016) and post-GAVI period data (household survey). Depending on the availability of the data, the HITAP team discussed the analysis plan including descriptive statistics to summarize indicators across the country as well as impact evaluation to detect causal effects of the program. Specifically, a difference in difference (DiD) analysis may be used to capture the differential effect of a treatment or intervention on a 'treatment group' versus a 'control group' by comparing them both, before and after the treatment or intervention was implemented. In order to conduct this type of analysis, one would need to have access to data from before and after the implementation of the GAVI HSS program.

The types of data for which access would be needed were discussed in detail. In the pre-GAVI period (before 2012), several surveys had been conducted such as the World Health Survey (2003), the Integrated Household Living Conditions Survey Myanmar (IHLCS) (2010) and Multi-Indicator Cluster Survey (MICS) (2009). The HITAP team requested the assistance of the MoHS to access to the data from the IHLCS and MICS surveys which are not currently publicly available. The main source of information for the GAVI period would be the monitoring and evaluation (M&E) data collected on a routine basis. The MoHS team shared the M&E data from 2012 to 2015 on the HEF; M&E data on the MCHVS & and hospital costing data are yet to be shared. In order to get a better understanding on the information available, it was suggested that a sample of patient records be extracted from the M&E data to identify key variables to compare across townships, look at trends and explore relationships between variables. For the post-GAVI period, two household surveys, the Demographic Health Survey (DHS) (2016) and the Myanmar Poverty and Living Conditions Survey (MPLCS) (2015) were identified as sources for the post-treatment analysis as these were

conducted after the implementation of the HEF and MCHVS. For both surveys, the HITAP team was asked to share a list of specific variables that would be needed for analysis, in case the entire database not be available, with the MoHS so that they may make an official request for the same. Further, the HITAP team asked the MoHS for a pre-release of the DHS data that is scheduled for public release in February-March 2017. The list of secondary datasets and their availability are summarized in Table 1 below:

Table 1: Summary of Secondary Data Sources

Identifying Data Sources	Name of the Survey	Data Availability
World Health Survey	Myanmar - World Health Survey 2003	Data Obtained
Multiple Indicator Cluster Survey (MICS)	MICS3: 2009-10	Not Yet Obtained (Report published)
	MICS2: 2000	Data Obtained
Demographic Health Survey (DHS)	Myanmar: Standard DHS, 2015	Not Yet Obtained (Key Indicators Report published)
Myanmar Poverty and Living Conditions Survey (WBG)	November, 2014	Not Yet Obtained (Report published)
Integrated Household Living Conditions Survey Myanmar (UNDP)	Integrated Household Living Conditions Survey in Myanmar (2009-2010)	Not Yet Obtained (Report published)
Myanmar Census Report	2014 Myanmar Population and Housing Census	Not Yet Obtained (Report published)
GAVI HSS M&E data and Hospital Data		

Survey

The survey component of the study aims to inform the following questions in the framework of the study: (#1) What is the level of awareness of HEF/MCHVS in the target population?; (#2) Is the process to identify the target population adequate in targeting the most poor and vulnerable?; (#3) Whether health services covered by the schemes matched need, demand and supply?; (#4) Whether utilization of health services

increased as a result of the schemes?; (#5) What is the impact of the HEF/MCHVS on OOPE/CHE of households?

After considering time constraints and available resources, the HITAP team proposed to only conduct a household survey[1]. An impact evaluation approach will be applied and two scenarios will be compared: what actually happened and what would have happened in the absence of the intervention. Thus, in addition to collecting data from groups where the intervention was implemented, control groups that are similar to the intervention groups on observable characteristics except for the presence of the intervention will be included in the study[2].

In the GAVI HSS Study, HEF and MCHVS may be viewed as two interventions. This study design compares the outcome of interest in three groups: two intervention groups, to account for the two schemes, and one control group (townships without HEF/MCHVS). By doing so, one can see the differences in the outcomes of interest such as OOPE between the control and intervention groups and estimate how much of the difference can be attributed to the intervention.

Sampling

The sampling strategy underwent several iterations over the course of the three days. The methods applied as well as the rationale for making changes are described below:

Day 1

On the first day, HITAP presented a preliminary sampling strategy and sample size calculation to the participants. The proportion of OOPE was used as an outcome to estimate the sample size (number of households) needed for the survey. A non-response rate of 10% and a design effect of 1.5 was accounted for. A multistage sampling approach was used: in the first stage, townships were purposively selected for one intervention group, while simple random sampling was applied for selecting townships in the other two groups; in the second stage, simple random sampling will be applied to select urban wards (30%) and village tracts (70%); and in the third stage, households will be identified using census data complemented by pre-listing.

The sample size needed for each group was calculated to be 640 households. So in total, 1920 households were required. As HEF and MCHVS have both been implemented in only 2 townships, both townships were selected for the first intervention group (HEF & MCHVS). For the second intervention group (Only HEF), 118 townships were included in the sampling list. Townships with security issues were excluded and for the remaining 96 townships, Excel was used to randomly select 2 townships from the 96 townships. The latter method was also used to select townships for the control group (neither HEF nor MCHVS). The selection of two townships per group was done so as to have the number of townships comparable to the first group which is fixed at two townships (both HEF and MCHVS).

The senior consultants and MoHS officials agreed to conduct only household survey with impact evaluation design by having 2 intervention groups and 1 control group. They also agreed that interviewing 10 households per village tracts/ward is feasible. However, Dr. Thiri Win discussed that the Deputy Director of Medical Research, MoHS suggested that for the selection of HEF townships and control townships, simple random sampling should not be used. Instead, purposive selection based on agreed criteria is more appropriate. Therefore, two criteria were suggested for selecting HEF and control

[1] Earlier, health-facility based surveys were part of the study design

[2] See *White, H., 2006. Impact evaluation: the experience of the Independent Evaluation Group of the World Bank.*

townships: the year of HEF implementation (years 1,2,3) and number of beds of the township hospitals (25-50, ≥ 100). By considering these two criteria, it was suggested that six HEF townships and three control townships would be needed for the survey.

Day 2

The selection of eight HEF townships was performed based on agreed criteria using data from the MoHS and the Myanmar Information Management Unit (MIMU). A total of 118 townships in the sampling list. Then, townships with security issues were excluded townships. After that, the HEF townships were divided into 3 groups according to the implementation year. In each group, the townships were categorized as ones being 25-50 bedded and ≥ 100 bedded hospitals. A new method of sampling to substitute random sampling was proposed by the HITAP team. Rather than randomly select treated or control townships, the HITAP team used a different approach of matching all available treated townships to available control townships (using the Coarsened Exact Matching program in Stata[3]). Pairs of townships similar to each other were examined and were purposively chosen based on quality of match. If one of the townships in the pair was not suitable e.g. for reasons of security or to satisfy other criteria, then the matching program re-run iteratively with the township excluded. For the control group (neither HEF nor MCHVS), it was proposed to match the characteristics of the control townships with HEF townships (i.e in only one intervention group). Matching essentially uses statistical techniques to construct a comparison group. For every possible unit under treatment, it attempts to find a control unit that has the most similar characteristics possible[4].

The HITAP team presented the six selected townships and the participants commented on the feasibility of some selected townships. Finally, six townships that were deemed feasible for data collection were selected. The selection of matched control townships involved the following approach which was decided and agreed upon in the meeting itself:

1. Each pair of treated and control townships would be located in one of four different state geographic landscapes, i.e. coastal, delta, central, and hilly.
2. The control townships would be located in the same state/region with the HEF townships.
3. The number of beds of health facilities would be considered in the same way in the control townships as with the HEF townships.
4. The control townships would have similar socioeconomic status as the HEF townships using selected indicators from the publicly available Census data 2014, obtained from MIMU.
5. Number of skilled birth attendants (SBA) and immunization status (diphtheria/pertussis/tetanus vaccine or DPT3), criteria for selecting GAVI HSS townships, would also be taken into consideration.

Day 3

Further matching of control and HEF townships was performed using Stata. However, attempts to match the selected HEF townships with the control townships did not yield sufficiently good matches. It was therefore suggested, and agreed, that the same number of HEF and control townships be matched and selected, i.e. by choosing more control townships and increasing the total number of townships to 10. MoHS and WHO staff discussed and provided additional information needed for matching, which incorporated the criteria discussed on Day 2. Participants also provided comments on the feasibility of the proposed matches. Townships with 3MDG Fund support were excluded as it was a similar program and its presence might have an impact on the outcomes of interest for the GAVI HSS program. After

[3] See work by Gary King at Harvard University for further details

[4] See *Gertler, Paul J., Sebastian Martinez, Patrick Premand, Laura B. Rawlings, and Christel M. J. Vermeersch. 2016. Impact Evaluation in Practice, second edition. Washington, DC: Inter-American Development Bank and World Bank.*

considering best available information, four pairs of townships were finalized. Figure 1 presents the match by state/region. The list of all 10 townships was finalized as shown in Table 2.

Figure 1. Matched Townships by State/Region.

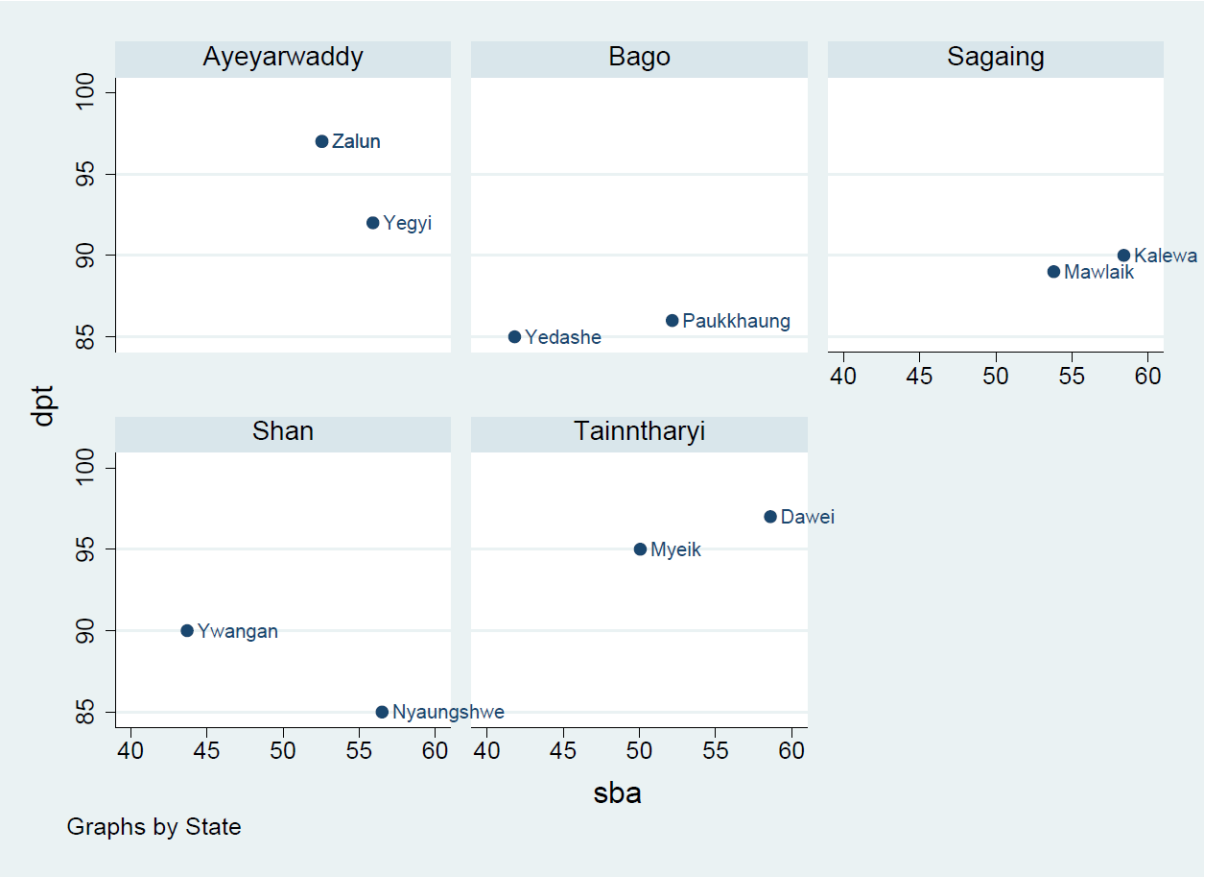


Table 2. The list of selected townships

Group	Criteria	State/region	Township
MCHVS and HEF		Bago	Yedashe
		Bago	Paukkhaung
HEF only	Year1 (25-50 beds)	Shan	Nyaungshwe (50)
	Year1 (>= 100 beds)	Tainnthary	Myeik (200)
	Year2 (25-50 beds)	Sagaing	Kalewa (25)
	Year3 (25-50 beds)	Ayeyardwady	Yegyi (25)
Neither HEF nor MCHVS	25-50 beds	Shan	Ywangan (25)
	25-50 beds	Ayeardwaddy	Zalun (25)
	25-50 beds	Sagaing	Mawlaik (50)
	>= 100 beds	Tainnthary	Dawei (200)

Role of Supervisors and Enumerators

HITAP presented the guideline for the role of supervisors based on a literature review as well as the protocol developed by HITAP. The MoHS officials said that they planned to have one supervisor for each township. Daily debriefing between supervisors and enumerators was discussed. Dr. Thiri Win said that

face-to-face interaction for daily debriefing will be not feasible. However, supervisors and enumerators can be in touch by phone on a daily basis and have face-to-face meetings on a weekly basis. Meetings among supervisor, enumerators and local authorities will be held in each township before data is collected. It was also agreed that the completed questionnaire will be verified by supervisors on a daily basis before sending the data to the central office. Also, in case of missing data, the supervisor would be responsible for contacting enumerators to re-visit the interviewee in order to obtain the missing data. The importance of the process flow i.e. completion of questionnaire, both qualitative and quantitative parts, verification of data as well as the exact date to send the competed questionnaire to central office was highlighted. Since the supervisor will be not traveling with enumerator to do the survey at household level, issues of quality control and logistical preparation were discussed. Interviews will be conducted by each enumerator independently and safety was not deemed to be an issue.

In the initial data collection plan, it was agreed that there would be forty enumerators and that each enumerator would survey two households per day, with an estimated 28-29 working days needed to complete the survey. However, the MoHS team informed that the number of enumerators would vary by township for example, there may be six enumerators for each of the townships in Bago whereas there may be fewer enumerators in each of the other townships. HITAP was requested to prepare a draft protocol for enumerators to be included in the contract of enumerators.

Training of Supervisors and Enumerators

Training of supervisors and enumerators was proposed to be held in the third week of January. It was agreed that field supervisors would be trained before the training of enumerators. The training of enumerators was confirmed to have only one training session and would be conducted in Nay Pyi Taw. The training will last five days; the first three days would be for training on data collection, followed by one day for pre-testing the questionnaire and one day for getting feedback on the questionnaire. Even as the training would be conducted in Myanmar language, it was agreed to have one or two people from HITAP participate in the training of supervisor in order to help with questionnaire before it is finalized. Four townships with ethnic minorities were identified as requiring 12 interpreters who may be volunteer health workers. In order to ensure standardization of the survey, training of interpreters will be conducted at the township levels and coordinated by the supervisor in each township.

Data Collection and Data entry

The possibility of using tablet (PDA) for collecting data was discussed. However, the cost of hiring the tablets was of concern, estimated to be USD 2,500-2,600 in total (for around 40 enumerators). It was agreed to keep the tablet as an option to be considered by MoHS and WHO. In case of using paper-based questionnaire, the use of a scanner facilitate data entry was discussed. However, it was decided to not use the scanner as it is hard to verify the completeness of the data.

Given the time and cost required for sending questionnaires to Thailand, the possibility of having data entry done in Myanmar was discussed. The Health Management Information System (HMIS) team was identified as one independent unit that could complete the data entry process. The data management process in case of using paper-based questionnaire was also discussed. The head office for managing data will be in Nay Pyi Taw. Courier service was not an option, except in Nay Pyi Taw where there is reliable service, as it was not feasible in some remote areas. Dr. Wai Mar Mar suggested the flow of sending the completed questionnaire which may be used: enumerators will be responsible for sending the completed questionnaire from villages to the township level by enumerator's private vehicle. The supervisor will be responsible for sending the data from township to state/region by supervisor's private vehicle and from

state/region to central office by public transportation service. For some remote areas, supervisors will be asked to take a photo copy/ scan the questionnaire before sending to central office to prevent loss of questionnaire during long-distance travel. Based on the experiences of the staff, there was no issue about losing questionnaires.

In selecting villages for the survey, there was a concern about selection bias. It was suggested that villages be selected that are closer to each other because it is difficult to get transportation in some remote areas however, it may not be possible to do so if villages are randomly selected. Upon discussing this further, traveling to remote areas by enumerators was not considered to be a major issue and it was agreed to select villages randomly.

HITAP staff were invited to join the data collection process which would require planning with the MoHS team as permission would be needed.

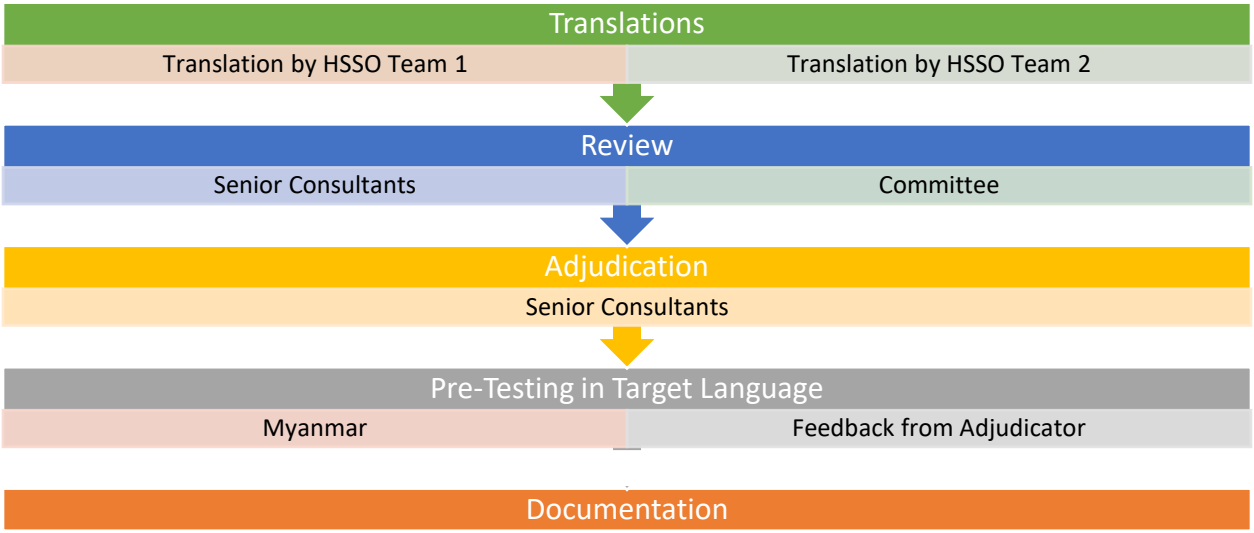
Translation

The questionnaire was developed and finalized in English, after being tested in Myanmar, the next step was to translate the questionnaire into Myanmar so that it may be used formally. As the HSSO team was to complete the translation process over the days after the workshops, a presentation was made and a discussion ensued on the framework and process for translation.

The process for translating the questionnaire for three other surveys in Myanmar was summarized. The guiding principles of translation viz, appropriateness for the target population, comparability with the source language questionnaire, feasibility and timeliness, were discussed, and some typical methods applied were presented. These include independent multiple translations, back translation and pre-testing among others. The Translation, Review, Adjudication, Pre-testing and Documentation (TRAPD) Team Translation Model was presented and adapted for the purpose of the study based on the translation plan.

Using this framework, it was noted that MoHS and WHO staff would translate the questionnaire separately and would meet to discuss the first draft of the translated questionnaire. The first draft would then be verified by the senior consultants. A simplified template for documenting changes was presented. Upon discussing further, it was agreed that changes made during the translation process would be recorded in a Word format in bullet points. The workflow is shown in Figure 2.

Figure 2: Process Flow for GAVI HSS Study for Translation of Questionnaire



Specific issues related to translation in the context of Myanmar were discussed. One key issue that emerged was that the questionnaire would only be translated into Myanmar while there may be variations in the languages used in the various regions and states. The use of interpreters to conduct interviews in these cases was mentioned as was training of interpreters to ensure standardization. Another point on the translated questionnaire related to maintaining the questions numbers in English[5].

Results

The three-day consultation meeting concluded with the following outcomes:

1. The list of townships for the survey was carefully finalized over the three day period. The treated and control townships were selected through a process of deliberation and care to ensure that bias in the study is limited and the study results are rigorous. In addition, it was discussed how to proceed with selecting the households.
2. The use of tablets for the data collection was suggested and discussed over the course of the meeting. The decision on using the tablets would be made at a later date by MoHS.
3. The process for translation as well as associated issues was discussed. The TRAPD model would be adapted for the purpose of this study. Further, use of interpreters in some states/regions where Myanmar language may not be widely spoken was discussed.
4. Access to secondary data was discussed. Sections of the datasets required are to be conveyed and requested by MoHS through official channels from other departments or agencies.
5. The WHO and MoHS teams shared M&E data for HEF and gave more of an idea about the implementation of the program.
6. A presentation by Save the Children on the experiences and findings from their study on out of pocket expenditure in Myanmar was made which provided insights including language barriers, quotations and sub-themes that came out of the data collection process until then.
7. The activities and timeline of the study were discussed and agreed upon.

[5] The administration of the survey using tablets may change this format.

Lessons Learned

An After Action Review (AAR) meeting was held on 9 January, 2017 among HITAP staff. The key areas and points raised are summarized in the table below:

Areas	Lessons
Preparation	• Presentation were done well and easy to understand. • The travel pack was helpful. • Suggestions were made as the agenda is a little bit flexible so, we need take preparation and take instant decision. • Plan for visa in advance.
Workshop organization	• Having flexibility in the agenda was good, but it is important to prepare for the changes. • Use of recorders was helpful in order to revisit discussions when pockets of discussion are missed. • Participants were good resources and gave valuable comments. So, it's very important to invite the relevant participants in advance. • It was good to have the meeting and accommodation at the same place.
Materials	• Having printed copies of materials was helpful. • Starting each day with a summary in the PowerPoint format was a great initiative.
Sampling	• Matching of townships was a good technique and provided strong arguments for sampling. • After addressing all concerns, everyone came to an agreement on the selection of townships.
Translation	• Participants were motivated to translate questionnaire by the end of the workshop. • Translation of MoHS will be verified by two national consultants.
Data Collection	• Explored possibility of using tablets for data collection
Secondary Data	• Discussed possibility of accessing databases through official channels
Capacity Building	• It may be useful to offer to the MoHS side some data management and analysis training/capacity building, if helpful.

Next Steps

On the third day, the activities, timeline and persons responsible were discussed. These are listed in the table below:

Activity	Timeline	Person in charge
Creating a mailing group to facilitate communication	19/12/2016	HITAP/WHO
Finalize the ethical proposal	16/12/16	HITAP and Dr. Thiri Win
Translation process	1st draft by 17/12/16 Verified by senior consultants by 31/12/16	MoHS and WHO officials
Sending variables of the MICS, DHS database	16/12/16	Rajibul
Discussion and summary of M&E data	16/12/16	Rajibul, Dr. Victoria and Dr.Thiri Win, WHO, MoHS
Draft protocol for enumerators and share with Dr. Wai Mar Mar so as to be included in the contract of enumerators	21/12/16	HITAP
Template to record the translation process	During translation process	MoHS and WHO officials
Meetings in township level	By 31/1/2017	HSSO (supervisors) + local authorities
Coordinate about data entry process with HMIS	31/12/2016	HITAP
Deciding on renting tablets for data collection	31/12/2016	Dr. Wai Mar Mar and WHO
Verify village tracts and wards/ check eligible households in the selected village tracts/wards	Before training	MoHS officials
Training of field supervisors	3rd week of January (1 day before training)	MoHS and WHO officials, HITAP
Training of enumerators	3rd week of January 2017	MoHS and WHO officials, HITAP
Pre-testing	3rd week of January 2017	MoHS and WHO officials
A summary of changes to the questionnaire and finalize the questionnaire	January after pre-testing	MoHS and WHO officials

Annex

Agenda

Consultation Meeting

Date: 14 December, 2016

Location: Yangon, Myanmar

Objectives:

- To share experiences, preliminary findings and lessons learned from the ongoing studies on out-of-pocket expenditure on health
- To plan activities and timeline for collaboration between the two studies

Attendees:

- Staff from Ministry of Health and Sports (MoHS), Myanmar, including GAVI HSSOs, Senior Advisors, WHO, World Bank, Save the Children and HITAP

Outcomes:

- Update on progress on the two ongoing studies on OOPE in Myanmar
- Experience and knowledge sharing on each study
- Planning communication, meetings and timeline for collaboration

Agenda:

Time	Session	Description	Person (s) Responsible
8:30 – 9:00	Opening remarks and introductions	• Introduction of consultation workshop and teams involved	• Dr. Alaka Singh, WHO
9:00 – 10:30	Update on experience from first township of data collection	• Steps to date • Lessons learned • Discussion	• Alyssa Davis & OOPE Field Researchers, Save the Children
Break			
10:45 – 12:00	Planned activities and next steps	• Activities • Timeline • Discussion	• Alyssa Davis & OOPE Field Researchers, Save the Children
Lunch			
13:00-13:30	GAVI HSS Proposal	• Background & Objective	• MoHS
13:30- 13:45	GAVI HSS Study: Overview of methodology	• Overview • Document review • Self-assessment form	• Saudamini Dabak, HITAP
13:45 – 14:45	GAVI HSS Study: Analysis of Existing Data	• Key questions addressed • Plan for datasets and analysis • Discussion	• Dr. Victoria Fan, University of Hawaii • Md. Rajibul Islam, HITAP
Break			
15:00 – 16:00	GAVI HSS Study: Survey	• Key questions addressed • Questionnaire development • Plan for data collection & analysis • Discussion	• Dr. Roongnapa Khampang, HITAP

16:00 – 17:00	Discussion on Collaboration	• Communication • Meetings • Timeline	• Dr. Alaka Singh, WHO
End			

Workshop on Survey Component

Date: 15 December, 2016

Location: Yangon, Myanmar

Objectives:

- To finalize sampling plan for household survey
- To plan next steps related to translation, management of data collection process

Attendees:

- Staff from Ministry of Health and Sports (MoHS), Myanmar, including GAVI HSSOs, WHO, HITAP

Outcomes:

- Detail sampling plan for household survey
- Plan for next steps

Agenda:

Time	Session	Description	Person (s) Responsible
9:00 – 10:30	Sampling strategy	• Discuss updated sampling plan	• Dr. Roongnapa Khampang, HITAP
Break			
10:45 – 12:00	Sampling Strategy (Continued)	• Discuss updated sampling plan	• Dr. Roongnapa Khampang, HITAP
Lunch			
13:00-14:00	Role of field supervisors	• Discuss role of supervisors • Discuss training on: • Managing data collection process • Conducting interviews • Ethics	• Akanittha Poonchai, HITAP
14:00- 14:45	Translation of questionnaire and handbook	• Process • Testing	• MoHS • Saudamini Dabak, HITAP
Break			
15:00 – 17:00	Next steps	• Sampling • Translation of questionnaire and handbook • Training for supervisors and enumerators	• Dr. Roongnapa Khampang, HITAP
End			

Meetings on Secondary Data

Date: 16 December, 2016

Location: Yangon, Myanmar

Objectives:

- To meet with relevant staff from Ministry of Health and Sports (MoHS) or other agencies to learn about availability of secondary datasets for use in analysis and identify/clarify variables for analysis

Attendees:

- Staff from Ministry of Health and Sports (MoHS), Other agencies, HITAP

Outcomes:

- Increased understanding of availability of datasets and variables of interest
- Analysis plan based on available data

Sr. No.	Dataset	Organisation/Agency
1	Myanmar Poverty and Living Conditions (WBG, 2015)	WBG
2	Integrated Household Living Conditions Survey Myanmar (UNDP, 2010)	MoHS
3	GAVI HSS Monitoring & Evaluation Data	GAVI Program Manager/Officer, MoHS
4	Hospital Data	MoHS

List of Participants

Sr. No.	Name	Designation	Organisation
1	Dr. Wai Yan Yee Mon	HSS Officer	WHO
2	Dr. Daw Than Sein	HSS Officer	WHO
3	Dr. May Phyo	HSS Officer	WHO
4	Dr. Nandar Thon Aye	HSS Officer	WHO
5	Dr. Thant Mon Cho	HSS Officer	WHO
6	Dr. Sithu Nairg	HSS Officer	WHO
7	Dr. Chit Zaw Min	HSS Officer	WHO
8	Dr. Aung Ye Phone	HSS Officer	WHO
9	Dr. Aung Kyan Hein	HSS Officer	WHO
10	Dr. Yee Yee Cho	NPO	WHO
11	Dr. Hsu Myat Myo Naing	NTO	WHO
12	Kaung Mon Winn	HSS Officer	WHO
13	Dr. Thet Zaw Htet	HSS Officer	WHO
14	Dr. Thiri Win	NPO	DoPH
15	Cho Cho Mor	NFO	DoPH
16	Dr. Aye Mya Mya Kyaw	M&E Officer	DoPH
17	Dr. Thanda Linn	Research Officer	DMR
18	Dr. Wai	Research Officer	DMR

19	Dr. Phone Myint	Senior Consultant	
20	Dr. Nilar Tin	Senior Consultant	
21	Dr. Alaka Singh	Deputy Head, WHO Country Office for Myanmar	WHO
22	Dr. Roongnapa Khampang	Researcher	HITAP
23	Dr. Victoria Fan	Assistant Professor	University of Hawaii
24	Md. Rajibul Islam	Technical Advisor	HITAP
25	Akanittha Poonchai	Research Assistant	HITAP
26	Saudamini Dabak	Technical Advisor	HITAP

Materials

The presentations and summaries of each days' proceedings are available at the following link:

Link: https://drive.google.com/open?id=0B9B2iYyLIGcCUUtRaFVkdHdabXc