GAVI HEALTH SYSTEMS STRENGTHENING SUPPORT (HSS) STUDY

REPORT ON TRAINING, 13 – 16 FEBRUARY, 2017

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

Acronyms and Abbreviations

3 MDG Fund	The Three Millennium Development Goal Fund
AAR	After Action Review
APW	Agreement for Performance of Work
CSO	Central Statistical Organization
DHS	Demographic Health Survey
DPT3	Diphtheria, Pertussis and Tetanus (3 doses)
GAVI	Global Alliance for Vaccines and Immunizations
HBP	Health Benefits' Package
HEF	Hospital Equity Fund
HH	Household
HITAP	The Health Intervention and Technology Assessment Program
HSS	Health Systems Strengthening Support
HSSO	Health Systems Strengthening Officer
iDSI	International Decision Support Initiative
LIFT	Livelihoods and Food Security Trust Fund
M&E	Monitoring and Evaluation
MCH	Maternal and Child Healthcare
MCHVS	Maternal and Child Healthcare Voucher Scheme
MIMU	Myanmar Information Management Unit
MoHS	Ministry of Health and Sports, Myanmar
MPLCS	Myanmar Poverty and Living Conditions Survey
NHP	National Health Plan
OOPE	Out of Pocket Expenditure
PDA	Personal Digital Assistant
PFM	Public Financial Management
PHC	Primary Health Care
RHC	Rural Health Center
SBA	Skilled Birth Attendant
SRHC	Sub-Rural Health Center
WBG	World Bank Group
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 (WHO), on behalf of the Ministry of Health and Sports (MoHS), Myanmar, to provide technical support for the study. The methodologies 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. The study was initiated in October, 2016 and will be completed by the end of September, 2017.

This report provides a summary of the fourth visit to Myanmar as part of this study. In preparation for data collection, a training was organized by the MoHS for supervisors and enumerators. HITAP delivered sessions on sampling of villages, wards and households, the manual for supervisors and development of identification codes. Further, HITAP staff were able to observe the training for using tablets for data collection. A meeting with World Bank staff was held to discuss collaboration on the GAVI HSS Study as well as other activities in Myanmar. Finally, next steps on the study were discussed with MoHS and WHO.

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. A third meeting was held on 13-15 December to exchange experiences with the team conducting the qualitative study on out-of-pocket expenditure (Save the Children/World Bank), finalizing sampling of townships for the survey and exploring data and options for secondary data analysis.

The objective of the visit on 13-16 February, 2017, was to deliver sessions on sampling of villages, wards and households and the manual for supervisors. The team also had the opportunity to attend the training on using tablets for data collection as well as training for enumerators. This report summarises the proceedings of the sessions and topics which HITAP was involved in and is structured as follows: Section Summaries, Results, Lessons Learned, Next Steps with supporting information in the Annexes.

Section Summaries

Sampling Methods

One of the components of the GAVI HSS Study is a household survey which seeks to determine the impact of the two health financing schemes. During the previous consultation meeting, it was agreed that there would be two intervention groups and one control group and a total of 10 townships were selected for this study: 2 townships where MCHVS and HEF were implemented (Group 1), 4 townships where only HEF was implemented (Group 2) and 4 townships where neither MCHVS nor HEF were implemented to serve as the control group (Group 3).Group 1 (intervention) townships were purposively selected and the townships in Group 2 (intervention) and 3 (control) were matched with each other based on the following criteria: state or region, skilled birth attendant (SBA) rates, DPT3 coverage rates, and township population size. Townships with security issues and the 3MDG Fund's health financing program were excluded for reasons of feasibility and separation of confounding factors, respectively. Additional factors such as geographic variation (hilly, coastal, delta, and central plains), type of hospital (measured by number of beds), and phase of implementation were taken into account. The list of selected townships is provided in Table 1.

Table 1: The List of Selected Townships

Group	State/region	Township
MCHVS and HEF	Bago	Yedashe
	Bago	Paukkhaung
HEF only	Shan	Nyaungshwe
	Tainnthary	Myeik
	Sagaing	Kalewa
	Ayeyardwady	Yegyi
Neither HEF nor MCHVS	Shan	Ywangan
	Ayeardwaddy	Zalun
	Sagaing	Mawlaik
	Tainnthary	Dawei

The selection of rural villages

The probability proportional to size (PPS) approach was applied to select sub-rural health centers (SRHCs) and rural health centres (RHCs). According to this approach, the probability of selecting SRHCs corresponds to the size of the population residing in rural areas in each township. Data from the Myanmar Information Management Unit (MIMU) was used to determine number of SRHCs and RHCs needed and so, the number of SRHCs per township varied. In each RHC, a maximum 4 SRHCs were selected. Table 2 shows the number of SRHCs and RHCs. In each SRHC, 15 households were required to be selected for the survey.

Table 2: Number of sub-centers and rural health centers per township

State/region	Township	No. of SRHCs	No. of RHCs
Bago	Yedashe	19	5
Bago	Paukkhaung	11	3
Shan	Nyaungshwe	11	3
Tainnthary	Myeik	11	3
Sagaing	Kalewa	3	1
Ayeyardwady	Yegyi	5	2
Shan	Ywangan	8	2
Ayeardwaddy	Zalun	4	1
Sagaing	Mawlaik	4	1
Tainnthary	Dawei	14	4

Villages were randomly selected using a multi-stage sampling approach using administrative data provided by the MoHS. Simple random sampling using the RAND command in MS Excel was applied to first select RHCs, then SRHCs and finally villages under each SRHC. Three villages selected under each SRHC and ranked in order of its priority in terms of the order of randomization. If 15 households could not be obtained from the first village, second village would need to be visited to obtain the rest of households required. If the second priority village also does not yield the required number of households, then enumerators may move to the third priority village to complete interviewing the 15 households required for that SRHC.

The selection of urban wards

The probability proportional to size (PPS) approach was applied to select urban wards. Townships with a larger urban population would have a larger number of wards being selected. Fifteen households were needed for each ward. Urban wards were randomly selected using the RAND command in MS Excel. Data from MIMU was used to identify and select the wards.

Table 3: Number of wards per township

State/region	Township	No. of wards
Bago	Yedashe	9
Bago	Paukkhaung	5
Shan	Nyaungshwe	2
Tainnthary	Myeik	9
Sagaing	Kalewa	1
Ayeyardwady	Yegyi	2
Shan	Ywangan	1
Ayeardwaddy	Zalun	9
Sagaing	Mawlaik	1
Tainnthary	Dawei	3

Total number of households

The summary of the number of households per township for rural and urban areas is presented in Table 4. In each group, 450 rural households and 210 urban households are needed yielding a total of 1,980 households for this study.

Table 4: Number of Rural and Urban Households

State/region	Township	No. of rural households	No. of urban households
Bago	Yedashe	285	135
Bago	Paukkhaung	165	75
Total		**450**	**210**
Shan	Nyaungshwe	165	30
Tainnthary	Myeik	165	135
Sagaing	Kalewa	45	15
Ayeyardwady	Yegyi	75	30
Total		**450**	**210**
Shan	Ywangan	120	15
Ayeardwaddy	Zalun	60	135
Sagaing	Mawlaik	60	15
Tainnthary	Dawei	210	45
Total		**450**	**210**

The selection of households

It was proposed and agreed that pre-listing of households in selected villages and wards was feasible. For this, enumerators would need to pre-list all households with the eligible survey population including 1) households with at least one woman who is/was pregnant or delivered a baby in the past 12 months, or 2) households with children aged 0-5 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 12 months. Pre-listing would be performed by checking the required information with RHCs or SRHCs in rural areas and verifying this information with community leaders or traditional healers, etc. The pre-listing form is included in the link to materials in Annex 3.

The list of all eligible households would then be used for selecting households to be interviewed. Household selection should be performed in accordance with the principle of sampling whereby each sampling unit has a known probability or non-zero chance of being selected and the selection of one unit is independent from the selection of another unit. Two methods of selecting households randomly were presented. The first method was the simple random selection with RAND command in MS Excel. This method was deemed to not be appropriate in this setting due to the requirement of the software. The second method proposed was systematic random sampling which was found to be more feasible for this study because it does not require a laptop in the field.

Systematic random sampling involves selecting households by using a fixed sampling interval by selecting a random starting point and moving in systematic manner through the list. During the

discussion, the following steps were identified for conducting systematic random sampling:

(1) Calculate the sampling interval by dividing the total number of eligible households by the required number of households in the sample. For example, the total eligible households is 60 and 15 households are to be selected, then the interval is 4.
(2) Select a number between 1 and the sampling interval (4) using random method. For example, if number 3 is selected randomly, so we start with third household.
(3) Repeatedly add sampling interval to select subsequent households. For example, the first household is household 3; then, the second household would be household 3+4 = 7.

In case of a non-response household, a replacement of the household is needed. The same list is suggested if number of eligible households is over 15 by starting from the household after the last selected households and adding the same sampling interval to select subsequent households until all 15 households is reached. In case, 15 households could not be obtained in the first round of sampling, the second round should be performed from the household after the last selected households and repeat the same method. Figure 1 shows the example of systematic random sampling of 15 households from the pre-listing form with replacement of 3 households. The starting point is the third household and the interval equals 4.

Figure 1: Example of systematic random sampling

1	11	21	31	41	51
2	12	22	32	42	52
3	13	23	33	43	53
4	14	24	34	44	54
5	15	25	35	45	55
6	16	26	36	46	56
7	17	27	37	47	57
8	18	28	38	48	58
9	19	29	39	49	59
10	20	30	40	50	60

Replacement of units

The HITAP team provided the list of selected RHCs, SRHCs and villages and wards (see next section for description of the file) to supervisors to verify and discuss the feasibility of collecting data. After the workshop, MoHS staff requested the following changes:

(1) In Yedashe, MoHS staff requested replacing Ma-Yoe-Khon RHC due to feasibility concerns. The RHC is located in a hardship area which takes at least 2 days for travelling. Given limited time for data collection, an alternative set of RHC, SRHCs and villages was selected. However, this limitation will be noted in the report.
(2) In Dawei, participants confirmed the list of urban wards with local authority and found that 2 wards, as identified in the MIMU data, do not exist. Therefore, 2 wards were reselected.

(3) In Mawlaik township, a ward named 6 Myo Ma (1) was found to consists of 6 wards. The MoHS staff randomly selected 1 ward out of these 6 wards. The iteration has been recorded.
(4) In Myeik township, data from MIMU was found to be inaccurate for 4 wards and limited eligible population was identified in 2 wards. Thus administrative data was used to reselect the 6 wards with wards identified as having limited eligible population being excluded.

Identification of Households and Individuals

A system of codes was developed in order to identify households and individuals. The identification code (ID) for each household would be formed by combining the codes for the various units. For each household, there would be a unique 13 digit ID whereas for each individual, there would be a 15 digit ID. A master file with information at the village/ward level, including variables on states/regions, townships, RHCs and SRHCs, was created. This dataset sorted by township followed by a variable identifying rural or urban areas, which was generated using the presence of an RHC/SRHC as a proxy. The codes for states or regions were taken from the MIMU. The codes for townships, RHCs, SRHCs and villages and wards were derived by numbering them from one through the number of items in the variable (e.g. 1 through 10 for townships). Households in urban areas will not have an identifying code for RHCs and SRHCs and will instead be marked as "99". A summary of the codes and their values are provided in the table below:

Table 5: Construction of a Unique ID for Households

Particular	# Digits	Values	Remarks
State/Region	2	5,6,7,14,17	Based on State/region IDs in MIMU
Township	2	1 - 10	
RHC	2	1 – 25, 99	99 for urban area*
SRHC	2	1 – 90, 99	99 for urban areas*
Village/Ward	3	1 - 308	
HH	2	1 - 15	15 households per village or ward
Individual (woman/child/emergency cases)	2	1 - 99	
Total number of digits			
HH	13	N/A	
Individual	15	N/A	

*The code for urban areas was originally to be "00" and was changed to "99" in order to be compatible with the software.

Examples of creating household and individual IDs in rural and urban areas is are provided below:

Table 6: Examples of Household and Individual IDs

	Rural		Urban	
Particular	**Example: 1**	**ID**	**Example: 2**	**ID**
State/Region	Sagaing	05	Tainnthary	06
Township	Mawlaik	09	Dawei	08
RHC	ကင်းတပ်	21	N/A	99
SRHC	တပ်ကွန်း	76	N/A	99
Village/Ward	ေယာစု (yaw su)	031	Bon Maw Ward (ဘုံမော်ရပ်ကွက်)	021
HH	(From pre-listing)	12	(From pre-listing)	03
Individual (woman/child/emergency cases)	(Woman) #2	02	(Child) #1	01
Household ID		0509217603112		0608999902103
Individual ID		05092176031202		06089999021030 1

Participants were asked to ensure that they input the number of digits as indicated in the table above for each category i.e. if the ID from pre-listing of households was "1", the ID for the household would be "01". If this practice is followed, then all household or individual records will have the same number of digits and identification of each would be smooth during the analysis.

A file with the IDs up to the village/wards was prepared for use[1]. The file included a master list at the village/ward level with IDs as well as separate sheets for each township for use. An additional sheet with the list of codes was also included. A variable for prioritizing villages, "Priority (1 = Highest)", was added, as explained under the section on Sampling. In case of replacement of any RHC, SRHC, village/ward, the new unit will assume the same ID as the one replaced. The list of variables in the master sheet and township sheet are provided in Table 8.

[1] RHC, SRHC and village or ward names would be updated using the appropriate Myanmar script

Table 7: Variable list of ID file at Village/Ward Level

Variable	Description	Values	Master List	Township List
Code_SR	State/Region Code	5,6,7,14,17	✓	✓
State_Region	State/Region Name	Text	✓	✓
Code_T	Township Code	1 - 10	✓	✓
Township	Township Name	Text	✓	✓
Code_RHC	RHC Code	1 - 25	✓	✓
RHC	RHC Name	Text	✓	✓
Code_SRHC	SRHC Code	1 - 90	✓	✓
SRHC	SRHC Name	Text	✓	✓
Code_Village/ward	Village/Ward Code		✓	✓
Village_Ward	Village/Ward Name	Text	✓	✓
combined_ID	Village/Ward ID	N/A	✓	✓
Total HH	Number of households	Number	✓	
# of HH	Number of households to be selected	Villages/wards selected: 15 or 17 Villages/wards not selected: 0	✓	
Group	Intervention or control group	1 = MCHVS/HEF 2 = HEF Only 3 = Neither MCHVS nor HEF	✓	
Rural_Urban	Rural or Urban area	R = Rural, U = Urban	✓	
Priority (1 = Highest)	Priority for selection of village	Rural: 1, 2, 3 Urban: 1	✓	✓

Supervisor Manual

A manual with forms for the recording and tracking progress of the survey was developed for the supervisors. The points were adapted from three supervisor manuals of standard surveys[2] for the purpose of this study in conjunction with inputs received during the previous consultation meeting. The key features of the manual were presented to supervisors on the first day of the training and feedback was solicited. The forms for tracking the progress of the survey were revised in consultation with the supervisors. The manual, forms and presentation are available in the link provided in Annex 3.

[2] These are: Demographic Health Survey (DHS), Global Adult Tobacco Survey (GATS) and National Family Health Survey 2015-16 (NFHS-4).

The manual provides an overview of the survey and details the responsibilities of the supervisor. It is organized into four main parts:

(1) *General Responsibilities*: As part of their general responsibilities, supervisors are entrusted with ensuring confidentiality of the data collected, data security and management of the enumerator team.
(2) *Fieldwork Preparation Activities*: Fieldwork preparation includes participation in training, coordination and management of materials, supplies and the budget.
(3) *Organizing and Supervising Fieldwork*: During the fieldwork, supervisors are expected to assign tasks to enumerators and provide support to them during the data collection process, including troubleshooting. Further, supervisors are expected to provide quality assurance and monitor the data collection process by observing interviews as well as analyzing the data to look for patterns of non-response. Finally, supervisors play a key role in ensuring the flow of data and communication from the enumerators to the field coordinator at MoHS and participants were asked to develop and agree on the process for the same.
(4) *Evaluating Enumerator Performance*: Supervisors are also required to manage the team of enumerators and ensure that the targets for data collection are met in a timely manner. Tracking the progress of enumerators and having regular communication to provide feedback was noted.

Three reporting forms were developed to aid supervisors in tracking and reporting the progress of data collection. The three forms are linked to each other but record information at different levels. These are summarized below:

Table 8: Summary of Reporting Forms in Supervisor Manual

Annex (Manual)	**Level**	**Use**
1 (a & b)	Village/Ward level	• Record the relevant population profile of each village or ward • Plan for number of interviews to be completed per week in each village or ward • Aggregate to higher level for planning and tracking
2	Household level	• Track micro-level information on households assigned and interviewed including number of eligible members • Track visitation history
3	Enumerator level	• Track progress by week of number of households assigned and completed

A presentation on tackling interviewer errors was made. Common data problems, including those arising from human error, were discussed. The main issues raised were around ensuring confidentiality of respondents, testing the application that is to be used and quality assurance of the data collected. Suggestions provided included the following: having two copies of informed consent forms – one for the respondent and one for records, to test the application in advance and save the data collected after each section, calling 30% of enumerators daily or having a conference call to provide real-time feedback, maintaining team morale and developing rapport among enumerators.

The management of interpreters in localities where Myanmar was not the dominant language was raised. During the consultation meeting in December, the use and training of interpreters to ensure standardization of interviews had been discussed. However, hiring and training of interpreters at the township level was not seen to be feasible. Two states/regions were identified as potentially requiring interpreters viz Shan and Tainnthary and it was agreed that interpreters would be hired on an ad hoc basis, if needed. As an alternative, one participant mentioned that during the previous HEF assessment, enumerators who could speak the local language were deployed in the areas where Myanmar was not spoken. However, there was a concern that having a local enumerator may bias results. It was therefore agreed that, if possible, an interpreter will be hired for the purpose and if that is not possible, someone who in conversant in both, the local language and Myanmar, will be asked to serve as an interpreter. As a last option, the household may be excluded and replaced by another, noting that this would be a limitation of the survey.

Use of Tablets

During the previous meeting, it was decided to use a tablet to collect data for the survey. The advantages of using a personal digital assistant (PDA) or tablet for data collection are manifold including application of a transparent and standard algorithm for the questionnaire, improved data entry and data integrity. In this regard, Xavey Myanmar Research Solutions has been contracted to provide the tablet and software for collecting data for the survey. The Xavey team is also responsible for training users on the devices and providing the clean data. The Xavey team conducted a training for supervisors and discussed the practical aspects of data collection on the second day of the training program.

The Xavey team developed an application (or apk file) for the HH questionnaire in Myanmar for this survey. The application is password protected for both, enumerators and supervisors. Further, it is user friendly, can be downloaded on smart phones and can be operated offline. The questionnaire is divided into the 6 separate forms corresponding to the following:

(1) WHO - Household List: Recording result of the interview and IDs
(2) WHO Section 1- 4: Covers Sections on Demographics, Household expenditure, Household income, Living conditions
(3) WHO Section 5 Intro: Initial set of questions for Section on Service utilization
(4) WHO - Service 1 – 4: Covers sections on Antenatal Care, Delivery, Postnatal Care (more than 24 hours after delivery) and Emergency life-threatening health conditions (all age).

(5) WHO - Service 5 – 6: Covers Sections on Immunization of Children and Children who have acute illness (aged 0- 5 years).
(6) WHO Section 6-7: Covers Sections on Hospital Equity Fund (HEF) awareness Section 7. Maternal and Child Healthcare Voucher Scheme (MCHVS) awareness

The application enforces skip patterns, requires responses to all questions and validates the value of the response. Only one question is displayed at a time on the screen which makes the interview process more clear. The codes and instructions are displayed on the screen reducing the burden on the enumerator. However, there may be some teething issues and challenges and require enumerators to be more careful while entering data in order to avoid misspelling responses to open-ended questions.

The Xavey team emphasized two points for using tablets: charging the equipment and the importance of backing up the data. It is important that tablets are fully charged particularly in remote areas where there are very limited accesses to charging. The Xavey team discussed the possible sources of power and options for charging the tablets, which can take a couple of hours each day. It was advised that enumerators charge the tablet fully and then start the data collection each day. Second, the Xavey team highlighted the importance of backing up the data. Enumerators need to make sure that application backs up the data when internet connection is available and if possible they should store multiple copies of the data on their computers.

During the session, the MoHS team discussed issues related to data management, missing responses, data entry errors and skip patterns. The HITAP team sought clarification on skipping pattern in the application which was different from the paper and was adapted for the electronic version. The various means of controlling data quality by using the application were noted. The Xavey team also showed and explained the data view in MS Excel format.

Discussion with World Bank Group

HITAP staff met with team members from the World Bank Group (WBG) working on health in Myanmar. The main areas discussed were the GAVI HSS Study, the Myanmar Poverty and Living Conditions Survey (MPLCS), other programs that have been in the country including the Bank's activities. Further, areas for collaboration between the Bank and HITAP were also discussed. These points are summarized below:

(1) *GAVI HSS study*: The study comprises four components, including a household survey and analysis of secondary data, and is focused on the health financing schemes under the GAVI HSS program. Lessons from the GAVI HSS study could help unpack design and implementation issues. It was pointed out that the study would also be helpful in teasing out the reasons for an increase or decrease in OOPE. The qualitative study being conducted by Save the Children and WBG will also add to understanding the underlying causes of OOPE in Myanmar.
(2) *MPLCS:* The Bank team advised that the MPLCS dataset is not available to the public and that one may need to approach the Central Statistical Office (CSO) directly. In terms of design, the MPLCS is not representative at the township and regional levels. The

Demographic Health Survey (DHS) may be relevant for this study as would census data which is available on the website.

(3) *Other programs/plans in Myanmar*: In addition to the GAVI HSS, there are other programs in the country that are similar in scope. These include: Emergency referrals/3 MDG program as well as a conditional cash transfer program called Livelihoods and Food Security Trust Fund (LIFT). The National Health Plan (NHP) and the free medicines' scheme are two other important policies being developed or implemented by the government.

(4) *Bank's activities*: The Bank has an Essential Health Services Access project, where the focus is on Primary Health Care (PHC), which will be restructured by July this year. The activities under this project include analytical work on fiscal space, PFM, benefits package and resource mobilization. Thus, the key areas of work are around health financing and PFM.

(5) *Areas for collaboration in the near term*: Two areas for collaboration between WBG and HITAP were identified: a dissemination event on the two studies on OOPE with senior policy makers in the government and sharing of Thailand's experience with public financial management (PFM) reforms. Both parties agreed that there may be opportunities to work together in other areas as well.

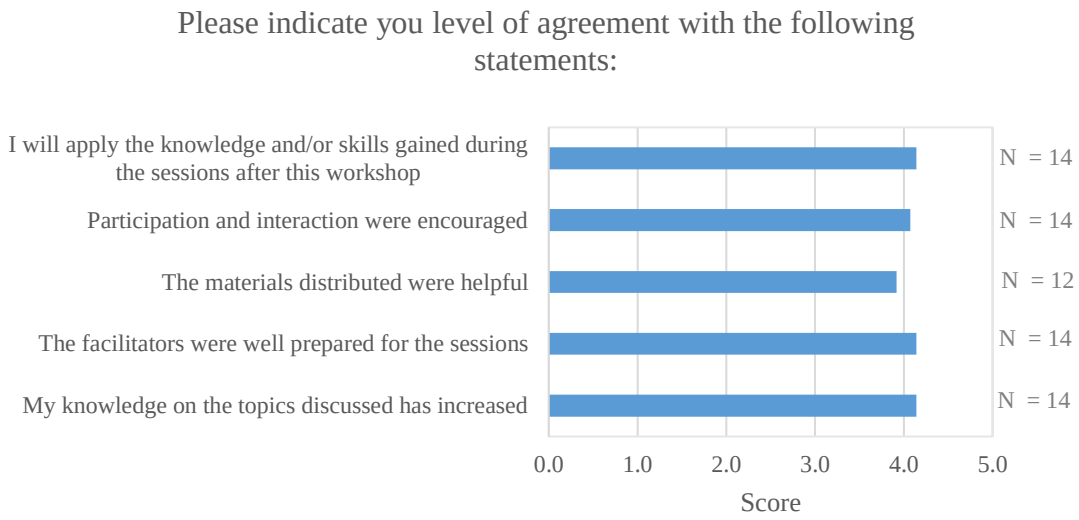
Results

The outcomes from this visit are listed below:

(1) Supervisors were trained on:
- Use of systematic random sampling of households.
- Application of manual including identifying common interviewing errors and supporting documents for supervisors.

(2) A feedback form was distributed at the end of the first day covering the aforementioned topics in (1). The participants largely agreed with the statements on four dimensions for the sessions conducted (average score = 4.1). However, participants rated the dimension on distribution of materials lower than others (average score = 3.9). This point was echoed in the suggestions for improvement of sessions where participants said that it would be useful to share the materials or information as well as having more discussions. Other suggestions included applying the knowledge presented to make decisions with a one remark on speaking slowly during presentations and discussions. Most participants indicated that they liked the topics covered (91%), with many stating that they liked the practical aspects of the training such as sampling and selection of households (58%). The results of the quantitative questions are provided in Figure 2 with supporting tables in Annex 2.

Figure 2: Feedback on Sessions



(3) Supervisors and enumerators trained on creating a unique ID for households
(4) List of selected RHCs/SRHCs & villages/wards.
(5) HITAP staff learned that MoHS requested but didn't receive DHS and MPLCS from relevant agencies.
(6) Monitoring and evaluation (M&E) data for MCHVS was received from MoHS
(7) Discussion with WBG on study and future collaboration

Lessons Learned

The HITAP team conducted an After Action Review (AAR) meeting on 24 February, 2017. The agenda for the meeting was to provide an overview and summary of outcomes of workshop, discussion on what went well and why as well as areas of improvement. The discussed covered the following: preparation, logistics, workshop content and coordination. Below is a summary of the discussion:

Table 9: Lessons Learned

Areas	Lessons
Logistics	• Arrangements were made in time for the workshop • It was helpful to have adequate local currency before reaching Myanmar, especially in Nay Pyi Taw, where money exchanges are not available at all times. • One may consider other hotels that are within the price range • Plan to have Wifi (pocket router) or buy sim cards • Carry HDMI connector and pointer
Materials	• Timely preparation of presentations and materials was helpful • It may be useful to carry and share print outs of presentations
Delivery	• Having a recap in PowerPoint format was still useful • It may be useful to engage in group work or other way with more hands on/real life examples for training in MS Excel.
Feedback	• Having a feedback form was useful and provides information for next visit • It would be useful to include a time slot for discussing feedback in agenda

Next steps

The following items were identified as next steps during the visit:

(1) During the data collection process, HITAP staff may support supervisors in field.
(2) HITAP and WHO agreed to follow up with WHO on potential work on medicines, visit of staff to Health Benefits' Package (HBP) workshop in South Africa and the second Agreement for Performance of Work (APW) for the GAVI HSS Study.
(3) The potential for collaboration with WBG on the qualitative study on OOPE and GAVI HSS Study was discussed. Further, both parties agreed to share information or explore other avenues of working together in Myanmar.

Annexes

Annex 1: Agenda

Agenda for HSS Study Training

(13-2-2017) to (19-2-2017)

Meeting Room, Office (47), Ministry of Health and Sports, Naypyitaw

Objectives:

- To conduct training for supervisors on electronic based data collection
- To discuss questionnaires and accompanying handbooks for surveys in terms of electronic format, to be conducted at Household level
- To train enumerators for household data collection with tablet
- To test questionnaires by tablet in field locations

Attendees:

- GAVI HSSOs, Enumerator team, Senior Advisors, WHO, and HITAP team

****Note: All sessions related to the computer based questionnaire were moved to Day 2 and sessions from Day 2 were moved to Day 1.*

	Description	**Responsible person**
13-2-2017		
9๐:30-10๐:00	Opening Remarks	Daw Aye Aye Sein, Deputy Director General (Admin/Finance)
10๐:00 - 10๐:30	Refreshment	
10๐:30- 12๐:00	Explanation Training of Questionnaires with Computer based (Tablet) for Supervision	Xavey Research Solutions Co.ltd
12:00 – 13:00	Lunch	
13:00 – 16:00	Explanation Training of Questionnaires with Computer based (Tablet) for Supervision	Xavey Research Solutions Co.ltd
13:00 – 16:00	Village & HH selection from received data	HITAP

	Description	Responsible person
14-2-2017		
9○:30 - 12○:00	Simulation exercise with Tablet based data collection	All facilitators
13:00 – 14:00	Protocol for Supervisors	HITAP
14:00 – 15:00	Selection of villages from selected townships & How to select Household in field	HITAP
15:00 – 16:00	Discussion	
15-2-2017	**Training of Enumerators**	
9○:30- 10○:00	Brief explanation about GAVI HSS closure study	Dr Wai Mar Mar Tun, Director (HSS)
10○:00-11○:00	Protocol for Enumerators	Dr Wai Mar Mar Tun, Director (HSS)
11○:00 - 12○:00	Questionnaires overview & Details of Section 1:Demographic	Dr Thiri Win
12○:00 - 13:00	Lunch	
13○:00 - 14○:00	Details of Section 2: Household expenditure	Dr Aye Mya Mya Kyaw
14○:00 - 15○:00	Details of Section 3: Household Income	Dr Thet Zaw Htet
15:00 - 16:00	Details of Section 4: Living Conditions	Daw Cho Cho Mar
16-2-2017	**Training of Enumerators**	
9○:30- 12○:00	Details of Section 5: Health Service Utilization	Dr Thiri Win
12:00 - 13:00	Lunch	

	Description	Responsible person
13:00-14:00	Details of Section 6: Hospital Equity Fund (HEF) awareness	Dr Aye Mya Mya Kyaw
14:00-15:00	Details of Section 7: Materanal and Chidl Health Voucher Scheme (MCHVS) awareness	Dr Thet Zaw Htet
15:00-16:00	Summary of Questionnaires Question and Answer	Dr Thiri Win
17-2-2017		
9:30 - 12:00	Practice on data collection with electronic based (Tablet) (Group work)	All Facilitators
12:00 - 13:00	Lunch	
13:00 -14:00	Discussion for data collection by using tablet	All Facilitators
18-2-2017		
9:30 - 15:00	Pretesting of tablet based data collection at Household survey	Lewe Townships
19-2-2017		
9:30 - 12:00	Discussion & Feedback from field visit	Central team
12:00 - 13:00	Lunch	
13:00 - 14:00	Trip plan for each township	HSSOs and enumerator team
14:00 – 15:00	Plan for data reporting	Central team
15:00 – 16:00	Discussion	

Annex 2: Supporting tables for feedback forms

Q. No.	Question		
	Please indicate you level of agreement with the following statements:	N	Av. Score
1	My knowledge on the topics discussed has increased	14	4.1
2	The facilitators were well prepared for the sessions	14	4.1
3	The materials distributed were helpful	12	3.9
4	Participation and interaction were encouraged	14	4.1
5	I will apply the knowledge and/or skills gained during the sessions after this workshop	14	4.1
6	What did you like most about the sessions today?	N	%
	Topics	11	92%
	Sampling	7	58%
7	Do you have any suggestions on how we can improve the sessions today?	N	%*
	Materials	2	40%
	Have discussions and Q&A sections	2	40%
	Need for decisions	1	20%
	*Denominator includes only valid responses		
8	Do you have any other comments?	N	%*
	Communicate slowly during presentations	1	20%
	Community participation needed for success	1	20%
	Positive view of	3	60%
	*Denominator includes only valid responses		

Annex 3: Training materials

Link to materials:

https://drive.google.com/open?id=0B9B2iYyLIGcCOXpZWkRYS0VmQnc

List of files:

Sr. No.	File Name
1	Survey_GAVI_HSS_February
2 – a.	Survey_GAVI_HSS_February_HH
2 – b.	Prelisting Form 2016-12-21
3 – a.	GAVI HSS Study - Supervisor Manual 2017-02-13
3 – b.	Draft Supervisor Manual 2017-02-15
3 – c.	Supervisor Manual Annex Forms 16 Feb 2017
4	Interviewer Errors Updated
5	IDcode15Feb_township
6	Summary_Feb13_Updated