GAVI HEALTH SYSTEMS STRENGTHENING SUPPORT (HSS) STUDY

REPORT: WORKSHOP ON REFLECTING ON DATA COLLECTION FOR GAVI HSS STUDY, 24-25 APRIL, 2017

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

Acronyms and Abbreviations

AAR	After Action Review
HEF	Hospital Equity Fund
HH	Household
HITAP	The Health Intervention and Technology Assessment Program
HSS	Health Systems Strengthening Support
HSSO	Health Systems Strengthening Officer
HTR	Hard-to-reach
iDSI	International Decision Support Initiative
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
OOPE	Out of Pocket Expenditure
PDA	Personal Digital Assistant
RHC	Rural Health Center
SARA	Service Availability and Readiness Assessment
SRHC	Sub-Rural Health Center
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 fifth visit to Myanmar as part of this study. A household survey was conducted during March and April 2017 as part of this study. In order to record the experiences and lessons from the data collection process, a workshop was held in Yangon on 24-25 April with the supervisors of the survey, MoHS, WHO and HITAP staff in attendance. The team also discussed the data management and the next steps on the study.

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. On 13-16 February, 2017, HITAP staff delivered sessions and participated in the training for supervisors and enumerators for the household survey.

This was the fifth visit to Myanmar as part of this project. The primary purpose of the visit was to reflect on the data collection process of the household survey conducted as part of the study and plan on the next steps of the study. Additionally, the Save the Children team presented their findings from the qualitative study on out-of-pocket expenditure for the Yangon region. 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

The two-day workshop opened with a presentation on the findings of the qualitative study on out-of-pocket expenditure (OOPE) conducted by Save the Children. Over the course of the workshop, supervisors, survey coordinators, WHO and the HITAP team deliberated on the data preparation, data collection, data cleaning and management issues, together with the software company, Xavey, hired for this purpose. These topics are described below:

OOPE qualitative study

The team from Save the Children made a presentation on preliminary findings from the qualitative study on OOPE in Myanmar. Household and provider surveys were conducted to understand the impact of OOPE decision making and coping mechanism related to OOP at household level and to understand how healthcare providers and informal providers manage resource from OOPE at the primary care level. Three different areas, in terms of settlement, namely, peri-urban, rural, and hardship areas, were selected for this purpose. Townships were selected purposively and the research team consulted with various stakeholders, including township medical officers (TMOs), international NGOs, and professional associations active in the township to better understand the profile of the township. In order to select villages in the townships, the team consulted with health assistants, lady health visitors from rural health centers (RHCs) and midwives from sub-rural health centers (SRHCs). Data was triangulated to the extent possible and households were selected through village mapping. There was variation in how the hard-to-reach (HTR) population was defined. In Yangon, for example, migrants were classified as being HTR whereas in rural areas, the relationship was more geographic. The closeness to health services was considered as were perspectives of people. NVivo software was used to code the data collected. An iterative second order analysis of data was conducted. Concept maps were developed, and initial coding of data was done in accordance with the analytical framework which was deductive in nature and areas were added in an inductive manner.

The preliminary results were presented for two townships viz Hlaing Thar Yar and Shwe Pyi Thar. The results of the wealth quintile varied with respect to the reference case which was either the entire country or the state or region. This comparison served as a check that the sample selected was from the target group, with the state or region being the main reference. The concept map for Yangon was presented for each strategic objective. For the first strategic objective on household OOPE, the source of money that people relied on for healthcare expenditure were categorized into five groups which were donations/charity, loan (with interest), borrowing (without interest), provider credit, and money in hand and each group they were branched out in to several sub-group to explore the final sources of money. The size of circle for each category shows how frequently it appears and for hospitalization, a loan is the first priority. There appears to be an order of prioritization and for example, if a health incident can be planned, households can borrow but if there is a sudden health incident, households have to undertake a loan with high interest rates. This may lead to forgone care. Donations were made to those identified as poor or vulnerable.

For the second strategic objective on the healthcare provider perspective, the concept map was developed to reflect that people may seek one or multiple providers simultaneously or

successively, especially when there are multiple health incidents or chronic health issues in a household. The behavior of seeking care was categorized into public health services seeking, private health services seeking, informal health services seeking, and self-medication. The type of costs vary according to the provider when they seek care and while self-medication will only include cost of medicine, seeking care from private health services, will involve more types of costs such as the cost for investigation, service fees, medicines, and cost of meals or transportation. Interestingly, it was found that the type of cost is more complex if households seek formal care at public service providers. There are some predictable, some unpredictable costs, some experienced in facilities and some outside the facility. Donations for traditional birth attendants are provided although it is unclear whether a donation was a fee for cost or not. Laboratory costs overlap with private providers as the lack of capacity in the public sector can have patients referred to private clinics.

The presentation was followed by a question and answer session. It was noted that this study looked at the supply side factors of OOPE and was taking a broader approach to services rendered. The asset index used in the qualitative study could also be constructed for the household survey in the GAVI HSS Study and be used to link the both surveys. A question was asked about what one can say about the increase in government health expenditure by the MoHS and its impact on reducing OOPE. In the same vein, a question was asked about the seeming difference between the expenditure structure at public and private facilities. The Save the Children team noted that private facilities vary by region as well as high density urban areas and rural or peri-urban areas. Households have a choice of using either public or private facilities and price may be seen as a signal of quality. Quality is an important consideration given that the government is spending more on health. This also highlights that all types of providers in the system are important, even though literature reviews have noted that the private sector dominates in the out-patient services and the public sector in in-patient services. The findings also show that public and private sectors collaborate with each other. It was clarified that the diagram on the second strategic question was not calibrated according to frequencies. Regarding the informal sector, it was noted that informal providers, which includes drug sellers, are preferred more than private providers as they offer more credit.

Preparation for survey and data collection

The management and supervisors of the survey were asked to describe the source for pre-listing, how the data was recorded during pre-listing and how enumerators were supervised and quality assurance was conducted. For the data collection phase, teams were asked to describe summary statistics, their experience using tablets and the process of supervision of enumerators and quality assurance (see Note in Annex 1). In addition, the team was asked to summarise the challenges and lessons learned during the preparatory and data collection process. MoHS staff and supervisors made presentations on their experiences. Further, a ten-question survey had been sent to supervisors prior to the workshop with time provided at the end of the first day of the workshop. The findings of the survey were presented on the second say of the workshop and have been integrated in this section (details in Annex 3). Given the common issues across the preparatory and data collection phases, these are presented together.

The MoHS staff provided an overview of the study and the preparation process. There were four staff from the HSS unit who served as field coordinators. They communicated with TMOs to get information on the township and to ensure that HSSOs had support. Some of the central staff served as supervisors as well. It took some time to get high level permission to go ahead with the survey. WHO arranged for having a software company, Xavey, to provide the tablets for data collection as well as provide the final dataset. The HSSOs served as supervisors and the enumerators were hired through the Association of Health Assistants. The supervisors were responsible in the field and had trained on using tablets including by doing exercises. They were asked to maintain hard copies as well as tablets.

Table 1: Teams Involved

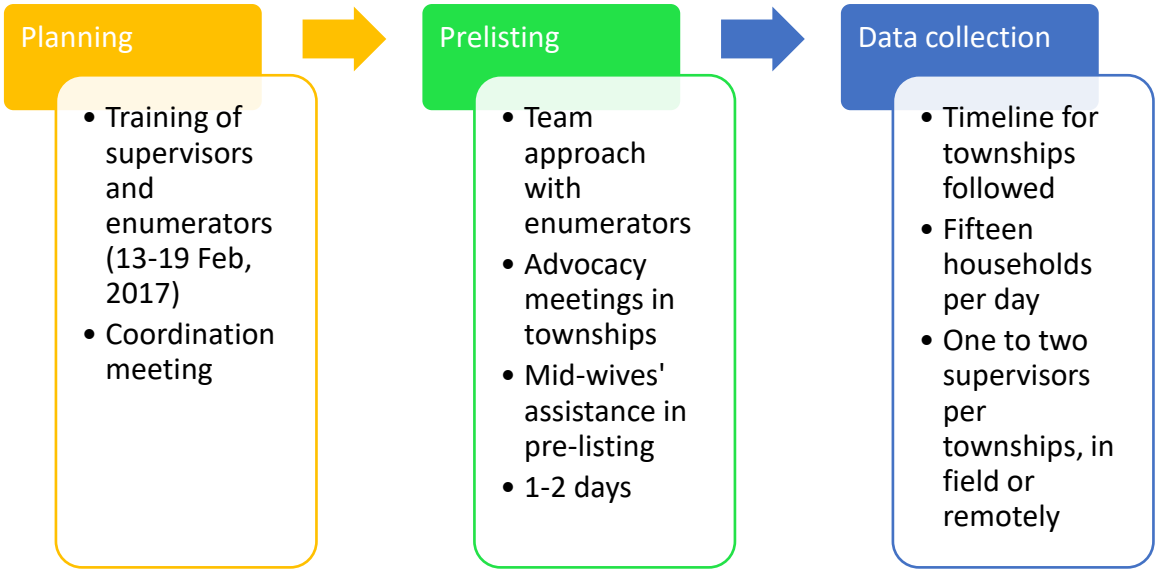
Function	Team
Central Coordination	Gavi HSS Team, MoHS with WHO
Supervision	HSSOs with support from Central Coordination and WHO team
Enumeration	Health Assistants

Training of supervisors and enumerators had been conducted in Nay Pyi Taw on 13-19 February, 2017. Following the training in February, a one-day field meeting was conducted to plan for the number of households, the number of households to be surveyed each day. In the survey, supervisors indicated that the training provided as well as the manual and resources provided to supervisors were useful. Sampling was noted as being useful by several supervisors. It was noted that using the Personal Digital Assistant (PDA), addressing technical issues such as missing data as well as using MS Excel for monitoring cold have received more attention during the training.

Prelisting was done by enumerators with the assistance of mid-wives as they had a list of all the eligible households in their catchment area. Prelisting was done in teams of 3-5 enumerators who moved together from one to another village or ward. A team approach was preferred over enumerators going along in pairs. If a household had to be replaced, the supervisor had to be informed in advance. Supervisors travelled with enumerators for up to ten days. Prelisting itself took about 1 – 1.5 days. Language was a barrier in some cases. During the immunization period, midwives were busy so volunteers who have basic training of midwives joined instead. Supervisors were posted at their duty station and would go back to field visit as needed.

In order to ensure smooth cooperation at the township level, instruction letters for the TMOs were prepared. However, the level of facilitation varied from township to township. In project townships, meetings were conducted with TMOs and mid-wives. This was time saving to meet as pre-listing could be done at the same time. If there had been more time, advocacy meetings with TMOs would be held in addition with other stakeholders. Sampling of households was conducted immediately after the advocacy meeting and this was more convenient for the supervisor. Urban wards have many eligible households and if there had been more time, it would have been easier to do the sampling in excel format.

Figure 1: Implementation of survey



There was a tight schedule to complete the survey, given the end of GAVI's no-cost extension, closing of contracts for HSSOs and the onset of the New Year holidays in March. There was also a gap between training of supervisors and enumerators and data collection. This offered an opportunity for enumerators to go over questionnaire. However, two enumerators had to be replaced and the new staff had to be trained again with the relevant supervisor closely monitoring the new enumerators. Further, due to the terrain, the enumerators could not complete the three visits required for each household before replacing the household. This also affected the survey team's HTR areas as there was a trade off in terms of time. There was poor infrastructure in several townships even in Yedashe, which is in the central zone, transportation was a major issue and supervisors had to take bullock carts and charcoal trucks to reach some households. Internet and electricity problems were faced by supervisors and enumerators. Ensuring availability of households for the interview during the limited timeline posed some constraints as households were away in the fields or village activities.

There were some issues related to sampling and these were addressed by the central coordination team which consulted with the HITAP team as needed. These issues related to changing the priority village, the sampling interval, resolving the difference in the urban wards selected for one of the townships, Mawlite, using the MIMU dataset and actual data. In Myeik, the actual number of wards was totally different for six out of the nine urban wards. In some village, the eligible households were not very large. In some cases, there was a discrepancy in the data but this could be confirmed with data collected from the TMOs. An effort was made to triangulate the information using information from various sources.

In one case, Nyaung Shwe, the TMO pointed out that the sampled village was too far from the township hospital and so households from that village would rather go to the station hospital close

to their residence, where they would receive similar services. Hence, the use of HEF would be under-reported. The team discussed that this would serve as a case study on the design of the scheme and which type of facilities should be covered. The Service Availability and Readiness Assessment (SARA) report may be used to identify other facilities that could provide services and perhaps, be covered by the HEF.

The enumerators, health assistants, were recent graduates. While they had experience in conducting group surveys, they had not conducted a survey of this scale. Some knew a lot about the localities and it is possible that they may have influenced the responses of households who may not have revealed their real responses. The enumerators, being young, were tech-savvy. At times, young staff had to be asked to behave appropriately and to maintain data confidentiality. Thus, there was a trade-off between limited field experience and application use. Even with regards to the interviewing process, enumerators had limited experience and while they were trained on the flow and concept of the questionnaire, some didn't follow the instructions. It was useful to have a practical training in the form of pre-testing for enumerators. The Health Assistants' Associated maintained the informed consent form and was also responsible for the management of tablets. Incentives were included in the contract to provide a token of appreciation to households in kind. However, it took some time for this to happen.

It was noted that the flow of the questionnaire was not easy to follow using the tablet, even for supervisors, and it was therefore important to know the questionnaire well especially the sections on expenditure and income. Sometimes, changes needed to be made and this was easier with a hard copy. Supervisors could not check the data in the field and it was easier to check the data remotely. One could go back and make changes before submitting and if there was missing data, then enumerators were to inform the supervisors to add the information once it comes to them from the server. Newly assigned enumerators were observed by supervisors. Supervisors were able to spot inconsistencies and for example, in one case, a child was counted under two households.

The teams respected the timeline and planned activities. On average, enumerators surveyed fifteen respondents per day and typically covered one village per day. The team said that it took enumerators at most an hour to conduct the interview. The teams would skip to other villages if there were less than the required number of households. The number of enumerators was not seen to be adequate and in Dawei, for example, there were only three enumerators for 195 households. Not only was there a shortage of enumerators, but also of supervisors. It was suggested that there should be one supervisor for at least two households per sub-centre to advocate the need for the survey among members of the community. There was some flexibility in reallocating resources although it was not possible to provide more staff. The team approach of all enumerators moving together as well as having advocacy meetings with the TMOs and community leaders facilitated the data collection process. Typically, basic health staff and other local staff were involved and in one village, the Myanmar Red Cross was also supporting the survey. However, there was no incentives for the local staff who supported the survey.

Data quality was a common issue encountered during both, preparation and collection. As noted above, supervisors were in the field only for one week, after which, supervision was done remotely. In some cases, such as Paukkhaung, two supervisors were able to accompany enumerators during

the survey. Supervisors followed every enumerator, however, it was not possible to cover all households. Supervisors would communicate with enumerators who needed additional attention at the end of the day. Even when the supervisors were not in the field, there were daily phone meetings between enumerators and supervisors. Common errors found included double counting, problems in data on expenditure which had to be recollected, ensuring that the notes in paper added up. Facilitation was needed by interviewers including asking probing questions. Some supervisors who also had the experience conducting a nutrition survey said that most respondents could not distinguish between amount spent on transportation and the amount earned. For immunization, some households maintained the immunization record while in other cases, the midwives kept the card so that it is not destroyed.

In terms of knowledge and skills gained, supervisors stated that they learned resource management, coordination, supervision and problem-solving skills. Administering the questionnaire and using a tablet was also a new experience for several supervisors and they also enhanced their recording skills. Through the survey, supervisors also gained exposure to the functioning of and bottlenecks in the health system. Supervisors felt that this survey would make an important contribution to future projects in Myanmar.

Table 2: Summary of key points on preparation and data collection

Particular*	Key Points
Challenges	• Timeline of survey • Transportation in reaching HTR households • Reaching and following up with households in hard-to-reach areas • Use of tablets (see next sub-section)
Sampling	• Discrepancy between administrative and actual data • Potential for limited results in in treatment townships due to random sampling
Data quality	• Limited number of staff for supervision • In field and remote supervision • Experience level of staff
Knowledge and skills gained by supervisors	• Resources management skills • Problem solving skills • Supervision skills • Administration of survey • Health system in Myanmar

**For use of tablets, see next sub-section*

Use of tablets for preparation and data collection of survey

This survey is among the early surveys in which electronic data collection has been used and hence, the experience of using a PDA or tablet will be instructive to others. Based on the discussions, the experience was mixed, with members agreeing that tablets made data collection easier, but there were teething problems and back-ups had to be maintained.

The use of a tablet made data entry easy as it could be used anywhere. The questionnaire was built using a Google application and was easy to use. The data from the tablets was synchronized with the server when an internet connection was available usually on a daily basis. Xavey checked the codes used during data entry and sent these back to the supervisors in excel or csv format. The data was checked by supervisors and then by the central team. Each interviewer had an individual file for each day and this made it easier for supervisors to check the data. Each day, a maximum of five households were covered. Some of the key parameters checked were the household IDs, date of data entry and time taken for each section, although in some cases, enumerators may have entered data at night. Having a "master" household list using the tablet was useful to identify which sections were relevant for each household and one could also reference the hard copy.

There were some problems related to using new technology. For example, some tablets didn't work and the survey responses had to be noted on paper and then re-entered. In Zalun, for example, there was no mobile connection and the team had to deliver the tablet to company. In order to account for malfunctioning of tablets, teams maintained stand by tablets. In some cases, it took two days to change the tablets. In some other cases, it was not possible to send the data at all such as in Zalun. In some cases, there was missing data due to the skip logic of the questionnaire and the data had to be collected again. There were some gap instructions in the tablet led to data being missed. For example, one missed asking about under five children if there was no household ID.

Discussion with software company

The team from Xavey, the software company hired to support this survey, explained the way in which the data was structured. As it is a long questionnaire, the data has been divided into five parts. The first is the household list which serves as the "master list" of all households and their members; it also contains the team name and worker ID. The second part comprises data from Sections 1- 4. Section 5 on utlisation of health services is divided into two parts to account for the structure of the data for pregnant women, children and emergency patients. Finally, the fifth part comprises data from section 6 and 7. Each of these parts is linked by a household ID. In all, there are 211 questions and 4000 variables.

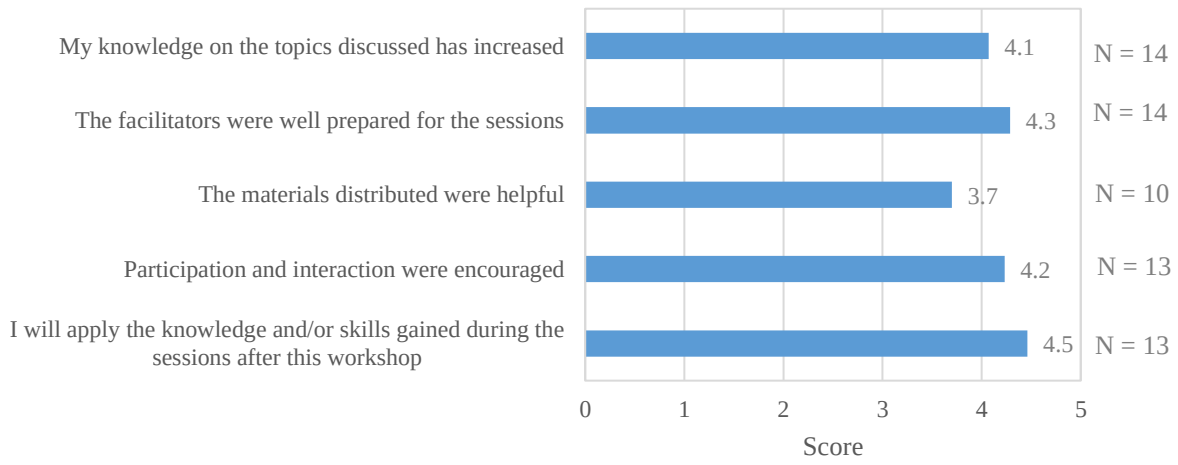
There will be three sets of data: 1) A household list, which will be kept as a reference material 2) data for questions at the household level and 3) data for questions at the individual level. It was noted that the introduction for Section 5 contains multiple entries for households and these may be changed manually so that there is only one entry per household. It was clarified that the "extra" tag in variables is for text variables. The missing data has been checked by supervisors. Separate files were available for each day. The files were being reviewed by the central team and were to be completed by 5 May, after which Xavey was to provide the complete dataset by 19 May.

Results

The outcomes of this visit are listed below:

1) Gained a better understanding of the data collection process, the challenges faced and the lessons learned from the management and supervisor perspectives.
2) Clarification on data structure and requirements with Xavey (software company).
3) Timeline for next steps of the study.
4) Update on findings from the Yangon region from the qualitative study conducted by Save the Children.
5) A feedback form was distributed at the end of the workshop, the results of which are described below:
   Participants mostly agreed on the five dimensions assessed in the feedback form viz increase in knowledge, facilitator preparation, helpfulness of materials, encouragement of participation and application of knowledge and skills (average score of 4.1). More than half of the respondents found the discussions useful for eliciting lessons on data preparation and data collection and a fifth noted that they appreciated the knowledge sharing aspect of the workshop.

Figure 1: Feedback on workshop



Among the five dimensions, helpfulness of materials received the lowest average score and this, perhaps, reflects the nature of the workshop in which no training materials were distributed. In addition, we received feedback on areas that could be improved. A third of the respondents suggested that experiences of all townships should have been presented, rather than only having one summary session, so as to learn from each one's experience. On a related note, respondents suggested having more time and having a more informal structure. A couple of respondents said that facilitators should try to enhance participation

of those who are silent. During the workshop, different methods of engaging participants were adopted such as presentations by HSSOs and a supervisor survey. However, more could be done to encourage participation. Other suggestions on delivery included using an example of another survey, having a practical exercise and also focusing on key points and summarizing discussions. One respondent noted the need for checking of the data collected during the survey process.

Lessons Learned

The HITAP team conducted an After Action Review (AAR) meeting on 4 May, 2017. The agenda for the meeting was to provide an overview and summary of outcomes of the workshop, discussion on what went well and why as well as areas of improvement. The discussion covered the following: preparation, logistics, workshop content and coordination. Below is a summary of the same:

Table 2: Lessons Learned

Areas	Lessons
Logistics	• Accommodation at the meeting venue was convenient. • The schedule for the visit was tight due to various factors. May plan to go the previous day so as to have time to prepare.
Content	• Going over household survey dataset with Software Company was useful. May plan to have a teleconference with relevant parties before the workshop. • For activities for which results need to be presented the next day, could use more time.
Delivery	• Informal structure of workshop was appropriate for an experience sharing and learning session. To ensure participation of all, moderator may ask each person for comments at the end of each session. • The time for each session could be managed better so as to complete all the tasks. The moderator/facilitator could focus on the main points to keep the time. • Facilitator should try to engage more with people so that they may speak up. This could be done by asking each person to speak one by one. • One should be careful about quoting in small groups.

Next steps

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

Table 3: Next steps

Particular	Actionable	Person (s) Responsible	Timeline
Data cleaning	Check data	MoHS	5 - 7 May
Data cleaning	Combine data into 4 files with unique ID: • Household list • Household level sections • Individual level sections	Xavey	19 – 21 May
Analysis: M&E data	Share tables on trends observed with WHO/MoHS to develop narrative	HITAP	12 - 19 May (extended to include 2016 data)
Analysis: HITAP to visit Yangon	Develop agenda and plan for visit	MoHS/WHO/HITAP	Week of 22 May (or week of 29 May, depending on progress)
Analysis: MoHS/WHO staff to visit HITAP for 2 weeks to complete report	Develop agenda and plan for visit	MoHS/WHO/HITAP	Week of 29 May (or week of 5 June, depending on progress)
First draft of report	Share report with Dr. Nilar Tin/Dr. Phone Myint	MoHS/WHO/HITAP	16 June
Completed report	Submit to GAVI	MoHS/WHO/HITAP	30 June

Annexes

Annex 1: Agenda

Workshop: Reflecting on Data Collection for GAVI HSS Study

Date: 24-25 April, 2017

Location: Yangon, Myanmar

Objectives:

- To share experiences and lessons learned from the data collection process
- To share preliminary findings from the qualitative study on out-of-pocket expenditure on health
- To plan and agree on activities, responsibilities and timeline for study

Attendees:

- Staff from Ministry of Health and Sports (MoHS), Myanmar, GAVI HSSOs, Senior Advisors, World Health Organization (WHO) and The Health Intervention and Technology Assessment Program (HITAP)

Outcomes:

- Documentation of lessons learned from data collection process of survey
- Experience and knowledge sharing of qualitative study on out-of-pocket expenditure on health
- Plan for next steps of the study

Agenda:

Day 1			
Time	**Session**	**Description**	**Person (s) Responsible**
13:00 – 13:30	Opening remarks and introductions	• Introduction of workshop	• Dr. Alaka Singh, WHO
13:30 – 14:30	OOPE Qualitative Study	• Share findings from study	• Save the Children
Break			
14:45 – 16:00	Overview of data collection process	• Organization Key issues	• MoHS
16:00 – 17:00	Preparation for Data Collection	• Sampling and Pre-listing o Description o Challenges o Lessons Learned	• HSSOs
17:00 – 18:00	Meeting with Xavey Team	• Discussion of data files	• Xavey Team • HITAP: Md Rajibul Islam/Saudamini Dabak
Day 2			
8:30 – 9:00	Recap	• Summary of discussion from previous day	• HITAP
9:00 – 10:30	Data collection	• Conducting interviews and quality assurance o Description o Challenges o Lessons Learned	• HSSOs
Break			

11:00 – 12:00	Results of Survey of Supervisors	• Overview • Results	• HITAP
Lunch			
13:00-15:00	Summary of Lessons Learned from Data Collection Process	• Training • On-the-ground support • Other	• MoHS • WHO • HITAP
Break			
15:30 – 16:30	Next steps for Data Analysis and Reports	• Activities • Responsibilities • Timeline	• Dr. Alaka Singh, WHO
16:30 – 17:00	Feedback	• Completion of feedback forms	• HITAP
End			

Note on presentations by supervisors on key issues encountered during preparation and data collection:

Supervisors will make one presentation for each session. Discussion is encouraged.

Minimum points to be addressed in presentations:

Session: Preparation for Data Collection

1. Description:
    - Source for pre-listing (mid-wife registry or community leader)
    - Recording data during pre-listing
    - Supervision of enumerators and quality assurance
2. Challenges
3. Lessons learned

Session: Data collection

1. Description:
    - Summary statistics: Days spent in field by supervisors, Number of respondents per day (average)
    - Experience using tablets
    - Supervision of enumerators and quality assurance
2. Challenges
3. Lessons learned

Annex 2: List of participants

Sr. No.	Name	Position/Organisation	24 April	25 April
1	Dr. Thiri Win	NPO, GAVI HSS	✓	✓
2	Dr. Thet Zaw Htet	HSSO	✓	✓
3	Hsu Myat Naing	NTO, GAVI HSS	✓	✓
4	Sithu Naing	HSSO	✓	✓
5	Aung Kyaw Hein	HSSO	✓	✓
6	Dr. Wai Yan Yee Mon	HSSO	✓	✓
7	Chit Zaw Min	HSSO	✓	✓
8	Dr. Daw Than Sein	HSSO	✓	✓
9	Thant Mon Cho	HSSO	✓	✓
10	May Phyo	HSSO	✓	✓
11	Dr. Htet Paing Soe	HSSO	✓	✓
12	Dr. Myo Thiri Zaw	HSSO	✓	✓
13	Dr. Aye Mya Mya Kyaw	M&E Officer	✓	✓
14	Dr. Soe Tint		✓	✓
15	Cho Cho Mar	NFO	✓	✓
16	Dr. Wai Mar Mar Tun	MoHS	✓	✓
17	Dr. Alaka Singh	WHO	✓	✓
18	Dr. Yee Yee Cho	WHO	✓	✓
19	Alyssa Davis (and team)	Save the Children	✓	
20	Saudamini Dabak	HITAP	✓	✓
21	Md. Rajibul Islam	HITAP	✓	✓
22	Suradech Doungthipsirikul	HITAP	✓	✓
23	Songyot Pilasant	HITAP	✓	✓

Annex 3: Supervisor Survey

In order to learn about experience of supervisors of the household survey, a survey was sent to supervisors by email. The questionnaire comprising ten questions was developed by HITAP staff. For those unable to complete the survey prior to the workshop, time was set aside on the first day of the workshop. In all, there were 12 respondents to the survey, the results of which are provided below:

1. The training was useful for supervising enumerators in the field

Most respondents agreed that the training held in Nay Pyi Taw in February, 2017 was useful in supervising enumerators in the field and the most useful training topics were:

- protocol for supervisors and selection of villages from selected townships
- data collection with app device
- case scenario
- how to monitor the data validity from the questionnaires
- how to report the supervisors

2. The supervisors applied the guidance provided in the manual during data collection

Most respondents applied the guidance provided in the supervisor manual during data collection and they thought it was useful. In addition, the respondents thought that the manual was quite complete and there was no need for additional information to be included.

"I usually applied the guidance provided in the supervisor manual not to make mistake and when I forgot about some items which were wanted to know thoroughly"

"I applied the guidance provided in the supervisor manual during data collection. I think that it needs to include how to control the enumerators when they didn't obey the survey rules and regulation"

"The supervisor manual was useful. Some of question were needed to be explain in detailed and some were completed"

3. The resources provided were useful

Most respondents agreed that the resources provided were useful. These included the pre-listing form, reporting forms, and manual for supervisor and enumerators. Challenges included difficulties in control townships, inadequate data on antenatal care (ANC) and post natal care (PNC) and use of paper based rather than electronic datasets

"The resources provided were very useful. Manual for supervisor and enumerators were useful because we can see something in the manuals easily when we want to know something"

"Reporting forms are useful. Because according to this basic information, we can check the basic data and did not miss the data discrepancy"

"Reporting forms ae useful but some of the staffs haven't detail address of AN, PN mother and immunization child especially in urban setting. Therefore, in the field, there were more replacement of eligible household were occurred"

4. Received timely responses to questions /concerns

In the field, when the supervisor had questions or concerns about the questionnaire, reselection, household sampling, prioritization most respondents agreed that they received timely responses to questions or concerns from the central team or Xavey.

"I received timely responses from central team and also Xavey company. I am ever contact with Dr Thiri Win from central team and she gave me useful supporting supervision"

"Yes, I received timely responses to the questions. For example, reselecting the name of wards for survey was quickly replied by the HITAP and therefore, our team could go on smoothly according to our plan"

"We usually ask the central coordinators before we go to the data collection. Therefore, we can get some clarifications of our unclear points"

5. Management of enumerators in township

The supervisor in each area have management the team. The activities conducted and issues faced in the field, remotely are as follows:

In field	Remote	Issues
• Advocacy meetings and introductions • Travel and field plan • On site supervision • Feedback • Applying team approach	• Daily feedback • Checking data discrepancy	• Incentives and gratitude for supporting staff in townships • Managing large groups of enumerators • Effectively managing "down time" • Received support from central team and Xavey

6. Conducting quality assurance of the data collected in township

Some supervisors thought that witnessing interviews is quality assurance and they conversed informally with enumerators every night to provide feedback. In addition, the supervisor conducted quality assurance such as:

- Supervisors had to supervise enumerators only one week in the field, so after returning from survey township, supervisors always contacted with enumerators and traced the condition of data collection process
- Visited households with the enumerators on some days in the field and daily feedback and reply to their actions and questions. Checking the server-sent data and daily contact with them for asking and feedback were done. If required, quick contact with the central team and replied to the enumerators. And contact with the midwives for support to the enumerators in the field
- By daily contact with enumerators and Xavey team over the phone.

In addition to all the above mentioned, there are also other quality assurance of the data collected in township such as, use the supervisor manual, use the monitoring sheets and give feedback in field.

7. The skills or knowledge to gained as a supervisor during the data collection process

- resource management skills
- supervision skills
- knowledge about how to management overall survey are gained during data collection process
- understood the condition of community and underground condition of health system of that township and obstacles faced by health staffs in providing primary health care
- problem-solving skill
- how to manage the different enumerators

In addition to all the above mentioned, there are also other knowledge such as the expenditure of household questionnaire (the asking approach) is very much interesting and it was a new experience. The tablet usage of questionnaires, management skills in doing survey in hard to reach remote villages

8. The challenges that encountered during the data collection process

- Resources management (time/man) because data collection process have tight time frame so challenges regarding resources management (time/man) are mainly encountered.
- less number of enumerators
- Enumerators had no experience in dealing with health staffs and understanding the structure of actual township health system. Then some supervisor explained how this survey was very important for our country and after the data analysis of this survey, such as "we could build strong health system in which health staffs could be happy and comfortable in providing health services to community."
- There were giving wrong information of daily finished households and sending to the server on two or three days later by the enumerators. Although the enumerators were requested to inform daily condition, no one called or sent message. So, phoning them daily and remind to inform correct number and send to the server daily if the internet is available was done. The server missed files and did not send the data for two households. After asking for, they found them and sent back to be checked.
- Technological error such as tablet for example all of the information of total 15 households that she collected under two sub-RHCs couldn't be sent to the Xavey team but Xavey team sent some kinds of information without completion of all information of these households. So, with the guidance of central supervisor, I sent this tablet back to the Xavey team and the responsible repaired it and sent it back to the ground. This process took two-days. In addition, mobile software based survey was not convenient for the process at that time.
- Electricity and travel difficulty problems. The electricity problem (we were charged the tablet with solar even [then] there is a risk of error. Supervisor could not check the data in the field (no internet connection) Transportation (very hard to reach villages could not be reached with car, we had to go with the charcoal trucks, the cow and buffalo carts).
- In this survey period, the villages had traditional ceremony and the villagers travelled from village to village. As the message was received from assigned Mid-wife, the pre-listed household was informed to go to traditional ceremony after survey on request and they willingly accepted it. In villages, every 5th day is the bazaar day and all villagers liked to go for shopping on that day. The village leader instructed that at least one responsible household key person should be left at home on that day for the data collection and they respected the instruction.

9. What would you do differently if you could be a supervisor for this study again?

- They will do pre-survey with my enumerators and focus group discussion with other supervisors at least one day after a week of data collection in the field. Also I encourage enumerators and supervisor to digest questionnaires
- The enumerators would be given time for field practice before going into the field surveying
- They will take more time in giving training to enumerators about our questionnaire and in practicing with tablet in order to be user-friendly.
- Supervisor needs to go to this township before data collections and needs to revise and records the eligible household with local authority and health staff
- Enumerator must be chosen by central team, this survey, we choose health assistant team, health assistant teams choose the enumerators.

So for another one said it interesting experiences are more precious than gold, so, I am sure that my supervising skills, management skills and advices will be improved if I could be a supervisor for this study again.

10. Other comments

For other comments most supervisor no comments, but there are some who mention about this study such as

- That Survey is the important for what HSS project had been done in Myanmar and it will be not only mile stone but also a road sign for further projects. Health System Strengthening is not just a project, it must be a sustainable goal for Health System.
- This survey is very wide and cover many areas of our health system and its outcome though survey's name is GAVI assessment survey. I think that this survey covers not only GAVI project but also other health services and activities. Based on the result of this survey, MOHS can build a strong and sustainable health system.

Annex 4: Supporting tables for feedback forms

Q. No.	Question		
	Please indicate you level of agreement with the following statements:	N Respondents	Av. Score
1	My knowledge on the topics discussed has increased	14	4.1
2	The facilitators were well prepared for the sessions	14	4.3
3	The materials distributed were helpful	11	3.7
4	Participation and interaction were encouraged	14	4.2
5	I will apply the knowledge and/or skills gained during the sessions after this workshop	14	4.5
6	What did you like most about the sessions conducted during this workshop?	N Respondents	%*
	Experience sharing	3	23%
	Discussion	9	69%
	Feedback	1	8%
	Recap session	1	8%
	**Denominator includes only valid responses*		
7	Do you have any suggestions on how we can improve the sessions conducted during this workshop?	N Respondents	%*
	Facilitation and engagement	2	20%
	Highlighting and summarising points	1	10%
	Suggestion on working during the survey	1	10%
	Providing an example	1	10%

Q. No.	Question		
	Including presentations on all townships	4	40%
	Having a practical session	1	10%
	**Denominator includes only valid responses*		
8	Do you have any other comments?	N Respondents	%*
	Useful workshop	1	25%
	Focus points	1	25%
	Time and structure of agenda	2	50%
	**Denominator includes only valid responses*		

Annex 5: Presentations

Link to presentations:
https://drive.google.com/open?id=0B6M8AX7jsc2rYm1BQnYxam9CWkE