MINISTRY OF PLANNING AND INVESTMENT
KON TUM DEPARTMENT OF PLANNING AND INVESTMENT
KON TUM DEPARTMENT OF HEALTH

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CITIZEN REPORT CARD
ON PUBLIC HEALTH SERVICES
AT COMMUNE LEVEL

Kon Tum City

December 2014

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LIST OF ACRONYMS

HI	Health Insurance
BCG	Bacille Calmette-Guerin (Vaccine for Tuberculosis)
CRC	Citizen Report Card
ANC	Antenatal care
MCH	Maternal and Child Healthcare
DPT – HBV - HIB	Pentavalent - Vaccine for diphtheria, pertussis, tetanus, hepatitis B and meningitis caused by Hemophilic influenza type b bacteria
MET	Medical Examination and Treatment
FP	Family Planning
OPV	Oral Polio Vaccine
CHS	Commune Health Station
PPC	Provincial People's Committee
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
USAID	US Agency for International Development
FPIEC	Family Planning Information, Education and Communication
CNS	Child Nutrition Services
CI	Child Immunization Services

EXECUTIVE SUMMARY

With a view to implementing the Comprehensive Program on State Administrative Reform – Period 2011-2020, Kon Tum Provincial People's Committee (PPC) has given the direction to step up on administrative reform in the province. On July 23rd, 2012, the PPC promulgated Decision 673/QD-UBND on the Plan of State Administrative Reform for Kon Tum province – period 2011-2015 whose objectives were specified as *"c) Enhancing the quality and efficiency of the single window mechanism…, increasing the level of satisfaction of individuals and organizations with the services provided by state administrative bodies to 65% by 2013 and to 80% by 2015".* On August 30th, 2013, the PPC issued Decision 635/QD-UBND on amending and supplementing part of the Plan of State Administrative Reform for Kon Tum province to accompany Decision 673/QD-UBND, where the former specified at Clause 1.f that "*the Provincial Department of Home Affairs shall take the lead and cooperate with relevant agencies to advise and make recommendation to the PPC and the Chairperson of the PPC on commissioning an assessment of the level of satisfaction of the general public with the services provided by administrative bodies and by public service delivery units in the fields of healthcare and education*"

The Health Department of Kon Tum province, with the financial and technical support from the United Nations Children's Fund (UNICEF) and under the coordination of the Provincial Department of Planning and Investment, has undertaken a survey of 400 mothers on the level of satisfaction with healthcare and nutritional services provided at Commune Health Stations (CHS), using Citizen Report Card (CRC) tool in 12 communes/wards of 4 district-level locations, including Kon Tum City, (Quang Trung and Truong Chinh wards, and Ngoc Bay commune), Dak Ha District (Ha Mon, Dak Psi and Dak Hring communes), Tu Mo Rong District (Tu Mo Rong, Mang Ri and Ngoc Lay communes), and Dak Glei District (Dak Nhoong, Xop and Muong Hoong communes).

Surveying service users' feedbacks and satisfaction levels of the health services provided at commune level and using CRC tool in Kon Tum aims at the following 2 specific objectives:

- To collect feedbacks of the general public on healthcare services *(antenatal care, maternal and child healthcare during and after birth, medical examination and treatment, family planning information, education and communication and child immunization)* and child nutritional services for the purpose of effective sharing with relevant parties in order to enhance service quality and better meet the demand of the general public, especially disadvantaged groups (the poor, ethnic minorities and children)

- To provide inputs for the development, implementation, monitoring and evaluation of the annual and 5-year plans of Kon Kum provincial health sector and local socio-economic development plans (2011-2015 and 2016-2020);

The survey collects users' feedbacks and evaluates their level of satisfaction on 7 aspects as follows:

1. Availability of services;
2. Access to services;
3. Use of services;
4. Quality of services;
5. Users' satisfaction;
6. Problems encountered by service users;
7. Recommendations for improvement.

This is a sociological survey with the participation of 400 mothers with small children under 2 years old who have used at least 3 out of the 6 above-mentioned services. A quantitative, cross-sectional descriptive statistical methodology was used.

The significant findings of the survey are presented below:

Availability and use of services: All CHS were assessed to be ready to serve the general public. Immunization services were provided at fixed days each months. The majority of respondents had no difficulty accessing healthcare services at CHS. Among the 6 types of services provided by CHS covered by this survey, child immunization was the most used (395/400 or 98.8%) and maternal and child healthcare (MCH) the least used (154/400 or 38.5%). The percentages of respondents using child nutrition service (CNS), family planning information, education and communication (FPIEC) service, antenatal care (ANC) and medical examination and treatment (MET) are 86.5%, 81.0%, 75.2% and 66.0% respectively. Users do not have to wait for a long time to be served and only pay the regulated fees.

Attitude of CHS health workers: The majority of users thought that the health workers were "caring and attentive" while serving them. The percentage of respondents considering CHS health workers as "caring and attentive" are 58.4%, 77.9%, 71.9%, 65.9%,58.7% and 53.9% for ANC, MCH, FPIEC, MET, CNS and CI respectively. The average score for CHS health workers' attitude is 3.74, while the individual scores are 3.66, 3.66, 3,66, 3.88, 3.76, and 3.84 for ANC, CNS, CI, MCH, FPIEC and MET respectively. Only one or two respondents complained that the health workers were cold to them.

Quality of services provided by CHS: The majority of users rated the quality of services provided by CHS as "faily good" and "good". Only few respondents thought that service quality was "poor" or "average". The percentages of respondents assessing service quality as good are 56.5%, 74.7%, 69.8%, 66.7%, 56.1% and 63.5 for ANC, MCH, FPIEC, MET, CNS and CI respectively. The average score for CHS healthcare service quality was 3.56 or "Good", with the breakdowns of 3.42, 3.76, 3.62, 3.61, 3.41 and 3.53 for ANC, MCH, FPIEC, MET, CNS and CI respectively

Level of satisfaction of users with CHS services: In general the respondents were satisfied with the services provided by CHS. The most satisfactory type of services was MCH at 83.8% while the least satisfactory was CHS at 66.2%. The satisfaction ratings for FPIEC, MET, ANC and IS are 80.5%, 75.4%, 75.2% và 74.8% respectively. The average score for CHS services is 3.87% or "Satisfactory", with the breakdowns of 3.84, 3.99. 3.90. 3.94. 3.69 and 3.84 for ANC, MCH, FPIEC, MET, CNS and IS respectively.

Antenatal Care: A large number of pregnant women were provided ANC services (369/400 or 92.2%), including 292 respondents who were served by CHS and the remaining 77 by other health facilities. 38 respondents or 7.8% did not go to any health facilities receive ANC services. Those without ANC were primarily from poor households (80.6%), ethnic minorities (100%), located in Tu Mo Rong (41.9%) and Dak Ha (32.3%) districts, between 22 and 30 years old (54.8%) and without education (41.9%). Among those who received ANC, 105 (35.9%) went for all three checks-up as advised.

85.3% of the respondents said they were immunized against tetanus at CHS while 12.5% said they were not immunized and the remaining 2.3% said they could not recall whether they were immunized. 82.7% took iron or multi-micronutrient supplements, with the main sources of supply for iron tablets being village health workers (42.1%) and CHS (39.7%). This figure indicates that village health workers have an active role to play in providing ANC services to local people.

In general, the respondents thought highly of the serving attitude of health workers towards service users as well as the quality of ANC services at CHS. 62.1% of the respondents said that health workers were "caring" and "very caring" towards them, while 59.7% considered healthcare services as "good" and "very good". However, a rather large number – 20.8% - said that service quality was just "average". 80.5% of the respondents said that they are either "satisfied" or "very satisfied" ANC services provided by CHS.

Maternal and Child Healthcare during and after birth: Survey results indicate that only a small proportion of pregnant women were provided support during delivery (9.5%). Among those who did not deliver their baby at CHS, 28% went to provincial hospitals and 15% to district hospitals. A large number of respondents gave birth at home without support of health workers (including village midwives), of whom 24.8% were helped by family members and 11.3% by traditional birth attendants.

Not many respondents received home-visits by health workers after delivery. Among 400 respondents, only 137 (34.3%) were visited by health workers, of whom 47.4% said that they received a check-up at home within 1 week after delivery and 36.5% said that they received 2 checks-up at home within 6 weeks after delivery.

83.1% of the users of MCH services assessed the attitude of health workers to be either "caring and attentive" or "very caring and attentive" at an average score of 3.88. In addition, 78.6% of the users rated MCH service quality as "good" and "very good" at an average score of 3.76. Furthermore, 91.6% of the respondents said they were either "satisfied" or "very satisfied" with service quality, which scored an average of 3.99.

Survey results indicate that the most advised topic was breastfeeding newborn baby, proper breastfeeding and exclusive breastfeeding within the first 6 month (50%), caring for and keeping the baby warm and clean (41%), nutrition for mothers nursing their babies (39.9%). However, 39.2% of the respondents were not given any advice after giving birth.

Family Planning IEC: Survey results show that 81% of the respondents were advised on family planning, of whom 95.4% were given information on safe birth control measures and 55.6% were advised that each family should have at most 2 children.

50.9% of the respondents said that they had accessed to FPIEC in village meetings, 42.9% in group-based IEC sessions organized by village health workers, and 33% through home visits.

74,1% of the respondents considered the health workers to be "caring" and "very caring" while providing FPIEC services and gave them a score of 3.76 for serving attitude. In addition 72.5% of the respondents said FPIEC service quality was either "good" or "very good" with an average score of 3.62. Furthermore, 86.1% of the respondents were either "satisfied" or "very satisfied" with FPIEC services, at an average score of 3.90 for satisfaction.

Medical Examination and Treatment: 264 (66%) out of 400 interviewed mothers said that they have visited a CHS within the last 12 months for medical examination and treatment, with 80 mothers and 194 children, and 7 family members[1] receiving medical checks-up.

In general people visit CHS for a check-up of normal diseases. 39.4% of all checks-up are related to cold, flu, fever and scarlet fever while 31.4% to respiratory diseases (cough, sore throat, bronchitis, pneumonia, and so on)

65.9% of the respondents who used to be checked and treated at a CHS said that the health workers there were "caring and attentive" towards the patients and gave them an average score of 3.84

66.7% of the respondents who used to be checked and treated at a CHS considered MET service quality as "good", while a similar number of respondents thought that MET services were just "fairly good" or "average" (14.4% and 14% respectively). The average score for service quality is 3.61%.

In general, the respondents are satisfied with MET services provided by CHS. 85.6% of the respondents were either "satisfied" or "very satisfied", with the satisfaction score averaging at 3.94.

Child Nutrition Services: Survey results indicate that 19.25% of children under 2 years old included in this survey were malnourished. The malnutrition rates were higher among poor households as opposed to the non-poor (26.5% versus 10.8%), mothers without schooling as opposed to mothers with schooling (33.8% versus 16.1%), locations further away from district center as opposed to closer ones (34.2% versus 8.7%), children above 6 months old as opposed to children under 6 months old (22.7% versus 7.6%), children without health insurance versus children with health insurance (25.7% versus 16.7%), ethnic minority mothers as opposed to Kinh mothers (25.6% versus 1.9%). In particular, child malnutrition rates were 36%, 24% and 10% for Tu Mo Rong, Dak Glei and Dak Ha districts respectively against 7% for Kon Tum City.

1 *This includes 17 mothers who also brought their children for medical check-up in the last visit.*

60.4% of the respondents said that they received advice when having their child weighed and measured. The numbers of advised respondents differs among the surveyed locations *(with the highest of 68.5% in Dak Ha and the lowest of 47.7% in Kon Tum City)* and among the distances to CHS *(decreasing from 69.2% for respondents located within 1km from a CHS to 60.9% for respondents located between 1km and 5km from a CHS and further to only 46% for respondents located further than 5km from a CHS)*.

56.1% of the respondents thought of CNS service quality as "good", 19.4% as "fairly good" and 20.2% as "average". There remained a number of respondents who rated CNS service quality as "poor" despite being much lower than the number considering service quality as "very good" (0.9% as opposed to 3.5%). In addition, 58.7% of the respondents said that the health workers were "caring and attentive" while 36.7% said the health workers were neither "caring" nor "cold". The average score for attitude is 3.66, which means "caring and attentive". The level of users' satisfaction depends heavily on service quality and serving attitude. This means the better the assessment for service quality, the higher the level of satisfaction. Similarly, users will feel satisfied with the services provided if they think that the health workers are caring. 66.2% of the respondents were "satisfied" with CNS services, 22% "fairly satisfied" and 6.9% "not really satisfied". Only 4.9% of the respondent were "very satisfied" with CNS services. The average satisfaction score is 3.69, equivalent to "satisfied".

Expanded Immunization: 98.5% of the respondents confirmed that their children were immunized at home (BCG), at CHS or at immunization locations organized by CHS. The use of child IS is similar among the surveyed districts and communes. Only 51.4% of the respondents still recalled their child being immunized and provided such information in the survey, of whom 69.9% kept their children's immunization records. More mothers who lived in communes closer to district centers kept records than those who lived further away. Among those who provided information on their children's immunization, 94.1% said their children were BCG-vaccinated, 54.2% said their children were vaccinated against Hepatitis B at birth, 87% said that their children were vaccinated with DPT – HBV – HIB and given OPV and 70.6% said that their children were vaccinated against measles. 74.7% of the respondents were "satisfied" with immunization services and 6.3% were "very satisfied", while 15.9% were "fairly satisfied" and 3% were "not really satisfied". The main reason for dissatisfaction was the long wait and unhappy attitude of the health workers ("because they had to vaccinate too many children under hot weather"), having to wait in a tight space with no fans and no seats. There is a difference in the level of satisfaction among different ethnic groups, age groups, education levels and poor/non-poor households.

Main recommendations are presented below:

General recommendations

1. Diversifying the formats and contents of health care IEC for mothers of different groups (pregnant women, mothers raising babies under 6 months old, Kinh mothers versus ethnic minority mothers, mothers from poor versus poor households), especially integrated forms of IEC;

2. Developing electronic records to monitor women and child health indicators.

3. Tighter supervision of and better support for CHS in order to improve serving attitude, ANC services, midwifery services, home-based postnatal care with a view to enhancing quality and efficiency of MCH services;

4. Institutionalizing CRC survey of healthcare services as an official information channel for annual collection of feedbacks from the general public, especially from poor households, ethnic minorities and children;

5. Disclosing publicly the criteria for assessing performance and health service quality at dif ferent level to boost the understanding of the general public for more active feedbacks and better efficiency.

Kon Tum Provincial Health Department

1. Disseminating the survey results with bodies within and outside the health sector and developing a plan to monitor and implement the recommendations which have been agreed to;

2. Building capacity (in terms of both quality and quantity) for CHS health workers and village mid wives;

3. Improving the management of information on child immunization and nutrition with the use of electronic records to monitor 0-5 year-old child immunization and growth;

4. Mobilization private sector resources for investment in health facilities in cities and towns with a view to sparing public resources for areas where it is difficult to access private investment, thereby contributing to the modernization and enhancement of the health system.

5. Dividing CHS into groups (urban/rural, lowland/highland, Kinh/ethnic minorities, populous/non-populous, and so on) and assessing the capacity and demand of each CHS with reference to the capac ity of neighboring health facilities to avoid inappropriate investments.

6. Adopting a proactive approaching in mobilizing technical and financial support form international organizations, governmental and non-governmental organizations depending on the specific charac teristics of each location.

District Health Centers:

1. Tighter supervision of and better technical support for CHS in order to enhance the quality of MET and ANC services, thereby easing the current situation of hospital overload at higher level and avoiding patients skipping to higher level health facilities;

2. Providing guidance to CHS in developing electronic records of 0-5 year-old (05YO) child immunization and growth records;

3. Providing guidance to CHS in developing electronic 05YO child growth records;

4. Proactively collecting and analyzing feedbacks of service users as inputs for healthcare planning to better meet the demand of the general public;

5. Proving support to organizations providing healthcare IEC with a view to raising awareness and encouraging them to change health-damaging behaviors.

Commune Health Stations:

1. Advising and providing guidance on health care to mothers of different groups (pregnant women, mothers raising babies under 6 months old, Kinh/ethnic minority mothers, mothers from poor/non-poor households);

2. Developing and updating electronic 05YO child immunization and growth records;

3. Regularly participating in discussion, training and supervisions sessions to improve serving attitude and responsibility of CHS health workers

4. Recommending CHS health workers for training and collaborating closely with the network of village midwives

FOREWORD

The viewpoint on "Public healthcare service quality" has been reflected in the political report of the Central Executive Committee of the Communist Party of Viet Nam of Xth Term which was presented to the 11th national congress of the Communist Party of Viet Nam as *"Enhancing public healthcare, family planning and maternal and child healthcare service quality. Paying more attention to preventive healthcare and public healthcare. Consolidating and enhancing grass-root level health facilities, improving the capacity of district and provincial hospitals, and modernizing a number of leading hospitals"*

The focus on improving public healthcare services has also been reflected in the fundamental solutions of Kon Tom provinces for public healthcare services which were specified in the political report of the Provincial Executive Committee of the Communist Party of Term XIIIth which was presented to the 14th provincial party congress as *"Consolidating and enhancing healthcare network in association with modernizing medical examination and treatment facilities, and improving the sense of responsibilities and quality of services provided by health workers".*

Enhancement of public healthcare service quality has been regarded as an important objective of Kon Tum province. The objectives set out in the 2011-2015 Socio-Economic Development Plan of Kon Tum province as well as of the health sector are *"Protecting and improving the health of the general public; bringing diseases under control and preventing widespread outbreaks; proving free healthcare services to the poor and ethnic minority people; and actively implementing preventive healthcare. Consolidating and enhancing grass-root level health facilities, improving access of the general public to basic healthcare services. Increasing the percentage of communes with a CHS of national standard to 50% and increasing the percentage of communes with a doctor to 100% by 2015"*

However, there are currently multiple difficulties in monitoring and assessing healthcare service quality due to the lack of information on the work done and results achieved. Besides, there is a shortage of effective measures to collect information and gather feedbacks from the general public as users of healthcare services.

On November 6th, 2013, the Minister of Health issued Decision 4448/QD-BYT on approving the Proposal on *"Methodology for measuring the level of satisfaction of the general public on public healthcare services"* on the basis of Resolution 30c/NQ-CP dated November 8th, 2011 of the Government on the Comprehensive Program on State Administrative Reform for period 2011-2020 which emphasized *"measuring the satisfaction of the general public to provide inputs for addressing the shortcomings in delivering public healthcare services".* This is an important legal foundation for the implementation of CRC for assessing healthcare services at different levels of service delivery in Kon Tum province.

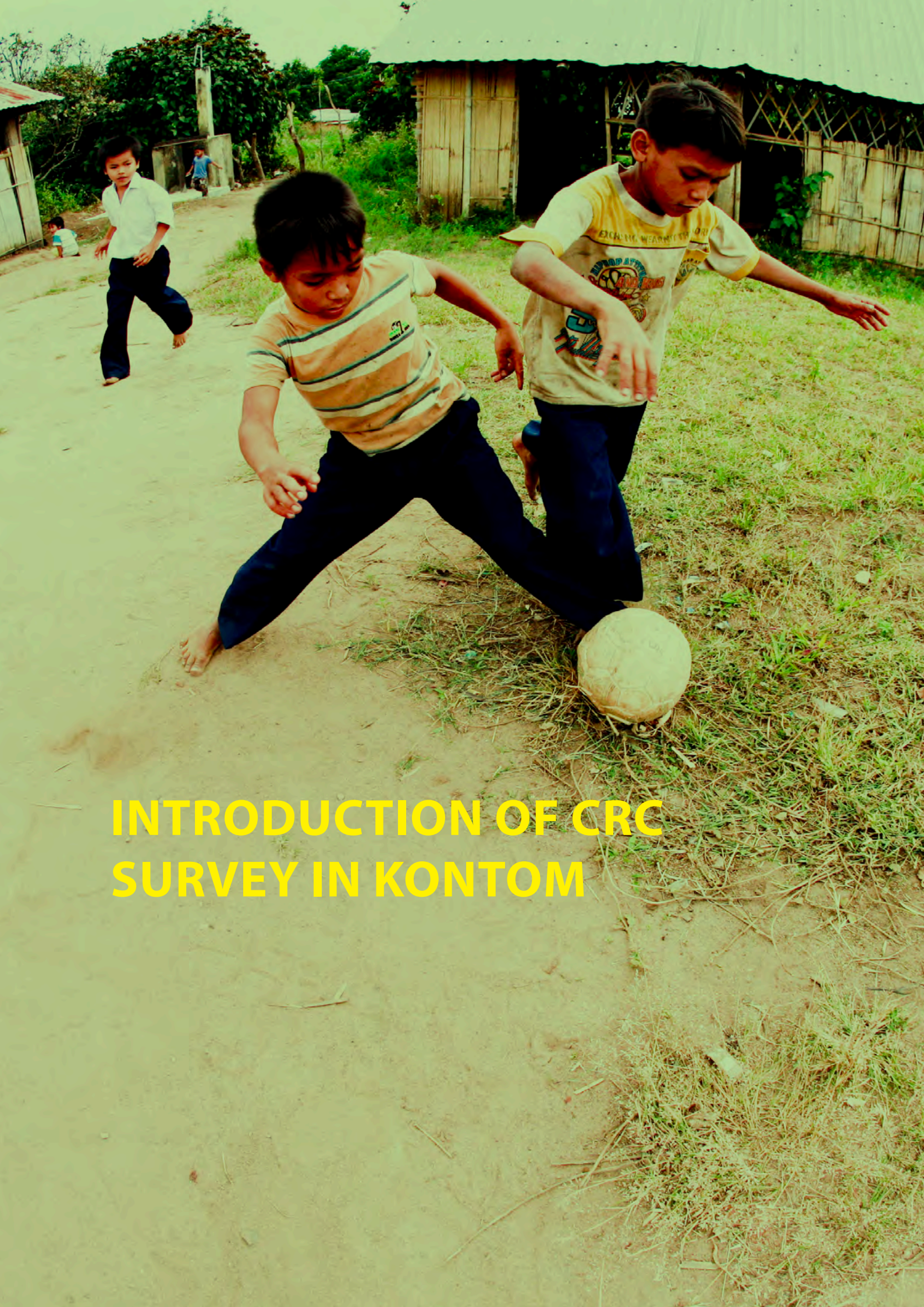
With the support of UNICEF via the Child Friendly Project which is implemented in Kon Tum province during the period of 2012-2016, the Provincial Health Department cooperated with the Provincial Department of Planning and Finance to undertake a survey on the satisfaction of the general public with healthcare and nutrition services at commune level using a social audit tool, namely Citizen Report Card (CRC) to provide inputs and recommendations for child-friendly socio-economic development planning process and health sector planning process, with the ultimate goal of enhancing the quality of public healthcare services, especially for the benefit of vulnerable groups (the poor, ethnic minorities, remote areas, and so on)

Citizen Report Card (CRC) was originally used in Bangalore, India in 1993. This is one of the effective social audit tools which are used to recognized feedbacks of the general public on public services, including healthcare. CRC was introduced in Viet Nam in 2003 for public administrative services, environmental sanitation, healthcare and education, first in Ho Chi Minh City and then to other areas with support from the World Bank, United Nations Development Program (UNDP), UNICEF and United States Agency for International Development (USAID). With the support of UNICEF, CRC was piloted in Muong Cha District of Dien Bien Province in 2011 to evaluate healthcare services for children under 6 years old. Then in 2013, CRC

was carried out to assess 6 types of commune-level healthcare services in Dong Thap Province and 5 types of commune level healthcare services in Dien Bien Province. MCH

The use of CRC has made it more favorable for the general public to exercise their civic rights by providing feedbacks and recommendations related to different aspects of public services. Thanks to this, public service delivery agencies can reassess their performance relying on service users' perspectives and come up with measures to improve service quality and better meet the needs of service users. CRC also make important contributions to enhancing the transparency of those accountable for the delivery of public services.

This report was prepared by the CRC working group which comprises officials of Kom Tum Provincial Health Department and T&C Consulting. The report provides detailed information on the objectives of the study, implementation steps and important findings about feedbacks of the general public and their level of satisfaction with commune-level healthcare services in Kon Tum Province, as well as a number of specific recommendations for enhancing commune-level healthcare services.



INTRODUCTION OF CRC SURVEY IN KONTOM

1. INTRODUCTION OF CRC SURVEY IN KONTOM

1.1. General information about surveyed area

Kon Tum is a province located to the North of the Central Highlands of Viet Nam, at an altitude of between 800m and 1,200m and with a total natural area of 9,689.61 km2. There are 9 district-level administrative units, including Kon Tum City and 8 districts, covering 102 communes/wards/townships (5 communes were established at the end of 2013) and 886 villages/population groups. The average population for 2013 was 489,800 with more than 22 ethnic groups.

According to data from the National Nutrition Monitoring System, the percentage of underweight in Kon Tum reduced from 35.8% in 2005 to 26.1% in 2013, while the figure for stunting fell from 50% to 40.8% over the same period. However, Kon Tum continues to be the province with the highest level of malnutrition among children under 5 years old in Viet Nam. Child mortality rates in Kon Tum were 5.6% and 5.4%[2], while infant mortality rates were 4.6% and 3.9%[3] in 2010 and 2012 respectively. The high rates of child mortality and stunting proves it necessary to continue the integrated malnutrition prevention program in Kon Tum Province.

The data on implementation and important targets for maternal and child healthcare program of Kon Tum Province is presented in Annex 5.2

4 district-level locations were selected in this CRC, including Kon Tum City and Dak Ha District (as representatives of developed economic areas with low poverty rates and a relatively large Kinh populations), Tu Mo Rong District and Dak Glei District (as representatives of mountainous and remote areas with high poverty rates and a relatively large number of ethnic minority people).

Kon Tum City is the political, economic, social, scientific and technical centre which is located to the South of the province, with a natural area of 43,298.15ha and a total population of 157,624 (as of 2013), including 20 ethnic groups comprising primarily Kinh people and the remaining 29.26% of ethnic minorities. There are 21 administrative units, including 10 wards and 11 communes, consisting of 182 villages/population groups, with a poverty rate of 8.4% as of 2012.

Dak Ha District is located 20km to the North of Kon Tum City, bordering Sa Thay District to the the West, Dak To District to the North, Kon Ray District to the East and accommodating part of National Road 14, thereby presented with an advantage for economic development. The district has a total natural area is 84,446.74ha and a population of 67.887[4], with 53.9% being ethnic minorities and 45% being religious. There are 9 administrative units, including 2 remote communes and 7 mountainous communes, 101 villages/population groups, with a poverty rate of 16.18% as of 2012.

Tu Mo Rong is a poor district to the North East of Kon Tum Province, located about 80km from Kon Tum City along Provincial Road 672. In terms of geographical location, it is bordered by Dak Glei District of Kon Tum Province and Nam Tra My District of Quang Nam Province to the North, Dak To District to the South, KonPlong District to the East, and Ngoc Hoi and Dak Glei to the West. Total natural area is about 85,769ha. The district's topography is primiarily high mountains separated by large streams. There are two distinct seasons. The district's population was 23,277 as of 2013, with 95.5% being ethnic minorities, comprising primarily Xo Dang people. Local people depend heavily on hillside farming and wetland rice cultivation using manual and outdated farming techniques. A number obsolete of customs and rituals have been hindering economic development. There are 11 remote communes and 91 villages, with a poverty rate of 53.05% as of 2012.

Dak Glei is a mountainous district[5] located to the North of Kon Tum Province. This is also the northernmost district of the Central Highlands. It is bordered by Phuoc Son District of Quang Nam Province to the North,

2 *Ministry of Health, National Institute of Nutrition & UNICEF (2010) General Nutrition Survey 2009-2010*

3 *Data collected from "Important Targets for the Healthcare Program of Kon Tum Province", Kon Tum Provincial Health Department, 2014*

4 *2013 Health Statistical Report of Kon Tum Province*

5 *Website of Dak Glei District, accessed on October 15th, 2014*

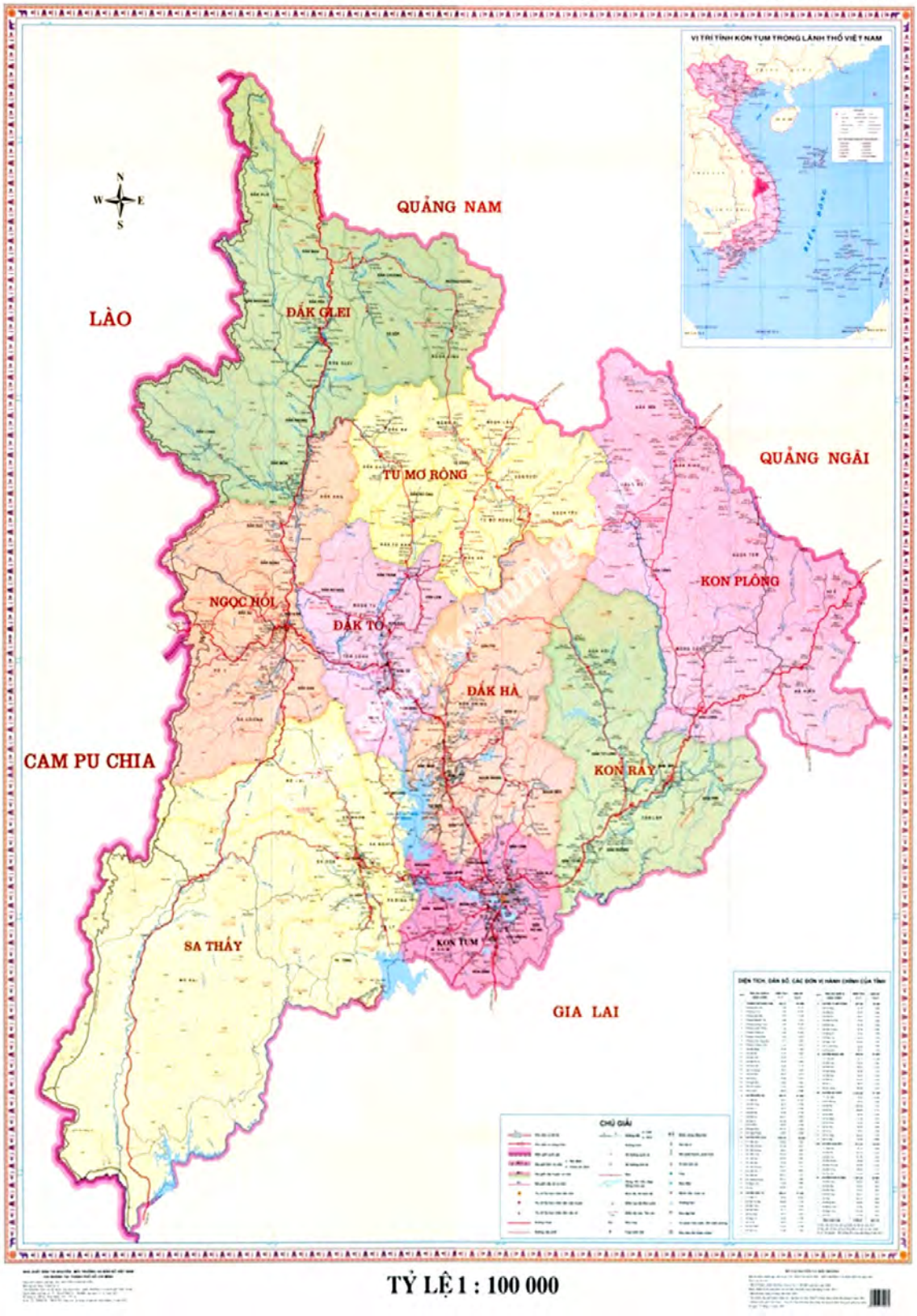
Laos to the West with a borderline extending 130km, Ngoc Hoi District to the South and Dak To District to the East. As one of the most disadvantaged districts of Kon Tum, its 11 out of 12 communes are classified as particularly disadvantaged with more than 90% of the population being ethnic minorities (including Gia Lai, E De, Gie Trieng, and so on). The district has a natural area of 1,495.26 km^2, a population of 43,191 as of 2013 which reside in 12 communes/112 villages and a poverty rate of 43.94% as of 2012.

Table 1: A number of indicators on maternal and child healthcare in 4 surveyed locations

Indicator	Kon Tum Province	Kon Tum City	Dak Ha District	Tu Mo Rong District	Dak Glei District
Infant mortality rate (‰)	40				
Child mortality rate (‰)	62.7				
Child malnutrition rate (underweight) %	26.1	22.3	21	32.1	28.7
Child malnutrition rate (stunting) %	40.8	31.8	24.1	48.6	39.1
CHS and human resources					
CHS - Total	97	21	9	11	12
Number of communes without a CHS	2	0	0	0	1
Number of CHS of national standard	20	6	1	0	6
Number of CHS with a doctor	89	20	7	6	12
Number of CHS with a midwife / Obstetrician assistant	94	21	9	11	12
Number of villages with a health worker	886	182	101	91	112

Source: 2013 Kon Tum Health Statistical Report

MAP OF KON TUM PROVINCE



1.2. Objectives of Kon Tum CRC

There are two objectives in conducting CRC survey in Kon Tum Province to assess the level of satisfaction of general public with commune-level healthcare services:

- Collecting, recognizing and sharing feedbacks of the general public on healthcare services (ANC, MCH, MET, FPIEC and IS) and nutrition services with related parties with a view to enhancing service quality to optimize service delivery for the benefit of the general public, especially disadvantaged groups (the poor, ethnic minorities and children)

- Contributing to develop, implement, monitor and evaluate annual and 5-year health sector plans of Kon Tum Province and local socio-economic development plans (2011-2015 and 2016-2020)

1.3. Scope and Subject of Study

This study recognizes and analyzes feedbacks of the general public on 6 types of healthcare and nutrition services for mothers and children currently provided by CHS, namely

1. Antenatal care (ANC);
2. Maternal and child healthcare during and after birth (MCH);
3. Family planning (FPIEC);
4. Medical examination and treatment (MET);
5. Child nutrition services (CNS);
6. Child immunization services (CI).

Aspects of studies and analysis include:

1. Access to services;
2. IEC;
3. Availability of services;
4. Use of services;
5. Quality of services;
6. Users' satisfaction;
7. Recommendations for improvement.

Mothers raising small children are the target groups which can provide the most information on the healthcare services selected for this CRC, including mothers raising children under 2 years old who can reminisce better, in particular regarding the healthcare services used during pregnancy (a very important period with significant impacts on the child's malnutrition condition later in life)

1.4. Research Methodology

Research methodology:

This survey aims to find out the level of satisfaction of the general public with commune-level healthcare and nutrition services. This is a sociological survey which was conducted using a cross-sectional descriptive statistical methodology and CRC tool. Respondents are people who used the listed healthcare services during the past year and would provide information/feedbacks in accordance with retrospective methodology. The survey was conducted following a study of secondary materials and group discussions with related parties about the scope of the survey.

The CRC Implementation Manual which was jointly developed by UNICEF and the Ministry of Planning and Investment (MPI) is a very close source of reference during the design and implementation of the survey

Tools for information collection:

The first tool is a questionnaire with 137 questions (including both closed and open types) which is structured into 7 sections – 1 general section and the others for 6 types of healthcare services. This is the primary tool for information collection of this study. After the survey, a list of the youngest children of the respondents were sent to 12 CHS for an assessment of malnutrition status based on their weight data and the results were then reported to the Provincial Health Department. Besides, an interview sheet consisting of 10 questions was also used to collect information from CHS health workers on the physical facilities and human resources of their workplaces, the difficulties, advantages and recommendations for improvement of service quality.

Data handling methods:

Information collected using the questionnaire was cleaned. In particular, questionnaire feedbacks and weight data/weight-based malnutrition assessment results were inputted into the system using Epidata 3.1, then analyzed using SPSS 20.0 for identification of the percentage and average value of the indicators for use of services, quality of services, attitude of health workers and satisfaction of users with respects to 6 types of services provided by CHS.

Data Analysis

For each type of services, respondents were asked about the services they had used. Responses on (i) attitude of health workers; (ii) quality of services and (iii) satisfaction with services used were analyzed based on the percentage and average value in accordance with a scale of 5 levels as follows:

1. Very cold/Poor/Completely unsatisfied
2. Cold/Average/Not really satisfied
3. Normal/Fairly good/Fairly satisfied
4. Caring and attentive/Good/Satisfied
5. Very caring and attentive/Very good/Very satisfied

Users' feedbacks were then summarized and analyzed using the following 2 methods:

Method 1: Calculating the percentage of respondents who were "satisfied". For example: If out of 395 respondents whose child were vaccinated, 295 said they were "satisfied" with immunization services, 25 were "very satisfied", 63 were "fairly satisfied" and 12 were "not really satisfied", then the level of satisfaction

would be calculated as (295+25) /395 x 100 = 81.01%. According to this method of calculation, the level of satisfaction is reflected as a percentage and the result of this example is interpreted that 81.01% of users were satisfied with immunization services.

Method 2: Calculating users' satisfaction using a scale from 1 to 5, where 5 is the highest score and 1 the lowest. According to this method of calculation, the overal score is the weighted average of the scores for each type of services by all respondents and is interpreted as follows:

Table 2: Interpretation of average score

Average value	Interpretation
1-1.80	Very cold/Poor/Completely unsatisfied
1.81-2.60	Cold/Average/Not really satisfied
2.61-3.40	Normal/Fairly good/Fairly satisfied
3.41-4.20	Caring and attentive/Good/Satisfied
4.21-5	Very caring and attentive/Very good/Very satisfied

According to the above example, the score for users' satisfaction is 3.84 - (25*5+295*4+63*3+12*2)/(25+295+63+2), which is interpreted as "Satisfied" based on the above table.

This indicator is used for comparison among different locations, groups and types of services, thereby creating incentives for public service delivery units to improve their service quality continually for better satisfaction score.

1.5. Survey Sample

Selection of surveyed districts:

4 districts were selected for this survey, all of which are typical and representative of Kon Tum province in terms on economic, geographical and social characteristics. In particular:

1) Kon Tum City and Dak Ha District are representative of more developed economic regions with low poverty rates and higher proportions of Kinh people.

2) Tu Mo Rong and Dak Glei districts are representative of poor rural, mountainous and remote areas, with high poverty rates and high proportions of ethnic minority people.

Selection of surveyed communes:

- The communes of each district was divided into three groups according to the distance to the district center (close/medium distance/far away from district center) based on Document 1090/UBND-KTN of Kon Tum PPC on classification of road types and distance of travel.
- 1 commune was randomly selected from each group
- The selection results are displayed below:

Districts	Close to district center	Medium distance to district center	Far away from district center
Kon Tum City[6]	Quang Trung (2 km)	Truong Chinh (4 km)	Ngoc Bay (8 km)
Dak Ha District	Ha Mon (4 km)	Dak Hring (11 km)	Dak Psi (26 km)
Tu Mo Rong District	Tu Mo Rong District (9 km)	Ngọc Lay (21 km)	Mang Ri (24 km)
Dak Glei District	Dak Nhoong (15 km)	Xop (34 km)	Muong Hoong (53 km)

Similar results were obtained using PPS sampling method based on WHO's STEPS tool.

Sample frame: List of children who were born after July 1st, 2012, extracted from the 0-5 year-old child (05YO) Child Growth Record

Selection of analysis unit:

- Surveyed units: Households (who have stayed in the surveyed locations for at least 6 months)
- Respondents: Women who gave birth during the period between July 1st 2012 and July 30th 2014

Calculation of sample size:

- Minimum sample size for application of statistical tool: 30 observations (Hair et al., 1998)
- Minimum sample size for extrapolation of sample's indicators as representative for the population with 95% confidence level: 385 observations (Hair et al., 1998)
- Normal sample size for regression analysis, correlation analysis, or group verification: at least 100 observations (experiences of multiple researchers)
- EPI Info software was used to calculate sample size based on the following parameters:
  - The size of the surveyed population, namely children under 2 years old in Kon Tum province, was estimated at 40% of all children under 5 years old (56,886) or 22,754
  - Expected rate of satisfaction: 80%
  - 95% confidence level, 5% error
  - Sample design coefficient (usually between 1 and 4): 1.57[7]
  - 12 population groups (ward/communes)

The sample size result calculated to be 372 observations. As such, the intended sample size of 400 is sufficient to meet the sample design requirement, with provision for 28 errors.

Sample distribution by location:

The sample were evenly distributed among 4 surveyed districts, with 100 questionnaires for each district, or 33-34 questionnaires for each commune

6 *The survey location was expanded and selected following the workshop and upon consultation with UNICEF. Survey locations in Kon Tum City were PPS-randomly selected following WHO's STEP tool.*

7 *Saifuddin Ahmed, Dept. of Biostatistics, School of Hygiene and Public Health, Johns Hopkins University, Methods in Sample Surveys (140.640) - Cluster Sampling. The coefficient used in UNICEF's MICS in Viet Nam was 2.*

Selection of respondents:

Respondents are mothers who were randomly selected from the list of children aged 0-2 in the 05YO Child Growth Record, including 34 mothers from the official list and 16-21 mothers from the standby list (for interview if the official respondent cannot be met). The official list of sample was formulated by inputting the necessary information into the website http://www.random.org/integer-sets/ *(creating a series of 34 random integers with values between 1 and the number of 0-2 year-old children in each commune)*. Afterwards, another 16-21 mothers were selected to form a list of standby observations. During the selection of the official observations, if a mother raising 2 children under 2 years old had been selected twice, she would only have been included in the official list as the mother of the younger child *(this situation did not materialize during sample selection)*. As such, 50-55 mothers were selected from each commune. The official observations were given priority during the interviewed, until 33-44 questionnaires were completed for each commune. If the interviewer had met with a mother who were raising 2 children under 2 years old where the younger child was not listed in the sample, he/she would have interviewed the mother regarding the experiences with the younger one, recorded the child's name in the questionnaire under the name of the replaced child and reported to the team leader and the supervisor *(this situation did not materialize during sample survey)*

307 official respondents (76.75%) and 93 standby respondents (23.25) were interviewed during the survey. There was no rejection for interview. Details of the survey sample are listed in table 1.5 of Annex 5.1.

1.6. Survey procedures

The survey was conducted following the steps listed below:

Step 1: Technical workshop

A technical workshop was held on June 19th, 2014 and facilitated by the Provincial Department of Health with the support from the consulting team and UNICEF. Participants include 14 officials from the Kon Tum province's PMU for Child Friendly Project, the Provincial Department of Planning and Investment, the Provincial Statistics Office, CRC Steering Committee – Provincial Health Department of the related centers, and managerial and staff from CHS of the three participating districts. The workshop aimed to (1) provide an introduction about CRC; (2) identify the objectives, scope and subject of the study: (3) discuss about the key and detailed contents of the questionnaire: (4) reach an agreement on the sampling method; and (5) discuss and agree on detailed survey plan.

Step 2: Development of study tool

After an agreement had been reached on the objectives, scope and subject of study, the survey team including personnel from the Provincial Department of Health, Provincial Reproductive Health Center, Provincial Health IEC Center, Provincial Health Center and the consulting team moved forward to design the questionnaire during the period from July 1st, 2014 to July 29th, 2014. Comments were sought from UNICEF and the questionnaire was piloted on 8 Ba Na mothers from village 5 of Dak Ha District. The pilot results showed that average interview time was about 60 minutes. 29 questions were then modified, with the most significant change being dividing questions with tables into smaller ones, which make the questionnaire longer but the interview easier and responses better recorded. Besides, a few questions were shifted in order to reduce the number of transition steps for each type of services. The consulting team made the adjustment accordingly and prepared a second version for use during the training.

Step 3: CRC technical training

A 3-day training course was organized for the interviewers and supervisions, including 27 technical staff from different units of the Provincial Department of Health and District Health Centers from August 6th to 8th, 2014. The class was designed as a hand-on experience by combining theoretical and practical training, where

the survey tool was piloted on 23 households in Quang Trung Ward of Kon Tum City. After the second pilot, the questionnaire was finalized for use in the official survey.

Step 4: Conducting the survey

The survey team consisted of 27 people who were selected from participating district-level health facilities and was divided into 3 groups, each including a provincial-level supervisor, a district-level supervisor and 6-7 interviewers. The list of all survey team members is enclosed with Annex 5.6.

All survey groups conducted interviews with the respondents to collect information while the supervisors performed random check on the interviews, reviewed the completed questionnaires and requested the interviewers to collect the missing information on the spot if necessary. Primary information collection using questionnaires took place between August 19th and 26th, 2014.

Before interviewing the respondents, the interviewers provided an introduction about the survey to make sure the respondents understand and only moved forward to interview those who agreed to participate. During the interview, a respondent might refuse to answer the questions they considered difficult or those they did not wish to answer. To ensure privacy, all of the information provided by respondents would be consolidated together and strict confidentiality would be maintained.

Early September 2014, the youngest children of the respondents were weighed at 12 CSH, then their malnutrition status was assessed and the results were sent to the Provincial Department of Health. After the children had been weighed by CHS staff, a few were then randomly selected for a re-weigh by the survey group team members to cross-check against the results reported by CHS to the Provincial Health Department. The survey team results were consistent with CHS weight data. On the other hand, immunization information was primarily recorded based on the responses during interviews and cross-checked against immunization sheets if they became available.

During data collection, the provincial survey team received direct technical support from the consulting team. UNICEF staff also supervised a number of interviews and a meeting was held in the Dak Psi CHS of Dak Ha District to conclude on the lessons learnt. The survey team interviewed 400 mothers and the consulting team interviewed 8 CHS Directors in Kon Tum City and the 3 other participating districts.

Step 5: Data input, handling and reporting

Before inputting the information collected during interviews into the data entry management software (Epidata 3.1), the interview sheets were coded according to specific locations, in particular:

District/City	Ward/Commune	Unit Code	Sheet Code
Kon Tum City	Quang Trung	11	From 1101 to2134
	Truong Chinh	12	From 1201 to2233
	Ngoc Bay	13	From 1301 to2333
Dak Ha District	Ha Mon	21	From 2101 to2134
	Dak Ring	22	From 2201 to2233
	Dak Pxy	23	From 2301 to2333
Tu Mo Rong District	Tu Mo Rong	31	From 3101 to3134
	Ngoc Lay	32	From 3201 to3233
	Mang Ri	33	From 3301 to3333
Dak Glei District	Dak Nhoong	41	From 4101 to4134
	Xop	42	From 4201 to4233
	Muong Hoong	43	From 4301 to4333

The entire 400 questionnaires were cleaned by 5 survey team members and data was entered into Epidata from September 1st to 6th, 2014. After receiving raw data from the Provincial Department of Health, the consulting team and data entry team reviewed all the questionnaires and inputted data to ensure completeness and accuracy. After 5 cleanings from September 7th to October 6th, 2014, the data was complete and ready for analysis and reporting. The report was then prepared by the Provincial Department of Health with the support of T&C Consulting. During data analysis, tests such as Cronbach's alpha, ANOVA, T-test *(for average values),* Chi-square, Phi and Cramer's V *(for ratios)* were used as and when necessary and appropriate. The draft report was sent to relevant provincial bodies, the PMU and UNICEF for comments.

Step 6: Draft consultation and report finalization

The draft report was sent to relevant provincial bodies, the PMU and UNICEF for comments. Afterwards, the consulting team finalized the report based on the comments and feedbacks of the stakeholders. A workshop was then organized to share the survey findings.

1.7. CRC limitations

CRC results reflect the landscape of healthcare services from the perspective of users. CRC survey does not incorporate feedbacks of health staff, managers and specialists. To date there are no standards/indicators for healthcare service quality at commune level[8]. As such, the first shortcoming of Kon Tum health sector CRC is the lack of expert's view.

The second limitation lies in the awareness and understanding of disadvantaged groups, or ethnic minority people in this case. To them, the concept of "quality" and "satisfaction" are new and very difficult to understand. Information on child immunization is also limited as a large number of mothers (48.6%) could not remember the name of the vaccines, there was no immunization data for verification, and the children were not checked for the TB vaccine scar.

Another hindrance of accurate users' feedbacks is their hesitance to give negative comments for fear of affecting local health staff.

8 *Only when the general public is provided with transparent information on the standards on a service can they have a basis for assessing service quality and their satisfaction. For example, with respect to public administrative services: if the general public knows that the maximum time allowable for handling documents, they will not be happy to wait 4-5 days. However, without knowing this, a lot of them would find it satisfactory. Better educated, more knowledgeable people are often more fussy when assessing public services.*

However, the above mentioned limitations do not affect the most important implication and results of this CRC, which is an opportunity for the general public to exercise their civic rights

and participate in local decision making process for public health services. This first CRC helps to facilitate the development of an effective and sustainable mechanism to exercise this significant right of people in Kon Tom. The regular implementation of CRC surveys following this mechanism will help to gradually address the listed limitation in the future.

SURVEY RESULTS

2. SURVEY RESULTS

2.1. GENERAL FINDINGS

2.1.1. Facilities and human resource of CHS

In general, human resource situation at 12 CHS in 4 surveyed districts were rather favourable for the implementation their technical duties and provision of healthcare services at commune level. Personnel were allocated in accordance with human resource master plan and there were doctors in 10 out of 12 surveyed CHS.

In terms of physical facilities, these 12 CHS could be divided into 3 groups. Group 1 included 3 CHS of national standard, namely Ha Mon CHs (Dak Ha Dictrict), and Quang Trung and Truong Chinh CHS (Kon Tum City). Group 2 included Muong Hoong CHS of Dak Glei District, Tu Mo Rong CHS of Tu Mo Rong District and Dak Hring CHS of Dak Ha District – these three cooperated with the local polyclinics and therefore could share their facilities. Group 6 included 6 remaining CHS which failed to meet the required standards and was disadvantaged in terms of facilities.

With respect to the CHS of national standard, some of their highly specialized equipment was not yet fully deployed and potentials not fully exploited. For example, Quang Trung CHS was equipped with 145 different types of equipment, some of were never used as their health workers were yet to receive training on how to operate such equipment. However, Quang Trung Ward is a central location where there is a tendency for people to use private health clinics and the provincial general hospital located there rather than the CHS for these medical procedures. On the other hand, in Ha Mon, people who are well educated and better off rarely use the health care services provided by the CHS there. When in need of a medical check-up or treatment, ANC or delivery, people often go to health facilities at higher level or private health clinics. This behavior has led to the under-use of facilities in these CHS.

In terms of the CHS in Muong Hooong and Dak Ring communes, they represented a good combination of healthcare providers from commune and district levels, where health infrastructure and facilities were sufficient to meet the demand for health care services of local people, who would have access to rather modern equipment such as ultrasound and electrocardiogram machines.

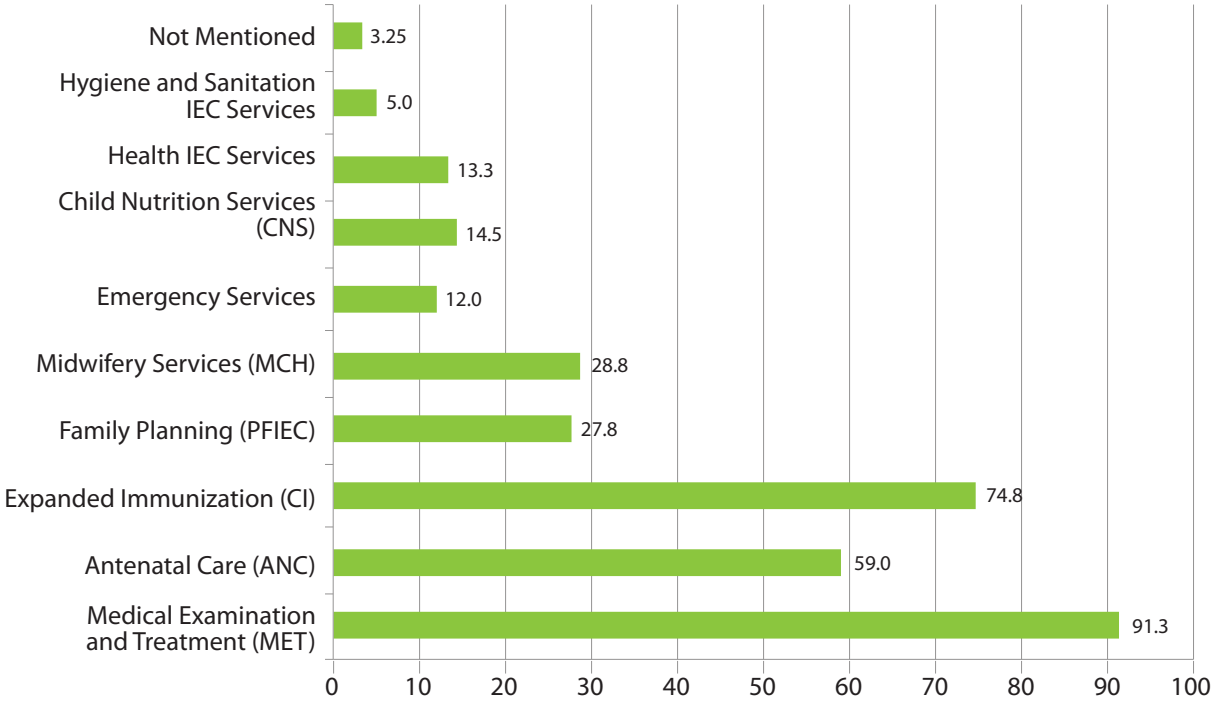
The remaining CHS shared a common feature of lacking facilities: not enough specialized rooms, no or little clean water, substandard toilets, not enough equipment for primary care. In particular, Tu Mo Rong CHS had to use borrowed rooms.

2.1.2. Access to healthcare services at CHS by the general public

This study recognizes and analyzes feedbacks of the general public on 6 types of healthcare services and nutrition services provided by CHS to mothers with children under 2 years old and the children themselves, including: (1) ANC, (2) MCH, (3) FPIEC, (4) MET, (5) CNS and (6) CI. These are the basic services which are currently provided by CHS.

MET services were the type most known to the respondents (91.3%), followed by IS at 74.8%, ANC at 59%. 13 respondents had no idea of the services provided by CHS. 5% heard that CHS conducted IEC for environmental sanitation and 12% knew about emergency services. 24% of the respondents knew about 3 services, 18% knew about 2 and 16.8% knew about 4. Only 1.8% were aware of 9 services provided by CHS.

Figure 1: Understanding of the general public on healthcare services provided at CHS



Source: 2014 Kon Tum Province CRC on CHS Services

With respects to the 6 surveyed services, there were a large proportion of people using such services at CHS. CI was considered the most used by respondents (98.8%) while MCH was the least used (38.5%).

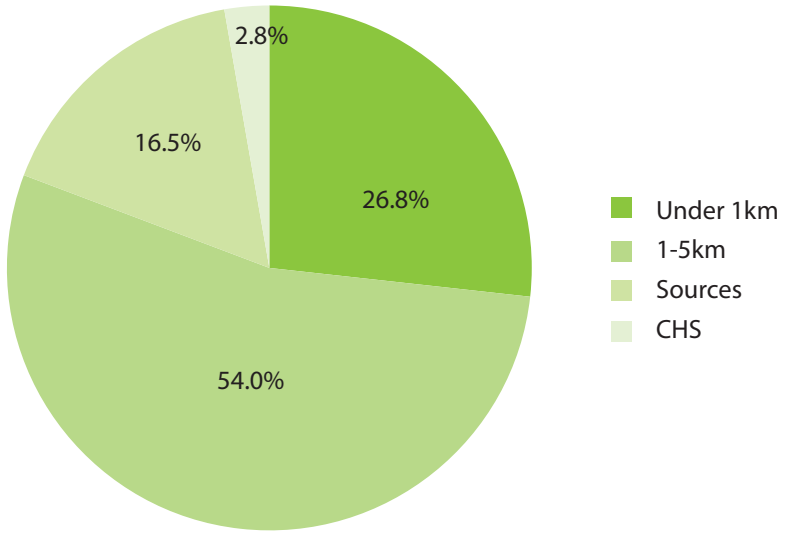
Table 3: Use of services provided by CHS

Services provided at CHS	Frequency	Percentage (%)
1. ANC	375	75.2
2. MCH	154	38.5
3. FPIEC	324	81.0
4. MET (within the past year)	264	66.0
5. CNS	346	86.5
6. CI	395	98.8

Source: 2014 Kon Tum Province CRC on CHS Services

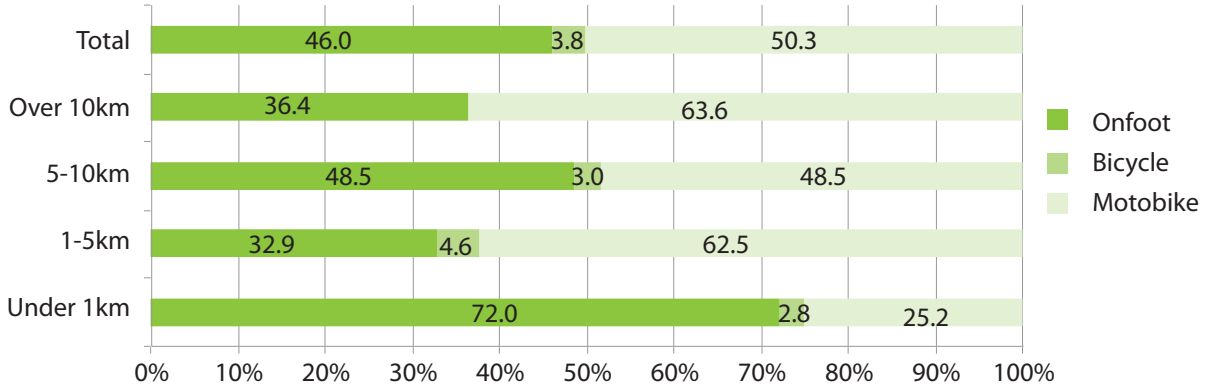
With respect to access to services, the survey indicates that the majority of respondents were located within 5km from a CHS (80.8%) while 16.6% lived between 5km and 10km from a CHS and 2.8% lived more than 10km away from a CHS (11 respondents altogether, including 7 Gie Trieng women and 4 Xo Dang women - 1 living on Dak Psi, 1 in Tu Mo Rong,7 in Dak Nhoong and 2 in Muong Hoong, all from poor households).

Figure 2: Distance to CHS



Source: 2014 Kon Tum Province CRC on CHS Services

Figure 3 : Distance and means of transportation to CHS



Source: 2014 Kon Tum Province CRC on CHS Services

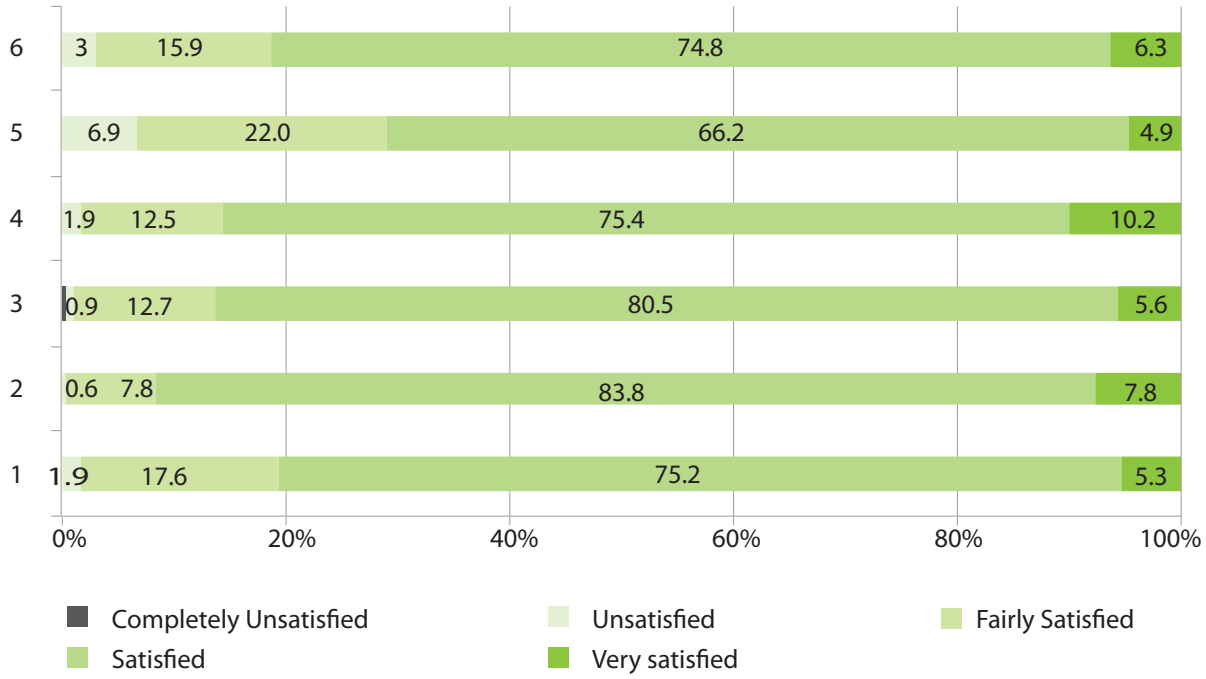
In general, the primary means of transport for travelling to CHS is motorbike (50.3%), followed by foot (46%). Among the respondents who lived more than 10km away from a CHS, 36% walked to the CHS while 63.6% travelled by motorbike.

In terms of travelling time, 72.8% of the respondents said it took them less than 30 minutes. Those who spent between 30 and 90 minutes travelling were mainly from poor households or ethnic minorities (Xo Dang, Gie Trieng, Ba Na, and so on), living in Tu Mo Rong and Dak Glei districts *(two of the economically disadvantaged districts and populous in terms of ethnic minorities of Kon Tum province)*. In particular, it took 15 respondents more than 90 minutes to travel to a CHS, including 2 respondent from Dak Ha Ditrict, 4 from Tu Mo Rong Districts and 9 from Dak Glei Districts – all ethnic minority people (3 Gie Trieng and 12 Xo Dang). Details on travelling time by location, ethnic group, and family economic condition are included in Table 2.1.2.1 of Annex 5.1

2.1.3. Level of satisfaction with healthcare services at CHS

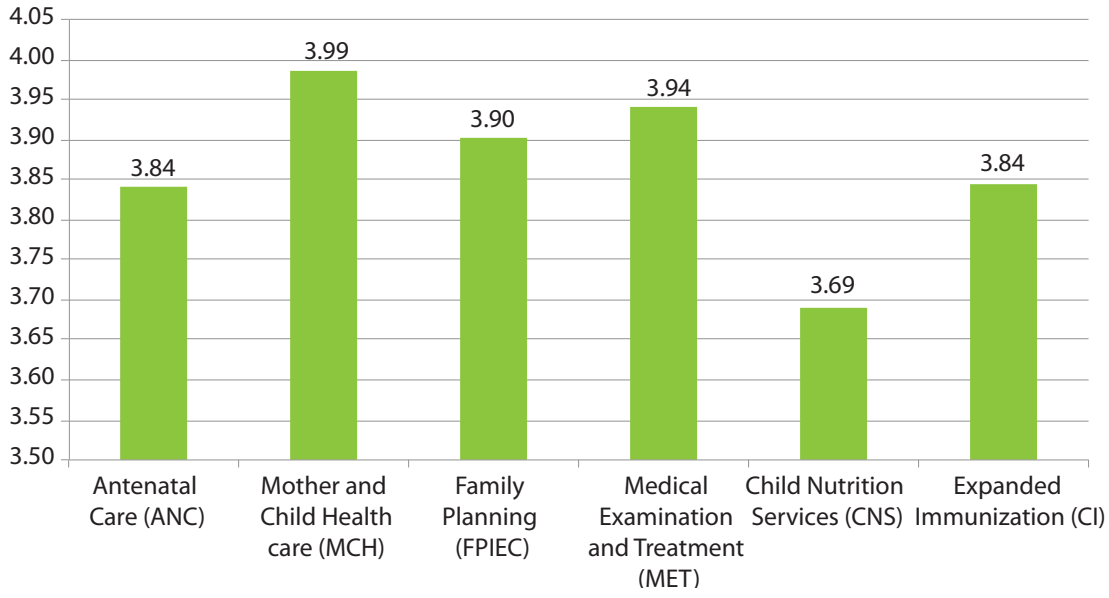
In general, a large proportion of the respondents in surveyed locations were satisfied with the 6 types of services provided by CHS. In particular, most people were satisfied with MCH at 83.8%, followed by FPIEC, MET, ANC, CI and CNS at 80.5%, 75.4%, 75.2% and 74.8% and 66.2% respectively.

Figure 4 : Level of satisfaction with 6 services



Source: 2014 Kon Tum Province CRC on CHS Services

Figure 5: Satisfaction score for 6 services



Source: 2014 Kon Tum Province CRC on CHS Services

2.2. FINDINGS BY SERVICE TYPE

2.2.1. Antenatal care

Grass-root level healthcare network, including CHS, plays an important role in providing primary care to the general public. One of the functions and tasks of CHS is to provide medical check-up for pregnant women and midwifery service for normal birth. Ensuring satisfactory ANC services will contribute to reduce maternal and infant mortality rates due to obstetric complications.

IEC on antenatal care

The respondents were asked whether they were advised or guided by CHS health workers for the latest pregnancy in terms of *(1) 3 checks-up in 3 trimesters; (2) Delivery at CHS; (3) Pregnancy hygiene; (4) Nutrition during pregnancy; (5) Breastfeeding; and (6) Signs of abnormality (risks of complication) during pregnancy, childbirth, after birth and handling.*

Among 400 respondents, 68% were advised on 3 checks-up in 3 trimesters. However, the least received guidance on signs of abnormality (risks of complication) during pregnancy, childbirth, after birth and handling (16.5%). In particular, 14.7% did not receive any guidance during pregnancy. 7.8% said they could not recall what they were advised on – they were from Tu Mo Rong and Dak Glei districts.

Table 4: ANC Counseling

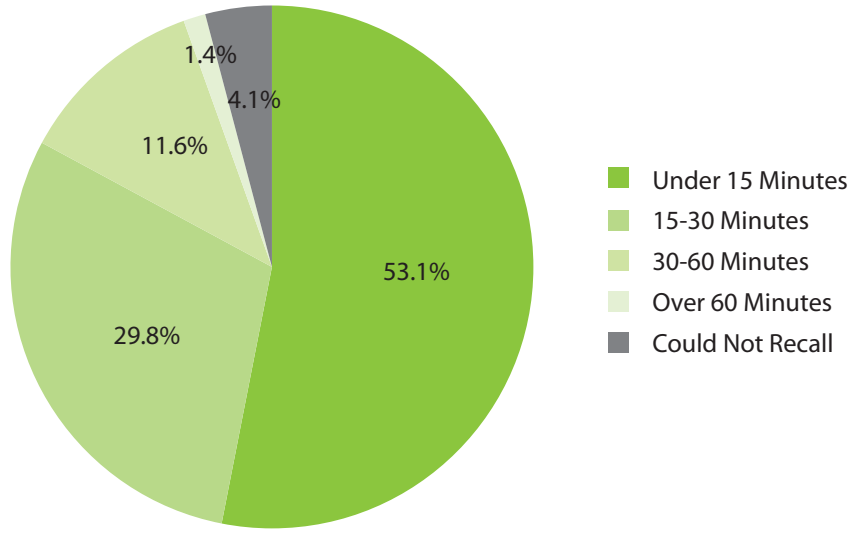
No	Counseling topics	Kon Tum City	Dak Ha District	Tu Mo Rong District	Dak Glei District	Total
1	3 checks-up in 3 trimesters	63	83	63	63	272
2	Delivery at CHS	42	57	47	42	188
3	Pregnancy hygiene	33	27	24	21	105
4	Nutrition during pregnancy	60	65	42	55	222
5	Breastfeeding	51	42	33	42	168
6	Signs of abnormality	23	18	15	10	66
7	Could not remember of the issue advised on	26	8	13	12	59
8	No memory of counseling	2	4	14	11	31
	Total	**100**	**100**	**100**	**100**	**400**

Source: 2014 Kon Tum Province CRC on CHS Services

Availability of services

Availability of services is reflected by waiting time for ANC at CHS. 82.9% of the respondent received a check-up within 30 minutes' waiting, 53.1% of which waited for less than 15 minutes. Only 1.4% had to wait for more than an hour. As such it could be seen that ANC services at CHS are highly available.

Figure 6: Waiting time for ANC services at CHS



Source: 2014 Kon Tum Province CRC on CHS Services

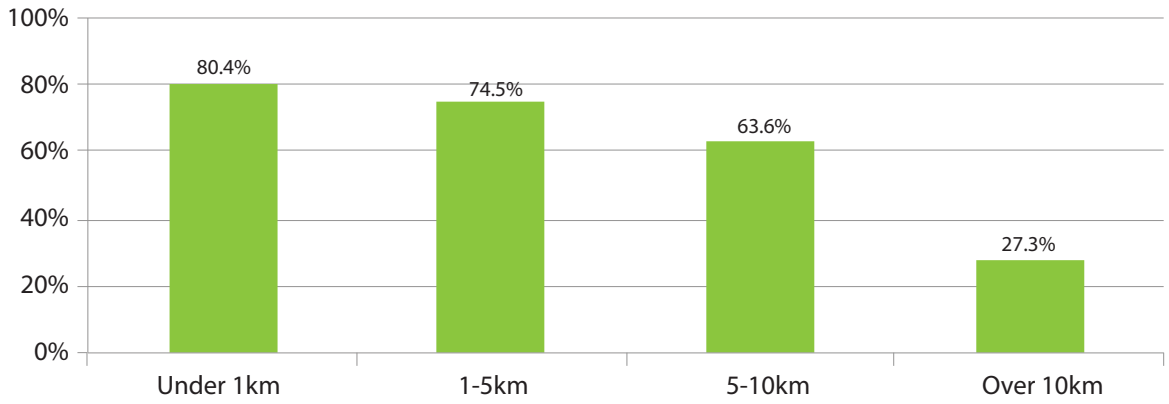
Use of services

The ANC services assessed during this survey included check-up, tetanus vaccination and taking iron tablets/ multi-micronutrient tables

Survey results indicated that there was a correlation[9] between the use of ANC services at CHS and survey locations, distance from CHS to district center, poor/non-poor classification (as of 2013), distance from home to CHS and ethnicity of mothers.

Dak Glei was the district with the highest number of respondents using ANC services at CHS, followed by Tu Mo Rong, Dak Ha and Kon Tum City at 79%, 71% and 61% respectively. Respondents who lived closer to district centers tended to use fewer ANC services at CHS (63.2%, 75.6% and 79.5% usage in order of distance). More respondents from poor households went to CHS for ANC services than those from non-poor ones (77.7% as opposed to 67.6%). More respondents living closer to CHS went there for ANC services than those who lived further away.

Figure 7: Use of ANC services by distance



9 *Chi-Square test indicated p result <0.05*

Source: 2014 Kon Tum Province CRC on CHS Services

There was also a correlation between use of services and ethnicity of mothers. More respondents from ethnic minorities went to CHS for ANC services than Kinh mothers (78.5% versus 57.9%), the latter lived primarily in Kon Tum City and Dak Ha District where there were more options for ANC service providers.

Interview results showed that a large number of respondents had at least one ANC check-up (92.2%), of whom 73% had their check-up at a CHS. Very few respondents were checked by village health workers or village midwives (0.8%).

Those who did not go for any ANC check-up accounted for 7.8%, including primarily respondents from poor households (25 people), ethnic minorities (31 people), from Tu Mo Rong District (13 people) and from Dak Ha District (10 people), aged between 22 and 30 years old (17 people) and without schooling (13 people)

Table 5: Place of ANC check-ups for the latest pregnancy

No	Place for ANC check-up	Number	Percentage (%)
1.	CHS	292	73
2.	Village health workers/Village midwives	3	0,8
3.	Regional general hospitals	0	0,0
4.	District hospitals	7	1,8
5.	Private health clinics	63	15,8
6.	Local herbalists/Shamans	1	0,3
7.	Others	3	0,8
8.	No ANC check-up	31	7,8
	Total	**400**	**100**

Source: 2014 Kon Tum CRC on CHS services

Among 292 respondents who went to CHS for ANC check-up during the latest pregnancy, 105 or 35.9% had the advised 3 checks-up during the 3 trimesters. The majority got checked on fetal heartbeat, blood pressure, belly size and weight.

Table 6: ANC checks and tests

Checks	Kon Tum City	Dak Ha District	Tu Mo Rong District	Dak Glei District	Total
1. Blood pressure	47	55	50	63	215
2. Fetal heartbeat	52	49	53	63	217
3. Body temperature	14	7	19	17	57
4. Weight	49	51	52	54	206
5. Urine	6	10	11	13	40
6. Belly measurement	53	55	51	52	211
7. Do not remember	1	5	10	3	19
8. Other	1	1	0	5	7
Total	**61**	**72**	**79**	**80**	**292**

Source: 2014 Kon Tum CRC on CHS services

84,2% of the respondents having their ANC check-up at CHS during the latest pregnancy said that they were given an appointment for a following check-up by the health staff and 92.5% felt safe and their privacy respected during their ANC check-up at CHS.

27.7% of the 292 respondents who visited CHS for ANC check-up said the CHS did not provide them with any ANC or MCH record/booklet. This proved that CHS were yet to perform well in terms of providing ANC records.

85.3% of the respondents said that they had been vaccinated against tetanus at CHS during their latest pregnancy. 12.5% did not receive tetanus vaccination, including 32 from poor households and 18 non-poor, locating evenly in all 4 districts. Among those 12 were Kinh and 38 were ethnic minorities, 17 were pregnant for the first time, 14 for the second time and 19 for the third to eighth time.

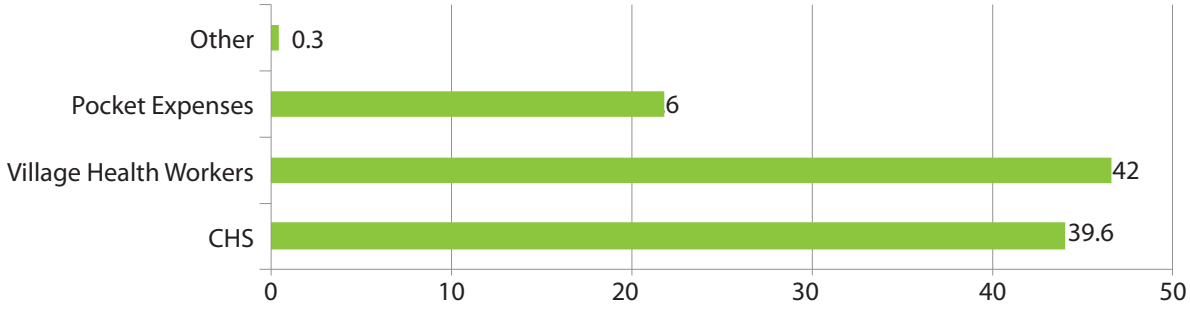
Among the 341[10] respondents who had been vaccinated against tetanus, 240 (70.4%) said that they had been vaccinated against tetanus once and 153 (44.9%) said they had been vaccinated against tetanus twice.

Survey results also showed that 82.7% of the respondents had been given iron or multi-micronutrient supplements during their latest pregnancy. More Kinh mothers took these supplements than ethnic minority mothers (97.2% as opposed to 77.5%).

Women who use ANC services at CHS, including check-up/tetanus vaccination/taking iron supplements do not have to pay any fees. The sources of supply for iron supplements are presented in the below figure.

10 9 respondents did not remember whether they were vaccinated against tetanus

Figure 8: Sources of supply for iron supplements to pregnant women



Source: 2014 Kon Tum CRC on CHS services

Level of satisfaction

Feedbacks on attitude of health workers, service quality and level of satisfaction with respect to ANC services at commune level were collected from respondents who had used at least one of the three services provided by CHS to pregnant women, namely (1) ANC check-up; (2) Tetanus vaccination and (3) Taking iron/multi-micronutrient supplements.

Survey results indicated that the respondents considered CHS health staff as caring and attentive, with good ANC service quality and in general they were satisfied with ANC services at commune level. The score breakdowns are displayed in the following table.

Table 7: Assessment of ANC services

Content	N	Average score
Attitude of health staff	375	3.66
ANC service quality	375	3.42
Level of satisfaction with ANC services	375	3.84

Source: 2014 Kon Tum CRC on CHS services

There was a difference[11] in the score for attitude of health workers in different locations. Variability could be observed in Kon Tum City and Dak Ha District. Respondents from Dak Ha District gave higher scores for health worker attitude than those from Kon Tum City.

11 *Statistical tests showed a p value under 0.05*

Table 8: Attitude of health staff

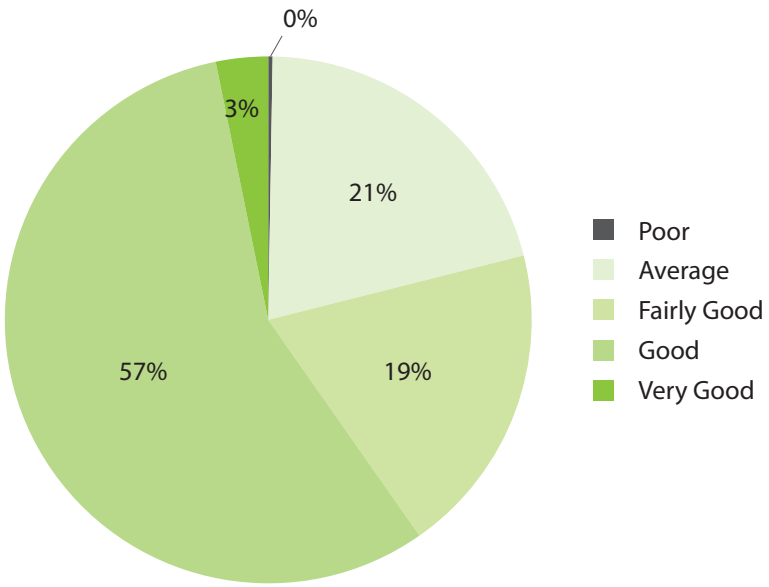
No	Location	N	Average score
1	Kon Tum City	92	3.51
2	Dak Ha District	96	3.74
3	Tu Mo Rong District	90	3.71
4	Dak Glei District	97	3.66
	Total	**375**	**3.66**

Source: 2014 Kon Tum CRC on CHS services

Besides, score differences also existed among groups of communes. The communes closer to district center received a score of 3.75 for health staff attitude while further away ones got 3.58.

In terms of service quality, 56.5% of the respondents said that CHS had good ANC services, 19.2% considered service quality as fairly good, 20.8% thought of it as average, 3.2% very good and 0.8% poor. The details are displayed in Figure 9 below.

Figure 9: Quality of ANC services - Percentage

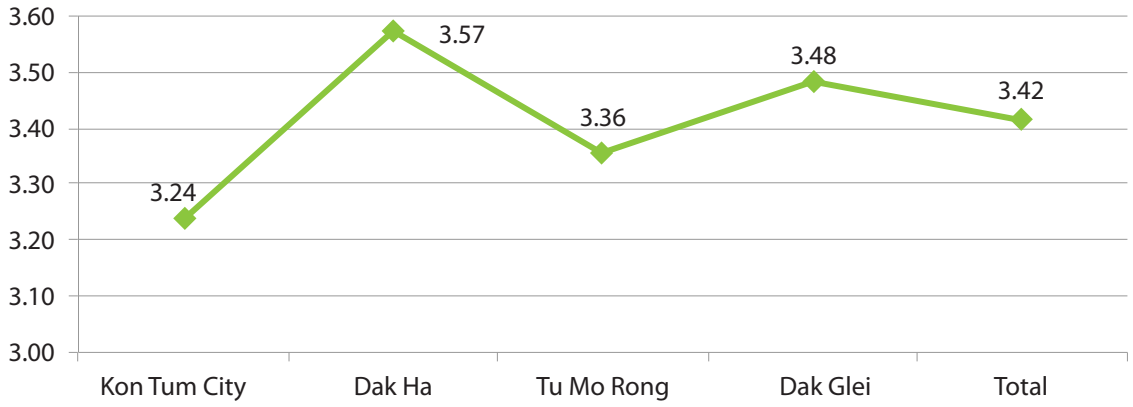


Source: 2014 Kon Tum CRC on CHS services

The respondents who gave positive feedbacks on ANC service quality said that CHS health *staff was caring, enthusiastic, attentive, cheerful, checked very thoroughly, provided very specific guidance, gave them medicine, got them vaccinated; the examination room was clean and they felt safe, and so on*. However, there were a few respondents who claimed that CHS health staff was neither enthusiastic nor caring. *In particular, some thought ANC service quality was unsatisfactory due to the lack of modern equipment (such as ultrasound or testing machines), shortage of health staff (doctors with high qualifications)*

There was a difference[12] in the score for ANC service quality among different surveyed locations, where respondents from Dak Ha rated ANC service quality higher than those from other locations, with Kon Tom City having the lowest score.

Figure 10: Quality of ANC services by location - Score

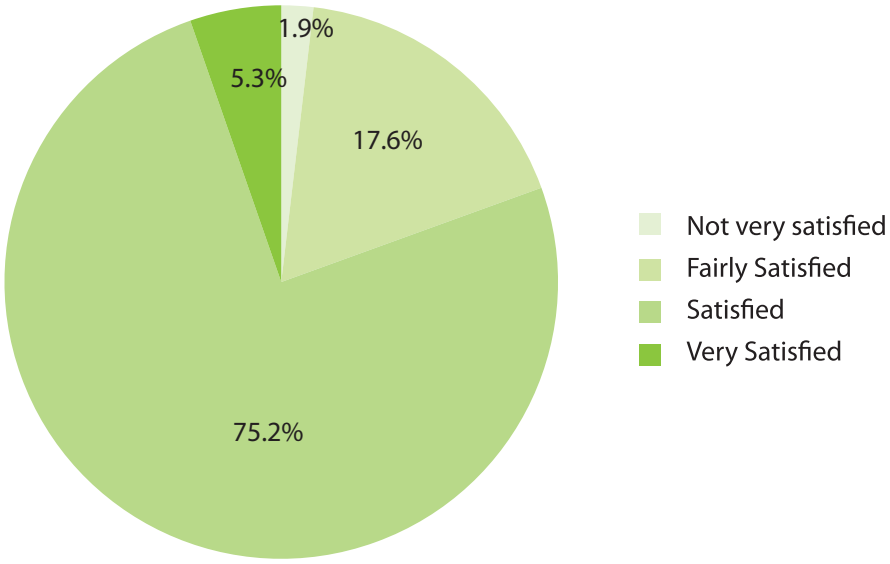


Source: 2014 Kon Tum CRC on CHS services

Differences also existed among ethnic groups, where respondents of ethnic minority (primarily Ta Re) thought more highly of ANC service quality than Kinh and Xo Dang respondents.

The majority of respondents were satisfied with ANC services provided by CHS. Among the 375 women who had used these services, 80.5% said they were either satisfied or very satisfied while 19.5% indicated that they were either fairly satisfied or not satisfied with the services. Reasons for dissatisfaction included *(1) Shortage of health workers and lack of equipment; (2) Unenthusiastic and uncaring health staff; (3) The check-up should have been done more thoroughly; and (4) Private health clinics had better ANC services.*

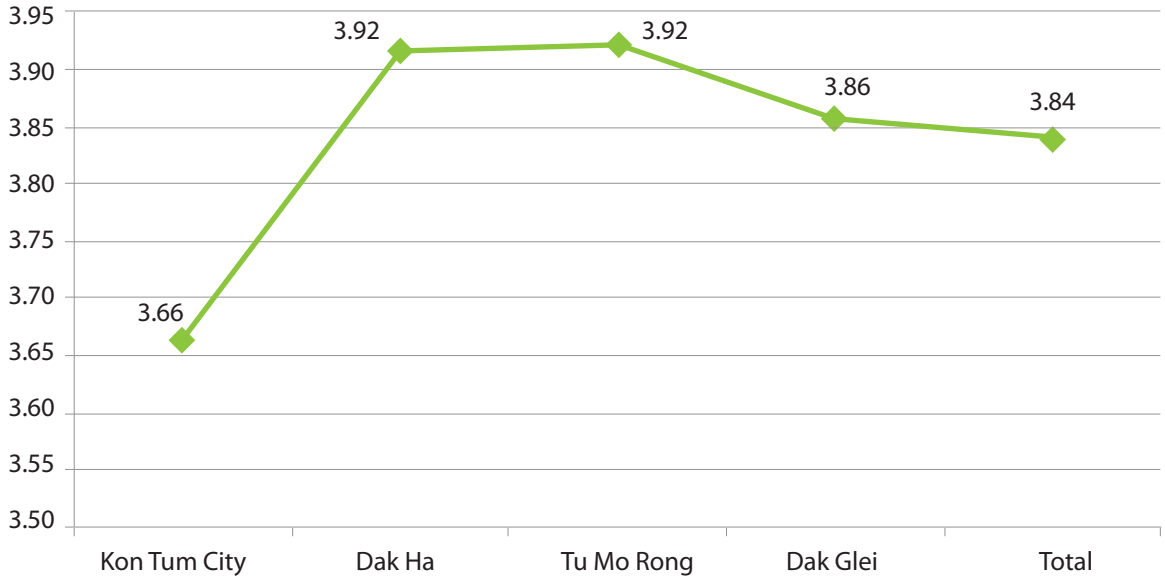
Figure 12: Satisfaction with ANC services - Percentage



Source: 2014 Kon Tum CRC on CHS services

12 *Statistical tests indicated a p value less than 0.05*

Figure 13: Satisfaction with ANC services - Score



Source: 2014 Kon Tum CRC on CHS services

Data analysis indicated that the level of satisfaction with ANC services provided by CHS depended[13] on factors such as location, distance from home to CHS, time spend waiting for ANC check-up, attitude of health staff, quality of ANC services and education level of respondents. In particular, the further the distance from home to CHS and the longer the time spent waiting for ANC check-up, the lower the satisfaction. In addition, more caring and attentive the health workers, and higher service quality would increase level of satisfaction. Besides, education level was negatively correlated with satisfaction level. Finally, the level of satisfaction was highest in Kon Tom City, followed by Dak Ha, Tu Mo Rong and Dak Glei.

Recommendations of respondents

In hope for improvement of ANC services provided by CHS, 116 respondents came with recommendations for CHS. 46 people wanted CHS to have ultrasound machines; 36 wished to be checked more thoroughly and advised more specifically; 16 hoped that CHS would have more health staff and qualified doctors and that these health staff should be supported by more and better equipment; 9 wished for more obstetricians; 7 wanted more supplements and more regular provision of iron/multi-micronutrient tablets.

2.2.2. Maternal and Child Healthcare

MCH service covered in this survey included: (1) Midwifery services and home-based care after birth; (2) MCH counseling after birth and (3) Home visits. Survey results showed that 154 respondents (38.4%) had used MCH services provided by CHS, of whom 23 respondents gave birth at CHS and were visited by CHS health staff at their home, 15 people delivered their babies at CHS but did not receive home visits afterwards, and 116 people who gave birth elsewhere received home visits after birth.

Use of services

Midwifery services and after birth care of newborns at CHS

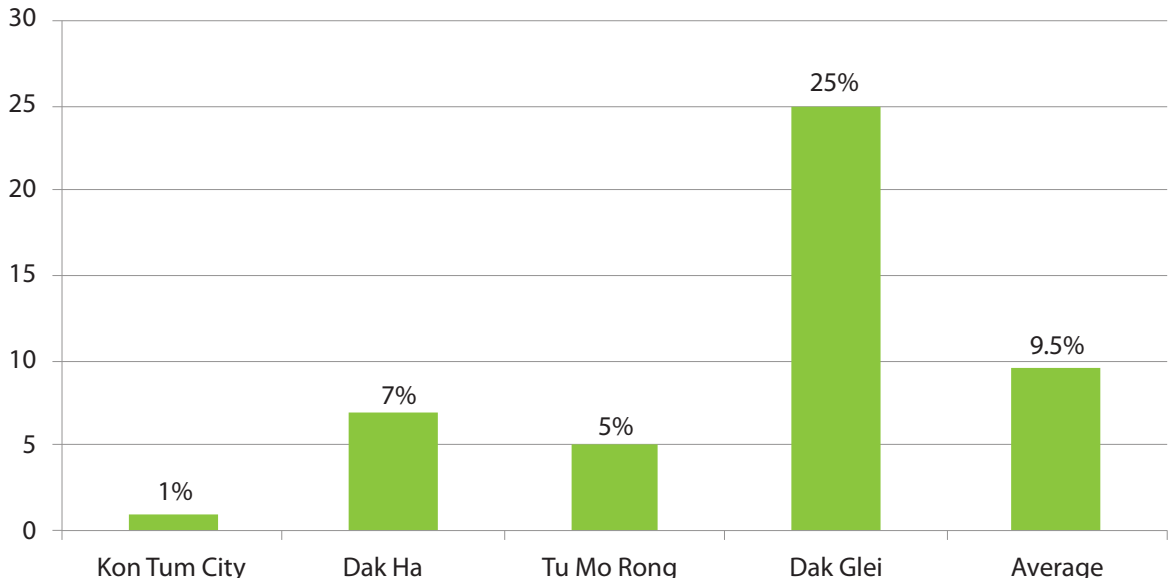
There were 38 respondents (9.5% who gave birth at CHS, of whom 26 said they received a check-up within 15 minutes of arriving at the CHS, 9 said they waited between 15 and 30 minutes, 1 respondent claimed that

13 *Regression analysis on factors affecting satisfaction level indicated p value under 0.05*

she had to wait between 30 and 60 minutes to be checked and counsel before delivery and 2 respondents said they did not remember how long they waited. As such, it could be seen that the MCH services are readily available at CHS.

There was a correlation[14] between place of delivery and surveyed location. Dak Glei District had the highest number of respondent giving birth at CHS while the least came from Kon Tum City (only 1 case). This again indicated that midwifery services of CHS were not actively used by women in urban areas where there are better services and people are better off and can afford such services.

Figure 14: Delivery at CHS by location



Source: 2014 Kon Tum CRC on CHS services

There was a correlation[15] between place of delivery and poor/non-poor classification. 28 respondents who gave birth at CHS came from poor households and the other 10 non-poor. This is another piece of evidence proving CHS has an important role to play regarding poor households, especially those in remote areas.

Among 38 respondents who gave birth at CHS, 36 were ethnic minorities (including Xo Dang, Gie Trieng, Ba Na and Ta Re) and only 2 were Kinh. All of them lived within 5km from the CHS where they delivered their baby.

35 out of the above 38 respondents said the delivery room was clean and the other 3 did not pay attention to hygiene conditions of the delivery room. None of them thought that the delivery room was unhygienic.

After birth care of newborns at CHS includes wiping the baby dry, keeping the baby warm, early detection of signs of umbilical cord infection, vaccination against Hepatitis B and re-examination before discharge. CHS health staff is to provide guidance to mothers on proper breastfeeding methods *(23/38 of the respondents who gave birth at CHS breastfed their baby within 30 minutes after birth).* Duration of stay at CHS after birth was less than 2 days.

14 *Statistical tests indicated a p value below 0.05*

15 *Statistical tests indicated a p value below 0.05*

Table 9: Duration of stay at CHS after birth

No	Duration of stay at CHS after birth	Frequency	Percentage (%)
1	Less than 1 day	16	42.1
2	From 1 to 2 days	13	34.2
3	From 3 to 4 days	3	7.9
4	From 5 to 7 days	5	13.2
5	Do not remember	1	2.6
	Total	**38**	**100.0**

Source: 2014 Kon Tum CRC on CHS services

Among the 38 respondents who gave birth at CHS, 3 said that they paid for the services, of whom one paid VND260,000 as she did not have health insurance at the time, another paid VND30,000 as required by the CHS and was given a receipt, and the last one paid VND20,000 for the umbilical cord clamp and drinking water.

Reasons for not giving birth at CHS

There are many reasons for not giving birth at CHS, of which the most popular one was not having enough time to each the CHS (19.6%), followed by complicated delivery and caesarian section (17.1%). It is worth noting that 18.8% of the respondents did not feel at ease about midwifery services at CHS. Specific reasons for not giving birth at CHS are listed in Table 2.2.2.1, Annex 5.1.

Data in **Table 2.2.2.2** of Annex 5.1 indicates that169 respondents (42.25%) gave birth at home despite the potential risks of complication. They were located primarily in Tu Mo Rong District (41.4%), of ethnic minorities (99.4%), lived far away from district center 55%) or came from poor households (72.2%).

Table 10: Place of birth delivery

No	Place of birth delivery	Frequency	Percentage (%)
1	CHS	38	9,5
2	At home, with the support of health staff	24	6,0
3	At home, with the support of traditional birth attendants	45	11,3
4	At home, with the support of mother, husband and/or other family members	99	24,8
5	District hospitals	60	15,0
6	Regional policlinics	12	3,0
7	Provincial hospitals	112	28,0
8	Others	10	2,5
	Ngoc Hoi Regional General Hospital	3	
	Hospitals in other provinces	5	
	Private health clinics	1	
	At home, with the support of neighbors	1	0,25
	Total	**400**	**100**

Source: 2014 Kon Tum CRC on CHS services

MCH counseling after birth

Counseling on postpartum care and after birth care of newborns is an important area of MCH and helps with early detection and timely handling of abnormalities in both mother and infant, thereby contributing to reduce maternal and infant mortality. Survey results indicated that the most popular topic of counseling is breastfeeding right after birth, proper breastfeeding and exclusive breastfeeding within the first 6 months (50%); keeping the baby warm, caring for the baby and hygiene issue (41%); and nutrition for mother during breastfeeding period (39.9%). There remained 39.2% who were not provided any guidance on these important skills.

Table 11: MCH counseling after birth by CHS

No	MCH Counseling	Frequency	Percentage (%)
1	Breastfeeding right after birth and proper breastfeeding	200	50,0
2	Keeping the baby warm, caring for the baby and hygiene issue	163	41,0
3	Nutrition for mothers during breastfeeding period	159	39,9
4	Postpartum complications such as hemorrhage and infection	67	16,8
5	Signs of abnormalities in babies which do not requires medical care	70	17,6
6	Child immunization schedule	121	30,4
7	Family planning	71	17,8
8	Other	3	0,8
9	No counseling	156	39,2
10	Do not remember	20	5,0

Source: 2014 Kon Tum CRC on CHS services

Home visits after birth

Home visit after birth is very important in helping detect risks, prevention and treatment of diseases which may cause infant death (within the first 7 days and 28 days after birth). However, survey results indicated that not many respondents received a home visit after birth. In particular, only 34.25% among the 400 respondents were visited by the health staff at home within 6 weeks of delivery.

Table 12: Home visits after birth

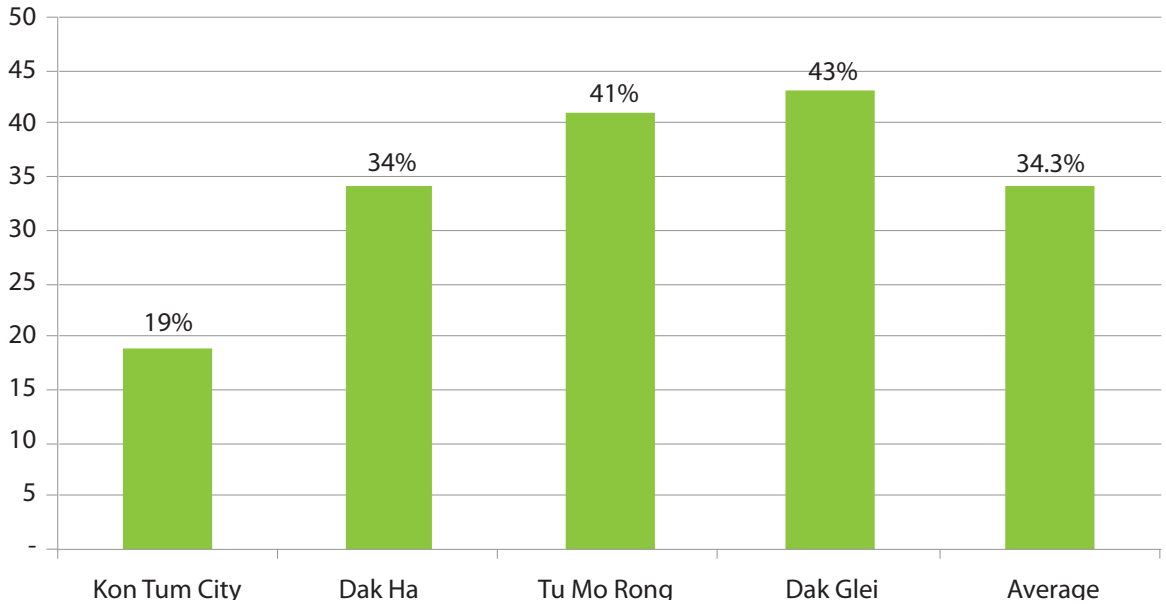
No	Number of home visits	Yes	No	Total
1	1 home visit within the first week after birth	65	72	137
2	2 home visits within 6 weeks after birth	50	87	137
3	Other (1, 3 home visits within 6 weeks after birth)	22	115	137

Source: 2014 Kon Tum CRC on CHS services

There was a correlation[16] between the numbers of respondents receiving home visits by location. A total of 137 respondents were visited by health staff at their home after birth (34.3%), where Dak Glei had the most home visits (43%), followed by Tu Mo Rong, Dak Ha and Kon Tum City at 41%, 34.3% and 19% respectively.

16 *Statistical tests indicated a p value below 0.05*

Figure 15: Home visits by location

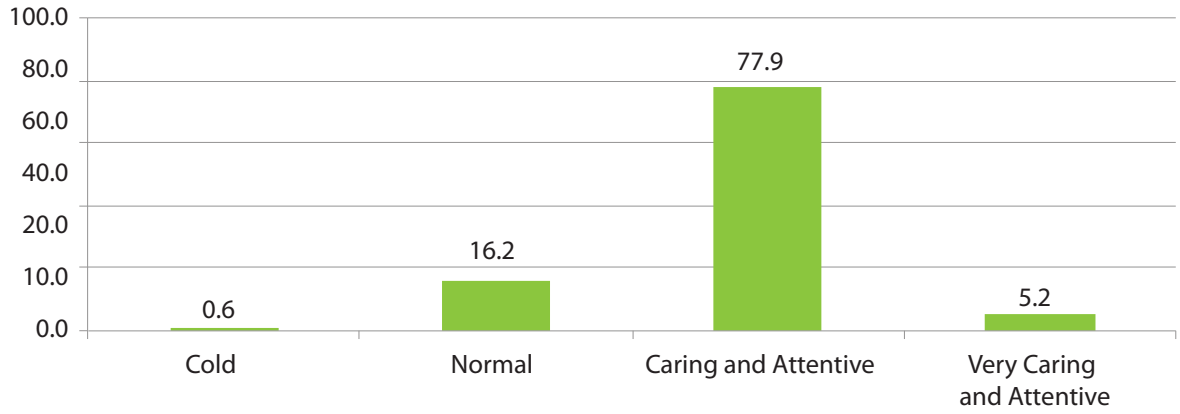


Source: 2014 Kon Tum CRC on CHS services

Level of satisfaction

77.9% of the 38 respondents who used MCH services provided by CHS provided positive feedbacks on attitude of health staff, said that they were caring and attentive, and gave an attitude score of 3.88. Only 1 respondent claimed that health staff was cold.

Figure 16: Attitude of MCH health staff



Source: 2014 Kon Tum CRC on CHS services

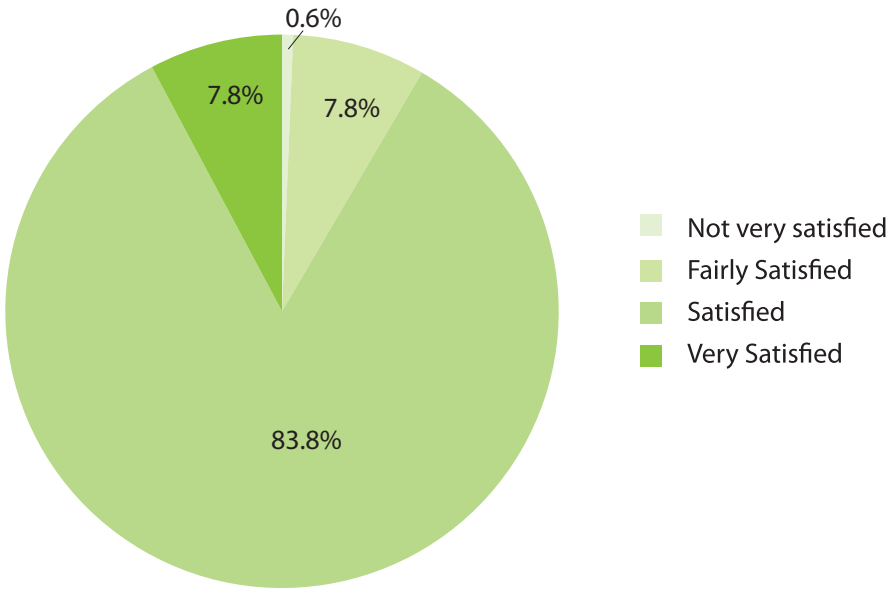
Survey results also indicated that the majority of respondents using MCH services thought these services were good (74.4% and average score of 3.76). No respondent considered the services as poor.

Table 13: Quality of MCH services at CHS

No	Quality level	Frequency	Percentage (%)
1	Average	10	6,5
2	Fairly good	23	14,9
3	Good	115	74,7
4	Very good	6	3,9
	Total	**154**	**100,0**

Source: 2014 Kon Tum CRC on CHS services

Figure 17: Level of satisfaction with MCH services



Source: 2014 Kon Tum CRC on CHS services

91.6% of the respondents indicated that they were either satisfied or very satisfied with MCH services. In addition, the average score was 3.99, equivalent to "satisfied". Respondent's satisfactions depended on health staff attitude and service quality. This is a positive and linear correlation, where satisfaction level increases with serving attitude and service quality.

Recommendations of respondents

Not many recommendations were made. However among those received, the focus was on the following two issues:

- Provision of more modern equipment and more health staff (doctors, nurses and female obstetrician assistants)
- Emphasis on home visits by health doctors for check-up and counseling

Not many respondents used MCH services provided by CHS (38.4%) and 39.4 % of the respondents were not given any MCH counseling. The majority of respondents thought that CHS health staff were caring and attentive, MCH services were good and satisfactory. The level of satisfaction depended heavily on perception of serving health staff attitude and service quality.

2.2.3. Family planning

Family planning is one of the main tasks of health facilities at commune level, including IEC, distribution of birth control pills and condoms, placement/removal of birth control devices, and abortion in case of unexpected and unplanned pregnancy. This survey only looked into other measures than abortion.

Use of services

Survey results showed that 81% of the respondents were advised by CHS on family planning. There is a correlation[17] between surveyed location and use of FPIEC services, Dak Glei had the largest number of respondents who had been advised on family planning (91%) and Kon Tum City the lowest (65%).

Table 14: Family planning IEC by location

Location	Yes		No		Total
	Frequency	Percentage	Frequency	Percentage	
Kon Tum City	65	65.0%	35	35.0%	100
Dak Ha District	80	80.0%	20	20.0%	100
Tu Mo Rong District	88	88.0%	12	12.0%	100
Dak Glei District	91	91.0%	9	9.0%	100

Source: 2014 Kon Tum CRC on CHS services

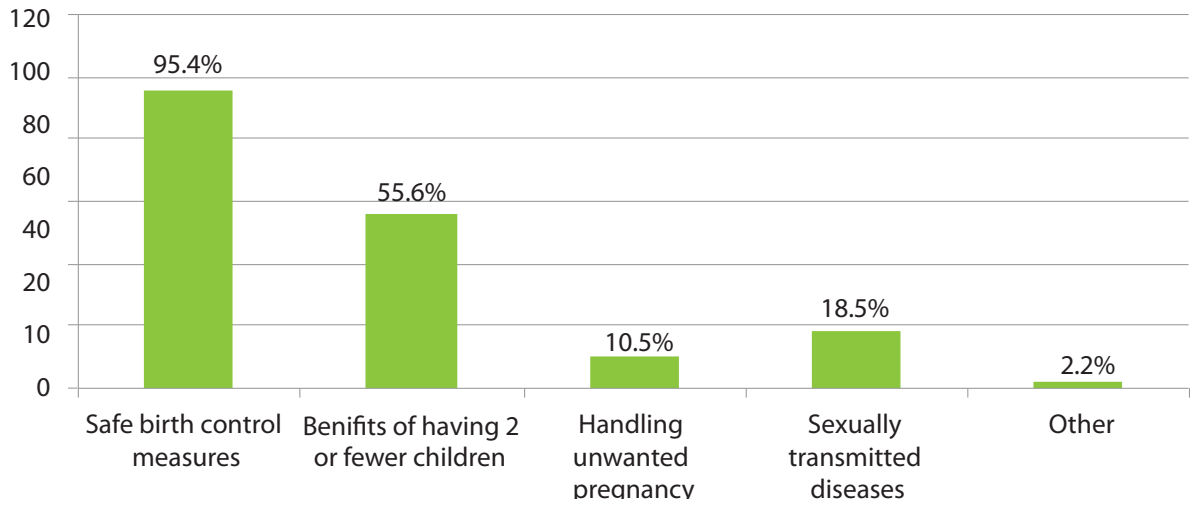
Survey results also indicated differences[18] in FPIEC for Kinh respondents and those from ethnic minorities. In particular, 65.4% of Kinh respondents had received family counseling as opposed to 87.6% ethnic minority respondents had been advised on such matters.

95.4% of the respondents had been advised on safe birth control measures (309 people) and 55.6% had been advised on the benefits of having 2 or fewer children (180 people).

17 *Statistical tests showed a p value below 0.05*

18 *Statistical tests showed a p value below 0.05*

Figure 18: Family planning IEC by location



Source: 2014 Kon Tum CRC on CHS services

50.9% respondents revealed that they had received family planning counseling in village meetings, 42.9% in IEC sessions organized by village health workers, and 33% through home visits.

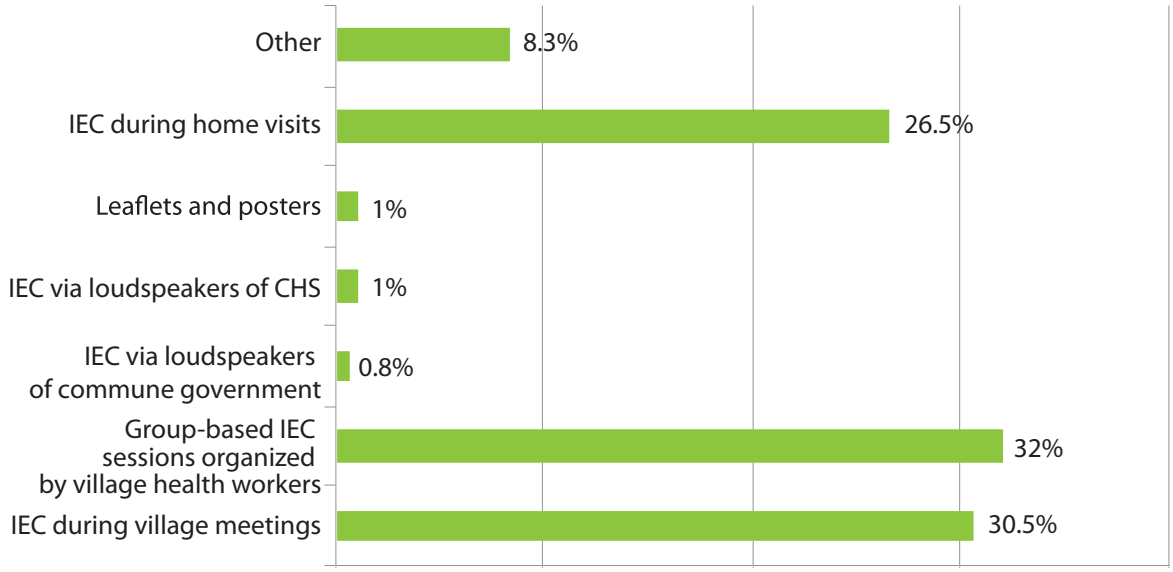
Table 15: Activities of IEC for family planning

No	Activity	Frequency	Percentage (%)
1	IEC during village meetings	165	50,9
2	Group-based IEC sessions organized by village health workers	139	42,9
3	IEC via loudspeakers of commune government	20	6,2
4	IEC via loudspeakers of CHS	7	2,2
5	Leaflets and panels	21	6,5
6	IEC during home visits	107	33,0
7	Other	32	9,9
	Direct IEC/counseling at CHS	*18*	
	Information from TV and printed materials	*6*	
	Integrated IEC in immunization sessions	*3*	
	Direct IEC by health workers	*2*	
	Finding out family planning information on their own	*1*	
	IEC by the local women's union	*1*	
	Do not remember	*1*	

Source: 2014 Kon Tum CRC on CHS services

The most favorite IEC activity was group-based IEC sessions organized by village health workers (32%), followed by IEC in village meetings (30.5%)

Figure 19: Favorite IEC activities



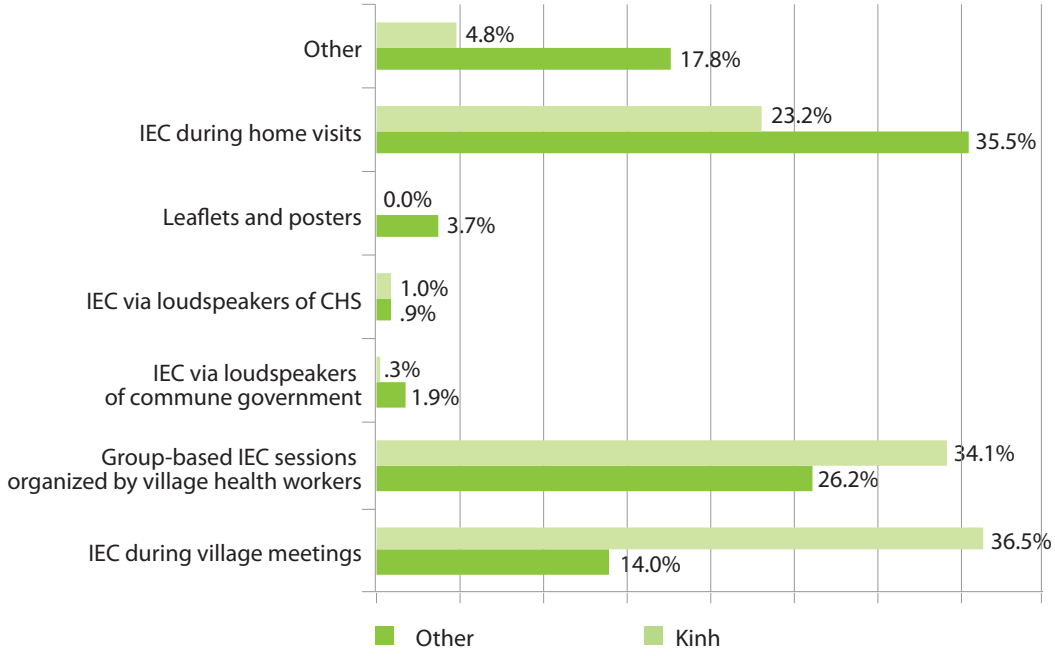
Source: 2014 Kon Tum CRC on CHS services

The three most favorite family planning IEC activities were also the most frequently conducted by CHS. As such, it could be seen that family planning IEC were up to the demand and expectation of the respondents.

Survey results also indicated a correlation[19] between most favorite IEC activities and ethnicity. In particular, Kinh respondents preferred home-based IEC (35.5%) while ethnic minority respondents favored IEC in village meetings (36.5%) and group-based IEC sessions organized by village health workers (34.1%).

19 *Statistical tests showed a p value below 0.05*

Figure 20: Favorite IEC activities by ethnicity



Source: 2014 Kon Tum CRC on CHS services

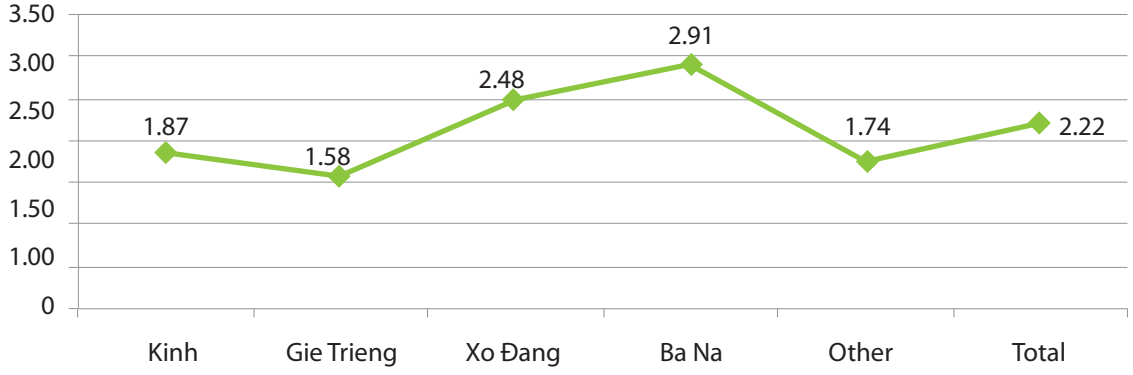
In terms of IEC language, 52% of the respondents wanted Kinh while the rest preferred dialects.

Apart from family planning IEC activities, CHS also provided condoms, birth control pills, contraception injections and placement of contraception devices. 48.5% of the respondents said that they had received condoms or contraceptive pills from CHS health staff or village health workers

The average number of children per mother among the 400 respondents was 2.2, where 293 respondents had 2 children or fewer (73.2%), 107 respondents gave birth to 3 or more children (26.7%), and 10 respondents had between 8 and 10 children (2.5%).

There was a difference in the average number of children between Kinh respondents (1.87) and ethnic minority respondents (2.34).

Figure 21: Average number of children per respondent by ethnicity



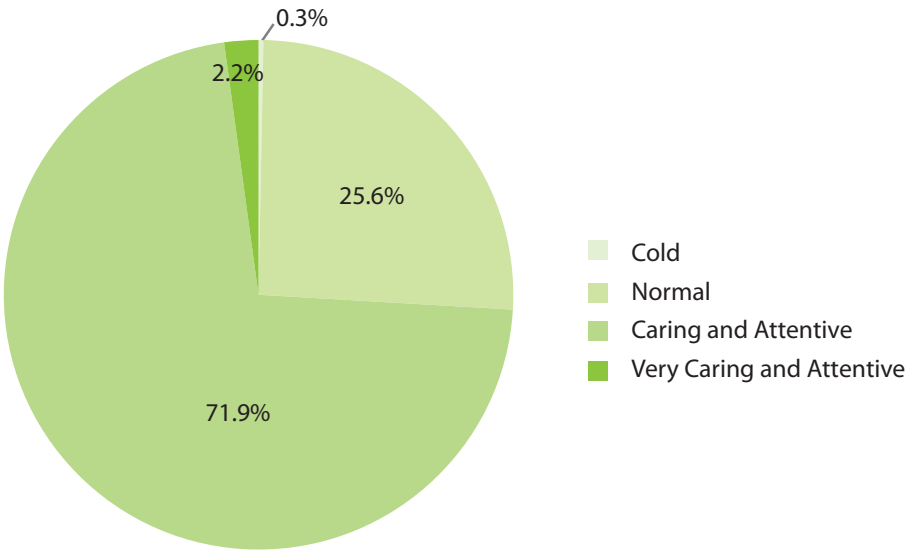
Source: 2014 Kon Tum CRC on CHS services

Level of satisfaction

This survey recognized the feedbacks of mothers raising children under 2 years old on family planning IEC with regards to *(1) IEC topics; (2) IEC activities; (3) Frequency of IEC activities; (4) IEC staff and (5) IEC language*

Survey results revealed that 71.9% of the respondents with IEC experience thought that health staff were caring and attentive when carrying out the task and gave an average score of 3.76 for attitude. Only 1 respondent said that the health staff was "cold" (0.3%).

Figure 22: Attitude of health workers



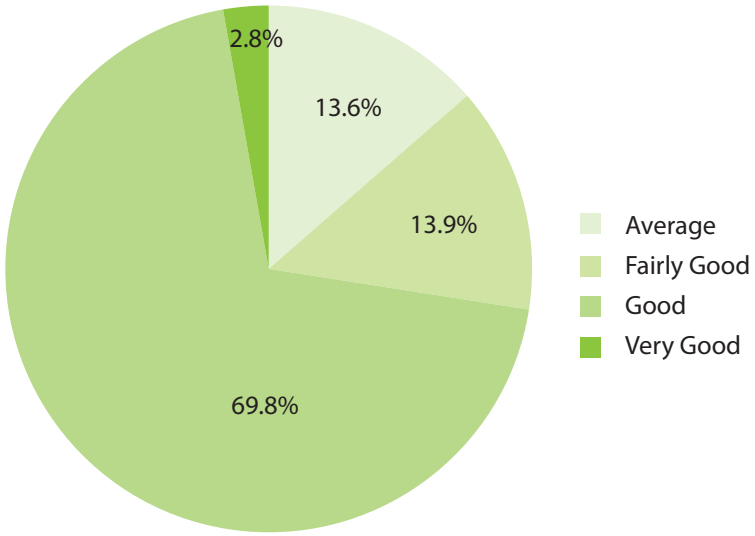
Source: 2014 Kon Tum CRC on CHS services

69.8% of the respondents with IEC experience thought family planning IEC activities of CHS are good and gave an average score of 3.62 for service quality. The reasons quoted included IEC staff being cheerful, enthusiastic, and caring; IEC topics being easy to understand and

specific; IEC activities being carried out regularly; health staff paying them a visit for IEC; and the respondents receiving appropriate contraception counseling.

However, 27.5% of the respondent said that IEC service quality was just fairly good and that more needed to be done to for improvement.

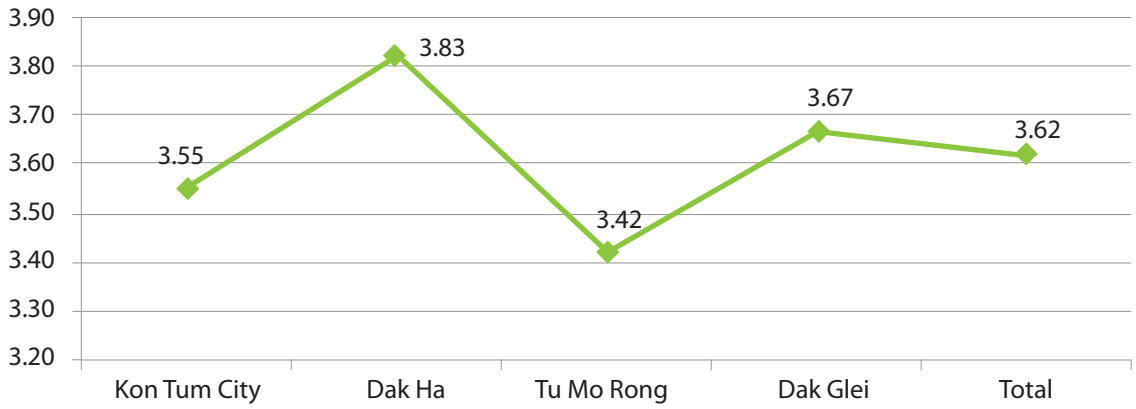
Figure 23: Quality of family planning IEC services



Source: 2014 Kon Tum CRC on CHS services

Survey results indicated a correlation[20] between the score for quality of family planning IEC services and location. The score was highest in Dak Ha District (3.83) and lowest in Tu Mo Rong District (3.42)

Figure 24: Average quality score for family planning IEC by location

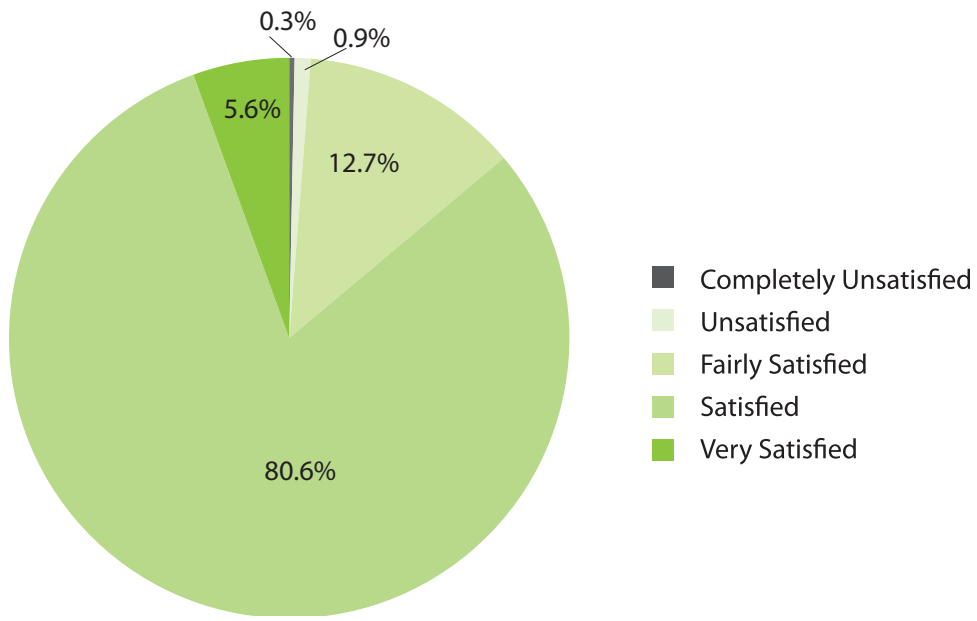


Source: 2014 Kon Tum CRC on CHS services

80.6% of the respondents said that they were satisfied with family planning IEC activities. Only 1.2% claimed that they were either not satisfied or not really satisfied. There was no significant difference in the level of satisfaction by location.

20 Statistical tests showed a p value below 0.05

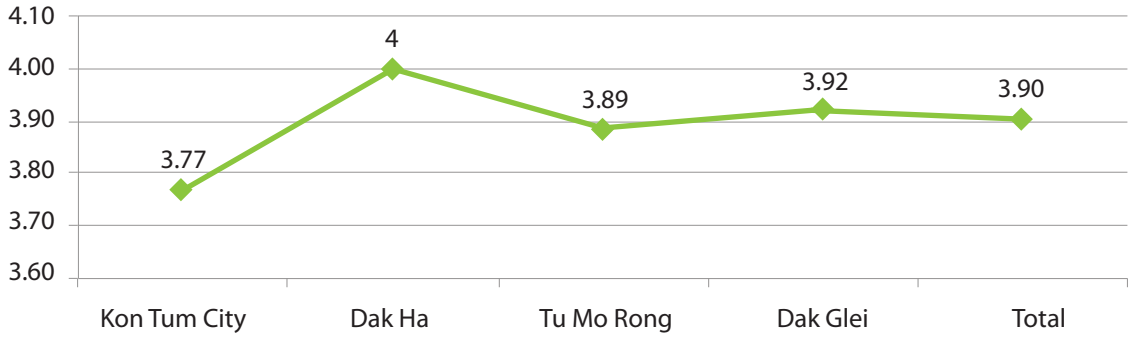
Figure 25: Level of satisfaction with family planning IEC



Source: 2014 Kon Tum CRC on CHS services

There was a correlation[21] between level of satisfaction and location. Respondents in Dak Ha District gave the highest satisfaction score (4.00) as opposed to those from Kon Tum City (3.77)

Figure 26: Satisfaction score by location



Source: 2014 Kon Tum CRC on CHS services

Survey results also indicated that level of satisfaction with family planning IEC depended heavily on respondents 'perception of health staff attitude and service quality. Those who thought that health staff was caring and attentive and service quality was good felt satisfied with IEC services.

Recommendations of respondents

Listed below are the recommendations made by respondents for improvement of IEC for family planning:

- More frequently organized
- More emphasis on home-based IEC, accompanied by more images and leaflets

21 *Statistical tests showed a p value below 0.05*

- Bilingual IEC (in both Kinh and local dialects)
- More cheerful, enthusiastic IEC staff and more through counseling on contraceptive measures.
- Female IEC staff for family planning to drive away the "hesitation" mentality among women.

2.2.4. Medical examination and treatment

Medical examination and treatment (MET) is one of the most important primary care services at commune level. Good performance in this area will help CHS not only to improve primary care but also control diseases, mitigate disease-related mortality risks in the local community and ease overload situation for health facilities at higher level.

Availability of services

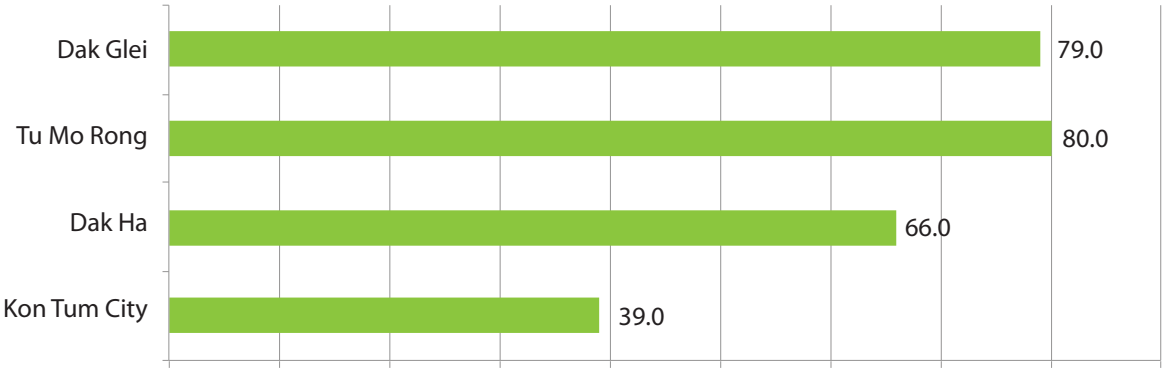
According to the respondents who had been checked or treated at CHS, they did not have to wait long to be served. 66.3% said they waited less than 15 minutes and 21.9% waited between 15 and 30 minutes. Only 9% had to wait between 30 and 60 minutes and 0.07% more than 60 minutes. As such, it could be seen that MET services were readily available at CHS.

Use of services

Among the 400 respondents who were interviewed, 66% said that they had been to CHS to get themselves, their children or family members checked or treated during the past 12 months.

Use of services[22] varied across locations. MET services provided by CHS were used the most by respondents from Tu Mo Rong Districts (80%) and the least by those from Kon Tum City (39%) as they had more options

Figure 27: Use of CHS's MET services by location



Source: 2014 Kon Tum CRC on CHS services

Survey results also revealed that more respondents from poor households used MET services provided by CHS than non-poor ones (74% as opposed to 56%)[23]. In addition, ethnic minority respondents went to CHS more often than Kinh women (75.1% versus 41.1%). This is another piece of evidence proving the significant role of CHS among ethnic minority community and the poor in remote areas. As such, it is critical that adequate resources should be provided to CHS there. In addition, CHS in remote and mountainous areas should be prioritized over their peers in urban areas to best meet the demand of local people.

22 *Chi-Square tests showed a o value below 0.05*

23 *Chi-square tests shows a p value below 0.05*

Table 16: MET services provided by CHS

No	People brought by respondents for MET at CHS	Frequency	Percentage (%)
1	Respondents who get themselves checked and treated at CHS	80	30,3
2	Respondents who get their children checked and treated at CHS	194	73,5
3	Respondents who get others checked and treated at CHS	7	2,7

Source: 2014 Kon Tum CRC on CHS services

The majority of respondents got themselves, their children or family members checked and treated at CHS for normal diseases. Most popular ones include cold and flu, fever (including scarlet fever and respiratory track diseases.

Table 17: Popular diseases checked and treated at CHS

No	Diseases	Frequency	Percentage (%)
1	Respiratory track diseases	83	31.4
2	Cold, flu and fever	104	39.4
3	Gastrointestinal diseases	32	12.1
4	Bone and joint disorders	10	3.8
5	Skin disorders	16	6.1
6	Gynecological disorders	8	3.0
7	Medical check-up	3	1.1
8	Other diseases	4	1.5
9	Do not remember	4	1.5
	Total	**264**	**100.0**

Source: 2014 Kon Tum CRC on CHS services

The study revealed that only simple equipment was used for MET, such as blood pressure monitor, heart rate monitor and thermometer. About 90% of the respondents got checked and treated with such equipment and there was no significant difference across locations.

Table 18: Medical equipment used for MET at CHS

Equipment	Kon Tum City	Dak Ha District	Tu Mo Rong District	Dak Glei District	Total
Total	39	66	80	79	264
MET using medical equipment	35	58	71	74	238
Blood pressure and heart rate monitor	11	13	19	21	64
Stethoscope	28	46	44	55	173
Thermometer	23	29	40	58	150
Scale	9	4	14	12	39
Do not know what the equipment is called	4	6	18	9	37
MET without using medical equipment	4	8	9	5	26
Others	5	3	0	1	9
Tongue depressor	*3*	*1*			*4*
Throat examination		*2*			*2*
Gloves				*1*	*1*
Torch	*1*				*1*
Do not know (staying outside examination room)	*1*				*1*

Source: 2014 Kon Tum CRC on CHS services

89% of the respondents said that they were given medication to be taken at home instead of being admitted to the CHS for inpatient treatment in the most recent used of MET services. Only a negligible number of respondents had to be treated at CHS (3.4%), while 2% were referred to higher level health facilities, and 4.9% did not require treatment. The majority of respondents who received inpatient treatment or who were referred to higher levels were children (13 out of 16 cases), who suffered from normal diseases which could be highly dangerous for children such as pneumonia, diarrhea, fever and cough.

Table 19: MET in latest visits to CHS

MET	Kon Tum City	Dak Ha District	Tu Mo Rong District	Dak Glei District	Total
Yes, medicine given to be taken at home	35	57	68	75	235
	89.7%	86.4%	85.0%	94.9%	89.0%
Yes, inpatient treatment	0	4	5	0	9
	0.0%	6.1%	6.3%	0.0%	3.4%
Yes, referred to higher levels	0	3	2	2	7
	0.0%	4.5%	2.5%	2.5%	2.7%
No treatment required	4	2	5	2	13
	10.3%	3.0%	6.3%	2.5%	4.9%
Total	**39**	**66**	**80**	**79**	**264**
	100%	**100%**	**100%**	**100%**	**100%**

Source: 2014 Kon Tum CRC on CHS services

222 out of 235 respondents (94.5%) who required medication had received prescription, of whom 99.1% had been given all the medication as prescribed and only 2 respondents said that not all the prescribed medication was dispensed by CHS health staff.

Table 20: Dispensation versus prescription by location

Were all the medication dispensed as prescribed	Kon Tum City	Dak Ha District	Tu Mo Rong District	Dak Glei District	Total
Yes, dispensed in full	34	55	61	70	220
	100 %	100 %	98.4%	98.6%	99.1%
Yes, incomplete dispensation	0	0	1	1	2
	0 %	0 %	1.6%	1.4%	.9%
Total	**34**	**55**	**62**	**71**	**222**
	100 %	**100 %**	**100 %**	**100 %**	**100 %**

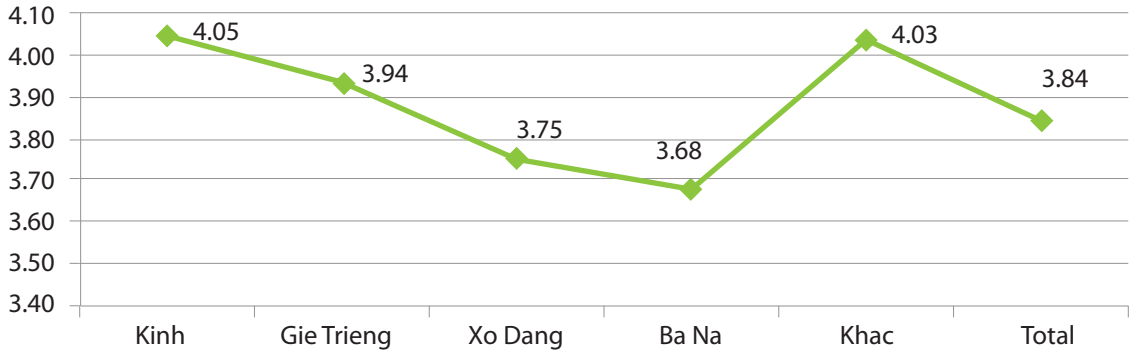
Only 2 cases (0.7%) had to pay for MET services at CHS, including 1 insured ethnic minority respondent paying for the drugs which were prescribed but not available at CHS and a non-insured Kinh respondent paying only a negligible amount of VND20,000-30,000

Level of satisfaction

65.9% of the respondents who had been checked or treated at CHS said that the health staff there was caring and attentive to patients and 9.5% thought that the staff was very caring and attentive. On the other hand, 24.2% claimed that the health staff was just normal.

There was a difference[24] in attitude score by ethnic city. In particular, Kinh respondents gave the highest score (4.05) and Ba Na respondents the lowest (3.68). In general, the differential was insignificant across ethnicities.

Figure 28: Attitude score by ethnicity

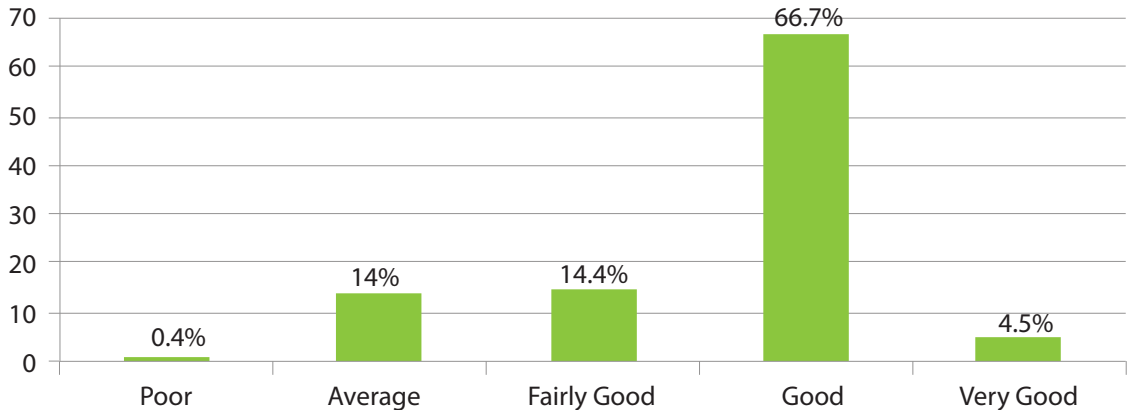


Source: 2014 Kon Tum CRC on CHS services

66.7% of the respondents who had been checked or treated at CHS thought that MET services there were good. A similar number of respondents rated the services as fairly good and average, at 14.4% and 14% respectively. Only 1 respondent said MET services were poor.

Those who thought highly of MET services said that CHS health staff were caring, enthusiastic and attentive, they were checked and treated immediately after arriving at the CHS without having to wait long, all the prescribed medication was dispensed in full, and they fully recovered after taking the medicine.

Figure 29: Quality of MET services provided by CHS

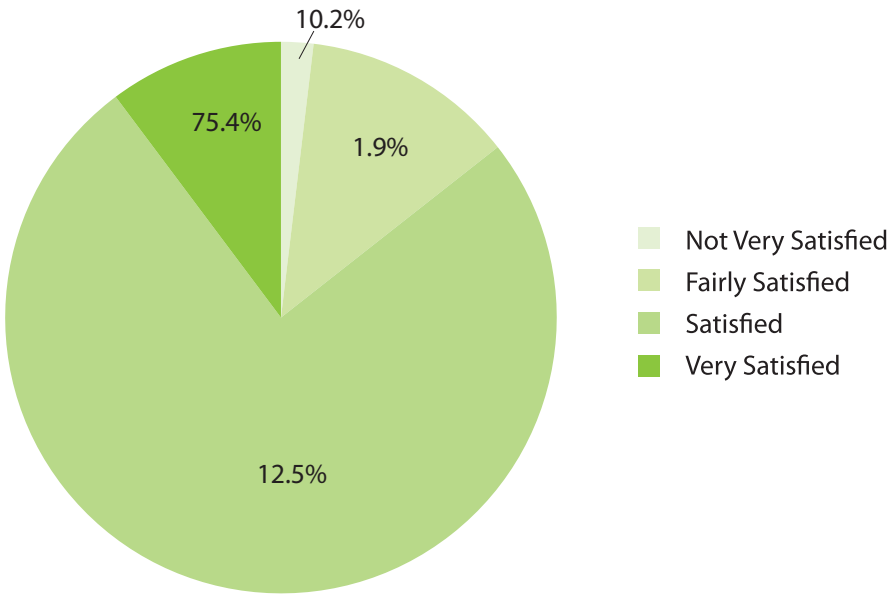


Source: 2014 Kon Tum CRC on CHS services

24 *ANOVA tests showed a p value below 0.05*

85.6% of the respondents who recently got checked or treated at CHS felt satisfied or very satisfied with the services. Only 1.9% were not really satisfied with MET services provided by CHS.

Figure 30: Satisfaction with MET services provided by CHS



Source: 2014 Kon Tum CRC on CHS services

Survey results indicated that the level of satisfaction with MET services provided by CHS was strongly correlated[25] to respondents' perception on health staff attitude and service quality. Those who thought highly of serving attitude and quality tended to feel more satisfied with the services provided. On the other hand, longer waiting time meant more dissatisfaction.

Recommendations of respondents

Not many recommendations were provided for improvement of MET services at CSH among those interviewed. 20% of the 264 respondents who had used MET services, only 20.8% indicated that they wanted better services. In particular:

- Health staff should be more enthusiastic and cheerful, provide more thorough examination and more specific counseling;
- There should be more doctors at CHS
- 10 respondents said they wanted CHS to have more modern and better medical equipment (ultrasound, testing and X-ray machines) for more accurate diagnosis so that they would not have to skip to higher level facilities for MET.
- There should be better and more diverse medication offered at CHS

MET services at CHS are used frequently in communes of ethnic minorities where a large number of service users are insured (91.7%). This is a highlight of commune-level healthcare in remote areas. The majority of MET service users thought highly of serving attitude and service quality and felt satisfied. However, MET services currently provided at CHS are rather simple and there is still room for improvement. To date MET services of CHS have only a modest role in Kon Tum City, similarly to those in other urban areas of Vietnam, where people often opt for paid services at health facilities with more advanced procedures.

25 *Statistical tests showed a p value below 0.05*

2.2.5. Child Nutrition Services

Nutrition is critical to child growth, especially those under 2 years old who are experiencing very fast development in physical and mental abilities, apart from other important factors such as hereditary and environment. Prevention of malnutrition at commune level aims at two main target groups: (1) pregnant women and/or women raising small children and (2) children under 5 years old with a focus on children under 2 years old. Performance indicator is the percentage of children under five year old suffering from malnutrition. Activities for mothers include IEC and counseling (to raise awareness and initiate behavioral change) and proper nutrition practices. On the other hand, children are weighed and measured regularly and given vitamin A, screened, counseled and treated for malnutrition. In order to reduce child mortality due to malnutrition and related diseases, children suffering from acute malnutrition are treated with instant food including HEBI nutritional products which is produced in Viet Nam with the support of UNICEF, or are admitted to public health facilities for inpatient treatment for more serious cases. The most significant bottleneck to child nutrition services (CNS) in Kon Tum province is disadvantages in terms of economic conditions which prevents families from providing sufficient nutrition to their children. Besides, many families are still performing improper practices of feeding babies under 6 months with solid food as opposed to exclusive breastfeeding, some even failing to ensure proper food handling and hygiene.

Children between 12 and 24 months are most at risk of malnutrition and the ratio of malnutrition under 5 years old is a cumulative indicator[26]. The survey indicates that 19.25% or 77 children under 2 years old were underweight. According to the results of 2013 nutrition monitoring by the National Institute of Nutrition, 26.1% of children under 5 in Kon Tum were malnourished. The above CRC's result provides further evidence that there should be more investment in child nutrition and early nutrition (pre-conception nutrition, pregnancy nutrition and nutrition for children under 2 years old) in order to prevent child malnutrition.

Survey results indicate that 28.25% of children under 2 years old and 56.52% of babies under 6 months were yet to be provided health insurance cards. The percentage of children under 6 months without health insurance card was higher than those between 7 and 24 months (19.8%).

It could be observed from the survey that there was a difference of statistical significance[27] in the ratios of child malnutrition across the groups:

- Poor households as opposed to non-poor households (26.5% versus 10.8 %)
- Mothers without schooling as opposed to mother with schooling (33.8% versus 16.1%)
- Mothers of ethnic minorities as opposed to Kinh mothers (25.6% versus 1.9%)
- Disadvantaged districts as opposed to better off ones (36% and 24% for Tu Mo Rong and Dak Glei districts respectively as opposed to 10% and 7% for Dak Ha District and Kon Tum City respectively)
- Communes located further away from district center as opposed to closer locations (34.2% versus 8.7% and 14.5%)
- Children under 6 months as opposed to older ones (7.6% versus 22.7%)
- Children without health insurance card as opposed to those with one 25.7% versus 16.7%)

There was no difference in lightweight rate between boys and girls.

26 Source: 2009-2010 General Nutrition Survey Report

27 Kiểm định Chi-square cho p <0,05

IEC for malnutrition prevention

261 or 65.3% of those interviewed said they had received information on malnutrition prevention. Access to IEC for malnutrition prevention varies across different groups:

- A similar percentage of roughly 70% of respondents in Dak Glei, Tu Mo Rong and Dak Ha districts were given IEC on malnutrition prevention as opposed to 47% in Kon Tum City where there are multiple IEC channels on this topic.

- The number of respondents with access to IEC on malnutrition prevention was inversely related to distance from home to CHS. In particular, 68% of the respondents living within 5 km from CHS were informed as opposed to 48% for those located more than 5km from CHS.

- Poor women received more IEC information than the non-poor, at 70.2% and 59.5% respectively, representing a rather large difference.

- In terms of ethnicity, more IEC were provided to ethnic minority people as opposed to their Kinh peers (70% versus 52.3%). This is compatible with the seriousness of malnutrition situation among ethnic minority people.

With regard to IEC topics, the most popular one was breastfeeding (86.2%), followed by proper supplementary nutrition after 6 months (70.1%) and finally by prevention of diarrhea, acute respiratory disorders, stunting, malnutrition, and vitamin A deficiency (46.4%). The numbers of mothers who given guidance on how to weigh and measure their children, record and use child growth chart; how to take care of malnourished children; and how to prepare nutritional rice porridge/regular check-up for their children were 32.2%, 26.1% and 6.5% respectively.

When asked about the most favorite IEC activity, the responses received were (1) village meetings (28.5%); (2) IEC sessions organized by village health workers (26.3%); (3) home-based IEC (26%); (4) nutrition practice sessions (10.8%); and (5) other activities such as experience sharing at CHS and direct IEC at CHS (5.8%). Perception of the most favorite IEC activity varies across different groups[28]. While the most preferred IEC activity to Kinh mothers was home-based IEC (37.4%), the most favorite among ethnic minority women was village meetings (34.8%)

28 Chi-square tests shows a p value below 0.05

Table 21: Favorite IEC activity by ethnicity

Favorite IEC activity		Kinh	Ethnic Minorities	Total
Village meetings	Frequency	12	102	114
	Percentage	11.2%	34.8%	28.5%
IEC sessions organized by village health workers	Frequency	28	77	105
	Percentage	26.2%	26.3%	26.3%
Nutrition practice sessions	Frequency	12	31	43
	Percentage	11.2%	10.6%	10.8%
Broadcasting through loudspeakers of commune government/CHS	Frequency	1	4	5
	Percentage	0.9%	1.4%	1.3%
Leaflets and panels	Frequency	3	3	6
	Percentage	2.8%	1.0%	1.5%
Home-based IEC	Frequency	40	64	104
	Percentage	37.4%	21.8%	26.0%
Other	Frequency	11	12	23
	Percentage	10.3%	4.1%	5.8%
Total	**Frequency**	**107**	**293**	**400**
	Percentage	**100%**	**100%**	**100%**

Source: 2014 Kon Tum CRC on CHS services

Availability of services

346 or 86.5% of the respondents revealed that there children had been weighed and measured, and taken vitamin A at least once in the past year. However, not many respondents received counseling or practice nutrition (23.6%) and only 1% of the children had been treated for malnutrition. In addition, 6.5% of the respondents did not remember whether their children received malnutrition treatment and another 6.5% said that their children were not treated.

The percentage of children being weighed, measured and given vitamin A varies across survey locations, ethnicities, distances to district center[29]. No difference was observed across respondents of different age groups and education levels.

Children are usually weighed, measured and given vitamin A twice per year (in June and December). The survey results showed that 131 children or 32.75% were weighed and measured once (including 35 children under 6 months).

29 *Chi-square tests showed a p value below 0.05, indicating statistical significance*

Respondents did not have to wait long to be weighed, measured and given vitamin A. 53.2% said their child was weighed and measured within 15 minutes' waiting, 28.6% waited between 15 and 30 minutes, 9.8% waited between 30 and 60 minutes and only 3.2% waited more than 60 minutes. Waiting time varies across communes: those living closer to district centers waited less than those further away (60% had their child weighed and measure within 15 minutes' waiting as opposed to 51.3% and 48.2%).

Use of services

Survey results indicated that 60.4% of the respondents were counseled when sending their child for weighing and measuring. The percentage of respondents receiving counseling differed across surveyed locations and distances from home to CHS[30], but approximated among ethnicities, poor/near-poor households, time traveling to CHS, distances to district center and age groups.

In particular, Dak Ha had the highest percentage of women given counseling when their child were being weighed and measured (68.5%), followed by Dak Glei at 65.2%, Tu Mo Rong at 59.9% and finally by Kon Tum City at 47.7%. In addition, counseling was provided to 69.2% of the respondents located within 1km from CHS, as opposed to 60.9% and 46% to those living from 1 to 5km and more than 5km from CHS respectively.

Depending on the seriousness of malnutrition condition, the child could be put on monitoring or receive treatment. 21% of the respondents whose children were under nutrition care thought that CHS provided treatment for malnutrition while the remaining 78.9% said that CHS did not treated their children. The treatment measures known to the respondents are listed below:

Table 22: Measures for malnutrition treatment

No	Measures	Frequency	Percentage (%)
1	HEBI	14	19.2
2	HEBI and medication	19	26.0
3	Mediation and counseling	8	11.0
4	Guidance on preparation of nutritional rice porridge	10	13.7
5	Unclear/No idea	19	26.0
6	Vitamins and supplements	3	4.1
	Total	**73**	**100.0**

Source: 2014 Kon Tum CRC on CHS services

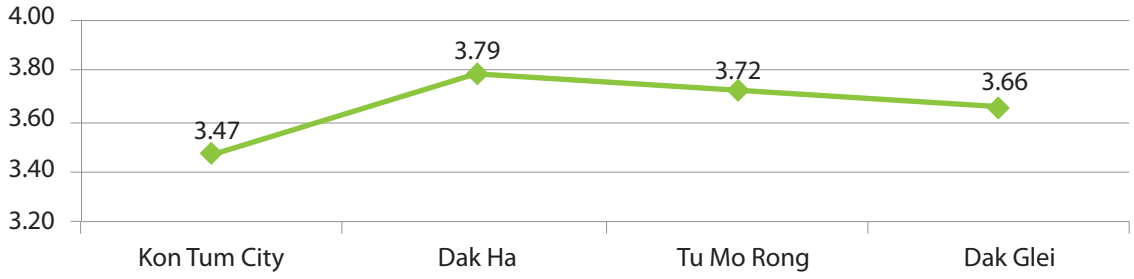
All of the respondents who children were under nutrition care confirmed that they did not have to pay for this services at CHS

Assessment of CNS services

58.7% of the respondents thought that health staff was caring and attentive while 36.7% said that they were just normal, neither caring nor cold. The average attitude score with respect to CNS services was 3.66, equivalent to "caring and attentive". There was no significant difference cross locations.

30 *Chi-square tests showed a p value below 0.05, indicating statistical significance*

Figure 31: Attitude of CHS health staff by location

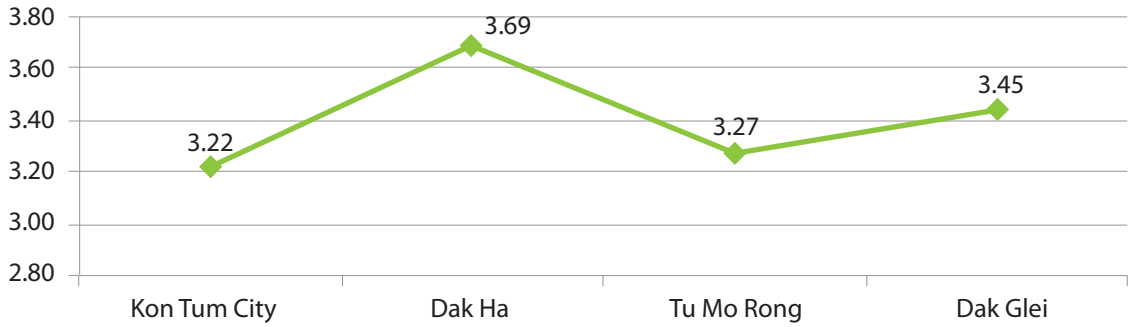


Source: 2014 Kon Tum CRC on CHS services

With regard to CNS service quality, 3.5% of the respondents rated the services as very good, 56.1% as good, 19.4% as fairly good, 20% as average, and 0.9% as poor. Reasons for dissatisfaction (average and poor) include irregular weighing and measuring, long waiting time for measuring and weighing, health staff who were undedicated, unhappy, cranky, uncaring and difficult to understand.

Average score for CHS service quality was 3.41, equivalent to "good" and there was a difference across locations and distances from home to CHS. In addition, those who thought highly of health staff attitude gave higher score for service quality.

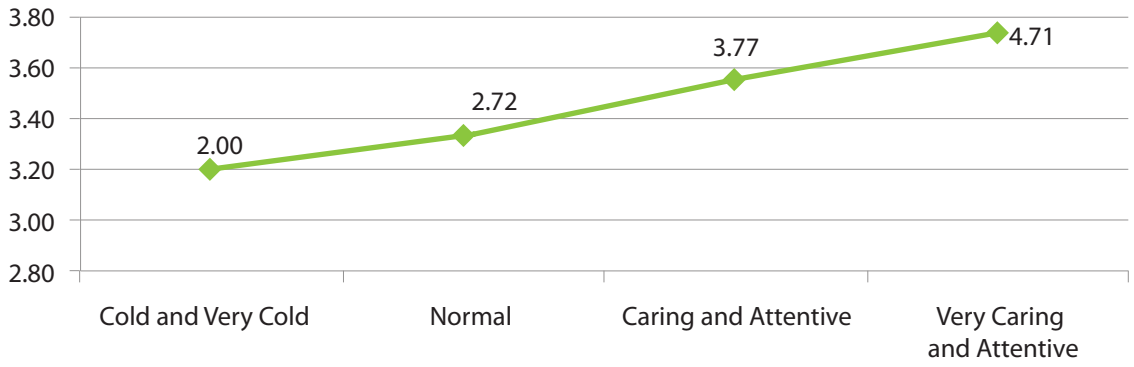
Figure 32: Quality of CNS services by location



Source: 2014 Kon Tum CRC on CHS services

Service quality scores in Dak Ha and Dak Glei were interpreted as "good" and higher than Kon Tum City and Tu Mo Rong which received a rating of "fairly good"

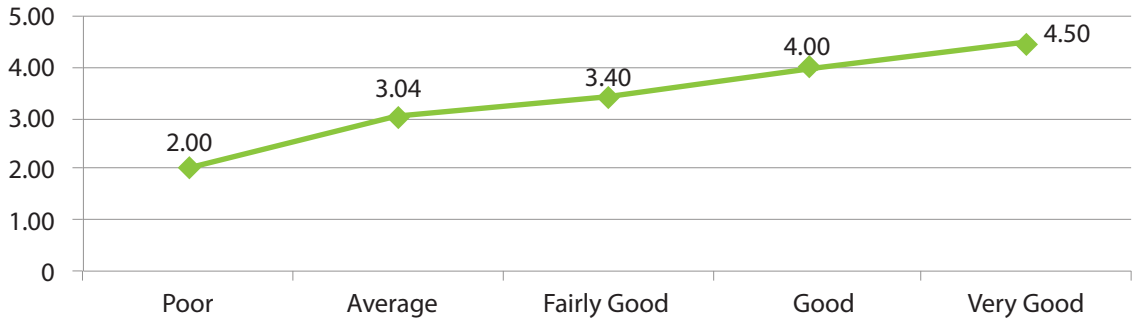
Figure 33: Quality of CNS services and attitude of health staff



Source: 2014 Kon Tum CRC on CHS services

In general the respondents were satisfied with CNS services, giving a satisfaction score of 3.68. There was no remarkable difference across locations, distances from home to CHS distances to district center, respondent's education levels, household economic conditions, attitude of health staff and service quality. 66% of the respondents felt satisfied, 4.9% very satisfied, 22% fairly satisfied and 6.9% not really satisfied

Figure 34: Satisfaction score and service quality



Source: 2014 Kon Tum CRC on CHS services

Satisfaction score was positively related to service quality. The overall satisfaction score of 3.69 was interpreted as "satisfied". On the other hand, the satisfaction score breakdown was 2 ("not satisfied"), 3.4 ("fairly satisfied), and 4 ("satisfied") for those who thought the quality were poor, average, and good respectively. Finally, those who thought of service quality as really good were really satisfied.

Recommendations of the respondents

Recommendations were provided by 65 respondents when asked about how to improve service quality and increase users' satisfaction with CHS services. In particular, 33 respondents wished to be given more IEC on malnutrition prevention; 14 wanted more medication and milk for children; 5 suggested that health staff should be more caring andattentive; 2 said that CHS should provide malnutrition treatment; 4 recommended that CHS should promote what they had been doing well – such as notifying the mothers after finishing weighing and measuring their children and providing counseling accordingly, that health staff should know

how to cook and love children in order to provide better guidance to mothers on nutrition practice, and that health staff should weigh and measure the children themselves rather than having the mothers do the job.

2.2.6. Immunization service

Child immunization services are carried out by CHS in accordance with Project 2 – Expanded Program on Immunization of the National Targeted Program for Healthcare. The performance indicator for this type of services is the percentage of children under 12 months fully immunized. This indicator reflects the effectiveness of the expanded immunization program and is a basis for assessing performance of local health sector in disease prevention and child healthcare.

The target set by Kon Tum Province in this project is that 97% of children under 12 months will be fully immunized as stipulated by 2015. Although 97.5% of children under 12 months was vaccinated in full in 2012, the number dropped to 83.1% in 2013. One of the main reasons for the reduction may have been complications among some children getting Pentavalent vaccine. Consequently, the Ministry of Health suspended this vaccine temporarily, leading to fear and hesitation among mothers. As a result, they refused to get their children immunized with Pentavelent when the vaccine was reintroduced later. Along with the target of full immunization, it is equally important to give another dose of vaccine to children once they pass the age of 1. In particular the second dose of measles vaccine is normally given when the child is 18 months old. According to current immunization standard, the vaccination schedule for children under 2 years old is as follows:

Table 23: Vaccination schedule – Expanded Program for Immunization

No	Age	Vaccinations
1	At birth	BCG Hepatitis B[31]
2	2 months old	DPT-HBV-HIB 1 OPV 1
3	3 months old	DPT-HBV-HIB 2 OPV 2
4	4 months old	DPT-HBV-HIB 3 OPV 3
5	9 months old	Measles 1
6	18 months old	Measles 2 DPT 4

Source: 2014 Kon Tum CRC on CHS services

IEC on child immunization

Survey results revealed that 89.8% of the respondents were given IEC information on the benefits of immunization. Most post popular IEC topics were vaccination schedule (73.5%),followed be immunization benefits (62.5%), and things to know when sending the children for vaccination (21%). 3.5% confirmed that they have received some information but could not recall what it was.

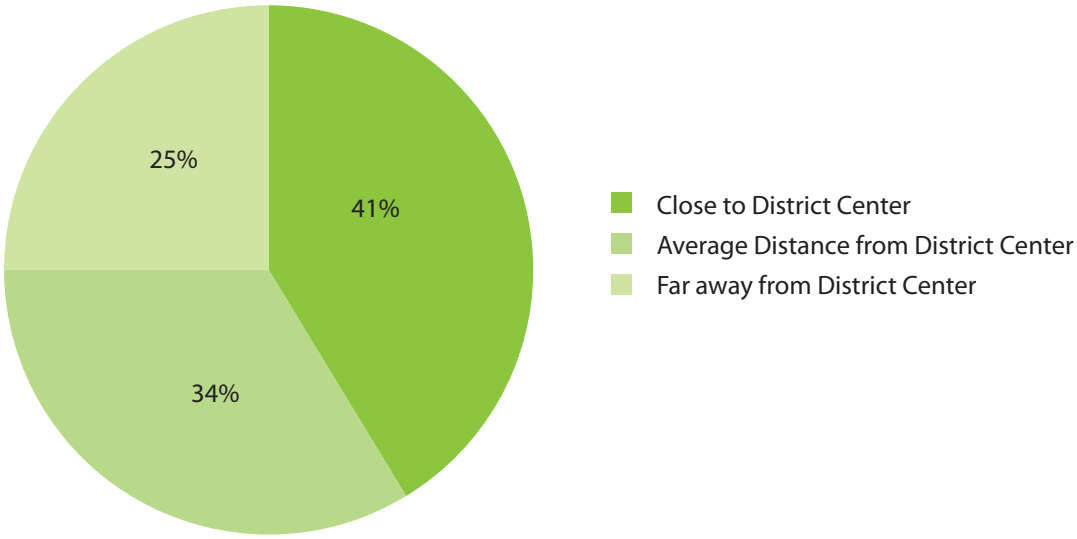
Use of services

Analysis and test results showed that factors such as ethnicity, distance from home to CHS, household economic condition, and mother's education level of were not related to whether the child got vaccinated.

31 This vaccination is excluded in calculating the percentage of children under 12 months old getting fully immunized.

395 out of 400 respondents (98.75%) said that their children were vaccinated at home (BCG), at CHS or at immunization locations organized by CHS. 69.9% still kept their children's immunization records, however the breakdown varied across locations, where more mothers who live closer to district center kept records than those further away (41.3% as opposed to 33.7% and 25%);

Figure 35: Respondents who kept immunization records of their children

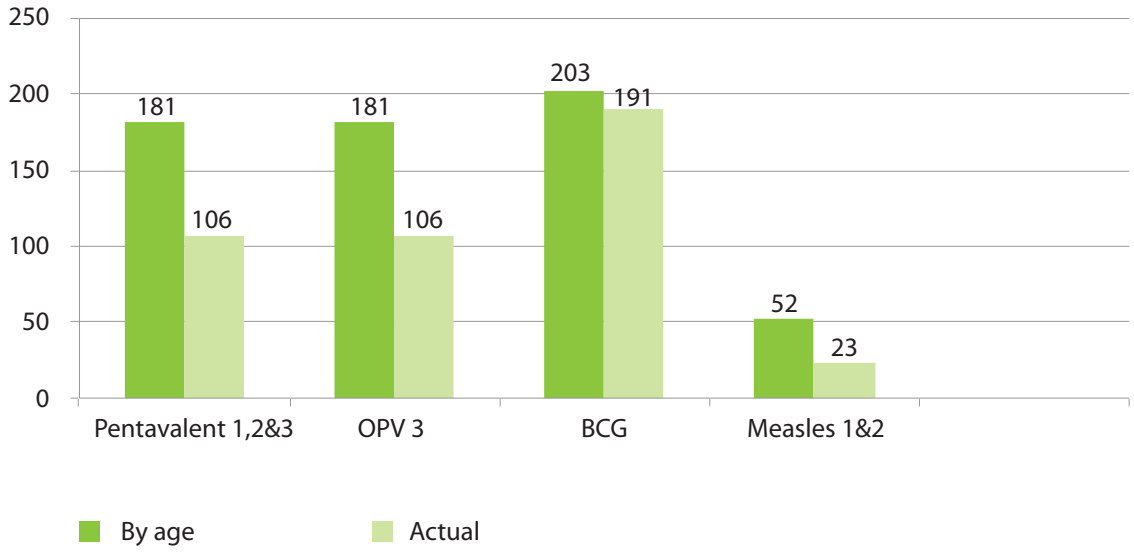


Source: 2014 Kon Tum CRC on CHS services

203 out of 395 respondents (51.4%) who had their children vaccinated at commune level could recall and provided information on vaccine names and dosage of vaccination. In particular, 94.1% of the children vaccinated with BCG, 54.25% with Hepatitis B at birth, 87% with Pentavalent and 70.6% with measles vaccine. Detailed information is presented in Table 2.2.6.1 of Annex 5.1.

Not getting fully vaccinated at the right age could affect children's immunization and their ability to prevent diseases. Out of 203 children with information on types and dosage of vaccination, 94.1% were vaccinated with BCG, 58.6% with Pentavalent, 87% with OPV and 70.6% with measles vaccine. Detailed information is illustrated in Figure 2.2.6.1 and Figure 2.2.6.2 of Annex 5.1.

Figure 36: Doses of vaccination by age



Source: 2014 Kon Tum CRC on CHS services

There was no result on the percentage of children under 12 months being fully immunized as 48.6% of the respondents could not recall vaccination information (either type or dosage) of their children and no verification could be made against data from administrative reports or immunization sheets kept at CHS.

Survey results also revealed that 63% of the children were always examined before injection, 10.6% received check-up sometimes, and 26.3% were not examined at all. More children of Kinh mothers were examined before vaccination than those born to ethnic minority mothers (76.63% as opposed to 57.99%). Breakdown by location was 77%, 65%, 55% and 52% for Kon Tum City, Dak Ha, Dak Glei and Tu Mo Rong respectively. In addition, more children from non-poor families received check-up that poor ones (70.7% versus 56.4%)

63.3% of the respondents said that they were given explanation by health staff before there children were vaccinated. The breakdowns across district and commune were almost similar, with small difference between Kinh and ethnic minorities (61.11% as opposed to 69.16%). Among the explanations provided, the most popular was complications after vaccination (48.1%), followed by benefits of immunization (47.1%) and vaccine status (4.6%). In addition, 3% of the respondents said that they were also informed about different types of vaccines and vaccination schedule.

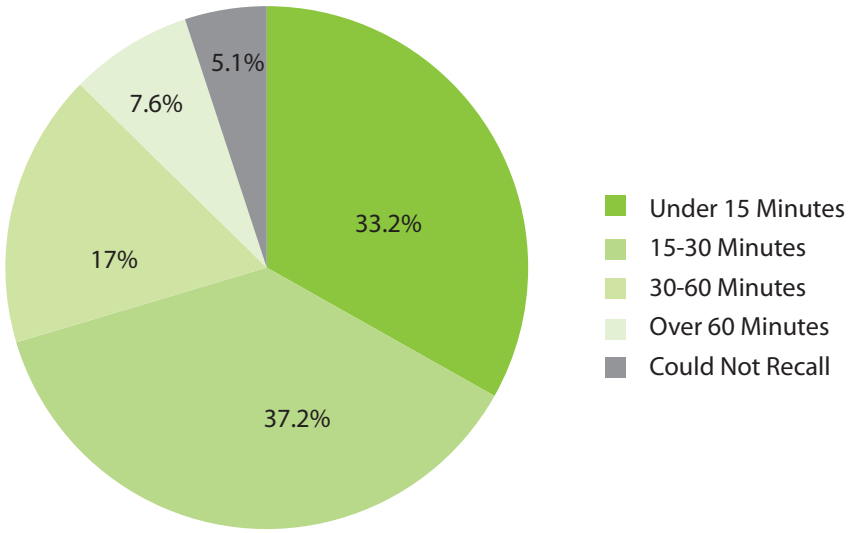
What is worth noting is that most of the respondents (82.2%) were given reminders right after their children were vaccinated. 66.3% were told by health staff to stay put for monitoring and observation, 50.4% were given guidance on how to monitor their children and 30.6% were instructed on how to handle complications. An equal number of respondents in Dak Glei and Dak Ha received post-vaccination counseling, compared to 92% of respondents in Kon Tum City and 71.9% in Tu Mo Rong. In addition, the figure was higher among Kinh mothers than ethnic minority mothers (89.7% as opposed to 80.2%).

Children under 2 years old can be vaccinated free of charge at CHS or other immunization locations organized by CHS. Survey results indicated that 100% of the respondents did not have to pay for their children's vaccinations.

Availability of services

In general, the respondents did not have to wait long to get their children vaccinated. 33.2% of the children were vaccinated or given oral vaccine within 15 minutes' waiting, 37.2% within 15-30 minutes, 17% within 30-60 minutes and 7.6% more than 60 minutes. In addition, 5.6% could not recall how long they waited.

Figure 37: Time spend waiting for vaccination



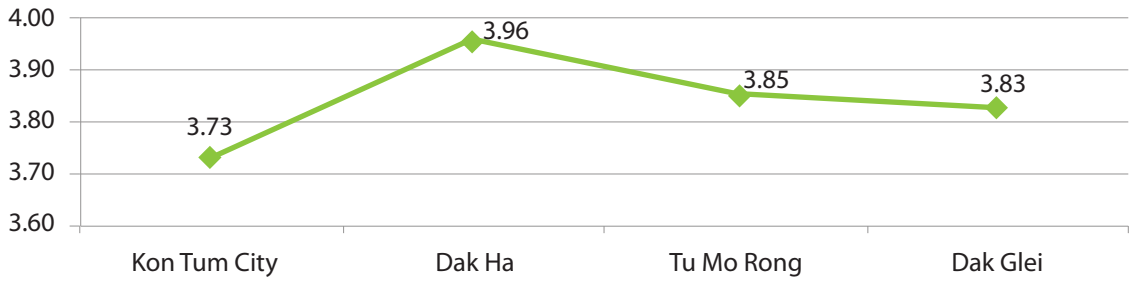
Source: 2014 Kon Tum CRC on CHS services

There is a difference in waiting time by location and ethnicity. Respondents with average distance from district center had to wait longer than those living either closer or further away, and ethnic minority mothers waited longer than Kinh mothers (except for 15-30 minute slot). In addition, 91.4% of the respondent thought waiting time was reasonable, and only 8.6% disagreed (13 of whom had to wait over 60 minutes, including 3 Kinh, 7 Gie Trieng, 3 Xo Dang and 1 Ba Na; 12 lived within 5-10km and 1 lived more than 10km from CHS).

Level of satisfaction

Overall 81% of the respondents felt either satisfied or very satisfied with immunization services (74.7% and 6.3% respectively). 3% were not really satisfied and 15.9% were fairly satisfied. The average satisfaction score was 3.84, interpreted as "satisfied". Factors affecting level of satisfaction with immunization services included waiting time, residential location[32], and were closely and linearly related to attitude of health staff and service quality[33]. There was no difference in the level of satisfaction across ethnicities, age groups, education levels and family economic conditions.

Figure 38: Satisfaction score by location

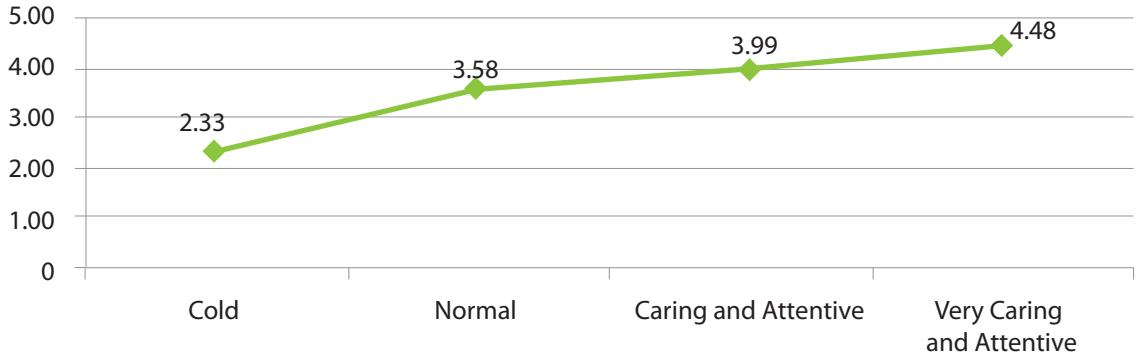


Source: 2014 Kon Tum CRC on CHS services

32 *Statistical tests showed p values 0.025, 0.027, and 0.22*

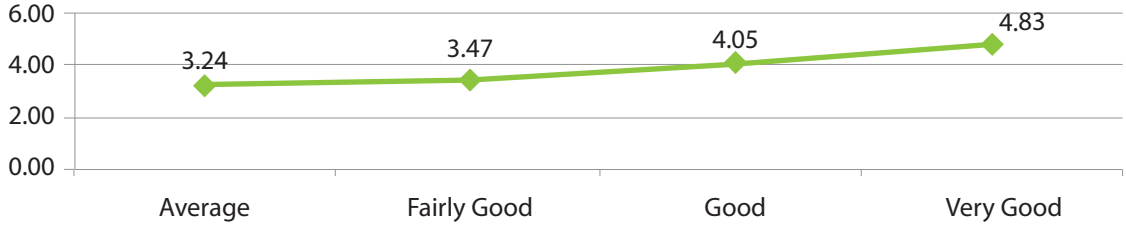
33 *Tests for correlation showed Cronbach's alpha = 0.8*

Figure 39: Satisfaction score and attitude of health staff



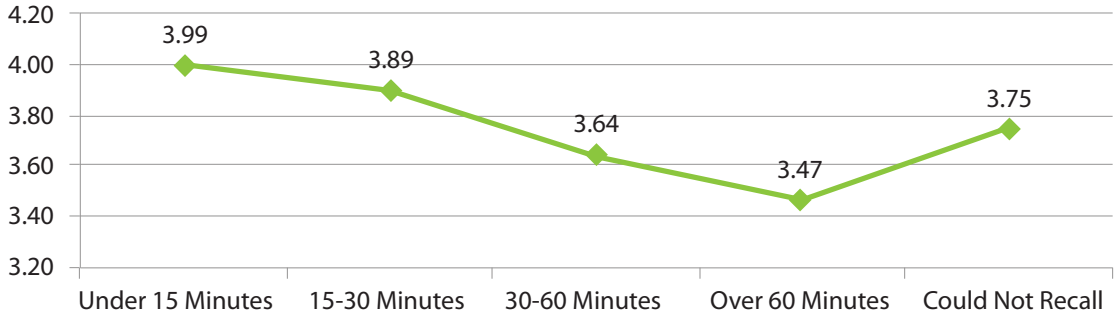
Source: 2014 Kon Tum CRC on CHS services

Figure 40: Satisfaction score and quality of immunization services



Source: 2014 Kon Tum CRC on CHS services

Figure 41: Satisfaction score by waiting time



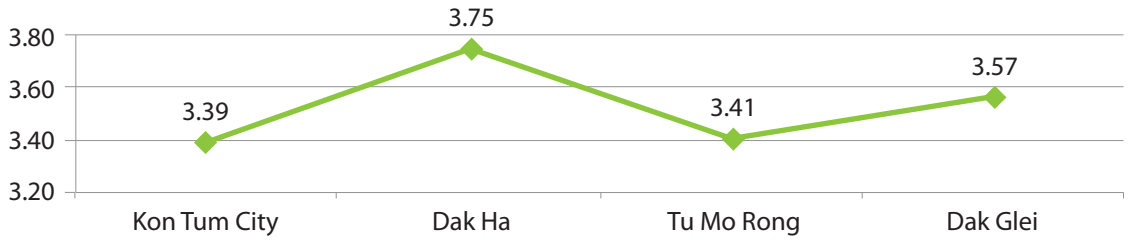
Source: 2014 Kon Tum CRC on CHS services

In terms of attitude of health staff, 53.9% of the respondents thought that health staff was caring and attentive, 6.8% considered them to be very caring and attentive, while 37.7% said they were normal and 1.5% claimed that they were cold. Average attitude score was 3.66, interpreted as "caring and attentive". Similar feedback on health staff attitude was provided by different groups with respect to location, ethnicity, family economic condition, age group and education level.

An average quality score of 3.53 was given by 395 respondents who children were vaccinated at commune level, which ws equivalent to "good". In particular, 63.5% rated service quality as good, 3% as very good, and 16.7% as fairly good and average. However there was a difference in quality score across locations, at 3.75, 3.51, 3.51 snd 3.39 for Dak Ha, Dak Glei, Tu Mo Rong and Kon Tum City. At 3.39, immunization service quality was only rated as "fairly good" in Kon Tom City.

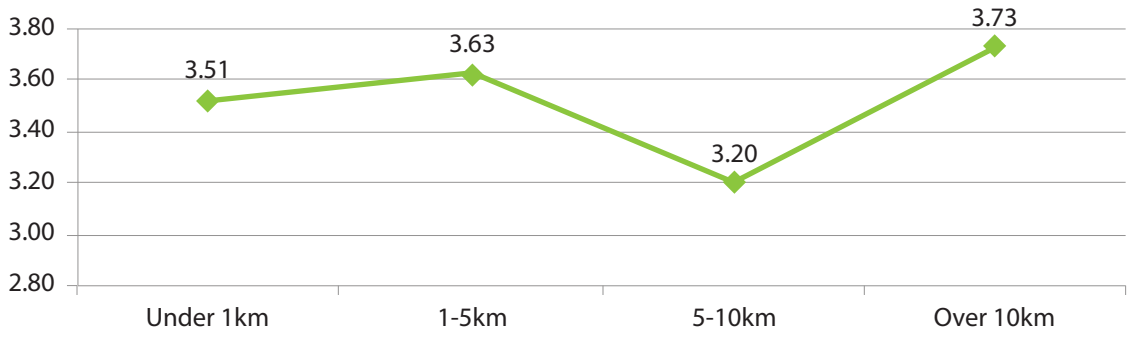
Statistical tests (ANOVA/T-test) indicated a closer correlation between respondents' perception and service quality and residential location, distance from home to CHS, waiting time and attitude of health staff. There was no difference in feedbacks on service quality by different groups in terms of ethnicity, family economic condition and education level.

Figure 42: Quality of services by location



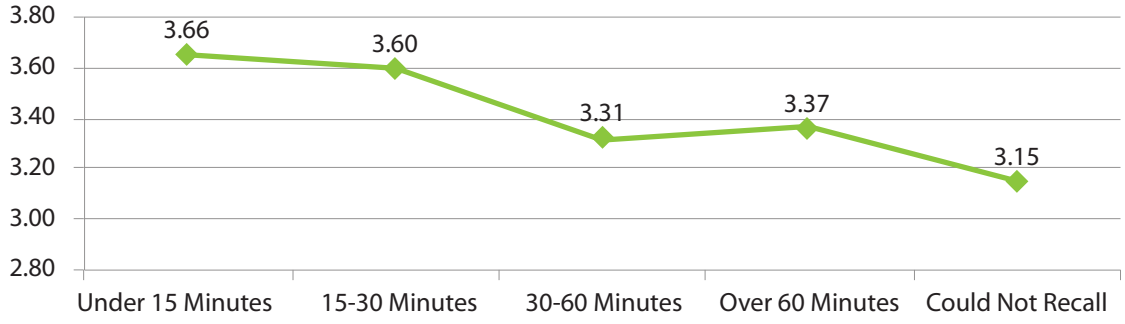
Source: 2014 Kon Tum CRC on CHS services

Figure 43: Quality of services by distance from home to CHS



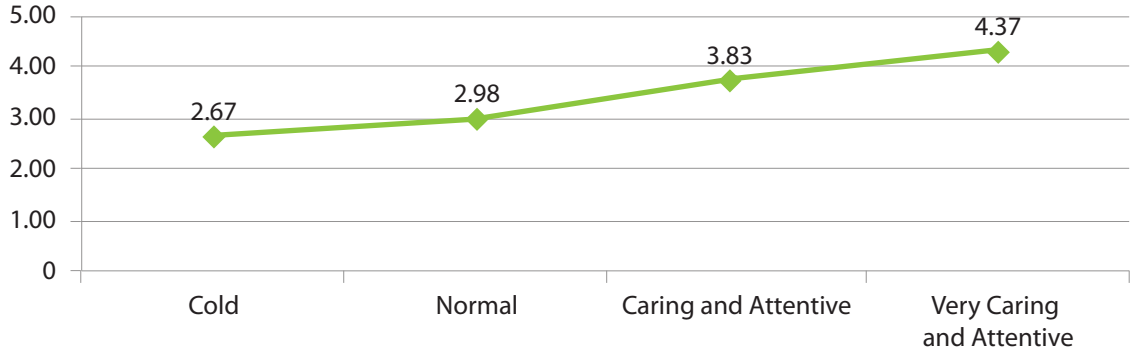
Source: 2014 Kon Tum CRC on CHS services

Figure 44: Quality of services by waiting time



Source: 2014 Kon Tum CRC on CHS services

Figure 45: Quality of services by attitude of health staff



Source: 2014 Kon Tum CRC on CHS services

Recommendations of respondents

Recommendations were provided by 88 respondents (22.28%) for improvement of immunization services. In particular:

- Health staff should be more attentive and cheerful when giving the injection, and should be more impartial (those who come first should be served first);
- A more diverse range of vaccines should be provided (flu, mumps), better and safer vaccines, better storage, and the children should still be vaccinated in case of shortage of vaccines.
- Clear and specific explanations should be provided prior to vaccination; there should be more immunization locations in order to avoid long waiting and commuting time;
- There should be more fans and seats in waiting areas, more immunization staff, better and more specific guidance, more thorough examination of children prior to vaccination, notification of vaccination schedule and better IEC

CONCLUSION AND RECOMMENDATIONS

3. CONCLUSION AND RECOMMENDATIONS

3.1. Conclusion

Availability and Use of services:

Feedbacks from the general public in this CRC indicate that CRC are ready for service at all times with respect to 6 types of services covered in the survey. In particular immunization services are provided at fixed days every month. The majority of the general public does not encounter much difficulty in accessing healthcare services at commune level. There were a large number of respondents using all 6 services offered by CHS, with the exception of MCH during and after birth (38.5%). The most highly utilized type of services was immunization (98.75%), followed by CNS, FPIEC, ANC and MET at 86.5%, 81%, 75.2% and 66% respectively. There were neither long wait nor any fees involved as almost off women are insured.

The survey results help to confirm the critical role of CHS with the general public, especially with ethnic minority community and the poor in disadvantaged areas of Kon Tum province. On the contrary, CHS has only limited role in urban areas such as Kon Tom City as people there have more options and access to better healthcare services.

Users' feedbacks on attitude of CHS health staff

A large number of service users said that CHS health staff was caring and attentive while serving them. Breakdowns by services include 58.4 for ANC, 77.9% for MCH during and after birth, 71.9% for family planning IEC, 65.9% for MET, 58.4% for CNS and 53.9% for immunization. A score of 3.74 (out of a scale of 5) was given for attitude of health staff, with the breakdowns of 3.66, 3.66, 3.66 3.88, 3.76 and 3.84 for ANC, CNS, CI, MCH, FPIEC and MET respectively. There was a negligible number of respondents who complaint that CHS health staff was cold.

Despite the relatively positive feedbacks of the general public on serving attitude of CHS health staff, there is still room for improvement, especially with respect to ANC and CI, in order to increase users' satisfaction

Users' feedbacks on quality of services provided by CHS:

The majority of users think that the quality of 6 types of services provided by CHS which was covered in this survey is either good or fairly good. Very few people think that service quality is average or poor. 56.5% of the respondents said that they experience good ANC services, in comparison with 74.7% for MCH, 69.8% for FPIEC, 66.7% for MET, 56.1% for CNS and 63.5% for CI. The average score for service quality was 3.56, equivalent to "good", of which breakdowns for ANC, MCH, FPIEC, MET, CNS and CI were 3.42, 3.76, 3.62, 3.61, 3.41 and 3.53 respectively. The cut-off threshold for "good" quality score was 3.40. Although not many respondents complained that service quality was poor, there were also few people who thought that service quality was very good. Another point worth noting is the lack of understanding by the general public on assessment indicators for service quality. Thereby, it could be seen that there was limited transparency and disclosure with respect to assessment indicators for healthcare service quality, especially in remote areas.

Level of satisfaction of service users with CHS services

In general, people in the surveyed location are satisfied with 6 types of services provided by CHS. The respondents felt most satisfied with ANC services (83.3%), followed by FPIEC, MET, ANC, CI and CNS at 80.5%, 75.4%, 75.2% và 74.8% and 66.2% respectively. The average satisfaction score was 3.84 and interpreted as "satisfied", of which breakdowns were 3.84, 3.99. 3.90, 3.94, 3.69 and 3.84 for NC, MCH, FPIEC, MET, CNS and CI. However, very few respondents said they were very satisfied with these 6 services.

Antenatal care: 73% of the respondents had been to CHS for ANC services while 7.8% (38) did not seek ANC care anywhere during there latest pregnancy. The latter consisted primarily of women from poor families (25

or 80.6%), ethnic minorities (31 or 100%), Tu Mo Rong (13 or 41.9%) and Dak Ha (10 or 32.3%), aged between 22 and 30 years old (17 or 54.8%) and without schooling (13 or 41.9%). Among the former, 105 (35.9%) received 3 checks-up during 3 trimesters as advised and 14 (4.8%) had more than 3 checks-up during their latest pregnancy.

341 (85.3%) respondents were vaccinated against tetanus at CHS, 50 (12.5%) were not given such vaccination, and 9 (2.3%) could not recalled whether they were vaccinated. 331 respondents (82.7%) said they received and took iron or multi-micronutrient supplements. The primary source of iron supplements was from village health workers (42.1%) and CHS (39.7%). This reflects an active role of village health workers in providing ANC services.

In general, respondents provided highly positive feedback on the attitude of health staff and quality of ANC services. 62.1% thought that health staff was either caring or very caring towards them. Besides, 59.7% considered service quality to be either good or very good, while 20.8% said it was just average. Finally, 80.5% of the respondents felt either satisfied or very satisfied with ANC services provided by CHS.

Survey results also indicates that there remained 59 respondents (14.7%) who did not received any counseling from CHS health staff during their latest pregnancy. The topic advised the most was 3 checks-up during 3 trimesters (68%) and signs of abnormality, risks of complications during pregnancy, childbirth and after birth and handling the least (6.5%)

Maternal and child healthcare: the survey point out the not many respondents gave birth at CHS (38 or 9.5%). Others chose to deliver their babies at higher level health facilities (28% at provincial hospitals and 15% at district hospitals) or give birth at home (36.35% without support of health staff, including village birth attendants, 24.8% with support from family members, 11.3% with traditional birth assistants, and .025% with support from neighbors). Among 400 respondents, 137 received home visits after birth, representing a rather moderate percentage. Out of this group, 65 (47.4%) were visited once within the first week after birth and 50 (36.5%) were visited twice within 6 weeks after birth.

83.1% of the respondents thought that health staff was either caring and attentive or very caring and attentive, giving them an attitude score of 3.88. Only 1 respondent claimed that health staff was cold. The majority (78.6%) of users said MCH service quality was either good or very good and gave an average score of 3.76. There was no respondent who said the service was poor. Overall 91.6% of the respondents felt satisfied with MCH services and satisfaction score averaged at 3.99. Only 1 claimed to be not really satisfied with the services.

The respondents revealed that the most popular counseling topic was breastfeeding right after birth, proper breastfeeding and exclusive breastfeeding within the first 6 months (200 or 50%), followed by keeping the baby warm, caring for the baby and hygiene issue (163 or 41%) and nutrition for mothers during breastfeeding period (159 or 39.9%). A relatively large number of respondents (156 or 39.2%) did not receive any counseling after childbirth.

Given the characteristic of sparsely distributed population over a large area, village birth attendants have a very important role to play in MCH care during and after birth. It is important to explain to these birth attendants that the fact that their allowances are paid once per month does not mean that the benefits are any less, but it simply means that all payments are grossed up for the purpose of payment convenience. This will help to provide more incentive and increase dedication for better services, thereby increasing the number of childbirth with support from health workers and reducing maternal and infant mortality rates.

Family planning: 81% of the respondents were given IEC guidance on family planning. The majority was advised on safe birth control measures (95.4% or 309), followed by benefits of having 2 or fewer children (180 or 55.6%). Popular IEC activities took place during village meetings (50.9%), group-based IEC sessions organized by village health workers (42.9%), and home-based IEC (33%).

Most of the respondents preferred group-based IEC sessions organized by village health workers (32% or 128), followed by IEC in village meetings (30.5% or 122) and finally home-based IEC (26.5% or 106). The least favored was IEC via loudspeakers of commune government (0.8%). Favorite languages for IEC were Vietnamese (Kinh) and local dialects.

Respondents with IEC experience thought highly of attitude of health staff. In particular, 74.1% said that health staff was either caring or very caring towards them and gate an attitude score of 3.76. In addition, they also provided positive feedback on IEC quality, with 72.5% indicating that service quality was good and very good, and an average quality score of 3.62. Overall, 86.1% were either happy or very happy with family planning IEC and gave a satisfaction score of 3.90.

Medical examination and treatment: 264 out of 400 respondents said that they had been to CHS for MET services within the 12 months preceding the survey, of whom 80 sought MET for themselves, 194 for their children and 7 for other family members[34]. Survey results indicate that people went to CHS for normal diseases, such as cold and flu, and fever/scarlet fever (39.4%), respiratory track disorders (cough, sore throat, bronchitis, pneumonia) (31.4%) and the rest for digestive track diseases (diarrhea, gastrointestinal disorders)

176 or 66.7% of the respondents who had used MET services at CHS said that the quality was good, while only 1 claimed that service quality was poor and a similar number of people considered the services as fairly good and average (14.4% and 14% respectively). Quality score for MET services averaged at 3.61.

Overall, the respondents were satisfied with MET services at CHS. In particular, 85.6% said they felt satisfied, giving an average satisfaction score of 3.94. On the other hand, 5 respondents (1.9%) were not really happy with the services. Despite providing positive feedback on MET services of CHS, most respondents complained that CHS were lacking in terms of facilities, equipment, modern medical equipment, and highly qualified health staffs. Other complaints include some health staff failed to provide through examination and were uncaring towards patients. These limitations should be addressed to improve MET service quality and increase users' satisfaction with healthcare services at commune level.

Malnutrition prevention: Survey results reveal that 19.25% of the children under 2 years old covered in this survey were malnourished. Furthermore, child malnutrition rate was higher in poor households as opposed to non-poor families (26.5% versus 10.8%), in uneducated mothers as opposed to educated mothers (33.8% versus 16.1%), in ethnic minority mothers as opposed to Kinh mothers (25.6% versus 1.9%), and in disadvantaged districts versus better-off ones. In particular, malnutrition rates among children under 2 years old in Tu Mo Rong, Dak Glei, Dak Ha and Kon Tum City were 36%, 25%, 10% and 7% respectively.

There was little wait involved to get the children weighed/measured/given vitamin A. Respondents closer to district center were served faster than those living further away. Similarly women living closer to CHS had to wait less to be served. There remained 35 children under 6 months (40% of all children in this age group) who were weighed/measured/given vitamin A only once per year. In addition, 60.4% of the respondents said that they received counseling when taking their children to CHS for weighing and measuring.

Users' satisfaction depends heavily on service quality and attitude of health staff. The more favorable users' feedbacks are for service quality, the more satisfied they are. Similarly, level of satisfaction is also positively related to attitude of health staff. 66.2% of the respondents felt satisfied with the services 0.49% were very satisfied, while 22% were fairly satisfied, 6.9% were not really satisfied. Average satisfaction score was 3.69 out of a scale of 5.

Although the feedbacks were positive, there is still room for improvement for better services. Recommendations include more IEC for malnutrition prevention, more attentive and caring attitude, early IEC for malnutrition prevention as a pre-emptive approach, provision of weighing and measuring services in different dates by location to avoid long wait.

34 *Including 17 respondents who got both themselves and their childrean checked or treated at CHS during their last visit.*

Child immunization: 98.5% of the respondents confirmed that their children had been vaccinated at home (BCG), at CHS or at immunization points organized by CHS. Use of services was similar among the districts, communes and groups. However, only 51.4% could recall vaccination information and provided feedbacks on this matter. 69.9% still kept their children's immunization records, with more mothers living closer do district center maintaining record than those living further away. Among those who provided immunization information, 94.1% said their children were vaccinated with BCG, 54.2% with Hepatitis B at birth, 87% with Pentavalent and OPV, and 70.6% with measles vaccines.

74.7% of the respondents felt satisfied and 6.3% very satisfied with immunization services, while 15.9% said they were fairly satisfied and 3% claimed to be not really satisfied. Main reasons for satisfaction were long wait, uncheerful attitude of health staff (*"because they had to vaccinate too many children and it was hot and muggy"),* tight space in waiting area, with no fans or seats.

Recommendations made include more caring health staff, more specific explanation of the benefits of vaccines, arrangement of immunization points and vaccination schedule by population group/village to avoid long time spent waiting and commuting, installation of fans and seats in waiting area, more and better IEC on immunization, especially notification of vaccination schedule, more and better variety of IEC materials.

3.2. Recommendations

Based on the feedbacks provided by users and verification against the results of this CRC survey in Kon Tum, the research group has arrived at a number of recommendations, which are presented below.

General recommendation

- Strengthening integrated IEC and diversifying IEC contents, materials and activities by target group.
- Tighter supervision and more support to CHS
- Conducting study and implementing electronic child health records for children under 5 years old
- Institutionalizing CRC survey of healthcare services as an official information channel to for annual collection of feedbacks from the general public, especially from most disadvantaged groups
- Disclosing technical procedures and assessment criteria for health care services at different level to boost the understanding of the general public for more active feedbacks and better efficiency.

Recommendations Kon Tum Provincial Health Department:

- Disseminating the survey results with bodies within and outside the health sector and developing a plan to monitor and implement the recommendations which have been agreed to.
- Dividing CHS into groups (urban/rural, lowland/highland, Kinh/ethnic minorities, populous/ non-populous, and so on) and assessing the capacity and demand of each CHS with reference to the capacity of neighboring health facilities to avoid inappropriate and lack-of-focus investments.
- Assessing training requirement and organizing training courses to provide knowledge and update to grass-root level health staff
- Collecting feedbacks from the general public on a regular basis to look into improvements as well as to recognize new and emerging issues in healthcare, apart from using CRC survey as mentioned in the general recommendations. This should not be restricted to commune-level healthcare services but shout be extended to district and provincial level.
- Strengthening international cooperation for better resource mobilization

Recommendations for 4 District Health Centers:

- Tighter supervision of and better technical support for CHS for quality improvement
- Strong cooperation with CHS for effective provision of commune-level healthcare services which are in demand (such as ANC, gynecology services, family planning – 1 session per week as the Family Planning Centers alone is in sufficient to meet the demand of all women in certain CHS)
- Proactively collecting and analyzing feedbacks of service users as inputs for healthcare planning to best meet the demand of the general public;
- Cooperate/coordinate with Health IEC Centers and CHS to organize IEC activities for awareness raising and initiation of changes away from health-damaging behaviors)

Recommendations for CHS

Antenatal care

- Better IEC to ensure pregnant women go for 3 checks-up during 3 trimesters as advised.
- Active counseling and guidance on health care for pregnant women
- Monitoring and updating information on pregnant women to increase the percentage vaccinated against tetanus and given iron supplements.
- Cooperating closely with village health workers/birth attendants to increase the number of women receiving care during pregnancy, childbirth and after birth.

Maternal and child healthcare during and after birth

- Encouraging pregnant women and their families to inform village health workers/ CHS health staff of the upcoming childbirth for support during childbirth and improvement of home-based after birth care by CHS health staff and village health workers (especially with respect to visits within the first week and 6 weeks after childbirth)
- Actively sharing information with young mothers to collect their feedbacks and recommendations for improvement of service quality

Family planning IEC

- Requesting support from local people's committee/youth union/women\s union in organizing integrated IEC activities.
- Actively participation and learning from IEC activities organized by Health ICE Centers to build capacity to organize similar activities once support from youth unions and/or women's unions becomes available.
- Providing recommendations to Reproductive Health Centers on suitable measures, topics and activities for more effective family planning IEC.

Medical examination and treatment

- Improving the range and quality of health counseling to the general public
- Regularly sharing experience, participating in training and supervision sessions to for improved attitude and higher sense of responsibility in service delivery

Child nutrition services

- Arranging IEC topics and activities by target group (pregnant women/mothers raising small children/ Kinh mothers as opposed to ethnic minority mothers/educated versus uneducated mothers/mothers living closer versus further away from district center)
- Arranging for the children to be weighed/measured in different dates depending on their residential location in order to avoid long wait.
- Providing information on child growth conditions (malnutrition, stunting) and advising mothers on how to care for their children afterwards.
- Cooperating with village health workers to provide guidance to pregnant women on proper nutrition and to carers (primarily young mothers) to feed the children properly.

Child immunization

- More IEC for mothers to increase the number of children being vaccinated, especially direct IEC by village health workers
- Performing all steps of immunization procedures, including explanation, counseling, and examination before injection and reminder after vaccination.
- Providing guidance to mothers on keeping a close eye on vaccination schedules and sending their children for vaccination accordingly
- Proposing vaccination schedules by population groups in order to avoid long wait
- Arranging fans and seats in waiting area
- Distributing vaccination schedule and advising mothers to put the schedule at a highly visible place at home for better tracking.

Health IEC

- More emphasis on integrated IEC.
- Developing suitable IEC topics and activities for specific target groups (Kinh/ethnic minority women, pregnant women, mothers raising children under/over 6 months old, mothers in disadvantaged/ developed areas)

LESSONS LEARNT

4. LESSONS LEARNT

This CRC could only be successful thanks to the direction and approval of the Provincial People's Committee and relevant provincial bodies, as well as support from district and commune governments in surveyed locations. The CRC was commissioned by the Provincial Department of Planning and Investment and conducted by the Provincial Health Department. It reflects for wish for better quality of primary care services at commune level and higher level of satisfaction among the general public, as well as collection of more information for developing planning indicators for the health sector in relation to other indicators of local soci-economic development plans. The direct and active participation of health sector personnel, especially those from Kon Tum Provincial health Department has helped to facilitate the design and implementation of the CRC.

During the survey, measures were taken to mitigate unwanted impacts of direct participation by health sector personnel. These include engaging independent consulting team, supervision by health officials from higher levels and especially by UNICEF staff.

Active reference to UNICEF Handbook for CRC Implementation and regular consultation with UNICEF staff throughout the survey help to ensure objectivity and that technical procedures are followed.

Evaluation of service quality without clear and specific criteria is difficult to the general public. Given a sample consisting of 53.75% of the poor, 73.25% of ethnic minorities and 17.75% without absolutely no education, it would have been easy for respondents to give the wrong answer had explanation been unclear. However, interviewers gradually got used to different responses and regularly read the evaluation scale for selection by respondents. As a result, satisfactory reasons were provided in cases where negative feedback were provided. As such, it could be seen that the absence of evaluation criteria may not be a significant limitation should interviews follow the Handbook's instruction for interviewing using questionnaire and have experience in how to work effectively with respondents.

This is the first time for the survey team to conduct a survey using questionnaires and all groups have encountered certain difficulties. In addition, respondents should not be asked to come to the communal house at the same time, as many would have to wait for a long time to be interviewed. It would be better for interviews to be conducted at their home ensures privacy, no distraction from noise (telephone) or strangers (some respondents could speak Vietnamese (Kinh) but chose not to due to shyness in front of strangers).

5 children included in the survey had been immunized but were not listed in the 05YO Child Growth Record. As such, the sample/list of observations should be examined and verified by population collaborators and/or village health workers at least 1 week before the survey.

Another limitation is the outnumbering of female interviewers by male interviewers, especially with respect to interviewing female respondents on birth control measures. The lesson learnt is that there should be more female interviewers. Male interviewers should be prioritized only for faraway and hard to reach locations which are difficult for female personnel. In addition, some interviewers skipped or gave a too brief introduction, although this section is critical for breaking the ice, building confidence in and gaining trusts from respondents for more active participation in the interview.

With 2 pilots, the questionnaire is free of errors and no adjustment was required during the survey. However, the amount of time spent on training and practicing interviewing skills using questionnaire was in sufficient. As such, some interviewers were not aware of probing skills for more information by asking other and related questions to confirm, verify and clarify the information provided by respondents. Besides, a number of interviewers also had difficulty examining completed questionnaire before ending the interviews. As a consequence, some questionnaires were found to have missing information upon handing over to the data entry team and supplementary telephone interviews were required

There was little information on child immunization. Depending solely on feedbacks from respondents may

not be very reliable, as 5 out of 10 responses may be incorrect. Some respondents remembered that their children had been vaccinated but could not recall the type and doses of vaccination. As such, cross-checked should be made against CHS's records for child immunization in cases where respondents do not maintain records or bring the record along with them to the interview.

The most time-consuming step in data analysis and reporting is data cleaning. More time should be invested in practice interviewing skills using questionnaire to address this weakness. In addition, there should be an independent data entry team external to the health sector (for cross-checked among the two teams) for better source data quality.

The selection of a third-party guide to lead interviewers to surveyed locations and arrangement of a guide to accompany each interviewer in case of faraway locations and 1 guide for each densely populated village will help to facilitate the survey.

Active participation by health staff is critical to collecting feedbacks of the general public on commune-level healthcare services. This is the first time for the Provincial Department of Health to apply CRC tool during survey. Moving forwards there will be more surveys and therefore more opportunities for applying this tool. As such, the experience and lessons learnt from this survey will help the Provincial Health Department and the survey team to have more success conducting similar surveys in the future.

5. ANNEXES

5.1. Data tables

Table 5.1.1: Summary of surveyed target groups

Grouping	Total	Users by type of services					
		ANC	MCH during and after birth	Family planning	MET	Malnutrition prevention	Immunization
Households							
Poor	215	201	94	187	159		
Poor	11	11	5	9	10		
Non-poor	174	163	55	128	95		
Ethnicity							
Kinh	107	100	30	70	44		
Gie Trieng	40	38	14	40	31		
Xo Dang	178	163	68	146	132		
Ba Na	44	43	17	38	28		
Other	31	31	25	30	29		
Education level							
No schooling	71	65	31	56	51		
Finishing primary education	69	62	26	61	45		
Finishing lower secondary education	151	144	67	129	116		
Finishing high school	109	104	30	78	52		
Age group							
Children							
< 1 months						8	7
2 months						9	12

Grouping	Total	Users by type of services					
		ANC	MCH during and after birth	Family planning	MET	Malnutrition prevention	Immunization
3 months						10	17
4 months						11	13
5-8 months						53	65
9-17 months						157	166
> 18 months						98	115
Mothers							
<16 years old	0	0	0	0	0		
16-21 years	103	97	51	86	82		
22-30 years	190	182	59	152	117		
>30 years old	107	96	44	86	65		
Surveyed location							
Kon Tum City	100	92	19	65	86	86	100
Dak Ha District	100	96	38	80	66	89	100
Dak Glei District	100	90	45	88	80	92	99
Tu Mo Rong District	100	97	52	91	79	79	96
TOTAL	**400**	**375**	**154**	**324**	**264**	**346**	**395**

Table 5.1.2: Time spent travelling from home to CHS, by household, ethnicity and district

Time		Household classification as of 2013			Ethnicity					Total
		Poor	Poor	Non-poor	Kinh	Gie Trieng	Xo Dang	Ba Na	Other	
< 30 minutes	Kon Tum City	8	1	85	54	1	1	37	1	94
	Dak Ha District	24	5	53	47	1	33	1	0	82
	Tu Mo Rong District	44	2	13	4	1	54	0	0	59
	Dak Glei	48	1	7	2	17	13	0	24	56
30-60 minutes	Kon Tum City	1	0	5		0	0	5	1	6
	Dak Ha District	7	0	1		0	8	0	0	8
	Tu Mo Rong District	30	1	2		0	33	0	0	33
	Dak Glei	27	0	5		16	11	0	5	32
60-90 minutes	Kon Tum City	0	0	0	0	0	0	0	0	0
	Dak Ha District	6		2		0	7	1		8
	Tu Mo Rong District	4		0		0	4	0		4
	Dak Glei	3		0		1	2	0		3
> 90 minutes	Kon Tum City	0	0	0	0	0	0	0	0	0
	Dak Ha District	0	1	1		0	2			2
	Tu Mo Rong District	4	0	0		0	4			4
	Dak Glei	9	0	0		3	6			9
Total		**215**	**11**	**174**	**107**	**40**	**178**	**44**	**31**	**400**

Table 2.2.2.1: Reasons for not giving birth at CHS

No	Reasons for not giving birth at CHS	Frequency	Percentage (%)
1	Insufficient time to travel to CHS	71	19.6
2	Unaware of CHS midwifery services	10	2.8
3	Aware of CHS midwifery services but not comfortable with service quality	68	18.8
4	CHS is too far away	19	5.2
5	No means of transportation	6	1.7
6	Discouraged by husband or family	16	4.4
7	Customs and rituals	27	7.5
8	Family members know how to help with childbirth	14	3.9
9	Complicated delivery or caesarian section	62	17.1
10	Simple delivery	9	2.5
11	Closer to hospitals or higher level health facilities	9	2.5
12	Local CHS does not offer midwifery services	9	2.5
13	Shyness	8	2.2
14	Advise by health staff on referral	8	2.2
15	Preference for home birth delivery	2	0.6
16	Lack of money	3	0.8
17	Delivery at home with support of health staff	3	0.8
18	Delivery in hometown	3	0.8
19	Present in Kon Tum City at the time of delivery	4	1.1
20	Delivery on weekends/holidays when there are no midwives	3	0.8
21	Other	8	2.2

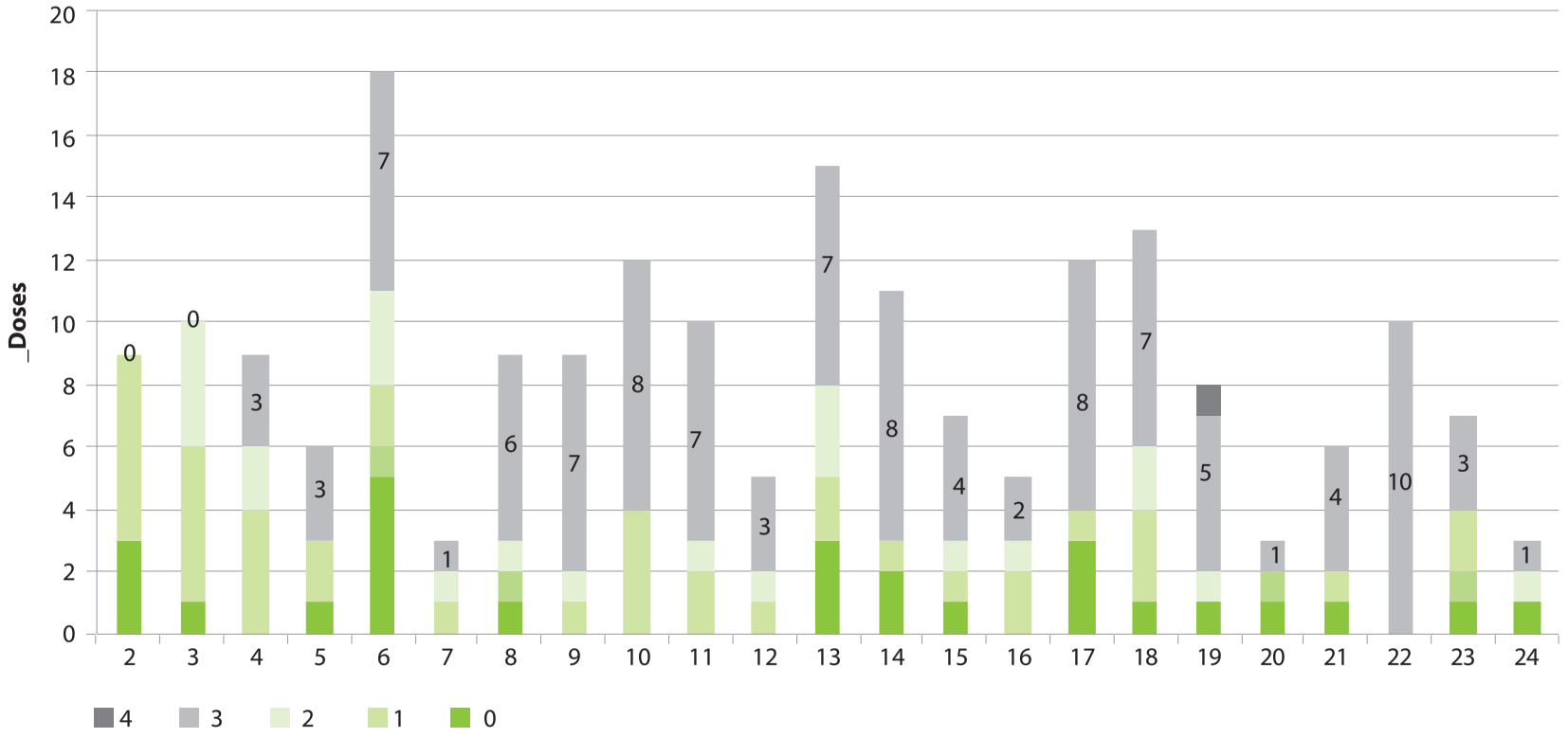
Source: 2014 Kon Tum Province CRC on CHS Services

Table 2.2.6.1: Number of children getting vaccinated

Vaccine	1 dose	2 doses	3 doses	4 doses	Could not recall	Total	No of children in immunization age	Percentage %
Vaccinated						203		51.4
BCG	191					191	203	94.1
Hepatitis B at birth	110					110	203	54.2
Petavalent	41	23	105	1	4	174	200	87.0
OPV	41	23	106		4	174	200	87.0
Measles	71	23			2	96	136	70.6
Hib	3	4			3	**10**	**100**	
Could not recall						**192**		**48.6**

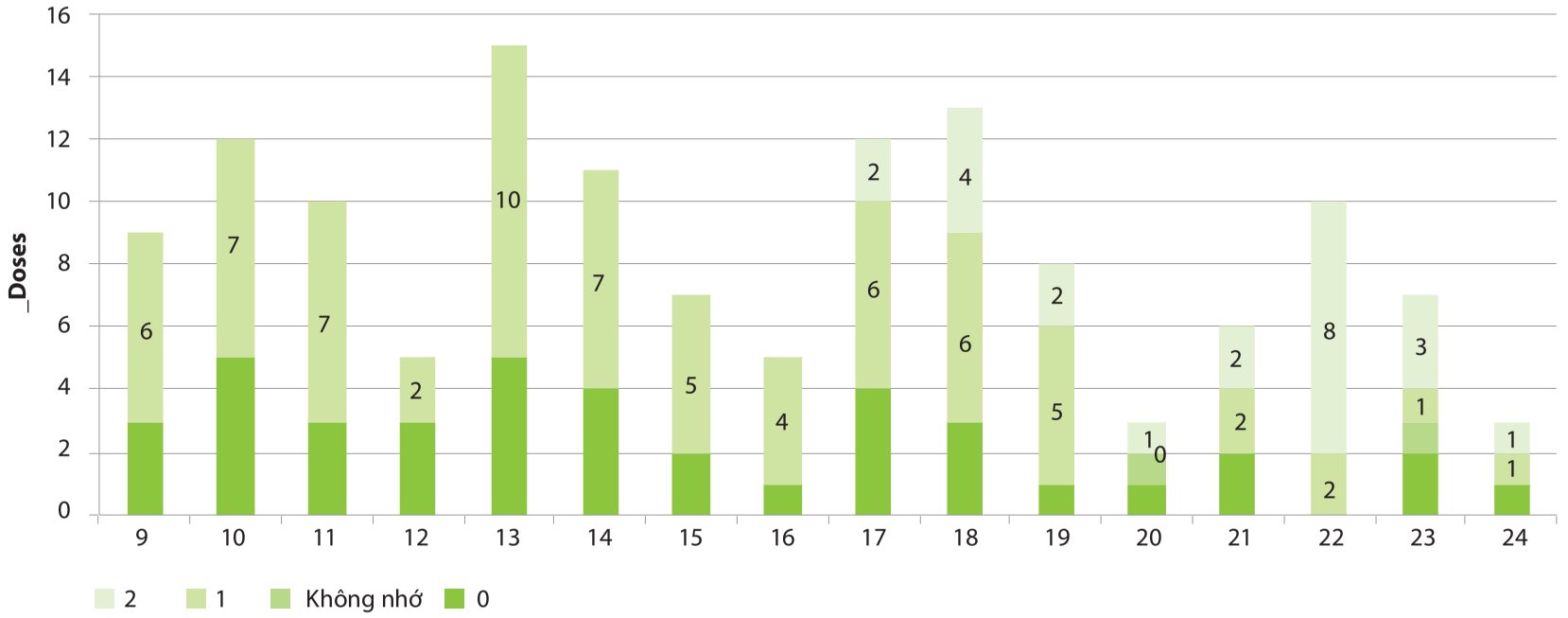
Source: 2014 Kon Tum Province CRC on CHS Services

Figure 2.2.6.1: Doses of Pentavalent vaccine by age in month



Source: 2014 Kon Tum Province CRC on CHS Services

Figure 2.2.6.2: Doses of measles vaccine by age in month



Source: 2014 Kon Tum Province CRC on CHS Services

5.2. Matenal and Child Health as of 2012

No	Indicator	Kon Tum Province	TP KonTum	Dak Glei District	Ngoc Hoi District	Dak To District	Tu Mo Rong District	Dak Ha District	Sathay District	Kon Plong District	Kon Ray District
1	Population	466,357	162,428	42,294	53,122	40,971	20,883	58,238	42,728	21,340	24,353
2	Number of households	109,029	36,257	10,079	11,647	9,890	4,986	14,810	10,149	5,425	5,786
3	Percentage of ethnic minority (%)	49.76	0.25	83.88	61.96	49.89	98.28	41.90	55.28	88.53	61.42
	Number of ethnic minority people	232,045	40,818	35,476	32,914	20,440	20,524	24,402	23,620	18,892	14,958
4	Percentage of poor households (%)		8.24	43.94	20.17	18.19	53.05	16.18	36.04	47.69	34.12
5	Percentage of children under 6 years old issued with health insurance card										
6	Total births										
7	Total live births	9,123	403	910	2,319	1,779	678	1,114	1,030	552	338
8	Number of women between 15 and 49	108,922	26,662	14,058	14,728	9,455	5,643	17,251	11,874	4,492	4,759
9	Number of children under 5Y	56,886	16,212	5,429	6,192	6,111	3,199	8,316	5,467	2,740	3,220
10	Number of children under 1YO	12,504	3,520	1,189	1,235	1,340	815	1,805	1,300	573	727
11	Maternal deaths										

No	Indicator	Kon Tum Province	TP KonTum	Dak Glei District	Ngoc Hoi District	Dak To District	Tu Mo Rong District	Dak Ha District	Sathay District	Kon Plong District	Kon Ray District
12	Child deaths	168	0	15	2	22	45	5	8	8	8
13	Infant deaths	119	0	15	2	17	29	3	5	9	7
14	Fetal deaths – 22weeks to delivery	153	0	8	14	17	9	7	2	0	9
15	Infant deaths within 7 days after birth	49	6	3	2	0	13	0	2	2	3
16	Infant deaths between 8-28 days after birth	75	3	2	2	6	16	0	2	8	4
17	Number of newborns ≤2,500gr at birth	807	3	44	113	49	23	18	26	38	16
18	Percentage of underweight among children under 5 (%)	26.3	22.30	28.70	19.70	22.80	32.10	21.00	22.20	32.70	25.70
19	Percentage of stunting among children under 5 (%)	41	31.80	39.10	36.60	36.70	48.60	24.10	32.40	40.30	34.40
20	Percentage of breastfeeding within 1 hour after birth (%)	96.73	100.00	100.00	87.85	90.27	92.33	88.51	96.44	100.00	100.00
21	Percentage of exclusive breastfeeding within the first 6 months (%)	29.73									

No	Indicator	Kon Tum Province	TP KonTum	Dak Glei District	Ngoc Hoi District	Dak To District	Tu Mo Rong District	Dak Ha District	Sathay District	Kon Plong District	Kon Ray District
22	Percentage of women having 3 examinations during 3 trimesters as advised (%)		29.73	33.66	31.37	29.56	34.87	12.88	51.21	42.14	37.82
23	Percentage of women taking iron or multi-micronutrient supplements during pregnancy										
24	Number of women given full UV vaccination upon delivery	11,778	3,139	1,166	1,403	1,736	617	2,060	829	511	317
25	Total delivery	15,543	402	913	1,554	1,800	695	1,116	1,028	552	338
26	Number of delivery at home	3,605	359	380	182	535	493	662	331	409	254
27	Percentage of delivery at home without trained support (%)	52.32	36.65	77.37	97.25	45.23	35.70		71.30	20.78	0.00
28	Percentage of delivery at home with trained support (%)	47.68	64.35	22.63	2.75	54.77	64.30		28.70	79.22	0.00
29	Percentage of delivery at health facilities (%)	73.88	10.70	58.38	85.36	70.28	24.15	40.68	67.80	25.91	24.85
30	Percentage of mother and child receiving after birth care within the first 7 days after birth (%)	90.83	85.03	100.00	84.17	91.98	99.84	97.07	88.01	99.80	78.70

No	Indicator	Kon Tum Province	TP KonTum	Dak Glei District	Ngoc Hoi District	Dak To District	Tu Mo Rong District	Dak Ha District	Sathay District	Kon Plong District	Kon Ray District
31	Percentage of children given BCG vaccination	99	99.2	100	100	98.7	97.8	96.1	98.8	100	96.1
32	Percentage of newborns given Hepatitis B vaccination at birth (during the first 24 hours)	70	87.4	50.6	85.3	67	33.5	60.6	84.2	28.6	43.2
33	Percentage of children given Pevatalent vaccination	97.5	98.2	97	96.8	96.2	96.9	97.5	96.5	97.9	96.6
34	Percentage of children given OPV3	97.6	98.5	97	96.8	96	96.9	97.6	96.5	97.7	96.6
35	Percentage children given measles vaccination	97.7	98.1	97	95.3	97.6	97.1	97.5	96.5	97.7	100
36	Percentage of children fully immunized	97.4	98.2	97	93.6	97.6	96.9	97.1	96.5	97.7	96.5

5.3. General Performance of the Health Sector in Kon Tum Province

No	Indicator	Unit	Results			2015 target	2020 target
			2010	2012	2013		
A	**Input indicator:**						
1	Doctors/10,000 people	%oo	6.3	8.3	8.6	10.5	11.5
2	University graduated pharmacists/10,000 people	%oo	0.27	0.4	0.5	0.5	1.0
3	CHS with doctors	%	62.9	89.7	91.8	100	100
4	Villages with health workers	%	100	100	100	100	100
5	CHS with female midwives or obstetrician-gynecologist assistants	%	89.7	89.7	96.0	100	100
B	**Performance indicator**						
7	Children under 1 years old fully immunized	%	93.4	97.5	83.1	>97	>98
8	CHS meeting national standard during 2011-2020	%	0	7.2	20.6	>50	100
9	Insured population	%	77.6	82.5	83.0	>80	>90
C	**Outcome indicator:**						
15	Prevalence of infant mortality	%o	46	39	Est. 39.2	35	30
16	Prevalence of child mortality	%o	56	54	Ước 47.4	47	42
17	Prevalence of stunting among children under 5 years old	%	28.3	26.3	26.1	<22	<17
18	Population	10,000	44.3	46.2	47.3	51	60
19	Annual population growth	%	2.38	2.38	2.34	2.9	3.3
22	Natural population growth	%o	19.5	21.3	21.1	14.7	11.8
23	Gender ratio at birth	boy/100 girl	-	106	109		

5.4. Questionnaire for service users5.5. Questionnaire for CHS health staff

5.5. Questionnaire for CHS health staff

Ministry of Planning and Investment Kon Tum Provincial
Department of Planning and Investment Kon Tum
Provincial Health Department

United Nations Children's Fund

CITIZEN REPORT CARD

A SURVEY ON USERS'S SATISFACTION WITH PUBLIC HEALTHCARE SERVICES AT COMMUNE LEVEL IN KON TUM PROVINCE

With a view to improving the quality of commune-level healthcare services in the province, Kon Tum Provincial Health Department, with the support from the United Nations Children's Fund (UNICEF) is undertaking a survey on users' satisfaction with public healthcare and nutrition services offered at commune level, including antenatal care, maternal and child healthcare during and after birth, family planning IEC and counseling, medical examination and treatment, malnutrition prevention and immunization. 4 districts are covered in this survey, namely Tu Mo Rong, Dak Glei, Dak Ha and Kon Tum City.

This survey aims to collect feedbacks from the general public, represented by mothers raising children under 2 years old, on 6 types of healthcare and nutrition services offered at commune level, for evaluation and recommendations for improvement of service quality. The survey also seeks comments from health staff who is directly involved in service delivery.

We wish for effective cooperation and your active participation is highly appreciated. We would like to confirm that all information collected will be used only for the above mentioned purposes.

Thank you very much.

GENERAL INFORMATION

INTERVIEWR

0.1 Full name:.....

0.2 Interview starts:.....Interview ends:.....Date: ...August 2014

RESPONDENT

0.3 Commune Health Station:.....0.4 District:.....

0.5 Full name:.....0.6 Sex (Male/Female):.....

0.7 Ethnicity:..... 0.8 Position:: .....

0.9 Telephone: .....

CHS facilities and human resources

1. Indicators for different types of services:

Antenatal care: .....

.....

Maternal and child healthcare during and after birth: .....

.....

Family planning .....

.....

Medical examination and treatment.....

.....

Malnutrition prevention .....

.....

Expanded program for immunization .....

.....

2. Please list 3 disadvantages/advantages that you have experienced while performing the tasks assigned

Advantages:.....

.....

.....

Disadvantagess: .....

.....

.....

3. Current CHS human resources:

No	Position	Number
1	Doctor	
2	Nurse	
3	Midwife	
4	Doctor assistant	
5	Obstetrician-gynecologist assistant	
6	Traditional medicine personnel	
7	Admin & Other.	
	Total	

4. Does the CHS have clean water?

1. ☐ Yes: 2. ☐ No

If no, please specify the source of water curently used:.....

5. Does the CHS have toilets?

1. ☐ Yes 2. ☐ No

6. Does the CHS have places for waste treatment?

1. ☐ Yes 2. ☐ No

Condition/description:.....

7. What technical rooms are available at the CHS?

1. ☐ Examination room
2. ☐ Traditional medicine room
3. ☐ Drugs counters/warehouse
4. ☐ Laboratory (para-clinical)
5. ☐ Disinfection room
6. ☐ First aid and emergency room
7. ☐ Counseling, health family planning IEC
8. ☐ Gynecology and birth control room
9. ☐ Delivery room
10. ☐ Injection room
11. ☐ Inpatient room
12. ☐ Administrative room
13. ☐ Duty room

8. Does the CHS have first aid and emergency facilities?

Does the CHS have stretchers or means of transportation for first aid patients? .....

.....

9. Does the CHS meet national standard? Please provide your evaluation of the tools and medical equipments at the CHS.

Satisfactory ☐ Unsatisfactory ☐

If satisfactory, what percentage?.....

10. Do you have any recommendations for improvement of service quality for 6 basic types of services offered by CHS?

Human resources: (Quality/quantity) .....

.....

.....

.....

Facilities .....

.....

.....

.....

Services (services offered, level of specialization) .....

.....

.....

Other:.....

.....

THANK YOU VERY MUCH

5.6. Survey team personnel

NO	Full name	Workplace
1	Dang Cong Lan	Kon Tum Provincial Heal Department
2	Hoang Long Quan	Kon Tum Provincial Heal Department
3	Nguyen Thi Thanh Hau	Kon Tum Provincial Heal Department
4	Dang Tran Huan	Kon Tum Provincial Heal Department
5	Ho Thi Dung	Health Sector Trade Union
6	Duong Thi Huu Hien	Reproductive Health Center
7	Pham Thi Oanh	Reproductive Health Center
8	Le Thi Luon	Reproductive Health Center
9	Nguyen Van Don	HIV/AIDS Prevention Center
10	A Trung Tin	HIV/AIDS Prevention Center
11	Do Thi My Loan	HIV/AIDS Prevention Center
12	Dao Thi Thi	Social Disease Prevention Center
13	Nguyen Thang Quoc	Center for Malaria, Parasite- and Insect-related Diseases
14	Tran Thai Hoang	Center for Malaria, Parasite- and Insect-related Diseases
15	Nguyen Thi Hang	Reproductive Health Center
16	Nguyen Ho Dinh	Dak Ha District Health Center
17	Le Thi Lua	Tu Mo Rong District Health Center
18	Tran Thuc Lan Trinh	Planning Division, Kon Tum City Health Center
19	Nguyen Van Hai	Dak Glei District Health Center
20	Nguyen Tam	District Office of Population and Family Planning
21	Y Dech Buon Ya	Health IEC Center
22	Le Thanh Hoe	Health IEC Center
23	Nguyen Van Hieu	Health IEC Center
24	Bach Thi Van	Health IEC Center
25	Pham Thanh Tu	Health IEC Center
26	Pham Thi Ha Phuong	Preventive Health Center
27	Nguyen Cong Thanh	Preventive Health Center
28	Nguyen Van Sang	Preventive Health Center
29	Vu Thi Yen	T&C Consulting
30	Tran Thu Huong	T&C Consulting
31	Ton That Tuan	T&C Consulting
32	Hoang Thi Thuy Nguyet	T&C Consulting

KON TUM DEPARTMENT OF PLANNING AND INVESTMENT

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