HIV/AIDS COORDINATING COMMITTEE

A NETWORK OF CIVIL SOCIETY ORGANIZATIONS WORKING ON HIV AND AIDS

HEALTH SYSTEM STRENGTHENING SURVEY REPORT

Study on Assessment of client satisfaction to access Health Care Services in 4 Provinces (Kandal, Svay Rieng, Kampong Cham and Kampong Thom)

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March 2013

ACKNOWLEDGE

HIV/AIDS Coordinating Committee (HACC) would like to express its sincere gratitude to Mr. Tim Vora (Executive Director), Mr. Heng Thona (Deputy Director Resource Mobilization and Program Management) and Dr. Leng Kuoy, (National Advisor) who have given advice and input into this study. HACC would also like to acknowledge Mr. Khun Rathana, (Health system Strengthen Project Coordinator), Mr. Cheav Samphy (Monitoring and Evalustion Coordinator), Ms Pov Hongmeng (Monitoring and Evaluation Officer), directors and staff of PKKO, REDA, NAS and MODE organizations, who were all coordination for data collection. I would finally like to thank the finance and admin teams were for their administrative work during data collection.

ACRONYMS

AIDS	Acquired immune deficiency syndrome
ANC	Ante Natal Care
CDHS	Cambodia Demographic and Health Survey
HC	Health Center
HIS	Health Information System
HSS	Health System Strengthening
HACC	HIV/AIDS Coordinating Committee
HIV	Human Immunodeficiency Virus
MoH	Ministry of Health
MoP	Ministry of Planning
Mode	Minority Organization for Development of Economy
NAS	Nak Akphivath Sahacum
NGO	Non-Governmental Organisation
OD	Operational District
PNC	Post Natal Care
PHC	Primary Health Care
PPS	Probability Proportion to Size
PHD	Provincial Health Department
PKKO	Punleu Komar Kampuchea Organization
REDA	Rural Economic Development Association
VHSG	Village Health Support Group
VL	Village Leader

CONTENTS

BACKGROUND

Utilization of health care facilities in Cambodia is of growing concern, due to the low number of people accessing public health care services among poor households. Evidence from CDHS 2010 has shown that people who are seeking treatment for illness and injury in public health service are lower compare to private sector in both urban and rural areas. For first treatment users only about 26% in urban and 29% of in rural areas have sought treatment at Public Sector provider. Whereas first treatment users have sought treatment in private sector 66% in urban areas and 55% in rural areas, health service users in general face a number of barriers to accessing health services in Cambodia in both demand and supply. These barriers include physical barriers, financial barriers, quality of service issues, poor user knowledge and socio-cultural barriers. These barriers are especially difficult to overcome for the very poor households, who are often excluded from necessary health care (Peter. L.A et al 2006)

Physical barriers refer to the distance of nearest public health facility, lack of transport, restricted hours of service of health facilities and long waiting times at facilities. *Financial barriers* refer to the direct and indirect costs of health services (including fees, travel, food costs), unpredictable informal (and formal) charges in public facilities, opportunity costs to users due to use of time, no system of phased or deferred payments and failure of exemption schemes to protect the poor. *Quality of service* refers to the real and perceived quality of care, facilities and medication, uneven clinical skills of providers and lack of medical staff, poor staff attitudes towards patients, lack of diagnostic equipment and/or materials, inadequate drug availability, weak regulatory mechanisms, weak referral mechanisms, conflict of interest of public health staff with private practices, poorly cleaned and maintained facilities, inadequate knowledge by users in reference to lack of confidence in public health services, lack of information on what services are available (where, and when), lack of knowledge of regulated fee schemes, exemption schemes, equity funds, or how to access these, uncertainty about real and hidden costs of health services, inadequate communication between providers and users, limited understanding of consumer rights and little awareness of community participation mechanisms (User Groups, VHSGs, etc.). *Socio-cultural barriers* refer to the preference for home-based health care, reluctance to travel far from the home, preference for traditional healers, belief in non-material causes of illnesses and remedies, seasonal variation in disease, opportunity costs, or ability and willingness to pay for health care (Peters et al, 2008)

HIV/AIDS Coordinating Committee (HACC) received HSS Round 5 from PR-MoH Global fund in July 2010 to support NGOs member to implement the project. Thereafter HACC has supported to five NGOs in five provinces (REDA in Svay Rieng, NAS in Kampong Cham, CSCN in Pursat, PKKO in Kandal and Mode in Kampong Thom). The project was implemented in November 2010.
The aim of this project is to increase demand for health services at the community level by improving access, availability and quality of the health services on the supply side.
The 5 objectives include:

1. Strengthen community level mechanisms,
2. Improve Responsiveness of Primary Health Care Facilities,
3. Increase Knowledge of Community Members Regarding the 3 Dieses and Client rights.
4. Lower access and utilization barriers and
5. Improve the Quality Climate for Community level Primary Care to response the community barrier of accessing health care services within project target area (HSS, GF 2010-2015).

HIV/AIDS Coordinating Committee (HACC) has designed a community based cross section survey to measure the impact of project health system strengthening that has been implemented since November 2010. The survey was conducted in 4 provinces (Kampong cham, Kandal, Kampong Thom and Svay Rieng), by 4 NGOs (Mode, REDA, PKKO, and NAS). The aim of the survey was to assess the magnitude and the risk factors of accessing health services by poor people in community within the project area. Implementation was funded by Global Fund Round 9 from PR-MoH.

GENERAL OBJECTIVE

To identify the Magnitude and Risk Factors of Accessing Health Services among Poor Household by 4 NGOs in 4 Provinces (Kampong Cham, Kandal,Kampog Thom, Svay Rieng).

STUDY OBJECTIVE

- To assess strengths and weakness of community based referral services to improve the effectiveness of the services.
- To assess health seeking behavior of community when they have health problem
- To assess satisfaction of community on community based referral services
- To assess factors contributing to the barriers of accessing health care services

METHODOLOGY

1. Sampling

The sample size was calculated by using single proportion for descriptive, with a 5% margin of error, 95% confidence interval, 1.5 design effect and 10% non-respond. Hence the total sample size required was 240 participants. A multi stage cluster sampling method was used to select eligible households for interview. Firstly, probability proportional to size was used to select 15 clusters, using population database from 357 villages in 41 communes covered by 4 NGOs in 4 provinces. The target area's assigned to NGO's include MODE in Kampong Thom, OD in Kampong Thom, NAS in Kampong Cham, OD in Cheung Prey, PKKO in Kandal, OD in Takmao, REDA in Svay Rieng and OD in Svay Rieng. Secondly, 16 eligible respondents of household members were randomly selected from each cluster for face-to-face interviews with the research team. The research teams were asked to divide total household houses in village by 16. The research team were randomly selected for interviewing households, and told to continue interviewing houses on the right hand side to until the number needed for the sample size for each village was achieved.

The research team was divided into 2 teams of 4 people. One interview team was responsible for 8 different clusters close to where the NGOs were based. The second team was responsible for 7 clusters in which were houses very scattered and far from where the NGO was based. Appointed village volunteer/village leaders were used as guides for each group to identify the eligible households in the target areas. If the household members were not present while the team arrived in their house, the two-recall method was used to re-appoint the households for interview based on the information from their neighbors. After doing the two recalls, if the household was still unavailable, the household was not included. Questionnaires were administered by the interviewers in face-to-face consultation once informed consents were obtained. The average interview time (including obtaining informed consent) was about 20 minutes. All participants were administered a one page sheet regarding the study protocol in Khmer before oral informed consent was obtained. An oral informed consent form was dated and signed by the interviewer prior to commencement of data collection. The collected data was entered into the database using Epi data 3.1 In order to respect the anonymity, a code was assigned to each participant with a cluster number, cluster code, and row of participant's included in the site.

2. Interviewer Training

The key objective of the training was to ensure that all interviewers understand and follow the same standard procedures when implementing the 41 semi-structured interview

administered questionnaires, in order to maximize the quality of the data collection. Therefore, all interviewers undertook a half-day training course prior to data collection. The training focused on crucial skills including interview techniques, confidentiality and privacy issues and interview practice and simulation. The team members were also familiarized with the study protocol during the training session, a practice questionnaire was shown in training. The interviewers were responsible for maintaining the quality of survey data and also for quality control of field work. This included rechecking and reviewing questionnaires before sending raw data to the researchers. Researchers carefully completed a final check and reviewed interview sessions with the interviewers for further information clarification before data entry.

3. Data collection

Community based cross sectional survey was the method used to collect quantitative data, by trained interviewers. Inform consent, confidentiality and privacy of the participants was rigorously maintained. Any volunteer member of each household was invited to interview individually. Research teams were the leading coordinators of this study. Questionnaires were administered by the interviewers in face-to-face consultation, once informed consent had been obtained. Estimated average interview time, including obtaining of informs consent, was approximately 20 minutes.

4. Exclusion Criteria

The study considered a relevant exclusion criterion to minimize the effect of variables. This included exclusion of any family member at age below 15 years of age and any household those have resided in the village less than 6 months.

5. Data analysis

The data was entered into a computerized database using Epi data version 3.1. The data entry was performed by a researcher team and double checked by the Research Coordinator. The data was then analyzed using STATA 11.1.

Descriptive statistics on the general characteristics and socio- demography of study participants (such as age, sex, education level of household head or husband, marital status, occupation of household member, history of illness, parity of child, average of income, number of children, number of household member, use of healthcare services, transportation means, duration for getting the service, person who bought them for health care services, and how they know health care service...etc). Univariate and bivariate analyses was done to determine factors that were significantly associated (such as age, education level, occupation, income, household size…etc.,). The chi square test was used to ascertain statistical significance of the variables at p value <0.05.

RESULT

1. Socio-Demographic Characteristic of Respondents

Of the total 236 of participants eligible for interview, in (Table1) the majority, 186 (80%), were females in comparison with the 47 (20%) who were males. Among participants with mean of age 44 (Median43) with have been staying in the village for a mean of 30 years. Participants reported the head of family as male (73.62%), versus female (26.38%). Of the participants interviewed, 156 people, (66.10%), reported as having 1 to 4 family members and 80 (33.90%) reported as having 5 to 11 family members. More than half of the participants, 129 (54.66%) had completed primary school, 48 (20.34%) had completed secondary school, 13(5.51%) had completed high school, 3 (1.27%) had completed university and 43(18.22%) never studied. The majority of participants interviewed 195, (82.98%) identified farmer as their occupation. In comparison to 72 (30.64%) who were factory workers, 74(31,49%) were small business owners, 51(21.70%) were construction workers, 5(2.13%) were teachers, and 6(2.55%) were government officers. The average of participant's income was 150 USD per month and spending on health care services about 177 USD per year. Of these, 81(34.32%) were reported having ID poor card.

Table 1 : Socio-Demographic Characteristics of Respondents

Characteristics	N = 236	
	n	%
Mean of staying in years	30 (33)	
Mean of age in years	44 (43)	
Mean of income in USD	150 (116)	
Mean of family member	5 (5)	
Mean of Spending on Health Care per year	708,408 Riels	
Mean of distance in km	4 (3)	
Age (N=236)		
15-30 years	42	17.80
31- 45 years	84	35.59
45-64 years	82	34.75
> 64 years	28	11.86
Sex (N=236)		
Male	47	19.92
Female	189	80.08
Head of Family (N=235)		
Male	173	73.62
Female	62	26.38
Family Size (N=236)		
1-5	156	66.10
6-11	80	33.90
Education level (N=236)		
University	3	1.27
High School	13	5.51
Secondary School	48	20.34
Primary School	129	54.66
No School	43	18.22
Occupation (N=235)		
Farmer	195	82.98
Factory Worker	72	30.64
Construction worker	51	21.70
Small Business Owner	74	31.49
Teacher	5	2.13
NGO worker	0	0.00
Government Officer	6	2.55
Income (N=236)		
Less than 1.50 $	43	0.18
More than 1.50$	183	0.82
ID Poor (N=236)		
Yes	81	34.32
No	155	65.68

2. Utilization of Referral Services Program Support

Table 2 shows that among of participants 71 (30.08%) have heard about referral services program in their village. Of these, 43 (53.09%) were families having who have the ID poor card, (p<0.001). Among participants who had heard information about referral services support, 35(48.61%) heard from VHSG, 34(48.57%) heard from village leaders, 26(37.14%) heard from HC staff and the remaining heard from their neighbors. Of the participant interviewed, 32 (44.44%) reported as having received transportation support fee from referral services program, and 28(65.12%) participants received services as families who have ID poor card.

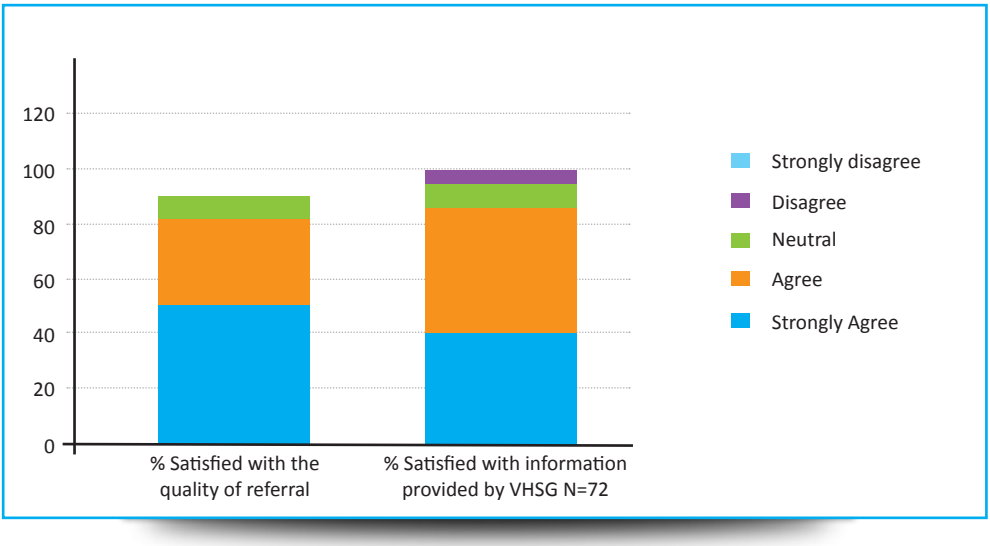
Table 2: Utilization of Referral Services program

Variable	N= 236		
	n	%	P- Value
Heard about referral services program in Village N= 236			
Yes	72	30.08	
No	165	69.92	
ID poor	43	53.09	*0.000
From whom N=72			
VHSG	35	48.61	0.327
Village leader	34	48.57	0.334
HC staff 26	37.14	0.444	
Neighbors	7	10.14	0.737
Receive Support from Referral services (N=72)			
Yes	32	44.44	0.368
No	40	55.56	
ID poor receive support from referral services N= 43	28	65,12	*0.000

2.1. Satisfaction with quality of referral and VHSG services

Figure 1 shows the level of satisfaction with quality of referral services program. Of respondents who used the referral services, 53.13% strongly agreed as being satisfied, 31.25% agreed as being satisfied, 6.25% were neutral and the remaining reported as never receiving support from referral services program in village. Level of satisfaction with information provided by VHSG also were highly signification (p=*0.000) respectively, of respondents 43.75% were strongly agreed, 46.68% were agreed, 6.25% were neutral and 3.13% were not satisfied with information provided by VHSGs. In conclusion among respondents, a statistically significant 90.63%, agreed (p=*0.000) with satisfaction of quality services program in the village. Of these, a statistically significant 96.88% agreed with information provided by VHSG.

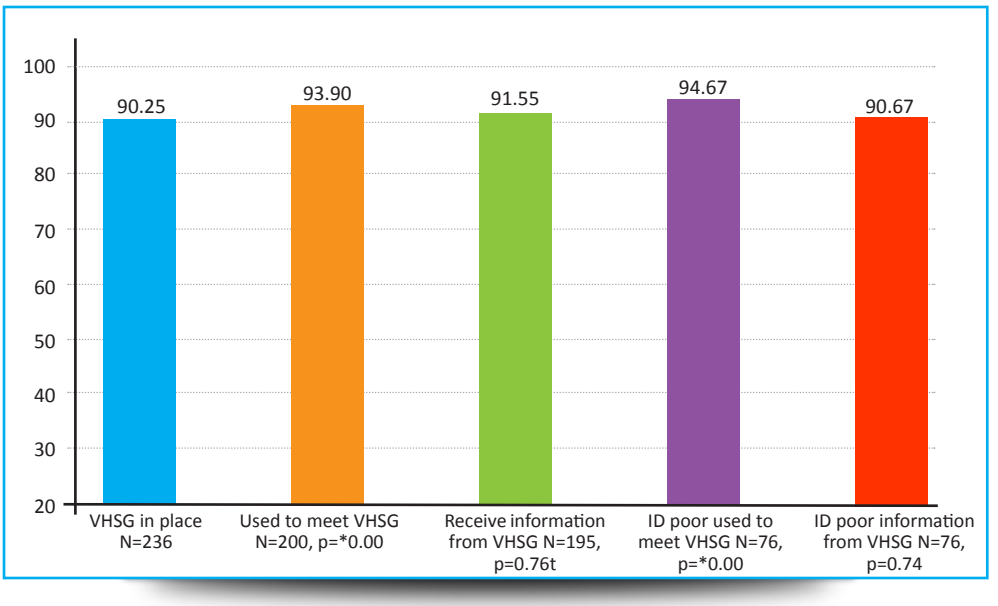
Figure 1: Percentage of satisfaction with quality of referral and VHSG Services



3. Community level mechanisms

Figure 2, shows that among respondents, 90.25% were reported having VHSG in their village, among these 93.90% reported meeting with VHSG, and 91.55% reported as having received information from VHSG. Of those reported having VHSG in their village about 32% were ID poor people, of these 94.67% reported as having used to meet VHSG and 90.67% reported as having used to receive information from VHSG.

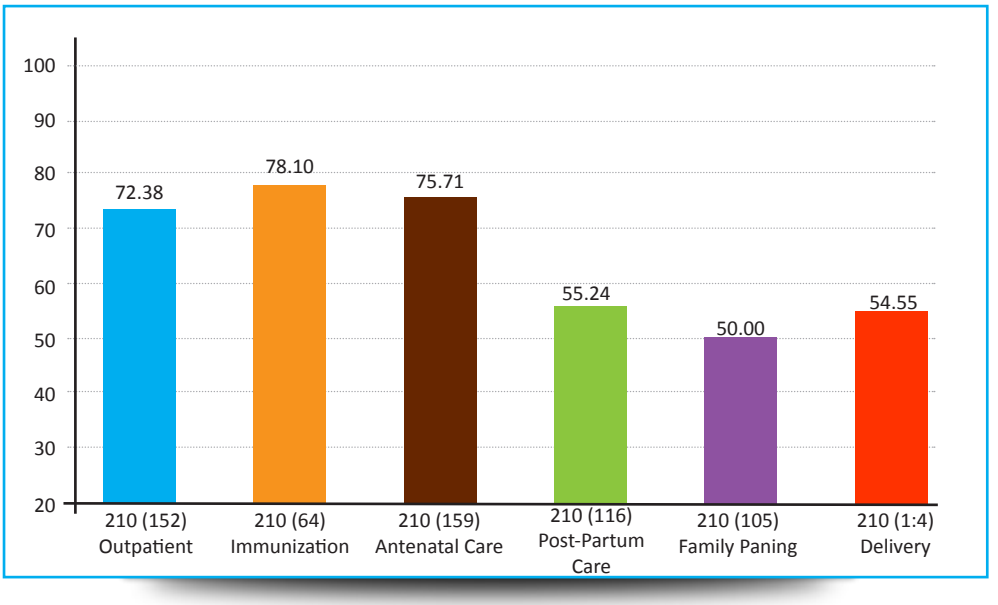
Figure 2: Percentage of respondents used community mechanisms



4. Utilization of Health Care Services

Figure 3, shows that among households who have used health care services at Health Centers, the majority, 78.10 %, used to receive immunization for both mother and child. In comparison with other services, 75.71% used to get antenatal care, 72.38% have used health center for outpatients, 55.24% have used post-partum care, and 50% have used family planning and 54.55% used birthing delivery at Health Centers.

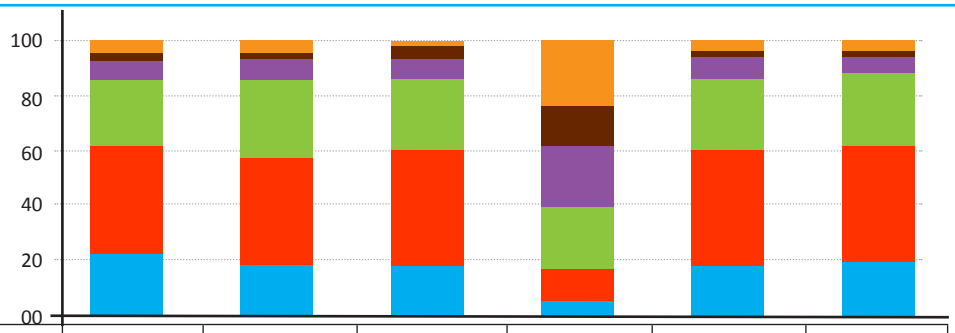
Figure 3: Percentage of household using health care services at Health Center



4.1. Satisfaction level of household with using health care services at Health Center

Figure 4, shows that there are significant agreed with satisfaction when using health care services. Of these a total of 24.29%, strongly agreed, 38.10% agreed, and 28.10% were neutral and about 10% were reportedly not satisfied with using health care services at Health Centers. Of the respondents reported as having used to receive the services, there was highly significant agreeing with satisfaction of received services as needed. Of these, 19.05% strongly agreed, 36.19% agreed, 33.33% were neutral and about 11% were not satisfied with services provided by health centers. Among respondents who reported as being highly satisfied with health care providers where also asked if they were treated with respect and dignity during visit the services provider. Around 20.48% strongly agreed, 37.62% agreed, 32.38% were neutral and about 10% did not agree with being satisfied with health care providers in regards to being treated with respect and dignity during their visit to health care providers. Of the respondents that reported that the resource/information provided was useful, 21.90% reported strongly agree with information being useful, 41.90% agree, 23.81% were neutral and about 12.38% were not satisfied. Among respondents, 20.95% strongly agreed, 44.76% agreed and 24.29% were neutral when asked if services provided by health centers make their family better. However, there were 10% that reported that they did not agree that services provided by health centers made their families better. Even thought there was high percentage of satisfaction of quality of services, ability to receive services as needed, health providers treating patients with respect and dignity, access to resources/ information, there still remained that 40.48% of respondents were reported that health care providers were not showing sensitivity while they were providing services to their clients.

Figure 4: Percentage of respondents satisfied with Health Care Services



	Satisfied with quality of services N=236 p=*0.000	I was able to get the services as I need N=236 p=*0.000	Staff treat with respect and dignity N=236 p=*0.000	Staff showed not sensitivity N=236 p=*0.001	The resource/ information provide is useful N=236 p=*0.000	The services make me and family better zzzN=236 p=*0.000
Never	3.33	3.81	1.90	22.38	4.76	2.86
Strongly disagree	1.76	0.95	0.95	12.86	0.48	1.43
Disagree	4.76	6.67	6.67	24.29	7.14	5.71
Neutral	28.10	33.33	32.38	24.29	23.81	24.29
Agree	38.10	36.19	37.62	13.33	41.90	44.76
Strongly Agree	24.29	19.05	20.48	2.86	21.90	20.95

4.2. Household Receive Transportation Fee Support of using Health Services

Among respondents that have used health care services, 19.52% received transportation fee. Of these 33.80% were ID poor people and among ID poor people, 40.85% reported receiving transportation fee (p= *0.000), respectively. Among respondents reported to have received transportation support fee, 11.43% received from Health Center staff and the average of transportation support fee were 1892 Riels. Of these, 84.29% reported that they had received adequate medicine from Health Centers and about 20.48% reported they had not seen any health care providers when they arrived at Health centers. Respondents reported that they have spent average about 708, 408 Riels on health care services per year (Table 3).

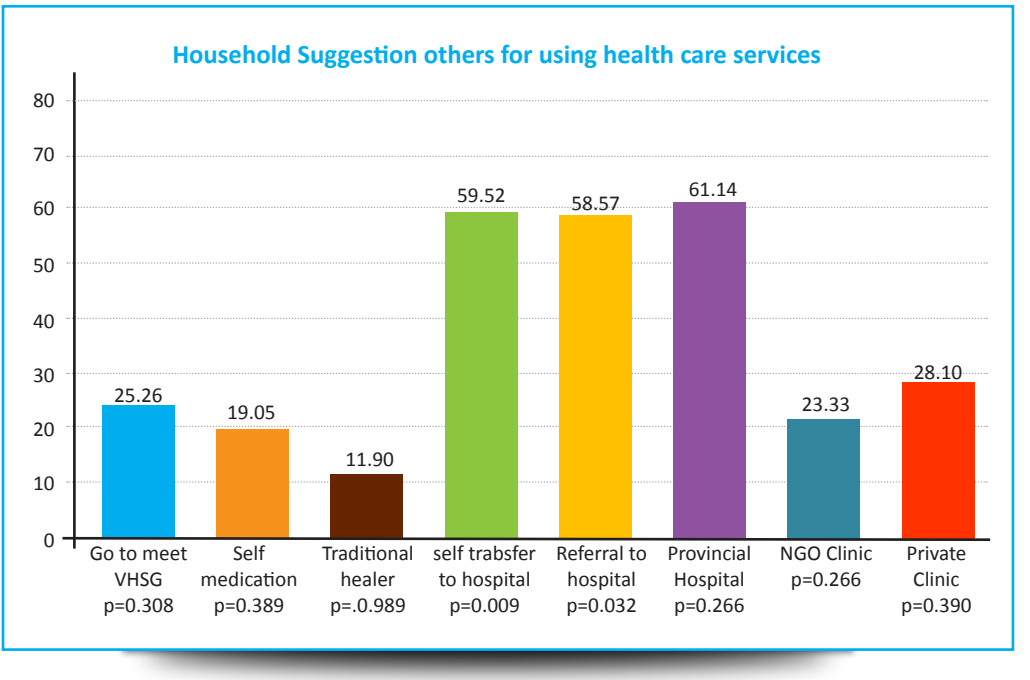
Table 3: Percentage of Household Receive Transportation Fee support of using Health Services

Variable	N= 236		
	n	%	P- Value
Receive paid for transportation fee Nº 210 among people use health care services	210		
Never	169	80.48	
Yes	43	39.52	
Receive support transportation fee for utilization of health care services among ID poor N=71	29	40.85	*0.000
Mean of transportation fee receive support	197	1892.00 Riels	
Received Adequate medicine N=210	177	84.29	*0.000
Experience not seen any health care provider N=210	43	20.48	0.011

4.3. Household Recommend to others for Using Health Care Services

Figure 5 shows that of the respondents who have recommended others for using health care services, 61.14% were recommended to use provincial hospital, 58.57% were referral to public hospital, 59.52% were self-transferred to health centers, 28.10% were referred private clinics, 25.26% were go to meet VHSG, 23.33% were NGOs Clinics, 19.05% were self-medication and 11.90% were referred to traditional healers. The majority of households using health care services were recommended to provincial hospitals, referred to public hospitals and self-transferred to health centers. However, the proportion of households recommended to self-medication, use tradition healers and private clinics were still considered as a concern and this should be taken into account.

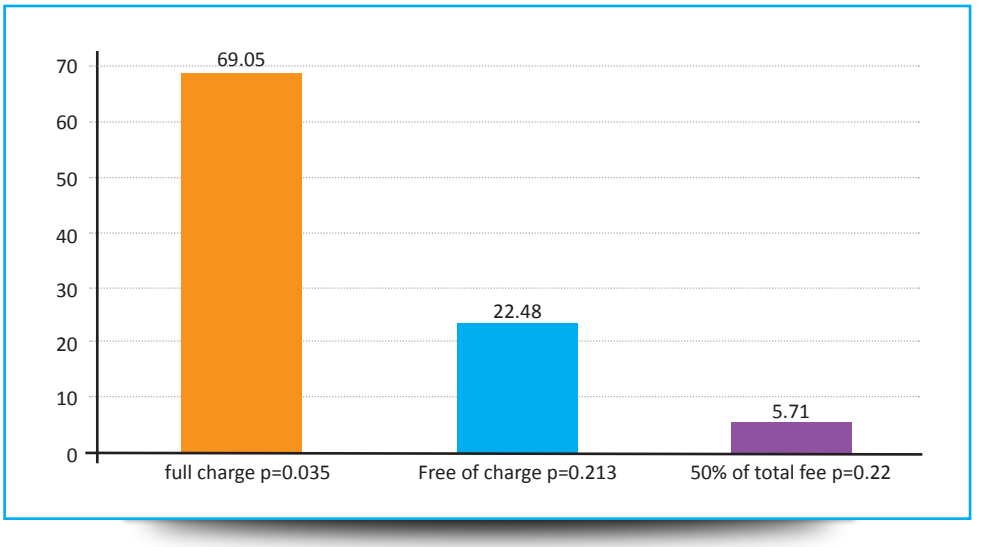
Figure 5: Percentage of Household Recommend to others for Using Health Care Services



4.4. Exemption Fee for Using Health Care Services

Figure 6 shows that among respondents that have received health care services, there were 69.05% reported as having been charged the full price, 22.48% had received free of charge and 5.71% had received 50% charge of total fee of using health care services.

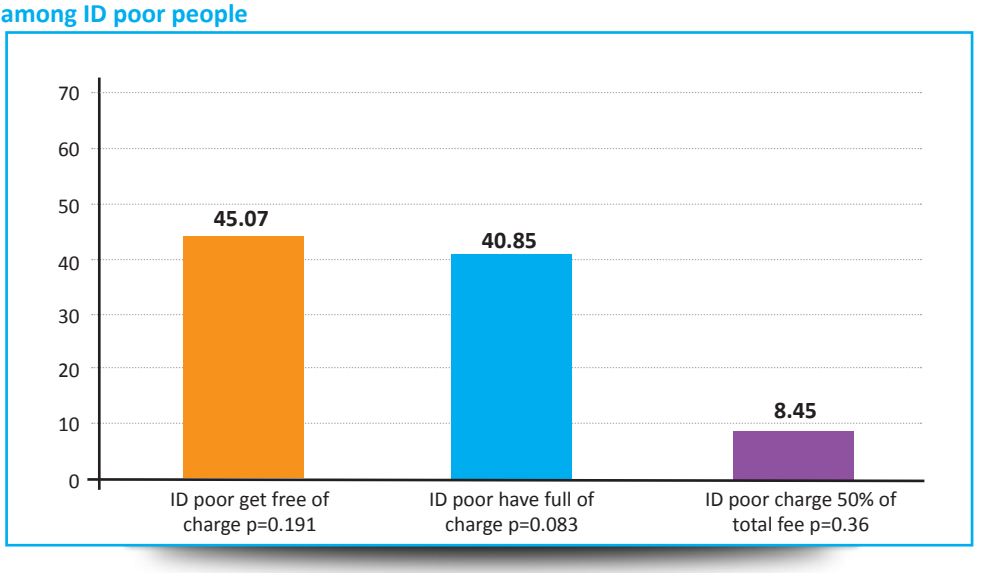
Figure 6: Percentage of Household Receive Exemption Fee for Using Health Care Services



4.5. Exemption Fee for Using Health Care Services among ID poor people

Figure 7 shows that among ID poor respondents who have received health care services at Health Centers, 45.07% had received free of charge, 40.85% had full charge and 8.45% had received 50% charge of total fee of issuing health care services

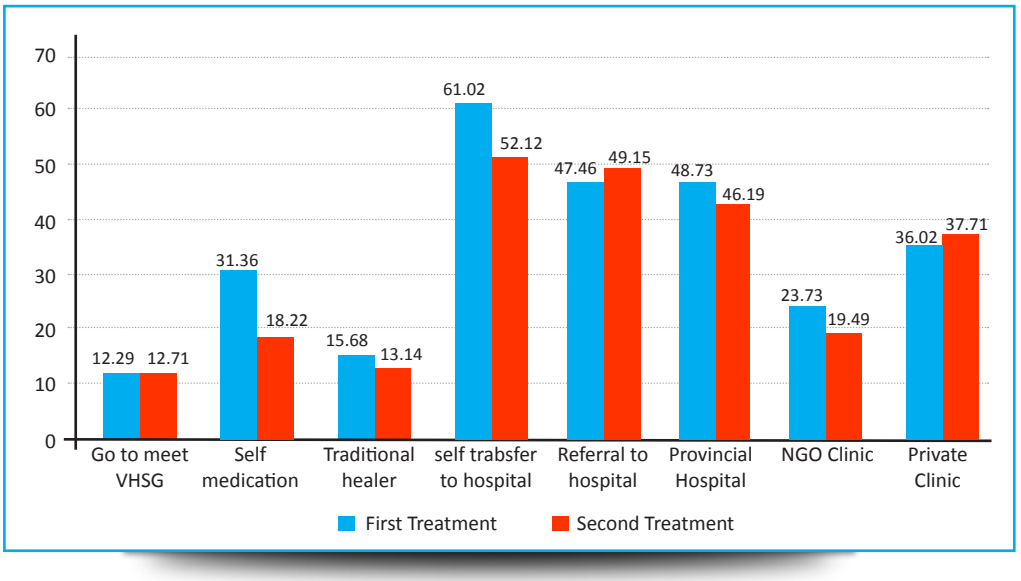
Figure 7: Percentage of Household Receive Exemption Fee for Using Health Care Services among ID poor people



5. Health care seeking behaviours of community

Figure 8 shows the health care seeking behaviors of households with the majority 61.02% having self-transferred to a health center for the first treatment which then increased to 52.12% for the second treatment. Of these, 47.46% were referred to hospital and it slightly increased to 49.15% for second treatment. Lastly 48.73% used provincial hospital for the first treatment and it was slightly decreased to 46.19% for the second treatment. Among those 23.73% as having reported to used NGOs Clinics for the first treatment, with 19.49% reported had use at second treatment. Among 12.29% have gone to meet VHSG before going to use public health facility for the first treatment and 12.71% used VHSG at the second treatment, Out of households reported as having used public health facilities services, 36.02% reported were private clinic or community based private health care providers at first treatment and 37.71% were used at second treatment. However, of the respondents reported 31.36% used self-medication for the first treatment and 18.22% used self-medication for the second treatment. Around 15.68% used traditional healers for first treatment and 13.14% were used traditional healers again at second treatment.

Figure8: Percentage of respondents seeking health care services when their families have serious illness



DISICUSSION

Figure 8 shows the health care seeking behaviors of households with the majority 61.02% The percentage of households had heard information on referral service programs were low (30%) this may limit awareness to whole household in villages. However, compared to households who have ID poor card have had significant increase to 53%,. This may be as the program has more of a focus on awareness for ID poor card households in comparison to normal households. More than 90 % of Households reported as having met and received information from VHSGs. The majority of house hold use health center services are immunization (78.10%), and antenatal care (75.71%). This may be the case as the health centers have a good immunization coverage program, HC based or outreach program. Households have made significant use of health care services provided by health centers, but there are still around 40 % of reported health care providers that have not been sensitive with patients. The root cause is that irregularly paid salaries force staff to seek alternative sources of income for their survival (Soeters et al 2003). Therefore, health providers have lack motivation from health care services system due to their lack of salaries. They also are responsible for many tasks which often creates an overload due to lack of human resources.

LIMITATION

- This survey cannot be generalized to the whole of 5 provinces (Kandal, Svay Rieng, Kampong Thom, Kampong Cham) nor can it be representative for Cambodia
- This survey did not calculate income classification at are presented to individual level, it was represented as household level, therefore it may be not representative of poverty indications
- The data was originally collected for descriptive purposes, not for analytic or hypothesis testing purposes
- There may have some problems with recall bias of household visits and using referral and health services, income and spending on health care services
- The natures of the survey as a cross sectional survey tend to be subject to temporal ambiguity (chicken and egg)

CONCLUSION

The percentage of awareness of information of referral services program support in village still remains low among general households, but were higher among household have ID Poor Card. Health Centers services providers were significant satisfactory as reported by general households especially households have ID poor. Households have significantly recommended and referred their neighbors to provincial hospital or other public hospitals Exemption fee of using health services among ID poor people were low and need to be improved. Health seeking behavior of households for the first treatment and second treatment were predominantly by self-referral to health center, referral to public hospital and provincial hospital. However, the percentage household using self-medication, traditional healing and home based health care services, or private facility should considered and taken into account.

RECOMMENDATION

- Based on findings, there is a need to increase awareness by NGOs, VHSGs and local authority to communities on referral support programs to general households, especially ID Poor's household.
- Ministry of Planning should routinely conduct a re-classification for poor people and produced and issue ID poor card to poor people as soon as possible after reclassification.
- NGOs, HC staff and VHSGs should increase awareness of health facility services to the community as much as possible
- Rapid health facility assessment to identify gaps, strengths and weakness of health care services within NGOs target areas need to be conducted
- Some health facilities need to increase times and days of workings hours, and include Saturday and Sunday

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ANNEX 1: SURVEY QUESTIONNAIRE

Questionnaire

Code of interviewee		First date of visit :	
Cluster code		Second date of visit :	
Interviewee's address			
Name of village			
Name of Commune			
Name of District			
Name of OD			
Name of Province			
Name of interviewer:		Signature	
Starting time		Ending time	
Name of Supervisor		Signature	
Starting time		Ending time	

We are committed to improving our services in this program. To help us do this, we survey customers about the services they receive in our program. You do not have to fill out this survey. If you choose to complete it the information you provide cannot be associated with you because we will never ask for your name. THANK YOU for your participation.

I. Socio Demographic Characteristics

1. How long have you been in this village (If they stay in this village less that 6 months will be excluded?) ……..

2. Age:_____

3. Gender:

a. Male 1
b. Female 2
c. Other (Please specified): ……..

4. Household headed

a. Male 1
b. Female 2

5. How many member in your family……..

6. Educational Background

a. University 1
b. High School 2
c. Junior High School 3
d. Elementary School 4
e. Never go to school 5
f. Others (Specified): ……

7. What is your occupation?

a. Farmer 1
b. Factory workers 2
c. Construction worker 3
d. Small Business Owner 4
e. Teacher 5
f. NGO worker 6
g. Government Officer 7
h. Other (Specified): ……..

8. How much could you earn for a month? ……..USD

9. Has your family had ID poor Card?

a. Yes 1
b. No 0

II. Used of Referral Services

10. Have you or member of your family heard about supporting transportation fee of program to health services in your village?

Yes 1 No 0

11. If yes from whom

a. VHSG/VHV
b. Village leader
c. HC staff
d. Neighbor
e. Other……..

12. Have you or member of your family received support transportation fee to health care services

Yes 1 No 0

13. How many times have you and your family member used referral services in the past one year? ……time/s

14. Please indicate your agreement with each of the following statements by tick the number that best represents your opinion. Please answer all questions. If the question asks about something you have not experienced circle number 0, indicating "N/A", Not Applicable. Thank You.

		Strongly Agree (5)	Agree (4)	Fairly Agree (3)	Disagree (2)	Strongly Disagree (1)	N/A (0)
14.1	I am satisfied with the quality of referral I've received in this program.						
14.2	I am satisfied with information provided by VHSG						

15. How would you change this referral services to better meet your needs?

……

……

……

……

16. Is there anything else you would like us to know?

……

……

……

……

III. Community level mechanisms

17. Has your village have VHSG?

a. Yes 1

b. No 0

18. Who are they (Please specify their names)?

a. ……..

b. ……..

19. Have you ever met VHSG in your village?

a. Yes 1

b. No 0

20. Have you ever received any message related to accessing health care services?

a. Yes 1

b. No 0

21. What kind of messages have you received from VHSG?

……..

……

……..

……

……..

IV. Utilization of health care services

22. What types of services have you or member of your family received at health care facility?

	Yes	No
a. Never go to any health care facility	1	0
b. Outpatient	1	0
c. Immunization for children	1	0
d. Antenatal Care	1	0
e. Post-partum care	1	0
f. Family Planning	1	0
g. Delivery	1	0
h. Others (Specified): ……		

23. What do you do when you or member of your family got serious illness?

	Yes	No
a. Never got any serious illness	1	0
b. Go to meet VHSG to get transportation support	1	0
c. Self-medication	1	0
d. Traditional healer	1	0
e. Self-refer to Health Center	1	0
f. Referral Hospital	1	0
g. Provincial Hospital	1	0
h. NGO Clinic	1	0
i. Private Clinic	1	0

j. Other (Please Specified): .....

24. What do you do, if you or member of your family does not get better after the first treatment?

	Yes	No
a. Never have this experience	1	0
b. Go get transportation support from VHSG	1	0
c. Self-medication	1	0
d. Traditional healer	1	0
e. Self-refer to Health Center	1	0
f. Referral Hospital	1	0
g. Provincial Hospital	1	0
h. NGO Clinic	1	0
i. Private Clinic	1	0

j. Other (Please Specified): .....

25. Please indicate your agreement with each of the following statements by tick the number that best represents your opinion. Please answer all questions. If the question asks about something you have not experienced circle number 0, indicating "N/A", Not Applicable. Thank You.

		Strongly Agree (5)	Agree (4)	Fairly Agree (3)	Disagree (2)	Strongly Disagree (1)	N/A (0)
28.1	I am satisfied with the quality of services I've received in this health care facility.						
28.2	I was able to get the services I thought I needed.						
28.3	The staff showed sensitivity to me						
28.4	The staff treated me with respect and dignity.						
28.5	The staff had paid attention to me.						
28.6	The resources/information provided to me by this health care facility was helpful/ useful.						
28.7	The services I've received in this health care facility have helped me to deal more effectively with my problem(s)						

26. How far from your house to that health care service is? ……

27. How much do you get paid for that transportation?

a. Not Receive 00

b. Yes: ……..

28. This transportation supported by:

a. Never paid 00

b. My own money 1

c. HC 0

d. Other (Specified): ……..

29. In average, how long did you spend to get your treatment at the health care facility? recode number in minute ……..mn

30. Have you been provided adequate drug according to your treatment?

a. Yes 1

b. Not adequate 0

31. What two things do you like the most about the health care services you received?

a ……..

b ……..

32. What two things do you like the least about the health care services you received?

a ……..

b ……..

33. How much do you spend on health per year? ……Riels

34. Have you and your family experience not seen any health care provider or health facility closed when you arrived at Health facility 1 0

If not meet health care provider why

……
……
……
……

35. Where will you recommend to others to access the following health care services:

	Yes	No
a. Go get transportation support from VHSG	1	0
b. Self-medication	1	0
c. Traditional healer	1	0
d. Self-refer to Health Center	1	0
e. Referral Hospital	1	0
f. Provincial Hospital	1	0
g. NGO Clinic	1	0
h. Private Clinic	1	0

i. Other (Please Specified): ……..

36. Why do you recommend them to the services you mention above?

……

……

……

……

……

37. Suggestions to improve referral and health care services

……

……

……

……

38. Is there any exemption scheme for you or member of your family on using health services

a. Free of charge	1	0
b. 50% of total fee	1	0
c. full charge	1	0
d. Do not know	1	0
e. Other……		

ANNEX 2: SURVEY TEAM

No	Name	Position	NGO	Tel
1	Cheav Samphy	Research Coordinator	HACC	012 619 765
2	Khun Rathana	Data Collection Coordinator	HACC	017 559 566
3	Pov Hongmeng	Data collection, data entry and cleaning Coordinator	HACC	081 205 868
4	Sok Ratanak	Interviewer	PKKO	097 24 60 683
5	Un Kap	Interviewer	PKKO	012 911 248
6	Kap Pech	Interviewer	PKKO	097 66 11 328
7	But Pao	Interviewer	PKKO	097 55 95 824
8	Boeurt Pet	Interviewer	REDA	017 535 865
9	Sam Tum	Interviewer	REDA	011 667 453
10	Y Sokkea	Interviewer	MODE	012 632 187
11	Sung Sokunthea	Interviewer	MODE	092 733 699
12	Krech Leang	Interviewer	MODE	092 626 607
13	Seng Sophearith	Interviewer	NAS	092 642 646
14	Oun Kosal	Interviewer	NAS	088 798 5879
15	Seng Sophois	Interviewer	NAS	077 877043

ANNEX 3: CLUSTER NAME AND NUMBER OF RESPONDENTS

លរ	ឈ្មោះអង្គការ	ភូមិ	ឃុំ	ស្រុក	ចំនួនប្រជាជន	Accummulate	Random	Cluster	Code For Participants
1	REDA	សណ្តោត	អង្គតាសូ	ស្វាយជ្រំ	៧៦៥	៧៦៥	៨៨០១	១	Q001-Q016
2		អូរសំដី	ពោធិរាជ	ស្វាយជ្រំ	៦០៣	១៣៦៧	២៨៣៦៦	២	Q017-Q032
3		ល្វា	គ្រួស	ស្វាយជ្រំ	៦៦៣	៦៦៣	៥១៩៣២	៣	Q033-Q048
4		តាកោរ	ស្វាយយា	ស្វាយជ្រំ	៩៩៥៩	១៩១៣	៧៥៩៥៧	៤	Q049-Q064
5		តាស្នាង	ចំលង	ស្វាយជ្រំ	២៩៨៩	៤១០២	៩៩០៦២	៥	Q065-Q080
6	MODE	កំរ៉ែង	ស្រយូវ	ស្ទឹងសែន	៨៣៣	៤៩៣៥	១២២៦២៧	៦	Q081-Q096
7		ចុងដា	ភ្លាំងក្រពើ	សន្លឹក	៩៩៩៩	៦១៣៤	១៨៦១៩៣	៧	Q097-Q112
8		ត្រាំខ្លា	ក្បែង	កំពង់ស្វាយ	៩១៨	៧០៥២	១៦៩៧៥៨	៨	Q113-Q128
9	NAS	ប៊ឹងជ្រោយ	សូទិព្វ	ស្រុកជើងព្រៃ	2132	៩១៨៤	១៩៣៣២៣	៩	Q129-Q144
10		ឈូក	គោករវៀង	ស្រុកជើងព្រៃ	870	១០០៥៤	២១៦៨៨៨	១០	Q145-Q160
11		កំប៉ាល់	សណ្តែក	បាធាយ	1896	៨៩៤៨	២៤០៤៥៤	១១	Q161-Q176
12	PKKO	រានថ្ម	សៀមរាប	កណ្តាលស្ទឹង	310	៩២៥៨	២៦៤០១៩	១២	Q177-Q192
13		វត្តអង្គ	ដើងគើប	កណ្តាលស្ទឹង	1058	១០៣១៦	២៨៧៥៨៤	១៣	Q193-Q208
14		ស្រែគោក	ជាតួ	កណ្តាលស្ទឹង	597	១០៩១៣	៣១១១៥០	១៤	Q209-Q224
15		ត្រពាំងចេក	ថ្នឹ	កណ្តាលស្ទឹង	584	១១៤៥៧	៣៣៨៧១៥	១៥	Q225-Q240

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