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PROVINCIAL STUDY FACT SHEET
POPULATION HEALTH STUDY
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Longitudinal Study of Population Health in Three Vietnamese Provinces
Prepared by the Social Science Research Council
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Overview and Purposes

The Social Science Research Council and the Vietnam Academy of Social Sciences (VASS) designed and implemented a multidiscipinary, longitudinal population health study (the Study) in three provinces in Vietnam.[1]

The goal of the study is to provide high quality, credible evidence to The Atlantic Philanthropies, the Ministry of Health, provincial, district and local health officials, potential donors, and other stakeholders in Vietnam's health system, around two key sets of questions:

1. How well is the provincial model developed and funded (or inspired) by Atlantic working? Answers to this question will help planners and implementers gain insight into how it might be improved, sustained, replicated and expanded across different parts of the provinces, country and populations.

2. To what extent has the model strengthened provincial health care and prevention work through improving access, increasing the range of services, improving staff capacity, quality of facilities, health seeking behaviors and quality of care? The Study measures change over time in people's health care access, health-related knowledge, utilization of commune health center services, satisfaction with those services and overall health status, especially among the most disadvantaged and vulnerable populations.

Achieving this goal is done through a research design that captures information <u>at four points in time</u>: an early stage **baseline** in 2008-09 (Round 1 or R1), as the model was first put in place; a set of in-depth **case studies** in 2011; a **second full round** of data collection five years after the first round, in 2013-14 (Round 2 or R2); and supplemental data collection in 2016-17.[2] The second round of data and analyses will be compared with those of the baseline study.

Research Sites
<u>Thai Nguyen, Khanh Hoa and Vinh Long</u> provinces were chosen to capture regional variation among the Northeast, South Central Coast and Mekong Delta regions and to reflect realities in the three provinces in which Atlantic provided support. Two districts were chosen in each province, for a total of six districts. Two communes from within each district were chosen, for a total of 12 communes. The choices of districts and communes were made via stratified random sampling. Case study fieldwork was carried out in 2011 in two surveyed communes in Khanh Hoa Province and in all 12 surveyed communes of the three provinces in 2013-14.

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[1] The Study was funded by The Atlantic Philanthropies, a limited life foundation (Atlantic), as part of its effort to "develop nationally replicable provincial and community models through interventions at several levels in selected provinces." The long-term goals of Atlantic support are to improve health seeking behavior, access to care, community outreach, quality of care, provincial health management system and operational sustainability.
[2] Ideally, the Study would be replicated every five years or so in order to measure change over time as the system matures, expands and changes.

Research Instruments and Sample Size

The study combines qualitative methods (in-depth interviews and observations) with quantitative methods (household survey, client-exit survey, and CHC and alternative provider facility survey) and links a population based, household survey (demand side) and a clinic and facility based (supply side) study.

- **Household Survey Questionnaires:**

  R1: 300 households (HHs) were randomly chosen in each study commune, for 1,200 per province and 3,600 in the total survey.

  R2: About 83% of same households from R1 were resurveyed as well as HHs that split from them. HHs that moved out of the commune were replaced with new HHs. Total of 3,921 HHs for all three provinces, in which 2,144 were also interviewed about maternal and child health.

- **In-depth Interviews (IDIs):**

  R1: 10% (120) of the selected households in each province were chosen for semi-structured in-depth interviews for 360 in total.

  R2: The same households were re-interviewed in 2013-14 along with some new HHs. Total of 554 IDIs.

- **Facility Based Surveys:**

  R1: 12 CHCs in the surveyed sites and 36 alternative providers were surveyed, including district hospitals, private western and traditional medicine providers, and drug stores.

  R2: 12 CHCs in the surveyed sites and 42 alternative providers were surveyed.

- **Client Exit Interviews**:

  R1: 720 individuals who had used the CHC or an alternative provider were interviewed immediately after they visited the health care facility.

  R2: 1,055 client interviews were conducted.

Purposes of Case Studies

First, in order to provide early feedback to Atlantic and Vietnam's health policy makers about what seems to be working and where there may be issues, SSRC designed two case studies in 2011, between the baseline and restudy. Using the case study method we are able to take an in-depth look at two of the communes in the original study and observe and record short-term change. In 2013-14 we did case studies for all 12 surveyed communes. The case studies offer insights into the extent to which the model Atlantic is putting in place is effective, which components may be more or less effective, how interventions might be fine-tuned to improve functioning in place and as they are replicated and additional interventions that might be useful. However, case studies will not, for example, show whether there are improvements in health indicators. This will be analyzed using both the baseline and restudy data.

Second, case studies enable us to ask "why" questions about realities and behaviors we noticed through the baseline study and gain a richer picture of on the ground realities. This knowledge has improved our restudy by helping us to rethink some aspects of our questionnaires and interview guides to conform more to realities on the ground and the perspectives of those seeking health care.

Key Issues Studied in the Case Studies and Framework for Comparing R1 and R2 Survey Data

The case studies examine change between 2008 and 2011 for two communes and change between 2008-09 and 2013-14 for all 12 communes related to four issues:

- How the new and upgraded CHCs are functioning several years after being put in place. We wanted to watch change at the CHCs as the interventions in infrastructure and services took hold, and to gain a rich sense of what is going well and less well. We hoped to see whether individual CHCs were proving to be better models and why.
- The duration and fade effect of Atlantic supported interventions. Even though three or five years is not much time in which to see change, we hoped the case studies could help discover whether some components of the interventions became stronger with time (duration) while others grew weaker or were abandoned altogether (fade) and to learn about what seems to make an intervention fade or stick.
- The replicability of the model and its components. We wanted to provide evidence to help decision making about whether and how to go to scale. Given limited resources, sometimes replication cannot be comprehensive. It will be useful for the government to know which components seem most effective and which aspects of an intervention seem core or peripheral to success. Cases may also help us to learn whether dissemination of the model is occurring with a higher or lower level of fidelity and with what effect.
- Changes in knowledge, health seeking behaviors and health practices with emphasis on the most disadvantaged and vulnerable clients, and to what these changes might be attributed. We wanted the cases to probe factors the baseline showed us were important to increasing utilization, such as health seeking behaviors, increased knowledge, and levels of satisfaction, as change occurs over time.

The case studies also include a mapping of providers, re-interviews of some households in the baseline study, a week of observations at the CHCs and a few days with alternative providers, exit interviews, collection of health information and other agency data, and interviews with CHC staff, Village Health Workers, Village Heads, health officials and other stakeholders. This information on short-term change is intended to assist in the scaling up and replication of the Atlantic supported provincial model.

Special Characteristics and Value of Baseline Study, Restudy and Case Studies

The Study was designed both to provide the strategic information that Atlantic and stakeholders need and to ensure its usage and impact. It did so by embodying characteristics that are not generally commonplace in data that has been previously collected in Vietnam. For example, the Study:

1. Uses rigorous, international standard, social science methods. Quality and reliability of the evidence is critical if Vietnamese decision makers and advocates are to take it seriously and base action on it.
2. Examines the issues from multiple perspectives through a variety of quantitative and qualitative research methods. It is designed to give an overview through the survey and to add depth, detail and the perspectives of users, providers and nonusers through related qualitative instruments.
3. Enables us to look at realities at the village and commune levels. Indeed, it samples more than one-third of the households in some of the communes surveyed. This is unique in Vietnam.
4. Shows how the interventions that make up Atlantic's provincial and community models are working and, ultimately, whether or not people's health status is improving. The overall study enables comparison between treated and non-treated communes across districts and provinces. It also allows comparisons by age, gender, ethnicity and socioeconomic group.
5. Is comparative with other Vietnamese datasets such as the Vietnam Living Standard Survey, the Vietnam National Health Survey, and the Viet Nam's Multiple Indicator Cluster Survey.[3]

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[3] This is done through using some similar questions.

High Quality Evidence on Issues of Interest to Health System Decision Makers

The Study data provides an excellent baseline for describing and analyzing the current situation with respect to health and the health system, as well as examining change over time, as the provincial health model expands and takes hold. For example, the Study provides insights into answers to questions of current interest to policy decision making, such as:

- Who are the CHCs currently serving and who do they need to serve but are not currently serving well? For example, mothers who give birth at home and others outside the system
- Is the quality of prenatal checkups meeting MOH and WHO standards?
- What are, and should be, the roles of CHCs and private providers, from the standpoint of users?
- How can the health care system better draw people into the new improved facilities? What are the best ways to spread knowledge of improved services and user satisfaction?
- How important are health information campaigns in changing perceptions and behaviors?
- What are the unintended negative consequences of improved health insurance coverage?
- How well are the health needs of the elderly being served?

The Study enables us to examine such issues as:

Health Status
- The health status of the populations at these research sites can be determined at baseline through our data on birth weight, maternal and infant health indicators, morbidity and mortality and lifestyle determinants of health including sanitation, helmet use, alcohol and tobacco use and socioeconomic information.

Infrastructure and Services
- What is a CHC's physical and human resources infrastructure like? What is the quality of services, the quantity of users, the quantity of staff, and the satisfaction levels of users and providers? What are the range of services available and the choice of providers, in a specific community? While there is little variation on some dimensions (e.g. all CHCs have electricity and provide immunization for children) there is quite a bit of variation across sites along dimensions such as funding, services provided and facilities.
- How are the CHCs doing in carrying out their main functions of communication and education, prevention, treatment, population and family planning, maternal and child care, immunization, provision of drugs and community action with respect to health issues?

Obstacles and Enablers to Access and Equity in Health Services Delivery
- What types of services are available, acceptable, affordable, appropriate, useful and efficacious? What are the most important barriers and facilitators to access and quality? How are the disadvantaged being served by the system today? When does access differ and why? The Study data lets us examine both supply and demand.
- Obstacles exist within the health services such as deficiencies in: equipment and infrastructure, access to essential drugs, the knowledge, abilities and attitudes of human resources, the insurance program, the health information system, resource allocation and spending and working conditions and professional prospects for health care workers. For example, a quick review of the facilities surveys shows that no CHC has all the basic equipment, chemicals, supplies and medicine covered by health insurance, in stock.
- Obstacles to better health also exist outside the health system itsef such as poverty, health illiteracy, water and sanitation problems, gender inequality, exclusion, stigma and discrimination.
- Health insurance is a key enabler of access and equity. Who has it and why or why not? Do those who need it have it? Why, when and how is it used or not used? How does it influence decision making and health seeking behavior? What out of pocket difference in expense are there for those with and without insurance?

Decision Making and Health Practices
- How are health decisions made? On what basis? What is the health seeking behavior among different groups on different health issues? How might it be changed if needed? The stories told in the in-depth interviews about illness episodes, decision making and health seeking are valuable as illustrations of the more quantitative data but some will be worth describing as vignettes of real people, with real problems, seeking real solutions who are either being served well by their system or not. These stories illustrate what is working and what is not, at baseline.

Knowledge and Behavior
- What is the basic knowledge level of the population with respect to a range of health issues and health services? How does that knowledge differ by age, gender, ethnicity and socioeconomic status? How is that knowledge improved, or worsened, by interaction with available health providers? How does knowledge impact practice?

Mothers and Children
- What are women's health knowledge and practices with regard to antenatal care, birth delivery, postpartum, postnatal and newborn care?