



PRACTICAL GUIDE TO SATISFACTION SURVEYS



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TO SATISFACTION SURVEYS**

MÉDECINS DU MONDE

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It has become very important in the healthcare sector in recent years to take account of patients' opinions when evaluating the quality of care.¹ Healthcare institutions around the world have adopted this approach to provide an indicator of care quality (Cheikh Diop, 2013).

The socio-anthropological surveys conducted by Médecins du Monde show that, of the various determining factors around access to care, the quality of the interaction between users and care providers, confidentiality within this relationship, the possibility for discussion, and the reception provided within the healthcare facility are decisive in the patient's choice to embark upon a therapeutic journey. Trust in the clinical relationship also increases compliance with and adherence to treatment and preventive behaviours (Hall, Zheng, *et al.* 2002).

MdM's new Mission Statement reaffirms and clarifies the organisation's fundamental values (provide healthcare; bear witness and advocate; support communities seeking social change) and places users at the centre of its projects.² This means that user representatives are involved in implementing activities—encouraging greater social acceptance—and their views are included in the design of the operational strategies for our projects throughout the project cycle, as prescribed by the Ottawa Charter. In line with this approach, MdM provides several tools to ensure accountability and responsibility,³ including conducting satisfaction surveys among project users.

1. "Giving people a voice to (...) objectify their care experiences is an essential step in understanding how the care system works." Mohamed Mebtoul, anthropologist. Mebtoul believes that "patients must not be seen reductively as mere consumers of care, but rather as key social actors who cannot be ignored in the care process."

2. See MdM's Mission Statement (2015).

3. See the 2015 toolbox accompanying the Healthcare Project Planning Guide, Médecins du Monde intranet link: <https://mdmi.sharepoint.com/directions/dsp/SitePages/Guides.aspx>.

☐ WHY CONDUCT A SATISFACTION SURVEY?

Assessing user satisfaction helps to ensure that projects meet users' needs and expectations as efficiently and transparently as possible, both in long-term development projects and in emergency projects. It makes it possible to improve users' acceptance of services and to respond to their comments on quality (reception, listening, respect, time spent, care, etc.). By including users in the decision-making process, they become actively involved in the evolution and sustainability of projects (IFRC, 2014).

Measuring user satisfaction is integrated into the cross-cutting indicators and objectives of the French and International Operations Directorates, and is required by an increasing number of donors. It should eventually be built into all MdM projects and should be planned as soon as a proposal is developed.

In this guide, we present a mixed-method survey methodology to provide information about expectations and satisfaction and dissatisfaction factors as perceived by the target population in relation to activities such as prevention strategies (communication channels, messages communicated, teaching materials used, languages and actors, etc.); screening strategies (physical setting, confidentiality, waiting time for results, counselling, etc.); and care strategies (reception, confidentiality, empathy, quality of medicines, provision free-of-charge, availability of qualified personnel), etc. These are descriptive studies, the objective of which is to provide the project with basic information on how satisfied the target population is with regard to current strategies and to provide information on their expectations in terms of service quality (what makes a good service).

PRELIMINARY NOTE

Distinction between satisfaction and quality: Assessing satisfaction is not the same as assessing the quality of a project (effectiveness of medical treatment, for example); these are two different evaluations. However, it should be borne in mind that the two dimensions are linked. The patient's condition at the end of a treatment influences their perception of the project and, in the same way, the quality of the project influences the medical treatment (lost to follow-up). Users' dissatisfaction with a project should not be confused with poor project quality (WHO 2000).

An assessment of expectations in terms of intervention quality requires detailed knowledge of the factors that influence individual satisfaction. On this topic, the literature mentions two main areas that are essential to understanding this concept and that make it pos-

sible to adequately evaluate the satisfaction of the group surveyed. These are the individual variables specific to the characteristics of users and their expectations, that is **the determinants of satisfaction**, and the variables directly related to services and care, that is **the components of satisfaction** (Hudak *et al.*, 2000; Sitzia *et al.*, 1997). The **multidimensional nature of patient satisfaction with regard to healthcare** is thus associated with various criteria: the technical competence of doctors, interpersonal aspects and communication between caregivers and patients, the accessibility and continuity of medical and non-medical care, the consideration of family members, and the financial implications of care (Amazian *et al.* 2013).

Satisfaction criteria can be organised into a reference model that includes the organisational, interpersonal and professional dimensions of services (Côté and McNeil, 1995). The organisational part relates to the organisation of the service. The professional part relates to the provision of services and refers to expertise. The interpersonal part refers to the relationship with the patient and the humanisation of care. These three dimensions are considered essential for a process of continuous improvement in service quality and user satisfaction.

This guide provides general directions for developing a satisfaction survey. It covers planning a satisfaction survey and presents the different survey stages. While it focuses on conducting satisfaction surveys in healthcare facilities, it can also be applied to other types of services.

The approach presented in this guide for assessing user satisfaction proposes a mixed methodology:

- **The qualitative methodology**, based on the triangulation of observation methods, individual interviews and focus groups,⁴ will produce a detailed analysis of the drivers of satisfaction or dissatisfaction. This helps in developing a satisfaction grid specific to the project, based on criteria defined by the users themselves, and in modifying projects to best meet users' needs.
- **The quantitative methodology**, based here on the use of a questionnaire (and/or self-report questionnaire), will enable a quantified measure of satisfaction to be obtained (in the form of a standardised score) and thus allow comparisons to be made between projects and over time (for trend monitoring).

The surveys can be repeated over time to facilitate comparisons and can also allow quantitative indicators to be added to the project monitoring system (monitool).

☰ MIXED METHODOLOGY SURVEY: OBJECTIVES OF THE SATISFACTION SURVEY

The main objective of a survey may be to assess satisfaction with the project as a whole or with a particular component or service. It may focus on all users of the services or on a certain category of users. It may also focus on the level of satisfaction before and after implementation of an intervention or a new service.



For example, a satisfaction survey might be conducted to gauge the satisfaction and expectations of young people aged 10-24 in relation to HIV prevention, testing and care and treatment services in Goma and Kinshasa. More specifically:

- The first stage is the collection of users' views and expectations of activities, such as prevention, screening and care and treatment activities (the service's physical, interpersonal and professional framework, including the quality of interactions with clinical and community providers (confidentiality, waiting time, confidence level, etc.)) as well as their views on the validity of prevention messages (credibility, feasibility of advice and messages, etc.) The information which is collected initially plays what can be described as an exploratory role, as it will be used to design the planned questionnaire, enabling the definition of the satisfaction criteria which will be measured during a second stage: what is a good service, a good message, etc. In addition, the data collected during this pre-survey will make it possible to use the vocabulary and expressions of the people surveyed, to get as close as possible to their linguistic universe and to detect possible misunderstandings of ambiguous terms.
- Measurement of user satisfaction with the services based on the criteria defined qualitatively during the first stage of the survey.



METHODO- LOGY

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This section deals with the different aspects of the methodology: the type of study and the choice of facilities and respondents.

The survey protocol should use mixed methods, i.e. both qualitative and quantitative techniques. The qualitative survey will precede the quantitative survey, which will build on the results of the first qualitative stage. In fact, the qualitative survey is the first stage of the satisfaction survey and is only conducted among a small part of the target population. It is expected that the qualitative data collection techniques used in socio-anthropological studies (literature review, interviews and focus groups) will enable the satisfaction criteria to be defined and qualified, and these will then be measured by the questionnaire. In addition, the observations made and the interviews carried out with the target population will help identify a method of conducting the questionnaire that best suits the local situation (appropriate times, places, etc.). The quantitative survey, which is the second stage of the satisfaction survey, is expanded from a larger sample to the entire population targeted by the MdM project.

☐ TYPE OF SURVEY

The proposed methodology has been designed using a mixed approach that incorporates various techniques.

- A. **Qualitative methodology**, based on the triangulation of observation methods, individual interviews and focus groups, in order to:
 - Explore what users expect from services.
 - Identify the criteria for each component that determine satisfaction/dissatisfaction.
 - Collect the structural and content elements needed to draft the questionnaire.

Qualitative questionnaires can thus be a preliminary step towards producing quantitative questionnaires.

- B. **Quantitative methodology**, based on using a satisfaction questionnaire with a sample of the population targeted by the programme, to obtain a quantitative measure of general and specific aspects of satisfaction. The objective is to identify shortcomings and guide future programme activities with a view to continuing improvements to service quality.

- ! Following the collection of field data, an information feedback session with survey partners should be held to validate the preliminary results and provide clarifications. In the interests of accountability, and where possible, it may be useful to invite users and their representatives (patient associations) to this feedback session.

☐ SURVEY PERIOD

The qualitative method period: the qualitative study may take place over a week, in order to have time to interview enough people and to make observations at the sites studied. The locations for the individual interviews can be chosen by the interviewees; they need a quiet place where they can speak freely. Focus groups take place in familiar and informal places (not health centres, for example), where people feel safe and comfortable. Users can suggest suitable locations.

The quantitative method period: the study may take place over one or more full or half-days. The survey period is ideally 7 to 15 working days, if possible **consecutive days**, in order to be representative of the project activity. If the days are not consecutive, the survey should be limited to a maximum period of four weeks, and care must be taken to spread the days so that user satisfaction with all the services offered by the project can be evaluated. For example, if specialist consultations

or activities take place on a specific day of the week, it is important to include them in the survey period.

A few days' margin should always be allowed in case of unforeseen circumstances. If there is only one facility in the study and it has a low volume of consultations, the survey may take place over a longer period of time in order to reach the number of people to be interviewed. In all circumstances, the maximum period should be four weeks. This quantitative part of the satisfaction survey should be carried out at the location where the service is provided by the project, in consultation with all stakeholders.

The satisfaction survey can be carried out at different times during the project and can be repeated over time to show trends. If the survey is repeated over time, it will not be necessary to repeat the qualitative survey, since the criteria will already have been defined by the users. Only quantitative questionnaires will be repeated at different stages of the project.

☐☐☐ CHOICE OF SURVEY AREAS

For the qualitative method: the criteria for selecting the areas to be surveyed are linked to the facilities involved in the programme and the rates and characteristics of prevalence (high or low), the phenomena associated with the issue (urban or rural), the presence of various stakeholders (community stakeholders, organisations, NGOs, etc.) and the characteristics of the service (type of activity, attendance rate, etc.).

It is, of course, necessary to inform the local health authorities and those in charge of the health facilities involved in the forthcoming survey and to share the terms of reference.

For the quantitative method: the survey is carried out at the project facilities and this is where the questionnaires are conducted. If the project is at a single site, this will be the only place where the survey will take place. If the project includes several sites, ideally the survey will be conducted at all the sites.

If this is impossible because there are too many sites, it will be necessary to select just some of them—those where it is particularly important to know about user satisfaction because of specific characteristics (particular services, frequency of attendance or accessibility, etc.). **Nevertheless, the overall satisfaction calculated by a survey conducted at a selection of sites cannot be considered as representing the level of user satisfaction with the whole project, even if the sites are randomly selected.**

If the survey is conducted at more than one site, the collection of quantitative data should take place over the same duration and with the same sampling interval⁵ for all sites. Thus, the number of people interviewed per centre will be proportional to the number of people visiting the centre.

It is necessary to have one contact person per site or someone who travels to each site to ensure the distribution and collection of the questionnaires and any assistance which may be needed.⁶ The survey can be conducted simultaneously at all sites or consecutively, one site after another, but keeping within a total maximum period of four weeks to avoid any variability due to the data collection period.

☐ SURVEY POPULATION

The first thing to consider is the population concerned, i.e. the users of the healthcare system. There may be a focus on certain groups which are more vulnerable to discrimination, such as ethnic minorities, people living with HIV (PLHs), sex workers, etc. The interview grids will focus on describing and clarifying satisfaction criteria and expectations.

During the qualitative phase of the survey, visits to facilities may also be planned to meet different actors (public sector, NGO and community stakeholders) in order to involve them in defining the satisfaction criteria too. These visits / interviews will also enable an objective view to be taken of the service, in addition to the observations.

The quantitative survey targets service users benefiting from the programme on the basis of “low” attendance estimates. This also takes into account the fact that, in some cases, the facilities may not be used at certain times due to security risks.

⁵. The sampling interval is the standard distance between the selected elements (subjects) of the sample.

⁶. In certain contexts, where it may be difficult to reach users, consideration should be given to collecting questionnaires using other methods (mobile phones, social networks, etc.).

☐ SAMPLING

CHOICE OF SAMPLING METHOD

Qualitative methods

For the qualitative methods, convenience sampling is used, which consists of selecting those elements of the community which are considered most likely to provide the desired information.⁷

Quantitative methods :

These methods are used for projects with fewer than 150 users where they are all interviewed consecutively (in order of arrival during the survey period). A sampling method must then be put in place (see the MdM guide, *Data collection. Quantitative methods*).

Number of project users/per health facility	Number of people to be interviewed
< 150	Everyone during the survey period*
150 - 500	150
500 - 1 000	200
1 000 - 1 500	250
1 500 - 2 000	300
> 2 000	350

*At least 30 people must be interviewed in order for the satisfaction survey to be relevant. In the case of very low attendance rates, there is no point in conducting the questionnaire. In such circumstances, it will be necessary to focus on the qualitative element.

It should be noted that the sample size initially planned may vary depending on field conditions such as security constraints. Consideration should also be given to project resources (whether or not to hire a consultant/team to lead the survey, data collection, coding and analysis).

SIMPLE RANDOM SAMPLING

The sample can be selected using a random sampling technique among users attending the targeted facilities. Users can be intercept-


⁷ For qualitative methods (observation, interviews and focus groups), see the Médecins du Monde guide, *Data collection. Qualitative methods*.

ed at random in various ways: upon arrival at the centre (waiting room/reception), upon departure from the centre (reception, end of consultation), in between (beginning of consultation or between two interventions), at the beginning or end of a treatment, routine visit, scheduled consultation or drop-in consultation, etc. Other users may be intercepted in the vicinity of selected health centres. It is important to keep the same recruitment process throughout the investigation period.

This type of random sampling is preferable, as everyone in the target group has the same chance of being in the sample and the results obtained will be representative of the population studied. This minimises selection bias. For practical questions, we suggest that in the context of quantitative satisfaction surveys, systematic sampling is used, during which users of the centres are interviewed according to a sampling interval (e.g. one person for every five consultations, please see the section on 'Calculating the sampling interval' in the Appendices, page 40). If all sites are surveyed for the same length of time, the survey population should be representative of all project users. Other more or less complex random sampling methods exist and these may of course be used if you have the skills in the team and if the project is suitable. Examples include randomly selecting n participants from a list of N . This can be used in cases where the complete list of members of the population is available and contactable. Alternatively, a "random number table" can be used, which can be designed and adjusted as appropriate (example in the Appendices, page 42).

CLUSTER SAMPLING

Stratification can be implemented, especially in multi-centre projects and/or at centres with multiple activities. In these cases, the participating facilities must first be identified, and the total number of surveys needed must be spread across the facilities. This method will ensure that all project activities are represented.

 **Examples:** multiple health centres/facilities in the same project, gender-disaggregated activities, activities at health facilities vs. community-based activities. If someone wishes to participate spontaneously, even if this doesn't correspond to the survey interval, he or she must be included in the survey.

 **Practical examples of sampling**

MdM Lebanon: In order to avoid selection bias, one person for every six consultations will be interviewed every day of the week for a week at each centre.

MdM Madagascar: In order to avoid selection bias, one person for every three consultations within the SRH services will be interviewed at each of the 33 participating health centres, to obtain 10 respondents per centre.

- 💡 A poster may be displayed in the centre (in the reception area or waiting room) to raise awareness about the survey (see MdM's, *Health education guide*).

☐ DATA COLLECTION PROCESS

QUALITATIVE AND QUANTITATIVE RESEARCH INSTRUMENTS

A literature review must be carried out before the start of the field survey. National researchers must first be trained in the various data collection techniques used in the survey. The tools must be tested so that the researchers can make any necessary adjustments to the concepts, analytical framework and tools.

Tools for collecting qualitative data

Qualitative data are collected by means of various tools that seek to explore the definition of satisfaction from the inside. This consists of developing a grid of questions so that what is being measured can then be qualified.

A guide is available on the methodology for the three tools below (see MdM, *Qualitative data collection methods*).

The tools are:

- **Semi-directive individual interviews.** An interview guide is designed for interviews with the individuals targeted by the qualitative survey (users, general population, public sector stakeholders, NGOs and service providers (health centres)). Specific questions are developed for each category of stakeholder. A maximum of 10 individual interviews are conducted at this stage.
- **Focus groups.** Focus groups are run during the qualitative phase of the survey and the participants are the users involved in the activities. Focus groups should address the views and expectations of satisfaction for the different services offered. It may be useful to have several homogeneous groups (same sex, same age category, etc.) and then to have a general focus group in order to compare the different points of view and results and stimulate debate.

→ **Observations.** In situ observations, which consist above all of understanding the meaning that actors attribute to their practices (construction of meaning), are a technical cornerstone of data collection. Direct observations are made at healthcare facilities, community facilities and other places from the sample of facilities involved in the survey. Observation may focus in particular on the prevention tools used in the facilities visited, the awareness sessions conducted by the various stakeholders and the use of health services.

Data collected through these techniques are transcribed into a report and/or field journal and then analysed using content and behavioural analysis techniques.

Collection of quantitative data

The qualitative data will then be used to design a questionnaire (maximum duration 30 minutes). The questionnaire should be designed as a comprehensive tool for collecting data on the components of user satisfaction, covering various dimensions and variables. This will enable satisfaction to be measured periodically during subsequent stages of the programme.

The questionnaire must not include either the first or last name. Each questionnaire includes an anonymous number that allows the paper version to be retrieved in the event of a data entry error. This number must not identify the survey participant. A two-letter code (e.g. interviewer's initials) and three digits (e.g. survey participant number) can be used.

The questionnaire must be administered by interviewers who speak at least one of the languages of the country. They must be trained in the objectives and methodology of the survey. Depending on the situations and topics discussed, it may be necessary to pay special attention to the gender of the interviewer (for example, in the case of a survey on sexual violence).

If the questionnaire is translated:

- Have the questionnaire translated from English into the local language
- Have this first version translated by another independent translator from the local language back into English (back translation)
- Compare the original version and the translated version and adjust the translations to produce a final version.

When completing the questionnaires, it should be borne in mind that certain formulations and attitudes of the interviewers may influence the responses. Possible biases are:



BASIC QUESTIONNAIRE TO BE ADAPTED ACCORDING TO THE RESULTS OF THE FIRST QUALITATIVE PART

The answers should be circled or ticked and free text should be written in capital letters.

- ! **Note:** When the service user completing the questionnaire is a child, the administrative questions should be asked of the accompanying adult (Section A). The questions relating specifically to satisfaction can be asked directly of the child (Sections B, C and D).

Section A: General information

- A0.** *Specify whether the person who received the service is the adult completing the questionnaire or a child accompanied by this person. In this case, specify the age and gender of the child. **The rest of the questions in this section apply to the adult respondent.***
- A1. Gender:** *gender of the person responding; male, female or transgender. Transgender describes someone who identifies at least partly with the gender opposite to that assigned biologically to them at birth (gender dysphoria) and adopts a lifestyle or behaviour which reflects this. This new gender identity does not necessarily involve sexual reassignment surgery.*
- A2. Age:** *indicate the age of the adult interviewed.*
- A3. Marital status:** *select the situation that corresponds to the person being interviewed. If it is an adult accompanying a child who is answering, the adult's marital status should be indicated here.*
- A4. Education:** *select the level of education that corresponds to the person being interviewed. If it is an adult accompanying a child who is answering, the adult's level of education should be indicated here. Technical education is considered to be training in a manual trade (baker, mason, mechanic, electrician, driver, etc.) as opposed to university education.*
- A5. Occupation:** *select the situation that corresponds to the person being interviewed. If it is an adult accompanying a child who is answering, the adult's occupation should be indicated here.*
- A6. Place of residence:** *indicate the district or village, as appropriate; to ensure anonymity, do not give a precise address that would make it possible to find the respondent.*

- A7. **Travel time to the centre:** give an estimate in minutes; this is the time spent between leaving home and arriving at the centre.
- A8. **Means of transport:** transport by animal (horse, donkey or elephant etc.) should be specified under “other”. If more than one means of transport is used, indicate the one that is used for the majority of the journey.
- A9. **Transport costs:** to be indicated in local currency, for a single trip.
- A10. **Name of the health centre:** name of the centre where the questionnaire was distributed; this is the only question that can be completed in advance or, in the case of non-response, by the researchers.
- A11. **Services received:** several answers are possible. The list is indicative but not exhaustive; before printing the questionnaire examples may be added (7, 8, 9, 10), depending on the project. This refers to the type of consultation and not to treatment.
- A12. **Payment:** for consultation/drugs/care: if yes, indicate the total cost paid, in local currency.

Section B: Overall satisfaction

Part B of the questionnaire is standardised; nothing should be modified or removed. Even if the questions are similar and seem redundant to you, it is very important to have answers to all these questions in order to calculate the satisfaction score. It is the personal and, therefore, subjective opinion of the respondent that matters. The answers alternate positive and negative responses first to limit the influence of the order of the possible responses on the answers.

- B1. Are you generally satisfied with the service received? It is the overall impression of the service that is being assessed here: excellent, good, acceptable, poor or very poor.
- B2. Does the service provided meet your expectations?
- B3. Would you be willing to recommend this service to those around you?
- B4. Would you say that the services you received were complete?
- B5. If necessary, would you request our services again?
- B6. In general, how do you rate the quality of the service you received?



- B7. Have you been able to effectively resolve your problem following the services you received?

Section C: satisfaction with specific services

These questions seek to identify the different dimensions involved in satisfaction in order to enable the way the centre operates to be adjusted. It is important to adjust this framework in line with the results of the previous qualitative part.

- C1. How long did you wait after the first symptoms appeared (or the need for the visit appeared) before coming to the health facility? *Here we are looking for the time period before seeking treatment, the answer is free and should be given in days (by convention, 0 days means the same day). The response may relate to the time since the onset of symptoms or since the need to consult (e.g. date of vaccination booster).*
- C2. Do you think the waiting time for a consultation was too long / quite long / quite short / very short? *Waiting time for a consultation is one of the key indicators of satisfaction.*
- C3. How were you received by the medical staff? *The first contact is fundamental; it is one of the elements that determines whether the individual will return. Here we are assessing the pleasant and welcoming nature or, on the contrary, the unpleasant nature of this first contact.*
- C4. What did you think of the centre? *Several answers are possible: crowded / comfortable / well organised / clean / other to be specified. These elements can easily be adjusted and the implementation of changes at this level can have a very positive impact.*
- C5. Do you feel that the principle of confidentiality was respected during the consultation? *This is a very important question; the individual must feel confident in the personal relationship in order to be cared for effectively.*
- C6. Do you feel that your privacy was respected during the consultation? *Corrective measures can be put in place to make people being examined feel more comfortable.*
- C7. Do you think the healthcare provider listened to your concerns? *The medical staff's ability to listen is also a key element of satisfaction.*

- C8. Do you feel that the provider spent enough time with you? *Another important time-related consideration is the length of the consultation. The individual wants to have time to ask all the questions that concern him-her.*
- C9. Are you satisfied with the way healthcare providers addressed you? *Kindness on the part of care providers is essential in the relationship between caregiver and patient. It is not enough to be polite.*
- C10. Do you feel that your condition/treatment was clearly explained to you? *It is important to identify and correct the use of medical jargon and terms that are incomprehensible to most people. People rarely ask the healthcare provider to explain and therefore won't understand their treatment. This is a factor in poor treatment compliance.*
- C11. Did you feel that you received a lower quality of care because of your gender, nationality, geographical origin, socio-economic status, or other? *It is important to identify any feeling of discrimination. A free space allows individuals to clarify their experience.*

Section D: Open-ended questions

The aim here is to identify the strengths and weaknesses of the services, and to identify problems that could not be ascertained from the previous questions.

- What did you like the most about this facility?
- What did you dislike the most about this facility?
- What would you suggest to improve the services offered?

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- *Acquiescence bias*: tendency to answer “yes” rather than “no”: to avoid this, it is better to use the principle of alternation by varying the wording of the questions so that the answer is positive or negative to the same opinion.
- *Prestige response bias*: the older you get, the more you lie about your age; qualifications can be exaggerated, incomes inflated or underestimated etc.
- *Social desirability bias*: the answer reflects a social and moral ideal but does not necessarily shed light on the person’s behaviour. The researcher must therefore ensure that during the qualitative interview both the ideal and the person’s experience are addressed.
- *Primacy effect*: respondents always choose the first option suggested.
- The “halo” or “contamination” effect describes the fact that the answer to one question leads to the next answer. Thus, responses that are likely to contaminate one another should be carefully spaced.

It is also important to ensure that the questionnaire is not too long and/or that the questions are well distributed, according to whether they require more or less concentration and detail, so that the quality of the responses does not decline as the interview progresses.

- ! **Note on the attitude of interviewers to translations:** whether qualitative or quantitative, the interviewer must accurately transcribe the notes and the words of the interviewees in their original language. The next stage is for the material to be translated into English with the help of an translator.

For both methods, the survey tools should be tested on a small number of people and the vocabulary adapted as necessary before starting the survey.

- 💡 **Resources for the qualitative survey:** ideally, the person who developed the tools (interview grids, focus groups and observations), with or without a translator, will collect the qualitative data, analyse them, write the report and submit the results. For more details on administration and material resources, please see the MdM guide, *Data collection: Qualitative methods*.
- 💡 **Resources for the quantitative survey:** in terms of input time, it can be complex to manage more than 300 questionnaires. It takes 15 minutes to record a questionnaire in the data input and analysis template. Significant resources may be required for the following tasks:

- Before the survey:
 - › Write the protocol
 - › Translate questions and provide interpretation
 - › Test the questionnaire

- During data collection:
 - › Coordinate data collection
 - › Present the research, obtain consent and distribute the questionnaires
 - › Complete questionnaires and/or assist with self-report questionnaires if necessary
 - › Collect completed questionnaires and ensure confidentiality
 - › Store completed questionnaires in a secure place with a contact person.
 - › Never involve the people who deliver the service which is the subject of the satisfaction survey

- After collection:
 - › Enter the data into the input template: ideally, as the research progresses
 - › Perform statistical analyses
 - › Interpret the results
 - › Write the report
 - › Organise the dissemination of results (including to users)

In the protocol, and depending on the objectives of the research and the organisational capacities of the centre, the time and place of the questionnaire should be defined.



E.g.:

- Upon arrival at the centre (waiting room/reception)
- Leaving the centre (reception, end of consultation)
- Between these two points (beginning of consultation, between two interventions)
- At the start/end of treatment
- Routine visit, scheduled consultation or open consultation
- Upon first contact with the project

Confidentiality must be respected when completing the questionnaires. Each user surveyed is informed of the objectives of the research, the voluntary nature of their involvement and the respect for confidentiality in data collection.

In the case of a self-report questionnaire, it must be completed on site where it was distributed, to avoid as many non-responses as possible. A well-identified location must be planned to collect the completed questionnaires (a letterbox or other closed box at the reception desk

or in the waiting room, for example). Assistance with completing the survey may be needed. It should be noted that the self-report questionnaire is the tool of choice because there is no bias related to the interviewer, anonymity is ensured, the cost is low and it does not require interviewer training. However, in many situations, for people who are illiterate or who have disabilities, self-report questionnaires cannot be used. In this case it is necessary to provide assistance with completing the questionnaire by using interviewers.

Processing and analysing quantitative data

Completed questionnaires are checked for completeness and then systematically coded. Double entry is recommended (independent data entry by two different people followed by comparison of the two databases) and it is essential to keep the original questionnaires so they may be consulted later. Each questionnaire has a unique anonymous number that allows it to be retrieved in case of doubt about the data entered. Once the analysis is complete, the data collected must be destroyed.

As with any database use, a data management stage is required to identify missing data, correct outliers and recode/reclassify variables.

The purpose of the data analysis is to describe user satisfaction in relation to various components of the services concerned. The level of satisfaction is calculated on the basis of the proportion of respondents who are satisfied, quite satisfied and not at all satisfied with various aspects of the services received.

The main steps in the statistical analysis are as follows:

1. Describe the characteristics of the survey population and the services received
2. Describe general satisfaction (average score and proportion of people above a threshold, and satisfaction related to specific aspects)
3. Compare general satisfaction according to the centres visited, the type of service received and socio-demographic characteristics (age, gender, etc.)
4. Examine which specific aspects are associated with overall satisfaction
5. Observe the wording used to talk about what was most liked/disliked

Particular attention may be paid to the production of gender-specific data and data for comparative analysis between urban and rural areas. Cross-analysis of these variables will highlight similarities and

differences in user satisfaction levels with the services evaluated. The results will reveal the general level of satisfaction of users and allow the specific sites/services/populations/aspects associated with a very good (or very bad) level of satisfaction to be identified. The final objective of the analysis is to identify strengths and areas for improvement in the service (see recommendations). The open-ended questions are processed manually and subjected to thematic content analysis.

ONLINE PLATFORMS FOR DATA COLLECTION AND ANALYSIS:

Online platforms such as Kobo Collect (<https://www.kobotoolbox.org>) make it possible to systematically create a questionnaire, collect data and analyse the responses. They allow data to be collected in the field using mobile devices such as mobile phones or tablets, as well as on paper or computers.

There are many advantages of such platforms:

- They are **fast**. Data do not necessarily have to be transcribed from paper to computer before they can be analysed. Some analyses can be applied within minutes of data collection.
- They are **accurate**. Enumeration errors are minimised due to the fact that data can be validated in real time as they are collected. Transcription errors are completely eliminated.
- They are **optimised for humanitarian work**. They are easy to use, operate offline and can be deployed quickly, even in the most difficult or remote situations. If this fails, paper formats can be used as a backup and integrated with other data.

⋮ ETHICAL CONSIDERATIONS

Due to the sensitive nature of certain topics, the researchers must be made aware of the importance of the anonymous and confidential nature of the survey. No data that can be linked directly to the respondents should be collected. Access to the data is limited exclusively to the research team. Data collection at the various facilities being surveyed must be carried out with the consent of the managers of each institution. A letter (assignment brief) must be prepared.

Consent must be obtained before the participant responds to the survey. It is important to take the time to explain the objectives of the survey and how it will be conducted, and to specify that there will be no consequences if the person wishes to give a negative evaluation, or if they refuse to participate.

A brief note should accompany the questionnaire, describing the objectives and stressing that participation is completely open and voluntary, that refusal to participate will not lead to any change in treatment and that the data entered will remain anonymous.

It is possible that the researcher may become aware of the existence of serious abuse, which often creates a dilemma between helping someone in danger and the rules of confidentiality. In this case, efforts should first be made to establish the provisions of the national legislation in the country where the research is being conducted, in order to find out whether the researcher has a legal obligation to report the abuse. However, it is also always necessary to consider whether reporting the matter could harm the person being interviewed. If necessary, a compromise must be found; in all cases, the best solution would seem to be to involve the person concerned. It is also necessary to investigate whether the services for handling this type of complaint are appropriate, and thus judge what information should be provided to whom and how to provide it.

⋮ LIMITATIONS OF THE SURVEY

A number of situations can lead to biases:

- The sampling does not allow the survey results to be extrapolated to the general population but only to the population covered by the project.
- The short duration of the survey limits the possibility of more in-depth insight into the issues. The data produced should therefore not be over-interpreted but should provide an empirical and non-exhaustive insight into the circumstances.
- There may be biases related to the quality and accuracy of the translation.
- Finally, when completing satisfaction surveys, people often don't want to give answers with a negative connotation, particularly for fear of the activities concerned being discontinued. For these reasons, questions relating to possible obstacles or barriers can help to qualify some positive assessments.
- Memory biases should be considered in relation to the responses, particularly when there is a significant time-lag between participants using the service and completing the questionnaire.

⋮ SCOPING MEETING BY THE SURVEY STEERING COMMITTEE

An MdM steering committee will monitor the progress of the surveys. Consideration may be given to involving local actors (civil society

organisations, leaders, local government officials, etc.) from this phase onwards in order to conduct a more participatory, inclusive and empowering satisfaction survey.

A scoping meeting between the steering committee and the research managers will allow the exact scope of the surveys to be determined.

Regular face-to-face or telephone meetings on the progress of the surveys will be held with the steering committee.

☐ EXPECTED OUTPUTS FROM THE SURVEY PROCESS

SCOPING NOTE

A preliminary scoping note for the study is expected. The scoping note will present the methodology and intended work plan as well as the tools to be used (questionnaires and interview guides). This note will be submitted to the steering committee for comments before the field phase.

PRELIMINARY FINDINGS AND RECOMMENDATIONS

A presentation of the preliminary results in the field will be made to the teams in the form of a PowerPoint presentation. It should be made clear to them that they are welcome, and in fact expected, to provide critical feedback at this point. These preliminary results should be sent to the steering committee for an opinion.

PRELIMINARY REPORTS OF THE RESEARCH

An interim report on the main results from the surveys should be produced at the end of the field phase. This will be accompanied by a PowerPoint presentation of the main findings and recommendations.

The steering committee then has seven days from receipt of the provisional report to make comments and observations.

The main text of the study results should be in Word format, between 20 and 30 pages (excluding appendices), in 12 point and single-spaced, and must include the following sections:

- Executive summary (maximum five pages)
- Introduction
- List of abbreviations

- Context (project description)
- Survey objectives
- Methodology and limitations
- Main results and analysis
- Conclusions and recommendations
- Appendices: scoping note, list of people interviewed (qualification, anonymity must be respected) and timetable, questionnaires, interview guides and observation grids.

If the main report is in another language, the executive summary should be translated into English.

FINAL REPORT

The final report must incorporate the steering committee's comments/remarks/exchanges/discussions.

The main text of the overall study report should be in Word format, between 20 and 30 pages maximum (excluding appendices), in 12 point and single-spaced, and must include the following sections:

- Executive summary (maximum 5 pages)
- Introduction
- List of abbreviations
- Context (project description)
- Objectives
- Methodology and limitations
- Main results and comparative analysis
- Conclusions and recommendations
- Appendices

If the main report is in another language, the executive summary should be translated into English.



CONCLU- SIONS



The results of mixed method satisfaction studies should lead to recommendations for the people managing the projects so they can adjust their work to the needs of the users. It is important to understand what the criteria for satisfaction are in the eyes of the users themselves and then to establish the extent to which they are satisfied or not. Finally, inspiration should be drawn from what is reported as “working well” and applied to the weakest facilities.

In any case, in addition to sharing the results within the project team, it is important to organise feedback to the staff at the health centres concerned and to the users of the services.



Example: conclusion tables from a satisfaction survey of young people aged 10-24 on HIV prevention, testing and treatment services in Goma and Kinshasa.

A “good” screening service according to the young people interviewed

The survey sought to find out what young people mean by “good screening services”. From analysis of the qualitative data a number of recommendations were made:

- A “good” screening service ensures rapid access to test results. The treatment centre has its own laboratory equipment to prevent people who have been tested from having to go to another centre/hospital to get their results.
- A “good” screening service provides support to young people when the results are given: collaboration with peer educators (including PLHs) is considered necessary if the results are to be accepted.
- Specialist staff ensure that results are communicated with complete discretion. Respect for the principle of confidentiality may be formalised through the signature of a specific commitment document.

The young people identified aspects which could help service providers give young people coming to be tested the right reception:

- An initial introduction by the service provider to build trust in the young people.
- The service provider treats the young person “as if he/she were his/her own child”.
- The service provider gives reassuring information about free HIV care in the event of a positive test.
- The service provider explicitly tells the young person that the result will be secret.
- The service provider is young and understands the way young people talk.

An advice session should provide information that is adapted to the information needs of young people. The young people interviewed hope to receive comprehensive information on prevention methods, risky situations, treatment options for PLHs (the HIV care pathway), the human rights of PLHs and parental responsibility for screening children (in the case of PLH parents).

In the event of a positive result, post-test counselling should emphasise the role of PLHs as actors in prevention. In case of a negative result, post-test counselling should provide clear information on the protective measures to be followed to remain HIV-negative (risk plan).

Prevention messages must include screening as part of a vision for the future of young people. They should highlight the positive effect of screening on health (in the long term).

A “good” care and treatment service according to the young people interviewed

The survey sought to find out what young people mean by “good care and treatment services”. A number of recommendations emerged from the analysis of the qualitative data:

- The care and treatment services have tools for collecting data on the youth population.
- All services involved in the care pathway for young PLHs are available at the same facility.
- The service provides psychosocial and educational support that will enable young people to better accept the test results. This is essential for minors who have been infected by vertical transmission. Support should also be provided to parents.
- Availability of nutritional care for PLHs from poor families.
- Availability of quality medical supplies (which do not expire in three months...) (HMLSFN, UNDP).

- Existence of a personal link with the service provider responsible for monitoring PLHs.
- The schedule of follow-up meetings is adapted to the needs of young people (e.g. closely-spaced appointments, once a week)
- Young people have access to reliable information on the side effects of treatment.
- Young PLHs have access to a mentor who will support them on their care journey.
- Providers respect the sexual orientation and human rights of PLHs.
- Providers are trained in the skills needed to identify the information needs of young people (depending on age, sexual activity and level of knowledge).
- Specific awareness-raising training for paediatricians is needed for them to perform a family mediation role so that children who have been infected by mother-to-child transmission can rebuild family ties and restore parent-child trust.



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World Health Organization, 2000. *Workbook 6. Client Satisfaction Evaluations*. Available at: www.emcdda.europa.eu/attachements.cfm/att_5868_EN_6_client_satisfaction_evaluations.pdf.

To find out more about conducting satisfaction questionnaires:

EUPAN. *European Primer on Customer Satisfaction Management*. Available at: www.eupan.eu/files/repository/20101215131727_EU_Primer_English_FINAL_LR.pdf.

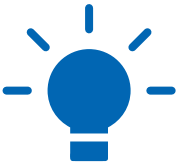
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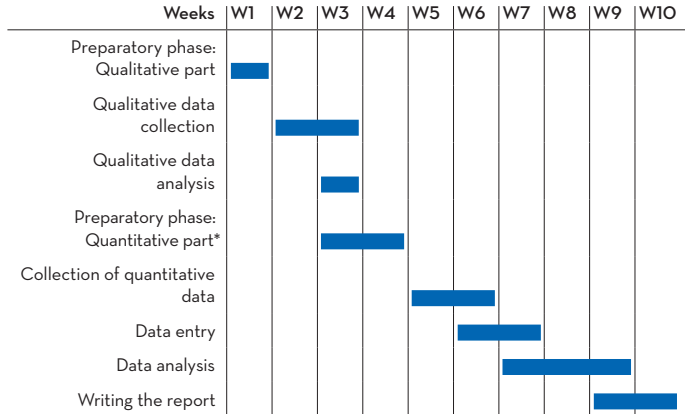
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EXAMPLE OF RETRO PLANNING

! Please note, this retro planning is provided for illustrative purposes only. It may be that the preparatory phase and data collection require more time.



*Establishing the sampling method, drafting the research protocol, printing the questionnaires and information note, recruiting and training interviewers, adapting and translating the questionnaire.

SYSTEMATIC SURVEY: CALCULATING AND USING THE SAMPLING INTERVAL

Systematic random sampling is a method where subjects to be included in the survey are selected at regular intervals from the study population. This interval is known as the “sampling interval”.

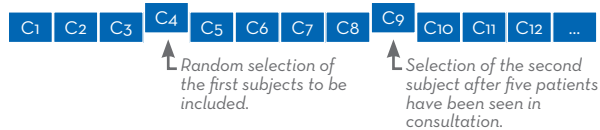
PROCEDURE

- A. Estimate the average number of weekly consultations, here referred to as N.
- B. Calculate the selection interval known as the sampling interval (p). This is calculated by dividing N by the size of the sample sought (n). $p=N/n$

- C. Randomly draw a number between 1 and p , the selected number will correspond to the first subject (respondent) who will be part of the sample. If they refuse to participate, ask the next person to take part in the survey.
How to proceed with this draw in simple terms.
- Cut out a number p of slips from a piece of paper;
 - On each slip of paper, note a consultation number, e.g.: C1, C2, etc.;
 - Fold each slip and place it in a basket. Randomly select the first user and ask them to take part in the survey.
- D. Ask the next people to take part in the survey by applying the sampling interval to constitute your sample.

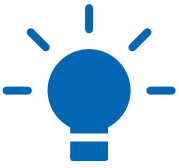
EXAMPLE

- ➔ You would like to interview $n=10$ people at a health centre; the average number of weekly consultations N is 50.
- ➔ Determine the sampling interval $p=N/n=50/10=5$. $p=5$;
- ➔ Number the consultations from 1 to 5 and place the slips of paper in a basket to make the draw;



- ➔ You randomly draw consultation number 4. You look at the register to see which user this corresponds to and ask them to take part in the questionnaire.
- ➔ To select the second user, third user, ... n user to be included, count five patients between each respondent.
- ➔ In this example, the second user corresponds to consultation number 9. Continue in the same way until the desired number of ten respondents for the survey is reached.

! Note: Within one centre, if it is decided to select the number of subjects to be included on different days of the week, the random selection process for the first subject to be interviewed must be carried out at the start of each day.



☐ EXAMPLE OF A RANDOM NUMBER TABLE

Range: 1 to 1000. Number: 300

696	140	537	467	292	827	454	130	407	453	169	281
212	620	182	563	404	967	211	690	534	724	928	455
34	989	5	345	706	996	939	745	652	870	137	399
855	621	883	638	354	818	971	748	486	4	476	222
937	496	218	92	111	332	761	187	348	645	612	148
69	735	37	881	412	96	260	15	851	434	240	241
40	824	138	76	865	922	86	133	953	418	103	167
95	128	288	456	352	428	635	316	799	80	788	153
532	651	775	435	812	346	774	504	379	499	189	190
604	259	503	7	589	958	46	62	147	410	105	522
708	949	58	26	833	97	938	508	570	422	899	938
246	369	591	327	746	925	462	391	90	174	463	514
330	209	757	44	840	56	677	633	541	581	531	679
120	142	235	374	228	784	57	224	256	896	28	443
882	355	489	129	554	813	113	611	183	211	286	223
389	897	535	32	334	565	319	512	888	152	284	707
311	519	779	778	599	84	841	490	199	956	671	262
744	301	572	294	770	931	55	549	427	116	13	513
74	377	533	583	2	309	367	859	680	248	924	441
630	510	253	673	124	850	661	112	902	449	446	303
91	500	948	647	204	871	699	107	257	887	675	826
48	738	341	144	426	114	878	220	239	769	180	271
340	102	616	411	781	983	349	795	615	727	582	160
966	653	992	477	528	166	555	910	89	960	749	501
691	314	904	161	608	488	266	416	728	261	1	

☐☐☐ EXAMPLE OF A QUALITATIVE SATISFACTION QUESTIONNAIRE

SATISFACTION AND EXPECTATIONS SURVEY OF YOUNG PEOPLE AGED 10-24 ON HIV PREVENTION AND CARE AND TREATMENT SERVICES IN GOMA AND KINSHASA

Through this interview we would like to obtain information on how satisfied young people (10-24 years old) are with HIV prevention and care and treatment services in the DRC. The information you provide will be very important in adapting HIV prevention programme interventions in the DRC to the needs of young people. The answers you give us will be confidential (your name will not be mentioned anywhere) and will allow the managers to work better with you. This interview will last approximately 40 minutes.

Date	
Researchers	
Start time	
Length of the interview	
Language used	
Location of the interview	
Province/Location	

No.	Questions	Code
1	How would you define a good health centre?	
2	What do you think are the five most important criteria for quality of care? How would you rank them?	
3	How did you imagine the service/What did you expect from the service (how it took place, relationship with caregivers, facilities, communication of results, etc.)?	
4	What were the differences between what you expected and what happened?	
5	How do you explain these differences?	
6	Ideally, if you could change anything, what would it be and how would you change it?	



EXAMPLE OF A QUANTITATIVE SATISFACTION QUESTIONNAIRE

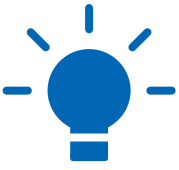
SATISFACTION AND EXPECTATIONS SURVEY OF YOUNG PEOPLE AGED 10-24 ON HIV PREVENTION AND CARE AND TREATMENT SERVICES IN GOMA AND KINSHASA

Through this questionnaire we would like to obtain information on how satisfied young people (10-24 years old) are with HIV prevention and care and treatment services in the DRC. The information you provide will be very important in adapting HIV prevention programme interventions in the DRC to the needs of young people. The answers you give us will be confidential (your name will not be mentioned anywhere) and will allow the managers to work better with you. It will take a maximum of 30 minutes to complete the questionnaire.

Date	
Researchers	
Start time	
Length of the interview	
Language used	
Location of the interview	
Province/Location	

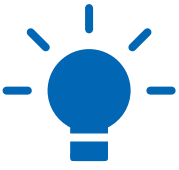
No.	Questions	Code
MODULE I. SOCIO-DEMOGRAPHIC CHARACTERISTICS		
1	What is your gender? a. Male b. Female c. Transgender	
2	What is your age (at your last birthday)? a. 10-14 years b. 15-19 years c. 20-24 years	
3	What is your marital status? a. Single b. Married c. With a partner d. With several partners e. Common-law marriage f. Divorced g. Widowed	

No.	Questions	Code
4	<p>What is your level of education?</p> <p>a. No formal education</p> <p>b. Primary 1 2 3 4 5 6</p> <p>c. Secondary 1 2 3 4 5 6</p> <p>d. Higher/University G1 G2 G3 L1 L2</p>	
5	<p>What is your current occupation?</p> <p>a. Trader/seller</p> <p>b. Student</p> <p>c. Civil servant/Civil servant</p> <p>d. Other (please specify)</p>	
6	<p>Do you have children?</p> <p>a. Yes</p> <p>b. No</p>	
7	<p>How many?</p> <p>0 1 2 3 4 5 or plus</p>	
8	<p>Part to be completed by the researcher based on the answers and observations. Indicate whether the respondent is part of a key population:</p> <p>a. MSM</p> <p>b. SWs</p> <p>c. Street children</p> <p>d. IDUs (injecting drug users)</p>	
<p>Module II. Expectations and aspects of satisfaction related to prevention services</p>		
9	<p>Young people have many sources of information about HIV. They can get information from teachers, parents, siblings, friends, doctors, books, films and magazines. What is your main and preferred source of information about HIV? From all the sources I am going to cite, please also say which ones you do not use to get information on preventing HIV.</p> <p><i>Possible responses:</i></p> <p>1 Preferred source (in terms of credibility)</p> <p>2 Main source</p> <p>3 This is not a source of information I use</p> <p>a. Your parents (father or mother, close family member) 1 2 3</p> <p>b. Peer educators, within prevention activities 1 2 3</p> <p>c. Community facilitator 1 2 3</p> <p>d. PLH 1 2 3</p> <p>e. Health worker 1 2 3</p> <p>f. Teacher 1 2 3</p> <p>g. Religious representative 1 2 3</p> <p>h. The media (radio, newspaper, video store, poster, television) 1 2 3</p> <p>i. Friend(s) 1 2 3</p> <p>j. Internet 1 2 3</p> <p>k. Key populations (other SWs, other MSM, other IDUs) 1 2 3</p>	



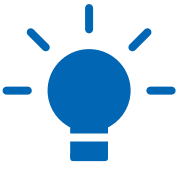
No.	Questions	Code
10	<p>In terms of prevention, are you satisfied with the information you have received in the following areas?</p> <p><i>Possible responses:</i> 1 Satisfied 2 Quite satisfied 3 Not at all satisfied</p> <p>a. Risky situations (e. g. burst condoms, exchanging sexual services for gifts, unprotected sex with several partners, etc.) 1 2 3</p> <p>b. HIV prevention advice (abstinence, fidelity, condoms, testing) 1 2 3</p> <p>c. HIV testing services (free-of-charge) 1 2 3</p> <p>d. STI screening and treatment 1 2 3</p> <p>e. Treatment and care of PLHs (ARV) 1 2 3</p> <p>f. Management of sexual violence 1 2 3</p> <p>g. Law that protects the rights of PLHs 1 2 3</p> <p>h. Information on youth-friendly spaces available for young people at health centres 1 2 3</p> <p>i. Safe sex negotiation (e.g., the respondent offers his or her partner a means of prevention but it is refused. The respondent has been provided with information on how to manage these situations). Explain the concept of consent. 1 2 3</p>	
11	<p>A few young people we interviewed identified certain barriers to accessing HIV prevention information. I will read some statements. Please rank them in order of importance to you.</p> <p><i>Possible responses:</i> 1 Important 2 Quite important 3 Not important</p> <p>a. Embarrassed to find out information (e.g. embarrassed to go to a health centre or pharmacy to ask for information, embarrassed to ask a parent or teacher about HIV, etc.) 1 2 3</p> <p>b. Difficulties finding someone you can trust (reliable source) 1 2 3</p> <p>c. Language too complicated, not adapted to the local language (Lingala or Swahili), not adapted to young people who cannot read. 1 2 3</p> <p>d. Lack of educational materials 1 2 3</p> <p>e. Lack of interest (respondent does not feel affected) 1 2 3</p>	
12	<p>How would you rate your access to HIV information?</p> <p>a. Accessible</p> <p>b. Could be improve</p> <p>c. Not at all accessible</p>	

No.	Questions	Code
13	<p>What type of awareness-raising measures do you prefer?</p> <ol style="list-style-type: none"> Door-to-door awareness raising Performance/cultural activity Dedicated hotline for young people and HIV TV advert Radio Internet (Facebook, specialist website) Phone (WhatsApp) Interpersonal communication (awareness-raising activities such as talks and debates, training, theatre, etc.) at a youth centre (Specify if CEICA) 	
14	<p>What would you like to hear in a prevention message for young people? I will read some statements. Please indicate the importance of each element to you, as a young person. <i>Explain the concept of a prevention message if necessary.</i></p> <p><i>Possible responses:</i></p> <ol style="list-style-type: none"> Important Quite important Not important <ol style="list-style-type: none"> The message must be communicated by a young person 1 2 3 The message gives specific information on the risky situations in which young people may find themselves (e. g. burst condoms, exchanging sexual services for gifts, unprotected sex with several partners, etc.) 1 2 3 The message explains to young people what to do if their partner refuses a suggested means of protection 1 2 3 The message presents a vision of the future for young people (e. g. PLHs making a success of their life plans) 1 2 3 The message makes young people want to be informed (e.g. on the internet, at health centres and/or at school) 1 2 3 The message makes people want to get involved in the fight against HIV (community mobilisation, religious initiatives, setting up or joining community-based organisations) 1 2 3 The message emphasises a shared approach to protection from HIV between boys and girls 1 2 3 The message highlights the experiences of young PLHs 1 2 3 	
15	<p>Do you think that what you have learned from prevention service providers can lead you to change your health behaviour (e.g., “I protect myself during every sexual encounter”)?</p> <ol style="list-style-type: none"> Yes No Not sure 	
16	<p>If “No” or “Not sure”, why?</p>	
17	<p>What would you do to improve HIV prevention for young people? <i>Indicate if the respondent does not know or does not feel concerned.</i></p>	



No.	Questions	Code
18	Overall, are you satisfied with the prevention services you have received? a. Satisfied b. Quite satisfied c. Not at all satisfied	
Module III. Expectations and elements of satisfaction related to screening services		
19	Have you had an HIV test at a health facility in the last 12 months? a. Yes b. No	
20	If "Yes", where? <i>Tick the place where the young person was tested.</i> a. Laboratory b. Hospital c. Rapid test organised by the provincial Ministry of Health d. Health centre e. Other	
21	If "Yes", how many times in your life have you had an HIV test? 1 2 3 4 5 More	
22	If "No", why not? a. Fear of being tested (fear of the result) b. Minimisation of risk (I don't need to do this) c. Does not know the procedures d. Too difficult to get tested e. Social embarrassment f. The health centre is far away g. He/she does not know what screening means or what it is used for	
23	How would you rate your satisfaction with screening services in terms of the following points? <i>Possible responses:</i> 1 Satisfied 2 Quite satisfied 3 Not at all satisfied a. Health facility opening hours suit the respondent's availability 1 2 3 b. Comfort (furniture, cleanliness, water, sanitary facilities) 1 2 3 c. Geographical proximity (check the time and cost of transport) 1 2 3 d. Waiting times before seeing the service provider (specify) 1 2 3 e. Simplicity of the procedures 1 2 3	

No.	Questions	Code
24	<p>When you were last tested, how would you rate your satisfaction with the following points?</p> <p><i>Possible responses:</i> 1 Satisfied 2 Quite satisfied 3 Not at all satisfied</p> <p>a. Reception (courteousness of the service provider) 1 2 3 b. Competence (know-how) of the contact person (e. g. knowledge of young people's issues, knowledge of HIV) 1 2 3 c. Trust in the service provider (e. g. at the beginning of the consultation the service provider introduces himself/herself, he/she treats you as if you were his/her own child, etc.) 1 2 3 d. Clarity of information 1 2 3 e. Absence of judgement (insistent looks, accusations of having several partners) 1 2 3</p>	
25	<p>Do you think that the principle of confidentiality was respected? (<i>Explain the concept of confidentiality in terms of secrecy between the individual and the service provider</i>)</p> <p>a. Yes b. No</p>	
26	<p>If not, why not? <i>Tick the alternative given by the young person</i></p> <p>a. The health facility does not have a separate room (no intimacy or privacy) b. I did not trust the service provider</p>	
27	<p>How long did you wait for the test results?</p> <p>a. less than 10 minutes b. between ten and 30 minutes c. between 30 and 60 minutes d. between 1 and 2 hours e. more than 2 hours</p>	
28	<p>What do you think of this waiting time?</p> <p>a. Long b. Not long c. Not at all long</p>	
29	<p>Are you satisfied with the advice you received in relation to the following topics?</p> <p><i>Possible responses:</i> 1 Satisfied 2 Quite satisfied 3 Not at all satisfied</p> <p>a. Negotiating safe sex 1 2 3 b. The correct use of condoms 1 2 3 c. Information on free treatment 1 2 3 d. Services to approach in the event of a positive test result 1 2 3 e. Organisations care for PLHs 1 2 3 f. Importance of partner screening 1 2 3</p>	



No.	Questions	Code
30	What do you mean by a “good” screening service? <i>Indicate if the respondent does not know or if he/she does not feel concerned.</i>	
31	Overall, are you satisfied with the screening services you received? a. Satisfied b. Quite satisfied c. Not at all satisfied	
Module III. Expectations and elements of satisfaction related to care services (module for young people only)		
32	What types of problems have you had with access to medicines? a. Out of stock b. Lack of resources to purchase drugs to treat opportunistic infections c. Scheduling problems d. Other	
33	How would you rate your satisfaction with the following points related to care services? <i>Possible responses:</i> 1 Satisfied 2 Quite satisfied 3 Not at all satisfied a. Schedules 1 2 3 b. Comfort (waiting room, toilets, cleanliness) 1 2 3 c. Geographical proximity 1 2 3 d. Financial accessibility (consultation costs, transportation costs, test costs and non-HIV drugs) 1 2 3 e. Monitoring of HIV-associated diseases 1 2 3	
34	Are you satisfied with the support you could have received as part of your care in the following areas? (<i>Explain options to respondents</i>) <i>Possible responses:</i> 1 Satisfied 2 Quite satisfied 3 Not at all satisfied a. Support in complying with treatment (explain the concept of compliance) 1 2 3 b. Nutritional advice 1 2 3 c. Psychological support 1 2 3 d. Family mediation 1 2 3 e. Specific self-help groups for young PLHs 1 2 3 f. Social or socio-economic support 1 2 3 g. Support for social and professional (re)integration 1 2 3 h. Legal support and combating discrimination 1 2 3	

No.	Questions	Code
35	<p>Are you satisfied with the relationships you have with service providers regarding:</p> <p><i>Possible responses:</i> 1 Satisfied 2 Quite satisfied 3 Not at all satisfied</p> <p>a. Reception (kindness, courtesy) 1 2 3 b. The skills (know-how) of the contact person (e.g. knowledge of young people's problems, knowledge about HIV) 1 2 3 c. The trust fostered by the service provider 1 2 3 d. The clarity of the information received 1 2 3</p>	
36	If "Not at all satisfied", why?	
37	<p>Some of the young people we have interviewed told us about unpleasant situations they may have experienced during their care, in relation to their interactions with health care providers. I will read some statements. If any are true for you, we would like to know how often you might have been dissatisfied because of these aspects.</p> <p><i>Possible responses:</i> 1 Several times 2 Once 3 Never</p> <p>a. Intimidating words 1 2 3 b. Suspicious and insistent looks 1 2 3 c. Accusations and judgements for having too many partners 1 2 3 d. Longer waiting time compared to people who arrived later 1 2 3 e. Insults ("ebembe ya kotala"; "ebembe ya kotelema"; "mwana mabe"; "akufa lobi"; "aniata 4 lettres" (this last insult more likely in the street) "mingimingi pe elobamaka na balabala") 1 2 3 f. Other 1 2 3</p>	
38	<p>Overall, are you satisfied with the care services you have received?</p> <p>a. Not satisfied b. Quite satisfied c. Satisfied</p>	
39	<p>If "Not very satisfied" or "Not at all satisfied", why? </p>	
40	<p>Can you make some recommendations for improving care? </p>	



☐☐☐ EXAMPLE OF A FRAMEWORK/DOCUMENT STRUCTURE

EXECUTIVE SUMMARY

INTRODUCTION

SURVEY OBJECTIVE AND ANALYTICAL FRAMEWORK

- A. *General context of the project in the country*
- B. *Origin of the request*
- C. *The XXX programme*
 - 1. Programme users
 - Direct beneficiaries
 - Indirect beneficiaries

METHODOLOGY

RESULTS

- A. *Satisfaction with*
 - 1. Aspects considered satisfactory
 - 2. Aspects considered unsatisfactory
 - 3. Recommendations
- B. *Satisfaction with*
 - 1. Aspects considered satisfactory
 - 2. Aspects considered unsatisfactory
 - 3. Recommendations
- C. *Satisfaction with*
 - 1. Aspects considered satisfactory
 - 2. Aspects considered unsatisfactory
 - 3. Recommendations

CONCLUSIONS

