Implementing a Client Feedback System to Improve the Quality of NGO Healthcare Services in Peru
The Quality Assurance (QA) Project is funded by the U.S. Agency for International Development (USAID), under Contract Number HRN-C-00-96-90013. The QA Project serves countries eligible for USAID assistance, USAID Missions and Bureaus, and other agencies and nongovernmental organizations that cooperate with USAID. The QA Project team consists of prime contractor Center for Human Services (CHS), Joint Commission Resources, Inc. (JCI), Johns Hopkins University School of Hygiene and Public Health (JHSPH), Johns Hopkins Center for Communication Programs (JHU/CCP), and the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO). It provides comprehensive, leading-edge technical expertise in the design, management, and implementation of quality assurance programs in developing countries. CHS, the nonprofit affiliate of University Research Co., LLC (URC), provides technical assistance and research for the design, management, improvement, and monitoring of healthcare systems and service delivery in over 30 countries.
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Table of Contents

I. Introduction ................................................................. 1
II. Research Setting ........................................................... 2
III. Research Design and Methodology .................................. 2
    A. Data collection ......................................................... 2
    B. Data analysis ............................................................ 4
    C. Providing client satisfaction results to Max Salud ............... 5
IV. Findings on Client Satisfaction ........................................ 5
    A. Effectiveness ............................................................ 5
    B. Efficiency ................................................................. 5
    C. Technical competence ................................................ 6
    D. Interpersonal relations .................................................. 7
    E. Access to services ..................................................... 7
    F. Safety .......................................................... 8
    G. Continuity ............................................................ 8
    H. Physical aspects ........................................................ 8
V. Findings: Analysis of Client Feedback System .................. 10
    A. Advantages and Disadvantages of the Data Collection Methods ... 11
VI. Findings: Use of Client Feedback at Max Salud .................. 11
    A. Quality committee of the management support unit ............ 11
    B. Balta quality committee ............................................. 11
    C. Urunaga quality committee .......................................... 12
VII. Lessons Learned: Improving Client Feedback .................. 13
VIII. Conclusion ............................................................... 14
References ........................................................................... 15

Abstract

Significant improvements to healthcare services are possible with an understanding of clients’ perspectives, but those perspectives often go unexpressed or are expressed without detail through verbal complaints or complaints dropped in suggestion boxes. Exit interviews and focus groups are among several methods for collecting detailed information from clients, but little research has been done to test those methods in developing countries.

The Quality Assurance (QA) Project investigated six methods for collecting client feedback at two healthcare clinics in Chiclayo, Peru, from September 1998 to April 1999. This report summarizes the results of that study, presenting both a description of the information collected and a comparison of six data collection methods. Information is also presented on how managers involved in the study used the data to improve clinic services. The report concludes with lessons learned and guidance on how to improve client feedback systems.

The study site was the Max Salud Institute for High Quality Health Care, started in 1994 with funding from the U.S. Agency for International Development (USAID). Max Salud is a private, nonprofit organization whose clients chose between using its services and nearby public clinics. At the time of the study, Max Salud provided a broad range of
Abstract Continued

health services to 20,000 low- to middle-income people through two clinics supported by a central management unit.

Max Salud wanted the client feedback system in order to collect clients’ perspectives of services and to convey those perspectives in summary fashion to its quality committees, which would then use the information for quality improvement. Exit interviews, follow-up visits, focus group discussions, interviews with discontinued clients, suggestion boxes, and community meetings were the intended data collection methods, although the community meetings, ongoing at the start of the study, proved to have been structured in such a way that elicited little client feedback.

The data from the client feedback system indicated high client satisfaction with the quality of services, especially the friendly personnel, clean and pleasant settings, and prompt service. Quality improvements resulting from the study included improving the response time to client complaints, sensitizing clinic personnel to clients’ concerns, and reducing waiting times.

The validity, utility, and feasibility/cost of the different methods varied considerably. For example, exit interviews were very feasible and provided quantitative data valued by quality committees, but their structured format limited clients’ expressions of dissatisfaction. Focus groups yielded rich, detailed information, but were expensive and time consuming.

Acknowledgement

This paper was written by Diana Santillán, principal investigator, Quality Assurance (QA) Project, and Maria Elena Figueroa, Johns Hopkins University Center for Communications Programs (JHU/CCP). The authors gratefully acknowledge the collaboration and support of the Max Salud Institute for High Quality Health Care, including the valuable input and assistance of Filiberto Hernández, Project Director; Luis Castañeda, Medical Services Director; Oswaldo Sierra, Training and Information, Education, and Communication (IEC) Advisor; Sonia Tamayo, Community Outreach Advisor; and Isidoro Benites, Information System Specialist.

Technical contributions in the study design and writing were provided by Max Tello, Marcela Tapia, Katy Cáceres, Gary Lewis, and Patricia Poppe (JHU/CCP); and Paula Tavrow, Paul Richardson, and Bart Burkhalter (QA Project). The study would not have been possible without the dedication of Silvia Arrascue and Fátima Linares, who participated as data collectors and research assistants. Raul Alberto Robles and Victor Hugo Vargas also provided important assistance to the research team.

Recommended citation


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Implementing a Client Feedback System
To Improve the Quality of NGO
Healthcare Services in Peru

Diana Santillán and Maria Elena Figueroa

1. Introduction

When clients experience high-quality healthcare and their health improves, they generally feel more satisfied. Interestingly, scientific evidence indicates the reverse is also true: increased client satisfaction can lead to better health outcomes. Satisfied clients are more likely to comply with treatment and advice and to return for additional care as necessary (Aharony and Strasser 1993; Lochman 1983). They are also more willing to pay for services (Scott and Smith 1994), thereby increasing revenue for healthcare, an important element of health sector reform. Client satisfaction has been characterized as both a rational evaluation of, as well as an emotional reaction to, the quality of care, that is, to the structure, process, and outcome of services (Pascoe 1983; Donabedian 1988). While the value of raising client satisfaction is well recognized, the optimal methods of collecting and using data remain unknown.

Although the literature on client satisfaction is extensive (Cleary and McNeil 1988; Pascoe 1983), it is mostly based on North American and European studies. Client satisfaction studies from developing countries are rare (Tavrow 1997). Moreover, few client satisfaction studies have assessed the use of client satisfaction data in quality improvement (QI) activities (Aharony and Strasser 1993). A study by Arnetz and Arnetz (1996) is a notable exception. A regional Swedish hospital staff used the results of a client satisfaction questionnaire to plan QI activities; client satisfaction was reassessed after the activities and showed significantly higher ratings (see also Shelton 2000; Williams, Schutt-Ainé, and Cuca 2000).

This report summarizes the findings of a study by the Quality Assurance (QA) Project, a nonprofit organization based in Bethesda, MD, and managed by the University Research Corporation-Center for Human Services (URC-CHS). The study tested a client feedback system at the Max Salud Institute for High Quality Healthcare, a nonprofit healthcare organization in Chiclayo, Peru. At the time of the study, Max Salud provided a broad range of healthcare services to about 20,000 low- to middle-income people. The study objectives were to gather client satisfaction data, analyze the data collection methods, and assess the use of the client satisfaction data by quality assurance (QA) committees. The client feedback system, implemented at two Max Salud clinics from May 1998 to May 1999, employed exit interviews,
follow-up visits, focus groups, household interviews of clients who had stopped using Max Salud services, suggestion boxes, and community meetings.

This report provides information on all three objectives, detailing the validity, utility, feasibility, and cost of the different data collection methods. It also describes the data and how they were used. Last, this report has recommendations for making client feedback an integral part of improving the quality of healthcare delivery in developing countries.

II. Research Setting

The Max Salud Institute for High Quality Health Care was founded in 1994 as part of the Strengthening Health Institutions Project/Northern Component, funded by the United States Agency for International Development (USAID) and implemented by University Research Co., LLC (URC) and Clapp & Mayne. Max Salud is located in Chiclayo, a coastal province in Peru. Max Salud decided to undertake the study after recognizing the connection between satisfying clients and financial sustainability.

The Max Salud Management Support Unit (MSU), comprised of directors, advisors, and administrative staff, provided technical and logistical assistance for the operation of the clinics. Quality committees were part of the organizational structure of Max Salud, both at the central and clinic level. The MSU quality committee included the project director, executive director, medical services director, clinic operations director, director of finance and administration, logistics and supplies director, and the training and IEC (information, education, and communication) advisor. Quality committees at each clinic included the clinic director, a doctor, a nurse, a certified midwife, an administrative assistant, and a social worker. The purpose of the committees, which met monthly, was to monitor, sustain, and improve the quality of Max Salud healthcare services.

The study implemented a client feedback system at both Max Salud clinics: Balta and Urrunaga. The Balta Clinic was situated in a busy, commercial downtown area. This small clinic offered primary healthcare services, 24-hour emergency services, and some medical specialties, such as pediatrics and gynecology. Approximately 12,500 people lived in its catchment area, but clients came from various parts of the city, often incorporating a medical visit into a day of errands downtown. The Urrunaga Clinic, located in a peri-urban community, served a lower-income population. It was open only half a day, six days a week, and did not provide medical specialty services. However, it engaged in more community outreach and health promotion activities than Balta, with the help of about 30 volunteer health promoters. The catchment area population for Urrunaga was 7,500.

III. Research Design and Methodology

The study implemented and continuously refined a client feedback system that included various methods to collect and analyze client satisfaction data and provide feedback to the quality committees. The research team—a principal investigator and two data collectors—performed two waves of data collection. After each wave, the team analyzed and summarized the client satisfaction results, and presented them to the quality committees at the MSU and clinics. During these feedback meetings, the quality committees discussed problems identified by clients and possible solutions to improve service quality, such as process improvements, rapid management responses, or individual follow-up with specific clients. Figure 1 illustrates the system implemented by the study.

A. Data collection

As noted above, two waves of each data collection method were conducted, as summarized in Table 1.

Exit interviews

Exit interviews of clients as they are leaving a clinic after using its services are frequently used to capture client perceptions of the quality of care. During each wave, data collectors completed at least 80 exit interviews at each clinic, on different days and at different hours to ensure a mix of clients. Only a few clients declined the interview.

At the Balta Clinic, data collectors interviewed clients while sitting on the benches of the waiting area or while standing just outside the entrance to the clinic. At the Urrunaga Clinic, a large room available for community meetings and near the entrance was used for these interviews. A questionnaire was used and had mostly open-ended questions with possible answers for each question. These answers were not read aloud; the data collectors simply marked the appropriate choice depending on the clients’ responses. Interviews took about 10 minutes each.

For purposes of the follow-up visits that would take place after the exit interviews, data collectors asked clients for permission to visit them in
Follow-up visits
Follow-up visits were used to control for possible “courtesy bias” in the exit interviews. For each wave, eight clients (10 percent) who had participated in exit interviews received a follow-up visit. Follow-up visits were semi-structured interviews held within a week after a client’s visit to the clinic. The follow-up guide covered the same topics as the exit interview. These interviews occurred at clients’ homes to allow clients to elaborate without clinic staff nearby. These sessions collected clients’ reflections after they had an opportunity to consider their clinic experience and allowed clients to report on the effectiveness of the treatment they had received. With client permission, data collectors tape-recorded each follow-up visit, which lasted approximately 20 minutes.

Although initially intended as a validity check for the exit interviews, another useful application of the follow-up visits emerged. Data collectors purposively selected a high proportion of clients who expressed dissatisfaction during the exit interviews for follow-up visits. This selection process generated more detailed information about negative experiences from the small subset of dissatisfied clients. Other clients for follow-up visits were selected at random.

Focus groups
Focus group discussions brought together groups of clients to discuss their experience with the clinic’s services. Eight focus groups, stratified

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1 Courtesy bias is when people give inaccurate information because of a desire to please others, to avoid insulting someone, or to prevent embarrassment.
by sex and age, were held (four per clinic). Participants were randomly selected using the Max Salud Management Information System. Based on the pre-test experience with focus groups, data collectors personally distributed invitations to about 30 clients to obtain six to eight participants for each group.2

Data collectors acted as facilitator and note-taker, and a focus group guide helped to direct the discussions, which were tape-recorded with the clients’ permission. At the end of each focus group discussion, which lasted about two hours, refreshments were served, and each participant received a small gift and money for transportation.

Household interviews
Identifying the sources of client dissatisfaction from clients who continue to use the facility excludes those who became so dissatisfied with services that they stopped seeking services there. In order to include clients whose dissatisfaction had achieved a level sufficient to cause them to discontinue use of Max Salud services, the research team interviewed “discontinued clients.” They were defined as clients who had visited the clinic a few times and had not returned for over a year. The expectation was that some of these clients had discontinued use because of dissatisfaction. Data collectors used Max Salud client lists to randomly select discontinued clients, excluding those who lived more than half an hour away (roughly 10 percent).

For each wave, the data collectors used a household interview guide to interview 10 clients from each clinic. Interviews averaged 25 minutes in length and were tape-recorded with the clients’ permission.

Suggestion boxes
Suggestion boxes are quite common in health facilities in Peru and were used at all Max Salud clinics before the study began. The data collectors compiled the comments from these boxes on two occasions to complement the other methods used in the study. The comments were written on forms designed by Max Salud, but had not been collected for several months.

After the second wave, the research team redesigned the suggestion box form in collaboration with the MSU training and IEC advisor. The new form included illustrations and asked clients to rank different aspects of the clinic by selecting a smiling, neutral, or frowning face, a technique intended to speed up the process of completing the forms and to accommodate clients with poor literacy. The research team tested the new form in a focus group and then distributed it to the clinics.

Community meetings
Data collectors attended community meetings, convened by Max Salud social workers at each clinic to discuss various health topics. The research team attended and observed some of these meetings in order to understand the local context and interpret clients’ comments. The meetings also provided a source of information in a more informal environment than the other data collection methods. The format provided an opportunity to hear community perspectives on health issues and might have generated different concerns than would arise in formal data collection exercises.

The community meetings were not specifically part of the study and no guidance or direction was provided to the meeting facilitators. At each community meeting, the data collectors took notes of their observations.

B. Data analysis
Data from the exit interviews were entered into a database developed for the client feedback system to generate tables summarizing the results.

Data collectors transcribed the tape-recorded follow-up visits, focus groups, and household interviews verbatim. Transcriptions were coded for key comments reflecting satisfaction and dissatisfaction using eight quality dimensions of healthcare delivery (Table 2). Data collectors also highlighted clients’ comments regarding barriers to services, comparison of Max Salud with other health services, and suggestions for improvement.

Clients’ comments from the suggestion box forms were entered into a spreadsheet as well. The community meetings were educational sessions and not interactive enough to render useful data about clients’ experiences in the community, contrary to the researchers’ prior expectations. Consequently, their content was neither analyzed nor presented to the quality committees. However, these meetings did enlighten the data collectors about the clinics’ cultural context, facilitating data interpretation.

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2 This suggests a potential self-selection bias. Project staff suspect that the participants tended to be more dissatisfied than non-participants and that these participants wanted to voice their complaints.
C. Providing client satisfaction results to Max Salud

The research team monitored serious client complaints, promptly bringing them to the attention of the MSU medical services director to ensure a rapid response. The research team presented the quantitative and qualitative results obtained in each wave of data collection during three meetings with the quality committees of the MSU and clinics. The MSU received results for both clinics, while the clinic committees received the results pertaining only to their clinic. The team and committees used these meetings to identify problems, opportunities for improvement, and possible solutions and quality improvement activities.

IV. Findings on Client Satisfaction

The study found that Max Salud clients had very positive perceptions of the services provided by both clinics. In general, more positive than negative remarks were obtained across all eight quality dimensions investigated. High satisfaction related to client-provider relations; cleanliness and pleasantness of the environment; and efficient, prompt service. Details relating to each of the eight dimensions of quality follow, along with comments from clients.

A. Effectiveness

Effectiveness relates to the accuracy of the medical diagnosis and the capacity of the treatment to cure the illness or, in the case of preventive services, to sustain health. Exit interviews rarely capture comments on effectiveness, since clients frequently do not know the outcome of their visit when they exit. However, qualitative data from the other methods show that clients highly value effective responses to their health concerns. Many clients reported being satisfied by “good medicine,” “accurate diagnoses,” and treatments that “control the illness.”

“The doctor gave me a prescription and now I’m better.”  
Urrunaga client, follow-up visit, 21-year-old woman

“I arrived sick and left well. That says everything.”  
Former Balta client, household interview, 18-year-old man

B. Efficiency

Effectiveness refers to clients’ perceptions of how well personnel perform administrative processes and use resources. Max Salud clients reported that the service was expeditious and that waiting times were reasonable. Few Balta clients (only 10 percent in each wave) stated upon exit that the waiting time was too long. During the first wave of data collection in Urrunaga, 28 percent of clients reported that the waiting time was too long, but for the second wave this percentage fell to 11 percent. This improvement reflected actions taken by the clinic management to address a personnel shortage during heightened demand for services. Taking both waves of data collection at both clinics into consideration, more than half (52 percent) of Max Salud clients reported waiting 15 minutes or less.

<table>
<thead>
<tr>
<th>DIMENSIONS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
<td>The degree to which desired results (outcomes) of care are achieved through appropriate diagnosis and treatment</td>
</tr>
<tr>
<td>Efficiency</td>
<td>The ratio of the outputs of services to the associated costs of producing those services (taking into consideration both material and time resources)</td>
</tr>
<tr>
<td>Technical competence</td>
<td>The degree to which tasks carried out by health workers and facilities meet expectations of technical quality (according to clinical guidelines)</td>
</tr>
<tr>
<td>Interpersonal relations</td>
<td>Level of respect, courtesy, responsiveness, empathy, effective listening, and communication between clinic personnel and clients</td>
</tr>
<tr>
<td>Access to service</td>
<td>The degree to which healthcare services are unrestricted by geographic, economic, social, organizational, or linguistic barriers</td>
</tr>
<tr>
<td>Safety</td>
<td>The level of trust, confidentiality, and privacy in the services and the degree to which the risks of injury, infection, or other harmful side effects are minimized</td>
</tr>
<tr>
<td>Continuity</td>
<td>The degree to which consistent and constant care is provided, including the value of visiting the same provider and continuing treatment</td>
</tr>
<tr>
<td>Physical aspects</td>
<td>The physical appearance of the facility and the level of cleanliness, comfort, and amenities offered</td>
</tr>
</tbody>
</table>

(Source: Brown et al. Undated)
“It is a good service, the quality and earnestness in their work. It’s fast. I didn’t have any problems, one gives the information that they need and straight ahead.”

Former Urrunaga client, household interview, 22-year-old man

“It is well organized, one gets the ticket and goes to the consultation right away without going from here to there, do this or the other; it’s faster.”

Balta client, focus group, women over 30 years old

The cases when waiting times were unacceptable related to communication problems or the occasional client who became “lost in the shuffle.” The fact that clients with appointments took precedence over walk-ins confused some who did not understand why clients were not served in the order of arrival.

“They take too long; they do not respect appointments. I have wasted time.”

Balta client, follow-up visit, 28-year-old man

“People arrived after me and they were already seeing them.”

Urrunaga client, follow-up visit, 19-year-old woman

Any waiting was unacceptable to clients who came for emergency treatment. Again, the problem was poor communication: clients were not made aware of clinic hours or staffing procedures for emergency care. Some Urrunaga clients with urgent problems felt they wasted time by going to the clinic, only to find that emergency care was not available when they needed it.

“Emergency care is supposed to be given quickly. We waste time if we have to take him all the way to the Balta Clinic instead.”

Urrunaga client, focus group of 18-30-year-old women

C. Technical competence

Technical competence refers to the ability and performance of health providers as measured against clinical guidelines. Clients often have difficulty assessing technical competence, but they value it and rely on certain indications to assess it. When asked what they liked most about Max Salud, Balta and Urrunaga clients ranked technical competence third (after friendly personnel and clean environment).

Many clients recognized that Max Salud health providers are trained professionals and appreciated that they take the time to examine them carefully. Clients did not want quick checkups, but rather meticulous and thorough ones. Rapid service, often considered a sign of efficiency, was considered an indicator of technical incompetence in the consultation room. In the case of dentistry, clients emphasized the importance of receiving painless care.

“They examine you from the top of your head to your toenail.”

Balta client, follow-up visit, 23-year-old woman

“The dentist does not make it hurt too much; he’s careful.”

Urrunaga client, follow-up visit, 20-year-old woman

Clients also valued specialists highly. In fact, when clients had doubts about the technical competence of providers, they assumed that they were interns, even though all Max Salud staff are fully trained professionals.

“There is no pediatrician, only general medicine; specialists are better trained.”

Former Urrunaga client, household interview, 24-year-old woman

“There are too many interns, and they do not know the laboratory work well.”

Urrunaga client, focus group of women over 30 years old
D. Interpersonal relations

Interpersonal relations refers to the verbal and nonverbal communications that clients experience. Interpersonal skills were very valued and appreciated by Max Salud clients. When asked what they liked most about the clinic, friendly personnel ranked first for both clinics’ clients, representing 33 percent of clients’ responses in the exit interview. Remarks about positive interpersonal relations, such as kindness and interest/concern shown by doctors, abounded in the clients’ discourse. Clients also highlighted the good interpersonal relations with nurses and administrative personnel at both clinics.

“The doctor explained very nicely; the nurse is also very friendly; they are all amiable. The doctor explained how things are, in a friendly way. They help us when we arrive in pain; they try to cheer you up.”

Urrunaga client, follow-up visit, 35-year-old man

“A few Balta clients complained about rude treatment from the medical specialists, such as the gynecologist and pediatrician. These specialists were not full-time Max Salud staff and, as such, had not received the same training in interpersonal relations and communication as full-time staff. Medical specialists attended to clients only a few hours a day, and yet these few hours were enough to mar the generally positive image of Max Salud regarding client-provider interactions.

“The gynecologist scares his patients with impertinent questions. ‘Is your husband young? Does he cheat on you?’ He is very serious and distant; he has a rough way of saying things.”

Balta client, focus group of 18- to 30-year-old women

“The pediatrician was in a bad mood; he was a despot; he was angry. He told me to calm down. I left confused; he didn’t explain anything to me.”

Former Balta client, household interview, 40-year-old woman

E. Access to services

Access to services refers to clients’ ease in visiting the clinic. Exit interviews indicated that 70 percent of Max Salud clients experienced no difficulties. Some clients reported that the clinics were located in dangerous areas, but others believe they are strategically located.

“People are afraid to go because there’s too much delinquency.”

Former Urrunaga client, household interview, 40-year-old woman

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Former Urrunaga client, household interview, 40-year-old woman

“Prices are very affordable, the medicine is close to affordable.”

Balta client, focus group of women over 30 years old

Service hours were less satisfactory in Urrunaga, where the clinic is opened only half a day, six days a week. Many clients felt that they had no assurance of receiving services when needed, especially worrisome for childbirth, which may take place at night and without warning. Both Balta and Urrunaga clients also mentioned that they experience difficulties when they need clinic services and do not have anyone to care for their children.

“When we have a medical problem, we don’t go because they do not provide service in the afternoon.”

Urrunaga client, focus group of women over 30 years old

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“When we have a medical problem, we don’t go because they do not provide service in the afternoon.”

Urrunaga client, focus group of women over 30 years old

“They are closed on Sundays. And what if there’s an emergency?”

Former Urrunaga client, household interview, 35-year-old woman
F. Safety
The quality dimension of safety from the client’s perspective relates to how secure clients feel at the clinic. In exit interviews, 98 percent of Max Salud clients reported that the providers respected their privacy (e.g., by not letting other people enter the consultation room without their permission). Also, clients felt the services were safe and trusted Max Salud providers.

“The truth is that I have faith in them.”
Former Urrunaga client, household interview, 25-year-old woman

“It’s tranquil; it’s safe. They inspire confidence; the instruments are hygienic.”
Urrunaga client, follow-up visit, 20-year-old woman

One client reported a serious complaint against a provider who had, either accidentally or intentionally, placed his hand on her leg during the consultation. This situation is either a serious misunderstanding or inappropriate behavior that would be a violation of someone’s sense of security.

“I felt uncomfortable. I like to converse so I don’t know if the dentist misinterpreted that or if he was trying to cross the line or maybe I am mistaken, but he placed his hand on my leg... I’m too embarrassed to return because of him. If I do go back, I will go in with my husband.”
Urrunaga client, follow-up visit, 25-year-old woman

G. Continuity
Continuity refers to whether clients obtain consistent care, such as being able to meet with the same provider every visit. The results indicated a clear tendency of clients to keep using Max Salud services. When asked if they would return to the clinic for needed services, virtually all clients (95 percent) responded positively in the exit interview. Similarly, 100 percent would recommend the clinic services to others. Overall, 80 percent of Max Salud clients stated that they would like to see the provider again.

“I have to go back; I still need some treatments. I would go to Max Salud always.”
Urrunaga client, follow-up visit, 20-year-old woman

“My daughter liked it. In fact, my husband took my other daughter the next day.”
Balta client, follow-up visit, 26-year-old woman

H. Physical aspects
The physical dimension of quality refers to its cleanliness, organization, and ambience. Clients responded positively on all of these. “Clean environment” was the second most frequent response (14 percent) for the exit interview question, “What do you like most about this clinic?” One client stated that the clinic’s cleanliness made it “a pleasure to enter, even if one is not sick.”

Remarks indicating that the facilities were “cozy,” “comfortable,” and “organized” also reflected clients’ satisfaction with physical aspects of the clinic. Clients enjoyed the decoration and colors of the clinic (blue and white), and amenities such as the television. One Urrunaga client stated that the clinic is a “luxury” for their low-income community. However, for Balta, there were several complaints about the small size of the clinic and congestion in the waiting area. The top-ranking suggestion for improvement given by Balta clients was “larger clinic” (24 percent of suggestions). There were also some complaints about stock-outs in the pharmacy.

“The clinic entertains one’s sight.”
Urrunaga client, focus group of 18- to 30-year-old men

“Their place is not adequate, the waiting area is very small.”
Balta client, focus group of men over 30 years old

“They almost don’t have medicines in the pharmacy. We did not find what the doctor prescribed; we needed to go find it outside.”
Former Urrunaga client, household interview, 30-year-old woman
### Table 3
Advantages and Disadvantages of Data Collection Methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exit Interviews</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Validity</strong></td>
<td>Large, random sample of clients is possible</td>
<td>Courtesy bias may result from nearness to clinic staff</td>
</tr>
<tr>
<td></td>
<td>Clients recall experience clearly</td>
<td>Clients have little time to process experience</td>
</tr>
<tr>
<td></td>
<td>Collects clients’ unedited first impressions</td>
<td>Clients may answer questions mechanically</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data collectors may ask questions mechanically</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Impersonal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clients are often pressed for time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No time to probe deeply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collects data only from clients who come to the clinic and receive services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quantitative, statistical analysis is “cold,” since it turns clients words and experiences into numbers</td>
</tr>
<tr>
<td><strong>Utility</strong></td>
<td>Information is practical, easy to understand</td>
<td>Too many distractions in clinic</td>
</tr>
<tr>
<td></td>
<td>Data can be used to measure compliance with standards</td>
<td>Requires a private, comfortable space</td>
</tr>
<tr>
<td><strong>Feasibility/ Cost</strong></td>
<td>Conducted in one place</td>
<td>Data entry is repetitive and tedious</td>
</tr>
<tr>
<td></td>
<td>Short duration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data collectors become familiar with tool due to the repetitive nature of this method</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Easy to identify participants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid data processing if computer database is used</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Short time needed for organization/preparation</td>
<td></td>
</tr>
<tr>
<td><strong>Follow-Up Visits</strong></td>
<td>Privacy may improve clients’ comfort and openness</td>
<td>Data collectors chose clients who are easier to reach (within 30 minutes), possibly biasing results</td>
</tr>
<tr>
<td></td>
<td>Complements and validates exit interview</td>
<td>Clients may feel that follow-up is redundant</td>
</tr>
<tr>
<td><strong>Utility</strong></td>
<td>Can be used to follow up on specific complaints from exit interviews and suggestion box</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More detailed, in-depth information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Effectiveness of treatment can be assessed after time lapse from clinic visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clients and/or family members may pose new complaints</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seeing or hearing client’s own words helps sensitize clinic personnel</td>
<td></td>
</tr>
<tr>
<td><strong>Feasibility/ Cost</strong></td>
<td>Access to clients is easier since they have already agreed to be interviewed (during exit interview)</td>
<td>Incorrect addresses deter access to clients</td>
</tr>
<tr>
<td></td>
<td>Accurate names and addresses are available</td>
<td>Difficult to follow up on out-of-town clients</td>
</tr>
<tr>
<td></td>
<td>Easy to identify participants</td>
<td>Unsafe neighborhoods can limit the available hours for interviews</td>
</tr>
<tr>
<td></td>
<td>More conversational interview with open-ended questions</td>
<td>Difficult to find male clients at home in some communities during hours available for interviews</td>
</tr>
<tr>
<td></td>
<td>Data transcription increases data collectors’ familiarity with data and facilitates analysis</td>
<td>Clients who had returned to facility need to be replaced for sample³</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transcription is labor-intensive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identifying and traveling to clients is time-consuming</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Transcribing interviews allows data collectors to self-assess their interview skills</td>
<td></td>
</tr>
<tr>
<td><strong>Focus Groups</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Validity</strong></td>
<td>Group dynamics may cause clients to express themselves more openly</td>
<td>Clients’ individual opinions can be influenced by the group’s opinion</td>
</tr>
<tr>
<td></td>
<td>Less courtesy bias due to privacy from clinic personnel</td>
<td></td>
</tr>
<tr>
<td><strong>Feasibility/ Cost</strong></td>
<td></td>
<td>High investment of time and cost: organization, collection, transcription, and analysis</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Empowers clients by giving them a chance to express themselves publicly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transcribing data allows data collectors to self-assess their facilitation skills</td>
<td></td>
</tr>
</tbody>
</table>

³ It is important to capture information consistently. If a client attends a focus group and is selected for follow-up but returns to the clinic prior to that follow-up, the intervening appointment would render the information inconsistent with other members of the sample.
### Table 3, continued

#### Advantages and Disadvantages of Data Collection Methods

<table>
<thead>
<tr>
<th>Data Collection Method</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Household Interviews</strong></td>
<td><strong>Validity</strong>&lt;br&gt;Less courtesy bias due to privacy from clinic personnel&lt;br&gt;Clients feel comfortable at home and express themselves openly&lt;br&gt;Clients have had time to consider their clinic experience and react</td>
<td>Clients do not recall experiences clearly&lt;br&gt;Information may be cut-of-date&lt;br&gt;Many clients did not stop using the clinic due to quality reasons, so it takes a lot of interviews to get significant information from truly dissatisfied clients</td>
</tr>
<tr>
<td></td>
<td><strong>Utility</strong>&lt;br&gt;Provides specific information on why clients have not returned to the clinic&lt;br&gt;Seeing or hearing clients’ own words helps sensitize clinic personnel</td>
<td>Transcription is time-consuming</td>
</tr>
<tr>
<td></td>
<td><strong>Feasibility/Cost</strong>&lt;br&gt;Easier to organize than focus groups&lt;br&gt;Transcribing data facilitates analysis</td>
<td>Incorrect addresses delay the process&lt;br&gt;Difficult to reach distant clients&lt;br&gt;Unsafe neighborhoods may limit available hours for interviews&lt;br&gt;Difficult to find male clients at home in some communities during available hours</td>
</tr>
<tr>
<td></td>
<td><strong>Other</strong>&lt;br&gt;Clients learn that the clinic cares about them and return their attention to clinic services&lt;br&gt;Transcribing data allows data collectors to assess their interview skills</td>
<td></td>
</tr>
<tr>
<td><strong>Suggestion Boxes</strong></td>
<td><strong>Validity</strong>&lt;br&gt;Client is assured anonymity if desired&lt;br&gt;Give clients a way to vent frustrations or express opinions at will&lt;br&gt;Could empower clients to express opinions and believe their opinions matter</td>
<td>Information cannot be verified&lt;br&gt;Data may be used inappropriately for internal conflicts or attacks on staff&lt;br&gt;Not random&lt;br&gt;All suggestions receive equal treatment, whether large or small, common or rare, etc.</td>
</tr>
<tr>
<td></td>
<td><strong>Utility</strong></td>
<td>Clients give incomplete information&lt;br&gt;The clinic quality committees do not have direct access to the box</td>
</tr>
<tr>
<td></td>
<td><strong>Feasibility/Cost</strong>&lt;br&gt;Easy to implement&lt;br&gt;Minimal cost</td>
<td>Many clients never notice the box; others do not know its purpose&lt;br&gt;Some clients do not like to write or are illiterate&lt;br&gt;Clients often feel it is a waste of time&lt;br&gt;Clients may prefer to give a face-to-face complaint to increase the likelihood that someone will take it seriously&lt;br&gt;Requires a certain level of client empowerment&lt;br&gt;Clients do not know who will receive the information&lt;br&gt;Clinics lack private space for completing forms</td>
</tr>
<tr>
<td><strong>Direct Observation of Community Meetings</strong></td>
<td><strong>Utility</strong>&lt;br&gt;Indicates the level of commitment of the community, which was helpful to the research team&lt;br&gt;Some information about the community’s opinion of clinic services</td>
<td>May not be interactive enough for community representatives to raise client complaints (communication at Max Salud was one-way: from clinic personnel to clients)&lt;br&gt;The meeting may not air issues suitable for QI</td>
</tr>
<tr>
<td></td>
<td><strong>Feasibility/Cost</strong>&lt;br&gt;Knowing cultural context facilitates data interpretation and analysis</td>
<td>Data collectors had to rely on social workers to inform them of planned events&lt;br&gt;Participants were often few&lt;br&gt;Few male or adolescent participants</td>
</tr>
</tbody>
</table>

### V. Findings: Analysis of Client Feedback System

As the findings on client satisfaction show, the combined data collection methods gave rich insights into clients’ perspectives on service quality. However, to implement all the methods required significant resources. A primary purpose of the study was to assess different data collection methods according to three criteria: relative validity, utility, and feasibility/cost. The assessment was based on interviews with data collectors and clients who had participated in the study, focus group discussions with Max Salud quality committees, and the research team’s observation of the data collection process. This section compares the data collection methods in terms of the criteria.
A. Advantages and disadvantages of the data collection methods

Understanding the advantages and disadvantages of each method with respect to validity, utility, and feasibility/cost allows managers to weigh these considerations and select the best methods relative to individual priorities and resource constraints.

- Validity is the degree to which the data seems to accurately capture what it is supposed to capture; validity is of primary importance because it indicates the extent to which the objectives of the data collection will be achieved.

- Utility refers to how useful the information for quality improvement activities; utility is the second most important criteria because it indicates the extent to which the results of the data collection will be used.

- Feasibility/cost refers to how easy or difficult and how costly it is to obtain participants, apply the tools, analyze findings, present results, and routinely use the data collection method.

Table 3 summarizes the strengths and weaknesses of each data collection method used in the client feedback system, according to these criteria.

VI. Findings: Use of Client Feedback at Max Salud

Feedback meetings with the quality committees sought to make the client satisfaction data “actionable rather than dust-collecting” (Shelton 2000). The committees reacted very positively to the results: several members expressed appreciation for the effort and the richness of the data collected. They reported that the data gave them a concrete way to evaluate their services. The Balta Clinic director said, “Without this information, we would never know these problems.” The feedback fostered the use of data in QI activities. The examples below illustrate some of the ways that Max Salud staff used client satisfaction data to improve services.

A. Quality committee of the management support unit

The MSU quality committee found the results useful because they revealed the clinics’ advantages and disadvantages compared to other public and private facilities. This information helped Max Salud address weaknesses and market its strengths. The results also helped the MSU quality committee correct misperceptions. For example, in response to clients’ expressions that interns were providing clinic services, managers urged staff to tell clients they are fully trained, certified professionals. Balta Clinic managers also addressed clients’ complaints about emergency services by increasing supervision of night shifts to ensure that emergency services were provided consistently and carefully.

Throughout the data collection phases, the research team immediately reported any serious client complaints to the Medical Services Director. In some cases, the Medical Services Director and Project Director met with staff to address complaints. For example, managers coached a gynecologist to improve his interpersonal skills. In another situation, managers responded to a client’s concern that a provider had been rude by meeting with the provider to warn him that he would be disciplined if complaints continued. This situation also caused managers to discuss the need for a guideline calling for the presence of a third party during clinical examinations. The guideline would protect clients from inappropriate treatment and providers from false accusations.

An unexpected benefit of collecting client data was that it gave managers concrete results to show to donors. Much of the data confirmed managers’ sense that clients appreciated the friendliness of personnel and prompt service more than other features of Max Salud compared to other health services. Although the feedback meetings concentrated on client dissatisfaction, in general Max Salud was highly rated by almost all clients. Max Salud was able to present this information to donors to show them their successes.

B. Balta quality committee

The Balta quality committee found clients’ perspectives useful in evaluating the quality of services. The results confirmed the need to expand the clinic in order to address complaints about size and congestion in the waiting area during peak hours. Plans to expand the facility were already underway. The results also gave the committee members ideas on how to redesign the clinic layout. Based on client feedback, the committee considered how to address the clients’ need for a child care facility, more privacy in the consultation room, and more benches in the waiting area.

Staff made several key improvements in admissions based on the client satisfaction data. Complaints often involved confusion about the hours of operation, misperceptions of certain administrative processes, and frustration with inefficient client flow. Balta staff began making the hours of
operations clear to clients, especially for medical specialists who were part-time. They also began explaining that clients with appointments took priority over walk-in clients. This information would encourage clients to make appointments and prevent feelings of preferential treatment.

The clinic director presented the findings to the entire staff, which allowed a self-assessment for staff members by sensitizing them to client concerns. Although the findings were presented without the names of clients or providers, the staff members could sometimes recognize themselves in clients’ comments and realized how clients interpreted their actions. The expectation is that having the data would help staff to step outside their own viewpoints to see interactions from clients’ perspectives and that this experience would change staff attitudes and behaviors.

C. Urrunaga quality committee

The Urrunaga quality committee had the unique opportunity of using the client satisfaction data in a training course on QI methods. The members of the Urrunaga quality committee decided to focus on client satisfaction during the training because they were concerned about low utilization rates. They formed a team to analyze the client satisfaction data, while learning and practicing the use of QI tools (flowcharts, fishbone diagrams, brainstorming lists, decision matrixes, tables, and graphs). The team developed indicators and output standards, and compared their standards to the exit interview results from the first wave of data collection (see Table 4).

Table 4

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Standard (Percentage)</th>
<th>Result (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Good Image</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients who say that Max Salud is the same as or better than other health centers</td>
<td>95</td>
<td>94</td>
</tr>
<tr>
<td>Clients who say they would return to the clinic</td>
<td>95</td>
<td>100</td>
</tr>
<tr>
<td>Clients who say they would recommend services to family/friends</td>
<td>90</td>
<td>100</td>
</tr>
<tr>
<td><strong>Access to Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients who say that prices are either average or low</td>
<td>95</td>
<td>97</td>
</tr>
<tr>
<td>Clients who do not experience any difficulties in visiting the clinic</td>
<td>80</td>
<td>58</td>
</tr>
<tr>
<td>Clients who say the hours of operation are not a difficulty</td>
<td>80</td>
<td>88</td>
</tr>
<tr>
<td>Clients who wait less than half an hour</td>
<td>90</td>
<td>66</td>
</tr>
<tr>
<td>Clients who say that waiting time is either average or short</td>
<td>90</td>
<td>72</td>
</tr>
<tr>
<td><strong>Personnel Performance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients who leave without any unanswered questions</td>
<td>100</td>
<td>95</td>
</tr>
<tr>
<td>Clients who say that the provider treated them kindly</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Clients who say that the provider greeted them</td>
<td>100</td>
<td>92</td>
</tr>
<tr>
<td>Clients who say that the provider respected their privacy</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>Client Preferences</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients who say there is nothing about the clinic that they dislike</td>
<td>80</td>
<td>62</td>
</tr>
</tbody>
</table>

Table 5

<table>
<thead>
<tr>
<th>Solution Strategy</th>
<th>Importance</th>
<th>Feasibility</th>
<th>Impact</th>
<th>Cost</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement scannable member cards and numbered tickets classified by colors according to services, and increase the participation of health promoters as facilitators and hostesses.</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Move free in-service supplies to consultation rooms, give the pharmacy an updated price list, train paramedical personnel to perform simple sutures, and provide emergency services only for cases that merit emergency care.</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Avoid repetitive steps; redesign prescription, laboratory, and X-ray forms, and print them in legible block letters.</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>18</td>
</tr>
</tbody>
</table>

4 For an account of the Urrunaga team’s problem-solving process, see Santillán 2000.
The team identified long waiting times as the key cause of dissatisfaction and developed solutions to address it. The team used a flowchart to analyze client flow and brainstormed to develop an exhaustive list of solutions. Next, they combined solutions that fit well together from a systems view to develop three sets of related solutions, or “solution strategies.” Staff voted for two strategies of the basis of each one’s importance, feasibility, impact, and cost. Table 5 shows the results of the voting and indicates that the second strategy was selected.

After the study, Max Salud continued to collect client satisfaction data. A rapid assessment in July 2000 showed a remarkable improvement in waiting times: clients who waited half an hour or less rose from 56 percent to 80 percent. Only one out of the 89 interviewed clients responded that their waiting time was too long, demonstrating an improvement from 72 percent to 99 percent for clients who reported that their waiting time was either regular or short. (These results are shown in Figure 2.) Thus, the Urrunaga quality committee was able to effectively use the client satisfaction data during team-based problem solving to improve client flow and reduce waiting times.

VII. Lessons Learned: Improving Client Feedback

Based on the analysis of the client feedback system, the following lessons learned should be considered when collecting and using client satisfaction data to improve the data collection, integrate findings, and optimize the use of data for quality improvement.

- Give timely feedback. No matter what collection method is used to gather client satisfaction data, the information should be processed quickly and presented to health managers and/or quality teams. Short turnaround ensures rapid responses to problems. Repeated use of the data collection methods resulted in shorter timeframes for both collection and feedback.

- Update data collection tools periodically. Client satisfaction and perceptions of quality care are highly dynamic. Cost may be a source of dissatisfaction at one point and later disappear as quality improves. Client expectations change over time, which affects people’s level of satisfaction with existing facilities. Some sources of dissatisfaction are relatively simple to solve (e.g., more benches in the waiting area) and, once addressed, will not appear in subsequent assessments of satisfaction. Because of this dynamic environment, programs should re-examine the results of past data collection activities and update data collection tools. Some issues may be expanded and others dropped from the questionnaire and discussion guides.

- Keep questions open-ended. While more structured methods may be easier to administer and analyze, data collection methods should also permit clients to express issues that researchers may not anticipate, and data collection tools should be designed to accommodate this possibility. Sensitive issues, such as interpersonal relations and communication, may require extra probing by data collectors, since clients may hesitate to discuss them fully at first.

- Use follow-up visits with dissatisfied clients as part of quality improvement activities. Follow-up visits were unplanned at the start of the study and were initiated to improve staff’s understanding of problems or clients’ suggestions for improvements. In some cases, following up a complaint was part...
of the solution, because the visit showed Max Salud’s concern for its clients.

- Carefully consider using focus groups. Focus group discussions are useful, but not very feasible. Organizing one is more labor-intensive than other methods, and considerable time is needed for data transcriptions and analysis. Focus group discussions also take considerable skill to administer and interpret—a skill that few facilities have among their staff. A well-directed focus group can create a social dynamic where clients share experiences with each other. To do this effectively requires a skilled facilitator.

- Keep in mind that discontinued clients may not be dissatisfied. Household follow-up interviews are useful for reaching discontinued clients. It is important, however, to understand that many clients cease attending health services for reasons not related to the quality of services. Some clients may have moved or may not have needed additional healthcare.

- Recognize that a suggestion box has limited value as a client feedback mechanism. The suggestion box is the least costly of all the data collection methods, and it gives clients an immediately visible opportunity to express their opinions. However, if health managers do not use it to improve quality of services, it becomes solely a clinic fixture that neither personnel nor clients take very seriously.

- Use community meeting observation in conjunction with other ethnographic techniques. The observation of community meetings could have yielded more useful information in this study if it had been used in conjunction with other techniques, such as observation in the communities. The contextual knowledge that observation of community action provides may be better gathered in meetings other than those organized by the clinic (e.g., mothers’ clubs, worker unions, etc.) and at community events.

- Give quality committees time, training, and follow-up to maximize the use of client satisfaction data. Quality committees need sufficient time to thoroughly analyze and respond to the client satisfaction data and to develop action plans. By using the data in their QI training, the Urrunaga quality committee learned how to approach the data systematically.

- Use both quantitative and qualitative data. Both are useful and do not seem to be duplicative. Qualitative data is important because it often captures specific client complaints that management can respond to promptly, although exploring problems in interpersonal relations requires time and sensitivity. QI tools for using qualitative data would optimize the use of this rich data, ensure rapid responses to specific complaints, and instigate process improvements.

- Explore the use of health promoters to collect client complaints. Health promoters are a crucial link to the communities, although they are traditionally used for clinic-to-client community mobilization, rather than client-to-clinic feedback. Health promoters could gather client complaints from the community.

VIII. Conclusion

The Max Salud client feedback system generated important information about the quality of services from the clients’ perspectives. Quality committees were successfully able to use this information for a variety of quality improvement activities, ranging from rapid management responses to improvements in organizational processes. Knowing the advantages and disadvantages of the various methods should assist health managers in selecting appropriate methods to collect clients’ perceptions and maximize the use of that information by quality committees. It is important to weigh any potential trade-offs among the validity, utility, and feasibility/cost of different methods. Where
resources are scarce, health managers are advised to choose a package of methods that would be sustained over time, because a one-time data collection has little value. Ultimately, no client feedback system will succeed without a dedication to providing high quality healthcare that truly places clients at the center of service delivery systems.

References


