STUDY QUESTIONNAIRE DIAGRAM

SATISFACTION OF USERS OF HEALTH CARE SERVICES IN CAPE VERDE

I. CHARACTERIZATION OF THE HEALTH SERVICE

Name and type of healthcare facility
Location of the interview
Prior experience
Reasons for coming to the establishment

II. CHARACTERIZATION OF THE RESPONDENT

Age
Sex
Education
Situation at work
Nationality
Residence
Inpatient experience

III. CONSULT

Waiting time
Administrative services
Care team
Professionals
Access/Accessibility

IV. EXAMINATIONS/TESTS

Waiting time
Administrative services
Professionals
Access/Accessibility

V. HOSPITALIZATION

Hospitalization
Access/Accessibility

VI. PHARMACY

Overall Rating
Access/Accessibility
Facilities
Proposals for improvement
Who filled it out?

VII. FINAL

Facilities
Overall Rating
Proposals for improvement
Who filled it out?

STUDY QUESTIONNAIRE DIAGRAM

SATISFACTION OF USERS OF HEALTH CARE SERVICES IN CAPE VERDE

|__|__|__|__|__|__|__|__|

We believe that the patient is the most important element in healthcare.
We want to take your opinion into account. Therefore, we ask you, in view of the quality of the care provided to you, take this quiz. This questionnaire is anonymous (you do not need to give your name) and the information you provide to us will be confidential.
For each question, mark with an x the answer you consider most appropriate.
If you do not agree with this study, you are free not to participate, there will be no consequences on the care provided.

I. CHARACTERIZATION OF THE HEALTH SERVICE

1. Name of the healthcare facility

_____

2. Type of healthcare facility
   - ☐1 Health center
   - ☐2 Hospital
   - ☐3 Community pharmacy (public or private)
   - ☐4 Doctor's office / Private clinic
   - ☐5 Diagnostic center / Tests

3. Interview location - Island: _____ County: _____

4. Is this your first time coming to this healthcare facility?
   - ☐1 Yes
   - ☐2 No → If **NO,** how many more times have you come to this health facility in the last 12 months? _____

5. What is(are) the reason(s) for your coming to this healthcare facility today?
   You can answer more than one option
   - ☐1 General practitioner medical consultation
   - ☐2 Specialty consultation
   - ☐3 Consultation of complementary therapies
   - ☐4 Complementary diagnostic tests *(e.g., X-ray, blood, urine, stool tests, HIV test)*
   - ☐5 Testing for Covid-19
   - ☐6 Conducting a medical inspection/medical certificate
   - ☐7 Specialty appointment booking
   - ☐8 Scheduling of complementary diagnostic tests *(e.g. X-ray, blood, urine, stool tests, HIV test)*
   - ☐9 Acquisition of medicines
   - ☐10 Purchase of other pharmaceutical products
   - ☐11 Other → Please specify _____

II. CHARACTERIZATION OF THE RESPONDENT

6. Age _____ years (Date of birth ____ / ____ / _____)

7. Sex
   - ☐1 Male
   - ☐2 Female
   - ☐3 Other → Please specify _____

8. Marital status
   - ☐1 Single/Not living with someone
   - ☐2 Married or in a non-marital relationship
   - ☐3 Divorced or separated
   - ☐4 Widower

9. Education
   - ☐1 No level of education (never went to school)
   - ☐2 Primary/Basic (includes preschool and alphabetization)
   - ☐3 Secondary/Medium
   - ☐4 Superior

10. Situation at work

Indicate the option that corresponds to your occupation most of the time
   - ☐1 Have a job or self-employed
   - ☐2 Unemployed
   - ☐3 Student or is in an unpaid internship/apprenticeship
   - ☐4 Retired from work or with early retirement
   - ☐5 Permanently disabled (permanent inability to work)
   - ☐6 Domestic
   - ☐7 Provides civic or community service
   - ☐8 Have another downtime situation

11. Nationality
   - ☐1 Cabo-Verdean
   - ☐2 Foreign → Please specify _____

12. Residence - Island: _____ County: _____

13. Have you ever been admitted to a hospital or health center in the last 12 months?
   - ☐1 Yes
   - ☐2 No

The completion of the remaining sections of this survey depends on the location of the interview and the type of demand of the respondent. The next sections are

III. Consultation in a health center, hospital, doctor's office or private clinic;
IV. Complementary diagnostic examinations or tests;
V. Hospitalization in a hospital or health center with hospitalization;
VI. Public or private community pharmacy;
VII. Final – To be filled in always, except if community pharmacy.

III. CONSULTATION

Section to be filled in only if the reason for your visit to this health establishment was to make an appointment at a health center, hospital, doctor's office or private clinic

C1. How long ago was this appointment scheduled?

_____ months _____ Days ☐1 I don't know ☐2 Unscheduled Appointment

C2. Generally, what is the average waiting time for care in this health facility (compute the waiting time from your arrival to leaving the health care service room)?

_____ hours _____ minutes ☐1 I don't know

C3. What is your assessment of the administrative services of this health facility in relation to:
Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Waiting time in the waiting room to be served	☐1	☐2	☐3	☐4	☐5	☐6
B. Time dedicated to administrative service	☐1	☐2	☐3	☐4	☐5	☐6
C. How you were clarified when you requested information from the attendant	☐1	☐2	☐3	☐4	☐5	☐6
D. Competence, courtesy and affection of the professionals of the customer service	☐1	☐2	☐3	☐4	☐5	☐6
E. Quality of the information provided	☐1	☐2	☐3	☐4	☐5	☐6
F. Respect with which you were treated by the attendant and how your privacy was maintained	☐1	☐2	☐3	☐4	☐5	☐6
G. Speed with which you were seen and referred to the health care service	☐1	☐2	☐3	☐4	☐5	☐6

C4. What is your assessment of the care provided by the care team of this establishment in relation to:
Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Interest shown by the care team in your health problem	☐1	☐2	☐3	☐4	☐5	☐6
B. Ease with which he felt comfortable telling them about his health problems	☐1	☐2	☐3	☐4	☐5	☐6
C. Attention paid to your health problems	☐1	☐2	☐3	☐4	☐5	☐6
D. How you were involved in decisions about the care provided by this team	☐1	☐2	☐3	☐4	☐5	☐6
E. Confidentiality of information about your health process	☐1	☐2	☐3	☐4	☐5	☐6
F. Freedom of choice of the health professional within the service and possibility of having a second opinion	☐1	☐2	☐3	☐4	☐5	☐6
G. How you were provided with quick relief from your symptoms	☐1	☐2	☐3	☐4	☐5	☐6
H. Help you received to feel good enough to perform your daily tasks	☐1	☐2	☐3	☐4	☐5	☐6
I. Help you received to cope with emotional problems related to your health condition	☐1	☐2	☐3	☐4	☐5	☐6
J. Support you received to understand why it is important to follow the advice of your care team	☐1	☐2	☐3	☐4	☐5	☐6
K. Knowledge of this care team about what has been done and said to you in previous consultations	☐1	☐2	☐3	☐4	☐5	☐6
L. Liaison with other specialties in relation to your health status	☐1	☐2	☐3	☐4	☐5	☐6
M. Respect with which you were treated by the care team and how your privacy was maintained	☐1	☐2	☐3	☐4	☐5	☐6

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
N. How quickly your urgent health issues have been resolved	☐1	☐2	☐3	☐4	☐5	☐6
O. How you were heard and supported by social workers	☐1	☐2	☐3	☐4	☐5	☐6
P. Competence, courtesy and affection of social workers	☐1	☐2	☐3	☐4	☐5	☐6
Q. How you were listened to and supported by the psychologist	☐1	☐2	☐3	☐4	☐5	☐6
R. Competence, courtesy and affection of psychologists	☐1	☐2	☐3	☐4	☐5	☐6
S. Health awareness and prevention information	☐1	☐2	☐3	☐4	☐5	☐6

C5. What is your assessment of the health professionals of this health facility in relation to:

Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Make you feel like you have time to talk to the medical team	☐1	☐2	☐3	☐4	☐5	☐6
B. How the doctor listened to you	☐1	☐2	☐3	☐4	☐5	☐6
C. Clinical examination by the doctor	☐1	☐2	☐3	☐4	☐5	☐6
D. Explanation of the medications, treatments, and tests prescribed	☐1	☐2	☐3	☐4	☐5	☐6
E. How you have been sufficiently informed about your symptoms and your illness	☐1	☐2	☐3	☐4	☐5	☐6
F. Competence, courtesy and affection of the medical team	☐1	☐2	☐3	☐4	☐5	☐6
G. Time dedicated to you by the nursing team	☐1	☐2	☐3	☐4	☐5	☐6
H. How the nursing team listened to you	☐1	☐2	☐3	☐4	☐5	☐6
I. Explanations given by the nursing team about the procedures and care provided	☐1	☐2	☐3	☐4	☐5	☐6
J. Competence, courtesy and affection of the nursing team	☐1	☐2	☐3	☐4	☐5	☐6
K. How quickly your urgent health issues have been resolved	☐1	☐2	☐3	☐4	☐5	☐6
L. How you were welcomed when you requested the support of the operational assistants	☐1	☐2	☐3	☐4	☐5	☐6
M. Competence, courtesy and affection of the operational assistants	☐1	☐2	☐3	☐4	☐5	☐6

C6. What is your assessment of the access/accessibility of this health facility in relation to:

Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Proximity to your home	☐1	☐2	☐3	☐4	☐5	☐6
B. Frequency of means of transport to get to the place	☐1	☐2	☐3	☐4	☐5	☐6
C. Transportation costs (from home to health facility)	☐1	☐2	☐3	☐4	☐5	☐6
D. Costs of services provided (user fee)	☐1	☐2	☐3	☐4	☐5	☐6
E. Easy to make an appointment according to your availability	☐1	☐2	☐3	☐4	☐5	☐6
F. Ease of access to care services	☐1	☐2	☐3	☐4	☐5	☐6
G. Facility opening hours	☐1	☐2	☐3	☐4	☐5	☐6
H. Schedule of routine appointments	☐1	☐2	☐3	☐4	☐5	☐6
I. Schedule of specialty consultations	☐1	☐2	☐3	☐4	☐5	☐6
J. Possibility to speak by phone to this health facility to request information and/or make appointments	☐1	☐2	☐3	☐4	☐5	☐6
K. Ease in being seen by a doctor and/or health professional you know, that is, who has already seen you in other consultations/procedures	☐1	☐2	☐3	☐4	☐5	☐6

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IV. COMPLEMENTARY DIAGNOSTIC EXAMS OR TESTS

Section to be filled in only if the reason for coming to this health facility was to carry out complementary diagnostic examinations or tests

E1. How long ago this exam was scheduled?

_____ months _____ days ☐1 I don't know

E2. Generally, what is the average waiting time for care in this health facility (compute the waiting time from your arrival to leaving the health care service room)?

_____ hours _____ minutes ☐1 I don't know

E3. What is your assessment of the administrative services of this health facility in relation to:
Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Waiting time in the waiting room to be served	☐1	☐2	☐3	☐4	☐5	☐6
B. Time dedicated to administrative service	☐1	☐2	☐3	☐4	☐5	☐6
C. How you were clarified when you requested information from the attendant	☐1	☐2	☐3	☐4	☐5	☐6
D. Competence, courtesy and affection of the professionals of the customer service	☐1	☐2	☐3	☐4	☐5	☐6
E. Quality of the information provided	☐1	☐2	☐3	☐4	☐5	☐6
F. Respect with which you were treated by the attendant and how your privacy was maintained	☐1	☐2	☐3	☐4	☐5	☐6
G. Speed with which you were seen and referred to the health care service	☐1	☐2	☐3	☐4	☐5	☐6

E4. What is your assessment of the professionals of this establishment in relation to:
Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Preparation received prior to the exam	☐1	☐2	☐3	☐4	☐5	☐6
B. Quality of the procedure provided by the professional	☐1	☐2	☐3	☐4	☐5	☐6
C. Competence, courtesy and affection of the technician/professional who assisted you	☐1	☐2	☐3	☐4	☐5	☐6
D. Explanations given by the professional/technician about the procedures and care provided	☐1	☐2	☐3	☐4	☐5	☐6
E. Respect with which you have been treated by the professional and how your privacy has been maintained	☐1	☐2	☐3	☐4	☐5	☐6

E5. What is your assessment of the access/accessibility of this health facility in relation to:

Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Proximity to your home	☐1	☐2	☐3	☐4	☐5	☐6
B. Frequency of means of transport to get to the place	☐1	☐2	☐3	☐4	☐5	☐6
C. Cost of transportation (from home to health facility)	☐1	☐2	☐3	☐4	☐5	☐6
D. Costs of services provided (user fee)	☐1	☐2	☐3	☐4	☐5	☐6
E. Ease of scheduling the exam or test according to your availability	☐1	☐2	☐3	☐4	☐5	☐6
F. Ease of access to services	☐1	☐2	☐3	☐4	☐5	☐6
G. Facility opening hours	☐1	☐2	☐3	☐4	☐5	☐6
H. Possibility to speak by phone to this health facility to request information and/or make examination appointments	☐1	☐2	☐3	☐4	☐5	☐6

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V. HOSPITALIZATION

Section to be filled in only if the reason for your visit to this health establishment was a hospital stay or an inpatient health center

I1. What is your assessment of the inpatient services of this facility in relation to:

Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Waiting time to be admitted	☐1	☐2	☐3	☐4	☐5	☐6
B. Speed with which you were seen and referred to the health care service	☐1	☐2	☐3	☐4	☐5	☐6
C. Attention paid to your health problems	☐1	☐2	☐3	☐4	☐5	☐6
D. How you were informed and involved in decisions about the procedures and health care received during hospitalization	☐1	☐2	☐3	☐4	☐5	☐6
E. Freedom of choice of the health professional within the service and possibility of having a second opinion	☐1	☐2	☐3	☐4	☐5	☐6
F. Competence, courtesy and affection of the health professionals who assisted you during hospitalization	☐1	☐2	☐3	☐4	☐5	☐6
G. Respect with which you were treated by health professionals and how your privacy was maintained during hospitalization	☐1	☐2	☐3	☐4	☐5	☐6
H. How you were provided with quick relief from your symptoms	☐1	☐2	☐3	☐4	☐5	☐6
I. Food served during hospitalization	☐1	☐2	☐3	☐4	☐5	☐6
J. Help you received to feel good enough to perform your daily tasks	☐1	☐2	☐3	☐4	☐5	☐6
K. Help you received to cope with emotional problems related to her health condition	☐1	☐2	☐3	☐4	☐5	☐6
L. Support you received to understand why it is important to follow the advice of the care team	☐1	☐2	☐3	☐4	☐5	☐6
M. Schedule of visits received during hospitalization	☐1	☐2	☐3	☐4	☐5	☐6
N. How you were listened to by social workers while you were hospitalized	☐1	☐2	☐3	☐4	☐5	☐6
O. Competence, courtesy and affection of social workers	☐1	☐2	☐3	☐4	☐5	☐6
P. How you were listened to and supported by the psychologist	☐1	☐2	☐3	☐4	☐5	☐6
Q. Competence, courtesy and affection of psychologists	☐1	☐2	☐3	☐4	☐5	☐6

I2. What is your assessment of the access/accessibility of this health facility in relation to:

Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Proximity to your home	☐1	☐2	☐3	☐4	☐5	☐6
B. Frequency of means of transport for your visitors to travel to the site	☐1	☐2	☐3	☐4	☐5	☐6
C. Cost of transportation (from home to health facility)	☐1	☐2	☐3	☐4	☐5	☐6
D. Costs of services provided (user fee)	☐1	☐2	☐3	☐4	☐5	☐6
E. Ease of access to essential health care services (consultations, complementary examinations, specialty consultations, complementary therapies, etc.)	☐1	☐2	☐3	☐4	☐5	☐6
F. Facility opening hours	☐1	☐2	☐3	☐4	☐5	☐6

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VI. COMMUNITY PHARMACY

Section to be filled in only if the health facility is a public or private community pharmacy

FC1. What is your assessment of this establishment in relation to:
Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Explanations given by the pharmacist/technician about the prescribed treatment	☐1	☐2	☐3	☐4	☐5	☐6
B. Availability of medicines	☐1	☐2	☐3	☐4	☐5	☐6
C. Variety of services/products offered	☐1	☐2	☐3	☐4	☐5	☐6
D. Quality of products and services offered	☐1	☐2	☐3	☐4	☐5	☐6
E. Information given by the pharmacist/technician about side effects/adverse reactions and problems related to the medication	☐1	☐2	☐3	☐4	☐5	☐6
F. Reimbursement system for medicines	☐1	☐2	☐3	☐4	☐5	☐6
H. Product/Service Pricing	☐1	☐2	☐3	☐4	☐5	☐6
I. Follow-up of reported cases of adverse reactions and medication-related problems	☐1	☐2	☐3	☐4	☐5	☐6
J. Quality of care	☐1	☐2	☐3	☐4	☐5	☐6

FC2. What is your assessment of the access/accessibility of this health facility in relation to:
Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Proximity to your home	☐1	☐2	☐3	☐4	☐5	☐6
B. Frequency of means of transport to get to the place	☐1	☐2	☐3	☐4	☐5	☐6
C. Cost of transportation (from home to health facility)	☐1	☐2	☐3	☐4	☐5	☐6
D. Costs of services provided (user fee)	☐1	☐2	☐3	☐4	☐5	☐6

FC3. What is your assessment of the facilities of this health facility in relation to:
Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Hygienic and clean conditions	☐1	☐2	☐3	☐4	☐5	☐6
B. Adaptation of spaces to the special needs of users with disabilities (e.g. physical, hearing, visual impairment, etc.)	☐1	☐2	☐3	☐4	☐5	☐6
C. General organization of the spaces of this health care establishment	☐1	☐2	☐3	☐4	☐5	☐6

FC4.	Strogly agree	Agree	I don't even agree I don't even disagree	Disagree	Strongly disagree
A. I don't see any reason to switch to another pharmacy	☐1	☐2	☐3	☐4	☐5
B. I recommend this pharmacy to my friends and family	☐1	☐2	☐3	☐4	☐5

FC5. In your opinion, how could the care provided in this health facility be improved??

FC6. Who filled out this questionnaire?

Please select one of the following options:

- ☐1 Yourself without help
- ☐2 Your own with help
- ☐3 An interview was conducted

THANK YOU VERY MUCH FOR YOUR COOPERATION!

To be completed by the inquirer and supervisor

Place and date of data collection _____ ____/____/_____

Name of the inquirer _____

Supervisor name _____

VII. FINAL

Section to always be filled in at the end of the interview, except pharmacies.

F1. What is your assessment of the facilities of this health facility in relation to:

Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Physical conditions and comfort of the waiting room	☐1	☐2	☐3	☐4	☐5	☐6
B. Physical conditions and comfort of doctors' offices and examination and treatment rooms	☐1	☐2	☐3	☐4	☐5	☐6
C. Quality of sanitary facilities	☐1	☐2	☐3	☐4	☐5	☐6
D. Locomotion conditions (doors, corridors, entrance, ramps, stairs, etc.)	☐1	☐2	☐3	☐4	☐5	☐6
E. Noise	☐1	☐2	☐3	☐4	☐5	☐6
F. Lighting of spaces	☐1	☐2	☐3	☐4	☐5	☐6
G. Hygienic and clean conditions	☐1	☐2	☐3	☐4	☐5	☐6
H. Guidelines on how to move around the facilities	☐1	☐2	☐3	☐4	☐5	☐6
I. Adaptation of spaces to the special needs of users with disabilities (e.g. physical, hearing, visual impairment, etc.)	☐1	☐2	☐3	☐4	☐5	☐6
J. General organization of the spaces of this health care establishment	☐1	☐2	☐3	☐4	☐5	☐6

F2. What general assessment do you make of the health facility in relation to:

Please select the appropriate position for each element:

	Excellent	Very good	Good	Reasonable	Bad	Don't know/Not applicable
A. Organization of services	☐1	☐2	☐3	☐4	☐5	☐6
B. Hygiene and comfort of the facilities	☐1	☐2	☐3	☐4	☐5	☐6
C. Opening hours of the services	☐1	☐2	☐3	☐4	☐5	☐6
D. Types of health care services provided	☐1	☐2	☐3	☐4	☐5	☐6
E. Quality of services provided	☐1	☐2	☐3	☐4	☐5	☐6
F. Overall assessment of the health facility/service	☐1	☐2	☐3	☐4	☐5	☐6
G. This health establishment/service responds to the needs and/or expectations of users/local population	☐1	☐2	☐3	☐4	☐5	☐6

F3.	Strogly agree	Agree	I don't even agree I don't even disagree	Disagree	Strongly disagree
H. I don't see any reason to switch to another health facility or service	☐1	☐2	☐3	☐4	☐5
I. I recommend this establishment or health service to my friends and family	☐1	☐2	☐3	☐4	☐5

F4. In your opinion, how could the care provided in this health facility be improved??

F5. Who filled out this questionnaire?

Please select one of the following options:

- ☐1 Yourself without help
- ☐2 Your own with help
- ☐3 An interview was conducted

THANK YOU VERY MUCH FOR YOUR COOPERATION!

To be completed by the inquirer and supervisor

Place and date of data collection _____ ____ / ____ / _____

Name of the inquirer _____

Supervisor name _____