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ASCEND

Accelerating Sustainable Control and Elimination of Neglected Tropical Diseases

LEARNING BRIEF

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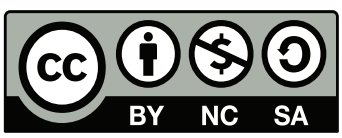
Accelerating Sustainable Control and Elimination of Neglected Tropical Diseases

ABOUT ASCEND

Accelerating the Sustainable Control and Elimination of Neglected Tropical Diseases (Ascend) is a programme funded by the UK Foreign Commonwealth and Development Office (FCDO) to achieve progress towards global targets for the control and elimination of neglected tropical diseases (NTDs). The programme supports countries in their efforts to control and eliminate five NTDs: Trachoma, Schistosomiasis, Onchocerciasis, Lymphatic Filariasis and Visceral Leishmaniasis. Ascend is managed geographically in two lots. Lot 1 focuses on 11 countries in East and Southern Africa and South Asia: Bangladesh, Ethiopia, Kenya, Malawi, Mozambique, Nepal, Sudan, South Sudan, Tanzania, Uganda, Zambia.

ACKNOWLEDGEMENTS

We would like to thank all the dedicated country lead and MEL staff who helped to implement these BFM programs with limited time, funding and support. Thank you also to the dedicated KIT and Crown Agents support staff who helped to provide feedback for the implementation of the BFM activities and this learning brief.



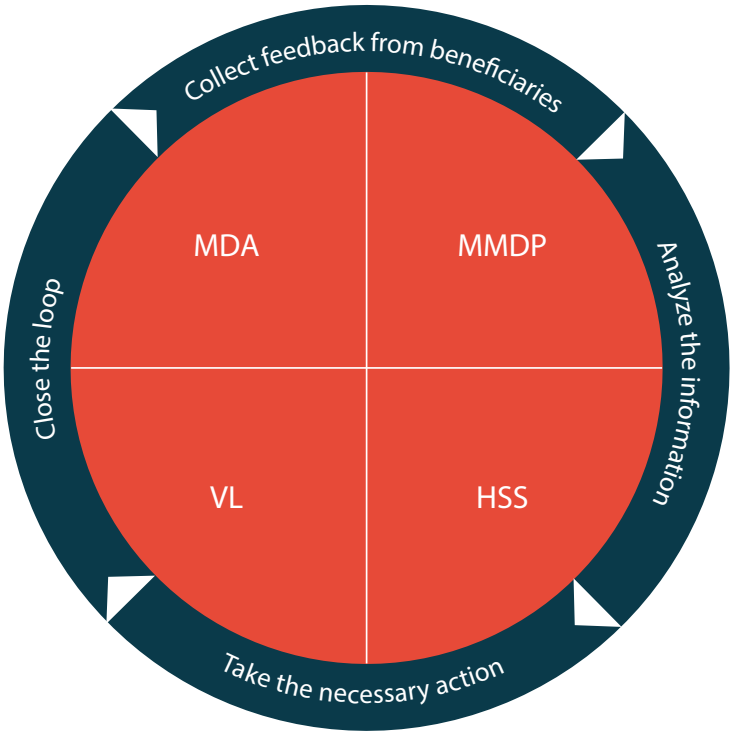
BENEFICIARY FEEDBACK MECHANISMS

To improve the delivery of health interventions, people-centred approaches are needed, both to ensure that interventions are accessible and address health care needs appropriately. There is a growing body of evidence demonstrating that the feedback of patients and community members can improve programmatic activities and lead to the more equitable and comprehensive distribution of the programme interventions.[1] Beneficiary Feedback Mechanisms (BFMs) provide a means of recording, evaluating and addressing the perspectives of beneficiaries into health care delivery (see Figure 1).

To inform the design of the beneficiary feedback strategy, we consulted with Ascend country leads, MEL staff and safeguarding focal points across the 11 countries in which the programme operates. We identified existing mechanisms and practices conducted by the Ministry of Health with regard to beneficiary feedback. These discussions highlighted that NTD programmes do not commonly systematically collect and use beneficiary feedback.

The Ascend Lot 1 approach to beneficiary feedback was centred around alignment with existing systems and processes to manage NTD activities where possible. In line with our focus on health system strengthening, we worked closely with Ministries of Health to introduce or enhance components of beneficiary feedback across NTD service delivery. Implementation of BFM followed the main NTD service areas featured in Ascend: Mass Drug Administration (MDA) campaigns, morbidity management and disability prevention (MMDP) and Visceral Leishmaniasis (VL) patient care. In this learning brief we describe the variety of different tools used within Ascend Lot 1 for collecting and using feedback and discuss lessons learned from the pilot implementations. All the guides and tools that were created are brought together in the Ascend lot 1 BFM Toolkit: Guides and Tools.

Figure 1: Beneficiary Feedback Mechanism Cycle



1. https://journals.sagepub.com/doi/10.1177/1077558713496318

BFM IMPLEMENTATION

In the second year of the programme, several BFMs were piloted across Ascend countries and intervention areas. The goal of the pilots was to examine the feasibility and efficacy of implementing these beneficiary feedback tools within the current interventions and to see which methods would work well for specific diseases and in specific countries. These pilots enabled the programme to gather systematic feedback from stakeholders and assisted a wider roll-out of BFMs across NTD programmes.

The BFM pilots covered a wide range of programmatic activities and were trailed in different countries to (1) introduce and sensitize BFMs to the widest possible range of Ascend staff, MoH workers and patients/community members, (2) obtain a wide range of lessons in implementing BFMs in various countries.

Figure 2 (page 5) shows the geographic areas of the various BFM pilots.

FEEDBACK COLLECTION METHODS

Mass Drug Administration

BFM can be implemented in many ways, as demonstrated by the wide variety of tools that have been used to collect beneficiary feedback on MDA activities. The supervisor's coverage tool (SCT) is a brief follow-up questionnaire taken on a sample of eligible individuals during the MDA in a purposefully selected location to try to provide real-time estimates of drug coverage. Appending BFM questions to the SCT in Mozambique and Sudan allowed the countries to gain insight on patient experience, optimal time and date of drug campaigns (gender-disaggregated), and adherence to COVID-19 control measures. Using BFM in this tool particularly provide the opportunity for programme intervention and re-steering of the MDA campaign if something needed to be urgently changed.

Similarly, the Independent Coverage Survey (ICS) also assesses the coverage of MDAs, but shortly after the MDA is completed and with a much larger sample size. Adding BFMs in the ICS in Uganda and Mozambique provided an opportunity for the collection of much more feedback and allows country teams and ministry members to make considerations for any necessary adaptations in future campaigns. Box 1 shows some sample questions used to obtain beneficiary feedback (a full set of questions is attached at the end of the document) and Box 2 (page 6) shows the results from participant feeback through ICS in Uganda.

Box 1: Sample BFM Questions in the ICS Survey

How convenient for you was the time of day that the treatment was offered?
Did you have a chance to ask questions?
How satisfied were you with the performance of the CDD?
Do you have suggestions to improve the MDA?
Do you have questions regarding the prevention of NTDs?
Do you have any suggestions to improve the communication around the MDA?

Figure 2: Ascend Lot 1 BFM Pilots from Nov 2020 to June 2021

The Sudan team found innovative ways to include BFM in programme activities. For example, using social media platforms and WhatsApp to create private groups[2] for communities that were visited during MDA activities. In these groups, the team was able to monitor real-time feedback from community members through their leaders and provide rapid responses if any issues arose. While such strategies might favour younger or more tech-savvy age groups who use these apps more frequently, they still proved to be a valuable way to supplement other forms of feedback. They also introduced a way to record BFM in meetings where community drug distributors (CDDs) would gather to discuss issues at the end of MDA days. Columns for feedback from the MDA and any challenges encountered were added to the CDD registers. This was the first step in referring complaints to programme supervisors, who, in turn, discussed the feedback with MoH members during MDA supervisory meetings. The involvement of the Ministry is key for the sustainable implementation of beneficiary feedback and was attempted at every stage possible in the project.

In general, BFM pilots, where the tools were added to existing programme elements that deal with beneficiary follow up, were effective and relatively easy to implement. This was certainly true for MDA activities, where BFM questions were added to SCT and ICS coverage surveys in numerous countries, in addition to the other methods used.

Box 2: Independent Coverage Survey and Participant Feedback in Uganda

Beneficiary feedback questions were implemented in the Uganda ICS at the beginning of 2021. Of the 2,555 participants who responded to BFM questions, 90% reported satisfaction with the CDDs during MDA campaigns.

There were considerable numbers of respondents in certain communities that did not recall certain elements of the MDA, such as the day and time of day that it occurred. This could be because the survey was conducted three months after the majority of MDA activities had already concluded. Doing the ICS closer to when the MDA occurs could yield more relevant results and be less prone to recall bias. This also provides an incentive for logging beneficiary feedback in the SCT, providing opportunities to evaluate feedback closer to the time of MDA activities.

The opportunity for participants to ask the CDD questions was evaluated, and it was found that 26% did not have a chance to ask questions during the MDA, which may have been a result of time pressures, but could also be a consequence of ambiguous wording or misinterpretation of the question. This demonstrates the importance of dedicated training for BFM questions for future ICS.

In the dissemination meeting following the ICS, BFM results were also reported and noted for consideration in the next phase of programming by MoH managerial staff.

MORBIDITY MANAGEMENT AND DISABILITY PREVENTION

BFMs in MMDP care activities often focus on individual patients who are at times getting sensitive and invasive treatments. As such, BFM for MMDP can often rely heavily on quality-of-care methods and focus on identifying deterrents and barriers for seeking treatment. While

2. Permission was requested from all community leaders and MoH workers to initiate groups; the confidentiality of community members was intact as all their claims were directed through community leaders, there was no mention of their names

there are differences between MDAs and BFMs in terms of activities, the same principles applied in that making use of existing programme structures proved to be the most feasible. For example, patient follow-up visits following hydrocele surgeries are an important element of patient care for this highly invasive procedure. These follow-up visits provided a good opportunity to obtain patient feedback, as demonstrated in the BFM pilot that was done in Bangladesh on 71 patients. Although movement restrictions, due to COVID-19, made it difficult for the country team to travel, they were able to successfully follow up with patients using phone interviews within three months of their surgery.

In Tanzania, trachoma focal staff were able to implement BFMs in a similar manner during patient follow-ups after surgeries. These 7–10-day post-operative visits entail a home visit and a clinical questionnaire about post-surgical complications and symptom management and provide a good opportunity for the patients to give feedback about their surgical experience. Table 1 (below) shows some of the methods that can be used to collect feedback from MMDP patients. Nepal, Bangladesh and Zanzibar demonstrate three separate tools developed to get BFM from hydrocele surgery patients.

Table 1: Methods of collecting feedback from MMDP patients.

Country/Intervention	Mechanism/Method	Status of Tool development/Planning
Tanzania- Trachomatous Trichiasis surgery	10-14 day post-operative patient follow up visits decided as best mechanism	Tool developed and feedback was taken from patients, collection is ongoing as of July 2021
Nepal – hydrocele surgery	7-10 day patient follow-up visit decided as best mechanism	Tool developed, next round of hydrocele surgeries/FCDO activity pause
Bangladesh – hydrocele surgery	Phone survey (due to COVID-19 & budget restrictions) in Bangla to be administered by country MEL staff >1 month after surgery, using phone numbers from pre-operative data repositories	Tool developed, translated into Bangla, data collection completed (71/94 patients interviewed), report drafted
Zanzibar – hydrocele surgery	Qualitative assessments 6 months post-surgery to be implemented by country team, possibly training medical students as data collectors	Tool developed, awaiting funding confirmation

VISCERAL LEISHMANIASIS

Treatment for VL is relatively short and takes place in health care facilities. As patients show up on an ad hoc basis, it is hard to find a large sample of VL patients at any given time from whom to get feedback. While there were no VL existing tools on which to piggyback BFM questions, countries like Kenya, and their implementing partner FIND, made use of VL focal persons' regular visits to health care facilities to do quality of care (QoC) checks to successfully obtain feedback from 29 patients (see Box 3).

Box 3: Feedback from Visceral Leishmaniasis Patients in Kenya

In Kenya, VL patients receive treatment for 17 days, to get feedback, tools were first designed by country and MEL staff and later adapted by FIND (the implementing partner) and given to a regional VL focal person working in the Ministry. This focal person took advantage of scheduled visits to health care facilities to get feedback from the VL patients on a paper copy of the tool. While this is a supplemental task, it makes use of existing quality of care checks. It is preferable to ask regional VL focal points to collect feedback, instead of using care providers within the facility as they may not be impartial and could potentially introduce bias.

Of the 373 patients being treated for VL in Kenya, results were received for 29 at the end of the second year of the Ascend programme. Of these 29 patients, 2 rated their quality of care as fairly good, 21 as good, 3 as very good, 1 as excellent, and 2 omitted a response. Some of the challenges that these patients recognized were treatments and transportation costs, delayed treatment due to COVID-19, a lack of drugs or being wrongly diagnosed as suffering from TB, lack of blood for transfusion, long distances to treatment facilities, shortage of food, and pain at the injection site.

The Bangladesh team was able to administer follow-up calls and contacted VL patients quickly and at a low cost. The results of these follow-up calls were entered on a google form, and the data were reviewed and analysed rapidly. In general, where electronic tools were utilized, data were analysed and discussed much more quickly.

Box 4: BFM Phone Interviews with Hydrocele Surgery Patients in Bangladesh

A combination of phone interviews and electronic data entry tools proved to be an effective way of collecting BFM in Bangladesh. While phone interviews may not be the most representative way to reach patients, as they can miss the most impoverished participants who have no phone access, it was an effective way to reach the majority of them and have real-time data to seek immediate improvements. While seeking isolated community members and the leave no one behind is central to Ascend, this method provided large amounts of real-time feedback that could be analysed quickly at no additional cost. With additional funding for BFM, this method could be improved with the addition of home visits to patients who did not have the opportunity to respond.

TRAINING

Many trainings have been given within the Ascend programme, on many aspects (e.g. governance, MDA, MMDP, monitoring and evaluation) and with various types of participants (e.g. CDDs, clinicians, MoH staff). To improve future training sessions, training feedback forms were created and introduced to capture participants' feedback. While pre- and post-test questions already existed in many of the countries, training feedback forms were relatively new to many of the country teams. Electronic feedback form templates were created at the central level, along with standard operating procedures advising on their use. Numerous countries across the platform began using feedback forms after training sessions, albeit paper-based forms, which were often more practical in field-based training. Countries that used training feedback forms included Bangladesh, Nepal, Kenya, Tanzania, Sudan, Ethiopia and Mozambique.

Box 5: Training Feedback Forms in Ethiopia

The VL Control Program in Ethiopia trained clinicians on the clinical case management and M&E for VL, and laboratory professionals on diagnostic tests for VL and external QA. After the training, feedback was obtained with paper-based feedback forms and the results were digitized. This allowed strengths and gaps to be more clearly identified.

Strengths:

- There was a multi-sectoral collaboration to ensure proper training is given for participants
- The venue was well suited for participants of such a number
- Training participants were involved in the training actively
- COVID-19 prevention measures were properly implemented.

Gaps:

- Due to a lack of VL treatment services in Adama hospital, it was not possible to organize a practical session for clinicians
- Some participants mentioned that the clinicians should not be responsible for M&E activities of VL
- Hard copies of training materials were not given to the training participants.

CASE STUDY

BANGLADESH: REACHING OUT TO PATIENTS AND TRAINING PARTICIPANTS

COLLECTING BFM

In the second year of the Ascend programme, BFMs were successfully implemented in several areas in Bangladesh. The country team developed an electronic tool to collect beneficiary feedback, and in March 2021, the team made calls to patients who had received VL treatment in facilities and issued questionnaires to those willing to provide feedback.[3] Contacting patients by phone proved to be effective, with 17 patients providing feedback. The use of phone interviews in combination with the electronic tool worked well in the difficult context of limited resources and movement restrictions due to COVID-19, and were also used to collect feedback from hydrocele surgery patients.[4] For these calls, feedback questions were combined with a second patient follow-up (the first took place in the health facility 7-14 days after surgery when the stitches were removed) and entered anonymously in an electronic data collection tool. Feedback was obtained from 71 of the 94 patients who had received surgery during the previous month(s).

> "I had a bilateral hydrocele. I'm living a normal life now after surgery. Previously I was living in hell, and I feel like I'm living in heaven now."
>
> Hydrocele Patient Testimonial

Training feedback forms were also usedcto collect data from training session participants. The forms became widely integrated into training sessions and continued after the initial pilot phase.

ANALYSING FEEDBACK

Feedback from VL and Hydrocele surgery patients was analysed relatively quickly as it was entered electronically, and dedicated staff distributed the results.

VL patient data collected through the BFM tools gave an interesting overview of patients' experiences seeking care. Alongside demographic data and patients' attitudes towards the treatment received, the tool provided insight into patient access to the treatment facility, patient perspectives on the reasons for the delay in diagnosis and treatment, and suggestions for improving the quality of services, which included:

- The provision of travel costs and subsidies for lab testing
- Having treatment facilities at the district level (decentralising treatment for easier access)
- Regular clinical follow-ups from the treatment facilities.

Feedback from hydrocele surgery patients was taken on a relatively large sample of the total number of patients who received the surgery (71/94), and in addition to previously mentioned indicators collected for VL, it also included data on health-seeking behaviour, COVID-19 as a barrier to seeking care, and patient testimonials. The feedback from the hydrocele patients showed that 85% had been living with their hydrocele for more than three years, and 42% had lived with their hydrocele for over a decade. Fifty-eight per cent of patients reported that they had not previously sought care due to a lack of money, and 70% said that their decision to get surgery came when they found out that it was free.

3. The decision to collect feedback was taken jointly with National Kala-azar Elimination Program and Ministry of Health and Family Welfare
4. The feedback was collected as per approved guideline for hydrocelectomy.

The standard travel time for 86% of patients was less than one hour, with 72% having to wait for less than a day for care in the hospital. There were areas of the feedback that provided clear indications of where improvement could take place in terms of quality of care, with only 86% of patients feeling as though they were properly informed of the risks prior to the procedure.

LESSONS LEARNED AND ACTIONS TAKEN

By collecting beneficiary feedback, the country team learned that phone interviews can be an effective way to follow up on patients when staff cannot travel due to movement restrictions. They also found that electronic data collection tools are preferable as data can be analysed in real-time. Pre-operative registers for hydrocele patients and health facility records for VL patients gave the country teams patient information for this process, such as phone numbers and the demographic information to verify the patient's identity during the call.

> "A very good initiative from the government to provide this surgery free of cost to deprived patients like us. We couldn't afford to pay for this surgery on our own."
>
> Hydrocele Patient Testimonial

BFMs from training feedback forms also resulted in changes to training programmes, such as participants reporting that training sessions delivered in English were poorly understood and should be changed to the local language. Furthermore, participants in the Lymphatic Filariasis (LF) training sessions recommended that more practical components were included in the training. Both of these suggestions resulted in changes in future training sessions. All subsequent training was conducted solely in Bangla and LF training sessions began to incorporate LF patients for hands-on learning. Community health workers were very happy with this change which was reflected in the feedback, and the patients who were able to help with teaching reported feeling empowered.

CLOSING THE LOOP

Sharing the BFM results of patients with the MoH during dissemination discussions was an important first step in closing the feedback loop. The sensitisation of Ministry officials on the benefits of BFM is a way to ensure that BFM is utilized more in the future, allowing for more cycles of feedback.

An important aspect of closing the feedback loop is communicating the actions taken from previous BFMs with the beneficiaries that gave or can give feedback. Such communication took place during phone interviews, where many patients reported feelings of empowerment and satisfaction from being able to participate in providing such feedback, and also with participants in re-designed training sessions. Seeing the positive changes that stem from previous feedback can encourage future cycles of feedback from new beneficiaries.

→ Patient after hydrocele surgery and his wife - Bangladesh

CASE STUDY

SUDAN: OPTIMIZING THE COLLECTION OF COMMUNITY FEEDBACK

COLLECTING BFM

Mass Drug Administration programmes aim to provide preventive treatment and care for large populations and require a wide range of tools/approaches to collect feedback and reach as many people as possible. While doing MDA activities in certain areas, the Sudan country team, alongside community leaders, created WhatsApp and Facebook groups as one method of implementing real-time BFM. These groups were operated by all members of the country team who regularly responded to comments from community members. These online groups allowed MDA participants to provide feedback on the quality of services during the MDA, and to ask follow-up questions regarding medication side effects, that they may not have been able to ask during drug distribution. Beneficiaries were also invited to call in and provide feedback on their experiences on TV and radio shows promoting the MDA activities.

→ Registration and recording feedback from participants - LF MDA South Darfur state - Photo: Dr Arwa Abubakar

Participants were also able to leave their feedback in an anonymous complaint box and through the safeguarding hotline. Additionally, feedback was collected by community drug distributors (CDDs), and part of their registers was adapted to create space for them to write down challenges and suggestions for improvements. These suggestions would then be discussed in daily coordination meetings at the end of each MDA Day. BFM questions were also added to the SCT, and feedback was asked for during religious gatherings in churches and mosques.

Box 6: Using Social Media

Social media and WhatsApp proved to be a valuable platform for community leaders to anonymously pass on feedback from community members and facilitated conversations with others in the community.

Having community leaders and group facilitators react to comments and complaints allowed the group to gain further insight into the challenges and limitations of the MDA campaign and inform the group in real-time. This feedback allowed country teams and MoH staff to address problematic practices.

While these groups do not guarantee equal representation, they offer a medium where voices can be heard, and drug recipients can learn more about the medications that they received.

5. Permission was requested from all community leaders and MoH workers to initiate groups; the confidentiality of community members was intact as all their claims were directed through community leaders, there was no mention of their names

ANALYSING FEEDBACK

While the Sudan country team created many innovative methods to collect feedback from a wide variety of beneficiaries, the data from all of these distinct methods and tools did not end up in one unified repository. Instead, feedback was often reacted to on an ad-hoc basis. The country team created a reporting hierarchy for BFM, where following the daily coordination meetings where BFM would be discussed at the end of each day, issues would then be passed up the chain and discussed in supervisory and leadership meetings with a member of the MoH present. This created two notable benefits, the first being that the process helped sensitise members of the MoH to the advantages of using BFM in the campaigns, and the second that this process would allow the country team and ministry to address problems in real-time. This created a scenario where feedback from community members was being discussed with the nation's top NTD officials within weeks or even days of being captured.

LESSONS LEARNED AND ACTIONS TAKEN

Social media and WhatsApp groups proved to be an effective way for the Sudan country team to obtain insights into the experiences of MDA participants. An important issue that was brought to light was the days of the week suitable for MDA. Initially, there was no MDA implementation on Fridays as it is the Muslim day of worship and it was thought that it would result in poor attendance. However, through the groups, it was discovered that more people were off work on that day than any other, making Fridays ideal for getting the highest level of participation.

Aside from MDA activities, further programme improvements came from BFMs at an NTD clinic in a refugee camp. Feedback from the camp indicated that many of the women were uncomfortable reporting medical issues through male translators, leading some to refrain from seeking treatment. To address this, the team was able to use female nurses as translators during NTD consultations in place of the men who were previously translating it. This made female patients feel more comfortable and open during consultations and may have encouraged better attendance as a result. Additional feedback at the camp requested that there also be a condom distribution area at the clinic, which the team put in place.

CLOSING THE LOOP

The Sudan country team was to close the feedback loop through responses to patients in social media groups. This highlights another potential advantage of using digital platforms to collect and discuss feedback. Country staff were not only able to address and answer comments and questions but also to communicate with community members that patient feedback had resulted in positive changes made to the methods of distributing drugs in communities.

The team trained new CDDs, who were volunteers from communities in MDA regions, on the importance of BFM and how changes, such as the day of MDA campaigns, could come from feedback. On a larger scale, they also informed radio and TV audiences of the power of feedback in bringing about programmatic change.

Sensitizing NTD workers in the MoH to BFM was also a component in closing the loop in Sudan. Proving the utility of using BFM to the people who will be implementing future MDA campaigns is more likely to initiate future feedback loops and encourage a culture of valuing a beneficiary-centred approach.

PRACTICAL TIPS

Implementing BFM in different countries with very different programme delivery methods was a great learning opportunity for how it can be best conducted in future. While BFM will always be country and contex-specific, there are important considerations and good practices to use during implementation:

- BFM should be included from the start of an activity, and funding should be allocated.
- Where possible, members of the MoH should implement BFM and facilitate changes.
- To ensure feedback is collected correctly and objectively, it is essential to provide sufficient training to those who will do the collection and to play their part in closing the loop by informing beneficiaries about previous improvements and the potential benefits of participation.
- People must always be asked if they want to provide feedback, accept that people may not want to provide feedback, they should be informed that not providing feedback has no consequences, feedback must always be collected anonymously, and permission must be sought to do phone interviews.
- It is important to have a dedicated analysis team that can synthesize results from a diverse array of sources and interpret what useful changes should be implemented.
- Beneficiary feedback should be put on the agenda of coordination meetings so that useful feedback that may improve programs can be discussed.
- BFM is particularly easy to implement when piggybacking on existing tools (SCT/ICS, TT/LF post-surgery patient visits).
- Using electronic data collection tools helps to expedite analysis and allows the program to respond faster to patients, and allows countries to act upon the recommendations more quickly.
- Not every BFM is equitable or favours leaving no one behind but collecting as much feedback as possible is still important. Social media groups and phone surveys do not necessarily reach everyone but are valuable and inexpensive ways to get feedback and should be used in combination with methods that access harder to reach populations.
- Guidelines are useful, but it is important to keep them adaptable as the context for collecting BFM will vary significantly from one setting to another.
- Feedback after training is fundamental, and the constructive feedback from participants has manifested in numerous positive changes across the Ascend programme.

Throughout this learning brief, there are many areas where we have demonstrated how much can be learned through the use of BFM, as well as the tangible changes to program activity that resulted from the feedback. BFMs are integral in the promotion of people-centred approaches in health programs. Any program not using BFM is at a disadvantage for maintaining optimal efficiency and is less likely to facilitate a beneficiary-centred approach.

When used correctly, BFMs have the potential to improve program coverage, program efficiency, communication between providers and beneficiaries, and facilitate more trusting relationships between beneficiaries and health care providers. They give a voice to underrepresented community members and can keep programs dedicated to their beneficiary-centred approach. Every program component has the opportunity to be improved by implementing BFMs, and more health workers and organisations must be sensitised to their benefits.

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Beneficiary Feedback Mechanism Questions in ICS Survey

How satisfied were you with the location of the venue?

not satisfied ☐ ○ ○ ○ very satisfied
1 2 3 4

What day of the week did they deliver treatment?

☐ ○ ○ ○ ○ ○ ○
Monday Tuesday Wednesday Thursday Friday Saturday Sunday

How satisfied were you with the choice of the day of the week?

not satisfied ☐ ○ ○ ○ very satisfied
1 2 3 4

At what time was the treatment administered?

☐

How convenient for you was the time of day that the treatment was offered?

not convenient ☐ ○ ○ ○ very convenient
1 2 3 4

How convenient for you was the time of the month that the treatment was offered?

not convenient ☐ ○ ○ ○ very convenient
1 2 3 4

How long did you have to wait at the venue before you received the treatment?

☐

How much time did it take you to participate in the MDA?

☐

How satisfied were you with the information you received from the community drug distributor (CDD) on the medicine that was given?

not satisfied ☐ ○ ○ ○ very satisfied
1 2 3 4

Did you have a chance to ask questions?

☐ Yes ○ No

How satisfied were you with the performance of the CDD?

not satisfied ☐ 1 ○ 2 ○ 3 very satisfied ○ 4

Do you have suggestions to improve the MDA?

Do you have questions regarding the prevention of NTDs?

Do you have any suggestions to improve the communication around the MDA?