The mean level of dissatisfaction among these negative response cases ranged from 10% in Mexico to 22% in Paraguay (Table 4).

The results of the follow-up surveys indicate that in all five countries, both the mean number of negative response cases and the mean level of dissatisfaction among those cases decreased. This suggests an apparent beneficial impact of the improvements implemented between the two surveys. The percentage decrease in dissatisfaction ranged from 28% in Trinidad and Tobago to 76% in Paraguay.

It is important to note here that the follow-up analysis was confined to questions that were negative response cases in the first survey. Thus, the number of negative response cases per survey (those included in the follow-up column) could at most equal the number in the initial survey. However, it was possible for questions that were not negative response cases in the first survey to have become negative response cases in the second, if the negative response level increased from less than to more than 5%. Indeed, in the majority of follow-up surveys, at least one new negative response case appeared.

Likewise, the mean level of dissatisfaction among negative response cases in the follow-up surveys included here refers to dissatisfaction associated with the negative response cases identified in the initial surveys only. If all negative response cases in the follow-up surveys were included, the mean level of dissatisfaction would be higher or lower, depending on the level associated with the areas that were not negative response cases in the first survey.

The questions that became negative response cases in the second survey were also included in the levels of dissatisfaction for the first survey, those levels would decrease, and the percentage change in dissatisfaction would be weaker than is shown in Table 4. Our rationale for not including those questions in the analysis is that because they were not identified as areas for improvement in the first survey, no action was proposed. Since we are attempting here to determine whether the implemented actions had positive effects on the areas identified for improvement, we chose to confine the analysis to negative response cases from initial surveys only.

We also broke down the comparison of the initial and follow-up surveys by area for improvement (Table 5). (The “other” category includes questions for which there was only one comparable negative response case among all the surveys.) Strong decreases in dissatisfaction are evident for each of the variables, again suggesting that improvements implemented by the clinics had a positive effect. Especially strong decreases were seen for insufficient time in consultation (64%) and not enough opportunity to ask questions and clarify doubts (60%), suggesting that the improvements associated with those variables (better control over doctors’ schedules, more doctors and consultation rooms, and refresher training for counselors) may have been particularly effective.

While appearing impressive, these results are aggregated from 16 sites and do not mean that client satisfaction necessarily improved for all variables at all sites. In Brazil, for example, client dissatisfaction with waiting time decreased at one site after the family planning association decided to keep the clinic open during lunch hours. However, dissatisfaction with clinic hours increased, apparently because BEMFAM simultaneously decided to close the clinic earlier in the afternoon (a decision that was subsequently reversed). Similar results at other sites show that one cannot expect satisfaction to improve following every single intervention.

Further, although aggregate dissatisfaction decreased strongly for all variables, the average level of dissatisfaction remained greater than 5% in four of the seven areas for improvement. In all individual cases where this is true, they remained negative response cases and require further improvement, even though satisfaction levels improved. In such cases, the family planning association and clinic are still expected to propose improvements to address them. This is meant to be a process of continuous improvement, one that does not stop with the application of one or two surveys. Indeed, many family planning associations found the methodology to be sufficiently useful that they continued to use it beyond the study period.

### Discussion

Our findings suggest that exit interviews using short, simple questionnaires among a small sample of clients can successfully identify areas of dissatisfaction among clients. Moreover, the results seem to show that efforts to address those concerns can lead to higher satisfaction. This approach offers several important advantages over other methodologies:

- **Ease and cost of application.** The questionnaires and interview guidelines are easy to use and require minimal training. They can usually be conducted by existing staff (if central-level staff are used as interviewers) or by outside interviewers, hired as needed. They are less costly to carry out than many other quality-evaluation tools. Reporting results is also easy and systematic, and managers receive rapid feedback in an easy-to-understand format.

- **Practicality.** In addition to the generic attributes listed above, the approach described here addresses some of the limitations of traditional methods of evaluating client satisfaction. Most important is focusing improvement efforts on areas with a negative response of at least 5%. This gives program managers something tangible to work with in analyzing results, and allows them to use results to bring about positive change. Ultimately, the methodology may be more useful as an impetus for quality improvement than as a strict evaluation device.

- **Client orientation and empowerment.** Client exit interviews are one of the few tools that provide quantifiable data on clients’ perceptions. They can also provide information...