

Level of Patient Satisfaction With the Quality of Care Offered in Health Centers of the Kwango Provincial Health Division

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ARTICLE INFO

Received: 13 October 2025

Accepted: 02 January 2026

Published: 13 January 2026

Keywords:

Level, patient satisfaction, quality of care, Kwango Provincial Health Division, Democratic Republic of the Congo, SERVQUAL

Peer-Review: Externally peer-reviewed

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To cite:

Nkwahata, N. R., Mayamba, M. M., Onoya, W. J., Nswele, I. O., Kasongo, M. E., & Masimango, G. C. (2026). Level of patient satisfaction with the quality of care offered in health centres of the Kwango Provincial Health Division. *Orapuh Journal*, 7(1), e1403
<https://doi.org/10.4314/orapi.v7i1.3>

ISSN: 2644-3740

Published by **Orapuh, Inc.**, F. Gaye Res., Sukuta-Jamisa, Greater Banjul, The Gambia.

Editor-in-Chief: Prof. V. E. Adamu
(editor@orapuh.org)

ABSTRACT

Introduction

Patient satisfaction is a critical performance indicator used to evaluate the efficiency, effectiveness, and quality of care in healthcare facilities, directly impacting service utilization and attendance. In the health centers of the Kwango Provincial Health Division (Democratic Republic of the Congo), patient dissatisfaction with the quality of care remains a persistent operational challenge.

Purpose

The objective of this study was to evaluate the level of patient satisfaction regarding the quality of healthcare offered across health centers in the Kwango Provincial Health Division.

Methods

An analytical cross-sectional study was conducted among 384 patients selected via simple random sampling across 21 health centers in seven health zones. Data were collected through structured face-to-face interviews using an adapted SERVQUAL questionnaire administered via the KoboCollect mobile application. Data were analyzed using IBM SPSS Statistics (Version 26) to generate descriptive statistics, including frequencies and percentages. Satisfaction levels were categorized using an author-defined four-tier classification benchmark.

Results

The overall patient satisfaction level across the Provincial Health Division was low. Out of 384 respondents, 196 patients (51.0%) reported being satisfied, whereas 188 patients (49.0%) were dissatisfied with the quality of care received. While privacy (66.6%) and affordability (67.9%) achieved moderate satisfaction, critical operational dimensions—including waiting times (47.1%), handwashing facility availability (45.5%), and caregiver collaboration (46.0%)—exhibited very low satisfaction levels.

Conclusion

Patient satisfaction in health centers within the Kwango Provincial Health Division remains suboptimal. Enhancing quality of care requires integrating patient satisfaction metrics into routine monitoring and evaluation frameworks, improving hygiene and facility infrastructure, and strengthening supervision by health zone management teams over healthcare providers.

INTRODUCTION

The evaluation of the second-generation National Health Development Plan in the Democratic Republic of the Congo (DRC) revealed substantial systemic shortcomings on both the supply and demand sides of health service delivery. Key challenges include low service utilization, poor facility attendance, and substandard quality of care, as reflected in patient dissatisfaction (Diallo, 2021).

Patient satisfaction derives directly from the perceived quality of services and care received. As a subjective personal evaluation formed through a dynamic cognitive process, satisfaction varies across individuals and serves as a fundamental benchmark for healthcare quality. Formally, satisfaction reflects the recipient's affective orientation toward the care received relative to their expectations and previous healthcare experiences (Ramanah et al., 2014).

Globally, patient satisfaction evaluations are central to health systems management. In France, patients reported high satisfaction with nursing care, with scores frequently exceeding 80% (Sanogo et al., 2019). High satisfaction was strongly correlated with attentive communication, emotional support, service quality, manageable waiting times, and prompt emergency response (Blondel, 2022). In rural Bangladesh, patient satisfaction in public health facilities depended largely on caregiver attitudes, particularly respect, consideration, courtesy, and technical competence (Mendoza Aldana et al., 2001). Conversely, an evaluation of surgical emergency care in Niger demonstrated that 54.6% (n = 124/227) of patients were satisfied with service delivery (Adamou et al., 2017).

In Sub-Saharan Africa, quality gaps remain widely documented. In Burkina Faso, over 50% of hospitalized patients in the internal medicine department of the Sourou Sanou University Hospital Centre (CHUSS) in Bobo-Dioulasso expressed dissatisfaction with medical management (Meda et al., 2019). Evaluated via SAPHORA-7 criteria, dissatisfaction stemmed from poor reception, weak provider-patient interaction, substandard catering, inadequate discharge planning, and prolonged hospital stays (Meda et al., 2019). Conversely, in Mali, a survey of 83 hospitalized patients in the Koutiala Health District yielded an overall satisfaction rate of 94.0%,

driven by trust in caregivers, prompt waiting times, patient safety, and transparent drug sales (Sanogo et al., 2019). In the DRC, a study in the N'djili health zone showed high maternal satisfaction regarding provider technical competence, professional conduct, and geographic accessibility; however, poor facility hygiene, perceived negligence, and unbudgeted out-of-pocket expenses generated dissatisfaction (Mpembele, 2020).

Relevance of the Study

An analysis of healthcare delivery indicates that the health system of the DRC—including the Kwango Provincial Health Division—faces severe operational challenges, notably substandard care quality manifested in widespread patient dissatisfaction. Formulating effective corrective interventions requires precise measurement of satisfaction. Previous regional studies were limited to reporting simple satisfaction percentages without categorizing overall satisfaction levels due to a lack of standardized benchmarks.

To address this methodological gap, this study applies a structured four-tier satisfaction classification scale proposed by the authors:

- i. < 50.0%": Very Low (Red)
- ii. 50.0% - 59.9%": Low (Yellow)
- iii. 60.0% - 69.9%": Moderate / Medium (Blue)
- iv. ≥ 70.0%": High (Green)

For this study, the acceptable minimum quality threshold was set at 60.0%.

Research Objective & Question

1. **Research Objective:** To determine the overall and domain-specific levels of patient satisfaction with the quality of care provided in health centers within the Kwango Provincial Health Division.
2. **Research Question:** What is the level of patient satisfaction regarding the quality of care delivered across health centers in the Kwango Provincial Health Division?

METHODS

Study Setting

The study was conducted across 21 health centers located within seven health zones (Boko, Kahemba, Kenge, Kimbau, Kisanji, Panzi, and Wamba Lwadi) in the Kwango Provincial Health Division, Democratic Republic of the Congo.

Study Design and Field

This was a quantitative, descriptive cross-sectional study situated within the domain of health services management. It investigated patient evaluations of healthcare quality in primary health centers.

Population, Sampling, and Sample Size

The target population comprised all 115,733 patients who sought curative care across the 21 selected Performance-Based Financing (PBF) health centers in the Kwango Provincial Health Division during the study period. Inclusion criteria required participants to have received curative care at a participating center and voluntarily consented to participate.

The sample size (n) was calculated using Cochran's (Fisher's) formula for population proportions:

$$n = [Z^2 \times p \times (1 - p) / e^2]$$

Where:

Z = 1.96 (corresponding to a 95% confidence interval)

p = 0.50 (assumed population proportion yielding maximum variability)

e = 0.05 (acceptable margin of error)

$$n = [(1.96)^2 \times 0.50 \times (1 - 0.50)] / (0.05)^2 = 384$$

A simple random sampling strategy was used to recruit the 384 participants.

Data Collection Techniques and Instruments

Data were collected via structured face-to-face interviews using an adapted SERVQUAL instrument administered through the KoboCollect application on Android smartphones. To minimize central tendency bias, a 4-point Likert scale was employed (*Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied*).

Data Collection Procedure

Interviews lasted approximately 35 minutes per participant. Respondents were identified at their community residences by trained community healthcare workers (*relais communautaires*) using address records retrieved from health center outpatient registers. Responses were directly digitized using mobile devices.

Data Analysis

Data were exported from KoboCollect to Microsoft Excel 2016 and imported into IBM SPSS Statistics Version 25. Univariate analysis was performed to calculate absolute frequencies and relative percentages for sociodemographic variables and satisfaction dimensions.

The **Satisfaction Rate (SR)** was calculated as:

$$\text{Satisfaction Rate (SR)} = [(\text{Number of Satisfied} + \text{Very Satisfied Patients}) / \text{Total Number of Respondents}] \times 100$$

Specific satisfaction levels were interpreted against the authors' standard benchmark: Very Low (<50%), Low (50%-59%), Medium/Moderate (60%-69%), and High ($\geq$ 70%).

Ethical Considerations

Ethical approval was granted by the Ethics Committee of the ISTM/Kinshasa Doctoral School (Approval No. 0003/CBE/ISTM/KIN/RDC/PMBBL/2024; dated February 16, 2024), pursuant to Decision No. 055/ESU/ISTM/DG/2022. Administrative authorizations were granted by the Kwango Provincial Health Division leadership. Written or verbal informed consent was obtained from all participants prior to enrollment. Participation was voluntary, and respondent anonymity and data confidentiality were maintained throughout.

RESULTS

Sociodemographic Characteristics

A total of 384 patients completed the study. Females comprised the majority of the sample (63.3%, n = 243), while males accounted for 36.7% (n = 141). The mean age of respondents was 37.3 ± 11.4 years (range: 18–67 years). Patients aged 30–49 years represented the largest age cohort (52.3%, n = 201).

Most participants were married (78.9%, n = 303). In terms of education, 45.8% (n = 176) held a state diploma

(secondary education diploma). By occupation, farmers constituted half of the sample (50.0%, n = 192).

Table 1:

Distribution of Respondents by Sociodemographic Characteristics and Overall Satisfaction (N = 384)

Sociodemographic Characteristic	Satisfied n (%)	Dissatisfied n (%)	Total Sample N (%)
Sex			
Male	70 (35.7)	71 (37.8)	141 (36.7)
Female	126 (64.3)	117 (62.2)	243 (63.3)
Age Group (Mean = 37.3 years)			
18–29 years	55 (28.1)	57 (30.3)	112 (29.2)
30–49 years	104 (53.0)	97 (51.6)	201 (52.3)
50–67 years	37 (18.9)	34 (18.1)	71 (18.5)
Marital Status			
Single	25 (12.8)	24 (12.8)	49 (12.7)
Divorced	6 (3.1)	3 (1.6)	9 (2.4)
Married	150 (76.5)	153 (81.4)	303 (78.9)
Widowed	15 (7.7)	8 (4.3)	23 (6.0)
Educational Level			
No Formal Education	33 (16.8)	34 (18.1)	67 (17.4)
Primary Education	38 (19.4)	23 (12.2)	61 (15.9)
State Diploma	92 (46.9)	84 (44.7)	176 (45.8)
University Degree	33 (16.8)	47 (25.0)	80 (20.8)
Occupation			
Administrative Staff	13 (6.6)	9 (4.8)	22 (5.7)
Trader	8 (4.1)	4 (2.1)	12 (3.1)
Farmer	88 (44.9)	104 (55.3)	192 (50.0)
Teacher	50 (25.5)	42 (22.3)	92 (24.0)
Student	19 (9.7)	17 (9.0)	36 (9.4)
Police Officer	7 (3.6)	4 (2.1)	11 (2.9)
Manual Laborer	11 (5.6)	8 (4.3)	19 (4.9)

Overall Satisfaction Level

Overall, 196 out of 384 respondents reported being satisfied with the care received, yielding an overall satisfaction rate of 51.0% (Low level). Conversely, 188 patients (49.0%) expressed dissatisfaction.

Table 2:

Overall Patient Satisfaction Frequency and Rate (N = 384)

Satisfaction Category	Frequency (n)	Percentage (%)
Dissatisfied	188	49.0
Satisfied	196	51.0
Total	384	100.0

Note: Overall Satisfaction Rate = 51.0% (Level: Low).

Satisfaction Across Health Zones and Health Centers

Satisfaction rates across the seven health zones ranged between 49.1% and 55.7%, placing all health zones in the "Very Low" or "Low" satisfaction brackets:

- a) **Very Low (<50%):** Boko (49.1%), Kisanji (49.1%).

- b) **Low (50% - 59%):** Wamba Lwadi (50.0%), Kahemba (50.9%), Kimbau (50.9%), Panzi (52.7%), Kenge (54.4%).
- c) At the health center level (n = 21), satisfaction ranged from 42.1% to 63.1%:
- d) **Moderate Level (60% - 69%):** 2 health centers (9.5%) – Pont-Wamba (63.1%) and Pala (61.1%).
- e) **Low Level (50% - 59%):** 12 health centers (57.1%) – including Bangongo, Kabongo, Kalenge, Kambundi, Kawana, Kibinda, Kingunzi, Kitanda, Mahanga, Mukulutu, Mutombo, and Shamusenga.
- f) **Very Low Level (<50%):** 7 health centers (33.3%) – including Fingonzi (42.1%), Kabwita, Kapanga, Kasese, Kibunda II, Kibwila, and Tangombe.

Figure 1:

Overall satisfaction rate by health zone and Provincial Health Division

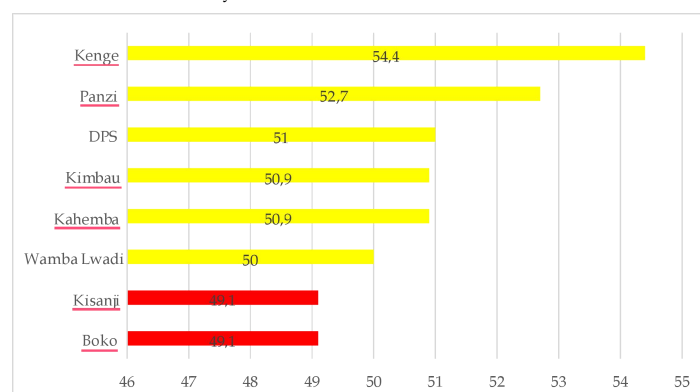
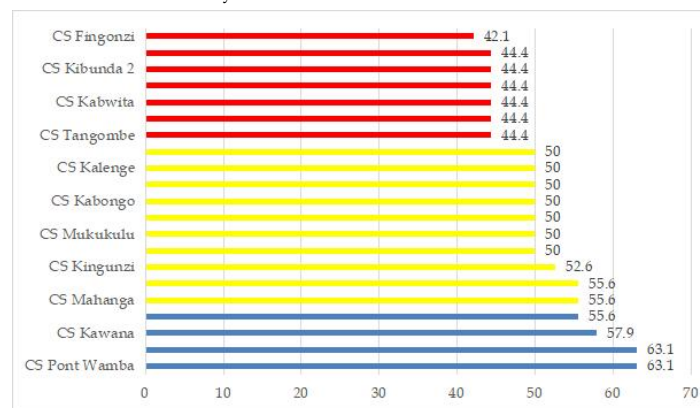


Figure 2:

Overall satisfaction rate by health center



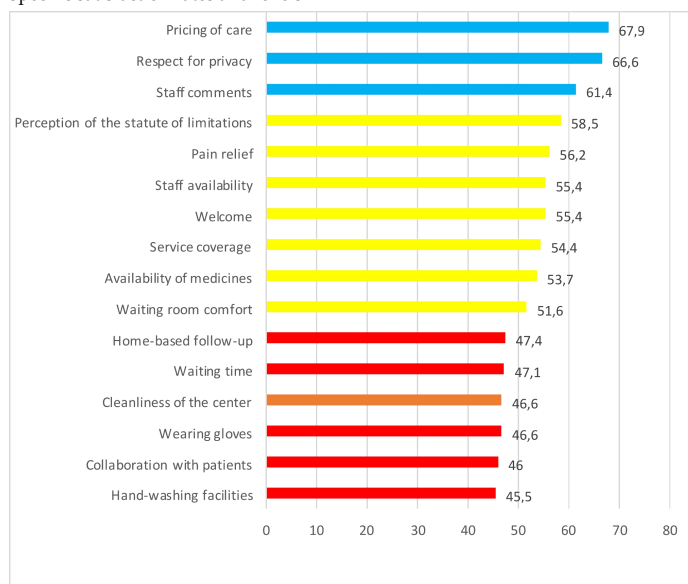
Specific Dimensions of Patient Satisfaction

Analysis of 16 specific care dimensions demonstrated variable satisfaction rates across operational, technical, and interpersonal areas.

Table 3:

Patient Responses, Satisfaction Rates, and Categorized Satisfaction Levels Across 16 Specific Dimensions (N = 384)

Care Dimension	Very Unsatisfied n (%)	Unsatisfied n (%)	Satisfied n (%)	Very Satisfied n (%)	Satisfaction Rate (%)	Satisfaction Level
Welcome / Reception	64 (16.7)	107 (27.9)	176 (45.8)	37 (9.6)	55.4	Low
Waiting Room Comfort	26 (6.8)	160 (41.7)	182 (47.4)	16 (4.2)	51.6	Low
Waiting Time	37 (9.6)	166 (43.2)	144 (37.5)	37 (9.6)	47.1	Very Low
Prescription Practices	127 (33.1)	32 (8.3)	195 (50.8)	30 (7.8)	58.5	Low
Pain Management	12 (3.1)	156 (40.6)	197 (51.3)	19 (4.9)	56.2	Low
Home Follow-Up	26 (6.8)	176 (45.8)	147 (38.3)	35 (9.1)	47.4	Very Low
Glove Use by Staff	57 (14.8)	148 (38.5)	143 (37.2)	36 (9.4)	46.6	Very Low
Facility Cleanliness	57 (14.8)	148 (38.5)	142 (36.9)	37 (9.6)	46.6	Very Low
Staff Availability	36 (9.4)	135 (35.2)	169 (44.0)	44 (11.5)	55.4	Low
Handwashing Facilities	128 (33.3)	81 (21.1)	153 (39.8)	22 (5.7)	45.5	Very Low
Medication Availability	37 (9.6)	141 (36.7)	188 (49.0)	18 (4.7)	53.7	Low
Staff Comments / Attitude	25 (6.5)	123 (32.0)	192 (50.0)	44 (11.5)	61.4	Medium
Service Continuity	55 (14.3)	120 (31.3)	181 (47.1)	28 (7.3)	54.4	Low
Patient Collaboration	28 (7.3)	179 (46.6)	144 (37.5)	33 (8.6)	46.0	Very Low
Respect for Privacy	40 (10.4)	88 (22.9)	243 (63.3)	13 (3.4)	66.6	Medium
Affordability of Care	107 (27.9)	16 (4.2)	242 (63.0)	19 (4.9)	67.9	Medium

Figure 3:
Specific satisfaction rates and levels

Only three dimensions achieved a **Medium** satisfaction level ($\geq 60\%$): Affordability of Care Pricing (67.9%), Respect for Privacy (66.6%), and Staff Comments/Attitude (61.4%).

Seven dimensions were rated as **Low** (50% - 59%): Prescription Practices (58.5%), Pain Management (56.2%), Welcome/Reception (55.4%), Staff Availability (55.4%), Service Continuity (54.4%), Medication Availability (53.7%), and Waiting Room Comfort (51.6%).

Six dimensions recorded **Very Low** satisfaction levels ($< 50\%$): Home Follow-Up (47.4%), Waiting Time (47.1%), Glove Use by Staff (46.6%), Facility Cleanliness (46.6%),

Patient Collaboration (46.0%), and Availability of Handwashing Facilities (45.5%).

DISCUSSION

Summary of Key Findings

This study evaluated patient satisfaction levels across health centers in the Kwango Provincial Health Division using an empirical classification scale. The initial hypothesis—that patient satisfaction would be high in Performance-Based Financing centers—was refuted. Overall satisfaction was low (51.0%), demonstrating that patients in this region are receiving care that fails to meet basic quality expectations, posing a barrier to achieving Sustainable Development Goal 3 (Good Health and Well-Being).

Comparison with Prior Literature

The overall satisfaction rate of 51.0% in Kwango is lower than rates reported in similar domestic and international evaluations. Diallo (2021) reported an 82.5% satisfaction rate among primary care users. Internationally, Gerbaud et al. (2002) observed a 91.0% satisfaction rate across public hospitals in France. In Kinshasa, Nyamdwe (2018) reported an overall satisfaction rate of 84.4% across major public referral centers (Clinique Ngaliema, Kinshasa General Referral Hospital, and Roi Baudouin Hospital). Similarly, Yamba et al. (2018) reported that over 75% of patients at the Kinshasa University Clinics expressed overall satisfaction, noting high satisfaction with confidentiality (86%) and health information (90%).

The modest satisfaction level in Kwango aligns more closely with findings from Nguyen Thi et al. (2002) in Ho Chi Minh City, Vietnam, where 50.2% of patients reported dissatisfaction related to prolonged waiting times, environmental sanitation, and staff interactions. In rural Bangladesh, Mendoza Aldana et al. (2001) observed that provider conduct (courtesy and respect) and reduced waiting times were primary determinants of user satisfaction.

Specific Satisfaction Dimensions

Specific operational dimensions in this study revealed structural quality defects. Hygiene and infection prevention indicators—such as glove usage (46.6%), facility cleanliness (46.6%), and handwashing facility availability (45.5%)—were rated very low. These results parallel findings by Diouf et al. (2010) in Dakar, where patient dissatisfaction was closely tied to hygiene deficits and poor provider attentiveness.

Interpersonal and administrative indicators showed moderate performance in privacy protection (66.6%) and price affordability (67.9%). However, prolonged waiting times (47.1% satisfaction) and poor home follow-up (47.4%) remain major sources of dissatisfaction. As noted by Mbuku et al. (2025) and Didier et al. (2020), operational delays and perceived staff unavailability suppress service utilization and weaken patient trust in rural health networks.

Limitations

This study has limitations. First, satisfaction surveys are subject to social desirability and courtesy bias, as rural patients may underreport dissatisfaction due to fear of compromising future interactions with local healthcare providers. Second, the cross-sectional design restricts causality inferences between specific facility characteristics and satisfaction scores.

CONCLUSION

This study demonstrates that patient satisfaction in primary health centers across the Kwango Provincial Health Division is low (51.0%), with no health zone achieving a high performance level. Dissatisfaction is driven by long waiting times, inadequate facility hygiene, poor patient-provider collaboration, and limited home follow-up.

To improve healthcare delivery, health zone management teams must:

1. Integrate patient satisfaction as a standard performance indicator within routine monitoring and evaluation frameworks.
2. Institute regular clinical and quality-of-care audits focusing on hygiene, infection control, and interpersonal communication.
3. Strengthen supervisory oversight of healthcare staff across primary care centers.
4. At the policy level, provincial health authorities should mandate routine user satisfaction evaluations across all public and private facilities to guide resource allocation and service improvements.

Acknowledgements: The authors express sincere gratitude to the facilitators of community participation structures, particularly the Health Committees (CODESA) and Community Animation Cells (CAC) of the health areas involved in this study. Special thanks are extended to the community relays (RECO) for their role in data collection and to the Chief Medical Officer of the Kimbau Health Zone for supervising the implementation of this research..

Use of Artificial Intelligence (AI) Declaration: The authors declare that no artificial intelligence (AI) or AI-assisted technologies were used in the study design, data collection, data analysis, or preparation of this manuscript.

Authors' Contributions:

- i. **Nkwahata NR:** Conceptualization, Writing – original draft.
- ii. **Mayamba MM:** Project administration.
- iii. **Onoya WJ:** Investigation, Formal analysis.
- iv. **Kasongo ME:** Methodology, Writing – review & editing.
- v. **Masimango GC:** Supervision.

Data Availability Statement: The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable academic request.

Ethical Approval: This study received ethical approval from the Ethics Committee of the ISTM/Kinshasa Doctoral School (Approval No. 0003/CBE/ISTM/KIN/RDC/PMBBL/2024, dated 16 February 2024), in accordance with Decision No. 055/ESU/ISTM/DG/2022 of 10 June 2022.

Informed Consent and anonymity: Written informed consent was obtained from all individual participants included in the study prior to blood sample collection and questionnaire administration.

Funding: This research received no specific grant or external financial support from any funding agency in the public, commercial, or non-profit sectors.

Conflicts of Interest: The authors declare that they have no conflicts of interest.

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