Master of Public Health

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“Tap here for Health Prevention”: Acceptability of a Kiosk for People Experiencing Homelessness in Toulouse, France

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List of acronyms

ASSH – A Medico-social Services Centre, located throughout France and operated by the French Red Cross (Acceuil de santé social et hébergement)

CRf – French Red Cross (Croix-Rouge française)

EU – European Union

HIV – Human Immunodeficiency Virus

HPV – Human Papilloma Virus

PEH – People experiencing homelessness

STI – Sexually Transmitted Infections

TAM – Technology Acceptance Model

VPD – Vaccine Preventable Disease

Abstract

Background : The HEALTH-HUB project seeks to addresses the urgent need for health prevention measures for people experiencing homelessness (PEH) including undocumented migrants in France, who face significant barriers to healthcare access. This project, led by the French Red Cross, aims to engage these vulnerable populations through an interactive kiosk placed in medico-social service centers. As part of a six-month pilot phase at a CRf center in Toulouse, an acceptability study was conducted to evaluate the kiosk's appeal and appropriateness for this context, highlighting areas for improvement. The general objective was to gather beneficiary feedback on the kiosk's effectiveness as a health prevention tool, with specific goals of understanding common perceptions and experiences with its features.

Methods : The study used a mixed-methods approach, including a focus group and a questionnaire to gather feedback from beneficiaries. The focus group was structured around themes such as first impressions of the kiosk, content perceptions, and barriers to use. The questionnaire complemented the focus group by collecting quantitative data on similar themes, utilizing the Technology Acceptance Model (TAM) to assess factors like perceived usefulness and ease of use. The questionnaire was administered on tablets, with responses categorized by the level of interaction participants had with the touchscreen. Different sections of the questionnaire addressed various themes, from visual attractiveness to specific features of the kiosk, aimed at understanding user engagement and satisfaction.

Results : The kiosk was found to be appealing to site beneficiaries. Overall use of the kiosk touchscreen was low, but this was not interpreted as due to a perceived poor ease of use, as this was regarded rather positively amongst participants. Rather, perceived usefulness and appropriateness of the kiosk features were the primary barriers to beneficiary engagement. There was a notable gap between *actual* perceived usefulness and *potential* perceived usefulness throughout the study. For example, focus group conversations demonstrated that the kiosk features are beneficial to the target population, but due to barriers such as poor advertising of kiosk features, maladapted health messaging and spatial incompatibilities, beneficiaries ultimately forwent use of the kiosk.

Conclusions : After analysis of study data, three recommendations were made: increase advertising of the kiosk features, improve content and delivery of video spots and relocate the kiosk to a more suitable space. The study highlighted the importance of early acceptability studies and the value of feedback from key population members in public health interventions.

Résumé

Contexte : Le projet HEALTH-HUB cherche à répondre à l'urgence des mesures de prévention en santé pour les personnes en situation de sans-abrisme (PEH), y compris les migrants de statut irrégulier en France, qui rencontrent des obstacles importants à l'accès aux soins. Ce projet, dirigé par la Croix-Rouge française, vise à engager ces populations vulnérables grâce à une borne interactif placée dans les centres de services médico-sociaux. Dans le cadre d'une phase pilote de six mois dans un centre de la CRf à Toulouse, une étude d'acceptabilité a été menée pour évaluer l'attrait et la pertinence de la borne dans ce contexte, en mettant en lumière les domaines à améliorer. L'objectif général était de recueillir les retours des bénéficiaires sur l'efficacité de la borne en tant qu'outil de prévention en santé, avec des objectifs spécifiques de comprendre les perceptions et les expériences courantes de ses fonctionnalités.

Méthodologie : L'étude a utilisé une approche méthodologique mixte, incluant un focus group et un questionnaire pour recueillir les retours des bénéficiaires. Le focus group était structuré autour de thèmes tels que les premières impressions de la borne, les perceptions du contenu et les obstacles à l'utilisation. Le questionnaire a complété le focus group en collectant des données quantitatives sur des thèmes similaires, en utilisant le modèle d'acceptation technologique (TAM) pour évaluer des facteurs tels que l'utilité perçue et la facilité d'utilisation. Le questionnaire a été administré sur des tablettes, avec des réponses catégorisées en fonction du niveau d'interaction des participants avec l'écran tactile. Différentes sections du questionnaire abordaient divers thèmes, allant de l'attractivité visuelle aux fonctionnalités spécifiques de la borne, dans le but de comprendre l'engagement et la satisfaction des utilisateurs.

Résultats : La borne a été jugée attrayante par les bénéficiaires du site. L'utilisation globale de l'écran tactile de la borne a été faible, mais cela n'a pas été interprété comme étant dû à une faible facilité d'utilisation perçue, car celle-ci était plutôt bien considérée parmi les participants. Au contraire, l'utilité perçue et la pertinence des fonctionnalités de la borne étaient les principaux obstacles à l'engagement des bénéficiaires. Il y avait un écart notable entre l'utilité perçue *réelle* et l'utilité perçue *potentielle* durant l'étude. Par exemple, les conversations du focus group ont montré que les fonctionnalités de la borne sont bénéfiques pour la population cible, mais en raison de barrières telles que la mauvaise publicité des fonctionnalités de la borne, des messages de santé mal adaptés et des incompatibilités spatiales, les bénéficiaires ont finalement renoncé à l'utiliser.

Conclusions : Après l'analyse des données de l'étude, trois recommandations ont été formulées : augmenter la publicité des fonctionnalités de la borne, améliorer le contenu et la présentation des spots vidéo, et déplacer la borne dans un espace plus approprié. L'étude a souligné l'importance des études d'acceptabilité précoce et la valeur des retours d'information des membres de la population cible dans les interventions de santé publique.

Introduction

Health prevention, also known as preventative care, consists of three stages or levels: primary prevention, whose aim is to prevent the occurrence of a disease on an individual level, for example by limiting exposures or through immunization efforts in otherwise healthy individuals; secondary prevention, which aims to detect the early disease prevalence (such as subclinical forms in which symptoms of disease are minimal or absent) through testing and screening efforts; and tertiary prevention, which seeks to minimize the severity of and lifestyle consequences due to a disease already present in an individual, for example through therapeutic or rehabilitation efforts (1). Access to preventative care is crucial, and a key pillar to building an effective, affordable, and equitable public health system.

The efficacy of health prevention

Medical advances have allowed for the invention of safe and effective vaccines, accurate and rapid screening and testing technologies, and successful interventions for improving longevity and quality of life for those impacted by disease. One does not need to look too far in the past to see how health prevention has been crucial to saving lives on a global scale, such as the case of the COVID-19 pandemic and the rapid rollout of preventative methods to limit exposure, viral testing tools, and vaccinations. Not only can the end of the COVID-19 pandemic be attributed largely to strides in health prevention, but so can the global eradication of Smallpox in the 1980s thanks to a coordinated global vaccination effort (2). Advances in breast cancer testing and the implementation of widespread early screening programs have decreased breast cancer mortality by an estimated 20% (3); support groups and therapy regimens for those suffering from mental disorders such as addiction, schizophrenia, anxiety and depression have helped countless folks to regain stability, function, belonging, purpose and pleasure in their lives and society (4–6). In other words, no single case-study or systematic review would suffice to measure the positive impact that health prevention has contributed to the current state of global public health.

The economic efficiency of health prevention

Preventative care not only saves lives, but it also saves money; literature is already plenty and yet still forthcoming within health economics with regards to the cost-effectiveness and cost-savings of preventative strategies in public health systems (7–11). Through large-scale vaccination campaigns, for example, incidence of disease can be limited and outbreaks prevented, relieving overall use of and stress upon the healthcare system as well as spending for individuals, insurance and universal healthcare schemes. Furthermore, at a moment in history where treatments are evermore advanced and effective due to technological and scientific advancements, such interventions often entail an hefty price tag; intervening proactively to prevent disease, or its

progression, cuts cost astronomically compared to downstream, complex and resource-heavy treatments. Of course, this discussion comes with its nuance; in reasons that will be elaborated later on, the cost-effectiveness of preventative interventions is much easier to evaluate in *theory* than in practice, which poses notable barriers to many promising interventions in health prevention.

Health prevention and health equity

Finally, preventative care is a key indicator as to the equitability of a given healthcare system; this can primarily be understood through the lens of access. Beginning before birth of an individual, such as through prenatal care to ensure the health of pregnant people and the developing fetus, through birth and critical childhood vaccinations, through the schooling years in the form of educational campaigns for healthy lifestyles and yearly physicals, through adulthood and into sexual and reproductive health and mental healthcare, to counseling and screening for chronic disease in the older years of adulthood: preventative care plays an essential role in every step of one's life course (12). Yet still, there are many who have limited or no access to it due to the unequitable healthcare systems, unable to provide equal access across social categories. This can be explained through the interaction of different social factors, such as gender, socioeconomic status, migration-status, language, housing status, education-level, ethnicity, geographical area, amongst others, which ultimately affect health status and access to healthcare. In other words, the farther down one goes on the social ladder, the greater extent to which health outcomes suffer as a result of decreased access to health and healthcare. This phenomenon is known as the Social Determinants of Health, and is the process through which social factors drive disparities in health outcomes globally (13). Nowhere else is this more evident than in health prevention, whereby marginalized populations suffer sobering access across all three levels of prevention and across their life histories.

The neglected state of health prevention amongst vulnerable populations

For example, globally, people experiencing homelessness (PEH) are found to have increased incidence of vaccine-preventable disease (VPD) (14), such as viral hepatitis, tuberculosis, pneumococcal disease (15), HPV, and COVID-19, amongst others disease (16), compared to those that are housed. Though data is limited, France is no exception (17,18). Not only can this be explained through the lens of access to healthcare through lack of immunization, screening, health behavior education, and other preventative services, but also through the uniquely difficult conditions that PEH are exposed to. The living conditions of PEH – inadequate or no shelter, dangerously unsafe conditions, even life in crowded homeless shelters – deprive individuals of adequate and stable access to essential needs like sanitation, heating, electricity and safety, putting PEH at an increased risk for disease acquisition (19). In the realm of alcohol and

drug addiction, prevalence is high amongst PEH, due both to poor access to tertiary preventative services like therapy and support groups for addiction, but also due to the living conditions which disparately expose PEH to addictive substances like recreational drugs, actually pushing them towards consumption. Thus, PEH experience a *compound* negative effect on their health, through which they are at once at an increased risk for exposure to disease while also at a decreased level of protection to said disease's health effects through inadequate access to health prevention.

Undocumented migrants in France, many of whom also experience homelessness, are similarly subject to structural forms of violence that ultimately impact their health outcomes. Again, data that demonstrates this phenomenon in France is regrettably quite lacking, often forcing public health actors in France to look towards other EU Member States for evidence. These studies often confirm the increased prevalence compared to host-country citizens of VPD such as tuberculosis and viral hepatitis, as well as other diseases for which effective non-vaccine health prevention measures exist such as HIV and other STIs (20,21). In France, one 2010 study demonstrated an increased prevalence of mental health disorders such as depression amongst immigrants compared to host-country citizens (22). A more recent and pioneering study for the French context, the Premiers Pas survey, found that amongst 1,223 undocumented migrants recruited across Paris and Bordeaux, 28.4% reported having a poor health status and 33.5% a chronic health condition (which can often be avoided or mitigated through health prevention); 43.2% had reported suffering dental infections (also avoidable via health prevention) and 12.9% reported at least one infection disease such as HIV or viral hepatitis, amongst other infections (23). Clearly, effective screening and prevention programming is lacking in the French context, negatively affecting vulnerable populations such as PEH and undocumented migrants.

Barriers to effective health prevention programming

Although this disparity in health access and status is largely evident to those familiar through work or personal experience with homelessness or migration, it is notoriously difficult to advocate for health prevention programs due to difficulties in demonstrating their necessity and impact (24,25). This can be explained by a few obstacles that prevention programming faces. First, in a public health landscape driven by data and outcomes, calculating the impact of prevention campaigns remains complex, expensive and often relies on faith. As the crux of health prevention lies in avoiding future health events; the results are inherently not immediately visible and difficult to measure as they require either robust surveillance systems or long-term follow-up to assess, which is of course particularly difficult for vulnerable populations. In other words, a prevention program "lacks drama", writes one scientist in *The Paradox of Disease Prevention*, rendering it less attractive compared to interventions in contexts that appear more conspicuous, easily measurable, and thus perceived as more urgent (26). A similar phenomenon can be observed amongst patients

themselves, as the urgency of immediate needs such as homelessness, food insecurity, or fears of violence often overshadows the importance of preventive health measures (27–29). Communicating the importance of prevention to vulnerable populations facing such immediate threats is challenging and often impossible.

Finally, health prevention is a type of care that often necessitates a coordinated, frequent, and enduring relationship with the healthcare system and a medical team, such as in the form of a primary care physician or family doctor, whom is able to accompany the patient across their life course, monitoring vaccination history, screening for disease, providing guidance for maladaptive behaviors and referring out for specialized care, amongst other needs. The rigor demanded, from the patient as well as the physician-side, in terms of time, energy, cost and coordination, for effective primary care gives way to numerous barriers which render preventative care challenging and often, impossible. Such is the case for vulnerable populations such as PEH and undocumented migrants, who, in many forms, face exclusion from society and consequently, from the healthcare system. This “rupture in care”, a broken relationship with the healthcare system due to cumulative barriers to care, presents a unique challenge to those wishing to intervene in this dynamic: accessing those without access to the healthcare system is difficult. When people do not seek out care for urgent needs, much less preventative needs, finding them becomes a significant challenge. Understanding their needs and experiences, and how these are being documented (and thus, observable in the data), is crucial. These are complex issues that those wishing to create preventative programming must address during the conceptualization and funding phases. Only after addressing these issues can the next step of determining how to fill the gap in care be approached.

A case in point as to the complexities of intervening in preventative medicine for vulnerable populations would be that of France’s recent launch of the My Health Check-up (*Mon Bilan de Santé)* program (30). This tool seeks to intervene in key age groups in France regarding priority areas of health prevention such as: nutrition, physical activity, substance-use, cancer prevention and testing, dental health, violence, sexual health, sleep hygiene, social and mental well-being, chronic disease, vaccination and environmental health. Health professionals are encouraged to conduct motivational interviews with patients to identify individual health needs and to co-construct goals and a plan to achieve them, in a visit that would be at no-cost to the patient. Though exciting and sure to promise interesting results for those able to benefit from this program, many are those who will be overlooked as the program is only accessible to those covered by France’s national healthcare scheme, *la sécurité sociale*, such as EU-citizens and migrants of regular status. Furthermore, the program presupposes access to a healthcare professional, as well as other basic needs that many do not have; a physical proof of coverage (either one’s health card, *la carte vitale*,

or a copy of one's health coverage form, *attestation aux droits ouverts)*, an online account to receive information about the availability of the program (*compte ameli*), a means to access the internet, the ability to comprehend and navigate the healthcare system and more fundamentally, an appreciation for the importance of health prevention. The irony lies in the harsh reality that this intervention will only further the gap in health prevention in the French context, as privileged groups enjoy improved quality of care all while vulnerable groups remain in a condition of social and political negligence.

Innovative approaches to health prevention: the HEALTH-HUB[1] project

The needs of PEH and undocumented migrants in France in terms of health prevention are dire, with severe consequences on their health outcomes. This is largely a question of access, as these groups are largely alienated from the healthcare system and society more generally. Where can these folks be targeted and how can public health actors best meet their needs in terms of health prevention?

Such is the question of an experiment in health innovation led at the French Red Cross (*Croix-Rouge Française, CRf*) Headquarters in Montrouge, France. The HEALTH-HUB project proposes an interactive kiosk that seeks to repurpose the time spent in waiting rooms to engage vulnerable populations in health prevention. By meeting vulnerable populations where they are located – such as medico-social services centers – HEALTH-HUB aspires to spark interest in and facilitate access of vulnerable populations to health prevention through a kiosk equipped with interactive and passive engagement methods.

Before considering expanding the HEALTH-HUB to further CRf establishments, a 6-month long pilot phase was conducted at a CRf medico-social services center (*Accueil de Santé Sociale*) in Toulouse, France. Halfway through this pilot phase, we led an acceptability study to assess the performance of this intervention within this context. Through analysis of this first round of feedback from beneficiaries of the CRf center, we assessed the appeal and appropriateness of the HEALTH-HUB kiosk experiment, and were able to reveal specific areas of improvement to increase these measures and thus this intervention's potential success in future establishments.

[1] The name of the project has been changed for confidentiality purposes

Objectives

Research question	“How is the HEALTH-HUB project received by beneficiaries of the ASSH Toulouse?”
General objective	The collection of perceptions from site beneficiaries regarding the appeal and appropriateness of the kiosk as a health prevention tool.
Specific objective 1	To identify common areas of feedback with regards to kiosk features.
Specific objective 2	To identify the relevant needs of beneficiaries in terms of health prevention.
Specific objective 3	To propose modifications to improve acceptability by beneficiaries.

Methods

Study Design

The present analysis is an acceptability study of the intervention of an interactive kiosk, HEALTH-HUB, designed to increase interest and facilitate access to health prevention in a CRf medico-social services center (*Accueil de Santé Sociale et Hébergement, ASSH*) in Toulouse, France. Results from this study would ultimately go on to inform recommendations for an update to kiosk features, as well as the ultimate decision of whether to expand the kiosk to further CRf establishments.

Beneficiary acceptability was assessed through two data collection methods, using a mixed-methods approach. First, a 2-hour small focus group was conducted on-site with site beneficiaries the morning of March 24th 2024, then a more general, approximately 5-minutes duration questionnaire incorporating quantitative and qualitative measures was conducted in-person with site beneficiaries the morning of March 25th 2024.

Participants and Procedures

Focus Group

The implementation of a focus group was chosen as a response to increasing calls for qualitative research methods in public health interventions, including even technology acceptance ones like mHealth projects (31). The focus group guide themes were informed through a review of the common challenges encountered during health kiosk implementation studies (32), and its structure shaped through a review of current literature on best focus group methodologies (33). In

preparation for the focus groups, site volunteers were asked to recruit 6-8 beneficiaries that frequently patron the establishment for participation in the focus groups according to the following set of criteria, in descending priority.

1. Willingness and comfortability to participate
2. Interest for the project, to share thoughts and experiences with the kiosk
3. Diversity of feedback based on prior conversations, if any - positive, negative and neutral
4. Diversity of nationality, having both French-born and immigrant representativity

Before beginning the focus group, participants were asked for verbal consent to record the conversation for transcription purposes and were informed that personal-identifying information would not be shared in subsequent analyses or reports. The roles in the focus group were divided as such: two co-moderators (one from the CRf and one representative from the HEALTH-HUB team); and one note-taker.

The focus group guide (see Appendix III) was designed around the following themes and subthemes:

1. General first perceptions and feedback from the kiosk
    a. Positive
    b. Negative
2. How to attract the attention of the beneficiaries towards the kiosk?
    a. The placement of the kiosk
    b. Clarity of the different features offered
    c. The role of volunteer mediation
    d. The perception of the spots screen
3. How the kiosk contents are perceived by beneficiaries?
    a. General perception of the contents, what is missing, what is unnecessary?
    b. Needs with regards to health prevention, what is interesting and pertinent?
    c. Barriers to use, in terms of language, phrasing, user interface

Questionnaires

The questionnaire (see Appendix IV) was designed in complement to the focus group discussion, allowing for the collection of beneficiary perspectives on similar themes but from a more quantitative standpoint, as well as providing the opportunity to further explore unexpected takeaways that could arise during the focus group. Thus, a first draft was prepared in advance of the visit to Toulouse and was finalized after the focus group but before the morning dedicated to questionnaire-collecting the following day.

The questionnaire was designed to incorporate elements of the Technological Acceptance Model (TAM) (see Appendix IV), a widely used and validated framework that helps to understand the different factors related to the acceptance of new technologies by users (34–36). It is particularly focused on the importance of the variables *perceived ease of use* and *perceived usefulness*.

The questionnaire guide was transformed into a Google Form and was accessible via internet connection on mobile tablets. Two study team members conducted the questionnaire by engaging beneficiaries and inviting them to respond to the short 5-minute survey. Questions were asked to participants while the team members entered their responses on the tablets.

All beneficiaries present in the ASSH the day of the questionnaire were eligible to respond to the questionnaire. In their rounds inside and outside the center, the study team offered snacks to beneficiaries as a first step to engaging them to participate in the study. Before participating in the questionnaire, participants were informed about the anonymity of their responses, their confidentiality, the purpose of their responses and their right to stop participation at any point.

The questionnaire was designed to separate participants into three different groups according to their level of interaction with the touchscreen, each of which would present questions specifically tailored to their level of use. The first group, Section A, was for those having used the touchscreen a lot (greater than 5 times); Section B was those having used the touchscreen a few times (greater than 0 but less than 5 times); and Section C, those having never used the touchscreen. The general assumption of the questionnaire was that all participants had observed the spot screen, be it with different levels of engagement, to at least a minimum extent while waiting in the waiting room of the ASSH.

All Sections included questions meant to explore themes of visual attractiveness of the kiosk, the perception of the spot messaging, intent to use the kiosk, and medico-social topic areas of interest.

Section A and B, destined for participants having interacted with the kiosk, was designed to explore deeper themes related to its use, such as what sparked interest in the kiosk, features consulted, *actual* perceived usefulness, adaptability, ease of use and enjoyment. Section B included one additional question to understand why the participant had not used the touchscreen further.

Section C, unable to ask participants about their direct use of the touchpad, focused on their perceived *potential* usefulness, ease of use and enjoyment of the touchpad. This section had one additional question to understand why the participant had never used the touchscreen.

At the end, all Sections were followed by a short demographic section collecting gender, age and country of birth; participants had the option to not respond to any of these questions. They also had the opportunity to leave any final comments in the form of a short-response field.

The great majority of questions were formulated as statements of agreeability rated using a 5-point Likert scale (Strongly disagree, Disagree, Neutral, Agree, Strongly agree). A few questions were also proposed in the form of a checklist, where missing responses could be written in.

Setting

The CRf medico-social services center is attached to a major public hospital in Toulouse, the Hôtel-Dieu Saint-Jacques. Run entirely by volunteers and frequented largely by PEH, many of whom are also undocumented migrants in France, the center's primary service is providing free, on-site showers to the public, as well as fresh beverages like coffee. The site also offers periodic services such as free on-site, walk-up medical consultations (*permanences médicales*), free haircuts, donation distributions and workshops. The center is open daily from 9h – 12h30 and is closed on weekends. Though visitor flow fluctuates throughout the week and throughout the seasons, on average the center welcomes 40-50 beneficiaries daily for services. Above all, in line with one of the CRf's core values of *réparation du lien social*, repairing social bonds, the site functions as a place of gathering, where beneficiaries and volunteers alike, interact and chat.

Kiosk features

The HEALTH-HUB kiosk (see Appendix I) consists of two screens :

- The touchscreen, which sits at the top of the kiosk, is an interface that allows users to access five different features such as: the weather, Google Maps, Whatizat (a multilingual website destined to migrants and refugees in France that provides information on various socio-medico resources), information about CRf local services, and games (origami and sudoku games). The first three items are able to be navigated much like on a computer, whereas the last two items are able to be printed, much like a receipt, enabling users to either leave with information or to play the games while waiting. For those with visual-impairment, color-blindness or dyslexia, display modes tailored to these needs are available in the bottom right-hand corner.
- The 'spot' screen, located at the bottom of the kiosk, displays informational 'spots' (see Appendix II), such as health prevention messaging, announcements about local CRf services, as well as short clips featuring CRf First Aid tutorials.

Analysis

Focus Group

The focus group discussion was analyzed using thematic analyses. Themes and subthemes were identified, and relevant quotes were attributed, along with notes.

Questionnaire

The questionnaire responses were analyzed using statistical analysis. Descriptive analyses of responses were performed for all questions using Jamovi software.

Results

Focus group

Participants for the focus group were recruited by site volunteers in advance. Ultimately, four participants were identified and invited to participate in the focus group, though only three participants were present for the day of the focus group. All participants were willing and eager to participate in the focus group, which lasted about two hours. All participants declined to being recorded, but consented to having notes taken during the conversation and for quotes to be attributed anonymously. All three of the participants present for the focus group identified as male and were between 30-50 years old. One of the participants was born and raised in West Africa while the remaining two participants were born and raised in France. All three participants were advanced and comfortable speaking in the French language.

The table below presents the common themes that emerged through thematic analysis of the Focus Group notes, as well as verbatim quotes, when available.

Table 1. *Thematic analysis of focus group discussion*

Theme	Sub-theme	*Quote(s)*	Notes
Interest for and purpose of kiosk			
	Kiosk sparks curiosity		Unanimous agreement that the kiosk catches the attention of those in the space.
		"I was surprised the first day it was installed. I was like, I need to check this out."	
	Purpose and functions of kiosk are not immediately evident		Though helpful once used, the utility of the kiosk is not apparent ; need to advertise features.
		"Once you've begun using the kiosk, you have access to everything. You find its very useful, but you don't know that until you try it."	

	Kiosk vs smartphone	All participants evoked the smartphone for comparison, saying the kiosk offers unique benefits, but these are not immediately relevant to those not having used kiosk. Need to advertise.
Touchscreen feedback		
	Extremely easy to use	All participants agreed that the touchpad is easy to use thanks to smartphones which have made this form of digital navigation more commonplace. Interface is simple, easy to read and understand.
	Weather and maps are useful	All participants praised kiosk for weather and maps features, which are extremely helpful for those experiencing homelessness.
	"The interactive map is nice ; its large and allows you to zoom in and really get your bearings of where you are and where you want to go." "The weather is a great tool, last week I learned it would rain later that evening so I had time to prepare my tent."	
	Watizat is beneficial and adapted, but perhaps not evident	Two participants mentioned using Watizat feature, which they found helpful. They mentioned how tailored its content and functionality was for PEH. One participant didn't use because didn't know what it was.
	"The interactive map is nice ; its large and allows you to zoom in and really get your bearings of where you are and where you want to go." "The weather is a great tool, last week I learned it would rain later that evening so I had time to prepare my tent."	
	Debate over games usefulness	Mixed feelings towards games – to explore in questionnaire.
	"We're not 5 years old, the origami is irrelevant" "The sudoku is great for passing the time"	
Spot videos feedback		
	Too many topics and it is overwhelming	All participants said messaging is too varied ; needs focus otherwise is too overwhelming. 2 participants agreed to abandon first aid spots.
	"There's too much info. The prevention spots, the first aid, the site info… its overwhelming." "The first aid spots are interesting but unless you have a mannequin to practice on, it's pointless."	
	Spots move too quickly	All participants, even those whose first language was French, agreed the spots pass too quickly.
	"It's great, but it goes by too quickly! I don't have enough time to read the messages well."	

	Messages are not appropriate	This was longest discussion of entire focus group ; the messaging of the spots is anxiety and fear-inducing. The messages show the severity of certain diseases without proposing next steps. This is not helpful, and also risks creating an aversion to kiosk. Messages should be empowering, positive.
		"I get it, I'm going to die in 5 minutes… the messages are scary, not enjoyable or positive… we're in need of that" "Stop smoking, its bad. Great, how do I do that?" "We get it, millions people have diabetes, cancer. We know that! Now what? What can we do about that?"
	Spots are great opportunity for relevant public health messaging	All participants expressed that spots are a promising tool, but must be rethought. Each gave examples of ways in which messaging could be improved.
		"Life on the streets is hard… I've seen how much it affects my physical health. Sun-exposure on my skin, my eyes… Carrying around my stuff and how it impacts my spine, it causes rashes. Simple gests I can do to help with that... that's what I need"
	Spots are comprehensible, perhaps can be more	The messaging of the spots is fairly clear, albeit only in French. 2 participants suggested translating into other beneficiary languages.
Appropriateness for context		
	The kiosk is not appropriate for the space	Another core topic of the focus group discussion ; the **kiosk is not appropriate for space**. Space is too **small** and **stressful** (people talking, showers, blow-dryers) which strongly **discourages use.** All participants suggested kiosk is better installed **outdoors** which is calmer, most folks wait here.
		"Overall it's great, but it gets in the way a lot because the space gets crowded… already it's not pleasant inside, that's why many of us wait outside instead." "It (the kiosk) makes it even harder to move around an already tight space."

Questionnaire

A total of 30 responses were obtained by site beneficiaries. The below tables provide descriptive analysis of the responses.

Table 2. *Demographic information of all questionnaire respondents* (n=30)

Gender		
	Male	93.3% (28)
	Female	6.7% (2)
Age		
	19-24 years	3.3% (1)
	25-44 years	46.7% (14)
	45-64 years	30% (9)
	65+ years	6.7% (2)
	Did not disclose	13.3% (4)
Country of birth		
	France	50% (15)
	Sub-Saharan Africa	30% (9)
	Arab Maghreb	20% (6)

Table 3. *Descriptive analysis of indicators of use, interest, usefulness and ease of use across Sections A, B and C (n=30)*

Have you ever used the kiosk ? [2]				
	YES use	36.7% (11)		
	NO use	63.3% (19)		
		Don't Agree	**Neutral**	**Agree[3]**
Appeal of kiosk				
The kiosk catches my attention.				
	YES use	9.1% (1)	0% (0)	90.9% (10)
	NO use	31.6% (6)	0% (0)	68.4% (13)
The kiosk shows interesting messages.				
	YES use	18.2% (2)	36.6% (4)	45.5% (5)
	NO use	36.8% (7)	15.8% (3)	47.4% (9)
The kiosk shows anxiety-inducing messages.				
	YES use	36.4% (4)	27.3% (3)	36.4% (4)
	NO use	73.7% (14)	21.1% (4)	5.3% (1)
Usefulness				
The kiosk is useful for me.				
	YES use	9.1% (1)	9.1% (1)	81.8% (9)
The kiosk seems useful for me.				
	NO use	36.8% (7)	21.1% (4)	42.1% (8)
Ease of use				
The kiosk is easy to use.				
	YES use	9.1% (1)	18.2% (2)	72.3% (8)
The kiosk seems easy to use.				

[2] Due to limited number of responses, in some analyses a binary variable : Have you ever used the kiosk ? *YES use* / *NO use*, was generated. Sections A and B were combined to generate the *YES use* variable and Section C represented the *NO use* variable.

[3] Due to limited number of responses, during analysis the 5-point Likert scale was reduced to 3-point scale of agreeability (Don't Agree, Neutral, Agree) to simplify response variability

	NO use	21.1% (4)	15.8% (3)	63.2% (12)
The kiosk is enjoyable to use.				
	YES use	9.1% (1)	18.2% (2)	72.3% (8)
The kiosk seems enjoyable to use.				
	NO use	15.8% (3)	15.8% (3)	68.4% (13)

Table 4. *Descriptive analysis of kiosk use for YES use variable, Sections A and B (n=11)*

What brought you to the kiosk for the first time ?	
It was new and I was curious.	81.8% (9)
I saw others using it.	36.4% (4)
The videos below interested me.	27.3% (3)
The touchscreen interested me.	18.2% (2)
What features on the kiosk did you use ?	
Weather	100% (11)
Games	36.4% (4)
Watizat	9.1% (1)
CRf site information	9.1% (1)
After having used the kiosk…	
I didn’t do anything and don’t intend to do anything.	45.5% (5)
I spoke about the topic with another beneficiary.	45.5% (5)
I spoke about the topic with a volunteer.	27.3% (3)
I went to a healthcare center.	9.1% (1)
I didn’t do anything but intend to do something.	9.1% (1)
I searched for further information online.	0% (0)
I spoke about the topic with a doctor.	0% (0)

Table 5. *Summary of topics of interest across Sections A, B and C (n=30)*

Was there a video spot that left an impression on you?	
No	46.7% (14)
Health prevention spot	40% (12)
CRf Site Info	23.3% (7)
First Aid Spot	10% (3)
I would like to know more about :	
Dental health	60% (18)
Housing, food and clothing resources	60% (18)
Mental health	56.7% (17)
Administrative procedures	46.7% (14)
Testing	46.7% (14)
Vaccination	43.3% (13)
Impacts of tobacco	30% (9)
Personal development, CRf workshops	30% (9)
Impacts of alcohol	26.7% (8)
Impacts of drug consumption	13.3% (4)

Table 6. *Summary of reasons for little and non-usage, Sections B and C (n=29)*

For what reason(s) did you not (further) use the kiosk ?	
I don’t have the time.	48.3% (14)
I already have a telephone.	44.8% (13)
The features don’t interest me.	24.1% (4)
I prefer to speak with someone.	10.3% (3)
I don’t understand the purpose.	10.3% (3)
I don’t understand the language.	10.3% (3)
It is complicated to use.	6.9% (2)

Discussion

Study overview

This acceptability study sought to evaluate the appeal and appropriateness of the HEALTH-HUB kiosk in a medico-social center of the CRf in Toulouse France. We accomplished this by engaging key site beneficiaries in the format of a focus group as well as by conducting a questionnaire with beneficiaries during two mornings of site operation. The approach was therefore mixed-methods, incorporating qualitative and quantitative measures, which sought to understand common perceptions and experiences with the kiosk features. By utilizing a common theoretical framework, the TAM model, for understanding behaviors surrounding the adoption of new technologies by potential users, particular attention was given to the concepts of *perceived ease of use* and *perceived usefulness* of the kiosk features, amongst others.

Early on during data collection, in the focus group and during the questionnaire, it was apparent that overall interaction with the kiosk was low – questionnaire analysis would come to indicate that only about 1/3 of all participants had interacted with the touchscreen of the kiosk, only 1 respondent of which had done so more than just a few times. This demonstrated that there was overall poor acceptability of the kiosk, as there were significant barriers in place that limited kiosk engagement; subsequent analyses sought to identify these barriers and where improvements, if any, could be made in the project.

Interpretation of findings

Kiosk appeal

Kiosk appeal was evaluated both during the focus group discussion as well as in the questionnaire, where beneficiaries overwhelmingly expressed satisfaction. During the focus group, participants unanimously agreed that the kiosk was attractive to the eye and immediately sparks curiosity. Questionnaire responses confirmed this finding, with upwards of 90% of users indicating that the kiosk catches their attention, while about 70% of non-users indicated the same (see Table 3). Though the video spots that circulated on the bottom screen were interesting for about 40% of those who would go on to use the touchscreen, it was overwhelmingly, at 80%, the novelty of the kiosk within the space that ultimately brought beneficiaries to interact with the kiosk, as evidenced in Table 4. We therefore concluded that the kiosk was significantly appealing to site beneficiaries.

Kiosk perceived ease of use

The ease of use of the kiosk was similarly overwhelmingly positive on behalf of participants. In the focus group, the overall theme of the intuitiveness and simplicity of the interface arose

unanimously amongst participants. In the questionnaire, the questions evaluating ease of use, at the bottom of Table 3, were moderately positive; about 70% of users stated that the touchscreen was easy to use. Amongst those who didn't use the touchscreen, this figure was only slightly lower at about 60%; we concluded, thus, that the kiosk was perceived as moderately easy to use amongst users and non-users. In other words, it was not the perceived difficulty of use that could explain the low rates of use amongst site beneficiaries.

Kiosk usefulness and appropriateness

On the other hand, it was the usefulness and appropriateness of the kiosk that was identified through data analysis as the primary areas of concern for barriers to acceptance. Key themes emerged through focus group and questionnaire analysis, and concern both the touchscreen and the video spot features of the kiosk.

We were content to find that the touchscreen offered useful features to beneficiaries; during the focus group, the participants unanimously agreed that both the weather and Google Maps features were greatly useful and the questionnaire supported this, with 100% of users expressing having previously used the weather app. In the focus group, it was revealed how crucial the weather is to safety and comfortability while experiencing homelessness, to be able to anticipate unfavorable weather conditions and to prepare accordingly. Google Maps as well, was helpful for gaining a deeper, more intuitive understanding of the city layout compared to printed maps common on social support flyers or on smaller phone screens. There was debate amongst focus group participants as to how the game features were perceived, and ultimately the questionnaire demonstrated this was the 2nd most utilized feature, though still it was consulted by only about 1/3 of users.

One of the major takeaways of this study was how perceived usefulness shifted according to level of engagement with the kiosk. For example, focus group participants, who had engaged the most with the kiosk, spoke at large about the usefulness of the Watizat feature, quickly connecting them to local medico-social resources on an easy-to-use and adapted platform; however, amongst questionnaire respondents, this feature was actually used very rarely. Similarly, amongst questionnaire respondents, while more than 80% of kiosk users agreed that the kiosk was useful, only about 40% of non-users perceived the kiosk as useful to them. In other words, a gap was identified between the *actual* perceived usefulness of kiosk features as expressed by users, and its *potential* perceived usefulness, expressed by non-users, which perhaps could explain lack of kiosk use amongst the latter group. This finding was connected to a larger theme that emerged during focus group analysis: that the purpose and features of the kiosk are not immediately evident to beneficiaries – in other words, they are poorly advertised. The lack of visibility, or highlighting of

the kiosk features represented, thus, one of several barriers to use, preventing individuals from appreciating the potential use the kiosk may serve to them.

Relatedly, focus group participants unanimously used the smartphone as a point of comparison for how the kiosk presents unique features and benefits. Though they expressed that the capabilities are similar to those of a smartphone, they highlighted the different advantages the kiosk possesses; for example, the kiosk is constantly connected to electricity and internet – therefore when a beneficiary's smartphone is out of battery, or the data expired for the month, they can use the kiosk to access crucial information instead, such as the weather or Google Maps. As previously mentioned, the participants evoked how much easier to navigate, detailed and intuitive the touchscreen was than a smartphone screen. Similar to focus group participants, questionnaire respondents were similarly using the smartphone for comparison, but lacking in-depth experience with the kiosk, largely forwent or even abandoned use of the kiosk in preference for the smartphone; indeed, about 45% of respondents attested to not using at all or only using a bit the kiosk due to already possessing a smartphone. It became evident, thus, that the smartphone was a natural comparator to the kiosk, but that the kiosk had demonstrated unique advantages that weren't evident to those with little to no experience with the touchscreen. Thus, we understood the need to couple this finding with the aforementioned theme of lack in advertising, and consequently understood the need to increase awareness of the unique advantages that the kiosk offers in comparison to the smartphone.

The video spots represented another feature of the kiosk that drew much feedback, both during the focus group and in the questionnaire. All focus group participants expressed enthusiasm regarding the potential benefit that the video spots provide, while also expressing disappointment regarding the appropriateness of the messaging. To begin, they expressed that the messages changed too quickly, which limited comprehensibility, especially for 2nd language speakers of French. They also expressed that although the messages were fairly clear and simple, it could be beneficial to translate messages into other languages common amongst site beneficiaries. Demographic measurements, Table 2, revealed that while 50% of questionnaire respondents were born in France, the remaining 50% were from North (Maghreb) and Sub-Saharan Africa. Though language was not immediately evident as a barrier while conducting the questionnaire – few beneficiaries interrogated on the day of data collection were not conversational in French – nor was it a barrier to using the kiosk expressed during data analysis – only 10% of respondents expressed this – we understood that translating messaging into Standard Arabic and English may have a positive impact on comprehensibility. This is especially true as conversational fluency does not indicate literacy in a given language. Illiteracy, a common and important factor to consider

especially in the context of precarious populations, was notably not measured directly in this study, nor was unable to be gauged as study staff conducted the questionnaire verbally.

Perhaps the largest theme to emerge regarding perceptions of the video spot content was the sense of overwhelm that they caused. We identified two key causes for this sentiment:

First, focus group participants expressed that there was too wide of a selection of topics covered, causing folks to feel overwhelmed: *"There's too much info. The prevention spots, the first aid, the site info… its overwhelming"* said one participant. By rotating across a selection of what was about 30 spots at the time, in a matter of minutes there were messages advertising the risks of cancer, to the importance of monitoring for diabetes, to the need to protect against STIs and HIV, and onto the dangers of smoking, amongst other topics such as the CRf site information and First Aid spots. It became evident that the breadth of subjects being addressed was excessively wide, necessitating a reduction in the number of topics covered. Table 5 is beneficial to this point, identifying that the First Aid spots did not leave an impression on beneficiaries and that perhaps the health prevention and site info spots should be prioritized. Questionnaire respondents were later asked which topics would be most interesting for them, which in turn provides guidance for content focus areas. For health prevention content, this includes dental and mental health, testing and vaccination and for CRf site information, this includes resources on housing, food, clothing and administrative procedures.

Secondly, video spot content was found to be overwhelming by participants due both to its tone and the information it sought to communicate to beneficiaries. Focus group participants were adamantly critical of the tone of the health prevention messages on display; as one participant expressed *"I get it, I'm going to die in 5 minutes… the messages are scary, not enjoyable or positive… but we're in need of that"*. The message spots were perceived to utilize a fear-based tone to convince participants to adopt health prevention measures. Appendix II includes such spots, which display how "*Breast cancer is the most common cancer amongst women and also the deadliest*" or "*783 million people globally have diabetes… get tested now to increase your life expectancy"…* These spots have a serious, ominous tone; it was no surprise thus that about 1/3 of users claimed that the messages were anxiety-inducing.

At the same time, the messages sought to intervene in health prevention amongst PEH by informing them about the risks and dangers of disease, though this, according to participants, was not actually what the beneficiaries need. As one participant put it *"We get it, millions people have diabetes, cancer. We know that! Now what? What can we do about that?"*. Instead, beneficiaries expressed the need for content to focus not on educating folks about the dangers of not practicing

health prevention, but rather providing next steps on how to practice health prevention, perhaps even showing them that health prevention actions are both achievable and effective.

These two key criticisms, regarding the tone and type of information communicated remain in line with current literature in health communication, which is increasingly critical of the improper use of fear appeal: messaging that relies on fear to motivate users to adopt healthier behaviors. Though fear appeal has the ability to be an effective strategy for behavioral change, studies demonstrate that both *self-efficacy*, one's belief in their ability to conduct a certain task, and *response effectiveness*, one's belief as to the effectiveness of their task in achieving a certain goal, are prerequisites to the success of a fear appeal intervention (37,38). When fear appeal is used towards an individual in which either or both of the aforementioned needs are absent, this runs the risk that the individual may not only become avoidant to this particular intervention, but also to related future health messaging (39,40). Indeed, participants expressed this gap in beliefs, and as such, the use of fear appeal within this study risked making beneficiaries averse not only to the kiosk spots entirely, but could further fracture an already precarious relationship between the beneficiary and the healthcare system, making successive health interventions more challenging.

Spot messaging, thus, must either be improved to incorporate self-efficacy and response effectiveness elements, or, must be modified regarding the framing it uses to inspire behavioral change, such as by adopting more optimistic (41) and even humoristic approaches (42), which have demonstrated as particularly successful in similar contexts.

Finally, the last theme to emerge through analysis of beneficiary feedback was the appropriateness of the kiosk for the context in terms of deployment location, a salient factor for consideration in similar health kiosk programs (43). Overwhelmingly, focus group participants relayed that the kiosk posed a physical nuisance in the waiting room of the ASSH. A small space with only a few chairs for the most immediate in line for a shower, the waiting room is not a space conducive to engaging with the kiosk; using the kiosk touchscreen at length necessitates standing in the middle of the waiting room where beneficiaries and volunteers alike are passing by, coming in and out of the showers and bathrooms, blow-drying their hair… in short, the space is loud and stressful – *"it's not pleasant inside"*, says one participant. Instead, beneficiaries by large prefer to wait outside, even in unpleasant weather like the rain and cold, as it provides more space to breathe and is an overall calmer atmosphere. Discussions revealed that only the next few in line for the shower actually wait in the room, only in the space for a matter of a few minutes. This perhaps explains why almost 50% of respondents expressed time as a barrier to using the kiosk; spending little time in the waiting room itself, beneficiaries spend waiting time outdoors. This ultimately revealed that the kiosk is incompatible for the waiting room of the ASSH, and instead that it must be installed outdoors to the ASSH or in another CRf establishment entirely.

Strengths

This study was unique in its ability to engage with a particularly hard-to-reach population of PEH, including undocumented migrants. Justifiably, many members of these backgrounds are hesitant and often fearful towards strangers like study staff, specifically surrounding certain subjects, such as health, disease, vaccination and testing. Within its limitations, this study was an important step towards engaging a demographic commonly absent in public health research through a mixed-methods approach.

On the day of the questionnaire, one member of the study staff, with a background in community outreach and whom shared a lived experience of migration with many beneficiaries, was particularly successful at engaging participants. Furthermore, as a polyglot, he was able to utilize his language skills in English, Italian and Spanish to engage participants who otherwise wouldn't have been able to participate in the study due to limited French-fluency; only two beneficiaries were ultimately unable to participate in the questionnaire due lack of a common language. Overall, the questionnaire response rate was high, at about 75% participation. This may also be thanks to the CRf site volunteers who continuously foster a compassionate, welcoming environment and relationship with site beneficiaries. Naturally, this intent to create a psychologically safe environment may increase willingness to engage with study staff.

Limitations

There were many limitations in the context of this study, reflective of the barriers faced in the field by program staff as well as the difficult lived experiences that the study population faces. Both the focus group and the questionnaire suffered from low sample size. In the case of the focus group, an ideal number of participants of six or greater participants was not achieved as volunteers struggled to find beneficiaries that were interested and comfortable with this dynamic. Naturally, there were logistical barriers such as assuring attendance of the focus group participants, evidenced by one participant who missed the discussion. As far as the questionnaire, the total number of all responses was moderately low, but especially low across sections; Sections A and B were poor in response number compared to Section C. Though an additional day of focus groups or questionnaires would have been interesting, this was not possible due to budgetary constraints. Ultimately this question of low sample size restricts the level of scientific and statistical rigor of study analyses, not allowing for more complex analyses such as bivariate analyses or factoring and composite scoring.

In the case of the questionnaire, about 25% of beneficiaries declined to participate. Data was not collected on those who were approached but ultimately did not participate, but this nevertheless raises the question of selection bias as we consider differences between the groups

of those who did and did not participate. Furthermore, due to the single-point nature of this study, our scope is limited; we lack insight from beneficiaries who may come other days of the week. As this study was held in early spring, we also risk lacking crucial insights which may only arise in warmer or colder seasons, given the demographic of this study population. Furthermore, it would be ill-advised to apply these takeaways from this singular context to other French contexts, given the vast diversity in population, weather, healthcare access, inequality and poverty and disease profiles across France. In this way, we are very limited regarding the generalizability of our study results and must extrapolate them more globally and to other contexts with caution.

Finally, this acceptability study deviated in two crucial ways from the standard for such studies. First of all, it was conducted at the halfway point of the experiment, rather late in the project timeline as it risks rushing the analysis of study results, as well as the eventual development and deployment of any modifications that may be necessary through analysis. Such is the case in this project, in which the suggested kiosk improvements were only implemented within the final weeks of the pilot phase, and in too short of a timeline for another evaluation phase. Secondly, this unfortunately represents the first point in the entire project timeline in which the feedback of beneficiaries was sought out and incorporated. Thankfully a standard towards which public health programming is moving, the early, meaningful and continued involvement of members of the study population is fundamental to producing an intervention that is successful, efficient and sustained. This gap affected the scope of this acceptability study; rather than more specific-objectives, the feedback was broad and rudimentary, as there were much territory to cover in the solicitation of study population feedback.

Conclusion and Recommendations

This study sought to assess the acceptability of this innovative approach in health prevention for PEH and undocumented migrant populations. Through a mixed-method approach, perceptions regarding kiosk appeal, appropriateness, as well as ease of use and usefulness were collected and analyzed. In evaluating beneficiary engagement and acceptance of this kiosk, concerns regarding its usefulness and appropriateness for the context were identified, which three recommendations sought to address:

1. Increase advertising of kiosk features
    a. Showcasing the usefulness the kiosk may provide to beneficiaries
    b. Describing the advantages the kiosk has to a smartphone
2. Improve video spot content
    a. Decrease total number of spots, concentrating on beneficiary key interest areas
    b. Translate messages into Standard Arabic and English
    c. Improve fear appeal methodology or shift tone entirely to a more motivational, empowering, optimistic or humoristic one.
    d. Provide information on simple, concrete, achievable health prevention measures
3. Relocate kiosk to outdoor space or to another establishment where indoor space is more conducive to kiosk interaction

This study has demonstrated the importance of conducting acceptability studies early-on in public health interventions to ensure the interest, need and relevance of the project and its approach. Furthermore, it illustrated the relevance of feedback from key population members, and the need to seek it early and to hold it in high regard throughout the project timeline.

In an era in which innovative approaches to addressing public health problems are growing rapidly, generating widespread excitement and attention, we must be sure to maintain focus upon the foundational concerns to every public health intervention: the population of concern in our study, their needs and how to best tailor a response to address these, all while prioritizing their early, sustained and valued perspectives and involvement. Hopefully, this study refocuses our attention on those for whom our interventions are oriented, so that future interventions can be better conceptualized, designed, and implemented.

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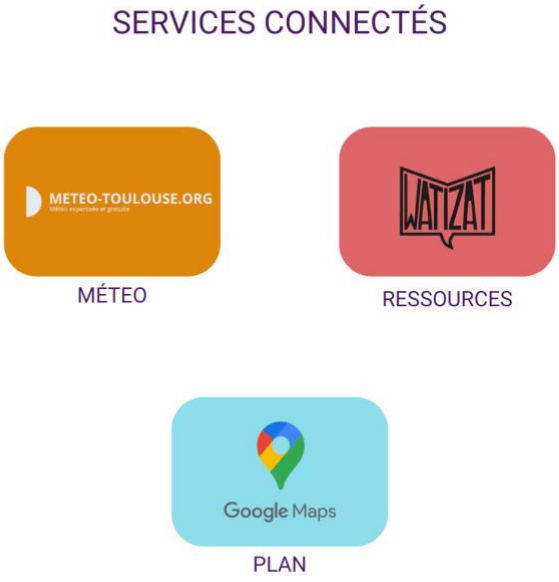
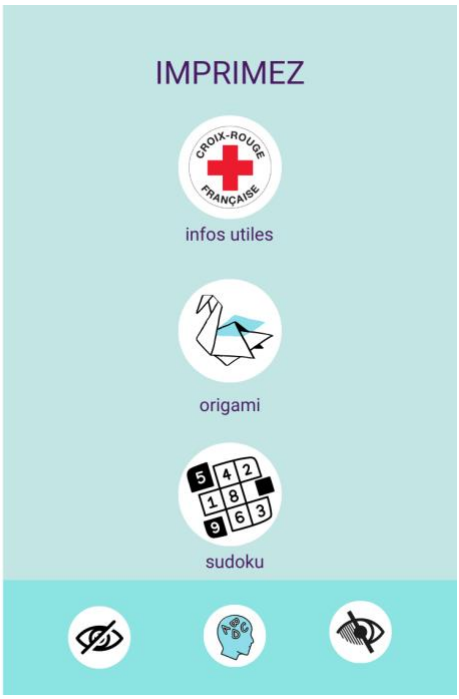
List of Appendices

Appendix I : Example of Kiosk, Touchscreen Features

Kiosk machine

Screenshot of touchscreen





Appendix II : Example of Spot Screen

Health prevention spots

First Aid Spots

Site Information Spots

Appendix III : Focus Group Guide

FOCUS GROUP MI-PARCOURS HEALTH-HUB

mercredi le 24 avril, 2024

ASSH Toulouse

- **Besoins :** 1 heure de temps, une salle privée, 8 chaises, des boissons, des goûters, des étiquettes nominatives
- **Rôles :**

2 co-modérateurs

1 preneuse de notes

AGENDA DU FOCUS GROUP (Durée de 1,5 - 2 heures)

I. Bienvenue et introductions (10 min)

a. Nom, d'où vous venez, icebreaker (Activité Dixit)

II. Présentation de la borne et le sujet du FG (10 min)

a. Introduction brève de la naissance du projet, les attentes

b. Le but du FG, l'agenda

III. Point sur la confidentialité (2 min)

a. Permission verbale / écrite d'être enregistré, photos

IV. Thème A : Les premiers retours globaux de la borne (30 min)

a. Les aspects positifs

1. *Qu'est-ce que vous aimez ? Quelles fonctionnalités sont bonnes, intéressantes ? Qu'est-ce qui marche bien ?*

b. Les aspects négatifs

1. *Qu'est-ce que vous n'aimez pas ? Quelles fonctionnalités ne sont pas bonnes, difficiles à utiliser ?*

V. Thème B : Comment attirer l'attention des personnes accueillies ? (30 min)

a. Emplacement de la borne

1. *La borne est-elle dans un bon endroit ? Visible ? Facile à approcher ?*

b. Des affiches autours

1. *Quand vous vous approchez, vous arrivez à trouver des infos ? Les différents outils / dispositifs, sont-ils clairs ?*

c. Médiation des bénévoles

1. *Vous êtes à l'aise de naviguer tout.e seul.e ou vous préférez qu'un bénévole vous la montre ?*

d. Des messages qui tournent

1. *Les messages en bas, vous les regardez ? Vous les comprenez ? Sont-ils intéressants, attirants, utiles, adaptés ?*
2. *A voir si possible, montrer des spots et demande leurs retours*

VI. Thème C : Une fois approchés à la borne, quels contenus / dispositifs leur intéresseraient ? (30 min)

a. Leurs besoins globaux
   1. *Quels contenus / infos voulez-vous voir sur la borne ? Quels dispositifs / ressources / outils / infos vous sont intéressants, nécessaires ?*

b. Leurs besoins en matière de santé, prévention
   1. *Par rapport à la santé, qu'est-ce qui vous intéresse / vous voulez savoir plus ? La vaccination, le dépistage, la santé mentale, tabagisme / alcoolisme, démarches administratives (AME), ressources logement / alimentation / vestiaire, opportunités d'emploi, développement personnel / ateliers / action CRf*

c. Freins d'utilisation (langue, texte versus images, simplification de l'interface)
   1. *Vous comprenez le langage en français ? Vous comprenez les termes ? Est-ce que c'est facile à utiliser, naviguer ?*

VII. Derniers remarques (10 min)

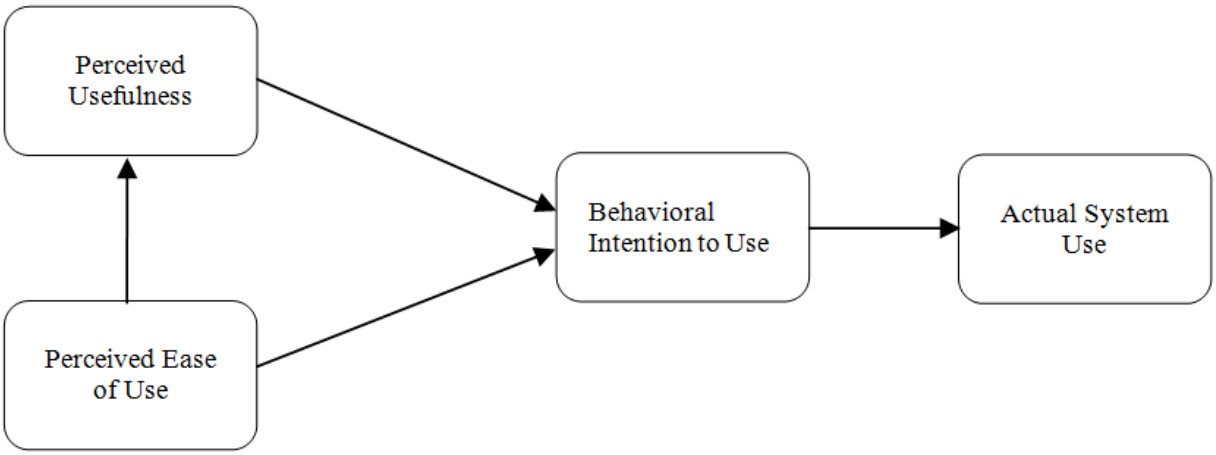
a. Petit synthèse de retours

b. Opportunité de rester pour donner plus de remarques / venir montrer sur la borne

VIII. Clôture et remerciements (2 min)

a. Seriez-vous intéressés à venir pour une phase II ?

Appendix V : Technology Acceptance Model



Appendix V : Questionnaire for Beneficiaries

LISA CONNECT : GUIDE ENQUÊTE
Mise en oeuvre 25 avril 2024
Version **2**

ENQUÊTE

Introduction : Bonjour ! Je m'appelle (nom) et je suis (fonction). Je veux comprendre ce que les gens pensent de cette borne. Avez-vous vu la borne lors de vos visites ? Puis-je vous poser quelques questions concernant ce que vous en pensez ? Ça va vous prendre moins de 5 minutes. Votre réponse peut nous aider à améliorer ce projet.

Confidentialité : Toutes les infos fournies dans ce questionnaire sont anonymes (nous ne vous demandons pas votre nom) et confidentielles (nous ne partageons pas vos réponses individuelles avec les autres). Les infos sont utilisées uniquement pour la recherche. Vous pouvez arrêter d'y participer à tout moment. Merci de votre participation.

Un exemplaire du format des questions : **Êtes-vous d'accord avec la phrase suivante ?** La borne attire mon attention.			• 😭 Pas du tout d'accord (0) • ☹️ Pas d'accord (1) • 😐 Indifférent (2) • 🙂 D'accord (3) • 😍 Tout à fait d'accord (4)
Questions			
1	Avez-vous utilisé la borne ? • Oui, beaucoup (aller sur Section A) • Oui, un peu (aller sur Section B) • Non, jamais (aller sur Section C)		
Section A :			
2A	Qu'est-ce qui vous a amené vers la borne la première fois ?		**⊞ Une personne CRf me l'a montrée/m'en a parlé** **⊞ Un proche me l'a montrée/en a parlé** **⊞ La tablette m'intéressait** **⊞ Les messages en-bas m'intéressaient** **⊞ C'était nouveau dans la salle et j'étais curieux** **⊞ J'ai vu d'autres personnes en train de l'utiliser**

			☐ **Autre :**				
3A	Quels contenus sur la borne avez-vous utilisés ?		☐ **Infos sur les établissements** ☐ **La météo** ☐ **Les jeux** ☐ **Watizat** ☐ **Autre :**				
4A	La borne attire mon attention.		**0**	**1**	**2**	**3**	**4**
5A	La borne montre des messages intéressants.						
6A	Les vidéos diffusées sont anxiogènes.						
7A	La borne est utile pour moi.						
8A	Je trouve des ressources adaptées sur la borne.						
9A	La borne est facile à utiliser.						
10A	J'apprends des choses sur la borne.						
11A	La borne est agréable à utiliser.						
12A	Je veux utiliser la borne davantage.						
13A	Après avoir utilisé la borne :		☐ **J'ai parlé du sujet avec un médecin** ☐ **J'ai parlé du sujet avec un autre bénéficiaire** ☐ **J'ai parlé du sujet avec un autre bénévole** ☐ **J'ai cherché plus d'infos sur un sujet diffusé** ☐ **Je me suis déplacé dans un lieu de soins** ☐ **Je n'ai rien fait mais j'ai envie d'agir** ☐ **Je n'ai rien fait et je n'ai pas envie d'agir** ☐ **Autre :**				
14A	Quand vous venez à la CRf, avec quelle fréquence utilisez-vous la borne ?		**Jamais** **Parfois** **Souvent** **Toujours**				
15A	Je veux en savoir plus sur :		☐ **La vaccination**				

			☐ **Le dépistage** ☐ **La santé mentale** ☐ **La santé dentaire** ☐ **Impact de l'alcool** ☐ **Impact du tabac** ☐ **Impact de consommation de drogues** ☐ **Démarches administratives** ☐ **Ressources logement / alimentation / vestiaire** ☐ **Développement personnel / ateliers / actions CRf** ☐ **Autre :**
Section B :			
2B	Qu'est-ce qui vous a amené vers la borne la première fois ?		☐ **Un personnel CRf me l'a montrée / m'en a parlé** ☐ **Un proche me l'a montrée / m'en a parlé** ☐ **La tablette m'intéressait** ☐ **Les messages en-bas m'intéressaient** ☐ **C'était nouveau dans la salle et j'étais curieux** ☐ **J'ai vu d'autres personnes en train de l'utiliser** ☐ **Autre :**
3B	Quels contenus sur la borne avez-vous utilisés ?		☐ **Infos sur dispositifs CRf** ☐ **La météo** ☐ **Les jeux** ☐ **Sites internet**
4B	La borne attire mon attention.		**0** **1** **2** **3** **4**

5B	La borne montre des messages intéressants.						
6B	Les vidéos diffusées sont anxiogènes.						
7B	La borne est utile pour moi.						
8B	Je trouve des ressources adaptées sur la borne.						
9B	La borne est facile à utiliser.						
10B	J'apprends des choses sur la borne.						
11B	La borne est agréable à utiliser.						
12B	Je veux utiliser la borne davantage.						
13B	Après avoir utilisé la borne :		☐ **J'ai parlé du sujet avec un médecin** ☐ **J'ai parlé du sujet avec un autre bénéficiaire** ☐ **J'ai parlé du sujet avec un autre bénévole** ☐ **J'ai cherché plus d'infos sur un sujet diffusé** ☐ **Je me suis déplacé dans un lieu de soins** ☐ **Je n'ai rien fait mais j'ai envie d'agir** ☐ **Je n'ai rien fait et je n'ai pas envie d'agir** ☐ **Autre :**				
14B	Pour quelles raisons n'avez vous pas davantage utilisé la borne ?		☐ **C'est compliqué d'utiliser** ☐ **Les fonctionnalités m'intéressent pas** ☐ **Je n'ai pas le temps** ☐ **Je ne comprends pas l'intérêt** ☐ **Je préfère parler avec quelqu'un** ☐ **Je ne comprends pas la langue** ☐ **Autre :**				
15B	Je veux en savoir plus sur :		☐ **La vaccination** ☐ **Le dépistage**				

			☐ **La santé mentale** ☐ **La santé dentaire** ☐ **Impact de l'alcool** ☐ **Impact du tabac** ☐ **Impact de consommation de drogues** ☐ **Démarches administratives** ☐ **Ressources logement / alimentation / vestiaire** ☐ **Développement personnel / ateliers / actions CRf** ☐ **Autre :**				
16B	Quand vous venez à la CRf, avec quelle fréquence utilisez-vous la borne ?		**Jamais** **Parfois** **Souvent** **Toujours**				
Section C :							
2C	La borne attire mon attention.		**0**	**1**	**2**	**3**	**4**
3C	La borne montre des messages intéressants.						
4C	La borne montre des messages anxiogènes.						
5C	La borne a l'air utile pour moi.						
6C	La borne a l'air facile à utiliser.						
7C	La borne a l'air agréable à utiliser.						
8C	Je veux utiliser la borne davantage.						
9C	Pour quelles raisons n'avez vous pas utilisé la borne?		☐ **C'est compliqué d'utiliser** ☐ **Les fonctionnalités m'intéressent pas** ☐ **Je n'ai pas le temps** ☐ **Je ne comprends pas l'intérêt** ☐ **Je préfère parler avec quelqu'un** ☐ **Je ne comprends pas la langue** ☐ **Autre :**				

10C	Je veux en savoir plus sur :		**La vaccination** **Le dépistage** **La santé mentale** **La santé dentaire** **Impact de l'alcool** **Impact du tabac** **Impact de consommation de drogues** **Démarches administratives** **Ressources logement / alimentation / vestiaire** **Développement personnel / ateliers / actions CRf** **Autre :**
Questions supplémentaires			
1D	Est-ce qu'il y a une vidéo en bas qui vous a marqué? (Si oui, sélectionnez les types de vidéo)		**Non** **Spots prévention** **Spots premiers secours** **Spots d'info CRf**
2D	Avez-vous d'autres commentaires à ajouter ?		**Texte court**

Renseignements signalétiques		
3D	Quel est votre genre ?	**Homme** **Femme** **Autre** **Je ne veux pas le dire**
4D	Quel âge avez-vous ?	**Texte courte**
5D	Quel est votre pays de naissance ?	**France** **Liste des pays avec d'origine courante des immigrants en France** **Autre (courte texte)**