CLIENT EXIT INTERVIEWS (CEIs) FOR WOMEN'S INTERGRATED SEXUAL HEALTH (WISH) PROGRAMME

ENUMERATOR TRAINING MANUAL

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ACKNOWLEDGMENTS

Work on this manual was initiated jointly by IPPF's WISH2ACTION programme, Genesis Analytics and Kantar Teams. This guide is written by Sarah Magni, Ayesha Ismail, Tamika Fellows and Joyce Mumah. The authors gratefully acknowledge the contributions of colleagues from IPPF WISH2ACTION HUB who provided useful insight and feedback during the development and finalisation of this manual.

This publication is coordinated by the WISH2ACTION Programme. For further queries, please contact Joyce Mumah JMumah@ippf.org

Suggested citation: Sarah Magni, Ayesha Ismail, Tamika Fellow and Joyce Mumah. Client Exit Interviews (CEIs) for Women's Intergrated Sexual Health Programme (WISH): Enumerator Training Manual. Nairobi: International Planned Parenthood Federation. 2021

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Core CEI Research Team

Members of the core CEI research team are shown in Table 1 below. Contact details are provided for the key contacts at each organisation.

Table 1: Core CEI research team

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In [Add name of country], [Add name of MA] is an integral partner for these CEIs. The names of the team from [Add name of MA] and contact details of the key person for the CEIs is shown below

Table 2: In-country research team

Organisation	Organisation
[Add name of MA]	[Add names of MA research team] and email for main contact
[Add IRC in Somalia, Ethiopia, Uganda and South Sudan]	[Add names of IRC research team] and email for main contact in Somalia, Ethiopia, Uganda and South Sudan.

Acronyms

AUs	Additional Users
CAPI	Computer-assisted Personal Interviewing
CBD	Community-Based Distribution
CEI	Client Exit Interview
CHW	Community Health Worker
CYP	Couple Years of Protection
FCDO	UK Foreign, Commonwealth and Development Office
DMI	Development Media International
FP	Family Planning
HI	Humanity & Inclusion
IDP	Internally Displaced Person
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
IUD	Intrauterine Device
KPI	Key Performance Indicators
MA	Member Association
MII	Method Information Index
MPI	Multidimensional Poverty Index
MSI	Marie Stopes International
MUAC	Mid-Upper Arm Circumference
NPS	Net Promoter Score
PAPI	Paper and Pencil Interviewing
PPI	Poverty Probability Index
QA	Quality Assurance
SBCC	Social and Behaviour Change Communication
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TOT	Training of Trainers
VCAT	Values Clarification and Attitude Transformation
W2A	WISH2Action
WISH	Women's Integrated Sexual Health

Glossary

Abstinence: Refraining from sexual intercourse of any type. Abstinence is 100% effective in preventing pregnancy, and also prevents transmission of STI's, including HIV.

Additional users: The number of additional women of reproductive age using modern contraception compared to a baseline, used as an aggregate metric across the 69 FP2020 focus countries compared to the estimated 2012 baseline number of modern contraceptive users in the same countries; this concept does not apply at the individual level, but rather refers to a net increase in the absolute number of users above a specified baseline.

Adopters: A person accepting a modern family planning method who was not using a modern family planning (FP) method within the past three months; adopters may be first-time users of modern contraception or may be lapsed users of modern family planning.

Cervical cap: The cap is a barrier method of contraception. It is made of rubber or silicone, smaller than the diaphragm, and it covers only the neck of the womb. At the start it needs to be fitted by a doctor or nurse. It must be inserted before intercourse, and must not be left in the vagina for more than 48 hours.

Community Based Distribution Channel: Trained community health workers (CHWs) who provide FP counselling, a limited range of FP methods (mostly short term methods) and referrals to other services.

Continuer: A person who continues using FP from the same provider.

Couple Years of Protection: Couple years of protection (CYPs) is a measure that estimates the protection from pregnancy provided by contraceptive methods during a one-year period.

Diaphragm: A diaphragm is a barrier method of contraception. It is a dome-shaped circle made of rubber or silicone that is inserted into the vagina to form a barrier between the sperm and the entrance of a woman's womb. It requires initial fitting by a doctor or nurse. It must be inserted before sex and should be used with a spermicide. It must be left in for at least 6 hours after sex (and no more than 24 hours).

Emergency contraception: Also called postcoital contraception, is a form of birth control that may be used by women after unprotected sexual intercourse or use of a failed birth control measure, to prevent pregnancy.

Family planning counselling: Individualised medical advice and/or guidance given to clients to help them choose and use family planning methods that suit them.

Family planning: The conscious effort of couples or individuals to plan the number of children they have and to regulate the spacing and timing of their births through contraception and the treatment of involuntary infertility. For this study, the term FP services is used to capture the following services: modern FP and FP counselling.

Family planning services: For this study, the term FP services is used to capture the following services: modern FP and FP counselling.

Female condom: Sheaths, or linings, that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film. Female condoms have flexible rings at both ends- one ring at the closed end helps to insert the condom the other ring at the open end holds part of the condom outside the vagina. The female condom works by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also helps to keep infections in semen, on the penis, or in the vagina from infecting the other partner.

Female sterilisation: Sterilisation is a permanent way of preventing pregnancy. Female sterilisation is called tubal ligation. It is a surgical procedure to cut or block the fallopian tubes (which carry the eggs from the ovary to the womb) so that the sperm cannot meet the egg. This operation will affect your fertility potential (ability to get pregnant in the future).

Fertility awareness method: There are several fertility awareness methods, all of them based on the fact that there are only a few days during each menstrual cycle - the days before and during ovulation - when a woman can get pregnant. The menstrual cycle begins the day a woman starts her period (bleed) and ends the day before her next period starts. These methods require a woman to observe various fertility signs such as changes in her body temperatures and cervical mucus.

First-time adopter: A person who received a modern FP method on the day of the Client Exit Interview (CEI) but who had never used a modern FP method before.

Glossary

FP2020: A global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have; through government commitments to increase access to family planning in 69 countries, FP2020 aims to expand family planning to 120 million additional women by 2020 in addition to continuing to provide services to the 260 million women who are already using modern contraception in those countries.

Implants: The hormonal implant is a small soft plastic rod containing progestogen that is inserted in your upper arm with minor surgery carried out by a trained doctor. The progestogen is released in tiny doses and the implant prevents pregnancy for three years.

Injectables: The hormonal injection contains the hormone progestogen. It is given by a doctor or nurse once a month or every 12 weeks

Internally Displaced Person: Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised State border.

Intra uterine device (IUD): The intrauterine device or copper coil is a small soft device with a copper thread or copper cylinders that is inserted into the cavity of your womb by a trained doctor. It can be left in for 3-10 years. The device sits in your womb, but does not rely on hormones. It is made of plastic and copper and works mainly by preventing sperm from surviving in your womb and reaching an egg.

Lactational Amenorrhea Method (LAM): A temporary family planning method based on the natural effect of breastfeeding on fertility ("Lactational" means related to breastfeeding. "Amenorrhea" means not having monthly bleeding.) The LAM method requires 3 conditions. All 3 must be met to be effective: the mother's monthly bleeding has not returned, the baby is fully or nearly fully breastfed and is fed often, day and night and the baby is less than 6 months old.

Lapsed adopter: A person who received a modern FP method on the day of the CEI but who had not used a modern FP method in the previous three months although they had used one before that.

Male condom: Sheaths, or coverings, that fit over a man's erect penis. Most male condoms are made of thin latex rubber. The male condom works by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

Method Information Index: This indicator is an index that summarises whether service providers supply adequate information to women when receiving FP services. It measures the extent to which specific information is provided to help women to make informed choices

Male sterilisation: Male sterilisation is also known as a vasectomy. It is a surgical procedure to cut the ducts that carry sperm so that, while a man can still ejaculate, there is no sperm present. The operation, which can be carried out under local anaesthetic, affects a man's fertility potential.

Method switcher: People who switch from one contraceptive method to another.

Mobile outreach channel: Outreach services in hard to reach areas providing a broad range of FP methods and integrated sexual and reproductive health (SRH) services to communities.

Modern methods: Methods including cervical cap, male and female condoms, emergency contraception, implants, injectables, intra-uterine device, oral contraceptives, patch, ring, spermicides and sterilisation.

Net Promoter Score: Is a metric, commonly used to measure the customer experience, is calculated using a 0-to-10 scale to answer 1 question: "How likely is it that you would recommend [company X] to a friend or colleague?"

Oral contraceptives: Are hormonal preparations that may contain combinations of the hormone's estrogen and progestin or progestin alone.

Glossary

Patch: The contraceptive patch contains the hormones estrogen and progestogen. It sticks to the skin and can be put on the stomach, thigh, buttocks or upper arm. It is not transparent, so this method is visible. The hormones are released continuously into the bloodstream through the skin. You wear a new patch each week for three weeks, followed by a week's break.

Provider changer: A person who received modern FP from a Member Association (MA) or WISH SDP/International Rescue Committee (IRC) on the day of the CEI but had previously received modern FP from another provider.

Provider continuer: A person who received modern FP from MA or WISH SDP/IRC on the day of the CEI and had previously received modern FP from the same provider.

Ring: The ring is a small flexible ring that contains the hormones estrogen and progestogen. It is inserted into the vagina by the woman and is kept in place for three weeks; it is then removed for a one-week break. Following the week break, a new vaginal ring is inserted.

Spermicides: Is a chemical that you put deep into the vagina right before sex. It prevents pregnancy in two ways: blocking the entrance to the cervix so sperm can't get to your egg, and stopping sperm from moving well enough to swim to your egg.

Static Channel: Services provided through fixed health facilities.

Traditional methods: Methods include the lactational amenorrhea method, withdrawal method, calendar or rhythm method and abstinence.

Unmet need for family planning: Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child.

Withdrawal method: Just before ejaculation, the man withdraws his penis from his partner's vagina and ejaculates outside the vagina,
keeping his semen away from her external genitalia.

Welcome

We train our fieldwork team to follow data collection protocols that ensure the highest quality of the data we collect. By the end of training, you should feel comfortable with the data collection instruments and your role in the data collection team. If you have any questions at any point, please ask.

A dedicated and professional fieldwork team is critical to producing quality data. Your attention to detail and adherence to the protocols you are trained on will help ensure that the client will get good data to help them make decisions that will affect people's lives.

Welcome to the team!

1. About this training

In this section, we explain the purpose of the training and outline training expectations.
After this session you should be able to:

- Describe the purpose of the training;
- Explain what to expect from the training; and
- Understand how to use the training manual.

1.1 Training objectives

The purpose of this training is to ensure that you are able to conduct the client exit interviews (CEIs) successfully.

The specific training objectives are to:

- Introduce the WISH programme;
- Explain the aims and objectives of the WISH CEIs;
- Learn how to conduct the CEIs including:
  - Selecting a participant
  - Determining their eligibility
  - Administering the information sheet and getting informed consent
  - Effectively administering the questionnaire
- Ensure that the CEIs meet the ethical requirements;
- Learn how to quality assure the CEIs; and
- Explain fieldwork procedures and implementation arrangements.

1.2 What to expect

Although some people have more practice at interviewing than others, anyone can become a good enumerator through **practice and experience.** Your training will consist of a combination of classroom training and practical experience. Before each training session, you should study this manual carefully along with the questionnaire, writing down any questions you have. Ask questions at any time to avoid mistakes during actual interviews. Enumerators can learn a lot from each other by asking **questions** and **talking about situations** encountered in practice and actual interview situations.

Each enumerator will receive a package with the following materials:

1. Training agenda
2. Pre-readings: Introduction to family planning, background documents on WISH programme, research protocol and questionnaire
3. Training manual
4. Tablet (with charger and pouch)

During the training, the questionnaire and instructions will be discussed in detail. You will practice reading the questionnaire aloud to another person several times so that you become comfortable and familiar with the material. You will also be asked to take part in role-playing in which you practice by interviewing another trainee.

You will first learn how to fill the paper questionnaire (PAPI). During training, you will also learn how to administer the questionnaire using the Computer-Assisted Personal Interviewing (CAPI) platform. The data collection tool will be programmed using the SurveyToGo software. Once you are familiar with the content of the questionnaire and with navigating the electronic platform, you will practice conducting the questionnaire using the CAPI on tablets.

The training will also include practice in data collection, in which you will interview people and collect and capture real data.

At the end of each day, we will provide you with homework that will need to be submitted the next morning. At the end of the training you will need to pass a competency test to be selected as an enumerator for this study.

Finally, the training you receive does not end when the formal training period is completed. Each time a fieldwork supervisor meets with you to discuss your work, your training continues. This is particularly important during the first few days of fieldwork. As you run into situations you did not cover in training, it will be helpful to discuss them with your team. Other enumerators may be running into similar problems, so you can all benefit from each other's experiences.

1. About this training

1.2.1 Training rules

We expect that all enumerators abide by the following training rules:

- Sign the attendance sheet at the beginning of each day;
- Keep to the time on the agenda;
- Put your mobile phone off or on silent mode when training is in session;
- Follow the instructions of the trainers and other core research team members;
- Guard the training materials that are given to you with utmost care;
- Be attentive and take everything you are learning seriously (your participation is key)
- Feel free to ask for clarity whenever required (your understanding is vital to the success of the work).

1.3 About this training manual

The primary purpose of the training manual is to provide a document that outlines the **standard procedure** for the fieldwork to ensure consistency and systematic enquiry across the data collection activities. In doing so, the protocol will ensure that the fieldwork is **consistent, rigorous** and that it upholds the highest degree of **ethical standards.**

This document also serves as an easy-to-reference manual for enumerators to use during the fieldwork phase as a consolidated source of information on the purpose of the client exit interviews (CEIs), the questionnaire and fieldwork logistics.

This manual follows the same structure as the training agenda.

2.The WISH programme

In this section we introduce the WISH programme and the multiple service delivery points (SDPs) used to deliver Family Planning (FP) services. After this session you should be able to:

- Explain what the WISH programme is and what it aims to do;
- Describe the different ways in which FP services are delivered under WISH;
- Describe the role of the member association (MA); and
- Describe how FP services are promoted.

In partnership with UK Department for Foreign, Commonwealth and Development Office (FCDO), Women's Integrated Sexual Health (WISH) is a flagship FP programme to deliver 20% of the UK's FP global commitments. With a value of over £200 million over three years the programme's service delivery budget is set to deliver an **additional 2.8m – 4.1m FP users** by end 2020. In working across Africa and Asia to provide a comprehensive package of Sexual and Reproductive Health Rights (SRHR), the programme has a primary focus on increasing the number of additional FP users alongside reducing maternal mortality and improving access to safe abortion.

Box 1: WISH terminology

In some countries, the name "Women's Integrated Sexual Health" is not culturally appropriate and has been adapted to be more locally appropriate. For example, in Nigeria, WISH stands for "Women's Integrated Services for Health". It is more important that you understand what the local name for WISH means in your country.

The priority populations include **youth** and some of the **poorest and marginalised** in society. The governments of all countries participating in WISH have signed commitments to FP2020, a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have.

WISH targets are supported by progress towards four cross-cutting outputs. These are:

- Enabling community and individual choice by promoting more supportive social norms and lowering barriers to safe and quality care;
- Promoting national ownership through improved legal, financial, and policy frameworks for SRHR;
- Expanding private sector access to quality, integrated FP and SRH services; and
- Developing global goods (tools, best practices and evidence) to improve programming and inform policymaking.

2. The WISH programme

2.1 Service delivery under WISH

WISH is implemented through two different funding streams (known as Lots) as shown in Table 3 below. These CEIs relate to **17 countries** in which IPPF and its partner, IRC, deliver services. Six countries in Lot 1 and 11 of the 12 countries in Lot 2 (Rwanda is excluded) will have CEIs. These are shown in bold text in table 3. Lot 2 is also referred to as WISH2Action (W2A).

Table 3: WISH programme data

	Lot 1	Lot 2
Consortium lead	Marie Stopes International (MSI)	International Planned Parenthood Federation (IPPF)
Consortium partners	IPPF, DKT, Ipas, THINKPLACE, Options, Leonard Cheshire Disability	MSI, International Rescue Committee (IRC), Development Media International (DMI), Options, Humanity & Inclusion (HI)
Countries	Burkina Faso, **Cameroon, Chad, Cote D'Ivoire, DRC,** Mali, Mauritania, Niger, **Nigeria**, Senegal, Sierra Leone	Afghanistan, Bangladesh, **Burundi, Ethiopia, Madagascar, Malawi, Mozambique, Pakistan,** Rwanda, **Somalia, South Sudan, Sudan, Tanzania, Uganda, Zambia,** Zimbabwe.

IPPF delivers services through its MAs. These are independent, locally founded and managed organisations which align with IPPF's vision and standards. The MAs provide a wide range of services beyond FP. In crisis-affected areas, namely in **Ethiopia, Somalia, South Sudan and Uganda,** IPPF's partner, IRC, delivers FP services within refugee and internally displaced persons (IDP) camps and the surrounding host community.

Table 4: Service delivery per country

Country	Member association/IRC
Burundi	Association Burundaise pour le Bien-Etre Familial's (ABUBEF)
Cameroon	Cameroon National Planning Association for Family Welfare (CAMNAFAW)
Chad	Association Tchadienne pour le Bien-Être Familial (ASTBEF)
Cote d'ivoire	Association Ivoirienne pour le Bien-Etre Familial (AIBEF)
DRC	Association de Bien-Etre Familial – Naissances Désirables (ABEF-ND)
Ethiopia	Family Guidance Association of Ethiopia, IRC
Malawi	Family Planning Association of Malawi (FPAM)
Mauritania	Association Mauritanienne pour la Promotion de la Famille (AMPF)
Mozambique	Associação Moçambicana para Desenvolvimento da Família (AMODEFA)
Nigeria	Planned Parenthood Federation of Nigeria (PPFN)
Pakistan	Rahnuma (formerly the Family Planning Association of Pakistan or FPAP)
Somalia	IRC
Sudan	Sudan Family Planning Association (SFPA)
South Sudan	Reproductive Health Association of South Sudan (RHASS), IRC
Tanzania	Uzazi na Malezi Bora Tanzania (UMATI)
Uganda	Reproductive Health Uganda (RHU), IRC
Zambia	Planned Parenthood Association of Zambia (PPAZ)

2. The WISH programme

Under WISH, the IPPF MAs and IRC use a mixed service delivery model. The combination of SDPs in each country differs, but broadly fall into three different channels as follows:

- **Static**: facility-based services;
- **Mobile:** outreach services in hard to reach areas providing a broad range of FP methods and integrated SRH services to communities; and
- **Community Based Distribution (CBD):** Through trained community health workers (CHWs) who provide counselling, a broad range of FP methods and referrals to other services.

2.2 Promoting FP to support service delivery under WISH

IPPF's media partner on W2A is Development Media International (DMI). DMI's work on demand creation primarily focuses on the first of the four WISH project outputs: Community and Individual Choice.

DMI is operating in six countries of relevance to this study: **Uganda, Ethiopia, Tanzania, Zambia, Malawi and Mozambique.** Five campaigns will be run. These will focus on: birth spacing, role of men, delayed childbirth, stigma among youth and myths and misconceptions.

However, in all countries, social and behaviour change communication (SBCC) is undertaken to support service delivery.

3. The Client Exit Interviews

In this section we describe the background to the CEIs and explain the aims and objectives. After this session you should be able to:

- Explain the background to the CEIs;
- Describe the aim and objectives of these CEIs;
- Describe how these CEIs will be conducted; and
- Describe who is eligible for inclusion in the CEIs.

2.2 Background

MSI (Lot 1 consortium lead) has conducted CEIs across their sites annually, using a tried and tested protocol and questionnaire. Findings from these CEIs are used to inform programmatic decision-making and to allow for comparison across country programmes.

IPPF wishes to learn from MSI and to conduct CEIs with FP clients from WISH sites in 17 countries in which they and their partner, IRC, provide services. These countries are: **Burundi, Cameroon, Chad, Cote d'Ivoire, DRC, Ethiopia, Malawi, Mauritania, Mozambique, Nigeria, Pakistan, Somalia, South Sudan, Sudan, Tanzania, Uganda, and Zambia.**

IPPF has contracted Genesis Analytics **(Genesis)** and Kantar Public **(Kantar)** to undertake these CEIs.

3.2 Aims and objectives

The aims of the CEIs are to:

- Understand characteristics of the FP client population;
- Monitor progress towards programmatic targets;
- Determine performance of WISH (for payment) against key programme indicators (KPIs); and
- Provide input to inform strategies, adaptive programming and learning.

The specific objectives of the CEIs are to:

- Characterise users of FP services
- Estimate the percentage of users of FP services by WISH SDPs who are under age 20
- Estimate the percentage of clients of FP services (provided by WISH SDPs) who are living in poverty
- Provide information needed to estimate the number of additional users of modern methods of contraception contributed by WISH
- Estimate the percentage of WISH FP clients counselled on a range of methods and potential side effects as defined by the method information index
- Estimate the percentage of FP clients who would recommend the WISH services as evidenced by the net promoter score (NPS)
- Estimate the percentage of WISH clients who demonstrated positive attitudes, practices and community support in relation to FP and SRHR
- Estimate the percentage of FP clients at WISH service delivery points reporting exposure to WISH social and behavioural change communication (SBCC) activities
- Estimate the percentage of users of FP services by WISH service delivery points who have a disability
- Estimate the proportion of FP clients who received at least one other SRH service during their FP visit on the day of the CEI
- Understand why FP users changed methods
- Explore the predictors of FP adopters
- Explore the predictors of being likely to promote FP services
- Determine impact of SBCC campaign on outcomes of interest.

3. The Client Exit Interviews

3.3 Methods

MSI has a tried and tested protocol and questionnaire which has been adapted for these CEIs. These CEIs are aligned as much as possible with those undertaken by MSI.

3.3.1 Study design

The CEIs comprise cross-sectional surveys of sampled FP clients receiving services from any or all of the three channel types: static, mobile, and CBD, under the WISH Programme in the 17 selected countries. For this study, the sample will be clients 15 or 18 years and above depending on the country (see Table 4) who reported they received a **FP service (s) on the day of the interview.**

Box 2: Defining FP services for these CEIs

For the WISH sites where IPPF and/or IRC are providing services, FP services include **modern FP methods** (cervical cap, male and female condoms, emergency contraception, implants, injectables, intra-uterine device (IUD), oral contraceptives, patch, ring, spermicides and sterilisation) and **FP counselling**. More detailed information about FP methods is provided in section 7.

This is in contrast to the MSI-led WISH SDPs, where FP services refers to FP methods only (includes Comprehensive Abortion Care/Post-Abortion Care), and does NOT include counselling.

In Francophone countries, when talking to men, the term "counselling" may not be appropriate. Men are "talked to"

3.3.2 Study area and population

The age of consent for respondents to participate in the study varies between countries due to IRB. In some countries, the age of respondent is 15 years and above, whereas in other countries, it is 18 years and above.

Table 5: Age of research participants by country

15 and above	18 and above
Burundi	Malawi
Ethiopia	Mozambique
Cameroon	Somalia
Chad	Pakistan
Cote d'Ivoire	Zambia
Democratic Republic of Congo	Uganda
Mauritania	
Nigeria	
South Sudan	
Sudan	
Tanzania	

3.3.3 Inclusion and exclusion criteria

Inclusion and exclusion criteria to determine who is eligible to be interviewed are as below. In order to be eligible the person must meet all of the inclusion criteria and none of the exclusion criteria, this is discussed further in section 5.

3. The Client Exit Interviews

Table 6: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Men and women	Men and women
Clients who have received a FP service on the day of the study. FP services include **modern FP** (cervical cap, male and female condoms, emergency contraception, implants, injectables, intra-uterine device (IUD), oral contraceptives, patch, ring, spermicides and sterilisation, IUD or implant removal) and/or **FP counselling.**	Clients who did NOT receive an FP service at all. Clients who received a FP service but NOT on the day of the study. Clients who received an abortion or other services only (with no FP service).
Older than 15 years in the following countries: Burundi, Cameroon, Chad, Cote d'Ivoire, DRC, Ethiopia, Mauritania, Mozambique, Nigeria, South Sudan, Sudan, Tanzania Older than 18 years in the following countries: Malawi, Mozambique, Pakistan, Somalia, Zambia, Uganda	14 years and younger in the following countries: Burundi, Cameroon, Chad, Cote d'Ivoire, DRC, Ethiopia, Mauritania, Mozambique, Nigeria, South Sudan, Sudan, Tanzania 17 years and younger in the following countries: Malawi, Mozambique, Pakistan, Somalia, Zambia, Uganda
Ability to provide informed consent in the form of a signature or thumbprint (or witnessed verbal consent in Pakistan)	Unable to provide informed consent

Note that we DO NOT exclude clients based on the FP method that they get. Box 3 below gives two examples to demonstrate this.

Box 3: Case study on FP method and inclusion

In Tanzania, a woman may come to a static facility to collect male condoms only. She is eligible for inclusion (assuming that she meets the other eligibility criteria too).

In Nigeria, a husband may collect an oral contraceptive refill for his wife. In this case the man has received an FP service and is eligible for inclusion (assuming he meets the other eligibility criteria).

In order to identify whether clients are eligible for inclusion, enumerators will administer the participant eligibility section of the questionnaire (section E) and section 5.3 of this training manual.

3.3.4 Data collection

The survey will be administered to clients by a trained enumerator after they have received FP services. The enumerators are part of a wider team including a supervisor; further details on the team and their roles are given in section 11.1. The survey takes approximately 25-35 minutes and data will be collected electronically using Computer-assisted Personal Interviews (CAPI) in all countries except Pakistan, where Paper and Pencil Interviewing (PAPI) will be used. PAPI will be used in Pakistan as there have been recent changes in regulations guiding the conduct of social research surveys. Part of the regulation includes the tight restrictions on the use of CAPI for data collection. For this reason and based on advice from the FPAP, we have opted to use PAPI in Pakistan. However, in cases where enumerators experience technical issues with CAPI, they will need to notify their supervisor.

4. General research principles

In this section we outline some key research principles. After this session you should be able to:

- Explain the importance of confidentiality;
- Describe the key ethical considerations for these CEIs;
- Discuss how the specific rights of minors and vulnerable groups will be protected and what the protocol for interviewing them in your country is;
- Understand your own biases and values in relation to family planning and abortion; and
- Explain and apply the key principles of effective interviewing.

4.1 Confidentiality and ethical considerations

The global study received ethics approval from the Liverpool School of Tropical Medicine (Study number: 19-073). In each country we have applied for ethical approval as shown in **Table 7** below:

Table 7: IRB in each country

Country	Name of IRB
Burundi	Institut de Statistiques et d'Etudes Economiques du Burundi (ISTEEBU)
Cameroon	Ministry of Health and Public Hygiene
Chad	Ministry of Public Health
Cote d'Ivoire	Ministry of Health and Public Hygiene
DRC	Publica Health and Town Hall
Ethiopia	Ethiopia Public Health Institute (EPHI) IRB
Malawi	National Health Sciences Research Committee
Mauritania	Ministry of Health
Mozambique	National Committee for Bioethics
Nigeria	Nigerian Institute of Medical Research (NIMR)
Pakistan	Pakistan Health Services Academy; Ministry of Interior, Pakistan
Somalia	Minister of Health
South Sudan	South Sudan Research Ethics Committee (SSREC)
Sudan	National Health Research Ethics Review Committee, Department of Research, Ministry of Health
Tanzania	National Institute for Medical Research
Uganda	Ethical Research Committee (Local) Uganda National Council of Science & Technology (UNCST) (National)
Zambia	ERES Converge

Confidentiality and ethical considerations are always the most important aspect of professional research. They are even more important than usual when conducting a study that involves asking people very sensitive and personal information, such as information about their sexual experiences, experiences of violence and abuse and their HIV status.

You are responsible for making sure that information you collect from the respondent is confidential. Do not share the information with anyone including other enumerators.

This means not telling any stories about 'guess what someone told me today…' even if you do not mention that person's name. Nothing that is said to you in an interview should ever be repeated, except if you have a serious concern about the welfare of the respondent (e.g. someone breaks down in the interview or someone says that they want to hurt themselves or someone else), in which case you can inform your supervisor so that the respondent can be assisted.

4. General research principles

Informed consent procedures

Informed consent must be sought from respondents. The information sheet and informed consent forms, contain all of the information the respondent needs to make an informed decision about whether or not to participate in the interview. More detailed information on how to administer these is provided in section 6.

In summary: At the beginning of each questionnaire after **section E** (Eligibility screening) is a consent script. You must complete the consent process prior to beginning an interview. Remember to read the consent form as it is written. Stress that the information collected is confidential, there are no direct benefits from participating in the survey and that they should give us honest answers.

Ethical conduct demands that respondents are given full disclosure regarding the study and their participation, prior to asking for their consent. This is to enable them to make a knowledgeable decision regarding their participation. You must complete the consent process prior to beginning the interview. This means that only respondents who understand the purpose of the study and are able to give consent can participate in the study.

In **Appendix 6,** we have developed a decision tree to guide you through the informed consent process.

In contexts where literacy is low, clients will be asked to thumbprint on the form instead of giving their signature. If a client is unable to sign or give a thumb print, he/she will not be interviewed. However, as mentioned earlier, verbal consent will be obtained in Pakistan. This will be recorded in a log, with a note that they were unable to sign/give a thumb print.

Confidentiality of respondents' information

You are responsible for making sure that information you collected during interviews is kept confidential. Do not share the results with other enumerators. You should never interview a respondent that you know, even if he/she is only a casual acquaintance. If you have come into contact with a known person, you should notify your supervisor so he/she can assign that interview to another research assistant/field investigator. You should not attempt to see the completed questionnaires for that known person, nor discuss the interview results with your colleagues or the respondent.

4. General research principles

Voluntary participation

It is important that participation in this study is voluntary. No respondent should be coerced into being interviewed. There is no penalty for not participating. If someone does not wish to participate, then this wish must be respected. Never pressure someone to be involved. This means too, that a person can refuse to answer a specific question or section of questions but may be willing to answer others.

No harm to the participants

Social research should never injure or harm the people being studied, even if they volunteer for the study. Such injury need not only be physical, but also sociological and psychological. The revealing of information that would embarrass them or endanger their home life, friendships, jobs and so forth are examples of harm that must be avoided.

The process of interviewing may bring up painful memories for the respondent, even if the information is not disclosed directly to you. Although it is not possible to eliminate these forms of "harm", it is possible to minimise them by being sensitive, respectful, and tactful throughout the interview.

It is important to be respectful and non-judgmental

You should not adopt a superior stance in relation to your respondents. You are trying to learn from them. As we are trying to understand their thoughts, perceptions and experiences, you do NOT know more than them in this context. Do NOT impose your opinions and values upon them.

They are not obliged to help you. So, you have to work at developing a relationship with them. After all, in this context they should be in a position of power. They can choose not to participate fully, or choose not to provide honest answers. Bear this in mind – you have to earn their trust and participation! (See section 4.2 for more information on effective interviewing).

You need to recognise the manner in which power relations are constructed. By virtue of the fact that you are an adult, of a particular gender or emerge from a particular socio-economic background, you may be in a position to exercise more power than your respondents. You should NEVER exploit this and use it to achieve your own ends. You should NEVER force them to participate or dictate the terms of their participation.

You need to reflexively analyse how your own beliefs about sexuality, gender etc. might affect the way that you pose questions, use terms or interact with your respondents.

In general, research is only empowering if it is honest, respectful and enables the respondents to express themselves in the best way that they can.

Bear in mind that you are interrupting their daily routines, livelihoods and social activities, so please thank them for their time and effort.

Their opinions must be listened to and respected. Their thoughts, ideas and concerns should be clearly noted and reported. They should be thanked for their input even when you disagree with their comments.

Importantly, is the need to assure the respondent and ensure that all information provided is treated with the highest level of confidentiality.

4. General research principles

4. General research principles

Power dynamics

An excellent enumerator understands the interplay of power dynamics. It is important to be mindful of how age, gender or the perception of a higher socio-economic background can make you exercise more power than your respondents. At no point should you as an enumerator exploit this power and use it to achieve your own ends. Also, you should never force them to participate or dictate the terms of their participation. You should not adopt a superior stance in relation to your respondents.

Child safeguarding and protection

This study includes children between the ages of 15 and 17 years, where permitted.

The process of interviewing may bring up painful memories for the respondent, even if the information is not disclosed directly to you. Although it is not possible to eliminate these forms of "harm", it is possible to minimise them by being sensitive, respectful, and tactful throughout the interview.

1. All enumerators must agree to abide by the Ethical Strategy and Child Protection policy in **Appendix 1.**
2. Respect the child and do no harm by avoiding questions, attitudes or comments that are judgmental or insensitive to cultural values, that place a child in danger or expose a child to humiliation.
3. Keep your questions to what is documented in the questionnaire.
4. Respect appropriate interpersonal space by avoiding unnecessary physical contact with the child.
5. If during the interview, the enumerator discovers that a minor is in need of immediate protection or has been a victim of sexual violence, the enumerator is obligated to report this to the member association immediately. This does not apply to adults; in this case the enumerator should offer to report it to the MA and only do so if the adult consents.

The distress protocol is **Appendix 2** gives you further detail on how to handle situations where respondents become distressed.

4.2 Effective interviewing

Establishing yourself at the site

When you arrive at the site, you need to introduce yourself to the facility manager or person in charge of the site. They will be expecting you, but it is important to make sure they know who you are and what you will be doing. This will also be a good time to verify clinic data which will be explained further in the next section. While you are at the site, it is important that you familiarise yourself with the rules of the site and make sure that you adhere to them and respect all other staff members.

Tips for effective research

Successful data collection is an art and should not be treated as a mechanical process. Each respondent interaction is a new source of information, so make it interesting and pleasant. The art of surveying develops with practice, but there are certain basic principles that are followed by every successful enumerator. In this section, you will find several general guidelines on how to build rapport with a respondent and conduct successful interviews.

Build rapport

As an enumerator, your first responsibility is to establish a good rapport (a good relationship) with a respondent. At the beginning of an interview, you and the respondent are strangers to each other. The respondent's first impression of you will influence his or her willingness to cooperate. Dress professionally and modestly. Give the respondent your full attention when you greet them and throughout the interviewing process. Be sure that your manner is friendly when you introduce yourself. Never interrupt an interview to take a phone call or similar.

Assure confidentiality of responses

If the respondent is hesitant about responding to you or asks what the data will be used for, explain that the information you collect will remain confidential, no individual names will be used for any purpose, and all information will be grouped together when writing any reports. Some sample responses to questions are provided in section 5.5.

4. General research principles

Answer any questions from the respondent frankly (truthfully)

Before agreeing to be interviewed, the respondent may ask you some questions about the survey or how he/she was selected to be interviewed. Be direct and pleasant when you answer. Some sample responses to questions are provided in section 5.5.

Respondents may ask questions or want to talk further about the topics you bring up during the interview. It is important not to interrupt the flow of the interview, so answer briefly and tell them that you will be happy to go into greater detail and talk further after the interview.

Do not change the wording or sequence of questions

The wording of the scripts and questions, and their sequence in the questionnaire, must be maintained. If the respondent has not understood the question, you should repeat the question slowly and clearly. If there is still a problem, you may reword the question, being careful not to alter the meaning of the original question. Provide only the minimum information required to get an appropriate response. Do not lead the respondent or answer the question for them.

Never, either by the expression on your face or by the tone of your voice, allow the respondent to think that she has given the "right" or "wrong" answer to the question.

Handle hesitant respondents tactfully (sensitively)

Some respondents may be reluctant to provide information for some sections of the questionnaire, for a variety of reasons. Although 'Don't know' or 'Refused to answer' are listed on your tablet as possible responses for all questions, do not read these aloud to the respondent as options. Only select these options if the respondent remains reluctant or reports they do not know, even after trying the strategies describe below.

There will be situations where the respondents simply say, "I don't know," give an irrelevant answer, act very bored or detached, or contradict something they have already said. In these cases, you must try to re-interest them in the conversation.

If the respondent is reluctant or unwilling to answer a question, explain once again that the same question is being asked of many different people and that the answers will all be merged together. If the respondent is still reluctant, simply enter "Refused to answer" on the tablet and proceed as if nothing had happened.

Asking about sensitive topics (sex, abortion)

This will be discussed in more detail during training but:

- Be aware of your own biases and any personal trauma
- Keep to the script when asking difficult questions
- Be aware of your interview technique, body language, non-verbal communication.

Language of the interview

The questionnaire for this study is in English and has been translated into other relevant languages in the different countries (in consultation with the MA/IRC), including French and Portuguese.

In each of the country trainings, we will discuss different terminology in local dialects in case there is need to explain these terms to the client. It is very important not to change the meaning of the question when you rephrase it or interpret it into another language.

Sensitivities when interviewing refugees in IRC sites

Many internally displaced persons have experienced violence, abuse and other forms of personal harm. We should be sensitive to their suffering, treat them with respect and dignity, and avoid creating more harm by requiring them to relive painful experiences through interviewing. We must also be careful to avoid creating false hopes and unrealistic expectations about what protection and assistance can be offered.

Please see **Appendix 3: guidelines for handling negative feedback and difficult conversations** and **Appendix 4: safety and ethical consideration for sensitive complaints.**

4. General research principles

Box 4: Special considerations for interviewing women or other person who have experienced sexual violence

It is important to recognise that many women will be reluctant to disclose details of their experience of sexual violence for well-founded reasons. It is often the case that even survivors who want to denounce the sexual violence and the perpetrator(s), are prevented from doing so for fear of reprisal and recriminations, as well as stigma and shame. In these circumstances where you become aware of clients' experiences of sexual violence, careful attention to ethical and safety issues is imperative. You must take steps to ensure that your actions are neither harmful, nor results in harmful consequences. As an enumerator you must:

- Have the following knowledge, skills and qualities: — interviewing skills (i.e. appropriate questioning skills, including an ability to use non-judgemental language and tone and to generally present a non-judgemental manner and attitude); — communication skills (i.e. listening skills, coupled with appropriate non-verbal (facial expressions, body language) and verbal responses); — empathy; — ability to record accurately what the participant is saying (as opposed to noting what one might expect to hear or wish to hear); — an understanding of the health, social, economic, emotional and psycho logical consequences of sexual violence.
- Ensure that the objectives of the information collection activity are clearly understood so as not to create unrealistic expectations among participants or in the community. It is important that enumerators are as transparent as possible and able to clear up any expectations or misunderstandings that interviewees may have.
- Ensure that there are support services available for both medical care and psychosocial support and make referrals when needed.
- Respect the participants right to confidentiality and autonomy under all circumstance provided they are not minors.

(WHO 2007 Ethical and safety recommendations for researching, documenting, and monitoring sexual violence in emergencies)

4.3 Values clarification exercise

We would like to conduct a values clarification exercise to clarify our personal values about FP. This exercise will help us think through own values in the context of how we conduct CEIs with FP clients, which will be conducted by the MA.

5. Sampling and recruiting a participant

In this section we discuss the two different stages of sampling, eligibility criteria and how to administer the information sheet and consent form. After this session you should be able to:

- Understand the two different stages of sampling;
- Explain how to select a respondent at SDPs per channel type in your country;
- Answer a respondent's questions on why they were selected and how their data will be used; and
- Know how to determine whether a client is eligible or for inclusion in the CEI; and administer the information sheet and consent form correctly.

Sampling takes place in two stages:

1. Deciding on a sampling approach and sample size for each channel type (static clinic, outreach and community based) in each country; this will be decided by the core research team
2. Selecting clients from the SDPs in each channel type.

There are then a few different steps under each. This is discussed in text below and summarised in the sampling decision tree below.

5. Sampling and recruiting a participant

Sampling Decision Tree

A more detailed description of the sampling is provided in the section below.

a: Check your sampling approach and sample size per channel type - it will either be cluster or census. This is based on a number of SDPs per channel and will be given to you by the core research team.

Decision One

Cluster

b: Where the cluster sampling is being used, you will be given a list of 40 randomly-selected SDPs. **The core research team is responsible for generating this list.** To determine the number of interviews you must conduct at each of the 40 SDPs, your field work supervisor will divide the total sample of size given to you in step a above by 40 and provide you with this number.
This will tell you the number of clients you need to interview at each SDP. This number will always be rounded up.

c: Go to the SDP site. Your supervisor will meet with management to verify the number of FP planning clients seen per day.

Census

b: Where census approach is used, you will be visiting **ALL SDPs** in that channel. Your field work supervisor will tell you how many SDPs there are. To determine the number of interviews, you must conduct at each of the SDPs, your field work supervisor will divide the total sample size given to you in step by the number of SDPs.
This will tell you the number of clients you need to interview at each SDP. This number will always be rounded up.

c: Go to each SDP site. Your supervisor will meet with management to verify the client flow. i.e the number of FP clients seen per day. The Supervisor is responsible for recording the client flow as this will be used in the weighting.

Decision Two

High Volume

d: In a site where the total number of FP clients over the 3-day period (FP client flow x 3 days) exceeds the sample size required for that, you or your supervisor will need to calculate the sampling interval (n). This will calculated by first multiplying the average daily client flow with the number of days you will spend at the SDP (i.e 3 days). This number is then divided by the total number of clients you will interview at the SDP to account for non-response, the interval (n) will be shortened by one.

You will interview every n^{th} cleint. Starting with the first client referred to you and allocate them the number zero. Counting the clients sequentially, interview every n^{th} until you reach your desired sample size.

Low Volume

d: In a site where the total number of FP clients over the 3-day period (FP client flow x 3 days) is less than or equal to the sample size required for that site,
you will interview every client until you reach the desired sample size given to you by your supervisor in step b

We also provide a practical case study of how this will work in the field in **Appendix 5: case study.**

5. Sampling and recruiting a participant

5.1 Deciding on a sampling approach and sample size per channel type per country

In each country, one of two sampling approaches will be used for each channel type. The decision about which sampling approach to use is based on the number of SDP sites per channel and is in line with MSI's standard sampling protocol. The two sampling approaches are described below.

Table 8: Sampling approaches

Approach	Census	Cluster
Description	When there are relatively few (<40) SDPs per channel type, a census approach will be used. This means that the fieldwork team will visit **all SDPs in that channel** and will select respondents from each (according to the agreed sampling procedure).	When there are more (>40) SDPs per channel type, a cluster sampling approach will be used. The core research team will randomly select 40 SDPs (per channel) which the fieldwork teams will visit. The fieldwork supervisors in each country will be given a list of SDPs which they will visit.

A total sample size per country has been calculated by the core research team using the standard MSI guidance. The sample size takes into account:

1. The number of SDP sites per channel type and sampling approach (for cluster sampling the sample size of the census approach will be doubled), and
2. The number of organisations implementing in each country. Where both IPPF and IRC are implementing (Ethiopia, Uganda and South Sudan), the sample size is increased accordingly and assumes that we would approach the sample for each organisation separately.

See Table 9 below for the draft sampling approach and sample size per channel per country. This is based on the number of SDPs and FP client flow received to date. These will be verified with the MA in country and it is possible that the numbers may change a little. Where this does happen, the trainer will flag this to the core research team to discuss any changes in sampling approach.

A cluster approach is shown in yellow and a census approach shown in orange.

Table 9: Sampling approach and size per channel type, per county

COUNTRY	IP	STATIC			MOBILE			CBD			SAMPLE SIZE
		#sites	#interviews	Approach	#sites	#interviews	Approach	#sites	#interviews	Approach	
Burundi	**IPPF**	45	214	Cluster	3	214	Census	5	107	Census	**428**
Cameroon	**IPPF**	11	107	Census	1	107	Census	3	107	Census	**321**
Chad	**IPPF**	36	107	Census		107					**107**
Cote d'Ivoire	**IPPF**	15	107	Census	7	107	Census	7	107	Census	**321**
DRC	**IPPF**	25	107	Census	16	107	Census	26	107	Census	**321**
Ethiopia	**IPPF**	535	214	Cluster		214					**214**
	IRC	28	107	Census		107					**107**
Malawi	**IPPF**	2	107	Census	2	107	Census	2	107	Census	**321**
Mauritania	**IPPF**	54	214	Cluster		214					**214**
Mozambique	**IPPF**	92	214	Cluster		214					**214**
Nigeria	**IPPF**	12	107	Census	5	107	Census			Census	**321**
Pakistan	**IPPF**	50	214	Cluster	10	214	Census	10	107	Census	**428**
Somalia	**IRC**	6	107	Census		107					**107**
South Sudan	**IPPF**	11	107	Census	6	107	Census			Census	**214**
	IRC	1	107	Census		107					**107**
Sudan	**IPPF**	273	214	Cluster	8	214	Census	8	107	Census	**428**
Tanzania	**IPPF**	194	214	Cluster	67	214	Cluster	105	214	Cluster	**642**
Uganda	**IPPF**	265	214	Cluster	6	214	Census	6	107	Census	**428**
	IRC	18	107	Census		107					**107**
Zambia	**IPPF**	188	214	Cluster	2	214	Census	1	107	Census	**428**

5. Sampling and recruiting a participant

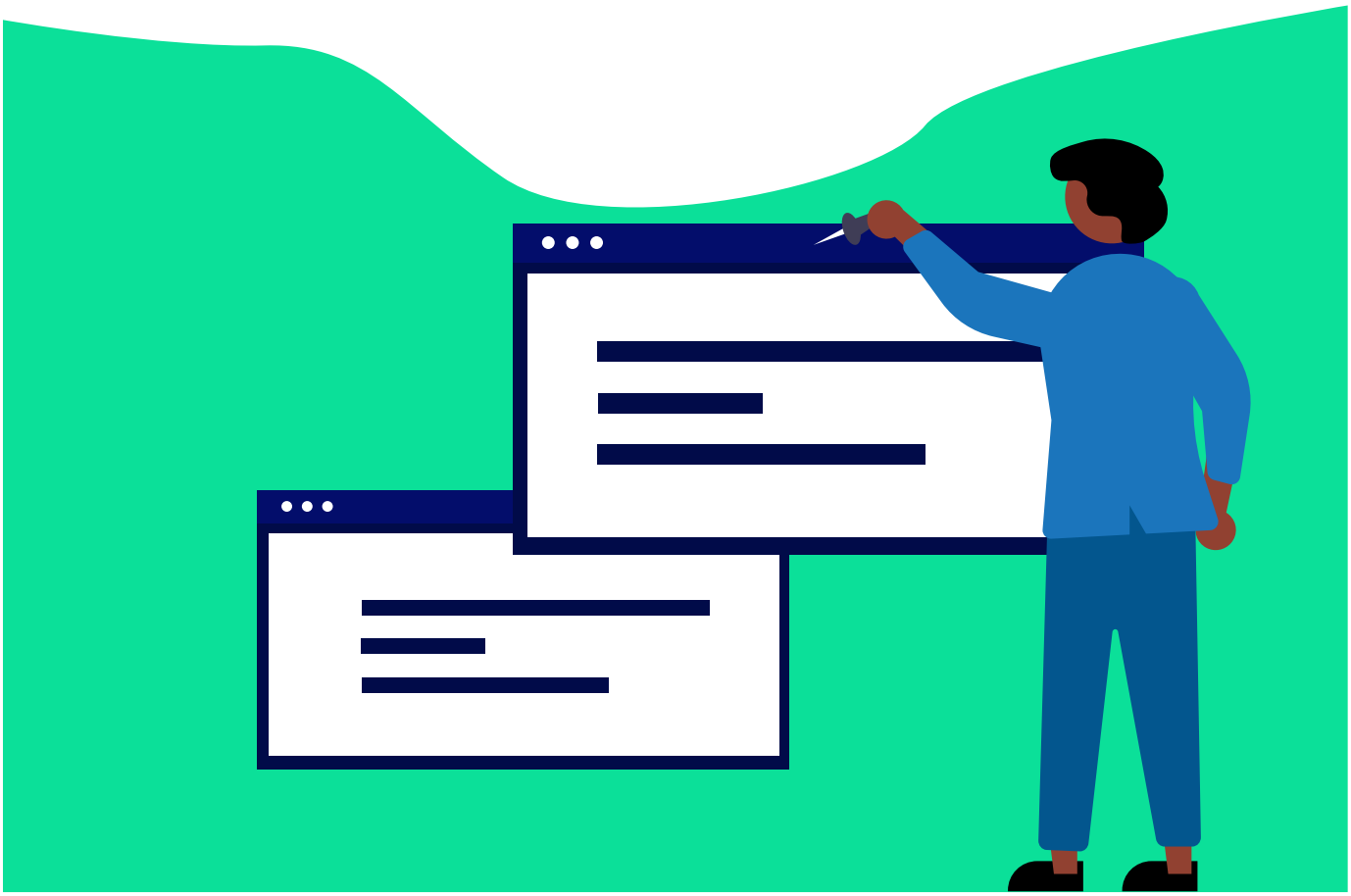
REMEMBER THAT ENUMERATORS ARE NOT RESPONSIBLE FOR DETERMINING WHICH APPROACH WILL BE USED PER CHANNEL TYPE PER COUNTRY. THE CORE RESEARCH TEAM WILL DO THIS AND IT WILL BE PROVIDED TO THE FIELDWORK SUPERVISOR.

Your fieldwork supervisor will have a list of SDPs and the number of respondents that will be recruited from each one. You should plan to collect data over a 3-day period.
We know that fieldwork does not always go according to plan. How to deal with issues relating to sampling is described in the box below (and in the section on fieldwork procedures).

Box 5: Dealing with uncertainties in the field

It may not be possible to visit all (census) or selected (cluster) sites due to unforeseen events like conflict or flooding. In this case, the core team will need to be informed and a decision made about either increasing the sample size at other SDPs (census) or replacing SDPs with those selected as "reserves". Let your supervisor know soonest so that the core research team can advise.

If the client flow is too low or refusal rate is high and you are not able to reach your desired sample size at a particular facility, you will need to discuss this with your supervisor. They will then decide if it is feasible for you to extend your data collection period so that you can reach the desired sample size for that SDP. If it is not feasible to extend the data collection period, the project field manager will then need to increase the sample size at a different site (for the same channel type, e.g. static/mobile/outreach) so that the desired sample size for the channel is still achieved.



5. Sampling and recruiting a participant

5.2 Selecting respondents from SDPs

Selecting clients at the SDPs is the responsibility of the enumerators with guidance from the supervisors. Sampling of clients depends on whether you are undertaking field work at a static/mobile SDP or a CBD site.

5.2.1 Static and mobile SDPs

Within static facilities and mobile SDPs, the approach you will use depends on whether the SDP you are at has a high FP client flow or a low FP client flow. The FP client flow is the average number of FP clients seen in a day.

ENUMERATORS ARE NOT RESPONSIBLE FOR DETERMING WHETHER A SITE IS HIGH OR LOW VOLUME. THE CORE RESEARCH TEAM WILL DETERMINE THIS AND YOU WILL BE PROVIDED WITH A LIST OF SDPs DESCRIBING THEIR VOLUME AND THEREFORE THE APPROACH. YOUR JOB IS TO:

- VERIFY THE CLIENT FLOW IN LINE WITH PROCEDURES DESCRIBED BELOW AND
- IMPLEMENT THE SAMPLING APPROACH CORRECTLY

The table below shows an example, from Nigeria, of the list you will receive. It shows a selection of the names and addresses of the SDPs, the channel type, the FP flow as received from the MA, whether this site is low or high volume and what the sampling interval is (this will be described in more detail later).

Table 10: Example of selected information to be provided to enumerators

Clinic Name	Address	SDP Type	FP client flow	Sample size required	High/Low volume	Sampling interval
PPFN Clinic Makurdi, Benue	No. 1 Ogiriu Oko Road, Opposite Police Headquarters, Makurdi, Benue State	Static	3	9	Low	N/A - All clients
Sambo Hospital Limited, Jigawa	No. 19, Off Maimalari way, Takur Adua, Dutse, Jigawa State	Static	2	9	Low	N/A - All clients
Albarka Clinic, Jigawa	No. 196, Olayinka Sule Road, along Government house, Duste, Jigawa State	Static	3	9	Low	N/A - All clients
Albarka Clinic, Jigawa	No. 15, Atiku Abubakar Street, Gwabba Close, Gwallaga, Bauchi.	Static	9	9	High	2

Verifying the client flow

The MA head office will have been in contact with each SDP which has been sampled and made them aware that the fieldwork team will be visiting and when. A recruitment notice, as shown below, will be placed in the waiting area to inform clients that a survey will be conducted to assess their experience in the facility, and that some or all clients will be asked to be interviewed.

Notice of client satisfaction interview

As valued clients, [MA/IRC name] is continuously striving to improve our services so that you have positive experiences with quality care.

This week we are conducting interviews and will be asking some or all clients for YOUR feedback on the services provided here.

The enumerators may ask you for 25-35 minutes of your time as you leave the clinic to help take part in the interview. Your help with this is important because your thoughts and impressions are highly valued and will help us to see how we can continue to improve the quality of our care to make YOUR experiences here better.

If you take part, we guarantee that we will not write or keep record of your name anywhere, and your answers will not be linked with your medical records: the interview is completely confidential and anonymous.

Your help will be appreciated, but whether you take part in the survey or not is completely up to you and will not in any way affect your care and treatment at this facility.

Thank you for your time

5. Sampling and recruiting a participant

The MA office will also have asked the SDP to prepare the summary of the number of FP clients they had in the last month. This number will be taken from the client register, see Figure 1 below for an example of what this register looks like in Nigeria.

Figure 1: Family planning daily client register

This will allow you to determine the average daily number of FP clients. Take note of this number on the client flow sheet shown below. This is critical because it is used for weighting in the data analysis stage. Please note: Make sure that this number is the number of **FAMILY PLANNING CLIENTS** who visit the SDP **PER DAY** and not the number of all clients who visit the SDP or the number of clients per month.

Box 6: How to calculate FP clients per day

If they give you a summary of the number of FP clients per month, you can calculate the average number of FP clients per day by dividing the total number of FP clients seen in one month by 21 (the average number of days in a month), as shown in the formula below.

$$\text{FP Clients per day} = \frac{\text{Total number of FP clients seen in one month}}{21}$$

For example: If an SDP site sees 210 patients in one month, divide 210 by 21 to get the average number of FP clients. This will be 10 FP clients per day.

If the average number of FP clients per day at the SDP is very different from the number that was given to you by your supervisor and you are concerned that you will not reach the required sample size, inform your supervisor immediately and then continue with the interviews as planned. Your supervisor will then decide if you need to change your sampling approach and calculate a new sampling interval for you or if you can continue as planned.

5. Sampling and recruiting a participant

CLIENT FLOW SHEET			
Name of country:			
Name of SDP:			
Channel type [Tick one]	Static	Mobile	CBD
Average MONTHLY family planning flow	Write number		
Average DAILY family planning flow	Write number		
Observations			
Day 1			
Day 2			
Day 3			
Day 4			
Enumerator name			
Signature			
Date			

Each SDP is either a low volume site or a high-volume site. The procedure for selecting respondents at each type of site is discussed in more detail.

SDPs where FP client flow is high:

High volume sites are defined as sites where the total number of FP clients over the 3-day period (FP client flow x 3 days) exceeds the sample size required for that site.

At these sites, you will not interview every client, but a sample of them. The procedure for doing so is described in the steps below.

Step 1: Receptionists or health educators will inform clients upon registration that they may be asked to help with the anonymous survey, but that it is not compulsory and will not affect their treatment or service today.
Step 2: You will confirm what the sampling interval for the SDP you are at is. It will be documented on a sheet like the one shown in Table 10 above.

Box 7: How the sampling interval is calculated (For information only) here

Enumerators are NOT responsible for calculating the interval but in case you are interested, here is how it is done:

- The average daily FP client flow is multiplied by the number of days planned to be spent at the SDP (3 days)
- This total is then divided by total number of clients which need to be interviewed at that site. The product is rounded up.
- To account for non-response, this number is shortened by one
- This is the final sampling interval (n)

For instance, at PPFN Clinic Gwallaga Bauchi in Nigeria:
- The average daily FP client flow is 9
- 9 x 3 days = 27
- This number divided by the number of clients who need to be interviewed at PPFN Clinic Gwallaga Bauchi (27÷9=3)
- To account for non-response, 3-1=2
- The sampling interval is 2.

In other words, the enumerator will interview every second FP client.

5. Sampling and recruiting a participant

Step 3: The receptionist will point out a client to you. Using this as your first client, count this client as number 0 and keep counting clients until you reach the number (n) your supervisor provided you with.

Step 4: Approach the selected client (the nth client) in a friendly manner and explain who you are, what your connection is to the clinic and why you have approached the client. If they are interested, you will then administer the eligibility form to determine if they are eligible for interview.

Step 5a: If the client is eligible read them the information sheet and get informed consent. After the interview is completed, count the number your supervisor provided you with (i.e. n) and interview that client.

Step 5b: If the client is ineligible make that client zero. You then need to count to n and approach that client to determine eligibility. Please note you CANNOT just interview the next client but need to follow the sampling process.

Box 8: Sampling interval of one for high volume sites

There will be some instances where the sampling interval is one even though the site is classified as high volume. This means that you should interview all clients similarly to a low volume site.

For your interest, this happens when the total expected number of clients in a 3-day period is greater than the required sample size but the sampling ratio is 2. One is then subtracted to account for non-response leaving you with a sampling interval of one.

SDPs where FP client flow is low:

Low volume sites are defined as sites where the total number of FP clients over the 3-day period (FP client flow x 3 days) is less than or equal to the sample size required for that site.
In this case, you will interview every client attending the SDP site on the day(s) of the survey until you reach the required sample size your supervisor has provided you with.

5.2.2 CBD SDPs

At CBD SDPs, the approach you will use depends on whether the SDP you are at has a high FP client flow or a low FP client flow.

SIMILAR TO STATIC AND MOBILE SDPs, ENUMERATORS ARE NOT RESPONSIBLE FOR DETERMING WHETHER A CBD SDP IS HIGH OR LOW VOLUME. THE CORE TEAM WILL DETERMINE THIS AND YOU WILL BE PROVIDED WITH A LIST OF SDPs DESCRIBING THEIR VOLUME AND THEREFORE THE APPROACH. YOUR JOB IS TO:

- **VERIFY THE CLIENT FLOW IN LINE WITH PROCEDURES DESCRIBED AND**
- **IMPLEMENT THE SAMPLING APPROACH CORRECTLY**

Verifying the client flow

The MA head office will have been in contact with each community health workers (CHWs) at each SDP which has been sampled and made them aware that the fieldwork team will be visiting and when.

They will also have asked the SDP to prepare the summary of the number of FP clients they had in the last month. This will allow you to determine the average daily number of FP clients. Take note of this number on the client flow sheet shown above. This is critical because it is used for weighting in the data analysis stage. See the box above on verifying client flow for more information on how to do this.

Each SDP is either a low volume site or a high-volume site. The procedure for selecting respondents at each type of site is discussed in more detail.

SDPs where FP client flow is high:

High volume sites are defined as sites where the total number of FP clients over the 3-day period (FP client flow x 3 days) exceeds the sample size required for that site.

5. Sampling and recruiting a participant

At these sites, you will not interview every client, but a sample of them. The procedure for doing so is described in the steps below.

Step 1: The CHW will have a list of clients they will be visiting each day.

Step 2: You will confirm what the sampling interval for the SDP you are at is. It will be documented on a sheet like the one shown in Table 10 above.

Step 3: Follow the CHW with whom you have been paired. Use the first client they go to as your first client, count this client as number 0 and keep counting clients until you reach the number (n) your supervisor provided you with.

Step 4: Approach the selected client (the nth client) in a friendly manner and explain who you are, what your connection is to the CHW is and why you have approached the client. If they are interested, you will then administer the eligibility form to determine if they are eligible for interview.

Step 5a: If the client is eligible read them the information sheet and get informed consent. After the interview is completed, count the number your supervisor provided you with (i.e. n) and interview that client.

Step 5b: If the client is ineligible make that client zero. You then need to count to n and approach that client to determine eligibility. Please note you CANNOT just interview the next client but need to follow the sampling process.

SDPs where FP client flow is low:

Low volume sites are defined as sites where the total number of FP clients over the 3-day period (FP client flow x 3 days) is less than or equal to the sample size required for that site.

In this case, you will interview every client attending the SDP site on the day(s) of the survey until you reach the required sample size your supervisor has provided you with.

5.3 Determining eligibility

Enumerators are then responsible for determining eligibility and administering the information sheet and consent form as shown in the decision tree in **Appendix 6** and discussed below.

Participants are eligible for selection per the criteria described in **section 3**. Once a client has been selected and are willing to be screened you will administer **section E** of the questionnaire as shown below.

5. Sampling and recruiting a participant

ELIGIBILITY SCREENING

READ TO RESPONDENT: I would like to ask you some questions about the services you received today and your past service use. These questions are used to understand whether you are able to participate in this survey and to understand how clients use these health services, so we can better meet the needs of our clients."

E0	SAMPLED RESPONDENT CONSENTS TO ANSWER SCREENING QUESTION	0= No > Thank participant and end interview 1= Yes > go to E1	
E1	ENTER RESPONDENT'S SEX	0 = Male 1 = Female	
E2	**How old are you?** **WRITE '333' IF THE RESPONDENT DOESN'T KNOW**	**----------years** • Client older than 15/18 [depending on country] > go to E3 • Client younger than 15/18 [depending on country] > go to E6 • Don't know > go to EA	
EA	**In which of the following age groups do you think you belong?**	0= < 15 > go to E6 1= 15-17 [Malawi, Mozambique, Pakistan, Somalia, Zambia] > go to E6 2= 18-20 3= 21-25 4= 26-30 5= 31-35 6= 36-40 7= 41-45 8= 46-50 9= 51-55 10= 56-60 11= 61-65 12= 66-70 13= 71-75 14= 76-80 15= 81-85 16= 86-90 17= 91-95 18= 96-100 19= >100 Don't know > go to E6	
E3	[Is the client able to understand and complete the consent form independently?]	0= No > go to E6 1= Yes > go to E4	
E4	**"Did you receive services related to any of the following today: cervical cap, male or female condoms, emergency contraception, implants, injectables, intra-uterine device, oral contraceptives, patch, ring, spermicides, sterilisation, IUD or implant removal?**	0= No > go to E5 1= Yes > go to E6	

5. Sampling and recruiting a participant

ELIGIBILITY SCREENING			
	[By services we mean receiving family planning counselling and/or a family planning method]		
E5	**What services did you receive?**	1= Counselling on sex and Sexuality 2= Counselling on relationships 3= Abortion care 4= STIs/RTIs prevention, testing or treatment 5 = HIV prevention, testing or treatment 6= Gynaecology including screening for breast and cervical cancer 7= Prenatal, postnatal or birth care 8= Counselling on violence 9= Urology 10= Fertility 11= Paediatrics 12=Other sexual and reproductive health services 13= Other general health services	
E6	1 = Eligible - ONLY if client is older than 15/18 [depending on the country] and E3-E4 are "Yes", > go to RI 2 = Ineligible - If client is younger than 15/18 [depending on the country] or E3 or E4 is a "No", please **thank the respondent and end the interview.**		

5.4 Dealing with non-respondents

There are several times where a respondent may be determined to be a "non-response".

Firstly, when the nth client has been referred to you, they may not even agree to have the eligibility questions asked. If this happens, you will choose the option to say that they were unwilling at this stage.

Secondly, a participant may be eligible but do not consent to the survey. In this case, we would like to know if those who choose not to participate are different from those who do.

After determining whether a respondent is eligible, you will administer the information sheet and consent form. Once this has been completed you move on to questions regarding service use.

If a respondent chooses not to participate, you need to politely ask them to answer a few very brief questions on the Contact Sheet as shown below so that we can understand why they do not want to participate.

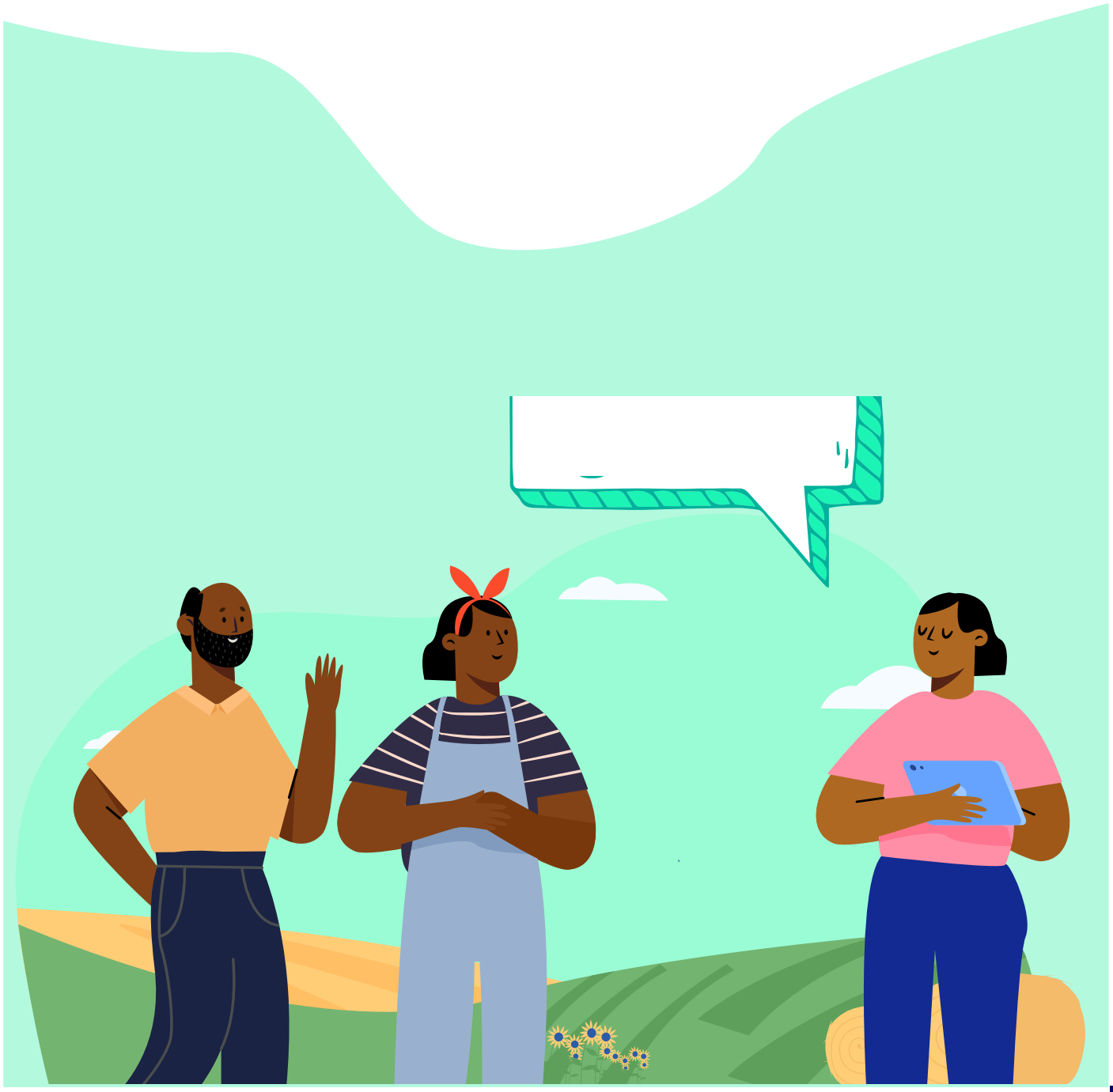
5. Sampling and recruiting a participant

This form will come up **at two** different times:

1. **Towards the beginning of the interview.** The Contact Sheet will be the third form that you will see when conducting the interview (1. Interview and Site Information, 2 Eligibility Screening and **3. Contact Sheet)**

2. **If the interview is terminated prematurely.** If the client indicates that they do not wish to continue with the interview at any other point, you can exit the interview by pressing the options button and saying "end interview". You will then be directed back to the contact sheet where you can ask the respondent why they chose to end the interview prematurely in addition to a few brief questions about their demographics.

Once the clients have answered the questions on their education, marital status, and occupation, and why they did not want to participate, you need to thank the client for their patience and participation up until this point and then end the interview. DO Not proceed with the rest of the questionnaire.



5. Sampling and recruiting a participant

CONTACT SHEET

READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED.

R1	**Are you willing to participate in this survey?**	1. If YES, administer information sheet and consent form and go to R2 2. If NO, go to R3	
R2	**Did the client sign the consent form?**	0=No Go to R3 1=Yes Go to S1	
R2	**What is your main reason for not wanting to participate in this survey?** **[ONE RESPONSE ONLY}**	1= Client feeling weak or tired from the service received 2= Client wants interview rescheduled 3= Not interested 4= No time to participate/Busy 5= Language barrier 6= Other, [Specify] 7= The respondent does not want to continue with the interview 999= Declines to answer	
READ TO RESPONDENT: **"I know that you would not like to participate but if you agree I would like to ask three short questions about yourself"** READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED.			
R4	**What is your highest level of education?** PROBE IF THE RESPONDENT COMPLETED THIS LEVEL OF EDUCATION, OR ATTENDED SOME OF IT, AND CHOOSE THE CORRESPONDING NUMBER.	0= None / non-formal 1= Some primary 2= Completed primary 3= Some secondary, vocational or technical 4= Completed secondary, vocational or technical 5= Some tertiary or higher 999= Declines to answer	
R4	**What is your marital status?**	0= Single 1= Married 2= Living with partner 3= Widowed / Divorced / Separated 999= Declines to answer	
R4	**What is your occupation, that is, what kind of work do you mainly do?**	0= Unemployed, not looking for work 1= Unemployed, looking for work 2= Agriculture 3= Unskilled manual 4= Skilled manual 5= Sales & services 6= Clerical 7= Professional technical / managerial 8= Student 999= Declines to answer	
THANK THE RESPONDENT FOR THEIR PARTICIPATION AND PATIENCE AND END INTERVIEW AND SAVE QUESTIONNAIRE.			

5. Sampling and recruiting a participant

5.5 How to answer respondents' questions about why they were selected

Q: Why did you choose me?

A: You are being invited to take part in this interview as you have received family planning services today. We would like to speak to you about the type of service you received and your views regarding the services and the staff members. We would also like to ask you some questions about your age, marital status, education level, and what types of items you own in your home.

Q: Do I have to participate?

A: Your participation is voluntary, but we'd greatly appreciate your help. You may refuse to participate or discontinue during the interview at any time. You have a right to not answer any question in the interview for whatever reason. You have a right to stop the interview at any time and to stop your participation in the study. Refusal to take part or withdraw from the study will not involve penalty or loss of any benefits to which you are otherwise entitled.

Q: What will you do with the results?

A: After we conduct the survey, researchers will analyse the information collected from the interviews. Your answers will be grouped together with answers from other people in this country so that no individual will be identified. The summary information will be given in a report to the client.
The results of the study will also be discussed and presented in small meetings in your community, at conferences and published. This study will also be presented to different government health organisations, so they may better provide programmes related to reproductive health.

Q: Will we get anything from you?

A: There will be no direct benefit to you, but your participation is likely to help us improve our understanding about the sexual and reproductive health needs of clients in this community. The findings are expected to contribute towards better planning for reproductive health services for community members here and in other parts of the [INSERT COUNTRY NAME] and beyond. Your participation will generate data that will be used to provide recommendations to Ministry of Health and other health organisations, as well as to family planning service providers that may improve services relating to sexual and reproductive health. Though there are no direct benefits to you for participating in the study, you may find an indirect benefit in knowing you participated in an important study that could help you and others in the future.

6. Administering information sheet and consent form

In this section we explain how the information sheet will be administered and how we get informed consent. At the end of this session, you should be able to:

- Know how to administer the information sheet and consent form correctly.

For this study, the **CLIENT INFORMATION SHEET contains all the information that** the respondent needs to make an informed decision about whether to participate in the study or not.

[NAME OF COUNTRY]

CLIENT CONSENT FORM

I agree to participate in this research project. The research has been explained to me and I understand what my participation will involve.

Please tick yes to statements you agree with and no to statements you disagree with.

I have carefully read (or been read) and have been offered a copy of the information sheet concerning this study, and I understand what is required of me if I take part.	YES	NO
My questions concerning this study have been answered by the study team.	YES	NO
I understand that the enumerator will request to take a measurement of my upper arm to gauge my health status, and that I am free to consent or to decline this	YES	NO
I understand that I may withdraw from this study or decline to answer a question without giving any reason and without affecting my access to health care.	YES	NO
I understand that a small portion of the interview will be recorded for quality control purposes but that I will not be identified with anything I say.	YES	NO
I agree that there will be no benefits or consequences associated with taking part in this study	YES	NO
I agree to take part in this study.	YES	NO
I consent to you sharing my non-identifiable data with other researchers doing similar studies	YES	NO

Signature/thumb print of client: _____

Date: _____

I, the enumerator, have explained the procedures to be followed in this study, and the risks and benefits involved to the participant in a language the participant understands.
Name of researcher/enumerator: _____

Signature of researcher/enumerator: _____

Date: _____

For clients who have provided full informed consent, direct them to a room or sheltered, private area that you have identified to be used, where clients can feel at ease to answer questions without anyone overhearing.

7. Introduction to key family planning methods

In this section we introduce key FP methods. After this session you should be able to:
Describe and identify key FP methods.

Definitions of each of the family planning methods mentioned in the questionnaire are provided in the figures in **Appendix 7.**

8. The CEI questionnaire

In this section we provide an overview of each section of the CEI questionnaire in detail. After this section, you should be able to:
Describe the ten different sections of the questionnaire; and
Explain the purpose of each section of the questionnaire.

If the client is eligible and happy to proceed with the interview you will administer the questionnaire which contains the sections shown below:

Notes for training found in red.

- **We have included the other names for FP methods used globally. MA will provide local terms used and enumerators should write them down here too.**
- **Unless the instructions say "Read out", you should NOT read out answer options.**

8.1 Interview and site information

This is the first section of the questionnaire and is directed at identifying facility name, type, location, region and date.

INTERVIEW AND SITE INFORMATION			
FILL IN THIS SECTION FOR EVERY CLIENT REFERRED TO YOU BEFORE YOU START THE INTERVIEW. YOU CAN FILL IN THESE ANSWERS WITHOUT ASKING THE CLIENT			
I0	Enumerator ID	**Select your name from the list of enumerator names provided.**	
I1	Unique questionnaire number	**Automatically generated by system. This is specific to this questionnaire.**	
I2	Country	1=Burundi 2=Cameroon 3=Cote D'Ivoire 4=Chad 5=DRC 6=Ethiopia 7=Malawi 8=Mauritania 9=Mozambique 10=Nigeria 11=Pakistan 12=Somalia 13=South Sudan 14=Sudan 15=Tanzania 16=Uganda 17=Zambia	**Choose the country in which you are conducting the CEI. Critical to get this right.**
I6	Region	**There will be a list of regions that are pre-coded based on the country that is selected in I2. You will need to select the region that you are conducting the CEI in.**	
I5	Type of location	1= Urban 2= Rural 3= Peri-Urban	**You will need to select the type of location you are conducting the CEIs in based on the list provided.**

8. The CEI questionnaire

INTERVIEW AND SITE INFORMATION			
FILL IN THIS SECTION FOR EVERY CLIENT REFERRED TO YOU BEFORE YOU START THE INTERVIEW. YOU CAN FILL IN THESE ANSWERS WITHOUT ASKING THE CLIENT			
I3	Name of facility	**There will be a list of WISH facilities in your country pre-coded on your device. Choose the name of the facility where you are conducting the CEI or with which the CBD is associated. Your supervisor should ensure that this is correct.**	
I4	Type of facility	1= Static Centre: MA owned/managed 2= Static Centre: Government owned 3= Static Centre: Private 4= Community-Based Distribution 5= Outreach/Mobile Clinics: MA Owned 6= Outreach/Mobile Clinics: Government	**You will need to select the type of facility where you are conducting the CEIs in based on the list provided.**
I8	Partner	1=IPPF MA 2=IRC	**This will be automatically pre-coded based on your answer in I3**
I8	Today's date	_ _/_ _/_ _ _ _ (dd / mm / yyyy)	**Enter this in order of day/month/year e.g. 01/11/2019**

8.2 Eligibility screening

This section aims to address the first and second inclusion criteria i.e. age and confirmation of respondent contact with modern FP services at the SDP on the day of interview.

ELIGIBILITY SCREENING			
READ TO RESPONDENT: I would like to ask you some questions about the services you received today and your past service use. These questions are used to understand whether you are able to participate in this survey and to understand how clients use these health services, so we can better meet the needs of our clients."			
E0	SAMPLED RESPONDENT CONSENTS TO ANSWER SCREENING QUESTION [DO NOT READ OUT]	0= No > Thank participant and end interview 1= Yes > go to E1	**DO NOT ask the respondent**
E1	ENTER RESPONDENT'S SEX	0= Male 1= Female	**Based on observation. Do NOT ask.**
E2	How old are you? WRITE '333' IF THE RESPONDENT DOESN'T KNOW	_____years • Client older than 15/18 [depending on country] > go to E3 • Client younger than 15/18 [depending on country] > go to E6 Don't know > go to EA	**Ask the respondent this question exactly as it is written.** **Age of eligibility depends on the country in which the CEI is being conducted. See section 5.3 of the training manual**

8. The CEI questionnaire

ELIGIBILITY SCREENING

EA	**In which of the following age groups do you think you belong?**	0= < 15 > go to E6 1= 15-17 [Malawi, Mozambique, Pakistan, Somalia, Zambia] > go to E6 2= 18-20 3= 21-25 4= 26-30 5= 31-35 6= 36-40 7= 41-45 8= 46-50 9= 51-55 10= 56-60 11= 61-65 12= 66-70 13= 71-75 14= 76-80 15= 81-85 16= 86-90 17= 91-95 18= 96-100 19= >100 Don't know > go to E6	**If a client is younger than 15 or does not know which of the ages groups they belong to, skip to E6.** **In Malawi, Mozambique, Pakistan, Somalia and Zambia, if the client is between ages 15-17, skip to E6.**
E3	[Is the client able to understand and complete the consent form independently?] [DO NOT READ OUT]	0= No > go to E6 1= Yes > go to E4	**DO NOT ask the respondent this question. This is a judgement you as an enumerator must make. The sorts of things you should look out for are: intoxication and mental disability.**
E3	**"Did you receive services related to any of the following today: cervical cap, male or female condoms, emergency contraception, implants, injectables, intra-uterine device, oral contraceptives, patch, ring, spermicides, sterilisation, IUD or implant removal?** **[By services we mean receiving family planning counselling and/or a modern family planning method]**	0= No > go to E5 1= Yes > go to E6	**Ask the respondent this question exactly as it is written** **You will need to ensure the client understands what is meant by "service". Note that it INCLUDES FP COUNSELLING, IN ADDITION TO RECEIVING FP METHODS. See section 3 (Box 2) of the training manual for definition.** **See Appendix 7 of the training manual for descriptions of FP services.** **If the client has received an FP service, skip to E6 and continue. If they did not, answer E5 and the questionnaire ends.**

8. The CEI questionnaire

ELIGIBILITY SCREENING

E5	**What services did you receive?** MORE THAN ONE RESPONSE POSSIBLE] [Is the client able to understand and complete the consent form independently?] [DO NOT READ OUT]	1= Counselling on sex and Sexuality 2= Counselling on relationships 3= Abortion care 4= STIs/RTIs prevention, testing or treatment 5 = HIV prevention, testing or treatment 6= Gynaecology including screening for breast or cervical cancer 7= Prenatal, postnatal or birth care 8= Counselling on violence 9= Urology 10= Fertility 11= Paediatrics 12=Other sexual and reproductive health services 13= Other general health service	**Abortion may also be called termination or termination of pregnancy.** **STI is a sexually transmitted infection.** **RTI is a reproductive tract infection.** **Gynaecology is a field of medicine dealing with women's health, particularly related to the reproductive tract.** **Cervical cancer is cancer of the cervix (the lower end of the uterus or womb).** **Prenatal means before birth. Postnatal means after birth.** **Urology is the field of medicine dealing with the urinary tract system.** **Paediatrics refers to services related to children** **Respondents will not say "other SRH services". You will be responsible for coding this based on their answers, which may include anything else that relates to sex or reproduction.**
E6	1 = Eligible - ONLY if client is older than 15/18 [depending on the country] and E3-E4 are "Yes", > go to RI 2 = Ineligible - If client is younger than 15/18 [depending on the country] or E3 or E4 is a "No", please thank the respondent and end the interview.		

8. The CEI questionnaire

8.3 Contact sheet

The section is used to capture respondents who are eligible but choose not to participate in the survey. For these participants we would like to know the reason as well as their education, marital status and occupation (age and sex will be captured under the eligibility screening).

CONTACT SHEET			
READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED			
R1	**Are you willing to participate in this survey?**	1. If YES, administer the information sheet and consent form and go to R2 2. If NO, go to R3	
R2	**Did the client sign the consent form?** **[DO NOT READ ALOUD]**	0 = No Go to R3 1 =Yes Go to S1	**Ensure that both you and the client have signed the consent form before moving on it S1**
R3	**What is your main reason for not wanting to participate in this survey?** [ONE RESPONSE ONLY]	1 = Client feeling weak or tired from the service received 2 = Client wants interview rescheduled 3 = Not interested 4 = No time to participate/Busy 5 = Language barrier 6 = Other, [Specify] 7 = The respondent does not want to continue with the interview 999= Declines to answer	**Where it says "specify" you should type in the respondent's answer**
READ TO RESPONDENT: **"I know that you would not like to participate but if you agree I would like to ask three short questions about yourself"** READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED.			
	What is your highest level of education? PROBE IF THE RESPONDENT COMPLETED THIS LEVEL OF EDUCATION, OR ATTENDED SOME OF IT, AND CHOOSE THE CORRESPONDING NUMBER.	0= None / none-formal 1= Some primary 2= Completed primary 3= Some secondary, vocational or technical 4= Completed secondary, vocational or technical 5= Some tertiary or higher 999= Declines to answer	**Where it says "specify" you should type in the respondent's answer**
R5	**What is your marital status?**	0 = Single 1 = Married 2 = Living with partner 3 = Widowed / Divorced / Separated 999 = Declines to answer	

8. The CEI questionnaire

CONTACT SHEET

READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED

R6	**What is your occupation, that is, what kind of work do you mainly do?**	0 = Unemployed, not looking for work 1 = Unemployed, looking for work 2 = Agriculture 3 = Unskilled manual 4 = Skilled manual 5 = Sales & services 6 = Clerical 7 = Professional technical / managerial 8 = Student 999 = Declines to answer	**Unemployed, not looking for work refers to those that do not currently have a job and are not actively looking.** **Unemployed, looking for work refers to those without a job but are actively trying to find a job.** **Agricultural category also include fishermen, foresters and hunters.** **Unskilled manual refers to workers who lack technical training and expertise.** **Skilled manual refers to a job where a specific skill, talent or experience is needed e.g. an electrician.** **Sales & services: This includes occupations in retail services like sales assistants, as well as customer and personal service occupations such as domestic helpers, porters, garbage collectors and others** **Clerical relates to occupations which involve storing, record-ing, organising and retrieving information. E.g. receptionist, cashier** **Professional technical /manage-rial: This includes individuals working in occupations which require a large amount of training or individuals who are in positions where they are in charge of controlling the activities of an organisation or group of people. Examples include engineers, lawyers, teachers, pilots, doctors and nurses, accountants, IT special-ists, public service officials and others** **Student refers to a person who is in school or studying at a university or other place of higher education**

THANK THE RESPONDENT FOR THEIR PARTICIPATION AND PATIENCE AND END INTERVIEW AND SAVE QUESTIONNAIRE

8. The CEI questionnaire

8.4 Service use

This section includes questions aimed at understanding how clients use these FP services provided at these facilities.

SERVICE USE

READ TO RESPONDENT: "I will ask you some questions about the services you received today and your past service use. These questions are used to understand how clients use these health services, so we can better meet the needs of our clients."

READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED

S1	**Which of the following services did you receive today?** **PLEASE READ EACH OPTION ALOUD. CHOOSE "1" (YES) OR "0" (NO) FOR EVERY OPTION**			
A	Counselling on family planning	0= No 1= Yes 999=Declines to answer	CODE: contraceptives	
B	Counselling on sex and sexuality	0= No 1= Yes 999=Declines to answer	CODE: Specialised SRH services	
C	Counselling on relationship	0= No 1= Yes 999=Declines to answer	CODE: Specialised SRH services	
D	Abortion care	0= No 1= Yes 999=Declines to answer	CODE: Abortion	
E	STIs/RTIs prevention, testing or treatment	0= No 1= Yes 999=Declines to answer	CODE: STI/RTI	
F	HIV/AIDS prevention, testing or treatment	0= No 1= Yes 999=Declines to answer	CODE: HIV/AIDS	
G	Gynaecology, including screening for breast and cervical cancer	0= No 1= Yes 999=Declines to answer	CODE: GYNAECOLOGY	
H	Prenatal, postnatal or birth care	0= No 1= Yes 999=Declines to answer	CODE: OBSTETRIC	
I	Counselling on violence	0= No 1= Yes 999=Declines to answer	CODE: Specialised SRH services (GBV)	
J	Urology	0= No 1= Yes 999=Declines to answer	CODE: Urology	**Refers to a field of medicine concerned with the urinary**
K	Fertility	0= No 1= Yes 999=Declines to answer	CODE: Subfertility	**Refers to the ability to conceive children**

8. The CEI questionnaire

SERVICE USE				
L	Paediatrics	0= No 1= Yes 999=Declines to answer	CODE: SRH Paediatrics	**Refers to services related children system**
M	Other sexual and reproductive health services	0= No 1= Yes [Specify] 999=Declines to answer	CODE: SRH Other	**The respondent will NOT say "other sexual and reproductive health services". You will be responsible for coding it based on their answers**
N	Other general health services	0= No 1= Yes [Specify] 999=Declines to answer	CODE: Non-SRH Medical	**The respondent will NOT say "other general health services". You will be responsible for coding it based on their answers. For example, the respondent could say "malaria prevention/treatment"**
O	**Family planning method**	0 = No > go to S7 1 =Yes > go to S2 999 = Declines to answer > go to A1		**This includes getting an FP method such as a condom, IUD or injection. See section 3 of the training manual for a description of modern FP methods**
S2	**What family planning method did you receive?** Anything else? **DO NOT READ OUT CHOOSE ALL THAT APPLY**	1 = Female sterilization/ bilateral tubal ligation 2 = Male sterilization/ vasectomy 3 = Intra-uterine system or device 4 = Implant 5 = Injectable contraception 6 = Contraceptive pills, non-emergency 7 = Male condoms 8 = Female condoms 9 = Emergency contracep - tion 10 = Other modern method (diaphragm, foam tablets, spermicidal jelly, vaginal ring, contraceptive patches, cervical cap) 11 = IUD or implant removal 999 = Declines to answer > go to A1	**GET FAMILIAR WITH THE LOCAL WAYS CLIENTS MIGHT REFER TO THE DIFFERENT METHODS** **Female sterilization/bilateral tubal ligation- Participants may call this "having their tubes tied"** **Male sterilization/vasectomy- Participants may say they got "the snip"** **Intra-uterine system or device- Other terms are IUD, the coil or the loop** **Implant- Respondent may use the trade name "Norplant"** **Injectable contraception- Another term is "The injection" or "Depo"** **Contraceptive pills, non-emergency- Another term is "The Pill** **Emergency contraception- Another term is "the morning after pill"** **Other modern method (diaphragm, foam tablets, spermicidal jelly, vaginal ring, contraceptive patches, cervical cap) The respondent will NOT say "other modern method". You will be responsible for coding it based on their answer of e.g. spermicidal jelly**	

8. The CEI questionnaire

SERVICE USE

> If respondent mentioned "IUD or implant removal" then proceed with asking questions S3 to S6
> If respondent did NOT mention "IUD or implant removal" go to S7
> If respondent does NOT choose any FP method in S2, confirm that this is correct and if so, go back to S1. Change the response to S1 "o" to "No". The correct skip pattern will then apply.

S3	**Why did you have the IUD or implant removed?** ONE ANSWER ONLY, CHOOSE MAIN REASON, IF MORE THAN ONE IS GIVEN	1 = It has expired/is about to expire > go to S5 2 = Want to become pregnant > go to S5 3 = Experiencing side effects > go to S4 4 = Want a tubal ligation instead > go to S5 5 = Family/ partner opposition > go to S5 6 = Infrequent or no sex/not fertile > go to S5 7 = IUD/implant failed (pregnant) > go to S5 8 = Other > go to S5 999 = Declines to answer > if S1o=1 and S2 =11 go to C1;	**Side effects refer to an undesirable effect of the IUD or implant. Examples which respondents may mention are: pain, cramping, irregular periods, depression or weight gain.** **An example for "other" is "fibroids"**
S4	**Can you please tell me what kind of side-effects you have experienced?** **DO NOT READ OUT CHOSE ALL THAT APPLY**	1 = Changes to menstrual cycle 2 = Pain or infection at insertion site 3 = Mood changes 4 = Health concerns 5 = Other [Specify] (Type in respondents answers) 999 = Declines to answer > if S1o=1 and S2=11 go to C1; else go to A1	**Another term for menstrual cycle is "period" or "menses" or monthly flow**
S5	**For the IUD or Implant that you had removed today, please tell me where you had this method inserted?** **ONE ANSWER ONLY**	1 = This facility or other [MA/IRC] site 2= Another provider 999= Declines to answer > if S1o =1 and S2 =11 go to C1; else go to A1	
S6	**For the IUD or Implant that you had removed today, please tell me when you had this method inserted?**	mm/yyyy **WRITE '333' FOR THE YEAR AND MONTH IF THE RESPONDENT CANNOT APPROXIMATE.**	**Only write in the month and year e.g. for June 2019 you would write 06/2019**
S6	**Have you or your partner done anything or used any family plan-ning method to delay or avoid getting pregnant during the past 3 months?**	0= No > go to S10 1= Yes > go to S8 333 = Don't know > go to S10 999= Declines to answer > if S1o=0 and S7=999 go to A1; if S1o=1 and S2=11 go to C1	**Take note that this question refers BOTH to the respondent AND the respondent's sex partner**

8. The CEI questionnaire

SERVICE USE

S3	**What were the methods that you were using in the past three months prior to your visit today?** Anything else? **More than one response possible**	1= Female sterilization/bilateral tubal ligation > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12 2= Male sterilization/ vasectomy > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12 3= Intra-uterine system or device > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12 4= Implant > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12 5= Injectable contraception> If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12 6= Contraceptive pills, non-emergency > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12 7= Male condoms > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12 8= Female condoms > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12 9= Breast-feeding (lactational amenorrhea method (LAM)) > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S10 10= Other modern method (diaphragm, foam tablets, spermicidal jelly, vaginal ring, contraceptive patches, cervical cap) [Specify] > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12 11= Fertility awareness methods (withdrawal, rhythm, abstinence) > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S12	**Side effects refer to an undesirable effect of the IUD or implant. Examples which respondents may mention are: pain, cramping, irregular periods, depression or weight gain.** **An example for "other" is "fibroids"**

8. The CEI questionnaire

SERVICE USE			
S8		11= Fertility awareness methods (withdrawal, rhythm, abstinence) > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S10 12= Emergency contraception > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S10 13= Traditional methods > If S1o = "No", go to S12. If S2 ≠ S8, go to S9. If S2= S8 go to S10 999= Declines to answer > if S1o=1 go to C1; else go to A1	
S9	**We see from your responses that you have switched methods today. What is the main reason why you switched methods?**	1 = Want another child soon > S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 **Fertility -related reasons** 2 = Not having sex > S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 3 = Infrequent sex > S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 4 = Menopausal/hysterectomy > S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 5 = Can't get pregnant > S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 6 =Not menstruated since last birth > S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 7 = Breastfeeding > go S10 if all response for S8 ≠ 1,2,3,4,5,6,7,8 or 10 else go to S12. 8 = Marital dissolution/separation > S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 9 = Up to god/fatalistic S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 **Opposition to use** 10 = Respondent opposed S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 11 = Husband/partner opposed S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 to A1	**There may be more than one reason. We are ONLY interested in the MAIN reason. Therefore, multiple responses are NOT allowed for this question.** **Where it says "Specify" you should type in the respondent's answer**

8. The CEI questionnaire

SERVICE USE

		12 = Others opposed S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 13 = Religious prohibition S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 **Method-related reasons** 14 = Side-effects/Health concerns S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 15 = Wanted more effective method S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 16 =Lack of access/too far S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 17 = Costs too much S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 18 = Preferred method not available S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 19 = No method available S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 20 =Inconvenient to use S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 21 = Interferes with menses S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 22 = Interferes with body's normal process > S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 23 = Other [Specify] S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 333 = Don't know S8 ≠ 1,2,3,4,5,6,7,8 or 10, go to S10; else go to S12 999= Declines to answer > if S1o=1 go to C1; else go to A1		
S10	**Have you ever used any other family planning method, or tried in any way to delay or avoid getting pregnant before today?**	0= No > If S1o=0 and S7=0 go to A1, if S1o=1 go to C1 1= Yes > go to S11 999= Declines to answer > if S1o=1 go to C1; else go to A1	CODE: 0=first time user	
S11	**What method did you use most recently?** Anything else? More than one response possible	1= Female sterilization/ bilateral ligation > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 2= Male sterilization/ vasectomy > go	CODE: 1,2,3,4,5,6,7,8,10 = lapsed adopter CODE: 9, 11, 12, 13 = first time adopter	**LAM is using breastfeeding as an FP method to prevent pregnancy.**

8. The CEI questionnaire

SERVICE USE

		to A1, unless S1o=1, S7=0 and S10=1 then go to C1 3= Intra-uterine system or device > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 4= Implant > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 5= Injectable contraception > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 6= Contraceptive pills, non-emergency > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 7= Male condoms > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 8= Female condoms > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 9= Breast-feeding (lacta - tional amenorrhea method (LAM)) > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 10= Other modern method (diaphragm, foam tablets, spermicidal jelly, vaginal ring, contraceptive patches, cervical cap) [Specify] > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 11= Fertility awareness methods (withdrawal, rhythm, abstinence) > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 12= Emergency contraception > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 13= Traditional methods > go to A1, unless S1o=1, S7=0 and S10=1 then go to C1 999= Declines to answer > if S1o=1 go to C1; else go to A1		**If the client selects "other modern method", type in the method in the box provided. This could be a method listed or an alternative modern method.** **The respondent will NOT say "other modern method". You will be responsible for coding it based on their answer e.g. spermicidal jelly.**
S12	**Prior to your visit today where did you get the meth- ods(s) you were using most recently?** **ONE ANSWER ONLY. CHOOSE MAIN PROVIDER, IF MORE THAN ONE IS NAMED.**	1= This [MA/IRC name] facility 2= Other [MA/IRC name] static facility 3= Other [MA/IRC name] outreach/mobile 4= Government provider 5= Private provider 6= Traditional healer/ unqualified doctor 7= Other community health volunteer/CBD 333= Don't know 999= Declines to answer > if S1o=1 go to C1; else go to A1	CODE: 1/2/3=provider continuer 4-7= provider changer	**MA/IRC name will be automatically coded.**

8. The CEI questionnaire

8.5 Client counselling

This section addresses the clients' interactions with facility staff & used to improve the information providers give

CLIENT COUNSELLING			
PLEASE READ ALOUD: "Now, I would like to ask you some questions about the counselling that you received today. These questions are used to understand your interactions with our staff and improve the information you receive from our service providers."			
C1	**Did the provider tell you about the potential side effects of the [method] you received?** AUTOCODE TO MAIN METHOD (S2) RECEIVED	0= No 1= Yes 333= Don't know 999= Declines to answer	**The MAIN [method] referred to by the respondent in S2 will be auto coded here**
C2	**Were you given clear instructions about what to do if you had any problems or side effects as a result of the [method] received today?** AUTOCODE TO MAIN METHOD (S2) RECEIVED	0= No 1= Yes 333= Don't know 999= Declines to answer	**The [method] referred to will be auto coded from the main method the respondent mentioned in S2.**
C3	**Which of the following methods to delay or avoid getting pregnant were you told about during your consultation with the provider today?** **PLEASE READ EACH OPTION ALOUD. CHOOSE "1" (YES) OR "0" (NO) FOR EVERY OPTION**		
A	Female sterilization / Bilateral tubal ligation.	0= No 1= Yes 999=Declines to answer	**Participants may call this "having their tubes tied"**
B	Male sterilization/ vasectomy	0= No 1= Yes 999=Declines to answer	**Participants may say they got "the snip"**
C	Intra-uterine system or device	0= No 1= Yes 999=Declines to answer	**Other terms are IUD, the coil or the loop**
D	Implant	0= No 1= Yes 999=Declines to answer	**Respondent may use the trade name "Norplant"**
E	Injectable contraception	0= No 1= Yes 999=Declines to answer	**Another term is "The injection" or "Depo"**
F	Contraceptive pills, non-emergency	0= No 1= Yes 999=Declines to answer	**Another term is "The Pill"**
G	Male condoms	0= No 1= Yes 999=Declines to answer	
H	Female condoms	0= No 1= Yes 999=Declines to answer	

8. The CEI questionnaire

CLIENT COUNSELLING			
I	Emergency contraception	0= No 1= Yes 999=Declines to answer	**Another term is "the morning after pill"**
J	Other modern method (diaphragm, foam tablets, spermicidal jelly, vaginal ring, contraceptive patches, cervical cap)	0= No 1= Yes 999=Declines to answer	
K	Breast-feeding lactational amenorrhea method (LAM)	0= No 1= Yes 999=Declines to answer	
L	Fertility awareness methods (withdrawal, rhythm, abstinence)	0= No 1= Yes 999=Declines to answer	**The rhythm method refers to using a calendar to track one's menstrual cycle to determine ovulation.**
C4	Were you told about the possibility of switching to another method if the method you selected was not suitable?"	0= No 1= Yes 333= Don't know 999=Declines to answer	

8.6 FP attitudes

This is to assess the general opinion or feeling of the client about family planning.

ATTITUDES TO FAMILY PLANNING			
READ TO RESPONDENT: "How much do you agree or disagree with the following statements? Do you strongly agree or agree/ strongly disagree or disagree?" **READ QUESTIONS TO RESPONDENT**.			
A1	A woman should wait until her youngest child is at least 2 years before becoming pregnant again	5= Strongly agree 4= Agree 3= Neither agree nor disagree 2= Disagree 1= Strongly disagree 999=Declines to answer	**The rhythm method refers to using a calendar to track one's menstrual cycle to determine ovulation.**
A2	A woman who uses contraception is likely to end up with health problems		**Contraception means using method to prevent pregnancy**
A3	A woman should be emotionally, physically and economically prepared for pregnancy before she has her first child		
A4	Young women who use contraception are promiscuous	5= Strongly agree 4= Agree 3= Neither agree nor disagree 2= Disagree 1= Strongly disagree 999=Declines to answer	**Promiscuous means having many sexual relationships**

8. The CEI questionnaire

ATTITUDES TO FAMILY PLANNING			
A5	Men should also be responsible for contraception	5= Strongly agree 4= Agree 3= Neither agree nor disagree 2= Disagree 1= Strongly disagree 999=Declines to answer	

8.7 Media access and marketing

This section aims to elicit responses on how clients chose facility and the media they use.

MEDIA ACCESS AND MARKETING			
READ TO RESPONDENT: "I will now ask you some questions about how you chose this facility and what media you use." **READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED.**			
M1	**How many days a week do you usually listen to the radio?**	0= Never 1= Less than once a week 2= 1 to 3 days a week 3= 4 to 6 days a week 4= Every day of the week 999=Declines to answer	
M2	**A woman who uses contraception is likely to end up with health problems**	0= Never 1= Less than once a week 2= 1 to 3 days a week 3= 4 to 6 days a week 4= Every day of the week 999=Declines to answer	
M3	**Do you have access to a cell phone/mobile phone?**	0= No > go to M6 1= Yes 999=Declines to answer	
M4	**Is it your own cell phone/ mobile phone?**	0= No 1= Yes 999=Declines to answer	
M5	**Are you able to view films/videos on the cell phone/mobile phone?**	0= No 1= Yes 333= Don't know 999=Declines to answer	
M6	**Have you seen this logo before?** **[INSERT MA/IRC logo here]**	0= No 1= Yes 333= Don't know 999=Declines to answer	**Show picture to respondent. This will differ for each country**
M7	**ONLY TO BE ASKED IN THESE COUNTRIES: Ethiopia, Mozambique, Malawi, Uganda, Tanzania and Zambia.** **Have you heard this before?** **[Play radio jingle]**	0= No 1= Yes 333= Don't know 999=Declines to answer	
M8	**Was your visit today the first time you visited this facility for your own health care?**	1= Yes > go to M10 2= No > go to M9 333= Don't remember > go to M10 999=Declines to answer > go to M10	**Note that the emphasis is on "FIRST" and "OWN"**

8. The CEI questionnaire

MEDIA ACCESS AND MARKETING

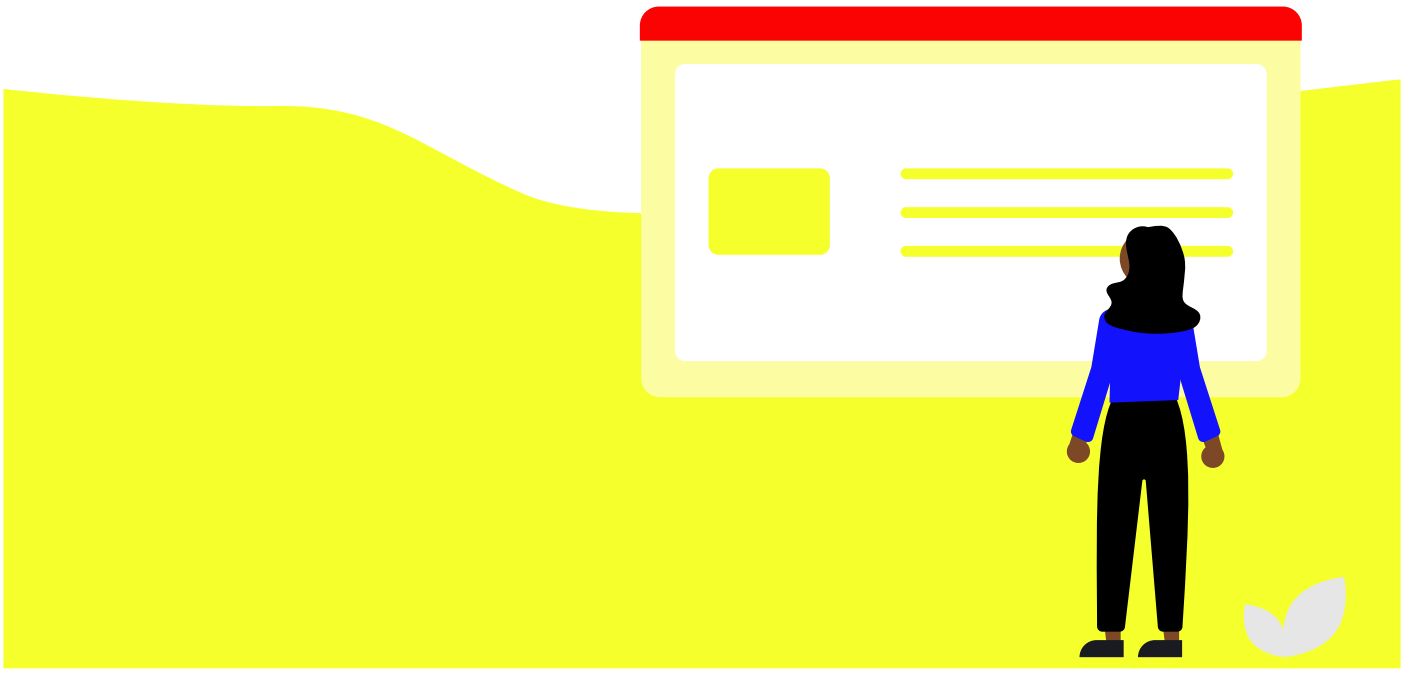
M9	**When was the first time you came here for your own health care – was it within the last year or more than one year ago?**	1= Within last year 2= More than 1 year 333= Don't remember 999=Declines to answer	**Note that the emphasis is on "FIRST" and "OWN".**
M10	**Which sources of information about this facility were important to your decision to come today?** Anything else? **[Probe for additional information sources after initial client responses]** **[IF THE RESPONDENT MENTIONS AN MA/IRC PROVIDER, YOU NEED TO ASK WHERE HE/SHE HEARD ABOUT THEM E.G. ON THE RADIO]** **CHOOSE "1" (YES) OR "0" (NO) FOR EVERY OPTION** **More than one response possible**	0= Never 1= Less than once a week 2= 1 to 3 days a week 3= 4 to 6 days a week 4= Every day of the week 999=Declines to answer 6= TV programme 7= Radio advert 8= Radio programme 9= Internet / website 10= Social media (Facebook / Twitter etc.) 11= SMS campaign 12= Newspaper / magazines 13= Promotional leaflets / poster / flyer 14= Promotional event 15= Loudspeaker on vehicle/streets poles 16= Directional signs outdoors 17= Short film seen on mobile phone 18= Contact center or Helpline 19= Someone you know who has used the service 20= Someone you know who has not used the service 21= If Other, specify 999=Declines to answer > go to K1	**[MA/IRC] will be pre-coded on the device** **Promotional event-An example may be a music event.** **Where it says "Specify" you should type in the respondent's**
M11	**Of those, which source of information was most important to your decision to come today?** **ONE ANSWER ONLY**	1= Community-based mobiliser/village health worker 2= Government run facility / provider 3= This [MA/IRC name] facility 4= Other private provider incl. pharmacies 5= TV advert 6= TV programme 7= Radio advert 8= Radio programme 9= Internet / website 10= Social media (Facebook / Twitter etc.) 11= SMS campaign 12= Newspaper / magazines 13= Promotional leaflets / poster / flyer 14= Promotional event 15= Loudspeaker on vehicle/street poles 16= Directional signs outdoors 17= Short film seen on mobile phone 18= Contact center or Helpline 19= Someone you know who has used the service 20= Someone you know who has not used the service 21= If Other, specify 999=Declines to answer > go to	

8. The CEI questionnaire

8.8 Community norms

Geared at identifying the general acceptable conduct with the clients' community with regards to FP.

CLIENT COUNSELLING			
PLEASE READ ALOUD: "I am now going to read a few statements that other people have made about family planning and contraception. "How much do you agree or disagree with the following statements? Do you strongly agree or agree/ strongly disagree or disagree?"			
K1	In my community using modern contraception is accepted	5= Strongly agree 4= Agree 3= Neither agree nor disagree 2= Disagree 1= Strongly disagree 999=Declines to answe	**Read out the answer options to the respondent after each statement.**
K2	My friends encourage me to use modern contraception	0= No 1= Yes 333= Don't know 999= Declines to answer	**The [method] referred to will be auto coded from the main method the respondent mentioned in S2.**
K3	In my community, I hear positive stories about using contracep-tion	5= Strongly agree 4= Agree 3= Neither agree nor disagree 2= Disagree 1= Strongly disagree	**Read out the answer options to the respondent after each statement.**
K4	My partner supports my decision to come for services today	5= Strongly agree 4= Agree 3= Neither agree nor disagree 2= Disagree 1= Strongly disagree 77= Not applicable (no partner) 999=Declines to answer	**Read out the answer options to the respondent after each statement.**



8. The CEI questionnaire

8.9 Demographics

This is to identify clients' age, occupation, educational level and existence of physical disability.

DEMOGRAPHICS			
READ TO RESPONDENT: "I would like to ask you some questions about yourself including your education and occupation, in order for us to ensure our services are reaching everyone in the community." **READ QUESTIONS TO RESPONDENT. DO NOT READ OUT ANSWERS UNLESS STATED.**			
D1	**What is your highest level of education?** **PROBE IF THE RESPONDENT COMPLETED THIS LEVEL OF EDUCATION, OR ATTENDED SOME OF IT, AND CHOOSE THE CORRESPONDING**	0= None / non-formal 1= Some primary 2= Completed primary 3= Some secondary, vocational or technical 4= Completed secondary, vocational or technical 5= Some tertiary or higher 999= Declines to answer	
D2	**What is your marital status?**	0= Single 1= Married 2= Living with partner 3= Widowed / Divorced / Separated 999= Declines to answer	
D3	**How many living children do you have?** WRITE '0' IF THE CLIENT HAS NO CHILDREN. WRITE '333' IF THE RESPONDENT DOESN'T KNOW.	_____ children 999= Declines to answer	
D3	**What is your occupation, that is, what kind of work do you mainly do?**	0= Unemployed, not looking for work 1= Unemployed, looking for work 2= Agriculture, self-em - ployed 3= Agriculture, employee 4= Unskilled manual 5= Skilled manual 6= Sales & services 7= Clerical 8= Professional technical / managerial 9= Student 10= Household, domestic 11= Housewife 999= Declines to answer	**Unemployed, not looking for work refers to those that do no currently have a job and are not actively looking.** **Unemployed, looking for work refers to those without a job but are actively trying to find a job.** **Unskilled manual refers to workers who lack technical training and expertise.** **Skilled manual refers to a job where a specific skill, talent or experience is needed e.g. an electrician.** **Sales & services: This includes occupations in retail services like sales assistants, as well as customer and personal service occupations such as domestic helpers, porters, garbage collectors and others** **Clerical relates to occupations which involve storing, recording, organising and retrieving information. E.g. receptionist, cashier**

8. The CEI questionnaire

DEMOGRAPHICS

			Professional technical /managerial: This includes individuals working in occupations which require a large amount of training or individuals who are in positions where they are in charge of controlling the activities of an organisation or group of people. Examples include engineers, lawyers, teachers, pilots, doctors and nurses, accountants, IT specialists, public service officials and others. **Student: refers to a person who is in school or studying at a university or other place of higher education**

DEMOGRAPHICS

READ TO RESPONDENT: I would like to ask you some questions about difficulties you may have doing certain activities as well as about your living conditions. I realize some of these questions seem unrelated to healthcare and may be sensitive, but the questions help us to understand what our clients' living situations are like. If you do not feel comfortable at any point during the questioning, please let me know. Remember that you may decline to answer any question or end the interview at any time. This understanding helps us to plan services that people can easily access and more readily afford. Please answer as honestly as possible, as this will allow us to better serve the community. Your answers will not affect the service you receive or the price you pay

READ QUESTIONS TO RESPONDENT EXACTLY AS WRITTEN. READ OUT THE RESPONSE OPTIONS EXCEPT "DECLINES TO ANSWER". CHOOSE THE NUMBER CORRESPONDING CLOSEST TO THE RESPONDENT'S ANSWER. ALL QUESTIONS MUST BE ANSWERED

D5	**Do you have difficulty seeing, even if wearing glasses?**	0= No - no difficulty 1= Yes – some difficulty 2= Yes – a lot of difficulty 3= Cannot do at all 999= Declines to answer	**Remember to read out the response options**
D6	**Do you have difficulty hearing, even if using a hearing aid?**	0= No - no difficulty 1= Yes – some difficulty 2= Yes – a lot of difficulty 3= Cannot do at all 999= Declines to answer	
D7	**Do you have difficulty walking or climbing steps?**	0= No - no difficulty 1= Yes – some difficulty 2= Yes – a lot of difficulty 3= Cannot do at all 999= Declines to answer	
D8	**Do you have difficulty remembering or concentrating?**	0= No - no difficulty 1= Yes – some difficulty 2= Yes – a lot of difficulty 3= Cannot do at all 999= Declines to answer	
D9	**Do you have difficulty (with self-care such as) washing all over or dressing?**	0= No - no difficulty 1= Yes – some difficulty 2= Yes – a lot of difficulty 3= Cannot do at all 999= Declines to answer	

8. The CEI questionnaire

DEMOGRAPHICS CONTINUED			
D10	**Using your usual language, do you have difficulty communicating, for example understanding or being understood?**	0= No - no difficulty 1= Yes – some difficulty 2= Yes – a lot of difficulty 3= Cannot do at all 999= Declines to answer	

8.10 Client satisfaction

This section addresses clients' experience at the facility and their satisfaction with the service they received on the day of the survey.

CLIENT SATISFACTION			
READ TO RESPONDENT: "Now I would like to ask you about your experience at the facility and your satisfaction with the service you received today. I would like to take this opportunity to remind you that all of your answers are completely confidential" **SHOW HANDOUT. READ QUESTIONS TO RESPONDENT AND CHOOSE THE NUMBER CORRESPONDING TO THE RESPONDENT'S ANSWER.**			
If 0 is not at all and 10 is very likely: Not at all <------> Very Likely			
CS1	**If your friend or family needed a similar service, how likely is it you would recommend this facility?**	0 1 2 3 4 5 6 7 8 9 10	
How satisfied are you with? **READ QUESTIONS TO RESPONDENT EXACTLY AS WRITTEN. READ OUT THE RESPONSE OPTIONS. CHOOSE THE NUMBER CORRESPONDING CLOSEST TO THE RESPONDENT'S ANSWER. ALL QUESTIONS MUST BE ANSWERED**			
CS4	**The friendliness and respect from the clinic staff?**	0= Not satisfied 1= Somewhat satisfied 2= Satisfied 3= Very satisfied 999=Declines to answer	
CS5	**The confidentiality at the facility?**	0= Not satisfied 1= Somewhat satisfied 2= Satisfied 3= Very satisfied 999=Declines to answer	
CS6	**The cost of service?**	0= Not satisfied 1= Somewhat satisfied 2= Satisfied 3= Very satisfied 77= Not applicable **(service provided free of charge)** 999=Declines to answer	
[IF THE RESPONDENT CHOSE "4=COMMUNITY BASED DISTRIBUTION" IN QUESTION I4] SKIP TO POVERTY SECTION.			

8. The CEI questionnaire

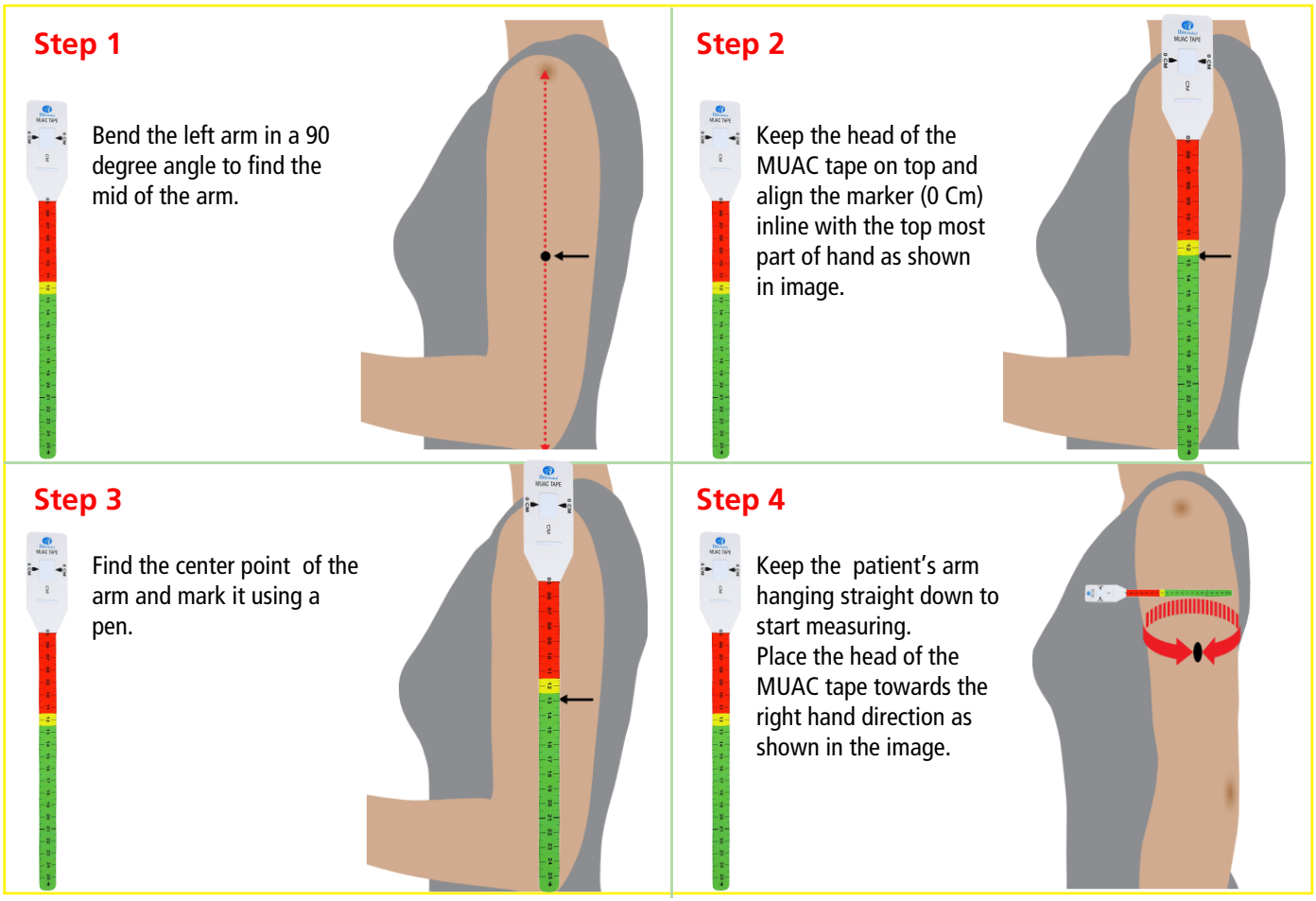
CLIENT SATISFACTION			
CS2	**The clinic working/operating hours?**	0= Not satisfied 1= Somewhat satisfied 2= Satisfied 3= Very satisfied 999=Declines to answer	
CS3	**The length of waiting time before receiving a service?**	0= Not satisfied 1= Somewhat satisfied 2= Satisfied 3= Very satisfied 999=Declines to answer	
CS7	**The general condition and cleanliness of the clinic?**	0= Not satisfied 1= Somewhat satisfied 2= Satisfied 3= Very satisfied 999=Declines to answer	

8.11 Poverty Index

Questions in this section are to elicit responses on clients' living situation.

In this section (Question PC) you will ask clients whether you can measure their mid upper arm circumference (MUAC) as a measurement of nutritional status. This involves using a tape measure to measure the width of the left upper arm. Prior to doing the MUAC measurement ask the respondent for permission to take this measurement. You will use a measuring tape to measure t is measured at the mid- point between the tip of the shoulder and the tip of the elbow as shown in Figure 2 below.

Figure 2: MUAC measurement



8. The CEI questionnaire

POVERTY

We are now going to ask you some questions about your household.

- Merged Multi-dimensional poverty index (MPI) and progress out of poverty Index (PPI) to be asked in: Burundi, Cameroon, Chad, Cote D'Ivoire, DRC, Ethiopia, Malawi, Mozambique, Nigeria, Pakistan, Tanzania, Uganda and Zambia

- MPI questions to be asked in Somalia, South Sudan, Sudan and Mauritania

Merged MPI/PPI questions for Nigeria

P1	**How many household members are there?**	1= Ten or more 2= Eight or nine 3= Seven 4= Six 5= Five 6= Four 7= Three 8= One or Two 999=Declines to answer	
P2	**Have any of your household members completed 5 years or more of schooling?**	0= No 1= Yes 999=Declines to answer	**Note "ANY"**
P3	**In your household, are there any children aged 7 to 14 who are not attending / did not attend school during the most recent school year?**	0= No 1= Yes 999=Declines to answer	**Note "ANY"**
P4	**Has a child aged under 5 in your household died in the last five years?**	0= No 1= Yes 999=Declines to answer	
P5	**How many separate rooms do the members of the household occupy (do not count bathrooms, toilets, storerooms, or garage)?**	1= One 2=Two 3=Three 4=Four 5=Five or more 999=Declines to answer	
P6	**The roof of the main dwelling is predominantly made of what material?**	1= Grass, clay tiles, asbestos or plastic sheets, or others 2= Concrete, zinc or iron sheets 999=Declines to answer	
P7	**What is the floor made of in your home?**	1= Dirt, sand or dung 2= Other 999=Declines to answer	
P8	**Do you have electricity at home?**	0= No 1= Yes 999=Declines to answer	
P9	**What is the source of drinking water in your household?**	1= Piped to house or yard, public tap, borehole or tube well, a protected well or spring, rainwater, or bottled or sachet water 0= Other > Go to P11 999=Declines to answer > Go to P11	

8. The CEI questionnaire

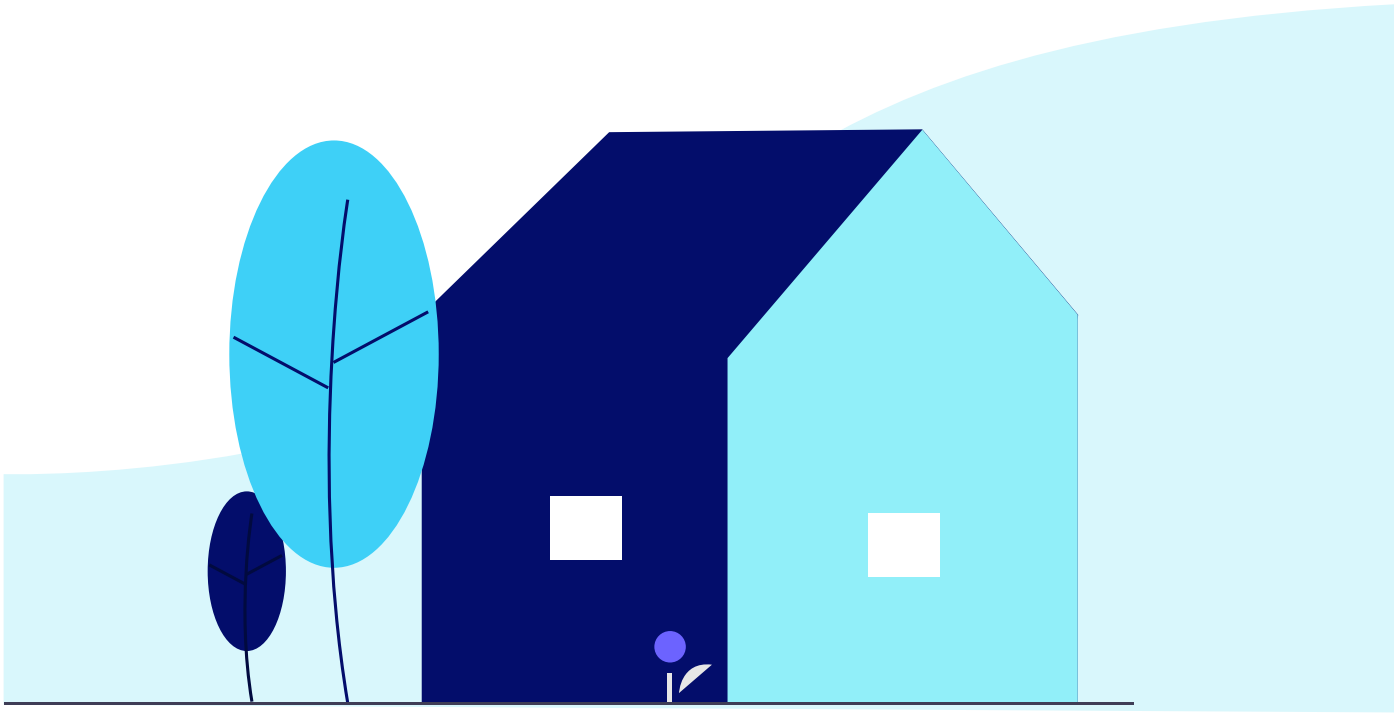
POVERTY

We are now going to ask you some questions about your household.

P10	**How far a walk is this source of drinking water from your house, roundtrip?**	1= Less than a 30-minute walk 0= More than a 30-minute walk 999=Declines to answer	**Roundtrip refers to there and back**
P11	**How far a walk is this source of drinking water from your house, roundtrip?**	1= None, bush, pail/bucket other > Go to P13 2= Pit latrine (no slab) or V.I.P 3= Pit latrine (covered slab) 4=Toilet on water 5=Flush to septic tank, or flush to sewage 999=Declines to answer > Go to P13	
P12	**Is the toilet or latrine shared with other households?**	0= No 1=Yes 999=Declines to answer	
P13	**What fuel does your household mainly use for cooking?**	1= Wood, charcoal, coal or dung 0= Other 999=Declines to answer	
P14	**How many mobile phones does the household own?**	1=None 2= One 3= Two 4=Three or more 999=Declines to answer	
P15	**How many mattresses does the household own?**	1=None 2= One 3= Two 4=Three or more 999=Declines to answer	
P16	**Does any member of this household practice any agricultural activity such as crop, livestock, or fish farming, or own land that is not cultivated? If so, does the household own any sprayers, wheelbarrows, or sickles?**	1=Farms or has uncultivated land, but no sprayers, wheelbarrows, or sickles 2=Farms or has uncultivated land, and has sprayers, wheelbarrows, or sickles 3=Does not farm nor has uncultivated land 999=Declines to answer	
Does your household own the following?			
P17	**A gas cooker, stove (electric, gas table or kerosene), or microwave**	0= No 1= Yes 999=Declines to answer	
P18	**TV**	0= No 1= Yes 999=Declines to answer	
P19	**Motorbike**	0= No 1= Yes 999=Declines to answer	

8. The CEI questionnaire

POVERTY We are now going to ask you some questions about your household.			
P20	**A car or a truck**	0= No 1= Yes > Go to PC 999=Declines to answer	
P21	**Bicycle**	0= No 1= Yes 999=Declines to answer	
P22	**Radio**	0= No 1= Yes 999=Declines to answer	
P22	**Refrigerator**	0= No 1= Yes 999=Declines to answer	
P22	**Refrigerator**	0= No 1= Yes 999=Declines to answer	
PC	Interviewer check: We would like to use a tape measure to measure the width of your upper arm. Do you consent to this happening now? **If consent is not given, indicate that the client declined to consent and go to P24**	1= Consent Given > Go to P24 0= Declined to consent > Go to end 999=Declines to answer > Go to end	**See instructions above this section on how to measure this. Note cultural sensitives about touching**
P24	If yes, measure mid-upper arm circumference (in cm to one decimal place)	_____ _____. _____ **centimetres e.g. 50.1cm**	

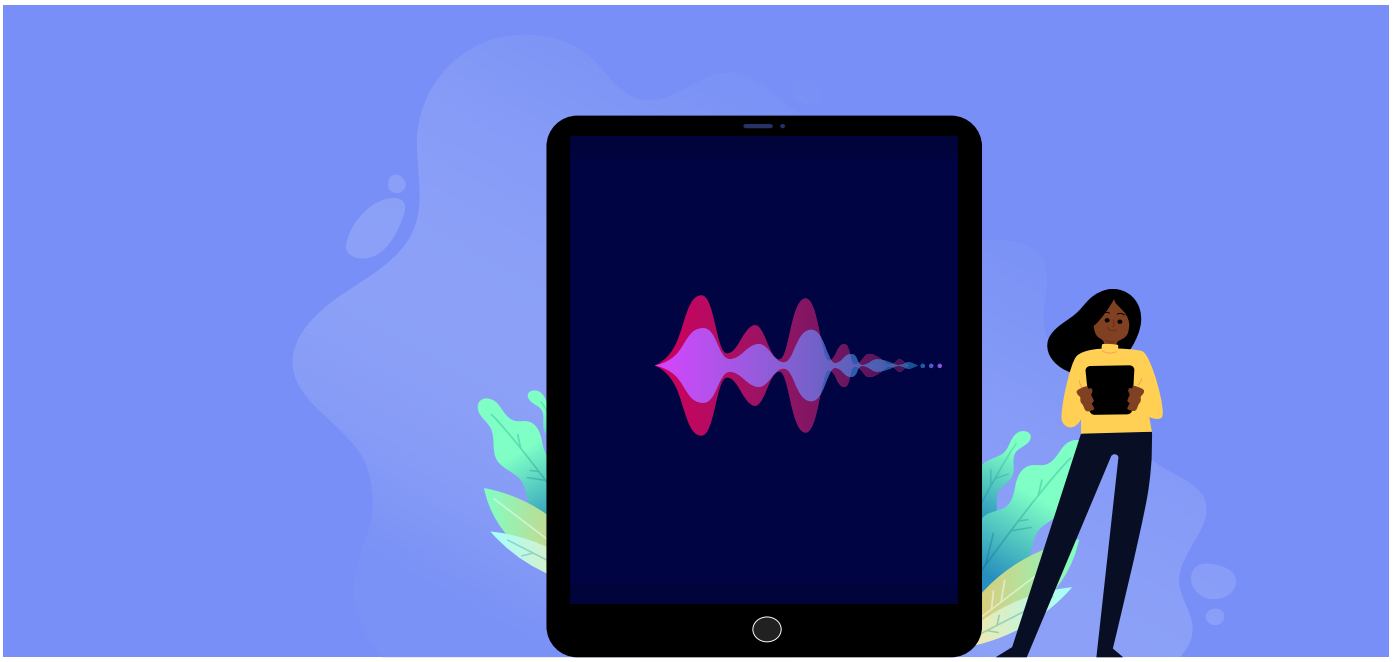


9. Using CAPI

In this section we provide an orientation to CAPI including basic programming, question types, answer types, synching and saving. After this session you should be able to:

- Use CAPI with confidence

See **Handout** on Survey To Go software.



10. QA procedures

In this section we discuss quality assurance procedures. After this session you should be able to:

- Understand how the quality of CEIs will be assured

Ensuring that the data we collect is of high quality is key to our reputation. Our enumerators make quality data possible, and we also have various measures in place to help us ensure data quality. Quality data means two things:

1. Data is **complete:** all questions for each respondent are answered
2. Data is **accurate:** what is recorded in the questionnaire is actually what respondents said.

We have put the below controls in place to check for both types of data quality.

10.1 Pre field: data completeness

Programming checks: the questionnaire is programmed on the tablet so that you cannot continue from one question to the next without recording an answer. It is also programmed so that the skip patterns are automated and you can't miss out on sections by accident.

10.2 In -field: by the supervisors and in-house quality assurance team

One of the main roles and responsibilities of the supervisors on this study include:

Conduct back checks to confirm that the team indeed visited health facilities in the sampling points. This will be done by physically visiting randomly selected health facilities in a pre-selected sampled area. A set of questions will be used in the exercise to ascertain if the selected facilities and respondents were asked these questions as part of the assessment. In scenarios where the sampling points are far, one can do telephonic calls just to validate on what is being captured by field team.

Observe the data collection process and give constructive feedback to the team. Each team will be led by a supervisor. Their role will include accompanying field teams when conducting CEI's. However, this is subject to respondent being comfortable with someone around. If the respondent is comfortable the supervisor will:

i Ensure the sampling criteria has been adhered to;
ii The consenting process is as per protocol;
iii Observe how enumerator is administering the questionnaire and ensure they are correctly completed;
iv During the first three days of field work, the supervisor will review 100% of all the completed interviews before the records are synchronised to the server. This will help to establish that the data is being properly collected. For this purpose, the auto-synchronisation function will be disabled on this survey. From the fourth day, the supervisor will continue reviewing the completed questionnaires up to 20% of all enumerator's work. The supervisor will subsequently sync all interviews that meet the survey's threshold and hold a debrief session with the enumerators to ensure that they understand how to complete the questionnaires accurately. This will mitigate against a replica of any data collection issues that the supervisor came across when s/he was backchecking.
v Observe interviewer's interviewing technique and;
vi Any other ethical concerns around research.

The information discussed above will be captured by the supervisor on the data quality control report shown below. The supervisor will be required to complete this form daily and share weekly updates with the project manager.

10. QA procedures

Data quality control report

Date	
Facility Name	
Field Supervisor's Name	

Check every interview completed by the interviewer on the following modules:

___ Sampling ___Accuracy of completion

___ Consenting ___ Interviewing technique

___ Completion of questionnaire

DESCRIPTION OF ISSUE	DATE CONVEYED TO INTERVIEWER	FOLLOW-UP/ RESOLUTION/ COMMENTS

10. QA procedures

Offer technical support to the team when in need be during data collection process. Supervisors will be tasked with trouble shooting devices that present problems during the survey period. We will offer one extra device to field teams to act as back-up during this assignment. Data collectors in all countries with exception of Pakistan will only be allowed to use paper version of the questionnaire if the supervisor is unable to provide an alternative tablet or unable to troubleshoot the problem at hand.

A central team of quality control officers based in Nairobi have been tasked with:

i **Listening in to random recordings just to ensure correct administration of this questionnaire.** In addition, we will silently record some key questions from the tool just to check on consistency and questionnaire administration of this assignment. This will be treated as an internal process that allow us to validate on those interviews which will present quality issues.

ii **Monitor the adherence to the stipulated sampling methodology in implementation of field activities.** For this study they will begin by looking at the basics for instance if the right sampling point was visited by the respective teams by overlaying the GPS Coordinates collected with the respective sampled regions. Next, they will review certain metrics across enumerator ID including, interview duration, interview time (in comparison to clinic opening times), completion rate, response patterns (e.g. an enumerator having an unusually high level of refusal or with many clients only accessing counselling services), high level of don't know or others without specifying. This will be a continuous exercise throughout the field work duration.

10.3 In and Post field

Data quality control report

When the forensic team based in Nairobi receives the synchronised data, they will ensure it goes through the carefully designed, three-step data-cleaning process. This includes:

1. Screening Phase - systematically looking for problems with the data;
2. Diagnostic Phase - identifying the condition of the suspect data; and
3. Treatment Phase – The affected cases are sent to the project manager and field manager for confirmation and advice on action to take i.e. Deleting or editing the data or leaving it.

Data Integrity Checks

The following data checks will be carried out on the data to ascertain if there are any integrity issues.
The forensic team will verify if the GPS coordinates of surveyed SDPs are within the sampled regions.

Missing (Blanks) on "All Respondent" variables
All variables (questions) that are asked of all respondents should be based on the total number of respondents in the data file.

There should be no MISSING or BLANK data for these questions.
Missing (Blanks) on variables within a Skip Pattern (i.e. filtered). All variables (questions) that are only asked of a respondent who should validly give an answer to that variable (question) should be included in the BASE for that question. There should be no MISSING or BLANK data for these questions and there should be no respondent answering these questions who has "skipped it due to the questionnaire routing:
E.g. Question S1o is comprised of 200 clients saying, "They used family planning". S2 then asks, "What family planning method did you receive?" The base for S2 must be N=200.

Unknown values
All values (answer categories) as supplied in the data file should exist in the questionnaire also. If the data file contains values (answer categories) that are not in the questionnaire then these need to be interrogated and corrected or reported on as required. However, this cannot pass in CAPI as the script is controlled to only accept the questionnaire elements. But can be expected in data from Pakistan.

Outliers in the numeric fields i.e. number of items in P1, P5, P14
Check for invalid character values. These have been inbuilt into the data capture system
Check for invalid values for all Likert scales in Pakistan. This will be achieved by only allowing data entry to be selected from that Likert code-list or also by using frequency table

10. QA procedures

Check for repeated IDs.
We will do this, first by sorting the data, then looking for repeats. Alternatively, this can also be done in frequency tables.

Checking dates for validity. For example, we will check that date of visit is not before the tablet date, or S6 is not before date of visit.

10.4 Post field

Manual checks: every interview that you complete is uploaded to our central server as soon as you close the instrument on the tablet. We have someone in our office checking every single interview as it comes in on the server to see if there is any missing information. If the team finds something out of order, we will call the team supervisor to check with you what happened on that interview.

The manual checks mentioned above also check for suspicious repetition of responses, which may indicate that an enumerator is entering fake data.

11. Fieldwork procedures

IIn this section we discuss fieldwork procedures. After this session you should be able to:

- Understand team structure, roles and responsibilities;
- Understand what to do in the case of an unexpected or adverse event; and
- Understand the basic workplan for each day.

11.1 Team structure and roles

The size of the country field team, as well as the number of field teams will vary depending on the number of SDPs per country. However, on average each country field team is likely to have up to, five members: four enumerators and a field supervisor. Each team of enumerators will comprise three female and one male interviewer. At least one enumerator in the field team will be male so that male enumerators can administer modules with gender-sensitive questions to male respondents.

Field supervisors will be responsible for the team and the day-to-day organisation and supervision of the team's work.

The overall field project manager, Mrs Acqueline Otieno will be responsible for managing the field supervisors in each country.

In addition to this, the supervisor will be in charge of:

- Submitting the notice of CEIs to SDPs prior to fieldwork;
- The team's itinerary (supervisors will place enumerators in clinics based on proximity and language), names and location of SDPs and Member Associations' contact numbers;
- Ensuring that the enumerators have all the equipment to administer the survey before they leave their base;
- Manage permission and approvals with the SDP's management;
- Manage the sampling of the clients in the selected SDP;
- Recording the average daily client flow at the site on the client flow sheet (this information will be provided by the receptionist at the facility/CBD provider).
- Coordinating with the overall field project manager to ensure that all SDPs have been correctly identified and visited as per the stipulated field work plan and all relevant information required from clients has been promptly done;
- Observing some interviews to ensure professional conduct and adherence to study protocol;
  - Completing the data quality control report for these interviews
- Supporting enumerators in dealing with difficult respondents;
- Reviewing data entry per interviewer prior to data upload
- Uploading data daily;
- Regularly communicating field updates, progress, procedural concerns and other issues to the field manager;
- Notify the SDP's management of any unforeseen irregularity.
- Arranging for team's travel to the sampled SDPs;
  With support from the field manager, arrange for team's accommodation within areas close to the sampled SDPs and
- Centre of communications with the team.

The enumerator's role is to:

- Recording the average daily client flow at the site on the client flow sheet (this information will be provided by the receptionist at the facility/CBD provider). Enumerators will not take on this role if they are not accompanied by a supervisor on the day.
- Correctly and efficiently administer the CEI, including knowing and following all administration rules while:
  - Contacting potential respondents at the SDPs;
  - Administering the eligibility screener;
  - Facilitating information sheet and informed consent form; and
  - Administering questionnaire to eligible clients using the CAPI device/paper questionnaire
- Accurately complete the contact sheet. This sheet will be used to capture respondents who refuse to be interviewed.
- Accurately record demographic data and responses;
- Identify responses as correct and incorrect;
- Correctly and efficiently use equipment, especially tablets;
- Work well as a part of a team;
- Adhere to SDP's visit protocols and reporting of any irregularities to their supervisor;
- Create a rapport with clients and SDP management.

11. Fieldwork procedures

The data manager's role is to:

- Respond to data quality reports generated in the field and communicates any problems that are discovered to the project managers and field supervisors.
- Report the nature and scope of these problems and suggest solutions.

11.2 Workplan

Before starting fieldwork each morning, verify that you have everything you need for the day's work. Some necessary supplies include:

- Fully charged and working tablet
- Information sheets and informed consent forms
- A charger
- Training manual
- Your name tag
- Identification badge
- A notebook
- Client flow sheet
- Pen
- A bag to carry your equipment and supplies

When arrive at field site, check in with team supervisor
Before starting field work, check that amount of battery life on the tablet will last throughout the day
In more detail:

1. Check in with team supervisor before 9am
2. Receive your copies of:
   i. Receive copies of the sampling approach
   ii. Information sheets
   iii. Consent forms
   iv. Client flow sheets

For each respondent:

1. Introduce yourself and the study to the respondent.
2. If the respondent agrees to participate, go through the eligibility screener and if eligible go through the information sheet and have them sign the consent forms (Keep the signed consent forms next to you during the interview.
3. If the respondent does not want to participate, complete the Contact Sheet.
4. Complete the interview with clients that have provided informed consent, ensuring that no-one else is listening or interrupts the discussion.
5. If the respondent shows signs of distress during the interview or break off the interview because they say they don't want to continue, respect their choice.
6. At the end of your time with a respondent (end of survey) you should express your gratitude for the respondent's time before leaving. Thank them for their cooperation and assistance.
7. Ensure that all sections have been filled out completely and accurately.
8. Keep the tablet clean and in their sleeves/pouches when not in use.
9. At the end of the day, check in with the team supervisor, submit all signed consent forms (interview consent, contact consent and testing consent), return unused information materials, report on the number of interviews completed and any challenges encountered.

11. Fieldwork procedures

11.2 Handling unexpected or adverse events

This section describes responses to unexpected or adverse events that may occur during the study and ways to minimize their impact on the study outcome.

Survey schedule: In rare circumstances, the schedule may be modified; in other words, some planned SDP visits may take place simultaneously or on a delayed schedule to accommodate weather, religious holidays, or any political uncertainties, such as elections.

Inaccessible sampled areas: During fieldwork, some SDPs may become inaccessible to the field teams. This can happen for a number of reasons, including physical limitations, such as a rainy season that washes out the access roads to the SDP, and security issues, such as political instability, that make it unsafe for interviewers. Consequently, data may not be collected in the affected SDPs. To compensate for a possible shortfall in the number of clients required for data collection, the Sampling team will draw a random-generated reserve sample as part of the initial sample draw.

Dropouts or temporary absences of team members: Each team should plan to train extra enumerators that will serve as back-up in case any enumerator drops off the survey. The standard that will be used is 10% (i.e.' 1 extra enumerator per team) of the overall team size. All field supervisors will be trained on all aspects of data collection and will serve as back-up for temporary absences of field interviewers due to health or family emergencies.

Security risks: In sampled areas that might pose security risk to the enumerators, the Field project Manager should organize with local administrative leadership on how best to work within the area. In some of the regions, security guards will be provided by the field project manager to accompany the teams.

12. Piloting of the questionnaire

Once training is complete the questionnaire will be piloted with clients at a health facility that will not be included in the sample in each country identified by the core research team. The pilot is a test run of the aspects of the main study.

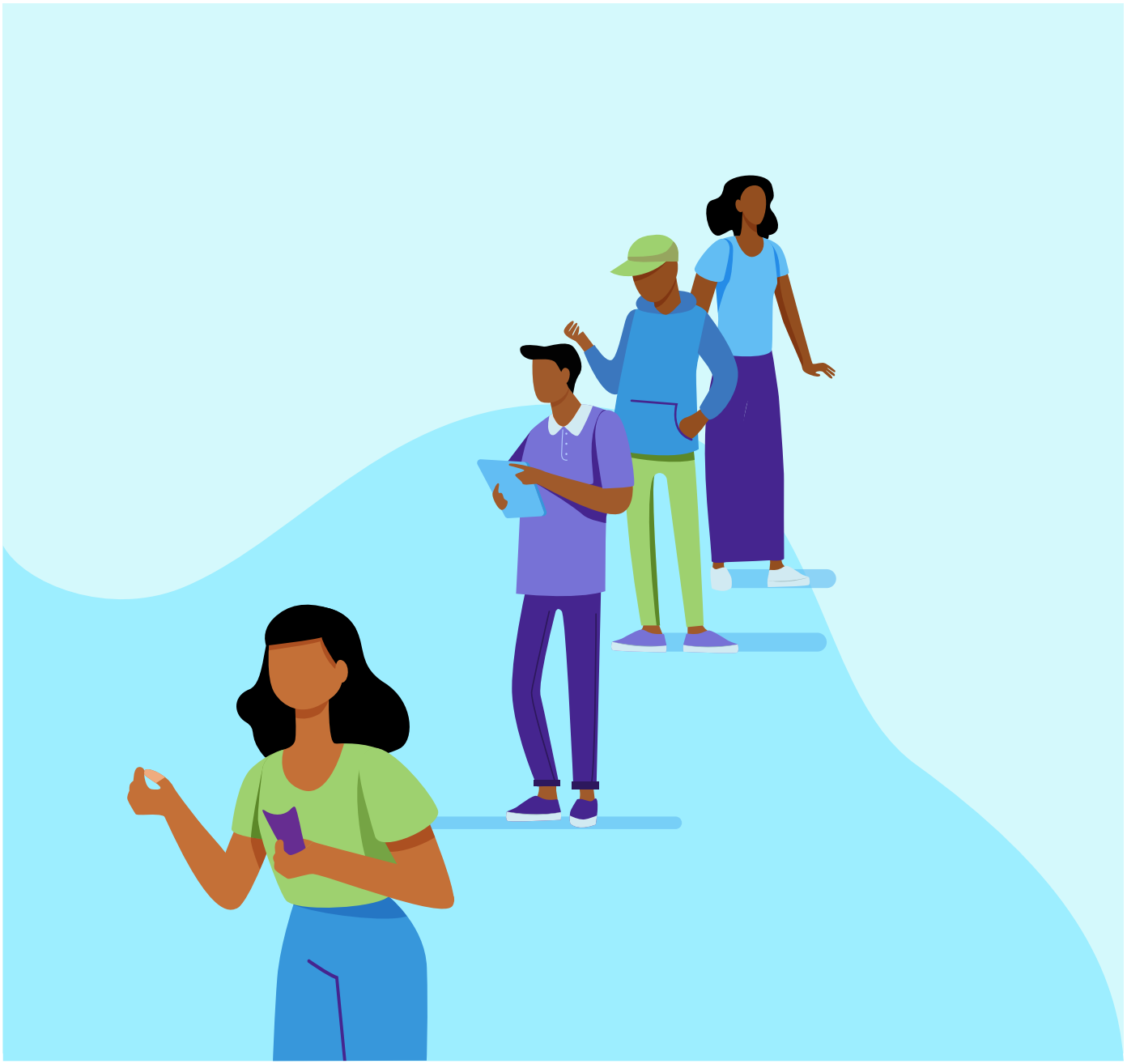
The purpose of the pilot is to:

- Refine and improve quality of the questionnaire;
- Address logistical challenges; and
- To ensure enumerators are comfortable administering the questionnaire.

When piloting the questionnaire, it is important to record the following information:

- Words and sentences which are not understood
- Questions that require prompting and explanation
- Respondents' reactions to certain questions especially sensitive ones
- Logistical data e.g. time taken
- Respondents' thoughts about the nature, style and timing of the questions

Once the pilot is over, we will hold a debrief session in order to understand your experiences administering the questionnaire. Your feedback is crucial in assisting us revise and optimise the questionnaire to ensure we obtain high quality data.



13. Appendices

13.1 Appendix 1: Ethical strategy and child protection policy

Ethics need to be incorporated into all stages of the research process, from the design of the research, to the data gathering, data analysis, report-writing, dissemination, monitoring and evaluation phases. At each of these stages the research needs to be:

- Empowering
- Consultative
- Sensitive and flexible
- Sensible and prepared
- Sanctioned by informed consent
- Cautious and protective
- Confidential
- Accountable

Empowering

Research can only be empowering if it is undertaken in an ethical manner and takes into account the following:

- You should not adopt a superior stance in relation to your respondents, whether they are adults or children.
- You are trying to learn from them. As we are trying to understand their thoughts, perceptions and experiences, you do NOT know more than them in this context. Do NOT impose your opinions and values upon them.
- They are not obliged to help you. So, you have to work at developing a relationship with them. After all, in this context they should be in a position of power. They can choose not to participate fully, or choose not to provide honest answers. Bear this in mind – you have to earn their trust and participation.
- You need to recognise the manner in which power relations are constructed. By virtue of the fact that you are an adult, of a particular gender or emerge from a particular socio-economic background, you may be in a position to exercise more power than your child respondents. You should NEVER exploit this and use it to achieve your own ends. You should NEVER force them to participate or dictate the terms of their participation.
- You need to reflexively analyse how your own beliefs about childhood, sexuality, gender etc. might affect the way that you pose questions, use terms or interact with your respondents. For instance, you might not be aware that simply using the terms 'victim' or 'at-risk' might serve to demonise and stigmatise these children and communities further. You need to think about your own beliefs regarding childhood: do you think they are capable of making decisions and expressing themselves? If you do not, you will come across as patronising and the children are unlikely to place their trust in you.
- You need to focus on the strengths of these children, families and communities. So, try to frame your questions and activities in a positive light highlighting their positive attributes, skills and how they help themselves. After all, in order to create long-term, sustainable solutions to the problems that many children face, we need to build upon these strengths.
- In general, research is only empowering if it is honest, respectful and enables the respondents to express themselves in the best way that they can.
- Bear in mind that you are interrupting their daily routines, livelihoods and social activities, so please thank them for their time and effort

Consultative

A wide range of actors need to be consulted including children, their families, communities, civil society organisations, state and other stakeholders. This consultation must not amount to a token gesture but must be meaningful. The following is important.

- Respondents can use the contact information on the information sheet to express their concerns or if they need any additional information.
- Their opinions must be listened to and respected. Their thoughts, ideas and concerns should be clearly noted and reported. They should be thanked for their input even when you disagree with their comments.
- Their skills and knowledge must be used as a resource that will benefit the project. Instead of thinking of these communities as 'at-risk', negative or dysfunctional, focus on their strengths, what they know and how they help each other.
- Their input must be used to inform the findings of the project.
- The results of this study will be discussed and presented at small meetings in the community, at conferences and published. This study will also be presented to different government health organisations so they can better provide programmes related to reproductive health.

13. Appendices

Sensitive and flexible

The research needs to be sensitive to the needs of the respondents, their families and communities.

- The local context, the socio-economic status of the respondents and their cultural norms must be taken into account
- Research tools need to be adaptable to this local context
- Research questions should be appropriate and responsive to the way in which gender, childhood, ethnicity, race, class and other categories are constructed in this particular context.

Sensible

The research needs to be sensible in the sense that the researchers and facilitators must act with foresight, anticipate possible risks and prepare in advance. It is the responsibility of the research team, supervisor, and enumerator to ensure that the children, their families and communities do not face any harm to their physical, social and psychological well-being directly or indirectly.

The research team will assess the short and long-term risks and the context, and on this basis, plan ahead:

- Local stakeholders will be consulted beforehand to ascertain what the potential risks may be in that particular setting. These risks pertain both to the child, their families, communities, and to the research staff themselves.
- This knowledge should be used to inform the research tools used, where the research is conducted, how it is conducted and who the respondents will be. It must be remembered that the child's well-being must come first.

Supportive

Support must be provided throughout the research project.

During the interview, you need to be prepared for children who may feel distressed or uncomfortable. Follow these steps:

1. Observe the children closely for signs of discomfort or distress
2. Approach the child without stigmatising the child in a group setting
3. Ask them if they feel comfortable enough to carry on with the questionnaire.
4. Be clear about your limitations. You cannot offer them long-term solutions but can refer them to individuals who may be in a position to do so.
5. Ask them if they would like to continue with the interview, if they need a break or would like to terminate it completely.
6. Ask them if you can contact anyone on their behalf. This may be a parent, friend or other person.
7. Provide them with contact information for other support structures e.g. organisations working on issues related to children and violence.
8. If you are particularly concerned about a child it is best to contact your supervisor who can provide you with advice before breaking their confidentiality.

Sanctioned by Informed Consent

Throughout the research process, informed consent needs to be attained from all the participants including the children, their families, communities and institutions. This consent needs to be based on a clear understanding of the research process, objectives, methods and outcomes:

- **Research process:** Explain why this research is being undertaken, what will happen to the information that is gathered and who will see it. Some may be concerned about confidentiality for example (see below for guidelines).
- **Objectives:** Explain clearly what this research is trying to understand and do not offer your opinions or feelings on the subject matter. Emphasise that the objective is to increase our understanding and not to undertake a particular project that they will derive immediate benefits from.
- **Methods:** Be practical. Explain how the questionnaire will be conducted, and the duration.
- **Outcomes:** Inform them how the findings will be used and where they will be disseminated. Once again, emphasise that there will not be any immediate advantages for them or those around them, but that this understanding will be used to improve services to better meet the needs of the community.

Encourage them to ask questions and give them time to think about the implications of this participation.

Never pressurise them into participating and make it clear that they can choose not to participate at any point.

Consent forms are often problematic because they depend on a certain level of literacy, often have a negative impact upon the researcher-respondent relationship; create a sense of obligation in the mind of the respondent and do not necessary guarantee that consent is informed. So, consider how they are being administered carefully!

In general, it is important to ensure that consent is informed, there is a genuine choice, and it is not treated casually!

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Cautious and protective

When deciding upon staff and allocating tasks, managers need to err on the side of caution:

- As an enumerator, your safety and security will be taken into account. In many instances it might be best if enumerators work in pairs, in public places or at particular times in the day. It is also useful if enumerators carry identifying documentation, notify others of their whereabouts and keep safety numbers on hand.
- The child's well-being is the most important consideration.

Confidential

Research should be confidential. The following must be undertaken:

- Discuss issues related to confidentiality upfront with the respondent so that they can decide at this juncture not to participate. Ask them if they think that your approach is suitable, and if they have any particular requests.
- Assure them that you will not use their names or any other identifying material.

If you encounter a child who you are particularly concerned about a child who may be in danger, follow these steps:

1. Discuss your concerns with the respondent first to establish whether he/she feels the same. Please do not assume that your perceptions of threat or harm correspond with those of the child.
2. Encourage them to tell another trustworthy adult
3. Refer them to an individual or organisation who could help them.
4. Inform them if you plan to take action with/without their consent.
5. Contact your supervisor to establish what action is appropriate. If you discover the child has been a victim of sexual violence, you must report this to the MA regardless of whether the child consents or not.
6. Contact individuals or organisations who may know of the child and who may be in a better position to provide assistance.

Accountable

The research needs to be accountable to the children, their families and communities:

- They must exercise a degree of ownership over the project.
- Expectations and targets need to be realistic. It needs to be emphasised that this research project will be used in future projects but cannot offer any immediate tangible benefits to the child or his/her community. Researchers need to be upfront about their limitations!

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13.2 Appendix 2: Distress protocol

The questionnaire contains questions that may be upsetting for a respondent to answer. Your job as an enumerator is to ask these questions in a matter-of-fact, non-judgmental manner. Despite your best efforts, you may still encounter a respondent who is upset by a question or series of questions. You should try to handle these situations by offering appropriate support. Such occurrences may be very rare; most enumerators will never encounter this problem. However, if such problems do occur, we have designed procedures for you to follow.

A respondent's emotional distress may be expressed in different ways and will likely vary as a function of the age of the respondent. For example, a respondent may be overcome with emotion or become so agitated or distracted that he/she is temporarily unable to continue with the interview. Occasionally a respondent may become preoccupied with a powerful memory and give you much more detail about a particular event than the question requires.

People do not generally have sudden emotional outbursts. There is usually a progression of verbal and nonverbal cues indicating that a respondent is becoming upset. As you conduct the interview:

1. Observe the respondent for cues that suggest distress if you are conducting a field interview (e.g., sudden agitated pacing);
2. Listen carefully for cues (e.g., lump in the throat; quivering voice), and acknowledge the behaviour or feelings. For example, if the respondent's voice becomes soft and frail, you can say something like "Are you all right?" or "Is this becoming difficult for you?"
3. If you observe a respondent struggling to maintain composure, or if he/she begins to cry, acknowledge the distress by saying something like "Would you like to take a short break?" and allow him/her time to regain composure.

Most often, the respondent will be able to continue. Once the respondent is composed, you should attempt to finish the interview. However, if he/she is too agitated or upset to continue, arrange to finish the interview at another time, on the same day, if they agree.

When a particular question triggers an emotionally-charged story from a respondent whose other responses have been to the point, it may be best not to try to redirect him or her as you would ordinarily. The respondent may need to describe a particular event, and you should wait patiently until you feel he/she is ready to continue. You may want to help regain focus with a comment such as "I see" and move on. Remember that you are responsible for getting the interview back on track. When you feel that the time is right, use a soft, direct manner and say something like, "I have a few more questions. If we go slowly, do you think we can continue with the interview?"

When a respondent becomes distressed, it may seem hard to **avoid taking on the role of counsellor**. Regardless of your background, your function on this job is that of an enumerator, not a counsellor. Providing counselling interferes with the interviewer-respondent relationship and compromises the quality of the data. Additionally, your counselling, despite your good intentions, could do more harm than good for the respondent. Never adopt the role of "patient advocate." Some individuals can be manipulative and lead well-intentioned, overly sympathetic interviewers in undesirable directions.

There are a few helpful **"nevers"** for you to remember regarding the enumerator-respondent relationship:

- Never engage in conversation with the respondent about events, behaviours, or feelings.
- Never give advice. Each person has his/her own best answers. Any advice that you give only means that this is what might work for you. More importantly, you may do harm by giving advice.
- Never tell a person that he/she "should" or "should not" feel a certain way. Feelings are not right or wrong, they're just "feelings."
- Never say that you are "surprised" about something that was said or done. This denotes judgment and criticism.

It is important to trust the respondent's ability to handle personal feelings or emotions. Most feelings are transitory. Sometimes just expressing feelings to a non-judgmental adult helps respondents to feel better. Although some parts of the interview may have been emotionally trying for the respondent, an extensive history of survey research on sensitive topics (such as emotional and behavioural problems), suggests you have not done any harm. Whatever the short-term effect of the interview, it is unlikely to have any lasting negative effect. In fact, some respondents may be relieved to have a neutral outsider to listen to the story, knowing there will be no further consequences.

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When respondents become emotionally overwhelmed, agitated, or preoccupied, you should be aware that you may feel emotionally drained after the interview. Just being aware that your reaction is normal should make it easier for you to deal with the situation. Remember that you cannot discuss information, even if that information or observation is distressful to you, with your friends or family members. If you need support – and we all do at one time or another – discuss your situation with your supervisor.

If respondents exhibit any kind of threatening behaviour or verbal abuse towards you, politely end the interview and inform your supervisor of the situation.

All instances of distress during the interview should be reported to your supervisor or field work manager within 48 hours who will also communicate this to the core research team. Document your experience in an e-mail or distress respondent report (shown below) to your supervisor.

You should ask the MA for relevant helplines or organisations when you arrive in field so that you have information on hand should you need to refer a distressed respondent to someone who will be able to offer them the appropriate care.

Respondents whose life or health are in imminent danger

During the CEI interviews, there is a very small chance that you could encounter a situation that causes you to believe that the life or health of the respondent or someone else is in imminent danger. You must be prepared to handle such a situation, using the procedures outlined below. You may suspect that a respondent's life or health, or the life or health of someone else (e.g., the respondent's spouse or child) is in imminent danger in their current living situation, even if the respondent does not explicitly say so.

If you believe that someone's life or health is in imminent danger, you should:

1. Offer resource information to the respondent;
2. Volunteer to make a call to a helpline for him/her while in the interview setting; and
3. Refer the client to relevant helplines or organisations provided to you by the MA.

You must also notify the facility manager and your supervisor immediately upon completing the interview so she can discuss the need for any further action.

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CEI Distressed Respondent Report

Case ID: _____

Interviewer ID: _____

Household Respondent or Individual Respondent: _____

Respondent Initials: _____

Distress Level (Mild-Level 1, Moderate-Level 2, Severe-Level 3): _____

Distress Description:

_____

_____

_____

_____

Interviewer Actions:

_____

_____

_____

_____

Supervisor Actions/Comments:

_____

_____

_____

_____

Date Reported to Facility Manager: _____

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13.3 Appendix 3: IRC guidelines for handling negative feedback and difficult conversations

Guidelines for Handling Negative Feedback and Difficult Conversations March 2018

Understanding Negative Feedback

Why do we receive negative feedback?

As humanitarians, we know that no project will ever be perfect. We often have an imperfect understanding of a crisis, inadequate resources, and too little time, and serious operating constraints. We ask for feedback so we can understand what our clients think could work better, and we use that information to improve. Feedback about how we can improve is often viewed as "negative feedback".

Feedback is a sign that people believe it is worth their time to communicate with us. Feedback may be positive at first, but negative feedback may arrive or increase over time. This can be a sign that our clients have developed trust in the IRC's ability to take their feedback seriously. Not receiving any negative feedback could be a sign that people are so disenchanted, cynical, or afraid that they refuse to tell us when they believe something is wrong.

Why is negative feedback hard to hear?

Negative feedback can be hard to hear in any circumstance. It is never comfortable to be criticised. We must acknowledge that this discomfort is human and work to overcome it.

People often worry about how negative feedback may affect the perception of their supervisors, and how it may affect their self-esteem, reputation and employment / career prospects. In some cases, we are also concerned about our donors' response if we report negative feedback to them.

Clients may often complain about issues far beyond our control. This could be because we haven't properly communicated the scope of our services and programmes. Our clients may even vent their anger at other actors at us, simply because we are present and therefore a convenient target for those frustrations. It is not the responsibility of crisis-affected populations to protect our feelings or guard their emotions for our comfort.

Negative feedback, when it is the kind that is beyond our control to fix, can be frustrating to receive. It reminds us of how powerless we are in some situations, which can be uncomfortable.

How does organisational culture influence our ability to handle negative feedback?

An organisational culture that handles negative feedback constructively requires:

- A consistent and transparent system for referring feedback and making decisions about it;
- Senior management actively requesting client feedback and taking client concerns seriously;
- Incentivising staff to share negative feedback; and,
- Replicating practices of "closing the loop" (acting on the feedback received and providing a response to the client) internally. Just as clients may get discouraged giving feedback if they never hear a response, staff may stop sharing feedback if they don't know what happens to it.

Nurturing a culture of listening within the IRC is everyone's responsibility, but it is particularly important for senior staff. A culture of listening has many benefits: senior staff will come to better understand the challenges of our clients; they will also understand the challenges of frontline staff and can better plan and allocate resources accordingly. If frontline staff feel that their opinion doesn't matter, their grievances are not heard and addressed by senior management, they are unlikely to pass negative feedback (or any other type of feedback) from clients. However, when we systematically document negative feedback, it can be useful for after-action reviews, for design of future programmes and strategy reviews, for advocacy at the cluster level to improve targeting and services, and for the IRC's own programme quality improvement efforts. In addition, frontline staff will feel more respected and recognised if they are involved in the decision-making process and empowered to take action and to propose solutions.

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What are the advantages of receiving and responding to negative feedback?

Information: Negative feedback can highlight those areas where we may be making poorly-informed choices, doing things wrong, or causing harm. Negative feedback helps us understand where we need to review our decisions, monitor our actions, focus our efforts on improving certain aspects of our projects, and generate ideas for ensuring better outcomes.

Prevention & mitigation: If we don't solicit negative feedback and address it now, it is likely that we will have to deal with the consequences of that inaction later down the road, including greater problems and resentment and mistrust from the community.

Empowerment: Soliciting and responding well to negative feedback can be an empowering experience for staff and clients alike. When we ask for feedback and deal with it satisfactorily, we convey to communities that they have the power to influence the type of aid that we are providing them, as well as the way we deliver it. Handing some decision-making power back to clients, who may have lost much control over their lives, can be an important step towards restoring their sense of agency.

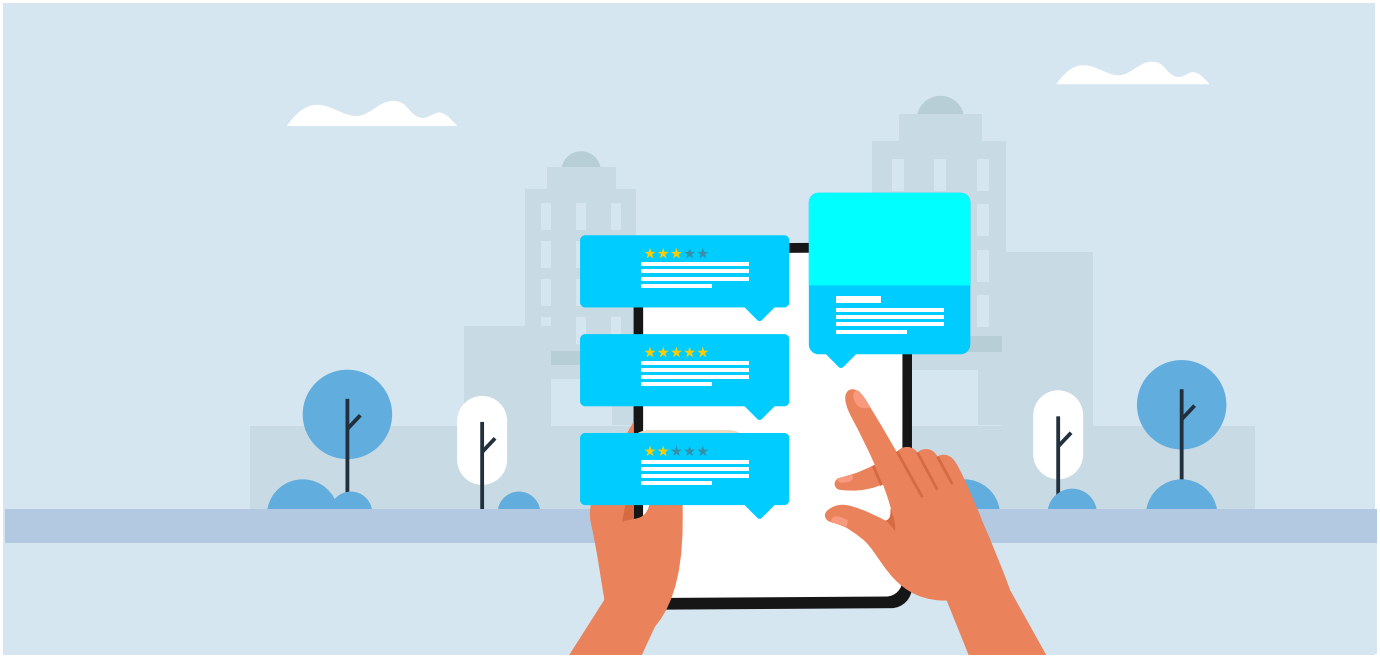
Engagement: From the IRC's perspective, it's also worth remembering that a proactive and engaged community that has a stake in the activities we deliver is a much easier population to serve. If they believe that our activities are theirs, they will take greater care in supporting our work, referring more people to us, and will protect and value what we do.

How should we manage the expectations of our clients?

As mentioned earlier, not all negative feedback is actionable. Often, clients will communicate with us about issues beyond our control. While we can't control what issues a client may bring up through a feedback channel, we can help clients to make their feedback more actionable by proactively communicating the IRC's mandate and the scope of our programmes.

We should communicate with our clients our mandate, programmatic scope, targeted clientele, and timeframe as clearly as possible to reduce the number of incidences of requests or complaints that go beyond what the IRC is there to do and the type of aid and services we are providing in a particular context. It is important that we also communicate this when planning our feedback channels, and when informing our clients about them. Crafting clear messages geared to regularly communicate this information to our clients will also help country teams and especially staff on the front-line to manage clients' expectations, and to ensure that requests outside of the IRC scope of work are handled in a consistent manner.

Most importantly, if we want to build trust and get useful feedback from our clients, we need to make sure they feel safe enough to express themselves. It should be made clear that any negative feedback will be treated with confidentiality and that clients will not suffer any consequences for speaking up. However, we should also explain that confidentiality is not about keeping secrets. If the feedback we receive is of a serious nature that puts people in danger, we will follow IRC's policies for appropriately alerting the right people to deal with it.



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Practical Guidance on Handling Negative Feedback

Tips on how to respond to negative feedback which you receive from a client

When we receive negative feedback from clients, it is important that we prepare ourselves for how to receive it in a professional and constructive way. Here are some practical tips that you can consider when receiving negative feedback from a client:

- Remain calm
- Focus on the problem being raised, not on the people who are delivering the message.
- Take a deep breath and don't get defensive. Don't take it personally. As IRC staff, we need to act professionally.
- Listen carefully. Do not interrupt.
- Acknowledge. Thank the client(s) for their feedback. Be sincere. Always mention that IRC cares about client views and feedback and wants to hear these.
- Clarify. Ask for clarification and specifics about the problem / issue. What exactly is the problem? What is its impact?
    - Ask for analysis of the problem. What has caused this problem? Why is it happening? It is important to hear clients' perspectives on why they think there is a problem or why it persists.
    - Ask clients what they would like to be different. If possible and appropriate, invite their suggestions for improvement or brainstorm possible solutions. This is an active feedback conversation and it shows you value their opinions and suggestions.
- Respond. If you have the answer to the client's questions, provide it right away.
    - Explain the next steps and clearly manage expectations about whether you or someone else from IRC can provide a response or take further action.
    - Give a realistic timeframe for when they can expect a response. If the issue is urgent and needs to be escalated to management, let the client(s) know that someone from IRC will be in touch within the designated timeframe.
    - Inquire about the best way to communicate your response on this particular issue. Consider what options IRC has available for closing the loop with clients, and do not promise any special treatment that you cannot follow through with.

Tips on how to communicate to a colleague the negative feedback you have heard from a client

Even if the negative feedback is not about our specific area of work, it may still be uncomfortable to pass along negative feedback to another person or department when that feedback concerns their work. We don't want to cause offense to our colleagues and we might be concerned about how they will respond. However, if people are too uncomfortable to share negative feedback, important information that is contained in the negative feedback may never reach key decision-makers. The following tips provide some advice on how to pass-on negative feedback to others.

Review the sensitivity and urgency of the feedback

Does the feedback concern an allegation of a breach of the IRC Way? If so, follow IRC protocol to refer the feedback to the Ethics and Compliance Unit, and keep it confidential.

Does the feedback concern an individual's behaviour or actions? If so, refer it to their supervisor, or refer it to the Ethics and Compliance Unit if appropriate.

Does the feedback concern a programme? If so, follow the tips below for communicating the feedback to the relevant staff in the programme.

Identify who to communicate the feedback to

Identify who is able to deal with the feedback: this could be the Client-Responsiveness focal person within your programme (if there is one) or another person with sufficient decision-making authority to be able to take on the feedback and the responsibility to appropriately handle it.

Ideally, your office would have already developed Internal Referral pathways that can help you make these decisions.

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Identify when to communicate the feedback

While it may be tempting to unburden yourself of complaints after a long day in the field, sharing negative feedback in the last 10 minutes before the office closes may not be very productive way of communicating. Consider when would be an appropriate time to share the feedback. Options include:

- Setting up a work meeting with relevant colleague(s) to discuss the feedback and next steps;
- Inviting colleague(s) for an informal lunch meeting to discuss feedback and next steps; or,
- Asking for time to share the issues at the next team meeting or directly with relevant team.

Communicate the feedback

When you are trying to present the negative feedback, try to depersonalise it. When people take negative feedback personally, they can get defensive and lose sight of the valuable information that negative feedback contains. Here are some tips on how to make the sharing of negative feedback constructive and action-oriented, instead of personal:

- Make notes of what you want to share before you communicate it with colleagues. If your team uses special templates for documenting observations, use it for your key points. Focus on the facts if these are known, and share a summary of clients' concerns;
- Discuss the implications of this feedback to the IRC country team as a whole and for specific programme teams.
- Discuss the suggestions and potential solutions that clients may have offered. Share your own options for resolving the issue. Brainstorm ideas from colleagues;
- Determine action steps required and assign responsibility for follow-through. Ensure that your colleagues know how to best communicate the response back to clients and by when.

Tips on how to address negative feedback

It's not enough to hear negative feedback; as a team, we should be prepared to act on it. Here are several things to consider when thinking about how to actually address negative feedback. When people express dissatisfaction with our services, it can translate into one of three situations:

There is something wrong that is in our control to fix: This is the best-case scenario, in which we get feedback about a problem that we have the resources, capacity, and authority to fix. This could be something as simple as providing shade for a distribution line or holding meetings at a more accessible location. This an important form of quality control, and the practice of responding to this kind of feedback (ideally by actually fixing the issue at hand) can help build trust in IRC and a sense of agency in the affected communities.

There is something "wrong" that we shouldn't fix: Crisis-affected populations are not homogenous groups. We may be getting complaints from a group with relative privilege that is upset about resources being prioritised for a more vulnerable group. This doesn't mean that we have to change how resources are being allocated, but it does alert us to certain resentments and divisions developing in the community.

We need to be aware of these dynamics and work to address those criticisms through transparent communication, or they may escalate into an active conflict between groups of affected peoples, or between you and the population you are trying to serve.

There is something wrong that is not in our control to fix: Often, feedback will relate to programmes that go beyond our mandate, our resources, our technical expertise, or our operational constraints. This can be the most frustrating kind of feedback to receive.

However, just because we cannot fix the problem, we are still responsible for responding to this feedback. We can work on practicing active listening, validating their experiences and frustrations, and communicating honestly but compassionately about the limits of our power or capacity. In an ideal situation, we can take these complaints and refer them to relevant institutions that have the capacity and authority to address them.

We can also share the trends in such complaints as part of our advocacy with humanitarian peers to improve our collective efforts. However, even when referrals are not possible, it's important that we continue to show up and listen, even when we don't have answers that these communities may want to hear. It's the most human thing to do.

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Tips on communicating a negative response back to clients

We all know the importance of "closing the loop" and telling clients what happened to the feedback they gave us. Unfortunately, we cannot always tell our clients what they want to hear. This is often because what the client wants changed is beyond our control, or because there aren't enough resources (whether financial, human, or material) to accomplish that change. Sometimes it is because the requested change goes against our policies or ethics. Regardless of the reason, it can be uncomfortable to communicate an answer to someone when you know it may disappoint or frustrate them. It can also be challenging to communicate a negative response in a way that is respectful and lets the client know we still want to hear from them.

Avoid invalidating the person's feedback

- If someone has provided feedback, even if that feedback isn't very actionable or helpful, we need to express our gratitude that they invested the time, energy, and trust to provide feedback in the first place. Start off every conversation thanking them for having given the feedback.
- Do not dismiss the person's feedback by telling them the feedback was unrealistic or impractical. It takes years of experience to become an expert in the structure of humanitarian assistance, and it isn't fair to assume that our clients know the extent of our mandate and capabilities.
- During the conversation, validate their position by saying something along the lines of "I appreciate the situation you are describing" or "Our team understands that this must be very challenging."

Use this moment to inform and explain

- The relationship between the IRC and our clients is like every relationship: both parties need to get to know each other better. Giving negative responses to feedback presents an important opportunity to educate our clients about how the humanitarian system works and what limitations an organisation like the IRC faces. If our clients have taken the time to educate us about their realities and challenges, then we owe them the same time and care.
- Be as open as possible about the challenges that your team faces. This can be difficult in situations with conflict and political tension (i.e. if the government is blocking a certain kind of aid for political reasons, it may not be helpful if people hear that you are blaming the government for something). But the more transparent you can be, the more our clients will understand the constraints we face and the choices we make.
- While you are trying to inform our clients about our challenges, do not be condescending or use a lot of jargon. Communicate in a way that is culturally appropriate and respectful.

Leave space for clients to be disappointed

- Be prepared for an emotional response. People may be providing feedback about issues very dear to them (their children's access to healthcare or education, for example), and a disappointing answer from the IRC can cause discouragement, sadness, frustration, and / or anger. People have the right to get upset. Part of our job as humanitarians is to bear witness to injustice, and we should be able to create space for our clients to express themselves, even if it makes us uncomfortable.
- If people do get upset, do not take it personally. If you feel yourself getting defensive or upset in return, take a moment to remind yourself that you are only the messenger.

Keep the door open

- It is important that a negative response to client feedback is not the end of the discussion, but rather the beginning of one. While we recognise that the experience of receiving a negative response to feedback may be disappointing, we do not want our clients to be discouraged from giving us future feedback.
- Before ending the conversation, remind the clients that the door is still open and that the IRC still wants to hear their thoughts, opinions, and ideas.

Additional Resources

1. DA/WHS (2015). Guidance on Engaging People in Crisis Affected Communities to #Reshape Aid
2. Douglas Stone, Patton B, Heen, S. (2010). Difficult Conversations: How to Discuss What Matters Most. Penguin Books.
3. Douglas Stone, Heen, S. (2015) Thanks for the Feedback: The Science and Art of Receiving Feedback Well. Penguin Books.

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13.4 Appendix 4: Safety and ethical considerations for sensitive complaints

Sensitive complaints should NEVER be recorded in general feedback logbooks. These types of reports, because of their nature, can present significant safety concerns for those reporting and for survivors involved (particularly if the survivor is not reporting directly). The following considerations represent the minimum needed to ensure that we are ethically and safely responding to these complaints.

Sexual Exploitation and Abuse/Sexual Harassment:

Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH) and other forms of abuse (including corruption, human right violations, etc) by IRC staff and partners. The Ethics Point page on Rescuenet goes through detailed practices in how to report complaints of exploitation and abuse perpetrated by IRC staff or partners. Teams should review this and reach out to Gender Equality/ ECU Advisors for more guidance if needed.

While not exhaustive, the following general considerations and practices should be followed:

- Do ensure team members understand community based, interagency, or IRC feedback mechanisms for reporting SEA/SH and other form of abuse and how to use them
- Do set up an accessible community-based mechanism for clients to report suspected cases of SEA/SH and other types of abuse and ensure they are reported to ECU. Recording those cases should be done separately from other type of feedback/ complaints received from clients. Reporting mechanisms should be accessible to all populations[1].
- Do have referral mechanisms in place to respond to the needs of survivors. Do consult a WPE Technical Advisor or Technical Coordinator when setting up these referral mechanisms. At minimum, ensure that third-party reports of SEA/SH/GBV are referred the WPE Technical Coordinator or GBV Sub-Cluster (where WPE is not present). These focal points will make a determi nation on if and when they can safely follow up with the survivor.
- Any staff member can also report to ECU. If a staff member reports to a supervisor, the supervisor should report to ECU.
- Do ensure team members know that they can report a complaint against a staff member/ IRC partner WITHOUT including victim/ survivor information. Do offer victims/ survivors the option to report anonymously.
- Do ensure team members understand they should never include victim/ survivor information in a SEA/SH or other types of sensitive complaint without the express informed consent of the survivor. This includes any identifying information.

Gender Based Violence:

Gender Based Violence[2] (not involving an IRC staff or partner as either perpetrator or victim/survivor). The IASC GBV Guidelines (2015) GBV Pocket Guide can be useful for staff to quickly reference best practices. More information can also be found on IRC's GBV responders website. Teams should review this and reach out to WPE Technical Advisors for more guidance if needed.

While not exhaustive, the following general considerations and practices should be followed:

GBV DO NOT's:

Do NOT share survivor information with anyone if the survivor does not consent to have information shared. This includes immediate supervisors.

Note: the only exception is in situations where the survivor is in imminent danger of losing her life and/or is under the age of 18.

Do NOT assume you know what someone wants or needs. Do NOT take any action without the expressed consent of the survivor.

Do NOT Ask about direct experiences of GBV through any type of feedback mechanism

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GBV DO's:

• Do be prepared by ensuring your team is aware of referral mechanisms and how to make safe referrals in your context by consulting with IRC WPE staff or the GBV sub-cluster.

• Do respond with a healing statement "thank you for sharing this with me" "you are brave to tell me this" "I am so sorry this has happened to you"

• Do offer information about available services and ask the survivor if she would like to be referred.

• Do ask how you can support with any basic urgent needs first.

• Do be honest about what you know and do not know with survivors.

• Do end the conversation supportively.

If a survivor (or a secondary source) reports a specific incident of GBV through proactive feedback channels:

• Do treat any information shared with confidentiality. If you need advice, guidance or support on working with a survivor, ask the survivor's permission to talk to a WPE or GBV specialist or colleague. Do so without revealing personal identifiers

• Do provide practical support like offering water, moving to a private place (if in a group setting or public area).

• Do respect the right of a survivor to make their own decisions. And DO share information on all services that may be available.

• Do ask for permission from the survivor before taking any action.

• Do ensure that information is private, i.e. if on a radio call-in, immediately take the call off-air.

DO NOT:

• Do NOT record any information regarding a GBV incident, including survivor's information in feedback logbook

If a survivor (or secondary source) reports a specific incident of GBV through reactive feedback channels:

• Do have a set plan to safely refer incidents of GBV. Do go through the WPE team or your GBV Sub-cluster.

• Do ensure teams members responsible for collecting information through reactive channels have completed a GBV Core Concepts or referral pathway training and know how to make safe, confidential referrals.

• Do treat any information shared with Confidentiality. Do NOT record any GBV incident in a complaint tracker or feedback logbook.

• Do make a referral to WPE team or GBV Sub-Cluster to ensure information is recorded in GBV IMS (Unless the survivor has indicated that this information cannot be shared with others)

DO NOT:

• Do NOT attempt to contact a survivor or follow up unless survivor has given express consent to do so.

• Do NOT record any information regarding a GBV incident, including survivor's information in feedback logbooks.

Other Sensitive Complaints:

Sensitive complaints also involve allegations of fraud, corruption, and abuse of power. Consider the following Do's and Don'ts for other type of sensitive complaints: allegations of fraud, corruption and other forms of abuse of power (not involving an IRC staff/ partner as perpetrator or victim/survivor)

• Do treat this information with confidentiality

• Do record this feedback separately from other (non-sensitive) client feedback

• Do not record or share the name/ identity of the victim

• Do inform the relevant member of the senior management team depending on the nature of the feedback and defined referral pathways

• Do understand that management may decide to request an investigation that may require external expertise and/or the involvement of the police and Judiciary

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Data Management and Protection:

General Data Protection is paramount for all sensitive complaints. In order to ensure proper data management, storage, and protection, teams must consider the following:

- Do ask staff to identify security risks specific to their context and to explicitly think through the possible implications for clients, their families and communities, and for the organization, if data gets into the wrong hands. All staff in contact with the data have a strong understanding of the sensitive nature of the data, the importance of data confidentiality and security.
- Do ensure that anytime individual level data is collected, especially in combination with any identifying information (names, registration ID, other unique IDs, fingerprints, contact information, etc.), it triggers an **informed consent for information sharing process** and documentation.
- Do ensure clients and/or their caregivers are giving their informed consent for the agency/agencies to gather and store their data before any information is recorded.
- Do ensure that staff are aware that when obtaining informed consent, clients may highlight particular information that they do not want shared with certain people, and that this must be recorded and respected.
- Do keep signed paper consent forms in a locked filing cabinet.
- Do ensure that information is not being passed to a third party without the informed consent of clients and/or their caregivers.
- Do have all staff working with data sign the data protection checklist/agreement as part of their hiring process. Review this agreement at regular intervals with staff.

Paper/Files Security:

- Do ensure paper files are being kept in a locked cabinet / drawer, accessible only to responsible individuals specified by the Site Manager. No one else should be given independent access to the paper files without permission.
- Do keep rooms containing paper and electronic information locked securely when the staff leave the room. Do ensure all staff are aware of the importance of being vigilant as to who is entering the room where they work and for what purpose.

DO NOT:

- Do NOT record names on the outside of paper files if information is stored in files according to the individual report.

Electronic Data Security:

- Do ensure all computers being used for data storage are password protected.
- Do ensure all applicable staff are aware that information should be transferred by encrypted and password-protected files whether this is by internet or memory sticks.
- Do ensure at least two backups exist – one stored in the location of the database and backed up each day data is entered, and the second sent for secure storage in a designated off-site location

Other Resources:

Relevant International Standards

- WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies http://apps.who.int/iris/bitstream/han dle/10665/43709/9789241595681_eng.pdf;jsession-id=DBBB51DB45374BED971379997F47CBB0?sequence=1
- 510 Initiative on Data Responsibility www.510.global/wp-content/upload…_V.2_PUBLIC-1.pdf
- Information Sharing Package (you can pull elements from this for guidance on how to share information) http://www.gbvims.com/wp/wp-content/uploads/ISP-Package-August-2014.pdf

Data Protection Podcasts:

- **What is our responsibility when it comes to data?** Data protection is more often the topic of discussion of late. But what about data responsibility? This goes beyond compliance or legal frameworks. What are the necessary ethical considerations when it comes to managing GBV survivor data? We dig into that question in this episode and talk about the Netherlands Red Cross new 510 Data Responsibility Policy www.510.global/wp-content/upload…_V.2_PUBLIC-1.pdf
- **What's so dangerous about email?** What's the problem with emails? In our setting as it relates to survivor data protection, the problem is we spend all this time talking about protecting survivor data and confidentiality, safe data management, safe data storage – all for nothing when we then send emails with identifying information about survivors in it.

13. Appendices

• **Data Protection Principles and Practices:** Data protection is the act of protecting personal information in how it is collected, stored, used, and shared. It is a crucial component of upholding our responsibility to survivors in ensuring their control of their data and protecting what data they have consented to be shared. In this episode, learn about the importance, when data is protected, and an overview of tools available.

13.5 Appendix 5: Sampling Case study Chilobwe static clinic, Zambia

You are the enumerator in Zambia. In Zambia there are 188 static sites, 2 mobile sites and 1 CBD site.
Using the standard sampling approach developed by MSI, the core research team tells you that you will use a cluster sampling approach for the static SDP sites and a census approach for mobile and CBD SDP sites.

This means that the total number of sites and interviews is as follows:

	No of sites where interviews will be conducted	**No of interviews**
Static	40	214
Mobile	2	107
CBD	1	107

You asked tasked with going to Chilobwe static clinic. You know that you need to interview 6 FP clients (214/40=5.3 ~6)
Your supervisor meets the facility manager who indicates that, on average, they see 8 FP clients a day. Since you will be there for 3 days, the total number of clients seen over the 3-day period will be 24 (8x3). Since 24 is greater than 6, this is considered a high-volume site.

Your supervisor calculates the sample size as follows:

- Multiplying the average number of FP clients, a day (8) by the number of fieldwork days at each SDP (3 days) = 24 (as discussed above)
- This number (24) is divided by the total number of clients you need to see at Chilobwe static facility (24/6=4).
- To account for non-response, 1 is subtracted from 4 so the sampling interval is 3.

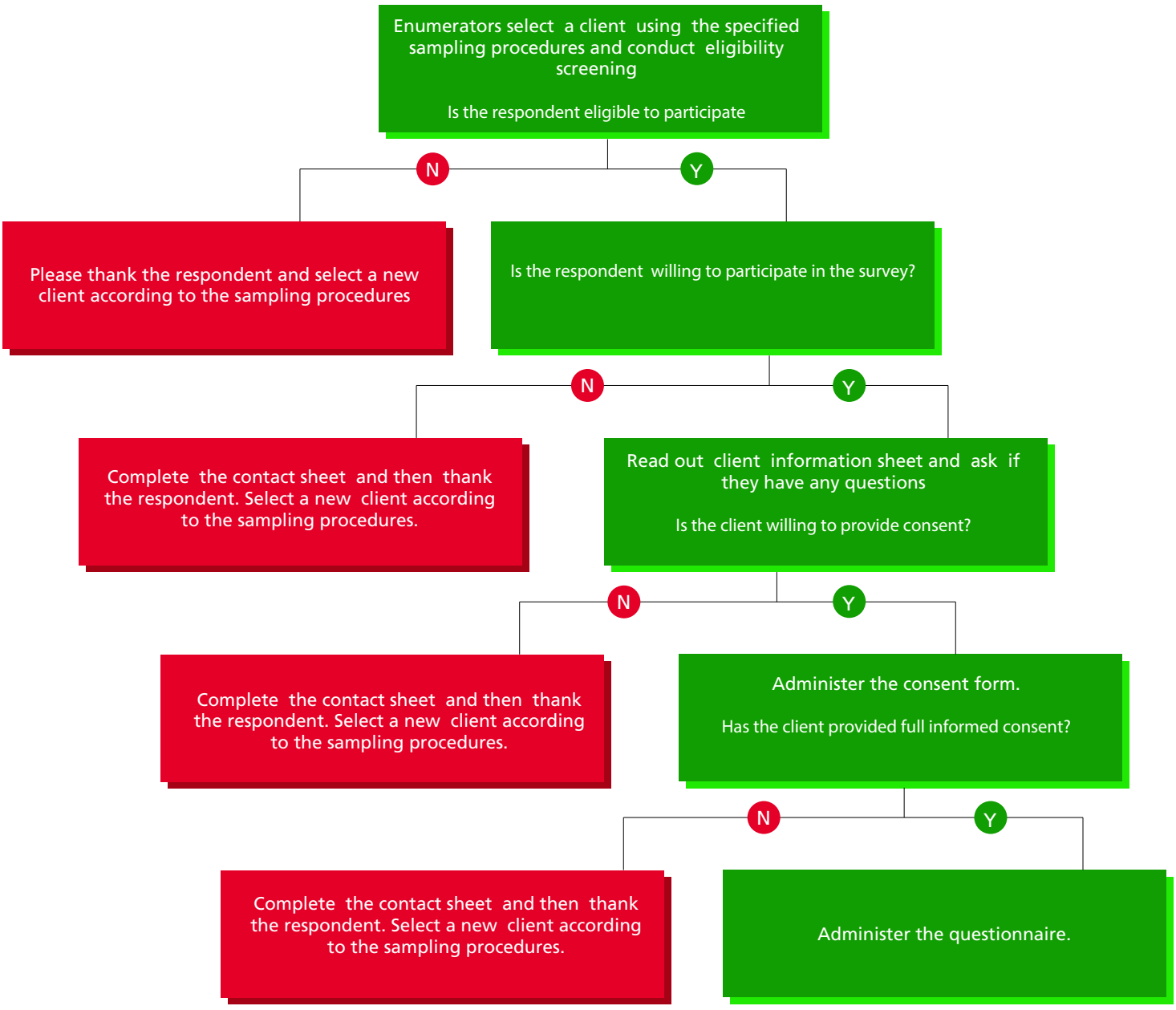
Take the first client referred to you and allocate them the number zero and count sequentially, interview every third client till you reach the desired sample size (6).

If the selected client is ineligible or refuses to participate then count that client as zero and count clients until you get to the third client.

13. Appendices

13.6 Appendix 6: Eligibility and consent process

You are the enumerator in Zambia. In Zambia there are 188 static sites, 2 mobile sites and 1 CBD site.
Using the standard sampling approach developed by MSI, the core research team tells you that you will use a cluster sampling approach for the static SDP sites and a census approach for mobile and CBD SDP sites.



13. Appendices

13.7 Appendix 7: Family planning methods

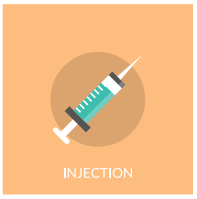
Short-acting contraception

CERVICAL CAP is a barrier method of contraception. It is made of rubber silicone, smaller than the diaphragm, and it covers the neck of the womb. At the start it needs to be fitted by a doctor or nurse. It must be inserted before intercourse, and must be left in the vagina for more than 48 hours.

CONTRACEPTIVE PATCH contains hormones estrogen and progestogen. It sticks to the skin and can be put on the stomach, thigh, buttocks or upper arm. It is transparent so this method is visible. The hormones are released continuously into the blood stream through the skin. You wear a new patch each week for three weeks followed by a week's break.

DIAPHRAGM is a barrier method of contraception. It is a dome-shaped circle made of rubber silicone that is inserted into the vagina to form a barrier between the sperm and the entrance of a woman's womb.

FEMALE CONDOM are sheaths, or linings that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film. Female condoms have flexible rings at both ends-one ring at the close end helps to insert the condom the other ring at the open end holds the part of the condom outside the vagina. The female condom works by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also helps keep infection on the penis or in the vagina from infecting the other partner.



INJECTABLE contains the hormone progestogen. It is given by a doctor or nurse once every 12 weeks

MALE CONDOM are sheathes, or coverings, that fit over a man's erect penis. Most male condoms are made of thin latex rubber. The male condom works by forming a barrier that keeps the sperm out of the vagina, preventing pregnancy. Also keeps infections in semen, on the penis or in the vagina from infecting the other partner.

ORAL CONTRACEPTIVES are hormonal preparations that may contain combinations of hormones estrogen and progestin or progestin alone.

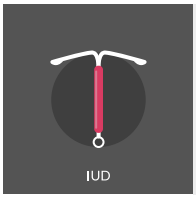
RING is a small flexible ring that contains the hormones estrogen and progestogen. It is inserted into the vagina by the woman and is kept in place for three weeks; it is then removed for a one week break. The following week a new vaginal ring is inserted.

SPERMICIDES are chemicals that you put deep inside your vagina right before sex. It prevents pregnancy in two ways: blocking the entrance to the cervix so the sperm can't get into your egg, and stopping the sperm from moving well enough to swim to your egg.

13. Appendices

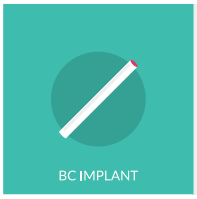
13.7 Appendix 7: Family planning methods

Long-acting contraception



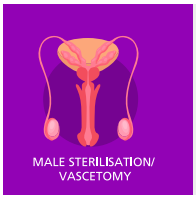
INTRA UTERINE DEVICE the intrauterine device or copper coil is a small soft device with a copper thread or copper cylinders inserted into the cavity of your womb by a trained doctor. It can be left in for 3-10 years, but it can be removed at any time. The device sits in your womb but does not rely on hormones. It is made of plastic and copper and works mainly by preventing sperm from surviving in your womb and reaching an egg.

Clients may call this "the loop"



IMPLANT the hormonal implant is a small soft plastic rod containing progestogen that is inserted in your upper arm with minor surgery carried out by a trained doctor the progestogen is released in tiny doses and the implant prevents pregnancy for three years.

Clients may use the trade name "Norplant"



MALE STERILISATION/VASECTOMY Is a surgical procedure to cut the ducts that carry sperm so that, while a man can still ejaculate, there is no sperm present. The operation which can be carried out under local anesthetic affects a man's fertility potential.

Clients may say they got "the snip"

FEMALE STERILIZATION/ BILATERAL TUBAL LIGATION is a permanent way of preventing pregnancy. It is a surgical procedure to cut or block the fallopian tubes (which carry the eggs from the ovary to the womb) so the sperm cannot meet the egg. This operation will affect your fertility potential (ability to get pregnant in future)

Clients may call this "having their tubes tied"

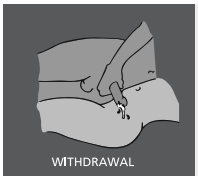
Emergency contraception

EMERGENCY CONTRACEPTION/POST COITAL CONTRACEPTION is a form of birth control that may be used by women after unprotected sexual intercourse or used of a failed birth control measure, to prevent pregnancy

Clients may call this "the morning after pill"

Fertility awareness based method

LACTATIONAL AMENORRHEA METHOD A temporary family planning method on the natural effect of breastfeeding on fertility. The LAM method requires 3 conditions. All 3 must be met: the mother's monthly bleeding has not returned, the baby is fully or nearly fully breastfed and is fed often, day and night and the baby is less than 6 months old.



WITHDRAWAL Just before ejaculation, the man withdraws his penis from his partner's vagina and ejaculates outside the vagina, keeping his semen away from her external genitalia.

Other family planning methods

FAMILY PLANNING COUNSELING is individualized medical advice and/or guidance given to clients to help them choose and use family planning methods that suit them.

13. Appendices

Published in October 2020 by the International Planned Parenthood Federation
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About IPPF The International Planned Parenthood Federation(IPPF) delivers sexual and reproductive health services that let people make their own choices. We fight for everyone to exercise their right to make those choices. We are local, through our members and volunteers, and global, through our network. We meet need, wherever it is, whoever requires it, for as long as they want it.

Published in February 2021

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