

Assessing the impact of scaling-up the Standard Days Method[®] in India, Peru, and Rwanda



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The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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The AWARENESS Project

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EXECUTIVE SUMMARY

This study was designed to assess the impact of integrating the Standard Days Method® (SDM) into existing services in India, Peru, and Rwanda. The method was introduced on a large scale and information was collected for two years through simulated clients, survey statistics, and household surveys in the intervention and control areas. Results of this study will help shape efforts to scale-up the SDM in various countries.

The SDM is a fertility awareness-based method of family planning that identifies days 8 to 19 of the menstrual cycle as the ‘fertile window’ – the days when unprotected intercourse is likely to result in pregnancy. To prevent pregnancy couples avoid unprotected intercourse during the 12-day fertile window. The method works best for women with cycles that usually range 26-32 days. The efficacy rates of the SDM are comparable to those of male condoms and better than those of other barrier methods. SDM introduction studies were conducted in several countries. They demonstrated that the method is easy to learn, teach, and use and is acceptable to providers and clients in many diverse settings. They also identified best practices for SDM service delivery.

The introduction studies integrated the SDM in a few health facilities in small geographical areas. They demonstrated the potential for incorporating the SDM into ongoing reproductive health and family planning services, but did not provide answers to a number of questions pertaining to scaling up SDM services. The next step in the development of the SDM was to fully integrate it into health and family planning services in a large geographic area, and assess the impact of integration on providers, clients, and the community.

The specific objectives of the study were to test the effect of SDM integration on provider behavior, client behavior and community perceptions, attitudes, and practices. The study spanned three years, beginning in the second half of 2004 and ending in early 2007. It was implemented in each country by local research organizations with supervision from the IRH local office and IRH-Washington.

The populations of the study sites in India, Peru, and Rwanda vary significantly in socio-demographic characteristics and contraceptive prevalence. In India the study took place in the Ranchi district of Jharkhand. Kanke and Ormanjhi blocks were selected as the intervention sites, Burmu as control. Study sites in Peru were in the San Martin district. Moyobamba was the intervention site and Jaén the control. In Rwanda the province of Byumba was selected for the intervention, and the province of Kibungo as the control.

The intervention was tailored to each country and involved integrating the SDM into existing public health and family planning services in all facilities in the intervention areas, so that it became one of the family planning options available to couples. Integration included advocating at the national, regional, and local level, making CycleBeads® available in all area facilities, training providers and supervisors to provide the SDM, monitoring and supervising services, and extensive information, education

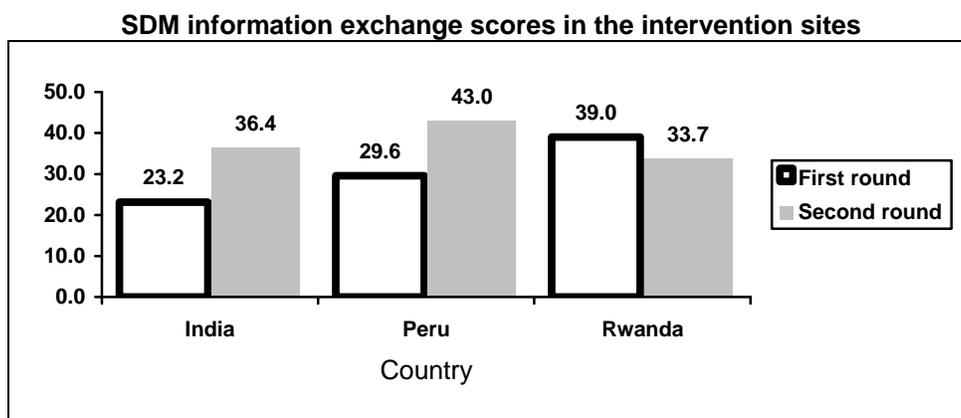
and communication (IEC) activities. In some areas the SDM was also made available in selected non-governmental organizations and private facilities.

Provider response

To test provider response to the integration of SDM into services we used the Service Test methodology. Trained simulated clients requested services, while providers believed they were attending real clients. Providers in both the intervention and control areas received a contraceptive technology update (CTU) on all family planning methods offered in the country. There were three rounds of simulated client visits. The first occurred 2-5 weeks after the CTU. Providers in the intervention areas were then trained in the SDM. This was followed by the second round of simulated client visits. Results from the second round were used to determine if any adjustments were needed to improve SDM service delivery. The final round of simulated client visits was administered following these adjustments.

Three client profiles were used in each country, each relating to the use of a specific family planning method: SDM and OC in all three countries, DMPA in Peru and Rwanda, and female sterilization in India. Each profile included background characteristics for a client that would lead a provider to offer that profile's method. After each clinic visit the simulated clients completed a check list, consisting of about 70 items, including items on interpersonal relations, diagnosis of the client's contraceptive needs, method options available to the client, contraindications the client may have to the contraceptive option, action mechanisms, advantages and disadvantages of the selected method, use instructions, and follow-up instructions. Each item on the checklist was coded 1 if observed, 0 otherwise. This coding system allowed us to calculate scores for the entire checklist or for sub-sets of items, and compare means between profiles and countries.

The following table shows information exchange scores (all items on the checklist other than interpersonal relations) from the second and third rounds of simulated clients in the intervention areas.



Large improvements were observed in India and Peru. These can be attributed to the adjustments in refresher training after the second round of simulated client visits. In

India the improvements may also be attributed to longer session lengths. In contrast, a decrement in information exchange was observed in Rwanda, where 16% of women seeking the SDM did not receive CycleBeads. These results suggest that when providers felt that the study was over they may have relaxed their quality of care standards. However, while provider scores in the final round of simulated clients were lower than their previous scores, they were still satisfactory.

As an indicator of providers' proficiency in offering the SDM, we examined the number of items that fewer than 50% of providers correctly addressed in the final round of simulated client visits. In India and Peru there were few such items (14 and 9 respectively); in Rwanda, however, 29 items were correctly addressed by less than 50% of providers, including nine items regarding follow up instructions. Therefore our results indicate that providers in India and Peru adequately informed their clients; providers in Rwanda were less successful.

We also used the checklists to determine if introducing the SDM improved or detracted from the quality of services for established methods. To do so we compared the overall simulated client scores from the first and third visits for the various profiles. In India, quality of care improved for both female sterilization and OC users in both the intervention and control areas. These improvements should be attributed to unknown sources, exogenous to our intervention. We conclude that integrating the SDM into services did not weaken the quality of care for established methods. Different trends were observed in Peru, where the control area experienced a slight but systematic decline in quality of provision of DMPA and OC counseling, while the intervention area had marked improvements. We can hypothesize that changes in provider's attitudes as a result of the intervention indirectly affected the quality of services in general, not just SDM services. In Rwanda, on the other hand, quality of service for OC declined in both the intervention and control areas; quality of services of DMPA declined in the intervention area, but remained the same in the control area. This suggests that SDM integration may have negatively affected the quality of DMPA care, but the specific mechanisms of this influence are not clear.

Client response – service statistics

Client response to the introduction of the SDM was assessed at the clinic level as it was reflected in the clinics' service statistics. The mechanism for collecting accurate service statistics was improved in all participating facilities before or during the CTU. Both intervention and control areas were included in all three countries. Services statistics were collected monthly starting three months before the first provider SDM training in each country, and continuing for 18 additional months. The study focused on new family planning users.

The number of new SDM users in India grew continually throughout the study period, especially in the last six months of data collection when community workers were trained. Peru also exhibited a continual growth in the number of SDM users for the duration of the study. Rwanda presented a different picture. The number of new SDM

users spiked in the second quarter of SDM services, then lowered somewhat and leveled off.

We also measured the overall number of new contraceptive users (regardless of chosen method). In India the number of new users increased in both the control and intervention areas. However it more than doubled in the intervention areas, and increased by a smaller margin in the control area. In Peru, the number of new contraceptive users decreased in the control area, and increased in the intervention area. This suggests that the SDM intervention stopped a declining trend. However, the amount of the difference between the changes in intervention and control areas cannot be accounted for by the presence of the new method alone. Other aspects of the intervention may have had an important role in these changes. In Rwanda the number of new users of all methods increased in both the control and intervention areas. We can conclude that the integration of services into services in Rwanda did not adversely affect the number of new users of other methods.

Of interest is whether new SDM users switched from another method, and if so, which one. In India, over 85% of new SDM users had never used a family planning method (not even a traditional method). In Peru, some SDM clients switched from rhythm, Billings Ovulation Method, or Lactation Amenorrhea, and a few switched from other modern methods; however, most (56%) had used nothing in the two months preceding their SDM use. In Rwanda, over 90% of new SDM clients had not been using another method in the two preceding months.

Client response – community survey

This component of the study involved household community surveys before the intervention began and two years later. A somewhat different research design was undertaken in each country. In Peru baseline and endline surveys were conducted two years apart, in both the intervention and the control areas. In India there were two endline surveys, the first two years after the baseline, the second nine months later. In Rwanda we only undertook the survey at endline (two years after the intervention began), and only in the intervention area. In total, we interviewed 11,184: 2019 men and 4716 women in India; 2255 women and 1578 men in Peru; 405 women and 211 men in Rwanda.

Considering the fact that the SDM had never been offered or promoted in the intervention areas in India and Peru until just two years before the endline surveys, a significant number of respondents had heard of the method, as shown in the following table. The fact that the SDM had already been introduced in sections of Rwanda prior to this study may explain the higher percentage of respondents who had heard of it.

Percent of respondents who had heard of the SDM in the intervention areas (endline)

	India			Peru		Rwanda	
	Female		Male n=692	Female n=629	Male n=524	Female N=405	Male n=211
	Endline-1 n=1165	Endline-2 n=1202					
Spontaneous	15.3	4.4	6.9	35.5	23.9	65.4	38.4
Probed	43.9	36.8	31.5	27.7	15.0	25.2	30.8
Total	59.2	41.2	38.4	63.2	38.9	90.3	69.2

Respondents who had heard of the SDM were asked a series of questions to determine their understanding of the method. Results suggest that while a significant proportion of participants had heard of the SDM, they did not always know what it is or understand how it is used. Respondents in Peru had lower scores than respondents in India and Rwanda. The following tables show the percent of respondents who had ever used the method and who were using the SDM at the time of the survey (intervention areas endline).

Percent SDM use (endline, intervention)

Score	India			Peru		Rwanda	
	Female		Male n=634	Female n=629	Male 564	Female n=405	Male n=211
	endline-1 n=1169	endline-2 n=1202					
Ever used the SDM	6.1	3.9	7.9	5.2	5.6	5.1	3.3
Currently using the SDM	5.0	1.2	4.7	3.8	4.1	0.5	2.4

In all three countries, most respondents who had heard of the methods thought highly of it – they had a score of 7 or higher on an acceptability scale ranging from 0 to 13. Some 40% of respondents had a score of 10 or higher. In Peru and Rwanda male respondents had a more favorable opinion of the method than female respondents. When asked directly if they liked the method, most respondents who had ever used the method responded positively (88.1% of women and 81.2% of men in India, over 97% of women and men in India, data are not available for Rwanda).

In India and Peru, where we had baseline information, we tested the difference in contraceptive prevalence before and after SDM introduction. In India there was a statistically significant increase in the prevalence of modern contraception in the intervention area, but not in the control area. Therefore our results for India support the hypothesis that the prevalence of family planning will significantly increase at the community level as a result of SDM integration. In Peru there was a significant increase in modern contraceptive prevalence in both the intervention and the control areas. We cannot assert that the increase is a result of our intervention. However, we can state that contraceptive prevalence in Peru did not decrease as a result of our efforts.

Conclusion

The results of this study have multiple implications for scaling up the SDM. Results address several issues that are often raised by policy makers and other stake holders. Study sites varied, yet common trends were observed. Demand for the method was high in all three countries, and it is clear that integrating the method did not adversely affect demand for and service delivery of other contraceptive methods. Lessons learned will help guide future scale up efforts.

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ACRONYMS

ACMO	Assistant Chief Medical Officer
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
BCC	Behavior Change Communication
CEDPA	Centre for Development and Population Activities
CHD	Community Health Distributor
CHW	Community Health Worker
CIEDEP	Centre Ingamba pour les Etudes socio-démographiques et le Développement de la Population
CMO	Chief Medical Officer
CTU	Contraceptive Technology Update
DHS	Demographic and Health Survey
GOI	Government of India
ISR	Instituto de Salude Reproductiva
IRH	Institute for Reproductive Health
DMPA	depot medroxy-progesterone acetate (Depo-Provera)
FOGSI	Federation of Obstetrics & Gynaecological Societies of India
HLFPPT	Hindustan Latex Family Planning Promotion Trust
IEC	Information, Education, and Communication
ISMP	Indian System of Medicine practitioner
IUD	Intrauterine Device
KGVK	Krishi Gram Vikas Kendra (an Indian NGO)
KIT	Knowledge Improvement Tool
LAM	Lactational Amenorrhea Method
LHV	Lady Health Worker
MHW	Male Health Worker
MIS	Management Information System
MO	Medical Officer
MOH	Ministry of Health
MWRA	Married Women of Reproductive Age
NFHS	National Family Health Survey
NGO	Non-governmental Organization
OC	Oral Contraceptive Pill
PHC	Primary Health Center (in India)
PSI	Population Services International
RMP	Rural Medical Practitioner
SDM	Standard Days Method [®]
SHG	Self-Help Group
STI	Sexually Transmitted Infection
TOT	Training of Trainers
UN	United Nations

1. INTRODUCTION

This study was designed to assess the impact of integrating the Standard Days Method[®] (SDM) into existing services in India, Peru, and Rwanda. The SDM is a fertility awareness-based method of family planning developed and tested by the Institute for Reproductive Health at Georgetown University (IRH). The method identifies days 8 to 19 of the menstrual cycle (inclusive) as the “fertile window” – the days when unprotected intercourse is likely to result in pregnancy. To prevent pregnancy, the couple avoids unprotected intercourse during the 12-day fertile window. The method works best for women with cycles that usually range 26-32 days¹. Most SDM users find CycleBeads[®] – a color-coded string of beads representing the menstrual cycle – helpful in tracking their cycles.

The study had four major components: the **intervention**, in which the SDM was integrated fully into services in intervention areas in the three countries; a **Service Test** consisting of simulated client visits to participating clinics; **service statistics**; and a **community survey**. All study components were approved by the Georgetown University Institutional Review Board.

1.1 Background

In an efficacy trial, 478 women from five sites in Bolivia, Peru, and the Philippines were followed for up to 13 cycles of method use. Study participants received a single counseling session. Women who had two cycles outside the 26-32 day range were counseled to switch to another method and exited from the study. There were 43 pregnancies, of which 28 were related to self-reported incorrect use of the method (having intercourse on days 8-19). The failure rate was 4.8 with abstinence on the fertile days², with a typical-use failure rate of 12. This is comparable to the efficacy of other user-directed family planning method.

SDM introduction studies were conducted in the Philippines, India, Bolivia, Peru, El Salvador, Honduras, Guatemala, Ecuador, Rwanda, and Benin. They demonstrated that providers can be trained in three to ten hours, depending on their educational level, as well as their experience and competency in family planning counseling. Most clients can learn the method in a single visit – usually less than 30 minutes.

Between 30 and 431 users were recruited into each of the introduction studies. A total of approximately 1,600 users were followed in 14 programs in the nine countries. In El Salvador, where 50% of women in union use family planning, results from a community survey suggest that about 4% of women were using the SDM one year after introducing the method. After one year of introduction, family planning agencies and Ministries of Health around the world reported that the SDM represented between 2%-7% of new

¹ Arévalo M, Jennings V, Sinai I. A fixed formula to define the fertile window of the menstrual cycle as the basis of a simple method of natural family planning. *Contraception*, 1999; 60: 357-360.

² Arévalo M, Jennings V, Sinai I. Efficacy of a new method of family planning: the Standard Days Method. *Contraception*, 2002; 65: 333-338.

family planning users. In Rwanda, where contraceptive prevalence is less than 5%, service statistics show that SDM users accounted for about 20% of all the new users of modern family planning methods at the research sites.

The method attracted men and women who had never before used family planning. For example, almost 60% of method acceptors in rural India reported that they were new to family planning. Other users had been previously using fertility awareness-based methods incorrectly. Women who had discontinued hormonal and other methods due to side effects were also attracted to the SDM. The percentage of SDM users with no previous family planning experience was 60% at CEMOPLAF (Ecuador), 50% at ASHONPLAFA (Honduras), 88% at the Peru Ministry of Health (MOH), and 62% at OSV (Benin)³.

1.2 Objectives, research questions and hypotheses

These introduction studies integrated the SDM in small geographical areas, in few health facilities. They demonstrated the potential for incorporating the SDM into ongoing reproductive health and family planning services, but did not provide answers to a number of questions pertaining to scaling up SDM services. The next step in the development of the SDM was to fully integrate it into health and family planning services in a large geographic area, and assess the impact of the integration from the program, the provider, and the user perspective.

The purpose of the study was to test the effects of scaling-up interventions to integrate the SDM into service delivery systems and make communities aware of it as a family planning option. The specific objectives of the study were:

Objective 1: *Test the effects on provider behavior of scaling-up SDM in service delivery systems.*

Objective 2: *Test the effects on client behavior of scaling-up SDM in service delivery systems.*

Objective 3: *Test the effects on community perceptions, attitudes, and behaviors of expanding SDM as a family planning option in targeted communities.*

Provider response (Objective 1)

The research questions regarding the response of providers to SDM integration were:

- **Will providers adequately offer the SDM under typical service delivery circumstances?** That is, will they present the SDM with enough detail to attract users and will they offer acceptors all the information needed to use the method effectively? The introduction studies have shown adequate provider management of SDM when they are under observation, i.e., under atypical circumstances. Yet, it has been shown that providers in general (not SDM providers in particular) return

³ Gribble J, Lundgren R, Velasquez C, Anastasi E. Being strategic about contraceptive introduction: the experience of the Standard Days Method®. *Contraception*. 2008; 77(3): 147-154.

to lower levels of quality of care when they are no longer observed^{4,5,6}. This study tests this assertion in the case of the SDM.

- ***Will providers neutrally present the SDM along with established family planning methods as they counsel clients?*** This is an important issue, because SDM might simplify other family planning methods if providers have a positive bias, and use of SDM may be very low if providers have a negative bias. The introduction studies focused on provider management of the SDM with a research approach that was non-comparative. The need remains to show that providers will present SDM to clients in an unbiased manner.

Client response (Objectives 2 & 3)

The research questions regarding the response of men and women in the community to the introduction of the SDM were:

- ***Will awareness of the SDM as a family planning option increase among married women of reproductive age (MWRA)?*** Word-of-mouth from satisfied users as well as focused information, education, and communication (IEC) efforts in the communities can be expected to increase awareness and use of the method among MWRA in the community at large.
- ***Will MWRA have positive attitudes toward the SDM?*** Awareness will not lead to acceptance if women perceive the method as ineffective or difficult to use and/or their partners are reluctant to use it.
- ***How many MOH clients will accept the SDM compared to established methods?*** This is an obvious criterion to evaluate client response to new contraceptive introduction. For example, Tu et al. (1999) compared acceptance of Norplant[®] and the Copper T intrauterine device (IUD), methods that were new to rural China, with acceptance of sterilization. The relative-popularity criterion is of central importance because it expresses the method's ability to respond to clients' perceived needs.
- ***Will the prevalence of SDM use significantly increase at the community level?*** The assumption is that the intervention's effect will transcend the MOH's service statistics and be reflected also at the community level.
- ***Will SDM introduction result in increased overall family planning use in MOH facilities?*** The introduction of Norplant suggested that a method may successfully

⁴ Miller RA, Ndhlovu L, Gachara MM, Fisher A. The situation analysis study of the family planning program in Kenya, *Studies in Family Planning*. 1991; 22,3:131-143.

⁵ Ndhlovu L. Quality in the context of Kenya's integrated reproductive health services, dissertation, University of London, London, 1999.

⁶ León FR, Espinoza V, Espinoza A, Meza B, Expectancy of being observed and quality of care offered. *Paper prepared for presentation at the 131st Meeting of the American Public Health Association, Session 4301.0*. San Francisco: November 17, 2003a.

attract new users, yet fail to increase overall family planning use. Studies that explored prior contraceptive use revealed that an overwhelming majority of new Norplant users had shifted from other family planning methods^{7,8}, i.e., the new method did not seem to significantly add to the protection already provided by existing methods. The Norplant studies did not establish the extent to which the new method added to, or substituted for, already existing protection. Yet, this is an issue of importance to the India, Peru, and Rwanda MOHs given their concern with the unmet need for contraception⁹. More than 100 million women in less developed countries, or about 17% of all married women have this unmet need¹⁰. By widening contraceptive choice, new methods are expected to reduce unmet need¹¹. It has been reported that addition of a method into a delivery system yields a net increase in contraceptive prevalence^{12,13} and that contraceptive prevalence depends upon the number of methods made available through multiple outlets in a country¹⁴. One of the goals of this study, then, was to assess the extent to which SDM introduction made a contribution to overall family planning demand, that is, the extent to which the global number of new users of methods increased by the SDM's introduction. The pilot studies showed that SDM was attracting people who previously had not used family planning. If this is replicated when the method is scaled-up, an increase in the total number of family planning users at the facilities can be expected.

- ***Will the prevalence of family planning among MWRA significantly increase at the community level?*** Again, the assumption is that the effects of the intervention will go beyond MOH clinics to the community at large.
- ***Will SDM users be new to family planning, or will they shift from established methods?*** Method shifting can be regarded as a positive outcome on three grounds. First, it can be acknowledged as a client's right; second, since it satisfies a perceived client need, it may strengthen continuation of family planning method use; third, method shifting may entail substitution of a less effective family planning method by a more effective one. By adding the SDM into its method-mix, the Peru MOH expected to attract actual or potential users of the rhythm method, a practice defined by a vague rule rooted in oral tradition: abstain when you are in about the

⁷ Shaaban, M, Salah, M, Zarzour, A. A Prospective Study of NORPLANT® Implants and the TCu 380Ag IUD in Assiut, Egypt. *Studies in Family Planning* 1983; 14: 163-169.

⁸ Lubis, F, Prihartono, J, Agoestina, T, Affandi, B, Sutedi, H. One-Year Experience with NORPLANT Implants in Indonesia. *Studies in Family Planning* 1983; 14: 181-184.

⁹ Casterline, J and Sinding, S. Unmet Need for Family Planning in Developing Countries and Implications for Population Policy. *Population and Development Review* 2000; 26 (4), 691–723.

¹⁰ Ashford, L. Unmet Need for Family Planning: Recent Trends and Their Implications for Programs. Population Reference Bureau (Measure Project). 2003.

¹¹ Simmons, R, Hall P, Diaz J, Diaz M, Fajans P, Satia J. The strategic approach to contraceptive introduction. *Studies in Family Planning* 1997; 28: 79-94.

¹² Freedman, R, and Berelson, B. The Record of Family Planning Programs. *Studies in Family Planning* 1976; 7 (1): 1-40.

¹³ Phillips, JF, Simmons, R, Koenig, M, Chakraborty, J. Determinants of Reproductive Change in a Traditional Society: Evidence from Matlab, Bangladesh. *Studies in Family Planning* 1988; 19, 6: 313-334.

¹⁴ Jain, A. Fertility Reduction and the Quality of Family Planning Services. *Studies in Family Planning* 1989; 20, 1: 1-16.

middle of your menstrual cycle. This traditional method, the leading one in Peru, ahead of any modern method¹⁵, presents a high risk of pregnancy. Not only are there no precise indications for using it, but the crude rule actually employed by users is often erroneous¹⁶. By incorporating the SDM into its method-mix, the Peru MOH offered a scientifically-tested option that was expected to improve the ability of couples using rhythm to avoid unwanted pregnancies. Small minorities of women use rhythm in India and Rwanda. Method switching from less effective methods to the SDM was expected.

- ***Will MWRA enhance their knowledge of the fertility cycle?*** In Peru, only 62% of the women who are using periodic abstinence know that they are likely to get pregnant during the days around the mid-cycle. Data from a community survey in India suggested that knowledge increased from 20% to 66% after SDM integration. But that has not been tested in a large-scale introduction.
- ***Will adult men show awareness and positive attitudes toward SDM?*** Positive attitudes among men toward the SDM are fundamental to adoption of the method and contribute to correct use.

Study Hypotheses

The study hypotheses posited that, as a result of the intervention:

- Hypothesis 1:*** Providers will adequately inform the client about SDM in pre-assessment as well as post-choice phases of counseling.
- Hypothesis 2:*** Providers will neutrally present SDM along with established family planning methods in the choice phase of counseling.
- Hypothesis 3:*** Clients will choose SDM in proportions that are similar to or greater than those seen in SDM pilot studies.
- Hypothesis 4:*** The total number of family planning users will increase in service delivery systems.
- Hypothesis 5:*** MWRA will increase their awareness of SDM as a family planning option.
- Hypothesis 6:*** Adult men will show awareness of and positive attitudes toward SDM.
- Hypothesis 7:*** The prevalence of SDM use will significantly increase at the community level.
- Hypothesis 8:*** MWRA will develop positive attitudes toward SDM.
- Hypothesis 9:*** The prevalence of family planning will significantly increase at the community level.
- Hypothesis 10:*** MWRA will enhance their knowledge of the fertility cycle.

These hypotheses were tested through three data components: (1) Service Tests, (2) service statistics, and (3) community surveys.

¹⁵ Demographic and Health Survey, Peru, 2005.

¹⁶ IBID

1.3 Research Sites

The study was designed as an intervention replicated in three very different settings in India, Peru, and Rwanda. Table 1 presents relevant data for each country.

Table 1. Economic and social data for participating countries

	India	Peru	Rwanda
Population (millions)	1,130	29	10
Labor force in agriculture (%)	60	9	90
Per capita Gross Domestic Product (US\$)	3,452	6,093	1,206
Rank in UN Human Development Index	128	87	161
Life expectancy at birth (years)	63.7	70.7	45.2
Infant mortality (per 1,000 live births)	34.6	30.0	85.3
Birth rate (per 1,000 population)	22.0	20.1	40.2
Fertility rate (born per woman)	2.8	2.4	5.43
Prevalence of use of contraception			
Urban	64.0	74.8	31.6
Rural	53.0	62.7	15.2
Prevalence of use of modern methods			
Urban	55.8	54.1	21.2
Rural	45.3	33.2	8.6
Prevalence of use of periodic abstinence			
Urban	5.0	14.7	6.9
Rural	4.9	22.5	3.7

The prevalence data for Peru is from 2004; India and Rwanda 2005; all other data is estimated for 2007. Sources: CIA World Fact Book, UN Human Development Index, DHS surveys.

The most widely used contraceptive method in Peru is periodic abstinence (17.5) followed by depot medroxy-progesterone acetate (DMPA, or Depo-Provera[®]; 11.2). The most widely used method in India is female sterilization (37.8) followed by condoms (9.8). The most widely used method in Rwanda is DMPA (4.7) followed by periodic abstinence (4.2). Following is a more detailed description of the countries and the study sites.

India

India accounts for 16% of the world's population and 40% of its poor. Poverty, high population growth, gender inequality, low literacy and environmental deterioration are among its major problems. According to the NFHS-3, about half of MWRA currently use a contraceptive method¹⁷. Sterilization, however, accounts for more than 75% of

¹⁷ 2005-2006 National Family Health Survey, India.

prevalence. Spacing methods such as the condom, oral contraceptive pill (OC) and IUD are used by about 10% of women; traditional methods such as the rhythm/safe period method or withdrawal are used by about 8% of Indian women. At the same time, only 40% of the demand for spacing is being met. The unmet need for spacing is highest among young married women and women with one child.

The site selected for the study in India was the state of Jharkhand, which has a population of 27 million. Of these, 27% are tribal groups and 20% represent urban populations. Only 31 % of the MWRA in union use any modern method of family planning¹⁸. Integrating the SDM in Jharkhand was consistent with the government's vision of expanding options, promoting informed choice and involving men in family planning through community-based initiatives.

Three blocks in the Ranchi district of Jharkhand were selected for the study. Kanke and Ormanjhi were selected as the intervention sites; Burmu as control. The public health system in each of these blocks consists of sub-centers, which report to a primary health center (PHC). In each sub-center, one auxiliary nurse midwife (ANM) provides services to an average of three villages. In Ormanjhi, in addition to these public providers, a non-governmental organization (NGO), Krishi Gram Vikas Kendra (KGVK), offers family planning services in six sub-centers. Table 2 shows the number of villages and sub-centers in each of the selected blocks.

Table 2. Characteristics of the study sites in India

		Estimated 2005 population (1,000s)	Villages	Sub centers
Intervention	Kanke	124	104	34
	Ormanjhi	76	89	32
Control	Burmu	77	101	23

Peru

Of the three countries included in this study Peru has the highest contraceptive prevalence rate. Of the 70% of MWRA using contraceptives in Peru, 66% use a modern method and 33% a traditional method, mainly a form of periodic abstinence. Yet, only 62% of MWRA know that the likelihood of getting pregnant is at its peak by mid-menstrual cycle. The unmet need for family planning is higher among the poor (15%).

Peru provided two of the sites for the efficacy study of the SDM. IRH later introduced the SDM in the San Martín region, one of the 34 health directorates of the Peru MOH, in two provinces: Lamas and Tarapoto. Moyobamba, another province in the San Martín district, was the intervention site for this study. Three contiguous districts within the Moyabamba province (Moyobamba, Jepelacio, Soritor) were included. The Peru MOH operates 32 facilities in the intervention area, including health centers and health posts.

¹⁸ 2005-2006 National Family Health Survey, India.

In an attempt to find a comparable control group we chose three contiguous districts (Jaén, Bellavista, Santa Rosa) in the province of Jaén in the Cajamarca region as the control area. The Peru MOH operates 30 facilities in this area. Table 3 shows some characteristics of the intervention and control areas in Peru.

Table 3. Characteristics of the study sites in Peru

	Province	Estimated 2004 population (1,000s)	MOH facilities	Contraceptive prevalence	
				Modern	Traditional
Intervention	Moyobamba	87	35	57.5	12.1
Control	Jaén	112	32	41.1	21.1

The differences in contraceptive prevalence and method mix between San Martín and Cajamarca are partially explained by cultural differences. Populations living in the *sierra*, as is the case in large portions of Cajamarca, are more conservative than residents of the Amazonian basin. The Jaén-Bellavista-Santa Rosa districts, however, can be expected to be closer to the Moyobamba-Jepelacio-Soritor districts in terms of these indicators because they are more similar socio-culturally. Contraceptive prevalence data are unavailable at district level.

Rwanda

Prior to 1994, 13% of women in union were using a modern method of family planning. At the time of the 2004 Rwanda Demographic and Health Survey (DHS), however, modern methods were used by only 10.3% of women in union. Outside Kigali city, the percentage ranges from 8.4 in the south through 10.3 in the west. The country is mostly rural, and there were stark differences in the prevalence of modern methods between urban (21.2) and rural (8.6) areas. In addition, 7.1% of women were using some form of natural or traditional method of family planning, with 4.2% being some form of periodic abstinence. Yet, only 32.7% of the users knew that women are most likely to become pregnant in the middle of the menstrual cycle. Among non-users of periodic abstinence the percentage was only 12.7. Unmet need for family planning was estimated at 24.5% (20.5% urban, 25.1% rural).

In 2002 IRH introduced the SDM in 13 pilot sites in Rwanda, in partnership with the Rwanda MOH and the IntraHealth PRIME program. Two years later 15 more sites were added in seven of the country's 12 provinces. The northeastern province of Byumba, selected for the intervention in this study, includes two of the 13 pilot sites. The province of Kibungo was the control site. There are no significant ethnic, income, or religious differences between the two provinces. Table 4 shows some characteristics of these provinces.

Table 4. Characteristics of the study sites in Rwanda

	Province	Estimated 2005 population (1,000s)	MOH facilities	Contraceptive prevalence	
				Modern	Traditional
Intervention	Byumba	712	20	3.3	10.5
Control	Kibungo	708	19	5.3	11.1

2. THE INTERVENTION

The purpose of the intervention was to integrate the SDM into existing public health and family planning services in all facilities in the intervention areas, so that it becomes one of the family planning options available to couples. The intervention included advocacy to create a positive policy environment at all levels; making CycleBeads available in all area facilities; training of providers and supervisors in SDM counseling, monitoring and supervision; and extensive IEC activities. In some areas the SDM also became available in facilities operated by interested NGOs and private facilities and providers. Information was collected in each study site about the cost of the intervention. This information is attached as Appendix A.

The intervention was tailored to each country. The remainder of this section describes the intervention activities for each country in detail.

2.1 India

The SDM was integrated into the services and education provided by all of the organizations currently mandated to provide family planning in the two intervention blocks (Ormanjhi and Kanke) in Ranchi District, Jharkhand. NGO providers and private practitioners interested in offering the SDM were also trained to offer it.

Advocacy and sensitization

The intervention began with advocacy activities designed to raise awareness and generate support for the SDM among key stakeholders. During the first six months of the project, KGVK compiled a list of individuals and organizations that had the potential to provide the SDM or conduct awareness-raising activities, as well as other key stakeholders who needed to be informed of the project. These included NGOs, government officials, physicians, ANMs, community health workers (CHW), village health workers, community organizations, and private practitioners such as pharmacies, Indian Systems of Medicine practitioners (ISMPs) and rural medical practitioners (RMPs). While conducting this inventory, KGVK conducted in-depth interviews and focus groups with community and religious leaders and other gatekeepers to provide information to help guide the design of strategies and messages to raise awareness and acceptability of the SDM.

Sensitization meetings were held in Ranchi, the capital of Jharkhand, with NGOs, Government of India (GOI) officials and other stakeholders; and at the district and village level with village health committees, self-help groups, private practitioners, and pharmacies. To initiate collaboration with the MOH, meetings were held with the Health Secretary and other MOH officials. At these meetings, the purpose of the impact study and the scope of the collaboration with the MOH to integrate the SDM into existing contraceptive services were discussed. The Health Secretary approved the project, and a Steering Committee was formed, consisting of the Health Secretary and other MOH officials, and representatives from KGVK and the Centre for Development and Population Activities (CEDPA). The first Steering Committee meeting was held on

August 18, 2004, the day the project was launched formally. The committee met regularly for the duration of the project, and was responsible for reviewing progress; sharing results, concerns and obstacles, and deciding the future work plan.

This government approval allowed for the incorporation of the SDM into the management information and inventory systems of public facilities (the SDM was already included in KGVK service registers). Inventory forms to keep track of CycleBeads distribution and other materials were also developed.

A series formal and informal meetings were held with various NGOs working in the intervention area. When it was recognized that these groups were concerned that offering the SDM would have a negative impact on their attempts to distribute OC and condoms, Research findings were shared to demonstrate that this was not the case. A meeting was convened in March 2005 with participants from CARE, Nav Bharat Jagriti Kendra, Population Services International (PSI), Hindustan Latex Family Planning Promotion Trust (HLFPPT), Holy Cross and Srijan Foundation. The purpose of the meeting was to share the intervention plan and progress to date, and explore the scope of collaboration with these stakeholders. Participants provided suggestions for involving various types of service providers such as RMPs, Anganwadi Workers (community health workers – AWWs) and Self-Help Groups (SHGs) for providing the SDM at the community level. Strategies for behavior change communication (BCC) activities were also discussed, including the use of street plays, posters, pamphlets, wall paintings, and slogan writing. The NGOs showed interest in collaboration for integrating the SDM into the services offered by their community level providers, and the SDM was then added to the service registers of participating organizations.

Professional organizations of physicians and health workers were also involved. All Chief Medical Officers (CMOs) and Assistant Chief Medical Officers (ACMOs) from Jharkhand received an SDM orientation during their monthly meeting at the state headquarters in January 2006, and again in July of that year. As a result, many medical officers at the district level had shown interest in offering the method. In addition there was a meeting in February 2006 with members of the Ranchi chapter of the Federation of Obstetrics & Gynaecological Societies of India (FOGSI). The meeting was very positive, and FOGSI members showed interest in including the SDM in their services.

Another important advocacy effort involved the media. An advocacy meeting was held in Ranchi in February 2006 that included representatives from the print and electronic media, including newspapers, local television and radio stations. Following the meeting several articles on the SDM and initial results and experiences of introducing the SDM in Jharkhand were published in English and Hindi newspapers and several Hindi women's magazines, and a telecast featuring the SDM was broadcast in July of that year.

Training and capacity building

An important part of the intervention was the training of service providers at all levels in SDM counseling. Materials for all training were developed by IRH, adapted to the

Jharkhand settings, and translated into Hindi. Training methodologies included discussions, case studies, role plays, and pre- and post- training assessment forms, to ensure that providers were prepared to offer the SDM. Table 5 shows the major training activities.

Table 5. India training activities

	Date of training	Type of provider	Number of providers	Type of training	Length of training
Intervention areas	September-Oct. 2004	All MOH providers	74	CTU	2 days
	January-February 2005	Medical officers	40	SDM counseling	2 days
		ANM/Lady health volunteer (LHV)/Male Health Worker (MHW)	84		
	February 2006	AWW	278	SDM counseling including abbreviated CTU	2 days
		Village animators	28		
	February and May 2006	RMP	42	SDM counseling	1 day
August 2005	CARE and CEDPA providers	30	Birth spacing method including the SDM	2 days	
	Several months after initial SDM training	All groups		refresher training in the SDM with adjustments based on service test results	½ day
Control area	September-Oct. 2004	All MOH providers	36	CTU	2 days

Providers in each group were not trained all together but in batches, to allow for continued service provision at the time of training.

Prior to the intervention, MOH providers in both the intervention and control areas were given a Contraceptive Technology Update (CTU), which included a discussion of the importance of family planning, unmet need for family planning in India and Jharkhand, quality of care in family planning, informed choice, counseling and overview of family planning methods (condoms, OC, IUD, sterilization, and emergency contraception). Providers were also reminded of how to keep accurate service statistics.

Providers in the intervention area were then instructed in SDM counseling. Training included guidelines on assessing eligibility of clients to use the SDM, and counseling clients in SDM use. Participants were provided with a handbook and job aids to facilitate SDM counseling. CycleBeads were also made available. All training, provider and client materials were produced by KGVK.

Several months after the initial SDM training, providers were given a refresher training to share with them the progress of the study and to ensure that they were correctly counseling in SDM use. Adjustments were made in the curriculum following results of the posttest round of simulated clients (see section 3 below). An important result of the

service test was the short time allocated for counseling in India – much shorter than Peru and Rwanda. It was apparent that not all SDM related items could be discussed in such a short time. As a result, the most essential elements of the SDM counseling session were identified, and these were emphasized in the refresher training.

Monitoring and supervision

Project monitors participated in the regular monthly meetings of MOH providers, where they collected (and shared) information on study activities and restocked CycleBeads. To monitor community health providers, they participated in village meetings and met with providers individually. Monitoring and supervision of SDM counseling were fragmented at the start of the study, with no specific guidelines and monitoring tools. A monitoring tool was then developed. The Knowledge Improvement Tool (KIT) is effective in assessing and reinforcing the knowledge of providers. KIT was applied by project monitors during their field visits and during monthly meetings of providers.

IEC activities

Since the SDM is a new method, an effective IEC strategy was essential. It is a couple method, so special care was taken to ensure that men were reached through the IEC efforts. Materials for these activities were developed and tested by KGVK. IEC activities included:

- An organization was hired to conduct street theatre and puppet shows in the villages to provide information about family planning, including the SDM;
- Public and private providers posted signs painted on tin announcing that they offer family planning methods, including the SDM. Wall paintings in public areas were also used;
- Simple leaflets presenting the method as a new option were supplied to providers, as well as to pharmacies and private practitioners who were willing to offer the method. The leaflets included messages designed for both women and men, and information to help couples determine whether the SDM may be an appropriate option for them;
- Providers conducted health fairs in the villages;
- The SDM was including in meeting of some self-help groups;
- Two village health workers - one man and one woman - from each village were identified and trained to raise awareness of the availability of the SDM. They conducted home visits and group talks in their communities.

2.2 Peru

In Peru the intervention focused on public sector facilities. The Moyobamba health network, which is part of the San Martin regional directorate, is subdivided into nine micro networks. Services were provided at 42 facilities: two hospitals, one of which is located in a rural area, seven health centers, and 33 health posts. The SDM was offered and provided at all these facilities, but only 32 participated in the study. The two hospitals were excluded from the study because of low client volume in the outpatient clinic; seven were eliminated due to civil unrest and one because of poor access.

Advocacy and sensitization

Activities related to the study started in April 2004. However, the SDM had been available in other areas of San Martin Department since September 2002, as part of a pilot introduction study to determine the feasibility of including the SDM in regular family planning services. This introduction was successfully completed in October 2005. As a result of this positive experience, the San Martin MOH and Moyobamba Network directors and technical managers were already involved, and approved of the SDM and of the impact study.

Training and capacity building

An important part of the intervention was training service providers in the participating facilities to provide the SDM. Given the successful implementation of the pilot study in San Martín, a similar training approach was undertaken. As in India, providers in both the intervention and control areas were given a CTU. Providers in the intervention area were then taught about the SDM. The training program was skills oriented, and also designed to build providers' knowledge. The design took into account providers' previous experience and knowledge, and their problem-solving approaches.

The first group trained consisted of 12 health workers, who had been selected to become trainers for their peers. These trainers-to-be included mostly midwives and a few physicians. Some technical managers were included, to facilitate study activities and full integration of the SDM into support systems.

This training of trainers (TOT) workshop lasted 16 hours. It included technical and programmatic aspects of the SDM, and also activities to strengthen trainees' training skills. Most activities were skills-development oriented, to ensure appropriate transmission of knowledge and skills to, particularly counseling skills. The workshop also provided an opportunity to validate training guidelines.

A cascade approach was followed to train providers and to roll out services, always making sure that recently-trained personnel had the support of their trainer or other more seasoned personnel to start carrying out their new SDM-related responsibilities. The training of the providers was done by their recently trained peers, with support from the local monitor of the Institute de Salud Reproductive (ISR), our research partner in Moyobamba.

Providers were selected for training by their respective facilities because they were already responsible for delivering family planning services. Hospitals and health centers usually sent midwives to be trained (two physicians also were trained); health posts mostly sent health technicians and midwives to the training. Training lasted approximately 12 hours. Overall 100 health workers were trained in Moyobamba, as shown in Table 6.

Table 6. Health workers trained in Peru

Type of provider	Number %*
Doctor	2
Midwife	28
Nurse	2
Health technician	68

Since exactly 100 providers were trained, these figures represent their actual number as well as their percent distribution.

At the end of the training, all providers took a post-test to assess what they had learned about the SDM. Most scored either fair (70%) or high (28%). Several months later providers received refresher training to reinforce their knowledge. This was done individually during the local monitor's periodic visits to each facility.

The trained providers carried out nine workshops for a total of 346 community health workers (CHW), who informed their communities about the SDM and referred potential users to the facilities.

While the original intervention plan focused only on MOH providers, some NGOs and private health services requested and received SDM training and went on to provide the SDM to their clients.

Several months after the initial SDM training, providers were given a refresher training to share with them the progress of the study, and to ensure that they were correctly counseling in SDM use. Adjustments were made in the curriculum following results of the posttest round of simulated clients (see section 3 below). The refresher training emphasized elements of the counseling that providers tended to overlook.

The simulated clients identified an important medical barrier. Some providers were asking potential SDM clients to keep track of their menstrual cycles for 4-6 months before returning to receive CycleBeads. This is an unnecessary requirement that suggests confusion with the traditional calendar rhythm method. This issue was addressed in the refresher training.

Another confusion that was addressed was the providers' insistence that the partner accompany the client for counseling. The SDM is a couple method, and it is beneficial for the partner to be present. However, in the Peruvian context this can be a significant barrier to access, because Peruvian men dislike participating in reproductive health consultations¹⁹. The presence of the partner at the consultation is desirable but not mandatory. Some providers in Peru unnecessarily demanded that the woman return with her partner before receiving counseling in SDM use. This issue was clarified in the refresher training.

Monitoring and supervision

The local study monitor visited each facility participating in the study approximately every other month to monitor study activities. Specific tasks included:

- Checking the accuracy of service statistics;
- Ensuring the availability of CycleBeads (at the facility levels CycleBeads were treated as any other contraceptive commodity, and were distributed to clinics through the same channels);
- Testing providers' knowledge and skills and reinforcing them as needed;

¹⁹ Cobián, E., and S. Reyes. Percepciones masculinas de las necesidades y servicios de planificación familiar y salud reproductiva: un estudio cualitativo en Chimbote. In F. R. León and M. Chu, eds. *Investigación de operaciones en planificación familiar y salud reproductiva: Conceptos y casos*. Lima: Universidad Peruana Cayetano Heredia. 1998.

- Applying the KIT (this was done once in each facility);
- Identifying barriers to SDM provision;
- Determining the availability of IEC materials; and
- Training new providers.

In addition, the staff of each micro-network met periodically. This was an opportunity for the study monitors to correct mistakes found during field visits, and discuss any concerns or misconceptions providers may have had regarding the SDM.

IEC activities

IEC had a crucial role in the Peru intervention. Activities included:

- Including the SDM in health fairs;
- Including the SDM in community-level informational campaigns;
- A radio spot, which was broadcast 180 times per month in each of six local radio stations;
- Interviews with local study monitors broadcast in local TV stations (presentation given by ISR when the study was launched was also broadcast); and
- Leaflets and brochures about the SDM were available in all participating clinics.

2.3 Rwanda

The intervention in Rwanda built on earlier efforts, in which the SDM was successfully offered in a number of MOH clinics throughout the country.

Advocacy and sensitization

IRH had a presence in Rwanda for several years prior to this study, and IRH representatives were members of the Maternal and Child Health Task Force and the national IEC committee. This facilitated the distribution of messages about the SDM to relevant stakeholders.

Advocacy efforts in Rwanda included several planning meetings with central and provincial government health officials at which the SDM and the study protocol were discussed. In the intervention area several orientation days were held to familiarize health personnel with the method, its delivery, and supervision efforts. Separate orientation meetings were held with influential religious leaders. This effort resulted in the establishment of several awareness-raising groups in certain health centers.

The SDM was added to the Management Information System (MIS) of the intervention area, and full integration in the national MIS system was underway at the time this report was produced. The SDM was also included in the contraceptive use and requisition forms that all centers use, and sent to the central level of government distribution.

Training and capacity building

As in India and Peru, providers in both the intervention and control areas received a CTU. The Rwanda CTU used the official Government of Rwanda curriculum for in-

service family planning training²⁰, which was longer than the CTU in the other study countries (five learning days, then five practice days in the clinics). The CTU in the intervention area already included the SDM, while the CTU in the control area did not. The CTU greatly improved providers' family planning knowledge in both areas.

Providers in the intervention area were trained to provide the SDM following the CTU. Training included a discussion of the SDM, how it works, eligibility, screening, and counseling in method use, including practice exercises. Overall three doctors, 125 nurses and eight auxiliary nurses were trained the SDM. In addition, 830 community health mobilizers were trained to provide information about the availability of family planning including the SDM, and to refer potential clients to their local health center for counseling.

Since family planning is integrated into the delivery of general health care services in Rwanda, all providers in each participating center were trained on the SDM. The selected providers were trained by IRH staff. They, in turn, trained all additional providers in their facilities.

At the request of the MOH, providers in the control area received training in the SDM also, but this was well into the intervention period, and did not interfere with the study. Training activities in Rwanda are listed in Table 7. The table represents only providers trained directly by IRH staff, not including the additional providers that they in turn trained.

Table 7. Rwanda training activities

	Date of training	Type of provider	Number of providers	Type of training
Intervention area	September 2004	Nurses Auxiliary nurses	22 2	CTU
	February 2005	Nurses	20	Training of health center directors and supervisors
	February 2005	Nurses Auxiliary nurses	18 2	Training of providers in offering the SDM
	March/April 2005	CHWs	443	Training on promoting family planning including the SDM and referring for services
Control area	September 2004	Nurses Auxiliary nurses	21 2	CTU
	October 2005	Nurses	21	Training of health center directors and supervisors
	November 2005	Nurses	25	Training of health center directors and supervisors
	March/April 2005	CHWs	387	Training on promoting family planning including the SDM and referring for services

²⁰ Ministère de la Santé, République du Rwanda . *Module de Formation Continue en Planification Familiale: A l'usage des formateurs, superviseurs et prestataires au niveau des centres de santé.* Kigali, Rwanda 2003.

Refresher trainings for providers were done regularly on site, often as a group and as part of supportive supervision. Some adjustments in the curriculum were made following the posttest round of simulated client visits – mainly a clarification regarding the need to have the client’s partner present during counseling, as in Peru.

Monitoring and supervision

Regular supportive supervision of providers was conducted by MOH personnel, often accompanied by IRH staff or a member of SMART consultancy, the research organization that worked with IRH on data collection in Rwanda. The KIT was applied on two occasions.

IEC activities

As in Peru and India, IEC played an important role in the Rwanda intervention.

Activities included:

- Flyers and posters distributed throughout the intervention area, including material targeted at men;
- Educational presentations on the SDM in health centers;
- Community meetings and presentations organized by community health workers with cooperation from the health centers and local leaders;
- Several radio programs on the SDM were aired; and
- Several articles in local newspapers and magazines.

3. PROVIDER RESPONSE

In this section we describe study activities designed to test the response of providers in the intervention area to the integration of the SDM. In particular, we examined whether providers adequately informed clients about the SDM both before and after the client made her choice to use the method (Hypothesis 1), and whether providers presented the SDM neutrally along with established methods before the client made her method choice (Hypothesis 2).

3.1 Methodology

To test provider response to the integration of SDM into services we used the Service Test methodology. Trained simulated clients requested services, while providers believed they were attending real clients. Several weeks before each wave of simulated client visits, providers in the participating clinics signed an informed consent form, agreeing to have simulated clients visit them. However they did not know the times and dates of the visits, and usually did not realize that the visits took place until they were told about it after the fact.

The simulated clients used scripts that included contraceptive history, partner relationship and method preference. After each clinic visit the simulated clients completed a checklist about their experience. This methodology had been validated in a

number of studies^{21,22,23,24}. Research has shown that this methodology results in unbiased observations in several related fields^{25,26,27}.

Research Design

To evaluate the quality of SDM services, determine whether adjustments should be introduced into the SDM delivery model, assess the results of the adjustments, and compare provision of the SDM and established methods, we used a single-group repeated-measurements design. To determine the impact of integrating the SDM into services on the provision of established methods we added a pretest and control areas to the design. Providers in both the intervention and control areas received a CTU on all family planning methods offered in the country. The pretest round of simulated client visits occurred 2-5 weeks later. Providers in the intervention areas were then trained in the SDM. This was followed by the posttest round of simulated clients. Results of the posttest were used to determine if any adjustments were needed to improve SDM service delivery. The follow-up round of simulated client visits was administered following these adjustments. The schedule of simulated client visits was the same in both the intervention and control areas, but only providers in the intervention areas were trained in the SDM. This research design as it pertains to provider response to the SDM is shown in Figure 1.

²¹ León, FR, Monge R, Zumarán A, García I, Ríos A. Length of counseling sessions and amount of relevant information exchanged: A study in Peruvian clinics. *International Family Planning Perspectives*. 2001; 27, 1: 28-33 & 46.

²² León FR, Espinoza V, Espinosa A, Meza B, Expectancy of being observed and quality of care offered. *Paper prepared for presentation at the 131st Meeting of the American Public Health Association, Session 4301.0*. San Francisco: November 17, 2003a.

²³ León FR, Brambila C, de la Cruz M, Bratt J, García Colindres J, Vásquez B, Morales C. Improving provider-client interactions at Guatemala MOH clinics: Extent and cost. FRONTIERS Project Final Report. Lima: Population Council, 31 January 2003b.

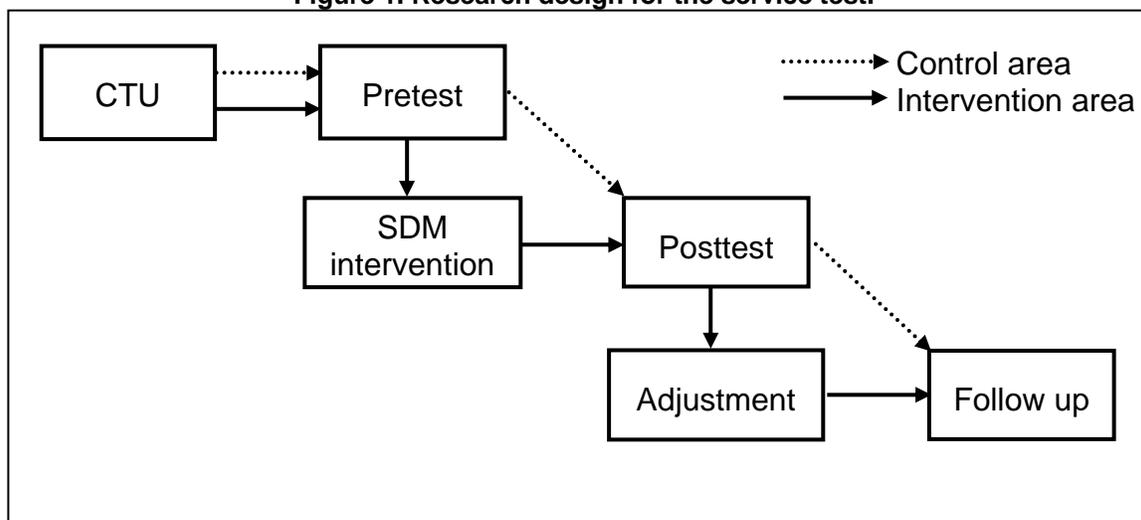
²⁴ León FR, Roca S, Ríos A, Zumarán A, Feijoo AR. One-year client impacts of quality of care improvements achieved in Peru. FRONTIERS Project Final Report. Lima: Population Council, 15 October 2003c.

²⁵ Luck J, Peabody JW. Using standardized patients to measure physicians' practice: validation study using audio recorders. *British Medical Journal*. 2002; 325: 679.

²⁶ Bolton, R. Mapping terra incognita: Sex research for AIDS prevention—an urgent agenda for the 1990s. In G. Herdt and S. Lindenbaum, eds. *The time of AIDS: Social analysis, theory, and method*, 1992: 124-58. Newbury Park, CA: Sage.

²⁷ Wright, J.D., and J.A. Devine. Counting the homeless: The Census Bureau's "S-Night" in five U.S. cities. *Evaluation Review* 1992; 16:355-64.

Figure 1. Research design for the service test.



Simulated client profiles and checklists

Three client profiles were used in each country, each relating to the use of a specific family planning method: SDM and OC in all three countries, DMPA in Peru and Rwanda, and female sterilization in India. OC was chosen because, like the SDM, it is a user-dependent method which requires detailed counseling. The choice of the third method for each country reflects the respective prevalence of these methods in each country. Table 8 shows the prevalence of the selected methods in the study countries.

Table 8. Percent of MWRA using OC, DMPA, and female sterilization

Method	India	Peru	Rwanda
OC	3.1	7.4	2.4
DMPA		11.2	4.7
Female sterilization	37.3		

Sources: DHS India (2005/6), Peru (2004), Rwanda (2005)

The profiles were as follows:

- **SDM script (used in all three countries):** A 25 year old woman who is new in town, has two children (ages three and two) but is not breastfeeding. She is in a mutually faithful relationship with no family violence, is healthy, and wishes to have more children in the future. She used OC in the past, but experienced frequent headaches. She stopped using the pill three months ago, knows little or nothing about other hormonal methods, does not have a specific method in mind, and is afraid of side affects of hormonal methods, and of inserting anything into her uterus. She will reject a pelvic exam (if offered) because she is shy. The day of her clinic visit is day four of her menstrual cycle. Her periods come every month when she expects them (approximately every four weeks), and she is able to provide the date

- of her last menses. She will choose the SDM if given the option and states that she and her husband will be able to abstain or use condoms on her fertile day.
- **OC script (used in all three countries):** Similar to the SDM profile, but with different contraceptive history. She has only used condoms before, and she currently uses them inconsistently, but her husband dislikes using condoms every time, and she wishes to switch to another method. She does not trust “natural” methods, is afraid of inserting anything into her uterus and does not want to use an injection. She will choose oral contraception if given the option.
 - **DMPA script (used in Peru and Rwanda):** Similar to the OC scripts, but she has used OCs in the past (and too often forgot to take the pill every day), and she does not mind using an injection. She will choose DMPA if given the option.
 - **Female sterilization script (used in India):** This profile is for an older woman (35 years old) with more children (four children, ages 2-13), who wishes to have no more children in the future. She has used hormonal methods before and experienced headaches she could not tolerate. Other characteristics are similar to the other profiles.

After each clinic visit the simulated clients completed a check list. The checklist for each method consisted of about 70 items (67 sterilization, 69 DMPA, 70 SDM, 79 OC), including items on interpersonal relations; diagnosis of the client’s contraceptive needs; methods options available to the client; contraindications the client may have to contraceptive options; action mechanisms, advantages, and disadvantages of methods; use instructions of the selected method; and instructions for follow up. Appendix B presents the four checklists.

Recruitment and Training of Simulated Clients

Simulated clients had a high school education and were selected based on interviews and psychological tests. They were all recruited locally, and had the same ethnic appearance as most clients of the health services. They went to the field dressed in the manner of typical clients.

Training of simulated clients lasted five days. The first three days were dedicated to introductory presentations and role-playing exercises in the classroom using the client scripts and checklists. Each candidate was trained on only one script/checklist. The simulated clients were to approach the clinics asking for family planning services; they were instructed to avoid volunteering information and just respond to the provider’s questions. The role-playing exercises followed a planned pattern. Written instructions to trainers who played the role of providers specified various levels of interpersonal relations and information exchange, and each candidate conducted role plays at each level and received feedback. The exercises were repeated until the simulated clients showed no errors filling out the checklists. The other two days were spent in visits to facilities outside the study area, so that the simulated clients could gain confidence enacting their role. At the end of training, the highest ranked candidates were selected.

Data Collection

The pretest round of simulated client visits took place in India in November and December 2004, in Peru in October and November 2004, and in Rwanda in February 2005, in the weeks immediately following the CTU. The posttest simulated client visits were undertaken after the first provider SDM training – in Peru in July and August 2005, and in India and Rwanda in August and September 2005. The follow up (and final) round of simulated client visits took place in India during the period of November through January 2007, in Peru in August 2006, and in Rwanda in August 2006, following adjustment to the training and supervision program of providers based on results from the posttest round.

In each of these rounds participating facilities in both the intervention and control areas were visited by three simulated clients each, one for each method profile. The simulated clients visited the person who happened to be providing family planning services in each facility when the simulated client arrived (most clinics had only one provider). In several instances the simulated clients could not receive services because the provider was visiting the community as part of a health campaign, or was not there for another reason. When this happened the simulated client repeatedly returned to the facility until she received services. In a very few facilities the provider identified the client as the simulated client, but this did not prevent the client from receiving services and completing the checklist.

Observer bias was controlled by switching the teams in each area. In Peru and Rwanda there were two teams of simulated clients for each round; each covered half of the facilities in the intervention and half of the facilities in the control areas. Since there were two intervention blocks and one control in India, there were three teams of simulated clients there, each undertaking the visits to a third of the facilities in each block.

Data management and analysis

Each item on the checklist was coded 1 or 0. Most items depicted a desirable outcome. These items were coded 1 Yes (or observed), 0 No (or unobserved). Some items, such as 'the counseling session was interrupted', related to an outcome that was not desirable. For these items the coding was reversed (0 if observed, 1 otherwise). This coding system allowed us to calculate scores for the entire checklist or for sub-sets of items, and compare means between profiles and countries. In addition, the simulated clients timed and recorded the duration of the counseling session.

To compare the quality of services provided to the simulated clients using the different profiles, we examined the means and the effect size which expresses the difference between means in pooled standard deviation units. In the calculation of effect sizes, we wanted to maintain the scale of original scores and used the g for independent samples (Kline, 2004), then calculated g 's 95% confidence interval using s_g (1.96), where $s_g = [g^2 / 2df_w + N / (n_1 * n_2)]^{1/2}$. We used this methodology to examine interpersonal relations (nine items) and information exchange (all other items) for each profile in the follow-up round of simulated client visits.

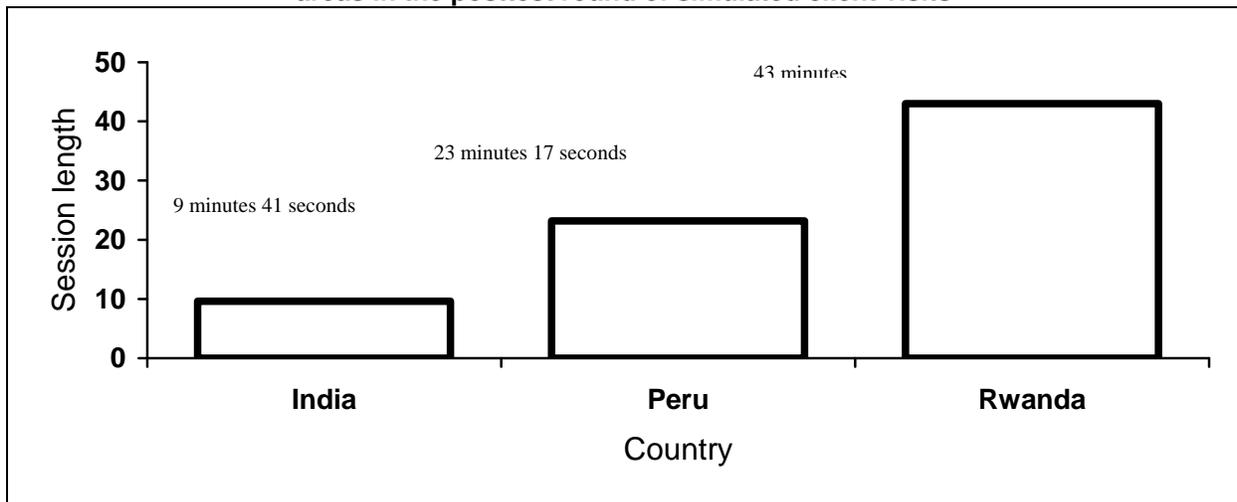
To examine the impact of the intervention on how the other methods were provided we used information from the control areas for comparison. Comparing changes in mean scores for each profile between the pretest and follow-up simulated client visits in the intervention and the control areas, allowed us to isolate the effect of the intervention on the service delivery of OC, DMPA (in Peru and Rwanda) and female sterilization (in India).

3.2 Results

Providing the SDM (Hypothesis 1)

The simulated clients used a watch to time the counseling session. They registered the times in which the consultation began and ended, so that the duration of the counseling session could be calculated. As seen in Figure 2 session length varied widely between countries.

Figure 2. Average duration of SDM counseling sessions in the intervention areas in the posttest round of simulated client visits



Source: posttest round of simulated client visits

The results from Peru suggest that providers were unusually motivated to offer long consultations. In past studies in this country, session length averaged 14 minutes in delivery of DMPA²⁸ and 13-17 minutes in delivery of OC²⁹. Session length in Rwanda was extremely long and suggested that providers were deeply concerned with the quality of care. The short consultations in India can be attributed to the fact that most providers could not be found at their clinics but delivering services in their communities, where there were many demands on their time.

²⁸ León, FR, Monge R, Zumarán A, García I, Ríos A. Length of counseling sessions and amount of relevant information exchanged: A study in Peruvian clinics. *International Family Planning Perspectives*. 2001; 27, 1: 28-33 & 46.

²⁹ León, F.R., A. Ríos, and A. Zumarán. Training x trainee interactions in a family planning intervention. *Evaluation Review* 2005; 29:576-90.

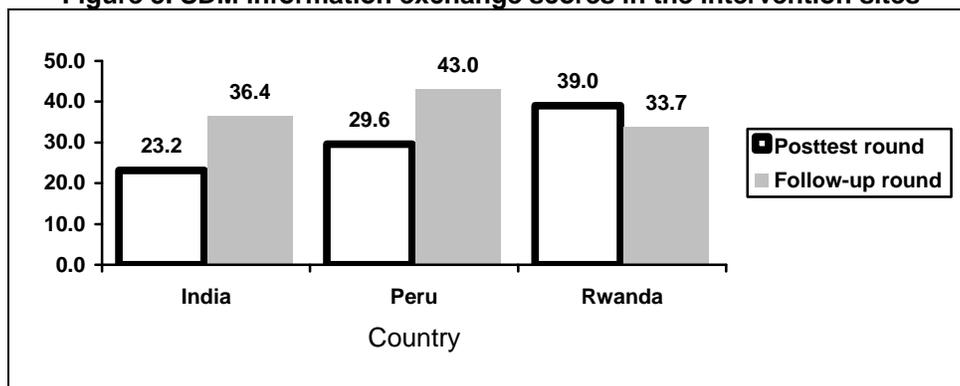
The first set of items in all the checklists was for interpersonal relations with clients, consisting of the following items:

- Counseling was individual;
- The counseling session was interrupted;
- There were strangers hearing what I said;
- The provider treated me amiably;
- I felt he/she cared for my health;
- He/she looked annoyed;
- Treated me respectfully;
- Asked me if I had any questions; and
- Responded to my questions.

In the posttest round of simulated client visits, Peruvian and Rwandan providers had similar scores (7.63 and 7.60 respectively), while India providers scored lower (6.04).

In addition to the interpersonal relations items, the SDM checklist contained 56 information exchange items that tapped six areas: needs assessment, relevant method options offered, information exchanged on contraindications to method use, instructions on SDM use, mechanisms of actions, advantages and disadvantages of the method, and indications for follow up. The checklist generated a summary identification score that was the sum of the item scores. Figure 3 shows the mean scores in the three countries for the posttest and follow-up rounds of simulated client visits. Note, that these averages may be somewhat inflated, due to the tendency to respond affirmatively. The tendency to respond Yes may be extrapolated also to Peru and Rwanda.

Figure 3. SDM information exchange scores in the intervention sites



Source: posttest and follow-up rounds of simulated client visits in intervention areas

Unexpectedly large improvements in the quality of SDM care were observed in India. These can be attributed not only to the adjustment in refresher training after the posttest round, but also to the important increase in average session length, which went from less than 10 minutes in the posttest to 15 minutes in the follow-up round. With more time invested in the consultations, most indicators showed improvements, and the general level of information exchange was raised significantly.

Adjustments to the training in Peru were also successful and resulted in a substantial improvement as well. In the follow-up round 97% of the consultations giving CycleBeads and other SDM tools to the client (up from 54% in the post-test round) and almost no clients were asked to bring their partner for consultation.

In contrast, a decrement in information exchange was observed in Rwanda, where in 16% of consultations in the follow-up round the simulated clients left without CycleBeads and other SDM materials. These results suggest that when providers felt that the study was over they relaxed their quality of care standards. However their scores in the follow-up round of simulated clients, while lower than their scores in the posttest round, were still satisfactory.

Table 9 shows the percent of providers who correctly address service test items in the intervention areas in the follow-up round of simulated client visits.

Table 9. Percent of providers correctly addressing service test items (SDM profile, follow-up round)

Item	India n=64	Peru n=67	Rwanda n=39
<u>Interpersonal relations</u>			
Counseling was individual	73	94	89
The counseling session was not interrupted	30	91	21
There were not strangers hearing what I said	17	91	68
The provider treated me amiably	96	100	100
I felt he/she cared for my health	72	89	63
He/she did not look annoyed	91	100	89
Treated me respectfully	98	100	100
Asked me if I had any questions	93	94	32
Responded to my questions	100	100	68
<u>Need diagnosis</u>			
Asked whether I had children	100	100	95
The age of the last child	83	26	79
If I wanted to have more children	69	34	79
If I was using a contraceptive method	58	100	21
About methods used in the past	54	94	63
Why I had abandoned the pill	51	83	63
If I already had a specific method in mind	13	100	47
Whether I could be pregnant (menstruation, others)	67	100	89
Whether husband cooperated in family planning	39	57	37
<u>Method options</u>			
Told me that the IUD is a copper device inserted in uterus	69	54	16
That the IUD prevents pregnancy for up to 10 years	57	57	16
That the injectable is effective if injected every 3 months	8	94	58
That the injectable may alter menstruation	10	94	16
That SDM requires abstaining from sex/using condoms days 8-19 of the fertile cycle	95	100	84
That SDM users rely on a visual aid to identify their fertile days	85	100	95
The provider asked me to choose a method	78	100	89
The provider did not try to convince me to use a specific method	29	94	89
Told me that the condom is the only method that prevents STIs	34	11	21

Item	India n=64	Peru n=67	Rwanda n=39
<u>Contraindications</u>			
Asked if I would be willing to abstain or use a condom on my fertile days	91	86	47
Whether my husband would accept the SDM	73	63	11
Whether my husband would be able to abstain or use a condom on my fertile days	90	69	58
Whether my periods come more or less when I expect them	98	100	58
The date of my last period and when I expect my next one	93	100	84
Whether my husband or I are at high risk for STIs	17	0	5
Whether I had used the pill in past 2 months	34	89	0
Whether I had used the injectable in past 2 months	05	9	0
Whether I can communicate with my husband about when to have sex	08	77	0
<u>Action mechanisms, advantages and disadvantages</u>			
Provider explained how the SDM functions	93	100	84
That the SDM has no side effects or health risks	76	97	58
What to do if my cycle is too long	88	100	74
What to do if my cycle is too short	88	100	63
That I should use a condom every time I have sex on the fertile days	97	100	79
Explained alternative sexual practices to use on the fertile days	64	37	5
That the white beads represent days in which I should abstain or have protected sex	98	100	84
That pregnancy is likely if you have unprotected sex on a fertile day	98	100	79
<u>Use instructions</u>			
Told me to move the black band to the red bead the day my menstruation starts	98	100	95
To mark the first day of menstruation on my card	95	100	79
That SDM users must move the black band every day	98	100	95
To always move the black band in the same direction	98	100	37
To check with the calendar if I forget to move the band	95	97	47
That the brown beads represent days in which I can have sex	98	97	84
Emphasized that if I have unprotected sex on the white-bead days I am likely to get pregnant	98	97	42
Told me to discuss with my husband how we are going to manage sex	15	86	0
<u>Follow up instructions</u>			
Offered to talk to my partner	12	49	42
Gave me a follow-up appointment	64	91	58
Gave me a CycleBeads and a calendar	95	97	84
Told me to return if my period does not return the day after the band passes through the last bead	93	100	68
Told me to return if my period returns before the day in which the band should reach the dark brown bead	93	94	63
Told me how to open the package and remove the condom	39	20	5
Explained to me how to place the condom on the penis	29	17	5
Said that the condom must be placed on penis before entering vagina	29	17	5
That the penis must be withdrawn while still erect and holding the condom	22	6	5
That I should use a new condom in each coitus	61	49	5
The provider verified that I understood what he/she had explained to me	76	94	32
Told me that I should return if I had any questions or concerns	86	100	47
That I should return if I would like to switch methods	25	60	0

Source: follow-up round of simulated client visits in intervention areas (SDM profile).

As an indicator of providers' proficiency in offering the SDM we examined the number of items that fewer than 50% of providers correctly addressed. In India and Peru there were few such items (14 and 9 respectively). However, in Rwanda 29 items were correctly addressed by less than 50% of providers, including nine items regarding follow up instructions; 12 items were correctly address by less than 10% of providers. The lowest items in all countries pertained to partner involvement, sexually transmitted infections (STIs) and condom use.

Hypothesis 1 posited that providers will adequately inform the client about SDM in pre-assessment as well as post-choice phases of counseling. Our results indicate that providers in India and Peru adequately informed their clients. Providers in Rwanda were less successful.

Hypothesis 2 stated that providers will neutrally present SDM along with established family planning in the choice phase of the counseling. The Method Options section of the check list (in Table 9 above) includes information given to the simulated clients about other methods during SDM counseling. Results are mixed. Over half of providers in India and Peru provided information about the IUD, but only 15% of providers in Rwanda; Indian providers did not often provide information about injections, because this contraceptive method is not widely used there. 94% of providers in Peru and 89% of providers in Rwanda did not try to convince the simulated client to use a specific method, compared to only 29% of providers in India.

Hypothesis 2 stated that providers will neutrally present SDM along with established family planning in the choice phase of counseling. Our results show that providers present the SDM neutrally or better than they present established family planning methods.

Providing the SDM compared to other methods

Table 10 shows the means and calculated effect sizes (see section II above) for the interpersonal relation score (consisting of 9 items – see Table 9 above).

Table 10. Interpersonal relations means and effect size

Country	SDM mean (SD)	Oral contraceptives mean (SD)	DMPA mean (SD)	Sterilization mean (SD)	Effect size		
					SDM vs. OC	SDM vs. DMPA	SDM vs. Sterilization
India (n=59)	6.72 (1.08)	7.22 (1.43)		7.57 (1.20)	-0.39		-0.74
Peru (n=35)	8.60 (1.53)	8.66 (0.59)	8.74 (0.51)		-0.08	-0.02	
Rwanda (n=20)	6.65 (1.53)	6.65 (1.42)	6.05 (1.23)		0	0.51	

Source: follow-up round of simulated client visits in intervention areas

Providers in India and Peru did not treat SDM clients as well as clients of other methods. However, providers in Rwanda treated SDM clients as well as their OC clients, and better than their DMPA clients. Table 11 refers to the information exchange, which consists of all items in the checklist excluding the interpersonal exchange items.

Table 11. Information exchange means and effect size

Country	SDM mean (SD)	Oral contraceptives mean (SD)	DMPA mean (SD)	Sterilization mean (SD)	Effect size		
					SDM vs. OC	SDM vs. DMPA	SDM vs. Sterilization
India (n=59)	36.35 (7.32)	37.13 (12.15)		27.12 (8.74)	-0.08		1.14
Peru (n=35)	42.97 (4.10)	38.49 (8.44)	33.71 (6.46)		0.67	1.69	
Rwanda (n=20)	30.70 (7.52)	25.40 (10.00)	14.80 (7.80)		0.68	1.95	

Source: follow-up round of simulated client visits in intervention areas

In India, the quality of care provided to women requesting OCs and the SDM was comparable. The quality of services provided to women requesting sterilization, however, was lower than that provided to SDM users. This may be explained by the fact that women requesting sterilization are referred to a higher level of services for the procedure and further counseling. Providers in Rwanda and Peru provided significantly better services to SDM clients than to clients of other methods, especially DMPA. The national norms in Peru require that women be in the first days of menstruation to receive DMPA. Similarly, the norms in Rwanda say that the woman receive the DMPA in the first seven days of her cycle, unless she has just quit the use of another method and is reasonably sure that she is not pregnant. The DMPA profile intentionally placed the women on day 20 of her cycle, so that the simulated client would not be injected during her visit. Our results suggest that providers may postpone counseling until the woman returns for her injection instead of providing the information during her initial visit.

Impact of the intervention on the provision of established methods

We determined if the introduction of the SDM improved or detracted from the quality of services for established methods. To do so we compared the simulated client scores from the pretest of simulated client visits (after the CTU in intervention and control areas, but before SDM training in the intervention area) with simulated client scores from the follow-up round.

The specific questions we address were: did the integration of the SDM into services have a negative (or positive) effect on routine service delivery of established methods? and what was the overall quality-of-care impact of SDM introduction? We used the means of the overall service test scores (including all items, both interpersonal relations and information exchange). Figures 4, 5, and 6 show the changes in the means from pretest to follow-up round in the intervention and control areas in each country.

Figure 4. Quality of care in provision of female sterilization and OC at pretest and follow-up, India

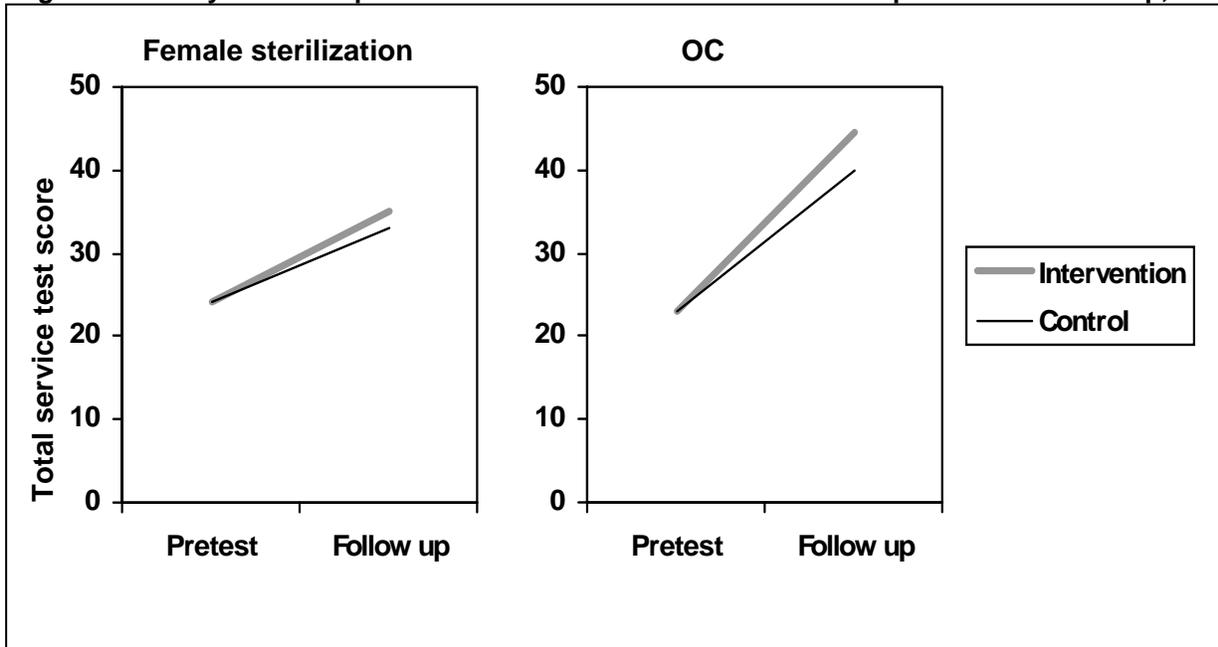


Figure 5. Quality of care in provision of DMPA and OC at pretest and follow-up, Peru

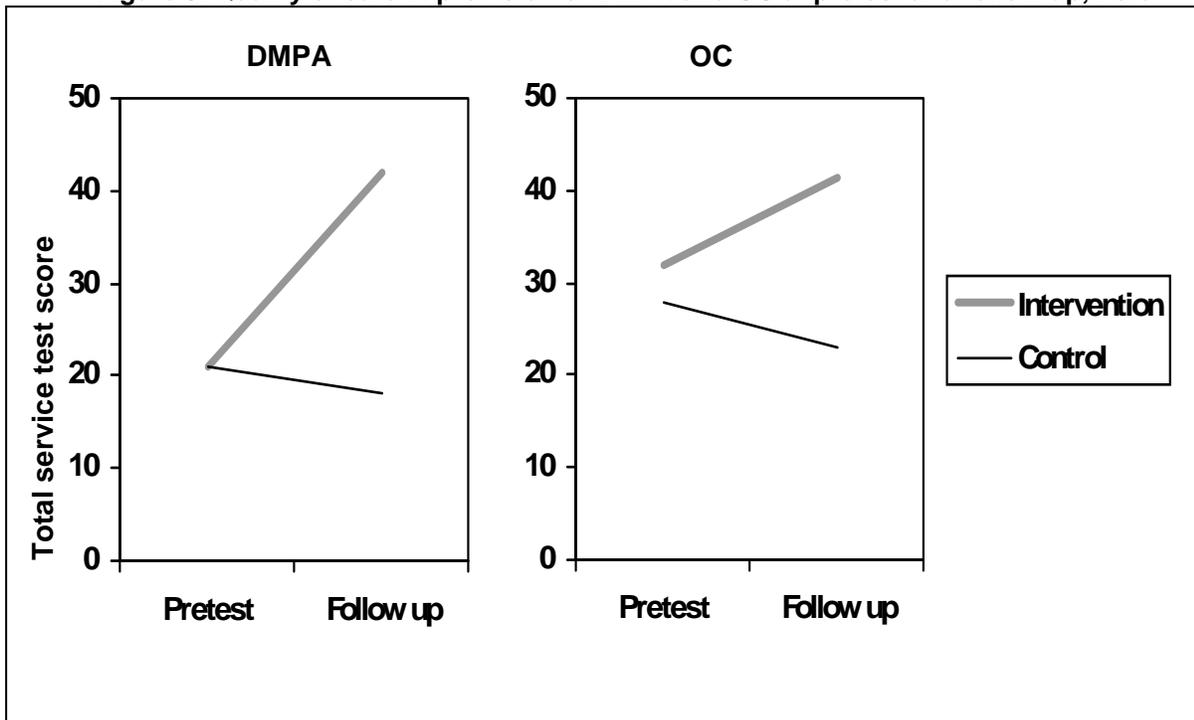
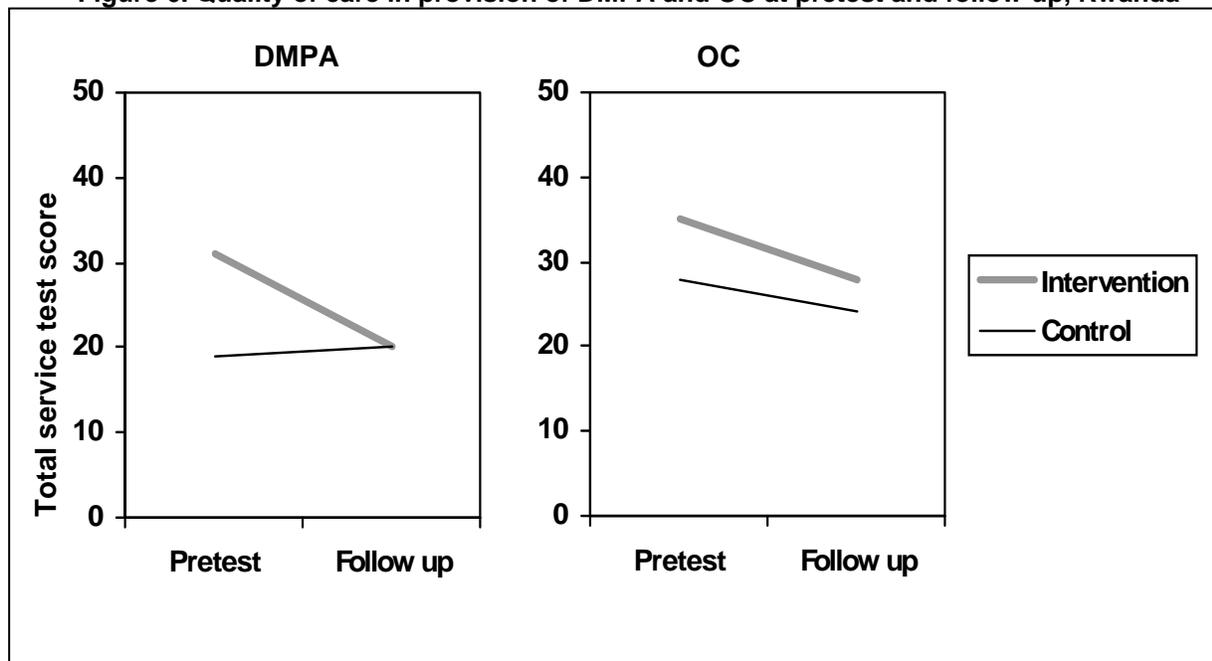


Figure 6. Quality of care in provision of DMPA and OC at pretest and follow-up, Rwanda



In India there was an improvement in quality of care for both female sterilization and OC in both the intervention and control areas. These improvements should be attributed to unknown sources, exogenous to our intervention. Improvements in quality of care for sterilization may be due to emphasis placed on this intervention by the government. We can conclude that integrating the SDM into services did not weaken the quality of care for established methods.

Different trends were observed in Peru, where the control area experienced a slight but systematic decline in the quality of provision of DMPA and OC, while the intervention area had marked improvements. We can hypothesize that changes in providers' attitudes as a result of the intervention indirectly affected the quality of their services in general, not just SDM services. While it is possible that exogenous factors contributed to the improvement, we can conclude that SDM integration did not impair the quality of service in providing DMPA and OC in Peru.

In Rwanda, on the other hand, quality of service for OC declined in both the experimental and control area; quality of services of DMPA declined in the intervention area, but remained the same in the control area. This suggests that SDM integration could have negatively affected the quality of DMPA care, but the specific mechanisms of this influence are not clear.

4. CLIENT RESPONSE I: SERVICE STATISTICS

In this section we describe study activities designed to test the response of clients of MOH facilities in the intervention area to the integration of the SDM. In particular, we tested the hypothesis that clients will choose SDM in proportions that are similar or greater than those seen in SDM pilot studies (Hypothesis 3) and the hypothesis that the

total number of users of family planning will increase in service delivery systems (Hypothesis 4).

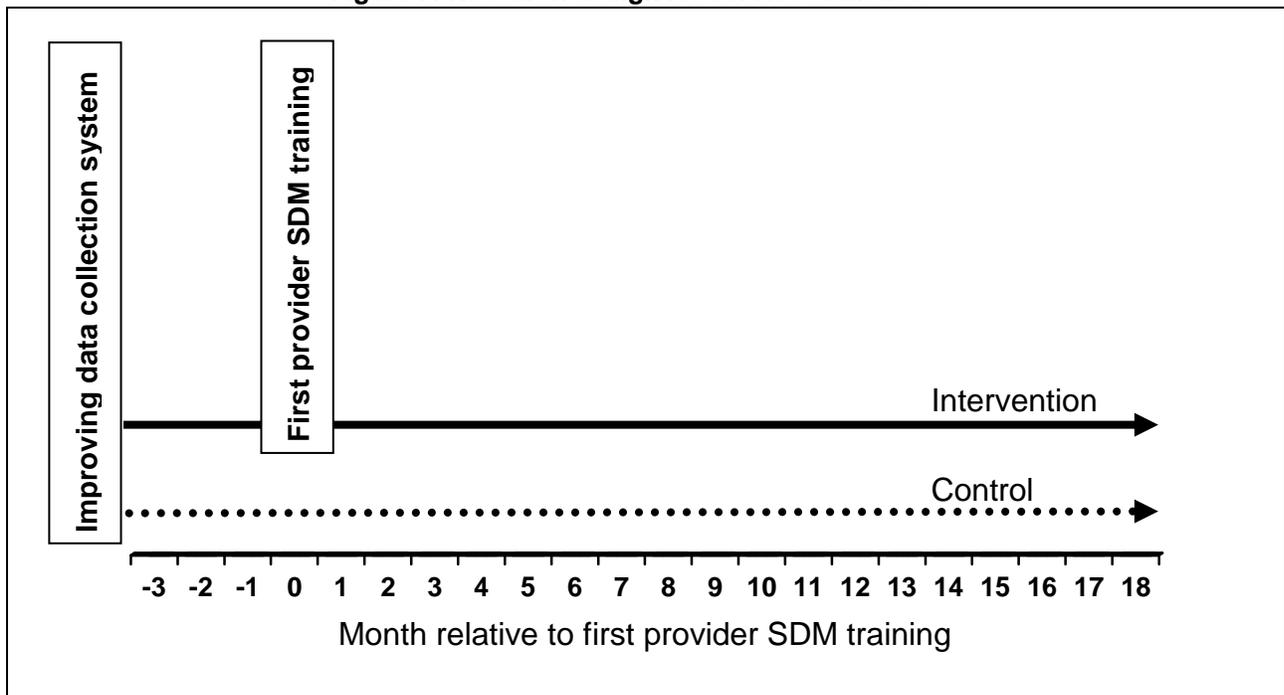
4.1 Methodology

Client response to the introduction of the SDM was assessed at the clinic level as it was reflected in the clinics' service statistics. The mechanisms for collecting accurate service statistics was improved in all participating facilities before or during the CTU. Both intervention and control areas were involved in all three countries.

Research design

Service statistics were collected monthly starting three months before the first provider SDM training each county, and continuing for 18 additional months. Figure 7 shows the research design.

Figure 7. Research design for service statistics



Data collection

In India, the SDM team at KGVK was trained by CEDPA on the purpose and use of the service statistics in August/September 2004. Then, all service providers were trained on data collection and entering the data in the forms as part of the CTU training. All data collected by providers since then were examined on a monthly basis at PHC meetings (at the block level). Data were crosschecked and verified by the medical officer in charge before submission to the project's block monitor. Since the block monitors also attended the monthly meetings at the PHC, necessary feedback was ensured at the point of data collection itself. The block monitors could crosscheck the data with the records of the service providers (ANM, lady health volunteers [LHVs] and medical officers [MOs]). Any kind of discrepancy was rectified by means of verification of the stock

register. After the community based distributors (CBDs) were trained in offering the SDM in February 2006, monthly information was collected from them during monthly supervision meetings.

In Peru, MOH authorities and two project monitors assigned to the intervention and control areas discussed the service statistics forms and procedures, then trained providers in the process of recording service statistics (September 2004). The providers were periodically visited by the project monitor in charge of data collection. In these visits, the data collector contrasted the official monthly report of the facility with a daily notebook (in the intervention area) and a daily SIS-240 form (in the control area) and corrections were made as needed.

In Rwanda, the two project monitors in charge of final data collection organized a two-day workshop in October 2004 for MOH providers and supervisors on "Family Planning Tools", which included the recording of the data both in the health facility book and on the client individual file. This was in addition to the two week CTU held in September 2004. The initial data collection was done by MOH supervisors who went through different health facilities each month, checked the providers' records for accuracy, and filling out the study forms. One supervisor compiled the data from facilities, then transmitted the data to the project manager. Project monitors visited facilities monthly to crosscheck the data sent by the health district supervisors.

The following information was collected on the service statistics forms:

- province,
- month,
- year,
- name of facility,
- name of data collector,
- date of data collection,
- number of days the facility was open during the month,
- number of active providers,
- number of new users per method,
- total number of continuing users, and
- for new SDM users – the method they switched from (if any).

For the most part the same methods were included in the forms in all countries. However Peru registered calendar-rhythm as a method, while India and Rwanda did not. The calendar-rhythm method is widely used in Peru, and the MOH offers the Ogino-Knaus method, which was registered in the service statistics. The method is not officially offered by MOH providers in the other two countries.

The service statistics in the three countries refer to new and continuing family planning users. Clients who received family planning for the first time were registered as a new user of the method received at the consultation. Women who changed methods – regardless of whether they obtained the previous method at the facility or elsewhere – were registered as new users of the method chosen in the consultation. Continuing

users were clients who were using a method supplied by the facility and came to the clinic for re-supply. A more ambiguous case is that of the person who had already received a method at the facility had stopped using the method, then re-started use after a time. In order for these cases to be registered as new users, a number of months had to have elapsed, depending on the method; otherwise, they were registered as continuing users.

Analysis

We refer to the three months immediately before provider SDM training as the pre-intervention quarter. As discussed in Section II, provider training was adjusted following the post-test round of simulated client visits, and providers received refresher training in all three sites. We refer to the quarter following the refresher training as post-intervention quarter. The calendar month for the pre-intervention and post-intervention quarters in each country depended on when providers were first trained in the SDM, and when they received refresher training. Table 12 shows the calendar months for the pre-intervention and post-intervention quarters in each country.

Table 12. Calendar months for the pre-intervention and post-intervention quarters

	India	Peru	Rwanda
Pre-intervention quarter	November 2004 – January 2005	January – March 2005	November 2004 – January 2005
Post-intervention quarter	may – July 2006	February – April 2006	August – October 2005

When looking at data trends, we aggregated the data into quarters, starting with the pre-intervention quarter. To examine the acceptance of the SDM compared to other methods we looked at the mean monthly number of new users of each method in the post-intervention quarters, comparing the intervention and control area.

A number of factors are known to have an impact on service statistics. We collected data on two such factors in the three countries: the monthly number of days the facility offered services and the number of active providers at the facility (in the case of India, the term ‘facility’ includes CBDs. For them the number of providers = 1). Many clinics (in addition to India’s CBDs) had a single provider and were closed when the provider was ill or absent for other reasons. The size of the clinic, as defined by the number of active providers, is also an important influence on service statistics. We performed regression analysis for each country that controls for these factors. The dependent variable is the average monthly number of new users of all methods (in India excluding sterilization), in the intervention areas, in the post-intervention quarter. The predictors were change (from pre-intervention quarter to post-intervention quarter) in the number of days the clinic was open, change (from pre-intervention quarter to post-intervention quarter) in the number of active providers in the clinic, number of new users at the pre-intervention quarter, and treatment (coded 1 if in the intervention area, 0 if in the control area).

The study focused on new family planning users. However, there was evidence in Peru

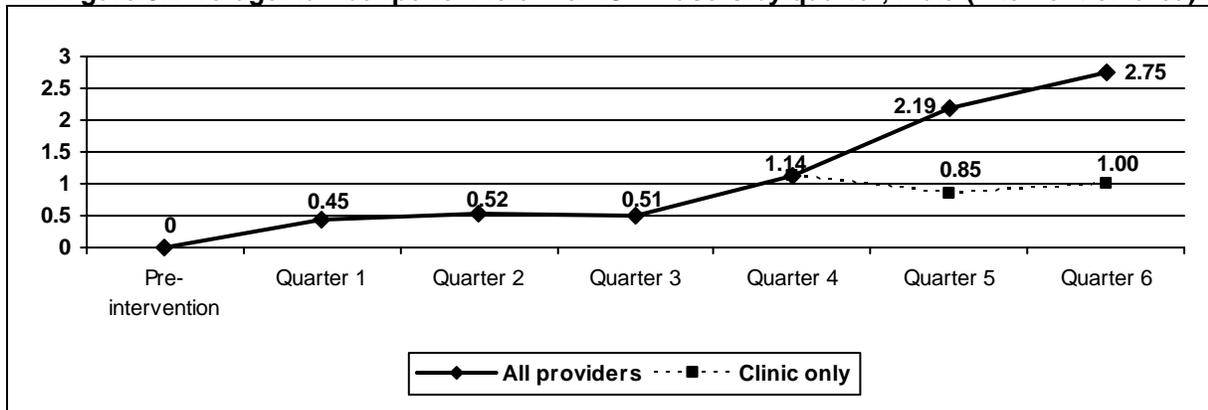
that an important percentage of new users of SDM shifted from established methods. To control for the effects of shifting, we included information on continuing users in the Peruvian regression analyses.

4.2 Results

SDM acceptance (Hypothesis 3)

Figures 8, 9, and 10 show the average number of new SDM users per clinic for India, Peru, and Rwanda respectively. Each quarter is a three month period, following the beginning of the introduction (when providers were first trained in the SDM). The calendar month each quarter refers to depends on when the interventions were started in each country. As expected, there were no new SDM users before the intervention started, in all three countries.

Figure 8. Average number per clinic of new SDM users by quarter, India (intervention area)



The number of new SDM users in India continually grew, especially in quarters 5 and 6 when community workers (Anganwadi Workers and animators) were trained. The dotted line refers to the number of users in the clinics; it shows that clinics continued to get new SDM users after the community workers were trained, but the number of new users leveled off. Peru also exhibits a continual growth in the number of new SDM users, for the duration of the study.

Figure 9. Average number per clinic of new SDM users by quarter, Peru (intervention area)

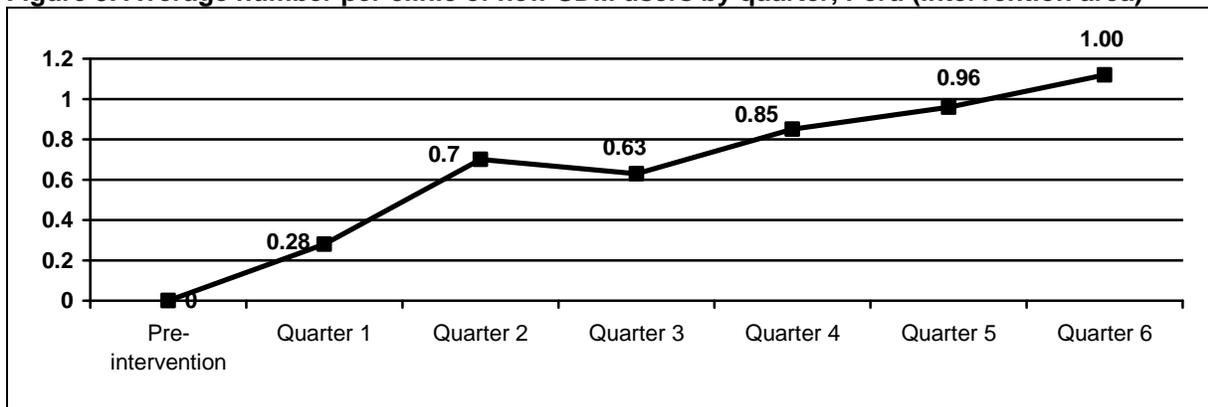
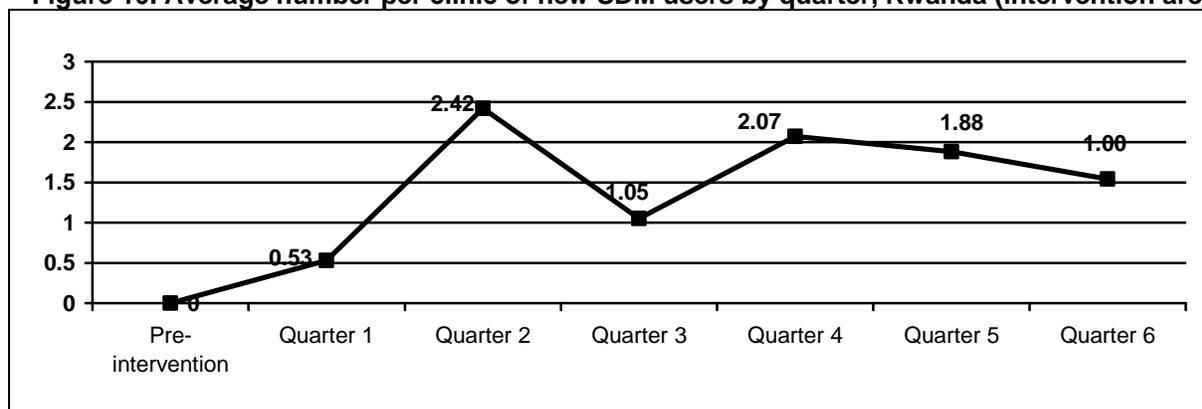


Figure 10. Average number per clinic of new SDM users by quarter, Rwanda (intervention area)



Rwanda presents a different picture. The number of new SDM uses spiked in the second quarter of SDM services, then lowered in Quarter 3. It spiked again in Quarter 4, with a slight drop in the last two quarters of the study.

Table 13 shows the mean (per facility) number of new method users per month in the intervention areas of India, Peru, and Rwanda, in the post-intervention quarter, per method

Table 13. Mean (per facility) monthly number of new users of methods in post-intervention quarter, and national DHS prevalence data (India, 2005/06)

Method	India	Peru	Rwanda
SDM	3.04	1.84	2.10
Condoms	12.05	2.61	0.98
Rhythm	0.00	0.01	0
Billings Method	0.00	0.00	0.02
LAM	0.00	0.04	2.98
OC	9.46	4.10	17.15
DMPA	0.00	4.42	32.57
IUD	0.55	0.12	0
Emergency Contraception	0.01	0.00	0
Female Sterilization	0.04	0.30	0
Male Sterilization	0.01	0.00	0

In the India intervention area, SDM ranked third, after condoms and OC. In the Peruvian intervention area, SDM ranked fourth, below DMPA, OC, and condoms. Given that such methods as the IUD and female sterilization are relatively prevalent nationally,

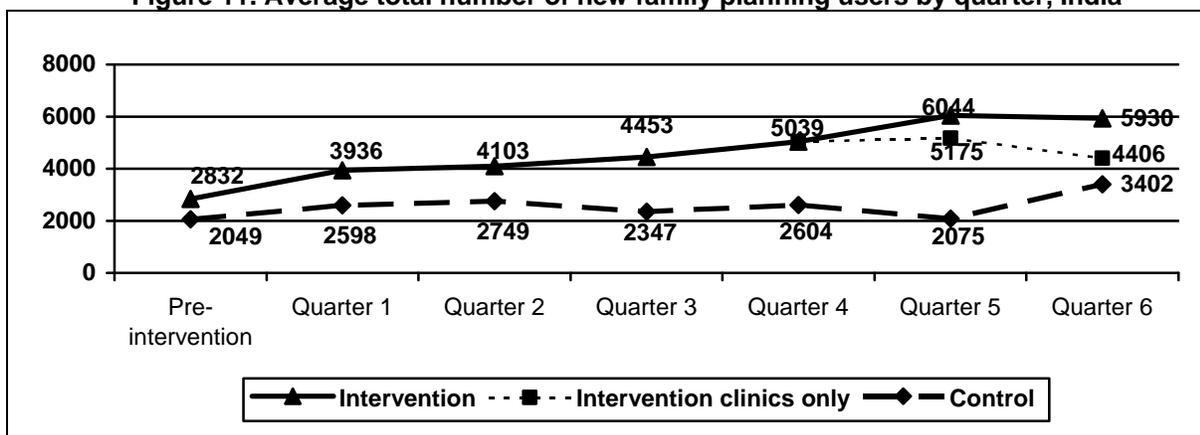
it is interesting that they accounted for so few new method clients in our study areas. In Rwanda SDM use was fourth after DMPA, OC, and Lactational Amenorrhea Method (LAM). The prevalence of DMPA and OC was significantly higher in our study areas than the reported national figures. This reflects a national drive to promote hormonal contraceptive methods in Rwanda since the last DHS data were collected.

Pilot studies of the SDM in a number of countries showed that SDM accounted for 2%-7% of all new method users in the study clinics. Hypothesis 3 posited that clients will choose SDM in proportions that are similar to or greater than those seen in SDM pilot studies. Our results clearly support this assertion in India and Peru, where the SDM accounted for 12% and 13% respectively of all new method users in the intervention areas, as well as in Rwanda where 4.1% of new method users chose the SDM.

Contribution to family planning demand (Hypothesis 4)

Figures 11, 12, and 13 are concerned with the average number of new users of all methods, per quarter, per clinic in the experimental and control areas. In India, the number of new users did not include female sterilization, because sterilizations are often done once or twice per year, and quarterly means cannot be computed. In addition in India, total numbers of users are shown instead of per clinic because of the use of community workers. Therefore the number of new users in the intervention areas and in the control areas should be directly compared to each other, because the intervention area consisted of two blocks, compared to only one block (so fewer clinics) in the control area. However, trends clearly show that in India, the number of new users increased in both the control group and intervention group (Figure 11). It more than doubled (from pre-intervention to quarter 6) in the intervention areas, and increased by a smaller margin in the control area. In the intervention group, however, a decrease was seen in clinics during quarters 5 and 6 due to the fact that community workers began offering the method, resulting in a decrease in clinic-based provision.

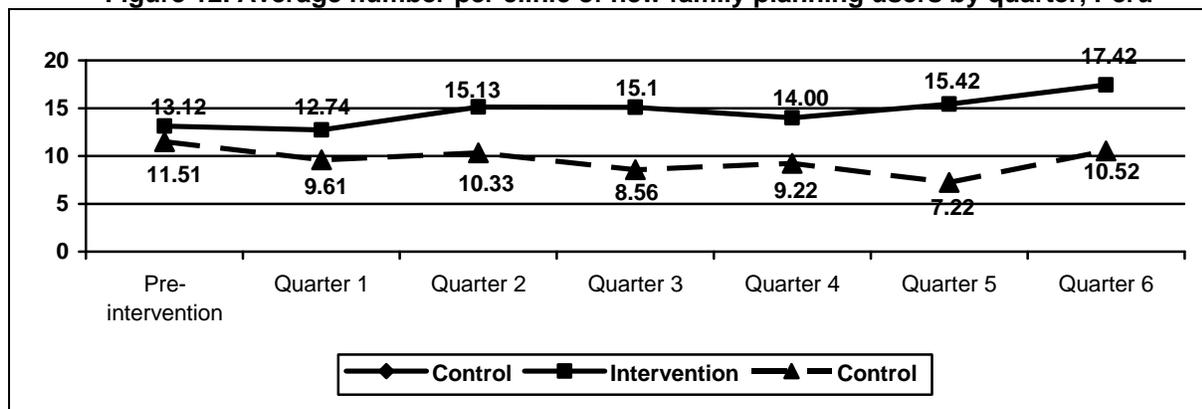
Figure 11. Average total number of new family planning users by quarter, India



In Peru (Figure 12), the number of new users of methods decreased from pre-intervention to quarter 6 in the control area while it increased in the experimental area. This suggests that the SDM intervention may have stopped a declining trend. However, the amount of the difference between the changes in intervention and control areas

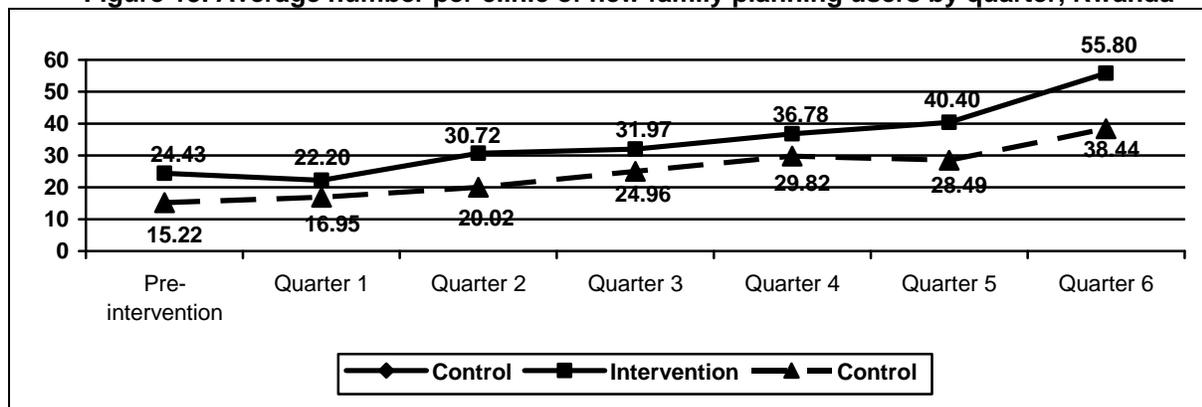
cannot be accounted for by the presence of the new option alone. Other aspects of the intervention may have had an important role.

Figure 12. Average number per clinic of new family planning users by quarter, Peru



In Rwanda (Figure 13) the number of new users of all methods increased in both control and intervention.

Figure 13. Average number per clinic of new family planning users by quarter, Rwanda



Tables 14, 15, and 16, present regression analysis that controls for the influence of the number of days facilities were open, and the number of providers in the clinic. Both of these factors may have an impact on service statistics.

Table 14. Regression of number of new family planning users (excluding sterilization) at the post-intervention quarter, India

Predictor	B	SE (B) ¹	Beta
Change in number of days clinic was open	0.23	0.11	0.35*
Change in number of active providers	-2.26	2.16	-0.17
Number of new users of methods at pre-intervention quarter	0.50	0.14	-0.22*
Treatment (intervention = 1; control = 0)	-4.10	2.40	0.41

¹ Standard error of B.

* p < 0.05.

In India the regression model accounted for 0.26 of the variance in the dependent variable. Most of this variance was accounted for by the change in the number of days the clinic was open and the number of new users at the pre-intervention quarter. This demonstrates that the SDM intervention did not have significant effect on overall family planning demand in India. The other predictors did not have a statistically significant effect.

In the Peru setting, we were able to incorporate an additional predictor: the change (from the pre-intervention quarter to the post-intervention quarter) in average number of continuing users. There was evidence that a percentage of new users of the SDM had switched from established contraceptives. Thus, we needed to exert control on method shifting. The results are presented in Table 15.

Table 15. Regression of number of new family planning users at the post-intervention quarter, Peru

Predictor	B	SE (B) ¹	Beta
Change in number of days clinic was open	0.05	0.33	0.01
Change in number of active providers	1.24	1.25	0.06
Change in number of continuing users	-0.04	0.07	-0.03
Number of new users of methods at pre-intervention quarter	0.77	0.05	0.90*
Treatment	4.41	1.56	0.16*

¹ Standard error of B.

* p < 0.01.

The Peru regression model accounted for 0.83 of the variance in the dependent variable. Most of this variance was accounted for by the number of new users of methods during the pre-intervention quarter. However, the treatment was also a statistically significant predictor, which demonstrated that the SDM intervention had a positive significant effect on overall family planning demand. The other predictors presented non-significant effects.

Table 16 presents the results for Rwanda. The regression model accounted for 0.61 of the variance in the dependent variable. Most of this variance was accounted for by the number of new users of methods at the pre-intervention quarter. The effect of the intervention was not statistically significant. This demonstrates that the SDM intervention did not have significant effect on overall family planning demand. The other predictors presented non-significant effects.

Table 16. Regression of number of new family planning users at the post-intervention quarter, Rwanda

Predictor	B	SE (B) ¹	Beta
Change in number of days clinic was open	-0.388	0.534	-0.080
Change in number of active providers	0.470	1.521	0.035
Number of new users of methods at pre-intervention quarter	0.957	3.999	-0.140*
Treatment	-4.635	0.132	0.826

¹ Standard error of B.

* p < 0.05.

Hypotheses 4 posited that the total number of users of family planning will increase in service delivery systems as a result of the intervention. This assertion was confirmed in Peru. In India and Rwanda the intervention did not result in increased (or decreased) number of new family planning users.

Method switching

Of interest is the method new SDM users switched from (if any). Table 17 shows the mean monthly number of new SDM users in quarter 6 that switched from other methods, by method.

Table 17. Method that new SDM users switched from (Quarter 6)

Method switched from	India	Peru	Rwanda
Switched from DMPA	0.01	0.09	0.02
Switched from OC	0.17	0.39	0.02
Switched from condom	0.23	0.43	0
switched form LAM	0	0.02	0.08
switched from Billings Ovulation Method	0	0.03	0
Switched from calendar rhythm	0	0.02	0
Had never used a family planning method	2.68		
Had not used a family planning method in the two months prior to accepting SDM		1.32	1.98
Total	3.07	2.31	2.10

In India, over 85% of new SDM users had never used a family planning method (not even a traditional method). In Peru, few SDM clients switched from rhythm, Billings Ovulation Method, or LAM. While some switched from a modern method, most had used nothing in the two months preceding their SDM use. In Rwanda, over 90% of new SDM clients had not been using another method in the two preceding months.

5. CLIENT RESPONSE II: COMMUNITY SURVEY

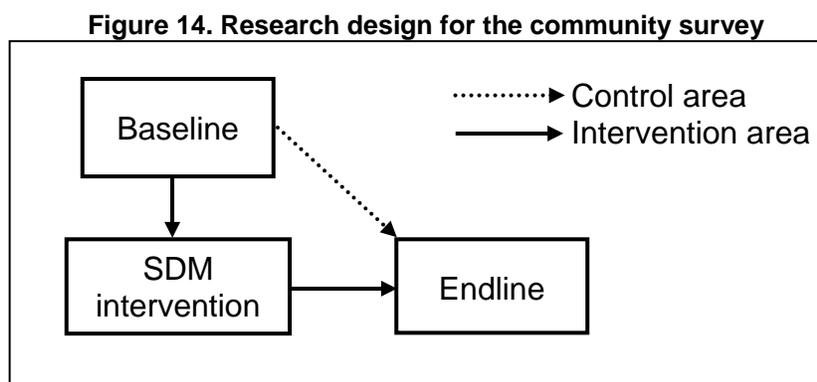
In this section we describe study activities designed to test the effect of SDM integration on women and men in the community at large. In particular, we tested the hypotheses that MWRA will increase their awareness of SDM as a family planning option (Hypothesis 5), that the prevalence of SDM use will significantly increase at the community level (Hypothesis 6), that MWRA will develop positive attitudes toward the SDM (Hypothesis 7), that the prevalence of family planning in general will significantly increase at the community level (Hypothesis 8), that MWRA will enhance their knowledge of the fertility cycle (Hypothesis 9), and that adult men in the community will show awareness of and positive attitudes toward the SDM (Hypothesis 10).

5.1 Methodology

This component of the study involved large-scale community surveys before the intervention began and two years later, in both the intervention and control areas in each country. To prevent confusion with terminology used in the Service Test section (pretest, post-test, follow up) and in the service statistics section (pre-intervention, post intervention), we used the term baseline for the survey that was conducted before service provision of the SDM started, and the term endline for the survey that was conducted two years later. In the case of India there were two endline surveys – endline-1 took place two years after the start of SDM service provision; endline-2 took place nine months later.

Study design and sampling

Figure 14 shows the research design for the community survey component of the study.



This research design was followed in India and Peru. In Rwanda, we only conducted the survey in the intervention area, because contraceptive prevalence in the country was expected to be so low that we could not attain the sample size needed to show change in contraceptive prevalence over time.

The primary focus of the community survey was married women of reproductive age (MWRA). However, a male survey (men married to MWRA) was conducted in parallel to more directly assess husbands' knowledge, attitudes, and behavior. In all sites

(intervention and control areas in all three countries) a household listing was used to randomly select households in the community. All MWRA within the households were interviewed. A randomly chosen 50% sample of men was also interviewed. To minimize the number of households lost due to addresses not found, we worked with the final sampling frame after thorough physical inspection of the addresses. To minimize the number of households where the appropriate respondent was not found at home, up to three repeat visits were undertaken, sometime early in the morning or late in the evening.

Sample size calculations in India assumed that the SDM could reach a prevalence of 3% among MWRA in the intervention areas, while the respective prevalence in the control area would be no greater than 0.1%. A few respondents or providers may move from one area to the other and the effects of the IEC may in some way reach the control area, but this influence was expected to be minimal. Accepting a Type I error = .05 and an experimental power of .95, the sample size needed according to a Poisson approximation was 396 per area if one-step sampling were used. In this study, however, we used multi-step sampling (villages within blocks, households within villages). Considering the reported sizes of the design effect associated with various contraceptive prevalence rates according to the latest India DHS (2001), we assigned a standard penalty of 30% to control for design effect. This brought the total sample size to 515 per block. A final sample size of 570 per block (or a total of 1710 for the two intervention and one control area), allowed us to tolerate over 10% of cases lost because of targeted-interviewees not found, rejections, etc. The target sample size for men was half that number.

A similar approach results in a desired sample size of 1300 MWRA in Peru – 650 in the intervention and 650 in the control area. Again, the target sample size for men was half that number. Sample size calculations were different in Rwanda because of the different research design. We assumed that at the endline (the only data point) knowledge of the fertility cycle, SDM awareness, and positive attitudes towards the SDM may reach a prevalence of 50% among MWRA in the intervention area. We accepted a 95% confidence interval. To obtain the desired sample size we used $1.96^2 PQ/5^2$, where 1.96 was the standard normal deviate associated with the 95% confidence interval, P was the expected percentage for the indicators of interest (50%), Q was 1-P, and 5 was the accepted variability range of the estimator. This resulted in a desired sample size of 384 MWRA if one-step sampling were used. Since multi-step sampling was used (villages within each area, household within villages), and considering the reported sizes of the design effect associated with various contraceptive prevalence rates according to the DHS, we assigned a penalty of 30% to control for design effect. This brought the total sample size to 499. By having a desired sample size of 600 we were able to tolerate over 20% of cases lost because of targeted-interviewees not found, rejections, etc. In Rwanda, as in the other two countries, the sample size for men was half the sample size for MWRA.

Questionnaires and manuals

To develop the questionnaires for the survey we adapted the core DHS to the study needs. Sections not relevant to the study (such as child immunization) were dropped, and questions specific to the SDM added. The advantage of basing the questionnaire on DHS forms, was that most of the questions asked in our survey were extensively used, checked, and validated in many countries. We developed a core survey questionnaire, which was translated into Hindi, Spanish and French. Each country added several country-specific questions to the core. The forms were validated in each study setting prior to the beginning of field work.

Appendix C is the female survey questionnaire from India (in English); Appendix D is the male survey questionnaire from India. Differences between these forms and the ones used in Peru and Rwanda are minor. The form for women included the following groups of questions:

- **Background characteristics** – age and date of birth, highest grade in school completed, occupation of woman and her husband, number of years of marriage, religion or ethnicity (in India also caste), urban/rural residence, number of living children, number of pregnancies, number of desired children, age of youngest child, and reproductive intention.
- **Contraception knowledge and use** – family planning methods known, beliefs about effectiveness of methods, source of information about family planning, knowledge about where to go to receive methods, family planning methods ever used, method currently used, who decided use, how long has current method been used, satisfaction with current method, and source of method. The Calendar Module of the DHS was included in the questionnaire and helped respondents place events in time. Women were asked to recall births, pregnancies, abortions and contraceptive use and discontinuation of specific methods months by month backwards, starting with the present and going back 12 months.
- **The SDM** – SDM knowledge and use, approval and husband's approval of the method, intention to use it, and where it can be obtained. The male questionnaire was very similar. It included most of the same questions, but excluded the calendar module.

Interviewer and supervisor manuals were also developed, based on DHS manuals but adapted to this survey. The interviewer manual for the women's questionnaire (Appendix E) included a description of the survey objectives and sampling strategy, the role of the interviewers, training and supervision procedures; tips on how to conduct an interview, such as how to build rapport with respondents; procedures for the field work; and general procedures for completing the questionnaire. This was followed by a detailed description of the questions. The interviewer manual for the men's questionnaire was very similar, but included only the questions asked in the male questionnaire. The supervisor manual was similarly structured, but included supervisory duties and procedures. The supervisor manual is attached as Appendix F.

Field work

Survey field work in each country was undertaken by local research organizations, with direction from the IRH country manager, as follows:

India

In India, field work for the baseline and endline survey was done by TNS Mode. Fieldwork for the final survey was conducted by GFK Mode Pvt Ltd. Both are private research organizations with offices in New Delhi. These organizations hired, trained, and supervised the work of household enumerators, interviewers and supervisors.

The work began with a household listing. Following a one-day training, the household enumerators went to the selected villages and listed all household members living in them, to construct the sampling frame for the survey. This was repeated before each endline.

Prior to data collection, all interviewers and supervisors were trained for four days. Training included two days of class work regarding the questionnaire, sampling, and other survey procedures, followed by a day of field practice and another classroom day for debriefing.

In each round (baseline, endline-1, endline-2), there were six teams of interviewers, each consisting of four female interviewers and a supervisor. To ensure good data quality the supervisors reviewed 20% of the completed questionnaires. A field executive from the research organization regularly spot-checked forms and reviewed 5% of them.

These procedures were successfully followed in the baseline. In endline-1, however, a misunderstanding resulted in a serious problem – women who had been sterilized previously (and husbands of sterilized women) were erroneously excluded from the sample. All other procedures were correctly followed, and the resulting dataset was valid. However it could not be used to calculate contraceptive prevalence. The second endline was therefore undertaken, to correct for this problem.

Data collection for the baseline was in November and December 2004; endline-1 was in December 2006; endline-2 was in September 2007.

Peru

Private consultants were instrumental in the field work in Peru. Wilfredo Padilla did the sampling, and Guillermo Cangahuala was responsible for organizing data collection. There were two data collection teams in the intervention area and two in the control. Each team consisted of women and men, and a monitor from ISR.

Training of data collection team members lasted three days – one day of classroom about the questionnaire and study procedures, and two days of field practice. To ensure good quality data, data entry was double entered in the ISR offices in Lima.

Rwanda

Rwanda had only one community survey conducted, about two years after the beginning of the intervention (October 2006). Field work was undertaken by Centre Ingamba pour les Etudes socio-démographiques et le Développement de la Population (CIEDEP), a local research organization. Two teams were involved, each consisting of six interviewers and a team leader who supervised the work. All had a secondary education certificate in medicine, were fluent in Kinyarwanda, and had previous experience collecting data for the Rwanda DHS.

Interviewers and supervisors received an eight-day training, including class work and field work, before the start of data collection. Completed forms were sent to the main CIEDEP main office, where they were reviewed. If a form was found to be incomplete or inconsistent, it was sent back to the field, and the respondent was visited again if needed to assure complete and accurate data.

Data management and analysis

The completed forms were transported to the office of the research organization in each country, where they were entered into a data base using a program created by IRH for this purpose in the SPSS Data Entry (version 4.0) software. The final file was submitted to IRH for analysis.

We constructed a scale to measure how much respondents knew about the SDM. The scale consists of several items, each coded 2, if the respondent knew about this aspect of SDM use and said so spontaneously; 1 if correctly responded after probing; and 0 if respondent did not know. The scores were totaled to arrive at the final scale, which was a continuous variable ranging 0-22. The following questions were included in the scale:

- The SDM is a fertility awareness, rhythm, or “risky days” method
- It defines as fertile days 8-19 of the menstrual cycle
- It comes with a visual aid: a necklace
- It requires a regular menstrual cycle
- It requires a 26-32 day menstrual cycle
- It requires partner cooperation
- It requires abstinence or use of condom in the fertile days
- It requires keeping track daily
- It requires moving the black band to the red bead the day menstruation starts
- It requires marking the first day of menstruation on the calendar
- It requires moving the black band every day
- It requires always moving the black band in the same direction
- It requires checking with the calendar if one forgets to move the band

A similar scale was constructed for the respondent’s opinion about the SDM. Opinion questions were scored 1 if answered yes, 0 otherwise. These were added, to arrive at the final scale which has a range of 0-13. The following questions were included in the scale.

- The SDM is easy to understand
- It is easy for one’s partner to understand

- It is simple to use
- It does not require too much work
- It does not interfere with one's sexual life
- It is effective if used correctly
- It is affordable
- It is easy to obtain
- It is popular in the community
- It is consistent with the respondent's religious beliefs
- It is consistent with the respondent's moral principals
- It is safe for the user's health

Analysis included cross tabulations, calculations of significance levels, and multivariate analysis as appropriate.

5.2 Analysis

Table 18 shows the number of respondents by country and survey round. In parentheses is the proportion this figure represents of the desired sample size. While the number of respondents at baseline (and in the Rwanda endline) fell short of expectations, we feel that sample size is large enough to test the hypotheses.

Table 18. Number of respondents (proportion of desired sample size in parentheses)

		Baseline		Endline-1		Endline-2
		Women	Men	Women	Men	Women
India	Intervention	789 (0.69)	692 (1.22)	1165 (1.02)	634 (1.09)	1202 (1.05)
	Control	382 (0.67)	366 (1.29)	580 (1.02)	327 (1.15)	598 (1.05)
Peru	Intervention	450 (0.69)	189 (0.58)	629 (0.97)	546 (1.68)	
	Control	458 (0.70)	216 (0.66)	718 (1.10)	627 (1.93)	
Rwanda	Intervention			405 (0.68)	211 (0.70)	

Respondent profile

Table 19 shows the socio-economic characteristics of female respondents in the intervention areas at endline (endline-2 in India)

Table 19. Respondent profile (female respondents, intervention area, endline)

Characteristic	India n=1202	Peru n=629	Rwanda n=405
Mean age	30.4	32.4	30.6
Mean number of children	3.2	3.0	4.0
% attended school	39.3	95.2	82.7

% literate	30.7	82.2	73.1
% Catholic		59.9	59.8
% Hindu	57.7		
% Muslim	21.7		
% worked for money	61.3	77.9	61.2
% ever used modern contraception	58.3	89.4	51.4
% approved of family planning	88.3	95.3	99.1

Peruvian respondents were older, and parity was higher in Rwanda. Indian respondents were significantly less educated. The higher percentage of Peruvian respondents who had ever used a modern contraceptive method reflects the high contraceptive prevalence in Peru. Most respondents in all three countries approved of family planning.

The study design was quasi-experimental, nonequivalent control groups. We expected that background characteristics would be somewhat different between control and intervention areas. In India, the only statistically significant differences between the control and intervention areas in endline-2 were in religious distribution (higher percentage of Hindu in control), and in the percent who worked for money (69.4%). In Peru, the intervention and control endline samples differed in literacy levels (86.3% literate in the control area at endline), religion (82.9% Catholic in the control area), and the percent who worked for money (61.9% in the control area).

We expected the baseline and endline samples in each area to be quite similar, but found some differences, especially in India. Endline respondents in India tended to be better off than baseline respondents in terms of education and contraceptive use. Only 27.7% of Indian respondents in the baseline had attended school (compared to 39.3% at endline-2); literacy was less prevalent, with only 20.5% of respondents literate at baseline; religious distribution was different, as was modern contraceptive prevalence (50.8% at baseline; 58.3% at endline-2). In Peru the only statistically significant difference between the baseline and endline samples in the intervention area was in the percent who worked for money (88.6% at baseline, 77.9% at endline).

Male respondents were older in all three countries, in all study samples. In India and Peru men were better educated than female respondents. Fewer Indian male respondents approved of family planning than female respondents in endline-2 (80.3% and 88.3% respectively). In Peru the pattern was similar, with only 80.3% of men approving of family planning at endline in the intervention area, compared to 95.3% of women. In Rwanda about 99% of both men and women approved of family planning use.

Awareness of the SDM (Hypotheses 5 and 6)

The survey included the question: “I would like to talk about family planning – the various ways or methods that a couple can use to delay or avoid a pregnancy. Which ways or methods have you heard about?” After participants had listed all the methods

they could think off, the interviewer probed about the various methods that were not mentioned. A ‘yes’ response, then, could be spontaneous or probed. The probe for the SDM was “Standard Days Method: Women can avoid pregnancy by not having unprotected sexual intercourse on days 8-19 of the cycle. They can use a necklace to monitor their cycle days.” Table 20 shows the percent of female and male respondents who had heard of the SDM at endline. For India we present results for both endline-1 and endline 2. While participants in endline-1 were less representative of the population because female sterilization users were excluded, endline-2 occurred almost three years after the intervention began, compared to endline-1, and the endlines in Peru and Rwanda, which took place about two years after the start of intervention.

Table 20. Percent of respondents who had heard of the SDM in the intervention areas (endline)

	India			Peru		Rwanda	
	Female		Male n=692	Female n=629	Male n=524	Female N=405	Male n=211
	Endline-1 n=1165	Endline-2 n=1202					
Spontaneous	15.3	4.4	6.9	35.5	23.9	65.4	38.4
Probed	43.9	36.8	31.5	27.7	15.0	25.2	30.8
Total	59.2	41.2	38.4	63.2	38.9	90.3	69.2

Considering the fact that the SDM had never been offered or promoted in the intervention areas in India and Peru until just two years before the endline surveys, a significant number of respondents had heard of the method (59.2% in India endline-1 and 63.2% in Peru). It is not surprising that a higher proportion of women in Rwanda (90.3%) had heard of the SDM, because the method had already been available in the country for a couple of years by the time of the survey. While the SDM had not previously been provided in the intervention area of this study, Rwanda is a small country, and IEC efforts in other areas may have influenced women’s awareness of the SDM throughout the country. In all three study sites, fewer men than women had heard of the method, perhaps reflecting that efforts to raise awareness of the SDM tended to target women. The proportion of female respondents in India who had heard of the method in endline-2 was significantly lower than in endline-1. This reflects the end of intervention IEC and promotion efforts after endline-1.

A small number of respondents in the control areas had also heard of the SDM at endline (7% in India endline-1, 4% in India endline-2, and 2.7% in Peru). This suggests some contamination between the intervention and control areas.

Hypothesis 5 stated that MWRA will increase their awareness of the SDM as a family planning option; Hypothesis 6 states that adult men will show awareness toward the SDM. Both of these hypotheses are supported by our results.

A multivariate analysis of hearing about the SDM allowed us to determine if women with specific background characteristics are more likely to hear about the method than

others. This information can be used to target specific audiences in IEC messages. Table 21 shows the results of logistic regressions for the three countries. The dependent variable is 'heard about the SDM', coded 1 if yes (spontaneous or probed), 0 otherwise.

**Table 21. Coefficients of logistic regression of hearing about the SDM
(female, intervention areas, endline)**

	India		Peru n=710	Rwanda M=405
	Endline-1 n=1154	Endline-2 n=1199		
Age	-0.054**	-0.077**	-0.049**	-0.026
Number of children	0.029	0.155**	0.005	0.100
Literate	0.508**	0.789**	0.825**	1.182**
Catholic			0.299	0.667
Hindu	-0.188	-0.054		
Works for money	0.034	0.392**	0.205	1.323**
Wants to have another child	0.066	-0.205	0.206	0.115
Constant	1.680**	0.506	1.015*	0.768
-2 log likelihood	1507.832	1370.946	882.811	221.467

** & * denote significance at <.01 and <.05 respectively

It is interesting to see patterns emerge across countries. First, in India and Peru younger women were less likely to hear about the SDM. Second, literacy was a factor in all three countries. Finally, in India endline-2 and in Rwanda, women who worked for money were more likely to have heard about the method. These findings may reflect the focus of the IEC activities. Future IEC efforts may include more emphasis on pictorial, rather than written, promotion materials, to better reach illiterate women.

We asked respondents who had heard of the SDM where they had heard about it, or who they heard about it from. Results for the intervention areas are shown in Table 22. Endline-1 and endline-2 combined in India.

Table 22. Source of information about the SDM (endline, intervention)

%	India		Peru		Rwanda	
	Female* n=1044	Male n=241	Female n=447	Male n=244	Female n=367	Male n=146
Friends, family, or neighbors	14.8	21.7	36.7	19.7	18.8	6.9
Spouse	3.1	11.1	1.6	32.8	1.6	6.8
Provider or community health worker	56.6	68.9	47.9	0	46.0	77.3
Community or clinic talk, or health fair	35.0	33.2	11.2	13.5	56.8	44.1
Posters	4.6	13.1	34.7	33.2	0.5	0
Mass media	4.6	8.2	31.3	35.8	15.6	19.4
Brochures or fliers	0.9	15.2	8.5	12.3	1.6	3.4

Percentages add to more than 100% because respondents could specify more than one

* Including endline-1 and endline-2

These distributions reflect the various IEC strategies implemented in each country. Community talks and health fairs were an important element of the strategies in India and Rwanda. In Peru, mass media and posters were also utilized. India and Rwanda implemented strategies to reach men, while in Peru many men learned about the method from their wives.

We asked respondents who had heard of the method a series of questions to determine their understanding of the method, how it works, and how to use it. We used the results to construct an SDM understanding scale, ranging 0-22. Table 23 shows the distribution of scores. Only respondents who had heard of the SDM were included in this analysis. In India we combined endline-1 and endline-2.

Table 23. Percent distribution of SDM understanding scores (intervention, endline)

score	India		Peru		Rwanda	
	Female* n=1044	Male n=178	Female n=458	Male n=246	Female n=367	Male n=146
0	6.4	6.7	19.4	26.0	0	5.5
1-5	21.7	17.5	28.4	25.6	4.6	12.3
6-10	17.4	20.2	23.2	16.3	34.9	33.6
11-15	36.6	41.0	19.4	19.9	31.9	45.9
16-22	17.9	14.6	9.6	12.2	28.6	2.7
mean	9.9	10.0	6.7	6.8	12.6	10.0

* Including endline-1 and endline-2

These results suggest that while a significant proportion of participants have heard of the SDM, they do not always know what it is or understand how it is used. Respondents in Peru had lower scores than respondents in India and Rwanda. Most respondents who had heard of the SDM said they knew where they could go to obtain the method (86.6% of women but only 58.2% of men in India; 89.3% of women

and 87.1% in Peru; 85.8% of women and 82.5% of men in Rwanda). Table 24 shows where they said they could obtain the SDM. Only respondents who said they knew were to obtain the method are included.

Table 24. Where SDM can be obtained (endline, intervention)

	India		Peru		Rwanda	
	Female* n=770	Male n=142	Female n=447	Male n=216	Female n=311	Male n=118
Government facility	11.5	43.7	97.4	99.1	95.8	98.3
Private facility	1.1	4.2	4.5	6.0	0	0.8
Community health worker	44.1	63.4	0	0	1.3	1.7
Pharmacy	0	0	1.6	4.6	0	0

Percentages may add to more than 100% because respondents could specify more than one
*Including endline-1 and endline-2, but response rate for this question in India (women) was low.

These figures reflect the service delivery options available in the intervention areas, and the focus of the interventions in the three countries.

Use of the SDM (Hypothesis 7)

Table 25 shows the percent of respondents in the intervention area at endline, who had ever used the SDM, and who were using it at the time of the survey.

Table 25. Percent used the SDM (endline, intervention)

Score	India			Peru		Rwanda	
	Female		Male n=634	Female n=629	Male 564	Female n=405	Male n=211
	endline-1 n=1169	endline-2 n=1202					
Ever used the SDM	6.1	3.9	7.9	5.2	5.6	5.1	3.3
Currently using the SDM	5.0	1.2	4.7	3.8	4.1	0.5	2.4

Hypothesis 7 stated that the prevalence of SDM use will significantly increase at community level. Given that the method was never offered in the study areas prior to the intervention, our result show significant increase in SDM prevalence in all three countries. The lower figures in India endline-2 compared to India endline-1 reflect the fact that sterilization users were excluded from the sample in endline-1, so the proportion of uses of other methods was larger. They also reflect the end of intervention IEC and promotion efforts after endline-1.

Attitudes toward the SDM (Hypotheses 6 & Hypotheses 8)

We asked respondents who had heard of the SDM a series of questions about their opinion of various aspects of the method. We used the responses to construct an SDM acceptability scale, ranging 0-13, where 0 reflects a negative and 13 positive opinion. Table 26 shows the distribution of scores. Only respondents who had heard of the SDM were included in this analysis. In India, we combined endline-1 and endline-2.

Table 26. Percent distribution of SDM acceptability scores (intervention, endline)

score	India		Peru		Rwanda	
	Female* n=1044	Male n=241	Female n=458	Male n=246	Female N=367	Male n=146
0	14.5	23.2	15.3	15.2	2.2	3.4
1-3	13.9	9.9	8.2	8.0	8.4	10.3
4-6	10.9	5.9	15.7	8.0	18.3	12.3
7-9	19.7	15.4	15.1	14.4	29.4	18.5
10-13	61.0	45.6	45.7	54.4	41.7	55.5
mean	7.0	6.9	7.32	7.94	8.2	11.0

*Including endline-1 and endline-2

Overall, most respondents in all three countries responded positively to at least half of the items (had a score of 7 or higher), and over 40% had a score of 10 or higher. It is interesting that in Peru and Rwanda male respondents had a more favorable opinion of the method than female respondents. When asked directly if they liked the method, most respondents who had ever used the method responded positively, as is shown in Table 27.

Table 27. Percent finding the SDM acceptable (intervention, endline)

Score	India		Peru		Rwanda	
	Female* n=682	Male n=178	Female n=458	Male n=246	Female n=367	Male n=146
% of the respondents who had heard of the SDM	53.8	67.7	68.6	69.8	84.8	84.3
% of the respondents who ever used the SDM	88.1	81.2	97.3**	97.1**	n too small	n too small

* Including endline-1 and endline-2

** n < 40

Hypothesis 8 posited that MWRA will develop positive attitudes toward the SDM, and Hypotheses 6 posited that adult men will show positive attitudes toward the SDM. Our results support both of these hypotheses.

Contraceptive prevalence (Hypothesis 9)

Table 28 shows the current family planning status of female respondents in the intervention areas, including both modern and traditional methods, and pregnancy status. Only endline-2 is included in India, because endline-1 excluded sterilized women.

Table 28. Contraceptive prevalence

Score	India		Peru		Rwanda
	Baseline n=1188	Endline-1 n=1128	Baseline n=456	Endline n=756	Endline n=405
Standard Days Method	0	1.2	0	3.8	0.5
Female sterilization	33.5	37.6	20.0	19.0	2.8
Vasectomy	0.1	0.1	1.1	1.0	0
DMPA	0.1	0	17.5	17.7	19.7
OC	3.6	5.5	12.5	15.2	6.4
IUD	1.1	0.5	2.2	1.6	0.8
Implant	0	0	0.2	0.3	0.3
Condom	3.7	6.3	3.7	1.8	2.0
Female condom	0	0.1	0	0	0.3
LAM	4.0	1.5	0.7	0.3	2.8
Withdrawal	6.9	3.7	2.2	3.1	7.2
Rhythm	2.9	1.8	17.8	14.9	6.1
Currently pregnant	8.2	8.9	6.0	7.6	13.0
Uses nothing	35.8	32.8	16.0	13.6	38.1

These figures reflect the known contraceptive prevalence for these countries. In India female sterilization is the most prevalent method, compared to DMPA in Peru and Rwanda. Traditional rhythm is still prevalent in Peru.

Table 29 shows the prevalence of modern contraception, including the SDM, sterilization, DMPA, OC, IUD, implant, condoms, and LAM, in the intervention and control areas in India and Peru. No control information is available for Rwanda.

Table 29. Percent using modern contraception

	India		Peru	
	Control n=1198	Intervention n=2395	Control n=908	Intervention n=1347
Baseline	45.9	47.8	49.6	46.9
Endline	49.6	50.8	56.6	57.6
χ^2	ns	<.05	<.01	<.01

Hypothesis 9 posited that the prevalence of family planning will significantly increase at the community level. In India there was a statistically significant increase in the prevalence of modern contraception in the intervention area, but not in the control area. Therefore, our results support Hypothesis 9 for India. In Peru there was a significant

increase in modern contraceptive prevalence in both the intervention and the control areas. We cannot assert that the increase is a result of our intervention. However, we can state that contraceptive prevalence did not decrease in Peru as a result of our efforts.

Fertility awareness (Hypothesis 10)

Respondents were asked if there are certain days, from one menstrual period to the next, when a woman is more likely to become pregnant. If they answered ‘yes’, they were asked if this time is just before her period begins, during her period, right after her period has ended, or halfway between two periods. Table 30 shows the percentage of female respondents who knew that there was a fertile window half way between the two periods.

Table 30. Percent who knew that there is a fertile window and that it is half way between periods

	India		Peru	
	Control n=1198	Intervention n=2395	Control n=908	Intervention n=1347
Baseline	15.2	15.1	46.0	60.2
Endline-1	20.0	31.8	55.5	56.5
endline-2	6.4	12.4		
χ^2	p<0.1	p<0.1	p<.05	ns

In India, fertility awareness increased sharply from baseline to endline-1, and then decreased again in endline-2, in both the intervention and control areas. In Peru, fertility awareness decreased from baseline to endline in the control area, but the change was not statistically significant. Hypothesis 10 stated that MWRA will enhance their knowledge of the fertility cycle. Our results do not support this hypothesis.

6. DISCUSSION AND CONCLUSIONS

The results of this study provide valuable information on the effect of integrating the SDM into existing family planning services in India, Peru and Rwanda. The study examined the effects of SDM integration at both the service delivery and client level.

Service Delivery System

Introducing a new family planning method should improve, not detract, from quality of care. Thus, it is important to assess whether providers adequately inform clients about the SDM. Simulated clients visited SDM providers after initial training and then again after reinforcement training, using a checklist of 56 items to score information exchange. Initially, providers in all three countries were imposing unnecessary medical barriers on women eligible to use the SDM, requiring that prospective users monitor their cycles and return to the clinic with their partners before they were given CycleBeads. After refresher training, the general level of information exchange was raised and these barriers were eliminated. The mean information exchange score increased significantly

in India and Peru to 36 and 43 respectively, while a decrease to 34 was observed in Rwanda. The majority of SDM-specific information items were covered, however certain items relating to partner cooperation, STIs and condom use were addressed by less than fifty percent of providers.

On occasion, providers become overly enthusiastic about a new method, pressuring their clients to use the new option over established methods. This did not seem to be the case in these studies. In India and Peru, for example, providers did not treat SDM clients as well as clients of other methods. Furthermore, in India, the quality of care provided to women requesting oral contraceptives and the SDM was comparable, although the care provided to women requesting sterilization was lower, perhaps because women were referred elsewhere for further counseling. In Rwanda and Peru, providers offered better services to SDM clients than to clients of other methods. However, this may be due to the fact that the DMPA profile was intentionally designed so that the simulated clients would not be eligible for the injection during the visit. As in the case of sterilization in India, some providers may have deferred detailed counseling until their next visit when they could actually receive their method.

A common concern is that introduction of a new method will detract from the quality of services for established methods. In India, simulated client results show that quality of care improved in both intervention and control areas, suggesting that SDM integration did not weaken quality of care for established methods. In Peru, however, marked improvements were observed in the quality of DMPA and OCs in the intervention area only. Thus, we can conclude that SDM integration did not impair the quality of services of other methods in either country. In Rwanda, on the other hand, it appears that SDM may have negatively affected the quality of DMPA care, but specific mechanisms are not clear.

Client Response

SDM popularity. Policy makers are only interested in offering a new method if they believe the women and men they serve adopt it in significant numbers. In India, the SDM ranked third in use, after condoms and OC. In Peru, SDM ranked fourth, below DMPA, OC, and condoms. In Rwanda, SDM use was fourth after DMPA, OC, and LAM. In India and Peru, the SDM accounted for 12% and 13% of all method users. In Rwanda, it accounted for four percent of new users. In both Peru and India, the number of new SDM users grew over time. This was especially notable in the fifth and sixth quarter in India when community workers were trained. In Rwanda, the number of new SDM users spiked in the second quarter then decreased over time.

Contribution to family planning demand. The expectation is that introducing a new method to a program will result in an increase in overall family planning users. Analysis of the number of new users of all methods in the control and intervention areas, suggests that the total number of family planning users did increase as a result of SDM integration in Peru. In India and Rwanda, however, the intervention had no effect (positive or negative) on the number of new family planning users.

Policy makers are frequently concerned that adding a new option to the method mix will result in users switching from established methods, rather than reaching new users. The results from all three countries suggest that SDM introduction does attract new users. In India, over 85% of new SDM users had never before used a family planning method. In Peru, although a few women switched to the SDM, most had used nothing in the two months preceding SDM adoption. In Rwanda, over 90% of new SDM clients had not been using another method in the two preceding months.

SDM awareness. Successful introduction of a new method depends on raising awareness among potential users of the availability of a new option. A considerable percentage of women had heard of the SDM in India and Peru (59% and 63% respectively). In Rwanda, 90% of women had heard of the method, perhaps because the method had already been available for some time in the country before the study began. In all countries, awareness of the SDM was lower among men, about 40% in India and Peru and 70% in Rwanda, perhaps due to the type of awareness activities conducted during the study. Multivariate analysis of SDM awareness suggests that younger, less literate women were less likely to be aware of the SDM than their older, better educated counterparts. Future efforts would benefit from new strategies to reach these groups. In India and Rwanda, the providers/community health workers and clinic/community talks were the most frequent sources of SDM information. In Peru, posters and mass media played an important role, reflecting the greater emphasis on print materials in that country.

SDM attitudes. Overall, most respondents in all three countries thought highly of the method (a mean score of seven out of a 13 point attitude scale). It is interesting to note that male respondents had a more favorable opinion of the method than female respondents in Peru and Rwanda. When asked directly if they found the method acceptable, 53% to 84% of women responded affirmatively.

SDM knowledge and use. Respondents who had heard of the SDM were asked a series of questions to determine their understanding of the method, how it works and how to use it. Results suggest that many participants did not know much about the SDM. Respondents in Peru had lower scores than respondents in India and Rwanda, perhaps because their information came from print materials rather than interpersonal communication. On the positive side, most respondents (over 80%) who had heard of the SDM knew where to obtain it. Results show a significant increase in SDM prevalence in all three countries, with ever use ranging from three to eight percent.

Contraceptive prevalence. The family planning literature has shown that expanded options are sometimes associated with increased contraceptive prevalence. This was the case in India, where a statistically significant increase in the prevalence of modern contraception was observed in the intervention, but not the control area. In Peru, contraceptive prevalence increased in both the intervention and control areas, suggesting that SDM introduction had neither a positive nor a negative influence on overall prevalence.

Implications for scale-up

The results of this study have multiple implications for SDM scale up. Study results have already been widely disseminated and utilized within India, Peru and Rwanda as well as globally to guide further efforts to integrate the SDM into family planning programs.

A major impetus for this study was the need to address the questions of policy makers regarding wide-spread integration of the SDM. The results of this study suggest that introducing the SDM will neither displace nor negatively affect the quality of care of established family planning methods. In fact, in at least one of the three study countries, SDM introduction was associated with enhanced quality of care and increased prevalence of all methods. Frequently, another concern of policy makers is whether or not there will be sufficient demand to warrant SDM introduction. Data from these three diverse countries suggest that there is substantial demand for the SDM, and that this demand grows over time as availability and awareness of the method increases. Perhaps most importantly, results suggest that the SDM is most popular among women who are not currently using an effective method, thus providing programs a strategy to reach underserved men and women.

In terms of the lessons learned for service delivery, a number of issues related to quality emerge. First, it is apparent that some type of reinforcement after initial training is desirable to fill in knowledge gaps and to address unnecessary medical barriers that newly trained SDM providers often impose – namely the requirement for women to monitor their cycles prior to SDM use and for their partners to receive counseling. Key areas for reinforcement are related to counseling on couple issues, STI risk and correct condom use – areas of broad importance to overall family planning quality of care.

Raising awareness of the availability of a new method is key to increasing utilization of the SDM. The IE&C efforts conducted in these studies had a modest but insufficient impact. Although many women had heard of the SDM, awareness was low compared to other methods and specific information was lacking. Further, key groups such as men, and younger, less-literate women were less aware of the availability of the method. Future introduction efforts should consider strategies to target and reach priority groups to complement the interpersonal communication activities used during these studies. Given the decline in knowledge observed between the first and second endline surveys in India, the need to sustain IEC over time should also be considered. On a final note, the intervention as implemented did not increase fertility awareness as measured by the knowledge that the fertile period is in the middle of the cycle. If this is a desired outcome of SDM integration, new IEC efforts must be developed and utilized.

APPENDIX A: COST INFORMATION

What Does it Cost to Introduce the SDM into Family Planning Program?

I. Introduction

This cost study was part of larger study to assess the impact of SDM introduction in three countries, India, Peru and Rwanda. In several study sites nothing had previously been done related to SDM introduction. Therefore, this provided an opportunity to document the complete costs of method introduction in these sites. The cost of method introduction varied widely by country, which is to be expected given the distinct circumstances in terms of the health systems in which the method was introduced as well as the difference in costs among the country for inputs such as labor, transportation and educational campaigns. All study components of the larger study, including the cost study, were approved by the Georgetown University Internal Review Board.

Justification:

Resources for family planning are shrinking, and program managers face important decisions in allocating funds. Choosing to include a new contraceptive in a program may mean forgoing other methods or activities. Managers need to know the effectiveness, acceptability, and cost of the contraceptive they are considering adding to their programs.

Study objective:

The objective of this study was to measure the costs of introducing SDM in India, Peru and Rwanda. The study describes the cost data collected and analyzes the implications this information has for policy makers and program managers.

II. Methods

Design:

The study measures the overall cost, cost per introduction phase, cost per user, cost per service delivery point, and cost per provider trained, in each of the three countries. The study includes both monetary costs and the value of in-kind contributions. Only direct costs are considered. Some inputs were donated by the partnering organization. Examples of donated inputs include training venues, transportation, and staff time. Market rates were used to value these donations. In determining what to include in the cost calculations, only costs were included that would be required for programs to implement services. Given that program planners and managers will be provided with the necessary tools and information to introduce SDM services these other costs should not be a factor.

The periods for which this data was collected varied by country, depending on when the intervention began and how long it lasted. The periods, by country, are shown in table 1:

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Country	Data Collection Periods by Country	Period
India		January, 2005 to May, 2006
Peru		March, 2005 to July, 2006
Rwanda		January, 2005 to May, 2006

Data was collected related to all phases of implementing SDM services. These phases were labeled preparatory, start-up and implementation. Table two provides detail regarding what each phase consisted of, the forms used, and information gathered. IRH staff were responsible for collecting the data, either documenting the costs of the activities they were directly responsible for or working with representatives from the respective ministries of health to collect the necessary information.

Eight data collection forms were used at the different phases of the introduction. The following table describes each form by phase of introduction.

Description of Data Collection Forms		
Phase	Form	Description
I. Preparatory	Meeting Expense Report(s)	This form captured the costs of only formal, planned meetings held with stakeholders (MOH, NGOs) or internally.
	Other Intervention Costs	This form was completed for materials and labor costs for each. flyer, pamphlet, training manual, etc.
II. Start-Up	Training Expense Report	This form was completed for each SDM training session conducted.
III. Implementation	Service Provider Time Worksheet	This form was used to estimate the amount of time providers spent counseling on the SDM over the course of a year. To determine total time spent, simulated client data was used to establish the average length of counseling.
	Supervisory Personnel Time Report	This form was completed by the project coordinator for different types of supervisors (community, clinic) from each of the organizations offering the method (NGOs, or MOH facilities). The project coordinator selected a representative sample of 3-4 different supervisors each quarter from each organization. Supervisors were asked to estimate the average amount of time they spent each month, over the previous three months, on supervising FP service providers.
	Project Personnel Monthly Time Report	This form was filled out by the project coordinator on a monthly basis. Time was valued based on average annual salary information which was collected separately.
	Dissemination of IEC Messages and Distribution of Materials	This form was completed on a quarterly basis by the study coordinator.
Annex	Salary and Benefits Report	This form was filled out just once and served as reference for calculating costs of different personnel's time.

SDM Implementation Model Phases and Activities:

The phases and activities of each stage of implementation were very similar in each country. The following bullet points breakdown activities by phase:

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- **Phase I, Preparatory.** This phase is defined as those steps and activities necessary to lay the groundwork for SMD introduction. This includes advocacy efforts, coordinating and planning meetings. The following is a list of the types of costs captured from each country under the heading preparatory phase:
 - *Meetings with stakeholders.* There were numerous meetings held with MOH officials, facility managers, and others. These meetings were to address numerous issues, such as coordinating trainings, IEC activities, and reporting issues.
 - *Formative research.* Costs related to research associated with the larger impact study were not included. Research costs attributed to implementing SDM services were limited to formative research used to inform the design of locally produced IEC materials.
 - *Design and production of training materials.* Costs for this activity were minimal as the materials already existed. However, costs were included for the reproduction of materials and any local adjustments or refinement that may have been made for the local context.
 - *Design and production of job aids.*
 - *Design and production of IEC materials.* This is an essential activity for any program introducing the SDM. IEC materials need to be created which are specific to the environment in which they will be used. Thus, generic materials can be used to form the basis of an IEC campaign, messages need to be adapted, tested, and validated. Then there is also the cost of actually producing the relevant materials. Activities included range from counseling potential clients in their homes, holding group discussions and meetings, holding exhibitions, and distributing booklets and pamphlets.
 - *Design of MIS.* The cost for this activity varies depending on the program and the existing infrastructure. Typically, the cost should be limited to adapting existing forms to include the SDM.
- **Phase II, Implementation.** Once the groundwork has been laid in the preparatory phase, the program is ready to implement. The costs associated with each step are detailed as follows:
 - *Training of Trainers:* Typically, a program employs a cadre of trainers to replicate skills and knowledge among those providing services. ToTs are an effective, relatively inexpensive way to train staff and are a strategy used worldwide by ministries of health, including those in India, Peru, and Rwanda. Once a group of master trainers exists, they can replicate trainings within their areas of responsibility.
 - *Training of service providers.* Master trainers work with groups of up to 20 service providers, who are generally grouped by level. Trainings ranged in duration from four hours to a day and half, depending on the program and level of the provider.
 - *Promotional activities.* In addition to generating awareness among the general public about the availability of the methods, efforts must be undertaken to “recruit” service providers. Large, decentralized organizations such as ministries of health need to conduct outreach to generate interest and support

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- from within. Activities included here are items such as informational materials and visits to service delivery points by supervisors/managers to inform personnel about the initiative.
- *Reinforcement training.* An initial training in itself has been found to be inadequate. Provider knowledge decays over time, and as with any method, SDM providers need follow up support and assistance. As such, follow-up visits and refresher trainings are included in the overall implementation strategy and these costs are considered when calculating the inputs necessary. Once fully integrated into the service delivery program, these costs should be minimal as it will be part of a larger effort to provide periodic refresher training for all methods being offered.
 - *CycleBeads procurement and logistics.* CycleBeads are the necessary commodity for offering the SDM. Costs captured here include the cost of CycleBeads, shipping, warehousing and inventory management. While CycleBeads represent an additional, constant cost, those associated with shipping and inventory management should benefit from economies of scale as the SDM would be integrated in an existing contraceptive commodities procurement and distribution system.
- **Phase III, Service Delivery.** The actual service delivery phase is an ongoing process. This primarily entails the time associated with providing the SDM.
 - *Conduct counseling sessions.* SDM counseling varies in length depending on the a number of issues, including the level of the provider, the health system and the time it typically dedicates to family planning counseling in general, the ability of the user to grasp the information required to use the method correctly. In calculating the amount of time providers spend counseling clients information from the larger study was taken whereby simulated clients timed the duration of the session. From these simulated client sessions average counseling session duration was calculated which is the multiplied by the actual number of SDM users. Using data on the cost of providers' time, along with the total time required to counsel SDM clients, we were able to arrive at the cost of counseling SDM users.
 - *Follow-up of users.* Ideally, there will be follow-up with users in the form of a return visit to the service delivery center, or depending on the program's service delivery protocol, a visit to the field. Providers reported on follow-up provided in terms of time and any additional cost incurred.
 - *Supervision.* Family planning programs have a supervision component in which a designated individual regularly supports to service providers to ensure quality of care. Supervisors were asked to self-report regarding how much time they were dedicating on a monthly basis in their supervisory efforts, specifically on the SDM. Given that this information is self-reported, several supervisors were polled, and the average was taken after discarding outliers.

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III. Results

The following table details the outputs of the SDM introduction effort in each country.

Country	India	Peru	Rwanda
Number Trained (providers and promoters)	529	446	966
Number of Service Delivery Points	131	40	20
Number of SDM users	3,555	848	870

Users, trained providers, and number of delivery points varied greatly from country to country. India has more than four times the number of users as Peru and Rwanda, and three to five times as many service delivery points.

Costs by phase, per country, were as follows:

Country	Phase I	Phase II	Phase III	TOTAL
India	\$3,900	\$1,073	\$15,789	\$20,672
Peru	\$15,127	\$16,983	\$5,233	\$37,343
Rwanda	\$3,385	\$2,113	\$4,789	\$10,287

Phase I, or the preparatory phase, represented the second most expensive phase for all three countries. In India it was approximately 19% of the total implementation cost, in Peru it was 40% of the total, and in Rwanda it was 33%. Table 5 shows more detailed information.

Country	India	Peru	Rwanda
Phase I Total	\$3,900	\$15,127	\$3,385
Phase I per number trained	\$7.37	\$33.92	\$3.50
Phase I per SDP	\$29.77	\$378.18	\$169.25
Phase I per new user	\$1.10	\$17.84	\$3.89

Phase II, or the implementation phase was the least costly for both India and Rwanda. It was the most expensive phase for Peru. For India this represent just over 5% of the cost of implementation and in Rwanda it is almost 21%. Both figures are low, given that this is one of the most resource intensive components of introducing the method, as it involves training. Labor costs are extremely low in these two countries, however, thus this may somewhat explain the costs. In Peru, where labor costs are higher, phase II represented over 45% of the total cost.

APPENDIX A: COST INFORMATION

Phase II Costs of SDM Introduction

Country	India	Peru	Rwanda
Phase II Total	\$1,073	\$16,983	\$2,113
Phase II per number trained	\$2.03	\$38.08	\$2.19
Phase II per SDP	\$8.19	\$424.58	\$105.65
Phase II per new user	\$0.30	\$20.03	\$2.43

Phase III, which is the service delivery component, consists of providers' and supervisors' time, for counseling, follow-up, and quality assurance. This was the most costly component of the India and Rwanda programs, representing 76% and 47% of the total costs, respectively. In Peru, this was the least expensive phase, which is in line with expectations given the low number of users and the brevity of the counseling sessions. In Peru, phase III represented 14% of the budget.

Phase III Costs of SDM Introduction

Country	India	Peru	Rwanda
Phase III Total	\$15,789	\$5,233	\$4,789
Phase III per number trained	\$29.85	\$11.73	\$4.96
Phase III per SDP	\$120.53	\$130.83	\$239.45
Phase III per new user	\$4.44	\$6.17	\$5.50

Table 8 shows the data in terms of cost per user, per SDP and per trained provider (both clinic and community). Comparing these costs across countries is not particularly valuable given that there are major distinctions among the programs and the contexts in which they are operating. Costs for fundamental elements of method introduction such as staff time vary widely. In addition, the circumstances in which each program is operating are vastly different. For example, lower contraceptive prevalence in the catchment areas in both Rwanda and India made it more likely that the programs would attract users.

Cost of SDM Introduction by Key Outputs

Country	India	Peru	Rwanda
TOTAL COSTS	\$20,672	\$37,343	\$10,287
TOTAL per number trained	\$39.08	\$83.73	\$10.65
TOTAL per SDP	\$157.80	\$933.58	\$514.35
TOTAL per new user	\$5.81	\$44.04	\$11.82

IV. Conclusion

The data presented here represents our best attempt to calculate the cost of introducing the SDM into different public sector programs. Numerous activities, both formal and informal, went into SDM introduction and documenting and valuing each would be impossible. Another limiting factor is the absence of cost data for the introduction of other methods in these same settings. Without being able to place

APPENDIX A: COST INFORMATION

SDM introduction into a larger context it is difficult to draw conclusions about the relative expensiveness of offering the SDM.

It is evident that provider time (captured in phase III) represents a significant portion of the cost. To reduce this expense, programs could rely on less expensive community-level workers, who have demonstrated an ability to offer the SDM effectively in numerous settings. Phase I, or the preparatory phase, also offer potential for cost reductions. This phase's biggest expenses consisted of outreach and IEC activities. By integrating SDM messages into larger, existing campaigns, these costs could be reduced considerably.

Comparing costs among the countries is of little value because prices vary tremendously in these three countries. Per capita income in Peru is several times that of India and Rwanda therefore it is not surprising the SDM introduction was significantly higher in that country. This data is most useful in allowing program managers to pinpoint where the biggest outlays are likely to be and to identify potential areas of savings within each based on their specific program's circumstances.

CLIENT PROFILES AND CHECKLISTS

The three client profiles included in this appendix are very similar concerning general personal characteristics but differ in contraceptive history and the family planning method that the mystery client chooses. The respective checklists are very similar or identical concerning interpersonal relations but differ in all the other respects. Each mystery client is to be trained on one, and only one, client profile and checklist.

WARNING

Clients are usually passive in the interactions with providers. Make sure that the mystery clients are generally passive in their own interactions with providers. They should wait for a provider action to respond to and should not take initiatives, unless indicated in the profile.

APPENDIX B: Simulated client profiles and checklists

Service Test: SDM Client Profile

In training you will learn how to enact the following client profile. According to it, you are:

New in town

Wife of small trader

Can provide address

25 years old, two-children (3 and 2 years-old)

Not promiscuous

No family violence

Used rhythm method (got pregnant)

Used pill (frequent headaches)

Abandoned use of pill 3 months ago

Wish children in the future

Healthy, Pap smear last year

Want to choose a contraceptive method

Do not have a specific method in mind

Afraid of side effects of hormonal methods

Afraid of inserting anything in any place

Will choose SDM if given the option

In day 4th of menstruation

Will reject pelvic exam (ashamed)

When the provider describes the SDM, ask “How long can I use this method?” and notice whether he/she responds

You would practice abstinence or use condoms on your fertile days

Husband would be able to abstain from sex or use condoms on your fertile days

Your period comes every month about the same time (approximately every four weeks)

Your period rarely comes before or after you expect it

You are able to provide the date of your last menstruation

You are not breastfeeding your baby

APPENDIX B: Simulated client profiles and checklists

Service Test: SDM Checklist					
Circle the digit that corresponds to the department/region in item 1. Continue on the cell below and circle the district that corresponds.					
1	Department/Region	Jaén	1	Moyobamba	2
2	District	Jaén	1	Moyobamba	1
		Bellavista	2	Jepelacio	2
		Santa Rosa	3	Soritor	3
Write down the required information below. Assign the corresponding codes.					
3	Name of Facility:			Code:	
4	Date:	Year:	Month:	Day:	Hour:
5	Observer Name:			Code:	
Instructions for Subsequent Items					
For each item, answer the question, Was it present in the consultation? Circle one of the numbers to the right signifying: Yes = 1, No = 0, or Do not remember = 99.					
#	Interpersonal relations	Yes	No	NR	
6	Counseling was individual	1	0	99	
7	The counseling session was interrupted	1	0	99	
8	There were strangers hearing what I said	1	0	99	
9	The provider treated me amiably	1	0	99	
10	I felt he/she cared for my health	1	0	99	
11	He/she looked annoyed	1	0	99	
12	Treated me respectfully	1	0	99	
13	Asked me if I had any questions	1	0	99	
14	Responded to my questions	1	0	99	

APPENDIX B: Simulated client profiles and checklists

#	Need diagnosis	Yes	No	NR
15	Asked whether I had children	1	0	99
16	The age of the last child	1	0	99
17	If I wanted to have more children	1	0	99
18	If I was using a contraceptive method	1	0	99
19	About methods used in the past	1	0	99
20	Why I had abandoned the pill	1	0	99
21	If I already had a specific method in mind	1	0	99
22	Whether I could be pregnant (menstruation, others)	1	0	99
23	Whether husband cooperated in family planning	1	0	99

#	Method options	Yes	No	NR
24	Told me that the IUD is a copper device inserted in uterus	1	0	99
25	That the IUD prevents pregnancy for up to 10 years	1	0	99
26	That the injectable is effective if injected every 3 months	1	0	99
27	That the injectable may alter menstruation	1	0	99
28	That SDM requires abstaining from sex or using condoms on days 8 to 19 of the fertile cycle	1	0	99
29	That SDM users rely on a visual aid to identify their fertile days	1	0	99
30	The provider asked me to choose a method	1	0	99
31	The provider tried to convince me to use a specific method	1	0	99
32	Told me that the condom is the only method that prevents STIs	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Contraindications	Yes	No	NR
33	Asked if I would be willing to abstain or use a condom on my fertile days	1	0	99
34	Whether my husband would accept the SDM	1	0	99
35	Whether my husband would be able abstain or use a condom on my fertile days	1	0	99
36	Whether my periods come more or less when I expect them	1	0	99
37	The date of my last period and when I expect my next one	1	0	99
38	Whether my husband or I are at high risk for STIs	1	0	99
39	Whether I had used the pill in past 2 months	1	0	99
40	Whether I had used the injectable in past 2 months	1	0	99
41	Whether I can communicate with my husband about when to have sex	1	0	99

#	Action mechanisms, advantages, disadvantages	Yes	No	NR
42	Provider explained how the SDM functions	1	0	99
43	That the SDM has no side effects or health risks	1	0	99
44	What to do if my cycle is too long	1	0	99
45	What to do if my cycle is too short	1	0	99
46	That I should use a condom every time I have sex on the fertile days	1	0	99
47	Explained alternative sexual practices to use on the fertile days	1	0	99
48	That the white beads represent days in which I should abstain or have protected sex	1	0	99
49	That pregnancy is likely if you have unprotected sex on a fertile day	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Use instructions	Yes	No	NR
50	Told me to move the black band to the red bead the day my menstruation starts	1	0	99
51	To mark the first day of menstruation on my card	1	0	99
52	That SDM users must move the black band every day	1	0	99
53	To always move the black band in the same direction	1	0	99
54	To check with the calendar if I forget to move the band	1	0	99
55	That the brown beads represent days in which I can have sex	1	0	99
56	Emphasized that if I have unprotected sex on the white-bead days I am likely to get pregnant	1	0	99
57	Told me to discuss with my husband how we are going to manage sex	1	0	99

#	Follow-up	Yes	No	NR
58	Offered to talk to my partner	1	0	99
59	Gave me a follow-up appointment	1	0	99
60	Gave me a necklace and a calendar	1	0	99
61	Told me to return if my period does not return the day after the band passes through the last bead	1	0	99
62	Told me to return if my period returns before the day in which the band should reach the dark brown bead	1	0	99
63	Told me how to open the package and remove the condom	1	0	99
64	Explained to me how to place the condom on the penis	1	0	99
65	Said that the condom must be placed on penis before entering vagina	1	0	99
66	That the penis must be withdrawn while still erect and holding the condom	1	0	99
67	That I should use a new condom in each coitus	1	0	99
68	The provider verified that I understood what he/she had explained to me	1	0	99
69	Told me that I should return if I had any questions or concerns	1	0	99
70	That I should return if I would like to switch methods	1	0	99

APPENDIX B: Simulated client profiles and checklists

Comments _____

APPENDIX B: Simulated client profiles and checklists

Service Test: DMPA Client Profile

In training you will learn how to enact the following client profile. According to it, you are:

New in town

Wife of small trader

Can provide address

25 years old, two-children (3 and 2 years-old)

Not promiscuous

No family violence

Used pill (worried because you too often forgot to take it every day)

Currently using condom inconsistently

Wish children in the future

Healthy, Pap smear last year

Want to stop using condoms (disliked by husband)

Know little about other methods

Do not trust “natural” contraception

Afraid of inserting anything into body

Has heard about DMPA

Will choose DMPA if given the option

In day 20th of your cycle

Not absolutely sure that are not pregnant

Will reject pelvic exam (ashamed)

When the provider describes the injectable, ask “How long can I use this method?” and notice whether he/she responds

If the provider is ready to inject, say “Stop it, please. I am sorry, but I would like to consult with my mother in law before receiving the injection”, say Bye, and leave.

APPENDIX B: Simulated client profiles and checklists

Service Test: DMPA Checklist					
Circle the digit that corresponds to the department/region in item 1. Continue on the cell below and circle the district that corresponds.					
1	Department/Region	Jaén	1	Moyobamba	2
2	District	Jaén	1	Moyobamba	1
		Bellavista	2	Jepelacio	2
		Santa Rosa	3	Soritor	3
Write down the required information below. Assign the corresponding codes.					
3	Name of Facility:			Code:	
4	Date:	Year:	Month:	Day:	Hour:
5	Observer Name:			Code:	
Instructions for Subsequent Items					
For each item, answer the question, Was it present in the consultation? Circle one of the numbers to the right signifying: Yes = 1, No = 0, or Do not remember = 99.					
#	Interpersonal relations	Yes	No	NR	
6	Counseling was individual	1	0	99	
7	The counseling session was interrupted	1	0	99	
8	There were strangers hearing what I said	1	0	99	
9	The provider treated me amiably	1	0	99	
10	I felt he/she cared for my health	1	0	99	
11	He/she looked annoyed	1	0	99	
12	Treated me respectfully	1	0	99	
13	Asked me if I had any questions	1	0	99	
14	Responded to my questions	1	0	99	

APPENDIX B: Simulated client profiles and checklists

#	Need diagnosis	Yes	No	NR
15	Asked whether I had children	1	0	99
16	Asked the age of the last child	1	0	99
17	Asked if I wanted to have more children	1	0	99
18	Asked if I was using a contraceptive method	1	0	99
19	Asked about methods used in the past	1	0	99
20	Asked why I wanted to change the condom	1	0	99
21	Asked if I already had a specific method in mind	1	0	99
22	Asked whether I could be pregnant (menstruation, others)	1	0	99
23	Asked whether husband cooperated in family planning	1	0	99

#	Method options	Yes	No	NR
24	The provider told me that the IUD is a copper device inserted in uterus	1	0	99
25	That the IUD prevents pregnancy for up to 10 years	1	0	99
26	That the injectable is effective if injected every 3 months	1	0	99
27	That the injectable may alter menstruation	1	0	99
28	That SDM requires abstaining from sex or using condoms on days 8 to 19 of the cycle	1	0	99
29	That SDM users rely on a visual aid to identify their fertile days	1	0	99
30	The provider asked me to choose a method	1	0	99
31	The provider tried to convince me to use a specific method	1	0	99
32	Told me that the condom is the only method that prevents STIs	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Contraindications	Yes	No	NR
33	Asked if I had observed vaginal bleeding other than menstruation	1	0	99
34	If I had or have had in the past liver disease (or yellow skin, eyes)	1	0	99
35	If I had heart disease	1	0	99
36	If I had hypertension	1	0	99
37	If I had ever had a stroke	1	0	99
38	If I had deep thrombosis of the leg	1	0	99
39	If I had migraines	1	0	99
40	If I had diabetes for 20 years or with damage to vision or kidneys	1	0	99
41	If I had or had ever had breast cancer	1	0	99

#	Action mechanism and advantages	Yes	No	NR
42	Provider explained how the method functions (one mechanism)	1	0	99
43	Provider explained how the method functions (two or more mechanisms)	1	0	99
44	Said that the injectable does not interfere with intercourse	1	0	99
45	That the method does not require daily action to be effective	1	0	99
46	That one of its advantages is privacy	1	0	99
47	That it may reduce anemia	1	0	99
48	That it does not cause cancer	1	0	99
49	That it may prevent some forms of cancer	1	0	99
50	That it prevents ectopic pregnancies	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Side effects and alarm signs	Yes	No	NR
51	That I could experience headaches	1	0	99
52	I may have bleeding or spotting between menstruations	1	0	99
53	I could have total or partial absence of menstruation	1	0	99
54	My weight could increase or decrease	1	0	99
55	These side effects are not dangerous	1	0	99
56	After using the method, the return of fertility could be delayed for 6 to 9 months after stopping use	1	0	99
57	I should return to the clinic if I have severe headaches	1	0	99
58	I should return to the clinic if my eyes or skin turn yellow	1	0	99
59	If I was late for my injection, no matter how late	1	0	99

#	Use instruction and follow up	Yes	No	NR
60	That I had to wait until my next period to get my first injection	1	0	99
61	That I should use condoms until my first injection	1	0	99
62	Explained how to open the package and remove the condom	1	0	99
63	How to place the condom on the penis	1	0	99
64	Said that the condom must be placed on penis before entering vagina	1	0	99
65	That the penis must be withdrawn while still erect and holding the condom	1	0	99
66	That I should use a new condom in each coitus	1	0	99
67	That I should return if I had any questions or concerns	1	0	99
68	That I should return if I would like to switch methods	1	0	99
69	The provider made sure that I understood what he/she had	1	0	99

APPENDIX B: Simulated client profiles and checklists

	explained to me			
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Comments _____

APPENDIX B: Simulated client profiles and checklists

Service Test: Pill Client Profile

During training you will learn to enact the following client profile. According to it, you are:

New in town

Wife of small trader

Can provide address

25 years old, two-children (3 and 2 years-old)

Not promiscuous

No family violence

Used condom (husband disliked using it every time)

Currently using condom inconsistently

Wish children in the future

Healthy, Pap smear last year

Want to change condom

Know little or nothing about other methods

Do not trust “natural” contraception

Afraid of inserting anything into uterus

Do not want to be injected (needles)

Will choose pill if given the option

In day 4th of your cycle

Will reject pelvic exam (ashamed)

When the provider describes the pill, ask “How long can I use this method?” and notice whether he/she responds

If the provider gives you a package of pills, accept it and thank him/her.

APPENDIX B: Simulated client profiles and checklists

Service Test: Pill Checklist				
Circle the digit that corresponds to the department/region in item 1. Continue on the cell below and circle the district that corresponds.				
1	Department/Region	Jaén 1	Moyobamba 2	
2	District	Jaén 1	Moyobamba 1	
		Bellavista 2	Jepelacio 2	
		Santa Rosa 3	Soritor 3	
Write down the required information below. Assign the corresponding codes.				
3	Name of Facility:		Code:	
4	Date:	Year:	Month:	Day: Hour:
5	Observer Name:		Code:	
Instructions for Subsequent Items				
For each item, answer the question, Was it present in the consultation? Circle one of the numbers to the right signifying: Yes = 1, No = 0, or Do not remember = 99.				
#	Interpersonal relations	Yes	No	NR
6	Counseling was individual	1	0	99
7	The counseling session was interrupted	1	0	99
8	There were strangers hearing what I said	1	0	99
9	The provider treated me amiably	1	0	99
10	I felt he/she cared for my health	1	0	99
11	He/she looked annoyed	1	0	99
12	Treated me respectfully	1	0	99
13	Asked me if I had any questions	1	0	99
14	Responded to my questions	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Need diagnosis	Yes	No	NR
15	Asked whether I had children	1	0	99
16	Asked the age of the last child	1	0	99
17	Asked if I wanted to have more children	1	0	99
18	Asked if I was using a contraceptive method	1	0	99
19	Asked about methods used in the past	1	0	99
20	Asked why I wanted to stop using the condom	1	0	99
21	Asked if I had a specific method in mind	1	0	99
22	Asked whether I could be pregnant (menstruation, others)	1	0	99
23	Asked whether my husband cooperated in family planning	1	0	99

#	Method options	Yes	No	NR
24	Told me that the IUD is a copper device inserted in uterus	1	0	99
25	That the IUD prevents pregnancy for up to 10 years	1	0	99
26	That the pill is effective if taken every day	1	0	99
27	That the injectable is effective if injected every 3 months	1	0	99
28	That the injectable may alter menstruation	1	0	99
29	That SDM requires abstaining from sex or using condoms on days 8 to 19 of the fertile cycle	1	0	99
30	That SDM users rely on a visual aid to identify their fertile days	1	0	99
31	Asked me to choose a method	1	0	99
32	Tried to convince me to use a specific method	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Contraindications	Yes	No	NR
33	Asked if I had severe headaches with blurred vision	1	0	99
34	If I had or had ever had liver disease (or yellow skin, eyes)	1	0	99
35	If I take medicines for convulsions or tuberculosis	1	0	99
36	If I have diabetes	1	0	99
37	If I smoke more than 15 cigarettes per day	1	0	99
38	About my blood pressure or measured it (or someone else did it)	1	0	99
39	If I had any heart problems	1	0	99
40	About breast cancer/breast lumps	1	0	99
41	About venous thrombosis or family history of it	1	0	99

#	Action mechanism and disadvantages	Yes	No	NR
42	Provider explained how the pill functions	1	0	99
43	Said that the pill does not interfere with intercourse	1	0	99
44	That some persons forget to take it every day	1	0	99
45	That the pill helps regulate menstruation	1	0	99
46	That the pill reduces menstrual cramps	1	0	99
47	That the pill prevents pelvic inflammation	1	0	99
48	That the pill may reduce anemia	1	0	99
49	That the pill does not cause cancer	1	0	99
50	That the condom is the only method that prevents STIs	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Use instructions	Yes	No	NR
51	Told me to initiate use of the pill on days 1-5 of menstruation	1	0	99
52	That I would need to take the pill every day	1	0	99
53	That taking the pill at a fixed hour is preferred	1	0	99
54	That I should start a new package the day after finishing the previous one	1	0	99
55	To take one white pill as soon as I remember if I forget one	1	0	99
56	To stop taking pills if I forget to take two or more white pills and use alternative protection until 7th day of new package	1	0	99
57	To do nothing special if I forget to take brown pills	1	0	99
58	To stop use two weeks before/after major surgical event	1	0	99
59	To use alternative protection for 7 days if I have diarrhea and/or vomiting during 2 days	1	0	99
#	Side effects and alarm signs	Yes	No	NR
60	That I could experience nausea or feel dizzy	1	0	99
61	That I could experience headaches	1	0	99
62	That I could experience breast tenderness	1	0	99
63	That these side effects are not dangerous and usually disappear	1	0	99
64	To return to the clinic right away if the side effects do not disappear in next 3 months	1	0	99
65	If I have severe headaches and/or blurry vision	1	0	99
66	If I have severe breast pain or severe respiratory problems	1	0	99
67	If my skin or eyes turn yellow	1	0	99
68	If my legs ache	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Follow up	Yes	No	NR
69	The provider gave me pills or told me that the clinic was out of pills and told me where to get them	1	0	99
70	The provider told me to return if I had any questions or concerns	1	0	99
71	The provider told me to return if I want to switch methods	1	0	99
72	The provider told me to return if I suspect pregnancy or if menstruation stops > 2 months	1	0	99
73	The provider explained how to open the package and remove the condom	1	0	99
74	The provider explained how to place the condom on the penis	1	0	99
75	The provider told me that the condom must be placed on the penis before entering vagina	1	0	99
76	The provider told me that the penis must be withdrawn while still erect and holding the condom	1	0	99
77	That I should use one new condom in each coitus	1	0	99
78	The provider verified that I understood what he/she had explained to me	1	0	99

Comments _____

APPENDIX B: Simulated client profiles and checklists

Service Test: Sterilization Client Profile

In training you will learn how to enact the following client profile. According to it, you are:

New in town

Wife of small trader

Can provide address

35 years old, four children (13, 12, 7, and 2 years-old)

Not promiscuous

No family violence

Used condom (husband disliked using it every time)

Used pill (did not tolerate headaches)

Using condom inconsistently

You and your husband do not wish children

Healthy, Pap smear last year

Would accept sterilization if offered the option

Do not trust “natural” contraception

Afraid of inserting anything in any place

Would expect same side effects of the pill with DMPA

Husband would not accept vasectomy

In day 4th of menstruation

Will reject pelvic exam (ashamed)

Do not have a specific method in mind

When the provider describes the sterilization, ask “How long can I think it about it before I make a decision?” and notice whether he/she responds

APPENDIX B: Simulated client profiles and checklists

Service Test: Sterilization Checklist						
Circle the digit that corresponds to the department/region in item 1. Continue on the cell below and circle the district that corresponds.						
1	Department/Region	Jaén	1	Moyobamba	2	
2	District	Jaén	1	Moyobamba	1	
		Bellavista	2	Jepelacio	2	
		Santa Rosa	3	Soritor	3	
Write down the required information below. Assign the corresponding codes.						
3	Name of Facility:			Code:		
4	Date:	Year:	Month:	Day:	Hour:	
5	Observer Name:			Code:		
Instructions for Subsequent Items						
For each item, answer the question, Was it present in the consultation? Circle one of the numbers to the right signifying: Yes = 1, No = 0, or Do not remember = 99.						
#	Interpersonal relations			Yes	No	NR
6	Counseling was individual			1	0	99
7	The counseling session was interrupted			1	0	99
8	There were strangers hearing what I said			1	0	99
9	The provider treated me amiably			1	0	99
10	I felt he/she cared for my health			1	0	99
11	He/she looked annoyed			1	0	99
12	Treated me respectfully			1	0	99
13	Asked me if I had any questions			1	0	99
14	Responded to my questions			1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Need diagnosis	Yes	No	NR
15	Asked how many children I had	1	0	99
16	If I wanted to have more children	1	0	99
17	If my husband wanted to have more children	1	0	99
18	If I was using a contraceptive method	1	0	99
19	About methods I used in the past	1	0	99
20	Why I wanted to stop using condoms	1	0	99
21	If I already had a method in mind	1	0	99
22	Whether I could be pregnant (menstruation, others)	1	0	99
23	Whether husband cooperated in family planning	1	0	99

#	Method options	Yes	No	NR
24	Told me that the IUD prevents pregnancy for up to 10 years	1	0	99
25	That the injectable is effective if injected every 3 months	1	0	99
26	That the SDM requires abstinence or condom use on fertile days	1	0	99
27	That vasectomy is a small surgical intervention for men	1	0	99
28	That tubal ligation is a small surgical intervention for women	1	0	99
29	That vasectomy and tubal ligation are permanent methods	1	0	99
30	That the condom is the only method that prevents STIs	1	0	99
31	The provider asked me to choose a method	1	0	99
32	The provider tried to convince me to use a specific method	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Contraindications	Yes	No	NR
33	Asked me if I was sure I did not want to have more children	1	0	99
34	Whether I had a stable relationship with my husband	1	0	99
35	If I had a vaginal infection	1	0	99
36	If I had had any genital cancer	1	0	99
37	If I had had a stroke	1	0	99
38	If I had symptoms of heart disease	1	0	99
39	If I had coagulation problems	1	0	99
40	If I had inflammatory pelvic infection	1	0	99
41	If I had diabetes	1	0	99

#	Action mechanisms and advantages	Yes	No	NR
42	The provider explained how the method functions (tubal ligation)	1	0	99
43	That the uterus would not be removed	1	0	99
44	That I would never be able to have children	1	0	99
45	That the sterilization would not alter sexual desire	1	0	99
46	That the sterilization would not interfere with daily activities	1	0	99
47	That I would continue menstruating	1	0	99
48	That the operation might have some risks	1	0	99
49	That the operation would take place at a hospital or primary health center	1	0	99

APPENDIX B: Simulated client profiles and checklists

#	Use instructions	Yes	No	NR
50	That it was better if I go when I am menstruating	1	0	99
51	That I might have to wait for an appointment after I was examined by a doctor	1	0	99
52	What hospital or primary health center I should go to	1	0	99
53	That I would have to bring a relative or husband	1	0	99
54	That both (I and the relative) would have to sign an informed consent form	1	0	99
55	The provider gave a referral to the hospital or primary health center	1	0	99
56	Told me that I could change my mind at any time before the operation	1	0	99
57	That I would have to take it easy for a few days after the operation	1	0	99

#	Follow-up	Yes	No	NR
58	The provider instructed me to continue using condoms until the operation	1	0	99
59	Told me how to open the package and remove the condom	1	0	99
60	Explained to me how to place the condom on the penis	1	0	99
61	Said that the condom must be placed on penis before entering vagina	1	0	99
62	That the penis must be withdrawn while still erect and holding the condom	1	0	99
63	That I should use one new condom in each coitus	1	0	99
64	That I would have to avoid strenuous exercise for a few days after the operation	1	0	99
65	That I would have to avoid sex for a few days after the operation	1	0	99
66	Asked if I had any questions	1	0	99
67	Verified that I understood what he/she had explained to me	1	0	99

APPENDIX B: Simulated client profiles and checklists

Comments _____

APPENDIX C: SURVEY QUESTIONNAIRE, WOMEN

STANDARD DAYS METHOD MODULE

October 2004

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Now let's talk about the Standard Days Method. What is the Standard Days Method? How does it work? CIRCLE CODE 1 AND CHECK THE 'SPONTANEOUS' BOX FOR EACH ITEM MENTIONED SPONTANEOUSLY in questions 401, 402, and 403. THEN PROCEED DOWN THE LIST AND ASK Did you know that the Standard Days Method . . .?		
01	Is a fertility awareness, rhythm, or "risky days" method?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
02	Defines as fertile days 8-19 of the menstrual cycle or those of white beads?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
03	Comes with a visual aid: a necklace?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
402	What woman can use the Standard Days Method? CIRCLE CODE 1 AND CHECK THE 'SPONTANEOUS' BOX FOR EACH ITEM MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN THE LIST AND ASK Did you know that the Standard Days Method . . .?		
01	Requires a regular menstrual cycle?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
02	Requires a 26-32 day menstrual cycle?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
03	Requires partner cooperation?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
403	How is the Standard Days Method used? CIRCLE CODE 1 AND CHECK THE 'SPONTANEOUS' BOX FOR EACH ITEM MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN THE LIST AND ASK Did you know that the Standard Days Method . . .?		

APPENDIX C: SURVEY QUESTIONNAIRE, WOMEN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	Requires abstinence or use of condom in the fertile days?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
2	Requires keeping track daily?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
3	Requires moving the black band to the red bead the day menstruation starts?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
4	Requires marking the first day of menstruation on a calendar?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
5	Requires moving the black band every day?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
6	Requires always moving the black band in the same direction?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
7	Requires checking with the calendar if one forgets to move the band?	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
404	Now, I would like to ask you about your opinion of the Standard Days Method. In your opinion, is/does the Standard Days Method . . .		
01	Easy for you to understand?	YES 1 NO 2 DON'T KNOW 3	
02	Easy for your partner to understand?	YES 1 NO 2 DON'T KNOW 3	
03	Simple to use?	YES 1 NO 2 DON'T KNOW 3	
04	Require too much work?	YES 1 NO 2 DON'T KNOW 3	

APPENDIX C: SURVEY QUESTIONNAIRE, WOMEN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
05	Interfere with one's sexual life?	YES 1 NO 2 DON'T KNOW 3	
06	Effective if used correctly?	YES 1 NO 2 DON'T KNOW 3	
07	Affordable?	YES 1 NO 2 DON'T KNOW 3	
08	Easy to obtain?	YES 1 NO 2 DON'T KNOW 3	
09	Popular in your community?	YES 1 NO 2 DON'T KNOW 3	
10	Consistent with your religious beliefs?	YES 1 NO 2 DON'T KNOW 3	
11	Consistent with your moral principals?	YES 1 NO 2 DON'T KNOW 3	
12	Safe for your health?	YES 1 NO 2 DON'T KNOW 3	
404a	Is the Standard Days Method acceptable to you?	YES 1 NO 2 DON'T KNOW 3	
405	Is the Standard Days Method acceptable to your partner?	YES 1 NO 2 DON'T KNOW 3	
406	CHECK 311: NOT CURRENTLY USING THE STANDARD DAYS METHOD <input type="checkbox"/> CURRENTLY USING THE STANDARD DAYS METHOD <input type="checkbox"/>		411
407	Do you think that the Standard Days Method may meet your needs for a family planning method in the future?	YES 1 NO 2 DON'T KNOW 3	409 409
408	Why not? RECORD ALL REASONS MENTIONED	IRREGULAR CYCLES 1 SPOUSE OPPOSED 2 EXPENSIVE 3 INEFFECTIVE/DON'T TRUST 4 LACK OF INFORMATION 5 DISLIKE ABSTINENCE 6 DISLIKE CONDOM USE 7 OTHER 8 (SPECIFY)	

APPENDIX C: SURVEY QUESTIONNAIRE, WOMEN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
409	If you decide to use the Standard Days Method in the future, do you think that your husband would approve?	YES 1 NO 2 DON'T KNOW 3	411 411
410	Why not?	EXPENSIVE 1 INEFFECTIVE/DON'T TRUST 2 LACK OF INFORMATION 3 DISLIKES ABSTINENCE 4 DISLIKES CONDOM USE 5 OTHER 6 (SPECIFY)	
411	Do you plan to seek more information about the Standard Days Method from your family planning provider in the future?	YES 1 NO 2 DON'T KNOW 3	
412	Who told you about the Standard Days Method? RECORD ALL PEOPLE MENTIONED, THEN ASK, Anyone else?	FRIEND/FAMILY/NEIGHBORS 1 SPOUSE 2 PROVIDER 3 COMMUNITY HEALTH WORKER 4 OTHER 5 (SPECIFY) CAN'T REMEMBER/DON'T KNOW .. 6	
413	Where did you get information about the Standard Days Method? RECODE ALL SOURCES MENTIONED ADD COUNTRY SPECIFIC OPTIONS	COMMUNITY TALK 1 HEALTH FAIR 2 CLINIC TALK 3 POSTERS 4 RADIO 5 TELEVISION 6 NEWSPAPER 7 BROCHURES/FLYERS 8 CAN'T REMEMBER/DON'T KNOW 10 OTHER 11 (SPECIFY)	
414	Do you know where to go to get the Standard Days Method?	YES 1 NO 2	416
415	Where? RECORD ALL PLACES MENTIONED	GOVERNMENT HOSPITAL 1 GOVERNMENT HEALTH CENTER... 2 FAMILY PLANNING CLINIC 3 GOVERNMENT MOBILE CLINIC..... 4 GOVERNMENT FIELDWORKER..... 5 OTHER PUBLIC 6 PRIVATE HOSPITAL/CLINIC 7 PHARMACY 8 PRIVATE DOCTOR..... 9 NON-GOVT. MOBILE CLINIC 10 NON-GOVT. FIELDWORKER 11 OTHER PRIVATE MEDICAL..... 12 SHOP 13 CHURCH 14 FRIENDS/RELATIVES 15 OTHER 16 (SPECIFY)	

APPENDIX C: SURVEY QUESTIONNAIRE, WOMEN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
416	Have you ever discussed the Standard Days Method with anyone?	YES 1 NO 2 DON'T KNOW 3	<input type="checkbox"/> → 418
417	Who did you discuss it with? RECORD ALL PEOPLE MENTIONED	HUSBAND 1 MOTHER 2 MOTHER IN LAW 3 SISTER 4 OTHER RELATIVE 5 FRIEND/NEIGHBOR 6 HEALTH PROVIDER 8 OTHER _____ 9 (SPECIFY)	
418	CHECK 311: <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>NOT CURRENTLY USING THE STANDARD DAYS METHOD</p> <p><input type="checkbox"/></p> <p>↓</p> <p>Do you know anyone who is using or has used the Standard Days Method?</p> </div> <div style="text-align: center;"> <p>CURRENTLY USING THE STANDARD DAYS METHOD</p> <p><input type="checkbox"/></p> <p>↓</p> <p>Do you know anyone else who is using or has used the Standard Days Method?</p> </div> </div>	YES 1 NO 2 DON'T KNOW 3	

APPENDIX D: SURVEY QUESTIONNAIRE, MEN

SECTION 4: STANDARD DAYS METHOD

October, 2004

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	<p>Now let's talk about the Standard Days Method. What is the Standard Days Method? How does it work?</p> <p>CIRCLE CODE 1 AND CHECK THE 'SPONTANEOUS' BOX FOR EACH ITEM MENTIONED SPONTANEOUSLY IN QUESTIONS 401, 402, AND 403. THEN PROCEED DOWN THE LIST AND ASK Did you know that the Standard Days Method . . . ?</p>		
01	Is a fertility awareness, rhythm, or "risky days" method	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
02	Defines as fertile days 8-19 of the menstrual cycle or those of white beads	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
03	Comes with a visual aid: a necklace	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
402	<p>What woman can use the Standard Days Method?</p> <p>CIRCLE CODE 1 AND CHECK THE 'SPONTANEOUS' BOX FOR EACH ITEM MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN THE LIST AND ASK Did you know that the Standard Days Method . . . ?</p>		
01	Requires a regular menstrual cycle	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
02	Requires a 26-32 day menstrual cycle	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
03	Requires partner cooperation	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	

APPENDIX D: SURVEY QUESTIONNAIRE, MEN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
403	<p>How is the Standard Days Method used?</p> <p>CIRCLE CODE 1 AND CHECK THE 'SPONTANEOUS' BOX FOR EACH ITEM MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN THE LIST AND ASK Did you know that the Standard Days Method . . . ?</p>		
01	Requires abstinence or use of condom in the fertile days	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
02	Requires keeping track daily	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
03	Requires moving the black band to the red bead the day menstruation starts	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
04	Requires marking the first day of menstruation on a calendar	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
05	Requires moving the black band every day	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
06	Requires always moving the black band in the same direction	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
07	Requires checking with the calendar if one forgets to move the band	SPONTANEOUS <input type="checkbox"/> YES 1 NO 2	
404	<p>Now, I would like to ask you about your opinion of the Standard Days Method.</p> <p>In your opinion, is/does the Standard Days Method . . .</p>		
01	Easy for you to understand?	YES 1 NO 2 DON'T KNOW 3	

APPENDIX D: SURVEY QUESTIONNAIRE, MEN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
02	Easy for your partner to understand?	YES 1 NO 2 DON'T KNOW 3	
03	Simple to use?	YES 1 NO 2 DON'T KNOW 3	
04	Requires too much work?	YES 1 NO 2 DON'T KNOW 3	
05	Interferes with one's sexual life?	YES 1 NO 2 DON'T KNOW 3	
06	Effective if used correctly?	YES 1 NO 2 DON'T KNOW 3	
07	Affordable?	YES 1 NO 2 DON'T KNOW 3	
08	Easy to obtain?	YES 1 NO 2 DON'T KNOW 3	
09	Popular in your community?	YES 1 NO 2 DON'T KNOW 3	
10	Consistent with your religious beliefs?	YES 1 NO 2 DON'T KNOW 3	
11	Consistent with your moral principles?	YES 1 NO 2 DON'T KNOW 3	
12	Safe for your health?	YES 1 NO 2 DON'T KNOW 3	
404a	Is the Standard Days Method acceptable to you?	YES 1 NO 2 DON'T KNOW 3	
405	Is the Standard Days Method acceptable to your partner?	YES 1 NO 2 DON'T KNOW 3	
406	CHECK 311: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>NOT CURRENTLY USING THE STANDARD DAYS METHOD <input type="checkbox"/></p> <p>↓</p> </div> <div style="text-align: center;"> <p>CURRENTLY USING THE STANDARD DAYS METHOD <input type="checkbox"/></p> <p>→</p> </div> </div>		411

APPENDIX D: SURVEY QUESTIONNAIRE, MEN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
407	Do you think that the Standard Days Method may meet your needs for a family planning method in the future?	YES 1 NO 2 DON'T KNOW 3	→ 409 → 409
408	Why not? RECORD ALL REASONS MENTIONED	IRREGULAR CYCLES 1 SPOUSE OPPOSED 2 EXPENSIVE 3 INEFFECTIVE/DON'T TRUST 4 LACK OF INFORMATION 5 DISLIKE ABSTINENCE 6 DISLIKE CONDOM USE 7 OTHER 8 (SPECIFY)	
409	If you decide to use the Standard Days Method in the future, do you think that your wife would approve?	YES 1 NO 2 DON'T KNOW 3	→ 411 → 411
410	Why not?	EXPENSIVE 1 INEFFECTIVE/DON'T TRUST 2 LACK OF INFORMATION 3 DISLIKES ABSTINENCE 4 DISLIKES CONDOM USE 5 OTHER 6 (SPECIFY)	
411	Do you plan to seek more information about the Standard Days Method from your family planning provider in the future?	YES 1 NO 2 DON'T KNOW 3	
412	Who told you about the Standard Days Method? RECORD ALL PEOPLE MENTIONED, THEN ASK, Anyone else?	FRIEND/FAMILY/NEIGHBORS 1 SPOUSE 2 PROVIDER 3 COMMUNITY HEALTH WORKER 4 OTHER 5 (SPECIFY) CAN'T REMEMBER/DON'T KNOW .. 6	
413	Where did you get information about the Standard Days Method? RECODE ALL SOURCES MENTIONED ADD COUNTRY SPECIFIC OPTIONS	COMMUNITY TALK 1 HEALTH FAIR 2 CLINIC TALK 3 POSTERS 4 RADIO 5 TELEVISION 6 NEWSPAPER 7 BROCHURES/FLYERS 8 CAN'T REMEMBER/DON'T KNOW 10 OTHER 11 (SPECIFY)	
414	Do you know where to go to get the Standard Days Method?	YES 1 NO 2	→ 416

APPENDIX D: SURVEY QUESTIONNAIRE, MEN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP		
415	<p>Where?</p> <p>RECORD ALL PLACES MENTIONED</p>	<p>GOVERNMENT HOSPITAL..... 1 GOVERNMENT HEALTH CENTER... 2 FAMILY PLANNING CLINIC 3 GOVERNMENT MOBILE CLINIC..... 4 GOVERNMENT FIELDWORKER..... 5 OTHER PUBLIC 6 PRIVATE HOSPITAL/CLINIC 7 PHARMACY 8 PRIVATE DOCTOR..... 9 NON-GOVT. MOBILE CLINIC 10 NON-GOVT. FIELDWORKER 11 OTHER PRIVATE MEDICAL..... 12 SHOP 13 CHURCH 14 FRIENDS/RELATIVES 15 OTHER 16 (SPECIFY)</p>			
416	<p>Have you ever discussed the Standard Days Method with anyone?</p>	<p>YES 1 NO 2 DON'T KNOW 3</p>	<p><input type="checkbox"/> 418</p>		
417	<p>Who did you discuss it with?</p> <p>RECORD ALL PEOPLE MENTIONED</p>	<p>HUSBAND 1 MOTHER 2 MOTHER IN LAW 3 SISTER 4 OTHER RELATIVE 5 FRIEND/NEIGHBOR 6 HEALTH PROVIDER 8 OTHER 9 (SPECIFY)</p>			
418	<p>CHECK 311:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;"> <p>NOT CURRENTLY USING THE STANDARD DAYS METHOD</p> <p><input type="checkbox"/></p> <p>↓</p> <p>Do you know anyone who is using or has used the Standard Days Method?</p> </td> <td style="width: 50%; text-align: center;"> <p>CURRENTLY USING THE STANDARD DAYS METHOD</p> <p><input type="checkbox"/></p> <p>↓</p> <p>Do you know anyone else who is using or has used the Standard Days Method?</p> </td> </tr> </table>	<p>NOT CURRENTLY USING THE STANDARD DAYS METHOD</p> <p><input type="checkbox"/></p> <p>↓</p> <p>Do you know anyone who is using or has used the Standard Days Method?</p>	<p>CURRENTLY USING THE STANDARD DAYS METHOD</p> <p><input type="checkbox"/></p> <p>↓</p> <p>Do you know anyone else who is using or has used the Standard Days Method?</p>	<p>YES 1 NO 2 DON'T KNOW 3</p>	
<p>NOT CURRENTLY USING THE STANDARD DAYS METHOD</p> <p><input type="checkbox"/></p> <p>↓</p> <p>Do you know anyone who is using or has used the Standard Days Method?</p>	<p>CURRENTLY USING THE STANDARD DAYS METHOD</p> <p><input type="checkbox"/></p> <p>↓</p> <p>Do you know anyone else who is using or has used the Standard Days Method?</p>				

Georgetown University – Center for Reproductive Health

Impact Study of the Standard Days Method

Interviewer's Manual Women's Questionnaire

**Georgetown Institute of Reproductive Health
4301 Connecticut Avenue, NW, Suite 301
Washington, DC 20008**

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APPENDIX E: Interviewer's Manual – Women's Questionnaire

I. INTRODUCTION TO THE SURVEY TO MEASURE THE IMPACT OF THE STANDARD DAYS METHOD

The survey entitled “Impact Study of the Standard Days Method” is a representative community-based survey designed to provide information on maternal health, reproduction, awareness and use of family planning methods, including the Standard Days Method (SDM) in [Country]. The survey will involve interviewing a randomly selected group of married women who are between 15 and 49 years and a randomly selected group of married men.

The Standard Days Method is a fertility awareness-based method developed and tested by the Institute for Reproductive Health at Georgetown University that is appropriate for women with regular menstrual cycles between 26 and 32 days long. It identifies days 8 to 19 of the menstrual cycle as the “fertile window”, i.e., the days when pregnancy is very likely. To prevent pregnancy, the couple avoids unprotected intercourse during the 12-day fertile window. The 12 days take into account the life span of the woman's egg, the viable life of sperm, and the variation in the actual timing of ovulation from one cycle to the next.^{1,2}

Most women who use the SDM find that CycleBeads, a visual aid that represents the menstrual cycle, are helpful for learning and using the method. CycleBeads, a color-coded string of beads representing the menstrual cycle, help a woman know which day of her cycle she is on, and identify whether she is on a day when she is likely to get pregnant.

SDM introduction studies were conducted in the Philippines, India, Bolivia, Peru, El Salvador, Honduras, Guatemala, Ecuador, Rwanda, and Benin. After one year of introduction, family planning agencies and Ministries of Health around the world report that the SDM represents between two to seven percent of new family planning users. In Rwanda, for example, where contraceptive prevalence does not reach 5 percent, service statistics show that SDM users accounted for about 7 percent of all the new users of modern family planning methods at the research sites.

The next step in the development and introduction of the SDM is expanding interventions to introduce SDM on a larger scale in delivery systems and communities. This survey will measure the impact of the Standard Days Method at the community level.

Women and men included in the survey will be asked questions about their background, the children they have given birth to, their knowledge and use of family planning methods, including the Standard Days Method, reproductive health, and other information that will be helpful to policymakers and administrators in health and family planning in expanding access to the Standard Days Method.

You are being trained as an interviewer for this survey to assess the impact of scaling-up the Standard Days Method at the community level. After the training course, which will take about three weeks to complete, selected interviewers will be working in teams, going to different parts of the country to interview women in their houses. This is called fieldwork. Depending on the areas assigned to your team and on how well you perform the tasks given to you, you may be working on this survey for up to [expected length of fieldwork] months. However, we have recruited more interviewers to participate in the training course than are needed to do the work, and at the end of the course, we will be selecting the best qualified among you to work as interviewers. Those not selected may be retained as alternates or data entry staff.

During the training course, you will be listening to lectures about how to fill in the questionnaires correctly. You will also be conducting practice interviews with other trainees and with strangers. You will be given periodic tests, and the questionnaires that you complete will be edited to check for completeness and accuracy.

APPENDIX E: Interviewer's Manual – Women's Questionnaire

You should study this manual and learn its contents since this will reduce the amount of time needed for training and will improve your chances of being selected as an interviewer.

A. SURVEY OBJECTIVES

The survey to measure the Impact of the Standard Days Method will be implemented in several countries. The objectives of the survey are to:

- Measure awareness of the Standard Days Method as a contraception option among women and men in the study area.
- Measure attitudes toward the Standard Days Method among men and women in the study area. Awareness will not lead toward acceptance if women perceive the method as difficult to use and/or their partners are reluctant to use it. Men's cooperation is expected to be fundamental both for adoption of the method by the couple and strengthening of the method's positive image in the community.
- Measure women's knowledge of the fertility cycle in the study area.
- Measure the prevalence of the Standard Days Method at the community level.
- Provide similar information across several countries to assess the impact of the Standard Days Method.

B. THE SAMPLE

There are several ways to gather information about people. One way is to contact every person or nearly every person and ask them questions about what you need to know. Talking to everyone is called a complete enumeration, and a national census is a good example of this type of information gathering. This is very costly because it takes a lot of people to talk to everyone. However, in cases such as a national census, it is necessary to have a complete enumeration despite the cost.

Another way to collect information is through a sample survey. When it is not necessary to know exact total numbers, a sample survey can collect information about people much more quickly and cheaply. Most often, we do not use whole numbers in making our decisions, but instead, we think in terms of percentages. For example, hearing that 800 people support a certain candidate in an election means very little to most of us. However, if we read that 55 percent of the voters support that candidate, we can judge that the candidate will probably win the election. The sample survey provides us with answers that are expressed in averages, proportions, or percentages, such as the proportion of children who are immunized against a certain disease or the proportion of women who do not want to have any more children. The sampling procedure allows us to collect data on a small number of people and draw conclusions that are valid for the whole country. The main reasons for using a sample survey instead of a complete enumeration are to reduce the time and cost of collecting information.

The accuracy of a sample survey depends, among other things, on the size of the sample. For example, if you only chose a sample of 100 people from a population of 100,000, the results of the sample would probably bear little resemblance to the total. On the other hand, a scientific sample of 3,000 would yield more accurate results. Therefore, the size of a sample is determined by how accurately the results must reflect the whole

APPENDIX E: Interviewer's Manual – Women's Questionnaire

population being studied. This is determined by statistical methods that we will not try to discuss in this training session. What you should know, however, is that the sample size is predetermined by the survey organizers according to the level of accuracy they need for the results. Consequently, it is critical to a survey that fieldworkers try their hardest to complete all assigned interviews to ensure that the correct number of people are included in the survey.

The accuracy of a sample survey also depends on another major factor, the absence of bias that would affect the proportions found through the sample. To control or prevent bias from creeping into the results, the selection of people included in the sample must be absolutely random. This means that every person in the total population to be studied has the same opportunity to be selected in the sample. This is why it is so important to make callbacks to reach those people who are not at home, since they may be different from people who are at home. For example, it may be that women who have no children are more likely to be working away from the house, and if we don't call back to interview them, we may bias the prevalence estimates of the Standard Days Method.

Certain households throughout [Country] have been scientifically selected to be included in the Standard Days Method survey sample. Currently married women age 15-49 will be interviewed using the Women's Questionnaire, and currently married men will be interviewed using the Men's Questionnaire. We expect to interview about [expected sample size] women and [expected sample size] men in this survey. Studying the fertility, health, and family planning behavior and attitudes of these women and men will provide insights into the behavior and attitudes of all women and men in the country.

The study team has already identified the households that are eligible to be a part of this survey. A total of xx households will be included in this sample. Based on statistical tests, this number of households will be large enough to ensure that the information can be used to compare findings in the study areas. All currently married women of reproductive age from each household will be selected for the survey. In every other household, all currently married men will be interviewed. There will be twice as many women as men included in the survey.

C. SURVEY ORGANIZATION

The survey to measure the impact of the Standard Days Method is a comprehensive survey involving several agencies and many individuals. [Name of organization] has the major responsibility for conducting the survey. In addition, there will be other surveys at the health facilities to assess provider behaviors in administering the SDM as a family planning option.

[Describe participation of other organizations or committees that are involved in designing or implementing the survey.]

[Description of survey organization, naming the project director, deputy director, and fieldwork coordinators. Clarification of how interviewers relate to these people and lines of authority.]

Each of you who is selected to work on the survey will work in a team consisting of one supervisor, one field editor, and [four] interviewers. Field supervisors and health technicians may be either male or female; however, field editors and interviewers administering the Women's Questionnaire should be female, since they will be interviewing female respondents about personal topics. There will be some mixed teams of male and female field editors and interviewers, and these teams will interview both women and men.

Each field supervisor will be responsible for one team of interviewers. He/she will be assisted by the field editor, who will be in charge in the absence of the supervisor. The specific duties of the field supervisor and

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the field editor are described in detail in the Supervisor's and Editor's Manual. Since the workloads of the field supervisor and the field editor will vary from day to day, it is expected that they will assist each other in completing their respective duties. In the central office, data entry staff and computer programmers will also be assigned to the project.

D. SURVEY QUESTIONNAIRES

Two questionnaires will be used in this survey, the Women's Questionnaire and the Men's Questionnaire. This manual includes information on how to administer the Women's Questionnaire. The Men's Questionnaire is explained in a separate manual.

You will identify which women are eligible (qualified) to be interviewed with the Women's Questionnaire. All women who are currently married and age 15-49 are eligible to be interviewed. This means that household members (persons who usually live in the household) and permanent visitors (persons who do not usually live in the household but who have slept there for at least 15 consecutive nights prior to the interview) are eligible to be interviewed with the Women's Questionnaire.

You will identify all eligible women in each household. After those women have been identified, you will use the Women's Questionnaire to interview all eligible women.

The Women's Questionnaire collects information on the following topics:

- Background characteristics. Questions on age, education, employment status and religion are included in order to provide information on characteristics likely to influence women's behavior. In addition, the woman will be asked about her husband or partner. These questions include information on employment status, as well as the woman's attitudes toward gender roles.
- Reproductive behavior and intentions. Data are collected on the number of children, current pregnancy status, and future childbearing intentions.
- Knowledge and use of contraception. Questions are designed to determine knowledge and use of specific family planning methods, including the Standard Days Method. Women who are not using family planning are asked their intentions for future use.
- Availability of family planning. Questions are included to determine where a user obtained her family planning method and whether nonusers know of places to get family planning methods.

E. INTERVIEWER'S ROLE

The interviewer occupies the central position in this survey, because she collects information from respondents. Therefore, the success of the survey depends on the quality of the interviewer's work.

In general, the responsibilities of a interviewer include the following:

- Locating the structures and households in the sample that are assigned to her
- Identifying all eligible women in each household
- Interviewing all eligible women in the households assigned to her, using the Women's

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- Checking completed interviews to be sure that all questions were asked and the responses neatly and legibly recorded
- Returning to households to interview women she could not contact during her initial visits

These tasks will be described in more detail throughout this manual and during your training.

F. TRAINING OF INTERVIEWERS

Although some people are more adept at interviewing than others, one can become a good interviewer through 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 may have. Ask questions you might have at any time in order to avoid mistakes during actual interviews. Interviewers can learn a lot from each other by asking questions and talking about situations encountered in practice and actual interview situations. [A list of training materials each interviewer should have may be included here.]

During training, the questionnaire sections, questions, and instructions will be discussed in detail. You will see and hear demonstration interviews conducted in front of the class [by two of the trainers] as examples of the interviewing process. You will also have a homework assignment for the evenings of this part of your training. You will practice reading the questionnaire aloud to another person several times so that you may become comfortable with reading the questions aloud. This is a very important assignment to prepare you for the next phase of training.

Another means of training is role playing in which you practice by interviewing another trainee. One person will be the interviewer and one will be the respondent. Later on, you will be assigned to groups according to language and will practice interviewing in your language.

A later phase of training will include field practice interviewing in which you will actually interview eligible women. You will be required to check and edit the questionnaires just as you would do in the actual fieldwork assignments.

You will be given tests to see how well you are progressing during your formal training period. They will test your familiarity and understanding of the questionnaire and the survey process. At the end of the training course, the interviewers will be selected.

Your training as an interviewer does not end when the formal training period is completed. Each time a supervisor meets with you to discuss your work in the field, your training is being continued. The formal training period merely provides you with the basic knowledge and information about the survey, questionnaires, etc. Continued observation and supervision during the fieldwork completes the training process. This is particularly important during the first few days of fieldwork. Again, as you run into situations you did not cover in training, it will be helpful to discuss them with your team. Other interviewers may be running into similar problems, so you can all benefit from each other's experiences.

G. SUPERVISION OF INTERVIEWERS

Training is a continuous process. Observation and supervision throughout the fieldwork are a part of the

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training and data collection process. Your team supervisor and the field editor will play very important roles in continuing your training and in ensuring the quality of the survey data. They will

- Observe some of your interviews to ensure that you are conducting yourself well, asking the questions in the right manner, and interpreting the answers correctly
- Spot check some of the addresses selected for interviewing to be sure that you interviewed the correct households and the correct women
- Review each questionnaire to be sure it is complete and consistent
- Uncover and take action on apparent omission of births the respondent has had or improper recording of dates of birth
- Meet with each member of the team on a daily basis to discuss performance and give out future work assignments
- Help you to solve any problems that you might have with finding the assigned households, understanding the concepts in the questionnaire, or dealing with difficult respondents

The survey director may release from service any interviewer who is not performing at the level necessary to produce the high-quality data required to make the survey a success.

H. REGULATIONS

During the next few weeks, your presence, interest, participation, and cooperation are absolutely vital. We will try to do all that we can during this time to provide you with the necessary information, training, tools, and support for you to accomplish this very important task. For the workload to be equally divided and the support equally shared, the following survey regulations have been established and will be strictly enforced:

1. Every position on the survey staff is vital to the success of the survey. If you are chosen to be on a team and accept the position, your presence is required for each day of fieldwork.
2. Except for illnesses, any person who is absent from duty during any part of the training or any part of the fieldwork (whether it is a whole day or part of a day) without prior approval from her supervisor may be dismissed from the survey.
3. There is a great deal of work to be done over the next few weeks and arriving late to the training sessions will not be tolerated.
4. The selection of the survey team members is competitive; it is based on performance, ability, and testing results during the training. Therefore, any person found offering assistance to or receiving assistance from another person during tests will be dismissed from the survey.
5. Throughout the survey training and the fieldwork period, you are representing the [name of survey organization]. Your conduct must be professional and your behavior must be congenial in dealing with the public. We must always be aware of the fact that we are only able to do our work with the good will and cooperation of the people we interview. Therefore, any team member who is consistently overly aggressive, abrupt, or disrespectful to the people in the field may be dismissed from the survey team.

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6. For the survey to succeed, each team must work closely together sharing in the difficulties and cooperating and supporting each other. We will attempt to make team assignments in a way that enhances the cooperation and good will of the team. However, any team member who in the judgment of the survey director creates a disruptive influence on the team may be asked to transfer to another team or may be dismissed from the survey.
7. It is critical that the data gathered during the fieldwork be both accurate and valid. To control for inaccurate or invalid data, spot checks will be conducted. Interviewers may be dismissed at any time during the fieldwork if their performance is not considered adequate for the high quality this survey demands.
8. Vehicles and gasoline are provided for the survey for official use only. Any person using the vehicle for an unauthorized personal reason will be dismissed from the survey.
9. Data are confidential. They should not be discussed with anyone, including your fellow interviewers. Under no circumstances should confidential information be passed on to third parties. Persons breaking these rules, and therefore the confidence placed in them by the respondent, will be dismissed.

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II. CONDUCTING AN INTERVIEW

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

A. BUILDING RAPPORT WITH THE RESPONDENT

The field supervisor will assign an interviewer to make the first contact with a household selected for the Standard Days Method survey. The interviewer will complete the Women's Questionnaire with all eligible married women aged 15-49 years in each household. As an interviewer, your first responsibility is to establish rapport with the 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/her willingness to cooperate with the survey. Be sure that your manner is friendly as you introduce yourself. Before you start to work in an area, your supervisor will have informed the local leaders, who will in turn, inform selected households in the area that you will be coming to interview them. You will also be given a letter or identification card that states that you are working with the [name of survey organization].

1. Make a good first impression.

When first approaching the respondent, do your best to make her feel at ease. With a few well-chosen words, you can put the respondent in the right frame of mind for the interview. Open the interview with a smile and greeting such as "good afternoon" and then proceed with your introduction.

The introduction for the Women's Questionnaire should be read exactly as it is printed in the questionnaire. For the Questionnaire, a good introduction might be

"My name is _____. I am a representative of [name of survey organization]. We are conducting a survey about family life and health, and we are interviewing women and men throughout this area. I would like to talk to you and ask you some questions."

2. Always have a positive approach.

Never adopt an apologetic manner, and do not use words such as "Are you too busy?" Such questions invite refusal before you start. Rather, tell the respondent, "I would like to ask you a few questions" or "I would like to talk with you for a few moments."

3. Stress confidentiality of responses when necessary.

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If the respondent is hesitant about responding to the interview 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 to write a report. Also, you should never mention other interviews or show completed questionnaires to other interviewers or supervisors in front of a respondent or any other person.

4. Answer any questions from the respondent frankly.

Before agreeing to be interviewed, the respondent may ask you some questions about the survey or how she was selected to be interviewed. Be direct and pleasant when you answer. However if she asks questions about family planning methods or medicines, tell her that you will try to answer her questions after you have finished the interview.

The respondent may also be concerned about the length of the interview. If she asks, tell her that the women's interview usually takes about 45 minutes. Indicate your willingness to return at another time if it is inconvenient for the respondent to answer questions then.

5. Interview the respondent alone.

The presence of a third person during an interview can prevent you from getting frank, honest answers from a respondent. It is, therefore, very important that the women's interview be conducted privately and that all questions be answered by the respondent herself.

If other people are present, explain to the respondent that some of the questions are private and ask where you can talk with her alone. Sometimes asking for privacy will make others more curious, so they will want to listen; you will have to be creative. Establishing privacy from the beginning will allow the respondent to be more attentive to your questions.

If it is impossible to get privacy, you may have to carry out the interview with the other people present. However, try to separate yourself and the respondent from the others as much as possible. Extra effort should be made to gain privacy if the other person is a man, particularly the husband.

B. TIPS FOR CONDUCTING THE INTERVIEW

1. Be neutral throughout the interview.

Most people are polite and will tend to give answers that they think you want to hear. It is therefore very important that you remain absolutely neutral as you ask the questions. 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. Never appear to approve or disapprove of any of the respondent's replies.

A respondent may ask you questions during the interview, for example, about certain contraceptive methods or treatments for diseases. Or she may ask you whether you use family planning or what you think the ideal family size is. Tell her that we are interested in her opinions and that you cannot answer her questions because otherwise you would slow down the pace of the work.

The questions are all carefully worded to be neutral. They do not suggest that one answer is more likely or preferable to another answer. If you fail to read the complete question, you may destroy that

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neutrality. For example, the following is a question in the survey: "Would you like to have another child or would you prefer not to have any more children?" It is a neutral question. However, if you only ask the first part—"Would you like to have another child?"—you are more likely to get a "YES" answer. This is what we call a "leading question." That is why it is important to read the whole question as it is written.

If the respondent gives an ambiguous answer, try to probe in a neutral way, asking questions such as:

"Can you explain a little more?"

"I did not quite hear you, could you please tell me again?"

"There is no hurry. Take a moment to think about it."

2. Never suggest answers to the respondent.

If a respondent's answer is not relevant to a question, do not prompt her by saying something like "I suppose you mean that. . . . Is that right?" In many cases, she will agree with your interpretation of her answer, even when that is not what she meant. Rather, you should probe in such a manner that the respondent herself comes up with the relevant answer. You should never read out the list of coded answers to the respondent, even if she has trouble answering.

3. Do not change the wording or sequence of questions.

The wording of the 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 she still does not understand, 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.

4. Handle hesitant respondents tactfully.

There will be situations where the respondent simply says, "I don't know," gives an irrelevant answer, acts very bored or detached, or contradicts something she has already said. In these cases, you must try to re-interest her in the conversation. For example, if you sense that she is shy or afraid, try to remove her shyness or fear before asking the next question. Spend a few moments talking about things unrelated to the interview (for example, her town or village, the weather, her daily activities, etc.).

If the woman is giving irrelevant or elaborate answers, do not stop her abruptly or rudely, but listen to what she has to say. Then try to steer her gently back to the original question. A good atmosphere must be maintained throughout the interview. The best atmosphere for an interview is one in which the respondent sees the interviewer as a friendly, sympathetic, and responsive person who does not intimidate her and to whom she can say anything without feeling shy or embarrassed. As indicated earlier, the major problem in controlling the interview may be one of privacy. This problem can be prevented if you are able to obtain a private area in which to conduct the interview.

If the respondent is reluctant or unwilling to answer a question, try to overcome her reluctance, explaining once again that the same question is being asked of women all over the country and that the answers will all be merged together. If she still refuses, simply write REFUSED next to the question and proceed as if nothing had happened. If you have successfully completed the interview, you may try to obtain the missing information at the end, but do not push too hard for an answer. Remember, the respondent cannot be forced to give an answer.

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5. Do not form expectations.

You must not form expectations as to the ability and knowledge of the respondent. Do not assume women from rural areas or those who are less educated or illiterate do not know about family planning or various family planning methods.

On the other hand, remember that differences between you and the respondent can influence the interview. The respondent, believing that you are different from her, may be afraid or mistrustful. You should always behave and speak in such a way that she is put at ease and is comfortable talking to you.

6. Do not hurry the interview.

Ask the questions slowly to ensure the respondent understands what she is being asked. After you have asked a question, pause and give her time to think. If the respondent feels hurried or is not allowed to formulate her own opinion, she may respond with "I don't know" or give an inaccurate answer. If you feel the respondent is answering without thinking, just to speed up the interview, say to the respondent, "There is no hurry. Your opinion is very important, so consider your answers carefully."

C. LANGUAGE OF THE INTERVIEW

The questionnaires for this survey have been translated into the major languages in which interviewing will take place. However, there may be times when you will have to use an interpreter or modify the wording of the questions to fit local dialects and culture. It is very important not to change the meaning of the question when you rephrase it or interpret it into another language. We will be practicing interviews in the local languages during training.

Of course, one of the first things you will do when you approach a household to do an interview is to establish the language or languages that are spoken there. We will be arranging the field teams in such a way that you will be working in an area in which your language is spoken, so there should be few cases in which respondents do not speak your language. In such cases you might be able to find another language that both of you speak and you will be able to conduct the interview in that language.

However, in some cases, it will not be possible for you to find a language that both you and the respondent speak. In this case, try to find out whether the respondent speaks a language that another member of your team or the team supervisor speaks. If so, tell your supervisor so that he or she can arrange for that person to conduct the interview.

If the respondent does not speak a language that any of your team members speak, you will need to rely on a third person to translate for you. Since the interview involves some sensitive topics, it is best if you can find another woman to act as an interpreter. Try to avoid using the respondent's husband as an interpreter. Children are also unsuitable interpreters. Remember, try to avoid using interpreters if at all possible since this not only jeopardizes the quality of the interview but will also mean that the interview will take nearly twice as long to conduct.

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III. FIELD PROCEDURES

Fieldwork for the Standard Days Method survey will proceed according to a timetable, and the survey will be successful only if each member of the interviewing team understands and follows correct field procedures. The following sections review these procedures and describe the proper procedures for receiving work assignments and keeping records of selected households.

A. PREPARATORY ACTIVITIES AND ASSIGNMENT SHEETS

Each morning, your supervisor will brief you on your day's work and explain how to locate the households assigned to you. When your supervisor assigns households to you, you should write the identification information on the Interviewer's Assignment Sheet (see Figure 1). The identifying information (household number, address), the date of assignment, and the final result will be written in Columns (1) through (4).

Columns (5) through (16) of the Interviewer's Assignment Sheet serve as a summary of the results of your work in the field for each household. At the end of the day, you will be responsible for recording in these columns the final outcome for all household visits and individual interviews you have conducted.

When you receive your work assignment, review it and ask any questions you might have; remember that your supervisor will not always be available to answer questions when the work begins. You should be sure that:

- Columns (1) through (3) of your Interviewer's Assignment Sheet are complete and that they contain all the information you will need to identify the selected households
- You know the location of the selected households you are to interview and have sufficient materials (maps, written directions, etc.) to locate them
- You understand any special instructions from your supervisor about contacting the households you are assigned
- You have several blank Women's Questionnaires.

After locating the household, you will record the name of all eligible women in Column (5) and the name of all eligible men in Column (11). Only those interviewers assigned to a mixed team (men and women) will be required to complete Columns (11) through (16) for eligible men. If you are only interviewing women, leave Columns (11) through (16) blank.

Ask each woman (and man) her/his age and marital status. If the woman is between 15 and 49 years of age and either married or in an informal union/living together, mark "X" in Column (8). This woman is eligible for an interview. Allocate a Women's Questionnaire for each eligible woman in the household. Fill in the identification information on the cover sheet of a Women's Questionnaire for each eligible woman identified for the interview.

After completing an interview, you will record the final result of the woman's interview in Column (9) and the final result of the man's interview in Column (15) of your Interviewer's Assignment Sheet. You will record the date on which you return the questionnaires for the eligible woman's interview to your supervisor

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in Column (10), and the date on which you return the questionnaires for the eligible man's interview to your supervisor in Column (16). Record any comments or observations in Column (17). If the woman is married to a man interviewed, make a note in Column (17). This information will be very important for analysis in the future. Procedures for identifying and interviewing eligible men are described in the Interviewer's Guide for the Men's Questionnaire.

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Figure 1: SDM Interviewer Assignment Sheet

Name of locality: _____

Name of interviewer: _____

Page ____ of ____

Cluster number

Household				Women						Men						Observations
HH No.	Address	Date assigned	Final Result	Name of all women	Age	Status	Eligible	Final Result	Date Return	Name of all men	Age	Status	Eligible	Final Result	Date Return	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)

CODES FOR COLUMN 4				CODES FOR COLUMNS 9 & 15											
1 COMPLETED	2 NO HH MEMBER AT HOME/NO COMPETENT RESPONDENT	3 ENTIRE HH ABSENT FOR EXTENDED PERIOD	4 POSTPONED	5 REFUSED	6 DWELLING VACANT/ADDRESS NOT A DWELLING	7 DWELLING DESTROYED	8 DWELLING NOT FOUND	9 OTHER	1 COMPLETED	2 NOT AT HOME	3 POSTPONED	4 REFUSED	5 PARTLY COMPLETED	6 INCAPACITATED	7 OTHER
CODES FOR COLUMN 7 & 13				CODES FOR COLUMN 8 & 14											
M MARRIED	U INFORMAL UNION/LIVE TOGETHER	S SINGLE	D DIVORCED	W WIDOWED	X WOMEN AGE 15-49 AND M OR U	X MEN M OR U									

NUMBER OF NUMBER OF NUMBER OF NUMBER OF

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ELIGIBLE
WOMEN

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WOMEN'S
QUESTIONNAIRES

--	--

ELIGIBLE
MEN

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MEN'S
QUESTIONNAIRES

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B. CONTACTING HOUSEHOLDS

1. Locating sample households

Recently, household listing teams visited each of the selected sample clusters and 1) prepared up-to-date maps to indicate the location of structures, 2) recorded address information for each structure or described their location (for areas lacking street names or numbers on structures), and 3) wrote numbers on structures.

A structure is a freestanding building that can have one or more rooms in which people live; it may be an apartment building, a house, or a thatched hut, for instance. Within a structure, there may be one or more dwelling (or housing) units. For instance, there would be one dwelling unit in a thatched hut, but there may be 50 dwelling units in an apartment building or five dwelling units in a compound. A dwelling unit is a room or group of rooms occupied by one or more households. It may be distinguished from the adjoining dwelling unit by a separate entrance. Within a dwelling unit, there may be one or more households. For example, a compound may have five households living within it, and each household may live in its own dwelling unit.

Specific households have been selected to be interviewed, and you should not have any trouble locating the households assigned to you if you use the structure number and the household address to guide you. The structure number is usually written above the door of the house, but sometimes, it may be on the wall. Although the supervisor of your team will be with you in the field, it is important that you also know how to locate the structures in the sample.

2. Problems in contacting a household

In some cases you will have problems locating the households that were selected because the people may have moved or the listing teams may have made an error. Here are examples of some problems you may find and how to solve them:

- The selected household has moved away and the dwelling is vacant. If a household has moved out of the dwelling where it was listed and no one is living in the dwelling, you should consider the dwelling vacant and record Code '6' on the Interviewer Assignment Sheet.
- The household has moved away and a new one is now living in the same dwelling. In this case, interview the new household.
- The listing shows only one household in the dwelling, but two households are now living there. In this case, interview both households, and make a note on the Interviewer Assignment Sheet of the household that was not on the listing. Your supervisor will assign this household a number, which you should enter on the questionnaire. However, if the listing shows two households, only one of which was selected, and you find three households there now, only interview the one which had been selected and ignore the other two. In either case, inform your supervisor of the situation.
- The house is all closed up and the neighbors say the people are on the farm (or away visiting, etc.) and will be back in several days or weeks. Enter Code '3' (ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD) on the Interviewer Assignment Sheet. The house should

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be revisited at least two more times to make sure that the household members have not returned.

- The house is all closed up and the neighbors say that no one lives there; the household has moved away permanently. Enter Code '6' (DWELLING VACANT OR ADDRESS NOT A DWELLING) on the Interviewer Assignment Sheet.
- A household is supposed to live in a structure that when visited is found to be a shop and no one lives there. Check very carefully to see whether anyone lives there. If not, enter Code '6' (DWELLING VACANT OR ADDRESS NOT A DWELLING) on the Interviewer Assignment Sheet.
- A selected structure is not found in the cluster, and residents tell you it was destroyed in a recent fire. Enter Code '7' (DWELLING DESTROYED) on the Interviewer Assignment Sheet.
- No one is home and neighbors tell you the family has gone to the market. Enter Code '2' (NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT), and return to the household at a time when the family will be back (later in the day or the next day).

Remember that the usefulness of the sample in representing the entire study area depends on the interviewers locating and visiting all the households they are assigned.

3. Identifying eligible respondents

To be "eligible" means to "qualify" for something. An eligible respondent is someone who is qualified to be included in our survey.

All currently married women age 15-49 who are either members of the household or visitors who have stayed in the household for the past 15 days are considered eligible, even if they do not usually live in that dwelling. In certain cases, you may find it difficult to decide whether or not a woman is eligible. Women in these examples are eligible for the women's interview:

- A visitor who spent the previous 15 nights in the house but is away at the market when you arrive.
- A usual resident who spent the previous night at her sister's house.

In some households, there will be no eligible respondents (i.e., there will be no usual household members or visitors who have stayed at the household for 15 consecutive days who are currently married women between the ages of 15 and 49).

C. PROBLEMS IN OBTAINING WOMEN'S INTERVIEWS

The following are examples of the kinds of problems the interviewer may experience in obtaining an interview with an eligible woman:

- Eligible respondent(s) not available. If the eligible respondent(s) is/are not at home when you visit, enter Code '2' (NOT AT HOME) as the result for the visit on the cover sheet of the

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Woman's Questionnaire and ask a neighbor or family member when the respondent(s) will return. You should contact the household at least three times, trying to make each visit at a different time of day. Under no circumstances is it acceptable to conduct all three visits on the same day and then stop attempting to contact the respondent(s).

- Respondent(s) refuse to be interviewed. The respondent's availability and willingness to be interviewed will depend in large part on the initial impression you make when you meet her. Introduce yourself and explain the purpose of the visit. Read the introduction printed on the Women's Questionnaire. If the respondent is unwilling to be interviewed, it may be that the present time is inconvenient. Ask if another time would be more convenient and make an appointment. If the woman still refuses to be interviewed, enter a Code '4' (REFUSED) as the result for the visit on the cover sheet of the Woman's Questionnaire and report it to your supervisor.
- Interview not completed. A respondent may be called away during the interview or she may not want to answer all the questions at the time you visit her. If an interview is incomplete for any reason, you should try to arrange an appointment to see the respondent again as soon as possible to obtain the missing information. Be sure that you record on the cover sheet of the Women's Questionnaire that the interview is incomplete by entering Code '5' (PARTLY COMPLETED) and indicate the time you agreed on for a revisit; you should also report the problem to your supervisor.
- Respondent incapacitated. There may be cases in which you cannot interview a woman because she is too sick, because she is mentally unable to understand your questions, or because she is deaf, etc. In these cases, record Code '6' (INCAPACITATED) on the cover sheet of the Women's Questionnaire and on your Assignment Sheet.

The outcome and date of the final attempt to contact an eligible respondent should be noted in Column (9) of your Interviewer's Assignment Sheet. It is important that you keep the visit record on the Interviewer's Assignment Sheet accurately since this form provides a summary of all eligible respondents in the sample. These forms will be returned to the central office for review after completion of interviewing and will be used to calculate response rates.

D. MAKING CALLBACKS

Because each household has been carefully selected, you must make every effort to conduct interviews with the households assigned to you and with the eligible women identified. You need to make at least three different visits when trying to obtain a women's interview.

At the beginning of each day, you should examine the cover sheets of your questionnaires to see whether you made any appointments for revisiting a household or eligible respondent. If no appointments were made, make your callbacks to a household or respondent at a different time of day than the earlier visits; for example, if the initial visits were made in the early afternoon, you should try to arrange your schedule so you make a callback in the morning or late afternoon. Scheduling callbacks at different times is important in reducing the rate of nonresponse (i.e., the number of cases in which you fail to contact a household or complete a women's interview).

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E. CHECKING COMPLETED QUESTIONNAIRES

It is the responsibility of the interviewer to review each questionnaire when the interview is finished. This review should be done before you leave the household so that you can be sure every appropriate question was asked, that all answers are clear and reasonable, and that your handwriting is legible. Also check that you have followed the skip instructions correctly. You can make minor corrections yourself, but any serious error should be clarified by the respondent. Simply explain to the respondent that you made an error and ask the question again.

Do not recopy questionnaires. As long as the answers are clear and readable, it is not necessary that the questionnaire itself be neat. Every time you transcribe the answers to a new questionnaire, you increase the chance of an error. For this reason you are not allowed to use work sheets to collect information. Record ALL information on the questionnaires you have been provided. Any calculations you make should be written in the margins or on the back of the questionnaires.

Anything out of the ordinary should be explained either in the margins near the relevant question or in the comments section at the end. These comments are very helpful to the supervisor and field editor in checking questionnaires. Comments are also read in the office and used to resolve problems encountered during data entry.

F. RETURNING WORK ASSIGNMENTS

Completed Women's Questionnaires are returned to your supervisor each day. Make sure you have filled in the final result and date of all interviews you completed and the date you returned the questionnaires to the supervisor on your Interviewer's Assignment Sheet. He/she will update the Supervisor's and Editor's Assignment Sheet, and give the completed Women's Questionnaires to the editor, as appropriate.

G. DATA QUALITY

It is the responsibility of the editor to review the Women's Questionnaires from a sample cluster while the interviewing team is still in the cluster. The editing rules followed by the editor are explained in detail in the Supervisor's and Editor's Manual. It is especially important for the editor to conduct thorough edits of questionnaires at the initial stages of fieldwork. The supervisor may assist in editing questionnaires during the first two or three weeks of fieldwork. The editor will then discuss with each interviewer the errors found in the collection of data. It may sometimes be necessary to send an interviewer back to a respondent in order to correct some data error.

H. SUPPLIES REQUIRED FOR FIELDWORK

Before leaving for the field, you should make sure you have adequate supplies for the day's work. These supplies include the following:

- A sufficient supply of questionnaires
- Interviewer's Assignment Sheets
- Interviewer's Manual

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- Identification documents
- A clipboard
- Blue ballpoint pens
- A briefcase or bag in which to carry the questionnaires
- Any personal items you will need to be comfortable, given the circumstances and the area in which you are working.

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IV. GENERAL PROCEDURES FOR COMPLETING THE QUESTIONNAIRE

To collect the information needed, you must understand how to ask each question, what information the question is attempting to collect, and how to handle problems that might arise during the interview. You must also know how to correctly record the answers the respondent gives and how to follow special instructions in the questionnaire. This part of the training manual is designed to familiarize you with the Women's Questionnaire.

A. ASKING QUESTIONS

It is very important that you ask each question exactly as it is written in the questionnaire. When asking a question, be sure to speak slowly and clearly so that the respondent will have no difficulty hearing or understanding the question. At times, you may need to repeat the question to be sure the respondent understands it. In those cases, do not change the wording of the question but repeat it exactly as it is written.

If after you have repeated a question, the respondent still does not understand it, you may have to restate the question. Be very careful when you change the wording, however, that you do not alter the meaning of the original question.

In some cases, you may have to ask additional questions to obtain a complete answer from a respondent (we call this probing). If you do this, you must be careful that your probes are "neutral" and that they do not suggest an answer to the respondent. Probing requires both tact and skill, and it will be one of the most challenging aspects of your work as an interviewer.

B. RECORDING RESPONSES

In the Standard Days Method survey, all interviewers will use pens with blue ink to complete all questionnaires. Supervisors and field editors will do all their work using pens with red ink. There are four types of questions in the questionnaire: 1) questions that have precoded responses; 2) questions that do not have precoded responses; 3) filters; and 4) the calendar.

1. Questions with precoded responses

For some questions, we can predict the types of answers a respondent will give. The responses to these questions are listed in the questionnaire. To record a respondent's answer, you merely circle the number (code) that corresponds to the reply. Make sure that each circle surrounds only a single number.

Example:

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
107	Have you ever attended school?	YES..... 1 NO..... 2	→111

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In some cases, precoded responses will include an "OTHER" category. The "OTHER" code should be circled when the respondent's answer is different from any of the precoded responses listed for the question. Before using the "OTHER" code, you should make sure the answer does not fit in any of the other categories. When you circle the code "OTHER" for a particular question, you must always write the respondent's answer in the space provided. If you need more room, use the margins or the comments section at the end, and write, "see note in comments section."

Example:

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
239	Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods?	JUST BEFORE HER PERIOD BEGINS1 DURING HER PERIOD.....2 RIGHT AFTER HER PERIOD HAS ENDED.....3 HALFWAY BETWEEN TWO PERIODS4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	

2. Recording responses that are not precoded

The answers to some questions are not precoded; in entering the response for these questions, you must write the respondent's answer in the space provided. Usually, you will record a number or date in the boxes provided. There are two ways this is done:

- a) For some questions, you will have to choose which are the correct boxes in which to record the response and only fill in one row.

Example:

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES					
237 A	When do you expect to get your next period?	DAYS 1 WEEKS 2 DON'T KNOW/NOT SURE.....3	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>				

Whenever the boxes are preceded by codes, you are to fill in boxes for one row only. You must circle the code that identifies the row you have chosen and then fill in the response for that row. If the respondent said she expects to get her next period in three weeks, you would circle Code '2' for WEEKS and write the response in the boxes next to WEEKS.

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b) For other questions, you fill in all the boxes provided.

Example:

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES								
316	In what month and year was the sterilization performed?	MONTH..... YEAR <table border="1" style="display: inline-table; vertical-align: middle; margin-left: 20px;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>								

Whenever boxes are provided without having codes in front of them, you provide the information for all the rows. As in the example above, for a sterilization performed in February 1988, you record the month and year.

Notice that if the response has fewer digits than the number of boxes provided, you fill in leading zeroes. For example, a response of '9' is recorded '09' in two boxes, or if three boxes had been provided, you would record '009.'

3. Marking filters

Filters require you to look back to the answer to a previous response and then mark an X in the box.

Example:

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
113	CHECK 111: CODE '2', '3' OR '4' CIRCLED <input type="checkbox"/>	CODE '1' CIRCLED <input type="checkbox"/>	115

↓

→

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4. The calendar

The following information is recorded in the calendar located in the flip-out section at the end of the Women's Questionnaire: births, pregnancies, contraceptive methods used, source of contraception, and reasons for discontinuing any method. The information is recorded for the period 12 months prior to the interview [since December 2003]. See Chapter VI (The Calendar) for a full explanation of its use.

C. CORRECTING MISTAKES

It is very important that you record all answers neatly. For precoded responses, be sure that you circle the code for the correct response carefully. If you made a mistake in entering a respondent's answer or she changes her reply, be sure that you cross out the incorrect response and enter the right answer. Do not try to erase an answer. Just put two lines through the incorrect response. Remember that if there are two responses for a particular question, it may not be possible later, when the data are being coded, to determine which is the correct answer. Here is how to correct a mistake:

Example:

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
107	Have you ever attended school?	YES.....1 NO.....2	—>111

D. FOLLOWING INSTRUCTIONS

1. Skip instructions

It is very important not to ask a respondent questions that are not relevant to her situation. For example, a woman who is not pregnant should not be asked for how many months she has been pregnant. In cases where a particular response makes subsequent questions irrelevant, an instruction is written in the questionnaire directing you to skip to the next appropriate question. It is important that you carefully follow skip instructions.

Example:

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	Now I would like to ask you about all of the births you have had during your life. Have you ever given birth?	YES.....1 NO.....2	—>225

Notice that if you circled Code '2' you would skip to Question 225. In this case, Questions 202-203 are only asked of women who have given birth.

2. Filters

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To ensure the proper flow of the questionnaire, you will sometimes be directed to check a respondent's answer to an earlier question, indicate what the response was by marking a box, and then follow various skip instructions. Questions of this type are called "filters"; they are used to prevent a respondent from being asked irrelevant, and perhaps embarrassing or upsetting, questions. For filter questions, it is important that you follow the instructions that ask you to check back to an earlier question. Do not rely on your memory. Remember that you do not need to ask the respondent the same question a second time. Check back and mark an "X" in the appropriate box in the filter; then follow the skip instructions.

Example:

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
604	CHECK 226: NOT PREGNANT OR UNSURE <input type="checkbox"/>	PREGNANT <input type="checkbox"/>	610

Note that all instructions for the interviewer are printed in all CAPITAL LETTERS, whereas questions to be asked of the respondent are printed in small letters.

E. CHECKING COMPLETED QUESTIONNAIRES

After you have completed an interview, you must review the questionnaire by carefully checking the answer to each question. It is important to check that you have followed all the appropriate skip patterns and that you have not omitted any sections. If necessary, you may correct your handwriting or clarify answers. You should review the questionnaire BEFORE you leave the household, so that if you need to question the respondent further, she is likely to still be available. You should write any comments about the interview that you feel would clarify the answers you recorded or that would be of interest to your supervisor. If you have any doubts about how to record an answer, feel free to write a note on the questionnaire and then check with your supervisor. She/he is there to help you.

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VI. CALENDAR

A. DESCRIPTION OF THE CALENDAR

The calendar is located in the flip-out section at the end of the Women's Questionnaire. It is called a "calendar" because it is where you will record information about the timing of recent events in the respondent's life. The calendar is "recent" in that only events occurring in the month of the survey plus one full calendar years preceding the current month are included.¹ On the vertical axis of the calendar, there are 13 boxes (each box representing one month of time). On the horizontal axis are three columns, each concerning different but related experiences in the woman's life:

- Column (1): Births, pregnancies, and family planning method use
- Column (2): Sources of family planning methods
- Column (3): Reason for discontinuing family planning method use

For example, in Column (1), you will place coded information that describes the timing of the woman's recent experience with pregnancy, childbearing and family planning use. In this chapter, we discuss the methods by which you are going to fill in the calendar. But before we proceed, a couple of points need to be understood:

- 1) You may at this point ask, "What and where are the questions that I am supposed to ask that will allow me to complete the calendar?" The answer to this question has two parts. First, the calendar is completed at the same time that the Women's Questionnaire is completed. Much of the information you need to complete the calendar is drawn directly from the responses recorded in the questionnaire. Second, the calendar will give you a visual "snapshot" of the woman's last year of life. The calendar is built in a series of steps. At each step, you can and should determine whether or not a woman's response is consistent with previous responses and where to place the event in relation to other events. For example, if there have been 10 months between the birth of Baby A and the beginning of the pregnancy resulting in Baby B, you can easily see in the calendar that these 10 months need to be accounted for in terms of use or nonuse of a contraceptive method. There are many ways to get this information, and the calendar allows you to be innovative in obtaining the responses you need to completely fill in the calendar with the correct codes. Simply bear in mind that there may well be more than one correct way to "build" the calendar.
- 2) Whereas interviewing procedures may be flexible, the method of recording information on the calendar is not. Only certain codes (shown to the left of the calendar) are acceptable for use in the

¹The calendar should cover the survey year up to the last month of fieldwork, plus the full 12 months prior to the survey year. For surveys fielded in 2004, the calendar begins with the year 2003, and for fieldwork beginning in 2005, 2006, or 2007, the years should be adjusted.

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calendar. You need to translate the woman's responses to codes. Only one code may appear in each box.

Column (1): BIRTHS, PREGNANCIES, AND FAMILY PLANNING METHOD USE

For each live birth in [November 2003] or later (Q.225), place a 'B' in the month of birth and a 'P' in each of the preceding months according to the duration of the pregnancy, for any of these months that was in the past year. For each birth, the number of 'P's must be one less than the number of months that the pregnancy lasted because the 'B' represents the final month. Write the child's name to the left of the 'B.' For women who are currently pregnant (Q. 226), place a 'P' in the month of interview and in each preceding month of pregnancy.

For all pregnancies that ended in a nonlive birth (Qs. 229, 230 and 231), place a 'T' in the month of pregnancy termination and a 'P' in each month of pregnancy. For example, if a miscarriage occurred in the fourth month of pregnancy (i.e., after three completed months) in June 1996, then place one 'T' in June 1996 and one 'P' in each of the three preceding months.

For contraceptive use in [November 2003] or later, write the code for each method used in the months it was used. If a method was used for an extensive period (at least four months), enter the code in the first and last months of use and connect them with a squiggly line. As a last step, months without any method use (and no pregnancy or pregnancy termination) should be coded '0' for no method (Qs. 310 or Q. 304 if the woman never used a method).

Every month in Column (1) must be accounted for, i.e., filled in with a code.

Column (2): SOURCE OF FAMILY PLANNING METHOD

For every use of a method that begins in [November 2003] or later, the source code is recorded in Column (2) in the first month of each use. For example, if Column (1) indicates first use of the pill during February 2004, then you should record the source code (source of family planning method) in Column (2) in the same month, February 2004. In this case, we are interested in the source of first use for each episode of continuous use. For example, if a woman used the pill continuously from March 1997 to September 1997, then stopped for four months and started using again in February 1998, you should record the source of the method in March 1997 and again in February 1998. Note that they may be different sources.

Column (3): REASON FOR DISCONTINUING FAMILY PLANNING METHOD USE

For every discontinuation of a method, the reason for discontinuation is recorded in Column (3) in the last month the method was used. For example, if Column (1) indicates discontinuation of pill use in April 1997, then you should identify and record the reason for the discontinuation in Column (3) in the same month, April 1997.

B. GENERAL COMMENTS

- Only one code is entered in any one box (month) of the calendar.
- In Column (1), all months should be filled in.
- Column (2) records the source of method use that occurs in Column (1). The code is entered in the first month of use.

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- Column (3) records a reason for each interruption of method use that occurs in Column (1). The code is entered in the last month of use.
- Each squiggly line must have both endpoints defined by the same code.
- To label the births, write the child's name to the left of the 'B.' This will make your work easier and more accurate because birth dates serve as your best reference points.
- Always refer to information that is already in the calendar to help the respondent recall dates. And remember, the calendar is built in steps; each entry should be consistent with previous entries.

C. ILLUSTRATIVE CASES

CASE #1

In Case #1, we will complete Column (1) of the calendar for two situations of increasing complexity, and we will complete Columns (2) and (3). We assume that the respondent knows the dates of birth of her children and also the dates during which she used contraception.

To complete Column (1), three steps are necessary:

- 1) Ask the dates of live births in the last year and record them in the calendar
- 2) Record the months of pregnancy (P) for pregnancies terminating in live births (B) and nonlive births (T)
- 3) Record the months of family planning method use and nonuse.

Case #1 (Situation 1): one live birth, no contraceptive use.

In this example, the respondent had one live birth since December 2003. The child was Alfredo, born on September 18, 2004. The woman responded that she has never used a contraceptive method. She was interviewed in December 2004.

The first panel shows the first step in recording these events. The date of birth of the child is obtained by asking the woman how many live births she has had in the last 12 months, and the date of birth for any live births. Record a 'B' in each month of birth and write the name of the corresponding child(ren) to the left of the 'B.'

In the second panel (Step 2), you record a 'P' in each of the months of pregnancy prior to each live birth. For Alfredo, the pregnancy extends from January to August 2004 (before the month of birth).

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In this case, Step 3 is very simple. There is no contraceptive use to consider so that you fill in the rest of the boxes in Column (1) with '0's representing nonuse.

Step 1

WOMAN'S RESPONSE		NUMBER OF MONTHS	ENTRY IN COLUMN (1) IN CALENDAR	
EVENT	DATE		MONTHS	CODE
Alfredo	Sept. 18, 2004	1	SEP 2004	B

Step 2

WOMAN'S RESPONSE		NUMBER OF MONTHS	ENTRY IN COLUMN (1) IN CALENDAR	
EVENT	DATE		MONTHS	CODE
Pregnant	Jan. - Sept. 18, 2004	8	JAN - AUG 2004	P
Alfredo	Sept. 18, 2003	1	SEP 2004	B

Step 3

WOMAN'S RESPONSE		NUMBER OF MONTHS	ENTRY IN COLUMN (1) IN CALENDAR	
EVENT	DATE		MONTHS	CODE
Nonuse	Dec. 2003 – Jan 2004	1	DEC 2003	0
Pregnant	Jan. 2004 - Sept. 18, 2004	8	JAN - AUG 2004	P
Alfredo	Sept. 18, 2004	1	SEP 2004	B
Nonuse	Sept. 18, 2004 - Dec 2004	3	OCT 2004 – DEC 2004	0

CASE # 1 (Situation 1), Column (1)

INSTRUCTIONS:

ONLY ONE CODE SHOULD APPEAR IN ANY BOX.
FOR COLUMN 1, ALL MONTHS SHOULD BE FILLED IN.

INFORMATION TO BE CODED FOR EACH COLUMN

COL. 1: BIRTHS, PREGNANCIES, FAMILY PLANNING METHOD USE

- B BIRTHS
- P PREGNANCIES
- T TERMINATIONS

- 0 NO METHOD
- 1 STANDARD DAYS METHOD
- 2 FEMALE STERILIZATION
- 3 MALE STERILIZATION
- 4 PILL
- 5 IUD
- 6 INJECTABLES
- 7 IMPLANTS
- 8 CONDOM
- 9 FEMALE CONDOM
- J DIAPHRAGM
- K FOAM OR JELLY
- L LACTATIONAL AMENORRHEA METHOD
- M PERIODIC ABSTINENCE
- N WITHDRAWAL
- X OTHER _____
(SPECIFY)

COL. 2: SOURCE OF FAMILY PLANNING METHOD

		1	2	3
DEC 04	C	0		
NOV	01	0		
OCT	02	0		
SEP	03	B		
AUG	04	P		
JUL	05	P		
JUN	06	P		
MAY	07	P		
APRIL	08	P		
MAR	09	P		
FEB	10	P		
JAN	11	P		
DEC03	12	0		

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- 1 GOVT. HOSPITAL
- 2 GOVT. HEALTH CENTER
- 3 FAMILY PLANNING CLINIC
- 4 GOVT. MOBILE CLINIC
- 5 GOVT. FIELDWORKER
- 6 OTHER PUBLIC
- 7 PVT. HOSPITAL/CLINIC
- 8 PHARMACY
- 9 PRIVATE DOCTOR
- A NONGOVT. MOBILE CLINIC
- B NONGOVT. FIELDWORKER
- C OTHER PRIVATE MEDICAL
- D SHOP
- E CHURCH
- F FRIENDS/RELATIVES
- X OTHER _____
(SPECIFY)

COL. 3: DISCONTINUATION OF FAMILY PLANNING METHOD USE

- 0 INFREQUENT SEX/HUSBAND AWAY
- 1 BECAME PREGNANT WHILE USING
- 2 WANTED TO BECOME PREGNANT
- 3 HUSBAND DISAPPROVED
- 4 WANTED MORE EFFECTIVE METHOD
- 5 HEALTH CONCERNS
- 6 SIDE EFFECTS
- 7 LACK OF ACCESS/TOO FAR
- 8 COSTS TOO MUCH
- 9 INCONVENIENT TO USE
- F FATALISTIC
- A DIFFICULT TO GET PREGNANT/MENOPAUSAL
- D MARITAL DISSOLUTION/SEPARATION
- I IRREGULAR CYCLES
- X OTHER _____
(SPECIFY)
- Z DON'T KNOW

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Case #1 (Situation 2): one live birth, one contraceptive method used at two different times.

This is simply an extension of Situation 1. The only difference is that here the woman has used a contraceptive method at two different points in time (an IUD, Code '5') before becoming pregnant with Alfredo and after giving birth to Alfredo. The first two steps of Situation 2 are exactly the same as in Situation 1. We thus proceed to step three.

After having probed about the timing of the woman's IUD use relative to Alfredo's birth date, the interviewer has determined that an IUD was first inserted in a government hospital in January 2003 and was later removed in November 2003. Since the calendar begins in December 2003, none of this information is recorded in Column (1). Because the beginning of the episode of use is before December 2003, the code for the source of contraception is not recorded in Column (2). After Alfredo was born, the woman had an IUD inserted again. This time, the IUD insertion was done in a government mobile clinic less than one month after delivery. The IUD is still in place. In Column (2), record the code for source of contraception (government mobile clinic), which is '4.'

Step 3

WOMAN'S RESPONSE		NUMBER OF MONTHS	ENTRY IN COLUMN (1) IN CALENDAR	
EVENT	DATE		MONTHS	CODE
IUD	Jan. 2003-Nov. 2003	11	NONE	
Pregnant	Jan. 2004 - Sept. 18, 2004	8	JAN - AUG 2004	P
Alfredo	Sept. 18, 2004	1	SEP 2004	B
IUD	Oct. 2004-present	3	OCT 2004 – DEC 2004	5

WOMAN'S RESPONSE		NUMBER OF MONTHS	ENTRY IN COLUMN (2) IN CALENDAR	
EVENT	DATE		MONTHS	CODE
Source of IUD	Oct. 2004-present	3	OCT 2004-DEC 2004	4

CASE # 1 (Situation 2), Columns (1) and (2)

INSTRUCTIONS:
ONLY ONE CODE SHOULD APPEAR IN ANY BOX.
FOR COLUMN 1, ALL MONTHS SHOULD BE FILLED IN.

INFORMATION TO BE CODED FOR EACH COLUMN

COL.1: BIRTHS, PREGNANCIES, FAMILY PLANNING METHOD USE

- B BIRTHS
- P PREGNANCIES
- T TERMINATIONS

- 0 NO METHOD
- 1 STANDARD DAYS METHOD
- 2 FEMALE STERILIZATION
- 3 MALE STERILIZATION
- 4 PILL
- 5 IUD
- 6 INJECTABLES
- 7 IMPLANTS
- 8 CONDOM
- 9 FEMALE CONDOM
- J DIAPHRAGM
- K FOAM OR JELLY
- L LACTATIONAL AMENORRHEA METHOD
- M PERIODIC ABSTINENCE
- N WITHDRAWAL

		1	2	3
DEC 04	C	5		
NOV	01	5		
OCT	02	5	4	
SEP	03	B		
AUG	04	P		
JUL	05	P		
JUN	06	P		
MAY	07	P		
APRIL	08	P		
MAR	09	P		
FEB	10	P		
JAN	11	P		
DEC03	12	0		

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X OTHER _____
(SPECIFY)

COL. 2: SOURCE OF FAMILY PLANNING METHOD

- 1 GOVT. HOSPITAL
- 2 GOVT. HEALTH CENTER
- 3 FAMILY PLANNING CLINIC
- 4 GOVT. MOBILE CLINIC
- 5 GOVT. FIELDWORKER
- 6 OTHER PUBLIC
- 7 PVT. HOSPITAL/CLINIC
- 8 PHARMACY
- 9 PRIVATE DOCTOR
- A NONGOVT. MOBILE CLINIC
- B NONGOVT. FIELDWORKER
- C OTHER PRIVATE MEDICAL
- D SHOP
- E CHURCH
- F FRIENDS/RELATIVES
- X OTHER _____
(SPECIFY)

COL. 3: DISCONTINUATION OF FAMILY PLANNING METHOD USE

- 0 INFREQUENT SEX/HUSBAND AWAY
- 1 BECAME PREGNANT WHILE USING
- 2 WANTED TO BECOME PREGNANT
- 3 HUSBAND DISAPPROVED
- 4 WANTED MORE EFFECTIVE METHOD
- 5 HEALTH CONCERNS
- 6 SIDE EFFECTS
- 7 LACK OF ACCESS/TOO FAR
- 8 COSTS TOO MUCH
- 9 INCONVENIENT TO USE
- F FATALISTIC
- A DIFFICULT TO GET PREGNANT/MENOPAUSAL
- D MARITAL DISSOLUTION/SEPARATION
- I IRREGULAR CYCELS
- X OTHER _____
(SPECIFY)
- Z DON'T KNOW

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CASE #2

The respondent was interviewed in December 2004. During the past one year, she had one birth (Carlos), occurring in December 2003, and one other pregnancy that miscarried after three months in July 2004. She is currently using the pill (Code '4'), which she began using one month after the miscarriage. The pills were obtained from a pharmacy (Code '8').

The pregnancy that led to Carlos' birth was planned—Code '2' in Column (3). Her subsequent pregnancy occurred accidentally while her partner was using the condom—Code '1' in Column (3). Her partner had been using the condom (purchased in a pharmacy) since the birth of Carlos in December 2003.

- CASE #2**
INSTRUCTIONS:
 ONLY ONE CODE SHOULD APPEAR IN ANY BOX.
 FOR COLUMN 1, ALL MONTHS SHOULD BE FILLED IN.
- INFORMATION TO BE CODED FOR EACH COLUMN**
- COL. 1: BIRTHS, PREGNANCIES, FAMILY PLANNING METHOD USE**
- B BIRTHS
 - P PREGNANCIES
 - T TERMINATIONS
 - 0 NO METHOD
 - 1 STANDARD DAYS METHOD
 - 2 FEMALE STERILIZATION
 - 3 MALE STERILIZATION
 - 4 PILL
 - 5 IUD
 - 6 INJECTABLES
 - 7 IMPLANTS
 - 8 CONDOM
 - 9 FEMALE CONDOM
 - J DIAPHRAGM
 - K FOAM OR JELLY
 - L LACTATIONAL AMENORRHEA METHOD
 - M PERIODIC ABSTINENCE
 - N WITHDRAWAL
 - X OTHER _____
(SPECIFY)
- COL. 2: SOURCE OF FAMILY PLANNING METHOD**
- 1 GOVT. HOSPITAL
 - 2 GOVT. HEALTH CENTER
 - 3 FAMILY PLANNING CLINIC
 - 4 GOVT. MOBILE CLINIC
 - 5 GOVT. FIELDWORKER
 - 6 OTHER PUBLIC
 - 7 PVT. HOSPITAL/CLINIC
 - 8 PHARMACY
 - 9 PRIVATE DOCTOR
 - A NONGOVT. MOBILE CLINIC
 - B NONGOVT. FIELDWORKER
 - C OTHER PRIVATE MEDICAL
 - D SHOP
 - E CHURCH
 - F FRIENDS/RELATIVES
 - X OTHER _____
(SPECIFY)
- COL. 3: DISCONTINUATION OF FAMILY PLANNING METHOD USE**
- 0 INFREQUENT SEX/HUSBAND AWAY
 - 1 BECAME PREGNANT WHILE USING
 - 2 WANTED TO BECOME PREGNANT
 - 3 HUSBAND DISAPPROVED
 - 4 WANTED MORE EFFECTIVE METHOD
 - 5 HEALTH CONCERNS
 - 6 SIDE EFFECTS

		1	2	3
DEC 04	C	4		
NOV	01	4		
OCT	02	4		
SEP	03	4		
AUG	04	4	8	
JUL	05	T		
JUN	06	P		
MAY	07	P		
APRIL	08	8		1
MAR	09	8		
FEB	10	8		
JAN	11	8	8	
DEC03	12	B		2

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- 7 LACK OF ACCESS/TOO FAR
- 8 COSTS TOO MUCH
- 9 INCONVENIENT TO USE
- F FATALISTIC
- A DIFFICULT TO GET PREGNANT/MENOPAUSAL
- D MARITAL DISSOLUTION/SEPARATION
- I IRREGULAR CYCLES
- X OTHER _____
(SPECIFY)
- Z DON'T KNOW

CASE #3

The respondent was interviewed in December 2004. The woman's only birth in this period (Wambui) occurred in December 2003. She is currently pregnant, having failed with the use of withdrawal two months earlier. She and her husband had been using withdrawal since the birth of Wambui. She also had a miscarriage in June 2004 after four completed months of pregnancy.

CASE #3

INSTRUCTIONS:

ONLY ONE CODE SHOULD APPEAR IN ANY BOX.
FOR COLUMN 1, ALL MONTHS SHOULD BE FILLED IN.

INFORMATION TO BE CODED FOR EACH COLUMN

COL. 1: BIRTHS, PREGNANCIES, FAMILY PLANNING METHOD USE

- B BIRTHS
- P PREGNANCIES
- T TERMINATIONS

- 0 NO METHOD
- 1 STANDARD DAYS METHOD
- 2 FEMALE STERILIZATION
- 3 MALE STERILIZATION
- 4 PILL
- 5 IUD
- 6 INJECTABLES
- 7 IMPLANTS
- 8 CONDOM
- 9 FEMALE CONDOM
- J DIAPHRAGM
- K FOAM OR JELLY
- L LACTATIONAL AMENORRHEA METHOD
- M PERIODIC ABSTINENCE
- N WITHDRAWAL
- X OTHER _____
(SPECIFY)

COL. 2: SOURCE OF FAMILY PLANNING METHOD

- 1 GOVT. HOSPITAL
- 2 GOVT. HEALTH CENTER
- 3 FAMILY PLANNING CLINIC
- 4 GOVT. MOBILE CLINIC
- 5 GOVT. FIELDWORKER
- 6 OTHER PUBLIC
- 7 PVT. HOSPITAL/CLINIC
- 8 PHARMACY
- 9 PRIVATE DOCTOR
- A NONGOVT. MOBILE CLINIC
- B NONGOVT. FIELDWORKER
- C OTHER PRIVATE MEDICAL
- D SHOP
- E CHURCH
- F FRIENDS/RELATIVES
- X OTHER _____
(SPECIFY)

COL. 3: DISCONTINUATION OF FAMILY PLANNING METHOD USE

		1	2	3
DEC 04	C	P		
NOV 01		P		
OCT 02		N		1
SEP 03		N		
AUG 04		N		
JUL 05		N		
JUN 06		T		
MAY 07		P		
APRIL 08		P		
MAR 09		P		
FEB 10		N		1
JAN 11		N		
DEC03 12		B		

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- 0 INFREQUENT SEX/HUSBAND AWAY
- 1 BECAME PREGNANT WHILE USING
- 2 WANTED TO BECOME PREGNANT
- 3 HUSBAND DISAPPROVED
- 4 WANTED MORE EFFECTIVE METHOD
- 5 HEALTH CONCERNS
- 6 SIDE EFFECTS
- 7 LACK OF ACCESS/TOO FAR
- 8 COSTS TOO MUCH
- 9 INCONVENIENT TO USE
- F FATALISTIC
- A DIFFICULT TO GET PREGNANT/MENOPAUSAL
- D MARITAL DISSOLUTION/SEPARATION
- I IRREGULAR CYCLES
- X OTHER _____
(SPECIFY)
- Z DON'T KNOW

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CASE #4

The respondent was interviewed in December 2004. She reported one birth in the past year in October 2004. At the time of Christina's birth, the respondent was surgically sterilized in a government hospital. Christina was conceived after one month of trying to become pregnant. Before this she had used the pill (obtained from a government health center), which she had started using three months after the birth of her previous child.

		1	2	3
CASE #4	DEC 04	C	2	
INSTRUCTIONS:	NOV	01	2	1
ONLY ONE CODE SHOULD APPEAR IN ANY BOX.	OCT	02	B	
FOR COLUMN 1, ALL MONTHS SHOULD BE FILLED IN.	SEP	03	P	
	AUG	04	P	
	JUL	05	P	
	JUN	06	P	
	MAY	07	P	
	APRIL	08	P	
	MAR	09	P	
	FEB	10	P	
	JAN	11	0	
	DEC03	12	4	2
				2

INFORMATION TO BE CODED FOR EACH COLUMN	
COL. 1: <u>BIRTHS, PREGNANCIES, FAMILY PLANNING METHOD USE</u>	
B BIRTHS	
P PREGNANCIES	
T TERMINATIONS	
0 NO METHOD	
1 STANDARD DAYS METHOD	
2 FEMALE STERILIZATION	
3 MALE STERILIZATION	
4 PILL	
5 IUD	
6 INJECTABLES	
7 IMPLANTS	
8 CONDOM	
9 FEMALE CONDOM	
J DIAPHRAGM	
K FOAM OR JELLY	
L LACTATIONAL AMENORRHEA METHOD	
M PERIODIC ABSTINENCE	
N WITHDRAWAL	
X OTHER _____	
(SPECIFY)	
COL. 2: <u>SOURCE OF FAMILY PLANNING METHOD</u>	
1 GOVT. HOSPITAL	
2 GOVT. HEALTH CENTER	
3 FAMILY PLANNING CLINIC	
4 GOVT. MOBILE CLINIC	
5 GOVT. FIELDWORKER	
6 OTHER PUBLIC	
7 PVT. HOSPITAL/CLINIC	
8 PHARMACY	
9 PRIVATE DOCTOR	
A NONGOVT. MOBILE CLINIC	
B NONGOVT. FIELDWORKER	
C OTHER PRIVATE MEDICAL	
D SHOP	
E CHURCH	
F FRIENDS/RELATIVES	
X OTHER _____	
(SPECIFY)	
COL. 3: <u>DISCONTINUATION OF FAMILY PLANNING METHOD USE</u>	
0 INFREQUENT SEX/HUSBAND AWAY	
1 BECAME PREGNANT WHILE USING	
2 WANTED TO BECOME PREGNANT	
3 HUSBAND DISAPPROVED	
4 WANTED MORE EFFECTIVE METHOD	
5 HEALTH CONCERNS	
6 SIDE EFFECTS	
7 LACK OF ACCESS/TOO FAR	
8 COSTS TOO MUCH	
9 INCONVENIENT TO USE	
F FATALISTIC	
A DIFFICULT TO GET PREGNANT/MENOPAUSAL	
D MARITAL DISSOLUTION/SEPARATION	
I IRREGULAR CYCELS	

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(SPECIFY)

- COL. 3: DISCONTINUATION OF FAMILY PLANNING METHOD USE
- 0 INFREQUENT SEX/HUSBAND AWAY
 - 1 BECAME PREGNANT WHILE USING
 - 2 WANTED TO BECOME PREGNANT
 - 3 HUSBAND DISAPPROVED
 - 4 WANTED MORE EFFECTIVE METHOD
 - 5 HEALTH CONCERNS
 - 6 SIDE EFFECTS
 - 7 LACK OF ACCESS/TOO FAR
 - 8 COSTS TOO MUCH
 - 9 INCONVENIENT TO USE
 - F FATALISTIC
 - A DIFFICULT TO GET PREGNANT/MENOPAUSAL
 - D MARITAL DISSOLUTION/SEPARATION
 - I IRREGULAR CYCELS
 - X OTHER _____
- (SPECIFY)
- Z DON'T KNOW

CASE #6

The respondent was interviewed in December 2004 and was in her third month of pregnancy at the time of the interview (had completed two months of pregnancy). Before becoming pregnant, she was using the Standard Days Method, starting in December 2002. She stopped using the Standard Days Method in June 2004 because she had irregular menstrual cycles. She didn't start using another method because she was afraid of side effects and became pregnant.

CASE #6

INSTRUCTIONS:
 ONLY ONE CODE SHOULD APPEAR IN ANY BOX.
 FOR COLUMN 1, ALL MONTHS SHOULD BE FILLED IN.

INFORMATION TO BE CODED FOR EACH COLUMN

COL. 1: BIRTHS, PREGNANCIES, FAMILY PLANNING METHOD USE

- B BIRTHS
 - P PREGNANCIES
 - T TERMINATIONS
 - 0 NO METHOD
 - 1 STANDARD DAYS METHOD
 - 2 FEMALE STERILIZATION
 - 3 MALE STERILIZATION
 - 4 PILL
 - 5 IUD
 - 6 INJECTABLES
 - 7 IMPLANTS
 - 8 CONDOM
 - 9 FEMALE CONDOM
 - J DIAPHRAGM
 - K FOAM OR JELLY
 - L LACTATIONAL AMENORRHEA METHOD
 - M PERIODIC ABSTINENCE
 - N WITHDRAWAL
 - X OTHER _____
- (SPECIFY)

COL. 2: SOURCE OF FAMILY PLANNING METHOD

- 1 GOVT. HOSPITAL
- 2 GOVT. HEALTH CENTER
- 3 FAMILY PLANNING CLINIC
- 4 GOVT. MOBILE CLINIC
- 5 GOVT. FIELDWORKER
- 6 OTHER PUBLIC
- 7 PVT. HOSPITAL/CLINIC
- 8 PHARMACY
- 9 PRIVATE DOCTOR

		1	2	3
DEC 04	C	P		
NOV	01	P		
OCT	02	0		5
SEP	03	0		
AUG	04	0		
JUL	05	0		
JUN	06	1		I
MAY	07	1		
APRIL	08	1		
MAR	09	1		
FEB	10	1		
JAN	11	1		
DEC03	12	1		

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CASE #7

The respondent was interviewed in December 2004. She has had two pregnancies (and no births) in the last year. The first pregnancy lasted for three months between November 2003 and January 2004 and ended in a miscarriage.

The respondent used contraception after the miscarriage. She and her husband used the condom (bought in a shop) except for the three-month period between April and June 2004, when her husband was temporarily away. Note that discontinuation of condom use is marked with a '0' in Column (3) for HUSBAND AWAY. She and her husband resumed using the condom (from a government field worker) after he returned until she accidentally became pregnant in November 2004.

CASE #7

INSTRUCTIONS:

ONLY ONE CODE SHOULD APPEAR IN ANY BOX.
FOR COLUMN 1, ALL MONTHS SHOULD BE FILLED IN.

INFORMATION TO BE CODED FOR EACH COLUMN

COL.1: BIRTHS, PREGNANCIES, FAMILY PLANNING METHOD USE

- B BIRTHS
- P PREGNANCIES
- T TERMINATIONS
- 0 NO METHOD
- 1 STANDARD DAYS METHOD
- 2 FEMALE STERILIZATION
- 3 MALE STERILIZATION
- 4 PILL
- 5 IUD
- 6 INJECTABLES
- 7 IMPLANTS
- 8 CONDOM
- 9 FEMALE CONDOM
- J DIAPHRAGM
- K FOAM OR JELLY
- L LACTATIONAL AMENORRHEA METHOD
- M PERIODIC ABSTINENCE
- N WITHDRAWAL
- X OTHER _____
(SPECIFY)

COL. 2: SOURCE OF FAMILY PLANNING METHOD

		1	2	3
DEC 04	C	P		
NOV 01		P		
OCT 02		8		1
SEP 03		8		
AUG 04		8		
JUL 05		8	5	
JUN 06		0		
MAY 07		0		
APRIL 08		0		
MAR 09		8		0
FEB 10		8	D	
JAN 11		T		
DEC03 12		P		

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- 1 GOVT. HOSPITAL
- 2 GOVT. HEALTH CENTER
- 3 FAMILY PLANNING CLINIC
- 4 GOVT. MOBILE CLINIC
- 5 GOVT. FIELDWORKER
- 6 OTHER PUBLIC
- 7 PVT. HOSPITAL/CLINIC
- 8 PHARMACY
- 9 PRIVATE DOCTOR
- A NONGOVT. MOBILE CLINIC
- B NONGOVT. FIELDWORKER
- C OTHER PRIVATE MEDICAL
- D SHOP
- E CHURCH
- F FRIENDS/RELATIVES
- X OTHER _____
(SPECIFY)

COL. 3: DISCONTINUATION OF FAMILY PLANNING METHOD USE

- 0 INFREQUENT SEX/HUSBAND AWAY
- 1 BECAME PREGNANT WHILE USING
- 2 WANTED TO BECOME PREGNANT
- 3 HUSBAND DISAPPROVED
- 4 WANTED MORE EFFECTIVE METHOD
- 5 HEALTH CONCERNS
- 6 SIDE EFFECTS
- 7 LACK OF ACCESS/TOO FAR
- 8 COSTS TOO MUCH
- 9 INCONVENIENT TO USE
- F FATALISTIC
- A DIFFICULT TO GET PREGNANT/MENOPAUSAL
- D MARITAL DISSOLUTION/SEPARATION
- I IRREGULAR CYCELS
- X OTHER _____
(SPECIFY)
- Z DON'T KNOW

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VII. WOMEN'S QUESTIONNAIRE

The Women's Questionnaire consists of eight sections as follows:

- Section 1: Respondent's Background
- Section 2: Reproduction
- Section 3: Family Planning Methods
- Section 4: Standard Days Method
- Section 5: Marriage and Sexual Activity
- Section 6: Fertility Preferences
- Section 7: Husband's Background and Woman's Work
- Section 8: Attitudes Towards Gender Roles

The Women's Questionnaire has a cover page to record identification information and the interview results. At this point, you should have completed the information identifying the eligible woman you are to interview. You will be filling in the area labeled "Interviewer Visits." Here, you will record your own name, keep a record of your visits, and record the final date and result code. You will also be entering this information into your Interviewer's Assignment Sheet.

A. SECTION 1: RESPONDENT'S BACKGROUND

INFORMED CONSENT

The respondent's consent for participation in the survey must be obtained before you can begin interviewing her. Read the informed consent statement exactly as it is written. This statement explains the purpose of the survey and the voluntary nature of the respondent's participation and then seeks her cooperation. After reading the statement, you (not the respondent) must sign in the space provided to affirm that you have read the statement to the respondent. Then circle '1' if the woman agrees to be interviewed and proceed with Q.101. If the woman does not agree to be interviewed, circle '2,' thank the respondent, and end the interview. Then write '4' (REFUSED) in the cover sheet.

In this section, we obtain some general background information about the respondent.

Q. 101: TIME

Record the time of the day you start the women's interview. If the hour or minutes are less than 10, put a zero in the first box. Record the time in hours and minutes, using the 24-hour system. So if it is 1:00 PM or later, you would add 12 to the current hour.

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	HOUR	0	9
Half past nine in the morning is:	MINUTES	3	0
	HOUR	1	6
Half past four in the afternoon is:	MINUTES	3	0

Q. 105: MONTH AND YEAR OF BIRTH

If the respondent knows her date of birth, write it in the appropriate boxes for MONTH and YEAR. You will need to convert the month into numbers. For this, January is '01,' February is '02,' March is '03,' and so on. If she does not know her month of birth, circle '98' for DON'T KNOW MONTH and ask her for the year of her birth. If she knows the year, write it in the boxes for YEAR. Try under all circumstances to obtain at least the year of birth. If the respondent is unable to provide this information, ask whether she has any documentation such as an identification card, horoscope, or a birth or baptismal certificate that might give her date of birth. Only when it is absolutely impossible to even estimate the year of birth should you circle '9998' for DON'T KNOW YEAR.

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Q. 106: AGE

[In countries that use calendars other than the Gregorian calendar, a conversion chart from one calendar to the other should be included in this manual.]

This is one of the most important questions in the interview, since almost all analysis of the data depends on the respondent's age. For example, one of the most important results of the survey, the proportion of women who use family planning, are calculated by the age of women.

You must obtain the respondent's age in completed years, that is, her age at her last birthday. You must record an age for the woman and you can do this in one of four ways, depending on the type of information you get from the respondent:

- 1) The woman knows her age.
If the woman tells you her age, simply write it in the space provided.
- 2) The woman does not know her age, but year of birth is reported in Q. 105.
If the woman does not know her age, but she did report a year of birth in Q. 105, then you may compute her age as follows. If the woman has had her birthday in the current year, subtract the year of birth from the current year [2004]. If the woman has not yet had her birthday in the current year, subtract the year of birth from last year [2003]. If the woman does not keep track of the time within a year when her birthday falls, it is sufficient to subtract year of birth from the current year [2004].
- 3) The woman does not know her age, and year of birth is not reported in Q. 105.
If the woman does not know her age and she could not report a year of birth, you will have to probe to try to estimate her age. Probing for ages is time consuming and sometimes tedious; however, it is important that you take the time to try to get the best possible information. There are several ways to probe for age:
 - a) Ask the respondent how old she was when she got married or had her first child, and then try to estimate how long ago she got married or had her first child. For example, if she says she was 19 years old when she had her first child and that the child is now 12 years old, she is probably 31 years old.
 - b) You might be able to relate her age to that of someone else in the household whose age is more reliably known.
 - c) Try to determine how old she was at the time of an important event such as war, flood, earthquake, change in political regime, and add her age at that time to the number of years that have passed since the event.
- 4) The woman does not know her age and probing did not help.
If probing does not help in determining the respondent's age and date of birth was not recorded in Q. 105, you will have to estimate her age. Remember, this is a last resort to be used only when all your efforts at probing have failed.

Remember, you **MUST** fill in an answer to Q. 106.

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CONSISTENCY CHECK: DATE OF BIRTH AND AGE

You must now check the consistency of the reported year of birth (Q. 105) and age (Q. 106). The woman's age plus her year of birth must equal the year in which she last had a birthday. There are two methods for checking whether the age and year of birth are consistent—the arithmetic method and the chart method. You may use either method, but do not perform the check until after you have asked Qs. 105 and 106.

I. Arithmetic method. You will choose the procedure explained in 1a or 1b to do the arithmetic, depending on the type of information you have recorded in Q. 105. Use the margins of the questionnaire to do the necessary arithmetic.

- 1a. IF BOTH MONTH AND YEAR ARE RECORDED IN Q.105. If the month of birth is before the month of interview (she has had her birthday this year), then her age plus her year of birth should equal the year of interview [2004]. If the month of birth is after the month of interview (she has not had her birthday this year), then her age plus her year of birth should equal the previous year [2003]. If the month of birth is the same as the month of interview, then a sum of either [2003] or [2004] is acceptable. If the sum is incorrect, then either the year of birth or the age (or both) are incorrect and need to be corrected. If the sum is off by exactly one year, then it is also possible that the month of birth is incorrect and the other information is accurate. In such cases, the age and the month and year of birth all need to be reviewed to see where the error lies.

EXAMPLE: If a respondent tells you that she was born in January 1955, she is 45 years old, and you are interviewing her in July 2000, you would add 1955 to 45. If the information the respondent gave you is consistent, the sum should be 2000, since July comes after January. If another respondent tells you that she was born in December 1968 and she is 31 years old, the sum should equal 1999 since she will not become a full year older until December (July is before December).

- 1b. IF ONLY YEAR OF BIRTH IS RECORDED IN Q. 105. Add the year of birth to the respondent's age and accept a sum of either [2003] or [2004]. For example, if she says she was born in 1970, but she does not know the month, she should be either [33] (since $1970+33=2003$) or [34] (since $1970+34=2004$). If the sum does not equal either [2003] or [2004], probe to find out whether the year of birth or age is incorrect.

2. HOW TO CORRECT INCONSISTENT ANSWERS. If the age plus the year of birth do not add to [2003] or [2004] as appropriate, probe to get consistent information. For example, if the sum equals [2002] and it should be [2003], then you need to add 1 to either the age or the year of birth after checking with the respondent to see which one is wrong. If the sum adds to [2006] and it should be [2004], you need to subtract 2 from either the age or the year of birth or else subtract 1 from both the age and the year of birth. It is important to understand that either the age or year of birth or both may be incorrect.

II. Chart method. Use the Age/Birth-Date Consistency Chart (Figure 2) to check consistency. You will choose the procedure explained in 1a or 1b, depending on the type of information you have recorded in Q.105.

- 1a. IF BOTH MONTH AND YEAR ARE RECORDED IN Q. 105. Enter the chart at the age you recorded in Q. 106. If the month of birth is before the month of interview (she has already had her birthday this year), use the right hand column to see what year of birth is consistent with that age. If the month of birth is after the month of interview (she has not yet had her birthday this year), use

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FIGURE 2. AGE/BIRTH-DATE CONSISTENCY CHART FOR SURVEY IN [2004]

Current Age	Year of Birth	
	Has not had birthday in 2004	Has already had birthday in 2004
	Don't Know	
0	2003	--
1	2002	2003
2	2001	2002
3	2000	2001
4	1999	2000
5	1998	1999
6	1997	1998
7	1996	1997
8	1995	1996
9	1994	1995
10	1993	1994
11	1992	1993
12	1991	1992
13	1990	1991
14	1989	1990
15	1988	1989
16	1987	1988
17	1986	1987
18	1985	1986
19	1984	1985
20	1983	1984
21	1982	1983
22	1981	1982
23	1980	1981
24	1979	1980
25	1978	1979
26	1977	1978
27	1976	1977
28	1975	1976

Current Age	Year of Birth	
	Has not had birthday in 2004	Has already had birthday in 2004
	Don't Know	
30	1973	1974
31	1972	1973
32	1971	1972
33	1970	1971
34	1969	1970
35	1968	1969
36	1967	1968
37	1966	1967
38	1965	1966
39	1964	1965
40	1963	1964
41	1962	1963
42	1961	1962
43	1960	1961
44	1959	1960
45	1958	1959
46	1957	1958
47	1956	1957
48	1955	1956
49	1954	1955
50	1953	1954
51	1952	1953
52	1951	1952
53	1950	1951
54	1949	1950
55	1948	1949
56	1947	1948
57	1946	1947
58	1945	1946

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29	1974	1975
----	------	------

59	1944	1945
----	------	------

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the left hand column to see what year of birth is consistent with that age. If the year of birth recorded in Q. 105 is not the same as the year of birth in the chart, then Qs. 105 and 106 are inconsistent and you will have to make a correction.

- 1b. IF ONLY YEAR OF BIRTH IS RECORDED IN Q. 105. Enter the chart at the age you recorded in Q. 106. The year of birth listed in either the left or right hand column is consistent with that age. If the year of birth recorded in Q. 105 is not the same as one of the two years of birth recorded in the chart, then Qs. 105 and 106 are inconsistent and you will have to make a correction.
2. HOW TO CORRECT INCONSISTENT ANSWERS. If the recorded year of birth (Q. 105) does not agree with the year in the chart, you must correct the inconsistency. Do this by further probing and adjusting either the age information, the date information, or both. It is important to understand that either or both of the two pieces of information may be incorrect. Do not always assume that an inconsistency means, for instance, that the date of birth was given correctly and that the age is incorrect. It could be that the date or both the age and the date are incorrect.

Finally, before moving on to the next question, verify that the respondent is indeed eligible. If the woman is younger than 15 years or older than 49, you have to terminate the interview. Do this tactfully by asking two or three more questions and then thank the respondent for her cooperation; write INELIGIBLE on the cover page of the questionnaire.

Q. 107: EVER ATTENDED SCHOOL

The term “school” means formal schooling, which includes primary, secondary, and postsecondary schooling, and any other intermediate levels of schooling in the formal school system.² This definition of school does not include Bible school or Koranic school or short courses like typing or sewing. However, it does include technical or vocational training beyond the primary-school level, such as long-term courses in mechanics or secretarial work.

Q. 108: HIGHEST LEVEL ATTENDED

Record the highest level she ever attended, regardless of whether or not the year was completed. For example, if she attended Form/Year 1 of secondary school for only two weeks, record SECONDARY.

The response categories for this question will need to be revised based on the local education system.

Q. 109: HIGHEST GRADE/FORM/YEAR COMPLETED

For this question, record only the number of years that the respondent successfully completed at that level. For example, if a woman was attending Form/Year 3 of secondary school and left school before completing that year, record ‘02.’ Although Form/Year 3 was the highest year she attended, she completed two years of secondary school. Note that you will record the number of years completed at the level that was recorded in

² Questions on education should be adapted according to the education system in each country.

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Q.108. If she attended only two weeks of Form/Year 1 of secondary school, record '00' for completed years.

The response categories for this question will need to be revised based on the local education system.

Q. 111: LITERACY

Based on your knowledge of the respondent, choose the card with the language in which the respondent is likely to be able to read if she is literate. Show the first sentence on the card to the respondent. Give the respondent enough time to read the sentence; do not rush her. Record whether the respondent was not able to read the sentence at all, was able to read only parts of the sentence, or was able to read the whole sentence. If the respondent asks for the sentences in another language and you were provided a card with sentences in that language, show the respondent the appropriate card. If there is no card with sentences in the language required, circle '4' and specify the language.

It is important to avoid the problem of having other respondents in the household overhear the sentence being read. Subsequent respondents in the household might be able to repeat the sentence when they are interviewed, even if they are unable to read.

Each card will need to be adapted to language appropriate to the country. For example, "Parents love their children", "Farming is hard work", "The child is reading a book", "Children work hard at school"). Cards should be prepared for every language in which respondents are likely to be literate in each country.

Q. 114: NEWSPAPER/MAGAZINE READING

The purpose of this question is to find out whether the respondent is exposed to influences outside her local community by means of reading newspapers or magazines. It does not matter what type of articles she reads, what language she reads in, or who buys the newspapers or magazines she reads. The question is simply whether she usually reads them and how often she reads them. Make sure that you read the entire question before accepting her answer.

Q. 115: RADIO LISTENING

If there is any doubt as to whether she listens almost every day, use your judgment. For example, if she says "I listen almost every day, but during the planting season, I'm away and I don't listen at all," record **ALMOST EVERY DAY**, since she usually listens almost every day. It does not matter who owns the radio and what program she listens to.

Q. 116: TELEVISION WATCHING

As with Qs. 114 and 115, the purpose is to get an idea of how much exposure the respondent has to influences outside her place of residence. It does not matter who owns the television and what program she watches.

[Q. 117: COUNTRY SPECIFIC ON RELIGION]

B. SECTION 2: REPRODUCTION

In this section, information is collected about the births that a woman has had during her life. This is a particularly important section, and you need to be especially careful to obtain all the required information. The questions in this section can be divided into three groups:

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- Qs. 201-203: Information about the total number of sons and daughters that a woman has given birth to.
- Qs. 225-231: Questions about current pregnancy and earlier pregnancies
- Qs. 237-239: Questions about menstruation.

GENERAL NOTES ABOUT Qs. 201-203

These questions collect information about all births that the woman has had (no matter who the father is). It is important that you understand which events to include. We want to record all of the respondent's natural births, even if the child no longer stays in the household and even if the child is no longer alive. Children who survived only for a few minutes (and showed signs of life by crying, breathing, or moving) should also be recorded.

It is also important to understand which events should not be recorded. You must not record adopted children or children of the husband to whom the respondent did not give birth herself. Also, you must not record children who were born dead, miscarriages, or abortions.

Q. 201: EVER GIVEN BIRTH

This question serves two purposes: to introduce the section and to learn whether the respondent has ever given birth. If the answer is YES, circle '1' and proceed to the next question. If the answer is NO, circle '2' and skip to Q. 225.

Q. 202: TIMES GIVEN BIRTH

This question asks about the number of times that the woman has given birth. Be careful to include all natural births, even if the child no longer stays in the household and even if the child is no longer alive. Children who survived only for a few minutes (and showed signs of life by crying, breathing, or moving), and children who were born dead should be recorded.

Q. 203: NUMBER OF CHILDREN ALIVE

These questions on children alive are extremely important. Some respondents may be reluctant to talk about this subject, especially if she has had children who have died, and may become sad or upset that you are asking such questions. Be sympathetic and tactful in such situations. Say that you know the subject is painful but that the information is important.

Q. 225: BIRTHS ON THE CALENDAR

Each birth in [2003] or later should be entered on the calendar. In Column (1), place a 'B' in the month of birth, ask the number of months the pregnancy lasted, and record 'P' in each of the preceding months according to the duration of the pregnancy. The number of 'P's must be one less than the number of months that pregnancy lasted.

Q. 226: CURRENT PREGNANCY STATUS

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If the respondent does not know for certain whether or not she is pregnant, circle '8' (UNSURE). If the respondent answers NO or UNSURE, skip to Q.229.

Q. 227: MONTHS OF PREGNANCY

If the woman does not know how many months she has been pregnant, probe to get an estimate. Remember that we are interested in completed months of pregnancy. To make sure that you are getting completed months of pregnancy, probe with a question such as, "Are you in your Xth month of pregnancy, or have you completed your Xth month of pregnancy?" Record the answer, putting a zero in the first box, if she has completed nine or fewer months of pregnancy. For example, record '03' for three completed months.

You will now record her pregnancy in Column (1) of the calendar. Write 'P' in the month of interview and for the preceding months of pregnancy. The total number of months recorded with 'P' for the current pregnancy will be the same as the number recorded in Q. 227, the number of completed months of pregnancy.

Q. 228: DESIRED TIMING OF PREGNANCY

Read the entire question to the respondent before accepting an answer, stressing the underlined words.

Q. 229: LOST PREGNANCIES

We want to know whether the respondent had any pregnancies that did not result in a live birth, so we ask about each type of lost pregnancy. If a pregnancy ended early and involuntarily, it was a miscarriage. If a woman voluntarily ended a pregnancy, it was an abortion. If a woman gave birth to a child that showed no signs of life, it was a stillbirth.

If the respondent answers NO, skip to Q. 237.

Q. 230: MONTH OF LAST PREGNANCY LOSS

If a respondent lost a pregnancy in the past year, write the month that the pregnancy ended.

If the respondent cannot recall the month when the pregnancy ended, you need to probe carefully. For example, ask her whether it ended in the dry or wet season, whether she remembers if it was at Christmas or Easter time, during the month of Ramadan, or during some other significant event/season of the year to try to determine the month of the pregnancy loss. Convert months to numbers, for example, '08' for August. If you cannot even estimate a month, write '98' for MONTH.

Q. 231: MONTHS PREGNANT AT LAST PREGNANCY LOSS

If the respondent lost a pregnancy in the past year, write the number of months pregnant when that pregnancy ended. Convert months to numbers as in Q. 230.

You will now record the number of completed months of pregnancy in the calendar. Enter 'T' in Column (1) of the calendar for the month that the pregnancy terminated. Write 'P' in Column (1) for the remaining number of completed months that were in the past year.

Q. 237: START OF LAST MENSTRUAL PERIOD

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The answers to this question will help to determine whether any of the respondents are actually menopausal or infecund because they have not had their periods in a long time. This is important in any study of fertility since menstruation is directly linked to pregnancy. Record the respondent's answer in the units that she uses.

For example, if she says "three weeks ago," circle '2' and record WEEKS AGO '03.' If she says "Four days ago," circle '1' and record DAYS AGO '04.' If the respondent appears to be rounding off her answer, probe for an exact answer. For example, if she says "About a week ago," say, "Do you remember which day? Was it before or after the weekend?"

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If the respondent gives you the date that her last menstrual period began, write the date in the space provided on the questionnaire. Calculate the amount of time that has passed, and record it. Note that it is not necessary to obtain a date. The space is provided only for cases in which the respondent gives you a date. If she tells you she is in menopause, record IN MENOPAUSE. If she has not menstruated since the birth of her last child, record BEFORE LAST BIRTH. If she has never menstruated, record NEVER MENSTRUATED.

Q. 237A: NEXT EXPECTED PERIOD

This question is important to verify Q. 237. Record the respondent's answer in the units that she uses. For example, if she says "three weeks ago," circle '2' and record WEEKS AGO '03.' If she says "Four days ago," circle '1' and record DAYS AGO '04.' If the respondent doesn't know, circle "997". If the respondent appears to be rounding off her answer, probe for an exact answer. For example, if she says "About a week ago," say, "Do you remember which day? Was it before or after the weekend?"

Qs. 238 and 239: KNOWLEDGE OF PREGNANCY IN MONTHLY CYCLE

First, ask Q. 238 to see whether the woman thinks there are times during a woman's monthly cycle when she is more likely to become pregnant. If she says there is no time that is more likely than another or she does not know, record the response and skip to Q. 301. If she says there is a time when a woman is more likely to become pregnant, record YES and ask Q. 239.

C. SECTION 3: CONTRACEPTION

This section collects information on the knowledge and use of various contraceptive methods, how a couple can avoid or delay pregnancy. The topic of contraception and family planning may be considered a personal matter by a respondent, and she may feel embarrassed to talk about it. To overcome her embarrassment, you must show that you do not feel embarrassed or uncomfortable in any way. Ask these questions as if they were no different from any other questions in the questionnaire. If she is hesitant to answer any of these questions, reassure her that everything she says will be treated confidentially and that the same questions are being asked of women all over the country.

Questions about the use of methods of contraception apply to all partners of respondents, whether or not the couple is currently living together or married. If the respondent has been married more than once, it does not matter with which particular husband or partner she may have used a method.

GENERAL NOTE ON CONTRACEPTIVE TABLE

The contraceptive table asks the respondent about her knowledge, as well as use, of specific contraceptive methods. In the first column of the table, you will record the respondent's knowledge of specific methods, while in the second column you will record whether she has ever used any of the methods that she has heard of.

This is how you should work through this table:

- 1) Read the introductory sentence at the top of the table. Then read Q. 301 and wait for the respondent to mention the contraceptive methods she knows about. Circle '1' in the first column for each method that she mentions.

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- 2) Now proceed down the list of methods, asking Q. 301 for any methods that the respondent did not mention, circling '2' in the first column if she knows the method and '3' if she does not know the method.
- 3) After you have completed the list of methods asking about knowledge, return to the top of the list and ask Q. 302 (ever use) for each method that the respondent has heard of.

It is important that you follow the above procedure of first asking about knowledge for all methods before asking about use, so that the respondent does not become confused about whether you are asking about knowledge or use of a particular method.

Q. 301: KNOWLEDGE OF WAYS TO DELAY/AVOID PREGNANCY

This is a general question to find out which contraceptive methods the respondent has heard of. Read the statement at the top of the table: "Now I would like to talk about family planning—the various ways or methods . . ." Then read Q. 301: "Which ways or methods have you heard about?" Wait for the woman to tell you which methods she knows about. Circle '1' for each method that she mentions "spontaneously." If she mentions a traditional or folk method (such as herbs) or any method not listed in the table, circle '1' for Method 16 at the bottom of the table and write the name(s) of the method(s) in the space provided (Figure 3). If she mentions more than two other methods for Method 16, record only the first two methods mentioned.

After you have recorded all methods the respondent mentioned spontaneously, for each method the respondent did not mention spontaneously, ask whether she has ever heard of the method. For example, if she did not mention the pill spontaneously, ask her about it now by reading the description of the method: "Have you ever heard of the pill? Women can take a pill every day to avoid becoming pregnant." If she says she has heard of it, record '2' for YES in the first column. If she has never heard of the pill, record NO by circling '3.' Repeat this for each method that she did not mention spontaneously, reading the description of each method.

At first you may feel embarrassed to talk about and describe these methods, but remember, if you are embarrassed, you may increase the embarrassment of the respondent. You should keep from smiling or giggling so that you encourage her to be direct and to feel more comfortable talking with you about this subject.

The respondent may not always understand what you are talking about when you describe a particular method. In such cases, repeat the description. If she still does not understand, you may need to explain the method in different words or in slightly greater detail. For this, you need to have some knowledge of these contraceptive methods yourself and must be familiar with names that people use to refer to each method. Some additional information about selected methods is given below:

FEMALE STERILIZATION

There are several types of operations a woman can have that will make her sterile, for example, "tube tie" (tubal ligation) or removal of the womb, uterus, or ovaries. You should stress the phrase "an operation not to have any more children." Operations to remove the womb or uterus are performed for reasons other than to provide contraceptive protection. Only when the operation was performed to enable the woman to stop having children should you record it as a sterilization.

MALE STERILIZATION

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This is a comparatively minor operation done on men for contraceptive purposes. It is also called vasectomy.

INJECTABLES

An injection of hormone that is released slowly into the bloodstream can be given regularly to women to prevent pregnancy. The most common type of injectable contraceptive is given every three months. This is known as *depomedroxyprogesterone acetate* (DMPA), Depo-Provera, Depo, or *Megestron*^R. Another injectable contraceptive, NET EN (also called *Noristerat*^R), is given every two months.

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FIGURE 3. SECTION 3: FAMILY PLANNING METHODS

<p>Now I would like to talk about family planning—the various ways or methods that a couple can use to delay or avoid a pregnancy. BEGIN BY ASKING QUESTION 301. FOR EACH METHOD MENTIONED SPONTANEOUSLY CIRCLE CODE 1. THEN PROCEED DOWN COLUMN 301, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE 2 IF METHOD IS RECOGNIZED, AND CODE 3 IF NOT RECOGNIZED. THEN, FOR EACH METHOD WITH CODE 2 CIRCLED, ASK 302.</p>			
301	Which ways or methods have you heard about? FOR METHODS NOT MENTIONED SPONTANEOUSLY, ASK: Have you ever heard of (METHOD)?		302 Have you ever used (METHOD)?
01	FEMALE STERILIZATION Women can have an operation to avoid having any more children.	Spontaneous 1 Yes 2 No 3	Have you ever had an operation to avoid having any more children? YES 1 NO 2
02	MALE STERILIZATION Men can have an operation to avoid having any more children.	Spontaneous 1 Yes 2 No 3	Have you ever had a partner who had an operation to avoid having any more children? YES 1 NO 2
03	PILL Women can take a pill every day to avoid becoming pregnant.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
04	IUD Women can have a loop or coil placed inside them by a doctor or a nurse.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
05	INJECTABLES Women can have an injection by a health provider that stops them from becoming pregnant for one or more months.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
06	IMPLANTS Women can have several small rods placed in their upper arm by a doctor or nurse that can prevent pregnancy for one or more years.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
07	CONDOM Men can put a rubber sheath on their penis before sexual intercourse.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
08	FEMALE CONDOM Women can place a sheath in their vagina before sexual intercourse.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
09	DIAPHRAGM Women can place a thin flexible disk in their vagina before intercourse.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
10	FOAM OR JELLY Women can place a suppository, jelly, or cream in their vagina before intercourse.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
11	LACTATIONAL AMENORRHEA METHOD (LAM) Up to 6 months after childbirth, a woman can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
12	RHYTHM OR PERIODIC ABSTINENCE Every month that a woman is sexually active, she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
13	STANDARD DAYS METHOD: Women can avoid pregnancy by not having unprotected sexual intercourse on days 8-19 of the cycle. They can use a necklace to monitor their cycle days.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
14	WITHDRAWAL Men can be careful and pull out before climax.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
15	EMERGENCY CONTRACEPTION Women can take pills up to three days after sexual intercourse to avoid becoming pregnant.	Spontaneous 1 Yes 2 No 3	YES 1 NO 2
16	Have you heard of any other ways or methods that women or men can use to	YES 1	

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	avoid pregnancy?	_____	YES 1
		(SPECIFY)	NO 2
		_____	YES 1
		(SPECIFY)	NO 2
		NO 2	

IMPLANTS

Also called Norplant, these are small rods surgically implanted in a woman’s upper arm. They usually protect a woman against pregnancy for five or more years.

FEMALE CONDOM

A thin, transparent rubber can be placed in the vagina before sex to avoid pregnancy.

DIAPHRAGM

This method is used in the vagina. Diaphragms and cervical caps are soft rubber cups that can be placed in the vagina to cover the cervix to block sperm from entering the uterus and tubes where sperm could meet an egg. Diaphragms and cervical caps should be used with spermicidal jelly or cream.

FOAM OR JELLY

Spermicides including foam, cream, jelly, foaming tablets, or suppositories are used to kill sperm or make sperm unable to move toward the egg. You must find out whether the respondent has heard of any of these methods.

LACTATIONAL AMENORRHEA METHOD (LAM)

Women can postpone the return of menstruation after a birth (and therefore remain unlikely to become pregnant) by breastfeeding frequently. A specially taught method that makes use of this principle is the lactational amenorrhea method (known as LAM). This method requires a woman to breastfeed frequently (without feeding the child anything else except water) and to know that the method can be used for up to six months after a birth as long as menstruation has not returned. The method also teaches women that if menstruation returns, the child becomes six months old, or the mother starts feeding her child anything other than breast milk or plain water, they should begin using another method of contraception if they want to avoid becoming pregnant.

PERIODIC ABSTINENCE

This is also called the safe period, the rhythm method, or the calendar method. Periodic abstinence is based on the principle that by not having sexual relations on certain days of her monthly cycle, a woman can avoid becoming pregnant. Note that this is not the same as prolonged abstinence where the couple stops having sexual relations for months at a time to avoid pregnancy without regard to the woman’s monthly cycle. To ensure that the respondent understands, stress the phrase “on the days of the month she is most likely to get pregnant” while putting the question to the respondent. Also, if a woman does not feel like having sex on particular days of her cycle, that does not mean that she is using periodic abstinence. She has to avoid sex to avoid pregnancy.

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STANDARD DAYS METHOD

The Standard Days Method is similar to the rhythm method, or the calendar method. Women use CycleBeads to identify the “unsafe period” where unprotected sexual intercourse must be avoided - between days 8-19 of the monthly cycle. To ensure that the respondent understands, stress the phrase “on the days 8-19 of the monthly cycle” while putting the question to the respondent. Also, if a woman does not feel like having sex on particular days of her cycle, that does not mean that she is using the Standard Days Method. She has to avoid sex on specific days, as identified by the CycleBeads, to avoid pregnancy.

EMERGENCY CONTRACEPTION

Women can take pills up to three days after having sex to avoid getting pregnant. These pills are also called “morning-after pills.”

ANY OTHER METHODS

Women may mention traditional methods such as certain herbs or medicines. If so, write the name of the method or methods. If she mentions prolonged abstinence or breastfeeding, write these down, since she considers them methods of family planning.

Q. 302: EVER USE OF CONTRACEPTIVE METHODS

After you have completed Q. 301, you are ready to ask the respondent about use of contraception. However, before you ask Q. 302 for each method, you must first check whether the respondent reported having knowledge of the method in Q. 301. Ask Q. 302 for each method that has a ‘1’ or ‘2’ circled, indicating that the respondent has heard of the method, either spontaneous or probed. Do not ask Q. 302 for methods the woman has not heard of (Code ‘3’ circled in Q. 301).

When asking about the use of female sterilization, say, “Have you ever had an operation to avoid having any more children?”

In asking Q. 302 for male methods, such as the condom and withdrawal, use the phrase, “Have you and your husband or any partner ever used (condoms/withdrawal)?” Similarly, when asking about male sterilization, say, “Have you ever had a partner who had an operation to avoid having any more children?” If she has had more than one husband or partner, we are interested in finding out whether any of them ever used condoms or withdrawal with her or was sterilized. Remember that the answer to this question is YES even if the respondent used a method for only a short time or with only one partner.

If she has named any other methods in Q. 301 (Method 16), be sure to ask whether she ever used them in Q. 302 and record her answer.

Q. 303: FILTER FOR EVER USED A METHOD

This is a filter for you to screen women according to whether they have ever used any method or have never used any method. Check the answers to Q. 302 and mark the appropriate box in Q. 303. The box on the left that is labeled NOT A SINGLE “YES” (NEVER USED) is for a woman who does not have a single YES recorded in Q. 302. This would be a woman who has never used a method of contraception. The box on the right that is labeled AT LEAST ONE “YES” (EVER USED) is for a woman who has at least one YES recorded in Q. 302. This means the woman has used at least one method of contraception. If there are no

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responses at all recorded in Q. 302 because the woman has never heard of any method, mark the box on the left.

Qs. 304 and 306: PROBE FOR EVER USED

The purpose of these questions is to be certain that neither the respondent nor her husband (or partner) has ever used anything to delay or avoid getting pregnant, since contraception is one of the most important features of the survey.

If the woman responds YES to Q. 304, ask Q. 306 to find out what she has used or done. Note that you should not record the answer YES to Q. 306 in the coding section to the right of the question. Instead, go back to the contraceptive table and correct Qs. 301, 302, and 303. For example, if the woman says here that her husband has used a condom with her, you may have to change Q. 301 in the row for the condom from Code '3' to Code '2.' Then, you must change Q. 302 to Code '1.' Finally, correct the filter in Q. 303 and then continue with Q. 308.

If the woman responds NO to Q.304, circle code '2.'

Q. 305: ENTER PERIODS OF NONUSE ON THE CALENDAR

If the woman says NO in Q. 304, that she (or a partner) has never used a method to delay or avoid pregnancy, record '0' in Column (1) of the calendar in each blank month (where there is no 'B,' 'P,' or 'T' code). Now, for women who have never used a method of family planning, there should be some code in each month of Column (1). Skip to Q. 329.

Q. 308: WOMAN STERILIZED

This question is a filter for woman who have had a operation to avoid having any more children through sterilization. Check Q. 302 (01), and if "1" is circled, then skip to Q. 311A. If "2" is circled, then ask Q. 309.

Q. 309: WOMAN PREGNANT

This question is a filter for women who are currently pregnant. Check Q. 226, and if the respondent is pregnant, skip to Q. 318. If the respondent is NOT pregnant or UNSURE, continue with Q. 310.

Qs. 310-311A: CURRENT USE OF CONTRACEPTION

These questions are some of the most important in the questionnaire. Since methods are effective for different lengths of time, you may have some difficulty deciding whether a particular respondent is currently using a method. Coitus-related methods such as condoms, vaginal methods and withdrawal are used with each act of intercourse, so current users of these methods will have used them during the most recent acts of intercourse. Current users of the pill should be taking pills daily. Other methods provide ongoing protection without daily or regular action by the woman. Contraceptive injections may have been administered two to six months earlier and still provide protection, while implants provide protection for up to five years, or until removed. An IUD, once inserted, protects against pregnancy until it is removed or expelled. If the woman has been sterilized, you will record FEMALE STERILIZATION as the current method. Or if the woman's current partner has been sterilized, you will record MALE STERILIZATION as the current method.

If the woman mentions more than one method, circle the code for all methods that are currently being used. If more than one method is circled, follow the skip instruction for the highest method on the list and ask the

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subsequent questions about that method.

Check to be sure that the response to Q. 311 is consistent with the responses to Q. 301 and Q. 302. For example, the respondent may say that she is using the pill but reported in Q. 301 that she did not know the pill or reported in Q. 302 that she has never used the pill. If this happens, probe further and correct the responses in Q. 301 to Q. 311 as necessary.

Although it is not common, you may encounter a woman who has had a hysterectomy, which is the surgical removal of all or part of the uterus. Such a woman is unable to become pregnant and therefore does not need to use contraception to avoid pregnancy. However, because the operation is usually not performed for contraceptive reasons, we will consider a woman with a hysterectomy as a nonuser of contraception. She is similar to a woman who is menopausal. In the filter in Q. 308 you would mark the box labeled WOMAN NOT STERILIZED, and in Q. 309 mark the box labeled NOT PREGNANT. In Q. 310, record NO (she is not currently using a method of contraception), and skip to Q. 322.

Q. 316/316A: DATE OF STERILIZATION OPERATION/START OF CURRENT METHOD

If the respondent does not remember the date when she or her partner had the sterilization operation, probe to help her remember. Perhaps relating it to the age and date of birth of her youngest child would help. You must get a date, even if it is just your best estimate.

For users of other family planning methods, ask when she started using the method most recently without stopping. For example, a woman started using the pill in June 1996. A few months later, she stopped taking the pill because she wanted to become pregnant. She gave birth to a child in January 1999 and started using the pill again in March 1999. When interviewed, she is still using the pill. In this case, record '03' for MONTH and '1999' for YEAR.

Check to see whether the date is AFTER the date of birth of the last child or last pregnancy termination. If not, ask the question again and make it clear to the respondent that we mean the date that she started using the current method WITHOUT STOPPING for any reason including a pregnancy. For example, a woman cannot have used the pill continuously for three years if she had a baby last year.

Q. 317: ENTER CURRENT USE ON CALENDAR

If the year in Q. 316/316A is [2003], mark the box on the left and enter the code for the method currently used in Column (1) and the source of the method in Column (2) of the calendar in the month of interview and in each month back to the date she started using or was sterilized. You will continue with Q. 318.

If the woman started using her current method in [2002] or earlier, mark the box on the right, and enter the code for the method currently used in Column (1) and the source of the method in Column (2) of the calendar in all months of the calendar. Then, skip to Q. 319.

Make sure that you use the method codes shown to the left of the calendar and not the codes shown in Q. 311, since the codes are different for most contraceptive methods. If she has been using her current method for a long time, write the code in the current month and the beginning month, and join them with a squiggly line. Do not draw the squiggly line through months she did not use a method.

Q. 318: CONTRACEPTIVE HISTORY

Question 318 asks both current and noncurrent users of contraception about previous times that they have

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used contraception in the past year, since [November 2003]. You need to find out her history of contraceptive use since [November 2003].

Now use the events that are already recorded in the calendar (birth dates, names, pregnancies, and pregnancy losses) as reference points for yourself and the respondent. Use these events to ask questions about contraceptive use and nonuse in the periods of time around these events.

For each period of time in Column (1) that is still empty (no 'B,' 'P,' or 'T' or contraceptive method code), you need to enter a code that reflects the respondent's contraceptive story. To do this, you need to find out several pieces of information:

- 1) Was the respondent using a method of contraception in a period of time, and if so, what method was she using?
- 2) When did she start using that method?
- 3) For how long did she use that method continuously; when did she stop using that method?
- 4) Why did she stop using the method?
- 5) What happened when she stopped using that method—did she not use any method, did she start using a different method, or did she become pregnant?

For example, if the respondent has two births, Mary and John, you could ask a series of questions that would fill in the respondent's contraceptive history in the period of time between the births of Mary and John. The first question you could ask would be, **“Between the births of Mary and John, did you use any contraceptive method or not?”** (The respondent tells you that she used condoms.) You would then ask, **“How long after the birth of Mary did you begin using condoms?”** (She tells you the third month after the birth of Mary.) This gives you the starting month in which she began using condoms, but you also need to know for how long she used condoms continuously and when she stopped using them. So you could ask, **“For how long did you use condoms continuously?”** (She tells you ten months.) Now you know when she started using condoms and when she stopped, but say there are 15 months between the birth of Mary and the time she became pregnant with John. You now need to find out what the respondent was doing between the time she stopped using the condom and became pregnant with John. Ask a question such as, **“After you stopped using the condom, and before you became pregnant with John, did you use any contraceptive method or not?”** (She tells you she did not use any method.)

Now you know:

- 1) That she used a contraceptive method between Mary and John and which method she used
- 2) At what point she began using that method after the birth of Mary
- 3) For how long she used that method continuously and when she stopped using that method
- 4) Whether she used another method after she stopped using the condom and before the birth of John.

This gives you the respondent's complete contraceptive history between the births of Mary and John. You would continue in a similar way until you filled in each month of Column (1) with a code. Enter the codes of the methods she used in each month of use and '0' in the months where she did not use a method. After you have recorded periods of use and nonuse, Column (1) should be completely filled. You will have accounted for every month since [November 2003] by recording either births, current pregnancies, lost pregnancies, use of contraception, or nonuse of contraception.

After completing Column (1), you must complete Column (2). For every use of a method that begins in [November 2003] or later, the source code is recorded in Column (2) in the first month of each segment of use. This is true even if it is a method that she had used before. For example, if she used injections for three

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months, stopped for a year and then started using injections again, you would write a code in the first month for each of these two segments of use, whether they are the same source or not.

After completing Column (2), you must complete Column (3). For each time there is an interruption of contraceptive use in Column (1), you need to ask the respondent why she stopped using that method. Do this by asking, **“Why did you stop using the (METHOD)?”** Record the reason for the interruption in Column (3) in the same month as the last month of use of that method recorded in Column (1).

For example, when a woman stops using condoms, in the next month she may:

- a) Be using a different method
- b) Not be using any method
- c) Be pregnant.

In cases in which a respondent tells you she used the method until she got pregnant, you will ask, **“Did you become pregnant while using (METHOD), did you stop to become pregnant, or did you stop for some other reason?”** It may happen that several months passed between the time that she stopped using the method and actually became pregnant. If she did in fact become pregnant while using the method, you will code '1' in Column (3); otherwise, you will ask, **“How many months passed between the time you stopped using (METHOD) and you became pregnant with (NAME)?”** Enter '0' in Column (1) for each month she was not using a method.

Qs. 322 and Q. 323: TOLD ABOUT SIDE EFFECTS AND PROBLEMS

The question asks whether at the time she obtained her current method, the respondent was told about potential side effects or problems. If there has been more than one episode of the use of the current method, ask about the time that she started using the method during the current episode of use.

Q. 323 is asked to a woman who said that she was not told about problems associated with using the current method. Ask her whether at any other time she was told of these problems.

Q. 324: WHAT TO DO IN CASE OF PROBLEMS

In this question, the respondent is asked whether she was told by the family planning provider or health worker what to do if there was a problem. For example, if the respondent says that the health worker told her to take some medication if she had too much pain during menstruation, circle '1.' If she says the health worker told her to come back if she was feeling unwell because of the method, also circle '1.'

Qs. 325 and 326: TOLD ABOUT OTHER AVAILABLE METHODS

These questions are an attempt to find out whether the respondent was told about other methods by the person who provided the current method. As in Qs. 322 and 323, Q. 325 refers to the current method, and Q. 326 is only asked if the response in Q. 325 is NO.

Q. 329: SOURCE FOR FAMILY PLANNING METHOD

This question is asked to women who have never used contraception. Ask the respondent whether she knows of a place where she can obtain a family planning method if she wants to use it. If the answer is YES, circle '1' and ask Q. 330. Otherwise, circle '2' and skip to Q. 331.

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Q. 330: SOURCE FOR METHOD

Record the response in two ways—write the name of the place provided on the questionnaire, and circle the code that indicates the type of place it is. Determine whether the place is run by the government (in the public sector) or in the private sector, and circle the appropriate code.

The broad coding categories need to be retained, but the specific categories may be revised based on the local situation.

Q. 330A: SOURCE NATURAL FAMILY PLANNING METHOD

As in Q. 329, this question is asked to women who have never used contraception. Ask the respondent whether she knows of a place where she can obtain a natural family planning method. Natural family planning methods include lactational amenorrhea method (LAM), rhythm/fertility-based awareness method, the Standard Days Method, or withdrawal. If the answer is YES, circle '1' and ask Q. 330B. Otherwise, circle '2' and skip to Q. 331.

Q. 330B: SOURCE FOR NATURAL METHOD

Record the response in two ways—write the name of the place provided on the questionnaire, and circle the code that indicates the type of place it is. Determine whether the place is run by the government (in the public sector) or in the private sector, and circle the appropriate code.

The broad coding categories need to be retained, but the specific categories may be revised based on the local situation.

Q. 331: VISITED BY FIELDWORKER

This question is asked to ascertain whether any fieldworker visited the respondent in the last 12 months and talked to the respondent about family planning. It does not matter whether it was a family planning worker, a health worker, or some other type of fieldworker, as long as family planning was discussed during the visit. It also does not matter whether the principal purpose of the visit was to give family planning advice or services. If any fieldworker talked to her about family planning in the last 12 months, circle '1' for YES.

Q. 332: VISITED HEALTH FACILITY IN PAST YEAR

This question refers specifically to the respondent and whether she went to a health facility for any purpose in the past 12 months for care for herself or her children. The visit did not have to be specifically for family planning. However, if the only visits she made were to accompany a friend, neighbor, or relative, circle '2' for NO.

Q. 333: FAMILY PLANNING INFORMATION AT THE HEALTH FACILITY

The respondent need not have gone to the health facility for the purpose of discussing family planning for the answer to be YES. Staff persons may take the opportunity to discuss family planning even if a client comes to the facility for another purpose. If any staff member at the health facility talked to her about family planning during any of her visits, circle '1' for YES.

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Q. 334: FILTER FOR STANDARD DAYS METHOD

This question is a filter for women who have used the Standard Days Method. If the respondent answered YES to Q. 301(13) OR Q. 302(13), proceed to Q. 401. If the respondent answered NO to Q. 301(13) AND Q. 302(13), then skip to Q. 515.

D. SECTION 4: STANDARD DAYS METHOD MODULE

The objective of this section is to obtain information related to the Standard Days Method. This is a particularly important section, and you need to be careful to obtain all the required information. The information obtained in this section is critical to evaluate the effectiveness of implementing the Standard Days Method.

At first you may feel embarrassed to talk about and describe the Standard Days Method, but remember, if you are embarrassed, you may increase the embarrassment of the respondent. You should keep from smiling or giggling so that you encourage her to be direct and to feel more comfortable talking with you about this subject.

The respondent may not always understand what you are talking about when you describe the method. In such cases, repeat the description. If she still does not understand, you may need to explain the method in different words or in slightly greater detail. For this, you need to have some knowledge of the Standard Days Method yourself and must be familiar with names that people use to refer to the method.

First, we want to record the respondent's spontaneous responses to questions 401, 402, and 403. Read the instructions in Q. 401, "Now let's talk about the Standard Days Method. What is the Standard Days Method? How does it work?" and record the respondent's spontaneous responses. Circle Code '1' and check the box "SPONTANEOUS" for each item spontaneously mentioned.

If the respondent does not answer or has finished, proceed down the list and ask "Did you know that the Standard Days Method"? for each item that did NOT receive a spontaneous response. Circle code '1' if the prompted response is YES and '2' if the response is NO. Ask all questions 401-403 for those items where the "SPONTANEOUS" box has not been checked.

Qs. 401(01)-401(03): KNOWLEDGE OF STANDARD DAYS METHOD

Read instructions in Q. 401: "Now let's talk about the Standard Days Method". Then ask: "What is the Standard Days Method? How does it work?" Wait for the woman to tell you what she knows about the Standard Days Method. For all responses spontaneously mentioned, circle Code '1' and check the box "SPONTANEOUS".

After you have recorded all spontaneous responses FOR Qs. 401-403, ask the respondent "Did you know that the Standard Days Method (INSERT EACH QUESTION)?" For example, if the respondent did not mention "fertility awareness, rhythm, or 'risky days' method" spontaneously, ask her about it now by reading the question: "Did you know that the Standard Days Method is a fertility awareness, rhythm, or 'risky days' method?" If she responds YES, circle "1". If she responds NO, circle "2". Repeat this for each question regarding knowledge of the Standard Days Method.

Qs. 402(01)-402(03): ELIGIBILITY FOR STANDARD DAYS METHOD

Read the statement at the top of the table: "Who can use the Standard Days Method?" Wait for the woman to tell you who can use the Standard Days Method. For all responses spontaneously mentioned, circle code '1' and check the box "SPONTANEOUS".

After you have recorded all spontaneous responses for Qs. 401-403, ask the respondent "Did you know that the Standard Days Method (INSERT EACH QUESTION)?" For example, if the respondent did not mention "Requires a 26-32 day menstrual cycle" spontaneously, ask her about it now by reading the question: "Did you know that the Standard Days Method requires a 26-32 day menstrual cycle?" If she responds YES, circle "1". If she responds NO, circle "2". Repeat this for each question regarding eligibility for using the Standard

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Days Method.

Qs. 403(01)-403(07): HOW USE STANDARD DAYS METHOD

Read the statement at the top of the table: “How is the Standard Days Method used?” Wait for the woman to tell you how the Standard Days Method is used. For all responses spontaneously mentioned, circle Code ‘1’ and check the box “SPONTANEOUS”.

After you have recorded all responses mentioned spontaneously for Qs. 401-403, ask the respondent “Did you know that the Standard Days Method (INSERT EACH QUESTION)?” For example, if the respondent did not mention “Requires abstinence or use of condom in the fertile days” spontaneously, ask her about it now by reading the question: “Did you know that the Standard Days Method requires abstinence or use of condom in the fertile days?” If she responds YES, circle “1”. If she responds NO, circle “2”. Repeat this for each question regarding how to use the Standard Days Method.

Qs. 404(01)-404(12): OPINION OF STANDARD DAYS METHOD

Respondents' opinion of the Standard Days Method is important. The opinion of others does not matter for these questions; we are interested in the woman's own opinion about the method. Make sure to probe the respondent to ensure that responses are the woman's opinion, and not her husband or family's opinion.

Read the statement in Q. 404: “Now, I would like to ask you about your opinion of the Standard Days Method.” Then read: “In your opinion, is/does the Standard Days Method (INSERT QUESTION)?” For example, for Q. 404(01), ask: “In your opinion, is the Standard Days Method easy for you to understand?” If the respondent replies YES, circle ‘1’; if the respondent replies NO, circle ‘2’; and if the respondent replies DON'T KNOW, circle ‘3’. Repeat this for each question on women's opinion of the Standard Days Method.

Q. 404a: STANDARD DAYS METHOD ACCEPTABLE TO RESPONDENT

The acceptability of the Standard Days Method is important to understand. If the method is acceptable, more couples are likely to use it.

Q. 405: STANDARD DAYS METHOD ACCEPTABLE TO PARTNER

This question is about the acceptability of the Standard Days Method to the respondent's partner. If the respondent thinks that the method is acceptable for her partner, she may be more likely to use the method.

Q. 406: FILTER FOR USING SDM

This question is a filter to identify those women currently using the Standard Days Method. Check Q. 311. If the respondent is currently using the Standard Days Method (‘M’ is circled), check the box on the right “CURRENTLY USING THE STANDARD DAYS METHOD”, then skip to Q. 411. If the respondent is not currently using the Standard Days Method (‘M’ is NOT circled), check the box on the left “NOT CURRENTLY USING THE STANDARD DAYS METHOD”, and proceed to Q. 407.

Q. 407 and Q. 408: SDM MEET FAMILY PLANNING NEEDS IN FUTURE

This is a question about whether the respondent feels that the Standard Days Method would meet her needs for family planning in the future, and the reasons why the Standard Days Method may not meet those future needs. This information is important to understand the barriers to use of the method in the future. Record as

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many reasons as the woman mentions.

If the woman's main reason is not listed as a response, write her response on the OTHER line and circle '8'.

Q. 409 and Q. 410: HUSBAND APPROVE FUTURE USE OF SDM

Q. 409 is a question about whether the respondent feels that her husband would approve of using the Standard Days Method, if she chose to use the method in the future. If the respondent's husband does not approve of future use of the method, Q. 410 asks for reasons why. This information will be useful in understanding barriers women may face in adopting the Standard Days Method in the future. Record as many reasons as the woman mentions.

If the woman's main reason is not listed as a response, write her response on the OTHER line and circle '6'.

Q. 411: SEEK ADDITIONAL INFORMATION IN FUTURE

This question should be asked to respondents currently using the Standard Days Method and those not currently using the method. It refers to the respondent's plans to seek additional information about the Standard Days Method from her family planning provider in the future. Understanding where women will seek information in the future is an important element of program planning and implementation.

Q. 412: SOURCE OF INFORMATION ON STANDARD DAYS METHOD

This question asks about who told the woman about the Standard Days Method. Read the question and record all responses that the respondent gives spontaneously, but do not read the responses to the woman. Afterwards, ask the respondent "Anyone else?" and circle all responses given. If the woman's main source of information is not listed as a response, write her response on the OTHER line and circle '5.' If the woman does not know at all who told her about the Standard Days Method, record CAN'T REMEMBER/DON'T KNOW and circle '6'.

Q. 413: WHERE RECEIVE INFORMATION ON STANDARD DAYS METHOD

This question asks the respondent where she received information about the Standard Days Method. Read the question and record all responses that the respondent gives spontaneously, but do not read the responses. If the woman's main source of information is not listed as a response, write her response on the OTHER line and circle '11'. If the woman does not know at all where she received information about the Standard Days Method, record DON'T KNOW and circle '10'.

Responses will be based on country specific information.

Qs. 414 and Q. 415: LOCATION TO RECEIVE STANDARD DAYS METHOD

This question asks if the respondent knows where to get the Standard Days Method. If the response is YES, proceed with Q. 415. If the response is NO, skip to Q. 416.

For Q. 415, read the question and record all responses that the respondent gives spontaneously, but do not read the responses. If the woman's main source is not listed as a response, write her response on the OTHER line and circle '16'.

Qs. 416 and Q. 417: DISCUSSIONS ABOUT STANDARD DAYS METHOD

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We are interested in knowing with whom the respondent discussed the Standard Days Method. In Q. 416, you are asking whether the respondent has discussed the method with anyone in the last few months prior to the interview. In Q. 417, you are asking who the respondent discussed the method with. It does not matter who initiated the discussion, and it does not matter whether the discussants approved or disapproved of family planning or the Standard Days Method. If the woman responds YES to Q. 416, ask her in Q. 417 to specify with whom she had the discussions. Circle all persons with whom she discussed the Standard Days Method over the last few months. If the woman mentions someone who is not included in the list of responses, circle '9', and write the response on the line marked OTHER.

Q. 418: KNOW OTHERS USING STANDARD DAYS METHOD

Q. 418 is a filter and a question. Check Q. 311. If the woman is not currently using the Standard Days Method ('M' is not circled), check the box on the left and ask the question "Do you know anyone who is using or has used the Standard Days Method?"

If the woman is currently using the Standard Days Method ('M' is circled), check the box on the right and ask the question "Do you know anyone else who is using or has used the Standard Days Method?"

E. SECTION 5: MARRIAGE AND SEXUAL ACTIVITY

GENERAL COMMENTS: Qs. 515-516 and 524-526 ON SEXUAL INTERCOURSE AND CONDOM USE

The purpose of these questions about sexual intercourse is to determine the respondent's exposure to pregnancy, since fertility levels are directly related to the frequency of intercourse. Condom use is of interest because it can help reduce the risk of transmission of AIDS and other sexually transmitted infections. In addition, condoms are an effective method to prevent pregnancy during fertile days for women using the Standard Days Method. These questions may be embarrassing for some respondents; therefore, ask them in a matter-of-fact voice and do not make the respondent feel embarrassed by your own behavior. A common reaction for people who are embarrassed is to giggle or laugh. If you laugh in return or act as if you are embarrassed too, it will make the respondent think that the questions are not serious. Make sure you maintain a serious attitude.

Q. 515: TIME OF LAST INTERCOURSE

Fill in the respondent's answer in the space according to the units that she uses. For example, if she says "three weeks ago," circle '2' and write '03' in the boxes next to WEEKS AGO. If she says "four days ago," circle '1' and write '04' next to DAYS AGO. If the respondent appears to be rounding off her answer, probe for an exact answer. For example, if she says "about a week ago," ask, "Do you remember which day? Was it before or after the weekend?"

In some cases, you may have to convert a respondent's answer. For example, if she says, "last night," circle '1' and write '00' for DAYS AGO. If she has not yet resumed intercourse since she had her last child, ask the age of her last child and how long before the birth of that child she had sex the last time. The YEARS AGO row should be used only if the last intercourse was at least one year ago. In other words, there should never be a response 00 YEARS AGO.

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Q. 516: CONDOM USED AT LAST INTERCOURSE

Condom use is of interest because if used correctly, condoms can reduce the risk of transmission of AIDS and other sexually transmitted infections. In addition, condoms can be used to prevent pregnancy during the fertile days for women using the Standard Days Method. Circle the appropriate code and continue with Q. 524.

Qs. 524 and 525: KNOWLEDGE OF SOURCE FOR CONDOMS

Question 524 asks about the respondent's knowledge of a source for condoms. You will be asking this question of both women who have used condoms and women who have not used condoms. If a respondent insists she has never used condoms and therefore cannot answer this question, explain that we simply want to know whether she is aware of a source for condoms. For example, if someone asked her for advice on where to obtain condoms, could she tell them where to go?

Record her response to Q. 525 in two ways: if it is a hospital, health center, or clinic, write the name of the place in the space provided on the questionnaire, and circle the code that indicates the type of place it is. It is not necessary to write the name of the source if it is a private doctor, fieldworker, pharmacy, shop, church, or friend or relative. When choosing a code, you need to know whether the place is in the public (run by the government) or private sector. If the respondent does not know whether the place is governmental or private, inform your supervisor after you complete the interview. Since you have recorded the name of the place, your supervisor will be able to learn what type of place it is from other people in the area.

If the woman tells you that she could get condoms from a doctor, ask her where the doctor is located. If she replies that the doctor is located in a hospital, ask her for the name of the hospital, and write it down. Then ask her whether it is run by the government or is privately owned. Record PRIVATE DOCTOR only if the doctor has his own practice that is not located within a larger facility.

If she mentions more than one place where she can get condoms, record all her answers since this is a multiple-response question.

Coding categories will be developed locally, but the broad categories must be maintained.

Q. 526: COMFORTABLE TO GET CONDOMS

We want to know whether the respondent is comfortable getting a condom herself if she wanted to. The comfort level of a woman to get a condom can be viewed as a measure of her independence.

Q. 527: ABILITY TO GET CONDOMS

We want to know whether the respondent able to get a condom herself if she wanted to. The ability of a woman to get a condom can be viewed as a measure of her independence.

F. SECTION 6: FERTILITY PREFERENCES

This section gathers information on desires for additional children, preferred birth intervals, attitudes toward family planning and family size, and unwanted pregnancies.

Q. 601: FILTER FOR WOMEN WHO ARE STERILIZED

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Check Q. 311/311A. If “A” or “B” is circled (FEMALE or MALE STERILIZED), skip to Q. 614. If neither “A” nor “B” is circled, continue with Q. 602.

Q. 602: PREFERENCE FOR ADDITIONAL CHILDREN

This question is a combination of a filter and a question. First, check Q. 226 to see whether the respondent is pregnant and mark the appropriate box. If she is not pregnant or unsure, ask the question on the left as follows: “Now I have some questions about the future. Would you like to have (a/another) child or would you prefer not to have any (more) children?” If she is pregnant, you will have to word the question differently saying, “Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer to not have any more children?” Note that we want to make sure that pregnant women do not think that we are asking them whether they want the child they are pregnant with now.

If the respondent would like to have a/another child, circle ‘1’ and proceed to Q. 603. If the respondent says that she doesn’t want more/no children, circle ‘2’ and skip to Q. 604. If the respondent says that she can’t get pregnant, circle ‘3’ and skip to Q. 614. If the respondent is undecided, there are two choices. If she is pregnant, circle ‘4’ and skip to Q. 610. If the respondent is not pregnant or not sure whether she is pregnant, circle ‘5’ and go to Q. 608.

Q. 603: TIME TO WAIT

Follow the same procedure as in Q. 602 for choosing the appropriate question to ask. Question 603 is to be asked of all women who say that they want to have another child. Note that the answer can be given in months or years. Circle ‘1’ if the response is in months or ‘2’ if in years, and record the answer in the appropriate boxes. If she says she would like to have a baby right away, record SOON/NOW. If the woman says she cannot get pregnant, circle ‘994’, and skip to Q. 614. If the woman tells you she would like to wait until after she is married to have a child, record AFTER MARRIAGE. If the woman gives a different answer, circle ‘996’ and write her response in the OTHER category.

Q. 605: FILTER FOR USING A METHOD

Check Q. 310. If you completed Section 3 correctly, then Q. 310 will be either YES because the woman is currently using a method of family planning; NO because she has used a method of family planning at some time in the past, but she is not currently using a method; or blank because it was not asked. If after checking Q. 310 you see YES recorded, you will mark the box on the right in this question for CURRENTLY USING. If after checking Q. 310 you see NO recorded, you will mark the box in the middle for NOT CURRENTLY USING. If after checking Q. 310 you see that it was not asked (she is either pregnant, sterilized, or has never used a method), you will mark the box on the left for NOT ASKED.

Q. 606: FILTER FOR TIME TO WAIT

Check Q. 603. If Q. 603 was not asked, you will mark the box on the left. If the woman gave a numeric response, check the number of months or years she would like to wait. If it is either 24 or more months or 02 or more years, you will mark the box in the middle. If the number is either 00 to 23 months or 00-01 year, you will mark the box on the right, and skip to Q. 610.

Q. 607: REASON FOR NOT USING A METHOD

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Check the woman's response in Q. 602. If she says that she wants to have a/another child (code '1' is circled), mark the box on the left and ask the question under that box. If she wants no (more) children (code '2' circled), mark the box on the right and ask the question under that box. There are many reasons that a person may not be using a family planning method, so listen to your respondent carefully. Record as many reasons as the woman mentions.

Code INFREQUENT SEX if the respondent says she is not sexually active enough to be using a method (NOT HAVING SEX would be appropriate if she says she is not sexually active at all).

MENOPAUSAL means she is no longer menstruating and therefore cannot get pregnant, and HYSTERECTOMY is an operation to remove her uterus.

Code SUBFECUND/INFECUND if she thinks she cannot get pregnant (not including being menopausal). If the respondent says she is not using because she has not resumed menstruation since her last birth, record POSTPARTUM AMENORRHEIC.

FATALISTIC means that the respondent feels that the pregnancy is predetermined by fate and she has no control over pregnancy.

RESPONDENT OPPOSED means that the respondent herself does not approve of family planning. If her husband or partner is opposed to family planning, circle the code for HUSBAND/PARTNER OPPOSED. If she says she is not using because someone other than her husband or partner tells her they are opposed to her using family planning, code OTHERS OPPOSED.

RELIGIOUS PROHIBITION means that she feels her religion does not allow the use of family planning. SIDE EFFECTS are undesirable consequences of using a method that do not adversely affect the health of the user. For example, side effects may be spotting or bleeding with the pill, while HEALTH CONCERNS may be that she heard that the pill may be linked to breast cancer.

INCONVENIENT would be if she considers the family planning method to be too troublesome to use, such as being messy. This is inconvenient to use, but not inconvenient to get the method, since LACK OF ACCESS/TOO FAR is a separate category.

If the woman's main reason is not listed as a response, write her response on the OTHER line and circle 'X.' If the woman does not know at all why she is not using contraception, record DON'T KNOW.

Q. 608: PROBLEM IF PREGNANT

This question is only asked of women who are not pregnant or who are unsure whether they are pregnant. Be certain to finish asking the entire question before accepting a response.

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Q. 610: INTENT TO USE FAMILY PLANNING IN THE FUTURE

This question is for all women who are currently not using a method of family planning and women who were not asked about current family planning use because they were pregnant at the time of the interview. The purpose of this question is to see whether the respondent has any intention of using a method of family planning at any time in the future.

Q. 611: PREFERRED METHOD

This question is for women who think they will use a method of family planning in the future. If the respondent mentions more than one method, ask her which one she prefers most; if she cannot make a choice, then circle the method that is higher on the list.

Q. 612: REASON FOR NOT INTENDING TO USE

This question is asked of women who are not currently using a method and do not intend to use a method in the future. There are many reasons that a person may not use contraception, so listen to your respondent carefully. Record what the respondent considers to be her main reason for not intending to use family planning.

Only record NOT MARRIED if the respondent offers this as her reason for not intending to use a method. If the woman's main reason is not listed as a response, write her response in the OTHER category and circle '96.' If the woman does not know at all why she will not use contraception, record DON'T KNOW.

Q. 614: PREFERRED NUMBER OF CHILDREN

Check Q. 216 to see whether the woman has any children who are alive. Mark the box on the right if she has no living children, or mark the box on the left if she has at least one living child. Ask the question under the marked box. If she already has living children, we ask her to imagine the time when she had no children and could choose exactly how many to have. We are not asking how many she would like to have by her current age (now), but rather, how many she would like over her entire life (including the future).

If she tells you a number, record it in the boxes by NUMBER, then proceed to Q. 615. If she gives an answer that is not a number, for example, "It's up to God," probe for a numeric response. If after probing, the woman will not state a number, write down her exact words in the OTHER category, and skip to Q. 616.

Q. 616: APPROVAL OF FAMILY PLANNING

This is the woman's own opinion, regardless of whether or not she herself is using a method.

Q. 617: HEARD FAMILY PLANNING MESSAGE?

We are interested in any information about family planning, whether it is a program concerned with giving information about family planning, an advertisement about family planning, or a speech in which family planning is mentioned. Read the introductory question and then each line; wait for her response and code it before moving on to the next line. There must be an answer coded for each line; do not leave any blank.

Country-specific codes will be added based on local situation.

Q. 618: COUNTRY-SPECIFIC QUESTIONS ON FAMILY PLANNING MESSAGES

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Qs. 619 and 620: DISCUSSED FAMILY PLANNING WITH OTHERS

In Q. 619 you are asking whether the respondent has discussed family planning with any friends, neighbors or relatives within the last few months prior to the interview. It does not matter who initiated the discussion, and it does not matter whether the discussants approved or disapproved of family planning. If the woman responds YES to Q. 619, ask her in Q. 620 to specify with whom she had the discussions. Circle all persons with whom she discussed family planning over the last few months.

Q. 623: DECISION TO USE CONTRACEPTION

In this question, we want to know whether the woman participated in the decision to use family planning, which would indicate that she exercised her right to control and monitor her reproductive health. Read the entire question before accepting a response. Question 623 is asked only of women who are currently using contraception. If the respondent says that someone other than her husband or partner or she made the decision, such as a doctor or a nurse, circle '6' and write her answer in the space provided.

Q. 624: PARTNER'S ATTITUDE TOWARD FAMILY PLANNING

This question asks the woman what she thinks her husband's or partner's attitude is toward family planning. It does not matter in this question whether or not the couple has recently discussed family planning; this is simply the woman's opinion of her husband's or partner's attitude.

Q. 625: DISCUSSION OF FAMILY PLANNING IN PAST YEAR

We are interested in knowing whether, and how often, the respondent and her husband or partner have discussed family planning in the past year.

Q. 627: HUSBAND'S AND WIFE'S PREFERENCE FOR CHILDREN

This question asks for the woman's opinion of her husband's preference compared with her own preferences. Read the entire question before accepting a response.

G. SECTION 7: HUSBAND'S BACKGROUND AND WOMAN'S WORK

In this section, if the woman has been married more than once, ask about her most recent husband or partner.

Q. 702: HUSBAND'S AGE

If you have difficulty obtaining the husband's age, use the same methods to probe for his age as described in Q. 106 for obtaining her age.

Qs. 703-705: HUSBAND'S EDUCATION

These questions are identical to Qs. 107-109, which were asked of the respondent. Again, note that in Q. 704, you record the highest level attended, and in Q. 705, you record the highest grade, form, or year completed at that level.

Q. 706: HUSBAND'S CURRENT (OR MOST RECENT) TYPE OF WORK

APPENDIX E: Interviewer's Manual – Women's Questionnaire

Chose the response that most closely resembles the respondent's answer. Probe for more detail if necessary. If you are not sure how to record the response, circle '7' and specify on the line marked OTHER.

"Not currently working" is not an acceptable response. If he is unemployed, get a description of his most recent job. If he does more than one job, write down what he does most of the time. If he is not working because he is in school, write "student" on the line marked OTHER.

Qs. 707-710: EMPLOYMENT

In this section, we are not asking about housework but about other work a woman may do. If the respondent answers YES she does work to Q. 707, skip to Q. 710. If in Q. 707 the respondent answers NO she is not working, ask Q. 708. It often happens that women who sell things, or work on the family farm, will not consider what they do work, especially if they do not get paid for the work. Read the introductory sentences of Q. 708 so the respondent understands what we mean by "work." Be careful to follow the skip patterns in Q. 708 and Q. 709.

Q. 717: CONTROL OVER MONEY EARNED

This is a single response question that asks who mainly decides how the money she earns will be used. The word 'jointly' refers to the respondent's making the decisions jointly with her husband or partner (code '3') or with someone else (code '5'). If the husband decides by himself, circle '2.' If the respondent is not involved in the decision and her mother-in-law makes the decision, circle '4' for SOMEONE ELSE.

H. SECTION 8: ATTITUDES TOWARDS GENDER ROLES

The objective of this section is to obtain information on attitudes toward gender roles. This is a particularly important section, and you need to be careful to obtain all the required information. The information obtained in this section is critical to evaluate the effectiveness of implementing the Standard Days Method.

At first you may feel embarrassed to talk about and describe the questions which ask about sexual habits and preferences. If you are embarrassed, you may increase the embarrassment of the respondent. You should keep from smiling or giggling so that you encourage her to be direct and to feel more comfortable talking with you about this subject. It is very important that respondents feel comfortable enough to answer these questions honestly and truthfully. Take care to make sure that the respondent is comfortable, and read each question slowly. You may have to re-read or explain certain questions.

These questions are about the respondent's own thoughts and attitudes. Make sure and probe to ensure that she is giving her own ideas, and not the thoughts or attitudes of her husband or other family members.

Q. 801: GREATER SAY IN DECISIONS

In Question 801, we are interested in learning who has the greater say in certain decisions. Read the introductory question and then each line; wait for her response and code it before moving on to the next line. There must be one answer coded for each line; do not leave any blank.

For example, if the respondent answers HUSBAND to Q. 801(b), circle '1', and then ask Q. 801(c), "deciding when to visit family, friends or relatives." If the respondent answers "BOTH EQUALLY", then circle '3', and if she doesn't know or says that it depends, then circle '8'.

APPENDIX E: Interviewer's Manual – Women's Questionnaire

Q. 802: HUSBAND JUSTIFIED TO HIT WIFE

In Question 802, we are interested in learning the respondent's attitude toward whether or not a husband is justified in hitting or beating his wife in certain situations. Read the introductory question and then each line; wait for her response and code it before moving on to the next line. There must be one answer coded for each line; do not leave any blank.

Q. 803: ASK HUSBAND TO USE A CONDOM

This question is very important to better understand women's attitudes toward asking husbands to use condoms if the woman thinks that her husband has a sexually transmitted disease. You may be embarrassed to ask the respondent this question, you should keep from smiling or giggling to make sure that the respondent is comfortable in answering the question.

Q. 804: WIFE JUSTIFIED IN REFUSING SEX

The ability to refuse sex during fertile days is an important aspect of the Standard Days Method. If women do not feel as though they can refuse sex during this period, the method will not work and the woman may become pregnant. Question 804 asks if the respondent feels as though a wife is justified in refusing to have sex with her husband in certain situations. Read the introductory question and then each line; wait for her response and code it before moving on to the next line. There must be one answer coded for each line; do not leave any blank.

In polygamous societies, Question 404(c) should be replaced with the phrase "women other than his wives".

Q. 805: REFUSAL TO HAVE SEX

The ability to refuse sex during fertile days is an important aspect of the Standard Days Method. Question 805 asks if the respondent thinks that if a woman refuses to have sex with her husband when he wants her to, then he has the right to do certain things. Read the introductory question and then each line; wait for her response and code it before moving on to the next line. There must be one answer coded for each line; do not leave any blank.

Q. 805: TIME INTERVIEW ENDED

Do not forget to write the time when you finished the interview, using the 24-hour system. If there was an extended break during the interview time; for example, the respondent excused herself to care for a sick child and returned to complete the interview 45 minutes later, make a note to report how long a break was taken.

Be sure to thank the respondent for her cooperation. At this point, check your questionnaire carefully. Before leaving the house, make sure you have followed the skip patterns correctly and that your marks are legible.

I. INTERVIEWER'S OBSERVATIONS

After you have checked over your questionnaire and thanked the respondent, note any comments on the last page. You may make comments about the woman you interviewed, about specific questions on the questionnaire, or about any other aspects of the interview. If anything about the interview was unusual or should be brought to the attention of the editor or supervisor, note it here. Even if the interview was

APPENDIX E: Interviewer's Manual – Women's Questionnaire

straightforward, a few comments on each interview will be helpful in editing and processing the questionnaires. For example, if a respondent attended school in a different country—one with a different system for dividing grades into primary and secondary—note that here. You may wish to explain why a result code was other than '1.' If answers that were not precoded require further explanation, use this space. All these comments are helpful to the editor, supervisor, and data processing staff in interpreting the information in the questionnaire.

APPENDIX E: Interviewer's Manual – Women's Questionnaire

¹ Wilcox AJ, Weinberg CR, Baird DD. Timing of sexual intercourse in relation to ovulation: Effects on the probability of conception, survival of the pregnancy, and sex of the baby. *New England Journal of Medicine* 1995; 333: 1,517-1,521.

² Wilcox AJ, Weinberg CR, Baird DD. Post-ovulatory ageing of the human oocyte and embryo failure. *Human Reproduction* 1998; 13: 394-397.

Georgetown University – Center for Reproductive Health

Impact Study of the Standard Days Method

Supervisor's Manual Women's and Men's Questionnaires

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NOTE TO SURVEY ORGANIZERS: HOW TO USE THIS MANUAL

This manual is designed to explain to field supervisors and field editors how to do their jobs. The instructions for both positions have been combined into one manual because supervisors and field editors are expected to share many activities, e.g., editing questionnaires and tracking interviewers' performance.

The most responsible and mature field staff should be appointed to the positions of field supervisor and field editor. Supervisors can be either male or female. It is usually desirable that field editors be women, since they will be observing interviews with female respondents about personal topics having to do with family building and child care. The first opportunity for the training of supervisors and field editors occurs with the pretest of the questionnaire. If at all possible, staff who will be supervisors and field editors during the main survey should participate in the pretest. They should attend all pretest training sessions, and female supervisors and field editors should get experience as interviewers during the pretest. This will provide a thorough knowledge of and experience with the questionnaire even before the training of field staff for the main survey.

In cases in which supervisors and field editors have been designated prior to the interviewer training, it is important that they participate in the interviewer training for the main survey. Active involvement of supervisors and field editors in interviewer training is necessary for an understanding of the role of the interviewer and the problems teams may encounter during fieldwork. Supervisors and field editors should participate with interviewer trainees in "role playing" interviews and supervise the practice interviewing in the field prior to the start of fieldwork. The latter activity gives supervisors, editors, and interviewers experience in working together as a team.

In other cases, the final selection of supervisors and field editors will be made after completion of interviewer training. In either case, after interviewer training and prior to the beginning of fieldwork for the main survey, two to three days of additional training should be provided on the specific duties of supervisors and field editors. This is to ensure that all teams will be following a uniform set of procedures. The additional training is particularly important for individuals who did not participate in the pretest but were selected to be supervisors or field editors at the conclusion of interviewer training. It is at this additional training that this manual will be discussed in detail.

APPENDIX F: Supervisor’s Manual – Women’s and Men’s Questionnaires

I. INTRODUCTION TO THE SURVEY TO MEASURE THE IMPACT OF THE STANDARD DAYS METHOD

The survey entitled “Impact Study of the Standard Days Method” is a representative community-based survey designed to provide information on maternal health, reproduction, and awareness and use of family planning methods, including the Standard Days Method (SDM) in [Country]. The survey will involve interviewing a randomly selected group of married women who are between 15 and 49 years and a randomly selected group of married men.

The Standard Days Method is a fertility awareness-based method developed and tested by the Institute for Reproductive Health at Georgetown University that is appropriate for women with regular menstrual cycles between 26 and 32 days long. It identifies days 8 to 19 of the menstrual cycle as the “fertile window”, i.e., the days when pregnancy is very likely. To prevent pregnancy, the couple avoids unprotected intercourse during the 12-day fertile window. The 12 days take into account the life span of the woman’s egg, the viable life of sperm, and the variation in the actual timing of ovulation from one cycle to the next.^{1,2}

Most women who use the SDM find that CycleBeads, a visual aid that represents the menstrual cycle, are helpful for learning and using the method. CycleBeads, a color-coded string of beads representing the menstrual cycle, help a woman know which day of her cycle she is on, and identify whether she is on a day when she is likely to get pregnant.

SDM introduction studies were conducted in the Philippines, India, Bolivia, Peru, El Salvador, Honduras, Guatemala, Ecuador, Rwanda, and Benin. After one year of introduction, family planning agencies and Ministries of Health around the world report that the SDM represents between two to seven percent of new family planning users. In Rwanda, for example, where contraceptive prevalence does not reach 5 percent, service statistics show that SDM users accounted for about 7 percent of all the new users of modern family planning methods at the research sites.

The next step in the development and introduction of the SDM is expanding interventions to introduce SDM on a larger scale in delivery systems and communities. This survey will measure the impact of the Standard Days Method at the community level.

Women and men included in the survey will be asked questions about their background, the children they have given birth to, their knowledge and use of family planning methods, including the Standard Days Method, reproductive health, and other information that will be helpful to policymakers and administrators in health and family planning in expanding access to the Standard Days Method.

Field supervisors and field editors for the Standard Days Method survey have an important position. They are the primary links between the director of field operations and the interviewers. As such, they are responsible for ensuring both the quality and progress of fieldwork.

This manual has been prepared to provide the information needed by field supervisors and field editors to carry out their duties. Candidates for the positions of field supervisor and field editor for the survey should study this manual carefully during their training. They should also study the Interviewer’s Manual (for both Women’s and Men’s Questionnaires) since it is necessary for them to thoroughly understand the questionnaires and the procedures for completing it. Individuals selected to serve as supervisors and field editors should continue to refer to these manuals throughout the fieldwork period.

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A. SURVEY OBJECTIVES

The survey to measure the Impact of the Standard Days Method will be implemented in several countries. The objectives of the survey are to:

- Measure awareness of the Standard Days Method as a contraception option among women and men in the study area.
- Measure attitudes toward the Standard Days Method among men and women in the study area. Awareness will not lead toward acceptance if women perceive the method as difficult to use and/or their partners are reluctant to use it. Men's cooperation is expected to be fundamental both for adoption of the method by the couple and strengthening of the method's positive image in the community.
- Measure women's knowledge of fertility cycle in the study area.
- Measure the prevalence of the Standard Days Method at the community level.
- Provide similar information across several countries to assess the impact of the Standard Days Method.

Data from the survey will be used by program planners and policymakers to evaluate the impact of the Standard Days Method as a family planning option.

B. SURVEY ORGANIZATION

The survey to measure the impact of the Standard Days Method is a comprehensive survey involving several agencies and many individuals. [Name of organization] has the major responsibility for conducting the survey. In addition, there will be other surveys at the health facilities to assess provider behaviors in administering the SDM as a family planning option.

[Describe participation of other organizations or committees that are involved in designing or implementing the survey.]

[Description of survey organization, naming the project director, deputy director, and fieldwork coordinators. Should be similar to what is presented in the Interviewer's Manual but with specific clarification of how supervisors and field editors relate to senior survey staff and lines of authority.]

Each field supervisor will be responsible for one team consisting of one field editor, [four] interviewers, [and one driver]. He/she will be assisted by the field editor, who will be in charge in the absence of the supervisor. Field supervisors may be either male or female; however, field editors should be female since they will be observing interviews with female respondents about personal topics. As the workload of the field supervisor and the field editor will vary from day to day, it is expected that they will assist each other in completing their respective duties.

C. TRAINING

It is important that field supervisors and field editors attend the interviewer training for the main survey.

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Supervisors and field editors should not skip any of the training sessions, even if they participated in the pretest. Active involvement of supervisors and field editors in interviewer training is necessary for an understanding of the role of the interviewer and the problems teams may encounter during fieldwork. Supervisors and field editors should participate with interviewer trainees in “role playing” interviews and supervise the practice interviewing in the field prior to the start of fieldwork. The practice interviewing gives supervisors, field editors, and interviewers experience in working together as a team.

After interviewer training, two to three days of additional training will be provided on the specific duties of supervisors and field editors. This is to ensure that all teams will be following a uniform set of procedures and to teach supervisors and editors how to check the fieldwork and edit completed questionnaires.

D. RESPONSIBILITIES OF THE FIELD SUPERVISOR

The field supervisor is the senior member of the field team. He/she is responsible for the well-being and safety of team members, as well as the completion of the assigned workload and the maintenance of data quality. The supervisor receives his/her assignments from and reports to the [field coordinator/project director]. The specific responsibilities of the supervisor are to make the necessary preparations for the fieldwork, to organize and direct the fieldwork, and to conduct periodic spotcheck reinterviews.

To prepare for fieldwork, the supervisor must—

- 1) Obtain sample household lists and/or maps for each area in which his/her team will be working.
- 2) Become familiar with the area where the team will be working and determine the best arrangements for travel and accommodations.
- 3) Contact local authorities to inform them about the survey and gain their support and cooperation.
- 4) Obtain all monetary advances, supplies, and equipment necessary for the team to complete its assigned interviews. Careful preparation by the supervisor is important for facilitating the work of the team in the field, for maintaining interviewer morale, and for ensuring contact with the central office throughout the fieldwork.

During the fieldwork, the supervisor will—

- 1) Assign work to interviewers, taking into account the linguistic competence of individual interviewers and ensuring that there is an equitable distribution of the workload.
- 2) Maintain fieldwork control sheets and make sure that assignments are carried out.
- 3) Regularly send completed questionnaires and progress reports to the central office and keep headquarters informed of the team's location.
- 4) Communicate any problems to the [field coordinator/project director].
- 5) [Take charge of the team vehicle, ensuring that it is kept in good repair and that it is used only for project work.]

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- 6) Arrange for lodging and food for the team.
- 7) Make an effort to develop a positive team spirit. A congenial work atmosphere, along with careful planning of field activities, contributes to the overall quality of the survey.

E. RESPONSIBILITIES OF THE FIELD EDITOR

The specific duties of the field editor are to monitor interviewer performance with the aim of improving and maintaining the quality of the data collected. Close supervision of interviewers and editing of completed interviews are essential to ensure that accurate and complete data are collected. Because the collection of high-quality data is crucial to the success of the survey, it is important that field editors are mature, responsible women (or men) who execute their duties with care and precision. This is especially important during the initial phases of fieldwork, when it is possible to eliminate interviewer error patterns before they become habits.

Monitoring interviewer performance requires that the field editor—

- 1) Observe at least one interview every day.
- 2) Edit all completed questionnaires in the field; editing must be completed prior to leaving the sample area. To the extent possible, the supervisor should assist the editor in performing this task so that all interviews are edited while still in the sample area.
- 3) Conduct regular review sessions with each interviewer and advise them of any problems found in their questionnaires.
- 4) Put completed questionnaires from a sample area in order and pack them up to be sent to the central office.

APPENDIX F: Supervisor's Manual – Women's and Men's Questionnaires

II. PREPARING FOR FIELDWORK

A. COLLECTING MATERIALS FOR FIELDWORK

Before leaving for the field, the supervisor is responsible for collecting adequate supplies of the materials the team will need in the field. These items are listed below:

Fieldwork documents:

- Supervisor's and Editor's Manual
- Men's Interviewer's Manual
- Women's Interviewer's Manual
- Maps and household listing forms for all clusters in the assigned area
- Letters of introduction to local authorities
- Women's and Men's Questionnaires in the appropriate languages
- Supervisor's/Editor's Assignment Sheets
- Interviewer's Assignment Sheets
- Interviewer Progress Sheets

Supplies:

- Blue pens for interviewers
- Red pens for the field editor and supervisor
- Clipboards, briefcases, and backpacks
- Paper clips, scissors, string, staplers and staples, cello tape, etc.
- Envelopes to store completed questionnaires
- First aid kit

Funds for Field Expenses:

- Sufficient funds to cover expenses for the team
- Funds for fuel and minor vehicle repairs
- [Funds for guides]
- [Funds for communicating with the central office]
- [Advances for per diem allowances for the team].

[Include a brief description of procedures for making periodic payments to the teams, including funds for fuel and vehicle repairs, guides, illnesses or injuries to team members, and communicating with the central office. Explain how and when advances for per diem allowances and salary payments will be made.]

B. ARRANGING TRANSPORTATION AND ACCOMMODATIONS

It is the supervisor's responsibility to make all necessary travel arrangements for his or her team, whenever possible, in consultation with the central office. [Vehicles are generally provided to transport the team to assigned work areas; however, in some cases, it may be necessary to arrange for other means of transportation. The supervisor is responsible for the maintenance and security of the team vehicle. The vehicle should be used exclusively for survey-related travel, and when not in use, it should be kept in a safe place. The driver of the vehicle takes instructions from the supervisor.]

In addition to arranging transportation, the supervisor is in charge of arranging for food and lodging for the

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team. If they wish, interviewers may make their own arrangements, as long as these do not interfere with fieldwork activities or break the team spirit. Lodging should be reasonably comfortable, located as close as possible to the interview area, and provide secure space to store survey materials. Since travel to rural clusters is often long and difficult, the supervisor may have to arrange for the team to stay in a central place.

C. CONTACTING LOCAL AUTHORITIES

It is the supervisor's responsibility to contact the regional, provincial, district, and village officials before starting work in an area. Letters of introduction will be provided, but tact and sensitivity in explaining the purpose of the survey will help win the cooperation needed to carry out the interviews.

D. CONTACTING THE CENTRAL OFFICE

Each supervisor should arrange for a system to maintain regular contact with the central office staff before leaving for the field. Regular contact is needed for supervision of the team by central office staff, payment of team members, and the return of completed questionnaires for timely data processing.

E. USING MAPS TO LOCATE CLUSTERS

A major responsibility of the field supervisor is to assist interviewers in locating households in the sample. The director of field operations/project director will provide the supervisor with maps and a copy of the household listing for each of the clusters in which his/her team will be working. These documents enable the team to identify the cluster boundaries and to locate the households selected for the sample. The representativeness of the whole survey depends on finding and visiting every sampled household.

Regional or provincial maps help the supervisor to determine the location of sample areas and the distance between them, while general cluster maps and sketch maps of the sampled clusters will help identify how to reach selected households or dwellings.

Each team will be given general cluster maps, household listing forms, and sketch maps and/or written descriptions of the boundaries of selected areas. A cluster is the smallest working unit in any census or survey operation that can easily be covered by one enumerator. It has identifiable boundaries and lies wholly within an administrative or statistical area. The general cluster maps may show more than one cluster (see Figure 1). Each cluster is identified by a number (e.g., EA-05, enumeration area 05). Symbols are used to indicate certain features on the map such as roads, footpaths, rivers, and railroads (see Figure 1). Sketch maps show more details of the selected cluster (see Figure 2).

In most clusters, the boundaries follow easily recognizable land features (such as rivers, roads, railroads, swamps, etc.). However, at times, boundaries are invisible lines. The location and determination of invisible boundaries will require some ingenuity. The following guidelines are suggested to locate the selected clusters:

- 1) Identify on the map the road used to reach the cluster. When you reach what appears to be the cluster boundary, verify this by checking the location of actual terrain features and landmarks against their location on the map. Do not depend on one single feature; use as many as possible.
- 2) It is usually possible to locate unnamed roads or imaginary lines by asking local authorities or people living in the area. In most cases, these people will know where the villages or other landmarks are, and by locating these, you can usually determine where the boundary runs.

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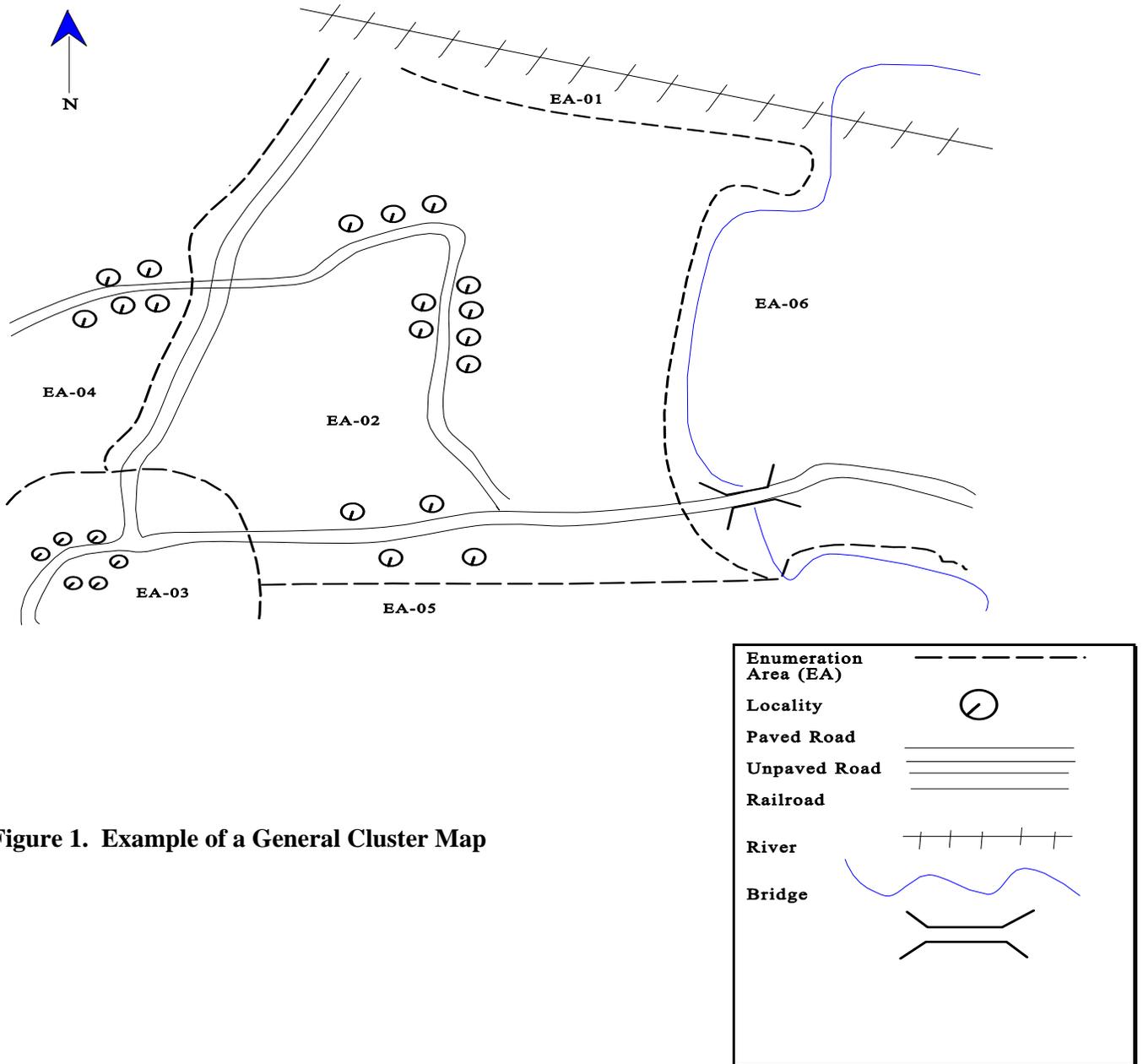


Figure 1. Example of a General Cluster Map

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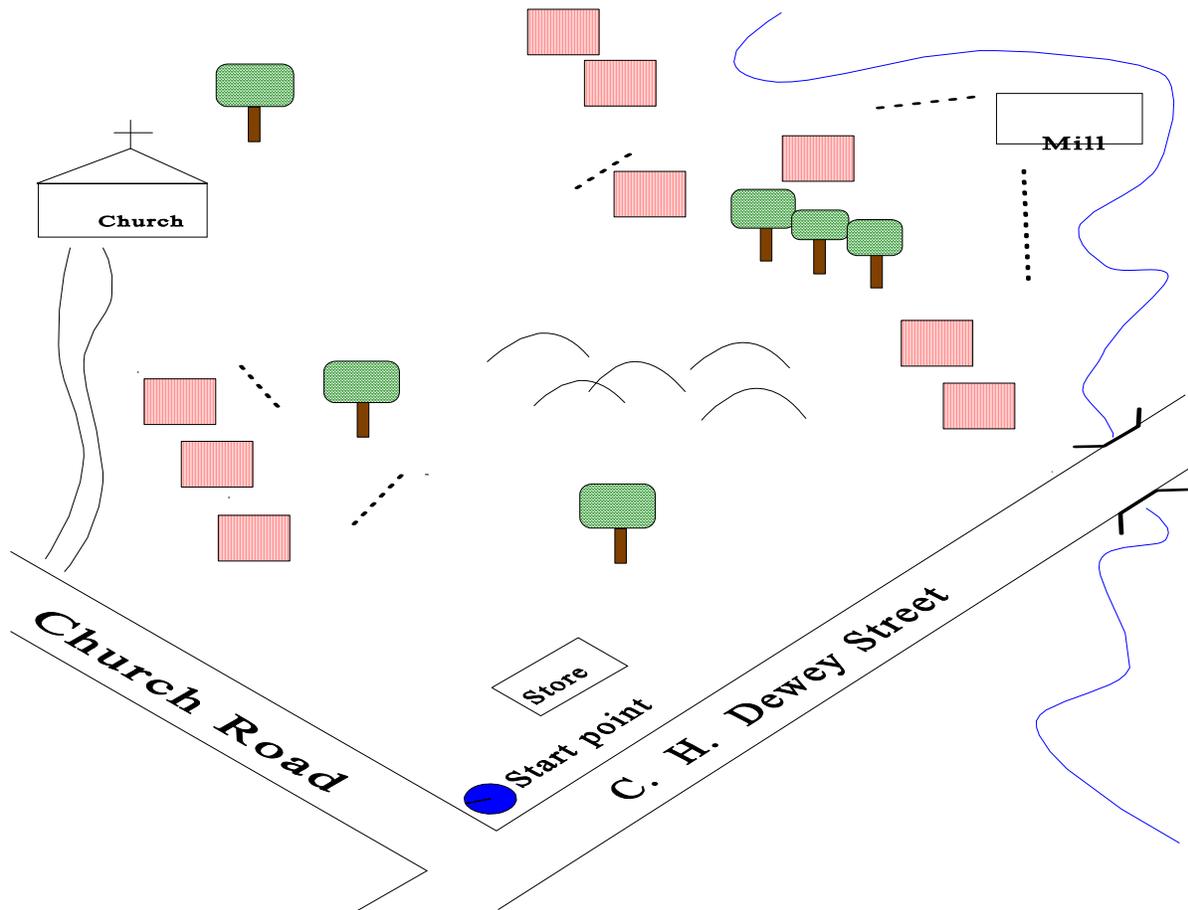
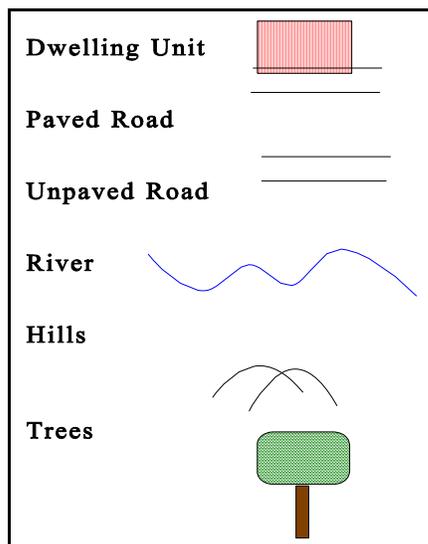


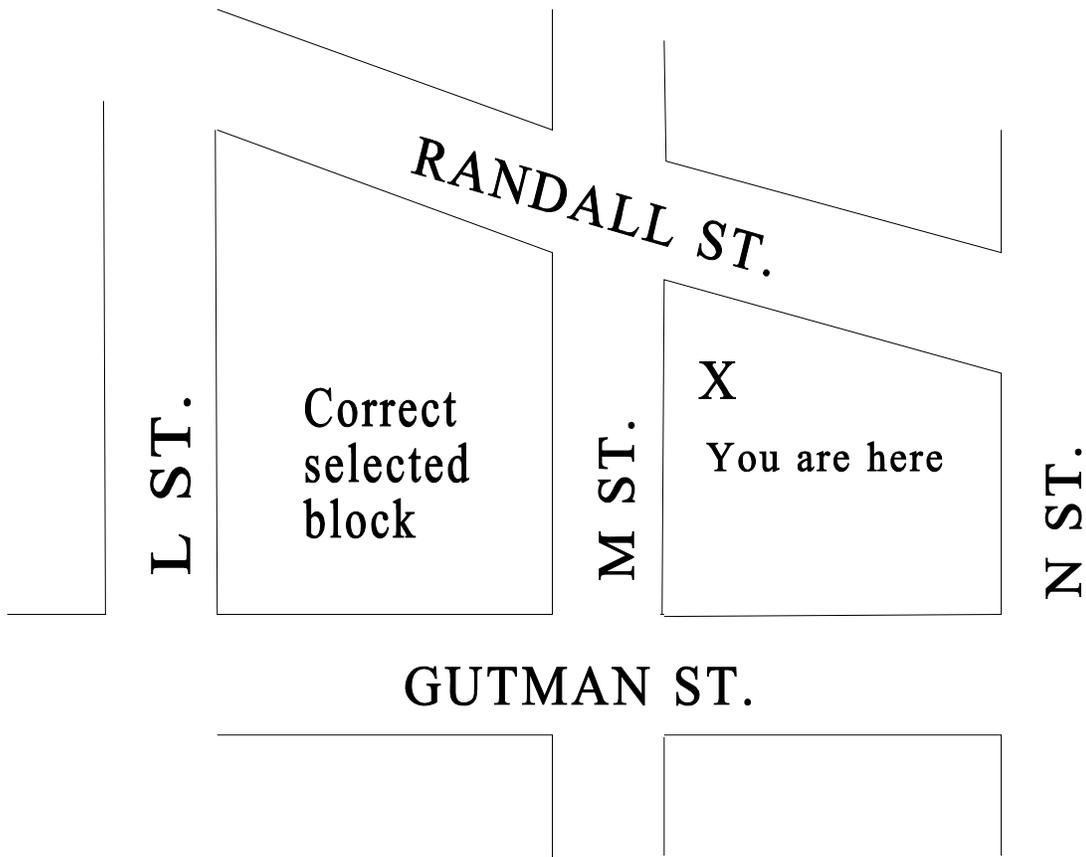
Figure 2. Example of a Sketch Map



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- 3) Although there are cases in which boundaries shown on the map no longer exist or have changed location (e.g., a road has been relocated or a river has changed course), do not jump to conclusions. If you cannot locate a cluster, go on to the next one and discuss the matter later with the field coordinator/project director.
- 4) In urban areas, street names will often help you locate the general area of clusters. Boundaries can be streets, alleys, streams, city limits, power cables, walls, rows of trees, etc.
- 5) Check the general shape of the cluster. This will help you determine whether you are in the right place.
- 6) Read the written description.
- 7) Locate all the cluster boundaries before you begin interviewing. For example, if the cluster is a rectangular block, the names of three boundary streets is not enough to unequivocally identify the cluster; check all four boundary streets (see Figure 3).

Figure 3. Importance of Identifying All Cluster Boundaries



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F. FINDING SELECTED HOUSEHOLDS

In most cases, the selected households can be located by referring to the household listing form or to the detailed maps of the selected clusters. Because people move around, and sometimes the listing teams may have made errors, you may have difficulty locating the residents of dwellings that were selected. Here are examples of some problems you may encounter and how to deal with them:

- 1) The household in the selected dwelling has moved away and the structure is vacant. If a household has moved out of the structure where it was listed and no one is living in the structure, you should consider the structure vacant and enter code '6' (DWELLING VACANT/ADDRESS NOT A DWELLING) on your Supervisor's/Editor's Assignment Sheet. (This sheet is described in Section IV.A.)
- 2) The household in the selected dwelling has moved away and a new one is now living in the same structure. In this case, the new household should be interviewed.
- 3) The listing shows only one household in the dwelling, but two households are living there now. In this case, both households should be interviewed. Make a note on your Supervisor's/Editor's Assignment Sheet next to the household that was not on the listing. Assign the new household a household number, enter the number on your Supervisor's/Editor's Assignment Sheet, and instruct the interviewer to enter the new household number on the Interviewer's Assignment Sheet and on the questionnaire. However, if the listing shows two households in the dwelling unit, only one of which was selected, and you find three or more households there now, only interview the one that had been selected and ignore the others.
- 4) The house is all closed up and the neighbors say the people are away and will be back in several days or weeks. Code as a '3' (ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME) on the Supervisor's/Editor's Assignment Sheet.
- 5) The house is all closed up and the neighbors say that no one lives there; the household has moved away permanently. Enter code '6' (DWELLING VACANT OR ADDRESS NOT A DWELLING) on the Supervisor's/Editor's Assignment Sheet.
- 6) A selected dwelling is actually a shop and no one lives there. Check very carefully to see whether anyone is living there. If not, enter code '6' (DWELLING VACANT OR ADDRESS NOT A DWELLING) on the Supervisor's/Editor's Assignment Sheet.
- 7) A selected structure is not found in the cluster, and residents say that the dwelling was destroyed in a recent fire. Enter a code '7' (DWELLING DESTROYED) on the Supervisor's/Editor's Assignment Sheet.

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III. ORGANIZING AND SUPERVISING FIELDWORK

A. ASSIGNING WORK TO INTERVIEWERS

The following tips may be helpful to the supervisor in assigning work:

- 1) Make daily work assignments. Be sure each interviewer has enough work to do for the day, taking into account the duration of an interview and the working conditions in the area. The director of field operations will advise you about how many interviews each interviewer should be able to complete in a day.
- 2) Assign more interviews than an interviewer can actually do in one day. This will be necessary because some households and/or women/men may not be available for interview at the time of the interviewer's visit. Sometimes there may be as many as three or four of these cases a day for a particular interviewer. Assign fewer households at the beginning of the survey to allow time for discussion of problems and for close supervision.
- 3) Distribute work fairly among the interviewers. Work should be assigned taking into account the capabilities and strengths of each interviewer but never consistently assigning more difficult workloads to certain interviewers. Drawing numbers out of a hat is a good system to ensure that team and interviewer assignments are distributed on a random basis and that interviewers are aware of this. Bad feelings among the interviewers can be avoided by using this system. If an interviewer is unlucky and consistently draws difficult assignments, the supervisor can purposely provide her some easier assignments.
- 4) Ensure that each interviewer has all the required information and materials for completing the work assignment.
- 5) Maintain complete records each day using the control sheets (see Section IV). All assignments and work completed by each interviewer and for each work area should be carefully monitored for completeness and accuracy.
- 6) Make sure that all selected households and eligible women/men for that cluster have been interviewed before leaving an area. See Section C for details on how to handle pending interviews.
- 7) Finally, it is the responsibility of the supervisor to make sure that the interviewers fully understand the instructions given to them and that they adhere to the work schedule. The work schedule is prepared in advance by the central office, and adherence to it is crucial to avoid overruns in the total amount of time and money allocated for the fieldwork. Supervisors should also monitor the work of each interviewer to assess whether she is performing according to the standards set by the central office.

B. REDUCING NONRESPONSE

One of the most serious problems in a sample survey of this type is nonresponse, that is, failure to obtain information for selected households or failure to interview eligible women and men. A serious bias could

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result if the level of nonresponse is high. One of the most important duties of the supervisor and editor is to try to minimize this problem and to obtain the most complete information possible. In many cases, interviewers will need to make return visits to households in the evening or on the weekends to reduce nonresponse. It is a time-consuming task and requires strict monitoring by means of the control sheets.

Nonresponse may be classified into three basic types:

Type 1: the interviewer is unable to locate the selected household

Type 2: the interviewer is unable to locate the woman and men eligible for the individual interview

Type 3: the respondent refuses to be interviewed.

Various ways of dealing with these types of nonresponse are discussed below.

Type 1 - The interviewer is unable to locate the selected household

- a) *Occupied structure inaccessible.* There may be some occupied structures for which no interviews can be made because of impassable roads, etc. The interviewer should be instructed to hold the questionnaire until later. She should make another attempt to reach the dwelling at a later date when the situation may have changed. The supervisor should immediately inform the director of field operations of any difficulty in gaining access to a whole cluster or a sizable number of structures within the same cluster.
- b) *Structure not found.* The supervisor should make sure the interviewer has tried several times to locate the structure using the household listing form, maps, etc. If she is still unsuccessful, the supervisor or field editor should attempt to locate the structure and ask neighbors whether they know anything about the structure or the household members. Again, if this problem occurs frequently, it should be reported to the director of field operations. Although no interview has taken place, the Interviewer's Assignment Sheet should be filled out and code '8' (DWELLING NOT FOUND) filled in for the result code.
- c) *Structure nonresidential, vacant, or demolished.* If the interviewer indicates that a structure is not a dwelling unit or that it is vacant or demolished, the supervisor or editor should verify that this is the case. If the interviewer is correct, there is no need for further callbacks (return visits). Although no interview has taken place, the Interviewer's Assignment Sheet should be filled out.

Type 2 - The interviewer is unable to locate the woman or man eligible for the individual interview

- a) *No one home at time of call.* The interviewer should make every effort to contact neighbors to find out when the members of the household will be at home or where they might be contacted. At least three visits should be made to locate the household members. Sometimes it may be necessary to call at mealtime, in the early morning, in the evening, or on the weekend. However, the interviewer should not make "hit or miss" calls just to fill the quota of three visits. Under no circumstances is it acceptable to make all three visits on the same day.
- b) *Respondent temporarily absent.* The respondent may not be at home or may be unable to complete the interview at the time of the first call. The interviewer should find out from other household members or neighbors when the respondent can best be contacted, and a return visit should be made then. If the respondent is still not at home at the time of the second visit, another time should be set for a return visit. At least three attempts should be made to locate the respondent. If the interviewer

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is not able to complete the entire interview during the initial visit, the procedure for callbacks should be followed.

Type 3 - The respondent refuses to be interviewed

The number of refusals reported by each interviewer should be closely monitored. If an interviewer reports an unusually high number of refusals, it may indicate that she gives up too easily or explains the survey inadequately. If this appears to be the case, the supervisor or editor should observe the interviewer promptly. Suggestions for handling potential refusals include the following:

- a) *Approach respondent from her point of view.* Refusals may stem from misconceptions about the survey or other prejudices. The interviewer must consider the respondent's point of view, adapt to it, and reassure her. If there is a linguistic or ethnic barrier between the respondent and the interviewer, the supervisor should, if possible, send a different interviewer to complete the questionnaire.
- b) *Postpone interview to another day.* If the interviewer senses that she has arrived at an inconvenient or awkward time, she should try to leave before the respondent gives a final "no"; she can then return another day when circumstances are more likely to result in a successful interview.
- c) *Have field editor carry out the interview.* The field editor's knowledge, skill, and maturity may enable her to complete a difficult interview when the assigned interviewer has been unable to do so.

C. HANDLING PENDING INTERVIEWS

When information has not been collected from a selected household or from an eligible respondent and the return visits have not been completed, the interview is considered "pending." All materials pertaining to this interview should remain with the interviewer until she/he has completed the pending interview. Supervisors and field editors should keep track of all assignments on the Supervisor's/Editor's Assignment Sheet (see Section IV.A).

Completing callbacks for pending interviews is time consuming and should be carefully planned. If a few interviews remain pending as interviewing in a cluster nears completion, one or two interviewers should be assigned to remain in the area and complete the interviews while the rest of the team proceeds to the next assignment area. In this way, the whole team is not kept waiting for one or two interviewers to finish. Clear instructions should be left with the interviewers as to where and when to rejoin the team and what method of transportation should be used.

D. MAINTAINING MOTIVATION AND MORALE

The supervisor and editor play a vital role in creating and maintaining motivation and morale among the interviewers—two elements that are essential to good-quality work. To achieve this, it is necessary to make sure that interviewers—

- Understand clearly what is expected of them
- Are properly guided and supervised in their work

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- Receive recognition for good work
- Are stimulated to improve their work
- Work in tranquil and secure conditions.

In working with the interviewers it may be useful to adhere to the following principles:

- 1) Rather than giving direct orders, try to gain voluntary compliance before demanding it.
- 2) Without losing a sense of authority, try to involve the interviewers in decision making, and at the same time, see to it that the decision remains firm.
- 3) When pointing out an error, do it with tact, in a friendly manner, and in private. Listen to the interviewer's explanation, show her/him that you are trying to help her/him, and examine the causes of the problem together.
- 4) When interviewers voice complaints, listen with patience and try to resolve them.
- 5) Try to foster team spirit and group work.
- 6) Under no circumstances show preference for one or another of the interviewers.
- 7) Try to develop a friendly and informal atmosphere.

Finally, remember that encouraging words, instructions, and constructive criticism are not worth anything unless the supervisor and editor set good examples. It is important to *demonstrate* punctuality, enthusiasm, and dedication in order to demand the same of other team members. Never give the impression that you are working less than other members of the team, or that you are enjoying special privileges; this may produce a lack of faith in the project and cause general discontent. An ill-prepared supervisor or editor will not be able to demand high-quality work from interviewers and will lose credibility and authority. Interviewer morale and motivation depend on your morale and motivation.

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IV. MAINTAINING FIELDWORK CONTROL SHEETS

Control of fieldwork within sample clusters is maintained by keeping control sheets for interviewer assignments. Three forms are used to maintain control of questionnaires and measure progress:

- 1) The Supervisor's/Editor's Assignment Sheet
- 2) The Interviewer's Assignment Sheet
- 3) The Interviewer's Progress Sheet

A. SUPERVISOR'S/EDITOR'S ASSIGNMENT SHEET

One Supervisor's/Editor's Assignment Sheet should be completed for each cluster by the supervisor and editor and returned to the head office with the questionnaires from that cluster. An example of the Supervisor's/Editor's Assignment Sheet is shown in Annex 1.

The first step in completing the Supervisor's/Editor's Assignment Sheet is to copy the cluster identification information (cluster number and name of the locality) from the household listing form or the map. The cluster number is a [three]-digit number and will be written on the top of each page of the household listing.

The next step is to record the information for all selected households from the household listing forms or the maps. They should be written on the Supervisor's/Editor's Assignment Sheet **in the same order** in which they are written on the household listing forms. When the households are written in a different order, it causes unnecessary confusion during the data processing operation, especially since the questionnaires will be put in order by household number. The director of field operations will provide the supervisor with the appropriate forms or maps for each cluster the team is assigned.

Several pages of the Supervisor's/Editor's Assignment Sheet will usually be needed to list all of the selected households in a cluster. The cluster number and name of locality should be filled in on all of the pages, and they should be numbered sequentially in the space provided at the top of the sheet (e.g., page 1 of 5, p. 2 of 5, etc.). If an additional sheet is needed because additional households were found during the interviewing, the supervisor should staple that sheet to the others for that cluster and correct the total number of sheets reported for the cluster.

Using the guidelines in Section III, the supervisor should assign each interviewer a number of households to interview. When making household interview assignments, Columns (1) through (3) of the Supervisor's/Editor's Assignment Sheet should be completed.

The interviewer is then responsible for 1) visiting the assigned households, 2) determining who in the household is eligible for interview with the Women's Questionnaire and the Men's Questionnaire, and 3) interviewing every eligible woman in each household and every eligible man in every OTHER household.

At the end of each day, the interviewers will return the completed questionnaires to the field editor or supervisor for checking.

First, review the Women's and Men's Questionnaires to check that—

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- 1) Eligible women and men have been correctly identified on the Interviewer's Assignment Sheet.
- 2) All eligible women from every household and all eligible men from every other household has a Women's or Men's Questionnaire, even if the interview was not completed.
- 3) The identification information on the cover pages of the Women's and Men's Questionnaires is correct.

Second, copy the information from the questionnaires about the results of the interview into Columns (4) through (10) of the Supervisor's/Editor's Assignment Sheet. Record the name of the eligible women in Column (4) and the name of the eligible men in Column (7). Record the final result of the woman's interview in Column (5) and the final result of the man's interview in Column (8) of your Supervisor's/Editor's Assignment Sheet. You will record the date on which the questionnaires were submitted to the supervisor/field editor for the eligible women's interviews in Column (6), and the date on which questionnaires were submitted to the supervisor/field editor for the eligible men's interviews in Column (9).

If there are more eligible women in a household than there is space on the Assignment Sheet, the results for that household should be entered on the final page of the Supervisor's/Editor's Assignment Sheet. Put a line through the information for that household where it was originally listed and put a note "SEE p. 5." On page 5, take the space for two households so that there is room to list up to six eligible women.

Remarks and comments about the interview assignment, results, or interviews may be recorded in Column (10). For example, reassignment of a pending interview may be recorded here. Also note here any irregularities observed during spotchecks or reinterviews.

Check to be sure that you have listed all the households on the Supervisor's/Editor's Assignment Sheet that were selected on the household listing form or map for that cluster. To ensure this, you are required to fill in the two boxes at the bottom of the Supervisor's/Editor's Assignment Sheet marked "Number of households" and "Number of households interviewed".

Always start a new cluster on a separate Supervisor's/Editor's Assignment Sheet. Be sure to write neatly since these forms will be used for control purposes in the central office.

B. INTERVIEWER'S ASSIGNMENT SHEET

Each interviewer will fill out an Interviewer's Assignment Sheet for each cluster (it may be necessary to use more than one sheet per cluster). The Interviewer's Assignment Sheet is similar to the Supervisor's/Editor's Assignment Sheet and helps each interviewer keep track of the households assigned to her/him, and which women/men are eligible for interviews within each household. The supervisor and editor should review the Interviewer's Assignment Sheets each evening and discuss the results of the interviews. The Interviewer's Assignment Sheet is described in detail in the Interviewer's Manual.

C. INTERVIEWER PROGRESS SHEET

The supervisor will keep an Interviewer Progress Sheet (see Annex 2) on each interviewer. The supervisor will update the Progress Sheet at the end of work in each cluster. The supervisor will keep these sheets until the end of fieldwork (they will not be included in the package of questionnaires going back to the central office).

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The Interviewer Progress Sheet is designed to give the supervisor and editor an objective and continuous measure of the interviewer's performance. Serious discord within a team can occur when one interviewer does much less work than the others. These cases must be identified and examined in order to assess whether there is good reason for lower performance or whether the interviewer is just taking it easy and leaving her/his colleagues to do most of the work. Similarly, this sheet will allow you to identify whether an interviewer is getting more nonresponses or refusals than others on the team. In such a case, spotchecking should be carried out to determine whether the nonresponses or refusals are due to poor interviewer performance. If the interviewer is at fault, the supervisor should have a serious talk with her/him, pointing out the problems, suggesting ways she/he can improve, and indicating that she/he must perform better. If her/his performance does not improve, the director of field operations must be informed. He or she will decide what further action to take.

Assign one Interviewer Progress Sheet for each interviewer. The supervisor will make entries on the sheet each time a cluster is completed. The procedure for filling in the Interviewer Progress Sheet is as follows:

Column (1): Enter each cluster number on a separate line in Column (1).

Columns (2) and (4): For each cluster, enter the number of completed Women's Questionnaires (i.e., with result code '1') in Column (2) and the number of Women's Questionnaires not completed (with result codes '2' through '9') in Column (4).

Columns (6) and (8): Enter the number of Men's Questionnaires completed in Column (6) and the number not completed in Column (8).

Columns (3), (5), (7), and (9): The figures recorded in these columns are cumulative for all clusters. In Column (3), you will keep a cumulative count of the numbers recorded in Column (2), and in Column (5), you will keep a cumulative count of the numbers recorded in Column (4), etc. (see example in Annex 2).

The cumulative figures make it possible to check at any time the number of interviews assigned to an interviewer and the results of her/his work. The supervisor and field editor can also check to see whether the workloads and the completion rates are approximately the same for all interviewers.

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V. MONITORING INTERVIEWER PERFORMANCE

Controlling the quality of the data collection is the most important function of the field editor. Throughout the fieldwork, she will be responsible for observing interviews and carrying out field editing. By checking the interviewers' work regularly the field editor can ensure that the quality of the data collection remains high throughout the survey. It may be necessary to observe the interviewers more frequently at the beginning of the survey and again toward the end. In the beginning, the interviewers may make errors due to lack of experience or lack of familiarity with the questionnaire; these can be corrected with additional training as the survey progresses. Toward the end of the survey interviewers may become bored or lazy in anticipation of the end of fieldwork; lack of attention to detail may result in carelessness with the data. To maintain the quality of data, the field editor should check the performance of interviewers thoroughly at these times.

A. OBSERVING INTERVIEWS

The purpose of the observation is to evaluate and improve interviewer performance and to look for errors and misconceptions that cannot be detected through editing. It is common for a completed questionnaire to be technically free of errors but for the interviewer to have asked a number of questions inaccurately. Even if the field editor does not know the language in which the interview is being conducted, she can detect a great deal from watching how the interviewer conducts herself/himself, how she/he treats the respondent, and how she/he fills out the questionnaire. The field editor should observe each interviewer many times throughout the course of fieldwork. The first observation should take place during interviewer training and may also be used as a screening device in the selection of interviewer candidates. Each interviewer should also be observed during the first two days of fieldwork so that any errors made consistently are caught immediately. Additional observations of each interviewer's performance should be made during the rest of the fieldwork. The field editor should observe at least one interview per day during the course of the fieldwork, with the heaviest observation at the beginning and end.

During the interview, the field editor should sit close enough to see what the interviewer is writing. This way, she can see whether the interviewer interprets the respondent correctly and follows the proper skip patterns. It is important to write notes of problem areas and points to be discussed later with the interviewer. The editor should not intervene during the course of the interview and should try to conduct herself in such a manner as not to make the interviewer or respondent nervous or uneasy. Only in cases where serious mistakes are being made by the interviewer should the editor intervene.

After each observation, the field editor and interviewer should discuss the interviewer's performance. The questionnaire should be reviewed, and the field editor should mention things that the interviewer did correctly as well as any problems or mistakes.

B. EVALUATING INTERVIEWER PERFORMANCE

The field editor should meet daily with the interviewers to discuss the quality of their work. In most cases, mistakes can be corrected and interviewing style improved by pointing out and discussing errors at regular meetings. At team meetings, the field editor should point out mistakes discovered during observation of interviews or noticed during questionnaire editing (see Chapter VI). She should discuss examples of actual mistakes, being careful not to embarrass individual interviewers. Re-reading relevant sections from the Interviewer's Manual together with the team can help resolve problems. The field editor can also encourage

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the interviewers to talk about any situations they encountered in the field that were not covered in training. The group should discuss whether or not the situation was handled properly and how similar situations should be handled in the future. Team members can learn a lot from one another in these meetings and should feel free to discuss their own mistakes without fear of embarrassment.

The editor and supervisor should expect to spend considerable time evaluating and instructing interviewers at the start of fieldwork. If they feel that the quality of work is not adequate, the interviewing should stop until errors and problems have been fully resolved. In some cases, an interviewer may fail to improve and will have to be replaced. This applies particularly in the case of interviewers who have been dishonest in the recording of ages of women and men.

C. REINTERVIEWS

As said before, the most important function of the supervisor is to ensure that the information collected by the interviewers is accurate. A powerful tool in checking the quality of the data is to systematically spotcheck the information for particular households. This is done by conducting a short reinterview in some households and checking the results with what was collected by the interviewer. Reinterviews help reduce three types of problems that affect the accuracy of the survey data.

First, reinterviews are used to check that the interviewer actually interviewed the selected household. Sometimes interviewers either inadvertently locate the wrong household or they may deliberately interview a household that is smaller or a household in which someone is home at the time they are in that area, thus making it easier to finish their work quickly. Occasionally, an interviewer may not interview any household and just fill in a questionnaire on her own. Reinterviews are a means of detecting these problems.

Another problem that arises frequently is that some interviewers may deliberately subtract years from the age of women who are 15-19 or add years to women who are over 40 in order to place them outside the age range of eligibility for the Women's Questionnaire. Sometimes interviewers may simply omit eligible women from the household listing, especially if they are visitors in the household. In these ways, they reduce their workload. If this happens frequently, it can have a substantial impact on the quality of the data.

To reduce the occurrence of such problems, supervisors or the field editor will be responsible for conducting one reinterview in each cluster. The supervisor/field editor should focus the reinterviews on households that contain women at the borderline ages, i.e., 12-14 or 50-52. Also, supervisors should make sure that households from all of the team's interviewers are occasionally reinterviewed. The reinterview should, if possible, be made on the same day as the interviewer's visit so that any visitors can still be contacted.

To conduct the reinterview, the supervisor should take a blank Women's or Men's Questionnaire, fill in the identification information on the cover sheet with a red pen, and write clearly "REINTERVIEW" on the top of the cover page. The supervisor should then visit the selected household with only the reinterview questionnaire (i.e., without taking the original questionnaire) and interview the woman or man on one or two sections of the questionnaire. DO NOT complete the entire questionnaire due to its length, and try to vary the sections used for each reinterview. After completing the reinterview, the supervisor should obtain the original questionnaire and compare the information. He or she should write the results of the comparison on the reinterview questionnaire.

The reinterview questionnaires should be included with the other materials sent back to the central office when fieldwork in the cluster is completed.

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VI. EDITING QUESTIONNAIRES

Ensuring that questionnaires are edited for completeness, legibility, and consistency is the most important task of the field editor. *Every* questionnaire must be completely checked in the field. This is necessary because even a small error can create much bigger problems after the information has been entered into the computer and tabulations have been run. Often, small errors can be corrected just by asking the interviewer. For example, if an answer of '02 MONTHS' is inconsistent with another response, the interviewer may recall that the respondent said '2 years,' and the error can easily be corrected. In other cases, the interviewer will have to go back to the respondent to get the correct information. Timely editing permits correction of questionnaires in the field.

Since errors make the analysis of the data much more difficult, the data processing staff has prepared a computer program that will check each questionnaire and print out a list of all errors. If the errors are major ones, an entire questionnaire may be omitted from the analysis. As you are editing questionnaires in the field, it may help to try imagining how the questionnaire would look to a clerk in the office. Would he or she be able to read the responses? Are the answers consistent? Since editing is such an important task, we have prepared a set of instructions that describe the procedures for editing questionnaires.

A. GENERAL INSTRUCTIONS

- 1) As you go through the questionnaires, if a response is missing (that is, there is no answer recorded because the question was not asked) or the response is inconsistent with other information in the questionnaire and you cannot determine the correct response, put a question mark ('?') next to the item **with a red pen**. Write the page number or the question number on the front or back of the questionnaire; this way, you can quickly remember later what problems you found. When you have completed the editing, discuss with each interviewer, individually, the observations you found. Any errors that you find frequently should be discussed with the whole team.
- 2) If the problems are major, such as discrepancies in the health sections, it will be necessary to go back to interview the respondent again. If a return visit is not possible, try to establish, with the interviewer's assistance, the correct response from other information in the questionnaire. For example, if there is no code circled to indicate a person's sex, you might be able, with the interviewer's help, to determine from the name which sex the person is.

NOTE: UNDER NO CIRCUMSTANCES SHOULD YOU MAKE UP AN ANSWER.

If it is not possible to return to the household to resolve inconsistencies or missing information, then leave the items as they are. Do not try to fill in every question or to make the questionnaire consistent.

- 3) In checking through each questionnaire, be sure that the numbers entered in boxes are readable and that the circles used by the interviewer to select the precoded numbers clearly mark only one of the choices (except in cases where more than one code is allowed).
- 4) In checking each questionnaire, make certain that the respondent was asked all questions appropriate for her/him (check that the interviewer followed the skip instructions). You will need to look for—

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a) Questions for which a response is recorded when it appears there should be *no* response (in this case, cross out the response by drawing two lines through the code with your red pen)

b) Questions for which *no* response is recorded when it appears there *should* be a response (in this case, try to find the correct response as described in paragraph (2) above or leave blank).

Correct errors following the system described in the Interviewer's Manual, e.g., drawing two lines through the existing code and circling or writing the new code.

ALWAYS USE A RED PEN TO MAKE CORRECTIONS.

- 5) Check the ranges for all variables that are not precoded (e.g., a man cannot have 24 sons living with him) and carry out the other consistency checks that are listed. Mark any inconsistencies with a red pen.
- 6) The field editor should advise the team supervisor about questionnaires that have been returned to interviewers for further work. All questionnaires for a given cluster that have been edited and corrected should be arranged in numerical order according to the household or dwelling number (see Section E: Checking the Entire Cluster).

B. EDITING THE WOMEN'S QUESTIONNAIRE

Check to see that *skip* instructions have been followed, that answers are readable, and that answers to related questions are consistent.

Cover Sheet

- 1) Check that the identification information has been completed correctly. This information must be the same as that on the Interviewer's Assignment Sheet.
- 2) Code the information on the cover sheet if the interviewer has not done so. If the final result is not '1' or '5,' check to see that the remaining pages are blank. If the final result is either '1' or '5,' continue to check the remaining pages of the Women's Questionnaire.

Section 1. Respondent's Background

- 1) Check that the informed consent statement has been signed by the interviewer.
- 2) TIME STARTED INTERVIEW. Check that the hour in Q. 101 is less than 24 and the minutes less than 60.
- 3) DATE OF BIRTH. Check that the answer to Q. 105 (month of birth) is either between '01' and '12' or '98,' that year of birth is not less than ['1950'] and not greater than ['1989'] or is '9998,' and that Q. 106 is between '15' and '49.' Question 106 must have an answer even if it is only the interviewer's best estimate. It can never be left blank. Also check that the date of birth and age are consistent. If these responses are inconsistent, discuss this with the interviewer.

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If at all possible, an effort should be made to revisit the respondent to resolve inconsistencies with age since it is one of the most important pieces of information collected in the questionnaire. If a revisit cannot be scheduled, it may be necessary to look at other information in the Women's Questionnaires in an effort to resolve the inconsistency.

- 4) AGE. If the respondent's age is either less than '15' or more than '49,' write "NOT ELIGIBLE" on the cover of the Women's Questionnaire. This questionnaire should not be processed.
- 5) EDUCATION. Make sure that the response given to Q. 109 is consistent with the level of education given in Q. 108.

Section 2. Reproduction

- 1) TOTAL NUMBER OF BIRTHS. Check that the total number of children who are alive (Q. 203) is not more than the number of times the woman has given birth (Q. 202).
- 2) LAST MENSTRUAL PERIOD. Check that Q. 237 has been filled in correctly. If a length of time is given, only one set of boxes (DAYS or WEEKS or MONTHS or YEARS) should be filled in.
- 3) CALENDAR, COLUMN (1). Now turn to the calendar at the back of the questionnaire. Make sure that each live birth (if any) that occurred since [2003] has been recorded with a 'B' in the appropriate month and year of birth, preceded by 'P's for each month of pregnancy. To the left of each 'B,' the name of the child should have been recorded.

Also verify that any pregnancy losses recorded in the sequence of Qs. 229-231 are recorded as 'T' in their month of occurrence, preceded by the appropriate number of months of 'P's. Check that for currently pregnant respondents, the number of 'P's entered in the calendar, starting with the month of interview and going back in time, is equal to the number of months she is pregnant in Q. 227.

Section 3. Contraception

- 1) HEARD OF OR USED METHODS. Wherever a code '1' or code '2' in Q. 301 has been circled for a specific method, Q. 302 should always be completed for that method.
- 2) CURRENTLY USING. Check that if the respondent is currently using a family planning method (Q. 311 has a code circled), Q. 302 for that method has been coded '1.'
- 3) STERILIZATION. Make sure that both set of boxes are filled in in Qs. 316 and 316A, i.e., MONTH and YEAR.
- 4) SKIPS AND FILTERS. Check through the remaining pages of Section 3 to ensure that all skip instructions were followed correctly, that the filters have been correctly marked, and that the appropriate questions have been answered.
- 5) CALENDAR, COLUMN (1). Now turn to the calendar at the back of the questionnaire. If the woman has never used contraception (Q. 304 is 'NO'), a '0' should have been entered in each blank month of Column (1) up to the month of interview. If the woman (or her partner) has been sterilized, (code '2' or '3') should have been entered in the month of the operation (Q. 316) and in the remaining months to interview. If the woman is a current user of some other method, the code for

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that method should be entered in the month and year she started using the method continuously (Q. 316A) and in the remaining months up to the month of interview.

- 6) **CALENDAR, COLUMNS (1) AND (2).** Now, focusing attention only on the calendar, there should be no blank squares in Column (1), except those later than the month of interview. If there are blanks, and the reason for the error is not obvious, a callback to the respondent may be required. Compare Columns (1) and (2). Each time a method was started in Column (1), there should be a code in Column (2), in the first month of use, indicating the place the method was obtained.

Compare Columns (1) and (3). Each time a method has been discontinued in Column (1), there should be a code in Column (3) in the last month of use, indicating the reason for discontinuation.

Section 4. Standard Days Method

- 1) **STANDARD DAYS METHOD.** For Qs. 401-403, make sure that if the box "SPONTANEOUS" is checked, then code '1' is circled.
- 2) **SKIPS AND FILTERS.** Check the skip pattern throughout the section; make sure that all filters have been correctly marked and that the proper questions were asked.
- 3) **MEET FUTURE FAMILY PLANNING NEEDS:** More than one response can be circled for Q. 408.
- 4) **HUSBAND APPROVAL OF FUTURE USE OF SDM:** Only one response should be circled for Q. 410.
- 5) **PLAN TO SEEK INFORMATION ON SDM:** More than one response can be circled for Q. 412.
- 6) **INFORMATION/DISCUSSION ON SDM:** More than one response can be circled for Qs. 413, 415, and 417.

Section 5. Marriage and Sexual Activity

- 1) **LAST INTERCOURSE.** Make sure that only one set of boxes is filled in in Q. 515, i.e., DAYS or WEEKS or MONTHS or YEARS. If more than one category has been coded, recalculate the answer and enter it at the appropriate unit of measurement.
- 2) **PLACE TO GET CONDOMS.** Make sure that the name of the place is listed and the appropriate code is circled for Q. 525.

Section 6. Fertility Preferences

- 1) **DESIRED SPACING.** Check that only one set of boxes is filled in in Q. 603, either MONTHS or YEARS.
- 2) **SOURCE OF FAMILY PLANNING INFORMATION.** Check to be sure there is a code circled for each item in Q. 617.
- 3) **SKIPS AND FILTERS.** Check the skip pattern throughout the section; make sure that all filters have been correctly marked and that the proper questions were asked.

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Section 7. Husband's Background, Woman's Work, and Residence

- 1) EDUCATION. Make sure that the response given to Q. 705 is consistent with the level of education given in Q. 704.
- 2) OCCUPATION. Make sure that one occupation is circled in Q. 710.
- 3) SKIPS AND FILTERS. Check the skip pattern throughout the section; make sure that all filters have been correctly marked and that the proper questions were asked.

Section 8. Attitudes Toward Gender Roles

- 1) SKIPS AND FILTERS. Check the skip pattern throughout the section; make sure that all filters have been correctly marked and that the proper questions were asked.
- 2) ATTITUDES TOWARDS GENDER ROLES. Check to be sure there is a code circled for each item for Qs. 801, 802, 804, and 805.
- 3) TIME ENDED INTERVIEW. Check the ranges for hour and minutes in Q. 805. This information should be reasonably consistent with Q. 101.

Summary of Editing Checks for the Women's Questionnaire

1. Range and consistency of Qs. 105 and 106
2. Consistency of Qs. 108 and 109
3. Numerical consistency of Qs. 202 and 203
4. Response to Q. 237 (last menstrual period) recorded correctly
5. Consistency of Calendar Column (1) with birth and pregnancy history
6. Consistency of Qs. 301 and 302
7. Consistency of Qs. 311 and 302
8. Consistency of Section 3 with Columns (1) and (2) of Calendar
9. Response to Qs. 401-403 recorded correctly
10. Response to Q. 515 (date of last intercourse) recorded correctly
11. Response to Q. 603 (desired spacing of next birth) recorded correctly
12. Consistency of Qs. 704 and 705
13. Response to Qs. 706 and 710 (Occupation) recorded correctly (only one response chosen)
14. Response to Qs. 801, 802, 804, and 805 (attitudes towards gender roles) recorded correctly.

C. EDITING THE MEN'S QUESTIONNAIRE

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Check to see that *skip* instructions have been followed, that answers are readable, and that answers to related questions are consistent.

Cover Sheet

- 1) Check that the identification information has been completed correctly. This information must be the same as that on the Interviewer's Assignment Sheet.
- 2) Code the information on the cover sheet if the interviewer has not done so. If the final result is not '1' or '5,' check to see that the remaining pages are blank. If the final result is either '1' or '5,' continue to check the remaining pages of the Men's Questionnaire.

Section 1. Respondent's Background

- 1) Check that the informed consent statement has been signed by the interviewer.
- 2) TIME STARTED INTERVIEW. Check that the hour in Q. 101 is less than 24 and the minutes less than 60.
- 3) DATE OF BIRTH. Check that the answer to Q. 107 (month of birth) is either between '01' and '12' or '98'. Question 108 must have an answer even if it is only the interviewer's best estimate. It can never be left blank. Also check that the date of birth and age are consistent. If these responses are inconsistent, discuss this with the interviewer.

If at all possible, an effort should be made to revisit the respondent to resolve inconsistencies with age since it is one of the most important pieces of information collected in the questionnaire. If a revisit cannot be scheduled, it may be necessary to look at other information in the Men's Questionnaires in an effort to resolve the inconsistency.

- 4) EDUCATION. Make sure that the response given to Q. 111 is consistent with the level of education given in Q. 110.
- 5) OCCUPATION: Response to Q. 122 recorded legible and specific.

Section 2. Reproduction

- 1) TOTAL NUMBER OF CHILDREN. Check that the total number of children who are alive (Q. 209) is equal to the total number of children living with the respondent and the number of children not living with the respondent (Qs. 203 and 205).
- 2) SKIPS AND FILTERS. Check through the remaining pages of Section 2 to ensure that all skip instructions were followed correctly, that the filters have been correctly marked, and that the appropriate questions have been answered.

Section 3. Contraception

- 1) HEARD OF OR USED METHODS. Wherever a code '1' or code '2' in Q. 301 has been circled for a specific method, Q. 302 should always be completed for that method if a response is possible.

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- 2) **ATTITUDES TOWARD CONTRACEPTION.** Check to be sure there is a code circled for each item Q. 306.
- 3) **CURRENTLY USING.** Check that if the respondent is currently using a family planning method (Q. 311 has a code circled), Q. 302 for that method has been coded '1' if a response if possible.
- 4) **STERILIZATION.** Make sure that both set of boxes are filled in in Qs. 316 and 316A, i.e., MONTH and YEAR.
- 5) **SKIPS AND FILTERS.** Check through the remaining pages of Section 3 to ensure that all skip instructions were followed correctly, that the filters have been correctly marked, and that the appropriate questions have been answered.

Section 4. Standard Days Method

- 1) **STANDARD DAYS METHOD.** For Qs. 401-403, make sure that if the box "SPONTANEOUS" is checked, then code '1' is circled.
- 2) **SKIPS AND FILTERS.** Check the skip pattern throughout the section; make sure that all filters have been correctly marked and that the proper questions were asked.
- 3) **MEET FUTURE FAMILY PLANNING NEEDS:** More than one response can be circled for Q. 408.
- 4) **WIFE APPROVAL OF FUTURE USE OF SDM:** Only one response should be circled for Q. 410.
- 5) **PLAN TO SEEK INFORMATION ON SDM:** More than one response can be circled for Q. 412.
- 6) **INFORMATION/DISCUSSION ON SDM:** More than one response can be circled for Qs. 413, 415, and 417.

Section 5. Marriage and Sexual Activity

- 1) **LAST INTERCOURSE.** Make sure that only one set of boxes is filled in in Q. 517, i.e., DAYS or WEEKS or MONTHS or YEARS. If more than one category has been coded, recalculate the answer and enter it at the appropriate unit of measurement.
- 2) **ATTITUDES TOWARD CONDOM USE.** Check to be sure there is a code circled for each item for Q. 556.

Section 6. Fertility Preferences

- 1) **DESIRED SPACING.** Check that only one set of boxes is filled in in Q. 604, either MONTHS or YEARS.
- 2) **SOURCE OF FAMILY PLANNING INFORMATION.** Check to be sure there is a code circled for each item in Q. 608.

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- 3) **SKIPS AND FILTERS.** Check the skip pattern throughout the section; make sure that all filters have been correctly marked and that the proper questions were asked.

Section 7. HIV/AIDS and Other Sexually Transmitted Infections

- 1) **PREVENTION OF HIV/AIDS TRANSMISSION.** More than one response can be circled FOR Q. 703.

Section 8. Attitudes Toward Gender Roles

- 1) **SKIPS AND FILTERS.** Check the skip pattern throughout the section; make sure that all filters have been correctly marked and that the proper questions were asked.
- 2) **ATTITUDES TOWARDS GENDER ROLES.** Check to be sure there is a code circled for each item for Qs. 801, 802, 804, and 805.
- 3) **TIME ENDED INTERVIEW.** Check the ranges for hour and minutes in Q. 805. This information should be reasonably consistent with Q. 101.

Summary of Editing Checks for the Men's Questionnaire

1. Range and consistency of Qs. 107 and 108
2. Consistency of Qs. 110 and 111
3. Response to Q. 122 (Occupation) recorded legible and specific.
4. Numerical consistency of Qs. 203, 205 and 209
6. Consistency of Qs. 301 and 302
7. Consistency of Qs. 311 and 302
8. Response to Qs. 401-403 (knowledge on Standard Days Method) recorded correctly
9. Response to Q. 517 (date of last intercourse) recorded correctly
10. Response to Q. 604 (desired spacing of next birth) recorded correctly
11. Response to Qs. 801, 802, 804, and 805 (attitudes towards gender roles) recorded correctly.

D. ORGANIZING QUESTIONNAIRES FOR RETURN TO THE OFFICE

- 1) Organize all the Women's Questionnaires sequentially in ascending order of the numbers of the respondents. Put the Men's Questionnaires after the Women's Questionnaires for each household.
- 2) Check the questionnaires against the Supervisor's/Editor's Assignment Sheet to be sure that—
 - a) The correct number of Women's Questionnaires are present
 - b) The women's final result codes are correct.
 - c) The correct number of Men's Questionnaires are present
 - d) The men's final result codes are correct.

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Remember, there must be a Women's Questionnaire assigned for each eligible woman, even if the interview was not conducted, and a Men's Questionnaire for each eligible man, even if the interview was not conducted. Those questionnaires will be blank except for the identification information and the result codes.

E. FORWARDING QUESTIONNAIRES TO THE HEAD OFFICE

After all the checking described above has been completed, the field editor should put all the questionnaires along with the Supervisor's/Editor's Assignment Sheet and the sketch maps for the sample point into the envelopes provided. On the outside of the envelope, she should write the cluster number, the name of the locality, and the number of Questionnaires for that cluster. If the questionnaires are too bulky to fit into one envelope, she should use two or more and write PACKET 1 OF 3, PACKET 2 OF 3, etc. on the outside of each envelope. The packets should be kept securely until they can be transported to the central office. It is very important that questionnaires are bundled and labeled properly and protected from dampness and dust. [Include or replace with country-specific instructions on bundling, labeling, and shipment.]

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ANNEX 1

SDM Supervisor's/Editor's Assignment Sheet

Name of locality _____
 Supervisor's Name _____
 Page ____ of ____

Cluster number

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Household			Women			Men			Observations (10)
Household number (1)	Structure number or address (2)	Interviewer and Date assigned (3)	Name of eligible woman (4)	Final result (5)	Date returned (6)	Name of eligible man (7)	Final result (8)	Date returned (9)	

NUMBER OF

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 NUMBER OF

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ELIGIBLE
HOUSEHOLDS

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HOUSEHOLDS
INTERVIEWED

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APPENDIX F: Supervisor's Manual – Women's and Men's Questionnaires

¹ Wilcox AJ, Weinberg CR, Baird DD. Timing of sexual intercourse in relation to ovulation: Effects on the probability of conception, survival of the pregnancy, and sex of the baby. *New England Journal of Medicine* 1995; 333: 1,517-1,521.

² Wilcox AJ, Weinberg CR, Baird DD. Post-ovulatory ageing of the human oocyte and embryo failure. *Human Reproduction* 1998; 13: 394-397.