A Process Evaluation of the Reproductive Health Assessment (RHA) Toolkit for Conflict-Affected Women

A Report of Findings, Recommendations, and Next Steps

Division of Reproductive Health
U.S. Centers for Disease Control and Prevention
September 2011

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This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Participating Agency Program Agreement, GHA-T-00-08-0004. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID, the Centers for Disease Control and Prevention or the United States Government.

CS236050

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1. BACKGROUND

In 2007, the Division of Reproductive Health (DRH) at the U.S. Centers for Disease Control and Prevention (CDC) developed the Reproductive Health Assessment Toolkit for Conflict-Affected Women (RHA Toolkit), to assess the reproductive health needs of crisis-affected women.

Funding for the development of the RHA Toolkit was provided by the U.S. Agency for International Development (USAID) and the Andrew Mellon Foundation. In anticipation of the final year of the funding cycle (2010–11), DRH undertook a process evaluation in 2009 to *examine if the toolkit provides necessary and useful tools to guide program staff in collecting reproductive health data that inform program planning in crisis settings.* In this report we present the results of that evaluation, including an examination of the factors that affect the use of the RHA Toolkit, and provide recommendations to sustain the RHA Toolkit post funding.

This report includes ten sections. The first section of this report provides an overview of the reproductive health in crisis field, outlining key actors and initiatives as well as the role of the RHA Toolkit in enhancing comprehensive reproductive health programming. The second and third sections outline the aim of this report and describe the methods used to perform the process evaluation. The fourth and fifth sections outline the findings of this evaluation, as well as cross-cutting themes related to data collection, analysis, and dissemination. The final sections outline lessons learned and recommendations and introduces initiatives undertaken to sustain the RHA Toolkit post funding.

1.1 Reproductive Health in Crisis: Framing the Issue

Political conflicts and natural disasters often lead to population displacement, economic disruptions, infrastructure collapse, and a breakdown in protective social systems and cultural norms.[1,2] Research findings have shown that such systemic adversity has a profound impact on the health of women and children, who make up the majority of displaced populations.[3] Although conflict and displacement are marked by increased rates of sexually transmitted infections (STIs), gender-based violence (GBV), and unplanned or poorly spaced pregnancies,[1,4] for many years reproductive health among crisis-affected populations was not prominent on the global agenda.

Reproductive health programs and services were often viewed as secondary to priority health issues in humanitarian response, including provision of adequate food, water, shelter, sanitation and basic health care services.[5] However, in 1994, a report by the Women's Refugee Commission* and the International Conference on Population and Development (ICPD) both acknowledged the need for comprehensive reproductive health programming

among crisis-affected populations.[5] The groundbreaking concepts that stemmed from the ICPD have founded many of today's reproductive health programs and services. Foremost among these was the formation of the Inter-Agency Working Group (IAWG) on Reproductive Health in Crisis (formerly the Inter-Agency Working Group on Refugee Reproductive Health) and the Reproductive Health Response in Crises (RHRC) Consortium, both platforms for organizations to work collectively in addressing gaps in reproductive health programs and services. In turn, such collaboration ushered the development of various initiatives, most notably the Minimum Initial Services Package (MISP) and the Inter-Agency Field Manuel (IAFM) on Reproductive Health in Humanitarian Settings, which facilitated the provision of reproductive health services in emergencies and affirms the place of reproductive health within primary care services during emergencies.[5] Despite early challenges, strides are being made to improve reproductive health programs and services for women in crisis-settings. However, the lack of reproductive health data to inform programs and services continues to be identified as a barrier to improving the health of women and children.

1.2 The Reproductive Health Assessment Toolkit for Conflict-Affected Women (RHA Toolkit): Addressing a Need for Population-based Data

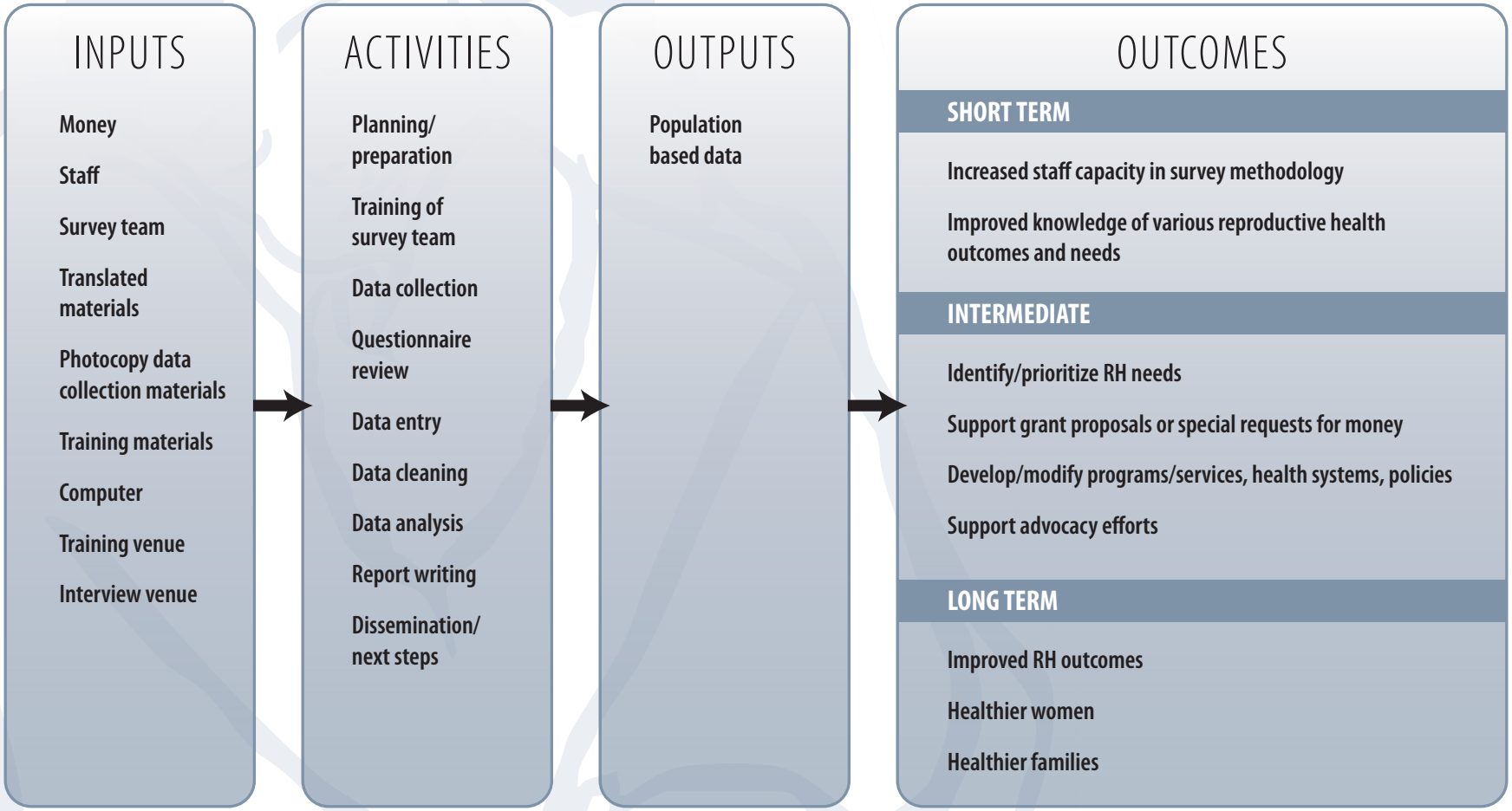
The RHA Toolkit was developed to help refugee-serving organizations with limited survey expertise to collect, analyze, and disseminate reproductive health data. Employing standardized survey methodology, the RHA Toolkit enables organizations to collect information on the reproductive health needs of women in conflict-affected areas and barriers to the provision of reproductive health services in these areas.

The RHA Toolkit consists of sampling instructions, a survey team training manual, a questionnaire, a data entry program, a data analysis guide, and suggestions for how survey data can be used. It allows organizations to collect information on a variety of reproductive health topics, including safe motherhood, family planning, sexual history, sexually transmitted infections (STIs), HIV/AIDS, gender-based violence (GBV), and female genital cutting (FGC). In recent years, the RHA Toolkit has been adapted and implemented at 20 within the following countries, including Democratic Republic of the Congo (DRC), Ethiopia, Colombia, Pakistan, Thailand, South Sudan, Rwanda, Uganda, Jordan, Djibouti, and Malaysia.

2. PURPOSE OF EVALUATION

In 2008, CDC decided to conduct a "process evaluation" of the RHA Toolkit,[6] the purpose of which was to assess the extent to which the toolkit helps program staff in collecting reproductive health data that can be used in subsequent planning for reproductive health programs in crisis settings.

Figure 1: RHA Toolkit Logic Model



In the evaluation, we attempted to identify factors that affected the application of the RHA Toolkit in survey planning, survey implementation, data analysis, and dissemination of findings. To do so, we attempted to answer the following questions:

- How many copies of the RHA Toolkit were distributed and to whom?
- Were RHA Toolkit questionnaires translated into the language(s) of the local population? Were translated questionnaires back-translated into English? What factors inhibited or facilitated these translations?
- Was the suggested training agenda appropriate? How was it modified to meet the needs of individual programs?
- Was the suggested budget template used? Were organizations able to solicit additional funding for their programs?
- Did CDC provide adequate remote technical assistance in a timely manner?
- Were steps taken to ensure quality data entry? Were staff members adequately trained to clean and enter data?
- Was data collection completed? What worked well during data collection? What did not work well during data collection?
- How have data been used to improve programs and services? What were facilitating and inhibiting factors in translating data into action?
- Did staff members gain new skills in survey implementation? Did use of the toolkit lead to an increase in institutional knowledge about data collection?

3. EVALUATION DESIGN AND METHODS

Process evaluations focus largely on eliciting the perspectives and perceptions of those with the most intimate knowledge of the program or instrument being evaluated. In our evaluation, we used both quantitative methods (a web-based survey) and qualitative methods (on-site interviews) to capture the experiences of "key informants" (i.e., people who had supervised or participated in the implementation of the RHA Toolkit survey). The CDC Institutional Review Board approved these interviews as program evaluation for public health practice. As part of our evaluation, we solicited information from key informants concerning the extent to which the toolkit helped them with survey budgeting, training, survey implementation, data analysis, and data dissemination. As shown in Figure 2, 5 survey coordinators,[1] 14 interviewers, 2 national-level staff members, and 9 headquarters staff members participated in this evaluation.

Figure 2: Key Informants for RHA Toolkit Process Evaluation

SITE	PERSONS INTERVIEWED	DATE
Web-based survey		
Multi-site	4 survey coordinators	April 2009
Rwanda		
Camp 1	4 interviewers	March 2009
Camp 2	4 interviewers	March 2009
Camp 3	1 survey coordinator and 1 country office staff member	March 2009
Thailand		
Camp 1	3 interviewers	March 2009
Camp 2	3 interviewers	March 2009
Camp 3	2 survey coordinators and 1 country office staff member	March 2009
Pakistan		
Atlanta, GA	1 survey coordinator	February 2010
United States		
Washington, DC	2 headquarters staff	January 2009
New York, NY	7 headquarters staff	February 2009

3.1 Web-based Survey

The web-based survey consisted of 52 questions and was administered on a secure website with use of Keynotes/Webeffective.[9] It was divided into the following sections: overall impressions, budget, training, technical assistance, data analysis, and overall assessment. The survey questions were in several formats, including single choice, multiple choice, Likert scale, and

open-ended. We used Excel[10] to enter and analyze all survey data and coded responses to open-ended questions for further analysis.

3.2 In-Depth Interviews with Key Informants

We also conducted in-depth interviews with 28 officials who implemented or monitored the implementation of the RHA Toolkit at eight sites in Rwanda, Thailand, or Pakistan. These interviews focused mainly on the training, planning, and surveying processes. In the interviews, we further explored respondents' perspectives on factors that contributed to their ability to carry out reproductive health surveys, key successes and challenges they experienced in implementing the surveys, and their overall survey implementation experience.

All 28 respondents gave written consent to be interviewed and recorded. We transcribed and coded their responses in accordance with a codebook designed by members of the evaluation team. We then further analyzed their responses thematically using the following four questions: (1) Why would organizations use the RHA Toolkit? (2) What does an organization need to implement the RHA Toolkit? (3) What factors influence the quality of data collected with the aid of the toolkit? (4) What would help future users of the toolkit? To increase the reliability and validity, we used inter-coder reliability measures, and we used MAXqda[11] to analyze transcribed interviews.

3.3 RHA Toolkit Database

In 2007, an Access database was developed to track RHA Toolkit distribution and implementation sites, as well as technical assistance requests. For this report, we compiled data on the number of toolkits distributed and types of agencies/organizations that have received copies.

4. FINDINGS

Figure 3 shows the evaluation questions in nine "topic areas" and the corresponding indicators derived from the responses to these questions.

Figure 3: Evaluation Questions and Corresponding Indicators

EVALUATION QUESTIONS	CORRESPONDING INDICATORS
4.1 Toolkit Distribution: How many copies of the RHA Toolkit were distributed and to whom?	• Number of toolkits distributed. • Types of agencies/organizations that received copies.
4.2 Translation: Were RHA Toolkit questionnaires translated into the language(s) of the local population? Were translated questionnaires back-translated into English? What were facilitating and inhibiting actors in questionnaire translations?	• Number of implementers who translated the RHA Toolkit questionnaire into other languages. • Percentage of translated questionnaires that were back-translated into English. • Key informant feedback on the success and challenges of questionnaire translation.
4.3 Training: Was the suggested training agenda appropriate? How was it modified to meet individual needs?	• Number of days allocated for training. • Feedback from key informants regarding organization of training, adaptations/ modifications made to the training manual, materials used for training, time allocated for training, and overall impressions of what worked and did not work in training.
4.4 Funding: Was the suggested budget template used? Were key informants able to solicit additional funding for their programs?	• Total cost of toolkit implementation. • Number of grant proposals or special requests for funding.
4.5 Technical Assistance: Did CDC provide adequate remote technical assistance in a timely manner?	• Number of key informants who contacted the CDC for technical assistance. • Perception of key informants with the quality and timeliness of CDC remote technical assistance.
4.6 Data entry: Were steps taken to ensure quality data entry? Were staff adequately trained to clean and enter data?	• Number of completed questionnaires double entered. • Number of persons trained for data-entry. • Feedback from key informants on the successes and/or challenges of exporting data, as well as data entry and clearing.

Figure 3 continued on next page

Figure 3 continued

4.7 Data collection: Was data collection completed? What worked well during data collection? What did not work well during data collection?	• Number of completed assessments. • Overall impression of key informants on the successes and challenges of data collection.
4.8 Dissemination and data use: How have data been used to inform programs and services? What were facilitating and inhibiting factors in translating data-to-action?	• Description of dissemination activities. • Evidence of how data informed programs and services.
4.9 Capacity building: Did staff gain new skills in survey implementation and methodology? How has implementing the RHA Toolkit informed institutional knowledge?	• Number of key informants who noted gaining new skills. • Key informant feedback on any institutional knowledge gained.

4.1 Toolkit Distribution

From 2007 through 2011, over 1,700 copies of the RHA Toolkit were distributed to more than 200 contacts in more than 24 countries, These contacts included individual researchers, universities, United Nations (UN) agencies, governmental organizations, and international non-governmental organizations (INGOs).

4.2 Translation

Several survey coordinators reported having difficulty ensuring that translated survey content was culturally and medically appropriate. Seven of the key informants specifically mentioned the importance of back-translation from the native language of respondents to English to ensure that the original translation of survey material was accurate. At sites where translation and back-translation were not optimal, survey coordinators employed various methods to ensure the accuracy of survey material, including hiring a research assistant to review the quality of the translation and providing interviewers English versions of surveys to use for reference and clarification of any ambiguities in the translated versions. At

> It did not translate well. Sometimes, some words… they don't exist for some things. That is why I say that translation was a challenge. Like some of the medical terms don't exist … For example, 'how long did your labor take?' In the first translation it's, 'how long did your work take?'.
>
> —*Survey coordinator, Thailand*

some sites, interviewers and study coordinators reviewed the survey translations for accuracy during the interviewers' training. Although they reported that such reviews were effective both in ensuring the accuracy of survey translations and in familiarizing interviewers with the survey, many interviewers felt that these reviews took up too much of their limited training time.

Problems with the translation process cited by key respondents included not allocating enough time for translation and back-translation, inadequate budgeting for translation and back-translation, and inconsistencies in translated materials. Other translation-related problems noted by key informants included no direct translation for certain words in the local-language, the translations being too technically difficult for respondents to understand, and the translations not being medically accurate. Despite these problems, informants at all sites reported having translated the survey into the local language and having back-translated the local-language version into English.

4.3 Training

In exploring the training component of the RHA Toolkit, we assessed the number of days that training was conducted and the number of staff members trained at each of the four sites and sought suggestions for ways to improve the training component. Both the length of training and the number of staff members trained varied widely among the four sites:

- Days of training ranged from 8 to 14.
- Number of interviewers trained ranged from 11 to 40.
- Number of locators trained ranged from 4 to 16.
- Number of data entry staff trained ranged from 1 to 3.

Organizations using the RHA Toolkit also trained coordinators, research assistants, and survey supervisors. Of the four respondents to a web-based question about the training manual's ease of use, one found it *easy* to use, two found it *somewhat easy* to use, and one found it *difficult* to use.

During the in-depth interviews, all key informants reported that the training sessions were well organized and that the materials used adequately supported the training agenda. One key informant suggested that training objectives could be communicated more effectively with the use of audio-visual aids. In general, suggestions for improving the quality of the training component fell into one of three main categories: (1) improve the quality of translated survey materials by allowing more time for their translation into the local language and for their back-translation into English; (2) hire and work with people with a background in reproductive health and/or previous surveying experience; and (3) allow adequate time to train people to conduct the reproductive health surveys (preferably at least 10 days as suggested in the RHA Toolkit).

4.4 Funding

Through the web-based survey, we inquired about three factors related to funding for reproductive health surveys: the amount of money an organization spent planning for and implementing the RHA Toolkit, the usefulness of the budget template provided in the RHA Toolkit, and any in-kind contributions the organization contributed or received. Three of the four respondents reported providing 10,000 US dollars (USD) for survey planning and implementation, and the other respondent was unsure of the costs associated with survey implementation. Two respondents reported using the budget template, and both found it to be useful. One respondent reported having provided at least one of the following in-kind goods or services: interview space, staff time, office supplies, vehicles and/or drivers, food and beverages, materials for the survey, gifts for survey participants, or flyers and marketing materials.

Through the in-depth interviews with survey coordinators, we learned that funding sources for reproductive health surveys included university research funds, small country office grants from external sources, and headquarter funds and that funds received ranged from 2,000 to 4,000 USD.

4.5 Technical Assistance

All four respondents to the web-based survey reported that they had contacted CDC for TA several times, with one participant reporting having done so 20 times. All four *strongly agreed* or *agreed* that CDC's TA was prompt. Three of the four *strongly agreed* that the CDC personnel who provided TA were knowledgeable about the topic area, and the other respondent was *undecided*. All participants *agreed* or *strongly agreed* that the TA they received was helpful.

Respondents highlighted two main challenges to the TA and subsequent reporting and dissemination processes:

1. **Challenges in understanding CDC analysis tables:** Through the web-based survey, we learned that all participants sent their data to CDC for analysis using SAS.[12] However, some key-informants noted challenges in understanding the completed analysis tables that CDC provided. (Please see section **6.3. Next Steps** on steps CDC is taking to address these concerns.)

2. **CDC's turnaround time for analysis tables was too long:** Key informants noted that delivery times for analysis tables took several months longer than expected. Responses to two web-based survey questions about CDC-produced analysis tables are shown on the following page:

My organization received analysis tables from CDC in a timely manner

Response Option	N of respondents
Strongly agree	—
Agree	2
Undecided	1
Disagree	1
Strongly disagree	—

The presentation of the analysis tables from CDC was well-organized and easy to understand

Response Option	N of respondents
Strongly agree	—
Agree	1
Undecided	—
Disagree	3
Strongly disagree	—

In response to the question, "If programming for table shells was provided in SPSS, would you and/or your organization be able to use it?," two participants said yes, one said no, and one did not respond. Lack of expertise was cited as the main reason for not being able to use such programming by the respondent who reported being unable to use it.

4.6 Data Entry

The number of data entry staff trained ranged from 1 to 3 per site. Most implementers found the data entry process time consuming but unproblematic. During the in-depth interviews, three key informants noted some challenges in using CSPro:[13] one found that the "other" field was too short to enter text, another noted that certain numerical commands (such as the number 8) were not recognized by CSPro, and a third reported challenges in exporting CSPro data files using the Vista operating system.

4.7 Data Collection

During in-depth interviews, key informants identified the following factors as helpful during data collection: having knowledge of local customs and language, creating comfortable interview environments, and providing strong on-site supervision. They also identified the following factors as be "challenges" to data collection: poorly translated questionnaires, limited understanding of the purpose of the survey, the need to navigate difficult physical terrain in order to administer survey questionnaires, and a lack of private spaces for interviews.

What worked:

A. Using interviewers from the communities in which the studies were conducted.

B. Creating comfortable spaces in which to conduct the interviews, providing thank you gifts to survey respondents, and carefully scheduling interview times so that survey participants do not have to wait unnecessarily.

C. Providing strong on-site supervision both to address problems as they arise and to confirm that surveys are completed.

Problems encountered:

A. Four of the five survey coordinators noted challenges in the translation and back-translation of the RHA Toolkit questionnaire.

B. Several key informants noted that both interviewers and locators had trouble communicating the purpose of the survey to potential respondents.

C. Two implementers noted the need to understand the layout of the camps or catchment area in which surveys are to be conducted, and one survey coordinator noted that navigating difficult physical terrain further complicated the interview process.

D. Four interviewers cited a need for greater privacy because of the sensitive nature of many interview topics, and several key informants cited a need to adequately train interviewers on issues of confidentiality.

4.8 Data Dissemination and Use

Key informants reported having disseminated survey data through policy papers, a Master's thesis, national workshops, presentations at scientific conferences, local workshops, funding applications, internal health campaigns, and memos to ministries of health. Audiences to which they reported having disseminated these data included internal health staff, local government authorities, partner agencies, funders/donors, UN agencies, and the local community in which the survey was conducted. Major barriers to data dissemination were heavy staff workloads, which often inhibited the completion of survey reports, and limited staff capacity to analyze the data collected. Even when data analysis was provided by CDC, key informants reported challenges in adequately interpreting and reporting the results of that analysis.

Despite these barriers, key informants reported using survey findings to help provide more comprehensive programs and services.

- In South Sudan, RHA Toolkit data, combined with health care facility data, were used to identify post-abortion care as the number one reason for clinic admission.
- In Pakistan, key informants used the data to demonstrate an increase in the percentage of women who used contraceptives from 9% in 2002 to 13% in 2007 to suggest that this increase was mostly likely due to targeted changes to family planning programs and services.

4.9 Capacity Building

All four survey coordinators reported that use of the RHA Toolkit helped increase their skills in managing a large project; three reported having gained skills in survey planning, sampling, survey implementation, and data analysis; and two reported having gained skills in data collection and report writing.

Participants in the key informant interviews reported increased capacity in three main areas as a result of using RHA Toolkit: (1) survey implementation skills, (2) knowledge about the reproductive health needs of the communities they served, and (3) the acquisition of new partnerships and working relationships.

5. CROSS-CUTTING THEMES

To better explore the interconnectivity of cross-cutting themes in the responses of key informants, we organized their responses as answers to the following three questions:

1. Why would organizations use the RHA Toolkit?
2. What does an organization need to implement the RHA Toolkit?
3. What factors influence the quality of data collected with use of the toolkit?

Following is a summary of key informants' responses related to these three questions:

5.1. Why would organizations use the RHA Toolkit?

- **The toolkit includes a ready-for-use pilot-tested survey.** Many key informants stated that having a ready-for-use reproductive health survey saved time because they did not have to start from scratch in developing a survey and testing survey questions.
- **The survey in the toolkit is comprehensive.** The survey included in the RHA Toolkit was designed to capture information on a variety of reproductive health issues, and use of this standardized survey at multiple sites allows for easy comparison of reproductive health measures across sites, as well as for comparison of results from other national surveys. Key informants reported having used the RHA Toolkit in conducting both baseline and follow-up surveys, which allowed them to monitor and evaluate the progress of their programs and services. Some key informants also suggested that the RHA Toolkit could be useful in developing core reproductive health indicators for displaced populations globally.
- **The toolkit helps build staff capacity.** The RHA Toolkit was designed to build capacity across a variety of survey planning and implementation skill sets, including data entry, analysis, interpretation, and dissemination. Some key informants also found the very process of conducting a reproductive health survey helped enhance their knowledge about the health of the women surveyed by creating an avenue for direct interaction between them and the women served by their program. Moreover, some key informants noted that the survey data collected helped identify their program's successes, challenges, and gaps in services.
- **The toolkit helps users build partnerships.** Key informants stated that use of the RHA Toolkit helped them build new partnerships and alliances at local, national, and international levels. At the local level, they reported that the process of

implementing the RHA Toolkit encouraged inter-agency collaboration and facilitated working relationships among organizations operating within the camps or catchment areas. At the national level, all survey coordinators noted that they had to work directly with national agencies, such as ministries of health, to gain approval for the implementation of reproductive health surveys. At the international level, all survey coordinators noted that use of the RHA Toolkit facilitated working relationships with various international agencies, including UN agencies, CDC, and INGOs.

> I definitely depended on that [RHA Toolkit] 100% to guide me in my process of it. Having never done a survey, I learned it all. It was more the implementation and the process of ensuring that everything was smooth. You had women setting up the space and the interviews, people trained, so it was all a learning process.
>
> —*Survey coordinator*

- **The RHA Toolkit is easy to use.** Key informants stated that the RHA Toolkit was easy to understand and use, had the necessary components from training to analysis, and was compatible with other survey instruments. Moreover, users found the survey was easy to download and modify to better suit their settings. For example, several sites removed the *female genital cutting* section as it was not applicable to their settings. Users also found using CSPro for data entry useful, as it was a public domain software and easy to download and learn.

5.2 What does an organization need to implement the RHA toolkit?

- **Time.** Because of the challenges of conducting surveys in humanitarian aid settings, many key informants felt that they did not have adequate time to plan for and conduct a survey or to distribute survey findings. They specifically called attention to a need for more time in the following areas: survey planning; translation and back-translation of survey materials; training program staff to conduct surveys; data collection; and data entry, cleaning, analysis, and dissemination.

- **Resources.** Key informants identified several types of resources they felt were important to adequate survey implementation. In the pre-implementation (planning and training) stages, these included assistance in securing funding, access to technical assistance with sampling, access to printers and photocopy machines, and access to vehicles for training and sampling purposes. In the data collection and data dissemination stages,

these included dedicated vehicles to transport interviewers to survey sites, information on how to modify the toolkit survey to meet local needs, access to affordable data entry and analysis packages, and headquarters' support in post-data-collection activities such as writing and disseminating reports based on survey data.

- **Staff skills.** RHA Toolkit users identified many skills necessary for adequate survey implementation; primary among these was the need for skilled **survey coordinators** to assess the social, cultural, and physical environments in which surveys were conducted. Implementing agencies identified the need for a detail-oriented person to supervise and keep track of changes in translations and other survey logistics, as well as skills in problem solving and communication. The following skills were deemed important for **interviewers, locators, and data-entry staff**: familiarity with reproductive health issues, survey experience, knowledge of local language, knowledge of local customs and geographic area, and basic data-entry and computer skills, specifically in using CSPro. Other skills that were deemed important include minimal working knowledge of statistical packages for data cleaning and analysis (such as SPSS), an ability to interpret data and translate data-to-action, as well as cultural and subject-matter competence. One survey coordinator noted the benefits of having staff members versed in trauma counseling to help negotiate sensitive sections in the survey. Three survey coordinators noted the importance of having someone who is versed in the local language to ensure adequate translation of the survey.

5.3 What factors influence data quality?

- **Quality of survey instruments.** Key informants stressed the importance of translating survey materials into culturally and technically appropriate content and of pilot-testing the translated materials before actually conducting the survey. Interviewers reported that pilot-testing allowed them to practice administering the survey, address any problems with survey content or skip-pattern comprehension, and address any shortcomings in the sampling methodology. Locators reported that pilot-testing allowed them to practice identifying eligible households and women.

- **Quality of data-entry training.** Key informants described three main factors necessary for adequate data-entry training: (1) the early identification of data-entry personnel to ensure consistency in how data are entered, (2) appropriate training for data-entry staff, including training in re-coding "other" responses when appropriate, and (3) training staff members to enter data as they are collected so that any errors can be identified and corrected early.

- **Quality of data-collection training.** The data collection process was greatly enhanced by adequate training, translation,

and supervision. Key informants noted that training should include a question-by-question review of the survey and opportunities to role play and assess difficult skip patterns. They also felt it was important to train supervisors in thoroughly reviewing the survey for completion, as well as in assessing skip patterns and other challenging components of the questionnaire.

- **Safety and comfort of environment in which survey data are collected.** Key informants stressed the importance of having private and safe spaces in which to conduct surveys. One participant suggested partitioning the interview space with curtains and providing child care for women being interviewed so that they can respond to the survey questions without being interrupted.

- **Survey implementation support.** Key informants noted the importance of structured support at several levels. At the community level, they noted the need for support from local governments, agencies, and community leaders (such as refugee committees, chiefs, and sheiks) in identifying survey approval mechanisms, reviewing survey content, and suggesting areas for adaptation. They also noted the need for inter-agency support for internal activities requiring subject matter expertise, such as the correct translation of medical terminology or counseling services for survey participants who reported being victims of gender-based violence, Key informants also noted the need for headquarters support in identifying funding for the survey, in planning and providing logistic support for the survey, and in providing technical assistance in data analysis and dissemination. Moreover, support from partner agencies in disseminating findings, as well as for support from CDC in data analysis and interpretation was deemed important.

6. LESSONS LEARNED

Several questions in both the in-depth interviews and web-based surveys inquired about how the RHA Toolkit could be improved for future use.

In the web-based survey, respondents stated that the sequence and structure of some questions were unclear and confusing. For example, the question related to reading ability does not always capture literacy skills, as one respondent states, "reading with difficulty can be caused by poor eyesight not merely illiteracy." When asked what should be added to the RHA Toolkit, respondents identified the following: simplify questionnaire, improve analysis, and include voluntary counseling and testing (VCT) and preventing mother-to-child transmission (PMTCT) acceptance rates.

In the in-depth interviews, we specifically inquired about lessons learned that could be helpful to future users. Key informants noted the following:

- **Allow ample time for planning, translation, training, and post-data-collection activities.**
    - **Planning**: Carefully consider logistics such as transportation, staffing, time spent navigating local terrain, photocopying needs, safety and accessibility of interview sites, and interviewers needs (compensation, transportation, meals, etc.).
    - **Translation**: Identify adequate sources for translation and back-translation early, preferably a few weeks before training starts. Use culturally and contextually appropriate language in translated materials.
    - **Training**: Spend more time on difficult content and skip patterns, also integrate greater practice and role-playing into training to build confidence around difficult and sensitive content areas. Key informants noted a greater emphasis should be given to adequately training locators, who should be able to explain the purpose of the survey to participants. Equally important was training locators in identifying households, and getting and retaining signed consent forms. Some key informants found it useful to spend time at the end of each day debriefing and discussing any challenges in surveying.
    - **Post-data-collection activities**: Allocate sufficient time for data analysis, report writing, and the dissemination of survey results. Carefully consider what your data needs are before implementing a survey to collect that data. As early as possible in the survey planning process, identify how information to be collected in the survey can be used to improve programs and services.

- **Ensure that adequate human resources are available**: Review the qualifications in the Toolkit and assure that staff meet at least the minimum qualifications. If using health staff as interviewers, carefully consider how staff time is allocated between the survey implementation and other work responsibilities; some interviewers found it difficult to balance the time needed to conduct interviews with their daily responsibilities.

- **Identify a single point-person (survey coordinator)** to coordinate both the implementation of the survey (including budgeting, personnel training, and survey translation) and the dissemination of survey results.

- **Facilitate buy-in and collaboration.** Use the survey process as an opportunity for team building as well as for capacity and partnership building. Work with staff to identify promising practices in survey implementation and the dissemination of survey results, provide interactive training sessions that incorporate a feedback process, and cross-train staff when possible. Allow participants to be engaged and have ownership, as this will facilitate buy-in.

7. RECOMMENDATIONS

Following is a summary of key informants' recommendations for how the RHA Toolkit and CDC's support of toolkit users can be improved:

- **Provide clearer guidance in the toolkit concerning the time that should be allocated to train program staff members to administer reproductive health surveys.** Most key informants noted they spent less than the suggested 10 days to train staff members. The training module should be revised to stress the importance of dedicating a minimum of 10 days to training.
- **Provide a detailed timeframe for the translation and back-translation of survey materials.** Some key informants expressed the need for more time in which to translate and back-translate the RHA Toolkit questionnaire.
- **Provide toolkit users with greater support in analyzing and reporting survey data.** Key informants generally expressed a need for better statistical interpretation and report writing skills. CDC personnel should evaluate the components of the analysis tables and engage toolkit users in the creation of more user-friendly analysis tables. They should also provide toolkit users with a sample template outlining the components of a survey report.
- **Assess ways to improve CDC response times**. Delivery time for analysis tables needs to be improved. However, changes in delivery time need to take into consideration time pressures on CDC program staff and statisticians. It should be noted that some surveys were conducted as far back as 2006, and since that time, CDC has worked progressively in refining technical assistance response mechanisms and turnaround time.

8. STEPS TAKEN

Following is a summary of three steps that CDC has taken to address the concerns raised by key informants and to support the continued use of the RHA Toolkit following the end of its initial funding.

1. **Developed three self-guided learning modules for toolkit users with limited survey implementation experience.** "Introduction to the RHA Toolkit" provides a basic introduction to the RHA Toolkit, illustrates its components, and highlights the benefits of using it. "Introduction to Data Use" demonstrates how to review descriptive analysis tables provided by CDC, assess programs and services on the basis of information in these tables, and communicate survey findings in a written format. "Determining Sampling Methods" explains the importance of sampling, describes the advantages and disadvantages of random and cluster sampling, and gives users an opportunity to better understand sampling concepts.

2. **Revised the analysis tables:** To address key respondents' concerns about the analysis tables, CDC reduced the number of tables presented, reduced the number of characteristics addressed in each table, made table headings and titles uniform, and created column percentages for all tables.

3. **Revised the survey questionnaire provided in the toolkit:** CDC reworded or removed questions that key informants found problematic, introduced new questions that they proposed, and attempted to make the various sections of the questionnaire more uniform.

9. LIMITATIONS

This evaluation had three notable sources of possible bias that could have affected its results. The first possible source of bias was from the evaluation being conducted by a team within CDC's Division Reproductive Health (DRH), which also played a role in the development of the RHA Toolkit. However, in an effort to be more objective, new staff who had not been part of the development of the RHA Toolkit took on major roles in data collection and interpretation. Secondly, the primary participants of this evaluation are project staff who have a vested interest in positively portraying the survey implementation process; therefore respondent bias is a potential factor in the objectivity of the data. To address this, we continually reminded participants of the need for honesty in their responses. Finally, there is the possibility of inter-coder bias as text was manually coded; however, our evaluation methodology employed four data reviewers who methodically constructed the coding categories.

10. CONCLUSIONS

This process evaluation set out to assess if the RHA Toolkit provides the necessary and useful tools to guide program staff in collecting reproductive health data that in turn inform program planning in crisis settings. Our findings indicate that the RHA Toolkit does in fact meet its objectives. All evaluation participants agreed that they were able to acquire valuable data, and that they would recommend the RHA Toolkit to future users. Respondents identified the following as particularly useful features: opportunity to learn and implement survey methodology, opportunity to identify evidence of best practice, and potential to identify gaps in services. Most of the challenges arose in the dissemination and reporting stages where respondents faced confounding issues, such as an inability to understand analysis from CDC and limited support and capacity in writing and disseminating findings. This was coupled with internal challenges in adequate translation, time management, and division of responsibilities.

In response to the evaluation findings, we have since updated our analysis tables so they are more concise and streamlined. In addition, we have also updated the questionnaire. Both of these documents are available on our website at **www.cdc.gov/reproductivehealth/**. We also hope that the three E-learning modules will enable users to gain additional insights to aid in their implementation of the RHA Toolkit and help them to better understand how to use the data that have been collected to inform their programs and services. The E-learning modules can be found at **www.rhrc.org** and **www.iawg.net**.

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