# Descriptions of MISP Process Evaluation Tools and Analysis Guidance

## Literature Review

The purpose of undertaking a literature review is to understand as much as possible about the context of the emergency before commencing field research. A thorough review will provide background information essential to the MISP process evaluation, such as the reproductive health (RH) infrastructure of country, population-based indicators on RH, and the status of the humanitarian RH response. It can minimize duplication in data collection as well as help identify cultural sensitivities on RH that are important to understand for a successful process evaluation. The MISP process evaluation literature review is different than a scholarly literature review, which entails synthesizing the theoretical literature and academic debate on a particular subject.

The objectives of the literature review are to:

1. Provide background information essential to the MISP, including
    a. Existing reproductive health (RH) infrastructure of country
    b. Host country RH policies
    c. Disaster risk reduction policies and procedures
    d. Demographic information
    e. Population-based indicators on RH
    f. Status of the humanitarian RH response
2. Facilitate the identification of cultural sensitivities, especially related to RH
3. Identify barriers and facilitating factors to implementing the MISP in previous process evaluations.

The literature review process involves conducting desk research to identify, summarize, and map qualitative and quantitative data using the enclosed tool. Literature refers to any existing material, such as published evaluations, sector/cluster meeting notes, and health information systems data. The tool provides guidance on what data to collect and where to find it.

Reviewing the literature is an ongoing process. Continue to monitor for updates and new research throughout the process evaluation.

## Key Informant Interviews

The purpose of undertaking key informant interviews (KIIs) during a MISP process evaluation is to understand the extent to which the MISP has been integrated into the humanitarian response and disaster risk and reduction (DRR) efforts.

The objectives of the KIIs are to:

1. Follow-up incomplete information from literature review on the integration of the MISP into DRR-related health policies and measures of the host country

2. Assess key informants' knowledge of the MISP and additional priorities
3. Explore key informants' knowledge about affected communities' priority RH concerns and needs
4. Explore key informants' engagement with affected communities including adolescents and persons with disabilities
5. Assess agencies' MISP response
6. Examine availability of MISP services
7. Explore accessibility of MISP services
8. Assess agencies' preparedness to implement the MISP
9. Determine key barriers and facilitating factors to MISP implementation in crisis response

Key informants include health, RH, HIV and gender-based violence (GBV) focal points representing:

- Ministry of Health (MOH) and other relevant government agencies such as National Disaster Risk Management (NDRM) agencies;
- Relevant United Nations (UN) agencies including the World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), UNAIDS and the United Nations Children's Fund (UNICEF); and
- Relevant international, national and local non-governmental organizations (NGOs).

Key informants are purposively selected prior to in-country data collection based on the MISP Literature Review. They are identified from the websites of the UN Office for the Coordination of Humanitarian Affairs (UNOCHA), UNHCR, Relief Web and any other coordination platforms that map who is doing what where in health and reproductive health in the emergency. Key informant representatives are also identified through further exploration via email with the agencies identified to ensure broad and thorough representation from the MOH, NDRM agencies, relevant UN agencies and international, national and local organizations. In addition, key informants are often identified once you are in the field as people make suggestions (called chain referral or snowball sampling). It may be necessary to undertake KIIs by Skype if informants are not available during the site visit. Please note key informants cannot be a member of the evaluation team.

The questionnaire, comprised of both closed-ended and open-ended questions, should be first piloted with three KIIs, including at least one in-country. The KIIs are undertaken by an individual knowledgeable and experienced in MISP implementation and, if possible, MISP evaluation. It is feasible for one person to conduct the interview as well as document the findings on the questionnaire, which takes approximately one hour to complete. Informed consent is to be obtained prior to initiating the interview.

## Health Facility Assessment

The health facility assessment (HFA) tool is to be used to assess health facilities for MISP implementation. The HFA tool examines the availability, quality and utilization of the clinical services of the MISP.

The objectives of the health facility assessment are to:

1. Establish the type of health facilities and their catchment population.

2. Explore the availability of basic infrastructure and systems at the health facility.
3. Determine health facility readiness with human and material resources.
4. Determine availability, accessibility and quality of MISP services.
5. Examine the utilization of MISP service.
6. Explore the availability of information about services at the health facility to the community.
7. Identify RH-related causes of morbidity and mortality at health facilities during the first 3-6 months after a disaster.

Health facilities are to be selected by their proximity and accessibility to refugees and internally displaced populations (IDPs) in both camp and non-camp settings. In addition to assessing the facility itself, individual interviews will be conducted using a purposive sample of health care providers representing different levels of the health system involved in the response. Depending on the size of the facility, with larger facilities requiring more diverse inputs, one to three interviews will be conducted per facility. The medical providers will be interviewed at a time and place most convenient to them. Note that providers should be interviewed when they are not seeing patients.

## CSPro Manual and Data Entry Forms for KII and HFA Analysis

The Census and Survey Processing System (CSPro) is a public domain software package can be used to enter, edit, tabulate, and disseminate census and survey data. A CSPro user manual and data entry forms are enclosed to assist in analyzing data from health facility assessments and key informant interviews. [See Appendix D: CSPro Files.] CSPro 6.1 can be downloaded for free at: https://www.census.gov/population/international/software/cspro/csprodownload.html. Alternatively, Excel can be used for quantitative data analysis.

## Focus Group Discussions

The purpose of undertaking focus group discussions (FGDs) during a MISP process evaluation is to better understand beneficiaries' (female and male) perceptions about and knowledge of reproductive health services, as related to the components of the MISP. It is not important that the beneficiaries understand the concept of the "MISP". The intent of the FGD is to gain information about beneficiary's knowledge of the available services, their perceptions of those services and barriers and facilitators to using reproductive health services.

The objectives of the FGD tool are to:

1. Understand the main sexual and reproductive health concerns among beneficiaries.
2. Explore beneficiaries' knowledge and perceptions of MISP services.
3. Gain insight on the availability of MISP services.
4. Explore factors that influence the accessibility of MISP services.

The data from FGDs offer the normative perspective from the community and can be compared against the data gathered through the other MISP evaluation tools to further understand factors influencing MISP services. Findings from FGDs can provide additional information about the general concerns of the

beneficiaries, which may inform programmatic decision-making. Certain questions about issues such as the use of anti-retroviral treatments and resources for survivors of sexual violence can be sensitive; thus, the FGD guide is designed to begin with broader questions to build trust before discussion of sensitive questions. During the design phase, it is crucial to carefully consider the context of the situation and assess that the general questions are culturally appropriate and sensitive. Modifications in the questions should be made, as necessary, to contextualize the tool for each setting.

Stratified purposeful sampling is used to recruit participants for the FGDs. Use of the purposive sampling technique allows the investigator to select participants based on specific characteristics and illustrate subgroups. Participants should be from crisis-affected populations and aged 18-49 years, with separate groups by sex and age (older: 24+ year and younger: 18-24 years). If legally and ethically possible, younger participants (youth or adolescents) may be recruited for sex-segregated discussions using child-friendly methods. Please find further guidance here.[1]

Participants can be selected with consideration of other demographics (e.g., socio-economic status, ethnic group and level of education). Stakeholders and relief agencies in the field should assist with defining the study population and recruitment of study participants.

**FGD Data Collection and Analysis**

*Preparation*
Prior to beginning data collection, it is essential that team members (facilitator and note-takers) are trained and prepared for data collection and the tools are pilot tested in each subgroup. [See Appendix F: MISP Evaluation Team Training – Sample Presention]. The interview questions should be translated, back-translated, and checked by research assistants during the training. A safe and private area should be identified in the planning phases to preserve confidentiality, such as a room in a school or community center. If held outside, there must be a form of crowd control to maintain privacy.

*Conducting the FGD*
When beginning a FGD, use the introduction section to ensure participants provide informed consent for participation. This includes a description of the study purpose, procedures, risks and benefits for participation, an opportunity to ask questions or share concerns, confidentiality, and voluntary participation. Informed consent must be obtained from all participants. [See Appendix E: FGD Consent Form].

Discussions are conducted by at least one facilitator and one note-taker. Responses can either be audio recorded and transcribed, or two note-takers can take comprehensive notes by hand in the language they are most comfortable. Note that use of a recording device may introduce challenges, as ambient noise can obscure the voices of participants and transcription is labor intensive. In cases where the facilitator does not speak the local language and an interpreter is needed, an interpreter can co-facilitate and the note-taker can write the notes in the local language and then translate them. FGDs last approximately 60 to 90 minutes and have the option of providing participants with a drink and/or snack at the end.

[1] Bennouna et al. Conflict and Health (2017) 11:5 DOI 10.1186/s13031-017-0108-y

To improve data quality, debrief sessions should take place immediately after each focus group, where the facilitator, note-taker(s) and interpreter can clarify notes and observations and document initial impressions in their field notes.

*Data Analysis*
One or two members of the evaluation team should develop an initial data analysis codebook guided by prevalent themes that emerged from the discussions based on the main topics covered. The team members should then finalize the codebook by applying it to a subset of transcripts (e.g. two to three). [See 6e. Example of Expanded Code List for FGD Data Analysis]. A second researcher can code a subset or all of the transcripts to triangulate across coders for additional insights. All FGD transcripts, field notes and memos should be reviewed during the analysis process. Coding and analysis can be conducted using a qualitative data analysis software, such as NVivo, ATLAS.ti, or Excel or by hand. During the analysis phase, emphasis is placed on identifying themes and patterns and selecting quotes to illustrate those findings.

For more information on FGDs, see FHI's Qualitative Research Methods: A Data Collector's Field Guide (2005).

## Field Observation

Field observation is a qualitative method in which the investigator observes and records her/his surroundings while in the study setting. While not a standardized activity, field observation can be useful to validate or challenge data gathered through the evaluation tools. Each member of the evaluation team should observe different areas within the camp or displaced setting. For example, try to observe how close the facilities that provide reproductive health services are situated in relation to where refugees/IDPs reside. At the facilities, observe the approximate number of women in line, whether or not chairs are available for waiting patients, and if any reproductive health-related IEC materials concerns are available. Record this data in a field notebook, as well as any anecdotal information provided by beneficiaries, and then compare this against the formal data that has been collected.