KIT Royal Tropical Institute

FIGO International Federation of Gynecology and Obstetrics
the Global Voice for Women's Health

ADVOCACY FOR SAFE ABORTION PROJECT

International Federation of Gynaecology and Obstetrics (FIGO)

Final Evaluation Methods Appendix

Introduction

This methods appendix for the final evaluation of the FIGO advocacy for safe abortion project serves to provide an overview of the methodology applied throughout the project in 10 countries. It can be used as a reference document to the individual country and synthesis reports.

Evaluation matrix

The final evaluation used a mixed methods design to collect and analyse both quantitative and qualitative data or information.
At the start of the end evaluation, an extensive evaluation matrix (Annex 1) was developed jointly between FIGO and KIT and with input from the societies. The matrix covers the key evaluation question under relevance, effectiveness, efficiency, sustainability and impact. It also describes the means of verification, sources of information (respondents and participants) and data collection methods applied to answer to the key evaluation questions. Below, a more detailed overview of the data collection methods used in this evaluation is presented.

Evaluation methods

Desk Review

A desk review of key documents took place at the start of the evaluation process in each of the 10 countries. The following types of evidence were included in the review: programme documents, such as action plans and progress reports; organizational policies and manuals; documents evidencing outcomes, including those following up activity reports; the outcome harvesting database; policies; guidelines; media items; public and organizational statements; and research reports.

Primary data collection

Outcome harvesting approach

In the course of the project outcome harvesting has been used to regularly monitor and reflect upon advocacy activities and results (a more detailed description on outcome harvesting can be found in annex 2). The harvested outcomes by the societies formed the starting point for the end evaluation and more outcomes were identified during the data collection process. The research team assessed and substantiated the outcomes together with a broad range of stakeholders such as the project teams, society members, healthcare staff, policy makers and others during stakeholder workshops, interviews and, in some cases, focus group discussions. Where more outcomes were generated during the data collection process, these have been included in the analysis and substantiation process and subsequently in the country reports. In some countries outcomes were very consistently generated, analysed and interpreted during the project and could as such be further dismantled and interpreted during the evaluation while in some other countries less outcomes were harvested by the local project team and the evaluation included the identification of outcomes in the data collection. Specific details for the countries can be found in the country reports.

Membership survey

A membership survey was conducted among obgyn society members about their professional attitudes towards abortion and their perspectives on the role of the national societies on advocacy for safe abortion. The survey was conducted at baseline to inform the project and repeated at endline to inform about the situation at the end of the project. A sample of the survey questions can be found in Annex 3. The questions and syntax were adapted for each country and used in Open Data Kit (ODK).

Capacity-strengthening survey among primary stakeholders

An online survey was conducted among project staff and other society members who received training from FIGO, to assess the usefulness of trainings and how the project contributed to strengthening the capacity of the societies (pathway 1 of the ToC). The survey gauged insights on management and organisation; finances; advocacy; communication; M&E and fundraising. The survey questions (Annex 4) were designed based on Kirkpatrick's model of training evaluation.[1] Issues identified in the capacity strengthening survey were further explored during the key-informant interviews with primary stakeholders.

Key-informant interviews primary stakeholders

In parallel to the surveys, qualitative interviews were conducted with the obgyn societies' project staff, focal point, executive committee members and safe abortion committee members amongst others, to respond to the evaluation questions related to relevance of the project, effectiveness of the five pathways of the Theory of Change, intended and unintended effects, efficiency of project implementation, learning and sustainability (see interview guide in Annex 5).

Semi-structured interviews and FGDs with secondary stakeholders (including social actors)

Semi-structured interviews were conducted with people who were influenced by or witnessed change (or a lack of change) as a result of the society's advocacy efforts. These included individuals, groups, communities, organizations or institutions. Examples are the Ministry of Health, Non-Governmental Organisations (NGOs), service providers

1. Kirkpatrick, Donald L. Evaluating Training Programs : the Four Levels. San Francisco : Emeryville, CA :Berrett-Koehler ; Publishers Group West [distributor], 1994.

(including gynaecologists, midwives, and general obgyn society members), community leaders and others who were targeted by advocacy. Selection of interviewees was context-specific and depended on the type of advocacy activities that took place.

For the semi-structured interviews with secondary stakeholders, two types of approaches were applied in relation to outcome harvesting:
1. For outcomes that were harvested by the PMU with sufficient evidence prior to the end evaluation, substantiation with secondary stakeholders took place to verify the accuracy of the outcomes and deepen the understanding of the significance and contribution of the project to this outcome.
2. In addition, where outcomes of certain activities and efforts were not harvested prior to the end evaluation, semi-structured interviews explored whether change did or did not take place and, what the significance was and to what extent the contribution of the project to the change could be established.

Depending on their knowledge of the project, secondary stakeholders were asked additional questions to assess the project's relevance, strength of the national society, intended and unintended effects and sustainability (see interview guide in Annex 6).

Semi-structured interviews international advocacy partners

In order to get an impression of the role FIGO played in the international field of safe abortion advocacy and to contribute to the cross-country analysis, semi-structured interviews were conducted with key partners in the international field. The interviews aimed to explore FIGO's contribution to international advocacy, how FIGO's activities and evidence are used to strengthen access to safe abortion globally and within UN standard-setting mechanisms and how this may or may not have supported advocacy at country level (see interview guide in Annex 7).

Sampling and recruitment

An overview of the type and number of participants and sampling strategy per method can be found in table 1 and is further described below.

Table 1. Table 1 Overview of methods, type of participants, sampling strategy and number of participants[2]

Method	Participants	Sampling strategy	Number of respondents
Membership survey	Obgyn society members	Convenience sampling	Varied per country, depending on membership, aiming for a similar # and representation as baseline
Capacity strengthening survey	Project management unit (PMU), focal point and others who received training by FIGO	Aiming to include all that have received training by FIGO	6-12
KII with primary stakeholders	PMU, focal point, executive committee members, safe abortion committee members	Purposive sampling	6-10
SSI and FGDs with secondary stakeholders	Network members, policymakers (MoH), health care workers/society members. Social actors (identified through the outcome harvesting database and action plans)	Purposive sampling	10-12

Membership survey

Probabilistic sampling was not feasible due to the limitations in having a complete and/or reliable sample frame for all or the majority of the societies. Therefore convenience sampling was applied with the aim to reach as many members of each society as possible (convenience sampling). Key events organized by the societies, such as the annual conference, were identified as the ideal occasion to conduct the survey. It was assumed that the societies' annual conferences were the events where the greatest number- and therefore largest variety- of members would be present and receptive to a survey. In case the dates of the annual conferences did not allow conducting the survey (at base- or endline) in line with the project timeline, other alternative meetings or approaches had to be identified:

- The selection of possible events or activities where the survey could be conducted took into account the following criteria:
  - Have invited all (or most) of the members of the Society
  - Have the highest expectation in terms of attendants
  - Are not focused on safe abortion themes but have a broad scope
- When convenience sampling during a key event was not possible due to various reasons including cancelation of face to face events due to COVID-19, respondents could also be sampled as randomly as possible from a list of members if available. This list was not necessarily

2. Actual number of participants in the surveys and interviews can be found in the country reports.

a complete one of the entire membership (hence not yet probabilistic sampling possible) and could be also, for example, be list of participants in the last society congress. Participants were randomly selected from these lists, invited and follow-up reminders were made via phone.

Data collectors recruited respondents at the selected events/activities. The surveys were self-administered using a tablet or a link for online administration on their own device. In some countries paper-based questionnaires were available in case that option was preferred. Data collectors explained the scope of the survey, asked for informed consent and then handed the tablet or paper to the respondent to fill in the survey by themselves. The respondents who used a tablet were instructed to mark the survey as complete when they finalised it. In case the data collector could not meet face-to-face, respondents were approached via phone, the procedures were explained and they were asked to fill out the survey online, while the research assistant remained available for questions. In some countries it was not possible to have exactly the same sampling strategy during base- and endline, though efforts were made to apply strategies as similar as possible. Country-specific details can be found in the country reports.

Capacity strengthening survey among primary stakeholders

An online questionnaire was sent out via Survey Monkey to the project staff and others who participated in capacity building activities by FIGO. As the respondents are known to the project, all email addresses were collected and contacted. Reminders were sent to increase the response rate. The survey did not take more than 10 minutes to complete and no names were collected. Moreover, the results were managed anonymously and data will be deleted three months after the country evaluation reports are completed.

Key-informant interviews primary stakeholders

The selection of key informants from among primary stakeholders was carried out by researchers based on lists of possible respondents and their characteristics provided by the project teams. As far as possible, researchers aimed to ensure diversity among participants with respect to age, gender and professional attitudes. The project team informed the potential respondents that they could be approached by researchers, and that project staff would not be informed about their participation or refusal to participate. The researchers obtained informed consent and conducted the interviews.

Semi-structured interviews and FGDs with secondary stakeholders

The following type of secondary stakeholders were considered for inclusion, depending on the relevance for the local context:

– Network members involved and not involved in implementation of project activities
– Society members who received training, trainers, members who received a small grant and members knowledgeable about the project but not directly involved
– Relevant policymakers, e.g. from MOH and other relevant Ministries, UN organisations, curriculum owners for health professional training who have CAC in their portfolio and or/were involved with SRHR policy, guidelines and curriculum development and implementation;
– Health workers, media, law enforcers and other secondary stakeholders who are knowledgeable about or influenced by the project, depending on the country context
– Community representatives and participants knowledgeable about SRHR activities and services in their community, and/or involved in project activities and living in an area the project or a project partner or participant(s) trained by the project were active in. Depending on the specific country activities, they consisted of adult men and women, youth above 18, members of Village Health Committees and participants in community activities linked to the project.

The outcome harvesting database and the action plan reports were used as one of the starting points for the selection of secondary stakeholders:

1. *Outcomes already harvested by the project staff* were selected from the outcome harvesting database. Project staff and knowledgeable partners were consulted on the relevance of the outcome and were requested to propose stakeholders who could substantiate the outcome. The selection focused on including social actors or observers of change that were not directly involved in implementation of the activity that the outcome is related to.
2. Also, *activities that had not yet generated outcomes/which outcomes were not yet documented* were selected based on the action plan of the project and respondents were selected in these areas. In this case, respondents were consulted to identify possible change, enabling and hindering factors in the change process.

The final selection of respondents was done by the researchers based on the lists of possible respondents and their characteristics and with the research team's knowledge of the local context. The selection process assured that a variety of opinions and observations among secondary stakeholders was included, as well as the intended and unintended effects and the influence of the wider context of the project. All respondents were 18 years or above and a variation in gender, age and socio-economic background has been taken into account to the extent possible. The PMU or the small grant owners informed the potential respondents that they may be approached by researchers for an interview. They confirmed to the potential respondents that they will not be informed about their participation and are free to take part or refuse. The researchers added relevant respondents from their own network where this would add to the contextual analysis. In some cases, project staff facilitated the organisation of the space for the interview but has not been present before, during or after the interview. The space where the interviews were held provided privacy to the respondents. The researchers obtained written informed consent.

Semi-structured interviews international advocacy partners

Together with FIGO HQ the research team compiled a list of key informants that were knowledgeable about the role of FIGO in the international field. Eight possible respondents were identified and invited for an interview, of which five agreed to participate.

Data procession and analysis

Data from each method was processed and analysed and then triangulated for reporting.

Data analysis of the survey

The survey data was analysed using Stata15E. The analysis was based on descriptive statistics at country level of all variables. The quantitative indicators of the final evaluation matrix were calculated for each country. A list of nine M&E indicators were calculated both at base- and endline (e.g. % of society members who are willing to provide safe abortion or make referrals according to the law). Due to the non-probabilistic sampling, the data at base- and endline were not representative of the full membership and an assessment on key demographics (e.g. age, gender, region of work, hospital level) showed that samples were not completely comparable. Therefore, a difference in percentage could not be interpreted as a change over time, and statistical significance could not be provided. Instead, there is an indication of the previous and current situation among a convenient sample.

Data analysis of the capacity strengthening survey

The data from the capacity strengthening survey was analysed in Survey Monkey. A descriptive analysis of the survey was conducted to identify capacity gained in the various capacity strengthening activities of FIGO, the most appreciated FIGO (training) activities, reasons for appreciation, the results of and factors influencing project support and access to resources.

Data analysis for the qualitative interviews and FGDs

Data from key informant interviews were transcribed. A coding frame was developed based on the evaluation framework and the ToC. A preliminary analysis was carried out between KIT staff, the national researcher and research assistants. A matrix analysis was used to compare conditions for success, barriers and opportunities for effective strategies for safe abortion advocacy, within the specific country context.

The semi-structured interviews with social actors were also transcribed and analysed. New emerging outcomes, unintended outcomes and negative outcomes were included and highlighted in the analysis. The transcripts were coded for contribution of the project to the outcome, significance of the outcomes, enabling and hindering factors and the conditions for success, barriers and opportunities of a specific intervention or outcome.

Validation meetings

In each of the 10 project countries preliminary results were discussed and validated with project staff via written feedback or during an online or hybrid workshop where also other stakeholders could join. These meetings were used to endorse or feedback on the main results and conclusions and to discuss the recommendations made in order for them to be actionable and make sense in the complex environments that the projects operate in.

Cross country analysis

A thematic cross-country analysis was conducted to identify commonalities in key findings and distil lessons learned across all countries. For this cross-country analysis, the five strategic pathways of the ToC were used in a matrix approach to collect the key findings for each country, including key results, project outcomes, main actors of change, conditions for success, challenges and mitigation strategies in project implementation and sustainability aspects. Subsequently common themes were identified and described, using the data from the various countries. To assess FIGO's role, data from the capacity strengthening survey from all 10 countries was used to demonstrate project staff perception on gained capacities and FIGO's role, amongst others. Qualitative interviews that were conducted with international partners were thematically analysed using an inductive approach and key findings were described.

Dissemination of results

The evaluation results are presented in 10 country and one synthesis report, which can be shared by FIGO and the societies with their partners. Some results may be further disseminated through the development of knowledge products in-country, e.g. policy briefs or scientific articles.

Ethical considerations

Risk-benefit

While the project activities in itself were not likely to generate potential risks, physical, psychological, social or legal, as they focused on professional perceptions within the existing legal and policy framework for abortion in the countries, the research team anticipated that respondents may feel some discomfort being asked about their beliefs in relation to abortion. Taking into account the potential discomfort, respondents answered survey questions on a tablet in a private environment and could withdraw at any moment from answering the questions. Discussions about changes in the community concentrated on general questions about changes observed in changes in SRHR related perceptions and services. Respondents in individual and group interviews were not asked for and were discouraged sharing personal experiences or opinions. Any persons who would express discomfort could be supported by experienced interviewers and if needed have access to a counsellor.

Safe abortion is a sensitive topic that is not easily discussed in public. The monitoring and evaluation of safe abortion advocacy in countries with a community component may have raised concern and lead to stigmatizing respondents when taking part in the evaluation. The national society and partner NGOs who have worked on this topic in the community have guided the research team on how to best use terminology to avoid people being stigmatized due to participation in evaluation activities specific on abortion.

The benefits of the end evaluation for the obstetrics and gynaecological associations lies in the creation of a process of joint learning, reflection and improvement of strategies. The research participants received reimbursement for travel or use of internet and mobile devices where applicable.

Informed consent

For all types of data collection, written consent was obtained except for online or telephone interviews where verbal consent was obtained. Please refer to Annex 8 for information sheets and consent forms. Respondents could refuse to participate, withdraw from the interview or refuse to answer questions at any time and this would not in any way affect their employment, status or access to services.

Privacy and confidentiality

All interview locations guaranteed privacy for the respondents. All survey transcripts and questionnaires only contain a unique identifier. There is no connection between transcripts and individual characteristics. Computer data was encrypted. All questionnaires, consent forms, topic guides and other material that could identify safe abortion as the focus of the evaluation was kept secure at all times and locked away during travel and field visits.

Procedures & logistics

KIT hired external research consultants in the regions to engage a fresh outsider perspective and enhance neutrality. All members of the research team were experienced in mixed-methods research in low- and middle-income countries. In some occasions, national researchers were supported by research assistants for data collection. Recruitment of research assistants and research officers experienced in either quantitative and/or qualitative data collection was done by the national research coordinator. Before the data collection started, KIT staff and the local research coordinator conducted a training workshop. Research assistants and research supervisors were trained specifically for the data collection phase and methods they were involved with.

Limitations

The sampling approach for the membership survey differed between baseline and end line. Both samples, at baseline and end line, were not representative of the full membership and were not completely comparable for key demographics. Therefore, a difference in percentage cannot be interpreted as a change over time. Instead, it gives an indication of the previous and current situation among a convenient sample.
For the qualitative data collection, there was difficulty in bringing healthcare providers together to conduct focus group discussions, mainly because of their busy work schedules. To mitigate this, the research teams opted to conduct semi-structured one-to-one interviews. In addition, most of the healthcare providers who participated in the qualitative interviews were of different cadres (nurses and clinical officers).

Outcome harvesting was introduced at the start of the project. Identifying the changes in stakeholders and working backwards was a new way of thinking about change for some participants. Also, thinking beyond output level and looking out for changes in the behaviour of stakeholders required another way of conducting monitoring. Outcome harvesting requires a significant amount of time of a group of stakeholders because discussing the outcomes and identifying the contribution and follow-up actions is best done in dialogue with stakeholders involved in the project. However, during the project implementation, there was not always sufficient time to invest in this dialogue. A more common limitation with outcome harvesting is that it captures outcomes that informants are aware of and that this may have led to some outcomes not being captured.

At the start of the project, a potential risk was identified in the research team's close involvement with the societies and how this could blur the distinction between the roles of implementation and evidence generation. Mitigation measures that were installed were a rigorous Quality Assurance process by two KIT senior researchers who are not involved as evaluators in the project. They have provided quality control to the research protocol and specifically the methods and reviewed all ten country reports and the synthesis report. Moreover, KIT hired external research consultants in the regions to strengthen objectivity.

Annexes

Annex 1. Evaluation Matrix

AREA OF INVESTIGATION: RELEVANCE				
Objective of analysing relevance: to investigate the extent to which target stakeholders find the intervention useful and valuable				
	Key evaluation questions	**Means of verification/indicators**	**Sources/key informants**	**Data collection method**
1	To what extent was the project design and set-up (working with member societies, focusing on advocacy and working with 5 different pathways) the right thing to do to create an enabling environment in the given contexts?	Assessment of the project's added value in relation to other processes ongoing at country level – this requires a thorough context analysis: understanding the (political) landscape at country level and an assessment of the project in relation to other initiatives Assessment of relative importance of each of the pathways in light of the overall results of the project Analysis of the Theory of Change (ToC), including reviewing the assumptions	At country level: MoH, network partners, NGOs working on Comprehensive Abortion Care (CAC)	Qualitative interviews with primary and secondary stakeholders
2	Did the project address the needs and priorities in relation to safe abortion of national ob/gyn societies and their members and how was this done?	Qualitative analysis of primary stakeholders' perception on the project's alignment with their priorities and needs: – Perspectives of PMU members/ Executive Committees/ Project Steering Committee and society members on alignment of the project with priorities of society – Perspectives of PMU members/ society members about changes within their society and relation with the project – Perspectives of society members on how the project navigated diversity of views and perception	PMU, executive committee and other primary stakeholders	Qualitative interviews with primary stakeholders
		Quantitative analysis of primary stakeholders' perception on the project's alignment with their priorities and needs: – % of (surveyed) society members who think that the project addressed the needs and priorities of the society on safe abortion – % of (surveyed) society members who think that the position on safe abortion of the Society changed by influence of the project – % of (surveyed) society members who think that the leadership of the Society on SRHR was strengthened in the last three years, influenced by the project – % of (surveyed) society members who think that the project contributed to (a) enhancing the skillset of service providers, (b) creating an enabling environment for CAC, and/or (c) addressing other needs of service providers	Sample of members	Membership survey

3	Did the project address the needs and priorities in relation to safe abortion of health care workers, media, community groups and policy makers (secondary stakeholders) and how was this done? *We will not focus on tertiary beneficiaries (e.g. women accessing CAC), since this is too much downstream in the results chain. However, in question 1: we propose to investigate whether a) working through the societies and b) focus on advocacy was the right thing to do to create an enabling environment for CAC.*	Qualitative analysis of secondary stakeholders' perception on the project's alignment with their priorities and needs: – Perspectives of service providers on the project's contribution to (a) enhancing their skillset and (b) an enabling environment for CAC, (c) their needs and priorities – Perspectives of media/ journalists on the project's contribution to (a) enhancing their skillset in reporting on CAC and/or ((b) an enabling environment for CAC, (c) their needs and priorities – Perspectives of community groups on the project's contribution to (a) their understanding of CAC and/or ((b) an enabling environment for CAC, (c) their needs and priorities – Perspectives of policy makers on the project's contribution to (a) data collection, provision and use, (b) contribution to clinical norms and guidelines and/or (c) their needs and priorities	Secondary stakeholders such as HCW, policy makers (MoH), media, community groups	Qualitative interviews with secondary stakeholders Results of training pre- and post-tests collected by societies

AREA OF INVESTIGATION: EFFECTIVENESS				
Objective of analysing effectiveness: to investigate if the project achieved its objectives and assess of the relative importance of the objectives and results				
	Key evaluation questions	**Means of verification/ indicators**	**Sources/key informants**	**Data collection method**
4	What have been the main changes throughout the project period in creating stronger management and organization of national societies and to what extent has the project contributed to this? (PATHWAY 1)	– Identification of the enabling and constraining factors in creating stronger management and organization of national societies Qualitative analysis of primary and secondary stakeholders' perception on the project's contribution to: • Societies' leadership on CAC (society as a whole) • Being equipped with the tools, expertise and capacity to conduct advocacy/implement the project • National advocacy on CAC (including assessment of international advocacy vis-à-vis country level advocacy) • Perception of changed attitudes in society's leadership (Ex committee/president) Quantitative analysis of primary stakeholders' perception on the change in functioning of the society: – OC In 1.2. % of society members who perceive the society's leadership role in SRHR for women, including access to safe abortion, to be (very) strong – OC In 1.1.1 % of society members who perceive that the communication of the society with its members on the institutional position on safe abortion is good (or excellent) – OC In 1.1.5 % of society members who indicate the Society facilitates its members involvement in advocacy for safe abortion – Self-assessment on professional skills development combined with data from FIGO's pre- and post-tests in the areas of: a. Management and organisation; b. Finances; c. Communication on safe abortion; Monitoring and Evaluation (M&E); e. Advocacy; f. Fundraising; g. Leadership – OC In 1.1.6. # PMU and executive board members who indicate to have access to and/or used supporting tools and documents for advocacy activities – OC In 1.1.3 stocktaking and description of policies and procedures (Human Resources, Financial, Audits, Constitution, ToRs) in place and operationalised structuring each National Society Quantitative indicators from FIGO M&E framework – # Trainings, # PMU trained, # members trained in:[3] Total and split by: Project management; Financial management; Advocacy and communications; Monitoring and evaluation; Fundraising; Leadership; SRHR, Comprehensive sexuality education? – Position statement written and disseminated [varies – 1.3.3/1.6 in Cameroon, 3.1 in Mali…] – Communication strategy developed and approved [e.g. 1.2.1 in Cameroon] – Other key activities around pathway 1.	PMU staff Executive committees Society members Network members and others who collaborated with the society	Qualitative interviews with primary and secondary stakeholders Membership survey endline Results of training pre- and post-tests collected by FIGO Capacity strengthening survey Desk review – action plans and reports + policies (quarterly and bi-annual)

3. Data has been collected at society level. This concerns both training delivered by FIGO and external partners. Please take care to not duplicate trainings delivered to multiple societies e.g. If HanValk was delivered to 5 Societies this should be recorded as 1 training across 5 Societies with X number of staff

5	What have been the main changes in relation to strengthening networks throughout the project period and to what extent has the project contributed to this? (PATHWAY 2)	– Identification of the enabling and constraining factors in building strong networks for safe abortion – Identification of signs of sustainability of project results – 2.1.1 [connectivity] Perception of network members about the efficiency of information sharing within the network – 2.1.2a [strength of the society in the network] Perception of (society) members about the level of engagement and leadership of the society in the network – 2.1.2b # of society members engaged and taking leadership positions in network for safe abortion advocacy – 2.1.3 [results] Perception of network members about collaboration among members and participation in advocacy activities Qualitative analysis of outcomes: harvested and substantiated outcomes will cover: – Position of society within network – Partnership with MoH/ UN/ (I)NGOs/ CSO – Linking with other stakeholders – Training and capacity of service providers Quantitative indicators from FIGO M&E framework – (Where relevant) # new networks established [e.g. 2.1 in Mali] – (Where existing networks] # new network organisational members since start of programme [e.g. 2.1 in Benin?] – # network meetings in the last 3 years – # Joint activities in the last 3 years [examples of activities incl. info on which society, in a call out box] – Other key activities around pathway 2	Network members PMU Society members	Qualitative interviews with secondary stakeholders (mainly network members) Outcome Harvesting and semi-structured interviews with social actors Desk review – action plans and reports + policies (quarterly and bi-annual)

6	What have been the main changes in relation to professional and public perception of CAC throughout the project period and to what extent has the project contributed to this? (PATHWAY 3)	– Identification of the enabling and constraining factors in working towards improved professional and public perception – Identification of signs of sustainability of project results Qualitative analysis of outcomes: harvested and substantiated outcomes will cover: *(professional perception)* – Development of professional norms and values – Value Clarification and Attitude Change (VCAT) – Perception and behavioural change – Implementation of professional code of conduct *(public perception)* – Changes within the media – Changes within communities, marriage counsellors, youth, schools etc. Indicators to be measured through membership survey endline): – OC In 3.1a Perception of society members on FIGO's statement of Resolution on Conscientious objection – OC In 3.1b % of society members who are willing to provide for safe abortion services according to the law – OC In 3.1c % of society members who are making referrals for safe abortion services according to the law – % (surveyed) society members who completed training, seminar or workshop on professional and personal norms and values towards legal and safe abortion in relation to abortion – % of (surveyed) members who completed a training (on VCAT, safe abortion or post-abortion care) by the society Quantitative indicators from reports/ FIGO M&E framework[4] – # VCAT training conducted & # attendees (feasible to split by attendee type or a list of attendee types) – # VCAT ToT training conducted and # attendees – # of sensitization sessions delivered to Parliamentarians and other government policy makers – # of sensitization sessions delivered to media personnel? – # of sensitization sessions delivered to lawyers and related professionals (e.g. police, correction services) – # of sensitization sessions delivered to communities – Other key activities around pathway 3	Health care workers Media/journalists MoH staff Policy makers Network members Action plans and reports + policies	Qualitative interviews with social actors & secondary stakeholders Outcome Harvesting Membership survey endline Desk review – action plans and reports + policies (quarterly and bi-annual)

4. Type of indicators to be collected here depends on activity plan and differs per country

7	What have been the main changes in relation to understanding of and navigating the legal framework for CAC throughout the project period and to what extent has the project contributed to this? (PATHWAY 4)	– Identification of the enabling and constraining factors in working towards improved legal framework – Identification of signs of sustainability of project results Qualitative analysis of outcomes: harvested and substantiated outcomes will cover: – Changed awareness among health providers, legal profession, communities about law – Stocktaking of what has been achieved in implementing existing law and guidelines – (OP In 4.1.1.2 # and description of disseminated guidelines (including the used format) through communication platforms (online, face-to-face) to health providers, facilities and other stakeholders) – Stocktaking of what has been achieved to amend Penal Code Indicators to be measured through membership survey endline): – OP In 4.1.1.1a # of society members who know the legal circumstances under which abortion is legal – OP In 4.1.1.1b # of society members who know the existence of national technical guidelines on safe abortion Quantitative indicators from reports/ FIGO M&E framework – # Awareness and dissemination of information on the law (sessions/workshops/trainings) by target audience e.g. society members, HCPs, policy makers, public – Other key activities around pathway 4[5]	MoH staff Network members Policy makers Health care workers	Qualitative interviews with social actors & secondary stakeholders Outcome Harvesting Membership survey endline Desk review – action plans and reports + policies (quarterly and bi-annual)

5. e.g. Kenya paper on legal framework drafted and disseminated

8	What have been the main changes in relation to improved data availability and use throughout the project period and to what extent has the project contributed to this? (PATHWAY 5)	– Identification of the enabling and constraining factors in working towards improved data availability and use – Identification of signs of sustainability of project results Qualitative analysis of outcomes: harvested and substantiated outcomes will cover: – Stocktaking of what has been achieved in advocacy for central monitoring system (OC In 5.1 Description of indicators capturing data on abortion are developed and integrated in central monitoring information systems (HMIS)) – Stocktaking of what has been achieved to identify and address knowledge gaps (including # of publications) – Stocktaking of what has been achieved in sharing, transferring and using knowledge and evidence for advocacy Quantitative indicators from reports/FIGO M&E framework: – # research studies completed by the society and subgrants – # of research findings included in advocacy activities (by the society) – # peer-reviewed journal publications – Other key activities around pathway 5[6]	Network members MoH Health Facility staff	Qualitative interviews with social actors & secondary stakeholders Outcome Harvesting Desk review – action plans and reports + policies (quarterly and bi-annual)
9	What have been the outputs and outcomes of FIGO international advocacy and how has this contributed to advocacy at national level? *And how has the project contributed to international advocacy?*	– Perspective of PMU members, Executive Committee and relevant stakeholders (network members) on how global advocacy on safe abortion contributed to bringing attention for the issue at national level – Perspective of FIGO staff on how the project contributed to international advocacy?	PMU Network members Selection of key stakeholders at international level (to be sourced by FIGO) + additional international stakeholders (e.g. IPPF, IPAS, MSI, WHO new platform – not In working relationship with FIGO)	Qualitative interviews with primary stakeholders and relevant secondary stakeholders (network members) Timeline analysis

6. e.g. Panama have been implementing digitization of SRHR data

10	What have been the unintended effects of the project, both positive and negative?	– Inventory of unintended effects	PMU FIGO staff Society members Network partners Other stakeholders	Qualitative interviews with primary stakeholders and relevant secondary stakeholders (e.g. network members)
11	How did learning take place in the project?	– Perspectives on learning between countries – Perspectives on how societies were supported with regional learning and ways FIGO can further support societies to have stronger regional networks	PMU FIGO	Qualitative interviews with primary stakeholders
AREA OF INVESTIGATION: EFFICIENCY				
Key objective of analysing efficiency: have the project results been delivered in a timely way and what were the enabling and hindering factors?				
	Key evaluation questions	**Means of verification/ indicators**	**Sources/key informants**	**Data collection method**
12	To what extent was the staff set up within the societies appropriate to carry out the project?	– Perception of staff on the level of clarity on their roles and responsibilities – Perception of staff on adequacy of personal / professional capacity strengthening – Overview of resources and tools developed and provided within the project – Perception of staff on adequacy of amount and quality of resources made available by FIGO – Perception of staff on adequacy on technical support from FIGO (advocacy, communication, M&E, finance and coordination) – Perception of staff on adequacy of support of the society leadership and Focal Point – Inventory of perceived additional support that would have improved project delivery (what was missing?)	PMU FIGO	Qualitative interviews with primary stakeholders Capacity strengthening survey
13	What was the impact of the covid-19 pandemic on the project implementation?	– Inventory of impact of COVID-19 on the delivery of activities and any other consequences and lessons learned – Inventory of adaptations due to COVID-19 pandemic including opportunities and events/activities that could not take place	PMU FIGO Selected society members	Qualitative interviews with primary stakeholders
14	What were the enabling and hindering factors for project implementation?	– Inventory of type of enabling and hindering factors mentioned	FIGO PMU	Qualitative interviews with primary stakeholders

AREA OF INVESTIGATION: SUSTAINABILITY				
Key objective of analysing sustainability: will the benefits of the project last beyond the project's lifespan?				
	Key evaluation questions	**Means of verification/indicators**	**Sources/key informants**	**Data collection method**
15	What is the likelihood of the project's results to be sustained?	– Inventory of aspects of the project which are likely and unlikely to be sustained after the end of the project – Inventory of the signs that the project's benefits will last at organizational and programmatic level as well as financially	PMU/selected society and network members/ FIGO	Qualitative interviews with primary stakeholders and relevant secondary stakeholders
16	How has the project contributed to the organisational sustainability?	– Perspective of PMU and key society members on the stability of the organisation (in terms of governance, finances, capacity etc), and the project's contribution to it – Perspective of PMU and key society members on sustainability of society's engagement with ob/gyn regional networks Quantitative indicators from the FIGO M&E framework & reports (depending on action plan per country): – # manuals developed (and disseminated?) [e.g. 1.2.1 in Peru] – Sustainability strategy developed and approved [e.g. 1.2 in Panama] – Business case developed	PMU	Qualitative interviews with primary stakeholders Desk review – action plans and reports + policies (quarterly and bi-annual)
17	What is needed by the societies in order to continue its work as advocates for safe abortion?	– Inventory of barriers to sustainability – Inventory of needs expressed by societies to continue its work as advocates for SA/CAC that could be provided by FIGO	PMU/selected society and network members	Qualitative interviews with primary stakeholders
AREA OF INVESTIGATION: IMPACT				
	Key evaluation questions	**Means of verification/ indicators**	**Sources/key informants**	**Data collection method**
18	What are the 3 things the project contributed to most?	– Testimonies (to be put in boxes throughout the report – like quotes)	PMU Network members Society members Secondary stakeholders	Qualitative interviews with primary and secondary stakeholders, including social actors

Annex 2. Outcome Harvesting

Outcome Harvesting (OH) is a Monitoring & Evaluation (M&E) tool deriving from the 'utilization branch of evaluation', and the 'Outcome Mapping'. Rather than measuring progress in the implementation of activities, this method focuses on collecting information about what has changed in behaviour, relationships, actions and policies, positively or negatively, intended or unintended, direct or indirect, and how actions contributed to this change and to the desired outcomes.

OH collects ("harvests") evidence of what has changed and then, working backwards, defines whether and how a programme contributed to these changes. Compared to conventional M&E approaches, OH provides a more in-depth understanding of the programme's outcomes. Outcome harvesting is particularly useful in complex situations and areas of work such as advocacy or policy influencing, mobilisation, capacity development, empowerment and network development, where there may be different actors influencing change. Outcome harvesting is particularly appropriate when the focus of M&E is on learning in order to improve future performance. In the case of this project it served to reflect on and learn from (anticipated and unanticipated) change influenced through advocacy: how did advocacy influence others (people, systems, organizations; also called social actors)?

During the project OH has been used for ongoing monitoring, in order to produce real-time information on change for decision-making. The outcome harvesting process during the ASA project was designed to encourage the participation of different stakeholders in M&E, which is key in the approach. Outcome harvesting uses a broad range of techniques to collect information: information 'harvested' from reports, dialogues during activities and other sources, such as media tracking, political statements and conversations with influential people [20-21].

- A **change agent** is an individual or organization that influences an outcome. In this project, the change agents are the FIGO headquarters and national societies and their partners (in case they implement activities).
- A **social actor** is an individual, group, community, organization or institution that changes because of a change agent's intervention. In this project, that could be the Ministry of Health, NGOs, service providers (including gynaecologists), community leaders, women and others.
- The **harvest user** is the stakeholder who uses the findings of an outcome harvest to make decisions or take action. In this project, harvest users are the people at FIGO headquarters, the obgyn national societies with their partners and, to a lesser extent, KIT. At the end of the line, the donor is also considered a harvest user.
- The **harvester** is the person or people responsible for managing the outcome harvest. In this project, this will be the person responsible for M&E in the PMU at country level. This person will manage and coordinate the outcome harvesting process at country level and should facilitate and support open participation during the process.
- **An outcome** is a change in the behaviour, relationships, actions, activities, policies or practices of an individual, group, community, organization or institution (the social actor) that the project aims to influence, but does not control. (Changes that are clearly unrelated to the programme are not included as outcomes).

Source: Adapted from Wilson-Grau and Britt (2013)

Annex 3. Capacity strengthening survey

Process: One survey was developed for all the 10 countries with questions in English, Spanish, Portuguese, French Tailor-made approach per country: Each of the survey questions was be contextualized to the realities of the various countries

Dissemination: Through PMU coordinator to rest of the team and where relevant, executive members/members of technical working group in society

Target audience: Primary stakeholders such as: project management unit (PMU), focal point and others who received training by FIGO

Objective: To gauge the utilization of learnings and the contribution of the project to capacity strengthening. Findings of the survey will be further explored during key informant interviews

Demographics

In which country are you based?	
What is your position in the ASA project?	PMU member; leadership of society; other, namely ….

Capacity strengthening in the ASA project

The following questions aim to gauge your learnings and newly acquired behaviour after the capacity strengthening activities delivered by FIGO through/with the society during the ASA project (2019 – 2022). These include trainings/ capacity strengthening activities in the areas of advocacy, communication, social media, finance, M&E, evidence on abortion, fundraising. If you have not received training on these aspects please check 'not applicable' (N/A).

On a scale from 1-5 (1=not at all, 2=a little, 3=somewhat, 4=a lot, 5=to a great extent, N/A =not applicable), please rate:	1 2 3 4 5 N/A
After advocacy and communication training(s), how confident are you in your ability to write an effective communication piece on access to Comprehensive Abortion Care (CAC), including safe abortion within the context of the law?[7]	
After advocacy and communication training(s), how confident are you in your ability to develop an effective advocacy strategy for CAC?	
After advocacy and communication training(s), could you indicate how much your acquired skills and knowledge have improved, as compared to before the training?	

7. In countries where abortion law is more restrictive and space to maneuver is limited, the addition of 'including safe abortion within the context of the law' will be added.

After social media training(s), how confident are you in your ability to write, publish and assess analytics for a social media post?	
After social media training(s), could you indicate how much your acquired skills and knowledge have improved, as compared to before the training?	
After finance training(s), how confident are you in your ability to use the trained budgeting and accounting tools to manage finance?	
After finance training(s), could you indicate how much your acquired skills and knowledge have improved, as compared to before the training?	
After M&E training(s), how confident are you in your ability to contribute to output monitoring and outcome harvesting?	
After M&E training(s), could you indicate how much your acquired skills and knowledge have improved, as compared to before the training?	
After training(s) on abortion research and data (including the Guttmacher training and any others), how confident are you in your ability to study and communicate evidence on abortion?	
After training(s) on abortion research and data (including the Guttmacher training and any others), could you indicate how much your acquired skills and knowledge have improved, as compared to before the training?	
After fundraising training(s) (including the HanValk training and any others), how confident are you in your ability to develop a proposal for fundraising?	
After fundraising training(s) (including the HanValk training and any others), could you indicate how much your acquired skills and knowledge have improved, as compared to before the training?	
After the High Impact Learning training, how confident are you in your ability to develop and deliver a training session?	
After the High Impact Learning training, could you indicate how much your acquired skills and knowledge have improved, as compared to before the training?	

Thinking back on your experience with trainings and other capacity strengthening activities in the project, which 3 have been the most successful for you? Why? 1. 2. 3.
Thinking back on your experience with trainings and capacity strengthening activities in the project, which have been unsuccessful or not as successful as they should have been? Why?
Thinking back on the capacity strengthening within the project, which of the trainings were of most value?
Do you have any comments on how to make capacity strengthening more effective?

Project Support

The following questions aim to gauge your perception on the effectiveness of the support delivered to the project.

On a scale from 1-5 (1=not at all, 2=a little, 3=somewhat, 4=a lot, 5=to a great extent, N/A =not applicable), please rate:	1	2	3	4	5	N/A
My role within the project is clear to me						
Please provide additional comments						
FIGO's technical support to the project implementation was timely and of good quality						
Please provide additional comments						
KIT's technical support in guiding Outcome Harvesting to support the M&E function of the project was timely and of good quality						
Please provide additional comments						
The resources made available by FIGO to support the project were sufficient and of good quality						
Please provide additional comments						
Society's leadership and the Focal Point (where applicable) supported the project[8]						
Please provide additional comments						
Which support has been lacking that would have made the project more successful? Please elaborate						

Access to resources

On a scale from 1-5 (1=not at all, 2=a little, 3=somewhat, 4=a lot, 5=to a great extent, N/A =not applicable), please rate:	1	2	3	4	5	N/A
FIGO has provided the project with the tool and documents to support advocacy activities						
I use the tools and resources provided by FIGO on a regular basis or as needed for my work						
I found the regional learning events useful to connect with and learn from other countries						
I have linked up with other country teams for learning on a regular basis						

8. Skip logic needed to ensure that focal point/ president will skip this question

Annex 4. Membership survey

FIGO Kenya endline survey Feb

Section 0. Membership and consent

0.01 Are you a gynaecologist/obstetrician?

- yes
- no

Kenya Obstetrical and Gynaecological Society (KOGS) and The Royal Tropical Institute (KIT) from the Netherlands are conducting an endline survey for the three years project of the International Federation of Gynaecology and Obstetrics (FIGO) (2019-2022) on strengthening the Kenya Obstetrical and Gynaecological Society and supporting their work on the prevention of maternal mortality arising from unsafe abortion and improvement of post abortion care.

The benefits from your participation in the survey will be the opportunity to share your own perspectives on the KOGS and on safe abortion.

For this survey ethical approval was obtained from the Mount Kenya ERB.

Purpose and questions asked: The survey has been developed by the Royal Tropical Institute in the Netherlands and has four main domains; The survey contains questions on your membership of the Kenya Obstetrical and Gynaecological Society (KOGS), the communication and advocacy strategy of the society, the position of the society towards abortion and your own professional position towards abortion. To ensure all voices are heard, as many members of the society as possible will be asked to respond to the survey. Your collaboration is highly appreciated and we value your honest opinion. The survey is completely anonymous and your identity will remain strictly confidential. Your name will not be taken nor used anywhere. The survey is self-administered, you will respond by yourself in a place that feels comfortable and private for you to complete.

It will take about 20 minutes to fill out the survey.

0.02 Do you have any questions regarding the information given to you?
If you have questions a research assistant is available at the conference ground to address them

- yes
- no

0.03 Briefly describe
Please address the questions that the participant might have

0.04 Have your questions been correctly addressed

- yes
- no

0.05 Do you agree to participate in the survey?

- yes
- no

1.01 Gender

- ○ female
- ○ male
- ○ no answer
- ○ Other

Specify other.

1.02 Age

Please slide the dot on the scale to indicate your age

18 ... 100

1.03 For how long have you been a gynaecologist/obstetrician?

- ○ For less than 5 years
- ○ For 5 to 15 years
- ○ For 15 to 30 years
- ○ For more than 30 years

1.04 Where are you currently working as a gynaecologist/obstetrician?

Multiple answers possible (if you currently work at different hospitals)

- ☐ In a private clinic
- ☐ Level VI hospital
- ☐ Level V hospital
- ☐ Level IV hospital
- ☐ Other

Specify other.

1.01 Gender

- ◯ female
- ◯ male
- ◯ no answer
- ◯ Other

Specify other.

1.02 Age

Please slide the dot on the scale to indicate your age

18 — 100

1.03 For how long have you been a gynaecologist/obstetrician?

- ◯ For less than 5 years
- ◯ For 5 to 15 years
- ◯ For 15 to 30 years
- ◯ For more than 30 years

1.04 Where are you currently working as a gynaecologist/obstetrician?

Multiple answers possible (if you currently work at different hospitals)

- ☐ In a private clinic
- ☐ Level VI hospital
- ☐ Level V hospital
- ☐ Level IV hospital
- ☐ Other

Specify other.

1.05 Where is the clinic/hospital where you are working?
Multiple answers possible (if you currently work in different regions)

- ☐ Nairobi
- ☐ Regional center (e.g. Mombasa, Kisumu, Eldoret, Nakuru)
- ☐ Other town
- ☐ Rural area
- ☐ Other

Specify other.

____

1.06 Are you a member of the Kenya Obstetrical and Gynaecological Society?

- ○ yes
- ○ no

1.07 For how long have you been a member of the Kenya Obstetrical and Gynaecological Society (KOGS)?

- ○ For less than 5 years
- ○ For 5 to 15 years
- ○ For 15 to 30 years
- ○ For more than 30 years

1.08 Are you an actively paying member of KOGS (ie. did you pay annual contribution in 2021)?

- ○ yes
- ○ no

1.09 How involved are you with the KOGS?

- ○ Not involved
- ○ Slightly involved (keep informed)
- ○ Moderately involved (e.g. keep informed and/or occasionally attend a meeting or activity)
- ○ Very involved (e.g. regularly attending meetings and activities)
- ○ Extremely involved (e.g. taking leadership roles in committees or activities)

1.10 What activities or events of KOGS do you attend?
Multiple answers possible

- ☐ Regular meetings
- ☐ Special Thematic meetings
- ☐ Conferences
- ☐ Trainings
- ☐ None
- ☐ Other

Specify other.

1.11 How frequently do you attend activities/events of KOGS?

- ◯ Never
- ◯ Rarely (less than once per year)
- ◯ Sometimes (may be once per year)
- ◯ Often (multiple times per year)
- ◯ Always

1.12 How informed are you about the KOGS/FIGO project on the prevention of maternal mortality arising from unsafe abortion and improvement of post abortion care with the International Federations of Gynaecologists and Obstetrics-FIGO?

- ◯ Not informed
- ◯ Slightly informed (e.g. you have heard of it)
- ◯ Moderately informed (e.g. occasionly read something about projects)
- ◯ Very informed (e.g. actively keeping upto date with certain projects)
- ◯ Extremely informed (e.g. when you are having a leadership role in a project)

1.13 How involved are you with KOGS-FIGO projects/work on the prevention of maternal mortality arising from unsafe abortion and improvement of post abortion care?

- ◯ Not involved
- ◯ Slightly involved (keep informed)
- ◯ Moderately involved (e.g. keep informed and/or occasionally attend a meeting or activity)
- ◯ Very involved (e.g. regularly attending meetings and activities)
- ◯ Extremely involved (e.g. taking leadership roles in committees or activities)
- ◯ I don't know of any KOGS-FIGO projects

1.14 To what extent did the project on the prevention of maternal mortality arising from unsafe abortion and improvement of post abortion care address the needs and priorities of the KOGS on abortion care, including safe abortion?

- ◯ 1- Not at all
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5- To a great extent

1.15 How?

Section 2. About the Kenya Obstetrical and Gynaecological Society position and role on safe abortion

We would like to know more about the KOGS and its position and role on safe abortion. As a member of the KOGS we invite you to answer the following questions:

2.01 Does the KOGS have a position towards safe abortion?

- ◯ Yes
- ◯ No
- ◯ I don´t know

2.02 If yes, what is the KOGS´ position towards safe abortion?

Briefly describe

2.03 In your opinion, is the position on safe abortion of the KOGS:

Select all the characteristcs that apply for the Society's position on safe abortion

- ☐ Publicly available
- ☐ Adopted at an institutional level
- ☐ Known by its members
- ☐ Known by other key stakeholders

2.04 To what extent has the position on safe abortion of the KOGS changed in the last three years?

- ◯ 1- Not at all
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5- To a great extent

2.05 Were the changes influenced by the project on the prevention of maternal mortality arising from unsafe abortion and improvement of post abortion care?

- ◯ yes
- ◯ no

How would you rate the communication of the KOGS with its members on:

Rate from 1-5: 1 (very poor), 2 (poor), 3 (average), 4 (good), 5 (excellent)

	1 - Very poor	2	3	4	5 - Excellent	I do not have an answer
2.06 The KOGS' management	◯	◯	◯	◯	◯	◯
2.07 The KOGS's general activities (e.g annual conference)	◯	◯	◯	◯	◯	◯
2.08 The KOGS's position towards safe abortion	◯	◯	◯	◯	◯	◯

2.09 The KOGS's activities on safe abortion	◯	◯	◯	◯	◯	◯
2.10 New evidence on abortion, abortion technical guidelines, policies and/or laws	◯	◯	◯	◯	◯	◯

2.11 How does the KOGS inform members about its position towards safe abortion?
Multiple answers possible

- ☐ Mails
- ☐ Institutional communication materials
- ☐ In meetings
- ☐ Through trainings
- ☐ The Society does not inform about it
- ☐ I don't know
- ☐ Other

Specify other.

____

2.12 How does the KOGS inform members about new evidence on abortion, abortion laws, policies and practices?
Multiple answers possible

- ☐ Mails
- ☐ Institutional communication materials
- ☐ In meetings
- ☐ Through trainings
- ☐ The Society does not inform about it
- ☐ I don't know
- ☐ Other

Specify other.

____

2.13 What role does the KOGS play in advocacy for safe abortion?
Multiple answers possible. Advocacy understood as a strategic use of information and action to shape opinions, policies and practices.

- ☐ The KOGS plays no role in advocacy for safe abortion
- ☐ The KOGS shares technical recommendations on safe abortion to Key Stakeholders (e.g. MoH)
- ☐ The KOGS generates evidence on safe abortion (research, data registers)
- ☐ The KOGS informs its members and/or health providers about the legal frameworks and technical guidelines
- ☐ The KOGS promotes reflections on professional attitudes towards safe and legal abortion
- ☐ The KOGS creates partnerships with other stakeholders to improve access to safe abortion
- ☐ I don't know
- ☐ Other

Specify other.

____

2.14 How would you rate the leadership role of the KOGS in SRHR for women, including abortion?

- ◯ Poor/weak
- ◯ Fair
- ◯ Good/strong
- ◯ Very good/strong
- ◯ Extremely good/strong

2.15 To what extent has the leadership role of the KOGS in SRHR for women, including abortion been strengthened in the last three years?

- ◯ 1- Not at all
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5- To a great extent

2.16 Was this influenced by the project on the prevention of maternal mortality arising from unsafe abortion and improvement of post abortion care?

- ◯ yes
- ◯ no

2.17 Does the KOGS facilitate the involvement of its members in advocacy for safe abortion?

Advocacy understood as a strategic use of information and action to shape opinions, policies and practices.

- ◯ 1- Not at all
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5- To a great extent

2.18 How does the KOGS facilitate its members involvement in advocacy for safe abortion

Multiple answers possible

- ☐ Providing trainings or webinars on advocay
- ☐ Sharing materials, toolkits and guiding documents
- ☐ Encouraging members to participate in meetings with key stakeholders about safe abortion
- ☐ Publishing or presenting members papers on safe abortion related topics (E.g. in the Society Journal or annual conference)
- ☐ Inviting members to provide input in the development of technical guideline on safe abortion
- ☐ Other

Specify other.

Have you ever received any in service training on the following themes:
Mark yes or no for each theme

	yes	no
2.19 Safe abortion care	○	○
2.20 Post abortion care	○	○
2.21 Reflections on professional values in relation to abortion (e.g. VCAT)	○	○

2.22 Who provided these trainings?
Multiple answers possible

- ☐ The KOGS
- ☐ A health facility
- ☐ The Ministry of Health
- ☐ A university
- ☐ An NGO
- ☐ I did not receive any in service training on the mentioned themes
- ☐ Other

Specify other.

To what extent do you think the the project on the prevention of maternal mortality arising from unsafe abortion and improvement of post abortion care contributed to the following?
Rate from 1- 5: 1(not at all), 2 (to a small extent), 3 (to some extent), 4 (to a moderate extent), 5 (to a large extent).

	1- Not at all	2	3	4	5- To a great extent
2.23 Enhancing the skillsets of service providers	○	○	○	○	○
2.24 Creating an enabling environment for Safe Abortion Care within the context of the law	○	○	○	○	○
2.25 Addressing other needs of service providers	○	○	○	○	○

2.26 What needs?

Section 3. About your professional position towards safe abortion

In this section we invite you to answer some questions on your professional position towards safe abortion: what is your perspective and opinion as a gynaecologists/obstetrician on safe abortion. Please remember that all the answers remain completely anonymous.

How informed do you feel about the following themes:

Rate from 1-5: 1 (not informed), 2 (slightly informed), 3 (moderately informed), 4 (informed), 5 (very informed)

---

	1 - Not informed	2	3	4	5 - Very informed
3.01 The national laws on safe abortion	◯	◯	◯	◯	◯
3.02 International guidelines on safe abortion	◯	◯	◯	◯	◯
3.03 National Policies on safe abortion	◯	◯	◯	◯	◯
3.04 Practical information related to the practice of safe abortion (guidelines, recommendations, procedures)	◯	◯	◯	◯	◯
3.05 International guidelines on post abortion care	◯	◯	◯	◯	◯
3.06 National policies on post abortion care	◯	◯	◯	◯	◯
3.07 Practical information related to post abortion care (guidelines, recommendations)	◯	◯	◯	◯	◯

3.08 Under which circumstances is abortion legal in your country?

Multiple answers possible.

- ☐ Never
- ☐ To save a woman's life
- ☐ In cases of rape or incest
- ☐ Because of foetal impairment
- ☐ To preserve a woman's physical health
- ☐ For economic or social reasons
- ☐ To preserve a woman's mental health
- ☐ Always, on request
- ☐ Other

Specify other.

3.09 Is there a National Technical Guideline on Safe abortion in Kenya?

- ◯ Yes
- ◯ No
- ◯ I don´t know

To what extent do you agree or disagree with the following statements about the role of health workers as abortion providers?

Select from 1 to 5: 1 (strongly disagree), 2 (disagree), 3 (neutral), 4 (agree), 5 (strongly agree)

	1- Strongly disagree	2- Disagree	3- Neutral	4- Agree	5- Strongly agree
3.10 Safe abortion should be part of healthcare and should not be separeted from the rest of medicine	○	○	○	○	○
3.11 Safe abortion should be prohibited in the public health system	○	○	○	○	○
3.12 Post abortion care should be part of health care and should not be separated from the rest of medicine	○	○	○	○	○
3.13 Health providers should be able to decide whether to perform or not safe abortions without any referral obligations	○	○	○	○	○
3.14 Health providers should provide public notice of professional services they decline to undertake on grounds of conscience, including legal safe abortions.	○	○	○	○	○
3.15 Health providers opposing to perform legal safe abortions should refer women to other health workers that will perform a legal safe abortion	○	○	○	○	○
3.16 Health providers should provide timely safe abortion care within the extent of the law to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well-being;	○	○	○	○	○
3.17 In emergency situations, all health providers should provide safe abortion care within the extent of the law regardless of their personal objections.	○	○	○	○	○
3.18 Health providers can never refuse providing post abortion care using claims of conscientious objection	○	○	○	○	○
3.19 Health workers have a role to play as advocates for safe abortion	○	○	○	○	○

3.20 What would you do if you receive an abortion request under circumstances permitted by law?

- ○ I would advise her to continue with her pregnancy and refer her to another health worker
- ○ I would refer her to another health worker who can inform about and provide a legal safe abortion
- ○ I would inform her about legal safe abortion procedures and eventually provide it in line with the national technical guidelines
- ○ Other

Specify other.

3.21 Do you think that Kenya Obstetrical and Gynaecological Society should play a role in advocacy for safe abortion?

- ◯ Yes
- ◯ No
- ◯ I don´t know

3.22 Have you ever been involved in advocacy for safe abortion?

- ◯ Yes
- ◯ No
- ◯ I don´t know

3.23 In what role have you ever been involved in advocacy for safe abortion?
Multiple answers possible.

- ☐ Developing technical recommendations on safe abortion
- ☐ Generating new evidence on safe abortion (research, data registers)
- ☐ Disseminating and communicating with members and/or health providers about the legal frameworks and technical guidelines
- ☐ Actively promoting reflections on professional attitudes towards safe and legal abortion
- ☐ Developing partnerships with other stakeholders to improve access to safe abortion
- ☐ Other

Specify other.

3.24 Was your involvement in advocacy for safe abortion through the KOGS or independently?

- ◯ Through the KOGS
- ◯ Independently
- ◯ Both through the KOGS and independetly
- ◯ Other

Specify other.

3.25 Was your involvement influenced by the project on the prevention of maternal mortality arising from unsafe abortion and improvement of post abortion care?

- ◯ yes
- ◯ no

3.26 How?

3.27 Would you support the Kenya Obstetrical and Gynaecological Society in advocacy for safe abortion?

- Definitely not
- Probably not
- Possibly
- Very Probably
- Definitely
- I don't know

3.28 In what role would you support the Kenya Obstetrical and Gynaecological Society in advocacy for safe abortion?
Multiple answers possible.

- Developing technical recommendations on safe abortion
- Generating new evidence on safe abortion (research, data registers)
- Disseminating and communicating with members and/or health providers about the legal frameworks and technical guidelines
- Actively promoting reflections on professional attitudes towards safe and legal abortion
- Developing partnerships with other stakeholders to improve access to safe abortion
- Other

Specify other.

Section 4. Final comments

4.01 Is your personal position on abortion different or similar to your professional position?

- Similar
- Different
- I don't know
- No answer

4.02 Explain
This is not a mandatory question

4.03 Any other comments you would like to share

You have reached the end of the survey. We thank you for your time and participation.

Annex 5. Key Informant interview primary stakeholders

Participants: PMU, focal point, executive committee members, safe abortion committee members (tailored to the specific contexts of each country)
Please note this is a topic guide and should be used as such, meaning questions will be asked in and probed for in such a way they are relevant for the respondent.

Relevance

Questions	Probe for
1. To what extent do you think this project is relevant and appropriate for creating an enabling environment for safe abortion in the country?	– The relevance of doing this through obgyn societies – The relevance of focusing on advocacy
2. To what extent do you think (each of) the five pathways (i.e. objectives) are relevant and appropriate for creating an enabling environment for safe abortion in the country?	– The relevance of: strengthening organization & management, strengthening networks, improving professionals & public perception, sensitization & implementation of legal frameworks, generation and use of data – What was missed? – Or: what would you in hindsight focus less on?
3. To what extent was the project design aligned with and adding to other initiatives in the country?	– Building on previous initiatives – Duplications
4. To what extent did the project align with needs and priorities from the national obgyn society?	– Was focus/were activities on certain needs/priorities missing?
5. The membership of a national society naturally contains a diversity of views and perceptions, how did the project navigate this diversity?	– Challenges and successes

Effectiveness and sustainability pathway 1

6. The project's pathway 1 in particular focused on strengthening the society. Do you think the project has been successful in doing this?	– governance, finances, capacity, etc.
7. To what extent is the obgyn society equipped with the tools, expertise and capacity to conduct advocacy as a result of the project?	– Trainings, materials, skills – How have they used/applied it? – How did it influence your work?
8. Can you elaborate on which new policies and procedures are in place and operationalized to structure the obgyn society, as a result of the project?	– e.g. Human Resources, Financial, Audits, Constitution, ToRs – Are these operationalized? How?
9. What internal changes with regards to perceptions and views on safe abortion in the obgyn society took place with this project?	
10. Have you seen changes in perception and attitude among the society's leadership structures (executive committee etc) in relation to CAC?	– Which changes? How?

11. To what extent did you see a change in the leadership position of the obgyn society on Comprehensive abortion care, as a result of this project?	– The society as a public institution taking action/showing leadership on the matter
12. Which unintended effects have you seen from the project?	– Positive and negative effects
13. Do you think the society will continue to be strengthened at the end of the current phase of the project?	– How? – Give examples
14. How about your network collaborations, in country and regionally (with other obgyn societies)?	– Sustainability of collaborations

Project implementation

15. A PMU was set up to carry out the project: to what extent was the composition of the PMU the right one?	– Were roles and responsibilities clear? – Anything missed?
16. How did you experience: – professional support/capacity strengthening from the project – provision of resources – technical support from FIGO – technical support from KIT – support from the society's leadership	– Tangible examples of how someone or the society's capacity increased – Resources/support in advocacy, communication, M&E, finance and coordination – What was missing? – What could be improved?
17. Which global events contributed to national advocacy and how? (open question)	
18. After this show the timeline outlining the various global activities and ask: – which activities are known/recognized? – which ones contributed to national advocacy efforts and change? – which ones were seen as most significant and why?	
19. Can you describe the effect of the Covid-19 pandemic on the implementation of the project? 20. What adaptations did you make?	– Mitigation actions
21. What (other) hindering factors did you face in implementing the project?	– How it affected the project – Mitigation strategies
22. What were some enabling factors for project implementation?	
23. How did you experience the learning between countries in the project?	
24. How can FIGO further support obgyn societies to have stronger regional networks?	

Overall sustainability

25. The current phase of the project will end at the end of March 2022. To what extent are the achievements of the society sustainable?	– Organisational sustainability (proper working of the organization structures that were developed as part of the project and/or the ability of systems developed to continue to function effectively) – Financial sustainability (ensuring a steady flow of funds and generating revenue for maintaining and continuing the organisations work) – Programmatic sustainability (continuation of the organization's projects to work towards improving access to safe abortion in the absence of donor support) – Social sustainability (social, cultural, legal changes that resulted from the project that will have a long-term impact and continue to provide benefits to the target community even after the grant expires)
26. What is needed by the societies in order to continue its work as advocates for safe abortion?	– Barriers – Needs

Impact

27. In your opinion what are the 3 things the project contributed to most?	– Write as testimonies

Annex 6 Semi-structured interview secondary stakeholders (including social actors)

Please note this is a topic guide and should be used as such, meaning questions will be asked and probed for in such a way they are relevant for the respondent.

Each interview will start with Scenario A or B, to substantiate outcomes harvested by the project (scenario A) or to identify whether additional change took place (scenario B).

SCENARIO A. To substantiate outcomes that were harvested before

Before having the interview: Type the outcome description, significance and contribution and send in advance to substantiator when requesting the interview.

Introductory questions	What do you know about the advocacy for safe abortion programme? Are you involved in the implementation of the ASA project? If yes, in what way?	*Probe for additional info to background information if relevant.*
Outcome title and description substantiation inquiry	1. Does this outcome adequately describe the change in behaviour you observed? If not adequately described, what change do you suggest? Why?	*Probe into why and make sure the suggested change is within the described change remit.* *What evidence is supporting this change?*
	2. Do you agree with how the significance is described? Can you please elaborate upon for whom this change was most significant?	*Probe for elements contributing to significance, e.g. first time it happened, represented change by/affecting many people, likely to be sustainable, benefits to specific groups, Was this a first step or a full-blown change?*
	3. How did the project/society (the project is the society plus all partners paid to implement) influence this change? What was their contribution? Do you confirm how the contribution is described?	*Did more than one organisation contribute to the change? If so, which ones, what did they do? How big/small do you see their contribution in relation to the contribution of the project/society? Would the change have happened anyway if the project did not exist? Was the project the primary reason the change happened? What was the added value of the project?*

SCENARIO B To identify whether change did take place

Introductory questions	What do you know about the ASA programme? Are you involved in the implementation of the ASA project? If yes, in what way?	*Probe for additional info to background information if relevant.*
To identify change	1. Looking back at the past three years, what do you think have been the most significant changes in [the domain of change, depending on the knowledge of the informant]:	*Depending on context and activities that took place can be probed for specific fields of change*
	- in relation to strengthening networks (PW2)	*Probe for Position of society within network, Partnership with MoH/ UN, Linking with other stakeholders, Training and capacity of service providers*
	- in relation to professional and public perception of CAC (PW3)	*Probe for:* *(professional perception)* – *Development of professional norms and values* – *Value Clarification and Attitude Change (VCAT)* – *Perception and behavioural change (to what extent did activities influence attitudes; to what extent did activities influence behaviour?)* – *Implementation of professional code of conduct* *(public perception)* – *Changes within the media* – *Changes within communities, marriage counsellors, youth, schools etc.*
	- in relation to understanding of and navigating the legal framework for CAC (PW4)	*Probe for:* – *Awareness among health providers/legal profession/communities about law* – *Implementation of existing law and guidelines* – *Dissemination of guidelines* – *Amendments in law or Penal Code*
	- in relation to improved data availability and use (PW5)	*Probe for:* – *Central monitoring systems* – *Identification and addressing knowledge gaps* – *Sharing, transferring and using knowledge and evidence for advocacy*

	2. Why was this change significant?	*Probe for elements contributing to significance, e.g. first time it happened, represented change by/affecting many people, likely to be sustainable, benefits to specific groups, was this a first step or a full-blown change?*
	3. How did the project/obgyn society (the project is obgyn society plus all partners paid to implement) influence this change? What was their contribution?	*Did more than one organisation contribute to the change? If so, which ones, what did they do? How big/small do you see their contribution in relation to the contribution of the project/society? Would the change have happened anyway if the project did not exist? Was the project the primary reason the change happened? What was the added value of the project?*

Depending on their knowledge, secondary stakeholders will be asked questions to assess evaluation questions related to relevance, strength of the national society, intended and unintended effects, and sustainability.

Relevance

Stakeholders	Questions	Probe for
Network members, NGOs working on CAC, policymakers	1. To what extent do you think this project is relevant and appropriate for creating an enabling environment for safe abortion in the country?	– The relevance of doing this through obgyn societies, – The relevance of focusing on advocacy
Network members, NGOs working on CAC, policymakers	2. To what extent do you think (each of) the five pathways (i.e. objectives) are relevant and appropriate for creating an enabling environment for safe abortion in the country?	– The relevance of: strengthening organization & management, strengthening networks, improving professionals & public perception, sensitization & implementation of legal frameworks, generation and use of data – What was missed? – What would you in hindsight advise the project to focus less on?
Network members, NGOs working on CAC, policymakers	3. To what extent was the project design aligned with and complementary to other initiatives in the country?	Tangible examples
Service providers (all cadres), media (if relevant), community groups, policymakers and/or other secondary stakeholders that were directly targeted by the program	4. To what extent did the project align with needs and priorities from your (professional) group?	Was focus/were activities on certain needs/priorities missing?

Service providers (all cadres), media (if relevant), community groups, policymakers and/or other secondary stakeholders that were directly targeted by the program	5. To what extent did the project contribute to enhancing the skillset of your (professional) group?	– For service providers: ask for skills on service provision – For media: skills in reporting on CAC – For community groups: understanding and dealing with the topic – For policymakers: contribution to (a) data collection, provision and use, (b) contribution to clinical norms and guidelines
All type of secondary stakeholders	6. Since April 2019, have the circumstances for the project i.e. the environment for CAC changed in your country and to what extent did the project remain relevant in these circumstances?	

Strength of the obgyn society and advocacy network

Stakeholders	Questions	Probe for
Network members, NGOs working on CAC, policymakers	7. To what extent did you see a change in the leadership position of the obgyn society on Comprehensive Abortion Care, as a result of this project?	– The society as a public institution taking action/showing leadership on the matter
Network members, NGOs working on CAC, policymakers	8. To what extent is the obgyn society equipped with the tools, expertise and capacity to conduct advocacy as a result of the project?	– Trainings, materials, skills
Network members, NGOs working on CAC, policymakers	9. Have you seen changes in perception and attitude among the society's leadership in relation to CAC?	If yes, which changes? How? If no, what do you think are the reasons for this?
Network members	10. How do you perceive: – Engagement and leadership of the society in the network – The efficiency of information sharing within the network – Collaboration among members and participation in advocacy activities	– Results as achieved through the collaborative efforts?
Network members, NGOs working on CAC, policymakers	11. What have been the enabling and constraining factors in building strong networks for safe abortion?	
Stakeholders involved in advocacy, e.g. network members	12. Which global events contributed to national advocacy and how? (open question)	
Stakeholders involved in advocacy, e.g. network members	13. After this show the timeline outlining the various global activities and ask: – Which activities are known/recognized? – Which ones contributed to national advocacy efforts and change? – Which ones were seen as most significant and why?	

Network members, NGOs working on CAC, policymakers	14. The current phase of the project will end at the end of March 2022. To what extent are the achievements of the society sustainable?	– Organizational sustainability (proper working of the organization structures that were developed as part of the project and/or the ability of systems developed to continue to function effectively) – Financial sustainability (ensuring a steady flow of funds and generating revenue for maintaining and continuing the organizations work) – Programmatic sustainability (continuation of the organization's projects to work towards improving access to safe abortion in the absence of donor support) – Social sustainability (social, cultural, legal changes that resulted from the project that will have a long-term impact and continue to provide benefits to the target community even after the grant expires)

Effectiveness

Stakeholders	Questions	Probe for
Network members, NGOs working on CAC, policymakers, media	15. What have been the enabling and constraining factors in working towards improved professional and public perception of safe abortion?	
Network members, NGOs working on CAC, policymakers	16. What have been the enabling and constraining factors in working towards an improved legal framework?	
Network members, NGOs working on CAC, policymakers	17. What have been the enabling and constraining factors in working towards data availability and use?	
Network members, NGOs working on CAC, policymakers	18. Which unintended effects have you seen from the project?	– Positive and negative effects
All type of secondary stakeholders	19. In your opinion what are the 3 things the project contributed to most?	– Write as testimonies

Annex 7. Topic guide for interviews international advocacy partners

	Questions	Probes
Introductory questions	Please introduce yourself and your organization	
	Could you describe your organization's role in advocacy for safe abortion?	
FIGO's activities	Could you elaborate on the activities you have undertaken in collaboration with FIGO in relation to advocacy for safe abortion?	– And/or what FIGO has done for your organization? – What was FIGO's specific role in the described activities? – Significance
Outcomes	What have you seen as a result of these activities?	– Advocacy outcomes in the international field (outcomes) – (If knowledgeable) FIGO's specific contribution to national advocacy of specific countries – Significance
Contribution	What has been FIGO's specific contribution to international movements and changes?	
	What is FIGO's unique position in supporting international advocacy for safe abortion?	– Strengths – What do they bring? – Examples
	FIGO has produced a number of outputs, both in the international as well as the national fields (show timeline). Examples are blogs, webinars, statements and evidence briefs.	– Did they contribute to changes and how (internationally and nationally)? – What type of outputs have been most valuable? – How could these be further leveraged to support advocacy?
	What has been the relative importance of these?	
	How relevant is the role of Figo as an organization in advocacy for safe abortion	– Why
Learning	This specific project, where FIGO supports the capacity strengthening of national obgyn societies in safe abortion advocacy is coming to an end. How could FIGO's role be sustained?	
	What learnings do you take away from FIGO's work	– What worked? – What could be improved?

Annex 8 Information sheet and consent form

Title of the proposed study: FIGO Advocating for safe abortion –evaluation research of a three years multi-country capacity building project'

Background and rationale for the study:
The Royal Tropical Institute (KIT) from the Netherlands is evaluating a three years project of the International Federation of Gynaecology and Obstetrics (FIGO) on strengthening the <country> Obstetrics and Gynaecology Society and supporting their work on legal safe abortion.

A description of sponsors of the research project and the organizational affiliation of the researchers: We are supported by the Royal Tropical Institute in the Netherlands and contracted by the International Federation of Gynaecology and Obstetrics (FIGO) to conduct an evaluation of a project that is carried out by *<country society>*. This project has focused on making safe abortion more accessible to people through advocating for change. The researchers are independent and recruited to conduct the research on behalf of the Royal Tropical Institute and are managed and supervised by the national consultant (name) and KIT.

Purpose:

The purpose of the research is to evaluate the <local name of the project> after it has been in place for 3 years. For that reason, we would like to explore your perceptions and observations of the way of working, the leadership, sustainability and how the projects linked to the wider SRHR environment. We want to learn more about the changes in relation to safe abortion you have observed, what do you think made these changes possible, the role of the project in influencing these changes, what these changes mean for women in the country. We would also like to discuss if you were actively involved in any of the changes observed. Did you take part in making them happen or in preventing any change to occur.

The estimated duration the research participant will take to in the research project: It will take about one hour to take part in the interview.

Procedures:

If you agree, we would like you to take part in a group discussion with other members of your community. We would also like to record the interview. The recording will be used to complement the notes taken during the interview. By taping the interview, we can thus better ensure that your perspective is reflected better in the evaluation. The tape will be destroyed as soon as the evaluation has been completed. If you do not wish the interview to be recorded only note taking will be done.

Who will participate in the study: Men and women who live in the area of the project activities or who have observed or have been part of what happened or who may know more about why changes in the situation and discussion about SRHR, including safe abortion changed, are asked to participate.

Persons who participated in project activities or who have observed activities, can confirm or disagree with results or who have insight in why changes in the situation and discussion about safe abortion changed, are asked to participate.

Who will participate in the study: Can participation harm you?
The participation is entirely on a voluntary basis and information will be kept confidential. A name will not be recorded and it will not be possible to identify in the reports or any other products of the evaluation.

However, this is a group discussion and we will ask all participants to keep what is discussed confidential but we cannot guarantee this. We ask to share opinions, ideas and discussions as they exist in the community. We do not want any personal information shared that may affect you …. when others get to know about it.

You are free to ask the interviewer to stop the group discussion at any point in time or not to answer a particular question. Withdrawing from the discussion will not in any way affect your reputation, access to care or have any other consequence.

Alternatives: You can refuse to take part if the interview without any consequences to you or your relationship with any organisation or services.

Cost, compensation and reimbursement: We will reimburse the costs for travel if you have to travel to the place the interview takes place.

Questions about the study: If you have any further questions about the study the following persons can be approached to answer your questions:
Questions about participants' rights: If you have any questions about your rights as a respondent you can get in touch with:

Statement of voluntariness: Your participation is entirely on a voluntary basis and your information will be kept confidential. You are free to ask the interviewer to stop the interview at any point in time or not to answer a particular question. Withdrawing from the interview will not in any way affect your reputation or have any other consequences. Withdrawal will not affect access to services.

Dissemination of results: The knowledge that we get from the interviews will be shared with you through the program (FIGO, KIT and AOGU).

Ethical approval: The study was approved by the Royal Tropical Institute Research Ethics Committee and the proposal is submitted and the <country> Ethics Committee approval was …........

STATEMENT OF CONSENT

.... has described to me what is going to be done, the risks, the benefits involved and my rights regarding this study. I understand that my decision to participate in this study will not alter my usual medical care. In the use of this information, my identity will be concealed. I am aware that I may withdraw at any time. I understand that by signing this form, I do not waive any of my legal rights but merely indicate that I have been informed about the research study in which I am voluntarily agreeing to participate. A copy of this form will be provided to me.

Name ……………………Signature/thumb print of participant …………………Date ……

Name ……………………Signature of interviewer/Person obtaining informed consent ……………………
Date ………………….

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