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THE CSSR / MSSA MIXED METHODS

RESEARCH TOOLKIT

ABORTION-SEEKING BEHAVIOURS AND PREFERENCES

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THE CSSR/MSSA MIXED METHODS RESEARCH TOOLKIT
ABORTION-SEEKING BEHAVIOURS AND PREFERENCES

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Critical Studies in Sexualities and Reproduction

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ABOUT US

Critical Studies in Sexualities and Reproduction

The Critical Studies in Sexualities and Reproduction research programme is a multi-disciplinary programme funded by the National Research Foundation South African Research Chair Initiative (SARChI), the International Women's Health Coalition, Marie Stopes, the Eastern Cape Liquor Board, and Rhodes University's research committee. It draws on the expertise of a number of researchers both within Rhodes University and at universities/NGOs in South Africa and across the world.

Marie Stopes South Africa

Established in 1993, Marie Stopes South Africa (MSSA) is the country's largest non-profit provider of sexual and reproductive healthcare services. MSSA is part of the 38-country strong Marie Stopes International Global Partnership, allowing us access to the latest innovations and expertise in the field of sexual and reproductive health.

MSSA seeks to impact the quality of life in South Africa by decreasing maternal and infant mortality, averting unsafe, illegal abortions, decreasing the number of unwanted pregnancies through contraceptive uptake, reducing the impact of HIV, STIs and cervical cancer and expanding their services whenever and wherever possible.

In South Africa, MSSA operates 17 centres across 7 provinces and are a Section 21 non-profit organisation recognised for the quality of their clinical services and non-judgemental, client-friendly approach. The fees MSSA charges for services are cross-subsidised across the network, meaning centres can offer prices that best suit the communities they serve. Any surplus generated is reinvested back into core work, allowing MSSA to grow our reach and range of services.

PURPOSE OF THIS TOOLKIT

It is well-known that there are multiple barriers to accessing abortion services globally. These barriers vary considerably, depending on legislative environment, health systems, socio-economic issues, cultural and social understandings of reproduction and the role of women, health service structures and delivery, gender norms, interpersonal dynamics, and personal attitudes and preferences.

The purpose of the CSSR/MSSA research toolkit is to provide a **step-by-step guide** in conducting mixed methods research – qualitative interviews and a discrete choice experiment (DCE) – on abortion-seeking behaviours and service preferences. The toolkit enables users to surface features relevant to their setting (through qualitative interviews) and to ascertain community preferences in terms of service provision (through the DCE).

Intended users

The CSSR/MSSA implemented this methodology in a low-income rural setting in South Africa, but the methodology can be implemented in a range of settings and adapted to specific country contexts. The intended users are **researchers or monitoring and evaluation personnel** at any private or government organisation/ department that would like to **introduce, expand, or adapt abortion services** in a particular setting. The results of the research enable programme managers to plan appropriate and accessible services within the relevant communities.

Users may decide to conduct just the qualitative component of this toolkit. That is perfectly do-able, and users can simply skip to the part of this toolkit that outlines the qualitative component. However, the DCE must be preceded by qualitative research.

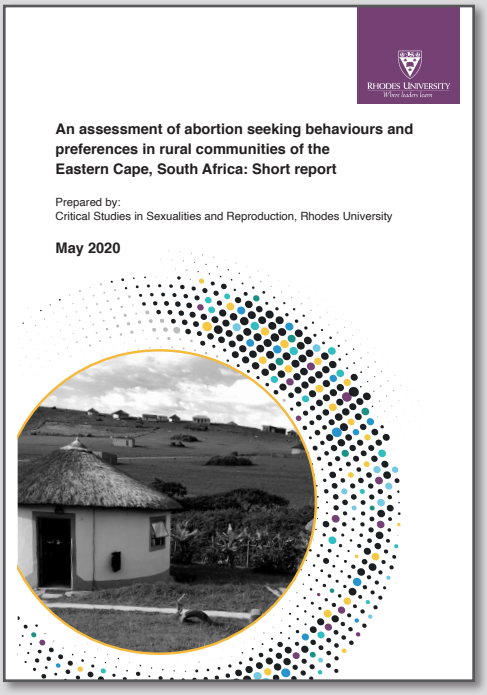
Aims of the CSSR / MSSA mixed methods research toolkit

Over-arching aim:

The over-arching aim of research conducted using this toolkit is to **focus abortion service delivery** to overcome barriers to safe abortion care (within the parameters of the law), reduce stigma and ensure access to appropriate service provision within communities. These questions can be adapted or added to.

Research questions posed to achieve this aim:

1. What understandings of problematic/unwanted pregnancies, abortion, abortion legislation, and abortion services are evident in men's and women's accounts within the community of interest?
2. What are the reported barriers to, and facilitators of, access to abortion services in the community of interest; and how are these barriers affected by social, psychographic, geographical or economic factors?
3. What are perceptions of the safety and quality of abortion services offered by different types of providers?
4. What are preferences for facility, location, provider type, information channels, costs and other identified attributes when accessing abortion services?



The Critical Studies in Sexuality and Reproduction (CSSR) at Rhodes University conducted a study based on this methodology in rural areas of the Eastern Cape of South Africa for Marie Stopes South Africa (MSSA) – the full report can be viewed on the CSSR website. This toolkit presents the process, along with a variety of lessons learned, to anyone who would like to conduct such research on abortion service preferences.

RESEARCH DESIGN

The research design is mixed methods, with qualitative data forming the foundation of the quantitative component of the study.

> The qualitative research component consists of individual interviews.
> The quantitative research component consists of a discrete choice experiment (DCE).

Rationale

A mixed methods design has the advantage of combining in-depth inductive (ground-up) data from the qualitative component with structured deductive (based on a priori categories and hypotheses) data from the quantitative component. This combination provides an in-depth and broad-ranging view of the issues at hand.

There are a range of types of mixed method designs. In this case, the qualitative data are used to: (1) inform the construction of the quantitative instrument (the DCE), and (2) act as a validity check for the results of the DCE. In addition, the qualitative data can be analysed to provide additional key insights.

Discrete Choice Experiment (DCE) involves asking individuals to state their preference in terms of hypothetical alternative service provision scenarios – each described by particular attributes. Alternatives must be adjusted and adapted to focus on aspects of a service that is specific to the area. This can be done through the initial qualitative interviews and a scoping review of the literature for your research context.

The DCE design has been used in several areas, including consumer products, customer services, and increasingly in the health care sector. In the last ten years DCEs have increasingly been implemented in middle and lower income countries, and the WHO published a guide to using DCEs for workforce recruitment in rural areas in 2012.

Previous studies have used the DCE methodology to generate insights on:

> Preferences for family planning service providers in Malawi [1]
> Preferences for obstetric care and places of delivery in Ethiopia [2,3]
> Women's preferences for first-trimester miscarriage management [4]
> Women's preferences for HIV prevention technologies in South Africa [5]

Stages

The type of mixed methods research used means that the study must be conducted in steps, as follows:

Stage 1: **Scoping review of literature** to assess the key issues for abortion service provision in the country and research setting.

Stage 2: **Decision-making** regarding site sampling; setting up partnerships with local civil society organisations or non-governmental organisations (NGOs) in these sites; setting up expert panel of stakeholders and technical experts .

Stage 3: **Development of research and ethics protocol**; ethics clearance.

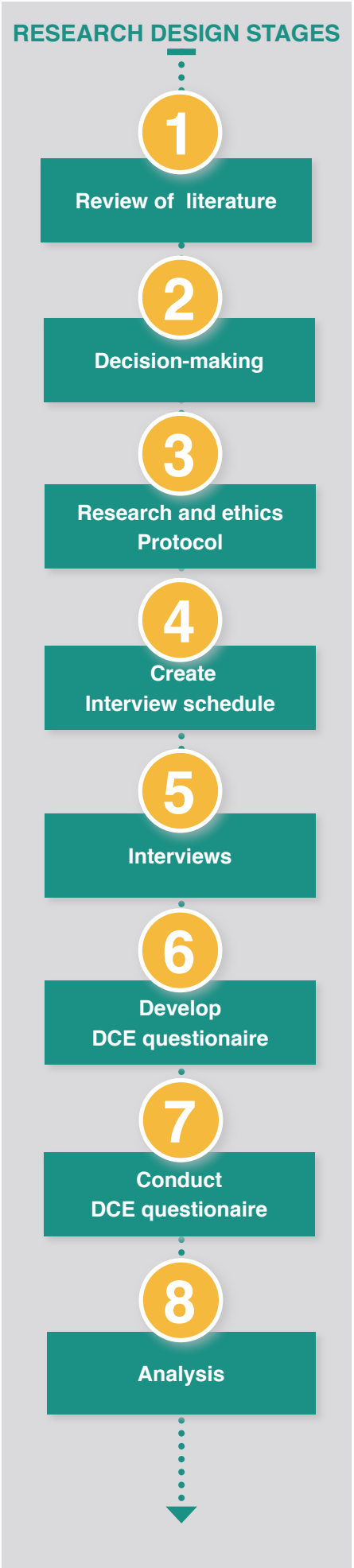
Stage 4: **Development of interview schedule for qualitative component.** The interview questions can be adapted based on the findings of the literature, the legal environment, and the country context.

Stage 5: Interviews with key informants to illicit data on participants' reports of the communities' understandings of problematic/unwanted pregnancies, abortion, abortion legislation and abortion services, the barriers to, and facilitators of, access to abortion services, as well as perceptions of the safety and quality of current abortion services.

Stage 6: **Development of the DCE questionnaire** and additional respondent characteristics questionnaire based on initial analysis of qualitative data and issues raised in the literature, with the support of a statistician. Where a statistician is not available or budget does not allow for an external consultant, consider a less rigorous rapid insight gathering method such as the Nominal Group Technique to elicit preferences.

Stage 7: **Conducting the DCE** (or alternative rapid insight gathering method – see Box on page 11).

Stage 8: Complete **analysis** of qualitative and quantitative data.



> Although the steps are conducted one after the other, the research design must be coherent. We therefore present each feature of the design in its totality (incorporating the qualitative and quantitative aspects).

NGO partnerships and the expert panel

Once the site (or sites) have been decided upon (see discussion in sampling section), a partnership should be formed with local health-related NGOs or civil society organisations. This increases your study's validity, research capacity and ethical practice. The purpose is as follows: (1) the NGO provides expert input on local issues to be considered in the research, thereby ensuring the appropriateness of the research; (2) members of the NGO form part of the expert panel (see below); (3) the NGO eases entry to the community, assists with recruiting participants, and facilitates communication with the community; and (4) NGO care-workers can act as field-workers and facilitate research findings feedback to the communities. An example of the CSSR/MSSA contract with NGOs in the Eastern Cape is attached in Appendix 1.

An expert panel should be consulted throughout the research process. This panel will differ according to context, but should consist of members of the research team, the implementing agency, relevant health-related NGOs operating in the community, and community members. The roles and responsibilities of the expert panel should be made clear to members. Input should be sought from the expert panel on the appropriateness of data collection tools, logistical issues and sensitivities related to researching abortion in the setting, and drafts of the reports.

Definition of Discrete Choice Experiment:

A DCE allows researchers to investigate how people in a particular context rate selected attributes of a service by asking them to state their preference for different hypothetical alternatives. Each alternative is described by attributes, and responses are used to infer the value placed on each attribute. It allows for the calculation of participants' trade-offs between attributes. This technique is useful where there is an intention to extend or alter services (or provide new ones where the current services do not yet exist). A useful book on the method is Esther de Bekker-Grob's 2009 book, *Discrete Choice Experiments in Health Care: Theory and Applications*.

SAMPLING

There are multiple issues to consider in sampling: sites, interview participants and DCE participants.

Sites

The site selected depends on the kind of area in which users wish to extend, alter, or introduce services. In the CSSR/MSSA case, rural areas of the Eastern Cape Province of South Africa were identified as the target districts in which MSSA wishes to introduce services. In order to generalise the findings as much as possible to the target areas, it is important to choose a site that is fairly representative of the areas in which services will be provided. It may well be that the target district is, in fact, quite diverse. If this is the case, it might be useful to choose several sites to capture this diversity. For example, the CSSR/MSSA Eastern Cape study was conducted in three sites .

Deciding on a site or sites requires ascertaining the key features of the targeted areas, and to ensure that the site(s) match these as far as possible. Key features will differ from site to site, but may include available health services, accessibility to transport, socio-economic factors, residential features, distances to clinics, and demographic features of the area.

Qualitative interviews

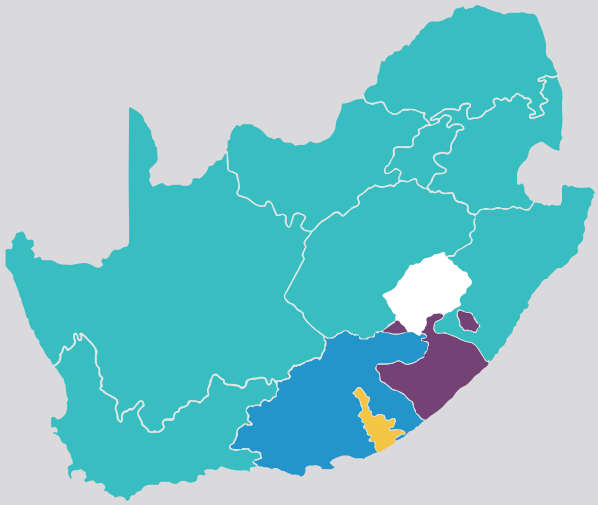
The participants in this and the DCE component are viewed as key informants, viz. people with knowledge about their community. The sample size should be between 45 and 60 people. Purposive and snowball sampling is used. Participants are selected to fit the purpose of potentially needing reproductive health and abortion services in the area, viz. be (i) of reproductive age, and (ii) a permanent resident of the area. Diversity among participants should be sought along the following lines: gender, age, reproductive status. Additional factors could be included here such as ethnicity, education level, or other socio-demographic variables. Specific key informants in the community can be interviewed such as local health

care providers, community health workers and activists. For both the qualitative and quantitative data collection we decided to include a minority of male participants because Marie Stopes wanted to have some idea of how preferences differ between the sexes.

Quantitative DCE

The sampling strategy will depend on the site, and the kind of information that you have about the population. In instances where there are sampling frames (such as lists of people living in an area), systematic sampling would be recommended (starting at a random name and then selecting the name of the person x spaces down the list, and so on). This is not always possible, and so cluster sampling may be used (divide the households into clusters and randomly select individuals from each cluster). Sample sizes of at least 300 are recommended, with a minimum of 200 participants per group for subgroup analysis. Sample size estimates must be reasonable to give statistically meaningful results in the full survey and can be checked after the pilot stage.

Example of site selection for the Eastern Cape study



The map on the left shows the locations of the former homelands in the Eastern Cape. One of our sites was in the Transkei (purple), one in the Ciskei (yellow) and the third site was in the south western part of the province (blue).

The first site consists of communal tenure land; it is far away from any large towns or cities, the roads are inaccessible, and there are few health services in the area. The second site also consists of communal land; it is slightly closer to large towns, and is situated around a small town which is reasonably accessible via road; there are several public clinics in the area. The third site consists of collections of homesteads in and around commercial farms. It is spread out and connected by smaller townships. Some people in this site happen to live close to these townships and have access to public clinics whereas others are served by a mobile clinic that rotates monthly among the farms.

DESIGNING THE RESEARCH TOOLS

Interview schedule: qualitative component

Users are free to adapt the interview schedule used by the CSSR/MSSA team. Whether doing this, or starting from scratch, the draft interview schedule should be designed to reflect the particular issues the research team would like to tap into. It should also be informed by a review of literature pertinent to the context. It is important that questions elicit the answers required to design the DCE.

Questions should be designed in such a way that participants understand that they are key informants. Participants should not be asked directly about their personal experiences[1]. Instead they are being interviewed because of their knowledge of the community viz a viz their membership within that community.

Questions should be open-ended and should indicate the information the fieldworker must probe for, should the key informant not provide the information in answering the main question. Interview questions could be framed as decision making questions such as:

> *Please explain to me how decisions about what to do in cases of unwanted pregnancies are made?*
> *If women were able to choose an abortion service, what influences their decision on where to go?*

The questions could be put forward as asking about viewpoints:

> *What are people's views on the safety and quality of the places where you can get an abortion?*
> *How much do you think people are willing to pay for an abortion?*

1 It is possible that participants will volunteer personal information. Interviewers should be trained in handling such situations. See further discussion under ethics.

The questions could enquire about barriers:

> *Are there any difficulties a woman might face in obtaining an abortion?*

> *Without naming any names, do you know of an instance in which someone wished to have an abortion, but could not do so? What was the reason they could not? What did this person do instead?*

Prompts from the fieldworker could direct the conversation towards something relevant to the research questions.

> *If a woman is pregnant but does not want to be pregnant, what are her options in this community? (Prompts: Where would she go? Who would she ask for information? What sort of information would she receive from these sources?)*

The draft interview schedule should be refined through input from the expert panel.

Once the draft schedule has been approved, it must be translated into the relevant language of the area. Back translation should be used to ensure both linguistic and conceptual equivalence. The process is as follows: one translator translates the schedule from English to X language; a different translator translates the X-language schedule back into English; the initial and translated English version are compared; where differences are noted, the two translators discuss the differences and agree on the best translation in X language or, alternatively, consult a third translator.

The translated version should be pretested with four people from the participant communities. These participants should be invited to provide feedback on the clarity, relevance and order of questions. Based on their responses the final interview schedule should be designed.

A copy of the final interview schedule used by CSSR/MSSA appears in Appendix 2.

Quantitative DCE:

Generating a DCE instrument means creating combinations of attributes of services and levels of each attribute. These are then combined into choice sets that the participants will be evaluating. Creating these choice sets through experimental design will require statistical software. If the research team does not have access to the required statistical software, consider using one of the following rapid insight methods (See box on the next page) .

Alternative methods for eliciting preferences without support from a statistician

The Normative Group Technique: a structured way for reaching consensus for prioritized solutions or recommendations that represent the group's preferences. This brief from the CDC provides a four-step process for facilitating an NGT session.

Card sorting: a simple exercise to identify your target audience's preference. Ask a small sample of respondents to sort cards labelled with categorical levels (e.g. type of abortion facility) from least preferred to most preferred. Take a note of their preferences as well as some key characteristics (age, sex, location) about your respondent to trace any associations between preference and background characteristics. IDEO.org have some simple guidance to facilitating card sort activities in their Design Kit website.

Relevant attributes for the DCE should be decided upon, using the following:

> Data from the qualitative interviews (translated and transcribed – see description below). Identify prominent themes that speak to barriers to access and preferences for services.

> Relevant literature: it is important to focus on literature produced in the country of study in relation to barriers to abortion care, the abortion decision-making process, and experiences of women seeking abortions. In our literature review the following attributes were identified through the literature review:

- Costs of travel
- Costs of procedure
- Type of abortion facility (public, private, informal, etc.)
- Confidentiality
- Health provider attitude
- Lack of information
- Lack of availability and service quality

The selected attributes should fulfil the following criteria: relevance to the research question and relevance to the decision context. For example, reading of our qualitative data showed that women are faced with an almost impossible task of keeping their abortion a secret. The communities in our sampled areas were said to be very judgmental. As a result, we produced the levels of several of the attributes to reflect possibilities for confidentiality. For instance, a free-standing clinic which might not provide as much confidentiality as a clinic that is part of a larger health centre.

Each attribute should be assigned levels (within a realistic range). Levels depend on the attributes but can be categorical (e.g. clinic or hospital), continuous (e.g. distance), or a probability (e.g. a 2%, 5%, or 10% chance of side effects). Levels should be restricted to three to four per attribute. Attribute levels should vary independently and not be correlated. The expert panel should be part of the process of choosing the attributes and their levels.

Options for presentation of choice sets include: (a) participants being presented with a set of many alternative profiles and asked to order or rank the profiles from most preferred to least preferred, and (b) profiles being grouped into sets, with participants choosing among the alternatives in each set. Typically, participants are asked to consider 18 choice tasks. The CSSR/MSSA team chose the latter because it suited the attributes and levels decided upon.

The DCE instrument should now be produced. The main part of the instrument consists of the choice sets. It should also include a set of additional questions such as participant information (sex, age, location, indicators of socioeconomic status) and possibly their general attitude to abortion. This allows you to test for systematic differences in preferences based on these characteristics.

As the task that participants are being asked to complete is probably unfamiliar to them, instructions must be clear. Include description of attributes and practice examples. Depending on the context, the instrument could include pictorial cues to assist in participant understanding of the task.

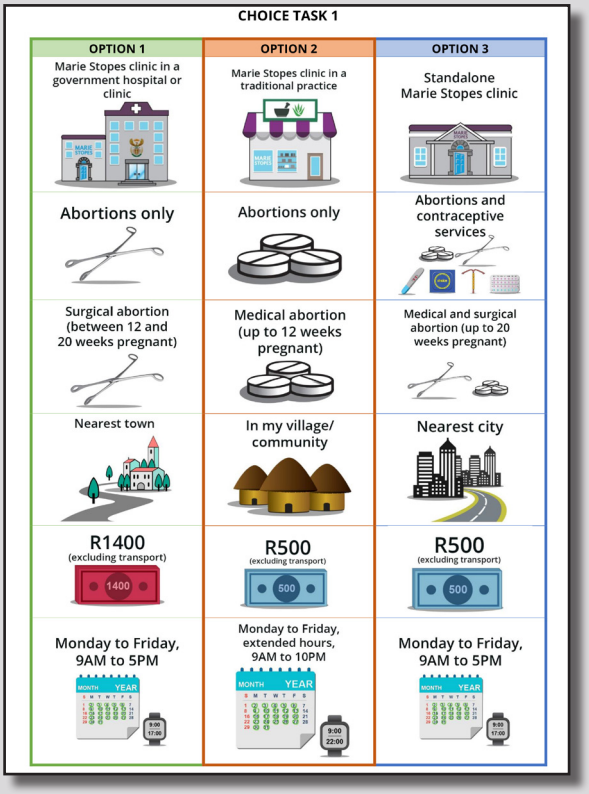
An example of Task 1 of the CSSR/MSSA choice sets/tasks sheets is in the box on the next page.We used a separate answer sheet so that the choice sets/tasks sheets could be printed in colour and laminated.

Validating the choice set

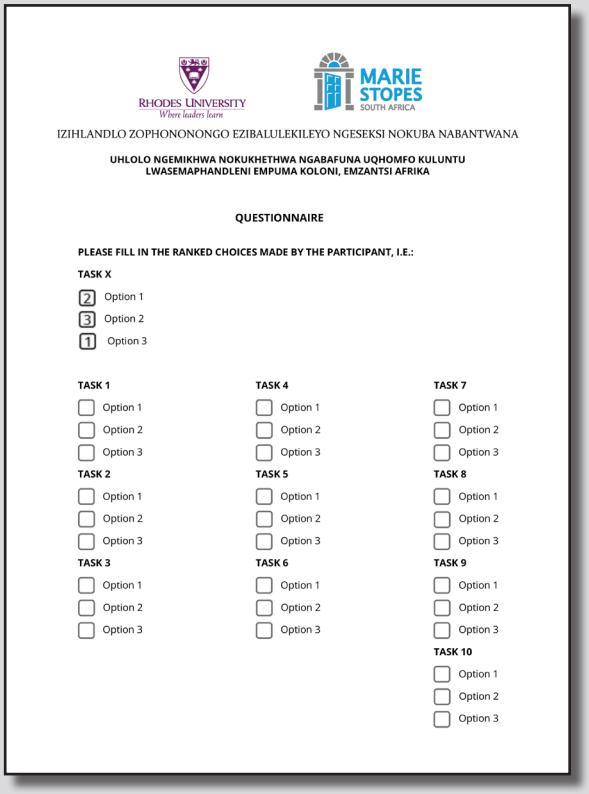
Ensuring internal consistency of responses could be done during the pilot phase by including one or two choice pairs in which one option is superior to the other on all attributes. Participants who fail to choose the superior option may have misunderstood the task or

For further reading on designing a DCE see the World Health Organisation's ***User Guide with Case Studies: How to conduct a Discrete Choice Experiment for Health Workforce recruitment and Retention in Remote and Rural Areas***. For information on experimental design (creating the choice sets) specifically see pages 23 to 28.

Example of one of the choice sets



Task Sheet



Answer Sheet

there may have been problems with communication or translation. This was not possible in our research since there were no possible superior options. Several versions of the instrument could be developed so that the profiles or choice sets and attributes are presented in different orders.

Piloting the choice set

Once the draft instrument has been devised, it should be piloted. This can be conducted individually or with groups. We conducted a focus group discussion and asked individuals, after they completed the questionnaire, to comment on the instrument and to provide feedback on its comprehensibility, the suitability of the attributes, and number of choice sets. We used pilot data to check the validity of the attributes and levels using statistical software, assessing direction and relative magnitudes, before analysing pilot data in a multinomial logit model to inform a d-optimal design (D error = 0.427). At this stage you should also check that sample size estimates were reasonable to give statistically meaningful results in the full survey. The feedback from the pilot and this analysis should be used to refine your choice sets/tasks sheets and answer sheet.

DATA COLLECTION

Qualitative interviews

Interviews should be conducted in participants' preferred language by trained interviewers. Interviewer training should be interactive, and allow for interviewers to contribute their insights, and to speak to any anxieties they may have about collecting data on a sensitive topic. Role-playing and input from peers assist in preparing the interviewers to conduct in-depth interviews. Training should ensure that interviewers:

> Are fully immersed in the study aims and goals and understand the reason why each interview question was chosen for inclusion.

> Understand the informed consent procedures – providing full information about the aim of the research, the person's role, the time the interview will take, the voluntary nature of participation, and the right of the person to withdraw up to the point of write-up.

> Understand their ethical role in relation to participants. They need to understand the rights of the participant, their duty to honesty, rules of confidentiality and accountability, and the need to remain professional at all times.

> Should be prepared for the specific issues they might encounter. These include participants revealing personal information or speaking about harm to self or others. See Ethics section for more detail.

> Are able to build rapport with participants and make them feel at ease to speak on a sensitive and potentially controversial topic such as abortion. This includes making sure that interviewers refrain from showing any judgement or express any personal opinions about the content of people's responses.

Depending on resources, interviewers can work in pairs in a community. This enables them to provide peer support and input during the process. At this point NGO partners could come in useful

in helping to recruit participants, making suggestions on what the tokens of appreciation might be, and monitor the interviewing process, flagging any deviations in the protocol.

Interviews should be conducted in a private space that is comfortable for the participant. They should be voice recorded with the permission of participants (see ethics discussion).

Quantitative DCE

Given the complexity of the DCE task, face-to-face administration of the instrument by trained fieldworkers is necessary. Training of fieldworkers should follow the same format as that spoken to above. Fieldworkers should be trained to understand the function of the DCE fully so as to avoid any mistakes.

Further reading on data collection and analysis

For authoritative guides on data collection see *The SAGE Handbook of Qualitative Data Collection* (2017), Wendy Olsen's *Data Collection: Key debates and methods in social research* (2011), and Anthony Coxon's *Sorting Data: Collection and Analysis* (1999)

DATA ANALYSIS

Qualitative interviews

Transcription and translation of the interviews can take place simultaneously. To ensure rigour, transcriptions should be checked by an independent bilingual speaker to ensure linguistic and conceptual equivalence of the translation and transcription.

1. Data can be analysed using thematic analysis. Thematic analysis enables an understanding of patterns across a data set. It is conducted in five stages, reiteratively as opposed to linearly.
2. Familiarize oneself with the data (repeated listening of audio data and reading of transcriptions).
3. Develop initial codes (labelling and organizing the data into succinct features based on descriptions and interpretations of the data).
4. Generate themes from the codes (identifying patterned responses by revisiting the codes and searching for similarity and linkages), reviewing potential themes (checking the themes against codes and data extracts to ensure that the themes reflect the data, which involves discarding any codes or themes, re-drawing boundaries of themes),
5. Define and name themes (themes need to be clear, distinct and coherent).

Quantitative DCE

Data analysis will depend on how the independent variables are coded (e.g. attribute levels may be categorical or continuous). The analysis of DCE data typically involves regression models such as a probit, logit or multinominal logit specification. The aim of the

regression analysis is to estimate the relative importance of the different attributes to patients. Orthogonal or D-efficient designs are most often used and can be created in SAS software or Ngene.

In the CSSR/MSSA study, we restricted the design to ten choice tasks to manage the burden on respondents. Ten rows were too few for a fully orthogonal design, so the design for the pilot was generated using a d-optimal algorithm with zero priors (D error = 0.432). The analysis of choice data is based on the random utility model where each respondent faces a choice amongst a number of alternatives repeated under a number of scenarios or choice situations. The utility obtained from a specific alternative in a particular scenario is linked to the attributes and the coefficients are estimated using multivariable Multinomial logit regression (MNL).

Regressions can be run for the pooled sample as well as by other demographic characteristics and site (if there are more than one site) in order to explore any differences in preferences in these groups. In our long research report (see discussion below) we presented the estimated coefficients and their standard errors by attribute, as illustrated in the following table. Statistically significant coefficients suggest that the particular attribute is associated with the utility of choosing an alternative. In Table 1, the MS clinic in a government facility is preferred by the pooled sample, and female respondents, with MS mobile clinics being the second most preferred alternative (-0.060). However, when looking a male preferences alone, the MS stand-alone clinic is most preferred (0.022), although the standard error for this preference is not significant (0.170) given that there were a small sample of men included in the CSSR/MSSA study.

Table 1: Example of MNL regression coefficients for facility type (pooled sample and by sex)

Facility type (vs MS in government facility)	**Pooled**	**Female**	**Male**
MS mobile clinic	-0.060 (0.094)	-0.009 (0.106)	-0.216 (0.221)
MS clinic in pharmacy	-0.179** (0.070)	-0.235*** (0.078)	0.022 (0.170)
MS stand-alone clinic	-0.315*** (0.083)	-0.482*** (0.094)	0.221 (0.191)
MS partnered with traditional healer	-0.377*** (0.072)	-0.442*** (0.081)	-0.194 (0.172)

Note: Standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01

PRESENTING FINDINGS

The findings of the study may be presented in a range of formats, including academic journals, research reports and reports for policy makers, operational staff and healthcare providers. These formats obviously differ according to the intended readers. Here we focus on the last form of reporting, as this report enables the findings to be taken up in policy and practice. This means that the report should clearly translate the research findings into concrete actionable recommendations. It should also be succinct, clear and easily readable. The CSSR/MMSA short report can be accessed on the CSSR website.

The report should start with an executive summary that briefly describes the rationale for the study, the research questions, key points from the literature review, a short description of the methodology (with linkages provided to the longer research report for those wishing to delve more deeply into the methodological decisions made), the main findings and recommendations. The main body of the report should follow the same structure.

The findings and recommendations section of this report is the most important. In it, insights from the literature review, the qualitative findings and the quantitative results should be integrated. In other words, each major theme (e.g. preference for type of facility) should refer to issues raised (if pertinent) in each of the three forms of information gathering. In laying out the findings, points should be succinct and linkages between the three sources of data pointed out. Readers should be able to clearly locate the rationale for a particular recommendation in the findings presented.

CREATING A TIMELINE

Managing a project of this size can be challenging. Creating a timeline with clear activities can assist. We present an example of a timeline below (if you are conducting just the qualitative component, the quantitative section can simply be removed). This can be adapted to suit your own needs. The project is divided into four phases that run across 12 months. Each phase takes a specific amount of time but will be dependent on your own and others' schedules including the ethics committees and the availability of expert panel members and partners.

PHASE 1: INCEPTION

Activity	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Inception Phase	■	■	■	■								
Identify research questions	■											
Write up sampling protocol	■											
Identify local partners	■											
Identify expert panel members	■											
Conduct literature review	■	■	■									
Conduct methodological review	■	■	■									
Produce qualitative instrument				■	■							
Produce permissions documents			■	■	■							
Apply for ethics clearance	■	■	■	■	■							
Visit the fieldwork sites	■	■	■	■	■							
Translate instrument, if necessary				■	■							

PHASE 2: QUALITATIVE DATA CAPTURE

Activity	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Data Capture Phase – Qualitative												
Identify pilot participants												
Pilot qualitative instrument												
Using pilot feedback adapt instrument												
Recruit fieldworkers												
Train fieldworkers												
Conduct fieldwork												
Transcribe and translate data												

PHASE 3: QUANTITATIVE DATA CAPTURE

Activity	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Data Capture Phase – Quantitative												
Analyse interview data												
Produce DCE												
Translate DCE												
Identify pilot participants												
Pilot the DCE												
Using pilot feedback, adapt DCE												
Recruit fieldworkers												
Train fieldworkers												
Do fieldwork												
Capture DCE data												

PHASE 4: ANALYSIS AND WRITE-UP

Activity	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Analysis and Write-Up Phase												
Analyse DCE data												
Write report/articles												
Provide feedback to communities												

ETHICS

Ethical clearance will be required from the appropriate committee prior to commencing with the research. Ethics issues will differ according to the context in which you are collecting data. Below, we outline some of the procedures we followed.

Recruitment

Local partners informed communities that the research is taking place. Participants were recruited with the help of local partners in the three sites. The local partners identified participants according to the sampling criteria and made contact with the potential participants, either on their own or with a researcher on the research team. This contact involved providing the relevant information to the potential participant and asking them if they would like to be involved in the study. The potential participant was provided with a recruitment information sheet (Appendix 3). If they agreed to be interviewed/questioned, a time and place was determined on which the interviewer/fieldworker would arrive. The participant had the option of being interviewed/questioned at the location of their choice. A neutral location with sufficient privacy was provided at every site.

Anonymity

Participants chose pseudonyms. During the qualitative stage, fieldworkers were trained to not ask for or write down any confidential information that might give away the identity of the participant or any other community member. All data were kept in a password protected folder. All individuals handling the data, including the researchers, fieldworkers, transcribers, and translators signed a confidentiality agreement outlining their duty to not disseminate any information in the data to anyone who is not on the research team. Once the data were transcribed and translated, all identifiers were redacted from it, and the audio files destroyed.

Consent

The consent forms, translated into X language, should include full details of the purpose of the research as well as what the participant's involvement in the study would involve. The right to withdraw and to not participate without any penalties should be included. Consent sheets should be kept as long as participants are allowed to withdraw and in order to be used to identify the data that might need to be withdrawn.

Data security

The programme manager should remain in close contact with all interviewers/fieldworkers while they are collecting the data. All data should be handed over at the end of the fieldwork day and transferred to a secure password protected folder. Any individuals handling the data should sign a confidentiality agreement in which they agree not to distribute any of the data to anyone who is not on the research team. Translators and transcribers should not be allowed to keep any data after they have handed the finished product back to the research team. The programme manager should remind the translators and transcribers to delete all data from their computers once they have handed it over. The research team should go through the qualitative data in detail in order to ensure that no information is present that identifies the participants or other community members. The anonymized data should be kept in a password protected folder.

Training

All fieldworkers should be thoroughly trained in the ethics of research including participants' rights, duty of honesty, the rule of confidentiality, professionalism and what to do in cases where issues arise. It is recommended that all fieldworkers are pro-abortion in their stance in order to reduce the chances of any judgmental behaviour on their part. Fieldworkers should also understand fully how the DCE works and why it was designed in the way it was to reduce the possibilities for misunderstanding and to provide the fieldworker with the correct information to inform any questions arising.

Feedback

An important aspect of ethical research is sharing the findings of the research with participants and partners. This can take place in many ways. In the CSSR/MSSA case two strategies were used. In two sites, an event was organized in conjunction with the NGO partners

in which the findings of the report were disseminated. In another site, the participants were asked to provide details for delivery of a summary form of the report.

Benefits

The obvious benefits of this kind of study are improved appropriateness, accessibility and quality of services. The research team must also decide whether participants will receive some compensation for their time and input. This issue is complicated particularly in low-resource settings, where compensation may be seen as a coercive. With input from our partners we opted for tokens of appreciation in the form of airtime or data during the qualitative stage. In South Africa, airtime and data costs are quite high, but despite this the use of cellphones are widespread. For the quantitative component, the provision of airtime and data was not feasible due to the high number of participants so we opted for a cash voucher for a nearby chain grocery store. This was also a suggestion from the local partner.

Risks

When doing research on a sensitive topic such as abortion, it is important to do whatever you can to mitigate the risk of an emotional response and the production of stigma. We opted to do individual rather than focus group interviews and participants were treated as key informants. The interview schedule did not include personalized questions and only required general reflection. However, we were cognizant of the fact that the interviews or DCE responses may evoke painful memories for people. Interviewers/fieldworkers were trained in how to deal ethically with emotional responses, should they arise. This involved: (1) listening sensitively to the story told by the participant; (2) not asking further questions or probing about the issue; (3) quietly allowing the participant to cry, if that occurs; (4) asking the participant if they are alright to continue or if they would like to terminate the interview; and (5) assessing with the participant whether referral for counselling or other health assistance was necessary. Interviewers/fieldworkers were also provided with a list of phone numbers for a variety of professional services such as counsellors, police and hospital services. They were advised to speak to their fellow interviewers and the project manager should any such events take place.

RESOURCE REQUIREMENTS

The required resources to conduct this research depend on the context. Minimally, you will need the following:

> A researcher with expertise in both qualitative and quantitative research who will act as the project manager

> Several interviewers and fieldworkers, who will be required to do the qualitative and quantitative data collection. Your sample size and the amount of time that can be put aside for fieldwork will determine how many fieldworkers you need. We opted for ten fieldworkers to collect the qualitative data. For the quantitative data collection, we trained the NGOs' home-based carers in two of the sites. In site three we trained our own fieldworkers from the local university population.

> Professional translators to translate the interview schedule, DCE, information sheets and consent forms.

> Bilingual assistants to transcribe and translate the interviews. Transcription and translation will be one of the biggest budgets.

> Experts in the analysis of qualitative and quantitative data is required. A statistician with knowledge of or prior experience in DCE analysis would be useful.

> Partnering with local organisations is highly recommended. Your partnership might involve paying them for their time and expertise. We made use of our partner organisation's home-based carers a great deal and they were an integral part of the research. Apart from recruiting the participants they also conducted the DCE in their areas.

GLOSSARY

Qualitative research is a type of research where data are unstructured and analysis is non-numerical. Data most often are in the form of interviews, observations, or documents.

Quantitative research relies on data that are quantifiable and uses statistical, mathematical, or computational techniques. Data are most often collected through surveys or questionnaires.

Mixed methods research is a methodology for conducting research that involves collecting and analysing, and often integrating, both quantitative and qualitative research.

An **inductive** approach to research is generally associated with qualitative research and concerns itself with generating new theory from the data. It does not begin with a hypothesis but rather uses research questions to narrow its scope of study and usually focuses on exploring new phenomena or looking at previously researched phenomena from a different perspective.

A **deductive** approach to research is generally associated with quantitative research and usually begin with a hypothesis. A deductive approach is usually employed to test a theory and generally focuses on causality.

A **hypothesis** is a starting point for a research investigation. It is an assumption made for the sake of an argument based on limited evidence. A research study can aim to test a hypothesis.

An **attribute**, as part of the DCE methodology, is an aspect or character of the service or phenomenon that is being investigated. If you want to know how far people are willing to travel to access a service, then 'distance' will be one of your attributes. There will be a set of different hypothetical attributes and the DCE analysis will reveal what value participants place on each attribute.

Attributes, in a DCE, have **levels**. Levels are options based on the attribute. The 'distance' attribute might have the following levels: 'local village', 'nearby village', 'nearby town', and 'nearby city'.

Categorical levels are options that have discrete categories with no specific order to them. An example is the facility type attribute in our DCE where the levels are 'clinic in a hospital', 'freestanding clinic', 'mobile clinic', 'clinic in a pharmacy', and 'clinic in a traditional healer's practice'.

Continuous levels are numeric or based on dates/times and consist of a set of continuous values. An example is our pricing attribute: 'Free', 'R500', 'R800', 'R1200'.

Probability levels are based on likelihood or chance of an event happening. In ascertaining choice preference for medication an attribute on side effects might be included with probability levels such as 2%, 5%, or 10% chance of side effects.

The DCE consists of a chosen number of **choice sets**. Choice sets are produced through an experimental design process using statistical software.

Key informant interviews are qualitative in-depth interviews with individuals who are particularly informed about a topic of interest.

A **sampling frame** is a list of people forming a population from which a sample is taken.

Systematic sampling is a type of probability sampling method in which sample members from a larger population are selected according to a random starting point but with a fixed, periodic interval. This interval, called the sampling interval, is calculated by dividing the population size by the desired sample size.

Cluster sampling is a probability sampling technique where researchers divide the population into multiple groups (clusters) for research. Researchers then select random groups with a simple random or systematic random sampling technique for data collection and data analysis.

Purposive sampling is a non-random sampling technique where researchers recruit participants on the basis of participants' knowledge and/or experience.

Snowball sampling, or 'chain sampling' is a sampling technique where researchers gain access to potential participants based on information provided from recruited participants.

An **open-ended question** is a question that is phrased in a way that it cannot be answered with a ‘yes’ or ‘no’, but rather requires a longer response.

To **prompt** someone is to motivate or remind someone toward an action. To prompt someone in an interview is to provide additional information that might precipitate conversation in that area.

Back translation involves taking the translated version of a document or file and then having a separate independent translator (who has no knowledge of or contact with the original text) translate it back into the original language.

Pilot studies are small-scale, preliminary studies which aim to investigate whether crucial components of the main study will be feasible.

Confidential information refers to any information or document that a business or individual wishes not to make public. Depending on your agreement with the ethics committee this may include personal information and information that can render participant or the identifiable. This could be extended to the sample site.

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[1] Michaels-Igbokwe, C., Terris-Prestholt, F., Lagarde, M., Chipeta, E. & Cairns, J. Young people's preferences for family planning service providers in rural Malawi: A Discrete Choice Experiment. ***Plos One*** 10, e0143287 (2015).

[2] Kruk, M. E. et al. Women's preferences for obstetric care in rural Ethiopia: A population-based discrete choice experiment in a region with low rates of facility delivery. ***Journal of Epidemiology and Community Health*** 64, 984–988 (2010).

[3] Kruk, M. E., Paczkowski, M., Mbaruku, G., de Pinho, H. & Galea, S. Women's preferences for place of delivery in rural Tanzania: A population-based discrete choice experiment. ***American Journal of Public Health*** 99, 1666–1672 (2009).

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APPENDICES

Appendix 1: An example of the CSSR/MSSA contract with NGOs in the Eastern Cape

RHODES UNIVERSITY
Where leaders learn

MARIE STOPES SOUTH AFRICA

CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

AN ASSESSMENT OF ABORTION SEEKING BEHAVIOURS AND PREFERENCES IN RURAL COMMUNITIES OF THE EASTERN CAPE, SOUTH AFRICA

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

PROJECT PARTNERSHIP AGREEMENT

The Critical Studies in Sexuality and Reproduction (CSSR) at Rhodes University would like to partner with your organisation in the implementation of the Marie Stopes South Africa (MSSA) funded project entitled 'An assessment of reproductive choice and abortion seeking behaviours in rural communities in the Eastern Cape, South Africa'. A partnership would help the CSSR embed the research in the local context by drawing from local knowledge and by having local stakeholders, such as yourself, participate in the fieldwork design and implementation. In turn, your own organisation will benefit financially, through training and individuals gaining useful new skills. This document serves as a description of the various requirements of the project on the partners.

As the Project Workplan indicates, the project consists of two fieldwork phases. The qualitative phase, which will be implemented around July/August 2019, consists of an interview schedule which will be administered to between 15 and 20 respondents in each fieldwork site. The interviews will be conducted by Rhodes University researchers fluent in the language of participants (isiXhosa, English, Afrikaans).

The second fieldwork phase will be in November/December 2019. This quantitative phase consists of a questionnaire that will be administered to 60 to 70 respondents in each fieldwork site.

During the second fieldwork phase we would like help in recruiting local community members or some of your NGO workers as fieldworkers. The fieldworkers do not need to be highly skilled. They will need competence in using an electronic device, following instructions, and speaking both English and isiXhosa/Afrikaans. The exact number of fieldworkers required will still be determined.

During the first and second stage of fieldwork we would like help in recruiting participants. How this will happen can be discussed. Participants should be between the ages of 18 and 45. A quarter of the participants should be men and the rest women. During phase 1 of the fieldwork we will, as indicated, bring our own trained interviewers. We would appreciate it if someone from the partner organisation could accompany the interviewers, or have a conversation beforehand introducing the project study to the participants and gaining their consent.

The other requirement of the partner organisation involves identifying an individual who is knowledgeable about the community and its dynamics, preferably a member of your organisation, who can serve on our expert panel. This panel will meet around three times during the year,

1

probably in Grahamstown, and the member will be compensated fully for their time and travel. Written input on some aspects of the project may also be requested. What is required from this individual is to provide input on our fieldwork plan, in particular involving the fieldwork site from which they come. This input should contribute towards making the fieldwork run smoothly as well as helping us embed the project in the community. If your organisation would like to nominate two individuals, this would be fine, but the compensation laid out below would remain the same.

If you agree to partnering with us, the table below outlines the expectations and compensation for time on task. All travel related expenses will be covered on a claim basis.

Task	**People involved**	**Approximate timing**	**Compensation**
Participate in written feedback and meetings of the expert panel	Local expert(s)	XXXXX	XXXXX
Assist with recruitment of participants for phase 1 and notify the community of the research study (qualitative research)	Fieldworkers	XXXXX	XXXXX
Fieldworker participating in training for phase 2 (quantitative work)	Fieldworkers	XXXXX	XXXXX
Participant recruitment and data collection for phase 2	Fieldworkers	XXXXX	XXXXX
Participate in support/debriefing meetings	Fieldworkers	XXXXX	XXXXX
Total			XXXXX

We would also like to come down to the fieldwork site and meet the organisation as soon as possible. Please note also that we will provide appropriate feedback to communities once the research is completed.

Signed:

_____

Prof Catriona Macleod for CSSR, Rhodes University

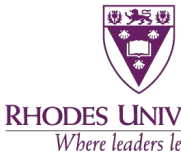
Date: _____

_____

Name, for Organisation

Date: _____

Appendix 2: Final interview schedule used by CSSR/MSSA



CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

AN ASSESSMENT OF ABORTION SEEKING BEHAVIOURS AND PREFERENCES IN RURAL COMMUNITIES OF THE EASTERN CAPE, SOUTH AFRICA

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

INTERVIEW SCHEDULE

Instructions to fieldworker

1. Describe in detail the purpose of the study and its main objectives and answer any questions the participant has about the study.
2. Explain to the participant what it means to be interviewed as a key informant (i.e. expert about the community) and that they will not be asked to divulge personal information.
3. Ask the participant to sign the consent form.
4. Ask the participant to respond in their preferred language.

Aims of the study

The aim of this study is to assist Marie Stopes South Africa (MSSA) in focusing their service delivery so as to overcome barriers to reproductive choice, including safe abortion care, reduce stigma and ensure access to appropriate service provision for people living in rural areas of the Eastern Cape.

The study seeks to addresses aspects surrounding understandings of problematic /unwanted pregnancies, abortion, abortion legislation and abortion services, barriers to and facilitators of access, to abortion services, perceptions of safety and quality of current abortion services.

Interview questions

1. In this community, what typically happens when a couple wants to get pregnant?

Probe if nothing is forthcoming or if the following elements are not covered:

- What discussions would partners have about having children?
- What happens when a couple *does not* want to get pregnant?

2. What happens when a couple gets pregnant?

- Do they go to the nearest public clinic? Are there other options? How far do they have to travel? Why do they choose to go to that facility?
- What happens during the pregnancy and childbirth?
- How are the partner, the family and the community involved?

3. What happens between a couple if a pregnancy is unplanned?

- How would they decide what to do?
- What does the women's partner usually do?

4. How would family and community members respond to unwanted pregnancies?

- Would partners/family/community members respond differently to an unwanted pregnancy if the couple is married or unmarried? If yes, how?
- What about if the couple are in a committed relationship or a casual relationship?

- What about if one or both partners in the couple are in other romantic relationships?
- What about if the couple already have children or have no children?
- What about if the one or both partners in the couple are very young?
- What about if the pregnancy is the result of rape?

5. If a woman is pregnant but does not want to be pregnant, what are her options in this community?

- Where would she go?
- Who would she ask for information?
- What sort of information would she receive from these sources?

6. Please explain to me how decisions about what to do in cases of unwanted pregnancies are made.

- Who would be involved in making the decision about the outcome of a pregnancy?
- How would the process unfold?
- What would happen if there was disagreement about what to do?

7. If a woman made up her mind that she wanted to get an abortion, what would she do?

- Where or to whom would she be most likely to go to get it done?
- Are there any other places/providers/methods available in this community other than the ones you just mentioned?
- What factors would influence her choice of place/provider/method?

8. What are people's views on the safety and quality of these places/providers/methods?

9. Are there any difficulties a woman might face in obtaining an abortion?

- Any other barriers/difficulties than the ones you already mentioned?
- Without naming any names, do you know of an instance in which someone wished to have an abortion, but could not do so? What was the reason they could not? What did this person do instead?
- Do you think the woman might want to hide the fact that she is getting an abortion? Would she perhaps go to a provider that is far away and where no one knows her?

10. If women were able to choose an abortion service, what influences their decision on where to go?

- Which of the following would be important to them: the cost, the distance, the safety, non-judgemental service, minimal waiting time, a service that is stand-alone or part of other services? [Ask the respondent to elaborate on why the factors identified as important are more important than those identified as less important.]

11. How much do you think people are willing to pay for an abortion?

- Would they prefer to pay less and travel further or the other way around?

12. Without giving a name, do you know of anyone who has had an abortion in your community? How did they describe the process of seeking and having an abortion?

- Did they face any challenges/barriers?

- How did they describe their choice of place/ provider/ method? Why did they choose that place/ provider/ method?

13. What do people in your community know about and understand about the abortion laws in South Africa?

- [if respondent makes a broad statement about legality or illegality] Do people believe that's the case for all circumstances?
- [if respondent answers no] Under what circumstances do people believe abortion is legal/illegal?

14. What do people in your community know about places where you can get legal termination of pregnancy?

- Do they know about accessing an abortion at [insert name of nearest termination of pregnancy clinic]?
- Do they know of any other providers of terminations, even if they are not legal?

15. If the community got to know about a woman having an abortion, what would their responses be?

- How would people in the community feel about a woman having an abortion if:
  - The woman is married or unmarried?
  - The woman is poor or wealthy?
  - The woman's pregnancy is early or late?
  - The partner did or did not want her to have an abortion?
  - The pregnancy is a result of rape?
- Do different figures/groups in the community feel differently about abortion in general?

16. What, if any, support is provided to women who have had an abortion?

- What type of support do such women need (e.g. medical, psychological and/or community/partner support)?
- What type of support is most important?
- Where/how do you think women should be able to access this support?

17. Without mentioning any names, please can you tell me a story about any of the issues we discussed today?

- Is there anything more you'd like to share with me?

Appendix 3: Sample Information Sheet

RHODES UNIVERSITY
Where leaders learn

MARIE STOPES SOUTH AFRICA

CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

STUDY ON REPRODUCTIVE CHOICE

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

INFORMATION SHEET

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to understand the following information carefully.

The study is being conducted in accordance with the Rhodes University research guidelines: (https://www.ru.ac.za/researchgateway//) and conforms to the National guidelines for research on human subjects: (https://www.ru.ac.za/researchgateway/ethics/nationalguidelinesonresearchwithhumanandanimalsubjects/).

What is the study about?
Due to various challenges affecting reproductive choice, including access to abortion services in poor and rural communities, Marie Stopes South Africa (MSSA) wishes to extend its service provision to the rural Eastern Cape. The aim of this research study is to assist MSSA in focusing their service delivery to overcome barriers to reproductive choice, including safe abortion care.

For this research, we would like to administer a questionnaire which provides a set of hypothetical options in accessing a service where one can terminate a pregnancy. By choosing your preference in each case, we will be able to identify the general preferences in the community in terms of abortion services.

We are administering approximately 600 interviews across three areas in the Eastern Cape - including among farm workers in the western part of the province, in rural villages between East London and Port Alfred, and in a remote part of the Mbhashe Municipal area.

Why have you been invited to participate?
You have been chosen to take part in the study because you represent a population group within a rural part of the Eastern Cape who might require a service such as is offered by Marie Stopes. Your insight into what characteristics such a facility should have to adequately serve the people in the community is very useful to our research.

Do you have to take part?
It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep if you want to and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

Taking part in this study is not an evaluation of your knowledge of the community or of reproductive choices. You do not have to have a particular viewpoint towards the topic of abortion to participate in this study, nor will your viewpoint be held against you. Your name will not appear on any documents or in any reports that might be seen by friends, family, other members of the community or the local NGO. Whether you choose to take part or not will have no impact on your future dealings with the NGO or the research team. All information you provide will be kept confidential and only in extremely exceptional circumstances (e.g. in cases where a threat to the health, welfare and safety of someone is revealed), is the researcher legally required to pass this information on to an appropriate individual or agency.

What are you taking part in?
In taking part, you will be presented with a list of hypothetical options where you will be required to state your preference. The questionnaire should not take longer than fifteen minutes to complete.

What are the benefits of participation?
Your participation will benefit us greatly in furthering our understanding of access to quality family planning services in rural areas and will affect the way that Marie Stopes designs their interventions. You will be compensated for any costs you incur in getting to the

interview venue, and we will be giving all participants a token of appreciation for taking the time to be interviewed.

What are the disadvantages of taking part?
There is no personal disadvantage to you in participating. We will not ask you to divulge personal information. However, the research does involve discussions of certain sensitive topics such as abortion. We will take due care to deal with these topics sensitively. Please feel free to terminate the questionnaire at any point if you feel uncomfortable or do not wish to proceed. If, for any reason, you feel any distress in participating, we will arrange for you to speak to a counsellor concerning the distress.

How will we treat your data?
Your real name will not be recorded on any written documents. We will ensure that your questionnaire data is safely stored electronically in a password protected file and that the hard copy is kept safely in locked filing cabinets. Data will be destroyed after a period of up to 5 years. Copies will be shared only with researchers in other institutions if they are to conduct analysis, and they will be required to store files only in a secure fashion. Researchers will not keep your interview data on their personal laptops or handheld devices for longer than is necessary.

Can you withdraw from the study?
Your participation in the study is entirely voluntary. All participants have the right to withdraw from the study at any time, up until the point of analysis (January 2020). Participants also have the right to remove their data from the project. You can inform the lead researcher in writing or verbally of your intention to withdraw from the research (see the details below).

What should I do if I want to take part?
The fieldworker will provide you with the Information Sheet and answer any queries you have. If you are happy to participate, please complete and sign the consent form provided, and keep one copy for yourself if you want to. Please also retain this Information Sheet.

Who is organising and funding this research?
The study is organised and led by researchers from Rhodes University working in partnership with the local NGO. This research is being funded by Marie Stopes South Africa.

Who has approved this study?
This study was approved by the Rhodes University Ethics Committee (RUESC), as well as the Marie Stopes Ethics Review Committee.

What will happen to the results of the study?
We propose to publish the findings of the research as a research report that will be used to inform Marie Stopes about expansion and improvement of their services. We will also be producing journal articles based on the data collected. We will provide feedback to your community about the research results in whatever form is deemed suitable by community members. Your name will not appear in this feedback or in any other report or publication.

How can you contact us?
For any further information, please contact the following people:

Lead researcher: Ulandi du Plessis, Critical Studies in Sexualities and Reproduction, Rhodes University, ulandidup@gmail.com, +2783 660 6018.

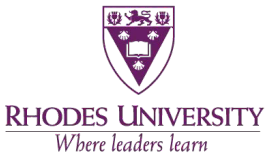
Head of institute: Catriona Macleod, Critical Studies in Sexualities and Reproduction, Rhodes University, c.macleod@ru.ac.za, +2782 802 9187.

If you have any concerns about the way in which the study is being conducted, please feel free to contact the Chair of RUESC who reviewed the project:

Roman Tandlich, Rhodes University Ethics Committee Chair, r.tandlich@ru.ac.za

Thank you for taking the time to read this information sheet.

Appendix 4: Sample Consent Form



CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION

STUDY ON REPRODUCTIVE CHOICE

PROJECT APPROVAL REFERENCE: MSI 013-19, RUESC 2019-0615-751

CONSENT FORM

Please tick each box to show that you agree:

☐	I have had the project explained to me and I understand the Information Sheet, which I may keep for my records.
☐	I have had a chance to ask questions and am satisfied with the answers.
☐	I have been given time to consider my decision.
☐	I understand that I am free to refuse to participate or to discontinue participation at any time without any negative consequences.
☐	I understand that I am free to withdraw my data from the study up to the time this is no longer possible without any negative consequence (January 2020).
☐	I understand that if I withdraw my data, it will be destroyed.
☐	I consent to being interviewed.
☐	I consent to having my interview recorded.
☐	I understand that any information I provide will be stored in a way that keeps my identity (and the identities of other people I have talked about) private.
☐	I consent to the use of anonymized quotes in publications from the research (this might include printed and online media) to be shared with donors, academic institutions, other NGOs and other relevant stakeholders.
☐	I understand that in **exceptional** circumstances (e.g. in cases where a threat to the health, welfare and safety of someone is revealed through the research), the researcher will be legally required to pass this information on to an appropriate individual or agency.
☐	I consent to the processing of my information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the Protection of Personal Information (POPI) Act.
☐	I consent to my non-identifiable data being stored at the CSSR offices for re-use in future research and analysis by the CSSR and/or Marie Stopes. I understand that it will be fully anonymized before storage. The data will not be used for any other purpose than the purpose for which consent was originally given, and it will be destroyed after five years.

Participant name: _____

Participant signature: _____

Date: _____

Interviewer name: _____

Interviewer signature: _____

Participant Copy/Research Copy

Appendix 5: Sample additional questions to DCE

IZIHLANDLO ZOPHONONONGO EZIBALULEKILEYO NGESEKSI NOKUBA NABANTWANA

UHLOLO NGEMIKHWA NOKUKHETHWA NGABAFUNA UQHOMFO KULUNTU LWASEMAPHANDLENI EMPUMA KOLONI, EMZANTSI AFRIKA

AFTER QUESTIONNAIRE:

1. **What is your sex?**

- ☐ Male
- ☐ Female

2. **What is your age?**

☐

3. **Are you employed?**

- ☐ Yes
- ☐ No

4. **Do you live and work in rural area?**

- ☐ Yes, I live and work in a rural area
- ☐ I live in a rural area
- ☐ I work in a rural area
- ☐ None of the above

5. **What is the average income of your household per month?**

- ☐ between R0 – R1000 per month
- ☐ between R1000 – R2000 per month
- ☐ between R2000 – R5000 per month
- ☐ more than R5000 per month

6. **What would be the most important to you, or someone like you, in choosing a provider? Please rate your choice: 1 being your top choice and 4 being your last choice.**

- ☐ Type of facility

1

- [ ] Location
- [ ] Price of abortion
- [ ] Opening hours

7. If you, or someone like you, wished to have an abortion, which provider would you choose? Please rate your choice: 1 being your top choice and 5 being your last choice.

- [ ] Government service
- [ ] Informal provider (like the pamphlets you see up in the city)
- [ ] Traditional healer
- [ ] Self-abort using improvised abortifacients
- [ ] Private provider such as Marie Stopes

8. From which information channel would you like to receive information about abortion? Please rate your choice: 1 being your top choice and 8 being your last choice.

- [ ] Radio/television
- [ ] Pamphlets/posters
- [ ] Schools/universities
- [ ] Friends/family
- [ ] Nurse
- [ ] Home-based carer
- [ ] Toll-free number to call
- [ ] Online

9. Which of the following describes your attitude towards abortion most accurately?

- [ ] I think abortion is acceptable
- [ ] I think abortion is acceptable in some circumstances such as rape
- [ ] I think abortion is never acceptable

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