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# HEALTH ACCESS AND UTILIZATION SURVEY PLUS (HAUS+)

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A Practical Step-by-Step Guide

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# List of Acronyms

<b>HAUS+</b>	Health Access and Utilization Survey Plus
<b>HIS</b>	Health Information System
<b>HQ</b>	Headquarters
<b>NARE</b>	Needs Assessment for Refugee Emergencies
<b>NGO</b>	Non-Governmental Organization
<b>ODK</b>	Open Data Kit
<b>PHS</b>	Public Health Section
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>WASH</b>	Water, Sanitation and Hygiene
<b>WHO</b>	World Health Organization

# Glossary

Terms and concepts	Definition
<b>Bias</b>	An error that consistently results in an over- or under-estimation of a value of measurement. Bias can be introduced at any step of a survey, from sampling, data collection to data analysis, if not properly treated. Use of a random and/or systematic sampling process may help prevent “selection bias.” The best way to reduce bias is to reduce non-sampling errors (such as errors committed in survey implementation and data processing, non-response, poor quality questionnaire, etc.) to a minimum.
<b>Confidence interval (limits)</b>	Indicates the range of possible values that the sample estimate will fall within a certain percentage of the time. Confidence limits are the highest and lowest values within that range, and are usually calculated at a level of 95%. That is, there is a 95% chance that the actual rate or proportion being estimated in the survey falls within the confidence interval.
<b>Precision</b>	A term that refers to the magnitude of sampling errors or the range of possible values for a given estimate. For example if an estimate of 45% is obtained from the survey, a 10% (absolute error) level of precision means that the true value is probably between 35% and 55%. A greater level of precision, for example 5% means that the true value is probably between 40% and 50%.
<b>Prevalence</b>	The proportion of a population who have a specific characteristic in a given time period.
<b>Probability proportional to size</b>	A sampling principle that ensures that the sample’s distribution mirrors the population’s distribution.
<b>Random number</b>	A number that is selected (by chance) from many numbers. Each number has an equal chance of being selected.
<b>Sample</b>	A group of units (such as individuals or households) selected from the target population.
<b>Sample size</b>	The number of units (individuals, households) selected from the population for inclusion in a survey.
<b>Sampling frame</b>	The list of every possible sampling unit within the target population from which a sample will be drawn.
<b>Sampling interval</b>	The total population size (N) divided by the sample size (n). Used as part of systematic sampling to select units from a sampling frame.
<b>Margin of error</b>	It is a statistical measure that indicates the precision of a sample estimate, and is used to calculate the confidence limits of that estimate. Typically, the 95% confidence limits of an estimate are calculated as the estimated value minus and plus two times its standard error.
<b>Strata/stratum</b>	Strata are mutually exclusive groups of sampling units constructed from the list of sampling units before sample selection. Examples of these groups are: types of residence, ethnic groups, administrative units. In a stratified sample, the sampling error depends on the population variance existing within the strata but not between strata. For this reason, it is important to create strata with low internal variability (or high homogeneity).
<b>Stratified random sampling</b>	Regroups similar unit into strata before sample selection, and then designs independent samples for the strata. It ensures that we have a large enough sample in each sub-group.

Terms and concepts	Definition
<b>Stratification</b>	When there are subgroups with important differences, we want to make sure that some of these groups are not under-represented in the sample. Stratification reduces this possibility. Stratification is a process by which the survey population is divided into subgroups or strata that are as homogeneous as possible using certain criteria (i.e., ethnic group, urban/rural, province, etc.). From a statistical perspective the main benefit of stratification is to reduce sampling errors caused by under-representation of certain subgroups. In addition, if enough respondents from each subgroup are included in the sample, we can obtain coverage estimates for subgroups as well as for the entire program area. However, in this case, we need to weight the coverage estimates from all subgroups to get a valid overall estimate. Stratification can be single-level or multi-level. A typical two-level stratification in large surveys is region crossed by urban-rural stratification.
<b>Systematic random sampling</b>	Selection of units using a random, periodic interval when units are geographically sparse, and each unit still has an equal probability of being selected, but the probability is now proportional to size. A random starting point is chosen and then cases are selected from the sampling frame at a sampling interval. In this approach, the selection of the first sampling unit completely determines the selection of the remaining sampling units in a given frame.
<b>Target population</b>	All persons of interest (e.g., mother of under 2 children, children under 5, etc.) in a defined area (e.g., country, region, etc.).
<b>Two-stage sampling</b>	A process involving more than one step of sampling before reaching the ultimate unit of interest. For example, first sample households from the population, and then, mothers/caregivers within sample households.

# Introduction

A growing number and proportion of the world's refugees are to be found in urban areas/setting. The scope and modality of public health programmes for refugees in urban settings varies according to the context. In cities and towns refugees can access multiple health service providers, including, state, private, local and international non-governmental organizations (NGOs) which means these programmes are less easy to monitor.

The United Nations High Commissioner for Refugees' (UNHCR) aim is for refugees to have access to the national health services at a level similar to that of nationals. UNHCR's major role in urban settings is to advocate for and facilitate quality health services to be available and accessed by refugees. While working with government and city authorities, UNHCR engages with a wide range of actors promoting shared responsibility, and advocates for an appropriate resource base to ensure that refugees receive protection and assistance. UNHCR's Public Health Section (PHS) has produced operational guidance to support public health programming in urban settings.<sup>1</sup>

In most camp or settlement settings, UNHCR and partners monitor the health status of the population, access and utilization of health services as well as health service quality using a range of health information system (HIS) tools. However, urban settings present a variety of challenges for surveillance, and for the collection of reliable data on the health status and health service needs of urban refugees. Health services are relatively scarce when compared to camp-based refugees. Furthermore, urban refugees face many barriers in accessing health services, including economic, geographic, cultural, linguistic and administrative. Health services in cities or towns may not be accessible to refugees because they are too expensive, too far away, the cost of transport is prohibitive, or because health care providers lack adequate cultural sensitivity to effectively communicate with people from different ethnic groups, or there are no translation services available. Additionally, access and utilization of health services might vary by place and length of residence, level of family education, and knowledge of available services.

For this reason, UNHCR developed the Health Access and Utilization Survey Plus (HAUS+) which allows for measurement of disease prevalence, health status, health expenditure and knowledge and access to key health services in a representative sample of the population. HAUS+ can also pinpoint barriers and facilitators in the ability to access and successfully use appropriate health care services.

HAUS+ updates and builds on the previously used HAUS which focused on health access and utilization. Previous HAUS have yielded useful information that has led to improved programmatic responses:

- In 2016 a HAUS conducted in Israel found that an increasing number of refugees and asylum seekers, who migrated to urban centers in Israel, were denied access to social services, like health insurance. The findings from the HAUS informed policy to facilitate allocation of funds available to improve healthcare delivery to refugees and asylum seekers.
- In 2014, an in-person household survey on health access and utilization in Jordan found that despite high levels of care-seeking, cost was a critical barrier to health service access for Syrian refugees<sup>2</sup>. On the other hand and despite the subsidized access to public health care services that has been granted to refugees in 2019, the 2021 HAUS findings showed low level of access to public services compared to private providers.
- Annual HAUS in Lebanon have enabled UNHCR to monitor awareness of availability of key health services among urban refugees<sup>3</sup>.

HAUS+ remains focused on health access and utilization but in line with a recognition of the importance of the social determinants of health, has additional questions on water, sanitation and hygiene, housing, food security and access to primary and secondary education. Repeat surveys allow for monitoring trends over time in how urban refugees access and utilize services and their living conditions.

This guidance document aims to (1) assist UNHCR Public Health Officers and partner organizations when considering conducting a HAUS+, particularly among urban refugees; and (2) standardize the approach. Comments, feedback and requests for further guidance should be directed to: [HQP@UNHCR.ORG](mailto:HQP@UNHCR.ORG).

<sup>1</sup> <http://www.unhcr.org/protection/health/4e26c9c69/ensuring-access-health-care-operational-guidance-refuhtml>

<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4946096/>

<sup>3</sup> <https://reliefweb.int/sites/reliefweb.int/files/resources/LebanonHealthAccessandUtilisationSurvey2017UNHCR.pdf>



# Health Access and Utilization Survey Plus

## What is a HAUS+?

- HAUS+ is a cross-sectional, household telephone survey that is simple, flexible and cost-effective to identify factors that may affect refugees' ability to access and successfully utilize appropriate health services when needed as well as household food security, water, sanitation and hygiene (WASH), education and housing situations. The ready availability of results are expected to guide sectoral responses for an ongoing humanitarian situation in a country and monitor the implementation of key activities.
- HAUS+ may be conducted in operations with a significant population of refugees with a high mobile phone coverage among the refugees. A complete database (sampling frame) with phone numbers of head of households is needed to select a representative sample of refugees to participate in the survey.
- In operations with low mobile phone ownership, or where there is no database containing refugee mobile numbers, key health access and utilization questions should be integrated into approaches such as the UNHCR Tool for Participatory Assessment in Operations<sup>4</sup>, and the Needs Assessment for Refugee Emergencies (NARE) Checklist for refugee operations<sup>5</sup>. A limited number of health access and utilization indicators have also been incorporated into UNHCR's Results Monitoring Survey and the Flagship survey. However, these surveys are focusing on high level and limited number of indicators which are not sufficient for the public health section to better monitor the health program.

## Why conduct a HAUS+?

- Urban refugees access health services through a variety of different providers with varying levels of availability, quality and access conditions including user-fee structures.
- Reliable data on the health service needs of urban refugees are more difficult to obtain compared to those living in refugee camps. It is likely that access and utilization of services vary by place and length of residence, level of education, costs associated with service utilization and knowledge of availability of services.
- In countries where refugees are included into national health systems and surveys (i.e. demographic and health surveys, multiple indicator cluster surveys), disaggregated data may not be available.
- UNHCR initially developed HAUS in an effort to conduct a cost-effective and efficient mechanism for regular monitoring of health access and utilization for urban refugees. With this update the questionnaire has been expanded to include key indicators relating to other sectors in a modular format as well as Covid-19 related questions and is now referred to as HAUS+. UNHCR recommends carrying out repeat HAUS+ annually to monitor the health access needs of refugees, utilisation of services, morbidity patterns, household food security, WASH, education and housing situations. Repeat surveys will allow analysis of trends over time, impact of interventions as well as changes in context and detection of emerging issues.

### Note:

While the HAUS+ tool is focused on urban settings, it can also be used in rural, refugee camp or settlement settings to complement other sources of health information if the required conditions are met including mobile phone access.

<sup>4</sup> <http://www.unhcr.org/publications/legal/450e963f2/unhcr-tool-participatory-assessment-operations.html>

<sup>5</sup> <https://emergency.unhcr.org/entry/119844/needs-assessment-for-refugee-emergencies-nare>

## HAUS+ Tool Components

- UNHCR HAUS+ is comprised of standardized sections outlined below:
  - 1) Demographic information
  - 2) Child immunization
  - 3) Nutrition
  - 4) Infant and Young Child Feeding Practices
  - 5) Primary and secondary education
  - 6) Sexual and reproductive health (SRH) practices
  - 7) Chronic Diseases, mental illness and disability
  - 8) Access to health care in the last three months
  - 9) Hospitalisation in the preceding year
  - 10) COVID-19 Knowledge, attitude and practice as well as vaccine coverage
  - 11) Access to health services and health seeking behaviour
  - 12) Health care expenditure
  - 13) Knowledge of available health services
  - 14) WASH
  - 15) Food security
  - 16) Access to health insurance schemes
  - 17) Housing
  - 18) Communication
- Demographic information of household member roster sections (i.e., questions administered to eligible household members, including child immunization, child nutrition, SRH, chronic disease, mental illness and disability, etc.), access to health care, hospitalization, expenditures, knowledge of available health services, COVID-19 are core sections, while education, WASH, food security, housing and health communication are optional. The standardised Enketo version of the questionnaire is available here: [HAUS+ global questionnaire](#).

## Steps for conducting HAUS+

The following are the steps for undertaking a HAUS+ in urban refugee settings. The steps may not always be conducted in the order presented below, but all of them should be considered during planning and implementation.

- Step 1:** Determine if there is a need, feasibility, and resources to conduct HAUS+
- Step 2:** Gather background information
- Step 3:** Define the objectives of the survey
- Step 4:** Define the population of interest
- Step 5:** Communicate with stakeholders
- Step 6:** Determine sampling method & calculate sample size
- Step 7:** Select households
- Step 8:** Select participants
- Step 9:** Design questionnaire and adapt to local context
- Step 10:** Select and train personnel on interview procedure and best data collection practices
- Step 11:** Collect data, analyze data, write and disseminate report
- Step 12:** Take appropriate action based on survey results





## STEP 1: Decide on the need for a survey

- a) Why should a HAUS+ be conducted?
- b) How frequently should HAUS+ be conducted?
- c) What other possible ways exist to assess health access and utilization?
- d) What budget is required for HAUS+?
- e) What are some limitations of HAUS+?
- f) What support can UNHCR HQ/ Regional Offices provide for a HAUS+?

### HAUS+ should be considered in order to:

- Evaluate urban refugees' access to, utilization of, and coverage of, key health services across different levels of health facilities, quality of care and user fee structures as well as primary and secondary education access, WASH, food security and housing situations.
- Identify critical factors and challenges faced by urban refugees that may affect their ability to access and successfully utilize appropriate health care services in a timely fashion.

### How frequently should HAUS+ be conducted?

- A baseline survey should be conducted in a country with a significant population of urban refugees, and high mobile phone coverage among the refugees.
- In the case of new refugee emergencies and/or influx, UNHCR recommends operations to carry out a HAUS+ within 6 months to 1 year.
- UNHCR also recommends that operations conduct follow-up HAUS+ annually and use the data to monitor trends in health access needs of refugees.

## What other possible ways exist to assess health access and utilization?

- There are significant logistical and financial challenges of routinely surveying urban refugees in person. Ad hoc reports from agencies providing services, routine disaggregated data from government, or purposive surveys paint inconsistent pictures and are not representative of the population. However, they can give an indication of the challenges facing refugees whilst seeking health care services.
- National surveys that include refugees may provide useful information. Even though disaggregated data by refugee and national may not be available, looking at information from cities or regions where large proportion of the population are refugees might give a fairly good picture of access and utilisation of services.
- HAUS+ can be used to accurately assess health access and utilization among urban refugees. However, they are not a substitute for more rigorous surveys that include home-visits and household-level direct observation.

## What budget is required for HAUS+?

- Budgets should cover staff/consultants travel, accommodation, interviewer stipends, telephone bills and costs of tablets. In order to account for all costs, sample size calculation and sampling must be considered very early on in the survey planning process.
- The cost of previous HAUS+ telephone surveys range from 4,000 – 10,000 USD.

## HAUS+ dates and timeline

Before any further planning can begin, the survey dates and timeline should be chosen. The survey dates should be discussed and confirmed with all stakeholders. Factors to consider when planning survey dates are outlined in [Appendix 1](#).

## What are some limitations of HAUS+?

- Given the logistical and financial challenges of routinely surveying urban refugees in person, HAUS+ participants are surveyed by telephone.
- Only households with valid mobile phone access are included in the sampling frame which introduces bias.
- The telephone does not allow for visual verification of, for example, vaccination records, housing properties, etc.
- The respondent may not always be aware of health and/or other needs of all household members.
- Other limitations include non-response, respondent is absent, lack of information from the respondent, recall biases or logistical challenges to use credible telephone lines only to reach refugees.

## What support can UNHCR HQ/Regional Offices provide for a HAUS+?

- UNHCR PHS/Regional Offices can provide remote technical guidance on HAUS+, such as methodology, data analysis, interpretation, advice on equipment, and identification of external resources.
- It is recommended to share implementation plans, including, survey protocols and draft reports of survey findings with UNHCR HQ/Regional Offices in a timely manner for feedback and validation.

## STEP 2: Gather background information

Before starting a HAUS+ , it is important to find out as much as possible about the population to be surveyed from existing sources (i.e., secondary information). This includes:

- Description of urban refugee situation in the country, including, population characteristics and figures, country of origin of refugees, demographic figures from UNHCR registration unit (average household size, percentage of children under 5 years, sex distribution, ethnic and/or nationality breakdown), population head counts or household listings done by partners and languages spoken.
- Description of the security and political situation in the host country, including administrative sub-units.
- Description of the context of available health services for urban refugees in the country, including cost of services (i.e., subsidized or free key health services or health insurance). Also, “health care access” defined as the opportunity to have health care needs fulfilled in the host country.
- Information on whether or not refugees in the country get issued any residency documents by the government or by UNHCR.
- Availability of sampling frame i.e., database containing names and mobile phone numbers of urban refugees registered in the host country. This can be sought from UNHCR registration unit.
- Previous surveys and assessments conducted by partners providing urban refugees with assistance; health statistics from ministry of health, UNHCR HIS if available, health centres and partner reports.

## STEP 3: Define the objectives of the survey

### General Objectives:

- Identify and measure key indicators of access and quality of health care available for refugees;
- Assess levels of knowledge of available health care services, access, and utilization of preventative and curative health services;
- Identify barriers to access;
- Assess levels of coverage for key health indicators, including measles immunization coverage in children under five, skilled attendance at delivery, and use of antenatal care, family planning uptake;
- Identify levels of conflict-related injuries or disability and the types of support received.

### Specific Objectives:

- Evaluate knowledge regarding the availability of health care services for urban refugees;
- Estimate the proportion of registered urban refugees seeking care in the preceding 3 months, types of care sought, whether or not care sought was received and in which type of facilities, difficulties faced in obtaining care;
- Assess the use of private facilities and the reasons for seeking care at private facilities;
- Assess access to care and barriers experienced for those with non-communicable diseases;
- Estimate coverage for key health and nutrition indicators including polio and measles immunization in children 9 – 59 months, use of antenatal care, skilled attendance at delivery, and infant and young child feeding practices;

- Estimate the proportion of households with injuries, chronic conditions, mental illness or disability and the type of support they are receiving.
- Assess current level of household food security, access to WASH, primary, secondary and tertiary education and housing.

## STEP 4: Define population of interest (target population)

### What is the population of interest (target population)?

- HAUS+ is carried out in households that are registered with UNHCR as being outside of a camp setting, and where the head of household has a valid contactable telephone number.
- The population to be assessed is all urban refugees registered with UNHCR. UNHCR HQ / Regional offices should be contacted for expert guidance on planning the survey.
- A representative sample of households will be selected from a complete database with names and telephone numbers of refugees residing or registered with UNHCR in a country.
- In each selected household, the head of household will be contacted on his / her registered number and consent sought to participate in the survey.
- In his / her absence, any other adult (18 years and older or according to the local age of majority) member of the family who responds to the registered telephone, and who is able to provide information on health utilization for all household members will be interviewed.
- Each eligible household will be called at least three times (each subsequent call at least two hours apart). Absent or non-responsive household will not be replaced. Individuals who did not respond to the call or whose phones were not valid or declined to take part in the survey will be recorded as non-respondents. Therefore, failure to obtain information from a designated household or individual respondent for any reason (absence, refusal to reply, invalid phone number etc.) is considered a non-response and the proportion of such households or individuals of the sample is called the non-response rate.

### Inclusion and exclusion criteria for individuals within a selected household:

Inclusion	Exclusion
<ul style="list-style-type: none"> <li>• Head of household</li> <li>• In case of absence of head of household, any adult (18 years and older or according to the local age of majority) who can provide response on behalf of head of household</li> <li>• Living outside refugee camps</li> </ul>	<ul style="list-style-type: none"> <li>• Not providing informed consent</li> <li>• Under 18 years of age (or applicable age majority in country)</li> <li>• Not living outside refugee camps</li> <li>• Not registered in the database</li> </ul>

### What are the target group(s) for each HAUS+ section?

The target group for each section of the questionnaire are outlined below:

- Demographic information – Head of household or adult respondent on behalf of household members
- Child immunization – Mother/primary caregiver of children between 9 and 59 months old
- Nutrition – Mother/ primary caregiver of children under 5 years old

- Infant and Young Child Feeding Practices – Mother/primary caregiver of children under 2 years old
- Education – Head of household or adult respondent on behalf of household members between 5 and 18 years old
- Reproductive health practices – Mother/primary caregiver of children under 2 years old
- Chronic diseases, mental illness and disability – Head of household or adult respondent on behalf of household members
- Access to health care in the last three months – Head of household or adult respondent on behalf of household members
- Hospitalisation in the preceding year – Head of household or adult respondent on behalf of household members
- Access to health services and health seeking behaviour – Head of household or adult respondent
- Health care expenditure – Head of household or adult respondent
- COVID-19 Knowledge, attitudes and practices – Head of household or adult respondent
- Knowledge of available health services – Head of household or adult respondent
- WASH – Head of household or adult respondent
- Food security – Head of household or adult respondent
- Access to health insurance plan – Head of household or adult respondent
- Housing – Head of household or adult respondent
- Communication – Head of household or adult respondent

## STEP 5: Communicate with stakeholders

- Since HAUS+ will be conducted by phone call, it is absolutely essential to inform refugees about the planned survey and its objectives to minimise non-response bias.
- Before survey implementation, it is important to obtain buy-in from the MoH and all key partners to ensure a more successful survey.
- The target population can be informed about the survey using combination approaches such as text message, WhatsApp, newsletters, etc.

## STEP 6: Sampling method and sample size calculation

- HAUS+ protocol
- What is the sampling frame for HAUS+?
- How is a household defined?
- How is the required sample size calculated?
- How are households sampled for HAUS+?

### What should be included in the HAUS+ protocol?

- Before embarking on the survey, a protocol should be written to explain the methods that will be used. The protocol should be shared with UNHCR HQ / Regional Offices and other key stakeholders within a timely manner, in order for them to provide feedback before the survey work begins. [Appendix 2](#) includes a sample protocol that may be adapted and used in the field.

## What is the sampling frame for HAUS+?

- A sampling frame is the essential backbone of all survey implementation. It comprises complete list of the units (households or individuals) from which a representative sample can randomly be drawn at each stage of the survey. Without such frames, it is impossible to undertake a representative survey.
- Typically, **there are two-stage sampling frames for HAUS+:** 1) **households** 2) **individuals within sampled households:**
  - The sampling frame from which survey households should be selected is the list of UNHCR registered households, which have valid telephone numbers.
  - The second stage sampling frame consists of target groups categorized as household members within sampled households from the first stage. This frame is established through a household roster, which is a listing of all household members along with associated information. It is generated by interviewers during the survey, after households have been contacted by phone through the head of households or a responsible adult within these households. After the household roster has been established, individuals who are eligible to respond to the various questionnaire modules corresponding to the different indicators can be interviewed.
- It is important to note that a highly incomplete sampling frame (i.e., where information on refugees is not routinely captured by UNHCR or where a high proportion of registered refugees provide invalid phone numbers), is less likely to generate a survey sample representative of the entire population of urban refugees in the country.
- Where the sampling frame is known to be incomplete, surveyors should carefully weigh the merits of conducting the survey against the risk of inappropriately generalizing study findings.
- The proportion of urban households that have provided none or an invalid phone number should always be reported, and the limitations this places on the generalizability of the discussed findings.

## How is a household defined?

- **There is no universal definition of a household.** However, a common definition of a household used in surveys is ***a group of people who live together and routinely “eat out of the same pot” or a group of people sharing the same dwelling and who have a joint budget.*** For example, if one or two families share “the same pot”, they should be assessed as one household.
- The household should be selected using an accurate and updated household lists from the UNHCR ProGres database. The following procedure should be followed when using ProGres list for sampling:
  - First select the eligible respondent (head of household or adult 18 years and older) from the list of households.
  - To complete household questionnaires, select all household members who live together and routinely eat out of the same pot or share the same dwelling and who have a joint budget or according to the definition used in the context where the survey is taking place.



### Please note:

- It can become very confusing for surveyors if there is no clear definition of a household before the survey starts – especially in polygamous settings or when extended families live together.
- If the surveyors do not understand the definition of a household, they may use different definitions in the same survey. It is important to ensure the same definition and same procedures are used in the same survey and in surveys from year to year, in the same setting. This will allow direct comparisons to be made.

## How is the required sample size calculated?

A [HAUS Plus Sample Size Calculator](#) has been designed to help calculate the sample size needed for a single survey designed to estimate levels at one point in time and for comparison of phases or groups using the below formulas.



- The **initial sample size needed for single survey designed for the estimation of indicators of proportions that ensure adequate precision is given by:**

$$n_{\text{initial}} = \text{DEFF} * Z_{1-\alpha/2}^2 * P_{\text{expected}}(1 - P_{\text{expected}}) / \text{MoE}^2$$

Where:

- DEFF is the estimated design effect of the survey, usually set between 1.5 and 2. If stratified sampling is used, provided that the strata are homogenous and sampling units (households and individuals) are selected randomly, the DEFF should be set at 1.
- $Z_{1-\alpha/2}$  is the critical value from the normal probability distribution. For HAUS+, the significance level should be typically set at  $\alpha = 0.05$ , giving a value of  $Z_{1-0.05/2} = Z_{0.975} = 1.96$ .
- $P_{\text{expected}}$  is the expected prevalence (proportion) of the indicator of interest
- MoE is the margin of error. This value is typically set between 5% and 10%.

- **For comparison of two phases (baseline and endline surveys for example), two levels of imprecision have to be taken into account for sample size calculation. In order to statistically demonstrate a difference between the two estimates, we will need a larger sample at each phase, thus, reducing the two levels of imprecision:**

$$n_{\text{initial}} = \text{DEFF} * [(Z_{1-\alpha} \sqrt{2P(1-P)} + Z_{1-\beta} \sqrt{P_{1,\text{est}}(1 - P_{1,\text{est}}) + P_{2,\text{est}}(1 - P_{2,\text{est}})}) / \delta]^2$$

Where:

- $n_{\text{initial}}$  is the initial sample size required by the surveys for each of the two time points (i.e., for both the baseline and end-line).
- DEFF is the estimated design effect of the survey, usually set between 1.5 and 2. If stratified sampling is used, provided that the strata are homogenous and sampling units (households and individuals) are selected randomly, the DEFF should be set at 1.
- $\delta$  represents the minimum meaningful effect size to be achieved over the time frame specified by the two surveys; note that  $\delta \neq 0$  in order to compute formula.
- $P_{1,\text{est}}$  represents a survey estimate of the true (but unknown) population proportion  $P_1$  at baseline. A value can be obtained from a recent survey that collects data on the same indicator, conducted in the same country or region of the country.
- $P_{2,\text{est}}$  represents a survey estimate of the true (but unknown) population proportion  $P_2$  at end-line. Since  $P_2$  represents a future value that is unknown at the baseline when the initial sample size must be computed, it can be approximated by  $P_1 + \delta$  for indicators where an increase is expected over time (such as measles vaccination coverage in children 5-59 months). Similarly, it can be approximated by  $P_1 - \delta$  for indicators where a decrease is expected over time.
- $P = (P_{1,\text{est}} + P_{2,\text{est}}) / 2$ .
- $Z_{1-\alpha}$  is the value from the normal probability distribution corresponding to a confidence level  $1 - \alpha$ . For  $1 - \alpha = 0.95$ , the corresponding value is  $Z_{0.95} = 1.64$ .
- $Z_{1-\beta}$  is the value from the normal probability distribution corresponding to a power level of  $1 - \beta$ . For  $1 - \beta = 0.80$ , the corresponding value is  $Z_{0.80} = 0.84$ .

- Once the initial sample size is calculated, it should be adjusted upwards, taking into account the number of households to be contacted for individual level indicators. Although some households will have exactly one member from a given sampling group, other households will have more than one eligible member from the sampling group and some households will have no eligible members from the sampling group. For sampling purposes, it is essential, therefore, to have not only an estimate of the number of eligible members from the various sampling groups that must be sampled, but also an estimate of the number of households that need to be called to obtain the required sample of eligible members from the associated sampling groups. For these reasons, the initial sample size,  $n_{\text{initial}}$ , should be inflated to determine the number of households to contact in order to meet the required sample for individual-level sampling groups. The following formula should be used:

$$\text{adj1} = [A * (1/1 - e^{-\lambda})] + 0.5[(1 - A)(1/1 - e^{-\lambda})]$$

Where:

- $A = (1 + \lambda) * e^{-\lambda}$
- $\lambda$  = proportion of the population in the age group underlying the indicator \* average household size.

- The sample size adjusted for the number of households to contact is then given by:

$$n_{adj-1} = n_{initial} * adj_1$$

- Lastly, another adjustment that needs to be made is related to anticipated household non-response. In all household surveys, it is expected that some proportion of households selected for the survey will be unreachable, unavailable, or unwilling to respond to any of the survey questions; this is called household non-response. If no past information is available on non-response rates, a generally accepted rule of thumb is to assume an estimated response rate of 60% - 70%. That is to say, if non-response rate of 30% is assumed, then the sample size should be multiplied by  $adj_2 = 1/(1-0.30) = 1.4286$ .
- The final sample size (denoted by  $n_{final}$ ), which is a product of the initial sample size and both adjustments, then becomes:

$$n_{final} = n_{adj-1} * adj_2$$

- The **final sample size will be chosen from among the variable sample sizes calculated for key indicators**. The recommendation is that the sample size for **all key indicators** from among the indicators being collected in the survey should be calculated and that **the largest sample size resulting from all samples sizes computed should be chosen to be the overall sample size for the survey**. This should be based on a balance between obtaining a sample size that ensures that key indicators are estimated with adequate precision, while being feasible in light of available programmatic resources. As illustrated in table 1 below, to calculate measles immunization coverage, a sample of 406 children is needed. We gather from programme data that, children 9-59 months account for 18% of the total population with average household size of 5 and 30% non-response. The number of households needed to calculate immunization coverage will be 796. However, given the fact that other information on other indicators of interested will be collected in parallel, the total number of households for the survey would be the 1141 which corresponds to the largest sample size calculated for the 4 indicators in this example (Table 1).

**Table 1: Variable Sample Size Estimates depending on Key Indicators of Interest (Confidence Interval (95%), Non-response (30%))**

Indicator of interest	Target group	Pexpected	MoE	DEFF	% of the population in the age group underlying the indicator	Average household size	Ninitial (number of refugees)	Nadj-1 (number of households)	Nfinal (number of households)
Knowledge of right to subsidized access to governmental PHC services	Heald of household or adult respondent	0.5	0.05	2	NA	NA	769	769	1099
Measles vaccination coverage	Mother of children 9-59 months	0.5	0.03	2	18%	5	406	557	796
Skilled birth attendant	Mother of children <2 years	0.5	0.05	2	4%	5	146	798	1141
Proportion unable to access treatment for chronic diseases	Head of household or adult respondent	0.5	0.05	2	80%	5	769	428	611

## Sub-population comparisons and their effect on sample size

- One important consideration with sample size is the number needed for the data analysis. If descriptive statistics are to be used, e.g., mean, frequencies, then nearly any sample size will suffice.
- HAUS+ allows analysis of the key indicators at country level. Thus, the sample size calculated applies to the entire population of refugees from which the sample will be drawn. However, when there are subgroups or strata (rural vs urban) with important differences, we may want to make sure that some of these groups are not under-represented in the sample. In this case, within each stratum, the sample is designed and selected independently to allow sub-group estimates in addition to global estimates.
- From a statistical perspective, the main benefit of stratification is to reduce sampling error caused by under-representation of certain subgroups in the selected sample. In addition, if enough respondents from each subgroup are included in the sample, it is possible to obtain coverage estimates for subgroups as well as for the entire survey area/location. However, in this case, weighted estimates from all subgroups will be needed to get a valid overall estimate.
- If we reduce the precision, or are measuring a much more prevalent factor, then the sample size will be reduced. But, if we want to be fairly precise, and only a small proportion of the population has the variable of interest, then the sample size needed to measure that variable in the population is going to be much larger.
- The decision about the level of precision versus feasibility should be weighted carefully and will depend largely on programmatic judgment, i.e., weigh the available resources against the benefit of having highly accurate data.
- Choose a final sample size by balancing precision with logistical feasibility. We recommend focusing on the operation's key indicators of interest for the target population, and what would be the most useful information from the survey. Then, determine what sample size is needed to measure the variable of interest.

## STEP 7: Sampling Households

- If the total size of the population being surveyed is below ~2,500 people (or ~<600 households), no sampling is necessary and an **exhaustive (census) survey** can be conducted, whereby all households are surveyed. If the population size is bigger than this, a sample should be selected for the survey.<sup>6</sup>
- Households will be selected using **simple systematic random sampling or stratified systematic random sampling from a UNHCR database** of households listed in the ProGres database. **Stratified sampling ensures that participants from each groups or strata (region, governorate, etc.) are included in the final sample whereas simple systematic random sampling does not ensure that groups or strata are represented equally or proportionately within the sample.**
- The households will be selected from this list based on a sampling interval/step calculated by dividing the number of households in the sampling frame (i.e., database with list of registered refugees with valid phone numbers), by the number of required households (sample size).
- Before selecting households, the list will be re-sorted by assigning a random number to each household in order to remove any bias associated with the original order of the list. After all households are numbered, a number between one and the total number of households (N) is selected through a random number generator: <https://www.randomizer.org/>.

<sup>6</sup> UNHCR Standardized Expanded Nutrition Survey (SENSO Guidelines for Refugee Populations. <http://sens.unhcr.org/introduction/pre-module-survey-steps-and-sampling/>

### Below are steps for selecting households to take part in HAUS+:

- 1) Potential households should be selected using **stratified systematic random sampling** where the number sampled in each group or strata (e.g., refugee leaving in region A) is sampled systematically and proportional to its known size in the parent population (probability proportional to size).
  - a. Firstly, obtain your sampling frame, which is the list of UNHCR registered households where the head of household has provided a phone number (UNHCR ProGres database).
  - b. Then, sort the sampling frame using Microsoft Excel.
  - c. Re-sort the list by assigning a random number to each household. This is in order to remove any bias associated with the original order of the list. Re-sort the list again, this time by region.
- 2) Calculate the sampling interval/step (separately for each region):
  - a. Firstly, calculate the sample size needed per group (e.g., per region) by multiplying the overall sample size needed for the entire survey by the proportion of the population living in that region (e.g., if 100 households overall should be surveyed and 10% of the population lives in region A; then you need to select 10 households from region A).
  - b. Calculate the regional sampling interval/step by dividing the sample size per region (as calculated above) by the number of households listed in that region (e.g., if 10 households are needed from region A, and 20 households are listed in region A, then the sampling interval would be 2).
  - c. Select survey households based on this sampling step (in the example above, you would select every 2<sup>nd</sup> household in the regional list).
- 3) Repeat for each sub-group in the population until the total sample size is selected. Create a '*Potential Household List*' with the households that will take part in the survey.

#### Stratified systematic random sampling with a list:

Used when there is an up-to-date list of all households in the population, with enough information to allow them to be located (valid phone number). This may be available from UNHCR ProGres database or from population head counts or household listings from partners (refer to explanation given above for stratified systematic random sampling).

## STEP 8: Selecting participants

- For recruitment, data collectors will call the head of households for each sampled household. Interviewers will introduce themselves and the survey, then seek permission to interview from an adult (18 years of age or whatever the local legal age of majority is). If an adult is available, the interviewers will ask screening questions (and fill out a screening form) to determine whether an eligible household member (mother, father, etc.) is present in the household.
- If there is an eligible participant, informed oral consent will be obtained before interviewing can commence (see step below). In all cases, eligible adult, women/primary caregiver and men will be interviewed per household. They will be asked specifically about their own health experience and about the health of their children and family members. Depending on the modules chosen they may be asked about their situation in relation to food security, housing, WASH and education (children in the household).

#### TIP:

There may be respondents from more than one target group in the same household. Interviewers should obtain a composition of the household and administer the modules that apply to each member of the household individually according to their age and sex. Example: For the nutrition module, the mothers or primary caregivers of children under five in a selected household should be interviewed. Likewise for the reproductive health module, the mothers of children under 2 years in a selected household should be interviewed to collect information on antenatal care, delivery, postnatal care, etc.





## STEP 9: Design questionnaire and adapt to local context

- A standardized questionnaire has been developed by the Public Health Section in consultation with relevant sectoral personnel and based on feedback from surveys conducted in the field: [HAUS+ global questionnaire](#). The questionnaire should be adapted to take into consideration the local context e.g. different types of health facilities or health policies on access to care as well as concerns and conditions identified during the pre-planning of the survey design.
- Change can be confirmed during the pilot testing for clarity of language, cultural appropriateness and ease of administration. **Overall, the survey team should try to minimize changes so as to maintain standardisation and comparability over time and across different countries.**

# STEP 10: Interview Procedure

## Ethical clearance, informed consent & confidentiality protection

- In general, HAUS+ does not require ethical clearance since the purpose is programmatic monitoring. However, every step must be taken to ensure the survey is conducted within the highest ethical standards, including, obtaining informed consent and ensuring that participants understand they have the right to decline participation in the survey and that this will not affect their access to protection or assistance.
- While the HAUS+ does not involve taking specimens and may present minimal potential for direct physical harm to participants due to their involvement, there could be household dynamics (e.g., male reaction that a female is speaking to a male interviewer), and high levels of ethical standards must be maintained at all times. The responsibility for the ethical conduct of research lies on every member of the survey team. It should also be considered during every step of the process, from protocol development to decisions about how and where results will be disseminated.
- Interviewers must be adequately screened and trained so they uphold the confidentiality of the participants and treat all household members with respect.
- Verbal, informed consent must be sought from all participants at the beginning of the interview. Only consenting households will be eligible for participation.
- Before interviewers start the interview they must explain (1) why they are calling, (2) why UNHCR is conducting the survey, and (3) ask for verbal, informed consent. They should not proceed unless informed consent is given. [Appendix 3](#) shows a template for requesting verbal consent.
- All participants will only be contacted by phone. It is expected that respondents will answer questions for a maximum period of 1h:00 to 1h:30 minutes. All telephone costs will be paid for by UNHCR and/or partners.
- No household visits will be conducted. No specimen collection will be done. However, all information collected during the survey will be treated as confidential. Some participants might feel a bit uncomfortable discussing some of the topics. This will be mitigated by assuring participants of the confidentiality of information provided.
- There will be no direct benefit for participants. However, results will be utilized by UNHCR and partner agencies to improve program service delivery. Results may also be used to advocate for additional resources targeting urban refugees.
- The survey team, including UNHCR staff, partners and consultants must comply with [UNHCR's Data Protection Policy](#). Country operation should seek approval from UNHCR data protection officer and may coordinate with relevant staff (data, identity management and analysis, information management officer, etc.) where applicable.

## Recruitment and training of the survey team

- Competent and experienced interviewers are the most important factor in producing useful, reliable data from HAUS+. The ability to attend training sessions must be a requirement for the survey team.
- Training of surveyors and pilot testing of the survey instruments and methods are important tasks for ensuring that the survey design is appropriate to the area and will help to identify any unforeseen problems. Well-informed interviewers will ensure the best possible data quality.
- Ideally, interviewer training should take place over 3 days allowing sufficient time to review all aspects of survey implementation. The training should include at least the following: survey objectives, interviewing and general communication skills, content of the questionnaire, household and respondent selection, practice interviews and final testing of the questionnaire before the survey begins.
- The number of persons needed will depend on the sample size selected, the length of the questionnaire and the time available to carry out the survey. In order to ensure reliability, each interviewer should interview a **maximum of 10 – 12 households each day**.



### Below are steps for collecting data:

- A ‘Potential Household List’ should be created and maintained by the survey coordinator.
- Each morning, the coordinator will provide each interviewer with the list of households to contact for the day.
- Once the interviewer reaches the head of household, or any adult family member or mother/primary caregiver of children who can provide health information on their behalf, they should begin completing the data collection form using the provided tablet or smartphone. Interviewers should follow the **interview process** outlined in [Appendix 4](#).
- Firstly, explain the survey procedures and request informed consent as outlined in the verbal consent form.
  - If the potential participant refuses to participate in the survey, record reasons for refusal and close the form.
  - If the potential participant agrees to participate in the survey, then continue through the form.
- The survey coordinator should record the outcome of each call on the non-response log ([Appendix 5](#)).
- Each eligible household will be called at least three times (each subsequent call at least 2 hours apart, otherwise the next day). Absent or non-responsive households will be recorded as non-respondents and will not be replaced.



#### TIP:

When selecting interviewers, consider the impact of gender dynamics on the quality of an interview and therefore, the quality of survey data. In many societies, it is not acceptable for a woman to have contact with a male other than her husband or relatives. Even when such restrictions do not exist, some females might feel more comfortable talking to another woman than to a man. On the other hand, male interviewers may be more appropriate for male population groups. A team of two interviewers (one male and one female) should therefore be appointed to ensure that questions are administered considering gender dynamics.

## STEP 11: Data collection, analysis, and report writing

### Data collection

- Data will be collected using Android-based tablets or smartphone on the Open Data Kit (ODK) application system. ODK is a set of free, open-source applications for creating questionnaires and storing data.
- The ODK data entry form will be prepared using the ODK “xls” form in Microsoft Excel.
- The standardized HAUS+ questionnaires will be programmed into the tablets and interviewers will record all responses directly on the phones or tablet. Detailed instructions for collecting and uploading data can be found on <http://opendatakit.org/>.
- The survey coordinator and interviewers should be familiar with smart phones and related technologies. A training should be conducted prior to data collection on use and handling of tablets and the ODK application.
- UNHCR recommends the use of UNHCR kobo server and dedicated smartphones and tablets that have UNHCR identifier for data collection. Advantages include more convenient data collection with improved error control, no need for data entry into computers and less data cleaning, resulting in higher quality data being collected with less burden on the survey team. It also allows for quicker dissemination of results.
- Technical support can be provided to countries from UNHCR headquarters or regional bureau if needed.

- ODK application is not a data repository. Therefore, after completion of the survey, the data should be migrated to Raw Internal Data Library and/or Microdata Library for secured storage for future analysis and use. Before being published in Microdata Library, data will go through a curation process and will be anonymized. In cooperation with the regional and field offices, this process will be overseen by the Curation Team at UNHCR HQ.

### Note:

- When using Android-based tablets/smartphones for data collection, the data will be in Excel format after collected data is uploaded to the server and then transferred to the survey computer as csv files.
- Excel files can easily be copied and used in the various analysis software such as SAS, STATA, SPSS and Power BI.

## Analysis

- Data analysis will be done using any statistical software package such as SAS, STATA, SPSS, Power BI or Excel. HAUS+ global questionnaire has been integrated with an interactive power BI dashboard which allows real time access to statistical analysis and reporting on key indicators: [HAUS PLUS GLOBAL DASHBOARD](#).
- Survey method will be used to conduct all analysis with the objective of producing descriptive statistics. It is important to remember that estimates from the survey are associated with a certain level of error. When reporting the results, it is helpful to state the confidence intervals, which indicate the margin of error for each survey finding.
- Appropriate weights will be used to ensure the final sample closely resembles the source population in terms of a certain characteristic (nationality, administrative or geographic regions) in case subgroup estimates are required.

### Note:

- When we estimate a rate or proportion in a survey, we expect the confidence interval to include the actual rate most of the time. How often is most of the time? Phrases like “95% confidence” give us an idea. When you calculate 95% confidence limits, you assume that there is a 95% chance that the actual rate being estimated by the survey falls within the confidence interval. The terms “confidence limits” and “confidence interval” are often used interchangeably. A confidence interval is the range of possible values, whereas the confidence limits are the lowest and highest values within that range.
- Survey result: 85% of children under five years of age in the survey have received a measles or MMR vaccine. The confidence limits are calculated as plus or minus 8%.
- Our conclusion: We are 95% confident that the true proportion of under five children in the population who are immunized against measles is between 77% and 93% (85%±8%). The best estimate of the true proportion is 85%.

## Final Report

- Compile a survey report (see [Lebanon HAUS+ 2021](#) for example). The report should include detailed description of the survey, present survey findings, and discuss the programmatic implication of those findings. Individuals who were not involved in the survey should be able to read the report and get a good sense of the process and methods, not just the major findings.
- The report should include but not be limited to the following sections:
  - 1) Cover page
  - 2) Table of contents

- 3) Executive summary (written last)
- 4) Background
- 5) Survey Methods
- 6) Results
  - Demographic characteristics (i.e., reason for non-response as well as characteristics of sampled households)
  - Levels of knowledge about available health service access and utilisation of service (coverage)
  - Overall access to health service and health seeking behaviour
  - Overall levels of access to care and treatment during the month preceding the survey
  - Overall levels of access to hospitalisation in the last year
  - Access to:
    - SRH services
    - Childhood vaccinations
    - Nutrition including IYCF
    - Chronic disease treatment
    - Disability care services
    - Covid-19 care and vaccination
  - Household level food security, WASH, housing situations
- 7) Discussions
- 8) Limitations
- 9) Conclusions
- 10) Recommendations
- 11) References
- 12) Appendix

## STEP 12: Take appropriate action based on survey results

The result of HAUS+ should be presented to the appropriate stakeholders, including refugees, MOH and partners to help decide what action to take. Stakeholder engagement is critical to ensuring the success of the survey which is implementing action based on the results. They should therefore be engaged at every stage of the survey process and be aware of the objectives and expected outcomes. Recommendations for the survey should be translated into actionable steps with designated person/entity responsible for their implementations. This could be illustrated in a workplan with stakeholders agreeing to the timelines. An agreeable schedule could then be set during the debrief meetings to follow up on the implementation of recommendations.

# References

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7. UNHCR (2015). Health Access and Utilization Survey among urban refugees in Jordan. <https://data2.unhcr.org/en/documents/download/42095>
8. UNHCR (2010). Public Health Equity in Refugee and other Displaced Persons Settings. <http://www.unhcr.org/4bdf1699.html>

# Appendix

## Appendix 1: Timeline for implementation

Activity	Month x Week y	Month x Week y	Month x Week y	Month x Week y	Month x Week y	Month x Week y
Drafting protocol or revising previous survey's protocol, if available						
Finalize objectives of the survey, sampling design, logistics						
Finalize translation of ODK questionnaire in English and relevant languages						
Sampling and baseline review of sample information						
Develop analysis plan for all measured outcomes						
Finalize testing of questionnaires in local relevant language(s)						
Recruitment of interviewers						
Training of interviewers						
Conduct household phone interviews						
Analysis						
Preliminary report						
Disseminate final report						

## Appendix 2: Sample protocol

1. Cover page with names of staff involved, affiliations and contact information
2. Table of contents
3. Background and rationale
4. Survey objectives
  - 4.1. Primary objective
  - 4.2. Secondary objectives
5. Methods
  - 5.1. Survey population
  - 5.2. Inclusion and exclusion criteria
  - 5.3. Sample size calculation
  - 5.4. Sampling methodology
6. Survey procedures
  - 6.1. Recruitment process
  - 6.2. Consent process
7. Survey implementation
8. Survey team composition
9. Training plans
10. Field monitoring and quality control checks
11. Questionnaires
12. Data management and analysis
13. Preliminary survey schedule
14. References
15. Appendix



### Appendix 3: Sample Verbal Consent Form

UNHCR is conducting a survey among refugees. The purpose of the survey is to learn more about the experience of using health care services for refugees in [country]. Your household has been randomly selected and we wish to interview the head of household and/or other adult household members. May we proceed?  
 Yes  No

You are invited to take part in the survey. We expect to interview about XX households who are registered with UNHCR. We are asking you to be part of the interview. If you agree to do so, we will interview you over the phone. This interview will take between 1 hour and 1 hour 30 minutes.

The interview will not cost you anything financially.

From this and other interviews, we may gain a better understanding of challenges that refugees living outside the camps face when seeking health care in [country].

The findings from these interviews may provide us with important information. The information we obtain will be used to assist refugees in receiving the health care and other services they need.

Please be assured that all the information will be strictly kept confidential and be used only for the purpose of the survey.

It will not affect any of your rights as a refugee or the services you receive from UNHCR. You are free to choose whether you want to take part in this survey and you can change your mind and stop at any time without penalty.

This decision will not adversely affect your relationship with UNHCR. It will not affect any benefits you may receive. It's your choice.

If you have any questions about this survey, please feel free to ask me.

## Appendix 4: Contacting Households and Recording Response Outcomes





