



**USAID** | **ZAMBIA**  
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# COMMUNICATIONS SUPPORT FOR HEALTH PROGRAMME

**ENDLINE EVALUATION REPORT**

**Contract No. GHS-I-00-07-00004-00; Order No. GHS-I-05-07-00004-00**

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The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.



## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	antenatal care
BCC	behaviour change communications
CHAMP	Comprehensive HIV/AIDS Management Programme
CSH	Communications Support for Health
CSO	civil society organisations
DHS	Demographic and Health Survey
FP/RH	family planning/reproductive health
GRZ	Government of the Republic of Zambia
HCRC	Health Communication Resource Centre
HIV	human immunodeficiency virus
HPU	Health Promotion Unit
IEC	information, education, and communication
IPTp	intermittent preventive therapy in pregnancy
IR	intermediate result
IRS	indoor residual spraying
ITN	insecticide-treated net
LOP	life of project
M&E	monitoring and evaluation
MCDMCH	Ministry of Community Development and Maternal and Child Health
MIS	Malaria Indicator Survey
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
NAC	National HIV/AIDS/STI/TB Council
NMCC	National Malaria Control Centre
PBMS	performance-based management system
PMEP	Performance Management and Evaluation Plan
SADC	Southern African Development Community
SMGL	Saving Mothers, Giving Life
STI	sexually transmitted infections
TOR	Terms of Reference
TWG	Technical Working Group
USAID	United States Agency for International Development

USG

United States Government

VCT

Voluntary Counselling and Testing

VMMC

voluntary medical male circumcision

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## 1. INTRODUCTION

The Government of the Republic of Zambia (GRZ), through the Ministry of Health (MOH), has committed to achieving Millennium Development Goal targets by improving the quality of health care services and providing greater and equitable access to health care for its people. To support these objectives, the United States Agency for International Development (USAID) is providing GRZ with technical assistance to strengthen national health communications activities. The aim is for GRZ health communications activities—supported by the Communications Support for Health (CSH) project—to translate into increased, sustainable, local capacity, and positive behaviour change that reinforces GRZ efforts in four focal areas: human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS); malaria; family planning/reproductive health (FP/RH); and maternal, newborn, and child health (MNCH), including nutrition, which is an integral part of MNCH.

CSH operates primarily at the national level, providing GRZ with technical assistance in the development, implementation, and evaluation of health communications activities. These activities have to be done consistently, with a focus on capacity building and transfer of skills. In the context of CSH, GRZ refers to three primary agencies—MOH, the National Malaria Control Centre (NMCC), and the National HIV/AIDS/STI/TB Council (NAC). The CSH project also worked with and supported other USAID partner programmes with behaviour change communications (BCC) to improve message effectiveness, consistency, and efficiency. CSH provided direct support to GRZ in the planning, design, implementation, and monitoring and evaluation (M&E) of communications campaigns and activities.

### 1.1 CSH Results Framework

The CSH Results Framework (Annex A) outlines the results that the project used to achieve its overall objective, which was to strengthen GRZ’s capacity to manage effective information, education, and communication (IEC)/BCC activities. *Effective* means that IEC and BCC activities implemented by GRZ result in a measureable reduction in the targeted populations’ practice of risky behaviours and/or in an increase in their demand for and use of health care services. This project objective was aligned with USAID’s strategic objective for health and activities, contributing to achieving mission results. The project worked towards the following four intermediate results (IRs), with each IR aligned to a defined contract task:

- IR 1: National health communications campaigns strengthened,
- IR 2: GRZ use of evidence-based health communications approaches increased,
- IR 3: Local capacity to support sustained implementation of IEC/BCC activities strengthened, and
- IR 4: Coordination of IEC/BCC activities between USAID projects increased.

Each IR (and task) represented a different approach to building local capacity. Although the IRs or tasks were presented separately, many linkages and interrelationships exist amongst them.

### 1.2 Endline Evaluation: Purpose and Structure of Report

The purpose of this report is to provide endline information on the different components of the Results Framework and, more specifically, on the indicators included in CSH’s Performance Management and Evaluation Plan (PMEP). The report provides a

comprehensive review of CSH's key achievements and results from the start of the project in June 2010 through the end of the project in December 2014. The findings in this report are presented following the order of the PMEP. Furthermore, the report includes the baseline and midline findings to allow for trend analysis and examination of the changes over time in the more descriptive sections.

## 2. METHODOLOGY

The endline evaluation was primarily informed by routine data collected through CSH's M&E system. The other data sources included CSH project and activity reports, various assessment and evaluation reports, and partner (including civil society organisations [CSOs] and subgrantees) reports. The CSH M&E team reviewed different CSH project and activity reports, including quarterly, semi-annual, and annual reports; portfolio review meeting presentations and reports; capacity assessment and evaluation reports; and other activity-level reports that are housed in the CSH performance-based management system (PBMS).

It is important to note that for the behavioural outcome and health impact indicators that are included in CSH's PMEP, no midline findings were included. Since these indicators are measured through national population-based surveys, including the Demographic and Health Survey (DHS) and Malaria Indicator Survey (MIS), no current survey(s) was (were) available at the time of the midline evaluation. For this endline report, data from the 2013/2014 DHS and 2012 MIS were used.

### 3. ENDLINE RESULTS

The results for the endline evaluation of the project are presented by each of the major components of the PMEP. The first section summarises the key results related to the behavioural outcomes and health impact indicators for GRZ's four main focal areas: HIV/AIDS, malaria, FP/RH, and MNCH and nutrition. This section is followed by the key results related to the main project objective, strengthening the capacity of GRZ to manage effective IEC/BCC activities, and for each of the four IR areas.

#### 3.1 Behavioural Outcomes and Health Impact Indicators for HIV, Malaria, FP/RH, and MNCH and Nutrition

The behavioural outcomes and health impact indicators are grouped by their specific focal area: HIV, malaria, FP/RH, and MNCH and nutrition. The data for these indicators come from the 2012 MIS and the 2013/2014 DHS.

##### 3.1.1 Overview of Zambia's Health Situation

Between 2007 and 2013/2014, the overall health situation improved in Zambia, particularly in relation to maternal and child mortality (refer to Table 3.1). While this set of indicators is not exhaustive in the information presented, it summarises trends in key indicators pertaining to USAID/Zambia's health portfolio and the specific areas that CSH's work helped to contribute towards.

**Table 3.1 Trends in Key Health Indicators for Zambia<sup>1</sup>**

Category	Indicator	DHS 2002	DHS 2007	DHS 2013/2014
HIV	HIV prevalence amongst adults aged 15–49	15.6%	14.3%	N/A
	Females	17.8%	16.1%	N/A
	Males	12.9%	12.3%	N/A
	Urban	23.1%	19.7%	N/A
	Rural	10.8%	10.3%	N/A
	HIV prevalence amongst pregnant women	19%	11.6%	N/A
Malaria	New malaria cases per 1,000 people	377	358	N/A
	Prevalence of malaria parasites amongst children under age 5	22.1% <sup>2</sup>	16% <sup>3</sup>	14.9% <sup>4</sup>
FP/RH	Total fertility rate	5.9	6.2	5.3
	Urban	4.3	4.3	3.7
	Rural	6.9	7.5	6.6
MNCH	Maternal mortality per 100,000 live births	729	591	398
	Under-5 mortality per 1,000 live births	168	119	75
	Neonatal mortality per 1,000 live births	37	34	24
	Infant mortality per 1,000 live births	70	95	45
	Child mortality per 1,000 live births	81	52	31
	Prevalence of stunting in children under age 5	46.8%	45%	40%
	Prevalence of children under age 5 that are severely stunted	22.2%	21%	17%

<sup>1</sup> Data from the DHS in 2013/2014 are based on preliminary data available at the time of the CSH endline evaluation. The preliminary data do not include results for all of the indicators and may be subject to change.

<sup>2</sup> 2006 Zambia MIS.

<sup>3</sup> 2010 Zambia MIS.

<sup>4</sup> 2012 Zambia MIS.

### 3.1.2 CSH HIV Indicators

The specific HIV indicators included in the CSH PMEP are provided in Table 3.2. Trends in multiple sexual partners and condom use remained relatively unchanged from 2007 to 2014.

**Table 3.2 CSH HIV Indicators**

HIV Indicator <sup>5</sup>	Baseline DHS 2007	Endline DHS 2013/2014
1. Percentage of women and men aged 15–49 who had two or more partners in the past 12 months	M: 14.4% F: 1.2%	M: 15.7% F: 1.7%
2. Percentage of women and men aged 15–49 who had two or more partners in the past 12 months and reported using a condom during their last sexual intercourse	M: 27.2% F: 33.1%	M: 29% F: 29.7%
3. Percentage of women and men aged 15–49 who received results from last HIV test in the past 12 months	M: 11.7% F: 18.5%	N/A
4. Percentage of women and men aged 15–49 who know that HIV can be transmitted by breastfeeding and that the risk of mother-to-child transmission can be reduced by the mother taking special drugs during pregnancy	M: 46.3% F: 62.9%	N/A

### 3.1.3 CSH Malaria Indicators

The specific malaria indicators included in the CSH PMEP are provided in Table 3.3. Trends for the malaria indicators remained stable from 2007 to 2014, with the exception of a 12 percent increase of children under age 5 and pregnant women who slept under an insecticide-treated net (ITN) the night before the survey.

<sup>5</sup> These indicators are in line with NAC’s 2011–2015 National HIV/AIDS/TB/STI M&E Framework.

**Table 3.3 CSH Malaria Indicators**

Malaria Indicator	Baseline MIS 2010	Endline MIS 2012
1. Percentage of households that received indoor residual spraying (IRS)	23.1%	25%
2. Percentage of children under age 5 and pregnant women who slept under an ITN last night	Children under age 5: 49.9% Pregnant women: 45.9%	Children under age 5: 57.0% Pregnant women: 58.2%
3. Percentage of pregnant women who received complete intermittent preventive therapy during their pregnancy (IPTp)	69.4%	69.8%
4. Percentage of febrile children under age 5 who received prompt and appropriate treatment	18.7%	20.4%

### 3.1.4 FP/RH

The specific FP/RH indicators included in the CSH PMEP are provided in Table 3.4. Preliminary DHS results showed a significant increase (20.2 percent) of women aged 15–49 currently using a modern method of contraception.

**Table 3.4 CSH FP/RH Indicators**

FP/RH Indicator	Baseline DHS 2007	Endline DHS 2013/2014
1. Median age of first birth amongst women aged 20–49	19.0	N/A
2. Percentage of births that occurred less than three years after the preceding birth	54.9%	N/A
3. Percentage of women aged 15–49 currently using a modern method of contraception	24.6%	44.8%
4. Unmet need for family planning (for spacing or limiting births)	Unmarried women: 18.0% (11.8% spacing, 6.2% limiting) Married women: 26.5% (17.1% spacing, 9.4% limiting)	N/A

### 3.1.5 Maternal Newborn and Child Health and Nutrition

The specific MNCH and nutrition indicators included in the PMEP are provided in Table 3.5. Preliminary DHS results show a substantial increase (20 percent) from 2007 to 2014 of deliveries in health facilities.

**Table 3.5 CSH MNCH/Nutrition Indicators**

MNCH/Nutrition Indicator	Baseline DHS 2007	Endline DHS 2013/2014
1. Percentage of deliveries in health facilities (in the five years preceding the survey)	47.7%	67.4%
2. Percentage of women aged 15–49 who received their first post-natal check-up between 4 and 23 hours after delivery	9.8%	N/A
3. Median duration (in months) of exclusive breastfeeding amongst children born in the past three years	3.1 months	N/A

### 3.2 Project Objective: Capacity of GRZ To Manage Effective IEC/BCC Activities Strengthened

The project objective states that, as a result of CSH activities, GRZ’s capacity to manage effective IEC/BCC activities will be strengthened. Based on the wording of the specific indicators, the capacity of GRZ will be defined as “strengthened” if the three criteria are fulfilled:

1. GRZ’s IEC/BCC management capacity is increased,
2. Campaigns are developed according to IEC/BCC guidelines, and
3. Campaigns are monitored and evaluated.

CSH has designated indicators to monitor these activities over the life of the project. The baseline, midline, and endline results are presented in Table 3.6 below. Overall, the targets for each of the indicators were met or exceeded, with the exception of the capacity score of MOH/Ministry of Community Development and Maternal and Child Health (MCDMCH).

**Table 3.6 CSH Project Objective Indicators and Results**

Project Objective Indicator	Baseline 2010	Midline 2012	Endline 2014	Life of Project (LOP) Target
1. GRZ’s score on IEC/BCC management capacity index	MOH: 54% <sup>6</sup> NAC: N/A <sup>7</sup> NMCC: T/A <sup>8</sup>	MOH: 54% NAC: N/A NMCC: 61% <sup>9</sup>	MOH/MCDMCH: 59.1% NAC: 74% NMCC: 88%	MOH/MCDMCH: 70% NAC: 70% NMCC: 70%

<sup>6</sup> CSH was able to establish a baseline for this indicator with MOH in 2012. Thus, the baseline and midline results for this indicator are the same.

<sup>7</sup> CSH attempted to carry out the Behaviour Centred Programming Capacity Assessment with NAC several times during 2011 and 2012 for the baseline and midline evaluations. However, the CSH Research, Monitoring and Evaluation unit was unsuccessful in scheduling a time whereby a sufficient number of staff from each institution could attend the workshop. Therefore, no baseline or midline value is available for either of these institutions.

<sup>8</sup> Similar to NAC, CSH attempted several times to conduct a baseline evaluation with NMCC.

<sup>9</sup> This score is from the results of the capacity index administered in 2013.

Project Objective Indicator	Baseline 2010	Midline 2012	Endline 2014	Life of Project (LOP) Target
2. Percentage of national IEC/BCC campaigns implemented annually that were developed according to minimum GRZ standards/guidelines	0%	63%	100% (6 out of 6 campaigns)	100% (12 out of 12 routine and nonroutine campaigns/6 campaigns for 2014)*
3. Percentage of national nonroutine IEC/BCC campaigns implemented annually that were developed based on formative research	6%	63%	100% (4 out of 4 campaigns)	100% (12 out of 12 annual campaigns/4 campaigns for 2014)*
4. Percentage of national IEC/BCC campaigns implemented annually that are monitored	0%	19%	100% (6 out of 6 campaigns)	100% (12 out of 12 annual campaigns/6 campaigns for 2014)*
5. Percentage of national IEC/BCC campaigns implemented annually that are evaluated	0%	0%	33%	33% (4 nonroutine campaigns)*

\* This target was adjusted based on discussions with and approval of USAID.

### 3.2.1 GRZ's IEC/BCC Management Capacity

#### MOH/MCDMCH

The capacity assessment index was administered with MOH/MCDMCH during the project's baseline, midline, and endline. Throughout the project, MOH/MCDMCH's Health Promotion Unit's (HPU) IEC/BCC management capacity demonstrated many strengths in BCC programme implementation, in particular with regard to the use of multiple communication channels to deliver BCC messages, frequent pre-testing of BCC materials, and high staff competence levels due to formal training in IEC/BCC. Furthermore, the HPU also demonstrated good BCC programme design through the conduct of situational assessments to better understand the health problems they wished to address. Despite the realignment of the ministries and creation of MCDMCH, strengths that were identified in 2007 and 2012 continued to grow and further enhance the capacity of the ministry in these areas in 2014, particularly in the area of programme implementation.

Unfortunately, low-performing areas for the HPU remained unchanged and included monitoring and evaluating BCC interventions/programmes, establishing new M&E systems, and utilising data for programme purposes. MOH relies on the Health Management Information System for programme planning, and activities proposed at the end of each administration of the capacity assessment index may not have been feasible given the current structures and resources in the ministry. The realignment of the ministry may have contributed to lack of advancement, as proposed by CSH.

A qualitative assessment, consisting of key informant interviews with representatives from each of the ministries, was conducted in 2014 to supplement the findings of the capacity assessment index. The qualitative assessment revealed that MOH/MCDMCH contributed much of its improvements in programme planning and implementation to the strategic use of partners and involvement in the MOH Technical Working Group (TWG). CSH trainings in BCC programming, formative research, and M&E were also cited as factors in the unit's capacity building. And despite limited growth in the unit's capacity to implement M&E systems, key informants stressed an increased awareness of the need and process required to establish a system, and that the lack of resources and infrastructure to do so was the cause of the lack of advancement in this area.

## NAC

The capacity assessment index was administered with NAC only during the project's endline because CSH was unable to schedule a time with key participants from the agency during the baseline and midline. The assessment of NAC's IEC/BCC management capacity demonstrated many strengths in BCC planning and designing, particularly in identifying health problems, conducting behavioural analyses, and establishing strategic partnerships. NAC also demonstrated good capacity in programme implementation, particularly in the implementation of communication strategies. NAC experienced the greatest strength in areas including the conducting of a situational analysis and behavioural analyses, implementation of communication strategies, and development of M&E frameworks and systems.

Although NAC showed remarkable growth in M&E frameworks and systems, overall NAC's capacity in BCC M&E remained the weakest area of capacity compared to the other areas. Due to funding restrictions, the M&E systems and systematic use of data were not fully functioning. Other areas that saw a reduction of capacity included staff capacity and supervision and quality of BCC intervention delivery, both reportedly due to vacant M&E positions.

The qualitative assessment revealed that NAC's capacity in each of the categories expanded substantially since the start of CSH. By the endline, NAC conducted more programme planning and focused on producing higher-quality products compared to previous years. Key informants also cited the usefulness of the NAC TWG in establishing a more efficient and timely process for reviewing IEC/BCC materials. In terms of implementation, NAC highlighted the development of the National HIV/AIDS Communication and Advocacy Strategy, with the support of CSH. And although the unit's capacity in M&E was its weakest area, the assessment demonstrated an increased awareness of M&E concepts and the unit's intention to build a database of IEC/BCC materials to track its use in subnational areas.

## NMCC

The capacity assessment index was administered with NMCC during the project's midline and endline. The assessment of NMCC's IEC/BCC management capacity demonstrated many strengths in BCC planning, designing, and programme implementation. Particular areas of strength included detailed communication planning, staff capacity, and implementation of communication strategies. NMCC experienced the greatest amount of growth from midline to endline of the project in detailed communication planning, implementation of communication strategies, supervision and quality of BCC intervention, M&E frameworks and systems, and data use.

Although NMCC illustrated significant growth in capacity of BCC M&E, this area still remained the weakest in comparison to the other areas. NMCC's M&E process for BCC needs to be further established with the development of a database and consistent use of data.

In each area of capacity, NMCC exhibited tremendous growth from the midline to endline of the project.

The qualitative assessment revealed that NMCC made great strides in programme planning largely due to the BCC and M&E trainings, revitalisation of the NMCC TWG, and the development of the guidelines for reviewing IEC/BCC materials. Although key informants explained that the NMCC central unit was unable to modify materials for specific end users, the unit provided guidance to provincial and district task forces to revise materials for local use. The assessment revealed that M&E received the least amount of funding and was not as much of a priority as other areas. Despite these challenges, NMCC worked to develop checklists and guidelines for supervisors. NMCC developed an M&E plan but has not been able to develop a database or mechanism for collection, and relies primarily on Health Management Information System data.

### **3.2.2 Use of IEC/BCC Guidelines**

National IEC/BCC guidelines were developed by CSH in collaboration with GRZ partners. The guidelines provided an outlined process detailing how the campaigns should be developed, including the design and pre-testing of campaign products and messages. At the midline, these guidelines were used to review the three large nonroutine campaigns implemented by GRZ in collaboration with CSH—*Safe Love*, STOP Malaria, and Mothers Alive—as well as seven routine campaigns. At the endline, the guidelines were used for all of the six campaigns implemented in 2014—including the *Safe Love*, STOP Malaria, Mothers Alive, 1,000 Days nutrition campaigns; Voluntary Counselling and Testing (VCT) Day; and World Malaria Week. All of the routine and nonroutine campaign messages and products were developed on the basis of evidence (from either new formative research findings or existing evidence), which is one of the requisites of the IEC/BCC guidelines.

### **3.2.3 Use of Formative Research**

GRZ, with the support of CSH, conducted formative research for the four large campaigns—*Safe Love*, STOP Malaria, Mothers Alive, and 1,000 Most Critical Days. Formative research included qualitative studies with target audience and pre-testing of campaign materials.

### **3.2.4 M&E of National Campaigns**

At the time of the midline, GRZ implemented approximately 12 campaigns annually, including both routine and nonroutine campaigns. Of these 12 campaigns, three were monitored, including *Safe Love*, STOP Malaria, and Mothers Alive. At the endline, six campaigns, including *Safe Love*, STOP Malaria, Mothers Alive, 1,000 Days nutrition campaign, VCT Day, and World Malaria Week, were planned for and monitored.

Monitoring data includes, for example, tracking the distribution of various campaign products and materials, the airing of mass media programmes, and community-level activities. Additionally, rapid surveys and evaluations to measure exposure to the different campaign

products and messages were an integral part of the monitoring plans for the three nonroutine campaigns. Monitoring activities, surveys, and evaluations included the following:

- Two rapid surveys and one outcome evaluation were conducted for the *Safe Love* campaign, and they demonstrated high exposure to the campaign’s TV spots and consistent recall of the main campaign messages.
- Regular community monitoring of the STOP Malaria and nutrition campaigns was conducted to assess trends in health indicators directly related to the campaign behavioural messages.
- Evaluation of the STOP Malaria campaign was conducted, and it demonstrated high exposure to the campaign and implementation of key behaviours to prevent malaria.
- Operations research of the nutrition campaign and the Saving Mothers, Giving Life (SMGL) birth plan, as part of the Mothers Alive campaign, was conducted to explore the campaign implementation and target audience response.
- Evaluation, including a household survey and qualitative research, of the SMGL initiative under the Mothers Alive campaign demonstrated high exposure to and consistent recall of the main campaign messages.

### **3.3 IR 1: National Health Communications Campaigns Strengthened**

IR 1 states that, as a result of CSH activities, Zambian national health communications campaigns will be strengthened. Based on the sub-IRs’ wording for IR 1, national communications campaigns will be defined as “strengthened” if the following three criteria are fulfilled:

1. Integrated malaria, MNCH, and nutrition campaigns are expanded,
2. Comprehensive HIV/AIDS campaigns are expanded, and
3. Evidence-based multichannel campaigns are increased.

The baseline, midline, and endline results for IR 1 are presented in Table 3.7 below. Overall, national health communications met or exceeded the targets.

**Table 3.7 CSH IR 1 Indicators and Results**

IR 1 Indicator	Baseline 2010	Midline 2012	Endline 2014	LOP Target
<b>Sub-IR 1.1 Integrated malaria, MNCH, and nutrition campaigns expanded</b>				
1.1.1 National integrated malaria, MNCH, and nutrition campaigns implemented with CSH support	Nonexistent	Milestones accomplished: <ul style="list-style-type: none"> <li>▪ Formative research completed</li> <li>▪ Campaign strategy completed</li> <li>▪ Campaign implemented</li> <li>▪ Campaign monitoring plan developed</li> </ul>	Milestones accomplished: <ul style="list-style-type: none"> <li>▪ Formative research completed</li> <li>▪ Campaign strategy completed</li> <li>▪ Campaign implemented</li> <li>▪ Campaign monitored</li> <li>▪ Campaign evaluated</li> <li>▪ Campaign results disseminated</li> </ul>	Milestones accomplished: <ul style="list-style-type: none"> <li>▪ Formative research completed</li> <li>▪ Campaign strategy completed</li> <li>▪ Campaign implemented</li> <li>▪ Campaign monitored</li> <li>▪ Campaign evaluated</li> <li>▪ Campaign results disseminated</li> </ul>
<b>Sub-IR 1.2 Comprehensive HIV prevention campaigns expanded</b>				
1.2.1 National comprehensive HIV campaigns implemented with CSH support	Nonexistent	Milestones accomplished: <ul style="list-style-type: none"> <li>▪ Formative research completed</li> <li>▪ Campaign strategy completed</li> <li>▪ Campaign implemented</li> <li>▪ Campaign monitoring implemented</li> </ul>	Milestones accomplished: <ul style="list-style-type: none"> <li>▪ Formative research completed</li> <li>▪ Campaign strategy completed</li> <li>▪ Campaign implemented</li> <li>▪ Campaign monitored</li> <li>▪ Campaign evaluated</li> <li>▪ Campaign results disseminated</li> </ul>	Milestones accomplished: <ul style="list-style-type: none"> <li>▪ Formative research completed</li> <li>▪ Campaign strategy completed</li> <li>▪ Campaign implemented</li> <li>▪ Campaign monitored</li> <li>▪ Campaign evaluated</li> <li>▪ Campaign results disseminated</li> </ul>
1.2.2 Number of the targeted population reached with individual and/or small-group level (HIV) preventive interventions (supported by CSH) that are based on evidence and/or meet the minimum standards required	Total: 0 Abstinence and/or be faithful messages: 0 Other prevention messages: 0	Total: 131,050 Abstinence and/or be faithful messages: 58,997 Other prevention messages: 72,058	Total: 470,545 Abstinence and/or be faithful messages: 158,396 Other prevention messages: 312,149	Total: 310,000* Abstinence and/or be faithful messages: 130,000* Other prevention messages: 180,000*

IR 1 Indicator	Baseline 2010	Midline 2012	Endline 2014	LOP Target
1.2.3 Percentage of the targeted population reached by channel (radio or TV) with CSH support <sup>10</sup>	Radio: 0%	First survey (2012 results) Urban: 37% Rural: 22% Overall: 29.6%  Second survey (2013 results) Urban: 10.3% Rural: 5.5% Overall: 8.2%	Overall: 75.4% Urban: 78.8% Rural: 64.0%	<u>Radio*</u> Overall: 50% Urban: 50% Rural: 50%
	TV: 0%	First survey (2012 results) Urban: 79% Rural: 49% Overall: 63.8%  Second survey (2013 results) Urban: 70.6% Rural: 24.3% Overall: 57.4%	Overall: 68.7% Urban: 72.2% Rural: 46.7%	<u>TV*</u> Overall: 65% Urban: 80% Rural: 50%
<b>Sub-IR 1.3 Evidence-based multichannel health communications campaigns increased</b>				
1.3.1 Annual number of BCC campaigns implemented in Zambia with CSH support that used two or more channels**	0	Total: 10 HIV: 3 Malaria: 3 MCH/ Nutrition: 4	Total: 6 HIV: 2 Malaria: 2 MCH/ Nutrition: 2	Total: 12 annually/6 annually in 2014*
1.3.2 Annual number of BCC campaigns implemented in Zambia with CSH support that used evidence from research to develop the campaign**	0	Total: 10* HIV: 3 Malaria: 3 MCH/ Nutrition: 4	Total: 4 HIV: 1 Malaria: 1 MCH/ Nutrition: 2	Total: 12 annually/ 4 annually in 2014*

\* This target was adjusted based on discussions with and approval of USAID.

\*\* The results presented for this indicator are for Year 2 for the midline and Year 4 for the endline only, as they do not allow for aggregation across multiple years.

### 3.3.1 Integration of MNCH, Malaria, and Nutrition

#### STOP Malaria

CSH collaborated with NMCC to develop an innovative integrated MNCH, malaria, and nutrition campaign called STOP Malaria. CSH led the design and implementation of a formative research study, in collaboration with partners from NMCC, to assess the barriers and influencing factors related to antenatal care (ANC) and use of delivery services, ITN use, and breastfeeding and feeding practices for young sick children. The findings from the formative research study were then used to inform the campaign strategy, in addition to

<sup>10</sup> This indicator is based on results of studies conducted by CSH. The midline results were collected from two rapid surveys, and the endline results were collected from an outcome evaluation of *Safe Love*.

the campaign products and messages. The campaign focused on increasing the uptake of various malaria prevention services/interventions, including ITN use, IPTp, and prompt and effective testing and treatment for malaria. Furthermore, the campaign promoted early initiation and consistent use of ANC services and healthy feeding of young children who are sick from malaria.

Due to challenges experienced with campaign funding, the implementation of the campaign was delayed in early 2012. By the endline, the campaign had been fully implemented. The main component included a “Champions Communities” activity, whereby communities lead and implement community activities and monitor progress towards behavioural goals set by the community. Additionally, the campaign included mass media programmes on the radio and TV, as well as community road shows, which included a number of activities, including leadership training, distribution of ITNs, nutrition counselling, and growth monitoring.

Evaluation of STOP Malaria was conducted in 2014 to assess campaign exposure and uptake of malaria prevention behaviours. The evaluation included a cross-sectional household survey in communities in which the campaign was and was not implemented. The evaluation revealed high exposure to the campaign and participation in community events. The evaluation also demonstrated, overall, a higher rate of bednet ownership and use and lower fever prevalence in intervention areas compared to others. Evaluation findings have been disseminated to key stakeholders.

### Mothers Alive and SMGL

CSH collaborated with NMCC to develop and implement the Mothers Alive campaign to contribute to the reduction of maternal deaths due to pregnancy and delivery complications. To inform the development of the campaign, qualitative formative research was conducted to identify factors that influence the practice of safe motherhood behaviours, sources of information for women, and types of communication strategies likely to encourage safe motherhood behaviours.

Using the “Change Champions” strategy, Mothers Alive included various initiatives. SMGL was one initiative in which GRZ worked with a wide range of private and public partners to create demand amongst pregnant women to seek a facility-based delivery, receive early antenatal care, complete all post-partum follow-up care, and learn about family planning. The main components of SMGL included the distribution of a pictorial birth plan by health providers and Safe Motherhood Action Group members, radio adverts on safe motherhood, a series of mobile video activities in 50 communities per district using a five-part video series called Journey to Becoming a Parent, and interpersonal communications activities amongst women, male partners, and community leaders.

In 2013, an operations research study was conducted to determine what improvements were needed (if any) to the design of the birth plan (in terms of its content, format, and layout) as well as how best to implement the birth plan nationally to maximise its effectiveness and, ultimately, its impact on maternal health. The birth plan was found to be a useful communication tool amongst health practitioners, women, and their male partners. The findings suggested that when implemented effectively, alongside other interventions, the birth plan can help women plan for and adopt healthy and safe behaviours during pregnancy, during labour, and after childbirth. Recommendations for improvement of the tool were

applied to the revision of the birth plan, which was distributed in the subsequent months of the initiative.

In 2014, an evaluation of SMGL was conducted to assess exposure to the campaign, perceptions of the campaign, and changes in behaviour influenced by the campaign. The evaluation consisted of a household survey with target audiences and in-depth interviews with campaign implementers. The evaluation showed high exposure to key components of the campaign at the time of survey implementation, consistent recall of campaign messages, positive perceptions of the campaign, and notable behaviour changes related to birth preparedness.

To further assess exposure to the SMGL birth plan, an audit of the distribution of the birth plan was conducted. The audit revealed that GRZ distributed 2,005,000 birth plans and that an estimated 139,200 people were exposed to family planning messages via the USAID-supported birth plan. This number included women aged 15–44 (95,314) and their male partners, friends, and family members (43,886).

In 2014, GRZ conducted an assessment of Change Champions and their role in promoting safe motherhood behaviours. The assessment included a short survey with 128 Change Champions, and revealed that the leaders had a good grasp of key behaviours and practices that contribute to Safe Motherhood, and that they were active in their communities—implementing or assisting with a variety of activities and also collaborating with a variety of groups to promote Safe Motherhood.

### 1,000 Most Critical Days

In 2013, CSH collaborated with NMCC to implement the 1,000 Most Critical Days nutrition campaign. A formative research study, including qualitative methods and Trials of Improved Practice, was conducted to inform the development of the campaign. The primary objective of this study was to establish influencing factors pertaining to child dietary intake—mainly complementary feeding and breastfeeding—and to explore the influencing factors for maternal diet during pregnancy and breastfeeding in Zambia and the feasibility of changing unhealthy practices.

Under the Champion Communities component, nutrition promoters conducted household visits and community meetings promoting behaviour change products created for the campaign—including a growth reminder card, a child feeding mat, a radio show, a child feeding game, and a child feeding bowl. Implementation of the campaign was delayed due to challenges with funding.

Operations research of the nutrition campaign was also conducted in 2014 to learn about the use of the nutrition communication programme materials and activities; their acceptability, usability, and usefulness; and their perceived effect on improving nutrition- and hygiene-related knowledge, attitudes, and practices. The study revealed great usability of the products and increased knowledge and behaviours around healthy nutrition, as well as a strong interest amongst campaign implementers to continue and expand the programme to other parts of Zambia. Study findings have been disseminated to key stakeholders.

An efficacy study of the child feeding bowl was also conducted in Samfya. Results indicated that the bowl greatly improved a mother or caregiver's ability to understand and measure not just how much food is offered to the child, but how much the child actually consumes.

### Community Monitoring

A monitoring plan for the campaigns was developed and implemented. Community monitoring included the collection of information at multiple levels, including the community, CSOs, and CSH, to track the progress of the campaign's implementation throughout the life of the campaign.

## **3.3.2 Comprehensive HIV/AIDS Campaigns**

### Development and Implementation

Comprehensive HIV/AIDS campaigns are those that include messages related to more than one HIV topic, such as different modes of prevention and different levels of intervention. In 2010, CSH, in collaboration with NAC, designed and launched a comprehensive HIV campaign called *Safe Love*. The overall goal of the campaign was to contribute towards the reduction of new HIV infections in Zambia by addressing key drivers of transmission, mainly low and inconsistent condom use, multiple concurrent partnerships, and low uptake of prevention of mother-to-child transmission services. The campaign also included messages on uptake of voluntary medical male circumcision (VMMC) to help reduce HIV transmission. The campaign, which targeted men and women aged 15–49, focused on promoting the following key behavioural messages for condom use, multiple concurrent partnerships, HIV testing, and VMMC.

The campaign included interventions targeted at the national, subnational, and community levels. Campaign components included TV and radio advertisements or spots, a radio drama series called *Life at the Turnoff*, a TV drama series called *Love Games*, interpersonal communication activities (e.g., small-group and one-on-one discussions, radio listening clubs), social media outlets (e.g., campaign website, Facebook, Twitter), and outdoor and small mass media (e.g., billboards, posters, fliers).

The campaign strategy, products, and messages were all informed through the findings of an initial desk review of existing research. Campaign materials were also pre-tested with target audiences.

### Campaign Monitoring

Based on the campaign strategy and implementation plan, a monitoring plan was developed and implemented. As part of the monitoring plan, the first rapid survey was conducted in 2012, and second one in 2013. Based on the first survey, approximately 30 percent and 64 percent of the targeted population were exposed to the radio and TV programmes, respectively. Furthermore, more than 184,000 people have been reached with individual or small-group counselling on HIV prevention messages (includes messages on multiple concurrent partnerships, condom use, abstinence, and fidelity). In 2013, exposure rates decreased, particularly in the case of radio. However, this decrease is likely due to the fact that the series had stopped airing about six months before the survey was conducted, thus, just at the cusp of the six-month recall period assessed in the survey.

To assess the work of the CSOs in the Safe Love Clubs, CSH conducted a series of outcome monitoring surveys to track changes in HIV-related knowledge, attitudes/beliefs, self-efficacy, intentions, interpersonal communication, and behavioural intent amongst the target audience over the course of a year, with specific focus on the topics discussed in the Safe Love Clubs. To measure changes in behaviours and/or intermediate outcomes of exposure to CSO club activities, CSH administered the quarterly anonymous surveys to the members of select Safe Love Clubs. Overall, CSH observed improvements amongst Safe Love Club members in each of the topic areas included in the monitoring surveys (multiple sexual partners, condom use, HIV testing, VMMC, outreach), as well as a sense that club members' experiences were positive and had a positive impact on their lives and the lives of others. Notably, more club members discussed *Safe Love* topics with friends and sexual partners as the year went on. While overall improvements were noted in the participants, it is important to note that there are still areas (e.g., consistent condom use) that require further emphasis and work in changing beliefs, attitudes, and behaviours.

In addition to campaign monitoring, CSH conducted an assessment of the *Love Games Live* Facebook page to explore the public's reaction to and perception of the *Love Games* series. Utilising Facebook Insight, the assessment focused on quantitative metrics, including growth of the Facebook fan base, potential reach of the page, level of Facebook user engagement with the page, and demographics of the fans. To examine the public response to the content of the show, CSH also conducted a content review of the fan responses to content on the page and reactions to the series during Seasons One and Two. The assessment showed a steady growth in the fan response, appreciation for the series, and some reported impact on attitudes and behaviours—primarily related to multiple concurrent partnerships and condom use. The study also showed a strong interest in fans to engage in discussions on the sensitive issues addressed in the series.

### Outcome Evaluation

In 2014, an outcome evaluation was conducted to assess the effect of the campaign on the target audience's behaviours and knowledge, beliefs/attitudes, self-efficacy, interpersonal communication, perceived social norms, and intentions related to condom use, multiple concurrent partnerships, HIV testing, and VMMC. The evaluation used a one-group post-test-only evaluation design with propensity score matching and was conducted in the nine districts where all the main components of the *Safe Love* campaign had been implemented. The survey was conducted with 4,114 women and men between the ages of 15 and 49. The findings of the evaluation demonstrated that the campaign reached the majority of people aged 15–49 in the nine districts surveyed and had an effect on changing key HIV preventive behaviours, most notably increasing the acquisition and use of condoms in urban areas and HIV testing amongst partners in rural areas. The campaign also had an effect on changing many important intermediate factors, which often precede changes in behaviours.

### **3.3.3 Multichannel and Evidence-Based Campaigns**

During both 2011 and 2012, MOH conducted a total of 12 campaigns, which included both routine and nonroutine campaigns. CSH helped to support 10 of these campaigns, which made use of multiple channels for disseminating the campaign, such as mass media programmes (e.g., radio and TV announcements, radio drama series), small media products,

and other community-level events, including interpersonal communication activities. The 10 campaigns included the following:

*Nonroutine campaigns:*

- Mothers Alive
- *Safe Love*
- STOP Malaria

*Routine campaigns:*

- Child Health Week (biannual)
- SADC (Southern African Development Community) Malaria Week
- Safe Motherhood Week
- Voluntary Counselling and Testing Day
- World AIDS Day
- World Breastfeeding Week
- World Malaria Day

Furthermore, of the 10 campaigns supported by CSH, all were developed on the basis of evidence from research (includes new formative research and existing research). In other words, the campaign strategy, products/materials, and specific messages were informed by research findings. The campaigns that were based on formative research and directly supported by CSH included *Safe Love*, STOP Malaria, and Mothers Alive.

In 2014, the targeted number of total campaigns was reduced to six campaigns, of which four were nonroutine campaigns. These included:

*Nonroutine campaigns:*

- Mothers Alive
- *Safe Love*
- STOP Malaria
- 1,000 Most Critical Days

*Routine campaigns:*

- Voluntary Counselling and Testing Day
- World Malaria Day

### **3.4 IR 2: GRZ's Use of Evidence-Based Health Communications Approaches Increased**

GRZ's use of evidence-based communications approaches will be defined as "increased" if the following two criteria are fulfilled:

1. GRZ's capacity to conduct formative research to develop national campaigns is improved, and
2. GRZ's capacity to use evidence from existing research to develop health communications campaigns is improved.

The baseline, midline, and endline results for IR 2 are presented in Table 3.8 below. Overall, targets for GRZ’s use of evidence-based health communications approaches were either met or exceeded.

**Table 3.8 CSH IR 2 Indicators and Results**

IR 2 Indicator	Baseline 2010	Midline 2012	Endline 2014	LOP Target
<b>Sub-IR 2.1: Capacity of the Health Communication Resource Centre (HCRC) to manage and disseminate information on IEC/BCC interventions increased<sup>11</sup></b>				
<b>Sub-IR 2.2: GRZ’s capacity to conduct formative research to develop national health communication campaigns improved</b>				
2.2.1 Annual number of GRZ staff trained with CSH support in conducting formative research to inform the development of IEC/BCC campaigns**	0	Total: 27	Total: 11 (61 staff in total were trained for the LOP)	Total: 50
2.2.2 Annual number of IEC/BCC campaigns for which formative research activities were conducted with support from CSH**	0	Total: 4 HIV: 1 Malaria: 1 MCH: 1 Nutrition: 1	Total: 4 HIV: 1 Malaria: 1 MCH: 1 Nutrition: 1	Total: 4* HIV: 1* Malaria: 1 MCH: 1 Nutrition: 1
<b>Sub-IR 2.3: GRZ’s capacity to use evidence from existing research to develop health communications campaigns improved<sup>12</sup></b>				

\* This target was adjusted based on discussions with and approval of USAID.

\*\* The results presented for this indicator are for Year 2 for the midline and Year 4 for the endline only, as they do not allow for aggregation across multiple years.

### 3.4.1 GRZ’s Capacity To Use Formative Research and Evidence From Existing Research

In the first year of the project, CSH designed and pilot-tested a training on conducting formative research for BCC campaigns/interventions for GRZ central-level staff. The training focused on building participants’ understanding in formative research methods, as well as their capacity to manage the process for undertaking a formative research study. After the pilot training workshop in May 2011, CSH revised the curriculum on the basis of participant feedback. The second training for GRZ central-level staff was conducted in February 2012.

Due to the expressed interest from GRZ, the formative research training curriculum was also adapted for GRZ staff at the provincial level. Subsequent trainings were carried out in August 2012 and June 2013. In total, CSH has trained 61 GRZ staff, exceeding the LOP target. An evaluation of the training, conducted approximately six months following the trainings, revealed that participants retained the knowledge they gained during the workshop. The evaluation also showed that confidence in applying new skills and knowledge obtained in the trainings, for the most part, had remained positive six months following the training.

In the second year of the project, CSH launched its “Formative Research in Action” activity, which targeted GRZ staff at the provincial level. The new activity used a blended approach that combined in-classroom learning and on-the-job training to increase knowledge and improve formative research skills. The activity was implemented with North Western

<sup>11</sup> Indicators for sub-IR 2.1 are included under sub-IR 3.1.

<sup>12</sup> Indicators for sub-IR 2.3 will be measured by the indicators under 2.2 (2.2.1 and 2.2.2), since use of existing research is part of formative research.

province conducting a study on maternal nutrition. Attempts were made to implement the activity in Western province, but due to the lack of commitment and provincial resources, the activity had to be cancelled. In 2014, CSH conducted an assessment of the activity with North Western province. The assessment revealed that the activity was a very positive and effective experience for North Western province. The model of classroom-based learning, complemented by hands-on technical assistance, provided an opportunity for the province to build its capacity to conduct formative research studies. The formative research training curriculum also provided a solid basis for learning the basic concepts needed to manage a formative research study.

As explained above, CSH collaborated with GRZ staff at MOH, NMCC, and NAC on carrying out formative research studies for four BCC campaigns: *Safe Love*, STOP Malaria, Mothers Alive, and 1,000 Most Critical Days.

For the formative research studies for *Safe Love*, STOP Malaria, Mothers Alive, and 1,000 Most Critical Days nutrition campaigns, the results were presented to all relevant stakeholders and CSH staff in a campaign strategy design workshop, where the findings were used to inform the communication strategy and messages for each campaign.

### **3.5 IR 3: Local Capacity To Support Sustained Implementation of IEC/BCC Activities Strengthened**

IR 3 states that, as a result of CSH, local capacity to support sustained implementation of IEC/BCC activities will be strengthened. The local capacity will be defined as “strengthened” if the following four criteria are fulfilled:

1. Local capacity to support sustained implementation of IEC/BCC activities is strengthened,
2. Private sector participation in IEC/BCC programming and capacity-building activities is increased,
3. IEC/BCC capacity-building programming for local institutions is strengthened, and
4. M&E Frameworks for IEC/BCC interventions are strengthened.

The baseline, midline, and endline results for IR 3 are presented in Table 3.9 below. Overall, local capacity of GRZ, CSOs, private sector partners, and academic institutions to support sustained of IEC/BCC activities met or exceeded its targets.

**Table 3.9 CSH IR 3 Indicators and Results**

IR 3 Indicator	Baseline 2010	Midline 2012	Endline 2014	LOP Target
<b>Sub-IR 3.1 Local capacity to support sustained implementation of IEC/BCC activities strengthened</b>				
3.1.1 Annual number of national IEC/BCC campaigns that have been reviewed by the IEC/BCC TWG and/or partners working in IEC/BCC**	0	10 campaigns Nonroutine campaigns: 3 Routine campaigns: 7	9 campaigns	12 campaigns annually/9 campaigns for 2014*
3.1.2 Annual number of formal meetings of the IEC/BCC TWG to review IEC/BCC campaigns**	0	Total: 20 meetings, 10 meetings annually	13 meetings	12 meetings annually*
3.1.3 Annual number of GRZ staff trained in IEC/BCC with CSH support**	0	Total: 161	Total: 113  (370 GRZ staff trained for LOP)	Total: 250*
3.1.4 National IEC/BCC tools developed and annually reviewed**	Nonexistent	Total: 6	Total: 10	Total: 10 tools
3.1.5 HCRC has materials that cover HIV, malaria, MNCH, FP/RH, and nutrition	HIV materials only	HIV, malaria, and MNCH materials available	HIV, malaria, MNCH, FP/RH, and nutrition materials available	HIV, malaria, MNCH, FP/RH, and nutrition materials available
3.1.6 Average number of HCRC visitors per month in 1 year**	572	602	2,456	1,200*
3.1.7 Annual number of IEC/BCC materials distributed by HCRC	524,657	Total (for Years 1 and 2): 453,903	Total (for Years 3 and 4): 81,985  Total (for LOP): 535,888	500,000*
3.1.8 Annual number of Talkline workers who successfully completed a training programme in other health topics, including malaria, MNCH, FP/RH, and nutrition**	0	Total: 19	Total: 0 (no trainings planned for 2014, 19 workers trained for LOP)	Total: 20
3.1.9 Average number of Talkline callers per month in 1 year**	Serviced calls: 1,632 Total calls: 5,818	Serviced calls: 3,553 Total calls: 14,085	Serviced calls: 7,399 Total calls: 23,538	Serviced calls: 5,000 per month Total calls: 16,000 per month*
3.1.10 Annual number of GRZ staff trained in M&E for IEC/BCC with CSH support**	0	Total: 0	Total: 0 (no trainings planned for 2014, 62 GRZ staff trained for LOP)	Total: 65

IR 3 Indicator	Baseline 2010	Midline 2012	Endline 2014	LOP Target
<b>Sub-IR 3.2 Private sector participation in IEC/BCC programming and capacity-building activities increased</b>				
3.2.1 Annual number of national IEC/BCC campaigns supported by CSH that have private sector support**	0	Total: 1	Total: 4	Total: 4
3.2.2 Annual number of private sector institutions that provide support to national IEC/BCC campaigns supported by CSH** <sup>13</sup>	N/A	N/A	Total: 6	Total: 6
<b>Sub-IR 3.3 IEC/BCC capacity-building programming for local institutions is strengthened</b>				
3.3.1 Annual number of selected local academic institutions that offer IEC/BCC-related coursework that uses the curricula developed with CSH support**	0	Total: 0 institutions	Total: 4 institutions	Total: 4 institutions
3.3.2 Annual number of CSOs receiving grants from CSH to implement BCC outreach activities that support campaigns**	0	Total: 7 CSOs	Total: 12 CSOs	Total: 12 CSOs
<b>Sub-IR 3.4 M&amp;E Frameworks for IEC/BCC intervention are strengthened</b>				
3.4.1 National HIV and Malaria M&E Frameworks (2011–2015) include IEC/BCC indicators	HIV and Malaria M&E Frameworks did not include IEC/BCC indicators	HIV and Malaria M&E Frameworks include IEC/BCC indicators	HIV and Malaria M&E Frameworks include IEC/BCC indicators	HIV and Malaria M&E Frameworks include IEC/BCC indicators
3.4.2 IEC/BCC M&E Framework for the HPU of MCDMCH developed	Nonexistent	Action plan for completing the framework developed	IEC/BCC M&E Framework for the HPU of MCDMCH developed	IEC/BCC Framework for the HPU of MCDMCH developed

\* This target was adjusted based on discussions with and approval of USAID.

\*\* The results presented for this indicator are for Year 2 for the midline and Year 4 for the endline only, as they do not allow for aggregation across multiple years.

### 3.5.1 National TWGs

At baseline, the IEC/BCC TWGs at the MOH/MCDMCH, NAC, and NMCC were in place, but were not actively meeting. With CSH support, the three IEC/BCC TWGs were revived and began having formal quarterly meetings approximately three to four times per year since 2012. Additionally, other meetings are held with the members of the different TWGs on an ad hoc basis, depending on their needs as other routine campaigns come up and are launched. Lastly, Terms of Reference (TORs) for the TWGs were developed and approved, which has allowed for the functions and role of the TWGs to be clarified.

<sup>13</sup> Indicator was added to CSH's PMP in 2013.

One of the main functions of the TWGs is to review IEC/BCC campaigns using standard IEC/BCC materials evaluation and pre-testing guidelines developed with support from CSH. After the TWGs were revived, they reviewed a number of CSH-supported BCC campaigns, which included campaign strategies, messages, and various products. In 2012, 2013, and 2014, CSH-supported campaigns were reviewed by the TWGs using standard guidelines.

To further improve the capacity of the members of each of the TWGs, CSH trained a number of their members in behaviour-centred programming to ensure that all members are aware of and understand the process for developing an effective BCC campaign including materials development, pre-testing, and production.

In 2014, qualitative capacity assessments were conducted with key members of each of the TWGs:

- **NAC:** The functioning of the TWG greatly improved, largely due to help from CSH in clarifying the mandate of the TWG and the different roles and responsibilities of the individual members, and trainings on how they can fulfil their role of developing and reviewing high-quality IEC/BCC materials. The TWG has met on a regular basis and acknowledged the critical role of the TWG in reviewing IEC/BCC materials. However, the challenge of how to secure resources needed to sustain the TWG efforts was noted.
- **MCDMCH:** This assessment showed the instrumental role that CSH played in improving the utility and functionality of the TWG. The establishment of the TORs and guidelines on reviewing IEC/BCC materials was a key success in allowing the TWG to spearhead changes in IEC/BCC materials and interventions at both the national and the subnational levels. TWG members have a strong drive to continue to improve the group even after the CSH project ends.
- **NMCC:** The assessment showed functioning of the TWG, and CSH support was integral in improving the processes to review, pre-test, and provide recommendations on materials. CSH support also strengthened partnerships amongst TWG members resulting in stronger skills and increased capacity. Lack of adequate resources and a resource mobilisation plan to sustain the TWG was the primary challenge identified.

### **3.5.2 BCC Capacity of GRZ**

During the first year of the project, CSH developed a behaviour-centred programming training curriculum that focused on improving knowledge and skills in the design, implementation, and M&E of BCC programmes. The training was pilot-tested and revised on the basis of participants' feedback. CSH used a training-of-trainers approach to scale up the training to GRZ staff at the provincial and district levels. By the endline, CSH trained 370 GRZ staff in BCC, including some of the members of the IEC/BCC TWGs. In total, CSH trained 655 people, including national partners, U.S. Government partners, and GRZ staff at both the national and the subnational levels. In 2014, CSH conducted two refresher trainings to gather feedback on the usefulness of the training experience in implementing the knowledge and skills gained, get recommendations for future trainings, and fill in knowledge and skills gaps identified from the initial trainings. A total of 38 GRZ staff representing all 10 provinces participated in the refresher workshops.

In 2014, CSH conducted a qualitative evaluation of the behaviour-centred programming trainings. The overall findings revealed that participants benefited from the trainings and found the workshops valuable and applicable to their work duties. Participants continued to benefit from the knowledge and skills they gained from the training and were able to apply what they learnt to work responsibilities.

### **3.5.3 Afya Mzuri Dziwani: Capacity To Manage Information**

At baseline, the Dziwani Knowledge Centre for Health at Afya Mzuri provided health communications resources and materials on only HIV/AIDS-related health topics. In 2014, CSH conducted a qualitative capacity assessment that showed Afya Mzuri achieved a wide range of activities over the two phases of the programme, including strengthening staffing, enhancing information technology infrastructure, improving marketing, procuring materials and storage space, developing and launching the web portal, establishing a database of IEC/BCC specialities, creating an interactive space for learning opportunities, and developing a long-term sustainability plan. CSH support was shown to be instrumental in the transformation of Afya Mzuri's Dziwani Knowledge Centre for Health into a health communication research centre. Yet, limited resources, lack of IEC materials, and challenges associated with implementing a sustainable programme are still critical areas to be addressed.

The demand for health resources remained high, as evidenced by the consistently high number of monthly visitors (both physical and online) to the centre, about 2,456 visitors per month by the endline. The focus of CSH's efforts expanded the centre; thus, the centre did not distribute the same amount of materials over the life of the project. The number of resources distributed has increased over the years to a total 535,888 pieces at the end of the project. CSH also coordinated with other partners to ensure that all U.S. Government partner IEC/BCC materials are available at the centre and on their websites.

### **3.5.4 Comprehensive HIV/AIDS Management Programme Health Talkline**

The Comprehensive HIV/AIDS Management Programme (CHAMP) Health Talkline is a phone-in health programme that was launched on World AIDS Day in December 2003 and became operational in 2004. At baseline, the programme offered information and counselling on topics related to HIV/AIDS, male circumcision, and human trafficking. A qualitative capacity assessment revealed that by end of the project, CHAMP achieved or developed a business plan, increased capacity of the 990 Talkline as a call centre for health information and consultative services, expanded the information and consultative services offered by the 990 Talkline to include other health topics, strengthened linkages to health care referral systems and resources, enhanced the information technology platform, and established a marketing strategy.

The Talkline experienced a notable increase in calls answered, with a monthly average of 7,399 by 2014, compared to an average of 1,632 per month in 2010. This increase was largely due to the increase of trained counsellors (19), which include male counsellors, and improved telephone systems. CSH support also proved to be instrumental in improving and expanding the Talkline's services. Remaining challenges, particularly in relation to sustainability, included insufficient funding and private partnerships to sustain and expand services and to fully market the Talkline.

### 3.5.5 Participation of the Private Sector

Private sector engagement in GRZ-led BCC campaigns at the beginning of the project was very limited and, for many of the campaigns, nonexistent. Furthermore, no strategy existed for engaging different private sector partners in IEC/BCC activities.

In Year 2 of the project, CSH developed a draft private sector engagement strategy that was presented to USAID and other U.S. Government partners. CSH has also worked to establish relationships with potential private sector partners in order to expand the reach of current CSH campaigns. By the end of the project, CSH collaborated with a total of 6 companies to provide support to the *Safe Love*, STOP Malaria, Mothers Alive, and 1,000 Most Critical Days campaigns.

An assessment conducted in 2014 revealed that companies provided a range of support for the campaigns. They supported broadcasting of the TV products; printing of materials; discounts for screenings, advertisements, and refreshments; campaign launches; transportation of materials; online broadcasting; and radio promotion. The costing analysis showed that companies were willing to provide multiple contributions and some long-term campaign support. The assessment also showed that companies saw the value in contributing to health campaigns with high-quality products, believing that their support benefited the company's brand. The study also revealed challenges in the process of collecting funds to be directed towards specific campaigns.

### 3.5.6 Capacity of Local Institutions

The baseline report found that very few IEC/BCC-related courses are offered in Zambia. The health promotion courses that are available are offered only at the post-graduate level. To build the capacity of local academic institutions to provide additional IEC/BCC course opportunities, CSH assisted in the development of IEC/BCC curricula and materials for the targeted institutions of higher learning. Prior to identifying academic institutions to collaborate with on these new courses, CSH designed and carried out an assessment of current IEC/BCC courses offered in Zambia. The aim of the assessment was to identify all IEC/BCC course opportunities available in Zambia, to review the content of current IEC/BCC curricula to identify gaps and courses that could be built upon/improved, and to identify institutions that CSH could collaborate with to develop the courses. The assessment was carried out in 2012, with a final report and presentation disseminated in a stakeholder meeting.

Following the assessment, CSH identified four institutions to collaborate with in the development of IEC/BCC courses. These institutions included the Institute of Economic and Social Research at the University of Zambia, the General Nursing Council of Zambia, Lusaka Apex Medical University, and the Zambia Institute of Mass Communications Trust. To support the continuation of the courses, CSH developed a protocol and instruments for institutions to measure the courses' impact on students' knowledge and confidence using IEC/BCC principles.

### 3.5.7 National M&E Framework

CSH provided technical assistance to GRZ in the development of new National HIV and Malaria M&E Frameworks for 2011–2015, including the selection of indicators to monitor

and evaluate IEC/BCC activities. The M&E Framework for MCDMCH was also developed and incorporated into the ministry’s communications strategy.

### 3.6 IR 4: Coordination of IEC/BCC Activities Between USAID Projects Increased

IR 4 states that, as a result of CSH, the coordination of IEC/BCC activities between USAID projects will increase. The coordination of IEC/BCC activities between USAID projects will be defined as “increased” if the following criteria are fulfilled:

1. IEC/BCC planning between U.S. Government programmes is increased.

The baseline, midline, and endline results for IR 4 are presented in Table 3.10 below. Overall, the coordination of IEC/BCC activities met its targets.

**Table 3.10 CSH IR 4 Indicator and Results**

IR 4 Indicator	Baseline 2010	Midline 2012	Endline 2014	LOP Target
<b>Sub-IR 4.1 IEC/BCC planning between USAID programmes increased</b>				
4.1.1 USAID partner framework for IEC/BCC coordination developed and annually reviewed	Nonexistent	Consolidated action plan developed	U.S. Government partner framework developed and reviewed	U.S. Government partner framework developed and annually reviewed
4.1.2 Annual number of U.S. Government partner meetings for coordinating IEC/BCC activities**	Total: 0	Total: 8	Total: 2	Total: 14 (4 per year for first 3 years, 2 planned in 2014)

#### 3.6.1 Coordination of IEC/BCC Activities Between USAID Projects

GRZ worked with U.S. Government agencies, other cooperating partners, and implementing partners to carry out broad health sector strategies focused on improving the health of Zambians. Other USAID-funded health programmes also supported GRZ to integrate health service delivery and to strengthen the overall health system. IEC/BCC was mainly incorporated in each programme as a central tenet to increase knowledge, healthy behaviours, and health-seeking practices that contribute to greater use of services offered by the health system.

To improve coordination amongst the different USAID-funded partners that implement IEC/BCC activities, an IEC/BCC coordination partner forum was developed in Year 1 of the project. The forum comprised representatives or focal persons from each of the respective partner organisations (approximately eight organisations) that work on USAID-funded projects and held coordination meetings on a quarterly basis. The aim of the coordination meetings was to achieve synergy, maximise use of resources, and avoid duplication of efforts with regard to the planning, management, implementation, and M&E of IEC/BCC activities in the health sector.

The main functions of the IEC/BCC coordination forum were as follows:

1. Bring together members once every quarter;
2. Plan and share progress, best practices, and lessons learned on IEC/BCC activities implemented by each member project;
3. Align IEC/BCC workplans, and identify areas of collaboration amongst partners to increase synergy and efficiency;
4. Identify important IEC/BCC evidence-based strategies, and recommend those for adoption by GRZ (i.e., MOH, NMCC, and NAC);
5. Review IEC/BCC interventions implemented by partner projects to determine the value, impact, and relevance of USAID project contribution to the overall national health communications implemented and managed by GRZ; and
6. Document and share success stories.

During the project, the partner forum met on a quarterly basis, for a total of 14 meetings. The partners developed a framework for coordinating their efforts of the project and, in 2013, developed an M&E framework for measuring their key achievements. Some key achievements made during the life of the project included partner coordination at a World Tourism Organization event, support for STEP-UP's ITN mass distribution exercise and support to update NMCC's malaria communications strategy, support to re-launch the VMMC in one of the local chiefdoms, and development of behaviour-centred programming training toolkits and roll out to the provincial and district levels. Two USAID projects worked together to support formation and orientation of provincial IEC/BCC TWGs and district health promotion committees countrywide.

## 4. CONCLUSIONS

This report presents the results from the endline evaluation conducted during October and November 2014, comparing results across the life of the project from baseline. It includes the review of IEC/BCC campaigns; approaches; messages and materials; and assessments of the HCRC, CHAMP Health Talkline, and GRZ's institutional capacity. It also includes endline data on project output and intermediate outcome indicators in CSH's Results Framework and PMP. The main conclusions for each section of findings, following the PMP structure, are as follows:

### ***Behaviour Outcomes and Health Impact Indicators for HIV, Malaria, FP/RH, and MNCH***

The endline results for both behavioural outcomes and health impact indicators was partially established, since only a portion of the preliminary results of the DHS 2013/2014 were available at the time. Using the available data, some indicators showed some marked improvement—including maternal and child mortality, women and children sleeping under ITNs, use of modern family planning methods, and facility-based deliveries. Other malaria indicators and indicators related to multiple concurrent partnerships and condom use remained relatively unchanged.

### ***Project Objective: Capacity of GRZ To Manage Effective IEC/BCC Activities Strengthened***

**GRZ's IEC/BCC Management Capacity:** Each of the ministries that participated in the capacity assessment index (NMCC and MOH/MCDMCH) prior to the endline showed growth in its overall capacity. This growth was most notable in NMCC, with a midline score of 61 percent to an endline score of 88 percent. Both NAC and NMCC surpassed the target capacity index score of 70 percent, while MOH/MCDMCH did not (59 percent). Each of the ministries seemed strongest in BCC programme planning and implementation and weakest in M&E.

**Use of IEC/BCC Guidelines:** IEC/BCC guidelines were revised and finalised in collaboration with CSH and GRZ partners. At the time of the midline, the guidelines were used to review 63 percent of national IEC/BCC campaigns, but had not been consistently used for all campaigns conducted by GRZ. Use of research to inform campaign messages and products has increased since the baseline evaluation, with 63 percent of campaigns using evidence from formative research or already-existing research to inform campaigns in 2012. By the endline, 100 percent of the six campaigns were using the guidelines and research to inform the development and implementation.

**M&E of National Campaigns:** Overall, monitoring of BCC campaigns increased over the life of the project, with 100 percent of the six campaigns being monitored by the endline. Evaluations of all of the four nonroutine campaigns were also conducted.

### ***IR 1: National Health Communications Campaigns Strengthened***

#### **Integrated Malaria, MNCH, and Nutrition Campaigns**

NMCC, in collaboration with CSH, developed an innovative campaign called STOP Malaria that integrates malaria, MNCH, and nutrition messages. The campaign focused on the promotion of ANC services and IPTp, use of ITNs, prompt and effective treatment of

malaria, and proper feeding of children who are sick with malaria. By the end of the project, the campaign accomplished all of the planned milestones. These included (1) completion of formative research (including a desk review of current existing research), (2) development of the campaign strategy, (3) launch and implementation of the campaign, (4) monitoring of the campaign, and (5) evaluation of the campaign.

MCDMCH and MOH, in collaboration with CSH, designed a maternal and child health campaign called Mothers Alive. Using the Change Champions model and implementing the SMGL component, the campaign focused on creating demand for a facility-based delivery, early ANC, completion of all post-partum follow-up care, and family planning. By the end of the project, the campaign accomplished all of the planned milestones. These included (1) completion of formative research (including a desk review of current existing research), (2) development of the campaign strategy, (3) launch and implementation of the campaign, (4) monitoring of the campaign, and (5) evaluation of the campaign.

In collaboration with CSH, MCDMCH designed the 1,000 Most Critical Days nutrition campaign focused on maternal and child nutrition using locally available foods and proper cooking and hygiene techniques. By the end of the project, the campaign accomplished all of the planned milestones. These included: (1) completion of formative research (including a desk review of current existing research), (2) development of the campaign strategy, (3) launch and implementation of the campaign, (4) monitoring of the campaign, and (5) evaluation of the campaign.

**Comprehensive HIV Campaigns:** NAC, in collaboration with CSH, has designed a comprehensive national-level HIV campaign called *Safe Love*. The main prevention messages that the campaign focused on included reduction of multiple concurrent sexual partnerships, consistent and correct condom use, prevention of mother-to-child transmission, and abstinence and faithfulness. By the end of the project, the campaign accomplished all of the planned milestones. These included (1) completion of formative research (including a desk review of current existing research), (2) development of the campaign strategy, (3) launch and implementation of the campaign, (4) monitoring of the campaign, and (5) evaluation of the campaign.

**Multichannel and Evidence-Based Campaigns:** CSH collaborated with MOH, NAC, and NMCC to support 10 routine and nonroutine campaigns. All 10 of these campaigns by midline, and six by the endline, made use of multiple channels for disseminating campaign messages, and all were based on research, from either new formative research or existing research.

## ***IR 2: GRZ's Use of Evidence-Based Health Communications Approaches Increased***

**GRZ Capacity To Use Evidence From Research:** Prior to the beginning of the CSH project, GRZ staff capacity in formative research was low, with none of the health promotion staff having had any training in formative research or use of formative research findings to inform the design of health communication activities. During the first year of the project, CSH designed and pilot-tested a formative research training for GRZ staff. By the end of the project, CSH had trained a total of 61 GRZ staff in formative research. Additionally, CSH launched an innovative Formative Research in Action activity that allowed GRZ staff to put into practice the knowledge and skills that they gained during the training through the implementation of their own formative research study. This activity proved to be beneficial to the participating province by further enhancing the training curriculum. Furthermore, GRZ

staff from MOH, NAC, and NMCC collaborated on four formative research studies with CSH during the project.

### ***IR 3: Local Capacity To Support Sustained Implementation of IEC/BCC Activities Strengthened***

**National TWGs:** With the support of CSH, the three IEC/BCC TWGs housed at MCDMCH, NAC, and MNCC were revitalised and are now conducting formal quarterly meetings. Furthermore, TORs were developed and approved for each TWG, helping to clarify their functions and role, which proved to be very helpful. One of the main functions of the TWGs is to review IEC/BCC campaigns based on the developed guidelines. TWG members' capacity has also been strengthened, as many of the members have undergone the CSH-sponsored behaviour-centred programming training and each TWG member has been provided with a booklet on standard guidelines for evaluating and pre-testing IEC/BCC materials.

**BCC Capacity of GRZ:** During the first year of the project, CSH developed and pilot-tested a behaviour-centred programming training curriculum. By the end of the project, CSH was able to train a total of 655 people in behaviour-centred programming, out of which 370 are GRZ staff, surpassing the LOP target of 250.

**Management Capacity of Dziwani HCRC:** The Dziwani HCRC has worked to expand its resource base to include a greater diversity of IEC/BCC materials and to grow into a more comprehensive learning centre.

The demand for IEC/BCC materials continued to increase from the start of the project, which is evidenced by high use of the centre (2,456 visitors per month) and high distribution of materials (535,888 for the LOP), each surpassing the LOP target.

**CHAMP Health Talkline:** With CSH support, the Talkline has expanded its services in terms of both the scope of health-related issues that Talkline counsellors are able to address with callers and its overall access through its new web portal. The expanded services allowed the Talkline to service more calls; serviced calls per month have increased from approximately 1,600 calls in 2010 to 7,399 calls per month in 2014, surpassing the LOP target. Additionally, CSH supported the revision of the counsellors' reference manual and used it to train all the Talkline counsellors in malaria, nutrition, FP/RH, and MNCH.

**Participation of Private Sector:** In Year 2 of the project, CSH developed a private sector engagement strategy and began identifying potential companies from which to seek out support. By the end of the project, CSH collaborated with 6 companies to provide support to the *Safe Love*, STOP Malaria, Mothers Alive, and 1,000 Most Critical Days campaigns.

**Capacity of Local Institutions:** CSH designed and carried out an assessment of current IEC/BCC courses offered in Zambia during Year 2 of the project. The findings from the assessment were used in Year 3 to assist in the development of curricula and materials to be used for select IEC/BCC courses. By the end of the project, CSH had collaborated with four local institutions of higher learning and supported review and revision of their existing curricula to include the behaviour-centred approach component.

**National M&E Framework:** New national HIV and Malaria M&E Frameworks for 2011–2015 have been developed and now include a set of indicators to monitor and evaluate

IEC/BCC activities. An M&E Framework for the MCDMCH has also been developed and incorporated into the communications strategy.

***IR 4: Coordination of IEC/BCC Activities Between USAID Projects Increased***

**IEC/BCC Planning Between USAID Partners:** To improve coordination and better harmonise IEC/BCC activities across different USAID partners, an IEC/BCC partner coordination forum was developed. The forum developed TORs and a consolidated action plan and met on a quarterly basis. Furthermore, subcommittees on specific areas/topics of interest were formed to further improve planning and coordination of activities.

In conclusion, the findings from the endline evaluation demonstrate that the project met the majority of its targets and, in some instances, surpassed the targets. Also, based on the available data, improvements in some of the key health and behavioural indicators—particularly the increased use of ITNs and facility-based deliveries—suggests that CSH efforts around malaria and safe motherhood have influenced the behaviours of women and their support systems.

# ANNEX A: CSH RESULTS FRAMEWORK

USAID Key Approach: Sustained Zambian individuals and collective action for health

1. HIV prevalence amongst aged 15–24
2. Infant mortality rate
3. Total fertility rate

## Health Status of Zambians Improved

1. Percentage of women and men aged 15–49 who had two or more partners in the past 12 months, NAC, MOH
2. Percentage of febrile children under age 5 who received prompt and appropriate treatment, NMCC
3. Median duration (months) of exclusive breastfeeding amongst children born in the past 3 years, MOH

## Project Objective: Capacity of GRZ to manage effective IEC/BCC activities strengthened

1. GRZ annual score on IEC/BCC management capacity index
2. % of national IEC/BCC campaigns implemented annually that were developed according to minimum GRZ standards/guidelines
3. % of national IEC/BCC campaigns implemented annually that were developed based on formative research
4. % of national IEC/BCC campaigns implemented annually that were monitored
5. % of national IEC/BCC campaigns implemented annually that were evaluated

### IR 1: National health communications campaigns strengthened

#### Sub-IR 1.1 Integrated malaria, MNCH, and nutrition campaigns expanded

1.1.1 National integrated malaria, MNCH, and nutrition campaign implemented with CSH support

#### Sub-IR 1.2 Comprehensive HIV prevention campaigns expanded

1.2.1 National comprehensive HIV campaign implemented with CSH support  
1.2.2 Number of the targeted population reached with individual and/or small-group level (HIV) preventive interventions (supported by CSH) that are based on evidence and/or meet the minimum standards required  
1.2.3 Percentage of targeted population reached by channel (radio, TV, SMS), developed with CSH support

#### Sub-IR 1.3 Evidence-based multichannel health communications campaigns increased

1.3.1 Annual number of IEC/BCC campaigns implemented in Zambia with CSH support that used two or more channels  
1.3.2 Annual number of BCC campaigns implemented in Zambia with CSH support that used evidence from research to develop the campaign

### IR 2: GRZ's use of evidence-based health communications approaches increased

#### Sub-IR 2.1 Capacity of HCRC to manage information on IEC/BCC interventions improved

NB: Indicators for this section are included in IR 3.1

#### Sub-IR 2.2 GRZ's capacity to conduct formative research to develop national health communication campaigns improved

2.2.1 Annual number of GRZ staff trained with CSH support in conducting formative research to inform the development of IEC/BCC campaigns  
2.2.2 Annual number of nonroutine IEC/BCC campaigns for which formative research activities were conducted with support from CSH

#### Sub-IR 2.3 GRZ's capacity to use evidence from existing research to develop health communications campaigns improved

NB: To be measured by indicators under IR 2.2 since use of existing research is part of formative research

### IR 3: Local capacity to support sustained implementation of IEC/BCC activities strengthened

#### Sub-IR 3.1 Local capacity of MOH, NAC, and NMCC to manage IEC/BCC interventions improved

3.1.1 Annual number of national IEC/BCC campaigns that have been reviewed by the IEC/BCC TWG using standard guidelines  
3.1.2 Annual number of formal meetings of the TWG to review IEC/BCC campaigns  
3.1.3 Annual number of GRZ staff trained in IEC/BCC with CSH support  
3.1.4 National IEC/BCC tools developed and annually reviewed  
3.1.5 HCRC has materials that cover HIV, malaria, MNCH, FP/RH, and nutrition  
3.1.6 Average number of HCRC visitors per month in one year  
3.1.7 Annual number of IEC/BCC materials distributed by HCRC  
3.1.8 Annual number of Talkline workers who successfully completed a training programme in other health topics, including malaria, FP/RH, and nutrition  
3.1.9 Average number of Talkline callers per month in one year  
3.1.10 Annual number of GRZ staff trained in M&E with CSH support

#### Sub-IR 3.2 Private sector participation in IEC/BCC programming and capacity-building activities increased

3.2.1 Annual number of national IEC/BCC campaigns supported by CSH that have private sector support  
3.2.2. Annual number of private sector institutions that provide support to national IEC/BCC campaigns supported by CSH

#### Sub-IR 3.3 IEC/BCC capacity-building programming for local institutions strengthened

3.3.1 Annual number of selected local academic institutions offering IEC/BCC-related coursework that uses curricula developed with CSH support  
3.3.2 Annual number of CSOs receiving grants from CSH to implement BCC outreach activities that support campaigns

#### Sub-IR 3.4 M&E frameworks for IEC/BCC intervention implemented

3.4.1 National HIV and Malaria M&E Frameworks (2011–2015) included IEC/BCC indicators  
3.4.2 Develop an IEC/BCC M&E Framework for the Health Promotion Unit of MCDMCH

### IR 4: Coordination of IEC/BCC activities between USAID projects increased

#### Sub-IR 4.1 IEC and BCC planning between USAID programmes increased

4.1.1 USG partner framework for IEC/BCC coordination developed and annually reviewed  
4.1.2 Annual number of USG partner meetings for coordinating IEC/BCC activities