





**USAID**  
FROM THE AMERICAN PEOPLE



This publication was produced for review by the United States Agency for International Development (USAID). It was prepared by ICF International as part of the USAID, funded by Communications Support for Health, and implemented by Chemonics International.

# **Understanding Monitoring and Evaluation: Concepts and Common Methods for Behaviour Change Communications Campaigns**

## **Participant's Guide Final**

**USAID Communications Support for Health Project  
Lusaka, Zambia**

### **Acknowledgements**

This guide was written, pre-tested, and launched as part of the United States Agency for International Development (USAID)-funded Communications Support for Health (CSH) project in Zambia. The project is implemented by Chemonics International in partnership with ICF International and The Manoff Group.



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## Welcome

Welcome to the Understanding Monitoring and Evaluation: Concepts and Common Methods for Behaviour Change Communications Campaigns Training. This training was developed by the United States Agency For International Development (USAID)-funded Communications Support for Health (CSH) project in Zambia. The objective of the training is to enhance the knowledge and skills of participants to effectively develop and critically review monitoring and evaluation (M&E) plans for behaviour change communications (BCC) campaigns. Specifically, after attending the training, participants should be able to

- Explain the role of M&E for BCC and how it is different from M&E for health service;
- Create M&E frameworks;
- Choose M&E indicators;
- Select an appropriate evaluation design, data sources, and collection methods;
- Design an M&E plan;
- Identify effective presentation and interpretation practices; and
- Make recommendations for campaign revisions.

## Training Materials

All of the materials you need for participating in the training are included in this guide. The guide includes materials for the lectures and exercises, as well as additional reference sources on M&E for BCC campaigns.



## Training Agenda

<b>DAY 1</b>		
<b>Begin</b>	<b>End</b>	<b>Activity</b>
8:30	9:00	Registration
9:00	10:15	<b>Session 1:</b> Workshop Introduction
10:15	10:30	Pre-Test
10:30	11:00	Tea Break
11:00	12:00	<b>Session 2:</b> What Is Monitoring?
12:00	13:00	Lunch
13:00	13:10	<b>Energiser 1:</b> Rainstorm
13:10	14:10	<b>Session 3:</b> What Is Evaluation?
14:10	15:00	<b>Session 4:</b> Foundations of the M&E Plan
15:00	15:30	Tea Break
15:30	17:15	<b>Session 5:</b> M&E Frameworks
17:15	17:30	Daily Evaluation

## Training Agenda

<b>DAY 2</b>		
<b>Begin</b>	<b>End</b>	<b>Activity</b>
8:30	8:40	Reporters
8:40	10:45	<b>Session 5:</b> M&E Frameworks (continued)
10:45	11:15	Tea Break
11:15	12:45	<b>Session 6:</b> Indicators
12:45	13:45	Lunch
13:45	14:00	<b>Energiser 2:</b> Mumble Jumble
14:00	15:45	<b>Session 6:</b> Indicators (continued)
15:45	16:15	Tea Break
16:15	17:15	<b>Session 7:</b> Data Collection
17:15	17:30	Daily Evaluation

## Training Agenda

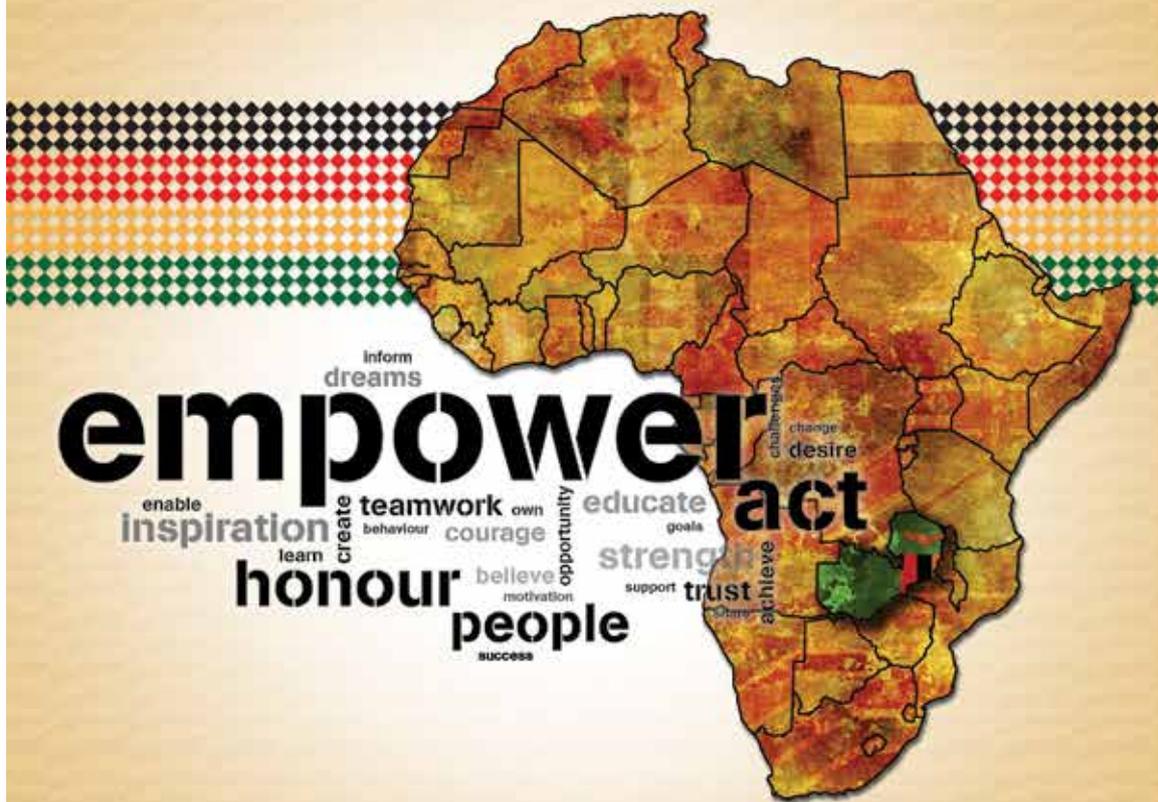
<b>DAY 3</b>		
<b>Begin</b>	<b>End</b>	<b>Activity</b>
8:30	8:40	Reporters
8:40	9:30	<b>Session 7:</b> Data Collection (continued)
9:30	11:00	<b>Session 8:</b> Evaluation Design
11:00	11:30	Tea Break
11:30	13:00	<b>Session 9:</b> Data Presentation
13:00	14:00	Lunch
14:00	14:15	<b>Energiser 3:</b> Kick the Ball
14:15	15:00	<b>Session 10:</b> Data Interpretation
15:00	15:30	Tea Break
15:30	16:20	<b>Session 11:</b> Final Report Out
16:20	16:35	<b>Session 12:</b> Workshop Closing
16:35	17:00	Daily Evaluation and Post-Test

### Optional Supplemental Session

20 minutes	<b>Supplemental Session:</b> Approaches to Analysis
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# SESSION I





## Session 1: Workshop Introduction

Slide 1.1

USAID FROM THE AMERICAN PEOPLE

PEPFAR

CSH  
Communication Support for Health

# Understanding Monitoring and Evaluation

Concepts and Common Methods for Behaviour Change Communication (BCC) Campaigns

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Slide 1.2

USAID FROM THE AMERICAN PEOPLE

PEPFAR

CSH  
Communication Support for Health

# Workshop Introduction

Session 1

2

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Slide 1.3

### Introductions

- Please share with us your
  - Name,
  - Organisation, and
  - Experience in monitoring and evaluation (M&E)—  
general and/or for BCC.

Session 1: Workshop Introduction 3

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Slide 1.4

### Expectations

- What do you **HOPE** this learning experience will be like?
- What knowledge or skills do you **WANT** to apply in your daily job as a result of this workshop?
- What **WORRIES** you about the learning process?

Session 1: Workshop Introduction 4

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Slide 1.5

### Training Objectives

- **After attending this workshop, participants will be able to**
  - Explain the role of M&E for BCC and how it is different from M&E for health service delivery;
  - Create M&E frameworks;
  - Choose M&E indicators;
  - Select an appropriate evaluation design, data sources, and collection methods;
  - Design an M&E plan;
  - Identify effective presentation and interpretation practices; and
  - Make recommendations for campaign revisions.

Session 1: Workshop Introduction 5

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Slide 1.6

### Agenda and Methodology

<ul style="list-style-type: none"><li>• <b>Structure</b><ul style="list-style-type: none"><li>– Sessions</li><li>– Tea breaks and lunch</li><li>– Energisers</li></ul></li> <li>• <b>Learning process</b><ul style="list-style-type: none"><li>– Presentations</li><li>– Discussions and participatory exercises</li><li>– Daily reporting</li></ul></li></ul>	<ul style="list-style-type: none"><li>• <b>Feedback</b><ul style="list-style-type: none"><li>– Pre- and post-tests</li><li>– Daily evaluations</li><li>– Guided discussion</li></ul></li></ul>
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Session 1: Workshop Introduction 6

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Slide 1.7

### Ground Rules

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- What do you need to ensure a healthy learning environment?

Session 1: Workshop Introduction 7

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Slide 1.8

### Icebreaker

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- Identify the 10 things you have in common with every other person in your group that have nothing to do with work.
- Do not include body parts or clothing (we all have legs, we all have arms, we all wear socks...) in your 10 things.

Session 1: Workshop Introduction 8

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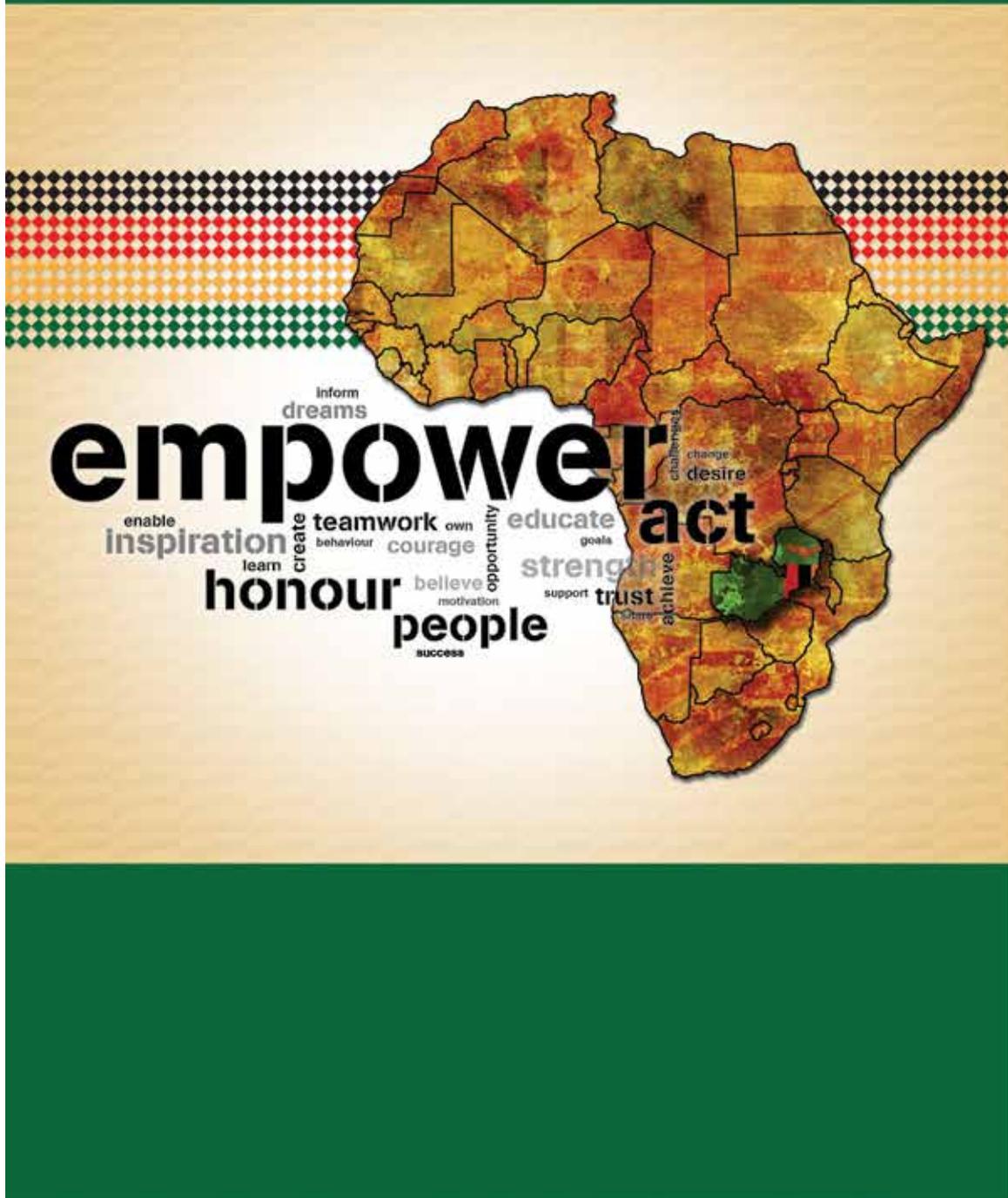
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# SESSION 2





## Session 2: What Is Monitoring?

Slide 2.1



Slide 2.1 features a header with logos for USAID (United States Agency for International Development), USAID FROM THE AMERICAN PEOPLE, PEPFAR (President's Emergency Plan for AIDS Relief), and CSH (Communication Support for Health). The main content area has a grey background with the title "What Is Monitoring?" and "Session 2" centered. A small number "1" is in the bottom right corner.

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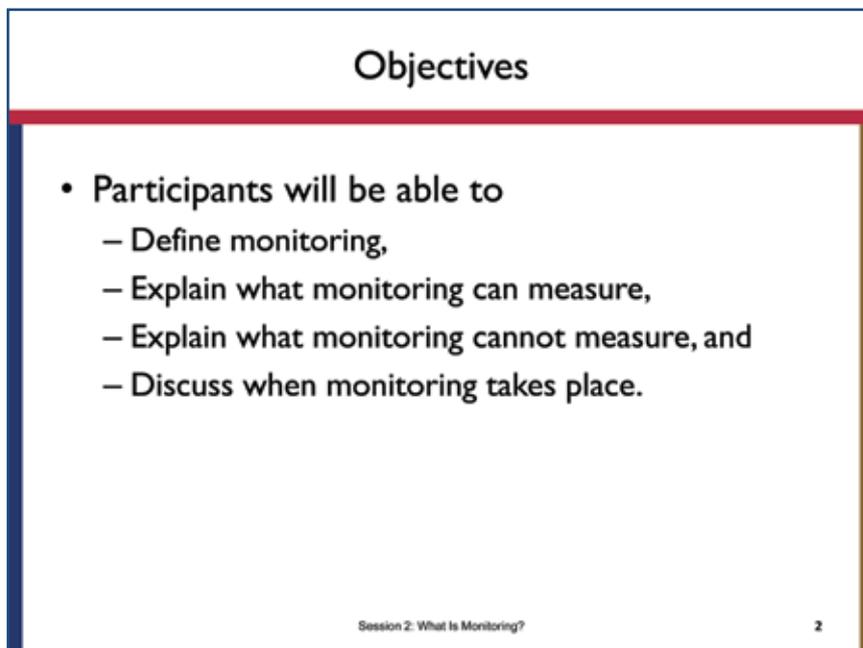
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Slide 2.2



Slide 2.2 has a white background with the title "Objectives" centered. Below the title is a bulleted list of objectives. At the bottom, it says "Session 2: What Is Monitoring?" and a small number "2".

- Participants will be able to
  - Define monitoring,
  - Explain what monitoring can measure,
  - Explain what monitoring cannot measure, and
  - Discuss when monitoring takes place.

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Slide 2.3

**Your Perspective**

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- What is monitoring?
- What does it mean to monitor a BCC campaign?
- How is monitoring different for a BCC campaign than for a health services delivery project?

Session 2: What Is Monitoring? 3

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Slide 2.4

**What Is Monitoring?**

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**Monitoring** is the process of collecting routine data for measuring the progress of campaign implementation.

Session 2: What Is Monitoring? 4

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Slide 2.5

**Monitoring**

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- Is a continuous, systematic process;
- Involves collecting and analysing information throughout the campaign implementation; and
- Can be used to determine if a campaign is being implemented according to plan and whether it needs to be changed.

Session 2: What is Monitoring? 5

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Slide 2.6

**Monitoring Looks at Process**

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- How well has the programme been implemented?
- How much does implementation vary from site to site?
- Did the programme reach the intended people? At what cost?

Session 2: What is Monitoring? 6

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Slide 2.7

**What Monitoring Measures**

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- **Monitoring measures**
  - *What did the project do?*
  - *How much was accomplished?*
- **Monitoring measures activities you have done.**

Session 2: What is Monitoring? 7

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Slide 2.8

**What Monitoring Measures (cont.)**

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- **Monitoring helps you measure how well a campaign is being delivered through tracking items or activities, such as**
  - Materials distribution,
  - Amount of media time bought,
  - Number of peer educators trained in counselling, and
  - Number of newspaper inserts developed on how to correctly use a condom.

Session 2: What is Monitoring? 8

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Slide 2.9

### What Monitoring *Doesn't* Measure

Monitoring is good at summarising what has been done. BUT

- Monitoring numbers are a very weak measure of the campaign's effects.
- Monitoring measures *programme activities*, not the *impact or effect of those activities*.

Session 2: What is Monitoring? 9

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Slide 2.10

### Monitoring Tells a Story

- Monitoring tells the story of what you have done.
- It can help you
  - Know where to implement changes in your campaign,
  - Formulate lessons learned for your project or other projects, and
  - Better understand your evaluation results.

Session 2: What is Monitoring? 10

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**Slide 2.11**

### Scenario Exercise: Monitoring Brainstorm

- Review the HIV/AIDS campaign plan.
- Identify some things you would want to monitor.

Session 2: What is Monitoring?

11

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# SESSION 3





### Session 3: What Is Evaluation?

Slide 3.1



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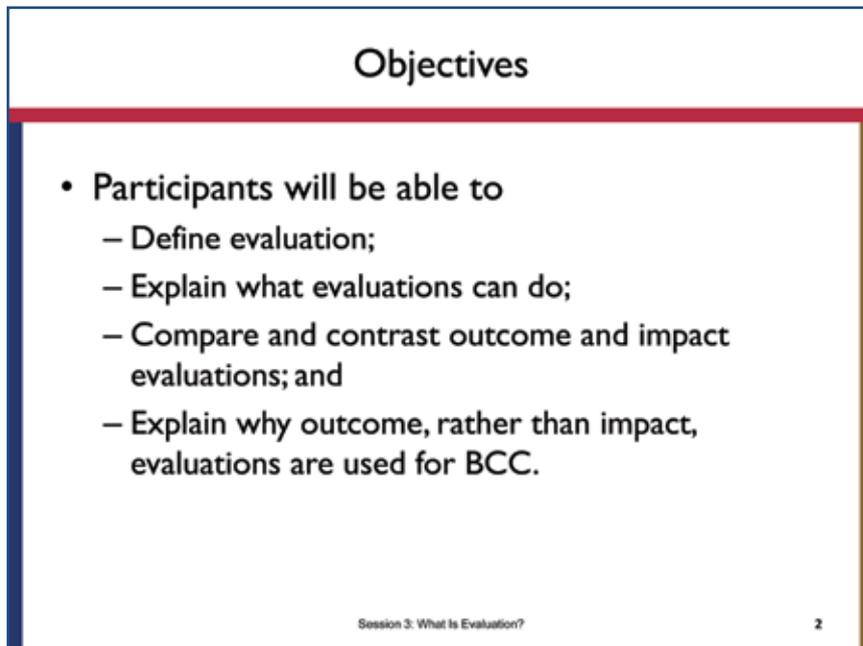
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Slide 3.2



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Slide 3.3

**Definition**

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- Evaluation measures how well the campaign or programme activities have met expected objectives.
- Depending on the design, evaluation can also measure the extent to which changes in desired outcomes can be attributed to the campaign or intervention.

Session 3: What Is Evaluation? 3

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Slide 3.4

**Main Evaluation Types**

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- **Outcome**
  - Used most frequently for BCC campaigns, and
  - Measures the result or influence of your campaign on the behaviour you are trying to change.
- **Impact**
  - Used rarely, if ever, to evaluate BCC campaigns; and
  - Measures change in health status (mortality or incidence rates).

Session 3: What Is Evaluation? 4

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Slide 3.5

### Outcome Evaluations

- Involve measuring changes in the target population on aspects the campaign was designed to influence, such as
  - Attitude
  - Behaviour
  - Policy change
- Include both intermediate and long-term outcomes.

Session 3: What is Evaluation? 5

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Slide 3.6

### Outcome Evaluation Example

- In a malaria campaign evaluation, you may want to look at changes in attitudes and knowledge around whether intermittent preventive treatment (IPT) is safe to take during pregnancy.
- In an HIV campaign evaluation, you may want to look at changes in the proportion of people who have reduced the number of partners they have.

Session 3: What is Evaluation? 6

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Slide 3.7

**Scenario: Evaluation Brainstorm**

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- What factors would you measure in an evaluation for the HIV/AIDS campaign?

Session 3: What is Evaluation? 7

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Slide 3.8

**Outcome vs. Impact**

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<p><b>Outcome Evaluation</b></p> <ul style="list-style-type: none"><li>• Assesses changes as a result of campaign strategies and activities.</li><li>✓ Have knowledge, attitudes, or perceived social norms changed?</li><li>✓ Has there been any behaviour change?</li><li>✓ Have any policies changed?</li></ul>	<p><b>Impact Evaluation</b></p> <ul style="list-style-type: none"><li>• Assesses whether the behaviour resulted in its intended health outcomes.</li><li>✓ Has health status changed (e.g., lower maternal mortality, lower incidence of malaria)?</li></ul>
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Session 3: What is Evaluation? 8

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Slide 3.9

### Your Perspective

- **Have any of you worked on an evaluation for a BCC campaign?**
  - What are some of the factors you evaluated?
- **Thinking of the latest BCC campaign you worked on, what would you want to evaluate?**
- **What type of planning or preparations did you do for your evaluation?**

Session 3: What Is Evaluation? 9

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Slide 3.10

### What Can Evaluations Do?

- **Evaluations help to objectively assess**
  - The extent to which the BCC campaign is having or has had an influence on the factors you want to change,
  - In what areas it is effective, and
  - Where corrections or improvements need to be considered.
- **Evaluations allow campaign managers to**
  - Meet organisational reporting and other requirements, and
  - Convince donors that their investments have been worthwhile or that recommendations to the campaign strategy should be considered.

Session 3: What Is Evaluation? 10

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Slide 3.11

### When Does Evaluation Happen?

- Evaluations usually happen at the end of a campaign or project, although they should be planned from the beginning.
- Data collection at the start of a campaign (to provide a baseline), and again at the end, is recommended to allow comparisons.
- Depending on the length of the campaign, funders may also want a mid-term evaluation.
- Advanced planning allows you to choose the best design for your campaign evaluation.

Session 3: What is Evaluation?

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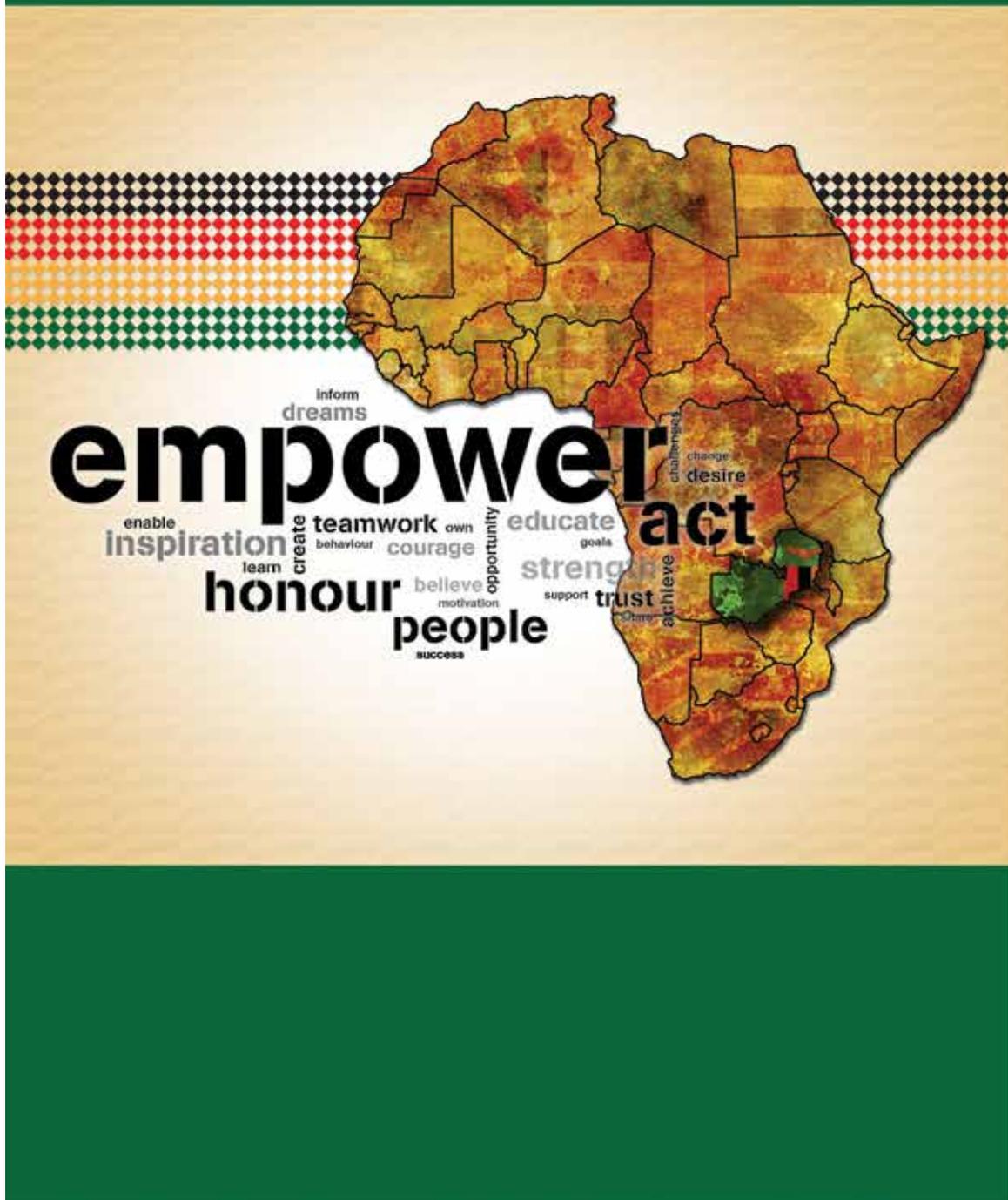
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# SESSION 4





## Session 4: Foundations of the M&E Plan

Slide 4.1



Foundations of the M&E Plan

Session 4

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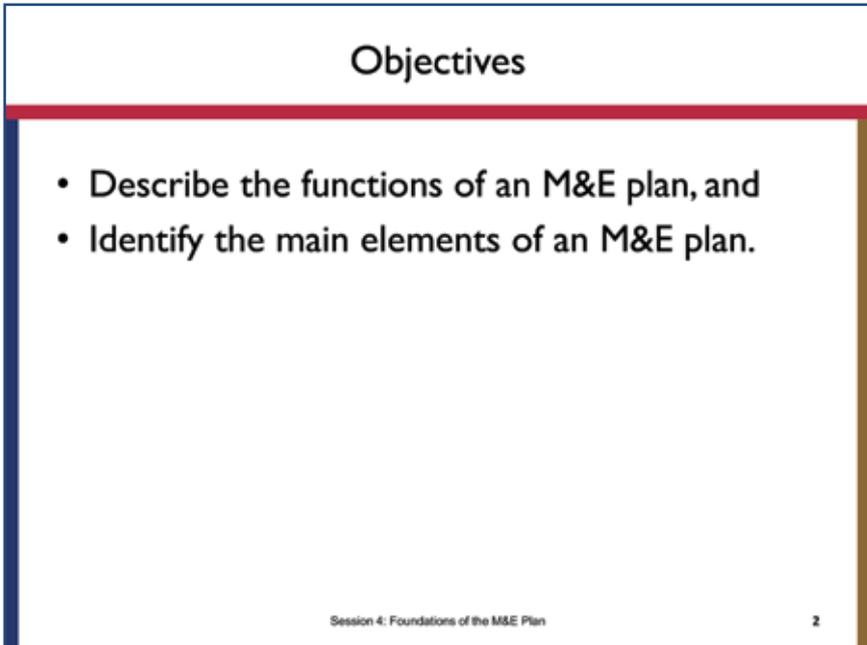
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Slide 4.2



Objectives

- Describe the functions of an M&E plan, and
- Identify the main elements of an M&E plan.

Session 4: Foundations of the M&E Plan

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Slide 4.3

### The M&E Plan

- Every campaign should have an M&E plan.
- M&E plans should be created during the design phase of a programme and can be organised in a variety of ways.
- The M&E plan should be closely tied to the programme plan, and both M&E staff and programme staff should be familiar with both documents.

Session 4: Foundations of the M&E Plan 3

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Slide 4.4

### The Purpose of an M&E Plan

- State how a programme will measure its achievements and therefore provide accountability,
- Document consensus and provide transparency,
- Guide the implementation of M&E activities in a standardised and coordinated way, and
- Preserve institutional memory.

Session 4: Foundations of the M&E Plan 4

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Slide 4.5

### Information the Plan Includes

- Purpose of the M&E plan,
- Campaign goal and objectives,
- Campaign interventions,
- Procedures to assess whether objectives are met,
- Data needed,
- Data collection and analysis,
- Assessment of data quality,
- Ways in which the data will be used, and
- Accountability of the programme to stakeholders.

Session 4: Foundations of the M&E Plan 5

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Slide 4.6

### Sections of the Plan

- Introduction
- Campaign description
- Logic model
- Monitoring plan
- Evaluation plan
- Data dissemination and use plan

Session 4: Foundations of the M&E Plan 6

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Slide 4.7

### The Introduction

- **Should include:**
  - The purpose of the M&E plan,
  - Information about the purpose of the campaign, and
  - Information about the stakeholders and the campaign context.

Session 4: Foundations of the M&E Plan 7

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Slide 4.8

### Campaign Description

- **The contents of this section should come from your campaign plan:**
  - Problem statement,
  - Conceptual framework (preferable),
  - Campaign goal,
  - Campaign objectives, and
  - Intervention descriptions (who, what, when, where, and how).

Session 4: Foundations of the M&E Plan 8

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Slide 4.9

### Campaign Description (cont.)

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#### Problem Statement

- Identifies the specific problem to be addressed, and
- Should be concise, with information about
  - The situation that needs changing
  - Who it affects
  - Its causes
  - Its magnitude
  - Its impact on society

Session 4: Foundations of the M&E Plan 9

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Slide 4.10

### Campaign Description (cont.)

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#### Problem Statement

- Zambia's maternal mortality ratio of 591/100,000 live births ranks among the highest in the world. This mortality is attributable to a number of complex and interwoven factors. Low contraceptive use in Zambia has resulted in high fertility trends over the years, with a current average fertility rate per women of 6.3. Only about half of pregnant women initiate antenatal care (ANC) by 5.1 months of gestation, preventing the opportunity for early detection of danger signs and adequate management of maternal complications. Half (52%) of all births occur at home, with rural areas recording much higher rates of home births than urban areas (66.5% as compared to 15.7%). But, even when a woman delivers in a facility, use of postpartum care services is extremely low. Nationwide, more than half (51%) of women do not receive any postnatal care.

Session 4: Foundations of the M&E Plan 10

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Slide 4.11

**Campaign Description (cont.)**

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**Goals and Objectives**

- A goal is a broad statement about the desired long-term outcome of the campaign.
  - For example, a reduction in home births in the Northern Province of Zambia.
- Objectives are statements of desired specific and measurable campaign results.
  - For example, to increase the number of facility-based births to 45 percent in the Northern Province of Zambia.
- These should come from the programme plan!

Session 4: Foundations of the M&E Plan 11

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Slide 4.12

**Campaign Description (cont.)**

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**Intervention Description**

- Basic description of campaign interventions, including:
  - Duration
  - Geographic scope
  - Target population
  - Intensity

Session 4: Foundations of the M&E Plan 12

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Slide 4.13

### Campaign Description (cont.)

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#### Conceptual Framework

- Visual model of the factors thought to influence the problem of interest and how these factors relate to each other.
- Session 5 will go into more details.

Session 4: Foundations of the M&E Plan 13

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Slide 4.14

### Logic Model

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- Shows the logic behind how the campaign should work by demonstrating how the interventions lead to achievement of the campaign’s goal and objectives,
- Serves as the foundation of the M&E plan, and
- Will be discussed more in Session 5.

Session 4: Foundations of the M&E Plan 14

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Slide 4.15

### Monitoring Section of the M&E Plan

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- Data collection plan
- Indicators (for monitoring *and* evaluation)
- Responsibilities
- Data collection tools needed
- Data quality assessment plan
- Data dissemination and use plan

Session 4: Foundations of the M&E Plan 15

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Slide 4.16

### Evaluation Section of the M&E Plan

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- Evaluation design
- Timing
- Data collection plan
- Responsibilities
- Data quality assessment plan

Session 4: Foundations of the M&E Plan 16

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Slide 4.17

### Other Considerations

- **Budget**—make sure you have the resources available to complete your activities. These include
  - Financial resources,
  - Human resources, and
  - Infrastructure resources (office space, equipment, and supplies).
- **Mechanism for updating the plan.**

Session 4: Foundations of the M&E Plan 17

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## Session 5: M&E Frameworks

Slide 5.1



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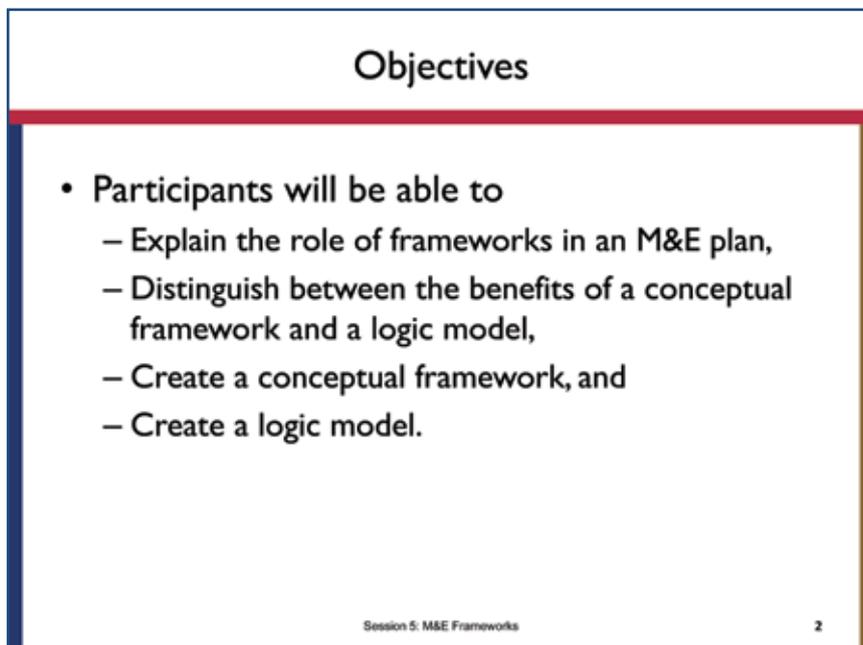
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Slide 5.2



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Slide 5.3

### What Are Frameworks?

- Frameworks visually show
  - The components of a campaign or project, and
  - The sequence of steps needed to achieve the desired outcomes or objectives of the campaign.

Session 5: M&E Frameworks 3

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Slide 5.4

### What Do Frameworks Do?

- Help increase understanding of how a campaign is supposed to work to achieve its goals and objectives,
- Define the relationships between factors key to implementation, and
- Outline the internal and external elements that could affect the campaign's success.

Session 5: M&E Frameworks 4

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Slide 5.5

### Two Common Types of Frameworks

- Conceptual framework
- Logic model

Session 5: M&E Frameworks 5

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Slide 5.6

### Your Perspective

- What is your experience with the conceptual framework or logic model?
- What are the advantages of using them?
- How did using the framework help your campaign? Why?

Session 5: M&E Frameworks 6

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Slide 5.7

### Conceptual Framework

- Is useful for identifying and illustrating the factors and relationships that influence the outcome of a campaign or intervention;
- Can either illustrate the problem itself OR the problem and how your campaign addresses it; and
- Should include all relevant factors, but how those factors are pictured can look very different.

Session 5: M&E Frameworks 7

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Slide 5.8

### Conceptual Framework (cont. )

- Identifies variables and how they interact,
- Shows how programme components will work together to influence desired outcomes,
- Outlines expected results,
- Assists campaign planners with identifying appropriate goals/objectives, and
- Assists M&E staff in identifying appropriate indicators.

Session 5: M&E Frameworks 8

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Slide 5.9



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Slide 5.10

### Conceptual Frameworks in M&E

- Helps to identify intermediate factors, and
- Is most helpful in campaign evaluation.
  - Identifies contextual factors and their causes, and
  - Helps evaluators take appropriate factors into consideration when assessing a campaign.

Session 5: M&E Frameworks 10

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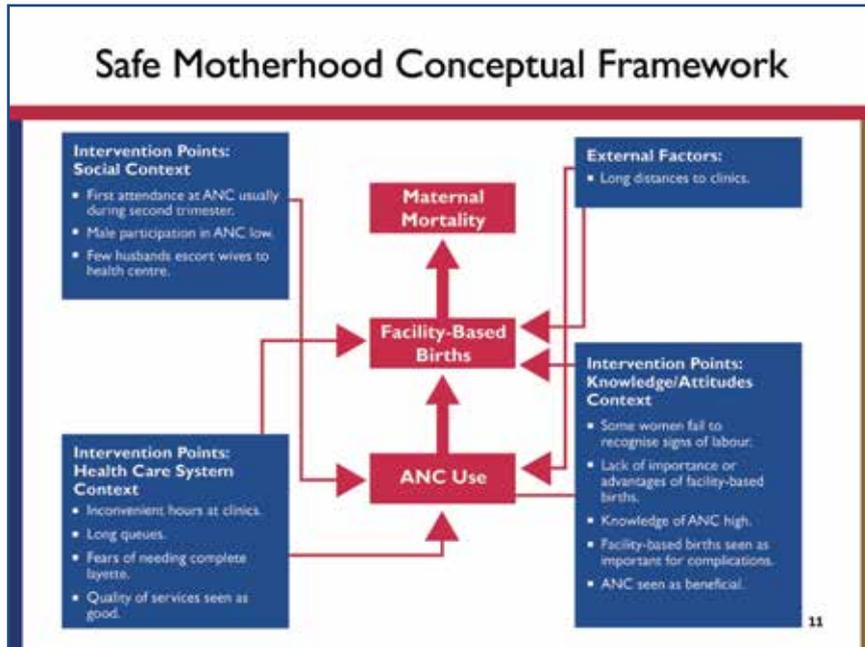
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Slide 5.11



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Slide 5.12

### Scenario Exercise: Conceptual Framework

- What would your conceptual framework look like for the HIV/AIDS campaign?
  - What categories of factors would you include?
  - What factors would you include?

Session 5: M&E Frameworks 12

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Slide 5.13

### Logic Model

- A logic model is a visual way of showing specific activities and the expected results of those activities.
- It is a management tool that gives a picture of how a campaign is supposed to work.
- It is a causal chain that shows each link and how it leads to the campaign's end goal.

Session 5: M&E Frameworks 13

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Slide 5.14

### Components of Logic Models

- Health/behavioural context (optional)
- Inputs
- Processes
- Outputs
- Outcomes
- Impacts

Session 5: M&E Frameworks 14

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Slide 5.15

### Simplified Logic Model Example

- Inputs → Processes/activities → Outputs → Outcomes → Impacts
- Million bednets → National distribution campaign → Number of nets distributed → Increase in percentage of households with everyone sleeping under nets → Reduction in malaria incidence

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Slide 5.16

### Logic Model: Safe Motherhood

HEALTH CONTEXT	INPUTS	CAMPAIGN ACTIVITIES	OUTPUTS	OUTCOMES Intermediate	OUTCOMES Long-Term	IMPACT
<ul style="list-style-type: none"> <li>• Low initiation of ANC services</li> <li>• Low compliance of ANC services (four visits)</li> <li>• High percentage of home-based deliveries</li> </ul>	<ul style="list-style-type: none"> <li>• Financial resources</li> <li>• Human resources: GAZ Health Promoters/Health Communications</li> <li>• Support for Health (CDPs, self and service organisations (CSOs))</li> </ul>	<p style="background-color: #2e5496; color: white; padding: 2px;"><b>HEALTH FACILITY</b></p> <ul style="list-style-type: none"> <li>• Development and distribution of counselling materials and other materials for health facilities</li> <li>• Training of health providers in Safe Motherhood counselling</li> </ul>	<ul style="list-style-type: none"> <li>• Counselling and other materials distributed, placed and/or received</li> <li>• Health care providers trained in Safe Motherhood counselling</li> </ul>	<ul style="list-style-type: none"> <li>• Improved client adherence with ANC</li> <li>• Improved attitudes towards value to early and complete ANC</li> <li>• Improved attitudes towards PMT testing during ANC</li> </ul>	<ul style="list-style-type: none"> <li>• Increased early initiation of ANC</li> <li>• Increased number of pregnant women fully completing ANC (four visits)</li> </ul>	<p><b>REDUCTION IN MATERNAL MORTALITY</b></p> <p><b>GOAL: 163 DEATHS PER 100,000 LIVE BIRTHS BY 2014</b></p>

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Slide 5.17

### Logic Model: Context

- **Underlying conditions (context) of the campaign**
  - Current behaviours
  - Disease burden
  - Social situation or cultural context
  - Communication access or technological context
  - Political situation or economic conditions

Session 5: M&E Frameworks 17

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Slide 5.18

### Safe Motherhood: Context

- **Safe Motherhood Health Context**
  - Late initiation of ANC services,
  - Low completion of ANC services, and
  - High percentage of home-based deliveries.

**HEALTH  
CONTEXT**

- Late initiation of ANC services
- Low completion of ANC services (four visits)
- High percentage of home-based deliveries

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Slide 5.19

### Logic Model: Inputs

- **Inputs:** The resources invested in a campaign to be dedicated or consumed.
- **Can include**
  - Technical assistance
  - Computers
  - Supplies (condoms)
  - Facilities
  - Staff
  - Time
  - Money
  - Training

Session 5: M&E Frameworks 19

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Slide 5.20

### Safe Motherhood: Inputs

- **Safe Motherhood Inputs**
  - Financial resources
  - Human resources
    - GRZ Health Promotion Unit
    - CSH
    - CSOs

**INPUTS**

- Financial resources
- Human resources: GRZ Health Promotion Unit, Communications Support for Health (CSH), and civil service organisations (CSOs)

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Slide 5.21

### Logic Model: Processes

- **Processes/activities:** The many things that a campaign does, using inputs, to fulfill its goals and objectives.
- **For example:**
  - Developing communications guidelines
  - Training educators
  - Creating radio public service announcements
  - Producing and distributing materials
  - Placing billboards

Session 5: M&E Frameworks 21

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Slide 5.22

### Safe Motherhood: Processes

- **Safe Motherhood Campaign Activities**
  - Development and distribution of counselling materials and other materials for health facilities, and
  - Training of health providers in Safe Motherhood counselling.

**CAMPAIGN ACTIVITIES**

**HEALTH FACILITY**

- Development and distribution of counselling materials and other materials for health facilities
- Training of health providers in Safe Motherhood counselling

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Slide 5.23

### Logic Model: Outputs

- **Outputs:** The immediate and direct products or consequences of campaign activities.
- Outputs are often measured by the amount of work accomplished, time consumed, funds spent, or people involved.
- For example:
  - The number of learning sessions that youth participated in,
  - The number of youth who participated in different campaign activities, and
  - The number of professionals who volunteered.

Session 5: M&E Frameworks 23

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Slide 5.24

### Safe Motherhood: Outputs

- **Safe Motherhood Outputs**
  - Counselling and other materials distributed, placed, and/or mounted; and
  - Health care providers trained in Safe Motherhood counselling.

**OUTPUTS**

- Counselling and other materials distributed, placed, and/or mounted
- Health care providers trained in Safe Motherhood counselling

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Slide 5.25

### Logic Model: Outcomes

- **Outcomes:** The set of intermediate or long-term changes achieved by the campaign through the execution of activities.
- These include the multitude of benefits gained by the people, communities, and organisations served by the campaign during or after participation.
- For example:
  - Consider changes in knowledge, skills, attitudes, or behaviour, and
  - Can be divided into initial, intermediate, and longer term outcomes.

Session 5: M&E Frameworks 25

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Slide 5.26

### Safe Motherhood: Outcomes

<ul style="list-style-type: none"> <li>• <b>Safe Motherhood Outcomes</b></li> <li><b>Intermediate</b></li> <li>• Improved client satisfaction with ANC,</li> <li>• Improved attitudes towards value in early and complete ANC, and</li> <li>• Improved attitudes towards HIV testing during ANC.</li> <li><b>Long-Term (behavioural)</b></li> <li>• Increased early initiation of ANC, and</li> <li>• Increased number of pregnant women fully completing ANC (four visits).</li> </ul>	<table border="1" style="width: 100%; text-align: center; font-size: small;"> <thead> <tr> <th colspan="2">OUTCOMES</th> </tr> <tr> <th>Intermediate</th> <th>Long-Term</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"> <ul style="list-style-type: none"> <li>• Improved client satisfaction with ANC</li> <li>• Improved attitudes towards value in early and complete ANC</li> <li>• Improved attitudes towards HIV testing during ANC</li> </ul> </td> <td style="padding: 5px;"> <ul style="list-style-type: none"> <li>• Increased early initiation of ANC</li> <li>• Increased number of pregnant women fully completing ANC (four visits)</li> </ul> </td> </tr> </tbody> </table>	OUTCOMES		Intermediate	Long-Term	<ul style="list-style-type: none"> <li>• Improved client satisfaction with ANC</li> <li>• Improved attitudes towards value in early and complete ANC</li> <li>• Improved attitudes towards HIV testing during ANC</li> </ul>	<ul style="list-style-type: none"> <li>• Increased early initiation of ANC</li> <li>• Increased number of pregnant women fully completing ANC (four visits)</li> </ul>
OUTCOMES							
Intermediate	Long-Term						
<ul style="list-style-type: none"> <li>• Improved client satisfaction with ANC</li> <li>• Improved attitudes towards value in early and complete ANC</li> <li>• Improved attitudes towards HIV testing during ANC</li> </ul>	<ul style="list-style-type: none"> <li>• Increased early initiation of ANC</li> <li>• Increased number of pregnant women fully completing ANC (four visits)</li> </ul>						

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Slide 5.27

### Logic Model: Impacts

- **Impacts:** The long-term effects, or end results, of the campaign.
  - The impact of a health communication campaign is a change in health status.
- **For example:**
  - Changes in health status or conditions that the campaign is intended ultimately to influence (mortality, morbidity, fertility, etc.), as measured by appropriate indicators; and
  - Reduction in malaria morbidity.

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Slide 5.28

### Safe Motherhood: Impacts

- **Safe Motherhood Impact**
  - Reduction in maternal mortality

**IMPACT**

**REDUCTION IN  
MATERNAL  
MORTALITY**

**GOAL:  
162 DEATHS PER  
100,000 LIVE BIRTHS  
BY 2014**

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Slide 5.29

**Scenario Exercise: Logic Model**

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- What would your logic model look like for the HIV/AIDS campaign?

Session 5: M&E Frameworks 29

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Slide 5.30

**Frameworks Summary**

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- Frameworks
  - Help develop a clearer understanding of the goals and objectives of a campaign,
  - Help identify measurable objectives for the short term and long term,
  - Define relationships between factors, and
  - Serve as the foundation for selecting indicators.

Session 5: M&E Frameworks 30

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## Session 6: Indicators

Slide 6.1



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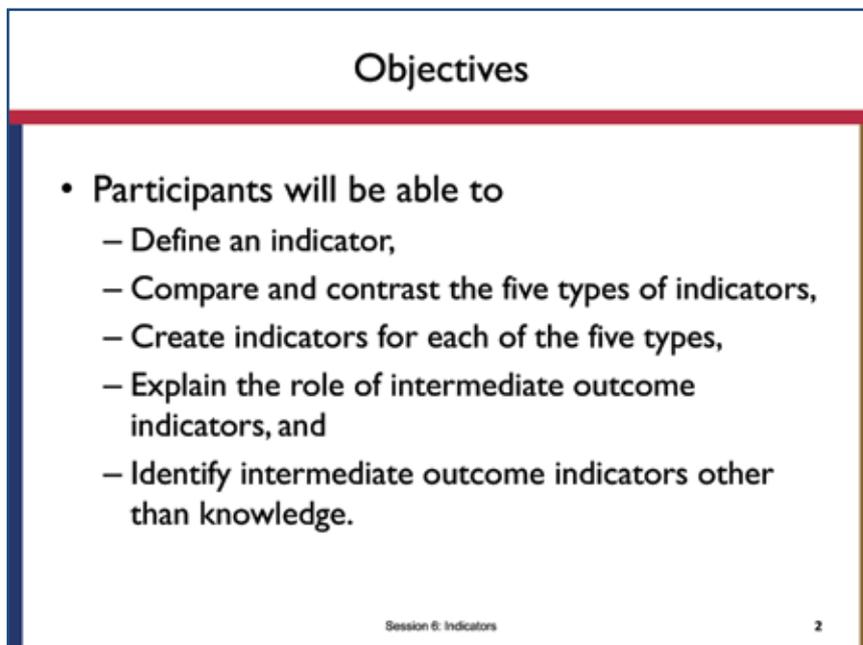
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Slide 6.2



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Slide 6.3

**What Is an Indicator?**

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**An indicator is**

- A **variable**
- That **measures**
- **One aspect** of a campaign or health outcome.

Session 6: Indicators      **3**

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Slide 6.4

**What Is an Indicator? (cont.)**

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- What we use to measure whether campaigns have met their objectives;
  - Measures the value of the change in meaningful units for campaign management.
- A narrowly defined sign or marker used to measure *one aspect* of a campaign; and
- Guide to show how close a campaign is to where it is supposed to be.
  - Should have at least one indicator for each significant aspect of campaign activities.

Session 6: Indicators      **4**

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Slide 6.5

### Common Indicator Metrics

- **Counts**
  - Number of providers trained in using BCC materials, and
  - Number of brochures or posters distributed.
- **Calculations:** Percentages, rates, and ratios
  - % of facilities with providers trained in using materials, and
  - Under-5 mortality rate.
- **Index**, composite measures
  - Exposure Index comprising the sum of scores on all exposure indicators, and
  - Wealth Index.

Session 6: Indicators 5

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Slide 6.6

### How To Construct an Indicator (Percentages)

- A percentage is a numerator divided by a denominator.
- For example:
  - Numerator: Number of people surveyed who recall hearing or seeing (spontaneous and aided/prompted) the campaign.
  - Denominator: Total number of people surveyed.

Session 6: Indicators 6

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Slide 6.7

**Components of a Percentage Indicator**

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- **Indicator:** The percentage of men who used a condom during their last sexual intercourse.
- What would the numerator be?
- What would the denominator be?

Session 6: Indicators      **7**

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Slide 6.8

**Five Types of Indicators**

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- Different types of indicators measure different things.
  - Input,
  - Process,
  - Output,
  - Outcome (including intermediate and long-term indicators), and
  - Impact.

Session 6: Indicators      **8**

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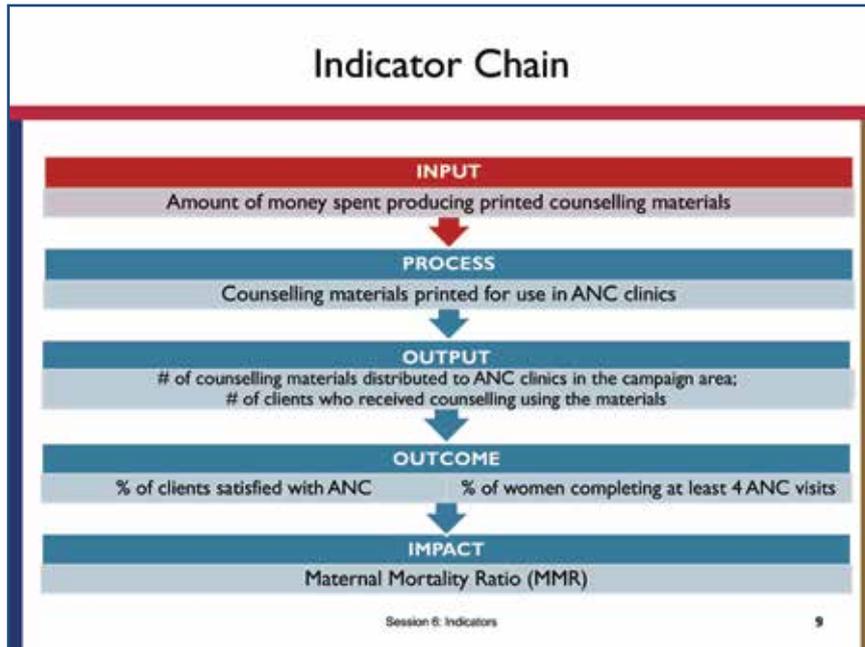
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Slide 6.9



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Slide 6.10

- ### Input Indicators
- Report the amount of resources used to develop and implement a campaign,
    - Resources can be human, financial, or material.
  - Gather information from accounting and campaign management records, and
  - Allow managers to monitor budget and cost-effectiveness.
- Session 6: Indicators 10

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Slide 6.11

### Examples of Input Indicators

- Funds spent on various components of your campaign, such as
  - Newspaper inserts
  - Billboards
  - Radio programmes
- Cost and number of bednets procured.

Session 6: Indicators 11

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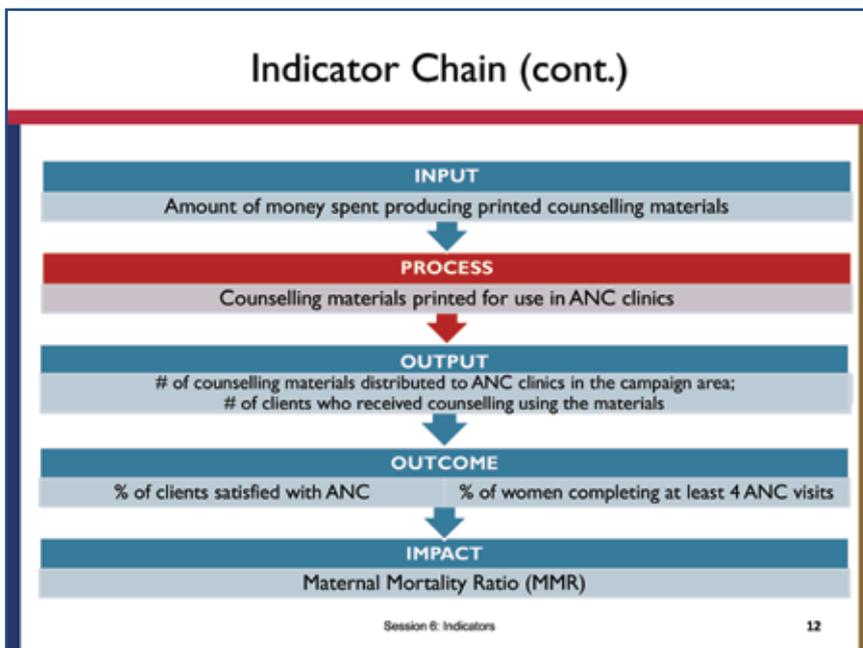
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Slide 6.12



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Slide 6.13

### Process Indicators

- Show what campaign activities were carried out
  - Number of trainings held
  - Number of radio episodes produced
  - Number of billboards bought
  - Number of focus groups held

Session 6: Indicators 13

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Slide 6.14

### Process Indicators (cont.)

- Process indicators also demonstrate the **quality** of activities.
- One way to assess quality is to look at how the campaign was designed.
  - Was the campaign plan reviewed by a technical working group?
  - Were materials pilot-tested?
  - Did the campaign include formative research?
  - Were the campaigns pilot-tested before becoming finalised?

Session 6: Indicators 14

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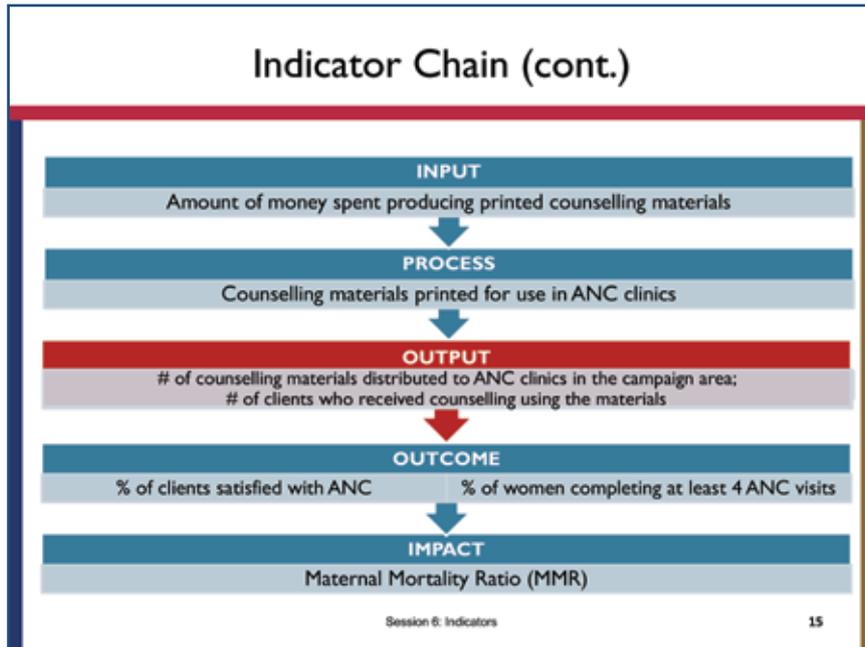
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Slide 6.15



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Slide 6.16

### Output Indicators

- Output indicators record what your activities have achieved.
  - Number of people trained,
  - Number of brochures distributed,
  - Number of people participating in one-on-one counselling, and
  - Number of people who participated in community event.

Session 6: Indicators 16

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Slide 6.17

### Output Indicators (cont.)

- Output indicators also include **reach** and **exposure**. For example:
  - Number of people reached by a radio programme,
  - Number of people reached by a newspaper insert,
  - Percentage of audience who recalls hearing or seeing a specific campaign, and
  - Percentage of audience who recalls a specific component/characteristic (e.g., main character, event, jingle, logo) of a campaign.

Session 6: Indicators 17

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Slide 6.18

### Output Indicators vs. Process Indicators

- Process indicators show activities themselves.
  - Output indicators show the **outputs** of those activities.
- Process indicators track whether you are doing the activities you said you were going to do.
  - Output indicators show the result of what you have done.

Session 6: Indicators 18

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Slide 6.19

### Scenario Exercise: Input, Process, and Output Indicators

- Determine the input, process, and output indicators for your HIV/AIDS campaign; and
- Create two of each kind of indicator.

Session 6: Indicators 19

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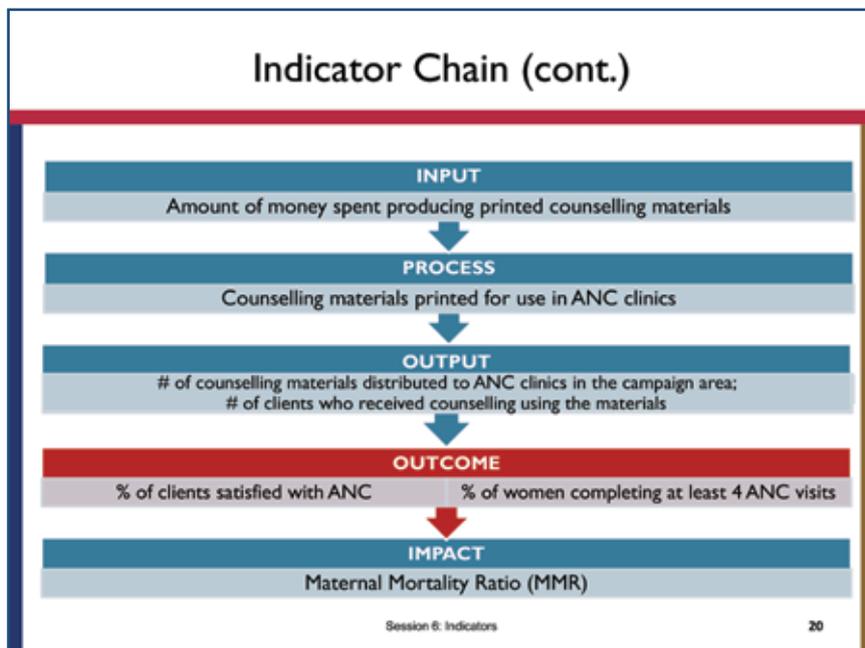
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Slide 6.20



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Slide 6.21

### Outcome Indicators

- Outcome indicators measure intermediate or long-term factors at the population level.
  - Should be defined by the communication and behavioural objectives of the campaign.
    - What do you want people to do as a result of your campaign?
    - How would you like knowledge, attitudes, or behaviours to change?

Session 6: Indicators 21

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Slide 6.22

### Intermediate Outcome Indicators

- Your campaign may not be long enough to reach the ultimate behavioural outcomes (such as the percentage of people using condoms).
- Another way to look at what you have accomplished is to look at the **short-term** or **intermediate** factors, which may change on the way to your goal.
- Intermediate outcome indicators measure things that frequently need to change **before** the behaviour itself changes.

Session 6: Indicators 22

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Slide 6.23

### Identifying Intermediate Indicators

- Indicators should be identified in the initial communications plan.
- M&E and programme staff must work together to develop the indicators.
- Indicators should be based on the objectives and messages of the campaign.

Session 6: Indicators 23

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Slide 6.24

### Finding the Right Intermediate Indicators

- Ask yourself
  - What **attitudes** need to change?
  - Which **skills** need to be learned?
  - Which **behaviours** must change before the target audience will be able to adopt the final desired behaviour?

Session 6: Indicators 24

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Slide 6.25

### Common Intermediate Factors

- Knowledge
- Attitudes
- Self-efficacy
- Skills
- Saliency
- Perceived social norms
- Interpersonal communication
- Behavioural intent

Session 6: Indicators 25

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Slide 6.26

### Knowledge

- **Knowledge** is one of the most frequently used intermediate indicators. It measures whether people know certain information.
- For example:
  - Percentage of women who know signs of labour,
  - Percentage of youth aged 15–21 who know two ways HIV is transmitted, and
  - Percentage of men who know that a person can have HIV without looking sick.

Session 6: Indicators 26

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Slide 6.27

### Beyond Knowledge

- **Knowledge alone does not necessarily change behaviour.**
- Many campaigns work in intervention areas where knowledge is **already** quite high.
- If knowledge starts out high, **you should target and measure change in other factors.**

Session 6: Indicators 27

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Slide 6.28

### Attitudes

- **Attitude** is defined as a person’s opinion (positive or negative) of a behaviour, product, practice, service, or other person.
- Attitudes are sometimes referred to as “beliefs.”
- For example:
  - Percentage of women aged 15–24 who believe that family planning helps a woman regain her strength before having her next baby;
  - Percentage of men who believe that family planning encourages a wife to become promiscuous; and
  - Percentage of women who feel they are treated respectfully at ANC visits.

Session 6: Indicators 28

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Slide 6.29

### Self-Efficacy

- **Self-efficacy** measures how strongly a person believes he or she could do a certain behaviour.
- For example:
  - Percentage of youth aged 15–21 who believe they could bring up the subject of HIV testing with their current partner(s).
- If a person does not think that he or she could do it, or does not have the skills to do it, that person will most likely **not** do it.

Session 6: Indicators 29

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Slide 6.30

### Skills

- **Skills** refers to whether a person has the skills and abilities necessary to perform the desired behaviour in different circumstances.
- It may take some skill to perform a certain behaviour (such as negotiating condom use or breastfeeding a baby).
- For example:
  - Percentage of men who know how to use a condom correctly.

Session 6: Indicators 30

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Slide 6.31

### Saliency

- **Saliency** is how important an issue is to an audience.
- It is possible that for some topics there is high awareness of an issue (knowledge is high), but the topic may not seem important or people may not feel personally at risk.
  - For example: The percentage of pregnant women who believe that it is important for them to give birth in a health facility.
  - [They might know it's a good idea, in general, but feel that it's not very important for them personally.]

Session 6: Indicators 31

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Slide 6.32

### Perceived Social Norms

- **Perceived social norms** are what people understand to be the standards of acceptable attitudes and behaviours. This can be amongst a person's peer group or amongst those people important to that person.
- For example:
  - Who would approve (or disapprove) if I do x?
  - Do others think it's a good thing if I do this?
  - Will I be looked at as a good mother if I do this, or will it reflect poorly on me?

Session 6: Indicators 32

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Slide 6.33

### Interpersonal Communication

- **Interpersonal communication** looks at whether people talk about a subject with someone else. Behaviours frequently need to be discussed or negotiated before they can be acted upon.
- For example:
  - Percentage of women aged 15–40 who have discussed family planning with a service provider in the past 6 months.

Session 6: Indicators 33

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Slide 6.34

### Behavioural Intent

- **Behavioural intent** is a measure of the likelihood that a person will engage in a specific behaviour. Does he or she plan to do x?
- There is a strong predictive relationship between people's **intentions** to perform a behaviour and whether they actually perform it.
- For example:
  - Percentage of pregnant women who intend to give birth in a health facility.

Session 6: Indicators 34

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Slide 6.35

**Exercise: Intermediate Indicators**

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- Which issue do the following indicators address?
  - % of mothers who are concerned that their children are at risk of malnutrition;
  - % of sexually active young people aged 15–24 who feel they could negotiate condom use with a partner;
  - % of mothers who believe that exclusively breastfeeding their baby shows that they want only the best for their baby; and
  - % of men who believe that the use of family planning promotes promiscuity.

Session 6: Indicators 35

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Slide 6.36

**Exercise: Intermediate Indicators (cont.)**

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- Which issue do the following indicators address?
  - % of mothers/caretakers who intend to use ITN to prevent malaria;
  - % of surveyed population that knows three primary warning/danger signs during pregnancy;
  - % of mothers who are able to prepare healthy foods for their children; and
  - % of women who have discussed condom use with their current partner or partners.

Session 6: Indicators 36

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Slide 6.37

### Long-Term Outcome Indicators

- **Long-term indicators** are sometimes called **behavioural indicators**. They measure what proportion of the population is doing a certain behaviour.
- For example:
  - Percentage of pregnant women receiving a full course of IPTp, and
  - Percentage of men reporting only one sexual partner in the past month.

Session 6: Indicators 37

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Slide 6.38

### Short- or Long-Term?

- BCC campaign objectives (and BCC outcome indicators) should include both intermediate **and** long-term outcomes.
- Intermediate outcomes usually show changes first.
- If you can show changes in the intermediate (short-term) objectives, you have evidence of some impact, even if your long-term indicators do not yet show change.

Session 6: Indicators 38

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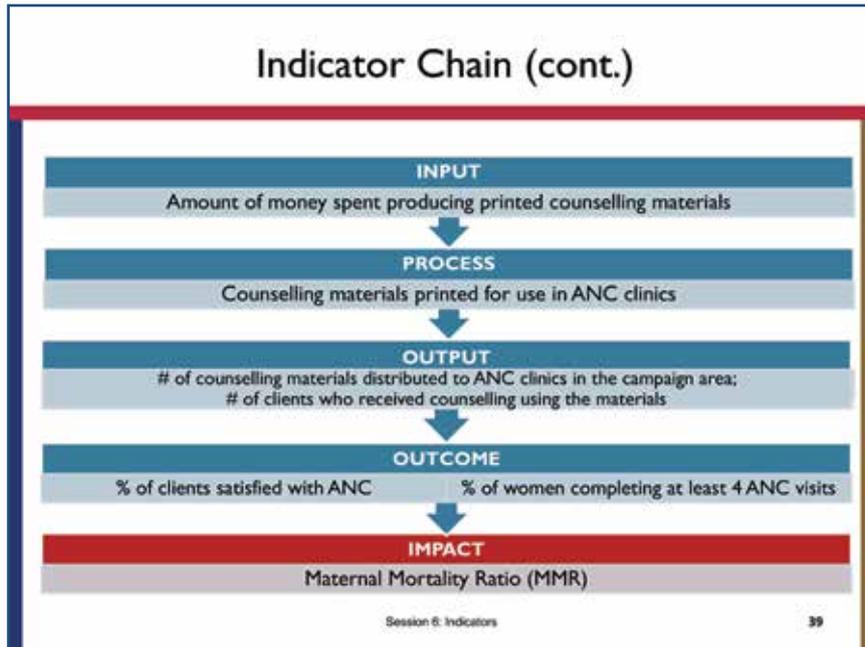
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Slide 6.39



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Slide 6.40

### Impact Indicators

- **Impact indicators** are related to impact on actual health status, such as HIV prevalence or maternal mortality.
- Most projects do not measure them (requires special studies with wide coverage and large budgets).
- **Outcome measures** are used as proxies for impact.
- Use the DHS when you can!

Session 6: Indicators 40

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Slide 6.41

### Outcome vs. Impact

Outcome Indicator	Impact Indicator
<ul style="list-style-type: none"><li>• Percentage of people using condoms,</li></ul>	<ul style="list-style-type: none"><li>• Prevalence of HIV,</li></ul>
<ul style="list-style-type: none"><li>• Percentage of mothers giving birth in a clinic, and</li></ul>	<ul style="list-style-type: none"><li>• Maternal mortality, and</li></ul>
<ul style="list-style-type: none"><li>• Percentage of children under age 5 sleeping under a mosquito net.</li></ul>	<ul style="list-style-type: none"><li>• Malaria-related child mortality.</li></ul>

Session 6: Indicators 41

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Slide 6.42

### Scenario Exercise: Outcome and Impact Indicators

- Identify the intermediate and behavioural outcomes AND the impact indicators for your HIV/AIDS campaign, and
- Pick two of each kind of indicator.

Session 6: Indicators 42

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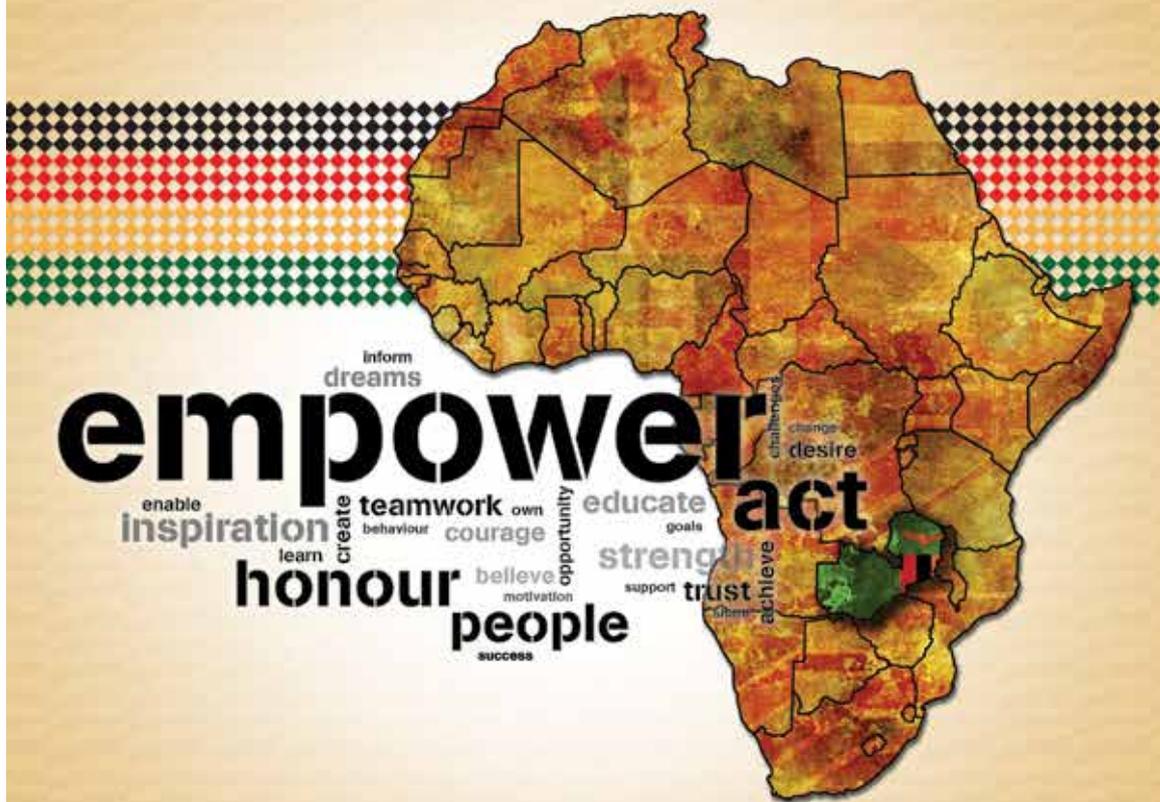
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# SESSION 7





## Session 7: Data Collection

Slide 7.1



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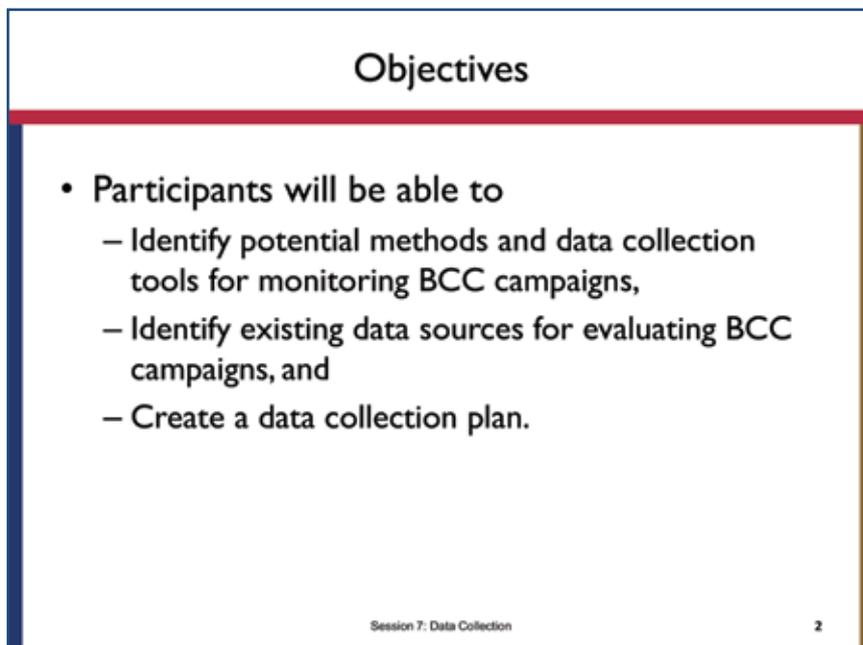
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Slide 7.2



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Slide 7.3

### Data Collection

- Data collection is the process of gathering data about the various activities related to your campaign that are relevant to your M&E framework,
- Collection involves getting data for analysis using various tools, and
- Data are collected using
  - Questionnaires
  - Interviews
  - Observation
  - Existing records

Session 7: Data Collection 3

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Slide 7.4

### Planning for Data

- Both monitoring and evaluation depend on data.
- It is best to think about data sources and data collection at the *beginning* of the campaign.
- Any necessary budgets or data collection forms should be included in the M&E plan.

Session 7: Data Collection 4

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Slide 7.5

**Your Perspective**

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- Where do data for M&E come from?
- What are your methods/sources for monitoring?
- What are your sources for evaluation?

Session 7: Data Collection 5

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Slide 7.6

**Routine Tracking for Monitoring**

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- Decide with campaign implementers which activities will be monitored and which indicators will be collected.
  - Who will collect the data?
  - When? How frequently?
  - What tools will be used to collect and record information?
  - Who will receive updates on indicators? How frequently?
  - Where will information be stored?

Session 7: Data Collection 6

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Slide 7.7

### Activities Drive the Method

- **Mass media**
  - Implementation data
    - Media monitoring company, and
    - Monitoring calendar completed by community or project staff.
  - Reach/exposure data
    - Media monitoring company, and
    - Rapid household survey (exposure).

Session 7: Data Collection 7

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Slide 7.8

### Media Monitoring Company

- A professional media monitoring company monitors when campaign productions are broadcast (output indicators/implementation data).
- **Pros:** Consistent quality data, reliable.
- **Cons:** Can be costly and have recurring (rather than a one-time) cost; media companies may not be able to monitor community-level radio.
- Ideal for programmes or public service announcements that are broadcast irregularly or on multiple channels.

Session 7: Data Collection 8

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Slide 7.9

### Community Monitoring

- Community members can tune into broadcasts and mark on calendars when they hear the programme.
- **Pros:** Inexpensive, increases community involvement.
- **Cons:** Can be unreliable, requires community training and records collection.
- Ideal for programmes broadcast at regular times on one or two channels.

Session 7: Data Collection 9

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Slide 7.10

### Sample Monitoring Calendar

**Radio Monitoring Calendar**  
January 2013

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

**For every day that you hear the radio show at the scheduled time, please mark an "X" next to the date.**

Session 7: Data Collection

**Radio Schedule:**  
[Days]  
At [Time]

In the case that you do not hear the show at the scheduled time, please immediately call the number below:

XXXX-XXXXX

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Slide 7.11

### Monitoring Reach and Exposure

- **Reach:** The number or proportion of people who potentially could be exposed to your message or campaign based on their access to the media used in your campaign.
  - This can be determined by a media monitoring company or by staff research into the media used in your campaign.
- **Exposure:** Percentage of people who have seen or heard your message or campaign.
  - This is best determined by a rapid household survey.

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Slide 7.12

### Rapid Household Survey

- A rapid household survey uses a small sample size in which individual surveys can be conducted in 15 minutes or less.
- “Small sample” can be difficult to define and may change depending on the reach of your campaign.
- Rapid household surveys aim to collect results quickly using minimal resources.

12

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Slide 7.13

**Activities Drive the Method (cont.)**

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- **Printed materials**
  - Implementation data
    - Tracking sheets
    - Printing bills and records
  - Exposure data
    - Rapid household survey
    - Facility-based survey

Session 7: Data Collection **13**

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Slide 7.14

**Activities Drive the Method (cont.)**

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- **Outreach**
  - Interpersonal (counselling and testing, one-on-one interaction between provider/patient)
    - Tracking forms
    - Facility-based survey (exit interview)
    - Observation
  - Festivals and community events
    - Tracking forms
    - Sign-up sheets
    - Rapid household survey

Session 7: Data Collection **14**

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Slide 7.15

### Observations

- Observations during random visits or spot checks to the field can verify that activities are implemented as intended.
- A simple checklist can be used to guide the visits.
- Frequency and location of the visits is based on the campaign.

Session 7: Data Collection 15

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Slide 7.16

### Sample Observation Guide or Checklist

#### Observation Checklist for Community Event

1. How many people are present at the event?
2. Did the role-play take place as intended?
3. Can the audience members easily see the people on the stage?
4. Can the audience members easily hear the people on the stage?
5. Did the main character clearly communicate the health message as intended?
6. How well did the audience engage with the presentation?
  - a) Did the presentation hold the attention of most people? Y N
  - b) Did most people stay for the entire presentation? Y N

Session 7: Data Collection 16

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Slide 7.17

### Scenario Exercise: Observation Guide

- Your project has decided to create an observation guide based on your scenario activities.
  - What event will you observe?
  - What will be on your observation guide?
  - Who will use the observation guide?
  - What will they do with the information?

Session 7: Data Collection 17

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Slide 7.18

### Things To Consider

- Cost
- Reliability
- Availability
- Breadth
- Time

Session 7: Data Collection 18

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Slide 7.19

### Data Sources for Evaluation

- **Secondary data sources**
  - Existing national or large-sample surveys such as DHS, and
  - HMIS or other routine outcome databases.
- **Primary data collection (methods will depend on evaluation design chosen)**
  - Representative household survey
  - Facility-based survey
  - Qualitative research

Session 7: Data Collection 19

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Slide 7.20

### Data Quality

- **Why is it important?**
  - You want to know that the results you are getting are reflective of reality and you are not wasting time or money.
  - Accountability is increasingly important for funding.

Session 7: Data Collection 20

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Slide 7.21

### Dimensions of Data Quality

<b>Validity</b>	Valid data are considered <i>accurate</i> : They measure what they are intended to measure.
<b>Reliability</b>	The data are measured and collected consistently.
<b>Completeness</b>	Data are completely inclusive: An information system represents the <i>complete</i> list of eligible names and not a fraction of the list.
<b>Precision</b>	The data have sufficient detail.
<b>Timeliness</b>	Data are up-to-date (current), and information is available on time.
<b>Integrity</b>	The data are protected from deliberate bias or manipulation for political or personal reasons.

Session 7: Data Collection 21

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Slide 7.22

### Scenario Exercise: Data Collection Plan

- Write a data collection plan outline for monitoring your activities. Be sure to include the following:
  - What activities will you monitor?
  - What methods and sources will you use for monitoring?
  - How would your plan change if you were given a large budget (or a sudden budget cut)?

Session 7: Data Collection 22

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## Session 8: Evaluation Design

Slide 8.1



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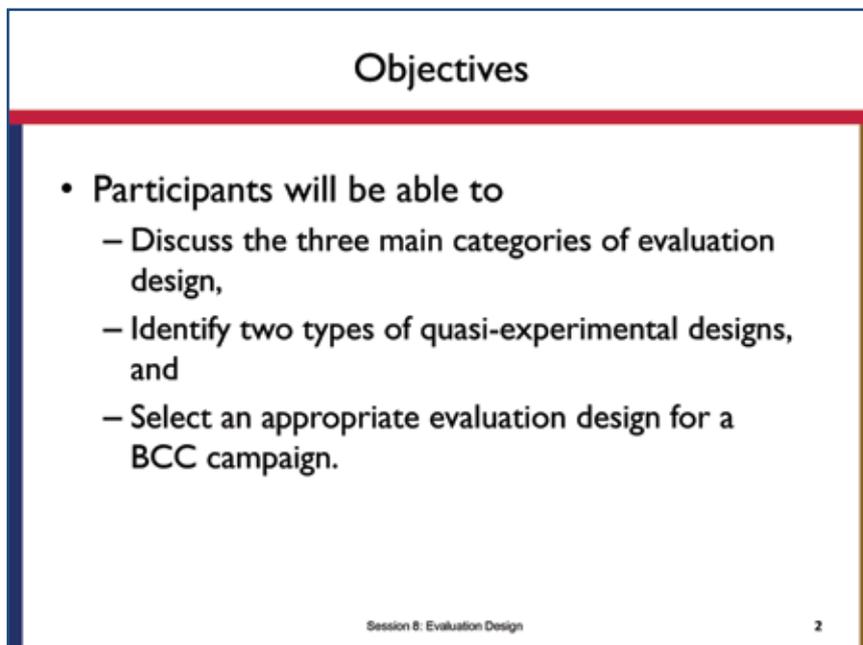
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Slide 8.2



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Slide 8.3

**Your Perspective**

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- How is evaluating a BCC campaign different from evaluating a health delivery service?
- What are some challenges you have come across when trying to evaluate a BCC campaign?

Session 8: Evaluation Design 3

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Slide 8.4

**Evaluation of BCC Campaigns**

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- Evaluating BCC campaigns is different from evaluating other campaign interventions.
- BCC evaluations are not always as clear-cut as how many shots have been given or how many nets have been distributed.
- **What** should be measured and **how** that should be measured can all vary.

Session 8: Evaluation Design 4

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Slide 8.5

### Challenges to Evaluating BCC

- Broadcast media is often at national level.
- Comparison groups can be difficult to find.
- Multiple campaigns and programmes work in the same environment, complicating attempts to attribute change to any one programme.
- Exposure to a campaign is difficult to measure.
- Short timeframes make intermediate outcomes more likely than changes in behaviour.

Session 8: Evaluation Design 5

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Slide 8.6

### Evaluation Designs

- Evaluation designs fall into three main categories:
  - Experimental
  - Quasi-experimental
  - Nonexperimental

Session 8: Evaluation Design 6

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Slide 8.7

### Experimental Designs

- Randomised controlled trials
  - Draw definitive conclusions about the effect of the campaign,
  - Require random assignment of individuals to treatment and control groups, and
  - Are almost never used in evaluating BCC campaigns.

Session 8: Evaluation Design 7

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Slide 8.8

### Quasi-Experimental Designs

- Do not require random assignment, and
- **Do** require a comparison group.

Session 8: Evaluation Design 8

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Slide 8.9

### Use of a Comparison Group

- Comparison to an unexposed outside group can more clearly show that changes are the result of the campaign.
- Data are collected from intervention and outside communities at various points, then compared.
- Comparison can help determine whether changes happened in the intervention group or in the outside group.
- Comparison groups (similar to intervention group except for exposure) can be challenging to find.

Session 8: Evaluation Design 9

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Slide 8.10

### Common Quasi-Experimental Designs

- Pre- and post-test with comparison group, and
- Time series design with comparison group.

Session 8: Evaluation Design 10

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Slide 8.11

**Pre-and Post-Test Designs With Comparison Group**

- Baseline with periodic follow-up data collection in the intervention and comparison groups, and
- Common to collect data at three points:
  - Baseline: Before the programme begins,
  - Midline: Halfway through the programme, and
  - Endline: At the end of the programme.

Session 8: Evaluation Design 11

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Slide 8.12

**Pre-and Post-Test Designs With Comparison Group (cont.)**

- Allow implementers to determine the changes that have taken place in their community during campaign implementation, and
- Demonstrate that clear changes may signal a successful project.

Session 8: Evaluation Design 12

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Slide 8.13

**Time Series Designs With Comparison Group**

- Are similar to pre- and post-tests, with more data points;
- Involve tracking the desired result (output or outcome) at regular intervals in both the intervention and comparison groups; and
- Frequently use routinely collected data, such as the number of visits to a facility.

Session 8: Evaluation Design 13

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Slide 8.14

**Time Series Designs With Comparison Group (cont.)**

- Goal is to test for significant changes immediately after the intervention(s).
  - Evaluator compares results for a period just before and just after the intervention; and
  - Do results change significantly in the desired direction soon after the onset of the campaign?
- Results frequently are presented in a histogram.

Session 8: Evaluation Design 14

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Slide 8.15

### Common Nonexperimental Designs

- Many BCC campaigns use nonexperimental designs. These include
  - Pre- and post-test designs without comparison group (most traditional approach in evaluating BCC),
  - Time series designs without comparison group,
  - Qualitative methods, and
  - Post-only designs.

Session 8: Evaluation Design 15

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Slide 8.16

### Quasi-Experimental or Non-Experimental?

- If you have a comparison group for a parallel analysis, the approach can be considered quasi-experimental. If you do **not** have a comparison group, it is **non**experimental.

Session 8: Evaluation Design 16

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Slide 8.17

### Qualitative Methods

- Method can complement and strengthen the evaluation findings.
- Qualitative results can help explain the quantitative findings.
  - **Quantitative** findings are the “what?” or “how many?”
  - **Qualitative** findings are the “why?” or “how?”

Session 8: Evaluation Design 17

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Slide 8.18

### Qualitative Methods (cont.)

- In-depth interviews,
- Direct observation,
- Focus groups, and
- Participatory rural appraisal/participatory learning in action.

Session 8: Evaluation Design 18

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Slide 8.19

### Post-Only Designs

- Post-only designs are those that do not include pre-tests or baseline data collection.
- Data collection takes place after the campaign has been implemented.
- Although these designs are considered nonexperimental, they can be very strong when combined with advanced statistical analysis.

Session 8: Evaluation Design 19

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Slide 8.20

### Scenario Exercise: Evaluation Design

- What evaluation designs would you use for the HIV/AIDS campaign?
  - What are some of the reasons you chose that design?

Session 8: Evaluation Design 20

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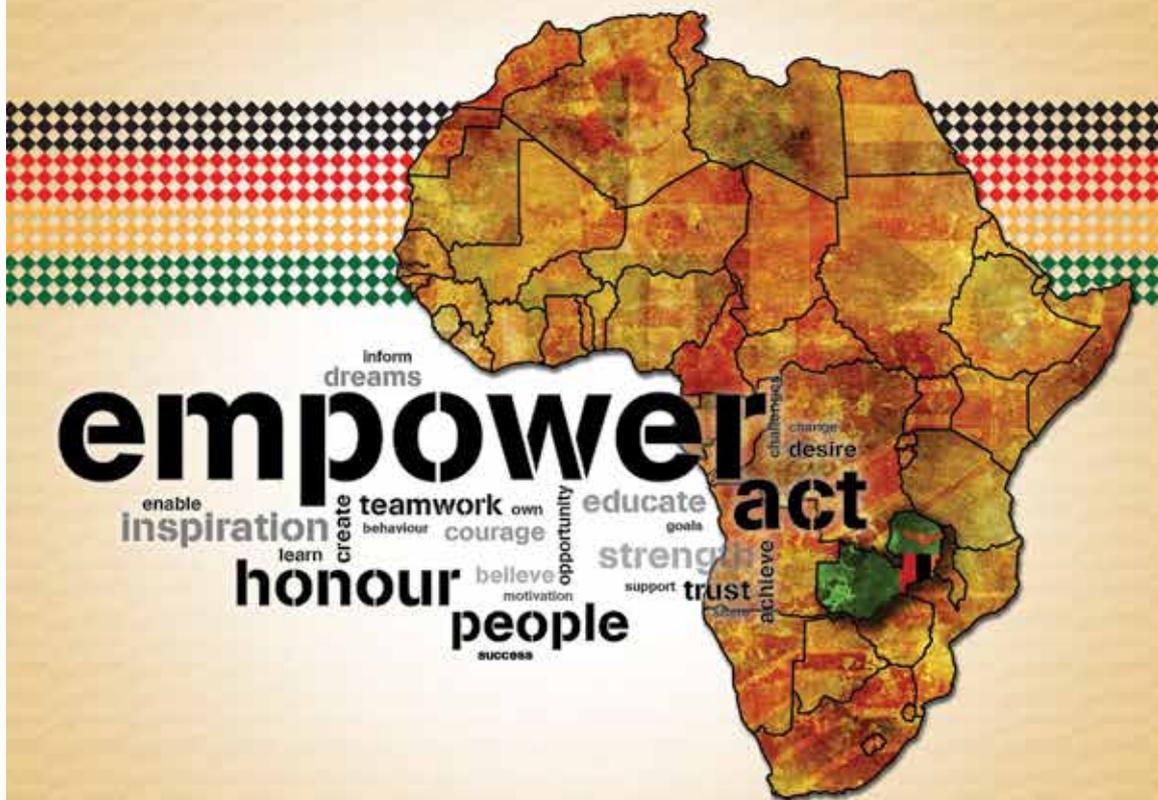
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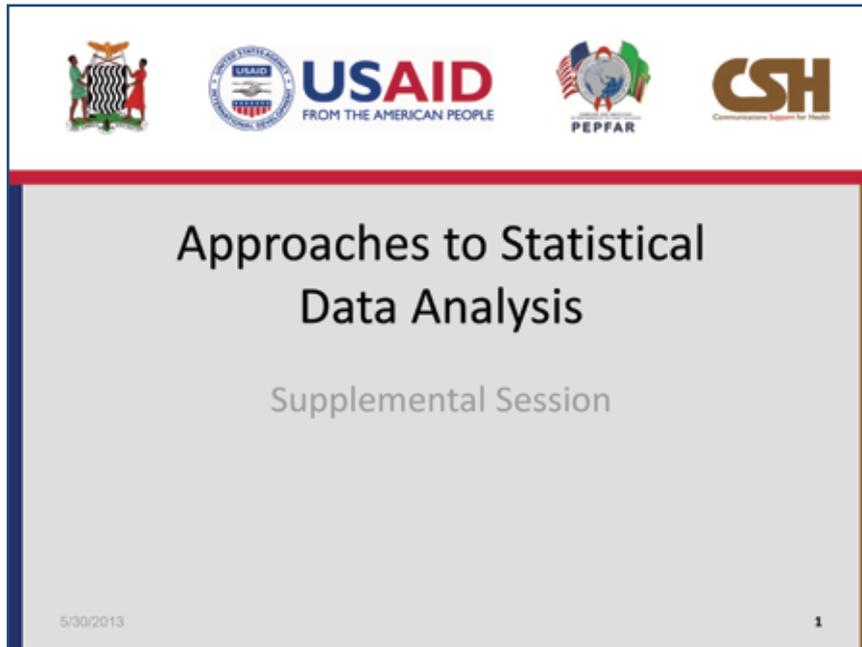
# SUPPLEMENTAL SESSION





## Supplemental Session: Approaches to Statistical Data Analysis

Slide SS.1



5/30/2013 1

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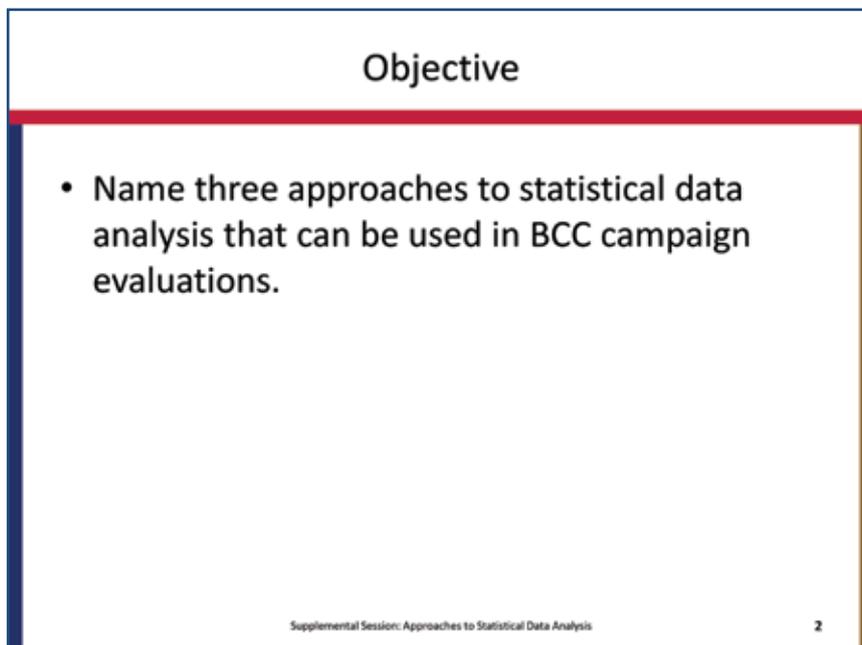
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Slide SS.2



Objective

- Name three approaches to statistical data analysis that can be used in BCC campaign evaluations.

Supplemental Session: Approaches to Statistical Data Analysis 2

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Slide SS.3

**Analytical Approaches**

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- Statistical data analysis is used to evaluate the effect of a campaign.
- Common approaches include
  - Multivariate logistic regression models
  - Propensity score analysis
  - Dose response analysis
- Usually conducted with data from a post-campaign survey for BCC campaigns.

Supplemental Session: Approaches to Statistical Data Analysis 3

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Slide SS.4

**Multivariate Logistic Regression Models**

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- Models look at the relationship between exposure to the campaign (often measured as exposed or not exposed) and the outcomes of interest.
- “Multivariate” means this type of analysis looks at more than one variable at a time.
- Other variables can be controlled or adjusted.
- Models ensure that any effect you see is the result of your programme, not a result of something such as socioeconomic status.

Supplemental Session: Approaches to Statistical Data Analysis 4

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Slide SS.5

### Multivariate Logistic Regression Models (cont.)

- **Logistic regression produces odds ratios.**
  - Shows how much the exposure to a campaign increased the odds (made it more likely) that a person would perform the desired outcome.
  - Does not give you a measure of effect or the percentage point difference in the outcome of interest between those exposed or unexposed.

Supplemental Session: Approaches to Statistical Data Analysis **5**

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Slide SS.6

### Propensity Score Analysis (PSA)

- Is increasingly being used to evaluate the effect of BCC campaigns since it only requires a post-campaign survey.
- Approximates a randomly controlled trial by creating a statistically equivalent “control group”:
  - Matches the unexposed and exposed groups so that they are equivalent (on average) in terms of observed characteristics (e.g., sociodemographic, access to media) included in the analysis.

Supplemental Session: Approaches to Statistical Data Analysis **6**

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Slide SS.7

**Propensity Score Analysis (cont.)**

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- Matching allows evaluators to compare the two groups and attribute any significant differences to the campaign.
- PSA produces the percentage point difference in the outcome of interest between those exposed and unexposed.
- The percentage point difference is interpreted as the change that occurred in the outcome as a result of exposure to the campaign.

Supplemental Session: Approaches to Statistical Data Analysis 7

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Slide SS.8

**Dose Response Analysis**

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- Also known as dose effect analysis.
- Tests the hypothesis that higher levels of exposure to a campaign are more likely to result in the desired outcome compared to lower levels of exposure.
- If a relationship between the “dose” of exposure and the desired outcome is found, then there is stronger evidence that a campaign affected an outcome.

Supplemental Session: Approaches to Statistical Data Analysis 8

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Slide SS.9

### Dose Response Analysis (cont.)

- Evaluators must measure exposure to the campaign through multiple channels.
- Evaluators cannot only measure whether a person knows of the campaign. They must look at the exposure and recall of multiple aspects of the campaign, such as
  - Name of campaign/campaign slogan/logo;
  - Small media/mass media components of the campaign; and
  - Campaign messages.
- Dose response can be used with logistic regression or PSA to control for other variables.

Supplemental Session: Approaches to Statistical Data Analysis

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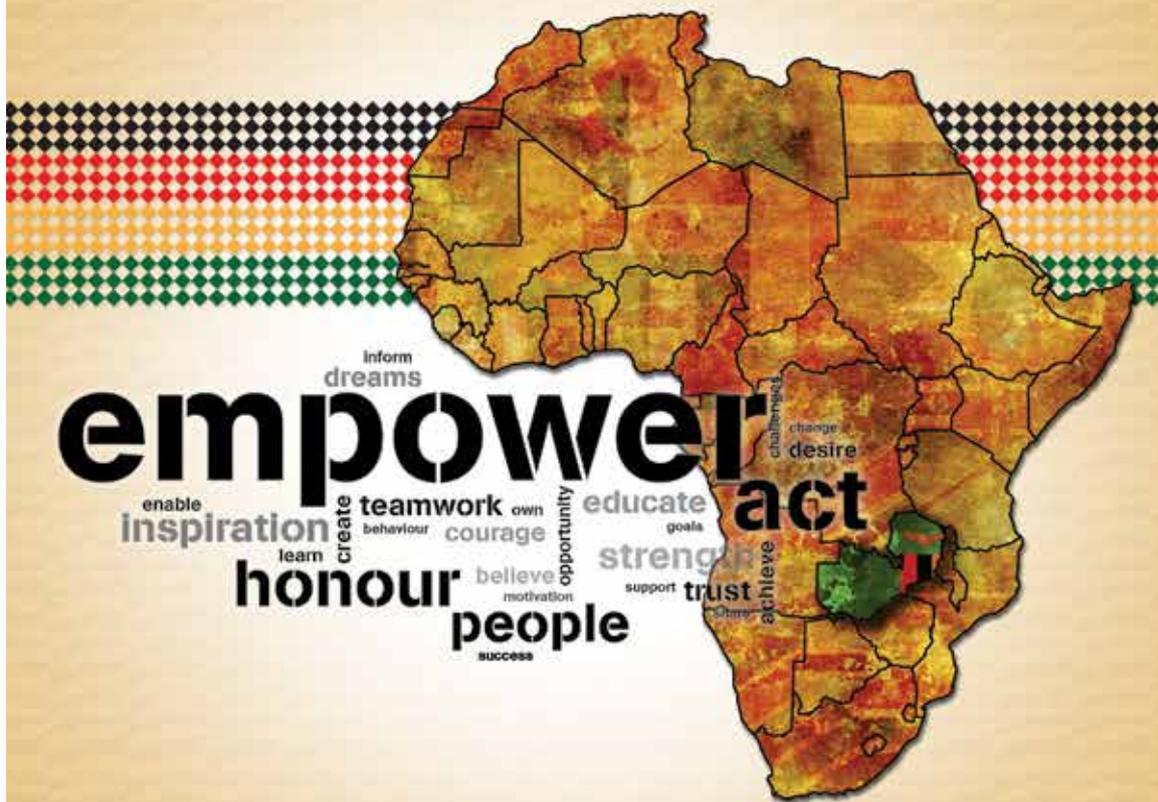
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# SESSION 9





## Session 9: Data Presentation

Slide 9.1



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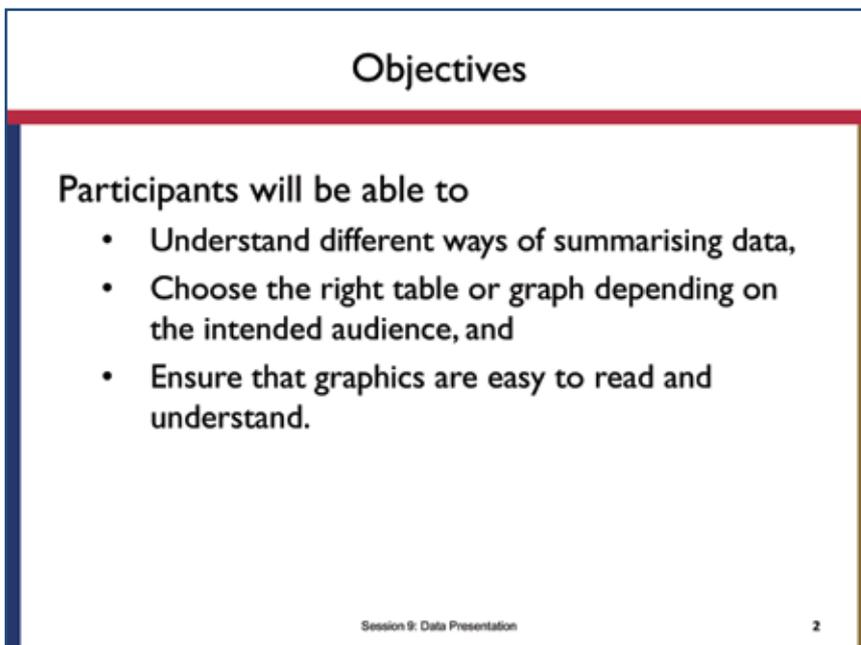
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Slide 9.2



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Slide 9.3

## Do You Present Yourself Like This?



Session 9: Data Presentation 3

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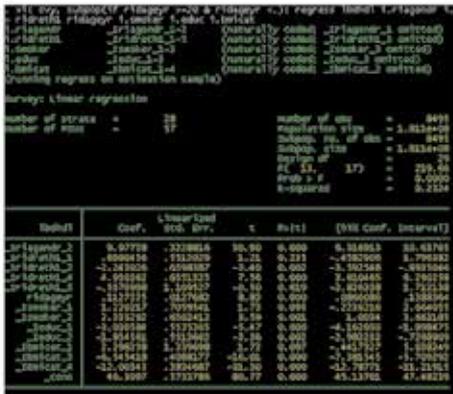
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Slide 9.4

## So Why Present Data Like This?



Session 9: Data Presentation 4

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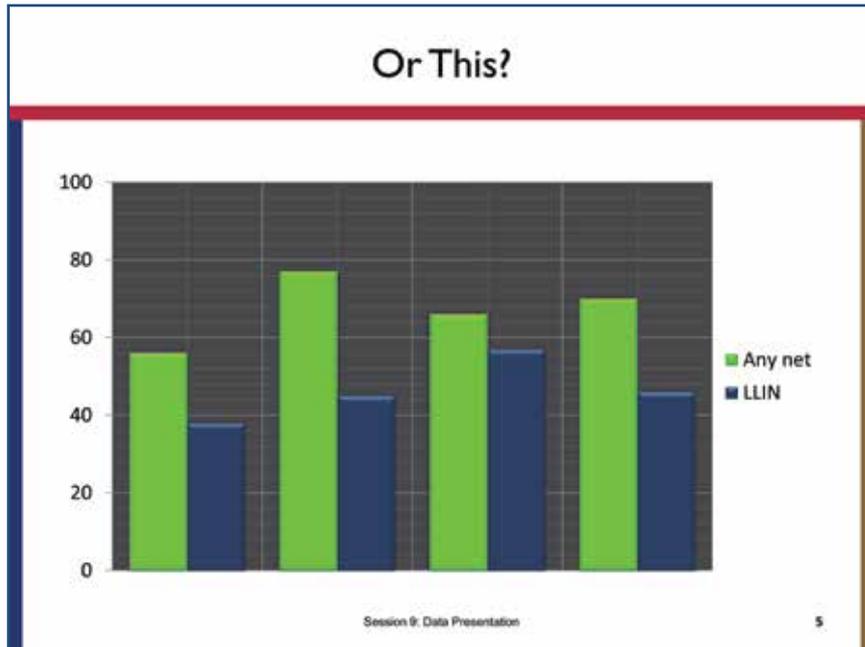
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Slide 9.5




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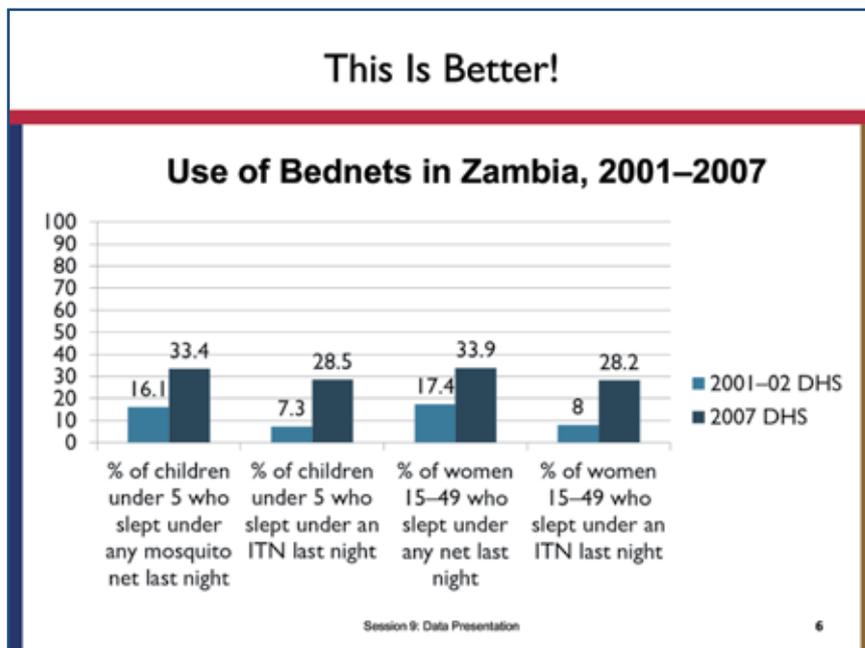
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Slide 9.6




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Slide 9.7

**Effective Presentation of Data**

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- Clear
- Concise
- Actionable
- Attractive

Session 9: Data Presentation 7

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Slide 9.8

**Tips for Presenting Data in PowerPoint**

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- Ensure that all text is readable from a distance;
- Use sans serif fonts
  - Gill Sans (sans serif)
  - Times New Roman (serif)
- Try to use graphs or charts, not tables;
- Keep slides simple;
- Limit animations and special effects; and
- Use high-contrast text and backgrounds.

Session 9: Data Presentation 8

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Slide 9.9

**Effective Presentation of Data (cont.)**

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- For all communication formats, it is important to ensure that there is
  - Consistency
    - Font, colors, punctuation, terminology, and line/ paragraph spacing.
  - An appropriate amount of information
    - Less is more.
  - Appropriate content and format for audience
    - Scientific community, journalist, and politicians.

Session 9: Data Presentation 9

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Slide 9.10

**Summarising Data**

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- Tables
  - These are the simplest way to summarise data.
  - Data are presented as absolute numbers or percentages.
- Charts and graphs
  - They serve as a visual representation of data.
  - Usually, data are presented using percentages.

Session 9: Data Presentation 10

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Slide 9.11

**Points To Remember**

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- Ensure that graphic has a title,
- Label the components of your graphic,
- Indicate source of data with date,
- Provide number of observations (n=xx) as a reference point, and
- Add footnote if more information is needed.

Session 9: Data Presentation 11

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Slide 9.12

**Choosing a Title for Tables and Graphs**

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- A title should express
  - Who
  - What
  - When
  - Where

Session 9: Data Presentation 12

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Slide 9.13

### Tables: Frequency Distribution

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#### Zambia Infant Mortality Rates, 1992–2007

Year	Mortality Rate
2007	82
2001–2	94
1996	108
1992	98

Source: ICF International, 2012 MEASURE DHS STATcompiler, <http://www.statcompiler.com>, November 28, 2012.

Session 9: Data Presentation 13

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Slide 9.14

### Use the Right Type of Graph

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- Charts and graphs
  - **Bar chart:** comparisons, categories of data;
  - **Histogram:** represents relative frequency of continuous data;
  - **Line graph:** displays trends over time, continuous data (e.g., cases per month); and
  - **Pie chart:** shows percentages or proportional share.

Session 9: Data Presentation 14

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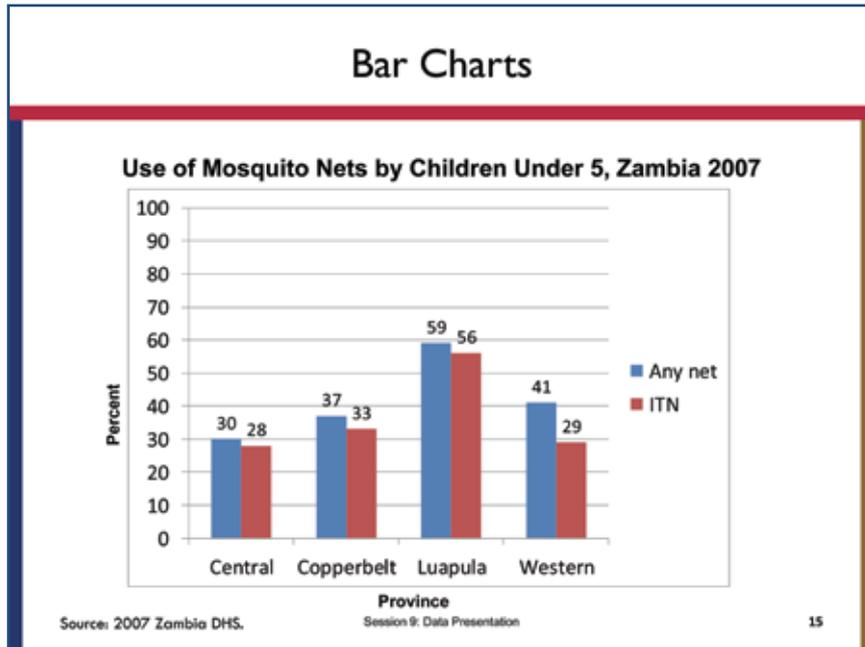
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Slide 9.15



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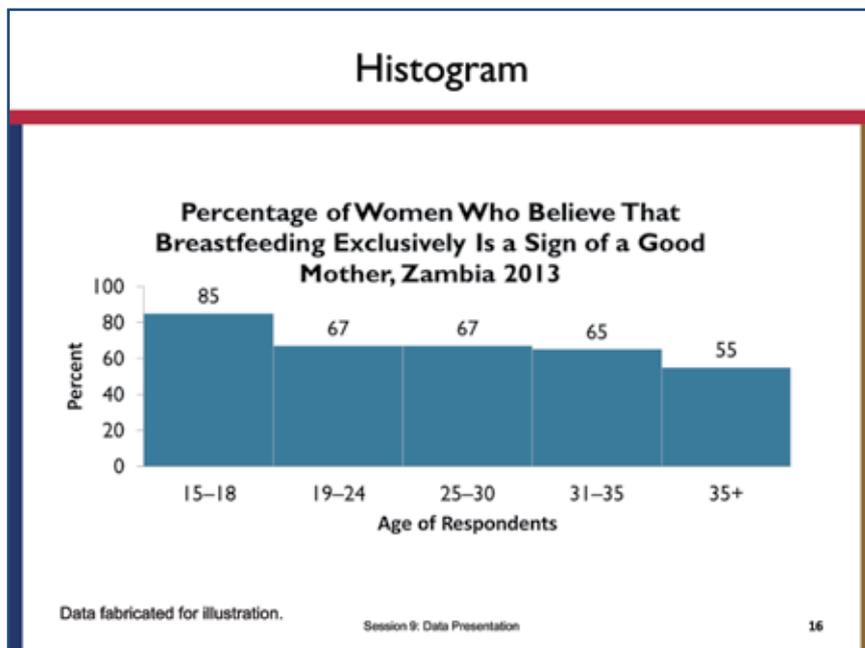
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Slide 9.16



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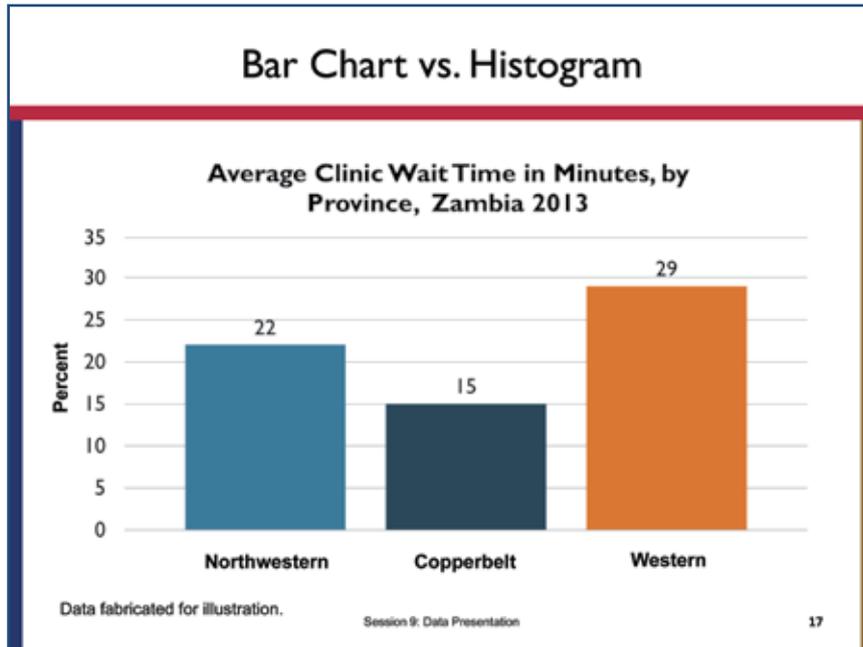
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Slide 9.17



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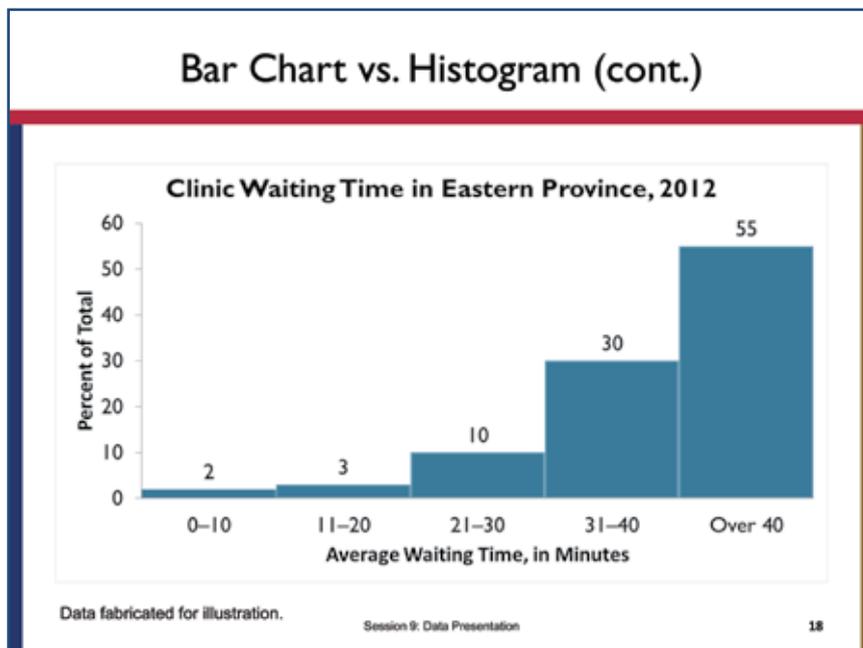
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Slide 9.18



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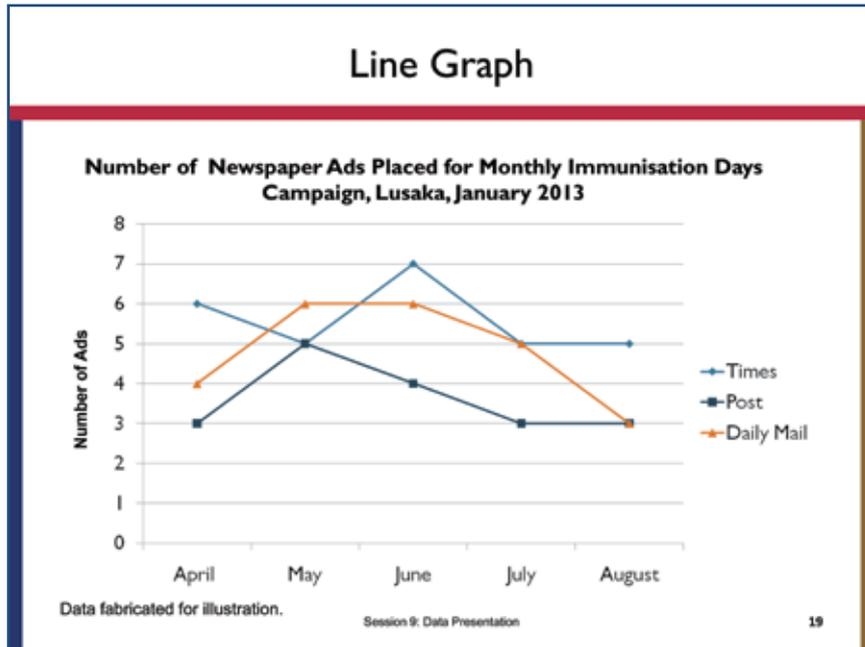
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Slide 9.19



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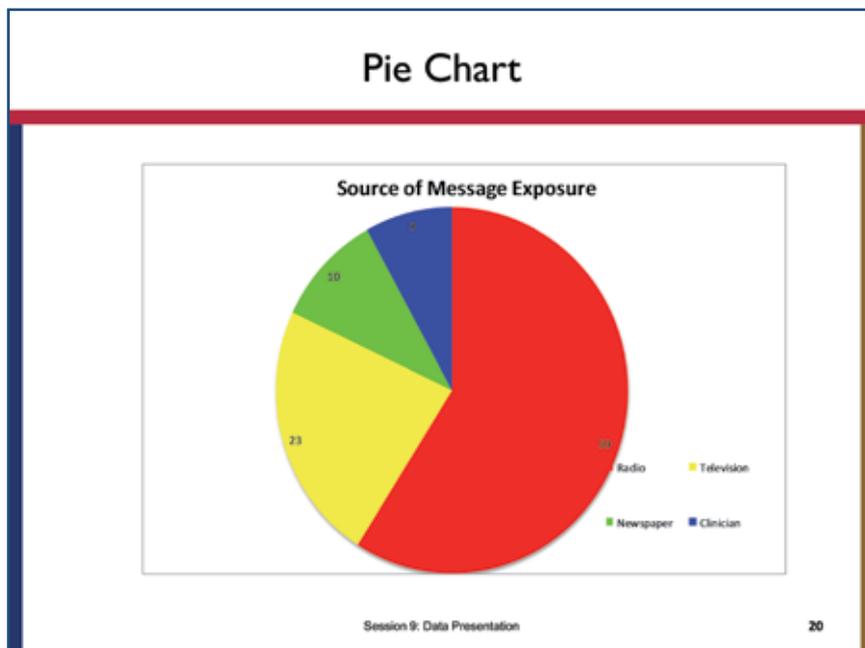
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Slide 9.20



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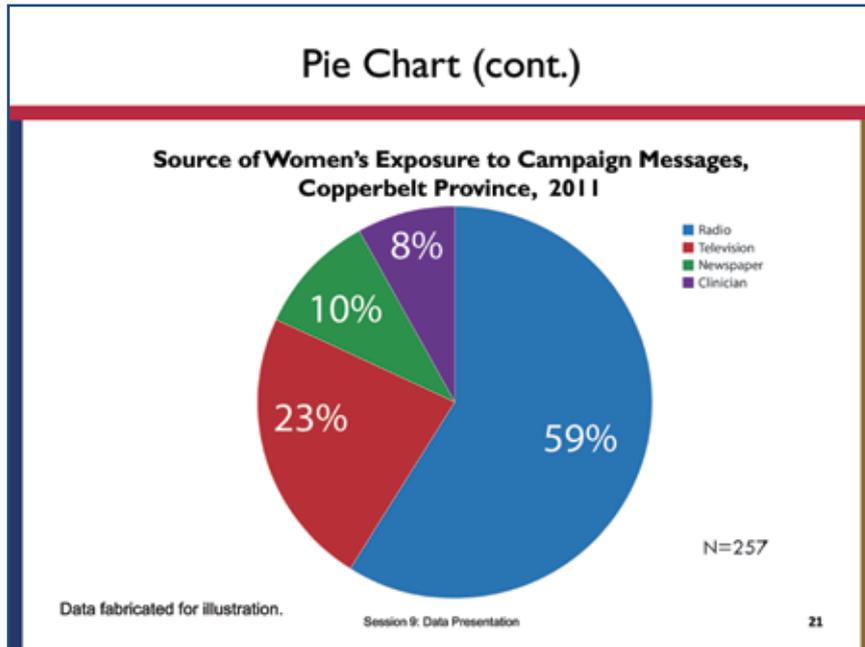
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Slide 9.21



Slide 9.22

- ### Exercise: How Should You Present?
1. Prevalence of HIV in three countries over a 30-year period,
  2. Data comparing breastfeeding in six different countries,
  3. Data on reasons why women are not using ANC (out of all women surveyed who are pregnant and not using ANC), and
  4. Percentage of women who intend to deliver in a health facility, by year (2007–2012).
- Session 9: Data Presentation
- 22
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Slide 9.23

### Data Presentation Summary

- Make sure you present your data in a consistent format,
- Use the right graph for the right data and the right audience,
- Label the components of your graphic (title, axis),
- Indicate source of data and number of observations (n=xx), and
- Make sure you use readable colors and typefaces.

Session 9: Data Presentation 23

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Slide 9.24

### Scenario Exercise: Data Presentation

- How would you present your data on the HIV/AIDS campaign?

Session 9: Data Presentation 24

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Slide 9.25

## Acknowledgements

*This presentation was adapted from MEASURE Evaluation.*

*MEASURE Evaluation is a MEASURE programme project funded by the U.S. Agency for International Development (USAID) through Cooperative Agreement GHA-A-00-08-00003-00 and is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Futures Group International; John Snow, Inc.; ICF International; Management Sciences for Health; and Tulane University.*

Visit us online at <http://www.cpc.unc.edu/measure>.

Session 9: Data Presentation 25

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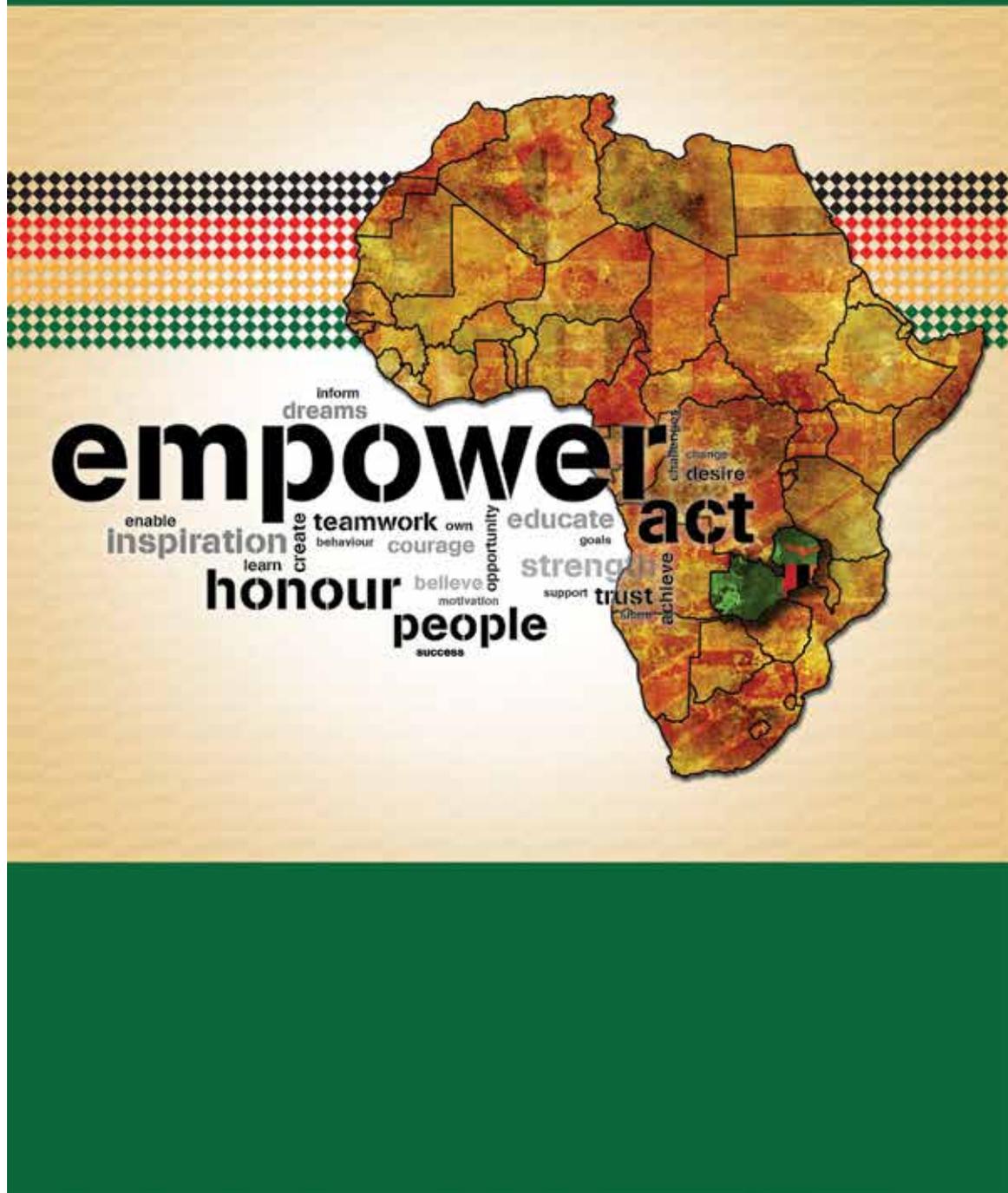
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# SESSION 10





## Session 10: Data Interpretation

Slide 10.1

6/3/2013

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Slide 10.2

### Objectives

- Participants will be able to
  - Describe the difference between analysis and interpretation, and
  - Interpret information presented in sample tables and graphs.

Session 10: Data Interpretation

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Slide 10.3

### Analysis vs. Interpretation

- **Analysis:** describing data with tables, graphs, or narrative; transforming data into information; and
- **Interpretation:** adding meaning to information by making connections and comparisons and by exploring causes and consequences.

Session 10: Data Interpretation 3

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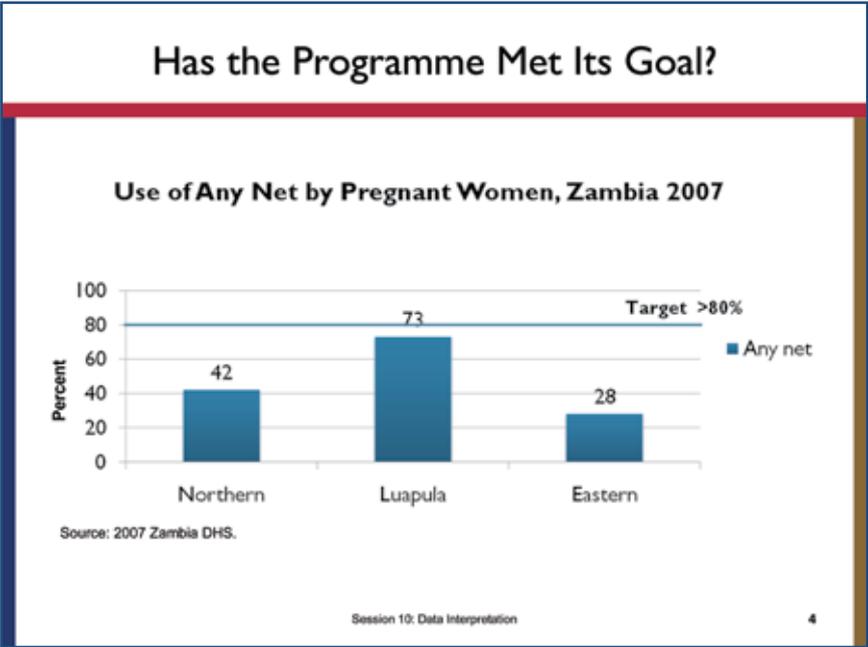
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Slide 10.4



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Slide 10.5

### Interpreting Data

- Does the indicator meet the target?
- What is the programmatic relevance of the finding?
- What are the potential reasons for the finding?
- What other data should be reviewed to understand the finding (triangulation)?
- How does it compare (trends, group differences)?
- Do we need to conduct further analysis?

Session 10: Data Interpretation 5

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Slide 10.6

### Practical

- You are conducting a campaign to increase women’s uptake of IPT during antenatal visits.
- Your monitoring plan also looks at women’s
  - Intentions to receive IPTp, and
  - Attitudes and beliefs about the treatment.
- You need to provide recommendations or guidance on how well the campaign is doing in promoting IPTp.
- What information should you consider?

Session 10: Data Interpretation 6

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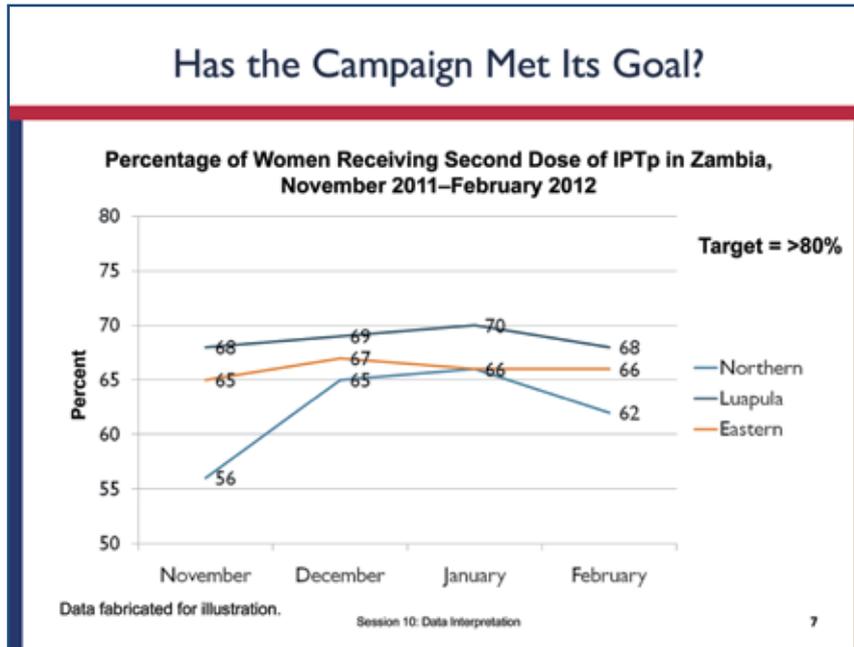
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Slide 10.7




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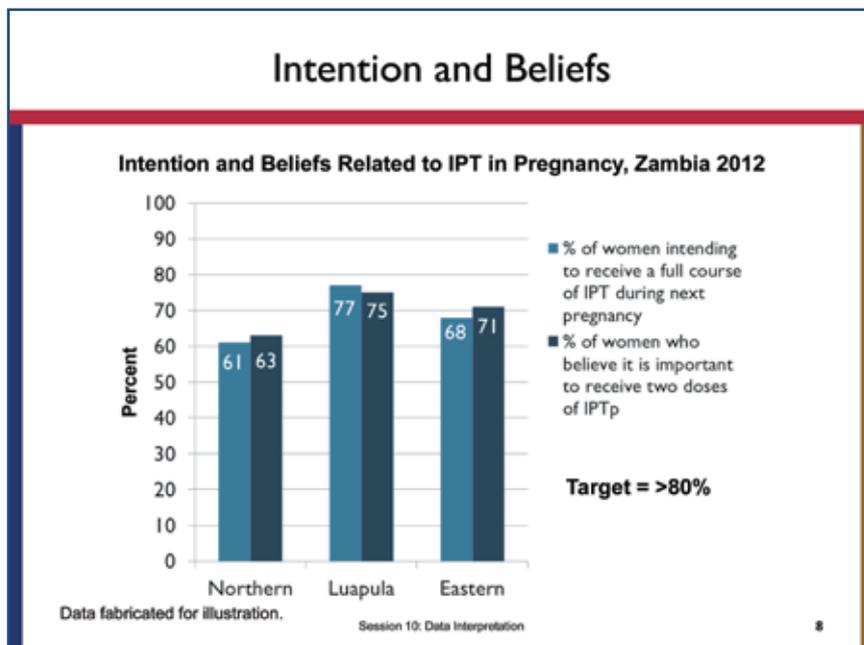
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Slide 10.8




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Slide 10.9

### Making Recommendations

- If you were managing this project, how would you use these data to advise the campaign?
- What other data or information should you consider in providing recommendations or guidance on how well the campaign is doing in promoting the use of IPTp?
- What happens to the recommendations you will make?

Session 10: Data Interpretation 9

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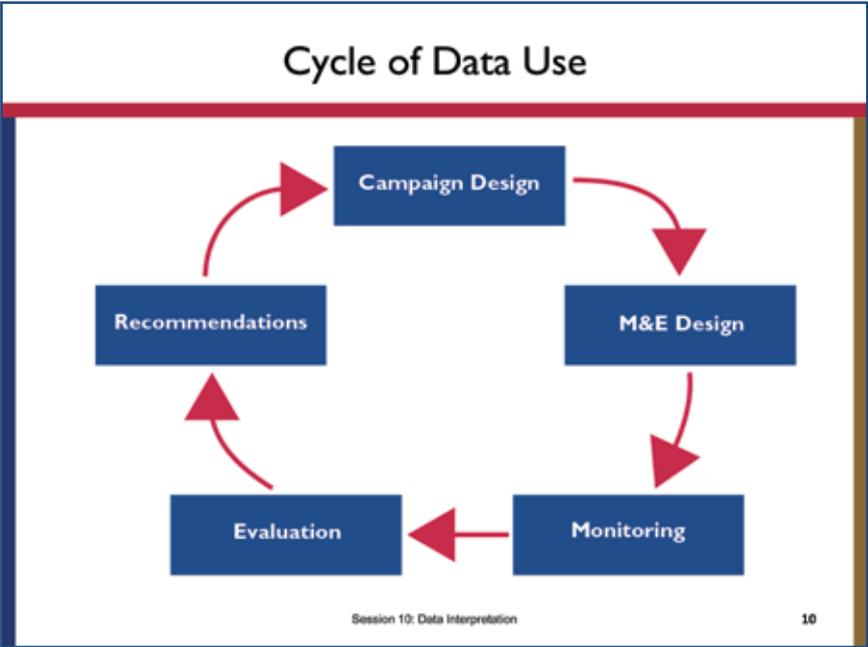
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Slide 10.10



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Slide 10.11

### Using Data in the Campaign

- Present trends,
- Have discussion between M&E staff and programme staff on what the findings mean for the programme,
- Develop strategic plan for campaign improvement based on results,
- Update your M&E plan, and
- Gather new data.

Session 10: Data Interpretation 11

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Slide 10.12

### Scenario Exercise: Data Interpretation

- Look at the sample graphs from the HIV/AIDS campaign on pages 175–178 of the participant booklet.
- Discuss possible responses to the discussion questions, based on the sample graphs.
- Present your graphs and interpretations of the graphs to the rest of the participants.

Session 10: Data Interpretation 12

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Slide 10.13

## Acknowledgements

*This presentation was adapted from MEASURE Evaluation.*

*MEASURE Evaluation is a MEASURE programme project funded by the U.S. Agency for International Development (USAID) through Cooperative Agreement GHA-A-00-08-00003-00 and is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Futures Group International; John Snow, Inc.; ICF International; Management Sciences for Health; and Tulane University.*

Visit us online at <http://www.cpc.unc.edu/measure>.

Session 10: Data Interpretation 13

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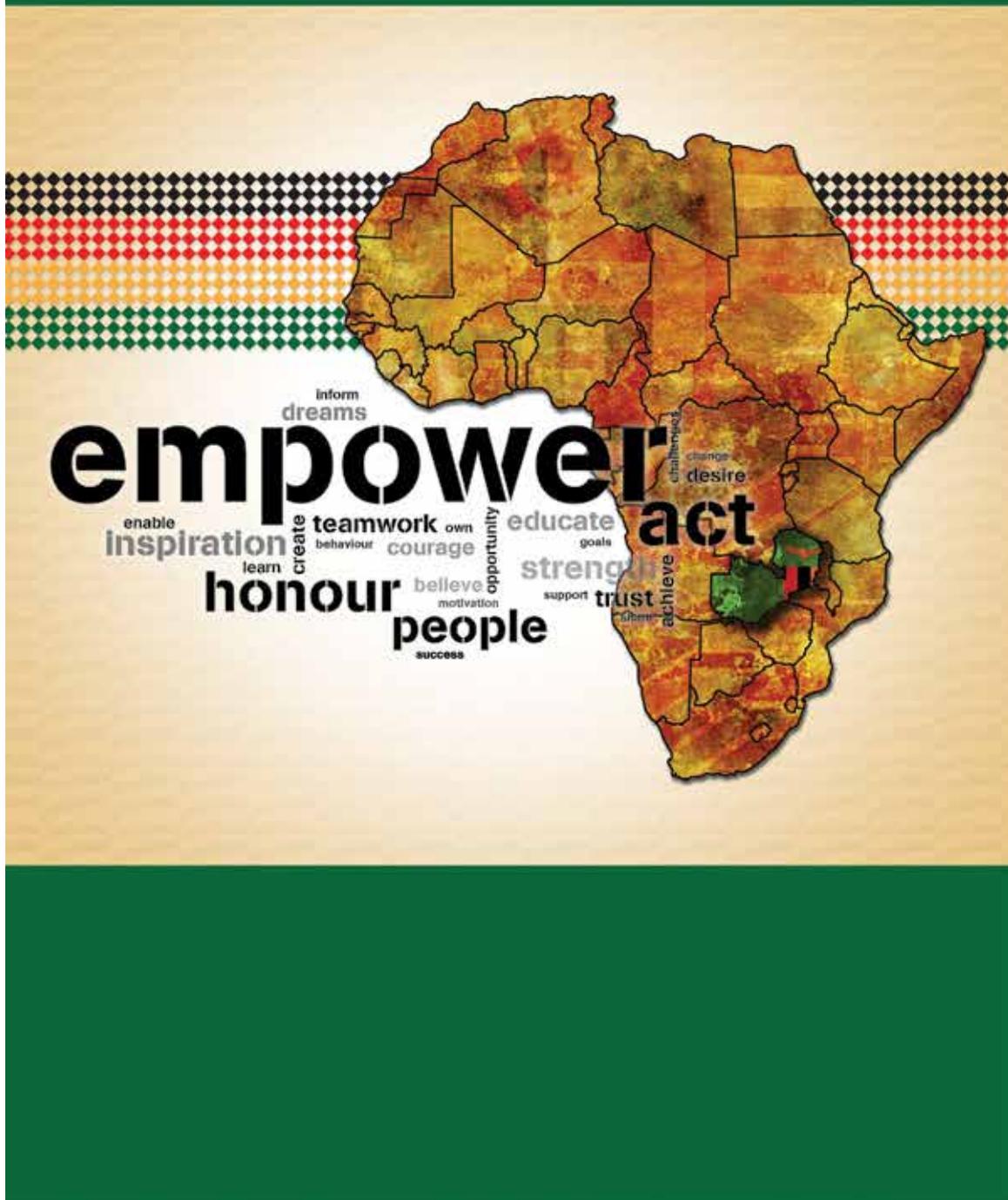
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# SESSION 11





## Session 11: Putting It All Together

Slide 11.1



USAID FROM THE AMERICAN PEOPLE

PEPFAR

CSH Communications Support for Health

# Putting It All Together

Session 11

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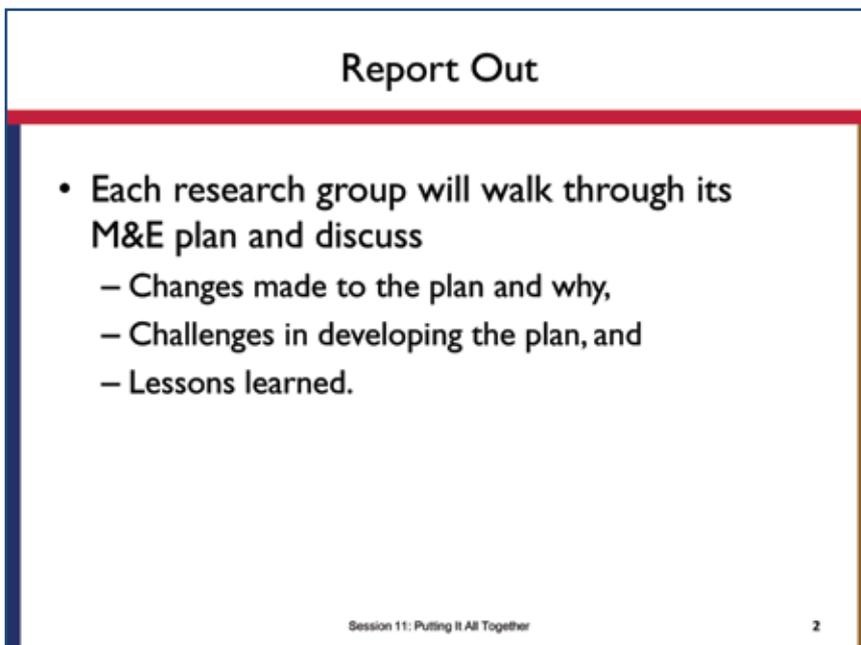
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Slide 11.2



## Report Out

- Each research group will walk through its M&E plan and discuss
  - Changes made to the plan and why,
  - Challenges in developing the plan, and
  - Lessons learned.

Session 11: Putting It All Together

2

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**Slide 11.3**

**Put Your Expertise to the Test**

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- What do you think of this campaign plan?
- What information will help you write your M&E plan?
- What information is missing or incomplete?

Session 11: Putting It All Together 3

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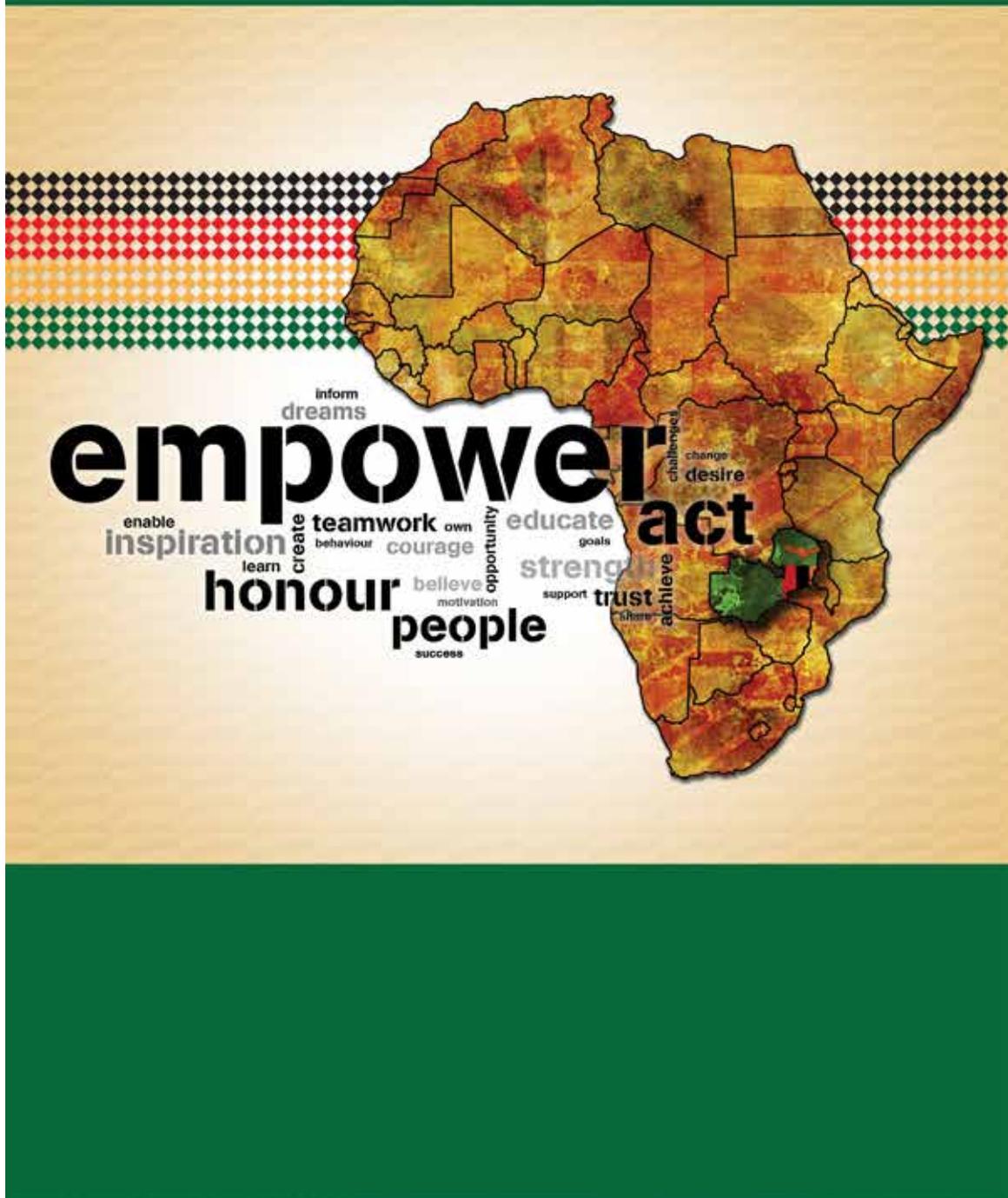
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# SESSION 12





## Session 12: In Closing

Slide 12.1



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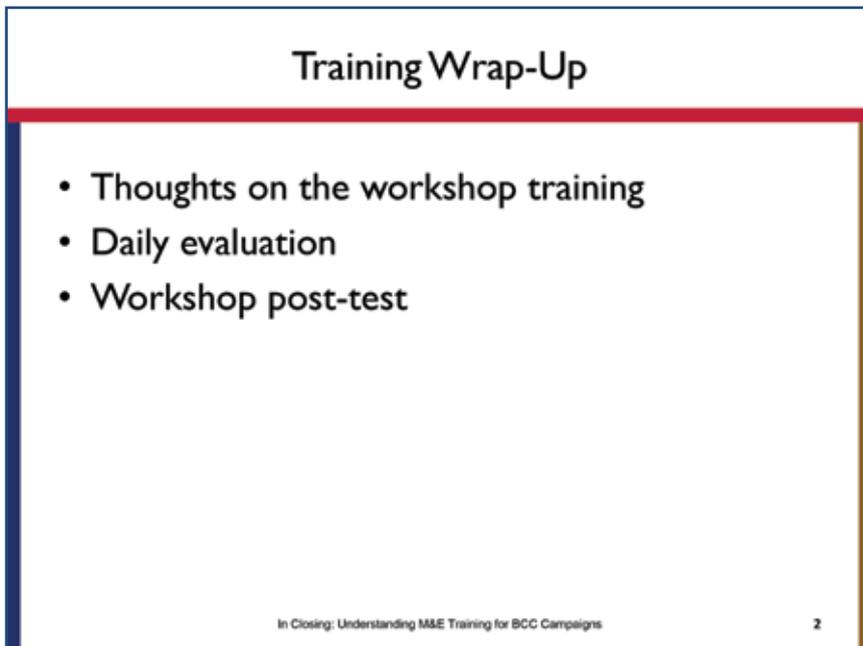
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Slide 12.2



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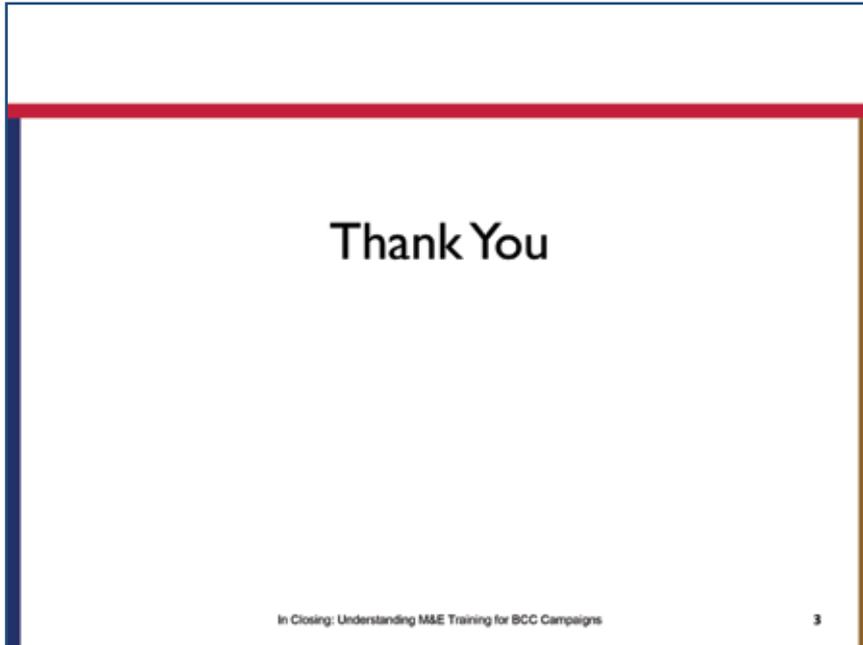
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Slide 12.3



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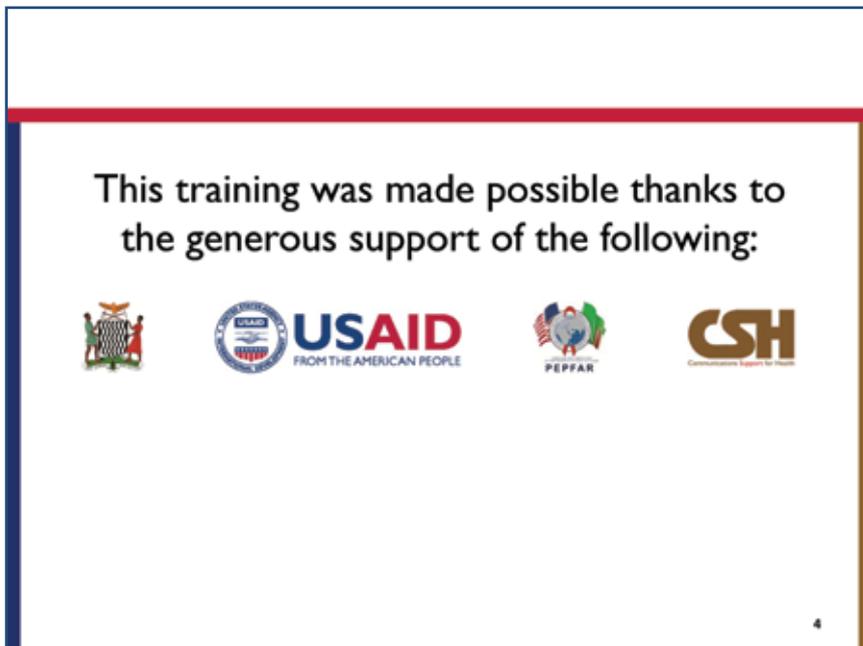
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Slide 12.4



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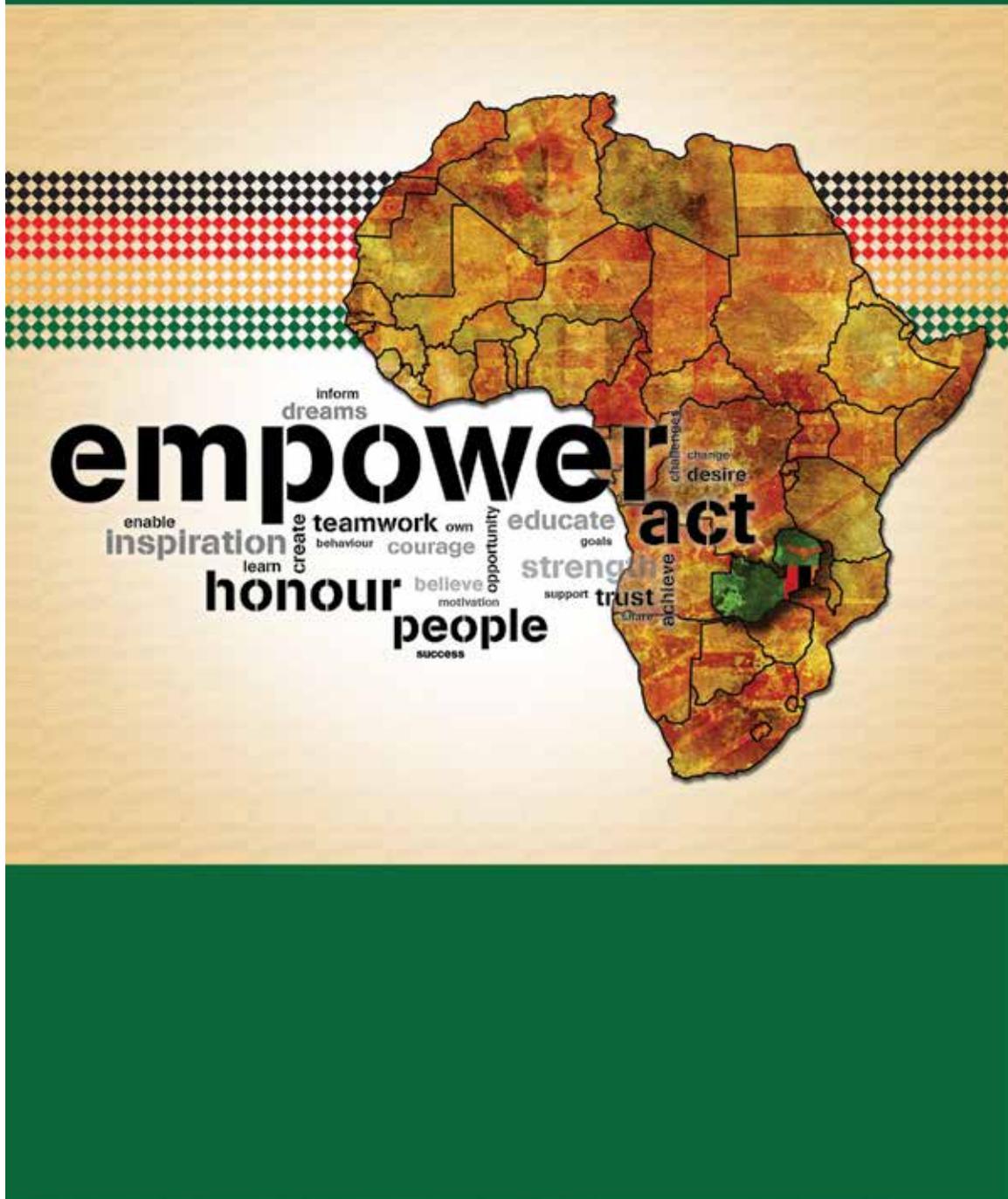
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# APPENDIX A: EXERCISE MATERIALS





## Scenario: HIV/AIDS Campaign Plan

### I. Campaign Background and Rationale<sup>1</sup>

#### HIV Situation in Zambia

While the percentage of HIV prevalence in Zambia has declined slightly over the past decade, it remains high at about 14.3 percent. Women continue to bear a greater burden than men, with 16.1 percent of women infected with HIV as compared with only 12.3 percent of men. The main mode of HIV transmission in Zambia is unprotected sex. An estimated 90 percent of adult infections are related to unprotected heterosexual activity with a casual partner, a long-standing partner, or a concurrent sexual partner. Stable relationships such as marriages or people living together have the highest HIV prevalence rates, estimated at 16 percent and 15 percent, respectively. Based on the HIV incidence model in Zambia, which looks at new infections in different exposure groups, the largest contribution to the total incidence came from individuals whose partners have casual heterosexual sex (37 percent of total incidence), followed by individuals who reported having casual heterosexual sex (34 percent). As of 2008, 71 percent of new infections were a result of casual heterosexual behaviours, including people engaging in multiple and concurrent partnerships. Concurrent partnerships are of high and special concern, as they raise the number of individuals who are infected over very short time periods—thus accelerating the spread of HIV.

Vertical transmission from mother-to-child is another key driver of HIV, accounting for about 10 percent of all new infections. Despite increasing availability of preventing mother-to-child transmission (PMTCT) services, uptake of the service has remained low because of various reasons, including stigma associated with HIV, gender-based violence, inadequate male involvement in PMTCT, and the opt-in approach to counselling, which depends on women consenting to an HIV test.

#### Zambia National HIV/AIDS Strategy

The priority of the Government of the Republic of Zambia (GRZ) is to prevent and control the spread of HIV/AIDS. The vision of the National HIV/AIDS/STI/TB Council (NAC) is a nation free of HIV and AIDS.

In 2009, NAC identified the following as the key drivers of HIV in Zambia:

- Multiple and concurrent sexual partnerships (MCP),
- Low condom use,
- Low levels of male circumcision,
- Mobile and migrant labour,
- Vulnerable and marginalised groups (e.g., female sex workers, prisoners, disabled),
- Mother-to-child transmission (MTCT), and
- Alcohol abuse.

In order to address these key drivers, the NAC developed the National HIV and AIDS Strategic Framework (NASF) 2011–2015. This framework has two main priorities: first, to improve people's level of comprehensive knowledge about HIV to ensure they can assess their personal risk and

<sup>1</sup> The data included in this section were obtained from various sources, including the 2007 Zambia Demographic Health Survey, the 2009 Zambia HIV Prevention Response and Modes of Transmission Analysis Report, and the 2011–2015 National HIV and AIDS Strategic Framework.

vulnerability to HIV infection; second, to promote social and behavioural changes, focusing efforts on the main key drivers of HIV infection. Two of the major priority areas are reducing MCPs and increasing the use of PMTCT services.

## II. HIV Campaign Description

In order to address the two main drivers of HIV, the GRZ and NAC, in collaboration with the Health Communications project, have designed a national HIV behaviour change communication campaign that will focus on reducing the proportion of adults who engage in MCPs and increasing the proportion of HIV-positive women who use PMTCT services. The overall goal of the campaign will be to help reduce the number of new HIV infections in Zambia by addressing these two key drivers of HIV. The objectives and strategies of the campaign were based on a thorough literature review and formative research carried out by the main partners (see Section III for a list of the objectives). This formative research also informed on the target audiences for the campaign, which will include sexually active adults aged 15–49 and HIV-positive women/women of reproductive age and their male partners.

The campaign will be launched in January 2013 and run through December 2013. It will include activities at both national and community levels in order to best reach target audiences. At the national level, different mass media programmes will be implemented, including a radio drama series that focuses on messages around reducing MCP, a TV drama series that discusses messages around MTCT, and a series of radio and TV promotional advertisements for both of these series. Additionally, the campaign will implement weekly informational inserts in the *Times of Zambia* newspaper, addressing various issues around both of these key drivers. At the community level, the campaign will work in three provinces: Lusaka, Luapula, and Copperbelt. Community-level activities will include developing a drama script and implementing a series of community drama events in each of the provinces. During each of the drama events, informational brochures will be produced and distributed. Peer outreach activities focusing on MTCT will also be implemented. These activities will consist of one-on-one and small group counselling done by trained peer educators. Lastly, the campaign will develop and produce posters around MTCT that will be distributed in all health facilities within the three provinces. A more detailed implementation plan for these activities is presented in Tables 1 and 2.

## III. HIV Campaign Objectives

### MCPs

The target audience for the MCP component of the campaign is adults aged 15–49 who are sexually active.

The objectives for the intermediate outcomes related to MCP are to increase the proportion of adults aged 15-49 who

1. Feel they are able to talk with their sexual partners about getting tested for HIV,
2. Intend to get tested for HIV,
3. Feel they are able to talk with their sexual partners about whether their partner has other sexual partners,
4. Believe that it is not acceptable to have more than one sexual partner at a time,
5. Understand that partner reduction is a protective behaviour against HIV, and
6. Intend to ask their partner to use a condom.

The objectives for the long-term behavioural outcomes for MCP are to

1. Increase the proportion of adults aged 15–49 who use condoms consistently with every sexual partner,
2. Increase the proportion of adults aged 15–49 who get tested for HIV and receive their results,
3. Increase the proportion of adults aged 15–49 who know their partner’s HIV status, and
4. Decrease the proportion of adults aged 15–49 who have had two or more partners in the last 12 months.

### MTCT

The primary audience for the MTCT component of the campaign is HIV-positive pregnant women and women of child-bearing age. The secondary audience is the partners of HIV-positive pregnant women and women of child-bearing age.

The objectives for the intermediate outcomes for the MTCT component are to increase the proportion of women aged 15–49 who

1. Intend to be tested for HIV,
2. Feel confident asking their partner to get an HIV test,
3. Know the risk of transmitting HIV during pregnancy, delivery, and breastfeeding,
4. Know risk-reduction strategies for vertical transmission of HIV, and
5. Believe it is beneficial to go early for antenatal care to receive HIV counselling, HIV testing, and PMTCT services.

The objectives for the long-term behavioural outcomes for MTCT are to increase the proportion of

1. Women aged 15–49 who have been tested for HIV and know their status,
2. Women aged 15–49 who know the HIV status of their partner(s),
3. HIV-positive pregnant women who use PMTCT services, and
4. Pregnant women who go for antenatal care before the fifth month (16th week) of their pregnancy.

## IV. HIV Campaign Implementation Plan

### MCPs

Table 1 outlines a few of the key activities focused on issues related to MCP that will take place from January 2013 to December 2013.

**Table 1. Implementation Plan for MCP Component**

Activity	Month of the Campaign											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
<b>National Level</b>												
Radio drama series (30 minutes) held on three different national radio stations. One new episode will be aired per month.  Number of times each episode is aired each month:	3	4	4	4	4	4	4	4	4	4	4	4
Radio promotional advertisements for the radio drama series aired on three different stations (30 seconds).  Number of times ad is aired per month:	80	80	80	60	60	60	60	30	30	30	30	30
Health-informational insert in <i>Times of Zambia</i> newspaper (150,000 estimated readers). One new insert will be provided each month.  Number of inserts circulated per month:	2	4	4	4	4	4	4	4	4	4	4	4

Activity	Month of the Campaign											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
<b>Local Level</b>												
Printed informational brochures for Lusaka, Luapula, and Copperbelt provinces.												
Number of brochures distributed at community events across all three provinces:	600	1,200	1,200	1,800	1,800	2,400	2,400	2,400	2,400	1,800	1,800	1,800
Community theatre events in Lusaka, Luapula, and Copperbelt provinces (one-hour plays).												
Number of plays conducted each month in all three provinces:	3	6	6	9	9	12	12	12	12	9	9	9

MTCT

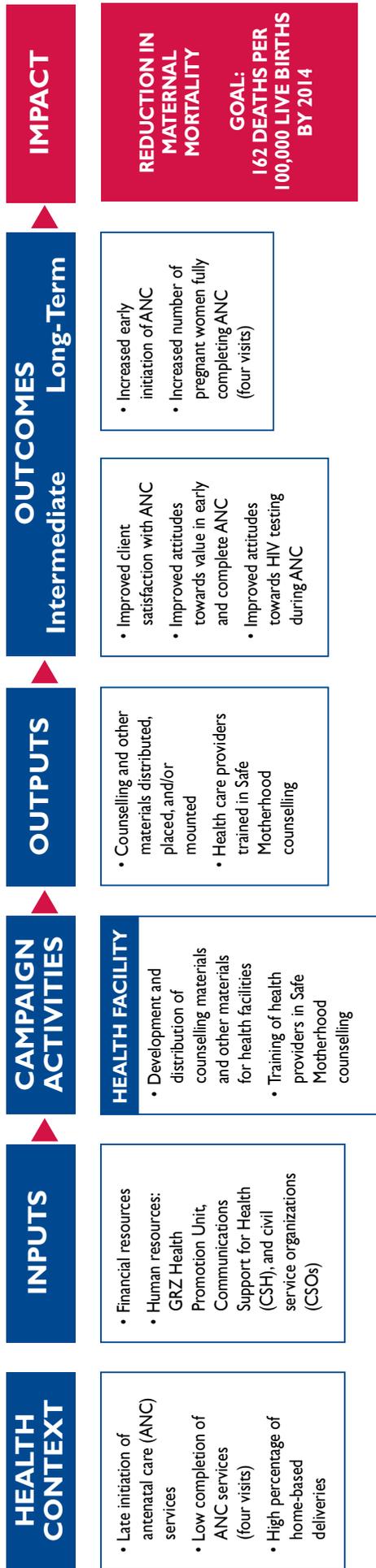
Table 2 outlines a few of the key activities focused on issues related to MCP that will take place from January 2013 to December 2013.

**Table 2. Implementation Plan for MTCT Component**

Activity	Month of the Campaign											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
<b>National Level</b>												
TV drama series (30 minutes each) held on one national TV station. One new episode will be aired per month.  Number of times each episode is aired per month:	3	4	4	4	4	4	4	4	4	4	4	4
TV promotional advertisements for TV drama series aired on one station (30 seconds).  Number of times advertisement is aired per month:	80	80	80	60	60	60	60	30	30	30	30	30
Health-informational insert in <i>Times of Zambia</i> newspaper (150,000 estimated readers). One new insert will be provided each month.  Number of inserts circulated per month:	2	4	4	4	4	4	4	4	4	4	4	4

Activity	Month of the Campaign											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
<b>Local Level</b>												
Printed posters for health facilities and community places in Lusaka, Luapula, and Copperbelt provinces. Number of posters distributed to health facilities and community places for each location:	100	0	0	100	0	0	100	0	0	100	0	0
Training of peer educators in Lusaka, Luapula, and Copperbelt provinces. Number of new peer educators trained per month:	25	25	50	50	50	50	0	0	0	0	0	0
One-on-one and small group counselling outreach activities conducted by peer educators in Lusaka, Luapula, and Copperbelt provinces. Number of women of reproductive age targeted per month:	200	400	800	1,200	1,400	1,500	1,500	1,500	1,500	1,500	1,500	1,500

## Logic Model: Safe Motherhood



Scenario Exercise: Logic Model

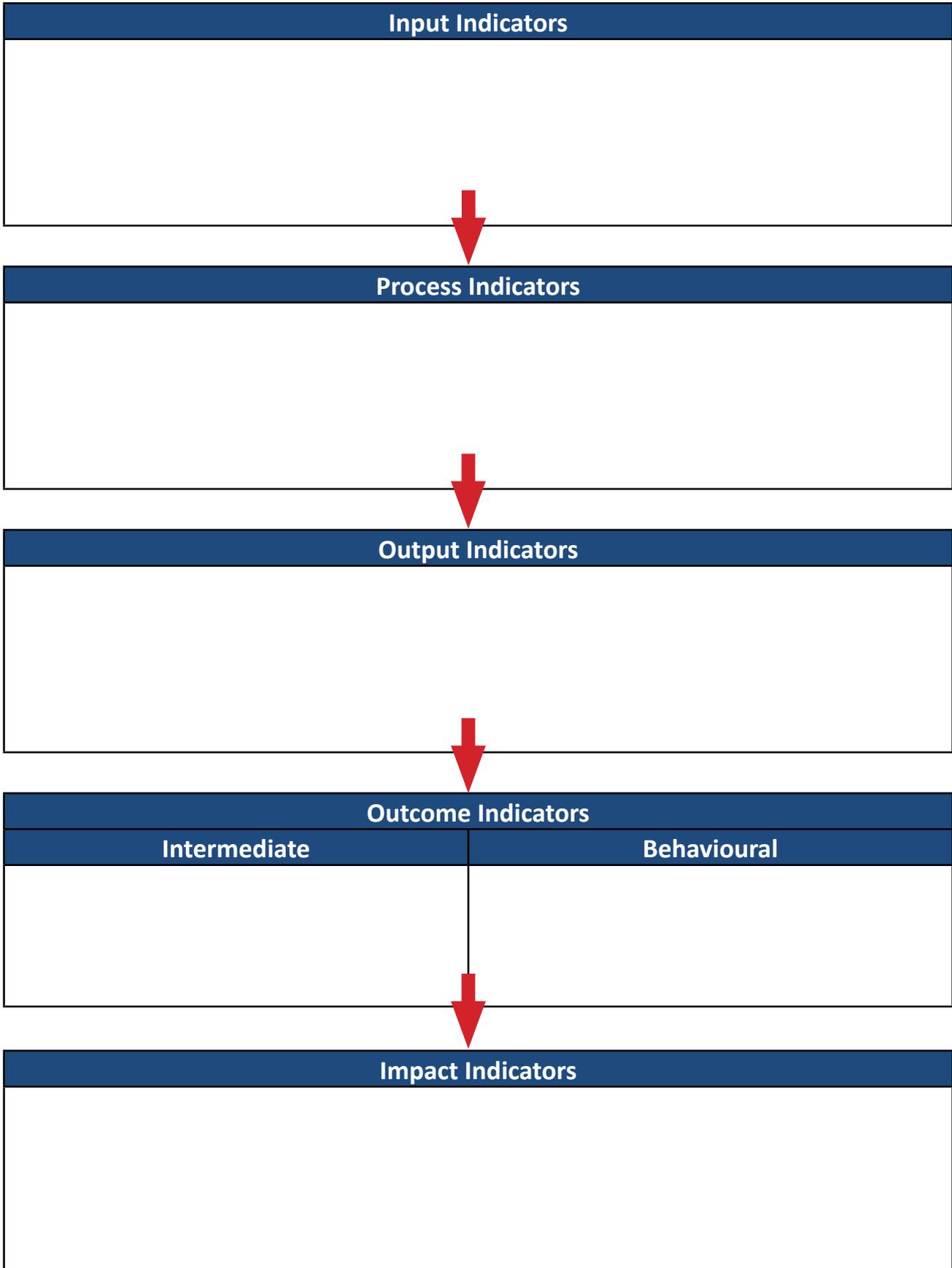
Inputs	
Processes	
Outputs	
Outcomes	
Impact	

Long-Term

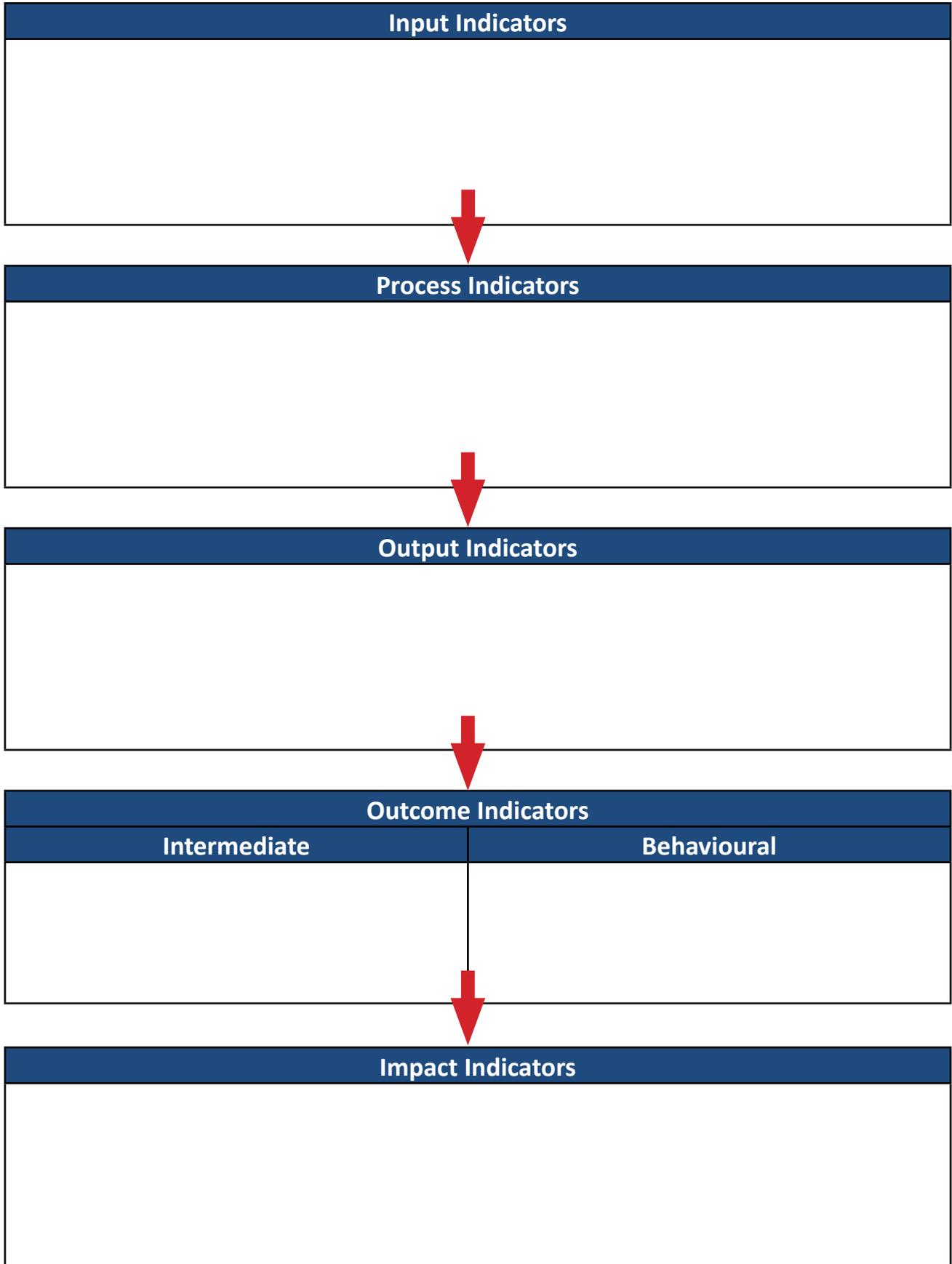
Intermediate

### Scenario Exercise: Indicator Chain

National Activity: \_\_\_\_\_



**Community Activity:** \_\_\_\_\_



## Scenario Exercise: Observation Guide

Activity to be observed: \_\_\_\_\_

**Scenario Exercise: Data Collection**

Activities	Methods & Sources for Monitoring	Methods & Sources for Evaluation	Changes for a Large Budget	Changes for a Small Budget

**Scenario Exercise: Evaluation Design and Analysis**

<b>Evaluation Design</b>	<b>Timeframe of Evaluation (e.g., before or middle of campaign implementation)</b>	<b>Analysis Method</b>

## Scenario Exercise: Data Presentation

### Exercise #1

**Scenario:** The following results are from a survey conducted to assess the target population’s exposure to your HIV campaign. Respondents were asked from where (e.g., from what source) they first had heard about the campaign. Use the data below to develop a graph(s) to represent the target population’s source of exposure to the campaign. Use the type of graph or graphs that you think would be the most appropriate for presenting the results.

Total Sample Size of Survey: 5,000

	Billboard	Poster	TV Advertisement	Radio Advertisement	Community Event	Total
Urban Residents	118	237	567	1,233	345	2,500
Rural Residents	39	445	297	1,441	278	2,500
Total	157	682	864	2,674	623	5,000

Chart/Graph:

### Exercise #2

**Scenario:** The following results are from a survey conducted to assess the target population’s exposure to the HIV campaign and its different components. The data below represent the number of respondents that recalled spontaneously, and/or when prompted, seeing the HIV campaign’s TV advertisement. Please develop a graph that displays the results (visually) of those who recalled the TV advertisement, by district. Use the type of graph or graphs that you think would be the most appropriate for presenting the results.

Total Sample Size of Survey: 600

District	# of Respondents Who Spontaneously Recalled TV Advertisement	# of Respondents Who Recalled TV Advertisement When Prompted	# of Respondents Who Did Not Recall TV Advertisement	Total
A	64	28	8	100
B	43	21	36	100
C	27	8	65	100
D	48	23	29	100
E	55	27	18	100
F	19	11	70	100

Chart/Graph:

### Exercise #3

**Scenario:** Your project has been conducting yearly surveys in your programme area to track whether there are increases in the number of women of reproductive age (aged 15–49) who have been tested for HIV and know their status. Use the data in the table below to calculate the indicator (percentage of women aged 15–49 who have been tested and know their status). The example of survey year 2008 has been done for you. After you have calculated the percentages, develop a graph that will show whether the project has improved the percentage of women who know their HIV status from the beginning of the project in 2008 to the end in 2012. Use the type of graph or graphs that you think would be the most appropriate for presenting the results.

Year of Survey	# of Women Surveyed Aged 15–49 Who Have Been Tested for HIV and Know Status	Total Women Aged 15–49 Sampled	% of Women Aged 15–49 Who Have Been Tested and Know Their Status
2008	565	1,000	56%
2009	615	1,250	
2010	590	1,300	
2011	750	1,250	
2012	725	1,100	

Chart/Graph:

### Exercise #4

**Scenario:** Your programme is doing peer outreach in the communities in which it works to promote messages around the importance of reducing the number of sexual partners one has at the same time. The table below shows the number of males and females (aged 15–49) reached with these messages by the peer educators over the past 6 months. Develop a graph that will demonstrate the programme’s progress in its peer outreach activities over the past 6 months. Use the type of graph or graphs that you think would be the most appropriate for presenting the results.

Month	# of Males Reached	# of Females Reached	Total # Reached With Message
January	110	105	215
February	120	125	245
March	115	120	235
April	135	140	275
May	140	155	295
June	155	170	325
Total	775	815	1,590

Chart/Graph:

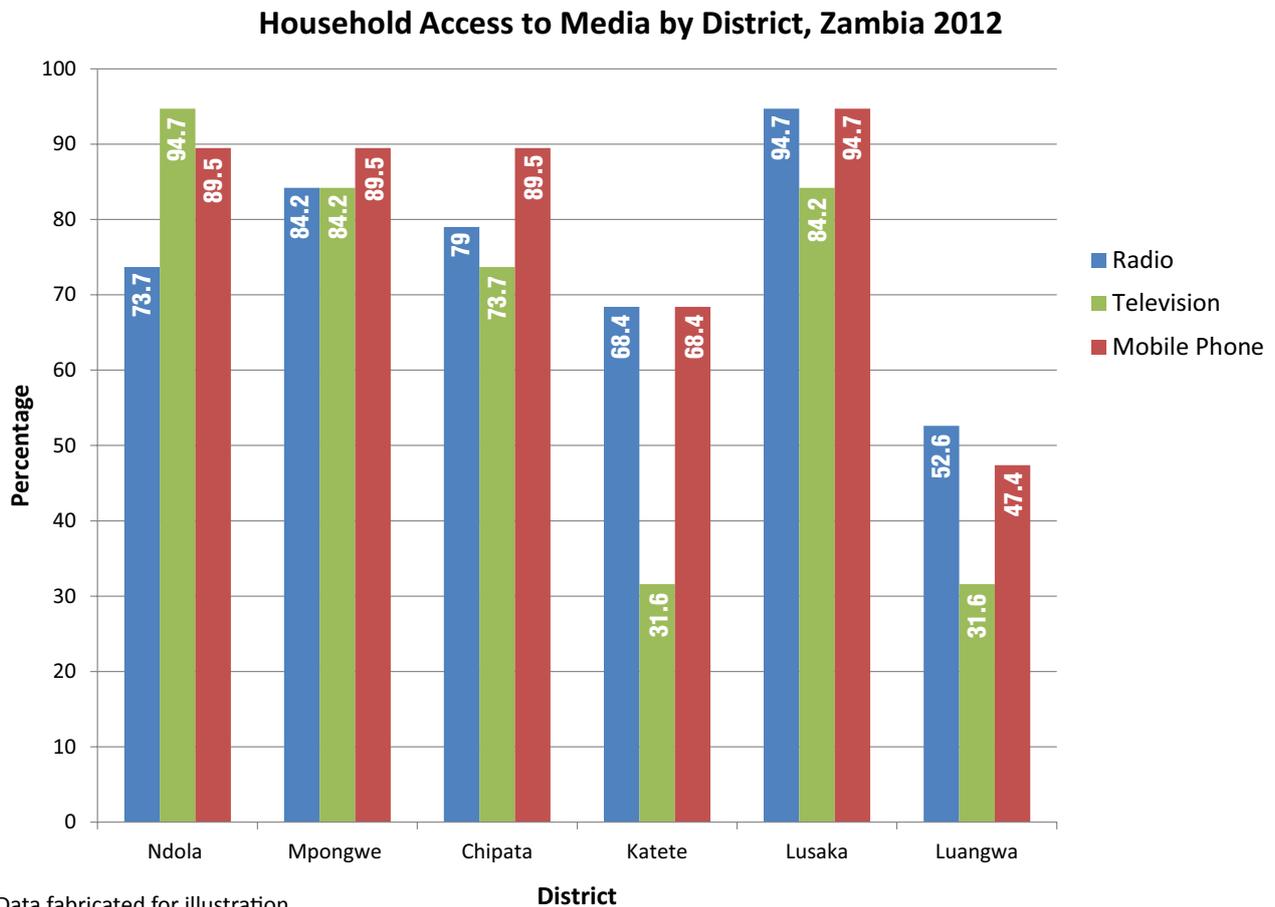
## Scenario Exercise: Data Interpretation

### Example 1: Household Access to Media by District, Zambia 2012

**Brief Description of Graph:** This graph shows access to various media at the household level (i.e., household owns a radio, TV, and/or mobile phone) by district in Zambia.

#### Discussion Questions:

1. Looking at this graph, which districts have the best coverage across the three media forum?
2. If you are a programme manager trying to decide what media forum(s) to use for your campaign in these districts, what would you recommend if you wanted to reach the greatest amount of people?
3. In what areas would you probably recommend using television programmes? Text messaging? Radio programmes?



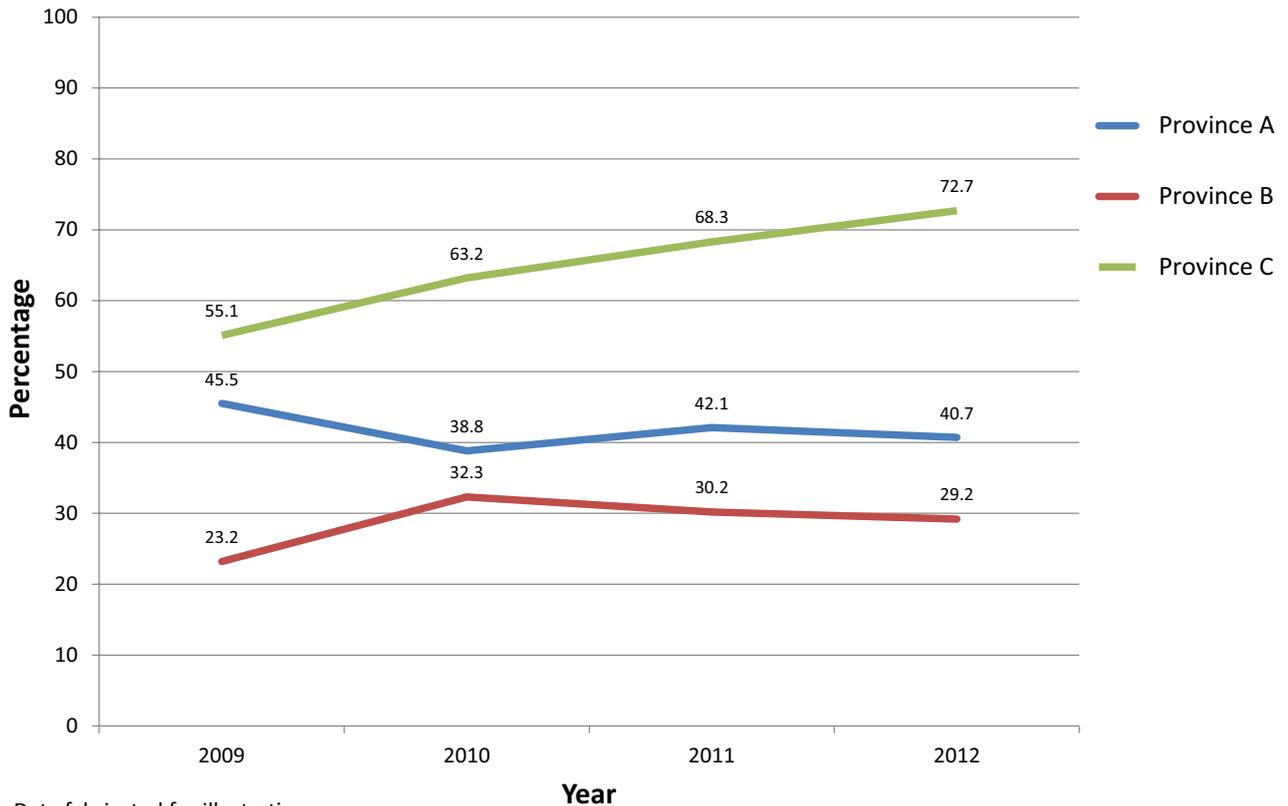
**Example 2:** Percentage of Adults Aged 15–49 Reporting Use of a Condom During Last Sex Act, by Province, 2009–2012

**Brief Description of Graph:** This graph demonstrates trends over time in the proportion of adults (aged 15–49) who used a condom during last sex act across three different provinces in Country X, from 2009–2012.

**Discussion Questions:**

1. If you are working on a communications campaign in these areas promoting condom use, what does this graph tell you about your progress in these three provinces of the country?
2. How are Provinces A, B, and C doing in terms of condom use?
3. Based on these results, what changes might you make to your programme to improve condom use in Provinces A and B?

**Percentage of Adults Aged 15–49 Reporting Use of a Condom During Last Sex Act, by Province, 2009–2012**



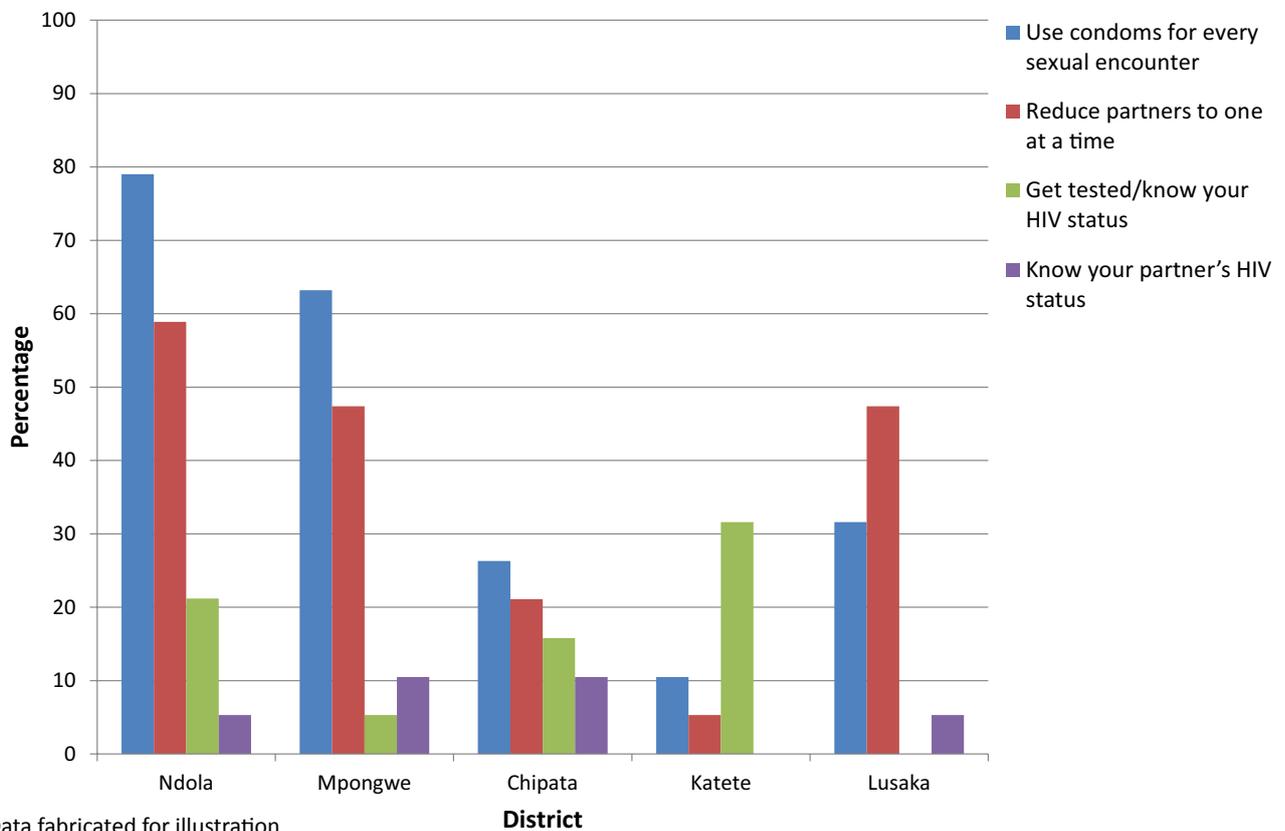
**Example 3: Recall of HIV Campaign Messages Amongst Targeted Population by District, Zambia 2011**

**Brief Description of Graph:** The graph demonstrates the targeted population’s spontaneous recall of the messages of the HIV campaign, by the districts that were sampled in the survey.

**Discussion Questions:**

1. In general, what does this graph tell you?
2. What message(s) were the most recalled? The least recalled?
3. What districts have better recall of the messages? Which have the least recall?
4. As a programme manager, what does this tell you about your programme? What might you do to improve the programme based on these results?

**Recall of HIV Campaign Messages Amongst Targeted Population by District, Zambia 2011**



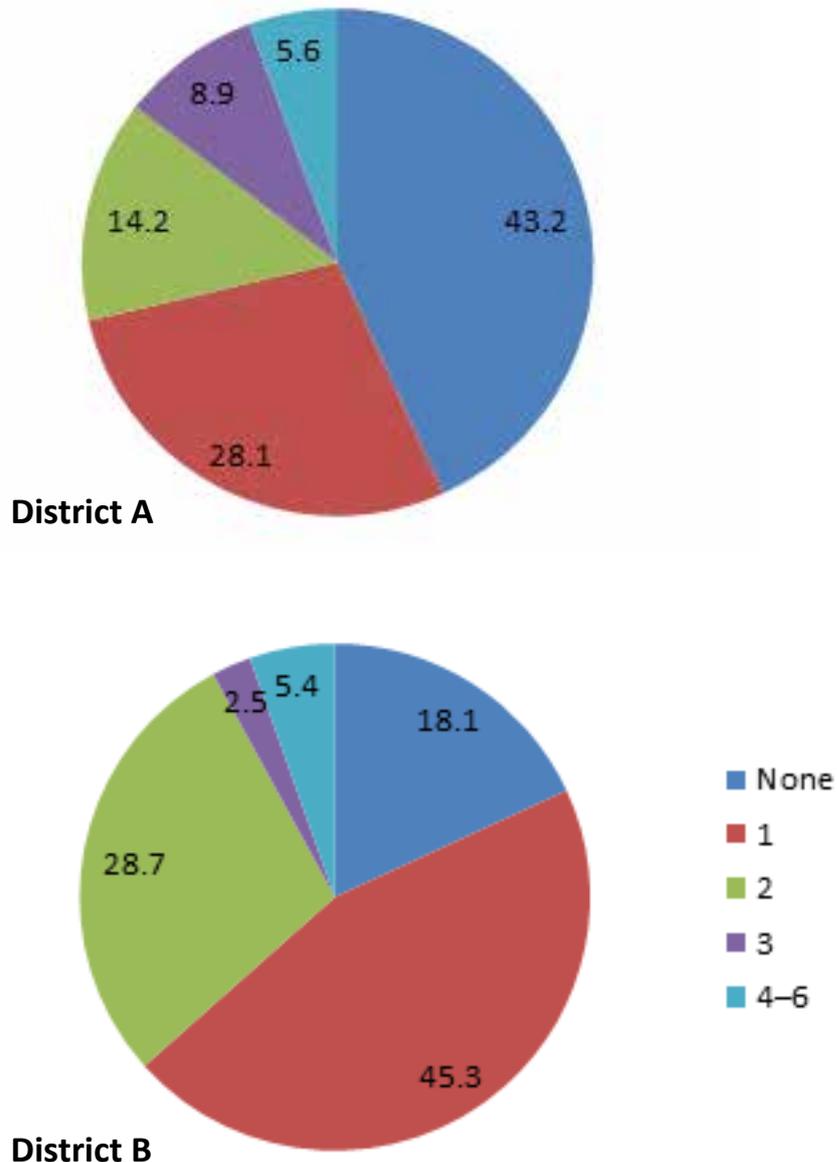
**Example 4:** Number of HIV Campaign Products/Materials Reported Seen by Targeted Audience, 2012

**Brief Description of Graph:** This graph is from a survey where the targeted audience was asked to recall how many different products/materials (e.g., billboards, brochures, pamphlets) they had seen from the campaign.

**Discussion Questions:**

1. What do these graphs tell you?
2. Does the campaign seem to have good coverage in terms of reaching its targeted audience with its various products/materials?
3. How does the coverage of the campaign’s products vary by districts?
4. Based on these findings, what recommendations might you put forth for improving coverage in District A?

**Number of HIV Campaign Products/Materials Reported Seen by Respondents, by District, 2012**



## Malaria Campaign Exercise

### Campaign Rationale

#### Prevalence

Malaria continues to be a major cause of morbidity and mortality in Zambia. According to the Health Management Information System (HMIS), Zambia had 3.2 million cases of malaria in 2009. Malaria also contributes significantly to mortality in children under the age of 5 years and continues to be a threat to pregnant women and infants.

#### Prevention Efforts

The use of insecticide-treated nets (ITNs) is one of the primary strategies for preventing malaria transmission in Zambia. Results from the 2010 Malaria Indicator Survey (MIS) show that 70 percent of Zambian households have at least one mosquito net, and 64 percent of households have at least one ITN. Further, the 2010 MIS indicates that 55 percent of all Zambian children under the age of 5 years slept under a mosquito net the night before the survey, representing an increase from 2008. This is despite challenges in increasing overall net availability in the country. In addition, the results indicate that 90 percent of children under 5 years of age who slept under a net the night before the survey slept under a treated net.

### Campaign Description

The goal of the malaria campaign is to reduce the number of new infections and mortality rates due to malaria.

The campaign will focus on the following promotion of consistent use of ITNs by pregnant women and mothers with children under 5 years of age.

### Campaign Audiences and Objectives

The target audiences include

- Pregnant women aged 15–49 years in both rural and urban areas;
- Parents and guardians of pregnant girls and young mothers;
- Mothers aged 15–39, in both rural and urban areas, who have children under 5 years of age;
- Male partners aged 15–59 years in both rural and urban areas;
- Health workers at health facilities; and
- Community health workers and volunteers.

The overall objective is to increase the correct and consistent utilisation of ITNs amongst women with children under 5 years of age and amongst pregnant women in Zambia.

Our specific objectives are to

- Increase the number of men and women who hang and use ITNs correctly,
- Increase the number of pregnant women who sleep under ITNs consistently,
- Increase the number of children under 5 years of age who consistently sleep under ITNs, and
- Reduce the number of people who misuse ITNs.

## Snapshot of Campaign Implementation Plan

Activity	Description
Mass media	National and community radio (on 10 community radio stations across each of the 4 priority provinces).
Malaria Q&A booklets	10-page A2-size booklet with common questions and answers about malaria prevention, diagnosis, and treatment.
Malaria flyer	Flyer containing basic facts about malaria.
Theatre for communities	Script developed in English, will be translated into local languages.





## Sample Campaign Strategy

### I. Background

Zambia as a nation has made extensive progress in recent years towards achieving the Millennium Development Goals. The Zambian health system continues to improve, and access to services is increasing. However, a number of health issues persist. One critical issue is maternal mortality. Zambia's maternal mortality ratio of 591 per 100,000 live births<sup>1</sup> ranks amongst the highest in the world. This mortality is attributable to a number of complex and interwoven factors. Low contraceptive use in Zambia has resulted in high fertility trends over the years, with a current average fertility rate per woman of 6.3<sup>2</sup>. Only about half of pregnant women initiate antenatal care (ANC) by 5.1 months of gestation,<sup>3</sup> preventing the opportunity for early detection of danger signs and adequate management of maternal complications.

Half (52 percent) of all births occur at home, with rural areas recording much higher rates of home births than urban areas (66.5 percent as compared with 15.7 percent). But even when a woman delivers in a facility, utilisation of postpartum care services is extremely low. Nationwide, more than half (51 percent) of women do not receive any postnatal care.<sup>4</sup>

To directly address these challenges, the Government of the Republic of Zambia (GRZ), as party to the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) framework, is launching aggressive efforts in both service delivery and creation of demand for services, with the goal of reducing its maternal mortality ratio (MMR) to 162 in 100,000 by 2015.

In support of this effort, the United States Government, through its Communications Support for Health (CSH) project, is supporting the GRZ in launching a national "campaign to promote safe motherhood." CSH and the GRZ, together with a number of implementing stakeholders, have identified several key areas where demand creation and individual and collective behaviour change are critical to the success of the initiatives. Specifically, women should choose and practise a modern contraception method prior to their first and between subsequent pregnancies; once pregnant, women and their partners need to understand the importance of and seek early ANC, complete at least four ANC visits prior to delivery, plan for and deliver their baby in a facility, and seek adequate postpartum follow-up at prescribed intervals after the baby is born (6 hours, 6 days, and 6 weeks). The campaign to promote these behaviours will run from 2012 until at least 2014.

### II. Process

Work on this campaign began in mid-2011 with consultative meetings with all partners working in maternal/reproductive health in the country in order to determine the overall framework for the campaign and the key issues that will be addressed. Formative research and a literature review of existing research were conducted before the final strategy for the campaign was developed. A design workshop was held outside Lusaka in early November 2011 to decide on the main activities and communications products that the campaign would support, and subsequent follow-up meetings were held with additional partners to ensure consensus on these concepts. The campaign will be launched in late March 2012.

### III. Vision

The campaign is a new communications initiative designed to run for 2 years, starting in March 2012. It will directly support efforts under the pan-African CARMMA framework and will

<sup>1</sup> Zambia Demographic and Health Survey, 2007.

<sup>2</sup> World Bank Development Indicators, 2009.

<sup>3</sup> Zambia Demographic and Health Survey, 2007.

<sup>4</sup> Zambia Demographic and Health Survey, 2007.

also align closely with the United States Agency for International Development's (USAID) Saving Mothers' Lives (SML) programme in the four districts where SML will focus. The campaign will take a comprehensive approach and will work at many levels of society to ensure that the results, as described below, are achieved.

#### IV. Impact

The lasting impact that this campaign seeks to have is ultimately a contribution to the GRZ goal of reducing maternal mortality in Zambia from 591 to 162 per 100,000.

#### V. Goals

The goals of this campaign are a set of six key behaviours practised by specific people that individually and collectively will translate into impact. These goals are

- To increase the percentage of women who use a modern method of family planning by 15 percent (from 32.7 percent to 47.7 percent);
- To increase the percentage of women initiating ANC services (focused antenatal care) before 16 weeks by 20 percent nationwide;
- To increase the percentage of women who complete at least four ANC visits by 20 percent nationwide;
- To increase the percentage of women who have created a birth plan by 40 percent (no baseline measured in the Demographic and Health Surveys (DHS); will be measured by CSH baseline);
- To increase the percentage of women delivering in a facility by 25 percent nationwide (from less than 50 percent to 75 percent); and
- To increase the percentage of women who receive three postpartum check-ups (6 hours, 6 days, and 6 weeks) by 25 percent (baseline data measured for one postpartum check-up received within two days (39 percent). Baseline for this specific goal will be established by CSH).

The timeframe for achieving these objectives is 2 years, the life of the campaign. Baseline figures given here are from the 2007 Zambia DHS, but will be updated using a baseline that will be conducted by CSH in the initial stage of the campaign development.

These specific behaviours were chosen at the exclusion of others, including nutrition-related behaviours such as using iron folate or increasing daily caloric intake, and adolescent reproductive health behaviours such as delaying sexual debut, because other campaigns (e.g., the Ministry of Health (MOH)/CSH 1,000 days campaign) will cover these behaviours. Further, selecting these most critical behaviours will ensure that the campaign stays focused for maximum impact.

#### VI. Audience Groups

Although the primary audience group for promotion of all of the key behaviours are pregnant women of any age, secondary target audience groups include other relevant family and community members, namely Safe Motherhood Action Groups (SMAGs), partners of pregnant women, traditional leaders, extended family members of pregnant women, and the community at large. Additionally, because the rates of facility-based deliveries and complete ANC attendance are much

higher in urban areas, much of the focus for this campaign will take place in rural areas through innovative strategies to reach women with less access to traditional media. However, urban women will still be exposed and, therefore, will benefit from the many mass media aspects of the initiative.

## VII. Summary of Research Findings

In an effort to understand the context for promoting these behaviours, CSH (in partnership with the MOH) conducted an extensive literature review on existing research on these practices, as well as its own formative research activity. Key findings are summarised below by topic.

### Antenatal Care

Knowledge about ANC is high; specifically, participants report knowing that they should plan for birth, the possible risks of malaria during pregnancy, and the necessity of knowing one's HIV status during pregnancy. Women also know some of the most common danger signs during pregnancy, including bleeding, vomiting, swelling of feet and legs, dizziness, and/or shortness of breath, reporting that a woman experiencing these symptoms should be rushed to a health facility.

In general, ANC is seen as beneficial because it contributes to safe delivery, especially in cases of pregnancy complications. This perception is reflected in the very high rates of women accessing at least one ANC visit (94 percent). However, only 60 percent of women attend the recommended four minimum ANC visits, and only half initiate care before their fifth month.<sup>5</sup> Most women indicate that the primary reason they do not seek ANC earlier is to reduce the number of times that they have to attend, and therefore pay transport to, the antenatal clinic. Others believe that it is not possible for health care providers to know any information on the baby during the early stages of pregnancy and, as such, there is no real reason to attend until the baby can be felt. Others see ANC as only for use to handle complications in pregnancy, and there are generally fewer visible/noticeable complications during early pregnancy than in later stages.

Amongst the services received by pregnant women at the ANC visit are check-ups for weight and blood pressure and an external physical exam to determine the condition of the baby. Generally, the quality of health care services is reported to be adequate and seemed to be measured by the type of reception received at the health centre or whether one was able to find the necessary answers to questions or help for a problem. However, many women also register dissatisfaction with services stemming from a long wait on queues before being attended to or the lack of adequate attention from health care providers.

### Delivery

Nearly half of all pregnant women deliver from home, either unintentionally or intentionally. The reasons for this include women failing to recognise the signs of labour in time, being embarrassed about not being able to buy the items needed to prepare for the birth of the baby, and not understanding or believing the risks of home delivery. Some are unable to pay for transportation or, in some cases, find transportation on short notice when labour starts. Staff shortage at clinics is also a barrier to facility delivery, as many women report having heard stories of, or experienced firsthand, instances where a traditional birth attendant who accompanies the mother to the facility ends up delivering her at the facility because there is no skilled attendant.

The United Nations Population Fund estimates that 605 additional trained midwives are necessary in Zambia to achieve 95 percent coverage of skilled attendants at delivery. Currently, nationwide there are 0.8 medical professionals (doctors or nurses) per 1,000 people. These systems issues directly influence a family's motivation to expend the financial and emotional effort of delivering in a facility.

<sup>5</sup> Zambia Demographic and Health Survey, 2007.

### Postpartum Care

As mentioned, utilisation of postpartum care is very low. Women are intently focused on the newborn in the postpartum period and, as such, do not prioritise their own care-seeking, especially when no problems are evident. The MOH has established a policy for postpartum care, recommending that a woman be checked through a physical examination at 6 hours, 6 days, and 6 weeks postpartum. Research indicates that even for women delivering in facilities, many leave well before 6 hours if the delivery itself was uncomplicated. Further, few women seek out a skilled attendant for the 6-day exam. Reasons given include a lack of awareness about the necessity of this exam, as well as cultural beliefs preventing a mother from leaving the house with a newborn in the first month of life. Many women do seek the 6-week postpartum exam because they are already going to the clinic to have their child immunised.

### Family Planning

The research is consistent in finding that knowledge about the use and benefits of contraceptives was fairly high, although the contraceptive prevalence rate for the country is still low at 41 percent.<sup>6</sup> The benefits of family planning reported by women included child spacing, limiting the number of children in a family to enable parents to care for all children adequately and to allow mothers an easier life. The most commonly known and used contraceptives in Zambia are the pill, injectables/Depo-Provera, and condoms. Contraceptives are generally available either through health facilities or pharmacies, although stock-outs are not uncommon.

Most of the information on modern contraceptives was obtained from health care providers and community health workers, and women say that this information is generally understood and accepted by the community. However, many women choose not to use family planning because of a fear of side effects—both accurate side effects and false ones, such as cancer and infertility. Additionally, some women report not using contraceptives because the health provider herself doubts their efficacy or safety.

The women who do use modern contraceptives say that they do so because their benefits were perceived to override the side effects. This was further enhanced by the women's ability to change contraceptives for ones that had fewer side effects. The choice of contraceptives was also based on the frequency and length of the stock-outs for that particular product. Decision making on the use of modern contraceptives was primarily a prerogative of the woman, with input from husbands. In some cases, despite a husband's refusal to use contraceptives, women choose to continue or initiate use of a method that does not require the husband's knowledge, such as injectables. Some women use traditional contraceptives. However, many do not, as there is a general perception that traditional methods are less effective and not easily accessible.

### Male Involvement in Issues of Safe Motherhood

Many men feel that pregnancy and childbirth are the domains of the woman. Although some do attend ANC with their partners, most do not and are not involved in saving money for transportation for ANC and delivery. Further, some women report that their partners are interested in them attending the ANC visit to get the HIV test, but they use the test results of the pregnant woman as a proxy for their own, rather than also getting tested.

### Traditional Leader Involvement in Issues of Safe Motherhood

In some districts in Zambia, the chief has taken it upon himself to issue policies whereby every woman delivers in a facility, with a penalty or fine imposed for those who do not. Many chiefs keep birth and death records and view themselves as being able to play a strong role in the decisions

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<sup>6</sup> UNICEF Country Statistics, Zambia.

people make in their life, including intimate moments such as childbirth. These success stories and the influence that these leaders can have on the decisions people make are being leveraged by CARMMA. Meetings have already been held to bring together chiefs to discuss how they might be involved.

### Channels for Accessing Information on Safe Motherhood

Information on issues during pregnancy, delivery, and postpartum was generally accessed through SMAG members or other community volunteers at the community level. Many organisations are currently working across Zambia to strengthen these various groups, but in many cases, they are still unequipped with the tools and training necessary to execute their jobs. People report the greatest level of trust in information obtained from a trained professional, such as a nurse or doctor, and access information at clinics when there for other reasons, although the time that the health provider has available to spend counselling each pregnant women is very limited. Information is also obtained from peers in the community, such as female parents, neighbours, and friends. Many myths and misconceptions about facility delivery, family planning, and postpartum issues are reinforced by perceived social norms and collective opinions.

### Synthesis

Using a model of behaviour change called “Opportunity/Ability/Motivation,” which is depicted in Appendix 1, the following critical barriers to the key behaviours were extracted from the research:

- Fear of HIV test as part of ANC;
- Disbelief in benefit of early ANC;
- Fear of process/experience of facility delivery;
- Disbelief that facility delivery is necessarily safer;
- Weak social support/involvement of families, leaders, etc. (and a corresponding lack of willingness to allocate financial and emotional resources to care-seeking);
- Transportation/access issues;
- Perception of lack of quality in clinics;
- Perception by pregnant women that the quality of care and treatment by health personnel is inadequate;
- Lack of preparation/birth planning;
- Fear of family planning side effects; and
- Lack of knowledge on diversity of family planning options.

### VIII. Communication Objectives

The communication objectives for this campaign will specifically address the key barriers (listed above). The following table shows the link between the key barriers, the communication objectives, and how these will be measured (indicators list).

Critical Barrier	Communication Objective	Indicators
<ul style="list-style-type: none"> <li>• <b>Fear of HIV test as part of ANC.</b></li> <li>• <b>Disbelief in benefit of early ANC.</b></li> <li>• <b>Fear of process/ experience of facility delivery.</b></li> <li>• <b>Disbelief that facility delivery is necessarily safer.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Convince women of importance/reasoning for early initiation of ANC, completing all four behaviours.</li> <li>• Demystify what happens in ANC during facility delivery and postpartum.</li> <li>• Address concerns around HIV test—how and when to get your partner involved, what the test is like, what happens if you are positive, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase percentage of women who report feeling confident that they can seek and obtain the necessary care to deliver a healthy baby by X percent.</li> <li>• Increase percentage of pregnant women who can identify at least three danger signs in pregnancy and labour by X percent.</li> <li>• Increase percentage of pregnant women who believe that a facility-based delivery is compatible with traditional ways by X percent.</li> <li>• Increase number of pregnant women who say that delivery in a facility is safer than delivery at home by X percent.</li> <li>• Increase number of pregnant women who agree that taking an HIV test is a critical step to ensuring a healthy baby by X percent.</li> <li>• Increase percentage of couples who discuss the HIV test and its implications by X percent.</li> <li>• Increase number of women who say that pregnancy carries special risks that need extra care from trained professionals from X percent to X percent.</li> </ul>

Critical Barrier	Communication Objective	Indicators
<ul style="list-style-type: none"> <li>• <b>Weak social support/ involvement of families, leaders, etc. (and a corresponding lack of willingness to allocate financial and emotional resources to care-seeking).</b></li> </ul>	<ul style="list-style-type: none"> <li>• Increase involvement of men in supporting women to practise key behaviours.</li> <li>• Increase social support for key behaviours.</li> <li>• Motivate “community change champions” to support mothers in seeking services, from ANC to family planning.</li> </ul>	<ul style="list-style-type: none"> <li>• Create a change champion in X percent of communities.</li> <li>• Increase percentage of men who believe that they have a role in family planning, pregnancy, and childbirth by X percent.</li> <li>• Increase percentage of men who say they support their wives completing all four ANC visits and delivering in a facility by X percent.</li> <li>• Increase percentage of men who support partners/wives in practising family planning from X percent to X percent.</li> <li>• Increase percentage of mothers and mothers-in-law of pregnant women who say they support the pregnant woman delivering in a facility by X percent.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Perception of lack of quality in clinics.</b></li> <li>• <b>Perception of pregnant women that quality of care and treatment by health personnel is inadequate.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Improve attitude/ quality of counselling skills on safe motherhood issues by health worker.</li> <li>• Change perception of quality at clinics.</li> <li>• Increase quality of interpersonal communication (IPC) messages in communities.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase number of women who rate their interaction with the health worker at the health clinic for ANC visits as excellent from X percent to X percent.</li> <li>• Increase number of women who report the opinion that all ANC visits are worthwhile from X percent to X percent.</li> <li>• Increase percentage of health workers who use the counselling materials with women by X percent.</li> <li>• Increase percentage of SMAGs who say they have appropriate tools for doing their job by X percent.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Transportation/ access issues.</b></li> <li>• <b>Lack of preparation/ birth planning.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Increase awareness of the necessity of birth planning and what birth planning means.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase number of couples who have completed a birth plan, including transportation savings, from X percent to X percent.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Fear of family planning side effects.</b></li> <li>• <b>Lack of knowledge on diversity of family planning options.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Address concerns and fear of side effects of family planning.</li> <li>• Increase knowledge on options for family planning.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase percentage of women who believe that modern contraception is safe from X percent to X percent.</li> <li>• Increase percentage of women who say they understand at least three options for family planning from X percent to X percent.</li> </ul>

(Note: Baseline and target numbers for all communications objectives will be determined by the baseline survey that CSH will conduct.)

## IX. Activities, Communications Tools, and Key Messages

In order to effectively deliver on these communications objectives and address the critical barriers, the MOH and CSH will carry out a broad range of activities. All activities will be nationwide, but they will be conducted at various levels: in communities, in health facilities, and via mass media—including mobile. CSH will implement some, such as mass media, directly in partnership with the GRZ and with support from the Technical Working Group and other U.S. Government partners. Some activities, however, are already being programmed and planned by other implementing agencies. In these cases, CSH’s role will be one of providing communications tools and resources to support those activities. **CSH understands that many of these tools are already in development or planned to be developed by partners. Through the GRZ/MOH, CSH will work with all partners to ensure that no products are duplicated and that the necessary tools are adapted and duplicated.**

The activities, products, intended user, and audience for the product are described in the table below, organised by the specific communication objective in which they will contribute to achieving.

Communication Objective	Activities	Communication Products	User/Audience
<ul style="list-style-type: none"> <li>• Convince women of importance/reasoning for early initiation of ANC, completing all four behaviours.</li> <li>• Demystify what happens in ANC, during facility delivery, and postpartum.</li> <li>• Address concerns around HIV test, such as how and when to get your partner involved, what the test is like, and what happens if you are positive.</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Use SMAGs and other community volunteers to counsel and educate women on family planning options, the necessary care to take once a woman gets pregnant, and the risks of pregnancy (early through postpartum period) and how to avoid them (in groups and house-to-house) as well as to reward families who are “safe.”</li> </ul> <p><b>Clinic Level</b></p> <ul style="list-style-type: none"> <li>• Use waiting rooms to air “Journey to Becoming a Parent” four-part series of videos or radio programmes on different aspects of pregnancy, delivery, and postpartum care.</li> <li>• Use health workers to provide additional counselling and explanations of what they are doing, and why and what the mother should be thinking about.</li> <li>• Produce low-text posters to reinforce messages (or where there is no radio/TV capability).</li> </ul> <p><b>Mass Media</b></p> <ul style="list-style-type: none"> <li>• Air national TV and radio “Journey to Becoming a Parent” four-part documentary series.</li> <li>• Use community radio to foster discussions and provide depth.</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Job aid “tool-kits” for SMAGs, with flipcharts and pictorial birth plan forms.</li> <li>• Certificates for “Safe Families” as recognition of a successful facility delivery and all postpartum follow-up visits.</li> </ul> <p><b>Clinic Level</b></p> <ul style="list-style-type: none"> <li>• “Journey to Becoming a Parent” documentary</li> <li>• Counselling checklist</li> <li>• Posters</li> </ul> <p><b>Mass Media</b></p> <ul style="list-style-type: none"> <li>• “Journey to Becoming a Parent” documentaries (TV and radio)</li> <li>• Discussion guides for community radio stations</li> </ul>	<p>User = SMAG or other community volunteer in communities, health worker in clinics</p> <p>Audience = women pre-pregnancy, pregnant women, extended families</p>

Communication Objective	Activities	Communication Products	User/Audience
<ul style="list-style-type: none"> <li>• Increase involvement of men in supporting women to practise key behaviours.</li> <li>• Increase social support for key behaviours.</li> <li>• Motivate “community change champions” to support mothers in seeking services, from ANC to family planning.</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Involve traditional and other leaders in a “Change Champions” programme.</li> <li>• Conduct outreach/meetings with men in gathering places or workplaces.</li> </ul> <p><b>Clinic Level</b> N/A</p> <p><b>Mass Media Level</b></p> <ul style="list-style-type: none"> <li>• Champion chiefs documentary and associated road show</li> <li>• Province-specific radio ads featuring local chiefs</li> <li>• “Becoming a Parent” documentary</li> <li>• “Becoming a Parent” radio documentary</li> <li>• Newspaper inserts for leaders</li> <li>• Newspaper inserts for men</li> <li>• Flyers/pamphlets/billboards for men on becoming a father and on family planning</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Materials for chiefs interested in becoming a champion chief.</li> <li>• <i>Becoming a Father</i> fact sheets.</li> <li>• Family Planning—the Man’s Role fact sheets.</li> </ul> <p><b>Clinic Level</b> N/A</p> <p><b>Mass Media Level</b></p> <ul style="list-style-type: none"> <li>• Champion chiefs documentary</li> <li>• Province-level radio ads for chiefs</li> <li>• “Becoming a Parent” four-part TV and radio documentary</li> <li>• Print materials for men (e.g., flyer, newspaper)</li> </ul>	<p>Change champions use materials to guide goal selection and activities (e.g., talks, discussion forums); Audience members are chiefs themselves, other leaders, and ultimately their communities.</p> <p>Community volunteers or SMAGs use materials for men to provide outreach, structure conversations with men; audience is ultimately men.</p>

Communication Objective	Activities	Communication Products	User/Audience
<ul style="list-style-type: none"> <li>• Increase quality of IPC messages in communities.</li> <li>• Improve attitude/quality of counselling skills on safe motherhood issues by health worker.</li> <li>• Change perception of quality at clinics.</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Provide support materials to SMAGs and other volunteers.</li> <li>• Provide quality IPC job aids to SMAGs and other volunteers.</li> </ul> <p><b>Clinic Level</b></p> <ul style="list-style-type: none"> <li>• Create counselling checklist for health worker/provider to use on issues of safe motherhood.</li> </ul> <p><b>Mass Media Level</b></p> <ul style="list-style-type: none"> <li>• Radio ads targeted to health workers promoting their role in safe motherhood.</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Support items for SMAGs (e.g., vests and bags).</li> <li>• SMAG job aid toolkit.</li> </ul> <p><b>Clinic Level</b></p> <ul style="list-style-type: none"> <li>• Counselling checklist</li> </ul> <p><b>Mass Media Level</b></p> <ul style="list-style-type: none"> <li>• Motivational radio ads (two versions) for health workers</li> </ul>	<p>User and audience = SMAGs/other community volunteer</p>
<ul style="list-style-type: none"> <li>• Increase awareness of the necessity of birth planning and what birth planning means.</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Use SMAGs and other community health workers (CHWs) to distribute and help couples use picture-based birth plans to think through and plan all activities around getting pregnant, being pregnant, and having the baby.</li> </ul> <p><b>Clinic Level</b></p> <ul style="list-style-type: none"> <li>• The same birth plan will be usable by health workers to counsel mothers-to-be on planning.</li> </ul> <p><b>Mass Media Level</b></p> <ul style="list-style-type: none"> <li>• As part of radio and TV documentaries, the steps to plan for birth will be reinforced.</li> <li>• Separate radio announcements.</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Picture-based birth plan</li> </ul> <p><b>Clinic Level</b></p> <ul style="list-style-type: none"> <li>• Picture-based birth plan</li> </ul> <p><b>Mass Media Level</b></p> <ul style="list-style-type: none"> <li>• One 60-second radio spot on how to plan for birth</li> </ul>	<p>User = SMAG or other volunteer in communities, health worker in clinics</p> <p>Audience = ultimately the woman and her partner/extended family</p>

Communication Objective	Activities	Communication Products	User/ Audience
<ul style="list-style-type: none"> <li>• Address concerns and fear of side effects of family planning.</li> <li>• Increase knowledge on options for family planning.</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Use SMAGs and community-based distributors of family planning services to offer counselling to women before and between pregnancies.</li> <li>• Work through schools to reach girls just before the average age of marrying to discuss what family planning is and explain that it is safe and that there are options when they are ready.</li> <li>• Work through traditional counsellors to offer counselling on family planning options and safety.</li> </ul> <p><b>Clinic Level</b></p> <ul style="list-style-type: none"> <li>• Use posters to dispel myths about safety of family planning.</li> <li>• Play first part of the “Journey to Becoming a Parent” series, which will deal with family planning issues in waiting areas.</li> <li>• Use health workers to provide counsellors to women during pregnancy and immediately afterwards on family planning.</li> </ul> <p><b>Mass Media Level</b></p> <ul style="list-style-type: none"> <li>• “Journey to Becoming a Parent” radio and TV series</li> <li>• Champion chiefs documentary series</li> <li>• Radio ads promoting family planning alone</li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>• Counselling cards on family planning (as part of job aid toolkit for SMAGs)</li> <li>• Fact sheet/ brochure for discussing family planning options with women</li> </ul> <p><b>Clinic Level</b></p> <ul style="list-style-type: none"> <li>• Posters</li> <li>• Documentaries</li> </ul> <p><b>Mass Media Level</b></p> <ul style="list-style-type: none"> <li>• Documentaries</li> <li>• Radio advertisements</li> </ul>	<p>User = SMAG or other community volunteer, traditional counsellor or teacher in communities, health worker in health facilities</p> <p>Audience = women before pregnancy and women in-between pregnancies</p>

## X. Key Messages

The key messages for the campaign are divided by audience group. Note that all of these messages will not be communicated all the time. Depending upon the purpose and audience for the specific product, one or more specific key messages will be highlighted.

### Nonpregnant Women of Childbearing Age

Adolescent girls and women who have not yet had children:

- A baby is a huge responsibility, one that will occupy you for the rest of your life. You have a choice to plan when you take that responsibility.
- Planning your family is safe; there are many options that work well for now, but will still let you have a baby when you are ready.

### Pregnant Women and Other Women of Childbearing Age (who already have at least one child)

- Your body is well made for giving birth, but it needs to rest between pregnancies. Space your children at least 2 years apart.
- There are many safe methods—both temporary and permanent—that you can choose from. If you choose a temporary method, you can still have children when you stop using it.
- Although some people experience minor side effects with some methods, many people don't. If you do, you can always change methods.
- Methods for family planning should always be available from your nearest health centre or via a community drug distributor. These people can also help you figure out what is right for you. (Customise this one based on each district's availability.)

### Pregnant Women

Messages for pregnant women are comprehensive, but specific and different for each stage of the pregnancy, delivery, and postpartum period.

### Overarching Message Concept

Becoming a mother is an amazing process, but it is not without risks. You and your family have the power to reduce those risks. Lean on your partner, your friends, and your family, and plan for a healthy and happy baby!

### During Pregnancy

- As soon as you know you are pregnant, go for ANC.
- At each ANC visit, you will learn a bit more about how your baby is doing. It is critical you go to as many as possible—try for at least four.
- At some ANC visits, you will get medicine, Fansidar, to make sure you and your baby don't get sick from malaria. It is safe for you and baby—just take a bit of food with you to clinic to help it settle in your stomach.
- During your first visit, the clinic will ask to do an HIV test. This test is important because if you are HIV+, you MUST know before you give birth, or you risk passing the disease to your baby. Plus, this way you can get treatment to ensure that you are able to enjoy your baby for a long time.

- The HIV test is quick, easy, and painless. You get your results right away, and only you decide who else should know.
- If possible, have your husband or partner go with you to the visit. Give him one of the fact sheets on becoming a father and talk with him about what you have learnt here.

### Delivery

- Women have been delivering babies forever—it is something we were meant to do, but sometimes problems happen. The baby can get stuck, or your body can start bleeding. In these cases, if you are at home, there is nothing to do. In a clinic, they can save you and the baby.
- Plan now for how to get to the facility for your delivery—save a little bit of money each week/each time you go to the market.
- When you are in labour, if you experience swollen feet (or other danger signs) you must get to a clinic as soon as you possibly can.

### After Delivery

- You still need care after the baby is born—it is still very important that you have your health care provider check you out within 6 hours, at 6 days, and at 6 weeks after you have the baby.
- After you have the baby, it is also time to think about deciding how you will ensure that you will not have another baby until your body is ready. There are many safe options open to you—ask your health care provider for details.

### Fathers-To-Be

- Pregnancy is something that happens to a woman's body, but having a baby is happening to the family.
- A father's role is to help ensure that the mother and the baby thrive:
  - Go with your wife/partner to at least four appointments before the baby is born.
  - Save enough money (a little per week) to pay for transportation to get her to a health facility for delivery or in an emergency.
  - Encourage your wife to return to the clinic for necessary check-ups for her after she has the baby—within 6 hours, after 6 days, and after 6 weeks.
- Your wife/partner's body needs time to rest between pregnancies to ensure that she stays healthy and delivers a big, strong baby.
- Planning your family means you are responsible. Talk with your partner about selecting a family planning method that is right for your family.

### SMAGs

- SMAGs are critical in ensuring that women heed the messages of safe motherhood; interacting with each mother on her own terms, validating her concerns, and encouraging her excitement will allow you to develop a better relationship with the mother, ultimately resulting in her listening to your advice concerning her pregnancy and delivery.

### Traditional Leaders/Chiefs

- As the leader and opinion maker in the community, you/a chief can make a difference in life or death. Become a champion chief and encourage all pregnant women and their partners in your community to go for early and complete ANC and to deliver their babies in facilities.
- Mothers and babies do not only belong to that family, but to the community as a whole. It is our role to make sure that they have the safest start to life and that those little babies have their mothers around to help them grow up.
- Traditional medicine is an important part of life, but not when it leads to death. Women do not need to die to become mothers of our children. As a chief, you have the power to make sure women and their families see that they can still respect their traditions AND have a modern, safe delivery.
- Safe motherhood means ensuring that a woman goes for ANC at a clinic immediately when she finds out she is pregnant, completing at least four visits to ANC, delivering her baby in a health facility, and obtaining postpartum care at 6 hours, 6 days, and 6 weeks after birth.

### Health Workers

- Women deserve respect, a smile, no judgement, and support in this amazing moment in their lives.
- Health workers are the most important voice for a pregnant woman. Use this voice and the new counselling checklist for ANC to wisely counsel the mother to make the best choices possible for her.

### General Public

- Pregnancy is a time of joy but also of risk. We all must do our part to minimise the risks and celebrate the joy.
- Ensuring all women deliver in a facility is everyone's responsibility.
- Possible roles include
  - Help mothers save enough for transportation,
  - Help take care of her other children when she goes to deliver or to the waiting home,
  - Help the mother around her house/with chores like fetching water, and
  - Encourage her to seek the necessary care.

## **XI. Creative Considerations**

### Tone

This campaign will be built on the concept of togetherness, connecting to the collective spirit of Zambian communities and the concept that ensuring maternal health is ensuring the future. It is not an individual mother's responsibility alone to ensure her health and the well-being of her child but, rather, also the responsibility of her family, her community, and her nation.

Name

To reflect the above overall tone of the campaign, possible campaign names include

- Mama Wangu (“Our Mother”)
- The Safest Mother
- My Mother
- Our Promise
- The Right Start
- No More
- Let’s Live
- One Mother
- The Heart of a Mother

Options will be refined (and new possibilities generated) and will be pretested and finalised as part of the creative product development.

Look and Feel

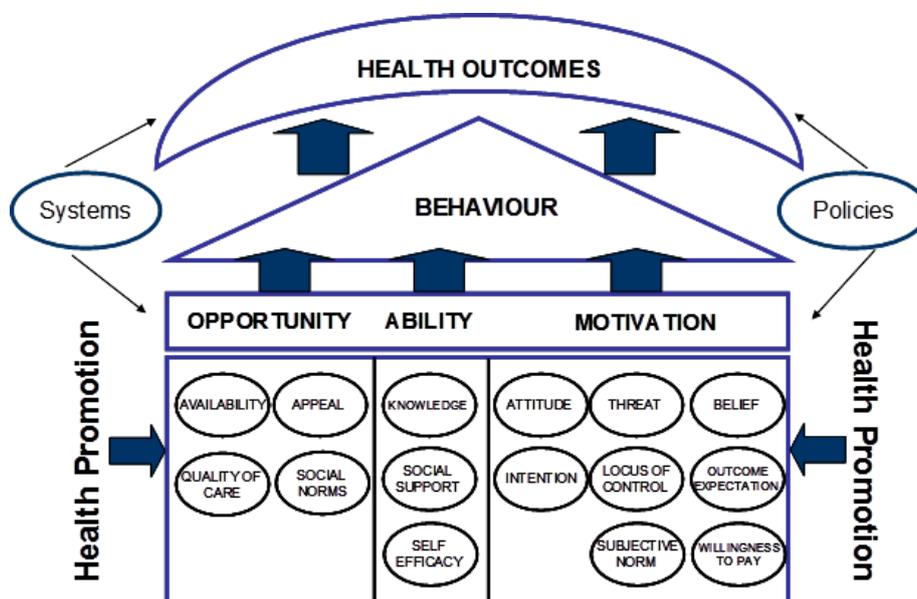
Communications products should be relatable to rural and urban mothers and their families. Products should inspire pride and hope in the capacity of everyone to protect our mothers. Images should be bright and colourful, approachable and fun, rather than sombre. The subject matter is serious, but the outcome is joy—a healthy mother and a healthy baby.

Local Language

All communications products should be as pictorially based as possible, and any text will be translated into all appropriate local languages through a process of translation/back translation.

Appendix 1

This model depicts the theory of behaviour change upon which this campaign is predicated. It was originally developed by Population Services International, but has been adapted by the Manoff Group and CSH to better reflect the inputs of health promotion specifically.



## Sample Monitoring and Evaluation Plan

### I. Introduction

#### Background on Maternal Health Situation in Zambia

Zambia as a nation has made extensive progress in recent years towards achieving the Millennium Development Goals. The Zambian health system continues to improve, and access to services is increasing. However, a number of health issues persist. One critical issue is maternal mortality. Zambia's maternal mortality ratio of 591 per 100,000 live births<sup>1</sup> ranks amongst the highest in the world. This mortality is attributable to a number of complex and interwoven factors. Low contraceptive use in Zambia has resulted in high fertility trends over the years, with a current average fertility rate per woman of 6.3.<sup>2</sup> Only about half of pregnant women initiate antenatal care (ANC) by 5.1 months of gestation,<sup>3</sup> preventing the opportunity for early detection of danger signs and adequate management of maternal complications.

Over half (52 percent) of all births occur at home, with rural areas recording much higher rates of home births than urban areas (66.5 percent as compared with 15.7 percent). But even when a woman delivers in a facility, utilisation of postpartum care services is extremely low. Nationwide, more than half (51 percent) of women do not receive any postnatal care.<sup>4</sup>

To directly address these challenges, the Government of the Republic of Zambia (GRZ), as party to the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) framework, is launching aggressive efforts in both service delivery and creation of demand for services, with the goal of reducing its maternal mortality ratio to 162 in 100,000 by 2015.

In support of this effort, the United States Government, through its Communications Support for Health (CSH) project, is supporting the GRZ in launching a national "campaign to promote safe motherhood." CSH and the GRZ, together with a number of implementing stakeholders, have identified several key areas where demand creation and individual and collective behaviour change are critical to the success of the initiatives. Specifically, women should choose and practise a modern contraception method prior to their first and between subsequent pregnancies; once pregnant, women and their partners need to understand the importance of and seek early ANC, complete at least four ANC visits prior to delivery, plan for and deliver their baby in a facility, and seek adequate postpartum follow-up at prescribed intervals after the baby is born (6 hours, 6 days, and 6 weeks). The campaign to promote these behaviours will run from 2012 until at least 2014.

#### Safe Motherhood Campaign

The Safe Motherhood campaign is a national behaviour change communication campaign focused on changing behaviours related to ANC, family planning (FP), delivery, and postpartum care, ultimately contributing to the reduction in maternal mortality in Zambia. The campaign will be launched in March 2012 and is expected to run for 2 years, until March 2014. The specific goals and objectives for the campaign are outlined in the monitoring and evaluation (M&E) framework for the campaign, in Section 3 below.

The primary audience for the campaign and the promotion of the key behaviours is pregnant women. The secondary target audiences for the campaign include the following: relevant family and community members, namely Safe Motherhood Action Groups (SMAGs); partners of pregnant women; traditional leaders; extended family members of pregnant women; and the community

<sup>1</sup> Zambia Demographic and Health Survey, 2007.

<sup>2</sup> World Bank Development Indicators, 2009.

<sup>3</sup> Zambia Demographic and Health Survey, 2007.

<sup>4</sup> Zambia Demographic and Health Survey, 2007.

at large. Because the rates of facility-based deliveries and complete ANC attendance in the rural areas is much lower than in the urban areas, the focus of many of the campaign's community-level activities will be in the rural areas. However, urban women will still be exposed to the mass media components of the campaign.

A formative research study and literature review were conducted and used to inform the goals, communication objectives, and strategies of the campaign. The campaign will include products and activities at the following levels: (1) community, (2) health facility, and (3) national via different mass media forums. Community-level activities include counselling and education through SMAGs and community health volunteers, carrying out a "Change Champions" programme led by traditional and other community leaders, and having community-level radio discussions. At the health facility level, activities include viewing and airing videos and radio programmes; working with health workers to provide additional counselling; developing counselling checklists and picture-based birth plans for health workers; and developing posters to display in health facilities. For mass media, the activities will include radio spots, TV and radio documentary series, a champion chiefs documentary, province-specific radio ads featuring local chiefs, newspaper inserts, flyers, pamphlets, billboards, and short message service (SMS).

## II. Objectives of the M&E Plan

The objectives of the M&E plan for Safe Motherhood are threefold: (1) to provide relevant and timely information to determine if the campaign activities and strategies are being implemented according to plan and reaching the targeted audience(s), (2) to provide information that informs adjustments to the campaign strategies and activities to improve the campaign's overall effectiveness, and (3) to evaluate whether the campaign interventions have had a positive effect on the outlined goals and objectives. The M&E plan includes a set of indicators that will be used for tracking progress and the effect of the campaign, the data sources, the data collection plan, plans for data reporting, dissemination and use, and the plan for evaluating the campaign.

## III. M&E Framework for Safe Motherhood Campaign

The M&E plan for the Safe Motherhood campaign is based upon the goal, the intermediate and long-term behavioural objectives, and the strategies and activities of the campaign. The M&E framework for the campaign includes the inputs, processes, and outputs that will lead towards the achievement of the intermediate and long-term behavioural outcomes and overall goal or impact of the campaign. This framework serves as the foundation for the M&E plan, as it informs the data that will be collected to show specifically how the inputs, activities, and strategies of the campaign will lead to changes in knowledge, attitudes, self-efficacy, and ultimately behaviour. The overarching goal of the campaign is to change safe motherhood behaviours with the aim of contributing to a reduction in maternal mortality in Zambia, from 591 to 162 per 100,000 live births in 2013.

The six behavioural goals of the Safe Motherhood campaign are as follows:

1. To increase the percentage of women of reproductive age who use a modern method of family planning by 15 percent (from 32.7 percent to 47.7 percent);
2. To increase the percentage of pregnant women initiating ANC services (focused antenatal care) before 16 weeks by 20 percent nationwide;
3. To increase the percentage of pregnant women who complete at least four ANC visits by 20 percent nationwide;
4. To increase the percentage of pregnant women who have created a birth plan by 40 percent (baseline to be determined (TBD));

5. To increase the percentage of pregnant women who deliver in a facility by 25 percent nationwide (from less than 50 percent to 75 percent); and
6. To increase the percentage of women who receive three postpartum check-ups (6 hours, 6 days, and 6 weeks) by 25 percent (baseline TBD).

The objectives of the campaign are organised by the specific health subtopic area under the campaign, including ANC, FP, delivery care, and postpartum care. These objectives focus on the intermediate outcomes that we would expect to see the campaign contribute towards achieving. These include changes in knowledge, attitudes, beliefs, and intentions, and they are the outcomes we would expect to see prior to changes in behaviour (Refer to the six goals of the campaign, above).

#### Antenatal Care

1. To increase the percentage of pregnant women who have planned for transport to a health facility for ANC and delivery care;
2. To increase the percentage of women of reproductive age who believe that there is value in initiating ANC early in pregnancy;
3. To increase the percentage of women of reproductive age who associate taking an HIV test during pregnancy with having a healthy baby;
4. To increase the percentage of couples who discuss the HIV test and its implications;
5. To increase the percentage of pregnant women who can identify at least three danger signs in pregnancy and labour;
6. To increase the percentage of women of reproductive age who know that pregnancy carries special risks that require care from trained health providers;
7. To increase the percentage of men who support their wives in completing all four ANC visits and delivering in a facility;
8. To increase the percentage of pregnant women who are satisfied with the quality of care provided at the health clinic during ANC visits; and
9. To increase the percentage of women who believe that all ANC visits are worthwhile.

#### Family Planning

1. To increase the percentage of women of reproductive age who associate practicing FP with staying healthy and having healthy children;
2. To increase the percentage of women of reproductive age who believe that modern contraception is safe;
3. To increase the percentage of women of reproductive age who know where to access FP;
4. To increase the percentage of women of reproductive age who know at least three options for FP;
5. To increase the percentage of men who believe that they have a role in FP; and
6. To increase the percentage of men who support their partner/wife in practicing FP.

### Delivery Care

1. To increase the percentage of women of reproductive age who report feeling confident that they can seek and obtain the necessary care to deliver a healthy baby;
2. To increase the percentage of pregnant women who believe that a facility-based delivery is compatible with traditional ways;
3. To increase the percentage of pregnant women who believe that a health facility delivery is safer than a home delivery;
4. To increase the percentage of men who believe that they have a role in pregnancy and childbirth;
5. To increase the percentage of couples who have completed a birth plan and saved money for transportation to a health facility for delivery.

### Postpartum Care

1. To increase the percentage of women who believe that both the woman and the newborn require attention from a trained health provider immediately after birth; and
2. To increase the percentage of women who know how many visits to the health clinic they should plan for during pregnancy and after birth.

The strategies and activities outlined in the Safe Motherhood Campaign Strategy demonstrate how each strategy/activity will contribute towards achieving the (above) objectives and goals of the campaign.

## **IV. Monitoring Plan**

### M&E Performance Indicators

The M&E system for the Safe Motherhood campaign consists of indicators for tracking inputs, campaign processes and outputs, and intermediate and long-term outcomes. The set of indicators will be used to track regularly the progress of the implementation of the campaign, to make any necessary improvements to the campaign, and to evaluate whether the campaign achieved its objectives and had the intended effect on both the expected intermediate and long-term outcomes.

Input indicators will measure the amount of resources that are put into implementing and carrying out the campaign interventions, including the human, financial, and material resources.

Process indicators will measure the basic processes (e.g., campaign was developed based on formative research) used for implementing the campaign. The process indicators that will be collected include:

- Number of communication channels used in campaign;
- Campaign developed based on existing evidence and/or formative research;
- Campaign developed according to minimum GRZ standards/guidelines;
- Campaign reviewed by the information, education, communication/behaviour change communication (IEC/BCC) Technical Working Group (TWG); and
- Campaign received private-sector support.

Key characteristics of the campaign, including the health topics and subtopics covered, the target audiences, and the length of the campaign, will also be recorded.

Output indicators will be used to measure whether campaign activities are implemented as planned and whether the campaign is reaching the target audience.

Outcome indicators will measure changes in knowledge, attitudes, beliefs, intentions, and behaviour. Table 1 provides the comprehensive list of indicators that will be used to monitor and evaluate the campaign.

#### Data Collection and Dissemination Plan

Data will be collected using a number of data collection tools developed by CSH, including both paper-based and electronic forms. All data will be entered into CSH's performance-based management system for data aggregation, analysis, and reporting.

Data will be collected for the indicators according to the frequency outlined in Table 1. Specifically, for project partners (civil society organisations) implementing activities at the community level, data will be collected on a monthly basis. These data will be reviewed and analysed by the CSH M&E team on a quarterly basis and shared with the CSH technical team, Ministry of Health (MOH), and United States Agency for International Development (USAID).

Data will be reported on a semiannual and annual basis, according to reporting requirements. Semiannual and annual results will be shared with campaign stakeholders (e.g., GRZ's MOH, civil service organisations (CSOs), USAID) to track progress and make any necessary programmatic changes to improve campaign implementation.

#### Data Collection Tools

The following data collection forms and tools will be used to collect data for monitoring and evaluating the Safe Motherhood campaign:

1. **Monitoring Form for Safe Motherhood Products:** This form will be used to track the production and distribution of the various materials/products produced for the Safe Motherhood campaign, including products distributed to other partners working in collaboration with CSH.
2. **CSO Data Collection Forms:** These forms will be used by CSOs to monitor their various activities, including community-based, small group, and individual-level activities and interventions. This will also include forms to track people trained and the number of products/materials produced and disseminated.
3. **Rapid Survey Questionnaires:** The survey questionnaire will be used to monitor the percentage of the population exposed to the Safe Motherhood campaign. It will be administered approximately twice a year. The questionnaire will assess exposure to the various broadcast and small media components of the campaign.

## **V. Evaluation Plan**

An evaluation of the Safe Motherhood campaign is proposed to be able to assess the effect of the campaign on the intermediate and long-term behavioural objectives. Specifically, the objectives of the evaluation will be to assess the levels of knowledge, self-efficacy, attitudes, intentions, and behaviours amongst the target audiences specifically related to ANC, FP, delivery care, and postpartum care. Additionally, the evaluation will assess the population's level of exposure to the campaign.

The proposed evaluation design is an endline household survey that will be conducted at the end of the campaign with the campaign's target audiences. Propensity score analysis will be conducted to look at the net effect of the campaign on the intermediate and long-term desired outcomes. Dose effect analysis will be used to test the hypothesis that the higher the level of exposure to the campaign, the greater the likelihood of the desired outcome (both for intermediate and long-term objectives) of the campaign.

The endline survey is proposed to be carried out from May through July 2014. The final evaluation design and dates for the evaluation will be decided upon with the MOH and USAID.

**Table 1. M&E Indicators for Safe Motherhood Campaign**

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
<b>Campaign Inputs</b>				
Annual financial resources spent on mass media activities (TV, radio, SMS)	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• TV/radio/SMS</li> </ul>	Review of CSH financial reports	CSH financial reports	Annual
Financial resources spent on materials production	N/A	Review of CSH and CSO financial reports	CSH and CSO financial reports	Annual
Financial resources spent on IPC activities (individual, small-group, family, and community-based activities)	IPC: Interpersonal communication activity	Review of CSH and CSO financial reports	CSH and CSO financial reports	Annual
<b>Campaign Processes</b>				
Health topic and subtopics of campaign	N/A	Review of campaign strategy and implementation plan	Safe Motherhood campaign strategy and implementation plan	Annual
Target audience of campaign	N/A	Review of campaign implementation plan, campaign activity reports	Safe Motherhood implementation plan, campaign activity reports	Annual
Number of communication channels used by campaign  (CSH PMEP Indicator 1.3.1)	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type of communication channel</li> </ul>	Review of campaign activity reports and monitoring calendar	Campaign activity reports, monitoring of calendar reports	Annual
Formative research conducted for campaign (CSH PMEP Indicator 2.2.2)	N/A	Review of formative research report for campaign	Formative research report	Once

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
<b>Campaign Processes</b>				
Campaign developed based on existing evidence and/or formative research (CSH PMEP Indicator 1.3.2)	<p><i>Evidence-based:</i> Health communication campaigns and activities that have messages and materials designed using research findings</p> <p><i>Formative research:</i> The initial research that is conducted in a particular technical area to inform the development of a campaign</p>	Review of campaign strategy and implementation plan	Safe Motherhood campaign strategy and implementation plan	Once
Campaign developed according to GRZ minimum standards/guidelines (CSH Indicator 0.2)	<p><i>GRZ minimum standards/guidelines:</i> Minimum GRZ standards refers to national guidelines on development and pretesting of messages and materials</p>	Review of campaign strategy and implementation plan against GRZ minimum standards/guidelines	Campaign strategy document, campaign implementation plan	Once

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
<b>Campaign Processes</b>				
Campaign reviewed by the IEC/BCC TWG  (CSH PMEP Indicator 3.1.1)	<i>Reviewed by IEC/ Malaria TWG:</i> Campaign is reviewed by the IEC/BCC TWG using established standard guidelines  <i>IEC/ Malaria TWG:</i> Technical working group that meets to coordinate and review health communication interventions in Zambia	Review of IEC/ Malaria TWG reports or meeting minutes	IEC/Malaria TWG report and/or meeting minutes	Once
Campaign received private-sector support  (CSH PMEP Indicator 3.2.1)	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>Type of support</li> </ul>	Review of campaign reports	Campaign reports	Annual
<b>Monitoring Implementation (Campaign Outputs)</b>				
Number of promotional advertisements aired per month	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>Communication channel (TV, radio)</li> <li>Programme (“Change Champion Chief” documentary, “Journey to Becoming a Parent”)</li> </ul>	Review of campaign media plans and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of national-level radio spots aired per month	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>Version of spot</li> <li>Language</li> <li>Radio channel</li> </ul>	Review of campaign media plans and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
<b>Monitoring Implementation (Campaign Outputs)</b>				
Number of district-specific radio spots aired per week	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Version of spot</li> <li>• District</li> <li>• Radio channel</li> </ul>	Review of campaign media plans and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of times the “Journey to Becoming a Parent” documentary is aired per month	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Part (documentary has four parts)</li> <li>• Communication channel (TV and radio)</li> </ul>	Review of CSH activity completion reports and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of times “Change Champion/ Champion Chief” documentary is aired per month	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Province</li> </ul>	Review of CSH activity completion reports and media monitoring calendar forms	Campaign media plan, media monitoring calendar form	Monthly
Number of health workers and SMAGs trained in the use of counselling materials on safe motherhood messages	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type of health worker (SMAG/health worker)</li> <li>• Province</li> <li>• Gender of trainee</li> </ul>	Review of CSH activity completion reports activity	CSO activity completion reports	Monthly
Number of materials placed and/or distributed	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type of material (e.g., posters, flyers, bumper stickers, billboards, pole lights, branding placed on walls or buses, leaflets, folders, caps, t-shirts, programme kits, job aids, pictorial birth plans)</li> </ul>	Review of CSH and CSO activity completion reports	CSH and CSO activity completion reports	Monthly

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
<b>Monitoring Implementation (Campaign Outputs)</b>				
Number of health newspaper inserts produced and disseminated	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Type of health newspaper insert</li> <li>• Newspaper</li> </ul>	Review of campaign media plans, media company monitoring reports	Campaign media plan, media company monitoring reports	Monthly
<b>Monitoring Reach of Campaign (Campaign Outputs)</b>				
Percentage of audience who recalls (spontaneously and aided/prompted) seeing and/or hearing about the Safe Motherhood campaign	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Spontaneously vs. aided/prompted</li> <li>• Gender</li> <li>• Urban/rural</li> <li>• Channel</li> </ul>	Rapid population-based survey	Rapid survey report	Every 4 months
Percentage of audience who recalls a specific component/characteristic (spontaneously and aided/prompted) of the Safe Motherhood campaign	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Spontaneously vs. aided/prompted</li> <li>• Gender</li> <li>• Urban/rural</li> <li>• Channel</li> </ul>	Rapid population-based survey	Rapid survey report	Every 4 months
Percentage of audience who recalls hearing or seeing (spontaneously and aided/prompted) a specific health message from the Safe Motherhood campaign	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Spontaneously vs. aided/prompted</li> <li>• Gender</li> <li>• Urban/rural</li> <li>• Channel</li> </ul>	Rapid population-based survey	Rapid survey report	Every 4 months

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
<b>Monitoring Reach of Campaign (Campaign Outputs)</b>				
Number of individuals reached through IPC activities	<p><i>IPC</i>: Interpersonal communication activity, such as one-on-one, small-group, family, or community-based activity/intervention</p> <p><i>Disaggregated by</i>:</p> <ul style="list-style-type: none"> <li>• Gender</li> <li>• Activity type (one-on-one, small group, family, community-based)</li> </ul>	Review of CSO programme records and reports	CSO programme records and reports	Monthly
<b>Intermediate Outcomes (Knowledge, Attitudes, Self-Efficacy, and Behaviour)</b>				
<b>Antenatal Care</b>				
Percentage of pregnant women who are satisfied with the quality of care provided at the health clinic during their last ANC visit	<p><i>Disaggregated by</i>:</p> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Client exit interview conducted at health facility	Client exit interview reports	Endline
Percentage of women who believe that all four ANC visits are worthwhile	<p><i>Disaggregated by</i>:</p> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women of reproductive age (aged 15–49) who believe that there is value in initiating ANC early in pregnancy	<p><i>Disaggregated by</i>:</p> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
<b>Antenatal Care</b>				
Percentage of women of reproductive age (aged 15–49) who associate taking an HIV test during pregnancy with having a healthy baby	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women of reproductive age (aged 15–49) who can identify at least three danger signs in pregnancy and labour	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women of reproductive age (aged 15–49) who know that pregnancy carries special risks that require care from trained health providers	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of male partners aged 15–59 who support their wife/partner in completing all four ANC visits	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
<b>Family Planning</b>				
Percentage of women of reproductive age (aged 15–49) who associate practicing FP with staying healthy and having healthy children	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
Percentage of women of reproductive age (aged 15–49) who know where they can access FP	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women of reproductive age (aged 15–49) who believe modern contraception is safe	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women of reproductive age (aged 15–49) who say they understand at least three options for FP	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of men aged 15–59 who believe that they have a role in FP	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of male partners aged 15–59 who support their wife/partner in practicing FP	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
<b>Delivery Care</b>				
Percentage of women of reproductive age (aged 15–49) who report feeling confident that they can seek and obtain the necessary care to deliver a healthy baby	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
Percentage of women of reproductive age (aged 15–49) who believe that a facility-based delivery is compatible with traditional ways	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women of reproductive age (aged 15–49) who believe that a facility-based delivery is safer than a home delivery	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of men aged 15–59 who believe that they have a role in pregnancy and childbirth	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
<b>Postpartum Care</b>				
Percentage of women of reproductive age (aged 15–49) who think that both the woman and the newborn require attention immediately after birth	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women of reproductive age (aged 15–49) who know how many visits to the health clinic they should plan for during pregnancy and after birth	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
<b>Long-Term Outcomes (Campaign Outcomes)</b>				
<b>Antenatal Care</b>				
Percentage of pregnant women who have planned for transport to a facility for ANC and delivery	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women who attended their last ANC visit accompanied by their partner*	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of couples who have discussed getting an HIV test	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women who initiated ANC services before the first 16 weeks of pregnancy*	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women who completed at least four ANC visits*	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
<b>Family Planning</b>				
Percentage of women of reproductive age (women aged 15–49) who use a modern method of contraception	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
<b>Delivery Care</b>				
Percentage of women who delivered in a health facility*	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline

Indicator	Definition	Methodology/ Data Collection Method	Data Source	Frequency of Collection
Percentage of pregnant women who have created a birth plan and saved money for transportation to a health facility for delivery	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
<b>Postpartum Care</b>				
Percentage of women who received a postpartum check-up within 48 hours after delivery	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline
Percentage of women who received three postpartum visits (at 6 hours, 6 days, and 6 weeks)*	<i>Disaggregated by:</i> <ul style="list-style-type: none"> <li>• Urban/rural</li> <li>• Wealth quintile</li> </ul>	Household Impact Survey	Household Impact Survey report	Endline

\* These indicators will be measured amongst women aged 15–49 who had a live birth in the past year.

Sample Logic Model: Safe Motherhood Campaign

HEALTH CONTEXT	Inputs	CAMPAIGN ACTIVITIES	Outputs	Outcomes		Impact
				Intermediate	Long-Term	
<p>Late initiation of antenatal care (ANC) services</p> <p>Low ANC care services (four visits)</p> <p>High percentage of home-based deliveries</p> <p>Low utilisation of postpartum care services</p> <p>Low male involvement in pregnancy, childbirth, and family planning</p> <p>High fertility</p> <p>Low contraception use</p>	<p>Financial resources</p> <p>Human resources: Government of the Republic of Zambia Health Promotion Unit, Communications Support for Health, Civil Service Organisations (CSOs), partner organisations, community facilitators/peer educators, health care providers, community leaders/traditional leaders/chiefs</p> <p>Private-sector in-kind/financial support</p> <p>Partner coordination</p> <p>Communication materials/products (e.g., mass media products, small media products, promotional materials)</p>	<p>HEALTH FACILITY</p> <p>Development and distribution of counselling materials and other materials for health facilities</p> <p>Training of health providers in Safe Motherhood counselling</p> <p>COMMUNITY</p> <p>Change Champions programme</p> <p>Outreach activities through Safe Motherhood Action Groups (SMAGs) and community volunteers</p> <p>Production and distribution of materials to CSOs and SMAGs</p> <p>MASS MEDIA</p> <p>TV/radio spots and corresponding media plans developed</p> <p>Documentaries and corresponding media plans developed</p> <p>Newspaper inserts developed</p> <p>Billboards developed</p> <p>SMS plan developed</p>	<p>Counselling and other materials distributed, placed, and/or mounted</p> <p>Health providers trained in Safe Motherhood counselling</p> <p>Health providers using counselling materials with clients</p> <p>Change Champions engaged and working with their communities</p> <p>CSOs and SMAGs materials distributed to the community</p> <p>Target population reached with outreach activities</p> <p>Radio/TV spots produced and aired</p> <p>Documentary series episodes produced and aired</p> <p>Newspaper inserts disseminated</p> <p>Billboards placed</p> <p>SMS messages disseminated</p> <p>Target population exposed to Safe Motherhood messages (via small/mass media/health facility)</p>	<p>Improved client satisfaction with ANC</p> <p>Improved attitudes towards value in early and complete ANC</p> <p>Improved attitudes towards HIV testing during ANC</p> <p>Improved knowledge of danger signs in pregnancy/labour</p> <p>Improved self-efficacy for seeking delivery care</p> <p>Improved attitudes and beliefs about facility-based delivery</p> <p>Improved knowledge of postpartum care for newborn and mother</p> <p>Improved male partner support for ANC and family planning (FP)</p> <p>Improved attitudes of male partners in their role in FP, pregnancy, and childbirth</p> <p>Improved attitudes and beliefs towards FP</p> <p>Improved knowledge of FP options and where to access FP</p>	<p>Increased early initiation of ANC</p> <p>Increased number of pregnant women fully completing ANC (four visits)</p> <p>Increased male partner involvement in ANC</p> <p>Increased number of pregnant women and couples developing birth plans</p> <p>Increased number of facility-based deliveries</p> <p>Increased utilisation of postpartum care services</p> <p>Increased use of modern contraception</p>	<p>REDUCTION IN MATERNAL MORTALITY</p> <p>GOAL: 162 DEATHS PER 100,000 LIVE BIRTHS BY 2014</p>

## **Additional Resources for Monitoring and Evaluation**

### General Monitoring and Evaluation

M&E Fundamentals Online Certificate Course, USAID MEASURE Evaluation, <https://training.measureevaluation.org/certificate-courses/m-e-fundamentals-en>

### BCC Indicator Data Sources

Demographic and Health Surveys: <http://measuredhs.com/>

Malaria Indicator Surveys: <http://www.malariasurveys.org/>

Sexual Behavior Surveys: <http://www.cpc.unc.edu/measure/publications/tr-10-73>

Knowledge, Practices and Coverage Surveys: [http://mchipngo.net/controllers/link.cfc?method=tools\\_modules\\_kpc2009](http://mchipngo.net/controllers/link.cfc?method=tools_modules_kpc2009)

PEPFAR Indicators: <http://www.pepfar.gov/documents/organization/81097.pdf>

### Data Analysis

Introduction to Basic Data Analysis and Interpretation for Health Programs: A Training Tool Kit, USAID MEASURE Evaluation, <http://www.cpc.unc.edu/measure/tools/data-demand-use/data-demand-and-use-training-resources/basic-data-analysis-for-health-programs>

Data Demand and Use Concepts and Tools: A Training Tool Kit, USAID MEASURE Evaluation, <http://www.cpc.unc.edu/measure/tools/data-demand-use/data-demand-and-use-training-resources/data-demand-use-concepts-tools/data-demand-and-use-3-day-training-materials.html>

Data Demand and Use Online Certificate Program, USAID MEASURE Evaluation, <https://training.measureevaluation.org/certificate-courses/ddu>

### Data Use and Making Recommendations

Improving Data Use in Decision Making: An Intervention to Strengthen Health Systems, USAID MEASURE Evaluation, August 2012, [http://www.cpc.unc.edu/measure/publications/SR-12-73/at\\_download/document](http://www.cpc.unc.edu/measure/publications/SR-12-73/at_download/document)

## Notes