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EVALUATION

THE TANZANIA CAPACITY AND COMMUNICATION PROJECT (TCCP): A PERFORMANCE EVALUATION

April 2015

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Mary Lyn Field-Nguer, Kennedy Musonda, Neema Fritz Matee, Mpundu Mwanza, Alex Mwita, Deo Mwingizi, Fredy Rutahindurwa and Rose Ernest.

Cover Photo by Mary Lyn Field-Nguer. Women and babies in clinic waiting area at hospital in Njombe, Tanzania.

THE TANZANIA CAPACITY AND COMMUNICATION PROJECT (TCCP): A PERFORMANCE EVALUATION

*Promoting healthy behaviors and building social
and behavior change capacity in Tanzania*

April 2015

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DISCLAIMER

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

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ACRONYMS

ACE	Advancing Communication Experientially
ADDO	Accredited Drug Dispensing Outlets
AFP	Advance Family Planning
AJAAT	Association of Journalists Against HIV/AIDS
AIDS	Acquired Immune Deficiency Syndrome
AMREF	AMREF Health Africa
ANC	Antenatal care
AOR	Agreement officer's representative
ART	Antiretroviral therapy
BCC	Behavior change communication
CBO	Community-based organization
CCA	Community Change Agent
CHAI	Clinton Health Access Initiative
CCP	Johns Hopkins Center for Communication Programs
CHBC	Community home-based care
CHMT	Council Health Management Teams
CHW	Community health worker
COCODA	Community Concerns of Orphans and Development Association
CPR	Contraceptive prevalence rate
DACC	District AIDS Control Coordinator
DFID	Department for International Development, United Kingdom
DHMT	District Health Management Team
DHS	Demographic and Health Survey
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FP	Family planning
FXB	Foundation François-Xavier Bagnoud
GIZ	German Federal Enterprise for International Cooperation
HC3	Health Communication Capacity Collaborative
HPE	Health Promotion Education
HIV	Human Immunodeficiency Virus
IDYDC	Iringa Development and Youth, Disabled and Children Care
IP	Implementing partner
IPC	Interpersonal communication
IPTp	Intermittent preventative treatment in pregnant women
JHU	Johns Hopkins University
LSHC	Leadership in Strategic Health Communication
MCH	Maternal and child health
MDH	Management and Development for Health
M&E	Monitoring and evaluation
MNCH	Maternal, neonatal and child health
MOEVT	Ministry of Education and Vocational Training
MOHSW	Ministry of Health and Social Welfare
MST	Marie Stopes Tanzania
MUHAS	Muhimbili University of Health and Allied Sciences
NACP	National AIDS Control Program
NACOPHA	National Council for People Living with HIV/AIDS in Tanzania
NGO	Non-governmental organization

OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PHCI	Primary Health Care Institute
PMTCT	Prevention of mother-to-child transmission
RCHCo	Reproductive and Child Health Coordinator
RCHS	Reproductive and Child Health Section
RHMT	Regional Health Management Team
RDL	Radio distance learning
RMO	Regional Medical Officer
RH	Reproductive health
RFA	Request for applications
SBCC	Social and behavior change communication
SDC	Safe motherhood (EMOC) and health
SO	Strategic objective
SP	Sulfadoxine-pyrimethamine
SW	Sex work
TACAIDS	Tanzania Commission for AIDS
TANAM	Tanzania National Malaria Movement network
TASHCOM	Tanzania Association of Strategic Health Communicators
TAYOA	Tanzania Youth Alliance
TB	Tuberculosis
TCCP	Tanzania Capacity and Communication Project
TCDC	Tanzania Communication and Development Center
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
T-MARC	Tanzania Marketing and Communications
TRCS	Tanzania Red Cross Society
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
UNICEF	United Nations Children's Fund
VCT	Voluntary counseling and testing
VMMC	Voluntary medical male circumcision
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The Tanzania Capacity and Communication Project (TCCP) has been funded by USAID since September 2010 and is due to close in May 2016. The purpose of this evaluation was to review, analyze and evaluate the project's progress in meeting its objectives and intermediate results. The findings are intended to provide a critical review of several dimensions of success and challenges across the life of the project. USAID/Tanzania will use this information to improve project performance and inform the design of a future social and behavior change communication (SBCC) activity.

The evaluation questions that guided the team included:

1. What were the outcomes of TCCP's SBCC programs in terms of behavior change among priority audiences?
2. What programmatic lessons about collaboration with the Government of Tanzania, U.S. Government and non-governmental organization (NGO) stakeholders can be drawn from TCCP's experience, with particular attention to the project's large-scale SBCC campaigns?
3. Which of TCCP's capacity-strengthening interventions have been most effective in improving the ability of individuals and institutions to design, implement and evaluate SBCC programming?
4. In what areas of behavior change research, design or implementation has TCCP successfully strengthened the capacity of Tanzanian individuals, institutions and communities?
5. What internal or external factors have influenced the project's ability to achieve its objectives?

PROJECT BACKGROUND

Tanzania has a population of nearly 42 million and is also home to one of Africa's fastest growing economies. Tanzania's nearly 7 percent annual national GDP growth since 2000 has been hardly perceptible among its predominantly rural (73 percent) population. However, the health status of Tanzanians has improved over the past decade. For example, investments in malaria control and access to safe drinking water have led to reductions in infant and under-5 mortality rates.

Several key health areas continue to deserve attention, and these were the focus of TCCP:

- *HIV/AIDS*: HIV prevalence varies by region and stands nationally at 5.1 percent.¹ The TDHS 2010 and THMIS 2012 indicate that the proportion of the population with comprehensive knowledge about HIV transmission and prevention has not changed significantly (among females from 48.6 percent to 42 percent; among males from 46.5 percent to 50 percent). The number of people receiving antiretroviral therapy (ART) has been increasing steadily since 2010, and by December 2013, a total of 1,366,402 were enrolled in care and treatment centers; 512,555 people living with HIV were receiving antiretrovirals, of whom 8 percent were children.²
- *Maternal and Child Health*: Despite high coverage rates of antenatal care (96 percent attend at least once), only 50 percent of women deliver in a health facility, and maternal mortality remains high at 454 deaths per 100,000 live births, accounting for approximately 8,000 maternal deaths per year.³

¹ UNAIDS, 2012. Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics, Office of the Chief Government Statistician (OCGS) and ICF International, 2013.

² NACP, 2014. Care and Treatment Report, 2013.

³ The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008–2015.

Notably, under-5 mortality rates have dropped by 40 percent, from 137 deaths per 1,000 births in the mid-1990s to 81 for the period 2006-2010.⁴ Nevertheless, neonatal mortality rates have been high at 32 per 1,000 live births, and account for 47 percent of the infant mortality rate.⁵

- *Family Planning (FP) and Reproductive Health:* The 2010 DHS indicates that 29 percent of all women, including 34 percent of married women and 51 percent of sexually active unmarried women 15-49, currently use contraception. Unmet need for FP remains high at 22 percent.
- *Malaria:* Among all households, 95 percent possess at least one mosquito net and 91 percent own at least one insecticide-treated net. Ninety-two percent of households are covered by vector control, and 31 percent of women in Mainland Tanzania with a live birth in the two years preceding the THMIS had received intermittent preventive treatment (IPTp).⁶

USAID/Tanzania manages a portfolio aimed at changing behaviors for positive health outcomes through a limited number of projects. Within that portfolio, TCCP is a five-year, USAID-funded cooperative agreement that was awarded on September 12th, 2010. In terms of the relationship of this project to the overall results framework of the USAID/Tanzania Country Strategy, there was no USAID/Tanzania results framework referenced in either the request for applications (RFA) or the technical proposal that was awarded. TCCP's original end date was in 2015, but the project has been granted a no-cost extension until May 11, 2016. TCCP is led by the Johns Hopkins University Center for Communication Programs (CCP) in collaboration with Media for Development International and CARE Tanzania.

The goal of this cooperative agreement is to increase the adoption of safer behaviors by Tanzanian adults and high-risk populations (adults and youth) to prevent or manage HIV infection; support FP uptake; and address maternal, newborn and child health and malaria.

USAID's agreement with CCP specifies two project objectives for TCCP:

1. Execute evidence-based, coordinated SBCC initiatives at scale.
2. Reinforce systems for coordinating and delivering SBCC.
 - 2.1.1 SBCC will be effectively coordinated at the national, regional and district levels.
 - 2.1.2 SBCC skills will be measurably transferred to Tanzanian institutions and organizations.

TCCP is premised upon the Integrated Change Model, which draws upon socioecological frameworks common in behavior change programming and posits that sustained behavioral change requires intervention at the individual, social and structural levels. TCCP's work in capacity strengthening expands upon this model, articulating a specific vision for development of sustainable SBCC capacity. The model describes four complementary pathways to national-level capacity: sustainable systems, communication institutions, and community and individual capacity.

EVALUATION DESIGN, METHODS AND LIMITATIONS

The evaluation is a retrospective performance evaluation. The questions focused on the performance of the project in three main areas: SBCC implementation, coordination and collaboration, and capacity building. The questions are detailed in Annex I (Scope of Work).

Methods: The mixed methods evaluation featured: (1) review of project documents (e.g., quarterly and annual reports) and other relevant literature; (2) secondary analysis of existing data (project surveys and internal evaluations conducted by the partner, capacity assessments and performance management

⁴ Demographic and Health Survey, 2010

⁵ National Road Map 2008-2015.

⁶ THMIS, 2011-2012.

plans); (3) semi-structured key informant interviews (KIIs) with stakeholders, capacity-building recipients and project staff; and (4) focus group discussions (FGDs) with community-based representatives.

Sample: USAID/Tanzania identified four regions for field work (Dar es Salaam, Iringa, Njombe and Mwanza), based on the following criteria: presence of both this project and another also being evaluated (Tanzania Social Marketing Project, or TSMP), multiple activity areas (HIV, FP/RH, MCH and malaria), mission priority areas, appropriate mix of settings and target populations, and travel and time considerations.

The team interviewed a total of 103 persons through a combination of 71 KIIs, and three FGDs and small group sessions. The full list of all interviewees appears in Annex III at the end of this report, and the tools used for each type of informant are available in Annex V. The sample included a mix of MOHSW program managers, leaders and health care workers at the national, regional and district levels of the system; international and local NGO staff; individuals and organizations who benefited from TCCP's capacity-building activities; community workers to provide insights about beneficiaries' needs and experience with TCCP programs; and TCCP prime and partner staff. Selection of individuals and groups to be included in the sample was done through contacts with the MOHSW and international and local NGOs with whom the project had collaborated over the life of the project, based on project reports and project and USAID recommendations. Contact information was provided by the project. The team used information gained during interviews to add informants to the sample.

Data collection and analysis: The team developed and pre-tested semi-structured KII and FGD guides in English that were translated into Swahili. Most KIIs and FGDs were conducted in Swahili, and the rest in English. Most KIIs and FGDs were audio-recorded, transcribed and translated into English before being coded and entered into NVivo for thematic analysis.

Themes for analysis: The team developed an initial list of themes for analysis to use as a basis for qualitative analysis using a grounded theory approach. The team revised the themes during the course of data collection to reflect emergent concepts and hone in on the evaluation questions.

Limitations: The evaluation primarily used rapid assessment methods such as KIIs and document review. Accordingly, the findings are subject to recall bias as well as social desirability bias. Due to time and logistical constraints, the team only visited a subset of regions and districts where the project was implemented. In some locations, project activities such as community mobilization were no longer active, which limited the evaluation team's ability to collect relevant information. The team attempted to mitigate these threats to validity by triangulating multiple data sources and reviewing original data from internal project evaluations. Lastly, the lack of recent population-based data through a DHS, Service Provision Assessment, or similar survey precluded the team from exploring the effect of programs among targeted beneficiaries.

While this was never intended to be an impact evaluation, it is worth noting that there is a growing interest and need for impact evaluations of health communication interventions for HIV prevention and other areas. Evaluation question #1 borders on being an impact question, which the team addressed through review of internal evaluations and the other methods described, and by way of evaluating the project's objective, to "execute evidence-based, coordinated social and behavior change communication initiatives at scale." However, there is a foundation for recommending that the next project consider building in a more robust evaluation design. Short of a randomized trial, which is likely not to be feasible for many reasons, articles referenced in Annex 4 describe possible alternatives, including types of quasi-experimental studies.

FINDINGS AND CONCLUSIONS

Findings are organized by TCCP's intermediate results.

Execution of evidence-based, coordinated behavior change communication initiatives at scale:

This is the outcome that the team used to evaluate question 1. For some of the campaigns and platforms, there were impact evaluations to inform the team's answer; in other cases, the level of outcome was more along the lines of whether the project implemented a sound program most likely to produce behavior change. The team found that TCCP's execution of SBCC programs at scale applied the Integrated Change Model well in its design and development of the communication campaigns. Implementation was systematic and based on evidence. At the national level, more than at the regional and district levels, the project involved stakeholders in the campaigns from the design through implementation stages. Informants almost universally reported that the campaigns and messages were of high quality.

TCCP's program consisted primarily of what the project refers to as five major platforms: *Wazazi Nipendeni* (safe motherhood, including safe delivery, ANC, eMTCT, SP, bed nets); *Tuko Wangapi? Tulizana* (multiple concurrent partnerships); Green Star (FP); *Siri ya Mtungi* (HIV prevention, FP, and maternal and child health); and *Aiissee!* (couples communication). Creating demand for voluntary medical male circumcision and promoting malaria case management were also program platforms.

Communication channels used for each platform were varied, including, among others, radio magazine shows, TV dramas, radio spots, social media, mobile health interventions, community outreach, mid-media and print materials.

KII and FGD findings reveal that the *Wazazi Nipendeni* campaign is popular and has been very effective in addressing HIV testing, malaria prevention in pregnancy, antenatal care attendance and delivery at a health facility. The campaign messages are perceived to be very clear, educational and, for the most part, contextually appropriate. Several key findings related to campaign impact on behavior and source of exposure to messages were documented in the 2014 impact evaluation of *Wazazi Nipendeni*.⁷ Selected key findings included that, for each message source to which a woman had been exposed, there were 20 percent greater odds that she delivered at a health facility, even controlling for all other variables. Also, 88.1 percent were tested as part of their antenatal care (two did not know), and of these (1,504), 96.3 percent received their results that day. Of the total sample (N=1,708), 89.3 percent reported having a bed net. The study found that the variety of sources where women heard or saw campaign messages had an impact on two key outcomes—delivery at a health facility and sleeping under a net—while overall message exposure influenced taking SP, developing an individual birth plan and knowledge about malaria prevention during pregnancy.

Regarding the Green Star campaign, a midline study completed by JHU in December of 2014 reported, "A national survey showed that about half of the participants (57.2% of men and 50.3% of women) were exposed to the campaign. Those who were exposed were significantly more likely to have heard of family planning than those who had not been exposed. Exposure to the campaign was also associated with higher family planning knowledge. Additionally, those exposed to the campaign demonstrated a significantly greater likelihood of family planning use over the last year and a likelihood of communicating about family planning."⁸

Respondents' perceptions of the *Tuko Wangapi? Tulizana* campaign indicated that the campaign has greatly contributed to behavior change among individuals in the reduction of multiple partners. The 2014 midline evaluation showed that campaign exposure was significantly associated with sexual protection self-efficacy, positive sexual attitudes and lower sexual risk behavior, positive condom

⁷ Love me, Parents-An Evaluation of Tanzania Safe Motherhood Campaign. September 2014.

⁸ Midline Study Report: Midline Evaluation of the Tanzania Capacity and Communication Project (TCCP) Programs *Wazazi Nipendeni*, Green Star, *Tuko Wangapi*, *Siri Ya Mtungi*, and *Aiissee!* Baltimore, MD, December 2014.

attitudes and condom use at last sex. However, *Tuko Wangapi* demonstrated no impact on attitudes towards multiple and concurrent partnerships.⁹

Collaboration with the Government of Tanzania, U.S. Government and NGO stakeholders:

TCCP collaborated with the MOHSW, particularly with the Directorate for Preventive Services, under which the Reproductive and Child Health Services (RCHS) and Health Promotion Education (HPE) sections and the National AIDS Control Program (NACP) and the National Malaria Control Program (NMCP) belong. TCCP also worked with the government's semi-autonomous commission for HIV and AIDS (TACAIDS).

The MOHSW sections and programs benefited from capacity building in SBCC through participation in the Leadership in Strategic Health Communication (LSHC) course and in the technical working groups, financial support, and SBCC material design, production and dissemination assistance. Through the technical working groups hosted by the Ministry, TCCP pulled together many U.S. Government partners, some UN organizations and local NGOs to participate in the design and development of campaigns. At the regional and district levels, there was a sense of wanting more inclusion by and consultation from TCCP.

Measurable transfer of SBCC competencies to Tanzanian individuals and institutions: TCCP's capacity-strengthening objective is to measurably transfer SBCC skills to Tanzanian institutions, organizations, communities and individuals. Three of the six evaluation questions were focused on TCCP's capacity-strengthening component. To achieve this objective, the project used the Pathways capacity-strengthening model, which includes the four components of sustainable systems, communication institutions, community capacity and individual capacity.

TCCP's capacity-building efforts included the following key components:

- Reinforcement of systems for coordinating and delivering SBCC, including the provision of individual-level capacity strengthening to key staff members within the MOHSW, NACP and TACAIDS, including participation in the LSHC training or the Advancing Communication Experientially (ACE) fellowship and internship program.
- Technical support to key Government of Tanzania technical bodies such as the MOHSW, NACP and TACAIDS, including leadership to technical working groups in the design and development of campaigns. This built capacity through "learning by doing."
- Harmonization of messages through coordination across implementing partners.
- Use of a training-of-trainers model for LSHC training to ensure roll-out at the district level.
- Support for the design and implementation of district-level SBCC campaigns by trainee teams, completed in seven out of eight districts selected.
- Development and production of a 26-episode radio distance-learning (RDL) program targeting community health workers.
- Establishment of the ACE fellowship and internship programs to provide applied learning opportunities in SBCC.
- Institutional capacity assessments of Tanzanian entities, and tailored SBCC capacity-strengthening services and/or referral to external resources based on identified needs.
- Support to PHCI (Primary Health Care Institute) and Muhimbili University of Health and Allied Sciences (MUHAS) for development and provision of SBCC-related short courses and degree

⁹ Midline Evaluation of TCCP Programs, December 2014.

programs, and building the capacity of the film industry to take on health themes through the program activity called *Swahiliwood*.

The project provided capacity strengthening to several technical working groups in the design, development, implementation and monitoring of national mass media campaigns. It also provided training in LSHC to more than 160 individuals from Regional and Council Health Management Teams (RHMTs and CHMTs) from the eight regions. TCCP has built the capacity of PHCI to provide diploma courses in SBCC and short courses in LSHC. While PHCI is able to sustain the training of CHMTs because they are funded by their respective councils, PHCI would need funding to sustain the ACE program in its current form, given the cost required to maintain it.

The project has exceeded the target of training 30 interns and 30 fellows as part of the ACE program. One limitation is its insufficient feedback loop between the mentor, fellows/interns, supervisor and JHU-CCP. Also, finding appropriate mentors for fellows and interns has been a challenge, and fellows need more practical experience in conducting research during the situation analysis stage of the communication process.

There are a number of areas in which SBCC competencies need to be further improved in Tanzania overall in order to provide sustained support to SBCC locally over time. SBCC should be integrated in all departments and units of the MOHSW. Competencies in the monitoring and evaluation of SBCC programs need to be further improved, and the RDL program needs greater facilitation and the establishment of radio listening groups.

Internal and external factors affecting the ability of the project to achieve its objectives: “Strong leadership and teamwork” helped the project succeed in several ways. The fact that most of the project staff are Tanzanian and that the project conducted extensive formative research and testing in campaign development contributed to the project’s understanding of the “social, cultural and political context.” A factor that limited the project’s capacity-building achievements was the lack of sufficient full-time personnel dedicated to this component.

There was also a need to strengthen the project’s system for distributing materials, and the project might have “done a better job of identifying individual staff members’ strengths, weaknesses, and skill sets, and creating teams within the project staff structure to build on these.” TCCP enjoyed the government’s support and willingness to participate in its efforts. The process of engaging multiple players and convening technical working groups to elicit multiple inputs to the design of campaigns and messages is valuable and necessary but at times slowed down implementation and might have compromised innovation somewhat. Project accountability to multiple stakeholders within USAID and the Government of Tanzania was at times cumbersome, and funding for a given health area varied from year to year and was insufficient in the area of capacity building. The project staff described this situation as being much like having a new project each fiscal year.

CONCLUSIONS AND RECOMMENDATIONS

TCCP has achieved much, and stakeholders perceive its programs and campaigns to be of high quality and generally culturally appropriate. The work captured the imagination of audiences, as evidenced by the common perception and interview findings that characters and messages were remembered and that terms used even became part of the local jargon and discussion. The messages translated into clear actions to be taken by the intended audience.

The evaluation team found, through its document review and interviews, that there could have been a more balanced approach of mass media and interpersonal approaches in achieving behavior change outcomes. It is well understood that—especially for health issues of a complicated or sensitive nature, and for those less motivated to use a method or adopt a given behavior—interpersonal communication

can boost the impact of mass media. The project agreement also called for the use of both strategies. There is evidence in the literature, specific to Tanzania, that mass media exposure significantly increased the likelihood that a man or a woman would discuss use of the female condom in the future. It has also been demonstrated that while peer educators and providers had limited coverage, they had a stronger impact than mass media on an individual's intention to use a female condom. The contacts with peer educators and providers can be considered as similar to interpersonal communicators, who can perform both the knowledge and persuasion functions of development communication.

No documents explicitly addressed the link between TCCP's mass media work and the interpersonal communication work of other implementing partners. The team found no reports, references, or evidence of meetings for the purpose of coordinating media and interpersonal communication (IPC) efforts of TCCP and other implementers. As noted in recommendations for the next project, the project design did not adequately address the role of IPC in the TCCP design and implicitly relied on other service delivery partners to conduct IPC work, without any structure for sharing what that IPC work was and how it might be coordinated or synergistic with other SBCC activities of TCCP. While CARE reached many individuals through small group interventions, some directly and some through local community-based organizations (CBOs), the midline study chart showing program channels used for each campaign clearly depicts a lack of prominence given to IPC activities, referred to here as community-level discussions. For some campaigns, this is not as important as others, but to change behaviors in areas that are culturally sensitive and deeply rooted in cultural norms, it is clear that mass media alone is insufficient, in theory and in practice, to promote changes in sensitive areas such as uptake of FP, change in sexual partnering behaviors, and revealing HIV test results to partners.

There was no clear structure set up by USAID or the project to ensure communication between TCCP and the U.S. Government-funded service delivery projects of implementing partners as a way to share valuable data related to the demand-creation efforts of TCCP, such as uptake of HIV testing, client understanding of HIV risk behavior, PMTCT, or other health behaviors. There was no evidence of ongoing communication between the MOHSW staff or service delivery implementing partners and TCCP regarding the results of their demand-creation efforts or ideas about critical gaps in patient knowledge or understanding that TCCP might address. This feedback could prove very valuable if it occurred in a planned, ongoing manner so that TCCP could hear inputs on a regular basis, such as what the evaluation team learned through the interviews.

While there was involvement of stakeholders at most levels of the system in the design and implementation stages, community-level stakeholders, local NGOs and the MOHSW at the regional and district levels could have been more involved in identifying needs for media and IPC, designing messages, and, in the case of CHMTs, being kept abreast of activities going on in their surrounding communities.

Areas that stood out clearly as being in need of improvement included the project's materials distribution system, collaboration with regional and district-level stakeholders, and greater tailoring of campaigns for non-urban audiences.

In the TCCP technical proposal's five guiding principles, one was to employ a "systems approach," i.e., to have holistic appreciation of how different levels and actors in a national coalition must be mobilized in concert if TCCP is to achieve sustainable change: "We will make a difference in the public health of Tanzania through effective coordination and collaboration among all parts of that system." The evaluation team found that TCCP adhered to the principles, as agreed, in its systems approach to SBCC in Tanzania through this project. While improvements were recommended for the regional and district levels, it is clear that implementation at scale was a focus, and was achieved with close Government of Tanzania and other partner collaboration and coordination.

The most effective capacity-strengthening intervention was the ACE program, even in light of needed improvements to the program. The ACE program has been effective in developing a cadre of entry-level

and mid-career professionals in SBCC. It has strengthened the skills of mid-career health communication professionals, while introducing the field to a new cohort of young professionals, many of whom have already demonstrated their competence in the field, having secured professional jobs in SBCC. As of May 2014, of the 33 interns who graduated and completed their extensions, 28 found immediate employment, an 85 percent success rate. Other capacity-building efforts, including TASHCOM and RDL, were positive in many respects and also in need of improvements that are detailed in the recommendations. The work with MUHAS needs attention, and PHCI was quite effective in conducting SBCC capacity building.

The project has done much to build the capacity of the MOHSW and TACAIDS in the design, development, implementation and monitoring of national mass media campaigns, leading to a greater appreciation of the importance of SBCC and subsequent requests for expansion of capacity building in SBCC to more regions and to a greater number of people. The capacity-strengthening area in need of the most work is the building of SBCC capacity for local NGOs that are able to implement SBCC projects. Building of SBCC capacity among local organizations was not a strong aspect of TCCP. A lag resulted from the need to terminate CARE as a sub-recipient due to budget cuts, so local capacity building is only now being taken up by TCDC as part of the project.

The capacity-strengthening component did not seem have been a major priority from a funding perspective, accounting for only an average of 8 percent of the annual budget. While there is no magic formula for a sufficient figure, moving local groups (including CBOs and media groups) to a greater level of ownership of program activities, with the ability to do monitoring and evaluation (M&E), produce high-quality programs, assume greater responsibility for design and implementation, and manage increased levels of funding, required more than was provided in terms of funding and dedicated capacity-building personnel. Even when adding staff LOE to the 8 percent, the TCCP staff did not feel they had sufficient budget support to do what was expected in capacity building.

Internal factors primarily boosted the project's achievement of its objectives. The only limiting internal factors were the lack of a sustained body of full-time staff dedicated to capacity building, and lack of a robust materials distribution system. External factors that negatively affected the project's ability to meet its objectives included unpredictable variations in annual funding and a large number of diverse stakeholders to satisfy, as well as many being required for work plan approval. Other challenges were access to data such as service uptake statistics from service delivery projects, and the lack of commodities and services to meet the demand it created.

In light of these conclusions, the evaluation team makes the following recommendations for the design of the next SBCC project in Tanzania:

First, USAID should consider one of the following three options in terms of prime lead for the next project:

1. Place an SBCC- and USAID-experienced local NGO prime with an international NGO as a partner with the ability to (a) support a local NGO by co-leading the financial and administrative aspects of the project with which the local NGO might not yet have had sufficient experience, and (b) provide expert SBCC advice, especially around mass media and production issues.
2. Develop a "mega-project" to consolidate several projects currently under USAID/Tanzania into one. This would include combining SBCC and social marketing, such as selling bed nets, condoms and other commodities through social marketing mechanisms, into one project, along with non-clinical service delivery, including community education and mobilization, and multi-channel behavior change communications programming for HIV, SRH/FP, MCH and malaria. Results would include national policy, planning and technical support; capacity building; regional, district and community-level

service delivery; social marketing; and SBCC at all levels. There is evidence that offering a product as a part of other SBCC work enhances the outcomes of the SBCC efforts.¹⁰

This design would call for a large, sophisticated international NGO prime with experience in all health areas, with two main subs—one for SBCC and one for social marketing—with a large NGO grants program for capacity building and implementation at the community level.

If the prime did not have SBCC and/or social marketing capacity, one other international NGO with expertise in SBCC and social marketing could be brought on as a sub to provide further technical assistance and capacity building to the two main local subs.

3. Continue having two separate projects for SBCC and social marketing, and the other health service delivery projects, with changes as noted in the other recommendations.

The following recommendations apply, regardless of which of the above three options is selected.

- USAID should design a project that features a better balance of nationally focused mass media, complemented by regional and community-focused mid-media, with the use of interpersonal communication methods at the community level.
- An evaluation design built in at the outset could yield valuable data for the entire public health community. This would require close collaboration with evaluation experts to select from a range of options for a non-randomized control evaluation design, and the solicitation would need to provide a budget and clear requirements for this element.
- The MOHSW should have a clear role during the project design phase with USAID, with national health priorities and needs at the center. The design should include a clear mandate with specific systems for collaborating with the MOHSW at all levels, from working groups at the national level down to consultation and reporting relationships with the CHMTs. The design should include clear guidance about how the project should work at the community level, including collaboration and capacity building with local NGOs and integration of community health workers into project implementation.
- An increased use of small grants to local NGOs as an implementation and capacity-building strategy should feature prominently in the next project. This helps on several fronts: tailoring more to local contexts, building local capacity and increasing the use of IPC. This should go hand-in-hand with support to the MOHSW work on local campaign designs, such as was started by TCCP.
- There should be closer coordination with service delivery projects, especially in terms of sharing data in order to monitor the impact of demand creation, and identifying knowledge gaps and attitudes affecting health behaviors among facility clients and community members that could be addressed through SBCC programming.
- The evaluation team did not come to a clear conclusion about combining an SBCC and social marketing project in the next design; the team received varying opinions about this from diverse stakeholders. However, in light of the need to consolidate project management in a large mission, and in the interest of greater synergies of effort, and efficiency, the team did not rule out a combination project as a possible option.

¹⁰ American Journal of Preventive Medicine, 2014; 47(3): 360–371.

- If the two projects are designed as separate entities, however, there should be much more collaboration and coordination between the two. There could be more coordination at all levels (national, regional, district).
- It is clear to the team that service delivery projects, and any SBCC project that addresses a project's area of service delivery, should be clearly directed to collaborate with an operational mechanism (e.g., technical working group) and regularly share data, with strong USAID leadership at the helm to coordinate, facilitate, reward and direct the effort across projects. TCCP was unable to obtain service delivery data (numbers of women attending PMTCT or following SP guidelines, FP uptake data, etc.) from implementing partners. USAID could facilitate this through a proactive stance on partner collaboration using a common platform, such as technical working group sharing.
- The project design should call for regional offices, at a minimum. The physical presence of staff trained in SBCC would go a long way in building the quality of programming for regional and district audiences as well as increasing the linkages and engagement with MOHSW stakeholders at these levels and other implementing partners in the field.
- The presence of only two staff in the regions for the current project limits the ability of the project to establish relationships with the local MOHSW offices, health facility staff, regional implementing partner staff, and those who could benefit from capacity building and mentorship that is not limited to the time boundaries of courses and workshops. This would facilitate community and stakeholder engagement as well as technical support and monitoring of project activities.
- To respond to the internal and external factors that affected the project's ability to achieve its objectives, it is recommended that USAID design the follow-on project with a clear plan as to how USAID will coordinate and more clearly direct funding streams to have some consistency and predictability over the life of the project. The focus areas of a similar project should remain more clear and consistent over the life of the project, with less flexibility for taking on new areas without a clear, documented modification to the agreement and scope of work language in the amendment.
- In addition, the future project design will have to take into account trends in HIV programming, such as the Country Operational Plan guidance, in which reference is made to UNAIDS 90-90-90 concept that aims to ensure that 90 percent of all people living with HIV know their HIV status, 90 percent of all people with diagnosed HIV infection receive sustained antiretroviral therapy and 90 percent of all people receiving antiretroviral therapy have viral suppression.¹¹ This might mean a change in the focus of the content of SBCC programming as well as a focus on districts with high HIV prevalence.
- A design should call for greater attention to the rural context in media productions, and the program should more fully engage stakeholders at the district and community levels in the design and development of programs and campaigns, and in providing interim feedback about programming. The program's work at the district level can evolve through granting mechanisms and mentorship by project staff based in the regions.
- District prioritization should proceed through project assessment and dialogue with the MOHSW. Variables to consider in prioritization should include epidemiology and need as well as the feasibility of locating suitable civil society organizations to implement through grants assistance. The purpose of the grants is to increase the reach to rural households, increase the impact of media through dialogue with individuals and communities to ensure greater understanding of messages and increased demand for services. Grants can also facilitate the work of NGOs and CBOs to improve

¹¹ PEPFAR Country/Regional Operational Plan (COP/ROP) 2015 Guidance, 12 February 2015.

the continuum of care through referral networks and enhance community mobilization and individual understanding and follow-through on behavior change messages.

- Given limited resources, one option to balance outcomes and resources for capacity building would be to use a central mechanism (e.g., HC3) for capacity building at the national level of lead stakeholders, such as central MOHSW staff, while reserving the funds of the bilateral for SBCC and other levels and types of capacity building.
- Several changes that are recommended for iterations of programs in the current project include: (1) Lengthen the duration of the ACE program so that more experiential practice can occur; (2) Increase the numbers trained in SBCC in the country; (3) Tighten the relationship between the project, mentors and interns in the ACE program sponsoring organizations so the experience can be more closely aligned with desired outcomes and so there are fewer instances of interns doing purely administrative work; (4) Add a listeners' groups training guide to the RDL program to facilitate discussion in peer group and individual settings, establish listening groups and set up systems that provide greater facilitation and monitoring of volunteers.
- The team recommends that USAID direct the next project to identify a strategy to provide funding and organizational development support to sustain the TASHCOM network of LSHC alumni. If it is determined that the MUHAS program is of value, USAID should reclaim it to be a part of capacity building by the successor project and should consider adding a mechanism for scholarship provision to ensure program completion by more students. This might be done through private sector leveraging.
- USAID would do well to align service delivery and the SBCC project much more closely with government services. This requires using baseline data and monitoring and maintaining communications between and across projects and the MOHSW and facilities over the life of the project in a manner different than has been done in the past with TCCP and other projects. This encompasses sharing of data and joint planning between service delivery, communications partners, DHMTs and CHMTs.
- The project design should specify a strategy to sync demand creation with supply to address the current failure of the health system to meet the needs of clients who take action based on behavior change messages but find services or supplies are unavailable, e.g., going to a facility for an HIV test only to find no test kits. Communication between an SBCC project, facilities and the MOHSW could trigger planning for an increase in demand.

I. INTRODUCTION

EVALUATION PURPOSE

The USAID/Tanzania Health Office requested a performance evaluation, including a process evaluation of the PEPFAR program components, of the Tanzania Capacity and Communication Project (TCCP), a cooperative agreement funded by USAID since September 2010 that is due to close in May of 2016.

The purpose of the evaluation was to review, analyze and evaluate the project's progress in meeting its objectives and intermediate results as the project enters its final year. The findings are intended to provide a critical review of several dimensions of success and challenges across the life of the project. USAID/Tanzania will use this information to improve project performance and inform the design of a future SBCC activity.

EVALUATION QUESTIONS

The evaluation team and USAID/Tanzania health team staff agreed on several key evaluation questions at the inception of the evaluation. These questions guided the development of the data collection tools, and the data that answer these questions are the focus of this report.

The evaluation questions included:

1. What were the outcomes of TCCP's SBCC programs in terms of behavior change among priority audiences?
2. What programmatic lessons about collaboration with Government of Tanzania, U.S. Government and NGO stakeholders can be drawn from TCCP's experience, with particular attention to the project's large-scale SBCC campaigns?
3. Which of TCCP's capacity-strengthening interventions have been most effective in improving the ability of individuals and institutions to design, implement and evaluate SBCC programming?
4. In what areas of behavior change research, design or implementation has TCCP successfully strengthened the capacity of Tanzanian individuals, institutions and communities?
5. What internal or external factors have influenced the project's ability to achieve its objectives?

II. PROJECT BACKGROUND

COUNTRY CONTEXT

Tanzania's population is estimated at nearly 42 million, and at the current growth rate, it is projected to reach 70 million by 2025.¹² Tanzania's life expectancy at birth is 52.46 years, and the population is primarily young (21.4 percent of women and 25.5 percent of men are between 15 and 19 years of age).

Tanzania has one of Africa's fastest growing economies. While the per capita gross domestic product (GDP) has increased, widespread poverty persists; in 2007, 68 percent of the population lived below the extreme poverty line of \$1.25 per day.¹³ The incidence of poverty weighs heavily on rural areas (33.3 percent) versus urban areas (21.7 percent). Tanzania's nearly 7 percent annual national GDP growth since 2000 has been hardly perceptible among its predominantly rural (73 percent) population.

The health status of Tanzanians has improved over the past decade. Investments in areas such as malaria control and increased access to safe drinking water have led to reductions in infant and under-5 mortality rates.¹⁴

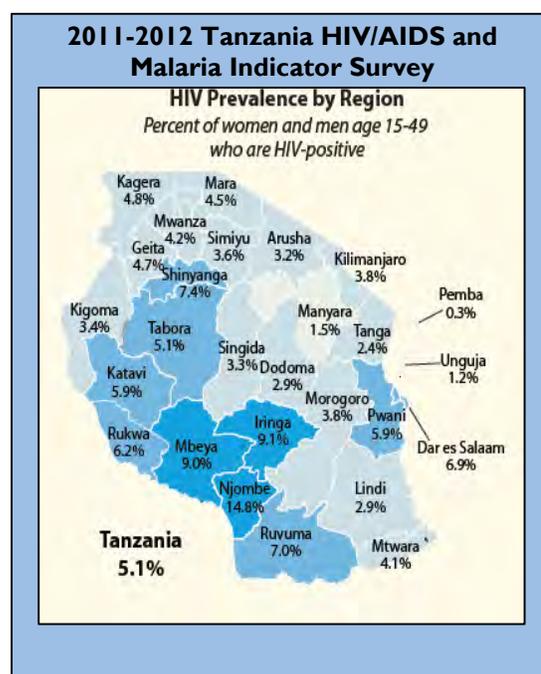
HIV/AIDS: HIV prevalence varies by region and stands nationally at 5.1 percent, a 0.6 decrease from five years ago.¹⁵ HIV prevalence is higher for women than men in every age group except 35-39.¹⁶

Among couples where both partners were tested for HIV, 5 percent were discordant (one partner is HIV-positive and the other is not). HIV prevalence is highest among women and men who are widowed or divorced/separated. Women and men who have never been married are least likely to be HIV-positive. The TDHS 2010 and THMIS 2012 indicate that the proportion of the population with comprehensive knowledge about HIV transmission and prevention has not changed significantly (among females from 48.6 percent to 42 percent; among males from 46.5 percent to 50 percent).¹⁷

The number of people receiving antiretroviral therapy (ART) has been increasing steadily since 2010. By December 2013, a total of 1,366,402 were enrolled in care and treatment centers, and 512,555 people living with HIV were receiving antiretrovirals, of whom 8 percent were children.¹⁸

Maternal and Child Health: Despite high coverage rates of antenatal care (96 percent attend at least once), only 50 percent of women delivered in a health facility, and maternal mortality remains high at

Figure 1. HIV Prevalence by Region



¹² Tanzania in Figures, 2012, NBS; projection figure from Tanzania's Population Planning Commission, 2007.

¹³ World Bank. World Development Indicators, 2012. Purchasing Power Parity measured in U.S. dollars.

¹⁴ USAID/Tanzania CDCS, Country Development Cooperation Strategy October 3, 2014–October 3, 2019.

¹⁵ UNAIDS, 2012.

¹⁶ Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics, Office of the Chief Government Statistician (OCGS), and ICF International 2013.

¹⁷ TDHS 2010 and THMIS 2012.

¹⁸ NACP, 2014. Care and Treatment Report for 2013.

454 deaths per 100,000 live births (accounting for approximately 8,000 maternal deaths per year) due to obstetric hemorrhage, obstructed labor, pregnancy-induced hypertension, sepsis, and abortion complications.¹⁹

Notably, under-5 mortality rates have dropped by 40 percent, from 137 deaths per 1,000 births in the mid-1990s to 81 for the period 2006-2010.²⁰ Nevertheless, neonatal mortality rates have been high at 32 per 1,000 live births, and account for 47 percent of the infant mortality rate.²¹ Data from the Tanzania DHS show that only half of Tanzanian women deliver in a facility, and only 13 percent of women received any postnatal care within 48 hours after delivery.

Family Planning and Reproductive Health: Demographic and Health Surveys (DHS) in Tanzania suggest a “gradual and steady increase” in contraceptive use among married women over the last two decades, with a concurrent increase in the use of modern methods. The 2010 DHS indicates that 29 percent of all women, including 34 percent of married women and 51 percent of sexually active unmarried women 15-49, currently use contraception. The large majority of these women use modern methods, with injectables, oral contraceptives and male condoms predominating. Unmet need for FP remains high at 22 percent.

Malaria: Among all households in Tanzania, 95 percent possess at least one mosquito net and 91 percent own at least one insecticide-treated net. Ninety-two percent of Tanzanian households are covered by vector control. Thirty-one percent of women in Mainland Tanzania with a live birth in the two years preceding the THMIS survey received intermittent preventive treatment (IPTp) during an antenatal care (ANC) visit, compared with 48 percent of women in Zanzibar.²²

THE TANZANIA CAPACITY AND COMMUNICATION PROJECT (TCCP): PROJECT OBJECTIVES

As stated in the RFA, TCCP was designed to support the achievement of the following USAID/Tanzania’s Assistance Objectives:

AO 10: Reduced transmission and impact of HIV/AIDS on Tanzania

Sub-element 1: Improved HIV/AIDS preventive behaviors and social norms

Sub-element 2: Increased use of HIV/AIDS prevention to care services and products

Sub-element 3: Improved enabling environment for HIV/AIDS responses from community to national levels

Sub-element 4: Enhanced multi-sectoral responses to HIV/AIDS

AO 11: Health status of Tanzanian families improved

Sub-element 1: Malaria morbidity and mortality reduced

Sub-element 2: Modern contraceptive prevalence increased

Sub-element 3: Maternal and child mortality reduced

USAID/Tanzania manages a portfolio aimed at changing behaviors for positive health outcomes through a limited number of projects that emphasize technical and operational capacity strengthening using complementary strategies that include community mobilization and outreach. Within that portfolio, TCCP is a five-year, USAID-funded cooperative agreement awarded on September 12th, 2010. In terms

¹⁹ The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008–2015.

²⁰ TDHS 2010.

²¹ National Road Map 2008–2015.

²² THMIS, 2011-2012.

of the relationship of this project to the USAID/Tanzania country strategy results framework, there was no results framework for the USAID mission referenced in either the RFA or the technical proposal that was awarded.

TCCP's original end date was in 2015, but the project has a no-cost extension with a closing date of May 11, 2016. TCCP is led by the Johns Hopkins Center for Communication Programs (JHU-CCP) in collaboration with Media for Development International and CARE Tanzania. Due to a reduction in anticipated funding levels, CCP ended its sub-award with CARE International in the second quarter of FY2015. In 2013, TCDC was added as a sub-partner.

The goal of this cooperative agreement is to increase the adoption of safer behaviors by Tanzanian adults and high-risk populations (adults and youth) to prevent or manage HIV infection, support the uptake of FP to reduce unmet need, address maternal, newborn, and child health issues, and address other health issues.

USAID's agreement with JHU-CCP outlines two project objectives:

1. Execute evidence-based, coordinated SBCC initiatives at scale.
2. Reinforce systems for coordinating and delivering behavior change communications.
 - 2.1 SBCC will be effectively coordinated at the national, regional and district levels.
 - 2.2 SBCC skills will be measurably transferred to Tanzanian institutions and organizations.

TCCP is premised upon the Integrated Change Model (see Figure 1). This model, which draws upon socioecological frameworks common in behavior change programming, posits that sustained behavioral change requires intervention at the individual, social and structural levels. TCCP's work in capacity strengthening expands upon the project's Integrated Change Model, articulating a specific vision for development of sustainable SBCC capacity. This model, presented below, describes four complementary pathways to national capacity.

Major activities to achieve Program Objective 1 included:

- Development and production of weekly variety shows or entertainment education programs on television and radio;
- Development and implementation of high-visibility, national multi-media campaigns addressing HIV prevention, FP, and neonatal and child health. Such campaigns have included community activities implemented through CARE and TCCP community outreach agents;
- Development of national and sub-national SBCC strategies pertaining to specific health areas, in conjunction with the Government of Tanzania and U.S. Government implementing partners;
- Development and oversight of a coordinated materials distribution system for Tanzania.

Figure 2 is the guiding conceptual framework for the capacity-building activities in SBCC that TCCP implemented.

Figure 2. Pathway to Sustainable Strategic Health Community Capacity



Activities contributing to Program Objective 2 have included:

- Reinforcement of systems for coordinating and delivering SBCC, including the provision of individual-level capacity strengthening to key staff members within the MOHSW, NACP and TACAIDS, and participation in the Leadership in Strategic Health Communication (LSHC) training or the Advancing Communication Experientially (ACE) fellowship and internship program.
- Technical support to Government of Tanzania technical bodies, including the MOHSW, NACP and TACAIDS, including leadership to technical working groups in the design and development of campaigns, a “learning by doing” capacity-building approach.
- Harmonization of messages through coordination across implementing partners.
- Using a training-of-trainers model for LSHC training to ensure roll-out at the district level.
- Support for the design and implementation of district-level SBCC campaigns by trainee teams, completed in seven out of eight districts selected.
- Development and production of a 26-episode radio distance-learning (RDL) program targeting community health workers.
- Establishment of the ACE fellowship and internship programs to provide applied learning opportunities in SBCC. The project conducted institutional capacity assessments to a variety of Tanzanian entities, with provision of tailored SBCC capacity-strengthening services and/or referral to external resources based on identified needs.
- Other activities in support of local capacity building included support to Muhimbili University of Health and Allied Sciences (MUHAS) for development and provision of SBCC-related short-courses and degree programs.

Deliverables that were added to the original agreement in year 4 included the following:

- Rural Communication Initiative
- Integrated district malaria plans and funding
- Linking Community Change Agent (CCA) activities with health facilities and villages
- Mobilizing communities to act on malaria prevention and treatment
- Mobile Video Units
- Supporting the CCA platform under CBOs
- Safe motherhood campaign
- Case management
- School Net program
- Technical assistance to NMCP
- Malaria Safe Program
- Zanzibar Continuous Distribution Campaign
- Zanzibar Case Detection
- Support to ZMCP BCC Cell
- Zanzibar Monitoring
- Zanzibar KAP survey
- IPTp3+ assessment for mainland

The major capacity-building strategies the project used included:

- ACE mentoring: individual and institutional capacity building through placement of interns.
- Capacity assessments: baseline and follow-up measures of organizational capacity in program and technical areas critical to SBCC programming.
- RDL: the use of radio for distance learning.
- Primary Health Care Institute (PHCI): a local institution that trains health care providers and used these skills to build SBCC capacity among the health teams.
- Swahiliwood: a program to train filmmakers to integrate health topics in films.
- TASHCOM Alumni: a network of former LSHC participants working on SBCC for sharing expertise and support.

Research, monitoring and evaluation have been central to TCCP's activities, informing design, determining reach and confirming impact. TCCP seeks to balance the need for routine and readily available programmatic data with more rigorous research exploring programmatic outcomes and behavioral impact. In addition to purchasing communication data collected through quarterly omnibus surveys and conducting ongoing pre- and post- surveys of its SBCC fellows and interns, TCCP has conducted several larger-scale evaluation activities, including project baseline and midline surveys, campaign pre-testing and evaluation and a qualitative assessment of its RDL program for community volunteers.

III. EVALUATION METHODS & LIMITATIONS

EVALUATION DESIGN AND METHODOLOGY

This evaluation is a retrospective performance evaluation. USAID/Tanzania developed a scope of work, and the team provided input during an in-briefing that included revisions to the questions and the sample. The evaluation questions, detailed in the evaluation matrix in Annex I (SOW), focused on the performance of the project in three main areas: (1) SBCC implementation, (2) coordination and collaboration and (3) capacity building.

Methods

The mixed-method evaluation featured: (1) review of project documents (e.g., quarterly and annual reports) and other literature; (2) secondary analysis of existing data (project surveys and internal evaluations conducted by the partner, organizational capacity assessment tools, and performance management plans); (3) semi-structured key informant interviews (KIIs) with stakeholders, capacity-building recipients and project staff; and (4) focus group discussions (FGDs) with community-based representatives.

Sample

USAID/Tanzania identified four regions for field work (Dar es Salaam, Iringa, Njombe, and Mwanza) based on the following criteria: presence of both this project and another also being evaluated (Tanzania Social Marketing Project, or TSMP), and multiple activity areas (HIV, FP/RH, MCH and malaria), mission priority areas, appropriate mix of settings and target populations, and travel and time considerations. In Dar es Salaam, the team also met with national representatives, implementing partner headquarters staff, other U.S. Government implementing partners and other stakeholders, as well as regional and district health team members.

Based on the activities that the projects have implemented, the team carefully selected interviewees that represented the main areas of focus, including SBCC implementation, coordination and collaboration, and capacity building in the major health areas, including HIV, MCH, FP/RH and malaria.

The team interviewed a total of 103 persons through a combination of 71 KIIs and three FGDs and small group sessions. The full list of all interviewees appears in Annex III, and the tools used for each type of informant are available in Annex V.

The sample included a mix of MOHSW program managers, leaders and health care workers at the national, regional and district levels of the system; international and local NGO staff; individuals and organizations who benefited from TCCP's capacity-building activities; community workers to provide insights about beneficiaries' needs and experience with TCCP programs; and TCCP prime and partner staff. Selection of individuals and groups to be included in the sample was done through contacts with the MOHSW and international and local NGOs with whom the project had collaborated over the life of the project, based on project reports, and project and USAID recommendations. Contact information was provided by the project. The team used information gained during interviews to add informants to the sample. There are only a few additional NGOs or personnel who interacted with or benefited from the program that were not interviewed. The team took the risk of bias into consideration and is confident that bias is not an issue in the sample.

The sample included nine staff of the MOHSW at the national level; 11 at the regional level and 21 at the district level. Regional and district level staff represented those managing HIV, reproductive and child health (RCH), malaria, and voluntary medical male circumcision (VMMC) programs. The team also interviewed health care workers who provided direct clinical services—two in RCH and three in VMMC.

Interviewees included eight persons from international NGOs, nine from local NGOs and six from PHCI and Muhimbili University. In addition, one media manager from a regional radio station, five ACE program participants, 10 RDL participants, nine community resource persons and five project partner staff were key informants. Four TCCP staff also provided interviews. Community resource persons were a part of discussion in focus group sessions.

Data collection and analysis

The team developed and pre-tested semi-structured KII and FGD guides in English that were translated into Swahili. While the majority of the interviews and focus groups were conducted in Swahili, some were conducted in English, such as interviews with implementing partners and the national government officials. In most cases, the evaluation team conducted KIIs and FGDs in teams of two, with one person taking the lead in asking questions and the other taking the lead for note taking.

Following each interview or focus group, evaluation team members debriefed with the team leader, highlighting major findings. Most KIIs and FGDs were audio-recorded, transcribed and translated into English before being coded and entered into NVivo for thematic analysis.

The data collection instruments featured the following tools (details in Annex II):

Semi-structured KII Guides

#1 Stakeholders and Implementing Partners

- a. National: MOHSW programs, including NACP, NMCP, TACAIDS, RCH, Health Promotion
- b. Regional: RMO, RHMT, RAC, RCHCo, VMMC and RCH health care workers
- c. District: CHMT, DAC, DRCHCo, TRCHCo, malaria focal person, VMMC and RCH health care workers
- d. U.S. Government implementing partners in Dar es Salaam and in regions

#2 Capacity-building recipients: organizations

- a. National (PHCI)
- b. Regional and district: RHMTs and CHMTs
- c. NGOs

#3 Capacity-building recipients: individuals

- a. LSHC alumni
- b. ACE mentors, interns, fellows

#4 RCH health care workers

#5 VMMC health care workers

#7 TCCP staff

FGD Guides

#6 Community contact persons working with beneficiaries

#9 RDL participants

#10 ACE program participants

Themes for analysis

The team developed an initial list of themes for analysis to use as a basis for qualitative analysis using a grounded theory approach. Themes were grouped around the key research questions addressing communications, collaboration and coordination, and capacity building. The team revised the themes during the course of data collection to reflect emergent concepts and hone in on the evaluation questions. The team conducted a subset of both translation and inter-coder reliability checks to ensure standard use of the codes.

LIMITATIONS

While the project did collect a large amount of data for internal management and evaluation purposes, as outlined in the SOW, the evaluation primarily used rapid assessment methods including KIIs and document review. Accordingly, the findings are subject to recall bias as well as social desirability bias. Due to time and logistical constraints, the team visited a subset of regions and districts where the project was implemented, and these sites may not be representative. Another limitation was that in some locations that the evaluation team visited, project activities such as community mobilization were no longer active, which limited the evaluation team's ability to collect relevant information. The evaluation team attempted to mitigate these threats to validity by triangulating multiple data sources and reviewing original data from internal project evaluations. Lastly, the lack of recent population-based data through a Demographic and Health Survey, Service Provision Assessment, or similar survey precluded the team from exploring the effect of programs among targeted beneficiaries.

While the TCCP evaluation was never intended to be an impact evaluation, it is worth noting that there is a growing interest and need for impact evaluations of health communication interventions for HIV prevention and other health areas. Evaluation question #1 borders on being an impact question, which the team addressed through review of internal evaluations and the other methods described, and by way of evaluating the project's objective, to "execute evidence-based, coordinated social and behavior change communication initiatives at scale." However, there is a foundation for recommending that the next project consider building in a more robust evaluation design. Short of a randomized trial, which is likely not to be feasible for a multitude of reasons, articles referenced in Annex 4 describe possible alternatives, including types of quasi-experimental studies.

IV. FINDINGS

The tools that guided the gathering of evaluation data reflect the evaluation questions, and the findings are organized around these questions to reflect the major themes of analysis. The recount of the findings reflects the major trends that emerged in the KIs and FGDs. For each evaluation question, conclusions and recommendations follow in Section VI of this report.

EVALUATION QUESTION 1: WHAT WERE THE MOST IMPORTANT OUTCOMES OF TCCP'S SBCC CAMPAIGN AND PROGRAMS IN BEHAVIOR CHANGE AMONG PRIORITY AUDIENCES?

To address this question, the evaluation team assessed the performance of the TCCP program's objective number 1, to “execute evidence-based, coordinated social and behavior change communication initiatives at scale.” TCCP’s SBCC program applied an Integrated Change Model (see diagram in Project Background) to guide the development, design and implementation of the program. This model is based on a socioecological model of behavior adoption and maintenance, recognizing four domains of influence on health behavior (social-political, service delivery, community and individual). This theory provides a suitable and well-rounded framework for developing interventions at different levels. The theoretical model states that, in order for an individual to take action, communication must address barriers in multiple domains.

The evaluation team’s findings confirmed that the project applied the model well in its design and development of the communication campaigns. They were done in a systematic manner and were based on evidence. At the national level, more than at the regional and district levels, stakeholders were involved in the campaigns from the design through implementation stages.

Those interviewed almost universally felt that the campaigns and messages were of high quality. Most perceived them to be clear, compelling, educative and wide in reach. One BCC expert respondent from an NGO stated, “The mass media strategies and design of messages were very culturally appropriate and very effective.” According to one MOHSW respondent, “TCCP has been instrumental in SBCC and has facilitated the positioning of health communications in the country.” Another stated, “Overall, it is good—they have been able to communicate with the different groups in the population on essential services and interventions—they usually come up with catchy messages where dialogue continues....”

Despite the consensus about the campaign and messages being of high quality, compelling and educative, most of the respondents in the rural areas felt the campaigns were tailored more to the urban than rural setting. Participants in the rural areas sometimes could not relate or identify themselves with certain images on posters. There were cases where campaigns and messages were adapted and localized to suit the communities, mostly through the community radio stations.

Many RHMTs, CHMTs and health care workers did not feel they were consulted or involved in the development of the campaigns, and there were suggestions as to how the messages could be more relevant at the periphery of the regional and district facilities.

While the use of radio was noted and applauded, there was a preponderance of opinion that there was an insufficient use of interpersonal communication at the lowest levels of communities, i.e., villages and households. A table included in the midline project report confirms that community discussions were not a prominent program channel, except in the Tuko Wangapi campaign.

Table I. Summary of TCCP Program Channels²³

Campaign	Wazazi Nipendeni	Green Star	Tuko Wangapi	Siri ya Mtungi	Aiissee!
Launch Date	November 2012	October 2013	May/June 2012	December 2012	January 2014
TV	Yes			Yes	
Radio	Yes	Yes	Yes		Yes
Brochures/Print Materials/Magazines	Yes	Yes	Yes	Yes	
Billboards	Yes				
Social Media			Yes	Yes	Yes
SMS	Yes	Yes			
Promotional Materials	Yes	Yes	Yes		
Community-level Discussions			Yes		
Health Facility Materials	Yes				
Other	Reality TV and radio show feature		University outreach, World AIDS Day activities	DVDs, YouTube episodes	Radio episodes

Two confounding factors contributed to the lack of IPC activities in the regions: Njombe is a new region that was added to the program, and TCDC has taken up the role of CARE, which is no longer a partner, in implementing IPC activities through local NGOs, but it has only begun work in regions that the team did not visit.

The perceived need for more IPC is reflected in the comment of one MOH manager: “Even radio messages are not much reached in villages...brochures and banners are not readable, most people they just take but do not read, you can find a woman having brochure as if she is reading, now if you ask her anything what is in the brochure, she will not answer. Most people here they don’t care about reading. TCCP or JHU-CCP—they are supposed to stop dealing with people in town, they should go to the villages by using influential people, community change agents (CCAs), peer educators.”

Another RCH manager noted, “I have also observed that messages, which are delivered to the community directly through dramas, meetings and forums, have more impact than those that rely on the TV and radio alone.

Example of a campaign, which has used this approach, is Tulizana campaign.”

As of December 2014, the numbers reached with IPC by CARE over the four-year period that it worked with the project were 532,080 for Tuko Wangapi? Tulizana and 62,584 for Green Star, in the final year.

Reviews of activity reports by CBTs, feedback from CARE program officers and field visits by the monitoring team have revealed a new, deeper level of understanding of HIV transmission and sexual networks. While the majority of community members seemed to understand that HIV is transmitted from one person to another, they did not know that concurrent partnerships put one in a network where only one person could spread infection to all people with the network.

TCCP 2011 Annual Report

A review of earlier TCCP reports (2011 Annual Report) reveals the inclusion of IPC in TCCP’s program through community outreach volunteers. However, it is clear from the RFA and JHU-CCP’s technical proposal that IPC in the form of one-on-one or small group interactions, including face-to-face counseling and education, is not prominent in the program design, and is not currently a robust component of the program, despite the ongoing and planned work of TCDC through small grants to

²³ Midline Evaluation of TCCP Programs, December 2014.

NGOs and CBOs in several regions. In year 5, TCCP will be implementing an aggressive expansion of work with community groups through TCDC, and it has already expanded to 17 regions, covering all districts and wards.

TCCP's program consisted of several key programs in the main health areas:

- *Wazazi Nipendeni* (safe motherhood, including safe delivery, ANC, eMTCT, SP, bed nets): Phase I, November 2012-December 2014 (2 years, 1 month); Phase II, launch July 2015
- *Tuko Wangapi? Tulizana* (multiple concurrent partnerships): Phase I, June 2012-March 2013 (10 months); Phase II, August 2013-December 2014 (1 year, 5 months)
- *Green Star* (FP): Phase I (called Jiamini), April 12-September 2012 (6 months); Phase II, October 2013-December 2014 (1 year, 3 months)
- *Siri ya Mtungi* (HIV prevention, FP and maternal and child health): Season 1, December 2012-March 2013 (4 months); Season 2, December 2014-March 2015 (4 months)
- *Aiissee!* (couples communication): January 2014-February of 2015 (1 year, 2 months)

TCCP also supported all VMMC partners, upon request, and used radio, print and promotional materials to create demand for male circumcision. TCCP supported VMMC campaigns in Tabora, Iringa, Njombe, Simiyu, Rukwa, Katavi, Shinyanga, Mbeya, Mwanza, Geita, Mara and Kagera regions through TV and regional radio programming.

A national malaria testing and treatment campaign in Phase 2 benefited from TCCP's work on "Not every fever is malaria." The project worked with PSI in Morogoro and Kigoma to test concepts and prototype materials and reached over 145,000 community members in six regions. TCCP provided technical assistance for the National Malaria Communication Strategy.

Details of the major campaigns follow.

Wazazi Nipendeni: Wazazi Nipendeni is a safe motherhood national campaign with the aim of empowering pregnant women and their partners to seek and adopt healthy behaviors during pregnancy and delivery. The campaign addressed the following areas: early and continued antenatal care attendance, birth planning, HIV testing, PMTCT enrolment, utilization of long-lasting insecticide treated bed nets and uptake of SP for malaria prevention during pregnancy.

KII and FGD findings reveal that the Wazazi Nipendeni campaign is popular and has been very effective in addressing HIV testing, malaria prevention in pregnancy, antenatal care attendance and delivery at the health facility. The campaign messages are perceived to be very clear, educational and, for the most part, contextually appropriate.

An RCH matron testified to the impact of the campaign on client behaviors: "Wazazi Nipendeni had the greatest influence because most pregnant women join early at ANC compared to previous days and they do HIV/AIDS checkups and for those who are positive they are taking ART to prevent their baby from getting HIV/AIDS, also women are using ART and many deliver their baby at health centers instead of home, also intake of SP for malaria prevention is high... most of my clients listen this campaign on the radios because radio is everywhere even on the mobile phone a person can listen to radio. Posters at the clinic, in the clinic we have posters showing a pregnant woman taking SP for malaria prevention, taking ARTs for HIV/AIDS for prevention from mother-to-child transmission, also we have posters of family planning, etc. All this help to educate clients who come here for services."

Interviewers asked providers about the behavior and attitudes of providers and clients in the areas of malaria and PMTCT. The most common response by most providers was that there are noticeable changes, in that providers are no longer prescribing malaria medication without testing clients. One health care worker noted: “Malaria testing—yes, there are changes in the provider nowadays—they are not prescribing malaria drugs without testing. And most of the families know the importance of bed net use so that they could not get malaria, and if they have fever they go to the health center for the testing before treatment. Pregnant women are taking SP so children who born with malaria are few.”

Respondents also stated that they could see some changes at the health center: they had started seeing women come to the facility with their partners to take the HIV test together. “There are changes, pregnant women are now coming with their partners and test for HIV together compared to previous days.”

Results from the Wazazi Nipendeni impact evaluation showed that for each message source to which a woman had been exposed, there were 20 percent greater odds that she delivered at a health facility, even controlling for all other variables.

Impact of Wazazi Nipendeni Campaign

- **Number of ANC visits:** Campaign exposure was a statistically significant factor for ANC visits, with greater exposure associated with more ANC visits, controlling for all demographic variables ($\beta=0.07$, $t=2.64$, $p<0.01$).
- **HIV testing:** Greater exposure to the campaign increased the odds of HIV testing by 18 percent, controlling for all demographic variables (Chi-square (1)=5.94, $p=0.02$).
- **Mosquito net use:** For each increase in message source to which a woman was exposed, there were about 61 percent greater odds the woman slept under a mosquito net the previous night, even controlling for all other demographic variables ($p<0.001$).
- **SP uptake:** Women exposed to more messages had about a 23 percent greater chance of having received two or more doses of SP, controlling for all other demographic variables ($p<0.001$).
- **Individual birth planning:** The more sources from which women reported hearing the Wazazi Nipendeni message, the more they prepared for the birth of their child, controlling for all demographic variables ($\beta=0.06$, $t=2.55$, $p=0.01$).

Love me Parents—An Evaluation of Tanzania Safe Motherhood Campaign, September 2014.

Campaign reach and recall are depicted in the text box below:

Wazazi Nipendeni: Campaign Reach and Recall

- Over a third of surveyed women (35.1 percent) were exposed to the campaign, with 16.5 percent reporting daily exposure.
- The primary source of exposure was radio (83.3 percent), which also provided the highest frequency of exposure.
- Over one-quarter (28.3 percent) of those exposed to the campaign recalled multiple messages, with the most commonly reported message being, “Go to the health facility as soon as possible.”
- 76.6 percent of women reported getting information about HIV/AIDS.

Love me Parents, September 2014

The most common form of exposure to messages was radio. Critical to the implementation of the campaign was the use of mHealth, supported by the CDC Foundation, to reach the target audience. While only 7.1 percent of respondents reported hearing about the SMS system, nearly one third (29.5 percent) of those that did texted the key word to the number provided, 83.3 percent of those completed registration in the system and 86.7 percent of those were still enrolled in the system. Half of

the women who texted the system told others about the information they learned through SMS; 83.3 percent said they would recommend it to others.²⁴

According to a project midline study, which included Wazazi as one of the project's platforms, all the participants exposed to the campaign (58 percent of men and 44 percent of women) showed that they had made improvement in developing better birth plans in the case of one of the twelve birth planning behaviors. Participants exposed to the campaign were more likely to know more about the danger signs in pregnancy and were more likely to have a facility-based delivery.²⁵

In support of the campaign's effectiveness, an NGO program manager felt the PMTCT messages were one of the best campaigns in the country to date. "When I look at the messages mostly the PMTCT messages is one of the best campaigns the country has." Other providers note that the campaign contributed to creating demand among women for HIV testing and ANC services: "Wazazi Nipendeni is much of RCH but has also HIV part of PMTCT. It is this campaign that has made a great contribution in creating demand for HIV testing during pregnancy and since most of the women are now attending ANC it becomes easy for the health care workers to test them for HIV, and sometimes they come with their partners so it has been very helpful."

Service statistics to support the results of the campaigns such as Wazazi were often unavailable to the project, and it is recommended to address this in the future project. TCCP staff expressed a desire to understand better what difference their demand-creation efforts were making, but it was difficult to get this data from service delivery implementing partners.

An internal midterm assessment by USAID in 2013 noted that community activities in support of Wazazi Nipendeni were at that point relatively undefined, and stakeholders interviewed as part of the assessment understood the strategy for community-level rollout of the campaign differently. It is not clear that this was clarified further, which is another example of where the multi-channel campaigns did not clearly have the implied balance of IPC, media and print components.

Tuko Wangapi? Tulizana: The Tuko Wangapi? Tulizana campaign is a national multi-channel campaign whose reach has extended to 500,000 community members through IPC and the use of mHealth. It aimed to encourage dialogue on issues around concurrent partnerships. The campaign is perceived to be very popular, effective and successful. Respondents' perceptions indicate that the campaign has greatly contributed to behavior change among individuals in the reduction of multiple partners, evidenced in one respondent's comments: "I know Tulizana Tuko Wangapi campaign because it is directly related to my work...this campaign wants people to stop having many partners, it wants people to limit the number of partners. This campaign has helped so many people to limit their number of partners and hence reduce HIV transmission. This campaign has been so popular to the extent that even people in Dala speak about it...you can find a lady telling a man... 'Tulizana,'"

As to whether the Tuko Wangapi, Tulizana campaign motivated any action on the part of its target audience, one health worker noted that the campaign "entertained a massive testing campaign on HIV. So many people showed up for voluntary testing."

²⁴ Tanzania Capacity and Communication Project (TCCP). 2014. "Love me, parents": An Evaluation of Tanzania's National Safe Motherhood Campaign. Baltimore, Maryland and Dar es Salaam, Tanzania: Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, TCCP.

²⁵ Midline Evaluation of TCCP Programs, December 2014.

Another respondent noted the effect on sex workers: “For me, the Tulizana campaign was very helpful because it raised awareness of people and helped them to get tested and reduce the number of partners...most people were speaking highly of the campaign and even the number of testing increased. Even the CSW reduced the number of their clients, they were saying that I used to have 10 clients but now I only have 3-5 because I do fear the network.”

While the midline report showed changes in behavior and certain attitudes, it did not show changes in attitudes towards multiple and concurrent partnerships themselves (see text box).

Green Star: In October 2013, the Green Star multi-channel campaign was rejuvenated, focusing on family planning and reproductive health (FP/RH). The campaign was re-launched with the purpose of contributing to the 60 percent national contraceptive prevalence rate (CPR) target by 2015.

As part of this campaign, CARE started IPC for FP in 2014. In addition, a series of regional launch events tied demand creation with service provision in low CPR regions. With the slogan, “Follow the green star for development,” key messages include healthy timing and spacing of pregnancy, male involvement in FP, couple communication and other issues and concerns around FP.

Among the channels used for the Green Star campaign was the m4RH SMS platform that is reported to have been very popular. The platform was utilized to advise clients about available FP methods and to connect them to the nearest clinic for services. Findings from interviews show that the m4RH channel was very effective, and USAID will continue to fund it until January 2016 while pursuing a sustainability strategy.

According to MOHSW staff, “Family planning was still in the Red Zone—family planning continues to be one of the poorly performing programs based on the national indicators.” One barrier to FP provision to youth in some areas was evidenced in one region where an NGO reaching youth reported that, “A regional commissioner had prohibited outreach to schools and no condoms for kids under 18—could only talk about abstinence...”

One health worker noted, “If the youth would freely use contraceptives, we would not be having so many abortions, something needs to be done to advocate for family planning use among the youth.” Most of the respondents felt there was need to target and involve schools in the promotion of family and reproductive health earlier in the school curriculum.

A midline study completed by JHU in December of 2014 states, “A national survey showed that about half of the participants (57.2% of men and 50.3% of women) were exposed to the campaign. Those who were exposed were significantly more likely to have heard of family planning than those who had not been exposed. Exposure to the campaign was also associated with higher family planning knowledge. Additionally, those exposed to the campaign demonstrated a significantly greater likelihood of family planning use over the last year and a likelihood of communicating about family planning.”

Siri ya Mtungi (SyM): A national television series promoting HIV prevention, FP, and maternal and child health through research-informed entertainment-education, “artfully weaving behavior change messaging into storylines...SyM tells the story of ‘relationships won and lost through a cast of colorful

“Over half of the participants (67.8% of men and 52.5% of women) were exposed to Tuko Wangapi messages. Campaign exposure was significantly associated with sexual protection self-efficacy, positive sexual attitudes and lower sexual risk behavior, positive condom attitudes and condom use at last sex. Additionally exposure to this campaign was associated with improved HIV prevention knowledge, HIV testing and communication about HIV testing among partners.

However, Tuko Wangapi demonstrated no impact on attitudes towards multiple and concurrent partnership.”

Midline Evaluation of TCCP Programs,
December 2014.

characters, inspired by love, brought down by fear, superstition and betrayal, and strengthened by the intimate bonds of family and friendship.”

Full-length episodes were posted on the Swahiliwood YouTube channel, and SyM DVDs were released in October 2013 and made available to implementing partners for health programs. Supportive communication channels include promotional television spots, posters distributed to video libraries and SyM’s Facebook page.

Most of the respondents interviewed in the regions did not know about the Siri ya Mtungi television series. Secondary analysis of the national, structured, household-based cross-sectional midline survey was conducted in April 2014 report, participants were asked if they had watched an episode of Siri ya Mtungi in the last six months. Of the participants interviewed during the midline study, 15 percent of the surveyed women and 18.4 percent of the men had watched the TV series within the last six months.

A midline study finding showed that exposure to this campaign showed a significant association with higher sexual protection self-efficacy, sexual risk behavior communication and positive condom attitudes compared to those who were not exposed. However, the campaign did not have any impact on sexual attitudes, HIV prevention knowledge and HIV testing.²⁶

Aiissee! (I say): Aiissee! is a multi-media campaign consisting of a 30-minute weekly radio game show, radio spots and social media. The program was launched in January of 2014, and aired countrywide with a focus on strengthening relationships and communications between couples. The team established that the midline survey was conducted three months after the program was launched, and therefore it was expected that the exposure results would be low. Of the participants who heard the program, only a third of both the men and women (34.6 percent of men, 28.9 percent of women) acknowledged listening to a full program, while 18.5 percent of women and 22.8 percent of men indicated that they had only heard the radio spot promoting the radio program. According to the midline report, neither Siri ya Mtungi nor Aiissee! showed any impact on sexual attitudes, HIV prevention knowledge or HIV testing; however, as noted above, the survey was conducted only three months after Aiissee! was launched. The evaluation team did not focus on asking for much input on Aiissee!, given that the project was instructed to discontinue this program earlier than planned.

There were other areas in which Aiissee! produced significant outcomes, as revealed in the midline, which showed that exposure to the campaign was significantly associated with improved sexual protection self-efficacy, sexual risk communication, and condom use with last primary sexual partner. Additionally, exposure to the campaign was significantly associated with an increase in HIV prevention knowledge, likelihood of having ever been tested for HIV, and discussing HIV testing with a partner.

EVALUATION QUESTION 2: WHAT PROGRAMMATIC LESSONS ABOUT COLLABORATION WITH GOVERNMENT OF TANZANIA, U.S. GOVERNMENT AND NGO STAKEHOLDERS CAN BE DRAWN FROM HOW TCCP DESIGNED AND IMPLEMENTED ITS LARGE-SCALE SBCC CAMPAIGNS?

Collaboration with Government

TCCP collaborated with the central MOHSW, and particularly with the Directorate for Preventive Services, under which the Reproductive and Child Health Services (RCHS) and Health Promotion Education (HPE) sections, and the National AIDS Control Program (NACP) and National Malaria Control Program (NMCP) belong. TCCP also worked with the semi-autonomous government’s commission for HIV and AIDS (TACAIDS), responsible for the non-medical HIV and AIDS mobilization and response interventions. The sections and programs at the Ministry benefited in varied ways,

²⁶ Midline Evaluation of TCCP Programs, December 2014.

including participation in SBCC training, learning through the technical working groups supported by TCCP, capacity building in SBCC, financial support, and SBCC material design, production and dissemination.

At the sub-national level, TCCP worked with the local government and collaborated with the RHMTs and CHMTs. District CHMT members received SBCC capacity-building training and tool kits with job aides covering topics on HIV/AIDS, malaria, FP and MNCH. Districts were invited to submit proposals for SBCC campaigns, and eight were selected for implementation that was supported by seed funds; seven of the eight have completed the process.

At the regional and district levels, there was a sense of wanting more inclusion by and consultation from TCCP. For example, one DRCHCo said: “Yes, I must say, everything stops at the office of the DMO. Most of these organizations reports at the DMO’s office and let him or her use discretion to choose to involve the heads of respective departments. Sometime issues stops at the DMO’s level even if are concerned with RCH issues. Sometimes DMOs attends RCH trainings or meetings even in our presence. So these organizations, despite of passing through the DMOs office, they should demand involvement of the respective heads of units to develop a more coordinated relationship and shared efforts that allows both parties to exercise justice to our citizens.”

One respondent remarked: “I suggest these projects, TCCP and TSMP should collaborate by informing themselves or by having stakeholders meetings or by setting up plans and locations so as to avoid collision while educating people. For instance, TCCP might go somewhere to educate a community—they could inform PSI to go that place and distribute condoms, water guard. Wherever each organization goes and find anything that is provided by the other organization, they should share that information, and coordinate.”

Collaboration with the U.S. Government and other partners

TCCP pulled together many U.S. Government partners, some UN organizations and local NGOs to participate in the design and development of campaigns. The table below indicates the technical working groups and committees with which TCCP collaborated. For each campaign or production, the relevant working group was responsible for design input, as well as review and approval prior to the airing of shows or printing of materials. It is appropriate to credit Wazazi Nipendeni, Tuko Wangapi and other campaigns at least partially to the work of the technical working groups with TCCP support.

Table 2. Working Groups and Task Forces

Chair	Secretariat	Member Organizations
1. Advocacy and Social and Behavior Change Communication (ASBCC) Technical Working Group–RCHS Umbrella Group		
RCHS and HPES	TCCP	UNFPA, AFP, CARE, THPS, EngenderHealth, EGPAF, PMTCT, NACP, FHI 360, CCBRT, Pathfinder, TGPSH–GIZ, T-MARC, PSI, UMATI, MST, AMREF, HDT, PATH, MDH and Aga Khan Health Services Tanzania–Joining Hands Initiative (JHI)
2. ASBCC–Family Planning Sub-group		
RCHS/FP	TCCP	AFP, HPES, MST, EngenderHealth, PSI, UNFPA, T-MARC, PATH, Pathfinder, CHAI, MSD, Merck, UMATI, Futures Group, CARE and AMREF
3. Family Planning Technical Working Group		
MOHSW	EngenderHealth	TCCP, UNFPA, AKHST- JHI, AFP, CARE, EngenderHealth, EGPAF, PMTCT, NACP, FHI 360, CCBRT, Pathfinder, TGPSH – GIZ, T-MARC, PSI, UMATI, MST, AMREF, HDT, PATH, MDH, HPES, NMCP, Jhpiego, FHI360, MSD, JSI, WHO, UNICEF, Women’s Dignity, IMA, CDC, CHAI and WLF
4. HIV/AIDS Tulizana Campaign Task Force		
NACP and TACAIDS	TCCP	AMREF, PSI, TAYOA, EngenderHealth, T-MARC, Jhpiego, AJAAT, UHAI, FEMINA HIP, NACOPHA and MOEVT
5. Wazazi Nipendeni Task Force		
RCHS	TCCP	RCHS/Safe Motherhood, HPES, PMTCT, Nutrition Services, Immunization and Vaccine Development, Jhpiego, CDC Foundation and JHI
6. Elimination of Mother-to-Child Transmission (eMTCT) Task Force		
PMTCT Unit	TCCP	Africare, ICAP, Deloitte–Tunajali, FXBT, T-MARC, Jhpiego, EGPAF, EGPAI and NACOPHA
7. Health Promotion Technical Working Group		
HPES	Health Promotion and Education Section	N/D, CHBC, NSHP, WHO, SDC, I Million CHW-Campaign, CCP, TCDC, PSI, Nova Media, IMA and WHO
8. National Malaria Control Program (NMCP)–BCC Technical Working Group		
NMCP	NMCP	PSI, CCP, TCDC, HEPS, TANAM, TRCS, CHAI, Jhpiego, USAID/PMI, CDC, RTI, Malaria No More
9. Long-lasting Insecticide-treated Nets (LLINs)/School Net Project Task Force		
NMCP	Swiss TPH	PSI, CCP, TCDC, USAID/PMI, NMCP, TRCS, RTI, PWC, DFID, JSI, Peace Corps and SDC

EVALUATION QUESTION 3: WHAT HAVE BEEN THE MOST EFFECTIVE CAPACITY-STRENGTHENING INTERVENTIONS THAT TCCP HAS USED TO BUILD THE CAPACITY OF TANZANIAN INDIVIDUALS AND INSTITUTIONS TO DESIGN AND IMPLEMENT, EVALUATE SBCC PROGRAMMING?

Overview of TCCP Capacity-Strengthening Approach

TCCP's capacity-strengthening objective is to measurably transfer SBCC skills to Tanzanian institutions, organizations, communities and individuals. Three of the six evaluation questions were focused on the capacity-strengthening component of the TCCP. The project used the Pathways capacity-strengthening model (see project background section), consisting of four components to achieve the capacity-building objective: sustainable systems, communication institutions, community capacity and individual capacity. The discussion of findings is organized according to these components.

Sustainable Systems

At the national level, the project provided capacity strengthening to several technical working groups in the design, development, implementation and monitoring of national mass media campaigns. The project also provided training in Leadership in Strategic Health Communication (LSHC) to more than 160 individuals from RHMTs and CHMTs from the eight regions.

The LSHC workshop integrates communication theory and experiential learning. The workshop guides participants through the steps of designing effective health communication and advocacy strategies in a participatory environment. Following the training in regions and districts, those trained have the opportunity to submit campaign ideas and compete for funding of those campaigns.

Out of all the districts from the eight regions that participated in LSHC and wrote proposals, eight districts were funded to implement localized SBCC campaigns. Seven out of eight of these districts have completed the implementation of localized SBCC campaigns. The districts were supported in implementing their SBCC campaigns by teams of mentors from the MOHSW, Care International, PHCI and TCCP. Although mentorship teams were supposed to visit districts every three months over the six-month period to monitor the implementation of SBCC campaigns, they were not always consistent in visiting districts because of time constraints.

Capacity building—it has been a success because we were training people and at the same time we gave them opportunities to see how the training they received could be applied in terms of actual campaigns.

We've done one or two rounds... we were planning to scale up but it didn't fly with USAID. The district campaigns, were a very good approach in my opinion because we trained people through the LSHC and we had a small funding for the different groups that were involved with the training to compete for that grant. So we've done one round in a couple of regions and I think that was very good, but then the capacity building component was very much reduced.

Interviewer 1: So for the past five years you'll have only done one round of the district campaigns?

Interviewee: Yes, we actually did that in year three and we were planning to continue in year four and five but when we were doing the work planning we had a huge cutback on funding and that was one of the component that USAID decided to drop.

KII, Local Organization Staff

There were several requests for expansion of the capacity building of regional and district government staff, as illustrated by the response in the text box. This requires both individual and systems-level capacity building, training individuals while working with the MOHSW regarding their role in the districts and what resource support would be needed from the Ministry and the project.

As part of building sustainable systems, TCCP also builds individual capacity. More details on this are provided in the individual capacity section below, but it is worth explaining the ACE program (Advancing Communication Experientially) as part of national level effort as well. The ACE program seeks out recent graduates of mass communications, sociology and other fields related to health communication for its intensive training program. Interns and fellows serve for six months to one year while learning the basics of strategic communication; participating in a seminar series on professional development, time management, presentation skills, online learning and other topics; receiving mentoring; and enjoying many other opportunities to advance their skills. Upon completion of the program, interns and fellows receive a certificate and are publicly acknowledged for their accomplishment through a graduation ceremony. ACE is one part of TCCP's efforts to build individual capacity in strategic health communication while helping institutions address their current capacity gaps.

TCCP aimed to build the capacity of two training institutions to sustain the long-term development of SBCC professionals: MUHAS and PHCI. MUHAS is offering a Master's Degree in Behavior Change Communications. However, the contribution is less than needed and intended. The team learned from MUHAS that only three out of the 45 students who expressed interest in the program have been enrolled over a three-year period. This has been at least partially attributed to the lack of student scholarships, a component for which TCCP was not responsible, given that USAID did

"The support from TCCP has tremendously helped the university in building its capacity because the support has increased the SBCC skills among the staff to teach the course and has enriched teaching and evaluation skills. We also have skills to in writing policy briefs as we have four members who are translating research into policy briefs."

KII, MUHAS

"Maybe support the Ministry to run short courses at the lower level for implementers, because now I don't know how many people through the JHU-CCP approach are trained. As implementers, we have 169 councils in the country.

If we could get all the health promotion focal persons at council level in all the 169 districts attending the short course...but the course should be done in a manner that it is coordinated between JHU-CCP and the Ministry so that we come up with the plans together.

Tailor the course for all the so-called health promoters....at least if we can achieve that by the time the program is ending or for the follow on project so that we make it sustainable....

We need JHU-CCP to support MOH to train District Focal Point Person and coordinators at district level countrywide so that they can become trainers themselves in order to make the program sustainable."

KII, MOHSW program staff

"Although we were not promised scholarships, we anticipated that the Master's program would have scholarships. That is why in three years of the Master's program, we have more than 40 students who registered for the program but only three have been enrolled because the rest cannot afford."

KII, MUHAS

not allow for scholarship funding. CDC now funds this activity, and TCCP has provided some technical support and lectures to the group. One respondent's impressions of what happened were reflected during an interview in which the respondent stated, "It was expected that CDC would provide scholarships for behavior change rather than for social and behavior change communication. But CDC pulled out in preference for HIV treatment."

TCCP has also built the capacity of PHCI to provide diploma courses in SBCC and short courses in LSHC. PHCI was contracted by TCCP to offer LSHC workshops for the ACE

program and for CHMTs. ACE interns and fellows interviewed in Mwanza who were trained by PHCI exhibited the same or an even higher level of understanding of the concepts presented in the training as those trained directly by JHU-CCP.

While PHCI is able to sustain the training of CHMTs because respective councils fund them, PHCI reports that it does not feel it can sustain the ACE program, because it is costly. It seems that, unless the situation changes, the two training institutions are unlikely to be able to sustain a meaningful role in the long-term development of SBCC professionals in Tanzania.

Communication Organizations

TCCP had the mandate to build institutional capacity of a number of Tanzanian local organizations. The starting point for building institutional capacity was conducting baseline organizational capacity assessments. To do that, the project developed an SBCC Capacity Assessment Tool (CAT)²⁷ that was used to measure the technical capacity and needs of local NGOs in SBCC. In addition, the project developed an organizational capacity index to collect self-assessment scores from the institutional capacity assessments.

The project work plans originally called for organizational capacity assessments of up to 15 local organizations as the basis for follow-on activities to build their capacity in SBCC. Each of these organizations was supposed to undergo a repeat assessment every twelve months. The project only managed to conduct organizational capacity assessments for eight organizations, and only four of these went through a repeat assessment, according to the TCCP capacity-building lead. Based on interviews and project reports, the team identified three factors that contributed to the project's failure to achieve the set targets. First, the midterm evaluation recommended that the project focus on building the capacity of four local organizations. Secondly, the project experienced funding irregularities for capacity building.

Apart from the two training institutions, the project worked with TCDC and Femina Hip to build their capacity. TCDC was started from the scratch by existing local staff of TCCP, while Femina Hip was relatively strong in SBCC even before capacity-building support was provided to the organization. A baseline assessment (March 2012) of Femina Hip provided scores in the key areas such as implementation of communication strategies and planning and design. Based on the scores, follow-up was planned with Femina Hip, which included a new staff orientation and an update of tools and templates that guide planning and policy. Technical assistance from TCCP was planned to facilitate an intervention design process, including a radio design workshop, as well as sharing of online training resources.

The project also built the capacity of two other categories of institutions: media institutions and local organizations such as IDYDC and IMO that implemented grants. Radio magazine programming was used to increase knowledge of and demand for services in the areas of VMMC, HIV prevention, HIV treatment, stigma, positive living, HIV testing and counseling, condom use, alcohol, most vulnerable children, STIs, FP, maternal and child health, and malaria. The platform was also used to strengthen existing radio programs that focus on health, build the capacity of radio producers, and support stations to improve facility infrastructure. There were independently produced weekly radio programs on 18 stations in 10 regions. The project built the capacity of local radio stations to produce quality radio magazines and also trained filmmakers on how to conduct research and produce movies through a project called Swahiliwood. The latter was discontinued after producing three movies by recommendations from USAID/Tanzania via a midterm evaluation.

²⁷ http://www.thehealthcompass.org/sites/default/files/strengthening_tools/CapacityAssessTool%2004Jan13.pdf

Community Capacity

Community capacity focused on training volunteers from different partner organizations through RDL, or *Kamiligado* in Swahili. RDL has 39 topics covering different health topics, which among others include malaria, condom use, couple testing, FP, malaria and safe motherhood. Each program has two components: community mobilization and a health topic. TCCP worked with a number of partner organizations that contributed content. According to project reports, the project recruited a total of 9,448 volunteers: 5,000 from RDL 1 and 4,448 from RDL 2, which far exceeded the target of 1,500 volunteers. RDL had listenership of more than 1.5 million people. RDL faced a number of challenges. The input of TCCP staff currently managing RDL is that the design stage took too long to be completed. Secondly, the program did not have a feedback mechanism to assess whether or not volunteers were listening to the program, apart from the quiz that some volunteers responded to. Additionally, a staff member noted, “It was easy to manage volunteers under partner organizations than those partners who are not contracted by TCCP. The program did not have a feedback mechanism to assess whether or not the volunteers are learning apart from the quiz. Volunteers were just listening in individually and not in the groups and did not have the facilitator. It is challenging to do RDL in Tanzania because of level of commitment by community members. The other challenge is that volunteers are learning individually because listening groups have not been formed.” Finally, RDL does not have a mechanism for monitoring the performance of volunteers or whether or not volunteers are acquiring knowledge from RDL.

CARE’s work at the community level on HIV prevention and FP includes the following:

- More than 500 community resource persons in 29 districts of the CARE TCCP project area were oriented on how to facilitate small group discussion to (a) create understanding of sexual networks and HIV risk perception and (b) increase self-efficacy to detach from the sexual network.
- More than 230 community resource persons from 16 districts in the Lake Zone were oriented on how to facilitate small group discussions to increase people’s understanding of FP, benefits and available methods, and where one can get FP services.

Individual Capacity: Individual capacity focused on the ACE program and the LSHC Alumni. The ACE program was intended to develop a cadre of entry and mid-career professionals in strategic health communication. The program targeted fellows and interns, who attended a two-week LSHC workshop. Thereafter, a one-day orientation meeting was held with supervisors, mentors, JHU-CCP, and mentees to discuss the mentorship modalities. After the two-week LSHC training, fellows and interns attended a seminar series for one year—later reduced to six months—to gain practical knowledge and experience in SBCC. During this period, interns were placed in host organizations, while fellows received funding to implement an SBCC project. The project has exceeded the target of training 30 interns and 30 fellows. ACE participants noted that the mentorship program lacks a feedback loop between the mentor, fellows/interns, supervisor and JHU-CCP. The parties only meet once at the beginning of the mentorship program, and the next time they meet is during graduation of mentees; no other review meetings take place during the mentorship program, except for the email communication between the mentor and JHU. There is also no formal relationship or consultation between supervisors and mentors.

“They should select mentors who are nearby so that the mentors, supervisors and the intern can have frequent face-to-face interactions.”

KII, ACE Fellows

The major challenge faced by the ACE program is finding appropriate mentors for fellows and interns. This is especially a problem outside of Dar es Salaam. The project went around this problem by enlisting successful fellows to continue on as mentors in future rounds. Even when mentors were recruited, some were not readily available to the interns and fellows because of conflict with their work schedules. One mentor interviewed said, “The major challenge I face as a mentor is time. I do not seem to have

enough time to be able to provide the mentorship that I need to. Sometimes I am available, but the mentee is not, and vice versa. There was a fellow who had only one mentorship meeting with me in the six months period.”

At this time, the ACE program participants and TCCP staff report a number of challenges:

- The program does not have a mechanism to motivate and provide recognition to mentors;
- Interns are not getting adequate experience from their host organizations to apply what they have learned;
- Interns’ expectations for employment at the conclusion of their internship program are not well-managed;
- Some supervisors do not support seminar participation;
- Mentor and supervisor expectations of interns are not managed to be realistic;
- Interns and fellows sense the need for a longer program to cover the material in the course and the mentorship program.

“(They) should find mentors who are committed to providing support to interns. It was difficult to find mentors who were committed to provide adequate support to interns since mentorship is done on a voluntary basis.”

“Mentors and supervisors should come from the same organizations. At the moment only supervisors come from host organizations while mentors are normally from another organization and there is no mechanism for the two to communicate.”

KII ACE Interns

The second component of individual capacity-building was the LSHC Alumni network, or TASHCOM. The network was intended to create a forum for annual review and planning of SBCC issues, maintaining a members’ database and establishing platforms to share information through groups, social networking

- *Training helped respondents to learn how to conduct analysis before messages are developed to target the primary and secondary audience.*
- *Respondents acquired knowledge in SBCC, which they did not have before enrolling in the ACE program.*
- *Respondents are now able to communicate effectively, especially in interpersonal skills.*
- *Respondents are able to use the SCOPE method in the development of messages.*
- *Respondents have gained skills in delivering SBCC messages that are already developed.*

Small group interview of ACE interns

and a website. TCCP facilitated a number of annual meetings for the Alumni and succeeded in getting 60 members to participate in its activities. In addition, the project facilitated the election of Alumni leadership. Unfortunately, the network is not strong enough, because the secretariat does not have resources to operate without the support of TCCP. The network does not have the ability to mobilize funds on its own, making it unsustainable. One of the mentors interviewed said, “The Alumni was developed and registered but it is not functional without JHU. It depends entirely on the funding and organization by JHU. It is a waste of time if the Alumni is not able to stand on its own.” JHU expected that the network would depend on membership fees, but this has not been the case.

EVALUATION QUESTION 4: IN WHAT AREAS HAS TCCP SUCCESSFULLY TRANSMITTED SBCC COMPETENCE TO INDIVIDUALS, INSTITUTIONS AND COMMUNITIES?

It is important to note that as a result of a USAID midterm assessment, TCCP suspended its work on Swahiliwood as well as support to TASHCOM and MUHAS scholarships. USAID instructed the project to refocus its efforts on building SBCC capacity in a few local organizations instead of funding eight additional districts to develop district campaigns.

Under the component of Sustainable Systems, TCCP has actively involved the MOHSW at the national level in the campaign/message design and development process. TCCP worked with the MOHSW and TACAIDS in the design, development, implementation and monitoring of national mass media campaigns. In the past, the Ministry provided information only, but now staff have acquired knowledge and skills to design, develop, implement and monitor SBCC campaigns. This has resulted in an appreciation by the MOHSW of the importance of SBCC in the promotion of positive health outcomes. At the regional and district levels, RHMTs and CHMTs have acquired some increased competency in designing, developing, implementing and monitoring local SBCC campaigns through the LSHC training and the SBCC campaigns that they implemented.

“The capacity building that was provided to the National Hospital has contributed to management’s appreciation of the importance of SBCC. The hospital has also been given the capacity to develop radio and TV programs to enhance the profile of the hospital.”

KII, Muhimbili Hospital

The project built the capacity of two training institutions (MUHAS and PHCI) to provide sustained long-term development of SBCC professionals. Under the Communication Institutions, TCCP has increased SBCC competencies to two local organizations: TCDC and Femina Hip in implementing SBCC programs. Based on the assessment of TCCP staff, the two organizations are now capable of leading development and implementation of SBCC programs and campaigns. These and other partner organizations have acquired negotiation and communication skills and are able to call for action using SBCC campaigns and messages. For example, Muhimbili National Hospital has managed to develop radio and TV programs to enhance the profile of the national hospital.

TCCP has furthered the use of the radio magazine platform. TCCP’s December 2014 quarterly report documents that partners continued to utilize the radio magazine platform to communicate health information and messages, create demand for services and discuss ongoing campaigns in specific regions and at the national level. The report goes on to say, “This quarter saw strong engagement of experts from RHMTs, CHMTs MOHSW and TACAIDS in the utilization of the program on different radio stations in the areas of HIV prevention, HIV treatment, MVC/OVC, VCT, Malaria, and eMTCT. [U.S. Government] and other international partners that utilized the program this quarter included PSI, Walter Reed, Jhpiego, Deloitte Tunajali, Red Cross, EngenderHealth, MDH, ICAP, Restless Development and EGPAF. Local partners that used the magazine platform included PASADA, EWAMEC, Mbeya Medical Research Center under NIMR, and COCODA.”

In terms of capacity building, TCCP/TCDC conducted supportive supervision visits to all radio stations to “review the successes, challenges, and recommendations for improving the radio magazine programming from radio presenters; meet with RHMTs, CHMTs, local and international partners in order to strengthen and improve the relationships that we have established; and to meet new partners.” TCCP visited eight radio stations in Southern Highlands regions from October 20–November 10, 2015, and four stations in Dar es Salaam.

Under the individual capacity component, TCCP has increased SBCC knowledge and skills to entry and mid-level SBCC professionals. Interns and fellows who have been trained in SBCC have contributed to the increase in capacity in organizations where they are placed. Fellows and interns now understand SBCC theories and how to use them to design, implement, monitor and evaluate SBCC.

Two different capacity-building indices were developed: one for individuals and one for institutions. These indices reflect the data collected from sources such as pre- and post-test scores for workshops and seminars, as well as the self-scoring from the Institutional Capacity Assessments. While these indices do offer some measure of capacity built, they would benefit from a bit more standardization and a more rigorous application.

TCCP staff identified the following as the outcomes of capacity-building efforts:

- There is a “large cohort of well-trained and experienced new entry and mid-career health communication professionals.”
- TCDC and Femina are key institutions that are able to carry out SBCC projects.
- PHCI can now sustain the long-term development of SBCC.
- A network of SBCC professionals who are “able to share experiences and lessons learned with each other is in existence,” i.e., TASHCOM.
- Several communities “have volunteers who are now better equipped to help their communities identify and solve local health problems.”

“I would want to learn computers, they should have made computer lessons to be part of the program...it would have been easier to use SCOPE to design messages.”

KII, ACE Program Interns

EVALUATION QUESTION 5: WHAT ARE THE AREAS AND BEST METHODS TO FURTHER IMPROVE COMPETENCE IN SBCC IN TANZANIA FOR INDIVIDUALS, INSTITUTIONS AND COMMUNITIES?

“I think research and evaluation are where we are all struggling for either capacity or resources—the constant question is to prove something worked. We see it we know it and experience it but writing it down, document it, etc.... We can do our own little research but there is not a lot of time of money to do much.”

KII, local NGO

There are a number of areas in which SBCC competencies need to be further improved. Under sustainable systems, some respondents felt that SBCC should be integrated in all departments and units of the MOHSW and not just a few units such as Information, Education and Communication. All departments and units should start integrating SBCC in their work to contribute to reducing the health and social burdens that the country is facing.

The second area where participants identified a need for further capacity strengthening support was in M&E of SBCC programs. TCCP has been receiving requests from a number of organizations and institutions to be supported in that area.

The third finding regarding TCCP’s capacity-strengthening efforts is that more support and competency building is needed in the measurement of participant knowledge acquisition and utilization by those running training and mentoring programs.

Finally, under individual capacity building, interns and fellows reported that they felt the need for more practical experience in conducting research during the situation analysis stage of the communication process. They also expressed a desire to participate in data generation rather than only using secondary data to design messages and campaigns.

EVALUATION QUESTION 6: WHAT INTERNAL AND EXTERNAL FACTORS AFFECTED THE ABILITY OF THE PROJECT TO ACHIEVE ITS OBJECTIVES?

Internal factors

According to TCCP staff, “strong leadership and team work” helped the project succeed in several ways. The fact that most of the project staff are Tanzanian contributed to the project’s understanding of the “social, cultural and political context.” The availability of experts in all the critical technical areas, and the fact that project staff gained SBCC expertise through their own participation in the LSHC course, contributed much to the project’s work.

A factor that limited the project’s achievement in the area of capacity building was the lack of sufficient full-time personnel dedicated to this component. When the originally hired staff member in charge of capacity building did not perform up to expectations and subsequently resigned, the JHU-CCP Capacity

Building Resident Advisor, who was only supposed to provide technical support, had to take on all responsibility for this objective. Later the staff member was temporarily reassigned to West Africa during the Ebola emergency. This was after the capacity building budget and activities were winding down in year 5 and was done with the approval of USAID. This position was never replaced. In addition, senior management on the project noted in retrospect that they might have hired other staff to support this component.

With strong Tanzanian leadership and some hard-working, diplomatic and visionary individuals with complementary skills sets, senior technical staff said that they might have done a better job of identifying individual staff members' strengths, weaknesses and skill sets, and creating teams that built on these. Instead, the project tended to use an "everybody" approach to knowledge sharing and input on issues, meaning longer meetings and less rapid progress on tasks. Over time, the project has gotten better at creating smaller teams and letting people run with ideas, at times making mistakes, learning from them and self-correcting through team discussions.

The project has identified the materials distribution system as an area needing improvement. The project acknowledged that they never managed to figure out a system for doing this well. Many pamphlets and brochures end up sitting in clinics, and there is no "pull" system whereby clinics track stocks of materials and notify the project when they are running out. Working through service delivery partners did not seem to remedy this. This was not mentioned at all by the MOHSW in the regions or districts, but only by the project.

External Factors

TCCP enjoyed the government's support and willingness to participate in its efforts. There was a favorable environment at the MOHSW at all levels, as well as the support of the President.

The process of engaging multiple players and convening technical working groups to elicit multiple inputs to the design of campaigns and messages is valuable and necessary, but it can slow down approval and implementation of campaigns. The working groups composed of U.S. Government implementing partners, local NGOs and the Government of Tanzania work closely on the design and development of each campaign. This is followed by MOHSW approval from multiple units. In the case of integrated messages that cover the multiple areas of maternal and child health, HIV, FP and malaria, there is a significant time lag between the phase of formative assessment and actual launch and implementation of a given campaign. In the opinion of TCCP staff, which participates on the technical working groups that review campaign and program materials, there is also often hesitancy on the part of the staff of the MOHSW to be accountable for approval.

Due to the fact that TCCP focused on multiple health areas, the project was accountable to multiple stakeholders within USAID and the Government of Tanzania. Whether a USAID team has a large or a small budget, their "expectations are large—people expect an amazing campaign," and this creates a need to manage expectations. In addition, as the main communication vehicle for health, the project was asked to include multiple unpredictable areas that were neither in the RFA nor in the cooperative agreement. These ranged from drunk driving to Dengue fever to prostate screening. In order to fund messages and campaigns in their area of responsibility, portfolio managers had to allocate a portion of their budgets to TCCP.

This posed a management challenge for the project. Each year, funding for communications in a given health area was different, as illustrated in the table and graph below. Because the changes occurred in an unpredictable manner, the project staff described this situation as being much like having a new project each fiscal year. As one staff member described it, the multiple players and funding streams "keep it fun and exciting," but there are many people to "keep happy." Another way in which this affected the

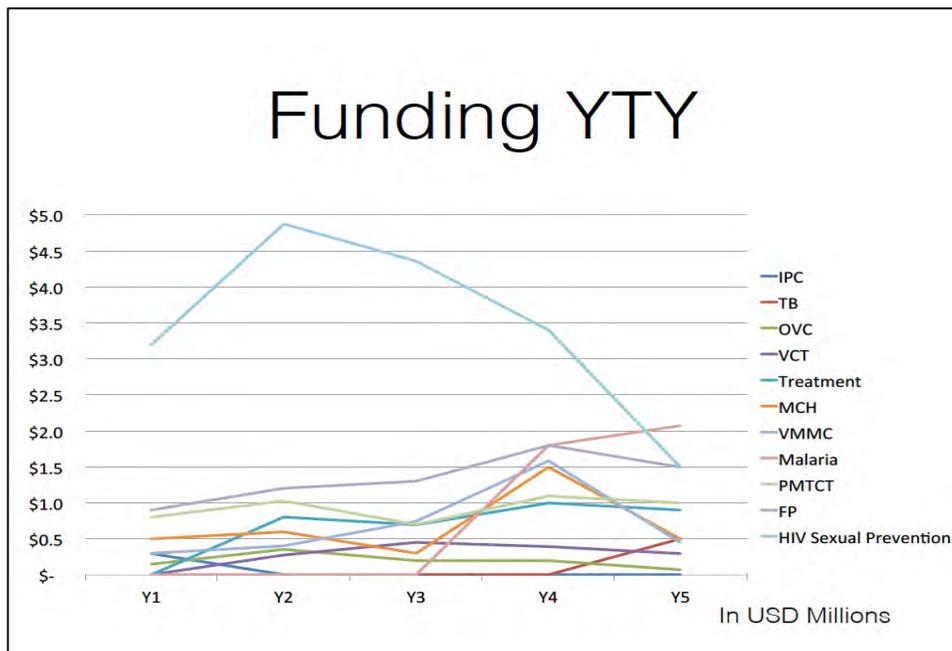
project is that, given the diffusion of health areas, related funding, and the desire of the AOR to be transparent and get the buy-in of all “investors,” work plan approval was at times significantly delayed.

Table 3. TCCP Funding by Year

TCCP Funding						
	Sep10- Sep11	Oct11- Sep12	Oct12- Sep13	Oct13- Sep14	Oct14- May16	Sep10- May16
TCCP	Y1	Y2	Y3	Y4	Y5	Total
IPC	0.3	-	-	-	-	0.3
TB	-	-	-	-	0.5	0.5
OVC	0.2	0.4	0.2	0.2	0.1	1.0
VCT	-	0.3	0.5	0.4	0.3	1.4
Treatment	-	0.8	0.7	1.0	0.9	3.4
MCH	0.5	0.6	0.3	1.5	0.5	3.4
VMMC	0.3	0.4	0.8	1.6	0.5	3.5
Malaria	-	-	-	1.8	2.1	3.9
PMTCT	0.8	1.0	0.7	1.1	1.0	4.6
FP	0.9	1.2	1.3	1.8	1.5	6.7
HIV Sexual Prevention	3.2	4.9	4.4	3.4	1.5	17.3
Total	6.1	9.5	8.8	12.8	8.8	46.0

In USD Millions

Figure 3. TCCP funding by year



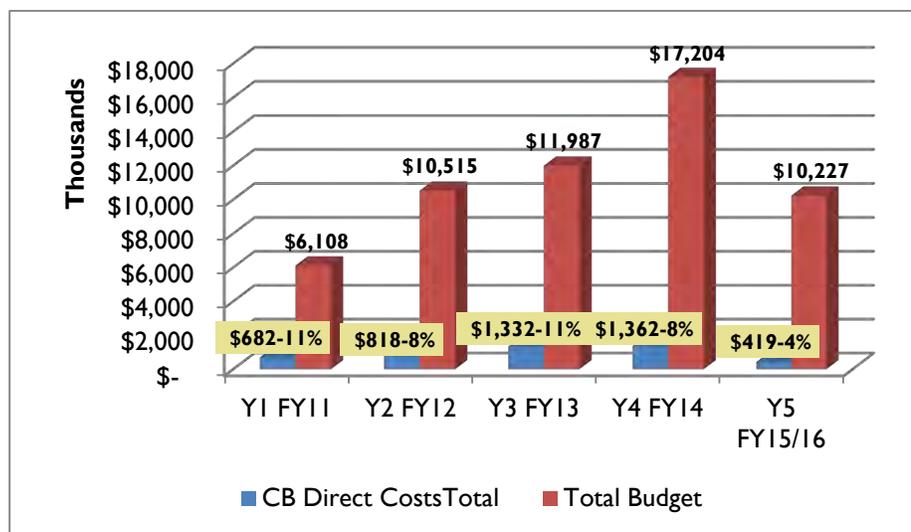
The year-to-year changes in budget and the diversity of areas that the project was asked to cover are also reflected in the fact that there were deliverables spanning multiple health areas added to the original agreement in year 4. These included the following: Rural Communication Initiative; integrated district malaria plans and funding; linking CCA activities with health facilities and villages; mobilizing communities to act on malaria prevention and treatment; Mobile Video Units; support to CCA platform under CBOs; safe motherhood campaign; case management; School Net program; technical assistance to

NMCP; Malaria Safe program; Zanzibar continuous distribution campaign; Zanzibar case detection; support to ZMCP BCC Cell; Zanzibar monitoring; Zanzibar KAP survey; IPTp3+ assessment for mainland (TCCP Performance Summary Tables, May 2015).

Project staff noted, “There is need for a reasonable budget to be allocated to capacity building.” One interviewee cited the issue this way: “Some of the funding managers at USAID might have as little as USD 50,000...if another manager is contributing USD 2 million to designing a campaign—and for this campaign they’re saying TB can have one radio spot because they’re contributing 0.1% of the campaign—but part of their money is supposed to go to capacity building. The funding managers start to question the need to contribute to capacity building, which is 3% of the contributed sum. They don’t understand that for their money to go on a certain part there are structures that have to be supported.”

The actual percentage of direct costs for capacity building, plus the salaries of dedicated capacity building staff in the total annual budget, is illustrated in the chart below.

Figure 4. Capacity-Building Funding by Year



The issues of capacity-building funding, prioritization and expectations are not unique to USAID/Tanzania or the TCCP project. This reflects a tension between the commitment of USAID to localization and sustainability, and the desire to reach targets and generate results, sometimes requiring, or seeming to require, an approach that overtakes capacity building in time and resources. The balance is challenging and requires clarity on the part of USAID and implementing partners from the design phase through implementation as to what is the priority and what resources are required to achieve what is being requested.

It is also important that capacity building not be limited to activities that require separate funding for training or workshops. Implementation side-by-side with local organizations can result in capacity building if the staff of the prime partner is skilled at the process of coaching and providing supportive supervision and skills transfer while implementing through a partner. While there was some activity of this nature through the national working groups, more could have occurred in the regions and at the district level.²⁸

²⁸ The evaluation team did not do a separate financial analysis of staff LOE and capacity building.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Evaluation Question 1

Overall, the evaluation team concludes that the design, development and implementation of the campaigns were done in a systematic manner, were evidence-based and were well grounded in an appropriate theory. The campaigns and messages were appropriate culturally, of high quality, easily remembered and segmented according to audiences, and they had clear action points to be taken by the intended audience. Despite the multimedia approach in its campaigns, there was insufficient use of interpersonal communications at the lowest levels of communities (villages and households). There was involvement of stakeholders at all levels of campaign through the implementation stage. There is a lot of potential at the community level to work with government structures and in collaboration with identified implementing partners.

As an overall conclusion about the project's approaches to behavior change, the evaluation team found, through its interviews and review of project documents, that there could have been a more balanced approach of mass media and interpersonal approaches in achieving behavior change outcomes. IPC was not being fully implemented in the areas visited. As one example specific to Tanzania, a study showed that mass media exposure significantly increased the likelihood that a man or a woman would discuss use of the female condom in the future. That study also demonstrated that though peer educators and providers had a limited coverage, they had a stronger impact than mass media on individuals' intention to use a female condom. Contacts with peer educators and providers can be considered as similar to interpersonal communicators, who can perform both the knowledge and persuasion function of development communication.²⁹

Tuko Wangapi? Tulizana and Wazazi Nipendeni were effectively implemented and successful at reaching their intended target audience and goals. Siri ya Mtungi and Aiiisee! appear to be good programs but have not been running for a long enough time for the evaluation team to assess their outcomes. The distribution system for campaign support materials was not well done. However, the Siri ya Mtungi fan page is one of Tanzania's most popular, with 254,891 fans as of June 26, 2015.³⁰

Evaluation Question 2

One of the TCCP technical proposal's five guiding principles was to employ a "systems approach," that is, "to have holistic appreciation of how different levels and actors in a national coalition must be mobilized in concert if TCCP is to achieve sustainable change....We will make a difference in the public health of Tanzania through effective coordination and collaboration among all parts of that system." This evaluation has confirmed that TCCP adhered to the principles, as agreed, in its systems approach to SBCC in Tanzania. While improvements were recommended for the regional and district levels, it is clear that implementation at scale was a focus and was achieved.

What has been learned about how collaboration was handled by TCCP is primarily that reaching the many levels required of a national project in a country such as Tanzania requires tailored and diverse strategies and the ability to have an impact by reaching people and areas for whom and where mass media might not be effective on its own. The inputs from those interviewed seem to point to a need for

²⁹ Sohail A, Rossem RV. "Impact of Mass Media Campaigns The Female Condom in Tanzania." *International Family Planning Perspectives*; 2002, 28, (3):151-158.

³⁰ www.socialbakers.com

more direct contact with different levels of the system. While the technical working groups and the like did involve many stakeholders and tried to address the needs of different levels of the system (regional, district, community), the impression of many below the central level is that they were not fully involved, consulted or kept informed of implementation in the areas they were responsible for.

In addition, the fact that since CARE has been out of the picture due the end of its contract, there is a gap in the ability of the project to reach communities through IPC activities speaks to the need to perhaps have more explicitly involved more community groups from the beginning through grants and capacity building at these lower levels.

Evaluation Questions 3-5

Despite having areas in need of improvement, the ACE program was the most effective capacity-strengthening intervention. The ACE program has been effective in developing a cadre of entry and mid-career professionals in SBCC. It has strengthened the skills of mid-career health communication professionals while introducing the field to a new cohort of young professionals, many of whom have already demonstrated their competence in the field, having secured professional jobs in SBCC. Professionals skilled in SBCC provide a platform for the improved quality of SBCC programs in Tanzania. It is a positive development that, as of May 2014, 85 percent of the ACE graduates were hired and will thus be in a position to contribute to SBCC quality in Tanzania.

Under sustainable systems, the project has successfully built the capacity of the MOHSW and TACAIDS in the design, development, implementation and monitoring of national level mass media campaigns. This has led to more appreciation of the importance of SBCC at the ministry level in addressing negative health behaviors and the role of SBCC in promoting positive health outcomes. LSHC has also been effective in building the capacity of RHMTs and CHMTs in designing, developing and implementing localized SBCC campaigns. The project successfully built the capacity of the two training institutions (MUHAS and PHCI) to sustain long-term development of SBCC professionals. Unfortunately, MUHAS has only attracted three students in three years, and while PHCI is able to sustain the training of CHMTs because they are funded by their respective councils, PHCI would need funding to sustain the ACE program in its current form, given the cost required to maintain it.

“At the national level, I am most familiar and the creation of the task forces that we did not have initially—then we stepped back to be sure the MOH staff were at the lead of the task forces and that meetings were held at the MOH—and that they send out the invites.

These seemed like small things, but they are actually big...it means that it takes longer... and comes with the risk of losing innovation—with the input of so many people...it can make campaigns less catchy. You have to know when to push and how to pick your battles.”

TCCP Technical Staff member

The capacity-strengthening area in need of the most work is the building of SBCC capacity for local NGOs that are able to implement SBCC projects. Only two of the 15 organizations that the project worked with can be said to have the capacity to implement SBCC projects. Local organization capacity building in SBCC was not a strong aspect of TCCP. PHCI did build SBCC capacity of eight DHMTs, with shortcomings as described earlier in terms of support for campaigns at this level.

Interventions for which interviewees had the most criticism and suggestions for improvements were the Alumni (TASHCOM) and the RDL. Unfortunately, the Alumni network is currently not sustainable because it is dependent on funding from the project, has weak leadership and cannot operate independently of the project. There are areas where it is not as vibrant and active as it could be. Some in Dar find it active, whereas others said they do not meet very often. It seems that a further assessment is needed to look at what alumni want, what is feasible, and what is needed to support it.

While the RDL was well designed, the major drawback is that it does not have a mechanism for monitoring volunteers' performance or acquisition of knowledge. In addition, the project does not have a mechanism to track the number of volunteers who are consistently listening to the radio program. These drawbacks are in addition to those less directly related to capacity building, such as the lack of listening groups, a common feature of successful RDL in other countries. RDL will be undergoing a separate evaluation, with the results expected in late 2015.

Although the capacity-strengthening component of the project has significantly contributed to the transfer of SBCC skills to Tanzanian institutions, organizations, communities and individuals, its performance was affected by two factors. First, the capacity-strengthening component did not seem to have been a major priority from a funding perspective. The project experienced funding irregularities for capacity strengthening, with what was perceived by project staff to be ambivalence on the part of USAID staff in charge of specific technical areas to allocate much of their funds to capacity building instead of demand creation and other activities directly related to a given technical area, e.g., MCH or malaria. Capacity building accounted for an average of 8 percent of the annual budget, despite being an IR of its own. It is not clear that it was given the same priority as other IRs, and this should be more clearly specified in the next project.

According to the project staff and from the perspective of the evaluation team, capacity strengthening was also affected by staffing issues. The senior staff currently in the project office were not as involved as the Capacity Building Advisor who was reassigned to Liberia for clear reasons of need. There are capacity-building advisors in Mwanza and Iringa who follow capacity-building efforts in those regions, but the team could not easily locate community groups benefitting from capacity building in the regions visited, and getting detailed information about the capacity-building program historically suffered from the absence of the Capacity Building Advisor. In addition, it is clear that the capacity-building component and the program campaigns are quite separate, with the regional advisors not very conversant about the ongoing campaigns in their regions.

Evaluation Question 6

Internal factors primarily boosted the project's achievement of its objectives. The only limiting internal factor was the lack of a sustained body of full-time staff dedicated to capacity building.

External factors that boosted the project's ability to achieve its objectives were the good relationship that TCCP enjoyed with the key players at national level of the Government of Tanzania and the quality and teamwork of the TCCP staff. The primary factor that limited performance was the multiple funding sources that varied from year to year and contributed insufficiently to capacity-building efforts. In addition, there was a lack of information, such as service delivery data, available to TCCP as a means of monitoring campaign outputs, such as increased uptake of HIV testing. Service delivery projects did not regularly or openly share their data.

In summary, a clear challenge that TCCP faced was to satisfy the array of program managers within USAID that their area was getting sufficient focus. In addition, the project had to do a balancing act with respect to capacity building versus interventions. This is not a problem unique to Tanzania's health program but is nevertheless a challenge. The project demanded flexibility and diplomatic negotiation with USAID managers and the Government of Tanzania when it came to campaign and message funding and approval. In the end, the Government of Tanzania seems to be more satisfied than USAID with how the project managed this process. TCCP management clearly needed to present a case to USAID about the funding for capacity building and how campaigns were effective in addressing the objectives for each health area. In a busy mission environment, this was clearly a challenge. The remedy might have been more advocacy on the part of TCCP, or perhaps a different design. However, there is no clear evidence that the project did not meet its objectives, despite seeming dissatisfaction on several sides with the process.

RECOMMENDATIONS

In light of the data that emerged from the FGDs and KIIs regarding TCCP's implementation of its SBCC component, the evaluation team makes the following recommendations:

- Based on the established concept that—especially for health issues of a complicated or sensitive nature, such as FP and HIV, and for clients less motivated to use a method or adopt a given behavior—interpersonal communication can boost the impact of mass media. The project agreement also called for the use of both strategies. Given that the evaluation team was not able to find on-the-ground evidence that there was an extensive and coordinated use of IPC with mass media for specific health issues, the team recommends that the next project increase the use of IPC methods—such as peer educators, individual counselling, community change agents and community health workers. This is in the process of being done through TCDC's work in several regions, and can be expanded to other areas. In order to accomplish this without undue cost or level of effort, close collaboration and coordination with the DHMTs, CHMTs and service delivery implementing partners is critical. Ways in which TCDC could bolster the quality of SBCC at the field level without requiring increased funding or staffing include targeting the training, coaching and mentoring to groups already implementing community communications activities, as well as joint reviews of materials being developed.
- In future productions and print materials, use images that depict and are attractive and relevant to rural communities as well as urban ones, when this is feasible.
- The program should ensure the involvement of stakeholders such as CHMT and DHMT staff when planning implementation and when reporting out about that activity in their communities. Engaging community members in planning activities in their communities is also critical to success.
- The project should continue to engage in discussions and advocacy efforts around youth sexual and reproductive health and FP needs. This would include working with others to craft creative solutions to meeting those needs while addressing the barriers currently preventing progress in these areas.
- Establish a more effective distribution system for print materials such as brochures, posters and handouts that support other media efforts. The project needs to continue efforts to establish a mechanism to ensure a consistent supply and appropriate use of materials by clinical facilities, engaging the help of implementing partners as needed. TCCP is aware of this issue and should continue trying to devise an effective strategy for the common and longstanding problem in Tanzania, and other countries, of ineffective materials distribution.
- Continue to build the capacity of community radio stations and support their use to reach communities with context-specific messages, thus expanding the reach and increasing the local understanding and application of the messages being disseminated at the national level.
- In the area of collaboration, the strategy of convening working groups and collaboration in the development and review of campaigns and messages should continue, with added attention to strategically developing ways in which to make the process of government approval more efficient. With proactive leadership from USAID, there should be efforts to

"It's best that stakeholders work with figures from the council, so that when it comes to phasing out the project the figures might suggest where to start next time, if they were to extend the project or begin another one. I'm looking at three levels, one is designing in such a way that the three levels which are the community, mid-media activities (road shows, cultural shows) and mass media balances very well. With TCCP I don't think if we had a good balance throughout the project life cycle."

KII, TCCP Staff

increase the collaboration and coordination of any communications project with service delivery projects through a mechanism for sharing service delivery data that informs campaign results monitoring. This would extend to the regions and districts where MOHSW stakeholders desire more of a voice in design and development, and more of a feedback loop about results of campaigns. In general, mechanisms for closer collaboration in regions and districts should occur. It is possible that having staff in the field and an increased number of sub-grants, or at least working relationships with NGOs and CBOs in communities, might enhance this level of collaboration.

In the area of capacity building, the evaluation team has several recommendations for the current project:

- Following an upcoming evaluation, the RDL program should be revamped to implement what is found in that evaluation, which is likely to include the addition of listening groups and greater facilitation and monitoring of volunteers.
- Recruit and develop a strong support and recognition system for mentors by establishing ways to recognize the most effective mentors, establishing a forum for mentors and providing them support materials like laptops and other materials.
- Improve the communication and feedback mechanism between mentors, supervisors, interns or fellows and JHU-CCP. There is a need for a meeting between the mentor, supervisor, mentee and JHU-CCP after three months of the mentorship. In addition, JHU-CCP should develop a strong follow-up system to ensure that mentors are having meetings with mentees.
- Strengthen the Alumni (TASHCOM) by funding the secretariat and developing regional/zonal associations.

To respond to the internal and external factors that affected the project's ability to achieve its objectives, it is recommended that for the future project, USAID should develop a mechanism to coordinate and more clearly direct funding streams to have some consistency and predictability over the life of the project. The focus areas of a similar project should remain more clear and consistent over the life of the project, with less flexibility for taking on new communication tasks for additional health issues, beyond those outlined in the agreement, without a clear, documented modification to the agreement and scope of work language in the amendment. If the mission deemed it critical that the project be able to respond to unpredictable requests over the life of the project, then the AOR and technical team should define clear criteria for responding to requests, and a mechanism to ensure sufficient funds without compromising original work plan components.

The connections between a social marketing project, if it is separate from the SBCC project, should be much stronger and more coordinated at all levels (national, regional, district). Service delivery projects, and any SBCC project that addresses a project's area of service delivery, should be clearly directed to collaborate with an operational mechanism (e.g., technical working group) and regularly share data, with strong USAID leadership at the helm to coordinate, facilitate, reward and direct the effort across projects. In the case of TCCP and the other USAID-funded service delivery projects, there was little evidence of active coordination by USAID or data sharing. Indeed, neither the RFA nor the agreement document spelled this out.

Future Program Design

Interviews with stakeholders included a question about recommendations to USAID for the design of future SBCC and social marketing projects. The question was an open-ended question with few probes. Because the question was often a part of the KIIs that asked about both TCCP and TSMP, some respondents did comment on how the projects did or should work together. The recommendations fell

into a few major areas: modes of collaboration and capacity building; campaign and message content and methods; health focus area; and geographic and target group focus. Based on the findings and conclusions, and the input of respondents, the evaluation team makes the following recommendations for the design of the future project or projects.

General Program Design Elements

- USAID should consider one of the following three options in terms of prime lead for the next project:
 1. Place an SBCC- and USAID-experienced local NGO prime with an international NGO as a partner with the ability to (a) support a local NGO by co-leading the financial and administrative aspects of the project with which the local NGO might not yet have had sufficient experience, and (b) provide expert SBCC advice, especially around mass media and production issues.
 2. Develop a “mega-project” to consolidate several projects currently under USAID/Tanzania into one. This would include combining SBCC and social marketing into one project, as well as non-clinical service delivery for HIV, SRH/FP, MCH and malaria. Results would include national policy, planning and technical support; capacity building; regional, district and community-level service delivery; social marketing; and SBCC at all levels.

This design would call for a large, sophisticated international NGO prime with experience in all health areas, with two main subs—one for SBCC and one for social marketing—and a large NGO grants program for capacity building and implementation at the community level.

If the prime did not have SBCC and/or social marketing capacity, one other international NGO with expertise in SBCC and social marketing could be brought on as a sub to provide further technical assistance and capacity building to the two main local subs.

3. Continue with the same structure of having two separate projects for SBCC and social marketing, and the other health service delivery projects, with changes as noted in the other recommendations.

The following recommendations apply, regardless of which of the above three options is selected.

- USAID should design a project that features a better balance of nationally focused mass media, complemented by regional and community-focused mid-media, with the use of interpersonal communication methods at the community level.
- An evaluation design built in at the outset could yield valuable data for the entire public health community. This would require close collaboration with evaluation experts to select from a range of options for a non-randomized control evaluation design, and the solicitation would need to provide a budget and clear requirements for this element.
- The MOHSW should have a clear role during the project design phase with USAID, with national health priorities and needs at the center. The design should include a clear mandate with specific systems for collaborating with the MOHSW at all levels, from working groups at the national level down to consultation and reporting relationships with the CHMTs. The design should include clear guidance about how the project should work at the community level, including collaboration and capacity building with local NGOs and integration of community health workers into project implementation.
- An increased use of small grants to local NGOs as an implementation and capacity-building strategy should feature prominently in the next project. This helps on several fronts—tailoring more to local

contexts, building local capacity and increasing the use of IPC. This should go hand-in-hand with support to MOHSW work on local campaign designs, such as was started by TCCP.

- If the new design designates one project to be a source of communications services, then there must be much clearer links with service delivery projects. The role of the project must also be more defined in terms of expectations for capacity development, implementation of SBCC interventions, or consulting to implementing partners who want help with the communications aspects of their projects. Currently, these functions are all a part of what is expected of TCCP, without clear coordination and support for all. Effectiveness was undermined by variables such as uneven funding streams, decreases in capacity-building resources over time, and insufficient coordination with service delivery partners through donor facilitation and mechanisms such as working groups or scheduled meetings. While the current project staff feel being a communications “services bureau” is a positive design approach, some of the evaluation findings point to expectations on the part of many stakeholders that the project go beyond this and do more direct implementation of behavior change communications at the lowest levels while also expecting higher-level collaboration, reporting and assistance.
- The project design should call for regional offices, at a minimum. The physical presence of staff trained in SBCC would go a long way in building the quality of programming for regional and district audiences as well as increasing the linkages and engagement with MOHSW stakeholders at these levels and other implementing partners in the field.

The presence of only two staff in the regions for the current project limits its ability to establish relationships with the local MOHSW offices, health facility staff, implementing partner staff in the regions, and those who could benefit from capacity building and mentorship that does not have to be limited to the time boundaries of courses and workshops. This would facilitate community and stakeholder engagement as well as technical support to and monitoring of project activities.

- In the areas of collaboration and coordination, there should be closer coordination with service delivery projects, especially in terms of sharing data to monitor the impact of demand creation, and identifying knowledge gaps and attitudes affecting health behaviors among facility clients and community members that could be addressed through SBCC programming. Also, MOHSW stakeholders need to have more of a voice in the design phase, and they should regularly receive reports about what is happening in their regions and districts.
- The evaluation team did not come to a clear conclusion about combining an SBCC and social marketing project in the next design; the team received varying opinions about this from diverse stakeholders. However, in light of the need to consolidate project management in a large mission, and in the interest of efficiency and greater synergies of effort, the team did not rule out a combination project as a possible option.

If the two projects are designed as separate entities, however, there should be much more collaboration and coordination between the two. There could be more coordination at all levels (national, regional, district).

- To respond to the internal and external factors that affected the project’s ability to achieve its objectives, it is recommended that for the future project, USAID should design the follow-on project with a clear plan as to how USAID will coordinate and more clearly direct funding streams to have some consistency and predictability over the life of the project. The focus areas of a similar project should remain more clear and consistent over the life of the project, with less flexibility for taking on new areas without a clear, documented modification to the agreement, with scope of work language in the amendment.

- In addition, the future project design will have to take into account trends in HIV programming, such as the Country Operational Plan guidance, in which reference is made to the language about 90-90-90, a UNAIDS concept that aims to ensure that 90 percent of all people living with HIV know their HIV status, 90 percent of all people with diagnosed HIV infection receive sustained antiretroviral therapy and 90 percent of all people receiving antiretroviral therapy have viral suppression.³¹ This might mean a change in the focus of the content of SBCC programming as well as a focus on districts with high HIV prevalence.
- It is clear to the team that service delivery projects, and any SBCC project that addresses a project's area of service delivery, should be clearly directed to collaborate with an operational mechanism (e.g., technical working group) and regularly share data, with strong USAID leadership at the helm to coordinate, facilitate, reward and direct the effort across projects. In the case of TCCP and the other USAID-funded service delivery projects, TCCP was unable to obtain service delivery data (numbers of women attending PMTCT or following SP guidelines, FP uptake data, etc.) from implementing partners. USAID could actively facilitate this through a proactive stance on implementing partner collaboration through a common platform, technical working group sharing and the like.
- In general, there should be a design that calls for greater attention to the rural context in media productions, and the program should more fully engage stakeholders at the district and community levels in the design and development of programs and campaigns, and in providing interim feedback about programming.
- Given limited resources, one option to balance capacity-building outcomes and resources would be to use a central mechanism (e.g., HC3) for capacity building at the national level of lead stakeholders, such as national level MOHSW staff, while reserving the funds of the bilateral for SBCC and other levels and types of capacity building. At the other levels, the project budget must target sufficient funding to meet capacity development goals and targets. At this point, the evaluation team cannot recommend a specific percentage of the budget that should be devoted to capacity building.
- Several changes that are recommended for iterations of programs in the current project include: (1) Lengthen the duration of the ACE program so that more experiential practice can occur; (2) Increase the numbers trained in SBCC in the country; (3) Tighten the relationship between the project, the mentors and the interns in the ACE program sponsoring organizations so that the experience can be more closely aligned with desired outcomes and include fewer instances of interns doing purely administrative work; (4) Revamp the RDL program to include a listeners' group training guide to facilitate discussion in peer group and individual settings, the establishment of listening groups, and systems that provide greater facilitation and monitoring of volunteers.
- The team recommends that USAID direct the next project to identify a strategy to provide funding and organizational development support to sustain the TASHCOM network. If it is determined that the MUHAS program is of value, USAID should reclaim the program to be a part of capacity building by the successor project and should consider adding a scholarship mechanism to ensure program completion by more students. This might be done through private sector leveraging.
- USAID would do well to align service delivery and the SBCC project much more closely with government services. This requires using baseline data and monitoring and maintaining communications between and across projects and the MOHSW and facilities over the life of the project in a manner different than has been done in the past with TCCP and other projects. This

³¹ PEPFAR Country/Regional Operational Plan (COP/ROP) 2015 Guidance, 12 February 2015.

encompasses sharing of data and joint planning between service delivery and communications partners, DHMTs and CHMTs.

Modes of collaboration and capacity building

- The project should call for close alignment with national health priorities and needs. There should also be a continuum of activity and communication between the project, the different levels of the MOHSW (national, regional and district), and community-level NGOs and civil society organizations. The new project should be called upon to develop a framework to guide the MOHSW and partner organizations in implementing SBCC at district and community levels. This should be operationalized through agreements, granting mechanisms, and established working groups, meetings and fora at national, regional and district levels. With staff based in the regions, this might be more feasible than it can be with the current design.
- The project can be accountable for being a capacity builder, communications expert and producer, and implementer through several mechanisms: staffing patterns that centralize key technical expertise in a country headquarters office with operations and administrative staff, complemented by implementation support staff in the field offices, which then provide small grants to local groups, technical support to the different levels of the ministry, liaison with service delivery partners and facilities, and capacity building to local staff and NGOs with assistance from the country headquarters office experts. At the national level, USAID plays a convening role between service delivery partners and the country headquarters staff to share needs, lessons and data across the service delivery projects and the communication project in order to identify gaps, needs, lessons and opportunities for leveraging, synergy and collaboration.
- The project design should specify a strategy to sync demand creation with supply to address the current failure of the health system to meet the needs of clients who take action based on behavior change messages but find services unavailable, for example, going to a facility for an HIV test only to find no test kits. Communication between an SBCC project, the facilities, and the MOHSW could trigger planning for an increase in demand. Currently there are commodities and services that clients are encouraged to seek only to find them not available. The products and services for which demand is created must be available at the facilities and in the communities if the intervention is to have an impact. The government should be providing services while the project provides funding for demand creation. As one RCH manager noted, “People are coming for HIV test –Wazazi tells to test for PMTCT—but they don’t have the reagents. Campaigns must go hand in hand with better supply chains.”
- Based on several suggestions for this in the interviews, and the challenge of one program such as TCCP reaching so many communities, the team recommends that there be an increase in numbers reached with courses such as LSHC and opportunities to develop localized campaigns with some technical and, at times, financial support. Individual and team courses on SBCC principles and ideas for implementation would be useful at the regional and district levels with the LHMTs and CHMTs. Scaling up the building of SBCC capacity in the LHMTs and CHMTs to more regions and districts beyond eight of the 30 regions in the country would increase coverage and contribute to the sustainability of SBCC capacity in the country.
- There should be an increase in funding for capacity building beyond the current allocation of 8 percent of total project funds per annum. This should consider an allocation of adequate financial resources to build the capacity of institutions that are able to sustain capacity-building efforts nationally. Include capacity-building methods that do not require additional funds, such as on-site mentoring, staff coaching on the job, or partnering with local groups to do “bench training” while implementing together.

- Make improvements to the ACE program, or an equivalent program in the new project, including: a mentor recognition program (see examples in capacity-building section); improving the linkages between the project and the organizations sponsoring interns so the experience can be more relevant and tailored; improving management of intern expectations; forging stronger relationships between the intern and fellow supervisors and the project so that seminar participation is highly valued by the supervisors; increasing the length of the program.
- Consider a way to feasibly extend the LSHC to one month instead of two weeks (two sessions of two weeks each for all trainees). For working professionals, this might mean weekend half days or some remote work as well as face-to-face work.

“(They) should find mentors who are committed to providing support to interns. It was difficult to find mentors who were committed to provide adequate support to interns since mentorship is done on a voluntary basis.”

“Mentors and supervisors should come from the same organizations. At the moment only supervisors come from host organizations while mentors are normally from another organization and there is no mechanism for the two to communicate.”

KII ACE Interns

- Ensure that any program within a university system to build SBCC capacity has a mechanism for scholarship support to students. This could be done through private sector leveraging.
- Implement several capacity building efforts in at least 15 organizations through the next project. This would entail several elements: increase the numbers trained through LSHC; provide organizational capacity building based on findings of the CAT, and provide ACE fellows to more local organizations.

Campaigns: channels, methods, content

- The future project should specify that the SBCC approach: (1) tailor messages in campaigns and programs to the epidemiological context, e.g., messages for the general population where HIV prevalence is highest, but for key populations in other areas; (2) be implemented where a health issue most needs the message (areas of high infant mortality, high HIV prevalence, high unmet need for contraception, high malaria incidence); (3) wherever implemented, be tailored to the local context in terms of urban vs. rural, cultural and language context, etc.; (4) ensure that channels used are the most accessible to and preferred by the population targeted; (5) utilize a mixed methods approach with IPC, mass media, print materials and community mobilization all working together with a consistent message, delivered at an intense level consistently over time.
- In all cases, mass media alone is insufficient, as is IPC alone. The combination is critical to effective SBCC. Small group and one-on-one interpersonal approaches clarify and reinforce what is gained through mass media messages. Community mobilization is critical to both, so that norms are influenced as much as individual knowledge or behavior. The use of trained drama groups as a tool for social mobilization and dissemination of health messages would be a good addition to the future project.

Geographic and target group focus

- Ensure that the project design calls for messages and programs designed for youth, and for communication programs that address the vulnerability of girls to HIV infections and the problem of unwanted pregnancies in young women.
- Because our findings showed a significant amount of attention to a felt need for tailoring and increased reach and coverage of communications for rural populations, the team recommends that this be a part of the new project design.

- For the future project, the HIV component will need to take into account the Country Operational Plan guidance. Reference is made to the UNAIDS 90-90-90 concept. PEPFAR Country Operational Plan guidance for 2015 states that “starting with this COP cycle, PEPFAR field teams are asked to employ the 90-90-90 framework in conjunction with epidemiologic data at the lowest sub-national unit available when setting targets and designing program activities....PEPFAR teams are expected to submit COPs that are strategic and set targets that will assist host country governments reach 80 percent coverage of PLHIV on ART by the end of [U.S. Government] fiscal year 2017.... in select high-burden sub-national units and/or populations.”³²

This could mean a change in the focus of the content of SBCC programming, as well as a focus on districts with high HIV prevalence. This might well require a more targeted SBCC approach in terms of which communities are prioritized for reach, to achieve economies of scale by focusing on higher-prevalence communities, and expanding to include more communication to support national treatment targets. Another way of targeting is to ensure that messages are tailored for those frequenting hot spots, and to attempt to ensure that hot spots in more rural areas are reached, as well as those in urban areas.

³² PEPFAR Country/Regional Operational Plan (COP/ROP) 2015 Guidance, 12 February 2015.

ANNEX I. SCOPE OF WORK

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067
EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
2/9/2015

INSTRUCTIONS: Complete this template in MS Word to develop a SOW for an evaluation, assessment, or other analytic activity. Please be as thorough as possible in completing this SOW, but if needed, your GH Pro technical advisor and project management team can assist you in developing your final SOW.

Refer to the USAID How-To Note: Developing an Evaluation SOW and the SOW Good Practice Examples when developing your SOW.

Note: When submitting this SOW, please also include relevant background documents that would assist in planning the analytic activity, such as a project description, contract/agreement, and implementing partner PMPs/reports.

I. TITLE: Combined evaluations for Tanzania Social Marketing Program (TSMP) and Capacity and Communication Project (TCCP)

Technical Directive Number (assigned by GH Pro): 007 & 008 (COMBINED)

II. Requester / Client:

USAID/DC (select by using pull-down menu) **Choose an item.**

USAID Country or Regional Mission (select by using Region pull-down menu)

Africa: **Tanzania**

Asia: **Choose an item.**

Europe & Eurasia: **Choose an item.**

Latin America & the Caribbean: **Choose an item.**

Middle East: **Choose an item.**

III. Funding Account Source(s): (Click on box (es) to indicate source of payment for this assignment)

3.1.1 HIV

3.1.6 MCH

3.1.2 TB

3.1.7 FP/RH

3.1.3 Malaria

3.1.8 WSSH

3.1.4 PIOET

3.1.9 Nutrition

3.1.5 Other public health threats

3.2.0 Other (specify): Mission

IV. Cost Estimate: \$400,000 (\$200K for TCCP & \$200K for TSMP) (**Note:** GH Pro will provide a final budget based on this SOW)

V. Performance Period: (Use pull down to indicate expected start and end dates – *choose any day in the month and year on pull down calendar*)

Expected Start (on or about): 23-Feb-2015

Anticipated End (on or about): 22-May-2015

VI. Location(s) of Performance Period: (Indicate locations where work will be performed to implement this evaluation or analytic activity)

Both projects implement in overlapping districts. For this reason, we recommend the following districts be for consideration as potential sites for these evaluations, where outcomes from both projects can be evaluated:

1. Njombe
2. Tabora
3. Kagera

4. Mwanza
5. Dar es Salaam (optional)

Selection of final locations will be finalized once Evaluation Team(s) meet with USAID/Tanzania.

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

Performance Evaluation (Check timing of data collection)

Midterm Endline Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

Process Evaluation (Check timing of data collection)

Midterm Endline Other (specify):

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the

observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. BACKGROUND

Background of project/program/intervention: **USAID/Tanzania Capacity and Communication Project**

Project/Activity Title: **Tanzania Capacity and Communication Project (TCCP)**

Award Number: 621-A-00-08-00005-00

Award Dates: 9/12/2010 to 5/16/2016

Project/Activity Funding (TEC): \$49,500,000

Implementing Organization(s): Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU-CCP)

Project/Activity COR/AOR: Naomi Kaspar

Country Context

Tanzania has a population estimated at nearly 42 million, of which almost 75% lives in rural areas. Driven by tourism, mining, trade, and communications, the private sector has grown considerably with economic growth averaging 7% over the last decade. Despite these gains, the percentage of people living in poverty has decreased only marginally during the past 10 years, while continued rapid population growth has increased the absolute number of Tanzanians living in poverty by more than 1 million, overwhelming an already-fragile social service system. Tanzania relies heavily on foreign aid; roughly one-third of the national budget is financed by direct budget support. Lack of basic healthcare and the impact of preventable diseases such as HIV/AIDS and malaria, low levels of education and agricultural productivity, widespread corruption, and an urgent need for reform of the business-enabling-environment persist as major challenges to development.

Tanzania's life expectancy at birth is 52.46 years, and the population is primarily young (21.4% of women and 25.5% of men are between 15 and 19 years of age).³³ Although there has been an overall downward trend in fertility in Tanzania from 5.7 (2004/05) to 5.4 (2009/10), at current growth rates, Tanzania's population will exceed 50 million by 2025. Demographic and Health Surveys (DHS) in Tanzania suggest a "gradual and steady increase" in contraceptive use among married women over the last two decades, with a concurrent increase in the use of modern methods. The 2010 DHS indicates that 29% of all women, including 34% of married women and 51% of sexually active unmarried women 15-49, currently use contraception. The large majority of these women use modern methods, with injectable, oral contraceptives, and male condoms predominating.³⁴ Unmet need for FP remains high at 22%.

The HIV epidemic in mainland Tanzania is mixed. Data indicate that there has been an overall reduction in national HIV prevalence from 5.7% to 5.1%; however, this reduction may represent a plateau in the epidemic rather than a true reduction in new infections. Although basic knowledge of HIV/AIDS is nearly universal, comprehensive knowledge is low and has remained relatively unchanged since 2004.³⁵

Tanzania has unacceptably high maternal and infant mortality rates, ranking 19th and 32nd in the world, respectively.³⁶ Despite high coverage rates of antenatal care (96% attend at least once), only 50% of women

³³ Preliminary results from Demographic and Health Survey, 2009/10.

³⁴ Demographic and Health Survey, 2010. [ADD complete citation].

³⁵ DHS, 2010.

³⁶ UN State of the World's Children, 2009.

delivered in a health facility, and maternal mortality remains high at 454 deaths per 100,000 live births (accounting for approximately 8,000 maternal deaths per year). Major direct causes of maternal mortality include obstetric hemorrhage, obstructed labor, pregnancy-induced hypertension, sepsis, and abortion complications.³⁷ Notably, under-five mortality rates have dropped by 40%, from 137 deaths per 1,000 births in the mid-1990s to 81 for the period 2006–10.³⁸ Nevertheless, neonatal mortality rates have been high at 32 per 1,000 live births, and account for 47% of the infant mortality rate.³⁹ The critical timeframe for lifesaving neonatal interventions is within 24 hours after birth – immediately during delivery and including postnatal visit. Data from the Tanzania DHS show that only half of Tanzanian women deliver in a facility and only 13% of women received any postnatal care within 48 hours after delivery.

USAID/Tanzania Vision: Social and Behavior Change for Health

USAID/Tanzania has worked to develop and support a behavior change portfolio that leverages deep technical expertise by consolidating marketing and communication activities under a small number of projects. The work of these projects is characterized by a strong emphasis on technical and operational capacity strengthening utilizing a variety of complementary strategies. Community mobilization and outreach are areas of particular programmatic priority.

TCCP project overview

The Tanzania Capacity and Communication Project (TCCP) is a five-year, USAID-funded cooperative agreement awarded in September 12th, 2010 with ending date September 11th, 2015. It is led by the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU-CCP) in collaboration with Media for Development International (MFDI) and CARE Tanzania.

The goal of this cooperative agreement is to increase the adoption of safer behaviors by Tanzanian adults and high-risk populations (adults and youth) to prevent or manage HIV infection; support the uptake of FP to reduce unmet need; address maternal, newborn, and child health issues; and address other health issues.

In support of this goal, TCCP has three program objectives:

- I. Execute evidence-based, coordinated social and behavior change communication (SBCC) initiatives at scale.
- II. Facilitate coordination of social and behavior change communication at the national, regional, and district levels.
- III. Measurably transfer social and behavior change communication skills to Tanzanian individuals and institutions

TCCP's areas of focus include HIV/AIDS (AB, OP, PMTCT, VMMC, OVC, and treatment); FP/RH; maternal and child health; and malaria.⁴⁰ To date, TCCP has implemented activities in eight priority regions: Dar es Salaam, Iringa, Mara, Mbeya, Mwanza, Pwani, Shinyanga and Tabora. Recent redistricting and adding component of malaria has expanded TCCP's work to 15 regions, now including Geita, Njombe, Ruvuma, Mtwara, Lindi, Kagera and Simiyu.

TCCP is premised upon the Integrated Change Model, shown below. This model, which draws upon socio-ecological frameworks common in behavior change programming, posits that sustained behavioral change requires intervention at the individual, social, and structural levels.

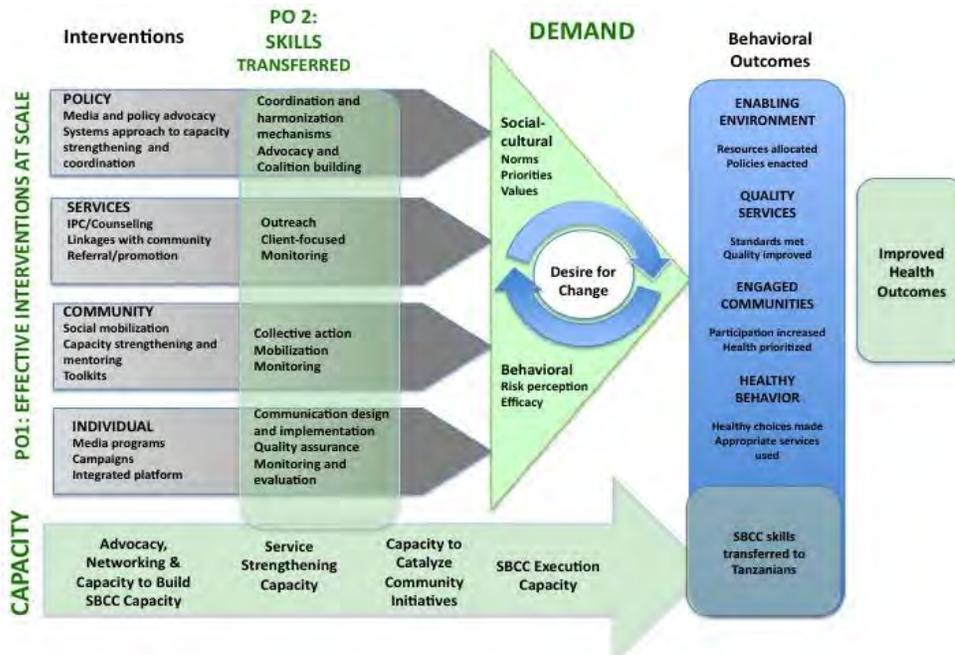
³⁷ The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 - 2015

³⁸ Preliminary results from Demographic and Health Survey, 2009/10.

³⁹ The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 - 2015

⁴⁰ Malaria activities, which were supported by JHU-CCP's Commit project from 2008-2013, were integrated into TCCP with the closure of Commit in October 2013.

Figure 1: Integrated Change



TCCP’s work in capacity strengthening (Program Objectives 2 and 3) expands upon the project’s Integrated Change Model, articulating a specific vision for development of sustainable SBCC capacity. This model, which is presented below, describes four complementary pathways to national-level capacity improvement: building sustainable systems, developing communication institutions, creating health competent communities and training and mentoring individual communication professionals.

[Note: This model may have changes since start-up. The Evaluation Team should use project documents for the current model.]

Approach and Implementation

Program Objective 1: Execute evidence-based, coordinated social and behavior change communication initiatives at scale.

Major activities contributing to the achievement of this objective include:

- Development and production of weekly variety shows or entertainment education programs on television and radio.
- Development and implementation of high-visibility, national multi-media campaigns addressing HIV prevention, FP, and neonatal and child health. Such campaigns include community activities implemented through CARE and TCCP community outreach agents.
- Development of national and sub-national SBCC strategies pertaining to specific health areas, in conjunction with the Government of Tanzania and U.S. Government implementing partners.
- Development and oversight of a coordinated materials distribution system for Tanzania.

Program Objective 2: Reinforce systems for coordinating and delivering social and behavior change communication.

Major activities contributing to the achievement of this objective include:

- Provision of individual-level capacity strengthening to key staff members within the MoH, NACP, and TACAIDS. Such capacity strengthening may include participation in the Leadership in Strategic Health Communication (LSHC) training or the Advancing Communication Experientially (ACE) fellowship and internship program, among other activities.

- Provision of technical assistance to key Government of Tanzania technical bodies, including the Ministry of Health (MoH), NACP, and TACAIDS. Such technical assistance may include revitalization or establishment of Government of Tanzania technical working groups or task teams pertaining to SBCC.
- Message harmonization, potentially in conjunction with development of a knowledge management platform to support continued coordination across implementing partners.

Program Objective 3: Measurably transfer social and behavior change communication skills to Tanzanian individuals and institutions.

Major activities contributing to the achievement of this objective include:

- Provision of the LSHC training using a ToT model to ensure roll-out at the district level, to be implemented in conjunction with local institutions. In some districts, this training has been extended and reinforced through design and implementation of district level SBCC campaigns by trainee teams.
- Development and production of 26-episode radio distance learning program targeting community health workers.
- Development of capacity and production value among Tanzanian film and television producers through co-production of entertainment education outputs.
- Establishment of ACE fellowship and internship programs to provide applied learning opportunities in SBCC.
- Delivery of institutional capacity assessments to a variety of Tanzanian entities, with provision of tailored SBCC capacity strengthening services and/or referral to external resources based on identified needs.
- Support to Muhimbili University of Allied Health Sciences (MUHAS) for development and provision of SBCC-related short-courses and degree programs.

Research, monitoring, and evaluation are central to TCCP's activities, informing design, determining reach, and confirming impact. TCCP seeks to balance the need for routine and readily available programmatic data with more rigorous research exploring programmatic outcomes and behavioral impact. In addition to purchasing communication data collected through quarterly omnibus surveys and conducting ongoing pre-post surveys of its SBCC fellows and interns, TCCP has conducted several larger-scale evaluation activities, including project baseline and midline surveys, campaign evaluations, and a qualitative assessment of its radio distance learning program for community volunteers.

Describe the theory of change of the project/program/intervention.

See above in Background

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

- I. Execute evidence-based, coordinated social and behavior change communication (SBCC) initiatives at scale.
- II. Facilitate coordination of social and behavior change communication at the national, regional, and district levels.
- III. Measurably transfer social and behavior change communication skills to Tanzanian individuals and institutions

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Priority Sites: Dar es Salaam, Iringa, Mara, Mbeya, Mwanza, Pwani, Shinyanga and Tabora.
New Sites: Geita, Njombe, Ruvuma, Lindi, Mtwara, Kagera and Simiyu

Background of project/program/intervention: **USAID/Tanzania Social Marketing Program**

Project/Activity Title: **Tanzania Social Marketing Program (TSMP)**
Award Number: 621-A-00-10-00020-00
Award Dates: May 15, 2010 to May 14, 2016
Project/Activity Funding: \$49,999,000 (TEC)

Implementing Organization(s): Population s Services International (PSI)
Project/Activity COR/AOR: Upendo Kategile

Country Context

Tanzania has a population estimated at over 47 million, of which almost 75% lives in rural areas. Driven by tourism, mining, trade, and communications, the private sector has grown considerably with economic growth averaging 7% over the last decade. Despite these gains, the percentage of people living in poverty has decreased only marginally during the past 10 years, while continued rapid population growth has increased the absolute number of Tanzanians living in poverty by more than 1 million, overwhelming an already-fragile social service system. Tanzania relies heavily on foreign aid; roughly one-third of the national budget is financed by direct budget support. Lack of basic healthcare and the impact of preventable diseases such as HIV/AIDS and malaria, low levels of education and agricultural productivity, widespread corruption, and an urgent need for reform of the business-enabling-environment persist as major challenges to development.

The HIV epidemic in mainland Tanzania is generalized with HIV prevalence (5.1%) similar to that of neighboring countries such as Kenya and Uganda. The most recent data on HIV prevalence, from 2011-12, indicates an HIV prevalence of 6.2% among adult females and 3.8% among adult males. Although historically HIV prevalence has been higher in urban and peri-urban areas, in recent years, it appears that rural areas are becoming more important as a source of HIV infections. This is likely due to the fact that HIV prevalence is declining faster in urban areas than rural areas. Although basic knowledge of HIV/AIDS is nearly universal, comprehensive knowledge is low and has remained relatively unchanged since 2004.⁴¹ Reported condom use is increasing among most population segments in Tanzania. For example, between the 2008 THMIS and the 2012 THMIS, among all women who had higher-risk sex during the last twelve months, reported condom use at last higher-risk sex increased from 43% to 55%.

Tanzania's life expectancy at birth is 52.46 years, and the population is primarily young (21.4% of women and 25.5% of men are between 15 and 19 years of age).⁴² Although there has been an overall downward trend in fertility in Tanzania from 5.7 (2004/05) to 5.4 (2009/10), at current growth rates, Tanzania's population will exceed 50 million by 2025. Demographic and Health Surveys (DHS) in Tanzania suggest a "gradual and steady increase" in contraceptive use among married women over the last two decades, with a concurrent increase in the use of modern methods. The 2010 DHS indicates that 29% of all women, including 34% of married women and 51% of sexually active unmarried women 15-49, currently use contraception. The large majority of these women use modern methods, with injectables, oral contraceptives, and male condoms predominating.⁴³ Unmet need for FP remains high at 22%

USAID/Tanzania Vision: Social Marketing for Health

USAID is committed to developing markets for health products and services in Tanzania that are vibrant and self-sustaining. Such markets will effectively engage the public, social marketing and commercial marketing sectors in a total market approach that supports effective brand development and marketing, and maximum cost recovery. Tanzanian partners will demonstrate the technical and operational capacity to design, manage, and evaluate high-quality, locally-driven social marketing initiatives that complement the services provided by the MoHSW and international organizations.

TSMP Project Overview

The Tanzania Social Marketing Project, or TSMP, is a 5-year cooperative agreement awarded in 2010. Under the leadership of Population Services International (PSI), TSMP provides technical support to two Tanzania organizations, T-MARC Tanzania and PSI/Tanzania, and engages key stakeholders from the public, non-profit, and private sectors to improve market segmentation, subsidy strategies, and distribution systems.

The goal of this cooperative agreement is to improve the health status of Tanzanian families, with an objective to ensure measurable behavior change (including use of effective health products) among project target groups.

⁴¹ Demographic and Health Survey, Tanzania, 2009/10.

⁴² Demographic and Health Survey, Tanzania, 2009/10.

⁴³ Demographic and Health Survey, Tanzania, 2010.

To support this goal and project objective, the Tanzania Social Marketing Program (TSMP) will ensure achievement of the following two intermediate results (IRs):

IR 1 Aggressively expanded impact of targeted social marketing initiatives that are aligned to measurable behavioral outcomes in HIV/AIDS, FP/RH, child survival, and malaria.

- IR 1.1: Access to HIV/AIDS, FP/RH, child survival and malaria social marketing products dramatically scaled up through a targeted approach
- IR 1.2: Consumer and trade understanding of the underlying public health issues and correct use of HIV/AIDS, FP/RH, child survival and malaria products significantly increased
- IR 1.3: Sales and use of socially marketed health products measurably increased

IR 2 Local capacity (civil, public, and private) to sustain social marketing activities in Tanzania strengthened to achieve public health outcomes.

- IR 2.1: Capacity of one or more Tanzanian organizations to implement social marketing programs and provide leadership in social marketing at the national level strengthened
- IR 2.2: Substantive partnerships with the civil, public and commercial sectors and donors to promote wider public health impact established and maintained
- IR 2.3: Capacity of public sector institutions to promote and regulate social marketing activities in Tanzania ensured

The TSMP team leverages the “Total Market Approach” (TMA) to social marketing to correct market inequalities and to develop more sustainable solutions to health problems by providing customers with wider and more effective choices. The goal of the TMA is to achieve a marketplace where all segments of society are reached with high quality products and services according to their ability to pay. In a balanced TMA, the poorest access products and services through free distribution, those who are somewhat better off through subsidized products, and those with greater ability to pay through commercially-distributed products. Social marketing organizations are essential to growing the overall market volume by attracting new user groups into the market and opening up new markets, particularly in rural areas through community-based distribution.

TSMP works primarily in the areas of HIV prevention and FP, supporting promotion and distribution of male and female condoms and oral contraceptives through its partner organization. T-MARC markets and distributes three products: *Dume* male condoms, *Lady Pepeta* female condoms, and *Flexi-P* oral contraceptives. With USAID funding through TSMP, PSI also provides Water Guard water purification tablets for distribution through PEPFAR home-based care partners along with *Familia* male condoms through commodity co-financing support from the Global Fund. In addition, TSMP will support the MoHSW's introduction of two new vaccines for diarrhea and pneumonia through a targeted communication campaign that will engage two of the poorest performing regions in Tanzania. Also through TSMP, PSI has provided support to sub-grantee the Clinton Health Access Initiative (CHAI) for improved product distribution through small-scale private pharmaceutical vendors (ADDOs).

Target Areas and Populations

T-MARC distributes male and female condoms nationwide, with T-MARC providing focused marketing and behavior change efforts in areas with elevated HIV prevalence, including Dar es Salaam, Arusha, Mwanza, and other major urban hubs. FP products are distributed nationwide, with promotion largely through IPC activities in Dar es Salaam, Dodoma, Mwanza, Arusha, Shinyanga, Mara, Manyara, and Mbeya.

Priority audiences for products marketed under TSMP are outlined in brief below:

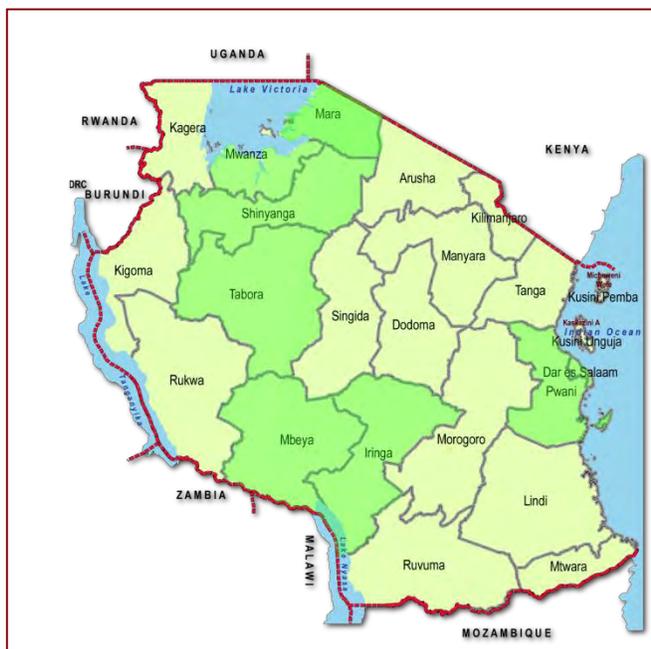
- **Dume male condoms:** urban and peri-urban men. Mid-market/moderate socio-economic status.
- **Lady Pepeta female condom:** commercial sex workers, women engaging in transactional sex (such as bar workers). Mass market, with heavy emphasis on free distribution in conjunction with IPC to encourage trial among new users.

- **Flexi-P oral contraceptive:** young, single, “independent,” urban women. Mid-market, with pricing likely to rise substantially pending Bayer registration.

TSMSP supported T-MARC in selecting these audiences based on country-level health needs, donor priorities, and primary behavioral research that allowed for identification of those groups most amenable to social marketing intervention for each product.

Priority audiences for PSI/Tanzania products relevant to TSMSP’s mandate and objectives include:

- **Salama male condoms:** rural men, mass market/lower socio-economic status.
- **Care female condom:** key populations at high risk for HIV infection, including discordant couples, injection drug users, and men who have sex with men.
- **Familia oral contraceptive:** married women.



TSMSP Approach and Implementation

IR 1: *Aggressively expanded impact of targeted social marketing initiatives that are aligned to measurable behavioral outcomes in HIV/AIDS, FP/RH, child survival, and malaria.*

Activities under this IR have centered on the continued shaping of the national markets for male and female condoms and oral contraceptives, with particular attention to establishing complementary targeting, positioning, and pricing between T-MARC and PSI/Tanzania brands. Promotion activities emphasize continuous below-the-line marketing (through interpersonal communication, experiential marketing, and public events) complemented by periodic mass media campaigns.

Major activities contributing to the achievement of this objective include:

- Nationwide distribution of social marketing products to increase access and accessibility to male and female condoms, oral contraceptives, and household water treatment products.
- Repositioning of the Dume and Salama male condom brands based on current research, with Dume moving into a mid-market niche and Salama retaining lower-priced, mass market targeting.
- Repositioning of the Flexi-P and Familia oral contraceptive brands (which currently utilize identical formulations), with Flexi-P targeting younger, unmarried, “Independent” women and Familia targeting married women, with an emphasis on male involvement. T-MARC anticipates that it will adopt an alternate formulation for Flexi-P in the coming year, further differentiating the two brands.
- Promotional activities to reposition products in accordance with the above strategies including promotion of products via television, public events, bar-based interpersonal communication, and other relevant communication channels.
- Convening of government, civil society, and private stakeholders to coordinate a total market approach to social marketing.

IR 2: Local capacity (civil, public, and private) to sustain social marketing activities in Tanzania strengthened to achieve public health outcomes.

Major activities contributing to the achievement of this objective include:

- Capacity strengthening activities carried out by PSI to improve T-MARC’s marketing, research, and implementation capacities.

- Assessment of T-MARC's management, operational, and financial controls, systems, and processes by PSI's Overseas Financial Operations Group.
- Through a partnership with RADAR training, provision of tailored management and leadership support to T-MARC and PSI/Tanzania staff.
- Continued support to small local NGO and CBO partners, such as the PRINMAT network of reproductive health clinics, in the development of a sustainable commodity supply chain and supportive supervision system for community-based distribution of health products.

Describe the theory of change of the project/program/intervention.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

See above in Background

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

T-MARC HIV focused: Dar es Salaam, Arusha, and Mwanza

T-MARC IPC: Dar es Salaam, Dodoma, Mwanza, Arusha, Shinyanga, Mara, Manyara, and Mbeya.

IX. SCOPE OF WORK

A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this evaluation is to review, analyze, and evaluate the results of the Tanzania TCCP and TSMP's activities against the objectives of each project, as the projects enter their final year. The evaluation seeks to answer descriptive questions that explore the projects' progress towards their objectives and intermediate results. This evaluation is intended to provide a critical review of TCCP and TSMP's achievements across the life of the projects, with attention to a variety of possible dimensions of project success. USAID/Tanzania is interested in improving project performance and informing future SBCC and social marketing mechanisms.

Note: This evaluation should present findings relative to each project.

B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID/Tanzania Health Office

C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

These evaluations are intended to provide USAID/Tanzania Health Office evidence for management of these projects and for use in the design of the follow-on projects dealing with SBCC and social marketing related to HIV/AIDS, FP/RH, maternal and child health (MCH), and malaria

D. **Evaluation questions:** Evaluation questions should be: a) aligned with the evaluation purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. **USAID policy suggests 3 to 5 evaluation questions.**

Evaluation Question		
	TCCP	TSMF
1.	To what extent have TCCP's SBCC campaigns and programs achieved behavior change among priority audiences?	IR 1: Expansion of social marketing impact through development of total market: To what extent have TSMF's interventions expanded the effects of targeted social marketing initiatives that are aligned to measurable behavioral outcomes in HIV/AIDS, FP/RH, child survival, and malaria?
2.	What programmatic lessons may be drawn from TCCP's experience in designing and implementing large-scale SBCC campaigns in collaboration with Government of Tanzania, U.S. Government, and NGO stakeholders?	IR 2: Strengthened capacity to sustain social marketing efforts among Tanzanian institutions (public, civil, and private sector): To what extent have TSMF's interventions strengthened local capacity (civil, public, and private) to sustain social marketing activities to achieve public health outcomes.
3.	To what extent, and in what manner, have TCCP's capacity strengthening interventions improved the ability of Tanzanian individuals and institutions to design, implement, and evaluate high-quality SBCC?	What internal and/or external factors have influenced the project's ability to achieve its objectives, how USAID and IPs can leverage these factors?
4.	What capacity strengthening approaches appear to most directly influence the quality of in-country SBCC design, production, and implementation?	Is the project's geographic and demographic focus appropriate given desired outcomes, epidemiological needs, and resources?
5.	To what extent can't the Government of Tanzania and local NGOs independently design and monitor health communication activities? What appear to be areas of competency? What are areas where additional support may be required?	

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation.)

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- E. **Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

■ **Document Review** (list of documents recommended for review)

For health data on Tanzania, the following reports apply to both projects: Tanzania DHS (2010) , THMIS (2007/2008 & 2011/2012) (http://dhsprogram.com/Publications/Publication-Search.cfm?ctry_id=39&c=Tanzania&Country=Tanzania&cn=Tanzania)

TCCP has conducted a number of rigorous, large-scale evaluations of its own efforts in Project Years 1-4.

Studies of particular relevance to this evaluation include:

- TCCP project baseline (2010) and midline (2014) surveys
- Wazazi Nipendeni MNCH campaign evaluation (2013)
- Kamiligado radio distance learning program evaluation (2014, and 2015 expecting results in July/August)

Project omnibus survey data and media buy data, while gathered largely for purposes of program planning rather than evaluation; also offer a valuable source of longitudinal data, particularly when reviewed against temporal trends in service utilization.

Additionally, project documents, such as, work plans, PMP, annual reports with indicator data will be reviewed

- TCCP Work plans Y1, Y2, Y3, Y4
- TCCP Quarterly Reports: Q1-15
- TCCP Project Monitoring Plan with updated data

- TCCP budgets: Y1, Y2, Y3, Y4
- TCCP TIPS Assessment
- TCCP midterm assessment
- Omnibus survey reports, 2010-2014
- Wazazi Nipendeni evaluation report
- Kamiligado radio distance education evaluation report
- TCCP project baseline (2010) and midline (2014) surveys
- TCCP media buy data overlaid or cross-walked against service statistics
- DHS 2010
- THMIS 2011/2012

TSMP has conducted a number of surveys of its target populations, formative research studies, and reviews of project activities during the last four years. Project survey data and formative research, whether gathered for the purposes of project planning or project evaluation, offer a valuable source of evaluation data. These reports, along with other project documents, such as, work plans, PMP, annual reports with indicator data will be reviewed. USAID/Tanzania and TSMP will provide the evaluators with key documents prior to the in-country evaluation. These documents include;

- Scope of Work from the PSI TSMP proposal
- TSMP Work plans: Y1, Y2, Y3, Y4
- TSMP Annual Reports: Y1, Y2, Y3
- Updated TSMP Project Monitoring Plan
- TSMP budgets: Y1, Y2, Y3, Y4
- PSI TRaC and MaP data demonstrating product availability and use
- Total Market Analysis Data, Tanzania (Excel file), 2004-2012
- Total Market Analysis Review by Pierre Moon, July 2013
- Mid-Term Project Assessment, August 2013
- Budgetary data illustrating unit cost/commodity distributed and unit cost/person reached with product promotion (by commodity) for TSMP Quarters 1-10.
- T-MARC Project Mid-Term Assessment, 2008
- PSI Platform Assessment Reports – PSI/Tanzania and T-Marc, 2010
- T-Marc Strategic Planning and Visioning Consultancy, Final Report

■ **Secondary analysis of existing data** (*list the data source and recommended analyses*)

The following datasets have reports, and therefore, the findings in these reports may be sufficient. However, if needed, the following datasets are available for secondary analysis:

Data Source (<i>existing dataset</i>)	Description of data	Recommended analysis
MTUHA	Tanzania Health Management Information System (HMIS)	Can compare service data from districts where TCCP and/or TSMP worked to matched districts with no USAID BCC and social marketing inputs.
TZ/DHS 2010	National representative data on population, health and nutrition	Available if needed. Can compare indicators for regions where TCCP and/or TSMP worked to regions with little USAID BCC and social marketing inputs.
THMIS 2011/2012	National representative data on HIV and malaria	Available if needed. Can compare indicators for regions where TCCP and/or TSMP worked to regions with little USAID BCC and social marketing inputs.
Omnibus survey, 2010-2014	A cross sectional household based survey carried out by IPSOS	Need to verify availability of Omnibus data. If available, can compare

Data Source (existing dataset)	Description of data	Recommended analysis
	quarterly. TCCP purchases questions on this survey. Other USAID health projects do so too.	indicators for regions where TCCP worked to regions with little USAID BCC inputs.
TCCP indicator data	Project performance indicators	Available from project
TSMP indicator data	Project performance indicators	Available from project
TCCP Cross-Walked Media Buy data and service statistics		

■ Key Informant Interviews (list categories of key informants and purpose of inquiry)

KIIs will be conducted with key stakeholders. When a key informant can provide information and insights on both projects, their interview will cover topics of both projects. Key informants will be selected from among the following. The final list of informants to be interviewed will be finalized in consultation with the USAID/Tanzania Health Office.

TCCP	TSMP
<ul style="list-style-type: none"> • ACE mentors • ACE fellows • ACE interns • LSHC trainers (PHCI) • LSHC alumni • Regional District & Ward health management teams • District-level LSHC campaign “teams” • Campaign team mentors <p>Staff of 3-4 organizations that have participated in institutional capacity strengthening activities with TCCP, such as Femina Hip, EngenderHealth, AMREF, FHI360, CDC Foundation, TCDC CBO, NACP, NMCP, TACAIDS, Primary Health Care Institute, Muhimbili Hospital, MUHAS, Restless Development, IDYDC, and IMO.</p>	<ul style="list-style-type: none"> • TSMP staff and partners: TSMP, T-MARC <p>Project stakeholders: MoHSW, TACAIDS, NACP, USAID HIV prevention team, JSI/DELIVER, PRINMAT network, etc.</p>

■ Focus Group Discussions (list categories of groups, and purpose of inquiry)

FGDs will be conducted to illicit reactions from those involved as beneficiaries of the projects. Beneficiaries are those who benefitted from the projects’ capacity building efforts and from SBCC and social marketing campaigns. When a group of beneficiaries are the same for both projects, such as community members, they will be combined within the FGD, but these FGDs will be longer sessions to accommodate questions related to both projects.

For the target beneficiary community FGDs, we will conduct separate discussion for men and women, to adjust for the potential power differential between men and women, and to assure women’s voice is heard equally to men. These FGDs will be conducted in the same locations as the site visits.

The Evaluation Team will finalize the target participants for the FGDs with USAID/Tanzania. Possible FGDs are:

TCCP	TSMP
<ul style="list-style-type: none"> • ACE mentors • ACE fellows & interns • LSHC alumni <p>Target beneficiaries: community members</p>	<p>Target beneficiaries: community members</p>

Group Interviews (list categories of groups, and purpose of inquiry)

--

Client/Participant Satisfaction or Exit Interviews (list who is to be interviewed, and purpose of inquiry)

--

Facility or Service Assessment/Survey (list type of facility or service of interest, and purpose of inquiry)

--

Verbal Autopsy (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)

--

Survey (describe content of the survey and target responders, and purpose of inquiry)

Individuals involved in SBCC (TCCP related activities) and social marketing (TSMP related activities) will be asked to complete an online survey that assesses their skills and perception about factors associated with success and shortcomings of their SBCC or social marketing efforts. Target respondents will be TCCP and TSMP staff, as well as individuals working with partner and collaborating organizations (public, private, and civil).

Observations (list types of sites or activities to be observed, and purpose of inquiry)

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Data Abstraction (list and describe files or documents that contain information of interest, and purpose of inquiry)

For TSMP, sales and distribution records from target distributors of products that were promoted through social marketing campaigns.

Case Study (describe the case, and issue of interest to be explored)

Two case studies will be conducted to compare the SBCC campaigns in specified locations that achieved very good results and one that have limited results. The two cases will be compared to determine factors associated with success and factors associated with shortcomings. USAID/Tanzania in consultation with TCCP will assist in the identification of campaigns and sites for data collection and document review that will be required to develop the two case studies.

Rapid Appraisal Methods (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

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Other (list and describe other methods recommended for this evaluation, and purpose of inquiry)

Organizational Capacity Assessment (OCA)

Standard organizational capacity assessment tools (OCAT) have been developed for SBCC, such as those developed by C-Change (<https://www.c-changeprogram.org/resources/sbcc-capacity-assessment-tool>). These tools, or a similar OCAT, will be adapted for use to assess organizational capacity for SBCC. Efforts will be made to adapt the OCA tool to evaluate capacity for social marketing as well.

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

Yes No

List or describe case and counterfactual”

Case	Counterfactual

X. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

Both qualitative and quantitative analysis of the achievements in relation to the objectives and targets for the output indicators for the cooperative agreement. Moreover, all analyses will be geared to answer the evaluation questions.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate. In the report the Evaluators will describe the statistical tests used.

Thematic reviews of qualitative data will be performed. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data does not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project performance indicator data, DHS, and THMIS) will allow the Team to triangulate findings to produce more robust evaluation results.

XI. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this end of program evaluation. These include TCCP's and TSMP's annual work plans for the last five years, M&E plans, quarterly progress reports, and reports from internal project evaluations. There are also national surveys that guided program planning and implementation, including the TDHS and THMIS. This desk review will provide background information for the Evaluation Team, and will also be use as data input and evidence for the evaluation.

Team Planning Meeting (TPM) in Tanzania – A three-day team planning meeting (TPM) will be held in Tanzania before the evaluation begins. The TPM will:

- Review and clarify any questions on the evaluation SOW;
- Clarify team members' roles and responsibilities;
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- Review and finalize evaluation questions;
- Review and finalize the assignment timeline and share with other units.
- Develop data collection methods, instruments, tools and guidelines;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a data collection plan;
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report; and
- Assign drafting/writing responsibilities for the final report.

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- Evaluation **launch**, a call among the USAID/Tanzania, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. The Mission will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review travel schedule.
- **In-brief** with USAID/Tanzania, following the TPM. This briefing will include the Evaluation Team, USAID/Tanzania Health Office and M&E team representatives. The Evaluation Team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-brief will be the format and content of the Evaluation report(s)
- The Team Lead will brief the Mission **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.

- A **final debrief** will be held approximately 3 days before departure, between USAID/Tanzania and the Evaluation Team. During this meeting [the findings from the evaluation will be presented in a draft report at a full briefing with USAID/Tanzania] [a summary of the data will be presented, along with high level findings and draft recommendations]. For the debrief, the Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report.
- **Stakeholders’ debrief/workshop** will be held following the final debrief with the Mission.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to TCCP/TSMP support sites for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID/Tanzania. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

XII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines
■ Launch Call	Late February
■ Work plan with timeline	Late February
■ Analytic protocol with data collection tools	Late February
■ In-brief with Mission or organizing business unit	Early-March
■ In-brief with target project / program	Early-March (following in-brief with Mission)
■ Routine briefings	weekly
■ Findings review workshop with stakeholders with Power Point presentation	Early April
■ Out-brief with Mission or organizing business unit with Power Point presentation	Late April
■ Draft report	Late-April – Early May
■ Final report (electronic only)	Mid-July

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval?
10 business days per report;

XIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities

The following skills should be covered by the members of the Evaluation Team:
 HIV, FP, SBCC, social marketing, organizational development (OD), and evaluation.

The following list of Key Staff are illustrative, and are to be used as a guide to insure all skills needed for this evaluation reside within the Team, once recruited and posted.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for individual team members, or for the team as a whole.

Key Staff 1 Title: Team Leader (**Note:** This person will be selected from among the other key staff, and will meet the requirements of both this and the other position.)

Roles & Responsibilities: The team leader will be responsible for (1) managing the team's activities, (2) ensuring that all deliverables are met in a timely manner, (3) serving as a liaison between the Mission and the evaluation team, and (4) leading briefings and presentations.

Qualifications:

- Minimum of 10 years of experience in public health, with technical knowledge and experience in HIV, preferably Pediatrics HIV and/or Child health interventions
- Excellent skills in planning, facilitation, and consensus building;
- Demonstrated experience leading an evaluation team;
- Excellent interpersonal skills;
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline.

Key Staff 2 Title: HIV Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, and provide technical expertise on HIV, particularly as it applies to SBCC and social marketing activities

Qualifications:

- Minimum of 10 years of experience in public health, with technical knowledge and experience of HIV.
- Strong background in HIV prevention, with a focus on looking at topics and targets for SBCC and social marketing campaigns and related efforts

Number of consultants with this expertise needed: 1

Key Staff 3 Title: FP Specialist; FP/MNCH Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, and provide technical expertise on FP, particularly as it applies to SBCC and social marketing activities. **Note:** These tasks can be absorbed by other Team members who have knowledge of FP and MNCH in addition to their primary specialty.

Qualifications:

- Minimum of 10 years of experience in public health, with technical knowledge and experience of FP.
- Strong background in FP, particularly commodities and services available in Tanzania, with a focus on looking at topics and targets for SBCC and social marketing campaigns and related efforts

Number of consultants with this expertise needed: 1

Key Staff 4 Title: Evaluation Coordinator

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance in the field on issues related to evaluation implementation, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. She will oversee the training of data collectors, insuring highest level of reliability and validity of data being collected. She is responsible for all data analysis and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. She will participate in all aspects of the evaluation, from planning, data collection, and data analysis to report writing.

Qualifications:

- At least 5 years of experience in USAID M&E procedures, project and implementation management
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools

- Experience in design and implementation of evaluations

Number of consultants with this expertise needed: 1

Key Staff 5 Title: Organizational Development Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate organizational capacity among target NGOs and other organizations who are partners and/or collaborators in SBCC and social marketing.

Qualifications:

- Background and at least 5 years' experience in organizational capacity development/strengthening.
- Knowledgeable in capacity building assessment and evaluation methodologies
- Experience working in organizational capacity development/strengthening with local NGOs working in the health field

Number of consultants with this expertise needed: 1

Key Staff 6 Title: SBCC & Social Marketing Expert

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate SBCC and social marketing activities, specifically for behavior change, social norms transformation, community outreach, and demand creation.

Qualifications:

- At least 5 years of experience working in the field on SBCC and social marketing programs.
- Experience should include mass media, community-based interventions, social/cultural norms transformations (i.e., gender norms transformation), demand creation for products and services, and other SBCC and social marketing related topics
- A degree in public health or related field
- Experience and knowledgeable on evaluation methodologies related to SBCC and social marketing.

Number of consultants with this expertise needed: 1

Key Staff 7: Title: Malaria Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate Malaria activities.

Qualifications:

- At least 5 years of experience working in the field on Malaria-focused programs.
- A degree in public health or related field
- Experience and knowledgeable on evaluation methodologies related to malaria.

Number of consultants with this expertise needed: 1

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

- 3 Research Assistants (local) will be hired to assist with qualitative and quantitative data collection, data entry, data analyses, and transcription of qualitative data. All Research Assistants will be under the supervision of the Team Leader and Evaluation Specialist.
- 1 Logistics/Program Assistant (local) will be hired to assist the team with arrangements for transportation, lodging, venues (as needed), setting appointments, and other assistance as needed. As this is a large and complex evaluation, this position is deemed essential for the conduct of an effective evaluation in Tanzania.
- Data Analysis Consultant will provide consultation to the Evaluation Coordinator and Team Lead on issues related to data analysis, including statistical tests/analyses.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

Yes – If yes, specify who:

No

Staffing Level of Effort (LOE) Matrix Instructions:

This LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- Immediately below each staff title enter the anticipated number of people for each titled position.
- Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
- Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in **days** for each Evaluation/Analytic Team member

Activity / Deliverable	Evaluation/Analytic Team							
	Team Lead / HIV Specialist	Malaria Specialist	OD Specialist	SBCC / Social Mktg Specialist	Evaluation Coordinator	Analytic Consultant	Data Collectors	Logistics/ Data Collector
Number of persons →	1	1	1	1	1	1	2	1
Launch Briefing	.5							
Desk review & Data Synthesis	5	5	5	5	5			
Preparation for Team convening in-country								2
Travel to country	2		1	1	.5			
Team Planning Meeting	3	3	3	3	3	3 (if available)	1	2
In-brief with Mission	1	1	1	1	1			1
Training data collectors	2	2	2	2	2		2	2
Prep / Logistics for Site Visits								3
Data collection / Site Visits	24	24	24	24	24		24	24
Data analysis	4	4	4	4	4	4	2	2
Debrief with Mission including Prep	1.5	1.5	1.5	1.5	1.5			.5
Findings Workshop with Stakeholders including prep	1.5	1.5	1.5	1.5	1.5			.5
Depart country	2		1	1	.5			
Draft report(s)	13	8	8	8	10			
GH Pro Report QC Review & Formatting								
Submission of draft report(s) to Mission								
USAID Report Review								
Revise report(s) per USAID comments	4	.5	.5	.5	2			
Finalization and submission of report(s)								
508 Compliance Review								
Upload Eval Report(s) to the DEC								
Sub-Total LOE	63.5	50.5	52.5	52.5	55	7	29	37
Total LOE	63.5	50.5	52.5	52.5	55		58	37

If overseas, is a 6-day workweek permitted Yes No

Travel anticipated: List international and local travel anticipated by what team members.

- Team Lead: travel from US
- OD Specialist: travel from country within sub-Saharan Africa (regional travel)

- The entire team will travel to TCCP and TSMP project sites in Mara, Mbeya, Mwanza, and Sinyanga within Tanzania

XIV. LOGISTICS

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

- USAID Facility Access
Specify who will require Facility Access:
- Electronic County Clearance (ECC) (International travelers only)
- GH Pro workspace
Specify who will require workspace at GH Pro:
- Travel -other than posting (specify): GH Pro Eval Team will need to arrange own transportation to project sites
- Other (specify):

XV. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, work plan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for Internal Distribution.

XVI. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities
<p>USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</p> <p>Before Field Work</p> <ul style="list-style-type: none"> • <u>SOW</u>. <ul style="list-style-type: none"> ○ Develop SOW. ○ Peer Review SOW ○ Respond to queries about the SOW and/or the assignment at large. • <u>Consultant Conflict of Interest (COI)</u>. To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates. • <u>Documents</u>. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment. • <u>Local Consultants</u>. Assist with identification of potential local consultants, including contact information. • <u>Site Visit Preparations</u>. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs. • <u>Lodgings and Travel</u>. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVII. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See How-To Note: Preparing Evaluation Reports)

USAID/Tanzania requests an evaluation report for TCCP and one for TSMP. Based on discussions with the Mission, it may be possible to do a Program report that covers both projects, and that highlights specific background and findings specific to each project, TCCP and TSMP. The final format of this report will be discussed and finalized during the Team Planning Meeting, in consultation with USAID/Tanzania.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.

The preliminary findings from the evaluation will be presented in a draft report at a full briefing with USAID/Tanzania and possibly at a follow-up meeting with key stakeholders. The format for the evaluation report is as follows:

- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 4 pages);
- Table of Contents (1 page);
- List of Acronyms
- Introduction: purpose, audience, and synopsis of task (1 page);
- Background: brief overview of BCC/social marketing program in Tanzania, USAID strategies and priorities, brief description of the program(s) purpose of the evaluation (2-3 pages);
- Methodology: describe evaluation design and data collection methods, including constraints and gaps (1 page);
- Findings/Conclusions/Recommendations: for each objective area (15-20 pages);
- Issues: provide a list of key technical and/or administrative issues identified (1-2 pages);
- Future Directions/Recommendations based on un gaps or innovation model to be scaled up (2-3 pages);
- References (including bibliographical documentation, meetings, interviews and focus group discussions);
- Annexes, which should include:
 - The Evaluation Scope of Work
 - Any "statements of differences" regarding significant unresolved difference of opinion by funders, implementers, and/or members of the evaluation team
 - Evaluation methods and all tools used in conducting the evaluation, such as questionnaires, checklists, survey instruments, and discussion guides
 - Sources of information, properly identified and listed
 - Disclosure of conflicts of interest forms for all evaluation team members, either attesting to a lack of conflict of interest or describing existing conflict of interest.

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

 All data instruments, data sets, if appropriate, presentations, meeting notes and report for this evaluation will be presented to USAID electronically to the Evaluation Program Manager. All data will be in an unlocked, editable format.

XVIII. USAID CONTACT PERSON

	Primary Contact (TCCP)	Primary Contact (TSMP)	Alternate Contact
Name:	Naomi Kaspar	Upendo Kategile	Moses Busiga
Title:	TCCP & TSMP Program		Monitoring and Evaluation Specialist
USAID Office/Mission	Health Office, USAID/Tanzania Plot 686 Old Bagamoyo Road, Msasani P.O. Box 9130 Dar es Salaam, Tanzania	Health Office, USAID/Tanzania Plot 686 Old Bagamoyo Road, Msasani P.O. Box 9130 Dar es Salaam, Tanzania	Health Office, USAID/Tanzania Plot 686 Old Bagamoyo Road, Msasani P.O. Box 9130 Dar es Salaam, Tanzania
Email:	nkaspar@usaid.gov	ukategile@usaid.gov	mbusiga@id.gov
Telephone:	+255 22 2294490 Ext. 4568		+255 22 2294490 Ext. 4595
Cell Phone (optional)	+255 755 766600		+255-659 269 188 / 0764 269 188

List other contacts [OPTIONAL]

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XIX. REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

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XX. Evaluation Design Matrix

Complete the following matrix to displays the methods by question they are designed to answer. Often more than one method can be employed in an analytic activity to obtain evidence to address more than one question. A method should be listed by question when it will include specific inquiries and/or result in evidence needed to address this specific question.

TCCP

Evaluation Questions	Illustrative indicators or other assessment criteria	Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis Method
I. To what extent have TCCP's SBCC campaigns and programs achieved behavior change among priority audiences?	Knowledge, attitudes and reported access to information & services for: <ul style="list-style-type: none"> • FP • PMTCT • Malaria 	Community FGDs.	<ul style="list-style-type: none"> • Women and men of reproductive age • Women and men with children under age 5 in the household 	Thematic Analysis
	Knowledge, attitudes and reported access to information & services for: <ul style="list-style-type: none"> • FP • PMTCT • Malaria 	Omnibus survey data	Specified locations &/or target groups.	<ul style="list-style-type: none"> • Review existing survey reports • 2° data analysis as needed

Evaluation Questions	Illustrative indicators or other assessment criteria	Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis Method
	Use of specified services: <ul style="list-style-type: none"> • FP • PMTCT • HTC • Malaria testing (<5 yrs old) • VMMC 	MTUHA or other service data	Compare use of target services in district with strong TCCP inputs to matched (similar) districts with no or minimal TCCP inputs	Descriptive statistics
2. What programmatic lessons may be drawn from TCCP's experience in designing and implementing large-scale SBCC campaigns in collaboration with Government of Tanzania, U.S. Government, and NGO stakeholders?	Best practices in SBCC program implementation	Document Review: Annual reports, baseline to midterm assessments (changes), Omnibus survey reports, campaign evaluation reports, etc.		Review
		KIIs	Individuals engaged in implementing campaigns, esp from Government of Tanzania, NGOs & other U.S. Government IPs	Thematic Analysis
		FGDs with partners, counterparts and stakeholders	ACE mentors, fellow & interns; LSHC trainers alumni & campaign team members; DHMTs; and community members (target audience(s))	Thematic Analysis
		Case Study	Cases (location &/or campaign) that reported 1) good results, and 2) limited results	Qualitative: Compare high & low results cases
3. To what extent, and in what manner, have TCCP's capacity strengthening interventions improved the ability of Tanzanian individuals and institutions to design, implement, and evaluate high-quality SBCC?	Institutional capacity development for implementing SBCC projects	KII and/or FGD	Individual from organizations TCCP worked with	Thematic Analysis
		Self-Assessment Survey	Individuals from local NGOs engaged in SBCC with TCCP	Descriptive statistics
		OCAT (C-Change OCAT or any preferred OCAT adapted)	Individuals from local NGOs engaged in SBCC with TCCP	OCAT analysis (score)
4. What capacity strengthening approaches appear to most directly influence the quality of in-country SBCC design,	Best capacity strengthening practices in SBCC program implementation	Document Review: Annual reports, baseline to midterm assessments (changes), Omnibus survey reports, campaign evaluation reports, etc.		Review

Evaluation Questions	Illustrative indicators or other assessment criteria	Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis Method
production, and implementation?		Kilis	Individuals engaged in implementing campaigns, esp from Government of Tanzania, NGOs & other U.S. Government IPs	Thematic Analysis
		FGDs with partners, counterparts and stakeholders	ACE mentors, fellow & interns; LSHC trainers alumni & campaign team members; DHMTs; and community members (target audience(s))	Thematic Analysis
		OCAT (C-Change OCAT or any preferred OCAT adapted)	Individuals from local NGOs engaged in SBCC with TCCP	OCAT analysis (score)
5. To what extent can't the Government of Tanzania and local NGOs independently design and monitor health communication activities?	Lessons learned, obstacles and limitations in program implementation and capacity for SBCC activities by Government of Tanzania and local NGOs	Document Review: Annual reports, baseline to midterm assessments (changes), Omnibus survey reports, campaign evaluation reports, etc.		Review
		Kilis	Individuals engaged in implementing campaigns, esp from Government of Tanzania, NGOs & other U.S. Government IPs	Thematic Analysis
		FGDs with partners, counterparts and stakeholders	ACE mentors, fellow & interns; LSHC trainers alumni & campaign team members; DHMTs; and community members (target audience(s))	Thematic Analysis
		OCAT (C-Change OCAT or any preferred OCAT adapted)	Individuals from local NGOs engaged in SBCC with TCCP	OCAT analysis (score)
		Case Study	Cases (location &/or campaign) that reported 1) good results, and 2) limited results	Qualitative: Compare high & low results cases

ANNEX II. EVALUATION METHODS AND LIMITATIONS

EVALUATION DESIGN AND METHODOLOGY

This is a retrospective performance evaluation to assess the achievements and lessons learned from TCCP. Based on the specific evaluation purpose and questions, the evaluation is a mixed-methods design with an emphasis on qualitative methods.

Specific methods included:

- Document review: Implementing partner work plan, quarterly and annual reports, project materials and artifacts, special studies and internal evaluations, and other materials. National health statistics and reports, government strategies and plans.
- Secondary analysis of existing data: Implementing partner surveys (TCCP midline and Omnibus surveys, OCAT baselines and follow-up), indicators from partner performance management plans, and sales data from TSMP distributors. The team will conduct a literature review to identify relevant studies and surveys of relevant knowledge, attitudes and behavior that can serve as a comparison point, as the most recent national surveys were completed in 2010 (DHS) and 2011/2012 (THMIS).
- Key informant interviews will be conducted with stakeholders. When a key informant can provide information and insights on both projects, their interview will cover topics of both projects.
- Focus group discussions will generally be comprised of individuals and organizations that have been targets for capacity building and who have served as partners in the various campaigns. These will include beauty salon managers, health care workers, community resource persons and Accredited Drug Dispensing Outlets (ADDO) representatives. As the evaluation is focused on answering questions about intervention design and performance—as opposed to impact—the focus groups will not include direct beneficiaries who are targets of the behavior change and social marketing. Instead, the community-based representatives will provide a broader view about activity implementation and experiences across community members.

Tools

The full list of data collection tools and their intended purposes is presented below. Draft tools are presented in an annex of this report.

#	Title	Participants	Tool	Type	Purpose
1	Stakeholders (government, implementing partners)	a. National: MOHSW programs, including NACP, NMCP, TACAIDS, RCH, Health Promotion; b. Regional: RMO, RHMT, RAC, RCHCo, VMMC and RCH health care workers; c. District: CHMT, DAC, DRCHCo,	I-TCCP-TSMP-Gov and IPs-KII	Key informant interview	Key stakeholder perceptions on the projects' accomplishments and contributions. How the projects have worked in their region/district/ community, and how the projects fit into their overall health and development objectives.

#	Title	Participants	Tool	Type	Purpose
		TRCHCo, malaria focal person; d. U.S. Government implementing partners in Dar es Salaam and in regions			
2	Capacity-building organizations reached by the project	Capacity-building recipients— organizations a. National (PHCI) b. Regional and District: RHMTs and CHMTs c. NGOs	2-TCCP-TSMP-Capacity building organizations-KII	Key informant interview	Perceptions of the organizations that received capacity building on whether their institution is stronger and more independent as a result of TCCP/TSMP efforts. Understanding improvements in technical skills, management, and operations.
3	Capacity building— individual beneficiaries	Capacity building recipient—individuals a. LSHC alumni b. ACE mentors, interns, fellows	3-TCCP-TSMP-Capacity building individual-KII	Key informant interview	Perceptions of individuals that received capacity building on whether their individual skills have improved. Understanding improvements in designing, implementing, monitoring and evaluating behavior change/social marketing campaigns.
4	Health care workers in RCH settings	RCH health workers at regional, district and community health facilities	4-TCCP-TSMP-Health care workers MCH-KII	Key informant interview	Health providers' perspective on client knowledge, attitudes and practices related to specific FP, MCH, HIV and malaria behaviors and social marketing practices. Impressions of campaigns and products.
5	Health care workers in VMMC services	VMMC nurses, other health staff who conduct VMMC at regional, district and community health facilities	5-TCCP-TSMP-Health care workers VMMC-KII	Key informant interview	Health providers' perspective on client knowledge, attitudes and practices related to VMMC. Impressions of campaigns.
6	Community workers and resource persons working with direct beneficiaries	Community resource persons	6-TCCP-Outreach participants-FGD	Focus group discussion	Outreach workers' perspective on community response to campaigns and products. Insight into their role in advancing healthy behaviors and products, and how well the interventions worked
7	TCCP Project Staff	TCCP project staff	7-TCCP-KII	Key informant interview	In-depth detail on project activities. Staff perspectives on the

#	Title	Participants	Tool	Type	Purpose
					notable accomplishments, challenges and recommendations.
8	Groups of those reached by capacity building under TCCP (ACE and LSHC)	ACE mentors, fellows and interns	8-TCCP-ACE and LSHC-FGD	Focus group discussion	Perceptions of individuals that received capacity building on whether their individual skills have improved. Understanding improvements in designing, implementing, monitoring and evaluating behavior change/social marketing campaigns.
9	Radio distance learning participants	Radio distance learning outreach workers	9-TCCP-Radio distance learning-FGD	Focus group discussion	Detail on how the radio distance learning approach worked. How outreach workers used the information, how this approach compares to other training programs.

Sampling methods

USAID/Tanzania has identified four regions for field work (Dar es Salaam, Iringa, Njombe and Mwanza) based on the following criteria: presence of both projects and multiple activity areas (HIV, FP, MCH and malaria), mission priority areas, appropriate mix of settings and target populations, and travel and time considerations. In Dar es Salaam, the team will meet with national representatives, implementing partner headquarters staff, other U.S. Government implementing partners and other stakeholders. The team will also conduct focus group discussions.

Based on the activities that the projects have implemented, the team will use expert case sampling to identify key policy/programming experts who can provide rich insights that can shape overall conclusions and recommendations. TCCP and TSMP will provide a matrix of contacts in government, non-government/civil society and the private sector with whom they have interacted in the districts for field work. The evaluation team will purposefully sample from this list based on the evaluation questions and time considerations. If possible, the evaluation team will use respondent-driven “snowball” sampling to identify additional respondents who can provide critical information to the evaluation but who would not have been identified by the mission and project partners.

Strengths and limitations of evaluation design

The strengths of the evaluation design include a mixed-method approach that explores both projects and how they relate to each other. The evaluation also includes a theory-based examination of the two projects’ theories of change in order to assess how what was expected during design compares to what happened in implementation. In addition, the projects appear to have strong M&E systems that have generated a large amount of data that can be used as one source, though they must be triangulated with other sources of information for a full analysis.

Limitations include the lack of recent nationally representative data on key health behaviors and attitudes, which restricts analyses on the potential effect or contribution of the individual projects. An additional limitation is that access may be limited by availability of key personnel during the evaluation period. When appropriate, the team will attempt to follow up with key respondents by phone or email if

necessary. Due to finite resources, sampling bias may arise, because only four regions in Tanzania have been purposefully selected for team field work where the activities are implemented. Moreover, the team will spend a short amount of time in each district for field work, restricting its ability to conduct more KIs and FGDs. There may also be potential bias in using the recommended individuals and groups from the partners. However, the team has attempted to control for this bias by receiving the full list of relevant individuals from the partners and sampling from within that group.

While the TCCP evaluation was never intended to be an impact evaluation, it is worth noting that there is a growing interest and need for impact evaluations of health communication interventions for HIV prevention and other health areas. Evaluation question #1 borders on being an impact question, which the team addressed through review of internal evaluations and the other methods described and by way of evaluating the project's objective, to "execute evidence-based, coordinated social and behavior change communication initiatives at scale." However, there is a foundation for recommending that the next project consider building in a more robust evaluation design. Short of a randomized trial, which is likely not to be feasible for a multitude of reasons, there are articles referenced in Annex 4 that describe possible alternatives, including types of quasi-experimental studies.

Data analysis plan

Existing sources of information

For an understanding of the baseline and early implementation phase of TCCP and TSMP, the Demographic and Health Survey (2010) and HIV/AIDS Malaria Indicator Survey (2011-2012) are available for population-level data about disease burden, behaviors, knowledge and attitudes.

For TCCP: The main sources of quantitative data for TCCP are the partner surveys (baseline and midline) and reports (quarterly and annual). TCCP has also conducted evaluations on specific campaigns, including Wazazi Safe Motherhood. Omnibus surveys are available on an approximately quarterly basis to gauge coverage and response to the campaigns. TCCP has quantitative and qualitative reports for organizational capacity assessments for seven organizations targeted for capacity building, and three of these organizations completed. A wealth of narrative information is available through the partner reports and TCCP midterm assessment conducted by USAID.

For TSMP: The main sources of quantitative data for TSMP are the Total Market Analysis Report and Measuring Access and Performance (MAP) surveys, which outline the number and availability of socially marketed products. Data from the Tracking Results Continuously (TraC) survey monitors target group awareness, message recall levels and behaviors. Quantitative data are also available through sales records and other indicators as outlined in the TSMP quarterly and annual reports. Additional narrative information is available through partner reports (quarterly and annual) and special studies on the specific products.

Quantitative data collection and analyses

Both

- Likert scale ratings: A limited number of statements gauging the activities' progress in key areas will be embedded in key informant interviews. The scale will provide ratings data as well as serve as a basis for discussion.
- Consider: Health information system statistics in campaign and focus regions (HIV, MNCH, FP/RH): Trends in a select number of service delivery indicators 2010-2014, that can potentially be included:
 - number of women receiving FP counseling
 - number of malaria cases treated with ACTs
 - number of pregnant women who receive two doses of IPT

- number of pregnant women who receive antiretrovirals for PMTCT
- number of male circumcisions performed, and
- number of ANC visits.
- Literature review to identify any more recent population-based surveys that would serve as context for health knowledge, attitudes and practices, likely in a specific zone or region.
- Cross activity analysis: The team will identify opportunities for quantitative analysis across activities, as appropriate.

TCCP

- Campaign exposure, message recall and health behaviors (by campaign), including analysis by target populations of interest (urban/rural, youth). Summary of Omnibus survey responses.
- OCAT scores for local organizations (comparison available for three)

TSMP

- Distribution, sale, and market share of TSMP marketed products (2010-2014)
 - Dume and Salama condoms, Lady Pepeta and Care female condoms
 - WaterGuard liquid and tablets
 - Flexi-P and Familia oral contraceptives
 - RDTs (2012-2014)

Qualitative data collection and analyses

The team will use semi-structured KII and FGD questionnaires. Interviews and discussion guides will be developed in English and translated to Swahili. The majority of the interviews and focus groups will be conducted in Swahili, though some will be in English, such as interviews with implementing partners and the national government officials.

Note taking: Researchers will generally be in teams of two for interviews and focus groups, with one taking the lead in asking questions and the other taking the lead for note taking. Following each interview or focus group, the researchers will complete the notes sheet that outlines answers by question. They will also highlight three main/most important points at the end of the note. The notes will be entered into Ethnograph software in English and coded according to the themes of interest.

Themes for analysis: An initial list of themes for analysis will be used as a basis for qualitative analysis, and the evaluation team will add emergent concepts throughout the course of data collection. Regularly during the data collection and analysis process, the team will review, refine and update the code list across team members. The team will conduct inter-coder reliability checks to ensure standard use of the codes. Once the qualitative data has been collected and coded, the team will use grounded theory to group coded quotations together, identify prevalent ideas as well as outliers, and develop summary findings. The team will also identify opportunities to analyze descriptive statistics, such as counts for key words and phrases and co-occurrence of certain codes of interest.

ANNEX III. PERSONS INTERVIEWED

Dar es Salaam		
Name	Title	Affiliation
Donan W. Mmbando	Permanent Secretary	MOHSW
Fatma Mrisho	Executive Chairperson	TACAIDS
Elizabeth Mapela	Coordinator, Adolescent Reproductive Health	MOHSW
Helen Semu	Assistant Director, Health Promotion and Education Section,	Directorate of Preventive Services, MOHSW
Linda Nakarra	Head of BCC	National Malaria Control Program
Karen Kramer	Head of Net Cell Program	National Malaria Control Program
Edda Katakiro	Head, Information, Education and Communication	National AIDS Control Program
Pelargia Mchuruza	Program Manager, PMTCT	MOHSW
Sweetbert Kamazima	Head of Department Behavioral Sciences	Department of Behavioral Sciences, Muhimbili School of Public Health
Haule Mtasingwa	M&E specialist	CDC Foundation
Eric van Pragg	Senior Technical Advisor	FHI360
Hally Mahler	Director of HIV Programs, Senior Regional Technical Advisor	Jhpiego
Dunstan Bishanga	Chief of Party-MCSP	Jhpiego
Mr. Hemedi Shoko	BCC Officer	National AIDS Control Program
Anitah MuruveAigi	Project Manager	Aga Khan Health Services
Joyce Ishengoma	Senior Technical Advisor for Integration and Health Systems Strengthening	EngenderHealth
Minou Fugelsang	Executive Director	Femina Hip
Lynn O'Rourke	Senior Media Advisor	Femina Hip
Mbonimpa Buyelwe	Regional Manager, Kigoma	TCDC
Ibrahim Salum	Regional Manager, Geita	TCDC
Steven Tibaigana	Regional Manager, Mtwara	TCDC
Assely Mwamaka	Regional Manager, Ruvuma	TCDC
Robi Wambura	Regional Manager, Kagera	TCDC
Mrs. E. Mkwizu	Regional RCHco	RHMT-Dar
Elizabeth Nyema	DACC	CHMT-Kinondoni
Edith Mboga	DRCHco	CHMT-Kinondoni
Patrick Lyaruu	DACC	CHMT-Temeke
Catherine Mbeyela	DRCHco	CHMT-Temeke
Dr. Kawawa	RACC	RHMT-Dar
Bob Karam	Chief of Party	TCCP
Waziri Nyoni	Director of Programs	TCDC
Jennifer Orkis	Technical Advisor for SBCC	TCCP
	ACE fellows	TCCP
	ACE Interns	TCCP
	LSHC Alumni	TCCP
Sada Mwintumu	RDL	TCCP
Isihaka Kalikawe	RDL	TCCP
Rose Tesha	RDL	TCCP
Emmanuel Hoza	RDL	TCCP
Sophia Kassim	RDL	TCCP
Peter Kizonga	RDL	TCCP
Selemani Justice	RDL	TCCP

Salehe Mohamed	RDL	TCCP
Iringa		
Name	Title	Affiliation
Mariam Mohamad	RCHCo and Acting RMO	RHMT-Iringa
Elina Malilla	Head, RCH	RHMT-Iringa
Olipa Madeha	Health care worker, RCH	RHMT-Iringa
Ritha Tesha	Health care worker, RCH clinic	RHMT-Iringa
Godfrey Richard,	Regional Coordinator, in charge of training-Iringa	TCCP
Kaiza	VMMC community mobilization	Jhpiego
Kapwani Mbunda	Counselor VMMC	RHMT-Iringa
Michale Mbishira	VMMC site manager	CHMT-Kilolo
Michael John	DMO	CHMT-Kilolo
Haji Shemhulu	Director	Primary Health Care Institute
Muhsin IDD	Tutor, IT	Primary Health Care Institute
Neema Mganga	Student	Primary Health Care Institute
Leonard Kadeit	Tutor	Primary Health Care Institute
Yosedha Swai	Administrator	Primary Health Care Institute
Mbwana Kiwera	ACE intern	
Matha Ndassa	ACE intern	
James Kiwera	ACE Fellow	
Amne Hamid	ACE Fellow	
Innocent Muhagama	DMO	CHMT-Mufindi
Moses Tawete	DRCHco	CHMT-Mufindi
David Mdaki	VMMC-Site Manager	CHMT-Mufindi
Ole Mkopi	DACC	CHMT-Mufindi
Njombe		
Name	Title	Affiliation
Samuel Mugema	Regional Medical Officer	RHMT-Njombe
Emmy Mbeyela	Health care worker, VMMC	RHMT-Njombe
Norice Mgaya	In-charge, RCH clinic	RHMT-Njombe
Felician Maligo	RCHCo Njombe	RHMT-Njombe
Patrick Msigwa	Acting DMO	CHMT-Njombe
Uria Mtwewe	Acting DACC	CHMT-Njombe
Emmy Mbeyela	VMMC-Site Manager	Njombe Hospital
Norrice Mgaya	RCH In-charge	Njombe Hospital
Magreth Msasi	DACC	CHMT-Makambako
Veronica Mgodha	Reproductive and Child Health Coordinator	Makambako Town Council
Elifrida Kombo	In-charge, Reproductive and Child Health	Makambako Town Council
Octavia Mnzava	Project Coordinator	COCODA
Daimon Kimwaga	Project Accountant	COCODA
Asante Mgeni	M&E Officer	COCODA
Isaya Mhagama	Program Accountant	COCODA
Abigaael Chilambo	M&E PT Project	COCODA
Martha Yotham	Project Coordinator, Tunajale II	COCODA
Jonathan Martin	ACE Fellow	COCODA

Mwanza		
Name	Title	Affiliation
Bahati Musaki	Acting Regional Medical Officer	RHMT-Mwanza
Esperance Makuza	Assistant RCH Coordinator	RHMT-Mwanza
Nicole Kapesi	Capacity Building Program Officer	TCCP
	ACE Fellows	TCCP
Khadija Said	ADDO	PSI
Bertha Noel	ADDO	PSI
Joyce Wamugisha	ADDO	PSI
Naomi Joseph	ADDO	PSI
Joyce Kaganda	ADDO	PSI
Hosea Njomla	ADDO	PSI
Nuru Hassan	Production manager	Afya Radio
Alex Chandika	VMMC coordinator	Bugando Medical Centre
Manase Nassania	Program manager	EngenderHealth
Cecillia Mrema	RCHco	RHMT-Mwanza
Godfrey Balyagati	District AIDS Coordinator	Ilemela District, Mwanza
HoloMuyanga	RCH In-charge	Ilemela District, Mwanza
Isabela Minga	District AIDS Coordinator	Nyamagana District, Mwanza
Emmanuel Justine	District AIDS Coordinator	Misungwi District, Mwanza
Joseph Budodi	RDL	TCCP
Alphonicina Alphonce	RDL	TCCP
Kizua Charles	RDL	TCCP
Veronica Joseph	RDL	TCCP
Edelina Leo	RDL	TCCP
Mebi Kazengo	RDL	TCCP
Sevanko Fimbo	RDL	TCCP
Winifridah Bwesigwa	RCH In-charge	Nyamagana
Laurent Ntenganija	CRPs	TCCP
John Josephat	CRPs	TCCP
Fortunata Mkwande	CRPs	TCCP
Salome Paulo	CRPs	TCCP
Anna Eliutha	CRPs	TCCP
Pili Legu	CRPs	TCCP
Selemani Y. Budeba	CRPs	TCCP
Johnmary Kaganda	CRPs	TCCP
Isale Msalaba	CRPs	TCCP

ANNEX IV. SOURCES OF INFORMATION

Background Documents

National Bureau of Statistics (Tanzania) and ICF Macro. 2011. Tanzania Demographic and Health Survey 2010. Dar es Salaam, Tanzania: NBS and ICF Macro.

Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International. 2013. Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and ICF International.

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Understandings and Interpretations of Communication Campaign Messages about Concurrent Partnerships, Acute HIV Infection and Sexual Networks in Botswana and Tanzania. September 2013. Baltimore: USAID Project SEARCH: Research to Prevention.

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Calum Davey, MSc,* Marc Boulay, PhD,† and James R. Hargreaves, MSc, PhD* Strengthening Nonrandomized Studies of Health Communication Strategies for HIV Prevention. *J Acquir Immune Defic Syndr*. Volume 66, Supplement 3, August 15, 2014.

Alternatives to randomisation in the evaluation of public health interventions: design challenges and solutions. C P Bonell, J Hargreaves, S Cousens, D Ross, R Hayes, M Petticrew, B R Kirkwood *J Epidemiol Community Health* (2009). doi:10.1136/jech.2008.082602.

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Mass Media Health Communication Campaigns Combined with Health-Related Product Distribution A Community Guide Systematic Review. Maren N. Robinson, MPH, Kristin A. Tansil, MSW, Randy W. Elder, PhD,, et al. *Am J Prev Med* 2014;47(3):360-371).

Project Documents

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Leadership in Strategic Health Communication: Making a Difference in Health and Development, A Workshop Manual, May 2014 edition.

Tanzania Capacity and Communications Project (TCCP) Technical Proposal in response to USAID-Tanzania-10-006-RFA, June 10, 2010.

Tanzania Capacity and Communication Project (TCCP) 2011 Baseline Survey, September 2012.

TCCP Omnibus Questions, October 2013.

TCCP Performance, September 2010 – May 2016, 13 March 2015.

Midline Study Report: Midline Evaluation of the Tanzania Capacity and Communication Project (TCCP) Programs *Wazazi Nipendeni*, *Green Star*, *Tuko Wangapi*, *Siri Ya Mtungi*, and *Aiissee!* Baltimore, MD, December 2014.

TCCP and TCDC Org Chart, 2014.

Tanzania Capacity and Communication Project (TCCP) Award Number: 621-A-00-10-00032-00 Quarterly Report Q17 FY15 Q1 | October to 31 December 2014 (17 February 2015).

Tanzania Capacity and Communication Project Award Number: 621-A-00-10-00032-00 Quarterly Report Q15 FY14 Q3 | April to 30 June 2014 (22 August 2014).

Quarter 15 Annexes:

Annex A: ACE Mentoring Program Participant List

Annex B: FP Meetings

Annex C: Radio Magazine Topics

Tanzania Capacity and Communication Project (TCCP) Award Number: 621-A-00-10-00032-00 Quarterly Report Q14 FY14 Q2 | January to 31 March 2014.

Tanzania Capacity and Communication Project (TCCP) Award Number: 621-A-00-10-00032-00 Quarterly Report Q13 FY14 Q, | October to 31 December 2013 (10 February 2014).

Tanzania Capacity and Communication Project (TCCP) Quarterly Report Q4 FY11 Q4 July-September 2011 Submitted November 7, 2011.

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ANNEX V. DATA COLLECTION INSTRUMENTS

OVERVIEW

#	Tool for selected sample sub-group	Type	Purpose
Oral Consent Form			
1	Stakeholders (government, implementing partners)	Key informant interview	Key stakeholder perceptions on the projects' accomplishments and contributions. How the projects have worked in their region/district/ community, and how the projects fit into their overall health and development objectives.
2	Capacity-building organizations reached by the project	Key informant interview	Perceptions of the organizations that received capacity building on whether their institution is stronger and more independent as a result of TCCP/TSMP efforts. Understanding improvements in technical skills, management and operations.
3	Capacity building– individual beneficiaries	Key informant interview	Perceptions of individuals that received capacity building on whether their skills have improved. Understanding improvements in designing, implementing, monitoring and evaluating behavior change/social marketing campaigns.
4	Health care workers in RCH settings	Key informant interview	Health providers' perspective on client knowledge, attitudes and practices related to specific FP, MCH, HIV and malaria behaviors and social marketing practices. Impressions of campaigns and products.
5	Health care workers in VMMC services	Key informant interview	Health providers' perspective on client knowledge, attitudes and practices related to VMMC. Impressions of campaigns.
6	Community workers and resource persons working with direct beneficiaries	Focus group discussion	Outreach workers' perspective on community response to campaigns and products. Insight into their role in advancing healthy behaviors and products, and how well the interventions worked.
7	TCCP project staff	Key informant interview	In-depth detail on project activities. Staff perspectives on the notable accomplishments, challenges and recommendations.
8	Groups of those reached by capacity building under TCCP (ACE and LSHC)	Focus group discussion	Perceptions of individuals that received capacity building on whether their skills have improved. Understanding improvements in designing, implementing, monitoring and evaluating behavior change/social marketing campaigns.
9	Radio distance learning participants	Focus group discussion	Detail on how the radio distance learning approach worked. How outreach workers used the information, how this approach compares to other training programs.

Oral Informed Consent for Focus Groups

USAID/ Tanzania Johns Hopkins University Center for Communications Programs (TCCP) and the USAID/ Tanzania Social Marketing Program (TSMP)

(to be read to the group by the moderator)

Title of Study: Performance evaluation of the USAID/ Tanzania Johns Hopkins University Center for Communications Programs (TCCP) and the USAID/ Tanzania Social Marketing Program (TSMP)

Facilitator: _____

Reason for the Focus Group Discussion

The purpose of this study is to gather information on the projects and see how the two projects have performed since 2010. The results of the evaluation will also be used in planning for the new project.

Your Part in the Focus Group Discussion

insert number of women/men/couples _____ will take part in this focus group discussion [*specify location of this site* _____]

Your participation is voluntary and there is no penalty for refusing to take part. You may choose not to answer questions that you do not want to answer.

The discussion will take about 1 hour, 30 minutes

With your consent, I would like to tape-record this interview so that I may better capture the details of what you will say and to help us create a report. If you wish, you are free to withdraw from the study at any time.

There are no risks of participating in this study or direct benefits to you. However, the information we get from you will help us to inform USAID and implementing partners on the future programming of the projects. Your participation will be kept confidential. Your name will not be written on this form, and it will be impossible to trace your responses back to you. There is no monetary compensation for participating in this focus group.

If you have questions, you are free to ask them now. If you have question later, you may contact me or at the number provided.

Contact Tel #

Consent Form to Be Signed by Moderator

1. Read and review the Oral Informed Consent Process for Focus Groups with each participant in a private setting.
2. Ask the following: “Are you willing to be in a focus group to talk about:
_____?”
3. Read the Oral Informed Consent Process for Focus Groups to the group before the first session begins. Whenever possible, this reading before the group should be (voice) tape-recorded.

I have reviewed the consent form with the focus group participants, and they have fully agreed to be in this focus group. I further agree to keep confidential anything that is said in the discussion group.

Moderator’s name (print clearly)

Signature of Moderator

Date

Oral Informed Consent for Surveys/Interviews

USAID/ Tanzania Johns Hopkins University Center for Communications Programs (TCCP) and the USAID/ Tanzania Social Marketing Program (TSMP)

Title of study: Performance evaluation of the USAID/ Tanzania Johns Hopkins University Center for Communications Programs (TCCP) and the USAID/ Tanzania Social Marketing Program (TSMP)

The purpose of this study is to gather information on the projects and see how the two projects have performed since 2010. The results of the evaluation will also be used in planning for the new project.

Your participation is voluntary and there is no penalty for refusing to take part. You may choose not to answer questions that you do not want to answer.

With your consent, I would like to tape-record this interview so that we may better capture the details of what you will say and to help us create a report. If you wish, you are free to withdraw from the study at any time.

There are no risks of participating in this study or direct benefits to you. However, the information we get from you will help us to inform USAID and implementing partners for future programming of the projects. Your participation will be kept confidential. Your name will not be written on this form, and it will be impossible to trace your responses back to you.

If you have questions, you are free to ask them now. If you have question later, you may contact me or at the number provided.

Contact Tel #

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this study have been explained to the volunteer.

Signature of Person Obtaining Consent / Date

Tool I

Structured Key Informant Interview Guide For Interviews with Government, Region, District Stakeholders and USAID Implementing Partners

Name
Title
Organization
Place/District/Region
Date
Interviewer

INTRODUCTION

Good morning/afternoon, I am [] and I am part of a team that has been tasked by USAID in Tanzania to evaluate the performance of two USAID-funded projects. We appreciate your time. I want to start by telling you a little about the two projects we are evaluating. USAID in Tanzania has funded Johns Hopkins University Center for Communications Programs to implement a project the Tanzania Capacity and Communication Project, or TCCP, and Population Services International or PSI to implement a project called Tanzania Social Marketing Program (TSMP). These projects have clear objectives and have been working in Tanzania since 2010.

TCCP's objectives are to increase the adoption of safer health behaviors by Tanzanians to prevent HIV infection, support the uptake of family planning and address MNCH and other health issues. TCCP was also asked to increase the capacity of Tanzanian individuals and institutions to implement strategic behavior change communication programs, and to coordinate social and behavior change communication at national, regional and district levels.

PSI's objectives are to improve the health status of Tanzanian families by increasing the use of selected health products, including condoms and oral contraceptives. They were also asked to build the capacity of civil, public and private bodies to sustain social marketing activities in Tanzania.

USAID will soon be planning new projects to take over the work of these two projects, so our evaluation of their performance and recommendations will be referred to in planning the new project. USAID is interested in what would be the most effective way to use those projects to have an impact on health in Tanzania in the areas of HIV, maternal neonatal and child health, family planning and sexual and reproductive health, and malaria.

We understand that you have interacted these projects in some way.

To begin, please let me know your specific role here atand how long you have been in this role.

How long have you been aware of the work of

TSMP _____

TCCP _____

How much have you worked with each of these projects?

TSMP - Weekly__ Monthly__ Quarterly__ Annually_____

Add specific working groups or committees

TCCP - Weekly___ Monthly__ Quarterly___ Annually_____

Add specific working groups or committees

For each of the projects, I would like to ask you a few general questions followed by more specific questions regarding their work in the areas of behavior change for TCCP and social marketing, for TSMP as well as capacity building and coordination for each.

1. In general, please describe what you know about the work of

TCCP:

TSMP:

2. I am going to describe what TCCP covered in several health areas.

In HIV, TCCP covered prevention of sexual transmission. It developed messages about behavior such as

- limit partners
- use condoms
- get circumcised (for men)

In prevention of mother-to-child transmission, it provided messages about the fact that women should

- attend ANC
- get HIV testing
- take medicines

Please tell me about TCCP's work in HIV.

In family planning/reproductive health, TCCP covered

- healthy spacing of children
- trust and confidence in using family planning methods
- using quality service sites (Green Star)
- partner communication

Please tell me about TCCP's work in FP.

In maternal and child health, it developed messages about

- early attendance at antenatal care clinic
- preparing a birth plan and delivering at a health facility
- exclusive breastfeeding and child nutrition
- immunization

Please tell me about TCCP's work in MCH.

In malaria, TCCP developed messages about

- net use
- treatment seeking and testing
- IPT for pregnant women

Please tell me about TCCP's work in malaria.

3. Of all of the ways in which TCCP communicated information about these health areas, which do you think was the most and least effective?

- TV spots
- TV series/dramas
- Brochures
- Posters
- Radio spots
- Radio magazines
- Movies
- Community mobilization
- Social Media
- Other _____

Probe: Did any of these works better together? Were there things in the community happening other than mass media?

4. I am going to describe what TSMP did in several health areas.

In HIV, PSI covered prevention of sexual transmission

- male condoms
- female condom
- safe water products (WaterGuard)

Please tell me about PSI's work in HIV.

In family planning/reproductive health, PSI covered

- OCs

Please tell me about PSI's work in FPIRH.

5. In terms of how PSI marketed the health products needed for HIV and FP, how effective were they in each of the following areas:

- clearly making distinctions about who products are for in distribution
- clearly targeting their promotion strategies
- improving access to male and female condoms and oral contraceptives
- contributing to overall uptake of public and commercial sector products
- coverage

6. Overall, I would say that TCCP's performance in influencing the behaviors of the people it has reached has been (Circle one)

Poor Fair Neutral Good Excellent Unable to comment

Please tell me how you chose your rating:

How would you rate each of these? (use one of the above descriptions)

- HIV prevention of sexual transmission _____
- Male circumcision _____
- PMTCT _____
- Maternal child health _____
- Family planning _____

Please tell me how you chose your rating.

- 7. Overall, I would say that TSMP's performance in increasing the demand for and use of specific health products in Tanzania has been (circle one)**
Poor Fair Neutral Good Excellent Unable to comment

Please tell me how you chose your rating.

How would you rate each of these? (use one of the above descriptions)

- Male Condoms _____
- Dume _____
- Salama _____
- Lady Pepeta _____
- Care female condoms _____
- Familia oral contraceptive _____
- Flexi P oral contraceptive _____
- WaterGuard _____

Please tell me how you chose your rating.

- 8. For each of the projects, please tell me how the project could have improved its work on behavior change for TCCP and product social marketing for TSMP.**

TCCP:

TSMP/PSI:

- 9. What about their collaboration and coordination efforts with your office?**

For JHU-CCP or TCCP

For PSI or TSMP

- 10. With each other and with other partners?**

For TCCP

For TSMP

11. Capacity-building efforts

A major objective of TCCP was to build local capacity to lead and maintain communications for behavior change. **Please comment on the results of TCCP's efforts in capacity building in relation to national groups, regional groups, civil society and media.**

Probe: How well are groups able to design? Implement? Monitor and evaluate? To what extent are Tanzanian institutions prepared to lead these efforts independently, as opposed to supporting these efforts with the assistance of donors and partners?

What is needed now and in the future to sustain social and behavior change communication capacity in Tanzania?

Efforts with other local community-based and non-governmental organizations?

Efforts with national/regional government actors? Technical support to your office?

Technical support to local NGO partners and U.S. Government implementers?

I2. This is your opportunity to help USAID improve its efforts on social and behavior change communications and social marketing for health outcomes in HIV, FP, malaria and MCH in Tanzania in the future.

A. What do you see as the most important needs in Tanzania for the future in these areas?

B. How do you recommend that USAID contribute to meeting these needs through projects such as TCCP and TSMP in the future?

C. Are there opportunities for synergy with upcoming work that your office or other offices or groups in Tanzania are planning, that you want to share with USAID?

Tool 2

Structured Key Informant Interview Guide (Capacity Building Recipients–Organizations)

Name
Title
Organization
Place/District/Region
Date
Interviewer

INTRODUCTION

Good morning/afternoon, I am [] and I am part of a team that has been tasked by USAID in Tanzania to evaluate the performance of two USAID-funded projects. We appreciate your time. I want to start by telling you a little about the two projects we are evaluating. USAID in Tanzania has funded Johns Hopkins University Center for Communications Programs to implement the Tanzania Capacity and Communication Project, or TCCP, and Population Services International, or PSI, to implement a project called the Tanzania Social Marketing Program (TSMP). These projects have clear objectives and have been working in Tanzania since 2010.

TCCP's objectives are to increase the adoption of safer health behaviors by Tanzanians to prevent HIV infection, support the uptake of family planning and address MNCH and other health issues. TCCP was also asked to increase the capacity of Tanzanian individuals and institutions to implement strategic behavior change communication programs and to coordinate social and behavior change communication at national, regional and district levels.

PSI's objectives are to improve the health status of Tanzanian families by increasing the use of selected health products, including condoms and oral contraceptives. They were also asked to build the capacity of civil, public and private bodies to sustain social marketing activities in Tanzania.

USAID will soon be planning new projects to take over the work of these two projects, so our evaluation of their performance and recommendations will be referred to in planning the new project. USAID is interested in what would be the most effective way to use those projects to have an impact on health in Tanzania in the areas of HIV, maternal neonatal and child health, family planning and sexual and reproductive health, and malaria. We understand that you have interacted these projects in some way.

To begin, please let me know your specific role here atand how long you have been in this role.

How long have you been aware of the work of
TSMP _____
TCCP _____

How much have you worked with each of these projects?

TSMP - Weekly____Monthly____Quarterly____Annually_____
Add specific working groups or committees

TCCP - Weekly___Monthly__Quarterly____Annually_____

Add specific working groups or committees

For each of the projects, I would like to ask you a few general questions followed by more specific questions regarding their work in the areas of behavior change for TCCP and social marketing for TSMP, as well as capacity building and coordination for each.

1. What were the major capacity gaps that TCCP identified when they did the first capacity assessment?
2. How many of these capacity gaps did they include in your capacity improvement plan?
3. What did TCCP offer to building capacity?
4. What was the most effective method that helped the most?
5. Where do you still need capacity building?
6. What made it difficult to use what you have learned?
7. What would have made it better?
8. What are the overall recommendations for further improving capacity building in your organization?

Tool 3

Structured Key Informant Interview Guide Capacity Building Recipients–Individuals

Name
Title
Organization
Place/District/Region
Date
Interviewer

INTRODUCTION

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We understand that you have interacted these projects in some way.

To begin, please let me know your specific role here atand how long you have been in this role.

How long have you been aware of the work of

TSMP _____

TCCP _____

How much have you worked with each of these projects?

TSMP - Weekly__ Monthly__ Quarterly__ Annually_____

Add specific working groups or committees

TCCP - Weekly___Monthly___Quarterly___Annually_____

Add specific working groups or committees

For each of the projects, I would like to ask you a few general questions followed by more specific questions regarding their work in the areas of behavior change for TCCP and social marketing, for TSMP as well as capacity building and coordination for each.

- 1. What work have you previously been involved in in the area of social and behavior change communication (SBCC)**
- 2. What did you learn about SBCC from TCCP? What did you expect to learn?**
- 3. What methods were used? What methods do you think were effective?**
- 4. Since you participated in the training, what difference can you see in your performance?**
- 5. What more would you like to get from the training?**
 - *Probe on the best methods for improvement*
- 6. What challenges faced during acquisition of the SBCC competences?**

Tool 4

Structured Key Informant Interview Guide Health Care Worker's Tool for MCH Services

**Interviewee
Name
Title
Organization
Place/District/Region/Date
Interviewer**

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PSI's objectives are to improve the health status of Tanzanian families by increasing the use of selected health products, including condoms and oral contraceptives. They were also asked to build the capacity of civil, public and private bodies to sustain social marketing activities in Tanzania.

We understand that people need information, motivation and health services. We want see if the projects we are evaluating are helpful to you and your patients in preventing HIV and malaria, and doing better at family planning and malaria treatment as well as maternal and child health.

To begin, please let me know your specific role here at _____ and how long you have been in this role.

How long have you been aware of the work of PSI _____ and TCCP _____?

How much have you worked with each of these projects?

TSMP

Weekly__ Monthly__ Quarterly__ Annually_____

Add specific working groups or committees

TCCP

Weekly__ Monthly__ Quarterly__ Annually_____

Add specific working groups or committees

I. What MCH services does this facility offer?

2. What do you know about Wazazi Nipendeni, Jiamini, nyota ya kijani Tuko Wangapi, Tulizana, Siri ya Mtungi Siyo kila homa ni malaria, campaigns

Probe for: HIV testing for pregnant women, IPT (SP), malaria testing before treatment, early ANC attendance, hospital delivery, birth plan, nutrition for women during pregnancy and breastfeeding, and immunizations.

3. Which of the campaigns do you think have had the greatest influence on your clients?

4. Have any of the messages or campaigns caused problems?

5. What has been the response of your clients to the campaigns or the marketing of the products?

7. What do you your patients say about male and female condoms (Dume and Salama, and the oral contraceptives (Familia & Flex P)?

8. What do you think has changed in the knowledge, behavior and attitudes of your client in the following areas:

- Malaria testing
- HIV testing
- ART uptake for PMTCT
- Condoms uptake
- Contraceptives uptake
- Immunizations uptake

Probe: Ask if it is due these campaigns and availability of (social marketing) products.

9. What do you think helped with those things that improved or contributed to things getting worse?

10. How have the campaigns and products met the needs of your clients?

11. What would have made the campaigns and products and product promotions even better?

12. What challenges do you face in the provision of HIV testing and services, malaria testing, contraceptives, condoms, antiretrovirals, vaccines, intermittent preventive prophylaxis for pregnant women (IPT)?

13. What would be the most useful to help you in your work with your clients on HIV, malaria, MCH, FP?

- *Probe: more one to one education in the community? More TV shows to decrease stigma?*

Tool 5

Structured Key Informant Interview Guide Health Care Worker's Tool for VMMC Services

**Interviewee
Name
Title
Organization
Place/District/Region
Date
Interviewer**

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PSI's objectives are to improve the health status of Tanzanian families by increasing the use of selected health products, including condoms and oral contraceptives. They were also asked to build the capacity of civil, public and private bodies to sustain social marketing activities in Tanzania. We understand that people need information, motivation and health services. We want see if the projects we are evaluating are helpful to you and your patients in preventing HIV and malaria, and doing better at family planning and malaria treatment as well as maternal and child health.

To begin, please let me know your specific role here at _____ and how long you have been in this role.

How long have you been aware of the work of PSI _____ and TCCP _____ ?

How much have you worked with each of these projects?

TSMP

Weekly__ Monthly__ Quarterly__ Annually_____

Add specific working groups or committees

TCCP

Weekly__ Monthly__ Quarterly__ Annually_____

Add specific working groups or committees

1. Can you tell me about your involvement with VMMC services at this facility?

Probes:

How long has VMMC been offered here?

How long have you been offering VMMC yourself?

2. Tell me about what your community is hearing about VMMC?

3. Who is teaching and mobilizing the community for VMMC?

Probe for:

- *Maisha ni sasa (life is now)*
- *Wahi tohara (do circumcision fast)*
- *Pata kinga (be protected)*
- *Kuwa*
- *Msafi (get clean)*

4. What do you know that prevents men from wanting to get circumcised?

5. What can you tell me about the campaign messages, and the response from the clients on the campaign?

6. Which of the messages do you think have had the greatest influence on your clients?

7. What do your clients say about voluntary male circumcision?

8. What do you think has changed in the knowledge, behavior and attitudes of your clients about voluntary male circumcision?

9. What is being done to educate men about what to do after they are circumcised?

10. How often are you being asked to offer VMMC and how is the attendance?

11. What challenges do you face in the provision of voluntary male circumcision services?

12. What would have made the campaigns and products and product promotions even better?

Tool 6
TCCP AND TSMP PROGRAM
FGD BEAUTY SALON AND COMMUNITY RESOURCES AGENTS

Date:
 Start time _____ End time: _____
 Region:
 District:

Interviewer code: _____

<u>Respondent S/N</u>	<u>Gender</u>	<u>Age</u>	<u>Type of Respondent</u>

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USAID will soon be planning new projects to take over the work of these two projects, so our evaluation of their performance and recommendations will be referred to in planning the new project. USAID is interested in what would be the most effective way to use those projects to

have an impact on health in Tanzania in the areas of HIV, maternal neonatal and child health, family planning and sexual and reproductive health, and malaria.

We understand that you have interacted these projects in some way.

1. I'd like to hear from you all what sorts of TV shows, radio shows, advertisements, brochures and other things this community has seen or heard that has to do with HIV

Probe for Tuko wangapi, Tulizana

How about family planning?

Probe for Jiamini and Nyota ya Kijani

How about mother and child health?

Probe for Wazazi Nipendeni

What about Malaria?

Probe for Sio kila homa ni malaria

What about condoms?

Male Condom: Dume, Salama

Female Condom: Lady Pepeta, Care

2. Ok, some of you have heard of (name campaign or product).....what did that show tell you about?

3. Who did you think that show or product was meant for? A city woman? A small girl? An old man?

Probe: How have other members of the community responded?

4. What did the advertisement or show or tell people to do?

- a. Probe: did you do it?

- b. What have you seen other people do differently in response to the calls to action?

5. What do you find difficult about doing what the message tells you to do?

6. How well did the campaign do in getting people to prevent HIV, or use FP, or prevent malaria?

Probe for themselves and the community in general.

Probe for the method used—is TV the best way? Radio? Face to face?

7. What have you heard about what pregnant women who have HIV are supposed to do to keep healthy and protect their babies? Has anything changed lately, and if so, how is the community reacting? What have you heard from pregnant women in the community?

8. What good things are supposed to happen for you or other community members if you follow what the campaign or show told you to do?

9. I understand that you have all gotten some training on these topics, but I want to confirm that, so let me ask you: Were you trained on how to mobilize the community or provide the education on
- HIV prevention
 - Family planning
 - Malaria prevention, health-seeking behavior, net use and adherence to medicine
10. How do you provide the health education?
What methods do you use?
- Probe for *face-to-face intervention (HBC), community discussion, public meetings*
11. What was the community reaction from the education provided?
Probe for community awareness of the product
- *Product utilization—female and male condoms, oral contraceptives (Flexi P and Familia)*
 - *ANC Attendance, HIV testing, malaria testing before treating, net use*
 - *Probe—are more women coming to ANC early, more people going for HIV testing, more using bed nets, more getting malaria tests before getting treated, more using condoms.....*
12. What is difficult about providing the health education to your clients and community? What would make it easier?
13. What do you think your community needs in order to be healthier in these areas—HIV, FP, malaria, mother and child health?

Tool 7

Structured Key Informant Interview Guide TCCP Project Staff Evaluation

Interviewee Name
Title
Organization
Place/District/Region
Date
Interviewer

INTRODUCTION

Good morning/afternoon. As you know, as part of the team's evaluation of TCCP, we have interviewed many people from the MOHSW, U.S. Government implementing partners, community groups, media partners, regional TCCP staff, and others in Iringa, Njombe, Mwanza and Dar es Salaam about the performance of the TCCP project over the past five-plus years.

We have learned about the work you have doing, perceptions of the value of that work, suggestions for improvements, and recommendations for the follow-on USAID project or projects for JHU-CCP's TCCP.

The stated goal of this project is to increase the adoption of safer behaviors by Tanzanian adults and high-risk populations (adults and youth) to prevent or manage HIV infection; support the uptake of family planning to reduce unmet need; address maternal, newborn, and child health issues; and address other health issues.

Objectives in support of this goal were to: (1) execute evidence-based, coordinated social and behavior change communication (SBCC) initiatives at scale; (2) facilitate coordination of social and behavior change communication at the national, regional and district levels; and (3) measurably transfer social and behavior change communication skills to Tanzanian individuals and institutions. TCCP's areas of focus include HIV, family planning and reproductive health, maternal and child health and malaria.

To begin with, please describe your role on the project, how long you have been in this role, as well as any other roles you have held.

- 1. What are the most important two or three things that you think the evaluation team should know about what the TCCP project has been doing in Tanzania since the project began?**
- 2. What do you think have been the most important outcomes of TCCP's work?**
 - Probe for *specific* outcomes in each area—HIV, MNCH, Malaria and FP/SRH outcomes.
- 3. Could you share with us TCCP's experience in regards to the implementation of SBCC at different levels (national, regional, district and community) and if at all there is anything that you would have done differently?**
 - Probe for IPC.
 - Probe for work with NGOs, CBOs.

- 4. What has TCCP learned about strategic behavior change communications programming in Tanzania over the past five years?**
 - *SBCC related to the areas of HIV, FP/SRH, MNCH and malaria*
- 5. Please describe the project's work in capacity building?**
 - *Major goals of the capacity building?*
- 6. People spoken with from the field have raised concerns about the way JHU-CCP has provided oversight over the ACE program. The responses depict lack of coordination and communications between JHU-CCP, the host organization and mentors. What do you have to say about this critique?**
- 7. What have been the major challenges to the project's work? And what did the project do to overcome these challenges?**
- 8. What would have made the project more successful in the following areas? (Include both resources as well as technical and programmatic strategies)**
 - *In meeting behavior change goals?*
 - *Building local capacity? (ACE, institutions, RDL)*
 - *Coordinating the work across levels, offices and partners?*
 - *Any way in which collaboration with PSI could have been different?*
- 9. What are the areas in which the project did not reach its objectives? (Probe for reasons)**
- 10. What internal factors have influenced the project's ability to achieve its objectives?**
- 11. What external factors have influenced the project's ability to achieve its objectives?**
 - *Probe for USAID communications and direction from them*
- 12. How would you summarize the legacy of the project after five years?**
- 13. Is there anything else you want to tell the evaluation team about TCCP?**

Tool 8

Focus Group Discussion for Ace Mentors, Fellows, Interns, LSHC Alumni Graduates

Interviewee Name
Title
Organization
Place/District/Region
Date
Interviewer

INTRODUCTION

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We would like to hear from this group what your experience has been with what TCCP is offering in Tanzania to improve SBCC capacity.

Try to get answers to questions 1-3 before the group starts.

- 1. Which organizations do you currently work for?**
- 2. What has been your participation in a TCCP program?**
- 3. What was that program all about?**
Probe: how long did it go?
- 4. What do you see as the major needs for health behavior change in the groups that you work with?**
- 5. What made you decide to participate in the program?**
- 6. What has been your work in Social and Behavior Change Communication (SBCC) before you participated in the TCCP program?**

- 7. Please tell me what the ACE program is all about.**
- 8. What did you learn on SBCC that you did not know before?**
- 9. What approaches has TCCP used to build your capacity in SBCC?**
Probe: Which of these have helped you the most?
- 10. What are you able to do today that you could not do before the ACE program?**
- 11. What challenges did you face during the training?**
- 12. Are there areas in SBCC that you would have liked to have seen covered that were not covered in the LSHC?**
- 13. What are your recommendations for making the TCCP activities to build SBCC capacity more effective?**
- 14. What challenges did you face during the training?**
- 15. What are your recommendations for making the LSHC program more effective?**

Tool 9

FGD for Radio Distance Learning (RDL) Participants

Interviewee Name
Title
Organization
Place/District/Region
Date
Interviewer

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We would like to talk you about the Radio Distance Learning (RDL) that you have participated in.

- 1. Let's hear from the group about the organizations you work with and what you were doing in social and behavior change communications before you began participating in RDL.**
- 2. Now let's hear how you would describe what RDL is all about.**
Probe: What it means be a community volunteer? Probe what they do, who they work with and area of focus. How one gets recruited into RDL?
- 3. Now, let's hear from each other about what you've learned from RDL and what difference it has made in how you work on SBCC in communities.**
Probe: areas where they feel the most confident and areas where they feel they need to build their skills further.
- 4. What about the way TCCP worked with you—what did you find most and least useful?**
- 5. What else do you want to get from TCCP in terms of your capacity in SBCC as a volunteer?**

- 6. What did you find to be most challenging in your efforts to increase your skills in SBCC using RDL?**
- 7. What do you want to tell TCCP about what you hope they will do in the future to improve the capacity of other community volunteers?**

ANNEX VI: DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Mary Lyn Field-Nguer

Digitally signed by Mary Lyn Field-Nguer
DN: cn=Mary Lyn Field-Nguer, o=, ou=, email=MFELDEMAIL@GMAIL.COM, c=US
Date: 2015.06.07 17:14:24 -0400

7 June 2015

Signature

Date

Name Mary Lyn Field-Nguer

Title Team Leader/HIV Specialist

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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Signature	Date
	13/12/2014
NEEMA FRITZ MATEE	
Name	Title RESEARCH ASSISTANT

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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12/05/2014

Signature

Date

Kennedy Musonda

Independent Consultant

Name

Title

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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ACCEPTANCE

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Signature 

Date 31.01.2015

Name MARTEMBA ALEX MWITA

Title MALARIA TECHNICAL
ADVISOR

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
- (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me;
 - (ii) becomes available to me in a manner that is not in contravention of applicable law; or
 - (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature

Date 28/02/2015

DR. DODAIJI MUMGIZI
Name

MEDICAL DOCTOR / RESEARCH CONSULTANT.
Title

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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ACCEPTANCE

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Signature

Rose Ernest

Date

14/01/2015

ROSE ERNEST

Name

Title Research Assistant

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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ACCEPTANCE

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Signature

Date 26/02/2015

FREDERICK E. RUTAHINDA

Name

Title SOCIAL SCIENTIST

Global Health Program Cycle Improvement Project

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